Technische Universität Berlin

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Impact of the Competition Strengthening Act upon Care Coordination

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&
European Observatory on Health Systems and Policies

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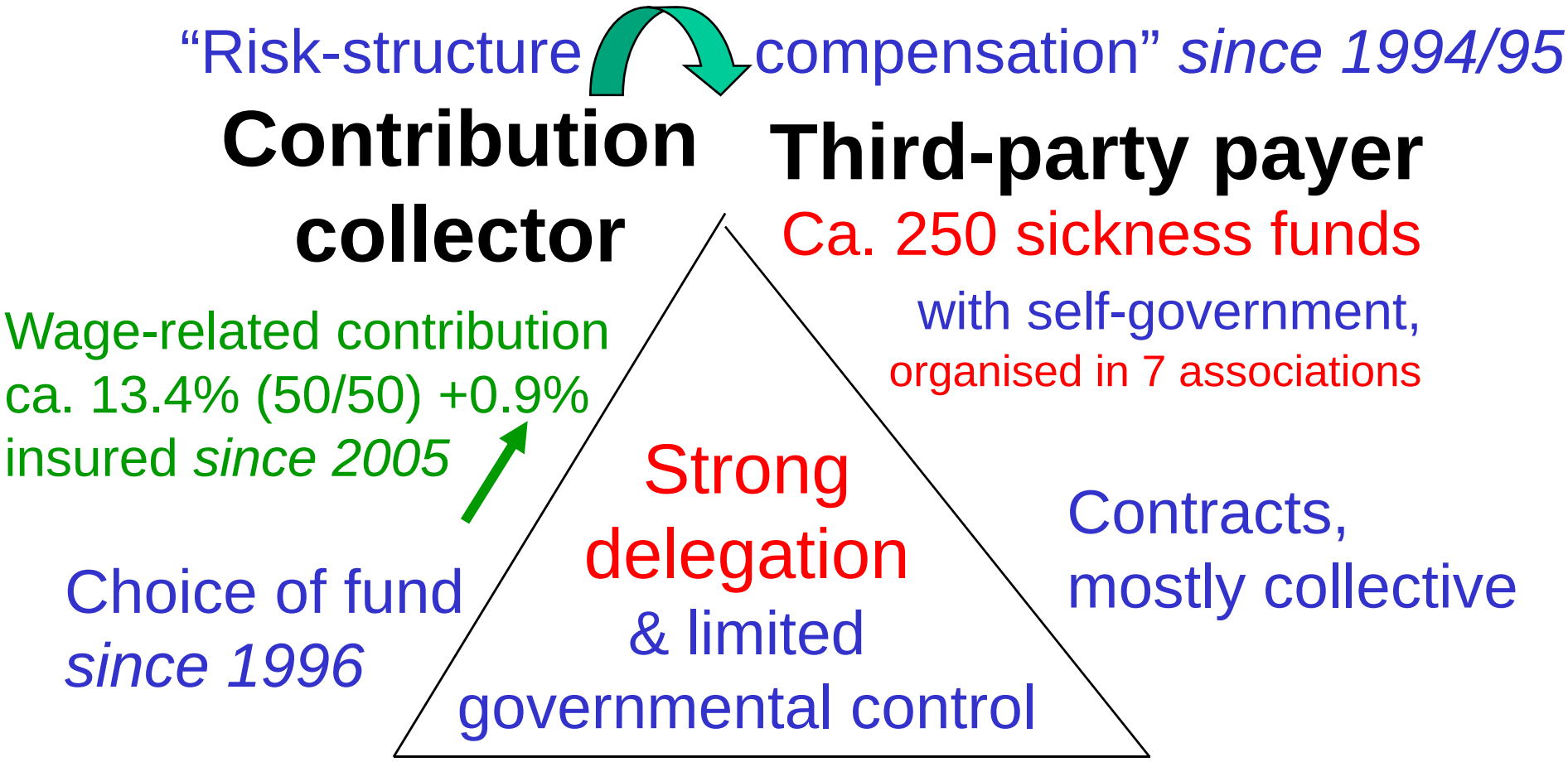
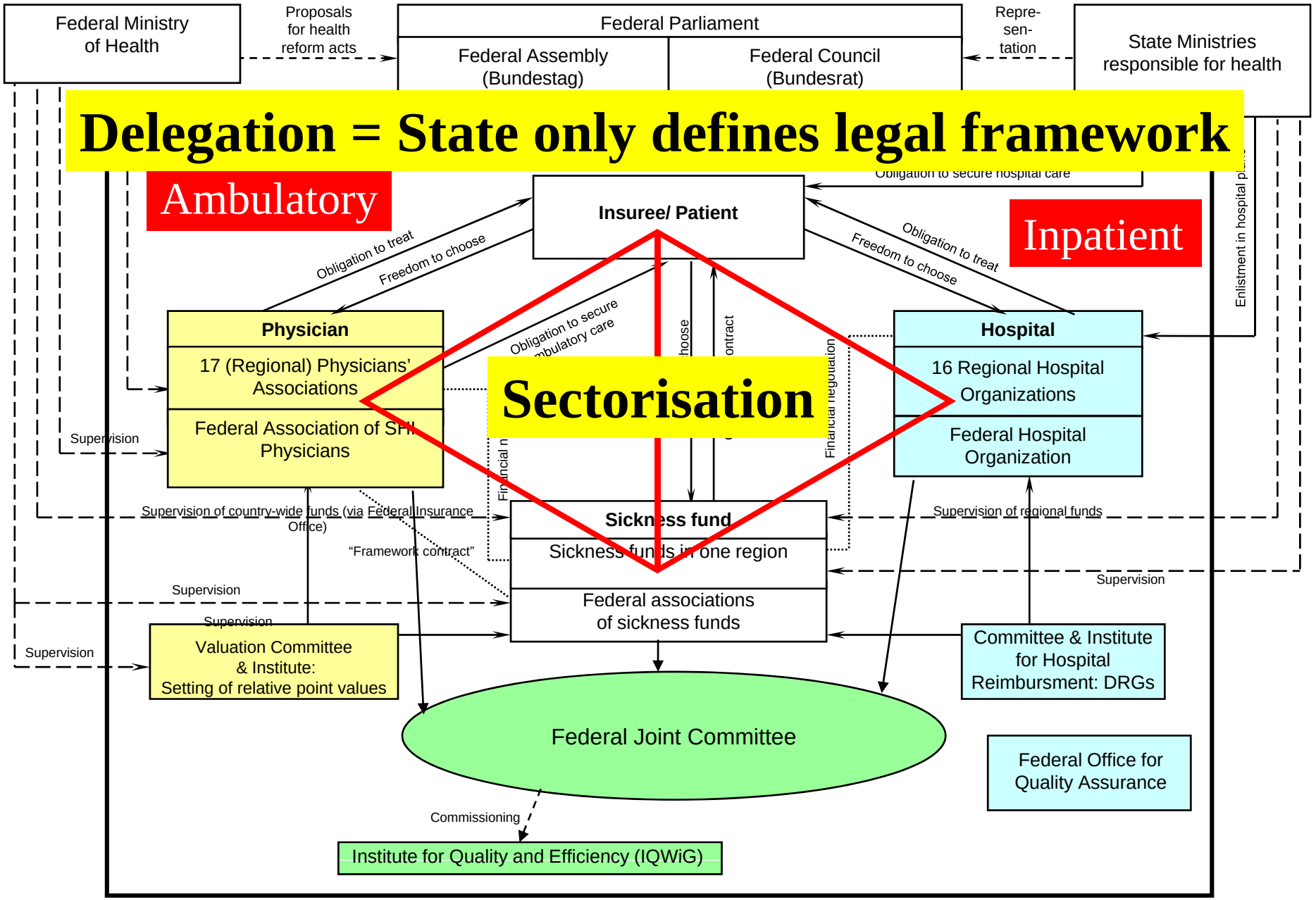
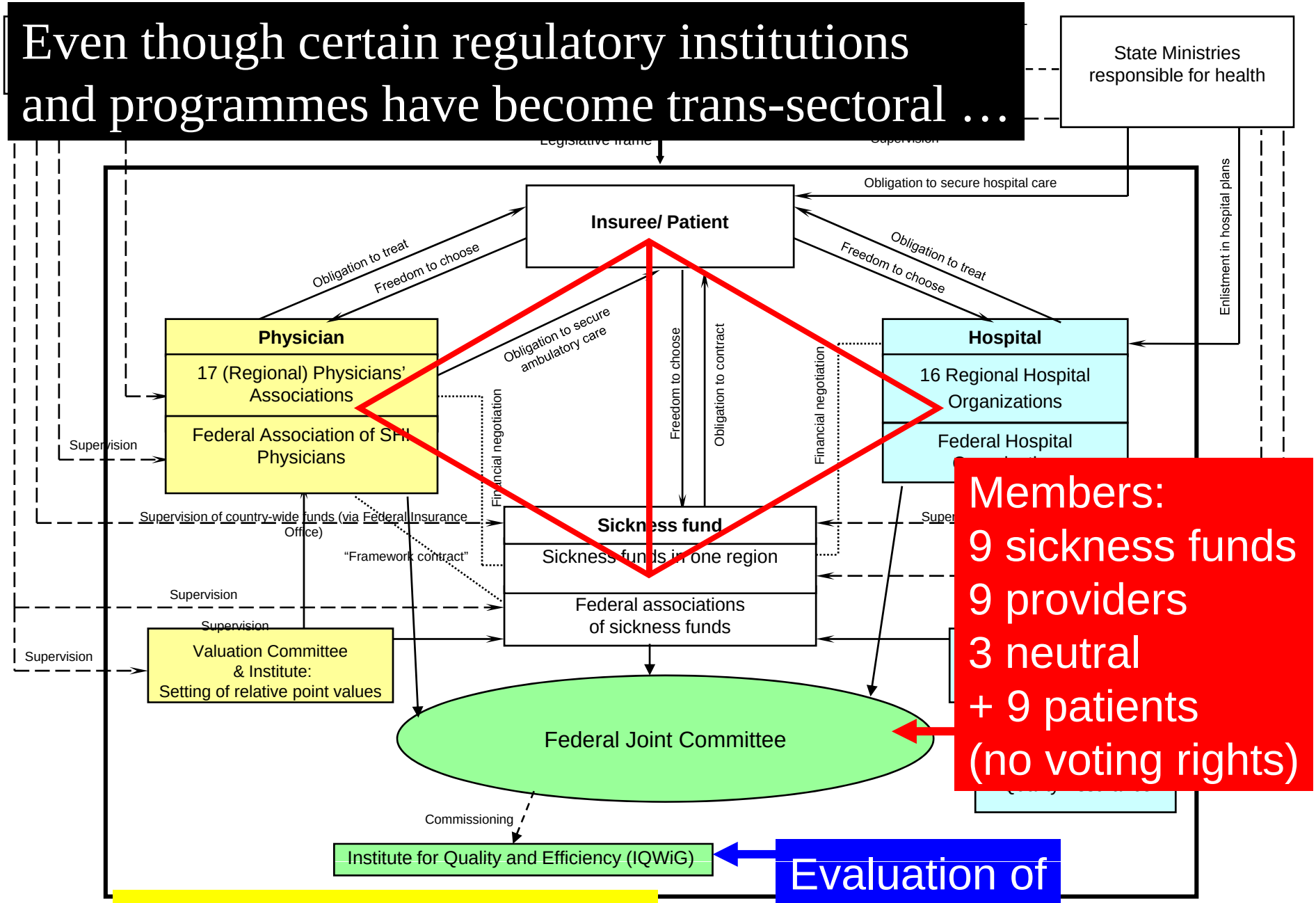


