Global trends in social health insurance systems

Strategies for advancing equity and sustainability: Germany's experience

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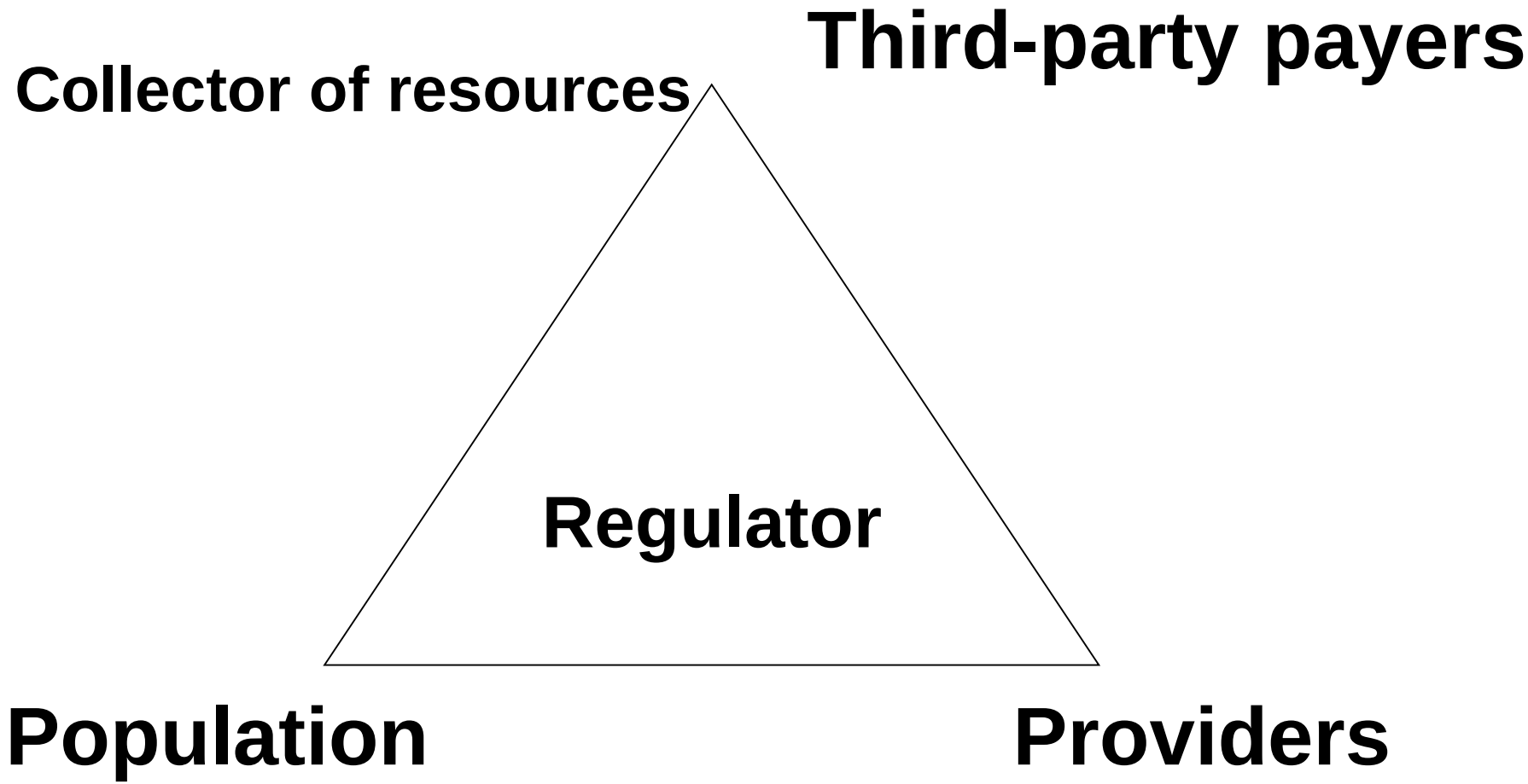
How we look at health systems



The German system at a glance (red SHI, blue PHI, purple both)

"Risk-structure compensation"

Collector of resources

Central reallocation pool

Uniform (set by law) + additional (set by sickness fund) wage-related contribution rate

Risk-related premium

Choice of fund/ insurer

Third-party payers

ca. 100 sickness funds

ca. 40 private insurers

Contracts, mostly collective

No contracts

Strong delegation

(Federal Joint Committee) & limited governmental control

Population

Universal coverage:

