

Conference

**Improving primary care in Europe and the US:
Towards patient-centered, proactive and coordinated systems of care**

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Country Case Study Germany

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Part 1

Summary information

Germany has a statutory insurance system with universal coverage. Governance, services to be covered and the general terms of finance are regulated by federal law. Hospitals are run by local or state (Länder) governments, churches and private companies. Their running costs are covered by a fee schedule base on treatment episode, diagnosis and procedures (DRG). Theoretically states should provide buildings, larger equipment etc., but in practice this is not sufficient.

Federal law provides only the framework for the health care system. Other decisions, including coverage of defined services, are taken by joint committees of funders' AND providers' representatives. This system of "self-governance" is perhaps what is unique about the health care system in Germany. As a result, the influence of government is limited. Payers and providers have to negotiate and agree on important issues, e.g. which services should be covered and which not. Since there is no powerful single player, the system is extremely slow to react to new challenges.

With few exceptions, ambulatory care is strictly separated from hospital care. In the community there are generalists (GPs/FPs; primary care internists; general paediatricians [*Hausärzte*]) and specialists in the ratio of about 2:3. There is no gatekeeping, a large number of specialists compete with generalists to provide often fragmented primary care (orthopaedics, ENT and dermatologists are notorious examples). On the other hand there are informal gatekeeping arrangements, i.e. specialists that accept patients only on a referral basis (e.g. most internal medicine sub-specialities).

Among health planners there is agreement that the system lacks efficiency since coordination of services is poor and doctor-shopping abounds. Experts agree that the generalist/specialist ratio should be reversed, however there are nor serious plans to establish some kind of medical workforce planning towards that goal.

Ambulatory care practitioners can only indirectly contract with sick funds. They have to be members of the "sick funds doctors' association" (KV). Although theoretically independent contractors, their work is heavily regulated including geographical limitations to ensure equal distribution of practices, intense cost control with regard to their own services, drug prescribing, physiotherapy, ergotherapy etc. The KVs have a dual, sometimes contradictory function: they have to administrate federal law and what has been decided at system level. On the other hand the KV is the ambulatory care doctors' "union" and has to negotiate on their behalf with insurances. Since specialists are usually in a majority position, primary care / family medicine interests are not represented well. Although governments, sick funds and health players support a strong primary care system at the lip service level, a system based on self-governance usually leaves primary care doctors in a precarious minority position.

Financing of ambulatory medical services is based on capitation at the system level. Insurances transfer capitation payments per member with some adjustments for employment status to the KV. Individual practitioners, however, are paid on a fee-for-service-basis. Fees are adjusted by a floating value scale. Since the overall cap is linked to the growth (or absence of it) of the economy at large, and doctors and services have increased, individual items have gradually been devalued. Fee schedules again have to be agreed upon by all stakeholders including sick funds. There have been frequent reforms with a gradual tendency to move

away from single items towards capitation fees based on quarters, i.e. there is no list system. Primary care has been protected by federal law by creating its own “pool” of funds. It has thus been buffered against some of the devaluation of items resulting from technology expansion on the specialists’ side. However, from next year on community generalists and specialists will have to fight for their share from the same budget again as was the case until about 7 years ago. The current system leaves morbidity risks with providers. However, federal law requires the establishment of morbidity based payment schemes so that risks will be shared between payers and providers. These are currently being developed.

Insurers are free to determine their premiums. Since most services provided are required by law, insurers can compete for individual customers mainly by price. To discourage “cream-skimming”, insurers with young and healthy members have to transfer some of their funds to insurers with old and ill patients. This adjustment scheme is based on age, sex and DMP-membership of an insurer’s population. Traditionally membership of sick fund was based on the employer. Even today, large companies are running their own non-profit health plan according to the stipulations of the law. However, governments have encouraged competition between insurers, people are encouraged to pick insurers with lower premiums.

Patients have direct access to any ambulatory care doctor whether specialist or primary care. To avoid additional user fees for other visits within a three months’ period, they have to get a referral if they want to visit another doctor. Although they can obtain this from any ambulatory care doctor, they usually collect referrals from a primary care doctor (*Hausarzt*). Since the surplus of specialists has created its own demand, the threshold for issuing a referral is rather low and in many instances is only a formal act, i.e. issuing of a form without any meaningful exchange of information either way.

