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The German Health Care System: A (Very) Short Introduction

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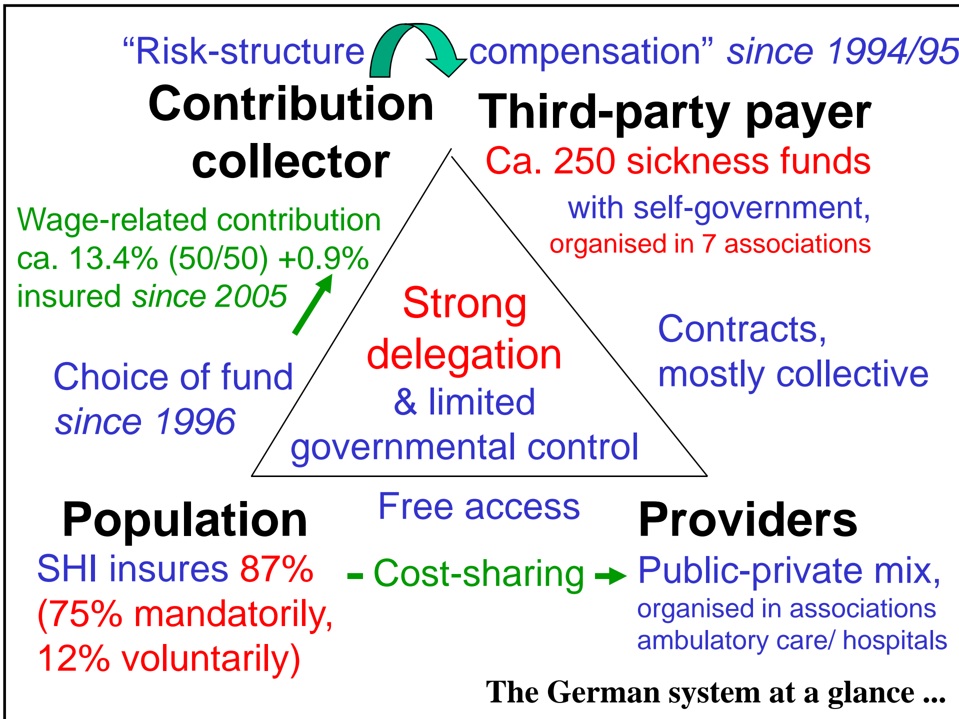
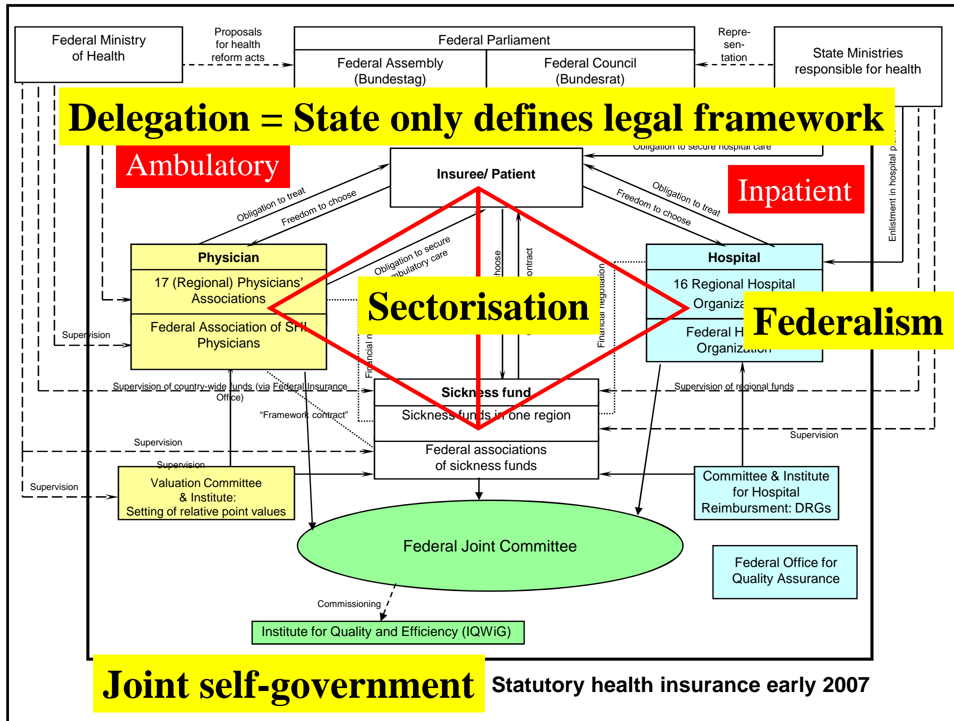
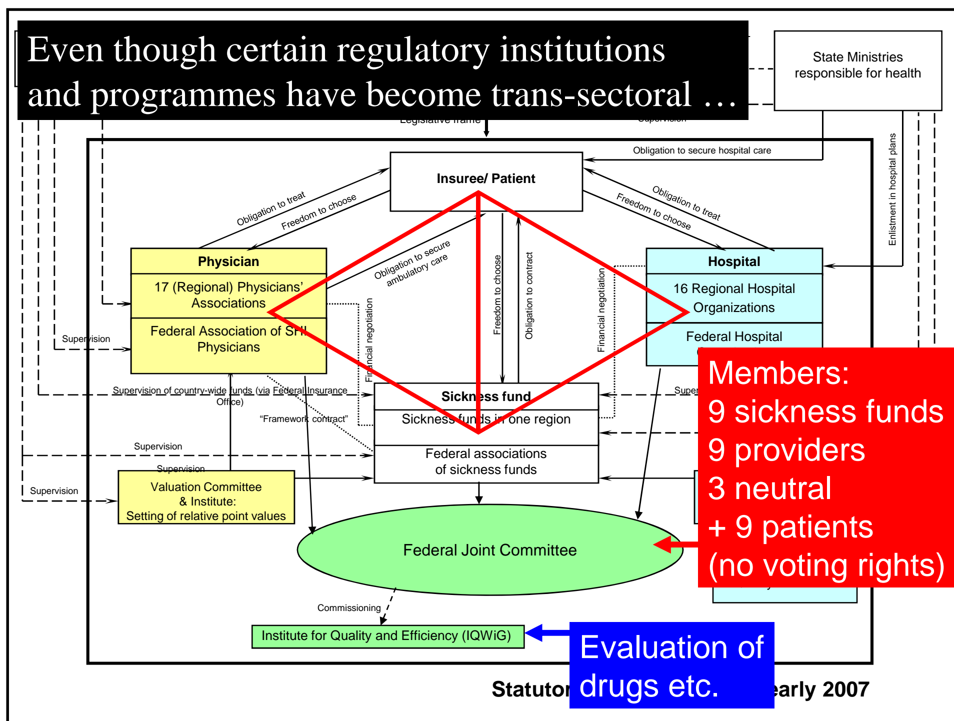
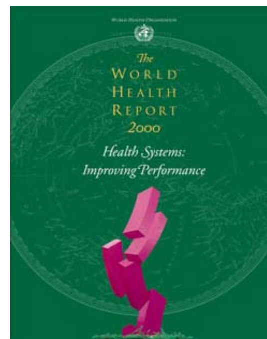