Statutory Health Insurance 88%,

Private HI 11%

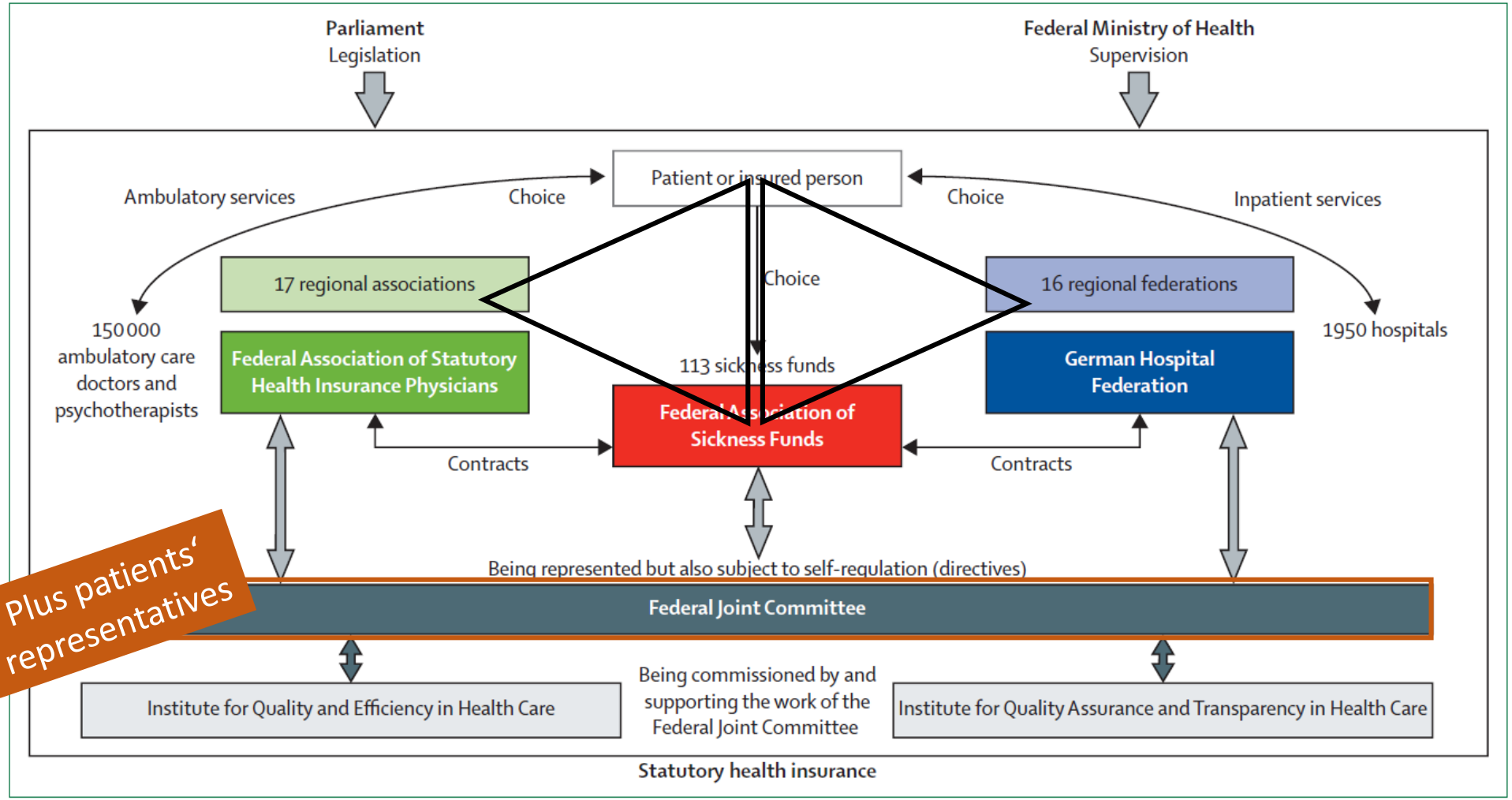
Choice →

Providers

Public-private mix,

organised in associations ambulatory care/ hospitals

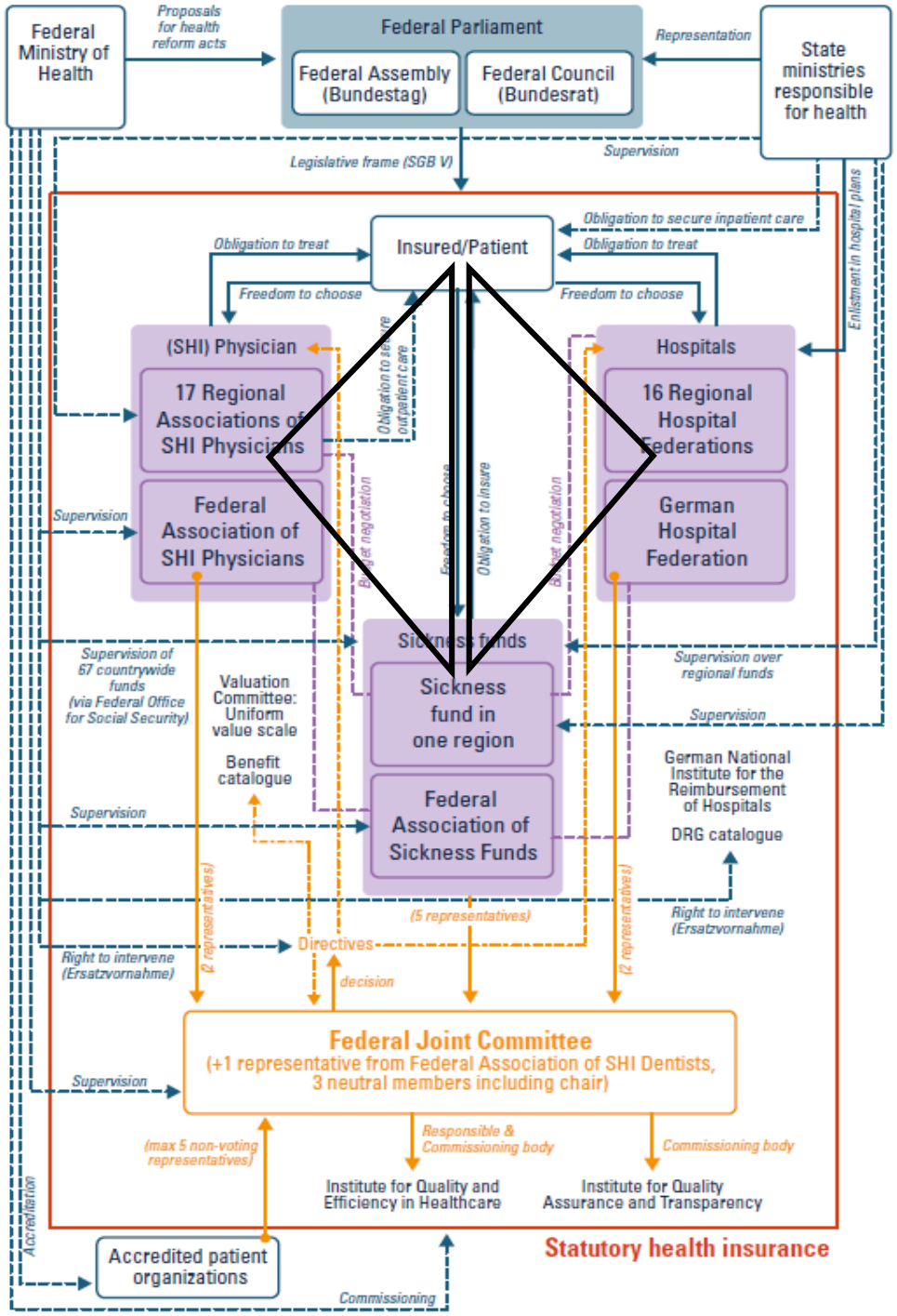
Self-governance and competition in SHI (among providers and payers): the central role of the cross-sectoral Federal Joint Committee



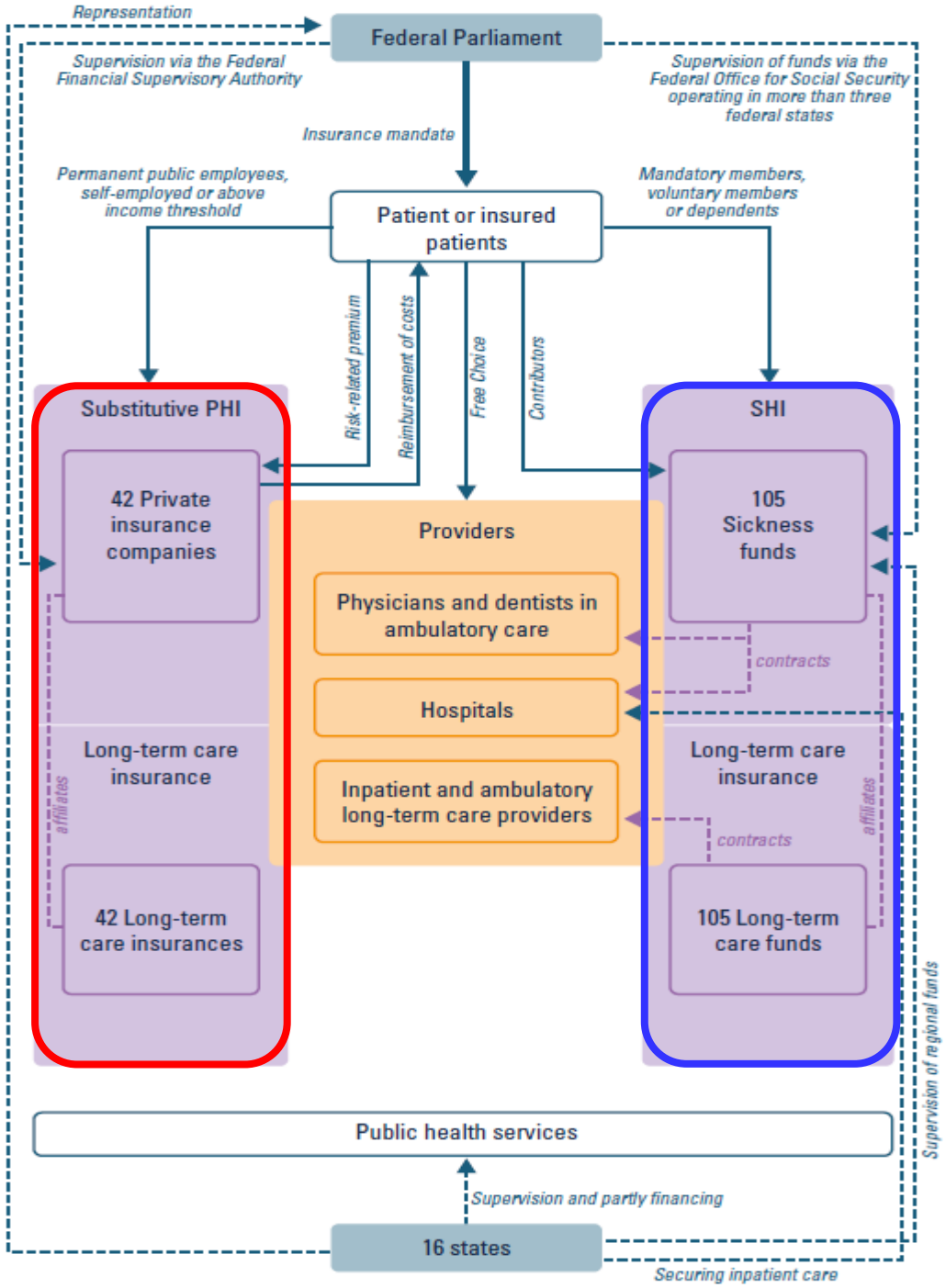
Objectives of Federal Joint Committee

- 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 access 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

The SHI system in more detail



SHI and PHI patients use the same providers – and there are separate long-term care systems on both sides



1871–1918 GERMAN EMPIRE AND FIRST WORLD WAR	**EXTENSION OF POPULATION AND BENEFIT COVERAGE**	
	1881:	Kaiser Wilhelm I's Royal Proclamation on Social Policy
	1883:	Establishment of SHI by Bismarck's Health Insurance Act, covering initially 10% of population
	1911:	Health, pension and accident insurance became integrated into the Imperial Insurance Code (in force from 1914)
	1913:	Berlin Convention on Ambulatory Care, the first step towards joint self-governance in SHI system
	1913:	35% of population are covered by SHI **30 years**
1919–1933 WEIMAR REPUBLIC	**STRENGTHENING OF MEDICAL PROFESSION**	
	1923:	Imperial Committee of Physicians and Sickness Funds
	1925:	Majority of population (51%) is covered by SHI **40 years**
	1931–1933:	Special presidential directives on ambulatory care; create Regional Associations of SHI Physicians and a "total payment" for ambulatory care
1933–1945 NAZI REGIME AND SECOND WORLD WAR	**FUNDAMENTAL STRUCTURES OF SHI REMAINED, *BUT***	
	1933:	Withdrawal of self-administration and exclusion of socialist and Jewish workers from the committees of the sickness funds
	1933–1938:	Work prohibition for Jewish physicians; denied access to health care for Jews and other minorities
	1934:	Regional Associations of SHI Physicians are merged into one National Association of SHI Physicians
	1934–1935:	Redefining organizational framework along the rules of Nazi-dictatorship: centralization of sickness funds, welfare organizations, and community health services by the Nazi Party
	1941:	SHI coverage for retired persons **60 years**

