

# The Techniker Krankenkasse experience: lessons for commissioners from a successful German statutory health insurer

The German health care system is a high-performing one, where recent policy reforms have attempted to contain costs and strengthen competition. With recent policy proposing the formation of a national commissioning board for England, we were interested to learn from Germany how a statutory not-for-profit national insurer was managing to achieve better value health care in an economically challenging environment.

## Introduction

This briefing sets out potential learning for the NHS in England from a study visit to Techniker Krankenkasse (TK), one of Germany's largest health insurance companies (see Box 1), in May 2010. The visit also included a tour of University Hospital Hamburg-Eppendorf, the largest hospital in Hamburg. The study visit was undertaken with colleagues from NHS Northwest and Manchester Business School.

## Overview of the German health care system

Like many industrialised countries, Germany is facing health care challenges associated with an ageing population and increasing levels of chronic disease.

Germany is well regarded internationally with respect to equity, diversity of available benefits, and access and waiting times. However, the German health care system is costly, accounting for 10.5 per cent of GDP in 2008 compared to 8.7 per cent in the UK. Despite attempts to contain costs, overall health care expenditure on Germany's population of 83 million rose from €195 billion in 1996 to €252.8 billion in 2007. Since the 1990s, major health reforms have focused largely on cost containment and strengthening competition as well as absorbing costs associated with reunification.

OECD data from 2008 show that the health system in Germany had more doctors, more nurses, and many more beds per head of the population than the UK (see Table 1).

**Table 1:** Overview of health care provision in Germany and the UK

	Germany	UK
Number of practising physicians per 1,000 population	3.56	2.71
Number of practising nurses per 1,000 population	10.68	9.52
Average number of physician consultations per capita per annum	7.8	5.9
Number of hospital beds per 1,000 people	8.2	3.4
Average length of stay in acute care	7.6 days	7.1 days

Germany's health care system is made up of health care insurers, the majority of which are in the not-for-profit statutory health insurance sector, who fund care on behalf of members from a range of private and not-for-profit health care providers. A limited amount of private care is purchased directly by patients. The system is highly regulated.

## Health care insurers

Germany has the world's oldest statutory health care system, dating back to Bismarck's Health Insurance Act of 1883. The key principles underpinning the system are solidarity (everyone is covered) and subsidiarity (local decision-making and personal responsibility). Mandatory health insurance originally applied only to low-income workers and certain government employees, but since 2009 all Germans must be covered by some form of health insurance. In 2010, people earning up to \$45,000 must belong to a not-for-profit statutory health insurance (SHI) scheme.<sup>1</sup> Those on higher incomes can opt for SHI or take out private health insurance. Overall, 85 per cent of the German population are covered by SHI schemes. For those in employment, fixed-rate contributions are made by both the employee and the employer. Income from all SHI schemes is pooled, mixed with a substantial subsidy from taxation, and redistributed among the schemes, according to a weighting to reflect morbidity in the insured population (described in more detail below). Insurers then purchase health care services from primary and secondary providers on behalf of their members, and

### Box 1: Techniker Krankenkasse

- Techniker Krankenkasse (TK) was founded in 1884, and originally offered cover just to technical workers. Now open to all, TK is one of Germany's largest SHI funds, with a 10 per cent share of the market. It provides cover for over 7.3 million Germans and has an annual turnover of €17.6 billion (2010), and 11,000 employees.
- Based in Hamburg, TK operates across the whole of Germany, unlike many schemes which restrict themselves to just one region.
- TK has been rated by the German Institute for Quality of Service as Germany's best health insurer, offering benefits and service that are above the level of other statutory insurers and with contributions that are cheaper than the German statutory insurance average.<sup>2</sup>
- Under EU law, TK's members are eligible to seek treatment abroad, and growing numbers do so (40 per cent of overseas episodes are for elective treatments).

also provide sickness benefit cover for members who are temporarily unable to work.

