The German Health Care System: An Introduction

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• General characteristics, reforms and decision-making
• Pharmaceutical assessment and pricing
• Physician payment
• Hospital payment (DRGs)
• Long-term care
The German system at a glance (2011)

**Third-party payers**

- Ca. 150 sickness funds
- Ca. 45 private insurers

**Choice of fund/insurer**

- Uniform wage-related contribution + possibly additional premium (set by sickness fund), Risk-related premium
- Choice of fund/insurer

**Providers**

- Public-private mix, organised in associations
- Ambulatory care/ hospitals

**Population**

- Universal coverage: Statutory Health Insurance 86%, Private HI 10%

**Collector of resources**

- Health fund

**Strong delegation**

- Contracts, mostly collective
- No contracts

"Risk-structure compensation"
German healthcare system overview

Key characteristics:

a) Sharing of decision-making powers between the sixteen Länder (states), the federal government and statutory civil society organizations
   i.e. important competencies are legally delegated to membership-based, self-regulated organisations of payers and providers

b) Statutory health insurance (SHI)
   SHI Cornerstone of health service provision is the Fifth Book of the German Social Law (SGB V)
   i.e. it organizes and defines the self-regulated “corporatist” structures and give them the duty and power to develop benefits, prices and standards
Key characteristics:

c) Sectoral borders

SGB V separates the provision of outpatient and inpatient services. Planning, resource allocation and financing are undertaken completely separately in each sector.

- Complicates the provision of health care delivery (e.g. communication)
- Increases the amount of specialists
- Increases the health care expenditure
### German healthcare system: key characteristics

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<tbody>
<tr>
<td><strong>Compulsory insurance</strong></td>
<td>... in the old times</td>
<td>Mandatory only for employed/pensioners/unemployed up to certain income</td>
<td>Universal coverage in SHI (or PHI)</td>
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<tr>
<td><strong>Choice between SHI and PHI</strong></td>
<td>For employed above certain income within 1 year</td>
<td>... for 3 years</td>
<td>... within 1 year</td>
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<tr>
<td><strong>Choice of SHI fund</strong></td>
<td>For employed above certain income</td>
<td>For most insured (97%)</td>
<td>For all insured except farmers</td>
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<tr>
<th>Financial contribution</th>
<th>Contribution rate differing among sickness funds</th>
<th>Uniform rate plus possibly add’l premium set by sickness fund</th>
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<tr>
<td></td>
<td>Actual amount capped at 1%</td>
<td>Average amount capped at 2%</td>
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In the old times

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## German healthcare system: key characteristics

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<tr>
<td>None; pooled expenditure for pensioners</td>
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<td></td>
<td>Risc structure compensation based on age and sex</td>
<td>+ DMPs as criterion &amp; high-cost pool</td>
<td>+ morbidity from 80 diseases</td>
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</tbody>
</table>
- Total expenditure 2008: €263 bn or €3200 per capita
- % of GDP for health care in 2008: 10.5%, 2009 probably >11%, 2010 ca. 11%
- Main blocks (2008): 57.5% SHI, 9.5% private insurance, 13.4% out of pocket
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem

How can we predict who these 5 or 10% are?
What constitutes a disease for the Risk Structure Compensation?

Scientific Expert Committee

- Diabetes mellitus 2 with severe complications
- Myocardial infarction/instable angina pectoris
- Bleeding in early pregnancy

Final version (Federal Insurance Authority)

- Diabetes mellitus 2
- Coronary heart disease
- Pregnancy
- Iatrogenic complications
- Hypertension

Disease?

Incentives?

Well defined? 20% of all insured!
Monthly deductions/ surcharges
for age and sex 2009 (from mean of € 186)

For a healthy
(none of the 80 diseases)
30-year old
male:
< €40/ month!

