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Health care management in Germany

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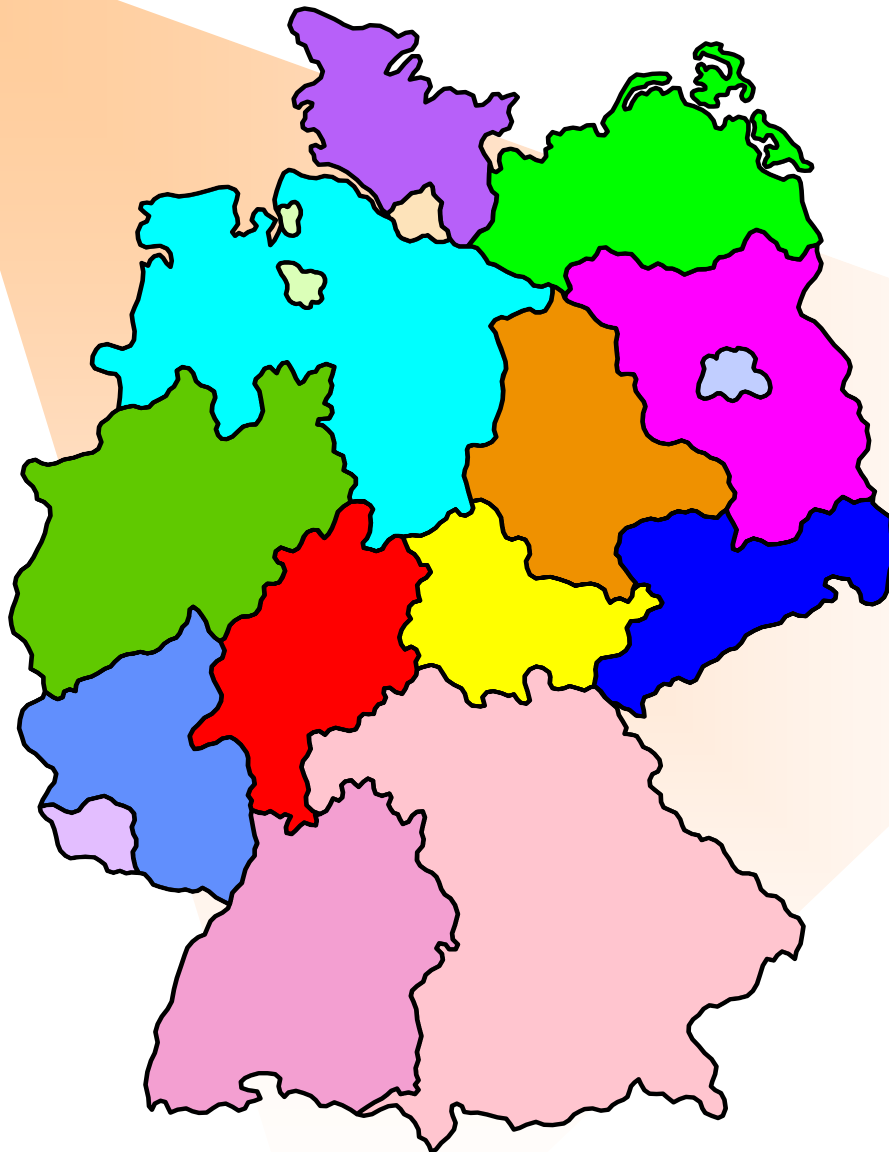
Outline

- Important characteristics of the German health care system
- In which places do we find persons with management responsibilities?
- Who are the people managing the various components of the system? What do they do? How are they qualified?
- What will change in the future?



1. Federalism,

German-style:

- Not devolved, but „bottom-up“
- Powers not explicitly given to the federal level remain with the „Länder“
- Länder have considerable power through Federal Council

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Third-party payer

= sickness funds
with self-government,
organised in associations

Not (health) risk-,
but wage-related
contribution

2. Strong delegation
& limited
governmental control

Contracts,
mostly collective

Choice of fund

Free access

Population

Statutory Health Insurance
compulsory for 75% + ca. 13%
voluntary members (9% private)

