

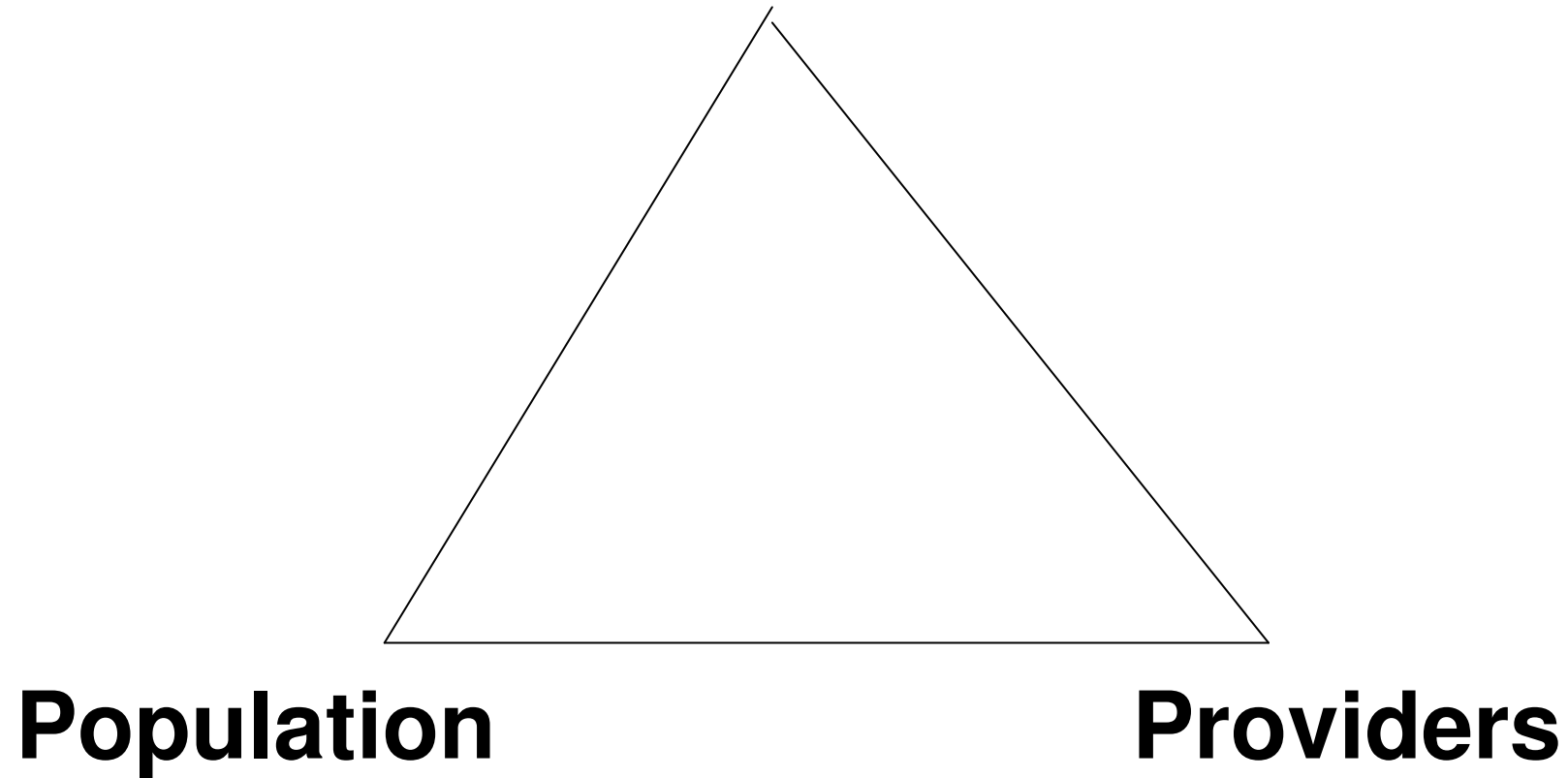
GKV-Wettbewerbsstärkungsgesetz: Erwartungen und Wirkungen / SHI Competition Strengthening Act: Expectations and Results

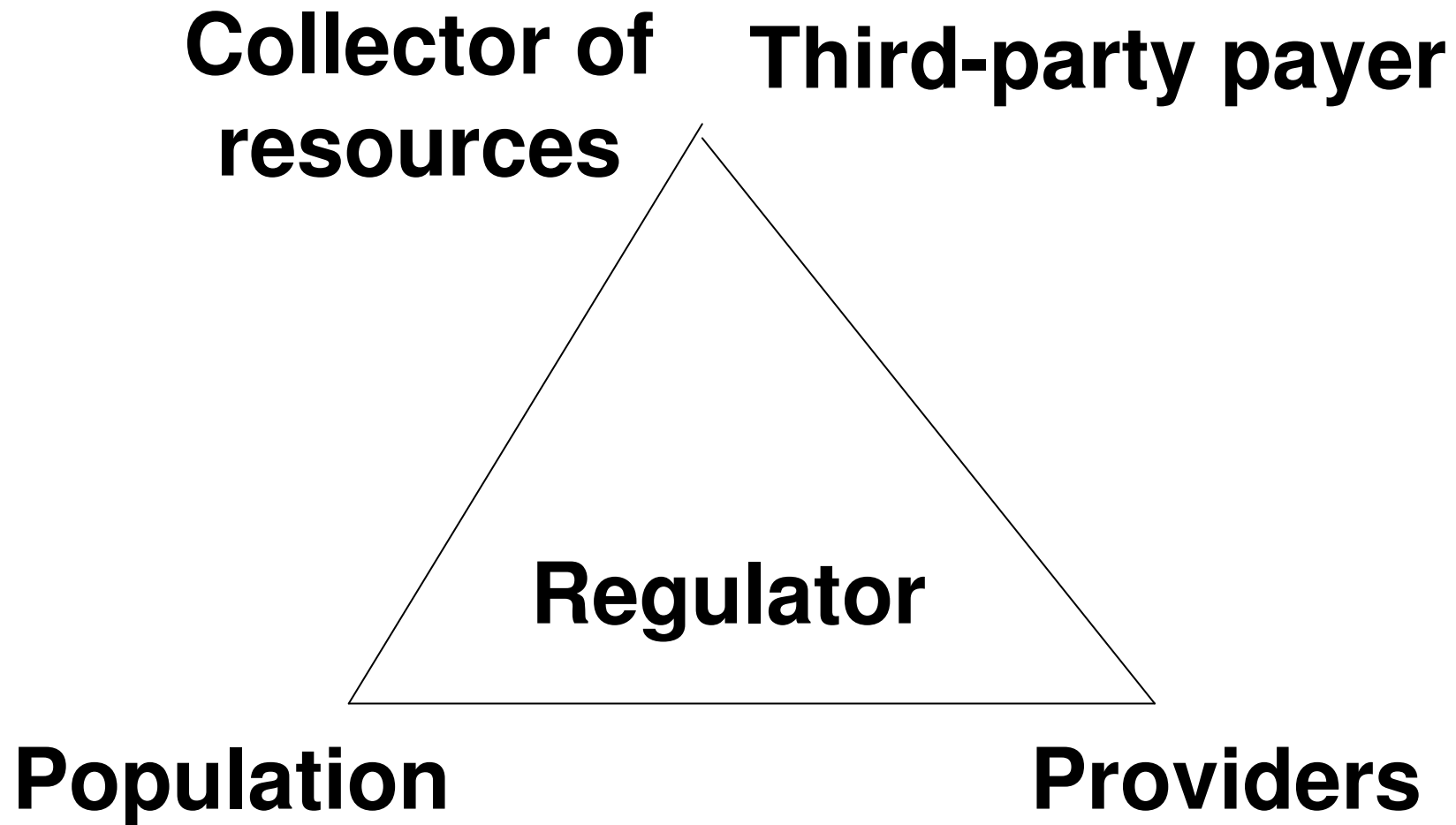
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European Observatory on Health Systems and Policies



Third-party Payer





“Risk-structure  compensation”

Collector of resources

Third-party payer

Ca. 240 sickness funds

Ca. 50 private insurers

Wage-related contribution

Risk-related premium 

Choice of fund

Strong delegation & limited governmental control

Contracts, mostly collective
No contracts

Population

Social Health Insurance 87%,
Private HI 10%

Choice 

Providers

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

The German system at a glance (2007) ...

“Risk-structure”

Collected resources

Third party payer

More morbidity orientation?
Or less RSC?

