



# Health care reform and Diagnosis Related Groups in Germany: The mediating role of Hospital Liaison Committees for Jehovah's Witnesses



Małgorzata Rajtar

Department of Ethnology and Cultural Anthropology, Adam Mickiewicz University, ul. Umultowska 89D, 61-614 Poznań, Poland

## ARTICLE INFO

### Article history:

Received 13 March 2016  
 Received in revised form  
 5 August 2016  
 Accepted 8 August 2016  
 Available online 9 August 2016

### Keywords:

Germany  
 Health care policy  
 Jehovah's Witnesses  
 Diagnosis Related Groups  
 Blood  
 Judicialization of health

## ABSTRACT

Resulting from health care reform in Germany that was implemented in 2003–2004, a new medical classification system called the “Diagnosis Related Groups” (DRGs) was introduced in hospitals. According to the media, social scientists, and a few physicians interviewed in this study the policy negatively transformed the German health care system by allowing the privatization of the hospital sector consistent with the neoliberal health care model. Allegedly, this privileged economic values over the quality of health care and introduced competition between hospitals. Nevertheless, members of the Hospital Liaison Committees (HLCs) of Jehovah's Witnesses argued that the DRGs system could be used to the advantage of Jehovah's Witness (JW) patients. HLCs often assist in the patient's search by providing names of physicians that would be willing to refrain from blood transfusions.

This article draws from nine months of ethnographic research with Jehovah's Witnesses, including members of the HLCs, carried out primarily in Berlin between 2010 and 2012. By focusing on JWs, whose refusal of blood transfusions is often exemplified as particularly difficult for the biomedical profession, it addresses the “unintended” consequences of the introduction of DRGs into the German health care system that remain unexplored by health and social science scholarship. It argues that although JWs have long been associated with the judicialization of religious freedom globally, they do not equally engage in the judicialization of health in countries such as Germany. The reason for this is embedded not only in health care policy that favors mediation over medical malpractice litigation. It also results from the synergy of health care reforms that prioritize standardizing and economizing measures such as DRGs as well as practices implemented by Patient Blood Management programs that JW institutions, such as HLCs, have tapped into.

© 2016 Elsevier Ltd. All rights reserved.

## 1. Introduction

In numerous countries worldwide, patients turn to courts to seek and often realize access to health care, a phenomenon called the “judicialization of health” (Biehl, 2013). The judicialization of health constitutes an example of the “judicialization of politics” which is sometimes characterized as the “most significant phenomena of late twentieth and early twenty-first century government” (Hirschl, 2008:2). The “judicialization of politics” refers to the fact that courts and the judiciary more often make decisions concerning major political issues, assuming the role of “ultimate decider,” with the ability to overrule executive directives and legislation passed by legislatures” (Richardson, 2015:4). Drawing from nine months of ethnographic research with Jehovah's

Witnesses (JWs) and physicians in Germany, this article addresses issues at the border of health care policy and religion. Within bioethics and biomedicine Jehovah Witness patients are known for their refusal of blood transfusions that often pose an ethical quandary for the treating physicians (Bock, 2012; Muramoto, 2001; Rajtar, 2013). However, they have also been known for their impact on American legal history (Knox, 2013). In the U.S., where courts have long played a “significant role in policy-making” (Hirschl, 2008:2) and in Europe more recently, JWs have significantly contributed to the “judicialization of religious freedom” (Richardson, 2015:7–9). Thus, given the Society's long-standing tradition of litigation for freedom to practice their religion worldwide, right-to-health-litigation might have seemed an obvious choice for JWs who refuse blood transfusion. Nonetheless, this is seldom pursued by JWs in Germany. Instead, as I argue, JWs effectively deploy their own structures such as Hospital Liaison Committees (HLCs) and often utilize discourses as well as

E-mail addresses: [mrjartar@yahoo.com](mailto:mrjartar@yahoo.com), [malraj@amu.edu.pl](mailto:malraj@amu.edu.pl).

bureaucratic and medico-economical practices and instruments introduced by health care reforms intended for religious patients. This issue has yet escaped the scrutiny of health and social science scholars.

This article starts with a short overview of health care reforms and specifically the introduction of the Diagnosis Related Groups (DRGs) system in Germany. After presenting research methods, it examines the JWs' position on blood and their engagement with the judicialization of politics, and the judicialization of health in particular. It highlights that unlike individual cases of right-to-health-litigation analyzed, for instance, in Brazil, the Society has been engaged in a broader "education and advocacy" project (Baron, 2011:544) to protect and negotiate rights of Witness patients. Simultaneously, it argues that due to a number of reasons, such as the low number of cases of medical malpractice settled in courts, moderate damages awarded, and the extensive social safety net (Roudik et al., 2009), medical malpractice litigation has not been an often pursued option in countries such as Germany. Thus, this study seeks to move beyond the perspective employed in the "judicialization of health" that points to the importance of the judiciary in access to health care. Instead, it illuminates the ways in which the Society and its Hospital Liaison Committees (HLCs) accommodate changes brought by health care reform, such as DRGs and standardization, and it participates in the establishment of the Patient Blood Management program in Germany.

