Technische Universität Berlin

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

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&
European Observatory on Health Systems and Policies

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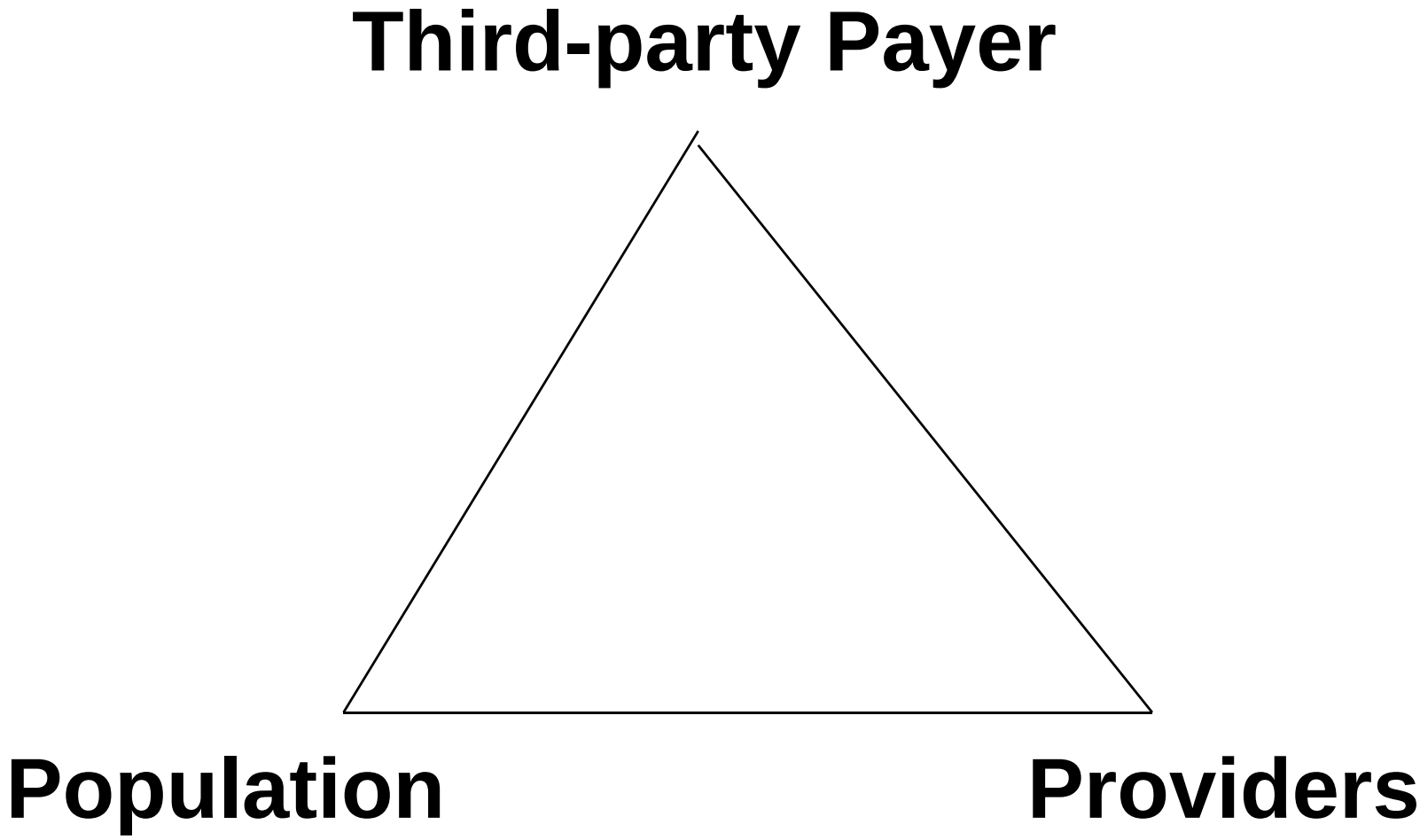

