Insights From Health Care in Germany

German Statutory Health Insurance (national health insurance) has remained relatively intact over the past century, even in the face of governmental change and recent reforms.

The overall story of German national health insurance is one of political compromise and successful implementation of communitarian values.

Several key lessons from the German experience can be applied to the American health care system. (*Am J Public Health.* 2003;93:38–44)

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GERMANY'S HEALTH CARE system presents us with a puzzle. Brown and Amelung[1] view the German case as "manacled competition," whereas Uwe Reinhardt[2] counters that "regulated competition" is a more apt description. However, the puzzle is not the nature of competition but why German health policy continuously reinforces the status quo. Even though recent reforms have introduced "competitive elements," they should not be mistaken as a crusade for market economics in health care. The guiding principles of German national health insurance—solidarity, decentralization, and nonstate operations—have not changed but are complemented by a new layer of ideas. (Updated details through January 2002 about German national health insurance and long-term care, mental health and public health, and references to a rich English-language literature on this subject have been outlined elsewhere.[3,4])

Historical analysis may prove useful in sorting out the German puzzle. Indeed, historical analysis is vital to cross-national health policy research. It allows us to sort out short-term from long-term factors, to pay attention to political factors, and to raise sensitivity to how concepts are bounded by particular cultures. Issues such as universal coverage, benefits, portability of insurance, and participation by physicians and hospitals are important in describing the German health care system (Table 1), but they are secondary to the history of power relations among the major stakeholders, agenda control, and the reinforcement of the structure of national health insurance at critical junctures in Germany's tumultuous history.[5–7]

Rather than being solely a lesson about leftist politics and the power of trade unions, health care in Germany is above all a story of conservative forces in society. These forces include public and private employers, churches, and faith-based and secular social welfare organizations. They remain committed to the preservation of equitable access to quality medical services, and they form crucial pillars for the delivery of medical services and nursing care.

HISTORICAL COMPROMISES

Several political compromises from the last quarter of the 19th century go a long way toward explaining the success, performance, and durability of German national health insurance. These compromises have had long-lasting effects, determining who has power over national health insurance, the role of government, and the effect of national health insurance on the health care delivery system (inpatient, outpatient, and office-based care).

The first compromise was the product of industrialization and urbanization, both of which came late in Germany compared with France or the United Kingdom, coinciding with the establishment of German national unity in 1871. Workers began to organize labor unions, fighting both industrial employers and the Prussian State. Under these pressures, business leaders realized it was in their own self-interest to develop "sickness funds" even before Bismarck pioneered a national plan.

The second compromise emerged as a conflict between regional and national forces. Regional elites felt threatened by what they saw as an overwhelming authoritarian state, particularly Bismarck's original plan to control health insurance from a central imperial office. The iron chancellor, known for his militarism, use of coercive powers, and exercise of repressive measures, lost out to these regional forces when national health insurance was created in 1883. Sickness funds, although mandated nationally, were organized on a regional basis.

A third compromise resulted in joint management of sickness funds by employers and employees in the last quarter of the 19th century and then adapted to the conditions of the 20th century. The model of labor and business mediation through nonprofit, self-governing bodies developed in 3 stages. First, between the 1860s and the 1920s, labor controlled two thirds and business controlled one third of the seats on the board of individual sickness funds. During the second period, from around the mid-1920s to 1933, each side had an equal representation. Under the Nazi regime, development was interrupted from 1933 to 1945 because health insurance became subject to total control by Berlin. After 1945, control over sickness funds in West Germany reverted back to business and labor. East Germany kept a state-run deliv-

TABLE 1—National Health Insurance at a Glance

Scope
- No citizen is without insurance—92% are covered by National Health Insurance; the rest are insured privately or are wealthy
- Mandatory contributions into National Health Insurance
- Choice of generalist physicians and specialists, dentists, hospitals, and long-term nursing care
- Portability of coverage across all hospitals, doctors' offices, regions, and communities
- Chip card (previously uniform forms) serves as membership identification; medical and dental offices, hospitals, and specialized facilities must honor it
- Choice of sickness fund (since 1993)
- About 7% of the population carries commercial insurance (civil servants and the self-employed—about 7.1 million in 2001)
- 7%–10% of those covered by National Health Insurance take out private insurance for amenities while hospitalized
- Private health insurance is offered by about 50 companies, although the private insurance sector is very restricted given National Health Insurance

