Technische Universität Berlin

Germany: How is outpatient reimbursement meant to be?

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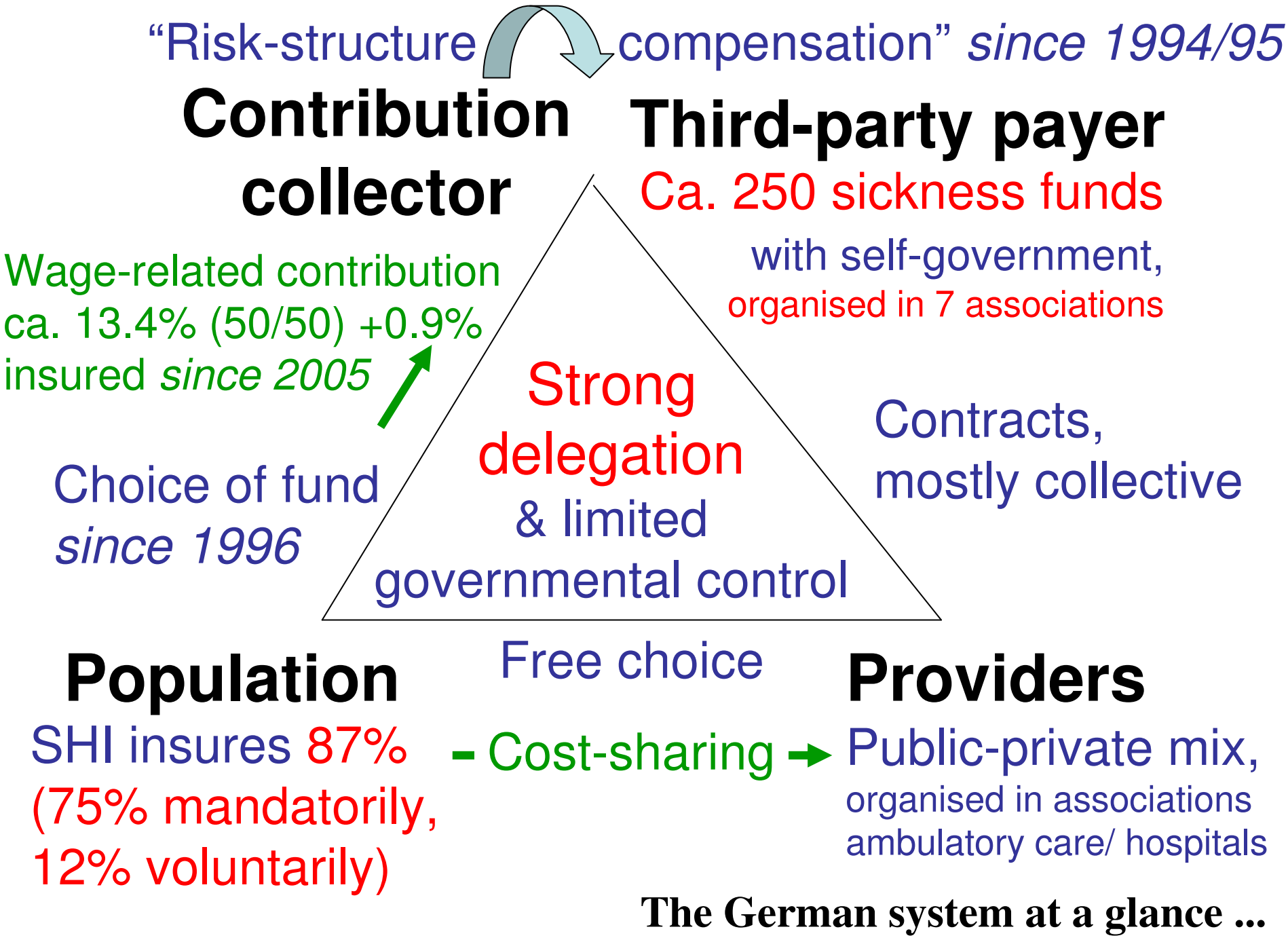
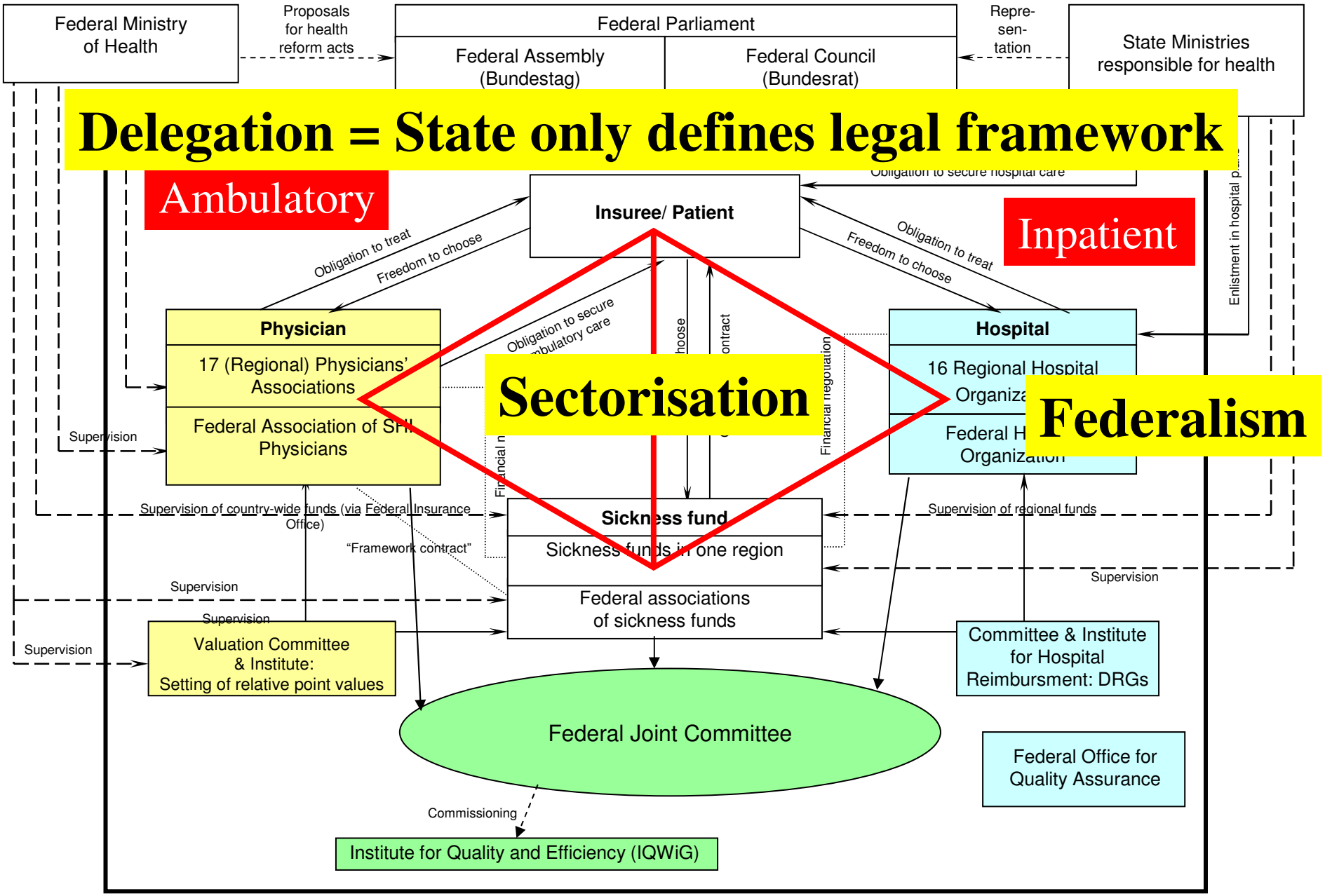
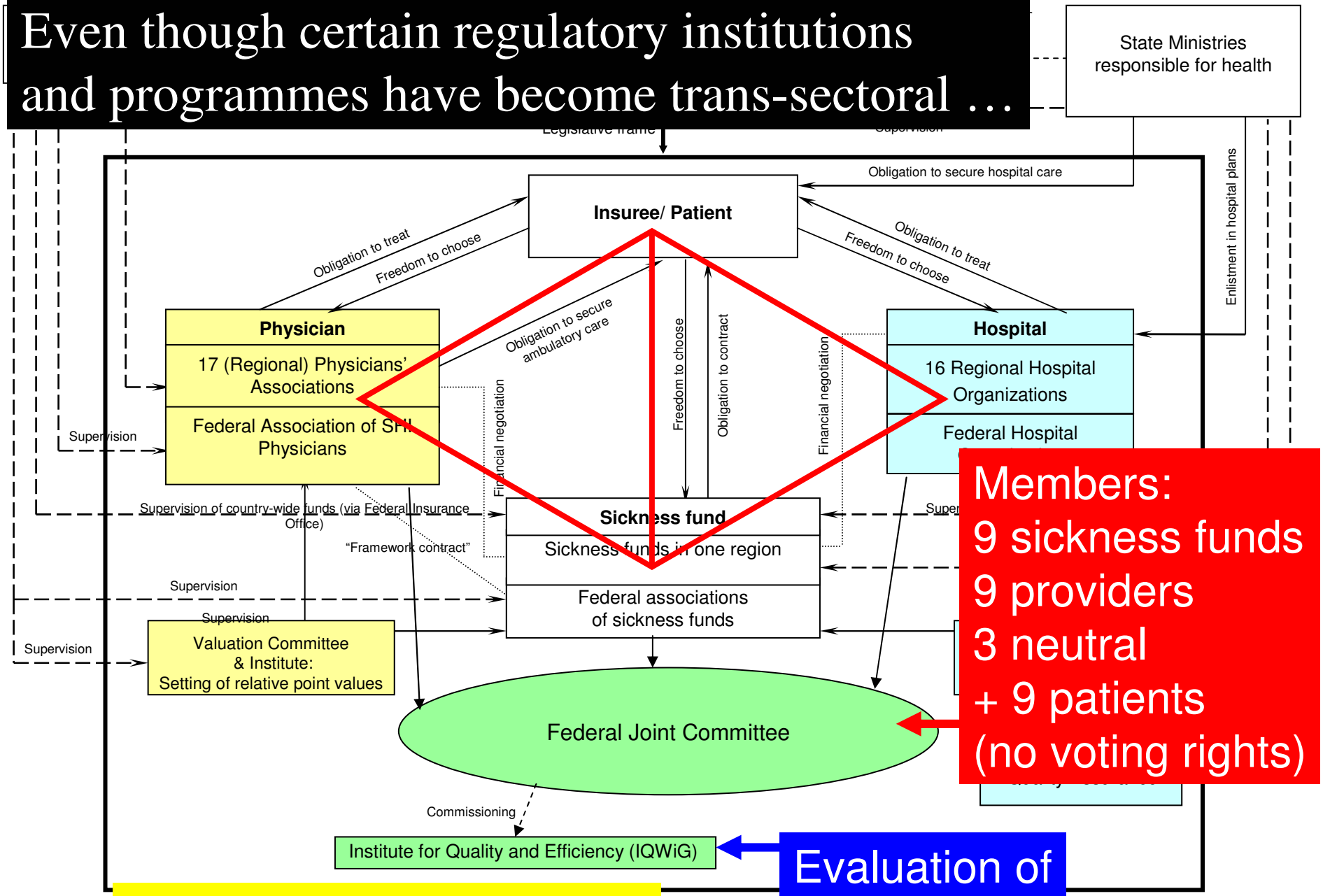


