Spitzenverband

Perspectives of the health insurance funds – Role and aims in the quality assurance system

HOPE Study Tour Berlin
"Quality assurance in German Hospital care"
30.10.2014

Dr. Wulf-Dietrich Leber

Outline

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1. **General set-up**
   1. About us
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Social Insurance in Germany

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- Welfare state principle [Art. 20, Subsection 1 German Constitution]
- Branches of the Social Insurance System:

- Basic Principles of the Social Insurance System:
  - compulsory insurance
  - contributional funding
  - solidarity principle
  - self-government
  - partial equivalence principle (pension, payment instead of a regular income)

Health insurance in Germany 2012

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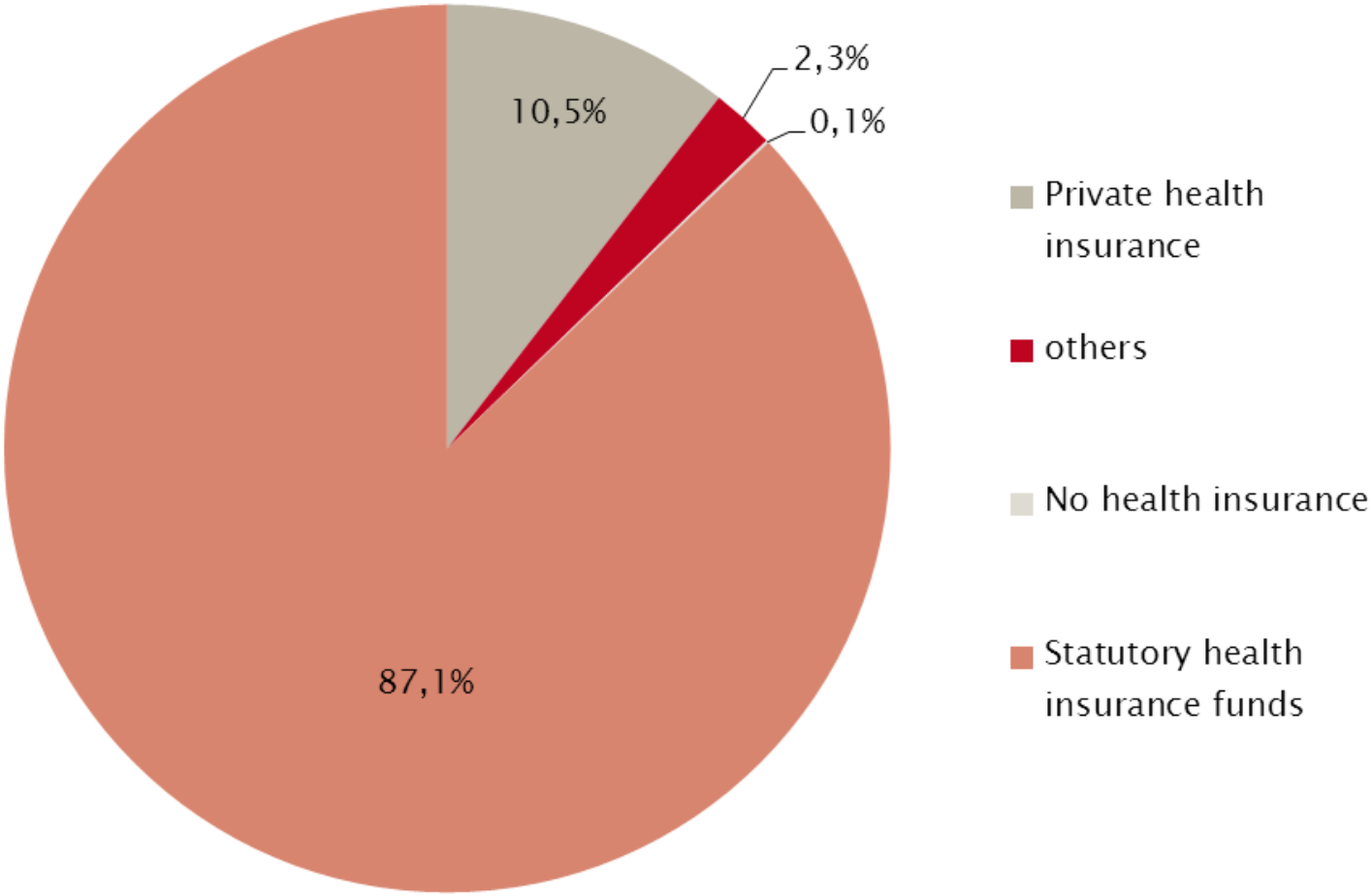

131 Health Insurance Funds in 2014

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- Free choice for the insurees among SHI-Funds
- Benefits as necessary
- Benefits in kind
- Solidarity principle

Number of SHI Funds in Germany

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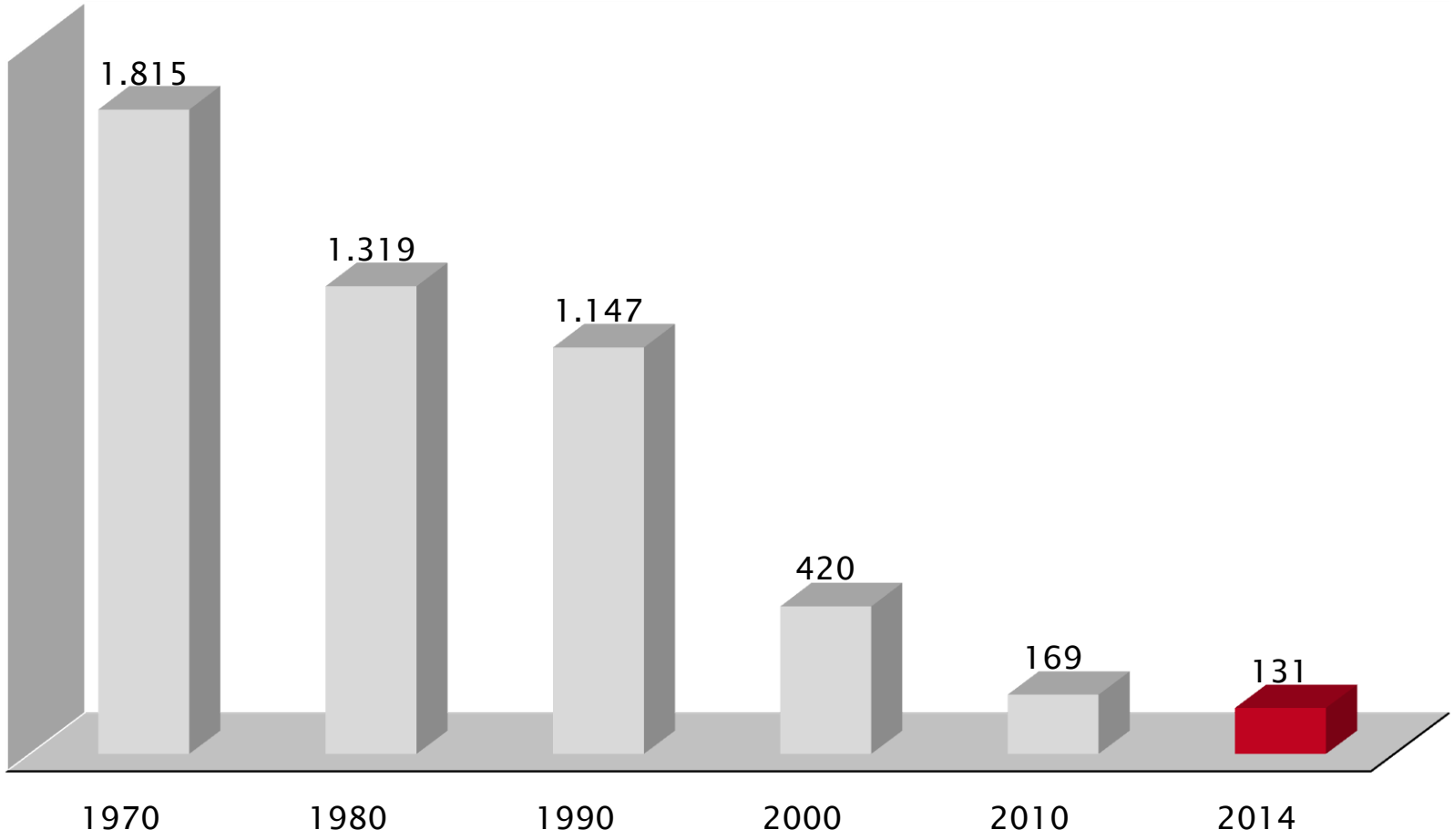

The National Association of SHI Funds

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- Is the central association of statutory health insurance funds at federal level and the National Association of Long-Term Care Funds
  - Has replaced the six associations of SHI funds at the national level since July 1st, 2008.
- Takes on all non-competitive tasks which require common and uniform action:
  - E.g. basic conditions regarding remuneration of physicians and hospitals, registration procedures, telematics.
  - Indirectly represents the interests of 70 million insurees as well as the interests of the employers as contributors.
  - Decisions concern about 70% of all health expenditures.
- Has three main areas of responsibility:

Shaping care

Budget and data management

Representation of interests

The National Association of SHI Funds

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Organisational Chart

Spitzenverband

Chair of the Board

Dr. Doris Pfeiffer

Deputy Chair of the Board

Johann-Magnus v. Stackelberg

Member of the Board

Gernot Kiefer

Policy
Michael Weller

Communications
Florian Lanz

Self-Government
Elke Sleeboom

Legal Affairs
Dr. Martin Krasney

Division
System-related Issues
Dr. Pekka Helstelä

Division
IT System Issues/Telematics
Rainer Höfer

Division
Medicine
Dr. Bernhard Egger

Division
Out-Patient Care
Dr. Manfred Partsch

Division
Hospitals
Dr. Wulf-Dietrich Leber

Division
Medicines and Remedies
Dr. Antje Haas

Contract Analysis

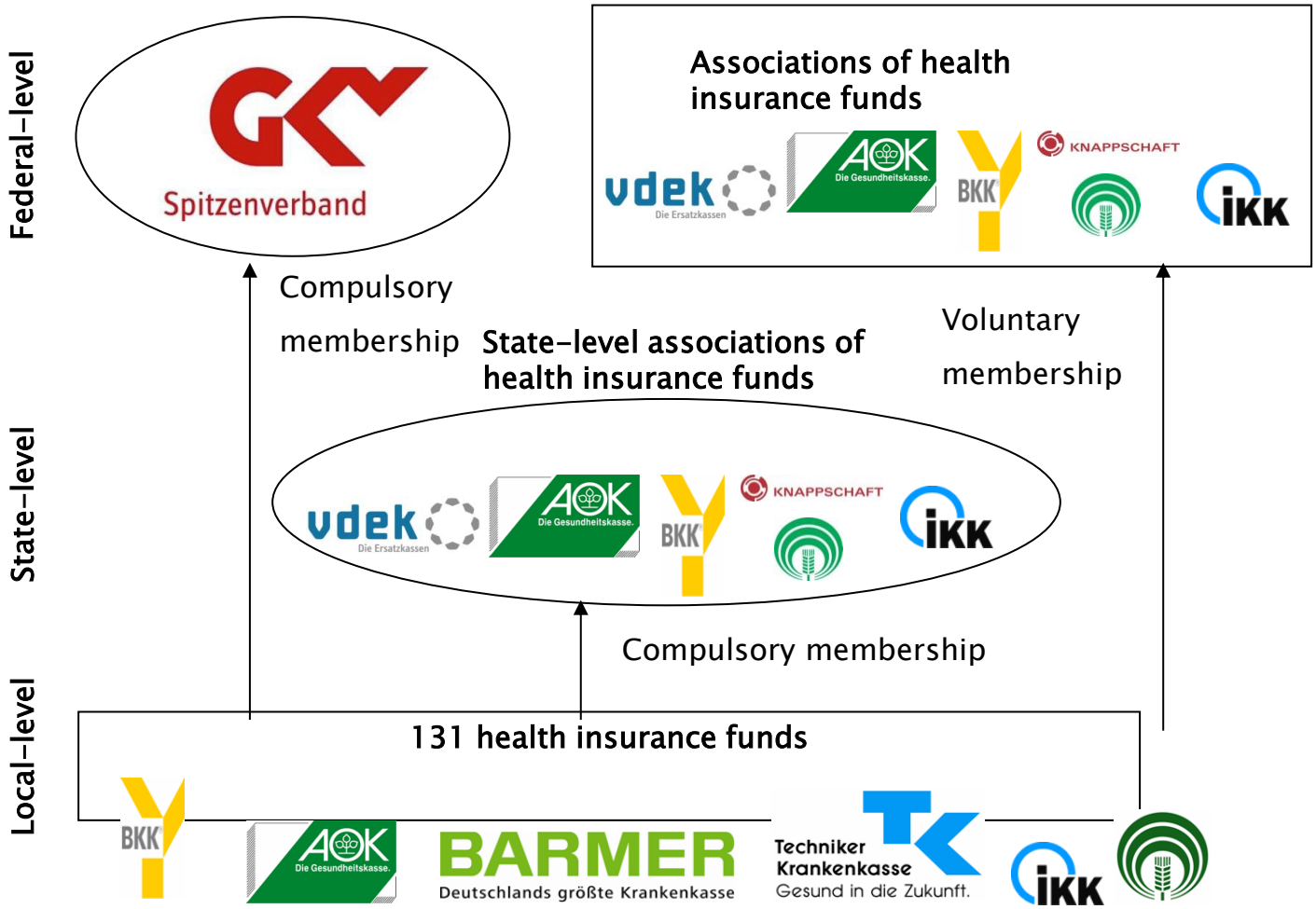
Thomas Staffeldt

Division
Health
Dr. Monika Kücking

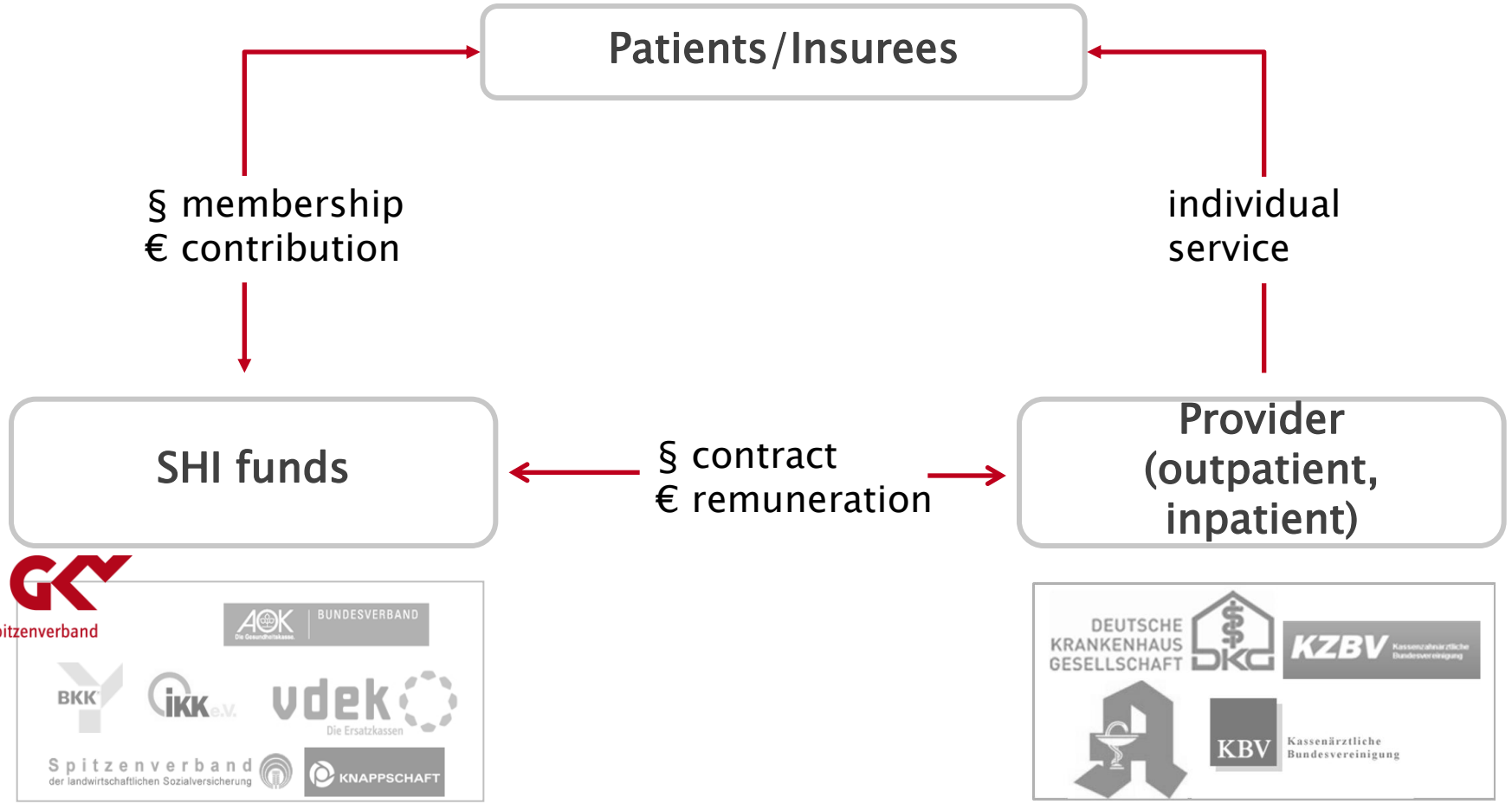
Division
German Liaison Agency Health Insurance – International
Hans-Holger Bauer

Division
Central Services
Jürgen Kellermann

Multi-level governance in the SHI



Arrangement of benefits and funding



Expenditure of the SHI in 2011: about 170 billion €!

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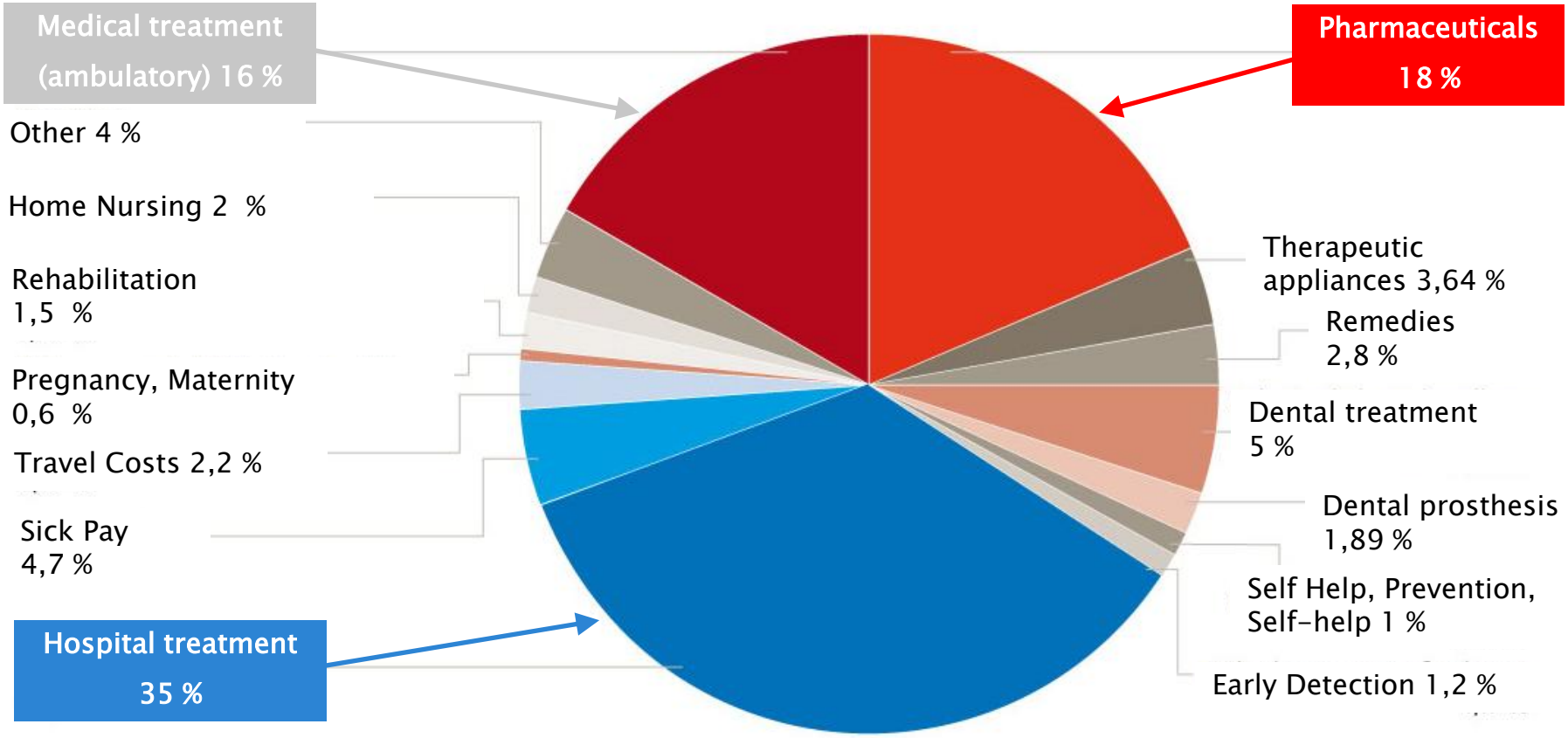

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German hospitals in 2012

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- 2.045 hospitals
- 502.000 beds
- 18 million cases
- 7,7 days average length of stay

Inpatient care: overview

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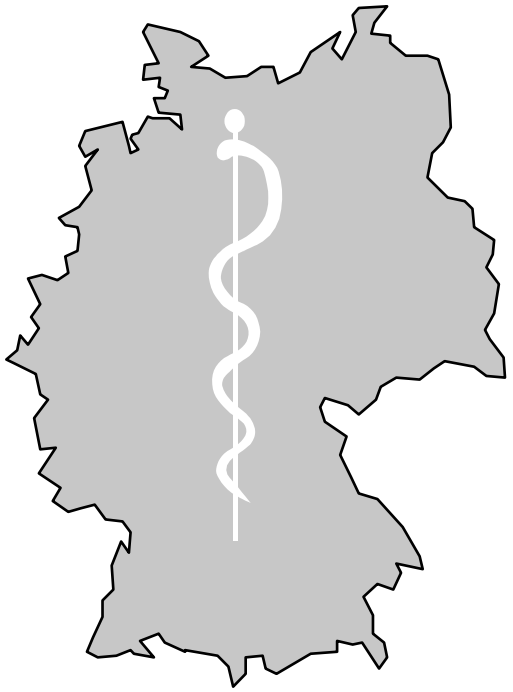
- **Competition** between the hospitals
- **Free choice** for patients
- “Hospital planning” by state (“Länder”)> **obligation to contract** for the SHI-Funds
- **Collective negotiation** between the associations of SHI-Funds and hospitals about the G-DRG-reimbursement/ budgets
- **Common regulatory and financing framework** independent of ownership
- **No** possibility for **selective contracting** between the SHI-Funds and the hospitals



