Why Streeck's proposal starts at the wrong level - and what has been known for 20 years



Prof. Dr rer. oec. Axel C. Mühlbacher Health Economics and Medical Management, Neubrandenburg University of Applied Sciences

>> In a television programme, Hendrik Streeck, a member of the Bundestag, raised the question of whether very old people should still be prescribed particularly expensive medication. He describes the final weeks of treatment for his father, who had lung cancer, and comes to the conclusion that a lot of money was spent without the therapies having any recognisable benefit. From this he derives the demand to think about limiting such therapies in old age.

The argument boils down to the following: it is suggested that the treatment of very old people with very expensive innovations has a poor cost-benefit ratio and that a system with limited resources must put a stop to this. The latent message is that age should be used as a criterion for rationing.

This perspective is not new. It is essentially what was already discussed in this debate at the beginning of the 2000s - at that time much more well-founded and at the same time just as politically toxic.

Breyer and Ulrich 2000: Demographic change, medical progress and contribution rates

In DIW Weekly Report 24/2000, Friedrich Breyer and Volker Ulrich analyse the long-term development of healthcare expenditure and the contribution rate in statutory health insurance. The starting point is a forecast by PROGNOS AG, which expected an increase in the average contribution rate from around 13.5 per cent to around 16 per cent by 2040 and had a broad impact on the political debate at the time.

Breyer and Ulrich show that this forecast has two central weaknesses. Firstly, it does not adequately reflect medical progress. Secondly, age-specific healthcare expenditure is overestimated because calendar age is

misunderstood as the driving factor. The authors present two alternative estimation approaches: They explicitly distinguish between people in the last year of life and all others and additionally use a regression analysis of SHI expenditure in which income, age structure and a time trend are included as an approximation for medical-technical progress.

The results are clear. The ageing of the population only leads to a comparatively moderate increase in expenditure and the contribution rate. The dominant driver is medical progress, understood as a sequence of cost-increasing innovations. Realistic assumptions about this innovation dynamic result in a contribution rate of around 23 per cent for 2040, i.e. significantly more than the 16 per cent circulating politically. Above all, demographic ageing generates a financing effect: the number of contributors falls in relation to the number of benefit recipients, which pushes up the contribution rate without per capita expenditure exploding.

The economic conclusion that Breyer and Ulrich draw from this is clear: if you want to limit increases in contribution rates, you have to focus primarily on medical-technical progress, incentive structures and the question of efficiency - not on the age of patients.

Parallel to this work, the so-called "red herring" thesis is being formulated internationally. Contributions by Peter Zweifel, Stefan Felder and Markus Meier, among others in Health Economics and the Journal of Health Economics, are central here. The key point of this literature is precise and directly relevant to the debate surrounding Streeck's proposal: The authors use individual and panel data to show that calendar age is a poor explanation for healthcare expenditure. The decisive factor is the proximity to death. Expenditure rises sharply in the last year of life, largely irrespective of whether this last year of life is reached at the age of 65, 75 or 85. If life expectancy increases, the expensive phase shifts backwards; however, this does not automatically lead to a permanent, linear cost drift throughout old age.

The DIW analysis complements this empirical perspective by visualising the mortality effect at the micro level. It thus provides a robust justification for the statement that it is analytically abbreviated to attribute cost pressure in the healthcare system primarily to "the elderly". The decisive mechanism is not age per se, but the fact that in modern healthcare systems the last year of life is treated very intensively - for understandable reasons.

Breyer 2003: Age rationing in "Report Mainz"

The link between contribution rate projections, medical progress and the near-death effect did not remain abstract. In June 2003, Friedrich Breyer

appeared together with theologian Joachim Wiemeyer in the ARD magazine programme "Report Mainz". In the programme entitled "No medicine for the elderly? - Provocative proposals for healthcare reform", they presented ideas for limiting expensive treatments for patients aged 75 and over.

The position was summarised as follows: in view of foreseeable increases in contribution rates and limited resources, society should consider dispensing with certain costly measures for very old patients or no longer financing them from SHI funds. It later became clear in various statements that Breyer saw this consideration as a possible, but not mandatory, option as part of a broader package of control instruments.

The reactions were fierce. Social organisations filed criminal charges, medical professional organisations and church institutions distanced themselves; the German Bishops' Conference made it clear that the positions expressed in the programme did not reflect its stance.

What is decisive for the current debate is that there was a clear economic line of argument - based on projections, financial burdens, proximity-to-death effects and the realisation that not all medically possible services can be financed. Nevertheless, the attempt to openly discuss age criteria failed due to political and normative rejection. It is precisely this pattern that now threatens to repeat itself with Streeck, only with significantly less analytical groundwork.

