

2002

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Recommended Citation

Alfred E. Miller, *Social Ethics and Organizational Structures Influencing the Allocation of Health Care in Germany and the United States*, 18 J. Contemp. Health L. & Pol'y 649 (2002).

Available at: <https://scholarship.law.edu/jchlp/vol18/iss3/8>

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SOCIAL ETHICS AND ORGANIZATIONAL STRUCTURES INFLUENCING THE ALLOCATION OF HEALTH CARE IN GERMANY AND THE UNITED STATES

Alfred E. Miller

I. ETHICAL ISSUES AND PRACTICAL CONSIDERATIONS IN THE ALLOCATION OF HEALTH CARE—WHY PROBLEMS OF SOCIAL JUSTICE DIFFER FROM THOSE OF INDIVIDUAL ETHICAL BEHAVIOR AND CALL FOR VERY DIFFERENT APPROACHES

Addressing ethical problems concerning the allocation of health care or other social goods and services requires understanding their special nature and finding strategies for solutions in ways that are quite different from individual ethical behavior in particular situations. On the one hand, allocation issues are correctly considered in terms of social justice and what ought to be available to all persons as their right in order to have the opportunity for a fulfilled life. On the other hand, if we analyze these issues in terms of concepts, decision processes and types of actions that are appropriate for individual ethical behavior, it is easy to overlook the important distinctions needed in dealing with allocation problems.

Typically, ethical behavior occurs in specific situations, at particular times and requires single individuals to act according to certain criteria to achieve immediate concrete ends. By contrast, the factors, criteria and social structures that affect the allocation of social goods and resources (social justice) are usually the result of collective decisions made cumulatively over generations. Uncritical extrapolation of approaches, appropriate for individual ethical behavior applied to problems of social justice, clouds the issues at stake, hides the true nature of the problems and hinders developing realistic solutions. Ordinary ethical behavior is usually a consequence of individuals both deliberating and implementing their own actions. Achieving social justice depends on the historical development of an entire society and requires long-term strategies and concerted, collective action to redress inequities.

Uncritical consideration of allocation problems in terms appropriate for individual ethical behavior can make it seem as if an identifiable mistake in ethical judgment—or some specific factor or even some conspiracy—were responsible for the existing injustice. This simplistic approach prevents us from understanding the complex structural nature and

historical dynamic of the underlying problems that obstruct achieving the widely desired, mutually advantageous goals. Looking for single causes and final solutions for obvious problems, results in overlooking the subtle but powerful interactions between competing interests and goals and how these interests ultimately impact the allocation decision process. As long as we fail to understand the underlying structural nature of the problems, it is impossible to arrive at realistic strategies for reshaping the faulty mechanisms responsible for the lack of proper allocation of resources and services.

Despite basing seemingly appropriate ethical decisions about allocation on system-wide analysis and working at the political level to implement corrective action, they often remain inadequate for dealing effectively with the kinds of problems involved. In the U.S., political decisions and political processes in the traditional sense have frequently been inadequate for reaching consensus or even for implementing actions that are widely agreed upon. Political mandates, such as those given in national elections, have not succeeded in bringing about the reform of the overall system necessary to make health care financially available to all, while keeping the costs in bounds. A central plank in the winning 1992 election platform was health care reform including some form of national health insurance. Public opinion polls, professional consensus and other indicators showed that there was firm political support for major reform of the health insurance system. Nevertheless, powerful lobbying and massively financed public opinion campaigns were able to derail the effort to enact the necessary legislation.¹ Where entrenched vested interests are threatened by the proposed changes, the implementation of political decisions regarding the necessary reforms seems to require more than a political mandate in the usual sense.

