

FUNDING CRITERIA FOR HEALTH SERVICES RESEARCH IN GERMANY: AN ECONOMIC PERSPECTIVE

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ABSTRACT

This article examines the extent to which funding criteria for health services research (HSR) and integrated care research (ICR), employed by central authorities in Germany (specifically, the German Innovation Committee), align with economic principles. A minimal consensus between mainstream and heterodox economics serves as the basis for this analysis. The consensus encompasses considerations such as opportunity costs, the utilization of financial incentives to induce behavioral change, and, albeit with some reservations, the role of markets in healthcare. An evaluation of funded projects in relation to these economic principles suggests that these principles have not been adequately incorporated. The omission of opportunity costs results in an underestimation of the total cost of HSR/ICR from a societal perspective. Furthermore, financial incentives enable a more comprehensive and systematic approach to improving the quality of care compared to the introduction of narrowly targeted interventions for quality improvement. In conclusion, drawing from a minimal economic consensus, this article identifies areas that may necessitate a revision of funding criteria for HSR/ICR research in Germany.

Keywords - efficiency, healthcare system, health services research, heterodox economics, market, quality.

INTRODUCTION

The German healthcare system faces the challenge of providing high-quality and efficient patient care while ensuring equal access to healthcare for all socioeconomic groups.¹ In 2015, the German Federal Government enacted a law aimed at strengthening healthcare delivery within the statutory health insurance (SHI) system, known as the SHI Health Care Strengthening Act (Gesetz zur Stärkung der Versorgung in der gesetzlichen Krankenversicherung). An integral part of this law was the establishment of an ‘Innovation Fund,’ funded by the SHI, to support health services research (HSR) and integrated care research (ICR) projects. The overarching goal of HSR and ICR is to analyze and enhance the quality and efficiency of healthcare. Funding decisions and project topics for HSR/ICR are determined by an innovation committee comprising representatives from the German Ministry of Health, the SHI umbrella organization, and other self-governed

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bodies, with input from academic experts. The first funding decisions were made in 2017. The aim of this study was to assess the extent to which economic principles were taken into account in the funding of HSR/ICR projects. To achieve this, publicly available summaries of funded HSR/ICR projects² (n = 197; as of September 11, 2018) and the officially announced funding criteria were analyzed. According to an official statement (Gemeinsamer Bundesausschuss 2020), funding for current and future HSR/ICR projects from the Innovation Fund will continue at least until 2024.

DEFINING A SHARED ECONOMIC PERSPECTIVE

In pursuit of the abovementioned goal, this article adopts an economic perspective. It is important to note that, within the economic profession, diverse viewpoints exist, and a single economic perspective is not universally agreed upon. Nevertheless, certain principles enjoy support from both mainstream and heterodox economics, forming a minimum consensus. In the following sections, we utilize Gregory Mankiw's (2017) "10 principles of economics" as a foundational framework for establishing this minimum consensus and assessing the projects. These principles encompass:

1. People face trade-offs;
2. The cost of something is what you give up to get it;
3. Rational people think at the margin;
4. People respond to incentives;
5. Trade can make everyone better off;
6. Markets are usually a good way to organize economic activity;
7. Governments can sometimes improve market outcomes;
8. A country's standard of living depends on its ability to produce goods and services;
9. Prices rise when the government prints too much money;
10. Society faces a short-run tradeoff between Inflation and unemployment.

The rationale behind this choice is that the 10 principles are frequently cited and are also accessible to non-economists. In detail, principles 5, 8, 9 and 10, which have a macroeconomic focus, are not further considered for the purpose of our analysis. To evaluate the acceptability of the remaining principles from the perspective of heterodox economics, we draw upon a recent critique of the 10 principles by Campbell et al. (2019). While the critique lacks extensive empirical evidence and may not represent all streams of heterodox economics, it provides one extreme viewpoint within heterodox thinking.