Providers
- Professional autonomy
- Peer review and self-regulation through self-governing bodies
- Advice, assistance, and care are mandated; right to representation is institutionalized
- Accountability to peers, the public, elected governments, and payers
- Income miserable from 19th century through 1960s, when fee-for-service reimbursement was introduced; bonanza lasted until mid-1980s, when income began to decline 2–3 times previous income
- Mandatory membership (generalists or specialists) in regional chapters of 2 medical organizations as precondition for practicing medicine and reimbursement under National Health Insurance
  - For reimbursement, Federal Association of Panel Doctors
  - For actual practice, Medical Chamber controlling medical education, continuing education, and specialty training; setting standards of care for each specialty and subspecialty
  - Dentists, pharmacists, and other health professionals share a similar history and guildlike organization

Coverage
- Working individuals, their spouses, and their children
- Retired persons
- Unemployed
- All students, whether at community colleges, senior colleges, or universities
- In principle, children are covered until age 18 (but, depending on whether a child works or is a student, can continue until age 23 or 25, respectively)
- Age limit can be waived for disabled children

Benefits, prevention, and early detection
- Any type of medical services delivered by an office-based generalist or specialist
- Unlimited hospital care, with copayment limited to 14 days per year regardless of repeat admissions
- Prescription drug coverage, subject to copayments
- Full salaries for mothers from 6 weeks before childbirth to 8 weeks afterward, including neonatal care for mother (10 visits) and child
- Home help
- Preventive checkups for children (9 visits from birth to age 6 years, +1 at the beginning of adolescence), plus for adults after age 35
- Yearly cancer screening for women starting at age 20 and men at 45

Continued

TABLE 1—*Continued*

- Dental care
- Patient-assisting devices (e.g., wheelchair, walker, hearing aid)

Financing (2-tiered organization of sickness funds)
- Mandated employer- and employee-financed contributions (payroll tax averaging about 7% of salaries and wages for each)
- Individuals can be a member of any one of these funds (competing for members since 1993)
- First tier
  - 7 general regional funds (*Allgemeine Ortskrankenkassen* or AOK)
  - 318 company-based funds (*Betriebskrankenkassen*)
  - 28 guild funds (*Innungskrankenkassen* or IKK)
  - 5 farmers' funds (*Landwirtschaftliche Krankenkassen* or LKK)
  - 1 miners' fund (*Bundesknappschaft*)
  - 1 sailors' fund (*See-Krankenkasse*)
- Second tier: 12 "substitute" funds (*Ersatzkassen*)—originally catered to workers with above-average earnings

ery system until the West German model was imported in 1989. Since the 1993 reforms, the minister of health has asserted more regulatory authority over the nonprofit, self-governing sickness funds. Based on history, however, it is doubtful that the German state will take on a larger role as in Canada, Britain, or even the United States with Medicare and Medicaid.

The basic structure and principles for securing access to health care—mandatory sickness fund membership, employer- and employee-funded coverage, defined benefits based on the state of medical knowledge, with portability of benefits—thus became embedded in German economic and political institutions (Table 1). As a consequence, German policymakers aimed at extending eligibility, improving benefits, defining quality services, and spreading geographic access to medical services. Efforts to reform health care delivery were minimal. The medical profession alone defined health care quality until the 1990s.

Because of solidarity among workers, eligibility also was extended to guest workers (*Gastarbeiter*). In the 1960s, trade unions made their inclusion under social insurance a prerequisite for accepting "importation" of "foreign" workers. Thus, both full- and part-time *Gastarbeiter* have the same rights and obligations under national health insurance and, since 1995, long-term care insurance; they and their families are entitled to the same benefits as other German workers. Health insurance also remains unchanged for all workers during unemployment. Their contributions to national health insurance are paid by federally administered statutory unemployment insurance, which is financed on the same basis as national health insurance.

The significance of the historical-political compromises outlined above cannot be underestimated. After 1883, a few policy options were no longer seriously considered. A single-payer system of financing like Canada's was never a real option; nor was a system like the United Kingdom's National Health Service. Instead, given the historical mix of public and nonprofit and faith-based and secular hospitals and

specialized facilities, service delivery was based on pluralism.

