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GERMAN HEALTH CARE - TOWARDS UNIVERSAL ACCESS

AN OVERVIEW OF THE PRINCIPLES OF ACCESS AND BENEFITS

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I. GERMAN HEALTH CARE SYSTEMS

In Germany, four systems provide benefits and services in case of illness:

1. Statutory health insurance
2. Private health insurance
3. Health-care system for civil servants
4. Welfare

Statutory health insurance (*Gesetzliche Krankenversicherung*) is the most central of these systems which include most employees, retirees, members of their families and other population groups serving over eighty-nine percent of the population. A further nine percent of the population is privately insured. Primarily, this includes persons who are not subject to compulsory statutory health insurance, particularly independent entrepreneurs and self-employed professionals such as doctors, pharmacists, architects and attorneys. In addition, employees who because of the amount of their salary are no longer subject to compulsory insurance may be privately insured. Civil servants may take out supplementary insurance to supplement the civil service health-care cost reimbursement system.

Persons who are needy and are not in a position to insure their livelihood themselves can claim welfare (*Sozialhilfe*). Welfare is granted both as assistance for indigents and in particular circumstances of disability or illness. If a welfare recipient is not insured under compulsory state insurance, necessary medical treatment (including medicine and in-patient treatment) is paid for him. The amount of assistance generally corresponds to benefits provided by statutory health insurance. Welfare is of course only a subsidiary system, an *ultimo ratio*; it is provided only for the needy and it ensures that nobody in Germany is left without sufficient medical care.

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These four systems and their interrelation are an expression of the social welfare state principle (*Sozialstaatsprinzip*) anchored in the German constitution. Beyond that, the Constitution demands that the state protects and respects the dignity of every individual person. From this, German courts derive a legal right of the individual to expect that the state assures a minimum living for everyone (*Existenzminimum*), including adequate medical care. However, the number of people dependent on welfare for medical care is low. Primarily because the unemployed are also insured under compulsory statutory health insurance.

This article presents a general picture of the requirements for and benefits of access to statutory health insurance. It addresses some problems with this system of insurance and examines politicians' suggested solutions. The questions that arise here are: Who is insured? What assistance does statutory health insurance offer? Who pays for all of this? What can we do to preserve the functionality of the system?

II. "THE FIVE PILLARS" OF SOCIAL SECURITY SCHEMES

Statutory health insurance in Germany has an over one hundred year-old tradition. Its basic structure has by and large been retained since its introduction at the close of the Nineteenth century to the present day. Statutory health insurance was introduced in 1883 as the first of the three so-called Bismarck social insurance laws. Workmen's compensation (statutory occupational accident insurance) law followed in 1884 and in 1889, the law on invalidity and retirement insurance was passed. In reaction to several economic crises, unemployment insurance was added in 1927. The statutory long-term care insurance of 1994 presents the latest act in the system of social insurance. This insurance covers extreme, long-term care needs arising from illness or frailty. It is closely connected with statutory health insurance because those insured by statutory health insurance are also automatically insured for long-term care.

III. STATUTORY HEALTH INSURANCE - COMPULSORY INSURANCE FOR EMPLOYEES AND OTHER GROUPS

Statutory health insurance is first and foremost a state ordered compulsory insurance for individuals - above all for employees. It is operated by health insurance funds (*Krankenkassen*), which are public statutory corporations and, thus, public authorities. Unlike private insurance companies, they are not profit oriented. Federal law regulates this insurance system down to the last detail including, among other things, who is compulsory covered by statutory health insurance, who may have a voluntary insurance policy, which payments are covered, how the

contributions to health insurance are calculated and who has to pay premiums/contributions (*Beiträge*). These regulations do not leave much room for individual arrangements on the part of the health insurance funds.

The most important element of statutory health insurance is dependent employment. However, employees are only subject to compulsory health insurance if their income falls within certain boundaries. Employees are subject to compulsory insurance if their pay totals more than 325 Euro a month or if they work at least fifteen hours a week. Compulsory insurance does not cover those whose salaries regularly exceed the upper limit, presently set at 3,375 Euro per month.

