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Spotlight on innovation: Disease Management in Germany

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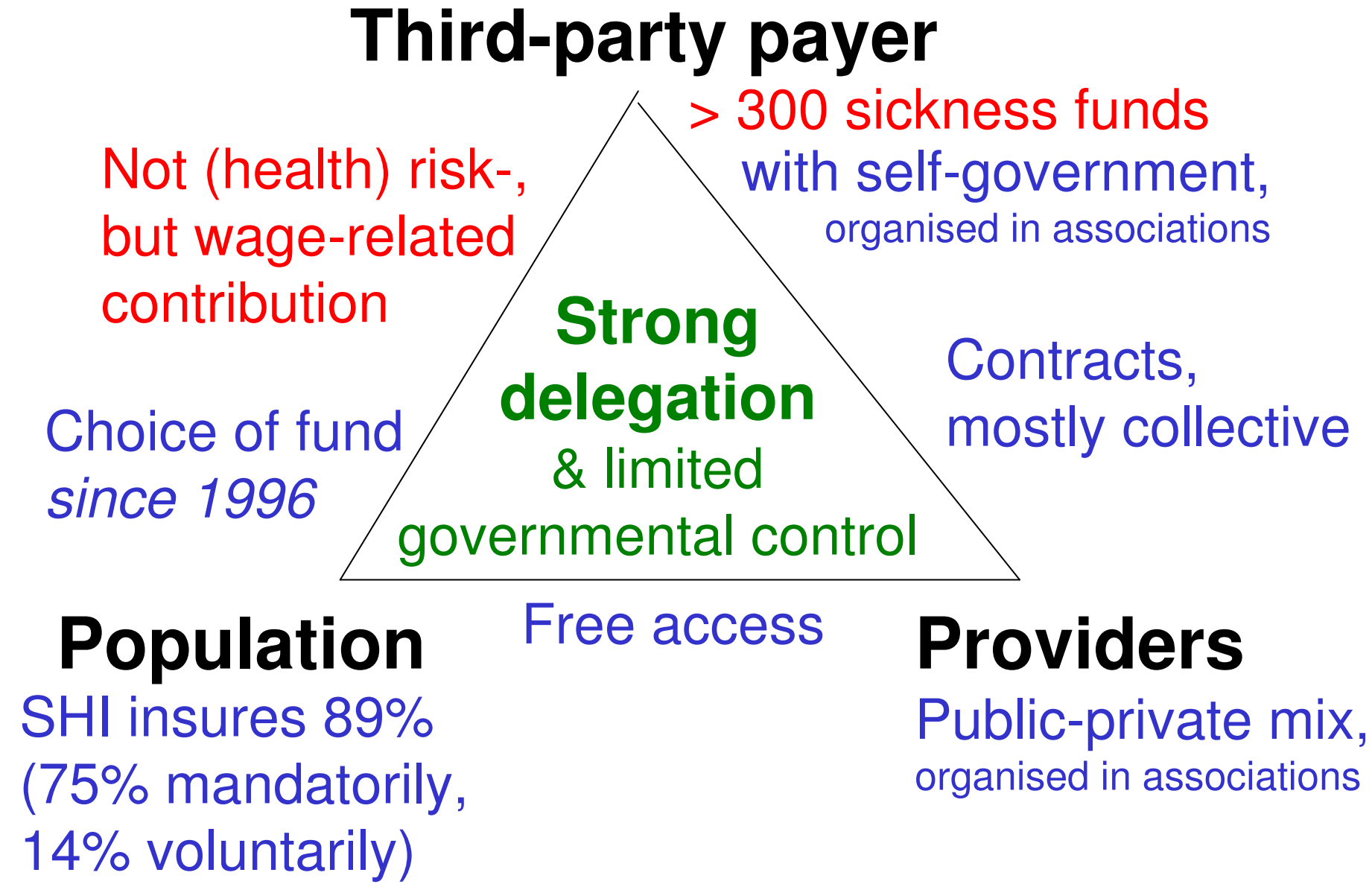
European Observatory on Health Care Systems

Surely a timely topic internationally ...

... but where is Germany?

The German system at a glance ...