Hospital ownership (2011)

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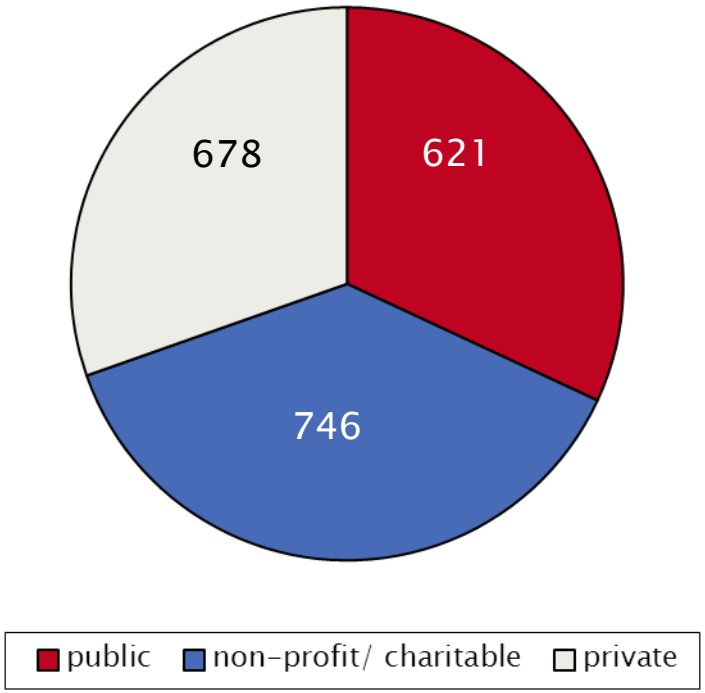
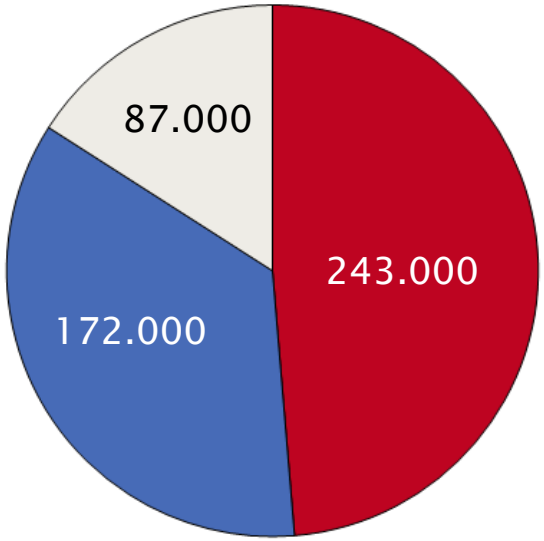
Hospitals by owernship (total): 2.045



Number of beds by ownership (total): 502.000



Dual hospital financing

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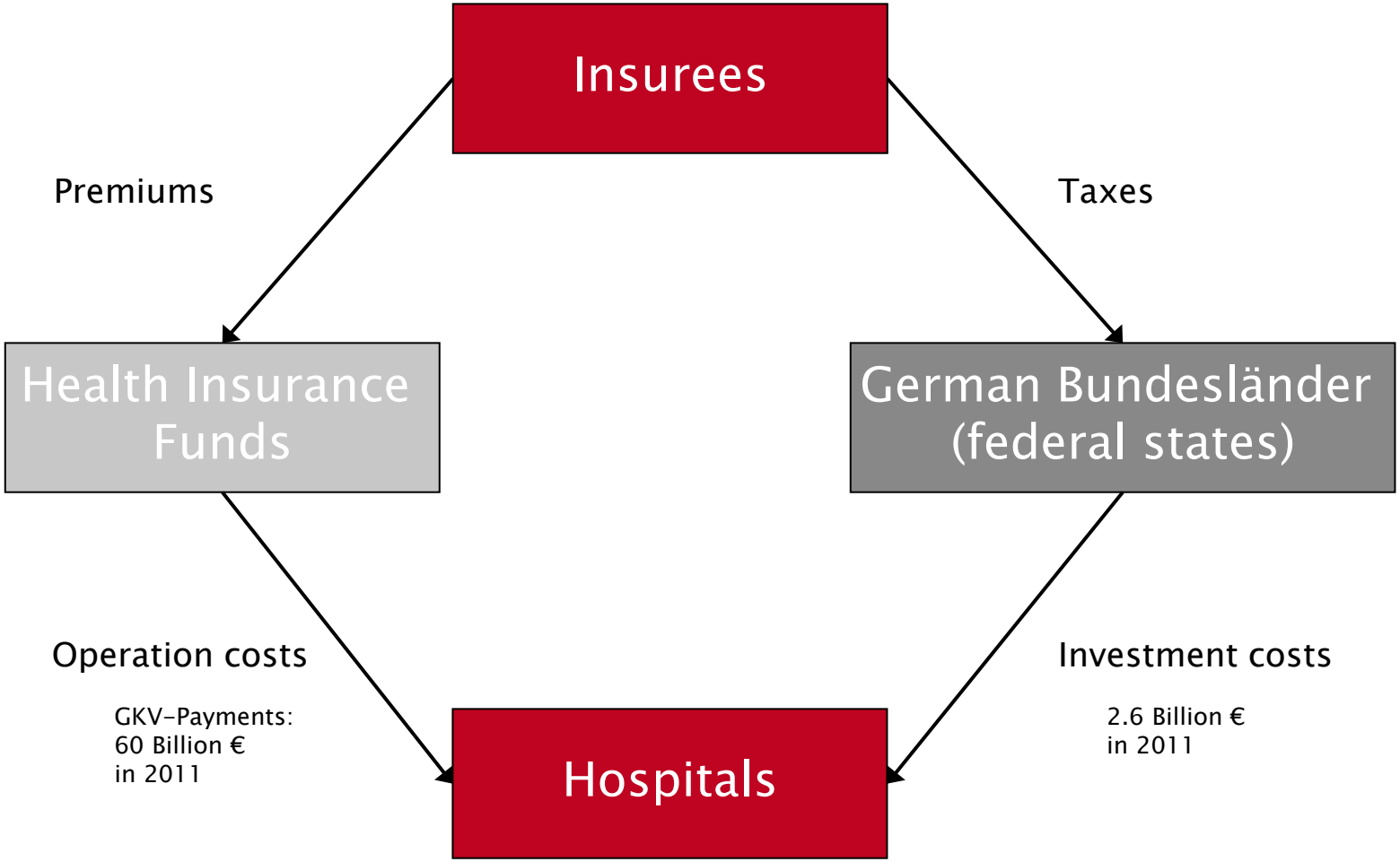

Decrease of investment cost financed by states („Länder“)

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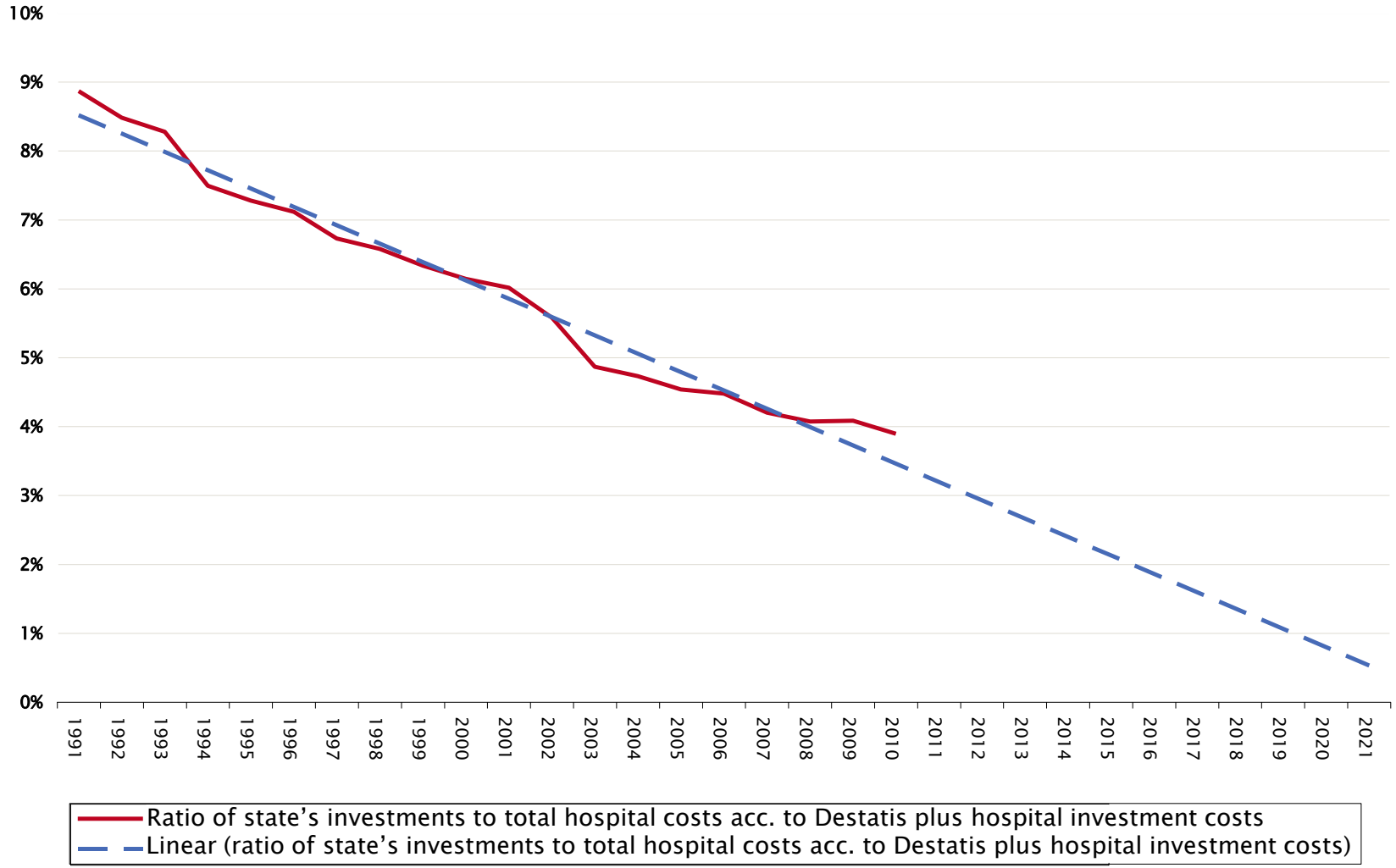

Hospital financing before the introduction of DRGs

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- Global budgets
- The higher the costs the higher the reimbursement
- No information about concrete hospital activity
- Lack of comparability of hospitals
- Budget payment according to length of stay 75 %

  (excessive length of stay)
- Inefficient and rigid structures

- In fact, SHI funds did NOT even know what they were paying for …

The political process of DRG-introduction

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- 1999 Parliament decides the introduction of DRGs (§ 17b KHG), → minimally detailed framework: text block of 10 rows for „DRG-system“
- 2000 Decision of the federal associations of hospitals and health insurance funds to introduce AR-DRGs
- 2002 Law to define the overarching structure of DRG-based hospital financing („Fallpauschalgesetz – FPG“)
- 2003 Voluntary („opt-in“) phase of DRG application
- 2004 „Budget-neutral“ DRG accounting/billing by all hospitals
- 2005 Allocative and reimbursement effect of DRGs („convergence-phase“)
- 2010 Completion of the DRG-introducion phase: equal price for equal service on the state-level

