Technische Universität Berlin

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

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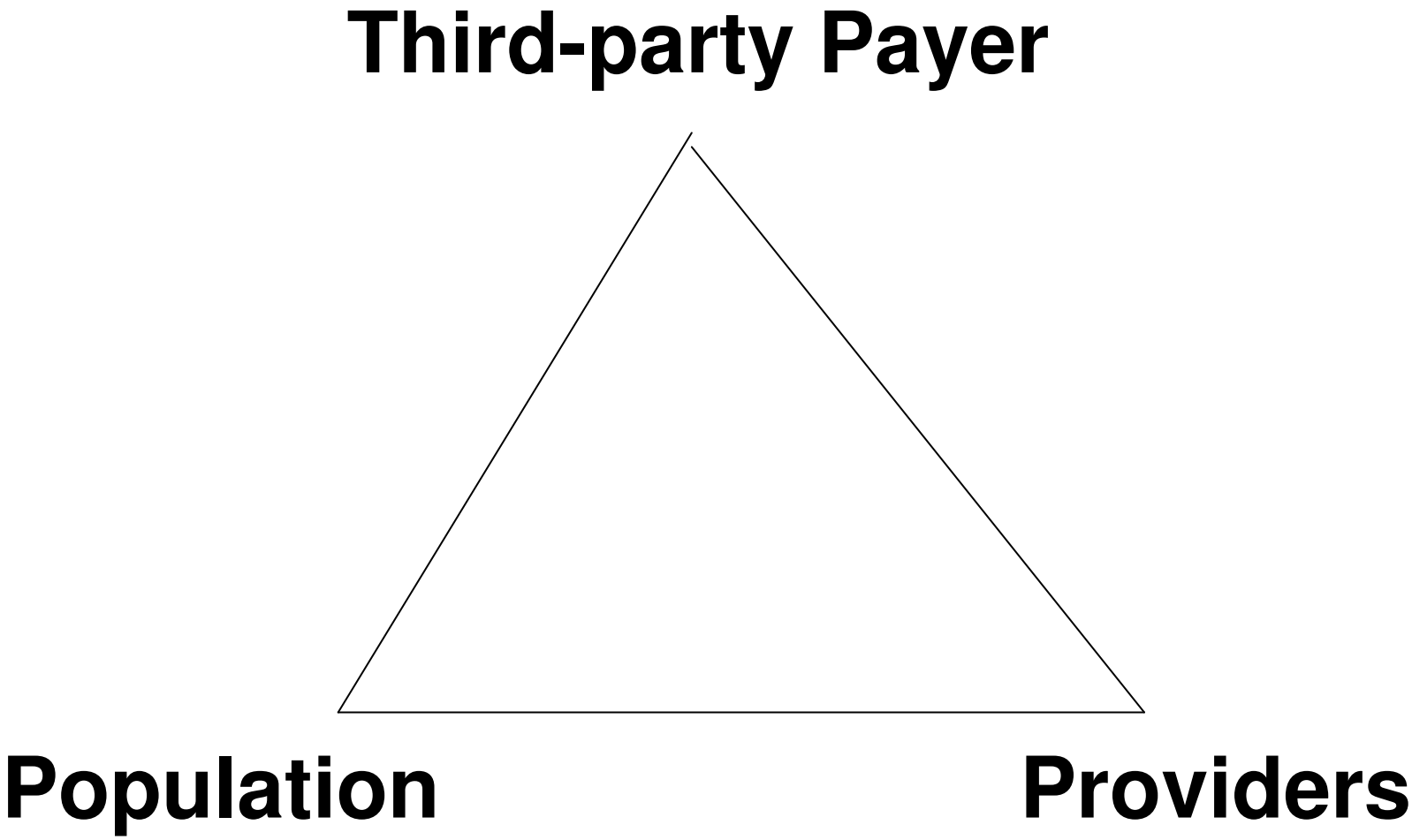
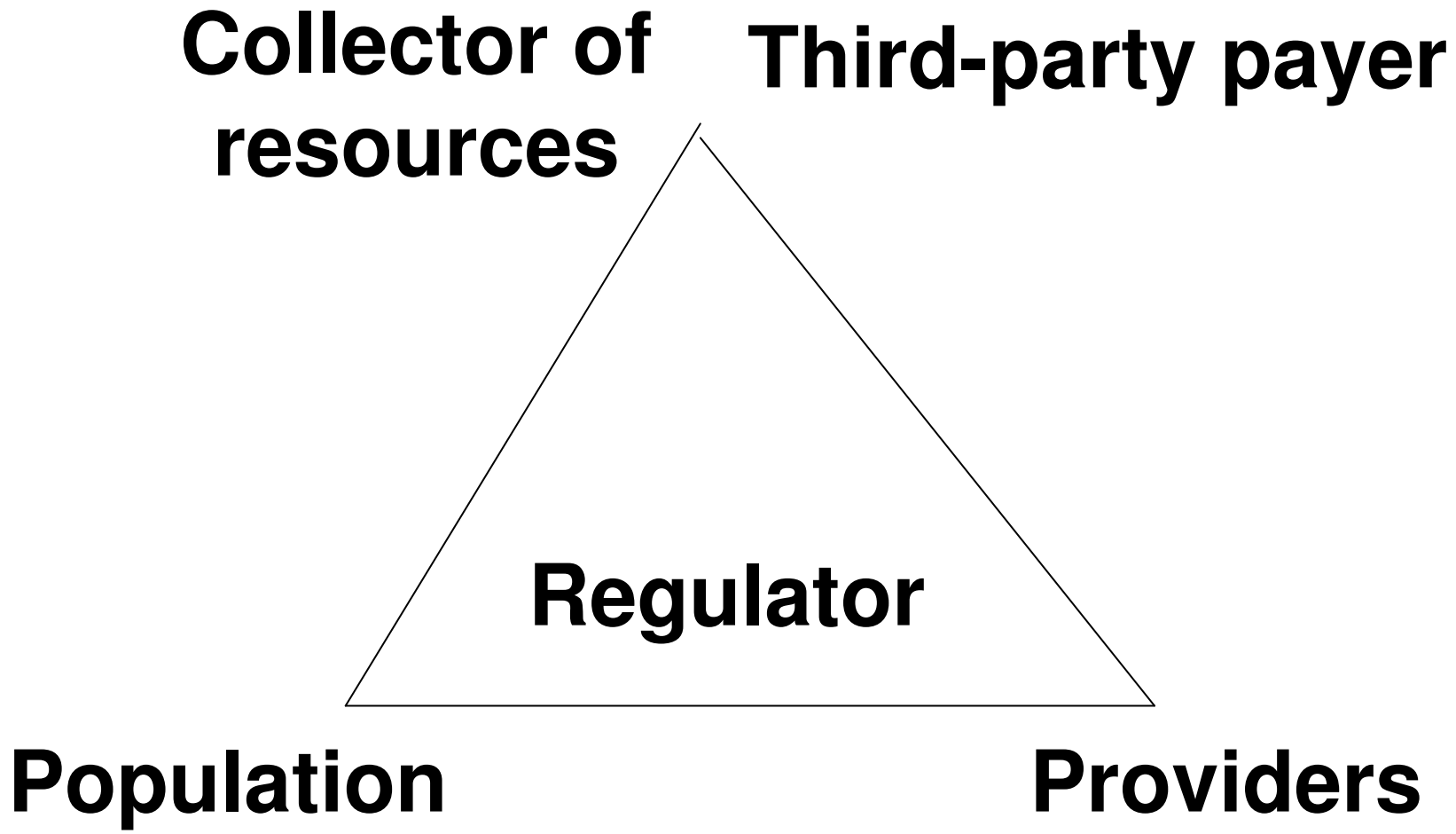
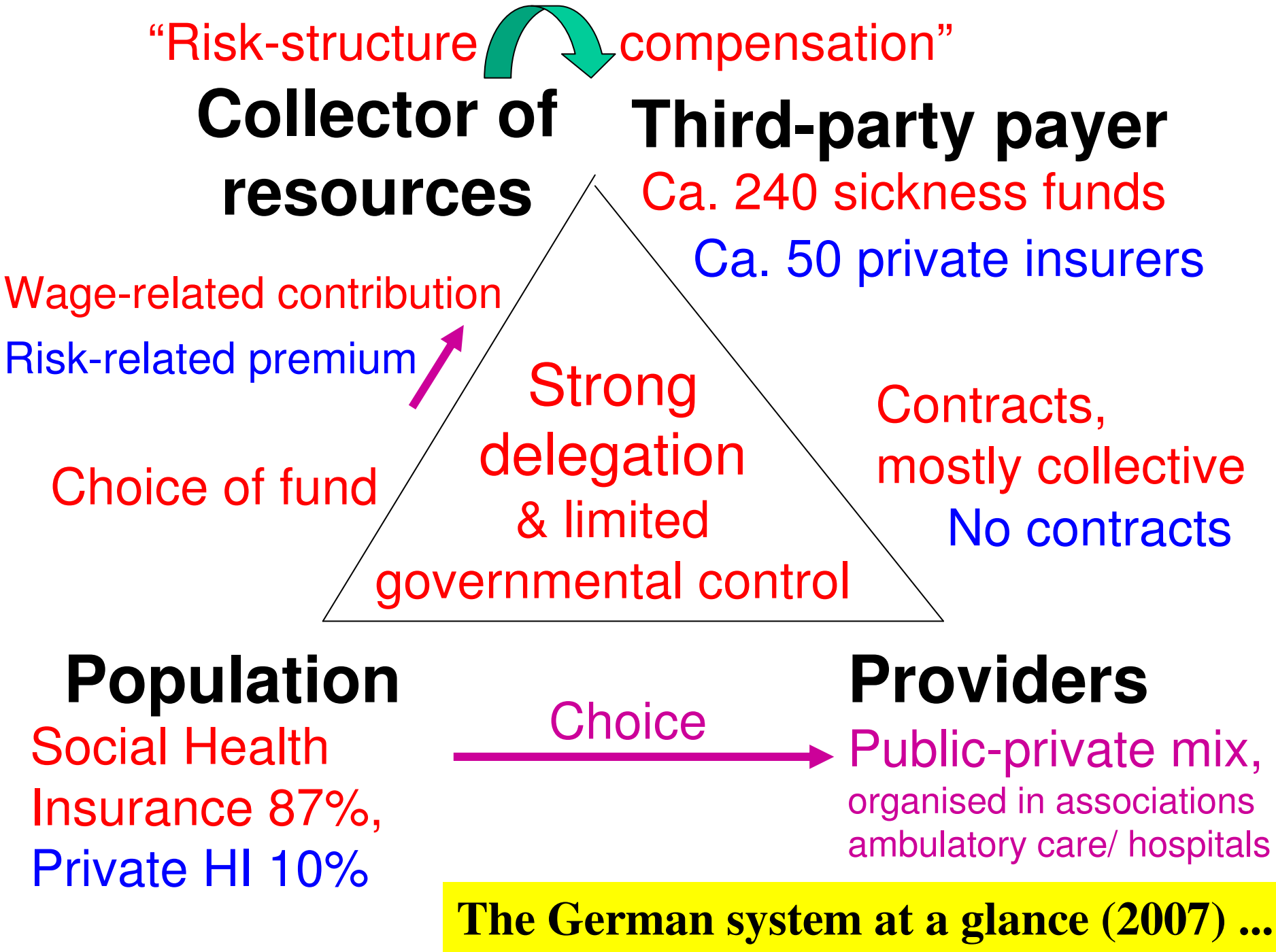
CHARITÉ

