Redefining German Health Care

Professor Michael E. Porter
Harvard Business School
www.isc.hbs.edu

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This presentation draws on Redefining German Health Care (with Clemens Guth), Springer Press, February 2012; Redefining Health Care: Creating Value-Based Competition on Results (with Elizabeth O. Teisberg), Harvard Business School Press, May 2006; "A Strategy for Health Care Reform—Toward a Value-Based System," *New England Journal of Medicine*, June 3, 2009; "Value-Based Health Care Delivery," *Annals of Surgery* 248: 4, October 2008; "Defining and Introducing Value in Healthcare," *Institute of Medicine Annual Meeting*, 2007. Additional information about these ideas, as well as case studies, can be found the Institute for Strategy & Competitiveness Redefining Health Care website at http://www.hbs.edu/rhc/index.html.

The Health Care Problem

- **Increasing demand**
  - Aging populations and increasing burden of disease
- More **treatable** diseases
- **Rising costs**
  - Health spending has risen faster than economic growth in most OECD countries since 1970
  - Significant challenge to government budgets
- Inconsistent **quality** and low **efficiency**
- Limited or non-existent **measurement** of costs or outcomes
- **Zero-sum competition** that is not focused on patients or patient outcomes

Strengths of the German System

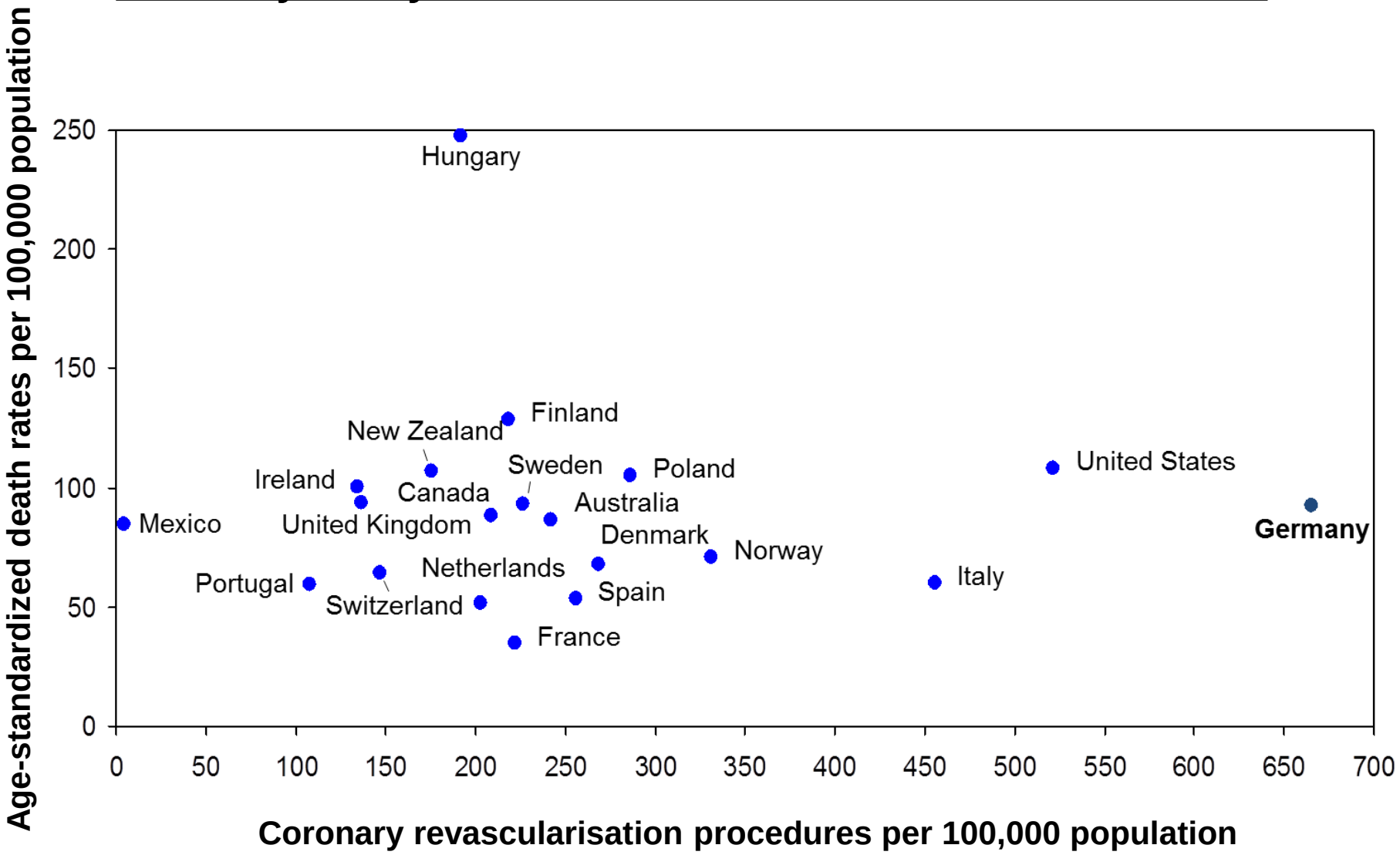
- **Universal access** to health insurance with **generous coverage** of a broad range of services
- Strong **solidarity principle** in providing coverage regardless of financial means
- **Free choice** of health plans and providers
- **Extensive network** of capable providers
- Many patients receive **excellent** and **compassionate care**

Issues Facing the German System

- High and **rising costs**
- Overcapacity and low reimbursement levels leading to **excessive utilization of services**
  - High service utilization and costs are not producing better health outcomes

Excessive Utilization Does Not Produce Better Outcomes

Coronary Artery Revascularization Rates Across Countries



Source: OECD Health Data 2009

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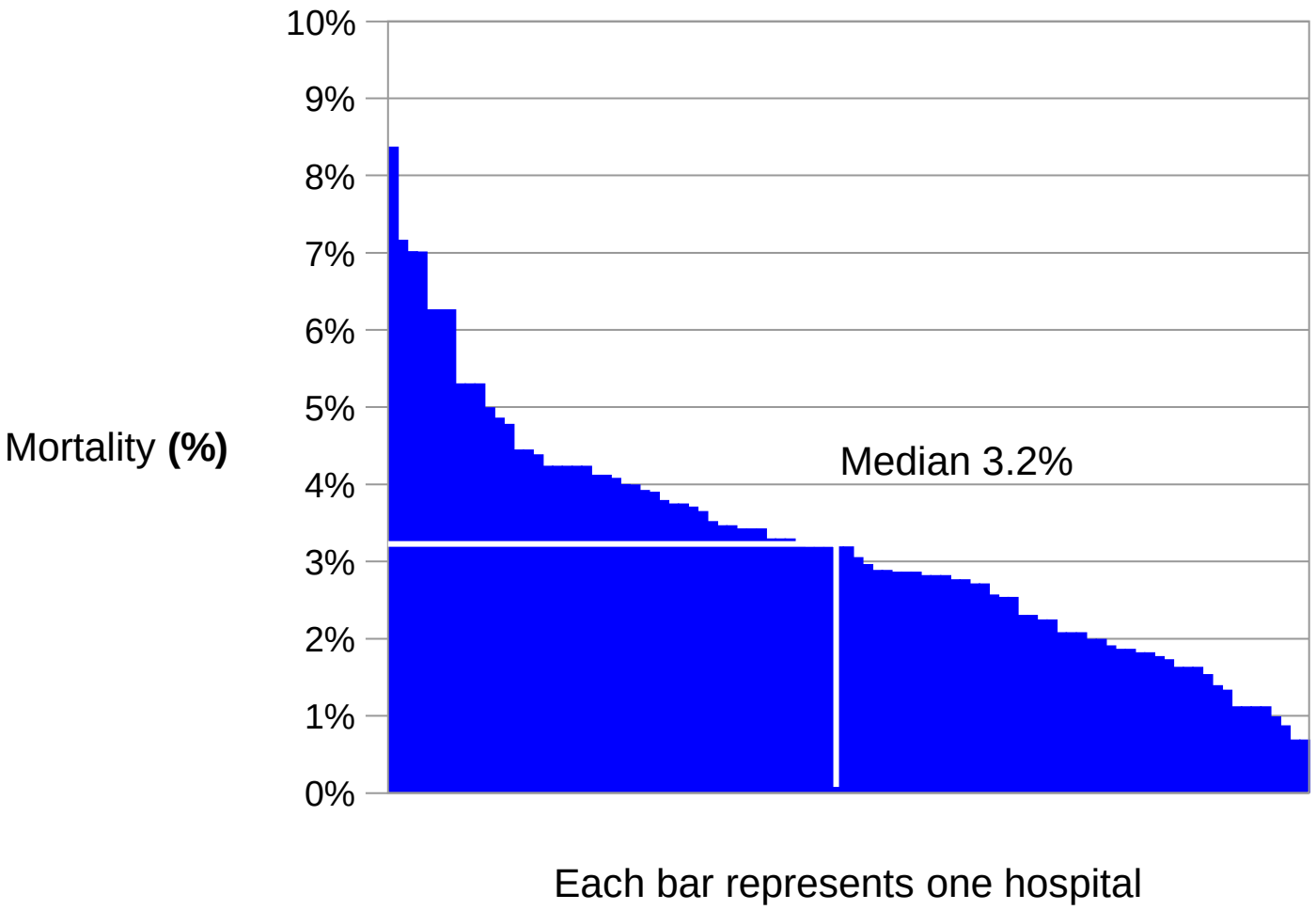
- Large variation in **quality** across providers

Variation in Quality Across German Providers:
In-hospital Cardiac Bypass Mortality for 77 hospitals (2008)



Source: BQS Ouctomes 2008 – see page 184 of *Redefining German Health Care* for graph on risk-adjusted results