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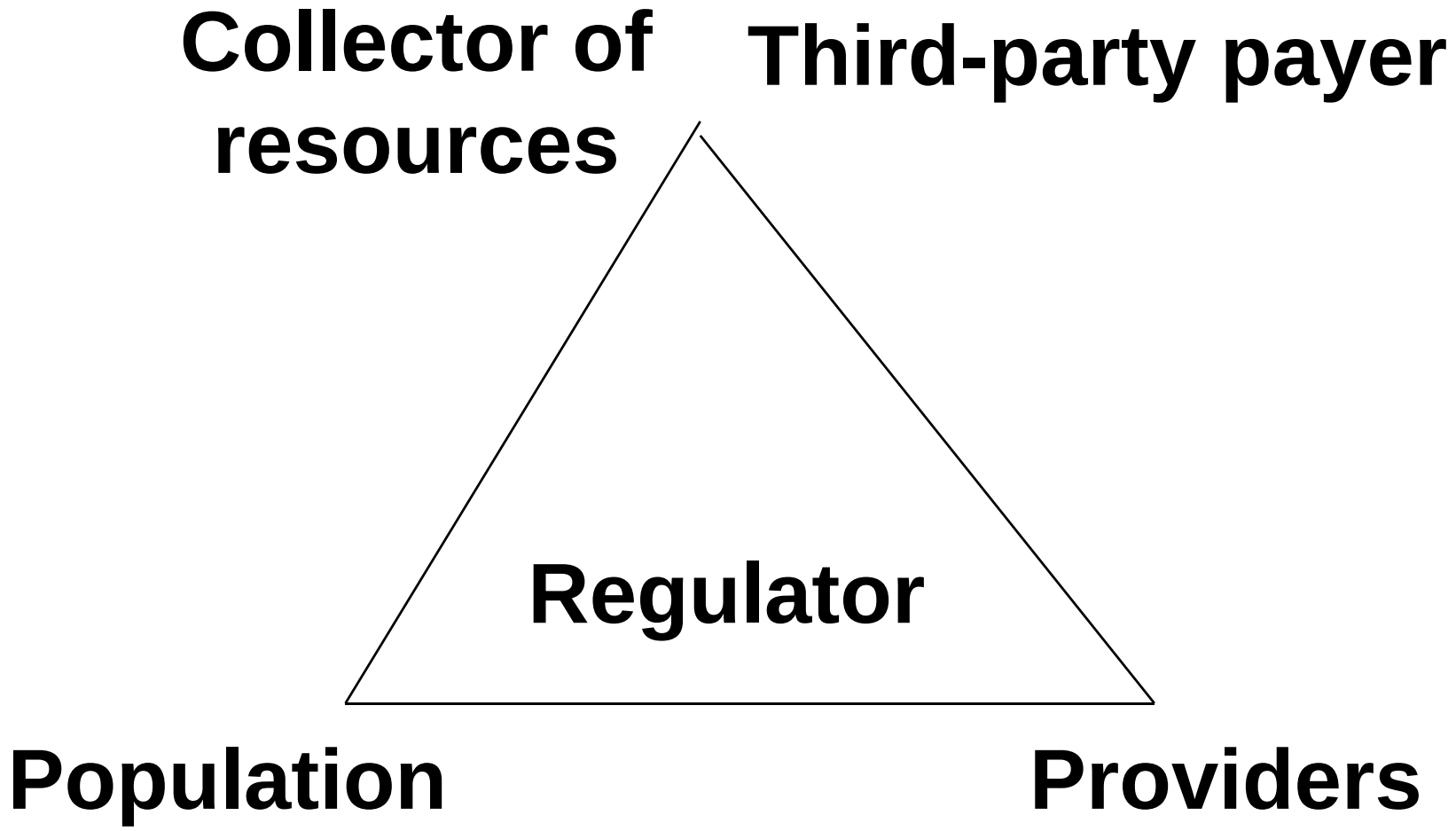

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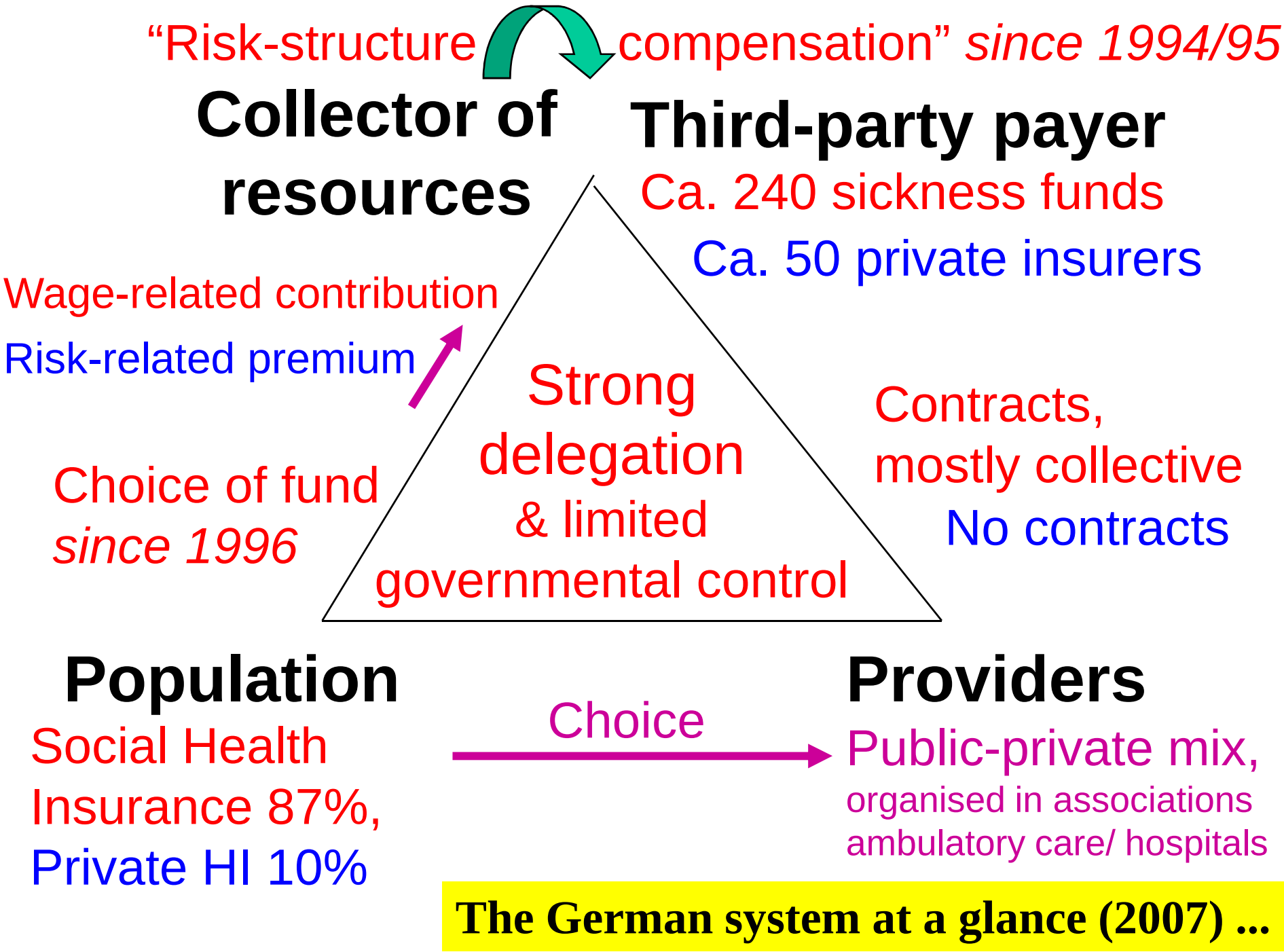
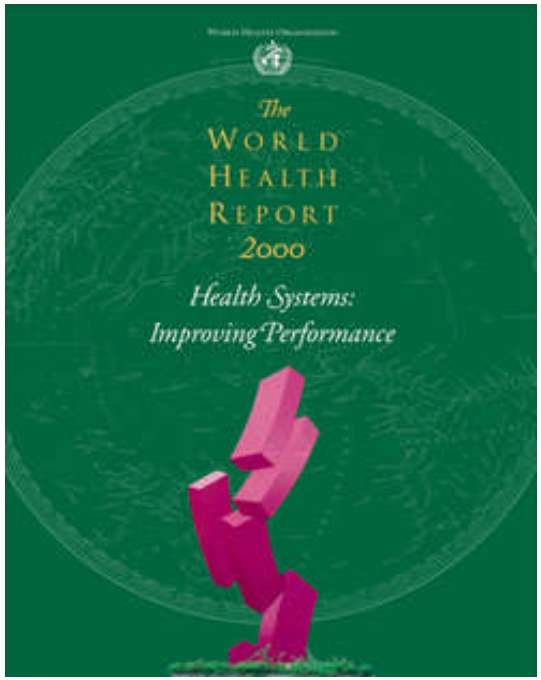


