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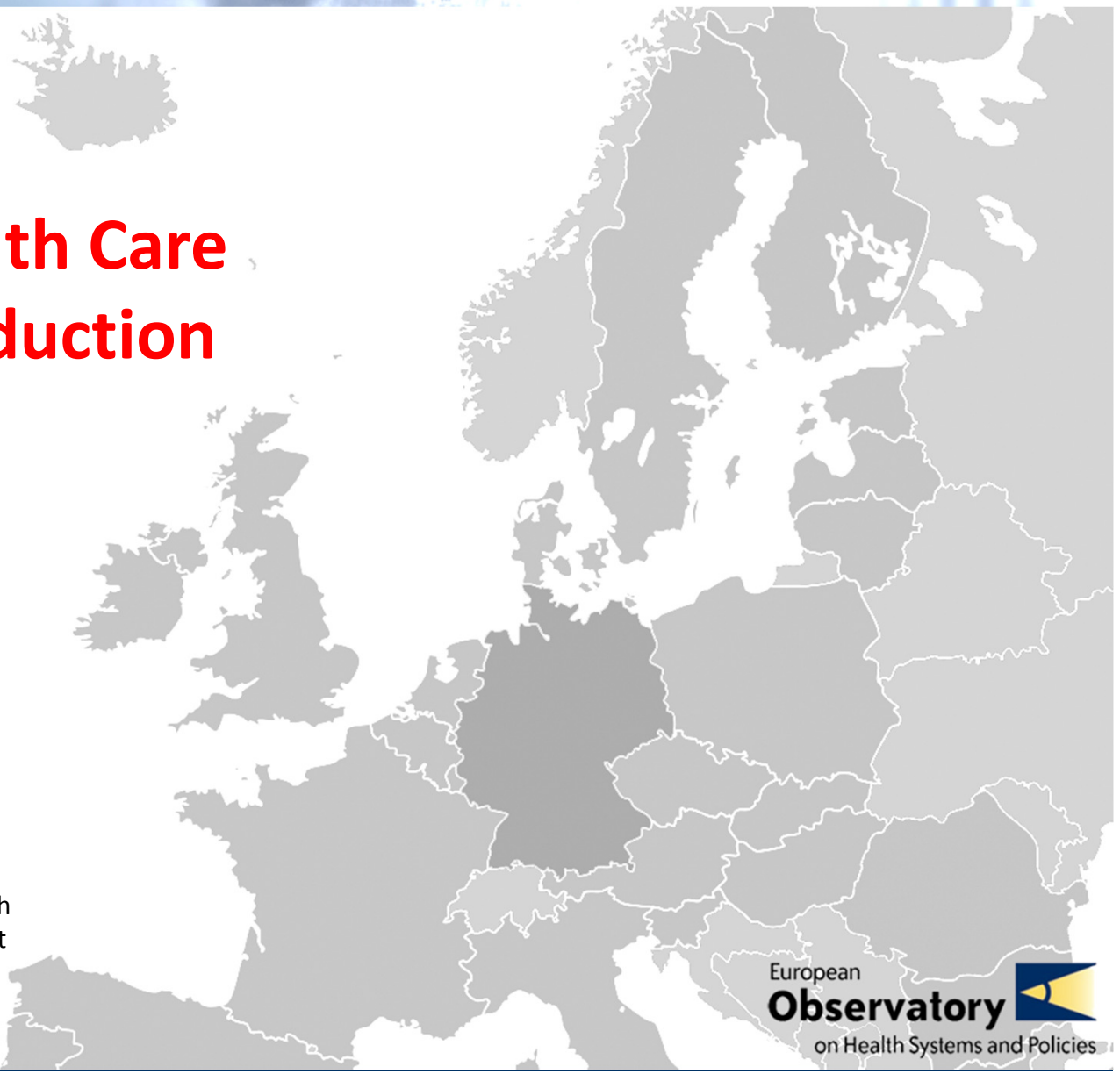
The German Health Care System: An Introduction



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WHO Collaborating Centre for Health Systems, Research and Management

European Observatory on Health Systems and Policies

Agenda

- General characteristics, reforms and decision-making
- Pharmaceutical assessment and pricing
- Physician payment
- Hospital payment (DRGs)
- Long-term care

"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. 150 sickness funds

Ca. 45 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

Key characteristics:

a) Sharing of decision-making powers between the sixteen *Länder* (states), the federal government and statutory civil society organizations

i.e. important competencies are legally delegated to membership-based, self-regulated organisations of payers and providers

b) Statutory health insurance (SHI)

SHI Cornerstone of health service provision is the Fifth Book of the German Social Law (SGB V)

i.e. it organizes and defines the self-regulated “corporatist” structures and give them the duty and power to develop benefits, prices and standards

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Key characteristics:

c) Sectoral borders

SGB V separates the provision of outpatient and inpatient services.

Planning, resource allocation and financing are undertaken completely separately in each sector.

→Complicates the provision of health care delivery (e.g. communication)

→Increases the amount of specialists

→Increases the health care expenditure

German healthcare system: key characteristics

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	… in the old times	Cons.-lib.		Red-green	Grand coalition		Cons.-lib.
		1994/95	1996/97	2004	2007	2009	2011
Compulsory insurance	Mandatory only for employed/pensioners/unemployed up to certain income				Universal coverage in SHI (or PHI)		
Choice between SHI and PHI	For employed above certain income within 1 year				… for 3 years		… within 1 year
Choice of SHI fund	For employed above certain income		**For most insured (97%)**		For all insured except farmers		

German healthcare system: key characteristics

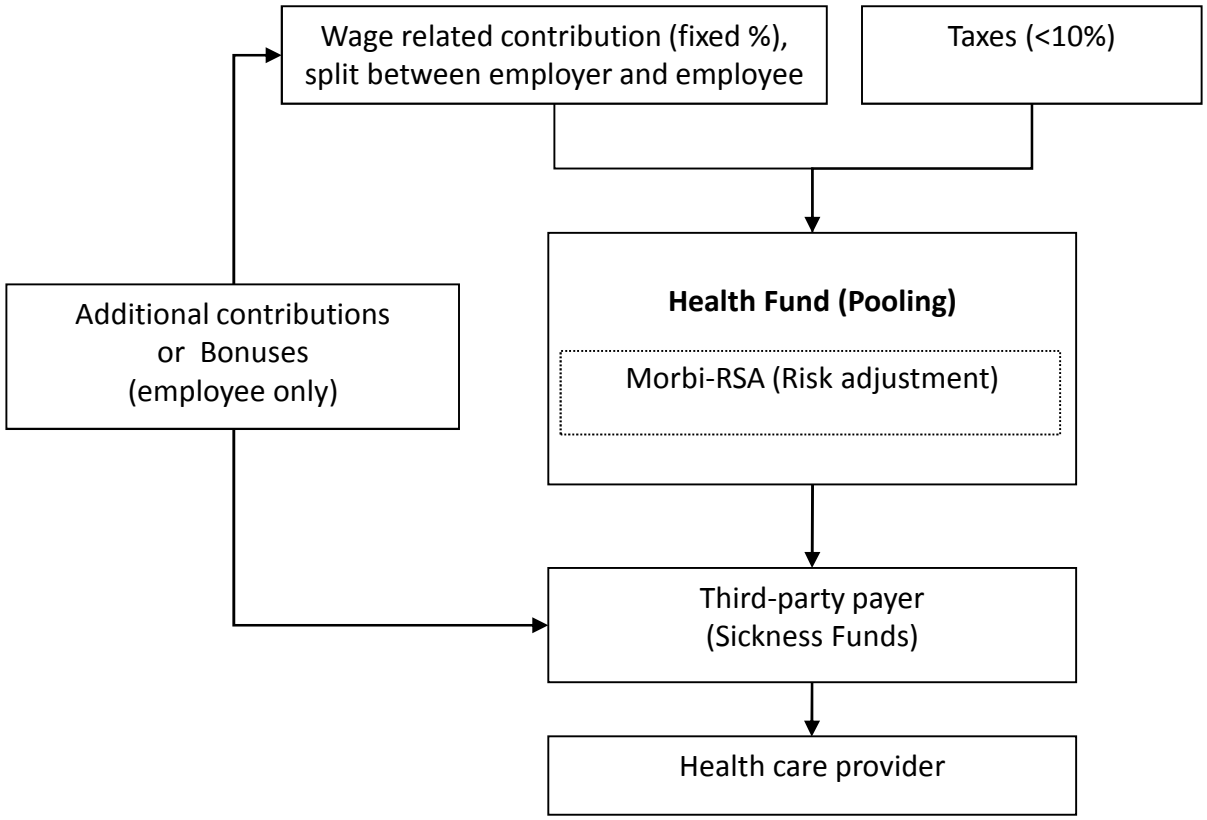
	... in the old times	Cons.-lib.		Red-green	Grand coalition		Cons.-lib.
		1994/95	1996/97	2004	2007	2009	2011
Financial contribution	*Contribution rate differing among sickness funds*					*Uniform rate plus possibly add'l premium set by sickness fund*	
						Actual amount capped at 1%	*Average amount capped at 2%*

German healthcare system: key characteristics

	... in the old times	Cons.-lib.		Red-green	Grand coalition		Cons.-lib.
		1994/95	1996/97	2004	2007	2009	2011
Risk-structure compensation	None; pooled expenditure for pensioners	**Risc structure compensation based on age and sex**		+ DMPs as criterion & high-cost pool		+ morbidity from 80 diseases	

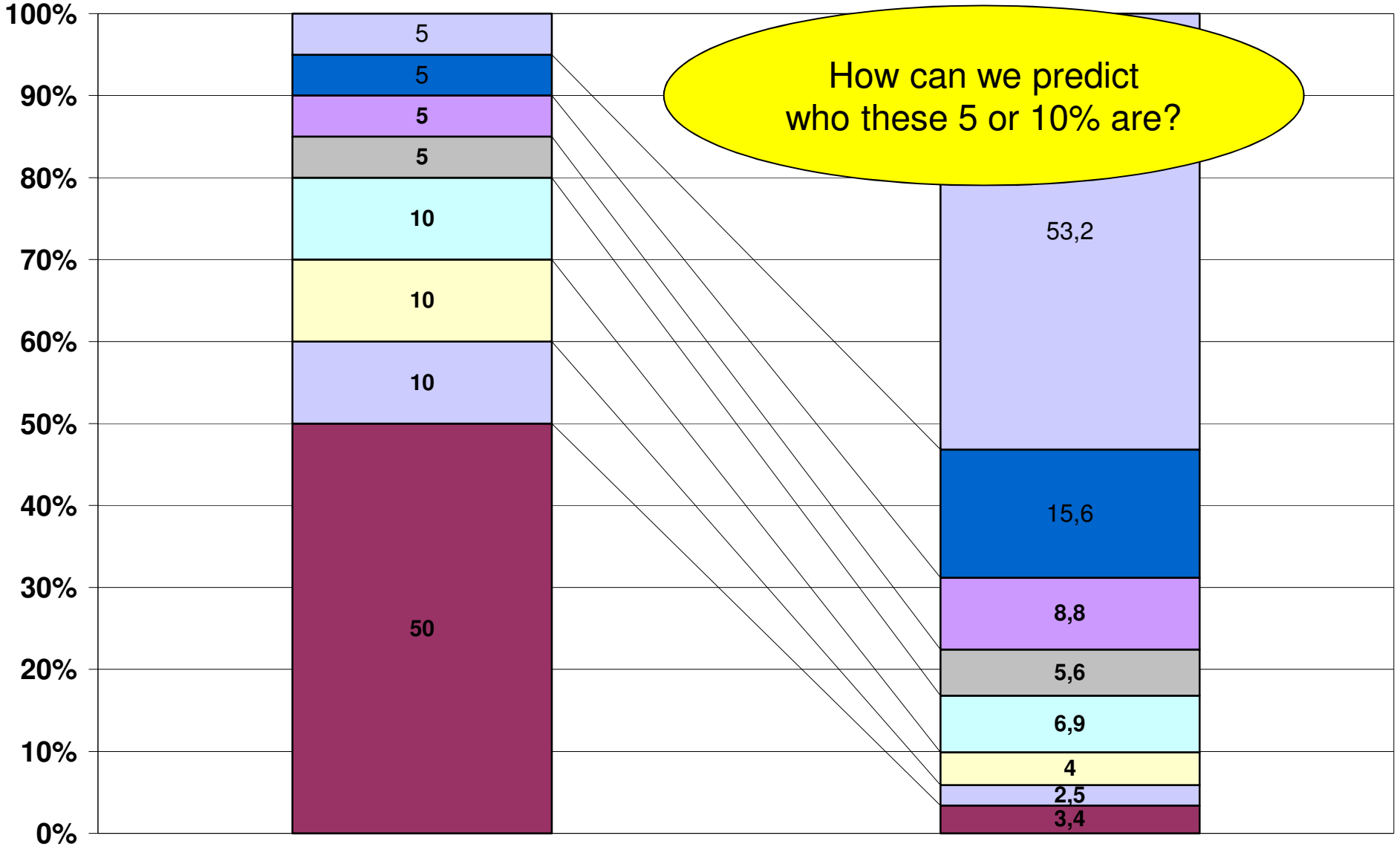
German healthcare system: expenditure & financial flows

- Total expenditure 2008: € 263 bn or € 3200 per capita
- % of GDP for health care in 2008: 10.5 %, 2009 probably >11%, 2010 ca. 11%
- Main blocks (2008): 57.5 % SHI, 9.5 % private insurance, 13.4 % out of pocket

