

ORIGINAL ARTICLE

Individual Health Services and the Limits to Service Provision in Insurance Registered German Medical Practices

Patient Experiences

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Initiative of the German Medical Association to Support Health Services Research:

This article is part of a series in which the results of the Initiative to Support Health Services Research are presented.

SUMMARY

Background: Persons with statutory health insurance (SHI) in Germany increasingly report being denied medical services and being asked to purchase individual health services (IHS). We performed a population-based survey to study the prevalence of this practice, patients' attitudes toward it, and any potential regional differences.

Methods: Systematic samples were drawn from the population registries of Lübeck and Freiburg. First, a postal screening survey explored the one-year and lifetime prevalence of IHS and medical service denial among 2448 persons in Lübeck and 2450 in Freiburg. In a second postal survey, the 915 SHI respondents reporting IHS and/or service denial in the past year were asked for further details of their experiences.

Results: The response rates were 53.2 % (screening survey) and 75.4 % (detailed questionnaire); more persons responded in Lübeck than in Freiburg, and women and older persons responded more commonly than men and younger persons. There was no regional difference in prevalence. Among the 1899 members of SHI that had consulted a physician in the past year, 41.7 % said they had been offered IHS, and 20.5% reported being denied medical services. In this group, 43.3% later had the denied service offered to them as an IHS.

Conclusions: These population-based data on IHS and the denial of medical services in German medical practices confirm and extend the findings of earlier studies.

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Key words: individual health services, denial of medical services, statutory health insurance, ambulatory care, population-based survey

Denial of medical services and individual health services (IHS) have become a common phenomenon for German physicians who treat patients with statutory health insurance (SHI) in SHI-accredited practices. The concept of individual health services was introduced in 1998 to offer medical services that are (for several reasons) beyond the SHI benefits catalogue. As a central characteristic, IHS are not paid or reimbursed by the SHI but are to be paid for privately by the patient (e.g. travel medicine).

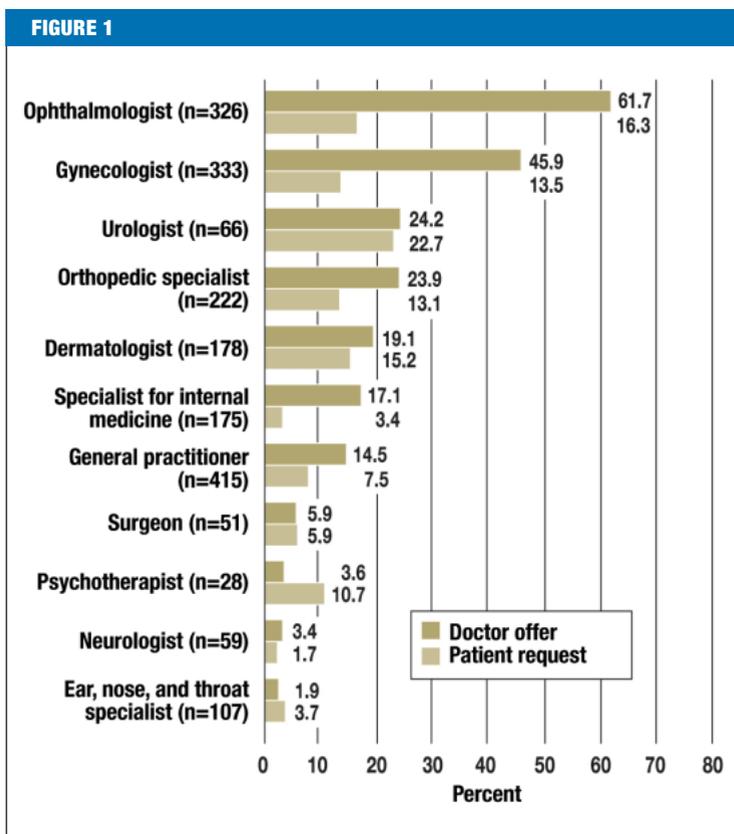
Both denial of medical services and individual health services have sparked controversial and critical public discussion. In 2006, the German Medical Association passed 10 pointers on the provision of IHS, which may be interpreted as suggestions for physicians' conduct in the context of IHS and were made available to the public in form of a patient brochure in 2008 (1, 2). Current data confirm an increase in experiences with IHS (with a 12 month prevalence of up to 27%) and denial of medical services (lifetime prevalence of 41%) in persons with SHI. The turnover arising from IHS is estimated to be 1bn euros (3–5). Up to 16% of members of SHI schemes have reported service denials during their latest consultation, and 58% fear further restrictions. Patients with disabilities or chronic diseases seem to be particularly affected (6). In 2005, 74.4% of physicians surveyed reported that IHS were becoming increasingly important in the provision of patient care, and 82.2% categorized IHS as financially necessary (7).

