



Health reform monitor

Ensuring access to health care—Germany reforms supply structures to tackle inequalities

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ABSTRACT

Germany's ruling coalition has recently introduced a new bill to Parliament, the Care Structures Act (CSA), which aims to improve outpatient care supply structures, decentralize decision-making, facilitate cross-sectoral treatment, and strengthen innovation in the nation's health care sector. These objectives are to be achieved through a variety of measures, including changes in financial incentives for physicians, the transfer of decision-making to the regional level, and the creation of a new sector for highly specialized care.

The opposition parties in Parliament and most health care stakeholders agree on the objectives of the reform package, but their evaluation of the bill is mixed. Physicians' representative organizations generally deem the law to be headed in the right direction, while the opposition parties, sickness funds, patients' rights groups and a majority of German federal states (*Bundesländer*) feel it does not adequately address the issues of supply inequity and sectoral division.

This skepticism seems well founded. The reforms aimed at attracting physicians to high-need regions have significant shortcomings, and the measures to overcome sectoral barriers between the outpatient care and hospital sectors remain weak. Furthermore, the new procedure for including innovative treatment methods in the SHI benefits catalogue falls short of internationally recognized standards.

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1. Introduction

Germany's ruling liberal-conservative coalition² has recently introduced its third major health care reform package into the legislative process. Its two previous reform packages, the Act on the Reform of the Market for Medicinal Products (AMNOG) and the SHI Finance Act (GKV-FinG), which passed into law, focused on the insurance and provider contract markets. The currently debated

Care Structures Act (CSA) is the coalition's first attempt to reform the services market.

2. Contextual analysis and policy formulation

2.1. Political and economic background

Over the past few years, there has been an ongoing debate over whether the number of physicians in ambulatory care – both specialists and GPs – is sufficient to meet Germany's present and future health care needs. Since there is currently no scientifically proven, needs-based measure of the optimal number of physicians in this sector, the answer to this question is rather controversial. Nevertheless, there is widespread agreement that certain rural areas and, to a lesser degree, socially deprived urban areas are currently underserved or on the verge of being so.

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² "Liberal-conservative" refers to the governing coalition parties which are the (liberal) Free Democrat Party and the (conservative) Christian Democrat/Social Union.

At present, the regionally based Associations of SHI Physicians, or *Kassenärztliche Vereinigungen*³ (KVen), are legally obliged to provide an equitable level of health care to all ambulatory patients according to their needs. They attempt to meet this objective through so-called 'needs-based planning', which is in fact a demand-based model. It determines the number of physicians who are authorized to open a practice in a certain district based on nationally defined physician-population ratios [1].

The adequacy of these target physician-population ratios, however, has come into serious question. Firstly, as they were codified according to the actual physician density in 1990, they preserve considerable differences in densities between districts and do not take into account important need factors, such as actual regional morbidity, social status and within-district transport infrastructure. Thus, many researchers see them as outdated [2]. Secondly, their enforcement remains weak. Several districts have recorded significant oversupplies for many years, particularly for specialized physicians, while remote areas are unable to fill vacancies despite offering financial incentives [1]. In these areas, the recruitment of GPs is especially low. Their share of the total number of physicians continues to fall, their average age is increasing, and it is becoming more difficult to replace them. Today they account for almost 60% of all vacant posts in ambulatory care [2,3].

2.2. Main objectives and stipulations

In this context, the CSA has been introduced in order to ensure "high quality, needs-based, local health care provision" [4]. Hence the bill has four main objectives. Its first goal is to secure the long-term supply of physicians in all regions. Second, it seeks to decentralize decision-making related to the remuneration of outpatient physicians. Third, it aims to facilitate cross-sectoral cooperation between hospitals and ambulatory care, especially for major and rare diseases. Finally, the bill is meant to widen opportunities for the financing of innovative treatment methods [4].

These objectives are to be achieved through various measures. To ensure adequate supply and geographical distribution of physicians, the CSA gives greater responsibility to regional bodies, especially the KVen. They may, for instance, allot more practice licenses in a certain district than allocated according to the national population-physician ratios set by law. These deviations must be approved by the regional sickness fund associations and justified by exceptional local health care needs. The KVen, in collaboration with the sickness funds, may refuse the sale of a license for a practice becoming vacant in an oversupplied area. Through this stipulation, which only enters into force in 2013, licenses may be taken off the market, reducing physician numbers in these districts.

