Between professional autonomy and economic orientation — The medical profession in a changing health care system

Zwischen professioneller Autonomie und ökonomischer Orientierung — Die medizinische Profession in einem sich wandelnden Gesundheitssystem

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Abstract

The current discussions surrounding the German health care system are being determined and defined by the concepts of "profitability", "efficiency" and "saving". These concepts also determine the demands made on this system and have had an effect on the medical profession. The economy's growing influence on physicians' decision-making and the increasing necessity to look at and regulate services under economic aspects arising from the need to save costs are seen by the medical profession as a threat to its autonomous conduct and freedom to make decisions, in other words it sees it as a danger to its medical orientation. Conflicts between medical autonomy and economic orientation in physicians' conduct are therefore already foreseeable, as are conflicts between medicine and economy in regards to who has the power to define the terms of the public health system.

Objective: This article will outline the area of conflict based on the available literature. It will discuss how the political and economic regulatory attempts affect the medical profession's autonomous conduct. It will also discuss which conflicts of conduct emerge for physicians, what types of solutions the medical profession tends to develop as a reaction, and whether or not this tension between medical and economic orientation can be resolved in an acceptable way.

Methodology: This article should first outline the changed economic and political basic conditions and the attempts to reform the German health care system, using this as a starting point. Following this, it will explore the significance professional autonomy acquires within the concept of profession from the point of view of the sociology of professions. With this in mind, the third part of this article will describe and analyze the effects of advanced economization on the medical profession's autonomous conduct, which has long been regarded as uncontested. This part of the article will also describe and analyze the medical profession's strategies it uses to defend its autonomy. Finally, this article will discuss whether or not a stronger integration of medical and economic responsibility is possible.

Conclusion and summary: The conclusion that will be drawn from this discussion is that the medical profession can only avoid the pending loss of its autonomy (deprofessionalization) if it is able to combine cost efficiency and quality (and integrate economic aspects into its actions). If it is unable to do so, it will lose more and more control over the public health system to the state, economy, and management.

Keywords: medical profession, professional autonomy, theory of professions, economy, efficiency, health care system, health care reform

Zusammenfassung

Die Begriffe „Wirtschaftlichkeit", „Effizienz" und „Sparen", die gegenwärtig die Diskussionen und die Anforderungen im deutschen Gesundheits-

system bestimmen und definieren, betreffen auch die medizinische Profession. Der wachsende Einfluss der Ökonomie auf die ärztlichen Entscheidungsprozesse und die aus dem Sparzwang resultierenden Anforderungen, medizinische Leistungen verstärkt unter ökonomischen Aspekten zu betrachten und zu steuern, werden von der ärztlichen Profession als Bedrohung ihrer Handlungsautonomie und Entscheidungsfreiheit wahrgenommen bzw. als eine Gefahr für die medizinische Orientierung gesehen. Konflikte zwischen medizinischer Autonomie und ökonomischer Orientierung auf der Ebene des ärztlichen Handelns sind damit ebenso vorprogrammiert wie Konflikte zwischen Medizin und Ökonomie hinsichtlich der Definitionsmacht im Gesundheitswesen.

Zielsetzung: Der Beitrag stellt das skizzierte Konfliktfeld auf der Basis der vorliegenden Literatur dar und diskutiert, wie sich die politisch-ökonomischen Steuerungsversuche auf die Handlungsautonomie der medizinischen Profession auswirken, welche Handlungskonflikte für Ärzte entstehen, welche Lösungstendenzen die Ärzteschaft als Reaktion entwickelt, und ob das Spannungsverhältnis zwischen medizinischer und ökonomischer Orientierung zu einem akzeptablen Ergebnis geführt werden kann.

Methodik: Dazu werden als Ausgangslage zunächst die geänderten ökonomischen und politischen Rahmenbedingungen und Reformversuche im deutschen Gesundheitssystem skizziert. Danach wird dargelegt, welcher Stellenwert der professionellen Autonomie im Konzept der Profession aus Sicht der Professionssoziologie zukommt. Vor diesem Hintergrund werden im dritten Schritt die Auswirkungen der fortschreitenden Ökonomisierung auf die lange als ungefährdet geltende Handlungsautonomie der medizinischen Profession sowie die Strategien der Ärzteschaft zu deren Verteidigung beschrieben und analysiert. Abschließend wird erörtert, ob eine stärkere Integration von medizinischer und ökonomischer Verantwortung möglich ist.

Ergebnis und Fazit: Aus der Diskussion wird der Schluss gezogen, dass die medizinische Profession dem drohenden Autonomieverlust (Deprofessionalisierung) nur dann Einhalt gebieten kann, wenn es ihr gelingt, Kosteneffizienz und Qualität zu verbinden (bzw. ökonomische Aspekte in ihr Handeln zu integrieren). Gelingt dies nicht, wird sich die Kontrolle über das Gesundheitswesen weiter in Richtung Staat, Ökonomie und Management verlagern.

