Committee 3
Values and the Social Order:
Order by Rules and Rules by Order

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VOLUNTARY AND COERCIVE ORDERS IN THE HEALTH CARE SYSTEM

by

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Progress in medicine went parallel with progress in the natural sciences. The costs in applied medicine, i.e. diagnostics, therapy and care, rose steadily but not explosively in the 19th and early 20th century. The dramatic rise of costs in medicine occurred during the last 60 years and still continues. The main reason is the enormous technical development in diagnostics, the increased costs for therapy and mainly the steadily rising wages of the people working in the health system as such. Here it is worthwhile to point out that the costs for the physicians are proportionally low, which is in contrast to the common believe. Another reason for the rise in medical costs is the increased lifespan of the individuals, which again depends mainly on medical progress.

We cannot and do not want to shorten the lifespan. High costs in medical technology will increase further and are difficult to rationalize. High wages depend on the average standard of living: They might be temporarily frozen but cannot be driven downward.

Financing a public health system gets more and more a severe problem. Nobody can want or expect the slowing down of medical progress. Principally, there are three ways of coping with the problem of expenses: First, let the state take care of it. Second, let the free market do it. The third possibility would be the way between. I am thinking of a system as free as possible, with only a smaller part

supervised by the state. However, this supervision must be controlled by a neutral commission.

Meanwhile we have enough data to be able to judge a pure state-run health-system. In this context let us not even talk about health systems in former communist countries. Very good examples for nationalization of a health system in the West are Great Britain and Sweden. In both countries a socialist government went that way. Great Britain was first to integrate health care into the state. After a little success in the beginning, soon stagnation set in, and when costs rose higher and higher, the break-up of the system began. It developed - which could have been foreseen - a two-class medicine. Sweden could, and should, have learned from that. But strangely the country went the same way - with one difference, though. Sweden started out on a much higher level.

I will only briefly go into details because the situation is by now known to everybody.

Nationalization always has ideological and political reasons and rarely if ever does it have objective reasons. This is of course also true about the health system. More and more promises are made to the voters (potential patients) and have to be redeemed. Quite soon it became obvious that nationalization had a high price, was hard to manage and difficult to control. In addition, there was hardly any individuality left over for the patients. One

can easily imagine the harmful effect on the treatment of a patient.

This paying of practically all costs inevitably drove itself ad absurdum. Let me just remind you of the famous wig story. In Great Britain everybody was entitled to a wig. Everybody, mind you, not patients.

A big psychological mistake was to leave the individual in total ignorance about the expenses of medical work and especially those he caused. He became aware of it first, when the taxburden became higher and higher which was necessary to finance this experiment of the state but still gave the patient no detailed information. Its taxes rose, Swedes began to understand that they themselves paid for medical costs. This is of course a necessary feature of the system: Keep the payments indirect and don't make them transparent for the "buyer". The politicians just promised more advantages in health care.

It is quite clear that everybody should bear the costs of his own sickness and take precautions in accordance. If you do this you surely listen to your doctor's advice concerning your way of living, your eating habits, alcohol and nicotine consumption for instance. Experience says that patients not directly involved financially with the doctor react only in life-endangering situations by changing their habits. But this often comes to late and causes new expenses.

Naturally the state is interested to take care of certain medical problems itself. The state owes this to its citizens to protect them from medical harm. I would like to mention here the regulations to avoid spreading infectious diseases. This also applies for diseases connected with a certain profession. The work of the Food and Drug Administration belongs to this field. Preventive medicine very often implies compulsory measure. Here we reach the problem of weighing advantages and disadvantages. What is good for the patient and what is good for the society? An example: X-ray screening of schoolchildren and teachers.

This weighing also applies to most vaccinations. It is understandable that parents became hesitant to let their children be vaccinated once they heard about all the possible side-effects. The expenses e.g. for a polio vaccination, compared to the possible costs of non-vaccination i.e. paralys are negligible. Thanks to vaccination, polio has practically disappeared. Another important example in preventive medicine is connected to pregnancy. In the beginning, testing more or less applied only to blood groups to exclude cases of incompatibility between mother and child. Meanwhile, the repertoire has become considerably bigger. Tests for toxoplasmosis, German measles, hepatitis, HIV-infection and others have been introduced to protect the newborn. There are differences from country to country, and in many countries these tests are obligatory. In those special cases, nobody talks about

expenses. I want to point out if it comes to the birth of a sick child, the expenses may become extremely high in the future. Not to talk about the extreme psychological strain on the parents. Such children very often need a lifelong special ward. In this field of preventive medicine, expenses are easy to calculate and therefore bearable. They will be accepted by all public and private insurances without discussion.

The costs become more problematic if very modern technical diagnostic equipment, such as computer tomography or nuclear spin resonance detectors will be used. The question is: When will it be necessary to apply such a costly method? Today, it is considered as medical malpractise if a doctor does not use one of these modern methods with a patient who suffers from headache for a certain period of time. Here the rising costs can become a unbearable burden.

It is very difficult to work out cost-lowering measures. The probably biggest problems are the hospital expenses. The relative anonymity of hospitals and of their supporters, (institutions such as communities or caritative organisations) is a problem leading to difficulties in cost-benefit calculations. Meanwhile we have learned that a well-run hospital needs a good economist in the management. But he or she is almost unable to produce the high costs for the salaries. These costs - with rising tendency - correspond to living standard of each country in question.

Now where are possibilities to cope with expenses? Are those steadily rising expenses bearable without end? If limitations become necessary, who is going to decide which limitations shall be done and to what extent?