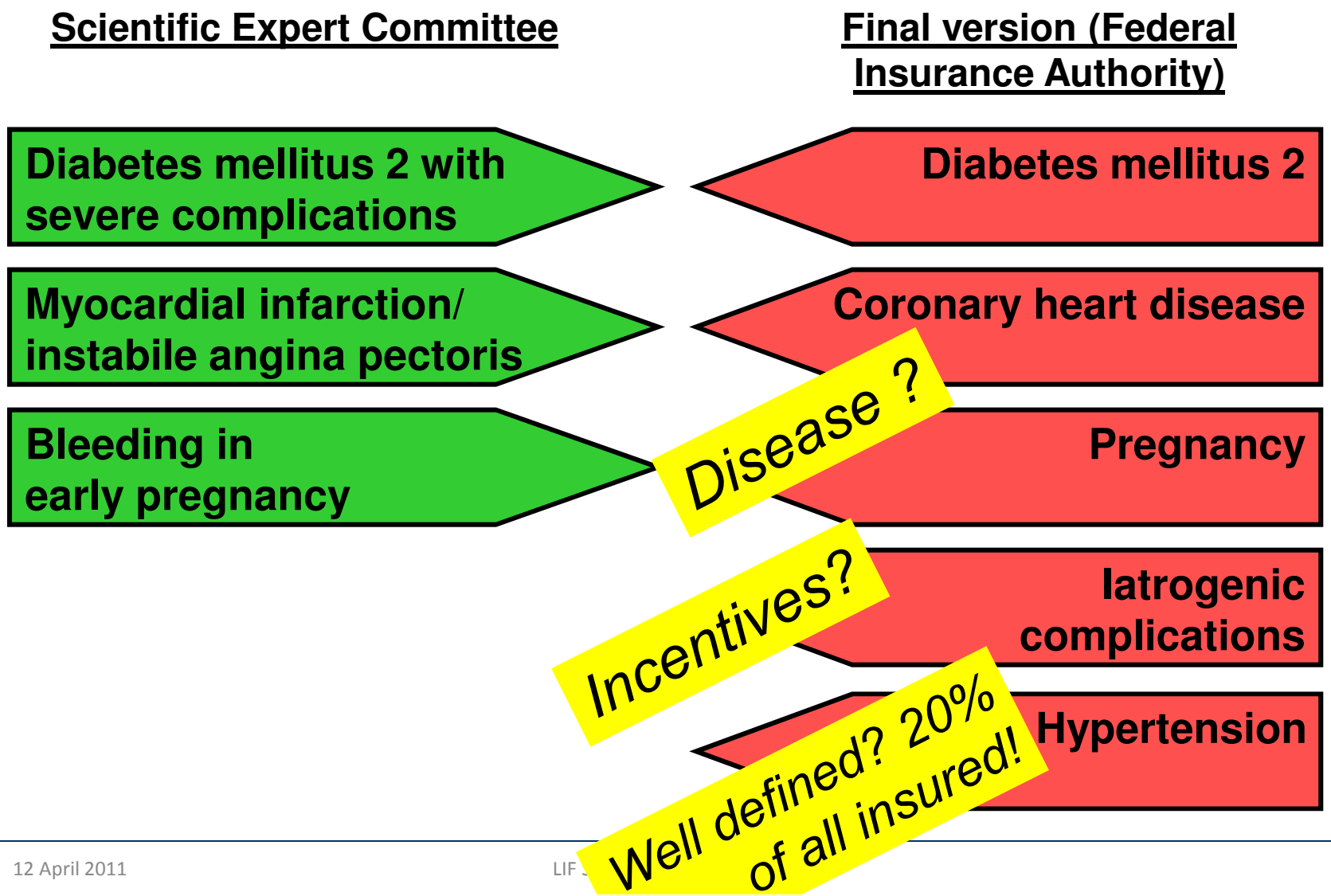


Financial flow in SHI

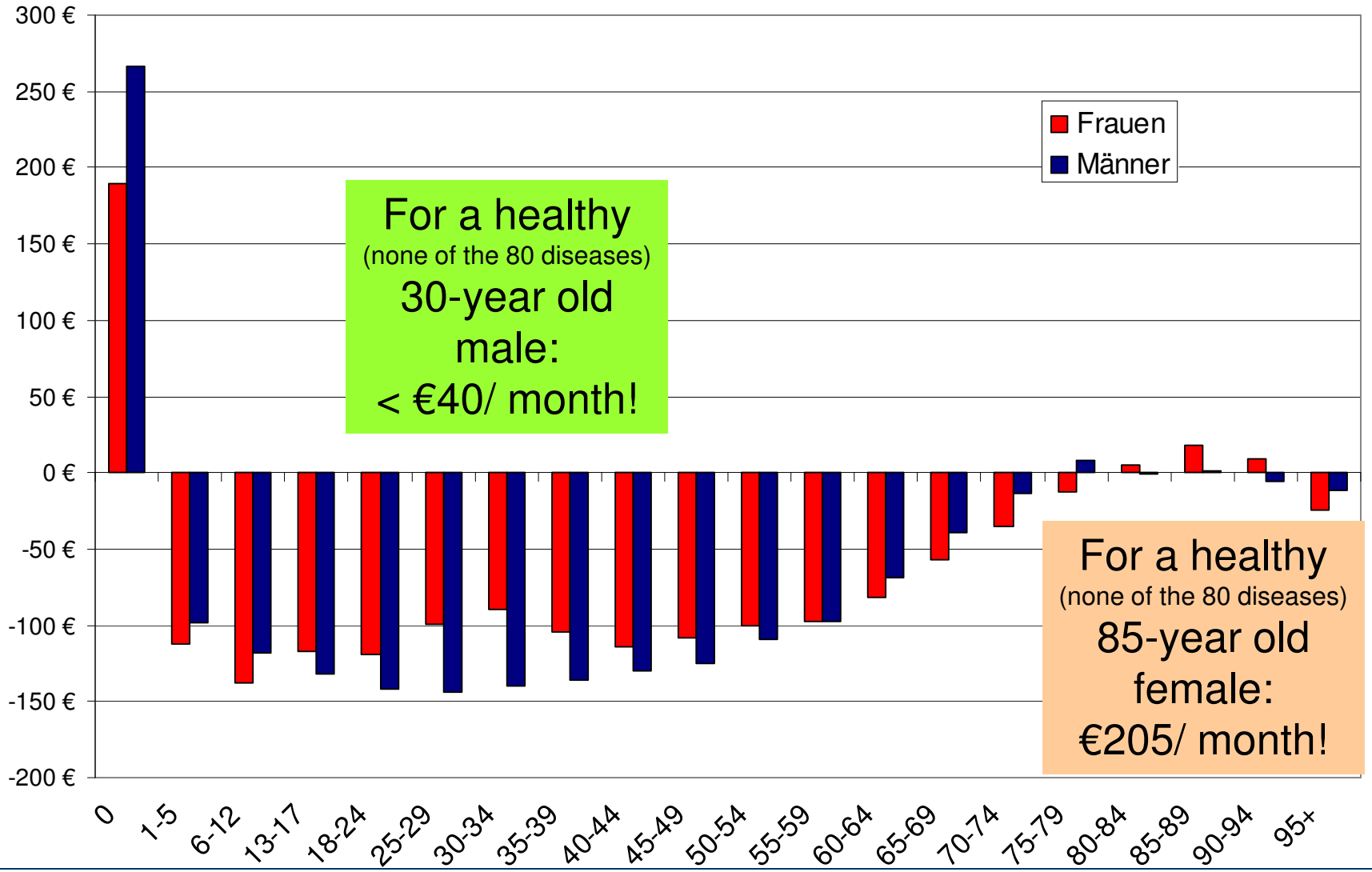
The well-known 20/80 distribution – actually the 5/50 or 10/70 problem



What constitutes a disease for the Risk Structure Compensation?



Monthly deductions/ surcharges for age and sex 2009 (from mean of € 186)



German healthcare system: key characteristics

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		1994/95	1996/97	2004	2007	2009	2011
Contents of benefit package	Relatively uniform but freedom for additions by sickness funds		Dental care for adults excluded (until 1999)	Palliative care incl.; OTC drugs excl.	**Almost uniform (only 0.7% of exp. for additions by sickness funds)**		
Decisions on benefits	Sectoral decisions			**G-BA responsible across sectors**			
	Not evidence-based		HTA for ambu-latory services	Drug benefit eval.; IQWiG founded	+ Cost-benefit assessment of drugs		+ early benefit evaluation of all new drugs

German healthcare system: key characteristics

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Selective contracts for integrated care (2000); financially incentivized 2004-08, but only ~0.3% of total expenditure

Mergers between different fund types allowed; sickness fund associations → Federal Association (2008)

No claim bonus, deductibles, additional benefits … in SHI insurance allowed

Das Glossar zur Gesundheitsreform

A | B | C | D | E | F | G | H | I | J K | L | M | N | O | P | Q | R | S | T | U | V | W | X Y Z |

Wettbewerb (im Gesundheitswesen)

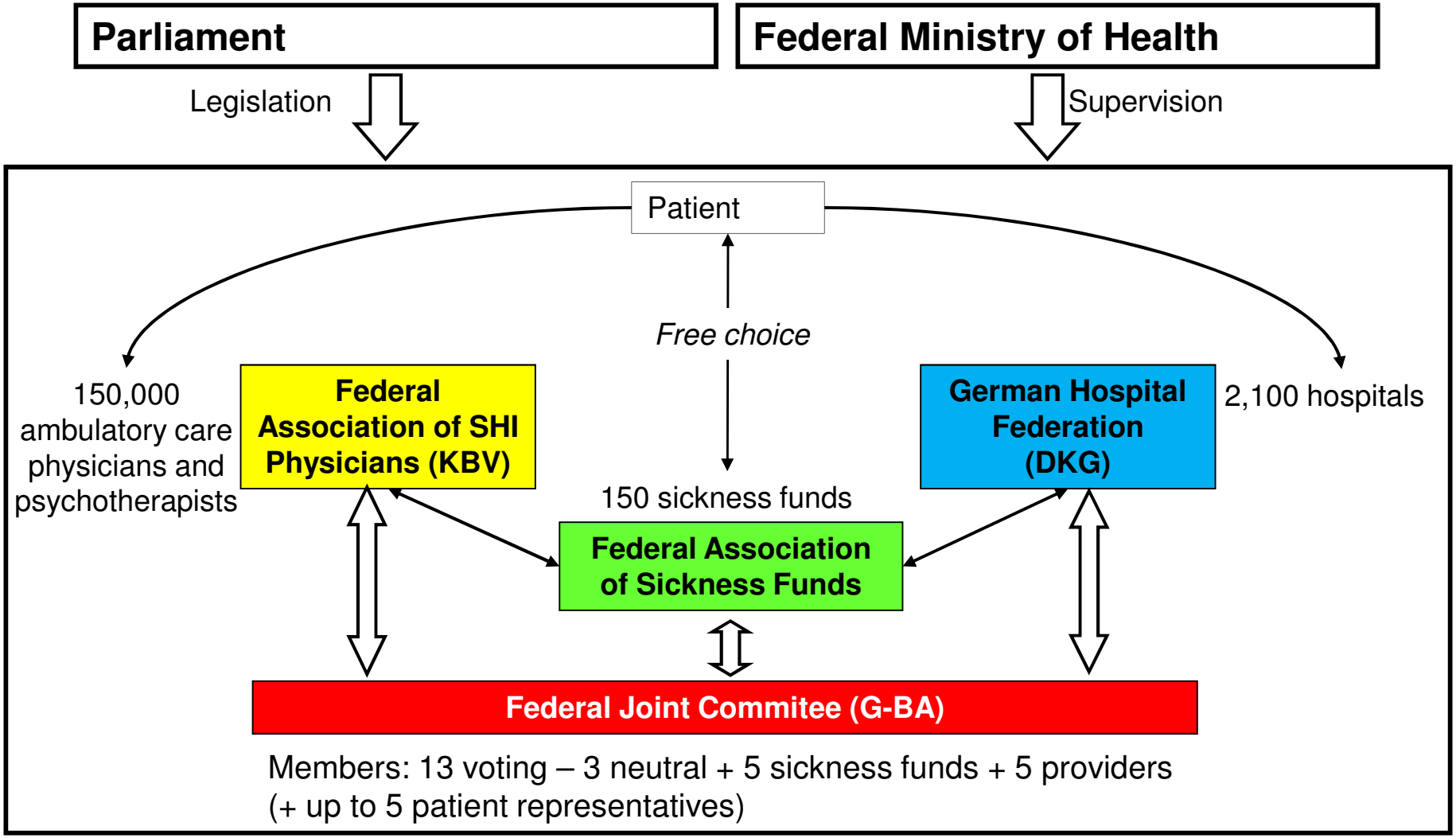
More competition in health care produces foremost more needs-based equity, better [quality], higer [efficiency], reduced costs and [less bureaucracy].

To achieve this, the idea of competition has to become stronger in all sectors of health care: among [sickness funds], among the providers of services, and between sickness funds and [providers] – physicians and hospitals.

In a healthy competition, the sickness funds compete to offer the best quality at the best possible price. The sickness funds have various possibilities to improve the quality of their offer beyond the statutory [benefit basket], e.g. in the form of [integrated *(NB: selective)* care contracts] or with optional tariffs (*NB: e.g. no-claim bonuses, deductibles*).

SOURCE: MY OWN TRANSLATION OF THE GERMAN MoH WEBSITE; NBs ADDED.

