Spreestadt Forum of the TU Berlin

Hecken: 'There will be no more changes'

The Spreestadt-Forum is an interdisciplinary lecture series with changing topics. Organised and scientifically managed by TU professors Busse and Kersting, the format takes place every semester; this time the guest was Prof. Josef Hecken, impartial chairman of the Federal Joint Committee, who spoke on 'The necessity of structural reforms in the healthcare system' and had more than clear words on the current hospital reform. His wish: 'I would prefer no law to any law at the moment'. Busse's response: 'Me too, to be honest.'

>> What can the G-BA do? In response to this initial question from Prof Dr Reinhard Busse, Professor of Management in Healthcare at TU Berlin, Hecken replied: 'Less and less, because the current Federal Minister is travelling with a few others. We will soon be able to see the results.' He was referring explicitly to the hospital reform, on which a hearing had just taken place. This was 'only a rudiment of what you were initially involved in', he addressed Busse directly in his role as a member of the government commission for modern and needs-based hospital care. At the hearing, 1.5 to 2 hours had originally been set aside for 127 statements, which is why he had decided not to attend, even though the G-BA had published a written statement in advance (1). Hecken: 'There's no need to sacrifice precious time to try and feed anything into the process.'



Prof Josef Hecken, re-elected impartial chairman of the G-BA for a further six years, at the Spreestadt Forum in front of around 50 attendees at the KBV and over 100 online participants.

Major financial challenges

The starting point for the need for structural reforms in the healthcare system is relatively simple. Germany spends an above-average amount on healthcare, which results in a 'relatively moderate outcome quality', measured in terms of survival rates for various diseases and the overall age of the population.

This is in line with megatrends such as demographic developments and huge advances in medical technology. The area of pharmaceutical expenditure is already the second largest block of SHI expenditure. 'This opens up opportunities for patients,' explained Hecken, who also pointed out the other side of the coin: 'On the other hand, we are facing financial challenges for which we need compensation at some point if we don't want to discuss QALY* or other things.' He presented two figures to illustrate the scale of the development rolling towards our society: Firstly, according to him, 0.07% of prescriptions for orphan drugs generate 12.7% of total pharmaceutical expenditure. Secondly, 1.2% of prescriptions were for oncological drugs, which in turn account for 24% of total pharmaceutical expenditure. Hecken: 'This means that 1.27% of all medical drug prescriptions account for over a third of total drug expenditure.' The wave only really starts to pick up speed when he takes a look at research and development, which includes active ingredients with expected annual therapy costs of 800 to 900,000 euros, with which hundreds of thousands of patients can be treated.

Massive reasons in favour of reform

This development is in line with demographics, as 13% of our gross domestic product (as of 2022) is already being spent on healthcare. This may sound relatively harmless, but when you consider that the SHI contribution rate is currently 13.8% and the federal subsidy of 14.5 billion euros is almost certainly capped if you take into account the 'black zero policy' of Federal Finance Minister Lindner. It is also important to realise that the aforementioned 13% of GDP spent on healthcare amounts to 498 billion euros per year, of which statutory health insurance - the area for which he is jointly responsible and for which he has been elected as impartial chairman of the G-BA for a further six years - accounts for 53%. By way of comparison, said Hecken: The 498 billion euros are 20 billion euros higher than the total volume of the federal budget in 2022, so it should be clear to everyone, he interjected, that it is necessary to manage the available funds reasonably adequately, even pro futura, because this expenditure cannot be increased at will.

The statutory health insurance scheme is currently expecting to spend 314 billion euros this year, of which hospital care accounts for the largest block at 33%, followed by pharmaceuticals at 18% (53.2 billion euros).

His warning: 'The peak is still a long way off if we simply take a look at what demographics look like.' He doesn't think much of any forecasts for the year 2324, but he does think a lot of looking at the people living in Germany today. If people continue to live according to the mortality table and the status quo is maintained, there will be 5.2 million more people living in Germany in just under 15 years' time than there are today. Apart from the resulting increase in potentially multi-morbid people, the following question must be asked and answered: 'Who finances the healthcare system?' His answer: the working population, which generates positive contribution margins. The revenue deficit is exacerbated by the fact that there will soon be 6 million pensioners instead of the current 5.2 million - with treatable multiple illnesses and thus cost increases - while at the same time lowering the pension level".

Currently, this amounts to just under 56% on average and in relation to earned income, but will be 48% in around ten years' time. In addition, there will be more and more people in employment who no longer have a complete employment history when they retire - due to unemployment, the 'internship generation', the minimum wage or because Generation Z prefers to work fewer hours and

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therefore earn less due to their work-life balance. Hecken: '48% of little is nothing.' If you add 16.8% health insurance contribution to this, then 'collecting contributions is no longer profitable'.