For a healthy
(none of the 80 diseases)
85-year old
female:
€205/ month!
### German healthcare system: key characteristics

<table>
<thead>
<tr>
<th>... in the old times</th>
<th>Cons.-lib.</th>
<th>Red-green</th>
<th>Grand coalition</th>
<th>Cons.-lib.</th>
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<td>2009</td>
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<tr>
<td>Contents of benefit package</td>
<td>Relatively uniform but freedom for additions by sickness funds</td>
<td>Dental care for adults excluded (until 1999)</td>
<td>Palliative care incl.; OTC drugs excl.</td>
<td>Almost uniform (only 0.7% of exp. for additions by sickness funds)</td>
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<tr>
<td>Decisions on benefits</td>
<td>Sectoral decisions</td>
<td>G-BA responsible across sectors</td>
<td>Not evidence-based</td>
<td>HTA for ambulatory services</td>
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<td></td>
<td>Drug benefit eval.; IQWiG founded</td>
<td>+ Cost-benefit assessment of drugs</td>
<td>+ early benefit evaluation of all new drugs</td>
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<td>German healthcare system: key characteristics</td>
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<tr>
<td>Contributions are determined by employing companies</td>
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<td>assessment of drugs</td>
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- **Selective contracts for integrated care (2000); financially incentivized 2004-08, but only ~0.3% of total expenditure**
- **Mergers between different fund types allowed; sickness fund associations → Federal Association (2008)**
- **No claim bonus, deductibles, additional benefits ... in SHI insurance allowed**
More competition in health care produces foremost more needs-based equity, better [quality], higher [efficiency], reduced costs and [less bureaucracy].

To achieve this, the idea of competition has to become stronger in all sectors of health care: among [sickness funds], among the providers of services, and between sickness funds and [providers] – physicians and hospitals.

In a healthy competition, the sickness funds compete to offer the best quality at the best possible price. The sickness funds have various possibilities to improve the quality of their offer beyond the statutory [benefit basket], e.g. in the form of [integrated (NB: selective) care contracts] or with optional tariffs (NB: e.g. no-claim bonuses, deductibles).

SOURCE: MY OWN TRANSLATION OF THE GERMAN MoH WEBSITE; NBs ADDED.
Decision-making in the German Statutory Health Insurance

Parliament

Federal Ministry of Health

Legislation

Supervision

Patient

Free choice

150,000 ambulatory care physicians and psychotherapists

Federal Association of SHI Physicians (KBV)

150 sickness funds

Federal Association of Sickness Funds

German Hospital Federation (DKG)

2,100 hospitals

Statutory Health Insurance (85% of population covered)

Federal Joint Committee (G-BA)

Members: 13 voting – 3 neutral + 5 sickness funds + 5 providers (+ up to 5 patient representatives)
**Objectives of Federal Joint Committee**

- Main functions: to regulate SHI-wide issues of access, benefits and quality (and not primarily of costs or expenditure).
  - Normative function of the G-BA by legally binding directives ("sub-law") to guarantee equal excess to necessary and appropriate services for all SHI insured.
  - Benefit-package decisions must be justified by an evidence-based process to determine whether services, pharmaceuticals or technologies are medically effective in terms of morbidity, mortality and quality of life.
  - By law, evidence based assessments can only be used to select the most appropriate (efficient) service etc. from others – not to prioritize among service areas: if a costly innovation has a significant additional benefit, the sickness funds must pay for it.
Federal Joint Committee: preparation of decisions

Decisions are prepared by 8 sub-committees:

• Pharmaceuticals
• Quality Assurance
• Cross-sector Care (especially disease management programs)
• Methodological Evaluation (inclusion of new ambulatory care services in benefit basket; NB: in hospitals, services can only be excluded)
• Referred Services (rehabilitation, care provided by non-physicians, ambulance transportation etc.)
• Needs-based Planning (ambulatory care; NB: hospital capacities are planned by state governments)
• Psychotherapy
• Dental Services
Federal Joint Committee: support through institutes

Parliament

Federal Ministry of Health

Legislation

Supervision

Patient

150,000 ambulatory care physicians and psychotherapists

Federal Association of SHI Physicians (KBV)

German Hospital Federation (DKG)

2,100 hospitals

150 sickness funds

Federal Association of Sickness Funds

Statutory Health Insurance

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Market authorization

- t0: Manufacturer sets price
- t0: Immediately prescribable (SHI covers fully)
- tx1: Doubts about additional benefit → IQWiG evaluation: additional benefit/ comparative effectiveness
- tx2
- tx3
- tx4: Additional benefit
- ty1: Doubts about cost-effectiveness → IQWiG cost-effectiveness evaluation
- ty2
- ty3
- ty4: Maximum reimbursement price

