

Health Insurance and Health Policy In The Federal Republic of Germany

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This paper presents a structured survey of the West German health care and health insurance system. The West German health insurance system is very comprehensive and generous. The scheme provides full coverage for all medically necessary services, including ambulatory and inpatient care, prescription drugs, dental care, medical appliances and even prolonged rehabilitation in the so called Kurorten (localities with health spas). Typically, patients do not bear any copayment at the point of service, or only very modest ones. Physicians are paid on a fee-for-service basis (according to negotiated fee schedules), hospitals are reimbursed on the basis of prospectively negotiated per diems, and the suppliers of drugs and appliances are reimbursed at what is referred to as "market prices" (that is, at prices set by suppliers with only mild indirect control from the public sector or third-party payors). This extraordinarily liberal insurance system causes West Germany to devote no greater a proportion of their Gross National Product (GNP) to health care than does the United States. Using the American definition of "national health care expenditures," both nations currently devote about 9.4 percent of their GNP to health care.

Introduction

Most modern societies view certain basic health care services as commodities to which every member of society should be guaranteed access regardless of ability to pay. This general proposition seems widely shared among nations, whatever their cultural and political complexion. Vastly different approaches, however, have been adopted to act on that precept.

Some nations have proceeded on the assumption that the desired guarantee requires the nationalization of both the *production* and the *financing* of health services. This approach has been favored in the United Kingdom and in the Socialist nations. The overall capacity of the delivery systems in these nations is determined by a political algorithm, and available capacity is distributed regionally on the basis of explicit planning. It is rationed among individual consumers on some basis other than monetary charges—usually on the basis of time prices or on the basis of the providers' medical judgment. The time prices faced by individual patients are, of course, also set indirectly by some provider's assessment of the patient's "need" for health services.

Research for this paper has been supported by the Health Care Financing Administration of the Department of Health and Human Services under Grant No. 95-P97309/2-01. That support is gratefully acknowledged.

At the other end of the spectrum are nations that seek to provide the desired guarantees with a minimum of public-sector intrusion into the production and financing of health services. These nations would prefer, in principle, to effect the guarantee simply by redistributing appropriate amounts of general purchasing power—for example, through negative-income tax schemes. Upon making the necessary transfers one could, in principle, rely on the price mechanism to determine the system's overall capacity and to distribute the resources among members of society. In practice, however, this ideal approach has typically been found infeasible because the necessary transfers of general purchasing power tend to exceed the political tolerance for such transfers. Consequently, one observes, even in these nations, varying degrees of public-sector intrusions into at least the *financing* of health-care services. The *production* of health services, however, has remained more or less completely in the private sector.

From the perspective of health policy in the United States, the second approach is clearly the more interesting. The nationalized and centrally planned health systems can—and do—claim for themselves certain advantages. In the United States, however, it is not generally believed that the advantages of centrally planned, publicly owned health systems compensate adequately for the rigidities inherent in them. Should

Americans ever wish to copy other nations' approaches to national health insurance, they would more probably look to contexts in which at least the production of health-care services remains in the private sector.

Even that confined scope, however, presents one with a remarkable variety of mechanisms used to provide the desired guarantees. Some nations (for example, Canada) have chosen to nationalize the financing of health services completely. Other nations (for example, Australia) seem to view complete nationalization of the financing mechanism as unnecessary and, indeed, undesirable. Still other nations (for example, France) have sought to have the best of both worlds. Although the financing of health services in France is accomplished through nongovernmental insurance funds—so-called *caisses d'assurance maladie*—these insurance funds operate under close supervision of the central government's ministry of health. So close is this supervision on a day-to-day basis that the insurance funds have, in effect, become the central government's arm in the implementation of national health policy.

In this paper I shall focus almost exclusively on the health insurance system of West Germany. That system is interesting because: (1) the delivery system resembles in important respects those found on the North American continent; (2) virtually the entire West German population is now covered by the most comprehensive health insurance imaginable; and (3) the public sector's role in the production and financing of health care is merely to provide a statutory framework, to occasionally provide compulsory arbitration, and to finance capital expenditures by hospitals (and with it, to participate in the planning of inpatient capacity).

The remainder of the paper is organized as follows. The next section presents a brief description of the West German health care delivery system, of its health insurance system and of recent trends in health care expenditures. In the section entitled "Control of Cost and Expenditures Under the Statutory Health Insurance System" the focus shifts to current issues in West German health policy, especially approaches to the control of health care costs and expenditures. The paper concludes with some general remarks on the arbitration of social conflicts concerning the allocation of health care resources.

Description of The West German Health Care System

Health Care Resources and Their Use

West Germany currently has a population of about 61.5 million. As Table 1 indicates, this population is served by roughly 1.7 million health workers, a term defined to include any person employed by the health care sector, in whatever capacity. Only about 700,000 of this total are health professionals as that term is used in the United States. Of these, roughly 120,000 are physicians.

TABLE 1
Employment In The West German Health Care Sector, 1976

Category	Number	Per 100,000 Population
Total Employment	1,710,000	2,780
Health Professionals:		
Physicians —Inpatient	54,648	89
—Ambulatory	56,969	93
—Other ¹	12,949	21
Dentists	31,858	51
Pharmacists	25,885	42
Other Health Professionals ²	487,709	793
Other Persons Employed in Health Care ³	1,039,982	1,691

¹Includes physicians in the public health departments, in administration and in industry.

²Includes nursing personnel and physicians in training.

³Includes workers in the industries producing supplies, medical equipment and drugs.

Source: Wissenschaftliches Institut der Ortskrankenkassen (1978), p. 33.

The labor force in the health care sector is complemented by about 3,500 hospitals with a capacity of about 11.6 beds per 1,000 population. As Table 2 shows, slightly over 54 percent of all hospital beds are in publicly owned facilities (mainly municipal hospitals), 35 percent are in hospitals founded and administered by private organizations (churches or foundations) on a non-profit basis, and 10.5 percent are in other private hospitals, some of which are operated on a for-profit basis. Only about 7.9 beds per 1,000 population are allocated to general acute care. The remaining beds are in long-term or special care facilities.