1972 farmers / 1975: disabled persons & students **90 years**

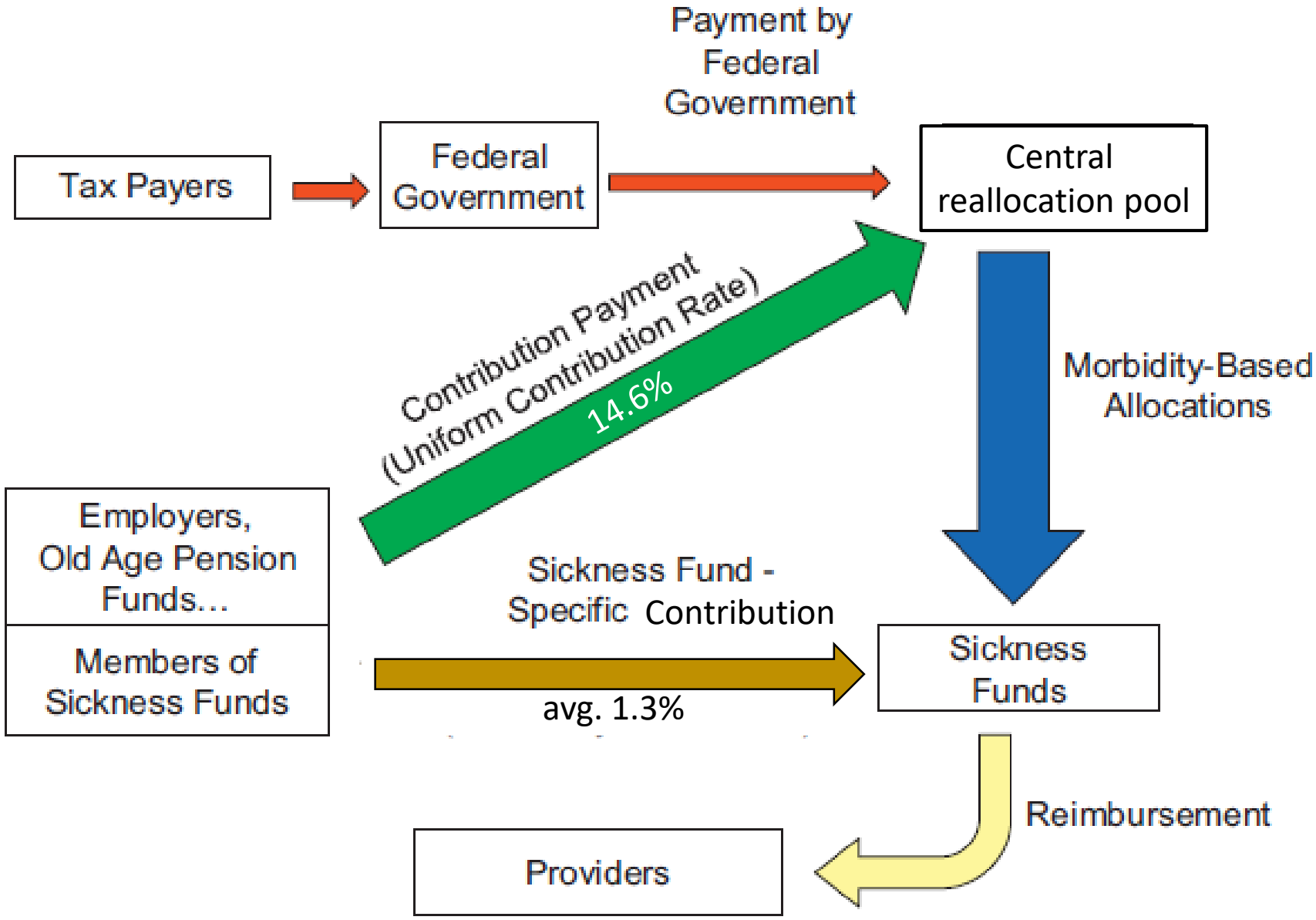
1981 artists **100 years**

Germany's SHI is oldest in the world but expansion of population coverage was slow

Over the last 30 years, the SHI system has changed a lot (more than in the 110 first years)

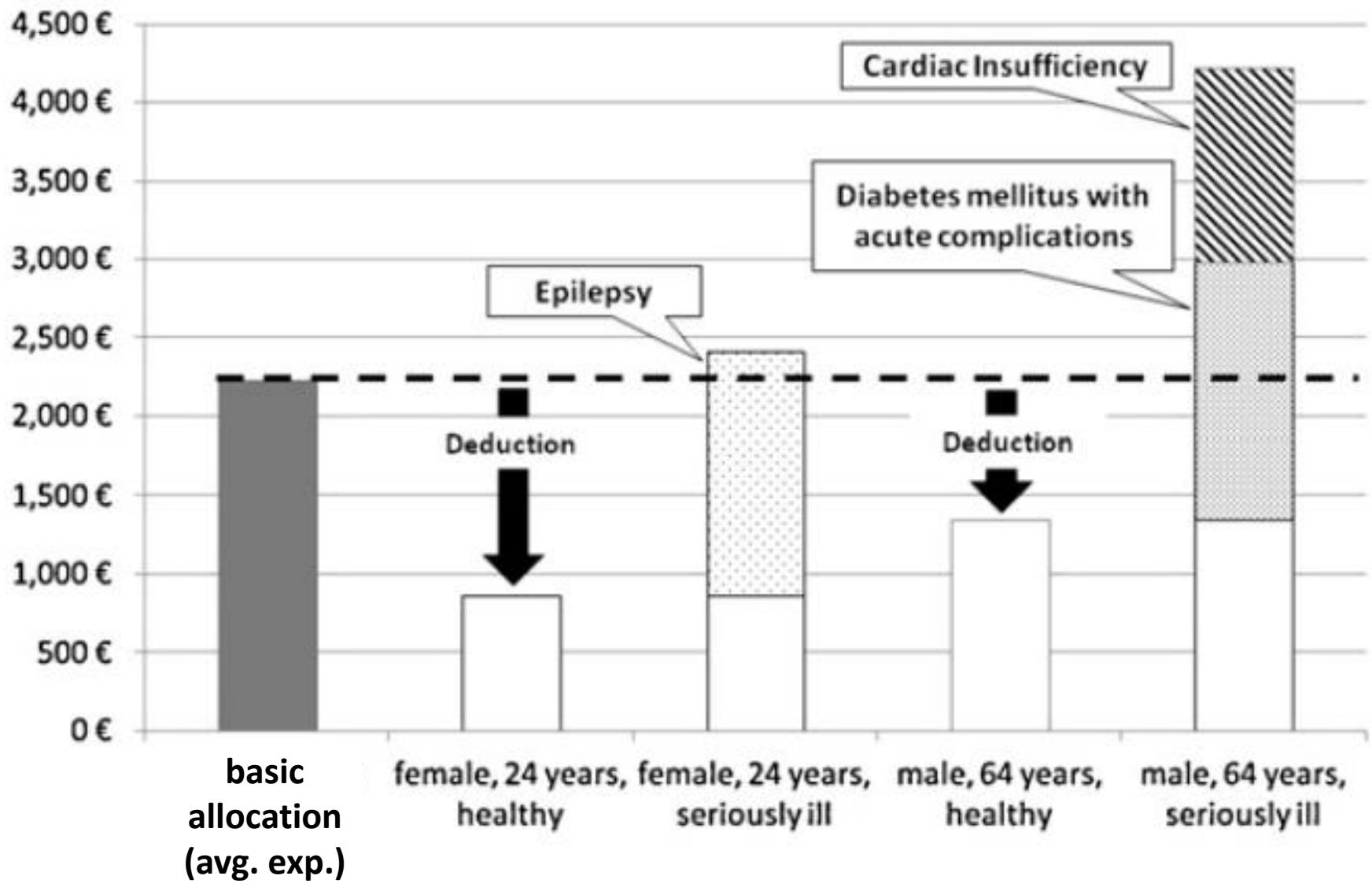
	Population coverage	Choice of fund	Responsibility for contribution rate	Re-allocation mechanism among sickness funds
-1993	Defined groups	Mostly pre-assigned membership	Sickness funds individually	Joint expenditure for pensioners; otherwise unpooled
1994				Cell-based re-allocation formula based on age and sex
1996		Free choice among funds		
2001				+ participation in disease management program
2007	Universal Health Coverage **125 years**			
2009			Government (+ sickness funds for additi-onal income-independent premium)	Central Reallocation Pool; formula based on age, sex & surcharges for 80 diseases
2011			By law (+ sickness funds for additional income-independent premium)	
2015			By law (+ sickness funds for additional income-dependent contribution rate)	
2021-				Extended to all diseases + regional factors