The central state, however, has retained several important functions within national health insurance. The national government operates as supervisor, enabler, facilitator, and monitor. National professional and management standards became the law of the land, contrary to a strong regional tradition in Germany before 1871 and after 1949. Universal, employer- and employee-funded insurance made it imperative that a line be drawn between regional rights and securing universal quality in health care; it was drawn for national standards. Thus, regional definitions of coverage, entitlements, and eligibility were never allowed to develop. Over time, national standards were to be phased in, setting the conditions for receiving medical services, long-term care, and mental and public health services and for engaging in medical practice. In tandem with these health care standards, national standards for industrial affairs, social security programs, and other welfare state programs became the rule.

In contrast to centralized policymaking, implementation was reserved for regional governments. Similarly, the provision of medical services and nursing care was left to private, nonprofit, and public providers. The provision of medical and nursing care requires a high degree of cooperation between providers and faith-based and secular welfare organizations. The *Länder* (regions) are also powerful in shaping federal legislation and, to a lesser degree, national standards. Federal legislation of standards that have implications for regional interests can be enacted only with the support of regional governments.

AGENDA CONTROL AND GOVERNMENT RESPONSIBILITY

Agenda control and the exercise of government responsibility are important for understanding why the financing and organizational elements of German national health insurance have been so durable. Control over the policy agenda results from elections and the role political parties play in the polity. The importance of health insurance has led the central government to maintain control over national health insurance.

Germany has a multiparty system, with roots in the 19th century. As a rule, Germany's parliamentary democracy does not encounter "divided government." The party who wins the majority controls executive-legislative powers; however, because majority control is a rare occurrence under proportional representation, control by a coalition of parties is more the rule. Control is crucial for the passage of legislative drafts; these typically originate in the cabinet rather than from individual parliamentarians (the rule in the United States) and subsequently are introduced to the federal council (where regions are represented) before they are debated in the federal lower house.

Of a total of 26 cabinets in the post-1949 era, only 4 were majority cabinets in which the winning party formed a government without needing a junior partner. Finding themselves in this situation 3 times, the Christian Democrats could have substantially changed health insurance; instead, they legislated improved benefits and extended coverage, passed long-term care insurance, and remained strong supporters of medical professional self-governance. Nor did the Social Democrats alter financing, organization, and control over national health insurance[8] or shift to a tax-financed system when in the same position. Neither the Christian Democrats nor the Social Democrats ever relaxed control over health insurance by leaving supervision to a junior partner in their coalition; health insurance was too important.

In contrast to political stability in post-1949 German democracy, the 14 years of the Weimar Republic (1918–1932) saw 21 cabinets.[9] Yet even with the mega-inflation in 1923 and the financial crash in 1929, health financing was never turned into a tax-financed system; national health insurance remained stable, based on employer and employee contributions, even during this unstable time.

RECENT REFORMS

The 1990s saw an incredible frenzy of legislative and regulatory interventions, including the redrawing of political boundaries between elected governments and medical professional self-governance structures.[3,4,10] Laws, regulations, informal provisions, and standard operating procedures in each service and care sector kept changing at such an incredible speed that rigorous assessment of these changes is difficult.

Still, even between 1883 and the 1990s, health policy in Germany showed a high degree of policy and structural stability amidst short-term conflicts and volatile politics. The structural stability is even more astounding given significant ruptures in the political and social order in 1918, 1933, 1945, and 1990. In the contemporary era, policy stability is being challenged by rising costs, an aging population, and increasing demands for quality health care and access to the latest available medical treatments.

Rather than being concentrated in one area, health care debates have always proceeded among several layers within an established hierarchy of decisionmaking. Debate over national health insurance in the political arena was dominated within the federal center; in the federal and regional arena, debate was confined to corporatist providers and payers and professional and expert circles. The general public, including self-help groups and individuals, was largely excluded from these debates. These layers of decisionmaking routinely came together only in the context of topics bearing on national health insurance. At the delivery end, effectively functioning circuits of cooperation and communication from one service sector to another hardly existed in the past but now are receiving heightened attention given the urgent needs of an aging population.