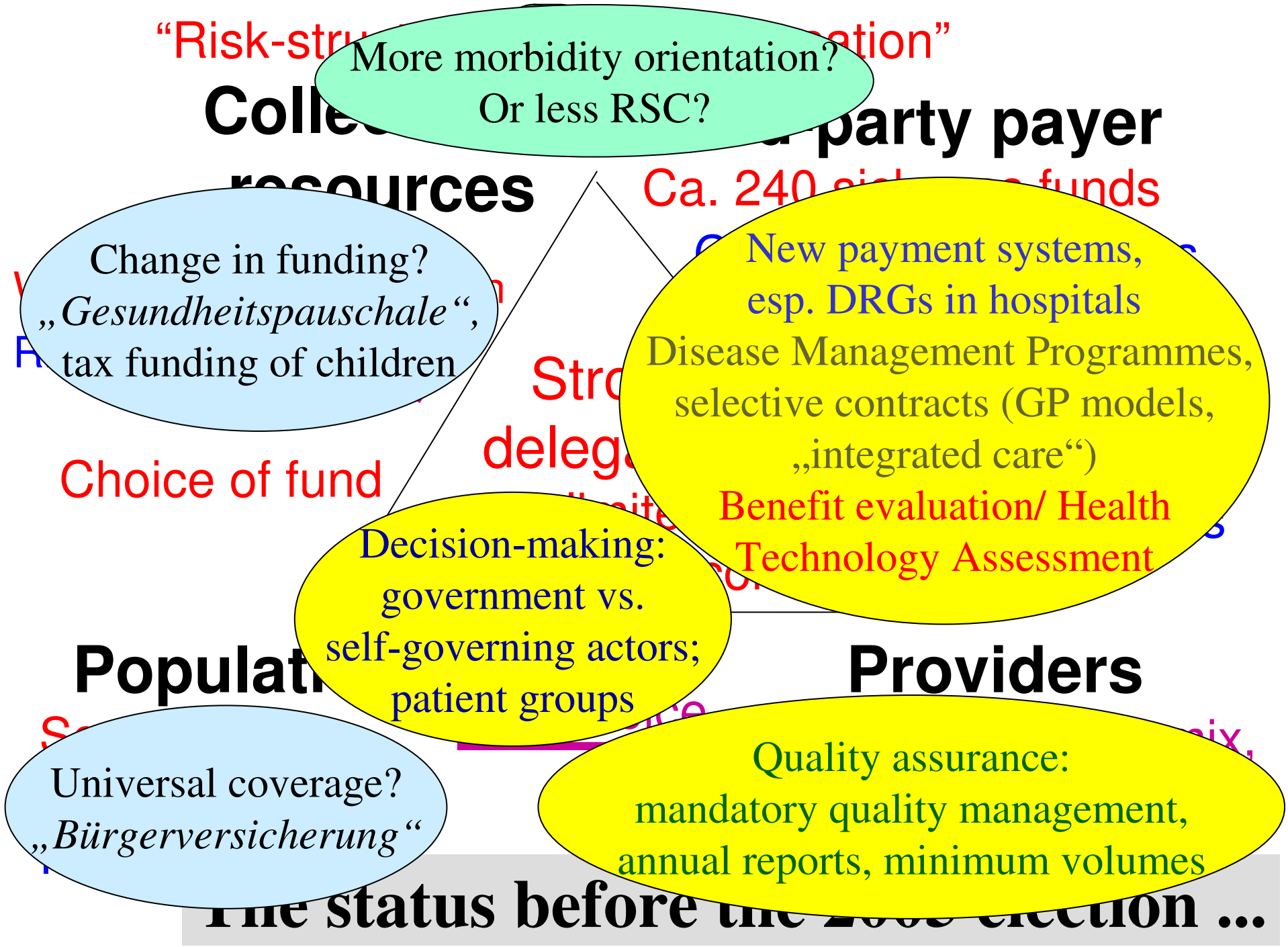
European Observatory on Health Systems and Policies