Doubts about cost-effectiveness → IQWiG cost-effectiveness evaluation

No additional benefit

Reference price

Maximum reimbursement price
Pricing and reimbursement of (new) drugs in Germany (from 2011; simplified)

**Market authorization**

- **t0** Manufacturer sets price
- **t0** Immediately prescribable (SHI covers fully)
- **t0** Dossier by manufacturer

**IQWiG evaluation: additional benefit/ comparative effectiveness**

- IQWiG Institute for Quality and Efficiency in Health Care

**Negotiation manufacturer & Fed. Ass. Sickness Funds**

- Additional benefit
- No add’l benefit
- Reference price

**Mediation Committee**

- Mediation
- Objection

**Reimbursement price**

- (valid from t13)

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<thead>
<tr>
<th></th>
<th>Primary care</th>
<th>Ambulatory secondary care</th>
<th>Inpatient care</th>
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<tbody>
<tr>
<td>France</td>
<td></td>
<td>(Primarily) Office-based specialists</td>
<td>Hospitals</td>
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<tr>
<td>Germany</td>
<td></td>
<td>Office-based based specialists</td>
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<tr>
<td>Netherlands</td>
<td>Office-based GPs</td>
<td>Outpatient departments: hospital-based specialists</td>
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<tr>
<td>England</td>
<td>GPs in out-patient dep’ts</td>
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<tr>
<td>Sweden</td>
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<td>GPs in out-patient dep’ts</td>
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Physicians in all countries are dissatisfied with their income – even the specialists in the Netherlands (7.6 x average income)
Traditional forms of paying GPs (until early 2000s)

France: FFS
Germany: FFS (regionally capped)
Netherlands: PHI: FFS
England: Capitation
Sweden: Salary
The apparent answer: “Blended payment” – but maybe you are as confused as I am what it is …

- Basically, I see two variants
  1. using different forms of payment on different levels, e.g. payer → all physicians in one area or in one institution vs. institution → individual physicians
  2. combining different forms of payment on one level (and there could be a combination of the two)
Main reforms in GP payment

- **England 2004**: new GP contract introduces (1) opt-out or FFS for “enhanced“ services and (2) quality bonus for reaching targets (“quality and outcomes framework“)
- **France**: on top of FFS (1) small lump sums for coordinating chronically ill patients (ADL; 2004) and (2) quality bonus for reaching targets or above-average improvement (2009)
- **Germany 2002**: GPs are paid small lump sums for activities under disease management programmes; 2009: (1) capitation payments → physicians associations based on actual “need“ (actually utilisation) and (2) separation of basic and additional services with separate FFS caps ensuring full FFS payments for services within caps
- **Netherlands 2006**: merger of SHI and PHI leads to new GP payment system consisting of capitation plus fee-per-visit
- **Sweden 2007**: starting in Halland county, a move towards additional private office-based GPs competing with public health centers → necessitates money-follows-patient payments
Germany – the ambulatory care sector

ca. 135,000 physicians, of which 120,000 self-employed

- ca. 73,000 single-handed practices (78%)
  - ca. 73,000 physicians (55%)

- ca. 19,000 group practices (20%)
  - ca. 45,000 physicians (40%)

- ca. 1,500 health centers (2%)
  - ca. 6,000 physicians (5%)

Mandatory membership in 17 regional associations
Germany – 2-step payment of physicians

Sickness fund X

Sickness fund Y

Capitation based on previous year’s utilisation, increase factor, adjustments

Sickness fund Z

Physicians‘ association (KV)

GP budget (ca. 1/3)

Specialists‘ budget (ca. 2/3)

FFS up to specialty-specific case-volume age-based caps for basic (RLV) and groups of special services (QZV)

GP 1

GP 2

GP 3

Spec1

Spec2

Spec3
## Physician payment (with innovations)

