How to improve the rationality of health policy?

- Health Policy Innovation through more evidence-based implementation?[1] -

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Outline

I What is a desirable Health Policy? What is best practice in Health Policy?

The working hypothesis for this chapter is that good ideas gain acceptance only in the long run. They are an essential part of health policy innovation but it takes often too long to implement the good ideas in the political processes, in some cases more than 10 years, as can be demonstrated by examples from Germany[2]. Some examples of a mind change or a shift in health policy paradigms that took place in the last 30 years not only in Germany are:

- the introduction of more competition in the health care sector in general and in particular the liberalization of the negotiations between providers of health services (hospitals, office-based physicians etc.) and the different funds in the statutory insurance system,

[1] A longer version is published in Kaal, Wulf. A., Schmidt, Matthias and Schwartze, Andreas , ed,, Festschrift zu Ehren von Christian Kirchner, Mohr Siebeck, Tübingen 2014, p.837-848

[2] See Henke, K.-D., Sachverständigenräte: Gute Ideen setzen sich langfristig durch. Was kann wissenschaftliche Politikberatung leisten? Wo liegen die Grenzen?, in Deutsches Ärzteblatt, Sonderheft, Dezember 2005, S: 7 -9

- the introduction of the risk structure equalisation in a Bismarckian insurance system as a prerequisite for a fair competition between the funds,
- the public understanding that the health care sector is a macroeconomic growth factor (health as human capital) and a labour intensive sector of the economy and a lot more than only a cost factor in an ageing society,
- Prevention as a new key element in the public discussion on health care,
- Integrated resp. managed health care in general and in particular in connection with certain types of diseases (disease management),
- Quality assurance in all areas of health care as a major and permanent challenge,
- the introduction of new payment systems such as e.g. the DRG-system in hospitals,
- Health in all policies
- Health economy as a driving economic force

The question is whether there are possibilities to improve an outcome-oriented and fiscally sustainable health policy in general and in Germany in particular and whether it is possible to speed up the process of renewal in the sense of a desirable health policy.

II Is there such a thing as a rational health policy?

The functional or professional rationality as exemplified in health targets is often at odds with the political rationality – the result being "social peacemeal engineering" (Popper) or muddling through and a step by step approach to economic policy (Lindblom, Tinbergen).

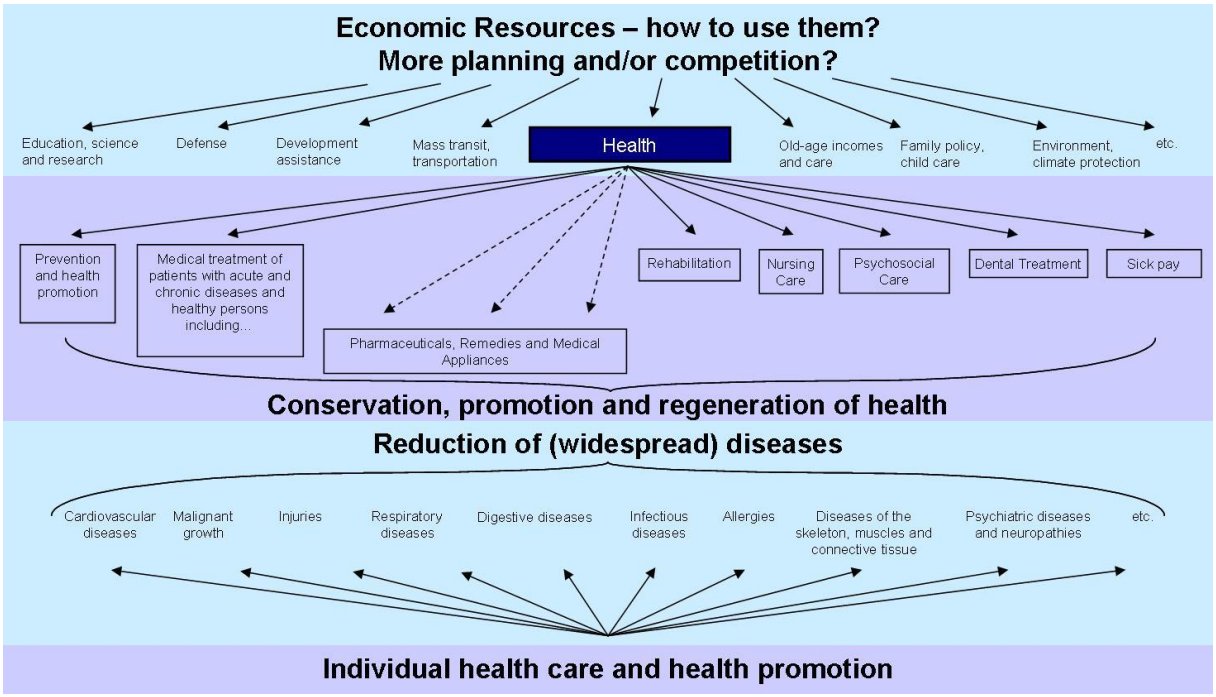
1) The functional rationality or the optimal allocation of scarce resources

