National Health Insurance in the Federal Republic of Germany and its Implications for U.S. Consumers

GORDON K. MacLEOD, MD

THE UNITED STATES is the last major industrial country in the world to develop its own national health financing machinery with the intent of reaching most, if not all, of its people. Awareness of consumer influence on similar financing schemes in other industrialized countries is important for health planners and for the medical profession in the United States because of (*a*) the irresistible nature of consumer demand for establishing and promoting a financing mechanism and (*b*) the continuing consumer effect on physicians, patients, and patterns of care. Most studies of the effect of new financing schemes and changing delivery patterns of the physician-patient relationship have viewed both functions from the vantage point of providers rather than consumers (*1–4*). However, the evolution of health care systems can best be understood by studying the influence of both providers and consumers on financing and delivery functions under national health insurance.

As the United States continues to debate national health insurance issues, systematic investigation of the consumers' role in social, political, and economic changes affecting all aspects of the health care system is warranted in countries with long experience in publicly mandated financing. A prime example for comparison is the Federal Republic of Germany which, like the United States, has a Federal-State form of government. In 1883 it became the first industrialized nation in the world to adopt a compulsory health insurance program. Even though the West German Government does not operate its health insurance system, it has had nearly a century of experience in grappling with problems related to health care delivery and financing in the private sector. Specifically, it is responsible for setting national policy, regulating the basic and supplementary levels of benefits, and overseeing the fiscal operations of local sickness funds.

Data for this article were collected in 1973 and 1974 through personal interviews with spokesmen for the Federal Republic of Germany, a national consumer organization, trade unions, employers' associations, physicians' associations, local sickness funds, and the private insurance industry. The same set of questions was directed toward each interviewee concerning the financing, planning, organizing, and delivering of health care services. Each interviewee was also queried about the consumer's recourse if dissatisfied with either the quality (acceptability) of service or with the technical quality of care.

Development of National Health Insurance

For many years before enactment of national health insurance legislation in Germany, consumer demand for health and sick pay insurance was already evident among industrial workers. Direct involvement by the labor force led to the establishment of mutual benefit funds organized to meet the increasing social welfare needs of skilled and semiskilled manual workers faced with growing industrialization. The demand was so great that thousands of small groups of consumers, usually from the same industry or trade, set up and operated local sickness funds, thus laying the groundwork for the consumers' role under national health insurance.

Upon enactment of national health insurance in 1883 under Chancellor Bismarck, some 22,000 nonprofit sickness funds were converted to quasi-official status. In the funds' new role, they were authorized to collect compulsory social insurance premiums in the form of employer-employee contributions through payroll deductions. In return, the funds were used to provide medical services—at no additional cost to the insured—along with cash sickness benefits. Expansion occurred gradually. For example, a time line shows that during World War I families of insured persons were included in the coverage at no extra premium. In 1941, health insurance for pensioners was introduced (*5*).

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Expansion of health insurance coverage and broadening of the benefit package have occurred mainly through legislation, often because of continuing consumer demand that the sickness funds themselves insure employees whose earnings were rising above a legislated insurable income ceiling or simply as a consequence of consumer interest in expanding benefits.

The progression of German national health insurance since the organization of mutual benefit funds in the mid-19th century follows a time line:

1883, compulsory health and sick pay insurance for industrial workers; 22,000 sickness funds
1903, coverage for office and transport workers
1911, coverage for domestic workers; 13,500 sickness funds
1914, reduction in benefits and contributions
1914–18, coverage for dependents of insured
1927, coverage for seamen
1934–39, regulation and supervision of hospitals, public health, cost control data, and financial auditing shared by States; 4,600 sickness funds
1941, coverage for pensioners; no time limits on coverage for medical care
1949, postwar benefits and contributions adjusted
1951, 1,992 sickness funds
1957, increased employer contributions for sick pay
1961, waiting period for sick pay abolished
1965, increased sick pay and household allowances
1970, coverage for employees regardless of income; full pay from employers for first 6 weeks of work loss
1972, coverage for farmers; 1,751 sickness funds

The original program in 1883 covered only those industrial and manual workers whose incomes fell below a certain level. The income ceiling for insurability rose steadily both for blue-collar and white-collar workers until it was eventually removed; now it exists only for some self-employed persons. Recent legislation expanded compulsory enrollment in sickness funds or offered equivalent coverage under private insurance to all salaried employees, even those formerly with incomes above the insurable ceiling, and to all self-employed persons below a specified income level.

