Value for Money- schon vor mehr als 40 Jahren formuliert

In vielen Industrieländern führen steigende Aufwendungen im Gesundheitswesen zu Konflikten, sind doch die gesellschaftlichen Ressourcen (z.B. Finanzmittel, aber auch Fachpersonal) begrenzt. In Deutschland beobachten wir unter dem Begriff "Medizin gegen Ökonomismus" einerseits Bemühungen um eine patientenzentrierte und ressourcenschonende Versorgung („choosing wisely"), während andererseits Träger von Gesundheitseinrichtungen zum Zweck der „Erlösoptimierung" mittels Kostensenkungen besonders im Personalbereich und Mengenausweitung lukrativer Leistungen versuchen, mikroökonomisch vorteilhaft, letztlich aber zu Lasten der Gesellschaft zu agieren.

Seit Anfang des Jahrtausends wird die Forderung lauter, anstelle der Bezahlung von „Leistungen" (medizinischer Maßnahmen, „input") das Ergebnis von Behandlungen aus objektiver und subjektiver Patientensicht („output") zum Maßstab der Ressourcenzuteilung zu machen und dabei auch den relativen Nutzen im Vergleich zu anderen Maßnahmen in die Überlegungen mit einzubeziehen. Hauptvertreter dieser Strömung sind insbesondere Michael E. Porter[1] und Sir J.A. Muir Gray[2]; die dazugehörigen Stichworte wären „Value Based Healthcare" oder „Triple Value Healthcare".

Vor diesem Hintergrund lohnt sich die Lektüre des vor mehr als 40 Jahren publizierten Buches „Value for Money in Health Services"[3] von Brian Abel-Smith, damals Professor of Social Administration an der London School of Economics and Political Science. In 12 Kapiteln auf gut 200 Seiten beschäftigt sich Abel-Smith mit grundlegenden gesundheitspolitischen Fragen von der Krankenversicherung über die Planung von Gesundheitsleistungen, die Ausbildung in Gesundheitsberufen, bis zur Honorierung der Ärzteschaft, dem medizinischen „Markt" und der Rolle der Pharmaindustrie.

Wiederholt betont Abel-Smith die entscheidende Bedeutung der professionellen Haltung („ethics and social commitment") der Ärztinnen und Ärzte als conditio sine qua non eines patientenzentrierten Gesundheitssystems. Viele seiner Gedanken haben an Aktualität und auch Dringlichkeit nichts verloren, die nachfolgend willkürlich zusammengestellten Zitate regen auch heute zum Nachdenken an.

(Hervorhebungen im Text mittels Fettdruck durch F. Gerheuser)

Chapter 5: Trademan or Priest: The Payment of the Doctor

"Inevitably the extent of abuse depends on the general standards of ethics in the medical profession in different countries. The ethos of a profession is strongly influenced by its leadership. Where medical teachers and leading clinicians strongly condemn abuse, the norms are likely to be communicated to each generation of students and maintained when they go into practice. The norms of professions are moreover not uninfluenced by those of the wider society in which the profession operates. Thus suspicion of abuse appears to be small in Sweden and much larger in Germany, Switzerland, France and particularly large in the United States under Medicare and Medicaid and voluntary insurance programmes." (S. 66)

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[1] Porter, M. E. (2010). "What is value in health care?" N Engl J Med 363(26): 2477-2481

[2] Gray JAM (2013) The shift to personalised and population medicine. Lancet 382:200-201

[3] Abel-Smith A (1976) Value for Money in Health Services. Heinemann Educational Books Ltd., ISBN 0 435 820006 0

[…]

"**The ideal remuneration system** which will encourage both quality and economy, which will secure an even distribution of services, promote effective preventive action as well as effective curative action, stimulate concern for patients' feelings as well as for their bodies, and establish medical priorities on the basis of need alone **does not exist**. A decision has to be taken on which are the most damaging effects to be avoided and how any drawbacks of a system ultimately chosen can be reduced to a minimum.

