Technische Universität Berlin

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

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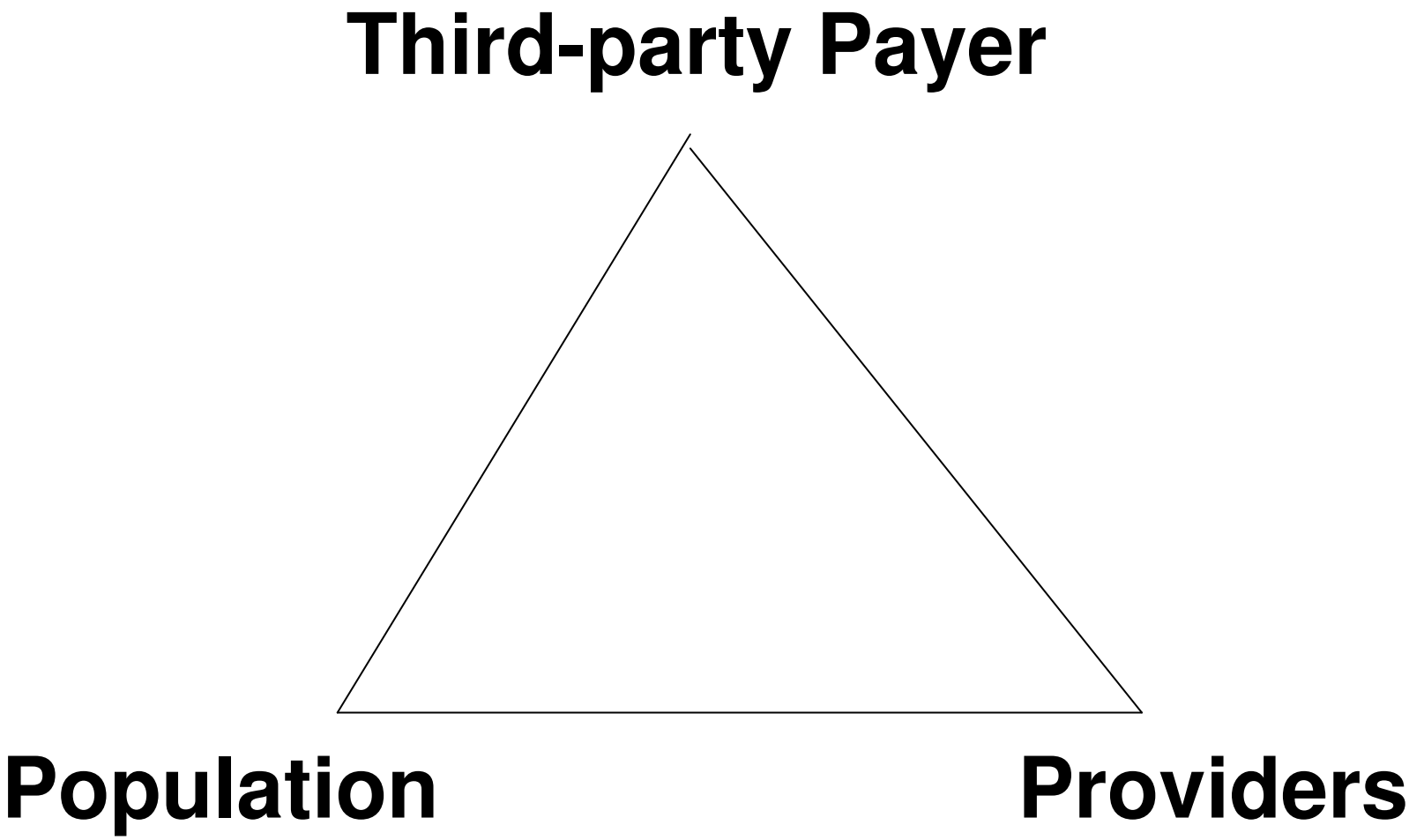
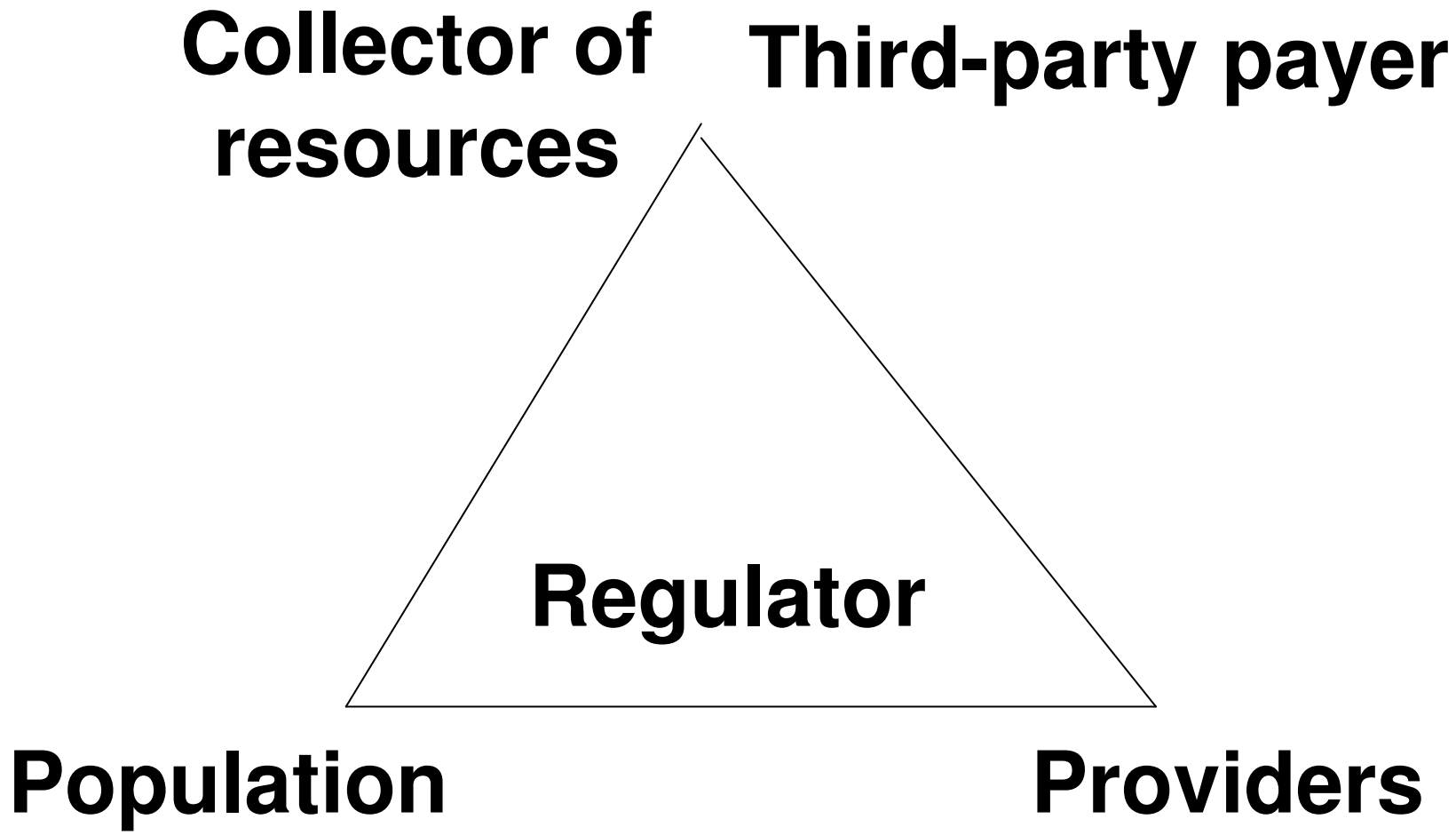
CHARITÉ

European Observatory on Health Systems and Policies



European Observatory on Health Systems and Policies



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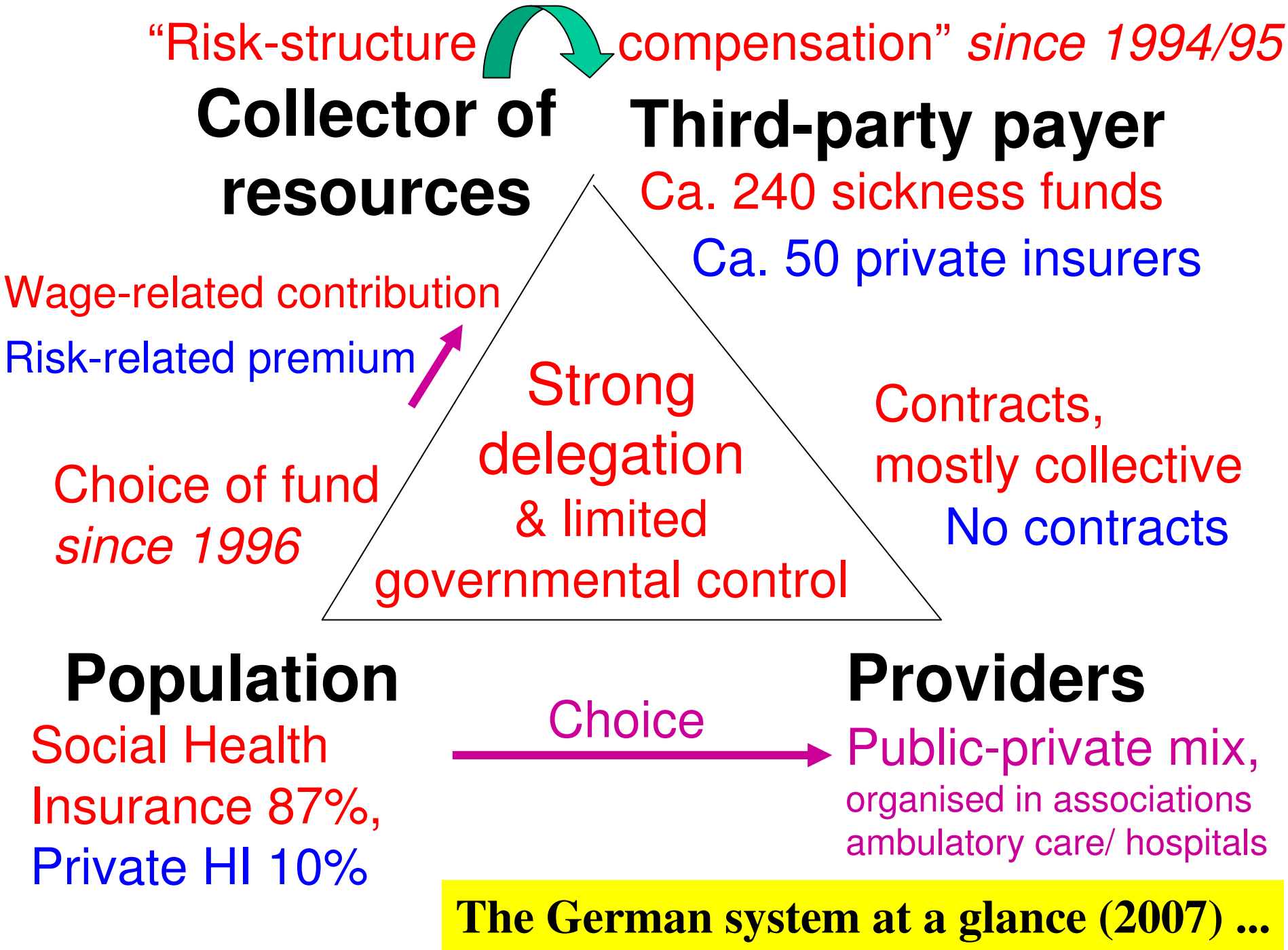
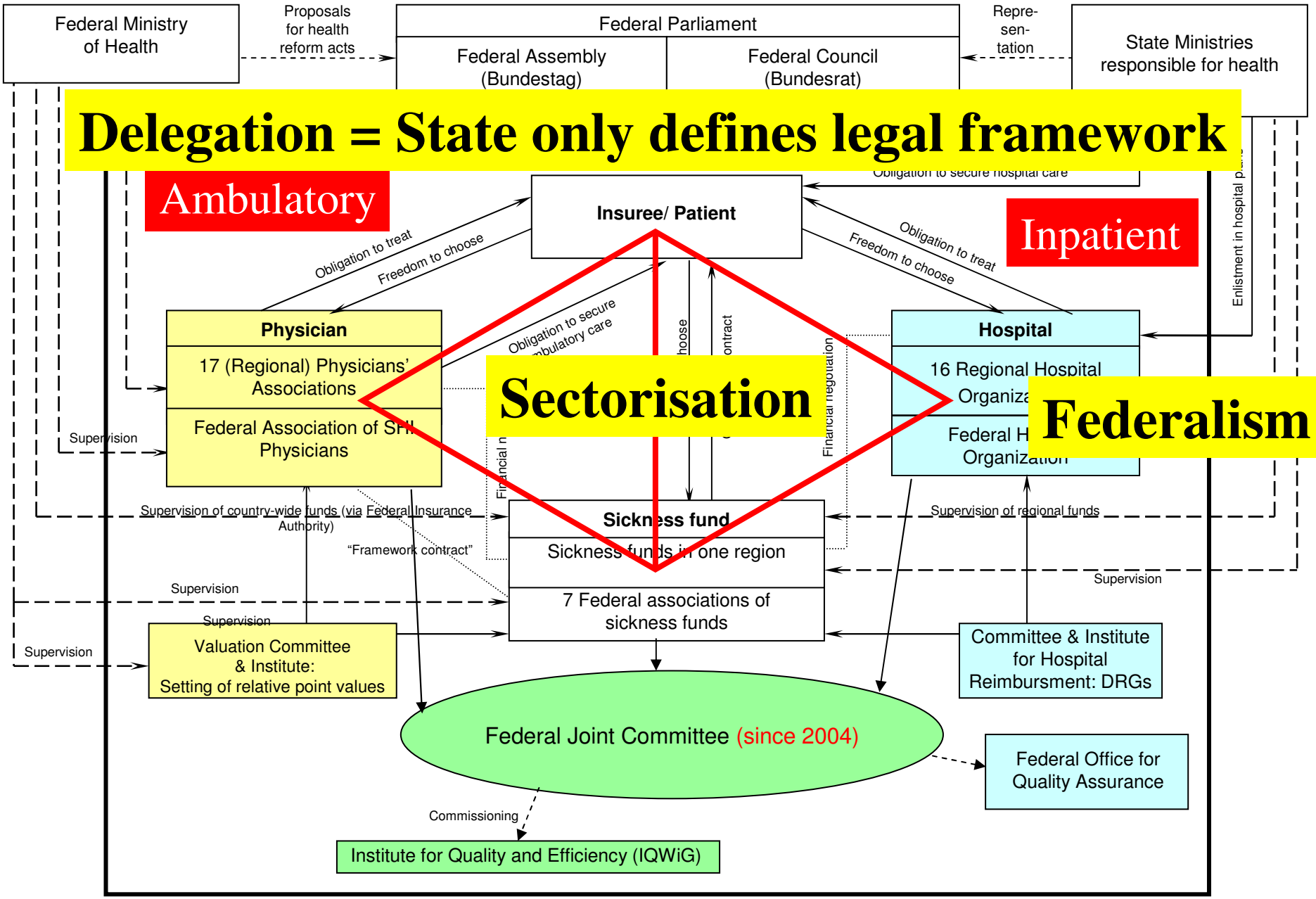