Alongside these regulatory measures, the reform package creates new incentives to make the medical profession

more attractive, especially for physicians in remote areas. It relaxes physicians' obligation to take up a private residence in the district of their practice, gives them the option to hire a replacement⁴ or assistant while on sick leave to care for a family member (Section 32 Accreditation Regulations for SHI Physicians), and abolishes service budget constraints on physicians in underserved districts (Section 87a SGB V [German Social Code V]). In addition, the CSA contains stipulations which aim to lighten the workload of office-based physicians by facilitating delegation to non-medical staff (Section 28 para 1 SGB V); authorizing doctors employed in nursing homes and rehabilitation centers to take part in ambulatory care (Section 116 SGB V); and promoting tele-medical services by including them in the ambulatory remuneration scheme (Section 87 para 2a SGB V).

The orientation towards more regional involvement and flexibility is also evident in the bill's new rules for physician remuneration. Currently, the mechanism for budget allocation among the different groups of medical specialists is determined at the national level involving physicians' and sickness funds' representatives. The CSA decentralizes this process by giving each KV a stronger say in its own regional mechanism for the distribution of the capped budget among physicians (Section 87b SGB V). With regard to the (nationally uniform) pricing scheme for physician services, the option to negotiate different price levels for underserved or oversupplied areas has been repealed.⁵ Instead, KVen and regional sickness fund associations in each *Bundesland* have the option to agree on price premiums for certain services or for certain providers in underserved areas. Greater flexibility in billing processes is to be fostered by withdrawing office-based physicians' obligation to comply with ICD-10-based disease-coding guidelines. These became mandatory in 2011 and have met with strong resistance from physicians, who considered them to be too bureaucratic.

To improve the quality of treatment for major diseases with severe progressions and rare diseases as well as other highly complex and specialized services, the CSA bundles their treatment into a new sector. Outpatient treatment of these patients may then be provided by both hospitals and ambulatory physicians and, preferably, be accompanied by close cooperation between both providers (Section 116b SGB V). Compensation will be based on a separate price list and paid by sickness funds directly, without budgetary constraints. This will make it an attractive sector, especially for SHI physicians whose budgets are otherwise largely capped. However, the precise design and implementation of this new sector depend on regulations to be drawn up by the end of 2012 by the Joint Federal Committee (G-BA), a regulatory body composed of physicians, sickness funds, and patients' representatives.

³ Generally, there is one KV for each *Bundesland*. An exception exists in the *Bundesland* of North Rhine-Westphalia, which is shared by two KVen that have preserved historical territories.

⁴ The option to hire a replacement currently only applies to care of a child. The CSA extends the length of leave to 12 months, from the current 6 months, and includes the option to hire an assistant for up to 36 months (in the case of absence for care of a child) or up to 6 months (for care of relatives) (Section 32 Accreditation Regulations for SHI Physicians).

⁵ The option to negotiate staggered pricing came into force in 2007, yet has been suspended by the liberal-conservative government for the years 2011 and 2012 (Section 87d para 1 SGB V).

The CSA also changes the process by which innovative treatment methods are introduced into the SHI benefits catalogue (Section 137e SGB V). At present, hospitals are not allowed to use a treatment method if the Joint Federal Committee recognizes a lack of evidence for the method's necessity, based on the patient's right to "sufficient, appropriate and economical treatment" (Section 137c para 1 SGB V). The CSA reverses this burden of proof. Any hospital treatment can be paid for with SHI funds until there is reliable evidence that the treatment does not have the "potential to be a necessary treatment alternative" (Section 137c SGB V). Moreover, the CSA allows providers in the ambulatory care sector to take part in the testing of innovative treatment methods, a right which is currently limited to the hospital setting. Finally, the bill tightens regulations related to the evaluation of treatment methods involving a new medical device. Evaluations are to be conducted under the auspices of the G-BA, even when the medical device producer has applied for them, and costs are not necessarily fully borne by the producer, but may be subsidized by public funds (Section 137e para 6 SGB V).