Issues Facing the German System

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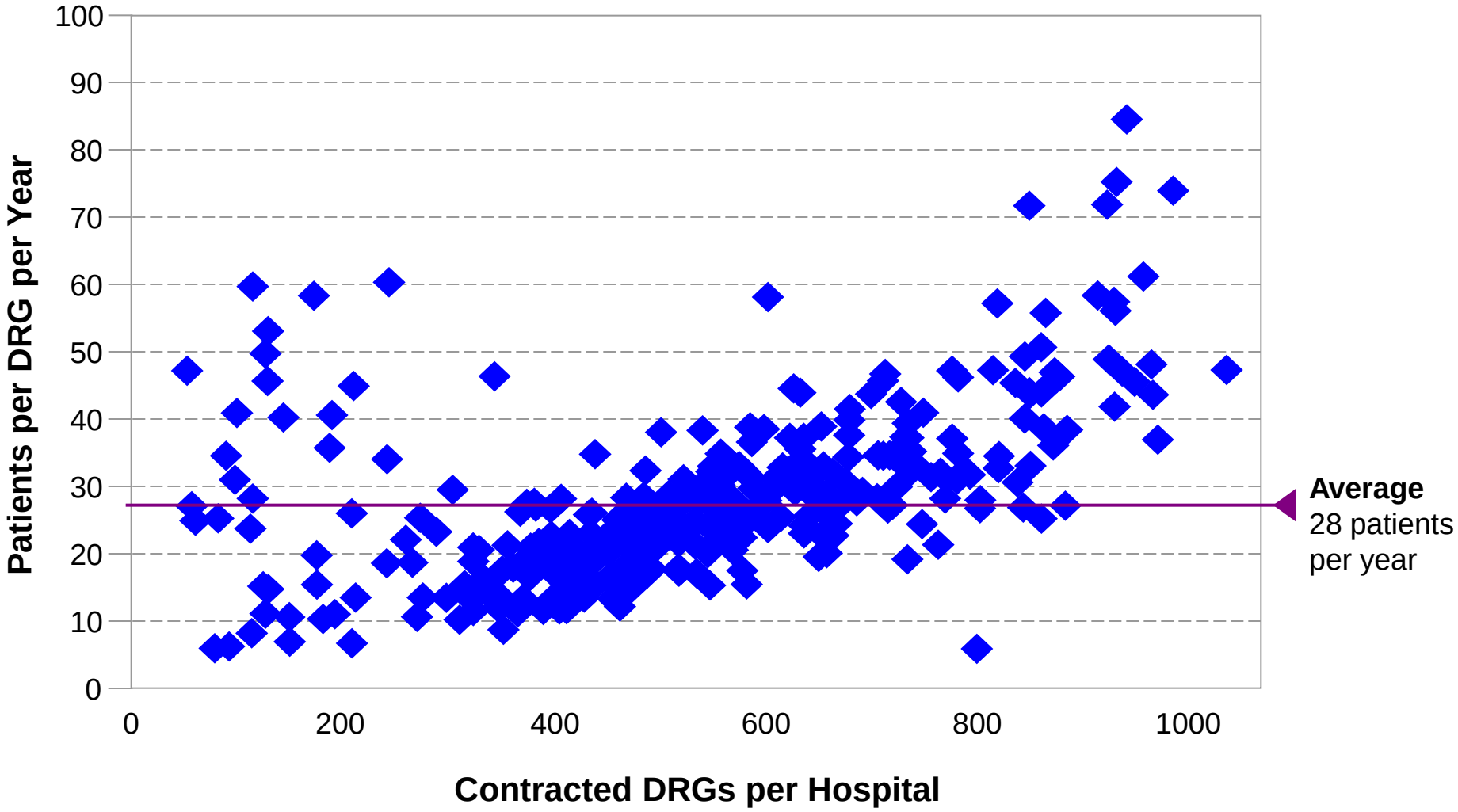
  - No systematic **measurement** of outcomes and costs
- **Hyper-fragmentation of services** across inpatient and outpatient care and **inadequate volume** of patients in a medical condition to achieve excellence

Fragmentation of Volume in Germany

Distribution of Patients and DRGs Across Hospitals



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- **Hyper-fragmentation of services** across inpatient and outpatient care and **inadequate volume** of patients in a medical condition to achieve excellence
- **Lack of solidarity** between the public and private system
- Many **incremental reforms** with limited impact
  - Focus on containing costs, rather than improving value

Redefining Health Care Delivery

- The overarching goal in health care must be **value for patients**

$$\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}$$

  - Outcomes are **health results that matter for a patient's condition** over the care cycle
  - Costs are the **total costs of care for a patient's condition** over the care cycle

- Value is the only goal that can **unite the interests** of all stakeholders
- The central challenge for Germany is to design a health care delivery system that **dramatically improves patient value**

Principles of Value-Based Health Care Delivery

- **Quality improvement** is the most powerful driver of cost containment and value improvement, where quality is **health outcomes**

- Prevention of illness
- Early detection
- Right diagnosis
- Right treatment to the right patient
- Rapid cycle time of diagnosis and treatment
- Treatment earlier in the causal chain of disease
- Less invasive treatment methods
- Fewer complications
- Fewer mistakes and repeats in treatment
- Faster recovery
- More complete recovery
- Greater functionality and less need for long term care
- Fewer recurrences, relapses, flare ups, or acute episodes
- Reduced need for ER visits
- Slower disease progression
- Less care induced illness

- Better health is **inherently less expensive** than poor health
- **Better health** is the goal, not more treatment

Higher Quality Care Drives Down Long-Term Costs

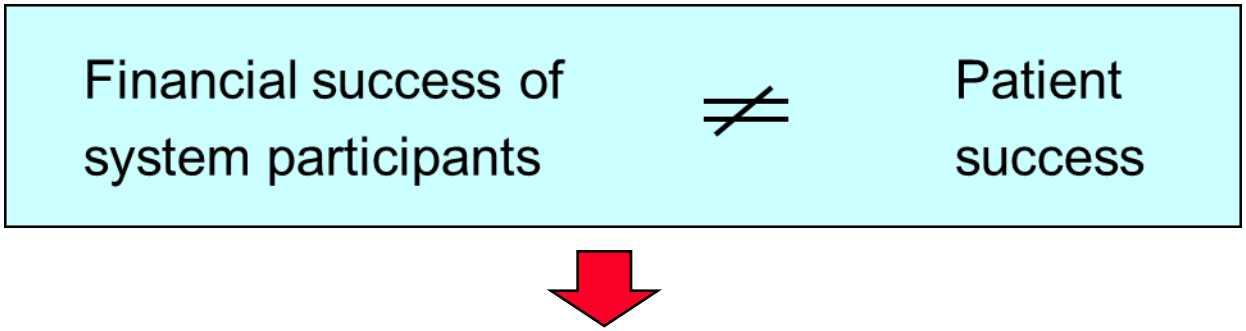
Hospital quality for hip replacements	Average 1-year follow-up hospital costs (EURO)	Number of patients
Patients treated in hospitals with below average outcomes	€10,042	26,049
Patients treated in hospitals with average outcomes	€9,112	73,481
Patients treated in hospitals with above average outcomes	€8,493	55,293
Patients treated in very low volume hospitals**	€11,199	3,685

* Less than 30 hip replacements per year for AOK health plan members

Source: Fahlenbrach C et al, Bonus ohne Extrakosten, Gesundheit und Gesellschaft, Issue 9/11

Creating a Value-Based Health Care System

- Significant improvement in value will require **fundamental restructuring of health care delivery**, not incremental improvements
- **Competition** and **choice** for patients/subscribers are powerful forces to encourage restructuring of care and continuous improvement in value
- Today's competition in health care **is not aligned with value**



- Creating a positive-sum **competition on value** is fundamental to health care reform in every country

Creating a Value-Based Health Care Delivery System

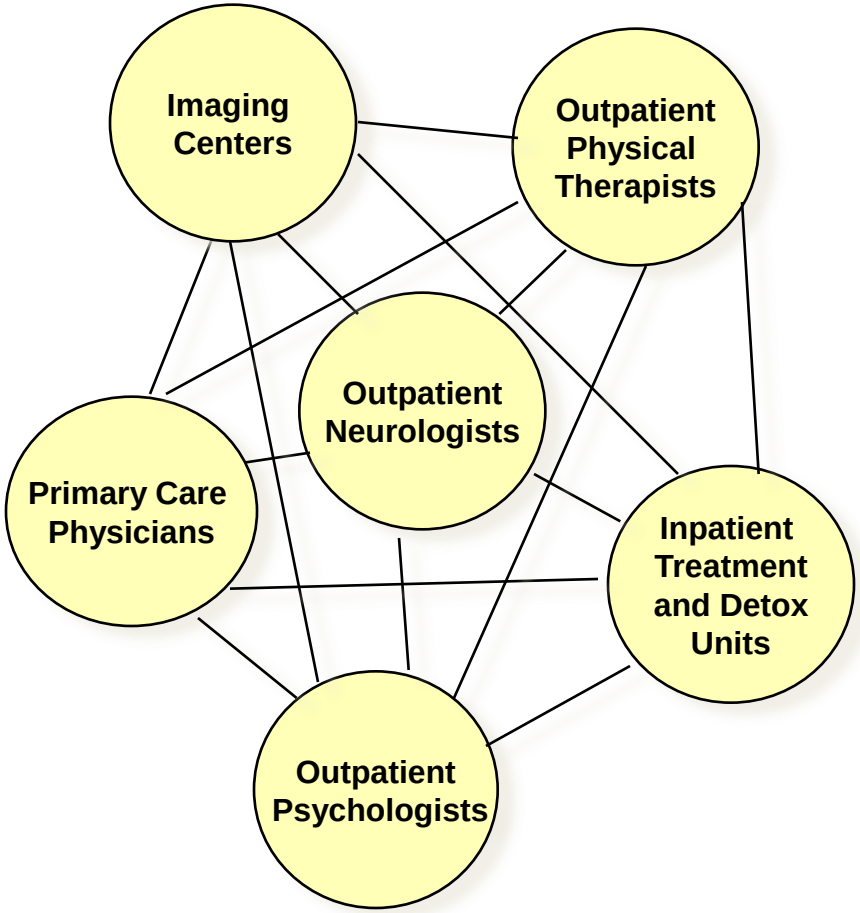
The Strategic Agenda

1. Organize Care into Integrated Practice Units (IPUs) around Patient Medical Conditions
2. Measure Outcomes and Costs for Every Patient
3. Reimburse Through Bundled Prices for Care Cycles
4. Integrate Care Delivery Across Separate Facilities
5. Expand Areas of Excellence Across Geography
6. Create an Enabling Information Technology Platform

