Priority setting at the national level: a European comparison

Germany

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Agenda

- Mapping models of prioritization
- Delayed and reserved engagement
- The German “Sonderweg”
- Implications
Mapping models of prioritization using the example of Sweden, Norway, England, and Oregon

Differentiation

- Substance
  - Severity of illness: Extraordinarily important and independent criterion in Sweden
  - Pain and suffering are comparatively subordinated in Oregon
  - Emphasis Cost-Effectiveness in England

- Perspective
  - Individual in Norway and Sweden
  - Collective in Oregon and England

- Execution
  - Qualitative appraisals, deliberation in Sweden
  - Technocratic in Oregon

- Results
  - Recommendations/guidelines in Sweden
  - Funding or exclusion in Oregon
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**Mapping normative cultures**

- **Person-centered solidarity**
  - Priority for the worst off / sickest first
  - Violation of health maximization
  - Sweden, Norway

- **Community-centered solidarity**
  - Health maximization
  - Conflict with the reduction of health inequalities
  - England, Oregon
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Germany...

- ...might be closer to person-centered solidarity
- ...but is still in its prioritization-infancy

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Delayed and reserved engagement

Committees’ and academic engagement

- **2000** ZEKO (Ethics Commission of the German Medical Association) issued a statement on setting priorities in health care
- **2005** Parliamentary Study Commission on Medicine held a meeting on resource allocation
- **2006** National Ethics Council held an international meeting on resource allocation
- **2007** ZEKO issued a second statement on setting priorities in health care
- **2008** German Ethics Council launched workgroup “resource allocation” / Declaration of Ulm: German Medical Assembly addresses prioritization
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- **2009** Scarcity of Resources as a central topic of the German Medical Assembly
- **2010** President of the German Medical Assembly Hoppe: Hidden rationing in the German health care sector
- **2011** German Ethics Council published statement “Medical benefits and costs in healthcare: The normative role of their evaluation”
- **2012** Founding of the German Medical Association’s Workgroup “Prioritization in Health System”
- **2013** Workgroup “Prioritization in Health System”: interim report and statement “Prioritization assisted by physicians is necessary and helpful”
Delayed and reserved engagement

Rejection of prioritization

Despite a professional discussion has established there is no serious debate on prioritization among the public or within health policy.

In Germany rationing and prioritization are not associated with fair distribution but with the withholding of necessary treatments.”
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2009: Ulla Schmidt (German Federal Health Minister 2001-2009): The requirement of having a ranking list of diseases considered suitable for treatment is highly criticized. It has “less to do with humanitarian claims”, is “rather inhuman” and more likely “scaremongering by functionaries.”

2009: German Ministry of Health of Health: “Even in future, insured persons have a claim to get full range of service within the statutory health insurance. Considerations on prioritization are therefore not on the agenda of the Ministry of Health.”

2010: Dr. Philip Rösler (German Federal Health Minister 2011-2013): “Prioritization in medicine? That is against my ethical principles as a physician.”
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Prioritization is rejected in particular for two reasons:

(a) There is no scarcity in health care.

(b) Priority setting endangers the solidarity-based health system and is “unethical.”
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The German “Sonderweg”

• Usage of economic evaluation at the national level differs essentially between countries

• Usage in Germany
  • Limited role of health economic evaluation
  • Increasingly important in the context of drug evaluation
    • Reasonable maximum reimbursement for drugs
    • Value-based pricing and negotiation
    • No decision about funding

• Players
  • The G-BA, the “Federal Joint Committee” of insurers and healthcare providers is the major decision maker
  • The IQWiG (Institute for Quality and Efficiency in Health Care) supports the G-BA with HTAs

• Methods
  • Special methods developed by the IQWiG (Institute for Quality and Efficiency in Health Care)
  • ..