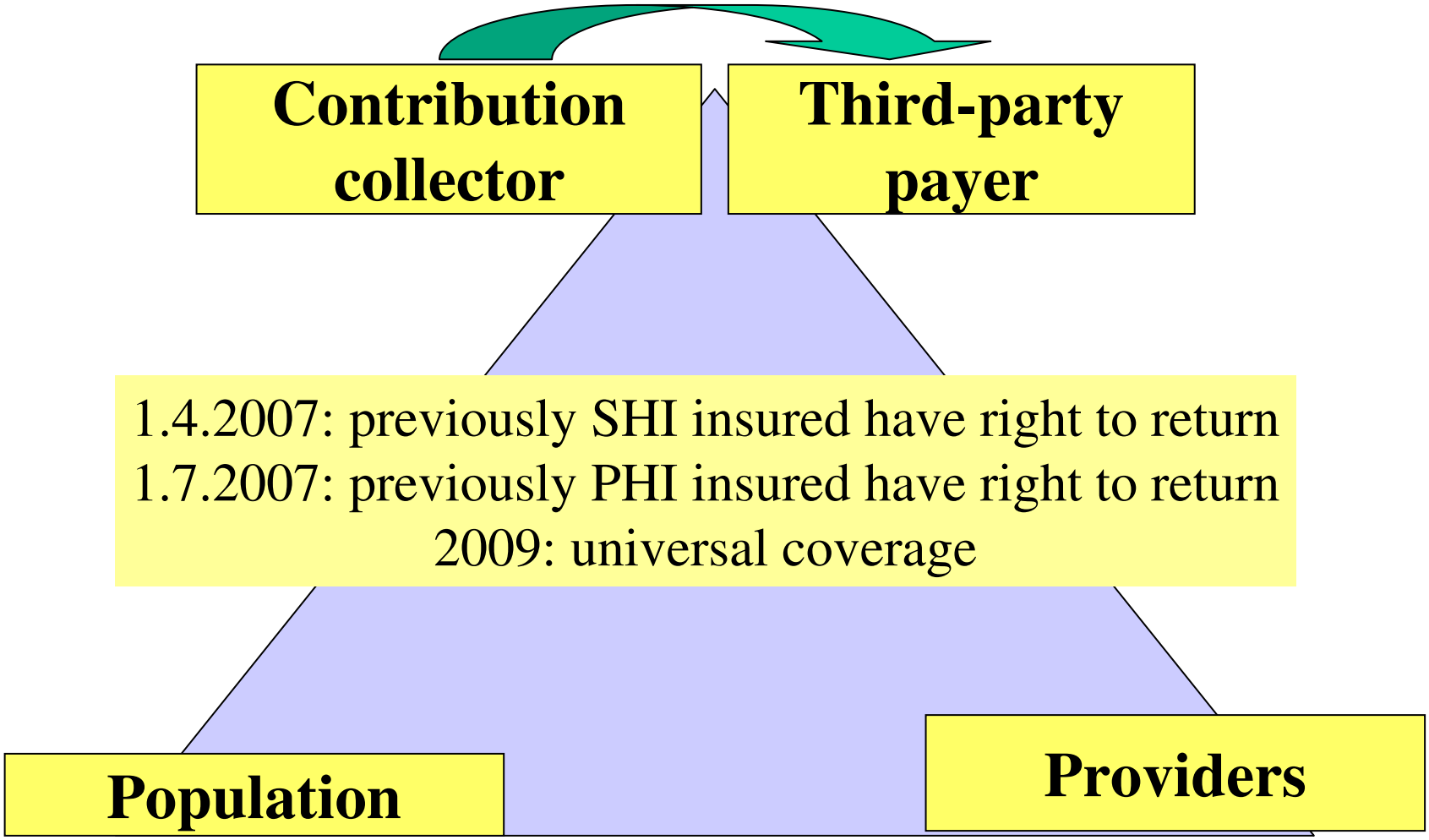





**The German system at a glance (2007) ...**

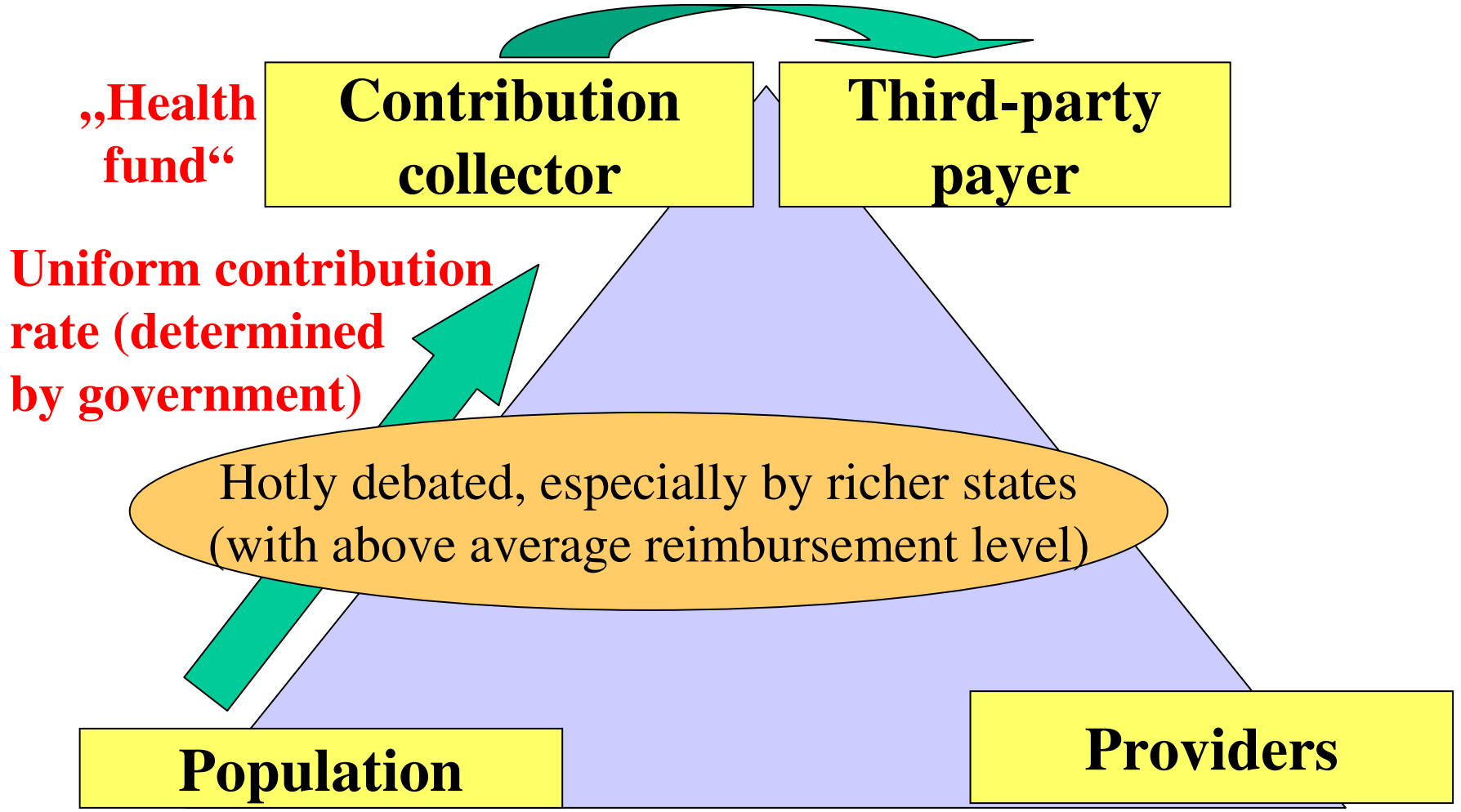

More morbidity orientation?
Or less RSC?
party payer
resources
Change in funding?
„Gesundheitspauschale“,
tax funding of children
New payment systems,
esp. DRGs in hospitals
Disease Management Programmes,
selective contracts (GP models,
„integrated care“)
Benefit evaluation/ Health
Technology Assessment
Choice of fund
Decision-making:
government vs.
self-governing actors;
patient groups
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)?



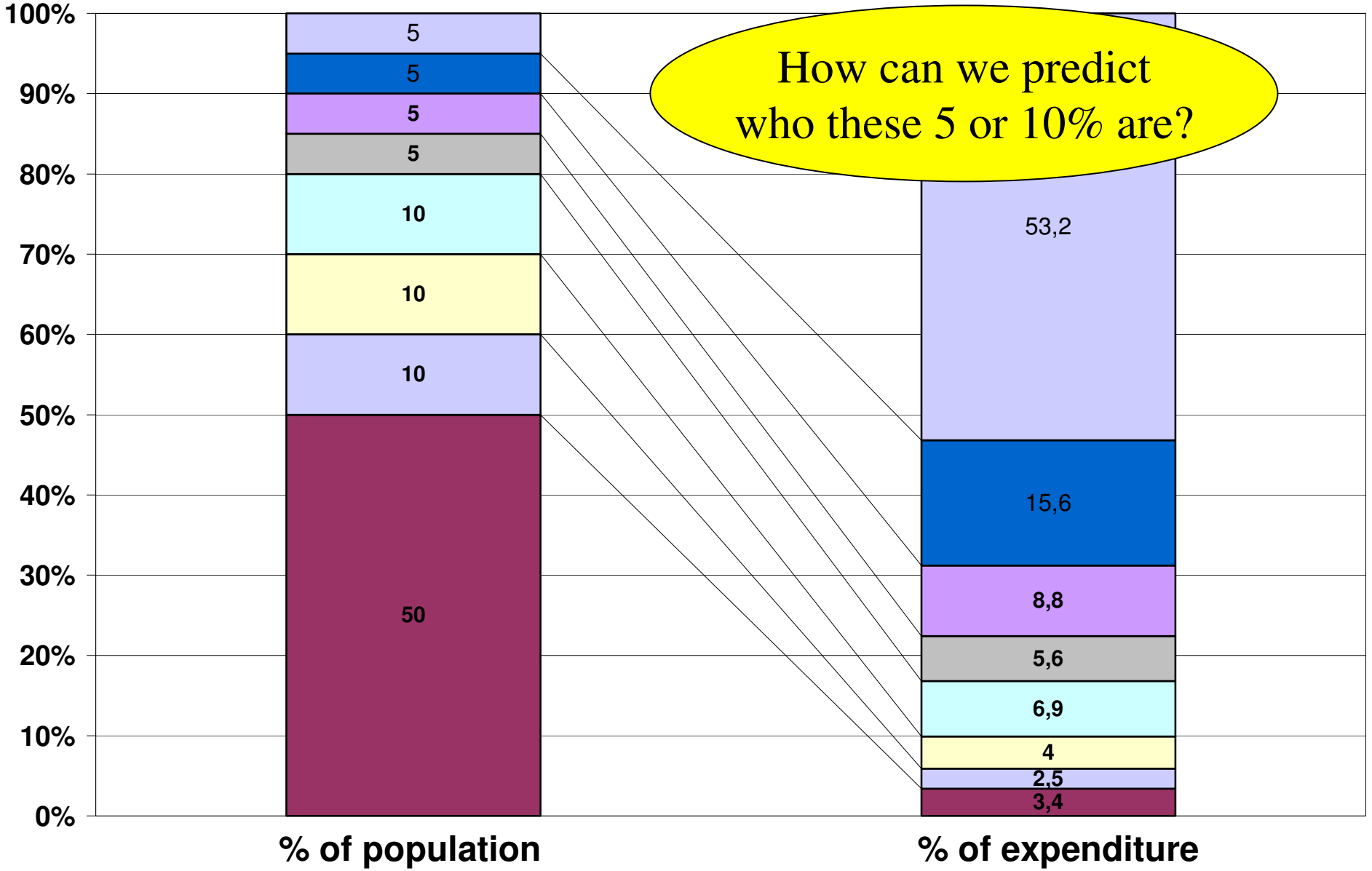

**PHI remains but: universal coverage + obligation to contract (for a capped premium)**

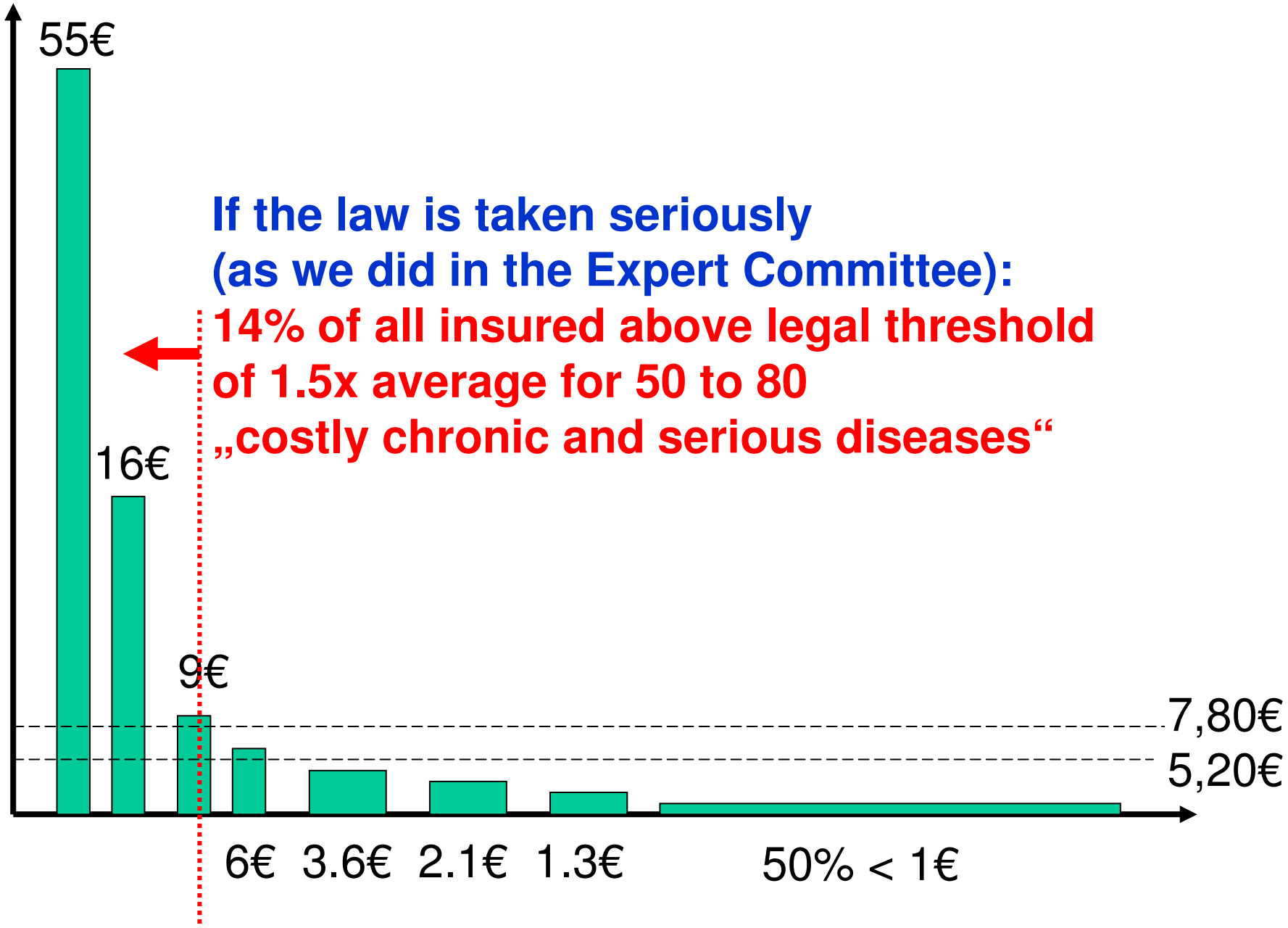
## Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases



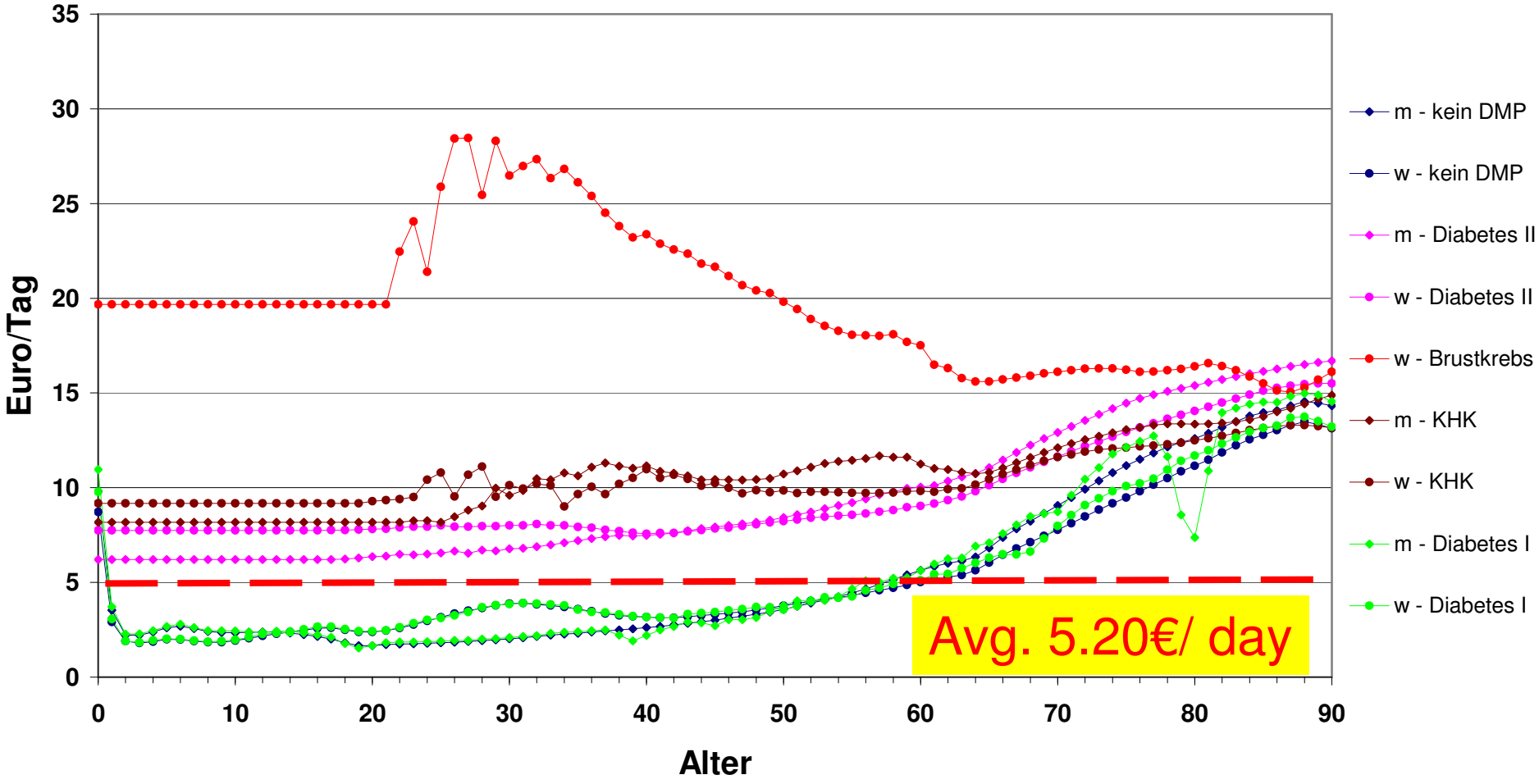

PHI remains but: universal coverage + obligation to contract (for a capped premium)

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

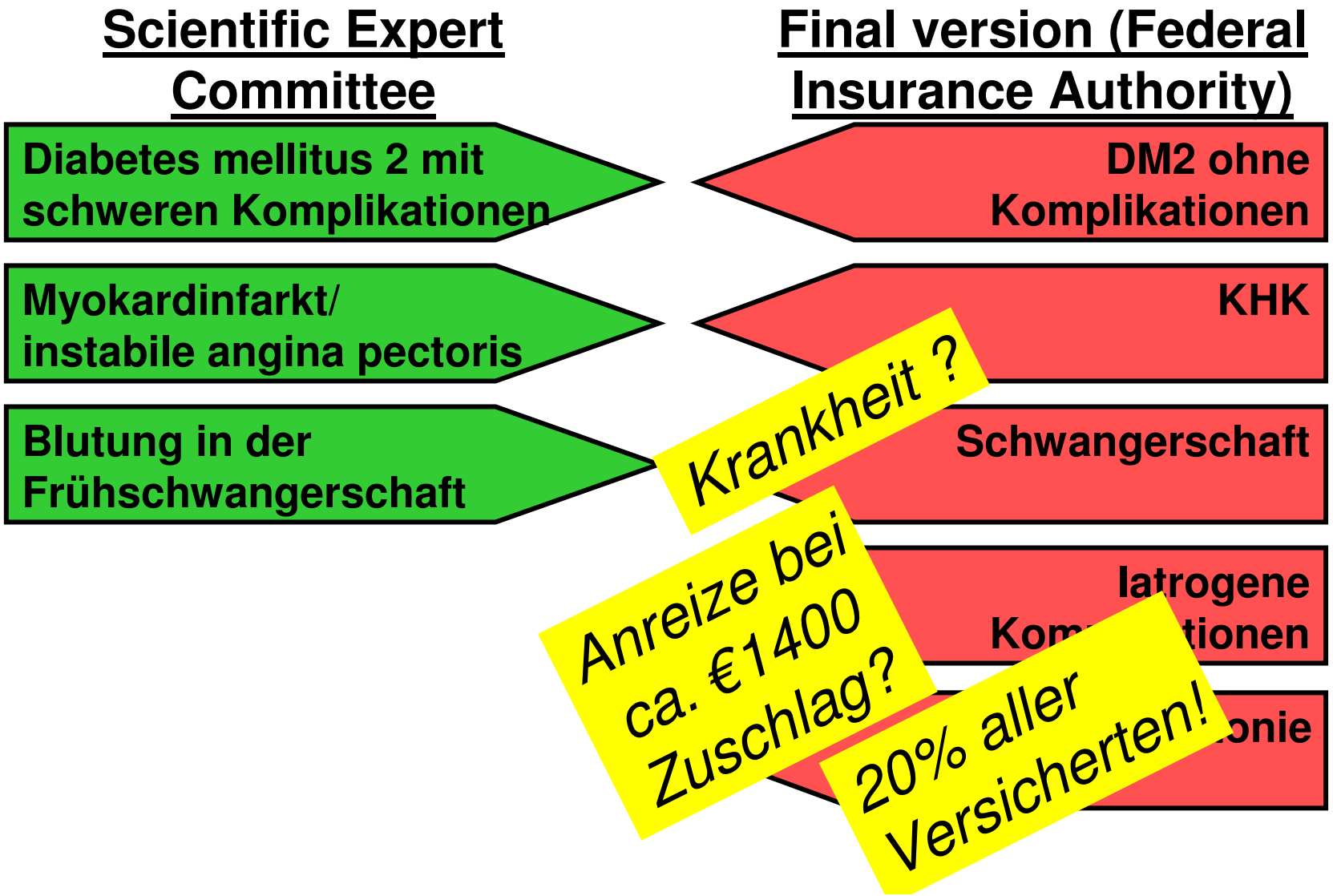



55€
16€
9€
If the law is taken seriously
(as we did in the Expert Committee):
14% of all insured above legal threshold
of 1.5x average for 50 to 80
„costly chronic and serious diseases“
7,80€
5,20€
6€
3.6€
2.1€
1.3€
50% < 1€

