Comment

Healthcare in Germany – what can be done?

Financers and users of healthcare and health insurance

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>> For many years, and increasingly so in recent months, developments in healthcare have been increasingly seen as a problem that urgently needs to be resolved. Whilst the discussions on change that have been ongoing for years relate to very different aspects, the pressure to act in recent months stems from financial developments in both health insurance and long-term care insurance. The reason for this is clear: expenditure is rising faster than revenue, and there are no signs that this trend is easing. On the contrary, there are fears that it may accelerate.

The implications of this trend are obvious:

• The contributions payable by insured persons and their employers are becoming ever higher.

• The burden on insured persons' household incomes is growing ever greater.

• The burden on businesses is leading to rising costs: the products manufactured there for sale worldwide are becoming more expensive and selling less well.

• Gradually, increasingly negative effects on employment and income are emerging in Germany, which are slowing economic development even without the negative impacts of the crises in Ukraine and the Middle East • and this may result in an even more critical financial situation in both health insurance and long-term care insurance – with further repercussions for

actual care provision on the ground.

At the same time – differently and much more markedly than in the past – structural deficits in health and care provision in Germany are becoming increasingly apparent: life expectancy in Germany appears to be falling below the EU average, satisfaction with healthcare seems to be declining among those surveyed, and in many ‘on-the-ground’ discussions, the consequences of ‘organised irresponsibility’ in healthcare are becoming apparent to everyone and are being criticised with increasing clarity. A situation that also creates new challenges for our democracy.

Hence the question: “What can be done?”

In this situation, the political arena currently seems to be favouring solutions that have already been tried in the past and were often largely unsuccessful: cutting benefits from statutory insurance, increasing co-payments for people with illnesses and those in need of care, andlimiting or reducing fees andexpenditure for service providers and manufacturers through statutory regulations.

To be more precise, the question is: *“What can* we*do better?”*

Can we not try to answer this important question with genuine ‘structural reforms’? The reform of the hospital reform has just been passed by the Bundestag and is thus underway in a – let’s call it – ‘light’ version; it will probably take some time yet before the effects actually attributable to it can be demonstrated; nevertheless, there is considerable uncertainty as to whether a meaningful solution to the structural and financial problems has already been found.

A second attempt at an answer, which is already being considered, is described by the term “primary medical care”; some already see this as the first step towards “primary care”.

In this context, “what can be done better?” means, for some, being able to better manage patient flows and thus the utilisation of the healthcare system, whilst others see it as an opportunity to counteract the “organised irresponsibility” perceived at local level in healthcare through better coordination.

Another attempt at a solution is the shift towards outpatient care, which in some eastern federal states is also referred to as “Stambulantisierung”.

These efforts to initiate responses within a complex system may well be right and necessary in some respects. But:

“Are the solutions envisaged so far sufficient?”

Have not the solutions we have attempted to provide over the last few decades led us precisely to where we are now? And are the looming “structural reforms” perhaps, in a certain sense, misguided?

And furthermore: does the problem with these approaches not perhaps lie in the fact that the implemented solutionswere (or are) (far too)‘input-oriented’ and, moreover, prescribe down to the smallest detail – through legislation, and above all through central government regulations – who is to do what and when?

And have we not, as a consequence, all done too little to meet the demand of the Expert Council for Concerted Action in the Health Sector (from its 1995 special report!) for “greater outcome orientation” in

healthcare and health insurance?

If we are to answer the question “what (better) to do?” to achieve greater results-orientation more precisely: would it not help to look at one of our most successful tools in the design of complex systems? Does this tool not consist of financial incentives?

Do such incentives not ensure that we get exactly what we pay for?

The diagram on the left shows just a few of the most common examples of “you get what you pay for”. The fact that these examples also highlight enormous problems (too many hospital admissions, too many individual services, etc.) does not in any way speak against the mechanism itself, but rather for the choice of unsuitable, indeed often incorrect, performance indicators for which payment is made.

So how about if we were to pay – at least a little bit – for healthcare outcomes?

And thus pave the way, just a little bit more, for a better focus on outcomes in the German healthcare system. <<

Citation

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