

# The non-existent **Priority-setting in Germany** and its implications for structures and utilization

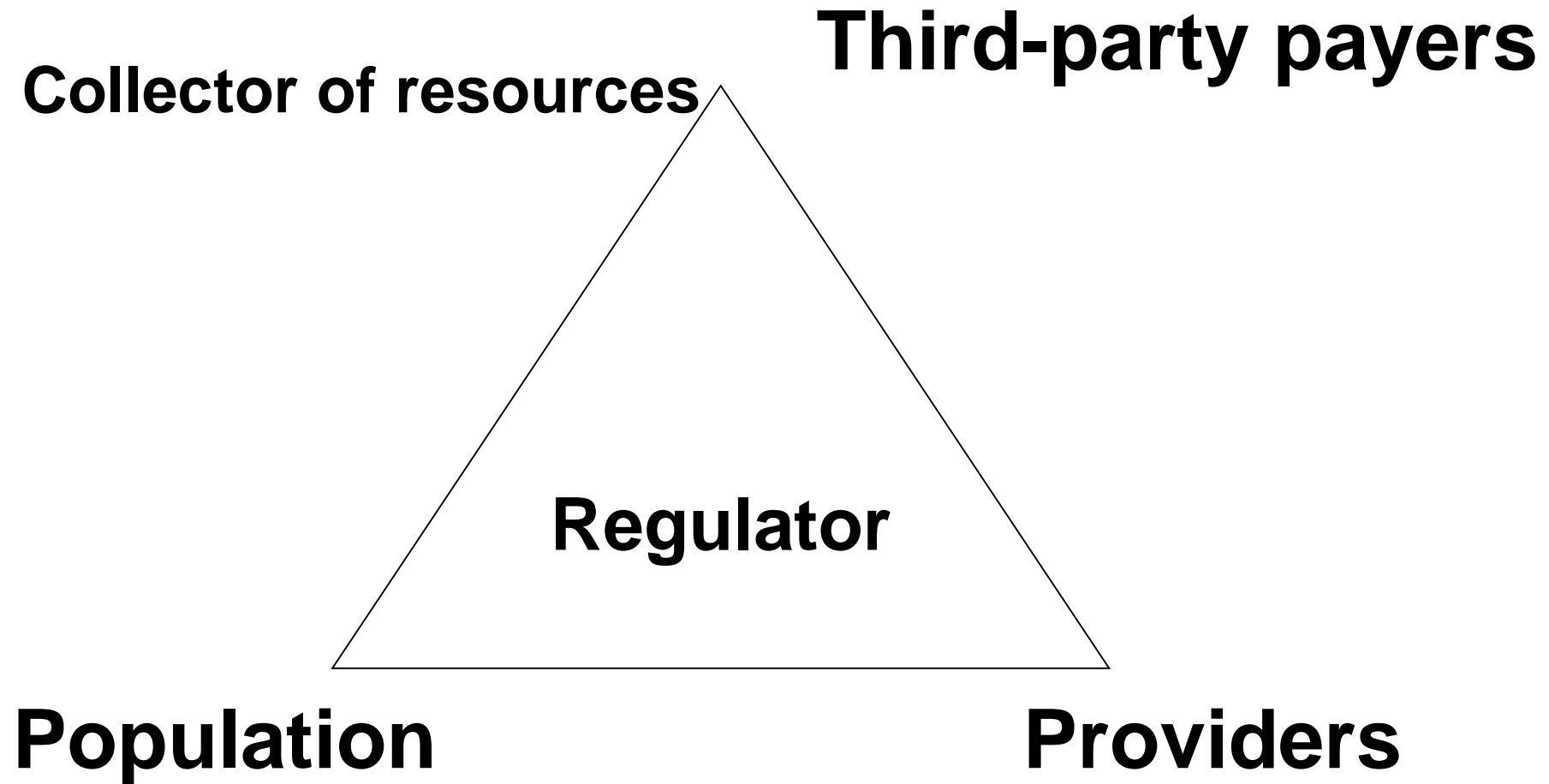
**Reinhard Busse, Prof. Dr. med. MPH FFPH**