The first two principles, which are interrelated according to Mankiw, are not categorically rejected. Instead, Campbell et al. criticize the socioeconomic context in which individuals encounter these principles. Since our article does not address individual decision-making or personal budgets but rather focuses on decisions made by the Innovation Fund and the funds provided by the SHI, this critique is not directly relevant. Consequently, the opportunity cost principle, embedded in the second principle, will be applied to funded HSR/ICR projects.

While Mankiw's third principle is criticized for its lack of real-world applicability (Campbell 2019) and is not further considered in our analysis, the financial incentives inherent in the fourth principle are not dismissed outright, but their importance is put into perspective ("Monetary incentives are not all that matters" (Campbell 2019)). Therefore, the fourth principle, which posits that people respond to incentives, will also be applied. Concerning the sixth principle, it is critiqued for its applicability to the healthcare sector ("private capitalist market-driven systems") and instead favors a "well run" single-payer healthcare system (Campbell 2019). However, competition in healthcare does not necessarily require the privatization of public institutions but can also be implemented among public institutions. Additionally, it remains unclear how a "well run" single-payer healthcare system should be organized and whether it is universally superior to the German multi-payer system with public sickness funds but regulated competition both at both payer and provider levels. Nonetheless, in the following analysis, the heterodox critique is acknowledged by giving lower priority to the sixth principle. Lastly, the seventh principle is criticized for not recognizing the significant role of governments in establishing markets and determining market outcomes (Campbell 2019). Since the seventh principle is closely linked to the sixth, it will also receive lower priority in our analysis.

OPPORTUNITY COSTS OF HSR/ICR

Based on the first two principles by Mankiw, the consideration of opportunity costs is a fundamental tenet of economics. This principle applies to various aspects of HSR/ICR. First, let's consider opportunity costs as the potential loss of private consumption for SHI policyholders resulting from increased insurance premiums due to the funding of these projects. In fact, the consideration of opportunity costs is mandated by the German Social Code Book V § 71, which upholds the principle of stable contribution rates. Therefore, it raises the question of whether funded HSR/ICR projects can align with this objective both during the project phase and beyond. Between 2016 and 2019, direct funding of HSR/ICR projects amounted to €300 million annually (Gemeinsamer Bundesausschuss 2020), which translated to a corresponding reduction in private consumption for SHI policyholders.

To maintain stable SHI contribution rates, it is imperative, as a first step, to conduct an ex-ante assessment of the impact of interventions planned within funded HSR/ICR projects on SHI expenditures. This necessitates modelling healthcare costs and outcomes before implementing a real-world project (Gandjour 2015a). This requirement holds true even in the absence of outcome data with a high level of evidence and is essentially regardless of any planned ex-post evaluation. For instance, let's consider a concrete example: a funded project aimed at promoting screening for cervical cancer.³ As screening incurs initial expenditures, it becomes essential to simulate the costs and savings generated by screening over the remaining lifetime. Without such a modelling exercise, funded HSR/ICR projects may lead to unacceptable increases in expenditure. Public funds should only be allocated to correct underuse (in this case, underuse of screening) if modelling demonstrates cost savings. Otherwise, in a market-driven economy, it would be appropriate to rely on the incentives provided to producers of screening tests to address the issue

of underuse. This is because correcting underuse yields higher profits (Gandjour 2018; for further elaboration, see the section on Market competition).

Opportunity costs of HSR/ICR also manifest at other levels. Engaging in HSR/ICR projects consumes time that could otherwise be allocated to alternative activities. For instance, HSR/ICR projects conducted at university hospitals may have repercussions on both basic and clinical research. Consequently, advancements in healthcare quality resulting from the Innovation Fund's projects may be offset by the potential forgone (future) clinical benefits elsewhere within the healthcare system. In an extreme scenario, this could even impact the development and export of new drugs and innovations, thereby affecting the overall gross national product.