The statutory rationale for these lower and upper limits (*Geringfügigkeitsgrenze- und Versicherungspflichtgrenze*) lies in the following consideration: persons, who pursue only part-time employment are generally not dependent on their jobs to make a living. Rather their livelihood, including health insurance, is provided by other means, such as through independent wealth or members of their family, particularly a spouse. Above the present 3,375 Euro a month upper limit, it is assumed that there is no longer a need for protection because the employee can independently arrange for his insurance from his income (be it through private health insurance, or through savings). The upper limit is adjusted annually based on the general development of salaries. Employees, who earn more, can take out private insurance. They also have the option to become a voluntary member of statutory health insurance or they may dispense with insurance completely in the hopes of never becoming seriously ill.

Compulsory insurance exists for employees engaged in professional education or training and for those who are receiving unemployment benefits (*Arbeitslosengeld*) or unemployment assistance (*Arbeitslosenhilfe*). Retirees are also covered by compulsory health insurance, if they were predominantly covered by such insurance when still gainfully employed.

However, compulsory insurance does not only apply to employees, unemployed and retired people. It also applies to students, independent artists, journalists and independent farmers. Disabled persons are subject to compulsory insurance if they work at an approved workshop for the handicapped or are in employment promotion schemes. Fifty-five percent of all people compulsorily insured in statutory health insurance are employees, about thirty-four percent are retired a further eight percent are unemployed persons.

IV. NON-CONTRIBUTORY DEPENDENTS' INSURANCE

A particular characteristic of statutory health insurance is non-contributory dependants' insurance (*betragsfreie Familienversicherung*). This insurance not only covers the employee, retiree or unemployed but also his spouse and children unless these dependents have their own insurance as employees. The insured does not need to pay an additional premium for such dependents' insurance. This distinguishes statutory health insurance from private health insurance, which demands premiums for each insured person, including children and spouses. In contrast, German social legislation generally pursues the goal of so-called family relief (*Familienlastenausgleich*). Those who support children have a right to have that decrease their resulting economic burden. In the ongoing discussion about financing the healthcare system, there are a growing number of people who criticize this. Some demand that non-contributory insurance coverage should be limited to children and argue that the spousal exemption from premiums should be eliminated or at least limited to those spouses who stay at home to raise children.

V. STATUTORY HEALTH INSURANCE - VOLUNTARY INSURANCE

Statutory health insurance also includes, to a very limited extent, a certain amount of voluntary insurance. If their compulsory insurance or dependents' insurance ends, those previously insured may remain a voluntary member in statutory health insurance plan if their dependents or their own compulsory insurance terminates. This applies especially to employees whose wages exceed the compulsory insurance limit or have become self-employed. The insured's spouse and children can apply for voluntary insurance if their coverage under the dependents' insurance ends, as long as the person has been in the health insurance plan for a sufficiently long time.

In statutory health insurance, approximately sixty-two percent of those insured are compulsorily insured and about nine percent are voluntarily insured. Twenty-nine percent of all inhabitants are covered by non-contributory dependents' insurance.

VI. STATUTORY HEALTH INSURANCE - IN-KIND BENEFITS AND SERVICES

Those compulsorily insured and those voluntarily insured - including members of their family – are equally eligible for in-kind benefits and services (*Sachleistungen- und Dienstleistungen*). Statutory health

insurance offers services for the prevention and early detection of certain diseases as well as comprehensive coverage to treat diseases. The insured are entitled to treatment, particularly for the following services:

- Medical treatment and a free choice of panel doctor
- Psychotherapy
- Dental treatment including dentures, also with a free choice of panel dentists
- Orthodontic treatment such as braces
- In-patient hospital treatment
- Medication
- Dressings
- Remedial services such as massages and physiotherapy
- Auxiliary aids such as wheelchairs, artificial limbs or hearing aids
- Medical Rehabilitation such as spa treatments
- Artificial insemination
- Maternity services

Sickness pay (*Krankengeld*) is paid only to workers if an employee is unable to work. The employer continues to pay the employee's wages or salary for six weeks (*Entgeltfortzahlung*). After that time, the health insurance pays a sickness benefit. This totals seventy percent of the employee's regular wages or salary but not more than ninety percent of take-home pay. It is paid for a maximum of seventy-eight weeks over a period of three years.