Since the mid-1970s, cost-containment policy has been a recurrent agenda item. Reformers have favored prevention (primary and secondary) and early detection of disease, although they have been timid and stopped short of advocating the reallocation of resources from the curative sector to prevention. National health insurance and service delivery reforms have been decided on, enforced and implemented from the top down, as have other measures such as setting specific health goals and moving toward outcomes-oriented evaluation. During the last few years, however, reformers have looked for greater "bottom-up" participation

of key target groups usually excluded from health policymaking: regional and local governments, service- and care-providing institutions, and regional and local associations. Still, patient empowerment is more rhetoric than reality.

On a positive note, after decades of opposition, Germany seems to be coming around to the institutionalization of prevention and health promotion on one side and best practices, evidence-based medicine, and medical guidelines on the other. Delay in leadership in these areas is in stark contrast to Germany's pioneering role in the 19th century in medical science, in public health, and in creating the first national health insurance program.

Germany is not shielded from the larger international environment and the challenge of rising costs. It has imposed supply side limits by introducing sectoral budgets and spending caps (Table 2). In 2000, Germany adopted a diagnosis-related group–based hospital reimbursement system to be fully operational by 2007; and 2002 has seen further legislation to improve long-term care and home care of the elderly.

PROSPECTS FOR THE FUTURE

At the heart of any debate about German health care reform lies the crucial economic questions of whether financing should remain based on insurance and solidarity, whether payroll taxes for national health insurance can be raised ad infinitum, and whether health spending should remain coupled to salary developments in the larger economy. The alternative is shifting the financing of health care to revenues from general taxes. However, the level of equity and quality achieved under national health insurance, including the general absence of waiting lists, compares favorably with the United Kingdom and the United States. Funding through general taxes has an even higher potential for political chicanery than current cost shifting from public budgets to national health insurance.[3,4] With general taxes, politicians can "play around" and hide the full implications of their actions.

A problem with dependence on payroll taxes is that they have declined in importance. Between 1980 and 2001, health care expenses grew from 8% to more than 10% of gross domestic product. During the same period, payroll decreased from 74% to 65% of gross domestic product; thus, the contribution rate grew from 11.4% to 14.1%. Before the assimilation of East Germany in 1990, expenses were closer to the European average.[11]

The once sharply drawn lines between ideologies have given way to a more inclusive policy community influencing the public debate. Still, health policy choices are limited. Christian Democrats and Free Democrats believe that medical services must be differentiated between national health insurance–covered core services and voluntary services paid out of pocket or through private insurance; the Social Democrats reject this idea. Some reformers want patients to pay first and be reimbursed; however, what is normal practice in the United States is a revolutionary proposal in Germany.

TABLE 2—Cost Containment Through Budgets and Spending Caps, 1989–2007

	Ambulatory Care[a]	Hospitals[b]	Pharmaceuticals[c]
1989–1992	Negotiated regional fixed budgets	Negotiated target budgets at hospital level	No budget or spending cap
1993	**Legally set regional fixed budgets**	**Legally set fixed budgets at hospital level**	**Legally set national spending cap**
1994			Negotiated regional spending caps
1995			
1996	Negotiated regional fixed budgets		
1997		Negotiated target budgets at hospital level	
1998	*Target volumes for individual practice*		*Negotiated target volumes for individual practices*
1999	**Negotiated regional fixed budgets with legally set limit**	**Negotiated target budgets at hospital level with legally set limit**	**Legally set regional spending caps**
2000			Negotiated regional spending caps
2001			(Regional budgets abolished; replaced by *Festbeträge* [fixed sum per package])
2002			
2003		(Diagnosis-related group system)	
2004			
2005			
2006			
2007		(Diagnosis-related group system to be operational)	

Note. Italics indicate less strictly regulated sectors; boldface indicates high levels of regulation; parentheses indicate that the importance of regulation is unclear at this time.
[a]Negotiated between corporately organized regional payers and providers.
[b]Negotiated between regional governments and payers (until 2002).
[c]Negotiated primarily between payers and physicians; lately, the ministry of health has played an increasingly important role.
Source. Reprinted with permission from Busse.[10]

TABLE 3—Co-payments in Euro (January 1, 2002) in Germany[12]

