

The health system in Germany – combining coverage, choice, cost-containment and quality

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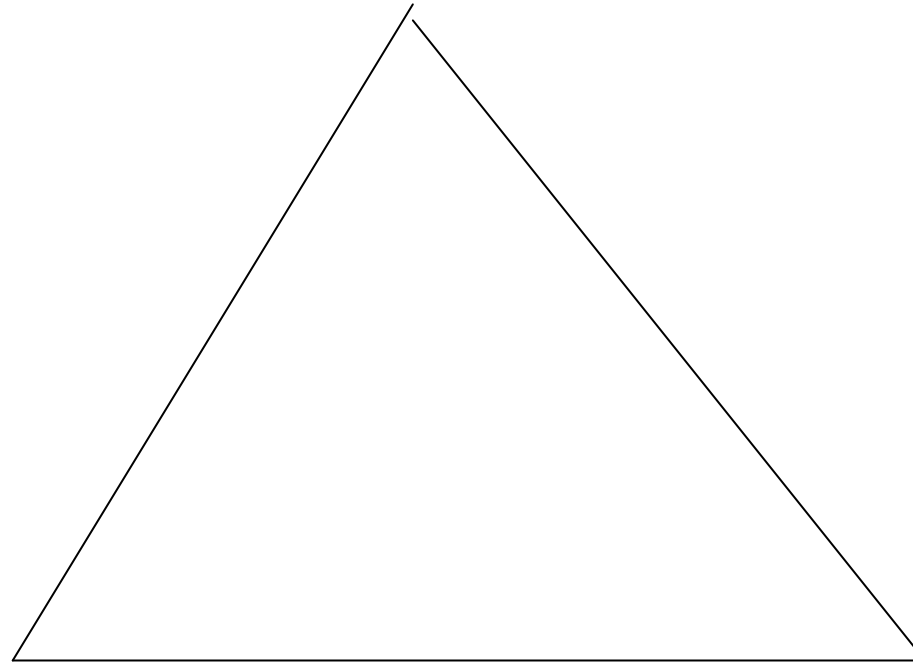
FG Management im Gesundheitswesen, Technische Universität Berlin
(WHO Collaborating Centre for Health Systems Research and Management)

