Science and health policy in Germany

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German Hospital Society
Deutsche Krankenhausgesellschaft

National Association of Statutory Health Insurance Physicians
Kassenärztliche Bundesvereinigung

Relevant actors in the German health care system

Federal Joint Committee
Gemeinsamer Bundesausschuss

National Chamber of Physicians
Bundesärztekammer

Health policy in Germany - Historical aspects

Sauerland 2009

England 1955

USES OF EPIDEMIOLOGY
by J. N. MORRIS, M.R.C.P., D.P.H.

BRITISH MEDICAL JOURNAL
LONDON SATURDAY AUGUST 13 1955

CLINICAL
USES OF EPIDEMIOLOGY
Public Health gap 1933 – mid-1980ies

epidemiology/clinical epidemiology ➔ practically nonexistent

mid-1980-ies ➔ new beginning

Public Health 1933-1945

population health discredited

EBM before 2000

• 1995 first publication in German language
  Klemperer D. Qualität und Qualitätskontrolle in der Medizin
  Der patientenzentrierte Qualitätsbegriff und seine Implikationen

• 1997 first EBM training courses

• 1998 German Cochrane Centre

• SHI Health Care Reform 2000
catalogue of benefits based on EBM

Questions addressed in all health systems

• (how) are individuals protected from the financial burden of disease?
• which services are covered?
  – which kind of filter?
  – who decides?
  – on which basis?

Keys aspects of the German health care system

German health care system
• health insurance: communal / obligatory / compulsory
• 90% members of the Social Health Insurance
• free choice of sickness fund and provider
• comprehensive benefit catalogue
• Ministry of Health sets the general rules
• details regulated by self-administration bodies
• solidarity principle contributions independent of individual’s characteristics, percentage of the income, services according to need

Social Code Book 5
services covered / not covered criteria for „filter”
„wirksam” (effective), „notwendig” (necessary), „wirtschaftlich” (efficient)

perspective of the individual:
care that is effective and necessary
• individual benefit: to cure, to prevent from progressing, to ease suffering
• scientifically proven
• available for all who need it
• no proven relevant benefit – no coverage
perspective of the community
  two options of equal benefit – favor the one which costs less
  • benefit assessment = comparative effectiveness research (CER)
  • rational basis for coverage decisions - to protect individuals from harm and the community from misuse of finances

health services
  • priority on clinical benefit,
  • secondary role for costs – no rationing

public health / population health
  misused 1933-1945 ➔ war against the weak, eugenics
  ➔ state-controlled medical policy met with reservation

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<th>Health expenditure 2008 according to sources of funding</th>
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<td>Sources of funding</td>
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<tr>
<td>Total sources of funding</td>
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<td>Public household budget</td>
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<td>Public health insurance</td>
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<td>Public long-term care insurance</td>
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<td>Public old age insurance</td>
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<td>Private households and private non-profit organisations</td>
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<tr>
<td>Total expenditure on health</td>
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<td>General government excluding social security funds</td>
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<td>Statutory health insurance</td>
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<td>Social long-term care insurance</td>
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Structures:
Federal Joint Committee and Institute for Quality and Efficiency in Health Care

Federal Joint Committee

13 Voting Members:
- 3 Impartial Members
- 5 Members
  - SHI (GKV-SV)
- 5 Members
  - Providers (2 DKG)
  - (2 KKV)
  - (1 KZBV)

5 Non-Voting Members:
- 5 Members
  - Patient organisations
**Federal Joint Committee**

- G-BA: authorised by law to issue directives which are binding on sickness funds, the insured population, panel physicians and hospitals
- decisions about what is and what is not covered
- decision made jointly
- government: monitors / oversees that legal obligations are met

**Federal Joint Committee**

Tasks include
- evidence-based coverage decisions regarding innovations
  - outpatient care: inclusion and exclusion of services
  - hospital care: only exclusion of services

**IQWiG**

Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen

Institute for Quality and Efficiency in Health Care

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rules of procedure

**§ 13 Gesamtbewertung im Versorgungskontext**

(1) Vor der Beschlussfassung nach § 14 Abs. 1 hat ein umfassende Abwägungsprozess unter Einbeziehung der wissenschaftlichen Erkenntnisse, insbesondere der nach Evidenzkriterien ausgewerteten Unterlagen zu erfolgen.

1. Systematic reviews and meta-analyses
2. Randomised controlled trials with definitive results (confidence intervals that do not overlap the threshold clinically significant effect)
3. Randomised controlled trials with non-definitive results (a point estimate that suggests a clinically significant effect but with confidence intervals overlapping the threshold for this effect)
4. Cohort studies
5. Case-control studies
6. Cross sectional surveys
7. Case reports

(Greenhalgh, T. 1997, p244.)

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**Federal Joint Committee**

pharmaceuticals: remuneration of drugs: exclusions / restrictions

no licensing

Federal Institute for Drugs and Medical Devices (BfArM)

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**Decisions of G-BA**

Possible Conclusions after Benefit-assessment

1. Permission or confirmation as service for the SHI care
2. Exclusion as service for the SHI care
3. Suspension of assessment procedure until new evidence is provided („Modellvorhaben“)
Charter of the Foundation for Quality and Efficiency in Health Care

The Institute will work on issues of fundamental importance for the quality and efficiency of the services performed within the framework of the statutory health insurance (SHI) system as an independent scientific institution of the Foundation, in particular in the following areas:

1. Search for, assessment and presentation of current scientific evidence on diagnostic and therapeutic procedures;
2. Preparation of scientific reports and expert opinions on quality and efficiency issues of SHI services, taking age, gender, and personal circumstances into account;
3. Issue of recommendations on disease management programmes;
4. Assessment of the benefits and costs of drugs;
5. Provision of easily understandable information for all citizens on the quality and efficiency of health care services, as well as on the diagnostics and treatment of diseases of high epidemiological relevance.

The National Disease Management Guidelines Programme - “German DM-CPG Programme” was set up in 2002 by the German Medical Association in order to provide evidence-based medical guidance for disease management programmes recommended by the Federal Joint Committee.

The DM-CPG Programme relies on a broad-based collaborative network of experts from medical research and in- and outpatient care, opinion leaders and consumers, designing tools to promote an evidence-based culture within the German health and disability sector. These tools include evidence-based guidelines, the circulation of the latest evidence-based news from Germany and abroad, and training.

The German hospital system

2008:
• 2,083 acute care hospitals
• 503,360 beds
• 16,924,180 patients
• 66,721,000,000 Euro spending

Sponsorship responsibility:
• government on the local level
• free non-profit institutions
• private for-profit companies and private for-profit hospital chains
German hospital system
- **Federal States:** infrastructure
  - hospital planning, funding of the infrastructure
- **users / HI:** the utilisation costs
  - **dual financing**
- **principle of cost coverage before 2003 / since 1972**
  - fixed daily rates per patient, independent of the characteristics of the individual case
  - incentive to prolong the length of the stay
  - principle modified in several reform steps,

  "Only a filled bed is a billed bed"

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**G-DRG tendencies**
- number of DRGs 40% ↑
- range of valuations more differentiated
- compression effect far less pronounced
- number of supplementary payments ↑
- fee for service payment - incentive for increasing volumes