

German health policy issues – a vademecum for confused outsiders (version 6.04)

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The German system at a glance ...

Third-party payer

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

Ca. 300 sickness funds
with self-government,
organised in associations

Choice of fund
since 1996

Strong
delegation
& limited

Contracts,
mostly collective

governmental control

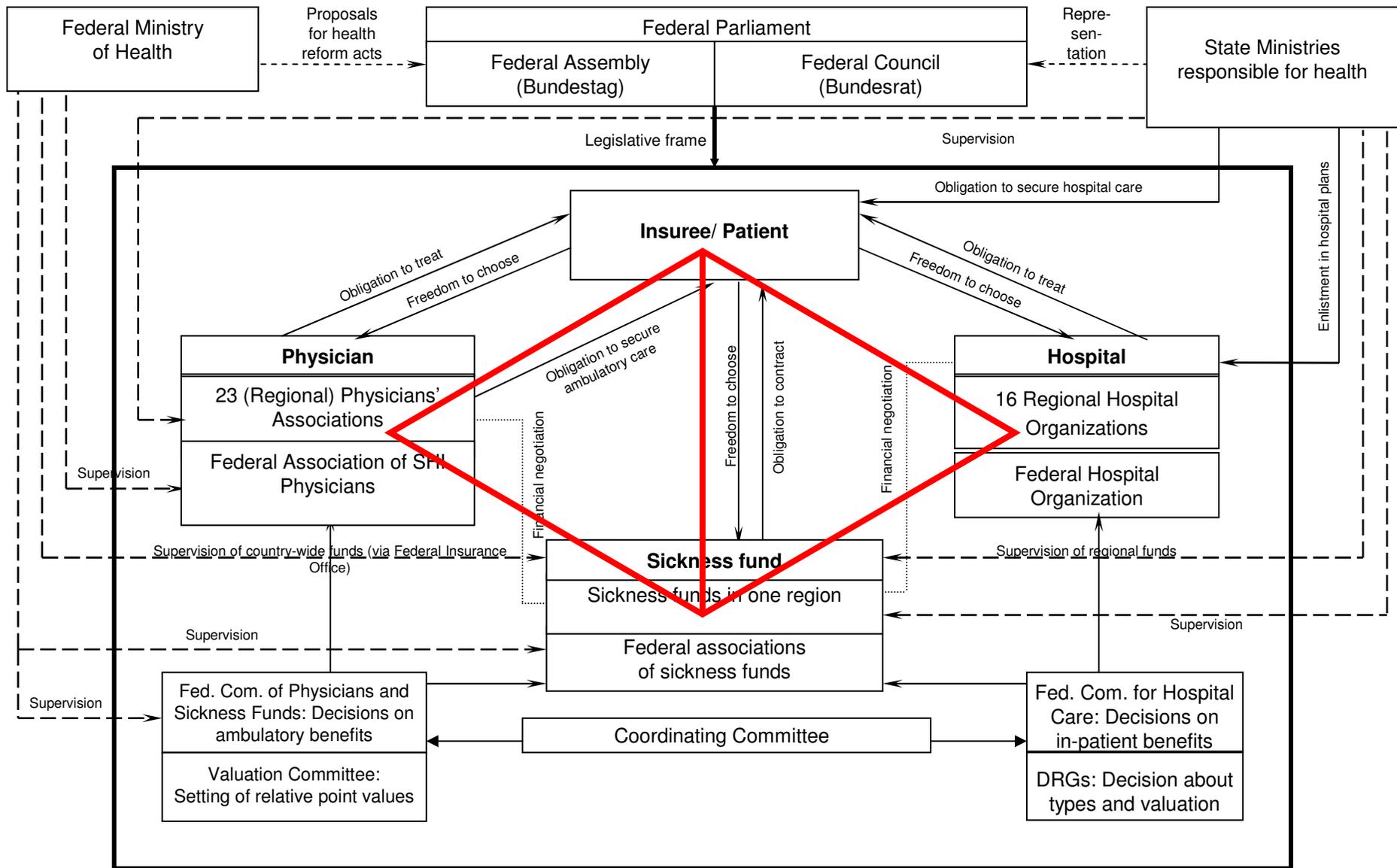
Population

SHI insures 88%
(75% mandatorily,
13% voluntarily)

