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Rationalisation or Rationing, a Way Out of the Crisis?

One third of hospitals operating ataloss".Thus ran the headline of a recent news item by the German Press Agency. The 2007 GermanHospitalBarometer survey of German hospitals has again highlighted that hospitals continue to wrestle with economic problems.

However, closer scrutiny of the economic situation reveals amore complex picture. According to the study cited above, 44.5% of the hospitals surveyed were undecided about their future economic prospects, while more than 23% rated themas good.

Some hospitals are more economically successful than others. This is a trivial observation; the interesting question is whether the longstanding demands and agitation for rationalisation as opposed to rationing in the health service are helpful or beneficial to hospitals and if they are the reason for theeconomicsuccessof somehospitals. Can and should hospitals choosebetweenthesealternatives?

An Inextricable Dilemma

For more than 15 years the German health systemhas been continually offered a choice between "rationalisation" and "rationing". Thus far, no clear response has been forthcoming, primarily because the implications of making this choice range from the trivial to the monstrous. A number of definitions developed by the philosopher and medical ethicist, G.Marckmann, are set out to help facilitate objective consideration of this issue and, hopefully, give answers tothisunresolvedquestion.

Rationing

According toMarckmann, rationing triction of services. It arises from the tension between limited resources and infinite demand. In this respect, it is neither a confrontational term, a "declaration of war" on the health systemor, as many politicians would argue, a means of differentiating between "valued" and "less valued" patients. On the contrary, it is a simple statement of fact. Services must be circumscribed because resources are scarce. The choicesmade and the constraints imposed as a result are not academic decisions but value judgments, which must be taken in the context of a broad political and societal debate. Individual service providers and thosewhobear the costsof healthcare cannot take responsibility for these decisions because it is not within their capabilities to do so. Such decisionsmust be preceded by a discussion about values, both at political and societal level.

Rationalisation

When resources are limited, the goal must be to deliver the same medical and care effect using fewer resources or deliver a largermedical and care effect using the same resources. The goal, therefore, is to increase efficiency, which is the hallmark of rationalisation.

Rationalisation is the primary strategy available for dealing with scarce resources. It stands to reason then that those who deliver the service are most familiar with the processes involved and best placed to identify potential improvements. Rationalisationmeasures should be administered at the service provider level, including in hospitals. Significant efforts are beingmade tosecure efficiency improvements and substantial successes have been achieved. Organisational changes such as the establishmentof specialist centres in medicine have delivered measurable rationalisation outcomes. There follows an analysis of new rationalisation approaches.

Rationalisation Potential: Evidence basedMedicine

Evidence basedmedicine (EBM) is a relatively new concept, which was first introduced in German healthcare only a decade or so ago. Despite its relatively recent origins, it has emerged from an intense and often divisive debate between methodologists and service providers as a key healthcare strategy. In a British Medical Journal readers'pollevidencebased medicine was rated the eighth most important medical advance since 1840. Implementing bodies in many health systems (for instance, G-BA, IQWiG, NICE) have adopted EBMapproaches as their legal and organisational modus operandi. Greater application of the principles of EBMoffers further potential for rationalisation.

In the absence of other indicators, conclusions about the effects of medical interventions have frequently been based on surrogate parameters. A series of false conclusions were reached for certain drug therapies and certain hospital treatments have also been found wanting when subjected to rigorous scrutiny (primarily randomised clinical trials). For example, the initial euphoria which greeted the use of robots in endoprostheses gradually gave way to the realisation that the procedure's shortcomings outweighed its benefits. The use of these robots has

been suspended and most of themnow languish in hospital basements. Gastric freezing for stomach ulcers, transmyocardial laser revascularisation and the use of MRT to diagnose multiple sclerosis have all suffered similar fates. Studies using EBM criteria showed that the disadvantages of these often expensive therapeutic and diagnostic procedures outweighed their utility.

Evidence based utility assessment offers significant rationalisation >

> potential. The instrument was established in German law through legislation enacted in 2004 to modernise the statutory health insurance systemand extended in a 2007 health reformwhich introduced cost-benefit analysis in the pharmaceutical sector.

It must be assumed that the use of these principles for utility assessment would contribute to rationalisation in hospital treatment.

“Knowledge Creates Health”: The Rationalisation Potential of Critical Health Literacy The courts did not censure the use of robots in surgery per se but noted the requirement to provide patients with complete and comprehensive information. Pressure frompatients for greater involvement in decisionsonmedical treatment is also increasing. Patient surveys carried out by the Technicians Sickness Fund show that only 5% of patients want treatment decisions to be left solely in the hands ofmedics.

These findings are replicated in all age groups andmedical conditions and provide evidence of a new and frequently ignored patient wish (Figure 1).

In view of the growing importance of patient and customer orientation, this wish should be taken seriously and addressed through appropriatemeasures. Some sickness funds have already started to take action in this respect.

Not only do enhanced patient participation and improved information reduce liability risks, they can also improve treatment outcomes. For this reason, health education should be developed.

The idea that “knowledge creates health” lies at the heart of strategies aimed at improving “health literacy”. The focusmust be on improving access to and understanding of existing information, rather than on providingmore information.

Frominformation, educationmust emerge. Improvements in the economic efficiency of treatments can also be expected fromsuchmeasures.

The results of patient education courses developed for diabetes treatments are a good case in point. This concept has been internalised inthemissionstatements of successful hospital operators.

Conclusion

Rationalisation and rationing are both indispensable strategies for the responsible organisation of medical care in an era of scarce resources. The dominant strategy is rationalisation for which service providers, owing to their in-depth knowledgeofcareprocesses, should have responsibility. Hospitals are also required tomake a contribution towards rationalisation.

Explicit rationingmeasures cannot be implemented in a responsible manner by individual service providers or those who bear the costs of healthcare. These decisions are contingent on the outcome of a political and society-wide debate on values. Individual hospitals cannot be given responsibility for taking such decisions.

It is high time that Germany engaged in a public debate on the values that will determine prioritisation in medicine. This means all sides must adopt unambiguous positions on what we will and will not pay for in our health system.

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