

# **Change – Reforms and reform proposals in Germany**

The Prague Symposium 2005

Speaker: Ralf Heyder, German Hospital Federation

Date: October 30<sup>th</sup>, 2005

## **Content**

## **Page**

- |  |           |
|--|-----------|
| <b>1. Health insurance coverage</b>                    | <b>4</b>  |
| <b>2. Sectoral division in patient care</b>            | <b>6</b>  |
| <b>3. Competition of social health insurance funds</b> | <b>13</b> |

## The German reform agenda is crowded – some of the reforms have begun, for others necessary political decisions have to be made

### Main topics on the reform agenda

- Redefine the **scope and role** of **private health insurance**
- Eliminate the **deficits** resulting from the **sectoral division** in patient care
- Redefine the **role** of social health insurance funds and the **nature of their competition**
- Reform the current **risk-based fiscal equalization scheme**

# 1. Health insurance coverage

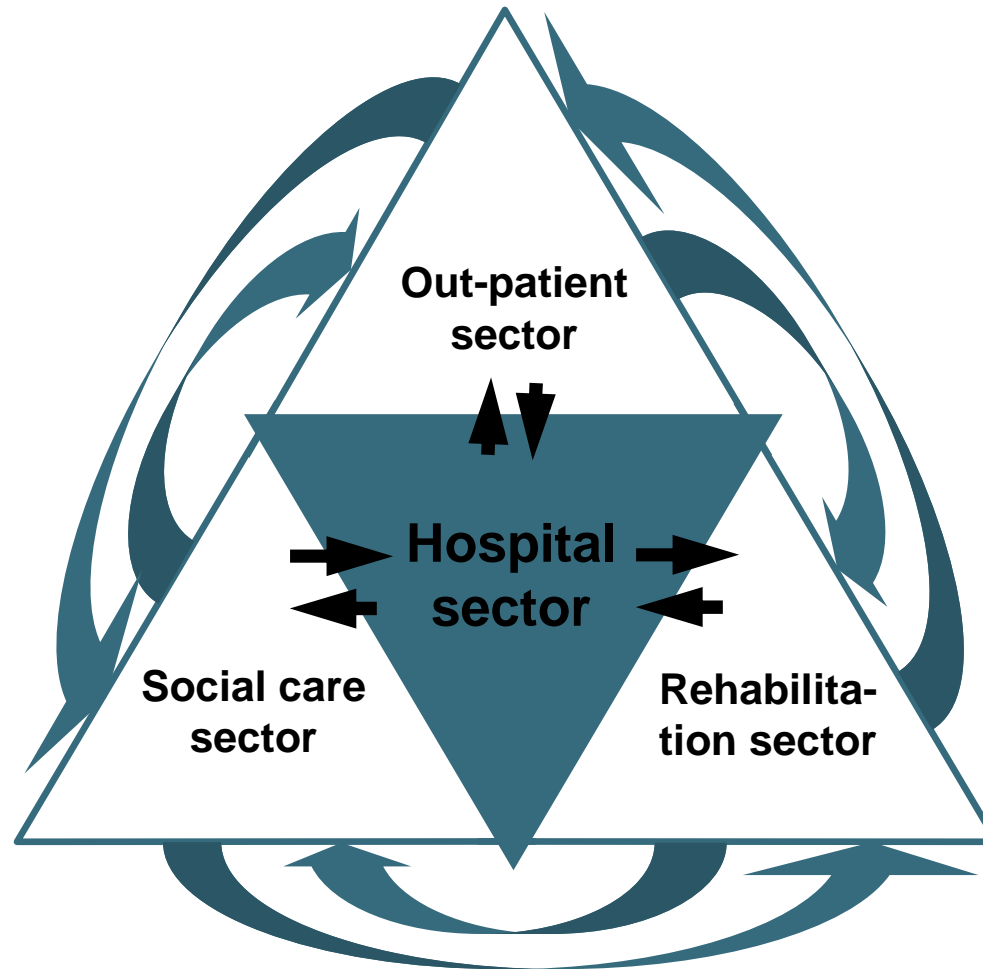
## In order to broaden the financial base of the solidarity system, the abolition of full-coverage private insurance is being discussed