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<th>England</th>
<th>France</th>
<th>Germany</th>
<th>Netherlands</th>
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<tr>
<td><strong>GPs</strong></td>
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<tr>
<td><strong>FFS</strong></td>
<td>for enhanced services (if contracted with PCT)</td>
<td>for self-employed GPs</td>
<td>for self-employed GPs up to case-volume age-based caps (RLV/ QZV)</td>
<td>Consultation fees</td>
</tr>
<tr>
<td><strong>Capitation/lump sum</strong></td>
<td>per patient for essential services; fixed allowance for costs related to setting up or maintaining practices</td>
<td>Lump sum for management of patients with long-term-diseases (ADL) and involvement in provider network</td>
<td>Lump sum for involvement in Disease Management Programs (DMP)</td>
<td>per year and registered patient</td>
</tr>
<tr>
<td><strong>Quality-related adjustments</strong></td>
<td>QOF; new P4P contracts for GPs</td>
<td>For individual contracts for practice improvement</td>
<td>--</td>
<td>As a pilot model</td>
</tr>
<tr>
<td><strong>Salary</strong></td>
<td>GPs working in hospitals, in service of a GP practice or PCT</td>
<td>GPs working in hospitals, in service of a GP or in health centers and preventive and social services</td>
<td>GPs working in hospitals, in service of a GP or in health care centers</td>
<td>GPs working in service of a GP practice or in primary care centers</td>
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### Specialists

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<th>England</th>
<th>France</th>
<th>Germany</th>
<th>Netherlands</th>
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<tbody>
<tr>
<td><strong>FFS</strong></td>
<td>For work in private practice (i.e., not within NHS)</td>
<td>For self-employed specialists (including specialists practicing in private for profit clinics)</td>
<td>for self-employed specialists up to case-volume age-based caps (RLV/ QZV)</td>
<td>75% of specialists (i.e., working independently in hospitals) as part of DBC payment</td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
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<tr>
<td><strong>Quality-related adjustments</strong></td>
<td>New contracts for specialists; Clinical Excellence Awards</td>
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<tr>
<td><strong>Salary</strong></td>
<td>Physicians working under the NHS contract</td>
<td>Specialists working in hospitals</td>
<td>Specialists working in hospitals</td>
<td>25% of specialists working in hospitals</td>
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<td></td>
<td>Halland</td>
<td>Stockholm</td>
<td>Västmanland</td>
<td>Region Skåne</td>
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<tr>
<td><strong>FFS</strong></td>
<td>Different fee per visit for registered patients and for other patients</td>
<td>Fee per visit for all patients (and reduced payments above a volume-ceiling for registered patients)</td>
<td>Different fee per visit for registered patients and for other patients</td>
<td>Fee per visit for not-registered patients</td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
<td>for registered patients based on four age-groups</td>
<td>for registered patients based on three age-groups</td>
<td>for registered patients based on four age-groups</td>
<td>for registered patients based on classification of diagnoses (80%) and socio-economic indicators (20%). Flat fee for drug prescription based on age and sex</td>
</tr>
<tr>
<td><strong>Quality-related adjustments</strong></td>
<td>Lump-sum penalty payment if non-compliance with drug recommendations</td>
<td>Increase or decrease of total payment up to 3% depending on performance, incl. drug recommendations</td>
<td>Bonus payment up to 2% of total payment depending on performance</td>
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<td>GPs working in hospitals, in service of a GP practice or in health care centers</td>
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Payment components in GP care

Objective:
- Appropriateness & outcomes
  - CAPI bonus
- Productivity & patient needs
  - Quality payment
  - Extra service payment
  - Basic service payment
  - ADL payment (France)
  - FFS (Germany, Netherlands, England, Sweden)
  - FFS with caps per service type (France)
  - "RLV" (capped FFS)
  - FFS (per visit & out-of-hours)
  - FFS ("enhanced services")
  - FFS (per visit)
  - Capitation

Objective:
- Admin. simplicity & cost-containment (& geogr. equity)
  - FFS (England, Sweden)
  - QOF bonus (England)
  - Bonus and/or Malus (Sweden)

France
- CAPI bonus

Germany
- Quality payment
- Extra service payment
- Basic service payment
- FFS
- Capitation

Netherlands
- QOF bonus
- Capitation

England
- Bonus and/or Malus
- Capitation

Sweden
- Bonus and/or Malus
- Capitation

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• **England**: sex and 7 age bands = 14 categories (1.0 = males 5-14 → 8.9 females 85+) *plus* adjustments for long-term illness and standardised mortality ratio *plus* adjustment for cost (GP, staff, land, buildings)