Decision-making in the German Statutory Health Insurance



Statutory Health Insurance (85% of population covered)

Objectives of Federal Joint Committee

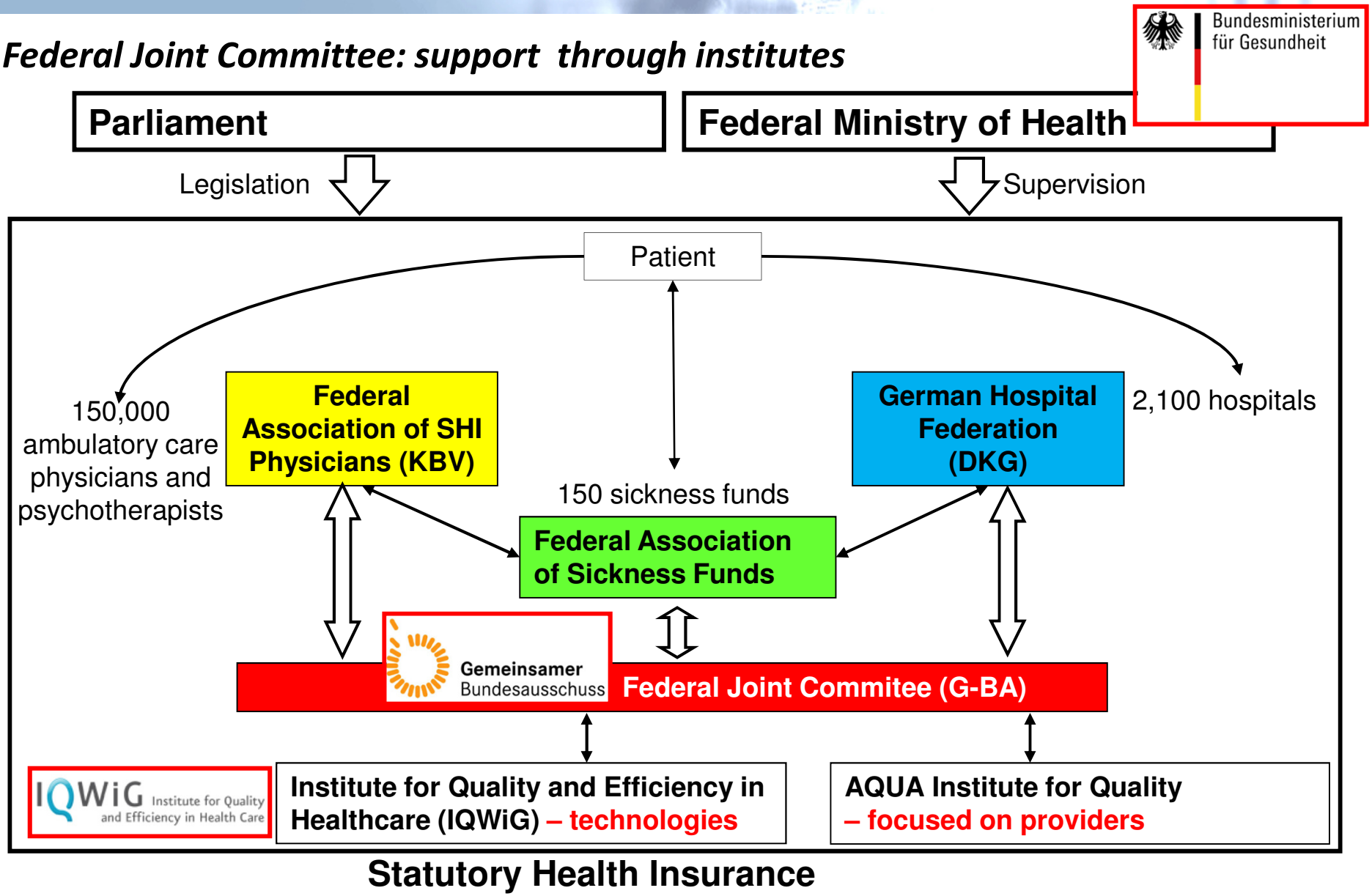
- Main functions: to regulate SHI-wide issues of access, benefits and quality (and not primarily of costs or expenditure).
- Normative function of the G-BA by legally binding directives ("sub-law") to guarantee equal excess to necessary and appropriate services for all SHI insured.
- Benefit-package 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.

Federal Joint Committee: preparation of decisions

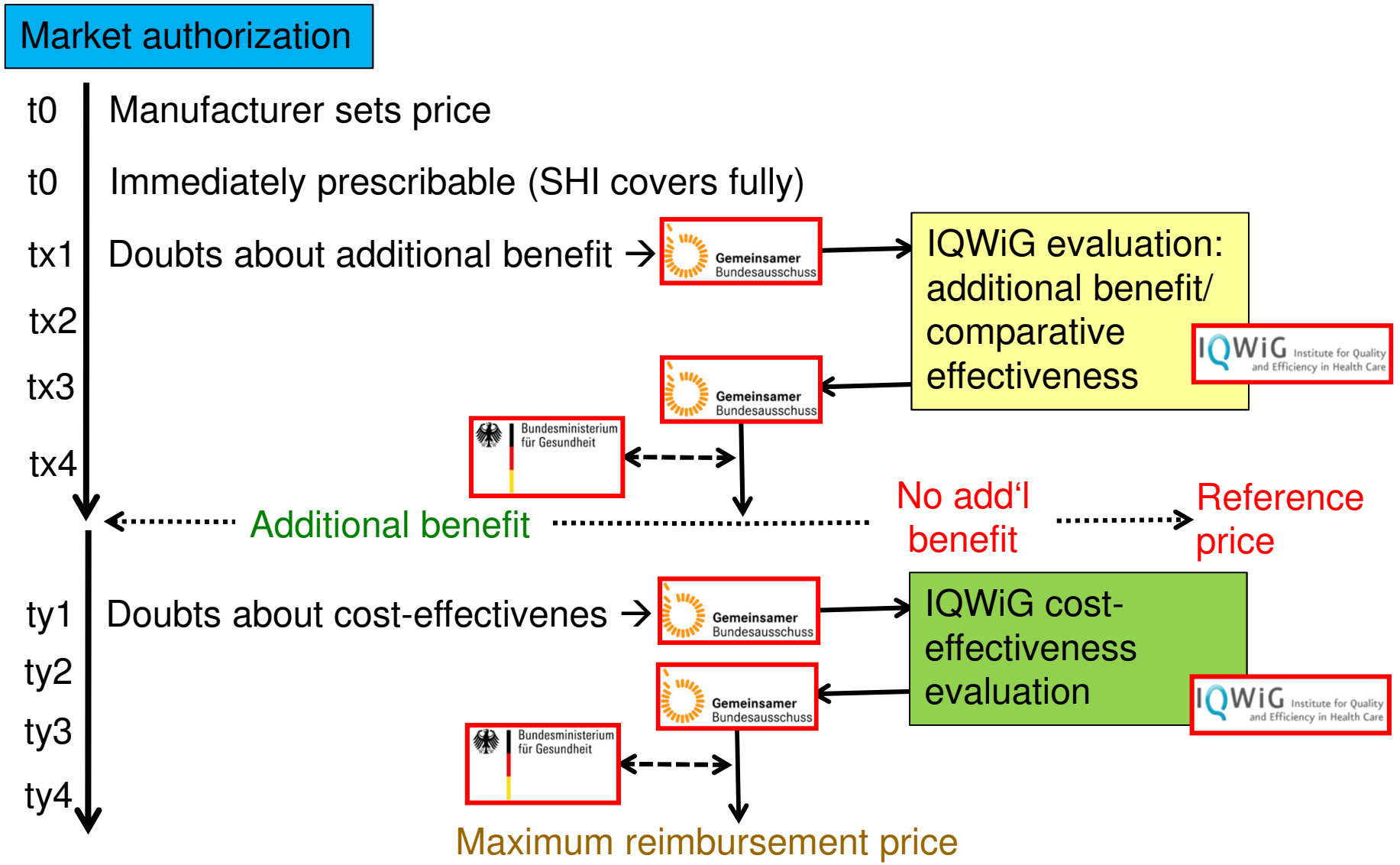
Decisions are prepared by 8 sub-committees:

- 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



Pricing and reimbursement of (new) drugs in Germany (until 2010; simplified)



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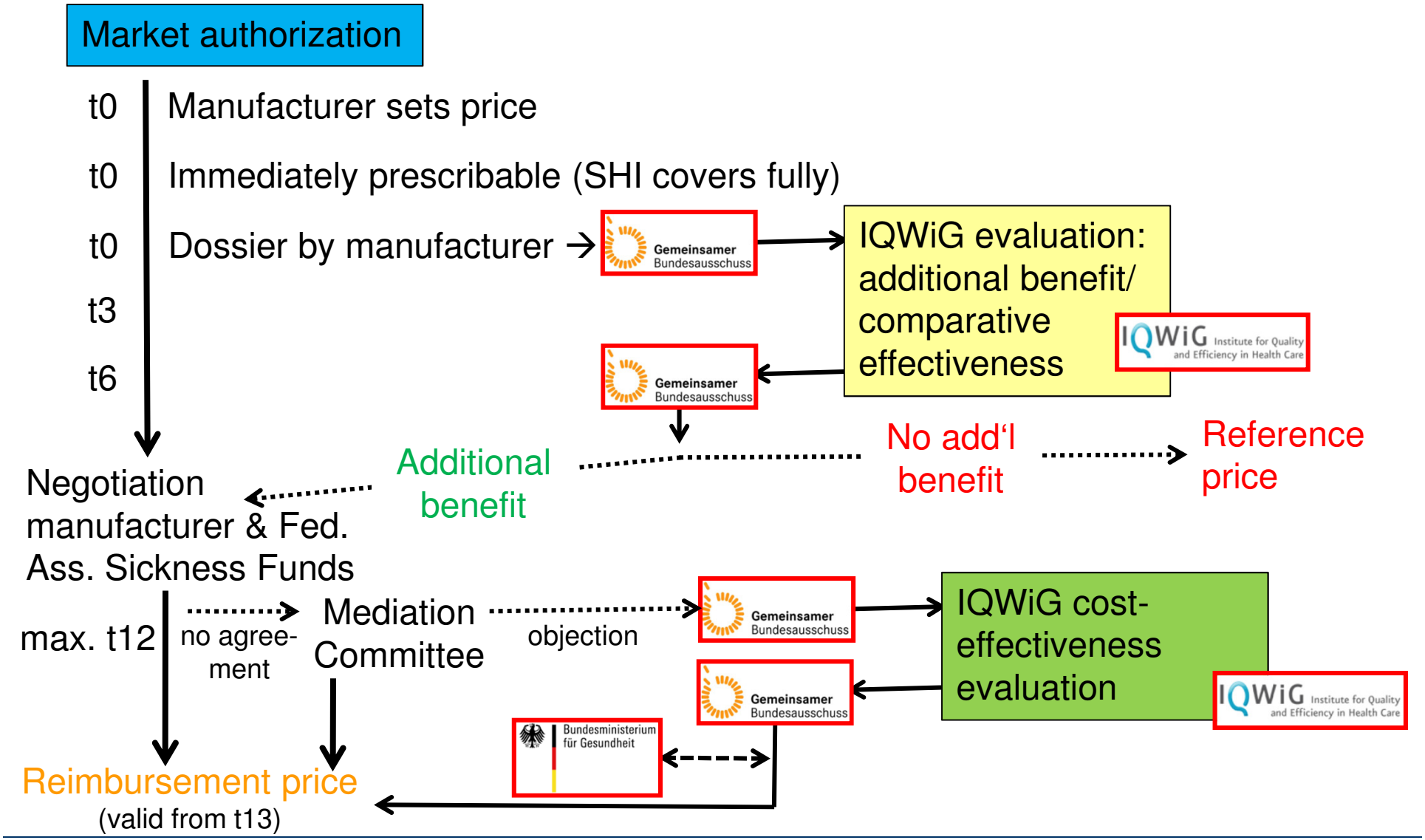
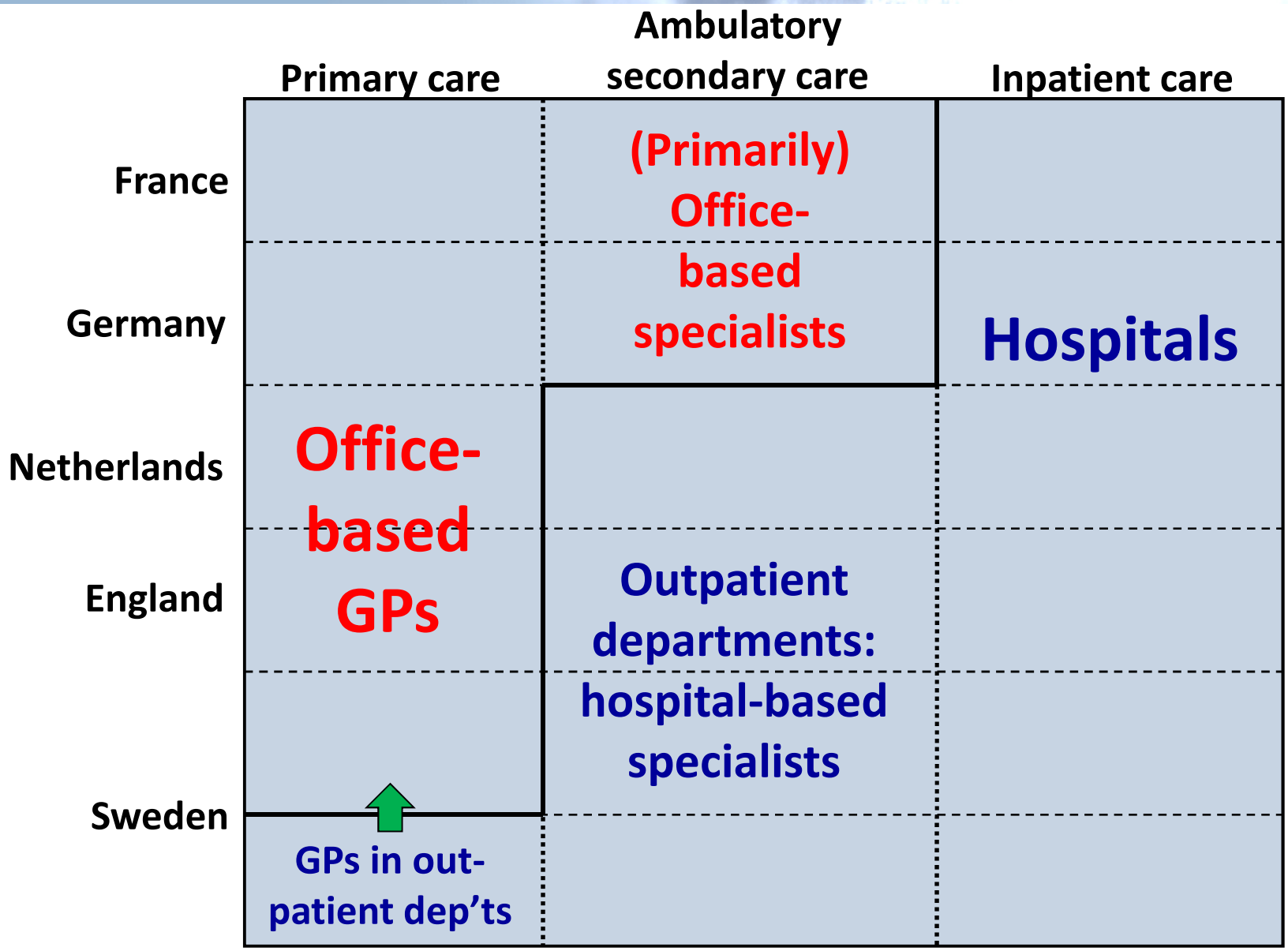
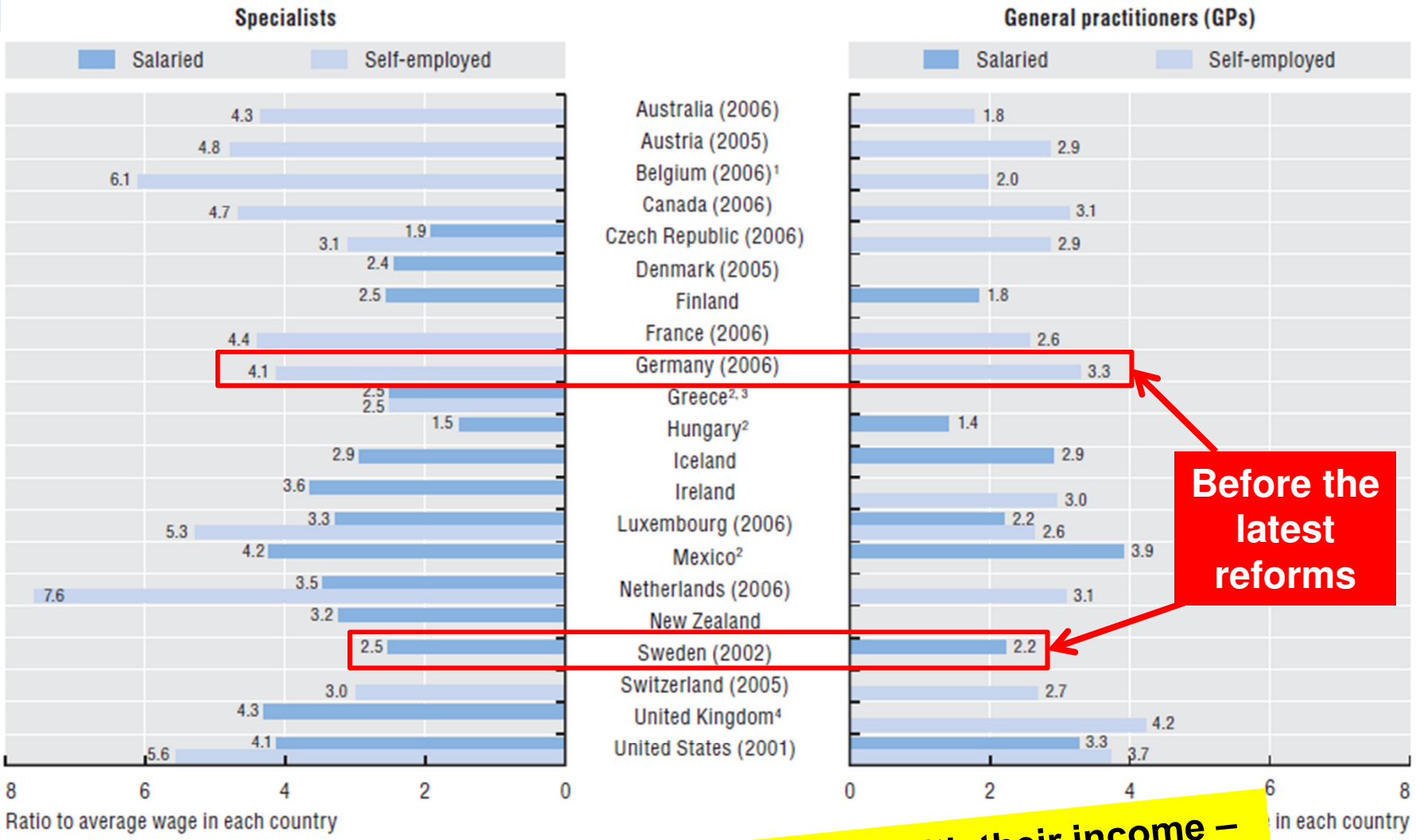