## 2. Background

### 2.1. The health care system in Germany

Decentralized and diversified, the German health care system is characterized by the sharing of decision-making powers between the *Länder*, the federal government, and civil society organizations. The federal and *Länder* governments delegate powers to "corporatist bodies," mainly sickness funds (Busse and Blümmel, 2014). Since 2009, health insurance has been mandatory for all citizens and permanent residents, either through statutory health insurance (*Gesetzliche Krankenversicherung*) (SHI) or private health insurance (PHI). In 2014, these covered 85% and 11% of the population respectively. Moreover, 4% of the population were covered by sector-specific governmental schemes. The majority of JWs in the study were covered by the SHI. SHI coverage allows one to choose from 132 sickness funds and guarantees "unrestricted access to all care levels" (Busse and Blümmel, 2014:XXI). Sickness funds are non-profit, quasi-public corporations, which are required by law to collect contributions from their members and transfer them to the Central Reallocation Pool which is administered by the Federal Insurance Authority; contributions are mandatory and are generally split between employers and employees; these contributions are dependent on income rather than risk (Busse and Blümmel, 2014:132ff.).

Between 1977 and 2010, Germany underwent a series of health reforms, which according to Michael Porter and Clemens Guth "fostered a system that is preoccupied with cost, but ignores value" (Porter and Guth, 2012:62). Changes brought about both by the *Gesundheitsreform* implemented in 2000 and the system of Diagnosis Related Groups (DRGs) from 2003 received particular scrutiny in the media (e.g. *Zeit Magazin* 05/16/2012). Physicians and nurses with whom I talked also found these changes unfavourable. Generally, it was argued that these changes degraded the quality of German health care. German historian of medicine and institute director at Charité hospital in Berlin, Paul Unschuld (2011:83) noted only half-jokingly that after the introduction of DRGs "coming through the door, every single patient who is brought to the hospital bears an invisible, albeit definitive price tag on their forehead."

### 2.2. Diagnosis Related Groups and treatment protocols

DRGs are a means to "categorize the variety of heterogeneous cases into clusters of medically and economically homogenous cases" (Ridder et al., 2007:2121). As a basis for ensuring uniform and systematic hospital payments, DRG's were first used by Medicare in the U.S. in 1983; since then, hospital payment systems that are based on DRGs have mushroomed in most high-income countries (Geissler et al., 2011b:9). Despite the diverse meanings ascribed to the term "DRG" itself in different countries, the objectives of introducing DRG systems were similar everywhere. These were twofold: (1) Increasing the transparency of services provided by hospitals (i.e. patient classification, measuring hospital output), and (2) a more efficient use of resources within hospitals, i.e. hospitals were paid "on the basis of the number and case treated" (Geissler et al., 2011b:10; cf. Mathar, 2007; Ridder et al., 2007). Together, increased transparency and efficiency were to bring about a better quality of care along with reduced waiting times and lengths of stay, support for patient choice, and competition between hospitals. According to Geissler et al. (2011b:12), in many European countries, the DRG system "fitted well with the paradigm of designing public policy according to general economic principles, in order to exert financial pressure and to incentivize efficient resource use (...) by mimicking product markets that produce at marginal costs."

When the DRG system was introduced in Germany in 2003, at first hospitals could voluntarily group their patients; by 2004 they were obliged to do it (Geissler et al., 2011a). Unlike some countries which introduced DRGs in the 1990s, primarily as a means of increasing transparency, (e.g. France, England, Finland), hospital payment has been the main reason for the introduction of the system in countries such as Estonia, Germany, the Netherlands, and Poland in the 2000s (ibid.). In Germany, the DRG system applies to all (i.e. public, non-profit, and for profit) hospitals as well as to all (irrespective of the type of health insurance they possess) patients, excluding rehabilitation and psychiatric, psychosomatic or psychotherapeutic patients (Geissler et al., 2011a:246). There were 1196 DRGs in 2014 (GKV-Spitzenverband, 2015); to assure proper coding, every hospital had to employ specialized staff and/or partially "release" some physicians from their medical duties (Geissler et al., 2011a; Mathar, 2007; Ridder et al., 2007).

In his analysis of the functioning of DRGs in an Eastern German hospital, Thomas Mathar (2007:70) argued that with their introduction "any diagnosis has a direct impact on the finances of a clinic" and that they have transformed "the hospital sector into a privatised neoliberal health care market, by changing all participants (physicians, nurses, and patients)." Specifically, Mathar focused on the implementation and impact of quality management techniques on the work of physicians and nurses. A key role in this process has been assigned to treatment protocols (*Behandlungspfade*). Since the introduction of the DRGs system, treatment protocols have become popular in hospitals, among hospital and quality managers in particular. Ideally, they should enable "the optimization of processes, reduction of costs and patients' lengths of stay, and simultaneously improve quality. (...) It was pre-supposed that the quality would improve as soon as a treatment course gets standardized" (2007:74). Nonetheless, as Mathar (2007:74) observed, *Behandlungspfade* "did not work well" in practice even if hospital management insisted on their implementation. Physicians, in particular, refused to participate in drawing up and implementing such "standardizing instruments" that would reduce their work to *Kochbuchmedizin* ("cookbook medicine"). Surprisingly, in the context of blood management, treatment protocols and standardizing instruments were assessed differently by both members of HLCs and the Society's officials I talked to. I will return to this issue later in this article.

Download English Version:

<https://daneshyari.com/en/article/7329188>

Download Persian Version:

<https://daneshyari.com/article/7329188>

[Daneshyari.com](https://daneshyari.com)