The population survey explored the following experiences of members of statutory health insurance schemes in the context of visits to practices of SHI-accredited physicians:

- Frequency, type of service, and patients' evaluation of IHS offered, requested, or performed
- Frequency relating to physician's specialty, type of services, and the patients' view on explanations for the denial of services
- Frequency with which denied services were offered as individual health services.

The ethics committee of the medical school at the University of Lübeck approved the project (AZ 06-141).

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Proportion of patients consulting a medical specialist offering IHS or requesting such services in the preceding 12 months (100 % corresponds to the number of SHI-insured respondents who consulted a specialist in the preceding months; multiple mentions possible)

Method

The authors extracted systematic random samples with set parameters from the population registries of Lübeck and Freiburg im Breisgau (inclusion criteria: age 20–79 years, main residence Lübeck/Freiburg, German nationality). Address, age and sex were also recorded.

Development of the questionnaire

The questions were based on existing studies of IHS and limits to health service provision. Since no standardized instruments were available to capture both phenomena, the authors developed their own instrument and validated this by using cognitive interviews and postal pre-tests.

Both techniques elucidate different problems with regard to the items and are complementary approaches (8).

IHS were defined as additional medical services that are not reimbursed by the statutory health insurers and therefore have to be paid for by the patients themselves (for example: "Which additional services that required payment from you directly were you offered in doctors' practices in the past 12 months, and which ones did you explicitly request?").

The authors defined service denial as services or prescriptions that patients did not receive from their

physicians, although they subjectively needed these (for example: "Which of these doctors did not offer you medical services in the past 12 months that you would have needed?").

Two-stage written survey

After the pretests, 2448 patients in Lübeck and 2450 patients in Freiburg received a screening questionnaire in the first stage of the survey study in February 2007, followed by a maximum of two reminders at two week intervals. The questionnaire captured sociodemographic information, as well as lifetime and 12 month experiences with IHS and service denials in insurance registered German medical practices. To estimate systematic bias in response behavior, the authors deployed two strategies: firstly, 82 randomly selected non-respondents were contacted via telephone interview and asked about their experiences. Moreover, the second reminder of the screening questionnaire was used to collect on a separate page potential reasons for a lack of willingness to participate (data not shown).

All screening participants who had consulted a physician in the preceding 12 months and reported experiences with IHS or denial of medical services were sent a detailed questionnaire about individual health services or denial of medical services, followed by a maximum of two reminders at two-week intervals (April to May 2007). Participants who reported experiences in both areas were sent both detailed questionnaires.

Statistics

The study is primarily descriptive and explorative; for this reason we did not adjust for multiple testing. Regional differences were calculated by using the Chi square test (nominal scale data) and t-tests for independent samples (interval scale data) with a probability of error of $\alpha = 0.05$. We used SPSS 15.0 to analyze the data.

Results

Screening survey

Altogether 2606 of the 4898 individuals who had received an invitation participated, which equals 53.2%. The willingness to participate was greater in Lübeck than in Freiburg (n = 1422, 58.1% versus n = 1184, 48.3%; Chi square = 46.9; $p < 0.001$). More women were willing to participate than men (n = 1451, 56.1% vs n = 1155, 49.9%; Chi square = 18.8; $p < 0.001$). Respondents were a mean 4 1/2 years older than non-respondents (mean age 49.4 years, standard deviation [SD] = 16.3 vs mean age 45.0 years, SD = 16.6; $t = 9.4$; $p < 0.001$).

