Maria M. Hofmarcher, Sophia Schlette *
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Health policy approaches in the 2013 German coalition contract: *Path-dependent with promises for better quality and more innovation*

Summary review

Health policy approaches in the 2013 German coalition contract are largely path-dependent. First, the contract continues to shift financing responsibilities of future cost growth onto employees as employer contributions are frozen. Second, it indicates strong support for individual doctors´ freedom to practise while leaving the divide between general medicine and specialty ambulatory care largely untouched. To foster innovation in service delivery additional funding will be available although the amount – at about 200 million Euros – is moderate. More funding is foreseen for long-term care, which also involves the establishment of a long-term care fund to accumulate reserves. This fund will be operated at the Bundesbank likely indicating that monies flowing into this fund will be assessed.

Key points

- Establishment of an Institute for Quality. Routine ambulatory and inpatient care data coming from sickness funds will be analysed and reported annually with the aim to enhance quality service provision, also through health services research.
- Creation of an Innovation Fund, which will be endowed with 300 million Euros funded by sickness funds. While half of this amount comes form the central Health Fund, 75 million Euros are earmarked to go to health services research. Criteria for awarding monies to innovative delivery systems will be developed and applied centrally by the Federal Joint Committee.
- Strengthened importance of the Federal Joint Committee, which is entrusted a number of new tasks spanning from measures to standardize service provision (DMPs) and to e.g. improved regulation of medical devices. Also, the Committee is requested to closely cooperate with the Institute for Quality.
- Enhancement of price control mechanisms in the pharmaceutical market. Early benefit assessment of pharmaceuticals continues to be applied but provisions to submit existing drugs on the market to the same process have been dropped. 2009 price levels are kept and industry rebates for prescription drugs is set at 7 per cent in 2014. Subject to monitoring it may be lowered but may not fall below 6 per cent of ex-factory prices.
- Freeze of employer contributions at 7.3 per cent, while the total contribution rate to health funding is set at 14,6 per cent, down from 15,5 per cent. Additional funding sickness funds may need in the future will be charged as a proportion of eligible incomes likely supporting progressivity. This will include the 0.9 percentage point additional contribution rate already borne by employees only.
- A prevention bill is envisaged to be passed into law in 2014 aiming at promoting "health in all policies" strategies across key areas of living conditions including occupational health.
- Maximum wait time for outpatient specialist appointments. Regional office-based physician bodies have to set up a central booking service to schedule specialty care appointments within four weeks or less or else advise utilization of ambulatory care in hospitals, paid at the expense of ambulatory physician budgets. Waiting times in particular for psychotherapy should be reduced through permitting more psychotherapists into the market.
- Access to ambulatory care remains a key responsibility of office-based doctors, but the contract foresees new provisions that municipalities may establish health centres where physicians can no longer ensure services. The innovation fund is expected to revitalise earlier care coordination policies. Also, improved discharge management should play a role here.

- A hospital reform is framed which involves (a) reporting on quality from the newly established Institute for Quality, (b) a "quality offensive" to reward high quality, (c) improved planning of hospital capacity based on accessibility not location and (d) adequate weights for labour inputs in DRGs used. A detailed proposal involving key actors is expected at the end 2014.
- Needs assessment for long-term care will be renewed and care at home will be promoted also by coordinated decentralisation of governance in this area. Further, training of non-medical staff will be reformed to ensure permeability of functions across care sectors.
- Contribution rates for long-term care will be increased in January 2015 by 0.3 percentage points. Of this proportion 0.1 percentage points will be used to built-up a fund for long-term care, which will be operated on the level of the Bundesbank. Once needs assessment for long-term care is renewed the contribution rate will further increase 0.2 per cent, leading to a total increase of 0.5 per cent throughout the envisaged government period.

The 2013 German government program for the period 2014-2018

On November 27, 2013 the German grand coalition government between CDU/CSU and SPD released the coalition contract for the next government period. While a final approval via popular vote of all members of the SPD is still pending coalition negotiations are largely finished. The health chapter frames policy approaches for ambulatory care, inpatient care, drugs, health workforce capacity, health services research, and prevention. Financing issues are dealt with at the end of the chapter before long-term care policy including future funding of this area is framed. Key points presented in this Fast Track largely follow this structure.

For more information: http://www.tagesschau.de/inland/koalitionsvertrag136.pdf (in German).

The German Health Care System

Key features of the German health care system are choice and regulated competition within a self-governed system, not a state-run health care system. Germans enjoy a high level of freedom to choose and change their providers and health plans.

Coverage is generous and includes ambulatory care, hospital care, and prescription drugs, and a range of other health care services such as check-ups, cancer screening, psychotherapy, and physiotherapy. Co-payments exist for prescription drugs, dental visits, vision aids, and elective services.

Outpatient providers are private practitioners working in solo or small-group practices as independent, self-employed entrepreneurs and are predominantly paid on a fee-for-service basis. Hospital ownership is split among municipal or state (regional) hospitals, not-for-profit and for-profit hospitals.

Germany is home to the world's oldest social security system. Its Statutory health insurance (SHI) is one of five pillars of social protection granted by law to every resident, the others being pension, unemployment, occupational accident, and long-term-care insurance.

As of January 2013, residents can choose among 134 sickness funds. Sickness funds operate like private companies and bear the financial risk for their members. By law they cannot reject applicants on the grounds of age, health status, or medical history ("guaranteed issue"). The SHI system is funded by contributions, divided equally between employers and employees, and to a small extent by general taxation. The German government sets the contribution rate. A virtual health fund collects and then distributes the money from and to the sickness funds based on their enrolled population's risk.

For more information:

- OECD Health at a Glance 2013. Released 11/21/2013: http://www.oecd.org/health/health-systems/health-at-a-glance.htm
- Obermann, K, Mueller P et al. : The German Health Care System. A Concise Overview. 2013
- Schlette, S and Hess R: Early Benefit Assessment for Pharmaceuticals in Germany: Lessons for Policymakers. The Commonwealth Fund, October 2013, http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Oct/Early-Benefit-Assessment-for-Pharmaceuticals-in-Germany.aspx.

* Sophia Schlette, MPH, is a health policy analyst, innovation scout, and health systems knowledge manager. Presently freelancing as a consultant, she is the founder of the Health Policy Monitor network and website, a project of the Bertelsmann Stiftung now merged with the European Observatory National Leads Institutions' Network as Health Systems and Policy Monitor.