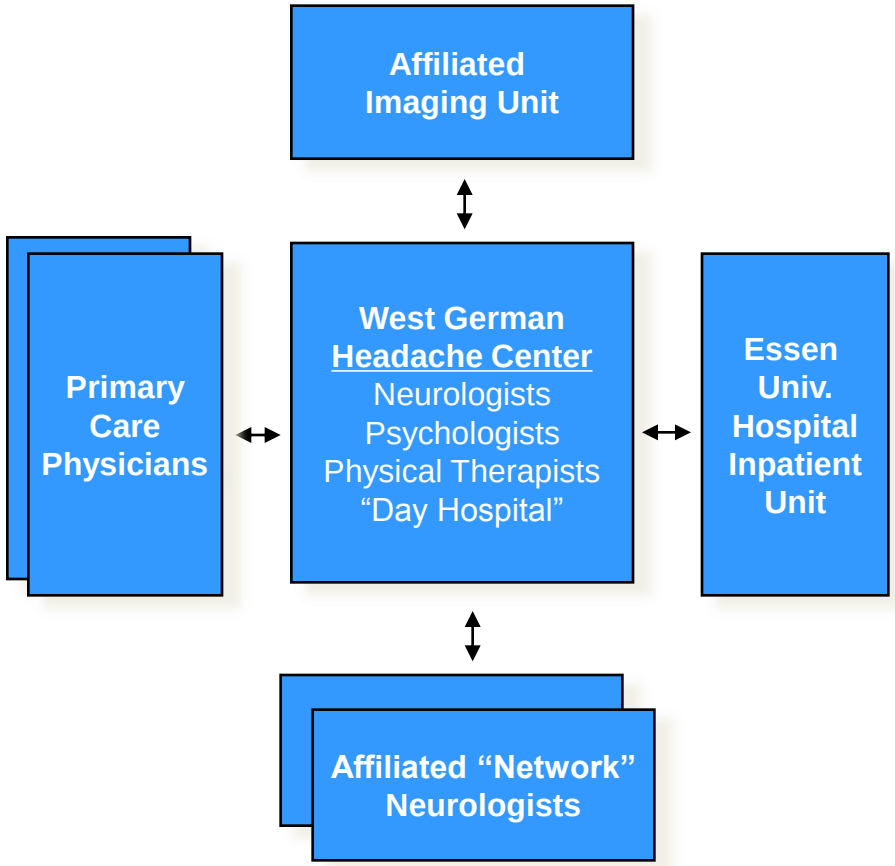
Organizing Around Patient Medical Conditions

Migraine Care in Germany

Existing Model:
Organize by Specialty and Discrete Services



New Model:
Organize into Integrated Practice Units (IPUs)



Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, *The West German Headache Center: Integrated Migraine Care*, Harvard Business School Case 9-707-559, September 13, 2007

What is a Medical Condition?

- A medical condition is **an interrelated set of patient medical circumstances best addressed in an integrated way**
  - Defined from the **patient's** perspective
  - Involving **multiple** specialties and services
  - **Including** common co-occurring conditions and complications

- In primary / preventive care, the **unit of value creation** is **defined patient segments** with similar preventive, diagnostic, and primary treatment needs (e.g. healthy adults, frail elderly)

- The medical condition / patient segment is the proper **unit of value creation** and the **unit of value measurement** in health care delivery

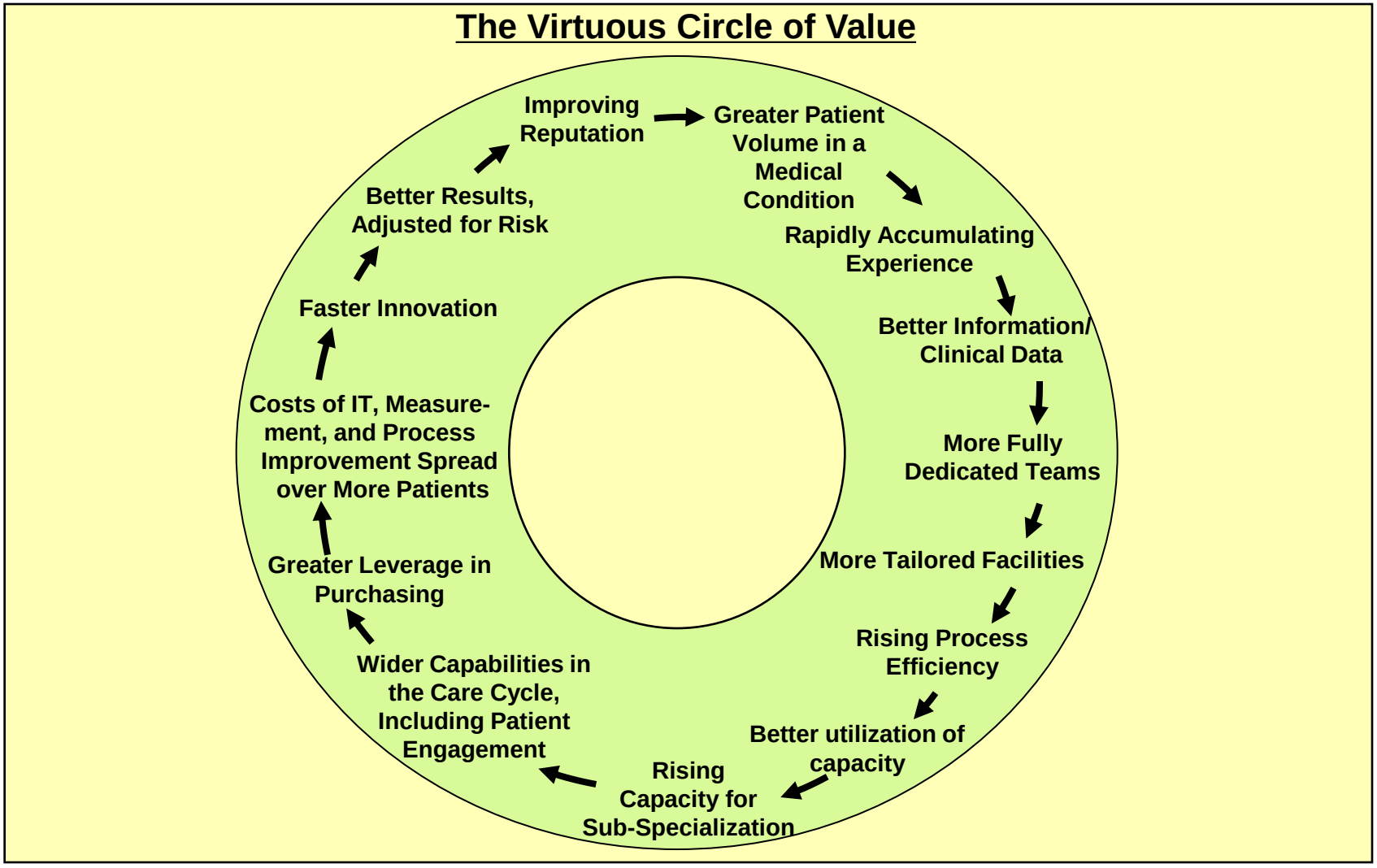
Integrating Across the Cycle of Care
Breast Cancer

	MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABING	MONITORING/ MANAGING
INFORMING AND ENGAGING	• Advice on self screening • Consultations on risk factors	• Counseling patient and family on the diagnostic process and the diagnosis	• Explaining patient treatment options/ shared decision making • Patient and family psychological counseling	• Counseling on the treatment process • Education on managing side effects and avoiding complications • Achieving compliance	• Counseling on rehabilitation options, process • Achieving compliance • Psychological counseling	• Counseling on long term risk management • Achieving compliance
MEASURING	• Self exams • Mammograms	• Mammograms • Ultrasound • MRI • Labs (CBC, etc.) • Biopsy • BRACA 1, 2… • CT • Bone Scans	• Labs	• Procedure-specific measurements	• Range of movement • Side effects measurement	• MRI, CT • Recurring mammograms (every six months for the first 3 years)
ACCESSING THE PATIENT	• Office visits • Mammography unit • Lab visits	• Office visits • Lab visits • High risk clinic visits	• Office visits • Hospital visits • Lab visits	• Hospital stays • Visits to outpatient radiation or chemo-therapy units • Pharmacy visits	• Office visits • Rehabilitation facility visits • Pharmacy visits	• Office visits • Lab visits • Mammographic labs and imaging center visits
	• Medical history • Control of risk factors (obesity, high fat diet) • Genetic screening • Clinical exams • Monitoring for lumps	• Medical history • Determining the specific nature of the disease (mammograms, pathology, biopsy results) • Genetic evaluation • Labs	• Choosing a treatment plan • Surgery prep (anesthetic risk assessment, EKG) • Plastic or onco-plastic surgery evaluation • Neo-adjuvant chemotherapy	• Surgery (breast preservation or mastectomy, oncoplastic alternative) • Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)	• In-hospital and outpatient wound healing • Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphedema and chronic fatigue) • Physical therapy	• Periodic mammography • Other imaging • Follow-up clinical exams • Treatment for any continued or later onset side effects or complications

Attributes of an Integrated Practice Unit (IPU)

1. Organized around the **patient medical condition** or set of closely related conditions
   - Distinct patient segment in primary care
2. Involves a **dedicated**, **multidisciplinary team** who devotes a significant portion of their time to the condition
3. Providers involved are members or affiliated with a **common organizational unit**
4. Provides the **full cycle of care** for the condition
   - Encompassing **outpatient**, **inpatient**, and **rehabilitative** care as well as **supporting services** (e.g. nutrition, social work, behavioral health)
5. Includes **patient education**, **engagement**, and **follow-up**
6. Utilizes a **single administrative** and **scheduling structure**
7. **Co-located** in **dedicated facilities**
8. Care is led by a **physician team captain** and a **care manager** who oversee each patient's care process
9. **Measures** outcomes, costs, and processes for each patient using a **common information platform**
10. **Meets formally and informally** on a regular basis to discuss patients, processes and results
11. Accepts **joint accountability** for outcomes and costs