Schlüsselwörter: Ärzteschaft, professionelle Autonomie, Professionstheorie, Ökonomie, Wirtschaftlichkeit, Gesundheitssystem, Gesundheitsreformen

Introduction

Increasing costs and limited financial resources have led to many considerations in the German health care system regarding economic efficiency [2]. Within this context, the medical profession and its share in the responsibility for its services being economically efficient have been increasingly criticized. It has been accused of being inefficient and of largely lacking economic orientation in the provision of its services. Health care policies have attempted to urge physicians through economic guidelines to act in a more cost-conscious manner than in the past. This has created a conflict-riddled relationship of tension between these attempts and medical orientation (as the basis of physicians' conduct), which is how the medical profession sees itself. The medical profession sees the economy's growing influence as a threat to its autonomous conduct and its freedom to make decisions. This article will discuss the following questions: How this area of conflict developed, how the economy's attempts to gain control are affecting the medical profession's autonomy, which possible conflicts arise for physicians in their conduct, which solutions the medical profession tends to develop in reaction, and finally whether or not the conflict of objectives between medical and economic orientation can be resolved in an acceptable way.

First, the changes in the basic economic and political conditions and the attempts to reform the German health care system will be outlined and used as a starting point. Following this, the significance of professional autonomy

will be discussed within the concept of profession from the point of view of the sociology of professions. With this in mind, the third part of this article will describe and analyze the effects of advancing economization on medical profession's autonomy, which has for so long been regarded as uncontested, as well as the medical profession's strategies to defend its autonomy. Finally, this article will discuss whether or not a stronger integration of medical and economic responsibility is possible. A summary will conclude this discussion.

Changes in the basic conditions and reforms of the health care system

The demographic development, the shift in the health problem situation, the continuing medical and technical progress, the rising care demands of those receiving services ("the spiral of demands"), and the increase in health care expenditure that has been caused by the complex ensemble of these factors (while financing possibilities become more limited and premium income erodes) have all put the German system of health care provision under constant pressure to reform and transform itself ([58], p. 8), ([59], p. 172). The result is a permanent political and scientific dispute as to which reforms are the right reforms. Economic measures are mainly treated as tools for regulation in this dispute. Many different programs and demands are represented in the debate on establishing a health care system that is both high in quality and meets patients' needs, while also operating under the condition of limited finances. These programs and demands tend to focus increasingly on practicing physicians' economic efficiency and quality of services. The number of physicians is still on the rise and has reached 304,177 (as of 12/31/2003) [3]. The hypothesis often expressed within this context, that the growing number of physicians is, in itself, responsible for the expansion of non-medically induced services (supply-induced demand) and, as a result, the increase in expenditure for treatment, is, however, much debated and still lacks clear empirical support [8].
Though the opinion is widely shared in Germany that the public health system needs to be reformed and the economic problems solved, it is still hard to perceive positive objectives for society and health care policies that could serve as a point of orientation. Also missing is a clear model for changes. Opinions differ greatly regarding which course the reforms should take and where they should lead ([70], p. 24 ff.). The spectrum ranges from positions that almost do not budge from the current applying regulations and deny that health can be discussed in economic terms to suggestions on how to rationalize medical services. There are also models for mandatory basic care with additional, voluntary services that may be assured, and the reform-oriented position of efficiently organized heath care that is still financed based on the principle of solidarity [16]. Lastly, there are the positions that demand a radical restructuring. They see competition and market-oriented self-regulation as the cure-all for providing better health care. The Swiss health care economists Zweifel and Breuer represent this last position. In their report "*Weiterentwicklung des deutschen Gesundheitssystems*" (The Future Development of the German Health Care System) (written from the point of view of health care economics), Zweifel and Breuer argue in favor of a competition in the public health system that is mainly deregulated and includes the insured, the insurers, and health care providers to equal degrees [89].
With this in mind, health care policy-making has for years felt its objective should be to initiate, organize and finance a change of the health care system that would both keep with the times and prove adaptable for the future. This objective demands that those politically responsible reach decisions on how to limit expenditure and how to utilize existing financial resources efficiently to meet society's needs. In order to gain control over the increase in spending that started in the middle of the 1960s and to keep the health care system affordable, reforms have been continually implemented in the last 25 years and the state has taken action that, according to the Council of Experts for Concerted Action in Health Care (SVR), focuses mainly on the strategy and measures for dampening the rise of costs and for limiting the budget (this is especially true for the period from 1975 to 1992). These were intended to induce economization and raise the cost awareness of service providers [69], ([83], p. 54). The medical profession, which largely autonomously decides who to treat according to which medical, and therefore financial, conditions ([67], p. 107 f.), is affected by important instruments applied to it by cost-containment policies. One of these instruments was the introduction of the limitation of spending based on the intake of revenue in the Statutory Health Insurance (SHI, in German: *Gesetzliche Krankenversicherung*, GKV). This limitation was based on the principle of stable premiums, which means spending should not increase more rapidly than revenue [44]. Another instrument was sector-based budgeting, which expanded slowly but surely to include all of the SHI's service areas. In addition to this, there were measures for strengthening the position of financing institutions (health insurance companies and funds) compared to the health care providers, or the Regional Association of Statutory Health Insurance Physicians (*Kassenärztliche Vereinigungen*) to be more precise. Attempts were also made to correct false incentives on the part of health care providers (such as through the reform of the German Drugs Act (*Arzneimittelgesetz*)). The resulting reorientation of the medical profession's reimbursement system in ambulant and in-patient treatment should urge health care providers to continue to rationalize health care processes ([67], p. 247 ff.), as should the introduction of the ambulant flat rate payment for each case type ("*Fallpauschale*") and standard benefit volumes ("*Regelleistungsvolumina*") with maximum points awarded for individual physicians.
All reform measures have in common that they try to solve the problem while remaining true to the principle of

