Scientific symposium organised by the WiDO to bid farewell to Jürgen Klauber

The 'miracle of Wertheim' of evidence-free politics

10 September this year was a very special day for the German healthcare system. Shortly after midday, the BMC presented its latest impulse paper in its online format 'Spotlight', in which 'a new chapter for healthcare' was opened and 'sector-independent care with value-based care' was proposed (page 42 ff.). This was followed just a few hours later by a scientific symposium to bid farewell to Jürgen Klauber - Managing Director of the Scientific Institute of the AOK (WidO) for 30 years - on his key topic of 'quality of care'. The coincidence in timing may be purely coincidental, but it does make one thing abundantly clear: in view of the facts, figures and data presented at this high-level symposium, it is truly not knowledge that is the problem, but the absence of evidence in far too many political decisions, such as the 'miracle of Wertheim'.

>> Prof Dr Ellen Nolte from the London School of Hygiene & Tropical Medicine opened with facts. She presented a whole series of international studies such as the Numbeo Health Care Index (1), the Commonwealth Fund (2) and the OECD publication 'Health at a Glance: Europe 2024' (3). She showed that Germany has less of a problem with access to care or equal opportunities, but one when it comes to care processes, outcomes and, above all, coordinated care. According to Nolte, all of this leads to a negative conclusion: although Germany is above the EU average in terms of the five-year net survival rate for most types of cancer, for example, the 'German system is expensive compared to what is produced'. The evaluation of quality and performance is essential for better target achievement and is an important guide for identifying the strengths and weaknesses of the healthcare system. Nolte: 'Performance evaluation can only improve the healthcare system if it is supported by a clear vision and embedded in the governance structures. '

Prof Dr Reinhard Busse from the Department of Healthcare Management at the Technical University of Berlin took an extremely hard line on politics. In his lecture 'Quality improvement in inpatient care: status and prospects of hospital reform' (5), he did not mince his words. He demanded: 'You have to be honest about the actual provision of care.' He was also absolutely opposed to loans being converted into grants, as this would 'only unnecessarily take the pressure' out of the system that is needed to get things moving. Busse: 'We all don't want the system to crash into the wall, but the danger is great.'

Busse, a member of the now-terminated government commission for modern and needs-based hospital care, underlined this warning with numerous facts, figures and some quite disturbing references; disturbing because it made it clear how politicians often act beyond any evidence.

Ad 1: Number of hospital beds

According to Busse, there are 50% more hospital beds in Germany than the EU average. And also 50% more than in our direct neighbouring countries. The problem, however, is that, according to Busse, hospitals are paid for using the beds. They normally get paid for putting patients in beds, but during the coronavirus pandemic, a different business model was introduced in which even empty beds were paid for instead of being paid according to quality.

For the healthcare economist, this mismanagement results in two overlapping problems.

Patients are not only distributed to far too many hospitals, but also to many hospitals that are often not adequately equipped. In addition, according to Busse, there are cases that are either inappropriate or have an excessively long length of stay. In Germany, for example, every cancer patient would be admitted to an inpatient bed 3.5 times on average in Germany, compared to just 1.2 times in the Netherlands. Busse: 'When it comes to cancer, you can see that we have a particularly drastic overutilisation of inpatient capacity.'

This leads to unnecessary costs and promotes inefficiency. In addition, the many incorrectly treated patients unnecessarily tie up staff. He also put an end to the lament that there are too few professional carers. 'We have the third most active nursing staff in Germany after Finland and Ireland.' But: too few nursing staff where they are really needed. And there are also too few doctors because they often need more than 30 minutes outside of core working hours to see patients, which in turn leads to unnecessarily poor quality.

Ad 2: Structural problems: Necessary cases are too often treated in hospitals with inadequate equipment

According to analyses by the latest Quality Monitor, patients with heart attacks are treated in 1,200 hospitals in Germany. However, only 600 of these have the facilities for left heart catheterisation, which is used to accurately diagnose heart diseases such as coronary heart disease (CHD) or a heart attack. It is evident that the use of this catheter examination or PCI significantly reduces mortality, reinfarction and stroke (from 14% to 8%).

At this point, Busse is often asked: 'But what about in the countryside? And the well-founded call that it is better to provide the population there with poor care than no care at all.

In order to refute this misconception, the economist took a rural area in Lower Saxony, the Weser-Ems region, and marked the hospitals with and without left heart catheters on a map, together with the number of cases treated there. And then analysed how far the journey would be if an ambulance did not go to the nearest hospital, but to the nearest hospital with adequate equipment. His unsurprising result: 'I didn't find a single hospital location that was more than 30 kilometres away from the nearest hospital with a left heart catheter. It's a complete miscon-

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ception that people have to be treated so badly because the nearest good hospital is too far away.'

