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Heidi Nadolski

BUDGETING AND RATIONING IN THE GERMAN HEALTH CARE SYSTEM

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It is the contention of this presentation that the budget system of the German health care system supports hidden rationing.

I. OBJECTIVE AND REALITY OF THE GERMAN HEALTHCARE SYSTEM

All citizens should enjoy ready access to comprehensive, high quality medical care no matter what their age, sex, marital status, income or individual health risks. Beneficiaries should receive sufficient, necessary, useful and affordable care.

However, the reality is that equal access is not guaranteed and not every patient receives the best possible medical care. Therefore, rationing is a fact of life.

II. THE HEALTH CARE SYSTEM IN GERMANY

Almost ninety-nine percent of the German population has health insurance. Almost ninety percent are insured by one of the 541 statutory health insurance funds (SHI-funds) and nine percent have private insurance.

The Fifth Book of the Social Security Code, part of Federal Law, governs the health care system. The German social security system is based on several principles.

FIRST IS SOLIDARITY

Solidarity means that the economically stronger members of society support the weaker members. Meaning those with higher incomes pay for those with lower incomes. Those who are employed pay for those who are not yet or no longer employed. Those who are young and healthy pay for those who are old and ill. Those who are single and childless pay for those with families.

Solidarity also means that contributions should increase with the ability to pay.

THE SECOND BASIS FOR THE GERMAN SOCIAL SECURITY SYSTEM IS CONTRIBUTION FINANCING

All employees or retirees earning less than the statutorily prescribed ceiling of 6,525 deutsch marks per month must join a SHI-fund. A person earning more than the ceiling may join a private sickness fund. The combined premiums of the members of one sickness fund corresponds to the total service demand by the community of persons being enrolled in that particular fund. Contributions to these funds are paid from salary based employee and employer pay-roll deductions, split equally between the two. Now the average contribution rate is 13.6 percent.

THE THIRD BASIS IS COMPREHENSIVE COVERAGE

The SHI-benefit catalogue covers a broad range of services provided by the SHI-funds. These funds cover preventive care, curative services, supply of drugs, remedies and medical supplies, hospital treatment and rehabilitation.

SHI physicians provide ambulatory care, prescribe drugs and medical appliances and decide who is to be hospitalized. Patients have free choice of all SHI doctors and dentists.

THE FOURTH AND FINAL BASIS IS GERMAN SELF-GOVERNANCY

The system is characterized by the close cooperation of the SHI funds, the association of physicians, the association of hospitals and other suppliers. Funding and providing health services are two different processes. The government enacts laws, issues guidelines for the organization of health care and then leaves it to non-governmental institutions to manage the health services. As a result, government agencies are not involved in the SHI system.

III. HEALTH CARE IN GERMANY UNDER A BUDGET SYSTEM

Germany has limited resources to treat its eighty million citizens. In 1998, Germany spent 10.9 percent of its Gross Domestic Product on health, compared to the 13.6 percent that was spent in the United States. Expenditure on public health is largely financed by the statutory health insurance system.

Due to the rapid rise in health care expenditure in Germany, a number of cost-containment efforts have been made since 1977 with a high degree of state intervention. The aim of these health care reforms is to bring the growth of expenditure in line with the growth of wages and salaries of the

fund members. Because the German health care system is mostly financed by employers and employees through payroll deductions, a rise in the monthly contribution rate leads to higher wage costs that harm the competitiveness of the German economy.

An important element of the most recent Health Care Reform ("GKV-Solidaritätsstärkungsgesetz") was the introduction of a fixed budget, which limited the amount of money coming into the SHI system. In 1999, the SHI system spent 240 billion deutsch marks (108 billion dollars). Within the global budget, politicians earmark the amounts for various sectors such as ambulatory care, hospitals, drugs and remedies. Ambulatory care received forty-two billion deutsch marks (nineteen billion dollars) in 1999, while the stationary sector received eighty-six billion deutsch marks (thirty-nine billion dollars) and the drug and remedy sectors received thirty-eight billion deutsch marks (seventeen billion dollars). Until now, the SHI physicians were collectively liable if the cost for drugs and remedies exceeded the budget. Such liability led to compulsory savings and very cautious prescription behavior.

VI. TYPES OF RATIONING AND EXAMPLES IN GERMANY

Rationing takes place in any system dealing with scarce resources, and the health care system is no exception. Several different types of rationing exist in the German system: hard rationing, soft rationing, hidden rationing and open rationing. Under hard rationing, there are natural or statutory limitations of health services with no possibility to obtain them elsewhere. Trading organs is an example of hard rationing, because it is illegal in Germany.

Under soft rationing, an individual may obtain the desired benefits by taking out an additional private insurance policy. Most benefits not covered by the SHI fund may nevertheless be self-paid or covered by supplementary private health insurance. For example, some members of the statutory health insurance system have supplementary private insurance to cover a senior consultant treatment in the hospital. Another example of soft rationing is the "expensive dentures treatment." Some Germans travel to Eastern European countries to get cheaper dentures. Compared to hard rationing, soft rationing is more widely accepted in society, although it violates the principle that every person should have the same access to medical benefits independent of his or her income.

Open rationing means that both the conditions of obtaining a benefit, as well as, the limitations of the benefit are well known. Contrarily, hidden rationing means that there is no transparency of the allocation criteria.

The process of rationing is always a combination of hard/soft and hidden/open. For example, the rationing process in palliative medicine in Germany is hard, as well as, hidden. Individuals may neither purchase appropriate care for patients in pain to fill the deficit of supply of medical care, nor are they aware of this deficit.