• **Germany**: based on actual utilisation in previous year

• **Netherlands**: 3 age bands plus deprivation in area = 6 categories

• **Sweden**: several age bands and/or morbidity factors (plus socio-economic factors)
For GP payment, countries are moving toward a “European model” consisting of:

1. **Capitation (inscription)/ capped FFS (visit-triggered)** to pay for providing basic services;  
   - 60%

2. **special lump sums** for specific patient groups (if capitation is not sufficiently risk-adjusted) + FFS for (potentially) underprovided services and/or requiring special expertise or technology;  
   - 20-30%

3. **quality-related bonus (or malus)** for (not) reaching certain targets.  
   - 10-20%
Range of activities and services in hospital sector

Pre-hospital care (GPs, Specialists)
- Referral by GP or specialist

Hospital Treatment
- Inpatient care
- Day-surgery
- Highly specialized care on in-and outpatient basis (e.g. Cystic fibrosis)

Post-hospital care (GPs, Specialists, Rehabilitation)
- Discharge to GP, specialist or rehabilitation
Aims of DRG introduction

- Achieving a more appropriate and fair allocation of resources by utilising DRGs instead of per diem charges
- Facilitating a precise and transparent measurement of the case mix and the level of services delivered by hospitals
- Increasing efficiency and quality of service delivery due to the improved documentation of internal processes and increased managerial capacity
- Cost containment based on LOS and bed capacity reduction
Operating costs

- Sickness funds negotiating activity based DRG budgets every year with every “planned” Hospital

- Budget over-run adjustment (hospital pays back):
  - 65% (standard DRGs), 25% (drugs, medical, polytrauma and burns DRGs), Negotiation for hardly predictable DRGs

- Budget under-run adjustment (hospital receives compensation):
  - 20% (standard DRGs)
Ten years of DRGs in Germany

<table>
<thead>
<tr>
<th>1) Phase of preparation</th>
<th>2) Budget-neutral phase</th>
<th>3) Phase of convergence to state-wide base rates</th>
<th>4) Discussion on Policy</th>
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<tbody>
<tr>
<td>2000-2002</td>
<td>Historical Budget (2003)</td>
<td>Hospital specific base rate</td>
<td>• Nationwide base rate</td>
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<td></td>
<td>Transformation</td>
<td></td>
<td>• Fixed or maximum prices</td>
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<tr>
<td></td>
<td>DRG-Budget (2004)</td>
<td></td>
<td>• Selective or uniform negotiations</td>
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<td>2003 - 2004</td>
<td></td>
<td>Statewide base rate</td>
<td>• Quality Assurance (adjustments)</td>
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<tr>
<td></td>
<td></td>
<td>15%</td>
<td>• Budgeting (amount of services)</td>
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<td></td>
<td></td>
<td>20%</td>
<td>• Dual Financing or Monistic</td>
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<td>2005 - 2009</td>
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<td>20%</td>
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<td></td>
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<td>20%</td>
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<td>2010 - 2014</td>
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<td>20%</td>
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<td>25%</td>
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</tr>
</tbody>
</table>

Statewide base rate:
- 15%
- 20%
- 20%
- 25%

Hospital specific base rate:
- 15%
- 20%

37 12 April 2011 LIF Seminar | Stockholm, Sweden
1) Phase of preparation

Ten years of DRGs in Germany

- **Health Policy**
  - Health Ministry (federal, state)

- **Administration**
  - Self-Administration (DKG, GKV, PKV)
  - Other Institutions (HTA, quality)

- **Consultation**

- **Development**

- **Goals and monitoring**

- **Forming a legal framework**

- **Contribution of expertise**

- **Technical management**

**G-DRG System**

- Variety of Institutions (Professional medical associations, industry groups)

- InEK (German DRG Institute)

- DIMDI (German Institute of Medical Information and Documentation)
1) Phase of preparation: Patient classification system

- **Case data**
  - (demographic and clinical characteristics)

- **Implausibility of major diagnosis, medical procedures, demographic characteristics etc.**

- **Error DRG**
  - Pre-MDC
    - MDC assign-ment based on major diagnosis
    - Pre-MDC process