Dimensions of solidarity	Private health insurance	Social health insurance
<b>Healthy with sick</b>	Rates based on risk assessment (no solidarity)	Rates independent of risk assessment (solidarity)
<b>High income with low income groups</b>	Flat insurance rates, no state aid (no solidarity)	Rates proportional to income (solidarity)
<b>Singles with families</b>	Flat rate for every family member (no solidarity)	No contributions for children and spouses without income (solid.)
<b>Young with old</b>	Rates calculated separately for each cohort (no solidarity)	One rate for all cohorts (solidarity)

**The entire population would be covered by social health insurance → private health insurance would only exist as complementary insurance**

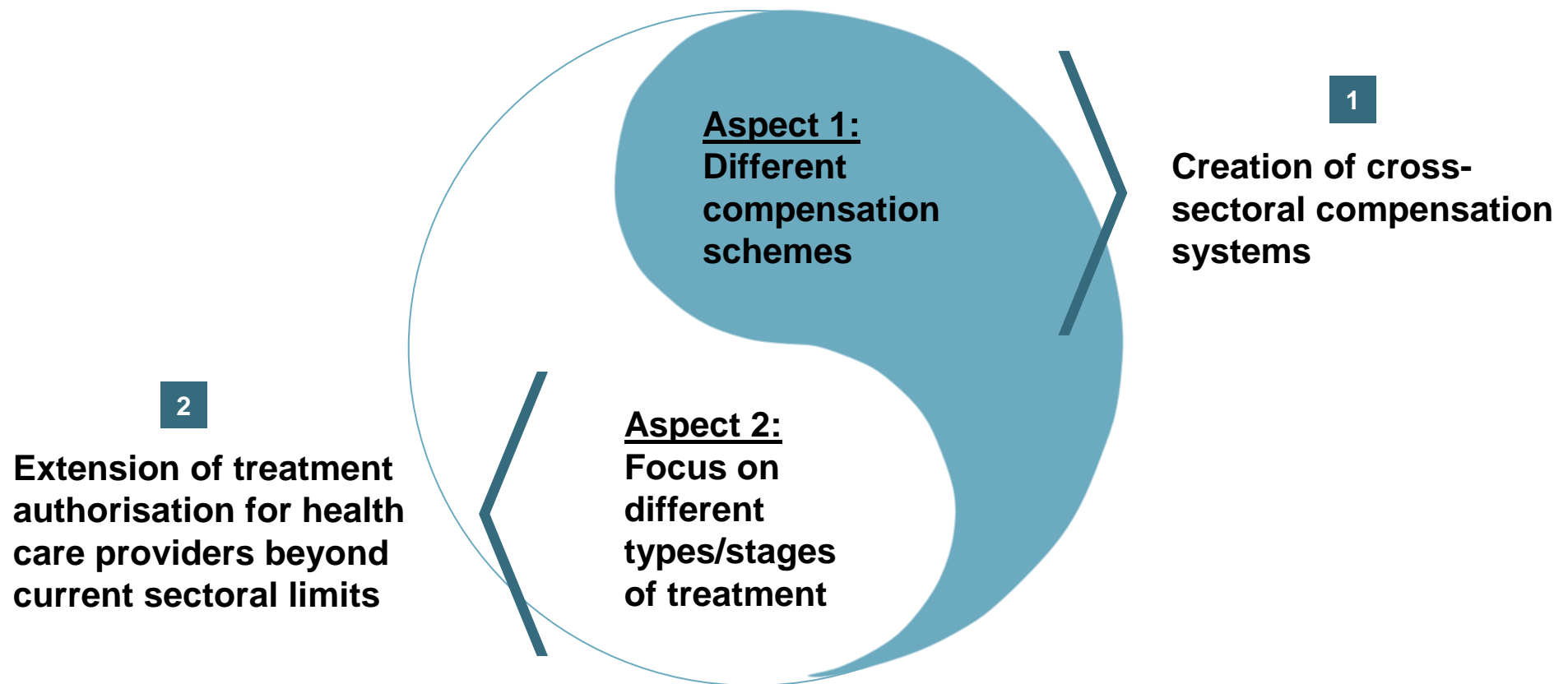
## **2. Sectoral division in patient care**