Except for sickness pay, the insured and the insured's dependants who are exempt from paying premiums receive all necessary services. There are neither time limits nor payment limits. The services are granted independent of the financial situation of the insured. Except in cases of self-mutilation, there is no inquiry into the cause of illness. Medical care is given even if it results from accidents in dangerous sports or from carelessness. If the illness is the result of an industrial accident or an occupational disease, it is covered by statutory workmen's compensation.

The only things excluded from statutory health insurance are medicines for common minor illness such as colds, laxatives or medicines against travel sickness. For drugs, spa treatments and additional medical resources, there is a slight individual co-pay for the insured. Thus, an insured person pays between four and five Euro for medicines depending on the size of the package. Insured persons must pay fifty percent towards dentures, and twenty percent towards other orthodontic treatment. For

in-patient treatment, the insured pays nine Euro per day for a maximum of fourteen days per year. Beyond that, no further out-of-pocket payment is required for outpatient or in-patient treatment. Insured persons with below-average income may be exempt in hardship cases from payment for treatment if their economic situation justifies it. This income threshold is currently about 940 Euro per month.

The quality and efficacy of the medical service or care given must correspond to the general standard of present medical knowledge. If this is the case, methods of treatment, medication and remedies of special therapies are not excluded. Borderline cases give rise to numerous lawsuits.

VII. THE "IN-KIND AND SERVICE PRINCIPLE"

Persons insured receive services from their health insurance fund in-kind and as services. Unlike private health insurance, the principle of cost reimbursement is not applied in this context. In statutory health insurance, the "in-kind and service principle" (*Sach- und Dienstleis-tungsprinzip*) is applied. This principle is the sum of the relationship between the insured, their health insurance fund and the associations of physicians.

The "in-kind and service principle" states the following: the health insurance funds are obliged to procure for insured persons the necessary services and in-kind benefits. To this end, the health insurance funds conclude contracts for those insured with associations of doctors, dentists, pharmacists, hospital owners and other service organizations. These parties do not receive payment directly from the insured. Payments are made by the health insurance funds to associations. These associations then redistribute the money received from health insurance funds to their members. Since the insured does not pay the doctor directly, as a rule, the patient does not know the cost of the treatment. This system is being criticized more and more. Some politicians are demanding that patients should have greater cost awareness. For instance, each patient should receive a list of treatment costs from his doctor.

The cited system also furthers distribution conflicts among doctors. The associations of health insurance funds and doctors establish the value of individual services (e.g. ECG) through joint commissions. They determine whether and at what level doctors may charge for new examination and treatment methods. The associations also determine so-called "medical practice budgets" in which they set the average number of services usually carried out per quarter year in a doctor's office and determine what

payment the doctor will receive. If a doctor exceeds these average levels without sufficient reasons, he receives no or only partial reimbursement for his services. A doctor's records are also inspected to see whether their costs fall within specified averages. If an uneconomical administration of medication is found, doctors may have to compensate the insurance company.

VIII. PRINCIPLE OF SOLIDARITY

Hospitals in Germany are built by the state. However, statutory health insurance finances all the operating costs of hospitals. These funds are provided solely from contributions/premiums (*Beiträge*) of the insured. There are no state subsidies for statutory health funds.

The premiums paid by the insured depend on the insureds' earnings and the premium rate of the respective health insurance fund. Premium-relevant earnings are the wages of compulsorily insured workers. In the case of retired persons, relevant earnings come from the statutory Social Security insurance or the company retirement fund. Other earnings, such as interest or rents, are not counted toward compulsory insurance. Income above the upper rate, now set at 3375 Euro, is not used to calculate premiums. The premium rate differs from fund to fund. It amounts on average to 13.5 percent. For example, an employee with a gross income of 3,000 Euro pays 420 Euro a month, if the employee's fund is at a premium rate of fourteen percent.

