Essays
in Healthcare

An Unusual Introduction

Klaus-Dirk Henke, Technische Universität Berlin,
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MetaForum – Innovation für mehr Gesundheit e.V.

About this publication

Klaus-Dirk Henke, Prof. emeritus of the Technical University of Berlin, has accompanied MetaForum for many years, almost decades. First as a member of the Scientific and Strategic Steering Committee (WSLK), then, after the initiative was transformed into the non-profit association "MetaForum - Innovation for Better Health", as its Chairman of the Board until 2020. Under his leadership, not only have numerous public events and publications of MetaForum been created (more on this at www.metaforum-innovation.de), but also various background and roundtable discussions have been held in order to provide our health care system with impulses according to MetaForum's conviction of "rethinking health". We hereby present an overview of Klaus-Dirk Henkes' thinking on health policy and, above all, health economics, as a thank-you for the many years of inspiring collaboration on his 80th birthday.

We are particularly pleased that we were able to win Christian Altschuh as the author of a foreword for this collection of essays. After all, Christian Altschuh is, in a sense, "to blame for everything": it was his idea to launch the "MetaForum" as an initiative of MSD Sharp & Dohme GmbH under the patronage of former Minister President Kurt Biedenkopf in 2009. And in this context, he not only brought Klaus-Dirk Henke on board from the very beginning, but also, at a very early stage, the signatories of this small introductory statement - whom he thus brought together to form a multifaceted collaboration that continues to this day. So it is to him that we owe our very personal thanks!

With this collection of essays, we hope to be able to give the esteemed readers a small insight into Klaus-Dirk Henke's world of ideas, which is closely related to the ideas of MetaForum, and wish you an insightful reading.

Köln / Vilafamés (Spanien) im August 2022

On behalf of MetaForum - Innovations for better health e.V.

Prof. Dr. Clarissa Kurscheid
Chairman of the Board

Dr. Albrecht Kloepfer
Managing Director

Foreword

Internationally, the German healthcare system has been regarded as efficient for decades, and healthcare provision as good. Especially in the Corona pandemic years since 2020, it has been able to demonstrate its quality.

Nevertheless, there is hardly anything so good that it could not be even better: German health care is considered expensive, and its effectiveness can be increased. The financing of social insurance on a pay-as-you-go basis is not crisis-proof, because it is susceptible to economic cycles through the wage linkage of contributions. Financing is not demographically stable because the number of contributions correlates with the number of employees subject to social insurance contributions. The allocation of financial resources to service providers is not always in line with demand and creates false incentives with regard to the services to be provided, while urgently needed areas such as (palliative) care or children's hospitals are chronically underfunded.
The system is increasingly suffering from a shortage of personnel, as working conditions and remuneration are increasingly competing with those in other sectors of the economy. The aging population poses further challenges for the health care system: chronic diseases with rising life expectancy, an increase in cases of dementia, little political support for prevention instead of cure, and ultimately too little health in all policies. In some cases, work on other areas has been slow for decades: in terms of digitization with electronic patient files, electronic prescriptions and vaccination cards, and health data for epidemiological and pharmaceutical research, Germany ranks among the lowest in the OECD. Data protection is sometimes seen as an end in itself or is used by interest groups as a powerful argument to prevent renewal.

These set screws are not new. Three citizens' conferences (so-called metaForums) were already held between 2007 and 2009. Around 200 representatives from many sectors of society (academia, sports, payers, health care professions, therapists, trade unions, associations for the disabled and self-help groups, the health care industry, the financial sector, etc.) discussed where there was a need for innovations for better health. The three-day events were chaired by the former Prime Minister of Saxony, Prof. Kurt Biedenkopf, and the discussion forums were moderated by, among others, the former Minister of Health, Andrea Fischer, the physician and social epidemiologist Prof. Friedrich-Wilhelm Schwartz (Hanover Medical School), the sociologist and political scientist Prof. Ilona Kickbusch (WHO and Yale University New Haven, CT, USA), the health economist Prof. Klaus-Dirk Henke (Technical University Berlin) and other proven system experts. The Fraunhofer Institute for Systems and Innovation Research (FhgISI) in Karlsruhe, Germany, as project partner, provided scientific support and evaluation. Other project partners of these metaForums were a large statutory health insurance company, a health insurance association, the Federal Association of German Industry, and two companies from the industrial health care sector. The results of these metaForums can be downloaded from the website www.metaforum-innovation.de. In 2010, the non-profit association MetaForum Innovation für mehr Gesundheit e.V. was constituted from the citizens' conferences project, which was completed in 2009. Its scientific advisory board included the professors mentioned above, as well as communication scientists and systems researchers from the FhgISI. The aim of the association was and is to provide impulses to politicians to improve health care in Germany and to ensure the sustainable existence of an efficient health care system. The association has continuously contributed to the health policy discussion with a large number of publications, parliamentary discussion rounds and federal press conferences.

The fields of action developed in the meta forums

- More active participation
- More investment in health instead of in disease care
- More transparency
- More focus on results as a measure of efficiency
- More sustainability
- More integration

- More subsidiarity and personal responsibility
- More benefits for the economy and society

can be assigned to the three dimensions of innovation, namely system, process and product innovation. Again and again, the fields of activity touch on the research area of health economics committed to people, as Prof. Henke has represented it for decades, one of the reasons for his appointment to the Council of Experts for Concerted Action in Health Care (1987-1998). This was also what prompted Prof. Henke to become actively involved in MetaForum from the very beginning. In many publications, he expresses what drives his decades of research:

- Patients should receive the best possible care.
- People should be able to live independently for as long as possible (e.g., Ambient Assisted Living).
- Service providers should be given the optimal framework conditions for their prrofessionalism to be able to offer their services for the benefit of patients without self-exploitation.
- Contributors should receive the optimal health benefits for their contributions.
- The industrial health care sector should be provided with the necessary framework conditions to be able to research innovations and bring them to the market, so that they benefit the economy and society equally.
- Society should achieve a so-called health dividend from good healthcare consisting of effective prevention and curative care.

Thus, after the conclusion of the citizens' conferences and from the founding of the MetaForum association, it was natural for him to put his research and expertise at the service of MetaForum. He has contributed to many of MetaForum's publications. In 15 "Essays on Health Care and Health Care of the Population: An Unusual Introduction," Prof. Henke addresses health policy and scientific issues in a concise and sophisticated manner. In each case, the focus is on a thesis that is examined argumentatively in the context of the question. The focus is on a critical examination of the respective topic through the development of one's own considerations and positions. The MetaForum publication aims to provide you, dear reader, with new food for thought for the health policy of today and tomorrow.

Dr. Christian Altschuh
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Klaus-Dirk Henke

Wall Street International Magazine
Essays on health care and population health care: an unusual introduction

The Genesis

The University for Peace established by the United Nations European Center for Peace and Development (ECPD) certified me as a lecturer in September 2014 and in November as a full Professor for the ECPD health programs on" Health Care: Process management, Financing and Purchasing".
During the years between 2014 and the beginning of the Covid-19-Pandemic in spring 2020 conferences took place in Montenegro. Serbia and Croatia. I attended these international and regional conferences regularly as a co-chairman and helped the ECPD in planning and organizing them. The major part of my work took place in form of lectures on the basis of the Power-Point Presentations 1-16 and 20. Only the contributions 17, 18 and 19 are already published in journals. The following topics belonged to my schedule and are now the background for my Essays in Healthcare.

1. Economic benefits of the healthcare sector, Brijuni 2014,
2. Improving value for money from a health economics perspective, Brijuni 2014,
3. From cost-based pricing to value-based purchasing, Brijuni 2015
4. Integrated Care: The Health Economy as a part of social and industrial policy, Milocer 2015,
5. Is permanent cost containment/cutting the right approach in health care?, Milocer 2016
6. Health care for migrants in Germany: a few remarks, Milocer 2016
7. The European Budget: Current status and the future, Milocer 2016
8. The role of competition in health care – The allocation of scarce resources in health - more questions than answers, Becici 2017,
9. „Is there a rational health policy? ", Becici 2017
10. The second health care market as part of the pharmaceutical sector? Opatija 2017
11. How to measure the benefits of the pharmaceutical industry – An empirical approach, Opatija 2017
12. Health Care in German hospitals between too much and too little (4 separate parts), Milocer 2018
13. Do we need governance in health care and, if so, what kind? – What are the driving forces in health care? – Opatija 2018,
14. Macroallocation of resources in healthcare: setting priorities and tools from an economist´s perspective, Opatija 2018
15. Financing and purchasing health care: Options and Solutions, Becici 2019,
16. Mobilizing resources to meet current and future fiscal sustainability of health systems, Becici 2019
17. Henke, Legler et al, Health Economy Reporting: A Case Review from Germany, International Journal of Business and Social Science Vol. 10 • No. 3 • March 2019 doi:10.30845/ijbss. v10n3p5
18. Von der Gesundheitsökonomie zur Gesundheitswirtschaft (from Health Economics to the Health Economy),2019, Perspektiven der Wirtschaftspolitik, PWP, Zeitschrift des Vereins für Socialpolitik, Band 20, Heft, S. 23-41
19. The effectiveness of the Health Economy: A case study of the Federal Republic of Germany (Position paper). SEEEJPH, posted: 21 January 2022. DOI:10.11576/seejph-5113
20. "Global Health" from a health economics perspective - developing and developed countries, 2020, EBS.

With this material as a background, I thought about publishing a book in this field of healthcare. The reader will recognize that I started more from a macro than from a micro perspective. "Financing and purchasing health care in Europa" is a topic and "Global Health: A new challenge" another example. The articles on "Healthy aging", the "Second Healthcare Market", "Voluntary Work in the

Healthcare Sector" and "Preventive Healthcare" document a more individual approach to health care.

The result of all these contributions is now available as a book and called "Essays in Healthcare". The scope of all articles is relatively small and comprises around 3 pages each. All of them were originally published on Wall Street International with the titles and subtitles shown in the contents of the book and are still available online. It is a text collection within health economics as a field of study and research at universities and universities of applied science and colleges. At the same time it is a kind of guide and practical help for lecturers and students, associations, social self-management and interested laymen.

As the Wall Street International Magazine is including in all its publications a picture related to the text, we kept it. It makes reading easier and more comfortable. In the contents you will find the original titles and subtitles of each article and the publication date. The individual articles are online under WSIM/Klaus-Dirk Henke together with a so-called gallery of pictures. www.wsimag.com

We decided together with the publisher to include a German version of all the articles. In this bilingual form it helps the reader and in particular the German students to better understand the original English and vice versa the English students to read the German translation.

The contents of the book will give the reader and lecturer on one page a first glance of what he may start to read and work with. Although there is a close connection between the different articles, you my switch between the topics in the two languages. As the articles have the character of essays, you may use them for your own research[1].

In case you have questions, remarks or would like to have more or other articles than the author has proposed do not hesitate to write the author.

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Berlin, April/May 2022

Only the first 2 pieces on the Corona Crisis in the EU are co-authored. Stefanie Ettelt (LSE) helped me to write about Coping with COVID-19 and Michael Broer (Ostfalia-University of Applied Sciences) co-authored on" Financing the Corona Crisis in the EU". At the end of their two essays, you will find their academic profiles.

[1] Thomas White: The essay is a written work intended to present an idea, make an argument, express a feeling, or provoke debate. It is a tool used to present the author's ideas in a non-fictional way. The many uses of this type of writing go far beyond that, ranging from political manifestos to art criticism to the author's personal observations and reflections.