The German system at a glance ...



Statutory health insurance early 2007

Even though certain regulatory institutions and programmes have become trans-sectoral …



Members:
9 sickness funds
9 providers
3 neutral
+ 9 patients
(no voting rights)

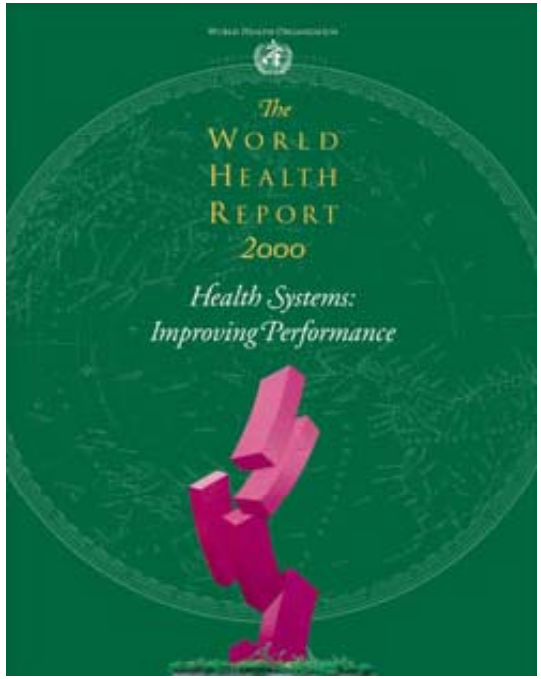
Evaluation of drugs etc.

Joint self-government

Statuto… …early 2007

… 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):

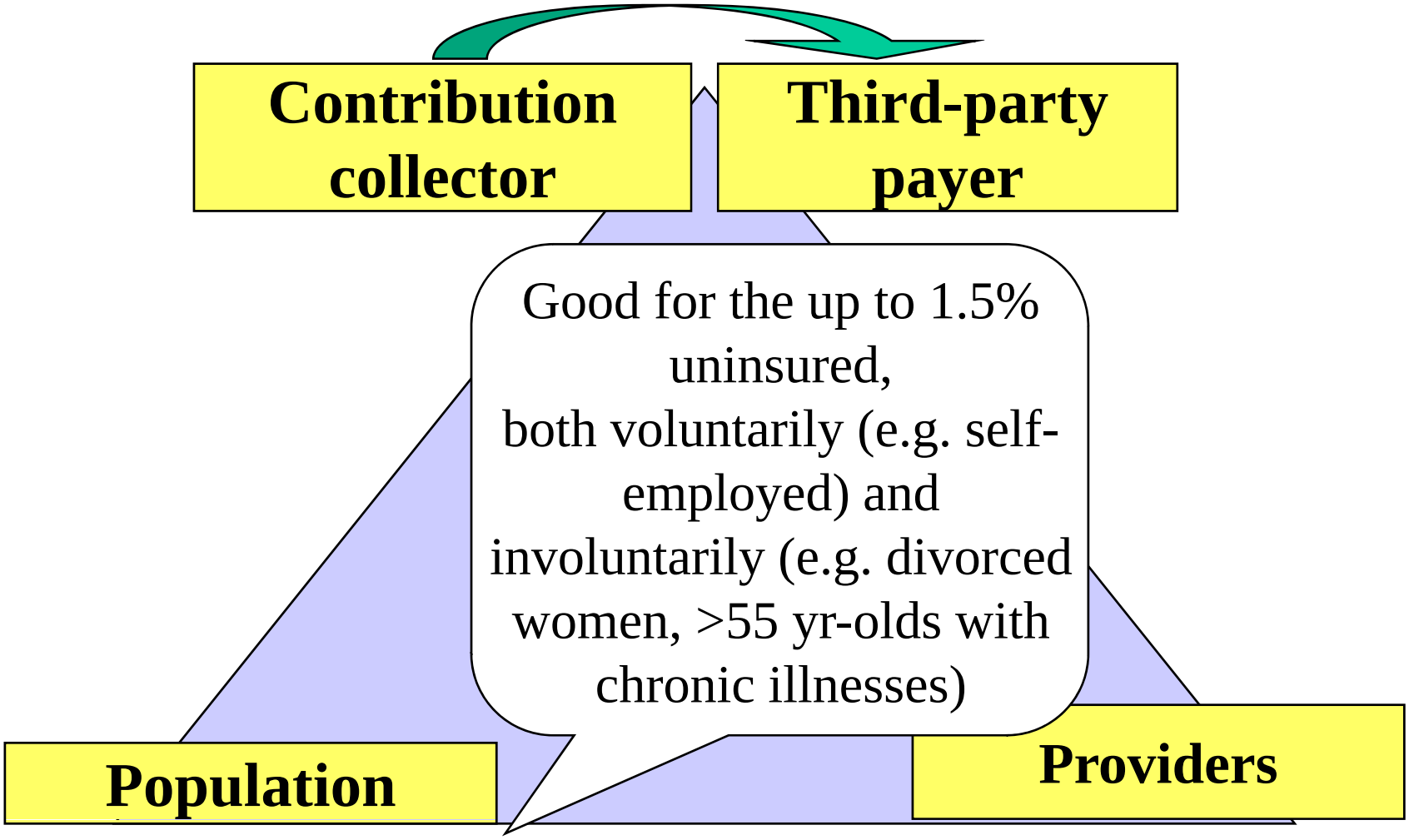
- Pre- and post- inpatient care in hospitals (1997)
- „Integrated [i.e. transsectoral] care“ contracts (2000, funded with 1% of expenditure since 2004)
- Disease Management Programmes (2002) -> *next slide*
- Polyclinics (potentially with hospital owners, 2004)
- „GP contracts“ (insured choose GP as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

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)

