

„The healthcare system reached a tipping point”

In an interview with 'Monitor Versorgungsforschung', Andreas Storm, Chairman of the Board of DAK-Gesundheit, presents his thoughts and demands for better and more resilient healthcare in the future. On the one hand, he names the reasons for the contribution tsunami he predicted three years ago and, on the other, a whole series of urgent tasks for the new federal government that need to be tackled quickly in the first six months. At the top of the list is the reform of social long-term care insurance, as it 'could be the first branch of our social security system to go into the ditch'.

In an interview: Dipl.-Volksw. Andreas Storm, Chairman of the Board of DAK-Gesundheit

>> An important leading indicator for assessing the quality of healthcare systems is the development of average life expectancy. According to the latest OECD report, Germany's life expectancy has fallen sharply in recent years compared to other European countries and is now even below the OECD average. This means nothing other than that our expensive healthcare system - after all, we spend the most on healthcare in Europe - is performing below average on the performance side, which in turn points to an inefficient organisation. However, there have certainly been efforts in recent years to make the system more efficient.

Individual efforts have been made, but they have not been enough. The main problem lies in the fragmentation of the system and the compartmentalisation of the sectors. There is a lack of constructive cooperation, which leads to an unnecessary loss of quality of life on the one hand, but also to high and ever-increasing costs on the other. What I expect from the future government is firstly the realisation and then, above all, the courage for a truly sustainable reform of our healthcare system, which must firstly function better regionally and secondly become more efficient and resilient.

Above all, it will certainly need the courage to tackle precisely the core problems that have ultimately derailed almost all efforts in recent legislatures to make our healthcare system more efficient.

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But of course. The core problem has been known for a long time: If you afford different sectors and also allow them to simply compartmentalise their boundaries, you should not be surprised that there is almost no translation between the different sectors. Even worse, however, is the fact that a great deal of money is wasted between the sectors and a great deal of quality of life is certainly lost as a result.

What are the DAK's ideas for creating a more efficient, resilient and sustainable system that is also better for patients?

One key lever is certainly the fact that the German healthcare system is almost unique in Europe when it comes to the free choice of doctor. This means that there is virtually no control in the outpatient sector, which almost inevitably leads to a loss of efficiency. It is therefore very welcome that even the German medical profession is now calling for a control function as a key factor in improving the quality of the healthcare system. The second largest lever is the development of financial resources, which is largely prevented by the extreme compartmentalisation of the sectors - here we urgently need permeability at the sector boundaries. The third point is the restructuring of our hospital landscape with regard to the internationally common practice of specialisation and quality optimisation. For this reason, the most important reform measure of the past legislative period was the decision on a fundamental amendment to the hospital sector. The fact that this will certainly be further developed after the general election is another matter. But at least we now have the chance of a paradigm shift towards a more specialised and, above all, quality-oriented hospital system in Germany. It must be the aim of all of us to finally move forward again and, in the process, to modernise our healthcare system in such a way that we no longer need to shy away from systematic international comparisons.

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However, the reform of emergency care is still unresolved.

The unsuccessful reform of emergency care has made the plight of German healthcare policy tangible and visible to all. It is sad that the third parliamentary term of the German Bundestag has already had to deal with this issue in parliamentary proceedings and we still have no emergency care reform. For me, this is further evidence of why we have fallen further and further behind in international comparison in recent years. In addition to the control elements in outpatient medical care and a modernised hospital landscape, reformed emergency care in particular will open up considerable potential to make our healthcare system much more efficient and, above all, better for patients.

This brings us to the question of patient-centricity and the status of PREM and PROM, which was the subject of our last specialist congress in December.

An optimally organised healthcare system must put people at the centre by introducing care and case management tailored to the needs and requirements of patients. If we want to set out on the path to implementing this idea, which is quite visionary for Germany, we need a management approach, which was recently proposed by the medical profession, but in partnership with the health insurance funds. And we also need to make use of the new opportunities offered by digitalisation in terms of evaluating findings on the state of health and self-reported experiences of patients. This also means that we can achieve a completely new structured and comprehensive quality in diagnostics and diagnosis by digitally recording patients' state of health via the electronic patient file. Of course, it may also be possible to utilise this wealth of data for the benefit of the people being treated if they agree to it.