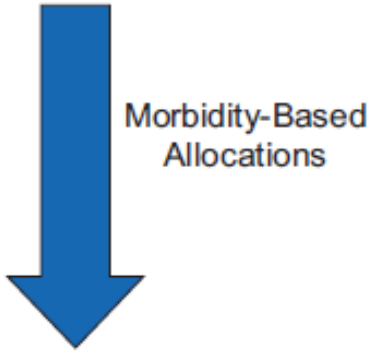
Financial flows (as of today)



Morbidity-Based Allocations

Calculated by regression analysis; how much of expenditure is due to particular disease (2009-2019: 80; since 2020: all); model uses >1000 DxG, which are sorted into “hierarchies” (within each hierarchy, only the most severe DxG per insured is used), resulting in 500 different surcharges





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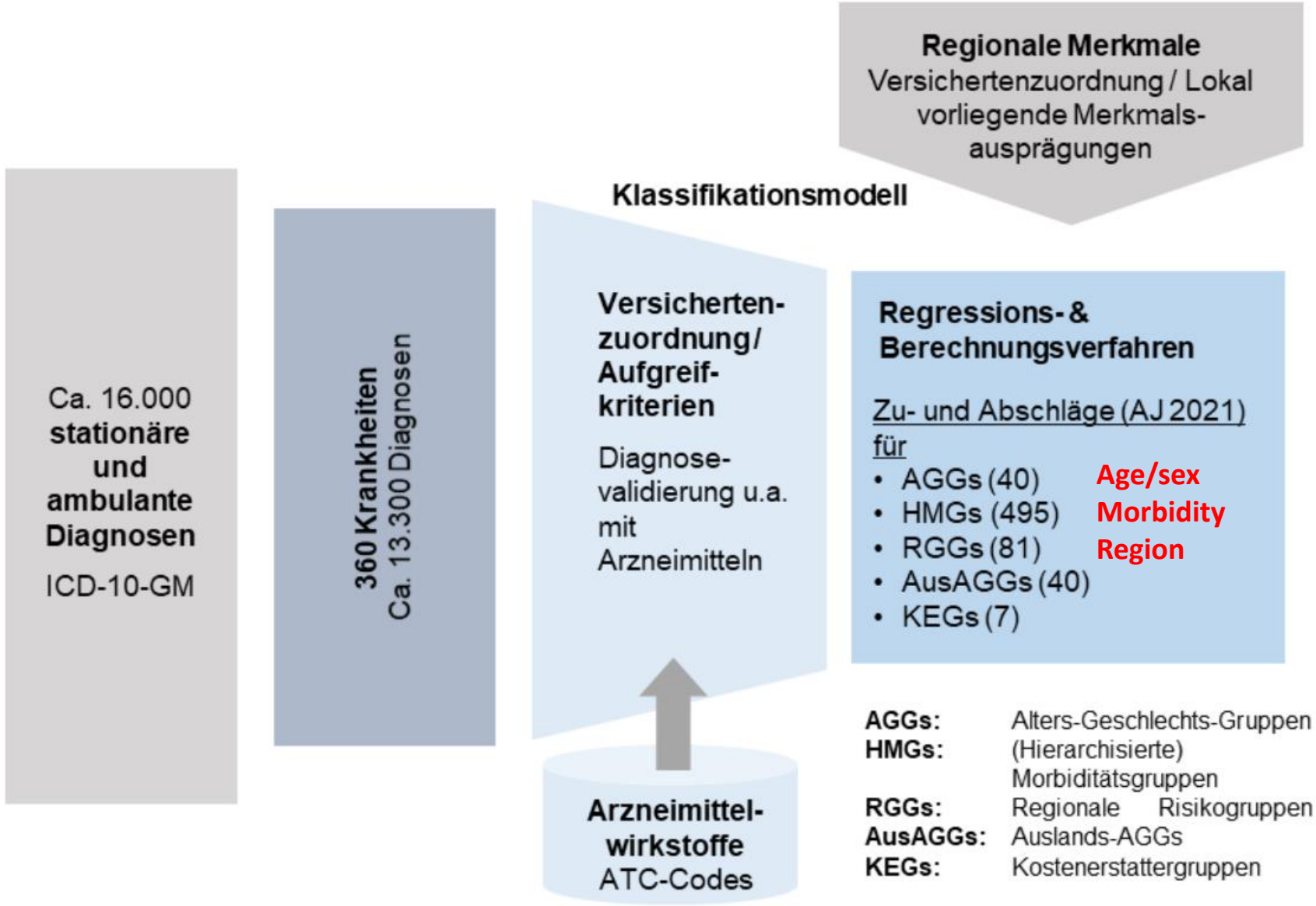
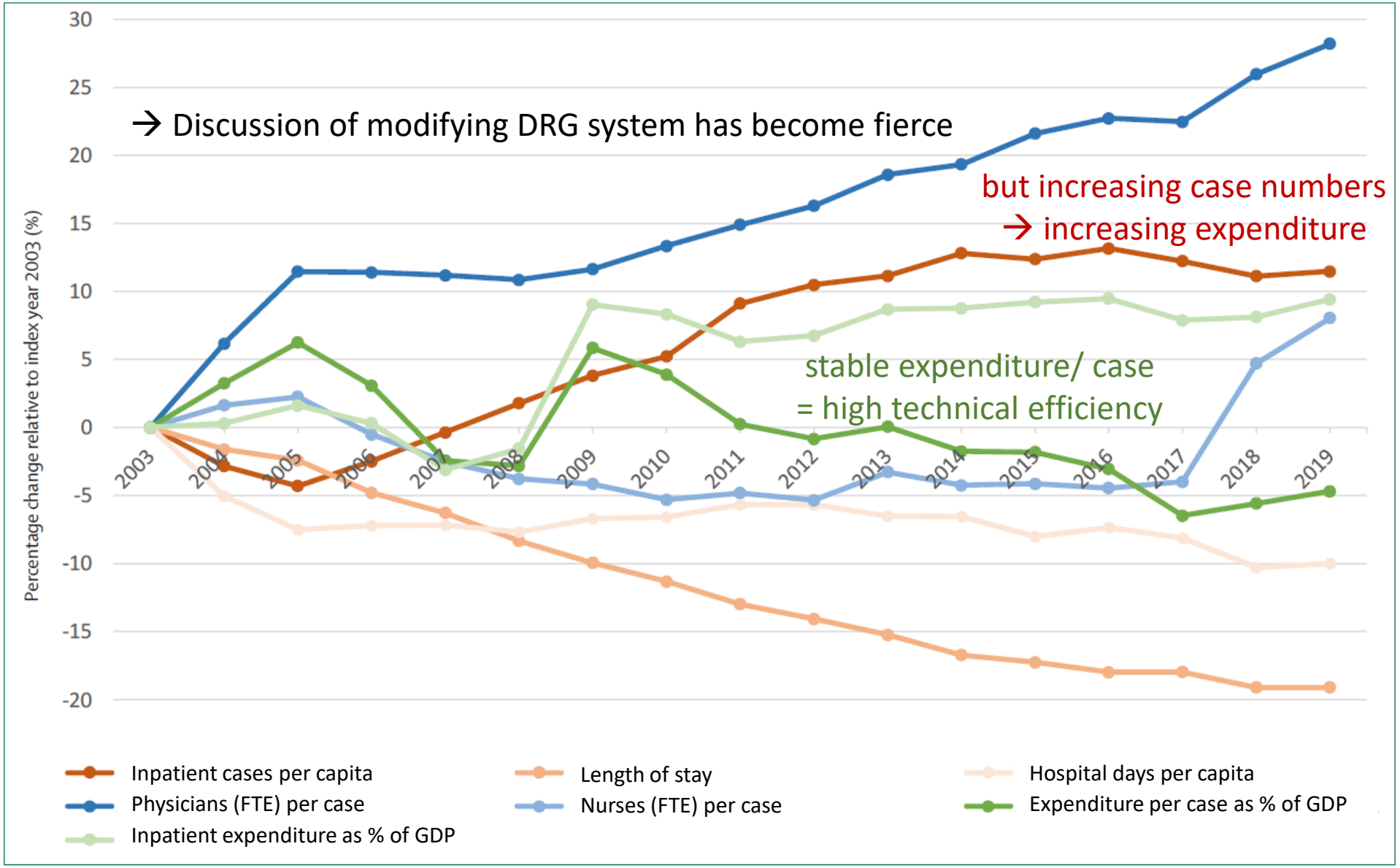


