Building Governance Infrastructure for a High Performing Health Care System

Can the US (and others) learn anything from the delegated self-regulatory system in Germany?

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"Risk-structure compensation"

Collector of resources

Health fund

Uniform wage-related contribution
+ possibly additional premium
(set by sickness fund),
Risk-related premium

Choice of fund/ insurer

Third-party payers

Ca. 160 sickness funds

Ca. 50 private insurers

Contracts, mostly collective

No contracts

Strong delegation
(Federal Joint Committee)
& limited governmental control

Population

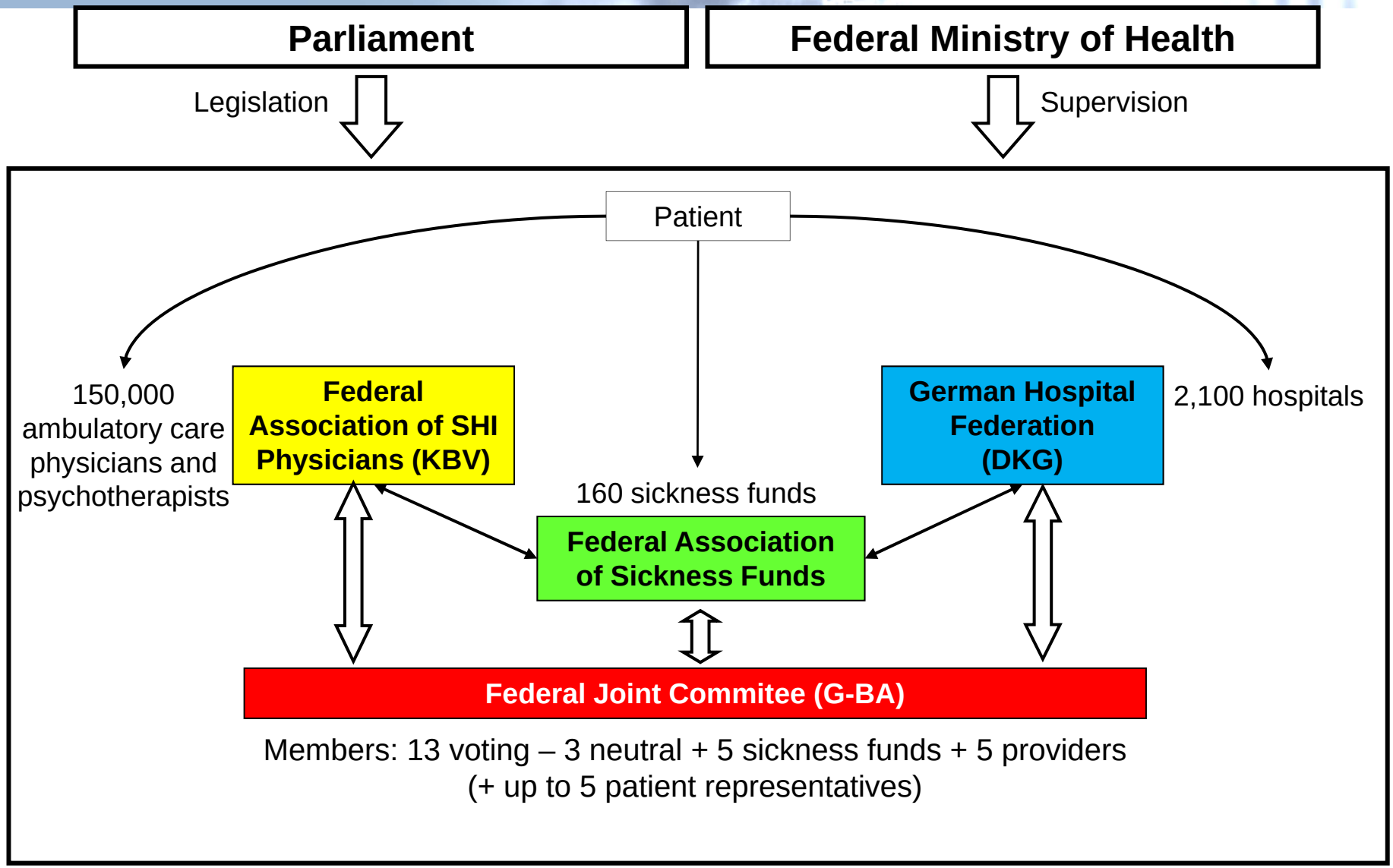
Universal coverage:
Statutory Health Insurance 86%,
Private HI 10%

