

**RECENT HEALTH CARE REFORM STRATEGIES IN GERMANY, WITH  
EMPHASIS ON THE TREATMENT OF CANCER**

Michael Hallek, M.D.  
Director of the Department of Internal Medicine  
Ronald Walshe, M.D.  
University of Cologne

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*Michael Hallek, M.D., and Ronald Walshe, M.D., University of Cologne*

## **Introduction**

In the World Health Organization's World Health Report 2000, which compares the health care systems of 191 nations, Germany is ranked 3<sup>rd</sup> for per capita expenditure, but 41<sup>st</sup> in performance on health and at 25<sup>th</sup> in overall health system performance<sup>1</sup>. Various deficits of the current system are held responsible for this poor result, most importantly the strict separation of the ambulatory and inpatient health care sectors, quality and efficiency problems, and adverse selection effects due to open enrollment in sickness funds. These deficits are likely to be particularly disadvantageous in the treatment of patients with complex chronic illnesses.

The fragmentation of ambulatory and inpatient sectors, sometimes referred to as sectorization, results from the regulatory and financial separation of Physicians' Associations which provide ambulatory care, and the hospital sector, which is, with few exceptions, confined to inpatient care. This separation results in a lack of coordination in patient care and contributes to quality and efficiency problems, namely medical overuse, underuse and avoidable harm from medical care for several chronic diseases<sup>2</sup>.

Another crucial factor influencing the quality of care for patients with complex and costly chronic illnesses are incentives for risk selection by sickness funds. Given the free choice of sickness funds implemented in 1996 in an attempt to promote competition and the impossibility of charging risk adjusted payments, there is an incentive for sickness funds to insure young and healthy persons. In fact, the devotion of resources to special care programs may even penalize sickness funds, as it may attract chronically ill patients<sup>3</sup>. While a risk structure compensation (RSC) mechanism based on sex and age was introduced in 1996, this was not able to prevent risk selection incentives derived from chronic disease<sup>4</sup>.

To address these problems in the German health care system, reform schemes in the past ten years have, increasingly, focused on quality, risk compensation and special programs for chronically ill patients. Some important steps taken by the German federal government are described below.

## **Disease Management Programs**

In Germany, the provision and financing of successful disease management programs (DMPs) for chronically ill patients was made possible by legislation in 2002 which allows for RSC payments for differences in morbidity structure, as special RSC groups can be created for insured persons enrolled in DMPs. As a result, standard costs of chronic illness related groups are calculated and included in risk compensation payments between sickness funds. Sickness funds which offer DMPs incur extra revenues while sickness funds which do not experience net losses. The German Social Code defines the scope of DMPs as conditions with high prevalence, variations in care, readily available evidence based guidelines, high costs and amenability to patient self management. Suggestions for DMPs are made by a Coordinating Committee representing sickness funds, Physicians' Associations, the Federal Physicians' Chamber and the German Hospital Organization. So far, the suggested diseases are diabetes mellitus types 1 and 2, chronic obstructive pulmonary disease, coronary artery disease, and breast cancer. For each DMP, specific requirements are set up, such as care targets, first line drugs and treatment schemes, quality management indicators and

documentation sheets. Until August of 2006, nearly 5000 regional DMPs with 1.6 million enrolled patients have been launched nationwide<sup>5</sup>. First meaningful evaluations of quality effects of DMPs are expected for the first quarter of 2007.

### **Integrated Care**

In Germany, integrated care is a legally defined term exclusively reserved to specific contracts agreed between individual health care providers and sickness funds and can apply to all sorts of diseases. The focus is on an organizational and financial level and promotes cross-sectoral cooperation between the ambulatory and hospital sectors<sup>6</sup>. Since the introduction of the Statutory Health Insurance (SHI) Modernization Act in 2004, every sickness fund is required to retain up to one percent of its over-all payments to health care providers for steps taken that improve integrated care in the years 2004 to 2006, which amounts to a sum of 680 million euros per year<sup>7</sup>, giving a strong incentive for health care providers to conclude contracts for integrated care.

Until June of 2006, a total of 2,590 contracts for integrated care with a reimbursement budget of more than 555 million euros have been agreed, and more than 3.7 million patients are taking part in the programs<sup>8</sup>. The preferred type of reimbursement is global fee payments<sup>9</sup>. Global fees are predetermined, single payments for the provision of health care services comprising diagnostics, treatment and follow-up.

