Technische Universität Berlin

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

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&
European Observatory on Health Systems and Policies

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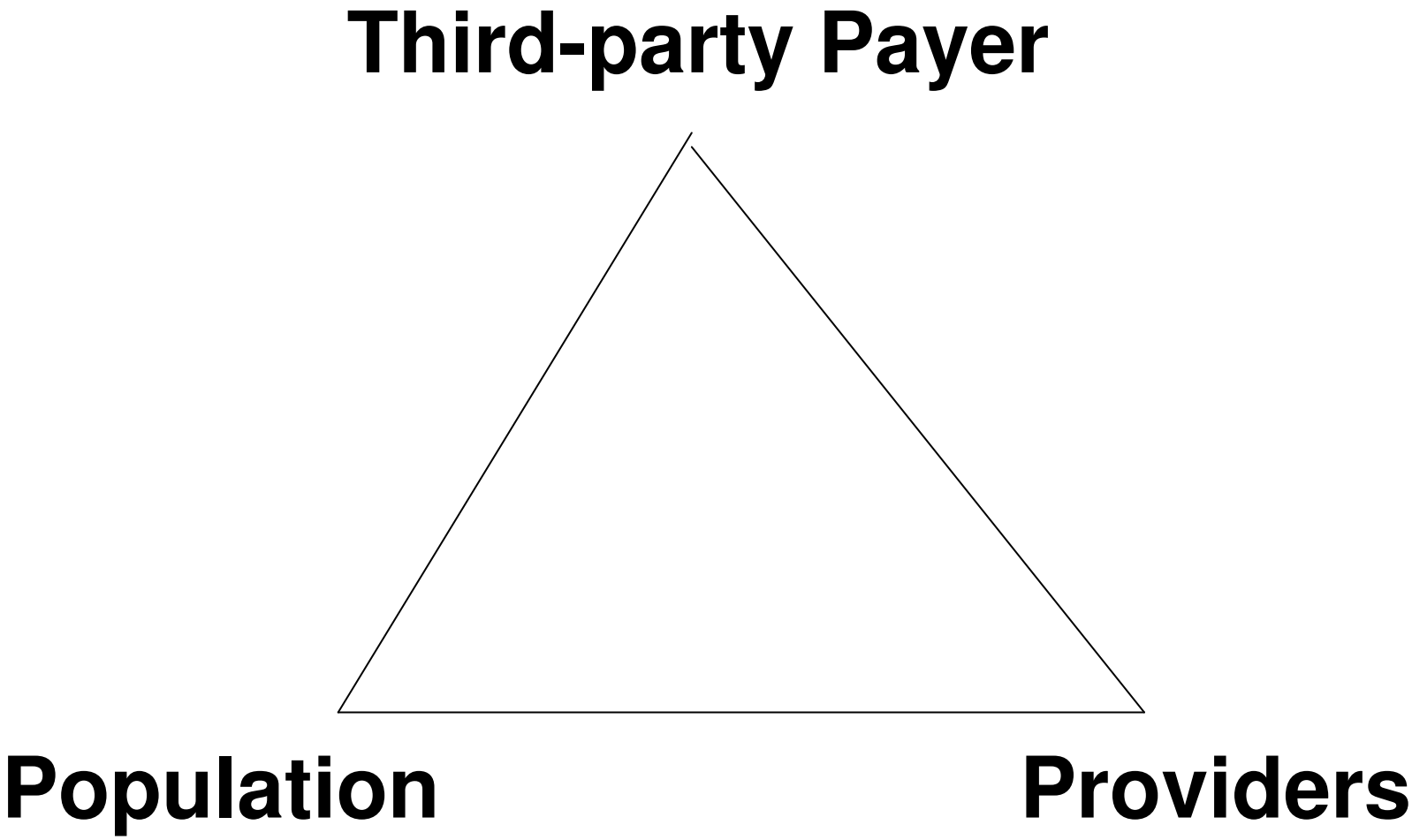
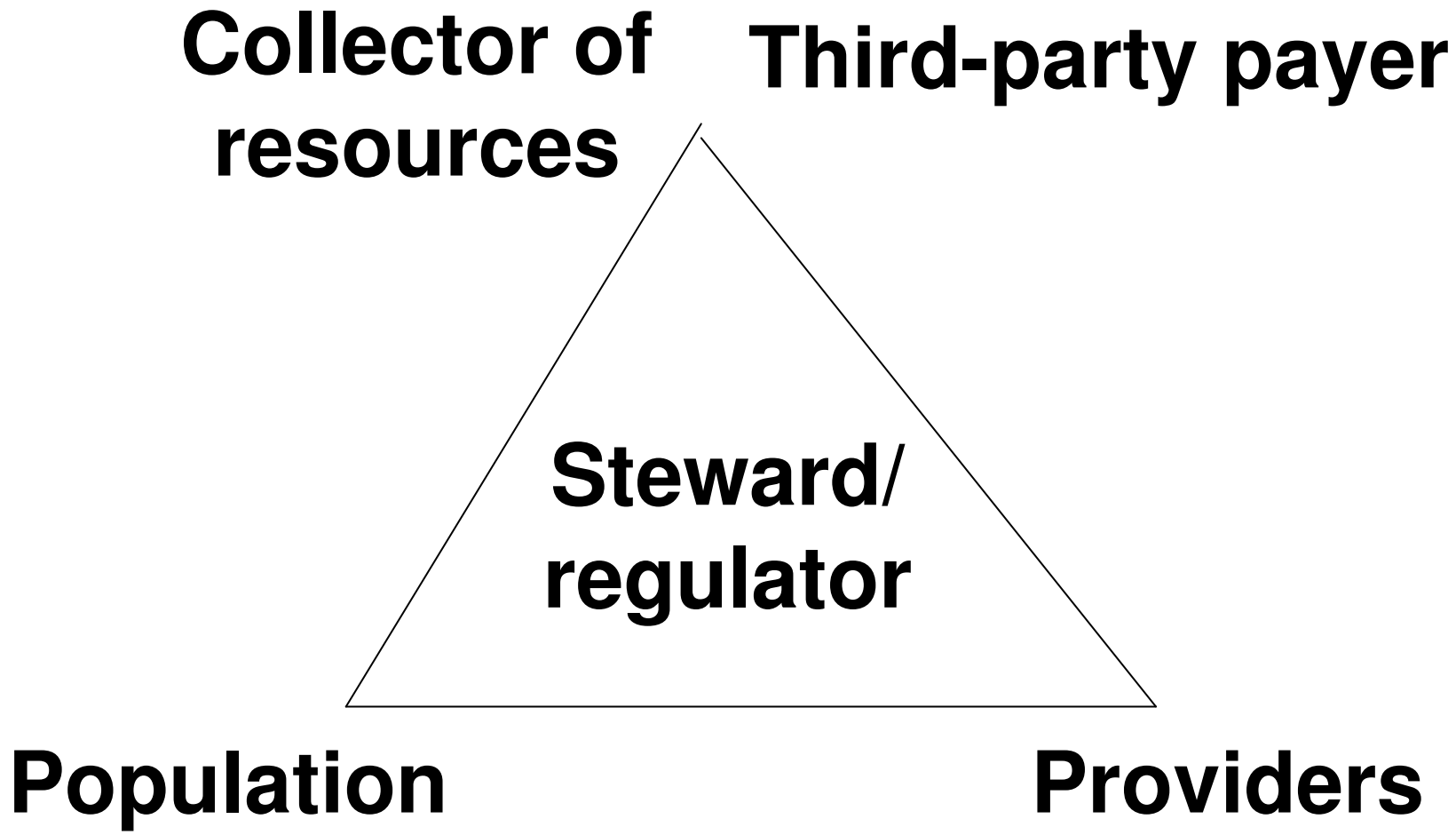