Recently, federal law has required sick funds to offer their members special “*Hausarzt*”-arrangements on a voluntary basis. This implies choice of a primary care generalist as a gatekeeper. However, the uptake by sick funds and patients has been mixed so far. Presumably mostly patients who accept their family doctor as an informal gatekeeper anyway have chosen this kind of arrangements. They obtain small reductions of user fees in return.

The advantage of growing numbers of community specialists is virtually universal access to diagnostic procedures and specialized treatments. If actively sought by the GP, specialist appointments in most fields can be obtained within days or even hours. Although there are waiting lists for routine appointments, urgent cases can easily be accommodated.

Traditionally, doctors have worked with assistants (“*Arzt-Helferin*”). Assistants complete a three years’ curriculum combining administrative (receptionist) and clinical (nurse) content. Their professional status and income are low. This is in contrast to the expanding range of tasks they have to fulfil within practices.

In Germany there has been a surplus of doctors until about 5 years ago. Now hospitals have difficulties filling positions. In rural areas a lack of primary care doctors seems almost inevitable. Governments (federal and *Länder*) are starting to realize that something has to be done. Programmes to support residency / vocational training for GPs are being discussed. There is some debate on establishing nurse practitioners in rural areas.

Main driver for reform have been governments, sick funds and academic groups. The Federal Government’s main concerns have been fiscal aspects, i.e. cost control. Disease management programmes (DMP) for common chronic conditions, e.g. diabetes, coronary heart disease, asthma and breast cancer, were introduced six years ago. Their reception with the medical

profession was negative and even hostile, a reaction which was in part due to the egocentrism of the profession but also to the bureaucratic shortcomings of the implementation process. DMPs require patients to attend a primary care practice at regular intervals with a recall system run by the sick funds. Laboratory results, current treatments and management goals agreed upon are recorded by the practice team. Results are collected by central data processing units with regular feedback for individual practitioners. There are guidelines for long-term medication, referrals and patient education. There is a complicated risk-adjustment scheme to avoid financial disparities between sick funds based on morbidity differentials. This scheme is partly based on DMP-membership, i.e. for each insured person in a DMP the insurance receives about 6 000 €/year from the pool of all insurers, i.e. membership is regarded as a marker for morbidity. There is thus an incentive for sick funds have as many persons as possible within their DMPs.

Although the powerful players in the system have their ideas, they usually do not present coherent plans for alternative solutions. Independent foundations, institutes related to sick funds and university departments dominate debate on health care reform. The self-governing structure may prevent the health care system from falling victim to the vagaries of governments' moods. However, the inertia of the system leaves players feeling helpless and becoming cynical with regard to prospects for change.

Academic departments of General Practice and Public Health have been active at developing new ways of caring for the chronically ill. Among these are guideline development and implementation, case management, self management, shared decision-making, motivational interviewing and behaviour modification. Departments typically cooperate with social scientists, epidemiologists and – partly – clinical specialties.

Relevant barriers to reform at the primary care level are a generally low morale and a widespread feeling among the medical profession that one's own work isn't appreciated. The latter relates to the public, but even more so to self-governing bodies mostly dominated by specialists' interest. Right now, primary care doctors have to cope with a new fee schedule negotiated with the sick funds. However, given the specialists' majority on most committees, they feel the results to be a threat for their future. While hospitals have increasingly difficulties filling junior doctors' positions, rural areas face a loss of primary care doctors in the near future. This is in stark contrast to urban areas, where large numbers of specialists and generalists compete against each other.

3. Micro level

3.1 Self-management support

Patients with common chronic conditions, e.g. diabetes type 1 or 2 or asthma, are offered brief training programmes. These include background knowledge with regard to their illness and current treatments, complications and self-management. Patients in DMPs are encouraged to take part, sessions are usually offered by certified practices.

A broad range of printed and internet-information sources are available. However, many are contaminated by commercial interests, e.g. manufacturers or medical practitioners. The National Institute for Quality and Cost-effectiveness (IQWiG) is developing a comprehensive database of information for patients.

Family practitioners are presumably quite heterogeneous with regard to involving their patients in treatment decisions. Some "transactional" decision aids are available, others are being developed. Most patients are able and willing to express their opinion in their encounter

with their family doctor. With marginal groups, e.g. the elderly, immigrants and socially disadvantaged there is still room for improvement with regard to patient involvement.

3.2 Decision support

There are three guideline programmes relevant for primary care. The German Society of General Practice/ Family Medicine (DEGAM) was the first scientific society / college to embark on an evidence-based development process. Guidelines cover primarily common symptoms or problems, e.g. tiredness, dysuria, or incontinence.