Moreover, the participation of clinical staff in HSR/ICR projects can exacerbate labor shortages in patient care. The decentralized nature of HSR in Germany may further amplify these challenges due to administrative inefficiencies. While the practical focus of HSR can serve as a catalyst for other scientific activities, the unique nature of projects and the administrative burden may limit the time for critical reflection, theory development, and conceptualization (cf. Stegmaier 2019).

Finally, opportunity costs also arise as a consequence of medical educational programs aimed at enhancing the quality of care. Specifically, they are incurred due to the time invested by participating physicians and other healthcare professionals. This is relevant at the project level, but becomes even more pronounced during large-scale rollouts if projects prove to be successful. Once again, questions arise concerning how the time commitment for participation in these programs can be justified, especially in light of labor shortages in healthcare, particularly in fields such as neurology or psychiatry. It is conceivable that less time will be available for patient care and other educational programs, potentially leading to a zero-sum game at the system level.

FINANCIAL INCENTIVES INVESTIGATED IN HSR/ICR

The primary funding areas, such as promoting research to facilitate cooperation between physicians and other professions, alongside the absence of projects centered on financial incentives, suggest that research prioritization leans towards enhancing communication among providers rather than exploring financial incentives for providers. However, this prioritization towards enhancing communication among providers occurs, even though financial incentives are considered relevant for behavior change, even from the perspective of heterodox economics. This viewpoint aligns with the conclusion drawn by Grimshaw et al. (2012), who based their assessment on empirical evidence from the healthcare sector regarding the impact of financial incentives. Furthermore, the escalating labor shortage among healthcare workers presents a dual set of opportunity costs for strategies relying on communication, encompassing both financial expenses and labor resources. In contrast, financial incentives entail a singular opportunity cost, mainly in monetary terms. The potential undermining effect of monetary rewards on intrinsic motivation underscores the relevance of conducting a comprehensive evaluation. It is important to note that the Innovation Fund has historically allowed the submission of grant proposals unrelated to topic-specific announcements. Thus, it remains speculative whether there have

been grant applications concerning financial incentives, and if the potentially limited number of grant applications reflects a similar prioritization as mentioned earlier, extending to grant applicants.

MARKET COMPETITION VERSUS GOVERNMENT REGULATION

As mentioned above, the stream of heterodox economics, represented by Campbell et al. (2019), has a critical viewpoint on the role of markets in healthcare. When observing policy changes by the German government over recent years aimed at improving efficiency and quality of care in the healthcare system, a noticeable trend towards establishing more market-based competition, particularly concerning quality improvement, becomes noticeable (Bundesministerium für Gesundheit 2023). However, the establishment of the government-regulated Innovation Fund marks a deviation from this general trend (cf. Albrecht 2018, p. 47). This raises a fundamental question: Which type of research is better suited to provide innovative solutions for healthcare system's challenges - research directed by the government and self-governed bodies or research conducted by market participants? In other words, are health services researchers employed at academic departments more creative in finding solutions, for example, in hospital discharge planning, compared to international consulting companies? Similarly, are health services researchers or market research departments of medical device manufacturers more innovative in addressing the underuse of the manufacturers' products?

To address these questions, we must delve deeper into the competition among healthcare providers. In an ideal competitive environment, the providers offering the highest quality of care emerge as winners. Their care processes and delivery serve as a benchmark for other providers (Gandjour 2011).⁴ A well-functioning competitive market necessitates transparency regarding the quality of care. This transparency is essential for patients to make informed healthcare choices. In this framework, the government's role is limited to establishing competition and preventing harm resulting from it. A government-supported HSR/ICR should primarily focus on creating competition and identifying and mitigating harm (Gandjour 2016). Following this mainstream economic principle, projects that are of particular interest to profit-driven market participants should not receive support. For example, projects aimed at detecting and addressing underutilization of medical devices or drugs should not be prioritized.

