

‚Hospital reforms are always evolutionary processes‘

Interview: Prof. Dr. Jonas Schreyögg, holder of the Chair of Management in Health Care, Hamburg Center for Health Economics, University of Hamburg and member of the German Council of Health Experts.

Prof. Dr. Jonas Schreyögg, holder of the Chair of Management in Health Care at the University of Hamburg and member of the German Council of Health Experts, is considered one of the most influential economists in this country. In an interview with ‚Monitor Versorgungsforschung‘, he has high hopes for the upcoming hospital reform, which he sees as an evolutionary step. But the litmus test is still to come, which will show what will actually happen if regional hospital plans lead to the closure of entire hospitals. Only after five or ten years will it be possible to say whether a model really works and which adjustments were the most effective.

>> Science must advise politics and society in a transparent way. This requires diversity of positions and evidence instead of eminence,' the Bonn virologist Hendrik Streek, who has been well known since the SARS-CoV-2 pandemic and is also a member of the German government's Corona Expert Council, recently told the Tagesspiegel. Prof. Schreyögg, as holder of the Chair of Health Care Management at the University of Hamburg, scientific director of the Hamburg Center for Health Economics (HCHE) and, on top of that, member of the German Council of Economic Experts, what are your experiences with the topic of ‚evidence instead of eminence', a dialectic that has accompanied us since the 1990s? In concrete terms: When will scientific evidence make the leap into political reality?

I have the feeling that health policy - if you look back over the last ten to twenty years - is increasingly oriented towards the available evidence. Of course, there are always exceptions, but on the whole the direction towards evidence-based decision-making is right. That makes us scientists happy, of course. But health policy is only one side of the coin; just as important, if not much more important, is the other side: that of translation. Here, the big question is whether evidence-based health policy actually leads to the fact that what is introduced is really evidence-based.

So you see a difference between what health policy decides on the basis of the available evidence and what is actually introducedinto health care at some later point in time through the resultinglaws?

Certainly. At this interface, where intentions become reality, there are often massive distortions. But this should not be surprising, because it is a big, very big step from what is agreed in a coalition agreement, for example, and what is cast into law after a democratic process, to what is actually implemented in practice. On this long road, many different interests have to be taken into account and stakeholders have to be persuaded to cooperate by making concessions of almost any kind. Therefore, it is usually not the case that a project, an idea or a health care innovation, which has been set up and evaluated by science in a clean, evidence-based manner beforehand, is implemented in an evidence-based manner in the end - this is perhaps what a scientist would imagine, but certainly not the reality.

Gerd Glaeske - Professor of Health Services Research in Bremen and a member of the advisory board of ‚Monitor Versorgungsforschung' from the very beginning - who unfortunately passed away much too early, therefore demanded throughout his life an evaluation that takes place with the introduction of innovations and a policy impact research based on it.

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We actually have a problem with this in Germany. It is even the case that even if a corresponding evaluation is prescribed by law, it is not really implemented. Many stakeholders duck away or are afraid of rigorous evaluations - that is a problem we unfortunately have to live with.

Have to live with? Or are there other possibilities and ways?

Of course there are, you just have to want them on the part of politics.

Don't politicians want to?

Politicians often want to, but they are often very afraid of either doing something wrong or they are afraid of not making innovations available to all citizens at the same time so as not to arouse resentment. It takes some courage to follow the example of Great Britain or the USA, where regional and local pilot projects can be implemented and then evaluated against control groups, instead of rolling out interventions that have yet to be researched nationwide, as is often done in this country.

Are you only talking about the policy side here?

Of course not. This also happens with model projects of health insurance companies. It would make more sense to stipulate by law from the outset that in the case of far-reaching health policy projects that are capable of actually changing health care, ideally of course improving it, a randomised study with a control group must be set up at the planning stage.

You mention here, for example, the introduction of disease management programmes.

DMPs are another case in point, but in principle you are absolutely right. The politically formulated requirement that all health insurance funds and service providers were obliged to do this created part of the problem of never being able to evaluate DMPs within the framework of an ex ante randomised experiment. This is where a rethink on the part of policy-makers must take place, which we in the Council of Experts have repeatedly suggested.

In your opinion, what is the reason for this resistance?

