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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

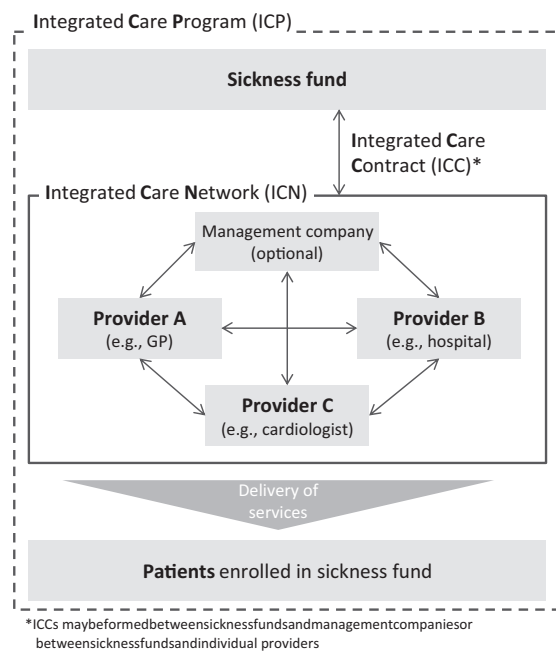


Fig. 1. Integrated Care Program (ICP), Integrated Care Networks (ICN) and Integrated Care Contracts (ICC).

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

Table 1
Number of contracts, participants and expenditure 2008–2011.

Year	No. of registered contracts	Enrollees participating	Expenditures [EUR million]
2008	6400	1,661,283	1225
2009	6262	1,635,270	1224
2010	6374	1,771,949	1353
2011	6339	1,926,133	1352

Source: Bundesregierung (2012) [6].

allowed. In addition, outpatient clinics [Medizinisches Versorgungszentrum] have been added to the list of eligible contract partners, while RASHIPs have been excluded. Then, in 2007, nursing homes became entitled to become contract partners, and in 2011, pharmaceutical companies and manufacturers of medical devices were added (see Table 2).

Following these changes, the number of contracts and participating enrollees increased rapidly from 679,000 enrolled in 2004 to 1,661,283 in 2008 [6,22]. During the same time, total financial capacity used for ICPs increased from EUR 248 million in 2004 to EUR 1225 million in 2008 [6,22]. Costs per patient varied widely, as few ICPs covered a large share of patients with a comparatively low budget. Out of the total of 6400 ICPs in 2008, 32 ICPs accounted for more than 90% of all enrollees but for only 17% of the total ICP expenditure [22]. The figures may be skewed due to the fact that only services that go beyond the general health benefit basket are counted as ICP expenditure, *i.e.*, the effect of ICPs providing an expensive non-reimbursed highly specialized treatment to a small number of people is analyzed together with the effect of large scale ICPs that provide additional non-expensive services, *e.g.*, screening tests. However, as evaluation of ICPs on the aggregate level is scarce and more recent data is not available, conclusions based on this data have to be drawn with care.

Since the cessation of start-up funding at the end of 2008, the growth of ICPs has slowed down, as ICPs that did not demonstrate improved quality and efficiency came under pressure. Later, the enactment of the Health Care Provision Act [GKV-Versorgungsstrukturgesetz] [26] in 2012 further decelerated uptake because it obliged sickness funds to calculate and guarantee savings for each ICP in order to obtain permission from the Federal Insurance Authority [Bundesversicherungsamt].

By the end of 2011, 6339 ICPs with 1,926,133 enrollees remained nationwide (see Table 1). The overall ICP budget totaled to EUR 1352 million in 2011 [6]. This was primarily spent on inpatient treatment (45%), followed by outpatient care (35%), and pharmaceuticals (10%) [6].

To date, most ICPs involve at least one inpatient provider and one outpatient physician, whereas other eligible providers, such as outpatient clinics, acute and rehabilitation hospitals, long-term care facilities, pharmaceutical companies, and medical device manufacturers, are usually less represented. Grothaus (2009) found that 64% of the ICPs included outpatient physicians and 54% included hospitals [22]. Pharmaceutical companies, medical device manufacturers, and rehabilitation hospitals were found to be involved in 13%, 11%, and 1% of all ICPs, respectively [6].