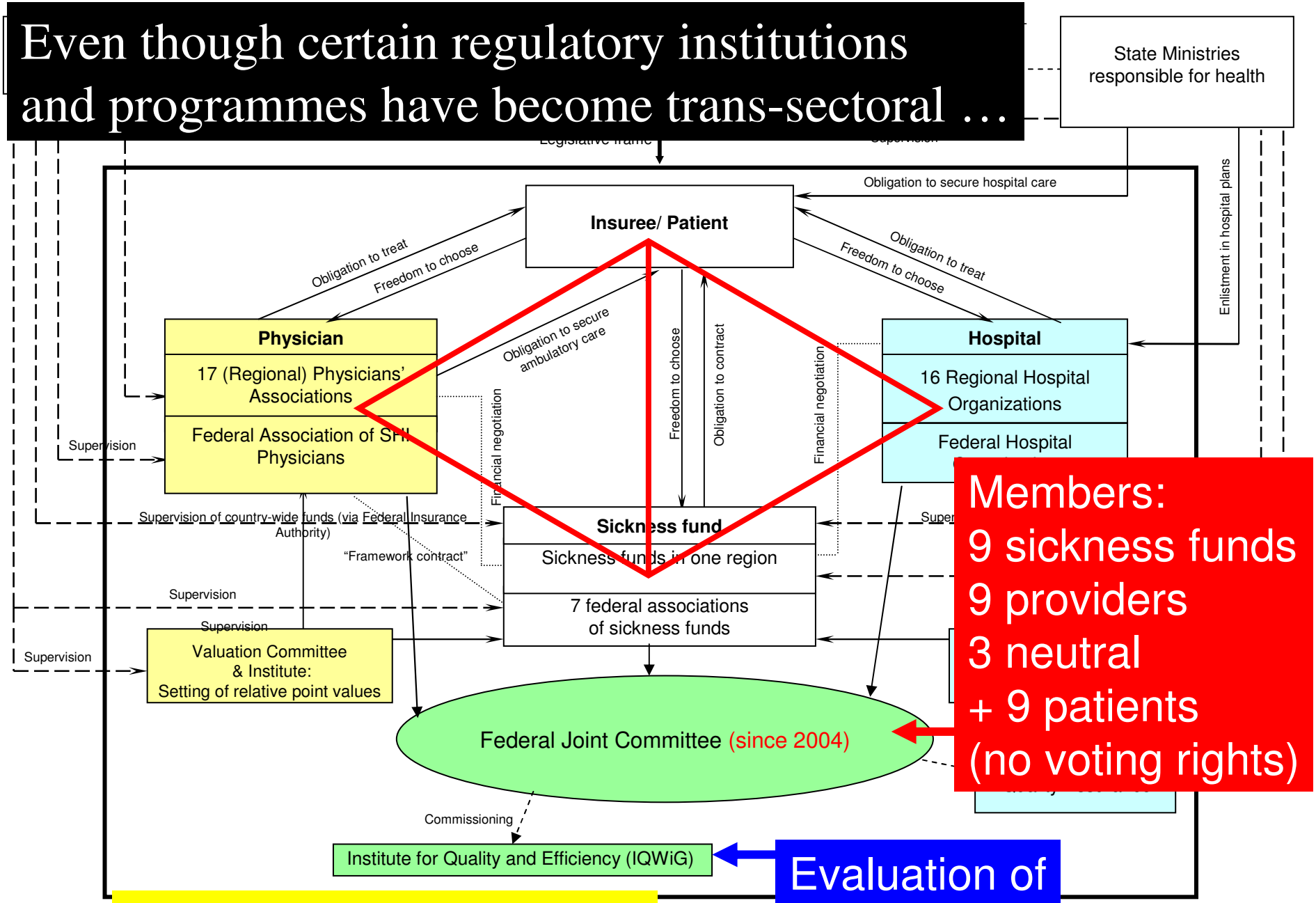
The German system at a glance (2007) ...

	Statutory Health Insurance (SHI)	Private Health Insurance (PHI)
Population covered	87%: 75% mandatorily (employed up to income ceiling, unemployed, retired …) + 12% voluntarily	10%, mainly excluded from SHI (self-employed, civil cervants)
Benefits covered	Uniform and broad: hospital, ambulatory care, pharmaceuticals, dental care, rehabilitation, transport, sick pay …	Depending on choice
Financing	Percentage on wages (on average 14.5%), shared between employer and insured – NOT risk-related	Risk-related premium *(better for high income)*
Insurers	Ca. 220 sickness funds (self-governing not-for profit entities under public law)	Ca. 50 insurers under prvate law (FP/ NFP)
Regulation	Social Code Book (= law), details through self-regulation (main actor: Federal Joint Committee)	Insurance law
Providers	Choice among all contracted providers (ca. 97% in ambulatory care, 99% hospital beds)	Free choice



Statutory health insurance early 2008

Even though certain regulatory institutions and programmes have become trans-sectoral …

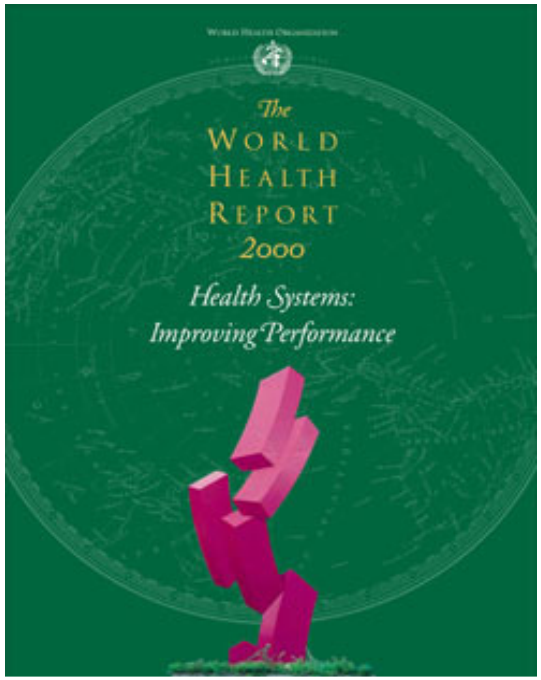


Joint self-government

Statuto… …early 2008

… 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)

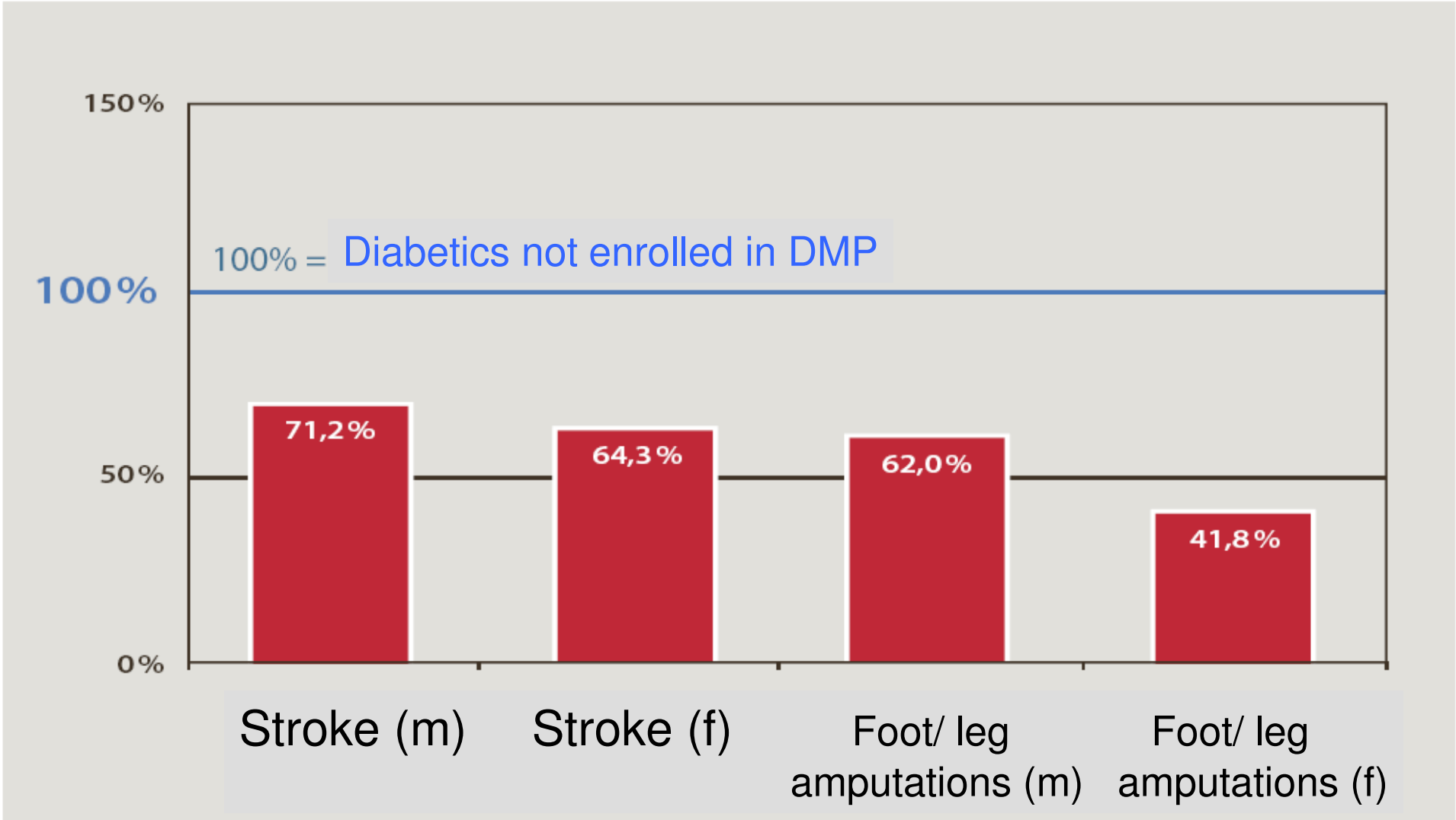
Disease Management Programs
(since 2002)

