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Wolf, Sascha; Amelung, Volker

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Sascha Wolf
Pforzheim University,
Business School
Tiefenbronnerstr. 65,
75175 Pforzheim, Germany
sascha.wolf@hs-pforzheim.de
Phone: +497231286325

Volker Amelung
Hannover Medical School
Carl-Neuberg-Str.1,
30625 Hannover, Germany
amelung.volker@mh-hannover.de
Phone: +495115325417

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LEVELLING VS COMPETITION – POLITICAL TREND REVERSAL IN THE GERMAN HEALTHCARE SYSTEM?*

Abstract

For almost 20 years, the German federal government has declared that competition is the key to ensuring the financial sustainability of the healthcare system. The aim of this paper is to investigate if German government indeed has followed a direct path to enhancing competition. For this purpose, a qualitative analysis of the most important healthcare reform acts has been conducted. In conclusion, especially since the introduction of the Health Fund in 2009, a clear trend towards more levelling and regulation can be observed. This trend is confirmed by the most recent healthcare reform act in June 2014. The abolishment of flat-rate premiums is the expression of the government's fear that competitive pressure could endanger the solvency and viability of sickness funds (statutory health insurance funds). In contrast, on the market for selective contracts, an ambivalent picture emerges. On the one hand, several possibilities for establishing new forms of healthcare and strengthening competition have been introduced. On the other hand, sickness funds as well as service providers are often reluctant to enter into selective contracts.

Keywords: German healthcare system, Health Fund, contract competition, integrated care, innovation fund

1. Introduction

On 5 June 2014, the German parliament (Deutscher Bundestag) passed the Law on the Further Development of the Financial Structure and Quality in Statutory Health Insurance (Gesetz zur Weiterentwicklung der Finanzstruktur und der Qualität in der Gesetzlichen Krankenversicherung). According to the Federal Minister of Health, Hermann Gröhe, the aim of the law is to "establish fair competition between sickness funds and to effectively strengthen the financial structure of the Statutory Health Insurance" (Bundesgesundheitsministerium 2014; author's translation). Thus, Hermann Gröhe continues the tradition of his predecessors: Once again, competition is evoked as the key to ensuring the financial sustainability of the German healthcare system and to improving the quality of medical provision.

Almost 20 years have passed since the Healthcare Structure Act (Gesundheitsstrukturgesetz) and

the introduction of free choice of health insurers in 1996. The intention of the Healthcare Structure Act was to transform a system of coercion into a free market for low-priced and high-quality health insurance. Since then, more than 40 healthcare reforms have been adopted – and the political authorities have almost always claimed that their goal was to strengthen competition. But a closer look into the reform packages reveals that in contrast to the pronouncements, the German government has in no way followed a direct path to enhancing competition in the last 20 years. Since at least the introduction of the Health Fund ('Gesundheitsfonds') in 2009, an obvious trend towards more standardization and further levelling can be observed. The most recent healthcare reform in 2014 confirms this trend in a striking manner. German government is planning to replace additional flat-rate premiums by additional income-related contributions, although flat-rate premiums exert much higher competition pressure.

2. Competition in the German Statutory Health Insurance System

According to Cassel et al. (2008: 37) competition in the healthcare system can be separated into three markets: First, the insurance market with sickness funds that compete for subscribers via premium rates. Other competitive instruments are the organizational structure of medical provision and specific services. Explicitly not part of competition is the benefit catalogue, which is mostly defined by law and the Federal Joint Committee (Gemeinsamer Bundesausschuss). Secondly, the market for medical treatments, where service providers compete for patients. Competition parameters are the type and quality of medical treatment as well as services such as appointment management. Finally, the market for selective contracts. In this market, physicians, groups of physicians, medical institutions and suppliers compete for individual contracts and agreements with sickness funds. Those agreements range from simple discount arrangements to the complete take-over of the healthcare responsibility for whole regions or population groups.

The political discussion in Germany focuses on the markets for insurances and selective contracts. This is due to serious transparency and principal-agent-problems on the market for treatments. The particularities of 'health' as a confidence and an experience good (Breyer et al., 2013: 190) restrict the functional capacity of competition on the market for treatments. Therefore, it is much more feasible to enhance competition on the other two markets and, by doing so, to influence the market for treatments indirectly.

