

ADVISORY COUNCIL
on the Assessment of Developments
in the Healthcare System

Competition at the Interfaces between inpatient and outpatient Healthcare

**Special Report 2012
Abridged version**

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Foreword

By submitting the unabridged version of this Report, the Advisory Council is fulfilling the December 2010 commission of the Federal Ministry of Health to prepare a Special Report on the subject of "Competition at the Interfaces of Healthcare". In this context, the present Special Report concentrates primarily on the interface between outpatient and inpatient healthcare.

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All trademarks and trade names used in the Report are the property of the respective owners. Further identification of such trademarks and trade names, when used, was dispensed with for the sake of greater clarity and better readability.

All references to sources and literature are included only in the unabridged version of the Report, and only that version is suitable for citation.

The Council bears the responsibility for any errors in the Report.

Bonn, June 2012

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Part I: Competition with the aim of need-based healthcare

1 Problem formulation and focuses of the Report

1.1 Conflicting views on the efficiency of the German health sector

1. The political debates concerning the efficiency of the German health sector in an international comparison are frequently dominated by two diametrically opposite estimations. According to the one thesis, the costs of German healthcare are too high, compared to the health outcomes they achieve, i.e. life expectancy and quality of life. Among other things, this thesis is empirically based on an international comparison of what is known as the healthcare ratio, i.e. the total health expenditure of a country in relation to the corresponding gross domestic product, with the respective life expectancy on the basis of data of the Organisation for Economic Cooperation and Development (OECD). According to the opposite thesis, Germany has the best health sector in the world, the high efficiency of which leaves hardly any potential for exploiting efficiency and effectiveness reserves. Empirical evidence of this is primarily furnished by universal health insurance cover, the almost ubiquitous availability of healthcare services, the high standard of medical services and the free choice of doctor. These arguments are supplemented by references to the fact that – also in comparison with the social health insurance systems of other countries – statutory health insurance (SHI) offers an extensive benefits catalogue with low co-payments and good accessibility, and that its insureds or the patients are hardly faced by rationing, such as long waiting periods for time-critical medical interventions.

2. The first thesis describes the causal relationship between the healthcare ratio as the input variable and the life expectancy at birth as the outcome indicator. According to the OECD statistics, Germany had the fourth-highest healthcare ratio in 2009, behind the USA, the Netherlands and France, but only came out below average among economically comparable countries in terms of the life expectancy of women and men. The healthcare ratio, which is geared to the gross domestic product (GDP) and where Germany even took second place in 1997, does not, however, give a valid picture of the resources employed in the provision of healthcare. It is dependent not only on the level of health expenditure, but also on the level of the domestic product and, *ceteris paribus*, is all the higher (lower), the

lower (higher) the domestic product is. The comparatively high healthcare ratio is largely attributable to the weak growth of Germany's gross domestic product in the 1990s. Thus, in 2009, Germany again took only 13th place among the OECD countries as regards the per capita national product adjusted for purchasing power, and 9th place as regards per capita health expenditure adjusted for purchasing power. In addition, the healthcare ratio ignores the influences exerted on the ratio of health expenditure to gross domestic product by German reunification. If these effects are taken to add up to one percentage point, Germany drops to 10th place as regards the healthcare ratio, then reaching a position similar to that for per capita health expenditure adjusted for purchasing power. From the outcome point of view, the latter constitutes an appropriate input indicator, insofar as the aim is to obtain insights regarding the employment of resources in conjunction with the efficiency of a health sector.

3. A further objection to the first thesis is that, for an international comparison, the absolute value of life expectancy is less suitable as an outcome indicator than the growth in life expectancy. In this context, Germany's mean, annual life expectancy growth rate for women and men in the period from 1960 to 2009 was well above the average of comparable countries, reaching 4th place in each case. Germany also achieves the same ranking as regards the mean, annual growth rate for the further life expectancy of 80 year-old women and men. So, in a comparison of per capita health expenditure adjusted for purchasing power (9th place) and the life expectancy growth rate (4th place), Germany's health sector in no way fares badly among the countries considered, a fact that is incapable of confirming the thesis of conspicuous inefficiency and ineffectiveness by international comparison. For instance, Germany has lower per capita health expenditure than Norway, the Netherlands and Denmark, but at the same time substantially higher life expectancy growth rates than these countries.

4. On the other hand, the empirical finding that analysis of the OECD data contradicts the thesis of below-average efficiency of the German health sector, does not mean that it holds a leading international position in terms of quality that makes it unnecessary to ask questions regarding inefficiency and ineffectiveness in the provision of medical services. First of all, Japan, Austria and Italy achieve even higher life expectancy growth rates, although Italy's per capita health expenditure is substantially lower than Germany's. In addition, while life expectancy is a valid and relevant outcome indicator, it represents only part of the target spectrum of healthcare (see 2.3 in this context). It gives only inadequate consideration to the complex and heterogeneous target dimension of quality of life, and totally excludes distribution aspects of healthcare outcomes. But it is more important that health expenditure and, with it, the entire health sector have only a limited influence on life expectancy. The level of, and increase in, life expectancy are far more dependent on factors outside the health sector and on transsectoral influencing variables. These particularly include the ecological environment, road safety, living conditions, the working world, the level of education, the social situation and, above all, the lifestyle of the population. It follows from this that comparative, international analyses, even if based on valid outcome

indicators, do not permit causal conclusions to be drawn regarding the efficiency of the respective health systems.

5. In an international comparison of the efficiency of national health systems, it finally has to be taken into account that all real health systems display more or less pronounced deficits in all areas and at all levels (cf. also 2.2). There is no national health sector that holds a clear, worldwide leading position in terms of efficiency on the basis of significant causal relationships between valid input and outcome indicators. In view of the complex relationships between the input and outcome indicators, the differences to be found in the level and growth of indicators for life expectancy and mortality do not permit the conclusion that one particular country has a better health sector than another. Although this means that international comparisons cannot be used to directly derive conclusions regarding the inefficiency and ineffectiveness of national health systems – and certainly not in quantitative terms – any conspicuous differences can provide valuable starting points for subsequent analyses of national healthcare.

6. Against the backdrop of these considerations, the Council has, since its extensive Report on "Appropriateness and Efficiency" (Report 2000/2001), repeatedly emphasised that, despite its numerous advantages, which also stand out from the international perspective, the German health sector still displays considerable potential for increasing the efficiency and effectiveness of healthcare as regards overprovision, underprovision and misprovision. This potential needs to be exploited to the greatest possible extent from the normative point of view. In this context, the interfaces between the healthcare sectors, and particularly the lack of integration of outpatient and inpatient healthcare, constitute one of the key weaknesses of the German health system. The present Report addresses these problems, first analysing the deficiencies before looking for possible solutions on a broad basis. In this respect, attention centres on the question of whether and to what extent competition, or its intensification, is capable of contributing to the reduction of inefficiency and ineffectiveness. The main question of interest is that as to the role which quality-based competition actually plays in relation to price-based competition, and the importance that accrues to it from the target-oriented perspective.

1.2 Content and structure of the Report

7. The Report comprises eight chapters that analyse whether and to what extent the strengthening of competition at the interface between the outpatient and inpatient sectors is capable of contributing to improving the efficiency and effectiveness of healthcare. The following Chapter 2 highlights not only possible starting points and forms of competition, but also the instrumental function that it has from the normative point of view in relation to the higher-ranking health targets. First of all, competition is an element of various coordination and allocation mechanisms, albeit in different forms and intensities, i.e. it is not limited to the market and price mechanism. Then, efficiency and effectiveness potentials

exist at various levels and in certain areas of the German health sector, and these can in principle be used as starting points for competitive processes. This consideration already spotlights the interface between outpatient and inpatient healthcare as the focus of efforts to improve efficiency and effectiveness. The subsequent presentation of healthcare targets and models serves to avoid input-oriented or purely instrumental examination, and at the same time to call for greater target-orientation of health policy. Finally, a functional system of price- and quality-based competition needs a legal framework, a subject addressed by statements concerning fundamental aspects of antitrust and public procurement law.

8. Chapter 3 deals with the prerequisites for target-oriented competition in the health sector. It begins with a brief review of the currently existing parameters of competition, which illustrates the still fairly modest possibilities of the health insurance funds for competitive differentiation. Functional competition presupposes a quantitatively and qualitatively adequate supply potential on the part of the healthcare providers. In this context, the main question arising is that of whether the volume and structure of the workforce in the health sector are sufficient to permit functional price- and quality-based competition – at the moment and, given the foreseeable demographic trend, also in the future. In this respect, securing the necessary professionals in the various healthcare professions is also in the interests of competition-oriented health policy.

9. In addition to a sufficient personnel supply potential, the competence of the users of healthcare services is another important prerequisite for target-oriented competition. Patient/user information and counselling is acquiring special relevance in the health sector, particularly in view of the information asymmetries in the individual healthcare sectors. To prompt competitive reactions of health insurance funds and healthcare providers, it usually suffices if just comparatively small numbers of insureds or patients have adequate transparency regarding alternative offers and make a choice in keeping with their preferences. However, the remaining insureds and patients do not benefit directly from these offers, meaning that potential welfare gains cannot occur. To permit this, these users need assistance in the form of information and counselling. The Report presents promising approaches in this respect. The current development status and the pending challenges are likewise discussed.

10. Part II of the Report discusses fundamental problems and possible solutions at the interface between the outpatient and inpatient sectors. Chapter 4 is devoted to the problems of inadequate interface management, from which chronically ill and multimorbid patients primarily suffer because their illness means that they frequently switch between outpatient and inpatient care. The supply of medicines displays substantial weaknesses at this interface, in particular. In this context, there follows an examination of whether and to what extent the use of information and communication technologies is capable of eliminating or alleviating these disadvantages. Being a multidisciplinary task, discharge management also encompasses the social services and nursing, which is the focus of the considerations in the further

course of this chapter. The innovations in nursing tested in recent years are addressed, in particular.

11. Chapter 5 analyses quality-based competition in the German health sector, with a cross-sectoral and population-oriented focus. Quality-based competition still tends to be neglected in German healthcare, also in comparison with price-based competition. This is partly due to methodological problems, since the aim here is to find valid indicators for process and outcome quality, and additionally to analyse their causal relationships with the respective medical treatments. Also, functional quality-based competition presupposes that the users possess sufficient information regarding the existing quality differences, and make their choice among the healthcare providers accordingly. In this context, the Report distinguishes between, among other things, competition regarding the quality of processes within a sector and competition in the framework of cross-sectoral healthcare. Without functional, quality-based competition in healthcare services, the insurance sector will continue to be one-sidedly dominated by price- or contribution-based competition.

12. The regulatory deficits at the sector boundary between the outpatient and inpatient sectors, subsequently described in Chapter 6, are revealed in that, for example, potentials for rendering outpatient medical services of relevance in the framework of healthcare provision in Germany remain unexploited. Of particular interest in this context is the field of outpatient specialist care, which was reorganised, including the framework conditions, by the Act on the Stabilisation and Structural Reform of SHI (GKV-VStG) with effect from 1 January 2012. An interface analysis particularly focuses on outpatient specialist care, which operates between the specialist and inpatient healthcare sectors. However, outpatient surgery, Medical Service Centres (MSCs) and the services of office-based doctors with hospital privileges can also generally contribute to solving interface problems.

13. In connection with the question, asked in Chapter 7, regarding efficiency and effectiveness improvements through selective contracts, the first matter to be discussed is whether the existing statutory possibilities constitute a function-oriented, competitive framework. It is from this point of view that there follows, among other things, a critical discussion of GP-centred care according to Section 73b, special outpatient medical care according to Section 73c, Disease Management Programmes (DMPs) according to Section 137f-g and forms of integrated care according to Section 140a-d SGB V (Book V of the German Social Security Code). Since the financial incentives for the last two of these special forms of healthcare expired at the end of 2008, it is also of interest in this context to ascertain how the corresponding activities developed subsequently and whether – and, if so, in what form – other framework conditions and new financial incentive structures for innovative, integrated care programmes appear necessary. The results of a Council survey on forms of integrated care indicate, among other things, the importance to the health insurance funds of adjustment of the budget for outpatient medical services in this context. In view of the fact that the options for selective contracts are still very limited, it seems obvious to examine whether, with a view to targets, further healthcare sectors are likewise

suitable candidates for selective contracts, e.g. outpatient specialist care and the hospital sector. Finally, liberalisation of the European health markets may also be accompanied by competitive stimuli for the German health sector.

14. Price- and quality-based competition in the healthcare sector can exert a variety of influences on competition in the insurance sector, this being the subject addressed in Chapter 8. First, advantages in terms of price-based competition enable a health insurance fund to offer its range of benefits at lower cost on the insurance market, i.e. for lower (supplementary) contributions. Given identical (supplementary) contributions, visible success in the competition for quality, or preference-oriented optional benefits, can serve to persuade current insureds to stay and to attract new ones. The supplementary contribution is first presented as a competitive parameter for the health insurance funds, and an empirical description is given of how the supplementary contribution has led to an increase in the number of people switching health insurance funds. This is followed by an overview of surveys of insureds regarding the decisive reasons for their choice of health insurance fund. In addition, a digression presents the results of a Council survey on the competitive parameters of the health insurance funds. In the concluding statements regarding the perspectives of the supplementary contribution, it is the concern of the Council that it should in future serve as a price signal in the financing sector, beyond stigmatisation (as an indicator of inefficiency), and, at the same time, that success be achieved in implementing and strengthening quality-based competition in the healthcare sector.

2 Competition as an instrument for realising efficient and effective healthcare

2.1 Competition as an element of different allocation mechanisms

15. Since the available resources in the health sector are never sufficient to satisfy all the demands and needs of the citizens, there is a need for a coordination or allocation mechanism that assigns the limited resources to the different uses or competing plans. There are three main general economic coordination mechanisms that can assume this allocative function:

- The market and price mechanism,
- Public planning or the development of budgetary objectives, and
- Corporative coordination.

16. As regards these allocation mechanisms, the health sector forms a "mixtum compositum", also from the international point of view. More elements of public planning are to be found in tax-funded health systems, stronger corporative coordination in contribution-funded systems, and a slightly stronger role of the market mechanism in price- or premium-funded systems, but nowhere does just one allocation mechanism apply in pure form. Compared to other sectors of the economy, the German health sector displays the special regulatory feature that different allocation mechanisms are dominant in its sub-markets. For example, public planning is the dominant allocation mechanism in the inpatient sector, and corporative coordination in the outpatient sector, while the market mechanism plays a relatively greater role in connection with drugs and therapeutic appliances, as well as medical equipment and products. However, with the exception of self-medication, the latter applies only to the supply side of these markets.

17. Among other conditions, competition between a host of different providers is an essential prerequisite for a functional market and price mechanism. However, competitive processes are not restricted to this allocation mechanism. As a result of the scarcity of resources, the other two main allocation mechanisms also include elements of competition,

at least implicitly. For example, in the framework of governmental Länder or need-oriented planning, hospitals compete for the licence to provide medical care for patients of the statutory health insurance scheme (SHI) and, at the micro level, also for patients, particularly in overprovided regions. Corporative coordination is likewise accompanied by competitive processes at several levels in the framework of joint self-government and, in particular, outpatient treatment. The elections within the joint self-governing bodies, which can influence the price relationships within the Standard Schedule of Fees (EBM), for example, can be interpreted as competitive processes. Moreover, with given price structures, doctors in private practice also compete for patients or treatment cases.

18. Since competition is not a specific feature of any one of these allocation mechanisms, a plea for more competition does not permit any conclusions to be drawn regarding the coordination instrument in question. As all three allocation mechanisms have their specific advantages and disadvantages, i.e. there are constitutional deficiencies in market-economy, state-administrative and corporative coordination, it is a question of the comparative efficiency of the respective allocation mechanism. In all three allocation mechanisms, however, the intensification of competition calls for an increase in the action parameters of the players and decentralisation of the decision-making levels. This means, for example, replacing the joint, standardised action of nationally operating central associations and organisations, and also corporative agreements at the level of the Länder or the Associations of SHI-Accredited Physicians, by decentralised negotiations between health insurance funds and healthcare providers to the greatest possible extent, i.e. insofar as target-oriented, or at least adding elements of competition. In terms of regulatory policy, however, these decentralised competitive processes need a nationally applicable framework in conjunction with central supervision of competition.

2.2 Levels of efficiency and effectiveness potentials

19. Efficiency and effectiveness potentials also exist in the health sector in the sense of economic allocation theory, whenever the resources employed are capable of realising a greater benefit or greater welfare gains for the recipients of the services, or the benefit or welfare level achieved can be realised employing fewer resources. As, in comparison with other sectors of the economy, the health outcomes, i.e. life expectancy and quality of life, give a fairly valid reflection of the abstract and not directly measurable benefit for the recipients of healthcare services as global welfare indicators, allocative efficiency targets an optimum ratio between health outcomes and economic resources. If this ratio displays obvious or suspected inefficiencies, either globally or in specific indications, its broad context and the frequently complex process of providing healthcare services usually mean that it still remains unclear as to the areas and points where the efficiency and effectiveness reserves in question lie. The following – formally tautological – breakdown of allocative efficiency into a production element and an effect element therefore serves to illustrate

possible inefficiency and ineffectiveness at certain input and outcome levels, and thus to better track down and locate existing rationalisation reserves. In this context, the production efficiency indicates the relationship between the economic costs and the treatment they are used to produce, while the effect efficiency describes the relationship between this treatment and the health outcomes it achieves. This breakdown of allocative efficiency already indicates that even an efficiently produced healthcare service or cost-optimised treatment, such as a specific medicine or prevention programme, does not automatically lead to an improvement in health outcomes.

20. To specify the rationalisation reserves in the production sector, production efficiency can, in turn, be split up into a financial and a physical component. In this context, financial production efficiency means the relationship between the production factors employed and the costs they cause. In contrast, physical production efficiency describes the relationship between the treatment produced and the production factors employed. In the event of rationalisation reserves, the financial production efficiency shows that the production factors employed to produce the healthcare service or the treatment cause excessively high economic costs, i.e. are associated with excessively high prices or remunerations. In addition, deficits in the field of physical production efficiency indicate sub-optimum use of the production factors employed, i.e. the healthcare service is provided at the wrong place, using inappropriate methods, without sufficient coordination, or in unsatisfactory quality, for example.

21. As in the production sector, efficiency in the effect sector can likewise be split up, into utilisation efficiency and benefit efficiency. In this case, the utilisation efficiency reflects the relationship between the utilisation goals and the treatment, while the benefit efficiency (effectiveness) describes the relationship between the health outcomes and the utilisation goals. In the field of utilisation efficiency, rationalisation reserves arise when a treatment goes unused. In this case, it is irrelevant whether the treatment in question was produced efficiently, since the improvement of health outcomes inevitably presupposes that the healthcare services be utilised. Examples of deficits in this field include the low level of participation in prevention programmes and the refused utilisation of prescribed drugs or therapeutic appliances by patients as a result of lacking compliance. There are efficiency reserves in the field of benefit efficiency if certain treatments possess no efficacy whatsoever or even entail a negative net health benefit, i.e. the negative side-effects exceed the positive effects on health.

22. Even if there are conspicuous relationships, these four efficiency categories, which together initially add up to production and effect efficiency, and thus also to allocative efficiency, do not permit conclusions to be drawn as regards the respective causes of these deviations, either globally or in specific indications. Being pure indicators, they cannot provide any information regarding the reasons for suspected rationalisation reserves. However, this breakdown of allocative efficiency may sharpen our perception of various types of inefficiency at different levels, and thus offer a starting point for more detailed

causal examinations. As already indicated, an efficiently produced healthcare service may have no effect, or even a negative effect, on health outcomes, whereas treatment produced at excessively high cost is capable of greatly improving health outcomes, and thus the welfare of its users. Nonetheless, inefficiency in the production sector also always causes welfare losses, as the resources unnecessarily tied up by the excessively high costs can then no longer be used for other purposes where they could generate an additional benefit. Despite all the reservations concerning the causal expressiveness of such efficiency indicators, both an analysis of the weaknesses of healthcare provision in Germany and international comparisons suggest that rationalisation reserves primarily lie in the field of physical production efficiency, i.e. healthcare services are frequently provided at the wrong place, without sufficient cross-sectoral coordination, with too little transparency for the users, and without a function-oriented competitive framework. This particularly applies to the interface between the outpatient sector and the inpatient sector, which is the focus of this Report.

2.3 Goals and models of healthcare

23. In the health sector, as in other sectors of the economy, competition and the associated allocation mechanisms are not an end in themselves, but instrumental in realising higher-ranking health targets. In this context, the Council has repeatedly called for greater reference of health policy to targets. Without explicit reference to valid, operational health targets, health policy lacks both adequate orientation for the measures to be taken, and functional criteria for ex post evaluation of the activities and projects. From the targets point of view, protection against the risk of illness and the provision of healthcare focus on improving the state of health of the population and providing need-based medical services. In keeping with the "medical orientation data", this primarily targets the following:

- Preventing avoidable death and prolonging life as far as possible,
- Preventing and curing illness and the associated pain and feelings of ill health, stabilising the course of illnesses and alleviating illness-related suffering,
- Restoring or maintaining physical and mental functional capacity, as well as independence and the capacity for self-help,
- Respecting human dignity and freedom, even in illness and death, and
- Guaranteeing the availability of treatment in a contingency as an optional benefit.

24. Beyond these central objectives, which essentially encompass life expectancy and quality of life, healthcare can also contribute to realising general, overall economic goals. This range of goals includes:

- Generating longer-term capacity and productivity effects by expanding production potential and improving human capital (at least in the case of under-utilised capacities in the national economy),

- Increasing the growth of the real national product, and
- Creating jobs.

25. As a kind of guideline, the health-related and abstract, overall economic goals can be extended by the following models for target-oriented healthcare:

- Provision of effective and high-quality, need-based medical services,
- Efficient and low-cost provision of services,
- Strengthening of the sovereignty, self-responsibility and personal skills of insureds and patients,
- Safeguarding of the autonomy of patients, and enabling their integration in health-related decision-making processes,
- Preservation of solidarity in the sense of intragenerational and intergenerational fairness,
- Securing the financeability of need-based healthcare,
- Creating sustainability and stability, and
- Transparency and planning security in the health system.

26. In addition, the instrument of functional competition specifically gives rise to the following expectations:

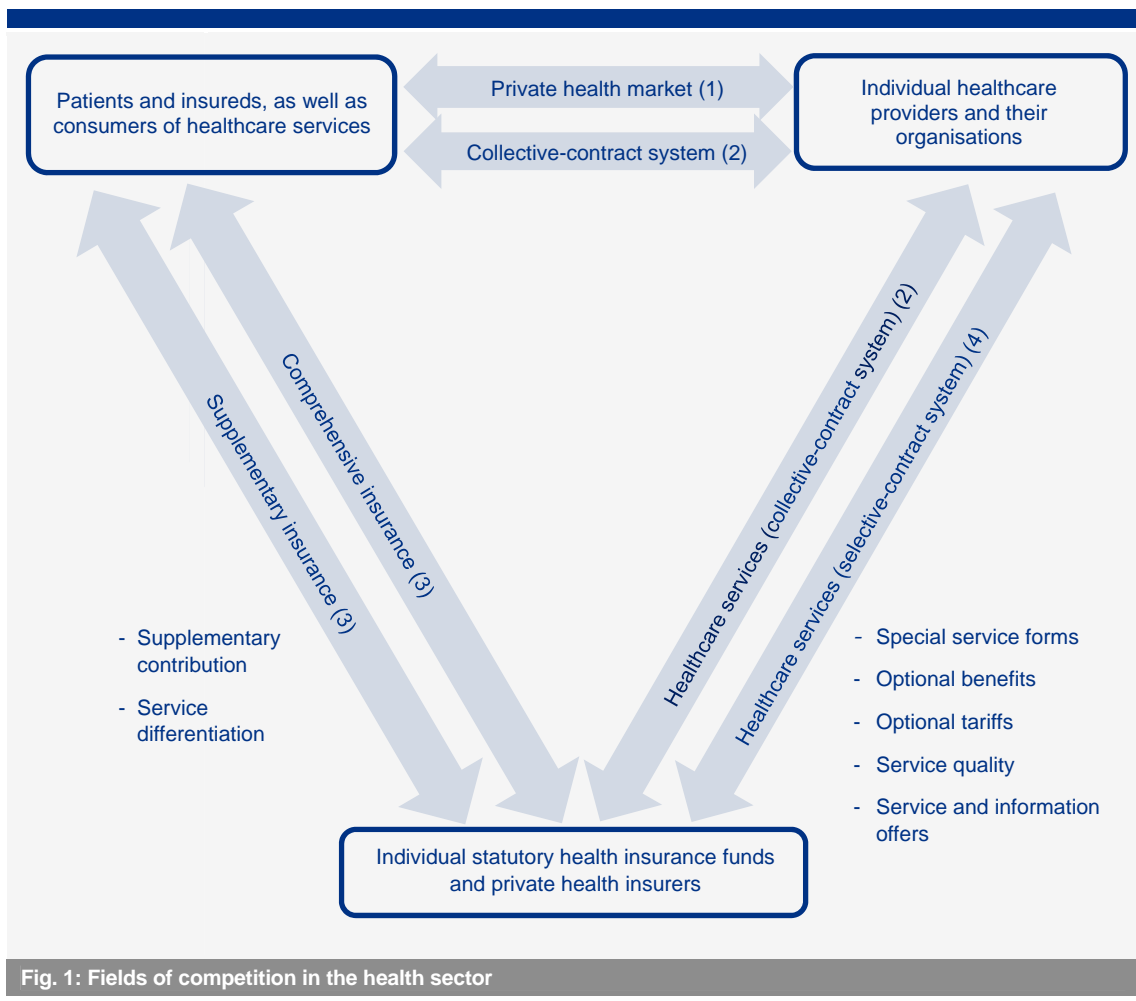
- Gearing of the services offered to the objectified demand,
- Consideration of the needs and preferences of the patients by steering the benefits,
- Payment according to service quality rendered through performance-based remuneration,
- Promotion of product and process innovations, primarily in the context of decentralised search processes, and
- Prevention of monopolistic abuse of power by state instances, health insurance funds and healthcare providers.

2.4 Fields of competition in the health sector

27. Particularly in relation to the regulatory framework conditions, a distinction can be made between four fields of competition in the health sector, each of which has different contract levels, partners and contents. As illustrated in Fig. 1, the *first field of competition* is formed by the private health market, where the healthcare providers compete for the private demand of patients and other citizens. Since the demand comes from individuals who purchase the corresponding healthcare services at their own expense, there is no need for specific state regulation. It suffices if state or other sovereign instances ensure the safety and

quality of these goods in the sense that they do not cause any damage to health. However, the scope and structure of this field of competition also depend on the benefit package of SHI, because its expansion or restriction causes this field to shrink or grow.

28. In the *second field of competition*, the collective-contract system or the healthcare services sector, there is no competition among the health insurance funds, since they conclude joint and standard contracts with individual healthcare providers (such as hospitals) or groups of them (such as Associations of SHI-Accredited Physicians). Nevertheless, the individual healthcare providers, e.g. doctors, hospitals and pharmaceutical companies, again compete for the demand of insureds and patients. Additionally, the Associations of SHI-Accredited Physicians could also trigger or install quality-based competition among their members in the collective-contract system with the help of corresponding remuneration systems. Moreover, a function-oriented, competitive regulatory framework at the interface between the outpatient sector and the inpatient sector could also stimulate price- and quality-based competition between hospitals and specialists in private practice in the collective-contract system.



Source: Own representation

29. The *third field of competition* comprises the insurance sector, where the individual health insurance funds compete to attract insureds. This competition was primarily intensified by the Health Structure Act, which came into effect on 1 January 1993 and gave the insureds in the SHI system extensive freedom as regards the choice of their health insurance fund. From the end of the 1990s, the legislature also granted the health insurance funds a number of competitive parameters that enabled them to competitively differentiate themselves, despite the standard catalogue of basic benefits (see 3.1 for more details). Although, in combination with the freedom of choice of the insureds, competition among the health insurance funds constitutes a "value in itself" for the welfare of the insureds, competitive processes in this field are not yet capable of improving the efficiency and effectiveness of healthcare. This presupposes that competition between the health insurance funds expands into the healthcare services sector, since that is where healthcare and the provision of medical services takes place.

30. In the *fourth field of competition*, the selective-contract system, the healthcare providers can, beyond the collective agreements, compete for contracts with the health insurance funds by means of the price and quality of their goods and services and/or the service they offer. In turn, the health insurance funds compete with each other for favourably priced and/or qualified healthcare providers, with whom they then advertise in the insurance sector and are thus able to increase their chances of attracting insureds. The latter have the possibility of also directly influencing this competition in the healthcare services sector by participating in certain programmes and accepting certain offers.

2.5 Price- and quality-based competition

31. The price-based competition of the health insurance funds aims to purchase a more or less homogeneous (healthcare) service at a favourable price. This enables them to keep their expenditure down, and thus to avoid a supplementary contribution or even pay a bonus to their members. The same cost effect is achieved by limiting the volume of benefits. The health insurance funds have substantial incentives for reducing their costs, as reflected in, among other things, intensive endeavours to obtain low prices and high discounts, as well as in substantial efforts regarding sickness benefit management and the control of hospital bills. Striving to reduce or limit costs does not necessarily contradict quality-related efforts, as a high quality of medical services may possibly also be able to contribute to an overall reduction in costs through its medium- and long-term effects.

32. From the normative point of view, quality-based competition should serve to improve health outcomes, i.e. life expectancy and quality of life, and thus the welfare of the insureds, through improved medical services. In this context, the health insurance funds have an interest in differentiating themselves and thus attracting insureds. Ultimately, it is primarily a question of creating quality-consciousness among the healthcare providers and

prompting them to practise continuous quality management. This can also include pecuniary incentives, i.e. payment based on the quality of the services provided.

33. In order to stimulate quality-based competition among the healthcare providers through targeted choices, the insureds and patients, and equally the health insurance funds, need sufficient market transparency, i.e. essentially valid information on the existing treatment alternatives and on the available service qualities. As also confirmed by studies, the measurement of quality using valid quality indicators holds the promise of improved healthcare, and thus also of positive effects on health outcomes. The conditions for in-house evaluation of quality on the part of the healthcare providers, in conjunction with corresponding external reporting, do not exist yet, mainly because there is no valid system of quality indicators. In this respect, a key prerequisite for functional quality-based competition in the healthcare sector is still missing, the results of which could constitute a target-oriented information basis, both for the choices of insureds and patients, and equally for the competition between health insurance funds. These deficits in the field of quality-based competition also partly explain why the health insurance funds have so far concentrated strongly on price-based competition, focusing on the development of contributions.