- 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)

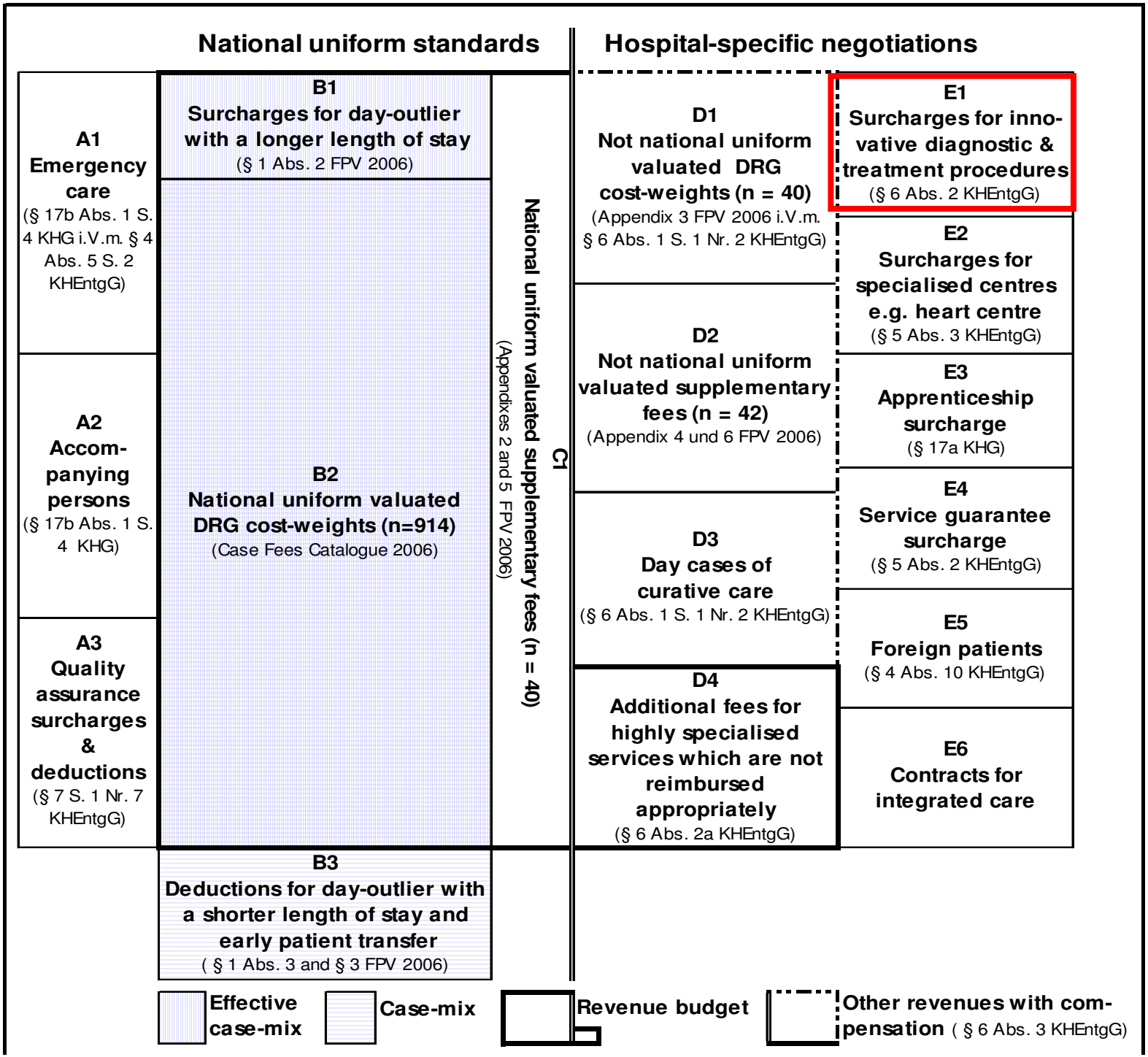
DMP diabetes – results

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



How does a new technology/ service enter the system?

- In ambulatory care officially: Sickness fund or physicians‘ asociation 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
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)

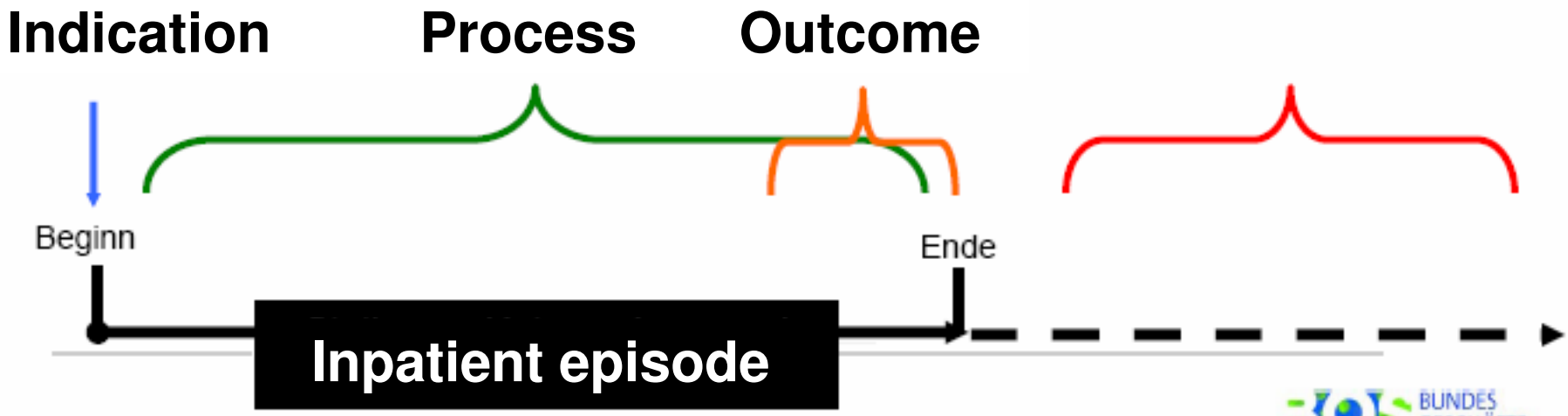
Federal Office for Quality Assurance (BQS)

since 2001 mandatory for almost 1600 hospitals,
170 indicators, with feedback and “structured dialogue“

Is the appropriate thing done? 13%

Is it done correctly? 27%

With what (short-term) results? 60%

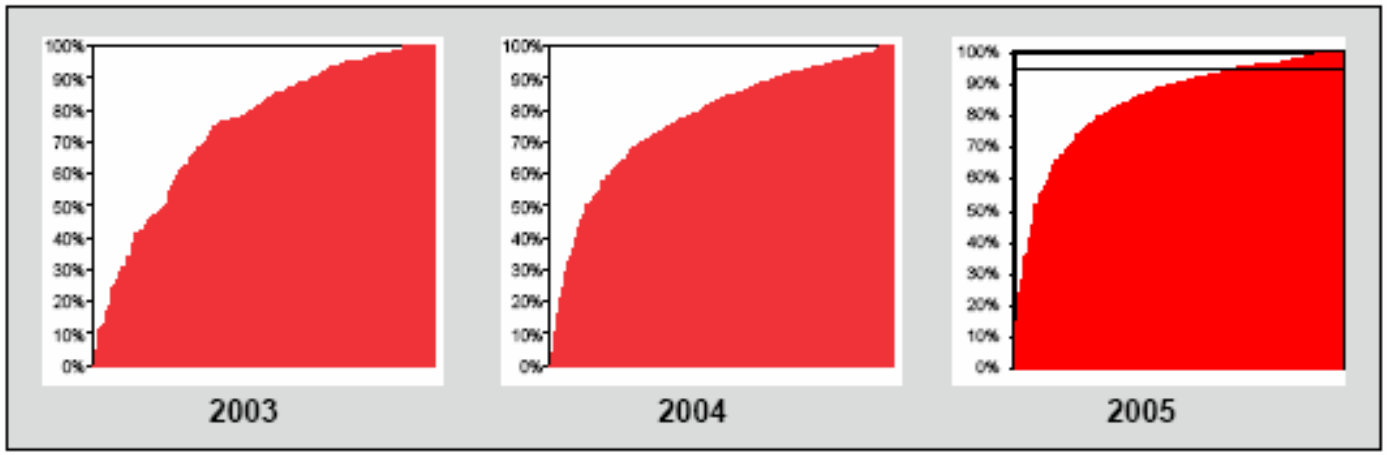


BQS-Bundesauswertung 2005

BUNDES GESCHÄFTS STELLE QUALITÄTS SICHERUNG GGMBH

An example (with slow progress):