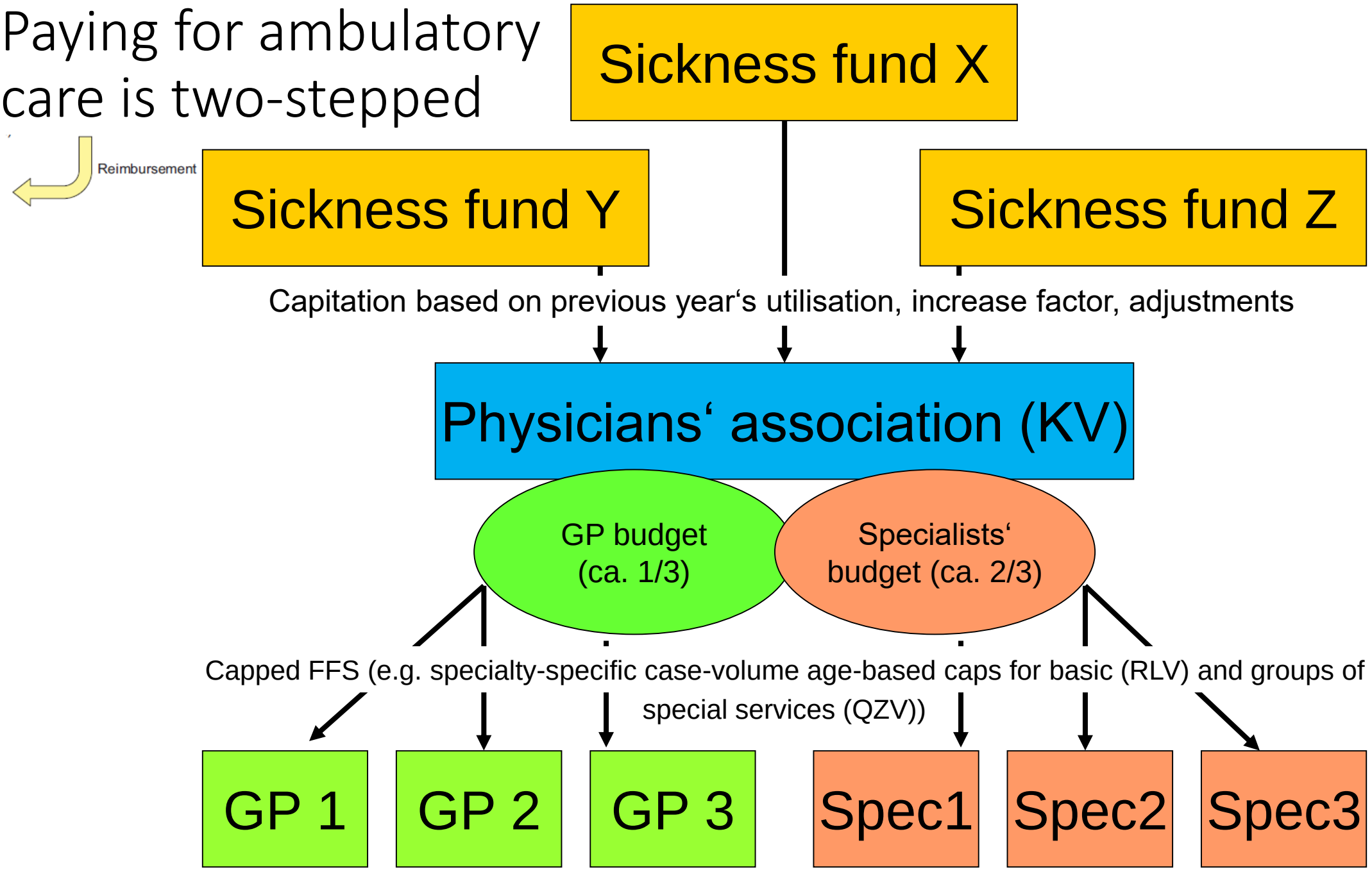
Paying hospital treatment by DRGs - important hospital utilization and cost figures, 2003 (DRG introduction) - 2019

Reimbursement



| Source: updated from Busse et al., Lancet 2017 |

Paying for ambulatory care is two-stepped



Detecting fraud and abuse

Ambulatory care: due to two-stepped payment, sickness funds are not directly affected; however, there are performance audits based on averages per specialist group etc. (also in regard to prescribed pharmaceuticals)

Inpatient care: the regional medical review boards are asked by sickness funds to check invoices in regard to necessity of inpatient treatment, length of inpatient treatment, appropriateness of used technologies, and correctness of invoice (in 2017, >50% of checked invoices were incorrect and hospitals to pay back € 2.8 billion or >3.5% of SHI turn-over)

Sources & more more information

Germany and health 1

Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition

2017

Reinhard Busse, Miriam Blümel, Franz Knieps, Till Bärnighausen

Bismarck's Health Insurance Act of 1883 established the first social health insurance system in the world. The German statutory health insurance system was built on the defining principles of solidarity and self-governance, and these principles have remained at the core of its continuous development for 135 years. A gradual expansion of population and benefits coverage has led to what is, in 2017, universal health coverage with a generous benefits package. Self-governance was initially applied mainly to the payers (the sickness funds) but was extended in 1913 to cover relations between sickness funds and doctors, which in turn led to the right for insured individuals to freely choose their health-care providers. In 1993, the freedom to choose one's sickness fund was formally introduced, and reforms that encourage competition and a strengthened market orientation have gradually gained importance in the past 25 years; these reforms were designed and implemented to protect the principles of solidarity and self-governance. In 2004, self-governance was strengthened through the establishment of the Federal Joint Committee, a major payer–provider structure given the task of defining uniform rules for access to and distribution of health care, benefits coverage, coordination of care across sectors, quality, and efficiency. Under the oversight of the Federal Joint Committee, payer and provider associations have ensured good access to high-quality health care without substantial shortages or waiting times. Self-governance has, however, led to an oversupply of pharmaceutical products, an excess in the number of inpatient cases and hospital stays, and problems with delivering continuity of care across sectoral boundaries. The German health insurance system is not as cost-effective as in some of Germany's neighbouring countries, which, given present expenditure levels, indicates a need to improve efficiency and value for patients.

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This is the first in a Series of two papers about Germany and health

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International experience in the price management of drugs: Germany's experience