solidarity (premiums established independently of individual risk), especially the Health Care Reform Act from 1989, the Health Care Structure Act from 1993, and the laws for the so-called 3rd stage of the health reform. They also have in common that they have not been especially effective up to this day ([64], p. 18), ([75], p. 240 ff.). They have always only partly achieved the goal of closing the financing gaps through cost-containing measures. For this reason, there is an intensely growing demand for health care policies that go beyond the previously dominant cost-containing policies and that are more than short-term crisis management and "muddling through" [67]. The experiences made in the last few years have thus shown that it is impossible to achieve long-term savings potential and quality improvement without truly far-reaching structural reform.

On January 1st, 2004, a new health reform law took effect that was established as a compromise after the Social Democratic and Green government and the Opposition reached an agreement: The Statutory Health Care Modernization Act (*Gesetz zur Modernisierung der gesetzlichen Krankenversicherung*, GMG), otherwise known as the Health Care Reform [23]. An important objective of this law, which is part of the so-called Agenda 2010 (an agenda that bundles all the government's planned structural reforms), is to keep the health insurance system affordable, at least in the middle-term, through the development of new financial sources (especially patients and the insured are immediately affected by additional payments) and through structural renovations. The many regulations of this law are sharply criticized by the medical profession and are regarded by politicians as the first step toward a structural reform. They affect not only patients and insured individuals, the regulations of this law also affect physicians, pharmacists, hospitals, health insurance companies and funds, and associations to different degrees. Some of the reform's important objectives are the strengthening of patients' control over their situation, the improvement of the quality of patient care, the further development of care structures, the restructuring of reimbursement in the area of ambulant treatment (expected in 2007), the reorganization of treatment with medications, the dismantling of bureaucracy, and the reform of organizational structures [7].

The structural measures that affect the medical profession and are especially expected to contribute to more quality in patient care and to greater economic efficiency in providing health care services include the establishment of care that centers on general practitioners, the support of competition between various forms of care provision (through the approval of ambulant medical care centers and the partial opening of hospitals for ambulant care), the improvement of conditions for "integrated care", and the requirement that physicians' practices apply internal quality management (with surveillance from the Regional Association of Statutory Health Insurance Physicians (*Kassenärztliche Vereinigungen*)). The Institute for Quality and Economic Efficiency in Health Care (IQWiG) should address questions of fundamental significance relating to the quality and cost-effectiveness of health care services. Furthermore, all panel physicians are required to further educate themselves on a continual basis, independent of their interests (mandatory further education), so that they can contribute to improving and assuring quality [7].

From the point of view of the author, the reform act appears to be a heterogeneous bundle of measures that hardly meets the demands for a comprehensive structural reform. However, there are many structural elements in this reform that point in the right direction: The strengthening of integrated care, for example, the general practitioner system, and requirement of physicians to further educate themselves, independent of interests. Beyond this, it is questionable and remains to be seen whether or not the reform, which the medical profession sees as regimentation, and the measures, which are necessary in principle for improving quality and efficiency, are tapping all health care providers' economic efficiency potential, and whether or not the stabilization of the statutory health insurance can be achieved in the middle-term, as expected. Experts are already now expecting new financing problems to arise in the public health system in the long-term. For this reason, it is to be expected that more decisive changes in the financing of the statutory health insurance will be necessary. Scientists and politicians today are already arguing about the next reform steps and about a fundamental change of systems in public health care. The models proposed in this discussion, such as the citizens' insurance ("*Bürgerversicherung*") or the capitation fee ("*Kopfpauschale*"), are based on the separation of financing health care services from job incomes (either through income-proportional fees or through a flat-fee that is the same for everyone) and require (not only in the author's opinion) a broad socio-political discussion that not only takes the organization of the possible change into account, but also the social, economic, labor market, and financial-political effects [62], [67].

Before this article discusses how the changed economic conditions and the reform and cost-containment policies affect the medical profession and its privilege of autonomy and freedom to choose therapies that society grants it, it will first explain what significance professional autonomy has within the concept of the profession from the point of view of the sociology of professions.