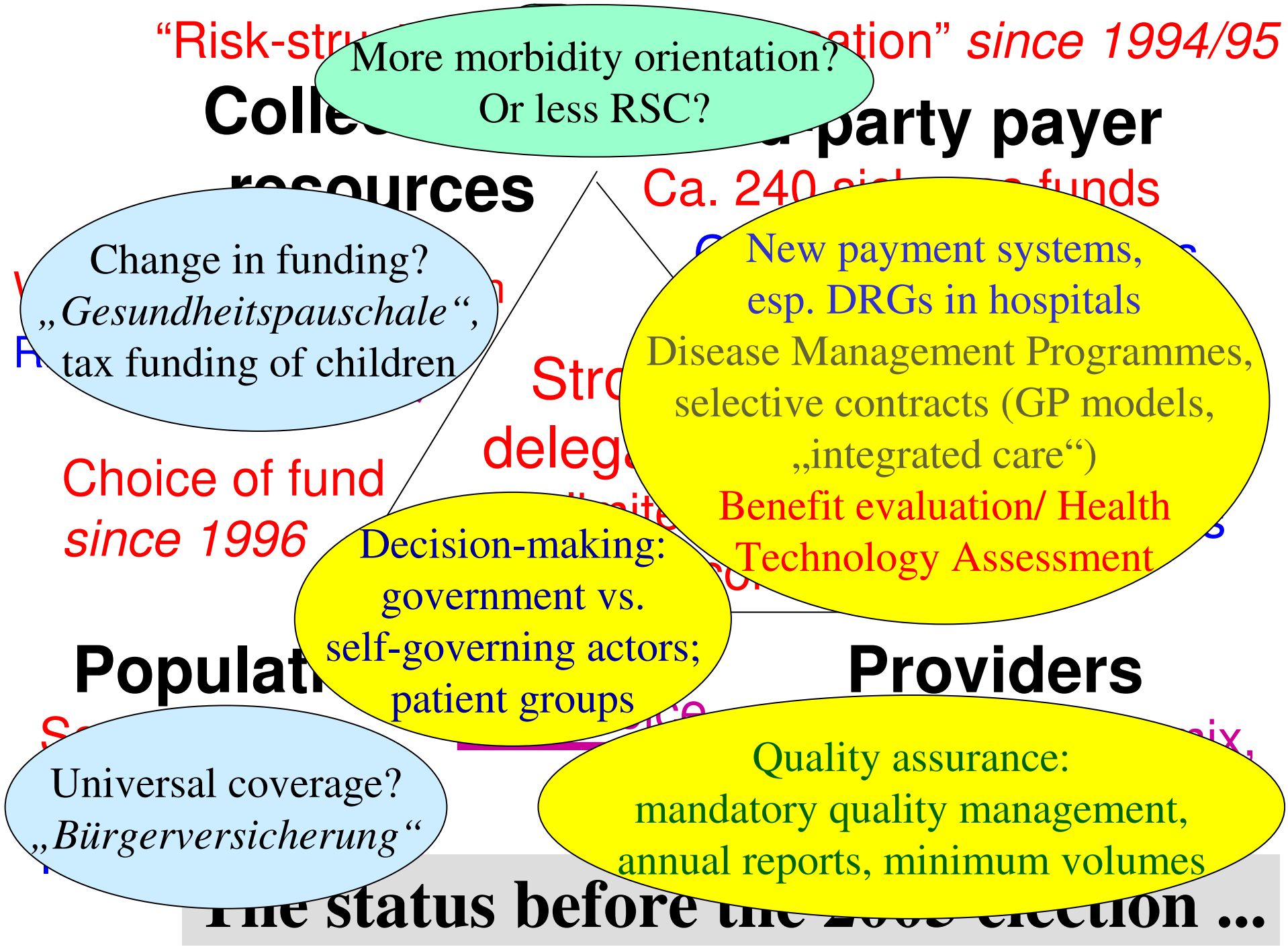
Documentation of operation distance to (breast) cancer



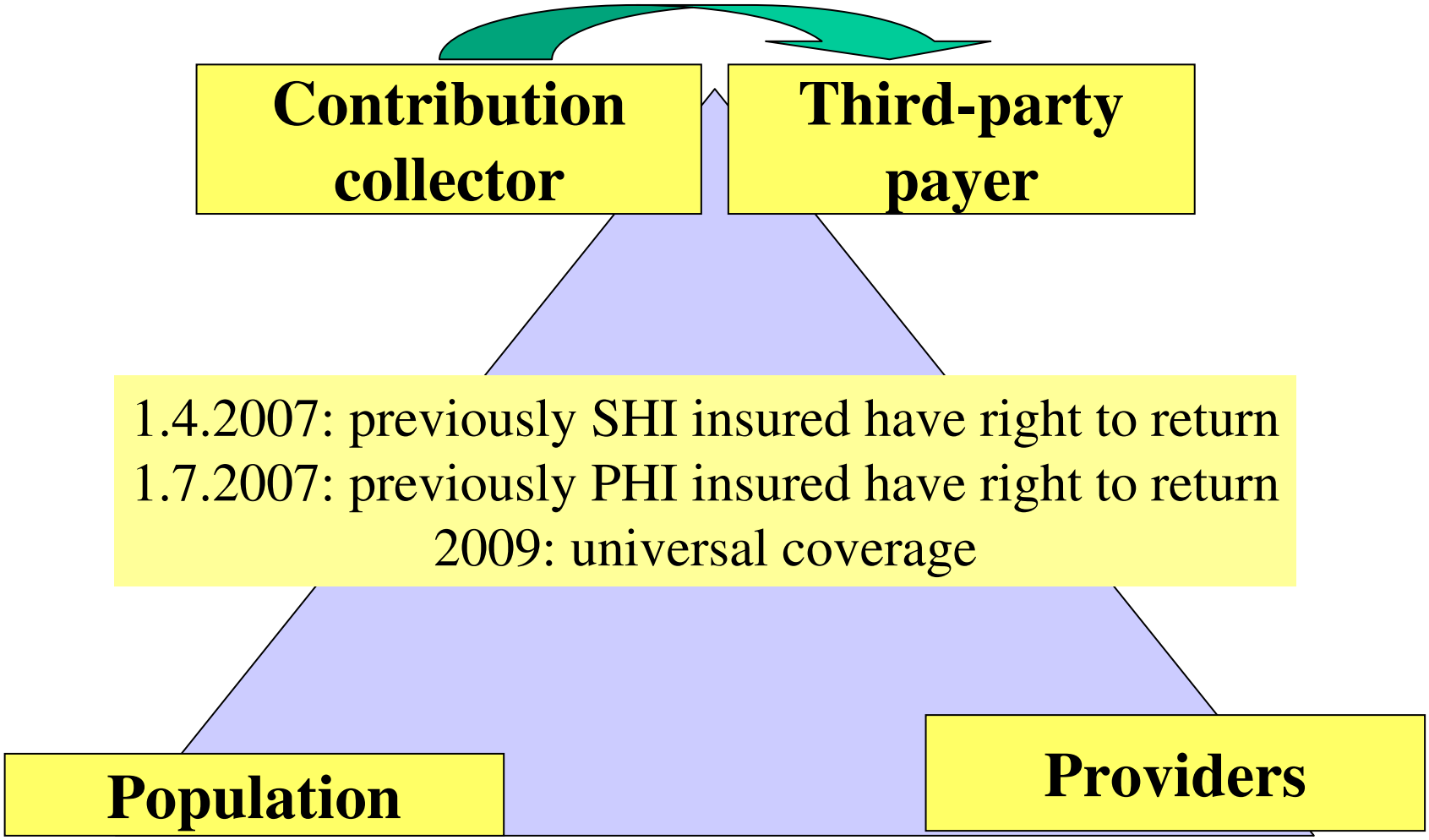
72,52% 75,67% 83,19%

Mammachirurgie 2005: Angabe Sicherheitsabstand bei BET (KeZ 68098)

BUNDES GESCHÄFTS STELLE QUALITÄTS SICHERUNG GGMBH

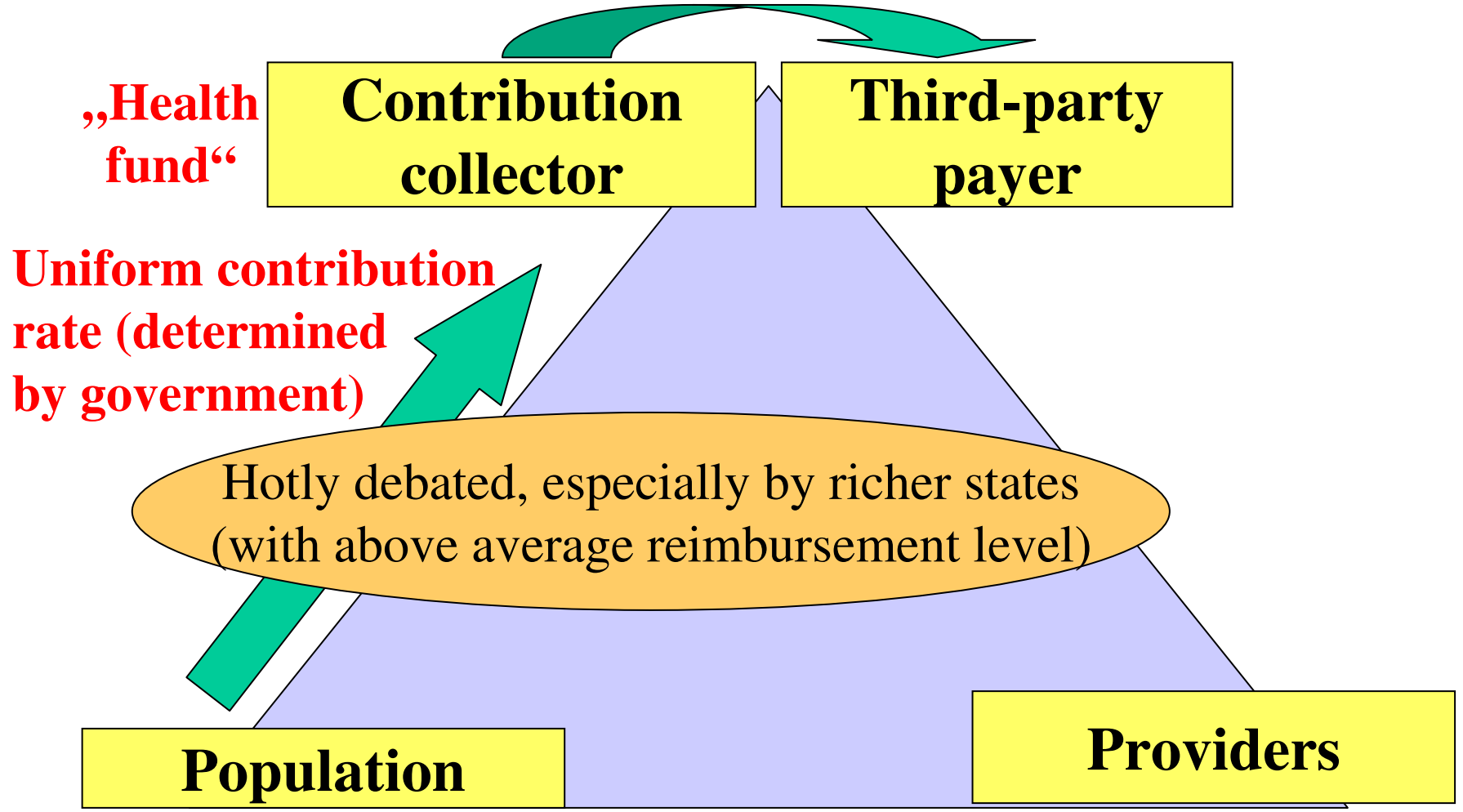

"Risk-stru tion" since 1994/95
More morbidity orientation?
Or less RSC?
Colle party payer
resources
Ca. 240 sic funds
Change in funding?
„Gesundheitspauschale",
tax funding of children
New payment systems,
esp. DRGs in hospitals
Disease Management Programmes,
selective contracts (GP models,
„integrated care")
Benefit evaluation/ Health
Technology Assessment
Stro
delega
Choice of fund
since 1996
Decision-making:
government vs.
self-governing actors;
patient groups
Populati
Providers
Universal coverage?
„Bürgerversicherung"
Quality assurance:
mandatory quality management,
annual reports, minimum volumes
The status before the 2005 election ...