European Observatory on Health Systems and Policies



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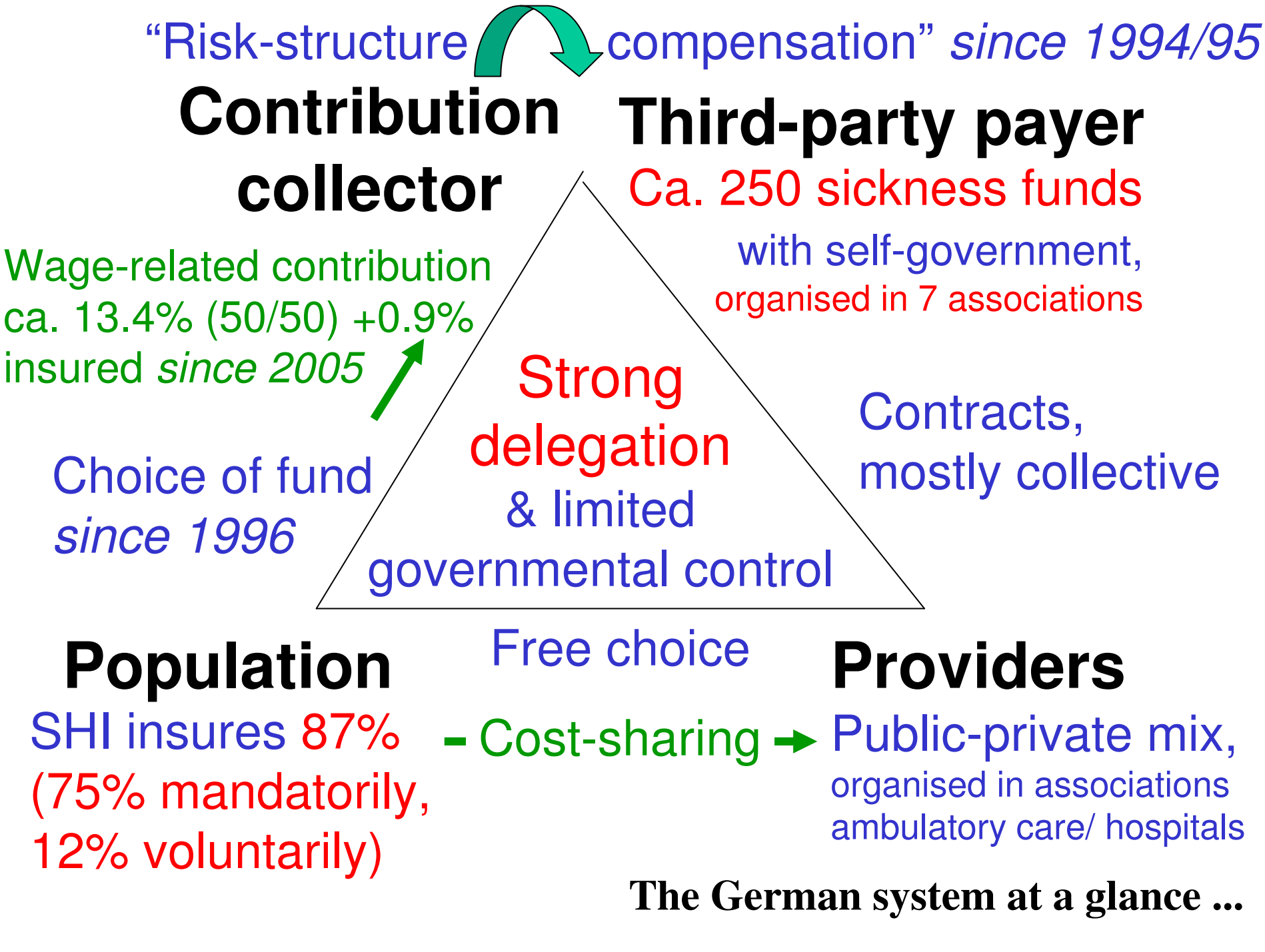
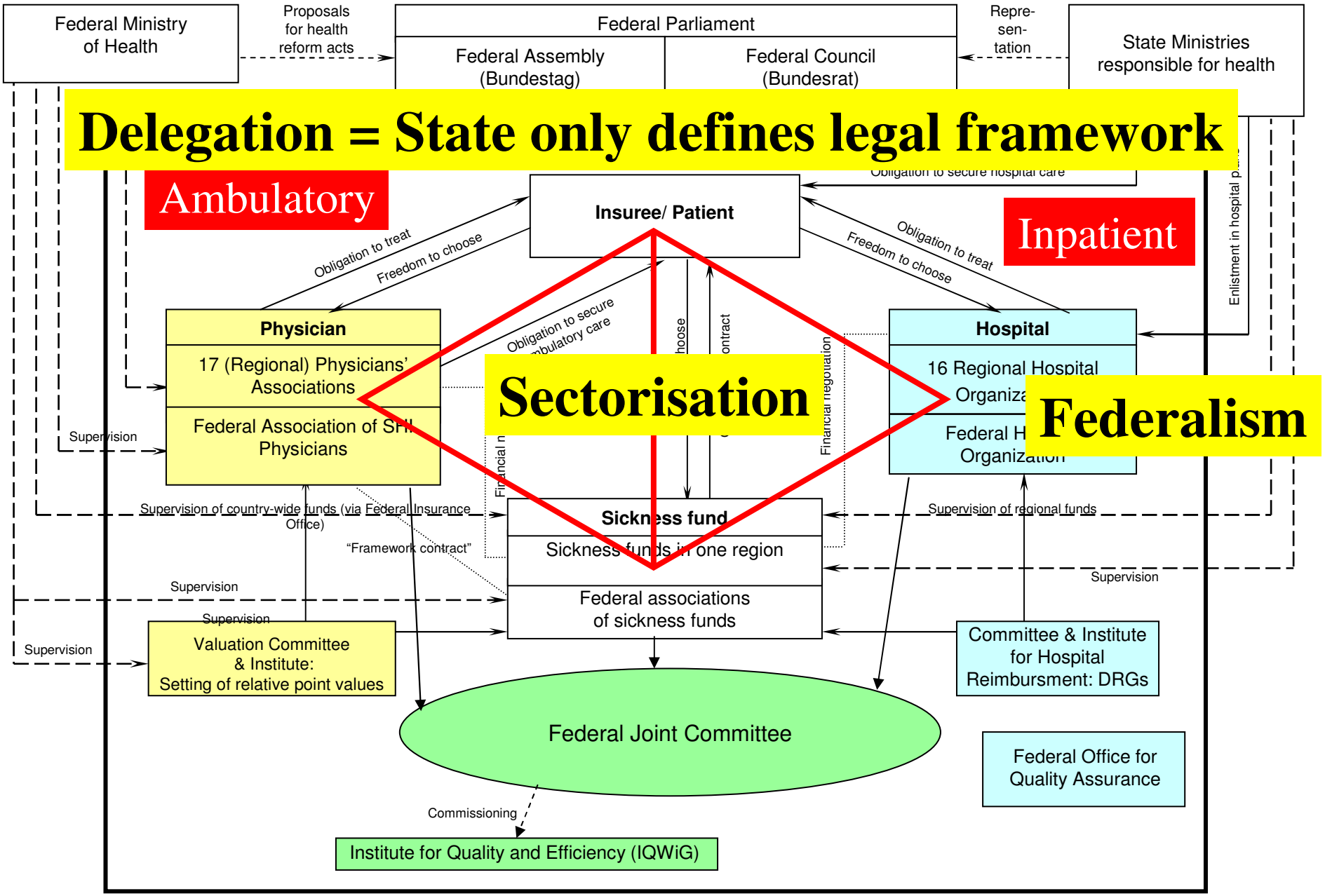
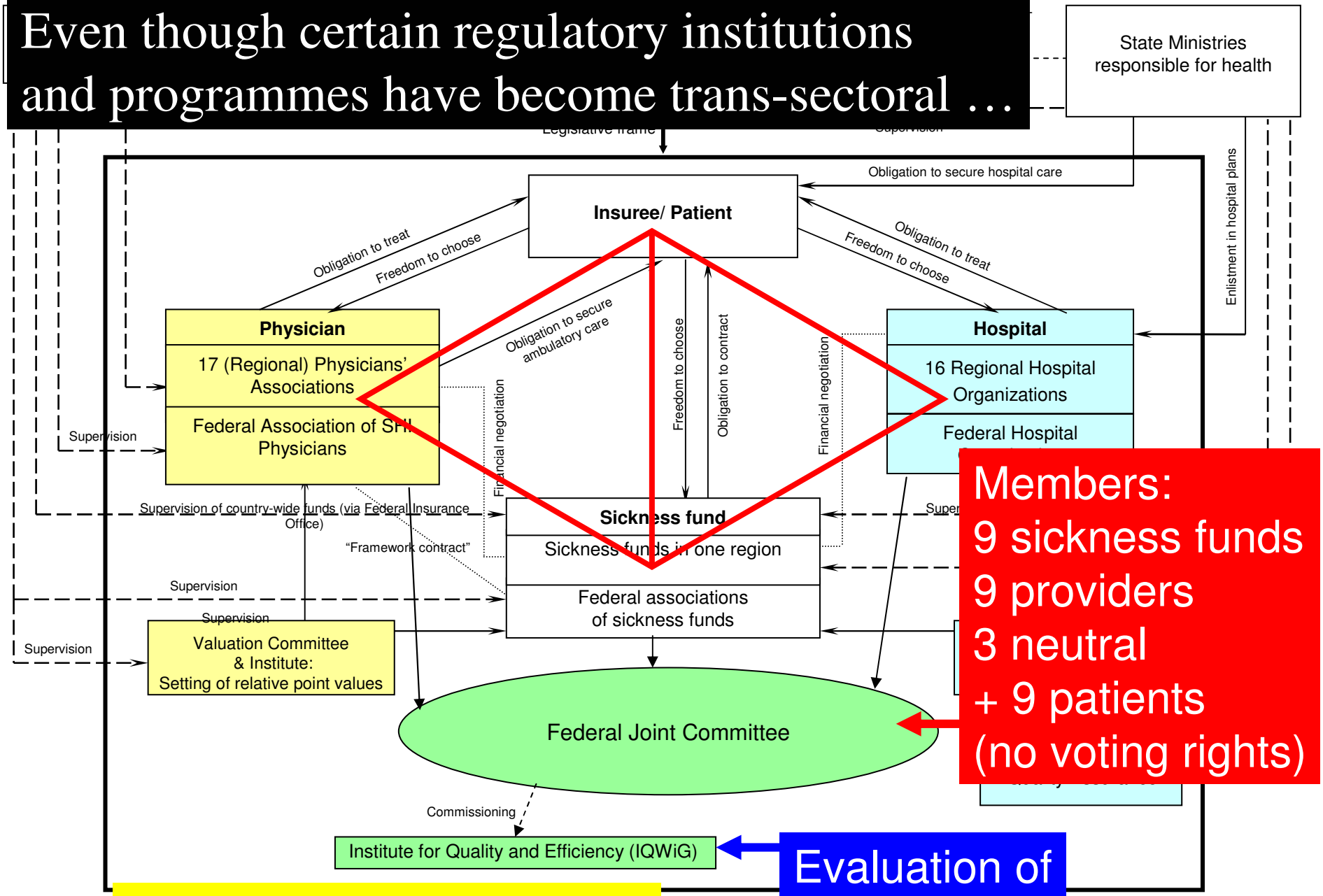