### **Integrated Oncology as an Example of Integrated Care in Germany**

The extensive contractual flexibility of health care provision and financing of integrated care provides a unique framework for specifying and financing complex treatment of high impact chronic illnesses. One example is the interdisciplinary and intersectoral program of cancer care at the Center for Integrated Oncology in Cologne which was developed in collaboration with two of the largest German sickness funds, BARMER<sup>®</sup> and Allgemeine Ortskrankenkasse (AOK) Rheinland<sup>®</sup>. This program is currently designed for patients with lung, colorectal and prostate cancer and is to be extended to all major types of cancer over the next years. It spans the coordinated services of the University Hospital Cologne and more than 100 office-based physicians in the Cologne area and aims to achieve the highest possible quality as well as economic efficiency of cancer care. For these ends, all participating providers have to adhere to evidence based guidelines and comply with extensive quality assurance procedures. Detailed treatment pathways for specific cancer entities serve to coordinate multi-disciplinary treatment planning, therapy and after care. Thereby, responsibilities in health care provision, communication and documentation are clearly assigned between hospital and office-based physicians, and this organizational framework avoids inconsistent and redundant medical procedures. Furthermore, interdisciplinary and intersectoral cooperation is boosted by a highly innovative financial structure of the program.

Reimbursement of the first 12 months of care is in the form of disease specific and clinical stage adapted global fees. In order to limit financial risk, additional payments are provided for outliers. The global fees fully reflect state of the art treatment and, for the first time in Germany, provide for adequate funding of palliative care for patients with cancer. The fixed price global fees are paid by the sickness funds to the university hospital, which in turn is in charge of remunerating office based physicians. This arrangement by-passes the financial dichotomy of the hospital and ambulant sectors which is characteristic of the German health care system and which is at the heart of the problem of fragmented health care delivery. Clearly, the actual effects of this program and its financial framework on quality and cost containment are unknown at this stage. While fixed reimbursements may increase economic

efficiency, they could also create incentives for undersupply, and this underlines the need for adequate financial provision for outliers.

### **Medical Care Centers**

Another important element of recent reforms in Germany has been the (re-)introduction of medical care centers (Medizinische Versorgungszentren, MVZ). A medical care center is a multidisciplinary ambulatory health care institution in which physicians from at least 2 different medical specialties work together under a common sponsorship. There is considerable flexibility in the legal structure of medical care centers, enabling physicians to be self-employed or salaried, allowing shareholding by private physicians and hospitals, and providing the opportunity to incorporate pharmacists, physiotherapists and other health care professionals.

The rationale of medical care centers is to enable office-based and hospital-based providers to cooperate closely and use a common technical and institutional infrastructure, and thus, increase flexibility and competition in health care. This institutional novelty may, therefore, contribute to increased quality and efficiency. To date (September 2006) 452 medical care centers have been established and their number continues to grow fast<sup>10</sup>. Whether they will play a significant role in the care of patients with high impact chronic illnesses, though, remains to be seen.

### **Institute for Quality and Efficiency in Health Care**

As part of the SHI Modernization Act of 2004, the Institute for Quality and Efficiency in Health Care (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen, IQWiG) was established as a state independent private foundation. The institute is responsible for the evaluation of therapeutic and diagnostic interventions, pharmaceuticals, guidelines and disease management programs and for supplying the public with easily accessible information on quality and efficiency<sup>11</sup>. Hence, the activities of IQWiG also concern quality and cost of care for complex chronic illnesses. IQWiG receives assignments for its reports from the Coordinating Committee and the Federal Ministry of Health. To date (September 2006), IQWiG has received 87 assignments. Eleven final reports and 7 preliminary reports have been published. Work on 31 other topics has started and for 14 of these, detailed project plans have been completed. Thirty-eight projects have been deferred temporarily. The projects assigned to IQWiG cover 6 main areas: (i) drug evaluation, (ii) medical biometrics, (iii) health economics, (iv) health care research, (v) nonpharmaceutical interventions such as stem cell transplants and (vi) patient information. An important focus of IQWiG is on high impact chronic illnesses such as diabetes, COPD, hypertension and cancer.

### **Conclusion and Outlook**

Over the past 30 years, the German SHI has moved from reform to reform. While cost containment has traditionally been the focus of political change, quality issues have received closer attention since risk compensation between sickness funds was revised in 2002, and the SHI Modernization Act was introduced in 2004. Our analysis of key elements of this legislation shows that the introduction of programs of disease management and integrated care and the creation of a national institute for quality and efficiency address the right issues. However, actual effects on quality of care and costs cannot be assessed yet, and some aspects of actual implementation require close attention and, possibly, intervention from policymakers, health care providers and payers. This is not surprising as the problem of providing high quality health care at reasonable cost is, and will continue to be, a major challenge to all industrialized economies. Therefore, it will be necessary that quality issues be

taken into account in future health political reforms and not be superseded by a financial perspective. In this context, a whiff of optimism may be justified, as the latest health care reform includes improved risk compensation, continuing financial incentives for integrated care and enhanced care management.

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