The German system at a glance ...



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)

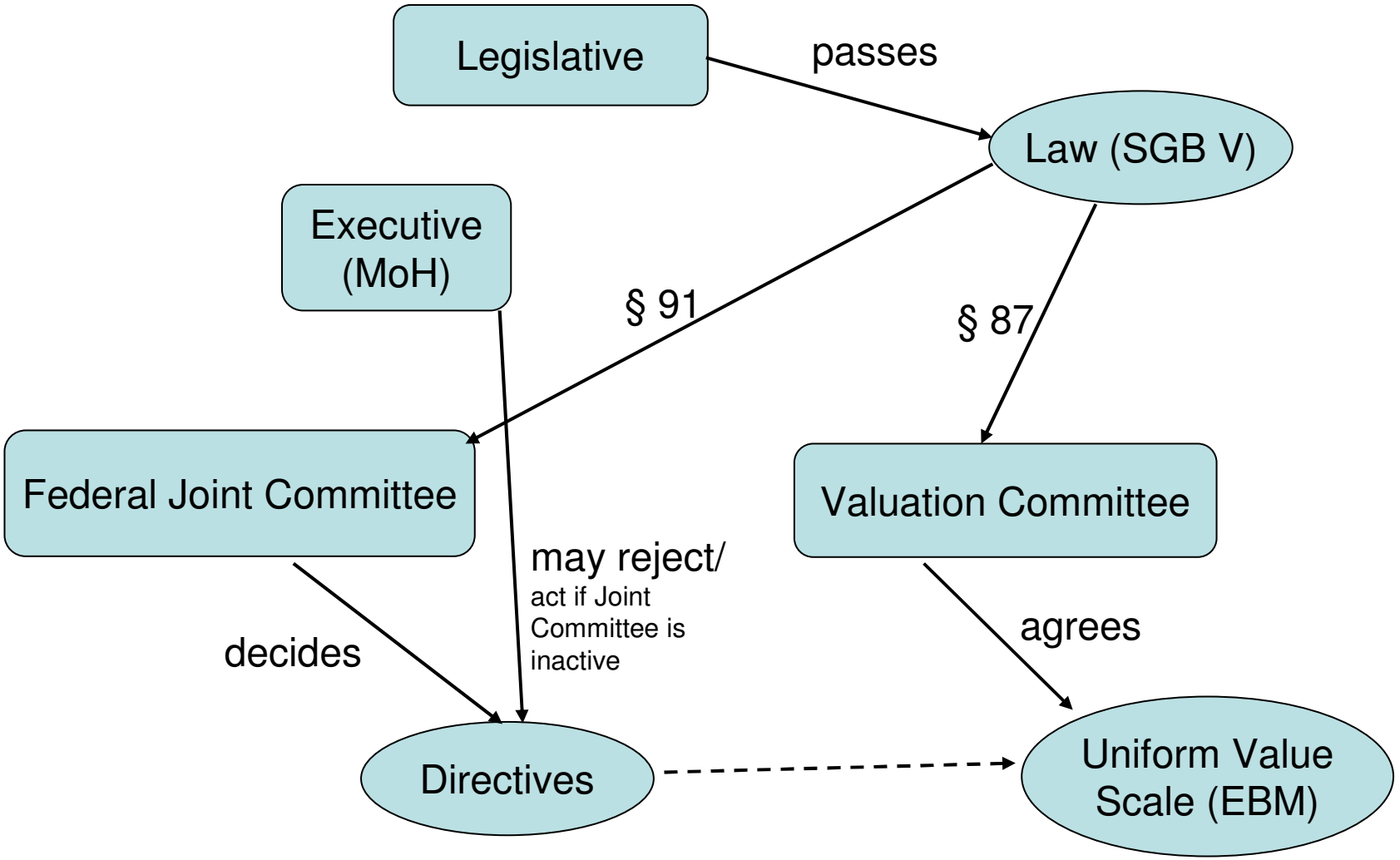
Evaluation of drugs etc.

Joint self-government

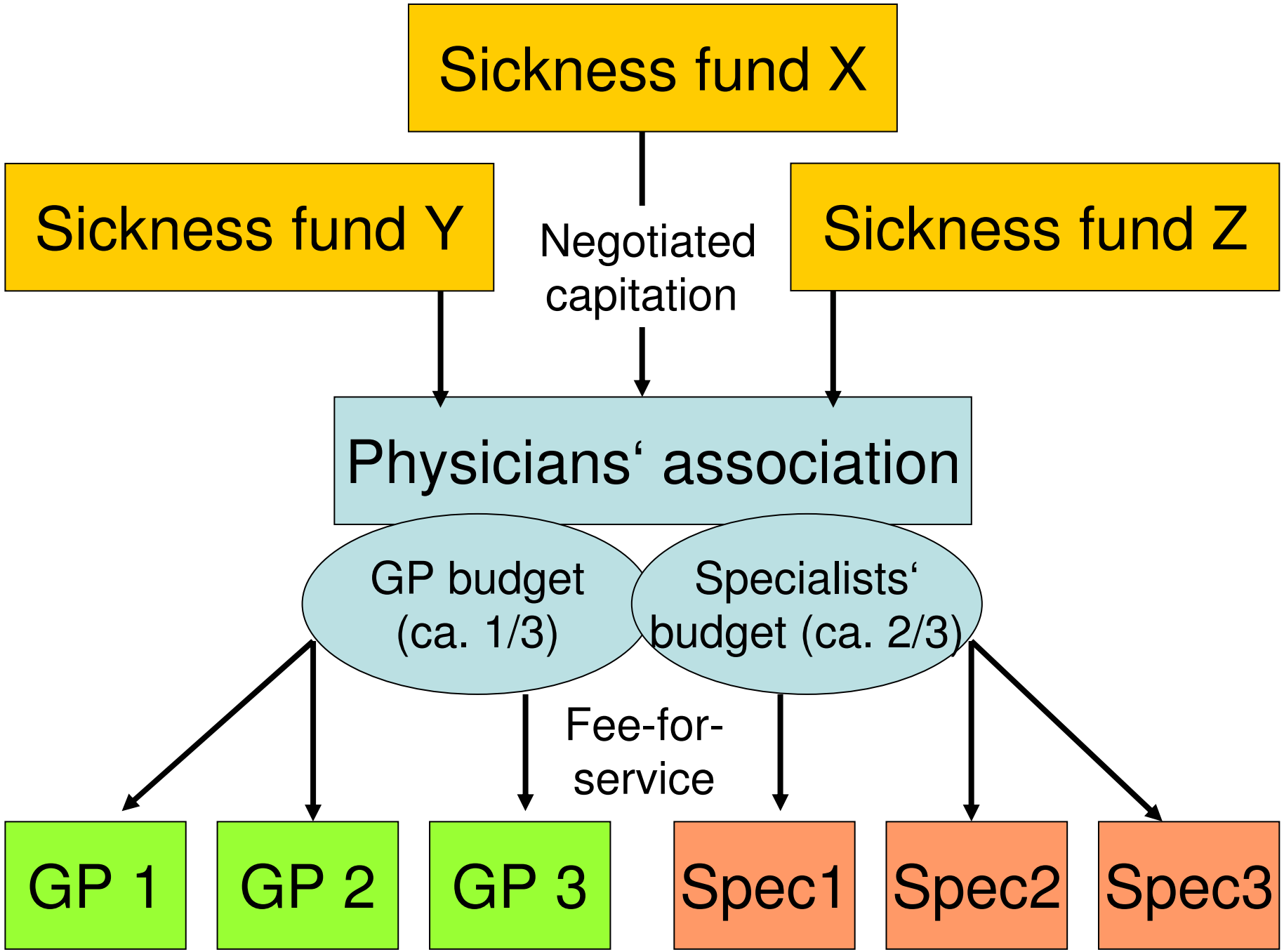
Statutor… …early 2007

Ambulatory care in Germany

- Services delivered by physicians in private practice (physicians‘ associations have legal monopoly for ambulatory care)
- -> very few ambulatory services by hospitals
- Services delivered by dentists
- Services by non-physicians upon prescription by physicians
- Goods: pharmaceuticals
- Goods: medical aids