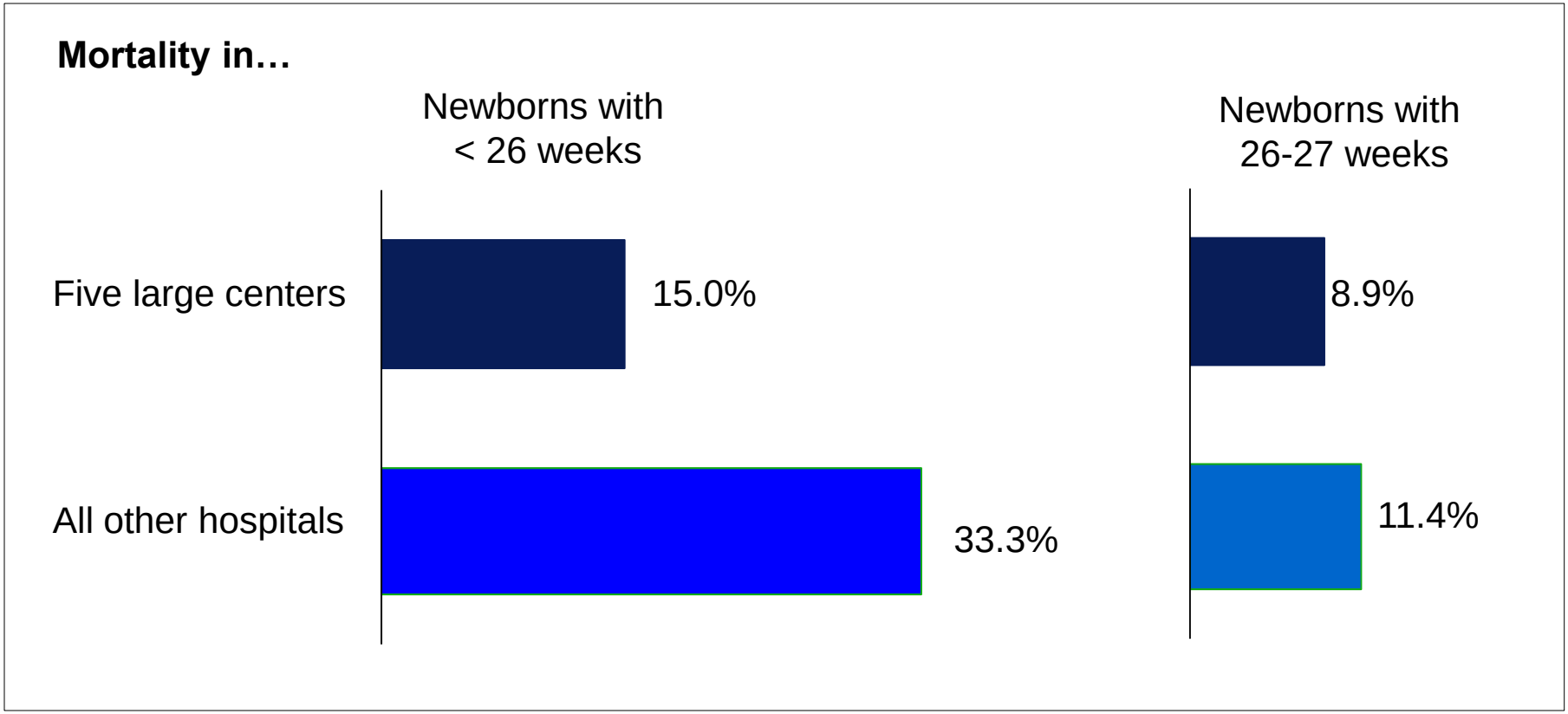
Volume in a Medical Condition Enables Value



- Volume and experience will have an even greater impact on value **in an IPU structure** than in the current system

Volume in a Medical Condition Enables Value

Pre-term Births in Baden-Würtemberg, Germany



Source: Hummer et al, Zeitschrift für Geburtshilfe und Neonatologie, 2006; Results duplicated in AOK study: Heller G, Gibt es einen Volumen-Outcome-Zusammenhang bei der Versorgung von Neugeborenen mit sehr niedrigem Geburtsgewicht in Deutschland – Eine Analyse mit Routinedaten, Wissenschaftliches Institut der AOK (WIdO)

Role of Volume in Value Creation

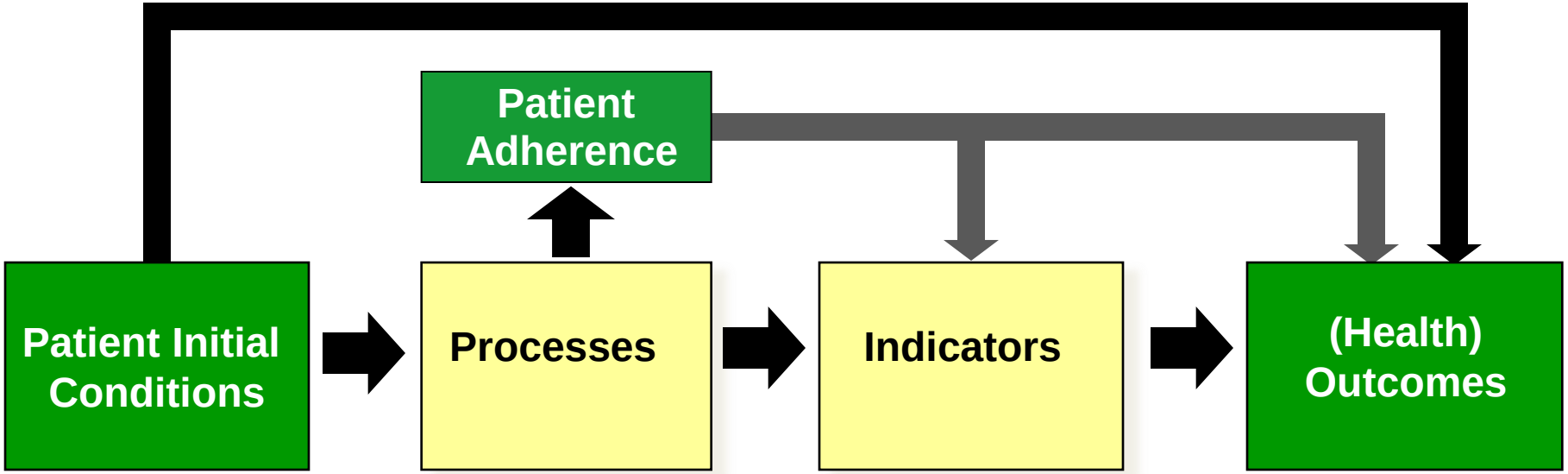
Fragmentation of Hospital Services in Sweden

DRG	Number of admitting providers	Average percent of total national admissions	Average admissions/ provider/ year	Average admissions/ provider/ week
Knee Procedure	68	1.5%	55	1
Diabetes age > 35	80	1.3%	96	2
Kidney failure	80	1.3%	97	2
Multiple sclerosis and cerebellar ataxia	78	1.3%	28	1
Inflammatory bowel disease	73	1.4%	66	1
Implantation of cardiac pacemaker	51	2.0%	124	2
Splenectomy age > 17	37	2.6%	3	<1
Cleft lip & palate repair	7	14.2%	83	2
Heart transplant	6	16.6%	12	<1

Source: Compiled from The National Board of Health and Welfare Statistical Databases – DRG Statistics, Accessed April 2, 2009.

- **Minimum volume standards** are an interim step to drive value and service consolidation in the absence of rigorous outcome information

Measuring Outcomes for Every Patient



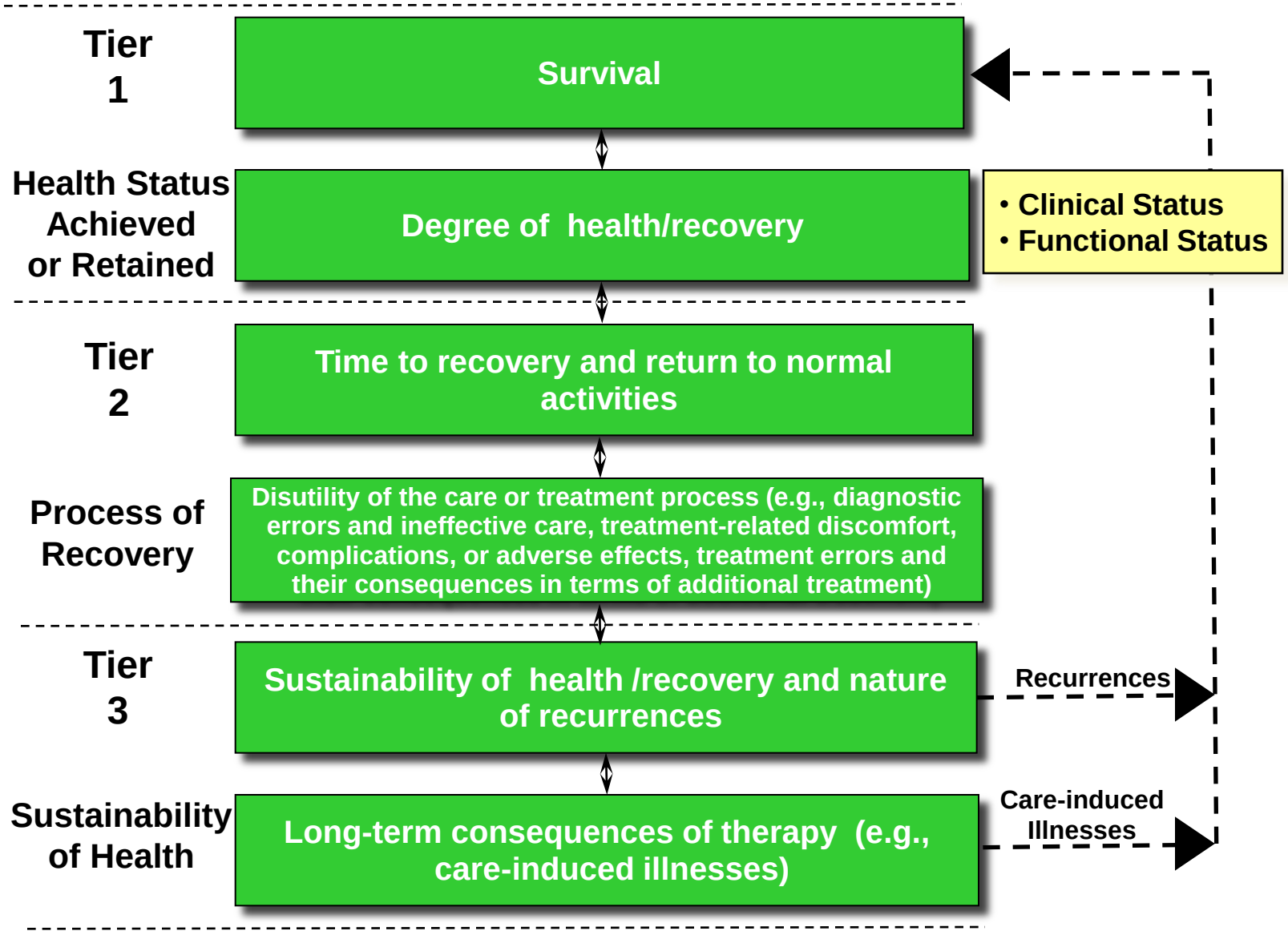
Protocols/ Guidelines

E.g., Hemoglobin A1c levels for diabetics

Structure

E.g., Staff certification, facilities standards

The Outcome Measures Hierarchy



Source: NEJM Dec 2010

The Outcome Measures Hierarchy

Breast Cancer

Survival

- Survival rate (One year, three year, five year, longer)