The guideline programme by the KV Hestia covers common chronic conditions with relevant prescribing volumes, e.g. diabetes, hypertension or heart failure.

The national working group of scientific societies (AWMF) are coordinating guidelines of their member societies. A reliable evidence base and formal consensus are encouraged, success has however been mixed so far. Most of these guidelines are dominated by specialist interests. As a result of this the impact on primary care has been limited.

Most GPs are member of a CME-group (quality circle). While most participation is voluntary and happens out of curiosity, some GPs had to take part because of their excessive prescribing. Before an individual GP is punished financially for excessive prescribing, remedial strategies are tried. In other instances, membership is an obligation based on a gatekeeper-contract with one of the insurers. The KV or quality assurance organizations provide feedback to individual practitioners with regard to their prescribing.

The system of quality circles provides a learning opportunity for many GPs that is learner centred and free of commercial interests. If there are curricular structures, these are based on relevant primary care guidelines (see above). There is an emphasis on prescribing topics and cost containment, other areas are sometimes neglected.

3.3 Clinical information systems

Billing information for the KVs has to be provided in electronic form. As a result, diagnostic and activity codes are documented by PC by virtually all practices. Practices differ to what degree they document their clinical information electronically. When practitioners analyze their patients' records this is mostly for questions related to billing (there used to be a complicated system of combinations and exclusions of codes, however, with the current much simplified fee schedule, this has become largely obsolete). While GPs might get feedback with regard to their prescribing by their KV, there is very little tradition to reflect on ones behaviour by performing an audit based on ones own records.

Patients increasingly obtain printouts of specialists' letters or other findings. They like to record home blood pressure readings, most diabetics carry a booklet with their blood sugar and glycosylated haemoglobin levels.

Biochemical and path laboratory results are usually sent to primary care practices in electronic form. Specialist letters etc. usually come as hardcopies. There is local experimentation with hospital records being shared with practices in the region. However, this is still the exception.

The development of a national health-card system is required by law. However, there are technical and confidentiality problems related to electronic records. It is not clear at the moment when the system will come into operation.

4. Further aspects

German doctors are obsessed with hi-tech medicine. As a result, simple things that improve population health are undervalued. Specialists and related commercial interests drain resources from primary care.

Whereas the general public tend to be impressed by hi-tech solutions as well, most people have a GP and appreciate continuous, individualized care.

5. Key findings

Barriers to improving primary care:

- A political decision-making structure at meso and macro level that favours specialists' interests and hi-tech solutions
- Low morale among primary care practitioners

Success factors for improving primary care:

- GPs are popular with the public and most patients
- Quality circles provide a system for professional learning independent of commercial interests
- Governments start to realize that primary care deserves special support

Part 2

Health Care Reforms and future prospects

Dr. Thomas Heil

In addition to Prof. Donner-Banzhoff's description of the current situation of health care especially primary care in Germany, the following part of the elaboration will explicate some characteristics of the ongoing health care reforms with regard to primary care.

The intentions of the health care reforms in Germany are to improve:

- quality in chronic care
- transsectoral coordination and controlling of treatment und care
- patient responsibility and their motivation for prevention of diseases

In addition, the reforms are to reduce (avoidable) hospitalizations and last but not least realize cost-containment.

With regard to primary care in Germany, the following health care reforms can be enumerated:

- Primary care gatekeeping programs (*Hausarztmodell / Primärarztversorgung*, § 73 b, SGB V)
- Particular ambulatory care (*besondere ambulante Leistungen*, § 73 c)
- DMPs (Disease Management Programs, § 116 f)
- Integrated health care (*Integrierte Versorgung (Managed Care)*, § 140 a-d)

ad 1) Primary care gatekeeping programs (Hausarztmodell / Primärarztversorgung, § 73 b SGB V)

The primary care gatekeeping model started in 2004 (Statutory Health Insurance Modernization Act).

Today approximately 5.8 million patients participate, and 38.000 GPs and 18.000 pharmacies are involved in this care model. Patient participation is voluntary.

When enrolled, patients may receive bonuses (e.g. cancelation of co-payment - charges for medical registration (*Praxisgebühr*)). Physicians are requested to follow guidelines as well as standards of documentation and quality. Nevertheless there is no obligation to keep these conditions and no punishment in case of non-compliance.