The German system at a glance (2007) ...

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

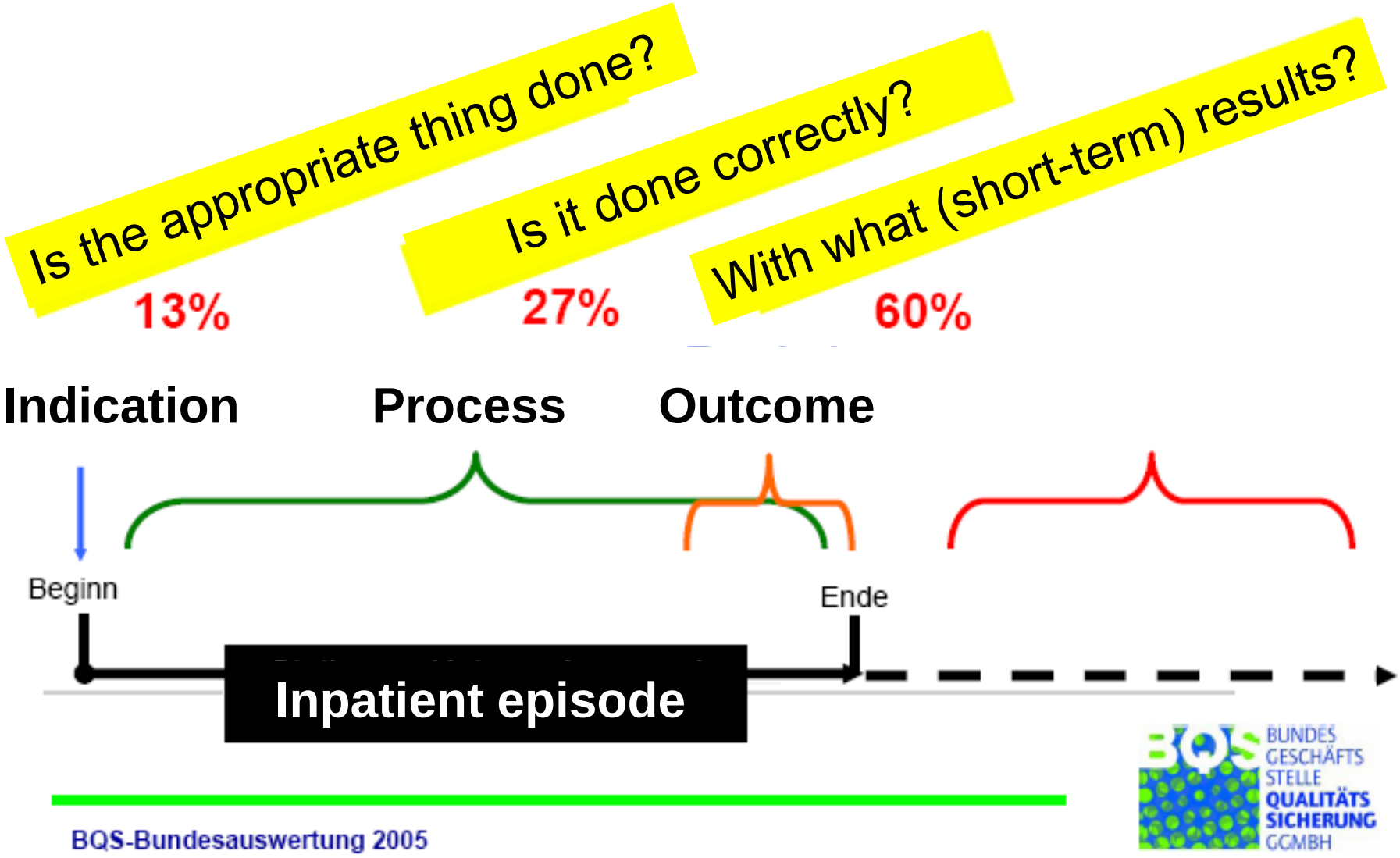
… care coordination, quality and cost-effectiveness are problematic