Of all 2606 screening participants, 2568 reported their health insurance status: 2120 (82.6%) were members of an SHI scheme, 322 (12.5%) were completely privately insured, and 126 (4.9%) were insured in other schemes. The following evaluations relate exclusively to the 2120 participants who were members of SHI schemes.

52.3% (n=1072) had at least once been offered IHS or had requested these, and 26.2% (n=550) reported having experienced denial of a requested or expected

medical service at least once. In the preceding 12 months, 1899 (89.6%) had consulted an SHI-accredited doctor (i.e., excluding dentists and exclusively private doctors). Of these, 41.7% reported having been offered IHS in the context of these consultations, or requesting these themselves. 20.5% reported having experienced service denials. Altogether 915 participants who were members of statutory insurance schemes were affected; 28.2% (n = 535) had been offered IHS or requested these themselves, 7.3% (n = 138) had experienced service denials, and 12.7% (n = 242) reported experiences with both phenomena. These 915 participants received detailed questionnaires in the mail.

Detailed survey

Of 915 members of statutory health insurance schemes, 690 (75.4%) participated in the second stage of the survey. Of these, 452 had experience only of individual health services, 89 only of denial of services, and 149 of IHS as well as service denials. The following analyses are therefore based on 601 detailed questionnaires on IHS and 238 detailed questionnaires on service denials.

Experiences with individual health services

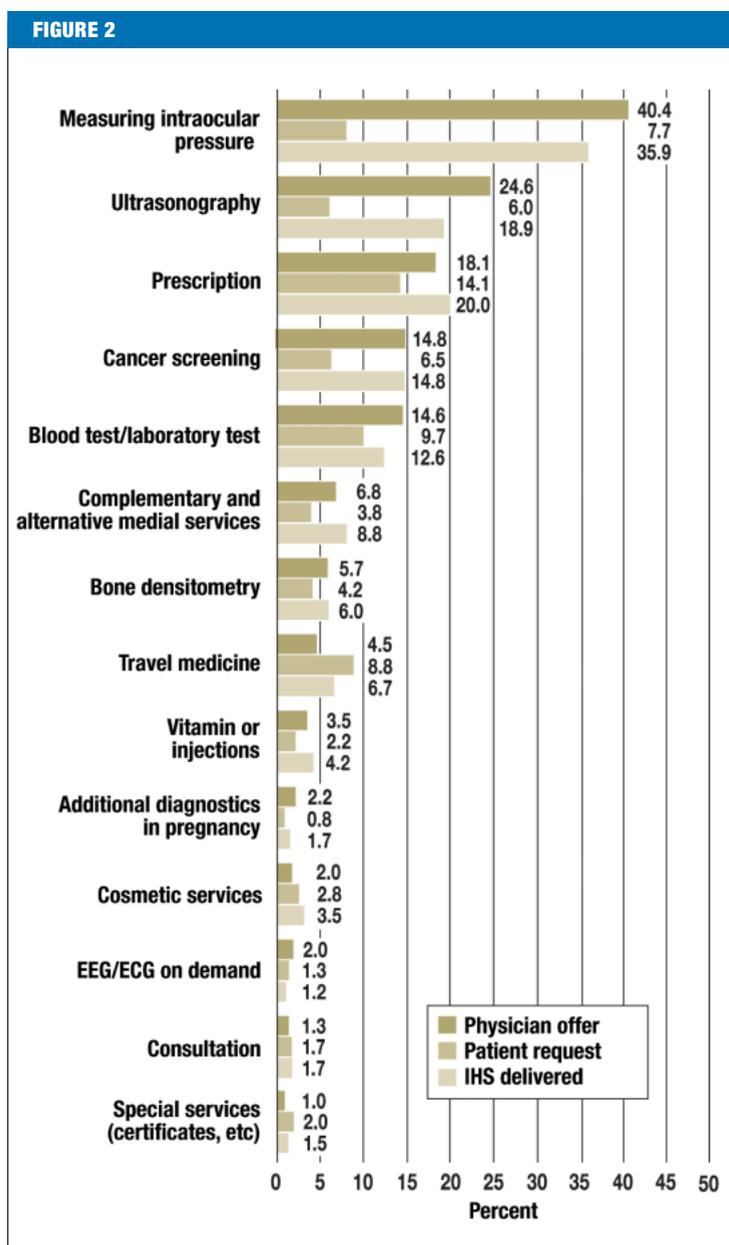
Primarily ophthalmologists and gynecologists had offered IHS; more than 60% of all members of statutory health insurance schemes who had consulted an ophthalmologist within the preceding 12 months had been offered IHS (Figure 1).