Free access

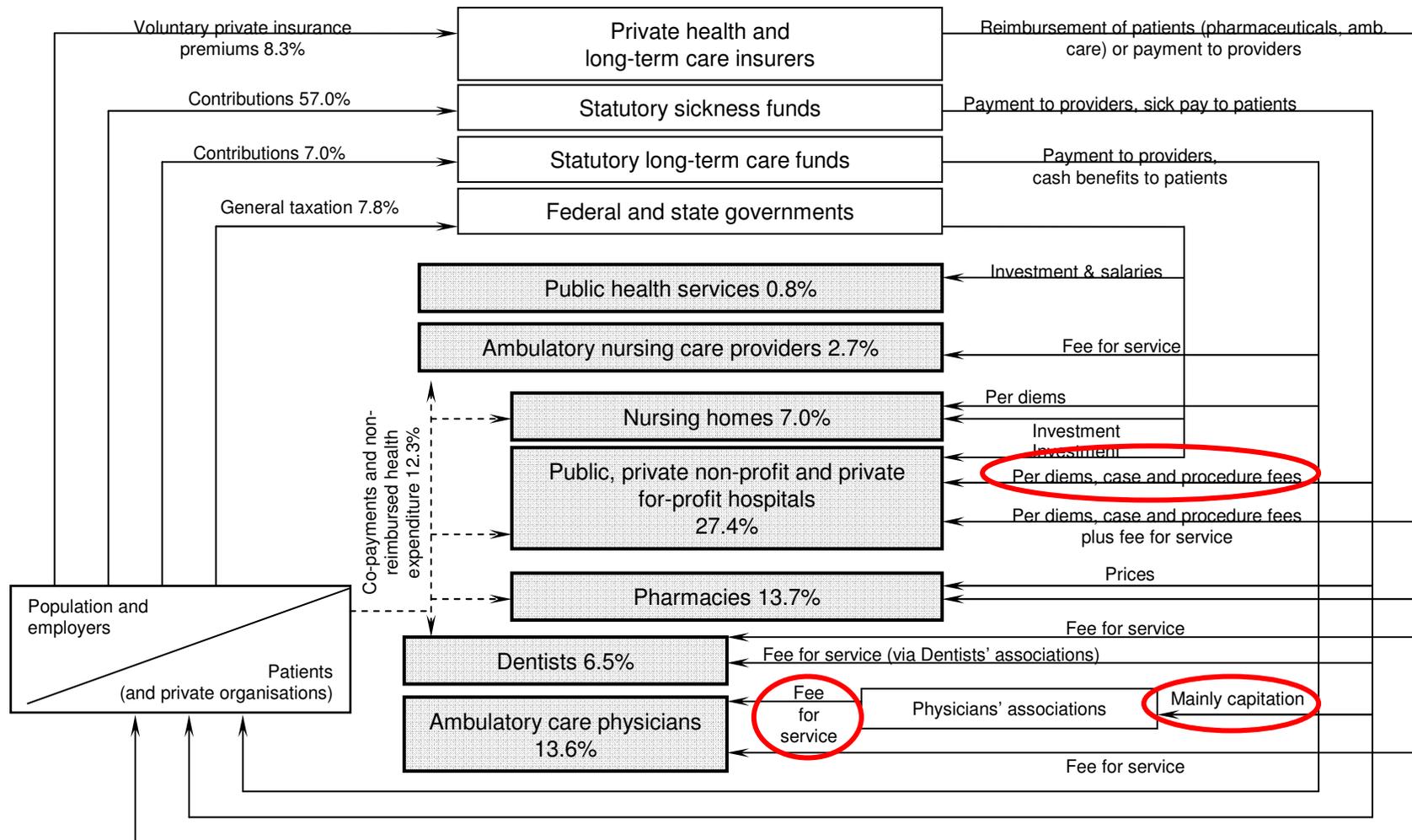
Providers

Public-private mix,
organised in associations



Statutory health insurance 2003

Problem 1: Strict separation between ambulatory and hospital (inpatient) care with different regulatory environment and rules



Problem 2:
 Financial incentives vary between sectors/ providers and are changed frequently – „solutions“ to old problems create new ones

Problem 3 (actually No. 1): Increase of contribution rate

Background: no tax subsidies;
sickness funds are
not allowed to incur deficits

Sub-problem:
sickness funds did go into debt –
estimated to be up to €10 billion
(< 1 monthly expenditure)

