

Care coordination gaining momentum in Germany

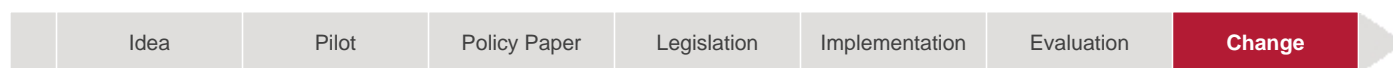
Country: Germany

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Reported by: Bertelsmann Stiftung, Gütersloh

Health Policy Issues: System Organisation/ Integration, Funding / Pooling, Quality Improvement, Access

Current Process Stages



1. Abstract

Because of strong segmentation of the different health care sector and resulting problems, the German administration introduced forms of integrated care into the system through the Health Care Reform Act 2000 and the Statutory Health Insurance Modernization Act 2004. Since then, IC in Germany has gained momentum. The new reform of 2007 (SHI-CSA), has broadened the possibilities of IC while start-up financing for integrated care contracts has been extended until the end of 2008.

2. Recent developments

The Statutory Health Insurance Modernization Act 2004 made possible new ways of organizing care delivery, which have been described in detail in the report ["Integration of care after 2004 reform act" \(6/2005\)](#):

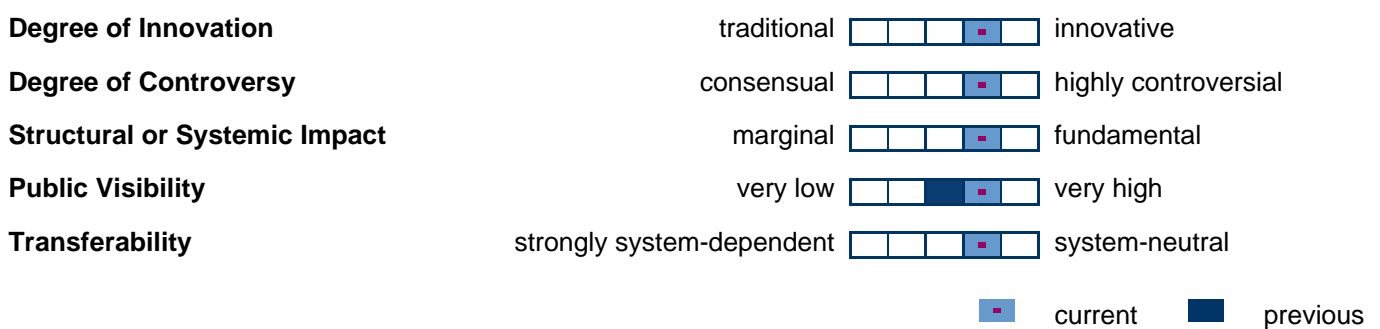
- GP as gatekeepers
- Polyclinics (Medical Centers)
- Integrated care networks on contractual basis

Since then, IC in Germany has gained momentum (see below in chapter "Adoption and Implementation"). Recent changes in legislation provide further support for this development:

1. **GP as gatekeepers:** Starting in 2007, statutory health insurance funds (or sickness funds) are obliged to offer gatekeeper contracts to their insured and may provide a financial incentive to join. Prior to the 2007 reform, sickness funds could offer gatekeeping agreements on an optional basis.
2. **Polyclinics:** Recent changes in contractual regulations between statutory sickness funds and SHI physicians ("Vertragsarztrecht") have reduced some restraints on polyclinics (Preusker 2007, 28). Cooperation of GPs and specialists in a polyclinic is now explicitly permitted by law. Also, it is now possible for physicians of the same specialist area to found a polyclinic together as long as they are focused on different subareas. Another new possibility is the cooperation between physicians and dentists within a polyclinic. Under the new law, there are more flexible regulations regarding part-time employment of physicians: e.g. hospitals can now have their employed physicians partly working directly at the hospital and partly for a polyclinic.
3. **Integrated care networks on contractual basis:** The Statutory Health Insurance Competition Strengthening Act (SHI-CSA) of 2007 extends the existing start-up financing for IC contracts (1% of SHI budget for hospital and ambulatory care) until the end of 2008. Furthermore, long term care (which is financed not through health