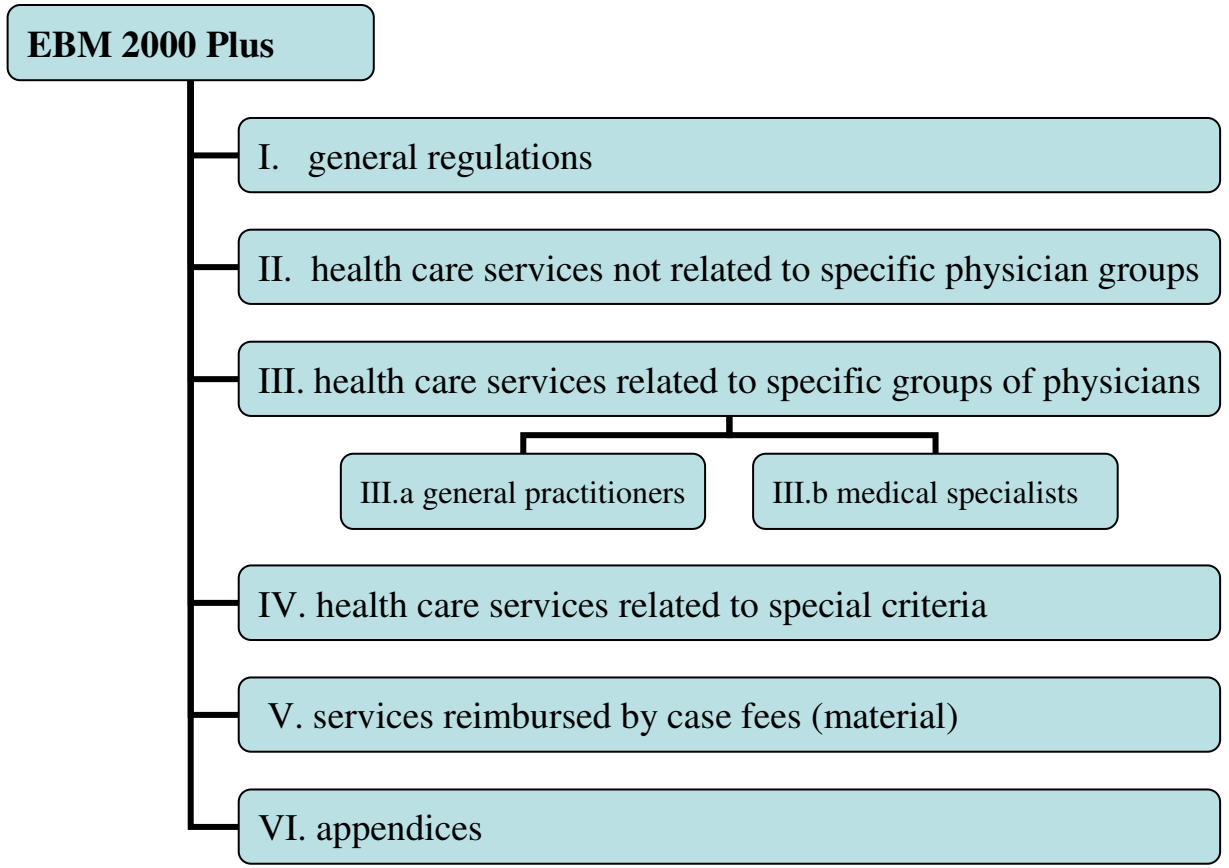


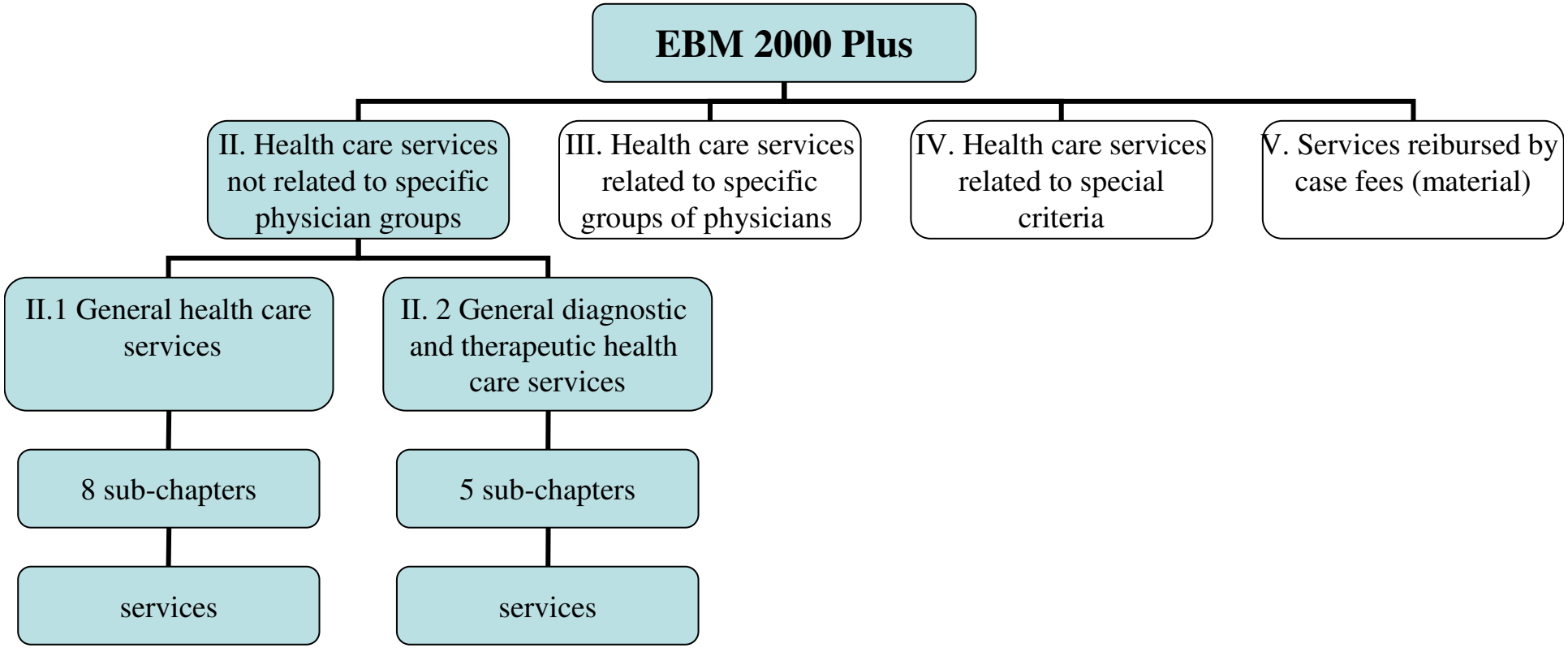
Decision-making on benefits in Germany (here: ambulatory care)