TABLE 2
Hospitals, Hospital Beds and Hospital Use in
West Germany, 1974

Number of Hospitals, All Types	3,483	100%
Public	1,309	38%
Private, Non-profit	1,200	34%
Other private	974	28%
Number of Hospital Beds	716,530	100%
in Public Hospitals	387,590	54%
in Private, Non-profit Hospitals	253,949	35%
in Other Private Hospitals	74,991	11%
Number of Beds Per 100,000 Population		
All Hospitals	11.56	
Acute-care Hospitals	7.85	
Special Hospitals	3.71	
Number of Admissions Per 100,000 Population	159	
Acute-Care Hospitals	140	
Special Hospitals	19	
Average Length of Stay		
Acute-care Hospitals	17 Days	
Special Hospitals	63 Days	
Average Utilization Rate		
Acute Care Hospitals	84%	
Special Hospitals	89%	
Number of Patient Days Per 1,000 Population		
Acute-care Hospitals	2,405	
Special Hospitals	1,206	

Source: Bundesminister für Jugend, Familie und Gesundheit (1977), pp. 239-249.

American or Canadian physicians typically treat their patients in their own practices and in the hospital(s) with which they are affiliated. Only about 6 percent of the West German physician population—typically, hospital chiefs of staff—enjoys similar hospital privileges. Other West German physicians work full-time either in their own private practice or in the hospital. Physicians in private practice (*Niedergelassene Ärzte*) typically treat their patients on a fee-for-service basis, with the bulk of the fees (about 85 percent) coming directly from third-party payors. Physicians in hospitals (*Krankenhausärzte*), on the other hand, are salaried, and only the chiefs of staff enjoy the privilege of treating private patients on the hospital's premises, for a fee.

The dichotomy between the ambulatory and inpatient physician practice is statutory and strictly enforced, and has a number of peculiar consequences. First, most hospitals are prohibited from operating outpatient departments, because the provision of ambulatory care

is the preserve of the *Niedergelassenen Ärzte*—that is, of physicians in private practice. Hospitals may intrude on this monopoly only if they are affiliated with a medical school and their outpatient clinic serves a teaching function. Second, a private physician sending a patient to a hospital loses both medical and economic control over the patient during the latter's hospital stay (although hospitals may and often do report back to the patient's private physician). A corollary is that, although West German patients have the right to choose their own physician for ambulatory health services, freedom of choice does not extend to treatment within the hospital, unless the patient is treated, on a private basis, by one of the chiefs of medicine. Finally, the strict division between ambulatory and inpatient care contributes to an excessive application of diagnostic tests, because hospital physicians do not invariably accept the diagnosis determined by the private practitioner and prefer to conduct their own tests, at the risk of repeating some tests. While this practice may enhance the accuracy of the diagnosis, it is expensive.

As Tables 2 and 3 show, West Germans rely rather more heavily on the hospital than do Americans. Although the West German admission rate is below the comparable rate in the United States, the average length of stay per admission in West Germany is roughly double the comparable rate in the United States. Case mix differentials may distort this comparison to some extent. On the other hand, the average length of stay for specific illnesses in West Germany tends to be much higher than that for identical illnesses in the United States. As a result of this differential, the number of patient days per 1,000 population is substantially higher in West Germany than it is in the United States.

TABLE 3
Hospital Use in The United States, 1974

	General and Special Hospitals	Psychiatric and Tuberculosis Hospitals
Admissions per 1,000 population	165	4.2
Total Days in Hospital per 1,000 Population	1,432	662
Average Length of Stay	8.7 days	N.A.
Occupancy Rate, Percent	76%	N.A.

Source: U.S. Statistical Abstract 1978, Table 168, p. 110.

Unfortunately, similar data on the use of ambulatory services are not publicly available in West Germany, as they are in the United States. Evidence exists that West German physicians see far more patients per office-hour than do their American counterparts and that they place heavy emphasis on diagnostic and other technical procedures in the composition of treatment packages. In this respect, West German physicians appear to respond to fee schedules that tend to reward technical procedures relatively more generously than face-to-face contact with patients, at least in comparison with the typical structure of fees in the United States.

The Health Insurance System

Institutional and Historical Background

The onset of national health insurance in Germany is usually dated to 1883 when low-income industrial workers and their families were compelled by law to become members of sickness funds, many of which had already been in existence throughout the nineteenth century. At that time, the statutory system covered only about one sixth of the population. The benefit package included mainly sickness cash payments and only a modest range of medical benefits in kind. In the ensuing decades, the system evolved in predictable directions: coverage was extended across both population groups and medical services. Today the system covers the bulk of the population and offers a remarkably comprehensive benefit package. Expenditures on benefits in kind now dwarf sickness cash payments.

From 1883 to the 1930's the sickness funds negotiated contracts privately with individual physicians and had the right to limit the number of physicians participating in their program. In 1931, the statutory basis was laid for collective contracts between regional associations of sickness funds and newly created professional associations of sickness fund physicians—the so-called *Kassenaerztlichen Vereinigungen* (KV's). These physician associations were originally chartered on a *Land* (that is, State) basis, but they eventually formed national associations as well. Under the 1931 statute, the sickness funds collectively transferred agreed-upon lump sums per insured patient to the physician associations, which in turn agreed to have their members render the insured all medically necessary services and disburse the lump sum to their members, typically on a capitation basis. The sickness fund associations have always negotiated separate contracts with individual hospitals, usually on the basis of agreed-upon per diem charges.

After World War II, West German physicians won the right to establish themselves as sickness-fund physicians without the funds' prior approval. The distribution of funds from the physician associations to individual physicians began to proceed more and more on a fee-for-service basis, according to fee schedules negotiated between the sickness funds and the professional associations. Until very recently, this system was open-ended. The sickness funds paid for whatever billings were submitted by physicians to their physician associations. Since 1976, attempts have been made to place a cap on overall physician reimbursement, although the success of this approach is not assured. These attempts, culminating in a formal cost-containment act in 1977, will be described in the section "Control of Cost and Expenditures. . .").