Free choice among sickness funds is accompanied by "risk structure compensation" (RSC)

- sickness funds = contribution collectors + payers
- RSC compensates for contribution base (wages) of fund members and expenditure due to differences in sex, age, work incapacity
- RSC is based on average expenditure per age/sex/incapacity category and carried out by Federal Insurance Office

The risk structure mechanism (1998): standardised expenditure/ day (DEM)

	Men (West/ East)	Women (West/ East)	Incapacitated men (W/E)	Incapacitated women (W/E)
0 y.	17.34/ 20.08	15.33/ 16.90		
5 y.	3.72/ 4.07	3.01/ 3.26		
20 y.	3.44/ 3.26	5.21/ 4.80		
35 y.	4.59/ 3.98	7.31/ 5.53	53.60/ 23.92	52.32/ 22.13
50 y.	7.99/ 6.52	8.67/ 7.47	35.17/ 29.48	31.88/ 23.72
65 y.	16.78/ 13.88	13.42/ 13.00	32.73/ 30.04	30.25/ 24.48
75 y.	21.08/ 18.57	19.47/ 16.07	**Differences within age groups are larger than between age groups (and morbidity not captured)!**	
85 y.	25.46/ 2021	24.05/ 18.71		
90+ y.	28.46/ 19.63	25.52/ 18.19		

x 12

x 8

Problem 1:
As the younger and healthier move more often, the overall risk pool has further desegregated

Evidence 1A: RSC transfers have increased

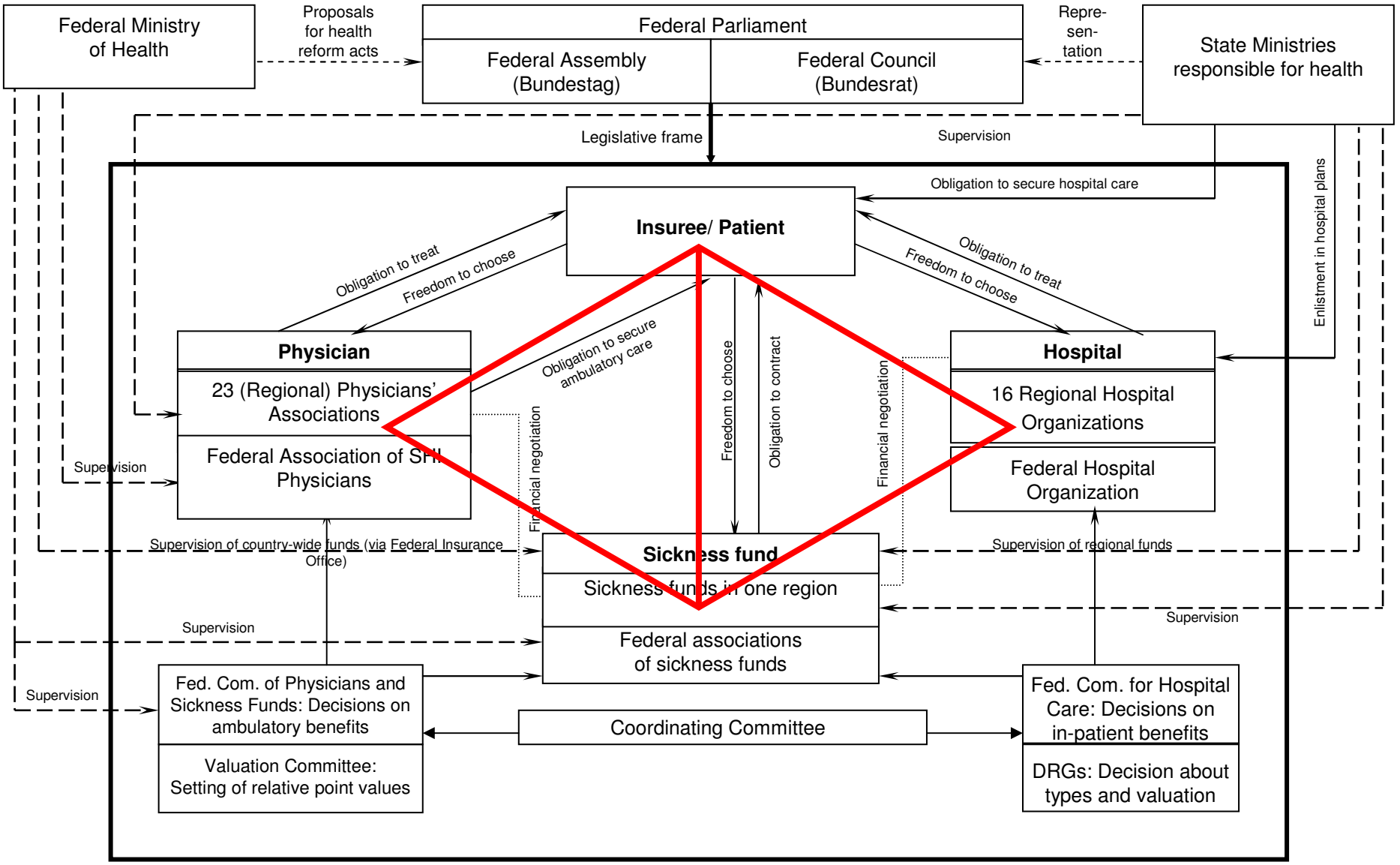
	West		East		Germany	
	RSC* / expenditure (billion Euro)**	**RSC as % of expenditure**	**RSC* / expenditure** (billion Euro)**	**RSC as % of expenditure**	**RSC* / expenditure** (billion Euro)**	**RSC as % of expenditure**
1995	6.90/ 97.29	7.1	2.36/ 19.70	12.0	9.23/ 116.99	7.9
1996	7.27/ 100.41	7.2	2.51/ 20.47	12.3	9.78/ 120.88	8.1
1997	7.71/ 98.23	7.8	2.63/ 20.05	13.1	10.34/ 118.29	8.7
1998	8.22/ 99.74	8.2	2.80/ 19.97	14.0	11.01/ 119.71	9.2
1999	8.30/ 102.68	8.1	3.29/ 20.52	16.0	11.60/ 123.21	9.4
2000	8.30/ 105.05	7.9	3.73/ 20.89	17.8	12.03/ 125.94	9.6
2001	9.09/ 108.89	8.3	4.43/ 21.75	20.4	13.52/ 130.63	10.3
2002	8.99/ 111.79	8.0	4.53/ 22.54	20.1	13.52/ 134.33	10.1