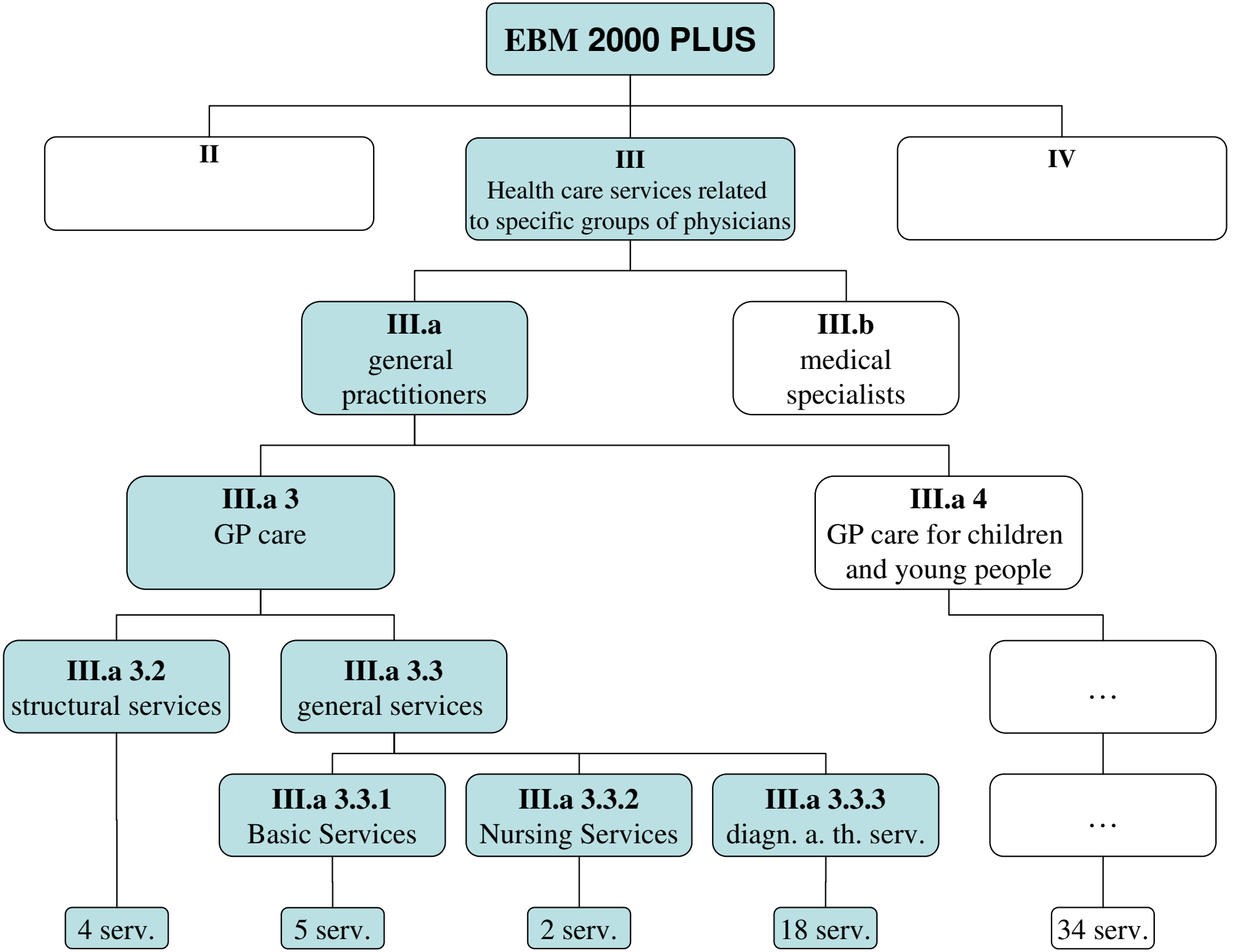

Sickness fund X
Sickness fund Y
Negotiated capitation
Sickness fund Z
Physicians‘ association
GP budget (ca. 1/3)
Specialists‘ budget (ca. 2/3)
Fee-for-service
GP 1
GP 2
GP 3
Spec1
Spec2
Spec3