Choice →

Providers

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

Decision-making in German SHI



Statutory Health Insurance

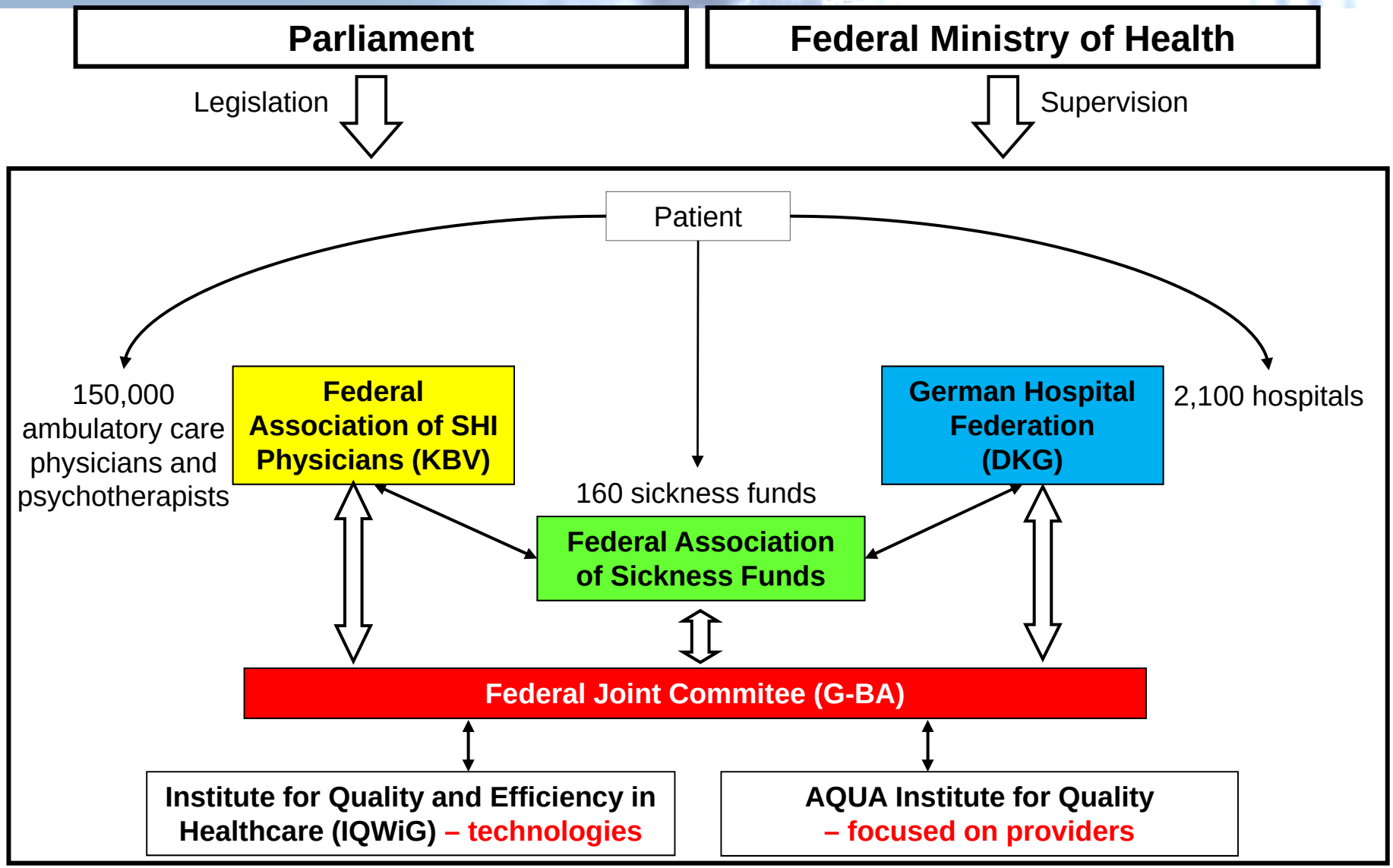
Objectives of Federal Joint Committee

- **Main functions: to regulate SHI-wide issues of access, benefits and quality (and not primarily of costs or expenditure).**
- ***Normative function of the G-BA by legally binding directives ("sub-law") to guarantee equal excess to necessary and appropriate services for all SHI insured.***
- **Benefit-package decisions must be justified by an evidence-based process to determine whether services, pharmaceuticals or technologies are medically effective in terms of morbidity, mortality and quality of life.**
- **By law, evidence based assessments can only be used to select the most appropriate (efficient) service etc. from others – not to prioritize among service areas: if a costly innovation has a significant additional benefit, the sickness funds must pay for it.**

Decisions are prepared by 8 sub-committees:

- Pharmaceuticals
- Quality Assurance
- Cross-sector Care (especially disease management programs)
- Methodological Evaluation (inclusion of new ambulatory care services in benefit basket; NB: in hospitals, services can only be excluded)
- Referred Services (rehabilitation, care provided by non-physicians, ambulance transportation etc.)
- Needs-based Planning (ambulatory care; NB: hospital capacities are planned by state governments)
- Psychotherapy
- Dental Services

Federal Joint Committee: support through institutes



Decisions regarding performance monitoring

Technische Universität Berlin

		Structure	Processes		Outcomes	
			Types/ numbers	Appropi-ateness	Intra-hospital	Long-term
Federal Joint Committee 2004	→	Internal quality management system 2000				
	→		Nationwide external quality ass system based on special docume			
	→		Disease Management Programs 2002			
	directives →	Concentration of services (minimum volume numbers) 2004				
	→	Assessments through Institute for Quality and Efficiency 2004				
	→	Public hospital quality reports 2005				
	→	Public hospital quality reports (revised requirements) 2007				

Will be cross-sectoral for certain indications (e.g. colon cancer)

- **No overall expenditure limit or cap – but since 1970s legal requirement for "income-oriented" expenditure growth.**
- **In 1990s main – legally required – instruments: sectoral budgets (ambulatory, dental, hospitals) and caps (pharmaceuticals), growing in line with contributory income of insured.**
- **Since 2001 (pharmaceuticals), 2005 (hospitals) and 2009 (ambulatory care) more flexible arrangements trying to balance need and expenditure control**
  → greater role for contract partners to negotiate volumes;

but legislator is intervening time after time, especially in times of financial deficit.