2.6 Fundamental aspects of antitrust and public procurement law

34. The legislature makes the competitive orientation of the health insurance market its declared goal and repeatedly refers to the need to strengthen it in the grounds for recent laws. Where competition exists, the law on competition also fundamentally applies. In addition to the law on fair trading, this particularly includes antitrust law, the task of which is to protect the freedom of competition and which is therefore indispensable for its proper functioning. However, the extent to which antitrust law is applicable to the field of statutory health insurance funds is not yet clear.

35. The authoritative provisions of antitrust law are those in Arts. 101, 102 of the Treaty on the Functioning of the European Union (TFEU) at the European level, and those of the Act Against Restraints of Competition (GWB) at the national level. According to the will of the national legislature, expressed in the 6th and 7th Amendment to the GWB, these provisions are to be interpreted identically.

36. The key concept as regards the applicability of provisions of antitrust law is the concept of the undertaking. In 2004, the ECJ expressly ruled out a status of German statutory health insurance funds and their associations as undertakings in the case of the Federal Association of Local Health Insurance Funds (AOK-Bundesverband). According to the ECJ, the German statutory health insurance funds fulfil a purely social purpose and do not engage in any business activity. Although the German legislature subsequently implemented numerous competitive instruments in the system of statutory health insurance

funds – especially in the framework of the 2007 Act to Strengthen Competition in SHI (GKV-WSG) – it cannot be assumed that the ECJ would reach a different verdict today, since redistribution based on solidarity continues to be dominant in, and characteristic of, SHI. The borderline has not yet been crossed, where the "social purpose" becomes the "business activity" of an undertaking. It can thus be stated that European antitrust law presumably does not currently apply to the competition between the SHI funds, this also being directly true of the German GWB owing to the concurrence of European and national antitrust law.

37. The German legislature took this circumstance into account – for the relationship between the health insurance funds and the healthcare providers (the so-called benefits market) – and, in the version of Section 69 Para. 2 SGB V valid since 1 January 2011 as a result of the Act on the Reform of the Market for Medicinal Products (AMNOG), expressly requires "appropriate" application of the ban on cartels and most of the other provisions of the GWB. However, the law so far remains silent as regards the application of antitrust law to the activity of the health insurance funds on the insurance market, i.e. in the price- and quality-based competition for insureds. Since statutorily required "appropriate" application is lacking in this context, the Hessian Higher Social Court assumed in its decision of 15 September 2011 (L 1 KR 89/10 KL), referring to the decision of the ECJ, that the GWB does not apply in this case.

At the moment, competition between the health insurance funds is thus effectively protected only on the benefits market, not on the market for insureds. The need to apply and concretise the general rules of competition in a sector-specific manner gives rise to the demand to completely dispense with these general rules.

38. Numerous voices in jurisprudence see an urgent need for action, as does the Monopoly Commission: they demand effective protection of competition. On the one hand, a sector-specific law on competition would be conceivable, which could then be integrated in SGB V. In this context, the competent supervisory authorities could be assigned competencies comparable to those of the Federal Cartel Office. On the other hand, an order to analogously apply the GWB, in accordance with the model of Section 69 Para. 2, first sentence, SGB V, could be considered. Based on the regulation in Art. 106 Para. 2 TFEU, it would then have to be ensured that the rules on competition take a back seat if their application would impede fulfilment of the tasks of the health insurance funds.

39. Prompted by the decision of the Hessian Higher Social Court and the debate in science and practice, the Federal Government took action and presented a first bill in the framework of the 8th Amendment of the GWB (Bundestag Printed Paper 176/12). The bill targets changes both in Book Five of the Social Security Code (SGB V) and in the Social Courts Act (SGG) and the GWB. The purpose of this bill is to protect competition within SHI, and it thus expands the application of the regulations of the law on competition to statutory health insurance funds. In particular, Section 4 Para. 3 SGB V is to be expanded by adding regulations providing for appropriate application of certain provisions of the GWB to

the mutual relationship between the health insurance funds and their associations, and also their relationship to the insureds, this particularly including the ban on cartels and the control of abusive practices.

This appears to be cogent. It establishes consistency regarding Section 69 Para. 2, first sentence, SGB V, and the competitive activity of the health insurance funds is extensively subjected to antitrust law. Antitrust law is also suitable for regulating competition among the health insurance funds: it does not give rise to an irresolvable conflict with the specifications of social security law, particularly the cooperation precepts provided for in SGB V. First of all, the Books of the Social Security Code are more specific than the GWB and thus take priority. Moreover, precepts and bans in antitrust law only take effect in those areas where the health insurance funds have freedom of action. If the health insurance funds are statutorily obliged to act in a particular way, this cannot induce sanctions under the law on competition according to the GWB, since the freedom that is a prerequisite for competitive behaviour does not exist. The fields of law are thus systematically and cogently interwoven, such that "fine tuning" and a conciliatory coexistence of antitrust and social security law are possible. This proposal is also supported by the Monopoly Commission – which had demanded that the nature of the activity of health insurance funds be unequivocally defined in law in order to avoid uncertainty regarding their status as undertakings – in its Special Report (Bundestag Printed Paper 17/8541) on the Amendment of the GWB. Implementation of the above-mentioned bill can represent an important, supportive step towards realising functional competition in SHI.

40. However, if antitrust law is applied to SHI – as the German legislature requires through Section 69 Para. 2 SGB V for the relationship between the health insurance funds and the healthcare providers, and in future also intends require for the relationship with the insureds according to its bill – the further question arises of whether this makes it dispensable to apply public procurement law to the health payers. Public procurement law encompasses rules and regulations to be observed by a public authority when procuring the material resources and services it needs in order to fulfil its tasks.

41. The health payers see public procurement law as being problematic in that it entails a major effort for all parties involved. Moreover, particularly when it comes to the purchase of healthcare services by health insurance funds, there is seen to be a risk of quality-based competition being neglected in favour of price-based competition, since quality is often not open to justiciable specification. In addition, the effort entailed by an invitation to tender occurs only when concluding selective contracts, not in the case of collective contracts. This distorts the competition between these two systems.

42. Nonetheless, antitrust law is no alternative to public procurement law, since the two regulatory areas pursue different purposes: while the application of antitrust law is also intended to strengthen competition on the health payer side, the function of public procurement law is to strengthen competition on the healthcare provider side. The aim of this is to make it possible to exploit the cost-cutting potentials offered by competition.

Furthermore, public procurement law is intended to ensure equal treatment of all healthcare providers as regards access to public contracts, particularly also for the benefit of healthcare providers from other Member States.

43. And it is also EU law that provides the decisive argument regarding why the health payers cannot be freed from the ties of public procurement law: the public procurement law of SHI is harmonised by a Directive on the Award of Public Contracts. This Directive covers the health payers as public buyers, and the services as public contracts. Since Art. 288 Para. 3 TFEU obliges the Federal Republic to transpose EU Directives into national law, the German legislature cannot go it alone in excluding public procurement law without infringing its obligations arising from the TFEU.

44. However, the German legislature is offered some latitude by the proposal of the EU Commission for a revised version of the Directive on the Award of Public Contracts, which provides for extensive regulatory freedom of the Member States as regards services in the social, health or education sector. It is currently hard to predict to what extent this will become reality. Should latitude be given in this respect, it must be examined whether use can be made of it, if and insofar as the efficiency gains through public procurement law are estimated as being lower than the associated outlay. In that case, however, other and better ways would have to be found for realising transparency and equal opportunities in such a way that the services to be put up for tender fulfil their purpose and can be rendered in a manner beneficial to the recipients. Proposals on this subject have been submitted, particularly the statement by the National Association of Statutory Health Insurance Funds of 8 March 2012, and these can also be brought into the discussion process regarding the final wording of the Directive. This especially applies to the proposal that the Directive should specify that a procurement procedure is only necessary in cases where the public buyer actually makes a choice itself.

3 Prerequisites for target-oriented competition in the health sector

3.1 Existing competitive parameters of the health insurance funds

45. SHI is still dominated by collective agreements between the associations of the health insurance funds, on the one hand, and the associations of the SHI-accredited physicians and the hospitals, on the other. This is accompanied by uniform and joint action of all health insurance funds, both on the funding side and on the expenditure or benefits side, i.e. competitive options are the exception. These health insurance fund-specific options are currently essentially limited to the following:

- Charging of a supplementary contribution or payment of a bonus,
- The selective contracts in the framework of the special forms of care,
- Special contractual agreements with selected healthcare providers to improve the quality of care or exploit efficiency reserves according to Sections 128 Para. 6 and 136 Para. 4 SGB V,
- Individual contracts within single fields of healthcare sectors regarding prices and discounts, e.g. for drugs and therapeutic appliances,
- Optional and discretionary benefits funded by special allocations from the Health Fund,
- Optional benefits according to Section 11 Para. 6 SGB V,
- Optional tariffs according to Section 53 SGB V,
- Mediation of private supplementary health insurance contracts according to Section 194 Para. 1a SGB V, and
- In addition to general services (offices and call centres), issue of information material, e.g. a hospital and nursing navigator, and development of a "brand".

46. In the event that a health insurance fund is incapable of covering its financial requirements through the allocation from the Health Fund, it must, pursuant to Section 242

Para. 1 SGB V, make provision in its statutes for charging its members an income-independent supplementary contribution. If the allocation exceeds the financial requirements, it can pay out corresponding bonuses to its members. All other competitive parameters relate to the expenditure side or the healthcare services of SHI. In this context, the special forms of care primarily aim to improve coordination and integration between GP and specialist treatment, and between the outpatient and inpatient sectors. All special forms of healthcare permit selective contracting between individual health insurance funds and accredited healthcare providers, or groups of them. Except in the case of the forms of integrated healthcare according to Section 140a-d SGB V, the Associations of SHI-Accredited Physicians can also act as the contract partners of the health insurance funds.

3.2 Employee scope and structure from the competitive point of view

47. Sufficient availability of personnel with good professional qualifications is one of the key prerequisites for target-oriented, quality-based competition. The demand for healthcare and nursing services will rise significantly in the future as a result of the changing age structure of the population, with a changed morbidity spectrum and increasing multimorbidity. At the same time, the potential number of professionals is dwindling, since it is in turn itself affected by the declining birth rate and demographic ageing. This development can be expected to continue, even though the healthcare and nursing sector is attracting increasing attention as a growth market and "employment motor". Consequently, securing the necessary professionals will continue to be an important topic in the future. Even today, it is not possible to secure a sufficient potential of professionals in all areas of the health sector. For example, there have been complaints about a shortage of doctors for some time now – especially as regards the provision of GP care in rural areas. In nursing, the shortage of professionals, or the "nursing emergency", has been a cyclically recurring topic since the 1960s. However, the shortage has become more acute in recent times. It is particularly noticeable in the hospital sector, where major nursing staff cutbacks have taken place in the past few years (despite the increasing amount of work), contrary to the situation as regards doctors. Attention is likewise being drawn to a growing staff shortage in long-term inpatient and outpatient care, and to its negative effects on the quality of care.

48. The growing demand for healthcare and medical services currently has to be handled by just under 334,000 working doctors (and approx. 67,000 dentists). All in all, the number of working doctors rose by 14.6% between 1999 and 2010 – a trend that was primarily concentrated in the inpatient sector (growth of roughly 19%). The number of residents per working doctor has fallen by approx. 13%. In the OECD comparison, the density of doctors in Germany takes a middle ranking among the economically comparable countries (data for 2009).

Nonetheless, according to available studies, there is no general surplus of medical personnel in Germany. While city centres have an oversupply of specialists, there are even signs of problems with personnel recruitment in some regions and fields. For instance, there are numerous vacancies for doctors in the hospital sector. In the outpatient sector, it is primarily in rural, structurally weak regions with a low population density that vacant positions for doctors cannot be refilled. This disproportion has a particularly strong impact as regard doctors in primary care (GPs).

49. There are diverse causes of this increasingly difficult personnel situation. One factor mentioned is the declining average volume of work per doctor's post, which, in the inpatient sector, is a consequence of, among other things, implementation of the European Working Time Regulation, and generally also of changing lifestyles and the increasing proportion of part-time jobs in the medical professions. In structurally weak regions, this is compounded by the seemingly unattractive possibilities for medical personnel to practise their profession and realise their life plans.

Other causes are the growing differentiation of employment opportunities for doctors outside the provision of medical services, as well as the migration of qualified doctors to foreign countries. Also of relevance for the declining desire to work in curative medicine for a relatively long time are the working conditions, such as the high workload, the lack of time off in return for overtime regularly to be done, the frequent irreconcilability of professional and private life, inadequately regulated working hours and insufficiently appreciative and participatory management models. Finally, it should also be mentioned that the demographic trend similarly affects the health professions: the average age of the workers has risen significantly in recent decades, especially among doctors and dentists.

50. The situation in nursing is partly different. The nursing professions face the same societal challenges as doctors, but have a poorer starting point and a position of weaker status in Germany. On top of this comes the fact that this professional group, which is the numerically largest in the health sector, has been in a state of upheaval since – after a major delay by international comparison – nursing also began to become increasingly professionalised and academic in this country some 15 to 20 years ago.

51. According to the Health Personnel Calculation for 2009, just under 1.46 million of the total of 4.74 million people working in the health sector are in nursing – 812,000 as healthcare and medical nurses, 258,000 as healthcare and medical nursing assistants and 388,000 as geriatric nurses or geriatric nursing assistants, these figures expressing the occupation actually practised, not that which was learned or in which vocational training was received. Nursing is traditionally a women's job with a high proportion of part-time workers. All in all, the number of employees in the nursing professions has also increased in recent years. However, closer examination reveals different developments in the various fields. Between 1996 and 2007, for example, the hospital sector saw continuous job cutbacks in nursing – in contrast to the rise in the number of jobs for doctors – even though it is equally affected by the increasingly heavy workload developing since the introduction of

DRGs, meaning that more patients have to be dealt with in the same amount of time. At the same time, the composition of the residents of inpatient (long-term) nursing institutions has changed greatly, as a result of which the need for nursing services has increased and now involves different professional requirements. It is also striking to note that growth in full-time jobs in all nursing professions in the period from 2000 to 2009 is substantially lower than the increase in the number of employees, owing to a shift in employment structures towards part-time and small-scale employment.

All in all, there has been a marked increase in employment in nursing in recent years. However, this fact does not permit conclusions to be drawn regarding the appropriateness of the personnel and service situation in the various fields of nursing. On the contrary, it can already be seen today that the development of professionals is not keeping pace with the expansion of, and change in, the population-based demand, and that a nursing emergency is again arising.

52. The causes of the difficult personnel situation in nursing are diverse. The demands and the necessary qualification profiles have altered as a result of demographic change. For example, qualifications from vocational medical nursing training are today often required in geriatric nursing and, conversely, qualifications from vocational geriatric nursing training are increasingly necessary in medical nursing. In addition, special clinical skills are increasingly required in long-term outpatient and inpatient care. Generally speaking, nursing has seen a growing demand for special skills and nursing expertise. This is intensified by the justified demand that nursing activities be evidence-based, a demand that so far usually encounters inadequate prerequisites (no scientific basis, inadequate expansion of nursing research, etc.). The existing training has likewise failed to keep pace with these changes – corresponding reforms for developing the nursing professions are making only slow progress. As a result, there is a growing dissonance between the qualifications acquired and the real demands in day-to-day nursing, this being accompanied by increasing dissatisfaction with the existing working conditions, which have deteriorated considerably from the point of view of nursing. Health problems, burn-out and a loss of attractiveness of the nursing professions are the consequence.

Projections regarding the development of professionals in the health sector

53. As regards doctors, various studies exist concerning the future development of professionals, all of which follow specific forecasting models, give consideration to different parameters and refer to other years. All in all, however, they indicate an increasing shortage of doctors from 2020 at the latest, in both the inpatient and the outpatient sector. Two studies predict that there will already be a shortage of 37,000 or 56,000 doctors by 2020, the number continuing to rise until 2030. While the demand forecasts take the anticipated population development into account, the currently observed age-specific morbidity rates and doctor-patient contact rates are taken as the basis, ignoring various other relevant

factors influencing future developments. Despite these limitations, the following statements can be derived on the basis of the studies presented:

- The personnel shortage currently already visible in some areas, in both outpatient and inpatient institutions, will increase up to 2020, and probably more acutely up to 2030,
- The "relative personnel shortage" will probably be more severe among doctors in private practice than in inpatient institutions from 2020 onwards,
- Potential personnel bottlenecks will occur earlier in inpatient institutions, but to a less severe degree in the medium term,
- With an eye to intersectoral competition, however, a shift in the expected short supply could also be relevant, e.g. if consideration is given to the growing demand for part-time employment, which can probably be better realised in the outpatient sector.

54. Similarly, several studies exist that give forecasts of the future demand for professionals in nursing (see Table 1). They all show that a substantial personnel shortage will arise in the future if the current structures in nursing are retained. Although the comparability of the studies is limited, there are strikingly large differences between the calculations regarding the extent of the personnel shortage to be expected in nursing.

Author (year)	Healthcare institutions	Profession	Status	Morbidity trend	Shortage of nursing professionals (year) in full-time equivalents
Afentakis and Maier (2010)*	Hospitals, outpatient and inpatient nursing institutions	Healthcare and medical nurse, healthcare and medical nursing assistant, geriatric nurse	Trained nursing professionals only	SQ**	193,000 (2025)
				MC***	135,000 (2025)
			Including semi-skilled/unskilled nursing staff	SQ**	112,000 (2025)
				MC***	55,000 (2025)
Ostwald et al. (2010)****	Outpatient and inpatient institutions of the health sector	Healthcare and medical nurse	–	No data	128,400 (2020) 393,100 (2030)
		Healthcare and medical nursing assistant	–	No data	36,400 (2020) 84,634 (2030)
			–	No data	–
Hackmann (2010)	Outpatient and inpatient nursing institutions	"Geriatric nursing staff"	–	SQ**	430,000 (2050)

Table 1: Shortage of professionals in nursing – Results of different studies

* The results presented are for extrapolation of the employment structure as existing in Germany in 2005. The authors also presented the effects when adjusting the employment structures to the level of Eastern and Western Germany (different rates of part-time work).

** Status quo forecast.

*** Forecast assuming morbidity compression.

**** Ostwald et al. give separate forecasts for outpatient and inpatient institutions. The total is shown here for simplicity.

Source: Afentakis/Maier 2010; Ostwald et al. 2010; Hackmann 2010. Own calculation and representation

The demand for professionals in nursing also depends on the future feasibility of, and preference for, certain care arrangements. This particularly affects long-term nursing care, where substitution and supplementation effects occur between professionally rendered services and care provided by relatives. As with the provision of medical services, regionally different developments also have to be taken into account in nursing. The extent of demographic change, and also the future regional demand for employees in nursing, differs in the Federal States ("Länder"), and even the developments in the towns and rural districts of a Federal Land demonstrate substantial differences. The various studies on the future personnel demand or shortage in nursing have numerous limitations. For example, in view of the growing importance of chronic illnesses, hospital diagnoses are not sufficient for determining the future demand for professional nursing staff in medical care. With regard to nursing according to SGB XI, the definition of a "permanent need for care" taken as the basis also has a significant influence. Of particular relevance as regards nursing is the future development of the ratio of part-time work, the years of service spent in the profession and the age structure of the employees (these aspects are touched upon in the studies). Similarly, the ageing of the population has an impact on the health professions. A further methodological weakness of the existing calculations is the lacking distinction between the different occupations and qualification levels in nursing. Even today, the calculations do not reflect the visible, horizontal and vertical differentiation of the qualification structures in nursing – from various forms of assistant training, all the way to professionals with university degrees. The demand for differentiated, specialised qualifications in nursing will grow in the course of the further restructuring of the healthcare system (keywords: trend towards more outpatient care (substituting inpatient services), cross-sectoral care, etc.).

55. However, the above-mentioned differences, uncertainties and limitations of the existing studies should not disguise the fact that they generally tend to agree: based on a strained situation on the labour market, the growing demand for nursing will have to lead to a substantial increase in the number of professionals. If the current employment structures remain unchanged, the shortage of professionals will worsen massively from 2015/2020. According to the forecast by Afentakis/Maier (see above), which the Council considers to be plausible, it will probably already be impossible to fill 112,000 full-time jobs needed in nursing in the year 2025.

Approaches for securing the professionals needed for quality-based competition

56. The following options for action are open to consideration in the medical sector:

Redistribution/new distribution of medical duties: relief of doctors from administrative tasks and documentation activities by recruiting appropriately qualified administrative professionals and utilising information systems. Also being discussed is delegation of activities that are not necessarily medical, but currently performed by doctors, to other health professions (e.g. to "physician assistants" based on Anglo-American models). Apart

from the fact that there are so far few corresponding occupations or qualification opportunities in Germany, it would probably not be easy to realise this kind of delegation in the future, if only because of the shortage of young people that is also emerging in these and similar occupations. Moreover, simple delegation is not enough. Rather, there is a need for sensible restructuring of the scope of duties and the division of labour (also in teams), involving the greater transfer of responsibility, on the one hand, and better development prospects for non-medical health professions, on the other.

57. Reconcilability of career and family: In this context, mention can be made of measures that are becoming increasingly relevant, primarily in connection with the growing proportion of women in medical care and the changing roles of the sexes. In addition to flexible child care close to the workplace, this also means improved opportunities for returning to work after a period of child-raising or nursing, as well as innovative models of family-friendly flexibilisation of working time and work organisation. Particular mention should be made of the expansion of part-time work (also for men), although this presupposes a change of attitude at the management level. Also necessary are "dual career" models, which are so far still rare in Germany. The trend towards a balanced ratio between work and leisure time, and towards reducing the overall workload, should likewise be better taken into account. Even today, not only female doctors, but also many male doctors, prefer to take time off rather than receive payment for standby duty and overtime. One point in favour of this is that a reduced time burden can have a positive influence on doctors' willingness to stay in a curative medical activity, or return to it after a family-related interruption. New working time models are also needed in outpatient care. They have increased significantly in recent years and will probably continue to grow in the future. Although they are easier to realise in many outpatient fields, they entail challenges as regards patient loyalty, and confront doctors with the task of compensating for the possible lack of personnel continuity by means of better communication and documentation.

58. At the same time, the problem of the lack of primary physicians in rural areas needs to be tackled, e.g. by increasing the attractiveness of the profession of general practitioner, by early contact of students with practice, and better opportunities for presenting, or more room for, the subject of General Medicine. Whether and to what extent scholarships have an impact on later work in underprovided areas, should be specifically tested and examined. In addition, further incentives for setting up in private practice in underprovided regions are recommended, such as job offers for the partner, too, and school and day-care offers for the children. Initial incentives in this respect have already been integrated in the Act on the Stabilisation and Structural Reform of SHI (GKV-VStG). It remains to be seen how successful they will be. The importance of monetary incentives when choosing the location to set up in private practice is greatly overestimated. The most important factors as regards setting up in private practice include good framework conditions for the family and the extent of professional commitments (e.g. stand-by duty).

59. Better employment of the doctors working in patient care: the sectoral distinction between outpatient and inpatient care often ties up medical capacities. Better meshing of the two is therefore desirable, also from the point of view of securing professionals, and should moreover increase the quality of the provision of services, as well as benefiting the doctor-patient relationship, since the patient can then be treated intersectorally by "one" – ideally multiprofessional – team. In this respect, growing commitment of hospitals and the establishment of a mix of inpatient and outpatient work can be expected in the future.

60. In the outpatient sector, there is currently an imbalance between overprovided and underprovided areas. The regional redistribution of doctors would thus be desirable. To achieve this, the Medical Licences Committee can, as of 1 January 2013 and on the basis of improved demand-oriented planning, refuse to fill the practice of an SHI-accredited physician becoming vacant in an overprovided planning area (because there is no need to fill the vacancy from the supply point of view and no special privilege exists), and the Association of SHI-Accredited Physicians can buy up the doctor's practice, taking the economic interests of the SHI-accredited physician into account (Section 103 Para. 3a, eighth sentence, SGB V). Before doing this, however, the need for medical services should be determined on a morbidity-oriented and reliable basis, in which context consideration must be given to special regional features. In the field of general practitioners, a buy-out of this kind is only open to consideration in a few conurbation areas.

61. Increasing the attractiveness of medical work in patient care: This includes numerous measures – such as combined, varied activity in the inpatient and outpatient sectors, and improvement of the reconcilability of career, family and leisure time, with the aim of increasing the amount of time spent working in patient care in the entire career. The improvement of working conditions is also part of this. In the inpatient sector, doctors could, for example, be more extensively involved in strategic decisions of the hospital management. Similarly, job satisfaction could be increased by creating lean hierarchies and establishing a participatory management style geared to team structures.

62. The promotion of longer exercise of their curative activity by (older) doctors necessitates different work organisation and structuring, such as a different distribution of tasks, more compensatory days (possibly via previously created lifelong working time accounts), reduction of night and weekend work, constant continuing medical education, further qualification and health promotion. In addition, the job satisfaction of doctors in outpatient care could fundamentally be increased by new stand-by duty models.

63. Not least, it is also necessary to optimise specialist medical training by providing attractive framework conditions, structured specialist training networks, especially for future specialists in General Medicine, individual mentoring, clearly defined specialist training targets and systematic evaluation and/or quality promotion.

64. Several proposals have been submitted for increasing the number of doctors working in patient care, including more extensive recruitment of foreign doctors. Quite apart from

the problem that emigration can likewise lead to a shortage of doctors (with major social consequences) in the country of origin, the differences in training, and also language barriers, must also be borne in mind, these primarily being noticeable in conservative fields (e.g. Internal Medicine, Neurology and Psychiatry). These doctors need long familiarisation periods that tie up considerable capacities.

65. There have been various discussions about increasing the number of places for students of Medicine in order to counter the growing shortage of doctors in patient care. According to information from the Stiftung für Hochschulzulassung (Foundation for University Admissions), a slight rise in the number of students starting a course in Human Medicine has been observed over the past three university years. However, this rise should not be equated with an increase in study place capacities, since it includes various effects (e.g. the shorter duration of studies), and the planned target number of study places to be allocated is fixed. The total number of students of Human Medicine has remained roughly constant since 1999/2000, amounting to just under 80,000 in study year 2009/2010. The expansion of student capacities in Medicine is confronted with very high investment costs. However, in view of the growing demand for doctors as a result of demographic ageing, and the significant decline in the volumes of work per capita, the Council is nevertheless of the view that capacities in the subject of Human Medicine should in future be adapted to the changes in requirements, taking efficiency reserves into account.

Beyond this, thought should be given as to whether the number of licensed doctors working in curative medicine can be increased by changing the way in which applicants for study places are selected. However, these measures could only take effect in the medium term. A lead time of at least 13 years would be necessary in the GP sector, for example (two latent years before implementation, six years of study, at least five years of specialist training).

Increase	Reduction
<ul style="list-style-type: none"> Increased need for medical care as a result of demographic change 	<ul style="list-style-type: none"> Population decline
<ul style="list-style-type: none"> Rising average age of doctors In the OECD comparison, Germany has only a medium ranking in terms of doctor density 	<ul style="list-style-type: none"> Increasing number of doctors
<ul style="list-style-type: none"> Emigration 	<ul style="list-style-type: none"> Integration and qualified immigration
<ul style="list-style-type: none"> Increase in administrative tasks No possibility for delegating tasks owing to a shortage of professionals in the other health professions 	<ul style="list-style-type: none"> New work distribution, delegation Relief from administrative and documentation tasks Use of information systems
<ul style="list-style-type: none"> Decline in the number and/or work volume of working doctors <ul style="list-style-type: none"> – Longer family-related interruption of work – Increase in part-time work – Rising average age of doctors – Preference for reduced working time ("time off beats pay") – EU Working Time Directives in hospitals – Systematic recording of working time 	<ul style="list-style-type: none"> Increase in the number and/or work volume of working doctors <ul style="list-style-type: none"> – Better reconcilability of family and career – Better possibilities for vocational reintegration after a family-related interruption of work – Increased attractiveness of curative work (e.g. lean hierarchies, changed duty models) – Age-appropriate structuring of work – Work parallel to old-age income
	<ul style="list-style-type: none"> Reduction of overprovision, underprovision and misprovision <ul style="list-style-type: none"> – Change in healthcare structures, e.g. better meshing of inpatient/outpatient care, elimination of redundant structures – Reduction of hospital beds – Reduction of misdistribution

Table 2: Factors influencing a future shortage of doctors

66. In the nursing sector, one of the priority tasks is to increase the number of professionals in nursing and expand the available vocational training capacities accordingly. More professionals will in future be needed in all nursing segments, but particularly in inpatient and outpatient long-term care. However, quantitative measures alone are not enough. Rather, there is a need for differentiated training concepts of the kind that have been discussed and demanded for a long time. This point needs to be emphasised all the more in that the tasks and responsibilities in many areas of nursing have changed greatly in the context of demographic and epidemiological change and progress in medical technology, meaning that new, appropriate qualification profiles are needed. The discrepancy currently existing also impairs competition, since the healthcare institutions cannot enhance their profile without correspondingly qualified personnel. There is therefore a need to tackle the training situation and to ensure in this context that nursing can in future arrive at evidence-based action in practice.

67. To this end, there must be a drive to make nursing increasingly professionalised and academic, and the expansion of undergraduate and dual study courses, combining practical training and university qualification at the bachelor degree level, must also be advanced. Such courses have long been customary at the international level, but are only now

appearing in the university landscape in Germany, where they still have the status of a pilot scheme. The Council recommends active promotion of this development.

At the same time, greater efforts will in future be necessary to establish a nationally consistent study course structure capable of achieving international standards. There is currently a wide variety of study course concepts, since each university implements the model that it considers to be attractive. It is also necessary to examine the follow-up study course level and increasingly establish Master degree courses leading to qualifications for specialised functions and roles in nursing. They are already a firmly established element of the university landscape in many countries, and have been demanded in Germany for a long time, because specialised nursing skills are becoming more urgent in many practical fields (e.g. patient education, interface or discharge management, process control).

68. On the other hand, there is also a need to expand capacities in three-year vocational training. However, new approaches are also called for in this context. For example, the integration of training in healthcare and medical nursing, healthcare and paediatric nursing, and geriatric nursing, tested in numerous pilot projects, is overdue and should be implemented swiftly by the planned Nursing Professions Act. No less important is the further qualification of "low-qualified" personnel, i.e. the auxiliary and assistant occupations in nursing. Finally, it should be possible to succeed in increasing the horizontal and vertical permeability of the vocational training/education system in nursing.