Ca. 240 sickness funds

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

Structural
delegation

Decision-making:
government vs.
self-governing actors;
patient groups

Population

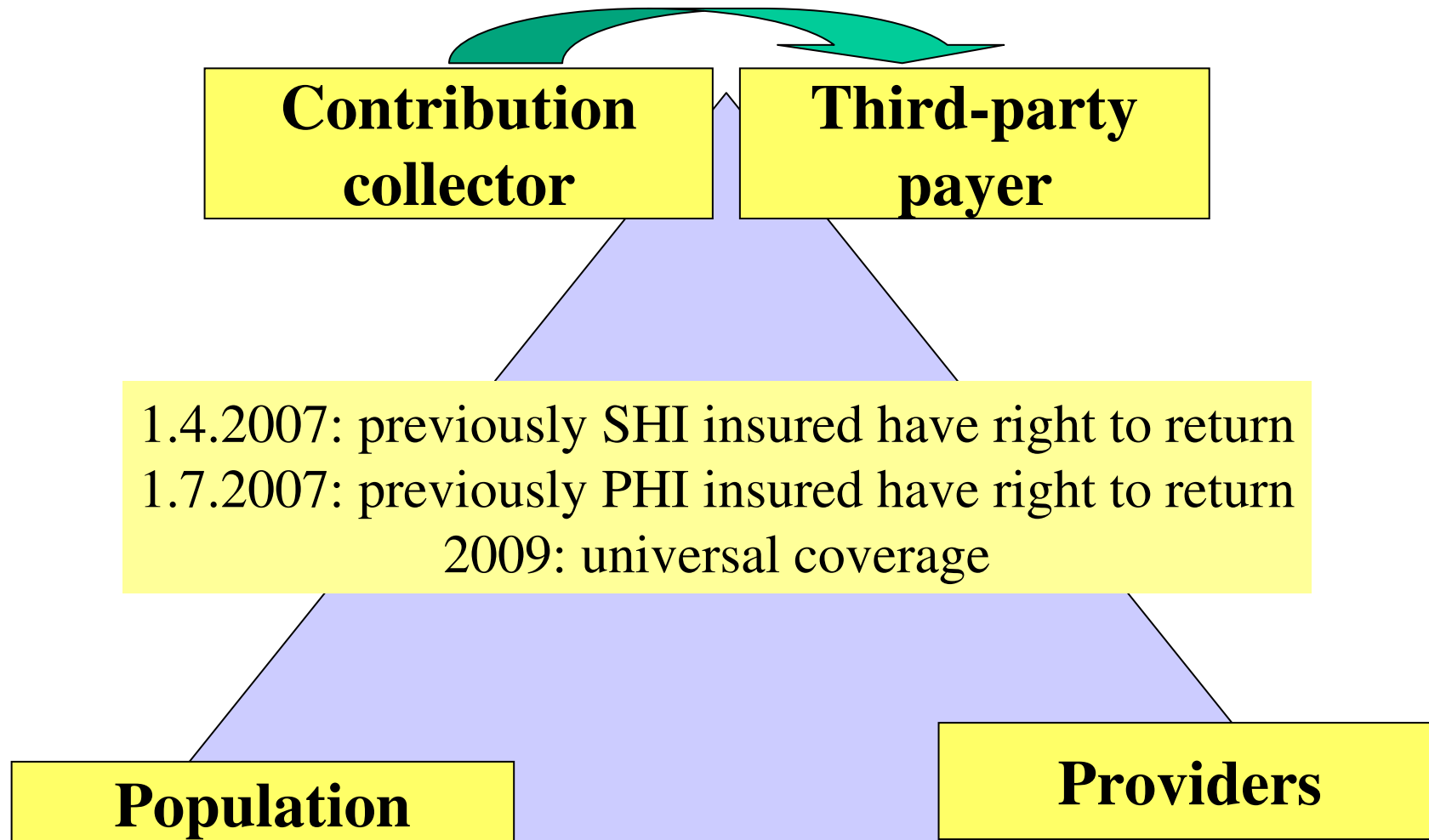
Providers

Universal coverage?
„Bürgerversicherung“

Quality assurance:
mandatory quality management,
annual reports, minimum volumes

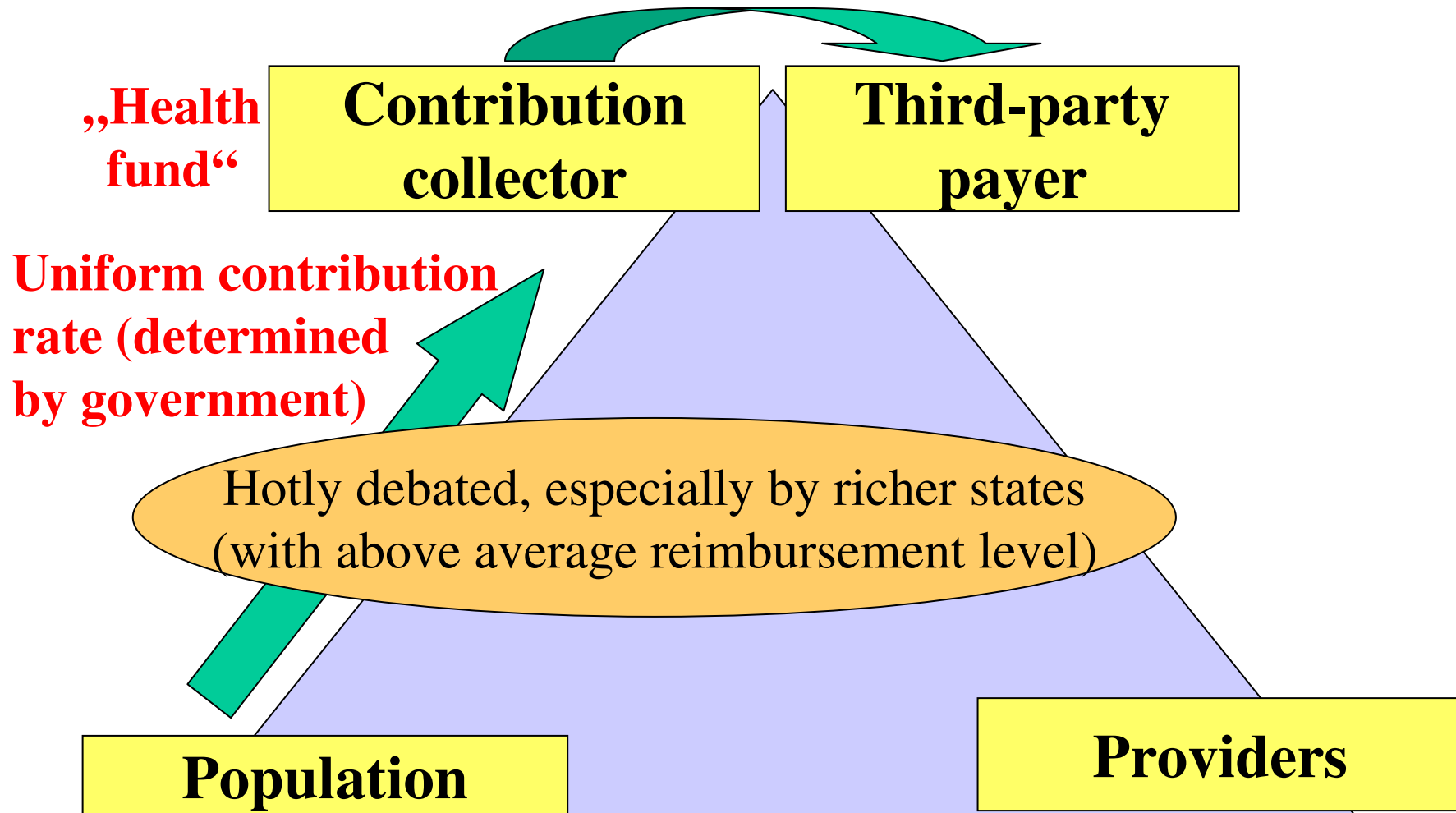
The status before the 2003 election ...

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



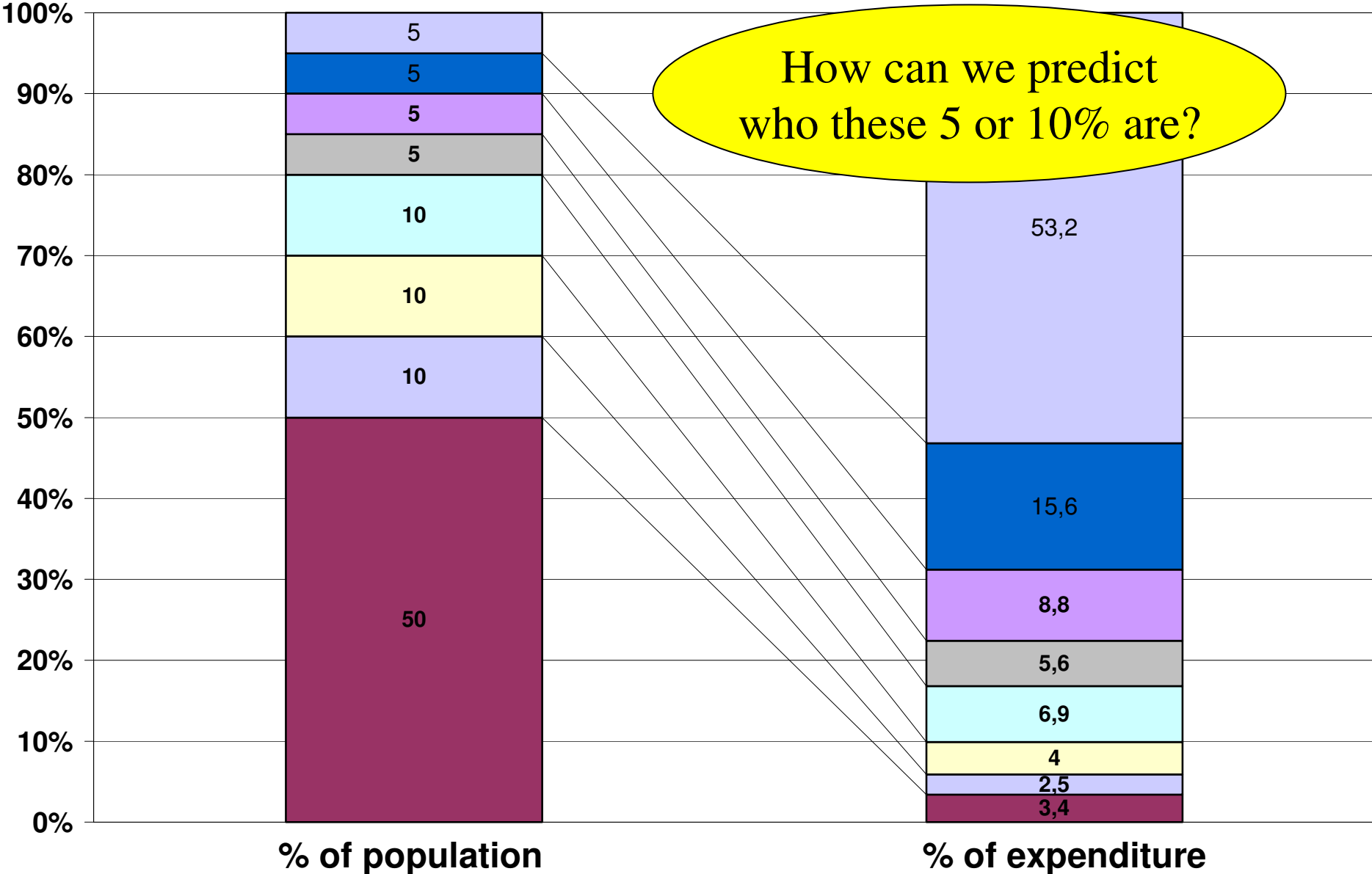
PHI remains but: universal coverage + obligation to contract (for a capped premium)