The German system at a glance ...



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)

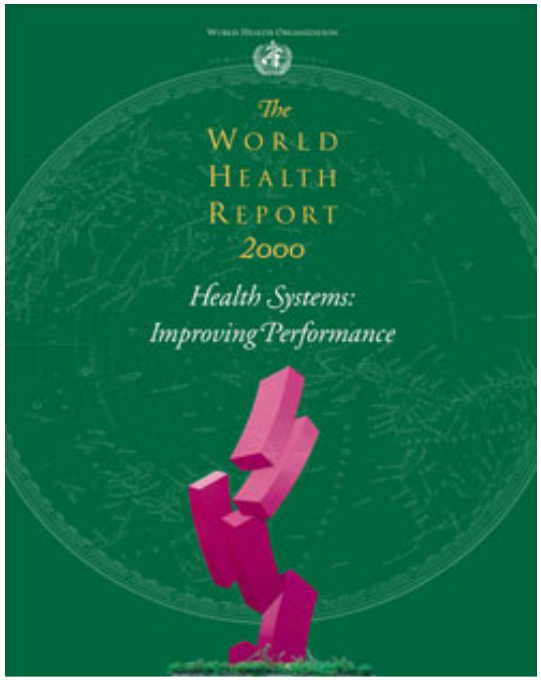
Evaluation of drugs etc.

Joint self-government

Statutor… …early 2007

… 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

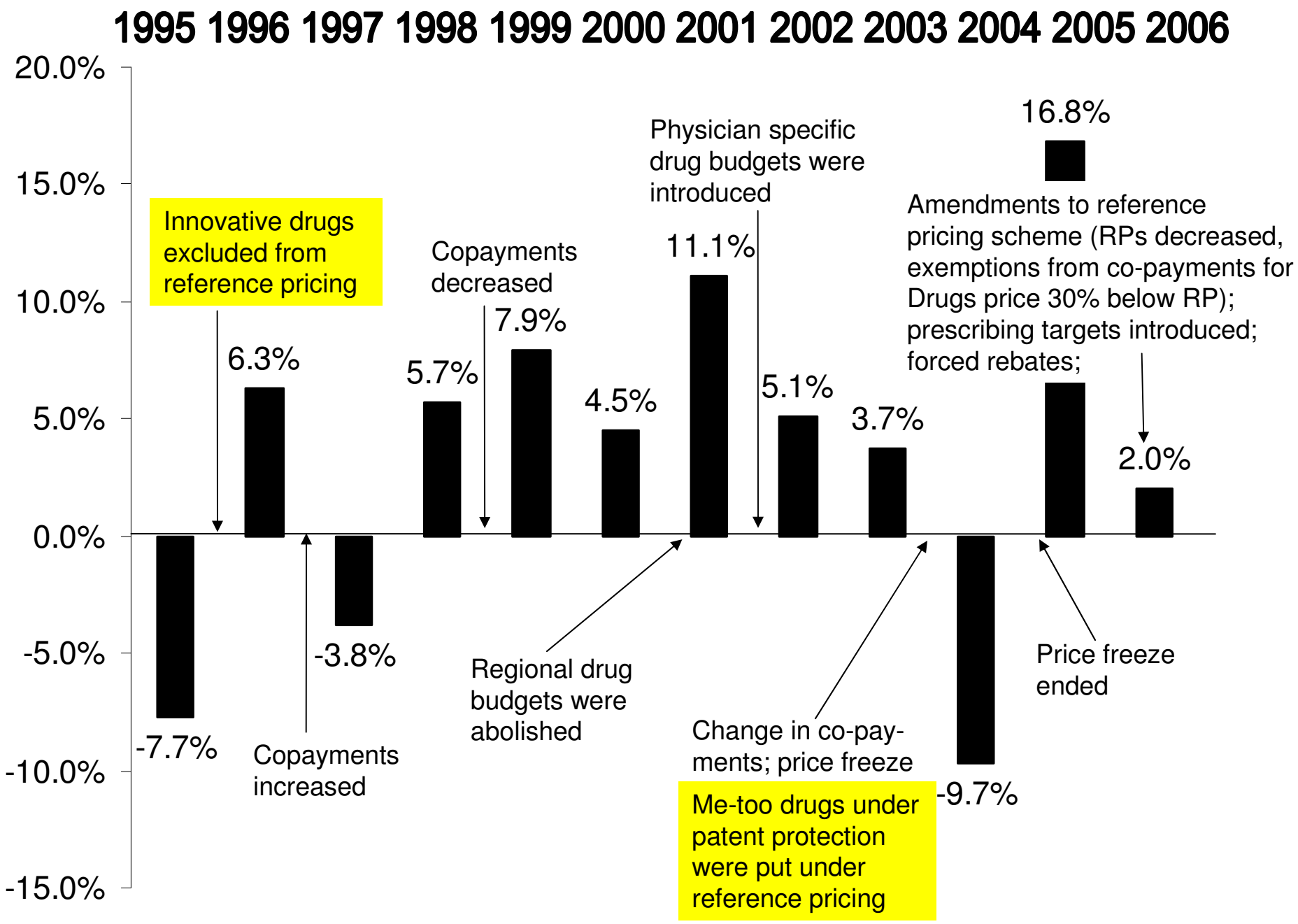
- Pre- and post-inpatient care in hospitals (1997)
- „Integrated [i.e. transsectoral] care“ contracts (2000, funded with 1% of expenditure since 2004)
- Disease Management Programmes (2002) -> *next slide*
- Polyclinics (potentially with hospital owners, 2004)
- „GP contracts“ (insured choose GP as gatekeeper;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