Under any system of payment it is the ethics and social commitment of the doctor which matter most of all. Where standards are low in these respects no financial structure can induce doctors to be what they are not. But where standards are high, salaried payment best indicates to the public the ethical stance of the doctor as a servant of the public, as a priest of medicine." (S.74)

Chapter 6: The Pharmaceutical Industry

"The task of ascertaining the full facts about all medicines has proved a formidable task for the richest country in the world and is well beyond the resources of developing countries. This is a task which the World Health Organisation might undertake on behalf of member countries. It is an international responsibility to secure not only that there is a common drug nomenclature but that this nomenclature is the one which is actually used by all doctors throughout the world. The introduction therefore of generic prescribing is of international importance. W.H.O. should be invited and financed by member countries to play a much larger role in the regulation of the world pharmaceutical industry. The smaller and poorer countries of the world particularly need protection from the unethical marketing of dangerous or ineffective pharmaceuticals just as the whole world needs to police the trade in addictive drugs. Given technical guidance from W.H.O each country needs effective legislation which is properly enforced to ensure that as far as possible medicines are used only when they ought to be used, and to secure that the prices paid for them are reasonable. First, there needs to be restriction on what preparations are marketed. Second, regular inspection of manufacturers' premises and testing of products is required to ensure both safety and quality. Thirdly, written advertising matter needs to be strictly controlled. Fourthly, the use of company representatives should be forbidden and instead each country needs to develop extensive continuing education for doctors to keep them up-to-date with new pharmaceutical developments. Finally, the role of patenting and branding needs to be curtailed to stimulate greater price competition. Ideally the control of marketing and advertising should be international rather than national. What is paradoxical is for countries to license doctors and encourage professional standards and yet allow the doctors they have licensed to be exposed to such enormous commercial pressure." (S.97-98)

Chapter 10: Planning in More Developed Countries

"Thus it is artificial to draw hard and fast lines between health care and social care. Where social services are well developed problems which would present themselves as sickness problems in primary care may come to be seen as social problems and be taken to the social services. Some people clearly need health services, others only need social services, but many need both. Requirements may often shift radically on a day-to-day basis. Yet in many countries of the world the pattern of services and the financing of services — particularly health insurance — is based on three unstated assumptions. First that health institutions and social services can be clearly delineated. Second that preventive medicine can or should be separated from curative medicine. Third that cure rather than care is the overwhelming need of Western nations. There is an unwillingness to accept that for many the prospects of ecre are limited and with an aging population it is the quality of care and support which is the most important requirement for the majority of bed-bound patients, for the chronic sick and the disabled." (S.166)

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“Moreover the concept of social care does not fit happily with fee-for-service payment. Here the task of the physician is not to deliver procedures but deliver emotional support — to comfort the dying, to prepare women for widowhood, to teach people how to live with a disability, to accept the consequences of aging and to give comfort to distressed relatives. These were tasks which in an earlier age many people looked to the Church to provide, but now many expect these services from their doctor. Is the doctor paid under fee-for-service expected to provide these time-consuming services free and at the sacrifice of time which could be spent in services for which he could readily claim? **The fundamental question is whether it is the task of the physician simply to perform medical acts or to deliver comprehensive health care**.” (S.167)

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“Thus the supply of health services needs to be planned. It is not enough to attempt to regulate the demands for resources made by doctors after they have been made. Planning needs to extend not only over hospitals and facilities for primary care but over medical and other manpower to staff the services and over all the related facilities for social care.
The quality of planning depends upon the quality of information used for the planning and the skill of the planners. But this in turn depends partly on knowledge of what resources should be used for what purposes and on evaluation of the results. But the best-laid plans can fail to be fulfilled unless those working in the services want to make them work. **Thus ultimately what matters is not just the financial incentives operating on those working in health services, but their ethos and their commitment to serve not only individual patients but the health of the community as a whole.** This is not true only of doctors, dentists or of administrators and managers, but of nurses, social workers, and paramedical workers as well.

Value for money in health care will not be secured until health professionals see it as part of their responsibility to see that it is. This has major implications for the original education and continuing education of those working in health services. It also has major implications for the selection of those who are educated and trained and for those who provide that education and training.” (S.174/175)

Chapter 13: Conclusion

“**The principal healer, the doctor, emerged from the priestly role he played in a variety of different cultures, and still plays in many primitive societies today, to become torn between the ethical values of professional service and the commercial values of capitalist societies.** How far should he become a capitalist himself, owning his own hospital and diagnostic equipment, selling his own drugs? Should he himself market comprehensive health services — become the owner of a Health Maintenance Organization? This capitalist model is to be found in its most developed, though heavily price-regulated form in Japan. Something approaching it is to be found in parts of France, Latin America, the United States, and elsewhere. Or should he be a public servant operating in a government service, paid a salary like the school teacher, university professor or judge, cooperating with other professionals to serve his local community? The doctor‘s main worry about this latter role is how far it is possible to combine professional freedom with government service.“ (S.217)

(Florian Gerheuser)