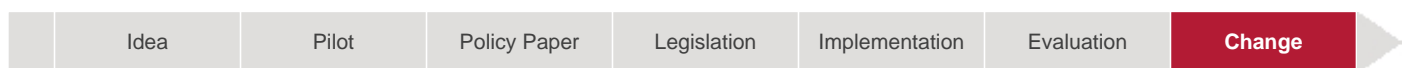
insurance but through compulsory long term care insurance) can now be included in IC contracts. Non-medical professions in healthcare (e.g. occupational and physical therapists) can become the main legal partner to sickness funds in IC contracts (formerly restricted to physicians). New contracts are supposed to focus on population-oriented IC, although disease- or procedure-oriented contracts continue to be possible and constitute most of the >4000 contracts that have been signed (also see below "Adoption and Implementation").

3. Characteristics of this policy



- **Innovation:** Current care coordination approaches in Germany are similar to those applied in other countries.
- **Systemic impact:** The introduction of IC into the German delivery system means a fundamental change, although at the moment the numbers of doctors and patients working and being treated in integrated systems still make for only a small part of care delivery (Example: While by March 2007 the number of physicians working in polyclinics has risen to 2934, this has to be seen in relation to more than 100,000 physicians working in single-practice or in small group practices covering only one medical field).
- **Public visibility:** The rising numbers of polyclinics, "GP as gatekeeper"-options and IC contracts offered to patients have lead to a slow increase in public visibility.
- **Transferability:** The approaches can and have been applied in other countries' health care systems with similar structural problems.

4. Purpose and process analysis



Initiators of idea/main actors

- Government
- Providers
- Payers

- Political Parties

Stakeholder positions

- Integration of care was initiated by the Federal Ministry of Health. In spite of a change in Government (from a coalition of Social Democrats and Green Party to a coalition of Social Democrats and Christian Democrats) in 2005, legislation has been consistently supporting integrated care. This seems to be due to the personal and political continuity at the Ministry of Health. Little or no technical objection came from the CDU, the former opposition leader and current coalition partner.
- Positions of physicians by now seem to be ambivalent. Some physicians accept forms of integrated care as a positive development regarding their work options in the outpatient sector as well as quality and effectiveness of care. Other physicians, working in the traditional ambulatory structures of care in Germany dominated by solo practices for generalist as well as specialist care, still perceive the new developments as a threat.

Actors and positions

Description of actors and their positions

Government

Ministry of Health

very supportive  strongly opposed

Providers

Regional Physicians Associations

very supportive  strongly opposed

Payers

Sickness funds

very supportive  strongly opposed

Political Parties

Social Democrats

very supportive  strongly opposed

Christian Democrats

very supportive  strongly opposed

 current  previous

Influences in policy making and legislation

Efforts to foster better coordination of care in the German health care system, in spite of the change of government in the autumn of 2005, seem to be consistent over time and independent from party politics remaining a priority issue. It is also true that major health care reforms in the past have always been the result of backstage grand coalition negotiations in order to pass legislation in the upper and lower house. The tradition of bringing about major reforms through broad consensus, while time consuming and at times erratic or opportunistic, nevertheless answers the "stickiness" of certain reform approaches. The Statutory Health Insurance Competition Strengthening Act (SHI-CSA) of 2007 has been a further step in promoting coordinated care. It extends the existing start-up financing for IC contracts until the end of 2008 and opens up new possibilities for IC contracts across different sectors of care. There was an attempt from the Federal Ministry of Health to allow start-up financing only for contracts targeting population-oriented integrated care. The attempt failed - the law now only mentions contracts for population-oriented IC as favored option. The provision of a "GP as gatekeeper" modell has been made mandatory for all statutory health insurance funds.