- 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)



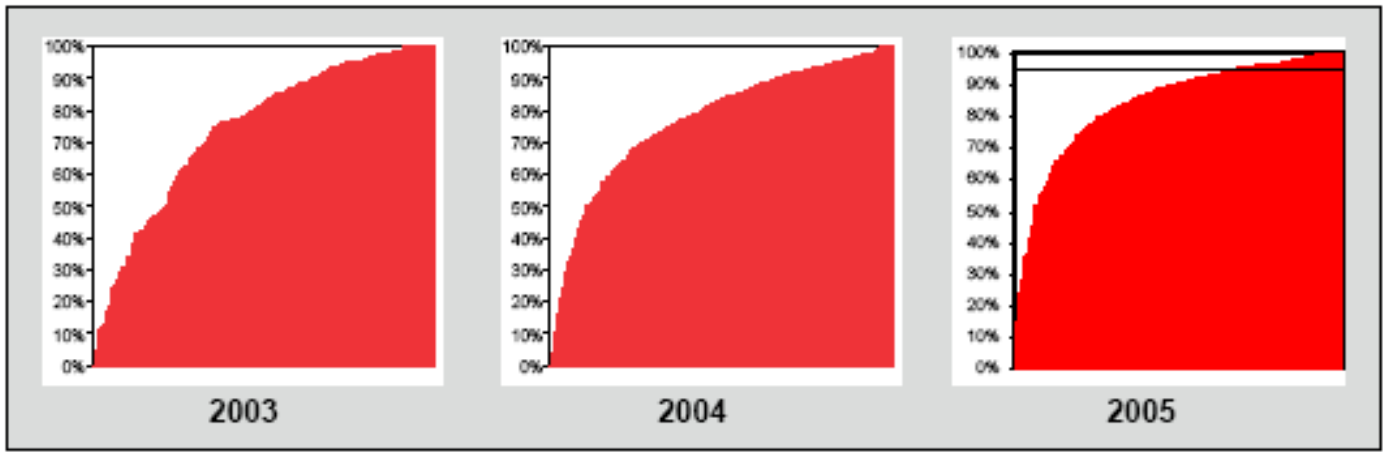
Federal Office for Quality Assurance (BQS)

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%

Mammachirurgie 2005: Angabe Sicherheitsabstand bei BET (KeZ 68098)