The profession and professional autonomy

Professions are a special type of occupation ([11], p. 9), [12] that is the subject of extensive research in the specialized sociology of occupations and professions [10], [29], [49]. What the constitutive characteristics of a profession are is a debated issue and is something focused on in its own respect within each variation of the theory of professions. Professions are considered for the most part to be relatively autonomous and science-based expert occupations in the service sector [50] that provide

special services for society and their own special clientele within a certain field of problems relevant to society, thereby following a specific logic of conduct. They are characterized by power and influence as well as privileged opportunities of qualification, employment, and control, and they therefore often enjoy a distinctive social esteem (prestige). Professions are also characterized by an extensive monopoly over specific fields of occupation and knowledge [1], [79]. They assert this monopoly against competing occupations mainly with the help of the state (social enclosure). Once established, professions are not unchangeable entities that exist independent of time, but rather transformable phenomena. They are influenced and altered by processes of social change, meaning they continually face the problem of adjusting to social changes and can lose their influence and independence while doing so ([73], p. 194 ff.). Looking at the development toward modern functionally-differentiated societies [81] from the socio-historical perspective, it becomes clear that the establishment of professions was accompanied by a "replacement of lay solutions by forms of rationalized expert solutions for problems" ([47], p. 15). The profession of physician is regarded as being the "prototype" of a fully professionalized occupation and is often the subject of thorough analysis [20], [27], [33], [79].

Professions can be seen from a variety of theoretical perspectives in the sociology of occupations and professions. A theoretical position that everyone can agree on that can capture all the facets of the field of occupations and professions in modern society cannot be found at this point in time, however ([49], p. XI f.), ([42], p. 18). In the "struggle" for an adequate view of professions, the classic theoretical positions are represented by the characteristics theoretical approach, which attempts to define and demarcate professions through outer characteristics and is regarded by the sociology of professions as being out-dated, although it continues to provide orientation in debates on policies of professions, and the structural-functional model of professions (Parsons), which focuses on the description of the social functions of professions. Newer theories include the revised (structural-theoretical) theory of professionalization (Oevermann) that builds on Parsons and brings the structural logic of professional conduct (application of scientific knowledge to each individual case) to the fore through the idea of representational interpretation, and the systems theoretical approach of professionalized systems of function. In addition to this, there are two theories that rely more strongly on collective and individual interests as a starting point: The interactional model of professions with its central categories of license and mandate, which focuses primarily on problems and paradoxes of professional conduct, and the power approach, which addresses interests and power and especially takes into account the active roles of occupational groups that pursue and try to politically assert collective and individual interests in the processes of forming and establishing professions ([63], p. 31 ff.).

Within sociological discourse, a trend may be seen that shows a movement from theories of characteristics toward theories of functions and finally toward theories of power (in the 1970s and 1980s) [9]. The turn toward theories of power approaches was accompanied by a critical questioning of the image of professionalism and professions that had been drawn in a primarily favorable light in literature up to the 1970s [34], [43]. In the sociology of professions in the German-speaking region, the systems theoretical approach of professionalized systems of functions [81], [80], the structural theoretical approach [61], [60], and the interactional approach [73], [74] predominantly determine the discourse of the sociology of professions.

A central characteristic that marks professions in their classic form, and therefore also the medical profession [21], [20], [79], is their relatively high degree of occupational "autonomy" ([31], p. 282), [48]. This is generally undisputed in the literature written on this subject, although some authors give it different emphasis. The far-reaching self-determination of occupational interests is not only guaranteed to professions as an active collective (collective autonomy referring to occupational self-organization [39]), but also granted to individual professionals in their occupational conduct (individual autonomy referring to the selection of treatment methods in each case). Autonomy, which Wilensky generally defines as "the authority and freedom to regulate one's affairs within an area of competence without surveillance" ([87], p. 206), is expressed in professional control over the content and conditions of occupational conduct, according to Freidson ([21], p. 134), or rather in the extensive substitution of external control by others through internal self-monitoring (surveillance by colleagues; peer-review). The acknowledgement of autonomy, which is regarded as a worthwhile objective of every professionalizing project ([56], p. 15), is a decisive criterion for an occupation that has undergone a successful professionalization, according to Larson and Freidson. Autonomy makes it possible to block external control and determine one's own actions and work processes [20], [43]. According to Daheim, having control over the assessment of the services and standards of practicing an occupation not only signifies independence from clients' evaluation of services, but also extensive organizational independence from employing organizations ([15], p. 26). Freidson says that there is an additional extensive independence from governmental instances and from the market [22], (see also [71], p. 229). Professional autonomy, however, also includes having control over the profession's scientific knowledge, meaning its production and conveyance as well as its application and evaluation in practice [1], [66], [65]. Autonomy of knowledge, autonomy of organization, and autonomy of clientele are therefore core elements of professional autonomy. Professions owe their privilege of autonomy, and the opportunity to assert and maintain it, to the state, which creates the required basic conditions through legislation. Self-regulation cannot be carried out without the state's protection [43].