Thus, allocation and its control have to be understood in terms of the overall system that provides the services and how it developed under the influence of multiple political and other collective actions and social

1. In retrospect, it is clear that failure to enact the electorally mandated legislation was primarily due to opposition from the vested interests threatened by the changes, rather than by inadequacy of the proposals. On the one hand, no serious alternative plan was put forward by opponents for reaching the same desired goals. On the other hand, the proposed cost savings by increased use of managed care (which were maligned as 'rationing' by the opposition) have now been widely put in place in order to save costs by the same groups who opposed them then, but without the originally proposed regulatory framework that would have assured much of the consumer protection now being sought in the so-called "Health Care Bill of Rights."

changes. Comparison of the structure and history of the U.S. and German health care systems and the ways in which they provide and allocate services provides a striking case study of how subtle but powerful differences in the structure of the systems as a whole profoundly influences the outcome in terms of availability and cost.

II. OVERALL SIMILARITIES BETWEEN THE U.S. AND GERMAN HEALTH SYSTEMS—BUT DIFFERENT OUTCOMES IN REGARD TO ALLOCATION AND COSTS

In the U.S. and Germany the basic components of the health system for delivering and financing health care are quite similar. Both systems are comprised of a mix of public and private organizations and service/fiscal relationships. Most medical services are provided on a private basis, while publicly operated services constitute a small sector of care for indigent or other special population groups. In addition, both countries finance the private delivery of care through an insurance system of payment, funded in part by employment-related premiums and in part by government-operated funds, that make the private delivery system accessible to certain parts of the population (particularly retirees and others not covered by the employment-based premium system).

Despite these basic structural similarities in the manner of delivery and financing of care, however, the outcomes in terms of allocation and cost of services are strikingly different in the two countries. The German health system provides essentially universal insurance coverage and a full range of benefits, including dental care and pharmaceuticals, with very little co-payment or restriction on utilization except for the peer-review by the physician associations. By contrast, the U.S. system leaves over forty million (fifteen percent) of the most needy with no health insurance at all and many more with inadequate benefits or high co-payments that act as serious barriers to utilization. Moreover, as a cost-saving measure in recent years, U.S. health insurers have increasingly instituted various forms of managed care to limit utilization by restricting the discretion of both consumers and providers.

At the same time, the German system provides more complete coverage and fuller benefit package at considerably less cost per capita than the more limited and restricted U.S. system. After the cost explosion of the 1960s in both countries, the West German health care budget was held at just above eight percent of GDP from the mid-1970s until reunification, while U.S. health expenditures continued to rise to over

fourteen percent of GDP at present and are expected to reach sixteen percent of GDP by 2010.² Yet in spite of the much higher rate of health expenditures in the U.S., there is no indication that it results in better outcomes or leads to greater satisfaction with the care received. Health indicators such as infant mortality, life expectancy and overall public satisfaction with health care are at least as good and often considerably better in Germany than in the U.S. Moreover, in the face of ingrained, often conflicting interests of the parties concerned (quite similar to those in the U.S.), the German system has succeeded in accommodating to major changing problems and needs of the population (e.g., the cost explosion beginning in the 1960s, absorption of the East German (GDR) health system and population and the growing need for long-term care as the population ages).

By contrast the U.S. health care system has repeatedly failed to accommodate to similar challenges. The German system is more highly regulated than the U.S. system, and regulation is strongly rejected in the U.S. as an acceptable solution for economic or service problems of this sort. However, the highly successful regulation of the German health system occurs largely by way of reaching negotiated consensus among all the parties involved. Unlike unilateral regulation, negotiation as a means of resolving disputes or reaching consensus among conflicting interests is generally considered an acceptable approach in this country as well. Why has it not been possible to negotiate solutions for health care problems in this country in ways like those employed in Germany? To answer this question it is necessary to examine the more subtle differences in structures and traditions of the health systems in the two countries, in

2. See *European Observatory on Health Care Systems, Health Care Systems in Transition: Germany*, 177-20 (2000). In the decade after reunification the much lower per capita GDP in the former East German states (GDR) with essentially equal per capita health care costs together with the general economic decline resulting from the economic strain of integrating and rebuilding the Eastern states led to an increase in the ratio of health expenditures to GDP from eight percent to ten percent. However, despite adding major new long-term care benefits to their health insurance program, evidence suggests that German health expenditures are holding steady at the new level while U.S. costs continue to rise ominously. See also Gerard Anderson, et al., *Health Tracking Trends: Health Spending and Outcomes: Trends in OECD Countries, 1960-1998*, HEALTH AFFAIRS, May/June 2000, at 19; U.S. data from: U.S. Health Care Finance Administration, *National Health Expenditures Projections: 2000-2010*; Stephen Hefler, et al., "Health Spending Growth Up in 1999; Faster Growth Expected in the Future," HEALTH AFFAIRS, 20 Mar./Apr. 2001, at 193-203.

particular the fiscal relationships between various components of the two systems and how they developed.