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



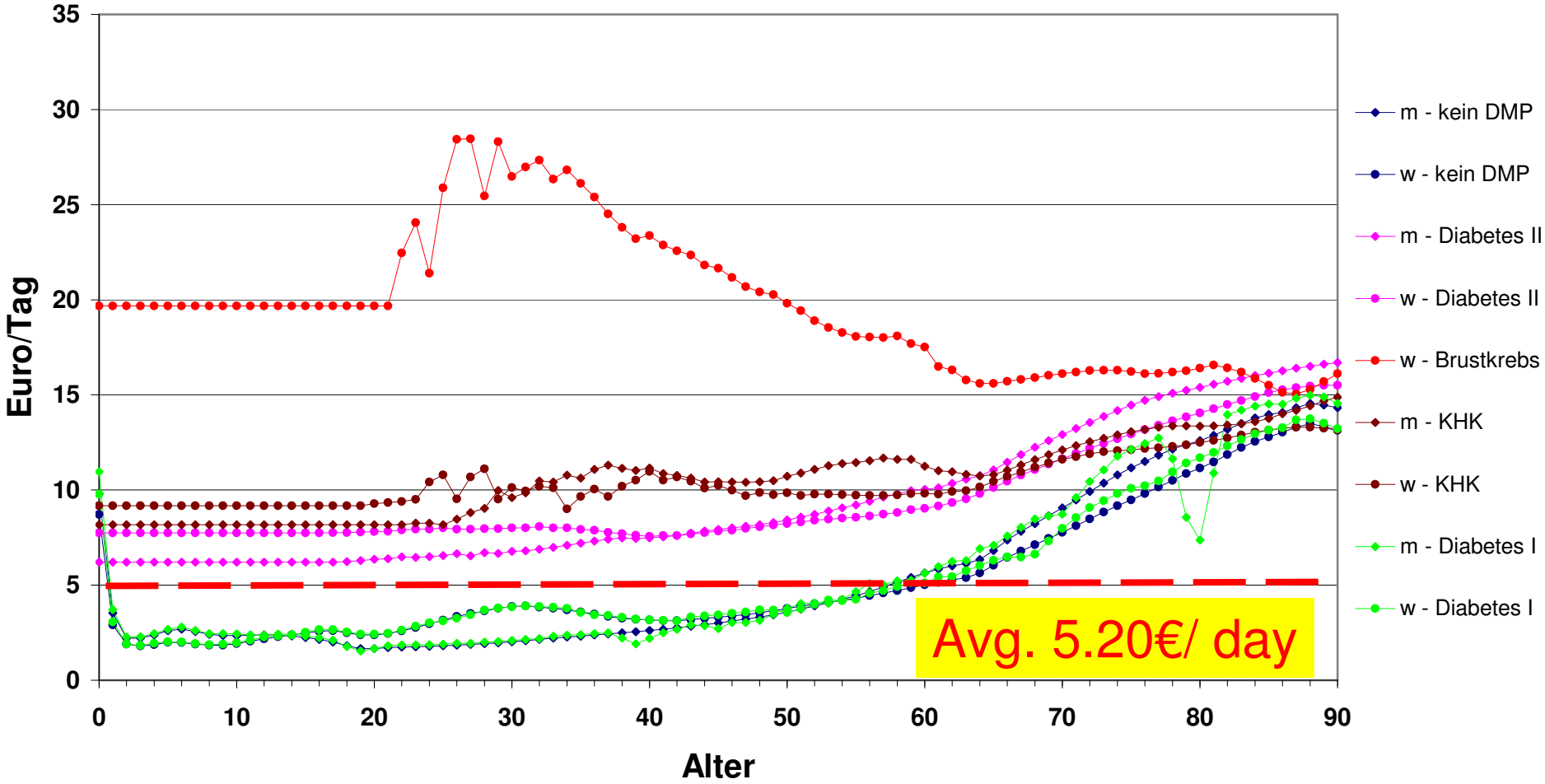
PHI remains but: universal coverage + obligation to contract (for a capped premium)

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

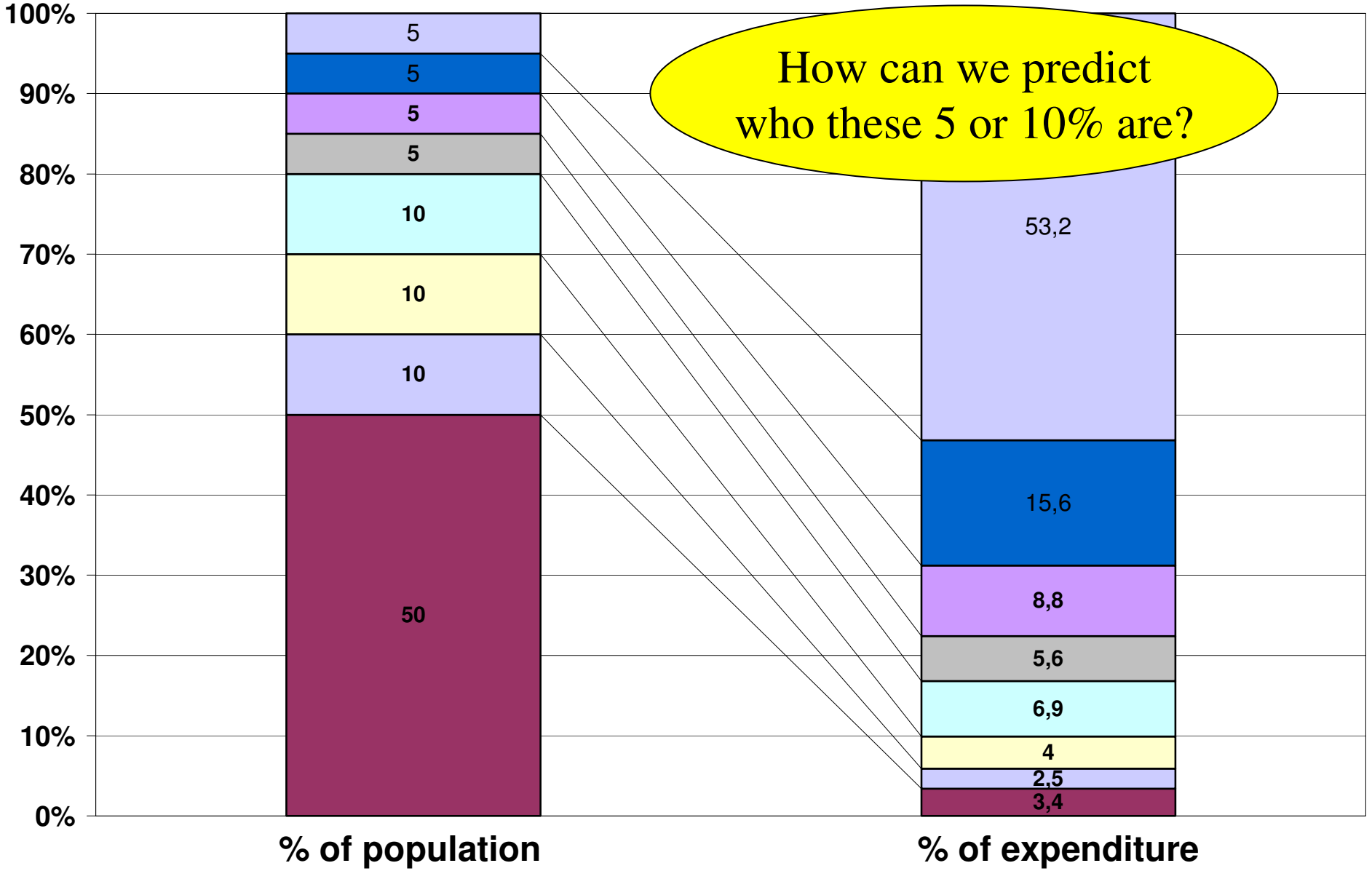


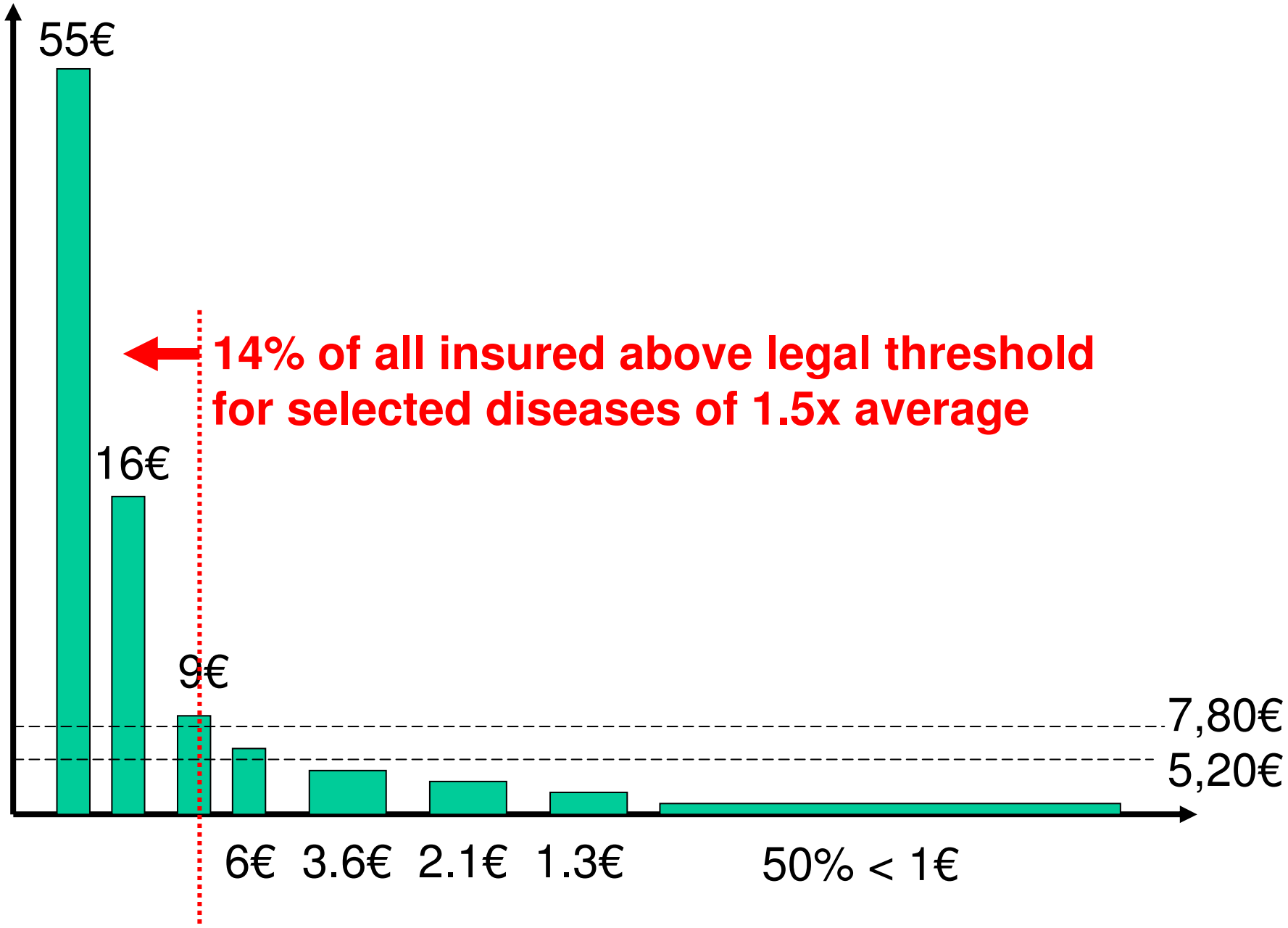
PHI remains but: universal coverage + obligation to contract (for a capped premium)