BUNDES GESCHÄFTS STELLE QUALITÄTS SICHERUNG GGMBH

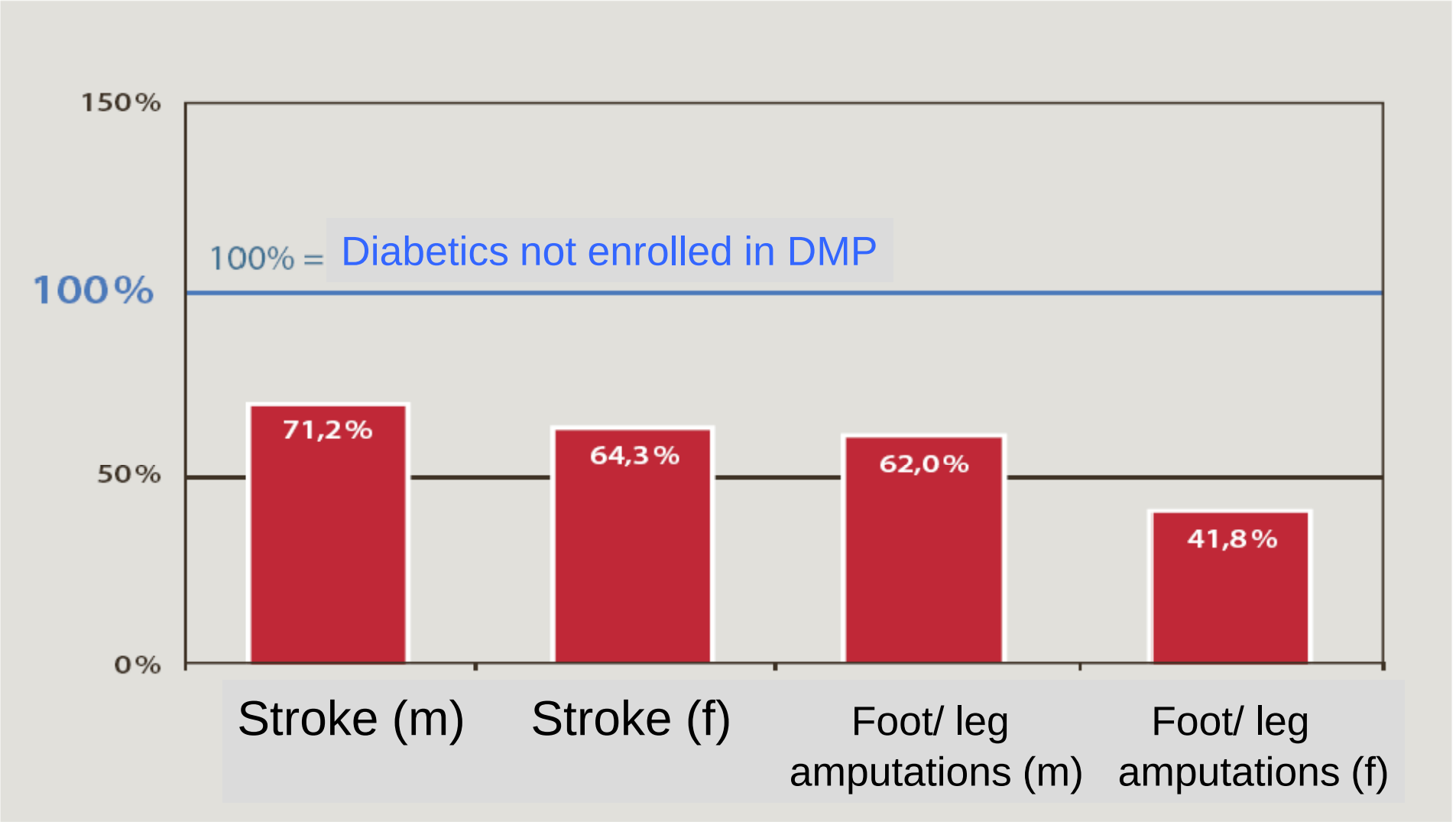
Disease Management Programs

(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)