The pilot phase for the electronic patient file was recently launched in the model regions of Franconia, Hamburg and the surrounding area, as well as in parts of North Rhine-Westphalia, and the usual disruptive fire surrounding the much-vaunted issue of data protection has been heard. This will certainly unsettle quite a few patients.

First of all, I think it is a decisive breakthrough that we have managed to achieve a model like the ePA for everyone. Here too, an

international comparison shows that the opt-in approach previously practised in this country has no chance of success if we want the patient record to be available almost everywhere. Many of our European neighbours have been showing us for years what can be achieved with an opt-out model, because the vast majority of patients simply want to participate in the electronic patient record service. It would be completely absurd to believe that we are almost the only country in Europe that is not in a position to offer an EPR for everyone. That's why I'm counting on the current year 2025 to bring about a breakthrough here. However, it is essential for acceptance that all possible security risks and concerns are eliminated during the pilot phase and that potential errors are consistently rectified. The principle here is: thoroughness before speed. The decisive factor for the nationwide roll-out is not that it begins just four weeks after the end of the pilot phase, but that it can - preferably a few weeks later - contribute to the successful dissemination of this important technological innovation to improve the efficiency of our healthcare system.

At our congress in December, Olaf Meyer from the Royal Danish Embassy explained that not only are PROM and PREM used to manage the healthcare system in Denmark, but that it is also 99% digitalised. Even with the ePA, we are still miles away from this.

And we are almost bringing up the rear in Europe. However, this applies not only to the healthcare system, but also to many other areas of economic and social life. Here, too, we must catch up in the coming years, otherwise our country will fall even further behind and will no longer be able to fulfil the leading role we once played in Europe. This is highly regrettable in that Europe will only play a role in global politics if the two largest countries at the heart of Europe - Germany and France - can once again assume a driving role. It is therefore important not only for us in Germany, but also for Europe, that we get back on track here. As I said: far beyond the healthcare system.

This requires money, a lot of money. What is the financial situation of the SHI system? Robert Habeck, the Greens' candidate for chancellor, is now even proposing taxing capital gains.

First of all, at the turn of the year just past, we experienced the highest increase in contributions in the history of the Federal Republic of Germany: the additional contributions have risen by an average of more than 1.2 contribution rate points and the average additional contribution actually levied since the beginning of the year is 2.9 per cent. This brings the total contribution rate for statutory health insurance to 17.5 per cent. On top of this, however, the contribution rate for social long-term care insurance has also been raised by 0.2 points. This means that we have experienced the contribution tsunami that I predicted three years ago - in the unfortunate event that politicians fail to act. This tsunami is the result of a combination of above-average growth in expenditure on the one hand and the underfunding of statutory health insurance on the other. This in turn inevitably leads to massively rising contributions. Politicians have not only ignored these well-known facts, but have actually exacerbated the crisis on a massive scale.

In what way?

The necessary reorganisation of the hospital landscape has been ignored, including the fact that a transformation fund is to be set up for this purpose. However, the fact that this is to be financed to the tune of 25 billion euros by the contributors to statutory health insurance is a bad decision. For this reason, after the general election there must be a correction to this serious burden on the SHI system, which many experts believe is also unconstitutional. This is also necessary due to the fact that the undisputedly necessary reorganisation of the hospital landscape is predominantly of an investment nature, for which the federal states and the state are responsible in the hospital sector. We health insurance funds already finance the running costs with the money of the people insured with us. To burden the health insurance funds with an additional hurdle here cannot be justified either legally or in terms of regulatory policy. Of course, anyone who acts in this way should not be surprised if a further significant increase in contribution rates is inevitable at the turn of the year. I think this is unacceptable and cannot be expected of either the insured or the economy.

So you are calling for ...