A fundamental but questionable functional approach is to be seen in chart 1. It shows the allocation of scarce resources in health care from a macroeconomic perspective "top down" and a microeconomic perspective "bottom up".

The objective of the use of scarce resources is either to conserve, promote or regenerate health or to reduce diseases by individual health care and health promotion. The individual perspective shown on the bottom of the graph is orientated according to the international code of diseases.

There are always trade-offs between health care spending and alternatives such as education, science and research, environment, climate protection or family policy and often these alternatives have themselves strong influence on the health status of the population, e.g. education. Thus from an epidemiological point of view avoidable morbidity and avoidable mortality is the ultimate goal and health care is only one of the major instruments.

Within the health care sector in chart 1 prevention and health promotion, medical treatment including pharmaceuticals, remedies and medical appliances, rehabilitation, nursing care, psychosocial and palliative care, dental treatment and last but not least sick pay are the areas where the resources resp. health expenditures flow to.



Nobody knows how much a society should spend on health care. There exists no optimal quota of health care expenditures neither in relation to GNP nor according to different sectors. There is so far no empirical evidence for the optimal amount of money spent to achieve the goals mentioned.

All the economists can tell us is that money should be spent in areas where the benefit to health is greatest or to put it more generally: The expenditures flows are to be reallocated so long until the marginal benefit or the health results per unit of cost in all sectors is the same.

Or the other way round: Expenditures should be reduced where the marginal benefit to people is the smallest resp. inefficiency is the highest[3].

Allocation decisions have to be made either by parliament, the self-governing bodies, through market mechanisms or through combinations of the three of them on different levels. In an ideal world a functional approach starts with clear targets for health outcomes or improvements, with process targets and system targets.[4] Then, the next step would be the development of strategies for the implementation of these targets on a federal, regional or local level by funds in a statutory health insurance system or with the commissioners on a regional basis e.g. in the UK. In this context more and more actors recognize that networks are superior compared to hierarchies or silos[5]. But even new kinds of networking need a legal framework or work on the basis of a gentlemen´s agreement.

In addition the question arises whether there is an optimal mixture of the different instruments for accomplishing the targets on the different levels. From a health economic point of view, the mixture involves the question about the mode of allocation. Can the target best be attained by using central planning, self governance in social insurances or market mechanisms? In case such a package or mixture of instruments exists or can be developed one may ask whether there is at all an institution that will bear the responsibilities for accomplishing the targets. In case it is a model of socially bounded resp. regulated competition the results stem from the innovation process by itself. And in case of networking models there is a clear legal framework the prerequisite for success.

As the system of allocating resources to health in a society is too complex these processes take place in real life in a step by step approach that in many countries includes more and more monitoring and evaluation procedures.

2) The political rationality or health policy as the art of feasibility

[3] See in more detail Porter, M. E., Teisberg, E.O., Redefining Health Care – Creating Value-Based Competition on Results, Boston 2006, 397-411

[4] See in detail M. Marinker, ed. Health Targets in Europe, Polity, progress and promise, London 2002 and I. Hernandez-Aguado, Innovation in the monitoring of health and well-being: what do we need to measure, in this volume.