Introduction of DRGs: from hospital prices to state-level prices

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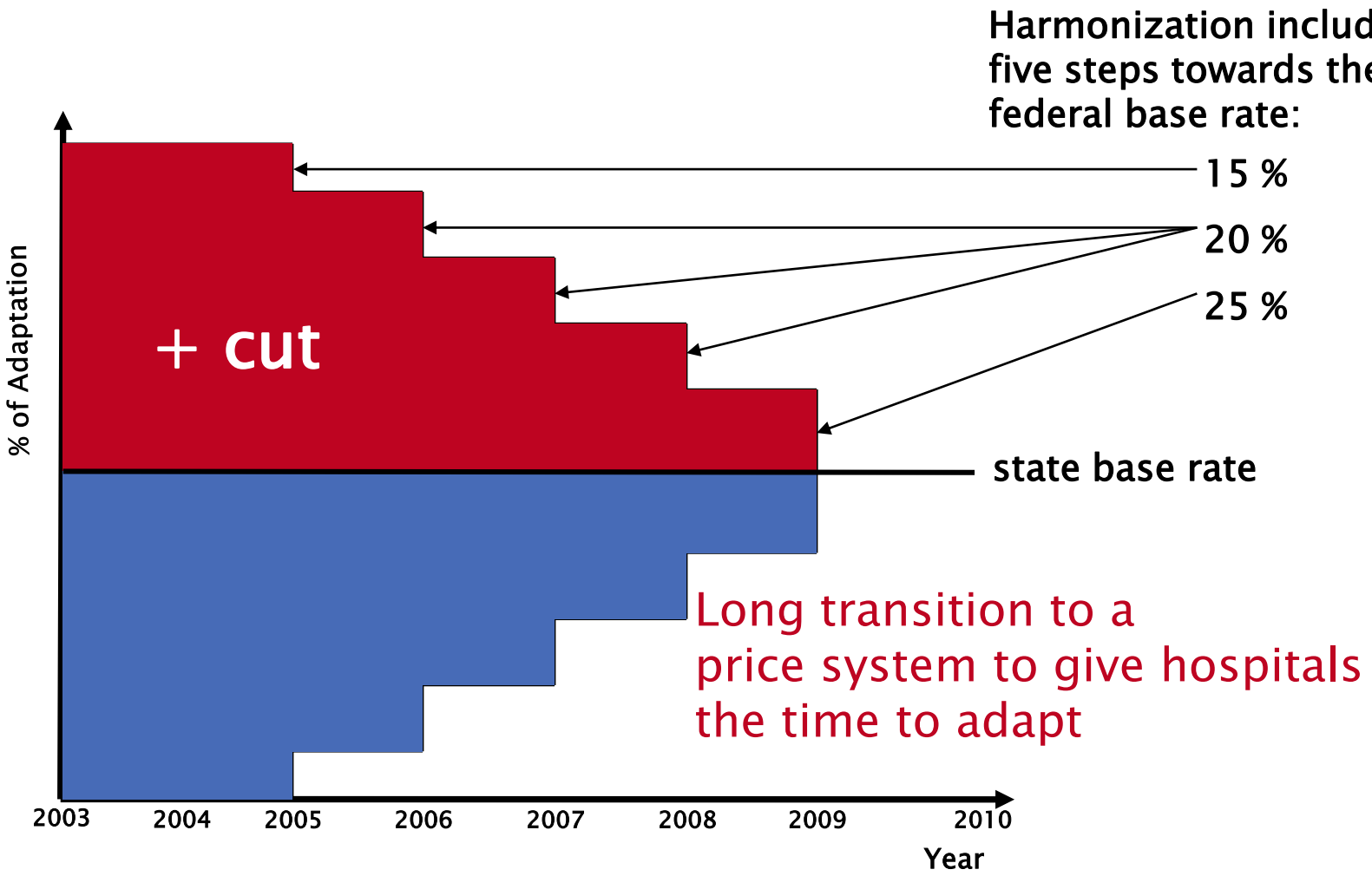

Selected OECD results per 100.000 inhabitants

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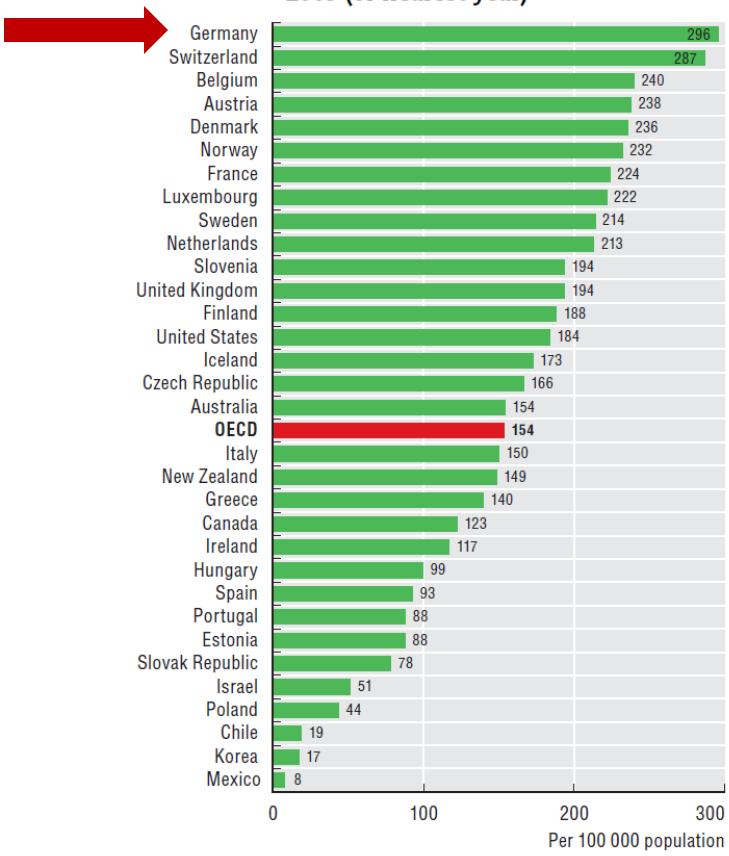
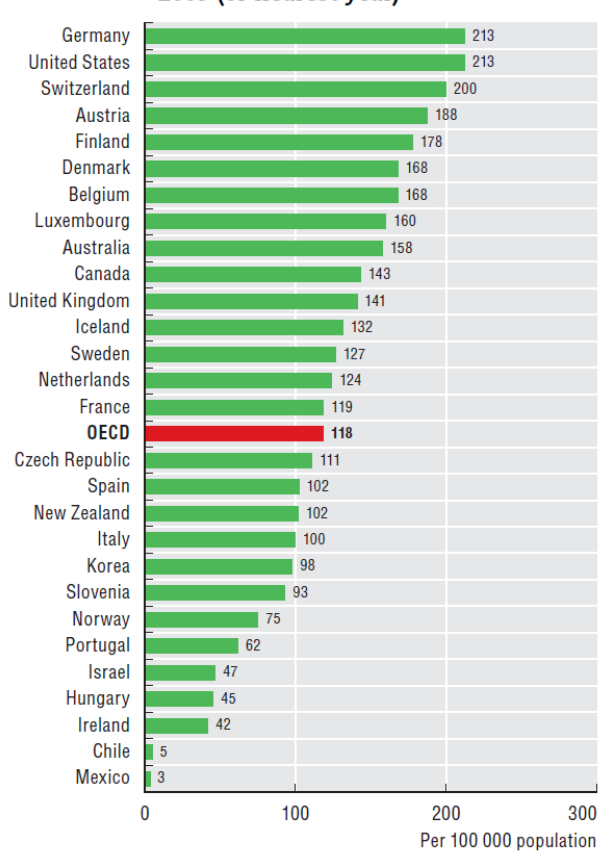
4.7.1 Hip replacement surgery, per 100 000 population, 2009 (or nearest year)



Source: OECD Health Data 2011.

4.7.2 Knee replacement surgery, per 100 000 population, 2009 (or nearest year)



Source: OECD Health Data 2011.

After the DRG implementation

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- All transparency aims reached. SHI now know:
  - each case of all their insurees
  - in each hospital
  - with all diagnoses
  - and all procedures
  - and all personal characteristics
  - with the exact price
- Competition between hospitals increased.
- High transparency in hospital performance.

- Unfortunately no effect on expenditures.

Quality – the framework

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- The introduction of DRGs formally facilitates quality measurement as procedures and diagnoses are documented in standardized manner.
- The Joint commission (G-BA) decides upon quality measurement and indicators.
- Currently about 200 mandatory quality indicators exist, for which (annually) 3 million questionnaires are filled out.
- 2/3 of these indicators are published in quality reports.
- Assessment is responsibility of a mandated institution, until 2009: BQS; now: AQUA.

About DRGs and Quality

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- The introduction of DRGs was the most important innovation in the German hospital sector in the last 30 years.
- The financing of hospitals changed from budget orientation to activity based funding.
- Significant changes in central hospital indicators. Hospitals align their activity to incentives.
- The transparency increased significantly, cost and quality control is still outstanding … – but necessary parameters are available.
- The German DRG system a success story? Yes! And there is more to come: Psychiatric hospitals, infrastructure costs.

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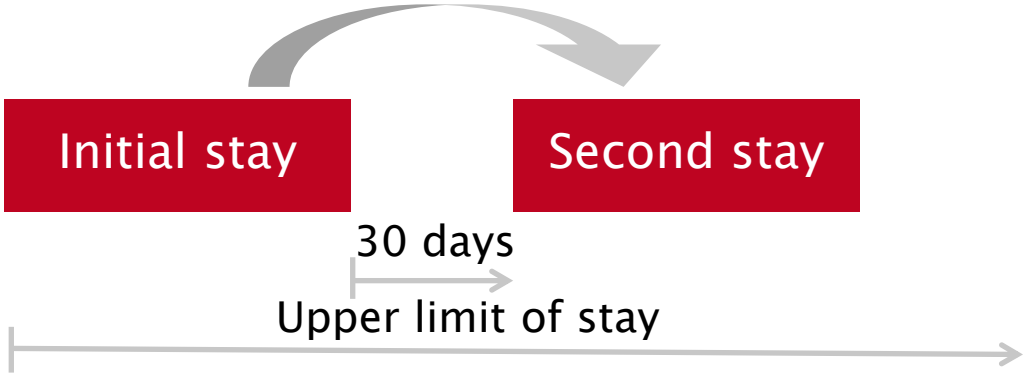
Billing rules

- Readmission:
  - Cases are combined with no extra payment, if a patient is admitted to hospital again after discharge …
    - … within the upper limits of stay
    - … within 30 days of discharge in the same MDC



  - Aim:
    - No case-splitting
    - No early discharge
    - Penalty for complications

Regulations of the federal joint committee on quality assurance

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- Quality of structure, processes and result/outcome
  - Regulations on structural standards, e.g. minimal specifications on equipment, personnel and their qualification
  - Regulations on essential processes requirements
  - Mandatory measures (indicators of quality) to ensure standard outcomes
- Standard hospital reporting, annual quality reports
- Minimum volumes
  - Regulations on hospitals where the outcome depends strongly on the numbers of treatment (experience), i.e. specification of minimal numbers of treatment/annum

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EQA follows the money

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- The first EQA was developed after the introduction of lump sum fees in 1996 (hip replacement, birth, …).
- The introduction of DRGs in 2003 enlarged the field for EQA.
- There is no EQA for psychiatric treatment.