69. It is moreover necessary to expand continuing medical education and specialist training offers, and to adapt them to the increasing differentiation in nursing. There is a need for concepts for lifelong learning, which should be established as an integral element of quality development, since a knowledge of the latest state of scientific progress and the available empirical findings is not only a prerequisite for safeguarding need-oriented, high-quality healthcare, but also constitutes an important competitive factor.

70. Beyond this, there is a need to improve the working conditions in nursing, and to develop and implement new work organisation models. For instance, it is recommendable to consider and implement Primary Nursing or Case Management more with an eye to work organisation aspects, since both concepts make it possible to supervise the increasing number of low-qualified employees in nursing, on the one hand, and to assure the quality of their work, and thus improve competitiveness, on the other. At the same time, they can improve patient orientation, in that people in need of nursing care are given a contact person who is responsible for them. However, the working conditions in nursing also need changing in other respects. For example, the length of time spent in the profession is quite short in some places, job dissatisfaction (particularly in hospitals) is on the rise, and the number of nursing employees off sick in hospitals and nursing institutions is above average. The reasons for the higher level of occupational disability in the nursing professions include not only age-related, physical impairments, but also the great psychosocial burdens resulting from working conditions inappropriate for the task, for example.

71. No less important are new cooperation models, be it within professions or between professions. This includes the expansion of multiprofessional team structures, the redistribution of tasks and responsibilities and, above all, less hierarchical forms of cooperation – a demand that clashes with the fairly rigid hierarchies and power structures in the health professions and the undefined spheres of responsibility that continue to exist in Germany. But without changing this and strengthening the position of nursing in the structure of the health professions, it will be impossible to realise team structures and difficult to lead nursing out of its acknowledged "social prestige crisis". After all, it has long been acknowledged that nursing has a low status and little social esteem. Similarly, the nursing professions are considered to be "dead-end jobs" with few opportunities for advancement, poor pay and tough working conditions (e.g. shift duty right up to the career end). In this respect, the image campaigns of past years alone are not enough. Rather, the underlying problems need to be tackled in order to increase the attractiveness of the nursing professions.

72. Moreover, efforts must be undertaken to improve pay, the working climate and the possibilities for participation and having a say – and similarly to arrive at employment conditions that are in harmony with the change in life plans.

73. In view of the health burdens involved, it is additionally necessary to invest more in comprehensive employee health promotion. A host of tried-and-tested models and projects can provide ideas in this respect. Greater attention must specifically be paid to the increase in the number of older employees that will emerge in the coming years, signs of which are already apparent in geriatric nursing today. It moreover necessitates more intensive efforts to create age-appropriate working conditions.

74. As in the provision of medical services, better reconcilability of family and career must also be ensured in nursing. It must be borne in mind in this context that increasing numbers of working people are confronted with a relative's need for nursing care, often finding this to be even less reconcilable with gainful employment than caring for children (e.g. in the case of dementia sufferers requiring extensive care). The Act on Care-Giving Leave and the Act on Family Care-Giving Leave recently improved the options for release from work and work reduction. In order not to lose staff, employers should pay greater attention to the subject of reconcilability of care-giving and career, and develop concrete measures, such as the introduction of flexible working time models. After all, people with private care obligations are often not so much interested in release from work or reduced working hours, as in more flexible splitting of their working hours to permit better coordination of family and career.

75. Finally, further studies on the subject of the shortage of professionals are required, and also on the working conditions in nursing. These topics have so far been addressed only rudimentarily in the still quite young field of nursing research. Moreover, both fields need not only studies on the subject of the shortage of professionals that give a differentiated picture of requirements, but also continuous health professions reporting (key figures regarding vocational training, demand development and employee numbers in the health

professions, above and beyond the reports of the Federal Statistical Office), in order to be able to detect shortage or overprovision tendencies at an early stage and react accordingly.

76. In summary, it can be noted that – unless substantial efforts are undertaken to reverse the trends described – a pronounced shortage of professionals in the health sector is to be expected in the future, making (quality-based) competition within the healthcare sectors and at the sector interfaces much more difficult.

3.3 Strengthening of user competence as a prerequisite for target-oriented competition

77. The 2000/2001 and 2003 Reports of the Advisory Council already dealt exhaustively with the possibilities for improving patient and user orientation through information and competence-increasing strategies and through increased participation, since they are essential elements of modern, viable prevention and healthcare. This applies equally to strategies based on personal competence and responsibility, or on empowerment.

78. At the same time, user competence also plays an important role from the point of view of competition. A number of prerequisites must be met if the instrument of competition is to achieve the desired effects. These prerequisites particularly include sufficient market transparency (essential criteria are the existence of a sufficient level of information of patients and users, the measurability of quality, and the existence of a functioning price system).

79. In the health sector, there are varying degrees of information asymmetry between health insurers, insureds and healthcare providers. However, patients and users must be aware of, and able to assess, the choices available to them if they are to be in a position to make sound decisions and thus actively contribute to maintaining or restoring their health. In this context, it is not always necessary for them to perform this assessment process themselves – rather, they can also avail themselves of the assistance of an expert.

Numerous players have to act simultaneously and at several levels in order to reduce information asymmetries. At the top level, it is the task of sovereign instances to define statutory minimum standards. Different solutions are open to consideration at the lower level, depending on the clinical picture and the available treatment options. The users themselves may be in a position to acquire assessment competence in the case of plannable, relatively simple healthcare services, for some of which the users bear a large share of the costs. In contrast, particularly in the case of complex services involving a high level of experience or credence good characteristics, consideration can be given to the use of information intermediaries to support patients and users in reaching decisions and coping with their illness.

So, from the point of view of competition, it is mainly a question of informing patients and users, and increasing their competencies, to enable them to exercise their function as

co-producers of health, and exhaust the options offered them by competition in the health sector. From the point of view of society as a whole, there are also further reasons for paying attention to the subject of patient and user information/competence.

80. User competence is also a prerequisite for acting as a "third force" alongside healthcare providers and health payers. To this end, patients/users need information and, above all, information and media skills. These prerequisites are so far only incompletely met in the health sector. At the same time, the need of patients and users for information and greater competence has increased as a result of the changed health requirements of the population – triggered by demographic ageing and, in particular, the increase and change in the nature and course of chronic illnesses. In addition, there has been a marked change in how the role of the patient is viewed. Patients are no longer seen as just passive benefit recipients or "laypersons", but as players and active co-producers of health, who play a constitutional part in treatment and healthcare and whose preferences regarding the choice of healthcare services are considered to be important.

81. In response to this, Germany has in recent years seen a remarkable increase in offers of patient/user information and counselling: at the start, primarily in the field of the healthcare providers and health payers and, since the Healthcare Reform in 2000 and the (initially pilot-scale) introduction of Section 65b SGB V, also in the field of "independent" patient and user counselling. The 2008 Act on the Structural Development of Long-Term Care Insurance additionally adopted the ubiquitous establishment of long-term care support centres (Section 92c SGB XI) and long-term care counselling in the sense of individual case management according to Section 7a SGB XI, progress with which has since been made slowly, but successively. Patient rights were also strengthened. First of all, the document "Patient Rights in Germany" was jointly published by the Ministries of Health and Justice in 2002. This was followed in 2005 by the "Charter of Rights of People in Need of Long-Term Care and Assistance". Moreover, in May 2012, the Federal Government adopted a bill regulating the rights of patients. Furthermore, the Federal Government appointed a Commissioner for Patients' Affairs for the first time at the end of 2003. Some Federal Länder have since adopted this model (Berlin since 2004, Bavaria since 2010, North Rhine-Westphalia since 2012). In turn, representatives of patient organisations have participated in the meetings of the Federal Joint Committee (G-BA) since 2004, having a right to take part in the deliberations and to table motions, but no right to vote. These are just a few steps, and more could be added, such as the efforts to achieve quality transparency. Not yet a politically important topic is, however, the involvement of patients in the planning and structuring of the healthcare system and in research, which has long been demanded internationally and is now also increasingly being discussed in Germany.

These examples show that substantial progress has been achieved in recent years, both in strengthening the position of patients/users, and also in expanding information and counselling. In the course of this process, a diverse information and counselling landscape with different approaches and concepts has emerged, where – as called for in the 2003

Report – attempts are being made in various ways to provide patients and users with the necessary knowledge, so that they can assume personal responsibility for maintaining their health and act as competent partners in the healthcare system. Based on international models, patient/user information and counselling has in the meantime developed into an independent sphere of activity in healthcare and become correspondingly institutionalised.

82. Despite the progress made, however, the situation is not yet satisfactory, as not least illustrated by the small number of studies available regarding the Health Literacy level or health-related knowledge of the population. In addition to existing knowledge deficits in relation to certain areas of the health sector, there is also insufficient knowledge of patient rights and the possibilities for lodging complaints in the event of treatment errors or deficits in medical services. Similarly, substantial information deficits exist as regards questions of quality and cost transparency. There appear to be major differences in this context, depending on age, gender and social status. The basic health-related knowledge of the German population, and knowledge regarding the fundamentals of scientific medicine, are also in need of improvement and frequently characterised by incorrect information. The availability of lots of information does not necessarily mean that people are well-informed, particularly if their information skills are inadequate or the information offered is deficient. Moreover, incorrect or deficient information consolidates incorrect judgements.

Similar results are also found at the European level. They confirm that the level and extent of Health Literacy differs among the participating countries, but also that, on average, almost one-half of the interviewees have limited health-related knowledge. Above all, vulnerable groups of the population demonstrate particularly poor Health Literacy. This particularly includes elderly people, people with a low level of education and few socio-economic resources, people in a fragile and poor state of health and many of the intensive users of the healthcare system, as well as immigrants. Consequently, investments in improving health-related knowledge and user competence should have a direct, positive effect on health status, and also on utilisation patterns. They are intended to help reduce excessive or incorrect utilisation of the healthcare system, and thus to support generally more cost-efficient healthcare. This once again shows how important it is to continue to invest in expanding patient/user information and counselling in future. At the same time, the existing concepts and approaches need to be reviewed, as pinpointed information and counselling (on individual issues) alone will probably not suffice to raise the Health Literacy level in the population. Rather, there is a need for systematic communication and learning processes regarding health-related issues that not only provide information, but also assist the acquisition, processing and utilisation of information/knowledge and impart the necessary information and media skills.

83. It is additionally necessary to pay special attention to population groups with a low Health Literacy level and to develop offers accurately tailored to their needs. At the same time, they are among the "hard-to-reach" target groups, and special forms and strategies are therefore required for addressing them. Moreover, special didactic concepts are needed for

these groups (who are often unaccustomed to learning), as well as special, target group-specific communication strategies. The Council is of the view that developing them likewise requires greater attention and higher investments.

84. At the same time, the Council recommends improvement of the data situation regarding the Health Literacy level of the population, and also regarding the extent and nature of the existing offers of information and counselling for patients and users. To date, counselling and information research is of only little importance in German (health) research. Above all, there is little empirical knowledge regarding the information and counselling landscape, which has not been funded in pilot projects and thus also not evaluated. This particularly applies to the information and counselling offers of the healthcare providers and health payers in the health sector, as well as in rehabilitation (SGB IX), nursing (SGB XI) or the social sector, and it applies equally to the field of "independent" user information forming part of standard care. Initial empirical findings are only available regarding the UPD (Unabhängige Patientenberatung Deutschland e.V., an organisation providing independent patient counselling services in Germany) and the long-term care support centres funded in pilot projects. On the whole, however, there is a lack of empirical knowledge regarding the scope and nature of the offers, the approaches and concepts of institutionalised patient/user information and counselling and its effectiveness, the working methods of the information and counselling centres, as well as the rapidly growing segment of Internet information and counselling, etc. Gaps in knowledge and information also exist as regards the actual and potential users of information and counselling offers, the nature of their information needs and their use of information, as well as the information pathways. Closing these gaps and advancing "counselling and information research" in Germany is indispensable for laying the foundations for systematic control of this increasingly important sphere of work/healthcare segment.

85. The Council welcomes the fact that institutionalised patient/user information and counselling has developed so dynamically in recent years, and that independent patient counselling was included in standard care in 2011. It sees this as an important contribution to strengthening the position of patients and competition in the health sector. For the future, however, it recommends reconsidering the current practice of inviting tenders for independent patient counselling, in the spirit of an interchangeable service, and prolonging the 5-year time limit currently imposed, since too short a time limit impedes the establishment of sustainable structures. The Council similarly considers it necessary to flexibilise and expand the framework for the funding of independent patient counselling, which has been fixed since the health reform in 2000, because independent patient counselling is today already incapable of covering the demand for information and counselling in the desired way due to existing capacity bottlenecks. Moreover, the number of independent patient counselling centres should be increased in order to arrive at ubiquitous structures. Similarly, the development of new offers and forms of intervention needs to be advanced, this likewise entailing financial consequences. Beyond this, an institutional construction should be sought that better guarantees independence in terms of content and finances.

86. The Council also fundamentally welcomes the nationwide expansion of information and counselling on long-term care issues in the form of long-term care support centres. However, it considers it necessary to advance their sluggish implementation in some Federal Länder, and to initiate efforts to arrive at a nationally uniform structure – preferably integrated in the existing information and counselling structures in the health sector. It also recommends revision of Sections 7a and 92c SGB XI in the framework of the Act on the Structural Development of Long-Term Care Insurance, since they allow interpretations that have, in some places, led to developments in the field of long-term care counselling that users consider to be counterproductive (and confusing). Greater attention must also be paid to ensuring independence and neutrality in this context.

87. The expansion of information and counselling in the rehabilitation sector is likewise to be welcomed. The common service centres of the rehabilitation providers have, however, not proven successful. New concepts and models are needed in this respect.

88. Although the information and counselling landscape has developed highly positively on the whole, there are still gaps in terms of structure and content. For instance, success has not yet been achieved in creating a sufficiently ubiquitous structure of information and counselling centres. There are still regional inequalities, and a general discrepancy exists between urban and rural areas. Changing this situation is an important task for the future. Further expansion alone will probably make little sense. Rather, new – regionally differentiated – models must be developed at the same time, in order to secure an adequate offer in thinly populated, rural regions, for example, be it through new forms of mobile counselling, telephone information/counselling, etc.

In addition to the development of new models for creating an effective and efficient, ubiquitous information and counselling structure, there is a need to fill gaps in the content of the offers. For example, this includes information and counselling on new forms of healthcare. The obligatory provision of structured information by the health insurance funds is necessary to permit individual assessment of advantages and disadvantages when selecting a health insurance fund/tariff, and of new forms of healthcare. Moreover, more intensive efforts for strengthening user competence are necessary (2003 and 2007 Reports), be it through targeted promotion of competencies to enable people to find their way through the healthcare system, develop usage patterns appropriate to the problem, reach informed decisions or deal with the changing role situation (and increasing role diversity) or to become clear about their own preferences as users.

89. Institutionalised patient/user information generally faces the challenge of reacting flexibly to new requirement situations and changing patient preferences, despite the lack of data on the requirements and the need for information and counselling. In addition to improving the data situation, there is also a need to critically examine the forms of information and counselling. For example, it can be seen across all the different fields of counselling that face-to-face information and counselling is slightly less important than initially expected. In contrast, the rating of telephone information is higher than assumed

and shows an upward trend. Although this varies by age group, the expansion of telephone counselling should nevertheless be encouraged, also in order to close existing regional gaps in coverage. The same applies to Internet-based forms of information and counselling, which are particularly in need of expansion in the independent segment of institutionalised patient/user information and counselling. Target group aspects are also attracting growing attention, but are not yet characteristics of daily work everywhere and need to be given more consideration in future.

90. Further challenges exist in the field of quality development and evidence-based work. This addresses different aspects. For example, documentation systems and systematic quality management are not yet ubiquitously standard elements of the working methods in institutionalised patient/user information and counselling. Self-evaluation for process optimisation is likewise not a matter of course.

The subject of "qualification" also needs to be borne in mind in this context. On the one hand, the people working in institutionalised user information need sound professional qualifications (in medicine, health science, nursing science, law) in line with the content-related focus of the respective institution or task. At the same time, they should have proven, sound intervention skills as counsellors, mediators of knowledge or also case managers. Proof of sound intervention skills is all the more important in that there is still a need to improve the level of the professional discussion and the application of pertinent intervention strategies in this field. Much the same applies from the professional point of view. This underlines the fact that there is still a need for development in quality management.

A further challenge is the technical quality of health information. Despite numerous activities in recent years, it is still in need of improvement and often lacks the necessary basis in evidence. However, patient participation – be it when reaching decisions or in the co-production of health and particularly in the self-management of chronic illnesses – presupposes evidence-based information. The criteria have in the meantime been elaborated, but are not yet applied everywhere in practice. Not all information for patients and users offers the necessary reliability. Its comprehensibility is often also in need of improvement, as much of the available information is so far not presented in user-friendly form: it reflects neither the relevance criteria and preferences of the users, nor their manner of acquiring information, nor is it in a form they can understand. Quality criteria have in the meantime also been defined for ensuring the user-friendliness of (evidence-based) health information, but there are so far hardly any instruments that make the various quality requirements comprehensible and applicable for users.

Practical tests by users are another possibility. A set of methodological instruments has in the meantime been developed for them that appears promising for optimising the comprehensibility of evidence-based health information. In view of the currently still low level of these efforts towards evidence-based information and information quality in practice, the development and testing of evidence-based, user-friendly health information should continue to be supported and promoted, e.g. through competitions for Best Practice models.

91. As pleasing as the expansive development of institutionalised patient/user information and counselling is, on the one hand, it also has adverse effects. Although a highly diverse range of offers has emerged, the multitude and diversity of institutionalised offers has at the same time led to greater fragmentation and confusion for users, meaning that integration efforts are necessary. The creation of new contact points, as called for in previous Council Reports, is one solution, but it results in the addition of further structures and could thus possibly entail disadvantages for users, since it increases the number of points for them to contact. It would probably make more sense to create integrated, cross-sectoral counselling models, where all counselling offers are pooled under one roof, preferably affiliated or close to medical service centres (such as primary-care practices, cf. Special Report 2009), or embedded in healthcare structures close to the home or neighbourhood. It must be ensured in this context that information and counselling are neutral and not subject to individual interests.

A further aim must be to seek solutions for eliminating the sectoral fragmentation of patient/user information and counselling. From the user point of view, it makes little sense to create separate information and counselling centres in accordance with SGB V, IX and XI. This would make it more difficult to find the right counselling centre, especially for patients and users with health impairments and burdens. There is also a need to change the inadequate meshing of health-related information and counselling centres with social information and counselling offers (housing counselling, senior citizens' counselling, etc.), e.g. by creating cross-sectoral counselling models.

92. In view of the rapid development of Internet-based information, greater attention needs to be devoted to this area. One challenge continues to be to improve the user-friendliness and quality of Internet information (see already 2003 Report), as well as linking and integration, in order to counteract the diversity of parallel, relatively unconnected information. A sensible idea would be a common health information portal, where publicly funded information offers are pooled under one roof and then rounded off by other information offers that are important from the user point of view.

93. It additionally makes sense to expand patient education and competence promotion, since information and counselling alone are not enough, especially in the case of the chronically ill, but also in the case of people having relatives who are sick or in need of assistance or long-term care, who likewise count among the users. Not only information and knowledge are demanded of patients and their relatives, but also a wide variety of competencies, if they are to be able to competently cope – often for years – with the course of chronic illnesses, to at the same time manage their own lives, everyday life and the illness, and to responsibly take the numerous decisions required (despite uncertainty). For instance, concrete abilities are required for dealing with treatment instructions, dietary rules or the handling of medication, etc. At the same time, extensive knowledge regarding disease relationships and the signs and progress of symptoms is necessary, in order to escape avoidable critical conditions and crises, promote restabilisation processes, contribute to the

maintenance of conditional health and relative stability, and prevent premature downhill trends and function losses. Therefore, patient education is of great importance, both for supporting self-management and the necessary skills, and for acquiring competencies for appropriate utilisation of the healthcare system. This realisation has in the meantime established itself on a broad basis in the field of rehabilitation, whereas there is still a need for development in many other fields of the health sector. The Council therefore welcomes such initiatives as the establishment of patient universities, which complement patient education in healthcare institutions by adding important elements. It recommends promotion and evaluation of this development, and that it be networked with institutionalised patient/user information and counselling. It also suggests that the development and implementation of new concepts and didactic strategies be promoted. After all, despite proclamations to the contrary, patient education is still often based on conventional "schooling" strategies, i.e. education and communication of knowledge, and pays too little attention to competence promotion, i.e. the communication of (problem-solving) abilities and skills for self-responsible dealing with health and illness, for promoting self-management and for empowerment. The latter concepts often serve primarily as theoretical justification rhetoric, but are not characteristic of practical action. Moreover, many concepts are predominantly geared to the outsider/expert perspective and pay too little attention to the patient perspective and the problems arising from the point of view of the patients. Similarly, the available international findings regarding the attributes and effectiveness of patient-focused interventions need to be given greater consideration in Germany. Much the same applies to available findings regarding which type of intervention is indicated in which phases of the course of an illness, e.g. when patients and users are ready to take in information, when they are receptive to education offers, and in which phases they more require protective support strategies.

Finally, more attention needs to be paid to the fact that patient groups with poor resources require not only information and education, but additionally also supervision, coaching and case management – intervention strategies that have increasingly become part of everyday healthcare in recent years, but need to be put on an even broader footing. Particularly with an eye to this user group, it is also necessary to improve information and counselling by the health professions.

94. Patient/user information and counselling has become an important competitive factor, mainly for the health payers, but also for many healthcare providers. This trend will probably continue in future, meaning that this segment of the health sector will also need great attention in the future. In addition to the promotion of quality, research, integration and user-friendliness, it will in future have to be borne in mind that competition cannot be the sole regulatory mechanism in this quarter. Rather, a joint, coordinated initiative of the providers of patient information, who are independent of individual interests, is needed, in order to close the substantial gaps in patient information by providing high-quality, coordinated offers, and thus to promote quality-based competition.

Part II: Fundamental problems and possible solutions at the interface between the outpatient and inpatient sectors

4 Securing continuity of care as a core task of interface management

95. The numerous interfaces in the German health sector hold a great risk potential for inefficiencies and welfare losses. This particularly applies to the interface between acute inpatient and outpatient care. New problems and challenges have arisen at this interface as a result of the structural changes in hospital care, and equally due to demographic trends and the associated change in the patient structure. Patients leave hospital with more serious health problems and, therefore, with a greater need for (continuing) care than in the past. Moreover, the average age of the patients is rising, and thus also the severity and complexity of their problem and requirements situations that need to be considered during the transition to (continuing) care. Consequently, the preparation of follow-up care is often time-consuming and demanding. At the same time, less time is available for this purpose.

96. Owing to these challenges, and as a consequence of functioning (quality-based) competition, there is a need to improve the interface structure, and thus the coordination and integration of (acute) inpatient and outpatient care. At the same time, interface management can be attributed a strategic differentiation potential – e.g. as regards the healthcare providers who compete for selective contracts with health payers in the framework of integrated forms of care. At the same time, there are again also possibilities for competition on the part of the health payers, which can be attractive for insureds as a result of selective contracting with healthcare providers having effectively functioning discharge management.

97. The obligation to avoid interface problems was laid down in the Act to Strengthen Competition in Statutory Health Insurance (GKV-WSG) in 2007 and formulated more precisely in the framework of the Act on the Stabilisation and Structural Reform of SHI (GKV-VStG) in 2011. This was expressed in the stipulation of the right of patients to Care Management (Section 11 Para. 4 SGB V) and, since 2011, to Discharge Management when transitioning from hospital to other fields of care (Section 39 Para. 1 SGB V). This met important prerequisites for eliminating, or at least greatly reducing, the interface problems that had existed, and been criticised, for decades. The prerequisites for this include, on the one hand, consistent implementation of the new legal provisions, observing the applicable professional standards, such as the directives of the National Expert Standard "Discharge Management in Nursing", and, on the other hand, the improvement of cross-sectoral

communication and information. Securing continuity of care at the interface between outpatient and inpatient care is a multiprofessional task. However, the tasks of the health professions involved have different focuses.

98. The task of doctors is to guarantee continuous medical treatment of the patient during the transition from the acute inpatient sector to the continuing treatment sector. The continuing treatment of patients with extensive care needs, in particular, necessitates cooperation between healthcare providers, both at the intersectoral level (outpatient/inpatient) and the intrasectoral level (e.g. between GPs and specialists), and is accompanied by a major coordination effort and need for information between colleagues providing joint or continuing treatment.

In this context, information and communication (I&C) technologies can help overcome the interface problem. The integration of digitised medical reports and patient files in an overall, interoperable information and communication technology concept offers the possibility of improving and accelerating both the cross-sectoral availability of information and document exchange, paying attention to concerns about data protection and maximum security standards. Various aspects have to be taken into account when designing the cross-sectoral implementation of I&C technologies and applications, including the determination of documentation requirements on the part of the healthcare providers in different institutions and sectors, and the definition of documentation standards on this basis. They can, for example, also be defined along an existing, cross-sectoral treatment path. To support this process, checklists can also serve as initial guides for cross-sectoral communication, the forwarding of findings and medication checks. Technical integration problems at the interface should be counteracted by corresponding specifications in the sense of obligatory interface disclosure to guarantee interoperability between the systems of software manufacturers for outpatient and inpatient information systems. These requirements could, for example, be drawn up by the G-BA as the body responsible for issuing guidelines. Evaluated and time-proven initiatives at the healthcare provider and/or health payer level can provide valuable indications regarding how sector-specific obstacles impeding the continuity of treatment can be overcome. The use of electronic case files can also be rated as an element of competition, since the facilitation of communication and the forwarding of information (e.g. including the arrangement of operation dates, rapid communication of findings) from the hospital to doctors in private practice can also prove advantageous for future patients in the sense of referrer loyalty.

99. Cross-sectoral drug therapy plays an eminent role in connection with improving cross-sectoral communication to secure continuity of care. The prescription of drugs is one of the most common therapeutic measures, particularly in the outpatient sector, but also in inpatient therapy, and particularly in the conservative disciplines there. Moreover, it is also relevant for discharge management in all disciplines. The following prerequisites have to be met in order to guarantee cross-sectoral care in the field of drug therapy:

- a) The attending physician must have a complete overview of the patient's medication history. This includes complete information regarding the medication currently being taken, including over-the-counter drugs, and, in individual cases, also medication taken previously. A comprehensive medication history, paying attention to previous drug therapies, their efficacy and tolerance, is the prerequisite for reduced-risk drug prescription and a complete medication list.
- b) When drawing up the medical prescription, it must be guaranteed that the medicines necessary for indication-based drug therapy are coordinated. The risk of possible interactions as a result of giving several drugs or different active-substance combinations must be weighed up, and the dose and presentation reviewed on the basis of patient-specific attributes (e.g. renal function, weight, age, allergies, living circumstances).
- c) It is moreover necessary that the medication history, the medication list and the accompanying medical report be made intersectorally available to the doctor providing joint or follow-up treatment, or that they are promptly made accessible to him/her in a standardised and clear form. This availability particularly applies to emergency situations, where appropriate provision of information is indispensable.

Medication information can be improved by intrasectoral and intersectoral communication and cooperation. This can also be supported by integrating pharmacies in the supply of medicines in the case of integrated, cross-sectoral care concepts, or by home-supplying pharmacies in the case of care home residents. Moreover, the use of computerised physician order entry (CPOE) systems and clinical decision support systems (CDSS) can increase the quality of safe drug therapy by drawing attention to possible medication risks or errors in the prescription process before the prescription is issued.

100. However, increased use of information and communication technologies, at both the intersectoral and the intrasectoral level, and introduction of the electronic health card, also raise new questions from the legal point of view and in relation to data protection. It can be seen in this respect that the opportunities offered by computer-based healthcare may, under certain circumstances, also be offset by certain risks that are also clearly perceived by the medical community and the public. They call for circumspect handling and conscious use of the possibilities available. Centralised data storage is particularly critical in this context. It can, however, be noted that the patients' personal data are already subject to comprehensive legal protection, based on the secrecy of telecommunications, the general right to privacy and various laws that specify the details of these two basic rights, above all the Telecommunications Act and the Federal Data Protection Act (BDSG). The principle of the rule of law affords protection against any future amendment of laws to the detriment of doctors and patients. There is at most a need for detail improvements in the field of social security data protection. Risks occurring in the event of loss of an electronic health card or a hacker attack on stored data, for example, must be counteracted by means of corresponding security technologies. Since personal health data are particularly sensitive data that are afforded special protection in accordance with Section 28 BDSG for good reason, concerns

relating to technical issues or aspects of data protection law must be taken seriously, especially those regarding centralised data storage.

The risks for the medical community tend to be smaller in the field of liability law. For example, doctors have only a slight liability risk if they continue to observe their prudence requirements that have been generally recognised for decades and specified in detail by the court decisions reached in countless cases. Possible uncertainties on matters of detail will have to be clarified in court. From the purely legal point of view, there are no major concerns as regards computer-aided healthcare, including the electronic health card.

101. As previously mentioned, interface or discharge management is considered in the international debate to be a multidisciplinary and interdisciplinary task, where different coordination tasks are assigned to the professional groups involved (doctors, social work/social services and nursing). The social services primarily provide social counselling and see to the initiation of follow-up care measures. The change in the patient structure and the growing importance of conditions requiring nursing have made it clear that the nursing sector also has numerous interface problems that need solving. For this reason, recent years have seen the development of new concepts for more nursing-oriented or nursing-based discharge management. One important milestone is the National Expert Standard "Discharge Management in Nursing", which was first agreed upon in 2002, updated in 2009 and formulates requirements that are intended to guarantee a certain quality standard when discharging patients from hospital. To implement the Expert Standard and as a reaction to international experience, numerous different innovations have emerged in nursing, whose concepts are geared to the directives of the Expert Standard and which usually see themselves as supplementing the social services, not as replacing them. For instance, increasing numbers of jobs in discharge management were created in the nursing service of the hospitals in the past decade ("care transition"), although no reliable figures are available as regards their spread. Models for discharge management by reference nursing staff or hospital-external services and other variations have also been tested. Increasing importance is also being acquired by clinical Case Management approaches, which are likewise intended to provide sustainable support in organising care and securing the continuity of care. Much the same applies to models of transitional care, which were explicitly developed with the aim of securing quality and continuity of care following discharge after a short stay in hospital.