[5] See in particular M. Warner and N. Gould, Health in all Policies at the local level, in this volume.

Health policy as a one-stop, unified whole is the dream of scientists, but hardly viable in a parliamentary democracy with proportional representation (as e.g. in Germany). Translating Herbert Giersch's definition of rational economic policy to healthcare reforms, rational health policy would have to be "aimed systematically at the realisation of a target system which is comprehensive, sophisticated and well-balanced", as well as "achieving the highest possible degree of success in the given circumstances". According to this definition, the current state of healthcare policy reform would be rational provided that all viable possibilities for improvement really have been exhausted. Health policy would then appear as the art of feasibility or, as Popper termed it, "social piecemeal engineering". The smallest common denominator is thus the foundation of the reform. One may choose to call the expected result an idle compromise, a settlement or even just an interim solution. In any case, the expected result of the political wrangle about the essential elements of the reform can be termed a lesson in the "art of feasibility". Therefore “social peacemeal engineering” (Popper, Giersch, Williamson) is the answer so far either by competition rules and/or by planning processes.

III Are there solutions which will lead the way out of the compromise trap?

In order to increase the rationality of health policy, always a source of controversy, solutions need to be sought which will lead the way out of the compromise trap.

1) Two obstacles

Obstacle 1: The role of the media

In this context a look at the media and their reports and comments (frequently inseparable) regarding the continual changes brought about by healthcare reforms is of interest. Since the 1977 reform in Germany the media have chosen to project the stereotype of a two-class medical system, as well as the ideas that chances for a fundamental structural reform are repeatedly thrown away, that everything is a "botched job", and that with each new reform the sick are shamelessly made to pay more. The leading article in the news magazine *Der Spiegel* on the occasion of the healthcare modernisation law in January 2004 was: "Are we a nation of losers, incapable of progress, governed by bunglers?" This was a reform by a informal grand

coalition which was described by critics of the current healthcare reform as exemplary. It is thus no exaggeration to say that the healthcare reforms are always better than we are led to believe by the media. Whereas the underlying economic and political conditions for reform have changed, criticism of healthcare reforms and amendments since 1977, the year in which stable contribution rates were introduced as an import political goal for statutory health insurance, has remained largely unchanged. Probably this description of the role of the media is typical for other countries as well.

Obstacle 2: The role of lobbyism

The institutional situation of a country also affects its point of departure for healthcare reforms. Germany, with its Federal Republic of 16 autonomous *Länder* (states) and consequent permanent state of campaign due to a plethora of regional elections, is not in a good position in this respect. Taking into account the additional fact that it is a country of unions and federations (providers, manufacturers, health insurance funds etc.) and corporatist structures, with marked lobbying in the healthcare sector (for every 500 employees in the Ministry of Health there are 4.000 people lobbying for unions or federations in Berlin), it becomes understandable why the OECD believes Germany to have a decisive comparative disadvantage in comparison to other European countries. The situation is further exacerbated by decrees passed by the Constitutional Court and numerous tribunals for social issues which usually have led not to healthcare innovations, but to higher SHI costs. The mere extent of the German social code with its level of detail slows down the diffusion of efficient health policy innovations.

The compromise trap is not atypical of parliamentary democracy with its lobbyism. The criticism from well over 50 federations, some of it expressed polemically and with no alternative concepts, is ultimately a result of the fact that the heftily debated further development of the healthcare system was largely set in motion without their involvement. In these reform proposals the expertise of the functionaries (Berlin declaration from September 2006; healthcare policy resolution from October 2006) has consequently been far less pronounced than in the past. The impression emerges that the vast number of federations within the German healthcare sector, repeatedly criticised especially by political and legal experts, is to be reduced to a more normal size. Leaving aside the question of whether the inclusion of all organisations in the development of an informed opinion about healthcare

policy would have led to chaos or out of the compromise trap, and forgetting the conventional procedures for a moment, there are also some fundamentally new ways of escaping from the compromise trap and of avoiding such traps in the future. Whether these more fundamental routes are really likely to be desirable, viable and successful remain to be seen.