The so-called *Ersatzkassen* (literally, "substitute funds"), whose membership includes primarily white collar workers, developed parallel to the compulsory insurance system. For the most part these funds have not been accessible to blue collar workers.¹ In competing with the compulsory sickness funds for voluntary² members, these *Ersatzkassen* have frequently sought to attract patients by offering their physicians better financial terms. It is sometimes alleged that the *Ersatzkassen* can do this because of an ability to select among risks. Evidence does exist that the role of the *Ersatzkassen* had shifted the evolution of the West German health insurance system in directions favored by physicians. The shift from capitation to fee-for-service reimbursement is one example. That shift was spearheaded by the *Ersatzkassen* sometime during the 1960's.

Administration and Financing of the Current System

The West German health insurance system is actually a mosaic of roughly 1,500 autonomous sickness funds organized on the basis of geography (the *Ortskrankenkassen*), of enterprise (the *Betriebskassen*), or of trade (*Innungskassen*). About half of the insured population has membership in the *Ortskrankenkassen*. Another one quarter of those insured are members of the *Ersatzkassen* (the substitute funds). Tables 4 and 5 provide further detail on the insurance status of the West German population and the distribution of insured "members" across sickness funds. The term "member" means the insured employee or retired person. Membership in a sickness fund automatically extends full coverage to all of the member's dependents as well. The number of persons insured by a sickness fund thus tends to exceed the number of its "members" significantly (see Table 4, item I).

¹ In 1974, only 3.9 percent of the members of the *Ersatzkassen* were blue collar workers (see Reinhart Schmidt [1978], Table 17 p. 59).

² As I will describe later, individuals not mandated by law to join a sickness fund often enjoy the right to join a fund voluntarily.

TABLE 4
Percentage Breakdown of the West German Population
by Health-Insurance Status,
1974

Insurance Status	Percent of the Population
I. Insured Under the Statutory System:	90.15%
Mandatory "Members"	30.75%
Voluntary "Members"	7.53%
Retired Person who are "Members"	11.82%
Dependents of "Members" Who are Automatically Covered	37.04%
II. Covered by Private Health Insurance	7.20%
III. Covered by Special Insurance Schemes:	2.36%
Policemen	1.00%
Person on Public Assistance	1.07%
Students	0.29%
IV. Not Insured	0.29%
Total Population	100%

Source: Reinhart Schmidt (1978), Table 15, p. 57.

TABLE 5
Membership in the Statutory Health Insurance System,
1974

	Percentage of All Insured "Members"
Local Sickness Funds (Ortskrankenkassen)	48.5%
Enterprise Funds (Betriebskrankenkassen)	12.9%
Other Funds ¹	11.0%
Substitute Funds (Ersatzkassen):	27.6%
Blue Collar Workers	1.1%
White Collar Workers	26.5%
Total: 31.64 Million Members	100%

¹Funds organized around a trade or craft: for example, funds for sailors, for miners and for farmers and agricultural workers.

Source: Reinhart Schmidt (1978), Table 18.

Depending on the member's economic status, he or she is either a voluntary member of a sickness fund or must join on a mandatory basis. Included in the group of mandatorily insured are:

- All blue collar workers;
- White-collar workers with incomes below a certain level;
- White-collar workers with incomes below a certain level;
- Retired persons;
- Virtually all farmers;
- Students and apprentices; and
- Sundry other groups of modest economic status.

Over three quarters of the persons insured under the statutory system now are mandated to be insured.

Persons not mandated to seek coverage have the right to join sickness funds on a voluntary basis.

About 7 percent of the population obtains private insurance coverage. This group includes civil servants who receive a cash supplement from the government in case of illness and obtain private supplemental insurance to cover costs not covered by the government indemnity.

The sickness funds are governed by boards composed of members representing employers and employees. The individual funds are members of associations at the level of the *Land* (State) which, in turn, form the national associations. The *Land* and national associations negotiate with their counterpart associations of health care providers.

In principle, each individual fund is expected to be fiscally autonomous. Its financial affairs are supervised, however, at the level of the *Land*. Overall supervisory authority over the statutory insurance system rests with the Federal government's Ministry of Labor and Social Affairs. Since the sickness funds must operate within statutory guidelines that prescribe, among other things, the benefit package that must be offered the insured under Statutory Health Insurance, the funds are actually fairly similar to one another. Broadly speaking, membership in a sickness fund entitles members and their families to all necessary medical and hospital services in case of illness, to certain types of preventive care, to prescribed drugs, and to cash benefits to cover loss of income due to illness.³ Maternity benefits, the services of health workers in patients' homes, medical appliances, dental care (including dentures), eyeglasses, stays in rest homes, and rehabilitative services are also included in the typical benefit package. Indeed, it is hard to think of medical services that are not covered by the statutory health insurance scheme.

West Germans insured under the statutory system usually enjoy first-dollar coverage for insured items. There is a modest copayment on prescription drugs (currently one Deutsche Mark, or about 50 U.S. cents, per item) and a 20 percent coinsurance rate on dentures. A wide range of medical supplies are fully covered, but only for certain basic models. Thus, the insurance funds will fully cover the cost of a basic type of eyeglass, leaving the cost of a more attractive frame fully to the consumer. A valid generalization, however, would be that cost-sharing by patients in West Germany is rare and insignificant in both absolute and relative amounts.

³ Since 1970, employers have been mandated to provide such cash payments (*Lohnfortzahlung*, that is, continuation of wages) directly, at least for some weeks. As a result, the percentage of such cash payments in total disbursements by the funds shrank from 21 percent in 1969 to 10.7 percent in 1978. It was 7.1 percent in 1979.