These examples show that nursing has in the past undertaken numerous efforts to improve the interface between outpatient and inpatient care and to enable a smooth transition from hospital to forms of follow-up care. In an international comparison, however, it must be noted that the German health sector has so far reacted rather slowly to the long-discussed requirements and problems arising at the interface between inpatient and outpatient care as a result of structural change and demographic trends. For instance, there can be no talk of ubiquitous introduction of discharge management models in accordance with the specifications of the National Expert Standard, when the latter has only been implemented in 44.8% of hospitals. There is still a lack of sufficient personnel resources, and

the adaptation of processes, organisational structures and traditional forms of division of labour and workflows in hospitals is also still in its early stages. The potentials that professional, structured discharge management could have for improving quality and competition, have thus so far remained very largely unexploited, or limited to comparatively few hospitals. The following framework conditions and measures are necessary to exploit them and to promote the necessary reorganisation:

- Improved personnel resources: In many hospitals, the personnel resources available for discharge management (in nursing) are insufficient to implement the directives of the National Expert Standard.
- Organisational, concept and instrument development: The better discharge management is integrated in the procedures of hospital care, and the better existing workflows are geared to the requirements of discharge management (already at the time of admission), the more can patients, professional players and the hospital as an institution benefit from the positive effects. Similarly, the more perfected the concepts, instruments and methods of discharge management are, the more likely is it that good results can be expected. There is still a need for development and improvement in all these fields in Germany.
- While the rooting of discharge management in SGB V is to be welcomed, it is to be feared that many of the previously tested innovations will be modified and tested again in a different constellation. Although a certain degree of experimental diversity leads to constructive developments in the health sector, there is a risk of resources being employed inefficiently here. This is all the more true in that many innovations in the field of interface and discharge management were also implemented without systematic and comparative evaluation in the past. The Council therefore recommends the promotion of (evaluation) research in this field of healthcare research, which has so far attracted little attention in Germany.

Recommendations for securing cross-sectoral continuity of care

102. The coordination and integration of (acute) inpatient and outpatient care at the interface between the inpatient and the outpatient sector must be improved. From the point of view of the Council, there is a need for the following action:

- Harmonisation of regulations in social law, especially the regulations in SGB V and XI. This also includes improving cooperation between hospitals and comprehensive care counselling according to Section 7a SGB XI, the statutorily prescribed mandate of which also includes the cross-sectoral coordination of healthcare services.
- Binding statutory specifications regarding the design of discharge management according to Section 39 Para. 1 SGB V in accordance with the directives of the previously tested, and partly implemented, National Expert Standard.

- Development of a national guideline on the design of interdisciplinary interface management on the basis of the National Expert Standard on Discharge Management. The interaction of admission and discharge management should also be guaranteed in this context.
- Elimination of structural obstacles to the development of demand-oriented forms of transitional care, and creation of suitable framework conditions for facilitating the establishment of offers of this kind. This particularly includes the expansion of the post-inpatient treatment options of hospitals in the sense of Transitional Care models. Since, according to Section 39 Para. 1 SGB V, discharge management is now a regular part of hospital treatment, this offers the possibility of crossing sectoral boundaries in order to secure continuous follow-up care. Existing offers of transitional care need to be developed further in order to be better able to do justice to rehabilitative requirements, which have become more important in the post-acute phase as a result of the shorter time spent in hospital.
- Greater consideration of the requirements of both interface and discharge management in hospitals, as well as adaptation and further development of in-house hospital structures and workflows. This requires target-oriented reorganisation, better personnel resources, a more binding nature of in-house procedural rules for all professional groups and, if appropriate, structural expansion. It is similarly necessary to develop organisational specifications in hospitals in order to improve and, where appropriate, restructure cooperation between the health professions involved. In the framework of selective-contract regulations, competition could contribute to advancing corresponding developments as a process of discovery.
- Documentation of unscheduled re-hospitalisation and its inclusion in quality reporting to create improved transparency. Development of further indicators to measure the implementation of patient-oriented discharge management.
- Binding definitions of minimum standards for multidisciplinary information communication at the time of discharge from hospital. On the doctors' side, the structuring, standardisation and prompt communication of medical reports, for example, can contribute to better and quicker overcoming of interface problems. The integration of digitised doctor's letters and electronic patient files in an overall I&C concept offers the possibility of improving and accelerating both the cross-sectoral availability of information and the exchange of documentation. Also, the documentation from the medical field and the nursing field should be combined.
- In addition to definitions of document standards, there is also a need for standardisation specifications for overcoming interoperability obstacles, and for definition of the requirements for securing quality and patient safety. To this end, the G-BA could be commissioned with defining binding framework conditions for promoting the cross-sectoral interoperability of I&C technologies to be used.

- A further need for action results from securing the continuity of drug therapy. This is supported by communication of the complete medication plan, including the reasons for any changes made. In addition, the integration of CPOE/CDSS systems when issuing prescriptions can also increase patient safety. This requires evaluation of the medium as regards the end points of morbidity and mortality, as well as quality of life and costs.
- I&C applications at the outpatient/inpatient interface can facilitate the forwarding of information, e.g. of findings or drug prescriptions, in the framework of electronic case files. This can be expected to bring improvements in care, especially in the case of multimorbid patients with a long history of illness and extensive medication. However, they need special protection when deciding on the use of electronic applications. To obtain the consent of patients to data disclosure, it is important to inform them about possible advantages, e.g. improved, reduced-risk drug therapy. The question should also be examined as to whether and to what extent the need for nursing information could be covered by I&C applications. Beyond this, I&C technologies can support quality assurance by providing routine data. The fundamental prerequisites are maximum data security and a possibility for patients to make use of their right to determine the use of their data at any time.
- However, in relation to the telematics infrastructure currently being established using an electronic health card, possible improvements in the cross-sectoral quality of treatment are almost exclusively to be expected of those applications of the electronic health card that patients use voluntarily. If it continues to prove impossible to gain the acceptance of the healthcare providers, they will not contribute to increasing the intensity of use by educating and supporting patients.
- The benefits of the electronic health card for improving the safety of drug therapy are currently being evaluated in ongoing projects. The results must be awaited before recommendations can be given regarding more extensive application of the electronic health card in this sector. Although improvements in the cross-sectoral quality of treatment are expected, the relevance of the improvement should be evaluated, particularly in relation to patient-related outcomes.
- Although numerous innovative efforts have been made in discharge and interface management in recent years, there is still a lack of systematic scientific knowledge and empirical findings. The Council therefore recommends that healthcare research in this field be advanced, including the promotion of scientifically supervised pilot projects and comparative evaluation studies, in order to lay the foundations for further development of suitable organisational models, action concepts and methods, and to expand knowledge regarding the elimination of interface problems. In this context, particular attention should be paid to interdisciplinary models, innovative concepts for transitional care and health-telematics applications for promoting the cross-sectoral exchange of information, especially since there is not yet any reliable cost-benefit assessment in this field.

5 Cross-sectoral and population-oriented quality-based competition

103. Not only the price, but also the quality of the healthcare services provided should be a distinguishing feature in competition at the interface. This releases innovative forces for new forms of care, and the best providers/provider networks with higher quality can assert themselves. The fundamental prerequisite for this is information on the quality of care. This information is missing to date, especially for cross-sectoral care, although this type of healthcare is today already the key area of real healthcare activities and will become even more important in an ageing population with complex treatment needs.

104. The quality of healthcare can be divided into three segments: the technical quality of care, which should reflect the state of the art, the quality of personal relations with medical and nursing staff, which should be characterised by trust and cooperation, and the quality of the environment, which describes spatial and temporal circumstances for the patient.

For patients, the quality of personal relations and of the environment is a particularly important aspect when it comes to choosing a hospital, a doctor or a nursing institution. From the point of view of the goals, the technical quality is a central prerequisite, above all else, for quality-based competition, in which health insurers also play an important role. Consequently, quality measurement with the help of indicators is particularly intended to also bring transparency to the technical quality or the quality of care.

5.1 Quality measurement

105. In the inpatient sector, this is done in the framework of external inpatient quality assurance (Section 137 SGB V). Many of the quality indicators used are accessible via Internet portals. In outpatient care, quality is so far only measured for internal purposes. Random testing is performed in institutional long-term care, the results being published on the Internet in the form of care grades.

The quality of care cannot be measured directly, which is why indicators are used, such as mortality rates or vaccination rates. The quality indicators should be relevant, valid, reliable,

practicable and target group-oriented. These criteria quite often impose opposing requirements on the indicators.

Different kinds of indicators are available for measuring quality. Donabedian divided them into structural, process and outcome indicators. The latter particularly measure mortality, morbidity and quality of life as the (long-term) consequences of treatment, and thus the results of treatment or long-term healthcare that are relevant to the patient. However, these events often only occur after a delay, particularly in the case of chronic illnesses. Moreover, the outcomes cannot be attributed to the quality of the health treatment alone. Rather, they are also influenced by environmental factors, patient cooperation and the provision of services in other sectors.

106. Structural and process indicators can already be measured ahead of treatment, or during it. One focus of many process indicators is the implementation of guidelines. However, guidelines have generally been developed for individual illnesses, whereas the simultaneous presence of several chronic illnesses predominates in practice. Particularly if the remuneration is dependent on it, rigid adherence to guidelines as an indicator can create the wrong incentives, especially in terms of overprovision and underprovision, and lead to poorer healthcare for multimorbid patients. The Council already recommended the development of guidelines for multimorbid patients in 2009. Their use should be taken into account as a source for developing instruments for measuring quality.

107. The problem of low case numbers is the main obstacle to reliable quality measurement in the health sector. Owing to the low number of cases, only a small minority of all quality indicators surveyed at the institutional level can indicate statistically significant deviations from the average or a previously defined target value. The less commonly an event (such as a death) occurs, the greater the number of cases must be in order to be able to make a sound statement. In the context of external quality assurance, the mortality rate is a reliable indicator only for some heart operations. The case numbers necessary for reliable statements are not reached by the majority of hospitals and for the majority of indicators.

In the outpatient sector, the treatment of chronic illnesses by far outweighs surgical interventions. Low case numbers per indication and practice make it difficult to reliably assess outcome quality.

108. Complication rates, and particularly mortality, involve not only the case-number problem, but also the problem of risk selection. Public reporting, and especially outcome-oriented remuneration, can increase the danger of risk selection. Healthcare providers could give preference to young patients in a good general condition in order to keep their mortality and complication rates low. Less risky procedures are then selected for older patients. It was found in the USA that serious cases were more likely to be referred to university hospitals (which may well make sense), while the average patients became increasingly "healthy" at the same time. The diagnosis of indications must therefore become part of

quality measurement. In addition, outcome indicators must be risk-adjusted according to age, gender, comorbidity and stage of the illness.

Quality assurance using selected indicators also holds the risk of areas that are not measured being neglected. Focusing on individual treatments also does not promote the integrated and comprehensive care of chronically multimorbid patients.

109. Indicators have to be not only relevant, valid and reliable in theory, but also implementable in practice. The effort required to survey them should be as little as possible, and be made good by the clinical improvements to be expected. For cancer registers or Disease Management Programmes (DMPs), clinical indicators are additionally documented directly in daily healthcare practice. Quality assurance in nursing is also based on separate nursing documentation. Its advantage is that it accurately meets the needs of quality assurance, while its disadvantage is the major documentation effort. In contrast, there is no need for separate surveys of routine data that are documented anyway. As a rule, this involves billing and social security data of the health insurers. The completeness of billing data tends to be better than that of separately surveyed quality data. Consequently, wherever possible, routine data of this kind should be used for quality assurance, rather than separately surveyed parameters.

Process indicators are generally more reliable than outcome indicators, since they are not subject to the problem of low case numbers or risk adjustment. Being presented in the form of key figures, structural indicators are the most reliable, but the least relevant.

110. Measuring process and outcome indicators always leads to patient-related data, whose collection and processing requires compliance with strict data protection requirements. To survey clinically relevant end points, the patient has to be followed up for a certain period and across the sectoral boundaries. The use of pseudonyms makes it possible to pool personal data in a register, while at the same time protecting personal health data. The statutory regulations on access to data should be designed in such a way that they permit quality assurance and healthcare research.

Quality-based competition

111. There are fundamentally two routes via which quality transparency through competition could lead to quality improvements. The first route is via the profession's own striving for excellence and via continuous, mutual learning. Providers who fare worse in rankings work on their weaknesses, specifically learning from the best to do so ("benchmarking"). In this long term, this raises the quality of all concerned to a higher level. Since the best also continuously improve, there are constantly new best performances to be reached. The outpatient Quality Circles and the Peer Review procedure of the Initiative of Quality Medicine show that this can work in practice. This procedure was recently introduced as obligatory for all hospitals in Switzerland and Austria. In Germany, too, the

"structured dialogue" of external inpatient quality assurance is to be further developed into a visitation concept.

112. The second, essentially suitable route is via selection: patients, referrers and health insurance funds wanting to conclude selective contracts decide in favour of the better doctors and hospitals. In this way, patients would specifically be treated where the quality is the best and the complication rate is low. Poor providers would be eliminated from the market in the medium to long term.

There is so far no unequivocal proof of the effectiveness of the second route to quality improvement – selection of the best providers by insurers or patients and elimination of the poorer ones. International studies consistently indicate that only about 3 to 4% of patients decide on a hospital on the basis of quality reports. They also document that, even if the rankings for technical quality are known, they are not of central importance for the patient's decision. The patients prefer the quality of personal relations and the quality of the environment. However, the relationship of trust between doctor and patient is very difficult to measure objectively and to present in comparison portals.

Even referrers, who have the medical knowledge to understand the quality reports of the hospitals, are sceptical about quality rankings and prefer to rely on their own experience.

113. Quality transparency holds the risk of scandals in the media, resulting in fewer patients and financial losses for the hospital. This kind of public reporting can lead to defensive handling of errors. However, a good error culture is based on freedom from sanctions.

Quality-based competition must not be allowed to jeopardise trusting, internal quality improvement in favour of purely external control. Even if they are statistically significant, deviations from a target value are not a direct measure of quality, but merely an instrument for detecting conspicuous situations that should be an occasion for reflection on improvement measures.

114. To date, the scientific findings regarding the effects of quality-based competition and quality transparency are based almost exclusively on studies from the USA. Generally speaking, the consequences and effectiveness of specific measures and contract forms can only be clarified by corresponding healthcare research.

115. A difficult tightrope walk has to be successfully managed on the way to quality transparency: if narrowly defined structural indicators are used, it rapidly atrophies into a pure marketing instrument, whereas broadly defined outcome indicators entice to risk selection. Even though transparency is important for patient orientation, the responsibility for quality assessment, as a prerequisite for continuous quality improvement, cannot be palmed off onto the patient alone as the consumer. Even those who are not (or no longer) in a position to choose the best provider, have a right to high-quality healthcare.

Quality transparency in the German health sector will increase further in the future, partly because informed citizens demand it. This development holds both opportunities and risks that need to be carefully weighed up against each other.

5.2 Cross-sectoral healthcare

116. The term "cross-sectoral" is applied to all activities at the interface. In analytical terms, this can be divided into treatments that are given in one sector and whose quality is measured in the same patient in another sector ("follow-up procedures"), identical treatments that can be given to different patients in both the inpatient and the outpatient sector ("sectoral-identical" procedures) and "trans-sectoral" procedures, where two sectors are involved in treating the same patient.

Follow-up procedures

117. By overcoming the strict separation of sectors in quality assurance, data from the one sector could be used to measure the quality of other sectors in order to reliably measure the outcome. The AQUA Institute is starting to use data from the outpatient sector to measure the quality of operations in hospitals. In this way, the entirety of external inpatient quality assurance is also to be supplemented by follow-up data. The fields of hip and knee replacement, obstetrics and neonatology are envisaged for the first trials. Follow-up methods can be based on routine data, thus requiring little effort and few data.

Sector-identical services

118. Identical quality requirements and standards should apply to identical healthcare services. Hospitals and specialist practices compete with each other for sector-identical services within the new outpatient specialist care segment and in outpatient surgery. The quality outcomes must be made comparable for this purpose.

The outcome indicators need to be risk-adjusted to permit a fair comparison of services between specialists in private practice and hospitals. In addition to standard adjustment by age and gender, adjustment according to the severity of the illness and co-morbidities would also be recommendable, since the less serious cases are probably more likely to be treated by doctors in private practice. It should likewise be examined whether and to what extent adjustment according to socioeconomic status is also sensible and possible. To avoid the expansion of indications, the Council recommends focusing on the quality of diagnosis of indications in external quality assurance of specialist care.

Elective services of outpatient surgery, which are not (yet) part of the new outpatient specialist care segment, are particularly suitable for selective-contract models on the basis of outcome quality and complication rates. In outpatient specialist care, the hospitals and

practices bill the health insurance funds directly. As a result, there is no central data pool, such as exists at the Associations of SHI-Accredited Physicians in outpatient SHI-accredited physician care and at the Institute for the Hospital Remuneration System (InEK) in inpatient SHI-accredited physician care. Some health insurance funds have sufficiently large numbers of cases to be able to calculate quality themselves. Cross-insurer analysis using pseudonyms complying with data protection regulations, similar to the AQUA method, would give all insurers this possibility.

5.3 Trans-sectoral, population-related healthcare

119. The Council presented a future model for population-related and cross-sectoral healthcare in its Special Report 2009. Chronic illnesses are the central challenge for the future of the health systems in all industrial nations. Their treatment requires a host of players. Consequently, success cannot be attributed to a single institution, and can only be measured on a cross-sectoral basis. Population-related indicators, i.e. simultaneously cross-institutional and cross-sectoral indicators, offer the opportunity to also do justice to a common responsibility for quality through common quality measurements, also taking prevention and rehabilitation into account in the process.

Moreover, population-related quality measurement makes it possible to record those dimensions of quality that cannot be measured with institution-related indicators. These include fairness of access, completeness and coordination, as well as prevention.

Population-related indicators are recommended for Germany, based on the work on quality indicators in the USA, Sweden, the UK, Canada, the OECD and the pertinent literature. Two concepts are of central importance in this context: potentially avoidable mortality as a quality indicator for the overall system, as already proposed by the Council in 1987, and avoidable hospitalisations as an indicator for the quality of outpatient care, particularly of chronic illnesses. Even though not every single case is avoidable, the total number of deaths and hospitalisations can nevertheless be reduced by good treatment. For this reason, reference is nowadays more often made to amendable mortality or avoidable hospitalisations.

120. The indicators are presented in population-related (not only patient-related) form. The reference to the population means that the indicators do not have to be broken down to the group at risk. This means that, for example, deaths due to a perforated appendix are referred to the population and not to the known cases of appendicitis. As a result, population-related indicators are easier to calculate than institution-related indicators. Since life expectancy has continued to increase since the 1980s, the standard age limit should be raised from 65 to 74 years. Other age limits apply to some indications. In the case of diabetes, for example, amendable mortality is only assumed up to the age of 49. Since infants should not be vaccinated against measles, mortality due to measles can only be reduced by vaccination from the age of 1 onwards.

5.3.1 Amendable mortality

121. The indications behind amendable mortality can be divided into three categories: first, illnesses that could have been avoided by primary prevention, such as childhood diseases for which there are vaccinations. The second category comprises illnesses whose chances of survival can be increased by early detection and timely treatment, such as breast cancer and cervical cancer. The final category includes those cases whose mortality rates can be reduced by improved medical treatment, e.g. hypertension or sepsis. Although Type I diabetes mellitus cannot be prevented, it should not lead to premature death if treated effectively. Elevated values in a region are not to be considered as a direct measure of quality, but as anomalies, and should be an occasion for examining structures and procedures and particularly for reducing potential losses of quality at the interfaces.

The indicators can serve to compare the provision of healthcare services, not only within Germany, but also internationally. On the whole, Germany fares well in this context. In 2010, no deaths were caused by the classical diseases that can be avoided by vaccination – typhoid, pertussis and measles. The number of deaths due to diphtheria (2), tetanus (2) and polio (1) was likewise very low. However, these diseases have not been eradicated, which is why the indicators should continue to be recorded.

There are marked differences as regards diseases where mortality could potentially be reduced by early detection, especially skin cancer and cervical cancer. For example, twice as many people per 100,000 inhabitants died of skin cancer in some regions as in others.

The mortality amendable by improved treatment can furthermore be divided into acute and chronic illnesses. In the case of acute illnesses (pneumonia, nephritis, sepsis, infections and parasites, inguinal hernia, influenza, appendicitis), for example, neither an East-West, nor a North-South gradient can be identified. The precise causes of these differences are initially unclear and have to be examined locally.

The chronic illnesses with amendable mortality are ischaemic heart disease, cerebrovascular diseases, chronic obstructive pulmonary disease, hypertension, epilepsy, pancreatic diseases, gastric ulcers, asthma, diabetes, bilious complaints and rheumatic heart diseases. There are signs of a possible correlation with the economic situation of the region in the case of these illnesses. The administrative districts in Eastern Germany record the highest numbers of deaths, the lowest figures being found along the Rhine and in Bavaria.

122. Above all, deaths caused by chronic illnesses demonstrate a close correlation with socioeconomic status. To possibly reduce them, there is a need not only for improvements in medical care, but also for changes in lifestyle and living environment. These are a task for the whole of society that needs to be tackled jointly by numerous players in the region. Thus, the figures not only point towards the possible quality of the health system, but are also influenced by education campaigns, the protection of non-smokers, opportunities for sport, industrial health and safety, communal catering, environmental protection and other

influencing factors. Differences in the burden of disease of a region can also arise as a result of unchangeable circumstances (climate, vegetation, etc.).

5.3.2 Avoidable hospitalisations

123. Interfaces exist not only between outpatient and inpatient care, but also within the outpatient sector. GP care, special outpatient care and outpatient specialist care, nursing, rehabilitation, psychosocial and palliative care, and remedies are each provided by separate institutions. Population-related indicators also apply the concept of common responsibility for quality to the outpatient sector, in the same way as it applies to hospital doctors within an institution. Even today, doctors in private practice cooperate on quality improvements in inter-practice quality circles or physician networks.

Up to now, quality-based competition in the outpatient sector has been impeded by the fact that no suitable measurements of outcome quality are available, since the numbers of cases in most outpatient institutions are too low for methodologically admissible measurement of outcome quality for the majority of indications. Clear assignment of the outcome to a healthcare provider is hardly possible and will become even more difficult in future as a result of the increase in the number of chronically multimorbid patients. The completeness of outpatient care and coordination between all the institutions and persons involved are particularly important when it comes to providing medical care for chronic illnesses. Coordination must be considered and measured not from the point of view of the institution, but from that of the patient.

Quality reporting in Germany has so far not reflected the central importance of chronic illnesses. There is naturally no indicator for chronic illnesses in external inpatient quality assurance, since the essentially long-term treatment of chronic illnesses predominantly takes place in the outpatient sector. Not one of the new cross-sectoral procedures primarily relates to a chronic illness. Instead, the spotlight is on operations.

Special indicators for "ambulatory care sensitive conditions" have been created in the English-speaking countries. They are based on the concept of "avoidable hospitalisations" and are a key set of indicators in the USA for measuring the quality of outpatient care. In Germany, too, this concept could be used to measure population-related outcome quality using routine data. Owing to particular circumstances, a stay in hospital may make sense in connection with illnesses that can be treated on an outpatient basis. Not every hospitalisation for indications that can be treated on an outpatient basis is a mistake in the provision of care. Corresponding figures are only relevant in comparisons.

Avoidable hospitalisations should likewise be surveyed with reference to the total population, and not with reference to all asthma patients, for example, since undiagnosed asthma illnesses, in particular, are an indicator for inadequate outpatient care. Hospitalisations for diabetes, asthma, heart failure and hypertension are recommended as quality indicators for outpatient care. They reflect the daily work of GP practices, and the prevalence of these

illnesses is so high that analysis at the district level is possible, which would roughly correspond to the area covered by many quality circles. The quality of coding first needs to be improved for other chronic illnesses, such as chronic obstructive pulmonary disease, for which hospitalisations can be avoided.

Older patients are not excluded from the indicators for avoidable hospitalisations. On the contrary, these indicators can also be specifically used to measure the quality of nursing care. The indicators hospitalisation with decubitus and dehydration are recommended for the quality of nursing. Definition work is still necessary regarding hospitalisations following falls. In this way, the outcome quality could be calculated for every nursing institution – be it for outpatients or inpatients – by comparing the data between health insurance and long-term care insurance. Cooperation between the care systems would make it possible to measure quality with few data.

124. Adverse drug reactions cause up to 5% of all hospitalisations. 30 to 40% of them could be avoided by better coordination of medication. Hospital admissions because of adverse drug reactions can reveal deficits in the coordination of outpatient treatment. The Council recommends examining whether and to what extent routine data (drug prescriptions, hospital diagnoses) can be used to measure the quality of the supply of medicines in the outpatient sector, especially its coordination and continuity.

5.3.3 Risk adjustment

125. For quality-based competition to work sensibly, the data have to be adjusted not only for age and gender, but also according to social stratum (income, education, occupation). Studies in Germany and international data shown a clear stratum gradient, not only in the prevalence of illnesses, but also in the rates of cure. These differences are not attributable to different risk-related behaviour alone. They distort the population-related outcome indicators, both at the level of the health insurers, and at the level of the regions.

Socioeconomic risk adjustment at the individual level is very elaborate. Consequently, an index according to post codes is currently being developed that can measure the deprivation of a region. The first results for Bavaria are highly promising. A Multiple Deprivation Index has been calculated from socioeconomic, sociodemographic and environment-related data of the Bavarian municipalities.

In this context, standardisation for purposes of quality comparisons in the health system may not go beyond the extent to which the differences in the treatment outcome lie beyond the sphere of influence of the healthcare system. Discrimination against certain groups as regards to access to healthcare, communication problems or underprovision in neighbourhoods with few private patients must not be concealed by standardisation. The Council therefore recommends that outcome indicators for groups at risk (e.g. with an immigrant background) be shown separately in order to detect inequalities in the provision of care ("stratification").

5.3.4 Organisation and responsibility

126. Many illnesses necessitate cross-sectoral care, but there is so far no cross-sectoral responsibility for quality. Measurement of the outcome quality of the entire treatment chain in which several inpatient and outpatient institutions are involved, i.e. measurement of the ultimate outcome of relevance for the patient, could support the development of this cross-sectoral responsibility for quality. Building on the future concept of integrated, cross-sectoral and population-oriented care, already proposed in the Special Report 2009, the Council proposes a competition for the quality of healthcare.

In the inpatient sector, the various professions and disciplines are interconnected through the hospital and bear joint responsibility for the overall outcome. There is certainly also a willingness to work jointly on improving quality in the outpatient sector, but the foundations yet need to be laid in terms of both communication and organisation.

Responsibility for the cross-sectoral quality of care has yet to emerge in the future. Hospitals and the various institutions in the outpatient sector must collaborate to this end. The first pilot projects of healthcare providers already exist. For example, hospitals and doctors in private practice are joining forces in oncological centres, or specialists and GPs in physician networks.

By providing special incentives, the health insurance funds could promote the establishment of corresponding networks in urban areas, thereby entering into quality-based competition. In rural areas, however, there are monopolies on the provider side, or a general lack of healthcare providers (such as GPs), meaning that no competing networks can be set up there. The Act on the Stabilisation and Structural Reform of SHI gave the Länder the possibility of creating Land bodies that give recommendations regarding issues of cross-sectoral care (Section 90a SGB V). These bodies are supposed to bring together representatives of the different sectors and of the Land. Their success will be highly dependent on the commitment of the respective Land governments. Consequently, further developments remain to be awaited. Schleswig-Holstein has initial plans for greater responsibility of the municipalities and a cross-sectoral Healthcare and Nursing Council.

5.4 Conclusion and recommendations

127. All in all, the health system needs to focus more on patient-relevant outcomes. Outcome indicators are more difficult to survey than structural and process indicators, and moreover need risk adjustment. Ultimately, however, only they offer room for targeted innovations in care structures. For the patient, it is unimportant how often his GP measures his blood pressure – what counts is whether he ultimately suffers a stroke or a heart attack. In a care network, the task of monitoring could also be assumed by other health professions.

Similarly, for example, there is no need to set up a separate, external procedure for measuring quality in physiotherapy. Rather, hip mobility following total hip replacement is measured as the overall outcome of the network. Quality deficits or improvements are then discussed and elaborated within the network.

128. Transparent, reliable information is a fundamental prerequisite for quality-based competition in healthcare. In addition to in-house quality management in the institution, there is also a need for standardised, external quality measurement to this end. This has already been effectively implemented in the inpatient sector. The quality of care in hospitals is measured using valid and reliable indicators. The data are risk-adjusted and made available to the public via comparison portals on the Internet. While the care grades of the long-term care institutions are largely transparent, the indicators still lack validity and reliability. External quality assurance is so far still missing in the outpatient field, not least because of the highly fragmented structure of this sector. The quality assurance of hospitals (SGB V) and long-term care homes (SGB XI) should be compatible. Mutual sectoral quality measurement can reduce the documentation burden.

129. The Council recommends focusing on population-oriented and cross-sectoral quality indicators. Potentially amendable mortality and avoidable hospitalisations for illnesses that can be treated on an outpatient basis constitute a key approach for improving quality. Cross-sectoral quality assurance in accordance with Section 137a SGB V is therefore to be consistently developed towards population-related indicators, and these must be regularly adapted to scientific progress. The data should be published and made available to healthcare research, so that regions, physician and provider networks and health insurers can be compared. These data should also be made available for the evaluation of integrated-care projects, so that outstanding care models can serve as examples for others.

130. Common responsibility for health outcomes presupposes a common organisational structure. Greater cooperation and coordination in physician networks could form the basis for common responsibility for quality, which can then be measured using population-related indicators. Providers of integrated healthcare can develop new care models in a competition for ideas, and be rewarded for good results. In rural areas, competition can take the form of quality comparisons (benchmarking) with other regions.

131. Comparable quality assurance methods are so far missing in dentistry and should be specifically developed. Dentists are currently not regarded as being part of cross-sectoral care. Accordingly, they are also not integrated in cross-sectoral quality assurance. Yet, for example, drug interactions should be coordinated with the GP. For instance, cancer of the oral diaphragm is usually first discovered by the dentist, then having to receive cross-sectoral treatment.

132. As a quality indicator for the coordination of the supply of drugs in outpatient care, the Council recommends examining whether and to what extent routine data (drug prescriptions, hospital diagnoses) can serve to derive avoidable hospitalisations resulting from

avoidable adverse drug reactions, or whether an additional coding field for differentiating between adverse drug reactions acquired as an outpatient or an inpatient would be helpful.