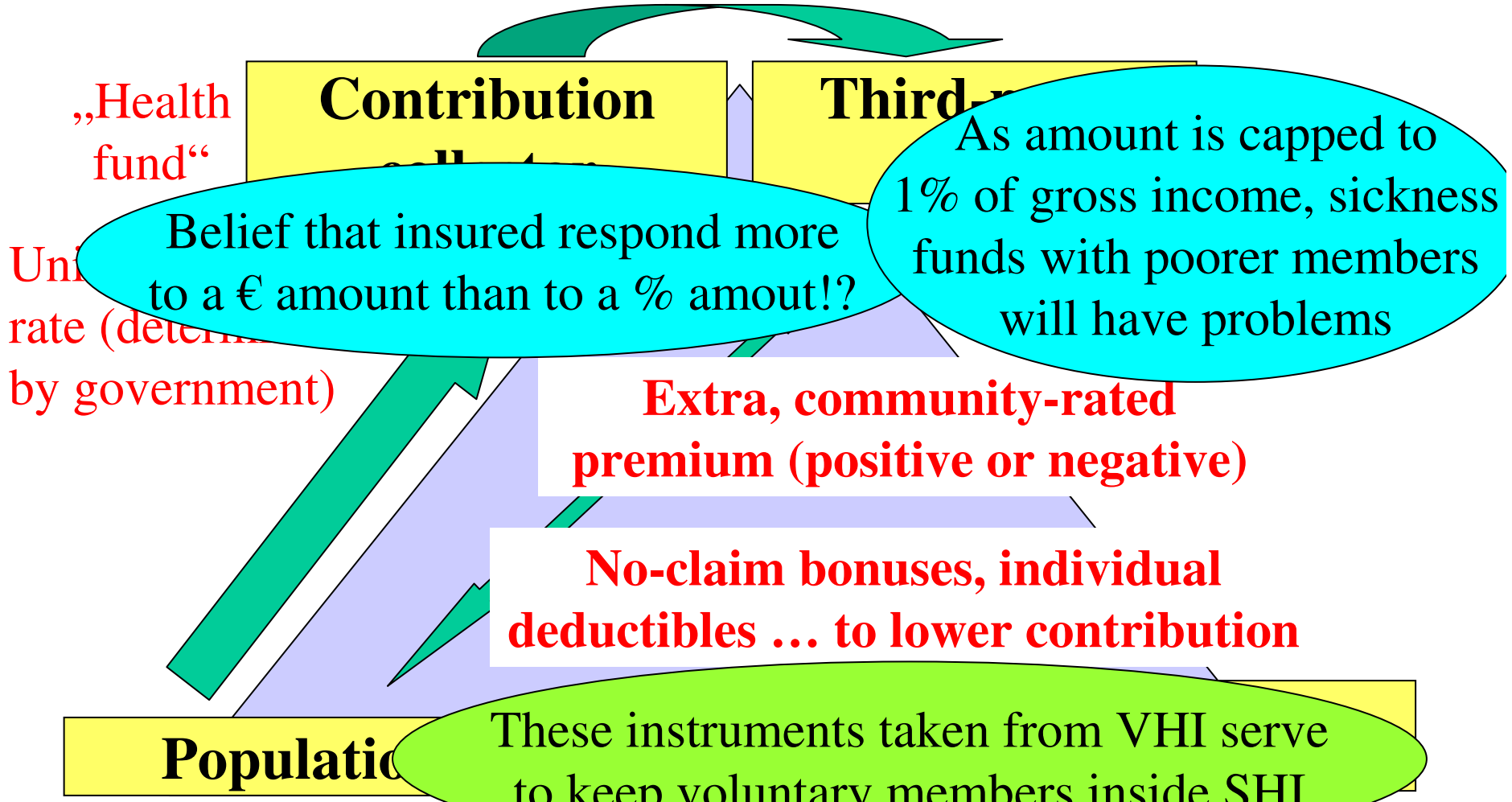
# „Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism for DMP participants and other insured (2006)



# What constitutes a disease for the Risk Structure Compensation?

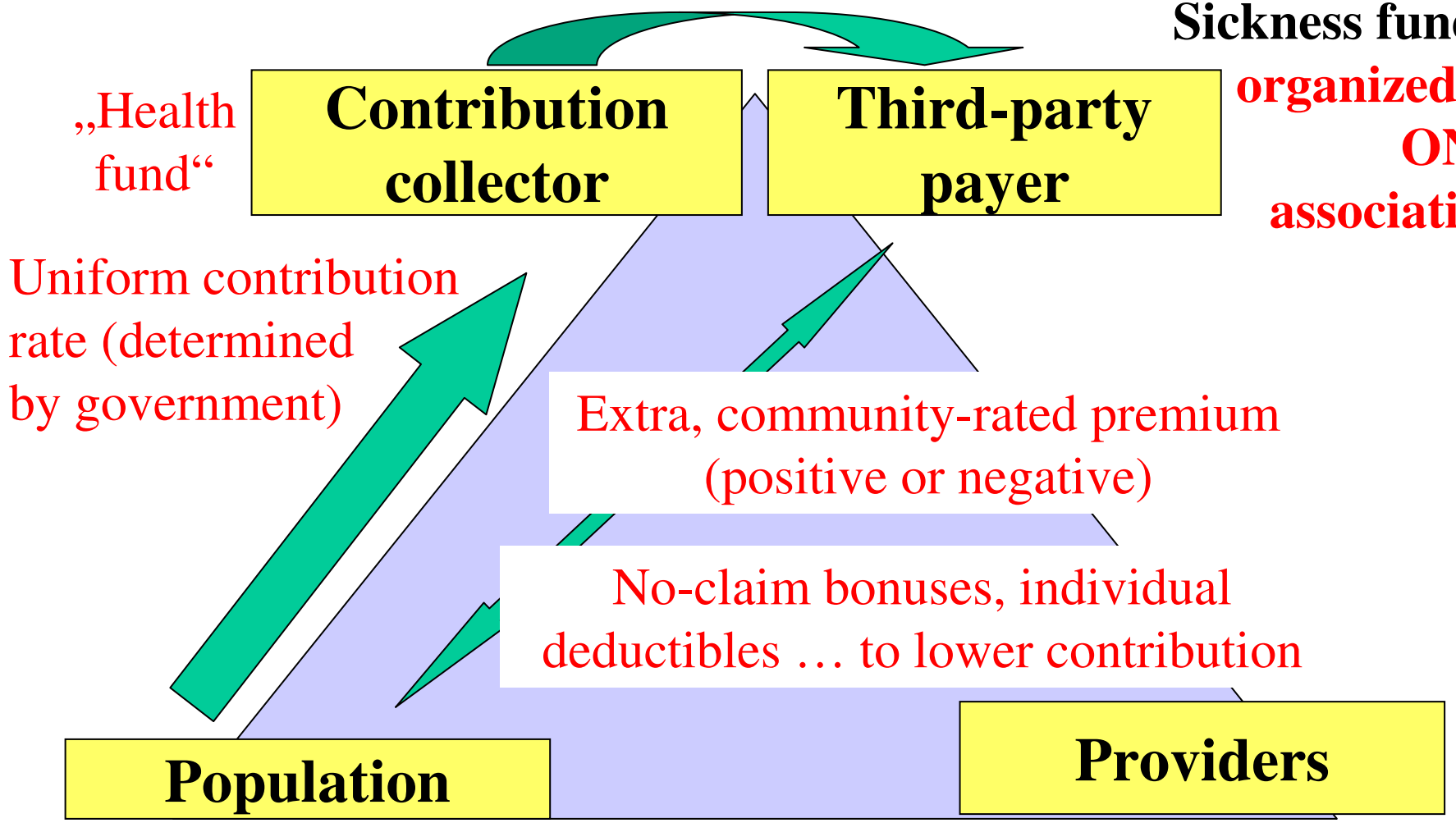


Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases




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

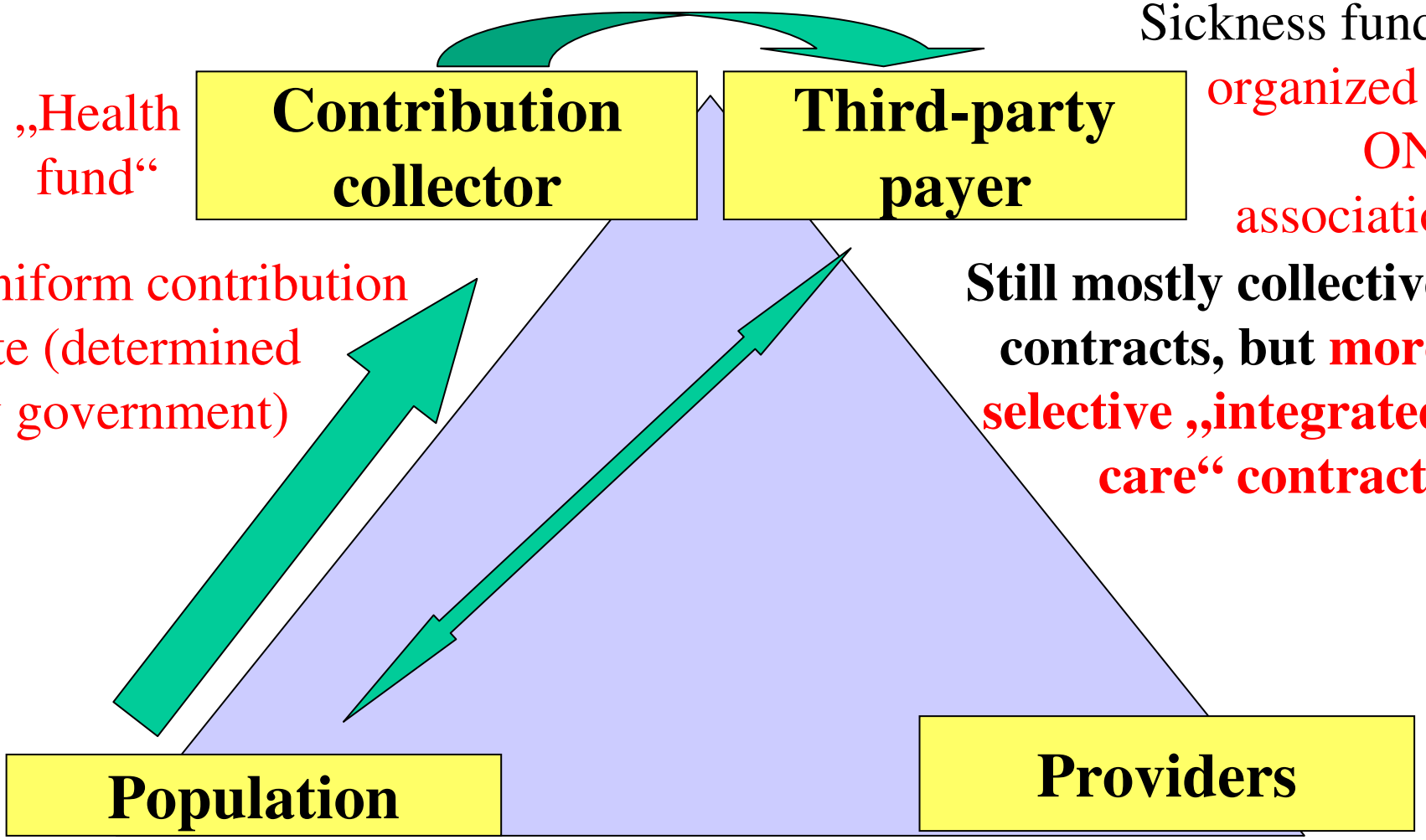



PHI remains but: universal coverage + obligation to contract (for a capped premium)