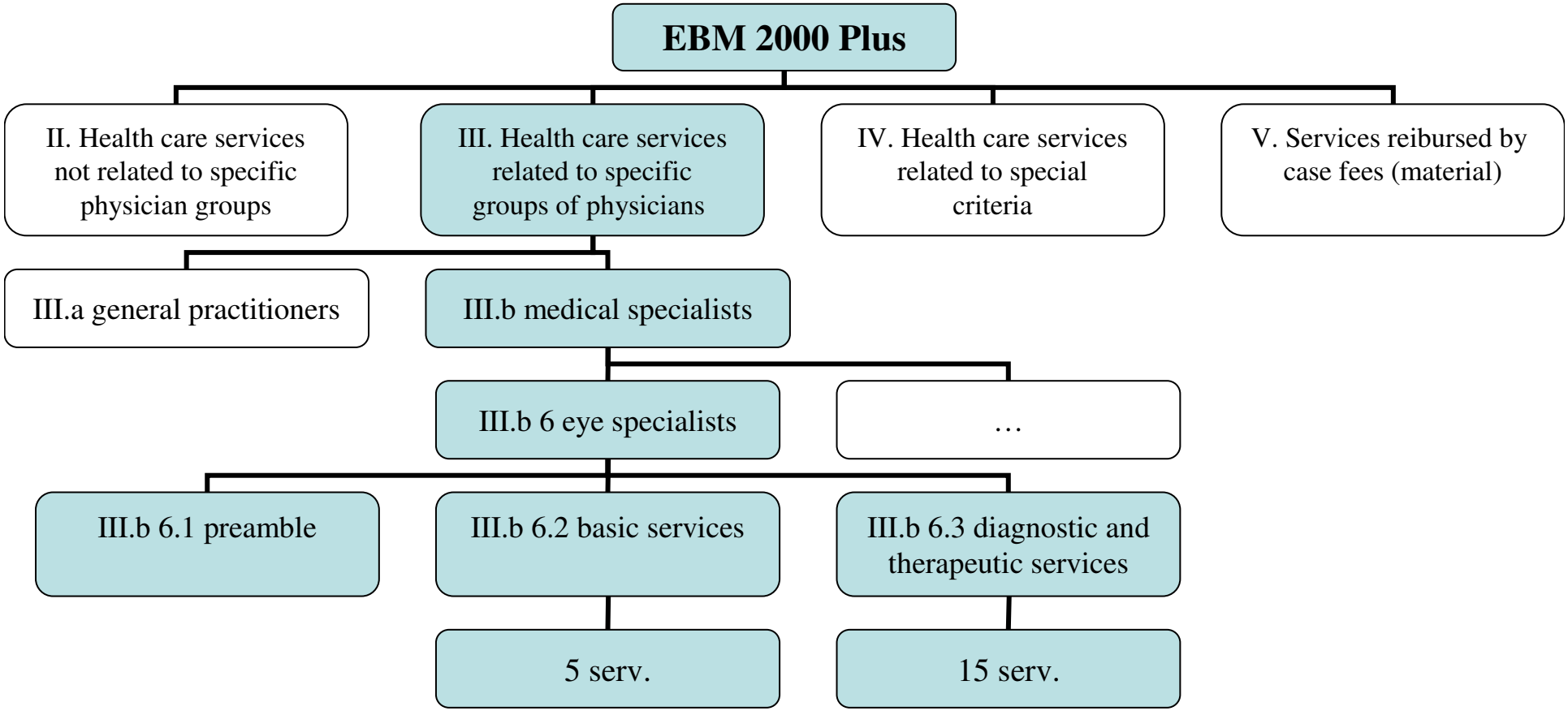
Fee schedule “Uniform value scale” *EBM 2000 plus* (since April 2005)

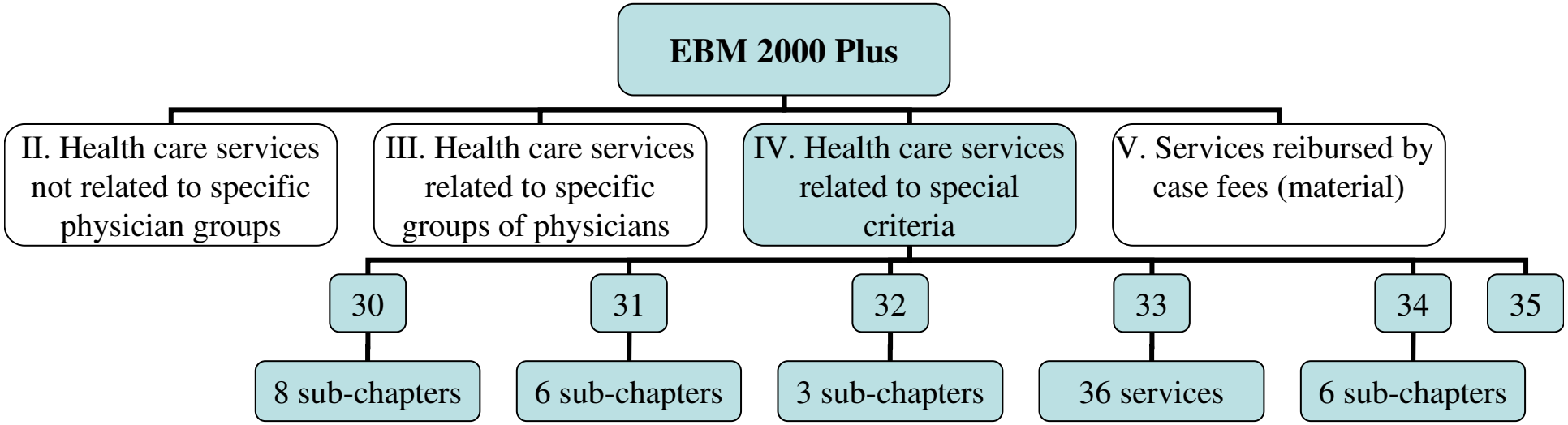
- Based on time units
- Negotiated value of physicians’ work: 0.77 €/ minute (ca. 95,000 €/ year)
- Multiplied by estimated average amount to provide service
- + monetary value of “technical” component (but devices for individual patients are paid separately through lump sum)
- Sum is divided by 0.051 € and expressed in points


EBM 2000 Plus
I. general regulations
II. health care services not related to specific physician groups
III. health care services related to specific groups of physicians
III.a general practitioners
III.b medical specialists
IV. health care services related to special criteria
V. services reimbursed by case fees (material)
VI. appendices


EBM 2000 Plus
II. Health care services not related to specific physician groups
III. Health care services related to specific groups of physicians
IV. Health care services related to special criteria
V. Services reibursed by case fees (material)
II.1 General health care services
II. 2 General diagnostic and therapeutic health care services
8 sub-chapters
5 sub-chapters
services
services


EBM 2000 PLUS
II
III
Health care services related to specific groups of physicians
IV
III.a
general practitioners
III.b
medical specialists
III.a 3
GP care
III.a 4
GP care for children and young people
III.a 3.2
structural services
III.a 3.3
general services
…
III.a 3.3.1
Basic Services
III.a 3.3.2
Nursing Services
III.a 3.3.3
diagn. a. th. serv.
…
4 serv.
5 serv.
2 serv.
18 serv.
34 serv.