Legislative outcome

Enactment

Actors and influence

Description of actors and their influence

Government

Ministry of Health



Providers

Regional Physicians Associations



Payers

Sickness funds



Political Parties

Social Democrats

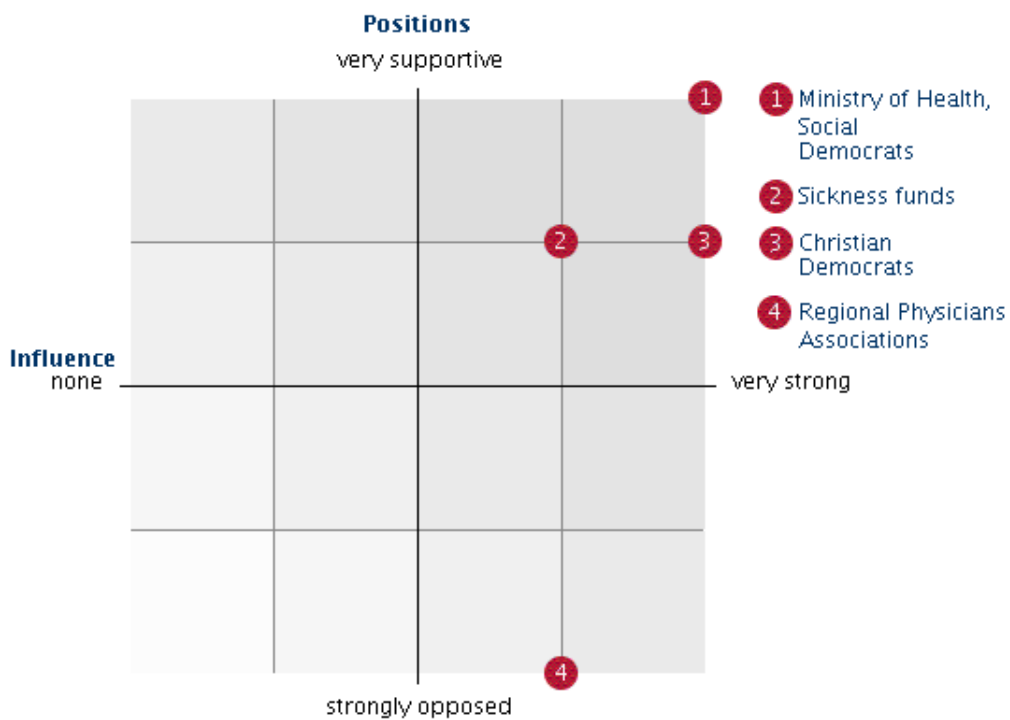


Christian Democrats



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Positions and Influences at a glance



Adoption and implementation

- 1. GP contracts:** In May 2007, about 5.3 million patients have already subscribed to a gatekeeper contract, compared to 2.6 million in February 2006 (Federal Ministry of Health). Especially elderly and chronically ill patients choose the gatekeeper option.
Most contracts are only offered in a certain geographical region; there are few nationwide contracts (only two in 2006). Almost all contracts are offered to all insured of the participating sickness funds, although some are only offered to patients suffering from one or more chronic illnesses. All contracts aim to strengthen the position of general practitioners by employing them as coordinators of care; financial incentives are linked to this role (Böcken 2006).
- 2. Polyclinics:** As predicted in our earlier report, the number of polyclinics has been growing and they are increasingly perceived to be a promising organizational form in outpatient care delivery. Starting off in 2004 with 17 polyclinics in Germany, in March 2007 their number has risen to 733. They include general practitioners, specialists (most often internists, radiologists and surgeons) and increasingly non-physician practitioners under one roof.

Source: www.kbv.de/koop/9173.html

For physicians, polyclinics provide the opportunity to participate in outpatient care delivery without facing the risk and bureaucracy connected to self-employment. The number of physicians joining a polyclinic as employees has risen from 472 in September 2005 to 1940 in March 2007.