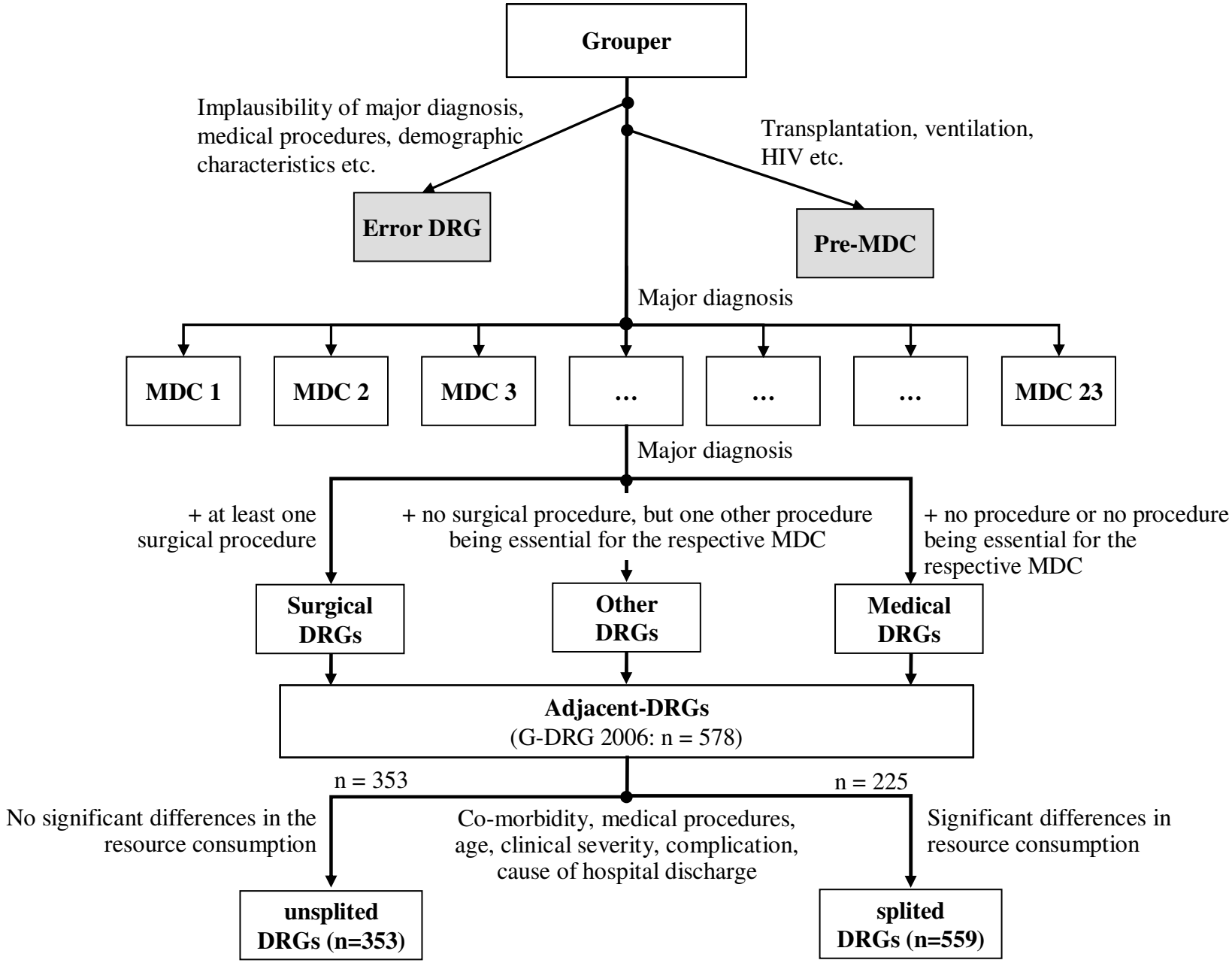
Disease Management Programmes (since 2002)

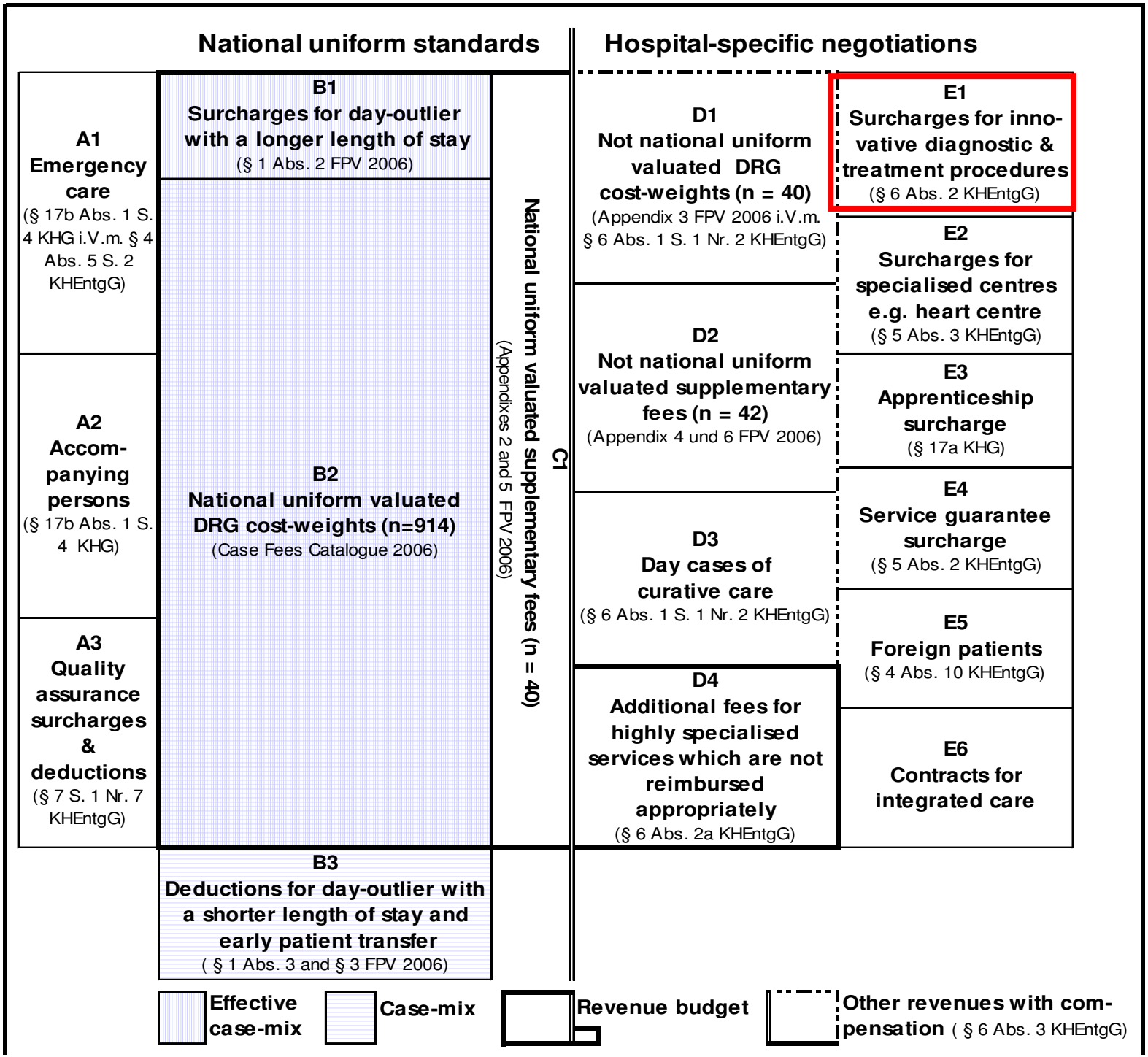
- Compensate sickness funds for chronically ill better (make them attractive) = reduce faulty incentives to attract young & healthy
- Address quality problems by guidelines/ pathways
- Tackle trans-sectoral problems by “integrated“ contracts
- = introduce Disease Management Programs meeting certain minimum criteria and compensate sickness funds for average expenditure of those enrolling (new RSC categories)