Federal Ministry of Health
Proposals for health reform acts
Federal Parliament
Federal Assembly (Bundestag)
Federal Council (Bundesrat)
Repre-sen-tation
State Ministries responsible for health
Delegation = State only defines legal framework
Ambulatory
Inpatient
Insuree/ Patient
Obligation to treat
Freedom to choose
Physician
17 (Regional) Physicians' Associations
Federal Association of SHI Physicians
Sectorisation
Federalism
Hospital
Sickness fund
Sickness funds in one region
Federal associations of sickness funds
Valuation Committee & Institute: Setting of relative point values
Committee & Institute for Hospital Reimbursment: DRGs
Federal Joint Committee
Federal Office for Quality Assurance
Commissioning
Institute for Quality and Efficiency (IQWiG)
Joint self-government
Statutory health insurance early 2007


Even though certain regulatory institutions and programmes have become trans-sectoral …
State Ministries responsible for health
Insuree/ Patient
Obligation to secure hospital care
Physician
17 (Regional) Physicians' Associations
Federal Association of SHI Physicians
Hospital
16 Regional Hospital Organizations
Federal Hospital
Sickness fund
Sickness funds in one region
Federal associations of sickness funds
Valuation Committee & Institute: Setting of relative point values
Federal Joint Committee
Members:
9 sickness funds
9 providers
3 neutral
+ 9 patients
(no voting rights)
Commissioning
Institute for Quality and Efficiency (IQWiG)
Evaluation of drugs etc.

Problem: Quality and cost-effectiveness

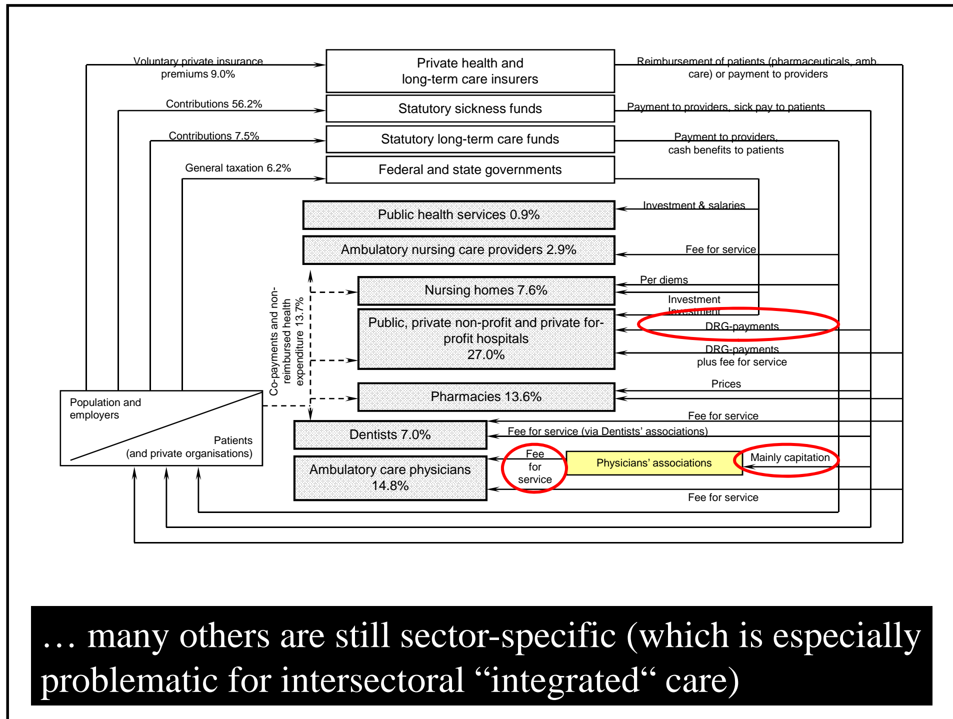
- Germany always knew that its health care system was expensive, but was sure it was worth it (“the best system“)
- Quality assurance was introduced early but concentrated on structure
- Increasing doubts since late 1990s: Health Technology Assessment introduced since 1997
- World Health Report 2000: Germany only # 25 in terms of performance (efficiency)
- International comparative studies demonstrate only average quality (especially low for chronically ill)



Disease Management Programmes (since 2002)

- 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)