- **MDC 1**
- **MDC 2**
- **MDC 3**
- **...**
- **...**
- **...**
- **MDC 23**

- **Major diagnosis**
  - + at least one surgical procedure
  - + no surgical procedure, but one other procedure being essential for the respective MDC
  - + no (essential) procedure for the respective MDC

- **Surgical Partition**
- **Other Partition**
- **Medical Partition**

- **Basis DRGs**
  - (G-DRG Version 2010 : n=594, including 6 Error DRGs)

- **n=294**
  - unsplit DRGs
  - Co-morbidity, medical procedures, age, clinical severity, complication, cause of hospital discharge

- **n=300**
  - split DRGs
  - Significant differences in resource consumption
1) Phase of preparation: Price setting mechanism

- Calculation of cost weights: Based on average costs of cases data sample:

<table>
<thead>
<tr>
<th>Year</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals participating in cost data collection</td>
<td>125</td>
<td>148</td>
<td>263</td>
<td>251</td>
<td>253</td>
</tr>
<tr>
<td>- excluded for data quality</td>
<td>9</td>
<td>0</td>
<td>38</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>- actual</td>
<td>116</td>
<td>148</td>
<td>225</td>
<td>218</td>
<td>225</td>
</tr>
<tr>
<td>- included university hospitals</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>- number of cases available for calculation</td>
<td>633,577</td>
<td>2,909,784</td>
<td>4,239,365</td>
<td>4,377,021</td>
<td>4,539,763</td>
</tr>
<tr>
<td>- number of cases used for calculation after data checks</td>
<td>494,325</td>
<td>2,283,874</td>
<td>2,863,115</td>
<td>3,075,378</td>
<td>3,257,497</td>
</tr>
</tbody>
</table>

- Cost weight of each DRG = Average costs of DRG inliers/Reference value
- Cost weight = 1 = average costs of all patients in Germany
1) Phase of preparation: Reimbursement rate and outliers

Revenues

Deductions (per day)

Short-stay outliers
Inliers
Long-stay outliers

Lower LOS threshold
Upper LOS threshold

Surcharges (per day)
Ten years of DRGs in Germany

<table>
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<tr>
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- Nationwide base rate
- Fixed or maximum prices
- Selective or uniform negotiations
- Quality Assurance (adjustments)
- Budgeting (amount of services)
- Dual Financing or Monistic

12 April 2011
2) Budget-neutral phase

Unit of reimbursement changed:

From:
2002  ➔  Reimbursement unit = per diem
To:
2004  ➔  Reimbursement unit = case (DRG)
Budget-neutral phase

Lead to a hospital specific base rate (historical Budget /Casemix)

Ex.: € 100 mn. Budget / 33 000 CM points = € 3030 Hospital specific base rate
### Ten years of DRGs in Germany

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</table>

*15 % 15 % 20% 20% 20% 20% 25% 25% 20% 20% 25% 20% 15 % 20% 15 %*
Phase of convergence

- **Losers**
  - 2004: -15% (of difference)
  - 2005: -20% (of difference)
  - 2006: -20% (of difference)
  - 2007: -20% (of difference)
  - 2008: -20% (of difference)
  - 2009: -25% (of difference)

- **Winners**
  - 2004: +15%
  - 2005: +20%
  - 2006: +20%
  - 2007: +20%
  - 2008: +25%
  - 2009: +25%

**Hospital-specific base rate**

**Statewide base rate**

**Reduction limit** (related to previous year’s budget)

- 2005: 1%
- 2006: 1.5%
- 2007: 2%
- 2008: 2.5%
- 2009: 3%
Phase of convergence: Changing cost weights

- Increased precision due to more cost weights
- Treatment costs were better reflected over time

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<tbody>
<tr>
<td>DRGs total</td>
<td>664</td>
<td>878</td>
<td>1082</td>
<td>1192</td>
<td>1200</td>
</tr>
<tr>
<td>Inpatient DRGs total</td>
<td>664</td>
<td>878</td>
<td>1077</td>
<td>1187</td>
<td>1195</td>
</tr>
<tr>
<td>Range of cost weights: min.-max.(rounded)</td>
<td>0.12 - 29.71</td>
<td>0.12 - 57.63</td>
<td>0.11 - 64.90</td>
<td>0.12 - 78.47</td>
<td>0.13 - 73.76</td>
</tr>
<tr>
<td>Day care DRGs total</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Supplementary fees</td>
<td>0</td>
<td>71</td>
<td>105</td>
<td>127</td>
<td>143</td>
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Ten years of DRGs in Germany

