The methods of treatment currently applied cannot be regarded as alternatives in the sense that one of them makes the other completely redundant. It also seems to be clear that the largest possible number of transplantations is being advocated and also as much home-dialysis or continuous ambulatory peritoneal dialysis (CAPD) as will then be possible. Because hospital-dialysis will have to continue in any event, the point to be discussed is what would be the ideal mix. Unfortunately, the economic analyses carried out so far have concentrated almost exclusively on a comparative evaluation of the individual methods of treatment. From this it can be deduced – as Pedersen showed very clearly – that at present the important analyses are those that investigate the programme from a comprehensive viewpoint; in the given situation and in view of the high complexity this seems most readily achievable by means of simulation as Pedersen has also indicated in his paper.

Let me now deal with problem areas that I believe have not been thoroughly dealt with. The “society as a whole” and the insurance concept, in the presence of a rare disease with even rarer secondary diseases, seem to me to be the opposite of the approach selected by cost-effectiveness analysis (CEA) and cost-benefit analysis (CBA): it is precisely the rare/high-cost disease against which I want to be insured. Does an isolated study such as that conducted in a CEA and CBA make any sense at all, or should not preference be given to a financing method based on a “mixed calculation”? The equity concept is worthless in the sense of a postulated “common weal”, “public interest”, or whatever because disease and death are the greatest “dis-equalizers” that one can imagine. On the other hand, we have long weighed some lives against others: in the vaccination programme, for instance, we sacrifice partly drastic side effects and lives to anticipated still worse consequences. The way out would seem to consist of a method of analysis that would strictly separate the insurance from the public interest point of view. The logical consequence would be a system providing basic services on to which specific insurance programmes could be grafted. It would then be up to the different sections of society to decide if and to what extent they are prepared to support “non economic” services that are nonetheless regarded as justified from a public interest perspective. Personally, I would prefer a system that did not pervert the egalitarian principle so far as to forbid someone from choosing an “uneconomic” method of prolonging his life if the persons surrounding him (or he himself) decide to give him the possibility of so doing.

Even if “society as a whole” is considered a realistic concept this does not necessarily lead to false conclusions: disability pensions and sick pay are, in my opinion, not merely a reshuffling of purchasing power, they drastically impair a society’s economic capacity to produce and, in my view, are not neutral in social terms.
What must characterize CBA and CEA in an area where alternatives are still very much in a state of flux, i.e. to what extent would CBA, were it taken seriously, change the perspectives, since economically potentially interesting objectives would not be attained at all because temporary “overpayments” are not recognized as such and therefore do not appear as necessary or sound investments?

To examine prevention and therapy jointly would be readily possible only when starting out from prevention: by this I mean to say, to what extent can we do without prevention if therapy is as effective as it is efficient. Setting out from therapy (after, so to speak, the baby has fallen down the well), the problem is given another basis of assessment in the sense of a point made above – that of the solidarity and insurance community. To me, the discussion of Fig. 9.4 seems important because it brings out the following point: therapy can be substituted for prevention. Prevention can be substituted for therapy only after splitting up the interests involved.

In the evaluative discussion it does not appear to me to be certain that the lifestyle of people actually supports the thesis that human beings prefer to live long though unsatisfactory lives rather than short but good lives: a popular poll would not be sufficient to obtain conclusive evidence. Such a poll should also at least provide for the probability that contrary to the thesis people actually live “badly and briefly” or “well and for a long time”.

What is a “decision-maker”? An example: costs of hospital confinements are borne by the German health services; even in earlier times 90% of all deliveries took place in hospitals on the basis of “medical interventions”. The health services simply took over the costs of the consensus that had long existed between physicians and patients.