133. For the new field of outpatient specialist care, uniform quality guidelines need to be defined that give particular consideration to the diagnosis of indications, are geared to patient-relevant outcomes to the greatest possible extent, and permit quality-based competition between specialists in private practice and hospitals working in the outpatient sector that gives doctors and hospitals the freedom to introduce process innovations. For treatments that can be provided both on an outpatient basis in a hospital and in a sub-specialised practice, the G-BA is currently elaborating a uniform quality assurance system that should be geared to the standards of external inpatient quality assurance.

134. A competition among quality measuring systems is not recommendable, since quality information constitutes an infrastructure in the sense of a collective good that will not develop optimally without centralised control. The continuous scientific improvement and review of quality measuring methods is all the more important as a result. Quality transparency must not be allowed to jeopardise trust and cooperation between institutions and professions, or the open handling of errors. It has been found that mutual learning is a better way of increasing overall quality than market streamlining through elimination of the poorest performers.

135. To lessen the documentation burden on doctors and nursing staff, routine data should form the basis for the indicators to the greatest possible extent. Clinical cancer registers can also help to facilitate communication and coordination between the doctors involved in treatment, and should therefore be expanded ubiquitously. These registers should also form the basis for research in the cancer centres in order to ensure data economy.

136. A Multiple Deprivation Index, illustrating socioeconomic differences, should be compiled for all municipalities in Germany, and also at the district level in larger cities, in order to permit fair, risk-adjusted comparison. This would make it possible in future to give consideration to the influence of social inequalities, which is as strong as expected. It must at the same time be examined whether and to what extent the stratification of outcomes according to social stratum is capable of revealing inequalities in care and access.

137. More development work is necessary before population-related, cross-sectoral quality indicators can be used to identify high-quality healthcare. Indicators generally only reveal anomalies that must then be examined within the region. The greatest advantage of population-related indicators – that they are not institution-related, but patient-related – is at the same time their greatest disadvantage: no one party is clearly responsible in an individual case. This responsibility for quality can and should be consciously organised at the regional level, depending on the respectively prevailing needs. Patient-relevant outcome indicators permit competition for structural and process innovations. They strengthen

cooperation and coordination between the players and, at the same time, permit quality-based competition between provider networks.

6 Competitive conditions at the sector boundary between outpatient and inpatient

6.1 Potentials of outpatient service provision

138. Technical progress in medicine makes it possible to shift services formerly provided on an inpatient basis to the outpatient care sector. In combination with foreseeable demographic developments, outpatient treatment at the interface between the outpatient and inpatient sectors is becoming more important. Moreover, the shifting of medical services to the outpatient sector is capable of at least partly alleviating the tension resulting from increasing demand for healthcare services in the face of persistently limited resources. In addition, this trend could also offer potential for overcoming the fragmentation of healthcare by increasing offers of integrated services.

139. Although no definitive figures can be given regarding the ultimate magnitude of outpatient substitution effects, there are signs that this potential is currently far from being fully exploited. In 2010, the period spent in hospital by more than one-third of all patients receiving inpatient treatment in hospital was a maximum of 3 days, i.e. over 6 million inpatient cases are currently regarded as "short-stay patients". While it is certainly the case that not all of these patients could have been treated on a outpatient basis, and that the reduction of the time spent in hospital can also partly be explained by the concentration of services, the continuous decline in the overall length of stay, the increasing percentage of short-stay patients and the existence of many cases lasting only a few hours indicate the potential for increasing the volume of services rendered on an outpatient basis. It is the frequently declared goal to shift the provision of services from the inpatient to the outpatient sector, at least for some of the short-term cases. In this context, it should ideally be irrelevant whether – presupposing identical quality – the outpatient service is then provided by a specialist in private practice or by a hospital and then charged at a standard rate. This would be left to competition.

140. By international comparison, the inpatient sector in Germany is characterised by below-average costs per case and an above-average number of cases and density of beds. The assumption that the fairly numerous outpatient specialists in Germany primarily refer serious cases for inpatient treatment, cannot be upheld on the basis of the comparison data.

Compared to other countries, Germany has a relatively high service density in both the outpatient and the inpatient sector.

141. The determination of function-oriented competitive conditions at the outpatient/inpatient interface acquires special importance, particularly as a result of the growing options for hospitals for rendering services on an outpatient basis. Permitting competition between hospitals and specialists in private practice under fair competitive conditions is one condition for exploiting efficiency and effectiveness potentials. Cross-sectoral optimisation of care, exploiting the potentials for innovation and creativity in the spirit of a competition of ideas, makes it necessary to standardise the competitive conditions.

6.2 Efficiency-increasing competition from a theoretical point of view

142. Cross-interface action by merging outpatient and inpatient elements of the health sector can also be understood as meaning the integration of different healthcare provider levels and described by the concept of vertical integration. The economic arguments point in different directions in this context. Increased vertical integration can fundamentally lead to increased efficiency, but also to restraints of competition: among the potentially efficiency-increasing effects are reduced transaction costs and, above all, improved control of service-providing activities across sector boundaries. The conceivable disadvantageous economic effects primarily include foreclosure and exclusion effects vis-à-vis non-integrated healthcare providers: so, potential negative consequences can first lie in closed-market effects, e.g. in that competing hospitals are denied access to doctors owing to their already being integrated with a competitor. Second, if vertical integration takes place between a hospital and several doctor's practices, this can also restrict horizontal competition between doctors in private practice. Third, greater (up to the point of monopolistic) negotiating power of the now stronger healthcare provider is possible vis-à-vis the insurer. However, the latter is hardly to be expected on the German market in the medium term. The healthcare providers are today organised in comparatively small units, although regional market power certainly exists in some cases (especially in the hospital sector) and needs to be taken into account. The primary task of strict cartel monitoring is thus to ensure that no provider succeeds in expanding its monopoly-like position into other fields of activity. Competitive advantages should be based on efficiency advantages, such as economies of scale and scope, but this must not be allowed to result in any distortion of competition to the detriment of third parties.

143. In the health sector, too, impacts of these economies of scale and scope are possible in larger, integrated units. They describe the advantages that can be offered by the production or provision of services on a relatively large scale. Economies of scope arise, for example, from declining transaction costs at the outpatient/inpatient interface, or also from the sharing of resources (premises, staff or equipment). In addition, larger units are also

more suitable as contract partners for health insurance funds for implementing comprehensive, population-related, integrated healthcare models. Positive effects from bundling transactions arise, for example, from the fact that only a single department would be needed to manage selective contracts. Also of importance are the potentials of fixed-cost reduction and the better options of larger units for spreading risks. In this context, cost-reducing effects primarily arise as a result of sharing buildings, equipment and staff, as well as from bundling operating functions. Examples include accounting and controlling, IT infrastructures, human resources management (part-time work, shift duty), marketing or also centrally coordinated emergency care. These are augmented by advantages of larger enterprises as regards procurement. Since they purchase greater quantities, larger economic units can greatly increase their negotiating power vis-à-vis suppliers, thus ultimately benefiting the insureds. Beyond this, advantages can be achieved in terms of specialisation and the division of labour: the greater the number of patients, the more efficiently can the work process be split up into individual sub-activities.

It can ultimately be expected that larger networks (of hospitals, MSCs and/or large-scale outpatient practices) will be in a position to fully exploit the existing rationalisation potential and to be the driving force behind cross-sectoral care for a certain time. More competition-oriented healthcare should be characterised by trust in the preferences of insureds and patients, diversity of the organisational, ownership and legal forms, as well as strengthening of the willingness to invest, also on the part of external financiers. On no account should there be external dictates in this respect regarding the most suitable form of cooperation/coordination, nor should individual forms be excluded from the market-inherent search process from the outset.

6.3 Target-oriented competition in the field of outpatient specialist care according to Section 116b SGB V

144. In the Act on the Stabilisation and Structural Reform of SHI, the legislature created an independent regulatory framework for outpatient specialist care. Although, on the surface, the establishment of a new pillar of care within the outpatient sector created a new (intra-sectoral) interface, standardisation of the competitive framework for hospitals and doctors in private practice is fundamentally to be welcomed.

145. One major change in the previous regulations in Section 116b Paras. 2-6 SGB V at the start of 2012 is that, in future, all authorised SHI-accredited physicians and hospitals are entitled to render outpatient specialist services, insofar as they meet the requirements and prerequisites of the G-BA. Access to care is thus obtained via uniform qualification and quality requirements, without demand-oriented planning and without volume regulation, being dependent exclusively on meeting the criteria formulated by the G-BA. The discretionary powers of the authorisation instances that existed until 2011 have thus been greatly reduced.

Status of implementation of outpatient service provision by hospitals

146. Only few, occasionally contradictory, figures are available regarding the implementation of Section 116b SGB V (old version) to date. However, the official statistics on the total annual expenditure of SHI do indicate the scope of the outpatient services currently provided by hospitals pursuant to Section 116b SGB V: although, especially since 2009, there has been a marked increase in total expenditure to the current sum of roughly € 99 million, this is still quite low in comparison with outpatient surgery, for example.

147. The incomplete, occasionally contradictory information available on the status of implementation of outpatient service provision by hospitals pursuant to Section 116b SGB V (according to the old legal situation) prompted the Council to conduct its own survey. Apart from submitting enquiries to the competent authorities in the Federal Länder, a questionnaire developed specifically for the purpose was used to examine the current status of implementation of outpatient specialist treatment in hospitals (with 50 or more beds) prior to introduction of the new legal situation. The data generated will now be used to present the starting point before reorganisation of this healthcare sector. The rate of response to the survey was 40.8% (information on the representative nature of the sample surveyed can be found in the unabridged version). When interpreting the results, it must be borne in mind that they paint a momentary picture of the status of implementation, which was as up-to-date as possible at the time of the survey, but that this is an ongoing, dynamic process.

148. 61.2% of all hospitals rate their own institution as suitable for providing services according to Section 116b Para. 2ff. SGB V (old version) in terms of their range of services and compliance with the statutory requirements and the targets of the G-BA. Just under half of these hospitals have so far submitted at least one application for authorisation to the Land authorities, roughly half of which were, in turn, successful. Consequently, by the start of 2011, 17.3% of German hospitals with more than 50 beds had received at least one authorisation to provide outpatient services pursuant to Section 116b SGB V.

149. The figures collected here lead to the result that a total of roughly 2,600 applications for authorisation to provide services according to Section 116b SGB V had been filed by the end of 2010 (the hospitals have to submit a separate application for each indication). All in all, 1,261 authorisation notices regarding outpatient treatment services according to Section 116b SGB V were issued in the whole of Germany by September 2011, of which 11.7% were the subject of lawsuits at this time. On average, 49.4% of these applications were approved by the authorisation authorities of the Länder. Based on the figures for 2010, this results in a scope of roughly 450,000 to 675,000 cases throughout Germany.

150. A decline in the number of applications can be observed over the course of time. While there were still just under 1,000 applications per year in 2007 and 2008, the figures in 2009 and 2010 dropped to an estimated 400 and 200 applications, respectively. This points to gradual saturation – accompanied by conflicts with doctors in private practice and Associations of SHI-Accredited Physicians in some cases. In total, 59.8% of all hospitals

having at least one authorisation reported problems triggered by third parties following issue of this authorisation.

151. Roughly half of all hospitals report oncology as being the indication with the highest number of cases in their respective institutions. This coincides with the results regarding the distribution of the applications made and authorisations granted, which likewise show oncology to be the determining indication in this healthcare sector: 55.3% of all authorisations and even 76.9% of all lawsuits relate to oncology.

Alongside a slightly above-average proportion of approval in the field of oncological diseases, experience to date shows – at least among the numerically relevant indications – comparatively high authorisation rates for the severe forms of rheumatological diseases and multiple sclerosis.

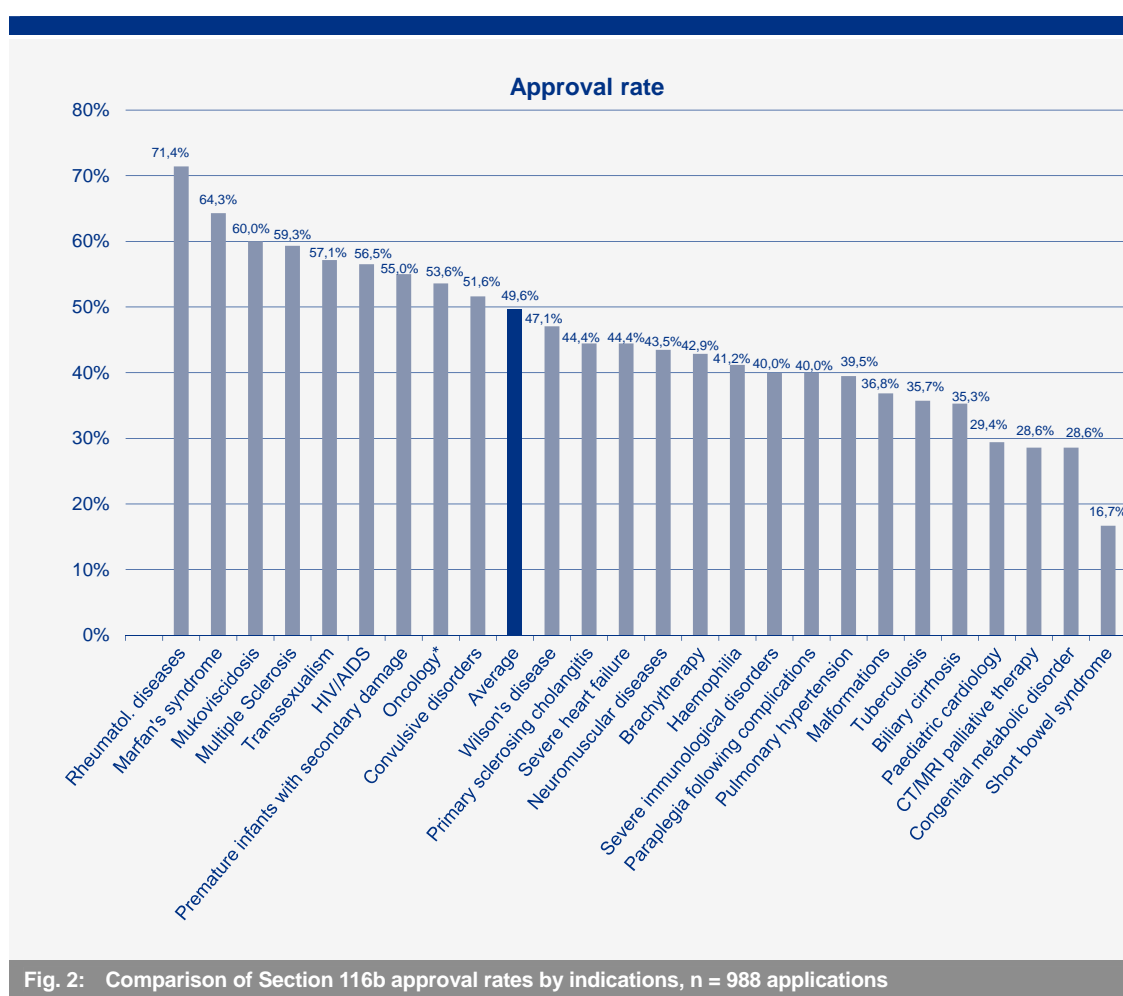


Fig. 2: Comparison of Section 116b approval rates by indications, n = 988 applications

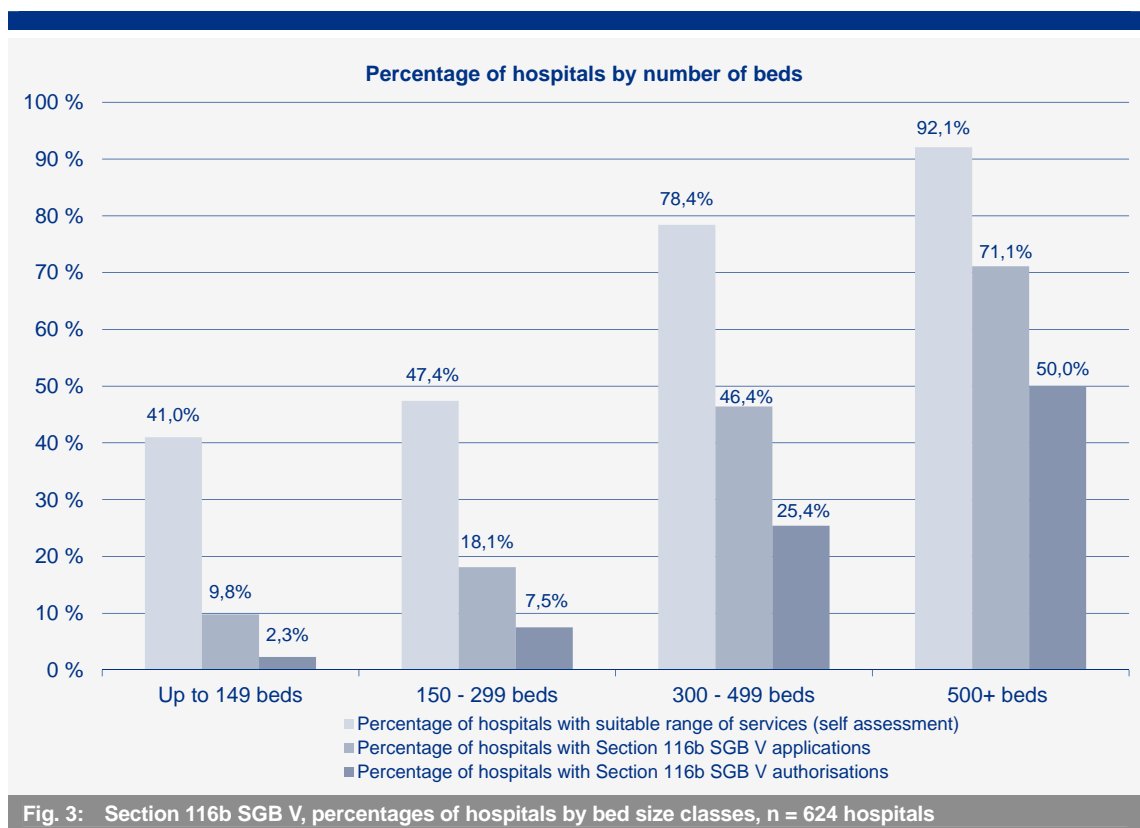
* The approval rates differ greatly within oncology, ranging from 44.4% in the field of "Tumours in children and adolescents" to up to 90.9% for "Tumours of the eye"

The difference between the average value of 49.6% and the previously reported 49.4% results from minor differences in the number of cases suitable for inclusion at this point.

Source: Own representation

152. The motives of the hospitals for filing an application are not so much based on purely economic arguments, such as utilisation of existing capacities or the profitability of the outpatient service itself. Rather, the responsible hospital managers emphasise the long-term advantages of patient loyalty (for future inpatient services) and the continuity of care (i.e. an integrated, cross-sectoral treatment process from a single source).

153. The size of a hospital is the most important variable influencing the probability of its taking part in the provision of services according to Section 116b SGB V. As the number of beds rises, a significant increase can be observed in self-reported suitability, the submission of applications and the number of authorisations already granted for rendering services according to Section 116b SGB V.



* All three values rise significantly with increasing hospital size (all $p < 0.001$) according to the Chi-squared test.

Source: Own representation

154. The regional location is another relevant classification variable. Section 116b authorisations are primarily concentrated in the larger hospitals in the core cities, whereas the hospitals in the moderately populated and rural environs make relatively few applications and complete fewer successful authorisation procedures. Only in the most rural category are higher authorisation probabilities to be found. It can be assumed that it is primarily the competitive environment that prompts the large hospitals in the core cities to attempt to advance into outpatient care, and that they have a good chance of meeting the

authorisation prerequisites of the G-BA, mainly because of their size and specialisation. The fairly high approval rate in rural areas is, on the other hand, more a result of efforts to avoid existing or impending gaps in care in the sector of specialists in private practice, and is thus mainly geared to the criterion of "consideration of the situation in SHI-accredited physician care", specified in Section 116b Para. 2 SGB V (old version).

155. Seen across all Federal Länder, application and authorisation activities display major differences that cannot be sufficiently explained by population, age or morbidity differences. As a consequence of the Land-specific approval patterns, clear differences arise in terms of the intensity of competition for patients between hospitals and doctors in private practice at the outpatient/inpatient interface. In relation to the total number of hospitals, comparatively large numbers of authorisations are to be found in Schleswig-Holstein, North Rhine-Westphalia, Brandenburg, Hesse, Saxony and the city-states. Unusually few authorisations relative to the total number of existing hospitals were granted in Bavaria, Baden-Württemberg and Saxony-Anhalt.

The need for differentiated interpretation is made clear by Table 3, below, which will be explained by taking the situation in Schleswig-Holstein as an example: 76.5% of all hospitals in this Federal Land consider themselves to be suitable for rendering services according to Section 116b SGB V. Equally many have also submitted at least one application and ultimately take part in providing care. Thus, every applying hospital has received at least one authorisation, but not all applications in this Federal Land were approved (the proportion of successful applications here is 88.6%, meaning that not every application was successful; however, every hospital received an authorisation for at least one indication).

Federal Land	Suitability of range of services	At least one application submitted	At least one authorisation granted	Average number of authorisations*	Duration of procedure (median)	Assessment of willingness to authorise (median)
Baden-Württemberg (n = 94)	57.5%	24.7%	4.7%	1.50	Over 24 months	Very low
Bavaria (n = 125)	54.1%	12.3%	4.4%	3.00	12-18 months	Fairly low
Berlin (n = 11)	90.9%	36.4%	27.3%	7.67	6-12 months	Fairly low
Brandenburg (n = 28)	73.1%	46.2%	42.3%	3.18	6-12 months	Fairly high
Bremen (n = 10)	77.8%	50.0%	50.0%	6.00	Over 24 months	Fairly high
Hamburg (n = 10)	90.0%	30.0%	30.0%	3.33	3-6 months	Fairly high
Hesse (n = 77)	55.4%	32.0%	21.3%	5.31	12-18 months	Fairly low
Mecklenburg-Western Pomerania (n = 14)	57.1%	35.7%	28.6%	0.75	3-12 months	Fairly high
Lower Saxony (n = 78)	58.1%	24.3%	5.4%	4.25	12-18 months	Fairly low
North Rhine-Westphalia (n = 88)	65.9%	37.5%	23.9%	3.71	12-18 months	Fairly low
Rhineland-Palatinate (n = 40)	51.4%	32.5%	22.5%	1.44	Over 18 months	Fairly high
Saarland (n = 10)	66.7%	77.8%	-	-	Over 24 months	Fairly low
Saxony (n = 50)	69.6%	34.0%	29.8%	4.36	3-6 months	Fairly high
Saxony-Anhalt (n = 17)	47.1%	29.4%	5.9%	2.00	6-12 months	Fairly low
Schleswig-Holstein (n = 20)	76.5%	76.5%	76.5%	8.38	3-6 months	Fairly high
Thuringia (n = 21)	70.0%	40.0%	5.0%	3.00	6-12 months	Fairly low
Germany	61.2%	30.5%	17.3%	4.30	12-18 months	Fairly low
Significance	0.108**	< 0.001**	< 0.001**	0.158***	< 0.001***	< 0.001***

Table 3: Comparison of Section 116b activities by Federal Länder (percentages of hospitals are shown)

n = Number of responding hospitals per Federal Land

* Average number of authorisations for different indications per authorised hospital; ** According to Chi-squared test;

*** According to Kruskal-Wallis H-Test

Source: Own calculation

156. An additional subject of the survey was examination of the further fields of activity of hospitals at the interface to the outpatient sector: in combined terms, 91.1% of all German hospitals with more than 50 beds are active in at least one of the fields of outpatient activity covered by the survey. More than three-quarters of all hospitals are active in the field of outpatient surgery; more than one-third currently operate an MSC or are at least involved in a centre of this kind, and the majority of all hospitals surveyed are moreover planning to expand their MSC activities. Disease Management Programmes and day-care services are also quite widespread, whereas the participation of hospitals in pilot projects can only be rated as marginal. Here, too, the size of a hospital influences the probability of it taking part in the rendering of outpatient services: all the forms of hospital outpatient services covered by the survey increase significantly as the number of beds increases.

Provision of services by hospitals at the outpatient/inpatient interface	No. of hospitals > 50 beds
Operation of/participation in a Medical Service Centre (MSC) (n = 619)	42.0%
...If so: Expansion of existing MSC activities planned in the next few years (n = 243)	79.0%
...If so: Participation of the MSC in integrated care pursuant to Section 140a-d SGB V (n = 241)	10.8%
Establishment of a (new or additional) MSC planned in the next few years (n = 542)	44.3%
Participation in Section 116b Para. 2-6 SGB V (old version) (n = 659)	17.3%
Participation in outpatient surgery (Section 115b SGB V) (n = 631)	79.4%
Participation in pilot projects (Section 63ff. SGB V) (n = 591)	1.7%
Participation in Disease Management Programmes (DMP) according to Section 137f-g SGB V (n = 587)	45.5%
Rendering of day-care services (n = 616)	49.8%
Participation in other forms of outpatient service provision (e.g. authorisations for outpatient treatment, external hospital doctors, outpatient departments of university hospitals, etc.) (n = 626)	88.7%
<i>Combined value: percentage of hospitals providing some kind of outpatient service (Section 116b, Section 115b, MSC, other forms)</i>	91.1%

Table 4: Forms of service provided by hospitals at the outpatient/inpatient interface (percentage of hospitals > 50 beds)

Source: Own calculation

157. 80.3% of all responsible hospital managers surveyed additionally state that the potential for providing outpatient services in hospitals will continue to increase in the future. The reasons stated for this view are again less based on possibly existing substitution possibilities for avoiding inpatient treatment, or exploitable economic potentials and their own growth strategies, but more on the necessary reaction to (existing or at least impending) underprovision. From the point of view of hospitals, there is a noticeable need to provide outpatient services in hospitals, in order to close gaps in the private-practice sector.

Demands on function-oriented competitive conditions between specialists in private practice and hospitals at the interface between the sectors

158. The prerequisite for functioning competition between specialists in private practice and hospitals in order to exploit efficiency potentials is that the regulatory framework provides corresponding incentives. Up to now, both the doctors in private practice and the hospitals have complained about unequal competitive conditions.

159. There was for a long time criticism that differences existed in relation to quality standards and quality assurance systems. Indeed, until Section 116b SGB V was revised, there certainly were differences between the outpatient and inpatient sectors as regards the design of external quality assurance and internal quality management systems. While the quality demands on hospitals, and the methods for external quality assurance, are essentially

determined by the specifications of the G-BA, it is mainly the Associations of SHI-Accredited Physicians that have this sovereignty in the private-practice sector. Consequently, the standard qualification and quality requirements now defined for all healthcare providers in the newly created field of outpatient specialist care are generally to be welcomed. However, it should also be noted that, even before this time, hospitals already had to fulfil numerous quality demands formulated by the G-BA (and at least comparable to the private-practice sector), in order to obtain authorisation in the field of Section 116b SGB V (old version).

160. Beyond this, the regulations regarding the possibilities for accessing new treatment methods in the field of outpatient specialist care have been standardised since 2012: in future, all healthcare providers will be able to apply new examination and treatment methods, unless they are explicitly prohibited. However, the problem in this context will probably be that a practice authorised to provide outpatient specialist care can use methods in this field of care that it is not permitted to use in other outpatient (general specialist) care, for which it is usually also authorised.

Even before, both the SHI-accredited physician and the hospital charged for outpatient treatment according to Section 116b SGB V by means of the Standard Schedule of Fees (EBM), meaning that the use of innovative methods was largely harmonised in formal terms. Consequently, the right to use an innovative method only after explicit approval of the method, as stipulated in the EBM, implicitly continues to apply until additional charging options for these innovative services are included in the remuneration catalogue.

161. There was and is a further need for regulation as regards the inequality of prices for occasioned services. For example, drugs can for the most part be procured at far lower prices by hospitals, since the regulations of the Drug Price Ordinance do not apply here, in contrast to the outpatient sector. However, unequal purchase prices also exist in the field of doctors' salaries, where hospitals are generally at a disadvantage owing to being bound by collectively agreed pay rates and working times. Different procurement prices additionally exist regarding large-scale equipment or the renting of premises. However, this is precisely where the efficiency potential lies that larger units are expected to exploit in comparison with the more fragmented outpatient care of the past. The only thing to be ensured in this context is that doctors in private practice and hospitals are granted legally comparable opportunities. It does not mean, however, that they are automatically entitled to, or must be guaranteed, these purchase prices. With the exception of drugs, and given an optimum choice of their organisational form, it would be equally possible for doctors in private practice to exploit the existing potentials. The production of unequal results as a result of unequal organisational forms is one of the fundamental characteristics of competition.

One option for solving the problem in the field of drugs could be that, by inviting tenders, the health insurance funds themselves procure the necessary drugs and pass them on to the healthcare providers at the outpatient/inpatient interface at uniform prices (particularly for services according to Sections 115b and 116b SGB V). The options already

existing as regards invitations to tender (in the field of oncological drugs) could be a starting point in this respect. It must, however, be borne in mind in this context that a wide-area tender-based solution would entail considerable logistical and data-processing challenges in everyday practice.

162. Likewise a repeated subject of criticism are the inconsistent regulations on investment financing: the different forms of investment financing lead to distortion of the relative prices between the sectors and moreover oppose the repeatedly postulated principle of "outpatient has priority over inpatient treatment". The criticised competitive advantage of hospitals is now to be balanced out in the newly regulated Section 116b SGB V by a 5% deduction on the remuneration in the event of services being provided in hospital. The distortions brought about by a dual financing system become particularly clear at this point: as long as dual financing of the inpatient sector is adhered to, a percentage deduction is a practicable option for reducing the distortion. However, fixing this deduction at 5% appears to be rather arbitrary, particularly since a standard deduction nationwide cannot do justice to the existing differences in investment financing in the individual Federal Länder.

163. For a long time, another serious form of unequal treatment between the outpatient and inpatient sectors was the fact that many of the fields of care in the private-practice sector listed in Section 116b SGB V (old version) were subject to demand-oriented planning and standard-service volumes, whereas no volume restrictions existed for hospitals. The misplaced incentives of the regulation applicable until the end of 2011 became particularly apparent at this point: different regulations applied, depending on how and where an outpatient service - that was identical both in terms of content and medically - was provided or charged, e.g. via the MSC, via Section 116b SGB V or via an outpatient department of a university hospital. The fact that this unequal treatment is now being eliminated is to be welcomed.