2.1 Competition on the Insurance Market – Past and Present

The history of competition in the Statutory Health Insurance (SHI) starts in 1992 with the 'Healthcare Structure Law'. In the context of the so-called 'Great Subject-Matter Coalition', negotiations between representatives of government and opposition took place in a three-week closed convention in Bad Lahnstein, under exclusion of both the public and interest groups (Wasem, 1998: 21). To this day, the proposed concept which was designed, the 'Lahnstein Compromise', represents an important break in German healthcare policy. In 1996 the system of attribution by law was abandoned and the insured persons were given the right to choose their sickness fund. Since the sickness funds are hardly allowed to modify the benefit catalogue, competition is almost completely based on differences in the contribution rates – and the health insurance schemes actively took the opportunity for price competition. In 2008, contribution rates varied from 13.4 to 17.4 percent (Eibich et al., 2011: 3). At the same time, the assessable income ceiling amounts to € 3,600 per month. Therefore, by changing their sickness fund, high earners could save up to €72 per month (the employer's contribution is not considered). Even an average earner with an income of € 2,550 could save €51 per month. Thus, there was a noticeable financial incentive to switch from expensive to cheaper health insurances. Price competition, however, did not lead to the expected results and substantial structural changes. From 2000 to 2009, on average only five percent of insured people switched their sickness fund (Schmitz et al., 2011).

The poor competitive pressure, which was perceived as inadequate, ultimately resulted in the development of new reform concepts. As early as 2002, the German government set up an expert commission to elaborate a proposal to ensure the

financial sustainability of the SHI (Kommission für die Nachhaltigkeit in der Finanzierung der sozialen Sicherungssysteme), but the commission failed to come to an internal agreement. Instead, the commission presented two diametrically opposed reform models: Citizens' Insurance (Bürgerversicherung) and Flat-Rate Health Contribution Model (Gesundheitsprämienmodell). And whereas the Social Democrats (SPD) proposed the Citizens' Insurance, the Christian Democrats adopted the Flat-Rate Health Contribution Model. The dispute went far beyond the question as to what extent competition is needed in the healthcare system. It revealed fundamental differences between the two German major parties with regard to their economical and distributional thinking. The Citizens' Insurance is based on the enlargement of the basis for contribution assessment and the abolishment of private health insurance. Hence, this reform, essentially, does not aim at increased competition, but tries to improve social justice. In contrast, the Flat-Rate Health Contribution Model focuses more on economic aspects. It releases employers from the obligation to pay half of the contributions of their employees. Thus, it tries to prevent increasing ancillary wage costs. Moreover, the introduction of capitation fees would strengthen price competition (for more information about the two reform models see Kommission, 2003).

The campaign for the federal election on 18 September 2005 was very much focused on health policy and the dispute about 'Bürgerversicherung' and 'Gesundheitsprämienmodell'. Both parties announced that, in the event of an election victory, they would introduce a comprehensive health care reform act (SPD-Parteivorstand, 2005: 54 and CDU-Bundesvorstand, CSU-Parteivorstand, 2005: 26).

Since the election resulted in the formation of a grand coalition, the new government was caught in a dilemma. During the campaign, both parties had emphasized the urgency of a reorganization of the SHI. Now, they saw themselves obligated to fulfil their announcement. However, the two existing reform concepts were not compatible with each other. Finally, the Scientific Advisory Council to the Federal Ministry of Finance (Wissenschaftlicher Beirat beim Bundesministerium der Finanzen) offered a solution. From the start it was the intention of the Advisory Council to find a practicable way "to strengthen competition in the SHI without determining a specific financing alternative." (Wissenschaftlicher Beirat, 2005: 1; author's translation). Based on the ideas of Richter (2005), the advisory council presented a consensual model which ultimately resulted in the introduction of the Health Fund in 2009 (Competition Reinforcement Law).

With the Health Fund, a uniform contribution rate for all statutory sickness funds was established. From then on, sickness funds received standardized, morbidity-oriented contributions for each insured person directly from the Health Fund. Therefore, due to the risk adjustment scheme, sickness funds with an above average number of ill insured persons obtain higher contributions from the Health Fund than sickness funds with comparatively few ill insured people. If the premium a sickness fund receives from the pool is not sufficient, it is obliged to raise additional contributions from its members (at the beginning both income-related contribution rates and flat-rate premiums were possible; since 2011 flat-rate premiums are mandatory). Conversely, if the contributions are higher than its expenditure, the sickness fund can give bonus payments to its members. Thus, since 2009 competition has no longer been due to income-related contributions, but instead flat-rate premiums.