The most important reasons for physicians to found a polyclinic instead of establishing a single-practice are a better market position (85%), the possibility of more effective care delivery (58%), and better marketing possibilities (48%) (KBV, MVZ-Survey 2005).

- 3. IC contracts:** The number of IC contracts between sickness funds and providers has also risen rapidly within the last few years. While the introduction of IC contracts in 2000 was followed by a slow start (there were only little more than 600 contracts by the beginning of 2005, for reasons see [report 6/2005](#)) by July 2007 their number has risen to more than 4000 with more than 4 million patients being treated within this form of integrated care. Most of the contracts to date focus on hip and knee surgery, other orthopaedic indications or cardiovascular disease. However, a few ambitious projects have developed models of population-oriented integrated care in Germany.

Monitoring and evaluation

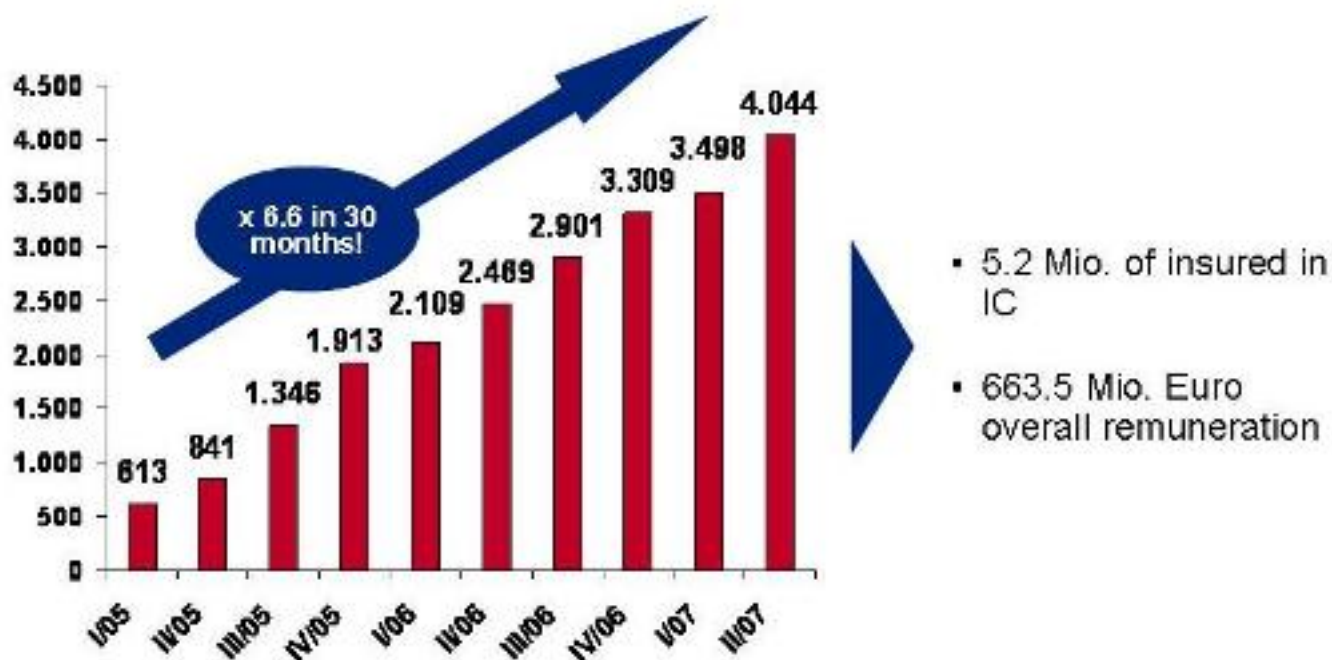
Legislation on integrated care in Germany does not foresee mandatory evaluation.

Coordination and integration of care are believed to improve the quality of care while at the same time having potential of reducing costs. However, evaluations proving these assertions to be correct are still sparse. This problem is increasingly gaining the attention of experts.

