Federal General Assembly 2024 of the Virchowbund

# Hedges: 'Laws will get bogged down in quicksand'

Although the 'alliance of the willing' that Daniela Teichert, CEO of AOK Nordost, has often called for is rarely formed, there is little chance that Robert Habeck's 'alliance of the sensible' will carry the outstanding legislative proposals of the collapsed traffic light coalition, especially those in the healthcare sector, over the 'ramp'. The latter was one of the statements made by Tino Sorge, health policy spokesperson for the CDU-CSU parliamentary group and CDU MP, during a panel discussion at the Federal General Assembly of the Virchowbund. He strictly denied that - quote - 'the CDU/CSU would have to take one or two of the project proposals of the Trümmer-Ampel' over the ramp out of national political responsibility. Sorge: 'I can say quite clearly that we will not do that.'

>> If Sorge's negative stance proves to be true, the health reforms and laws that have not yet been passed could well 'bog down in quicksand', as Prof Josef Hecken, impartial chairman of the Federal Joint Committee (G-BA), put it in his hour-long keynote speech. This would then affect the ongoing procedures for the Healthcare Reinforcement Act (GVSG), the Health Digital Agency Act (GDAG), the Nursing Competence Act (PKG), the reform of emergency care (Emergency Act), an announced Bureaucracy Relief Act and a Pharmacy Reform Act (ApoRG) as well as the Healthy Heart Act (GHG).

Hecken was particularly critical of the latter, but also of the hospital reform and its creator. For him - as Hecken certainly also said with regard to the host - the private practice sector with its GPs and specialists is the 'backbone of all sensible medical care'. However, in recent years he had gained the impression that politicians had 'become a little more concerned with hospitals' and that the 'political aim' was obviously to provide as many services as possible in inpatient or semi-inpatient facilities. The level 1 hospitals in question could actually be considered quite good if an unfair competitive situation had not been created by perpetuating authorisation requirements. When he looks at the laws of the last three years, he recognises 'a planned approach' in which, at best, there is still room for GPs, but where the aim is to 'shift specialised specialist care to hospitals at the end of the day'. Hecken: 'That's why I have perceived the past few years as years in which there has been widespread discrimination against doctors in private practice.'

Hecken said 'full of fervour' that the impression had been systematically created over the last three years that patients in the Federal Republic of Germany had been 'systematically treated badly and maliciously and only for the benefit of the service providers' over the last 50 to 60 years. Anyone who created this impression was insulting the hundreds of thousands of people who were trying to achieve the best for patients 365 days a year, 24/7, in private practice, in inpatient care and in care facilities. Hecken, who was awarded the Kaspar Roos Medal at the Federal General Assembly of the Virchowbund, which is intended to honour his commitment to defending the medical profession against attacks from politics and self-government. 'That's why I say,' he said to applause from the delegates present: 'We need a return to the large, broad-based private practice sector.' You only have to look at the figures to see who provides the majority of patients: even if you were to build 100 more hospitals instead of reducing the number of hospitals, you would not be able to care for the patients, which is why you simply need doctors in private practice. The Federal Minister must 'say this publicly at some point' instead of saying: 'I'm not talking to you'. This is mainly because doctors, like him, have been dismissed as lobbyists.

The laws that have been put on the table over the past three years, 'most of which are now very likely to be lost in quicksand', were created without any practical relevance. Their content was the result of the Federal Minister personally reading a study and elevating this study to the gold standard, as was the case with the 'Healthy Heart Act', he said, adding that the Health Minister, whom he had not even mentioned by name up to that point, had at best spoken to experts at university chairs who make calculations but are not the ones who shape care. But no one had spoken to 'us lobbyists', at best we had been 'invited to hear the announcement of certain decisions at the cat's table'. And if you then objected, you were told that what you're doing here is being triggered by vested interests. Hecken: 'In the end, this is the reason why many laws are well thought out, but in the end their implementation and content completely miss the mark in terms of healthcare practice.'



*Josef Hecken, impartial chairman of the Federal Joint Committee (G-BA)*

Returning to the initial question of his keynote speech entitled 'Are we treating the right people? Control of patients by the healthcare system', which he hadn't even touched on yet, he said 'emphatically no'. He said that there were simply too many patients being treated for illnesses that were not indicated, who were not patients, but citizens who subjectively felt unwell. He is explicitly not talking here about supply-induced volume expansion, which also exists, but about doctor-patient contacts that are not necessary, but which contribute to blocking appointments and treatment options for pati-

ents who actually need to be treated. A very large proportion of this service utilisation is carried out because people believe that their health insurance contribution entitles them to at least one monthly consultation with a doctor, preferably 'until I get the diagnosis that I previously found on Google, or until I get what I want'. Hecken: 'Health is worth nothing to people as long as it is not linked to financial benefits.'