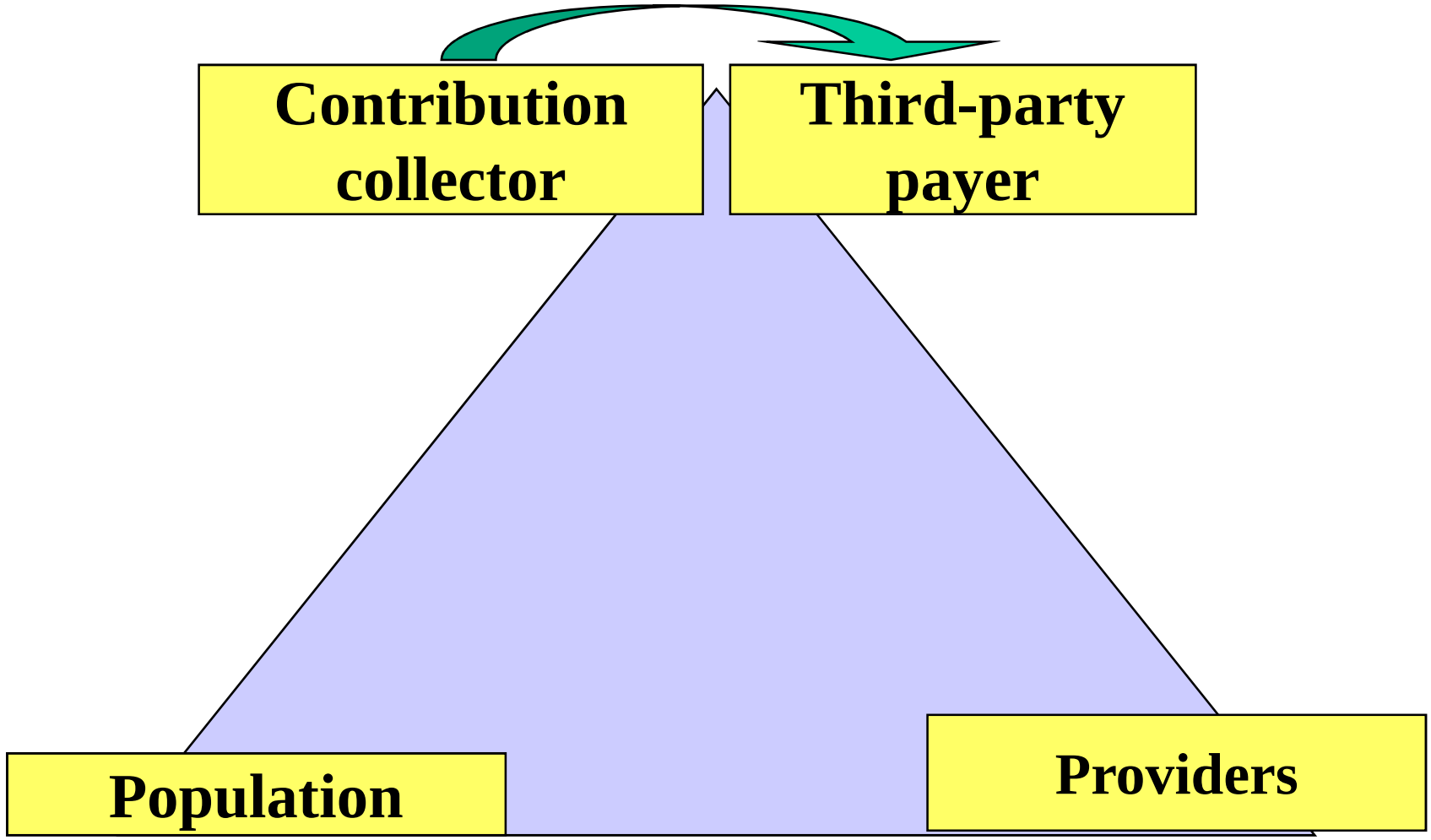
DMP diabetes - results



Decision-making on (new) benefits/ technologies

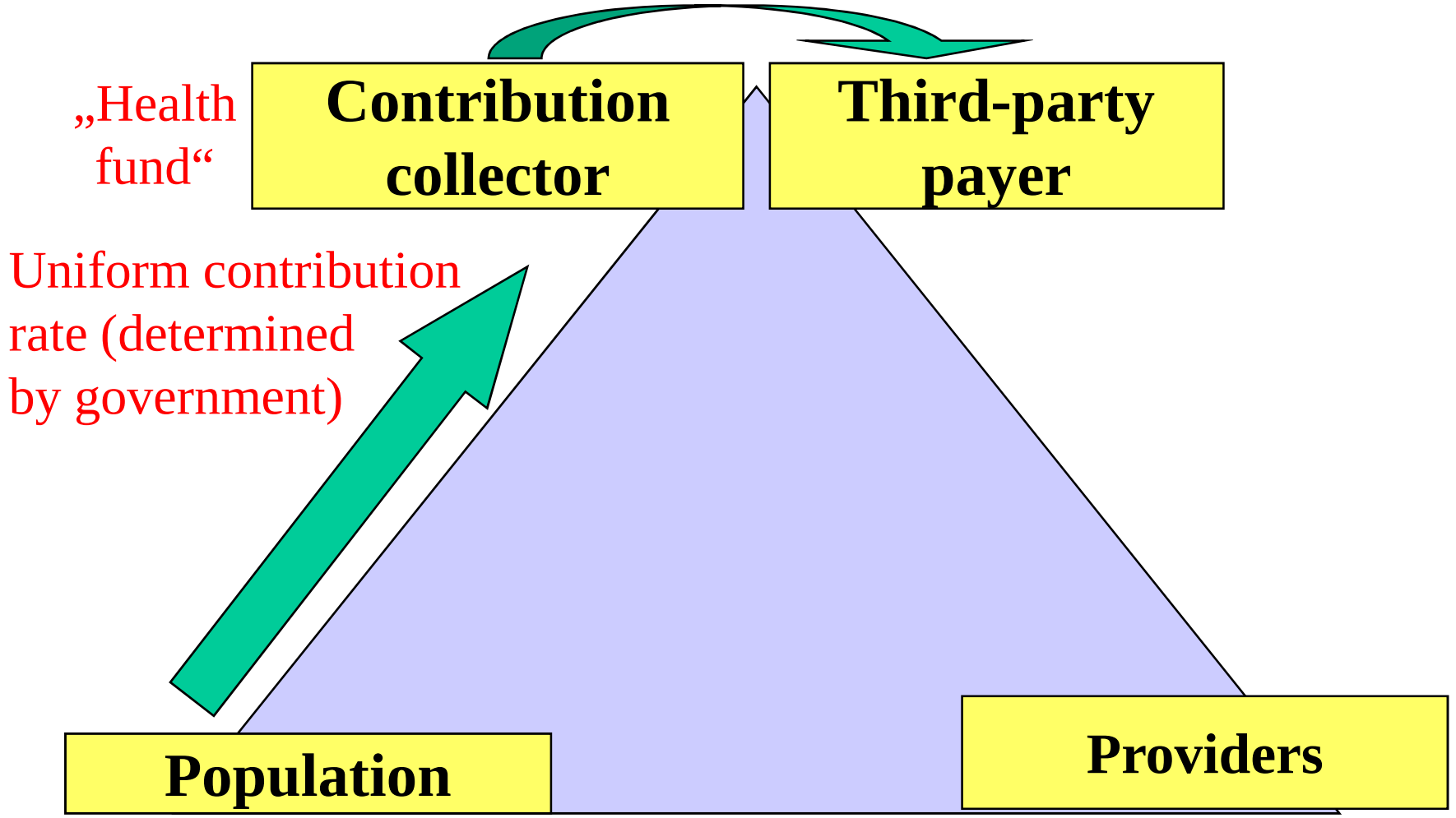
- Decided by Federal Joint Committee (FJC): 9 provider, 9 sickness fund representatives, 3 neutral members, 9 non-voting patient reps
- FJC may commission IQWiG (Institute for Quality and Efficiency, since 2004) with assessment of comparative effectiveness, from 2008 also of cost-effectiveness