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Hospital specific base rate

- Nationwide base rate
- Fixed or maximum prices
- Selective or uniform negotiations
- Quality Assurance (adjustments)
- Budgeting (amount of services)
- Dual Financing or Monistic
Main facts

- Central role of self-governing bodies

- Data driven system with annual updates

- Detailed analysis of hospital costs

- Ten-year process of introduction
Strengths and weaknesses of the G-DRG system

<table>
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<th>Strengths</th>
<th>Weaknesses</th>
</tr>
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<tbody>
<tr>
<td>Transparency and documentation</td>
<td>No quality adjustments for reimbursement</td>
</tr>
<tr>
<td>Compliance of hospitals</td>
<td>No reflection of different input prices</td>
</tr>
<tr>
<td>Reimbursement tool</td>
<td>Uniform accounting system but no full sample of hospitals</td>
</tr>
<tr>
<td>Precision</td>
<td>Increasing complexity with number of DRGs</td>
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</table>
Burden of disability and dependency

2.25 million people in need of long-term care (2.5% of the population) in 2007

<table>
<thead>
<tr>
<th>Home care</th>
<th>Institutional care</th>
</tr>
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<tbody>
<tr>
<td>1.54 million recipients (68%)</td>
<td>709,000 recipients (32%)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Informal care</th>
<th>Professional care</th>
</tr>
</thead>
<tbody>
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<td>1.03 million recipients</td>
<td>504,000 recipients</td>
</tr>
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- **Informal care**: 61.8% Level I, 29.9% Level II, 8.3% Level III
- **Professional care**: 52.5% Level I, 35.4% Level II, 12.1% Level III
- **Provided by family & other non-professional caregivers**: 11,500 providers
- **Institutions**: 11,000 institutions

*1.5% not assigned

Source: Adapted from German Federal Statistical Office 2008b

12 April 2011
### Burden of disability and dependency

<table>
<thead>
<tr>
<th></th>
<th>€</th>
<th>Cash</th>
<th>Home</th>
<th>Inst</th>
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<tbody>
<tr>
<td>I</td>
<td>235</td>
<td>450</td>
<td>1023</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>440</td>
<td>1100</td>
<td>1279</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>700</td>
<td>1550</td>
<td>1550</td>
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</table>

- **Home care**
  - 1.54 million recipients (68%)
  - Care levels: 61.8%, 29.9%, 8.3%

- **Informal care**
  - 1.03 million recipients
  - Care levels: 52.5%, 35.4%, 12.1%

- **Professional care**
  - 504,000 recipients
  - Care levels: 35.7%, 42.3%, 20.5%

- **Provided by**
  - Family & other non-professional caregivers: 11,500 providers
  - Institutions: 11,000 institutions

*Source: Adapted from German Federal Statistical Office 2008b*
The Ageing Crisis: A Health Systems Response

The Objectives: To bring together high and mid level policy-makers in a stimulating environment to focus on ageing and what it means for health systems. Summer School draws on the latest evidence; a team of experts; the experiences of participants in practice; and a tradition of promoting evidence-based policy-making and fostering European health policy debate. It aims to raise key issues, share learning and insights and build lasting networks.

Approach: The six day course combines a core of formal teaching with a highly participative approach involving participant presentations, round tables, panel discussions and group work. There will be opportunities for participants to develop a concrete case study that cuts across themes and to engage in political dialogue at the opening session.

Accreditation: Summer School is accredited by the European Accreditation Council for Continuing Medical Education and participation counts towards ongoing professional development in all EU Member States.

Organization: Summer School is organized by the European Observatory on Health Systems and Policies and the Veneto Region of Italy, one of its partners.

Recent Summer Schools: have focussed on Human Resources for Health (2007), Hospital Re-engineering (2008) and Health Technology Assessment (2009), EU Integration and Health Systems (2010).
Presentation available at:

www.mig.tu-berlin.de

Visit also:

www.healthobservatory.eu