4. The new Health Care Strengthening Act lowers barriers for ICPs

The new Health Care Strengthening Act introduces several changes to foster the implementation of ICPs. First, the legal basis of ICPs is aligned with the legal frameworks of other forms of selective contracting, *i.e.*, so-called ‘structure contracts’ (§73a SGB V) and ‘special outpatient physician contracts’ (§73c SGB V). This extension of the ICP understanding alleviates the prerequisite for cross-sectoral cooperation because those contracts often cover only one specialty within one health-care sector, *e.g.*, outpatient surgery. Second, new start-up funding is provided for innovative ICPs, totaling approximately EUR 300 million annually (Innovationsfonds, §§ 92a–92b SGB V), whereof EUR 75 million is reserved for evaluation and health service research. Its objective is to foster programs that improve cross-sectoral collaboration or to promote innovative programs such as telemedicine, the provision of care in rural areas or projects that improve drug safety for multi-morbid patients. Compared to the start-up funding granted in 2004–2008, there are major differences. Decisions on grant allocations are now made by a subcommittee of the Joint Federal Committee, Germany’s highest decision-making body of self-administration. This subcommittee consists of 10 members that represent providers, payers, and government officials. The funds are only available for health-care services that exceed the budgeted standard care and that have the potential to be implemented in the benefit basket of standard care in the future. Funds are granted for measures that increase health services quality and efficiency, reduce care gaps, improve the collaboration between sectors, providers, and staff groups, or foster inter- and multidisciplinary cooperation. In addition projects are favored that promise transferability of the results to other conditions and regions, projects with a favorable cost-benefit ratio, and project that promise good assessability. The draft bill mentioned especially telemedicine projects, health services solutions for rural areas, improvement of geriatric care, and drug safety programs. However, until now further details on the requirements for application process has not been defined in detail. The EUR 680 million p.a. start-up funding granted in the years 2004–2008 included services that were budgeted in standard care, and thus the EUR 300 million now granted per annum is considered to be a far larger budget. Third, budget adjustment procedures are simplified, as sickness funds and RASHIPs are no longer obliged to adjust their budgets based on the number and the morbidity of the patients. Both parties can agree on a general flat budget adjustment or can even

Table 2
Evolution of integrated care regulation.