The Health Fund was a perfect political compromise between the two major parties. On the one hand, the solidarity-based financing of the SHI was preserved. Moreover, the basis for contribution assessment was expanded by higher tax subsidies. This can be seen as a first step towards Citizens' Insurance. From this point of view, the new financing concept was a clear step in the direction of more levelling. On the other hand, the introduction of flat-rate premiums corresponded with the Flat-Rate Health Contribution Model and was associated with the expectation of stronger competition.

Indeed, the new financing mechanism intensified competition on the insurance market significantly. The introduction of flat-rate premiums has resulted in a doubling of the individual change-probability from 5 to 10 percent (Eibich et al., 2011: 9). Obviously, flat-rate premiums have increased price transparency. Additionally, in the old system the contributions were deducted from an employee's monthly wage and passed on to the health insurance. In the new system, the employee has to pay the additional flat-rate premium directly. This difference is of high psychological importance and results in stronger competition in the new system, although in the old system potential savings had been greater (Schulze-

Ehring, Köster, 2010: 8).

The higher competitive pressure had its consequences. In April 2010, the City BKK was declared insolvent (Bundesverwaltungsgericht, 2012) by the German Federal (Social) Insurance Office (Bundesversicherungsamt). Shortly thereafter the German government passed a new financing reform (GKV-Finanzierungsgesetz, 2011). The standardized contribution rate was increased from 14.9 to 15.5 percent from January 1, 2011. In fact, the increase could not prevent the bankruptcy of the City BKK (Bundesversicherungsamt, 2011). However, due to the increasing and the sustained economic upswing, the necessity of additional flat-rate premiums diminished progressively (Henke and Richter, 2013: 17). At the present time no sickness fund requires any additional premium (Bundesministerium für Gesundheit, 2013).

However, the less sickness funds require an additional premium, the higher the economic risk if a sickness fund does try to introduce such a premium. A loss of members between 10 and 40 percent is feasible (Ulrich, 2014: 10). Therefore, the most important aim of the sickness funds is to avoid additional premiums. The increase of the standardized contribution rate has suspended price competition on the insurance market.

The recent Law on the Further Development of the Financial Structure and Quality in SHI (Gesetz zur Weiterentwicklung der Finanzstruktur und der Qualität in der Gesetzlichen Krankenversicherung) is an attempt to reanimate competition on the insurance market. The aim of the government is to establish a moderate but functioning price competition: "The situation, that a single sickness fund [City BKK] was forced to require an additional premium while many other sickness funds had much better means […] had led to an undesired dominance of price competition" (Entwurf eines Gesetzes zur Weiterentwicklung der Finanzstruktur und der Qualität in der gesetzlichen Krankenversicherung, 2014: 1; author's translation). Consequently, what is demanded is a functioning price mechanism which does not exert too much pressure on sickness funds. For this purpose, the German government is planning to introduce two changes from 1 January 2015: First, the standardized contribution rate will be reduced from 15.5 to 14.6 percent. The resulting financing gap of 11 billion euro (or 0.9 percentage points) shall force most sickness funds to introduce additional premiums. In doing so, the government follows the recommendation of many health economists (e.g. Greß and Wasem, 2009). However, the changes go beyond those recommendations: From 1 January 2015 additional premiums will only be allowed in the form of income-related contributions. This takes account of the fact that flat-rate premiums exert much higher competition pressure.

2.2 Competition on the Market for Selective Contracts – Past and Present

Numerous studies confirm that German healthcare, compared to other OECD countries, is characterized by high costs, ruptures in treatment when transitioning from one medical sector to another and low information flow between the service providers (e.g. Schoen et al., 2011). The reasons for this are well-known: First, care is still dominated by uniform contracts between the traditional associations of the sickness funds and the service providers. Competition for contracts and the provision of care is very limited. Second, there is a lack of cooperation between physicians and other medical professions such as highly qualified nurses or caregivers. Third, medical sectors are largely separated and each sector has its own specific compensation system, budget, planning structure etc. A lack of transparency and false incentives result in inefficient diagnostic processes and unnecessary double treatments. This occurs not only at the interface between outpatient and inpatient treatment, but also within sectors, such as the decision process between specialists and primary care physicians.