It is worth noting that a portion of funded projects aligns with a market-based paradigm. These include projects that address market failures in healthcare, such as those aimed at detecting or reducing harm (e.g., errors in drug administration due to labor shortage or fatigue).⁵ Additionally, research that addresses inequality resulting from competition is within scope. Projects that rectify information asymmetry between physicians and patients by providing patients with relevant healthcare information (Gries 2004) also fall under this category. Lastly, research aimed at enhancing the measurement of quality of care and data collection is fundable, provided it contributes to establishing competition and reducing its adverse effects. Research not previously funded but aligning with the agreed-upon economic principles would analyze and improve financial incentives for

competition and care delivery. To avoid zero-sum games, financial incentives should encompass a wide range of activities (cf. Vlaanderen 2019).

Mainstream economics also exercises caution in funding projects related to new interventions that have not yet been reimbursed by sickness funds. These may involve investigations into new computer-assisted programs, apps, and educational programs. The rationale for this caution stems from the relatively low potential for harm (e.g., apps that monitor disease progression or aid patients with motivation and education⁶) and doubts about the generalizability of study results to other settings, especially for educational programs, given their variable ‘dosage’ (Gandjour 2011, Fischer 2013, Gandjour 2015b, Huckvale 2015). The justification for research lies in a trade-off, for instance, between costs and benefits or between benefits and harm.⁷ Research is primarily warranted for interventions that are not evidently cost-effective, and where research can help determine cost-effectiveness (Gandjour 2011). Therefore, the goal of the Innovation Committee should not be to identify projects with the most obvious savings or health benefits because, in these cases, the impact of research tends to be marginal, largely reaffirming prior knowledge and intuition, leading to inefficiencies. Similarly, conducting overly conservative studies that offer only incremental insights does not significantly contribute to healthcare improvement (Health Services and Primary Care Research Study 2020, p. 71). Moreover, in times of digitalization, the results of implementation studies may become obsolete at the time of publication (Houston 2019). Furthermore, for implementation and educational programs, it is crucial to recognize that there are essentially an endless number of possibilities for their design (Gandjour 2011). Randomized controlled trials, while valuable, “address only a fraction of the unanswered questions relating to healthcare organizations and systems” (Greenhalgh 2018).

In the case of other types of intervention in the healthcare system, the German government has not applied the same evaluation process. For example, at the time of writing this article, the German government does not intend to formally assess a recent amendment in German law that mandates the implementation of the results of early drug assessment in the prescription software for physicians (Gandjour 2018). Given that this amendment is unlikely to result in harm, the decision by the German government is consistent with the principles of mainstream economics.

Instead of providing funds for the formal assessment of the aforementioned interventions, it is more plausible, in line with the consented economic principle of financial incentives, to incentivize patient-relevant outcomes through measurement and reward systems (Gandjour 2011). Thus, all providers have an incentive to innovate, not just those with prior experience in submitting grant proposals and conducting scientific studies (cf. Albrecht 2018, Prognos 2019). Furthermore, financial incentives allow for a broader and more systematic approach to improving the quality of care than introducing narrowly targeted interventions for quality improvement. At a general level, this condition, which assumes a lack of data for rational economic planning, is known as the ‘local knowledge problem’ (Hayek 1945). Hayek (1940), a winner of the Prize in Economic Sciences in Memory of Alfred Nobel, argued that a “planning authority” does not possess the knowledge of “individual entrepreneurs.” Jean Tirole, another Nobel Laureate, phrased it as follows: “Wouldn’t it be smarter to create conditions favourable to investment (...)

rather than “picking winners” in advance?” (2017, p. 366). He argues that “[s]tates have no particular talent for detecting future successful (...) activities” (2017, p. 369).

For new interventions of the types mentioned earlier that have not been reimbursed so far, risk-sharing agreements between sickness funds and companies may offer an alternative approach to facilitate their market entry. As a basis for a reward, sickness funds and companies may use the types of patient-relevant endpoints that would otherwise be investigated in a trial.