Degree of recovery / health

- Degree of remission
- Functional status
- Breast conservation
- Depression

Time to recovery or return to normal activities

- Time to remission
- Time to functional status

Disutility of care or treatment process (e.g., treatment-related discomfort, complications, adverse effects, diagnostic errors, treatment errors)

- Nosocomial infection
- Nausea/vomiting
- Febrile neutropenia
- Suspension of therapy
- Failed therapies
- Limitation of motion
- Depression

Sustainability of recovery or health over time

- Cancer recurrence
- Sustainability of functional status

Long-term consequences of therapy (e.g., care-induced illnesses)

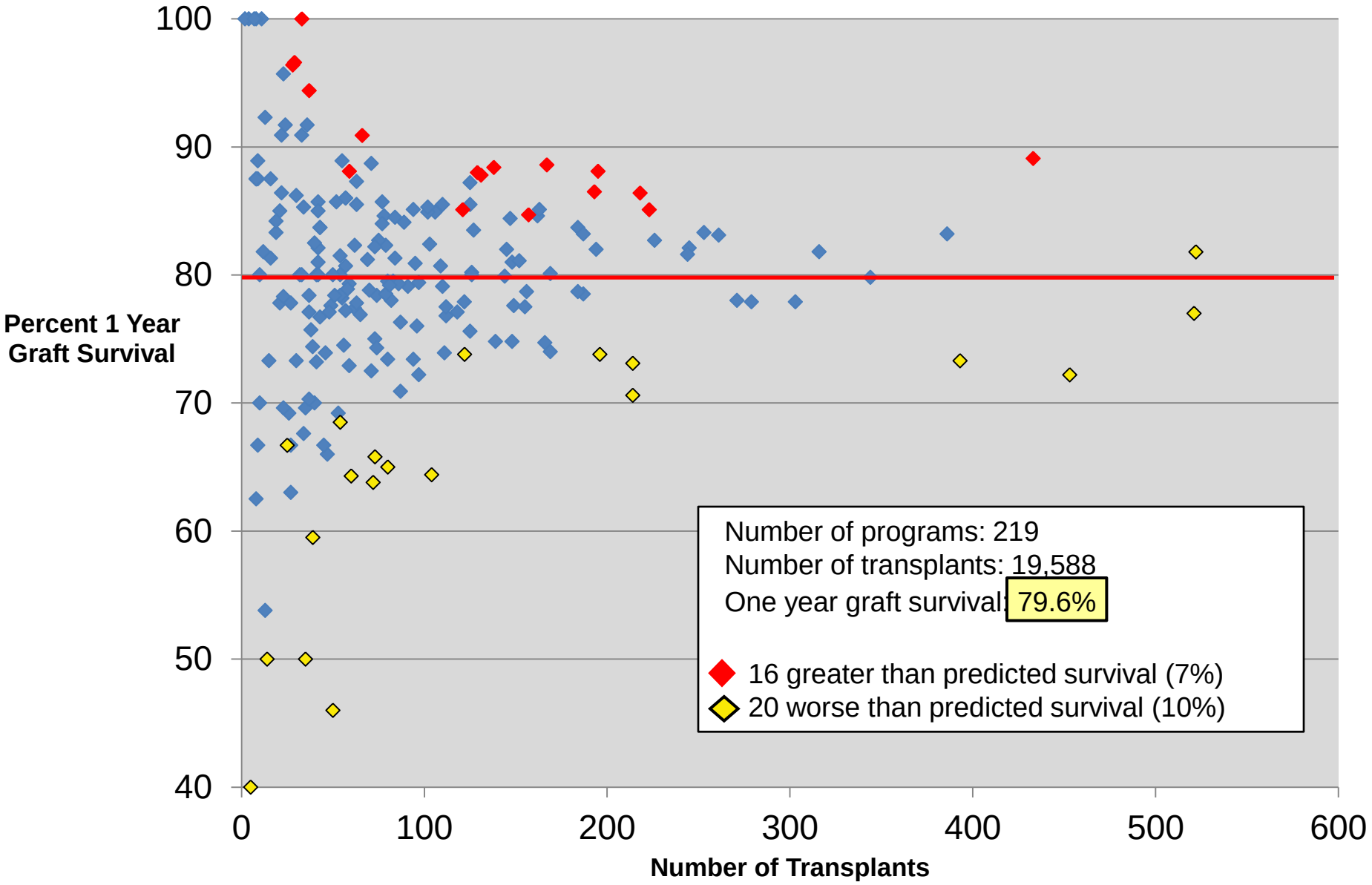
- Incidence of secondary cancers
- Brachial plexopathy
- Fertility/pregnancy complications
- Premature osteoporosis

Initial Conditions/Risk Factors

- Stage upon diagnosis
- Type of cancer (infiltrating ductal carcinoma, tubular, medullary, lobular, etc.)
- Estrogen and progesterone receptor status (positive or negative)
- Sites of metastases
- Previous treatments
- Age
- Menopausal status
- General health, including co-morbidities
- Psychological and social factors