In contrast to SHI premiums which are wage-related alone, private premiums are risk-related, and are often lower than those in the statutory sector. The role of private sector insurance and private provision is considerable with, private expenditure on health in 2007 reaching 23.1 per cent of total expenditure on health, compared to 18.3 per cent in the UK (Global Health Observatory Database).

## Health care providers

Delivery of health care can be broadly divided into two sectors: ambulatory and hospital care. Within ambulatory care (i.e. office-based doctors) around half practice as family physicians (some 25 per cent of whom are specialists in internal medicine or paediatrics), the other half being specialists (mostly in gynaecology, neurology, ophthalmology, orthopaedics, dermatology and ENT). Specialist physicians are split more or less half and half between hospital and office-based settings; it is not possible for a physician to work in more than one setting. Specialists are well-paid in Germany and it is financially attractive to purchase a private, office-based specialist practice with expensive diagnostic technology.

1. These figures are determined annually.

2. The Institute (*Deutsches Institut für Service-Qualität*) rates insurers on the basis of the services it offers to its clients and not on the basis of health care services that the insurers pay for.

### Box 2: What's it like to be a patient insured with TK?

From the patient perspective, the German health care system has a number of key differences from the UK National Health Service. A patient insured with TK will experience:

- 24/7 phone service providing help and guidance to identify and access appropriate medical care
- short or no waiting times for elective care
- long waits for psychotherapy
- direct access to specialists rather than having to go through a gatekeeper
- dealing with an organisation (TK) with a strong customer focus
- a small co-payment at point of use
- no continuous medical record (records are not shared between providers)
- some long waits at the GP surgery
- a benefits package extending beyond core medical services to include, for example, residential spa treatments either in Germany or abroad, if required.

Since January 2004 members of the statutory insurance plan have had to pay €10 to see a GP, with a maximum payment of €10 per quarter.<sup>3</sup> The fee is collected by the physician, but passed back to the insurer. The aim is to reduce attendances, although this appears to have met with little success.

German hospitals are under diverse ownership: in 2002 there were nearly 1,900 acute hospitals with 712 being publicly owned, 758 private non-profit and 428 private for-profit (Busse and Riesberg, 2004). The proportion of private for-profit hospitals has been growing steadily in recent years and is expected to increase further (the share of beds having risen from 8.9 per cent in 2002 to 12.4 per cent in 2006, according to Ettelt and colleagues, 2008). Hospitals provide the majority of inpatient care and generally little in the way of out-patient services. Only university hospitals have formal outpatient facilities (see Box), although since 2004 other hospitals can provide certain forms of specialist outpatient care.

The general practitioner – *Hausarzt* – has not traditionally played a gate-keeping role in Germany, with patients free to go directly to a SHI-affiliated specialist doctor of their choice. Legislation in 2004 attempted to change this by requiring SHI funds to incentivise GP gate-keeping, and thereby manage access to specialist

### Box 3: Universitätsklinikum Hamburg-Eppendorf (UKE)

- The University Medical Centre Hamburg-Eppendorf is the largest hospital in Hamburg. UKE has approximately 1,400 hospital beds and treats 50,000 inpatients and 250,000 outpatients each year, as well as 50,000 emergency patients. There are no waiting lists.
- UKE offers a wide range of care, from diagnostic services to highly specialised and complex treatments for rare diseases, with 160 clinics for complex, rare and chronic syndromes.
- Leadership of the hospital combines a clinical, managerial and economic ethos: the CEO is a radiologist. Regular monitoring of salary and non salary expenditure encourages doctors to think in economic terms, with a deficit resulting in spending freeze on staff and equipment, but a surplus offering opportunities for additional spend.
- Discharges are managed to maximise income: full reimbursement is dependent upon discharge that is neither premature nor delayed.
- An international office facilitates provision of services to patients from outside Germany. This provides an important and growing income stream.
- UKE has been a university hospital since 1934. There remains a strong incentive for the hospital to maintain its academic status, with payments from government for successful research applications and high-profile publications.

services. GPs do act as gatekeepers to German hospitals, but since so much specialist care is provided outside the hospital sector, patients continue to exercise considerable choice. As a result, only about 20 per cent of patients use the *Hausarzt* and this figure has remained stable for some time.