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1. Coping with Covid-19?

Health care capacity in Germany

Published April 18, 2020

The government has called on retired nurses and doctors to return into service

In Germany, 2799 patients have died of Coronavirus to date and 123,016 have been tested as carrying the virus (Robert Koch Institut, n.d.). The low number of deaths relative to those confirmed as infected has led to much speculation about the reasons for this state, which, to be clear, is no more than a snapshot of a rapidly evolving situation. The number of fatalities will continue to rise dramatically over the coming days and weeks. Much will depend on preventative measures to take effect, and the additional demand on treatment capacity. Yet it is also hoped that the extensive capacity available in the German health care system will be able to buffer the impact of COVID-19.

Not known for its efficiency. The stereotype associated with Germany is the efficiency of its inhabitants and industries. The same stereotype is not typically applied to describe its health care system. There are two main reasons for this: decentralization and hospital capacity. Health system governance is decentralized to the point of fragmentation, with responsibilities for organizing care split between the federal government, state governments and municipalities. In addition, many governance decisions are taken by representatives of payers and providers (within the selfgoverning Bismarckian system), which also limits the scope for action for government. On top of that, both the funding and provision part of the system are purposefully pluralistic, with 100 statutory insurance funds in place, to name just one aspect.

In the case of the COVID-19 response, the 16 Länder (federal states) are responsible for public health decisions, leading to some states closing schools and kindergartens earlier than others (they are now all closed). While the federal minister for health, Jens Spahn, could facilitate the coordination of actions between states, he was not in the position to force them. However, by German federalist standards there has been remarkable central leadership in the fight again COVID-19. On 16 March, Chancellor Merkel, often criticized for her hesitant leadership style, took the unprecedented step to urge citizens to stay indoors and show solidarity with those vulnerable to infection (Die Bundeskanzlerin, 2020). She also explained the reasoning behind her government's actions and the economic and social costs of shutting down public life (another omission in previous crisis management). The federal government also launched an emergency funding programme for hospitals, which includes extra payments (of Euro 50.000) for each bed made available for the intensive care and artificial ventilation (Bundesministerium für Gesundheit, 2020).

Large number of hospitals and hospital beds.

Another efficiency concern is about hospitals and hospital beds (Wissenschaftlicher Beirat, 2018). Germany has a large number of hospital beds, by almost any standards. The Länder are responsible for planning and controlling hospital capacity, although many of them have used their authority to reduce capacity in the hospital sector only reluctantly. Total bed capacity stands at nearly 8 per 1000 population, compared to in 5.9 in France, 3.3 in the Netherlands and 2.5 in the UK (OECD data for 2018 or latest available).

Despite efforts to reduce hospital capacity (always hugely unpopular with citizens), there are still more than 1900 hospitals, of which about a third are in public, private and not-for- profit ownership respectively. The 35 university teaching hospitals, which run the largest intensive care units, are almost all state owned. But many hospitals are small by international standards, and some of them struggle to attract qualified professionals and to keep abreast of technological change. There have always been claims of under- funding, but funding levels have increased over time, reflecting several years of economic growth and statutory insurance surplus (counter-intuitively the Germany economy boomed in the years following the global financial crisis in 2008). Underfunding, where it exists, is nowhere near the experience of austerity shared by some of its European neighbors, although structural issues, such as those outlined above, continue to exist.

While the Länder are expected to maintain hospital infrastructure, hospitals make their own investment and purchasing decisions and have reputational and financial incentives to invest in technical equipment. This has resulted in substantial technical capacity. There are 28,000 intensive care beds routinely available and additional beds can be made available to in

crease capacity for COVID-19 patients. As of 1 April, about 1850 patients are treated in intensive care (Biermann et al., 2020). As in other countries, most hospitals are expected to postpone elective surgery to free up hospital beds. Many patients will have to wait for their planned surgery, but it will certainly reduce pressure on stretched resources.

Testing and tracing of COVID-19 infections.

There is also substantial capacity for diagnostic testing. It is estimated that 410.000 tests have been conducted to date (based on statutory insurance billing data) and capacity has been ramped up to provide up to 360.000 tests per week (Der Spiegel, 2020). The Society for Virology currently lists 54 laboratories offering SARS-CoV-2 PCR tests, of which 28 are labs in university hospitals, 22 are in private ownership and 4 are run by public health authorities (Gesellschaft für Virologie e.V., 2020). The Berlin based Charité, the largest teaching hospital in Europe, runs 600-700 PCR tests per day. But in addition to those large testing facilities there are a large number of privately-owned labs. The Association of Accredited Laboratories (ALM) reports that its member organizations (mostly privately owned labs and policlinics) have analyzed over 260,000 samples in the week following 16 March and over 400.000 since the beginning of March (Akkreditierte Labore in der Medizin e.V., 2020). It is difficult to develop a full picture of the German laboratory infrastructure, which is not well researched and, one suspects, less then highly regulated. Geographically, labs are unevenly distributed, with few of them located in the Eastern part of Germany; however, as long as capacity for testing is sufficient nobody seems to complain.

Testing for the Coronavirus is free at the point of use under both statutory and private health insurance. Until now, German policymakers have tried to encourage doctors to only test those who meet certain criteria, i.e., show symptoms of COVID-19 with a demonstrable risk of infection. This was to keep the worried well from clogging up the diagnostic supply chain. However, new guidelines published by the RKI on 25 March encourage a more lenient approach, by offering tests to everyone with symptoms, irrespective of severity, as long as there is sufficient testing capacity. The advice notes that medical personnel and vulnerable patients should be given priority if capacity reaches its limit, but the move suggests this is not a prime concern as yet. People are discouraged to pay privately for testing, although in principle, they are allowed to do so.

Doctors are required to report any positive COVID-19 testing result to the local health authority in their area. These electronically transmit these data to the RKI at least once a day, but it is acknowledged that it may take them 2-3 days to report their data in full (the statistics on the RKI website show that this sometimes takes even longer). This, in addition to staff shortages especially over the weekend, has led to delays in data reporting, which makes it difficult for the national institute to provide a precise daily account of the progression of the virus. While this may not be optimal, it is a huge improvement from the 2-3 weeks it took to alert the RKI to the outbreak of pathogenic e-coli in 2011 that claimed 53 lives (Schulte von Drach, 2011).

Despite the rising number of confirmed infections, efforts are still being made to track those who have been in contact with the infected person. To boost the capacity of overstretched local health authorities, the RKI has announced to recruit an additional 500 people as scouts for contact tracing, principally aimed at recruiting students. The combination of testing and tracing is also seen as an important part of any future exit strategy from the current ban on human contact in public life.

There is growing concern about the economic impact of the outbreak, with some predicting a decrease of up to 18% of GDP in the years to come (Lauer et al., 2020). Although measures to limit the spread of the virus are not as strict as in some other countries, people are encouraged to stay at home and to avoid any contact when they go outside. Gatherings are banned and exchanges limited to two people only unless they are members of the same household. German politicians are keen to emphasize that no curfew is exposed but a ban on contacts.

This week, the federal government announced a bundle of measures to protect the economy and reduce financial hardship on citizens (Die Bundesregierung, 2020). This includes easy access to loans, credit assistance to companies and the provision of short-time work subsidies, which mean that companies can keep their workforce while offering shorter work hours at full pay. There are separate provisions for freelancers, artists and the self-employed. Whether this will be enough to prevent a substantial economic downturn remains to be seen. Additional emergency provisions are made in many places and differ between the Länder.

Shortage of nursing staff.

Possibly the biggest challenge during the COVID-19 crisis will be the lack of nursing staff. Shortage of nursing personnel has been a long-standing concern in Germany and is partly the result of having a large number of small hospitals. Several attempts have been made to improve the pay and work conditions for nurses, and to hold hospitals to account for maintaining sufficient nursing capacity. Controversially, but not unlike other high-income countries, the German government has actively engaged in attracting nursing staff from other, often poorer, countries to fill the gaps. Some hospitals had high hopes to attract nurses returning from the UK following the Brexit referendum, but this has not happened in large enough numbers to make a material difference.

However, there is now widespread acknowledgement that this will not be sufficient to cover the need for nursing during the COVID-19 crisis, especially in critical care nursing. ICUs will need to find more qualified staff to care for the severely ill, which is perhaps the most limiting factor to expanding capacity. The government has called on retired nurses and doctors to return into service and there are regional initiatives to recruit medical students and other types of volunteers. Whether this will be sufficient to cope with the demand from COVID-19 remains to be seen.

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2. Financing the Corona Crisis in the EU

The Next Generation EU Recovery Package and the EU's Multiannual Financial Framework

Published February 18, 2021

European Commission President Ursula von der Leyen

At the special meeting of the European Council of July 17-21, 2020, the heads of state and governments of the European Union (EU) agreed in principle for all 27 member states on the "Next Generation EU" (NGEU) recovery package and the EU's Multiannual Financial Framework (MFF), which sets out the EU's revenues and expenditures for the years 2021 – 2027. The European Parliament and all the national parliaments adopted the bills on Dec. 17, 2020.

In the Official Journal of the European Union, L 433 I, Legislation, Volume 63, of 22 December 2020 you will find the international Agreement of 16 December 2020 between the European Parliament, the Council of the European Union and the European Commission:

- On budgetary discipline;
- on cooperation in budgetary matters;
- on sound financial management;
- on new own resources;
- including roadmap towards;
- the introduction of new own resources.

This is the legal background and a general regime of conditionality for the protection of the Union budget. This Regulation establishes the rules necessary for the protection of the Union

budget in the case of breaches of the principles of the rule of law in the Member States. This Regulation shall enter into force on the third day following that of its publication in the Official Journal of the European Union. It shall apply from 1 January 2021 (ibid).

Table 1: Next Generation EU

Programs	Amount in Billion Euros
Buildup and resilience	672.5
• Credits	360
• Grants	312.5
Other Grants	77.5
• React EU	47.5
• Horizon Europe	5
• Invest EU	5.6
• Rural development fund for a just transition	7.5
• Resc EU	10
	1.9
Total	750

Next Generation EU

To this end, the MFF will be linked to the recon- struction pact. The accordance

of the timing of the two decisions is a coincidence in that the old multi-annual financial framework had just expired in 2020 and the Corona crisis changed the world at the beginning of the same year. However, these decisions were intended not only to strengthen the traditional tasks of the EU after the Corona pandemic but at the same time to embark on new ways of financing the desirable ecological and digital transformation in the member states.

The EU budget 2021 to 2027 is endowed and continued with a volume of 1,074 billion euros. In addition to the traditional 2021-2027 multi-annual budget with its commitments there is the Corona Reconstruction Fund ("Next Generation EU") with a total volume of 750 billion (table 1).

The NGEU serves primarily to finance the damage caused by the Covid-19 pandemic. These funds are to be used for new tasks of the EU, especially in these fields of action: climate policy (the Green Deal), public security, asylum, medical care and the digital revolution. The reconstruction assistance is intended to repair the damage caused by the Corona crisis.

To this end, the EU Commission is authorized for the first time in history to raise funds on the capital and money markets on behalf of the EU. The 750 billion euros will be given in credits (360 Euro) and grants (table 1). The credit has to be payback by the end of 2058. Whether the means will come from increased membership dues (the contribution paid by the member states), a cut in future public spending (expenditures), or from new (quasi-tax) revenue sources is still on the agenda for the near future, i.e., 2021/2022. Of course, a mixture of these different approaches is also conceivable and likely.