The chosen path of abandoning demand-oriented planning and volume limits is certainly one way of harmonising market access for all potential participants. However, it is doubtful whether this solution is target-oriented in the sense of efficient provision of services. On the bottom line, it gives rise to incentives for a supplier-induced expansion of demand. Although many of the treatments of outpatient specialist care are of only limited suitability for induction of demand by suppliers, it is to be suspected that various potentials for processes of this kind are to be found, particularly in the field of diagnosis (e.g. of rare illnesses) and repeat appointments.

Discussion of competition policy

164. Introduction of the standard legal framework created largely fair competitive conditions in the field of outpatient specialist care, under which healthcare providers can compete for patients. Precisely because of these improved conditions, further services located at the interface should now be gradually transferred to this sector. From the regula-

tory point of view, it should subsequently be left to the search-and-discover process of competition to determine where and in what form of cooperation the services are provided at the outpatient/inpatient interface.

165. In the current legal situation, however, what is still missing is the additional step that also turns the competition for patients into a competition among health insurers (for good care and thus, ultimately, for insureds). At the moment, the principal task of the health insurance funds is to pay for the rendered services on the basis of standard prices. In contrast, the introduction of selective-contract options in this sector would make it possible to achieve a competition-strengthening solution for this form of care. Also for this reason, there is a need to strengthen the possibilities for selective contracts, and practicable budget adjustment regulations are necessary in order to avoid double financing.

It would have been possible to base outpatient specialist care on selective contracts – as a kind of test for the other fields of care. The starting point for individual-contract solutions could be the targeted separate, increasingly globalised, monistic remuneration system (including material and investment costs). In the long term, many of the outpatient operations previously regulated in Section 115b SGB V should be incorporated in it, as should other services, such as short-time cases hitherto still treated on an inpatient basis or the services of outpatient departments of university hospitals.

Since it is generally a question of services of supraregional importance, where patients today already accept longer travelling distances, health insurance funds or groups of health insurance funds could invite tenders for these services, thereby separating them from the collective-contract systems of current outpatient and inpatient care. Long-term (but not unlimited) authorisations through concluding contracts with the insurer would be a solution in this respect, in which case the health insurance funds would bear the responsibility for ensuring sufficient care capacities. This sector would be particularly suitable for transitioning the entire system to a selective-contract system, also making it possible to gather initial experience regarding the impact of greater competition between the health insurance funds for healthcare providers (and vice versa).

166. To avoid indirect risk selection on the part of the health insurance funds, the state (e.g. in the form of the Land administration) would have to prescribe a minimum medical service density that would subsequently have to be implemented by the health insurance funds through selective-contract regulations. In contrast, there should be no specifications regarding the partners to be used by the insurers to guarantee this provision. Similarly, the state should assume responsibility for monitoring the quality of care in this competitive system. Nationwide benchmarking should be in a position to give health insurance funds incentives to look for the best possible healthcare structures, even in regions where there is little pressure of direct competition.

In contrast, underprovided regions can probably only be organised in a competitive form within limits, meaning that they represent a regulatory exception. Consequently, one im-

portant point for discussion is, first of all, the definition of underprovision itself. In regions where a shortage of medical care has been determined, the health insurance funds should first undertake every possible (financial and other) effort to guarantee outpatient specialist care as prescribed. All these efforts for securing ubiquitous care in the specialist care sector should initially be tackled by the health insurance funds themselves by means of selective-contract regulations (possibly in cooperation with Associations of SHI-Accredited Physicians, medical associations or municipalities) and only in a second stage by state intervention, e.g. by the municipality. Collective contracts should only be possible as the very last resort, in order to guarantee sufficient provision of care; this particularly applies to the provision of specialist emergency care. The role of the state in this competitive model would be different, but no less important: planning competencies of the Länder would lie in participation in the definition of criteria for underprovision, in setting minimum standards, including the aforementioned (quality) monitoring, and in a kind of framework planning, but not in the concrete granting of authorisations. The competitive system outlined here could be in a position to reduce overprovision in the foreseeable future and, at the same time, to increase the relative attractiveness of hitherto underprovided regions.

6.4 Target-oriented competition in the field of outpatient surgery

167. A total of roughly 1.81 million operations were performed in hospitals on an outpatient basis in 2009. This is more than triple the number compared to 2002, although growth has slowed significantly in recent years. In 2010, SHI incurred expenditure of just under € 2.28 billion for outpatient surgery services (including approx. € 619 million or 27.1% in hospitals). This form of service provision is thus by far the financially most important expenditure item at the outpatient/inpatient interface.

168. Alongside medical potentials resulting from fewer complications, less physical and mental stress on patients and high patient satisfaction, outpatient surgery also has extensive potential from the financial point of view, compared to full hospitalisation. Inpatient treatment can be avoided, or at least performed on a day-care basis. This is confirmed by looking at the situation abroad, where far higher percentages of operations are carried out on an outpatient basis in some cases. At the moment, however, it is still unclear whether and to what extent the increase in the number of cases observed in Germany is substitutional. Based on the studies currently available, no definitive assessment can be given for most indications regarding whether previous full-time hospitalisation really is being avoided, or whether previously untreated cases are additionally being treated.

169. An international comparison of the proportion of outpatient operations relative to the total number of operations shows that level of outpatient surgery in Germany is comparatively low. Other countries are way ahead of Germany in this field (especially the USA, Canada and the Scandinavian countries).

170. Standardisation of the framework conditions has been quite consistently pursued for the field of outpatient surgery in recent years (see Outpatient Surgery Contract). Consequently, there really is pronounced competition between the providers today. There is nevertheless still a need for further standardisation of the regulatory framework. The transfer of services to the newly structured field of Section 116b SGB V could further promote this. In addition, attention needs to be paid to two other important aspects:

171. First, there currently seems to be an incentive for hospitals to define services that could potentially be rendered on an outpatient basis as regular inpatient cases. Although hardly distinguishable in terms of content, one and the same intervention can be performed and charged in different sub-systems. The remuneration for short-stay inpatient cases is in some cases substantially higher than the outpatient remuneration. To resolve this problem, the remuneration should be adapted in the medium term, in such a way that it is also economically attractive for hospitals to offer a service on an outpatient basis, if this is medically justifiable. The profit contributions from outpatient operations must at least be comparable to those of the corresponding inpatient stay in hospital. This can still mean that the remuneration continues to be lower than that for the inpatient stay. It merely needs to be ensured that, following deduction of the costs incurred, the hospital retains at least a comparable profit contribution in the event of providing an outpatient service. When providing outpatient services, for example, no costs are incurred for overnight accommodation, and savings result from the fact that less or no monitoring is required, meaning that it also does not have to be paid for. In the long term, a standardised remuneration system of this kind also eliminates the need to make a legal distinction between inpatient operations, one-day cases and outpatient surgery, since a legislative specification of this kind is no longer necessary. It would be conceivable in this context to build on the existing DRG system, applying corresponding deductions.

Second, positive effects of the competition that certainly already exists today are not getting through to the health insurers: services according to Section 115b SGB V are currently paid for without a cap and outside the budget, i.e. in addition to the overall remuneration payable to SHI-accredited physicians anyway. This encourages supplier-induced demand and resultant increases in volumes. One solution to this problem again lies in the selective-contract regulation of this field of medical service provision. In the framework of direct agreements between health insurance funds and healthcare providers, it would also be possible to exclude the problem of additive (rather than substitutional) outpatient operations or to make adjustments to reflect the general morbidity trend. Complicated budget adjustment regulations would be largely superfluous here, given that remuneration is currently outside the budget.

6.5 Target-oriented competition in the field of MSCs

172. There was a total of 1,700 MSCs in Germany at the start of 2011. A quite rapid and continuous increase could be seen from quarter to quarter, although they still account for only a small portion of overall healthcare. MSCs are more likely to be found in urban locations, but they are also of significant relevance for providing healthcare services for rural areas – in addition to the effect of also providing the environs that they automatically trigger. According to the latest figures, a hospital is involved in the operation of 675 MSCs in Germany, while 776 institutions belong to SHI-accredited physicians and 366 to other owners, particularly from the field of providers of remedies and therapeutic appliances (multiple operators are also possible). The legal forms encountered are almost exclusively limited liability companies (GmbH) or civil-law partnerships (GbR), only four institutions (or 0.24% of all MSCs) being operated as private limited companies (AG) in the first quarter of 2011.

173. The potentials of quality improvements through intermeshing of healthcare steps and of the division of labour, procurement optimisation, fixed-cost reduction, sharing of premises, equipment and personnel, reduced transaction costs or improved possibilities for spreading risks and raising capital, can also develop their positive effects in the field of MSCs as long as they are not eroded again by monopolistic tendencies at the healthcare-provider level. However, these positive effects only develop their full impact upwards of a certain size. The sharing of resources is to be rated positively from the economic and care-oriented point of view, especially in the case of hospital-owned MSCs, even though there are repeatedly problems in this quarter regarding the appropriate allocation of costs and the assignment of investment funds.

174. Particularly worthy of emphasis in connection with MSCs are the specialisation advantages resulting from the division of labour: these include the splitting of medical activities and management skills among experts who are specifically trained for the respective work and have corresponding core skills. Further positive effects are also possible in this context, such as the offer of attractive working conditions for doctors. This includes professional exchanges and cooperation with colleagues, team work, avoidance of the entrepreneurial risk of establishing a private practice, and working-time models that facilitate the reconciliation of family and career.

Given corresponding incentives, hospitals could make increasing use of the possibility of outsourcing services before and after hospitalisation, and also outpatient surgery, to outpatient institutions of their own, thus extending their own care chain. In this way, there is a chance of offering true integrated healthcare from a single source, enabling cooperation between the individual disciplines and further reducing the length of hospital stays. The previously described potential of reduced hospitalisations (in favour of increased outpatient treatment) can also be exploited by falling back on the infrastructure of the affiliated inpatient capacities. On the other hand, there is also a risk of medically unjustified referrals

to institutions of the same owner. This danger can be counteracted by cross-sectoral aggregate lump sums and monitoring of the integrated providers under the laws on competition.

175. The fear that admission of non-medical financiers influences the quality of service provision is not confirmed by studies – the risk of influence is at least not primarily dependent on the ownership structure, but more on the economic pressure weighing on the provider. There are no reliable indications that the ownership or the legal form in itself negatively impacts the therapeutic freedom of the medical staff or the treatment outcomes.

The medical management of an MSC and the uninfluenced work of all doctors working there is a suitable regulation for licensing and operation of the institution, but these personal management or liability issues can easily be separated from the question of the ownership situation. In contrast, qualitative aspects of basic and specialist medical training or the independence of medical activity from external control should in no way be open to question. A further point against ownership regulation is past experience with medical services rendered by employees in hospitals (some quoted on the stock exchange).

176. The better capital resources of larger units can be interpreted as an expression of a possibly more efficient form of production that has to prove itself in competition in the long term. The participation of external, non-medical financiers does not constitute a distortion of competition, since this route would also be open to every hitherto self-employed doctor in private practice. From the point of view of efficiency, there is no justification for a guarantee for the existence of small practices or for the independence of doctors working in the outpatient sector as the only form of provision of outpatient services worthy of protection.

177. In summary, stricter regulation of the ownership of MSCs is not target-oriented. Preferential treatment of individual healthcare providers as regards the right to establish MSCs or in issues of refilling vacant doctor's practices, inhibits innovation and cannot be justified from the point of view of either healthcare policy or economics. Rather, fair, competition-oriented outpatient healthcare should be characterised by trust in patient preferences, provider diversity (in terms of organisational, ownership and legal forms) and strengthening of the willingness to invest, also of external financiers. In smaller towns, MSCs, in particular, could offer the opportunity to recruit doctors not wanting to be self-employed for new organisational forms. As in hospitals, this requires a responsible medical manager. On the other hand, there is no justification for the holder of this position and the owner of the MSC having to be one and the same person.

6.6 Conclusion and recommendations

178. The options currently open to hospitals for providing outpatient services differ greatly in terms of their historical development and underlying objective. Simply the existence of this inconsistent juxtaposition of different forms of care is an indication of the

need to reorganise the entire sector. Efficiency is suspected of being lost as a result of hitherto unexploited substitution and relocation potentials between the provision of inpatient and outpatient services.

179. Whenever healthcare providers originally belonging to different sectors compete for the provision of identical services at an interface, a single regulatory framework is needed in order to be able to exploit efficiency potentials. In addition to comparable quality assurance systems, identical regulations regarding charging for new treatment methods, standard service definitions, comparable legal possibilities as regards purchasing options and standard regulations on licensing and budgeting, this also includes the harmonisation of remuneration and investment financing.

180. There is no empirical evidence to show that certain legal forms are more suitable than others for achieving individual goals of healthcare policy. The potentials described can develop in any form of organised, large, networked units. Search-and-discover processes, without predetermined results and geared to the preferences of the insureds, permit a greater degree of consumer sovereignty.

181. One important point in the context of eliminating sector boundaries is the demand for the equalisation of remuneration between the two sectors. At the moment, one and the same treatment can be provided in different sub-systems and charged in entirely different ways. The remuneration for short-time inpatient cases is currently well above the outpatient remuneration, which gives hospitals the incentive to fully utilise their capacities and retain existing inpatient capacities. Thus, in addition to transferring the morbidity risk to the integrated healthcare provider and introducing monistic financing, the average profit contributions achievable from outpatient treatment should also correspond at least to those of comparable inpatient stays in hospital. This fee scale must apply equally to all potential providers, have a case or patient reference, differentiate between different degrees of severity and also include material costs. To this end, the relative weights could be calculated in standard fashion nationwide, the concrete remuneration levels, volumes and quality requirements subsequently being specified in detail in the regulations of selective contracts. As in the DRG system, adjustments should be performed at regular intervals, in order to pass on realised efficiency advantages to the insureds as well. Here again, the need for effective budget adjustment regulations also deserves special emphasis at this point.

182. By creating the field of outpatient specialist care, the Act on the Stabilisation and Structural Reform of SHI undertook a first attempt to put the previously fragmented and partly contradictory regulations on care at the outpatient/inpatient interface in a uniform legal framework. This plan can basically be rated positively, although this first step must be followed by others in order to better exploit the outpatient potential. This primarily includes increased use of selective contracts in care and also less regulation of ownership. Furthermore, additional services should be included in the field of outpatient specialist care. So far, the fragmentation of the legal framework concerning the provision of services at the interface has hardly been reduced. Outpatient surgery, interventions replacing inpatient

treatment (also beyond the framework of the current Section 115b SGB V), short-time inpatient cases and the fields of Sections 117ff. SGB V (outpatient departments of university hospitals, outpatient departments of psychiatric institutes and social paediatric centres) should now be gradually transferred to this pillar of healthcare, with identical competitive conditions for all providers.

183. When assessing the Act on the Stabilisation and Structural Reform of SHI, it is apparent that a complete switch to a competition-based system at the outpatient/inpatient interface is still not envisaged. What is missing is the step that also turns the competition among healthcare providers for patients into a competition among health insurers for good care and thus, ultimately, also for insureds. Effectively securing healthcare nationwide is not in itself an area inaccessible to competitive approaches. On the contrary, the approach of small-scale, sectoral demand-oriented planning to reduce underprovision has proven to be unsuccessful and also inefficient in avoiding so-called overprovision. Competitive solutions would be possible, particularly in regions that are already overprovided today (big cities with a host of hospitals and doctors in private practice), since there would be sufficient options there for functioning competition for contracts between health insurance funds and healthcare providers.

7 Improved efficiency and effectiveness through selective contracts

7.1 Restricted contractual freedom as a result of over-regulation

184. With the aim of intensifying competition among and between the health insurance funds and the healthcare providers, and at the same time of overcoming the boundaries between the healthcare sectors, the legislators have, since the late 1990s, implemented several elements in SHI, in the framework of the so-called special forms of care, that are geared to the concept of "Managed Care", developed in the USA. According to Section 53 Para. 3 SGB V, these special forms of care encompass:

- GP-centred care ("gatekeeping") (Section 73b SGB V),
- Special outpatient medical care (Section 73c SGB V),
- Integrated forms of care (Section 140a-d SGB V),
- Disease Management Programmes (Section 137f-g SGB V), and
- Pilot projects (Sections 63-65 SGB V).

185. While success was initially achieved, with the help of these forms of care, in getting integrative and competitive movement into healthcare, a certain degree of disillusionment has since emerged. This is attributable not only to possibly exaggerated expectations, but also to the weaknesses of the respective framework regulations, which counteract efficiency and effectiveness improvements. For example, the Council already criticised in previous reports that the law obliges the health insurance funds to offer GP-centred care, this contradicting contractual freedom. Moreover, the statutory regulations significantly restrict contractual freedoms, in that they subject GP-centred care to strict contribution rate stability. Accordingly, any additional expenditure has to be financed through contractually secured savings and efficiency increases, this adding up to a virtually prohibitive demand in view of the uncertainties regarding future earnings. In this context, aspects of regulatory and competition policy suggest abolition of the compulsion to conclude contracts and to leave the content of the contracts, including remuneration, exclusively to the contracting parties.

186. The Act on the Stabilisation and Structural Reform of SHI further restricts the contractual freedom of the parties in that it also subjects special outpatient medical care and the integrated forms of care to contribution rate stability. This tight linking to contribution rate stability makes it virtually impossible to initiate innovative projects that initially cause comparatively high costs, but later pay back and can additionally contribute to improving health outcomes. All in all, the current statutory regulations bear witness to a mistrust in contractual freedom and in the efficiency and effectiveness potential that can be exploited with the help of selective contracts and competitive processes.

7.2 Further development and expansion of selective contracting options

187. Of the special forms of care, only the integrated forms of care, the Disease Management Programmes and the pilot projects, which have been greatly neglected in recent years, meet the statutory prerequisites for cross-sectoral care. While these three special forms of care encompass the statutory bases for cross-sectoral care at the interface between the outpatient and inpatient sectors, they are not capable of guaranteeing cross-sectoral coordination processes. To do justice to the central concern of cross-sectoral coordination, the integrated forms of care should presuppose cross-sectoral orientation as a necessary condition. This mainly applies in the event that the legislature would in future again like to give financial incentives for "integrated healthcare" projects. Otherwise, there is a risk of financial promotion according to the watering-can principle, as in the past.

Despite promotion through start-up financing up to the end of 2008, the integrated forms of care did not – and do not – make legal provision for evaluation. As a result, no sound information is yet available regarding the cost/benefit ratio of these projects, and thus also of the start-up financing, which also makes potential learning effects impossible. This lack of transparency also appears to be a problem in that SHI-accredited physicians and hospitals not taking part in these projects co-financed the start-up financing as a result of global budget adjustment and should be entitled to be informed of the corresponding results.

188. In contrast to the integrated forms of care, Section 137f Para. 4 SGB V obliges the health insurance funds or their associations to have the Disease Management Programmes (DMPs) externally evaluated by independent experts. Although over 5.9 million registered insureds are in the meantime taking part in over 10,890 ongoing programmes in the framework of these DMPs, there is still no representative, valid evidence of their efficiency. First of all, there are still only few accompanying studies, compared to the scope of the DMPs, and the great majority of them moreover concentrate on, or are limited to, the indication of Type 2 diabetes mellitus. In addition, many studies display conceptual weaknesses, such as small study populations or deficient control group design. In this case, the legislators dispensed with the requirement of evaluation according to the criteria of

controlled, randomised studies, i.e. comparison with a selected control group consisting of patients not taking part in the respective DMP. No attention was paid to deficits that were already explicitly pointed out at the time of introduction of the programmes, or to methodological demands on the evaluation of DMPs.

Following abolition of their exclusive linking to the risk equalisation scheme at the end of 2008, there are no convincing reasons for the – even previously problematic – special legal status of DMPs and their associated separation from the integrated forms of care according to Section 140a-d SGB V. DMPs are already a subject of integrated care insofar as, according to Section 137f Para. 1 SGB V, a need for cross-sectoral treatment is a key criterion for their selection. Medical and economic aspects speak against the special status of six indication areas and for their inclusion in the integrated forms of care. The inclusion of DMPs in the integrated forms of care not only means equal treatment of the different indication areas, but also offers the chance to again give greater opportunities for competition among selective contracts in the framework of these programmes. Insofar as the integrated forms of care presuppose cross-sectoral orientation as a necessary condition, as proposed above, this also strengthens the integration efforts of the contract partners.

189. By realising the concept of outpatient specialist care in Section 116b SGB V, the Act on the Stabilisation and Structural Reform of SHI complied with a repeated demand of the Council to create equal access and competitive conditions for hospitals and specialists in private practice at the interface between the outpatient sector and the inpatient sector by means of a uniform regulatory framework. The scope of this field of care is, however, restricted to a narrow range of services and even falls short of the previous legal situation as a result of the limitation of diseases with special courses to severe forms. In contrast, the bill of 27 July 2011 still provided for expansion of this field of care to include operations that can be performed on an outpatient basis and other interventions replacing inpatient care from the catalogue according to Section 115b Para. 1 SGB V. By restricting the initially envisaged range of services, the legislature primarily catered to the objections of Federal Länder and health insurance funds, which feared a supplier-induced expansion of services owing to the absence of demand-oriented planning and the abolition of volume limits. As a regulatory solution, it would therefore be logical, as already proposed in Chapter 6.3, to subject this field of care to selective contracting. This would then give the health insurance funds the possibility of stipulating volume limits or corresponding remuneration reductions in contracts, in order to prevent undesirable or medically unjustifiable expansions of services in this way. Under these conditions, outpatient specialist care could also include all outpatient operations from the outset. In addition, this area would then have the nature of a pilot for testing selective contracting, which would in this case serve as the sole allocation mechanism, not in parallel with collective contracts, but independently of them.

Compared to doctors in private practice, hospitals are hardly confronted with selective contracts, since they agree on their care contracts with the health insurance funds at the Land level, across the funds and jointly. In absolute terms, the contracts between hospitals

and health insurance funds on integrated forms of care or DMPs also remained largely negligible until the end of 2008, and the inpatient sector has no counterpart to contracts on GP-centred care and on special outpatient care. Since Diagnosis Related Groups (DRGs) constitute fixed prices, hospitals do not have the chance to influence demand via the price of their services. The Council therefore proposed in its Report 2007 that the DRG system be partially opened up to price-based competition. The contract partners should have the option of concluding selective contracts with special price and quality agreements, at least for a certain range of selected hospital services, e.g. for elective interventions and treatments. As a result of the interdependencies between inpatient and outpatient care, and the continuing increase in the potential of outpatient treatments in the future, allocation in the inpatient sector is also accompanied by effects on the interface between outpatient and inpatient care.

7.3 Targeted promotion of healthcare innovations and healthcare research

190. The currently stagnating willingness of the health insurance funds to invest in innovative care concepts is largely due to financial considerations regarding what they see as the uncertain return on such projects. The occasionally substantial initial investments in establishing new care structures are only later offset by highly uncertain earnings, meaning that there is initially a risk of an expenditure surplus in the early years. In addition, at the time of reaching the decision, it remains largely unclear whether and to what extent the positive effects of these investments will in future be reflected in savings on expenditure or pure quality improvements in care. As also documented by the results of the Council's survey (on this subject, see the Digression in Chapter 8), the health insurance funds concentrate their efforts more on limiting and controlling expenditure, i.e. priority is given to checking hospital bills, the discount agreements with pharmaceutical companies and the avoidance or reduction of sickness benefit claims, whereas contracts on integrated care, for example, do not even appear in the top half of the economising measures they consider to be important.

At the moment, a number of financing models for promoting innovative care concepts are up for discussion to eliminate, or at least alleviate, these current obstacles to investment. Independently of the specific financing model, the Council initially proposes the following regulations to promote innovative care models:

- Limitation of the funding to five years, this constituting an adequate planning period,
- Restriction to cross-sectoral projects,
- Obligatory, systematic evaluation that, to assess the results, includes an appropriate control group, as well as outcome indicators, and

- Prioritisation of population-related care concepts (encompassing all indications) and those that incorporate the hitherto neglected field of nursing services.

191. In view of regulatory aspects, and of the problems involved in making a promising ex ante choice of care concepts worthy of promotion, also taking target-oriented criteria into account, suitable financial incentives would be not so much running payments from the Health Fund as reduced-interest loans from a capital fund. Accordingly, to finance their innovative care projects worthy of promotion, the health insurance funds would receive, waiving security, reduced-interest or interest-free loans for their additional costs after budget adjustment, which they only have to repay after five years. Provided that the project in question refinances itself through later savings, repayment of the loan should not cause the health insurance fund any problems. If the project fails to refinance itself through later savings on expenditure, but its evaluation documents unequivocal improvements in health outcomes, this could be grounds for a partial waiver of repayment, with financing from the Health Fund. This form of financial incentive for innovative care projects has the following advantages:

- The health insurance funds are relieved of the financial burden at the start of the projects,
- They are given a clearly defined planning period for refinancing the projects,
- No deadweight effects are generated,
- The Health Fund or collective, central budgets are hardly burdened – and if they are, then only in the case of proven success, and
- Financially relevant decisions are shifted more from the ex ante assessment to the later, ex post evaluation.

7.4 Adjustment of outpatient medical remuneration

Need for adjustment

192. One fundamental problem when concluding selective contracts is that the payments of the health insurance funds to the Associations of SHI-Accredited Physicians initially have to be made independently of the services of which their insureds avail themselves in the collective contract. If certain elements of healthcare are provided on the basis of selective contracts, this does not initially change the payments of the health insurance funds to the Associations of SHI-Accredited Physicians. The healthcare providers now no longer render the separated services in the framework of the collective contract and also receive no remuneration for them under the collective contract. Instead, they have to be remunerated by the health insurance funds contracting with them for the services to be provided under the selective contract, since it would otherwise be unattractive for healthcare providers to participate in selective contracts. So, without adjustment of the overall

remuneration, the health insurance funds concluding selective contracts pay a second time for services for which they have already paid in the overall remuneration.

193. From the regulatory point of view, adjustment is consequently an important prerequisite for functioning competition, if a corporatistically organised collective-contract system and a selective-contract system with more decentralised control are simultaneously to be developed side-by-side. In an undistorted competition, care would always be provided in the system in which it displays the most favourable cost/benefit ratio. To achieve this, the adjustment procedure must deliver the most accurate possible estimate of what the mandate to provide care of the respective selective contract would have cost in collective-contract care.

If patients whom the doctor participating in the selective contract would otherwise have treated under the collective contract register for a selective contract, the health insurance fund must be able to adjust the overall remuneration payable to the Association of SHI-Accredited Physicians by the amount that the doctor participating in the selective contract would have received, had he treated the registered patients under the collective contract. This adjustment amount puts the health insurance fund in a position to exactly balance out the fee losses of the participating doctors.

To guarantee competitive neutrality, the adjustment amount must also include the payments that doctors not participating in the selective contract would have received, had there been no selective contract. These shifts of activity and savings must benefit the parties to the selective contract, since, for example, they cannot otherwise finance investments (e.g. in infrastructure for improving the coordination of care) to achieve these savings.

The adjustment problem will be alleviated, but in no way solved, when the remuneration regulations provided in the Act on the Stabilisation and Structural Reform of SHI enter into force. According to these regulations, a health insurance fund's share of the Morbidity-Related Overall Remuneration (MOR) in an Association of SHI-Accredited Physicians is in future to be gauged by share of the insureds of the health insurance fund relative to the services utilised in the Association of SHI-Accredited Physicians in the last four quarters.

Applicable adjustment methods

194. Adjustment will first be examined at the level of the Morbidity-Related Overall Remuneration (MOR). In this context, the adjustment resolution of the Committee for Rating Office-Based Doctors' Services distinguishes between "selective contracts with ex ante registration of the insured" (e.g. contracts for GP-centred care) and "selective contracts with situative registration/utilisation" (e.g. contracts for indication-specific care of patients with hip replacements).

The following procedure applies to contracts with ex ante registration: the historical, care contract-specific service requirement for 2008 (limited to one quarter) is determined for each registered insured and deducted from the overall remuneration. For this purpose, the

scope of the care mandate first has to be defined in the selective contract. This is done on the basis of the EBM, in exactly the same way as charging by doctors in the collective contract. Once the parties to the adjustment contract have agreed on the scope of the care mandate under the selective contract, the contracting health insurance fund can determine the extent to which each participating insured utilised the corresponding EBM numbers in 2008. The services from 2008 are weighted with the regional point value for the standard case. The same adjustment factors are subsequently applied as for the overall remuneration. All in all, the MOR is reduced by the amount that the contracting health insurance fund would otherwise implicitly have paid to the Association of SHI-Accredited Physicians for the participating insureds for the separated scope of care.

195. The procedure for adjusting selective contracts with situative registration/participation is likewise based on the service definitions of the EBM. For this type of contract, however, it makes no sense to consider the historical service requirement. In the case of services that an individual insured utilises only rarely, or only once in a lifetime in extreme cases, the historical service requirement is in most cases zero. Therefore, the sum total of the contract-specific services of a health insurance fund in 2008 is determined instead and then divided by the number of insureds of this health insurance fund utilising these services. The result is a contract- and fund-specific utilisation average. This average value then has to be multiplied by the mutually established number of persons utilising these services under the selective contract.

196. Beyond this, adjustment at the physician level is also necessary when the MOR is adjusted. In this context, the question is how to distribute the reductions of the MOR among individual doctors and groups of doctors. The adjustment regulations at the physician level are also highly relevant for the functional capacity of the competition of systems between collective and selective contracts.

For contracts with *ex ante* registration, the number of cases of the doctor and the case value of the group of doctors can be used as a starting point. According to the adjustment resolution applicable until entry into force of the Act on the Stabilisation and Structural Reform of SHI, it is established for every doctor in a selective contract in every quarter, how many of the insureds treated by him in the same quarter of the previous year were registered in a selective contract. If the doctor himself takes part in this selective contract, his standard service volume (SSV) is reduced by the corresponding number of cases. In contrast, there is no reduction of the number of cases for doctors not taking part in the selective contract.

The remaining, adjustment-induced changes in the MOR that are not taken into account by case number reductions at the physician level, must lead to adjustment of the case values. In this context, the adjustment resolution makes provision for the case value to initially fall for all doctors in a group of doctors (or to rise if insureds with a below-average historical service requirement are registered). However, this change in the case value is limited. Any differences possibly remaining are taken into account by reducing (or increasing) the case value only for the doctors taking part in the selective contract.

For contracts with situative registration, the amount to be adjusted at the MOR level is distributed among the participating doctors in accordance with their historical share of the contract-specific scope of care.

197. The Act on the Stabilisation and Structural Reform of SHI stipulates that fee distribution can only be performed by the Associations of SHI-Accredited Physicians. It is consequently also incumbent upon them to define distribution rules between doctors in collective and selective contracts.

