Ladies and Gentlemen,

let me welcome you to this first open international conference dedicated exclusively to the analysis of regional variations in health care. The emphasis here is on the fact that this is an open conference. For me, this is an important landmark.

Let me explain this to you. At this very moment I stand here in a double function. As the CEO of the Central Research Institute for Ambulatory Care in Germany, or short Zi, I am very proud to welcome you on behalf of the organizers of this conference. As the CEO of the Federal Association of Statutory Health Insurance Physicians I am the political representative of roughly 165.000 physicians and psychotherapists who provide ambulatory care to 87 percent of the population under statutory health insurance. This is just about half of all practicing physicians in this country. The Federal Association is in charge of guaranteeing that every statutorily insured person in Germany has access to appropriate ambulatory care anytime and anywhere in Germany. We are creating the federal framework for this while implementation is the responsibility of 17 Regional Associations. The 17 Regional Associations and the Federal Association are the founders of Zi as a research unit in support of our responsibilities toward the public. After the creation of a nationwide claims database Zi has embarked on geographic analyses. Since the year 2010 this has lead to an increasing understanding of the importance of regional characteristics influencing the provision of medical care. It has also lead to recognizing the importance of regional responsibilities for improving care in the respective regions. But this renaissance of decentralized responsibilities has been accompanied by an increasing body of research providing benchmarks to identify best and better practice as and need for improvement in other regions. Therefore , geographic health services analysis has become, and is still becoming, a vital part of our way of handling our responsibilities.

Needless to say, that in doing this we need to pay tribute to the seminal work of Professor John Wennberg of Dartmouth College and his team who started looking into small area variation both as an analytic approach and as a way to discuss and shape health policy. Unfortunately Professor Wennberg can’t be with us today, even though he would have enjoyed visiting Berlin again. Now after five decades the field of research has become an international one. In organizing this conference Zi is therefore deeply indebted to David Goodman from the Dartmouth Institute for Health Policy and Clinical Practice.

We are glad and thankful to David Goodman and Gwyn Bevan for their initiative to create the Wennberg International Collaboration, short WIC, as a joint venture of the Dartmouth Institute and the London School of Economics. The WIC workshops have successfully brought together researchers from all over the world to exchange their ideas, to share their methods and knowledge, and to understand the policy implications which can be derived from the analyses.

This conference may be seen as a spin-off of these WIC workshops. As it is the first conference of its kind, a specific name has been coined for it: The WIC policy conference. I sincerely hope that this label will be firmly established for a series of conferences of this type. There are plenty of reasons why there should be an annual or bi-annual WIC policy conference. Let me list a few of them:

To begin with, variation is a fact in health care. It is here to stay and I do not believe that we will ever get rid of it. We can and should, however, attempt to reduce unwarranted variation. We should use the analysis of variation as a way to identify best practice within the given framework of our existing health care systems. We can use the analysis of variation to formulate targets for improvement of the care that patient populations in our respective countries should receive.

This is particularly relevant to health care delivered within the framework of systems designed to provide universal access. To the extent to which we all expect to have equal rights to access and to benefit from care as a way of equity we need to ensure that geography, contrary to Professor Wennberg's famous observation, isn't "destiny health care". We may have accepted that life – and health care – in remote areas differs from life – and from health care – in metropolitan areas. Asking the question whether we need a doctor in every village is to some degree unavoidable. Let me say that in my opinion this is neither necessary nor practicable. But we need to use the analysis of variation to observe the degree to which these differences develop and to take informed policy decisions regarding the degree of acceptable variation. I will return to this aspect later because at least here in Berlin it directly relates to a hot parliamentary debate on reforming capacity planning as part of the present health reform law.

But apart from being a useful tool in the social policy debate, the analysis of variation in health care should be deeply rooted in medicine itself. As medical doctors we rely

on methodically sound studies to identify therapies that really work. We are trying to follow up every patient to make sure that we did the right things in terms of diagnosis and therapy. So, why wouldn't we embrace the possibilities of using the routine data which are being created by the administration in each health care system to understand the patterns of variation as a means to identify ways of improvement in our daily routine? And why shouldn't we use the analysis of regional variations to identify regions in which we need to negotiate the support of the insurers and third party payors to provide the necessary resources to achieve desired levels of care in just the same way as the payors look into ways of improving efficiency to make savings in some regions? Every improvement requires effort and every additional effort needs its respective incentive.

This is the background against which Zi in 2011 created its health atlas as the internet portal www.versorgungsatlas.de with the support of the 17 Regional Associations of Statutory Health Insurance Physicians and their Federal Association. The idea is that the information generated by this atlas can be used by researchers who may download the published data for further research. But even more importantly, given that we have a system of regional collective contracts between the Physician Associations and the associations of all third party payors together, the health atlas is intended to provide benchmarks which can become part of regional negotiations. For this all Regional Physician Associations have agreed to pool their claims data base to create a nationwide data base which can be used by Zi for its analyses.