In the case of low-cost interventions that are already included in the reimbursement catalogue and have a low potential for harm, government-funded assessments may face similar challenges. Nevertheless, given that these interventions may be prone to overuse, research aimed at reducing their overuse can be justified on the grounds that it addresses a market failure due to negative externalities (external effects) in the form of higher insurance premiums or tax payments (Gandjour 2016).

Some may argue that competition among health services researchers for funding from the Innovation Fund is still compatible with the principles of mainstream economics. However, it is essential to note that the specification of research topics and the size of the fund have no theoretical foundation, which can result in opportunity costs and inefficiencies.

CONCLUSIONS

This article examines the funding criteria for HSR/ICR used by the German Innovation Fund, based on established economic principles. It is possible that decision-makers have already considered and discussed the alternative criteria and approaches mentioned in this article without openly acknowledging any disagreements or providing reasons for their choices. Conversely, certain trade-offs and opportunity costs may not have been fully recognized to date and thus require more explicit discussion.

Regardless of these speculations, it is clear that the costs associated with HSR/ICR must take into account the opportunity costs that arise in both the short and long term. As discussed in this article, these opportunity costs manifest at various levels and encompass private consumption by the general public, basic and clinical research, clinical care, and participation in unfunded educational programs. Regrettably, these costs have largely been overlooked in public discussions surrounding HSR/ICR projects. To accurately assess the economic cost of HSR/ICR from a societal perspective, it is imperative to incorporate these opportunity costs alongside the out-of-pocket costs.

Furthermore, the presence of certain opportunity costs raises questions regarding alternative funding avenues. For example, projects that aim to increase the utilization of physician time may exacerbate the shortage of available physicians and subsequently lead to higher salaries being offered by healthcare institutions. This raises the question of why the underlying research is not supported by medical societies.

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As proposed in this article, the acceptance of funding criteria and project selection should align with the chosen conceptual framework chosen for the healthcare system. This article has highlighted the current trend in the German healthcare system, which leans toward more market-based elements. Ideally, HSR/ICR projects should be integrated into the framework chosen for the healthcare system. If this framework is perceived as market-based, then authorities must define the specific market failures that HSR and ICR are intended to address (cf. Tirole 2019). Failing to do so could allow lobbyists, ideological biases, and opinion leaders, including those from academia, to exert undue influence over topic selection and funding decisions. It is essential to note that this criticism applies equally to a more regulated healthcare system. Consequently, it appears beneficial to develop an algorithm capable of prioritizing funding projects while considering the conceptual framework of the healthcare system. Investment in research on the prioritization of HSR and ICR projects is likely to yield significant benefits and may help mitigate the influence of lobbyists and other opinion leaders (cf. Mitton 2004).

NOTES

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- ² <https://innovationsfonds.g-ba.de/projekte/>
- ³ <https://innovationsfonds.g-ba.de/projekte/versorgungsforschung/praezis-praevention-des-zervixkarzinoms-und-dessen-vorstufen-bei-frauen-im-saarland>.
- ⁴ Benchmarking also plays an important role when learning from other healthcare systems based on quality and efficiency indicators. The benchmarking process may involve data analysis to establish relationships between clinical and economic outcomes on one hand and indicators of structural and process quality on the other. In a competitive market where payers incentivize high-quality care, research of this kind would typically be funded by healthcare providers themselves rather than the government (cf. Gandjour 2011).
- ⁵ It is worth noting that harm may not only result from competition but also from inadequate regulation, such as insufficient educational requirements for physicians. The role of HSR should encompass the investigation of harm, irrespective of whether it is caused by competition or regulatory aspects of competition (Gandjour 2016).
- ⁶ <https://innovationsfonds.g-ba.de/projekte/neue-versorgungsformen/rise-up-ruecken-innovative-schmerztherapie-mit-e-health-fuer-unsere-patienten.72>
- ⁷ The scientific rationale for conducting additional studies is based on the expected net benefit of sample information, which refers to the difference between the expected value of sample information and the costs associated with research (Schlaifer 1961).

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