&

European Observatory on Health Systems and Policies

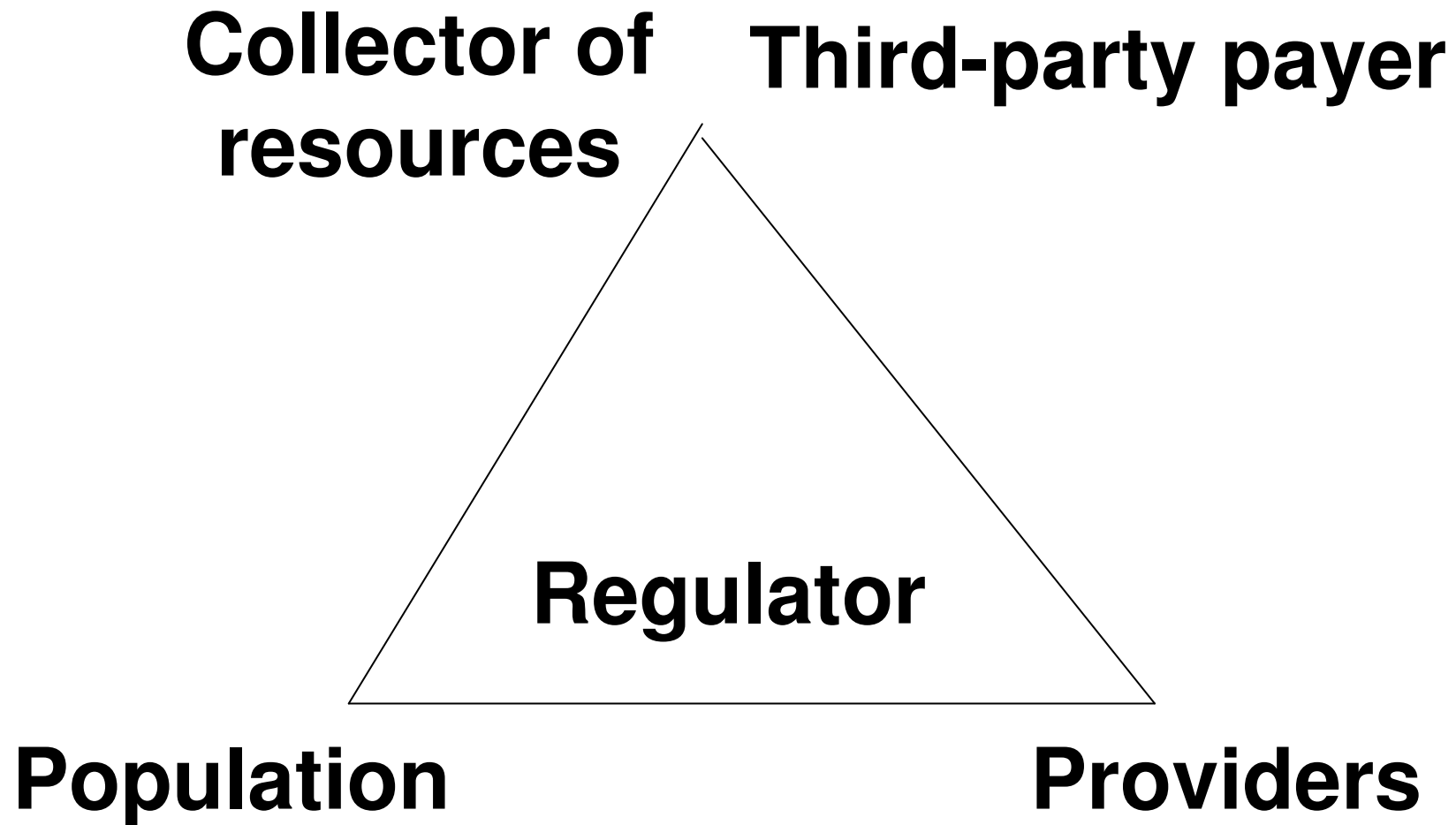


Third-party Payer



Population

Providers



“Risk-structure  compensation” *since 1994/95*

Collector of resources

Third-party payer

Ca. 240 sickness funds

Ca. 50 private insurers

Wage-related contribution

Risk-related premium 

Choice of fund
since 1996

Strong
delegation
& limited
governmental control

Contracts,
mostly collective
No contracts

Population

Social Health
Insurance 87%,
Private HI 10%

Choice 

Providers

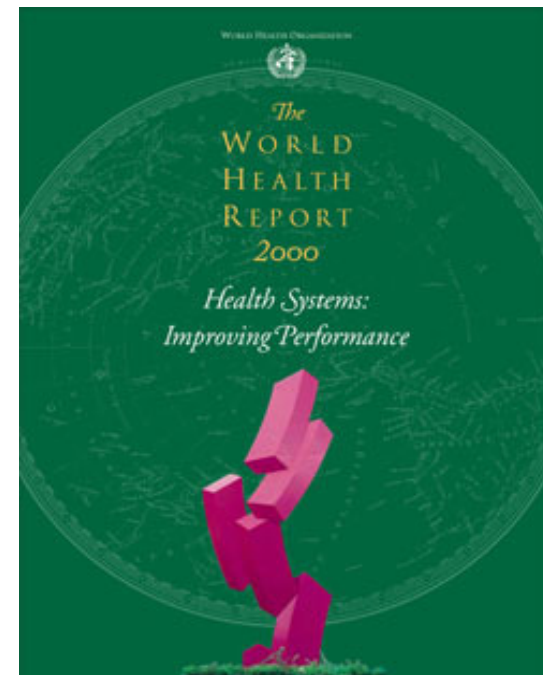
Public-private mix,
organised in associations
ambulatory care/ hospitals

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

	Statutory Health Insurance (SHI)	Private Health Insurance (PHI)
Population covered	87%: <u>75% mandatorily</u> (employed up to income ceiling, unemployed, retired ...) + <u>12% voluntarily</u>	10%, <u>mainly excluded from SHI</u> (self-employed, civil servants)
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 (<i>better for high income</i>)
Insurers	Ca. 240 sickness funds (self-governing not-for profit entities under public law)	Ca. 50 insurers under private 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