Providers

Public-private mix,
organised in associations

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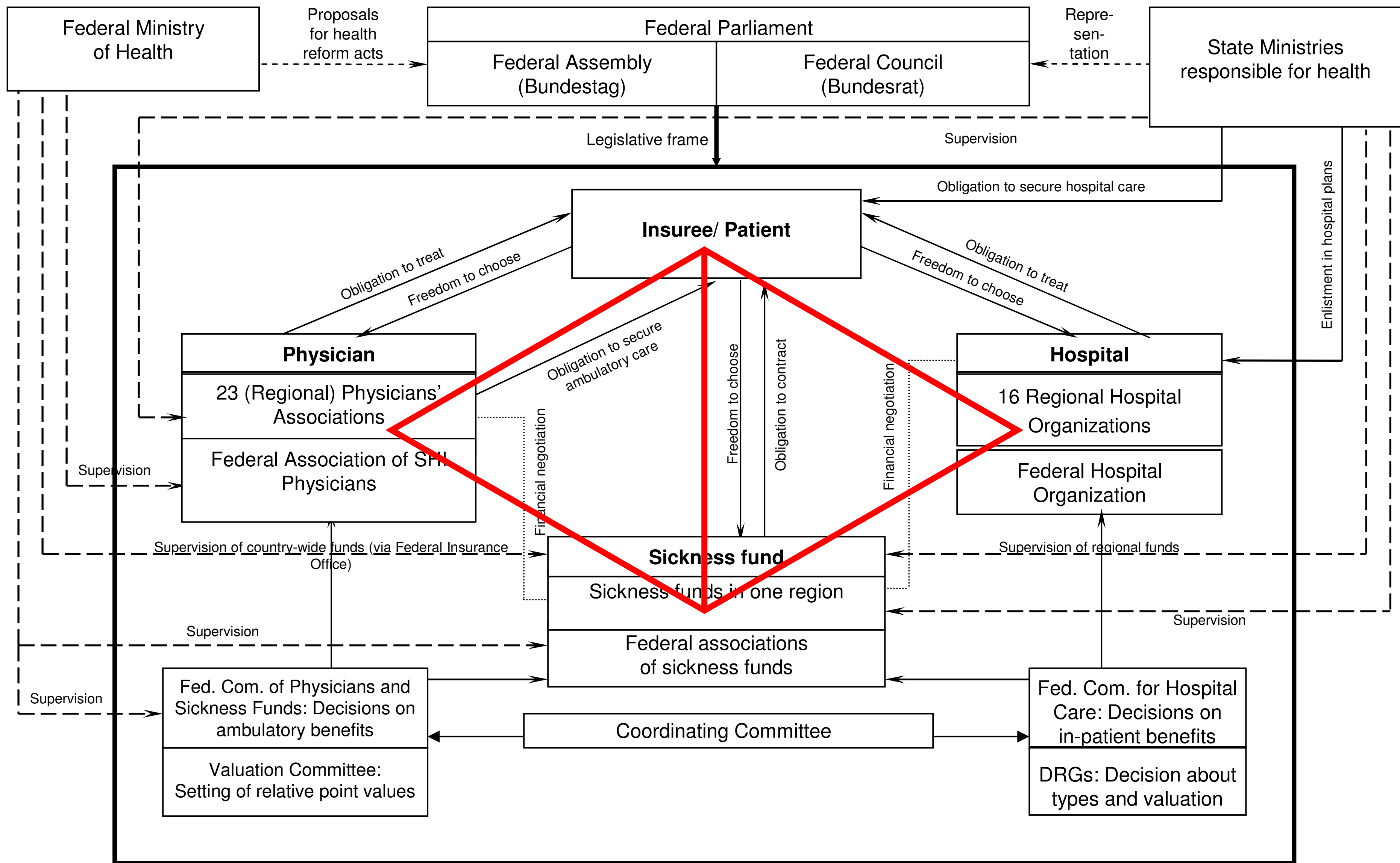
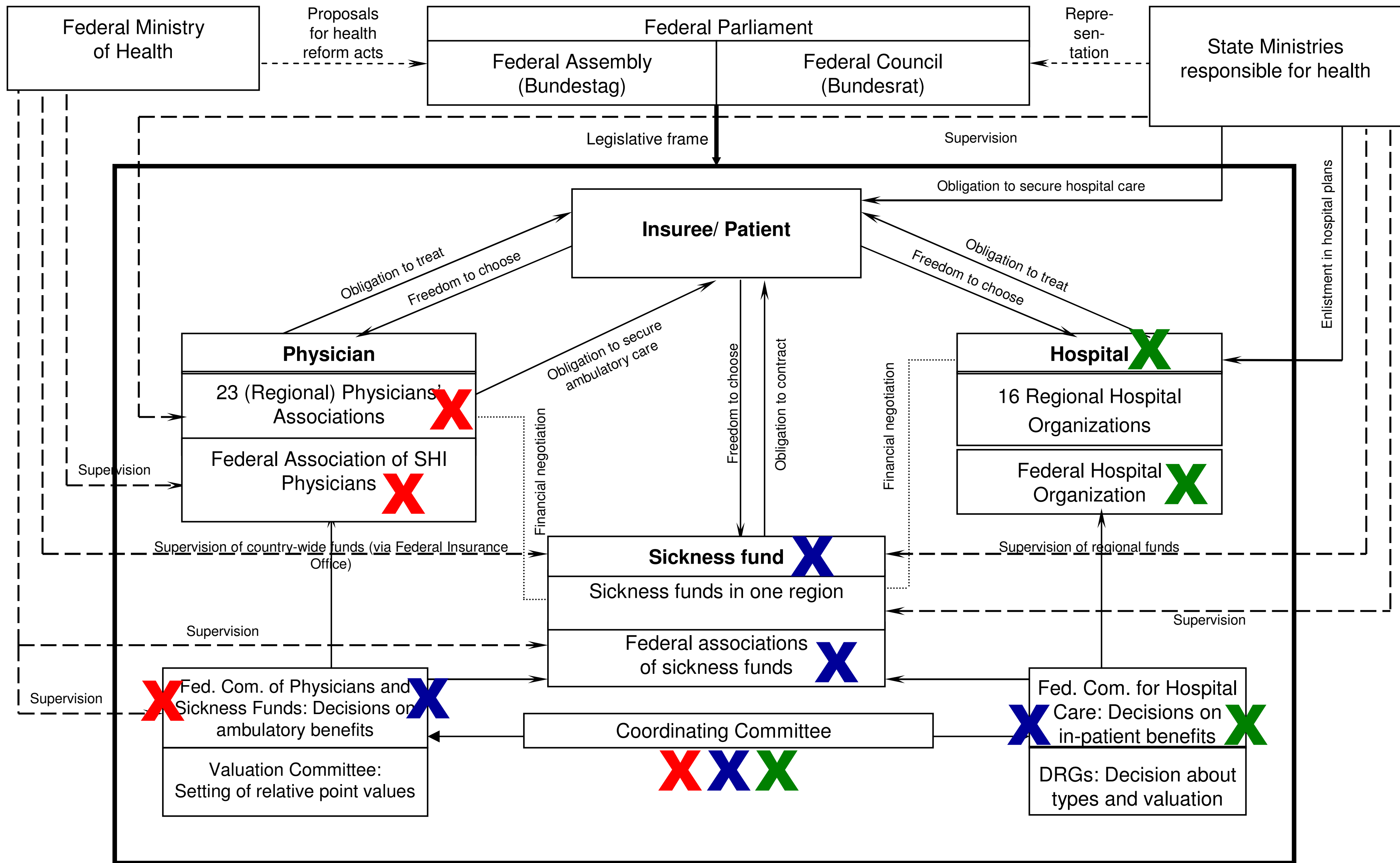