FG Management im Gesundheitswesen, Technische Universität Berlin  
(WHO Collaborating Centre for Health Systems Research and Management)

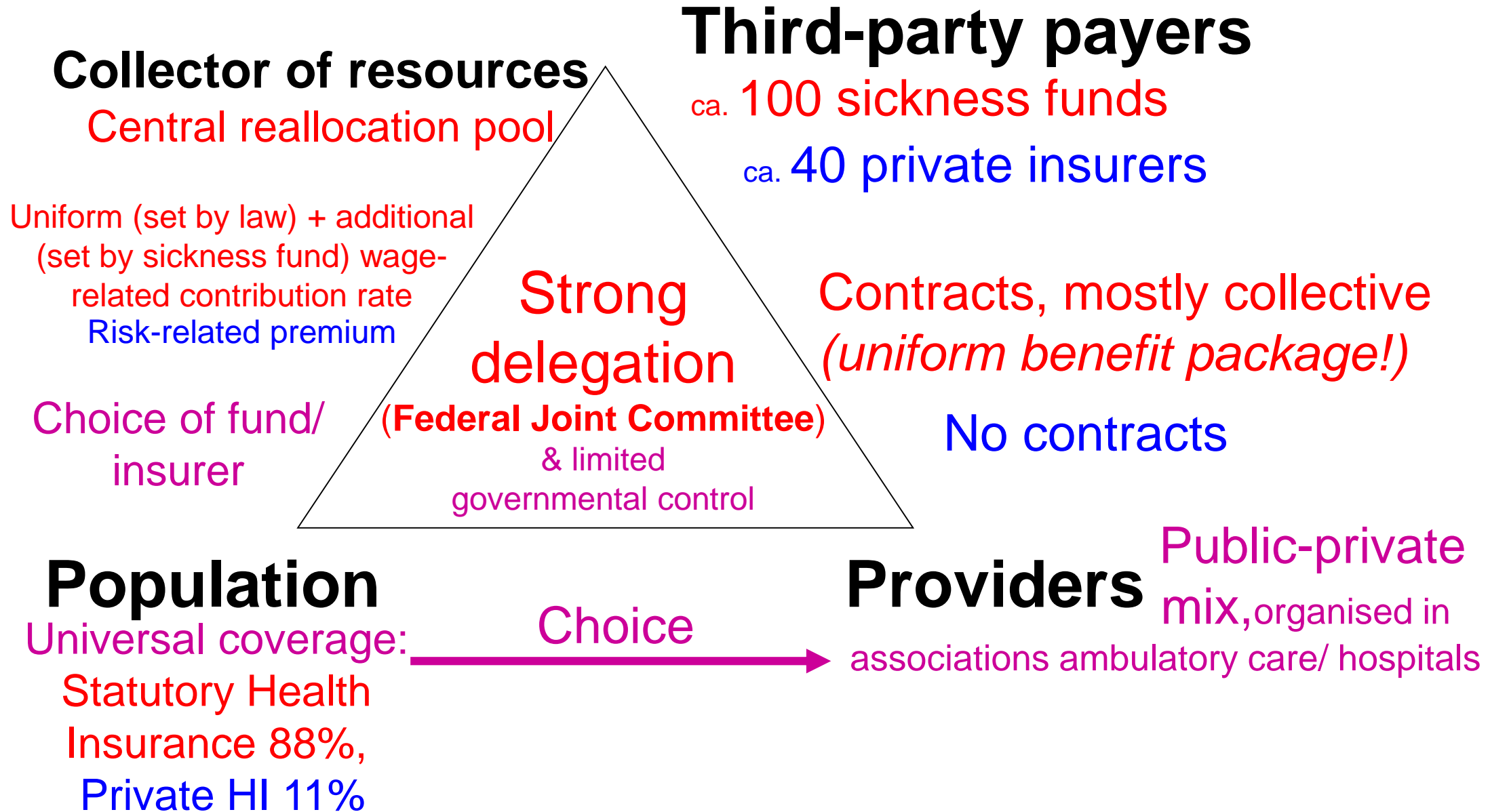
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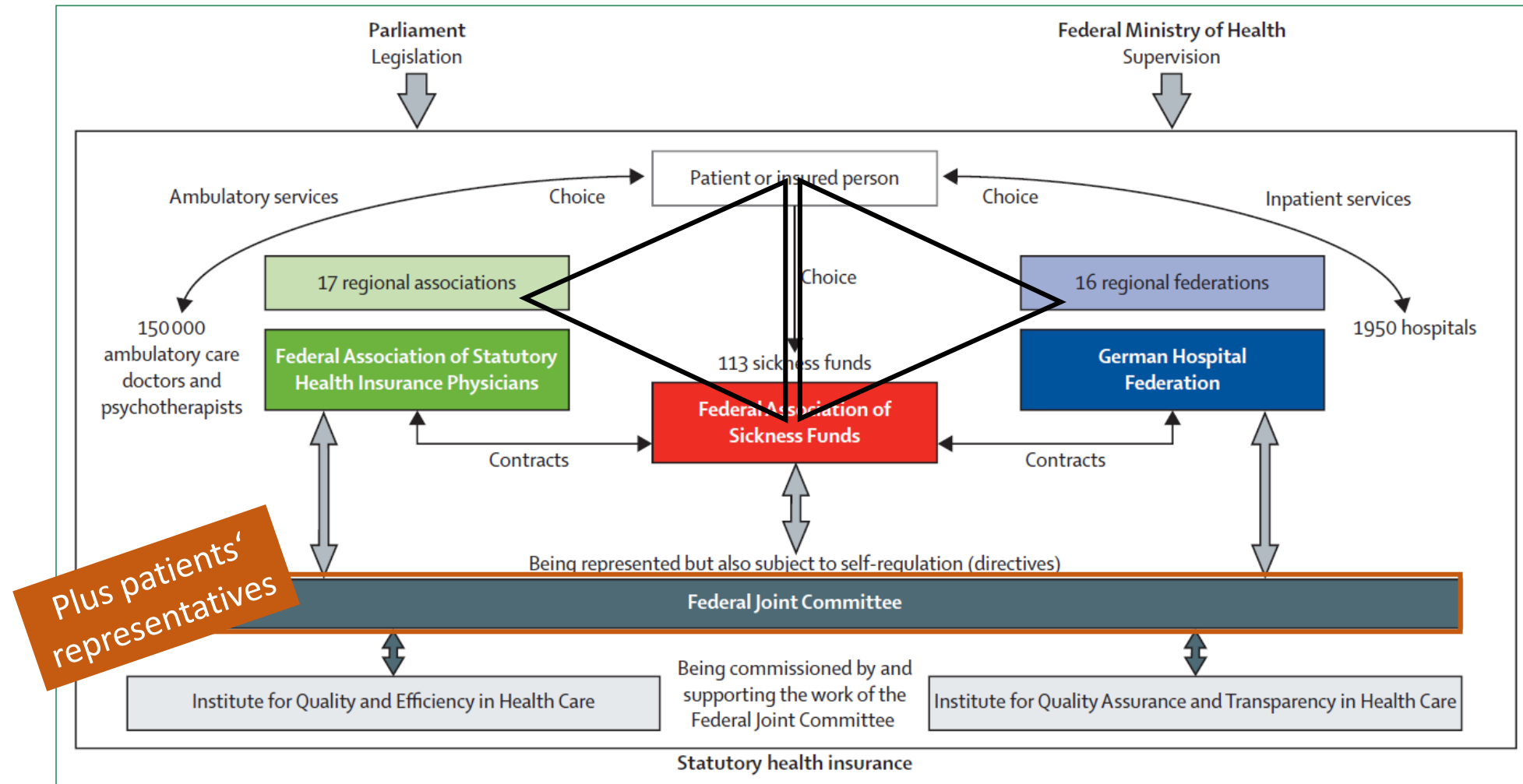
# How we look at health systems



