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SHAPING HEALTH CARE FAIRLY THE SITUATION IN GERMANY FROM A POLITICO-ETHICAL PERSPECTIVE

AT A GLANCE

Providing a viable health care system and avoiding social disparities in medical treatment are among the welfare state's most important tasks. In principle, the German health care system does indeed provide that, but it also presents a series of structural problems. Prevention policy remains a cause for concern, in particular its inadequate efforts to eliminate the considerable social inequalities besetting health care.

INTRODUCTION

Health care is a special good. Being healthy is not only a key component of personal well-being, but also a precondition for participating in many other areas of everyday life, such as the world of work. One of the welfare state's key tasks is thus to ensure viable, generally accessible health care that meets people's needs and helps them deal with health problems. Making sure that no one has to face illness alone is also a symbolic expression of the mutual concern that citizens of a free and democratic community owe one another. Health care provision must therefore be inimical to social differentiation. The kind of medical care someone receives – or indeed whether they receive any at all – should not depend on their ability to pay. A two-tier health care system would be unfair.

At the same time, citizens have an interest in health care provision that is not only good, but also affordable. This calls for more economical and focused management of the available resources. The health care system must be designed to be as efficient as possible («rationalisation»). In light of medical advances and demographic developments, however, thought must also be given to which services should come first («prioritisation») and which are not strictly necessary («rationing»), so that health care costs do not rise to unacceptable levels (Huster 2011). Yet it is also important to bear in

mind that excluding and restricting services risks opening up a social divide with regard to health care provision, because these services can then (only) be accessed by better-off citizens who have the means to pay for them.

This is particularly worrying given that there is already a close link between social and health status in Germany. For example, the life expectancy of men in the lowest income quintile is almost 11 years shorter than that of men in the uppermost quintile, while among women the difference is around eight years. If only the years spent in good health are taken into account, the differences are even greater (Lambert/ Knoll 2014). In a country where 90 per cent of the population is covered by statutory health insurance, this inequality of health care opportunity cannot – or can only marginally – be attributed to different levels of access to health care; more important are social determinants of health, such as working and living conditions, lifestyle and experiences of social exclusion (Siegrist/Marmot 2008). Hence, any attempt to address this inequality needs to involve other policy areas, such as education, environmental protection and social policy. On one hand, this suggests that when it comes to health care – and also the distribution of health-related resources – one needs to look beyond provision; on the other hand, health care provision should not exacerbate these social inequalities – the needs of vulnerable groups should receive particular consideration.

Looking at the German health care system in these terms, one finds strengths and weaknesses (cf. Busse et al. 2017). By international comparison, it provides good, generally accessible medical care – albeit with room for improvement. Yet the costs are high and certain structural problems adversely affect quality, efficiency and fairness of provision. This con-

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cerns funding, organisation and performance. Urgent action is required on health care provision and, in particular, tackling social inequalities pertaining to health care.

THE FUNDING OF THE HEALTH CARE SYSTEM

The fundamental rule concerning the fairness of health care system funding is that no one be denied access to medical treatment for financial reasons. In addition to the fair distribution of financial burdens, it is also important to consider the incentive effects and organisational impact of particular modes of financing.

Within this framework there is a range of design options. Germany's statutory health insurance system, largely funded with income-related contributions, is based on social contract principles, with redistribution not only from good to bad health risks, but also from higher income segments (up to the contribution assessment ceiling) to the lower income ones. The social redistribution achieved in this way is also possible in other transfer systems, however, such as the tax system. In many respects, this would even be advantageous because income-dependent insurance contributions can distort competition between insurance funds. One might also ask whether linking to income from dependent employment still provides a realistic reflection of ability to pay.

In any case, the dualism between statutory health insurance and private health insurance – unusual by international comparison – is open to criticism. A uniform health care system for all – »citizens' insurance« or »integrated health insurance« – would not only ensure that civil servants, the self-employed and higher earners could not opt out of solidarity-based funding of the statutory health insurance system. It would also avoid disincentives for health care providers arising from the fact that private health insurers pay higher fees. However, the juxtaposition of statutory and private health insurance has evolved over time and would be especially difficult to abolish. Whether health policy actors decide to invest their energies in such an expensive and complex restructuring process, which would be fraught with numerous political and legal obstacles, is a question of political will.

THE STRUCTURE OF THE HEALTH CARE SYSTEM

The German health care system is characterised by a regulatory mix of government regulations, elements of competition and – decisively – corporatist self-governing bodies. This complex governance system not infrequently leads both to overregulation and to gridlock.

Particular attention has therefore been paid in recent years to the increasing introduction of competitive elements, such as competition between insurance funds for members or among service providers for insurance fund supply contracts. The fee-per-case system in hospitals is also designed to instigate competition for the best and also most cost-effective provision. In the meantime, however, the impression has emerged that this has led to the economisation or commercialisation of health care provision. For example, one of the fundamental principles of health care provision is that

treatment decisions are based solely on medical criteria and that the hospital's financial interests do not come into it. If, as is suspected, it turns out that procedures are increasingly being decided not on medical but on economic grounds (for a discussion of this see Schreyögg/Busse 2014), urgent political action will be required. As a result, many hospitals in Germany will come under financial pressure (Leopoldina 2016).

There are also considerable disparities in the availability of statutory health insurance (SHI)-doctors. Especially in some rural areas, obtaining a doctor's appointment may be difficult and require a considerable expenditure of effort. This calls for innovative solutions that require cooperation between the medical profession, insurance funds and local councils. The opportunities arising from digitalisation and telemedicine should also be taken advantage of to provide, in particular, elderly patients with adequate medical care.