In its current report (June 2007), the influential Advisory Council on the Assessment of Developments in the Health Care System calls the interim results of IC in Germany unsatisfactory, since a breakthrough towards a more effective or efficient delivery of care has not been proven so far. The council therefore calls for the further development of IC to be accompanied by more profound evaluation looking at outcome indicators.

Rapid development of integrated care

number of contracts



Source: Federal Office for Quality Assurance II/2007

5. Expected outcome

1. **GP contracts:** Among the different forms of IC in Germany, GP contracts are the most widely known among patients and possibly the easiest to understand. This leads to a high level of acceptance: In a recent survey conducted by the Bertelsmann Foundation 80% of the respondents state to be generally willing to consider joining a gatekeeper contract. However, a closer look at the details will probably reduce the percentage of those actually willing to join (Schnee 2007).

To what extent GP contracts actually improve quality of care and reduce costs can so far hardly be answered. A larger evaluation of GP contracts in five federal states is currently under way, results are expected by November 2007 (AQUA-Institut 2007). A patient survey conducted by the Bertelsmann Foundation presents rather sobering results: 90% of respondents in a GP contract did not perceive a difference in care delivery after joining the contract. 10%, however, perceived an improvement in the quality of care they received (Böcken 2006).

Because of the high acceptance of the GP-model among the insured population, the existing financial incentives for patients to join ([see report 6/2005](#)), and the new regulation making it obligatory for sickness funds to offer GP contracts, a further increase in participants can be expected.

2. **Polyclinics:** Increasing cooperation of practitioners across specialty areas under one roof is going to be a continuing trend in the German delivery system. The concept "polyclinic" has taken root in Germany and some very successful examples have been established (e.g. [Polikum](#) in Berlin). However, there are two obstacles that

might reduce its potential. These new regulations might lead to polyclinics being one form among others in this area.

First, polyclinics are opposed by many SHI physicians working in in solo practice. Since this group is very influential in the German health care system, it can deter the development of polyclinics, especially of those with hospital involvement. The number of polyclinics founded by hospitals has not risen as quickly as many expected and makes for about 1/3 of all polyclinics. Many self-employed physicians in a region fear polyclinics founded by the local hospital as new and strong competition in the outpatient sector. On the other hand, hospitals fear the bad will of SHI physicians in their region, whose referrals of patients they depend on, and therefore may drop their plans of establishing a polyclinic (Preusker 2007). In March 2007, only 232 of the 733 existing polyclinics included a hospital.

Second, changes in contractual regulations between statutory health insurance funds and SHI physicians in 2007 have provided physician practices with new possibilities which so far had been sole privileges of polyclinics. Practices can now form local and regional associations to jointly treat their patients ("Berufsausübungsgemeinschaften"). Furthermore, for physicians shying away from self-employment there are new options of working as employees in physician practices. This might reduce the attraction of polyclinics for physicians looking for employment in the ambulatory sector (Preusker 2007).

- IC contracts:** Start-up financing for IC contracts has been an effective incentive for providers. The rising numbers of contracts but also the intensity of discussion about possibilities of IC among providers and the level of maturity which some of the projects have reached show that the changes introduced by the legislation of 2004 have brought about a breakthrough for IC in Germany (Amelung 2006). Now that a "point of no return" has been reached a development from indication-focused contracts towards more examples of population-oriented IC can be expected.

Quality of Health Care Services



Level of Equity



Cost Efficiency



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Regarding the effect of IC on the quality of health care in Germany as well as on costs it is too early to tell. Also the variation of contractual arrangements, their contents and their scope make a systemic impact evaluation difficult. In any case, the effect on quality and costs at this point are rather marginal because of the currently small proportion of IC within the German health care system.

To assess the impact of this change, it might be more appropriate to look at probable future outcomes. If the assumed positive effects of IC on costs and quality can be proven and the different forms of IC keep on growing at the same pace, the future impact of integrated care will be fundamental. Since coordination of care in Germany aims at increasing the quality of care rather than realizing all the possible cost savings, the effect on quality will probably be higher than the effect on costs.

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