Areas of quality assurance in hospitals

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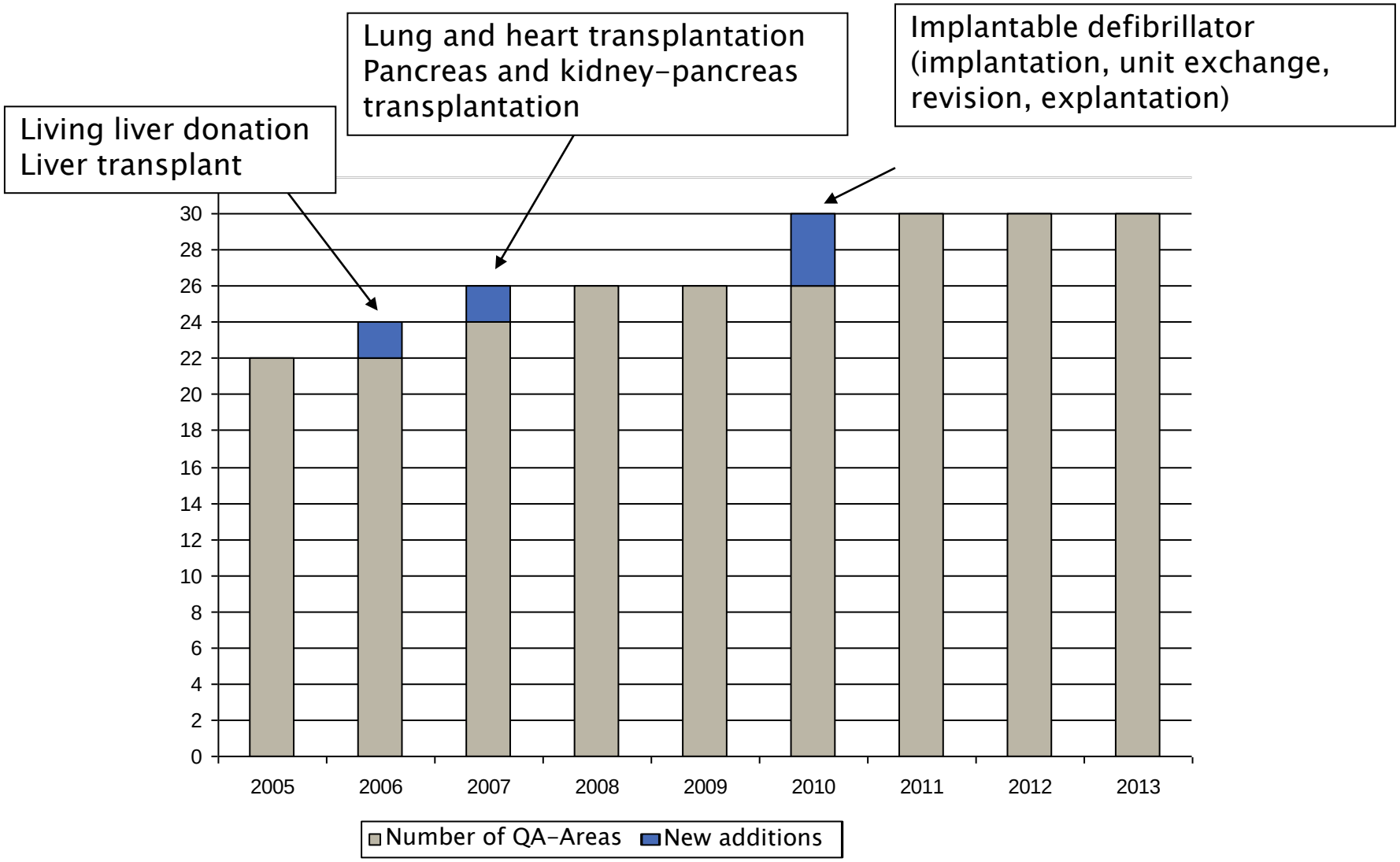
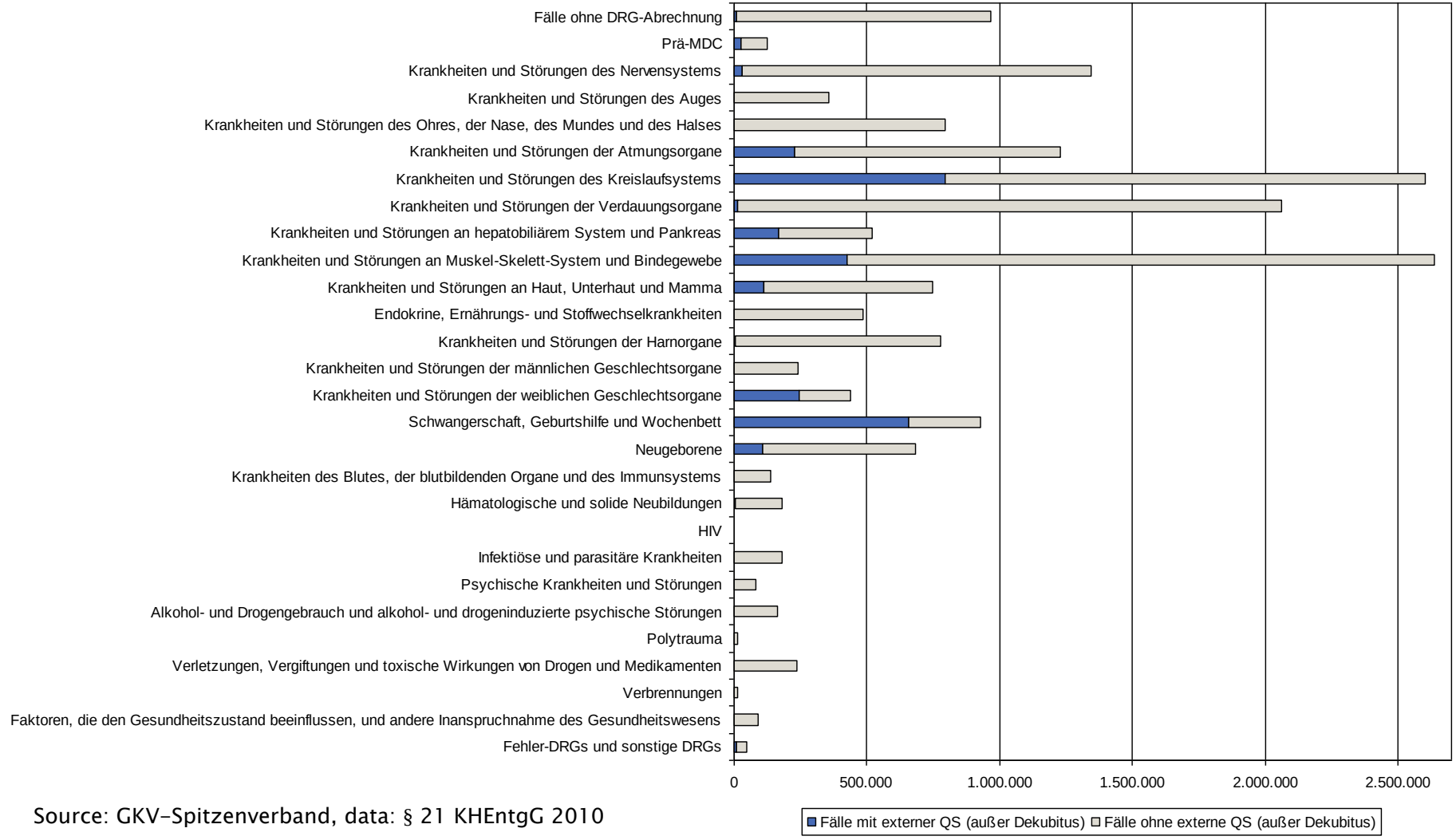


How good is the current QA?
Coverage per Major Diagnostic Category



Source: GKV-Spitzenverband, data: § 21 KHEntgG 2010

How good is the current QA?
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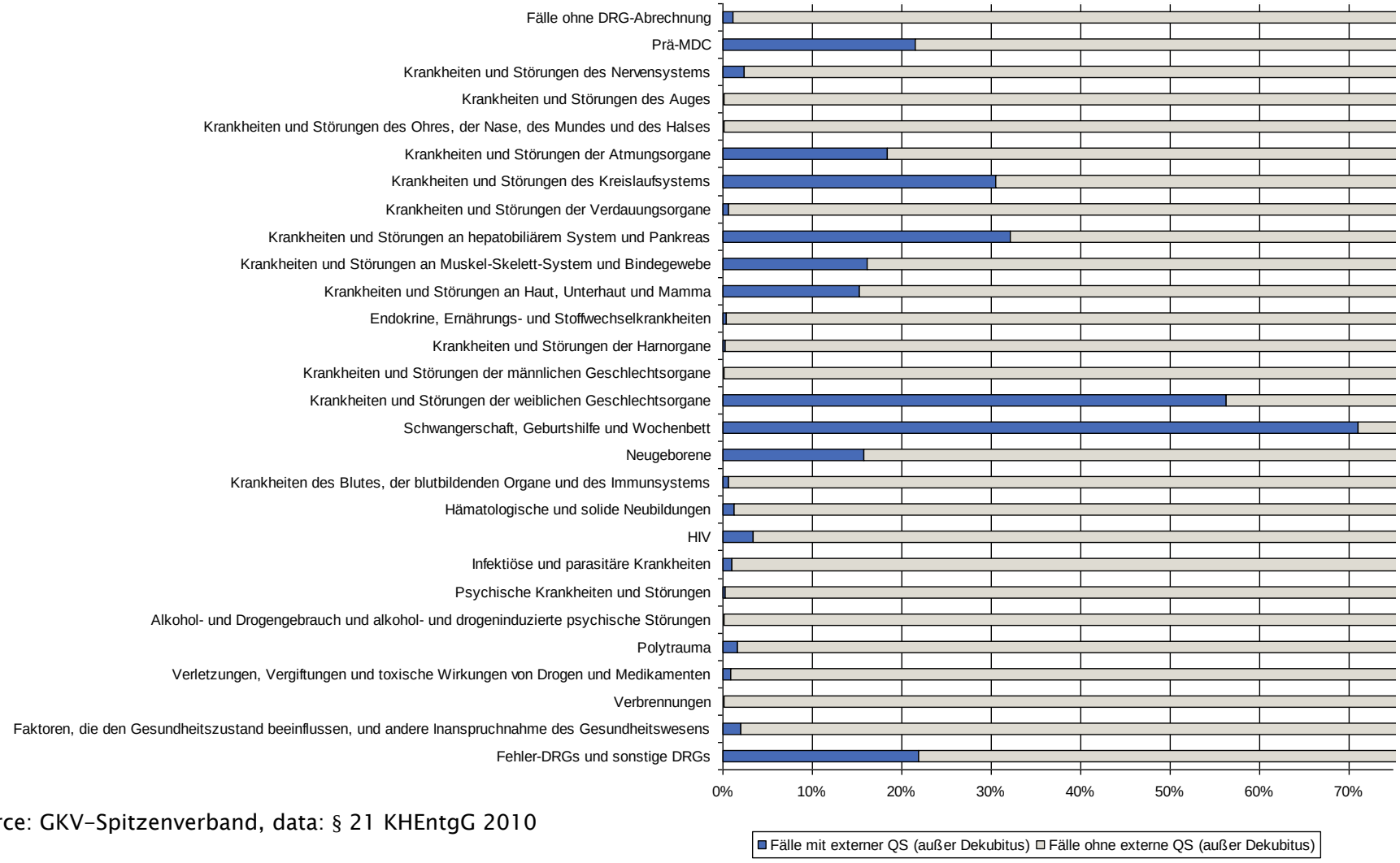

Source: GKV-Spitzenverband, data: § 21 KHEntgG 2010

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History of the quality transparency (1/4)

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1st phase: quality reports without quality indicators

- In the early days of external QA: consensus not to publish the results.
- Only the participation (yes or no) and the rates of documentation were published.
- Result: The first quality report (2014) was only a report on quantities – without any information on quality.
- Increasing discussion about non-transparency.