Within the statutory health insurance framework, many decisions on structural matters and services are taken by a central joint administrative body consisting of doctors and insurance funds, the Federal Joint Committee (Gemeinsamer Bundesausschuss). Whether this body – the »junior legislator« in the health care system – adequately represents the interests concerned has long been a topic of discussion, particularly because patients' concerns may be neglected in favour of the financial interests of service providers and the insurance funds. The Federal Constitutional Court, too, has expressed doubts concerning the legitimacy of individual decision-making powers within the Federal Joint Committee (Federal Constitutional Court 2015). Politicians and policy makers will have to come up with new procedures in this regard, so that rational and democratically legitimated decisions on health care provision can be made that adequately address, in particular, the concerns of vulnerable groups. A »politicisation« of decision-making on health care provision under pressure from lobby interests and the media would, however, also be cause for concern.

One structural feature of the German health care system is the strict separation of the outpatient and inpatient realms, which leads to mismanagement and interface problems. This separation must be abolished or at least significantly reduced and patients must be given more guidance when moving between the two sectors (Brandhorst et al. 2017).

CATALOGUE OF SERVICES

From the patients' standpoint the key question is what services are available in the public health care system and which ones they are entitled to. The guiding principle here must be that needs-based provision with universal access is guaranteed. Given limited resources, however, no absolute entitlements can be derived from this to specific services or procedures – for example, very expensive but only moderately beneficial treatments; only an entitlement to standard health care without discrimination can be ensured.

Generally speaking, the German system meets these requirements. Problems may arise for recipients of basic security benefits (»Hartz IV«) and social assistance, however, if they are additionally financially burdened by being excluded from certain services or having to make additional payments in order to access them. There is also a group of people who

are subject to substantial restrictions with regard to standard provision under statutory health care insurance, namely authorised claimants under the Asylum Seekers Benefits Act, Article 4 of which restricts their entitlement to »treatment of acute illnesses and states of pain«. Whether this reduced – albeit for a maximum of 15 months – level of provision satisfies the constitutional requirement of minimum subsistence in accordance with human dignity is controversial. Even more troublesome is provision for people – such as refugees not even reached by medical services.

Furthermore, the principle of health care equity has to be specified in practice. In recent years the view has prevailed that scientific criteria and methods should be used to determine whether an examination or treatment method has a patient-related benefit (»evidence-based medicine«). Broadly speaking, this development is welcome, but some suspicions remain that publically undeclared value judgements and cost considerations are brought into such assessments and that patients' concerns are not addressed satisfactorily. In any case, for a crisis situation arising in the event of a life-threatening illness the Federal Constitutional Court has now established direct constitutional entitlements independent of such assessments (Federal Constitutional Court 2005). This is by all means open to criticism because assessing the benefits of treatment methods is complex, calling for appropriate procedures and institutions. This court ruling shows, however, that the current design of assessment procedures no longer enjoys unqualified approval; in particular – as already mentioned – the legitimacy of the Federal Joint Committee is in doubt. To be able to show reasonable grounds for restricting services, open cost/benefit analyses can no longer be avoided.

PREVENTION OF ILLNESSES AND COMBATING SOCIAL INEQUALITIES PERTAINING TO HEALTH CARE

In a welfare state, which, pursuant to Art. 1 of the Basic Law, has the duty to respect and protect human dignity, patients' medical care has special urgency. However, it must not be overlooked that the health of the population as a whole is decisively determined by social determinants that pre-exist the health care system. This also applies to the social distribution of health and health prospects. Coming up with a prevention and public health policy that takes due account of such determinants is, for many reasons, a challenge.

First and foremost, such a policy cannot be restricted to health care policy in the narrow sense, focussing on the system of health care provision. Improving vaccination, for example, is undoubtedly of crucial importance but health care entails a lot more than medical interventions of this kind. Public health requires rather that proper attention be paid to key factors pertaining to health and illness in all policy areas. This involves cooperation at different levels and between various actors, but in Germany the sectoral and federal fragmentation of the health care system makes this difficult to achieve.

Furthermore, measures aimed at promoting healthy living risk accusations of paternalism and nanny-statism. In a free society, an individual's decision whether and to whatever extent to reduce health risks through healthier eating, being more active and giving up smoking and drinking must be

left up to him or her, which curtails the state's options somewhat (Huster 2015).

The task facing prevention policy is thus not only to appeal to people to change their lifestyles – especially because certain social strata are not amenable to this kind of behavioural prevention – but to shape the living environment in such a way that it promotes better health (»situational prevention«) making it easier to live healthily and enabling people to take responsibility for their own health. It also represents a starting point for reducing social disparities pertaining to health.

It is debatable whether these tasks will be dealt with satisfactorily by the Prevention Act passed in 2015 (after several attempts). It is both politically and constitutionally questionable that prevention services be financed out of statutory health insurance resources, although public health is a task for society as a whole (Spiecker gen. Döhmann/Wallrabenstein 2016). Most importantly, however, initial experiences with this law indicate substantial implementation difficulties (Böhm 2017). It is also open to question whether the competing insurance funds are really the right actors for coordinated prevention. As a result of all this, we are still a long way from an integrated policy on provision and a national prevention strategy that take account of health care concerns in all policy areas (»health in all policies«) – for example, social, education and urban planning policy – and in particular the elimination of inequalities of opportunity related to health care.

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