III. KEY DIFFERENCE BETWEEN THE U.S. AND GERMAN HEALTH SYSTEMS: THE REGULATORY AND NEGOTIATIONAL RELATIONS THAT STEER ECONOMIC AND SERVICE ARRANGEMENTS

The German health insurance system is privately operated and performs essentially the same basic functions as those of U.S. health insurance companies or organizations like Blue Cross/Blue Shield, such as collecting premiums from employers and/or employees and paying providers for furnishing services to those who are insured. Nevertheless, there are important differences in the way the German system is organized and its relations to the payers and providers. The organization of the German system makes it possible for the interests of the various components to be appropriately represented in negotiations that determine the cost, nature and conditions of services.

Most U.S. health insurers exist as organizations independent of both consumers and providers and typically are for-profit corporations meaning their primary responsibility is to their shareholders.³ By contrast the German health insurance and payment system is actually divided into two parts, which represent the interests of the consumers/payers on the one hand and the providers on the other hand. The sickness funds (statutory health insurance organizations) collect premiums from employers and employees on a 50-50 basis and are governed by boards representing their payers in the same ratio. These sickness funds negotiate with provider organizations, such as physician associations, to purchase services for their consumer members. The physician associations represent their members in the negotiations and distribute the contributions received in payment from the sickness funds to their physician members in proportion to the individual services rendered to beneficiaries. Similar arrangements exist between the sickness funds and hospitals or other providers.

The German payment system simultaneously comprises a negotiational framework between providers, payers and consumers. This enables reaching a consensus that protects the essential interests of all parties.

3. The tremendous variety of different types of health insurance organizations in the U.S. cannot be considered in the present paper. Since our primary concern is contrasting the U.S. and German systems, only the pattern-setting type is discussed, which largely determines how the reimbursement system works as a whole.

Each party is organized and represented in such a way that its own interests are protected, but also the general public interest, since it remains to the advantage of all parties to balance cost and effectiveness. This structure allows the parties to reach acceptable compromises while at the same time maintaining control over the overall cost of care. Sickness funds represent the common interests of the employers and employees in obtaining the best care for the best price. Since they represent a large number of purchasers of services collectively, they have a strong hand in bargaining with providers. Physician associations and similar organizations for other providers represent the interests of their members, but they also have a strong interest in curtailing unnecessary or unfair utilization generated by providers because they are responsible for distributing the negotiated overall budget obtained from the sickness funds to fairly reimburse their individual provider members.

This negotiation and payment arrangement takes place within a statutory framework supervised and to some degree directly regulated by government agencies. It is kept on course by modifications of the underlying law when necessary to maintain the proper balance between public and private interests. In response to rapidly escalating costs and other system-wide structural problems, this negotiation process has been more closely controlled and formally organized under government supervision in the context of the *Konzertierte Aktion* (orchestrated action) for the past twenty-five years. This official arrangement brings all parties together biannually at the national level to set guidelines for fixed budgets to be negotiated in detail at more local levels. In addition to the formal process of negotiation, there is a research and advisory council of health care experts and representatives of parties concerned with the mandate to study problems independently and make longer-term recommendations for needed legislation and administrative adjustments in the system. These recommendations together with legislative and administrative actions in the public interest provide further ingredients shaping the negotiations.