	Jan 2000	Jan 2004/Jan 2007	Apr 2007/Jan 2011/Jan 2012	Jul 2015
Legal basis	<ul style="list-style-type: none"> Health Care Reform Act [GKV-Gesundheits-reformgesetz] [14] 	<ul style="list-style-type: none"> Health Care Modernization Act [GKV-Modernisierungs-gesetz] [23] Physician Amendment Act [Vertragsarztrechtsänderungsgesetz] [25] 	<ul style="list-style-type: none"> Competition Reinforcement Act [GKV-Wettbewerbs-stärkungsgesetz] [27] Pharmaceutical Market Restructuring Act [Arzneimittelmarkt-neuordnungsgesetz (AMNOG)] [28] Health Care Provision Act [GKV-Versorgungsstrukturgesetz] [26] 	<ul style="list-style-type: none"> Health Care Strengthening Act [GKV-Versorgungs-stärkungsgesetz] [28]
Key elements	<ul style="list-style-type: none"> Introduces ICPs as cross-sectoral modes of care (population and indication based programs) Provides framework agreement between the National Association of SHI Physicians and the seven National Associations of Sickness Funds Regulates content, reimbursement, quality standards and budget adjustment Requires obligatory ICP approval of the RASHIPs 	<ul style="list-style-type: none"> Removes need for framework agreement Introduces start-up funding for period 2004 to 2006 Prolongs start-up funding for the period 2007 to 2008 Offers free disposition of start-up funding between all eligible contract partners 	<ul style="list-style-type: none"> Restricts disposition of start-up funding to out- and inpatient care in 2007 Introduces necessity for pre-approval of the ICPs by the Federal Insurance Authority in 2012 	<ul style="list-style-type: none"> Removes necessity for cross-sectoral design of ICPs Introduces need to demonstrate economic viability after four years Integrates previously separately regulated 'structure contracts' (§73a SGB V) and 'special outpatient physician care' (§73c SGB V) into the integrated care framework Removes necessity for pre-approval of ICPs by the regulatory agency Reintroduces RASHIPs as eligible contract partners
Eligible ICN partners	<ul style="list-style-type: none"> Networks of general practitioners, specialist physicians, and dentists Other outpatient providers incl. their networks RASHIPs Hospitals Rehabilitation centers Alliances of the above-mentioned partners 	<ul style="list-style-type: none"> Allows contracts with individual general practitioners, specialist physicians, and dentists Excludes RASHIPs as eligible contract partner Added outpatient clinics as eligible partners in 2004 	<ul style="list-style-type: none"> Added long-term care facilities and their payers (long-term care funds) as eligible partners in 2007 Added pharmaceutical companies and manufacturers of medical devices as eligible partners in 2011 	
Budget adjustment	<ul style="list-style-type: none"> Adjustment of in- and outpatient budgets necessary based on number of patients to stabilize contribution rates 	<ul style="list-style-type: none"> Waived adjustment of in- and outpatient budget for period 2004–2008 	<ul style="list-style-type: none"> Introduces necessity for budget adjustment based on number of patients and risk structure from 2009 	<ul style="list-style-type: none"> Simplifies the adjustment procedure by allowing a general flat budget adjustment and allows waiving adjustment if efforts exceed benefit of adjustment
Financial incentives	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Allows start-up funding of up to EUR 680 m p.a. (sickness funds are allowed to withhold up to 1% of the in- and outpatient budget) 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Reintroduces start-up funding of up to EUR 300 m p.a. for the period 2016–2019 (sub-committee of federal joint committee decides on start-up funding)

waive the budget adjustment if efforts exceed the benefit of adjustment. In addition, the adjustment can be made retroactively. Prospective budget adjustments were always challenging because the forecast often did not correspond with the reality [29]. Fourth, RASHIPs are allowed to become a contract partner within an ICP. This had been deliberately precluded after 2004 because the government wanted to increase competition within the oligopolistic outpatient provider market, which was dominated by RASHIPs.

5. No obstacles for the new legal basis of integrated care

The Health Care Strengthening Act has passed through the legislative procedure without any notable peculiarities. The proposal was published by the German Federal Ministry of Health on February 25th, 2015 and passed the three readings in the German Bundestag and the two readings in the German Bundesrat after 135 days. The bill passed the last reading in the German Bundestag with a large majority. This was not surprising, as the current coalition of Christian and Social Democrats holds 70% of the votes in the German Parliament. The act was signed by the President and came into effect at the end of July 23rd, 2015.

Sickness funds generally supported the changes in integrated care, as the new legislation lowers bureaucratic effort by merging ICPs with two other types of selective contracting and by removing the prerequisite of preapproval by the regulatory agency [30–33]. Some sickness funds hoped for stronger deregulation around the budget adjustments, as this procedure often led to disputes with the RASHIPs [30–33]. In addition, there were some discussions about the fund's volume among several associations of sickness funds. Some argued that a one-time payment of EUR 300 million would be sufficient to revitalize ICP uptake, while others criticized the fund for being surprisingly high, as they feared that the high subsidies could attract undesirable projects that are not cost-efficient [30,32,33]. Another major point of criticism was the incongruence between the payment and allocation of funds; whereas sickness funds were obliged to finance half of the start-up funding, a subcommittee of the federal joint committee determined the resource allocation. The composition of this subcommittee, consisting of three government officials out of ten members, was particularly viewed critically, as the German social health-care system has a long tradition as being self-governed with a high degree of autonomy [31]. The representation of all RASHIPs—the National Association of Statutory Health Insurance Physicians (NASHIP)—also supported the changes made to ICPs, mainly because RASHIPs now became eligible as contract partners. However, the NASHIP highlighted concerns about quality assurance in ICPs that include other services as standard care, the blurred model of hospital and outpatient physicians, and the high administrative effort arising from budget adjustments [34].