In Germany, everyone always wants to do everything right. When it comes to innovations, the entire population should have access to everything, preferably at the same time. This always-doing-everything-right is largely a cultural issue that we should slowly say goodbye to. I am aware that this will be a long-term process. This is mainly because temporary postponed introductions of innovations need to be explained, because one has to withhold innovations from one or more groups of the population in order to eventually arrive at an improved version of an innovation that will then benefit everyone.

Here we urgently need to discuss the principle of equality and the underlying ethics.

Is this really a cultural problem? Or not simply an outgrowth of a health system as such?

For example, there is no such thing as the American health system as there is the German one. There are very many in the USA, some

of them extremely heterogeneous. So it is not at all noticeable if, for example, an innovative care programme - as was the case with pay-for-performance - is introduced in Pennsylvania, but not in California or Texas. In much smaller Germany, such a stepped-wedge approach would be difficult to sustain - at least at present.

‚Hospital reforms are always evolutionary processes that must gradually address many necessary changes and, above all, eliminate disincentives in remuneration and distortions of competition.‘

Isn't that a question of communication?

Sure, like so many things. Such approaches need not only good study designs, but also very strategically designed communication concepts with good argumentative lines designed for the different target groups. If a project were designed ex ante in this way, from the idea to the implementation, one could also achieve much more in Germany than before, instead of often having to look enviously overseas or even across the English Channel. Then there would be more innovations in Germany based on ex ante randomised interventions with control groups.

In recent days, two large-scale health care models have come to an end or interim conclusion - ARMIN in Saxony-Anhalt and Thuringia on the one hand, and family doctor-centred health care, or HZV for short, in Baden-Württemberg on the other. Both care models have been positively evaluated, yet ARMIN is on the verge of being discontinued and HZV is only used in two federal states. Both times because there is no regulatory framework for a transfer to standard care or an obligation to provide better care. Why are there neither?

Because the respective interests are too different. Do the stakeholders determine the policy?

The G-BA determines the reality of health care policy and how it is shaped by its authority to define the catalogue of services to be reimbursed by the statutory health insurance funds. This is where it is determined what is included in standard care and what is not.

However, it does not define which model project will become standard care. This can only be done by the politicians by amending certain paragraphs of the Social Code Book V.

You are right, such a thing would have to be decided by health policy.

No one complains when, despite available evidence, lives and lifetimes were wasted by not introducing good care models and hospital costs were not avoided because - for whatever reason - the worse established system was preferred to the better new system. Why is there no legal entitlement to - if evident - better care?

An evidence-based automatism would certainly be desirable, but from a legal point of view - I am an economist, not a lawyer - certainly questionable. Any decision that would follow such an automatism would inevitably interfere with legislative periods far in the future. Politicians already have a hard time making far-reaching decisions that only affect the budget of the current legislative period. Therefore, I would be sceptical at this point as to whether such an automatism is legally viable.

This begs another question: what evidence actually needs to be available for such a move?

If we were to demand strict evidence with the highest evidence class for political decisions, we would run into problems with many models of care. For example, if we look at the HZV or DMP that you mentioned, there is no exante randomisation. But since the reality of health care and our culture do not permit this, there can be no such automatism.

Unfortunately, you have taken away my illusion of a better world. This leads me to another question: Has health care improved in the last ten to twenty years? Since this question is difficult to answer, let's ‚only' take the hospital sector, on which you have been researching for a long time and, among other things, sat on the review board of the Bertelsmann Foundation, which called for fewer hospitals with the report ‚Sustainable Hospital Care'. What has happened in this good decade?

I have never been someone who suggested going over the existing hospital structure with a lawnmower, so to speak. I don't think that makes sense or is appropriate, and it's also unrealistic. The reason for this is that, unfortunately, in the German context, no matter how good and sophisticated the planning perspective, it will not be successful. We are neither Denmark nor France nor Great Britain, where centralised action is much stronger than here. In Germany, the Länder have sovereignty over hospital planning - whether they fulfil this task well or badly is a moot point. However, the federal government, mindful of federal self-determination, can create the legal prerequisites and the legislative framework for a modern hospital landscape. That is the federal government's task. And there is much to be done, if we only think of a very important prerequisite, such as the right remuneration, which avoids false incentives and creates a better process and quality structure.

We already had this with the Hospital Structure Act from 2015 and now again with the currently discussed Hospital Financing Act.