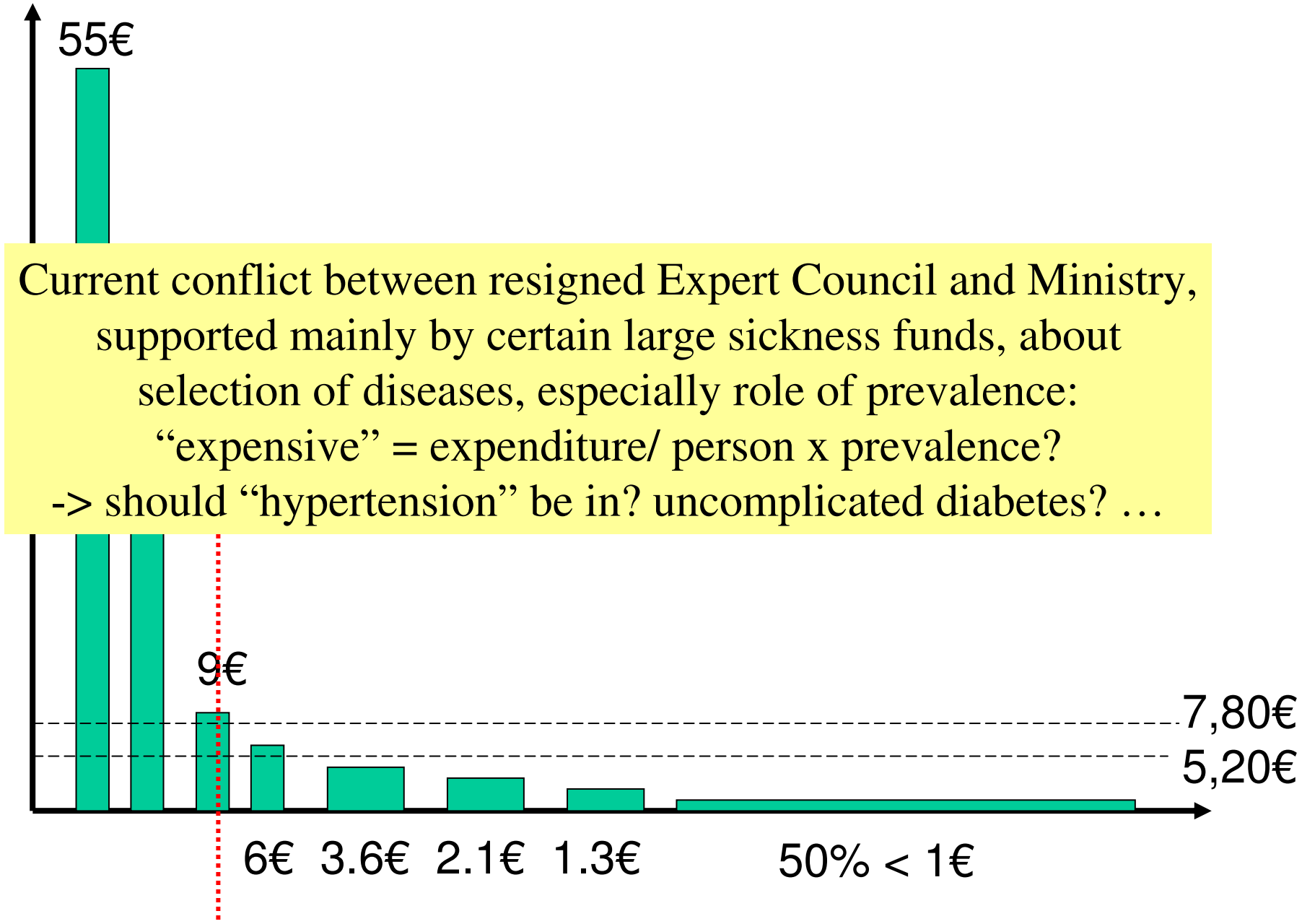
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism for DMP participants and other insured (2006)



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

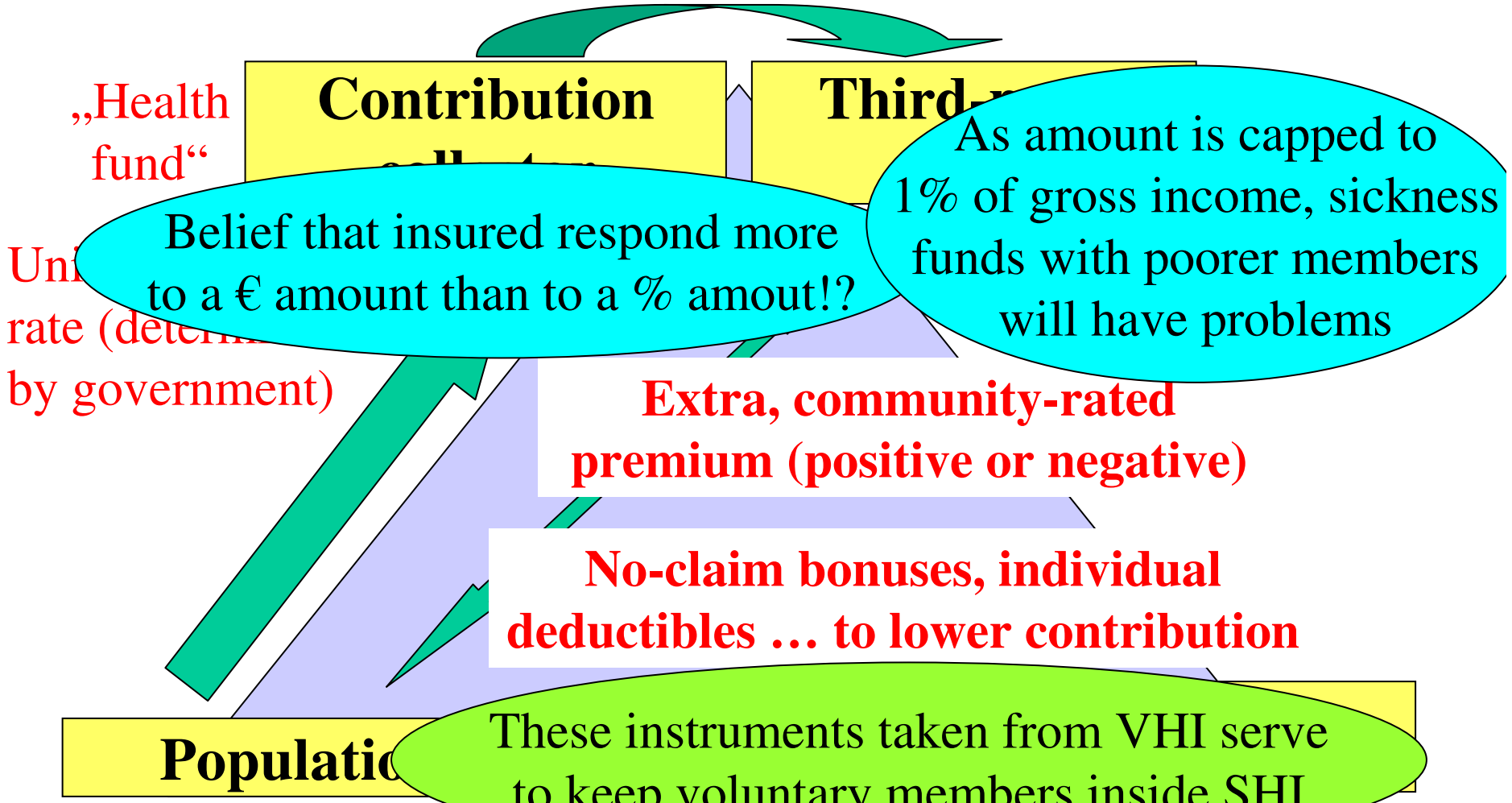



55€
16€
9€
14% of all insured above legal threshold
for selected diseases of 1.5x average
7,80€
5,20€
6€
3.6€
2.1€
1.3€
50% < 1€



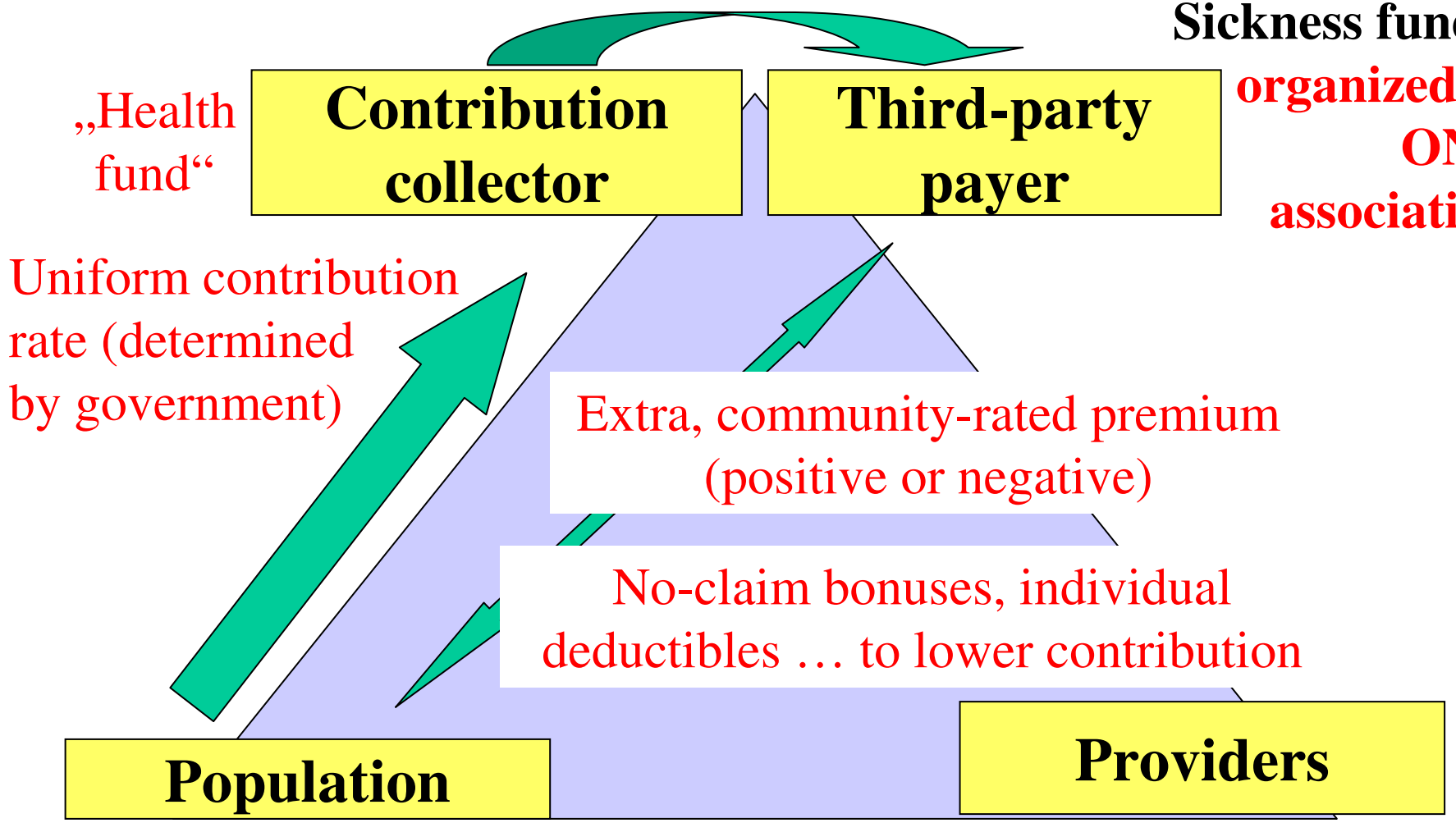
Current conflict between resigned Expert Council and Ministry, supported mainly by certain large sickness funds, about selection of diseases, especially role of prevalence:
"expensive" = expenditure/ person x prevalence?
-> should "hypertension" be in? uncomplicated diabetes? …