His second question: 'Who will organise healthcare in an age in which more and more people are clamouring for a work-life balance?'

According to him, both facts mean nothing other than that 'we will have a foreseeable funding problem' on the one hand and a staffing problem on the other. The whole thing is then garnished by medical-technical progress. This, it must be clearly stated, is a blessing for the patients concerned. However, in view of the resulting cost situation, he was somewhat astonished by the hospital reform currently being initiated by the BMG.

He gave the example of healthcare kiosks, which until recently had been a major priority for the BMG, but have since been removed from the draft bill. According to Hecken, staff can work in these kiosks, which are then no longer available in doctors' surgeries and hospitals, and where money is then spent that may no longer be available for other interventions. For him, 'general life counselling without a clear range of tasks' does not constitute a SGB V service, as the actual purpose of the kiosks is to introduce groups that are far removed from health to the system. If around 3 billion euros are allocated for this, which is roughly what 1,000 kiosks - which have already been cancelled - would have cost, the question of cost distribution also arises: 'Why should the SHI fund 80% and the local authorities 20%?' In his opinion, it should be the other way round, as the local authorities are responsible as part of their general services of general interest. He did not want to say anything against prevention, but it would take a long time for prevention to pay off.

Hecken illustrated the personnel problem using a chart that shows the dramatic nature of the work-life balance. For example, around 3.5% more people are currently working in the field of statutory health care - based on 2014 - but the number of hours available has fallen by 1.5%. Hecken: 'This means that we are generating fewer services with more heads.' This means that we need to think carefully about how the scarce resource of staff should be deployed in line with the tasks.

His key question: 'What can we do? His answer: 'We can talk openly about QULY, because we already have hidden rationing today.' He personally considers both to be unethical and incompatible with the principles of the welfare state, but the consequences must now be drawn. For example, in the hospital sector. Here, citizens would protectively throw themselves in front of every district hospital with 63 beds, regardless of whether the hospital offers high-quality care or not.

Hecken said that it was worth taking a look at the discussion on minimum volumes as part of the hospital reform and the level 1i clinics brought into play by the government commission, in which the outpatient-inpatient demand situation is considered together.

He pointed out that small hospitals in particular would have an economically unfavourable structure, as relatively high basic care would have to be financed for too few cases. In addition, it is difficult to generate the necessary staff because it is now no secret that a doctor who is somehow interested in advancing their career is relatively reluctant to work in a hospital where the maximum range of services is the appendix, the gall bladder and a major colon operation once a quarter; almost everything else is now performed laparoscopically.

And then, according to Hecken, there is also the G-BA with its minimum volumes, so that the last possibility of self-realisation is taken away, which - he said explicitly - is carried out at the expense of the patients. The G-BA will therefore continue to do this 'as long as the Federal Minister does not prohibit us from doing so'. So far, nothing has been included in the 'Hospital Structure Reform Assistance Act'. The next minimum volume agitator will be colorectal surgery, where 'considerable differences in quality' have become apparent. Here, minimum volumes will be decided this year, regardless of the hospital structural reform, which 'will certainly not result in the streamlining of structures'; at least not 'in the next six years for which I have been elected'.

For him, the main problem is the structural requirements that were perhaps initially formulated 'a little too sharply' by the government commission. These have now been watered down to such an extent that we now only have a few 'lax structural requirements' from which the federal states can 'deviate at their own discretion in individual cases'. Hecken: 'We will soon see this everywhere in the Federal Republic of Germany. It's nice that we've been talking about this for three years. It's nice that we might still be pouring 50 billion into it and in the end we won't have what we need, namely quality-assured bundling of services.'

The current concept also states that the mere existence of structural requirements is sufficient to prove quality. This effectively means the end of quality assurance because, according to the current draft bill, there can no longer be any new structural requirements from the G-BA; and the previous ones only apply until they have been overwritten by a new committee. And the Medical Service will 'also only come at some point and only as a last resort' because it is assumed that the 'structural requirements have been ticked off'. Hecken: 'Hospital planning sovereignty apparently means that everyone can do what they want.' In this way, the quality indicators degenerate into a legal regulation requiring approval. Hecken's prophecy: 'Nothing will happen. There will be no more changes that reflect medical-technical progress, and there will be no more new structural guidelines.' <<

von: MVF-Chefredakteur Peter Stegmaier

* englisch quality-adjusted life year

1: https://t1p.de/xhbda