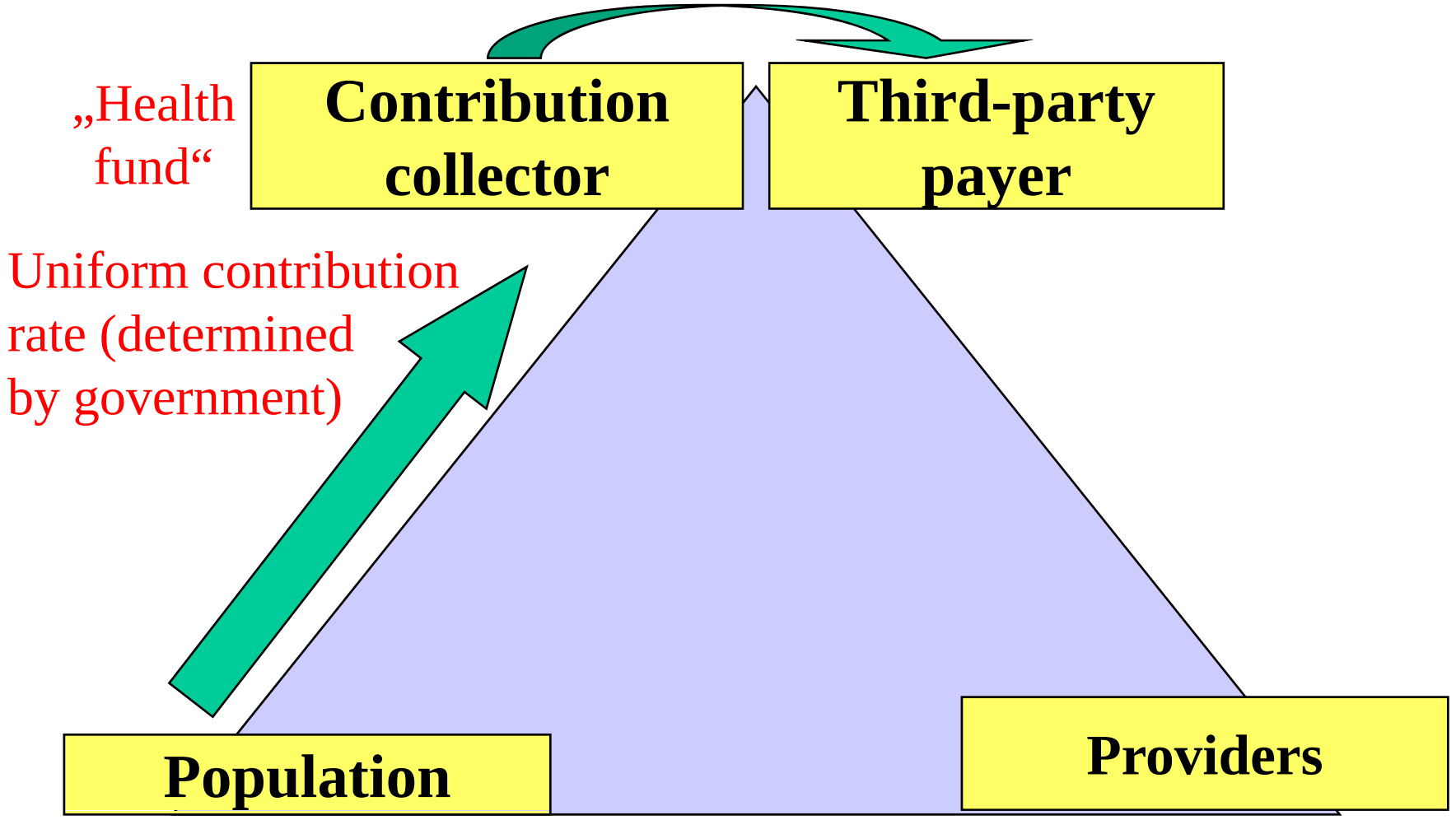
double incentive for sickness funds:
potentially lower costs + extra compensation!
By early 2007: 3.5 mn enrolled (5% of SHI insured)

What has or will be changed by the Competition Strengthening Act and what is the (likely) impact on care coordination?