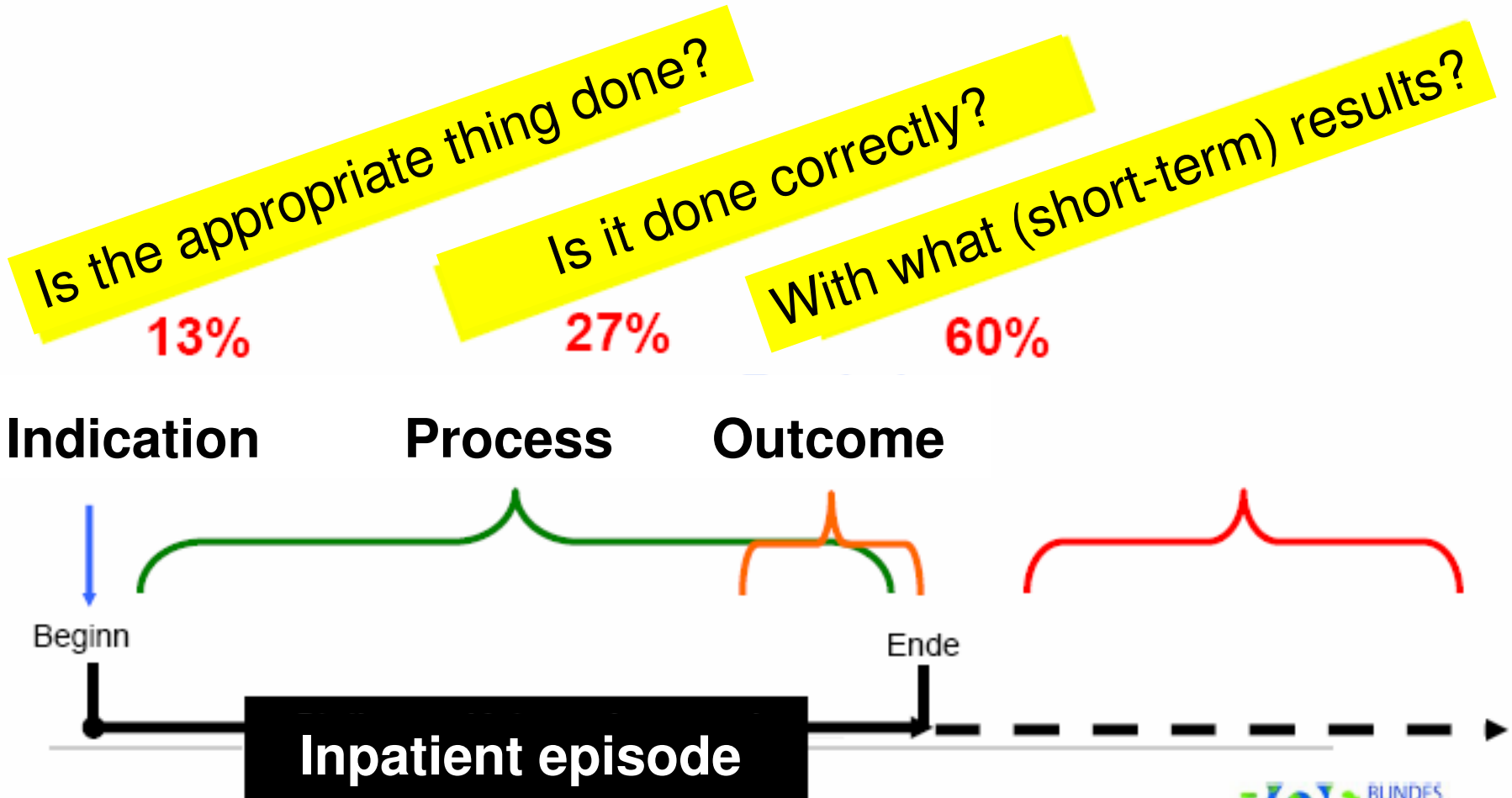
... care coordination, quality and cost-effectiveness are problematic

- 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)



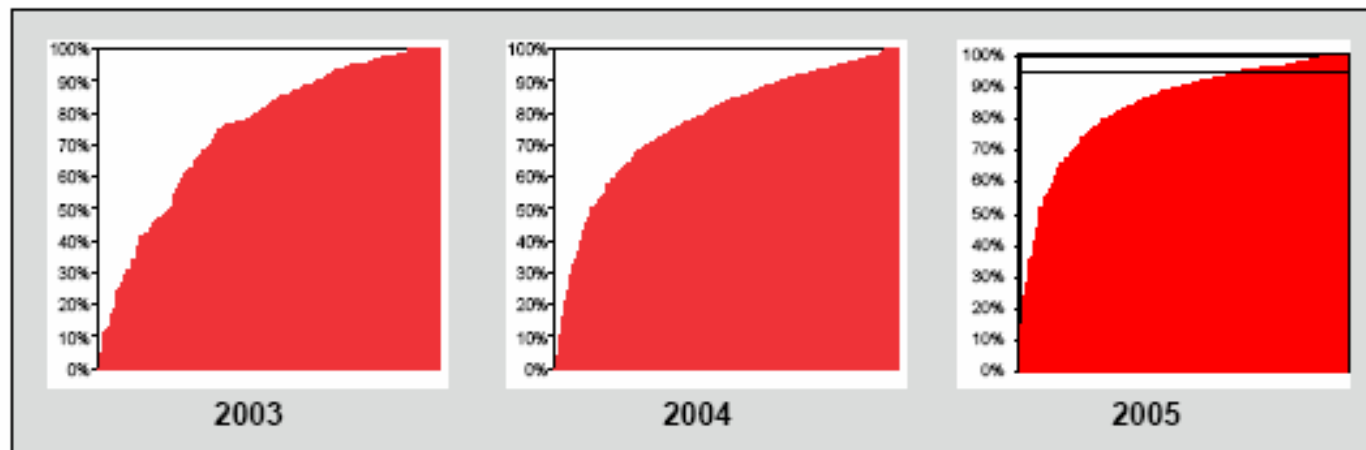
Federal Office for Quality Assurance (BQS)

since 2001 mandatory for all 1800 hospitals,
170 indicators, with feedback and “structured dialogue“



An example (with slow progress):