The commonest procedures offered were measurements of intraocular pressure and ultrasonography (Figure 2). Patients initiated IHS far less often (Figure 1). For this reason, information requests about IHS mainly related to prescriptions of medical drugs/remedies/devices, blood/laboratory tests, and travel medicine services (Figure 2).

With regard to the German Medical Association's 10 pointers on the provision of IHS, the picture is varied. Just under 90% of study participants reported, for example, that they had received information about the benefits and costs of the service. Only 45% reported having received information on potential risks. Figure 3 summarizes the data.

Experiences with denial of medical services

Members of SHI schemes who had consulted an orthopedic specialist, primary care physician, or doctor for ear, nose, and throat medicine in the preceding 12 months proportionally reported the highest instances of denial of medical services (Figure 4). The services that were denied concerned mainly remedies (n = 113, 52.1%) or medications (n = 102, 47.0%), and, more rarely, rehabilitation (n = 18, 8.3%) and devices (n = 13, 6.0%). In most cases, the physicians explained the denial of medical services with lack of coverage by statutory health insurance providers; the patients often suspected a depleted practice budget (Figure 5). Only one quarter of patients reported being understanding of the doctors' explanation. 43.3% (n = 94) of patients were offered the denied medical service as an IHS (Figure 6).

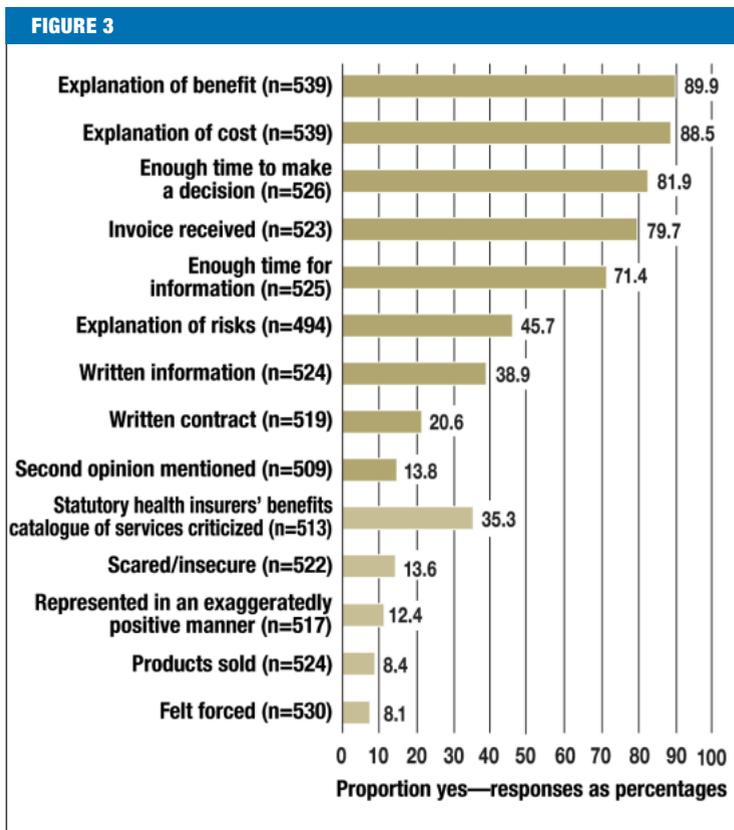


IHS offered by physician, requested by patient or actually provided in the preceding 12 months (100% relates to 601 surveyed participants)