History of the quality transparency (2/4)

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2nd phase: „Qualify“ – an obstacle for transparency

- **Standardized methodical evaluation** of quality indicators through QUALIFY (Reiter et al. 2007), evaluation by each professional group.

- As a result, an indicator was only be identified as suitable for public reporting, if **all 14 criteria resulted in a positive rating and** a non-technical explanation would be formulated.

- Only **31 of the approximately 180 quality indicators** fullfilled these criteria.

History of the quality transparency (3/4)

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3rd phase: quality campaign und marketing overtake the federal state committee

- Hospitals and hospital chains publish everything, that is gathered in context of external quality assurance – and more ...

Quality campaign besides the federal joint committee

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Qualitätskliniken.de

- 340 indicators for outcome quality
- 21 indicators for patient safety
- 10 indicators for referring physicians and patient satisfaction

- **Members: 115 hospitals**
- Provider: Asklepios, Rhön und Sana
- In addition: Vivantes Berlin und university hospitals

History of the quality transparency (4/4)

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4th phase: the federal joint committee catches up

- Suggestion of the Association of SHI Funds:
  - Publish all EQA- indicators, unless they are extremely misleading.
  - In the medium run no documentation of quality indicators that are not good enough for publishing.

- Decision in 2010 for AQUA by the federal joint committee to test all indicators for their suitability for public reporting.

Quality indicators recommended for publication

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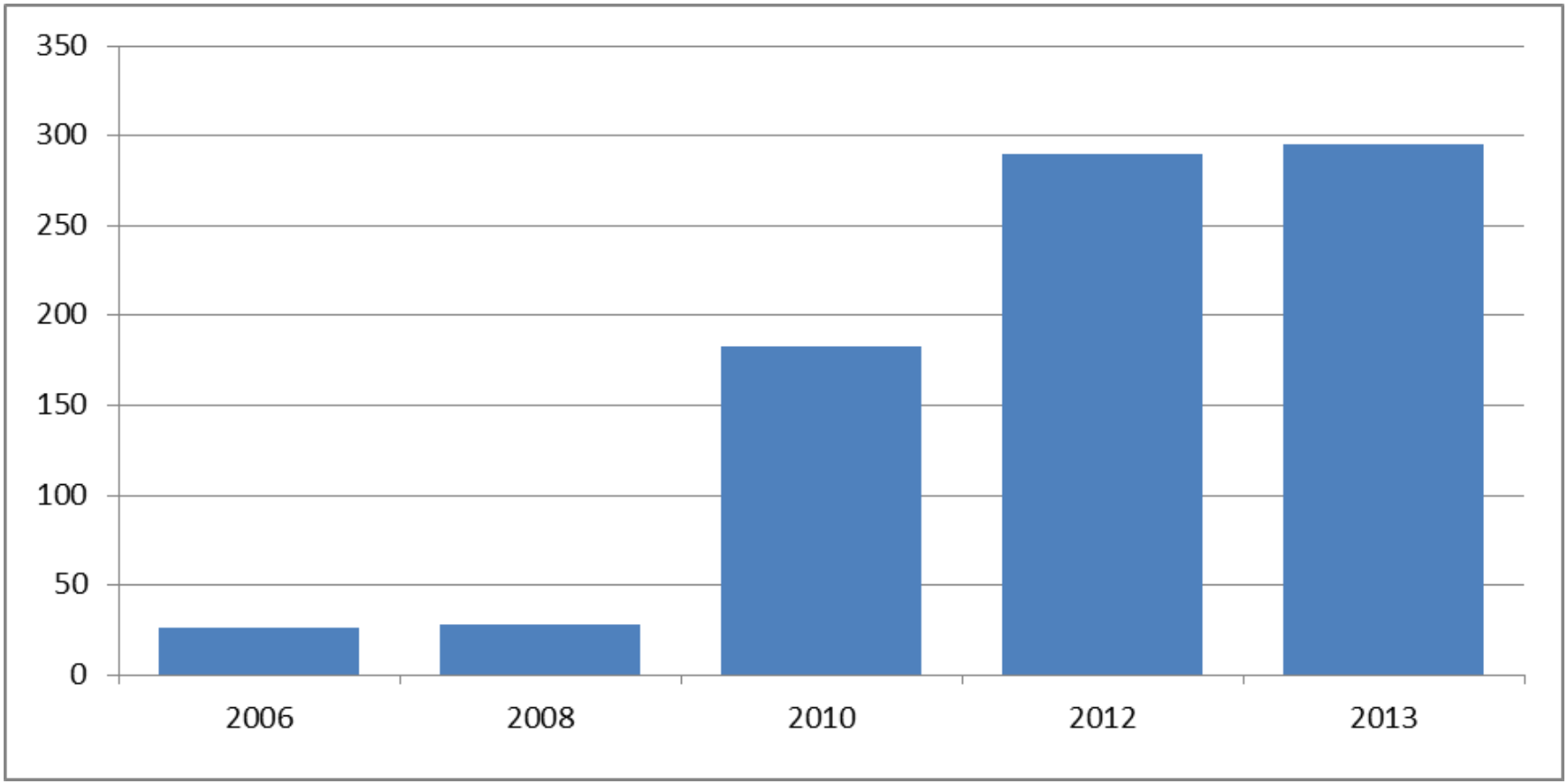

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Summary

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- Established and elaborated system of quality assurance within the statutory health care
- Challenges:
  - Coverage of all sectors of health care and address the relevant issues (complexity vs. efficiency).
  - Enforce programmes within the federal and participative structures with partly different interests.
  - Establish consequences of quality assurance.

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Minimum volume regulation in Germany

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- Usage of minimum volumes
  - Speciality Training Regulations
  - Suspension decisions (testing methods/testing regulations)
  - Outpatient treatment's in hospitals in accordance with § 116b SGB V
  - Outpatient treatment
  - Inpatient treatment
- MINIMUM VOLUME (§ 137 (3) sentence 1 No. 2 SGB V)
- Special case: transplant centres

Minimum volumes in speciality training – an example

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Guidelines of the State Medical Council of Baden-Württemberg on terms of medical training (Effective: February 2014)

7.8 Facharzt/Fachärztin für Viszeralchirurgie

Untersuchungs- und Behandlungsverfahren

	Anhalts-zahl
Untersuchungs- und Behandlungsverfahren der Basisweiterbildung	
sonographische Untersuchungen des Abdomens, des Retroperitoneums und der Urogenitalorgane	400
Durchführung und Befundung von Rekto-/Sigmoidoskopien	50
Operative Eingriffe, davon	
- an Kopf/Hals, z.B. Schilddrüsenresektionen, Tracheotomien	25
- an Brustwand einschließlich Thorakotomie und Thoraxdrainagen	10
- an Bauchwand und Bauchhöhle einschließlich Resektionen, Übernähungen, Exstirpationen, endoskopischer und interventioneller Techniken, z.B. Lymphknotenexstirpationen, Entfernung von Weichteilgeschwülsten, explorative Laparotomie, Magen-, Dünndarm- und Dickdarmresektionen, Notversorgung von Leber- und Milzverletzungen, Appendektomie, Anus-praeter-Anlage, Hämorrhoidektomie, periproktitische Abszess-Spaltung, Fistel- und Fissur-Versorgung, davon	400
- Cholezystektomien	25
- Herniotomien	25

Minimum volumes in 116b (old version)

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- Minimum volume of 50 for rare diseases (one treatment per week)
- Minimum volume „one per mille of the prevalence" for diseases with special ailment patterns
- Conflicting decisions, but easy implementation

Leistung	Menge (alt)	(neu)	
CT/MRT	50		
Mukoviszidose	50		
Gerinnungsstörungen	40		
schwere immun. Erkrankungen	50 (Erwachsene)		
biliäre Zirrhose	50		
Morbus Wilson	keine		
Marfan Syndrom	50		
Pulmonale Hypertonie	50 (gestaffelt)		
TBC	20	**20**	
gastrointestinale Tumore	280	**140**	+ arztbez. MiMe
Lungen- und Thoraxtumore	70		
Knochentumore	50		
Hauttumore	50		
Gehirntumore, periphere Nerventumore	50		
Kopftumore	70		
gynäkologische Tumore	330		
urologische Tumore	320		
lymphatische Tumore, Blutbildung	90		
HIV/Aids	60		
Rheuma	240 (Erwachsene)		
schwere Herzinsuffizienz	500		
MS	120		
Anfallsleiden	330 (Erwachsene)		
neuromuskuläre Erkrankungen	50		
vor/nach Lebertransplantation	50		

Examples for minimum volume regulations according to § 135 para. 2 sentence 1 SGB V

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- Histopathology in skin cancer screening (2009)
  - Personal diagnosis of at least 1,000 derma-histological samples in 12 months
- HIV/Aids (2009)
  - Independent care for an annual average of 25 HIV/Aids patients per quarter
- Colonoscopy (2012)
  - Independent implementation of at least 200 total colonoscopies and ten polypectomies without faults within 12 months
- Vacuum-assisted biopsy of the breast (2012)
  - 25 vacuum-assisted biopsies within 12 months
- Mammography screening (2012)
  - 5.000 examinations (10.000 pictures!) per year

Minimum volume regulations according to § 137 (3) sentence 1 No. 2 SGB V (§ 137 (3) sentence 1 SGB V)

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Annual minimum volume	Service/operation
20	Liver transplantations
25	Kidney transplantation
10	Complex operations on the organ-system esophagus
10	Complex operations on the organ-system pancreas
25	Stem cell transplantation
50	Full knee replacement surgery **(currently suspended)**
–	Coronary operations (included without specific definition of the minimum volume)
30	Care of preterm infants and neonates with birth weight < 1.250 g **(currently 14)**