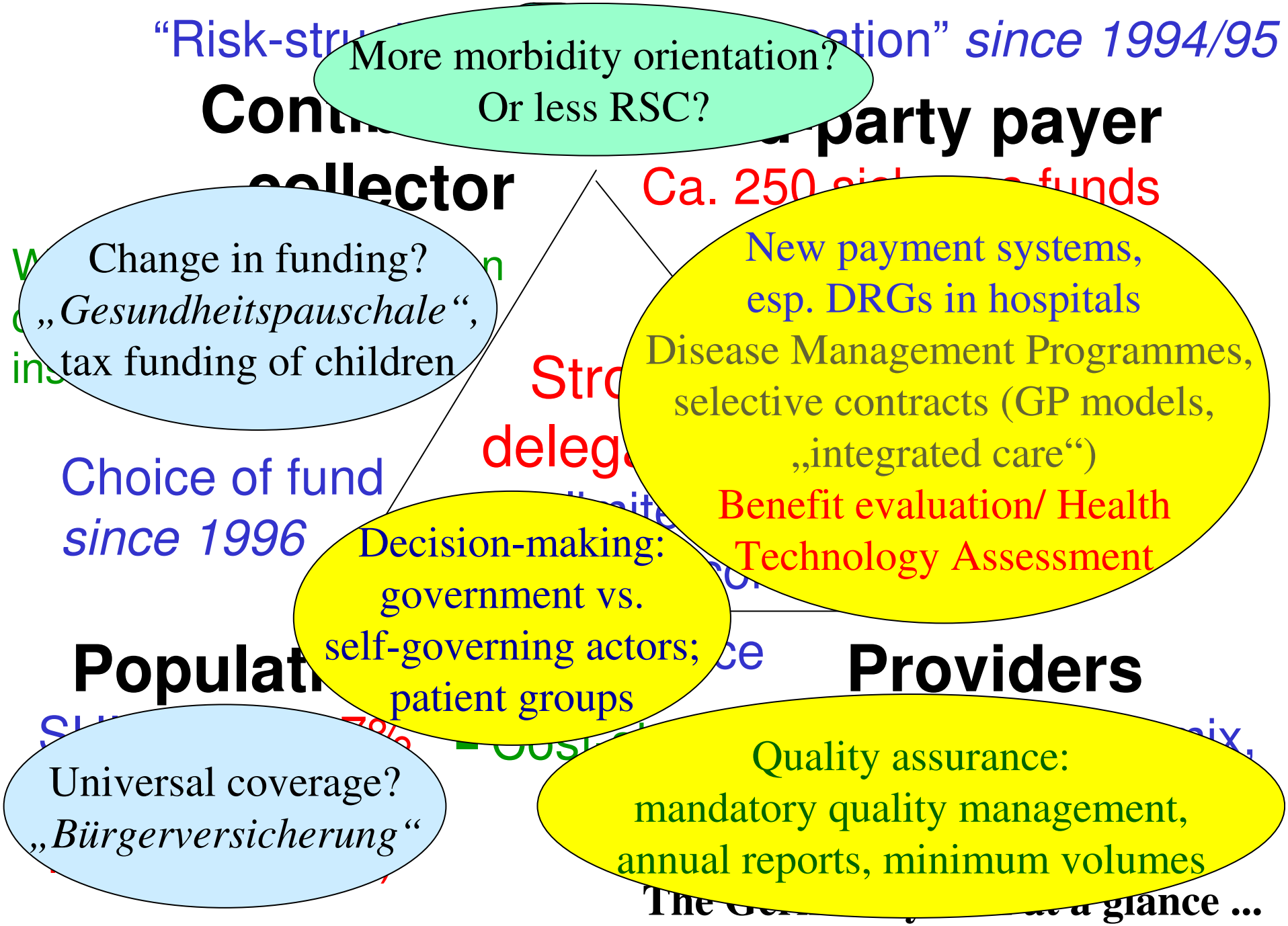
double incentive for sickness funds:
potentially lower costs + extra compensation!
By early 2007: 3.5 mn enrolled (5% of SHI insured)