To answer such a question one must know in the first place how such a health system is constructed. Indeed, nothing speaks in favour of complete nationalization as in Sweden. The Swedish example is the best argument against nationalization. In Sweden the health system went into total authorization by the state. Seven Swedish crowns was the personal cost to a patient. Private wards disappeared from the hospitals, private doctors became very constrained in their work, and the free choice of a doctor was practically impossible. One had to go to "one's doctor" or hospital. If one went to a private doctor one almost got no reimbursement from the insurance system. Long waiting lists arose for non-acute operations. Those who were able to afford it had it done in a foreign country. But this group became smaller and smaller because the Swedish crown lost more and more of its value. In Sweden one had the right to take sick-leave for a certain time without certification by a doctor. This very often happened on a Monday or Friday, and damaged the economy. The government tried to change things, and introduced prescription fees for the patient, and after that a personal contribution to medicines prescribed by the doctor. A personal contribution to the hospitalisation was introduced. Why should a patient eat

and live on the expenses of an insurance? Rather late, one recognized this fact. Meanwhile some private enterprises like smaller hospitals and ambulatories were installed. Now these installations have a contract with the state insurance because the government found to its surprise that they are cheaper than the state-run hospitals. You can find private doctors again.

Now, could there be an alternative to a state-run health system? The answer would be a complete free-market, managed by economists and physicians alone. This could definitely be an alternative. The free enterprise system would be able to deal with cost-risk comparisons much better. In this free market though it would be very important to have some kind of supervision council. It must be able to inhibit the formation of cartels which of course would drive up costs. I think of the insurance companies or the pharmaceutic industry and last not least also of the doctors.

Such a council should consist of all groups involved in health care. Only these are able to judge trends in medical development and costs. As each citizen is obliged to pay taxes, he or she would be obliged to have a health insurance policy. However, not everybody is able to pay for such an insurance. These people do not pay taxes either. They will depend on social welfare. Therefore members of a government and/or the Internal Revenue will have to belong to the council. Such a council will best be suited to do all the calculations about insurance premiums, hospital

costs and so on, which are necessary to cover the basic medical needs. Detailed questions about control systems etc. must be adjusted to local conditions. Remember, this is precisely the system that applies in form of personal liability insurance.

It is extremely important to keep the insured totally informed about all the expenses of the health care. But not in the way of statistics and percentages but whith detailed information of, for example, the cost of local anesthesia or gastroscopy. So each individual is able to determine - as with his car insurance - the range of his personal excess. It must become known that medical progress has its price.

So far Germany has chosen a middle course between state and private health system. There are both private and so-called public health insurance set-ups. About 90% of the insured population belong to the public health insurance (i.e. a semi-state organisation). Crucial is that every employee is obliged to belong to a health insurance. Every employer is obliged to pay at least half of the premium. Private insurance companies mostly have a higher premium than the public ones. They offer a wider range of conditions and are more flexible with regard to personal excess. The public insurances make contracts with groups of physicians. Together with these and representatives of the social security they decide about conditions, work and payments to the doctor. These are considered "binding" for the doctors.

The doctors are paid by the public insurance. Not all doctors are have such a contract. This means that the patient has no free choice of a doctor. But the majority of doctors are "contract-doctors".

The privately insured always pays directly to the physician and his redeemed just in accordance with his individual policy. If insured by a public insurance, one does not pay anything to the doctor. The doctor will recieve his fee later on by the insurance through his representation. It is not allowed to refuse treatment of a patient insured in a public insurance. The doctor is also entitled to take part in a certain emergency duty. For the majority of doctors it is very important to be a contract-doctor because - as mentioned - almost everybody belongs to a public insurance. Lately contract-doctors are more and more limited in numbers. But I have the impression: The more doctors, the higher the costs.

The expenses for health-care in Germany are steadily increasing. The answer of the state is to act more and more dirigistically, cutting fees and limiting insurance benefits. The government does not dare increasing the obligatory premium to the public insurance. The government is afraid of losing voters. Thus it will be more restrictions and limitations. Smaller ones for the patients, bigger ones for the doctors. They are in the minority and are not allowed to refuse work. At the present time, the insured does not suffer from these measures. He

now has to pay a prescription charge, he gets less physical therapy, expenses for certain drugs like cold tablets, vitamines and similar are not free anymore. The main reduction is done to the doctors' fees. But these measures did not help very much. The government decided to do a "New Deal". The state leaves all internal organisation and regulations to the doctors and the insurances. So far, so good. The motto is: *Divide et impera*. *"Divide"* means here: Put the responsibility on the doctors and the insurances. *"Impera"* means here: The government decides the amount of money which can be spent whithin the health system. This amount is not allowed to exceed the given limit. This means, that every medical measure automatically becomes lowered when the whole amount is not sufficient. At times, this goes so far that doctors are forced to pay from their own pocket if they have prescribed for example too many drugs or too expensive ones.

With regard to the private insurances they still have different conditions. But even now, we can already see how they plan more restrictions instead of offering a greater variety of premiums. So far they still can - without consideration to politics - increase their premiums within a certain limit. But even the private doctor is bound by a state-controlled fee system. Thus it is easy to see that in Germany the influence of the state within the health system (public and private) becomes stronger and stronger. All this in the vain hope to cope with rising costs.

Surely there are political reasons that the government does not dare to apply measures of the free market. The German way will soon reach similar results as in Great Britain or Sweden. Therefore it is time to change the system to a free and open one because the present one is no longer practicable.