Physician payment and sector of care



3.5.1 Doctors' remuneration, ratio to average wage, 2007 (or latest year available)

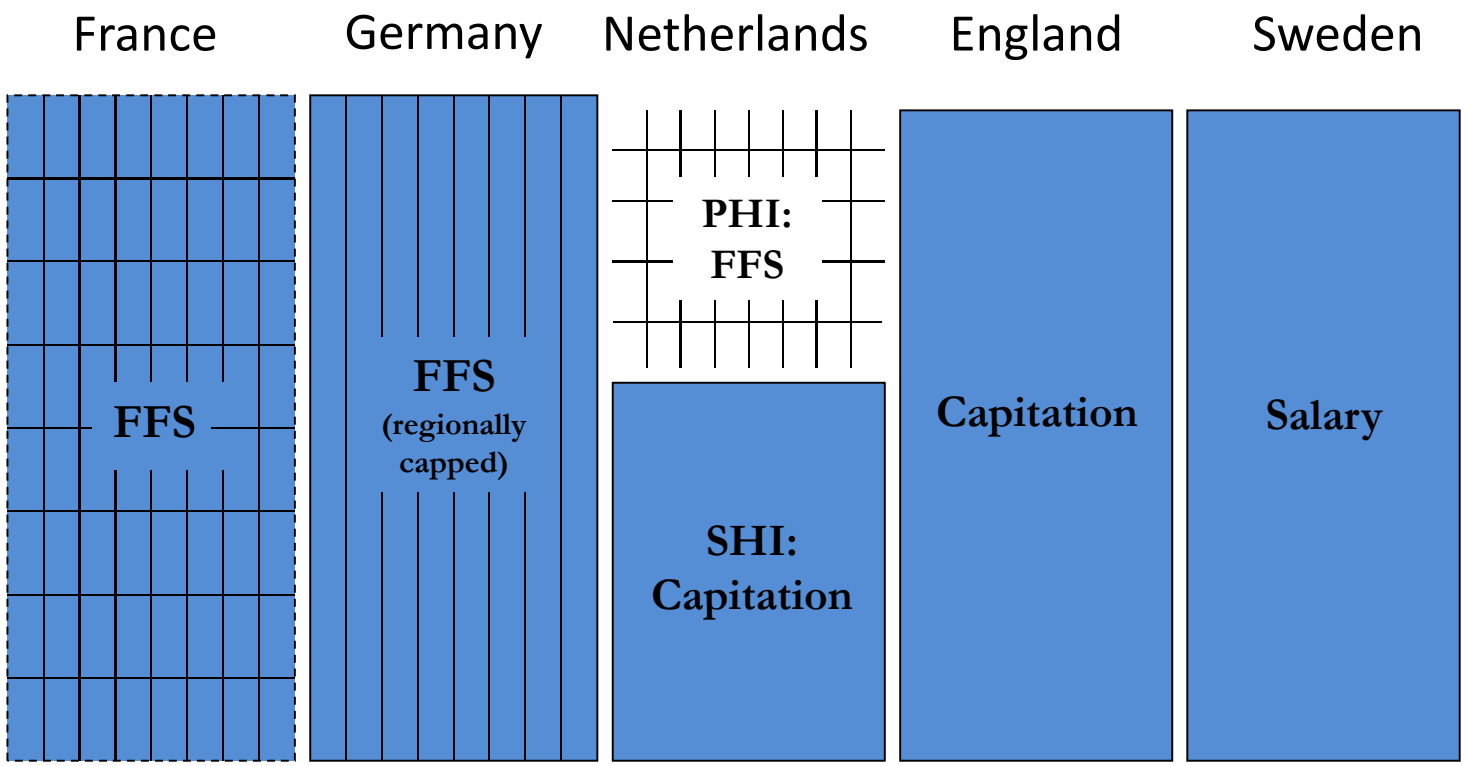


Before the latest reforms

1. Data include practice expenses, resulting in an
2. Data on salaried doct
priva
working in the
3. Remu
self-employed specialists is for 2004.
4. Remu
is for 2006 and the income of salaried specialists is for 2007.

Physicians in all countries are dissatisfied with their income – even the specialists in the Netherlands (7.6 x average income)

Traditional forms of paying GPs (until early 2000s)



- **The apparent answer: "Blended payment" –**
  but maybe you are as confused as I am what it is …

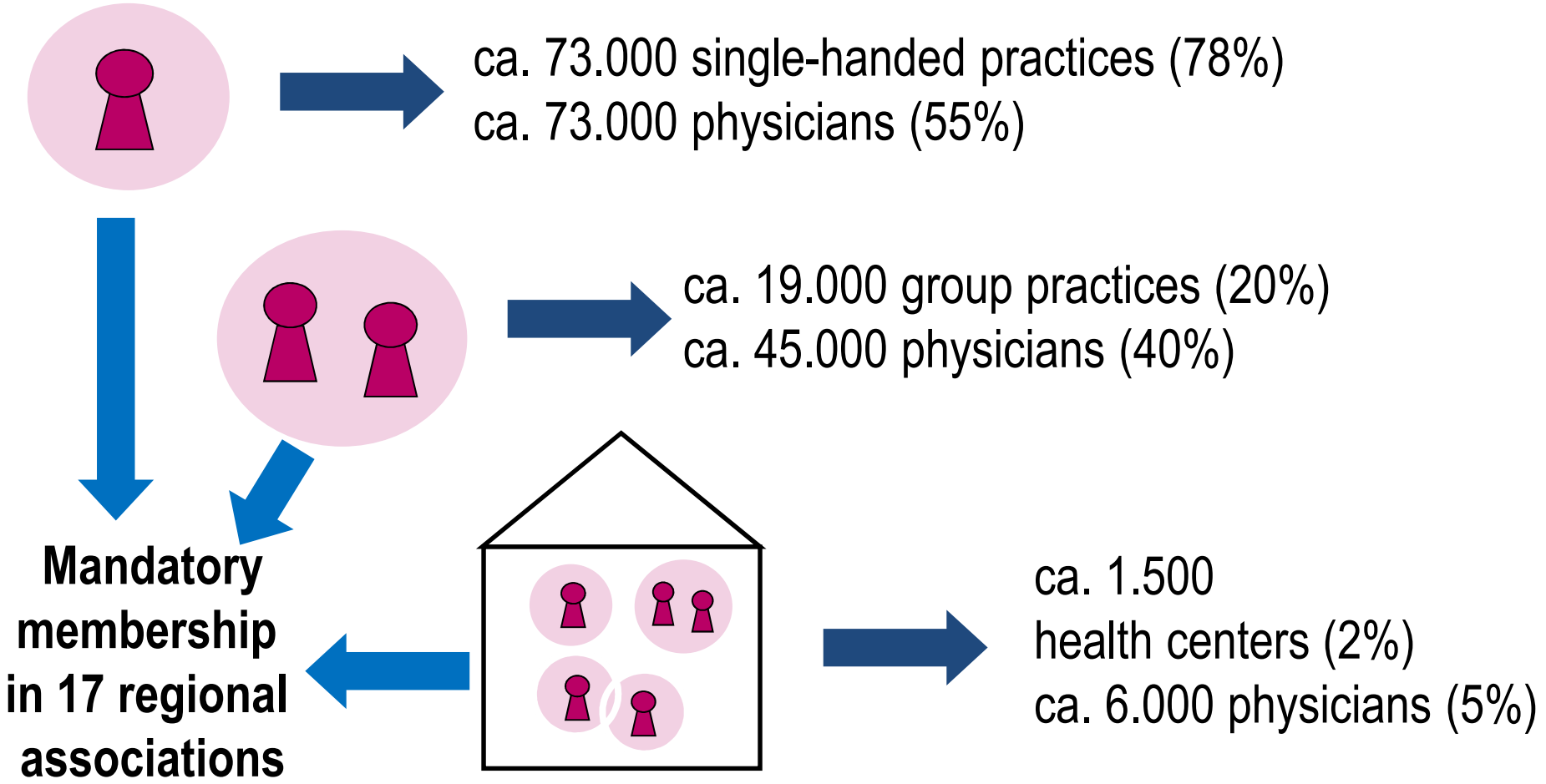
- Basically, I see two variants
  1. using different forms of payment on different levels, e.g. payer → all physicians in one area or in one institution vs. institution → individual physicians
  2. combining different forms of payment on one level

  (and there could be a combination of the two)