Tables 6 to 8 provide information on the financing of the Statutory Insurance System. The system is almost wholly financed by employers and employees. Contributions for insured members are raised in the form of a flat payroll tax, with employers and employees

each paying an equal share. Contributions for members who are retired are made by their respective pension funds. The public sector itself makes only modest contributions to the system (Table 6) and mainly indirectly through pension funds.

TABLE 6
Direct and Indirect Sources of Finance for the Statutory Health Insurance System in West Germany, 1974

Employers	39.0%
Private Households (Mainly Employees)	48.8%
Federal Government (Bund)	7.2%
States (Länder)	1.7%
Municipalities	1.9%
Other	1.4%
Total, in Deutsche Marks	DM 51.705 billion

Source: Reinhart Schmidt (1978), Table 20, p. 96.

TABLE 7
Secular Change in Contribution Rates to the Statutory Health Insurance System, 1974-1978

Year	Local Sickness Funds	Enterprise Funds	Other Funds	Substitute Funds for:		All Funds in the System
				Blue Collar Workers	White Collar Workers	
Percentages of Gross Earnings ¹						
1-1-74	9.35%	8.63%	8.95%	9.38%	9.81%	9.36%
1-1-76	11.34%	10.20%	11.10%	11.09%	11.85%	11.30%
1-1-78	11.51%	10.61%	11.34%	11.47%	11.82%	N.A.

¹Shared equally by employers and employees.

Source: Bundesverband der Ortskrankenkassen, *Die Ortskrankenkassen im Jahre 1977*, (mimeographed, 1978), Table II.

TABLE 8
Variation in Contribution Rates to the Statutory Health Insurance System, 1975

Contribution Rate, In Percent ¹	Local Sickness Funds	Enterprise Funds	Other Funds	Substitute Funds	All Funds
Number of Sickness Funds					
0-6%	-	12	-	-	12
6.1-7%	-	56	1	-	57
7.1-8%	7	155	8	-	170
8.1-9%	34	299	30	1	364
9.1-10%	84	318	53	2	457
10.1-11%	134	113	60	8	315
11.1-12%	49	12	12	4	77
12.1-13%	6	-	-	-	77
					6
Total	314	965	164	15	1458

¹Percentage of gross earnings, shared equally by employer and employee.

Source: Reinhart Schmidt (1978), Table 43.

Contributions to the sickness funds are made on the so-called "solidarity principle" which means that members should contribute according to their ability to pay, regardless of the number of dependents or their health status. No attempt has ever been made to set contributions for individual members within a fund on actuarial principles. A fund as a whole, however, must set its overall contribution rate strictly on the basis of the actuarial cost of serving the entire membership (and dependents). Because the actuarial cost per member depends on the demographic mix of members, and the latter can and does vary among sickness funds, one observes a rather striking variability in the contribution rates imposed by the various funds (see Table 8). In recent years, this disparity in contribution rates has become, quite understandably, an increasingly controversial issue. The disparity has so far persisted because there is actually little effective competition for members among the numerous funds. By and large, an employee's or retired person's membership is dictated by his or her employment, geographic location, or both.

Expenditures

Table 9 presents details on the pattern of expenditures under West Germany's Statutory Insurance System. To provide a basis of comparison, gross national product data are shown as well.

TABLE 9
Total Expenditures Under the Statutory Health Insurance System by Type of Service, 1978¹

Category	Billions of DM	Percent of Total
Ambulatory Medical Services	13.2	19.1%
Dental Services and Dentures	10.6	15.3%
Drugs	10.6	15.3%
Hospital Services	21.8	31.6%
All Other Expenditures (Medicinal Aids, Maternity Benefits, Preventive Care, etc.)	9.6	13.9%
Administration	3.3	4.8%
Total Expenditures, Excluding Cash Benefits and Administration	69.1	100.0%
Cash Benefits	5.3	7.7%
Gross National Product	1,278.0	-

¹Preliminary data.
Source: Federal Department of Labor and Social Affairs; cited in Ulrich Geissler (1978), Table 4

Total expenditures by the Statutory System (excluding cash benefits) amounted to about 5.4 percent of West Germany's gross national product in 1978. This figure is, of course, not directly comparable to the national health care expenditure series published in the United States. The West German figure excludes

expenditures by private households for non-prescription drugs, public-sector expenditures for capital investments in hospitals, medical schools, and medical research, as well as expenditures made by the private insurance carriers. It is difficult to estimate an exact counterpart of the U. S. figure from the available West German data. A reasonable approximation, however, can be developed from data published by West Germany's Federal Ministry of Labor and Social Affairs (See Bundesminister für Arbeit und Sozialordnung, 1978). According to these data, total national expenditures from all sources for inpatient care, ambulatory care, drugs, supplies and dentures, medical research and public health services amounted to 97 billion Deutsche Marks (DM) in 1975, a figure that includes 6 billion DM for administrative costs. Gross national product in 1975 amounted to 1,030 billion DM (Geissler, 1978, Table 4). Using the more comprehensive U. S. definition of health expenditures, then, West Germans appeared to spend roughly 9.4 percent of their gross national product on health care in 1975. In other words, the total expenditure figure of 69.1 billion DM attributed to the Statutory Health Insurance System in Table 9 represents only about 71 percent of the total that approximates the American concept of national health expenditures. This ratio should always be kept in mind in reacting to data strictly on the Statutory System.

Table 10 presents the distribution of expenditures by the Statutory System (including 4.2 billion DM cash-benefits payments) over the various categories of sickness funds in 1974. The table also indicates the

TABLE 10
Distribution of Expenditures Over Categories of Sickness Funds, and Expenditures Per Member by Category of Sickness Funds, 1974

	Percentage of Total Expenditures Paid by Funds	Expenditure Per "Member"
Local Sickness Funds	47.7%	DM 1,446
Substitute Funds for White Collar Workers	26.7%	1,467
Enterprise Funds	13.3%	1,529
Funds for Miners	4.2%	1,902
Funds for Trade Guides	4.1%	1,306
Funds for Rural Workers	2.7%	1,368
Substitute Funds for Blue Collar Workers	1.1%	1,488
Funds for Seamen	0.2%	1,396
Total	100.0%	1,469 ¹

¹Standard deviation of category means about overall mean is DM 182.