More financial autonomy for the EU Commission

The new revenue autonomy does not include so far tax sovereignty. Until now, a plastic tax has been proposed, depending on the amount of non-recycled plastic waste. In addition, the experts in the EU Commission are discussing a CO2 boundary equalisation mechanism (see Kafsack 2020), a digital levy (from the beginning of 2023), a revision of the Emissions Trading System (ETS) and possibly its extension to air and sea transport with additional revenue for the EU budget, and a financial transaction tax whose usefulness can be discussed (Advisory Board to the German Federal Ministry of Finance, 2020).

In view of this background, it cannot be ruled out that, perhaps only temporarily, partial tax sovereignty will come into play to finance the EU's debts. However, a European tax would only be possible by amending the European treaties. The proposals under discussion may perhaps remain within the framework of the own resources system, so far, the major way of financing the EU on the basis of the GNP of the member states. Thus, an own tax sovereignty of the EU is not connected with it.

The reconstruction plans are to be reviewed in 2022 and adjusted if necessary. The grants are to be disbursed only if the targets and milestones are achieved. Repayment of the debt is to begin as early as 2021.

The use of funds

The EU commission uses the borrowed funds for expenditures foreseen under the "New Generation EU" reconstruction assistance. At the same time, this marks the beginning of the use of the grants given to the member countries. Among other things, this raises the questions of what for, for how long and under what conditions? Or even more concretely for the use of funds including grants and credits. The following questions arise (Kafsack, Mussler, 2020):

- How will aid from the reconstruction plan be distributed?
- What is the money from the reconstruction plan used for?
- How much money do states get?
- Are there conditions attached to the allocation of the money? How "green" is the fund?
- To what extent can other member states control the recipient countries' reform plans?
- Should the funds be conditional on compliance with EU rule of law standards?

- Should the EU get new direct sources of revenue?
- What about national contributions? Will there continue to be rebates?
- Will the 2021 to 2027 budget framework be modernized as originally envisaged?

The so-called "European Semester" could be used to examine whether the funds are spent wisely (Kafsack, Mussler, 2020 as well as Mussler, 2020). The semester approach was introduced in 2011 with the aim of not only issuing "country-specific recommendations" but also monitoring their compliance, e.g. by the European Court of Auditors. Thus, more conditionality is demanded.

Regardless of the specific answers to these many questions, the overarching problem is the final responsibility for these decisions, their implementation and monitoring (Wolff, 2020).

In the allocation of resources, outcome or program quality is often pitted against procedural or administrative efficiency. Procedural efficiency deserves spe- cial attention within the many institutions of the EU. Of course, the best possible outcome would be simultaneously a high program efficiency and very good management or administrative efficiency (Zimmermann, Henke, Broer, 2021, chapter 6). This requires ongoing monitoring and evaluation by the European Court of Auditors of the different allocation mechanisms used by the member countries. Given the size of the sums involved, it is a matter of providing the necessary transparency and ongoing scrutiny of how funds are raised on the capital markets and how they are used for the various tasks and expenditures by different institutions at the European and national levels. In this context the principle of subsidiarity should not be disregarded (Henke 2006).

Summary

The Covid-19-pandemic was the starting point for the analysis of the conventional EU-Budget and the supplementary reconstruction Pact (Next Generation EU). The financial autonomy for the EU Commission with debt and one day in the future perhaps taxation power are new steps in the direction of a European fiscal union (Broer, Henke, Zimmermann (2020).

It examines the extent to which more power for the EU can become a reality in various fields of action such as climate policy, public security, asylum, migration and medicine (European public goods). After all, the reconstruction program amounts to 750 billion. It is also necessary to examine for whom, for how long and under what conditions these funds may be used. Since the EU's credits do not have to be repaid until 2058, it is necessary to clarify, whether - in order to balance the longterm EU budgets - the necessary debt service payments will lead to spending cuts, more and more public debt, or perhaps even a tax for the EU.

Whether the fight of the corona crisis and the supplementary reconstruction Pact (next generation EU) will go together with strengthening the European Par- liament is an important additional open question. History will finally show us whether the international Agreement of 16 December 2020 between the European Parliament, the Council of the European Union and the European Commission will fulfill our expectations.

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3. Funding Healthcare from an Economist's Point of View

Fiscal Sustainability in Healthcare

Published May 17, 2021

The goal is to overcome the segmentation in health care and to work on an integrated medical care network

Experts have developed a comprehensive program designed to raise awareness and encourage the active use of health targets as an approach to health policy decision-making. Fiscal sustainability in health care is a topic often neglected not only in the academic environment of health targets but also in practical health policy.

Financing health care. What is needed from an economist's point of view is a sort of gold standard for funding health care, i.e. in financing and purchasing structures in health services. To many experts funding health care, it is a book with seven seals. This is why it could serve as a good example for an academic attempt to support the development and implementation of health targets by encouraging the efficient and appropriate use of scarce resources in health policy planning. Health target strategies, specifically in the areas of treatment options, outcomes research and drug interventions, should include answers in regard to financial gaps due to aging and due to medical progress and many other factors.

From my point of view, fiscal sustainability has a lot to do with long-term financing of health care through general revenue (i.e. taxes), payroll taxes (i.e. contributions by employers and employees), risk-oriented premiums, out-of-pocket-expenditures, co-payments, etc. In terms of a gold standard, large financing pools are necessary to avoid risk selection or in other words no risk selection, but risk adjustment is asked for.

Given a population-wide coverage with health services, tax-financing on the basis of the abilityto-pay-system is one approach and funding through social security on the basis of the benefit or insurance principle is the other way to finance health care. Within the second approach, a riskadjustment process is necessary and a prerequisite for fair competition.

In addition to the question whether a Beveridge - or a Bismarckian-System should be preferred there are a lot of academic work done on intergen- erational accounting (e.g., publications by the OECD) and the measurement of conflicts between generations in face of the demographic challenges. But politically not much has happened so far. Partially funded systems based on the idea of saving money for old age would balance risk management to the severe demographic challenges that are faced by many nations. New ways of funding health care are high on the agenda.

Purchasing health care services. Apart from these overall options of financing which are quite differently used throughout Europe and which de- scribe different ways of collecting money (external financing) purchasing of health services from hospitals and rehabilitation institutions, from office- based physicians and

purchasing of drugs, remedies, medical appliances and so forth is the second important aspect to be considered in the context of health care. It can be called internal financing, i.e., the reimbursement or payment of each health care service. In terms of a gold standard, all ser- vices should be delivered according to medical guidelines, best practices and in regard to outcome measures. The reimbursement systems should be less revenue-oriented but more outcome-driven and not reimburse on a fee-for- service basis.

Network budgeting. In many countries, the overall goal is to overcome the segmentation in health care and to work on an integrated and quality- assured medical care network. To achieve this target a functional approach to health care is indispensable for necessary reforms. For an integrated care de- livery system new forms of selective contracting between providers of health services and sickness funds are needed. The provision of medical treatment and nursing care, including rehabilitation, systematically belongs together and should be covered through joint remuneration by way of network budget- ing and new kinds of fee-per-case payments. Comprehensive all-round care is the new subject of financing. In the figure shown below health care for elderly patients is taken as an example of the desired integration of health service providers. So far, no golden rule for purchasing all these services can be seen, so that probably more competition is the answer to this problem.

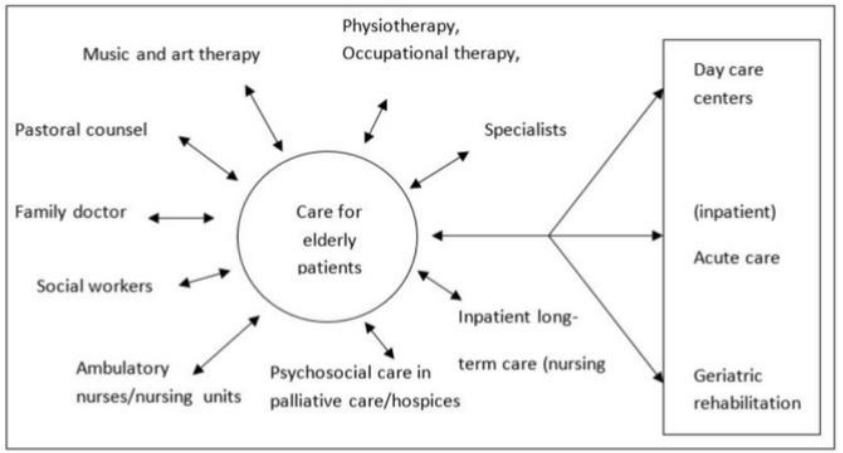


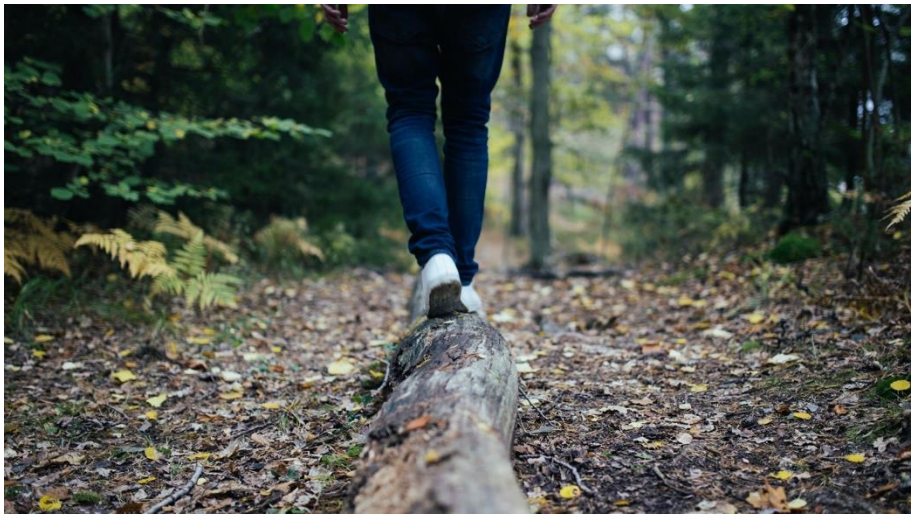
Figure 1: Integration of health service providers in health care of the elderly

Integration of health service providers in health care of the elderly. To propose such a network is much easier than to accomplish it. Pricing, purchasing (e.g. through DRGs, reference prices, or on the basis of a fee sched- ule), expenditures, and financing (taxes, contributions, premiums etc.) of health services represent a highly complex picture for all the participants. It raises more questions than answers and hopefully, a socially bounded com- petition may help to further develop the institutional details in providing, funding and purchasing required health care not only for the elderly but for the entire population.

