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Impact of the Competition Strengthening Act upon Care Coordination

Reinhard Busse, Prof. Dr. med. MPH FFPH
FG Management im Gesundheitswesen, Technische Universität Berlin
(WHO Collaborating Centre for Health Systems Research and Management)
&
European Observatory on Health Systems and Policies
“Risk-structure compensation” since 1994/95

Contribution collector

Wage-related contribution ca. 13.4% (50/50) +0.9%
insured since 2005

Choice of fund since 1996

Third-party payer

Ca. 250 sickness funds with self-government, organised in 7 associations

Contracts, mostly collective

Strong delegation & limited governmental control

Free access

Cost-sharing

Population

SHI insures 87%
(75% mandatorily, 12% voluntarily)

Providers

Public-private mix, organised in associations
ambulatory care/ hospitals

The German system at a glance ...
Delegation = State only defines legal framework

Ambulatory

Physician
17 (Regional) Physicians’ Associations
Federal Association of SHI Physicians

Supervision

Valuation Committee & Institute: Setting of relative point values

Inpatient

Hospital
16 Regional Hospital Organizations
Federal Hospital Organization

Supervision

Committee & Institute for Hospital Reimbursement: DRGs

Statutory health insurance early 2007
Even though certain regulatory institutions and programmes have become trans-sectoral...
... coordination, quality and cost-effectiveness are problematic

- 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)
Legal attempts to improve care coordination (selection):

- Pre- and post- inpatient care in hospitals (1997)
- „Integrated [i.e. transsectoral] care“ contracts (2000, funded with 1% of expenditure since 2004)
- Disease Management Programmes (2002) -> next slide
- Polyclinics (potentially with hospital owners, 2004)
- „GP contracts“ (insured choose GP as gatekeeper; 2004, have to be offered since 2007)
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!*

  *By early 2007: 3.5 mn enrolled (5% of SHI insured)*
What has or will be changed by the Competition Strengthening Act and what is the (likely) impact on care coordination?

Contribution collector  Third-party payer

Good for the up to 1.5% uninsured, both voluntarily (e.g. self-employed) and involuntarily (e.g. divorced women, >55 yr-olds with chronic illnesses)

Population  Providers

PHI remains but: universal coverage + obligation to contract (for a capped premium)
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases.

- Contribution collector
- Third-party payer
- "Health fund"

Uniform contribution rate (determined by government)

Population

Providers

PHI remains but: universal coverage + obligation to contract (for a capped premium)
"Standardised" (= avg.) expenditure used for the Risk Structure Compensation mechanism (2006)

Avg. 5.20€/ day
Effect of “illness“ by age differs greatly (2006)
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem
14% meet threshold of > 1.5fold avg. expenditure
Participation in a DMP will not qualify anymore: will reduced incentives lead sickness funds to stop offering them?

Or: the opportunity to concentrate on (cost-)effective programmes with risk-strata, for patients with multiple conditions etc.?

We need to identify 50 to 80 diseases explaining these costs!
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases

Problematic as chronically ill will not benefit (= loose) – but according to a survey they don’t realise that

Uniform contribution rate (determined by government)

Extra, community-rated premium (positive or negative)

No-claim bonuses, individual deductibles … to lower contribution

„Health fund“

Contribution collector

Third-party payer

Population

Providers

PHI remains but: universal coverage + obligation to contract (for a capped premium)
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases

Sickness funds, organized in ONE association

Contribution collector

Third-party payer

Uniform contribution rate (determined by government)

„Health fund“

Probably overrated for chronic care coordination; mostly used for acute care-rehab. „packages“

Still mostly collective contracts, but more selective „integrated care“ contracts

Population

Providers

PHI remains but: universal coverage + obligation to contract (for a capped premium)