EBM 2000 Plus
II. Health care services not related to specific physician groups
III. Health care services related to specific groups of physicians
IV. Health care services related to special criteria
V. Services reibursed by case fees (material)
III.a general practitioners
III.b medical specialists
III.b 6 eye specialists
…
III.b 6.1 preamble
III.b 6.2 basic services
III.b 6.3 diagnostic and therapeutic services
5 serv.
15 serv.


EBM 2000 Plus
II. Health care services not related to specific physician groups
III. Health care services related to specific groups of physicians
IV. Health care services related to special criteria
V. Services reibursed by case fees (material)
30
31
32
33
34
35
8 sub-chapters
6 sub-chapters
3 sub-chapters
36 services
6 sub-chapters

How does a new technology/ service enter the system?

- In ambulatory care officially: Sickness fund or physicians‘ asociation make proposal to Fed. Joint Com. which may commission an evaluation through IQWiG; if positive -> passed to Valuation Com. to determine point value
- Inofficially moreoften through reformulation of service definition through Valuation Com.
- Contrast to inpatient care: Hospital can provide any service which is not explicitly excluded - but (separate) reimbursement is a different matter

Fee schedule: changes from 2008/09

- Calculated income of physicians increased from 95,000 € to 105,000 €
- Number of points to be increased on average by 10% in 2008 (but with great variations among specialties, favouring GPs)
- More services will be included into “quarterly case fees” (especially, but not only for GPs)
- Points will be changed to € values in 2009
- Capitation from sickness funds to physicians’ associations will be morbidity-adjusted

Medical aids

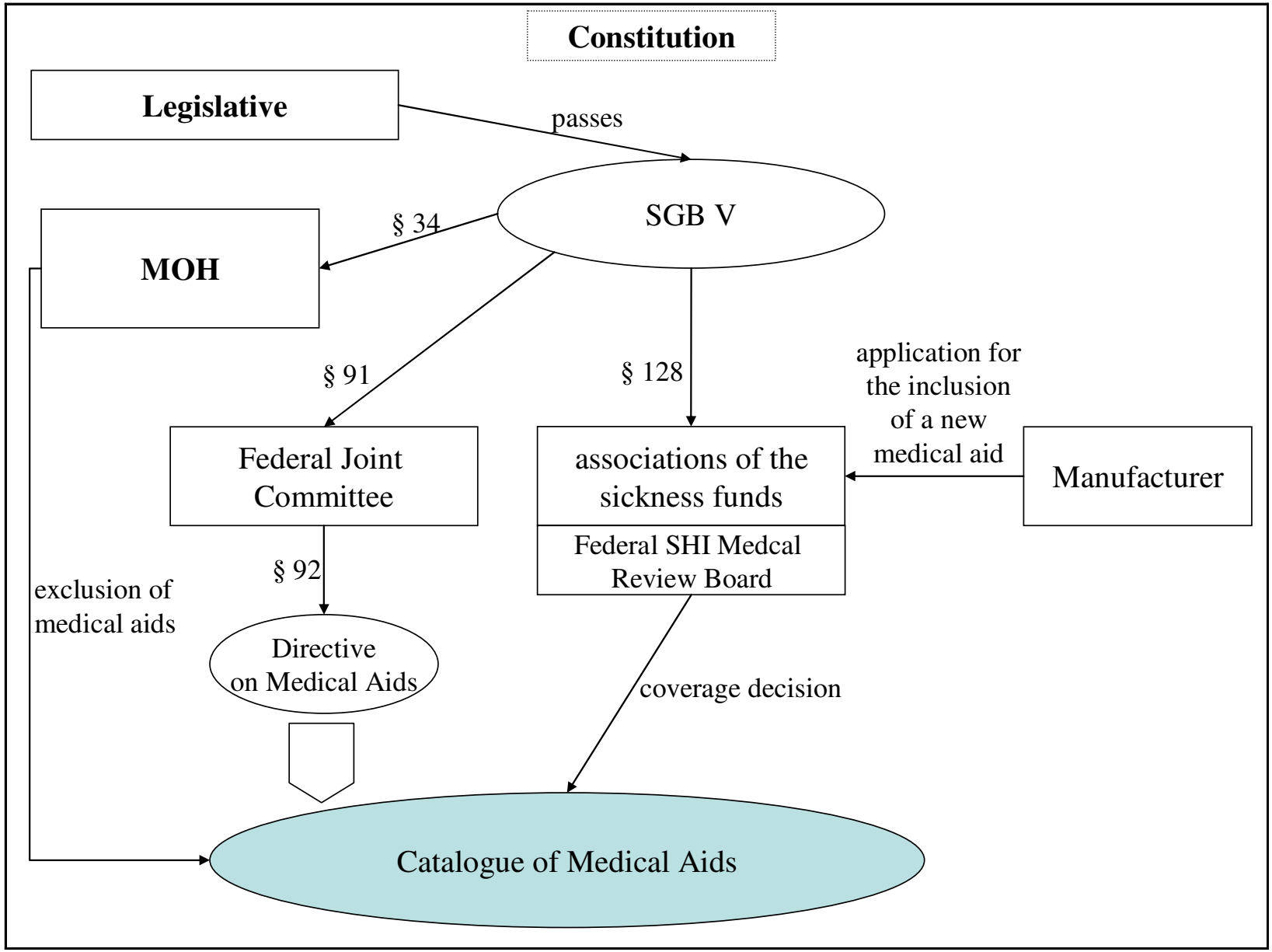
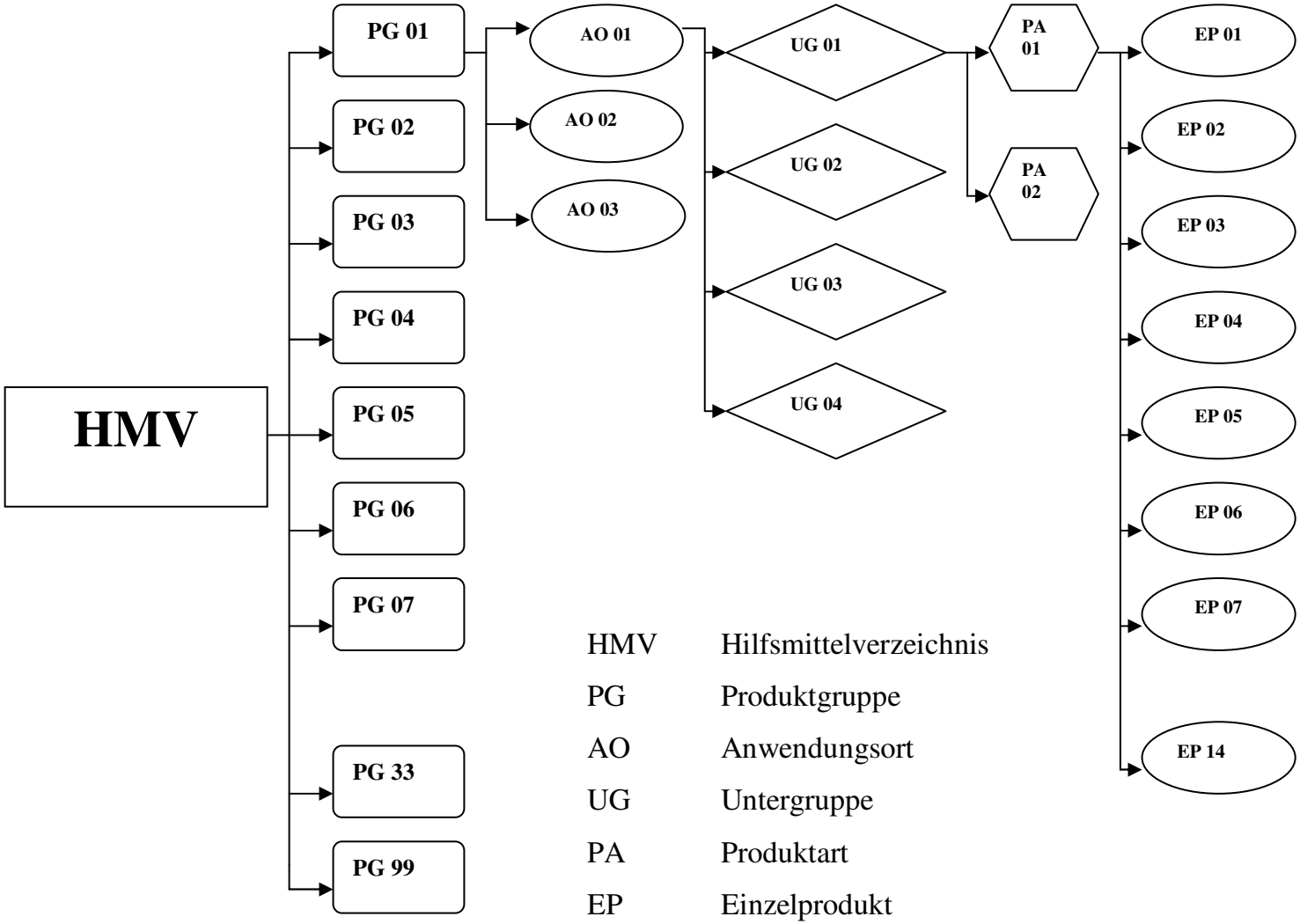