4. Is A Rational Health Policy Possible?

A Functional Approach

Published June 18, 2021



Nobody knows how much a society should spend on health care

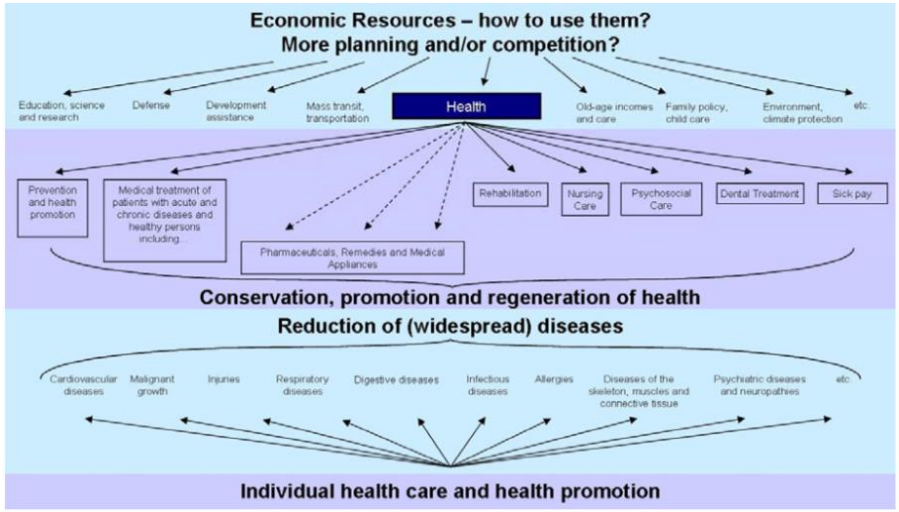
The functional or professional rationality as exemplified in health Targets and a legal framework is often at odds with the political rationality – the result being piecemeal social engineering (Popper) or muddling through with a step-by-step approach to economic policy (Lindblom, Tinbergen). A functional approach is to be seen in chart 1. It shows the allocation of resources in health care from a macroeconomic perspective top-down and a microeconomic perspective bottom-up.

The functional rationality or the optimal allocation of scarce re- sources. The objective of the use of scarce resources is either to conserve, promote or regenerate health as to be seen in the upper part of the chart. The lower part deals with the reduction of (widespread) diseases including 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, e.g. cardiovascular diseases, injuries or malignant growth.

There are always trade-offs between health care spending and alternatives such as education, science and research, defense, development assistance, mass transit and transportation, environment, climate protection, old-age incomes and care, or family policy and child care. Often these alternatives have themselves a strong influence on the health status of the population, e.g., education. Thus, from an epidemiological point of view, avoidable morbidity and avoidable mortality are the ultimate goals and health care is one of the major instruments.

Within the health sector in chart 1 starts on the left side with prevention and health promotion, medical treatment of patients with acute and chronic diseases and healthy persons. Included are 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 respectively 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 or per person. 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 scientifically: The expenditure flows are to be reallocated as long as 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 (See in more detail Porter, M. E., Teisberg, E.O., Redefining Health Care – Creating Value- Based Competition on Results, Boston 2006, 397411).



Source: Henke (2014)

Allocation decisions have to be made either by parliament, self-governing bodies, through market mechanisms or through a combination of the three of them on different levels. In an ideal world, a functional approach starts on the basis of the legal background with clear targets for health improvements, with process and system targets. Then, the next step would be the devel- opment of strategies for the implementation of these targets on a national, 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. Thus the ques- tion 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 cen- tral planning, self-Government 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 the 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 and in real life only in a step-by-step approach that in many countries includes more and more monitoring and evaluation procedures.

Finally, management resp. administrative efficiency is part of the spe- cific program efficiency in the sector dealt with. In this context, more and more actors recognize that networks are superior compared to hierarchies or silos. (Henke, K.-D. “How to improve the rationality of health policy”, in: Kaal, W.A., Schmidt, M und A. Schwartze, Hrsg., Festschrift zu Ehren von Christian Kirchner, Tübingen 2014, S.837-848).

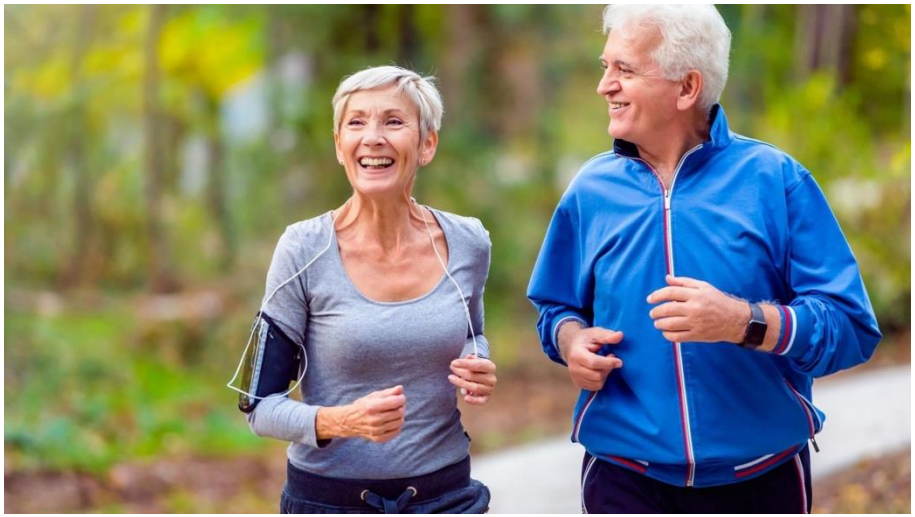
The political rationality or health policy as the art of feasibility.

Health policy as a one-stop, unified whole is the dream of scientists, but hardly viable in a parliamentary democracy with proportional representa- tion. Translating Herbert Giersch’s definition of rational economic policy to healthcare reforms, rational health policy would have to be “aimed system- atically at the realisation of a target system which is comprehensive, sophis- ticated and well-balanced”, as well as “achieving the highest possible degree of success in the given circumstances”. (Giersch, H., Allgemeine Wirtschaft- spolitik, Wiesbaden 1961, p. 22). 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, “piecemeal social 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”. Thus, again Popper, Giersch and Williamson have given the answer to the question of this article.

5. Healthy Aging

The Effectiveness of the Health Economy

Published July 18, 2021



Healthy aging increases the productivity of the population

Normally, the population associates the health care system with the provision of medical care and health care for patients. Stereotypically, this image includes excessively high costs and the need to curb them. Completely dis- regarded is the fact that the health care system is not only a cost factor but also a growth industry.

Its economic importance is impressively demonstrated by its contribution to employment, value-added and exports. 16.9% of the labor market, 11.9% of gross value added and 7.3% of exports in the overall economy in 2017 are already impressive figures that other industries do not have.

The German Federal Ministry for Economic Affairs and Energy regularly publishes facts and figures on the core and extended sectors of the healthcare industry and the associated collectively and individually financed healthcare services. These reliable data are available not only nationally but also at the regional level down to the individual county. For example, it can be seen that the health economy in Mecklenburg-Western Pomerania and in Schleswig-Holstein makes a particular contribution to regional employment and gross value added, while in southern Germany the industrial locations of the health economy are in the foreground.

The economic importance of health care is also reinforced by the fact that healthy aging increases the productivity of the population and triggers a growing demand for services and goods. It can be seen that healthcare is not only a cost factor, but also an economic sector that makes a stable long- term contribution to the national product and, above all, to employment, alongside tourism, the education sector, the energy industry, and the auto- motive industry. The described economic footprint is further strengthened by the fact that this economic sector stabilizes the national economic power due to the low input ratio. Finally, it can be shown that the industry grows one percent faster over time than the German economy as a whole.

Despite the regular and systematic statistical coverage of the health economy by the German Federal Ministry for Economic Affairs and Energy and the economic research institute WifOR, there are additional aspects that re- quire further investigation. For example, the question arises as to whether savings are also generated by a healthier society. However, there are hardly any reliable calculations on this assumption. There is a lack of meaning-ful medical results. This requires calculations for specific disease patterns, for different population groups and, if possible, differentiated by region. A frequent question, therefore, relates to the health benefit, somewhat superficially also referred to as the “health dividend” of the health care system. In Germany, we have taken a major step forward with institutionalized benefit measurement through the German Medicines Market Reorganization Act (GMMRA) and the associated Institutes for Quality Assurance, Efficiency and Evaluation of Medical Interventions.

Nevertheless, there are increasing complaints about the associated increase in bureaucracy in self- administration and thus in the healthcare system. Increasing transparency seems to be increasing bureaucratization even more. It is actually a pity that competition hardly plays a role in this context.

The health insurance funds mainly manage themselves, and the Social Code (SGB V) does not allow them to organize health care in an entrepreneurial way. The health benefits of the health economy are not equally apparent as is the case with calculations of value-added, employment and exports based on standardized national accounts. On the way to more transparency, comprehensibility and an evaluation of the benefits of the health care industry, attention should therefore be drawn to only a few selected and easily comprehensible ways as examples.

New tasks include suitability for everyday life and the elderly as a care goal that is gaining in importance. The health economy includes medical devices and prosthetics, combined with sports and fitness equipment, weight and blood pressure measurement, home emergency call systems and the measurement of irregular body states (digital health). In these more medical- technical areas, given their economic benefits here and there, they can even be expected to be self-financing.

Another path is more strongly oriented toward individual physical functioning in the field of ophthalmology, using the example of extremely successful cataract operations. The healthcare industry contributes a great deal to a better quality of life in this area. Accidents in the home, in sports or in traffic, completely different segments, can also be isolated in the context of the health economy and analyzed in terms of their health benefits. Often over- looked is the fact that these small-seeming sectors include a huge number of medium-sized companies that have turned healthcare into an industry. More than 45 million people wearing spectacles and more than 800,000 cataract operations also have to be managed in a technical sense, even if the focus is on vision, hearing or mobility for the individual.

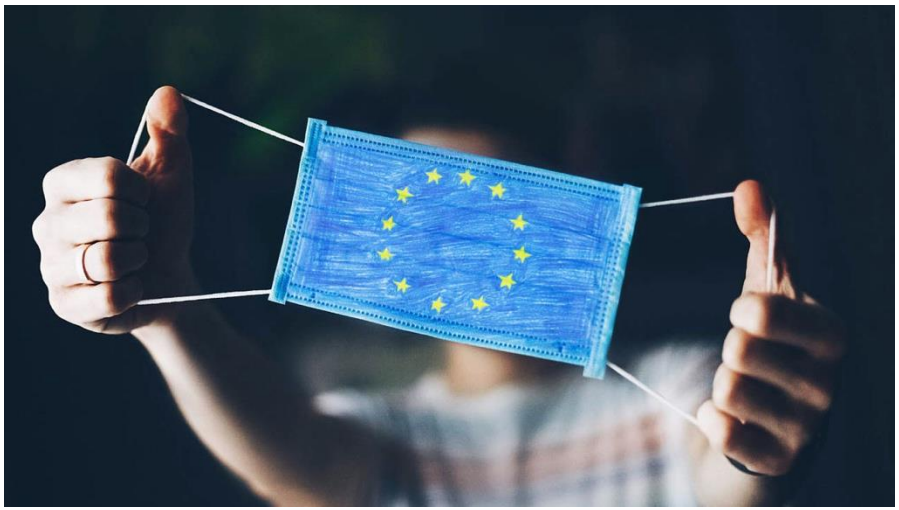
Assisted living and age-appropriate assistive technologies also contribute to better health or everyday fitness in the familiar and neighborhood environment. Accessible health is not just a buzzword but a prerequisite for open access to healthcare services. In the case of chronic illnesses, the focus is on new technologies that are often initially paid for individually before they come into widespread use as standard services. In the case of interventions that can be scheduled, special clinics with their particularly sophisticated medical equipment play a special role. Last but not least, reference should be made to medical services and aids, medications and the rapid medical- technical progress in general and especially in university hospitals. Here, too, the public rarely perceives the healthcare system as a sui generis branch of industry; yet the healthcare industry is an indispensable prerequisite for the provision of healthcare to the population.