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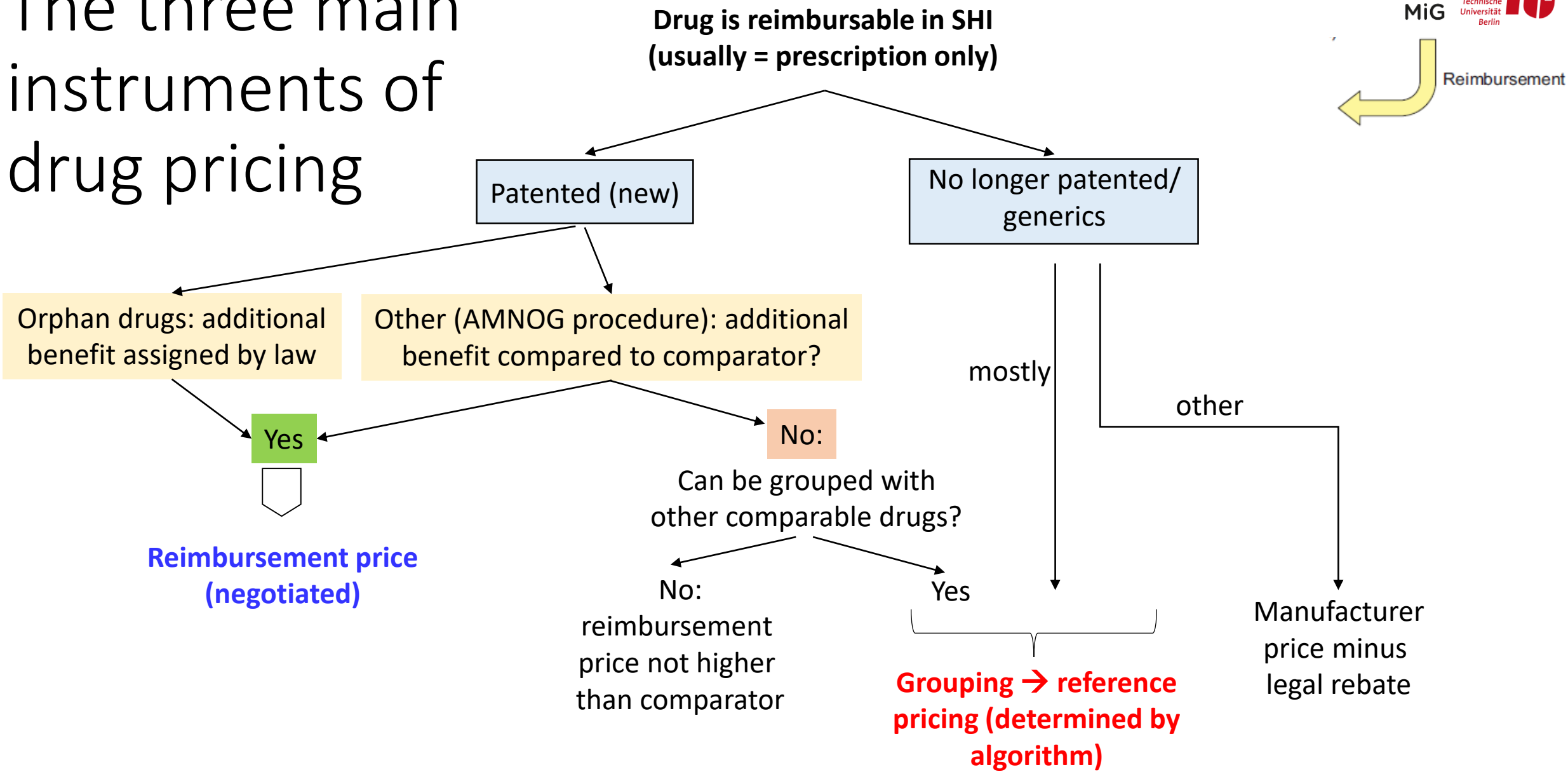
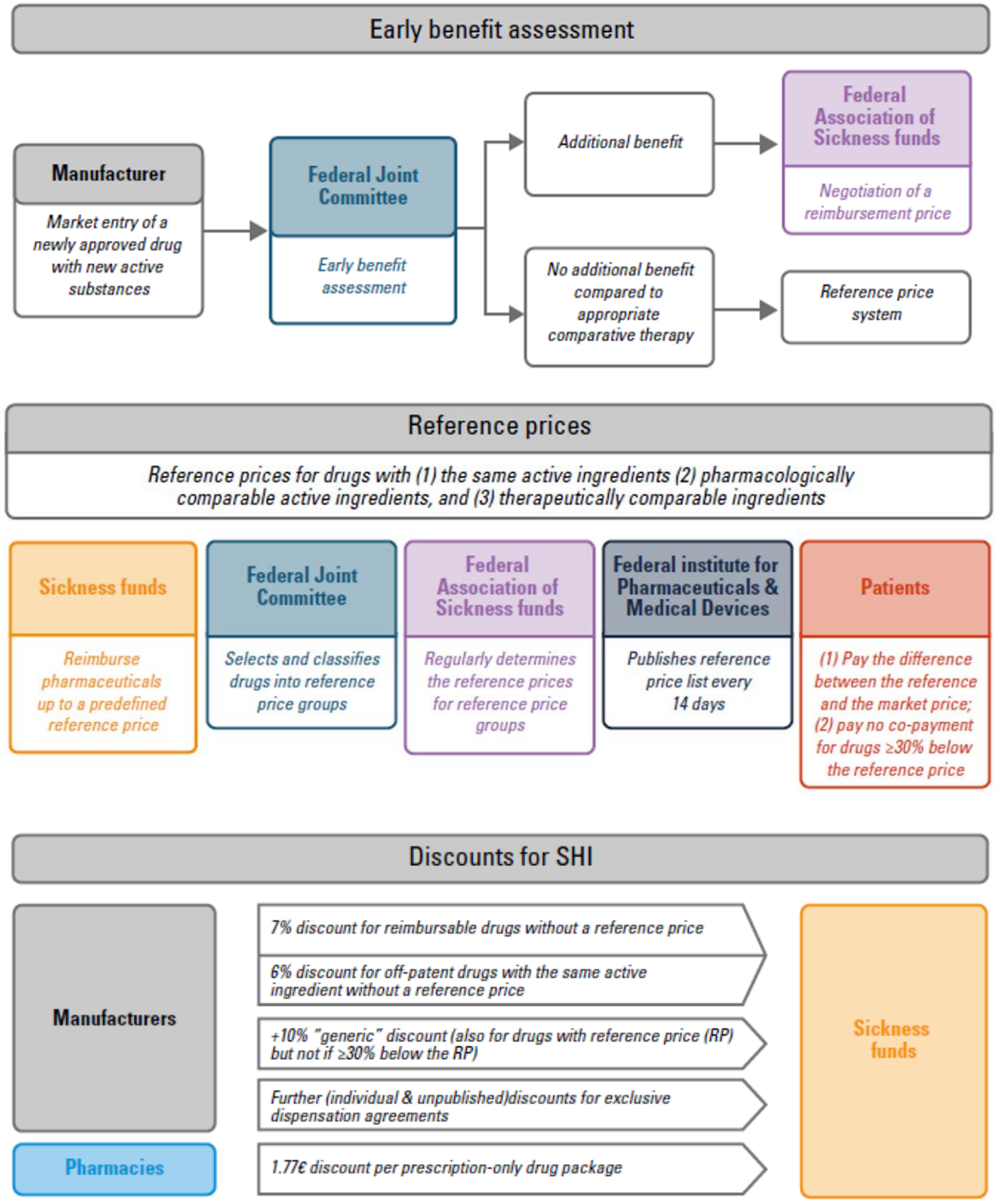
The three main instruments of drug pricing