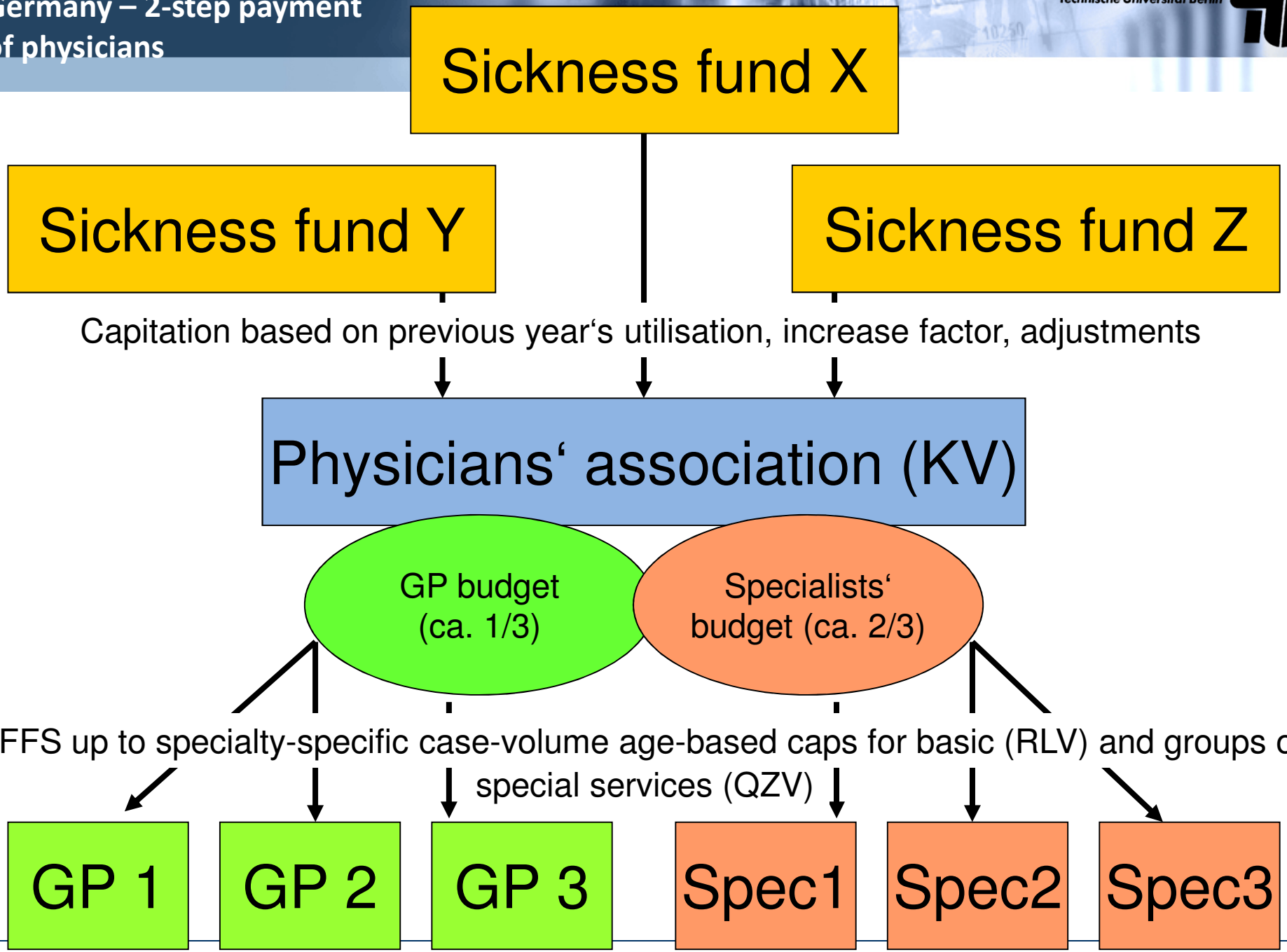
Main reforms in GP payment

- England 2004: new GP contract introduces (1) opt-out or FFS for "enhanced" services and (2) quality bonus for reaching targets ("quality and outcomes framework")
- France: on top of FFS (1) small lump sums for coordinating chronically ill patients (ADL; 2004) and (2) quality bonus for reaching targets or above-average improvement (2009)
- **Germany 2002: GPs are paid small lump sums for activities under disease management programmes; 2009: (1) capitation payments → physicians associations based on actual "need" (actually utilisation) and (2) separation of basic and additional services with separate FFS caps ensuring full FFS payments for services within caps**
- Netherlands 2006: merger of SHI and PHI leads to new GP payment system consisting of capitation plus fee-per-visit
- Sweden 2007: starting in Halland county, a move towards additional private office-based GPs competing with public health centers
  → necessitates money-follows-patient payments

ca. 135.000 physicians, of which 120.000 self-employed



Germany – 2-step payment of physicians



Physician payment (with innovations)

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	England	France	Germany	Netherlands
GPs				
FFS	for enhanced services (if contracted with PCT)	for self-employed GPs	**for self-employed GPs up to case-volume age-based caps (RLV/ QZV)**	Consultation fees
Capitation/ lump sum	per patient for essential services; fixed allowance for costs related to setting up or maintaining practices	Lump sum for management of patients with long-term-diseases (ADL) and involve-ment in provider network	**Lump sum for involvement in Disease Management Programs (DMP)**	per year and registered patient
Quality-related adjustments	QOF; new P4P contracts for GPs	For individual contracts for practice improvement	--	As a pilot model
Salary	GPs working in hospitals, in service of a GP practice or PCT	GPs working in hospitals, in service of a GP or in health centers and preventive and social services	**GPs working in hospitals, in service of a GP or in health care centers**	GPs working in service of a GP practice or in primary care centers
Specialists				
FFS	For work in private practice (i.e., not within NHS)	For self-employed specialists (including specialists practicing in private for profit clinics)	**for self-employed specialists up to case-volume age-based caps (RLV/ QZV)**	75% of specialists (i.e., working independently in hospitals) as part of DBC payment
Capitation	--	--	--	--
Quality-related adjustments	New contracts for specialists; Clinical Excellence Awards	--	--	--
Salary	Physicians working under the NHS contract	Specialists working in hospitals	Specialists working in hospitals	25% of specialists working in hospitals

Physician payment (with innovations) 2
GPs in Swedish counties/regions

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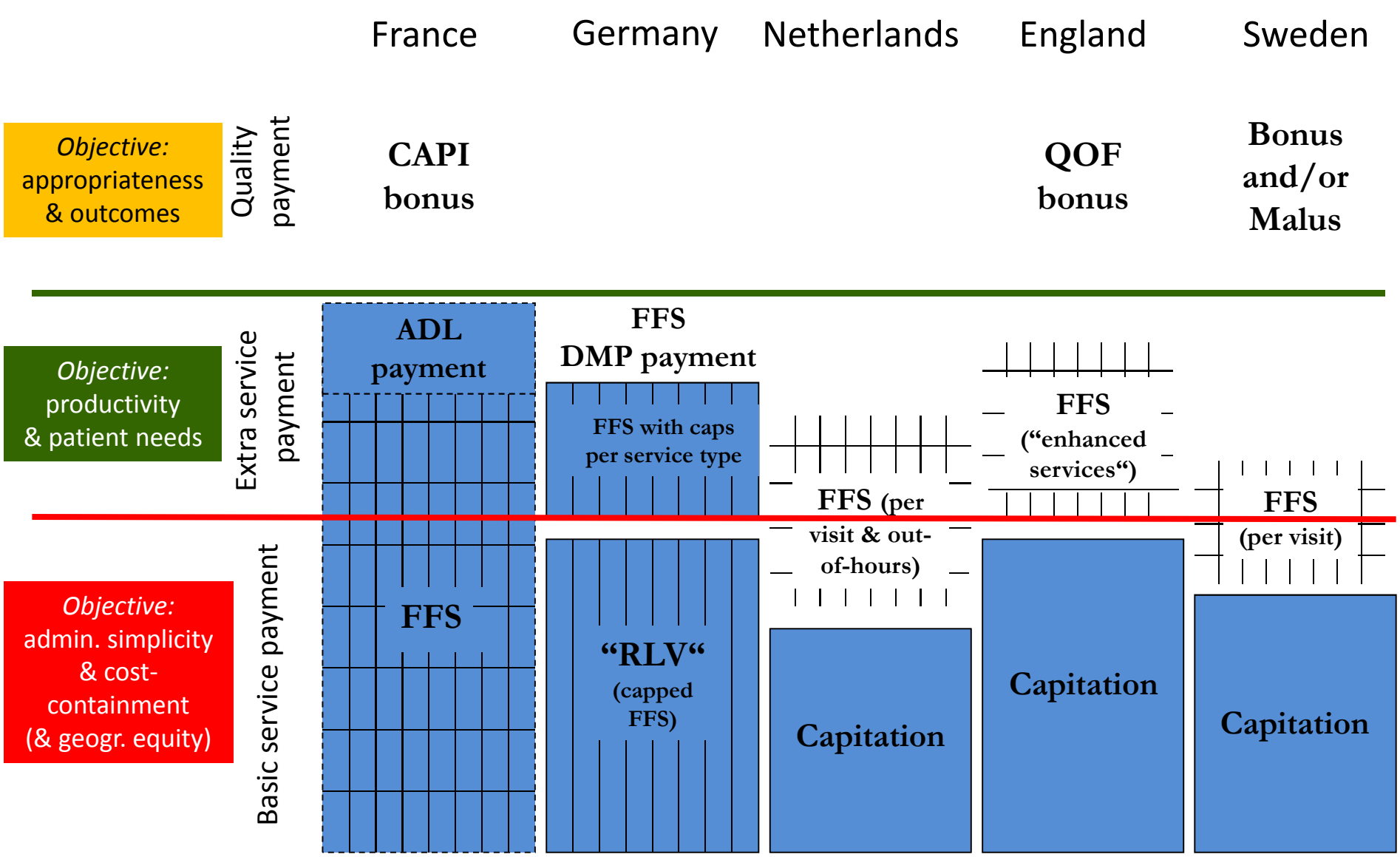
	Halland	Stockholm	Västman-land	Region Skåne	Västra Göta-landsregionen
FFS	Different fee per visit for registered patients and for other patients	Fee per visit for *all* patients (and reduced payments above a volume-ceiling for registered patients)	Different fee per visit for registered patients and for other patients	Fee per visit for not-registered patients	Fee per visit for not - registered patients
Capi-tation	for registered patients based on four age-groups	for registered patients based on three age-groups	for registered patients based on four age-groups	for registered patients based on classification of diagnoses (80%) and socio-economic indicators (20%). Flat fee for drug prescription based on age and sex	for registered patients based on age and sex (50%) and classifica-tion of diagnoses (50%). Possible additional flat fee based on socio-economic indicators & geographical location
Quality-related adjust-ments	Lump-sum penalty payment if non-compliance with drug recom-mendations	Increase or decrease of total payment up to 3% depending on performance, incl. drug recommendations	Bonus payment up to 2% of total payment depending on performance	Bonus payment up to 2% of total payment depending on performance	Bonus payment up to 3% of total payment depending on performance
Salary	GPs working in hospitals, in service of a GP practice or in health care centers				

Payment components in GP care



- England: sex and 7 age bands = 14 categories (1.0 = males 5-14 → 8.9 females 85+) *plus* adjustments for long-term illness and standardised mortality ratio *plus* adjustment for cost (GP, staff, land, buildings)
- Germany: based on actual utilisation in previous year
- Netherlands:
  3 age bands plus deprivation in area = 6 categories
- Sweden: several age bands and/or morbidity factors (plus socio-economic factors)

Conclusions

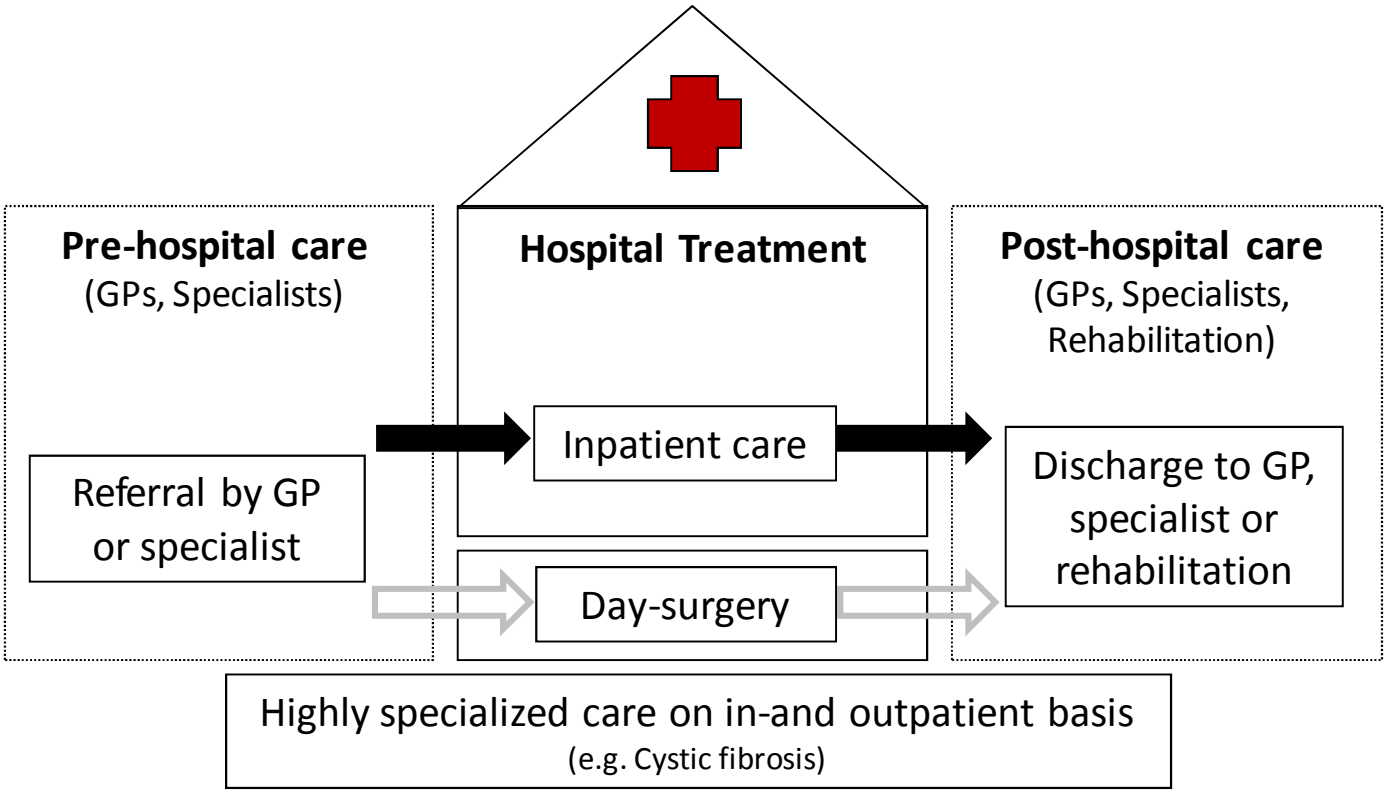
For GP payment, countries are moving toward a "European model" consisting of:

(1) Capitation (inscription)/ capped FFS (visit-triggered) to pay for providing basic services; **60%**

(2) special lump sums for specific patient groups (if capitation is not sufficiently risk-adjusted) + FFS for (potentially) underprovided services and/or requiring special expertise or technology; **20-30%**

(3) quality-related bonus (or malus) for (not) reaching certain targets. **10-20%**

Range of activities and services in hospital sector



Aims of DRG introduction

- Achieving a more appropriate and fair allocation of resources by utilising DRGs instead of per diem charges

- Facilitating a precise and transparent measurement of the case mix and the level of services delivered by hospitals

- Increasing efficiency and quality of service delivery due to the improved documentation of internal processes and increased managerial capacity

- Cost containment based on LOS and bed capacity reduction

Operating costs

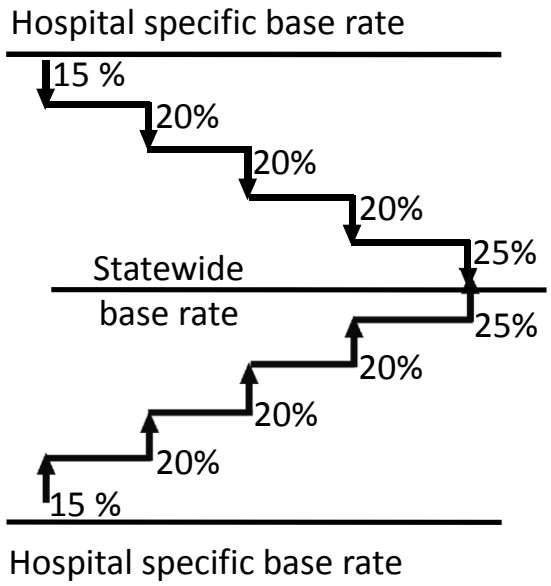
- Sickness funds negotiating activity based DRG budgets every year with every "planned" Hospital

Casemix X Base rate	+	Supplementary fees	=	**Hospital budget**	+	Extra-budgetary payments (e.g. for innovations)

- Budget over-run adjustment (hospital pays back):
  - 65 % (standard DRGs), 25 % (drugs, medical, polytrauma and burns DRGs), Negotiation for hardly predictable DRGs

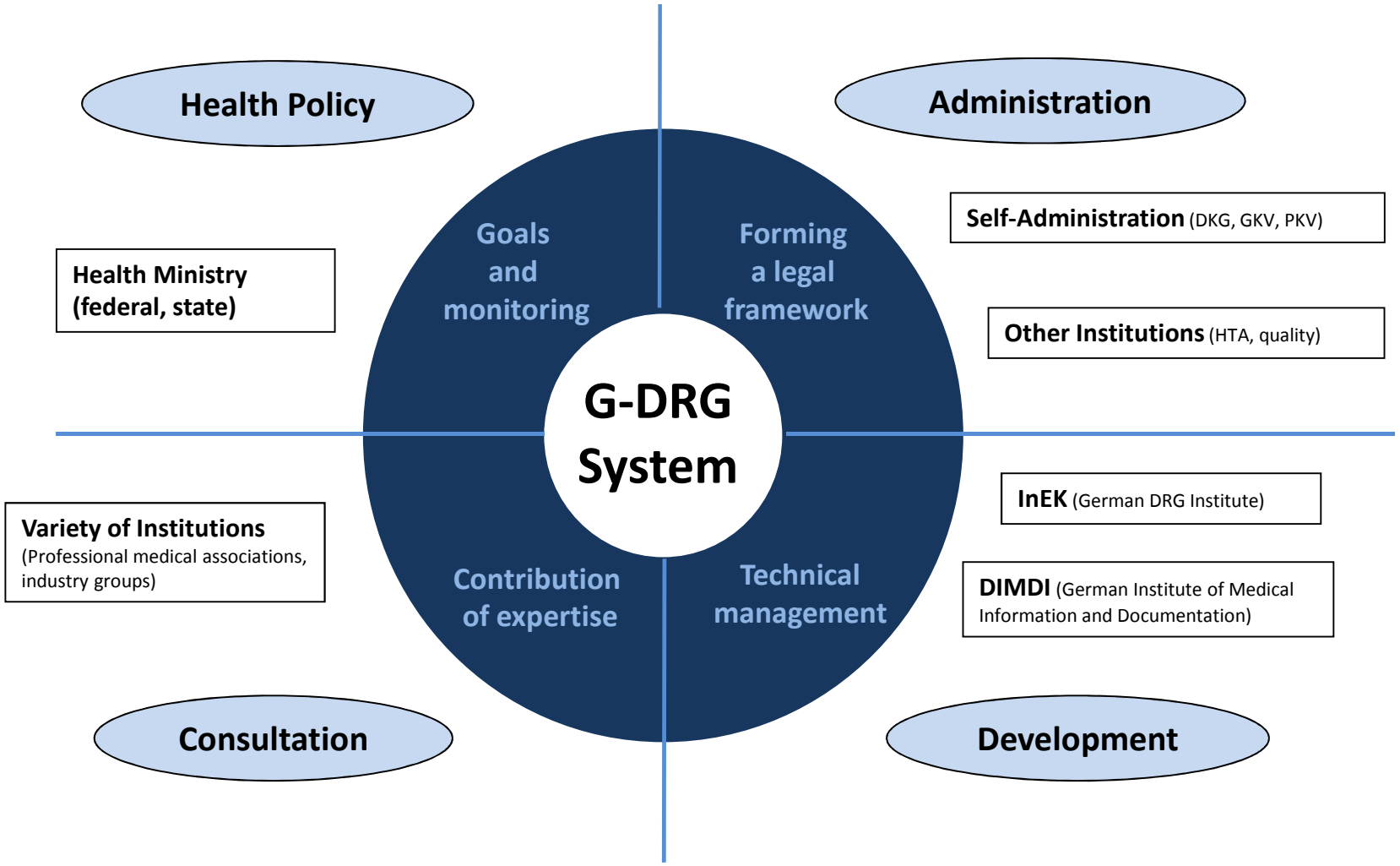
- Budget under-run adjustment (hospital receives compensation) :
  - 20% (standard DRGs)

Ten years of DRGs in Germany

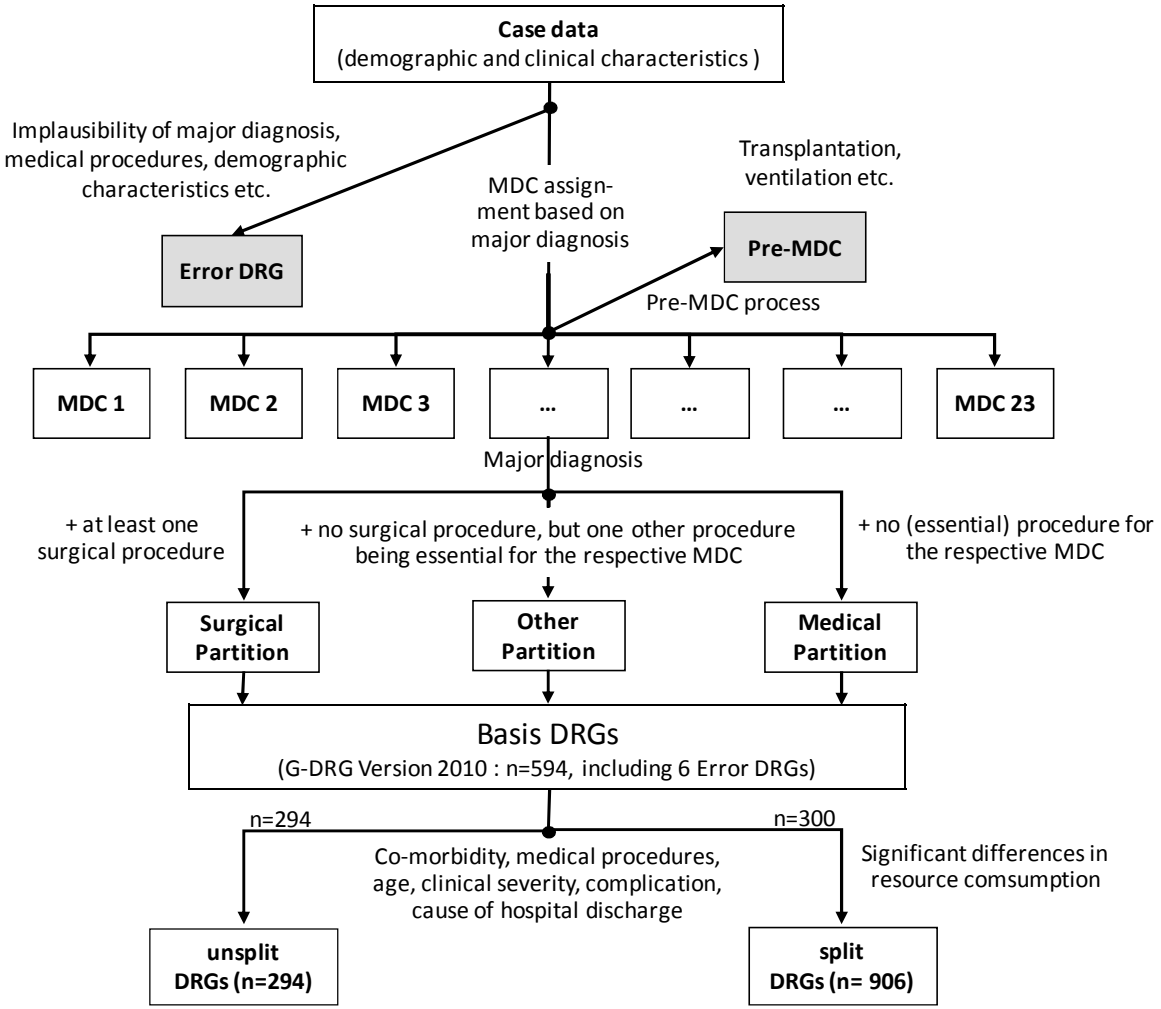
2000-2002	2003 - 2004	2005 - 2009	2010 - 2014
1) Phase of preparation	**2) Budget-neutral phase**	**3) Phase of convergence to state-wide base rates**	**4) Discussion on Policy**
	Historical Budget (2003) ↓ Transformation ↓ DRG-Budget (2004)		• Nationwide base rate • Fixed or maximum prices • Selective or uniform negotiations • Quality Assurance (adjustments) • Budgeting (amount of services) • Dual Financing or Monistic

Ten years of DRGs in Germany

1) Phase of preparation



1) Phase of preparation: Patient classification system



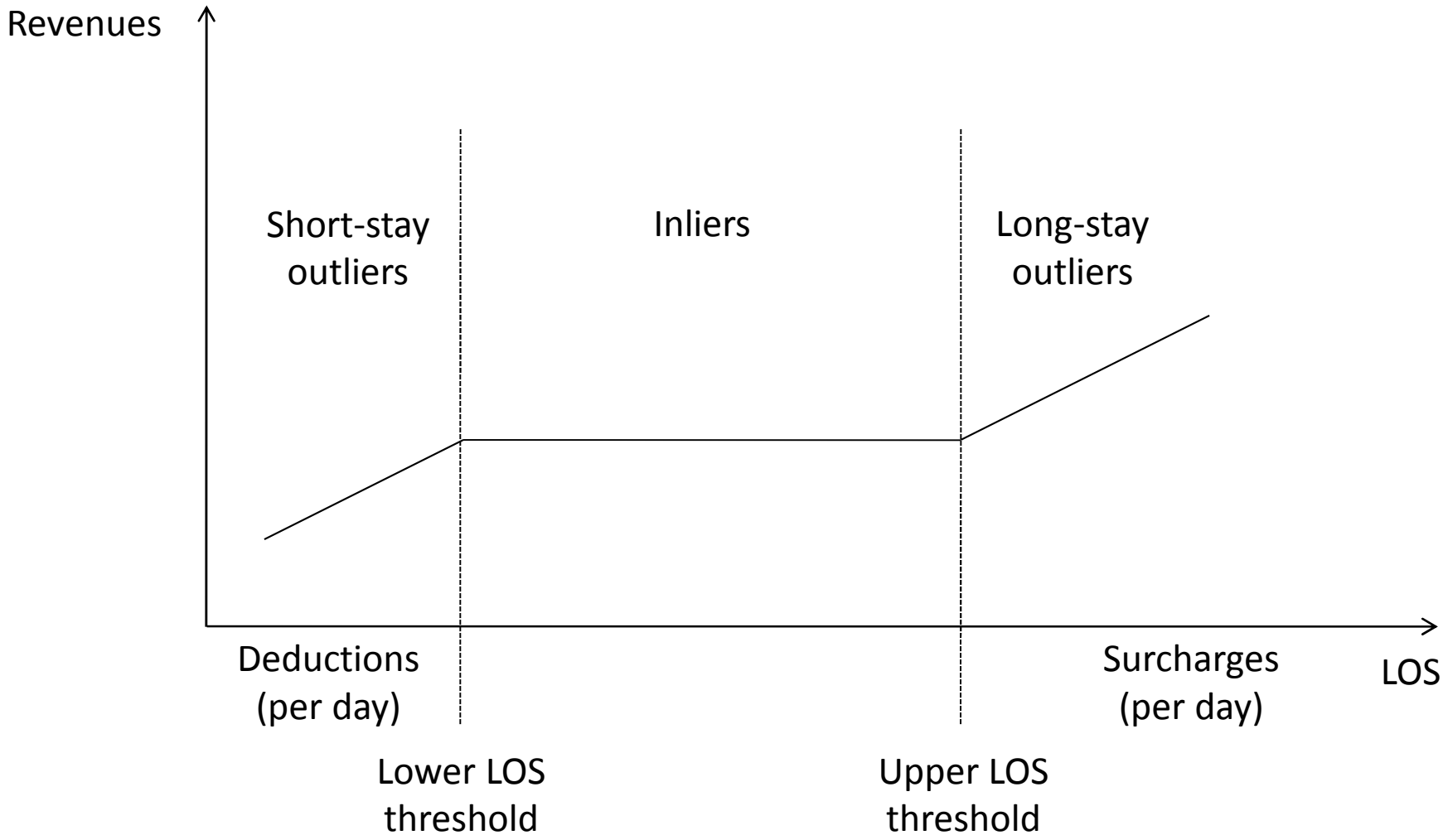
1) Phase of preparation: Price setting mechanism

