Healthcare system: ways out of the impasse

Can they or won't they?

Almost all experts agree that the German healthcare system has reached its limits and needs to be comprehensively overhauled. Although insured persons and taxpayers spend a great deal of money on healthcare, they do not always receive top-quality services in return. This is despite the fact that highly competent service providers are active in the healthcare system and efficient facilities and structures are available in many areas. On the other hand, there are brakes on performance that create dysfunctionalities in various areas, sometimes with serious consequences: insufficient ability to compromise between federal and state policy, dysfunctional sectoralisation, discrepancies between supply and demand, competition between quality and economy and, on top of all this, the inadequate participation of patients/insured persons - after all, they finance the healthcare system! This article goes beyond the description of the current situation and attempts to analyse why Germany has not succeeded in translating the very good substantive and structural conditions into a modern, efficient and adaptive healthcare system.

>> It was emphasised time and again that the problem is not one of knowledge, but of implementation . Ideally, one would expect a modern system to automatically identify and recognise deviations from targets. This is followed by an analysis by those responsible, who initiate appropriate corrections. This is what we know from well-managed companies. The implementation of such a system can only succeed from the top down: It starts with the clear political setting of goals and values and the creation of favourable framework conditions.

Although health policy-makers and functionaries fundamentally agree that the healthcare system must be centred on the patient, this is not possible because the various decision-makers in health policy and self-administration first emphasise their criticism and own demands like a mantra when the other side makes corresponding proposals. This can be seen impressively in the current discussions on hospital reform and the introduction of the long overdue digitalisation of the healthcare system. Many necessities are clear, obvious and widely accepted.

However, a cross-structural and comprehensive solution is not being achieved. The small-scale solutions in the respective areas of responsibility are often inadequate and hardly transportable. The joint success would be significantly greater with more comprehensive measures, the effort would be reduced and the benefits would be felt by everyone - especially patients.

An observation in passing: in almost all commentaries, position papers and discussion papers, only one's own point of view and demands are emphasised; patients and citizens hardly feature in the discussions. The discussions also go over the heads of patients/insured persons and often remain misunderstood because they are unable to evaluate the arguments of functionaries and self-governing bodies for themselves due to the complexity of the healthcare system (lack of health literacy). In addition, citizens and patients are not yet effectively organised and have no lobby. The German Patient Protection Foundation cannot achieve this either, as it was founded to protect patients and not as a platform for the reorganisation of the healthcare system.

Responsibility and action

Valuable time and a great deal of money is lost in numerous negotiations: it is depressing to realise how many competent politicians and functionaries meet time and again without coming to forward-looking decisions. They actually have a shared responsibility for this::

> 'One is responsible not only for what one does, but also for what one does not do.'
> ***(Lao-Tse)***

Why do those responsible find it so difficult?

Politicians, members of self-government and decision-makers in healthcare institutions are not malicious people. Nevertheless, they fail to find clever solutions even for obvious problems. In this sense, they all bear responsibility for what they fail to achieve. When it comes to clarifying cause and effect, everyone points at each other with conviction and blames them for the expected catastrophe: instead of changing their perspective and asking themselves what the path to a solution might look like. At a meta-level, it is relatively easy to recognise that it is not the fundamental will that is failing, but the overlapping of substantive problems with secondary interests that have little to do with the problem to be solved.

So everyone has responsibility in their own area and rightly insists that no one interferes with them:

> Those who bear responsibility must also be able to make decisions!

This could be the first principle of management. The various areas in the healthcare system are highly interconnected, and the complexity has been emphasised several times. So who should cut the Gordian knot if too many are working against each other tosecure their own interests andnot together to strengthen the common good?

Thinking in terms of structures and resources regularly leads to discussions about organisational sovereignty and the distribution of resources, ultimately about power and not about measures.

This could easily be overcome by changing our perspective: After all, the purpo-

se of the healthcare system as a whole is to provide healthcare to the population at a high level of quality at a reasonable cost [1]. To this end, an appropriate and efficient quality of care should be achieved with efficient allocation of resources in accordance with the care objectives. The German Ethics Council has stated this several times in a commonplace manner.

> The healthcare system must be thought of from the patient's perspective!