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



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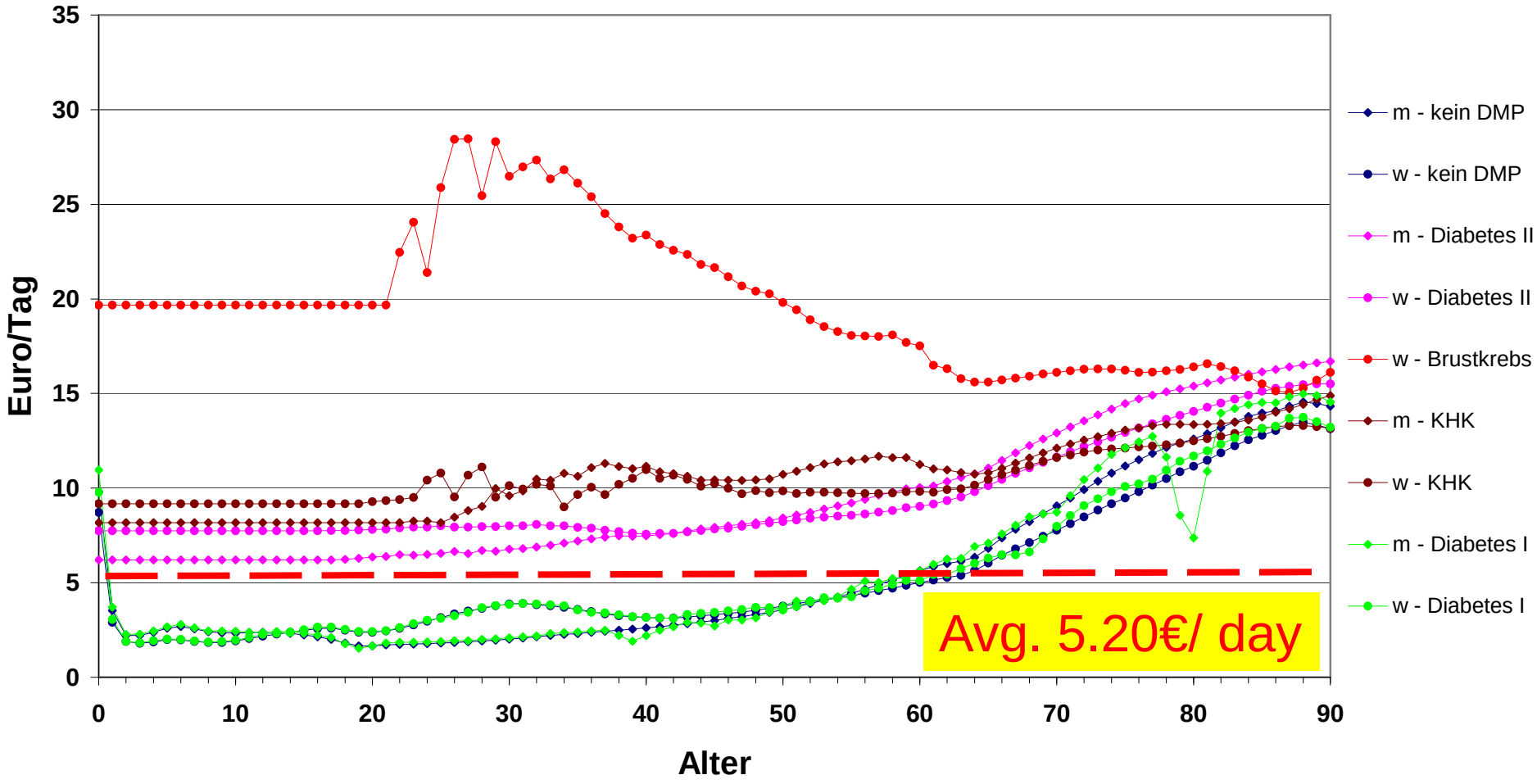