Therefore, the German government has introduced various laws in the last 15 years. These aimed to encourage competition for care concepts between health insurances and more leeway for players in the various sectors of health care (Amelung, 2008). To this day, several different possibilities for individual contracts between physicians, sickness funds, industry etc. have been established. Special forms of the provision of healthcare in Germany range from Group Contracts (Section 73 a SGB[Sozialgesetzbuch = Social Insurance Code] V) to Pilot Projects (Sections 63-65 SGB V), General Practitioner-Centred Models (Section 73 b SGB), Particular Outpatient Care (Section 73 c SGB V), Integrated Care (Section 140 a-d SGB V), and Disease Management Programmes (Section 137

f-g SGB V). Apart from Group Contracts and Disease Management Programmes, all of these special forms allow selective transactions. With the exception of General Practitioner-Centred Models, all of them are interdisciplinary and most of them even cross-sectoral (Sachverständigenrat, 2007).

The German government placed its greatest hope in Integrated Care (Section 140 a-d SGB V). Integrated care was introduced in 2000 via the Health Care Act 2000. However, at the outset, the effects were minimal because the conclusion of contracts required the approval of the physicians' associations. Only since 2004 and the Healthcare Modernization Act have individual physicians and physician networks been able to become direct contract partners with the health insurances through selective contracts. At the same time, the government introduced a start-up financing fund of up to almost 700 million euros, i.e. 1 percent of the entire compensation of physicians and hospitals. The attractive financial support triggered a boost in integrated care contracts. Within four years, approximately 6,000 contracts were concluded (Amelung et al., 2012: 2). Nevertheless, the dynamic development collapsed immediately after the expiration of the start-up financing fund at the end of 2008. Today there are still more than 6,000 contracts, but their share of total expenses stagnates below 1 percent of total health care expenses (Sachverständigenrat, 2012: 349). Even successful pilot projects which have proved capable of lowering expenditure and improving health care quality remain regional and are not applied to improve health care provision nationwide (Hildebrandt et al., 2008).

The stagnation of integrated care in Germany is not a new issue (Amelung, Wolf, 2012). However, to this day, the central obstacles to integrated care have not been addressed by the German government. Instead, the recent health care reform on medical provision – the Health Care Structure Law which took effect in January 2012 – introduced new instruments for interdisciplinary and cross-sector models of care such as mandatory discharge management for hospitals. Moreover, an outpatient specialist care sector, in which inpatient as well as SHI-authorized physicians can equally take part, has been established. This is a new approach which can contribute to reducing the frictional losses at the sector boundaries (Amelung et al., 2012: 3). However, it does not eliminate the barriers to integrated care and selective contracting. Instead of pluralistic provision, the government chooses the path of obligation (discharge management) and instead of tearing the sector borders down, it establishes an additional new sector (outpatient specialist care).

3. Approaches for More Competition

Competitive pressure can be created by means of two components: price and quality. The potential for price competition in the German healthcare system is highly restricted. On the insurance market, price competition is only accepted socially and politically as long as it does not jeopardize the sickness funds' economic situation. The most recent healthcare reform act shows very clearly that the German government fears the selective power of competition. Therefore, price competition on the insurance market is substantially limited by politics. It must be concluded that the political goal of strengthening competition on the insurance market has eroded more and more. The introduction of the Health Funds in 2009 was already an important step towards levelling the insurance market. With the decision in favour of income-related additional premiums, the government is abandoning the last component of the competition-oriented model of the Flat-Rate Health Contribution Model.

On the market for medical services, price competition is rejected on principle. This is shown by the example of the so-called 'doctor's office visit fee' (Praxisgebühr), i.e. a medical consultation fee of 10 euros per quarter. In November 2012, the German parliament (Deutscher Bundestag) abolished this small out-of-pocket payment with a historical voting result of 100 percent (Bundesministerium für Gesundheit, 2012). As soon as people gain the impression that medical provision depends on the willingness to pay or – even worse – on the ability to pay, many people resist. Price competition is, at best, accepted on the market for contracts – but only when it means achieving cost-savings due to rebate contracts (Amelung et al., 2013).