Characteristics:

- Patient's informed consent
- Patients first select the general practitioner (family doctor, *médecin traitant*)
- Consultation of specialists only by GP referral
- Patient authorizes the GP to transmit personal medical data to specialists
- Health insurances enter into contract with specially qualified GPs (specific training)
- Medical centers with GPs
- Selected pharmacies
- Health insurances direct their members to the partner GPs (GP register)
- Bonus arrangements – e.g. no co-payment

Annotation:

Gensichen, J. et al (2006): In Germany, primary healthcare for patients with chronic diseases needs to be improved. Taking the example of depression, congestive heart failure, diabetes and diseases of the musculoskeletal system we analyzed to which extent the 'Chronic Care Model' allows for improvements.

Results:

- 1) Diagnosis and therapy of chronic diseases comply insufficiently with the evidence.
- 2) Patients are too passive and/or receive only little effective support.
- 3) Treatments are often uncoordinated and fragmented.
- 4) The follow-up of treatment results is often neglected.
- 5) Approaches to indicated diseases are promising.

Conclusions: The 'Chronic Care Model' could improve chronic care in Germany. Disease Management Programs (DMP) should be amended to account for multimorbidity and individual healthcare and/or facilitate implementation in general practice.

ad 2) Particular ambulatory care (*besondere ambulante Leistungen*, § 73 c SGB V)

This innovative reform (since 4/2007) enables the sickness funds to enter a contract directly with the social health insurance (SHI) affiliated physicians (bypassing / excluding the regional associations of SHI-accredited physicians). The object of the contract can be the regional organization, the performance and responsibility for primary care (as occurred with a sickness fund in Hesse in October 2007).

The SHI here is in a position to negotiate the details of care directly with the physicians (or a health center) irrespective of the physician's fee schedule.

ad 3) DMPs (Disease Management Program, § 116 f SGB V)

The DMPs started in January 2002. Today four chronic diseases (Diabetes mellitus (I & II), Asthma bronchiale, Coronary Heart Disease, COPD) and breast cancer are included in the program.

Objectives of DMPs:

- Coordination of diagnostic and therapeutic measures during the entire treatment process
- Improvement of treatment quality
- Limiting costs of the treatment of chronic diseases
- Treatment based on guidelines (Evidence Based Medicine)
- Standardization and coordination of care, case management (ambulatory + inpatient care)
- Data transparency
- Comprehensive and continuous information to the patient (disease, treatment, results)
- Training programs to improve patient's initiative and responsibility for health
- Prevention of disease impairment
- Evaluation of the therapeutic results

Financing of DMPs:

Hospitals and physicians: regular rates for treatment plus extra fee for administration

Insurances: refinancing from risk structure compensation (RSC)

Status Quo (December 2007)

Registered approx. 3.5 million patients (in total)
2.2 million patients with Diabetes mell. (II)
59.000 patients with CHD
25.000 patients with breast cancer

(Source: AOK im Dialog, Zukunftsmodell DMP)

ad 4) Integrated health care (*Integrierte Versorgung*, § 140 a-d SGBV)

This reform was initiated in January 2000, but due to complicated regulations and without any refinancing system this reform did not develop as expected by the health ministry. In 2004 regulations were simplified and a start-up financing was initiated, subtracting 1% of the funds available for ambulatory physician and hospital care.

Integrated Care implies:

Medical providers of different sectors offer a specific care program and enter into a direct contract with the SHI sickness funds. The compensation is negotiable and independent from the established reimbursement systems.

Objectives:

- Improvement of quality in health care
- Development of standardized health care programs
- Treatment adjusted to disease and patient requirements
- Generation of benefits compared to “normal” health care regarding medical, economic and service aspects
- Comprehensive information for the patient
- Evaluable benefit for the patient
- Marketing tool for the health insurance company (competition)
- Individual contracts between sickness fund and medical providers
- Defined and coordinated treatment program (in every service section)
- Treatment based on guidelines (EbM-Evidence based Medicine)
- Fixed inclusive rate per case (includes all the case-associated diagnostic and therapeutic measures)
- Case management
- Management competence in quality management, economy, health care, risk management

Stauts quo (December 2007)

Number of contracts	5069
Number of patients enrolled	5.617.547
Reimbursement	765.866.855 €