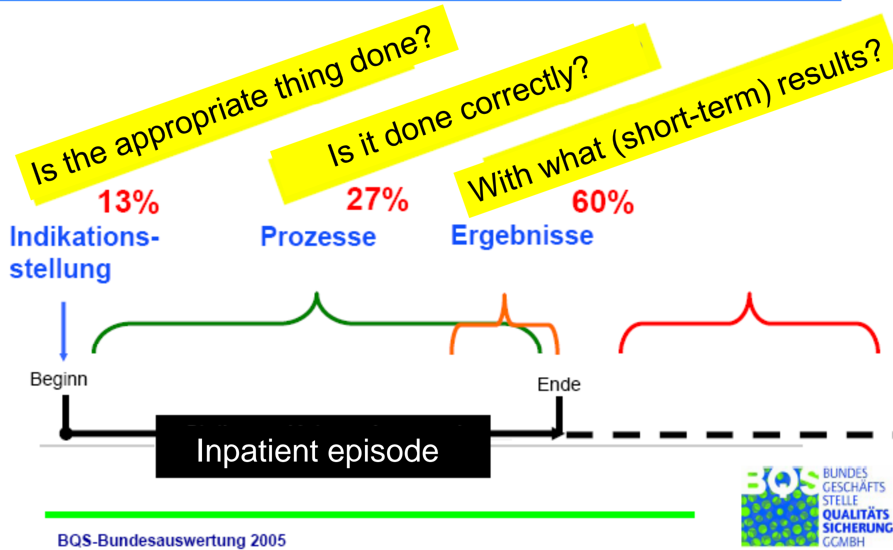
double incentive for sickness funds:
potentially lower costs + extra compensation!



… many others are still sector-specific (which is especially problematic for intersectoral "integrated" care)

	Ambulatory care	**Hospitals**
Capacity planning & "accreditation" of providers	Sickness funds and physicians' associations	State governments
Benefit basket	Inclusion of (new) technologies through Fed. Joint Com.	Only exclusion through Fed. Joint Com. (generous DRG exceptions)
Quality assurance	…	Minimum volumes, quality indicators

Federal Office for Quality Assurance (BQS): mandatory for all 1800 hospitals, 170 indicators, with feedback and "structured dialogue"

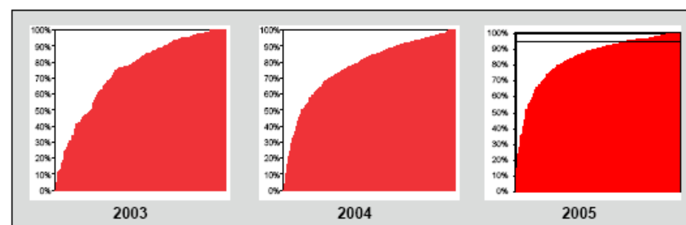


BQS-Bundesauswertung 2005

BUNDES GESCHÄFTS STELLE QUALITÄTS SICHERUNG GGMBH

An example (with slow progress):

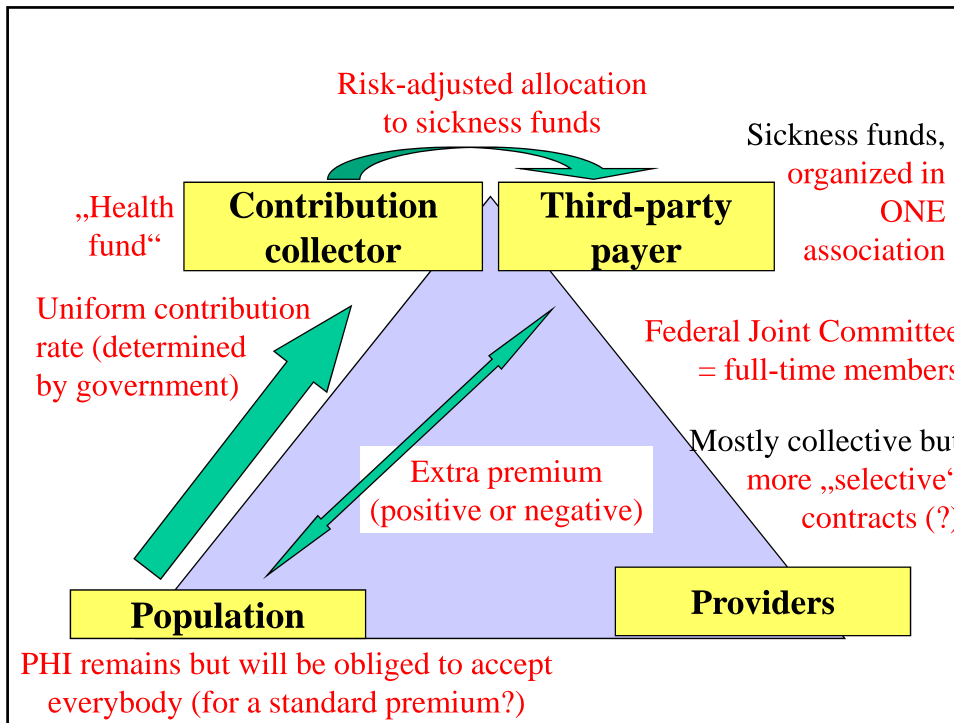
Documentation of operation distance to (breast) cancer

