Opportunities and challenges in German long-term care and hospital markets

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   b) Regulating market entry and quality
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4. Summary and conclusion
1. Health care in Germany
Many resources/expenditures => good access

But only average health status and mixed quality signals
Health insurance funds (HI)

Mandatory statutory and private health insurance funds (SHI vs. PHI or GKV vs. PKV)

- Around 90% of population in SHI:
  - Pay-as-you-go system based on solidarity
  - 2019: 14.6% + 1% (on average, varies between 0.2 and 2.5%) of gross income, split equally between employer and employee (if not self-employed), capped

- Around 10% choose PHI:
  - Income thresholds to get into PHI (or being civil servant or self-employed)
  - Pays the doctors better (in general not the hospitals, though). Premium based on individual health risks (low for young and healthy)
  - Higher increase in costs despite the better risk structure
Organisation of German health care

- Total expenditures for health care: 375 Mio Euro per year (11.5%) in 2017
- Low share of private payments (11 to 13% between 1995 and 2017)
- Self-governance
- Joint Federal Committee is very strong
  - (consists of members of associations: hospitals, health insurance funds, physicians. Patients can only advise)
  - Decides on coverage of treatments, medical devices, medical aids
  - Decides on additional benefit assessment of drugs
  - Distributes funds to member associations
- Innovations need to go through this, which takes some time
2. Long-term care in Germany
2. Long-term care in Germany

- Leading principle: Informal care preferred to ambulatory preferred to inpatient care!
- 14,500 nursing homes with 764,648 employees (USA: 23,500 nursing homes)
- 14,100 ambulatory care services with 390,322 employees
- more than 2/3 of the staff work part-time
- 75% women
Long-Term Care Financing

- Long-term care insurance is mandatory
  - 3.05% to 3.3% (without kids) of gross income in 2019
  - Pays lump-sum based on care type (informal, ambulatory, stationary) and care need (since 2017: seven care grades)
  - High co-payments (increasing)
  - Communities cover co-payments if people in need (and their close relatives cannot afford them)
  - 40% of people in nursing homes receive some social benefits
  - Cost and co-payments vary regionally a lot
Ageing challenges German social security systems (health care funds, pensions), which are financed mainly on a pay-as-you-go basis.
Challenges and policies in LTC: demand side

• One of the oldest populations across OECD countries (20.9% are currently older than 65 years and 5.6% are aged over 80, compared to an OECD average of 17% and 4.4%, resp.)

• High prevalence of dementia

• The federal government has adopted a number of reforms in recent years to improve long-term care services for people
  • The scope and depth of the benefits package covered by LTC insurance has increased, with a particular focus on the needs of patients with dementia.
  • Support for informal carers: introducing short-term paid leave to organise care for long-term care dependent relatives or offering longer respite care for carers.

=> Both means increase cost for care!
Biggest challenge: Lack of ambulatory and stationary nurses: policies on the supply side

- Pofessional development in related fields
  - Policy goal: +36,000 people within next 5 years
  - Does not seem realistic as of today.

- New nursing law generalizes education
  - Until now: registered nurses had to specialise into hospital or long-term care
  - Since 08/19: nurses can specialise to become general registered nurse
  - Advantage=disadvantage: more flexible but also less trained in special fields

- No training costs anymore
More trained nurses needed: other political plans (not realised yet)

- Simplify immigration (from other occupations and from other countries)
  - Acknowledge foreign education more easily

- Improve working conditions
  - Better compatibility of family and work
  - More technological support, robotics, digitalisation

- In general: Increase labour force participation, extend child care

- Alternative: strengthen informal care
  - Extend use of technologies such as smart homes and Ambient Assisted Living (AAL) systems, domestic help

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Wage increases due to increasing need of nurses for the elderly

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Monthly gross wage 2017</th>
<th>Monthly gross wage 2012</th>
<th>Difference 2012 to 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse (hospital)</td>
<td>3.337€</td>
<td>2.958€</td>
<td>+12,8%</td>
</tr>
<tr>
<td>Assistant nurse (hospital)</td>
<td>2.502€</td>
<td>2.284€</td>
<td>+9,5%</td>
</tr>
<tr>
<td>Registered nurse (elderly)</td>
<td>2.744€</td>
<td>2.373€</td>
<td>+15,6%</td>
</tr>
<tr>
<td>Assistant nurse (elderly)</td>
<td>1.944€</td>
<td>1.682€</td>
<td>+15,5%</td>
</tr>
<tr>
<td>Median of all employees</td>
<td>3.209€</td>
<td>2.876€</td>
<td>+11,6%</td>
</tr>
</tbody>
</table>

Current discussions about regional collective agreements for registered nurses are – in my opinion – needless.

