German Health Care 2008 – learning from others, or to learn from?

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Population Providers

Population:
- Social Health Insurance 87%
- Private HI 10%

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

Provider Mix:
- Ca. 240 sickness funds
  - Wage-related contribution
  - Risk-related premium
  - Choice of fund since 1996
  - Strong delegation & limited governmental control

Choice of Fund:
- Contracts, mostly collective
- No contracts

Third-party payer:
- Ca. 50 private insurers
- "Risk-structure compensation" since 1994/95
- "Collector of resources"

The German system at a glance (2007) ...
<table>
<thead>
<tr>
<th><strong>Population covered</strong></th>
<th><strong>Statutory Health Insurance (SHI)</strong></th>
<th><strong>Private Health Insurance (PHI)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ca. 50 insurers under private law (FP/ NFP)</td>
<td>Ca. 220 sickness funds (self-governing not-for profit entities under public law)</td>
<td>10%, mainly excluded from SHI (self-employed, civil servants)</td>
</tr>
<tr>
<td><strong>Benefits covered</strong></td>
<td>Uniform and broad: hospital, ambulatory care, pharmaceuticals, dental care, rehabilitation, transport, sick pay …</td>
<td>Depending on choice</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Percentage on wages (on average 14.5%), shared between employer and insured – NOT risk-related</td>
<td>Risk-related premium (better for high income)</td>
</tr>
<tr>
<td><strong>Insurers</strong></td>
<td>Social Code Book (= law), details through self-regulation (main actor: Federal Joint Committee)</td>
<td>Ca. 50 insurers under private law (FP/ NFP)</td>
</tr>
<tr>
<td><strong>Regulation</strong></td>
<td>Choice among all contracted providers (ca. 97% in ambulatory care, 99% hospital beds)</td>
<td>Free choice</td>
</tr>
</tbody>
</table>
Delegation = State only defines legal framework

Ambulatory

Physician
17 (Regional) Physicians’ Associations
Federal Association of SHI Physicians

Valuation Committee & Institute: Setting of relative point values

Inpatient

Hospital
16 Regional Hospital Organizations

Federal H. Organization

Sickness fund
Sickness funds in one region
7 Federal associations of sickness funds

Committee & Institute for Hospital Reimbursement: DRGs

Federal Joint Committee (since 2004)

Institute for Quality and Efficiency (IQWiG)

Statutory health insurance early 2008
Even though certain regulatory institutions and programmes have become trans-sectoral …

Joint self-government

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

Statutory health insurance early 2008

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 initially 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 2004-2008)
• 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 Programs
(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 for diabetes I/ II, asthma/ COPD, CHD, breast cancer
- = introduce Disease Management Programs meeting certain minimum criteria and compensate sickness funds for average expenditure of those enrolling

*double incentive for sickness funds: potentially lower costs + extra compensation!*  
*By end of 2007: 3.8 mn enrolled (5.5% of SHI insured)*
DMP diabetes – results

(not from official evaluation with post-intervention no control group design)

100% = Diabetics not enrolled in DMP

- Stroke (m): 71.2%
- Stroke (f): 64.3%
- Foot/leg amputations (m): 62.0%
- Foot/leg amputations (f): 41.8%
How does a new technology/service enter the system?

• In ambulatory care officially: Sickness fund or physicians’ association make proposal to Federal Joint Committee which may commission an evaluation through IQWiG; if positive -> passed to Valuation Committee to determine point value

• Inofficially moreoften through reformulation of service definition through Valuation Committee

• Contrast to inpatient care: Hospital may provide any service which is not explicitly excluded
### 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) |

### 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) |
| 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 |

### Revenue budget

- Effective case-mix
- Case-mix
- Other revenues with compensation (§ 6 Abs. 3 KHEntgG)
Federal Office for Quality Assurance (BQS) since 2001 mandatory for almost 1600 hospitals, 170 indicators, with feedback and “structured dialogue“

Is the appropriate thing done?
Is it done correctly?
With what (short-term) results?

13%  27%  60%

Indication  Process  Outcome
Beginn  Ende

Inpatient episode

BQS-Bundesauswertung 2005
An example (with slow progress):

Documentation of operation distance to (breast) cancer

Mammachirurgie 2005: Angabe Sicherheitsabstand bei BET (KeZ 68098)
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)

1.4.2007: previously SHI insured have right to return
1.7.2007: previously PHI insured have right to return
2009: universal coverage
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases

„Health fund“

Contribution collector

Third-party payer

Uniform contribution rate (determined by government)

Hotly debated, especially by richer states (with above average reimbursement level)

 Population

 PHI remains but: universal coverage + obligation to contract (for a capped premium)
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism for DMP participants and other insured (2006)

Avg. 5.20€/ day
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem

How can we predict who these 5 or 10% are?
14% of all insured above legal threshold for selected diseases of 1.5x average
Current conflict between resigned Expert Council and Ministry, supported mainly by certain large sickness funds, about selection of diseases, especially role of prevalence: “expensive” = expenditure/ person x prevalence? -> should “hypertension” be in? uncomplicated diabetes? …
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases

**Contribution collection**

Belief that insured respond more to a € amount than to a % amount!?