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



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

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

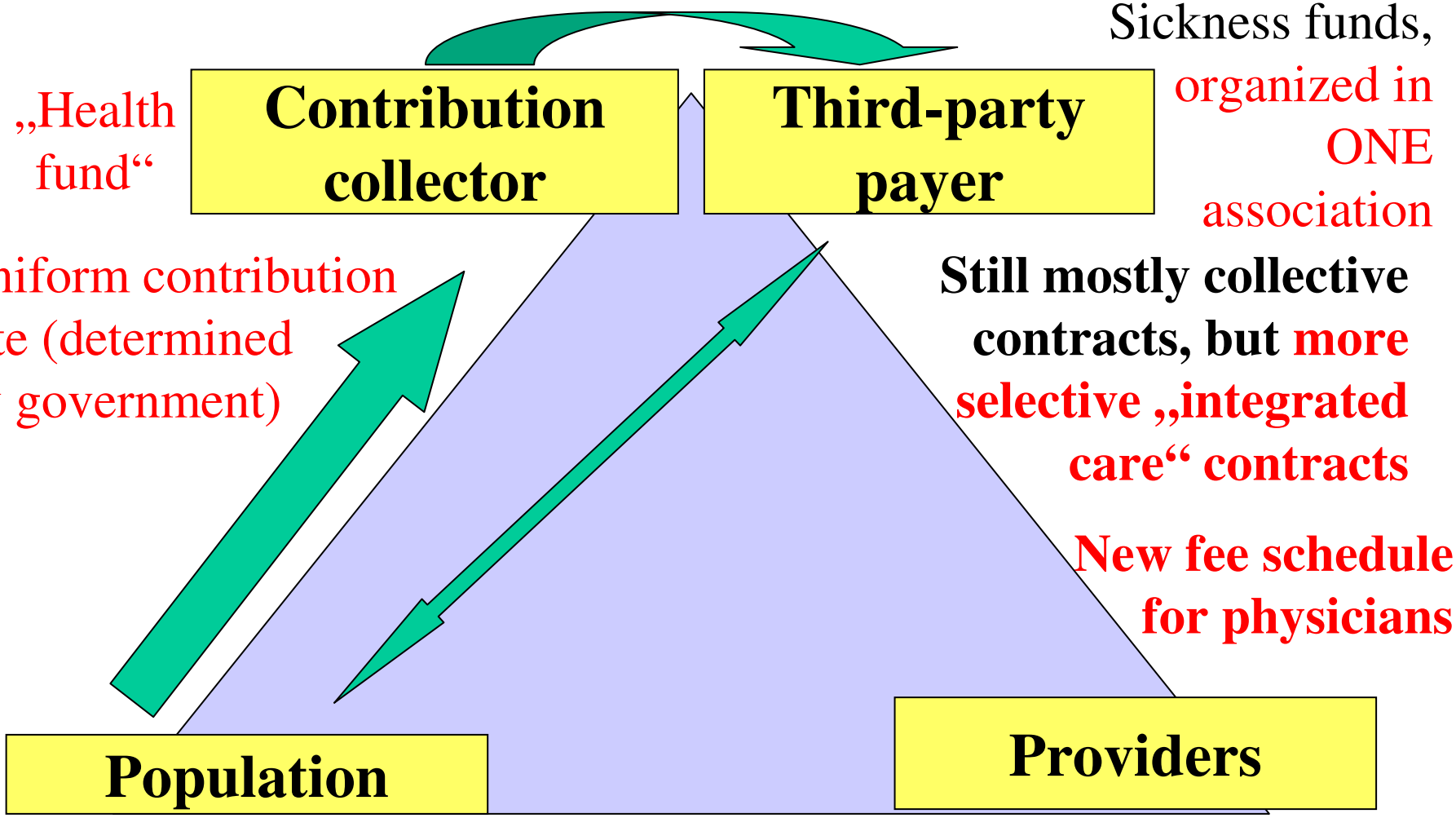


PHI remains but: universal coverage + obligation to contract (for a capped premium)

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

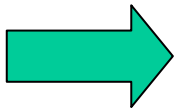


PHI remains but: universal coverage + obligation to contract (for a capped premium)

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% belkow 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% belkow 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

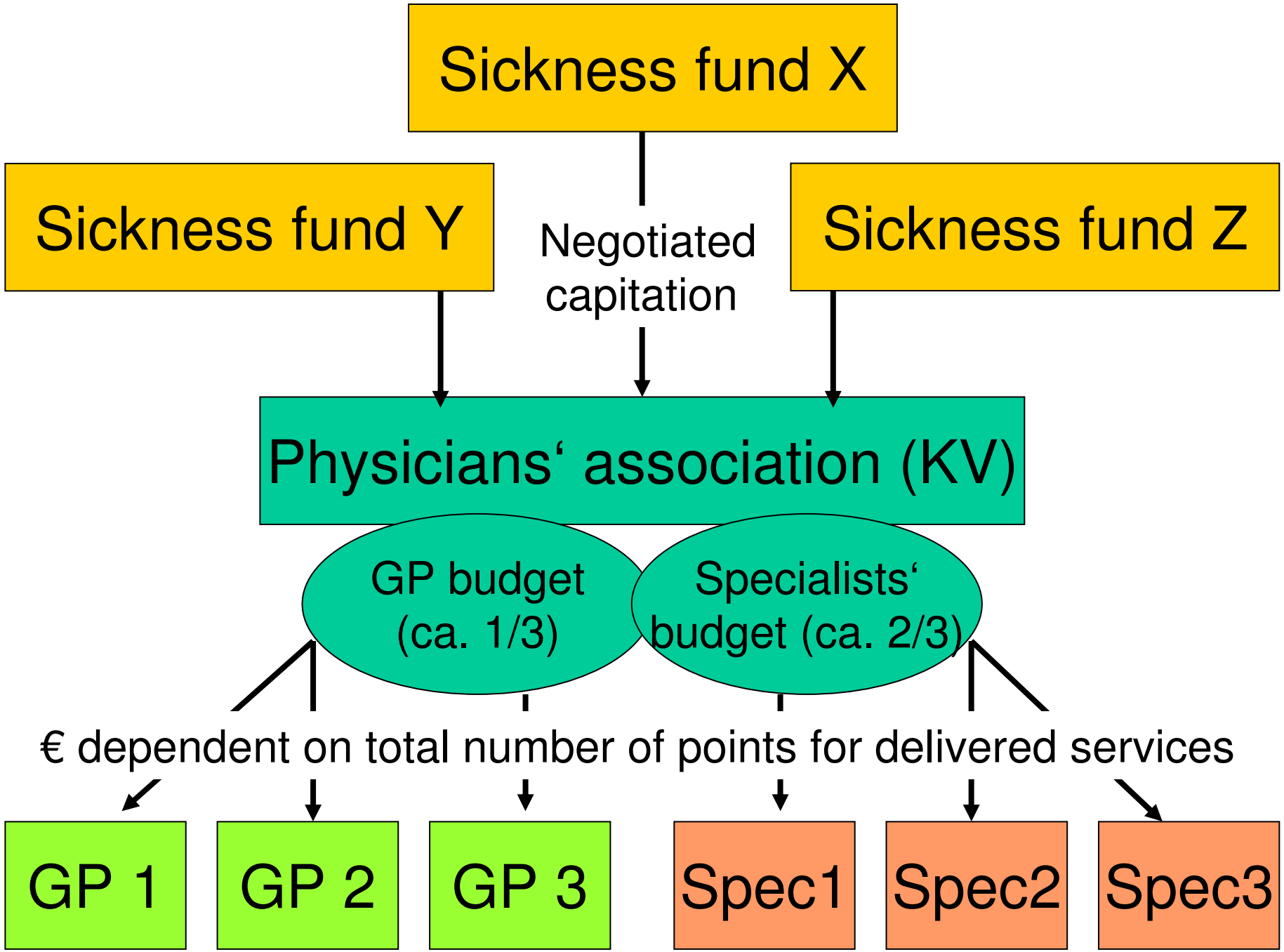
Current regulatory framework inconclusive (e.g. physicians can hardly be held liable for prescription expenditure as prices under procurement are not known or to be influenced)

Medical aids (medical products on prescription)

- Politicians have discovered medical aids as 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*

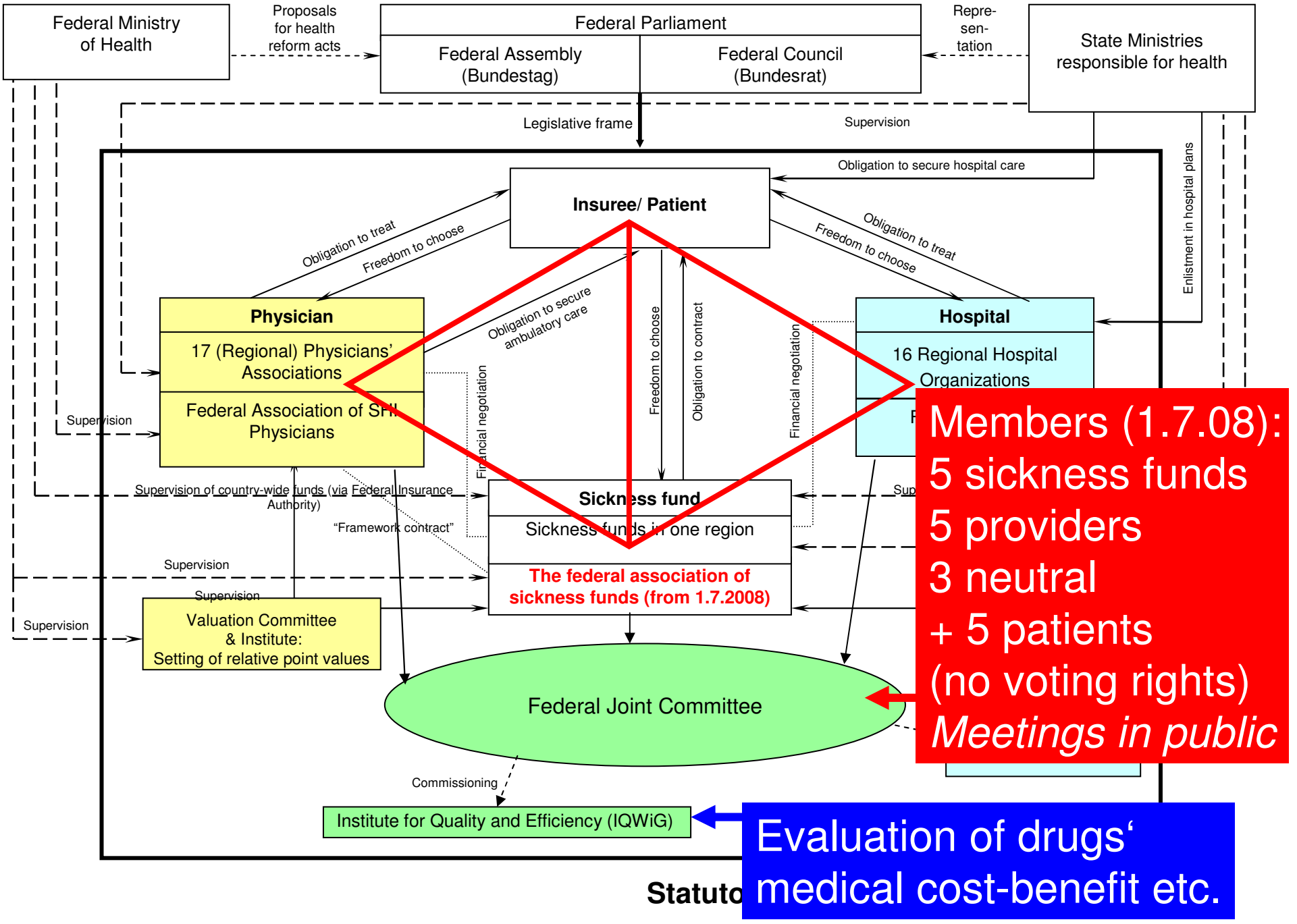
Fee schedule “Uniform value scale” *EBM 2000 plus* (since April 2005)

