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
Third-party payer

= sickness funds with self-government, organised in associations

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

Choice of fund

2. Strong delegation & limited governmental control

Free access

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

Providers
Public-private mix, organised in associations
3. Strict separation between ambulatory and inpatient care
The Statutory health insurance system today

X = physician managers  X = hospital managers  X = sickness fund managers
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
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
Sickness fund managers II

Tasks, often competing

• within individual sickness fund:
  keeping budget in balance (if not: increase contribution 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)
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 background, are viewed with suspicion by physicians
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
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*
Full report available at: http://www.observatory.dk and http://mig.tu-berlin.de (as well as many other downloads)