... a financial reform of statutory health insurance after the general election. One dictum is unavoidable: in future, we must not spend more than we take in. This means that we must return to a revenue-orientated spending policy. However, this does not mean that we have to cut or freeze benefits. Rather, a revenue-oriented spending policy means that, assuming a forecast increase in revenue of four per cent per year, expenditure must remain within this corridor and cannot increase by seven or eight per cent as it has in the past.

A lofty goal.

But an achievable one if - as already mentioned earlier - we introduce control by the medical profession in the outpatient medical sector, reform emergency care and modernise the hospital landscape in the medium term. Everyone must realise that all structural measures to tap efficiency reserves require a considerable lead time. On the other hand, however, this means that we must finally start, otherwise we will never finish. With bold steps, it will be possible to stop the spiral of contributions. However, we will only be able to do this if this issue is one of the priorities of the new federal government after the general election.

However, the topic of healthcare plays virtually no role in the election campaign. Except for the Green candidate for chancellor, who proposed broadening the tax base by including capital gains. He was verbally attacked for this to an unprecedented extent.

This just goes to show that the nerves of many of those involved in health policy discussions are extremely tense.

What do you think of Habeck's proposal?

The proposal is not new and has been discussed for many decades. The proposal sounds tempting at first glance, but it has some very serious problems.

What are they?

The first problem is that the actually correct idea, according to which people with a higher capital income should make a correspondingly higher contribution to financing healthcare expenditure, not

least for reasons of fairness, will fail simply because most people with a high capital income are not covered by statutory insurance at all, but by private insurance. If I combine this with high tax-free allowances for people with low investment income who are covered by statutory insurance, it is simply no longer worthwhile and is also associated with an extreme administrative burden. These reasons alone suggest that this approach will not really be feasible. Added to this is the current discussion about broader capital accumulation, including for people with low and middle incomes. However, this discussion, which is right in itself, takes a turn for the worse when it is combined with the statement that precisely those asset earnings to be built up will in turn be burdened with additional levies in order to keep health insurance contributions more stable. To cut a long story short: I advise against pursuing this proposal any further.

Although it can certainly be justified from a regulatory point of view.

Certainly. If you want to limit the burden on labour income, you must logically also consider an increased burden on other types of income than wage income. However, this theoretically convincing idea will probably not find social acceptance.

It is surprising, however, that the issue of citizens' insurance has not come up again.

We may be facing a change of era in the political debate here. Around two decades ago, at the height of the first wave surrounding the citizens' insurance model - propagated at the time primarily by Professor Karl Lauterbach himself - there was a standard argument against citizens' insurance.

It was: ageing provisions?

That too, but I mean a much more mundane one: Germany has one of the best healthcare systems in the world! Even if people with statutory insurance may have to wait a few days longer than those with private insurance to get an appointment with a doctor, they still receive good and fast medical care, according to the narrative. Because this is the case, or was better, it would be almost absurd to change this successful system. This quickly put an end to the discussion.

But today, the situation is completely different.



Dipl.-Volksw. Andreas Storm

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It is not only the OECD study that suggests that our German healthcare system, which used to be so highly praised, has now fallen behind many of our neighbouring countries in international comparison. From the population's point of view, the efficiency of the healthcare system has also fallen sharply and at the same time waiting times for an appointment with a specialist have increased in many regions. As a result, the quality of healthcare and the issue of arranging appointments with doctors has become a socio-political hot potato. The argument that we have a two-tier society, at least with regard to the allocation of appointments, is now much more relevant to social policy than it was 20 years ago.

What do you expect?

My prediction is that we won't have a discussion about the introduction of a classic citizens' insurance scheme like 20 years ago, but we may have a discussion about equalising the conditions between private and statutory health insurance patients in the outpatient sector. After all, this is the central area in which SHI and private health insurance still differ today.

However, the purely subjective impression of the population that the quality of care has declined in comparison to the past is not limited to the outpatient sector.