Prioritisation: interventions first, people last

The aforementioned work by Breyer, Ulrich, Zweifel and others leads to a simple but harsh economic conclusion: prioritisation is unavoidable in a system with finite resources. The decisive factor is the order in which criteria are introduced.

At the first level is the evaluation of interventions. This involves questions such as: Which treatment brings what additional benefit compared to the alternative? Which intervention causes which opportunity costs, i.e. which other services must be omitted if it is financed? How high is the additional benefit per euro? Which effects are relevant from the patient's point of view?

At the second level are programmes, indications and care pathways. Here it is clarified in which indication areas, for which patient groups and under which conditions an intervention makes sense.

Only at a third level - and only in situations of real scarcity or emergencies - does the question of individual prioritisation criteria such as age, comorbidity, prognosis or other patient-specific characteristics arise.

It is inconsistent to move to level three if levels one and two are structurally inadequate. This is exactly what happens when people - like Streeck - talk about rationed therapies for the very old without there having previously been a consistent, systemic economic evaluation of the interventions.

The institutional gap: Benefit assessment without cost-benefit logic

In Germany, there are now institutional structures that would theoretically be suitable for enabling prioritisation at intervention level. These include, above all, the methods of IQWiG and the Federal Joint Committee. These institutions currently assess the additional benefit of new drugs compared to the appropriate comparator therapy. However, they explicitly do not answer the question or transparently whether this additional benefit justifies the prices charged or which alternative is displaced by the funding.

The result is an asymmetrical system: the additional medical benefit is evaluated in relative detail - on the basis of expert judgement - while the economic dimension (cost-benefit ratio, budget impact, opportunity costs) is only institutionally mapped to a very limited extent. Patient preferences or population-related value judgements have so far only played a subordinate role in this benefit assessment.

This is precisely where there is a central gap between what the literature has been calling for years and how decisions are actually made.

IQWiG's unused efficiency frontier

It is possible to carry out efficiency analyses. IQWiG has presented a comprehensive methods paper on the assessment of the relationship between the benefits and costs of medical interventions and has developed the concept of the efficiency frontier. The efficiency frontier is a relative cost-effectiveness criterion. It shows which combinations of costs and benefits of already reimbursed interventions are acceptable in an indication area. New interventions should then only be reimbursed at prices that are no worse than these reference points in relation to their additional benefit. In economic terms, the efficiency frontier is an attempt to visualise opportunity costs within the existing system.

In fact, this instrument has only been used in Germany to an extremely limited extent or not at all.

Critics speak of the "German special path" of the IQWiG cost-benefit assessment and discuss methodological and political reasons why the efficiency frontier does not play a central role in routine care. However, the consequence is clear: the possibility of prioritising interventions on the basis of

a consistent efficiency logic exists, but is not or hardly ever used. The methodological framework exists, but practical implementation remains the exception. This means that the system lacks precisely the tool that would be needed to enable a rational approach to expensive innovations before thinking about age limits or other individual criteria.

The demand derived from this is direct: before discussions are held about restricting benefits for certain age groups, the existing instruments for assessing cost-effectiveness - efficiency thresholds, cost-benefit analyses, systematic budget impact assessments - must be used consistently and developed further. Only when it is clear which interventions are efficient in which indication can it be meaningfully discussed whether and where individual criteria should also play a role.

Streeck's proposal in the light of 20 years

Streeck's intervention moves in a field that has been surveyed for two decades. The work of Breyer and Ulrich, the red herring analyses by Zweifel and colleagues, Breyer's overview articles on the relationship between demographics, medical progress and expenditure trends and the debates on age rationing following the 2003 "Report Mainz" programme form a well-documented background.

The conclusion from this literature can be summarised in three sentences:

- **Firstly** , demographic ageing primarily generates a financing effect and only a limited expenditure effect. Proximity to death is more relevant than age.

- **Secondly** , the real driver of expenditure is medical progress, embedded in a system that introduces innovations quickly and pays dearly for them without systematically asking about efficiency.

- **Thirdly** , appropriate prioritisation must start with interventions, not with people. It is not the doctors and nurses who should make social decisions for us, but the democratically legitimised decision-makers.

Streeck addresses precisely this third point without systematically addressing the first two. He asks whether it is still "worthwhile" to finance expensive therapies for very old people, although the German system has neither established a functioning efficiency frontier nor does it have a routine for cost-benefit analyses that make opportunity costs visible. He thus follows the same line of argument as Breyer 2003, but without the explicit link to the model calculations developed at that time and without the clear distinction between the levels.

Conclusion

The debate that Streeck has initiated is necessary, but it is being opened in the wrong place. The discussions of the last twenty years clearly show that increases in contribution rates and expenditure dynamics can only be attributed to a comparatively small extent to the ageing of the population. The decisive factors are medical progress, technological innovation chains and institutional incentives. Demographic changes primarily exacerbate the financing problem (the system has fewer and fewer contributors).