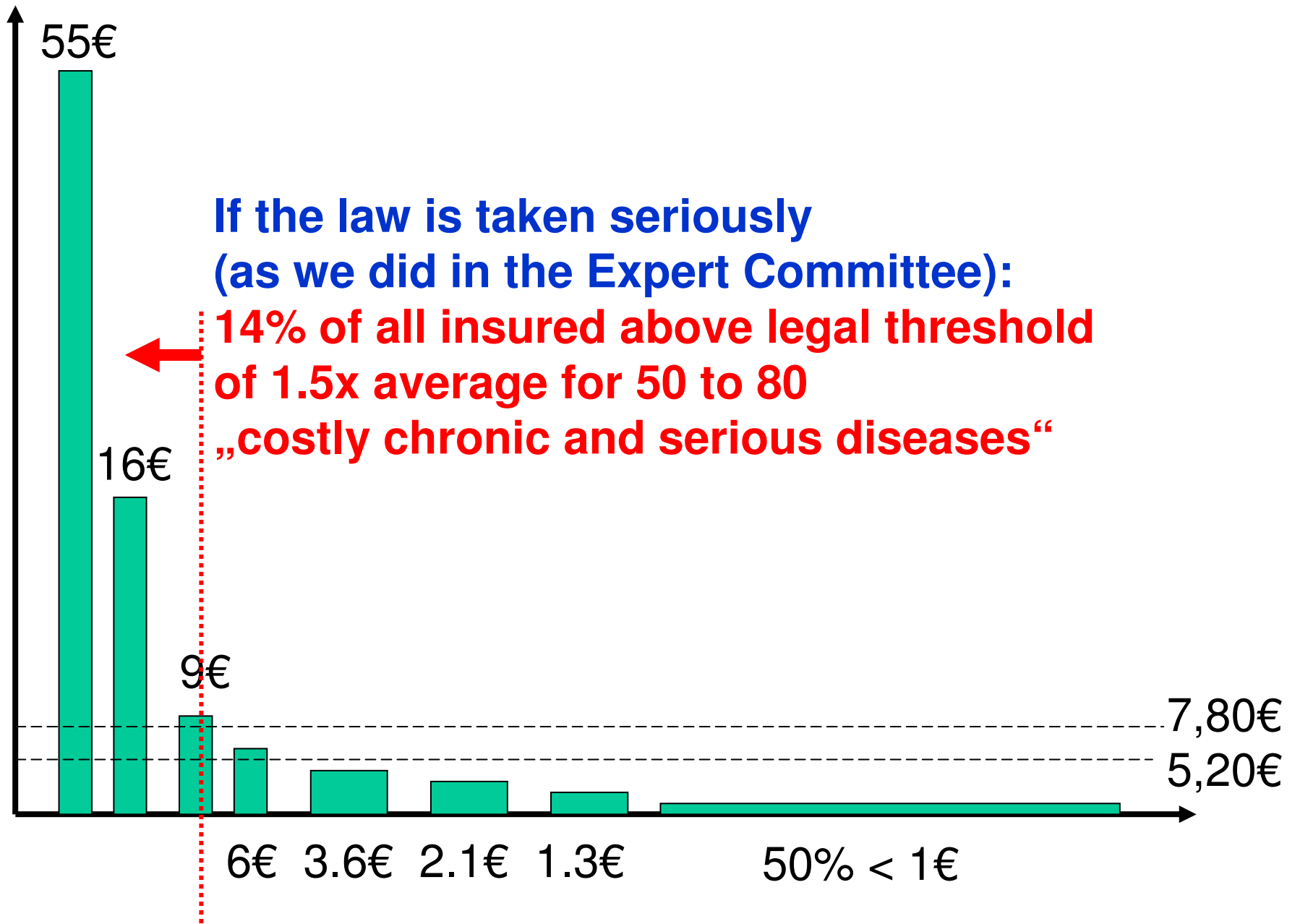
**Redesigning the risk-adjusted allocation
formula to include supplements for 50 to 80 diseases**



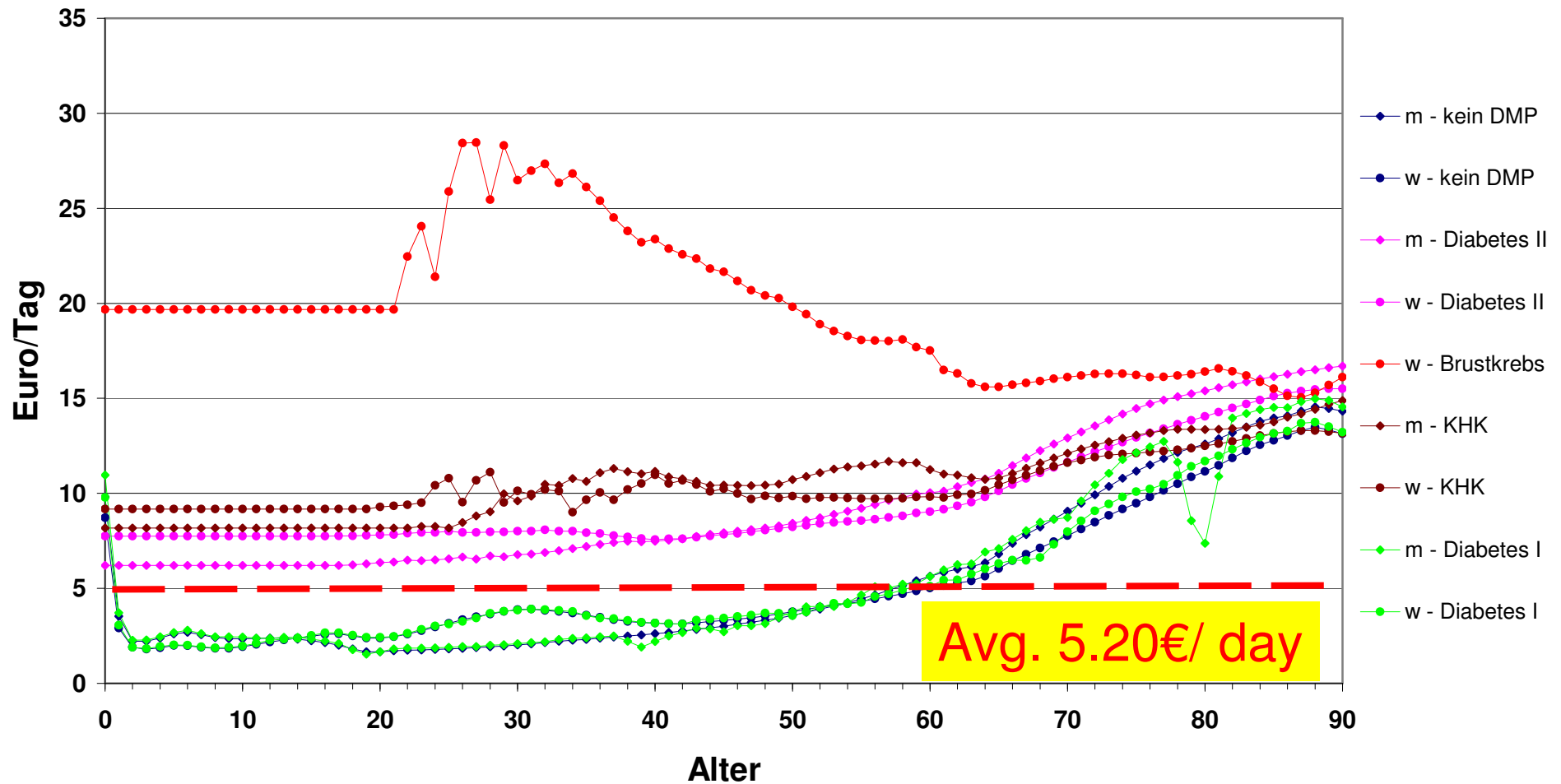
**PHI remains but: universal coverage +
obligation to contract (for a capped premium)**