Blockades inherent in the system

The resources currently totalling almost 500 billion euros [2] would be sufficient to operate a healthcare system at the highest level of quality. Expert reports and commentaries from recent years make it appear very likely that this has not yet been achieved. However, this is not due to a lack of competence on the part of decision-makers in politics and self-administration, but rather to dysfunctionalities inherent in the system that have developed in the interplay of free forces. This is because the development of the healthcare system was not goal-orientated - health and care goals have still not been formulated [3]. Over the last few decades, economic necessities (e.g. rising costs) have often taken centre stage alongside structural problems (e.g. shortage of nursing staff) or expansion of services (e.g. due to disincentives), to name just a few drivers.

Such dysfunctionalities regularly lead to blockades of future-orientated developments. Although acute problems are repeatedly resolved, at least for a limited period of time, longer-term corrections have not been made to a sufficient extent despite numerous indications from recognised experts to a sufficient extent. Current developments show that there are some changes that can be made in the healthcare system to reduce serious consequences. The parties involved are therefore not remaining rigid, which would also cause them considerable harm. They often reach compromises that only cure symptoms and only temporarily lead out of unbearable situations.

According to their own analyses, these compromises are usually formulaic compromises that balance the interests of those involved in the sense of give and take. The focus is on the question: What does this bring me and what does it cost me? Formula compromises are not enough, however, if the aim is not only to find a balance between the parties involved in the blockades, but also to find future-proof solutions to factual problems. Rather, co-operative compromises would be necessary at this point, in the sense that those involved should ask themselves:

What can I contribute to achieving the health and care objectives?

Kompromissart	Zweck
Formel-kompromiss	Ausgleich zwischen Geben und Nehmen (Selbsterhaltung)
Kooperativer Kompromiss	Bedingungen schaffen, damit die Gesundheits- und Versorgungsziele erreicht werden können.

So far, health policy and self-administration have tended to focus on their own goals. The citizens' forums of the Neustart! [4] project have clearly shown that both groups can hardly fulfil citizens' ideas and expectations with this orientation.

The discrepancy between the purpose of the healthcare system and particular objectives results in significant system-immanent blockages:

Ebene	Systemziele	Partikularziele
Gesundheits-politik	Umfassende Neuausrichtung	Wiederwahl
Selbstverwal-tung	Patienten- und bedarfsorien-tierte Gesundheitsversorgung	Partikularziele der SV-Organe
Versorgungs-einrichtungen	Versorgungsqualität und Wirt-schaftlichkeit	Ökonomie

Blockades arise from an apparent incompatibility - at least at first glance - between system objectives and particularobjectives.

However, the resulting formulaic compromises do not really solve problems in the long term. Patient-orientation usually falls by the wayside.

1 Healthcare system: The purpose of the healthcare system is to ensure that patients receive appropriate healthcare. Sections 12 and 70 SGB V describe this in outline. In the past, the healthcare system has developed in the free play of various forces. As health and care targets have never been formulated, there is no reliable basis for assessing whether the purpose of the law is being fulfilled. Health targets on a voluntary basis do not have the desired effect [5]. More systematic approaches have been used in Austria for several years [6].

The fact that health policy and self-administration are orientated towards their own goals rather than the demands of patients and service providers is the subject of numerous publications, such as the summary of the Robert Bosch Foundation's Neustart! project [7].

2 Health policy: Health policy has a duty to further develop healthcare provision in line with changing requirements. As the healthcare system is a complex system, the effects of legislative influences cannot be predicted with sufficient accuracy. In addition, the formulation and implementation of laws require a period of time that often extends beyond the boundaries of legislative periods. As a rule, the administration first has to establish itself at the beginning of a legislative period. In the last third of a legislature, there is no longer enough time to get laws through the entire process so that they can still be discussed and passed by the legislature before the end of the legislative period. he result is a dysfunctional discrepancy between the concept of time from the planning to the passing of a law and the duration of legislative periods for more comprehensive interventions. This leads to oppressive delays in solving urgent problems such as the reform of long-term care insurance [8].

There are two major competing issues in healthcare policy: the solution of substantive problems and the promotion of re-election in the following federal election and the interim state elections.

3 Self-governance: The self-governing bodies are represented in the Federal Joint Committee: GKV, DKG and KBV as well as KZBV. They share the votes with three independent representatives. Some have criticised the lack of patient representation and participation in this body. These bodies represent their respective members and are bound by statutes to represent their interests [9].