# Sickness fund reorganisation –
## 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

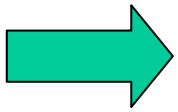



PHI remains but: universal coverage + obligation to contract (for a capped premium)

# 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, signed in May 2008

How to separate capitation payments to KV?

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

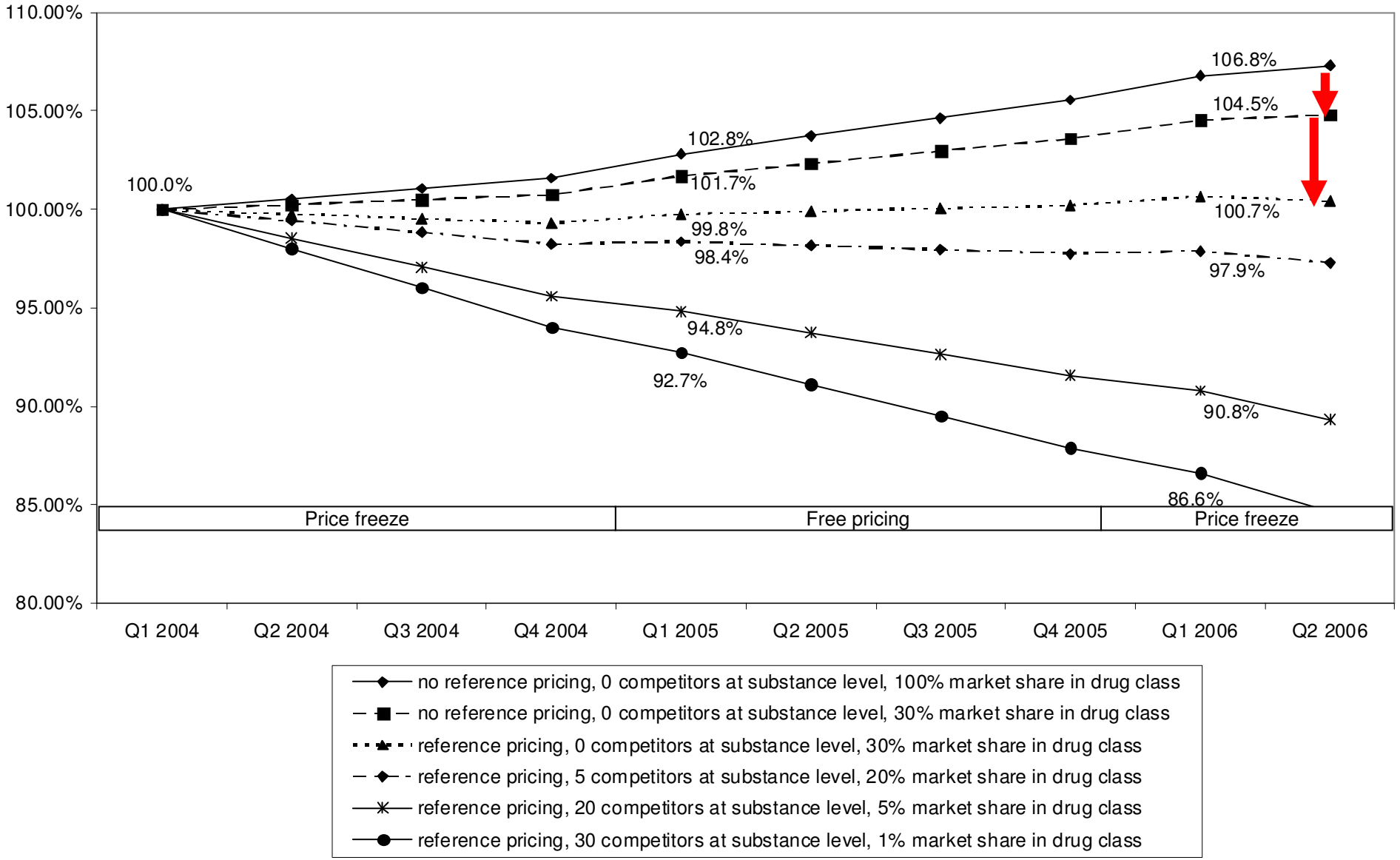
How (cost-)effective?

# 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 strenghtened its effectiveness



# Pharmaceutical policies today

Traditional, interventionist approaches

*Still in force*

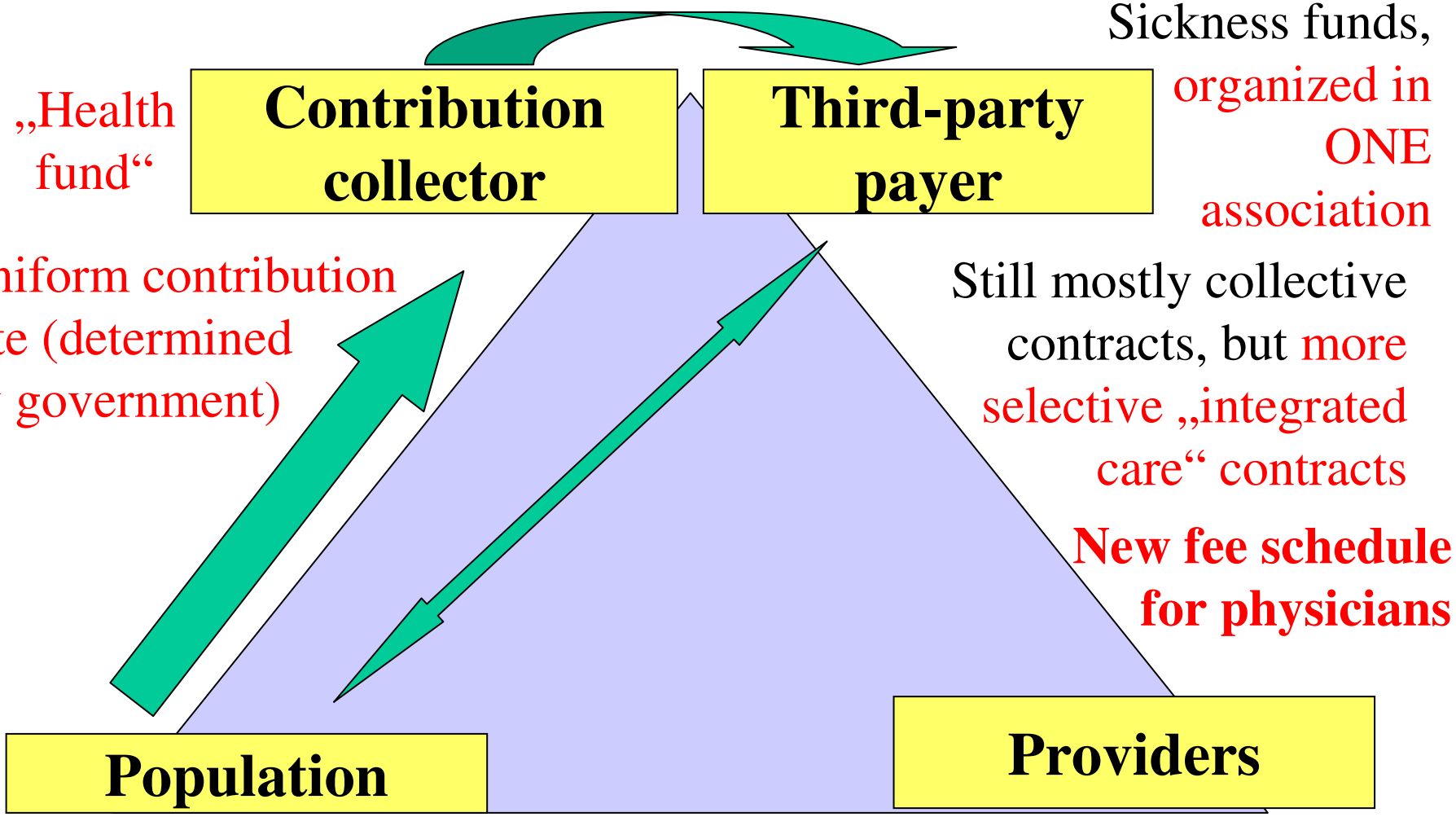
New approach since 2007

- Contracts/ public procurement:
  sickness funds <=> manufacturers
- Winning manufacturer gets monopoly for that substance,
  i.e. no choice for patient, prescribing physician or pharmacist