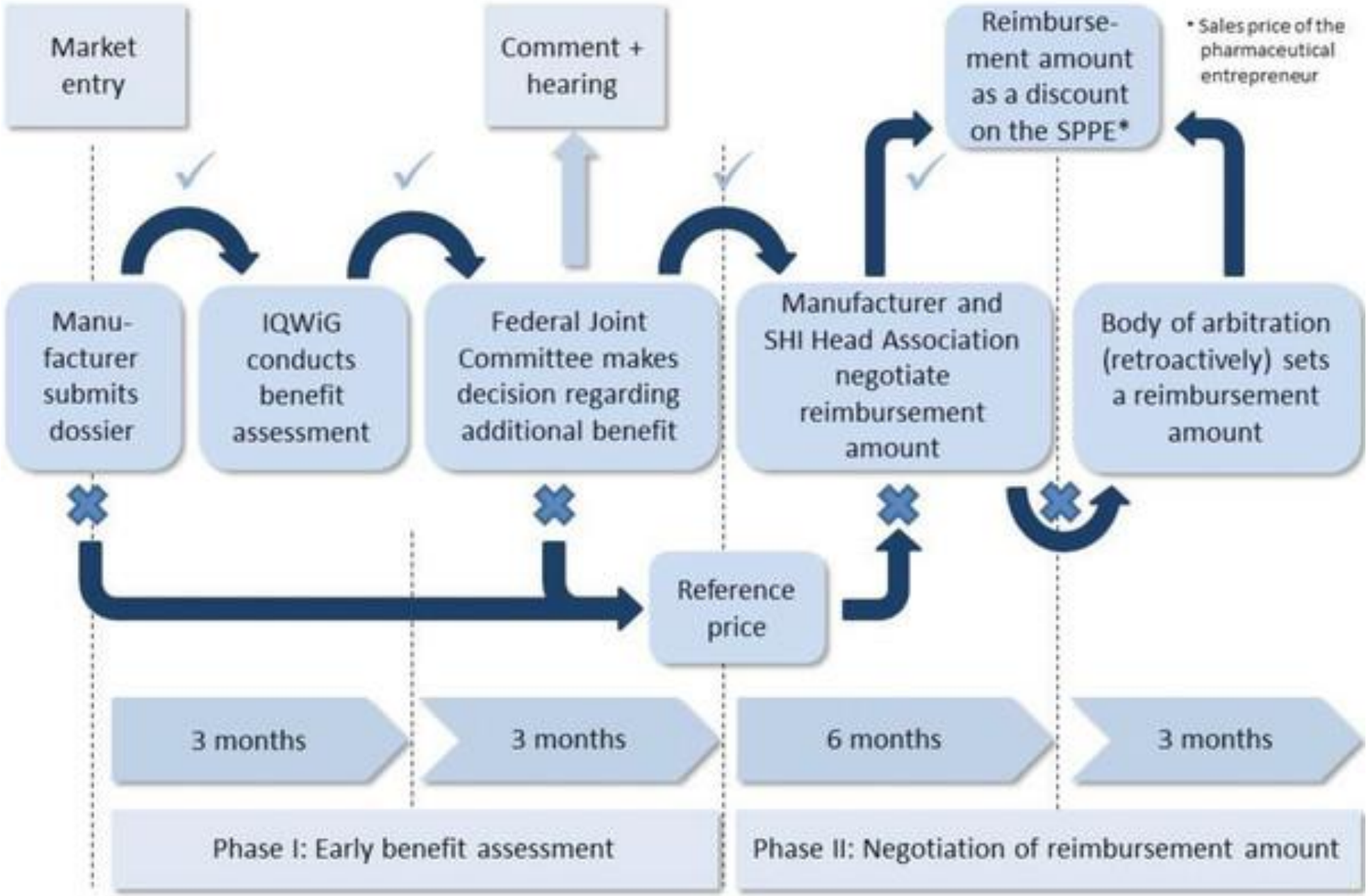


Possibly minus **sickness fund-specific discounts** (negotiated, not published); mostly for generics

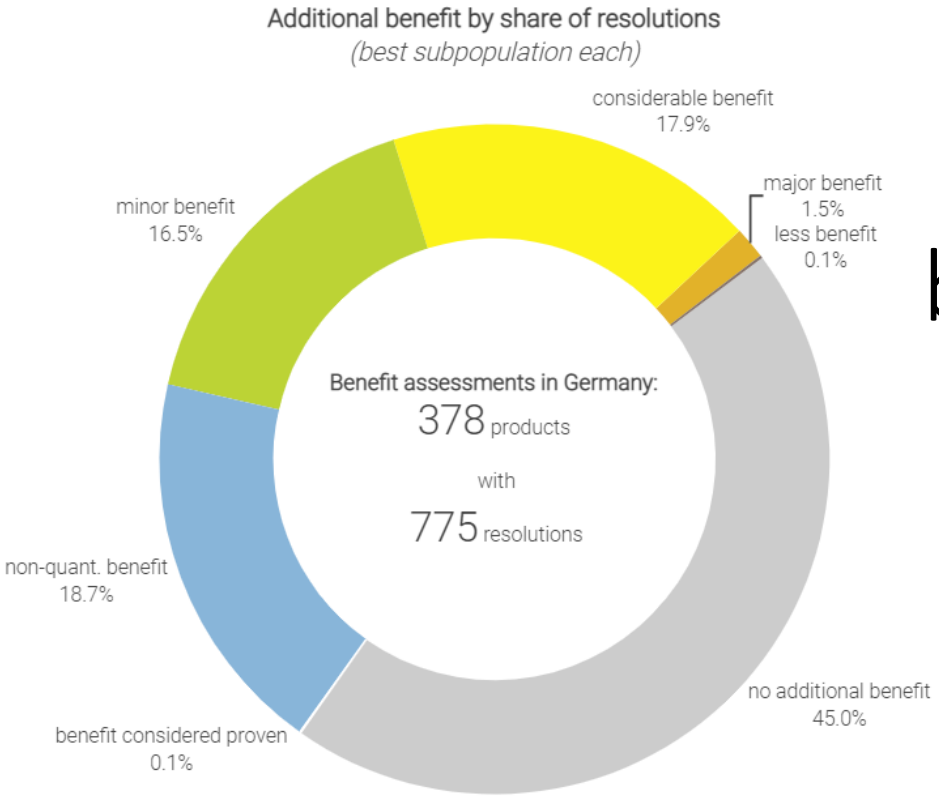
Different & divided responsibilities for three main instruments of drug pricing