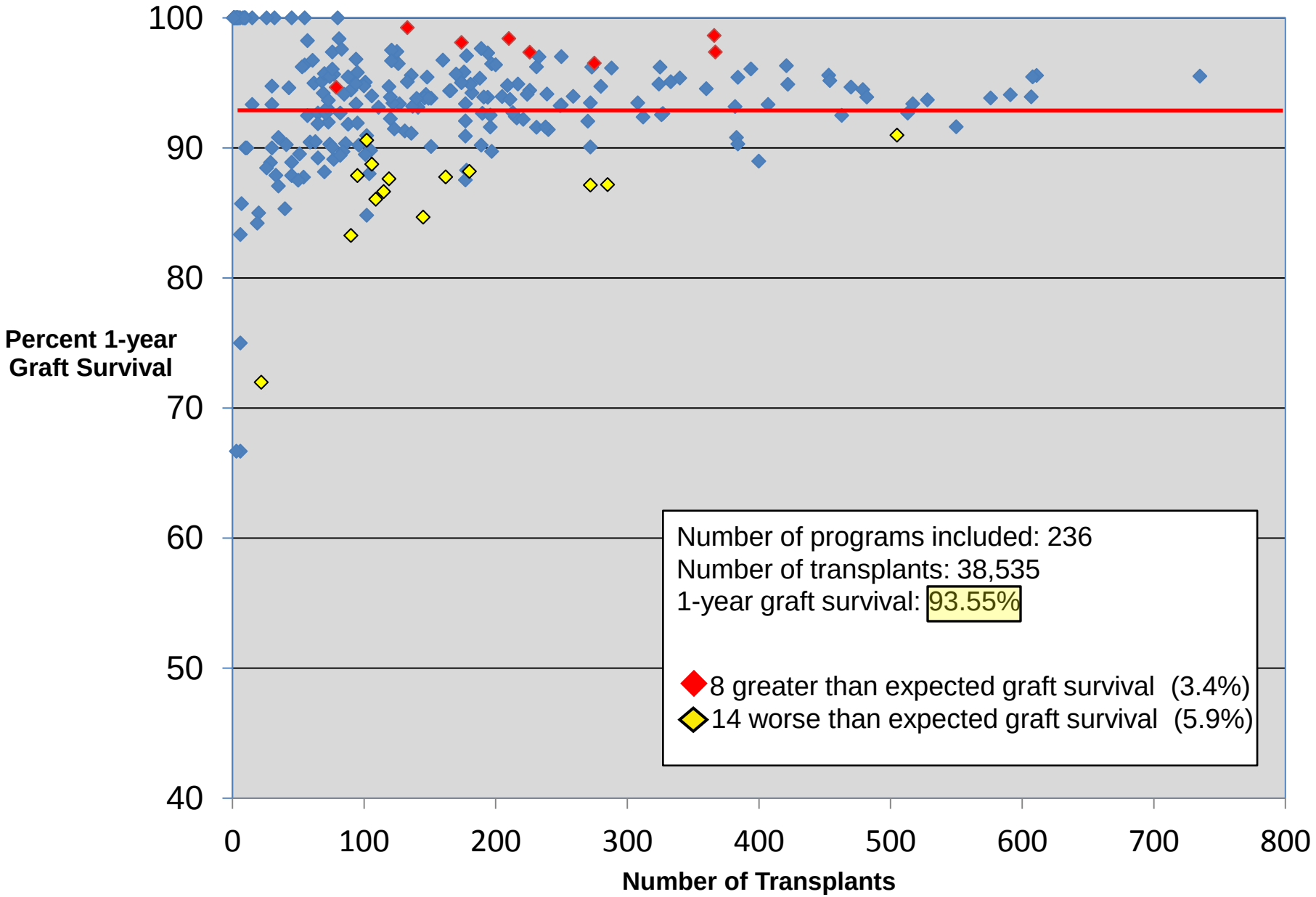
Adult Kidney Transplant Outcomes

U.S. Centers, 1987-1989



Adult Kidney Transplant Outcomes

U.S. Center Results, 2008-2010

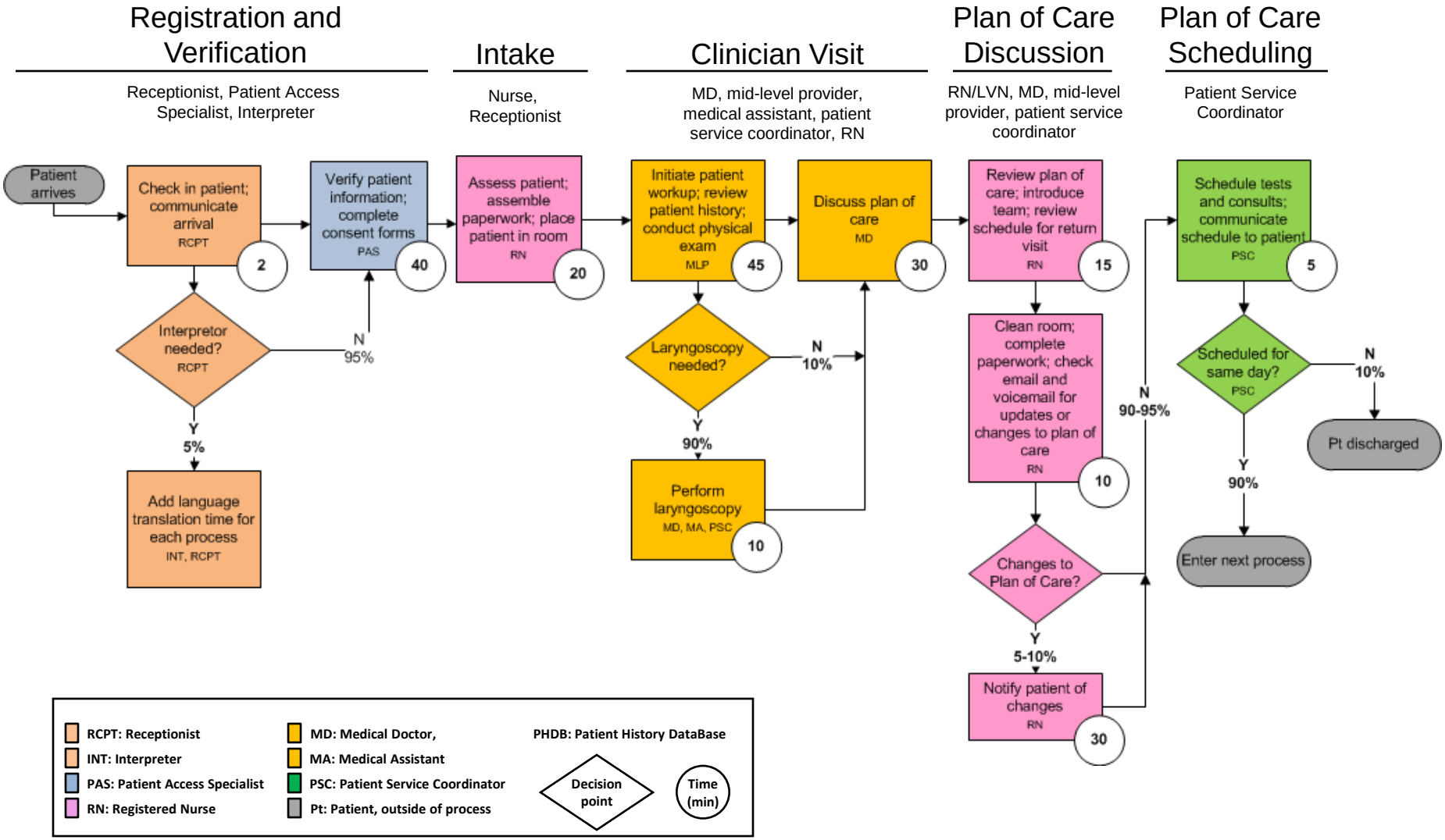


Measuring the Cost of Care Delivery: Principles

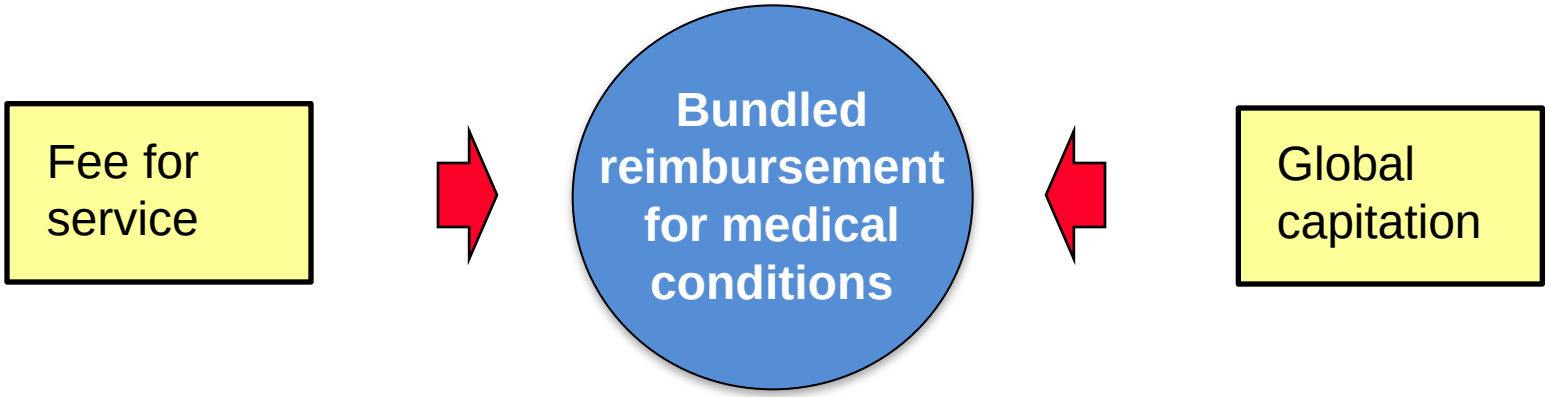
- Cost is the **actual expense** of patient care, not the **charges** billed or collected
- Cost should be measured around the **patient**
- Cost should be aggregated over the **full cycle of care for the patient's medical condition,** not for departments, services, or line items
- Cost depends on the **actual use of resources** involved in a patient's care process (personnel, facilities, supplies)
  - The **time** devoted to each patient by these resources
  - The **capacity cost** of each resource
  - The **support costs** required for each patient facing a resource

Mapping Resource Utilization

MD Anderson Cancer Center – New Patient Visit



Move to Bundled Prices for Care Cycles



Bundled Price

- A single price covering the **full care cycle for an acute medical condition**
- Time-based reimbursement for overall care of a **chronic condition**
- Time-based reimbursement for **primary/preventive care** for a **defined patient segment**

Bundled Payment in Practice
Hip and Knee Replacement in Stockholm, Sweden

- **Components** of the bundle

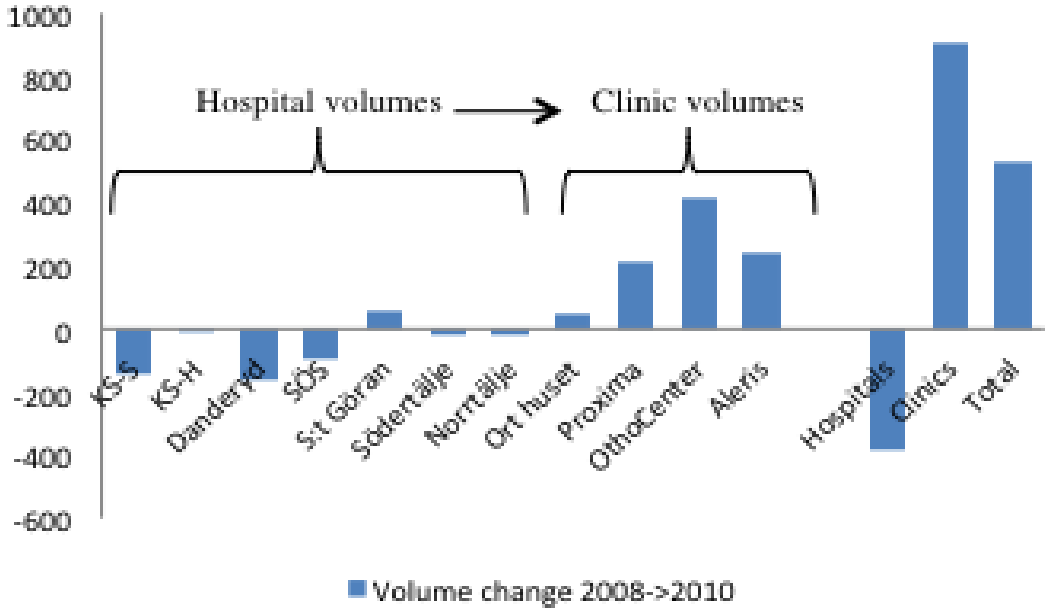
- Pre-op evaluation - Lab tests - Radiology - Surgery & related admissions - Prosthesis - Drugs - Inpatient rehab, up to 6 days	- All physician and staff fees and costs - 1 follow-up visit within 3 months - Any additional surgery to the joint within 2 years - If post-op infection requiring antibiotics occurs, guarantee extends to 5 years

- Currently applies to all **relatively healthy patients** (i.e. ASA scores of 1 or 2)
- The same **referral process** from PCPs is utilized as the traditional system
- **Mandatory reporting** by providers to the joint registry plus supplementary reporting
- Applies to **all** qualifying patients. Provider participation is **voluntary**, but all providers are continuing to offer total joint replacements

- The Stockholm bundled price for a knee or hip replacement is about **US $8,000**