In addition to these major reforms, the CSA contains several smaller, yet noteworthy, institutional changes. Building upon the health care reform of 2009, which encouraged sickness funds to compete for patients based on quality of care rather than prices, it expands the variety of additional services that sickness funds can include in their coverage. It also stipulates changes in the structure of the Joint Federal Committee, penalties for risk selection by sickness funds, changes in dentists' remuneration, an obligation for sickness funds to publish annual financial statements (as of 2014), and easier access to data for research purposes.

The CSA was adopted by the governing coalition parties in the *Bundestag* and entered into force on 1 January 2012.

3. Stakeholder and critical analysis of the reform

3.1. Stakeholder positions

The CSA involves or affects various stakeholders. Among them are the ruling coalition in Parliament, the opposition parties, the *Bundesländer*, the physicians, the sickness funds, and the patients/insured.

The liberal-conservative coalition has introduced this bill in reaction to the ongoing debate among health care providers, sickness funds, the scientific community, and the media on the adequacy of the level of health care provision in all regions. Prior to its adoption the bill has stoked controversy among key members of the coalition regarding its impact on SHI expenditures since there is no additional budget earmarked for the SHI in the upcoming years. Therefore, the Minister of Health had to include a clause in the bill clarifying that all additional costs stemming from the reform would be borne by the insured persons through higher social security contributions [5].

The opposition parties have voted uniformly against the CSA [6]. While they recognize the need for tackling undersupply in remote areas, they believe the bill's stipulations in that regard are too soft. Furthermore, they claim, the design of a new sector for specialized care lacks budgetary

constraints and sufficient quality standards and incentives. Some say the likely increase in SHI expenditures under the CSA will do little more than line the pockets of physicians who they deem to be the political cronies of the liberal party.

Although the *Bundesländer* appreciate the CSA's attempt to give them a stronger role in the planning and steering of ambulatory care, they do feel the bill could go further in this regard. They also demanded stronger obligations on the KVen to reduce oversupply and successfully exerted pressure on the ruling coalition in Parliament to limit the scope of the specialized care sector [7].

The KVen, their national umbrella organization the KBV, and the German Association of General Practitioners endorsed the CSA's principal approach [8,9]. The regionalization of decision-making, increased flexibility regarding residency, and abolishment of uniform disease coding guidelines have long been on the list of demands made by physicians. Nevertheless, a few critics have spoken up. Psychotherapists bemoaned the bill's failure to set the regional allocation of psychotherapist posts on new grounds [10], and the KVen would have preferred even more regional autonomy in the allocation of the budget [11].

The sickness funds also endorsed the reform objectives, especially the attempt to tackle supply inequities and to improve cross-sectoral treatment of patients. Nevertheless, they are convinced that the adopted measures will not be sufficient to ensure a more needs-adjusted distribution of physicians. In addition, they are skeptical towards the benefits of the specialized care sector compared to related increases in expenditures [12].

Patient and consumer associations applaud the general thrust of the bill. The improvement of local ambulatory care structures and the facilitation of cooperation between inpatient and outpatient medical providers have long been on their agenda. They are disappointed, however, that the bill is not more patient-oriented. In particular, they bemoan its failure to allow for greater local adaptability in the current regulatory framework for the regional allocation of physician posts; its lack of implementation of accessibility rights; and its half-hearted approach to patient involvement in the various policy-setting bodies [13,14,15].

3.2. Critical analysis

The bill's transfer of decision-making responsibilities to the regional level could be an important step in loosening the rigidity of the care supply system – if the KVen and associations of sickness funds are able to come to agreement and are willing to take an active steering role. Furthermore, a certain degree of undersupply in remote areas could be absorbed by the stipulations that increase the attractiveness of the office-based medical profession and aim to integrate other health professionals.