Source: Adapted from Reinhart Schmidt (1978), Tables 34 and 35.

variability of expenditures per insured "member." This number is not to be confused with expenditures *per capita*, because membership in a sickness fund automatically extends full coverage to all of the insured "member's" dependents. The interfund variability in expenditures per member, therefore, reflects to some extent mere differences in the demographic mix of the funds' membership, including differences in the number of dependents per "member."

Table 11 exhibits the secular growth in health care expenditures by the Statutory System. Although all categories of these expenditures increased more rapidly than gross national product during the 1960's, that differential in growth rates reached remarkable proportions during the first half of the 1970's. Overall expenditures during that period grew at more than twice the rate of growth of the gross national product. The pattern received widespread and highly critical comment in the media and eventually triggered public intervention in the form of a Federal cost containment law. This law and its impact so far are examined in the next section.

Reimbursement of Providers

Hospitals are reimbursed by the sickness funds on the basis of negotiated *per diems*. These *per diems* cover all operating costs incurred in connection with inpatient physician care, including the cost of drugs and supplies. The *per diems* do not cover capital costs which are, since 1972, supplied from State and Federal sources in conjunction with regional planning. The

negotiated *per diems* are unique to each hospital; but they are subject to approval by a State authority. As already noted, hospital physicians are salaried, and only chief medical officers are permitted to deliver health care to private patients on a fee-for-service basis.

The sickness funds pay pharmacists for drugs and supplies furnished to patients against prescriptions obtained from ambulatory-care physicians. Payment is at so-called "market prices." The latter are the sum of wholesale prices paid by pharmacists to the producers of pharmaceuticals or to wholesalers, plus a mark-up (*Handelsspanne*) fixed by law and not subject to any influence by the sickness funds. Precisely what countervailing power makes this retail price a "market price" is an intriguing question. In principle, the individual physician is to prescribe the lowest-priced drug within any set of drugs of comparable bio-availability and effectiveness. In practice, this mandate had been widely circumvented for lack of information on drug equivalence.

A recently established commission of physicians, pharmacists and representatives of the pharmaceutical industry has been charged with the task of devising an officially accepted list of bio-equivalencies and associated drug prices. That list is expected to contribute toward greater economy in the prescription of drugs. Furthermore, experiments have been done—notably in the state of Bavaria—with reimbursement methods that hold the individual physician fiscally responsible for excessive prescribing of drugs.

The reimbursement of ambulatory physicians and dentists is somewhat complicated, as Figure 1 shows.

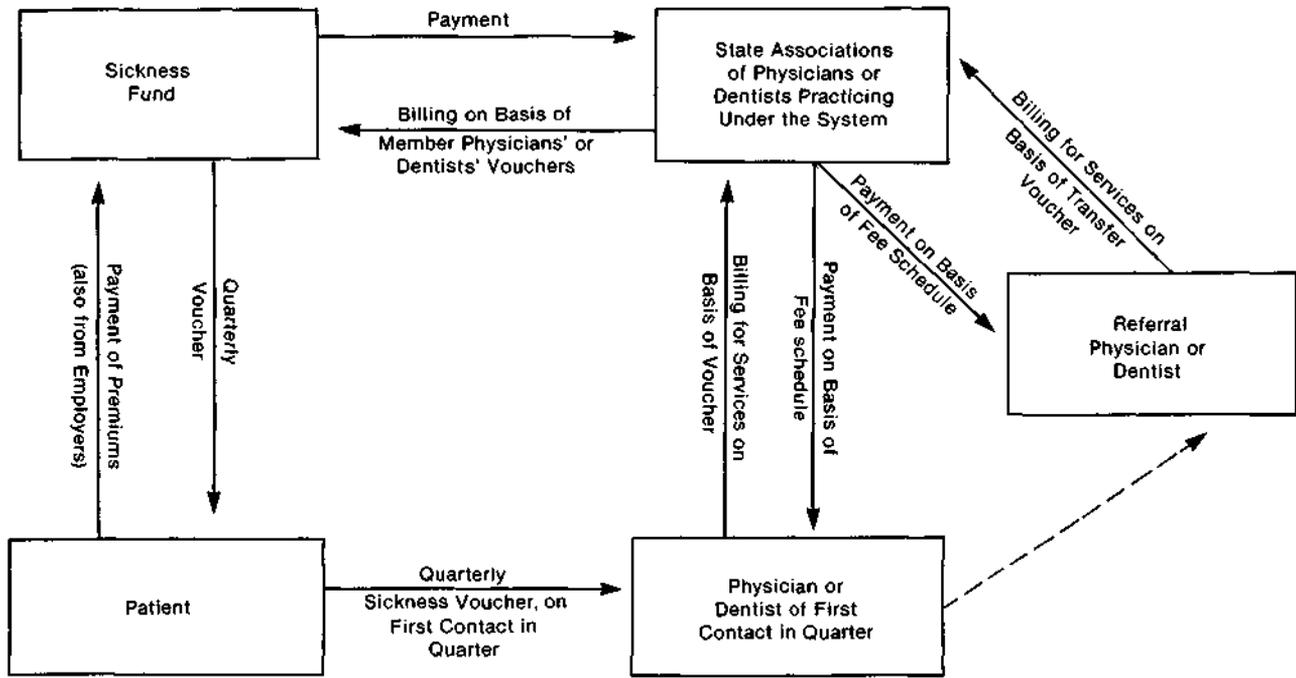
TABLE 11
Average Annual Growth Rates in Selected Expenditures Under the Statutory Health Insurance System, 1960-1978

Category	Average Annual Percentage Growth					
	1960-1965	1965-1970	1970-1975	1976	1977	1978 ¹
Ambulatory Medical Care	11.3%	11.4%	15.6%	5.9%	4.6%	5.7%
Dental Services and Dentures	13.1%	13.8%	26.8%	15.6%	3.4%	6.2%
Drugs	13.1%	15.9%	16.1%	8.3%	1.5%	8.7%
Hospital Services	13.5%	15.3%	23.9%	9.8%	5.7%	7.1%
Total Expenditures						
Excluding Cash						
Benefits for						
Sickness and						
Administration	12.3%	13.8%	20.1%	10.0%	4.3%	7.2%
Gross National						
Product	8.8%	8.3%	8.5%	9.1%	6.2%	7.1%

¹Preliminary data.