Since individuals have free choice of provider there is little opportunity for SHIs to act as gatekeepers. Individual SHIs cannot restrict members' access to providers. They can only advise members on the quality of specific providers.

Participation in integrated care models offers new opportunities for hospital providers to become active in ambulatory care. Separately negotiated contracts support integration between providers that span two parts of a care pathway.

3. Unless the patient visits another physician without a referral.

#### Box 4: TK's integrated care contracts

- TK has over 320 integrated care contracts worth €120 million in 2010 in areas such as mental illness, heart surgery, endoprosthesis, imaging and back pain. The back pain contract allows TK to refer patients with chronic back pain for intensive therapy for 12 hours per week that includes pain management, psychological and physical therapy by integrating different therapy providers under one contract.
- Patients are offered what TK calls an 'integrated care plan' at no additional cost, aimed at providing coordinated care across the ambulatory and hospital based sectors.
- Evaluation shows that individuals receiving integrated services return to work 72 days earlier than those receiving routine care and 80 per cent are still fit to work after six months.
- 90 per cent of TK's selective contracts focus on one disease area, with coordination across only two providers.
- Integrated care contracts have led to savings for TK because SHI funds in Germany also pay sickness benefits as well as health service costs. SHI funds have a strong incentive to focus on developing occupational and other health services that support people to remain in employment and rapidly return to work after an episode of illness.

Whilst the recent focus of integration in the UK has largely been around structural or organisational integration (for example via the Transforming Community Services agenda), the focus in Germany is on managing and coordinating care pathways. The development of such models of integrated care is currently limited, with uptake of integrated care contracts remaining low. However, new regulations and incentives from the federal government, aimed at promoting disease management programmes, have attracted interest among hospitals, most of which have been hesitant up to now to join disease-management programmes (Busse and Riesberg, 2004).

## System governance and coordination

The independent SHI funds and healthcare providers within the German system follow the principle of self-governance, but in a highly regulated and structured way. The overall organisational structure reflects the two-tier German political system, with some decisions and negotiations being made at federal level for the whole nation, and others taking place at the level of Germany's 16 constituent states, or *Länder*. At each level, negotiations take place between associations representing the four main interest groups: the health insurance funds, the hospitals, the dentists, and the physicians (the self-employed doctors who may be GPs or specialists).

The four national associations are all represented on the Federal Joint Committee, alongside non-voting members from patient organisations. The Federal Joint Committee sets legally binding directives outlining the catalogue of benefits available to patients under statutory health insurance, based on the principle of 'medically necessary' treatment. Decisions are influenced by evidence from IQWiG – the German Institute for Quality and Economy – Germany's closest equivalent to the UK's National Institute for Health and Clinical Excellence (NICE), which has been seeking to evaluate the cost-effectiveness of drugs since 2008. Although the Federal Joint Committee is under the supervision of the Ministry of Health, there have been occasions when decisions have been disliked by the Ministry, and the case has gone to court.

A basic contract agreed at federal level between physicians and statutory health insurers sets out such details as practice opening hours and systems for authorising treatment. Fees are agreed by another committee, the Committee for Rating Doctors' Services – the so-called the 'Valuation Committee' – which draws three members each from the insurers' association and the physicians' association. The fee schedule set by the committee uses a points system to for services, with various categories of supplementary payments available to GPs and specialists respectively. Basic rates are graded according to the age of the patient. Payments are meant to cover office rent, materials, wages for support staff and so on, as well as physicians' own incomes. The schedule sets out how much time each procedure is meant to take, as well as how often a patient is entitled to have it.

### Box 5: Health regions of the future: mental health network in Hamburg region

**Problem:** Mental illness is a top priority area for WHO and EU. The Hamburg area has one of the highest rates of mental illness in Germany, for reasons that are poorly understood. Delays in benefitting from specialist treatment range from 1.8 years for anorexia and 14.7 years for anxiety disorders. Thirty per cent of patients fail to turn up for their appointments for assessment and treatment with ambulatory specialists. One of the insurance funds approached the network seeking help because of waits of 14 months to access psychotherapy.