However, these measures alone will not fully address the inequitable geographical distribution of physicians and the numerical decline of GPs. The CSA's stipulation to reduce physician oversupply through practice license buy-outs by KVen is not a new idea. The regional KVen are already entitled to buy up medical practices. The problem, in fact, is that there are few reasons for them to utilize

this option since they are neither offered any financial incentive nor legally obliged to do so. Moreover, with the abolishment of staggered pricing levels for regional over- or undersupply of health care services, the CSA actually removes some of the existing instruments for reducing inequities. Although never used due to its controversial nature, this option could have proven to be an effective instrument for increasing or decreasing the attractiveness of setting up a medical practice in certain regions. The new stipulation permitting price premiums may be useful in improving services in underserved areas, but it has only a limited impact on oversupplied regions, as there is no option for reducing prices. This, along with the CSA's abolishment of service budget constraints on physicians in underserved areas, might ultimately increase costs while effects are probably limited.

Closely related to these changes are the new regulations concerning the decentralization and deregulation of remuneration mechanisms. Following the principle of subsidiarity, a stronger say from the regional KVEn in this area may improve these mechanisms in theory. However, it remains to be seen how these changes will affect both regional imbalances in remuneration levels and systematic imbalances between physician groups. Eventually, both issues may have consequences for the guarantee of equitable standards of health care services. Also worth considering here are the potential adverse consequences of abolishing ambulatory disease coding regulations. Not only are they important for the stipulated morbidity-based budget allocation but they are also a prerequisite for standardized national quality assessments that are supposed to be introduced in ambulatory care over the next few years.

The CSA's creation of a new specialized care sector is also a step forward in principle. Ensuring that patients' treatment is provided close to home, whenever possible, and does not encounter obstacles due to sectoral divisions would be a major achievement for the affected patients, for instance for those with severe oncological diagnoses or with rare diseases. However, the current framework contains hidden risks. Firstly, the lax provider-authorization procedure could hurt quality of care. Secondly, the unrestricted billing allowance might undermine initiatives to contain costs, and, by creating a financially attractive sector for highly specialized physicians, contradict attempts to induce young doctors to become GPs. Nonetheless, the CSA only stipulates a sketchy framework for this new sector; the precise design will have to be negotiated by sickness funds, the hospital association and the association of SHI physicians in the Joint Federal Committee. Considering their challenge to conclude an agreement on the precise scope, remuneration, and definition of patient pathways by the end of 2012, a definite assessment of the benefits and risks associated with this reform aspect will have to wait at least another year.

Another aspect of the CSA, namely the changes to the scientific evaluation of innovative treatment methods, has only been a side aspect in the debate of the reform, yet contains important changes. The integration of the ambulatory sector into the evaluation process is a move in the right direction as it will allow researchers to more accurately assess the effectiveness of a treatment in routine care. But

other aspects of the stipulations seem detrimental or contradictory. The reversal of the burden of proof, for instance, could negatively impact care. The Institute for Quality and Efficiency in Health Care, which is the responsible institute for the effectiveness analyses, claims that proving an innovative treatment method lacks potential is "practically unimaginable" [16]. The stipulation referring to the testing of treatment methods involving medical devices, for its part, also gives rise to concerns. Conducting these studies under the auspices of the G-BA and obliging the producer to reimburse only an "adequate" part of the costs based on his "economic capacity" [17] stands in stark contrast to the authorization procedure for pharmaceuticals, in which the responsibility and costs for a clinical study usually lie entirely with the manufacturer.

4. Conclusion

The Care Structures Act correctly identifies the need for a more adequate distribution of physicians, better care structures for patients with special needs, and incentives for fostering innovation. Despite a broad consensus on these objectives, the reform package falls short in the measures it proposes to implement these objectives. Some of the introduced incentive schemes are ambiguous; standards on the quality of care are in some instances sidelined; and current mechanisms for regional physician allocation are left untouched despite a broad consensus on their inadequacy.

The recent work of different scholars, policy papers from stakeholders or a look to our neighboring countries could have provided many promising approaches for a fundamental reform of care structures. Powerful measures would have been the introduction of a sophisticated planning system for projecting local patient needs and the required physician supply, a regional allocation of practice licenses based on these health plans, a clear framework for fostering cooperation between sectors, and a comprehensive set of regulatory or incentive-based measures to ensure the effective implementation of the resulting policies. Hence a first step has been taken, but the issues addressed in this reform will surely remain on the public agenda in the coming years.

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