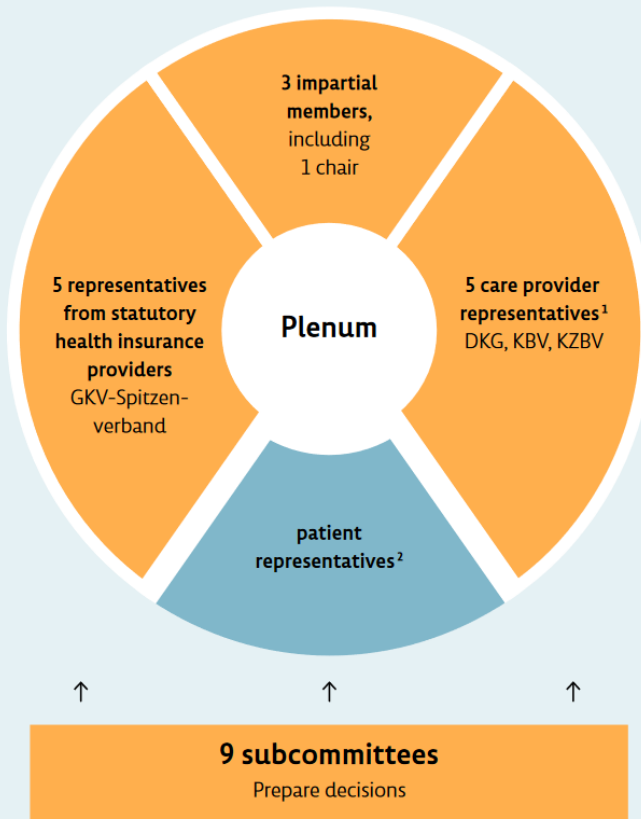
# The German system at a glance (red SHI, blue PHI, purple both)



# Self-governance and competition in SHI (among providers and payers): the central role of the cross-sectoral Federal Joint Committee