From the functionalist point of view, occupational independence represents a kind of acknowledgement from society of the professions' achievement in processing and managing existential issues that have an exceptional, social significance ([52], p. 574). From this point of view, the medical profession's autonomy is based on the fact that society can expect physicians not (or not only) to act in the interest of maximizing their benefits but primarily in the patient's and in the community's interest [13], [84]. From the power theory point of view, professional autonomy, meaning extensive occupational self-determination, is created by successful professional policies established in cooperation with the state; it is an "expression of the power resources belonging to each group of occupations" ([68], p. 316). The extent of professions' autonomy varies from country to country, and these differences relate mainly to the role of the state: In particular, autonomy is more pronounced in American professions than in German ([68], p. 317).

Professional autonomy has fallen increasingly under criticism and intensified influence in the last few years: Society's confidence in professions' self-monitoring and orientation toward the public good is dwindling [34], [57], the level of education is rising and is leading to a decreasing gap between professional knowledge and lay knowledge (physicians, for example, are increasingly faced with "informed" patients who get the latest information about their illnesses via the Internet), and the fact that professionalized occupations are part of bureaucratic organizations today are all developments that limit professions in their occupational autonomy ([65], p. 291).

Medical autonomy before and in the age of economization and cost-containing policies

The medical sociologist Siegrist stated that there are only a few groups of occupations today that are capable of exercising occupational autonomy to such a great extent as the medical profession does. By this, he means the medical profession is able to determine the content, quality and quantity of work it performs on its own ([77], p. 234). Physicians' orientation toward the public good and their ability to heal and soothe physical and mental illness legitimizes their claim on autonomy. This also means that the medical profession insists on the monopoly of interpretation in medical questions and has significant control over the development of the knowledge of health and disease. According to Siegrist, three elements form the core of autonomous medical conduct, ensuring physicians a position of supremacy over other health care occupations, though this varies from country to country [18]. The three elements are: "Having the qualifications and the right to make a diagnosis, having the qualifications and the right to conduct operative procedures, and having the qualifications and the right to administer healing measures, especially to prescribe medications ([77], p. 237 f.).

The necessary condition for asserting occupational autonomy in society is the professionalization [24], [33], in other words the institutionalization, of medicine as an academic discipline. This institutionalization is based mainly on physicians having separated knowledge from patients' patterns of interpretation and thereby moving it out of the range of patients' control and the control of non-physicians ([30], p. 97 ff.). This means that physicians within the SHI (Statutory Health Insurance) system acquired a central position of power over insured patients who needed treatment [19]. This position of power has been and will continually be secured and expanded, if possible, by medical lobbyist policies.

According to the Social Security Code (*Sozialgesetzbuch*, SGB V), the medical profession is, by and large, allowed to define what is medically necessary and appropriate. The medical profession thereby also decides who will be treated for how long and under which financial conditions ([14], p. 61 f.). Even in the age before cost-containment policies, which Freidson calls the "golden age of medicine" ([22], p. 182 ff.), the medical power of definition has been closely tied to the "rule of economic efficiency" that is dictated by the Social Security Code and which limits medical autonomy at least somewhat ([17], p. 16). According to the Social Security Code (SGB V), "Health care services must be sufficient, appropriate and economic; they should not exceed the measure of necessity. Health care services that are not necessary or are not economic cannot be claimed by insured patients, cannot be performed by health care providers, and cannot be approved by SHI funds" ([78], § 12). When considering the valuation of appropriateness and economic efficiency, the generally acknowledged state of medical knowledge and medical progress must be taken into account ([78], § 2). The Federal Council of Physicians and SHI Funds (*Bundesausschuss der Ärzte und Krankenkassen*) decides which services in ambulant treatment meet these criteria, while the Federal Council of Hospitals (*Ausschuss Krankenhaus*) decides which services in in-patient treatment meet these criteria ([67], p. 91). In cases of uncertainty, the scientific communities of physicians define what is necessary and economically efficient ([76], p. 273). The physician decides for his/herself which services are necessary, appropriate, and sufficient in each specific case of treatment, while also determining their economic efficiency.

The task of paying attention to economic efficiency, more precisely distinguishing between the medically necessary and the medically dubious and therefore having a part in the economic control of resources, is therefore an essential part of medical autonomy and an important criterion of medical conduct. The much-discussed economic efficiency of physicians' conduct today is therefore nothing new, though the relevance of this criterion has changed decisively alongside the developments of the basic economic conditions.

Until the middle of the 1980s, it was enough to valuate medical measures from the physicians' point of view without relating them to the economy or the national economy's ability to afford health care. Until that point in time, there were sufficient financial resources available for financing all medical services provided (because premium revenue was high and unemployment low, among other things) ([64], p. 17). Since the middle of the 1980s, at the latest, experts have repeatedly pointed out that the health care system would probably surpass its load-bearing capacity sometime in the future, though these warnings did not receive a great response either in political debate or from the medical profession, which did not think it needed to take part in such a discourse because of its apparently safe monopolistic position. The reimbursement per service rendered established by the Statutory Health Insurance (SHI, or GKV in German) in 1955 was effective until the Health Care Structure Law was introduced in January 1993 and meant that the SHI paid for all services that a physician decided were necessary for a patient, even if a physician chose the more expensive of two measures, thereby creating an advantage in income for him/herself. For this reason, the physician was able to refrain from making a decision based on either the criteria of economic rationality and efficiency or on the Social Security Code's rule of economic efficiency. Rather, the physician was able to concentrate fully on his/her profession's ethical obligation of serving the patient. "He/She was able to fade out the business management motives of profit and did not need to think about the economic objective of saving costs. The physician, faithful to the Hippocratic oath, could do everything possible for the patient" ([53], p. 102). A conflict did not develop between medical and economic orientation regarding the choice and administering of medical measures (microlevel of medical conduct) because such a conflict was ruled out by an insurance system that covered all costs. The economic efficiency of the health care system as a whole (macrolevel) was also not an objective of physicians' conduct affecting their use of resources. As a whole, medicine was therefore outside the reach of the economy.