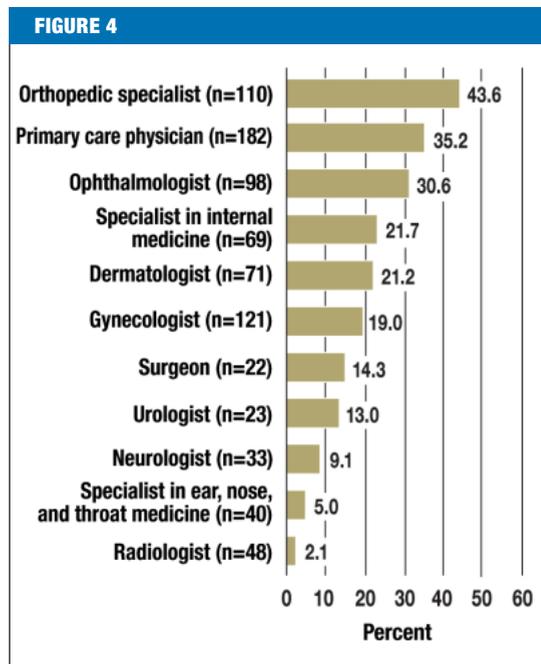
Discussion

Strengths of the study

Compared with earlier studies, the current study differentiates more comprehensively between offer and request for individual health services. The authors asked for IHS that had actually been purchased, aims, appraisal, and adverse effects. Further, the data permit for the first time conclusions about the relative frequency of IHS and denial of medical services that are specific to medical specialties. Collecting data on the combination of denial of medical services with a simultaneous or later offer of IHS is also a new approach. The study did not require prior knowledge of IHS and denial of medical services. To clarify the definitions for patients and to validate the



Assessment of IHS delivered; percentages relate to the number of valid responses (n) of 601 survey participants; dark=positive aspects, light: negative aspects



Proportion of patients consulting a specialty physician who experienced denial of services in the preceding 12 months (100% correspond to the number of members in statutory health insurance schemes who had consulted a specialist physician in the preceding months; multiple mentions possible)

instruments we used cognitive interviews and postal pre-tests in developing the questionnaires.