**Goal:** The goal is to promote mental health and to detect and treat illness at the earliest possible stage. Three objectives are to improve mental health care on a sustainable basis, strengthen the regional value-added chain, and transfer the business model and service products to other regions in Germany

**Projects:** There are five projects, covering education, prevention, diagnosis, self-help and case study development. They include media campaigns, collaboration with two large employers, chamber of commerce, eight hospitals, five universities and a new partnership model with health insurance funds. A general practitioner project involves the attachment of nurses to general surgeries to treat patients and to ensure that they also take up the referrals to ambulatory specialists. A network of eight psychiatric hospitals is involved in self-health promotion for those affected and their relatives. There are five networks for particular conditions: depression, psychosis, anorexia, psychosomatic disorders and addiction. An innovative selective contract has been signed with insurance funds for seriously ill patients, with a treatment regime eight times more intensive than the average, for a fixed fee which is dependent on a 50 per cent decrease in the cost of treating psychosis and a shift in place of treatment from an inpatient to an outpatient setting.

New techniques and treatments are allowed in the inpatient sector, but not outside hospitals, unless they are authorised at federal level. Outpatients can choose to pay privately for a treatment that is not in the benefits package.

At state level, regional associations of providers and health insurers can agree supplementary contracts to the

basic national one, adjusting the point value of payments to reflect varying health needs not just between regions but also within regions.

A small amount of selective contracting (6,407 contracts to a total value of €811million in 2008) takes place between individual SHI funds and selected providers, on the basis of cost and quality.

However, by far the majority of health care is delivered through collectively negotiated contracts which leaves individual SHI funds with little leverage over providers and little ability to select providers for contracting on the basis of cost or quality. Within these collective contracts, the price paid by each sickness fund is determined solely by the type of fund, for example whether it is a local fund or a national fund such as TK. The fragmented nature of the system also means that 'whole population' health improvement initiatives are severely constrained. The mental health network initiative in Hamburg (see Box 5) is an exception to this and an interesting example of partnership working to overcome a service weakness.

## Finance and cost management

From January 2011, the federal government will increase the percentage contribution to be made by employers and employees from a combined contribution of 14.9 per cent of employee salaries to 15.5 per cent. The higher contribution rate is expected to bring in an extra €6 billion in addition to the €175 billion expected in 2010. This will partly address the €11 billion deficit that SHI funds are expecting to face in 2011.

SHIs cannot use benefits management techniques such as pre-authorisation or utilisation review to limit cost growth, since the rules as currently set out put no barriers in the way of patients accessing care. In the case of hospital stays, for example, SHIs have to reimburse hospitals stays for as many days as are deemed medically necessary. This poses a challenge to SHIs to remain financially self-sufficient, while lacking a mechanism to drive down costs within providers. Over time, more SHIs may be forced to charge an additional premium to address shortfalls in revenue. If the allocation from the central health fund does not adequately cover their costs, they are permitted to charge an additional premium, but this may not exceed two per cent (as of 2010) of assessable income, exempting many members from any additional premium costs. Conversely, any funds with an operating surplus can give members a refund if they have a surplus.

### Box 6: Data mining in TK

Data mining involves analysing large, pre-existing databases in order to discover patterns and relationships that were previously unknown. TK uses data mining to study regional differences across Germany, for predicting which patients will become high-cost (predictive modelling), for setting fair pay-for-performance rules, and for analysing patterns of morbidity.

Data sources available to TK's analysts include information about inpatient and outpatient care (diagnostic codes, costs, length of stay, dates, physician codes), information about prescriptions and medical devices, and information about patient satisfaction. Data on inpatient care is available within two days of the treatment episode but there is a time lag of six to nine months on the reporting of outpatient data.