The Statutory health insurance sytem today

3. Strict separation between ambulatory and inpatient care



The Statutory health insurance sytem today

x = physician managers

x = hospital managers

x = sickness fund managers

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Physician managers

- 23 regional associations with compulsory membership of SHI-accredited physicians in ambulatory care
- + Federal SHI-accredited Physicians‘ Association
- run by physicians via indirect elections
- i.e. usually no management experience, only learning on the job
- “Managers“ (= elected physicians) try to shift blame for their decisions to politics, even though much decision-making powers are actually delegated to them

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Sickness fund managers I

- Fully until lay managers 1992 (proposed by trade unions and employers‘ associations)
- Since 1993 Health Care Structure Act: professional managers legally required, greater demands due to competitive environment, fewer sickness funds (>1200 in 1992, now ca. 320)
- No specific training, multitude of backgrounds

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Sickness fund managers II

Tasks, often competing

- *within individual sickness fund*:
  keeping budget in balance (if not: increase contibution rate); attract new/ keep members of sickness fund; in future contracting providers
- *within sickness fund association*:
  marketing for “brand“ (e.g. AOK, BKK); solidarity with funds in financial difficulties
- *within all sickness funds*:
  collective contracts with providers; participation in joint decision-making (e.g. on uniform benefit catalogue)

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Hospital managers I

- Traditionally *“triumvirate“* of medical director, nurse director and head administrator – all without particular management skills
- 1993 Act: abolishment of “full cost-cover principle“, i.e. risk of loss/ chance of profit
- Rapid increase in professional managers – due to new tasks, “functional privatisation“ (partly with out-sourced management) or “real privatisation“
- “New managers“ often have economic back-ground, are viewed with suspicion by physicians