Evidence 1B:
Insured in fast growing sickness funds cause 20-30% lower than average expenditure

Sickness funds need to increase contribution rate

Membership of fund 1995-1999	Number of insured in 1999 (x 1,000)	Expenditure in relationship to standardised expenditure in 1999 (%)	
		Drugs	Hospitals
Decreasing/ stable	48,356	101.0	102.8
Growth up to factor 2	19,768	97.7	92.0
Growth factor >2 to 5	765	88.3	83.5
Growth factor >5 to 10	284	80.8	79.5
Growth factor >10 to 20	127	81.9	75.0
Growth factor >20	422	79.5	70.3

Sickness funds can lower contribution rate

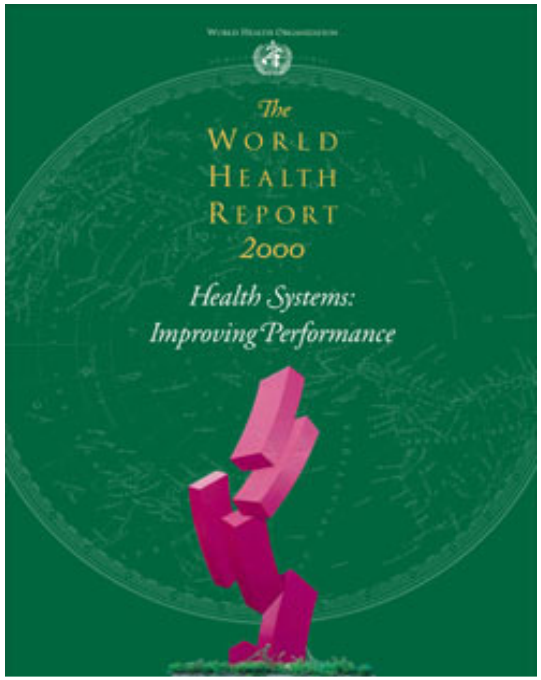


Statutory health insurance 2003

Problem 2:
Strict separation between ambulatory and hospital (inpatient) care

Problem 3: Quality and cost-effectiveness

- Germany always knew that its health care system was expensive, but was sure it was worth it (“the best system“)
- QA was introduced early but concentrated on structure
- Increasing doubts since late 1990s: Health Technology Assessment introduced in 1999
- World Health Report 2000: Germany only # 25 in terms of performance (efficiency)
- International comparative studies demonstrate only average quality (especially low for chronically ill)



