Integration of care after 2004 reform act

Country: Germany
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Current Process Stages

1. Abstract

The German health care system still is characterised by a strong segmentation of different sectors of care. Fragmentation leads to duplication of services, suboptimal quality outcomes and adds to rising health care costs. The Statutory Health Insurance Modernization Act 2004 introduced new ways of organizing care delivery into the German SHI system in an attempt to foster better coordination and integration of care.

2. Purpose of health policy or idea

The Statutory Health Insurance Modernization Act 2004 introduced several innovations in the way care delivery is organized within the German SHI system in an attempt to foster better coordination and integration of care.

**GP as gatekeepers**

One option is the family physician centered care model with general practitioners or family physicians acting as gatekeepers (see HPD 4: Family physicians as gatekeepers). Patients sign in for a GP contract and agree to always see their GP first before they contact any kind of specialist. For the insurees this system is voluntary. An incentive for the patients is to save the ten Euro user charge per quarter.

**Polyclinics -"Medizinische Versorgungszentren"**

Another innovation consists of the so called Medizinische Versorgungszentren. According to this new type of outpatient care service provision, medical care centers bring together general practitioners and specialists under one roof.

This organisational form did not exist in the western part of Germany but was well known as "Polyclinics" in the GDR. It was agreed in the Contract on the German unification to allow this model as a legal speciality in the new "Länder" where a number of polyclinics still exist. The 2004 reform facilitates the establishment of this type of outpatient care throughout Germany.

New after the 2004 reform act is that physicians can be employed in those centers and do not necessarily have to be self-employed anymore. This is somehow an organizational revolution in outpatient care in the German system.

With these medical care centers outpatient care moves in the direction of a more hospital type of care. This is underlined by the fact that several of those polyclinics were founded by hospitals and are often built near by to a hospital. The hospitals try to use the Medizinischen Versorgungszentren to better organize the referrals from...
outpatient to inpatient care. Nevertheless those Medical Care Centers do not play a major role in the German system yet but the number is growing.

**Integrated Care** Last but not least, there is the option to build integrated care networks on a contractual basis. This option was already introduced with the Health Care Reform Act 2000 and has been reformed and improved with the 2004 reform. Details see below.

**Integration of care as method of competition**

One aim behind the 2004 reform act was to introduce more competition to the German health care system. The integration of care and especially managed care were planned to be the tool to bring about competition. Integration and competition were to go hand in hand.

During the mid 1990s, competition according to contributions between sickness funds was established. During that time, competition between health care providers did more or less not exist. On the contrary a system of collective contracts under which all physicians were operating was and still is in place. A physician is obliged to be member of the Regional Physicians Association. These Regional Physicians Associations contract with the sickness funds of the same region and with those sickness funds operating on a national level. The model of selective contracting and competition between providers was established in addition to this collective system not to replace it.

A further aim of the 2004 reform act was to introduce another dimension of competition between sickness funds: that of quality. Since then sickness funds are supposed to compete not only on contributions but also on quality of care as mean of diversification. Quality should be improved through a better integration of care.

**Main objectives**

- Foster coordination and integration of care
- Improve quality of care
- Increase efficiency

**Type of incentives**

**Financial:** one percent of total payments of the physicians and one percent of hospital bills are used to fund the development of the integration of care.

**Groups affected**

Providers, Sickness funds, Insurees/Patients

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### 3. Characteristics of this policy

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<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovate</th>
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<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
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<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
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<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
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<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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4. Political and economic background

5. Purpose and process analysis

<table>
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<tr>
<th>Idea</th>
<th>Pilot</th>
<th>Policy Paper</th>
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Origins of health policy idea

First steps in the Nineties The first steps towards better integration of care were led by the center-liberal (CDU/CSU-FDP) government together with the social-democratic (SPD) majority in the “Bundesrat” in the mid-nineties when integrated care contracts became possible for the first time. This however, was initiated solely on an experimental basis. A number of physician networks all over the country were set up but only for outpatient care still not overcoming the segmentation between outpatient and inpatient care. Those networks were using Information Technologie and electronic patient records for the first time to better communicate and share information about patients and medical procedures.

Health Care Reform Act 2000 - first legislation on integrated care not on an experimental basis After the 1998 election the newly elected red-green coalition (SPD-Green Party) with - for the first time in Germany - a Minister of Health from the Green-Party went further to support integrated care. A new paragraph was introduced to the Social Code Book V allowing integration between outpatient and inpatient care.

However this with the Health Care Reform Act 2000 introduced attempt failed because of too many legal, tax and organizational obstacles. A major challenge was that the Regional Physicians Associations ought to be an obligatory partner of the integrated care contracts. Hence there had to be multilateral agreements between physicians, hospitals, Regional Physician Associations, and the sickness funds; a rather complicated construction with many conflicting interests. This was one of the reasons why integrated care never really grew until the next reform act came.

Statutory Health Insurance Modernization Act 2004 With the Statutory Health Insurance Modernization Act of 2004, the Red-Green government, still seeing the necessity of the integration and coordination of care, initiated substantial changes which were negotiated together with other, more controversial issues with the Christian Democrats (CDU/CSU) during a one week negotiating process towards the end of 2003. By that time a more common understanding that the segmentation needs to be overcome existed at least between politicians but obviously not necessarily under interest groups.

First step agreed was, that Regional Physicians Associations are no longer an obligatory partner of integrated care contracts. This still was rather controversial but an agreement between the negotiating parties in the 2004 reform negotiations was reached in the end.