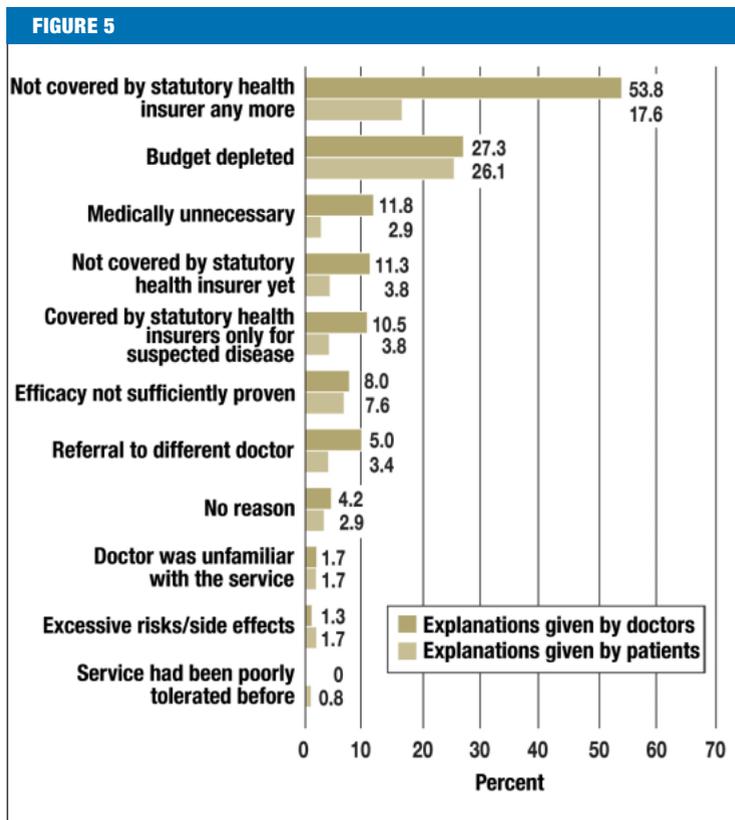
Limitations of the study

The wide range of IHS has resulted in a situation whereby individual subject areas can be operationalized within questionnaires only to a limited degree if at all (for example, assessing the benefits of an individual health service). Further aspects can be captured only in a relatively unspecific manner in the context of a questionnaire. Collecting data on the aims, reasons for, and assessments of how and why the IHS were delivered is not possible for individual services. Further, it needs to be borne in mind that the data reflect patients' perceptions and cannot be assessed with regard to their objective appropriateness or evidence base (for example, patients' estimates of the length of time given to think about the service, trustworthiness of the IHS, or statements relating to information about risks and benefits). Positive bias owing to a tendency to reduce cognitive dissonances is thus possible for the directly prompted subjective assessments. Although the questionnaires were developed by means of cognitive interviews and postal pre-tests, the reliability and validity of the instruments have not been fully clarified. The results of the study merely reflect a momentary snapshot from spring 2007.

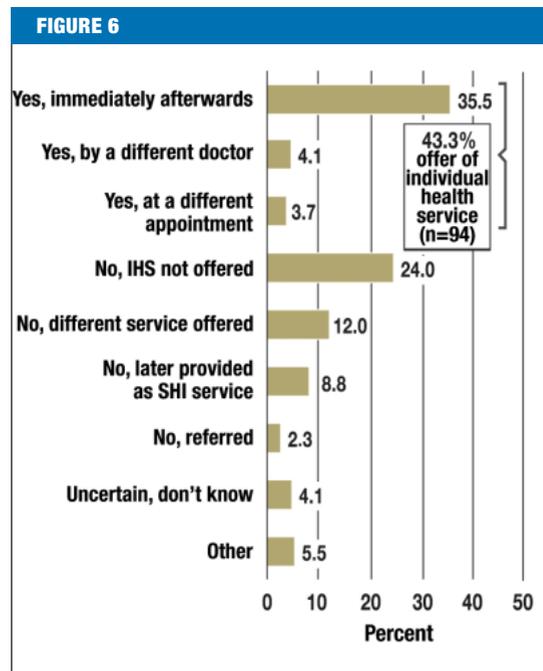
IHS are defined inconsistently in the literature. Therefore, data from different studies are comparable to a limited degree only. When interpreting results obtained through statistical inference it needs to be considered that because of the primarily descriptive character of this study, no adjustments were made for multiple testing. In the context of the screening survey (response rate 53.2%), selection bias cannot be excluded. The non-response analysis, which was restricted to age, sex, and region, indicates limited representativeness of the screening survey. Similar experiences are known from other epidemiological studies, for example in the context of population surveys about back pain (9). To assess non-response bias, the authors conducted postal and telephone follow-up interviews with the non-respondents. The results indicate a potential overestimation of the 12 month prevalence of IHS in the postal screening survey (telephone follow-up 30.4%, postal screening survey 41.7%). The experiences with denial of medical services, however, were equally common in telephone follow-up and screening survey (telephone follow-up 19.6%, postal screening survey 20.5%).

Individual health services

The lifetime prevalence and the 12 month prevalence of IHS in members of SHI schemes were 52% and 42%. In



Explanations given by doctors and patients for denial of medical services (100% relates to 238 survey participants)



Offer of denied medical services as IHS (100% correspond to n=217 valid responses)

the studies of the Scientific Institute of the AOK (a large general statutory health insurance company), only a quarter of SHI scheme members (n = 3000) reported being offered or billed for medical private services in the preceding 12 months. In contrast to our study, however, these prevalence estimates related to the total number of members of SHI schemes, not those who consulted their doctor in the time period under consideration (4, 10). With regard to the medical specialties and the type of offered/requested individual health services, the current study data are similar to those of earlier surveys (4, 10, 11). The assessment of the provision of additional services follows the 10 pointers from the German Medical Association (1). These were made available to the general public as a patient brochure only after we conducted our study (2). This study for the first time operationalized the stipulated requirements, whereas earlier surveys were restricted to few partial aspects (4, 10). With regard to 2 items on the list, the German Medical Association points out the fundamentally separate provision of IHS and services under SHI schemes, and points out the need for quality assurance and adherence to limits of expertise. In our opinion, patients are generally able to judge these factors only to a limited extent; for this reason these aspects were not captured in our study.