In short: The situation in 2001

- Increasing movements of young & healthy sickness fund members
- Sickness funds with chronically ill face disproportionally increasing expenditure
- Quality problems are acknowledged, especially for the chronically ill, especially at sectoral borders
- Internationally, the system seems behind

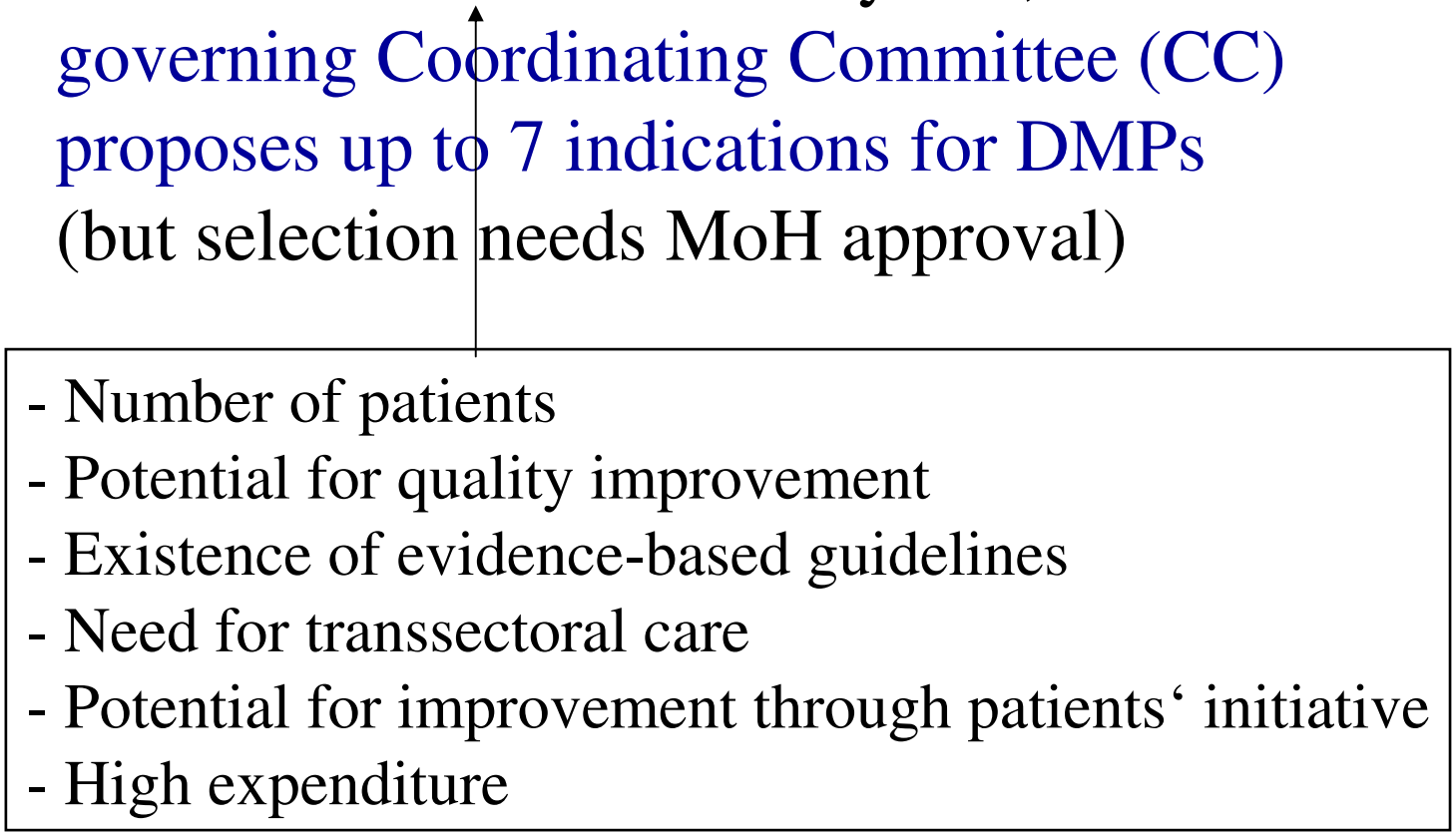
The basic idea

- Compensate sickness funds for chronically ill better (make them attractive) = reduce faulty incentives to attract young & healthy
- Address quality problems by guidelines/ pathways
- Address trans-sectoral problems by “integrated“ contracts
- = introduce Disease Management Programs meeting certain minimum criteria and compensate sickness funds for expenditure of those enrolling

double incentive for sickness funds:
potentially lower costs + extra compensation!