**The hospital sector is connected to all three other sectors – there is a need for managing these interfaces**



# Two strategies can be applied to abolish the sectors and thereby overcome the sectoral divide

## Strategies to overcome sectoral division



## In order to overcome the sectoral divide the option of individual contracts has been created in addition to collective contracts

### Collective contracts

Social health insurance funds **collectively sign contracts** with individual hospitals and physicians' associations



### Individual contracts

**Individual** social health insurance funds **sign contracts** with individual health care providers

There are **different types of contracts** with different legal requirements. Integrated care contracts provide a **limited cross-sectoral budget** in order to encourage cross-sectoral cooperation. Other contracts are meant for **opening hospitals** for a limited number of **out-patient treatments**

**Regular health care provision (sectoral)**

**New models of health care provision (cross-sectoral)**

## Medical care centres open up the possibility of addressing deficits resulting from sectoral division

- The „**Health Care Modernisation Act**“ from 2003 has made possible the foundation of medical care centres („Medizinische Versorgungszentren“) in the whole of Germany. Before, such centres only existed in eastern Germany. They were remains of the old GDR health care system
- **Legal definition:** A facility directed by a medical doctor, in which doctors work either as employees or on a self-employed basis
- Medical care centres are **part of the ambulatory sector** and are subject to the regulation of this sector
- **Every provider** that is authorized to provide health care services within the social health care system **may found a medical care centre** (including hospitals)

➔ **Medical care centres still follow the logic of sectoral division. But for hospitals the organisational link with these centres creates opportunities to address deficits resulting from sectoral division**

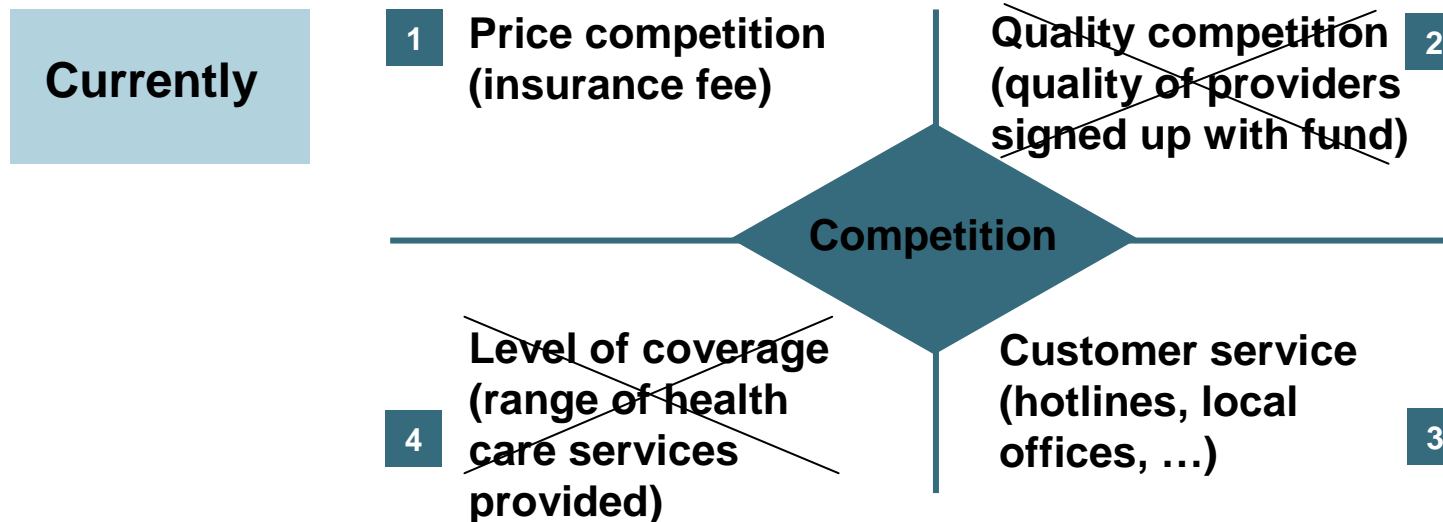
## Further reform initiatives aim at improving the management of sectoral interfaces