At that time, we made good progress. And now, too, there is a great opportunity to make further progress. Hospital reforms are always evolutionary processes that must gradually address many necessary changes and, above all, eliminate disincentives in remuneration and distortions of competition. If the federal government takes on this mammoth task , which is certainly not easy, the ground will be prepared for better care in the hospital sector. Mind you: the ground, because implementation always takes place regionally, on the one hand through competition, on the other hand in interaction with the municipalities, their circumstances, peculiarities and interests as well as the respective state policy.

Does the current hospital reform really prepare the ground well enough or is it not just another step in the evolution?

I think we can take another important step forward this time, but further steps will certainly be necessary in the coming years.

Where do you see the most far-reaching adjusting screws?

It certainly makes sense to introduce retention fees. Even if I don't think that every hospital really needs retention rates. Some that only provide elective care, for example, manage very well wi-

thout this kind of flat rate. But it will not be possible to implement this politically in any other way because of the culture already discussed in terms of the principle of equal treatment. In addition, it can be argued that the volume incentive is more strongly curbed by a retention flat rate for all. However, there would be many other steps that we would have to take; it remains to be seen whether these are also capable of gaining majority support.

For example?

For example, the definition of certain performance groups. If certain procedure and service groups can only be reimbursed if certain structural conditions are met, the hospital landscape and the care reality and quality they generate will change. But this will not happen overnight either, because it has taken a long time, for example, to develop the structural features that already exist.

Currently, three regional hospital reforms are underway: Lower Saxony, North Rhine-Westphalia and Saxony-Anhalt. If you mentally juxtapose these three: Which concept is the most far-reaching from an economic point of view?

At the end of the day, they are all models that will only show in a few years which one works better. First of all, it is absolutely welcome that the federal states are taking the trouble of structured hospital planning and not just continuing with the status quo.

The question is: What will they achieve?

I am reluctant to answer this question. We will see whether service providers can effectively sue in the event of the closure of a specialist department or an entire hospital, which has already happened in some cases. That is why it is extremely difficult for a federal state to reduce even individual beds against the resistance of a hospital operator, let alone to close a department or even the entire hospital.



Prof. Dr. Jonas Schreyögg

has held the Chair of Health Care Management since 2010 and has been Scientific Director of the Hamburg Center for Health Economics (HCHE) at the University of Hamburg since 2011. After studying business administration and economics at the Technical University of Berlin, he also completed his doctorate here at the Department of Finance and Health Economics (Prof. Dr. Klaus- Dirk Henke) as Dr. rer. oec. After his doctorate, he was a post-doc at Stanford.

Does this make hospital reform per se unrealistic?

I am curious to see what results we will see from the changes in hospital planning in the next few years. The litmus test is still to come, which will show us what will actually happen if regional hospital planning should lead to the closure of entire hospitals. Only then, when individual hospitals and providers can no longer sue their way into the care system, will planning become a reality. Until then, there will be many public discussions about which hospital with which number of beds should be retained and which should not. Opinions, fears and demands will clash here, and it is completely open how it will all turn out. In spite of everything, it is good to formulate a goal and orientation in which direction a federal state wants to develop its care. We will then see whether orientation leads to action and at some point it becomes a new reality.

Which will again take a lot of time.

From a purely scientific point of view, it will only be possible to say after five or ten years whether a model really works and which adjusting screws were the most effective. Only then, through the preliminary work of a few states, will we have a sustainable system that several states could welcome.

On the basis of an evident metaplan, for example?

The way of planning and the importance of a plan in itself is overestimated. Of course it is right for a federal state to establish a structured procedure, as has happened in Lower Saxony, for example. But the real processes that ultimately lead to a hospital being converted, closed or taken over will not primarily run along the lines of a plan, no matter how obvious it may be. This can, however, provide support.

Are politics and science overestimating themselves?

Both can only provide a guideline. Inthe end, it depends on which democratic forces will prevail ina region or - better - in a municipal association. Mayors, district councillors, state and federal representatives, citizens' initiatives and, of course, service providers - all have their own agenda. In this setting, there is a black-and-white view in which it is often not possible to objectively point out alternatives, let alone discuss and weigh up a kind of structural menu.

Please elaborate on this.

Hospital closures and bed reductions are usually only the hard end points that come into play in the worst case. Sustainable planning would proceed differently by presenting a bouquet of options - a structural menu. Such a menu must always take into account local and regional circumstances, but also formulate conditions that can make better care possible. Under certain circumstances, this can be a regional care centre with a ward with a certain number of beds that can admit older people for general medical observation. But it could also include an outpatient surgery centre, a helipad or a 24-hour on-call paediatric service.