Prescription drugs	4, 4.5, or 5€, depending on the size of the package
Medical supplies, bandages	4€ per type of supply or bandage
Aids to treatment (*Heilmittel*[a]) (e.g., massages, therapeutic baths, physical therapy, speech therapy, other therapies)	15% of costs reimbursed by sickness funds (no change)
Transportation (e.g., ambulance)	13€
Aids to compensate for a handicap (*Hilfsmittel*[a]) (e.g.,bandages, orthotics, hearing aids, intersections, eyeglasses)	20% of costs reimbursed by sickness funds (no change)
Dental services	50% of costs without bonus reimbursed by funds
	40% of costs with bonus
	35% of costs subject to proof of continuous dental care
Hospital services	9€ per hospital day (up to a maximum of 14 days per year)
Rehabilitation for mothers	9€ per day
Rehabilitation after acute illness	9€ per day (up to a maximum of 14 days per year)
Preventive hospital and rehabilitation	9€ per day (up to a maximum of 14 days per year)
Physical therapy	8€ (depending on individual sickness fund)

Note. Costs converted from *deutsche marks* by the author, at a rate of 1X = 1.96 DM.
[a]These are legal categories as defined in Sozialgesetzbuch V (translated as Social Code Book V).

Democratic Socialists in former East Germany and Greens would like to return to state-run clinics and community health centers.

Co-payments (Table 3) will remain an essential element of health care reform, albeit modest in comparison to US deductibles and copayments. Both major political parties agree that waivers of co-payments are imperative for low-income groups and the chronically ill and that out-of-pocket payments should not exceed 2% of annual income. But some policymakers seek to tax all incomes, even from low-paying jobs that have not been taxed previously.

Most reformers recognize the need for better coordination across all types of medical, rehabilitative, nursing, and home care; they envision networks of providers and individual caregivers that cut across the highly sectorized delivery system of medical services and nursing care in hospitals and doctors' offices. They promote flexible contracts between individual providers and payers, thus bypassing physician associations.

Christian Democrats wish to redraw the balance between solidarity, subsidiarity (public–private relations), and individual responsibility. Income from real estate and investments and other forms of wealth must be part of the calculations of an acceptable financial burden. They feel strongly that the combined payroll taxes of all insurance programs (social security, unemployment, nursing care, and health services) plus income tax should not exceed 40% of salary and intend to restore taxes to 1995 levels.

The perception that enormous reserves still exist in the health care system, which should be put to better use, has led to the introduction of evidence-based medicine, practice guidelines, and health care technology assessment. Compared with Germany's European neighbors, these reforms have been introduced later, and reformers believe that these initiatives must be pursued wisely and intelligently. By themselves, they are not a panacea for rising costs.

The political support for national health insurance and self-governance arrangements, or "the cozy cartel of providers and payers,"[1] remains strong, embedded as it is in the historical compromises mentioned above and the tumultuous political development of Germany during the 20th century. Nevertheless, some want to relax the decisionmaking monopoly of providers and strengthen the power of payers instead. Support for both options can be found in the 2 major parties. The newly elected SPD-Green coalition government intends to redraw the boundaries between providers, payers, and the ministry of health.

Germany's autonomy over national health insurance is being challenged by European integration and market globalization, resulting in a decline of political authority in certain policy sectors. In health, patients may be among the winners. Under European arrangements for cross-border health care, a European citizen or resident already encounters fewer obstacles in receiving health care away from home than does an American consumer enrolled in an East Coast health maintenance organization who is on the West Coast.[13] Much also will depend on how European competition law and German antitrust law are interpreted by the European Court of Justice and how fast the European Court of Justice can deliver case law that will further strengthen cross-border health care.

LESSONS FOR THE UNITED STATES

The German experience does have lessons for the United States (Table 4). First, solidarity-based (employer and employee) financing, rather than funding from general taxes, has served health protection and industrial relations in Germany well, even with constant grumbling from employers. German employers have had the unenviable position of enduring the highest nonwage costs in the Organization for Economic Cooperation and Development for 12 years in a row.[15] Yet, despite complaints notably in recent years from employers and physicians, employer- and employee-funded national health insurance remains intact.