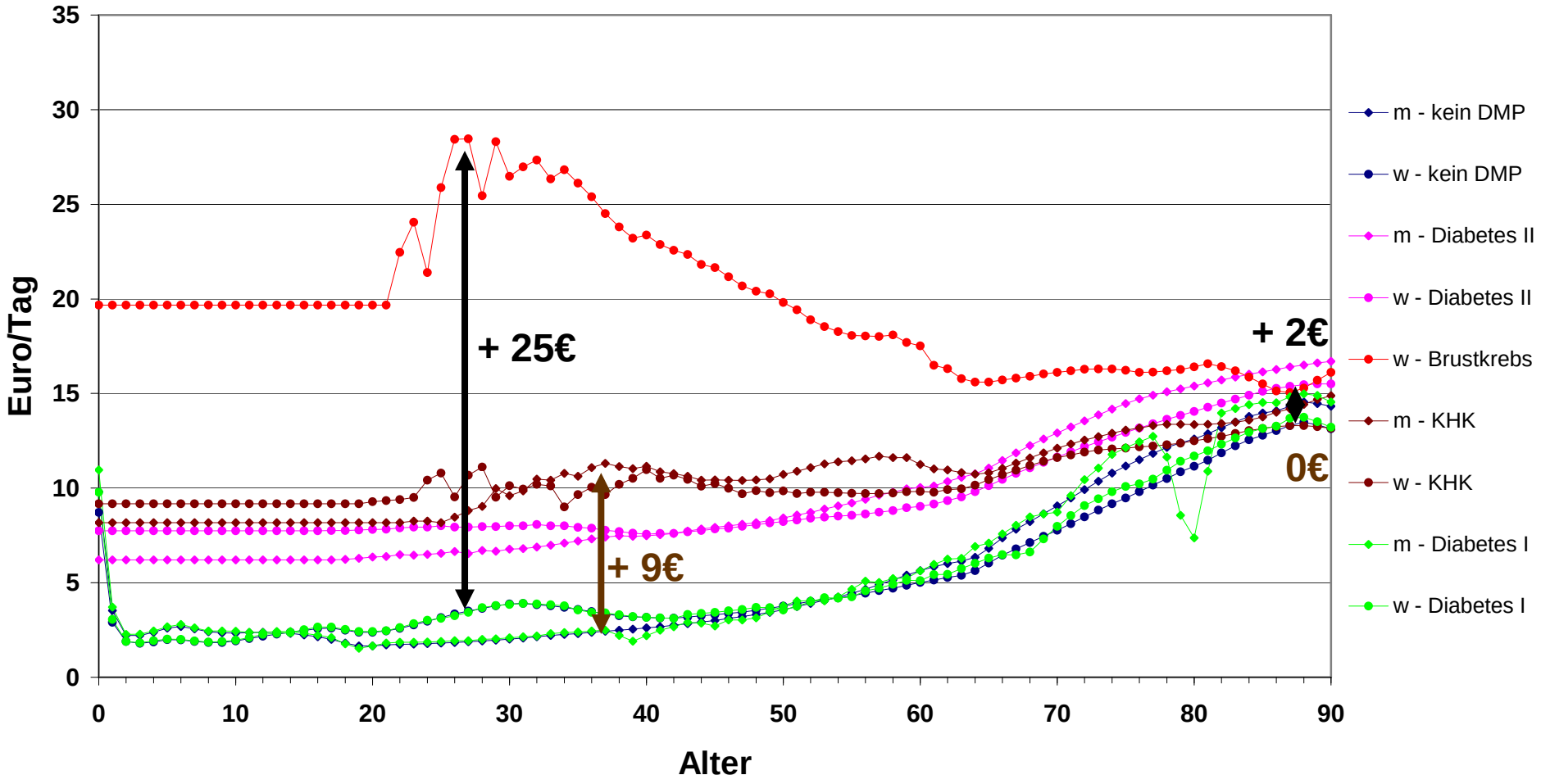
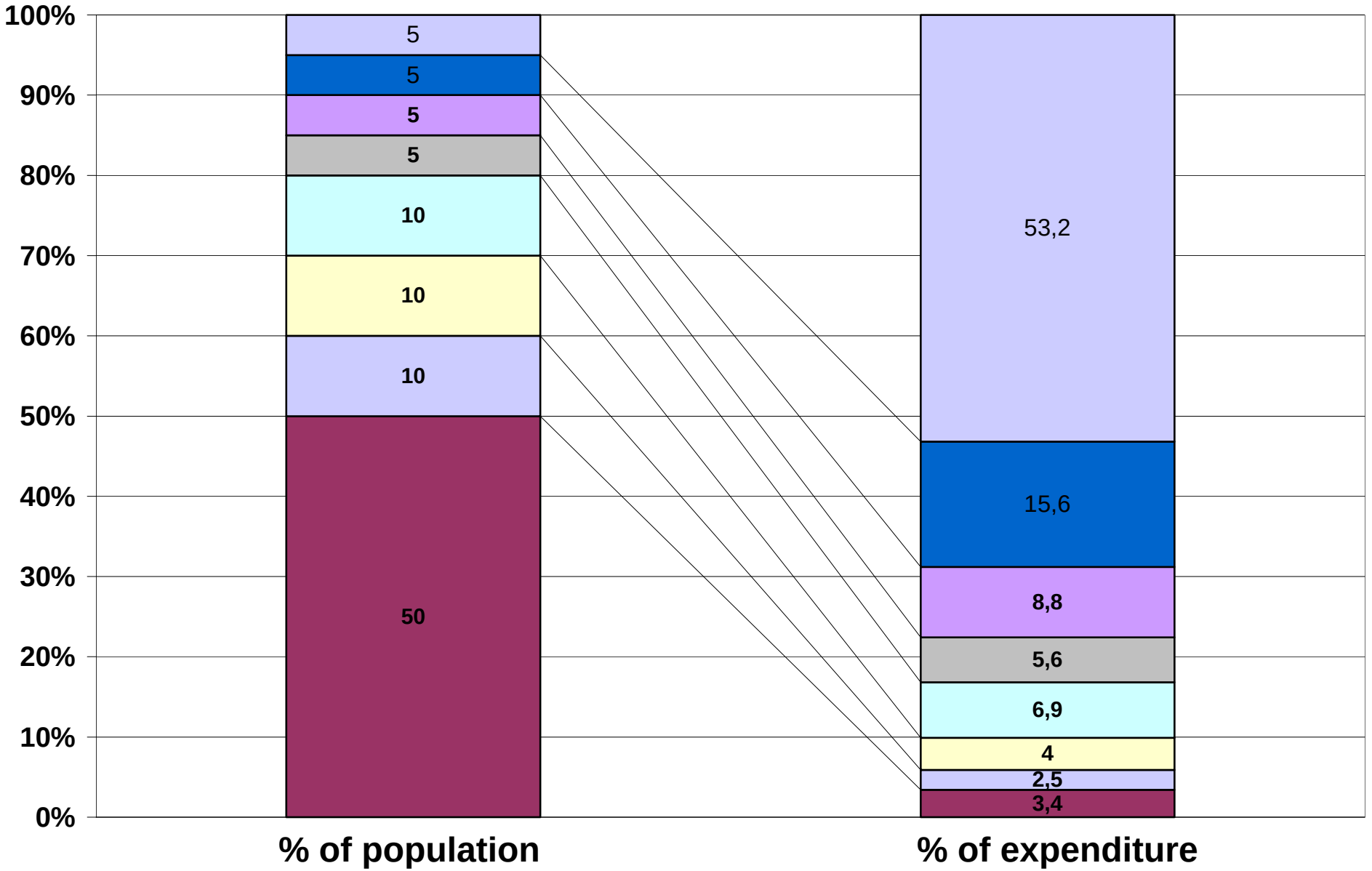
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism (2006)