Consequently, the principle aim of the German government is creating quality-based competition. However, there are tight limits here too. As the heated debate around the abolition of the reimbursement of dentures has confirmed, it is politically almost impossible to reduce the benefit catalogue

of the SHI. Consequently, the sickness funds are faced with the challenge of differing in quality despite the benefit catalogue being almost completely predefined and unchangeable. The qualitative parameters of competition are structure and process optimization, coordination, supervision, lifestyle-products and services. As shown in chapter 2.2, sickness funds and service providers have a large number of tools at their proposal to influence medical provision and to design treatment processes and structures. However, it is obvious that the legislator has underestimated the inertia of the various actors in the sphere of public health and the healthcare sector (Amelung, Wolf, 2013). Medical provision in Germany is still dominated by collective decision-making and uniform provision. The apparent contradiction between the huge number of 6,000 selective contracts and only one percent proportion of health care expenditure can be understood by looking at the different contract competition fields.

Innovative forms of care and healthcare delivery are interesting for sickness funds if they involve a low level of economic risk and if they are attractive for large groups of insured persons. For this reason, they concentrate their activities on indication-oriented models of care which deal with widespread diseases such as depression and back pain. Common treatment methods such as endoprosthetics are also lucrative. Moreover, sickness funds often offer alternative treatment methods which are likely to attract young and healthy members and can be used for public relations. Competition is fully functional in these segments.

In contrast, contract competition is insufficient in the field of ambitious structural innovations and population-oriented approaches, especially when it is difficult to reach large groups of insurants. Sickness funds are still reluctant to undertake high initial investments when the return to investment is exposed to a relatively high risk. There are also not enough incentives on the part of the service providers. A physician does not agree to a selective contract if the share of his or her patients who are affected is too low. This is particularly the case if the healthcare model is regionally limited and the market share of the sickness fund is low. After all, there are a lot of successful pilot projects, but these models usually fail when it comes to finding financiers for permanent realization after the pilot phase has been completed.

The third task of contract competition is to open up a new field of experimentation for quality and efficiency, improving process innovations which are not necessarily cross-sector or interdisciplinary. Until now, there has been no legal basis for the realization of such innovative forms of care. For such projects, sickness funds often use the legal basis for Integrated Care (Sections 140 a-d SGB V). However, this entails the risk of the regulatory authority refusing its consent. A prominent example is the primary care physicians and primary care pharmacists model of the Barmer Ersatzkasse. 18,000 pharmacists and 38,000 physicians were involved in the project for which the Federal Social Court (Bundessozialgericht) refused approval purely on formal grounds (Amelung, Wolf, 2013: 116).

4. Lessons learned

Implementing dynamic contract competition would require two steps: first, the willingness to invest must be promoted. Second, a simple and easy to understand legal basis is needed which enables the introduction of innovative care concepts in a less bureaucratic way.

Investment requires investors being willing to assume risk. However, in the German healthcare sector, neither the sickness funds nor the service providers are characterized by readiness to assume risk. For the sickness funds, the risks outweigh the advantages. As a corporation under public law, a statutory sickness fund is obligated to think in yearly budgets. Innovative care models often demand high initial investments, but the return on investment usually comes in three to five years. Thus, the risk and the use of resources necessary for innovative care reforms are often classified as unreasonably high. In order to change this, health insurances could be given more flexible entrepreneurial leeway which would also allow them to invest in projects whose revenue may only accrue in some years' time. In addition, innovation budgets could be introduced in health insurances for the development of innovative forms of care. To ensure that the funds are appropriated used, standardized evaluation would be inevitable (Amelung et al., 2012).

Many service providers are dissatisfied due to their high workload and the earning potential in the SHI.

However, there is only low economic pressure to be involved in selective contracts. Consequently, there is too little initiative from the service providers. Almost none of them need be afraid of being excluded from the system. Moreover, many physicians fear that a change in the structure of care could restrict their authority, increase surveillance and interfere with their freedom of treatment. Thus, beyond the compensation system, incentives could be offered to physicians for their participation in innovative forms of care. Pay for performance would enable each party to attain additional income through individual performance and would enforce the desired quality-based competition (Amelung et al., 2012). Despite this, establishing pay for performance in the SHI is not under serious consideration. There are however some few tentative experiments with pay for performance elements e.g. in the general practitioner care contract in Baden-Württemberg.