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

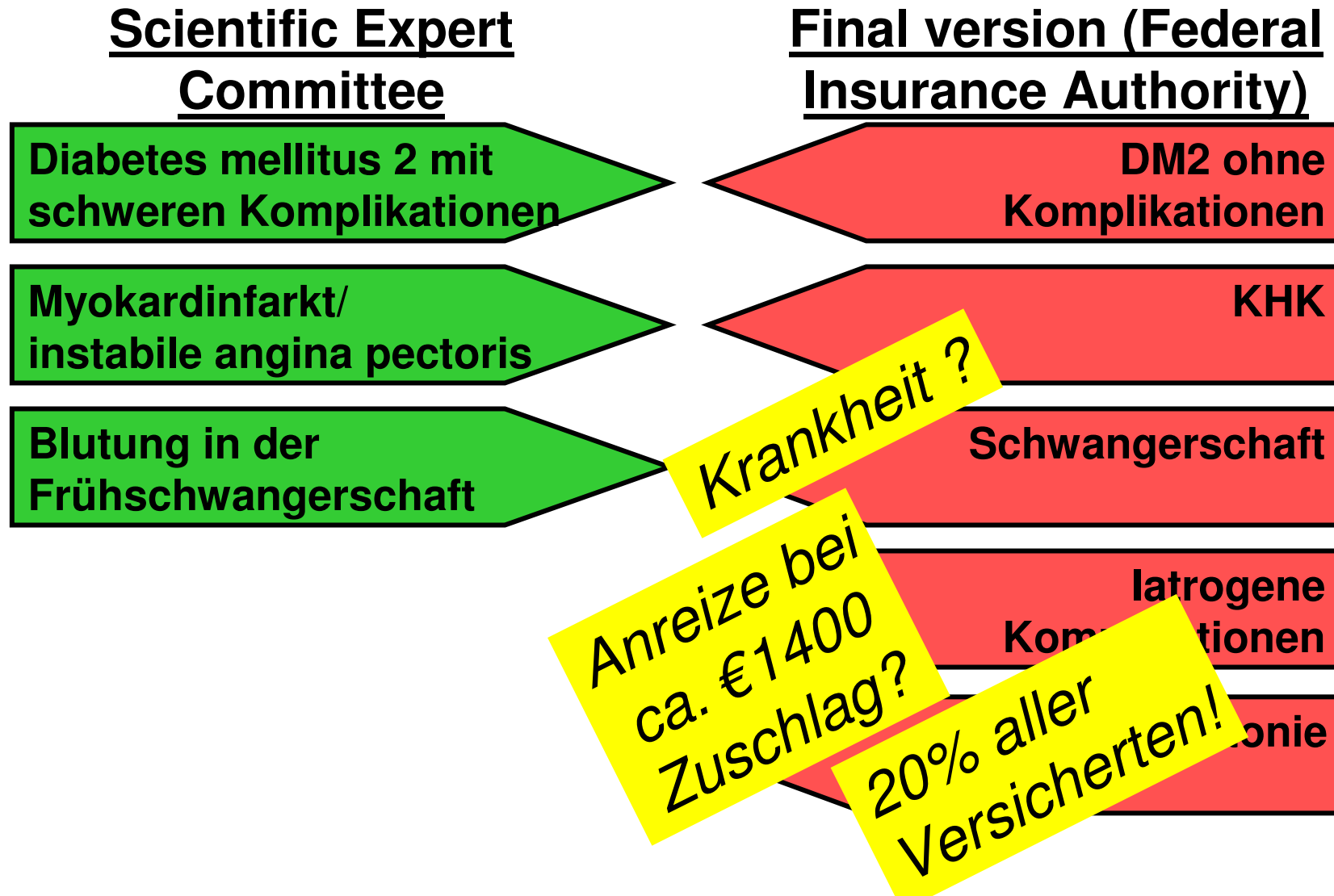




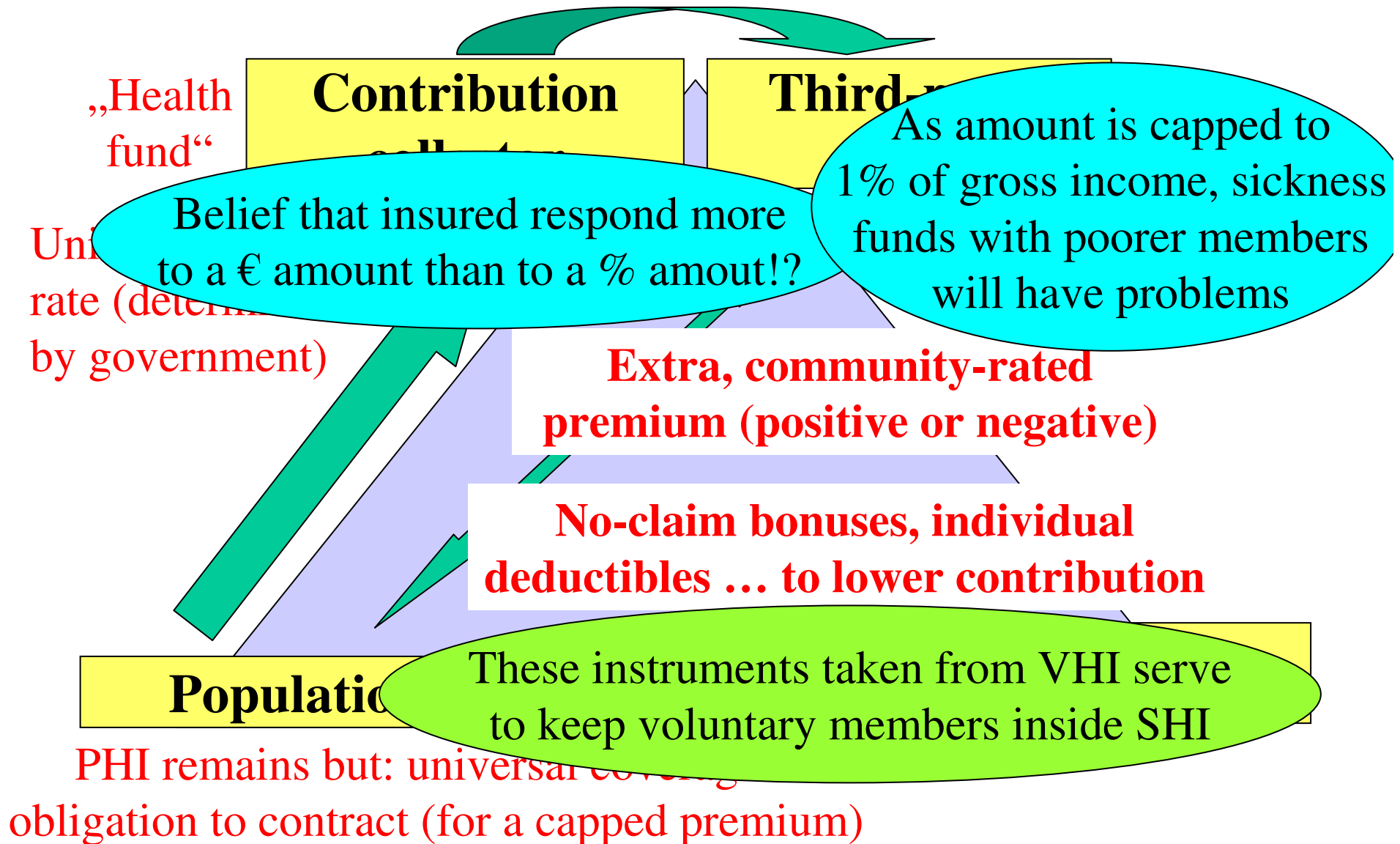
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism for DMP participants and other insured (2006)