Contradiction. The main reason for the perceived two-tier society in the outpatient sector - as we know from surveys that the Allensbach Institute for Public Opinion Research has been presenting in the middle of the year for many years - is first and foremost the unsatisfactory allocation of appointments. Until the start of the coronavirus pandemic, we had a very high level of public satisfaction with the German healthcare system as such, regularly exceeding 80 per cent, even by international standards. In the past year, however, this approval rating has fallen significantly and is now only just over 60 per cent. Some early indicators now suggest that approval will continue to fall. It should be noted that last year's survey was conducted before the avalanche of contributions at the turn of the year. I therefore expect that the next survey will once again be a driver for a further decline in public approval of the efficiency of the healthcare system following the increase in contributions.

Basically, with a certain time lag, these demoscopic findings only reflect what the OECD statistics convey.

To be precise: we are falling behind in terms of efficiency. The system is inefficient and the population naturally recognises this.

Isn't the perceived inefficiency of health a threat to the understanding of democracy?

I fear that if we don't come to a comprehensive reform of the healthcare system in the sense discussed earlier very soon after the general election, we run the risk of the healthcare system reaching a tipping point. In other words, it will become a factor that the population will repeatedly use to underpin their own experiences and thus reinforce the impression that our healthcare system, which used to be so good, is one of the deficient elements that now characterise our country. We must prevent this at all costs. That is why I am very much in favour of putting healthcare policy high up on the agenda of urgent reform areas.

It will certainly not have a positive effect on the satisfaction of the population if more and more hospitals are closed in rural areas.

Even after two years of intensive public debate, we have the almost irrational finding that the population clings to the main criterion of being close to home. This is despite the fact that the Federal Minister of Health and many others explain in numerous talk shows how important it is to be treated in a specialised hospital in the event of a serious illness. And that the criterion of proximity to home is really the last thing that should be the deciding factor. But the acceptance of the quality of treatment has unfortunately not increased among the population in most federal states as a result. When you then see how some of the parties outbid each other with location guarantees in the last state elections, you can really have serious doubts as to whether Germany is still in a position to initiate far-reaching structural improvements to our healthcare system. Nevertheless, I am optimistic, even if it will take many years until the reorganisation of the hospital landscape has progressed to such an extent that we can then, firstly, actually tap into efficiency reserves in financial terms and, secondly, make significant progress in international comparisons with regard to improvements in important outcome indicators. We will certainly need a lot of staying power. However, it gives me some hope that we are finally having a discussion about quality again instead of continuing to chase the narrative that our healthcare system is of very good quality per se. Unfortunately, this has not been the case for a long time.

Don't we also need a paradigm shift towards pay for outcome or, better still, per result?

In theory, this is a very convincing approach, but in practice it's a very mined field. It's almost like the idea of wanting to include investment income in the assessment of contributions for reasons of fairness. However, it would be a real game changer if it were possible to implement more quality-orientated remuneration. If it succeeds - let's be confident - we should do it, even if the road is complicated and rocky. Until then, we should tackle the measures listed above first.

Finally, let's move on to another topical discussion: the current high sickness rate.

We have to take several phenomena into account here. We have carried out an in-depth study with the IGES Institute, which analyses the fact that the increased sickness rate - put simply - can be attributed to two reasons. The main reason is simply the switch to electronic sick notes.

How so?

Well, with electronic sick notes, they are automatically forwarded to the health insurance company, which was not necessarily the case in the past when we still had the yellow slips. That's why we used to simply under-record sickness incidents. In other words, we don't currently have an increase in sickness notifications because they were actually higher in the past - but nobody knew that because some of the sickness notifications were not received by the health insurance companies. However, this accounts for around 60 per cent of the effect compared to the time before corona.

Of course, this only applies to those sickness notifications for which the health insurance companies did not yet have to pay sick pay, which is only the case after a few days of illness. What about the increase in 'genuine' sickness notifications?