The benefits of the above-mentioned and other treatments result from the products and services of the health economy, which must be available millions of times in terms of type and scope. Thus, the health care of the population and its health assistance belong inseparably together with the health economy. Supporting everyday competence combined with the skills and abilities of older people, i.e., successful aging, remains an ongoing challenge in aging societies. New ways in the health economy contribute significantly to this and are still underestimated in their importance for the health care of the aging population.

6. The Corona Reconstruction Fund

Raising of Funds, Use of Funds, Repayment

Published August 18, 2021



The NGEU is the basis for financing the damage caused by the Covid-19

The Coronavirus pandemic plunged Europe into the deepest economic and social crisis in decades. The EU responded to the crisis quickly and vigorously with far-reaching measures. The Recovery and Resilience Facility is the central instrument of the temporary European recovery program.

The necessary fund will not be raised through the traditional revenues of the 27 EU countries. The relatively small European budget is currently financed through a small number of customs duties and mainly by contributions of the member states. They are calculated on the basis of the value-added tax (VAT) and Gross National Income (GNI) and amount to a little more than 1% of the total European national income. Thus, in regard to a continent with a population of some 447 million people, it is very small considering the situation of the member countries like France, Sweden, Germany or the Netherlands with a share between 35 to 55%.

The new EU budget 2021 to 2027 is endowed and continued with a volume of 1,074 billion euros. In addition to this traditional multi-annual budget (7 years) with its commitments, there is the Corona Reconstruction Fund (Next Generation EU) with a total volume of 750 billion. The NGEU is the basis for financing the damage caused by the Covid-19. This huge amount (4 years) goes into different fields of action, as e.g. climate change with The Green Deal (Wissenschaftlicher Beirat beim Bundesministerium der Finanzen, 2021), asylum and migration, medical care, digital revolution and public security. In the center stands the repair of the damage caused by the Corona crisis.

Starting in 2021 the European Reconstruction Fund will be financed through debt from the money and capital markets. The debt sovereignty of the EU, organized through the European Commission, is a historical event and changes the Financing structure of the EU in the future considerably. For the first time in history the EU commission is authorized to raise funds on the worldwide capital market on behalf on the EU. Some experts regard the EU therefore no longer as a confederation but more as a new fiscal union. However, the length of this new situation is limited. But some groups wish an unlimited solution in the future. And as the end is at present limited at 2058 there is a lot of time for potential political changes. The topic will therefore stay on the academic and political agenda in the years to come.

The funds available through the sale of the EU bonds (2021-2026) will be invested in the first step via credits (loans) and via lost grants in the 27 EU countries with almost the same sum. The legal basis is the Next Generation EU Funding plan for the period June-December 2021 on the ground of the Recovery and Resilience Plans in the member states. In this second step, the available funds will be used in the individual member states according to the criteria of the EU Commission and the individual countries. Among other things, the use of funds raises the questions of what for, for how long and under what conditions.

Effectiveness and efficiency are in the foreground of the review by the European Court of Auditors, the European Semester and other forms of conditionality (e.g. rule of law). Peer reviews will be necessary to judge the quality of all the work accomplished in the different fields and countries by independent judges. The allocation of resources, outcome and program quality is a difficult task. But ongoing monitoring and evaluation is an indispensable prerequisite. In this context, the principle of subsidiarity should not be disregarded.

Repayment (amortization) as the third step starts in 2028 and will be finished by 2058. There are different alternatives to repay all loans in time. One or several approaches at the time are available:

- an expansionary fiscal policy (Keynesian economics) stays in the center
- higher membership fees and cuts in expenditures are always possible
- new debt is expected in context with the first alternative and finally
- European taxes could be introduced as proposed in the special meeting of the European Council of July 17-21, 2020. (e. g. on plastic waste, a digital levy or a financial transaction tax (Wissenschaftlicher Beirat beim Bundesministerium der Finanzen, 2020)).

Given this background, many experts see the EU with debt (and tax) sovereignty on the way to a federal state and no longer as a mere confederation. In be- tween these two legal frameworks, there is perhaps room for the fiscal union mentioned earlier. Therefore, many economists see the EU on its way to a Liability and Transfer Union. Obligatory financing of lost grants through the EU budget and joint liability in case of non-payment of loans from single countries are the major arguments. Perhaps monitoring and control of EU finances by the EU Commission and the European Court of Auditors could help to keep the liability small. Finely a lot depends on the political decision about the length of time of the fiscal capacity: Will it be a permanent one or stay as a fixed period of time.

Result

new EU tasks and financing channels are the features of the EU future.

- European-wide tasks: pandemic control, climate change, digitalization, asylum and migration policy, security/defense policy with new responsibilities, human rights, cybersecurity and geopolitical objectives.
- New ways of financing (fiscal union) with temporary debt sovereignty, a budget right for the European Parliament and tax sovereignty in the very long run?
- European-wide cooperation in civil protection, know-how transfer in organizational questions, in tourism, through better cooperation of po- lice, customs, tax authorities, universities, in traffic, in the media, in sports, etc. that can be perceived by European citizens.
- Decisions with a qualified majority (restriction of the right of veto by majority decisions) should be made possible.

Appendix

The EU: what it is, what it does:

History in short:

1. Start EEC (1958) with Belgium, Germany, France, Italy, Luxembourg and the Netherland.
2. 2020 Withdrawal of the United Kingdom.
3. Status EU (2021): 27 European states, total population: 447 million.
4. EU activities in 35 policy areas.
5. Free movement of people, services, goods and capital.
6. 2012 Nobel Peace Prize for peace, democracy, reconciliation and human rights.
7. Monetary union, common monetary policy, and national fiscal policy (The European Union, 2021).

New territory for the EU in the face of a global pandemic:

- approval of vaccines for Europe, patents, licenses;
- ordering the vaccines;
- payment/subsidization of production costs;
- vaccination strategies, requirements for testing, vaccination cards, etc.

Europe-wide public spending:

- CO2 emissions from coal, oil, gas (at 85%) vs. wind, solar, hydro, nuclear, geo-thermal and bioheat (at 15%), climate change;
- asylum and migration policy, human rights;
- geopolitical goals, foreign policy;
- cybersecurity, defense (Schrötter, Europe, 2020).

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7. Health Governance: Hype or Help?

A Look at What Determines Good Governance in Healthcare

Published September 18, 2021

Does good governance lead to better health outcomes?

There are many forces driving and governing health care, such as patients, healthcare service providers, insurance systems, as well as the parliament with its forms of regional, local and corporate governance. Social media is an important tool of these driving forces, which enables users to network on the Internet (e.g., TV, Press, interest groups, consulting offices and unions); while sustainable governance helps a company to implement strategies, man- age goal-setting and reporting processes, strengthen relations with external partners, and ensure overall accountability. Finally, leadership and stewardship serve as alternative steering systems in this sector. Bad governance (inefficiency, red tape, maladministration, corruption and secrecy) and good governance (rule of law, transparency, accountability and sustainability) are all part of this picture.

Do all these forces build the foundation for health governance together with competition, the market and central planning with all its bureaucracy? Is Governance - including fiscal, self, economic, medical and political governance with all its issues and elements - everywhere?

What is hype? Hype governance is used everywhere and for many purposes. The term health governance is therefore not needed because it can mean what you want it to mean. It is a form of advertising that is very unusually aggressive or spectacular. Everyone talks about health governance but nobody really knows how to use it. Concerted action is, therefore, in- dispensable for an accessible understanding of health governance from an entrepreneurial and policy perspective.

The so-called Gartner hype-cycle shows invention, unrealistic expectations, a valley of disappointment, realistic pathways and finally a level of productivity of new technology. It claims to provide a graphical and conceptual presentation of the maturity of emerging new goods and services through all these phases. But it is hardly applicable in healthcare.

Governance in healthcare. The premise that good governance will ultimately lead to better health outcomes has been central to the proliferation of work in this area over the past decade. Health coaching to improve healthy lifestyle behaviors is part of this approach. Kickbusch/Gleicher, 2018, define health governance as actions and means a society adopts to organize itself for promoting and protecting the health of its population. But there are so far no specific prescriptions for these actions and means. For e.g., there are no explicit health expenditure quotas, optimal forms and structures of financing or optimal numbers of fiscal agents in healthcare.

Within the allocation of resources in healthcare, the explanatory value of governance differs significantly in different European health systems, regard- less of whether they are funded by taxes (Beveridge) or within a social security system (Bismarck). According to the WHO these challenges to health policy

include a lot more, such as those listed below:

- Ensuring equitable access to health care services
- Emphasizing the importance of empowering citizens and patients
- Using resources efficiently by such means as health technology assessment
- Monitoring and evaluation
- Aligning research objectives and policy needs
- Interconnecting primary and specialized care and
- Training human resources, which includes strengthening the role of universities

All these issues could have something to do with the notion of health governance. But they do not give an answer to the question, what is governance for health? Is there a take home message?

Result. The term governance is not needed because it can mean what an individual author wants it to mean, and not only in health care. It is arbitrary so that the explanatory value of governance differs far too much within the sectors and issues in health care. Perhaps, at least the above-mentioned definition by Kickbusch may help in some cases.

What is it that remains?

- The driving forces which govern the healthcare system. These are of great importance, particularly social media and the interest groups.
- Influencing individual lifestyles and behavior as a possible part of good governance in healthcare.
- Health and patient coaching in a local environment, such as a region or a particular town, for a specific population group and/or for a certain disease.

To sum up, path dependencies, stop and go interventions and social piecemeal engineering will remain in the foreground.

8. Financing and Purchasing Healthcare in Europe

The Complexities of External Versus Internal Finance

Published October 21, 2021

Does good governance lead to better health outcomes?

All that is needed for external financing of health care is a budget. Tax- financed health care systems are financed from general revenue, mainly taxes and public debt. The revenue (absolute amount or percentage) for health care systems stems from earmarked taxation or from a budget financed by the global "household."

The health budget within the global public "household" is transferred to regions on the basis of political decisions. These regions, e.g., in the UK, are using the received money to finance the provision respectively to the providers of services according to certain rules, fee and time schedules. Finally, the providers use the money to purchase the services for the patients including equipment and labor (salaries and wages).

In payroll tax-financed health care systems the revenue stems mainly from the contributions which are collected from the employers and employees. The tax base consists of mainly wages and salaries. The money is paid according to the payroll-tax rate, e.g., 14%, depending on the different insurances. The contribution rate depends on the economic situation of a country, because the tax base fluctuates. Thus, the difference in fiscal sustainability between the payroll tax-financed system and the purely tax-financed system depends on both economic and political factors.

Risk-oriented premiums, for example in Germany and Spain, are rare. Many of these systems are capital-funded and not on a pay-as-you-go basis. Risk oriented insurances depend mainly on age, sex and health status etc.

The last part of external financing of health care refers to private pay- ments, respective of consumption. The major examples are co-payments for drugs, i.e., over the counter products and services. It is the second health care market, with individual out of pocket expenditures for wellness, healthy food and such.