Expenditure

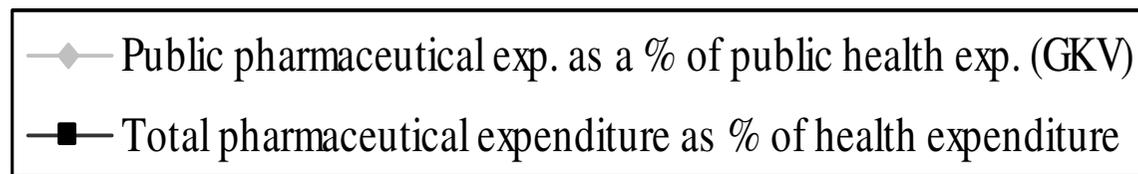
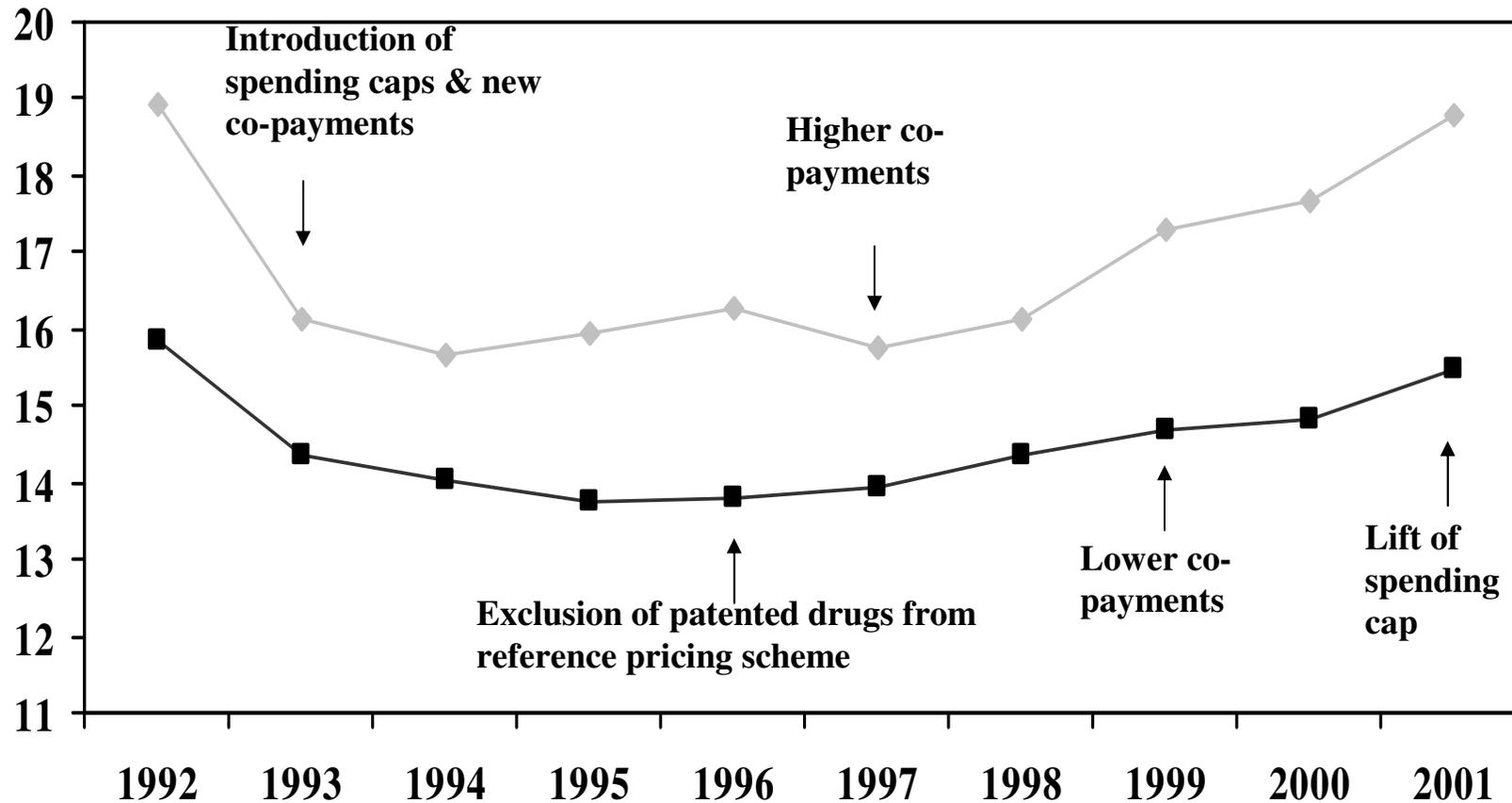
= contribution rate

Contributory income
(wages up to threshold; pensions;
50% of wages for unemployed ...)