The expansion of health care structures in the period between 1965 and 1975 ([75], p. 230) and the growing volume of provided health care services caused health care expenditure to increase enormously from the middle of the 1960s onward. Health care policies must therefore face the task of resolving the resulting tension between guaranteeing sufficient and qualitatively good medical care on the one hand and not overtaxing the national economy's resources on the other. The medical profession and its professional organizations have fallen increasingly under criticism in the debates concerning the reasons and solutions for their increase in spending that resulted in the depletion of resources for other areas of society (labor market policies, education, culture, and so forth). Doubt has arisen as to whether or not the medical profession is able to live up to its social responsibility regarding economic resources. Furthermore, the medical profession has been faced with the accusation of putting its own professional and financial interests before orientation toward the public good (by ensuring dominance in the public health system and securing income opportunities) ([55], p. 194), [13]. The growing doubt as to "whether or not the medical profession is doing its share in the regulation of resources and can be regarded as a reliable trustee", the fact that most physicians refuse to look beyond their own field of profession in order to apply the public health approach through the incorporation of the economic dimension and society's point of view [26], the widely-held public and political accusations and doubts as to "whether or not physicians' specialized political arguments really serve the public good and are not primarily meant to increase their own income", and the lack of the profession's acknowledgement of the fact "that it completely lost the economic knowledge needed to control the system despite the enormous expansion of services" ([72], p. 77) have all led to the growing demand that the medical profession's activities be placed under state and market-mediated control [57].

The result of these developments was that basic legislative guidelines imposed economization on medicine (more on the term "economization" see [28]), which started in all industrial countries, more or less, in the middle of the 1980s. Through the political guidelines for budgeting and business administrative demands and regulating mechanisms (such as transformation to integrated care, evidence-based medicine, guidelines) established by the reform laws, the medical profession should be forced and urged to act in a more cost and quality-conscious manner and to utilize existing resources in the most efficient way possible. The medical profession is required to be more result-oriented, more efficient, and more economically profitable, without neglecting the quality of care and attention given to patients. Furthermore, health care providers are urged to work together more intensely for the benefit of patients and to treat this teamwork in a more systematic way. The objective of this is to activate available resources for economic efficiency. Under the conditions of cost containment, decisions made by physicians therefore acquire a new dimension, or a new point of view to be precise: Valuation based on monetary costs, which many health care providers see as an unjustified restriction on the practice of health care as they know it. The result of this is that, even under the condition of assuring and improving economic efficiency, the provision of high-quality medical care to patients must be guaranteed. Measures specifically designed for quality improvement are thereby expected to keep the rationalization and cost-containment from causing a drop in the quality of service at the cost of the patient. Medical services are therefore no longer seen only according to the medical criterion of best-possible cure, but increasingly according to the economic criteria of economic profitability and efficiency. Therefore, the Health Care Structure Act from 1993, for example, budgeted an upper limit for services for physicians with practices in order to urge them to utilize their