An additional premium is not charged to cover dependents. Thus, the father of five children pays the same premium as a bachelor who earns the same wages. Furthermore, the amount of the premium is not decided on the basis of individual risk of illness. Statutory health insurance has neither risk premiums nor exclusion for specific conditions. A sick person pays the same premium as a healthy person with the same income. Finally, the in-kind benefits and services for all those insured are equal. Those who have a high income, and consequently pay high premiums, do not receive more or better services than those who pay lower premiums.

Here we see a typical and basic principle for social insurance at work. Statutory health insurance wants to create risk compensation through insurance and it intends to create a social balance between the strong and the weak, the poor and the rich, and the young and the old. It demands solidarity within the community of insured people.

A further structural principle of statutory health insurance has always been the inclusion of employers. Employers are not only responsible for the cost calculation and the transfer of premiums, but they also have to pay one half of these premiums. So for example, with a premium of 420

Euro for an employee earning 3,000 Euro gross, the employer pays 210 Euro of the total premium. The other 210 Euro are paid by the employee, usually by deducting it from his salary and transferring it to the health insurance fund. A corresponding procedure applies for pensioners. The Social Security insurance bears half of the contributions of the pensioner. Voluntarily or privately insured employees receive a contribution allowance from their employer to their insurance holder. Thus labor costs are directly impacted by fluctuations in health insurance premiums.

IX. EXPENDITURES AND FINANCIAL PROBLEMS

Just as in other countries, the costs of medical care have consistently increased in Germany. The costs have outpaced wage increases resulting in higher insurance premiums. The total expenditure on statutory health insurance in 1997 amounted to over 270 billion DM. This amounts to approximately 6,400 DM per person and roughly 11.5 percent of gross national product. Approximately forty-seven percent of total expenditures were borne by statutory health insurance funds and only about five percent by private funds. The average individual contribution to statutory health insurance has climbed from 8.2 percent of income in the year 1970 to 13.56 percent in the year 2000. Combined contributions to social insurance, i.e. health, long term care, pensions and unemployment insurance total over forty percent of income; of which employers and employees share equally.

There are several causes for this increase in costs, however, I would like to focus on only a few. The average life expectancy of the population is continually rising, in part because of medical progress. However the birth rate and the number of workers is falling. Thus, the increase in the age of the population has opened a gap between healthcare costs and revenue generation. The progression of medical technology often leads to new, and sometimes costly, methods of diagnosis and treatment methods. These do not only replace old procedures with more efficient ones, but in many cases, they widen the available spectrum of possible treatments through additional procedures.

Also, although the population has been declining, the number of those offering services has more than tripled over the last forty years. In 1960, there were about 92,000 practicing physicians in Germany. In 1999, there were 291,171. In 1960, the doctor-inhabitant ratio was 1 to 793, in 1988, it was 1 to 286. Of the approximately 291,000 physicians practicing in 1989, roughly 126,000 were in private practice. Further 137,000 doctors worked in hospitals and the remainder for the authorities or in other areas.

Each supplier creates demand for his services and in the process increases the services offered on the market. Thus supply and demand theory should limit the number of doctors and dentists to present needs. Whether this need-based limitation would stand before the Federal Constitutional Court is doubtful. Up to now, the Constitutional Court has derived a right of qualified doctors and dentists to be part of the health insurance system as a panel doctor from the basic right to professional freedom. The reason for this is that statutory health insurance has a factual monopoly over the German public health sector. Anyone who wants to work as a physician or dentist in Germany is practically dependent on treating persons insured by statutory health insurance. If the doctor is not allowed to do so, he is essentially unable to practice. The points discussed so far have affected the increases in health insurance fund costs and the decline in health insurance fund revenues. Also contributing to the problem is the persistently high unemployment rate – in excess of ten percent - and the increase in the number of self-employed workers over the years.

Many of these developments are not new. However, the speed of medical and technical progress and social change is new. For example, an economically united Europe makes the costs of labor and, more importantly, non-wage labor costs more comparable. The costs of health care under work contracts are now seen as an element directly impacting competition, investments and location decisions. Therefore, countries with a low cost of health care are – ceteris paribus - in a position to produce goods at a lower cost. It is understandable that politicians and parts of the industry are endeavoring to prevent further cost increases in public health or are looking for new sources of revenue. On the other hand, many industrial sectors and professional groups profit from these increases and, consequently, oppose savings measures that could affect their own field. The health sector has itself become an important sector of business.