Of course there is also a relationship between the two obstacles. For example, many lobbyists regularly publish articles and act as experts in the different media. Thus the media benefit from lobbyists who finance media advertisements.

2) Four ways of escaping from the compromise trap

Is the role of experts overestimated?

Firstly, one could have started the intended healthcare reform all over again, or even have shelved it until the next general election. In both of these cases it would then have been possible to concentrate more calmly on the scientific expertise and in particular that relating to the economics of healthcare. The problem is, though, that the scientists do not have a model of consensus or a patent remedy either, so that even the experts need to compromise if they are to agree at all. This is further confirmed - at least in Germany - by a perusal of the reports by the committee of experts evaluating overall economic development (the "German Council of Economic Experts"), the reports of the nearly 20-year-old committee of experts for healthcare (the "Advisory Council on the Assessment of Developments in the Health Care System), the numerous reports and comments by the two scientific advisory committees to the German Ministries of Finance and the Economy, the transdisciplinary study by the Berlin-Brandenburg Academy of Sciences and Humanities, as well as the reports by the Rürup and Herzog Commissions

A well-respected colleague recently commented on how good it is that at least some decisions are political, since the scientific boards could not even agree in small circles and even then would only apply their specialised rationality measures which are usually too narrow and frequently not even interdisciplinary. For now at least, this is not the silver bullet answer to the compromise trap[6].

[6] The major independent federal advisory body established in 1997 in the United States is The Medicare Payment Advisory Commission (MedPAC). In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare´s traditional fee-for-service program, MedPAC is also

Is a constructive dialog between all parties for the development of an informed opinion about health policy at all possible?

A second path was taken in connection with the last reform in Germany via the proposals put forward by the parliamentary opposition fractions ALLIANCE 90/THE GREENS, FREE DEMOCRATIC PARTY and LEFT PARTY which were pointing in a similar direction, departing from principal criticism of proposals by opposing parties and moving towards a constructive dialogue for the development of an informed opinion about healthcare policy in both the upper and lower German parliamentary houses. This complex path involved a hearing with the German parliamentary committee for health policy which on its own lasted for more than 30 hours. Linked with the proposals for amendment put forward by the upper house this has meant and still means numerous alterations, delays and thus a situation close to the status quo desired by the various federations and the German *Länder*. The reform, which essentially commenced on April 1st 2007, is certain to lead to yet more debates and desired amendments via several delays.

Consolidation of elections in Germany

A third, long-term path would be to alter the election system (majority representation instead of proportional representation). An example of this system is to be found in Great Britain. This thorny path would lead to abolition of the smaller parties and reduction of the desirable variety on the political scene and among socio-political shapers of public opinion. On no account can it be discussed within the sole context of healthcare reforms.

A consolidation of the dates for general and regional elections, as proposed by the Bertelsmann Foundation, is more realistic and presumably also easier to implement. Without the non-stop election campaigns generated by German federalism, many of the current bones of contention would assume a whole new significance. This path clearly demonstrates the difference between more political rationality, geared strongly towards the retention of power and re-election, and functional rationality, for example from a medical, legal or economic perspective, which is only geared towards political matters in exceptional cases.

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tasked with analysing access to care, quality of care, and other issues affecting Medicare. See e.g. Assessing Alternatives to the SUstainaable Growth Rate System, March 2007

Devolution of powers, more elements of direct-democracy and a more regionally oriented health policy