According to Busse, the problem detected here also occurs with strokes: Over 1,000 hospitals treat strokes, but only 354 have certified stroke units. This is despite the fact that survival times are significantly better in stroke units: the 1-year mortality rate is a quarter lower in hospitals with vs. without a stroke unit (23% vs. 30%). The same applies to cancer, where the WiZen study shows significantly higher survival rates for treatment in cancer centres, and even clear survival advantages of up to 23% for 11 types of cancer.

And yet the state of Schleswig-Holstein, in which 19 hospitals treat patients with breast cancer but only 10 have a breast cancer centre, is suing the Federal Joint Committee. If he had taken the figures from Brandenburg, the ratio would look even worse, Busse added.

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Busse singled out the Berlin/Brandenburg area, where there are an average of 3 pancreatic operations per day. And yet these operations are carried out in 33 hospitals (since 1 July 2013 also in Strausberg): 13 in Kaulsdorf, 14 in St. Hedwig and 17 in Bad Saarow - and all this despite a minimum volume of 20 defined by the G-BA.

Looking ahead to the hospital reform that may come at some point, Busse asks: 'How many of them will receive the pancreatic surgery service group if a cancer centre is not a requirement?' His tip: 'I believe that almost exactly 33 hospitals will be allocated this service group.'

Ad3: The chicken and egg problem

His question: 'Do we have so many beds because we have so many cases, or so many cases because we have so many beds?' According to Busse, it is important to know that Germany is in second place in the OECD countries after Bulgaria. Overall, the number of hospital cases is two-thirds higher than the OECD average. In Switzerland, on the other hand, there are 25% fewer cases, in Denmark 40% and in the UK and the Netherlands even 50% and 60% less respectively. His calculation: 'If we had the same number of cases as Switzerland, we would have 12.5 million inpatient cases instead of 16.5 million, and Denmark would only have 10 million.'

Of all these many cases treated as inpatients in hospitals in Germany each year, the main diagnosis is diabetes in around 1%. Busse's nasty question: 'Why are these patients hospitalised at all?' He gave the answer himself: 'Either because there was no outpatient care or the outpatient care was so bad that the patients needed an inpatient amputation.' The KBV would certainly not agree with this statement, but the question is legitimate: 'What are these patients doing in hospital?' To make matters worse, according to Busse, there are significantly higher rates of avoidable 'outpatient-sensitive' hospital cases in Germany than in any other EU country.

After an excursion into the Hospital Care Improvement Act (KHVVG) and the draft Hospital Adjustment Act (KHAG), in which the care levels originally proposed by the Commission with hospital-wide minimum requirements have been cancelled and the service groups have been eroded, Busse went on to discuss the present and possible future.

Unfortunately, three years ago, when the Commission developed and presented the reform proposal, he had the feeling that 'there were politicians who understood what we were proposing'.

He no longer believes that.

He took a look at the hospital reform in the state of North Rhine-Westphalia.

Here, he said, there was a recognisable will on the part of politicians to shape the main problem of hospitals wanting to operate unnecessarily too often. However, there is still overuse for some indications, as the old actual case numbers represent the new target. The main problem of too many locations with too many beds is also not being tackled in NRW.

Even worse: in the federal state of Baden-Württemberg, a hospital that was already insolvent would even have had to reopen, which the ARD morning programme would have described as the 'miracle of Wertheim'. Busse can only shake his head at this: According to him, there are four hospitals for 130,000 inhabitants in the Main-Tauber district. If the figure were to be rolled out nationwide, there would even be 2,500 hospitals in this country.

However, the town of Wertheim has now found a private operator who will receive up to 2.75 million euros per year to compensate for the deficit. On the morning when the ARD 'Morgenmagazin' programme reported on the case, 20 of the 80 existing beds were occupied. If you extrapolate this to one year, the local authority would have to pay 2,000 euros per patient in addition to what the health insurance companies pay. If this amount were extrapolated to the national average with its 16.5 million hospital cases, the hospital budget would increase by 33 billion.

As far as quality is concerned, the hospital's website states that it claims to have a stroke unit, but has neither a neurology department nor a CT scanner in-house (only 'via a partner practice'). Heart attacks are also explicitly mentioned as an indication, although there is no left heart catheter; patients are stabilised and then transferred. Busse: 'This is completely against the guideline, but you can simply claim anything on websites.' His question: 'What about efficiency, what about the quality of care? It will be interesting to see which service groups they are assigned to.' <<

by: MVF editor-in-chief Peter Stegmaier

Literature

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