Since the Healthcare Modernization Act in 2004, the government's ambition to strengthen contract competition has significantly diminished. In 2004, integrated care and contract competition were praised as a solution for more quality and efficiency in healthcare. However, at least since the 'Healthcare Structure Act' in 2012, it is obvious that politicians have changed their minds. The focus has shifted from integrated care to the so-called 'Out-Patient Specialist Care' (Ambulante Spezialfachärztliche Versorgung, Section 116 b SGB V), i.e. a new form of cross-sectional and interdisciplinary co-operation. Without going as far as debating the pros and cons of 'Out-Patient Specialist Care', it is clear that this new form of care is only suitable for a handful of medical indications. Thus it can only improve medical provision selectively. It is certain that overcoming the boundaries between the different healthcare sectors requires integrated care.

From this point of view, the coalition agreement of the new federal German government is encouraging. With the aim of boosting integrated care and selective contract competition, the Grand Coalition has announced the introduction of a new form of start-up financing and a substantial simplification of the legal basis for innovative care concepts (Koalitionsvertrag, 2013). This combination of start-up financing and legislative simplification may succeed in giving a clear impetus for innovative healthcare concepts. These announcements have been recently considered in the draft bill of the law on strengthening the provision of healthcare in the SHI (Gesetz zur Stärkung der Versorgung in der gesetzlichen Krankenversicherung).

5. Conclusion

To evaluate the effectiveness of competition in the SHI, the insurance market and the market for selective contracts must both be analysed separately. At least since introduction of the Health Fund, a trend towards less competition and more levelling can be observed on the insurance market. More independence for the sickness funds to set the level of contributions is urgently needed. In contrast, on the market for selective contracts, an ambivalent picture emerges. On the one hand, several possibilities for establishing new forms of healthcare and strengthening competition have been introduced. On the other hand, it is safe to say that the initial euphoria has since dissipated. Sickness funds as well as service providers are often reluctant to enter into selective contracts. To strengthen competition two things are required: first, the willingness to invest must be promoted. Second, a simple and easy to understand legal basis is needed which enables the introduction of innovative care concepts in a less bureaucratic way. The current draft bill of the law on strengthening the provision of healthcare in the SHI includes the relevant measures for overcoming the rigidity of the German healthcare system. However, it is the implementation that now becomes important.

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(Endnotes)

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Sascha Wolf
Volker Amelung

Izjednačavanje nasuprot tržišnom natjecanju – politički obrat u trendovima njemačkog zdravstvenog sustava?

Sažetak

Gotovo 20 godina njemačka savezna vlada tvrdi da tržišno natjecanje ima ključnu ulogu u osiguravanju financijske održivosti zdravstvenoga sustava. Cilj ovoga rada je istražiti je li njemačka vlada doista slijedila izravan put prema jačanju tržišnoga natjecanja. U tu svrhu, provedena je kvalitativna analiza najvažnijih zakona o reformi zdravstva. Zaključeno je da se uočava jasan trend većeg izjednačavanja i propisivanja, pogotovo od uvođenja Fonda za zdravstveno osiguranje 2009. godine. Taj trend potvrđuje i najnoviji Zakon o reformi zdravstva iz lipnja 2014. Ukidanje paušalne premije odraz je straha Vlade da bi pritisak konkurencije mogao ugroziti solventnost i održivost fondova za zdravstveno osiguranje (fondova za obvezno zdravstveno osiguranje). Nasuprot tome, na tržištu za ugovore o selektivnoj distribuciji javlja se ambivalentna slika. S jedne strane, uvedeno je nekoliko mogućnosti uspostavljanja novih oblika zdravstvene zaštite i jačanja tržišnog natjecanja. S druge strane, fondovi za zdravstveno osiguranje, kao i davatelji usluga, često nevoljko sklapaju ugovore o selektivnoj distribuciji.

Ključne riječi: njemački zdravstveni sustav, Fond za zdravstveno osiguranje, konkurentnost ugovora, integrirana zaštita, inovacijski fond