Wolgast springs immediately to mind.

Exactly. After resistance from the citizens, it was possible to create adequate care through a children's portal clinic with on-call service, despite the closure of an inpatient paediatrics unit. To create outpatient surgery centres, however, we need sectoral remuneration, for which a legal basis has already been created; now the corre-

sponding legal ordinance is still missing. Then, little by little and on top of that, we can succeed in creating care structures that are as demand-oriented as possible and that do not let costs get out of hand while maintaining high quality. I am, by the way, very confident about the latter: for the expenditure on services in an outpatient or outpatient-inpatient setting is usually always cheaper than keeping a loss-making hospital with extensive equipment and staff on the network.

And that with a national average bed occupancy rate of 70 percent.

In many municipal hospitals we are talking about occupancy rates of only 30 or 40 percent. And there are quite a few of them. This goes hand in hand with correspondingly high deficits and pressure to act on the part of the municipalities and the respective owners. For these locations, experienced moderators are needed who are able to point out ways to a possible future.

A major issue has always been the sheer accessibility. Surely it must also be the task of science to ensure that this supremacy of the topic of accessibility is taken back in 20 minutes and transformed into a discussion about quality.

That's right, that is also the task of science. As a scientist and expert, I never tire of emphasising that there is good evidence in this regard, for example in the area of strokes and heart attacks. Here it is often the case that further distance even leads to better outcomes, if the right hospital is approached. But in recent years, this dictum of 20-minute accessibility has been much better accepted by doctors and patients than in the past - people are voting with their feet because quality is becoming more and more important. I have the feeling that this trend has been reinforced by Corona and that people no longer go to their hospital around the corner, but accept further distances. This in turn increases the misery for many hospitals, especially in rural areas.

Let us look into the crystal ball: What kind of care reality will we have in ten years' time, if the hospital reforms of the Länder are successful? Will we have a Danish model?

I don't see us going in the direction of Denmark, because this Nordic country is really far removed from the German situation. Of course, we can learn a lot from the Danes in emergency care, also in terms of digitalisation. But in Denmark, planning is very strict and then also carried out, which - as mentioned before - does not quite work here. We see a rather comparable situation to ours in France, on the other hand. There, there is something like a double specialist track, a similar hospital structure with university hospitals and also the social security system is comparable. France has also achieved a lot in the hospital sector in recent years and is currently developing regional health centres, for example, on the basis of laws that have already been passed. This is certainly something we can and should orient ourselves on. This, too, will be a long process and here, too, no one will come to cut Gordian knots with one mighty stroke. Politics, and thus also policy advice, is always an evolutionary business in which all those involved have to patiently and often repeatedly impart knowledge anew. This is democracy in action and our preferred method of slow but steady progress in an often very immobile system. In Great Britain and the USA it is quite different: there, an innovation is constantly introduced and often abolished again after a short time. This kind of action would perhaps do us good, because experience is gained relatively quickly, but the whole system also becomes much more flexible.

How can we bring more quality into the system?

We need more process and structural quality, but above all more sanctions. At the moment, we have a very detailed quality assurance system in the inpatient sector with mainly self-reported quality indicators. But we have almost no possibilities for sanctions if a hospital deviates from the average for a longer period of time. In the outpatient sector it is different, because in every region (partial) withdrawals of approval for doctors are possible. In the inpatient sector there is no such thing.

Except for public reporting.

We have just published a paper on this, which clearly shows that public reporting leads above all to the worst improving slightly, but the best unfortunately worsening.

Why?

Quite trivially, because there is no incentive to continue improving.

Inthe final analysis, this is a marginal cost issue.

Economically, this can certainly be explained. But the shaming-blaming effect, which has already been shown in various other constellations, also plays a role here. No provider wants to see it written in the newspaperagain and again :My hospital is one of the worst again. But what is the point of being among the very best? The public does not notice whether a hospital is among the five or ten percent of the best. Therefore, there is no incentive to improve further. If you wanted that, you would need incentives that go beyond that.

Which in turn would have to be created by politics.

Exactly. For this reason alone, I think the discussion about forming and grouping service groups is good. However, one could also take the already existing structural features, expand them and group them more strongly. Building on existing structures always makes implementation easier. But in Germany everything is a red rag, as it were, when it comes to quality and sanctions.

As we have seen in the discussion about pay-for-performance.