This formal and legally established negotiating system makes the German health system accountable and responsive to the general public as well as the specific needs of health care consumers. In addition, the cabinet system of government (with party responsibility rather than individual representatives being dependent on campaign contributors) together with the traditional respect for the fairness and proficiency of the bureaucratic process enables rapid legislative and regulatory response to new problems and adjustment of the existing system. This is closely intertwined with the cultural tradition of expecting the government to

assure a safety net of social services and accepting the necessary regulation and limitations needed to make it work. This so-called 'social solidarity principle' is explicitly written into the laws and regulations governing the operation of the health insurance system. In turn, the effective operation of that system in providing needed services at a reasonable cost is an important part of maintaining confidence in that principle and commitment to it. Therefore, the cultural norms and social institutions mutually reinforce each other in enabling the system to work effectively.

IV. STRUCTURAL DIFFERENCES IN THE PAYMENT ARRANGEMENTS AND REGULATORY RELATIONS OF THE U.S. HEALTH SYSTEM THAT ACCOUNT FOR THE DIFFERENCES IN ALLOCATION AND COST

The U.S. health insurance system, while performing essentially the same fiscal functions as the German system, provides few of the opportunities or mechanisms for negotiation to accommodate the various needs and interests involved—much less on behalf of the general public interest. The U.S. system has two largely independent sectors. Private insurance is mainly provided as a fringe benefit of employment, while Medicare and Medicaid, serve specific populations who have no financial access to private insurance. The latter are highly regulated as direct federal programs. The former are essentially unregulated in regard to the efficacy of their function in the health care system and respond only to market forces.⁴ Insurance companies are typically for-profit and therefore primarily responsible to their shareholders, not to consumers, providers or the general public interest. There is little representation of consumers, providers or employers (as payers) on insurance company boards to represent their interests in corporate decision-making. Therefore, neither these groups nor representatives of the general public interest have any significant leverage over the organizations that largely control health expenditures and conditions for the provision of services in the private market—except to the extent that the payers must be wooed within free-market competition among insurers.

4. As corporations whose stock is publicly traded, health insurers are, of course, subject to auditing and accounting regulations under which any such corporations must operate. In addition, as insurance companies they are subject to the security requirements of state insurance regulations to assure that they can meet their obligations. None of these requirements, however, in any way regulates their role within the health system as such major influences on the allocation and cost of care.

Even if national health insurance could be enacted legislatively, there is no existing organizational structure within which representatives of the various interest groups could negotiate toward consensus or exercise any coordinated control over the virtually independent components of the health care payment system as it is presently structured. Physicians are not organized in associations that could represent their collective professional and financial interests in exchange for responsible self-control of costs or mode of providing services. Consumers have no direct interest in constraining costs since the tax structure encourages full payment of premiums by employers and have no organized power to do so. Consequently, they do not adequately support political or administrative efforts to change the system in ways that would rationalize it, especially when the changes would potentially restrict their utilization of care. As a result, cost control is only possible by means of heavy-handed (unilaterally imposed) regulation in the case of federal programs, and rationing of budgets and utilization through mechanisms like managed care (largely by for-profit organizations) in the private sector.

V. HISTORICAL DEVELOPMENT OF THE GERMAN HEALTH INSURANCE SYSTEM THAT ACCOUNTS FOR ITS PRESENT STRUCTURE

Historically speaking, the German national health insurance system was put in place in 1883, for political motives. It was implemented as a means of preempting the appeal of socialism and furthering a mercantilist-like approach to rapid industrialization by encouraging solidarity between employers, workers and government. The concept of social solidarity and fair allotment of premium contributions and services received was an integral part of the original legislation and became an ongoing component of the cultural tradition. Together with other social insurance programs, such as unemployment and retirement insurance, national health insurance was enacted at a time when the German people were more accepting of paternalistic approaches to problem solving and regulation of social life. There was little resistance from physicians because medical care was a luxury of the upper classes, which still made very little difference in the outcome of disease. Consequently, the primary objective of the initial legislation was to provide ongoing income (sickness pay) for workers who became sick or injured and lost their income while unable to work. The medical benefits were a minor part of the package so that physicians did not feel threatened or interested financially. Hospitals at this time primarily served the poor under the support of church, state or other charitable or public auspices.