Structure of the Plenum –  
the core decision making body of the G-BA



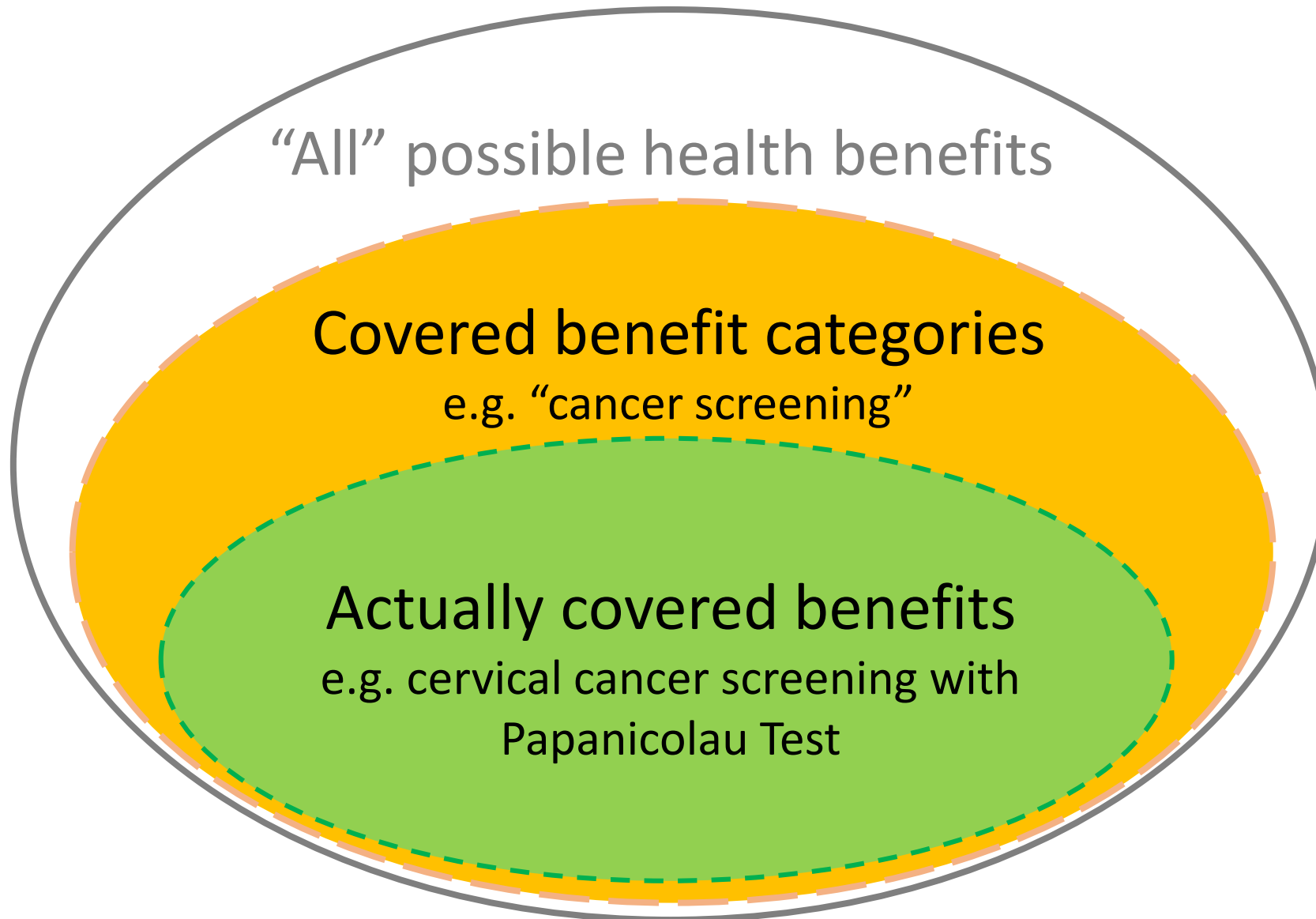
# Objectives of Federal Joint Committee

- Main functions: to **regulate SHI-wide issues of access, benefits and quality** (and not primarily of costs or expenditure)
- Normative function of the G-BA by legally binding directives (“sub-law”) to guarantee **equal access to necessary and appropriate services/ technologies** for all SHI insured
- Benefit package decisions must be justified by an **evidence-based process (= Health Technology Assessment)** to determine whether services, pharmaceuticals or technologies are medically effective in terms of morbidity, mortality and quality of life
- By law, evidence based assessments can only be used to select the most appropriate (efficient) service etc. from others – not to prioritize among service areas: if a costly innovation has a significant additional benefit, the sickness funds must pay for it