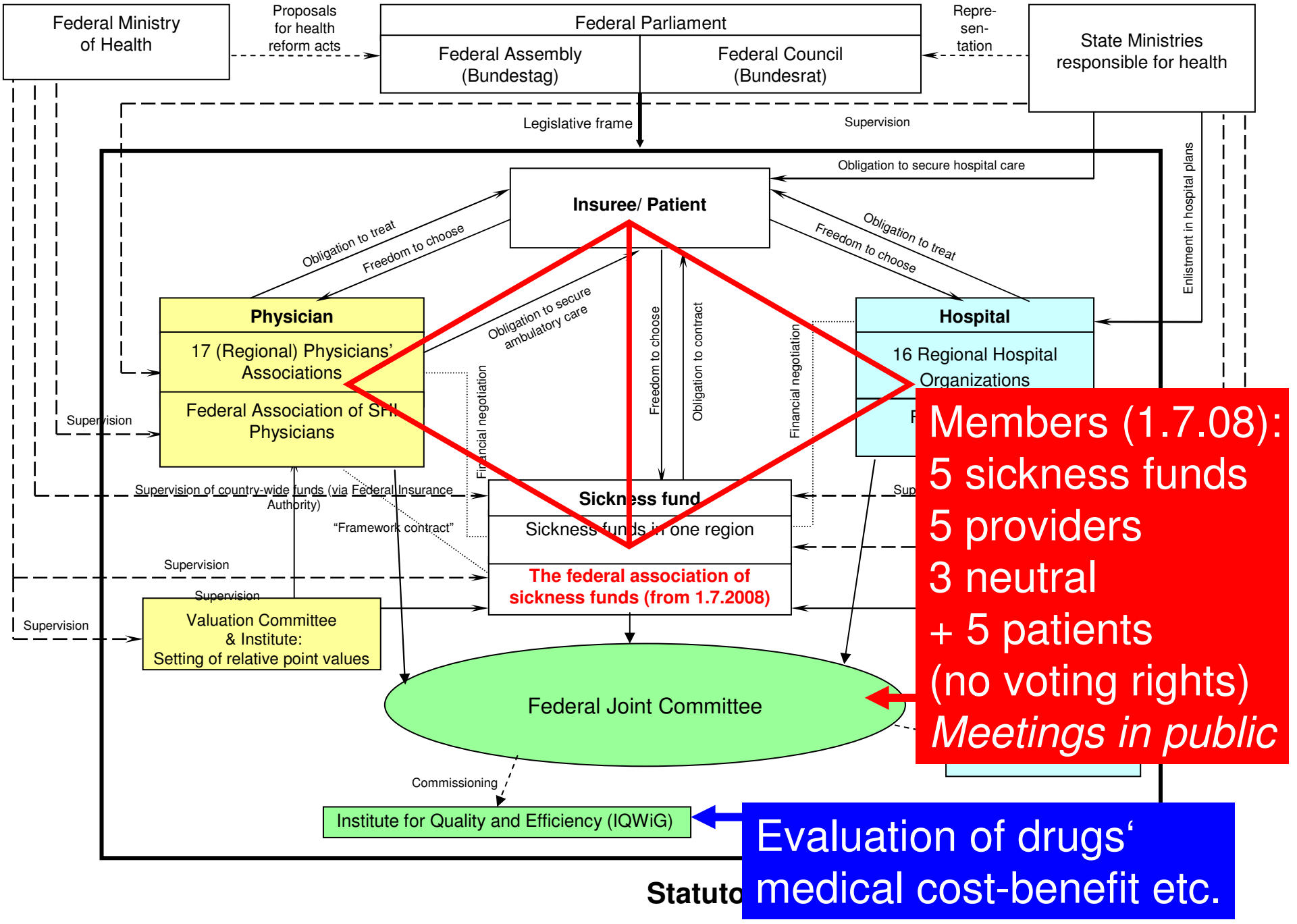
-> initially ignored by large manufacturers -> turn-over by small Indian/ Israeli ... manufactures increased drastically

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)

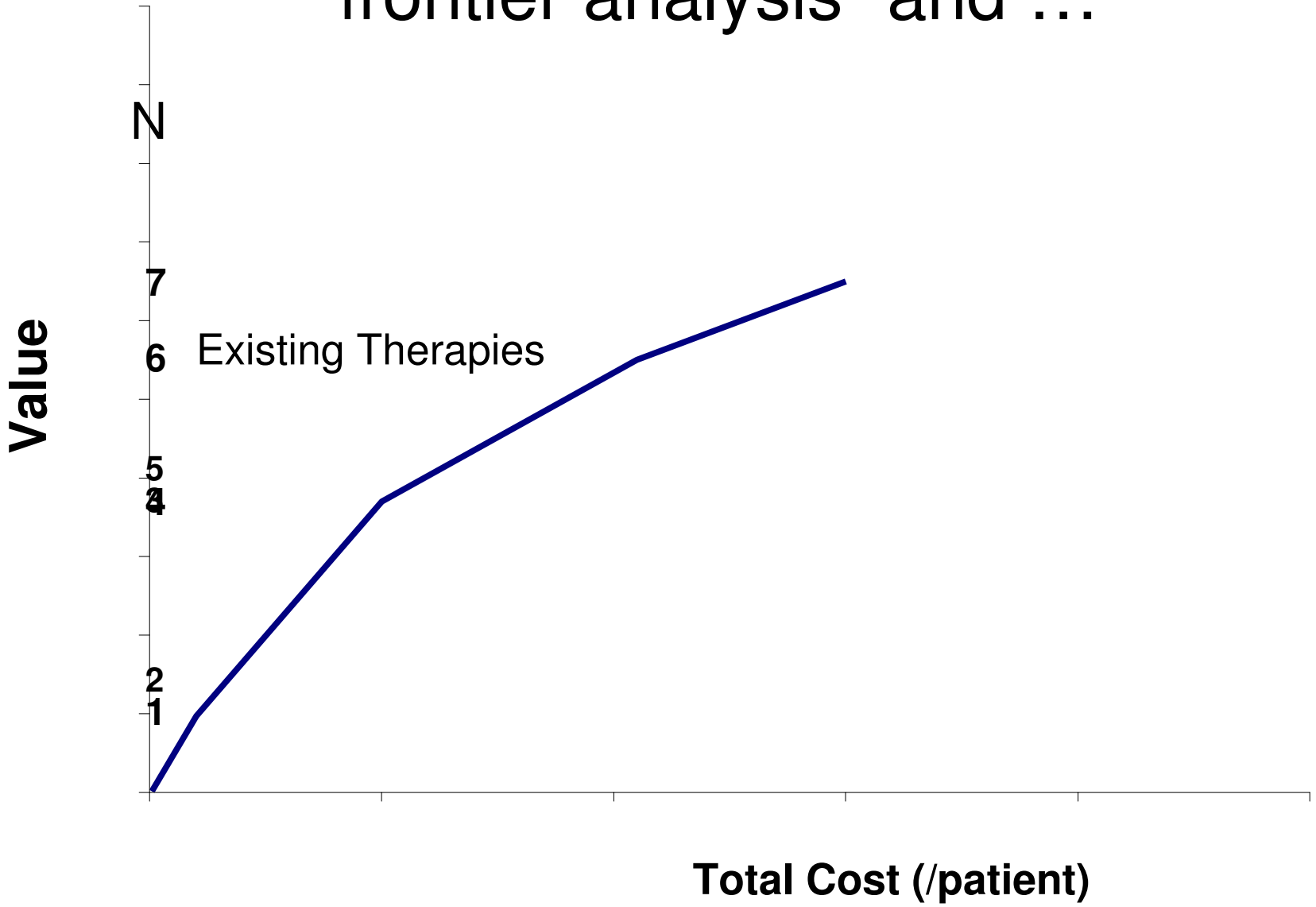
Redesigning the risk-adjusted allocation formula to include supplements for 50 to 80 diseases