Sharp increases (1991-93; 2001-03) have always triggered major reform!

Reform act	Year passed
Health Care Reform Act 1989 ("First step") Unification Treaty (extension of SHI to eastern part)	1988 1991
Health Care Structure Act 1993 ("Second step") Introduction of Long-term Care Insurance	1992 1995
Health Insurance Contribution Rate Exoneration Act	1996
1 st & 2 nd Statutory Health Insurance Restructuring Act ("Third step")	1997
Act to Strengthen Solidarity in Statutory Health Insurance	1998
Reform Act of Statutory Health Insurance 2000	1999

Spending caps: effective for cost-containment but politically unsustainable



The dilemma of equality vs. competition

- **1989:** equalisation of benefits and health care provision between sickness funds
 - **1994/95:** minimisation of contribution rate differences through "risk compensation scheme"
 - **1996:** free choice of sickness fund for (almost) everybody
- > How to compete with (almost) identical benefit baskets, an (almost) identical system of health care provision and similar contribution rates?
- > Selective contracting!? CHOICE? ACCESS?

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

Problem 4:

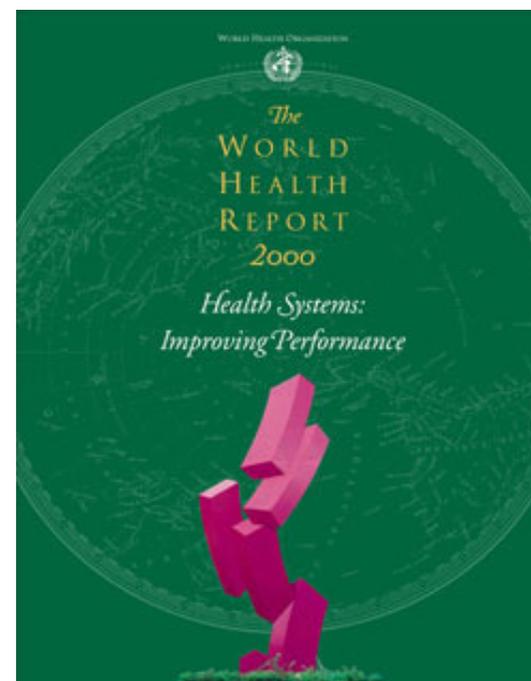
As the younger and healthier move more often,
the overall risk pool has further de-mixed

**Evidence: RSC transfers have increased as
percentage of total expenditure**

	RSC transfers (billion €)	SHI expenditure excluding administration (billion €)	RSC transfers as % of SHI expenditure
1995	9.23	116.99	7.9
1996	9.78	120.88	8.1
1997	10.34	118.29	8.7
1998	11.01	119.71	9.2
1999	11.60	123.21	9.4
2000	12.03	125.94	9.6
2001	13.52	130.63	10.3
2002	13.92	134.33	10.4

Problem 5: 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 since 1997
- World Health Report 2000: Germany only # 25 in terms of performance (efficiency)
- International comparative studies demonstrate only average quality (especially low for chronically ill)



<ul style="list-style-type: none"> • Act to Newly Regulate Choice of Sickness Fund • Act to Introduce the Residency Principle for Physicians' and Dentists' Reimbursement • Act to Reform the SHI Risk Adjustment Mechanism • Act to Adjust Reference Price-Setting Regulations • Pharmaceutical Spending Cap Lifting Act 	<p>2001</p> <p>Health care reform became confusing even for insiders!</p>
<ul style="list-style-type: none"> • Act to Limit SHI Pharmaceutical Spending • Act to Introduce a Case Fees-System in Hospitals 	<p>2002</p>

Solution 1:

Re-structuring financial incentives

- **Pharmaceutical** spending caps abolished – emphasis on “value for money” and substitution if equally effective (lowered reference prices, re-inclusion of “me-toos” into reference price system)
- **DRGs**: originally adopted from Australia but categories were changed significantly from 2003 to 2004 (only 20% were retained unchanged!); DRGs as real reimbursement mechanism will be phased in from 2005 to 2007 (dispute: university hospitals)

Solution 2 (introduced 2002): Disease Management Programmes

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

*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)