Second, universal health care comes with a price; it has never been free for German consumers. Although Germany ranks second among Organization for Economic Cooperation and Development countries (after the United States) in terms of public-mandated spending on health care, it spends 3% of gross domestic product less than the United States.[8] Mandated coverage and employer and employee contributions in Germany buy substantially more comprehensive medical services than

TABLE 4—Benefits of Communitarian Health Care for Employers and Employees

Comprehensive, portable benefits and access to quality care
Independent of employers' largesse
No uninsured
No differentiation between high-risk and low-risk employees
Benefit plans do not depend on size of the employer
Employers have the same insurance costs regardless of size
Affordability of offering health insurance to employees less an issue in Germany than in the United States
Same cost-sharing requirements by patients are used under National Health Insurance
No deductibles and maximum annual out-of-pocket costs for employees before benefits kick in
Modest co-payments for all on an equal basis
No variations in health plans and cost sharing
Low administrative costs for sickness funds; although increasing, only 5%–6% (compared with the United States, with 10% of premiums for large employers and 20%–25% for small employers)
Employer-based human resources departments implement the same national rules
No expenses for advertisement, marketing, and billing
No need to discuss the issue of employees' access to health insurance
All employers and employees get the same value for their contribution
No need to screen any employer for potential risks of their employees
Federal health care reform applies equally to all parties involved
No need to use health characteristics in setting premiums

Source. Adapted from US General Accounting Office.[14]

under any US health maintenance organization or commercial insurance plan.

Endorsing universal health and accepting the conditions that make it work in the United States would mean dramatic power shifts for which neither most of the American public nor stakeholders appear to be ready. However, the price for relying on employer-provided benefits for most of the American labor force is abdication of control and total dependence on employer goodwill. When pinched, employers will offer less coverage, which translates into higher deductibles, co-payments, and benefits exclusions for employees. It also means total dependence on the powerful insurance and pharmaceutical industries. As the historical record has shown repeatedly, elected representatives in the United States cannot be relied on to vote for universal health but tend to be captive to special interest lobbies. The loser is the American patient and consumer.

Third, long-term care has arrived in Germany, although with a time lag of some 120 years when compared with earlier social insurance programs. Mandatory long-term care insurance has provided access to nursing home care and other forms of nonmedical care since 1995, thus keeping the elderly in the mainstream rather than marginalizing them. The employer- and employee-funded contribution into long-term care insurance is set at 1.7%, or 0.85% for each side. The income ceiling for health and long-term care protection on which the payroll tax is calculated is 3375€ per month starting in January 2002; likewise, the annual income ceiling now is 40 500€.

Obviously, coordination at the macro policy level across national health insurance and long-term care insurance is a high priority. An ever-greater need exists for offering integrated services at the community and family level. This seems to work best when home visits are offered by networks of different kinds of providers. In this way, medication can be changed; a referral to a hospital or a specialist can be obtained; and patient-assisting devices, which require a physician's prescription, can be ordered when needed.

Finally, business and labor leaders, federal and regional policymakers, and most segments of the German public remain convinced that solidarity is a better mechanism to resolve conflicts and secure access to health care than fierce competition and adversarial politics. However, there is also agreement that solidarity, subsidiarity, and self-governance can blossom only under 5 conditions: (1) the profit motive (especially investor-owned insurance companies) must be kept out of health care or at least kept to a minimum to save substantial sums, which otherwise pay for advertisements, billing, and marketing; (2) a communitarian and inclusive culture surrounding the delivery of care must be emphasized; (3) countervailing forces (federal vs regional, payer vs provider) should be used and relied on for problem solving[17]; (4) federal or regional offices should act as facilitators, enablers, and monitors of last resort; and (5) the link between the voting public and elected officials must not be severed through special interest politics, which can lose sight of the "woman on the street."

Health policies are the product of politics and a particular institutional and ideological context. Irrespective of ideological differences, US stakeholders and the American public share similar convictions, have similar antigovernment attitudes, endorse a firm belief in "rugged individualism," and, deep down, have in common the strong belief that money has a legitimate place in society. All of these factors mitigate against collective solutions for universal health, whether tax financed or employer and employee funded. However, the situation would be different if we could just get to the point where Americans, like Germans, can say: "Don't take my health insurance away." This works for Medicare; why should it not work for universal health care? ■

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