External financing of health care and internal purchasing of health ser- vices lead to many different segments. Paying the providers occurs:

1. in hospitals, e.g., diagnosis related groups;
2. at the office-based doctor;
3. at the dentists;
4. in pharmacies;
5. for remedies, such as physiotherapy;
6. for eyeglasses and hearing aids;
7. for accident rescue;
8. for patient transport;

9. in nursing homes;
10. in rehabilitation facilities;
11. out-patient treatment in medical and nursing care.

In total, a question may arise as to whether the many internal financing systems seem easier to clarify than the external system with its complexity. In between external and internal financing, we need fiscal agents, or funds, on the basis of which the money will be distributed to providers. For this purpose, institutions or agents are required, to collect the money and to allocate it according to a given legal framework to those who provide the health services. These processes between financing and purchasing health care are highly complex and are handled differently amongst the European nations.

How many fiscal agents and budgets are necessary for a sustainable system? Should hospital financing, health expenditures, long term nursing, rehabilitation centers and pension funds be in one hand? Do we need more competition as a prerequisite for better health care?

Perhaps network-budgeting with more cooperation between the providers is the answer. A newly founded management company in a certain legal framework develops the network for more coordination between the different sectors and services. Financing and purchasing health care will be increasingly in one hand. Thus, network budgeting is no longer a dream but (at least) a direction and a new approach for further projects, in the center of which are the patients with their needs.

To summarize, the options and solutions for financing and purchasing healthcare are:

- external financing: tax-financed budget for health care;
- internal financing: paying the providers (from earmarked payroll tax-
- financed, premium-financed, co-payments or private consumption);
- fiscal agents in between external and internal financing;
- network budgeting, as a solution for the future.

9. Global Health: A New Challenge

A Path to Advancement in the Worldwide Health

Published November 18, 2021

Global health is high on the medical, economic and political agenda worldwide especially since the outbreak of COVID-19

Lately, since COVID-19, 'global health' is high on the medical, economic and political agenda worldwide. It will probably stay there for a long period of time and strengthen the further development of a European Health Union. Thus, global health will be an additional topic for the EU. Many terms have been assigned to precede definitions for global health. The different characteristics stem from the perspectives of who is using the term. Is it health as the classic definition by the WHO (1946), is it public health, international health, planetary health, one health or is it global health in a new setting de- fined by the World Health Summit in 2017? Health was seen by this summit as a political choice and strategy, defined by six key areas of global health with a commitment to:

1. Strong and reliable Governance.
2. Ensure global health security.
3. Healthy and resilient cities.
4. Responsible approaches to big data.
5. Research, innovation and development.
6. Innovation and health systems strengthening in Africa.

The epidemiological background is well known and presented in many statis- tics about the morbidity and mortality in the poorest countries of the world (Sierra Leone, Niger, Mali, Burundi to name only a few). Life expectancy and the literacy rate are indescribably low, whilst the spread of diseases is very high (e.g. malaria, tuberculosis, cholera or hepatitis). In addition to the so-called poverty-privileged diseases there are many neglected diseases (NTDs) such as ebola, coronvirus and other pandemics. Finally, there are the many infectious diseases, for example those of the respiratory tract.

Given this initial situation, there are countless essential health services in poor countries to improve the status quo. Indispensable in most of these countries are: basic medical care, clean water, electricity, toilets, contraceptives, training (especially of the mother and midwife), nurses, school education, immunization, vaccination programs, school education, medication, preventive measures and ready-made food health coverage. (See in more detail Hans Rosling et al., Factfulness, 4th edition 2019.)

One may be ashamed of all this data given the health status and the health services in the western world, with its many superfluous amenities. Even small amounts of health expenditures in the industrialized nations would help thousands of people to survive in poorer countries. Nevertheless, the industrialized countries do a lot to help improve the global health of the world population. To a selected list of institutions which support the less developed part of the world belong: Development aid from the richer countries, WHO and the World Bank, UNICEF, G7, G20, the Bill Gates Foundation, churches (Bread for the World, Misereor), Médecins Sans Frontières, the World Food Program, World Health Summit, global alliance for vaccines and immunization Gavi, Official Development Assistance (ODA) and Access to Medicine Foundation.

As we do not have a world government, we go continent by continent and country by country; in particular with the help of the WHO, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. A long list of the different projects for poor countries is available through 'Global Health – An investment in the Future' by the German Ministry of Development Aid (BMZ) 02/2019.

Global health is not plagued by a lack of funds. Following the judgement of the active actors in these programs, a better coordination of their activities would be helpful. As the funds differ between countries and diseases, their allocation is always up for discussion. The money spent often does not confer with a positive outcome.

Apart from the worldwide attempts, there are nations and regions with more decentralized approaches. One of them is the European Union with its 27 member states, organized with a lot of effort through the EU-Commission. The EU4Health 2021 - 2027 – a vision for a healthier European Union – stems from the European Commission, and is described in detail on the official EU website dated 12th March 2021. Together with the recovery spending (next generation EU) the EU may now start making funds available under the Recovery and Resilience Facility. This is the major EU instrument for Economic Recovery from the COVID-19 pandemic.

Last but not least, the growing population on our planet must be fed in a fair and sustainable manner as the World Food Convention 2021 is describing:

Producing enough food causes new, different problems which harm the climate. On top of that, the COVID-19 pandemic endangers the security of food production and the stability of supply chains, threatening food safety.

Thus, climate change will cause the situation to deteriorate, especially in poor countries, even though they did not contribute to the crisis.

10. Voluntary Work in the Healthcare Sector

The Key to Social and Healthcare Integration with Immeasurable Benefits to Society

Published December 18, 2021

Volunteering is a satisfying and fulfilling activity in healthcare and other sectors of the community

Voluntary activities are broadly based. They can be used in the context of associations, initiatives or charitable institutions and may range according to Wikipedia from rescuing shipwrecked people to telephone pastoral care. It is a voluntary unpaid activity. Volunteering is not only a satisfying but a fulfilling activity in many different fields of life. It is involved in civic activities, takes on tasks, responsibility and practical activities in the interest of the common good and recognized idealistic purposes. Such an activity does not establish an employment relationship in the legal sense. The scope differs from country to country and by type.

Usually, the statistical offices of the individual countries inform about the statistical situation of the voluntary work. Statista, the German federal statistical office, publishes regularly these figures. The number of people in Germany who work on a voluntary basis is between 2017 and 2021 according to this office between 14.9 and 16.2 people in millions. (More figures at kundenservice@statista.com).

Volunteering in health care facilities is rewarding for many reasons. It helps to make regular contact with others, which is improving the well- being. It is keeping the participants mentally and physically active and often support additionally the state of mind of the medical volunteer as well.

For **health care students** volunteering is also a great way to learn new skills, gain hands-on experience, and explore ways to turn your passion for helping people into a successful career. Volunteering in Healthcare makes a difference (www.edumed.org/resources/volunteering-in-health care/). In addition, volunteering is improving the local and rural community which has often limited access to medical treatment. Furthermore, it will enact positive change by meeting people from all areas of life. Students will often volunteer in local hospitals with minimal resources. This will be not only challenging but also rewarding at the same time. In a hospital you may acquire new skills, built up an innovative network and improve your mental health in this process as well.

Another perspective of voluntary work in the health care sector is given through **medical volunteer abroad** (www.volunteerworld.com/en/volunte- er-abroad/healthcare), in particular within the National Health Service. Ambulance Trusts in the United Kingdom, e.g., have a wide field of volunteer work. It ranges from providing patient transport to being a community responder who supports and reassures patients while an ambulance is on the way (www.england.nhs.uk/get-involved/volunteering).
Last but not least there is a lot of **volunteer work** possible **in developing countries**.

Assist local doctors and nurses with treating those who need it most. Premed, medical college or high school students, there are programs available for every level of medical training or experience (Medical Volunteer Abroad/Healthcare Programs 2021).

Medical volunteer programs in a foreign country offer a very good opportunity to experience the different health care systems. It includes the industry in a developing country in comparison with the more developed industrial world (in more detail Henke on "Global Health" in WSIM on November 18th).

Volunteering in public health is another topic (https://www.publiche-alth.org/volunteering). In this context the social impact plays a major role in strengthening our society by acting as a bridge between socioeconomic divides. On a local level the organization you become a part of is likely to collaborate in social networks with other volunteer organisations and local governments, providing health care services. The "Johanniter" ("Johanniter- Unfall-Hilfe e.V.") and the "Malteser" ("Malteser Hilfsdienst e.V.") are voluntary aid societies working in this context already for centuries. They are authorized to render assistance to the regular medical services in the different sectors of health care.

Creating a **Global Culture of Volunteering** (https://www.pointsof- light.org) is another approach to voluntary working. A report by the Points of Light Institute states that if volunteers were paid for the services they freely offer, the wages would amount to between $113 billion and $161 billion a year. Thus, the economic impact of voluntary work as a third sector between the market and the public sector is substantial.

Figures for the health care sector are also available on a national and a regional basis. https://www.nationmaster.com/nmx/sector/healthcare.

"Providing **nursing care for elderly** clients should not only be isolated to one field but is best given through a collaborative effort which includes their family, community, and other health care team. Through this, nurses may be able to use the expertise and resources of each team to improve and maintain the quality of life of the elderly" (Geriatric Nursing Care Plans: 11 Nursing Diagnosis for the Elderly nurseslabs.com/geriatric-nursing-care- plans/).

Experts argue that "the voluntary sector is key to health and social care integration, not an optional extra". With the demographic challenges in the near future there is a growing demand not only for voluntary work in the health care sector but also for voluntary activities broadly based in all areas of life.

11. The Second Healthcare Market

What Will Be the Fiscal Impact of Technical and Social Developments in the Health Sector?

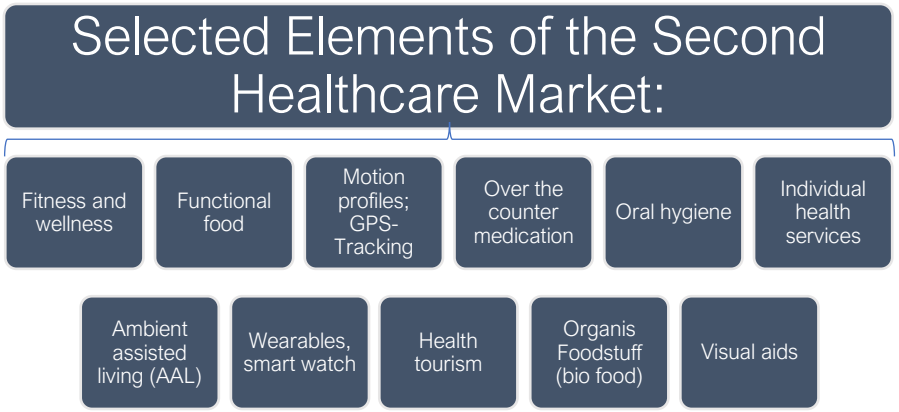
Published January 18, 2022

The second healthcare market will be a growing part of the total health economy

The extended health sector is often the pioneer for new health care goods and services. These innovative types of health care are not previously classified in official statistics as belonging to the health sector. The second healthcare market will be a growing part of the total health economy. Thus, there is a core health economy financed through pooled public and private funds and an extended part of the health economy, financed through direct private payment. Whilst the basic mandatory coverage for everybody is available, voluntary supplement protection and private coverage gains in importance. The wellness and fitness revolution cannot be stopped. Enabling and empowerment of the population in health is a topic high up on the agenda.