With regard to the positive aspects in doctors' provision of additional services, most members of statutory

health insurance schemes report having had the benefits and costs of such additional services explained to them. Further, most of the survey participants had enough time to gather information about IHS (71%) or to decide in favor of or against IHS (81%), which is consistent with the requirement of appropriate provision of information and enough time for patients to think things through. Almost 80% had received an invoice after treatment had been completed.

Deficiencies transpired mainly with respect to explanations of risk, written information, written treatment contracts, and the advice that a second opinion might be sought. About one third of patients reported that the doctor criticized the services provided by the SHI while explaining additional services, or that s/he had represented the additional services in a very positive light, which is not consistent with factual provision of information and trustworthy advice. In contrast to the range of permitted services, additional products were sold in the context of the individual health service offer in individual cases. The rule of trustworthy advice seemed not to be met in only a few instances; some participants felt scared or insecure when faced with IHS, or forced to accept the service. For all aspects, the open question remains of possible discrepancies between subjective and objective appropriateness and trustworthiness. This question cannot be answered by means of postal surveys.

Denial of medical services

Among the members of an SHI scheme who had consulted a physician in the preceding 12 months, 20.5% reported having experienced a denial of medical services in the consultation. Earlier surveys have yielded an inconsistent picture (12, 13).

Among those SHI members who had consulted specialty doctors in the preceding 12 months, patients reported experiencing denial of medical services most often for orthopedic specialists, ophthalmologists, and dermatologists. Altogether, the declarations from doctors and patients that are captured in our study seem to reflect the breaks and changes in the health reforms, for example, the capping of particular medical prescriptions, and the restrictions to the list of services covered by the statutory health insurers. In other surveys, patients as well as doctors gave financial, rather than medical, reasons for denying a service (12, 14).

Combination of denial of medical services and individual health services

Of those persons with SHI who reported a denial of medical services for the preceding 12 months, 43.3% were offered the denied services mostly immediately afterwards as individual health services. Of the 94 members of statutory health insurance schemes who were offered a denied service as an individual health service, about two thirds agreed to actually having the individual health service delivered. In this regard, our study provides detailed data for the first time. The literature thus far has provided only one insight: doctors offered denied medications later at private expense to up to a third of statutory health insurance scheme members (15).

Outlook

Owing to the wide range of potential medical services, some aspects of IHS and denials of medical services could not be included in postal questionnaires. We therefore followed the survey with a qualitative study phase,

using focus groups in both cities. These looked at questions such as the benefits of the services, the consultation situation, and the effects on patients' trust, and set out practice pointers and ideas from a patient's perspective. The intention is for the results to find their way into patient centered recommendations for doctors' handling of IHS and denials of medical services and will be made available to doctors and their SHI-insured patients.

Conflict of interest statement

The authors declare that no conflict of interest exists according to the guidelines of the International Committee of Medical Journal Editors.

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Key messages

- In the preceding 12 months, 41.7% of surveyed members of SHI schemes reported having been offered IHS when visiting their doctor or requesting these themselves.
- IHS are offered primarily by ophthalmologists and gynecologists.
- A stronger emphasis should be on written information/agreements and explanations of the potential risks of individual health services.
- 20.5% of participants reported having experienced denial of medical services, especially when consulting orthopedic specialists, primary care physicians, and dermatologists.
- 43.3% of participants reported being offered the denied services mostly immediately afterwards as individual health services.

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The original German questionnaires are available at
www.aerzteblatt-international.de/article09m433