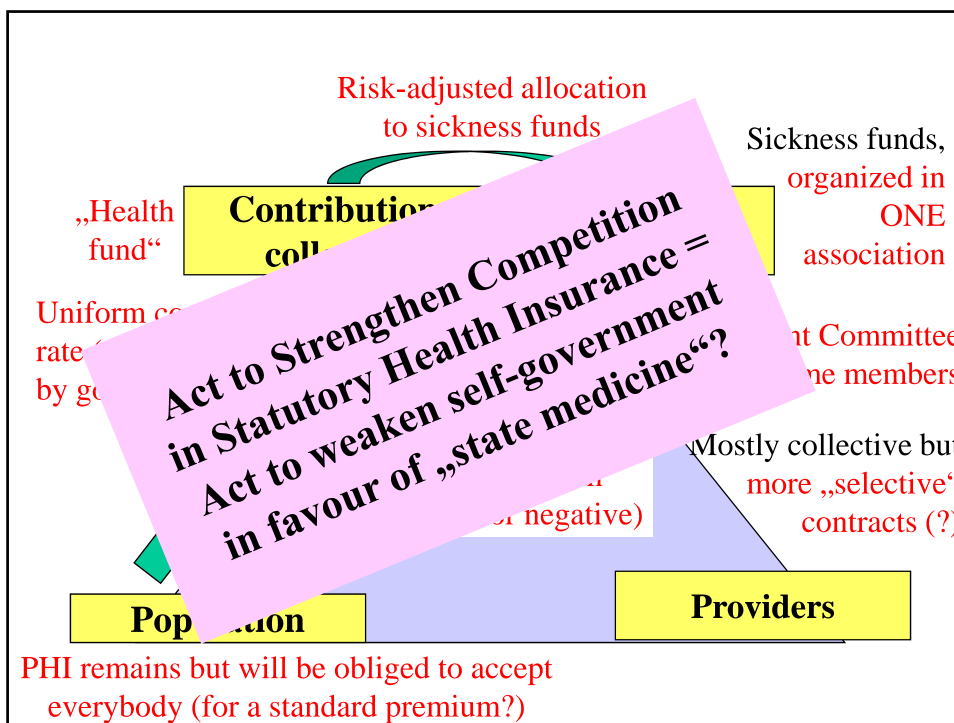


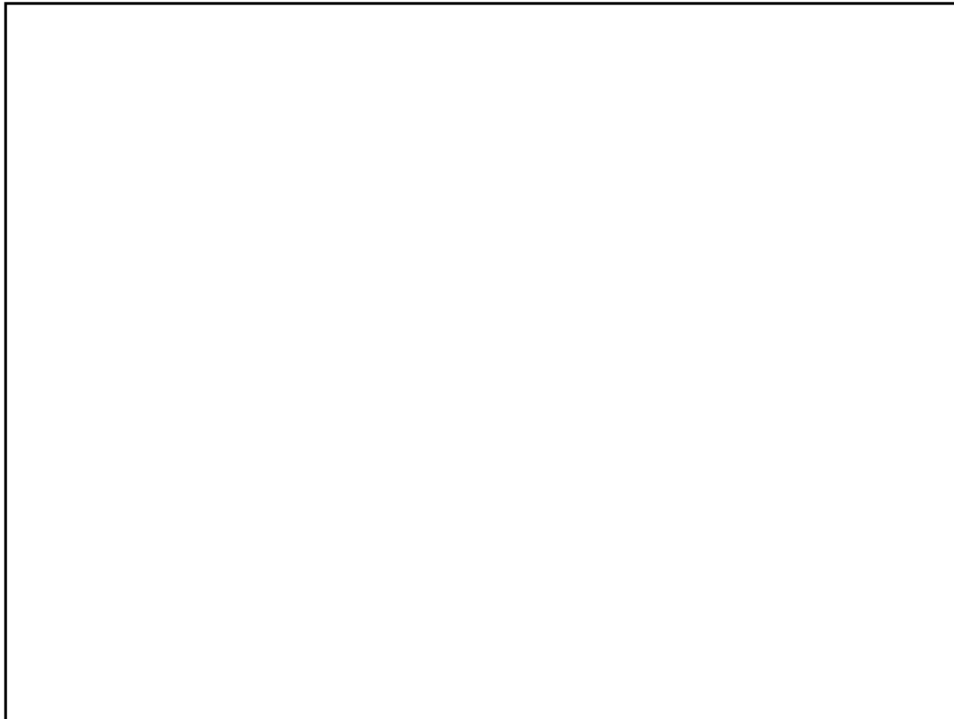
72,52% 75,67% 83,19%