1. Only few nurses organised in unions but majority is necessary for collective agreement.
2. Competition for high-skilled staff will increase wages.
Supply side 2: Nursing home market

- Service guarantee ("Sicherstellungsauftrag") of the regional statutory health care funds is transferred to the nursing care funds ("Pflegekasse")
- The state ultimately bears the responsibility for maintaining a sufficient nursing care structure
- No central state planning. **Free market entry. But communities can deny building applications and thus influence locations!**
- A supply contract is to be agreed with the nursing care funds for each nursing home for at least one year. Only then, nursing homes receive investment subsidies of the federal states.

→ Prices vary by NH and state
Highest co-payments for nursing homes in NRW (historic reasons + high share of non-profit nursing homes)

Lowest in Eastern Germany (low income and many new private NH after reunification)
Number of nursing homes by ownership type and total 1999 to 2017

- **private non-profit** (freimeinnützig)
- **private for-profit** (privat),
- **public** (öffentlich)
- Patients receive same benefits from LTC Insurance
Quality

• High demands on documentation and regular monitoring
  • Public reporting since 2009. High improvements in published grades (Herr, Nguyen, Schmitz, 2016). However, grades do not measure care quality well.
  • New quality reports (that are published online) from Oct. 2019
  • Higher prices increase quality (Herr and Hottenrott, 2016)
• Single room share: E.g., in Baden-Württemberg and North-Rhine Westphalia all (new) nursing homes may only provide single rooms => Higher investment costs, but also higher utility for people in need if total capacities remain (Herr and Saric-Babin, 2019)
• Discussion about minimum staffing levels (not introduced yet)
Long-Term Care

Opportunities

- Free market entry, both in ambulatory and stationary care
- Prices negotiated for each institution at MDK level (Medical Service of the Health Funds), which basically corresponds to federal states.
- Prices may depend on staffing/costs (e.g., in North-Rhine Westphalia)
- Policies to improve LTC (slowly)

Challenges

- Ageing population challenges communities/tax payers in a pay-as-you-go system
- Investments must be covered by care dependents
- Prices may depend on lowest cost of comparable homes in the same state (e.g. in Bremen)
- Lack of registered nurses, lack of technical assistance
3. Hospital Markets
3. Hospital markets in Germany

- Increasing number of private for-profit chains
- Federal states plan number of beds for each hospital unit, no free entry
- Recently, minimum staffing levels introduced in four case-sensitive units (intensive care, accidents, cardiology, gerontology)
- Prices fixed (DRGs)
- Slow to implement innovations
- P4P, on average, objected
- Lack of IT solutions in communication and elsewhere
German DRGs and hospital financing

Dual financing:

• 1. DRGs
  • to cover costs of treatments => incentives to over-perform in some indications
  • Same DRG for private and public health care funds and independent of hospital ownership
  • Additional benefits for privately insured, again independent of hospital ownership
  • Only cover medical treatments and devices that are approved by the G-BA

• 2. Federal states supposed to cover investments in technologies and infrastructure
  • However, they do not spend sufficiently much => Hospitals need to use their profits from DRGs to cover investments => slow transformations
Doctors per 1,000 population in OECD countries, 2000 and 2015: close to Nordic countries

Practising doctors per 1000 population, 2000 and 2015 (or nearest year)

Source: www.oecd.org
Nursing staff per 1,000 population in OECD countries, 2000 and 2015 (or nearest year): close to Nordic countries

Source: www.oecd.org
Nurses per bed ratio: very low => lack of nursing staff or too many beds?