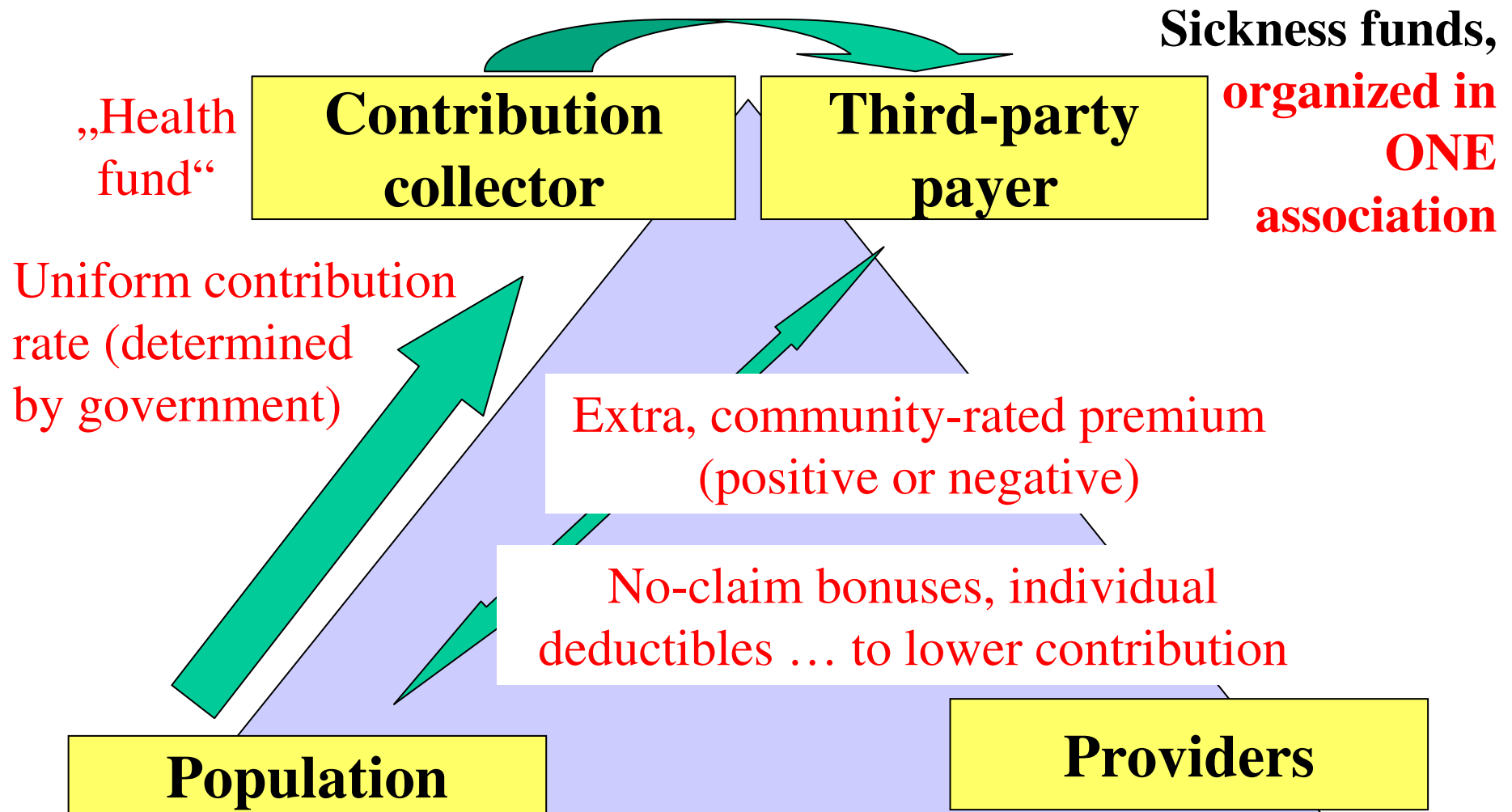
What constitutes a disease for the Risk Structure Compensation?



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



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

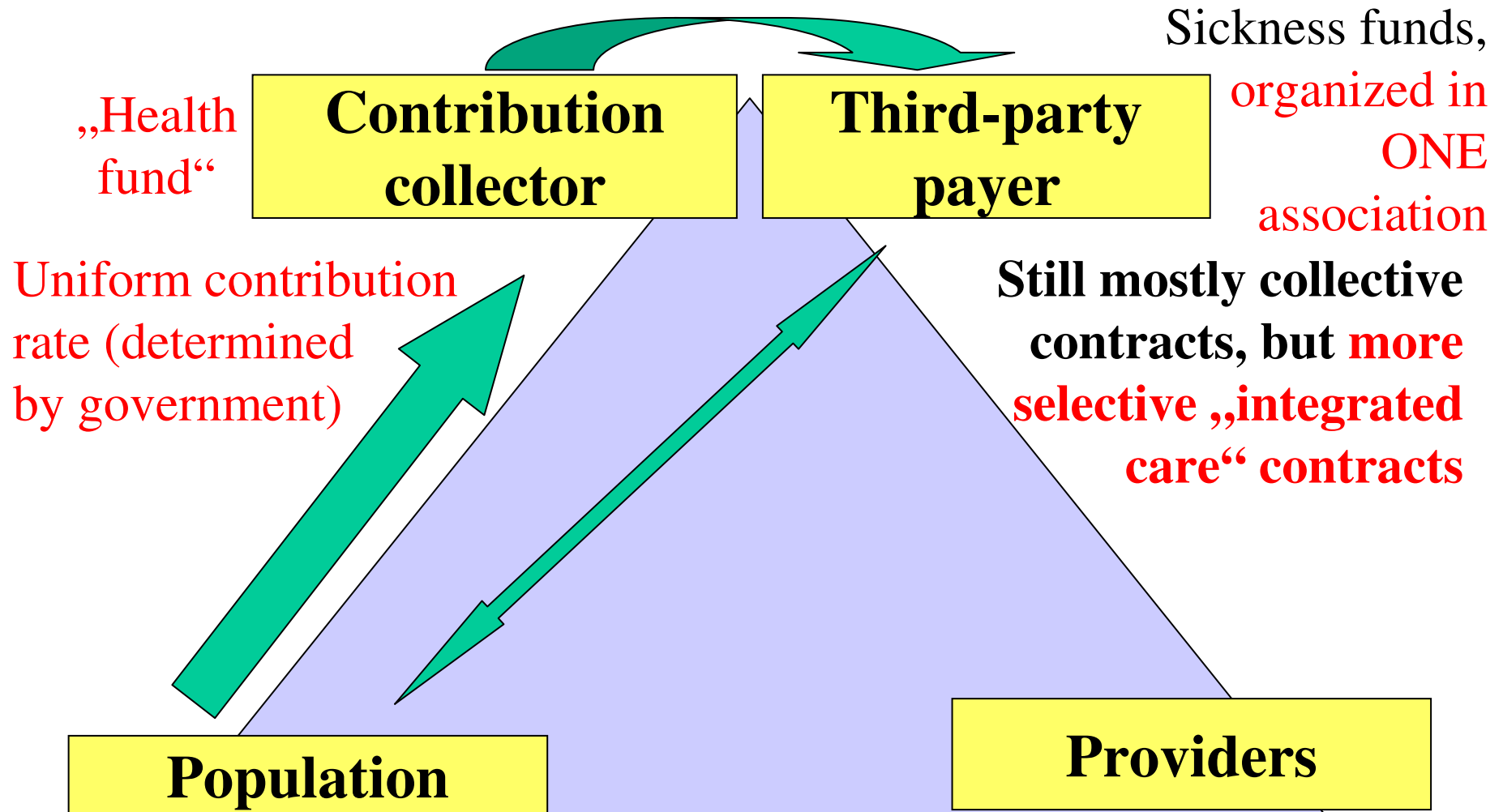


PHI remains but: universal coverage +
obligation to contract (for a capped premium)

Sickness fund reorganisation – statism or a necessary step for more competition?

- One association (under public law)
- Previous associations dissolved (most continue on voluntary basis under private law)
- Mergers between sickness funds belonging to different associations possible (and happening: cf. **TK** and **IKK direkt**)
- Sickness funds may go bankrupt

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



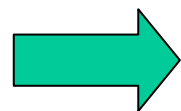
PHI remains but: universal coverage +
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Selective contracting for services

Allowed within

- model projects
- „integrated care“ contracts (since 2000/04)
- „GP contracts“ (insured choose GP as gate-keeper; may be done without *KV* since 2007)

first contract without *KV* in Baden-



Wuerttemberg, signed in May 2008

How to separate capitation payments to KV?