The sickness insurance program originally covered only a small part of the low-income, blue-collar population, about ten percent of the overall population. Once in place, however, the program was easily expanded to more employees by increasing the income level below which insurance was mandatory and by also making it optionally available to those with higher incomes who wanted the advantage of being insured for care. By the time of WWII about ninety percent of the population were covered by statutory or substitute sickness funds of some kind with the remaining (primarily high-income) groups largely covered by some type of private insurance.

In the early decades of the 20th century as medical care began to make a significant difference in the outcome of illnesses and became financially important for all involved, physicians had to organize and negotiate their way into the existing insurance payment system. Although health insurance was originally established for blue-collar workers, who accounted for only a small part of physicians' incomes, its rapid expansion to meet the growing health care needs of the middle class as well, meant that it was becoming an important potential source of income for physicians. Originally, the sickness funds ran clinics themselves and hired physicians to staff them. Even when independently practicing physicians were reimbursed for services, the sickness funds were able to control costs by determining which physicians were allowed access to payment from their revenues for treating their members. As a result, many physicians soon were excluded from a major part of the population they wanted to serve. From 1900 onward, professional associations were organized for the purpose of gaining professional recognition, setting standards and acting as collective bargaining and pressure groups to attain the political and economic goals of their members. They used strikes, boycotts and other political and economic actions and negotiations to gain wider access to sickness fund patients. This led incrementally to the present system in which these physician organizations negotiate payment rates and terms of service with sickness funds and act as intermediaries to distribute the agreed-upon payments among their members in accord with the services provided. This historical development established the negotiating structure between consumers, payers and providers, which the government only needs to supervise and correct when costs or power relations grow out of balance. For example, when costs escalated rapidly and new needs and problems arose after WWII, it was relatively easy politically to superimpose a more heavy-handed government regulatory policy and additional legislation on the existing negotiational structures in order to correct the problems and deal with the new needs.

The negotiating structure itself was formalized and incorporated into the national health insurance law and regulations as it gradually developed from 1900 onward. The existence of the functional and adaptable regulatory/negotiating system, together with the long-standing legislative approach to health care and other social safety-net problems, accustomed citizens to expect and support the solidarity principle as part of their cultural tradition. These cultural and political attitudes facilitate legislative and administrative changes needed to keep the overall system in line with the best interests of the population as a whole. In turn, the effectiveness of the system has enhanced trust in government and created greater readiness to restrict the basic commitment to free-market economics, which Germany shares, when increased regulation is necessary to keep some aspect of the system functioning appropriately and in the interest of the public at large.

VI. HISTORICAL DEVELOPMENT OF THE U.S. HEALTH INSURANCE SYSTEM AND THE ORGANIZATION OF FACTORS AND VESTED INTERESTS THAT ACCOUNT FOR ITS FAILURE TO PROVIDE COMPLETE COVERAGE AND CONTROL COSTS

In contrast to the German system, the U.S. health insurance system developed in stages, from the bottom up, by way of limited responses to special financing problems at particular moments in its history. Blue Cross and Blue Shield plans developed in the late 1920s and early 1930s under the aegis of hospitals and physicians to assure payment to those organizations and professionals when the importance and cost of care became a major concern and potential burden on the middle class. Commercial health insurance coverage came into widespread existence as a result of labor union negotiations for health benefits as part of collective bargaining after WWII, after unions had gained increasing influence and bargaining power in the preceding decades. When the cost of health care for the aged grew rapidly in the 1960s and they were unable to obtain insurance coverage at an affordable price, political pressure arose for the enactment of Medicare to meet the needs of this key constituent group to which Congress had to be responsive. Medicaid was enacted as part of the same legislative movement to provide some degree of coverage for the most poverty-stricken groups unable to obtain or pay for private insurance.