They have a high level of expertise

within their field. Without common goals, they concentrate on their own objectives. Patient-orientation and the common good are therefore given lower priority, despite bold statements to the contrary. This can be seen from the lack of meaningful indicators for these parameters alone.

As a logical consequence, the Federal Joint Committee must fail in its task of devising and establishing high-quality, efficient and future-orientated healthcare for citizens and patients. Only the legislator could decide on this anyway.

4 Healthcare facilities: Healthcare facilities are professional institutions characterised by the fact that decisions on the content and quantity of care and decisions on finances and organisation are in separate hands. To put it simply, content and quantity determine income, while organisational structure and processes primarily determine costs. Quality of care and efficiency are closely linked in functional terms. Neither side has the authority to issue directives to the other.

As a consequence, on the one hand this led to the organisational side wanting to create material incentives for additional income. Most recently, the 128th German Medical Assembly in 2024 spoke out firmly against 'bonuses with targets that have a financial impact' [10]. On the other hand, some providers cut costs, particularly in the area of nursing care, which led to significant losses in quality. The legislator attempted to take countermeasures [11].

In 2022, the 126th German Medical Assembly adopted a catalogue of measures to counter the pressure for commercialisation in outpatient and inpatient care [12]. Karl Lauterbach stated in an interview that patients should be treated according o symptoms and findings when admitted to hospital and not be assessed according to a DRG catalogue [13]. This is certainly one-sided and must be considered separately for hospitals run by different organisations. However, the statement describes possible false incentives, as already described by the Council of Experts [14].

Of willingness and ability

For years, relevant bodies have been formulating proposals for reorganising the healthcare system in the face of obvious and increasingly urgent problems: German Council of Experts on Health and Care [15], Leopoldina [16], German Ethics Council [17], German Network for Health Services Research [18], Netzwerk Neustart! [4], Bertelsmann Foundation Health 2023 Programme [19] - to name just a few. In expert reports, annual reports, memoranda, statements and position papers, they describe fundamental problems in the healthcare system and make numerous practical suggestions for improvements. So far, they have only been realised in part.

How can it be that such obvious problems, some of which have expensive and serious consequences, are not adequately addressed? Justifications for this more than unsatisfactory situation from key institutions in politics and self-administration are largely missing. For patients and the insured, the question arises: Do those responsible/ the decision-makers not want to or are they unable to? On the subject of financing, Josef Hecken summarises strikingly: 'Planning how we want to commit suicide together' [20].

In view of the overwhelming facts, this is obviously a problem of implementation. At the level of the responsible decision-makers, it can be assumed that rational reasons generally determine their actions. If obvious requirements are not implemented properly, two alternatives can generally be assumed at this level:

> You don't want to do it or you can't do it.

The decision-makers involved either don't want to (case A below) or they can't (case B below) - see Figure 1.

Case A: They don't want to.

'They don't want to' means that a measure is deliberately omitted despite knowing better.

It is important for us to emphasise this: None of the groups involved are assumed to have the intention of deliberately harming the common good. Collateral damage is, however, accepted with approval, as avoiding individual disadvantages or ensuring personal benefit is given priority over optimising the common good.

> However, patient welfare is and remains the goal of the healthcare system.

The decision-makers behave logically according to the settings in which they have to fulfil their tasks. Each of the decision-makers represents their own interests and the interests of the group they represent. They are obliged to do so by contract, statute or group consensus.

This is one of the decisive dysfunctionalities in the system! The acting persons behave logically according to the conditions and demands of their social or entrepreneurial micro-environment. If they wanted to simultaneously optimise the common good of the macro-environment under the prevailing conditions, the necessary compromises would almost inevitably lead to contradictions with their mandate. This applies to political parties at federal and state level as well as to the self-governing bodies in the Federal Joint Committee.

If a compromise solution is found at the end of negotiations, it is often a formulaic compromise that balances out concessions on logically unrelated issues. Each negotiating partner has then represented the interests of their own group - but the benefit for the common good usually remains suboptimal.

Those who want something find ways. Those who do not want something find reasons.'

This sentence can be placed at the end of these considerations:

> 'Those who want something find ways. Those who do not want something find reasons.'
> (Lao-Tse)

This can be described by health and care goals , the formulation and binding definition of which is repeatedly called for. Such goals are supplemented by shared values and constructive framework conditions. The competences required for planning, simulation and implementation are derived from this. A lack of methodological expertise is therefore not a problem at decision-maker level; it can simply be compensated for by external resources (technical and professional expertise).