- Calculation of cost weights: Based on average costs of cases data sample:

Year	2003	2005	2007	2009	2010
Hospitals participating in cost data collection	**125**	**148**	**263**	**251**	**253**
- excluded for data quality	9	0	38	33	28
- actual	116	148	225	218	225
- included university hospitals	0	10	10	10	10
- number of cases available for calculation	633,577	2,909,784	4,239,365	4,377,021	4,539,763
- number of cases used for calculation after data checks	494,325	2,283,874	2,863,115	3,075,378	3,257,497

- Cost weight of each DRG = Average costs of DRG inliers/Reference value
- Cost weight = 1 = average costs of all patients in Germany

1) Phase of preparation: Reimbursement rate and outliers



Ten years of DRGs in Germany

2000-2002	2003 - 2004	2005 - 2009	2010 - 2014
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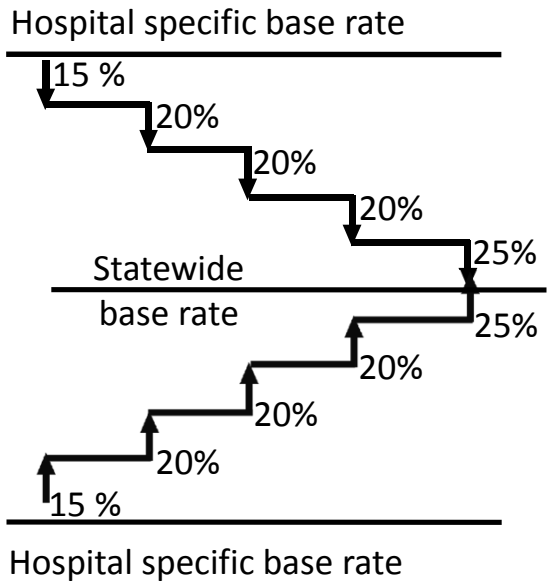
	Historical Budget (2003) ↓ Transformation ↓ DRG-Budget (2004)		• Nationwide base rate • Fixed or maximum prices • Selective or uniform negotiations • Quality Assurance (adjustments) • Budgeting (amount of services) • Dual Financing or Monistic

2) Budget-neutral phase

100 Million Euros

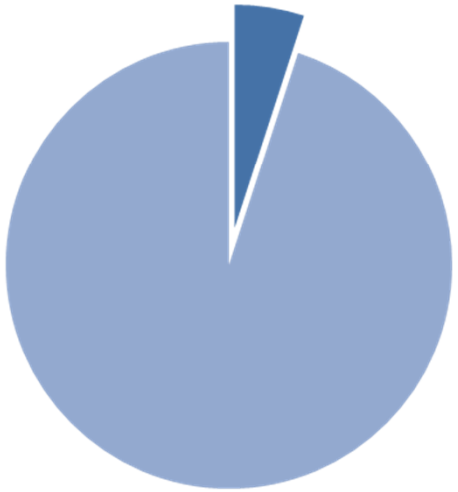
Unit of reimbursement changed:

From:

2002 → Reimbursement unit = **per diem**

To:

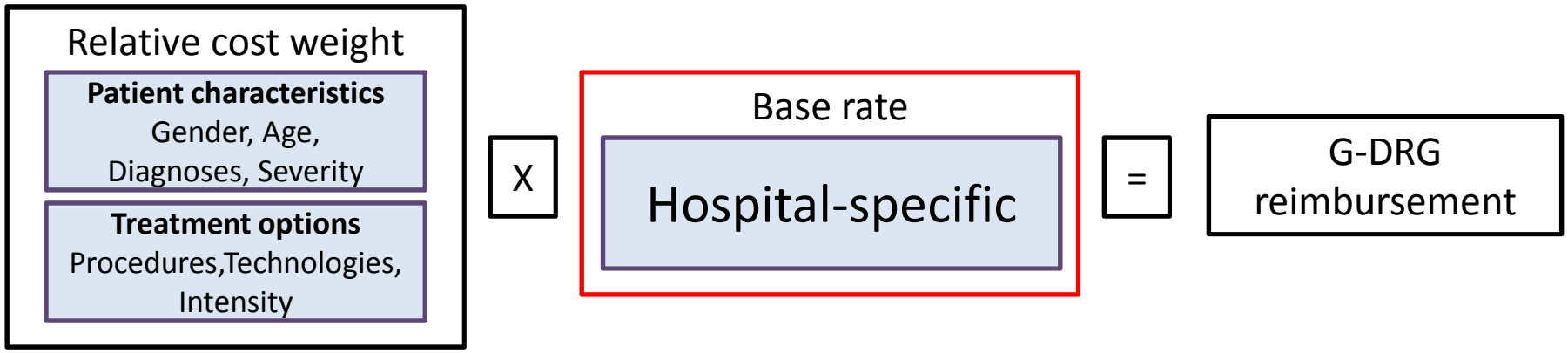
2004 → Reimbursement unit = **case (DRG)**



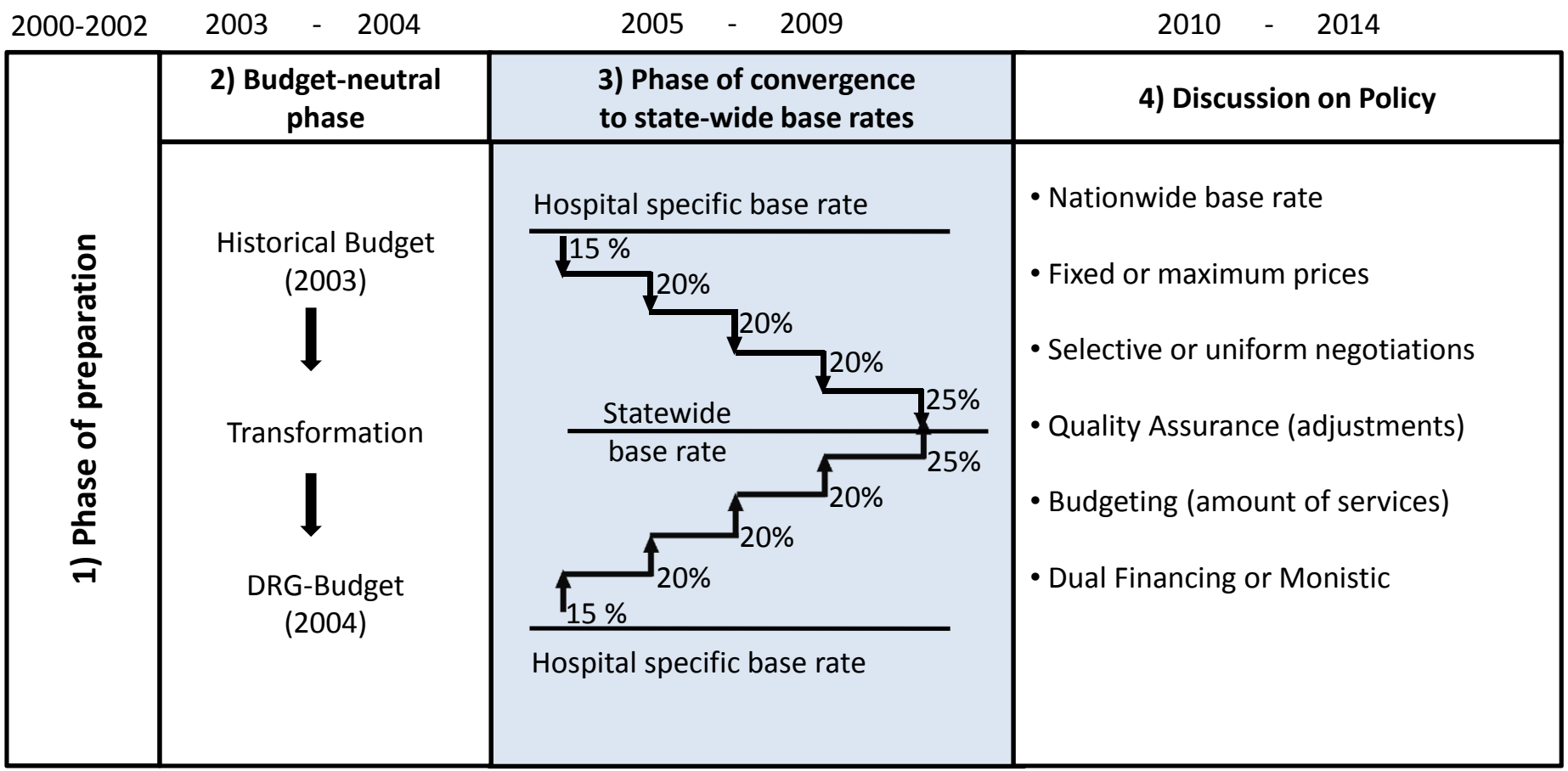
Budget-neutral phase

Lead to a hospital specific base rate (historical Budget /Casemix)