Of course there are. They mainly relate to two types of illness: mental illness and respiratory illness. The data from everyday practice shows us that we do indeed have a significant increase in cases of illness here. However, what definitely cannot be proven is a significant increase in misuse - the often haunting phenomenon of 'blue collar work', which is said to have been triggered by sick notes over the phone. Of course, there have always been people who call in sick even though they are not ill, but the proportion of this group of people - at least according to the statistical analyses available to me - has not increased as a result of telephone sick notes. I would therefore consider it a disastrous signal to want to abolish telephone sick notes again. We have just learnt during the coronavirus pandemic that it makes sense not to go to the doctor's surgery for certain illnesses, but to take sick leave by other means - not only for your own protection, but especially for the protection of other people.

What about the waiting day, which has also been brought into play in the current debate?

In terms of cost savings for companies, this is possibly an instrument that can be discussed from a purely economic policy perspective. In terms of health policy, however, I don't think a day off is a suitable instrument. Because it prevents sick people from doing exactly what they need to do to get well again as soon as possible. That's why I think it sends out a fatal signal when companies increasingly pay bonuses to employees who don't call in sick. A holistically organised company health management system would make more sense here.

The current federal government has initiated numerous reform projects. Which reforms or parts of them do you consider to be the most important, and which major problems have been left unresolved?

The most important measure was passed: That was the hospital reform. However, there is a risk that it could be unconstitutional

because, on the one hand, the federal government may have paid too little attention to the constitutional rights of the federal states and, on the other hand - as already mentioned - financed the reorganisation of the hospital landscape through the transformation fund unconstitutionally. I see a considerable constitutional risk here. It would therefore be important to remedy these deficits in the hospital reform concept as soon as possible and to make corrections very quickly. In addition, it will of course be important for the federal states to do their homework so that the reorganisation of the hospital landscape can also begin quickly. Otherwise, unfortunately, I can name relatively few areas in which we were actually able to make far-reaching progress in the last legislative period. This is mainly due to the fact that Federal Health Minister Lauterbach started his reform projects so late in the legislative period and was therefore unable to complete them before the end of the traffic light coalition. social care insurance, the upgrading of the nursing professions with the Nursing Competence Act and that of training in the nursing sector with the Nursing Assistance Act. And of course the important emergency reform, all of which were sent over the starting ramp but did not make it to the finish line. The above-mentioned reforms must be relaunched right at the beginning of the next legislative period.

How would you summarise the health reforms of the 24th federal government?

This legislative period was very disappointing for statutory health insurance. The reason for this is that not only has the financial stabilisation of statutory health insurance and social long-term care insurance not been tackled, but a number of measures have been taken that have further exacerbated the imbalance in SHI finances. I very much regret this. That is why the list of issues to be addressed by the new federal government has become even longer than it was in the previous legislative period.

Why don't you name the key issues that need to be tackled quickly in the first six months of the new federal government?

The first is the reform of social long-term care insurance. We have an acute funding crisis here, which could lead to social long-term care insurance as the first branch of our social security system going into the ditch. It is therefore important that a fundamental reform of social long-term care insurance is initiated in the first six months. In the area of statutory health insurance, we also need to set the course in the first six months if we want to prevent the spiral of contributions from continuing virtually unchanged at the turn of the year. In addition, we should very quickly tackle the corrections to the hospital reform that I have mentioned, the emergency reform and the upgrading of the nursing professions with a nursing skills act. The reform of the outpatient sector should then also be tackled in the second half of the year.

The key question is: do politicians really want to tackle this task at last or are they continuing to push it aside?

It is with great regret that I have to realise that the importance of healthcare policy is not yet where it should be at the moment. I am most optimistic that fundamental reforms to social long-term care insurance can already be tackled in the first few months, because some of the election manifestos of the major political parties propose very far-reaching measures in this area, so that a rapid agreement should be reached quickly. However, we still have a lot of convincing to do, particularly with regard to the urgent need for action, especially to stabilise statutory health insurance, so that these issues do not fall by the wayside again in the end.

What are they?

I would mention, for example, the reform in the outpatient sector with the Healthcare Reinforcement Act. Then there are all the important reforms in the care sector, such as the structural reform of the

Mr Storm, thank you for talking to us. <<

The interview was conducted by MVF publisher Prof Dr Reinhold Roski and MVF editor-in-chief Peter Stegmaier.

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