Source: Federal Department of Labor and Social Affairs; cited in Ulrich Geissler (1978), Table 5.

FIGURE 1
Reimbursement of Physicians and Dentists Under the Statutory Health Insurance System



Each insured person in Germany receives from his or her sickness fund a so-called *sickness-voucher* every quarter. The patient surrenders this voucher to his or her physician on the first contact in a quarter. Referrals to specialists proceed on a transfer certificate issued by the referring physician, although patients may go directly to a specialist as initial contact with the medical system. The physician notes individual services rendered on the voucher (or transfer certificate) and submits it to the appropriate physician association for reimbursement on a fee-for-service basis. If the association faces an overall cap on distributable funds—as is being attempted now—then individual fees are scaled up or down by the association to meet the budget constraint. Utilization review to control overservicing is, in the first instance, in the hands of the physician associations, although the sickness funds have recently gained the right to participate actively in utilization reviews. The reimbursement system for dentists parallels that of physicians.

The fee schedules used under the statutory system are negotiated periodically between associations of the sickness funds on the one hand, and the professional associations on the other. The overall structure of the fee schedule (that is, relative value points) are negotiated at the national level. The original basis for these negotiations is a Federal fee schedule issued by the Ministry of Economics in 1965.⁴ The national negotiations take the form of amendments to this schedule.

The money value of the relative value points is negotiated between sickness funds and professional associations at the level of the *Land* (State). Although fee levels vary across the States, such variations are small compared to regional variations of fees in the United States. (In 1976, for example, the highest level was only 6 percent above the lowest level of fees). Minor variations in the fee levels also occur among the various types of sickness funds, but, once again, they are in no way comparable to the variations in fees one observes in the United States.

For patients insured under the statutory scheme, physicians (and dentists) must accept the negotiated fees as payment in full. They may, and invariably do, charge private patients considerably higher fees. Indeed, it is not uncommon for physicians to divide their day into practice hours for statutorily insured and privately insured patients, and to adopt different practice styles for the two types of patients. Table 12 presents data from a recent study of practice styles in the city of Munich. These data suggest that practice styles are sensitive to differences in insurance coverage. Patients covered by the *Allgemeine Ortskrankenkasse* (local sickness fund), which generally offers physicians

the least generous terms, tended to spend considerably more time in the waiting room than private patients (who paid relatively higher fees). Private patients also spent more time per visit with the physician than did patients under the statutory system.

TABLE 12
Average Wait Time in the Office and
Average Length of Patient Visits by
Insurance Status of Patients
Munich, West Germany, 1979

	Patients Insured by		Local
	Local Sickness Fund	Private Insurance	Sickness Fund
Men Age 18-55:			
Wait time in the office (minutes)	45.2	28.9	1.56
Length of Patient visit (minutes)	10.5	11.9	0.88
Women Age 18-55:			
Wait time in the office (minutes)	47.0	28.0	1.68
Length of patient visit (minutes)	10.5	13.5	0.78

Source: Neubauer and Birkner (1980). Figures 1 and 2, pp. 155-156.

Control of Cost and Expenditures Under the Statutory Health Insurance System

Under the Statutory Health Insurance System of West Germany, providers and patients are mandated to economize in the use of health-care resources. That mandate, however, is not really compatible with the financial incentives built into the system. With few exceptions, all insured services and supplies are received by patients free of charge at the point of delivery.

Physicians are reimbursed on a fee-for-service basis, and hospitals are reimbursed for the number of patient days they report. Both face a fiscal incentive to service their patients generously. In the wake of a rapid expansion of health-care resources—both facilities and manpower—the sharp secular increase in expenditures during the 1970's is not surprising.

The system has always been equipped with formal cost control mechanisms. The prices of drugs, for example, are reviewed and authorized by the Ministry of Economics. The fees for physician's services are negotiated between sickness funds and physician associations. The use of physician services and the prescription of drugs are monitored by the physician associations themselves and, in principle, controlled by them. The funds flowing to the hospital sector are controlled, at least in part, through negotiated *per diems* on the basis of approved cost sheets. Finally,

⁴This is the so-called *Gebührenordnung für Ärzte* (fee schedule for physicians). The annual amendments to the relative-value structure in this basic schedule are called *Bundsmantelverträge* (Federal envelop contracts).

since 1972, the physical capacity of the hospital sector has come under the influence of regional planners whose approval is required for State and Federal financing of capital expenditures by hospitals.

As Table 11 shows, these various controls either failed to work during the early 1970's or they were not applied. Because the secular growth during this period led to successive increases in the premium rates (see Table 7), both organized labor and employers pressed for more overt forms of cost control. In that climate the Federal government succeeded in enacting its Health-Care Cost-Containment Act of 1977, an act that seems in keeping with West Germany's penchant for policy by consensus.