One way in which these data are used is to compare actual costs with expected costs, then analysing how the difference or residual differs according to geography, contracts, remuneration and patient behaviours.

Predictive modelling involves using patterns in routine data to predict which individuals will be high-cost in the future. TK uses predictive modelling to select patients for preventive care services and for calculating morbidity-adjusted remuneration groups, which they incorporate into selective contracts for these patients. Senior officials at TK believe that predictive modelling offers them a win-win opportunity because they are able to increase patient satisfaction whilst increasing income for both the provider and the SHI fund. New developments in this field are likely to include an increase in the number of patients offered this additional care, improvements in model accuracy and stability, detailed evaluation, and automation of the predictive modelling process.

The 2009 health reforms changed the basic financing of the social insurance system. The centrepiece of the reform was the creation of a central health fund administered at the federal level to equalise funding across SHI funds. Employers and employees contribute to the central fund on the basis of a fixed percentage of employee income. The 166 individual SHI funds then receive their allocation from the central fund on the basis of a morbidity adjusted formula. The purpose of this reform was to account for differences in the membership of SHI funds. As five per cent of the population accounts for over half of all expenditure, the risk equalisation

scheme transfers money to those funds with higher-risk people, notably the state-based funds that tend to have a greater number of elderly and unemployed members than national funds such as TK.

The level of remuneration available for each person is determined by a system of risk adjustment. Currently, risk adjustment is based on groups of diagnostic (ICD-10) codes. These groups of codes are called 'Modified Hierarchical Condition Categories' (Modified HCC). These were defined by the American company previously known as DxCG and now called Verisk. Each HCC group contains a list of diagnoses that cost roughly the same amount to treat. The risk adjustment model used by the Federal Social Health Insurance Office (BVA) also incorporates variables relating to demographics, disability, prescribed pharmaceuticals, and patterns of inpatient and outpatient care.

Health insurers such as TK receive a basic allowance of €2,227 per person, plus a risk-adjusted weighting. For an example, the allowance for a 62-year-old woman with no diagnostic codes would be adjusted downwards by €997, so the insurer would receive €1,250; whereas a 62-year old woman with diabetes and hypertension would be allocated a supplement of €462 for hypertension and €794 for diabetes, so the insurer would receive a total allocation of €3,843 for this person. The cost weights in the risk adjustment model are recalibrated each year.

Insurers see risk adjustment as an extremely important part of their business. However, there are risks that a SHI may try to manipulate the risk adjustment results by encouraging service providers to 'improve' their diagnostic coding (ascribing more severe diagnoses to their patients in order to increase remuneration; otherwise known as 'upcoding').

### Competition between insurers

Since the early 1990s, successive German governments have been trying to increase competition, by allowing citizens to have a free choice of any statutory insurer, rather than limiting them to an insurer associated with particular profession or geographical area. Citizens can shift from one insurance fund to another every year if they wish. Over the years, many insurance funds have been forced out of the market or have been merged and the result has been a decrease from over 1,147 funds in 1990 to 166 in 2010.

TK has increased its share of the statutory health insurance market from 4.6 per cent in 1996 to around 10 per cent in 2010, with opportunities for further expansion through mergers and growth in new markets (within Germany, as well as wider European, markets).

### Box 7: TK customer relations management

- TK prides itself on its customer service and was the first insurance fund to establish a '24/7' call centre to handle queries relating to its services; this is in addition to their 24/7 medical advice line, staffed by doctors. They aim for a high degree of personalisation in their relationships with callers in the knowledge that initial contact by phone establishes long-term loyalty. They recruit diverse staff to match the diversity (age, background etc) of their members. There is a 'first contact' solution rate of 82 per cent.
- TK carries out sophisticated recording, management and analysis of customer information, drawn from the eight million contacts per year that the organisation has with customers.
- There is an emphasis on assessing and quickly responding to members' needs (for example, answering phone calls within 15 seconds) as a means of maintaining and potentially increasing market share.
- Customer relations management features on the TK research agenda, (for example a patient survey of doctor-patient relationships); data are fed back into improving health care delivery and increasing customer satisfaction.
- The top three recent complaints were speed of dealing with requests, handling of the bonus on the disease management programme and the new arrangements for prescribing of generic drugs.