How popular? Currently 2000 GPs enrolled, but <100000 insured

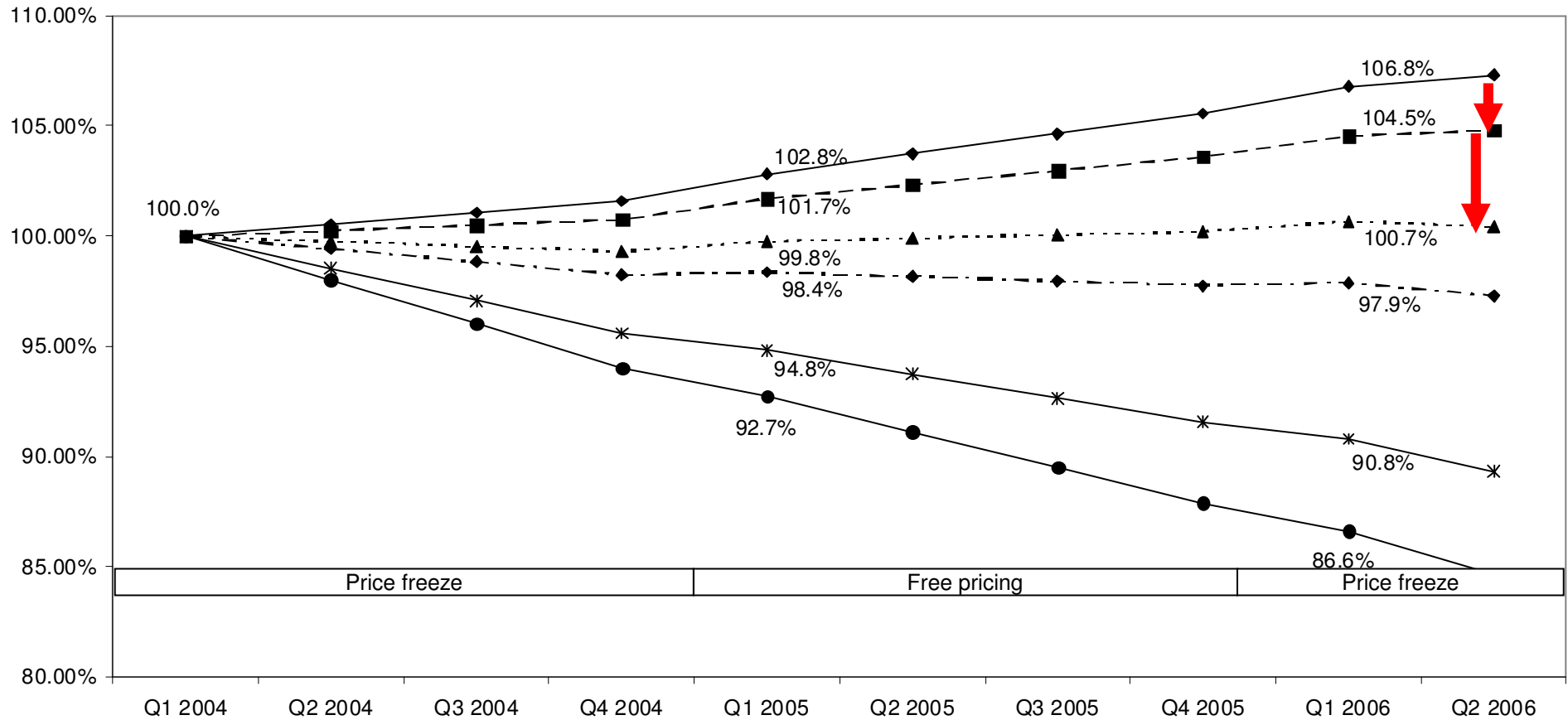
How (cost-)effective?

Pharmaceutical policies pre-WSG

Traditional, interventionist approaches

- National SHI-wide reference prices (RP, *Festbeträge*)
- Hard „budgets“ (actually prescription caps) for *KVen* (physicians' associations) and softer targets for individual practices
- Substitution
- Parallel imports
- Mandatory rebates for manufacturers
- To stimulate price-setting well below RP, patients are exempted from co-payments if price is at least 30% below RP

And we now know (based on TK data): regulation worked – and competition strengthened its effectiveness



- ◆— no reference pricing, 0 competitors at substance level, 100% market share in drug class
- no reference pricing, 0 competitors at substance level, 30% market share in drug class
- ▲— reference pricing, 0 competitors at substance level, 30% market share in drug class
- ◆— reference pricing, 5 competitors at substance level, 20% market share in drug class
- *— reference pricing, 20 competitors at substance level, 5% market share in drug class
- reference pricing, 30 competitors at substance level, 1% market share in drug class

Pharmaceutical policies today

Traditional, interventionist approaches

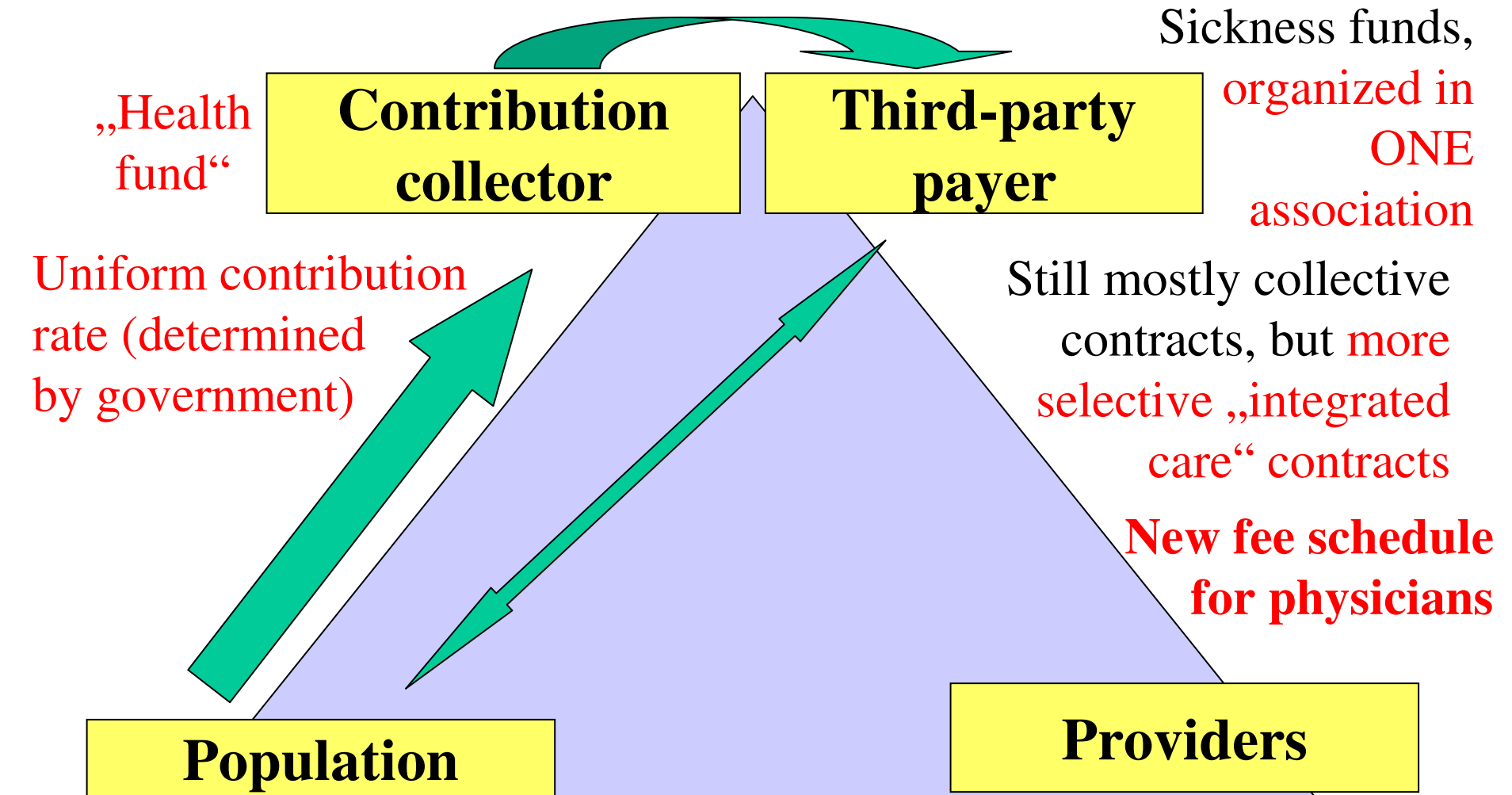
Still in force

New approach since 2007

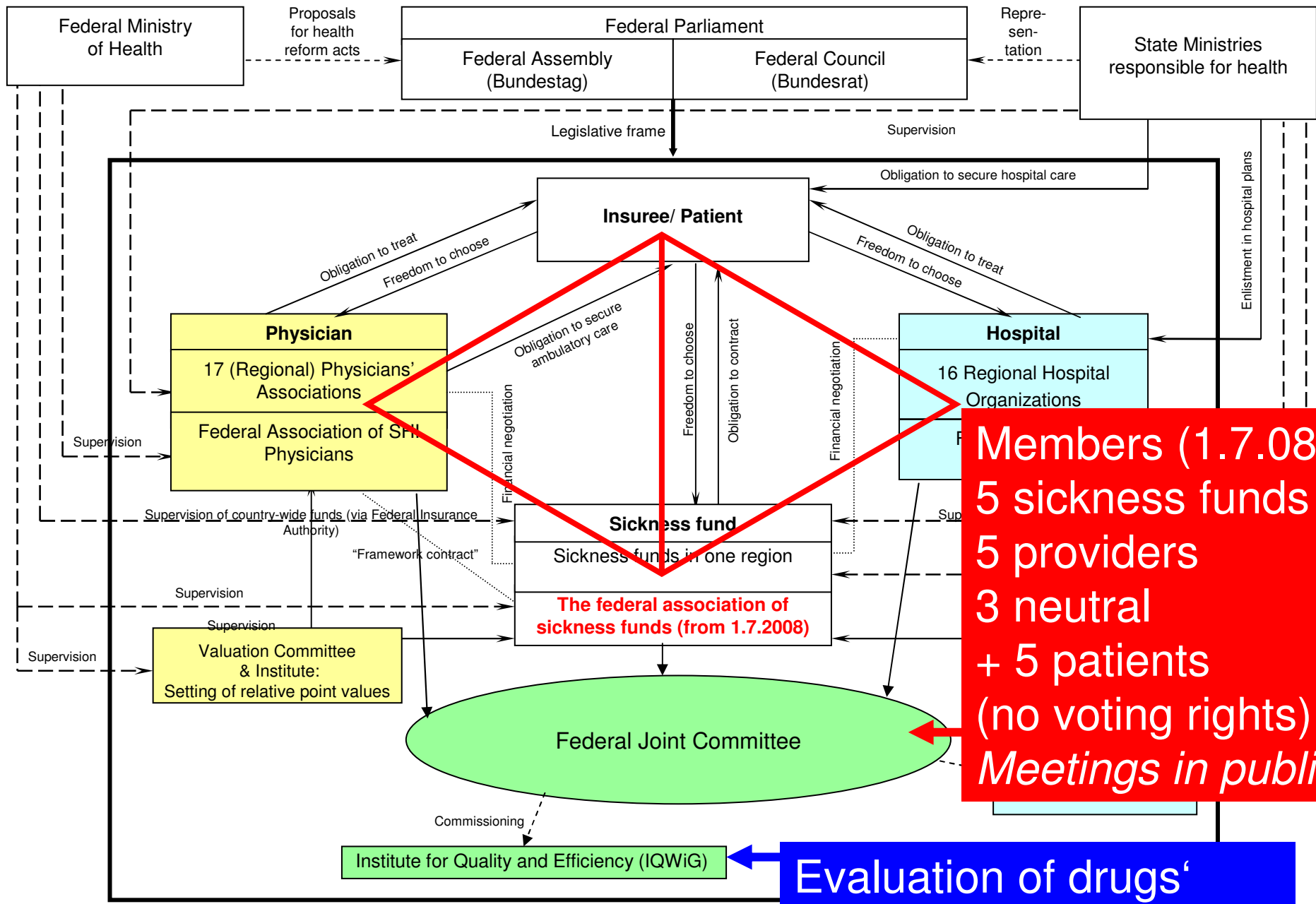
- Contracts/ public procurement:
sickness funds \Leftrightarrow manufacturers
 - Winning manufacturer gets monopoly for that substance,
i.e. no choice for patient, prescribing physician or pharmacist
- > initially ignored by large manufacturers -> turn-over by
small Indian/ Israeli ... manufactures increased drastically