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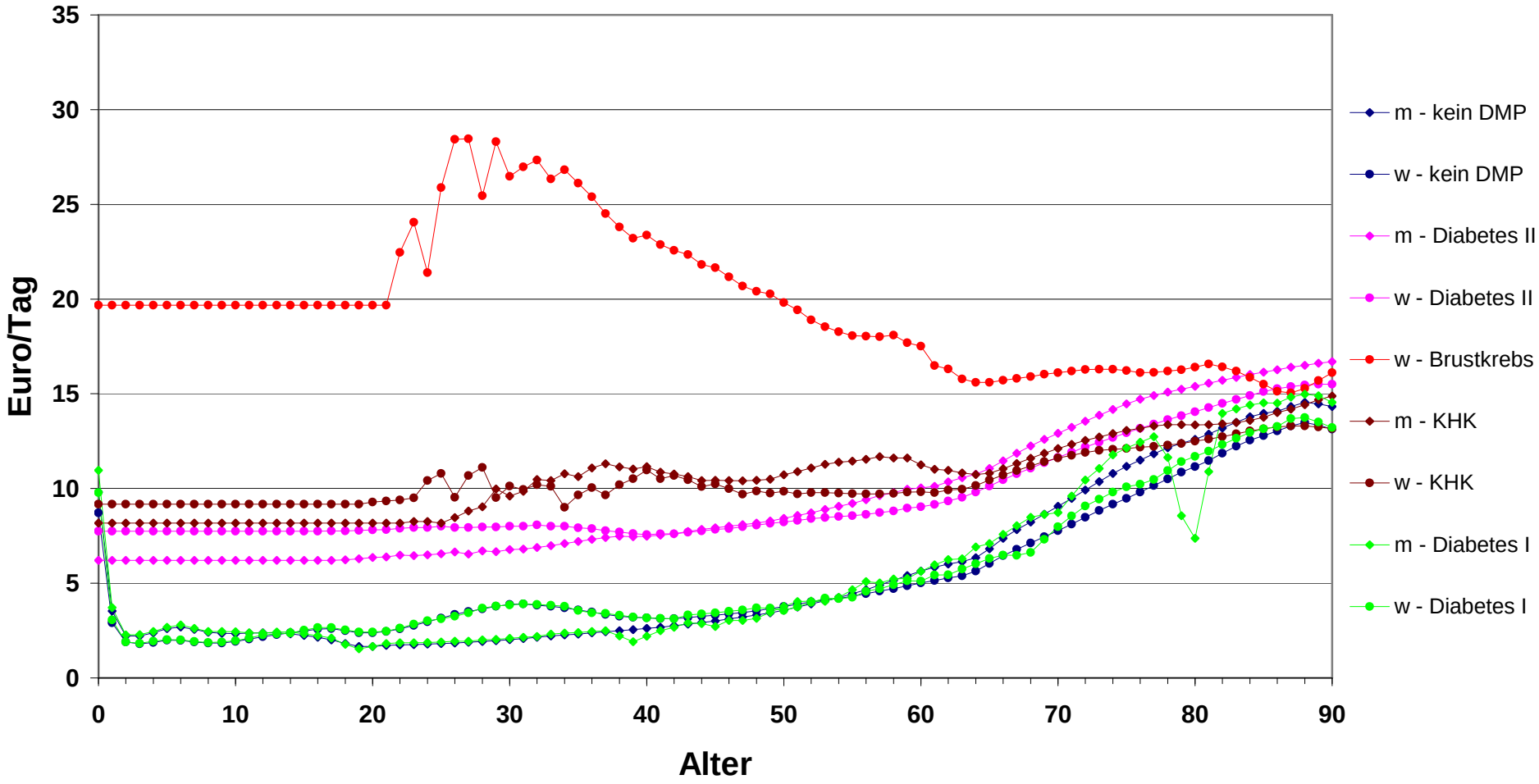
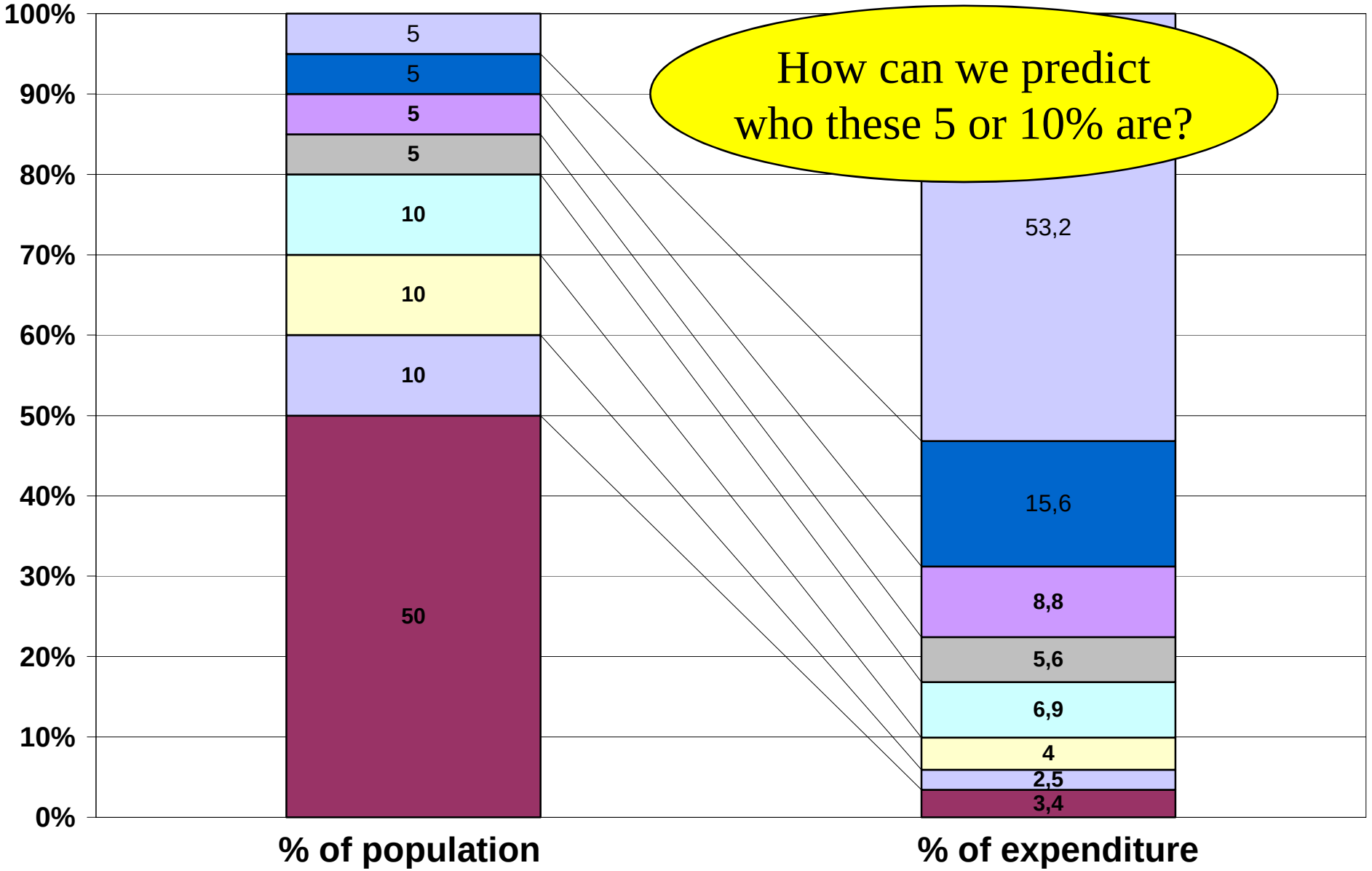
„Standardised“ (= avg.) expenditure used for the Risk Structure Compensation mechanism for DMP participants and other insured (2006)