In Germany rationing is mainly hidden, due to the German budgeting policy, which raises many ethical problems. There are many examples of hidden rationing in Germany. First, is the extending and postponing of medical treatment. It is a proven fact that many medical treatments were either stretched out or postponed to a new budgetary period. Particularly towards the end of the year, the number of prescriptions decreased dramatically. For example, the budget allocated to one physician is often not high enough to pay for the customary ten treatments for the speech therapy of a child with a speech disorder. Some of these ten treatments were postponed to the next budgetary period, although this is medically counterproductive.

Next, is the shortening of medical treatments. For every treatment there exists specific time frame recommendations. Due to budgetary restraints, the duration of treatment often falls short of the recommended time frame. Whether a treatment is to be shortened or not is a decision made either by the physician, by the sickness-fund or by the patient (the latter if the patient is paying for the treatment out of his or her own pocket). For example, time-consuming services for which the physician is not reimbursed, like medical counseling, are reduced to a minimum.

Third is the loss of quality. There is a danger that strict budgets result in a lower quality of medical care. For example, multiple sclerosis is often successfully treated with the drug Interferon. The problem is that such an up-to-date medical treatment costs 30,000 deutsch marks a year (13,500 dollars). Consequently, many patients are treated with sub-optimal, old-fashioned, yet cheaper drugs. Up-to-date treatment with Interferon is provided to only twenty percent of multiple sclerosis patients.

In addition, tight budgets in the hospital sector result in an understaffing of hospital doctors. The remaining hospital doctors have to work overtime and currently account for fifty million hours in unpaid overtime. An individual physician often works more than twenty hours on duty without a break. This may possibly lead to a decline in medical quality and an increase in medical errors.

A fourth example is the refusal of treatment. Sickness funds receive strong pressure to keep their premiums low in order to be competitive. Therefore, some sickness funds reimburse physicians only very reluctantly. Patients may appeal to the administration of the sickness-fund, but many

patients give up and either forego the treatment or pay for it out of their own pocket. Most of those affected are specific high-risk populations, such as elderly patients with chronic illnesses that benefit from expensive, but effective medications. For example, sickness funds consistently refuse to pay for the physiotherapy necessary for the rehabilitation of stroke patients.

Also, the providers of medical care will not – or can no longer - provide their services to all needy patients because they do not receive enough money. Patients requiring expensive treatments may even be rejected up front.

In 1999, a sickness-fund paid the psychotherapists in Schleswig-Holstein only 0.145 deutsch marks (seven cents) for a fifty minute session. In the long run, this service will probably no longer be offered – or at least covered.

V. SUMMARY AND POSSIBLE SOLUTIONS

These examples demonstrate that rationing of medical care takes place in Germany. The objective that all citizens should have ready access to comprehensive high quality medical care is not met. It is arguable whether the ideal of a total equality is possible at all. In any economic system with scarce resources it is never possible to avoid rationing completely, even when the system is being rationalized. Even when the health care system is not capped but open, the individual would not spend all of his or her money on medical care. A perfectly equal distribution of scarce goods is an illusion. The question remains, however, how to obtain an appropriate amount for a health care budget.

The new budgeting system in Germany is only economically motivated, not medically motivated. Expenditures are supposed to rise by the annual increase of the premiums collected by the sickness funds. The budget increases when the wage-related contribution revenue increases, although this can hardly be expected due to the high rate of unemployment in Germany. The system guarantees stable contribution rates and is favored by the government, the SHI funds and the employers. In contrast to them, physicians demand to arrive at a budget using epidemiological and medical indications.

Physicians particularly oppose the drug and remedy budget, primarily because these budgets prescribe collective liability of physicians when the budget is exceeded, no matter how carefully or wastefully they prescribe. The new secretary of health has cut back the drug and remedy budget, but replaced it with a similar restrictive system. Now the intention is to introduce individual budgets by stipulating specialist-related prescription limits.

If a physician exceeds the prescription limit by more than a certain percentage, he or she would have to undergo a utilization review and would be held liable unless the prescription over the limit could be justified by practice-specific particularities. This new system does not change the fact that the provider must decide who receives the drugs.

From an ethical perspective, it is very problematic that the German budgeting system supports hidden rationing because the people concerned – the patients and the insured – are excluded from the allocation process. It would be completely obscure and arbitrary to let health care administrators decide who is to receive treatment, because there are no fixed and published conditions under which these decisions are made. Third party-payers are likely to impose limits on expenditure-based criteria which neither reflect, nor embody the values previously associated with providing health care and professional service.

In every system with scarce resources rationing is unavoidable, but it should happen openly. Open rationing means transparency of the allocation process. The criteria under which the allocation of benefits and services takes place must be comprehensible for all, otherwise it is completely arbitrary whether somebody gets a benefit or not. The aim is that unavoidable regulations and limitations are based on medical, economical, ethical and socio-political criteria, and that patients as well as experts are involved in the decision making process. Ideally, society should decide how egalitarian the health care system should be, which health benefits should be paid according to the solidarity-principle and which groups can pay benefits out-of-pocket.

One solution of the hidden rationing problem might be to reduce the SHI benefit catalogue to a basic catalogue in which the most necessary medical care is guaranteed for every insured citizen. Optional benefits may be offered additionally by the SHI funds or by private insurance. This is the subject of much discussion in Germany. Proponents of a more privatized system argue that it takes a willingness to pay into an account. Opponents suggest that privatization of the health care system leads to "two-class-medicine" and to an "Americanization of the conditions". This discussion is important, because it concerns the appropriateness and the practicality of the basic elements of the German health care system: solidarity, contribution financing, comprehensive coverage and self-governancy. The final aim should be to allocate available resources that ensure that the citizens get sufficient, necessary, useful and affordable health care now and in the future.