funding more economically and to take the economic objective of saving money more into consideration.
As to medical thought and conduct in occupational practice, the demands for economic efficiency and for budgeting gave it the task of maximizing the greatest possible use of health care for certain patient collectives within a given cost budget while also distributing services in the fairest possible way. Physicians using the criterion of economic efficiency must not only estimate what every diagnostic and therapeutic measure contributes to solving a pending problem, they must also consider whether or not the same or a similar effect could be achieved using less resources or causing fewer costs. Economically-oriented medicine can no longer simply ask: "What is medically possible and sensible?" It must also try to achieve the best cost-benefit ratio possible.
As a result, medical conduct has, for the first time, experienced and is experiencing the manifestation of conflicts between medical and economic orientation, or rather between ethics and the imperatives of the trend of economization. It can therefore no longer avoid making compromises ([53], p. 103 f.), [41]. In addition to this, physicians are also committed to those covering the costs and to economic guideline objectives, that is to say the business performance of his/her institution (a hospital, for example). The physician Stiefelhagen [82], (see also [25]) speaks for many physicians when he says that every physician must resolve this ever-growing conflict between ethical and economic objectives every day in his or her professional environment (such as: According to which criteria should possible decisions of rationing be made? Should the public good be put above the good of one individual? Should costs be allowed to play a role in therapy at all?). At the same time, physicians complain about the stressful work conditions that accompany economization (such as the disregard of the Working Hours Act), the pay that does not reflect the hours worked (which results in the drifting of younger physicians toward alternative professional areas, for example), and the increasing bureaucratization (such as the increase in documentation DRGs need), all of which lead to the insufficient provision of care for patients and a drop in care quality. Physicians tend to see themselves more and more as being forced into the role of rationing agents and entrepreneurs. This means giving up central basic philosophies of the profession and altruistic motivations for pursuing this career as well as the danger of losing authority and prestige (a social resource of professional autonomy) ([5], p. 1 ff.).
At the same time, the changes brought about by economization are creating new fields of practice and career opportunities for physicians, meaning new possibilities of professionalization in such areas as Medical Controlling, Health Care Management, Health Management, Quality Improvement, and Quality Management in public health institutions, and so forth [38]. Acquiring additional qualifications in one of the fields just mentioned, with the resulting professionalization, grants physicians the opportunity to fill the key positions in health care institutions and, for example, to implement measures for quality improvement and for controlling autonomously, or self-determinedly. The strengthening of physicians' autonomy cannot be expected if these positions are occupied by competing occupations (such as economists).
Another effect of cost containment and economization are the emerging disputes between medicine and the economy regarding who is allowed to do the interpreting and defining in the public health system. This can be seen in the fact that, in addition to the Council of Experts for Concerted Action in Health Care, there is a growing number of so-called health care economists that are active in political consulting and who follow a different logic than the medical profession.
The medical profession believes its autonomy and freedom to make decisions is being massively restricted by the external, political, and economic framework of the health care and structure reforms and by their business administrative perspective on the provision of medical services ([64], p. 18). From the medical professional organizations' point of view, this questions the prioritization of medicine over economy and casts doubt on the medical profession's independence of content, while it also questions physicians' autonomous decisions as to when, how long, and at what cost medical procedures should be performed on patients. For this reason, it is hardly surprising that the medical professional organizations are fiercely fighting the threat of their privilege of autonomy being restricted and dominated by outside influences.
The medical profession is fighting against the demands to be more economic and limit their budget, which they see as a means for the state to gain control. It is also fighting against the suspicion that it is mainly interested in upholding its own (economic) advantages at the cost of society [32], [82]. It fights on both fronts by putting more emphasis on its orientation toward the public good [55], [54] and by trying to convince the public that if patient care (in the sense of representing patients' interests) is committed to humanitarian objectives, it has no room for cost-benefit analyses. Physicians also argue that the financing of health care services must be oriented toward the particular services needed, and not vice versa. Furthermore, physicians argue that the quality of medical services cannot be appropriately judged from a position outside the medical profession (by health care economists, for example). According to the president of National Medical Council (*Bundesärztekammer*), Hoppe, the core tasks of medical professional policies must therefore be to reestablish a sufficient measure of medical freedom for physicians [32].
That the medical profession's resistance to outside control can be successful is visible in the shape the health care reform has taken. Although the implemented structural measures of the Health Care Reform Act that took effect in 2004 have influenced and limited the medical profession's autonomy, this has been to a much lesser degree than the government coalition originally intended. Important areas of physicians' responsibilities have remained intact due to the medical profession's power potential,

which is still strong. As a result, the new Institute for Quality and Economic Efficiency in Health Care (IQWiG), which designs guidelines for treatment and provides expert reports, remains outside of the state's direct influence. Further education also remains physicians' own responsibility. Even the monopoly of the Regional Association of Statutory Health Insurance Physicians (KV), which conducts the payment negotiations with SHI institutions and is responsible for the allotment of funding among groups of physicians, remains largely untouched.

The medical profession fears and laments that the health care reforms implemented so far have meant an increasingly stronger regulation by the state on their free professional conduct. However, they have overlooked the fact that extensive autonomy (as it existed in the time before the reforms) can only be claimed as long as it lives up to its responsibility to the public health system and its share in the economic use of resources [84], [13]. In other words, as the health care expert Schmacke stated, "the measure of responsibility and power granted by politics and society to regulate economic resources in the public health system will remain intact as long as society's expectation connected with this responsibility can be validated" ([72], p. 77). The medical profession stresses its medical orientation and adherence to the public good as justification for its claim to autonomy when arguing with representatives of the political system and the public. According to Meuser and Hitzler [54], [55], this can be understood as an attempt of professional policies to gain acceptance, though it is hardly enough to keep health care economists and health care policy-makers from criticizing physicians' lack of cost responsibility.