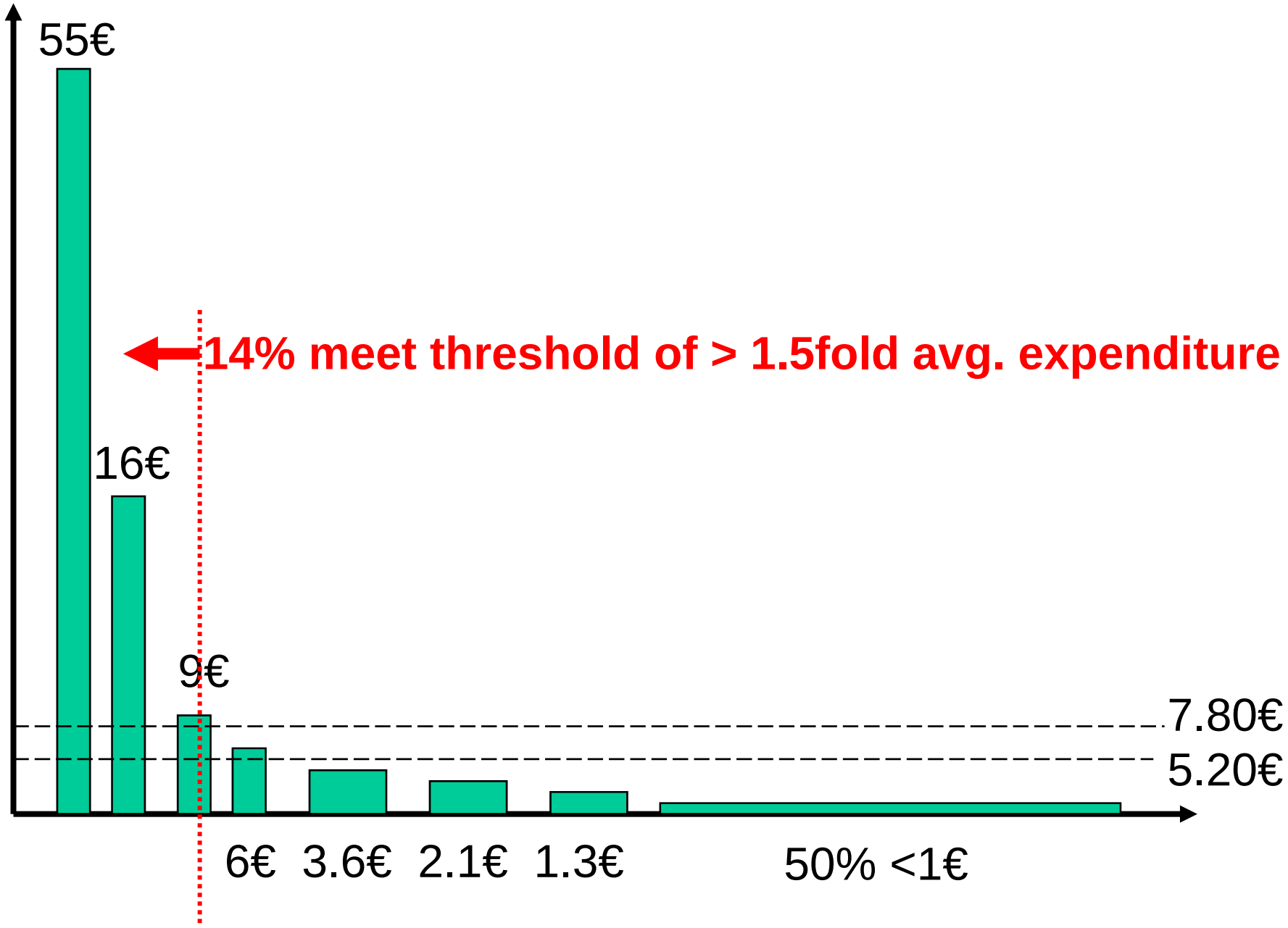


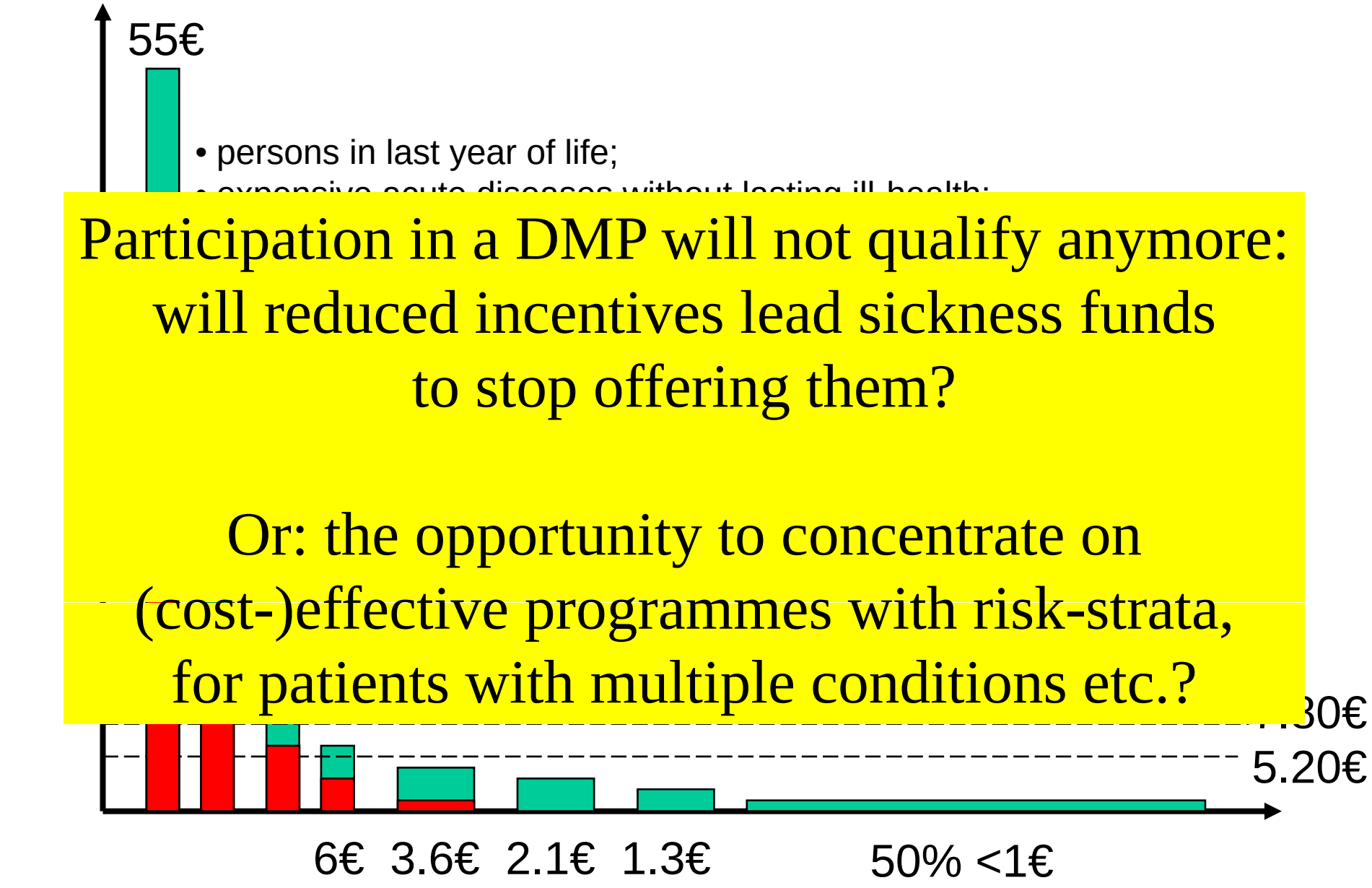
Effect of „illness“ by age differs greatly (2006)