There is very limited scope for competition between SHI funds based on price. The 2009 reforms set a standard level of premium, based on income, to be charged by all funds. To a large extent, the 2009 financing reforms removed a large part of the incentive for members to switch between SHI funds, given that the benefit package offered by all funds is comprehensive.

With such a competitive market, insurers are keen to identify other potential means of increasing their market share. For many this means providing additional benefits beyond those prescribed in law, with no additional cost to the member. This might include areas such as medical hotlines, domestic help, check-ups, health seminars/prevention courses or 'gentle therapies'. For instance,

TK actively supports the desire of a growing number of their members for alternative forms of treatment such as homeopathy, health spa treatment and rehabilitation, providing access to medical related treatments across a number of health resorts in Europe. In addition, insurers place great emphasis on customer relations management (see Box 7) as a means of engaging with, and responding effectively to, their members.

### Future challenges for the German health care system

There is considerable uncertainty in the system particularly posed by the year-on-year increase in health care expenditure at a time of uncertain economic growth. Possible policy options could have been to bear down on expenditure or identify other sources of funds but in fact the decision has been taken to raise the employee contribution to SHI above the 'psychological ceiling' of 14 per cent of wages to 15.5 per cent with effect from January 2011.

Other tensions include the fragility of coalition politics in the Bundestag, the balance of power between national (federal) and local decision-makers, and the relationship between SHI and private health insurance. Prioritisation and rationalisation are relatively new concepts in Germany but are now being aired: this will entail a new relationship between insurers and providers, with the former moving beyond their traditional role of 'payer'. In terms of prioritisation, the country is moving, via the activity of its competing sickness funds, towards more selective contracting to complement collective contracting. Selective contracting remains limited but is seen as important route to providing the additional quality or intensive care deemed effective particularly for patients with long term conditions. In this sense, prioritisation is not a cover for 'rationing' which is how it has been widely interpreted in the UK NHS (for example, local prioritisation frameworks such as the Portsmouth Scorecard to identify treatments of limited clinical effectiveness).

With regard to rationalisation, it can be argued that the separation between purchasing and provision – which is a feature of social health insurance systems – has resulted in an over-supply of hospital facilities, especially beds. This may be one of the reasons for quite long lengths of stay in some specialties. Discussions have begun about the ongoing feasibility of this state of affairs.

## Learning for the NHS in England

Through this study visit, using TK as a case study, we found a number of strengths and weaknesses in the German health care system that have relevance for the NHS in England.

From the **patient's perspective**, there are some impressive advantages: free choice of insurer, direct access to specialist advice and treatment, free choice of provider and very strong customer service provided by the insurance fund. In England, the GP gatekeeping function has traditionally been viewed as a strength, but given the high performance, in terms of health outcomes (such as cancer survival), of countries with weak gatekeeping (for example Germany and France) it may be time to identify precisely which aspects of GP gatekeeping operate best in the 21st century and which may act as a barrier to patients in terms of securing timely specialist care. On the other hand, we found considerable duplication of services due to direct access to specialists in Germany, alongside weaknesses in coordination of care, particularly the lack of a continuous patient record, and some long waits in the Hausarzt's office (GP surgery) and for psychotherapy.

From the **insurance company perspective**, there were frustrations in not having strong levers over providers, particularly with a nationally based company. There were also financial risks given that the role is more as 'payer' rather than as 'commissioner'. Selective contracting (where costs/numbers/care pathways are specified) remains a very small proportion of overall expenditure, and collective contracting is the norm. The fund must reimburse without question all 'medically necessary' treatments that have been provided as agreed by federal and regional negotiating bodies. There is a uniform contribution rate from members for all funds with risk-adjustment pooling determined centrally. The two financial risks are therefore that providers will 'over-perform' and that the central health fund risk-adjustment process operates against certain sickness funds with so-called 'healthier' patients. Weak gatekeeping into specialist care also carries financial risk. There were, however, opportunities for insurance companies to be entrepreneurial, for example in selective contracting, particularly for high-risk groups. There was good use made of the vast data warehouse available from having seven million members.

