The German Health Care System –
A short introduction for the uninitiated

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Third-party payer

Collector of resources

Steward/regulator

Population

Providers
**Contribution collector**
- Wage-related contribution ca. 13.4% (50/50) +0.9% insured since 2005
- Choice of fund since 1996

**Strong delegation & limited governmental control**

**Third-party payer**
- Ca. 250 sickness funds with self-government, organised in 7 associations
- Contracts, mostly collective

**Population**
- SHI insures 87% (75% mandatorily, 12% voluntarily)

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

**“Risk-structure compensation” since 1994/95**
- Free choice
- Cost-sharing

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

Ambulatory

Inpatient

Sectorisation

Federalism

Statutory health insurance early 2007
Even though certain regulatory institutions and programmes have become trans-sectoral …
care 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/ overcome sectorisation

- 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)
Innovations and reimbursement: drugs + hospital care
Innovative drugs excluded from reference pricing

Copayments increased

Copayments decreased

Regional drug budgets were abolished

Physician specific drug budgets were introduced

Amendments to reference pricing scheme (RPs decreased, exemptions from co-payments for Drugs price 30% below RP); prescribing targets introduced; forced rebates;

Me-too drugs under patent protection were put under reference pricing

Change in co-payments; price freeze

Price freeze ended

16.8%
Implausibility of major diagnosis, medical procedures, demographic characteristics etc.

Transplantation, ventilation, HIV etc.

Major diagnosis

MDC 1  MDC 2  MDC 3  ...  ...  ...  MDC 23

+ at least one surgical procedure

+ no surgical procedure, but one other procedure being essential for the respective MDC

Surgical DRGs

Other DRGs

Medical DRGs

Adjacent-DRGs

(G-DRG 2006: n = 578)

n = 353

No significant differences in the resource consumption

unsplited DRGs (n=353)

Co-morbidity, medical procedures, age, clinical severity, complication, cause of hospital discharge

splited DRGs (n=559)

Significant differences in resource consumption

n = 225
National uniform standards

A1 Emergency care
(§ 17b Abs. 1 S. 4 KHG i.V.m. § 4 Abs. 5 S. 2 KHEntgG)

A2 Accompanying persons
(§ 17b Abs. 1 S. 4 KHG)

A3 Quality assurance surcharges & deductions
(§ 7 S. 1 Nr. 7 KHEntgG)

B1 Surcharges for day-outlier with a longer length of stay
(§ 1 Abs. 2 FPV 2006)

B2 National uniform valuated DRG cost-weights (n=914)
(Case Fees Catalogue 2006)

B3 Deductions for day-outlier with a shorter length of stay and early patient transfer
(§ 1 Abs. 3 and § 3 FPV 2006)

Effective case-mix

Case-mix

Hospital-specific negotiations

D1 Not national uniform valuated DRG cost-weights (n = 40)
(Appendix 3 FPV 2006 i.V.m. § 6 Abs. 1 S. 1 Nr. 2 KHEntgG)

D2 Not national uniform valuated supplementary fees (n = 42)
(Appendix 4 und 6 FPV 2006)

D3 Day cases of curative care
(§ 6 Abs. 1 S. 1 Nr. 2 KHEntgG)

D4 Additional fees for highly specialised services which are not reimbursed appropriately
(§ 6 Abs. 2a KHEntgG)

D5 Foreign patients
(§ 4 Abs. 10 KHEntgG)

D6 Contracts for integrated care

B1 Surcharges for day-outlier with a longer length of stay
(§ 1 Abs. 2 FPV 2006)

E1 Surcharges for innovative diagnostic & treatment procedures
(§ 6 Abs. 2 KHEntgG)

E2 Surcharges for specialised centres e.g. heart centre
(§ 5 Abs. 3 KHEntgG)

E3 Apprenticeship surcharge
(§ 17a KHG)

E4 Service guarantee surcharge
(§ 5 Abs. 2 KHEntgG)

E5 Foreign patients
(§ 4 Abs. 10 KHEntgG)

E6 Contracts for integrated care

Effective case-mix

Other revenues with compensation
(§ 6 Abs. 3 KHEntgG)
The German system at a glance...

- **Population providers**: Ca. 250 sickness funds with self-government, organised in 7 associations
- **Cost-sharing**: Wage-related contribution ca. 13.4% (50/50) +0.9% insured since 2005
- **Choice of fund**: since 1996
- **Strong delegation**: & limited governmental control

- **Contribution collector**: "Risk-structure compensation" since 1994/95
- **Third-party payer**: "Gesundheitspauschale“, tax funding of children
- **New payment systems**: esp. DRGs in hospitals
- **Disease Management Programmes**: selective contracts (GP models, "integrated care")
- **Decision-making**: government vs. self-governing actors; patient groups
- **Benefit evaluation/ Health Technology Assessment**: mandatory quality management, annual reports, minimum volumes
- **Universal coverage?**: "Bürgerversicherung"
- **Quality assurance**: more morbidity orientation? Or less RSC?
- **Change in funding?**
What has or will be changed by the Competition Strengthening Act (in force since April 2007)?

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

Uniform contribution rate (determined by government)

„Health fund“

Contribution collector

Third-party payer

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)

Average: 5.20€/ day
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem
Contribution collector

Third-party payer

Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases

Uniform contribution rate (determined by government)

„Health fund“

Extra, community premium (positive or negative)

No-claim bonuses, individual deductibles … to lower contribution

Population

Providers

Sickness funds, organized in ONE association

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

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