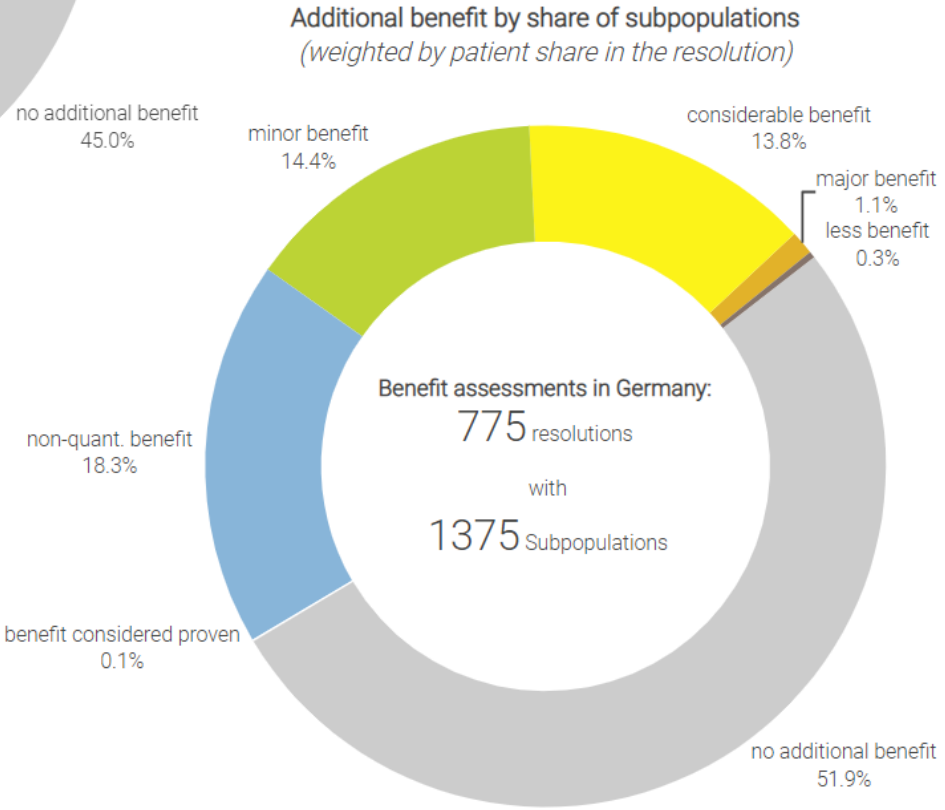
The AMNOG procedure

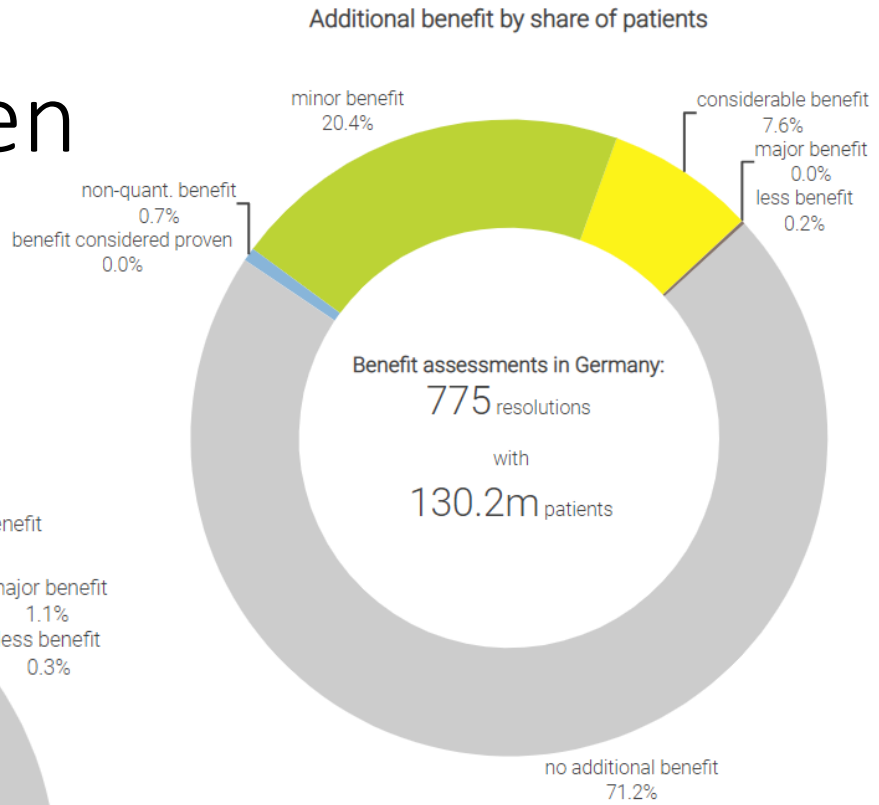


An additional benefit has been found for …



55% of drugs, 48% of subpopulations, and 29% of patients …

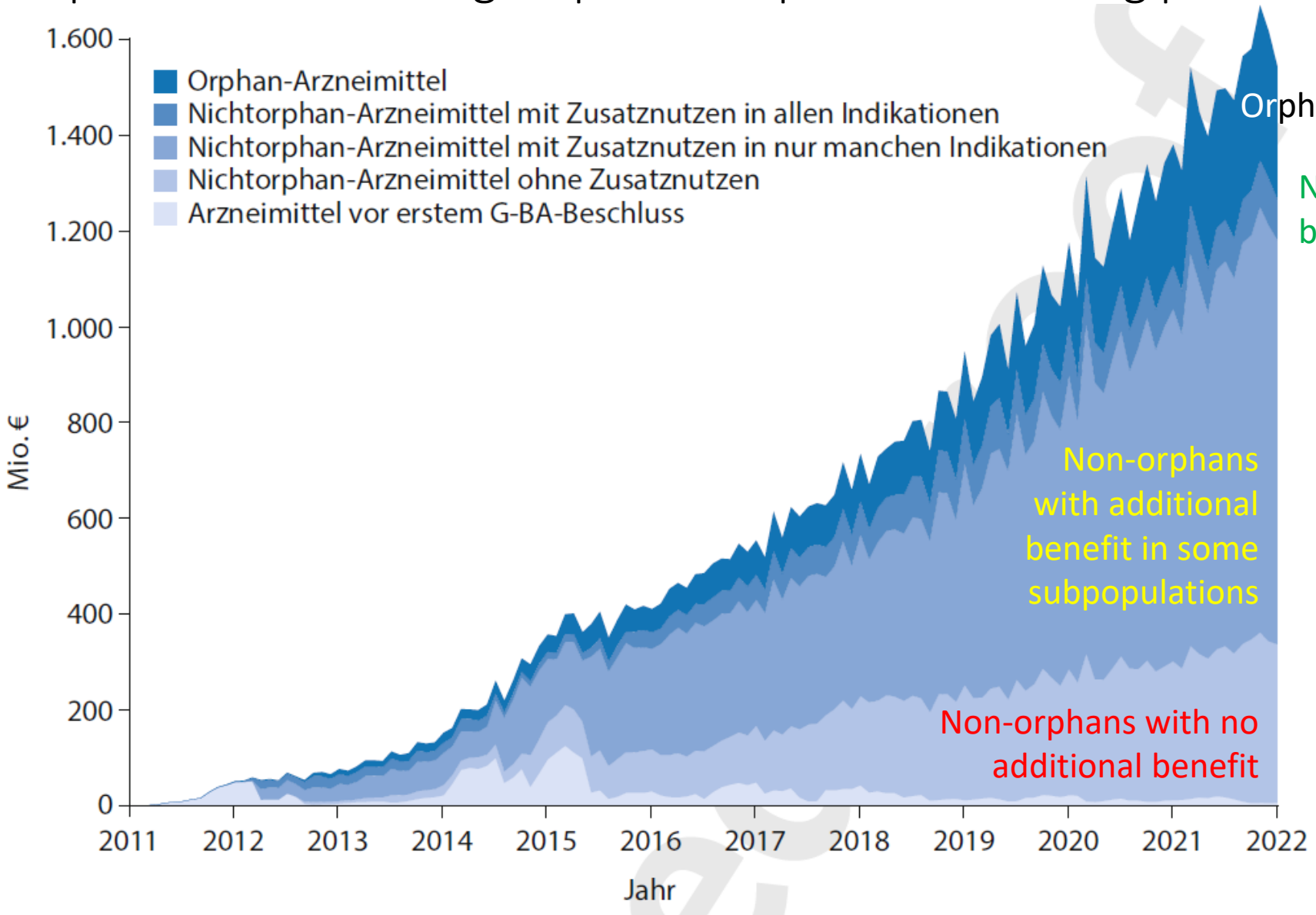




but all drugs remain prescribable for all patients

While AMNOG may be considered a success, two problems remain: new drugs with additional benefit in only some subpopulations are responsible for the largest part of expenditure among patented drugs

Problem 1



Orphan drugs

Non-orphans with additional benefit in all subpopulations

Non-orphans with additional benefit in some subpopulations

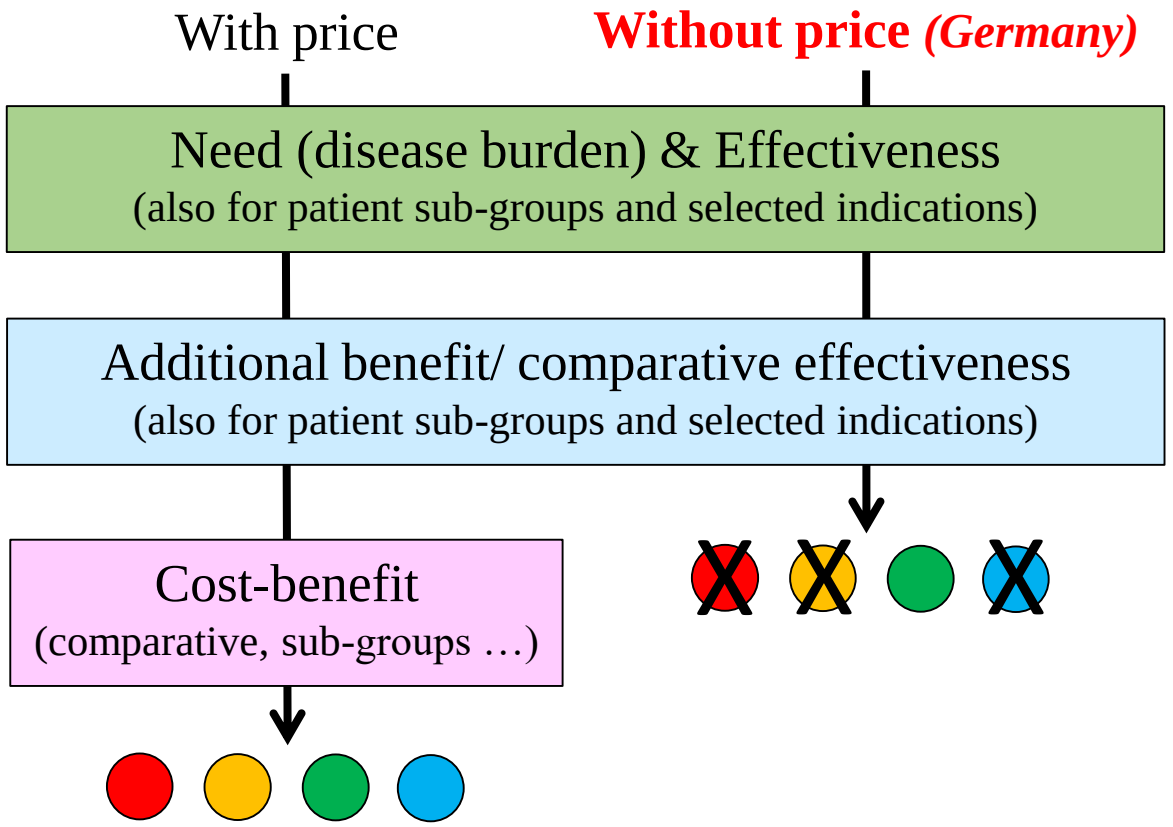
Non-orphans with no additional benefit

Comparison of German AMNOG approach to early benefit assessment with other countries

Problem 1

New drug/ device/ intervention:

Important input = structured information (dossier of manufacturer/ promoter)



- not reimburseable
- reimbursable only for selected indications, selected providers, second line … ("optimised")
- reimburseable
- only in research (CED; coverage for evidence development)

Orphan drugs (accountig for <0.1% of DDDs) have become *the* driver of expenditure increase (both due to higher consumption and prices)

Problem 2

	Expenditure (€ bn; %)	Change vs. 2020	DDD bn. (%)	Change vs. 2020	Exp./ DDD (€)	Change vs. 2020
Total market	50.2 (100%)	+8.8%	46.3 (100%)	+1.8%	1.09	+7%
Patented	26.4 (52.5%)	+14.4%	3.0 (6.5%)	+4.7%	8.74	+9%
Non-patented	23.9 (47.5%)	+3.2%	43.3 (93.5%)	+1.7%	0.55	+2%
Orphan drugs	6.8 (13.5%)	**+24.7%**	0.03 (0.07%)	+13.5%	213.53	+11%
Non-orphans	43.5 (86.5%)	**+6.6%**	46.3 (99.93%)	+1.8%	0.94	+4%