X. PRESENT REFORM DISCUSSION

On the revenue side, there are suggestions to raise the current compulsory insurance limit (Versicherungspflichtgrenze) from 3,375 Euro to roughly 4,500 Euro a month. This would mean that many employees would become compulsorily insured, who up to now could opt for private insurance. This would mean an expansion of individuals in statutory health insurance and also a higher level of covered earnings. Private insurance companies are understandably resistant to such plans. They fear a considerable loss of policy holders. This "no-conflict zone"

("Friedensgrenze") between statutory and private health insurances would shift at the expense of private health insurance companies. High-income employees are also resisting this expansion of covered earnings; they see themselves robbed of the chance to take out cheaper private insurance, especially singles, who cannot take advantage of family insurance policies.

In addition, there are some plans to calculate the premiums of those subject to compulsory insurance based on their entire income, including their salary and pension. This is already the case for voluntarily insured persons. This would require new methods for premium payment, since an employer could not know what to deduct from an employee's salary. Each insured would have to disclose his entire income to the health insurance fund. Some also fear that such an expansion of covered earnings punishes those who have behaved responsibly and who protect themselves through savings and private precautionary measures.

The employer associations demand that the current employer premiums (Arbeitgeberbeitrag) be "frozen" and paid out to the employee in the form of a single salary increase. In the future, the entire health insurance premium would then be the responsibility of the employee alone. This would have the economic advantage of eliminating increases in health insurance contributions that directly impact on labor costs. On the other hand, employees would have to be compensated to pay for increases in health insurance costs, likely through collective bargaining. Whether this would succeed seems doubtful. In any case, the risk of cost increases in the public health sector would be shifted to employees alone. An essential structural element of statutory health insurance, the joint responsibility of employers and employees for a common, but financially viable health care would be abandoned.

Another suggestion for reform concerns the present type of financing. The discussion is centered on demographic development. In Germany, this is characterized by an increasing percentage of elderly people in the population. Fewer and fewer gainfully employed persons must provide pensions and social security of the older generation. Additionally, the highest healthcare costs occur in the later years of life. For these reasons, there are discussions about giving up the present pay-as-you-go principle (*Umlageverfahren*). At present, the health insurance funds' income is immediately spent on services. Political efforts are underway to supplement this type of financing by a fully funded system (*Kapitaldeckungsverfahren*), in hopes of making the financial state of the health insurance less dependent on the ups and downs of the business cycle and on the current number of workers. However, there is no answer

on how to raise the necessary additional funds to supply the necessary capital.

Finally, there are plans to split the current spectrum of services into basic and optional services. Statutory health insurance would continue to be responsible for basic health care. The insured would be responsible for optional services. Private insurance companies are particularly interested in this model. They hope to create a new market for the insurance of optional health services not covered by statutory health insurance. On its face this model strengthens individual freedom and responsibility. It is doubtful, however, whether this model could actually ease the situation of statutory health insurance or whether it would simply mean that overall costs would go up even more. Also, it remains to be seen whether the insured would actually be willing, and financially able to assume responsibility for their own health care. It is not likely that a division into basic and optional services would go hand-in-hand with a reduction of current premiums causing individuals to have more funds to spend. Finally, it is debatable whether a consensus could be achieved regarding which services are basic and which are "luxuries." This decision is left to legislators. Such a decision touches the elementary rights of the persons insured and cannot be left to negotiations between the health insurance funds and associations of service providers. Past experience does not suggest that parliament will muster the strength to take such a far-reaching position that would fundamentally change the existing system.

The system of statutory health insurance has endured numerous economic downturns as well as two World Wars. We must hope that it can also survive the present times of relative prosperity and find the strength to carry out the necessary adjustments. Conferences like "The Ethics of Health Care" can contribute to that end. A comparison of the systems of different countries can shed new light on the questions: What is unnecessary ballast in the current system, what is worthy of being retained and what can we learn from other systems?