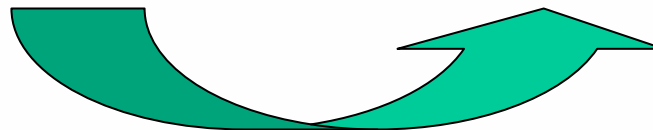
Documentation of operation distance to (breast) cancer



72,52%

75,67%

83,19%

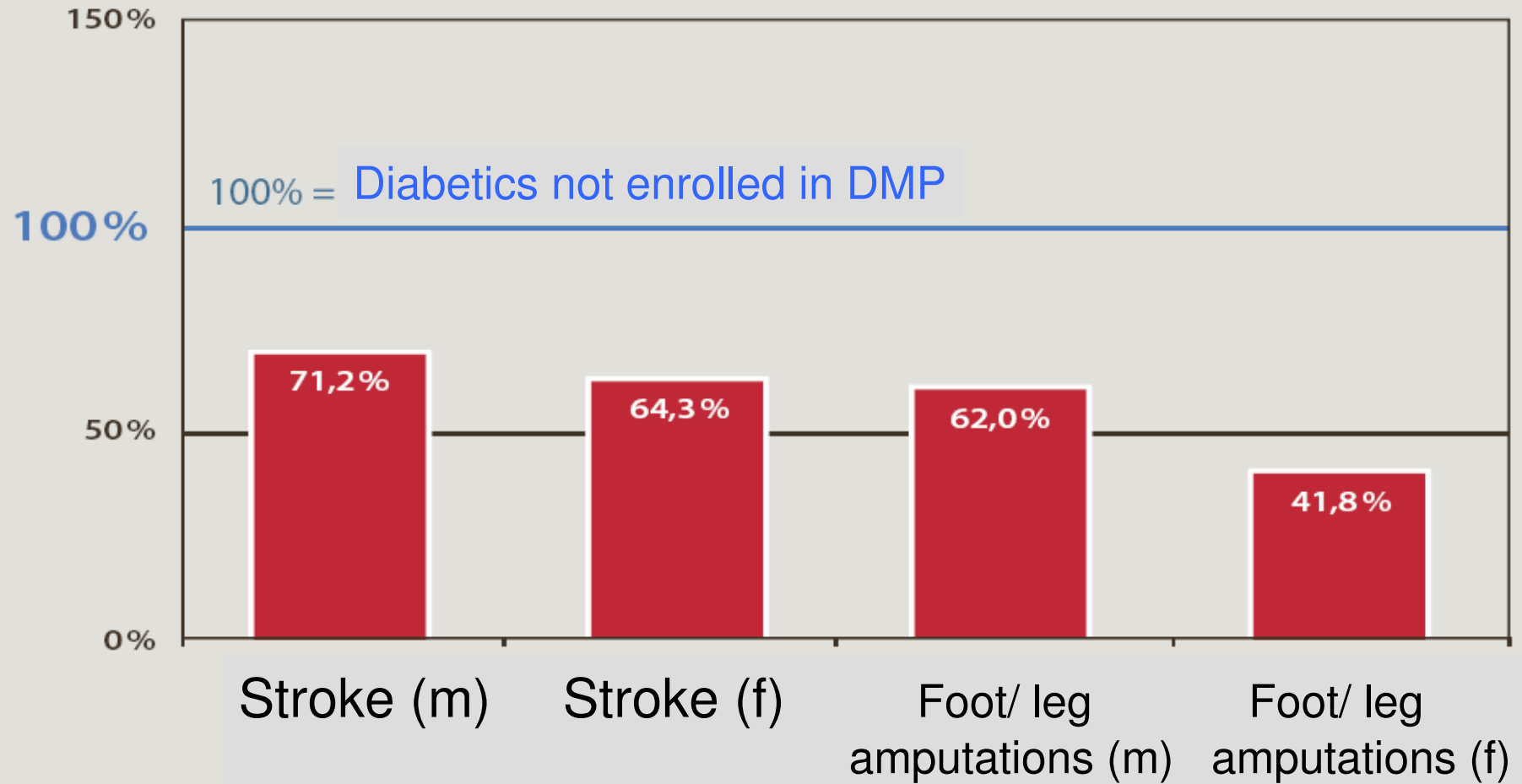


Disease Management Programs

(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)