The well-known 20/80 distribution – actually the 5/50 or 10/70 problem

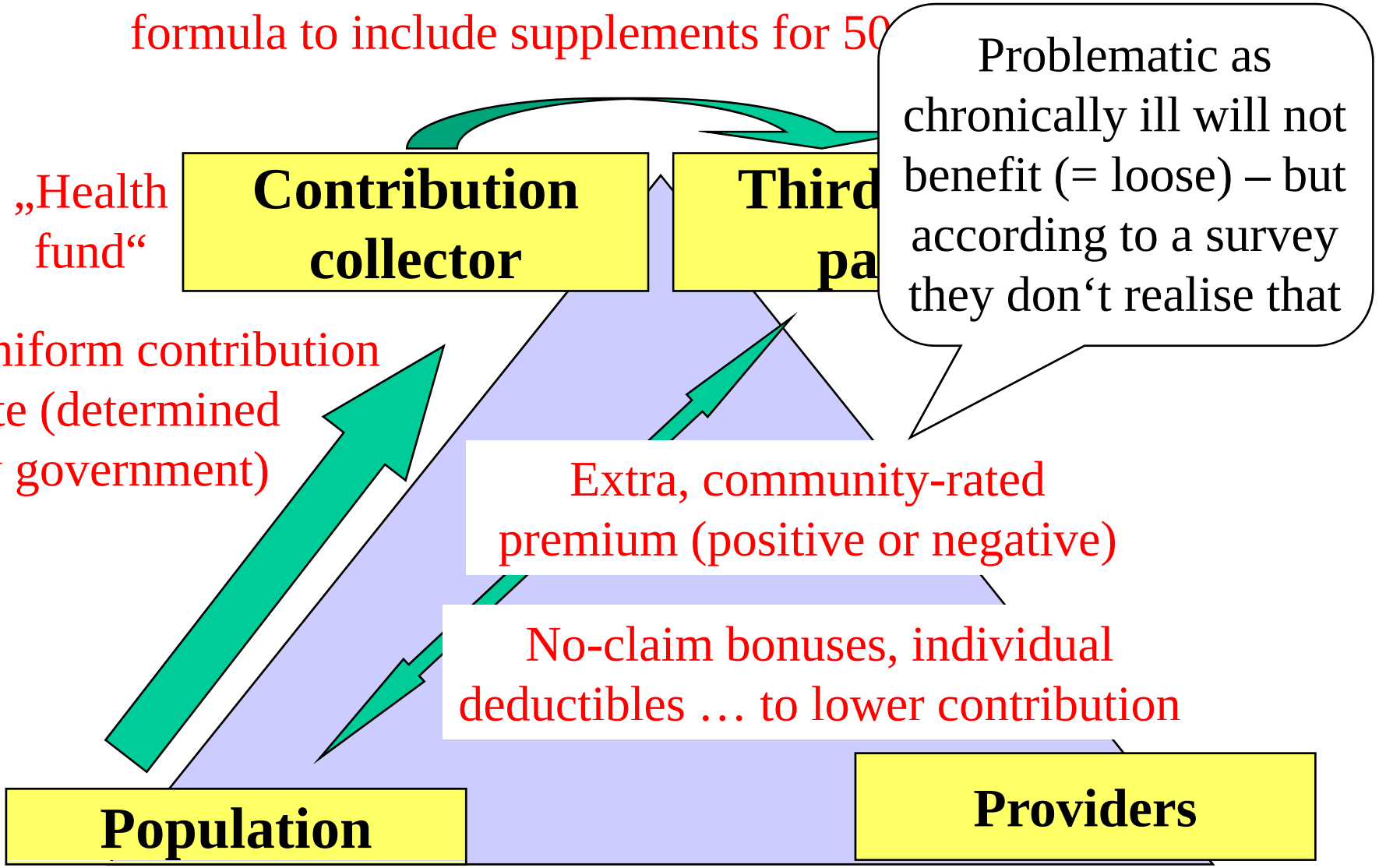



55€
14% meet threshold of > 1.5fold avg. expenditure
16€
9€
7.80€
5.20€
6€
3.6€
2.1€
1.3€
50% <1€



We need to identify 50 to 80 diseases explaining these costs!

Redesigning the risk-adjusted allocation formula to include supplements for 50



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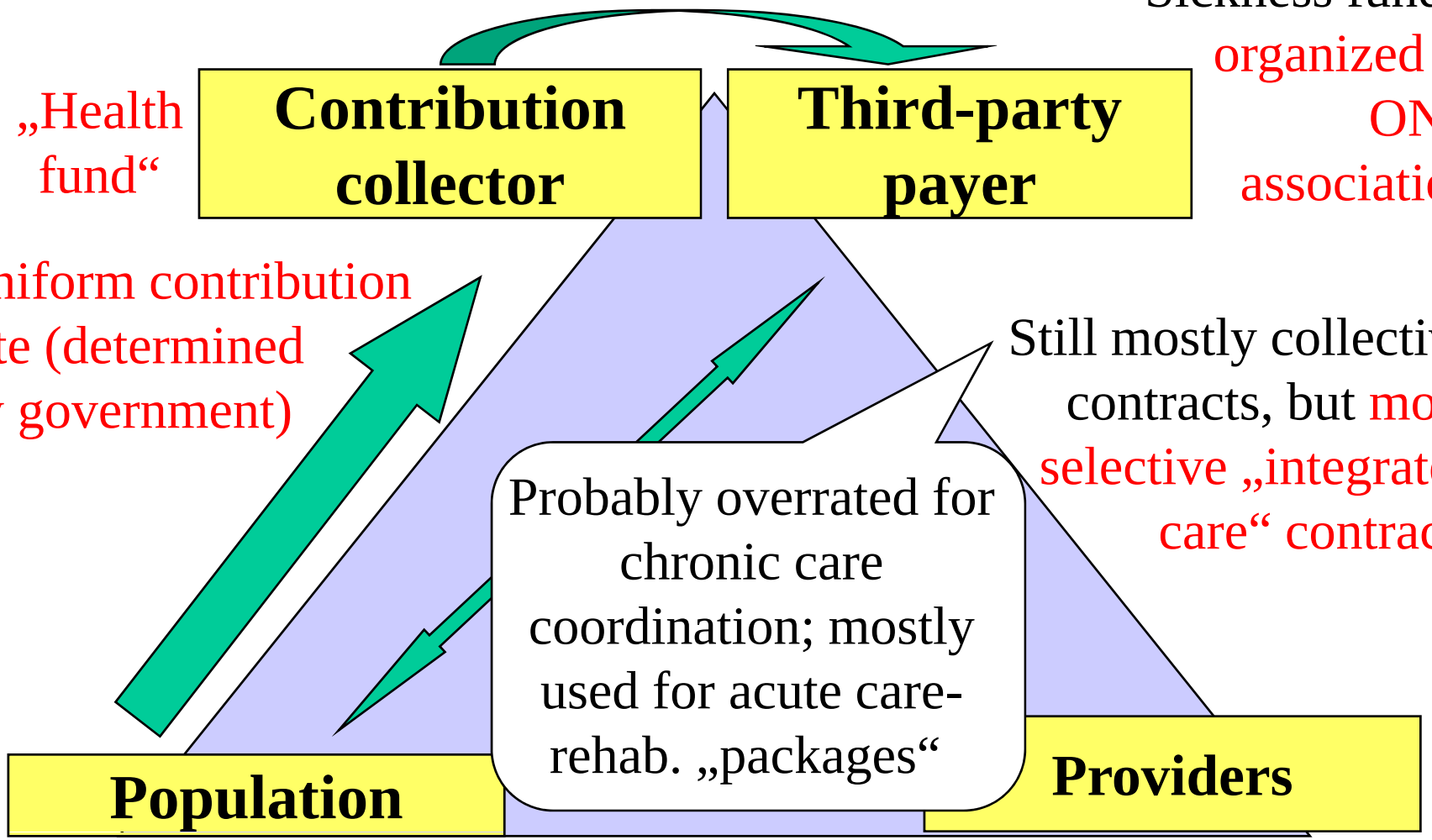

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