- diabetes
- breast cancer
- asthma/ COLD
- CHD

- Number of patients
- Potential for quality improvement
- Existence of evidence-based guidelines
- Need for transsectoral care
- Potential for improvement through patients' initiative
- High expenditure

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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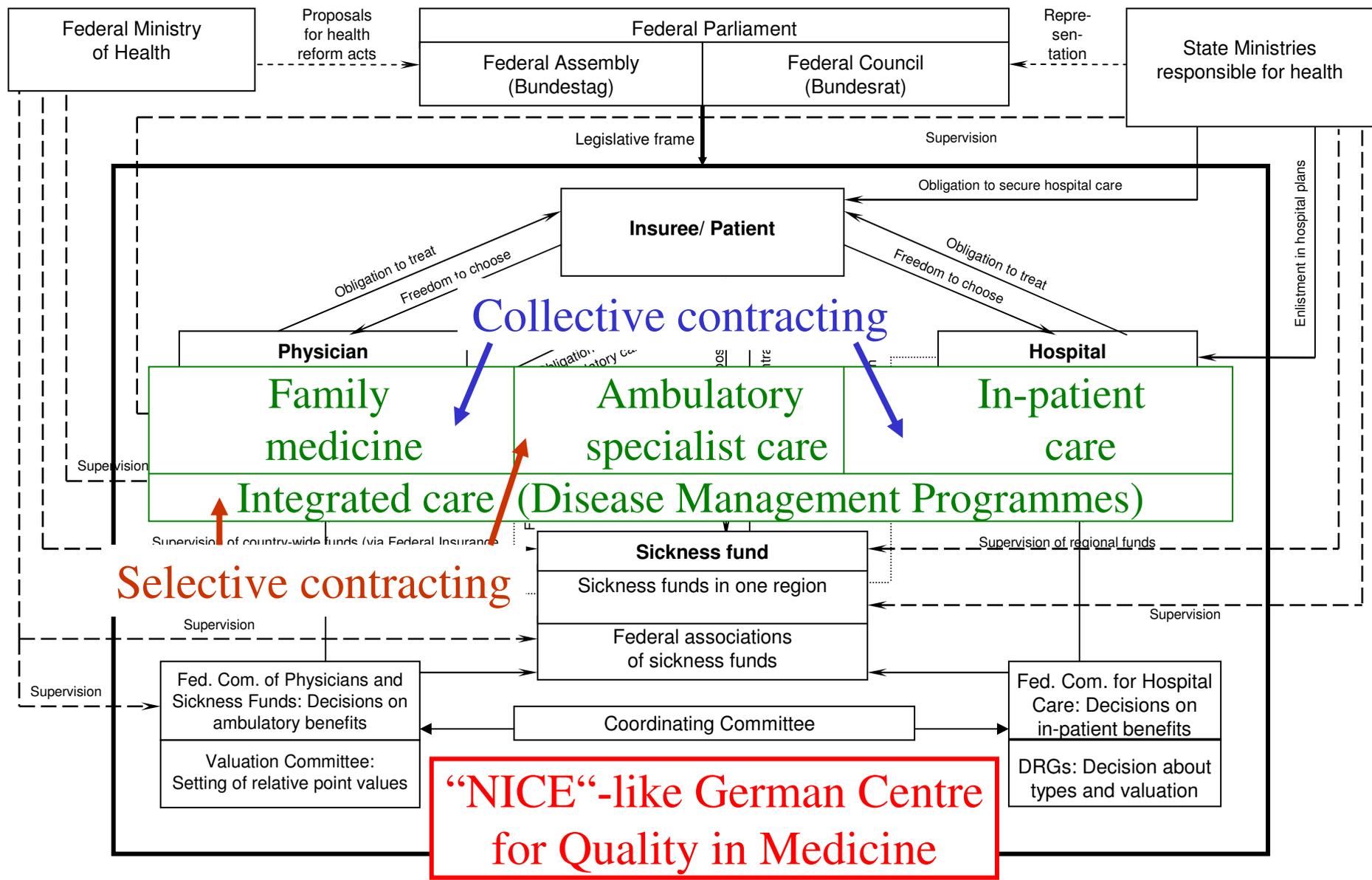
But DMPs German-style ain't easy!