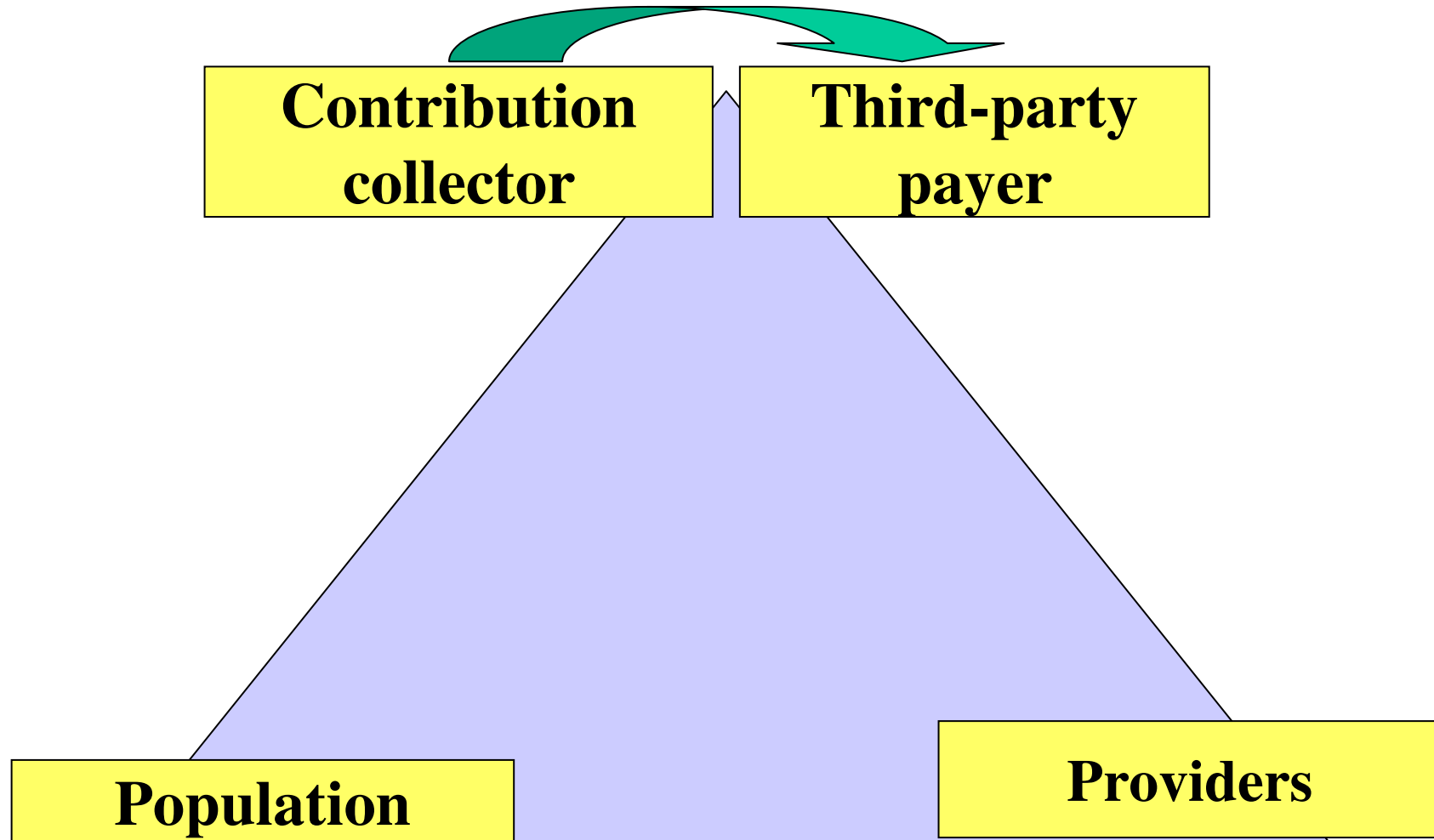
DMP diabetes - results



Decision-making on (new) benefits/ technologies

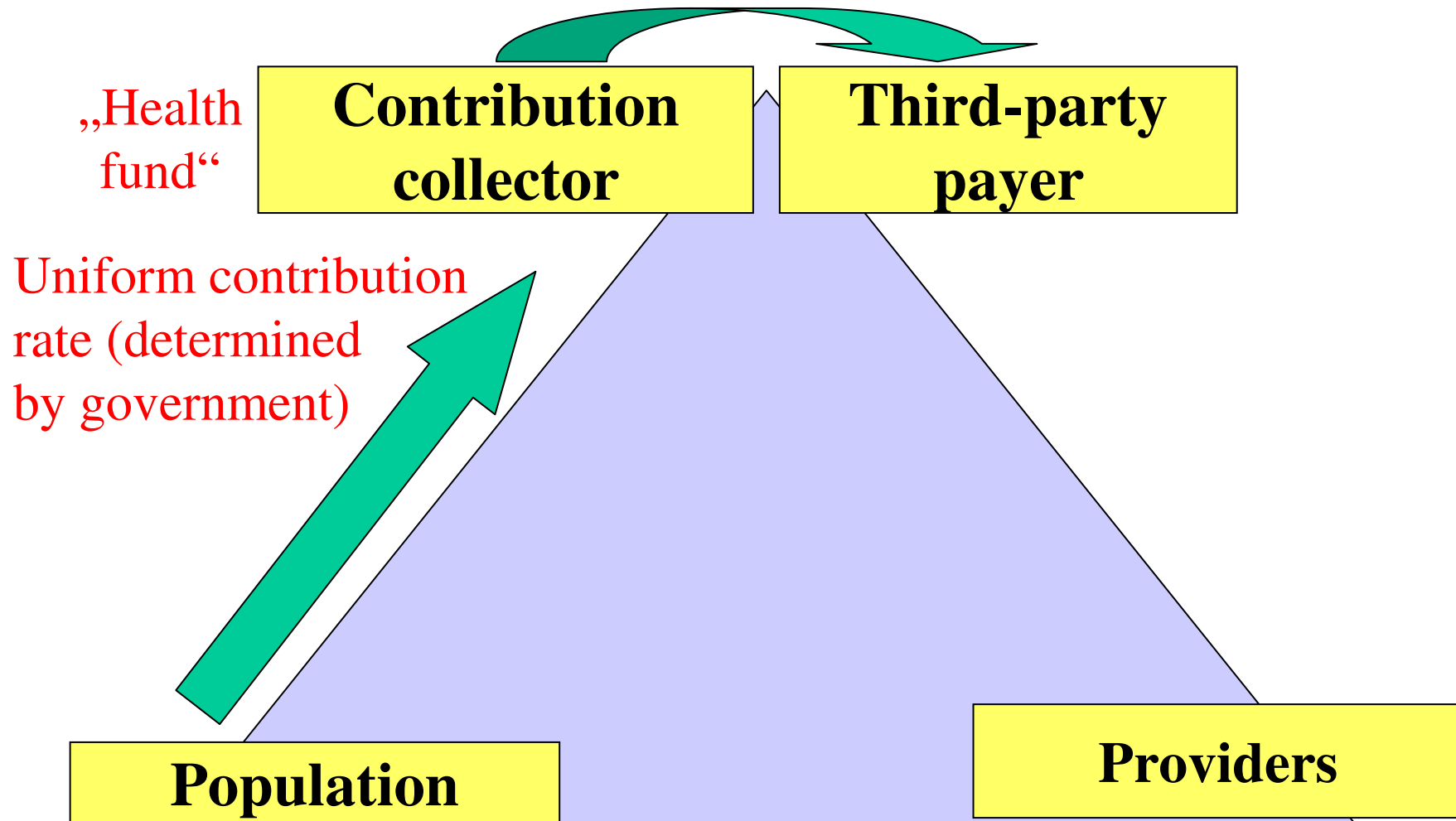
- Decided by Federal Joint Committee (FJC):
9 provider, 9 sickness fund representatives,
3 neutral members, 9 non-voting patient reps