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Hospital managers II

- Introduction of diagnosis-related groups (DRGs) for reimbursement from 2003/04 further increases management responsibilities (and privatisation)
- Managers try to “share“ management responsibilities by making head physicians (of each department) responsible for budgets etc.
- New health care management programmes focus particularly on this physician clientele

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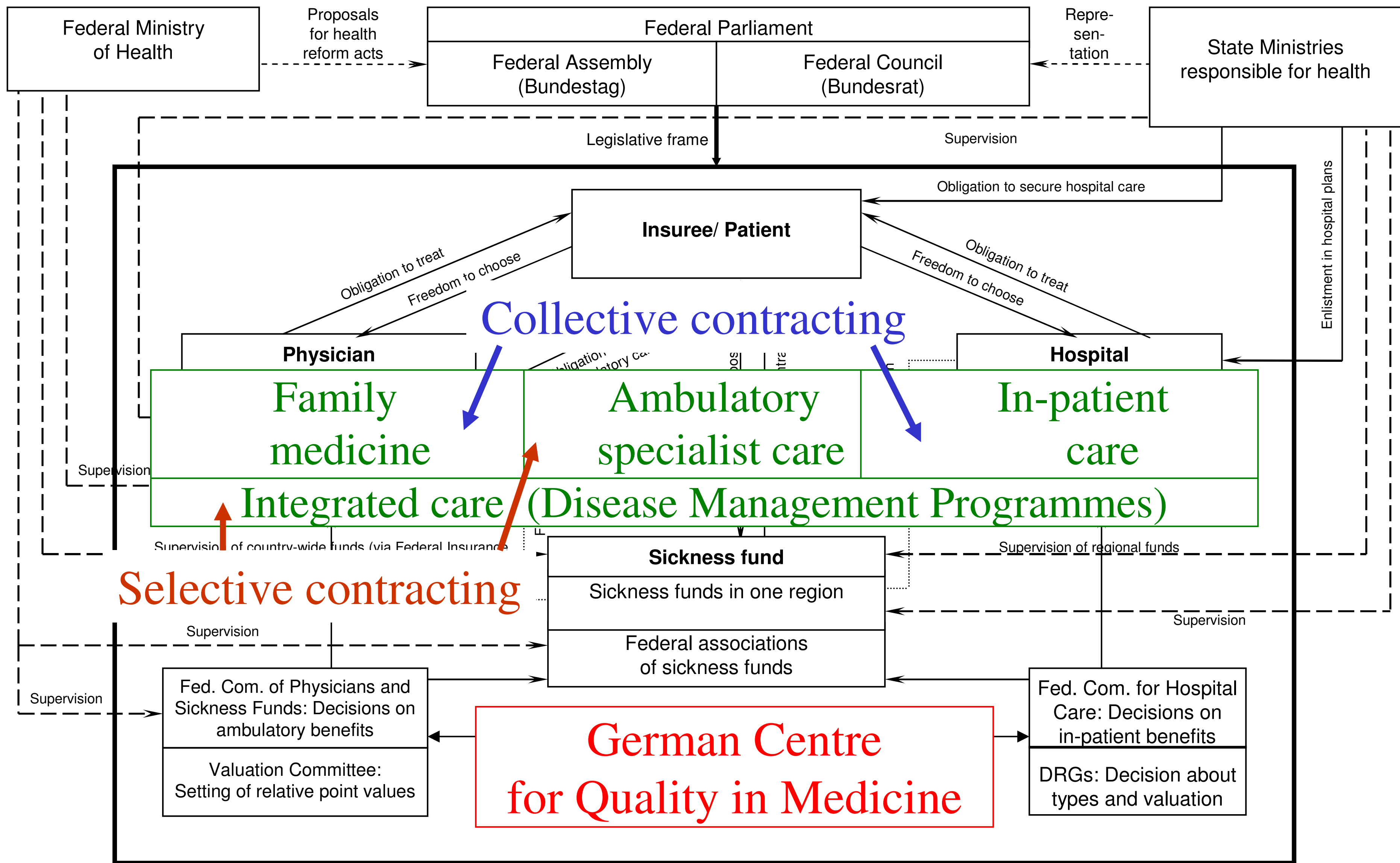

Proposed "Health Care System Modernisation" Act 2003

Consequences for management

- Fewer physicians associations with fewer rights but *professional* managers
- Negotiations between “physicians“ and “sickness funds“ = *manager-manager negotiations?*
- Selective contracting with specialists and integrated care arrangements will *increase power of – and demands on – sickness fund managers*
- Increasing role of the new public Centre for Quality will create a *new cast of managers*

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Full report available at: http://www.observatory.dk and http://mig.tu-berlin.de (as well as many other downloads)