



Perspective

Communal Responsibility for Health Care — The Example of Benefit Assessment in Germany

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Many German observers are bewildered over the U.S. health care reform debate. Most Europeans see affordable health insurance for everyone as a fundamental element of a stable and

prosperous society — an element founded on the principle of communal responsibility. Like the United States, Germany is a wealthy, democratic society with strong nongovernmental community institutions.¹ In Germany, 90% of the population pays affordable contributions into the community-based system of statutory health insurance funds, which is supplemented by employer contributions and some taxes. The remaining 10% of citizens, most of whom have above-average incomes, pay into private insurance schemes. For the small group of people who receive state income support or have no income, contributions are financed from taxes.²

Most people in Europe believe that a strong community is a central driving force for both a good health care system and a prosperous society. Adequate medical care can be so expensive that few can afford it on their own. But if the risks are divided among us, optimal medical care can be offered to all. Communal responsibility is not an unrealistic ideal. Healthy people's communal support of the sick is in their own interest, since one day they may need an expensive treatment for which they will have to rely on the working healthy — and if not, at least they are spared the worry that they will be on their own at a time of need. Such an approach is not communism

or socialism but simply common sense. Indeed, this system was introduced 125 years ago by the conservative German politician Otto von Bismarck.³

Some Americans may fear that in such a system their individual well-being might be sacrificed to that of the community. But U.S. physicians largely support the idea of limiting expensive drugs and procedures if doing so means being able to extend access to basic care to all.⁴ In a community-based health care system, every possible treatment cannot be provided to everyone — any more than everyone can have everything in a tax-based or private insurance system. But there are criteria for determining what will be restricted, and how. In Germany, these principles are laid out in law: a service must be necessary in order to be covered by the statutory health insurance system. This criterion builds on the in-

dividual-patient perspective: patients have a right to care that is objectively necessary to cure their disease, prevent a disease from progressing, or ease their suffering. But the perspective of the community is also considered: the costs must be reasonable in relation to the potential benefit.

Such care is deemed to be “necessary” if it has a scientifically proven benefit — clinical trials must show that it reduces the risk of death or disability or improves health-related quality of life. If a treatment is genuinely beneficial, it should be available to all who need it, and individual need is determined by patients and their doctors. But if a technology has no proven relevant benefit, it must not be financed by a community-based system; and if there is an acceptable alternative with similar benefit that is more cost-effective, a technology does not have an automatic claim on the community’s purse.

The method by which these criteria are applied, called benefit assessment in Germany and comparative-effectiveness research (CER) in the United States, is being debated in both countries. A community can meet its responsibilities to its members fairly only if there is a rational basis for coverage decisions. It is therefore no coincidence that virtually all European countries with community-based statutory health care systems also have a form of benefit assessment, intended to protect patients from harm and the community from misuse of finances.

Germany introduced CER because many products that are marketed as “innovations” are in truth merely modifications of old products in new, more expensive packaging. Sometimes, a new

product is actually worse than a time-proven one, and it can be rejected without detriment to health.

Assessments and decision-making criteria must be adapted to particular health care systems and cultures. The German system places clear priority on clinical benefit for patients; costs play a secondary role unless there is an alternative that is determined to be equally good, or almost as good, medically. This emphasis on the health and rights of the individual over costs is a reaction to German history: during the Third Reich, we were scarred by the Nazi state, which abused the name “public health” — by the compulsory sterilization of disabled people, for example.

Since the fear of state-controlled medical policy runs deep here, day-to-day decisions are made not by “the state” but by an independent authority representing the health care system: representatives of the health insurance system, physicians, patients, and hospitals must decide jointly.⁵ The government merely monitors the proceedings of this authority — the Federal Joint Committee — to ensure that it is carrying out its legal obligations. To help ensure that the committee’s decisions are based on sound evidence, the independent Institute for Quality and Efficiency in Health Care, which I direct, provides this panel with CER reports and scientific recommendations.

Our approach to coverage decisions is easiest to describe in relation to drugs. A benefit assessment is the first step. If a drug proves to be a real breakthrough, health insurance must pay for it at whatever price the manufacturer sets. Since the in-

attention is to reward real innovations, there is no limitation on price. However, if it turns out that a new drug has only slight advantages over other drugs — for example, because it needs to be taken once a day instead of three times a day — then a comparison of benefit and costs can be conducted. On the basis of this assessment, the health insurance system has the right to set a maximum reimbursement level. If the manufacturer does not lower the price to that level, patients must pay the difference themselves. An unfavorable cost-benefit ratio does not mean that a service receives no public funding support but rather that price pressure is exerted on the manufacturer.

Another possibility is that a drug proves to be just as effective as the competing drugs. Such drugs may be combined into “reference price groups.” The health insurance system allows only a fixed reimbursement for all drugs in such a group — an amount oriented to drugs in the lower price range. If a manufacturer does not lower the price of a drug accordingly, the patient must bear the additional cost; in practice, however, most patients simply switch to other alternatives. In this manner, choice is limited for physicians and patients for the good of the community — a form of access limitation that finds little favor with German physicians or the pharmaceutical industry but has no health disadvantages for patients.

In general, only if a drug proves to be less effective than other drugs can it be completely excluded from statutory health insurance coverage. Patients must pay the entire cost themselves if they wish to have it. However, in

rare cases when inclusion in a reference price group is for some reason not possible, a drug that is more expensive but no more effective can also be excluded from the reimbursement list.

Of course, the German system is also under pressure, and some people are unhappy with it — especially some physicians, mostly because they expect higher incomes. Nevertheless, this limitation of access to interventions without proven superiority contributes to the long-term stability of a system that can ensure high-quality, needed medical care for all citizens. Potentially harmful rationing would occur if services that are medically necessary and

for which there are no alternatives were limited or excluded. By contrast, some restriction of choice among equally effective alternatives is not rationing; it is merely rational. What is more, such assessments protect patients from the harm caused by overtreatment and ineffective treatments. One of the strengths of a community-financed and community-managed health care system is that it turns the Hippocratic oath's promise of sparing patients unnecessary (and thus usually harmful) medical treatment into a legal obligation.

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