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## Competition policy for health care provision in Germany



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### ABSTRACT

Since the 1990s, Germany has introduced a number of competitive elements into its public health care system. Sickness funds were given some freedom to sign selective contracts with providers. Competition between ambulatory care providers and hospitals was introduced for certain diseases and services. As competition has become more intense, the importance of competition law has increased. This paper reviews these areas of competition policy. The problems of introducing competition into a corporatist system are discussed. Based on the scientific evidence on the effects of competition, key lessons and implications for future policy are formulated.

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### 1. Introduction

Traditionally, Germany's social health insurance system is governed jointly by associations. The national association of sickness funds, the national and regional associations of physicians and the German Hospital Federation negotiate contract conditions and payment schemes for ambulatory and hospital care. In the 1990s, however, competitive elements were introduced in the system. The first major reform concerned sickness funds. Since 1996, almost all individuals insured in the social health insurance system can choose freely among sickness funds. This has fundamentally transformed the funds from administrative entities into service-oriented institutions.

Initially, sickness funds had few possibilities to influence the provision of health care services as these were predominantly determined by collective negotiations and legal requirements. Inspired by managed care in the US, sickness funds were given some freedom to sign selective contracts with providers in the late 1990s. Today sickness funds offer Disease Management Programs, Integrated Care

Contracts and Gatekeeping Contracts. The vast majority of health care services, however, continue to be managed by the corporatist system.

A prominent feature of the German health care system is the strong separation of the outpatient and inpatient sector. Hospitals are mainly restricted to inpatient care. Outpatient specialist care is provided by physicians with specialist training. In the last decade, some competition between the sectors was introduced. Hospitals were allowed to offer ambulatory care for specific diseases and for certain specialized services. Hospitals also opened medical treatment centers for patients seeking outpatient care. Both, hospitals and ambulatory specialists, offer ambulatory surgeries.

As competition in German health care has become more intense, the importance of competition law has increased. Selective contracting by sickness funds is subject to competition law. The competition authority is also responsible for mergers of sickness funds and of hospitals. Between 2004 and 2014, 182 hospital mergers were approved and 7 prohibited.

This report provides information on these areas of competition policy in Germany. In Section 2, a short overview of the German health care system is given. In Section 3, com-

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petition policies are reviewed. Section 4 concludes with key lessons and implications for future policy. The focus is on competition between health care providers. Section 2 also provides summary information about health insurance competition.

## 2. Institutional set-up

### 2.1. Basic characteristics

In 2014, Germany spent 11.2% of its GDP on health care [1]. Most health care expenditure (66%) was financed by “Statutory Health Insurance” (SHI, *Gesetzliche Krankenversicherung*), the public health insurance program in which sickness funds provide health insurance. A share of 9% was paid for by the private health insurance system which insures public servants, self-employed persons and individuals who opt out of SHI. The remaining share was financed by private households and non-profit organizations (13%), by other social insurance programs or from public budgets (7%) and by employers (4%).

In the SHI system, currently 118 sickness funds insure about 87% of the population. Mergers have decreased the number of funds considerably. In 1990, there were still 1147 funds. Sickness funds are quasi-public corporations and non-for-profit institutions. A major characteristic of SHI in Germany is self-governance. Payers and providers are organized in “corporatist bodies” with mandatory membership and special legal status. In particular, this comprises the national association of sickness funds, the national and regional associations of SHI-physicians and the German Hospital Federation. These associations negotiate contract conditions and payment schemes for ambulatory and hospital care. The regulatory framework is provided by the Social Code Book V (*Sozialgesetzbuch*). The federal and state (*Länder*) authorities supervise the self-governance of the associations. The most important decision-making body is the Federal Joint Committee (*Gemeinsamer Bundesausschuss*) which consists of ten representatives of the associations and three neutral members. Five patient representatives can put topics on the agenda, but have no voting rights.

To finance SHI, a contribution rate of 14.6% is levied upon labor income up to an income ceiling of €4237.50 in 2016. This leads to a maximum levy of about €619 per month. The contributions are transferred to a Central Reallocation Pool which is administered by the Federal Insurance Authority (*Bundesversicherungsamt*). For each member, sickness funds receive risk-adjusted capitation payments based on age, sex, disability status and morbidity. In addition, sickness funds can charge an additional contribution rate on the same income base. It currently ranges from 0.3 to 1.7%. Information on prices and supplemental benefits, such as alternative health care or integrated care, is readily available (see, e.g., <https://www.gesetzlichekrankenassen.de/>). However, there is no official publication of performance indicators.

As the benefit package of sickness funds is to a large extent specified by law, competition between sickness funds focuses on price. A study by Bünnings et al. [2] with

data from 2007 to 2010 finds that price differences are the main factor for the choice between sickness funds. Service quality and supplemental benefits only seem to play a minor role. From 2009 to 2014, premium differences between sickness funds were expressed in absolute Euro values as opposed to percentage point differences in contribution rates. Schmitz and Ziebarth [3] show that this policy change strongly increased the willingness to switch funds. Demand elasticities increased by a factor of four. There is an ongoing debate about the risk adjustment scheme. Among the issues discussed are the number of diseases considered and the manipulation of diagnostic information. In a field experiment, Brosse and Himmel [4] find evidence for risk selection by sickness funds against elderly and those with chronic diseases.

In contrast to sickness funds, private health insurers charge premiums related to risk. In 2015, about 11% of the population were covered by private health insurance. Of the 42 members of the association of private health insurers, 24 are for-profit companies and 18 are mutual insurance societies. The privately insured consist of active and retired civil servants, self-employed and employees who have opted out of the sickness fund system. Opting out requires that income exceeds a threshold (in 2016, a yearly income of €56,250). Most physicians treat both SHI-patients and private patients in the same practice. Private patients pay according to a different fee schedule for outpatient services which is considerably more generous than payment for SHI-patients and not subject to volume restrictions. In hospitals, private patients often pay for additional services, e.g. for treatment by the head doctor. Payments by private patients are an additional and important source of income for both physicians and hospitals. According to a study by the Federal Statistical Office, private patients generated 28% of physicians' income compared to 69% for SHI-patients [5]. Roll et al. [6] find that private patients obtain appointments earlier and remain shorter in the waiting room.

Private health insurers compete on price and on the level of coverage, e.g., on the size of the deductible. There is also competition with sickness funds for high earners who have the possibility to opt out of the sickness fund system. Private health insurers typically offer lower premiums for young, single and healthy individuals. However, social health insurance is attractive for those with pre-existing medical conditions. In contrast to private health insurers, sickness funds also insure children and a non-working spouse without additional contributions.

Private health insurers save part of the premium income in early years to dampen premium increases in old age. Until 2009, these old-age provisions were not transferable. This strongly restricted competition within the private health insurance system. On the other hand, this regulation avoided that individuals who remain healthy opt out of contracts, leaving insurers with an adverse selection of individuals. Since 2009, a share of old-age provision has become portable. Karlsson et al. [7] examine the data of a private insurer and find only a small effect of portability on

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