From the **provider perspective**, the university hospital that we visited had a high level of freedom and was well funded and organised. There is however an odd system constraint, based on a historical agreement, that it is not possible for a doctor to work both in a hospital and in outpatient (ambulatory) care. Reimbursement

for outpatient care was also low and this could inhibit a greater flow of work from inpatients to outpatients. The lack of a continuous medical record was also seen as a relative weakness but as with GP gatekeeping the precise effect of this on patient care was far from clear.

From the **health system perspective**, we found three weaknesses: a potentially wasteful use of resources through patients having direct access to specialists (where in the UK the health problem could be effectively handled in primary care); second, and related to the first, an insufficient focus on primary care; and, third, an unhelpful separation of hospital care from ambulatory care. Taken together, the system 'pulls' patients to the highest (and most expensive) tier for care and treatment. On the other hand, we found that there was a greater emphasis on preventive care and management of patients compared to the NHS – whilst preventative activities remain opportunistic, insurers have a financial incentive to offer their members health promoting activities because they also pay for sick leave. The principal lever here is that the insurance fund is responsible for paying sickness benefit (payments to persons not fit to work) as well as funding health treatments. A secondary lever is the use of the concept of the 'fully engaged' patient as a co-producer of their own health, which is encouraged by the insurance fund through their interactions with their members, as well as being ingrained in the ethos of the German health care system.

## Conclusions

Transferring ideas for reforming or managing health care from one country to another is not straightforward. However, we believe our experience offers some useful insights for the NHS. These are particularly relevant in England in the face of current reforms outlined in the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010). We therefore propose five key lessons, as follows:

- There is scope to examine and re-appraise the role of **GP gatekeeping**, currently much less significant in Germany than it is in England. Under proposed reforms, English GPs will have two potential mechanisms for controlling use of secondary care – at the individual level, and at the collective level.
- The tradition of **specialist care being delivered outside hospital** is popular with patients in Germany. This supports proposals in England for the delivery of a greater proportion of specialist care outside hospitals and, where appropriate, closer to people's homes; and the need for further development of specialist skills and expertise among doctors working in the primary sector.

- There are opportunities for the NHS to develop a more **customer-oriented approach**, similar to that in TK focused on clearly communicating to the public what is in the benefits package, promoting wellness/preventative care, and emphasising the role of patients as partners in creating and maintaining health. Learning from TK, health care organisations can develop a clear brand message positioning patients as members working to a shared agenda with the organisation. The new GP-led commissioning bodies are well-placed to develop such a customer approach, should appropriate resources be available.
- The **dual role of SHIs as funders of health care and funders of sickness related benefits** is a strong feature of the German system. At a very broad level, this is also true in England (the state providing both through tax revenue). However, in practice health care and benefits are conceptualised and experienced as very separate. The proposed new model for the NHS in England risks extending this: with neither commissioning (by GP consortia) nor delivery of care (by GPs and foundation trusts) in the hands of state organisations. Public health functions will remain in the public sector, but move outside the health service.
- TK's **use of routine data** for predictive modelling and risk management is strong and effective, but requires considerable investment and skills. New commissioning bodies in England may wish to prioritise data management, and look towards economies of scale by working with neighbouring consortia and/or local authorities to provide or commission these functions.

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## References

Busse R and Riesberg A. (2004) *Health care systems in transition: Germany*. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Department of Health (2010) *Equity and excellence: Liberating the NHS*. Cm. 7881.

Ettelt S, Nolte E, Thomson S, Mays N and the International Healthcare Comparisons Network (2008) *Policy Brief: Capacity planning in health care. A review of the international experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

World Health Organisation Global Health Observatory Database. Available at: [www.who.int/gho/en/](http://www.who.int/gho/en/).

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