- 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 €

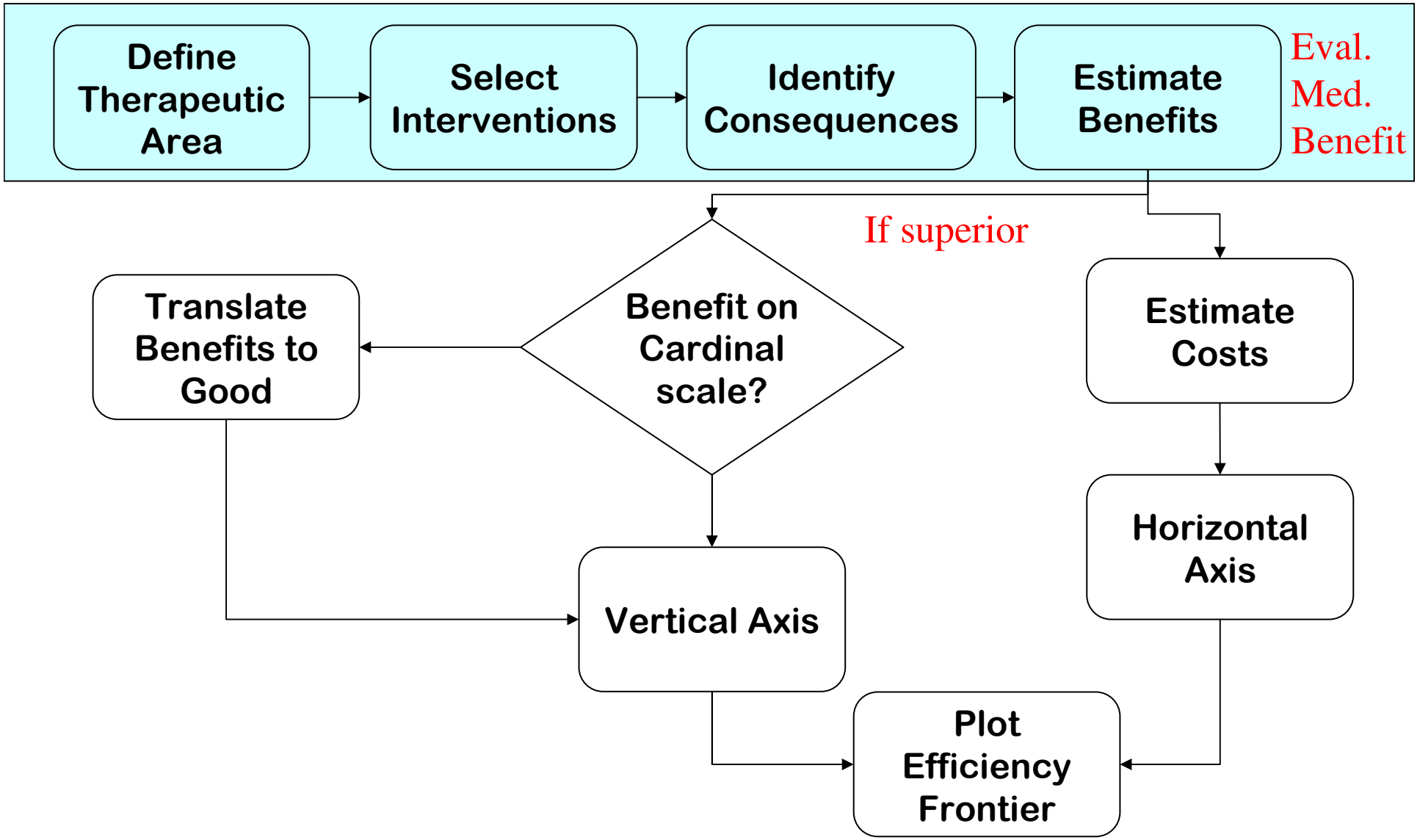

Sickness fund X
Sickness fund Y
Negotiated capitation
Sickness fund Z
Physicians‘ association (KV)
GP budget (ca. 1/3)
Specialists‘ budget (ca. 2/3)
€ dependent on total number of points for delivered services
GP 1
GP 2
GP 3
Spec1
Spec2
Spec3

Ambulatory physicians' fee schedule: changes from 2008/09

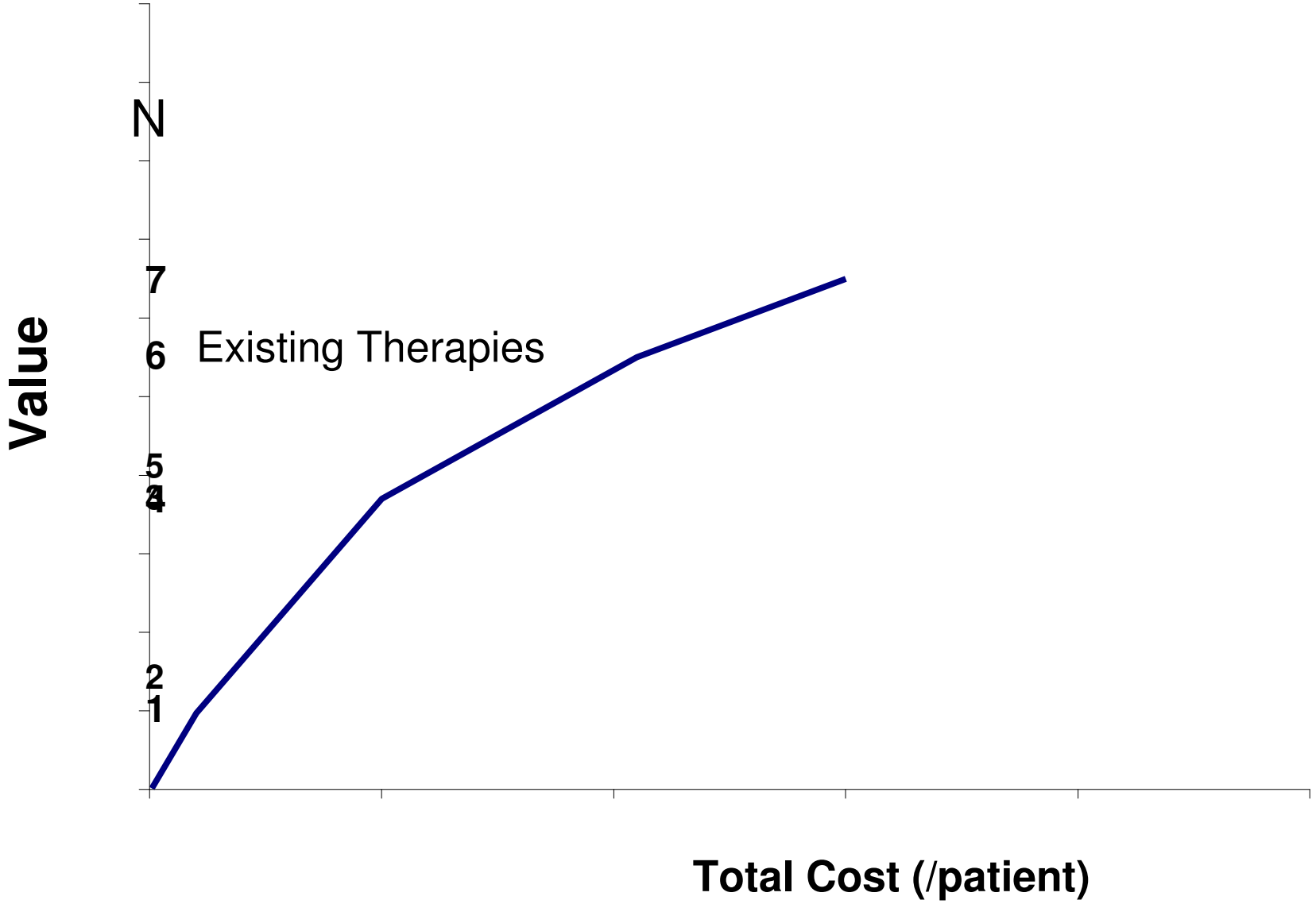
- Calculated income of physicians increased from 95,000 € to 105,000 €
- Number of points to be increased on average by 10% in 2008 (but with great variations among specialties, favouring GPs)
- More services will be included into "quarterly case fees" (especially, but not only for GPs)
- Points will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


Federal Ministry of Health
Proposals for health reform acts
Federal Parliament
Federal Assembly (Bundestag)
Federal Council (Bundesrat)
Repre-sen-tation
State Ministries responsible for health
Legislative frame
Supervision
Obligation to secure hospital care
Insuree/ Patient
Obligation to treat
Freedom to choose
Obligation to treat
Freedom to choose
Enlistment in hospital plans
Physician
17 (Regional) Physicians' Associations
Federal Association of SHI Physicians
Obligation to secure ambulatory care
Freedom to choose
Obligation to contract
Financial negotiation
Hospital
16 Regional Hospital Organizations
Supervision
Supervision of country-wide funds (via Federal Insurance Authority)
"Framework contract"
Financial negotiation
Sickness fund
Sickness funds in one region
The federal association of sickness funds (from 1.7.2008)
Supervision
Supervision
Supervision
Valuation Committee & Institute: Setting of relative point values
Federal Joint Committee
Commissioning
Institute for Quality and Efficiency (IQWiG)
Statuto
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.

Pharmaceuticals may be subject to economic evaluation by IQWiG: proposed method

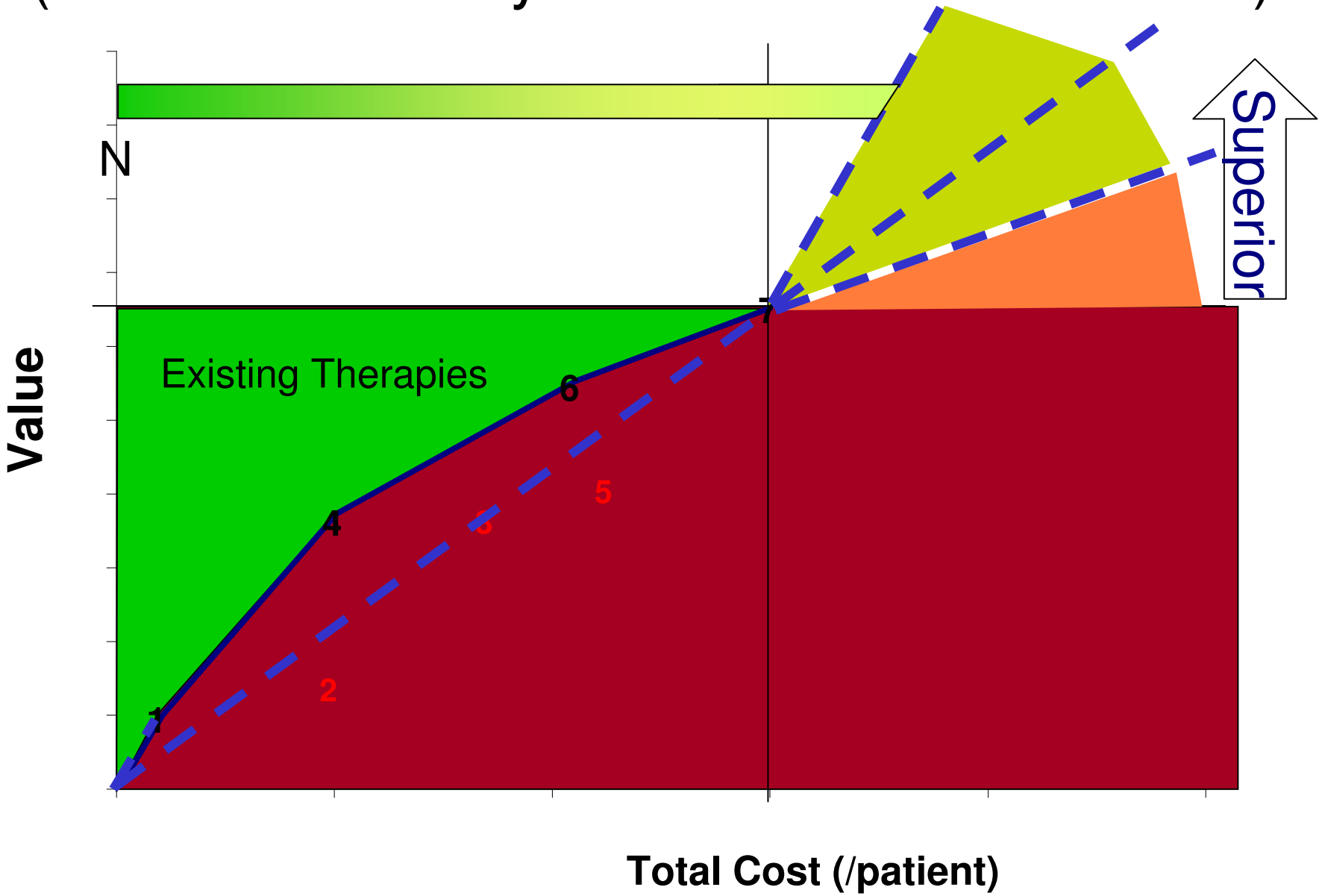


Constructing the frontier (in one therapeutic area)



Decision zones

(decision taken by Federal Joint Committee)



Conclusions

- Competition Strengthening Act has more components than initially relalised
- 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