Innovations and reimbursement: drugs + hospital care

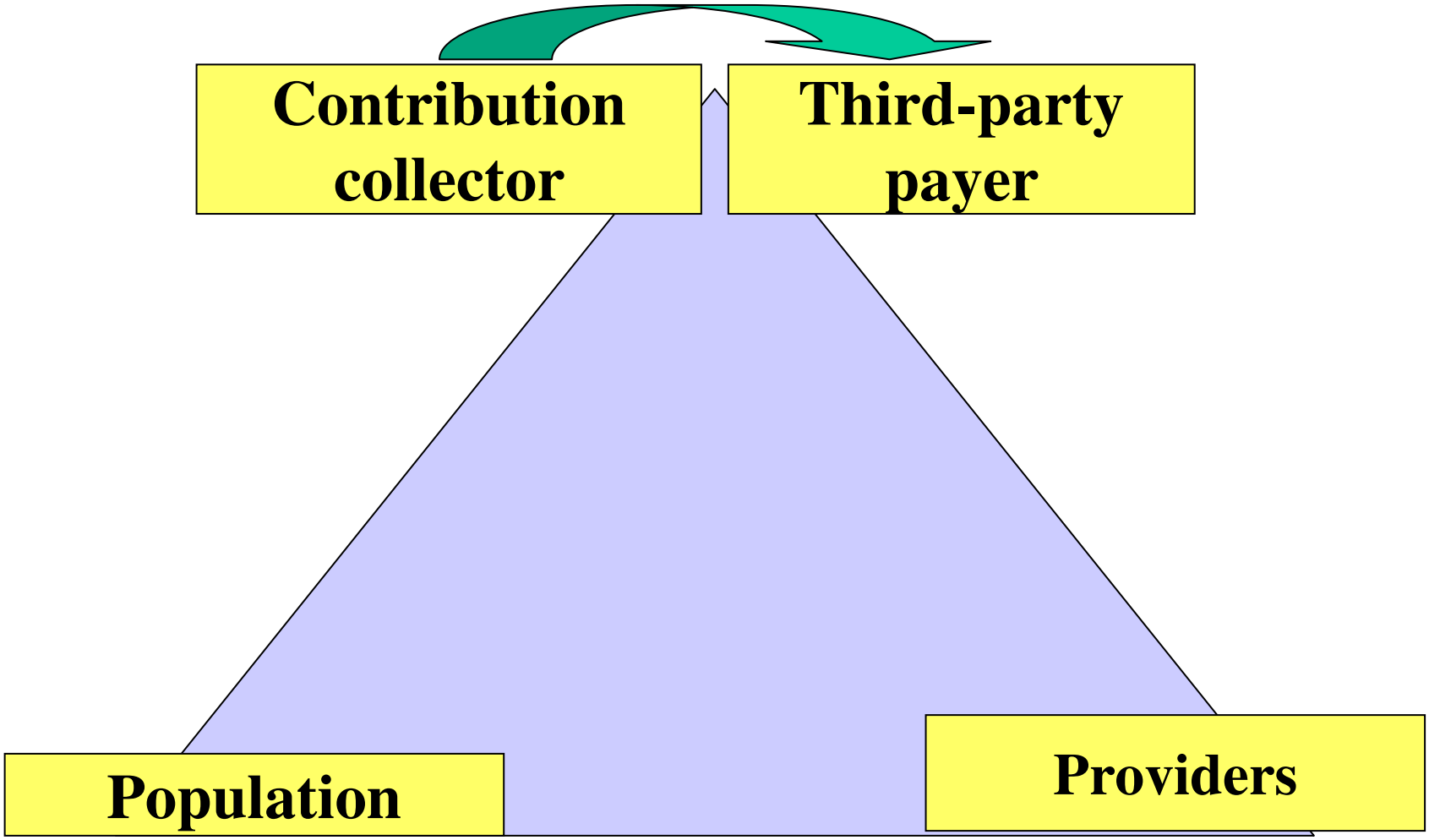

1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006
20.0%
15.0%
10.0%
5.0%
0.0%
-5.0%
-10.0%
-15.0%
Innovative drugs excluded from reference pricing
-7.7%
6.3%
Copayments increased
-3.8%
5.7%
Copayments decreased
7.9%
Regional drug budgets were abolished
4.5%
Physician specific drug budgets were introduced
11.1%
Change in co-pay-ments; price freeze
5.1%
Me-too drugs under patent protection were put under reference pricing
3.7%
-9.7%
16.8%
Amendments to reference pricing scheme (RPs decreased, exemptions from co-payments for Drugs price 30% below RP); prescribing targets introduced; forced rebates;
Price freeze ended
2.0%


Grouper
Implausibility of major diagnosis, medical procedures, demographic characteristics etc.
Transplantation, ventilation, HIV etc.
Error DRG
Pre-MDC
Major diagnosis
MDC 1
MDC 2
MDC 3
…
…
…
MDC 23
Major diagnosis
+ at least one surgical procedure
+ no surgical procedure, but one other procedure being essential for the respective MDC
+ no procedure or no procedure being essential for the respective MDC
Surgical DRGs
Other DRGs
Medical DRGs
Adjacent-DRGs
(G-DRG 2006: n = 578)
n = 353
n = 225
No significant differences in the resource consumption
Co-morbidity, medical procedures, age, clinical severity, complication, cause of hospital discharge
Significant differences in resource consumption
unsplited DRGs (n=353)
splited DRGs (n=559)


National uniform standards
Hospital-specific negotiations
A1
Emergency care
(§ 17b Abs. 1 S. 4 KHG i.V.m. § 4 Abs. 5 S. 2 KHEntgG)
A2
Accom-panying 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)
C1
National uniform valuated supplementary fees (n = 40)
(Appendixes 2 and 5 FPV 2006)
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)
E1
Surcharges for inno-vative 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
Case-mix
Revenue budget
Other revenues with com-pensation (§ 6 Abs. 3 KHEntgG)

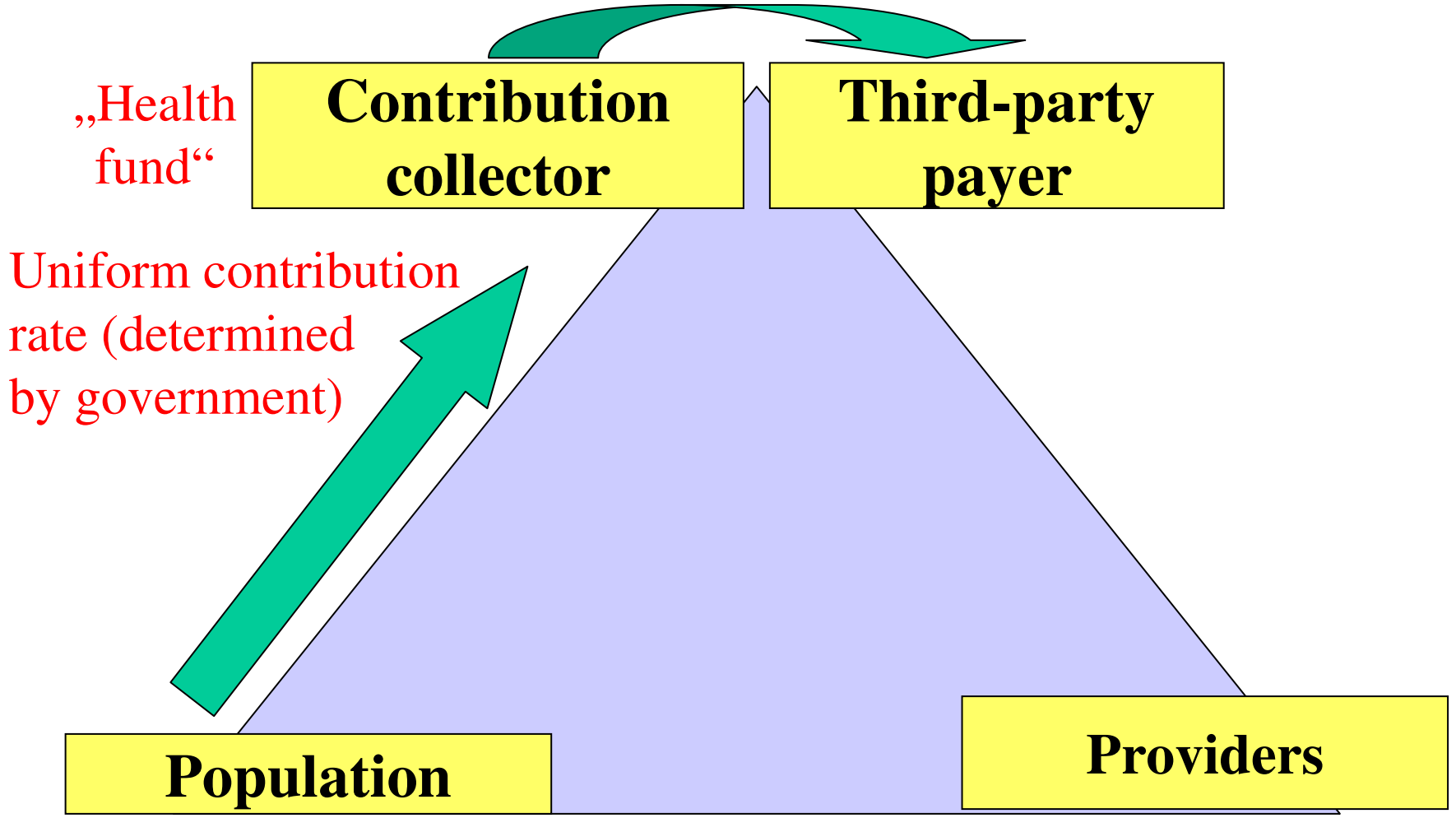

More morbidity orientation?
Or less RSC?
party payer
collector
Change in funding?
„Gesundheitspauschale“,
tax funding of children
New payment systems,
esp. DRGs in hospitals
Disease Management Programmes,
selective contracts (GP models,
„integrated care“)
Benefit evaluation/ Health
Technology Assessment
Choice of fund
since 1996
Decision-making:
government vs.
self-governing actors;
patient groups
Providers
Universal coverage?
„Bürgerversicherung“
Quality assurance:
mandatory quality management,
annual reports, minimum volumes

What has or will be changed by the Competition Strengthening Act (in force since April 2007)?