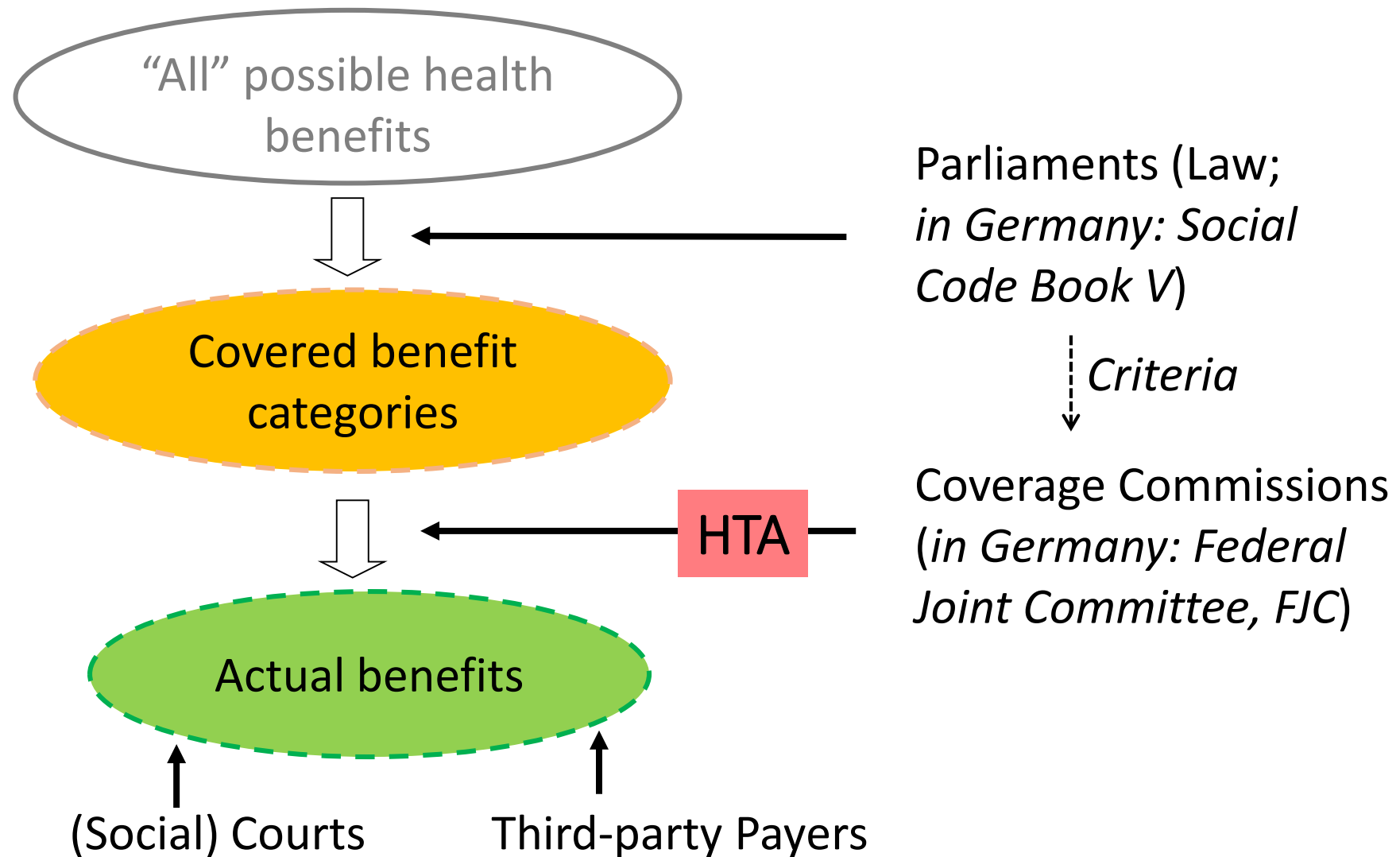
# Germany is

- far from any priority-setting by groups of indications (preventive, life-threatening ... as long as it is not explicitly mentioned in law), actual indications, age/ sex, ...
- but at least it has advocated „evidence-based“ decision-making for ca. 25 years – how far is it with that?

# Understanding the concept of HTA for making decisions on coverage, and possibly priority-setting, of services/ technologies