Therefore, before talking about intelligent control methods in the system, responsible politicians should think about the good old practice fee in a modified form with regard to the question of financing. At the time, this was stillborn because it was too complicated and very administratively complex and therefore had a limited control effect. 'We will only get control of this system if we communicate to people that the solidarity-based community also pays for CAR-T cells and, if necessary, maximally invasive interventions, but demands a certain degree of personal responsibility,' explained the G-BA Chairman, who was recently confirmed in office for a further six years. This is also expressed in the fact that 'one must be involved in some way in every utilisation of services' - of course in a socially acceptable manner and with overcharge clauses. However, social compatibility should never mean that 'anyone's co-payment is reduced to zero'. He does not want to use any clichés here, but as a self-confessed chain smoker, he says that the 'excess to be borne by the individual should be at least the equivalent of a medium-sized packet of Marlboros' so that sensible decisions are also made. He is referring to what he wrote together with Jochen Pimpertz (Head of the State, Taxes and Social Security Cluster at the German Economic Institute) in a very recent publication by the Konrad Adenauer Foundation entitled 'Courage for new ideas - for the long-term reliability of our healthcare system' (1). Among other things, it states that 'further socially acceptable co-payments in the form of additional payments should not be a taboo subject in the long term' in order to raise awareness among the insured of the immense costs of good healthcare and to reduce 'the completely unnecessary utilisation of services that can be observed in some cases'. To achieve this, the principle of solidarity should not be undermined, but the insured persons should be required to make a cost-conscious decision about the desired form of care.

## 'Personal responsibility abolished'

While he was on the subject of smoking, he returned to his favourite topic of the 'Healthy Heart Act', which has now probably become obsolete with the end of the traffic light system. It might make sense for children as young as five years old to be screened for familial hypercholesterolaemia in the U9 examination, he said, and there might also be some justification for the use of the statin regimen planned by Mr Lauterbach - mentioned for the first time! - statin regimen planned by Mr Lauterbach, but he is not aware of this. However, this would lead to the abolition of primary health prevention and thus personal responsibility, because parents would be led to believe that the problem could be solved with 'a statin', whereas it would be enough for children to 'move their bums' and perhaps eat a little more healthily. Overall, he sees this proposed legislation as a 'declaration of bankruptcy for any sensible health policy'. In times of demographic change, in which there are too few staff and, on top of that, too little money to care for the sick, they would want to treat more or less healthy people and thus also send the signal that people no longer have any responsibility for themselves because the 'system will sort it out'. In addition, the Federal Minister argued that the whole thing would cost a maximum of 800 million euros. Hecken's question: 'Where am I supposed to get the 800 million from?' This is a 'completely wrong course', and the same applies to the opening of disease management programmes for healthy people. This is not feasible in terms of both personnel and financial capacities.

The Chairman of the G-BA also had little good to say about the reform of emergency care. Although it was right to reform the 'lousy' rescue service, especially across the borders of the federal states, the 600 to 800 planned new integrated emergency centres (INZ) were not feasible in terms of personnel requirements alone if not only a hospital doctor but also a doctor in private practice had to be present there around the clock all year round. Hecken: 'You must have taken some kind of drug to come up with such an idea.'

According to Hecken, the Federal Joint Committee adopted a guideline on a structured and validated initial assessment system at hospitals two years ago. This could be used in hospital to decide who needs treatment within six hours in hospital and who needs treatment within 12 or 24 hours and is sent to a registered doctor with a fixed appointment the next day. The BMG objected to this G-BA decision with reference to the major emergency reform. In response to a parliamentary question, State Secretary Franke said that everyone is entitled to emergency treatment in hospital, regardless of whether it is an objective emergency. He coined the famous 'subjective emergency concept', because: 'If I feel like an emergency, I am an emergency in the sense of an emergency and then I am treated in the most expensive form of care, even though I should actually have the shopping bag with the pants and towel knocked around my ears.'

However, as the Rescue Services Act would now fail, he believes it would be a very good initiative if the contested G-BA directive were to come into force for the transitional period. With a view to the parliamentarians present, he said that it would be sufficient for the German Bundestag to call on the BMG to do so. Hecken: 'Then we would at least have some patient control for the transitional period.'