Hip and Knee Replacement in Stockholm, Sweden

Provider Response

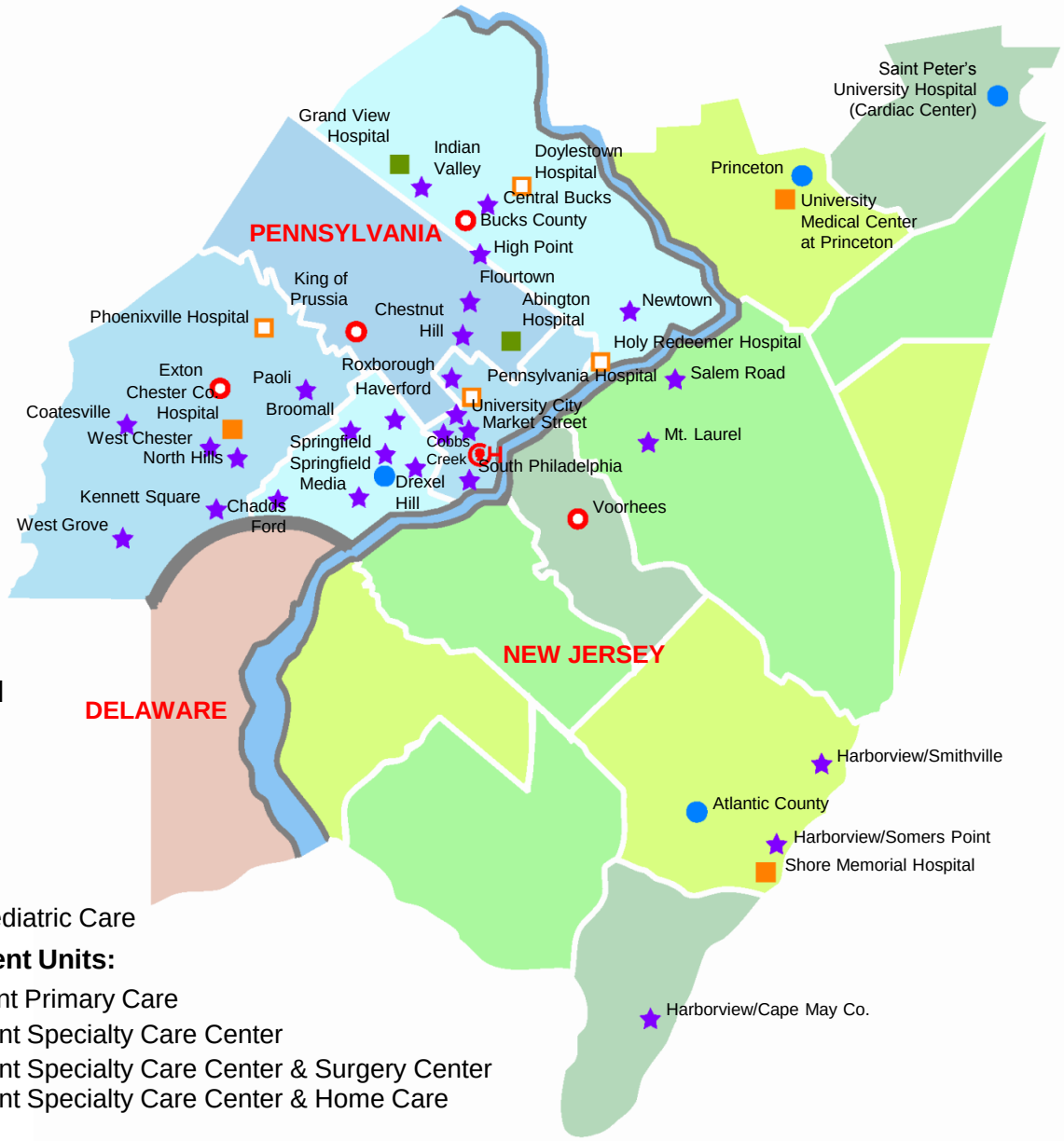


- Under bundled payment, volumes shifted from full-service public hospitals to specialized orthopedic hospitals
- Interviews with private providers revealed the following innovations:

– Care pathways	– More patient education
– Standardized treatment processes	– More training and specialization of staff
– Checklists	– Increased procedures per day
– New post-discharge visit to check wound healing	– Decreased length of stay

4. Integrating Care Delivery Across Separate Facilities

Children's Hospital of Philadelphia Care Network



The Children's Hospital *of* Philadelphia®

Network Hospitals:

- CHOP Newborn Care
- CHOP Pediatric Care
- CHOP Newborn & Pediatric Care

Wholly-Owned Outpatient Units:

- Pediatric & Adolescent Primary Care
- Pediatric & Adolescent Specialty Care Center
- Pediatric & Adolescent Specialty Care Center & Surgery Center
- Pediatric & Adolescent Specialty Care Center & Home Care

Four Levels of Provider System Integration

1. Choose an **overall scope of services** where the provider system can achieve excellence in value
2. **Rationalize service lines / IPUs across facilities** to improve volume, better utilize resources, and deepen teams
3. Offer specific services at the **appropriate facility**
   - E.g. acuity level, resource intensity, cost level, need for convenience
4. Clinically integrate care **across units and facilities** using an IPU structure
   - Integrate services across the care cycle
   - Integrate preventive/primary care units with specialty IPUs

There are major value improvements available from **concentrating volume** by medical condition and moving care **out of heavily resourced** hospital, tertiary and quaternary facilities

5. Expanding Areas of Excellence

Regional Providers

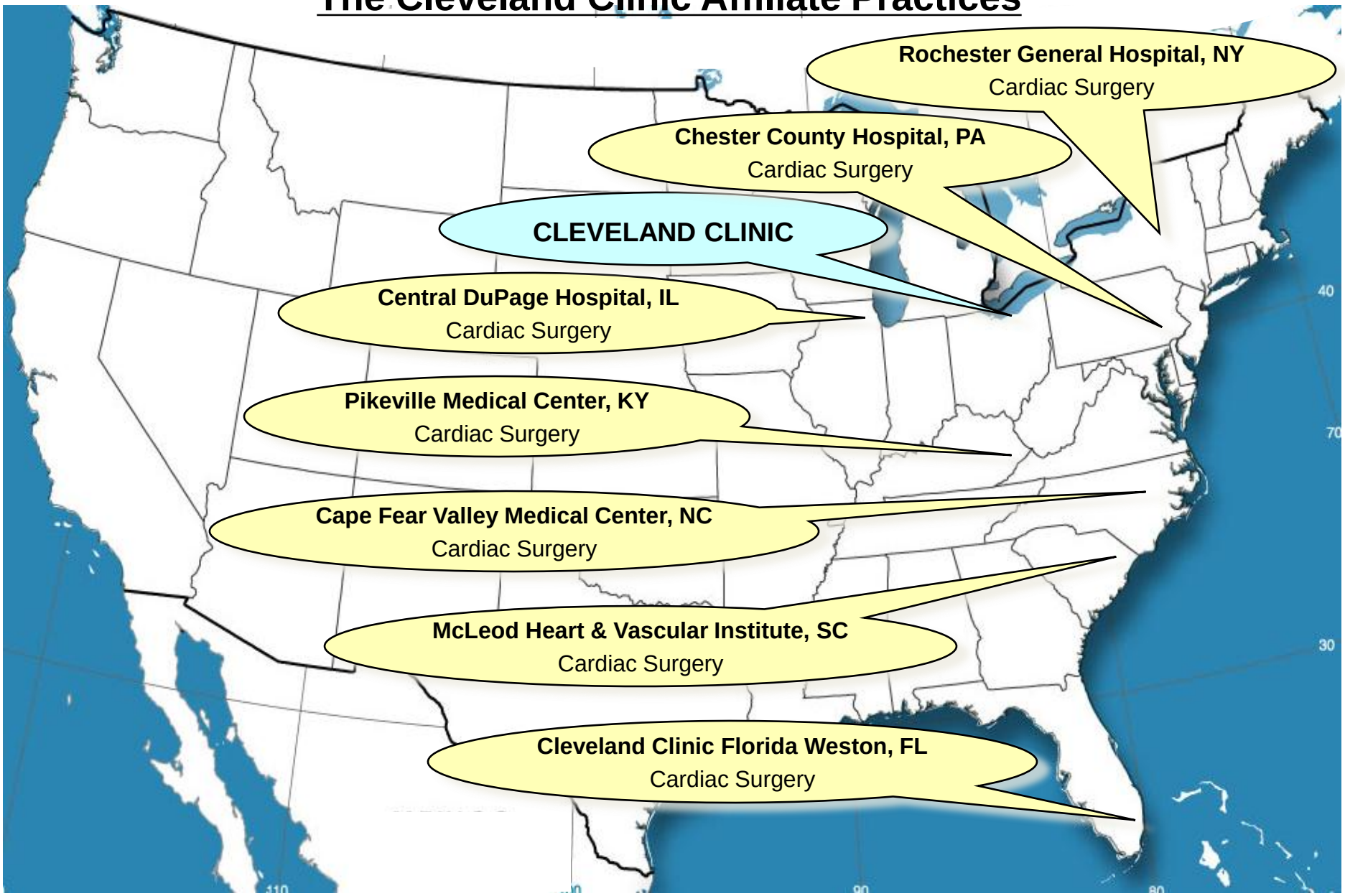
- Increase the **volume** of patients in **particular medical conditions** or **primary care segments** within the service area
- Grow **areas of excellence across geography**:
  - Hub and spoke expansion of satellite pre- and post-acute services
  - Affiliations with community providers to extend the reach of IPUs
- **NOT** Further **widening** service lines locally, or adding new **broad line** units

Community Providers

- **Affiliate with excellent providers** in more complex medical conditions and patient segments in order to access expertise, facilities, and services to enable high value care
  - Focus community and rural hospitals on appropriate conditions, services, and follow-up in a partnered IPU structure