The necessity of redetermining the relationship between medical and economic orientation

Whether or not medically-responsible conduct and the management of limited resources (and its accompanying logic) are mutually exclusive, or if they can be combined, remains a point that is constantly disputed. Though the medical profession has mainly kept itself away from economically rational criteria so far, the demand to be simultaneous oriented toward both the patient's well-being and economic conditions forces it to at least take economic aspects more into account or add economic orientation (by weighing benefits and costs of several kinds of medical intervention) to their otherwise exclusively medical orientation (doing everything that could help the patient). This therefore results in the necessity to reflect more on a fundamental redefinition of the relationship between medical and economic orientation and its integration (for example in the development of integrated care that contains new forms of organizing health care). This means the point of view representing this particular profession and physicians' responsibilities must be expanded to form a perspective that is oriented toward the entire system and to include an economic dimension and the idea of community solidarity (public health care perspective). This must then be conveyed at all levels of college, training and further education (as for the economy and for management, the opposite is needed: recognizing medical ethics within medical orientation and integrating this in education). Medical autonomy is not a right acquired forever, but rather a concession made to physicians in exchange for medical, and now economic, responsibility. If the medical profession chooses not to take part in a constructive and necessarily interdisciplinary debate on how medical and economic orientation can be conveyed and kept in balance sensibly and on how the quality of health care can be optimized (the medical profession could push ahead with the first step in this direction by establishing forums for the active, interdisciplinary exchange of ideas with the objective of establishing legitimating bodies and processes for solving the dilemma), then it will lose more control over the public health system, which will be increasingly under the conditions of shrinking resources (expected in the mid-term), to the state, economy, and management. This would mean that the erosion of physicians' autonomy, which scientific experts have observed (in Germany and other industrial states) [51], [4], ([22], p. 185 ff.) and the trend toward deprofessionalization that some authors have observed since the 1970s (and which Krause calls "the fall of a giant"; [40]) would continue [6], [88]. Therefore, as the medical historian Unschuld states, physicians will indeed be demoted from being designers to co-designers, from those responsible to those sharing responsibility [85].

The erosion of medical autonomy has increased in intensity in the last few years due to the fact that health care occupations are being made into academic subjects and being professionalized (nursing, for example) and the fact that the increasing number of new expert occupations (and the qualifying academic education programs they require) are developing and establishing themselves as players in the public health system, occupations such as health care managers, health care economists, nursing scientists, nursing managers, and so forth [36].

Although physicians' dominance and autonomy is undermined by the public's loss in confidence, the increase in state and economic regulations inspired by cost issues, patients becoming more and more assertive, and the volume of new expertise occupations, the medical profession is still the most important discipline and the most powerful player in the public health system with its extensive dominance over the other health care occupations (from the point of view of the sociology of professions, there is a controversial debate as to whether or not evidence-based medicine strengthens physicians' autonomy, or if it rather weakens it [86], [48]). This paradoxical image characterizes the current situation of the medical profession in Germany and in other industrial nations [26], [46], [45]. In regards to the dimension of autonomy in the medical profession discussed here, it remains to be seen whether or not external political and

economic regulations are indeed able to guarantee an occupation's quality in the same way professional autonomy has, at least in principle, been able to do.

Conclusion and outlook

The reorganization of the health care system to establish an effective and efficient system that meets patient's needs but also equally takes basic economic conditions into account has become a constant task of health care policies. The medical profession has yet to provide its own stringent reform plan for this reorganization. Furthermore, the medical profession appears to have underestimated the speed, the degree, and effects economic change has had on the public health system for some time (this is apparent in the fact that management functions in health care institutions are increasingly performed by economists and lawyers, for example, who only have limited medical expertise). Not only will new and changed forms of organizing care and patient-related services emerge within the process of changing the public health system to incorporate more integrated care (individual practices could be a thing of the past), but physicians will also have to face radical changes in the structure of their profession. The Health Care Reform Act that took effect in 2004 has created the opportunity for physicians (together with other health care providers) to develop and try out new forms of organization that make more quality and economic efficiency possible (for example by supporting competition between the different forms of care, by approving ambulant medical care centers and by opening up parts of hospitals for ambulant care). It is likely that medical quality will thereby become a decisive factor of competition. The successful physicians of the future will be those who are able to combine cost efficiency and quality and integrate economic aspects into their occupational conduct without compromising their medical orientation.

It is not easy to resolve this conflict of objectives between medical and economic orientation; it will require a solution in the near future (though there is no satisfactory solution in sight today). However, this conflict could lead to an acceptable solution through the utilization of potential economic efficiency and processes of optimization (at least in the mid-term). If it is not possible to relieve this tension, then it is the patients who could especially suffer negative effects (through the rationing of health care services, for example). However, this is not the only reason why the medical profession should be taking part in, or even leading, the attempt to change the public health system so that it meets patients' needs, is affordable, and anticipates future developments.

In order to meet their future demands, physicians need more than just their medical expertise, they need to have a solid knowledge of the economy and of management, be able to work in a team, and cooperate and communicate with other professionals. This cooperative ability must also be integrated in medical education and training on all levels [35]. A new form of professional competence may also be necessary. Hitzler and Pfadenhauer propose to call this new form of professional competence "reflexive competence" [30] (keeping in mind the increasing dissolution of the binary concept of "healthy" and "ill"). What they mean by this (with the acknowledged and considered ambivalences arising from the progress of medical and technical knowledge and with the unintended consequences of medical conduct in mind) is that "reflexive competence" qualifies physicians to be able to constructively deal with ambivalences professionally and to provide innovative answers to the questions discussed here and to the problems of modern health care.

Notes

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