A fourth path leads via elements of direct democracy, for example those to be found in Switzerland (referendums and people-initiatives), to a more regionally orientated healthcare policy and thus also out of the compromise trap. This penultimate proposal focuses on so-called "non-majoritarian institutions" in order to reduce rent seeking, i.e. of the striving of agents to promote their own advantage. For individual interest groups, lobby activities only pay off if the gain achievable from the influencing is larger than the means required for the group to work. The more decentralist German healthcare policy were to become, and the more tightly the cost-of-service principle were to be adhered to, the fewer federations and functionaries there would be in the healthcare sector. The insured parties and in particular patients with their next of kin would become the focus far more than is currently the case. Furthermore, regional health policy might produce a “laboratory of health policy innovations” that could help accelerate the implementation of efficient health care regulation. However, the limits of this path are tied to the fiscal and judicial autonomies of the regional authorities in question.[7]

IV Is evidence-based health policy possible? Health policy through an independent body

The last and clearest path envisages new sustained conditions and incentive structures, through which the (warranty or supervision) state would protect the healthcare sector from intervening politicians and federation functionaries by guaranteeing their desired distance through an independent body for the entire social welfare system (like the central bank), or at least for health insurance as its most complicated subdivision in Germany. In addition to creating an independent body, one could also argue for the introduction of a rule-based health policy. In analogy to a rule-based monetary policy, the health policy rule would stipulate how the independent body should react to certain health policy developments (e.g. alter premiums, expand or reduce reimbursement of drugs, devices and services, and so forth)[8].

[7] See Reimers, L. (2007), p. 371.
[8] See Wilensky, G.R. Developing a Center for Comparative Effectiveness Information, in: Health Affairs, 7 November 2006,572-585

In this connection one may see the future of NICE, IQWiG, National Health Care Basket of Services in Israel and similar institutions that will perhaps one day help to implement more often at least pieces of an evidence-based health policy. The instruments these evaluation agencies are using are the same that could be applied to policy proposals.

Through a body of this kind, a path away from the service or welfare state towards a warranty or supervision state could be sought and found with far less influence from lobbyists. In this environment the basic or compulsory coverage would certainly have to be defined and developed further in a dynamic manner. In an environment more strongly governed by competitive and civil law, the future would be marked by new forms of patient care both within and beyond compulsory insurance. Individual prevention would gain increasing significance, as in the Netherlands, particularly as there is no stopping of the health, fitness and beauty revolutions and additional new healthcare markets within the nutrition sector.

A sustained framework including social compensation, partial accumulation of capital and more choice with regard to both private health insurance and the growing secondary healthcare market, would in the long term surely be a way out of the compromise trap. In this context the scope for experiments would grow, as is already the case with some beacon projects for integrated care and medical care centres. A willingness to experiment, as has repeatedly been called for by the committee of healthcare experts, is still lacking in the fields of patient care and healthcare supervision.

Whether or not one of the illustrated paths out of the compromise trap really will be adopted by politicians remains to be seen. Until that time we shall have to continue living with compromises of the existing kind and thus also with the lasting nagging of politicians, as well as criticism regarding the technical skills of the negotiators. Ex-Chancellor Schmidt may well have been right, however, when he recently commented that the debates about healthcare reforms should not be so high up the political agenda. After all, he continued, we do have in the European Welfare States the best systems of patient care in the world and we act as had we no problems of a more pressing nature in Germany one of them being the relatively high unemployment rate. If challenges like that were to be better mastered in our society, then with full employment and continueing economic growth a completely new point of departure for future healthcare reforms would emerge. However, these reforms would also be concerned

with sustained financing, more competition regarding the provision of services, as well as the future of the healthcare economy as a contributor to economic growth.

V Open questions

Further research is needed to compare the experience with more rationality and a higher quality in health policy in other nations. Are there already clear approaches of evidence-based health policy? Is there best practice to be seen within the Common Market and the open method of coordination? And are these results more on a micro basis, i.e. on a local level or for certain kinds of diseases, or is it possible to show the superior systems of financing and purchases health care. Probably from a macro point of view the path dependency is still very much in the center of health policy in most of the countries[9]. And what is the motivation for doing things better than in the past? Where is the country with a treatment of diseases, with preventive lifestyles, with empowered population groups, integrated care, with a healthy climate etc. where one would like to live in ceteris paribus?

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[9] See e.g. B.v. Maydell et. al., Enabling Social Europe, Springer, 2006

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