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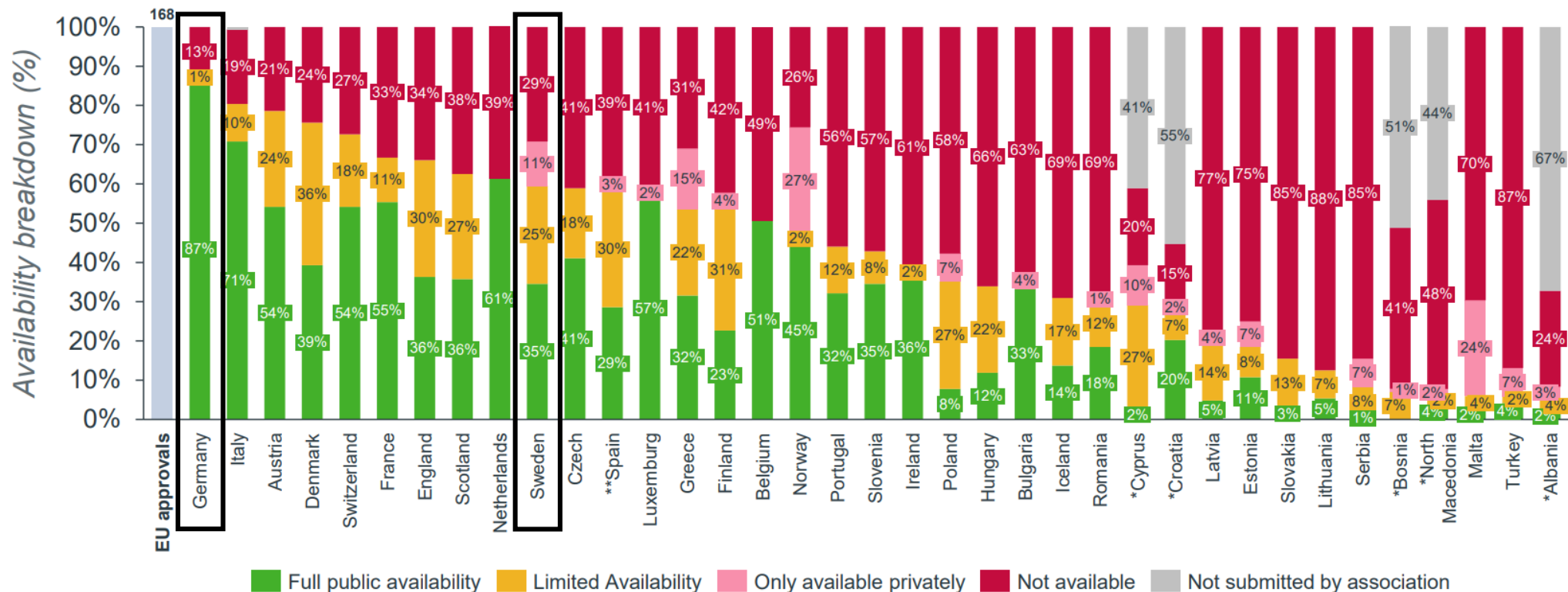
# But HTA is positioned very differently by sector

	Ambulatory care (prevention, curation ...)	Pharmaceuticals	Inpatient care
Evaluation of effectiveness/ additional benefit vs. comparator necessary for inclusion in benefit coverage	YES, for all services applied for	YES, of all new pharmaceuticals/ new indications vs. comparator given by FJC	NO, only if an exclusion is proposed
Cost-effectiveness evaluation	NO	PRINCIPALLY POSSIBLE (but never done sine 2011)	-
Usage of effectiveness evaluation	Coverage and fee	Price only (no pharmaceutical excluded as result of evaluation)	-

In Germany, almost all new drugs are publicly covered - but it pays 1.79% of GDP for pharmaceuticals (vs. Sweden's 1.04%)