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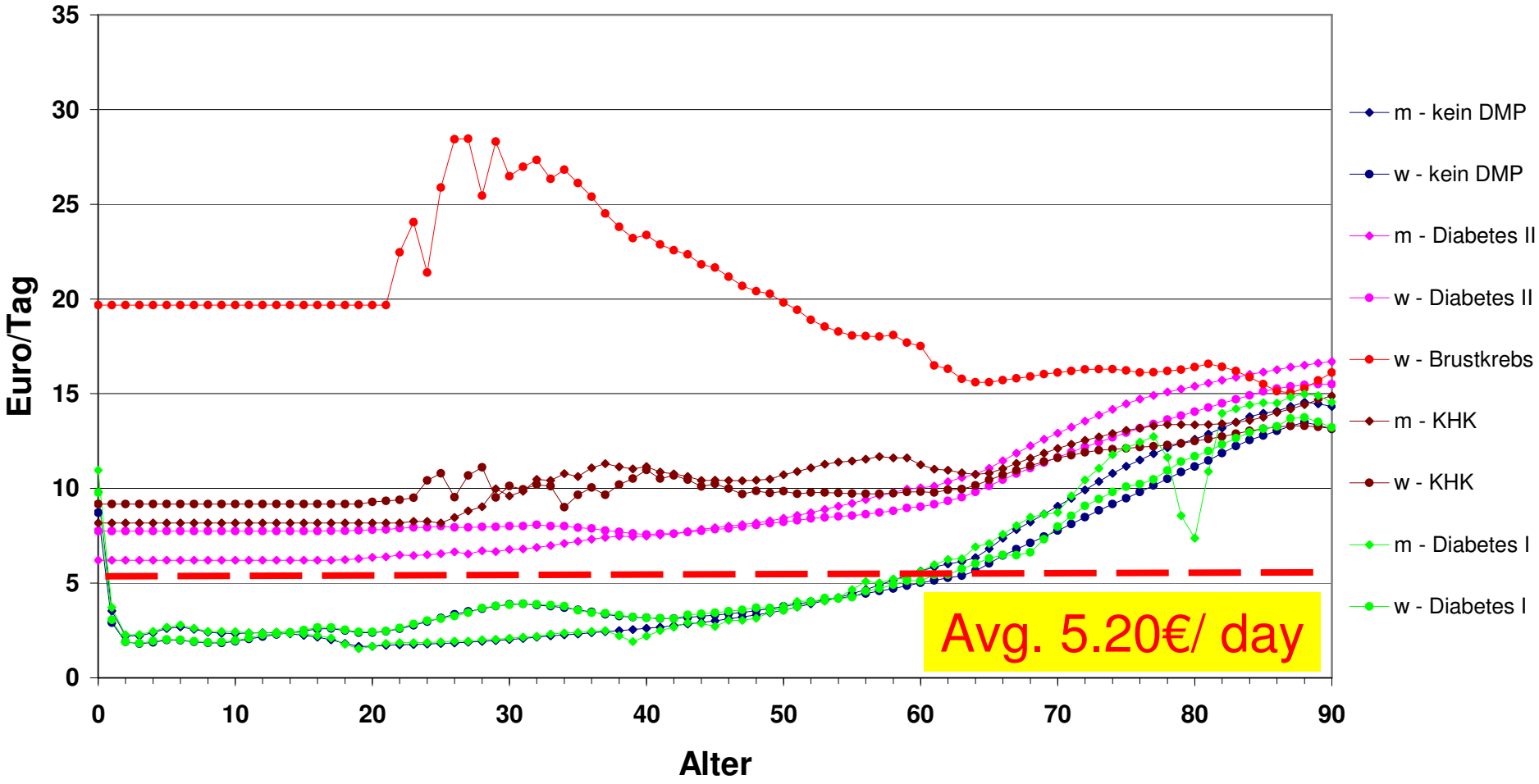
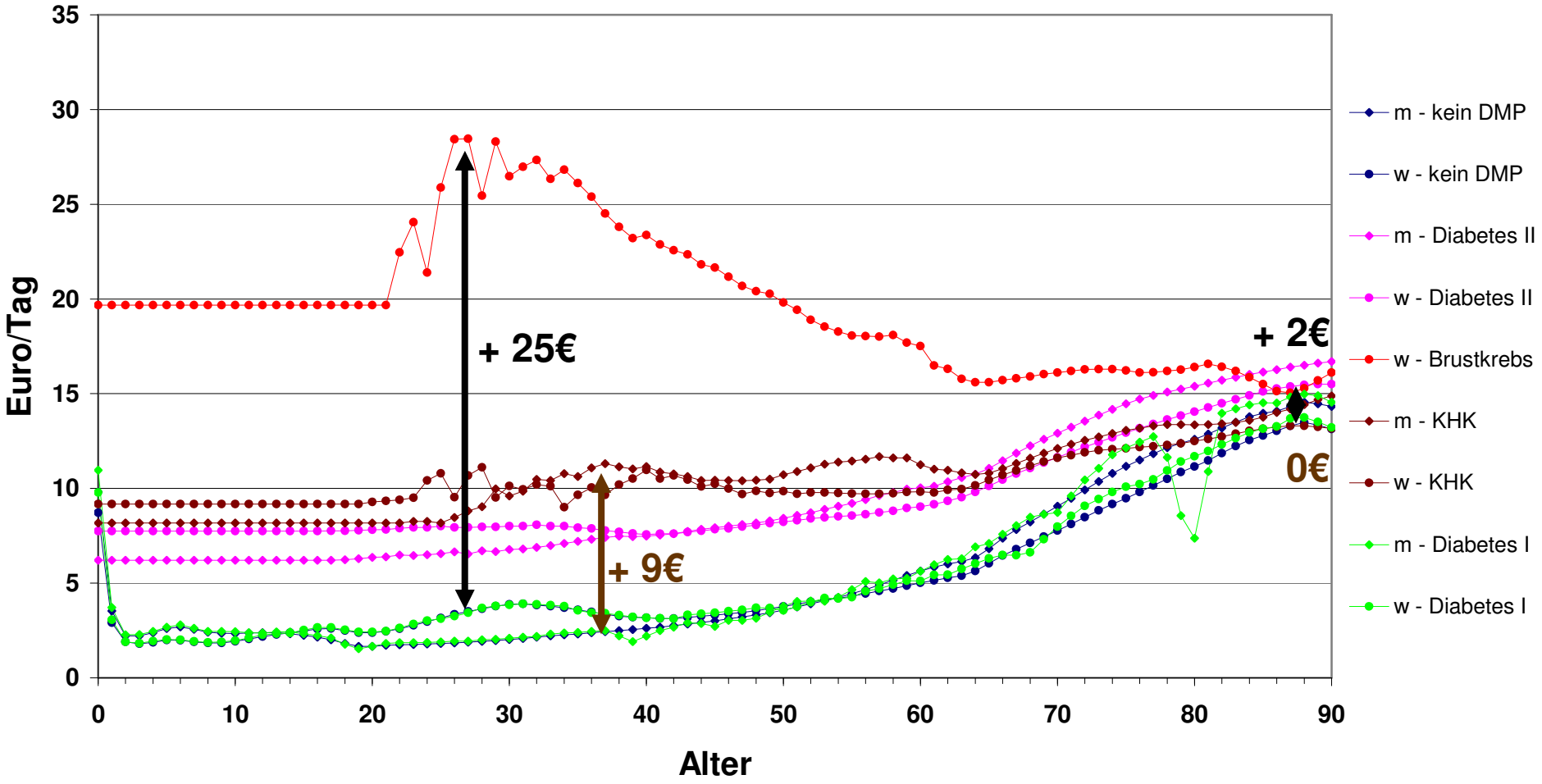
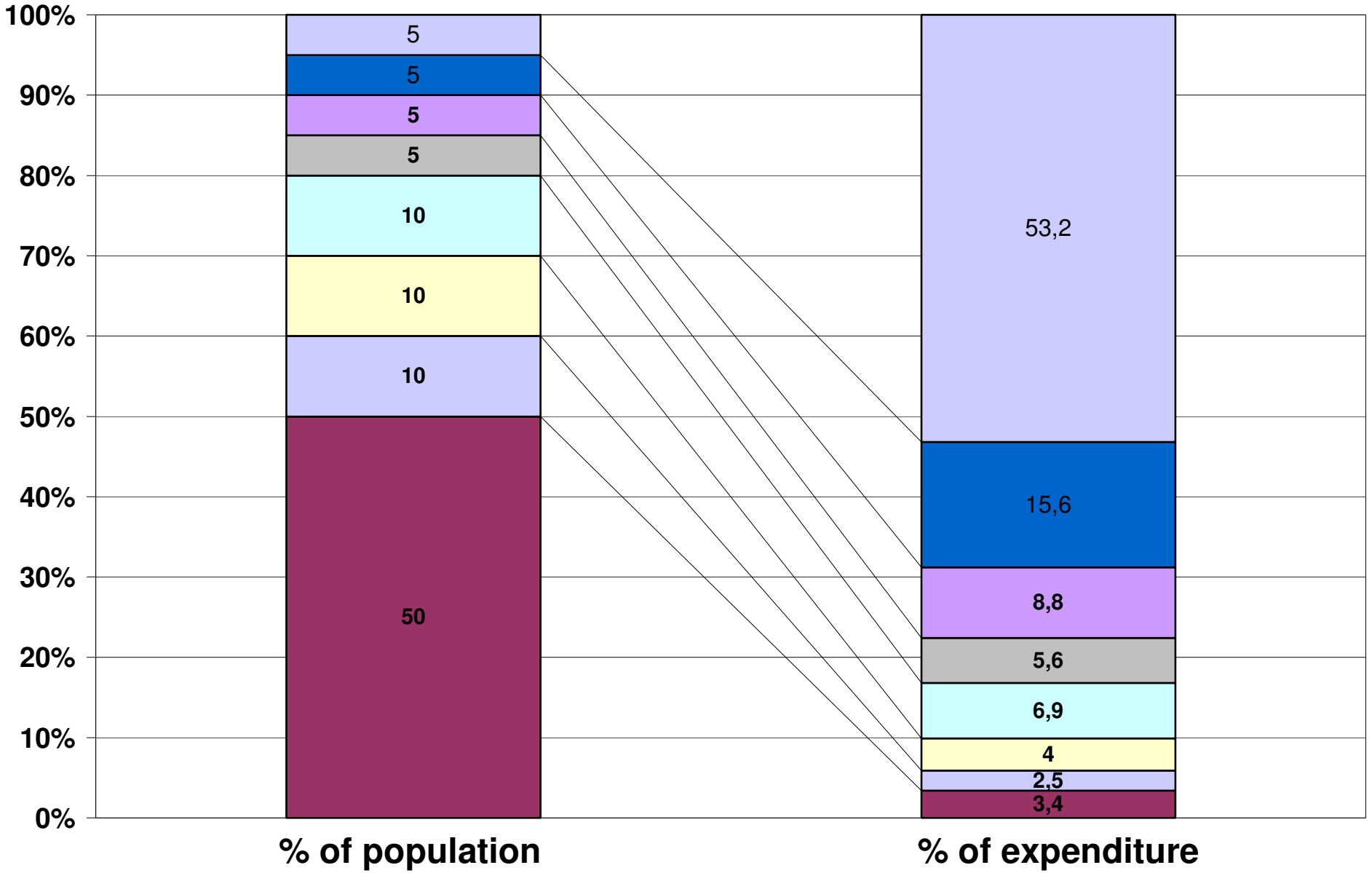
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism (2006)