Expanding Across Geography

The Cleveland Clinic Affiliate Practices

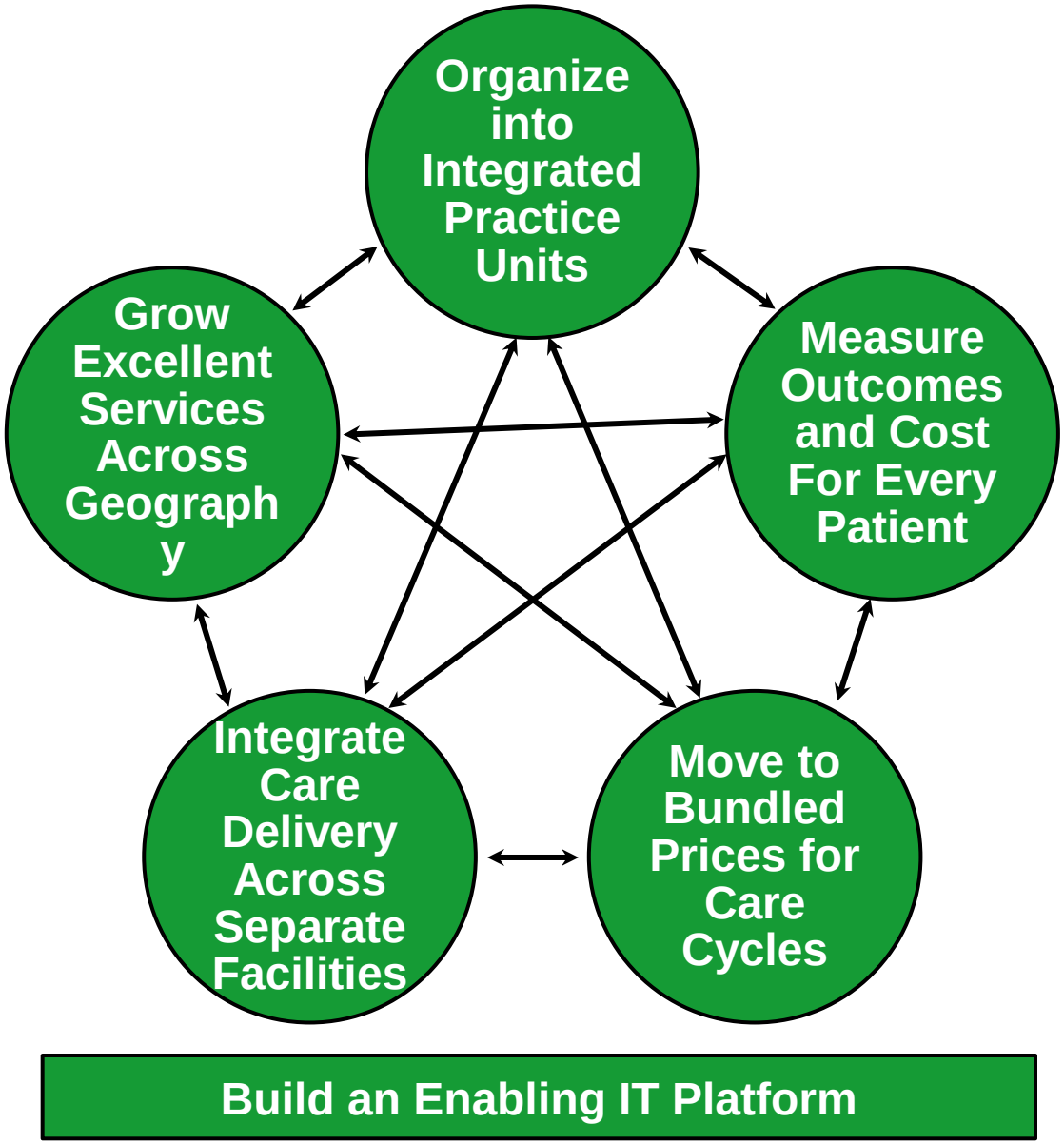


6. Building an Enabling Information Technology Platform

Utilize information technology to enable **restructuring of care delivery** and **measuring results**, rather than treating it as a solution itself

- Common **data definitions**
- Combine **all types of data** (e.g. notes, images) for each patient
- Data encompasses the **full care cycle**, including care by referring entities
- Allow access and communication among **all involved parties**, including with patients
- **Templates** for medical conditions to enhance the user interface
- "**Structured**" data vs. free text
- Architecture that allows easy extraction of **outcome measures**, **process measures**, and **activity-based cost measures** for each patient and medical condition
- Interoperability standards enabling communication among **different provider** (and payor) **organizations**

A Mutually Reinforcing Strategic Agenda



Moving to a High-Value German System

1. Make **patient value** the central goal of all reforms
2. Reorganize care into **Integrated Practice Units** around patient medical conditions
   - Certification standards should require **multidisciplinary teams**, integrated scheduling, and coordinated case management
   - Primary and preventive care should be tailored to serve **distinct patient segments**
3. Eliminate the **separation** between inpatient, outpatient, and rehabilitation care
   - Integrate care across the care cycle, with more care shifting to the **outpatient setting**
   - Reduce **cost-shifting** between care settings by eliminating the different models of reimbursement for inpatient and outpatient care
   - Harness the **power of IT** to enable integrated care delivery

Moving to a High-Value German System

4. Mandate measurement and reporting of **outcomes** for every patient
   - Create a **national body** to oversee the development of outcome measures
   - Mandate **publication** of risk-adjusted outcomes
   - Until outcome data is widely available, expand **minimum volume standards**
   - Build on successful German efforts (e.g., QSR measures)
5. Introduce new cost-accounting standards to measure **costs**, not charges, at the level of patients and care for medical conditions
   - Establish a **national body** to develop common costing standards
   - Introduce new **cost-accounting standards** that provide accurate cost data across providers and allow costs to be measured around the patient
6. Shift reimbursement to **bundled payments** for the full care cycle
   - Introduce a universal **reimbursement catalog**
   - Maintain group, as opposed to selective, **contracting** between health plans and providers

Moving to a High-Value German System

7. Encourage consolidation of **providers** and provider **service lines**
   - Expand **minimum volume standards** and focus on high-volume service lines
   - Open up laws to eliminate quasi-monopolies

8. Level the playing field between statutory and private health plans
   - Require private plans to **contribute to the risk pool** along with statutory plans
   - **Harmonize reimbursement** for private and statutory plan patients

9. Transform health plans through reporting and service standards into **health management organizations** competing to maximize subscriber health

Reorganize Care into Integrated Practice Units Around Patient Medical Conditions

Care needs to be organized around patient medical conditions (for specialty care) and distinct patient segments (for primary care).

German system today:

- Care delivery is organized around **specialties** and the **supply of services**
  - No integration across specialties and across the care cycle
  - **Fragmentation** results in unnecessary provider visits and inconsistent quality
- **Intense competition** to retain patients works against value
  - Referrals occur too late or not at all
- Most patients make choices based on **convenience** and short-sighted **cost-savings**

Recommendations:

- Reorganize care around the patient:
  - Patient **medical conditions** for specialty care
  - Distinct **patient segments** for primary care
- Eliminate all obstacles that maintain the **separation** between inpatient, outpatient, and rehabilitation care
- Engage patients in wellness and participation in their health care
- Harness the **power of IT** to enable integrated care delivery

Mandate Measurement and Reporting of Outcomes for Every Patient

Only when outcomes are known can providers improve the quality of care, patients choose excellent providers, and excellent providers grow.

German system today:

- Mandatory quality systems are focused on **structural** and **process** measures
  - Limited acceptance in the medical community
- No universal **outcome** measurement
  - BQS/AQUA measures cover a small number of conditions
  - Results are not published universally
- Limited culture of **continuous improvement**

Recommendations:

- Create a **national body** to oversee the development of outcome measures
  - Focus on **outcome**, not process, measures
  - Measure **multiple outcomes** for each medical condition across the entire care cycle
- Build on successful **German efforts**
- **Publish** risk-adjusted results widely
- Charge **physicians** with leading these efforts

Measure Costs, Not Charges, at the Level of Patients and Care for Medical Conditions

Understanding the true costs of care delivery is essential to improving value. Flawed cost-accounting leads to inappropriate reimbursement and ill-advised cost-cutting measures.

German system today:

- Poor understanding of the **true costs** of delivering care
  - **Charges** are often mistaken for costs
  - The focus is on **low reimbursement** rates per visit, not lower total costs
- **Flawed cost-accounting** is the root cause
  - Costs are aggregated around **departments and products**, not patient conditions
  - Providers cannot accurately match costs to individual patients
  - Costs do not reflect **actual resource utilization**

Recommendations:

- Establish a **national body** to develop common costing standards
- Measure costs **around the patient**
  - Use **TDABC** to calculate the actual resources utilized in patient care
- Aggregate costs over the full care cycle
- **Cost savings** will come from numerous opportunities to improve efficiency
- Accurate cost data will encourage a **reduction in service lines**

Reimburse Providers Through Bundled Payments Covering the Full Care Cycle

Risk-adjusted bundled payments will align reimbursement with value creation and encourage integrated care.

German system today:

- The reimbursement system rewards **volume**, rather than value
- **Cost-shifting** occurs between the inpatient and outpatient sector
  - Different **reimbursement models** for inpatient (DRG) and outpatient care (capitation and fee-for-service)
  - Multiple **funding agencies** across the care cycle
- Higher **reimbursement levels** for private patients
  - This leads to **cross-subsidies** and skewed **incentives**
  - Price differences do not correlate with differences in underlying costs

Recommendations:

- Replace discrete payments for visits and services with risk-adjusted **bundled payments** covering the entire care cycle
  - Reimbursement should cover inpatient, outpatient, and rehabilitation care for a medical condition
  - Moving to capitated bundled payments will allow arbitrary provider **budgets** to be phased out
- Establish a universal **reimbursement catalogue**, applicable to all providers
  - **Harmonize** the reimbursement scheme for private and statutory patients

Encourage the Consolidation of Providers and Provider Service Lines

A critical mass of patients per medical condition is needed to foster deep expertise, dedicated teams, and tailored facilities that offer integrated care for the condition and its common co-occurrences.

German system today:

- German providers try to do everything for everyone
  - They provide **broad service lines**
- There is significant **overcapacity** of hospitals, outpatient practices, and rehabilitation centers
  - More hospital departments are still being opened than closed
  - **Minimum volume standards** are limited in reach and often not enforced
- Current **licensing laws** grant quasi-monopolies to providers

Recommendations:

- Care should be concentrated in fewer providers who provide excellent—not local—care
  - Focus on **high-volume** service lines
  - Expand **areas of excellence** across geography
- Use **positive-sum competition** to drive consolidation in the provider sector
  - **Publish** experience (volume) and outcome data on all providers
  - Expand minimum volume standards
  - Open laws to **eliminate quasi-monopolies**

Require Private Plans to Contribute to the Risk Pool Along with Statutory Plans

The playing field between statutory and private health plans must be leveled. Competition should be based on achieving superior health value for subscribers, rather than risk selection.

German system today:

- Private and statutory health plans are engaged in **zero-sum competition** with each other
- Private plans gain competitive advantage through **risk selection**, not value improvement
  - **Access** to private plans is restricted
- Higher **reimbursement rates** for private patients distort incentives for providers
- The current structure erodes the **solidarity** principle at the heart of the German system
  - Private plans do not contribute to the **risk pool** along with the statutory funds

Recommendations:

- The playing field between statutory and private health plans should be leveled
  - Private health plans should contribute to the morbidity-adjusted **risk pool**
  - Reimbursement for private and statutory patients should be **harmonized** for inpatient and outpatient care
  - This will unleash **positive-sum competition**
- With even competition, it would be feasible to **open up** the primary private health insurance market to all citizens

Transform Health Plans into Health Management Organizations Competing on Maximizing Subscriber Health

Health plans can add value by assembling outcome information, assisting subscribers in selecting excellent providers, and engaging in wellness and disease management.

German system today:

- Health plans are primarily focused on minimizing **short-term costs**
- Health plans compete on **low premiums**, rather than enabling better health
  - Plans offer almost **identical services**
  - Plans compete around marginal premium differences
- Health plans attempt to hold down premiums through **cost-shifting** and **rationing**, rather than improving care
- Health plans attempt to game the system through **risk selection**

Recommendations for Germany:

- Health plans should become **health management organizations** that strive to maximize subscriber health
  - Shift focus from cost-containment to improving **care delivery**
- Health plans should support outcome measurement, disease management, and subscriber selection of high-quality providers
  - Build **medical competence** within plans
  - Build **disease-specific** offerings
- **Risk pool** should be further improved to reduce the incentive for risk selection
- Encourage further **consolidation** in the health plan sector