Uniform contribution rate (determined by government)

„Health fund“

**Third-party payer**

As amount is capped to 1% of gross income, sickness funds with poorer members will have problems

Extra, community-rated premium (positive or negative)

No-claim bonuses, individual deductibles … to lower contribution

**Population**

These instruments taken from VHI serve to keep voluntary members inside SHI

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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Contribution collector

Third-party payer

Population

Providers

Sickness funds, organized in ONE association

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

• One association (under public law)
• Previous associations dissolved (may continue on voluntary basis under private law)
• Mergers between sickness funds belonging to different associations possible (and happening)
• Sickness funds may go bankrupt
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases

- Contribution collector
  - Uniform contribution rate (determined by government)
- Third-party payer
  - Sickness funds, organized in ONE association
  - Still mostly collective contracts, but more selective "integrated care" contracts
  - New fee schedule for physicians

Population

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

How to separate capitation payments to KV?
Pharmaceutical policies I

Traditional, interventionist approaches
- National SHI-wide reference prices
- Hard „budgets“ (actually prescription caps) for 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 (currently ca. 12,000 drugs)
Pharmaceutical policies II

Traditional, interventionist approaches

- National SHI-wide reference prices
- Hard “budgets” (actually prescription caps) for 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 (currently ca. 12,000 drugs)

New approach since 2007

- Contracts/public procurement through sickness funds directly with 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)
Medical aids (medical products on prescription)

- Politicians have discovered medical aids as a field for regulation relatively recently
- => national reference prices (= max. reimbursement price for sickness funds) per product group since 2005
- => procurement of medical aids through sickness funds since 2007: contracts with suppliers (not manufacturers!) who get regional monopoly
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
- Actual reimbursement/ point depends on capitations paid and total number of points, usually around 0.035 €
Sickness fund X

Sickness fund Y  Negotiated capitation  Sickness fund Z

Physicians‘ association (KV)

GP budget (ca. 1/3)  Specialists‘ budget (ca. 2/3)

€ dependent on total number of points for delivered services

GP 1  GP 2  GP 3  Spec1  Spec2  Spec3
Ambulatory physicians’ 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
Freedom to choose

Federal Hospital Organization

Freedom to choose

Federal Parliament

Federal Assembly (Bundestag)

Federal Council (Bundesrat)

Representa-
tion

State Ministries responsible for health

Insuree/ Patient

Obligation to secure hospital care

Repre-
sent-
ation

Supervision

State Ministries responsible for health

17 (Regional) Physicians’ Associations

Supervision of regional funds

Federal Association of SHI Physicians

Supervision of country-wide funds (via Federal Insurance Authority)

“Framework contract”

Obligation to treat

Freedom to choose

Obligation to treat

Freedom to choose

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Freedom to choose

Sickness fund

Sickness funds in one region

The federal association of sickness funds (from 1.7.2008)

Supervision

Valuation Committee & Institute: Setting of relative point values

Supervision

Evaluation Committee

Institute for Quality and Efficiency (IQWiG)

Commissioning

Federal Joint Committee

Meetings in public

Obligation to secure hospital care

Supervision

Commissioning

Evaluation of drugs’ medical cost-benefit etc.

Members (1.7.08):
5 sickness funds
5 providers
3 neutral
+ 5 patients
(no voting rights)
Pharmaceuticals may be subject to economic evaluation by IQWiG: proposed method

1. Define Therapeutic Area
2. Select Interventions
3. Identify Consequences
4. Estimate Benefits
5. Translate Benefits to Good
6. Benefit on Cardinal scale?
   - If superior
     - Estimate Costs
     - Horizontal Axis
     - Plot Efficiency Frontier
   - Vertical Axis

Eval. Med. Benefit
Constructing the frontier (in one therapeutic area)
Decision zones
(decision taken by Federal Joint Committee)

Existing Therapies

Total Cost (/patient)
Conclusions

• Competition Strengthening Act has more components than initially realized
• Probably largest structural impact upon system of any reform
• In many respects, Germany has learnt from other countries
• But: actual implementation will again provide examples for other countries