Criticism of the adjustment resolution and proposals for improvements

198. The clear definition of the care mandate of selective contracts often proves to be difficult, particularly in the case of indication-oriented contracts. The options of the parties to selective contracts are additionally greatly restricted by the compulsion to gear them to the EBM.

The historical service requirement and the actual service requirement can differ substantially. The adjustment amount is too small if the service requirement of the insured has risen since the reference period of the historical service requirement. In the current procedure, the service requirement is underestimated for all those persons whose costs have risen by an above-average degree since 2008. For insureds newly joining selective contracts, this problem can be alleviated by using more recent reference periods. However, no more recent service requirement from the collective system is available for insureds who have been in selective contracts for many years.

199. It is not justifiable that the adjustment resolution of the Committee for Rating Office-Based Doctors' Services makes no provision for reducing case numbers for doctors in collective contracts. It is inappropriate that the switch of a patient from a collective contract to a selective contract is treated differently, depending on which doctor the patient comes from. Provision must also be made for reducing case numbers for doctors in collective contracts.

200. The adjustment of the case values is more difficult to assess. If a doctor registers patients of his own with above-average morbidity in a selective contract, the solution most likely to be neutral in terms of competition is differentiated adjustment of the case values in the individual contracts. This approach ensures that the SSVs of the doctors participating in the selective contract are reduced by exactly the amount that the health insurance fund can deduct from the MOR in the framework of the contract. Distribution problems within the group of doctors participating in a specific selective contract can be cushioned by corresponding remuneration models in the contract.

Even today, the SSV, which is based on average values, is not sufficient to cover all the services rendered in the case of doctors having a patient population with above-average morbidity. If this group of doctors cedes patients to selective contracts, but does not itself participate in the selective contracts, the reduction of their SSV by the complete historical

service requirement of the patients ceded would lead to exacerbation of this deficit. This is a point in favour of distributing the necessary case value reduction over a larger group. The solution most likely to be neutral in terms of competition would be to only reduce the case values of the doctors not participating in the respective selective contract.

However, this differentiated solution imposes higher demands on the fee distribution systems of the Associations of SHI-Accredited Physicians. As long as selective contracts account for only a small share of the market, there will be no major distortions if the case value is reduced for all doctors in a group of doctors without differentiation. However, the advantages of differentiation would probably dominate upwards of a certain threshold.

201. The solution in the adjustment resolution regarding the adjustment of contracts with situative participation is particularly unsatisfactory. The use of an average amount, regardless of the morbidity of the participants, can lead to incentives for selection. Shifts in activities cannot be mapped by this procedure. Adjustment is only applied to doctors in selective contracts, even if potential collective-contract patients are recruited. Although possibilities for improving the adjustment of contracts with situative participation do exist, the nature of these contracts makes it extremely difficult to adjust this procedure in a satisfactory manner.

202. Since they have sole responsibility for fee distribution, the Associations of SHI-Accredited Physicians have it in their hands to massively obstruct selective contracts. This could be prevented by a statutory requirement that all fee distribution issues relating to selective contracts and adjustment be resolved by mutual agreement with the health insurance funds.

In the framework of adjustment across the Associations of SHI-Accredited Physicians, the care mandate of the selective contract agreed upon with the contracting Association of SHI-Accredited Physicians should automatically be recognised by other Associations of SHI-Accredited Physicians, eliminating the need for individual negotiations with every Association of SHI-Accredited Physicians responsible for the place of residence of the patient. The periods for supplying data for participants in selective contracts should be shortened.

Alternative adjustment procedures

203. Direct morbidity orientation of the adjustment amounts is susceptible to up-coding. Instead, the Council proposes internal adjustment between the parties to the selective contract. Accordingly, the doctors participating in the selective contract continue to charge all services rendered by them to the Associations of SHI-Accredited Physicians. So, at the accounting level, the procedure is initially as though no selective contract existed at all. In theory, the Associations of SHI-Accredited Physicians would not even need to know that a selective contract exists.

In the second step, the doctors participating in the selective contract directly pass on to the health insurance funds the fee they have received from the Associations of SHI-Accredited Physicians for the services rendered in the framework of selective contracts (which are still charged to the Associations of SHI-Accredited Physicians).

In the third step, the health insurance funds then have the possibility of remunerating doctors in selective contracts according to other yardsticks, e.g. by greater use of flat rates and/or "pay for performance". Given ideal internal adjustment, the payments of the Associations of SHI-Accredited Physicians for the corresponding services are a transitory item for the doctors. Of relevance for their actions are only the incentives emanating from the remuneration system chosen by the health insurance funds. Also conceivable are models where the doctors retain part of the remuneration from the Associations of SHI-Accredited Physicians and additionally receive payments from the remuneration system provided specifically for the selective contract.

204. The proposal has a number of advantages and a few limitations. The fees lost by the participating doctors automatically correspond to the savings of the health insurance fund. There is no need to fall back on a historical service requirement that may no longer be applicable. No delays occur due to data delivery periods, etc. The services covered only have to be defined in negotiations between the parties to the selective contract. Moreover, if doctors register their own patients, there is no need to adjust the SSV, and health insurance funds can comply with their statutory adjustment obligations more easily and with less bureaucracy.

205. The disadvantages of this procedure lie in the fact that doctors have to issue two bills and that savings in the outpatient sector only partly benefit the parties to selective contracts. If the use of innovative fee forms leads to a decline in the utilisation of services, the amount received by the health insurance fund from the Association of SHI-Accredited Physicians declines equally. Partial compensation is achieved if, according to the remuneration regulations of the Act on the Stabilisation and Structural Reform of SHI, declining utilisation is also accompanied by a corresponding decline in the health insurance fund's share of the MOR. However, since the MOR initially remains constant at the Association of SHI-Accredited Physicians in question, the reduced share of the health insurance fund does not lead to complete equalisation. Selective contracts, which mainly target savings in the outpatient sector and not primarily effects in other sectors, such as the reduction of hospitalisations or more efficient drug therapy, could then become uneconomical.

So, all in all, internal adjustment is also more a pragmatic adjustment procedure than a perfect one. The legislature should nevertheless create the prerequisites necessary for application of this proposal. It can then be left to the free discretion of the parties to selective contracts to decide whether and in which situations (probably more in the specialist sector than in the GP sector) they want to make use of this new procedure, or whether they would prefer to fall back on the procedure applicable today.

7.5 Referral for reward

206. Section 73 Para. 7 SGB V entered into force on 1 January 2012 and contains a ban on referral for reward. The reason for including the ban in the Act was the special attention received by the ban stipulated in Art. 31 Para. 1 (Model) Professional Code for Physicians in Germany (MBO) as a result of the increased implementation of elements of competition in the health sector. The instruments of competition are intended to influence the conduct of medical healthcare providers and give economic incentives. These instruments are extremely desirable for promoting the efficiency and quality of medical care and should be further expanded in the future. It must, however, continue to be borne in mind that this can give rise to a conflict with the ban on referral for reward. It must be ensured that competitive steering mechanisms do not jeopardise the independence of doctors and lead to doctors being guided more by economic aspects than by medical considerations. The problem of distinguishing between desirable cooperation in the framework of integrated care and impermissible referral for reward particularly arises where a network acts without the involvement of a health insurance fund. The legislature must not lose sight of the associated risk when developing its competition-related reforms.

7.6 Results of a survey on integrated care according to Section 140a-d SGB V

7.6.1 Survey of health insurance funds

207. Since start-up financing expired at the end of 2008, there have no longer been detailed data regarding contracting activities in integrated care according to Section 140a-d SGB V. And yet, precisely the end of this funding could have induced an important structural change in developments. Against this backdrop, the Council decided to conduct its own surveys on the subject of integrated care according to Section 140a-d SGB V.

Methodological approach and response rate

208. All statutory health insurance funds, and also the six Regional Associations of Company Health Insurance Funds and their Contract Working Groups, were surveyed between July 2011 and January 2012 with the help of a questionnaire developed by the Council. The survey mainly focused on 2010, since it was the most recent year for which complete data were available when the survey began. The response rate of 69.2% of all health insurance funds was high. It was even higher if not the number of health insurance funds was considered, but the numbers of insureds of the responding health insurance funds. The insureds-based response rate was 95% overall, varying between 80.8% and 100%, depending on the type of fund.

Development of integrated care according to Section 140a-d SGB V

209. With once exception, all the health insurance funds surveyed take part in integrated care. The contract numbers are attributed great importance as an indicator for the development of forms of integrated care. It must be borne in mind in this context that the counting of contracts at the fund level performed here yields a "gross number of contracts", which is well above the number of existing different contracts ("net number of contracts"). Also, this method of gross counting overestimates the share of company health insurance funds relative to overall contracting activities.

The development of integrated care is shown in Table 5. The contract numbers were extrapolated on the basis of the number of insureds of the responding health insurance funds for 2008 and subsequently updated by the relative development of the contract numbers of the responding health insurance funds. The contract numbers have largely stagnated since 2008.

	2008	2009	2010	2011
Contracts (gross)	6,400	6,262	6,374	6,339
Participants	1,661,283	1,635,270	1,771,949	1,926,133
Expenditure	1,225,064,973	1,224,214,367	1,353,068,055	1,352,305,185

Table 5: Development of integrated care

Source: Own calculations, KJ 1, KV 45

210. However, the development of the gross contract numbers was very heterogeneous. The number of contracts not involving company health insurance funds showed a marked structural change at the transition from 2008 to 2009. It fell by roughly 25% and remained almost unchanged from 2009 onwards. The number of contracts concluded by company health insurance funds themselves (i.e. the contracts outside Contract Working Groups and Regional Associations) declined slightly after 2008, also remaining below the starting level in 2011.

211. The contracts of the company health insurance funds concluded with third parties account for roughly two-thirds of the estimated gross contract numbers from 2009 onwards, although the "net" figure only involves roughly 200 contracts. This is the most important reason why the net number of 1,600 contracts estimated for 2010 amounts to only roughly one-quarter of the gross number of contracts for that year. While company health insurance funds have a share of more than three-quarters of the gross number of contracts, they account for only 22% of the net contracts. In the case of the latter, the substitute health insurance funds dominate with a share of 40%.

212. Even if no exact net number of contracts can be calculated for the years 2008 and 2009, it can still be assumed that there was a marked decline in this period. The number of participants was estimated on the basis of the expenditure of the respective health insurance

funds for integrated care according to Section 140a-d SGB V according to the KJ 1 statistics. The participant figures present a slightly different picture than the numbers of contracts. Following a slight decline by 1.6% from 2008 to 2009, there was a steady rise up to 2011. The number of participants in 2011 was 16% higher than in 2008.

213. The expenditure development figures shown in Table 5 are based on the KJ 1 statistics (or the KV 45 statistics for 2011). However, corrections were made after consulting a number of health insurance funds. The expenditure in 2008 and 2009 was almost identical (marginal decline of less than 0.01%). It then rose relatively strongly by more than 10% in 2010, then again falling minimally in 2011.

With a figure of 44%, the Knappschaft miners' health insurance fund accounts for almost half of the expenditure in integrated care. Of decisive importance in this context are the population-related and cross-indication models "prosper" and "proGesund", in particular. However, a number of other health insurance funds also have a relatively high share, as a result of which four health insurance funds are responsible for roughly 70% of total expenditure.

214. The expenditure figures are also available broken down by sectors. It can be seen that, as in conventional care, the expenditure for hospital treatment accounted for the highest share, with between 44% and 46% in 2008 to 2011. With figures of 33% to 37%, the share of outpatient medical care was likewise higher than in conventional care in this period. In contrast, the share of drugs was smaller, at between 9% and 11%.

Type and design of the contracts

215. The percentages and absolute figures presented below refer to the raw results and were not extrapolated.

68% of contracts were cross-sectoral in 2010 and 2011. The outpatient medical remuneration was only adjusted in 1.5% of contracts in 2010, this figure increasing to 2.2% in 2011. The subject of 18% of all contracts in 2010 and 2011 was outpatient surgery. Only 10% of all contracts provided for permanent registration. 26% of contracts in 2010 (2011: 28%) made provision for participation over a lengthy, but limited period. 64% of contracts in 2010 (2011: 62%) referred only to the provision of a single, defined service or only to one quarter. 70% of contracts were concluded jointly by several health insurance funds. Health insurance funds of other types were involved in 20% of the contracts concluded.

57 contracts with long-term care institutions existed in 2010, the figure for 2011 being 58. This accounts for a share of just under 1% of all contracts in each case. It must be borne in mind in this context that this result includes multiple counts. Only 17 of the contracts concluded involved long-term care insurance funds. 11% of the health insurance funds had concluded contracts involving medical device manufacturers, and 10% had concrete plans to sign contracts of this kind. 13% of the health insurance funds had concluded contracts

involving companies from the pharmaceutical industry, and 11% had concrete plans to do so.

216. The existing contracts for integrated care are not comprehensively evaluated. 17% of the health insurance funds never evaluate their contracts, 56% only occasionally. This contrasts with a mere 5% of the health insurance funds that always evaluate their contracts, and 22% that at least usually evaluate them. Almost one-quarter of the health insurance funds that perform evaluations never publish the results, and 68% only partially. Merely 10% usually publish the evaluation results, and only one health insurance fund always does so. 49% of the health insurance funds perform their evaluations entirely or predominantly in-house, 51% having them performed entirely or predominantly externally. All in all, there is very little probability of a contract being evaluated externally and the results being published.

Additionally surveyed were the measures taken by the health insurance funds to structure the interface between the outpatient and inpatient sectors. Measures for avoiding duplicate examinations are taken most frequently. Other commonly mentioned measures include an improved exchange of information and trans-sectoral treatment paths. In contrast, less frequent use tends to be made, even in integrated care, of more extensive measures for overcoming the sectoral divide, such as a common electronic patient file or longer support of patients by the hospital.

Terminated contracts

217. There was a marked rise in the number of contract terminations in 2008 and 2009. The raw result for 2008 was 701 terminated contracts, the figure for 2009 being 741. The result for 2009 presumably also includes many contracts that expired at the beginning of the year (e.g. 1 January 2009), meaning that the end of start-up financing probably also still played a significant role in this year. The number of terminated contracts declined significantly again in 2010, the raw result showing 545 terminated contracts.

218. The health insurance funds stated that 552 contract terminations were attributable to the end of start-up financing. This figure is, however, greatly influenced by a single, large health insurance fund. Disregarding this health insurance fund, the share of contracts terminated for this reason is just under 21% of all 1,442 contract terminations in 2008 and 2009. Beyond this, the health insurance funds stated that (after eliminating one outlier) 10,5% of the 545 contract terminations in 2010 were attributable to concerns regarding the need for a supplementary contribution.

219. Cost problems played a clearly dominant role among the other reasons for contract terminations. The most important single criterion was "excessively high costs", but also "volume increases on the part of the healthcare providers". An "excessively long time to payback" likewise indicates that the terminated contracts were uneconomical for the health insurance funds, at least in the short term.

Another weighty problem area is patient participation: the second most important reason given for terminating contracts was an "insufficient number of participants", fifth place being taken by "lack of interest or scepticism on the part of patients". Budget adjustment, legal uncertainty and IT problems played a less important role as regards the termination of contracts in these years.

220. The greatest difference between continued and terminated contracts is to be seen in the "time to payback" criterion: 58.8% of the health insurance funds stated that it was shorter for the continued contracts than for the terminated ones. 27% of all terminated contracts can be assigned to the primary diagnosis group "diseases of the muscles, skeleton and connective tissue". Contracts belonging to this category were terminated to a greatly over-proportional extent. Contracts for psychological illnesses were likewise terminated disproportionately often, while the figure for palliative care contracts was disproportionately low.

Expectations of integrated care according to Section 140a-d SGB V from the point of view of the health insurance funds, and obstacles to implementation

221. From the point of view of the health insurance funds, the most important aspect as regards participation in integrated care is the improvement of quality, followed by cost reductions and an increase in patient satisfaction. The avoidance of hospitalisation and better coordination between the sectors are also of great importance. The image gain for the health insurance fund, expanded options for action as a result of the selective choice of healthcare providers and the structuring of the remuneration, as well as the possibility of applying innovative treatment methods in the outpatient sector, prove to be aspects of moderate importance. In contrast, only a secondary role is played by the improvement of prevention and the granting of concessions to the insureds.

The expectations of the health insurance funds tended to be best fulfilled by the possibility of selectively choosing healthcare providers, followed by the increase in patient satisfaction and the image gain for the health insurance funds. The expectations were least fulfilled as regards the improvement of prevention, cost reductions and coordination between the sectors.

The gap between expectations and reality is by far at its greatest in connection with the aspect of "cost reductions". This result also fits in well with the finding that excessively high costs were the most important reason for terminating contracts. The gap is also relatively large as regards aspects of improving healthcare: quality improvements, avoidance of hospitalisation, and coordination between the sectors come directly after.

222. The health insurance funds see the need to apply a formalised bidding procedure as being the most serious obstacle to the conclusion of future contracts. The associated expense would probably even further aggravate the already evident cost problems of integration contracts. This particularly applies to smaller health insurance funds, where such costs per contract participant have greater weight.

The regulations on budget adjustment are a similarly serious obstacle. Here, too, a major administrative effort is involved. Moreover, there is a risk that, in the negotiations with the Associations of SHI-Accredited Physicians, some of the services provided in the framework of the selective contract may not be recognised as adjustment-relevant and that the amount to be adjusted for an insured is well below his or her actual service requirement. This assessment of the existing method of adjustment by the health insurance funds underlines the need for reforms, such as recommended in Section 7.4, for example.

Development of special outpatient medical care according to Section 73c SGB V

223. The figures presented in Table 6 are the result of an extrapolation based on the number of insureds of the responding health insurance funds. A marked rise can be seen not only in the number of contracts, but also in the number of participants and the expenditure.

	2008	2009	2010	2011
Contracts	168	322	422	538
Participants	136,520	144,090	584,330	716,281
Expenditure	23,636,803	26,803,772	46,784,759	62,553,342

Table 6: Development of special outpatient medical care according to Section 73c SGB V

n = 61 health insurance funds

Source: Own calculation

From the point of view of the health insurance funds, the most important aspects for the failure of promising concepts for special outpatient medical care were volume increases on the part of the healthcare providers. Several health insurance funds noted in the spaces for free comments that volume increases resulted in contracts according to Section 73c SGB V driving up costs. This problem counteracts the low-cost procurement of healthcare services that is the principal motive of the health insurance funds for participating in special outpatient medical care. Much as in integrated care, adjustment problems also played an essential role. When weighted according to the number of insureds, this aspect is again the most serious one in this context. The least problem appears to be the insufficient ability of the health insurance funds to assess the quality of the doctors.

7.6.2 Survey of hospitals

Participation rates and numbers of contracts

224. 37.1% of the hospitals participated in integrated care in 2010. Participation varies greatly, depending on the number of beds. Only 21.6% of the hospitals with between 50 and 149 beds participate, and 31.4% of the hospitals with between 150 and 299 beds. With between 300 and 499 beds, the figure already rises to 45.5%, while 61.6% of the hospitals with 500 beds and more participate in contracts of this kind.

The differences are also substantial when distinguishing according to the level of care: while only roughly one-third of basic- and standard-care hospitals participate, the figure for maximum-care hospitals is more than two-thirds. Moreover, there are significant differences depending on the type of settlement structure. While only 18.3% of the hospitals in rural areas participate in integrated care, the figure for core cities is 54.9%. However, the degrees of the variables "level of care" and "type of settlement structure" correlate strongly with the number of beds, meaning that the different participation rates are also partially attributable to effects of scale.

225. The raw result for the participating hospitals showed 626 integrated-care contracts for 2010 and 637 contracts for 2011. An estimate of the total number of contracts, based on the number of beds, yielded a result of 1,490 contracts for 2010 and 1,518 for 2011.

In the framework of integrated forms of care, 47.8% of all hospitals exchange structured admission and discharge information, in addition to conventional care. Similarly, 47.8% of hospitals additionally apply special treatment paths and guidelines. This is followed, a good way behind, by quality circles (31%), patient surveys (29.4%), additional quality indicators (27.8%) and patient training (26.3%). In contrast, of extremely little importance are additional measures for detecting and avoiding errors, and quality-oriented remuneration ("pay for performance"). In last place, with a figure of 7.1%, comes the shared electronic case or patient file.

Reasons for not participating in integrated care according to Section 140a-d SGB V

226. For hospitals, there are two decisive reasons for not participating in integrated care: the uncertainty of its economic success for 46.9% of the non-participating hospitals, and the major bureaucratic effort for 43.5%. The third most frequently indicated reason (28.5%) is the lack of contract partners on the health insurance fund side. As when providing services according to Section 116b SGB V, potential conflicts with non-participating healthcare providers, e.g. referrers, additionally play an important role for 25.6% of the hospitals. Moreover, no less than 23.8% of the hospitals can see no significant problems at the interfaces of healthcare and do not participate in integrated care for this reason.

A lack of cooperation partners on the healthcare provider side, a lack of interest among treating physicians, and legal uncertainty are apparently of only moderate importance for non-participation. In contrast, failure of the hospital to meet the prerequisites for participation, e.g. due to insufficient size or lack of capacities, hardly plays a role at all. Finally, lack of interest or scepticism on the part of patients is the least frequently named reason.

21.7% of all the hospitals surveyed that do not so far participate in forms of integrated care, would like to change this within the next two years. This result suggests a substantial, hitherto unexploited hospital potential.

Terminated contracts

227. The hospitals that had taken part in integrated care according to Section 140a-d SGB V at some time in the period 2008 to 2010 were requested to indicate how many of their contracts had expired or been terminated between the end of 2008 and the end of 2010. The 273 hospitals responding to this question together terminated 197 contracts during this period. However, only 41.7% of these hospitals had terminated one or more contracts, 58.3% having terminated no contracts.

In the great majority of cases, the health insurance funds took the initiative in terminating contracts. 46.6% of the hospitals affected by contract terminations indicated that they would have liked to continue these contracts.

From the point of view of the hospitals, by far the most important reason for terminating contracts was insufficient case numbers. This result fits in with the statements by the health insurance funds that an insufficient number of participants was a decisive reason for terminating contracts. The hospitals state inadequate remuneration as the second most important reason. All in all, therefore, the hospitals were of the view that economic reasons were primarily responsible for the termination of contracts, and equally for not participating in integrated care. In third place, a lack of interest on the part of the treating physicians appears to have played a more important role in the termination of contracts than in non-participation.

A lack of interest, or scepticism, on the part of patients played at least a certain role in the termination of contracts, both for the hospitals and equally for the health insurance funds, in contrast to the reasons for non-participation. On the other hand, while being feared by the non-participating hospitals, potential conflicts with referrers are apparently of almost no importance for the termination of contracts. This could be due to the fact either that only those hospitals where no conflicts probably need to be expected participate in integrated care, or that non-participating hospitals overrate this problem.

Expectations of integrated care according to Section 140a-d SGB V, and satisfaction

228. According to the statements by the hospitals, the most important reason for participating in integrated care was to improve patient satisfaction. The fulfilment of expectations also achieves its highest value for this criterion. An increase in the number of cases and greater referrer loyalty are the second and third most important reasons for participation. Here, too, the motive of boosting income dominates, particularly the volume component, ahead of the price component. Better or additional remuneration only follows in sixth place. Coming in fourth place, the image gain for the hospital probably likewise has the long-term goal of at least maintaining, or preferably increasing, the number of patients.

In contrast, aspects relating to the reduction of interface problems between different healthcare sectors, which are of particular interest for this Report, play only a subordinate role as regards the participation of hospitals in forms of integrated care. The last five places

are taken by (alongside the other cost reductions) better coordination with doctors in private practice, improved admission and discharge management, shorter periods in hospital, and facilitation of the provision of outpatient services by hospitals. Better coordination between the sectors plays a slightly greater role for the health insurance funds, possibly because they themselves are more severely affected by the financial consequences of coordination problems.

The expectations of the hospitals were most badly disappointed as regards referrer loyalty. There is likewise a major gap between expectations and reality as regards the number of cases and the increase in patient satisfaction.

Comparison between health insurance funds and hospitals

229. 71.6% of the health insurance funds consider the quality in the integrated forms of care to be better than in conventional care, while 27.2% find it equally good and only one health insurance fund is of the opinion that conventional care is better. In contrast to the health insurance funds, a large majority of 69.2% of the hospitals consider the care to be equally good. 5.3% even find conventional care better. Only slightly more than one-quarter of the hospitals think healthcare in the integrated forms of care is better. So, as regards their verdict on quality, the hospitals are far more sceptical than the health insurance funds.

Much the same applies as regards the fulfilment of expectations of integrated forms of care in general. While almost half of the health insurance funds see their expectations as being fulfilled, the figure for the hospitals is just 32%.

The lesser satisfaction of the hospitals initially appears to be contradictory to the fact that it was particularly the health insurance funds that terminated contracts. However, bearing in mind that the dissatisfaction of the hospitals mainly originates from the fact that not enough patients participate in the contracts and too little turnover is ultimately generated, these two findings do appear to be compatible.

7.7 Liberalisation of the European healthcare markets

230. Liberalisation of Europe's healthcare markets was essentially brought about by the strengthening of patient rights in the event of cross-border utilisation of healthcare services. The cross-border utilisation of healthcare services is ultimately a question of whether and to what extent a health payer of a national health system must pay for the costs of a healthcare service utilised by a patient in another Member State of the European Union.

European law grants patients rights regarding the cross-border utilisation of healthcare services, not only through secondary legislation regarding the coordination of social security systems (now Regulation (EC) No. 883/2004), but also, since the leading decisions in the Decker and Kohll cases, also through primary legislation.

Unlike the Regulation law, which is based on the principle of provision of benefits in kind, the claim to cost reimbursement derived from primary legislation directly targets the competent national health payer and is limited to the amount refundable under the national system.

The German legislature reacted to this decision of the ECJ regarding the claim to cost reimbursement in the event of cross-border utilisation of healthcare services, creating Sections 13 Para. 4 and 5, and 140e SGB V in connection with the SHI Modernisation Act (GMG) of 14 November 2003. The European legislature took up the principles of the ECJ decisions by issuing "Directive 2011/24/EU on the application of patients' rights in cross-border healthcare" in March 2011, which has to be transposed into the national law of the Member States by 25 October 2013. According to Art. 1 Para. 1, first sentence, and Recital No. 10, the Directive, which is based on Arts. 114 and 168 TFEU, aims to establish rules for facilitating access to safe and high-quality cross-border healthcare in the Union, to ensure patient mobility and to promote cooperation on healthcare between the Member States.

The formulation of the claim to cost reimbursement in the Directive reveals a marked difference between sectors: the utilisation of outpatient healthcare services in another Member State generally does not require approval. In contrast, provision can be made for an approval procedure prior to inpatient care. The ECJ considers approval to be necessary and reasonable in this field, in order to ensure efficient, stable, balanced and good hospital care. In other words: the approval procedure is designed to cater to the circumstance that inpatient treatment abroad normally causes significantly higher costs for the national health payer than outpatient treatment. Moreover, hospital treatment necessitates much more extensive planning. A situation must be avoided where the national health system incurs double extra costs as a result of empty beds in domestic hospitals, on the one hand, and additional treatment costs abroad, on the other. Approval may only be denied if it is ensured that the service can be provided domestically "within a medically justifiable period of time". The German legislature availed itself of the possibility of providing a requirement for approval in Section 13 Paras. 4 and 5 SGB V.

This makes it far less attractive for patients to utilise inpatient rather than outpatient treatment in other EU countries, since the claim to cost reimbursement is uncertain and such treatment presupposes a time-consuming approval procedure. This assumption is confirmed by the analysis of the results of the Techniker Krankenkasse health insurance fund for 2007: according to these figures, inpatient treatment accounts for only 7% of the treatments received by insureds of the Techniker Krankenkasse in other European countries.

8 Competition in healthcare services and the supplementary contribution

8.1 The supplementary contribution as a competitive parameter of the health insurance funds

231. As illustrated above in Fig. 1 in Section 2.4, the insureds or patients have choices at two levels or in two fields of competition in the SHI system: on the one hand, they have a choice between different, competing health insurance funds and, on the other hand, they can choose among various healthcare providers, who compete with each other, and possibly different forms of healthcare and types of service. In this context, it is the contribution that plays the key role in the insurance sector, as a price signal for the members, while the health insurance funds have the competitive option in the healthcare services sector of distinguishing themselves by means of selective contracts reflecting the preferences of the insureds, for example. Given sufficient transparency in the insurance and healthcare services sectors, insureds can also make these two choices/decisions simultaneously. There has so far been significantly greater (market) transparency in the insurance sector of SHI, than in the healthcare services sector. It is logical that, in competing with each other, the health insurance funds pay more attention to the comparatively obvious and easily remembered contributions in the insurance sector than to the hard-to-measure and more intransparent quality criteria and differences in healthcare services. Accordingly, there is an all too one-sided dominance of price-based competition over quality-based competition in the healthcare services sector. It is therefore incumbent upon the competitive framework system to give the health insurance funds such incentives that they gear themselves to the preferences of the insureds, both in their price-based competition and in their quality-based competition.

232. Since, given the benefits-in-kind principle prevailing in SHI, the price plays hardly any role for the users when utilising services, and they consider the range of services of the health insurance funds and its quality to be largely homogeneous, the contribution rate was, following introduction of the free choice of health insurance fund, the dominant decision-making criterion and, consequently, the dominant competitive parameter for the health insurance funds, until the end of 2008. Following introduction of the standard contribution rate by the Act to Strengthen Competition in SHI at the start of 2009, the focus shifted to the

supplementary contribution or the possibility of bonus distributions. For the health insurance funds, this eliminated the contribution rate as an instrument of competition, but not the contribution as such, since they now have the option of distinguishing themselves in terms of the level of the contribution in the insurance sector, by charging a supplementary contribution or distributing a bonus. This switch in no way restricted the competition of the health insurance funds on the revenue side, but greatly intensified it. First, the fixing of the employers' contribution rate intensifies competition, since the expenditure differences between the health insurance funds are now reflected solely in the employees' contributions. In addition, being a lump sum, the supplementary contribution is more easily remembered than contribution rate differences, and it is not automatically withheld by the employer.

233. As a result of the relatively high general contribution rate, which was presumably defined by the legislature based on the assumption of a less prosperous economic trend, and the still quite favourable economic situation, the average supplementary contribution is currently zero. Nonetheless, as experience in recent years has shown, individual health insurance funds may find themselves forced to charge a fund-specific supplementary contribution, while others may be in a position to distribute a bonus to their members. The causes of these differences in the fund-specific supplementary contributions may be attributable, among other things, to the following factors and divergences:

- Level and structure of optional and additional benefits,
- Density of the branch network and intensity of service,
- Economising on the checking of hospital bills, discount agreements and avoidance or reduction of sickness benefit claims,
- Management and cost reduction in the administrative sector, and
- Imperfections still existing in the risk equalisation scheme.