Policy makers should be deliberate in designing new legislation on integrated care and consider, balance, and align incentives with the overall regulatory framework.

As the German health system became fairly complex, interactions and interrelations between different regulations get more common. For example, the introduction of surplus premiums in 2015 led to opposing incentives for SHIs as the uptake of new ICPs comes often with high initial investments with later payoffs. These initial investments induced an increase in insurance premiums and led therefore to high churn rates of price-sensitive insurees.

6. Scenarios on the impact of the Health Care Strengthening Act

The objective of the new act is to foster the integration of health-care services in Germany. It is not directly apparent how the number of ICPs will develop as there is a trade-off between higher start-up funding and the administrative burden resulting from the budget adjustment and the mandatory evaluation. In an optimistic scenario, start-up funding is the main driver of the ICP growth, the market for ICPs is not yet saturated, and additional efforts due to assessments and budget adjustment are completely offset by the additional funding. A similar positive effect of start-up funding was observed during the time of 2004–2008 in Germany and financial incentives have also been proved to be an important facilitator of integrated care in other European countries [35,36]. This environment will make many new ICNs enter the market, and the strong increase in ICPs as seen in 2004–2008 would be repeated. In a rather pessimistic scenario, it comes to a consolidation of ICPs in a saturated market. RASHIPs would fully make use of their new eligibility as contract partners and drive smaller ICNs with less market power out of the market. The plurality of different providers and services would decline, as RASHIPs have the power to replace numerous small competitors with a single contract. In the short-term, large providers may be considered beneficial for sickness funds because of lower transaction costs. In addition, the administrative barriers to obtain start-up funding may be too high for smaller ICNs. The result would be a decline in the number of ICPs, although the number of enrolled patients may increase or stabilize. Both of the sketched scenarios will probably not reflect reality in four years' time. In general, the new act comes with substantially higher start-up funding compared to 2004–08 but also with higher administrative needs in terms of evaluation and budget adjustment. If one notes that only a fraction of the earlier start-up funding has been used for integrated care contracts, it is very likely that the funds that are provided in the upcoming period will be sufficient and effective to attract new ICPs. However, as the administrative barriers to accessing start-up funding especially regarding evaluation are higher, only promising projects will be realized. In addition, the obligation to transfer successful programs from selective contracts to standard care will restrain innovative providers from applying for funding because payers and ICNs will lose their unique selling points. Sickness funds and providers will most likely apply for funds to improve IT infrastructure, which is underdeveloped compared to other countries [37] but an important driver in the integration of health-care services [38].

7. Conclusion

The decentralized German approach, supported by substantial start-up funding has shown to unleash creative ideas to re-design integrated care of different sectors. With more than 6400 ICPs, Germany has now a flourishing integrated care scene with many ICPs being able to contain costs or improve quality (e.g., in schizophrenia [18,39], cardiovascular diseases [40], or in population based settings [41,42]). However, the huge number of programs makes it difficult to identify the most promising ICPs—especially as evaluations on quality and cost savings are often not publicly available. There is especially little evidence publicly available if ICPs fail because of a low number of participants, lack of cooperation between providers, lack of management capacity, or unfavorable results regarding outcomes. A mandatory reporting of a set of pre-defined and aligned quality indicators might improve the situation.

Time will show whether the government set the right course for improving the integration of health-care services in Germany. Certainly, the government satisfied long-standing demands for new start-up funding for innovative programs and lower administrative barriers. Experience from other countries, such as Austria, Spain, Sweden, and the United Kingdom, shows that integrated care requires a proactive government to overcome its barriers [35]. Even if the most optimistic scenario unfolds, it will be still a long journey for Germany to reach coordination of care standards set by the leading countries such as the United Kingdom, New Zealand or Switzerland [10]. However, although Germany lags behind other countries in integration of care, the Germany has succeeded in creating a fruitful environment for innovative integrated healthcare solutions. Therefore, 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.

Conflict of interest

None declared.

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