The upstream task is therefore not to decide whether 80 or 85-year-olds still "deserve" certain therapies, but to clarify which interventions are efficient in which setting. The IQWiG methodological report on the assessment of cost-benefit ratios with the concept of the efficiency frontier provides instruments for this purpose that have so far only been used selectively or not at all. As long as these instruments are not used systematically, any debate on age-related rationing is analytically truncated and politically skewed. Firstly, interventions and alternatives should be evaluated on the basis of costs, benefits and opportunity costs. Then programmes and indications should be prioritised. Only at the very end, if at all or in emergencies, can the question be raised as to whether individual criteria such as age should play a role within narrow limits.

With his proposal, Streeck is moving in a field that has been scientifically mapped in Germany since 2000 at the latest, but has never been consistently addressed politically. This is precisely what makes his intervention so vulnerable - and at the same time so symptomatic of a system that does not utilise its own economic instruments, but is prepared to save on patients when in doubt.

Why there are in fact no economic analyses in Germany

At this point, an obvious question arises, but one that has so far received surprisingly few answers: Why are the instruments provided for in the law for analysing cost-effectiveness not used in practice? And why is the perspective of systematic, cross-indication efficiency largely ignored, even though the health economic tools exist?

Firstly, on the formal side: Section 35b SGB V expressly provides for the cost-benefit assessment of drugs. The paragraph clearly states that the Federal Joint Committee (G-BA) can commission the Institute for Quality and Efficiency in Health Care (IQWiG) to carry out a cost-benefit assessment on the basis of an application in accordance with Section 130b (8) SGB V. Among other things, the commission must define the comparator therapy, the patient groups, the "type of benefit and costs" and "the measure of overall benefit". The legal basis is therefore clearly in place.

Nevertheless, this instrument does not actually take place. IQWiG openly writes in its own FAQs that the G-BA can "in principle" commission the Institute to carry out cost-benefit assessments to examine whether the benefits of a new drug justify the costs - "but IQWiG has only done this once so far". You don't really need to say more than that: no analysis without a commission. The legislator created the instrument, the G-BA practically does not use it. Why the G-BA does not make use of this option is not officially explained; only the G-BA itself can answer this question seriously. Speculative political-economic assumptions - such as that additional transparency would force painful distribution decisions via efficiency - are obvious, but remain speculation.

The second question is more subtle: Why are there no cross-indication cost-effectiveness analyses, i.e. no explicit opportunity cost logic across indication and sector boundaries? IQWiG itself is surprisingly clear on this point. In the early draft methodology for the cost-benefit assessment (version 1.1), it is explicitly stated in the preamble and in the summary that it was not the task of the expert panel to develop a method for setting reimbursement priorities in the entire healthcare system. Instead of system-wide prioritisation, the method is merely intended to compare the efficiency of healthcare technologies within a given therapeutic area and derive maximum amounts for reimbursement. The explicit focus "on one indication" is emphasised as a specifically German characteristic; questions of resource allocation across the entire system and the associated trade-offs are deliberately excluded.

The result of this doubly narrow construction is clear: we have a legal instrument for cost-benefit assessment that can only be activated on request - and this request is practically never given. And even if the instrument were used, it would be designed from the outset to be indication-specific, not as a mechanism for prioritisation across society as a whole. The opportunity cost logic is left out; it is indirectly negotiated in many individual case decisions, but not systematically operationalised.

The real explosive charge is contained in § 35b SGB V in exactly one sentence: "The G-BA shall specify in the mandate which time period, which type of benefits and costs and which measure of overall benefit are to be taken into account in the assessment."

If you take this seriously, it means nothing less than: The G-BA would have to define a benefit function or value function. It would have to decide which outcomes count at all (length of life, symptom reduction, functional capacity, quality of life, side effects, burden on relatives, etc.) and how these dimensions are to be weighted against each other. This is not a detailed technical question,

but a social value or preference decision. Whoever determines the measure of overall benefit implicitly defines a social welfare function - and thus the normative framework within which prioritisation is conceivable at all.

In my view, it is precisely at this point that the system systematically sidesteps the issue. The legislator writes "overall benefit" in the paragraphs, but does not provide any infrastructure to determine this measure in an empirically and normatively sound manner - for example, by systematically surveying patient and population preferences. Instead, the overall benefit remains an empty formula in practice, which is substituted by expert judgement, negotiating power and the logic of the individual case. Formally, the law states that the G-BA should define a measure of overall benefit. In fact, this central task is bypassed. This is precisely why the cost-benefit assessment remains blunt - and the actual prioritisation issue in the German healthcare system remains unresolved. <<

by: Prof. Dr rer. oec. Axel C. Mühlbacher1(ORCID: 0000-0003-4402-9211)

1: Health Economics and Medical Management, Neubrandenburg University of Applied Sciences

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