Of course, as the means of data analysis progress, other initiatives exist in Germany to use routine data for regional analyses of health care. Many maps are being produced by specific sickness funds, i.e. third party payors, and of course by the Bertelsmann Foundation which is well known among WIC members. The specific feature of Zi's Versorgungsatlas is that anyone can upload their studies onto this webportal. In fact, it is meant to become a meeting place for the exchange of information of various sources about the geography of health care in Germany. This feature is not yet widely used but we sincerely hope that this will improve in the coming years. We need more rather than less transparency about what our health care system is able to do or not to do.

Improvement needs an open instead of a defensive mind. I think as an organization we are demonstrating this open mind with our atlas initiative. The real challenge, however, is not just to keep an open mind. It is to actually change behavior. In order to reduce unwarranted variation we need to change the behavior of the decision makers responsible for regional budgets, we need to reach out to hospital managers, we need to affect physicians in both inpatient and outpatient settings and last not least we need to change behavior of patients. Given that any change in the health care systems needs 10 years from the idea to some degree of practical impact or success, we are facing a tall order.

Changing patterns of care is certainly nothing for impatient characters. It's a long term effort and that is another reason why we will need repeated reminders by variations studies, media coverage, CME and quality circles and other initiatives to turn the tide. Occasionally it also helps to glance over the fence and get new ideas from the international community in the field. And this is another reason why I sincerely hope that this conference will be starting a tradition and that you will have reason to come back to Berlin for more WIC policy conferences.

Before you start out for these two days let me give you a brief idea of some of the themes that shape the present health policy agenda in this country. You may not be surprised to hear that we are discussing both over- and underprovision of care at the same time.

Let's start out with apparent underprovision. Presently government is concerned about waiting times when accessing secondary care in the ambulatory setting. By international comparison this may be hard to understand. In Germany patients do not have to enlist with specific physicians. There is no compulsory gate keeping but free access to any physician of almost any specialty at any time at no out of pocket cost to the patient. Still, 77 percent of patients get access to secondary care on the same day or within 3 weeks. Only 22 percent wait longer than 3 weeks for an appointment. This includes elective and preventive services which is why dissatisfaction with the remaining waiting times is even lower. German physicians work longer hours than their colleagues worldwide and treat many more patients in that time. A recent study published in the Journal of the German Medical Association compared the workload of German GPs to that in other nations. On average a German GP treats 250 patients per week. According to the study this is 1.5 times the number of patients

treated by Italian GPs, twice that of Australian GPs, 2.5 times that of US GPs and 5 times that of Swedish GPs. It is more difficult to compare ambulatory secondary care internationally. But there is no reason why the shown tendency should be any different for utilization of ambulatory specialty care. Yet, the projected legislation will require that Regional Physician Associations install appointment service units to ensure that no patient with a GP referral will wait longer than 4 weeks. This is an ambitious goal. Given that really urgent conditions need and already get a much quicker treatment we are headed for a sensationally broad access to ambulatory care when we compare Germany to other countries.

The overly ambitious nature of this plan becomes apparent when you hear about other aspects of the projected legislation which also aspires to reform capacity planning. In this case the government relies on outdated physician/population ratios based on ambulatory care during the early 1990's which no longer reflect the changes that occurred in medicine since then and certainly do not reflect intensified utilization of ambulatory care in Germany. Presently, if these ratios are exceeded by 110% in any region there are limitations for the accreditation of physicians in those regions. According to government plans there will be an actual ban on further physician accreditations in those areas where physician/population ratios are exceeded by 140%. In that case the Regional Physician Association will have to use own resources to compensate the owners of existing practices at market value for waiving to sell their practice to a successor. Inspite of the fact that medical practice is constantly improving ways to provide more treatment on an outpatient rather than an inpatient basis, the government in effect expects us to reduce treatment capacities in the ambulatory sector. To be fair: There are also plans to reduce inpatient capacities. But there is no plan suggesting a sensible investment strategy to improve our health care system where it needs improvement.

Health services research seems to suggest ways in which we could derive such an investment strategy. Recent analyses show that within Germany we observe great variation in the division of labor between ambulatory care and inpatient care. In fact, it can be shown that for an increasing number of conditions, the so-called ambulatory sensitive conditions, ambulatory care can be a substitute for inpatient care. If low hospitalization rates suggest a better overall quality of the ambulatory care in the respective regions than we would have a lead here for further research aimed at

shaping an investment strategy which improves our health care system both in terms of desired outcomes of medical care and economic efficiency. This lead, unfortunately, has not yet been taken up by our politicians. Here, we need to focus our attention and create a better understanding among those responsible for shaping the process of political decision making.

Finally, I think we do need national and international variation studies to keep us tuned to the question of appropriateness of care. In aging societies with ever increasing demands on resources, in societies that seem to head for a division into declining rural areas with a tendency to increased deprivation on the one side and continuously growing cities with their own socio-economic dynamics on the other we need to address appropriateness of care deliberately. We need to define minimum standards as well as a level of sufficient care to be paid for by social insurance. And we need to look into new ways of providing this appropriate care. This may entail a greater use of telemedicine, delegated care, patient transportation and so forth. This may be another field of useful international comparison from which we could derive more benefit than was hitherto accepted.

With this I would like to thank you for your attention. I wish you a successful conference with many insights and – what may be even more important – new questions for further research. Hopefully then, in a couple of years you will be able to present the answers back here in Berlin at another WIC policy conference.

Dr. Andreas Gassen