- Introduction of **gatekeeper-models**
- **Electronic health insurance card** (including electronic patient file, e-prescription, e-referral etc.)

➔ **These initiatives do not aim at abolishing the sectors themselves. They only provide tools to improve the management of sectoral interfaces**

### **3. Competition of social health insurance funds**

## Currently health insurance funds primarily compete on the basis of price and service, but recent reforms provide for more flexibility

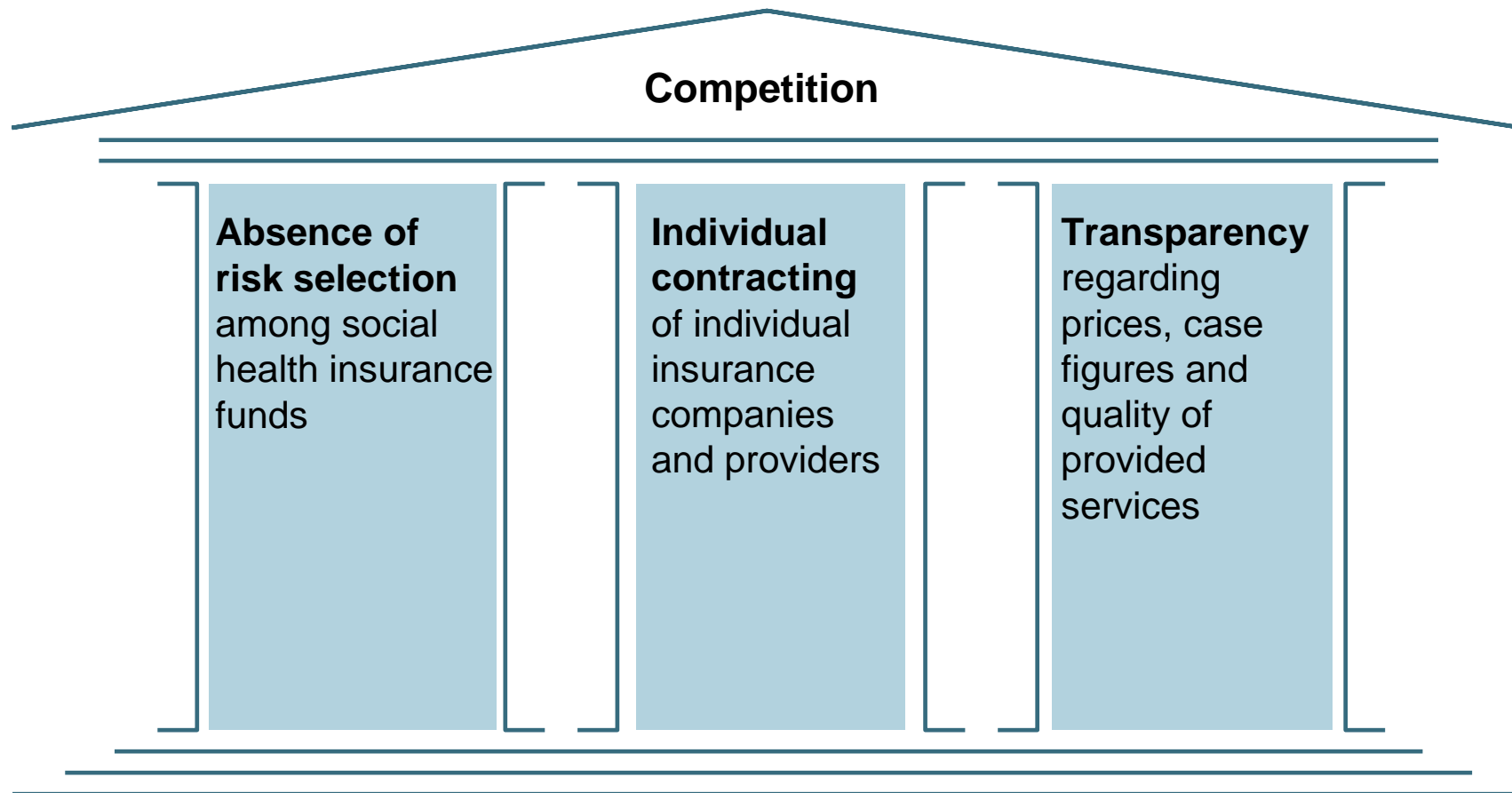


**Problem**

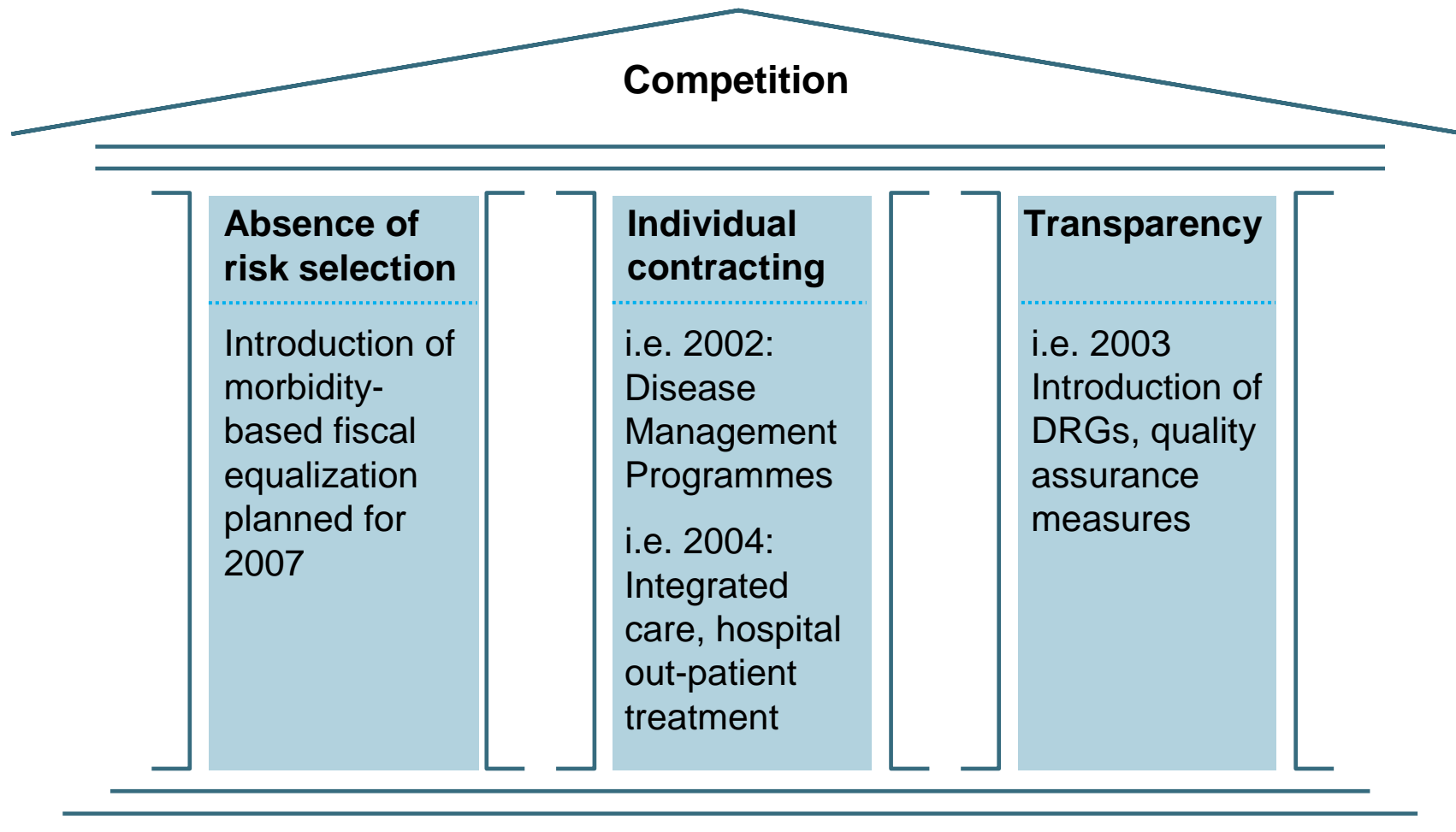
Due to **collective contracting** (uniform compensation schemes) insurers have almost **no room for individual price negotiations**