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

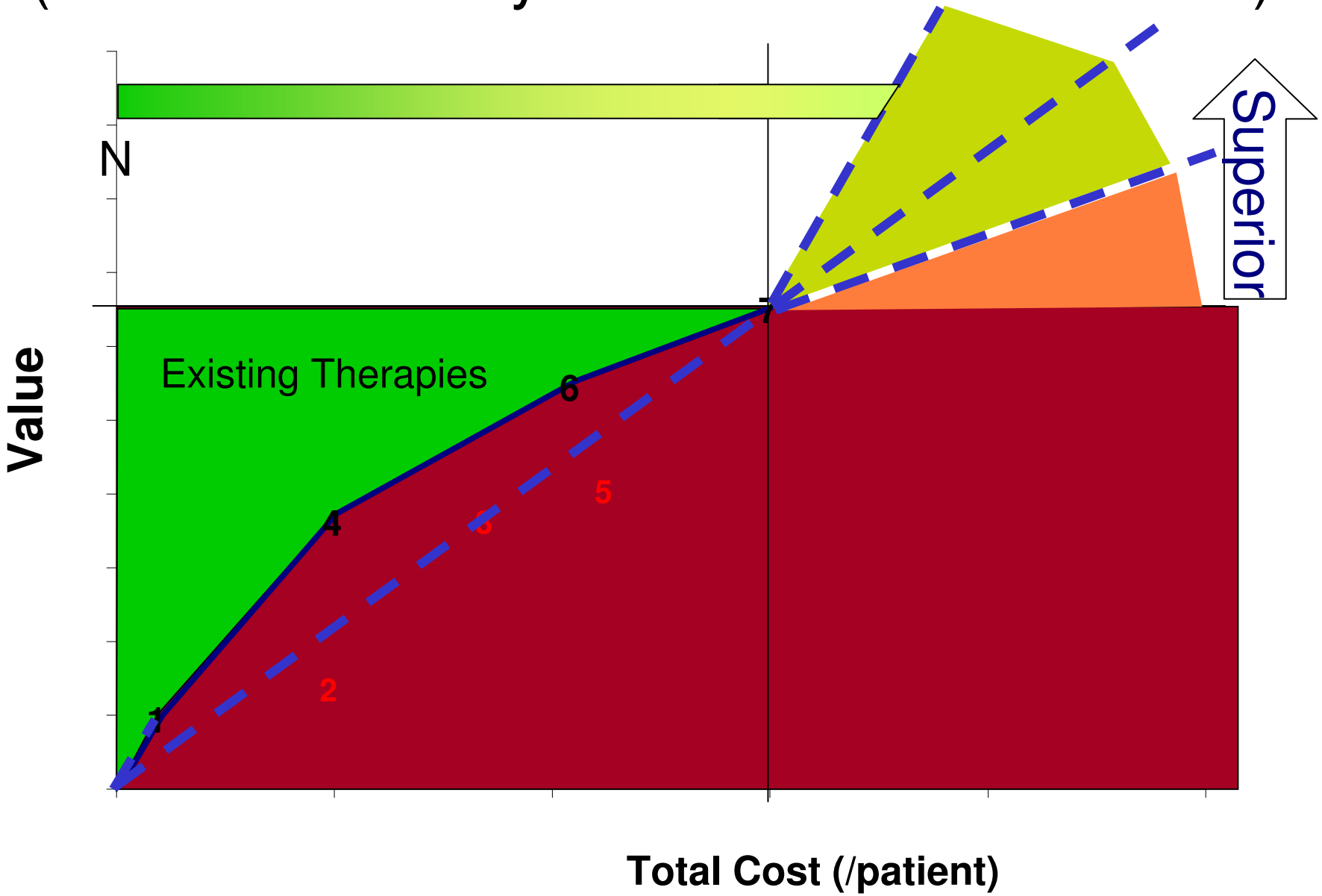

Federal Ministry of Health
Proposals for health reform acts
Federal Parliament
Federal Assembly (Bundestag)
Federal Council (Bundesrat)
Repre-sen-tation
State Ministries responsible for health
Legislative frame
Supervision
Obligation to secure hospital care
Insuree/ Patient
Obligation to treat
Freedom 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
Financial negotiation
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"
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 "frontier analysis" and …



# … “decision zones”

## (decision taken by Federal Joint Committee)

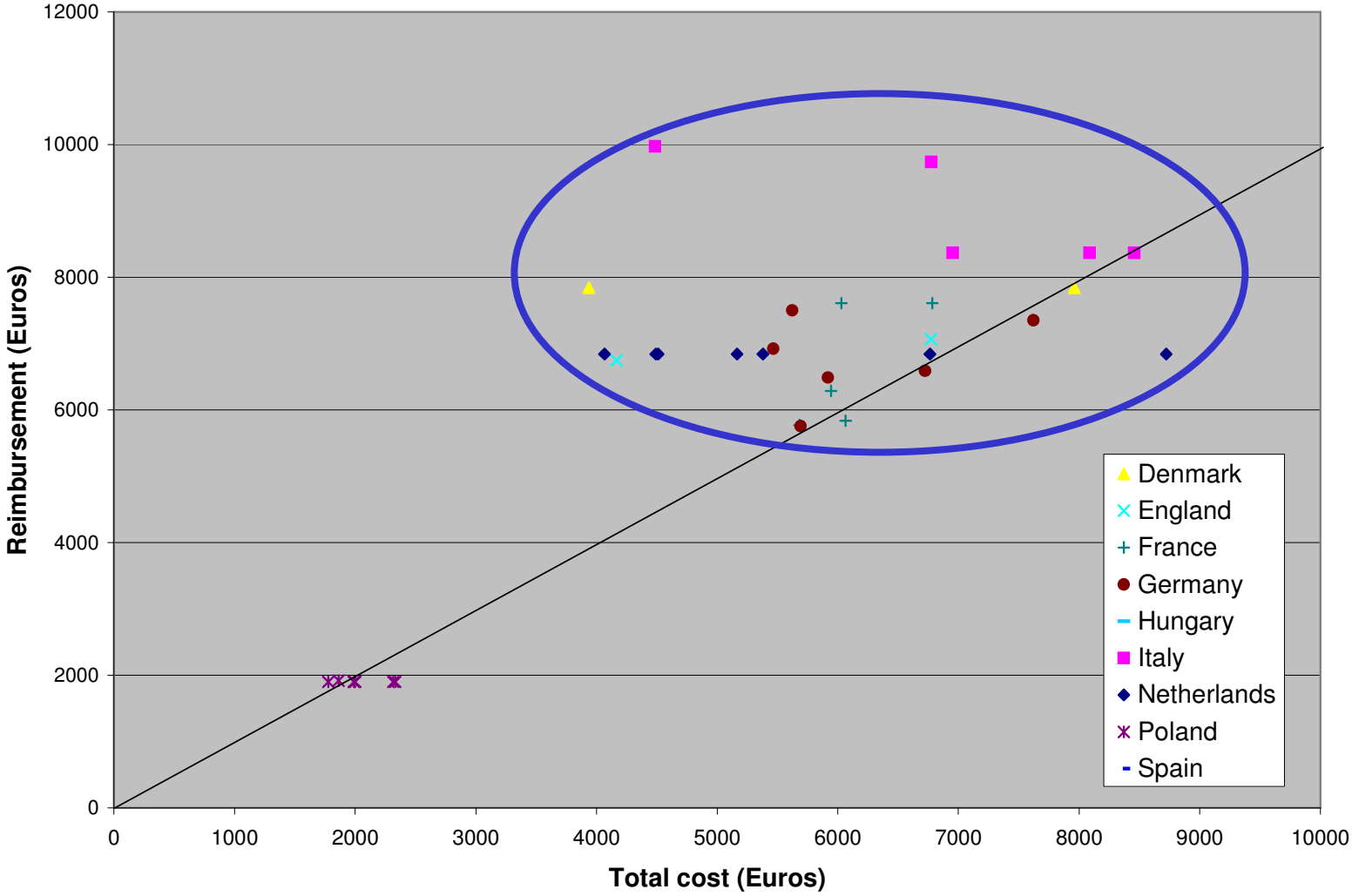


# Conclusions

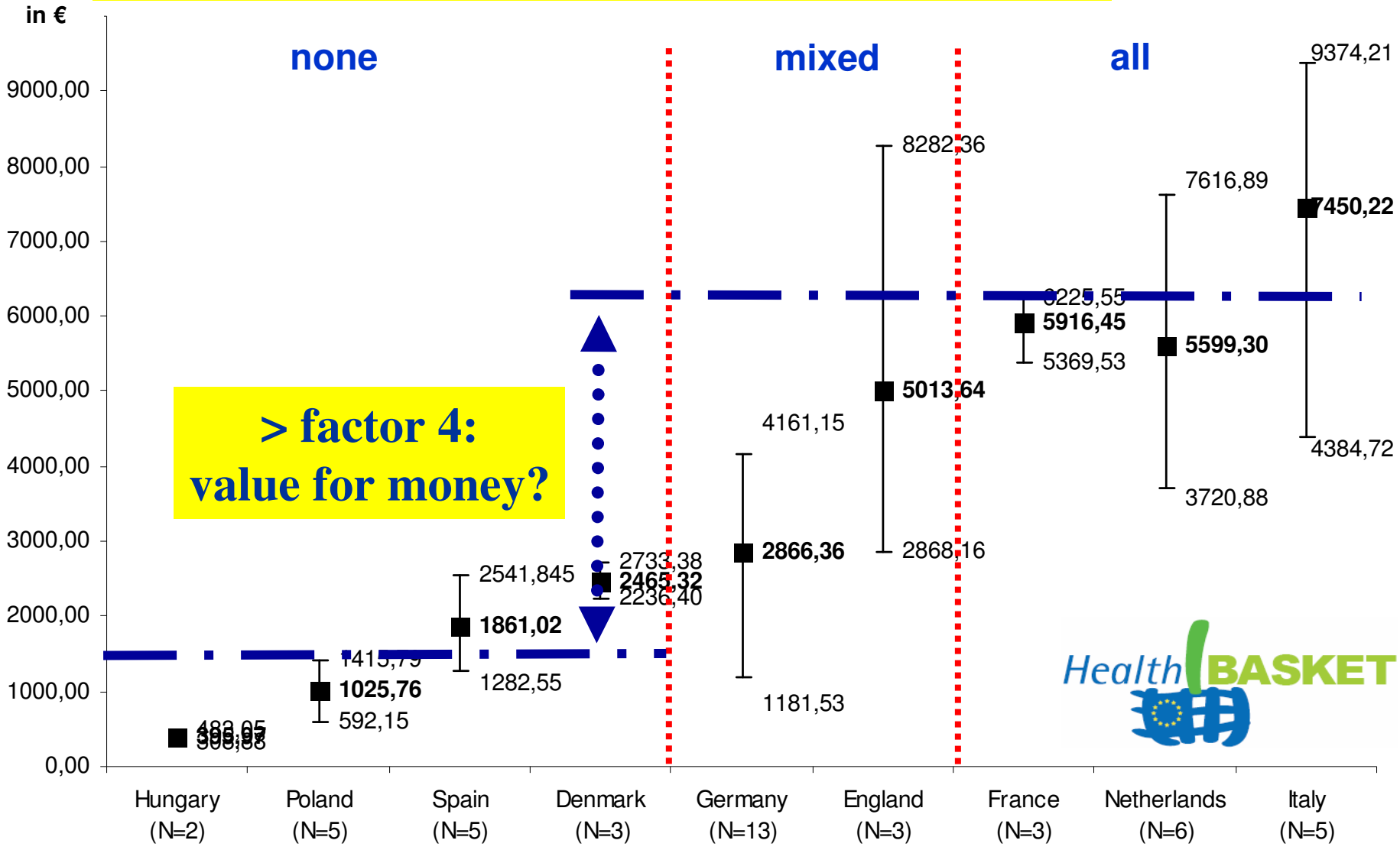
- Competition Strengthening Act has more components than initially realised
- Probably largest structural impact upon system of any reform
- Contains both planning as well as competition elements -> partly incongruent framework (e.g. pharmaceuticals)
- In many ways, the German system has become more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

# But: The European dimension is still underestimated …

## Example: Hip replacement



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



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# Presentation and further material at:

# http://mig.tu-berlin.de


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