Overview of the transplant centres
red: n < minimum volume or n < 5

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Bezeichnung	Niere		Leber		Herz		Lunge		Pankreas	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Universitätsklinikum Aachen	26	28	67	44	6	<4				
Zentralklinikum Augsburg	42	30								
Kerckhoff-Klinik Bad Nauheim					9	4				
Herz- und Diabeteszentrum Bad Oeynhausen					73	76	<4	6		
Deutsches Herzzentrum Berlin					29	25	31	24		
Charite Universitätsmedizin Berlin	242	236	79	77					10	10
Knappschafts-Krankenhaus Bochum	81	69							31	22
Universitätsklinikum Bonn	28	21	17	35					8	<4
Klinikum Bremen-Mitte	32	20								
Universitätsklinikum Dresden	69	52							<4	<4
Herzzentrum Dresden GmbH					<4	<4				
Universitätsklinikum Düsseldorf	105	94			10	14				
Klinikum der Friedrich-Alexander-Universität Erlangen-Nürnberg	88	85	5	7	12	15			5	5
Universitätsklinikum der Gesamthochschule Essen	133	90	139	116		<4	8	16	<4	<4
Klinikum der Universität Frankfurt	61	61	33	27	<4	<4			<4	<4
Universitätsklinikum Freiburg	87	82					17	20	7	6
Universitäts-Herzzentrum Freiburg					14	17				
Klinikum Fulda	20	13								
Uniklinikum Gießen	32	21			6	9	15	17		
Kliniken der Georg-August-Universität Göttingen			15	16	5	5				
Martin-Luther-Universität Halle	43	40								
Universitäts-Krankenhaus Eppendorf Hamburg	78	76	72	76					<4	<4
Universitäres Herzzentrum Hamburg					12	11	8	4		
Nephrologisches Zentrum Niedersachsen Hann. Münden	105	84								
Medizinische Hochschule Hannover	171	142	101	72	22	15	133	141	10	11
Universitätsklinikum Heidelberg	145	143	110	108	22	23			17	9
Universitätskliniken des Saarlandes Homburg	30	23	10	17			14	17		
Klinikum der Friedrich-Schiller-Universität Jena	62	48	59	42	12	6	14	10	9	7
Westpfalz-Klinikum Kaiserslautern	23	17							<4	<4
Kiel	41	36	35	50	6	6	<4	4	6	8
Kliniken der Stadt Köln - Betriebsteil Merheim	79	65								<4
Klinikum der Universität Köln	59	56	8	6	<4	5		<4	5	5
Universitätsklinikum Leipzig	37	39	61	16					<4	4
Herzzentrum Leipzig					38	26	30	32		
UNIVERSITÄTSKLINIKUM Lübeck	61	55								<4
Otto-von-Guericke Universität Magdeburg			14	14						
Klinikum der Johann Gutenberg-Universität Mainz	30	23	35	49			6	13	<4	
Klinikum der Stadt Mannheim	29	25								
Klinikum Universität Marburg	22	27							4	4
Klinikum der Universität München Innenstadt-Großhadern	111	94	48	50	33	26	73	57	19	11
Klinikum rechts der Isar der technischen Universität München	61	48	31	8					<4	
Universitätsklinikum Münster	84	117	35	26	6	9	6	8	<4	
Klinikum der Universität Regensburg	62	44	52	49	21	12			5	<4
Universitätsklinikum Rostock	40	35	<4	4					<4	6
Klinikum Stuttgart	70	58								
Klinikum der Eberhard-Karls-Universität Tübingen	56	47	59	51					5	<4
Klinikum der Universität Würzburg	41	28	10	10	4	<4				

Source:
Reports according to § 11 (5) TPG

Knee-TEP minimum volume in Bavaria

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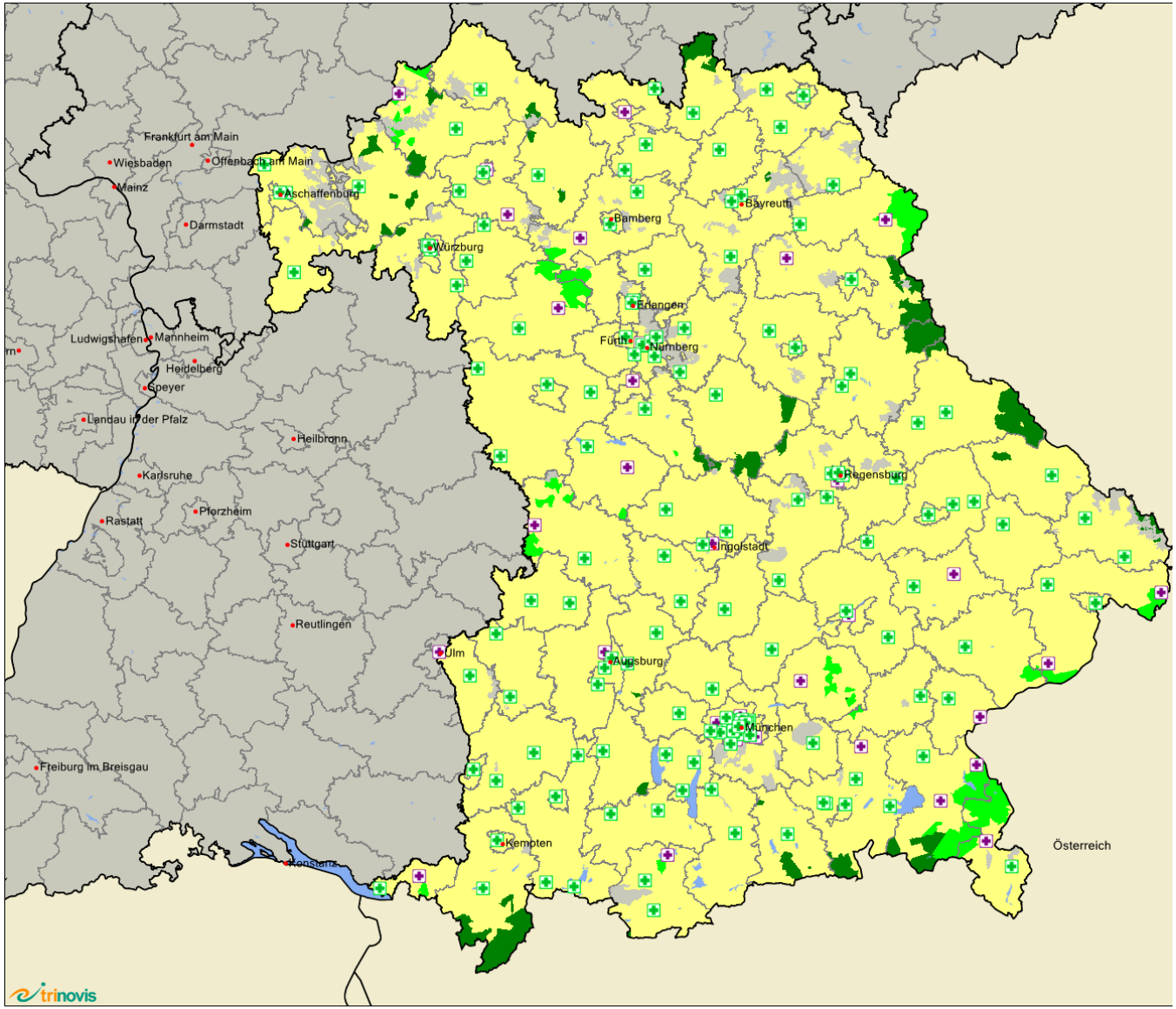

Knee-TEP-hospitals (186)

Green: minimum volume reached after recursion (145)

Purple: minimum volume not reached after recursion (41)

Let minimum volume regulation work!

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- The relationship between volume and outcome is a universal law.
- Less bureaucratic but powerful quality assurance tool.
- Prevents occasional services.
- Increases patient safety.
- Do not ask for a “special" volume-outcome relation (change § 137 SGB V).

Outline

Spitzenverband

1. **General set-up**
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   1. EQA: A short history
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   3. “Tear down this wall”

Code of Hammurabi (1750 BC)
First law, first fee.

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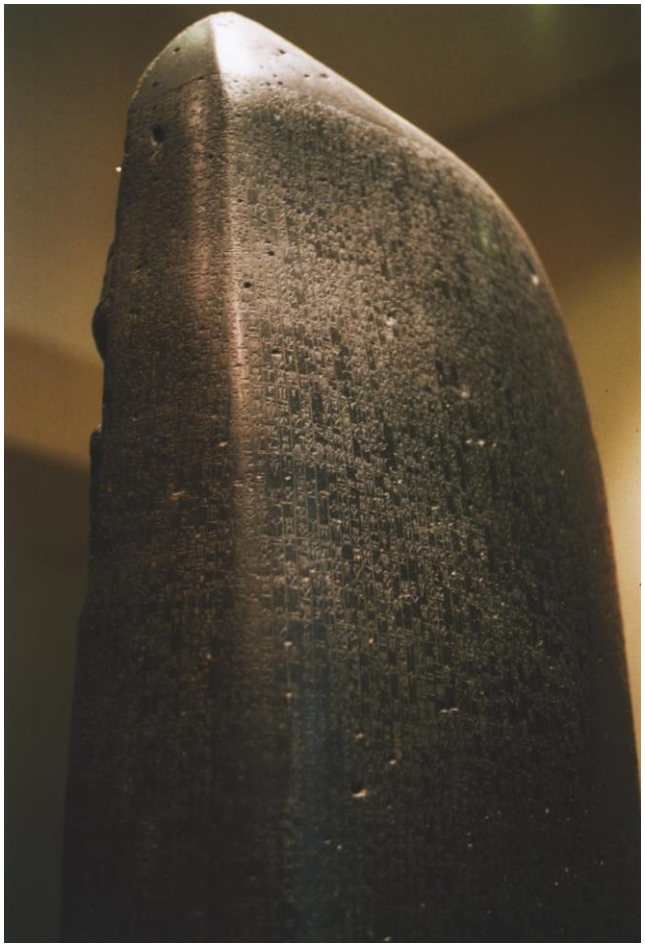

- „If a physician make a large incision with an operating knife and cure it, or if he open a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money."
- "If the patient be a freed man, he receives five shekels."
- "If he be the slave of some one, his owner shall give the physician two shekels."

(The text of this work is based on the 1915 translation by L. W. King)

Quality Assurance 1750 BC

Spitzenverband

- “If a physician make a large incision with the operating knife, and kill him, or open a tumor with the operating knife, and cut out the eye, his hands shall be cut off.”

- “If a physician make a large incision in the slave of a freed man, and kill him, he shall replace the slave with another slave.”

- “If he had opened a tumor with the operating knife, and put out his eye, he shall pay half his value.”

Quoted from: http://www.innovateus.net/content/medicine-code-hammurabi

Coalition Agreement: Selective contracting

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- 2015 – 2018: Pilot projects for selective contracts for four elective services defined by the Federal Joint Committee
- Evaluation of these quality contracts
- Definition of quality criteria by health insurance funds at state level
  - The Health Insurance Funds ask for selective contracts for elective services since 2007.
  - The proposals do not go far enough: Only quality as object of a contract. Price and quantities remain unaffected.
  - Evaluation is useful; maybe basis for further development (prices, quantities).

Quality – the solution: selective contracting in a DRG-framework?