Current regulatory framework inconclusive (e.g. physicians can hardly be held liable for prescription expenditure as prices under procurement are not known or to be influenced)

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



PHI remains but: universal coverage +
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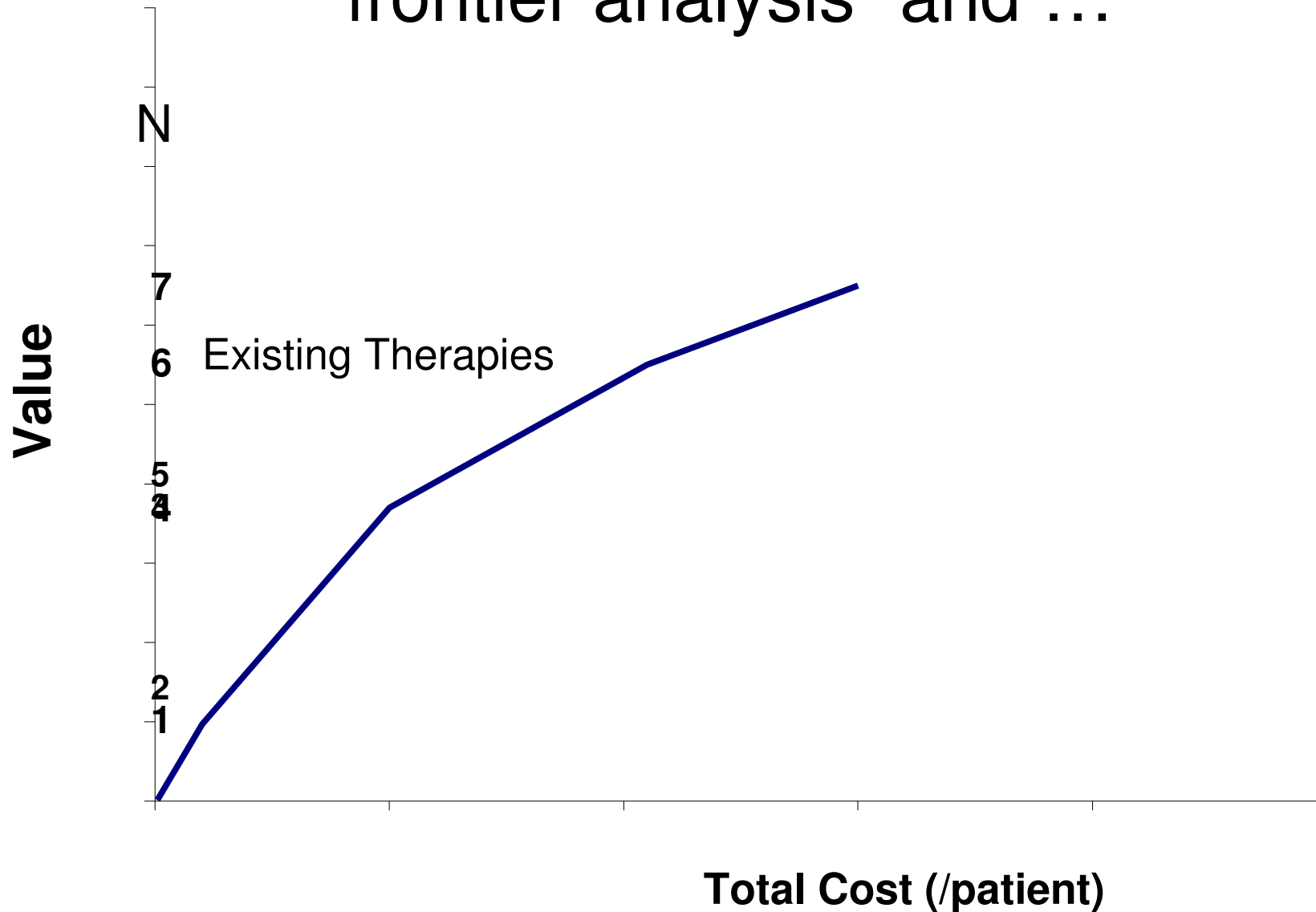


Members (1.7.08):
 5 sickness funds
 5 providers
 3 neutral
 + 5 patients
 (no voting rights)
Meetings in public

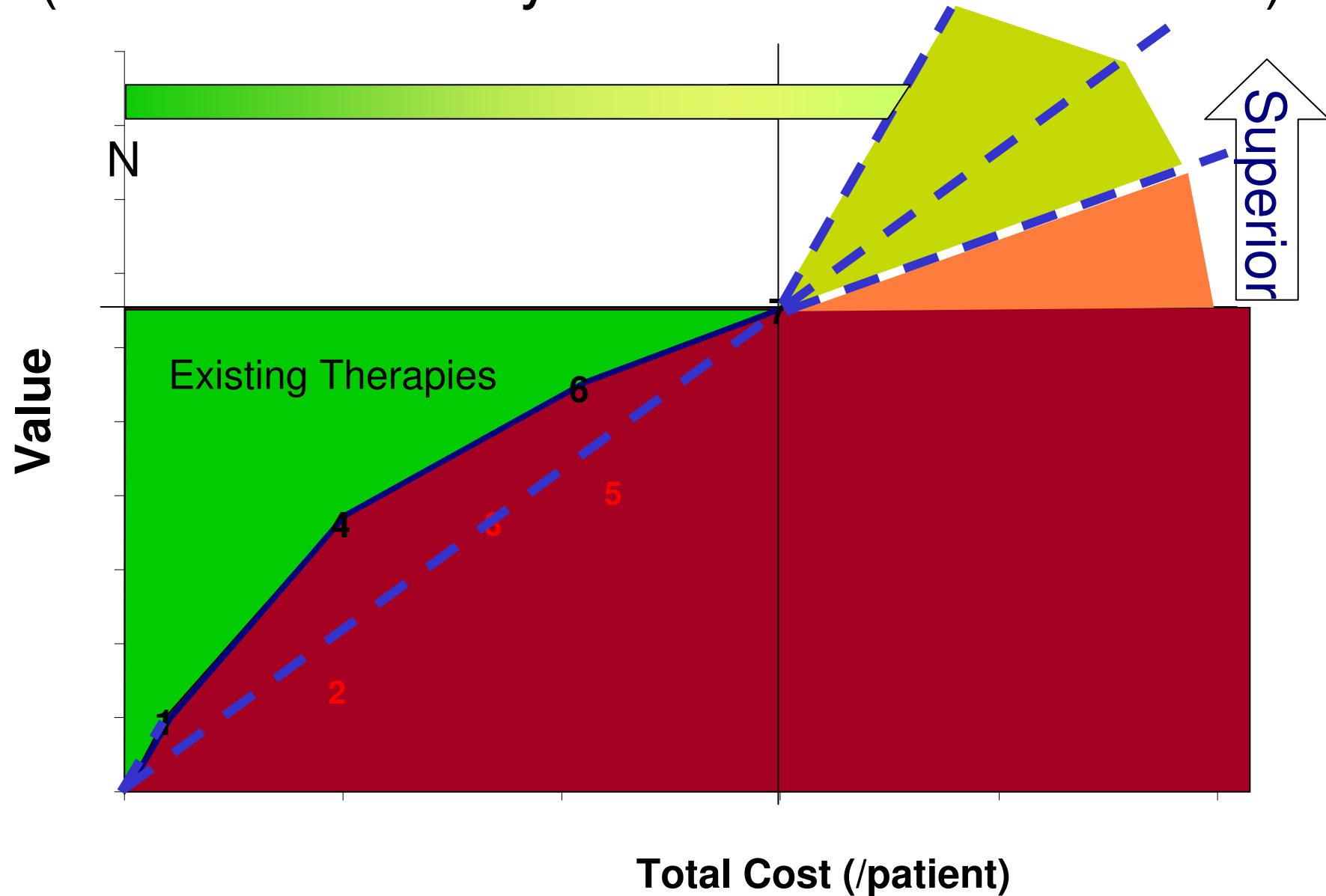
Evaluation of drugs'
 medical cost-benefit etc.