Elements of the second health care are to be seen in the figure below and show a new understanding of health. To name just a few: sport equipment, over the counter medication (homeopathic and anthroposophic medicines), health tourism, smart watches (some), visual aids (some), GPS-Tracking and bio food (dietary supplements and fitness doping). In case the health outcome of these new types of health care services is proven and positive the eligibility for reimbursement will follow after a while in a competitive market. Ambient assisted living (AAL) will be a major example.

Figure 1: Selected Elements of the Second Healthcare Market. Private Coverage?



Technical development has been on the rise over the last decades – especially regarding communication and data processing. E-health as a collective name for the use of information and communication technology in the health system is, meanwhile, a common expression. Also, in health and in long term care the use of techniques improves a lot. Better health through AAL systems with assisted technologies keep people away from public services in the traditional sense (Professor Uwe Fachinger, of the University of Vechta).

On the one hand, smart meters can give an exact overview of the consumption of residents. They can visualize the consumption on a daily basis, from one week to another, from weekends to weekdays etc., thus increasing awareness. On the

other hand, they can easily be used to determine that an elderly person used water, electricity etc. late at night but not again the next morning. Detecting irregularities and/or a failure to use gas, water and electricity supplies can help to reveal an emerging illness. This may be a perspective for the second health care market in the long run.

Of course, nobody should know absolutely everything about a resident's daily routine - but the home itself could know, learn and self-configure. The home could - in suspicious circumstances - send information. A sudden increase in wakeups during the night could, maybe, cause a traffic light signal to switch to amber; no life signs at all would switch it to red. Then somebody could start the necessary care.

New professions in therapy, new study fields and research areas are developing at the same time. These technical and social developments lead to a better basis for financing other parts of the economy. The fiscal impact of the secondary health market requires further investigation. Perhaps AAL is already partially co-financing the first market?

To sum up: What we need is a new understanding of health and healthcare. Towards an open health society new form of insurances and payment systems will develop instead of mainly public financing. Health care is no longer to be seen as a cost factor. A new understanding will lead in the long run to increasing work forces, new career opportunities, to an efficient investment in human capital and at the same time to higher productivity. Instead of too many separate silos we need health in all areas of life and lifelong. And the second health care market is an important part of this development.

12. Preventive Healthcare

Three Levels of Prevention to Improve Wellbeing and Reduce Medical Costs

Published Fabruary 18, 2022

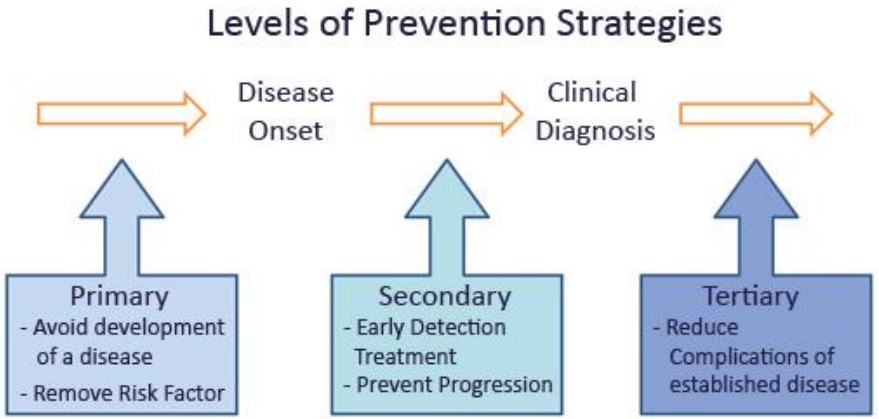
Regular exercise is an example of primary prevention

Prevention refers to any measure aimed at reducing risks or the harmful consequences of disasters, or to weaken other undesirable situations. Preventive healthcare deals with the prevention of illness and can be applied at all stages across the lifespan and along a disease spectrum, to prevent further decline over time. Early detection will limit the need for medical treatment.

There are three distinct levels of prevention. Measures that prevent the onset of illness or injury belong to **primary prevention**. Vaccinations and regular exercise are examples. At the primary level there is a huge prevention potential in individual lifestyles through altering risky behavior, for example: smoking, alcohol abuse, malnutrition or insufficient physical activity.

To detect diseases in their early stages before the illness progresses is the concept of **secondary prevention**. Early diagnosis and prompt treatment to prevent more severe problems are part of it. Good examples are screening for high blood pressure (nearly half of the adults in many countries have this) or the self-examination of certain diseases, for example breast cancer. Thus, early treatment for the health problems of the population is important.

Tertiary prevention refers to measures following illness, such as rehabilitation or reduction of established diseases. Professional help may work to retrain or re-educate people with impairments. At this level, education of people to take their medication appropriately is important, at the time of rehabilitation of the individual patient who had already a disability.



Source: PCORE (n.d.)

Preventive medicine and public health share the same objectives: promoting population health, preventing disease and improving the health environment on the basis of epidemiological data in cooperation with centers for disease control and prevention.

Preventive care includes doctor visits, well-child visits, dental cleanings, immunizations, contraception, etc. The underuse of many of these preventive services do not stem from a gap in information, according to experts, but more from implementation and a lack of health education.

A frequently asked question is: does preventive care save money? It is difficult to say; selected empirical studies show mixed results. They depend on the cost-effectiveness of selected preventive measures and treatments for existing conditions. Such a comparison between guided self-management and traditional care for asthma, for example, done on the basis of 599 studies showed that less than 20% of preventive options fall in the cost-saving category, whilst 80% add more to medical costs than they save. (Russel, 2012).

The prevention potential within chronic diseases is particularly positive in the long run. The individual lifestyle of the population may improve the health status a lot. On the basis of this assumption, there is a clear cost decrease over a time span of 20 years. (Martin and Henke, 2008)

An overall answer is so difficult because of the separation between primary prevention, on the one hand, and secondary and tertiary prevention, on the other hand. As primary prevention includes less medical treatment than the other two forms of prevention, the calculations done on the basis of the cost-of-illness studies show results ranging from higher expenditures through prevention programs to lower costs of other programs. The avoidance of indirect costs is so far less important than the containment of direct costs (expenditures). Thus, we are saving at the wrong end!

Health impact assessment (HIA) might be a better approach or at least an alternative. It is a type of study that helps policy- makers identify the likely health impacts of a decision in other fields. HIAs can help decision makers to avoid unintended health risks, reduce unnecessary costs, find practical solutions and leverage opportunities to improve the well-being of the community in which the project or policy is proposed. Some experts call it macro allocation.

Finally, a prevention-oriented society may try to find additional healthy life years on the basis of three key hypotheses:

1. a healthier society saves money on medical treatment through primary prevention;
2. healthy aging gives a demand-side boost by increasing private demand for non-reimbursable health related goods and services (second health market);
3. furthermore, a better health status raises productivity and thus gives a supply-side boost to quality of life and economic growth.

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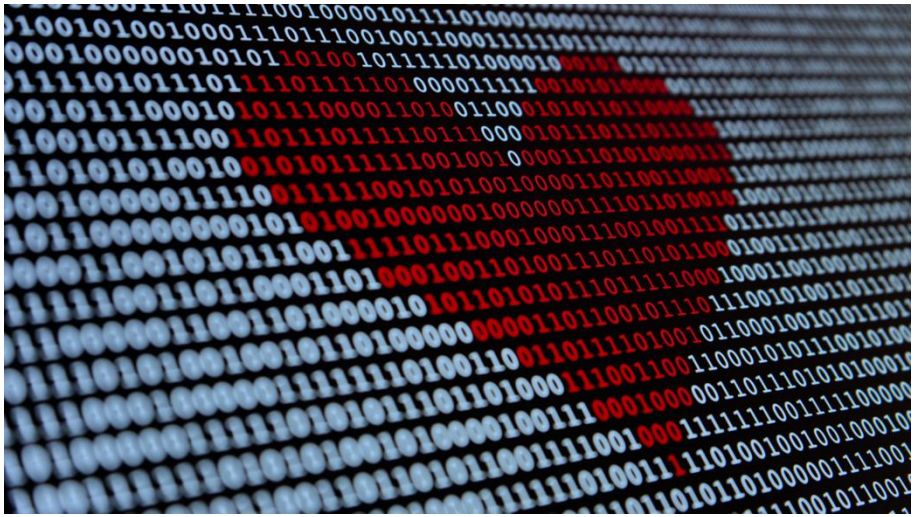
13. Healthcare's Economic Data

How Can We Use a Range of Healthcare Data to Make Better Decisions?

Published March 18, 2022



Healthcare data and statistics inform us about health status, the quality of healthcare and social characteristics

Epidemiological Data on Morbidity and Mortality

Epidemiological data are perhaps the most important statistics on the assessment of health care systems. They show not only the health status, but give perspectives on how to reduce illness, invalidity and premature death. Often these data include information about the satisfaction of the population with their health services and the quality of health care.

As a field epidemiologist, we collect and assess data from field investigations, surveillance systems, vital statistics, or other sources (Fontaine, n.d.). On such a basis the allocation of resources from a macro, meso and micro point of view is possible. Cost-of-illness studies show us the most expensive diseases (according to expenditures, life years lost etc.) and offer a basis for priority setting. With the help of these data we produce economic facts and figures.

Economic Data

We often associate healthcare with high costs and the need to curb them. The topics are related mainly to health expenditures, share of health expenditures as a proportion of GDP or per capita, revenue deficits, life expectancy at birth or misuse of certain services. A shortage of skilled personnel during the pandemic is also high on the political agenda of economic data.

Sometimes disregarded is the fact that the healthcare system is not only a cost factor but is also a growing industry. Its economic importance is impressively seen by the contribution to employment, value-added services and exports. These figures are sometimes higher than those of other industries (Henke, 2022). The German Federal Ministry for Economic Affairs and Energy regularly publishes facts and figures on the core and the extended sectors of the healthcare industry and the associated collectively and individually financed healthcare services.

Data on Effectiveness and Efficiency

From an overall perspective there are often complaints by patients and providers about a lack of efficiency in healthcare systems. Over and underuse of health care services are attributed to a lack of coordination across and between health care providers and missing competition on the demand side for health services. An answer to this problem is perhaps the establishment of more managed care in the system through GP-centered care, disease management programs and integrated care and medical care centers.

Social Data (Social Cohesion and Solidarity)

Often neglected and rarely discussed are social characteristics of health care. One of the reasons is perhaps the difficulty in quantifying them. It is easier to use figures and statistics on the financial and employment situation than to quantify terms as equity and social cohesion (solidarity), access and rights or duties and choice in healthcare. Many people associate equity and equality with a basic level of care for all, an equal distribution of burdens and not a two-tiered system.

On the benefit side, healthcare services should be available according to the needs of the population, to all citizens independent of their income, residence or social status. A basic minimum of benefits that ensures that no citizen falls beneath a particular level of subsistence, i.e., the same level of quality of health care should be equally accessible to all.