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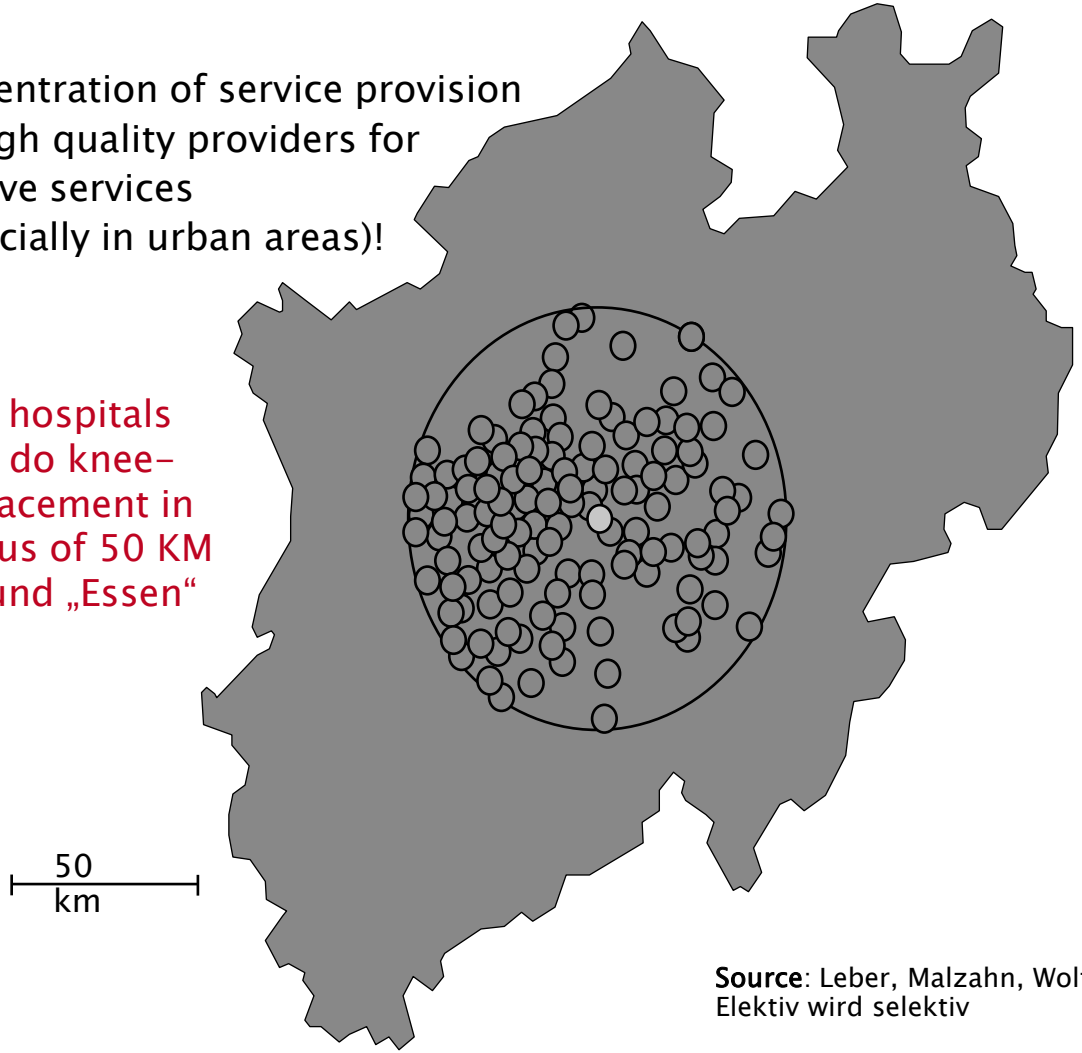
Concentration of service provision on high quality providers for elective services (especially in urban areas)!

106 hospitals that do knee-replacement in radius of 50 KM around „Essen“



Source: Leber, Malzahn, Wolff (2007): Elektiv wird selektiv

Quality oriented price increases and deductions?

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- Position of the German Hospital Association:

  „Poor services do not get any better by price deductions, ...“

- Position of the Association of SHI Funds:

  „..., but they become less likely!“

The search for the perfect indicator

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- The perfect indicator …

- … discriminates between good and bad quality.
- … focuses on outcomes.
- … is evidence based.
- … is significant und risk-adjusted.
- … is to be documented with little administrative effort (preferably routine data).
- … delivers results soon.
- … assigns quality source-specific.

Start quality-based payment now!

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- Health insurance funds do not want to make money out of poor quality.
- Start with appropriate indicators of the external quality assurance.
- Improvement by use of cross-sector routine data.
- Development of financing mechanisms that motivate providers to improve performance.

Structural and outcome quality

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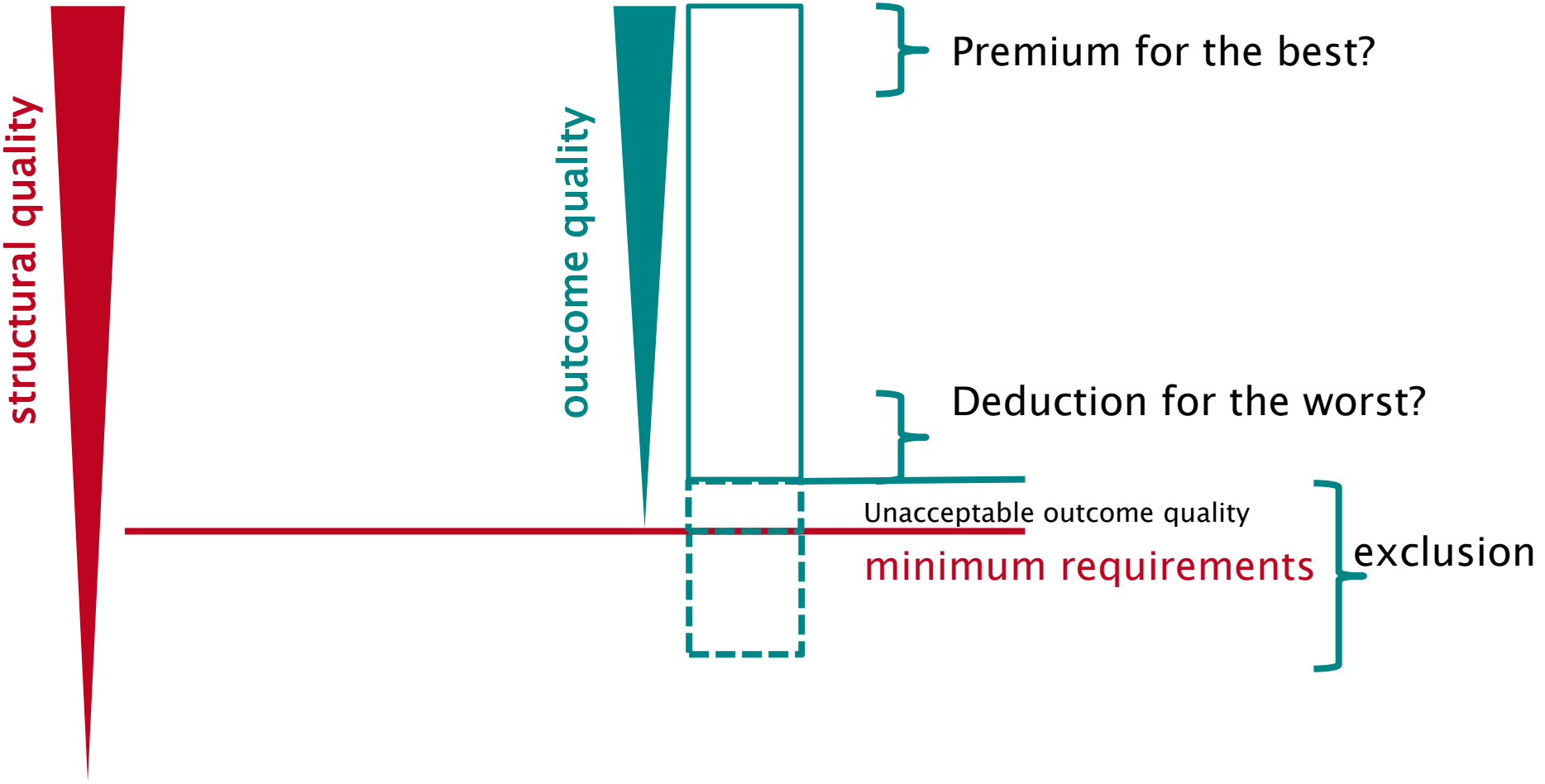

Start quality-based payment now

Example: hip endoprosthesis primary implantations (2013)

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- ICD M16.- coxarthrosis; OPS 5-820.0
- DRG I47B, effective price per case 7.052,34 €
- Case number >100.000 in ca. 1.000 hospitals
- Total expenditure: ca. 750 million €

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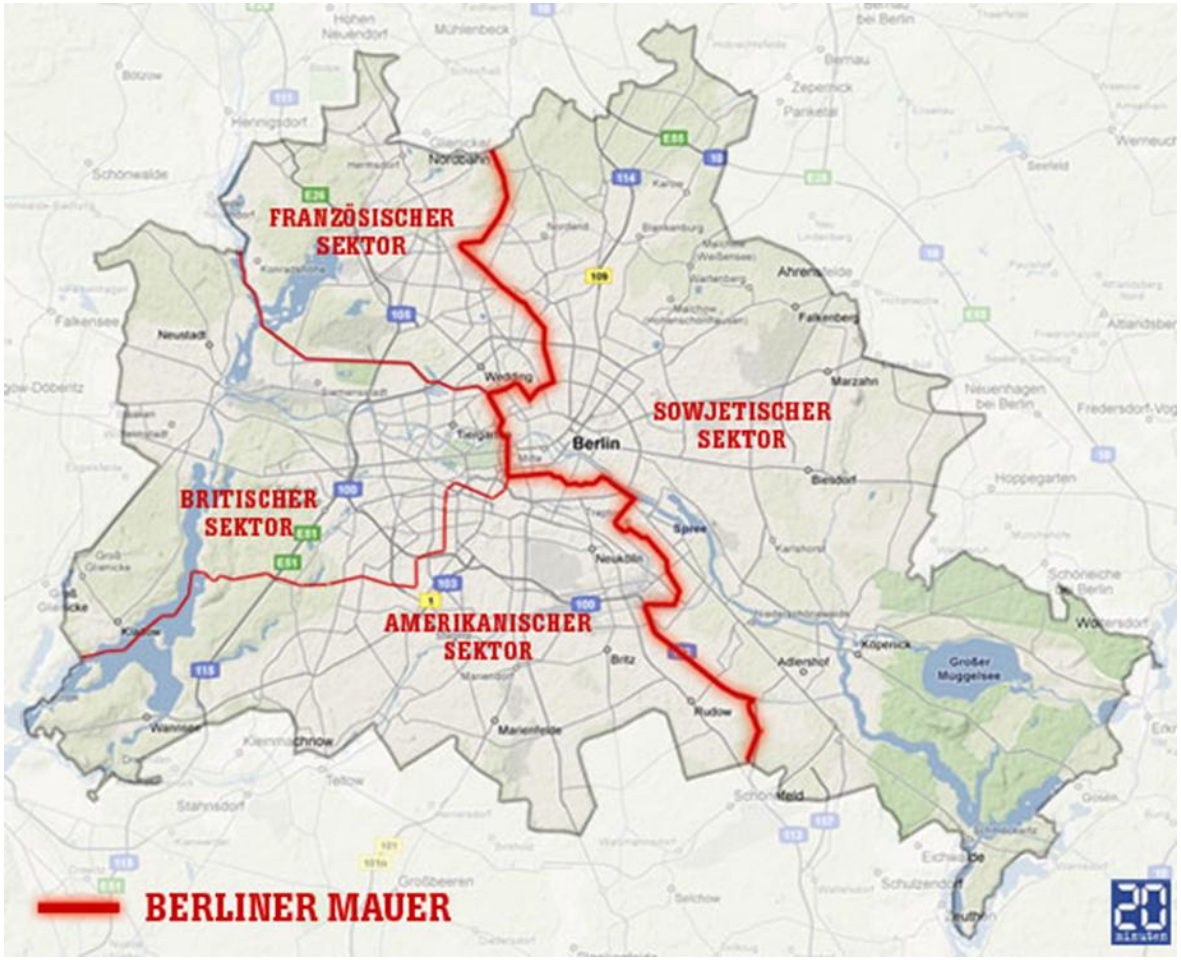

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"Mr. Gorbatschow, tear down this wall"

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„Tear down this wall“
Overcome sectoral boundaries

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Success or failure of a treatment can be assessed only if results, complications or secondary procedures can be measured after discharge.

- Documentation rules for diagnoses and procedures in the outpatient setting
- Standardized documentation rules for all areas of care
- Accelerate the development of cross-sectoral methods in the federal joint committee
- Use routine data from all relevant treatment areas
- Include data of private health insurances
- Neutral institutions at state level

The vision: One quality report for Germany

Spitzenverband

Qualitätsbericht

Gesundheits-versorgung in Deutschland

Spitzenverband

Thank you for your attention.