And a little more would be added if the GP-centred care model, which has been tested and evaluated in Baden-Württemberg for years, were to become the norm. Analyses have shown that there have been significant decreases in uncontrolled visits to specialists, as well as decreases in drug prescriptions, hospital admissions and the number of hospital days. 'The bottom line is that the additional remuneration that we pay to the primary physicians here has more than paid for itself,' concludes Hecken. In addition, patients are highly satisfied, which is also due to the fact that Baden-Württemberg has not taken an ideological approach by only having one primary doctor system and every specialist intervention should be carried out in hospital. <<

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## 'Courage for new ideas - for the long-term reliability of our healthcare system'

Prof Josef Hecken (G-BA) and Jochen Pimpertz (Institut der deutschen Wirtschaft) call for 'Courage for new ideas' in their 30-page paper recently published by the Konrad Adenauer Foundation. In it, they venture the prognosis that market-based control elements can only have the desired effects if the realisation of efficient forms of care is equally worthwhile for the insured, health insurance funds and service providers. To achieve this, the principle of solidarity does not have to be undermined, but the insured must be required to make a cost-conscious decision about the desired form of care. However, according to the authors, any attempt to correct false incentives resulting from the non-market control logic will inevitably affect established expectations or vested interests. Resistance is therefore to be expected: for example

- from the health insurance funds due to the entrepreneurial risks ,
- the doctors' association, because the doctors' association loses its claim to sole representation ,
- or among insured persons, on whose behalf political actors or lobbyists insist on the free choice of doctor (which will nevertheless continue to be possible).




However, regardless of the direction from which resistance threatens, in the opinion of Hecken and Pimpertz, it is not the abolition of false incentives that needs to be justified, but the 'non-market incentive conditions that are put to the test of economic and socio-political justification'. Otherwise, the unchecked growth in expenditure threatens to suffocate the room for manoeuvre in health policy. Their conclusion: 'If the challenge is to manage the complex interaction between the players, then this is also a political opportunity to address necessary reforms as a joint task.'

In their paper, the authors analyse the current and future situation in detail and develop a 'therapy plan for outpatient care'. According to the authors, the initial question of whether and how market-based control elements can be utilised in the outpatient care of SHI-insured patients is based on 'the assumption that efficiency potential lies dormant in the system'. If one asks where this potential is to be located, then the analysis has shown that 'insured persons, health insurance funds and service providers are equally responsible' . They justify this all-round approach by stating that it is not enough to simply change the incentive conditions for individual players, as this will not be able to solve the fundamental problem. The reason: 'Complex interactions arise between the players in the SHI system.' Based on their decades of experience in the healthcare system, Hecken and Pimpertz go on to say that one could now come up with the idea of breaking this cycle and organising insurance and care separately, similar to the food market, in order to allow competitive forces to take effect in the respective markets. In their view, this would be tantamount to breaking the system and would have little prospect of political success, not least because the solidarity-based SHI system enjoys a high level of acceptance among the population. It is therefore important to bear this in mind when implementing market-based control elements:

- SHI is a health insurance scheme financed on the basis of solidarity .
- The promise of benefits and solidarity-based equalisation are not undermined .
- Medical care is provided according to the principle of benefits in kind .

In their opinion, even under these conditions, SHI policyholders can be given the opportunity to choose between tariffs with different care models, with the same scope of benefits for all. In addition, the insurance promise can be fulfilled in different ways within the framework of care close to home.

At this point, they advocate a GP-centred model. They write: 'When choosing a care model that deviates from the free choice of doctor, the insured persons undertake to request medical services from the (specialist) doctors authorised for this tariff. At the end of a commitment period, they can switch back to the free choice of doctor or choose a tariff with a different form of care. This maintains competition on the provider side.' It is important that concepts for localised care are developed. This refers to care in the municipality or in a city district, but not necessarily in another location. This is based on the assumption that the majority of doctor-patient contacts take place in GP and specialist practices close to home. According to Hecken and Pimpertz, different care concepts should be able to compete for these cases. On the other hand, it will hardly be possible to ensure care anywhere in Germany - for example during a holiday or business trip - that guarantees the full scope of services with a limited choice of doctor. To this end, the legislator has already provided for GP-centred care as an alternative to the free choice of doctor (Section 73b SGB V). However, other forms of care are also conceivable: In densely populated regions, for example, it would be conceivable to link outpatient specialist clinics to GP care, to test interdisciplinary care centres or other neighbourhood-based concepts. In contrast, other solutions are necessary in rural regions where there is a risk of shortages. Which concepts are possible and correspond to the wishes of the insured should be tested in competition.

**Literature**

1: https://t1p.de/i8kvx