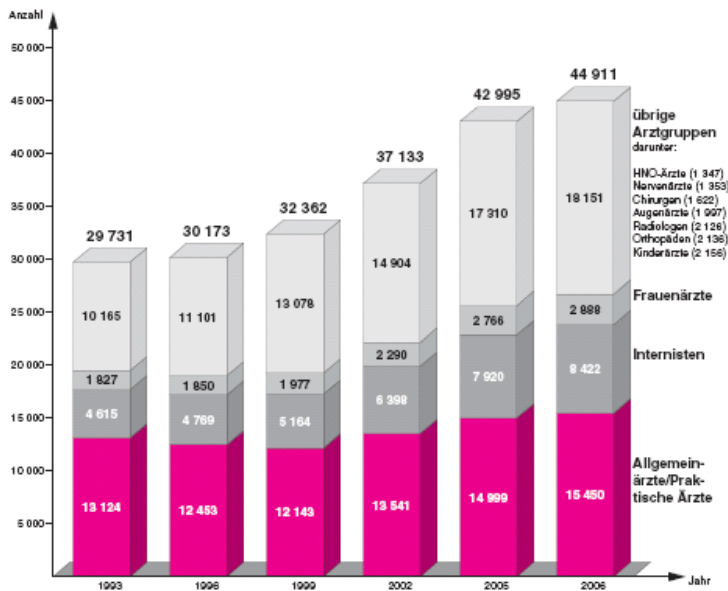
Several integrated health care projects could already demonstrate an explicit improvement of treatment and outcome quality with concomitant cost-containment or even reduction.

Integrated care contracts (2005-2007)

Fehler! Es ist nicht möglich, durch die Bearbeitung von Feldfunktionen Objekte zu erstellen.

The above mentioned reforms are to initiate more and better collaboration as well as structured transsectoral cooperation between the health care providers of all sectors. Increasing cooperation activity between physicians is registered by the National Association of SHI accredited physicians (see graphic “Physicians in group practice”). The number of physicians in group practice increased from 29.731 in 1993 to 44.911 in 2006.

Physicians in group practice, 1993 - 2006



Quelle: Bundesärzteregister der KBV

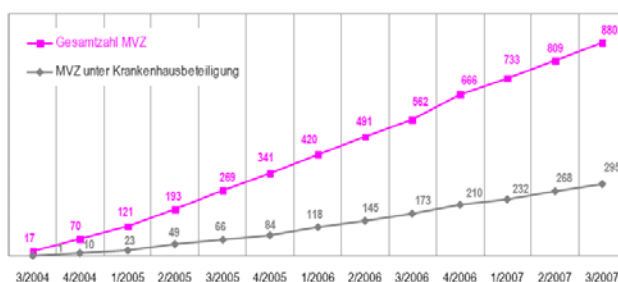
Medical centers (polyclinics)

Also the number of medical centers (*Medizinisches Versorgungszentrum (MVZ)*) – which can be compared to polyclinics - is increasing fast up to now approximately 900 centers (see graph “Number of medical centers in Germany”). The red line shows the total number of medical centers, the grey line shows the number of medical centers that are run by hospitals.

Number of medical centers in Germany

MVZ-Gründungen

Die Anzahl der MVZ insgesamt und auch die Anzahl der MVZ bei denen ein Krankenhaus als Träger beteiligt ist, steigt stetig.



These multidisciplinary institutions are providing ambulatory care and can offer services in family medicine, specialist ambulatory care and integrated care. They can be run by physicians or by hospitals. SHI sickness funds are highly interested in directly contracting with such professionally managed centers to arrange well coordinated health care programs with defined therapeutic results, quality parameters, additional services and precisely calculated fees. Centers are obligated by contract to perform professional quality management and are responsible for processes and results.

Conclusion

The transsectoral coordination of diagnostic and therapeutic measures as well as outpatient and home care is not yet optimized and therefore one of the major problems in primary care.

Fehler! Es ist nicht möglich, durch die Bearbeitung von Feldfunktionen Objekte zu erstellen.

To improve coordination and to avoid organizational impairment, several health care reforms have been designed to stimulate cooperation between GPs, specialists, hospitals, ambulatory care, physiotherapists, nursing homes etc.

Technical innovations like telemedicine for better monitoring of chronic diseases (CHD, diabetes) have shown positive results and could help to avoid hospitalization.

Information technology for effective and safe information and data transfer as well as therapeutic innovations for the treatment of chronic diseases can support the improvement of primary care.

Due to the current health care reforms all providers receive innovative tools to initiate effective health care programs. Therefore all health care providers need more positive motivation for closer collaboration as well as more courageousness and entrepreneurship.