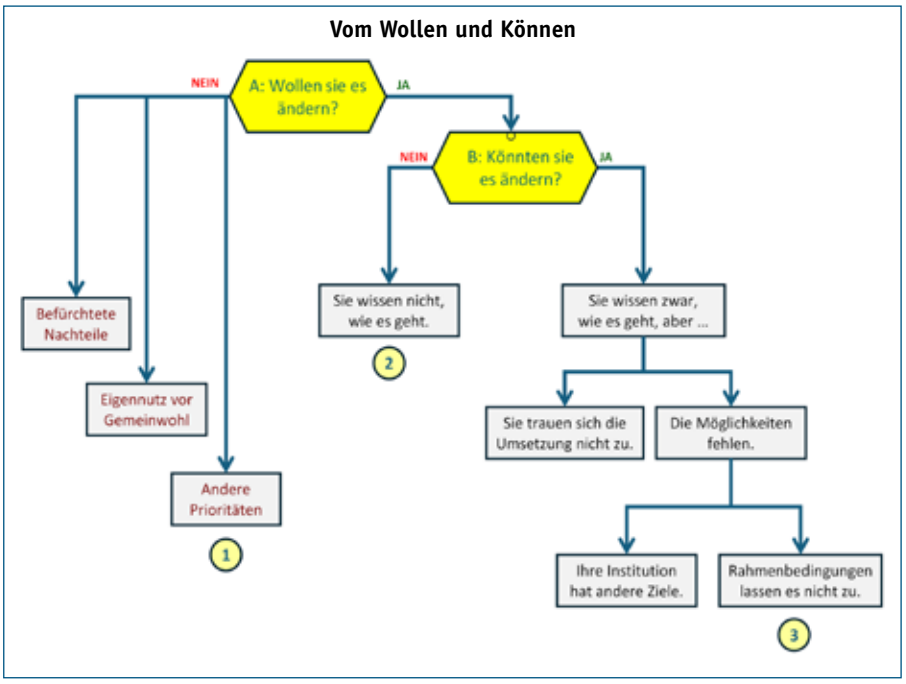


Fig. 1: *Something should be changed because it is necessary and makes sense: When solving problems, the people involved first decide whether they want to solve the problem and then whether they are able to do so. In doing so, it may be necessary to clarify external influences such as: 1: prioritisation in the statutes, 2: use of methodological expertise, 3: changes to the legal framework, for example.*

Case B: You can't.

There are two possibilities here: Either there is a lack of expertise or there is a lack of opportunities (Fig. 1).

Lack of expertise:

The healthcare system is a highly complex system and the required transformation is at least as complex. Nobody would expect such methodological competences to be available among politicians or at functionary level. This is not a problem, because the central task of politics and self-administration is to determine, together with the citizens, what the healthcare system should achieve .

Lack of opportunities:

Do politicians and functionaries in self-administration have the opportunities to reform the healthcare system from the ground up?

Perhaps a look behind the scenes will help here: Article 21, paragraph 1 of the Basic Law states that parties shall participate in the political decision-making of the people. In order to be able to act effectively on the basis of this will-forming process, they need majorities to shape it. They must therefore convince voters that they best represent their interests and convictions. The parties responsible for government use their majorities to determine which laws are passed and implemented. However, a demand that affects the entire population to the same extent as a functioning healthcare system should not be based solely on temporary majorities,but on a cross-party consensus. Is this idea realistic? No: in the current understanding of politicians and functionaries, probably not.

Comparable mechanisms are at work in the self-governing bodies . All self-governing bodies - GKV, DKG, KBV and KZBV - have enshrined in their respective statutes that their representatives (must!) represent the interests of their members in the organisation process. As their leading elected representatives are also elected, they are faced with the same question as in the party landscape: How can they show that they have best represented the interests of their respective members? And they have to do so in the struggle with the other bodies and in the struggle between the different interest groups within their members.