- FJC may commission IQWiG (Institute for Quality and Efficiency, since 2004) with assessment of comparative effectiveness, from 2008 also of cost-effectiveness

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



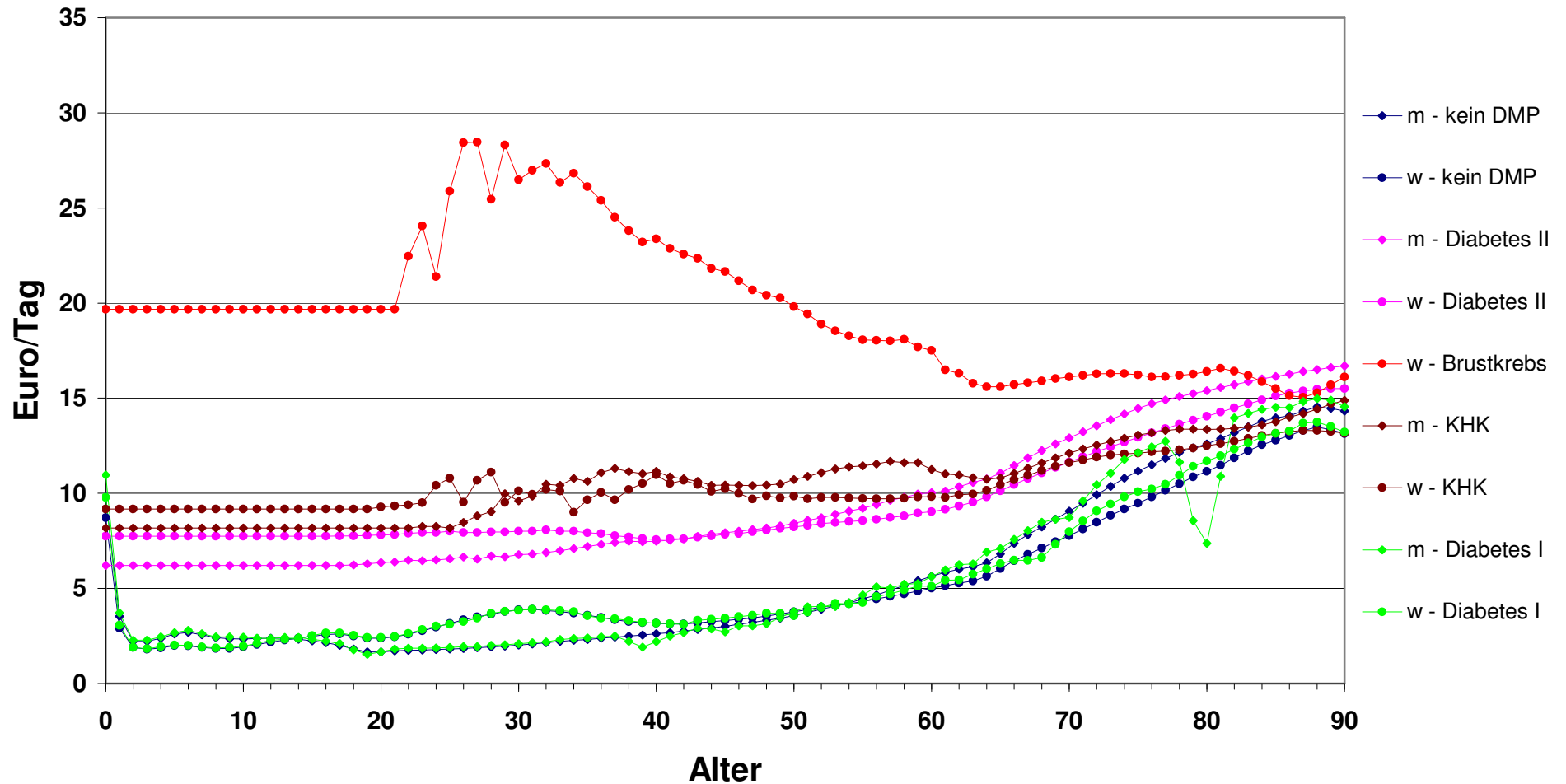
PHI remains but: universal coverage +
obligation to contract (for a capped premium)