Second, the reform also introduced the possibility that sickness funds can sign contracts with so called management organizations (Management Gesellschaften) which can be set up to manage integrated care networks. Partners of these management bodies can be institutions or individuals who are defined as providers of care in the sense of the Social Code Book V. This includes physicians, dentists, hospitals, institutions for inpatient or outpatient rehabilitation, pharmacists, and groups of these providers. This however does not include the pharmaceutical industry.

Incentive structure to promote integrated care Finally, a major difference to the 2000 reform is that the 2004 reform not only focused on changing the above mentioned obstacles, but also introduced a huge incentive scheme to promote the integrated care pilots: Initially approved for three years, one percent of total payments of the physicians
and one percent of hospital bills are used to fund the development of the integration of care. This represents a reallocation of around 280 million Euro from the standard system towards integrated care.

This incentive structure did not only get support from the various player in the system. Especially those hospitals or physicians who did not sign any kind of integrated care contract complained that the money was withdrawn from the regular reimbursement scheme and allocated towards integrated care even if no contract had been signed.

Initiators of idea/main actors
- Government
- Providers
- Payers
- Political Parties

Approach of idea
The approach of the idea is described as: renewed: The approach is new in the German system but obviously not new in an international context amended: Health care reform act 2000

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Adoption and implementation

An institution has been introduced to register all integrated care contracts. By end of September 2005 following data has been published (Bundesgeschäftsstelle Qualitätssicherung gGmbH: Gemeinsame Registrierstelle zur Unterstützung der Umsetzung des § 140 d SGB V):

Overall 1407 integrated care contracts have been signed up from 841 in June and 600 in March 2005.

- These 1407 contracts include 2.7 million insures.
- The region with the most contracts is North-Rhine (194 contracts) including 41.712 insures.
- In Saxony-Anhalt on the other hand, only 57 contracts have been signed including 530.719 insures.

Who are the main drivers within integrated care in Germany?

- 25 percent of all signed contracts are between hospitals and sickness funds.
- 19 percent are signed by physicians and hospitals together
• 19 percent are contracts including hospitals and institutions of rehabilitation
• 10 percent have been signed among physicians.
• Contracts across more than two sectors, like those with physicians, hospitals and rehabilitation facilities represent only 5 percent of all signed contracts.

With these examples it can be seen that hospitals are most using the opportunities of integrated care in Germany; they are involved in around 70 percent of all integrated care contracts.

What type of contracts exist? Integrated care contracts can be classified as follows:

• Contracts related to a medical procedure, e.g. hip replacement
• Contracts related to an indication, e.g. stroke.
• Contracts related to a medical discipline, e.g. psychiatry
• Contracts with a population-based approach: A management organization as described above or a network of providers takes responsibility for the organization of care for a certain region including the financial responsibility (budget holding).

Hospitals are mostly signing contracts in the first category. In almost every region in Germany, contracts dealing with hip replacement or other orthopedic procedures can be found. Another big group are contracts related to an indication. Population based integrated care in the sense of a HMO type model is only at the evry beginning in Germany.

Provider and sickness funds slowly approach integrated care
Both providers and sickness funds use the contracts of a limited scope of integration as test markets for further integrated care projects. Because this model of care is new to the German system, providers and sickness funds need to gain experiences in this field. They will also have to invest in human resources and capacity building before they will be willing and able to assume higher financial risks.

At this point risk aversion on both sides is only one of the obstacles for integrated care contracts at a higher scale. Sickness funds and providers simply do not have enough experience in managing integrated care models. Sickness funds never had to manage care activities. They will have to grow into their new role as a player rather simply a payer in the system. On the provider side hospitals had been forced to analyze their cost structure with the introduction of DRGs -an essential requirement to negotiate integrated care contracts with sickness funds.

Integrated care as method of competition
Above it was pointed out that integrated care as well had the purpose to lead to more competition within the German health care system. Numbers show that the a small majority of contracts were signed by only one sickness fund (53 percent of all integrated care contracts) instead of a group of funds (47 percent of contracts). Nevertheless these numbers do not necessarily point to more competition in the German health care system. They might even be an indicator that the sickness funds are not yet making full use of selective contracting as a method of diversification and competition.
6. Expected outcome

The level of integration in Germany is still rather low. Contracts are primarily related to medical procedures. Population based approaches in the HMO sense are still rare. One can see that the German health care system is in an early stage of integration. Sickness funds and providers are not yet using the full scope of the reform and it will take more time before a fundamental change to the system will have happened - if ever. However the opening of contractual options has already profoundly impacted the provider landscape in Germany. The new government elected in September 2005 has extended the one percent budget allocation for the funding of new integrated care contracts for another two years (2007-2008). Whether or not this percentage will be increased to 2% or more has not yet been determined though.

| Quality of Health Care Services | marginal [ ] [ ] [ ] | fundamental [ ] [ ] [ ] |
| Level of Equity                | system less equitable [ ] [ ] | system more equitable [ ] [ ] |
| Cost Efficiency                | very low [ ] [ ] [ ] | very high [ ] [ ] [ ] |

7. References

Sources of Information
Bundesgeschäftsstelle Qualitätssicherung: Gemeinsame Registrierungsstelle zur Unterstützung der Umsetzung des § 140d SGB V. http://www.bqs-register140d.de/ (in German)


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