Table 1: Overview of the 34 product groups specified in the Catalogue for Medical Aids

Product group	No.	Product group	No.
suction devices	01	transportation	18
adaptors	02	nursing care aids	19
applicators	03	storage aids	20
aquatic therapy aids	04	measuring instruments	21
bandages	05	mobilzing aids	22
radiation units	06	orthotic devices	23
appliances for amaurotics	07	artificial limb	24
arch-supports	08	spectacles	25
electrical stimulation devices	09	sitting aid	26
crutches	10	speaking aid	27
medical aids against decubituss	11	standing aid	28
aids for persons without larynx	12	stoma products	29
hearing aids	13	splints	30
inhalators	14	shoes	31
medical aids for incontinence	15	therapeutical motion device	32
communication appliances	16	toilet aids	33
elastic compression	17	miscellaneous	99

Therapeutic appliances and medical durables: Hilfsmittel-Verzeichnis



HMV	Hilfsmittelverzeichnis
PG	Produktgruppe
AO	Anwendungsort
UG	Untergruppe
PA	Produktart
EP	Einzelprodukt

Latest developments

- Politicians have discovered medical aids as field for regulation relatively recently
- -> reference prices (= max. reimbursement price for sickness funds) per product group
- -> inclusion of prostheses with discussion good vs. service component
- -> new law calls for procurement of medical aids through sickness funds

Some general reflections about paying service providers and goods manufacturers

What do we pay providers and manufacturers for? (1)

- For being there, having staff with the right qualifications and the necessary technologies ("availability/accessibility"): This can be institution-based (i.e. taking the size, number of staff and available technologies into account) or population-based (which requires a defined catchment area for the provider).
- For providing services and goods if, when and to the degree necessary: This payment form is what is usually termed "capitation". It requires that the persons for which a capitation is paid (who not necessarily all become patients) are well defined, either by their insurance status, their inscription or a defined catchment area. The capitation may be risk-adjusted (by age, sex, morbidity/ illness status). Certain types of services and/ or goods may be excluded, i.e. paid separately (through one of the other payment mechanisms).

What do we pay providers and manufacturers for? (2)

- For the effort to provide all services to presenting/ admitted patients: This will result in a payment only for actual patients and is often referred to as “case fee” and can be based on a visit, a hospital stay or a care episode over a defined length of time. It may be differentiated by the indication (i.e. the reason for presentation/ admittance), demographic variables and/or health status (severity of disease and/or comorbidity).
- For the effort to provide individual services: This is the classical “fee-for-service” system. A characteristic is the degree of freedom to the provider to determine the provided services and therefore their level of reimbursement.
- For the “ability to improve” (potential “value”): Under this logic, the amount of payment is tied to the expected health improvement (based on clinical trials and/or registers with previous patients). The price will be set as a monetary value per expected unit of improvement. It may be based on the average benefit or vary by sub-group.

What do we pay providers and manufacturers for? (3)

- For choosing the appropriate technology (service and/or good), i.e. “to do the right thing”: This will be in the form of a bonus/malus system modifying one of the other payment mechanisms) – with, in the extreme case, a malus of 100% for providing a clearly inappropriate service.
- For quality, i.e. “doing the thing right”: It will be most likely by used in the form of a bonus/ malus system modifying payments based on other mechanisms.
- For actual outcome (actual “value”): Under this logic, the payment awards (or punishes) the actual change in health status vs. not having provided the service or good. It will be most likely by used in the form of a bonus/ malus system modifying payments based on other mechanisms.
- As a “damage compensation” for the patient, i.e. the impaired health status will determine the amount of money paid. Most likely the amount will be based on the price for the “repair”; either based on the minimum or the average price.