Statute

Pharmaceuticals may be subject to economic evaluation by IQWiG: proposed method “frontier analysis” and ...



... “decision zones”
(decision taken by Federal Joint Committee)



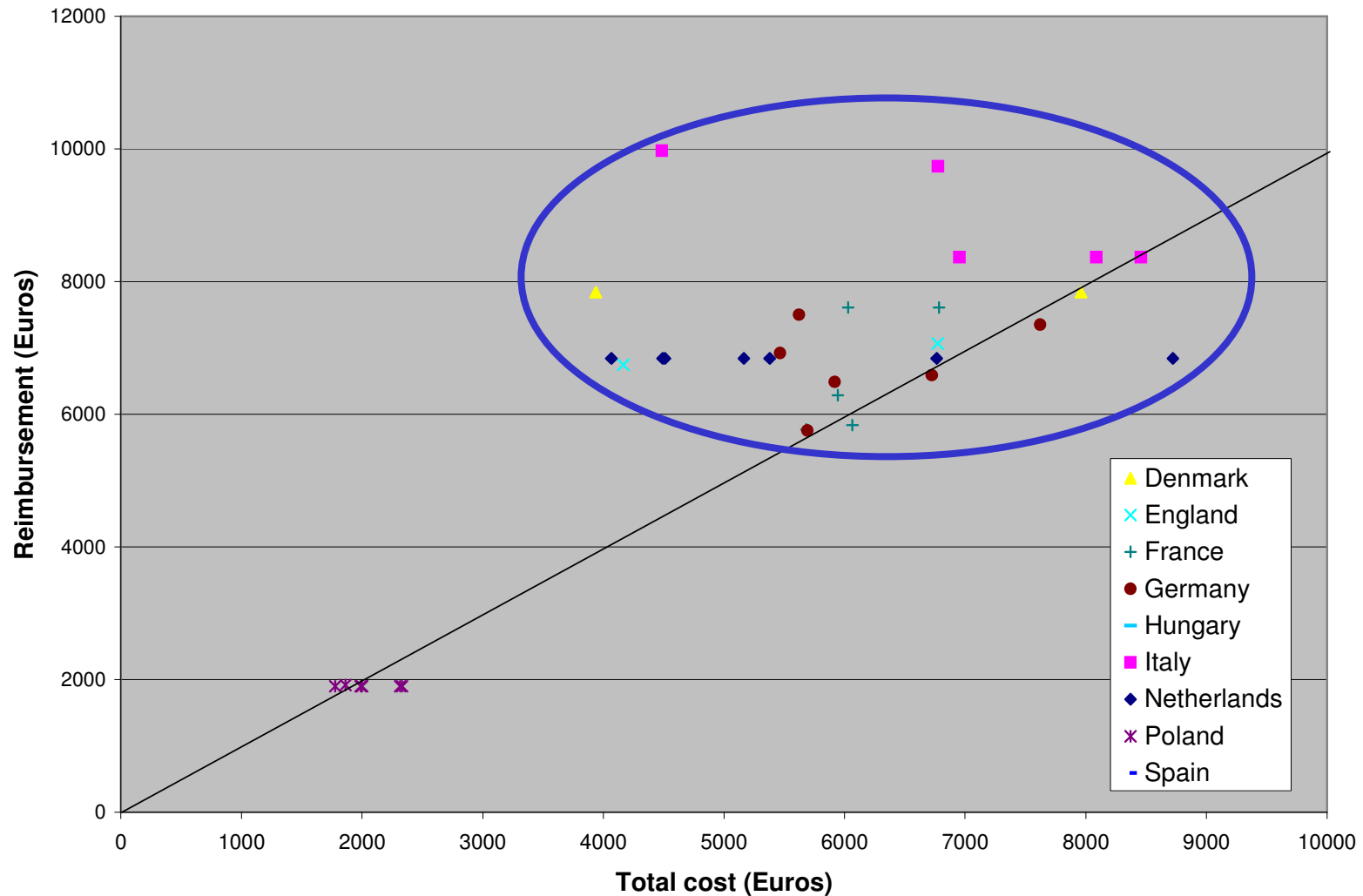
Conclusions

- Competition Strengthening Act has more components than initially realised
- Probably largest structural impact upon system of any reform
- Contains both planning as well as competition elements -> partly incongruent framework (e.g. pharmaceuticals)
- In many ways, the German system has become more “normal” (similar to other) ...

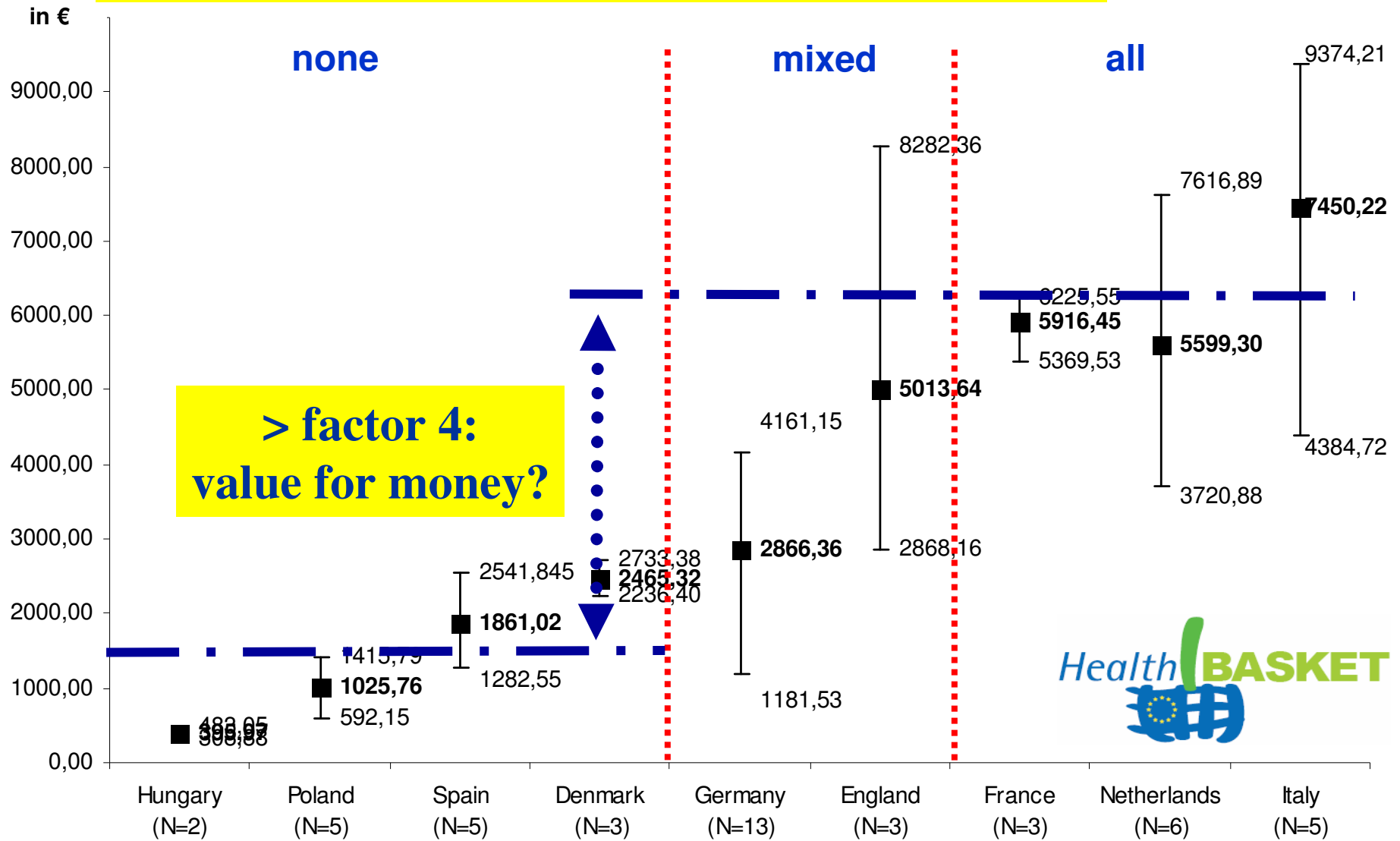
But: The European dimension is still underestimated ...



Example: Hip replacement



Acute myocardial infarction: Hospitals performing PCI (PTCA/ Stenting)



**Presentation and further
material at:**

<http://mig.tu-berlin.de>

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