Between 1965 and today, repeated efforts to legislate plans to provide coverage for further marginal lower-income groups all failed because there was no political constituency for them strong enough to overcome

the resistance of the health insurance industry or the professional interests of other components of the health system. In the same way, legislative efforts to control costs in the private sector failed to overcome similar political resistance from well organized and financed professional groups and the insurance industry. As a result only the cost of Medicare and Medicaid programs (under direct control of government regulation) could be controlled to any significant extent.⁵ Finally, when the cost of health insurance fringe benefits threatened to damage the competitiveness of U.S. employers in world markets, insurance companies adopted the strategy of managed care as a mechanism of cost control through utilization rationing. Insurers turned to this strategy (seizing on the known economic advantage of true health maintenance organizations) in order to maintain their market-share with employers by holding down the rate of premium increases and simultaneously to improve their own margin of profit between premiums and benefits paid.

Therefore, because of the piecemeal, uncoordinated way in which the health insurance system developed in this country, there is no overall legal or administrative framework for structuring the fiscal or service relationships between its parts. In particular there is no negotiating structure, such as in Germany, for reaching compromises between consumers, payers and providers to achieve collective agreement regarding mutually acceptable solutions to problems that are in the general public interest. Thus, the different way in which the insurance system developed historically in the U.S. and in Germany and the different cultural settings in which this occurred have led to major differences in how the two systems work despite great similarity in the basic components of both. The political power of free-market ideology, vested interests and lobbying arrangements in the U.S. make it extremely difficult to legislate reform or impose regulation except in very limited and specific ways. The failure of cost control through legislative or negotiated means in turn has led to rationing of budgets and utilization by non-professionals through managed care by the insurance companies. This was forced by the need to compete for the business of employer-payers who are increasingly squeezed by the high cost of fringe benefits. In this way, allocation decisions have effectively been taken out of the hands of consumers, providers, employer-payers and even the political system itself. As a result, without major changes in the balance of power between the

5. See ALFRED E. MILLER, & MARIA G. MILLER, *OPTIONS FOR HEALTH AND HEALTH CARE*, (Wiley) (1982) (providing a more complete analysis of the historical development of the U.S. health care systems and its problems).

players, there is little chance that traditional ethical considerations regarding the right to health care can have any real significance in the U.S.

VII. CONCLUSION

Comparative examination of the German and U.S. health systems makes it clear that the ethics of allocation cannot be realistically considered without careful analysis of the social structures, payment mechanisms and cultural traditions within which allocation takes place. Real change in the allocation of health care to improve social justice in the U.S. would require long-term political approaches to overcome the structural resistance to reform within the present system. In particular it would require reforming the political system itself so that legislative action could occur to remedy the present inadequacies of allocation and cost control. Thus, allocation ethics has to be more concerned with the practical means (e.g., long-term political strategies) for obtaining desirable ends rather than merely with what would ideally be just in modern society. Accordingly, the primary ethical issues at stake are how legitimate vested interests and other deep-rooted obstacles to structural change can be reconciled with the objectives necessary for the general welfare of the population, while taking into account the social and economic situation and institutional arrangements that have developed over time. For example, how can the need for campaign-finance reform to moderate the influence of powerful special-interest groups be reconciled with the Constitutional rights of free speech and unrestricted use of private property?⁶ How can the successful free-market orientation of this country be reconciled with the need for certain forms of overall regulation necessary to promote the general welfare?

Based on comparison with the German system, one practical step might be taken for developing potential strategies for improving the allocation of health service in this country. A standing independent council with input from all parties concerned could be established to conduct policy investigations and make recommendations for promoting the overall public good in health care matters along the lines of the one advising the national negotiation process in Germany. Given the right mandate such a

6. Of course, special-interest lobbying also plays an important positive role in bringing particular issues to the attention of Congress and advocating legislation for the overall public interest. The problem arises when undue amounts of money are available to support lobbying and public-opinion campaigns in favor of legislation that benefits only those who have the resources to do so, while being to the disadvantage of the general public.

council might be able to devise feasible strategies for reforming the overall structure of the system to bring the interests of the component parts into accord with the best interests of society and the economy as a whole. The only argument likely to influence meaningful political action for bringing about the needed structural and payment-system reform would be the credible demonstration that the long-term economic and social good of the nation requires certain fundamental structural changes in the health care system as a whole.