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



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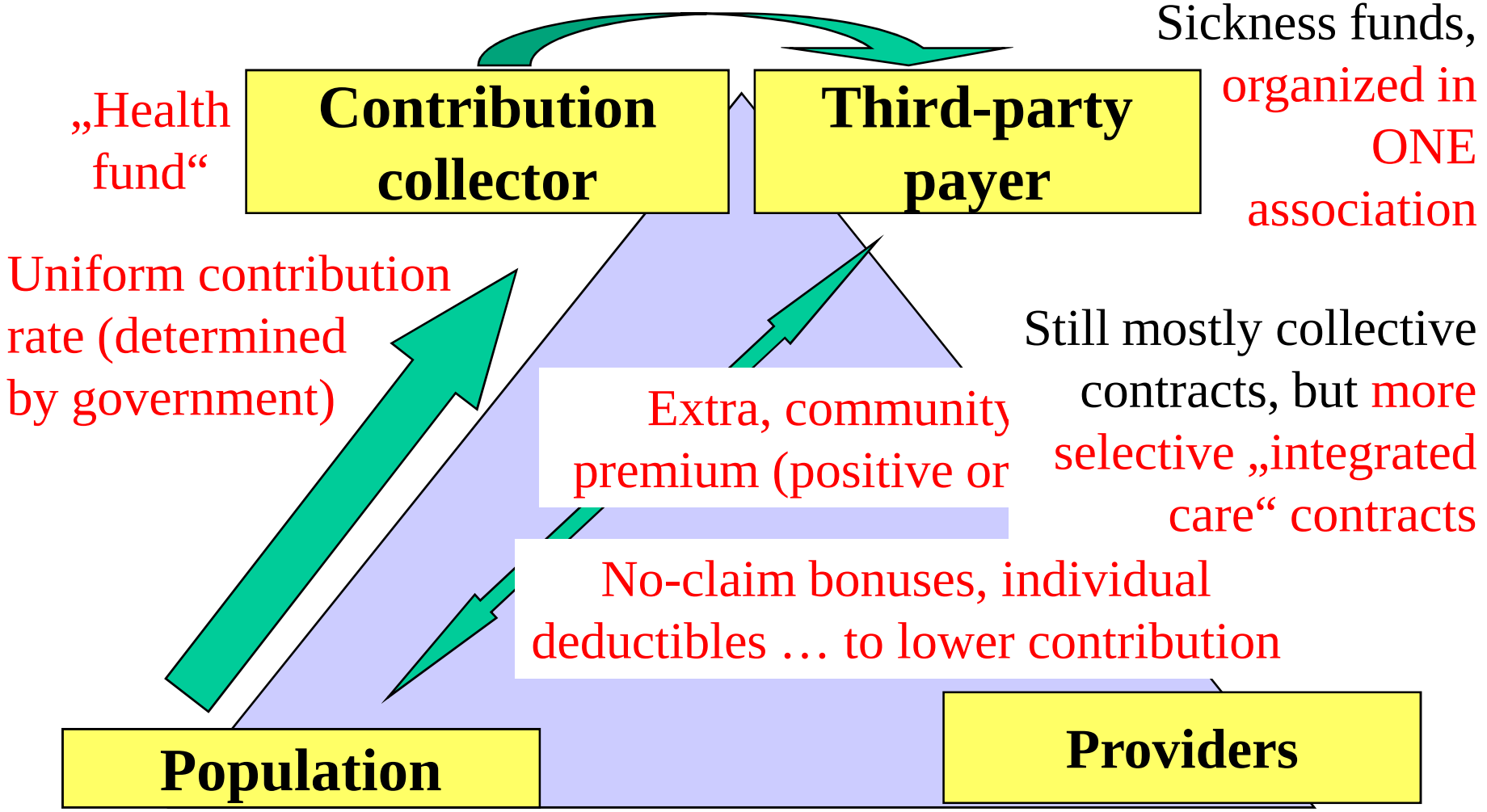

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