If the average supplementary contribution exceeds two percent of the assessable income of a member, this member has a claim to social compensation according to Section 242b Para. 1 SGB V, this being financed from taxes. The linking of this social compensation to the average supplementary contribution, rather than the fund-specific supplementary contribution, also provides an incentive for members who do not pay the contribution themselves, or have a claim to this social compensation, to switch to health insurance funds that do not charge an above-average supplementary contribution. On the one hand, this intensifies competition and, at the same time, offers the chance of a certain degree of mixing of the members of the health insurance funds in social terms. Financing the social compensation from taxes leads to a situation where not only the members of the SHI system contribute to it, but also people with private health insurance. While the linking of social compensation to assessable income causes a relatively minor administrative effort, it falls short in terms of social policy. In this respect, a more appropriate reference variable in the spirit of the financial capacity of a member, the "gross annual income for subsistence", is to be found in

the regulation that applies to co-payments, e.g. for drugs, remedies and therapeutic appliances, in the framework of the hardship clause according to Section 62 Para. 1 SGB V.

8.2 Intensification of changes of health insurance fund by the supplementary contribution

234. In the period from 2000 to 2009, roughly five percent of SHI members per year changed their health insurance fund. Prior to introduction of the currently valid contribution system, the price differences between the individual health insurance funds were much greater than today. For the period up to 2009, numerous studies showed that the contribution rate was the dominant competitive parameter and the key variable influencing a change of health insurance fund. In contrast, differences in benefits, special forms of care or differences in the service offered played only a subordinate role.

235. A good three years after introduction of the new legal situation, empirical analyses continue to confirm the outstanding importance of financial aspects. Insureds affected by a supplementary contribution demonstrate substantially greater willingness to change: the charging of a supplementary contribution was repeatedly identified as the principal motive of insureds for changing. This led to significant migration, particularly in 2010 and 2011. As a result, roughly 90% of all net member losses of the statutory health insurers were recorded by health insurance funds charging a supplementary contribution.

Four of the insurers among the twenty largest health insurance funds in Germany charged a supplementary contribution at the end of 2011. Between the beginning of 2010 and 1 October 2011, the number of members of these four health insurance funds had decreased by an average of 12.6%. All in all, the number of members of these four health insurance funds alone fell by more than a million persons in less than two years. Particularly among relatively young, healthy, educated persons, the charging of a supplementary contribution is the factor triggering a change of health insurance fund and can hardly be compensated for by the insurer offering additional benefits or services.

236. Further studies confirm the marked intensification of price-based competition: prior to introduction of the Health Fund and supplementary contributions, the individual probability of a change was roughly five percent. In the current system, this value is in the region of ten percent for the groups of insureds affected by supplementary contributions. It is also remarkable that the converse effect of a contribution refund is far less pronounced. According to this study, members not paying a supplementary contribution display an individual probability of change of only about 3.5%. It is also worth while to examine the connection between the changes of health insurance fund actually undertaken and preceding price increases: while, before the reform, the individual probability of a change in the event of a contribution increase of € 10 per month statistically rose from 5.6% to 6.5% (i.e. by 0.9 percentage points), the difference after the reform is about six percentage points.

Moreover, an almost threefold increase in price elasticity on the demand side can be seen since introduction of the new contribution structure in 2009. The strong intention to change following even small supplementary contributions illustrates the large proportion of price-sensitive insureds. The small leeway of the health insurance funds for distinguishing themselves by way of their benefits is hardly perceived by insureds today and is not capable of compensating for supplementary contributions.

8.3 Empirical findings on the choice of health insurance fund

237. To obtain information regarding the preferences of insureds when choosing a health insurance fund, the Council evaluated various surveys of insureds by health insurance funds, as well as other relevant literature on the subject. Only in few studies were the respondents asked to compare different price or performance aspects in the sense of an assessment of the price/performance ratio. Studies that ask about the insureds' wishes, without a need to weigh up or arrange in order, are of limited informative value; however, if they were otherwise suitable, these studies were not excluded, since they still yielded some insights. It must also generally be borne in mind that a major proportion of insureds would preferably not like to tackle the subject of health insurance cover at all, reacting to new options with uncertainty and scepticism, all the way to total rejection.

238. Referred to the part of the competitive instruments perceptible by insureds, health insurance funds can at the moment essentially distinguish themselves from each other, and thus compete for insureds, in the following four areas:

- Price (supplementary contribution, bonus distribution, contribution-relevant optional tariffs),
- Quality/organisation of care (e.g. integrated care, GP-centred care, special networks, etc.),
- Scope of the benefits offered/benefit volume (e.g. additional prevention offers, optional benefits, accommodating granting of benefits, etc.),
- Service aspects (branch network, hotlines, etc.).

239. It can first of all be stated that the identified surveys and studies examining the preferences of insureds when choosing their health insurance almost unanimously arrive at the conclusion that price-related arguments (the contribution rate in the past, the supplementary contribution today) are of eminent importance for the decision to change or stay put. Only if supplementary contributions and bonus payments pay no role in the considerations of the insureds (i.e. if neither the current, nor the potential new health insurance fund gives such price signals) are further arguments also of importance. Persons with no intention to change are another, important exception. Thus, benefit-related arguments are primarily of interest to customers with no acute interest in a change, also contributing to

their willingness to stay put – this applies at least as long as no event causing dissatisfaction occurs in the form of the charging of a supplementary contribution.

Analysis of the benefits side shows that many different individual measures can contribute to the satisfaction of the insureds. However, it should also be borne in mind when assessing the findings that several studies contained indications that the insureds are hardly aware of the benefits offered by their health insurance fund.

It can be concluded from a number of studies and surveys that insureds primarily attach great value to promises of a particularly high quality of care and good treatment coordination, as well as "preferential treatment" with access to innovations and a network of specialists. On the other hand, the free choice of healthcare provider is also of great importance to the insureds. Roughly 40% of insureds would not even sacrifice this freedom if they were offered financial compensation in addition to better coordination of healthcare. When explaining this apparent contradiction, it may play a role how highly the insureds rate the credibility of the promise of better coordination.

Some studies additionally indicate the importance of extended preventive healthcare offers or other preventive health promotion offers, and also of image. In contrast, such aspects as the offer of alternative therapeutic treatments or local reachability in the form of a dense network of branches are – relative to the other items – of less relevance to the insureds. All in all, however, it can be stated as regards these benefit-side arguments of the health insurance funds that the insureds currently do not assign any of these individual aspects any value that could compensate for the charging of a supplementary contribution.

240. No unequivocal statements regarding optional tariffs are available from surveys or studies, but conclusions regarding the preferences of the insureds could be drawn from the concrete number of participants. At first glance, the high number of participants of approx. 8.5 million insureds in optional tariffs for special forms of care (according to Sections 63, 73b, 73c, 137f or 140a SGB V) confirms the previously identified preference for offers for improving the quality of care and treatment coordination. However, it is questionable at this point whether the insureds registered here are really always aware that they have joined an optional tariff.

241. To sum up the insights gained in the framework of this section, it is necessary to come back to the categories of options for competitive action mentioned at the beginning. From the point of view of the insureds, the order is roughly as follows:

1. Price,
2. Quality/organisation of care,
3. Scope of the benefits offered/benefit volume,
4. Service aspects.

Differences in the preference-driven choice of insurance primarily exist as a function of age, gender, health status and level of information of the insureds. When it comes to changing health insurance fund, young insureds with a good income and good education prove to be more flexible than older and health-impaired insureds. The latter, however, are the ones who can judge the quality of care (and thus also the benefit volume and organisational performance of the insurer) on the basis of their own experience.

Digression: Own survey on the competitive parameters of the health insurance funds

a) Importance of existing options of the health insurance funds for competitive action

242. In contrast to the insureds, there are hardly any studies on the attitudes of the health insurance funds. The Council thus included a second part on the competitive parameters of the health insurance funds in its survey of health insurance funds (see 7.6).

The survey focused on three questions:

- How important are the existing options for competitive action of the health insurance funds, and to what extent are they utilised?
- How important is the supplementary contribution for the actions of the health insurance funds?
- What further options for action would the health insurance funds like to have?

Instruments for reducing costs

243. The health insurance funds were asked to rate the importance of various instruments for reducing costs on a five-point Likert scale, higher numbers indicating greater importance (1 = not at all important; 5 = extremely important). The means of these ratings are presented in Table 7.

Instruments	Mean
Checking of hospital bills	4.77
Discount agreements with pharmaceutical companies	4.45
Avoidance or reduction of sickness benefit claims	3.81
Checks of outpatient physicians (accounts, prescriptions, etc.)	3.65
Case Management	3.51
Contracts with therapeutic appliance manufacturers	3.46
Check of prescriptions for remedies and therapeutic appliances	3.44
Efficiency improvements in administration	3.26
Management of the obligation to pay of other social insurance agencies (long-term care insurance, accident insurance, pension insurance)	3.11
Fund-specific organisation of GP-centred care	3.10
Targeted prevention measures (savings also from measures in previous years)	3.09
Control of (other) misconduct in the health sector, e.g. abuse of patient chip cards	3.04
Contracts for integrated care	2.96
Agreements with healthcare providers on financial incentives for cooperation in the exploitation of efficiency reserves according to Section 128 Para. 6 SGB V	2.91
Fund-specific organisation of rehabilitation measures	2.82
Fund-specific organisation of Disease Management Programmes	2.74
Contracts for special outpatient medical care	2.73
Retentive granting of rehabilitation benefits in the framework of the statutory specifications	2.54

Table 7: Instruments of the health insurance funds for reducing costs (assessment from the point of view of the health insurance funds)

n = 87 health insurance funds

Source: Own calculations

The checking of hospital bills takes a clear first place. The only slight spread of the responses additionally shows that the health insurance funds largely agree in this assessment. Well ahead of the remaining measures, discount agreements with pharmaceutical companies are the second most important instrument for reducing costs.

The third most important measure is sickness benefit management. Even before the start of sickness benefit payments, many health insurance funds check whether incapacity to work really does exist, and what assistance can possibly be granted to restore the capacity to work. Fourth place is taken by checks of outpatient physicians. These checks will probably become even more important after implementation of the Act on the Stabilisation and Structural Reform of SHI.

In fifth place comes Case Management. Counselling and coordination services, tailored to individual insureds, are offered in an attempt to provide better, more effective and less expensive treatment for high-expenditure patients, in particular. In sixth place come contracts with therapeutic appliance manufacturers according to Section 127 SGB V. Further measures involving checks follow in seventh, ninth and twelfth place. Eighth place is taken by efficiency improvements in the health insurance funds' own administration. Tenth place goes to the fund-specific organisation of GP-centred care. Coming in eleventh, prevention measures take only a lower-middle place. The health insurance

funds appear to share the frequently expressed view that prevention cannot make any major contribution to reducing costs.

A more sceptical view tends to be taken of most of the options of the health insurance funds for steering healthcare, i.e. contracts for integrated care according to Section 140a-d SGB V, fund-specific organisation of rehabilitation measures and Disease Management Programmes and, lastly, contracts for special outpatient medical care. The unfavourable assessment of DMPs is not surprising, since the health insurance funds in fact have only very few options of their own and the programmes of different health payers hardly differ at all. The poor assessment of contracts for special outpatient medical care is consistent with the survey results on this form of healthcare in Section 7.6, the complaints of the health insurance funds particularly relating to volume increases by the healthcare providers and budget adjustment problems (resulting in double payments).

An unfavourable rating is likewise given to agreements with healthcare providers on exploiting efficiency reserves according to Section 128 Para. 6 SGB V. Clearly the poorest rating is given to reticent granting of rehabilitation benefits. This could, however, be due to "socially desirable response behaviour" on the part of the respondents.

Instruments for improving the quality of care and the satisfaction of the insureds

244. In complete contrast to the potentials for reducing costs, prevention measures get the top rating in this context, followed by optional benefits. Case Management, in third place, also appears to be highly suitable for the purpose of improving quality. A far more positive assessment in relation to quality is likewise given of selective contracts for integrated care according to Section 140a-d SGB V and of special outpatient medical care, these two items taking fourth and fifth place, respectively. They are followed by patient information and counselling, generous granting of benefits, reduced copayments, optional tariffs, supplementary insurance and rehabilitation measures. A more critical assessment is given of the fund-specific organisation of Disease Management Programmes and GP-centred care. Even poorer ratings are achieved by agreements with healthcare providers according to Section 128 Para. 6 SGB V and contracts with Associations of SHI-Accredited Physicians for promoting quality. Far behind in the last two places come the arrangement of treatment abroad and the promotion of self-help.

Substantial differences emerge if the responses of the health insurance funds are weighted with their numbers of insureds. Patient information and counselling appears to be very important to large health insurance funds. According to their own statements, large health insurance funds are in a better position than smaller ones to exploit the options of selective contracts for integrated care according to Section 140a-d SGB V and special outpatient medical care to improve the healthcare provided.

245. In view of the expanded possibilities for offering optional benefits, provided for in the Act on the Stabilisation and Structural Reform of SHI, this instrument was

examined more closely in the Council's survey. Exactly one-half of the health insurance funds expect that this expenditure will increase in the next two years. In contrast, 44% expect no change and 6% even anticipate a decline. By far the most commonly named new possibility for optional benefits is expansion of prevention services, which were already dominant up to now. 45.8% of all health insurance funds will most probably exploit this option, while only 9.6% rule it out. This result is also consistent with the highly positive assessment of prevention as a means for improving quality and the satisfaction of the insureds. 32.6% of all health insurance funds have plans to conclude individual contracts with non-accredited healthcare providers. The "psychotherapy" and "outpatient treatment in hospital" benefits not included in the Act on the Stabilisation and Structural Reform of SHI fare much better in the assessment of the health insurance funds than many other possible optional benefits. By far the greatest rejection is recorded for the supply of non-prescription drugs (45.7%).

Taking the unweighted results, it can be seen that a majority of the health insurance funds (62.5%) would prefer to offer additional benefits in the framework of optional benefits, only 30% preferring optional tariffs. When weighted by insureds, however, the majorities are reversed: 50% would prefer to provide the benefits as optional tariffs, and only 42% as optional benefits. This reveals different relative appreciations of optional benefits and optional tariffs by small and large health insurance funds. For example, the administrative effort for costing, approval and announcement of optional tariffs could have a stronger deterrent effect on many small health insurance funds.

Regarding the contract terms and conditions, it would be conceivable, for example, for the minimum commitment periods to be defined by the health payers themselves – at least within a statutory framework. Also conceivable are waiting periods, such as are customary in private health insurance. This would make it possible, for example, to prevent insureds from deciding on optional tariffs just at the time when they would like to utilise the corresponding benefit. 67% of all health insurance funds would like options of this kind, the figure rising to 86% when weighted by insureds. 60% of all health insurance funds would like greater room to manoeuvre as regards the premiums for the optional tariffs. When weighted by insureds, this figure increases to 83%.

Efficiency of different instruments from the point of view of the health insurance funds

246. Several of the examined instruments of the health insurance funds are fundamentally suitable both for reducing costs and for improving the quality of care. Therefore, the mean of these two assessments was calculated. It can be interpreted as being an approximate measure of the efficiency of an instrument from the point of view of the health insurance funds, since it gives simultaneous consideration to the assessment dimensions of quality and costs.

Accordingly, Case Management appears to be most efficient. This is all the more remarkable in that, unlike most of the other instruments mentioned here, it was never the subject of special promotion. It is, however, difficult to state figures regarding the persons for whom the health insurance funds practise Case Management, since they subsume very different activities under this term. The results must be interpreted with corresponding caution. According to their own statements, the health insurance funds practise Case Management for an average of 2.1% of their insureds. Extrapolated to SHI as a whole, this would mean roughly 1.4 million people. This result is, however, too high owing to a number of outliers. The median is less than one percent, meaning that it should more likely be assumed that Case Management is applied to roughly 700,000 people.

Prevention activities follow in second place, ahead of contracts for integrated care according to Section 140a-d SGB V and for special outpatient medical care. GP-centred care takes a middle position. Rehabilitation measures and Disease Management Programmes are considered to be less efficient. Last place is taken by agreements with healthcare providers according to Section 128 Para. 6 SGB V.

The results look very different if the responses are weighted with the number of insureds. In this case, contracts for integrated care according to Section 140a-d SGB V are regarded being as the most efficient instrument. Disease Management Programmes likewise fare much better, as does GP-centred care. In contrast, the large health insurance funds rate prevention as less efficient. Here, again, agreements according to Section 128 Para. 6 SGB V bring up the rear.

Attitude of the health insurance funds towards supplementary contributions

247. By exercising their options for action discussed so far, the health insurance funds can exert an influence on the level of the supplementary contribution to be charged by them. Many consider it to be the most important parameter in the competition between funds. It is widely agreed that insureds react much more strongly to the supplementary contribution than to the differences in contribution rates of the past. This is completely or predominantly true in the opinion of 87% of the health insurance funds. A similarly great majority of the health insurance funds is of the view that the supplementary contribution will also continue to be by far the most important competitive parameter in the next few years. 89% of the health insurance funds state that this is completely or predominantly true.

There is slightly less agreement with the statement that a massive number of members would be lost if their own health insurance fund were to charge a supplementary contribution. Even fewer health insurance funds agree unconditionally with the statement that not even higher quality of care and service could stop the loss of members caused by supplementary contributions. However, 33% of the health insurance funds are

still of the view that this is completely true, while 39% think that it is predominantly the case.

The opposite picture is, however, obtained when the health insurance funds are asked about their actual behaviour. Only 5% state that they have on some occasion terminated contracts for special forms of care, or not signed them in the first place, because of concerns about the need for a supplementary contribution. The only small proportion of health insurance funds whose contracting activities are influenced by the supplementary contribution, could also be attributable to the fact that many of the responding health insurance funds have such adequate financial reserves that a supplementary contribution does not currently constitute a real threat for them. Moreover, since the additional costs for contracts for special forms of care are very low in relation to total expenditure, they are probably of no relevance as regards the supplementary contribution.

The result concerning the influence of the supplementary contribution on the contracting behaviour of the health insurance funds is consistent with the results of the survey on the reasons for terminating contracts for integrated care according to Section 140a-d SGB V, where a relatively small proportion of health insurance funds likewise confirmed that the supplementary contribution was of importance. However, this survey only covered the reasons for terminating contracts up to and including 2010. The supplementary contribution also never took one of the top places when questions were asked about obstacles to the conclusion of contracts for integrated care and for special outpatient medical care.

A mean of 4.7% was obtained for the share of expenditure on benefits that the health insurance funds can, in their own view, control and influence themselves (as opposed to expenditure governed by statutory regulations or by joint and uniform action). It is plausible to suspect that large health insurance funds can exert more influence on their expenditure. This is illustrated by the fact that a figure of 6.3% is obtained when the responses are weighted with the number of insureds. All in all, however, these results do show how limited the options for action of the health insurance funds are in relation to overall activity in the health sector.

b) Further options for action wanted by the health insurance funds

248. In the framework of this survey, 79% of all health insurance funds stated that they would like to be able to control a greater share of their expenditure themselves. In contrast, no less than 21% reject this. When weighted according to the number of insureds, 97.5% would like greater freedom of action. This makes it very clear that health insurance funds with few insureds, in particular, do not want tougher competition.

Top priority goes to selective contracting with hospitals, which is so far only possible in the framework of integrated care according to Section 140a-d SGB V. Second-highest

priority was given to extended options for checking outpatient services and bills. Third place is taken by options for selective contracting in the framework of the outpatient specialist care segment newly created by the Act on the Stabilisation and Structural Reform of SHI. However, there is so far no provision for control by means of selective contracts in this new field of care (cf. Chapter 6). In fourth place come expanded possibilities for offering optional benefits, as provided for by the Act on the Stabilisation and Structural Reform of SHI, followed by expanded possibilities for offering optional tariffs. Coming in sixth place, the re-introduction of start-up financing is more of medium priority. The group tariffs that follow are a measure already provided for in earlier drafts of the Act on the Stabilisation and Structural Reform of SHI. The health insurance funds are less willing to assume the task of guaranteeing hospital care, possibly because it often necessitates unpopular decisions and can prove to be very expensive and time-consuming.

Low priority is given to the introduction of an Innovation Fund. In this context, many health insurance funds could fear not receiving an allocation, or of receiving correspondingly smaller allocations from the Health Fund as a result of prior deductions. Finally, last place is taken by expanded options for the health insurance funds to operate their own institutions.

The health insurance funds were moreover asked to state whether they would themselves implement the measures previously rated with priorities, should they have the possibility of doing so. The checking of outpatient accounts received the highest number of "yes" replies. The optional benefits took second place. Otherwise, the order of "yes" replies is largely identical to the order of priorities.

However, there is a massive change in the proportions of "yes" replies when the responses are weighted with the number of insureds of the respective health insurance fund. Well over 90% replied "yes" to the three measures considered to be the most important by the health insurance funds. The re-introduction of start-up financing also did very well, with a figure of 89%, as did the Innovation Fund with 86%. It can again be seen here that larger health insurance funds have a generally more positive attitude towards creative options of their own.

Selective contracting

249. Both health insurance funds and hospitals were asked whether they would make use of various forms of selective contracting if they had the option of doing so. As expected, the greatest approval of the hospitals (73%) was recorded for higher case-specific flat-rate fees in return for additional quality demands. However, 37% of the health insurance funds would also make use of this option. The second-highest level of approval among the hospitals (46%) and the highest level of approval among the health insurance funds (64%) was achieved by budget responsibility of the hospital for the entire

treatment chain. This form achieves the highest overall level of agreement between hospitals and health insurance funds. It is also promising in that it offers approaches for overcoming the sector boundaries.

The second-highest level of approval among the health insurance funds (63%) is recorded by the selection of hospitals on the basis of quality criteria (in the case of elective benefits). However, with a figure of 26%, this possibility receives the lowest level of approval from the hospitals, meaning that comparatively few contracts can be expected to be concluded.

Willingness to engage in selective contracting generally grows with increasing size of both the health insurance funds and the hospitals. Consequently, in the case of large units, the levels of mutual agreement are far more favourable still than those presented here.

8.4 Competitive aspects of the supplementary contribution

250. Some elements in politics and the media additionally encouraged the anticipated intensification of changes of health insurance fund, and thus of competition, by stigmatising the supplementary contribution as being an indicator of inefficiency. A further reason for the substantial intensification of changes of health insurance fund as a result of the introduction of the supplementary contribution was its original and current reference level of zero. To avoid any misunderstandings: this Report is not concerned with the fundamental advantages and disadvantages of flat-rate per capita contributions as opposed to income- or wage-dependent contributions. However, the current reference level of zero does tend to trigger major reactions on the part of the insureds to even small price differences. From the point of view of competition, it certainly makes a relevant difference whether a health insurance fund charges an 8 Euro higher supplementary contribution starting from a reference level of zero or of 40 Euros. Against the backdrop of these fundamental and situative aspects, it was not surprising that no health insurance fund charging a supplementary contribution succeeded in compensating for this price disadvantage with comparative advantages in healthcare services.

251. The empirical findings show that the price component in the insurance sector was already the dominant reason for insureds to change their health insurance fund, even before the introduction of supplementary contributions. Quality differences between the benefits offered – if they existed at all – played a much smaller competitive role, simply because of their lack of transparency. Since the supplementary contributions intensified price-based competition in the insurance sector, and thus also in the healthcare services sector, the years 2010 and 2011 saw the health insurance funds continue to concentrate one-sidedly on the price component, while quality-based competition got stuck in its infancy, despite various efforts on the part of the legislature. Regardless of the importance of price-based competition, the aim from the target-oriented point of view must be to avoid a situation where

one-sided competition, geared to the short term, to avoid supplementary contributions prevents the emergence of more long-term, quality-based competition for innovative forms of care in the first place. The orientation of the health insurance funds needs a longer-term perspective and corresponding planning security to this end. At the same time, apart from valid indicators, functioning quality-based competition presupposes a willingness of the healthcare providers and their associations to face up to these processes and implement corresponding remuneration systems in agreements with the health insurance funds.

252. Given that the Health Fund is in a highly favourable financial position at the moment, the health insurance funds that currently charge a supplementary contribution can abolish it again this year in accordance with their announcements. A financial development of this kind could hardly be foreseen by the legislature at the time of introduction of the Health Fund, and its effects on supplementary contributions were presumably also not intended. As a result of this levelling-out of supplementary contributions, it can be expected that changes of health insurance fund, and thus also price-based competition in the insurance sector, will show a major decline this year and next. Health insurance funds that are currently generating substantial surpluses – partly thanks to the unexpectedly favourable economic trend – can fundamentally use them to

1. Distribute bonuses to their members,
2. Set up or boost their reserves,
3. Adopt optional benefits, particularly according to Section 11 Para. 6 SGB V, or
4. Invest in innovative healthcare concepts.

253. Against the backdrop of the foreseeable financial developments in SHI from 2013 onwards, where the assessable income will probably rarely grow faster than expenditure, the decision of the health insurance funds to allocate current surpluses to their reserves appears to be not only understandable, but also rational, from the point of view of competition. Were a health insurance fund to disburse its surpluses to its members in the form of bonuses, it would later have to cancel this granting of bonuses and, moreover, then charge a supplementary contribution sooner, meaning that a positive action from the point of view of the members would later be offset by two negative decisions. In addition, the results of surveys show that insureds and members do not rate the granting of bonuses as positively as they rate supplementary contributions negatively. Furthermore, according to Section 175 Para. 4 SGB V, the insureds and members have a (special) right of termination when a health insurance fund charges a supplementary contribution for the first time, increases it or reduces a bonus payment. Ultimately, every change in bonus payments and supplementary contributions entails administrative friction costs for the health insurance funds.

254. If an attempt is to be made to counteract the declining willingness of insureds to change health insurance fund owing to there being no supplementary contributions this year and next, the following fundamental options are available:

1. Reduction of the tax subsidy with a given general contribution rate of 15.5%,
2. Reduction of the general contribution rate without changing the tax subsidy,
3. Return to the system of different contribution rates (possibly with employer and employee each paying half), and
4. Obligation of the health insurance funds to pay bonuses if their reserves exceed those demanded to safeguard their solvency according to Section 261 Para. 2 SGB V by a certain percentage.

Reducing the tax subsidy, with the aim of generating a supplementary contribution, is a dubious measure from the point of view of regulatory policy. While this subsidy and its level may be a subject for debate, it should, once granted, not be dependent on the financial situation of the Health Fund and the majority of the health insurance funds – not all of them have substantial reserves – in order to give the health insurance funds the necessary planning security. From the regulatory point of view, it should be established permanently, regardless of its respectively selected form and level, in order to guarantee the health insurance funds stable framework conditions.

The general contribution rate should be reduced in target-oriented fashion, in such a way that the supplementary contribution thus generated not only leads to functioning competition in the insurance sector, but also opens up leeway for effective quality-based competition in the healthcare services sector. As already indicated, however, this presupposes ad hoc an average supplementary contribution well above the current reference level of zero. Otherwise, the intensity of changes of health insurance fund would probably reach a level similar to that at the time of the introduction of supplementary contributions in 2010 and 2011, which would tend to make it more difficult to work towards greater implementation of quality-based competition in the healthcare services sector. In this respect, competitive aspects would favour a higher average supplementary contribution, where the differences between the health insurance funds act as price signals, but do not generate hectic changes of health insurance fund. However, the legislature could not agree on a financing reform of this kind when introducing the Health Fund, and there currently does not appear to be any political willingness to do so.

A return to the system of different contribution rates, with employer and employee each paying half, does not hold the promise of a sustainable improvement, either in the insurance sector or in the healthcare services sector, as regards functioning price- and quality-based competition, since 50:50 financing distorts the price signal for the insureds, thus fundamentally weakening the intensity of competition in the insurance sector.

A statutory obligation of health insurance funds to distribute bonuses to their insureds and members under certain circumstances, restricts their latitude in both the insurance sector and the healthcare services sector, and contradicts the competitive intention of turning them from pure "payers" into creative "players" in the health system. Apart from

restricting their autonomy in the insurance sector, this compulsion would be more likely to reduce the inclination of the health insurance funds to implement innovative healthcare models in the healthcare services sector and improve their image in the eyes of their insureds by offering higher-quality services.

255. Compared to the current system and its prospects emerging under the given conditions, the outlined options do not on the whole have any comparative advantages. Following the very intensive changes of health insurance fund in the first two years after introduction of the Health Fund and supplementary contributions, weakening of this trend as a result of the temporary abolition of supplementary contributions would appear to present no problems, simply because, in the current system, numerous health insurance funds will probably already charge supplementary contributions again from 2014 onwards, this then again stimulating price-based competition in the insurance sector. Discretionary interventions on the part of the legislature would jeopardise the planning security of the health insurance funds and tend to create less favourable prerequisites for the innovative healthcare projects targeted by the Council, as well as for competitive processes relating to the quality of healthcare services. Despite the current dominance of the price signal in the insurance sector, insureds taking part in surveys also indicate significant preferences for qualitative elements in the healthcare services sector. From the point of view of the Council, the aim should be to promote this in the spirit of efficient and effective healthcare, and to make it more transparent for the insureds with the aim of achieving functioning quality-based competition.

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Legal basis for the activity of the Advisory Council on the Assessment of Developments in the Healthcare System

Social Security Code, Book Five

Chapter Five

Advisory Council on the Assessment of Developments in the Healthcare System

Article 142

(1) The Federal Ministry of Health and Social Security shall appoint an Advisory Council on the Assessment of Developments in the Healthcare System. The Federal Ministry of Health and Social Security shall establish an office to support the work of the Advisory Council.

(2) The Advisory Council shall have the task of preparing expert reports on the development of healthcare services, including the medical and economic effects. In the framework of the expert reports, the Advisory Council shall, giving consideration to the financial framework conditions and existing efficiency reserves, develop priorities for the reduction of medical services deficits and existing overuse, and indicate ways and means of further developing the healthcare system; it may include developments in other branches of social security in its reports. The Federal Ministry of Health and Social Security may define the subject of the reports in detail and also commission the Advisory Council with the preparation of special reports.

(3) The Advisory Council shall prepare the report at intervals of two years and submit it to the Federal Ministry of Health and Social Security, generally on 15 April and starting in 2005. The Federal Ministry of Health and Social Security shall present the report to the legislative bodies of the Federal Government without delay.

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