Ex.: € 100 mn. Budget / 33 000 CM points = € 3030 Hospital specific base rate

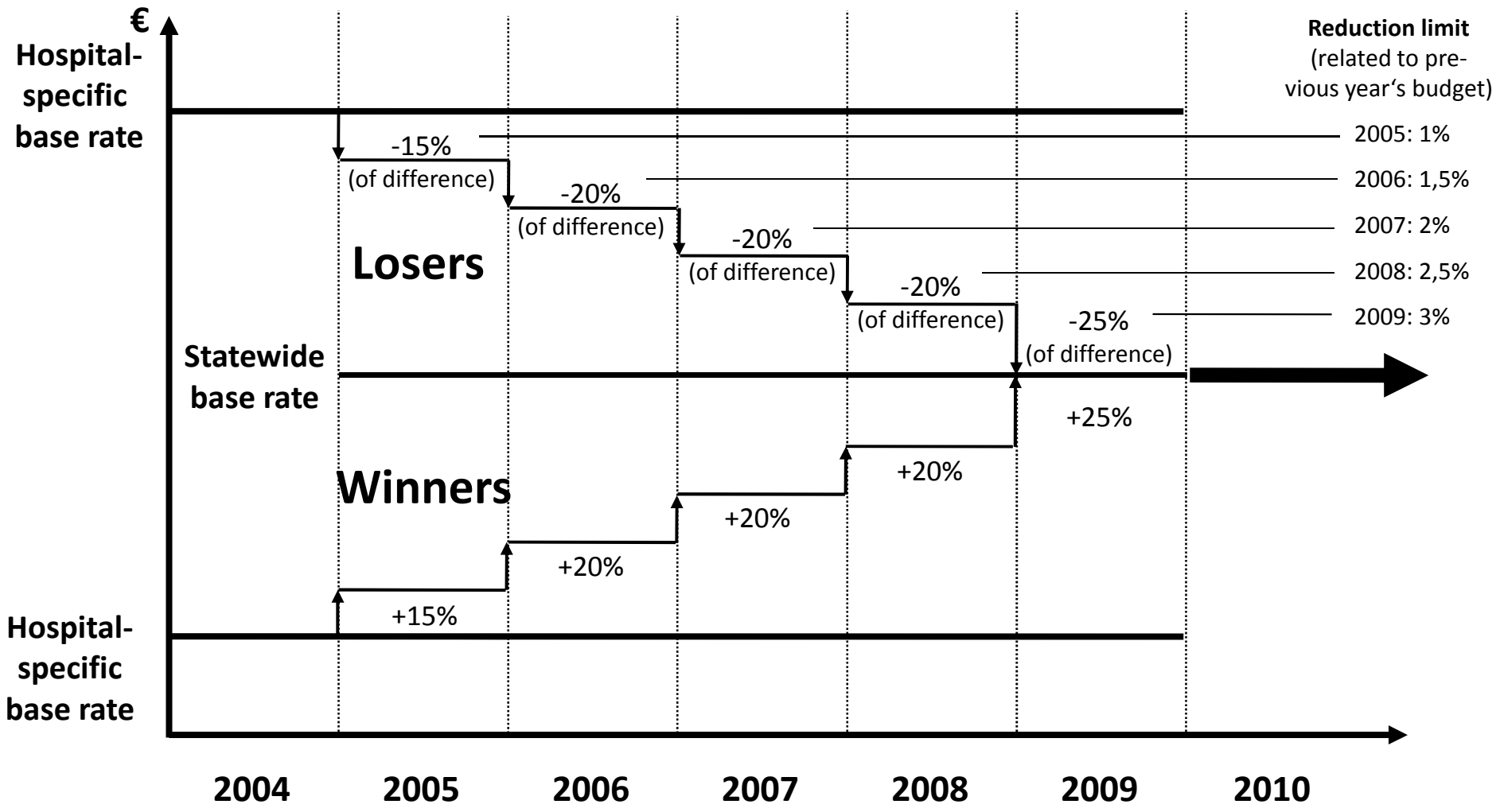


Ten years of DRGs in Germany



Ten years of DRGs in Germany

Phase of convergence

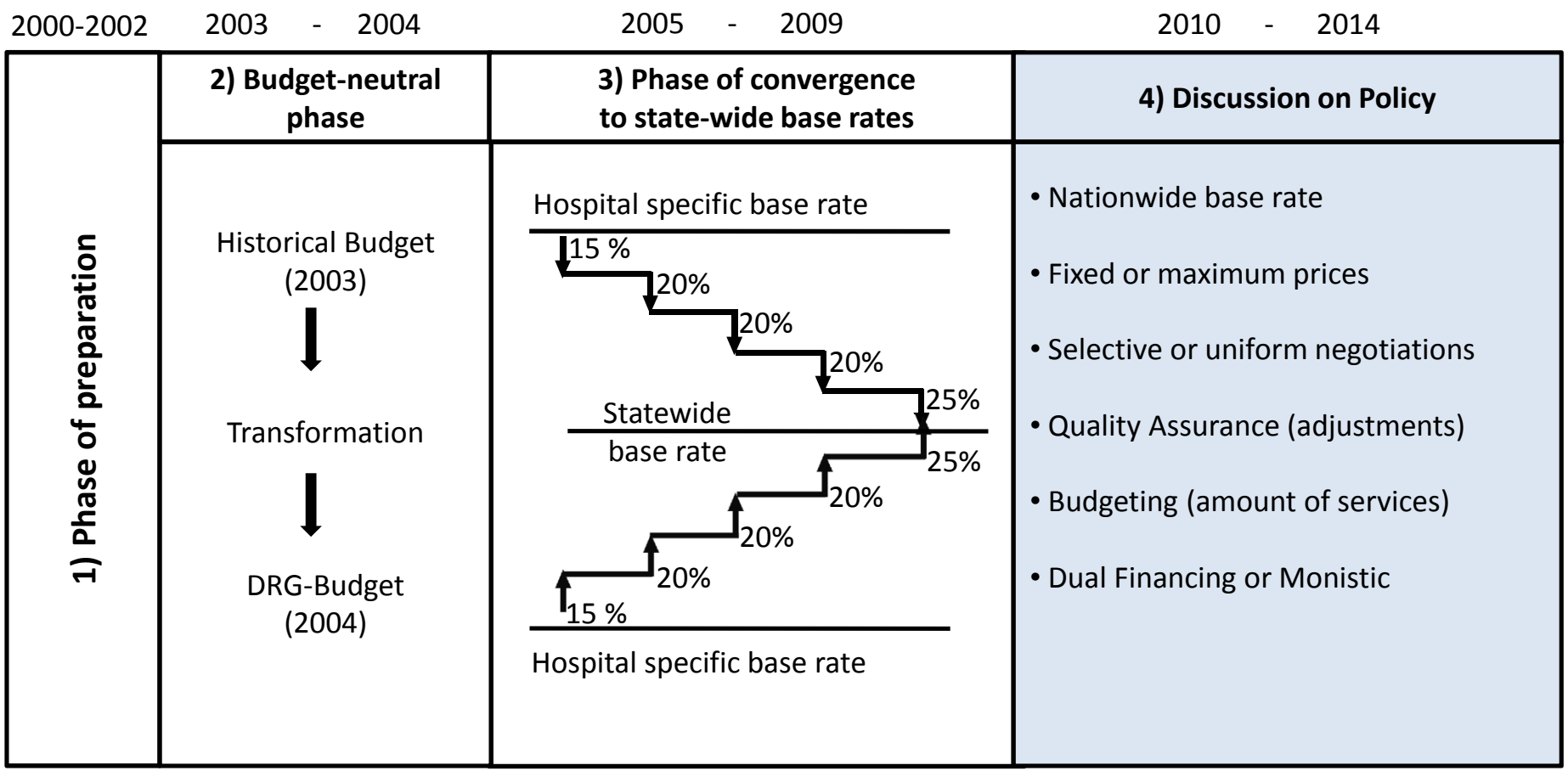


Phase of convergence: Changing cost weights

- Increased precision due to more cost weights
- Treatment costs were better reflected over time

Year	2003	2005	2007	2009	2010
DRGs total	664	878	1082	1192	1200
Inpatient DRGs total	664	878	1077	1187	1195
Range of cost weights: min.-max.(rounded)	0.12 - 29.71	0.12 - 57.63	0.11 - 64.90	0.12 - 78.47	0.13 - 73.76
Day care DRGs total	0	0	5	5	5
Supplementary fees	0	71	105	127	143

Ten years of DRGs in Germany



Main facts

- Central role of self-governing bodies

- Data driven system with annual updates

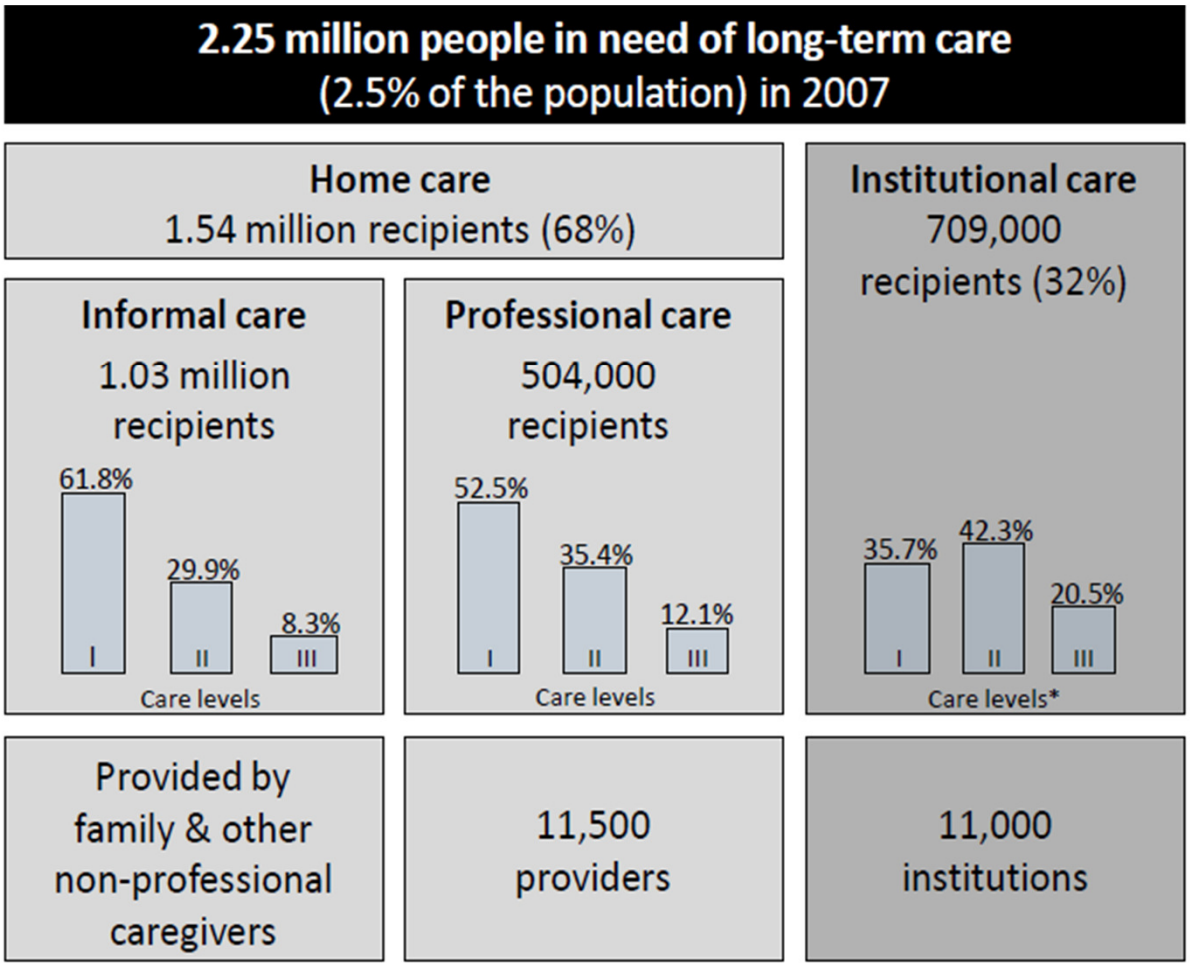
- Detailed analysis of hospital costs

- Ten-year process of introduction

Strengths and weaknesses of the G-DRG system

Strengths	Weaknesses
Transparency and documentation	No quality adjustments for reimbursement
Compliance of hospitals	No reflection of different input prices
Reimbursement tool	Uniform accounting system but no full sample of hospitals
Precision	Increasing complexity with number of DRGs

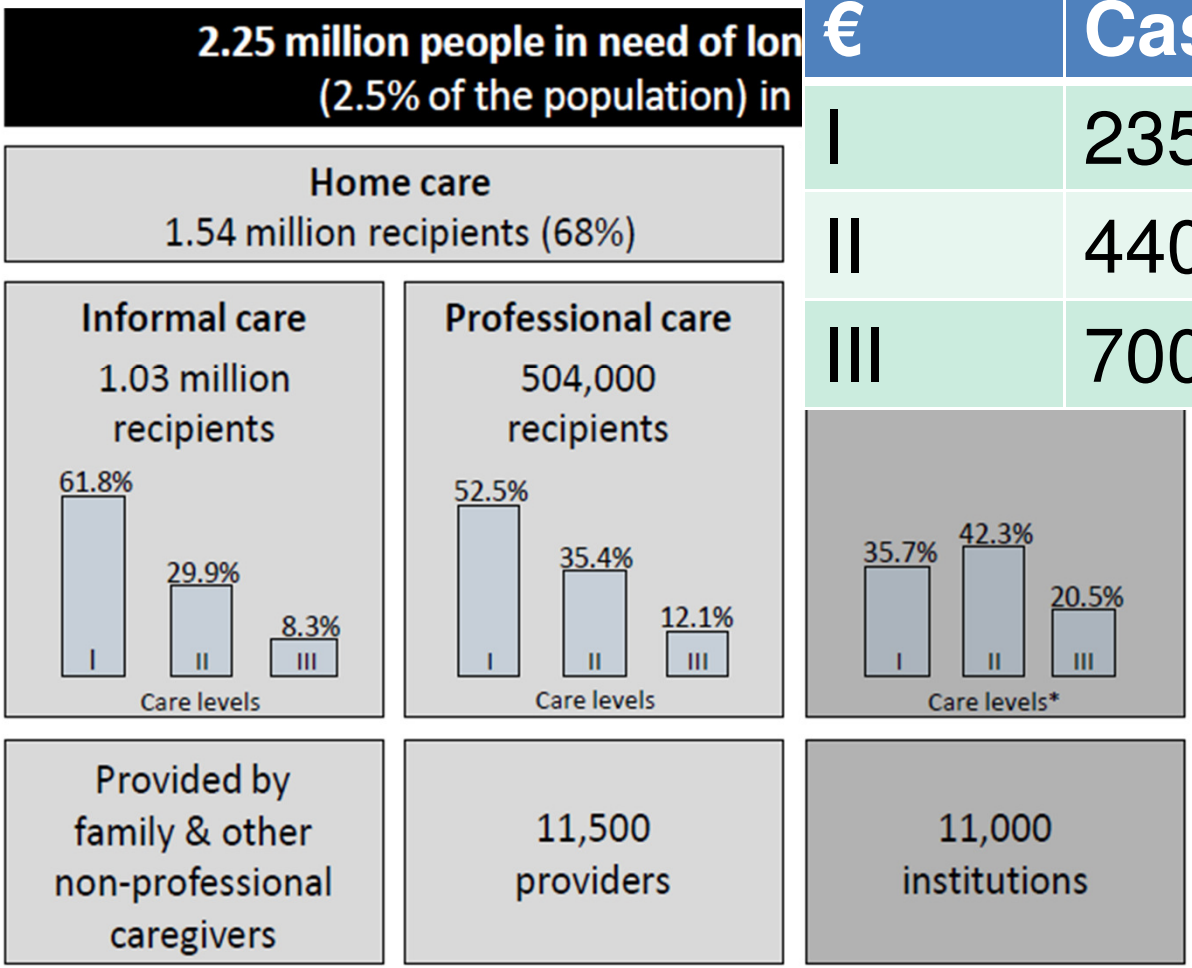
Burden of disability and dependency



*1.5% not assigned

Source: Adapted from German Federal Statistical Office 2008b

Burden of disability and dependency



€	Cash	Home	Inst
I	235	450	1023
II	440	1100	1279
III	700	1550	1550

*1.5% not assigned

Source: Adapted from German Federal Statistical Office 2008b

European Observatory on Health Systems and Policies

Observatory Venice Summer School 2011

The Ageing Crisis: A Health Systems Response

San Servolo, Venice, 24–30 July 2011

www.observatorysummerschool.org

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Background

The Ageing Crisis: A Health Systems Response

The Objectives: To bring together high and mid level policy-makers in a stimulating environment to focus on ageing and what it means for health systems. Summer School draws on the latest evidence; a team of experts; the experiences of participants in practice; and a tradition of promoting evidence-based policy-making and fostering European health policy debate. It aims to raise key issues, share learning and insights and build lasting networks.

Approach: The six day course combines a core of formal teaching with a highly participative approach involving participant presentations, round tables, panel discussions and group work. There will be opportunities for participants to develop a concrete case study that cuts across themes and to engage in political dialogue at the opening session.

Accreditation: Summer School is accredited by the European Accreditation Council for Continuing Medical Education and participation counts towards ongoing professional development in all EU Member States.

Organization: Summer School is organized by the European Observatory on Health Systems and Policies and the Veneto Region of Italy, one of its partners.

Recent Summer Schools: have focussed on Recent Summer Schools have focused on Human Resources for Health (2007), Hospital Re-engineering (2008) and Health Technology Assessment (2009), EU Integration and Health Systems (2010).

Presentation available at:

www.mig.tu-berlin.de

Visit also:

www.healthobservatory.eu