The overall thrust of the Cost-Containment Act is to constrain the growth of expenditures to the growth of gross national product. The basic mechanism is an annually negotiated agreement of overall health-care budgets at the Federal and State level. To accomplish this the Act mandates the establishment of a National Health Conference (*Konzertierte Aktion*) embracing all major interest groups active in the health-care sector, including the sickness funds, the associations of sickness funds' physicians, hospitals, the pharmaceutical industry, unions (representing consumers), associations of employers, the State (*Land*) governments and the Federal government (Geissler, 1978). The Conference is mandated to develop annually a consensus on guidelines for the economic development of the statutory health-insurance system, including the growth of total expenditures by type of service and, indirectly, increases in fees and prices. To illustrate, during its first sessions in December 1977 and March 1978, chaired by the Federal Minister of Labor, the Conference reached a consensus on the following recommendations for July 1, 1978 to June 30, 1979:

1. Expenditures per insured member for ambulatory physician services are to increase by not more than 5.5 percent above the previous fiscal year. Of this total, 2.5 percent is allocated to increases in fees, and 3.0 percent to increases in use.
2. Similarly, expenditures per member for dental services (excluding materials and laboratory costs) from July 1, 1978-June 30, 1979 may exceed the previous year's expenditures by only 2.5 percent.
3. Drug expenditures per insured member in the second half of 1978 may exceed average expenditures during 1977 by only 3.5 percent.

Physicians, pharmacists, the pharmaceutical industry, and the sickness funds agreed on recommendations 1 and 3. These recommendations, therefore, had force. Because the dental association dissented from recommendation 2, the reimbursement of dentists was

left for further negotiations between dentists and the sickness funds. An explicit recommendation for the hospital sector could not be offered because that sector is not covered by the Cost-Containment Act.⁵

To implement the recommended guidelines, the Act mandated the sickness funds and physician associations to establish so-called Economic Monitoring Committees at the State level, with equal representation of both parties and rotating chairmanship. The Committee's monitoring system screens the charge profile of every physician. Physicians whose average number of services or prescriptions per case (voucher) exceed their class average by 30 percent are selected for further examination. If the observed deviations are not justified the physicians' reimbursements are cut accordingly. Under this system, the individual physician can, therefore, be held fiscally liable for excessive prescribing of drugs.

A remarkable feature of the West German approach to cost containment is that the guidelines recommended by the Conference are reached by consensus and they are not binding upon the negotiating parties. Although the guidelines may thus appear as a toothless tiger, they are nevertheless thought to influence the direction of negotiations, especially the compulsory arbitration that is triggered whenever negotiations between the sickness funds and providers break down. In effect, the law represents an attempt to replace the vacuum left by the secular erosion of market forces with a new type of market—one in which professional and economic interest groups bargain collectively toward a national consensus within a set of constraints provided by statute.

By contrast, the thrust of public policy in the United States has been, by and large, to replace the eroding market forces in health care by direct and often unilateral regulation of the health-care sector.

How successful the West German approach to cost containment will be in the long run remains to be seen. As Table 11 shows, the growth of expenditures under West Germany's statutory health insurance system has abated markedly since 1975, although the most dramatic decline in the growth rate actually preceded the introduction of the Cost-Containment Act of 1977. The explanation generally given for this early decline is that health-care providers agreed to a stringent voluntary cost containment effort in anticipation of Federal legislation, to demonstrate its redundancy.

⁵ The hospital sector was excluded from the Act, because some of the States—notably the city State of Hamburg—were reluctant to relinquish their control over hospitals to the Conference. At the time of this writing, the hospital sector still remains outside the Act and has not been subject to any separate cost-containment legislation. For more information, see "Kostendämpfung und Strukturverbesserung im Gesundheitswesen" (1978)

Also, the relative harmony prevailing at the early sessions of the Conference has given way to more open dissent in subsequent sessions. Some observers of the West German health system—policymakers among them—appear increasingly disillusioned with the approach.⁶ One reaction to this sense of frustration may be stronger government interference in the health sector. A provision in the Cost-Containment Act, for example, mandates the Federal executive to report, in 1981, to Parliament on the effectiveness of the Act and to assess the need for more potent policies.⁷

An alternative reaction might be to subject the delivery and financing of health care more extensively to classical market mechanisms—for example, to significant cost-sharing among patients. Some economists (for example, Henke and Metze, 1978) have advocated this approach, as has organized medicine in West Germany. On the other hand, neither policymakers nor politicians in West Germany seem to have shown any inclination to employ cost-sharing by patients as a cost containment strategy.

The economist's case for coinsurance rests on a well known body of theory which assumes that patients are: 1) well informed; and 2) capable of rational action on accurate information concerning their health status and alternative approaches to treating given medical conditions. Also, it is assumed that even if patients were not well informed or were incapable of choosing rationally among treatment alternatives, physicians would keep the patient's financial interest in mind when choosing treatment on their patient's behalf.

Why physicians would favor cost-sharing by patients is not as clearly evident. When physicians do make the case for cost-sharing they typically do so on the argument that it would: 1) elicit more responsible

conduct on the part of patients; 2) free medical practice from trivial cases; and 3) contribute toward expenditure-containment. The first argument, and possibly the second, may have merit. One doubts, however, that physicians seriously believe the third. Organized medicine is not known to favor policies that reduce the aggregate flow of funds to physicians. As M. L. Barer *et al.*, (1979), have recently argued, a more plausible explanation for the profession's posture is that cost-sharing, coupled with third-party coverage, is believed by physicians to draw more money overall to the physician sector than could otherwise be had from third-party payers under universal first dollar coverage, because it is usually more difficult to maintain an overview of and control over fiscal flows from many spigots than to control a single source.

In West Germany, the discovery of additional sources of revenue for physicians has a particular urgency. Current prognoses put the number of active physicians per 100,000 population in the year 2000 at 406 to 485, (Lefelmann and Geissler, 1979) depending on the assumptions embodied in the forecast. Because the hospital sector is not likely to expand significantly, the bulk of this projected increase in physician density will spill over into the ambulatory-care sector where physicians are free to establish a private practice without the approval of an intervening institution, such as a hospital. Table 13 indicates the effect of this expected spill-over. In reacting to these projections, one should keep in mind that the physicians included in the table will cater solely to the population's need for *ambulatory* physician services. Just how, in the face of these numbers, West Germany proposes to keep the growth of total physician remuneration roughly in line with the growth of gross national product—the apparent goal of cost-containment policy in that country—is an interesting question. From the American vantage point, the resolution of this question may yield instructive lessons.