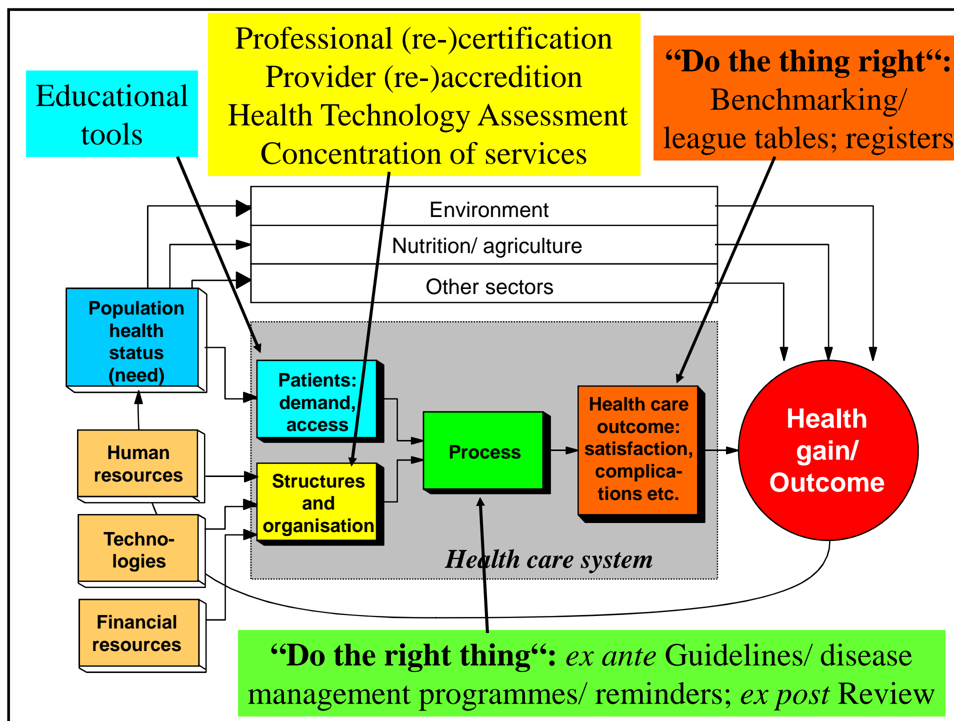
Mammachirurgie 2005: Angabe Sicherheitsabstand bei BET (KeZ 68098)