→ **price competition** is mainly based on **risk selection**, not on differences in customer service and the efficiency of healthcare organisation

## Competition among social insurance funds rests on three pillars – absence of risk selection, individual contracting, transparency



**In order to stimulate competition, reforms affecting all three pillars are either planned or have already been implemented**



## The introduction of a morbidity-based fiscal equalisation scheme is planned for 2007

### Absence of risk selection

#### Currently

The current **risk-based fiscal equalisation** scheme is based on the following criteria:

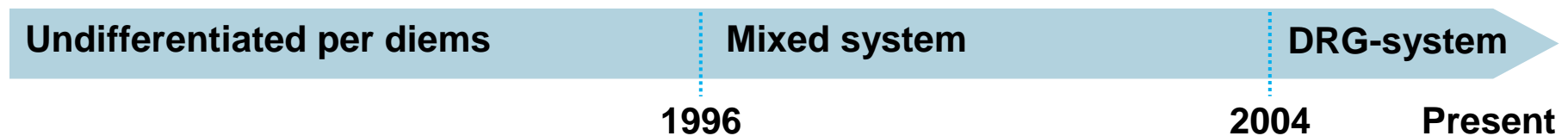
- **Income, Age, Sex**
- Number of insured **family members exempted from contributions**
- Number of pensioners who receive pensions as a result of a **reduction in earning capacity**
- Claims for **sick pay**
- **Chronically ill** who have signed up for a disease management programme
- **Risk pool** for very expensive insured persons

#### Future

The future **morbidity-based fiscal equalisation scheme** will use hospital diagnoses and prescription information to **group people** according to morbidity. For each morbidity group an **average cost rate** is calculated. Based on these average rates health insurance funds receive payments for their insured

# The introduction of DRGs provides transparency regarding prices and the number and types of cases treated in each hospital

## Transparency of prices and case figures



### Before 1996

Within each hospital all per diems were equal

Differences in patient treatment were not accounted for in the per diems

### 1996 – 2003 (Mixed system)

75 % of cases: reimbursement through a two-tier system of per diem charges: a base per diem (non-medical costs) and a department-specific per diem (medical costs)

25 % of cases: reimbursement through case fees or procedure-related fees

### Since 1.1.2004 (DRGs)

Reimbursement through case fees

Goal: The vast majority of services should be reimbursed through case fees

## Various quality assurance measures have been initiated in the in-patient sector – they contribute to improved transparency

### Quality transparency