But DMPs German-style ain‘t easy!

- Based on criteria defined by law, the self-governing Coordinating Committee (CC) proposes up to 7 indications for DMPs
  (but selection needs MoH approval)



State
Self-government
Sickness funds
State Agency

But DMPs German-style ain‘t easy!

- Based on criteria defined by law, the self-governing Coordinating Committee (CC) proposes up to 7 indications for DMPs
  (but selection needs MoH approval)
- CC proposes conditions for each indication

- Treatment according to guidelines
- Necessary quality assurance measures
- Conditions and process of patient enrollment
- Training/ information for providers and patients
- Documentation
- Evaluation of effectiveness and costs
- Duration of program accreditation

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But DMPs German-style ain‘t easy!

- Based on criteria defined by law, the self-governing Coordinating Committee (CC) proposes up to 7 indications for DMPs
  (but selection needs MoH approval)
- CC proposes conditions for each indication
- MoH issues ordinance on conditions
- Sickness funds (individually or collectively) negotiate contracts with providers (individually or collectively)

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But DMPs German-style ain‘t easy!

- Sickness funds individually design DMP around that contract (e.g. add information, evaluation) and apply for accredition of DMP
- Federal Insurance Office accredits DMP
- Sickness funds invite their members to enroll (which is voluntary), reimburse providers etc.
- Federal Insurance Office uses average total expenditure for DMP-enrolled members per indication per age/sex combination in risk structure compensation

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Road to Disease Management Programs in Germany I

2001

June: Bill to Reform the Risk Adjustment Scheme including DMPs presented

August: Advisory Council report on "Underprovision, overprovision, inappropriate provision"

October: Lauterbach report on DMPs

November: Act to Reform the Risk Adjustment Scheme passed

2002

1 January: Act in force

8 January: Coordinating Committee (CC) proposes four indications for DMPs: Diabetes, Breast Cancer, Coronary Heart Disease (CHD), Chronic-obstructive pulmonary disease (COPD)

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Other

Road to Disease Management Programs in Germany II

2002

13 May: CC agrees on conditions for Diabetes II DMPs

13 June: CC agrees on conditions for Breast Cancer

1 July: MoH ordinance on DMP conditions in force

Period of blockade by physicians

20 September: General elections to Federal Assembly

28 October: First contract on Breast Cancer DMP between sickness funds and providers (Northrhine)

13 December: First contract on Diabetes II DMP between sickness funds and regional physicians' association (Saxony-Anhalt)

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Road to Disease Management Programs in Germany III

2003

1 January: MoH ordinance changes conditions for Diabetes II DMPs (less documentation required)

27 February: First DMPs are accredited (Breast Cancer, Northrhine, various sickness funds)

4 March: First patients enroll in DMPs

31 March: CC agrees on conditions for CHD DMPs

1/3/9 April: First DMPs for Diabetes are accredited (in Thuringia, Saxony-Anhalt and Salzgitter city)

1 May: MoH ordinance on conditions for CHD DMPs in force

July: Federal Insurance Office evaluates DMP applications for Breast Cancer from 2 regions and for Diabetes from 13 regions

October: AOK sickness fund association claims that 165,000 members have enrolled so far in its DMPs

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Other

German DMPs – a very premature evaluation

German DMPs clearly present trade-offs:

- large incentives for the sickness funds (which work – sickness funds have never been so active so rapidly!) but
- a complicated process and tight regulation
- leading to rather “standardised“ DMPs with little risk stratification, categorisation problems for those with >1 chronic illness, and difficulties to innovate

Cave: DMPs‘ effects on quality improvement (and on sickness funds‘ expenditures) are not yet known.