## Breakdown of availability (% , 2018-2021)

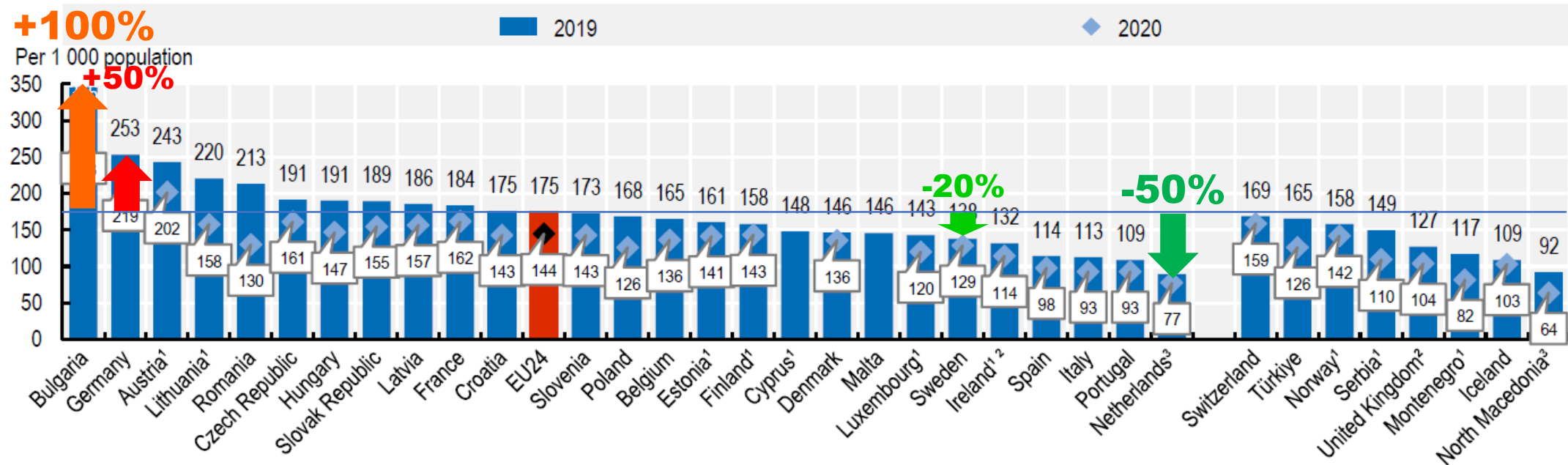
The **breakdown of availability** is the composition of medicines available to patients in European countries as of 5<sup>th</sup> January 2023 (for most countries this is the point at which the product gains access to the reimbursement list<sup>†</sup>). This includes all medicine's status to provide a complete picture of the availability of the cohort studied.



European Union average: 76 products available (45%), Limited availability (14% of all products). Netherlands did not submit complete information on restrictions to available medicines meaning LA\* is not captured in these countries. †In most countries availability equates to granting of access to the reimbursement list, except in DK, FI, LU, NO, SE where some hospital products are not covered by the general reimbursement scheme. \*Countries with asterisks did not complete a full dataset and therefore availability may be unrepresentative. \*\*In Spain, the WAIT analysis does not identify those medicinal products being accessible earlier in conformity with Spain's Royal Decree 1015/2009 relating to Medicines in Special Situations

Germany has 50% more inpatient treatments than EU average (and 80% more than Sweden) ... and inpatient spending is 3.4% vs 2.4% of GDP (2020)

Figure 7.24. Hospital discharges per 1 000 population, 2019 and 2020



Note: The EU average is unweighted. 1. Data exclude discharges of healthy babies (between 3-10% of all discharges). 2. Data exclude activity in private hospitals (in Ireland, private hospitals account for about 15-20% of hospital discharges). 3. Data include discharges for curative (acute) care only.

Source: OECD Health Statistics 2022; Eurostat Database.

For intensive care, the difference is much larger

Country	Number of hospitalisations per 100,000	Number of ICU patients per 100,000	Number of ICU patients per 1,000 patients
Denmark	19,181	473	25 (1 : 40)
England	12,874	436	33 (1 : 30)
France	18,802	932	50 (1 : 20)
Germany	20,124	1870	93 (1 : 11)
Italy	8,713	150	16 (1 : 65)
Sweden	12,755	421	34 (1 : 30)
The Netherlands	7,670	366	26 (1 : 40)
FACTOR	2.6x	12x	6x

# Conclusions

- In many respects, the German health system is the opposite of the Swedish system ...
- no priority setting with most services and goods covered, high accessibility but limited emphasis on outcomes ...
- and very similar population ratings on satisfaction over the last 25 years.
- Time for a more in-depth comparison!