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

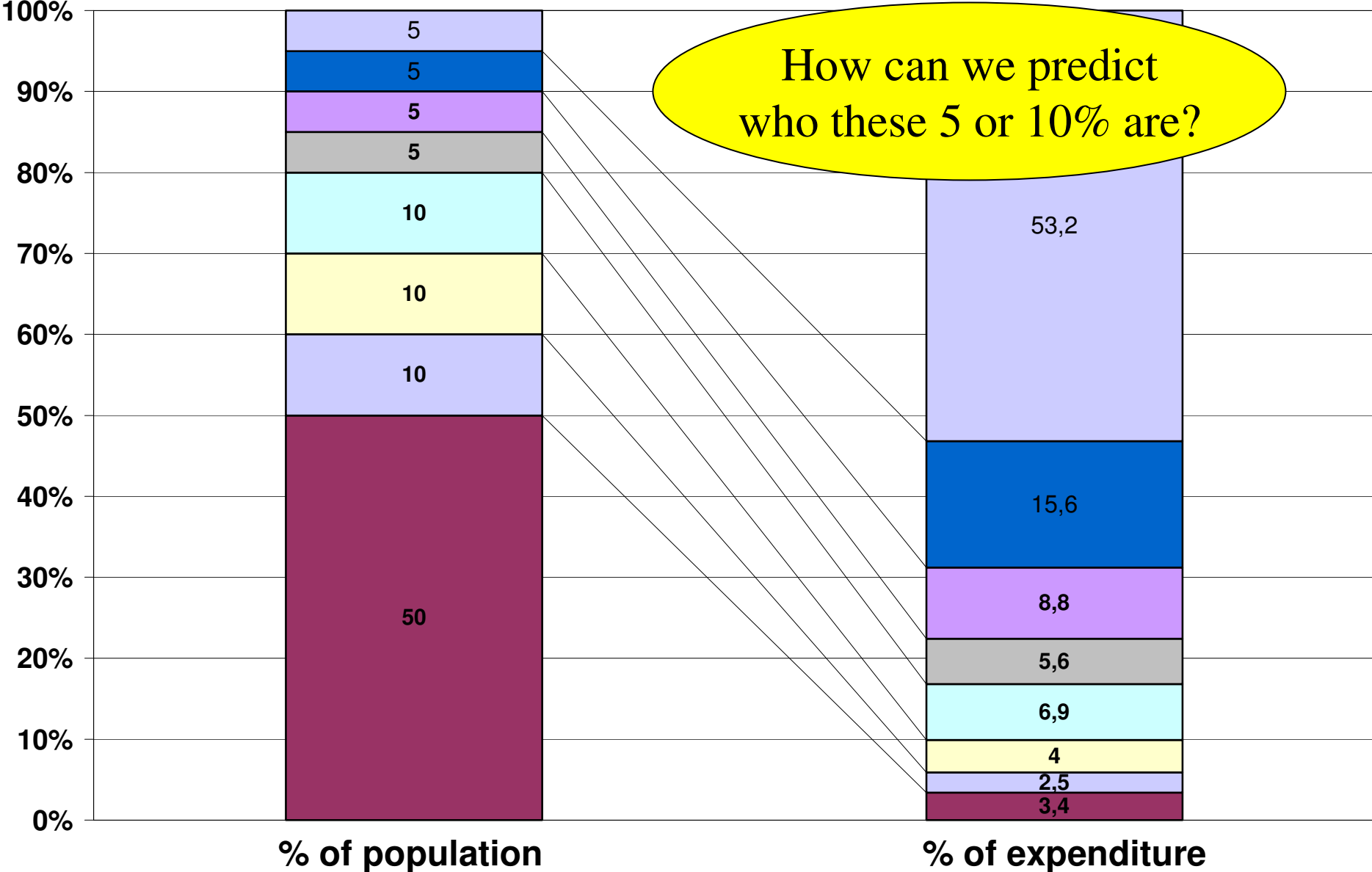


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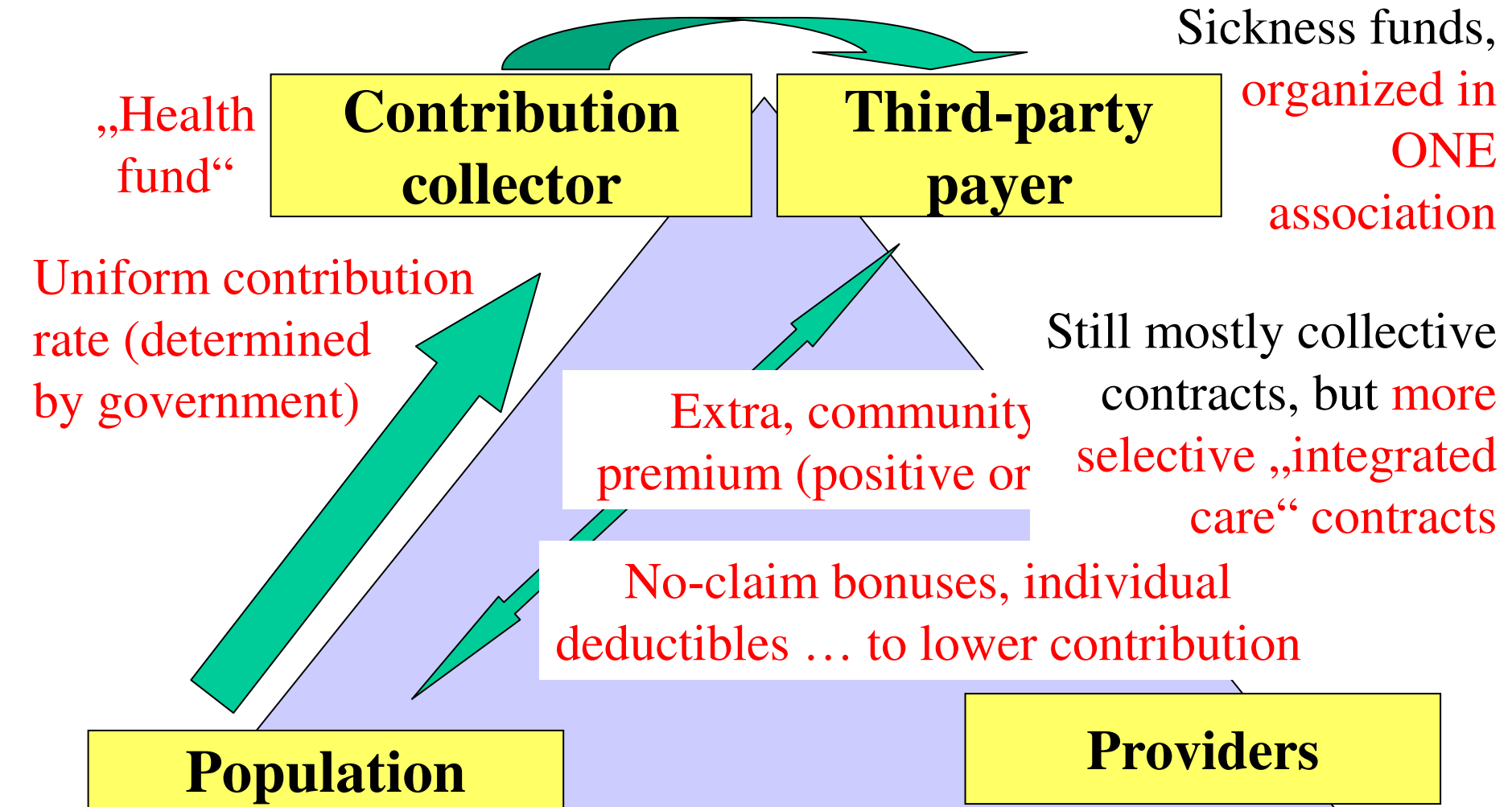
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism for DMP participants and other insured (2006)



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



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



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