Unfortunately. But also because in this country P4P was usually only discussed in connection with the link between remuneration and outcomes. P4P in an international context can also function in connection with certain structural or process parameters, which is much easier to convert into remuneration than outcome parameters. However, P4P can also make sense beyond hospitals, because we need stronger coordination, especially in the care of the chronically ill. Because this is usually lacking, this large population is cared for worse in Germany than in many other countries with often much lower overall budgets.

What should be done?

Better coordination must be incentivised. But not only on the part of the hospital sector, but also on the part of the health insurance funds. A commission of the Heinrich Böll Foundation, for

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example, suggested public reporting for health insurance companies more than ten years ago. Of course, this requires the definition of suitable indicators at the health insurance fund level, such as: How well did the health insurers manage the insured through the health system? How often were duplicate examinations reimbursed? How often did insured persons get an appointment with a specialist in a timely manner? What is the rehospitalisation rate? With all these questions, every health insurance company could do its part. And if they fulfil this task well, it must also be worthwhile for them. For this, however, the health insurance funds need not only more leeway than before to set up and communicate such systems, but also greater legal certainty for data analysis.

What the legislator could integrate in a Morbi RSA 2.0.

You are absolutely right. That would basically be a further development of the purely morbidity-oriented RSA into a morbidity-oriented and quality-oriented RSA.

Then selective contracts would be worthwhile again.

That would be desirable. The only thing that must be avoided is that, as with the DMPs, there is a renewed competition for enrolment. This has cost the system a lot of money, but on the other hand it has also ensured that a lot of people are treated in the DMPs. Which, after all, is a good thing. <<

Professor Schreyögg, thank you for the interview.

The interview was conducted by MVF-Editor-in-Chief Peter Stegmaier

Less staff shortage due to hospital reform

>> The planned shift of hospital treatment to the outpatient sector in the course of the upcoming hospital reform and the quality-oriented concentration of hospital services at fewer locations can also make important contributions to solving the staffing problems in German hospitals. This is shown by the current hospital report of the Scientific Institute of the AOK (WIdO) on the subject of ‚personnel'. On the occasion of the publication of the report, the AOK Federal Association demands that the Federal Government and the Länder do not lose sight of the central goal of a better quality of care for patients in the reform discussions. Prof. Jürgen Wasem, Chair of Medical Management at the University of Duisburg-Essen and co-editor of the Hospital Report, emphasised that there is great potential for avoidable hospital days in the so-called ‚short-stay patients', who are treated as inpatients for less than four days. ‚The 30 most common surgical procedures with a low degree of medical severity alone account for about four percent of all nursing days in hospitals,' Wasem said. If one considers the entire potential of ‚outpatientisable' operations and treatments, many more hospital days could be avoided. The planned reform of emergency care also opens up opportunities to reduce staffing. In Germany, for example, about 50% of emergency cases are admitted as in-patients, while in the Netherlands it is only 32% and in France 22%. ‚Overall, the hospital reform currently under discussion offers a whole range of starting points for the urgently needed relief of staff in hospitals and for a better allocation of the available workforce,' Wasem said.

At the presentation of the report, Dr. Carola Reimann, chair of the AOK Federal Association, pointed out that improving the quality of treatment remains the central goal of hospital reform and must not be allowed to fall by the wayside in the current negotiations between the federal and state governments: ‚In view of the still widespread provision of occasional care, something urgently needs to change here.' This goal must not be thwarted by soft regulations or opening clauses at the expense of patient safety. <<

Vision Zero Congress on 19 and 20 June

>> ‚Wasted years of life, forfeited quality of life and unnecessary deaths must no longer be accepted or virtually accepted as God-given or ascribable to fate.' This is what Prof. Dr. med. Christof von Kalle, Director of the Clinical Study Center of Charité and BIH and member of the Expert Council on Health, demanded in the cover interview of ‚Monitor Versorgungsforschung' (02/23). Von Kalle, also chairman of the scientific advisory board of Vision Zero e. V., is following up this demand with action and wants to create the basis for a new, better future of health care with a large Vision Zero congress (19/20 June in Berlin and via stream). Von Kalle: ‚Come to our Vision Zero Congress in Berlin, let's discuss together how we can take a big step forward through modern, risk-adapted prevention and screening measures, through even more precise diagnostics and innovative therapy concepts, but above all through the intelligent digitalisation of all patient-related data.' Participation is free of charge thanks to sponsors. <<

Link: http://www.vision-zero-summit.de