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The Health Care Strengthening Act: The next level of integrated care in Germany☆

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ABSTRACT

The lack of integration of health-care sectors and specialist groups is widely accepted as a necessity to effectively address the most urgent challenges in modern health care systems. Germany follows a more decentralized approach that allows for many degrees of freedom. With its latest bill, the German government has introduced several measures to explicitly foster the integration of health-care services. This article presents the historic development of integrated care services and offers insights into the construction of integrated care programs in the German health-care system. The measures of integrated care within the Health Care Strengthening Act are presented and discussed in detail from the perspective of the provider, the payer, and the political arena. In addition, the effects of the new act are assessed using scenario technique based on an analysis of the effects of previously implemented health policy reforms. Germany now has a flourishing integrated care scene with many integrated care programs being able to contain costs and improve quality. Although it will be still a long journey for Germany to reach the coordination of care standards set by leading countries such as the United Kingdom, New Zealand or Switzerland, international health policy makers may deliberately and selectively adopt elements of the German approach such as the extensive freedom of contract, the strong patient-focus by allowing for very need-driven and regional solutions, or the substantial start-up funding allowing for more unproven and progressive endeavors to further improve their own health systems.
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1. Background

The integration of health-care services across sectors is broadly accepted as a necessity to effectively address the most urgent challenges in Western health care systems, such as the aging population, the increase in chronic conditions, rising expenditures, and the scarcity of medical services in rural areas [1–5]. Similar to other countries with a Statutory Health Insurance (SHI) system, the lack of cooperation between various sectors and specialist groups has been a persistent problem in Germany [1,6–8]. However, to date, strengthening the integration of different sectors has had limited success [1,9]. In 2013, The Commonwealth Fund ranked Germany lowest after Sweden out of eleven OECD countries in the category of 'Coordinated Care' [10].

Germany's challenges to integrate care are not unique and shared with most OECD countries that have also experimented with different approaches, such as pay-for-performance, bundled payments, and disease management programs [11–13]. The German

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approach grants high degrees of freedom to payers and providers in designing new models of care and therefore facilitates competition and innovation. On July 10th, 2015, the German parliament passed its latest bill to strengthen the delivery of health-care services within the SHI system. The Health Care Strengthening Act [GKV-Versorgungsstärkungsgesetz] places high importance on the integration of health-care services across different sectors and promotes the "demand-based, nationwide, and accessible" delivery of high quality health-care services [8]. Looking back on more than a decade of experience in reforming integrated care, this study aims to share lessons learned of the German approach across countries and health systems.

2. Integrated care in Germany: freedom of contract as basic principle

Integrated care programs (ICPs) (§ 140a social code book V (SGB V)) were introduced as an important element of the Health Care Reform Act [GKV-Gesundheitsreformgesetz] in 2000 [14]. The rather narrow German definition of ICPs differs substantially from its wider international understanding [15–17]. For example, ICPs do not include centrally governed disease management programs (DMP) that are codified separately in § 137f SGB V. However, within ICPs, the German interpretation is much wider as it allows for a large flexibility and experimenting. The basic premise of ICPs is that providers from various sectors form an integrated care network (ICN); *e.g.*, a hospital forms an ICN with outpatient physicians, psychologists, psychotherapists, and social workers to prevent re-hospitalizations and thus optimizes the quality of life for patients suffering from schizophrenia [18]. These networks or the individual providers then create an integrated care contract (ICC) with a payer, *i.e.*, a sickness fund, and provide the negotiated services to the patient (see Fig. 1). Within ICPs, all contracting partners enjoy a high degree of freedom. ICNs and payers are free to negotiate payment schemes, the provision of care as well as the type and scope of potential evaluations. Providers, payers, and patients have no obligation to take part or enroll in an ICP. In most ICPs, patients are incentivized to participate by non-financial incentives, *e.g.*, by the promise of better quality and access to care and shorter waiting times; however, in some cases, patients may be offered a financial bonus for compliance, such as an exemption from co-payments for pharmaceuticals and medical devices [19]. ICPs are very diverse in nature due to the large degrees of freedom. Interested readers may be referred to the 'Gesundes Kinzigtal' as an example of a population based ICP [1,20] or to a program on recurrent osteoporotic fractures as an example of an indication based ICP [21].

3. The development of Integrated Care Networks has come to a halt

Although introduced in 2000, the substantial uptake of ICPs effectively started in 2004 following the Health Care Modernization Act [GKV-Modernisierungsgesetz] [22]. This act made three major changes to ICPs: first, it

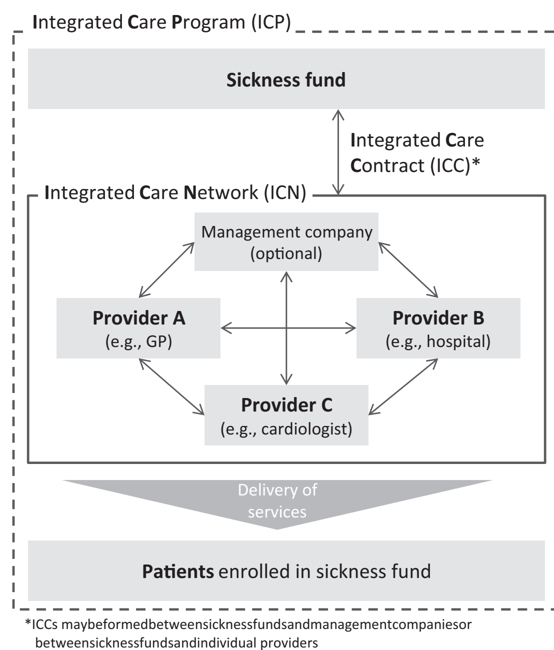

Fig. 1. Integrated Care Program (ICP), Integrated Care Networks (ICN) and Integrated Care Contracts (ICC).

abolished the need for approval from the *Regional Association of Statutory Health Insurance Physicians* (*RASHIP*), which was regarded as the main obstacle to creating ICPs by sickness funds and independent providers. Second, the government introduced generous start-up funding that allowed sickness funds to withhold up to 1% of the in- and outpatient budget, *i.e.*, EUR 460 m p.a. originating from the inpatient and EUR 220 m p.a. from the outpatient budget from 2004 to 2006 [23,24]. The period was later extended to 2008 by the Physician Amendment Act [Vertragsarztrechtsänderungsgesetz] in 2006 [25]. Third, the need to adjust the in- and outpatient budgets was waived, which substantially relaxed requirements of financial viability and reduced bureaucratic effort. Budget adjustments are especially for RASHIPs of large effort, because these bodies are responsible to allocate the budget at individual physician level. Therefore the RASHIPs have not only to solve the resource distribution conflicts between different specialties but also within a specialty, *i.e.*, between physicians taking and not-taking part in ICPs. As such a breakdown makes use of allocation keys, it is never considered fair from the viewpoint of all affected physicians. Therefore, the adjustments caused many conflicts and disputes within the RASHIPs.

In addition, the eligible contract partners have also been extended by several amendments since 2000. While initially, only inpatient care providers, rehabilitation facilities, RASHIPs, and networks of outpatient providers were entitled to form an ICN, this restriction was steadily relaxed. In 2004, the need to close a contract with a network of outpatient physicians was abolished, and contracts between sickness funds and individual physicians were

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