⁶ For more information, see, for example, Jonathan Spivak, (1979)

⁷ Article 2, paragraph 6 of the Cost-Containment Act. For more information, see Ulrich Geissler (1978), p. 13.

TABLE 13
Actual and Projected Number of Active Physicians in West Germany,
1975-2000

Category	—Year—			
	1975	1980	1990	2000
Total Number of Active Physicians	118,007	136,900	190,400	256,600
—in Research and Administration	11,819	13,100	18,900	24,200
—Primarily in the Hospital	52,340	57,000	60,000	62,000
—in Private, Ambulatory Practice	53,848	66,800	111,500	170,400
Number of Physicians in Private Ambulatory Practice, per 100,000 Population				
—Number	87	110	191	306
—Index, 1975 = 100	(100)	(126)	(220)	(351)

Source: Adapted from Gerd Lefelmann and Ulrich Geissler (1978), Tables 2 and 3, pp. 16 and 17.

Concluding Remarks

In the Western democracies, conflicts over the allocation of real resources among members of society are usually arbitrated by private-market forces. Ideally, this process takes the form of competitive bidding with purchasing power that is distributed among individuals on the basis of a mixture of merit, lineage and luck. In general the resource-allocative verdicts of this arbitration process tend to be accepted with remarkable equanimity as long as the bidding process itself has been reasonably fair, this is, competitive. Almost invariably the impersonal, though often harsh, verdicts of private markets are accepted more tranquilly than possibly less harsh verdicts by identifiable individuals, for example, by public servants.

For many decades—indeed, centuries—this form of arbitration was accepted also in conflicts over the allocation of health-care resources. As I have asserted in the introduction, however, one cannot think of a modern society that still favors this process. Many societies—for example, the United States and Australia—wish to guarantee their members access to at least a *minimally adequate set of health services*, regardless of the distribution of purchasing power, although not necessarily on an equal footing.⁸ Other societies—for example, Canada, the United Kingdom, the Continental European nations and the socialist nations—profess as a basic tenet that all members of society ought to have unfettered access to *all technically available and medically justifiable health care* on an equal footing. Although these nations have not so far been able to implement this tenet fully in practice, at the very least they pretend to structure their health-care and health-insurance systems on this fundamental principle.

Whatever particular ethical principle various societies posit for their health systems, all of them have found it necessary to replace the classical process of free-market arbitration at least partially with some alternative, collective process of arbitration over resource conflicts in health care. A widely shared belief among American health economists—and some European ones as well—is that one ought to move cautiously in this direction and never more than is absolutely necessary for the sake of equity.

⁸Practically, equal footing in health care means that two patients falling victim to the same medical condition in a given locality would receive the same treatment regardless of their socioeconomic position.

Many policymakers in the United States and, apparently, most policymakers elsewhere, seem to have despaired long ago of the economist's favored strategy. In particular, little credence is given to the notion that consumers could participate sensibly in resource-allocative decisions in health care, even if they were given the basic information for such decisions—information health-care providers sometimes withhold from them.⁹ Lacking any faith in the consumer's competence, the thrust of public health policy almost everywhere has been to replace market mechanisms altogether with something else, in piecemeal or wholesale fashion.

In the United States this tendency has manifested itself in a penchant for centrally directed planning and direct regulation of individual's behavior—for example, Professional Standards Review Organization (PSRO's) or Certificates of Needs (CON's) for hospital capacity. In West Germany, the thrust of public health policy so far has been not to move sharply towards either planning or direct regulation,¹⁰ nor to resurrect the long moribund play of free-market forces. Instead, public policy has attempted to create novel, quasi-economic, quasi-political markets that fall somewhere between the extreme of classical markets and central planning.¹¹ The ideal decision-making units in these quasi-markets are freestanding associations of the individuals and organizations active in these markets (for example, association of providers, of insurers, of the insured, and so on). The process of reaching equilibrium through the myriad of independent bids, as envisioned for classical markets, give way to collective bargaining among these freestanding associations, all within a statutory framework that guards the rights of weaker parties and provides for compulsory arbitration of inconclusive negotiations. The so-called Health Care Conference (*Konzertierte Aktion*) provided for in the Health Care Cost-Containment Act of 1977 can be interpreted as an attempt to refine this type of "market" mechanism.

⁹This asymmetric management of information in health care is often justified, by physicians, as part of a good therapy. As it happens, however, the asymmetry bestows both medical and market power on the provider. The motives behind it may, therefore, be questioned.

¹⁰The exception here is the application of planning in the hospital sector as part of the financing of capital expenditures.

¹¹A clear exposition of this strategy can be found in Philipp Herder-Dornreich (1977).

It can be asked whether, at this time, anyone can seriously claim to know the superior, universally applicable form of arbitration in health care—or even the clearly superior mechanism for the United States.

During the 1960's and early 1970's, when economic growth was rapid everywhere and resources plentiful, almost any chosen form of conflict-arbitration in health care seemed to work, after a fashion. Potential conflicts over real resources were simply smothered in funds and resolved by muddling through with what was thought to be only temporarily fixed physical capacity. In the meantime the very nature of the allocation problem has changed. Plenty of physical capacity exists but there is widespread unwillingness to allocate *budgets* for the use and longrun maintenance of this capacity. All of the Western industrialized nations find themselves in the midst of this new problem and all of them are seeking to develop civilized and acceptable rules to solve it. Just what set of rules other nations—for example, West Germany—will develop and how they work shall be of more than mere academic interest to American observers.

Acknowledgments

The author is indebted to Professor Klaus-Dirk Henke, Technische Universität, Hannover, West Germany and to Dr. Peter McMenamin of the Health Care Financing Administration of the Department of Health and Human Services for their careful review of the manuscript and for their many helpful comments.

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