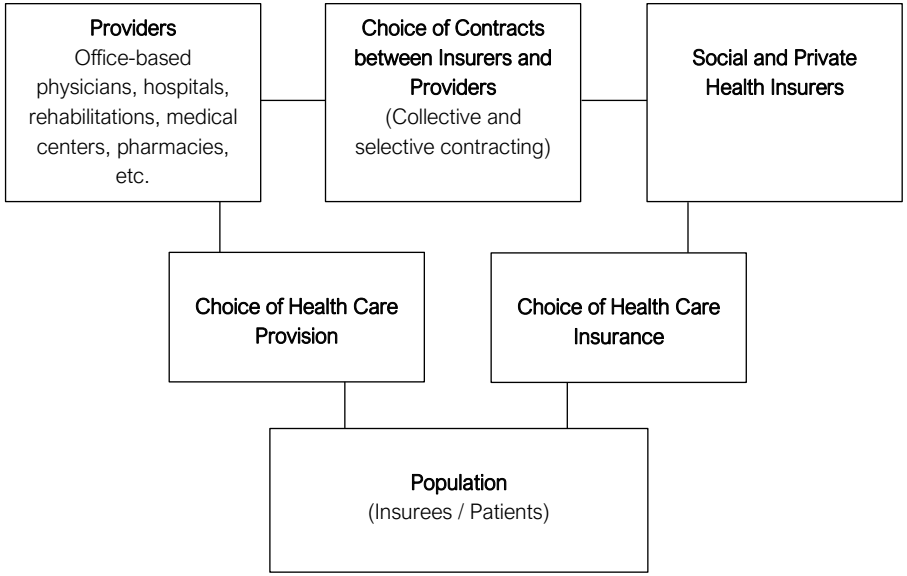
On the financing side, the provision of care should be guaranteed according to the ability to pay either out of taxes or on the basis of a social security system. Earmarked payroll tax financed solutions through employer and employee contributions (Bismarckian-System) are typical for France, the Netherlands and Germany, whilst the tax-financed solutions (Beveridge- System) are in place in the UK and Scandinavian countries.

Data on Different Dimensions of Choice in Health Care

Choice in health care is associated with freedom to choose providers in general, or within integrated care certain disease management programs offered by the insurance funds. The table shows the choices in a Bismarckian health care system. Collective and selective contracting takes place between the insurances and the providers.

From an insured person's point of view there is a choice between different social and private insurance companies. In addition, there are different benefit packages within one insurance company and often there is a choice between certain types of co- payments for ambulatory and inpatient care.

Choices in a Bismarckian health care system



Data on Legal Rights and Duty to Live A Healthy Lifestyle

As a member of a social security system, one is entitled to receive the necessary health services. The citizen has a claim on treatment because he has paid his contributions regularly. This membership is based on a social jurisdiction and systems of arbitration. This right to health is combined, at least from a moral point of view, with a duty to live a healthy lifestyle. Thus, the individual lifestyle and preventive health care is a lifelong topic by moral standards.

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14. Healthcare and Sustainable Development

Mobilizing Resources to Meet Fiscal Sustainability of Health Systems

Published April 18, 2022

Economists would propose that resources are best invested where the highest health outcomes are achieved per dollar spent

Economists regard resources as factors of production, i.e., labor, capital and entrepreneurship. The price paid to labor for its contribution to the process of production is called wages. The higher the quality of labor (physical and mental), the more productive the workforce is. Capital refers to manufactured resources such as factories and machines, i.e., man made goods used in the production of other goods. Entrepreneurs are a vital engine of economic growth helping to build some of the largest firms as well as some of the small businesses in your neighborhood. The payment an entrepreneur receives is profit as a reward for the risk he is taking.

Health Systems

Health systems are responsible for delivering services that improve, maintain or restore the health of individuals and their communities. According to the WHO, this includes the care provided by hospitals and family doctors, but also less visible tasks such as the prevention and control of communicable disease, health promotion, health workforce planning and improving the social, economic or environmental conditions in which people live.

Fiscal Sustainability

Fiscal sustainability in the public sector refers to the public budget with its functions on a yearly basis, medium term planning (2-5 years) and over longer periods of time, say more than 30 years (OECD). Is it always a balanced budget, or running a deficit as well? As William Vickrey (Nobel Prize 1996 in Economics) stated: “deficits are considered to represent sinful profligate spending at the expense of future generations who will be left with a smaller endowment of invested capital.”

Sustainability in the broadest sense means: ensuring healthy lives and promoting the wellbeing for all and at all ages for a long period of time. It is essential to sustainable development. The Social Development Goals of the UN/UNESCO address in this context the global challenges we face, including those related to poverty, climate, environmental degradation, prosperity, and peace and justice.

What is sustainability within health systems?

According to the Wake Forest University (Winston-Salem, NC) it consists of:

- constructing and managing health care facilities following sustainable

practices;

- designing sustainable health care processes;
- promoting daily sustainable practices for healthcare employees and departments.

Financial sustainability draws on various sources of revenue (taxes, payroll taxes, premiums, out-of-pocket-expenditures etc.), allowing it to support its ongoing efforts and to undertake new initiatives. It also means equity in financing. Households should contribute to the health system on the basis of their ability to pay. Financial protection should ensure that the cost of care does not put people at risk of a financial catastrophe. To improve the fiscal sustainability of health systems, one could try to restructure the resources on different levels, as shown below. Resource mobilization means better use of existing factors of production.

Generally speaking, economists would propose that resources should be invested, where the health benefit is the highest, or as M.E. Porter proposed: "value defined as the health outcomes achieved per dollar spent." Politicians should use as their empirical basis for their political decisions the results from evidence-based medicine (EBM), health technology assessment (HTA) and/or health assessment (HA).

Unfortunately, there is no gold-standard for health systems and no optimal health expenditures quota, but certain rules do exist, such as comprehensive coverage for the whole population, irrespective of social status, income and place of residence. In addition, there are often examples of best practice in a specific country, community or for a medical treatment. Health in all areas of life and throughout one's life is also important but it is more a goal than a system.

An ex-ante macroallocation of resources is indispensable, but through whom within health care and with which mechanism and institutions? NICE in the UK (National Institute for Health and Care Excellence), GBA in Germany (Federal Joint Committee of Insurance Companies and Physicians) or similar regional institutions, competition, markets, NGOs, the parliament, democratic processes, social media, press, ministries and interest groups etc. Finally it is an interplay among patients and providers of medical services in the public, private, semi-public and the self-governmental sector. The total system is mainly interest-driven by all the participants.

The famous Brundland Commission has put forth a conceptual framework that many nations agree with, but it has been difficult to change these concepts about sustainability into concrete actions and programs. A comprehensive plan of action came out and entails actions to be taken globally, nationally, and locally in order to make life on earth more sustainable going into the future. Its *Agenda 21* reinforces the importance of finding methods to generate economic growth without hurting the environment. The commission was a sub-organization of the UN that aimed to unite countries in pursuit of sustainable development. The Brundtland Report was intended to respond to the conflict between globalized economic growth and accelerating ecological degradation by redefining 'economic development' in terms of 'sustainable development'.

On another note: look at sustainable cultivation and processing of goods and services. Take coffee as an example. Coffee cultivation should not contribute to deforestation or reduction of biodiversity; it should protect soil, water and air, respect human rights, labor and land rights, educate well-trained farmers to improve productivity and profitability etc.

We can ensure compliance with economic, social and environmental criteria for coffee production and processing in order to establish sustainable coffee supply chains. Thus, there is a functional equivalence between completely different production functions (Coffee and health services).

15. The Role of Competition in Healthcare

Socially Bound Competition as the Answer

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Competition is not an end in itself, but an instrument in different areas

Competition in general may be seen

- as a process of disruptive innovations by pioneering entrepreneurs (Schumpeter),
- as a discovery procedure (v. Hajek) or
- as a public good if its effects will be available for all, e.g., by reducing the

pioneer profits in favor of lower prices for the consumer.

Prices, quantities and quality are the major instruments. Competition needs rules and a legal framework. Its promotion is part of economic policy.

Within healthcare there are several financing parameters of competition and more specifically differences in contribution rates (earmarked pay-roll taxes), risk-oriented premiums, co-payments or out-of-pocket expenditures. Depending on the health system (Bismarckian- or Beveridge-type) there is a market for public and private insurances including a choice for different health services for the individual. Selective contracts between insurance funds and healthcare providers are possible; they offer e.g., choices in regard to customer services, waiting time, access, or bonus-malus incentives. User/patient satisfaction is another important way of judging the advantages of competition.

Many of these forms of competition are available in different health systems in the European Common Market. To avoid protectionism, state monopolies, barriers to entry there is a European competition law and Government restrictions on competition (e.g.) are part of these rules.

Irrespective of the anticipated benefits of competition in healthcare there are risks as well, e.g.

- Anarchy of markets (K. Marx); competition leads to social chaos.
- Competition increases complexity, so-called transaction costs are rising.
- Incomplete and asymmetric information gain in importance.
- Hunt for subsidies and unproductive rent-seeking.
- Ruinous competition and
- Competition is not an end in itself but only an instrument.

Given these differences in the evaluation of the pros and cons of competition some experts call for a "socially bounded competition" and combine their proposal with different forms of Integrated Care (IC). Integrated Care appears in many different versions, all of them are affiliated with competition as a compromise between free trade and protectionism:

- IC is a concept bringing together inputs, delivery, management and organization and health promotion. It is a means to improve health services and health products in relation to access, quality, user satisfaction and efficiency.
- IC is a worldwide trend in health care reforms and new organizational arrangements focusing on more coordinated and integrated forms of care provision (see above).
- IC as a response to the fragmented delivery of health and social services being an acknowledged problem in many health systems (silo effect) and
- IC should avoid over-, under- and misuse of healthcare services and products.

To sum up: Competition is not an objective per se but an instrument in different connections. Opposite to free trade and competition is more protectionism and bureaucracy.

In the architecture of allocating scarce resources, it means a step-by-step approach. As there is no gold-standard and no panacea we need a flexible stop and go system or a piecemeal social engineering as Popper called it.

Review and Outlook

Healthcare is and will remain a central issue

All the chosen healthcare issues are permanently up-to-date and high on the political agenda all over the world and they are a lasting subject of health economics and health policy. The reason for this situation is manifold.

As there is no gold standard for healthcare the economics of priority setting stand everywhere in the center of the scientific and political discussion. Healthcare financing, purchasing health services, cost-effectiveness studies, global health, healthy aging, basic healthcare packages and best practice, the health economy, competition and sustainability in health care belong to the keywords and challenges all nations are facing.

As long as there is no panacea and no patent recipe available society will face a variety of systems of health care. Avoidable mortality and morbidity need answers for which people with ill health are waiting for. Medical progress is therefore a great desire for the population with specific illnesses; better nursing care for the elderly today and tomorrow is another part of healthcare. Strangely enough dental care is not so often high on the list, although it is one of the most expensive diseases.

Sometimes neglected and rarely discussed are the social characteristics of health care. One of the reasons is perhaps the difficulty in quantifying them. It is easier to discuss statistics on the financial situation and employment in healthcare than to quantify terms as equity and equality, social cohesion or solidarity. Most experts however associate equity with a basic level of care for all citizen independent of their income, residence or social status.

Another overall perspective is for many experts what they call a “socially bounded competition” with different forms of integrated care. Such an approach is affiliated with permanent changes bringing together inputs, delivery, management, health promotion, access and solidarity. This may lead to a dichotomy between “free trade and competition” on the one hand and “Protectionism and bureaucracy” on the other one. Asked for an improvement of medical and dental care and a higher rationality of health policy the answer from an economist´s point of view is often a better Health Policy through more evidence-based implementation.

To sum up: The overall architecture of allocating scarce resources leads to a flexible stop and go system or as Popper called it a piecemeal social engineering. Therefore, healthcare is and will remain a central issue.