- **Sickness funds individually design DMP around that contract (e.g. add information, evaluation) and apply for accreditation 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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Self-government
Sickness funds
State Agency

2003: The SHI Modernisation Act

- Background: rising contribution rates (from 13.6% in 2001 to 14.4% in 2003) + perceived quality problems
- original core elements (government bill):
 - “patients rights“,
 - “German Centre for Quality in Medicine“ (incl. 4th hurdle for pharmaceuticals),
 - re-organisation of contractual relationships between sickness funds and providers,
 - moderate cost-shifting (sick pay)

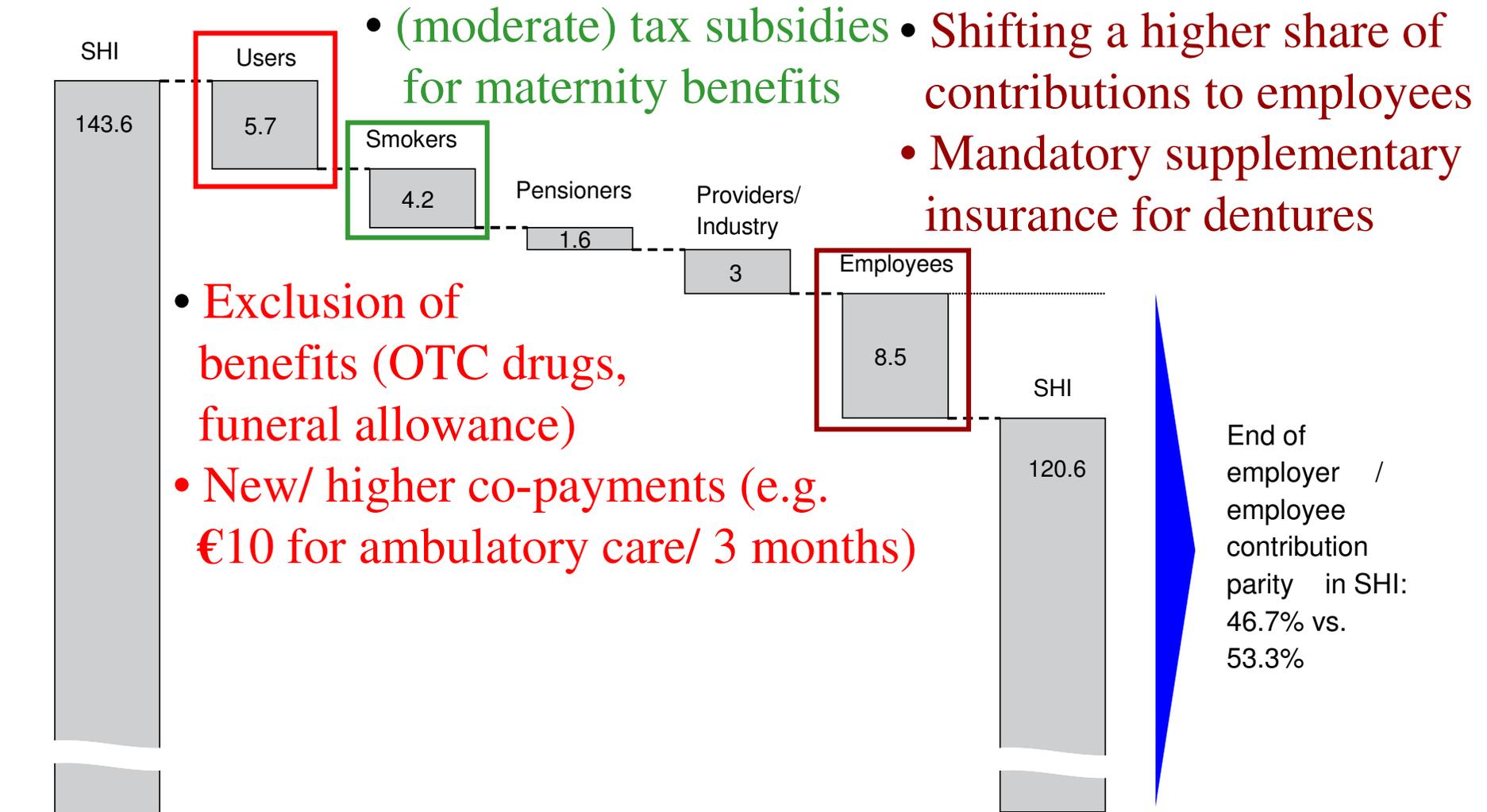


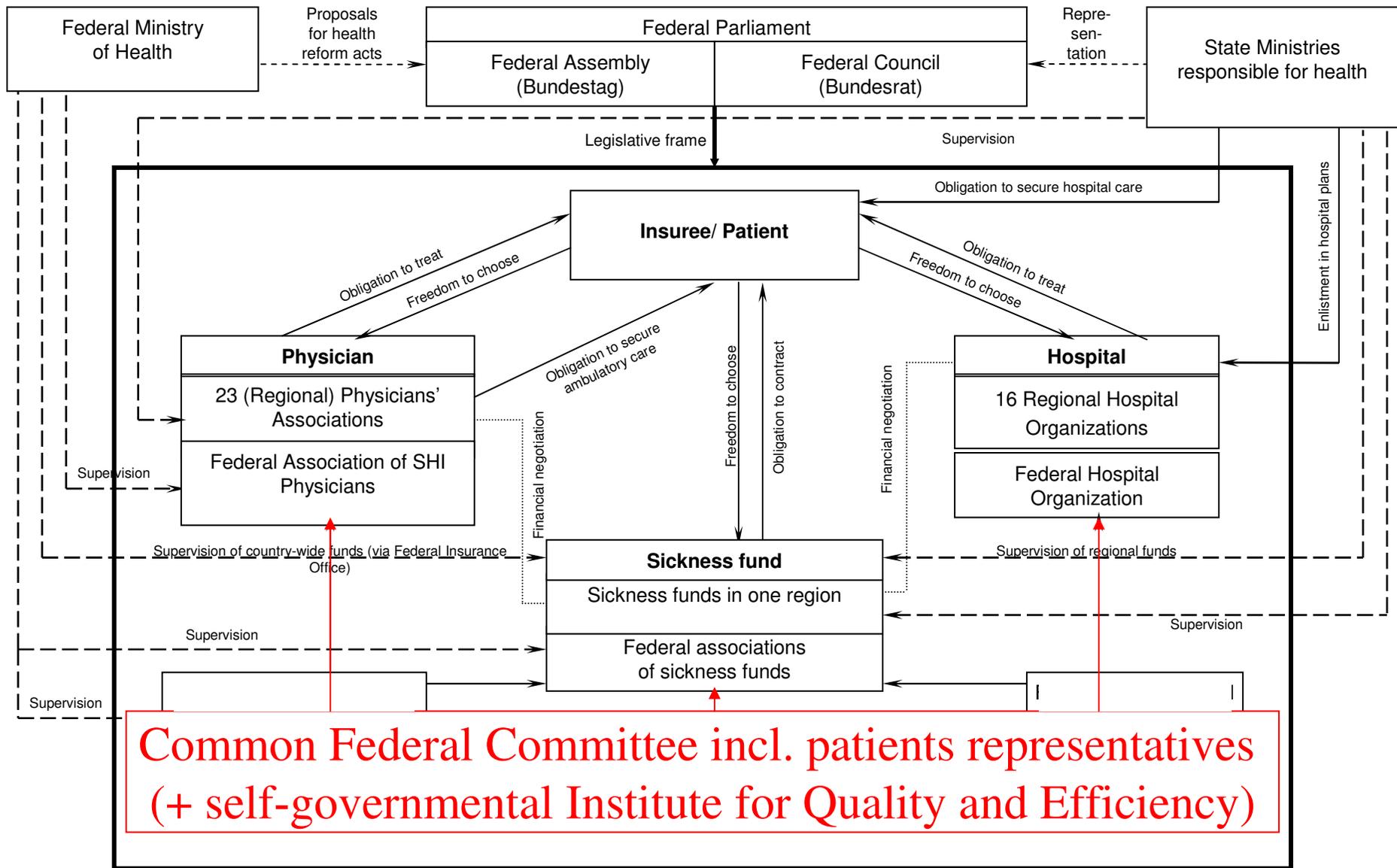
Health Care System Modernisation bill – the plan

2003: The SHI Modernisation Act – continued

- Opposition threatened to block Modernisation bill
- All-party negotiations in July 2003
- Result: shift in emphasis from re-organisation of contractual relationships to cost-shifting; major re-organisation/ bundling of delegated decision-making
- Act passed in November 2003

SHI Modernisation Act: Anticipated cost-shifting from employers and healthy employees to users of healthcare, smokers, pensioners, providers and industry, and the *de facto* end of contribution parity in SHI (in billion €)