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



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



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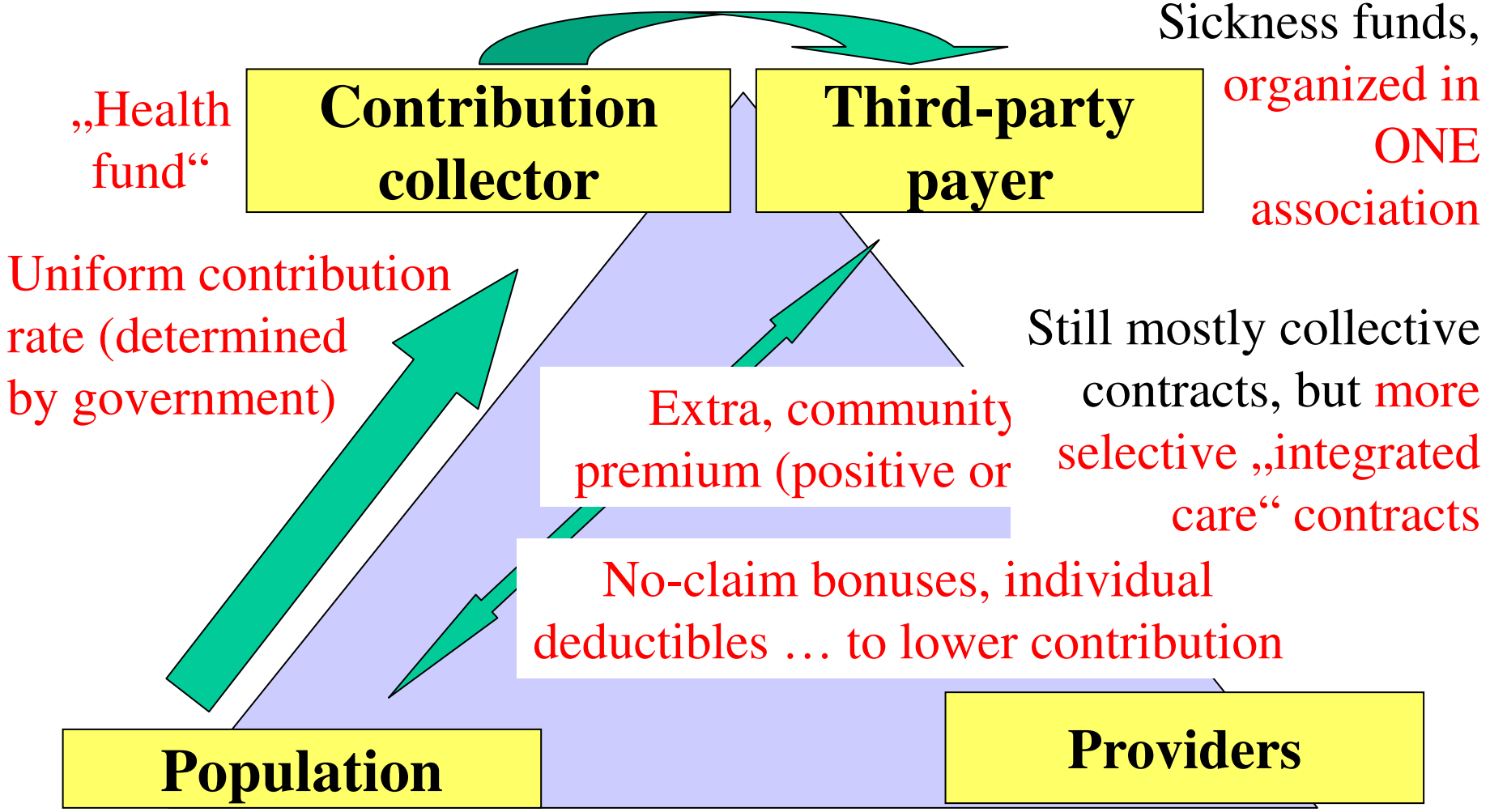

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