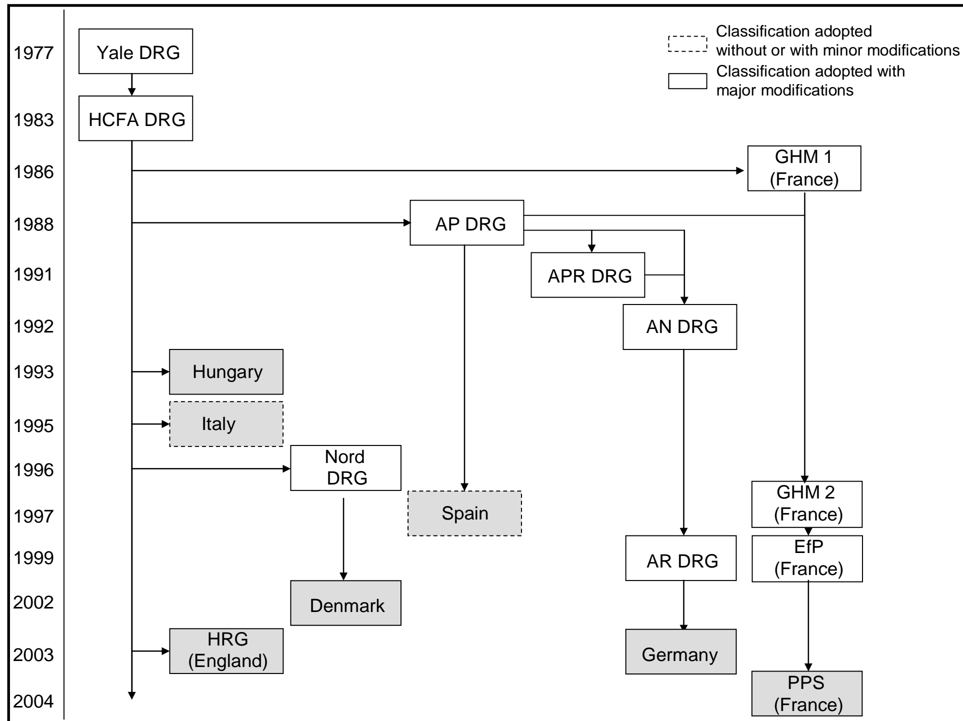
BUNDES GESCHÄFTS STELLE QUALITÄTS SICHERUNG GGMBH


Risk-adjusted allocation
to sickness funds
„Health
fund“
Contribution
collector
Third-party
payer
Sickness funds,
organized in
ONE
association
Uniform contribution
rate (determined
by government)
Federal Joint Committee
= full-time members
Mostly collective but
more „selective“
contracts (?)
Extra premium
(positive or negative)
Population
Providers
PHI remains but will be obliged to accept
everybody (for a standard premium?)


Risk-adjusted allocation
to sickness funds
„Health
fund“
Sickness funds,
organized in
ONE
association
Act to Strengthen Competition
in Statutory Health Insurance =
Act to weaken self-government
in favour of „state medicine“?
Mostly collective but
more „selective“
contracts (?)
Providers
PHI remains but will be obliged to accept
everybody (for a standard premium?)




Educational tools
Professional (re-)certification
Provider (re-)accredition
Health Technology Assessment
Concentration of services
“Do the thing right“: Benchmarking/ league tables; registers
Environment
Nutrition/ agriculture
Other sectors
Population health status (need)
Patients: demand, access
Human resources
Structures and organisation
Process
Health care outcome: satisfaction, complica-tions etc.
Health gain/ Outcome
Techno-logies
Financial resources
Health care system
“Do the right thing“: ex ante Guidelines/ disease management programmes/ reminders; ex post Review


Classification adopted without or with minor modifications
Classification adopted with major modifications
1977
1983
1986
1988
1991
1992
1993
1995
1996
1997
1999
2002
2003
2004
Yale DRG
HCFA DRG
GHM 1 (France)
AP DRG
APR DRG
AN DRG
Hungary
Italy
Nord DRG
Spain
GHM 2 (France)
EfP (France)
AR DRG
Denmark
HRG (England)
Germany
PPS (France)