Assuming that a cross-group constructive and co-operative design process would lead to a convincing result. Then, as just described, the respective groups would have to convince the voters in their public communication that they were each decisive for the successes. The communication channels of the groups involved vary in their effectiveness. Smaller parties often fear that their contribution to the compromise will not only not be recognised, but could even be interpreted as a failure by their respective clientele. As a result, it is observed with shocking regularity that every proposal from one party is reflexively devalued by the others as insufficient, inadequate or even dangerous. Even if it contains approaches that could be further optimised in a cooperative process - as in the current draft of the Healthcare Improvement Act (GVVG).

But this is not happening: fundamental criticism attracts far more media attention than a co-operative compromise geared towards the common good . The question always arises: Who is credited with the good result?

Each group will always publicly claim that they have the common good of the citizens in mind. However, the results for the healthcare system as a whole show a different picture: various parties even fear that the healthcare system is being driven to the wall with its eyes wide open.

Of willingness and ability

Ways out of the impasse

The basic prerequisite for all conceivable ways out of the impasse is the political will to shape the system . After the political decision to make the healthcare system fit for the future, there is a need to understand and accept that the healthcare system is complex. According to Marco Wehr, there is then an opportunity to recognise and escape first-order (impact) and second-order (decision) complexity traps [21]. According to Wehr, it is also important to distinguish between natural and manufactured complexity in order to find a way out of the impasse. The former must be dealt with (e.g. the complexity of the content of healthcare provision), while the latter can and should be reduced (e.g. dysfunctional blockages, fragmentation of the healthcare system).

A group from the Neustart! [22] with forward-looking theses for new formulations within the framework of social legislation.

In the current setting of health policy and self-administration, when evaluating alternative solutions, the groups involved reflexively check to what extent their own benefit is increased and their burden reduced. It is easy to lose sight of the solution to the problems at hand and, in particular, patient-centredness.

A paradigm shift is needed: decision-makers should ask themselves what their respective group can contribute to increasing the common good.

Such an attitude does not arise by itself, but must be specifically and consistently incentivised. Specific indicators can evaluate this and form the basis for corresponding incentive systems.

There is widespread agreement that value-based health care would be a suitable model for reorientation [23]. The starting point for such a development is the formulation of binding health and care goals. Only with clear goals can the right strategies be strategies, plan measures and establish processes:

'If you don't know about the goal, you can't have the path. '
Christian Morgenstern

The following example makes this clear, as seafarers have long known that if you want to reach a destination on the high seas, you first need to know where you are. Together with the destination coordinates, the direction to the destination can then be determined. You can check the sea and weather charts: Are there favourable winds, is there a threat of storms, can currents help, are there shoals or cliffs. Finally, you ask what the ship and crew can do. Who is best at what? What instruments are available?

Conclusion

Over the last few decades, the healthcare system has developed in the free play of forces due to a lack of binding health and care goals and accompanying values. In the process, dysfunctional blockages of a fundamental nature and system-immanent blockages have emerged at the three levels of health policy (macro), self-administration (meso) and healthcare facilities (micro).

In the face of rapidly growing new challenges, further developments often result in formula compromises. Formulaic compromises serve more to equalise the benefits between the groups involved than to tackle the problems at hand. What is needed, however, are co-operative compromises for the concrete solution of upcoming problems.

To make matters worse, there are currently no binding health and care targets against which the quality of the compromises could be assessed with a view to increasing the common good.

With the political will to organise, the blockades could be overcome with the following measures:

- Developing and adopting binding health and care targets [2] with the participation of citizens and patients .
- Concentration of political organisation on

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the specification of goals, values and resources .
- Freeing the self-governing bodies from the dilemma of having to help shape the healthcare system while at the same time representing the interests of their members .
- Specification of clear institution-specific requirements for participation in regional care models. A balance is struck between quality of care, patient-orientation and economic success in accordance with Section 70 SGB V 'Quality, Humanity and Efficiency'.
- Target-orientated and resource-conserving use of modern information technology as the basis for documentation and communication .

Finally, it should be emphasised once again that the persons involved are not personally to blame. They cannot rationally behave differently in the dysfunctional blockades. They can only be freed from this dilemma if incentives are set for the promotion of patient benefit and the common good and not for the maximisation of group-specific advantages. <<

von: Dr. Dr. Klaus Piwernetz[1]
und
Prof. Dr. Edmund Neugebauer[2]

1: medimaxx health management GmbH, München (ORCID: 0009-0003-9448-4471)
2: Medizinische Hochschule Brandenburg, Neuruppin (ORCID: 0000-0002-6192-8692)

Zitationshinweis

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