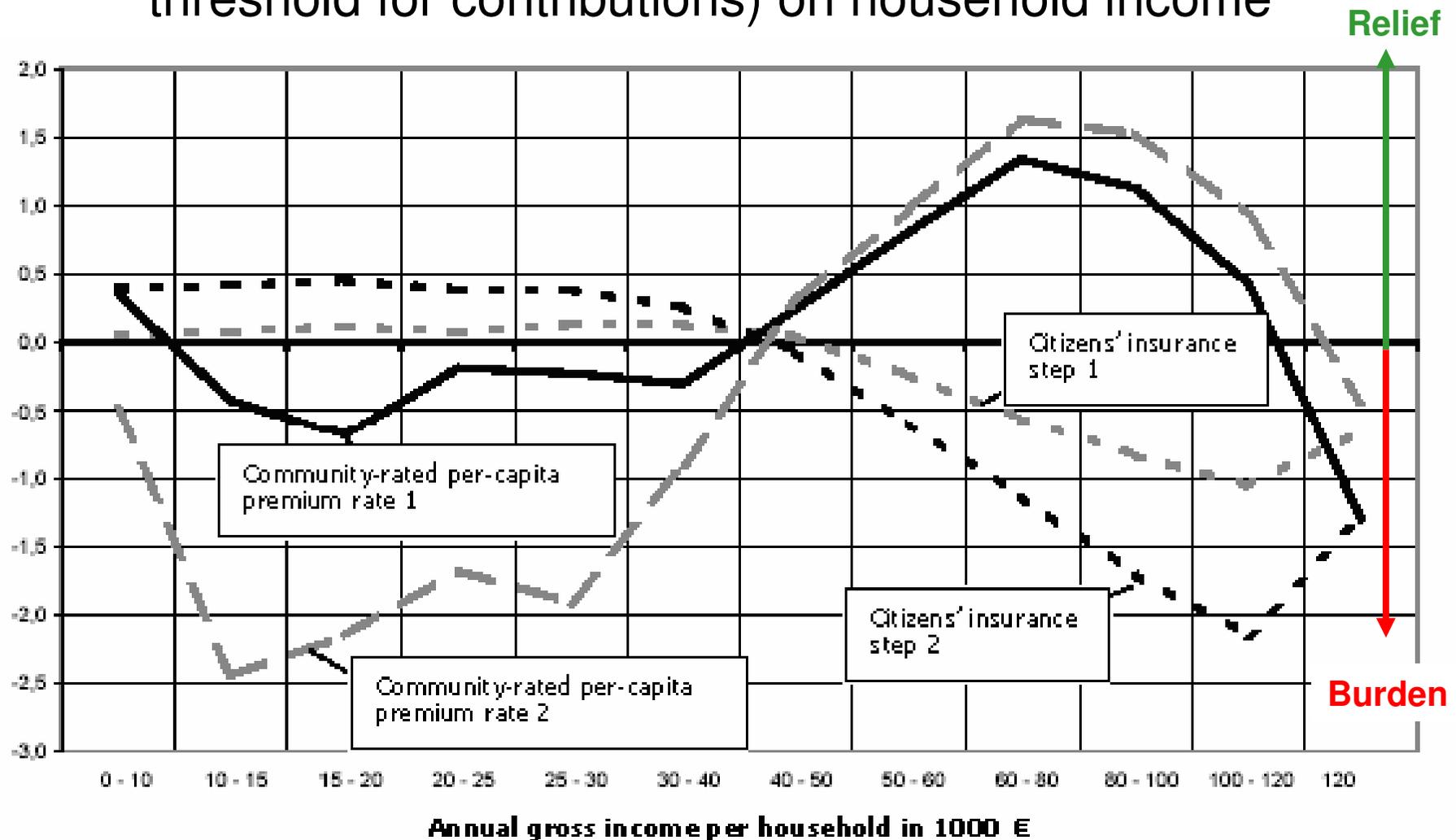


SHI Modernisation Act – the outcome

Discussion about funding basis

- *Extension of SHI to entire population*
- Option 1: Extension of contributory basis (to non-wage income, higher threshold)
- Option 2: Change from income-dependent contribution to community-rated (*or age-dependent?*) per-capita premia
 - *Partial complement of pay-as-you-go principle through capital stock*

Financial effect of the two options 1. per-capita premium (with varying level of tax subsidies for low income) and 2. universal contributory insurance (with varying level of upper threshold for contributions) on household income



Presentation, articles etc. are available at:

<http://mig.tu-berlin.de>