Ratio of nurses to beds, 2016

Source: www.oecd.org
Hospitals in Germany: over-provision of inpatient services

• 70% more hospital beds in Germany than on average across the OECD on a per capita basis

• High utilization:
  • second highest number of discharges (255 per 1,000 population) and 60% above the OECD average
  • highest number of coronary angioplasty performed in Germany (393 per 100,000 population)
  • numbers of hip and knee replacement surgeries are 80% and 60% above the OECD average.

• Certain surgeries (e.g. tonsillectomy) are still predominantly performed in an inpatient setting in Germany

• For some chronic conditions such as diabetes: high hospitalisation rates that should be largely avoidable
Efficiency gains possible in inpatient care

⇒ Moving more treatments out of hospitals. Strengthening primary care services and better co-ordination of care delivery across sectors

⇒ Systematic public reporting of geographical variations in some high-volume procedures, involving patients in shared-decision making. Changing financial incentives

⇒ Improving care quality in hospitals by fostering centralisation of complicated interventions (Danish example)

⇒ Reduction in bed capacity of low performing hospitals

What has been done:

⇒ Introducing quality as a criterion in hospital planning (only eleven quality indicators for obstetrics, gynaecological surgery and breast surgery are monitored since 2017)


⇒ Health Insurances are allowed to store and analyse data up to 10 years back!
Coverage of new methods or medical devices by SHI

Coverage decisions by G-BA / GKV Spitzenverband (SHI Association) depend on type of treatment/device

1. Medical apps: simplified due to new Digitalisation Act (covered for one year, time for producer to prove benefits) from 2021

2. Medical devices: new law under discussion. Changes according to EU regulation

3. New treatments/methods or methods with essential new high risk medical aids need to prove
   1) Benefit
   2) Medical necessity
   3) Economic Efficiency

   https://www.g-ba.de/themen/methodenbewertung/bewertung-erprobung

If 1) or 2) cannot be proven (yet), the producer can apply for a trial phase.
Inpatient care

Opportunities

- Generous health care funds IF the treatment or medical device makes it into the GKV catalogue. Quality assurance
- Low price elasticity due to low co-payments
- Very good access, low waiting times
- Federal state financing covers losses to secure regional access
- Slight improvements in quality monitoring and digitalisation (a bit)
- Minimum staffing levels in some units

Challenges

- Lack of nursing staff
- Difficult to get into GKV-catalogue. Decision by GB-A (Joint Federal Committee) based on medical evidence
- Efforts to reduce costs. Rationing? Hospital closures?
- DRGs influence medical decisions (profitable to provide more or less treatment than necessary)
- Dual financing makes hospital depend on regional political decisions. - Inflexible.
- Far behind in digitalisation and telematics.
4. Recent and future policies and conclusion
4. Policies tackling the challenges

Ministry of Health tries to
1. improve the quality and efficiency of the health care system
2. strengthen patients' interests
3. while contributing to the stabilisation of contribution rates.

Current discussions and laws
1. Nurse staffing law to increase number of registered nurses and improve working conditions
2. Minimum nurse staffing standards in care-sensitive units: to improve hospital quality
3. Digitalisation and innovation: Easier to cover medical apps. IT infrastructure must be implemented. Electronic patient record to be implemented in 2021 (planned)
Conclusion

• Big challenges for the German health care system
• Government in charge is very active to solve / reduce some of them (e.g., lack of nursing staff, invest into digitalisation)
• However, reforms are mostly small-scaled and do not change the system as such
• More radical ideas:
  • Abolish difference between private and statutory health insurances
  • Decrease number of beds and thereby increase nursing staff per bed by closing hospitals (Danish example)
  • Consequently digitalise health care in all types of care and connect providers
Thank you for your attention!

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How have wages developed over time?

Wage development over time, 2010-2014

Source: www.oecd.org
Source: Federal Ministry of Health (BMG)
Nurse to physician ratio in OECD countries in 2015: Doctors delegate less in Germany than in other countries

Ratio of nurses to doctors, 2015 (or nearest year)

Source: www.oecd.org