The steady expansion of coverage to all but the wealthy led to almost complete protection against financial catastrophe from the escalating costs of health care through enrollment in sickness funds by more than 90 percent of the 62 million people in the Federal Republic of Germany. By 1972, 99 percent of the population was covered by sickness funds or private health insurance policies (*6*).

Cash Sickness Benefits

For the past 20 years, an increasing proportion of the premiums collected by the local sickness funds has been spent on health care rather than for cash sickness benefits because the administrative responsibility for compensation during illness has been shifting directly to employers. In 1957, a law was passed that provided additional employer contributions to cash sickness benefits for manual workers, and by 1961 the waiting period for receiving sick pay had been abolished. Since 1970, all employees too ill to work have been entitled to receive full pay from their employers for the first 6 weeks of work loss; this has brought the position of manual workers into line with that of non-manual workers—a longstanding demand. After the first 6 weeks of employer payments, the local sickness funds pay between 75 and 85 percent of customary wages for a maximum period of 18 months within a 3-year period. The trend toward increasing employer responsibility for compensating employees during sickness has tended to separate the administration of West Germany's growing health insurance expenditures from that of other aspects of social security.

Consumer Satisfaction

From the outset, consumers have been engaged in the development of national health insurance policy, while providers have remained primarily responsible for planning, organizing, and delivering health care services.

The consumers' role has been institutionalized by legally mandated elections of employee representation on governing boards of local sickness funds. With few exceptions, half of each governing board of the sickness funds is elected by employers and half by employees. Consumer participation in quadrennial elections for membership on the governing bodies has waxed and waned. Separate elections for membership on the governing board are held for the employers' associations and for workers, each selected from a single slate of candidates. In the past, as few as 15-20 percent of the employees voted in the elections. New regulations now encourage open competition. Since 1974, up to 50 percent of employees have been voting. Of note, physicians are ineligible to serve on the governing boards because of the possibility of a conflict of interest.

Trade unionists, some 35 percent of the employed population in West Germany, have an excellent channel for registering complaints against the insurance system through their social legislative departments, whose members also often serve as consumer representatives on the governing boards of the local sickness funds. No such organized assistance is available to the rest of the insured population. Dissatisfaction with complaint procedures has prompted governmental consideration of a consumer representative for the general public, particularly for senior citizens. Nevertheless, repeated surveys have shown that West German consumers are overwhelmingly satisfied with the national health insurance system.

Providers of Health Care

One explanation for consumer satisfaction is the ready availability of personal physicians. Nationally, the ratio is 1 physician to about 650 people. Of the 93,934 physicians active in 1971, 50,379 were community practitioners, almost equally divided between general and specialty practice; 33,770 were salaried hospital physicians—700 of these were chiefs of services, and 9,785

were primarily administrators (7). Although the 1971 count showed 3,700 foreign-born physicians in West Germany—and many others in training—few were permitted to practice outside of hospitals. Foreign-born physicians are usually employed at modest salaries in contrast to the incomes of community practitioners and particularly to those of hospital chiefs of services. Community practitioners and hospital chiefs in West Germany are among the highest paid physicians in the world. The hospital chief, unlike most staff members strictly on salary, is able to earn fee-for-service income on top of his salary.

Outpatient care is almost completely separate from inpatient care in West Germany. In contrast to the free choice of physician outside the hospital, inpatients have little oportunity to select their physicians unless they have purchased supplemental health insurance or they themselves pay the physician directly. This separation of responsibility for inpatient and outpatient care has resulted in almost a complete lack of continuity of care and has been sharply criticized by many community practitioners, particularly as it relates to the education and training of all physicians. However, a small number of specialists in teaching hospitals do provide a limited amount of outpatient care, usually upon referral from community physicians.

Although patients have a free choice of hospitals, they must be referred for admission by a community practitioner to qualify for insurance coverage. Sickness funds reimburse hospitals for each day of inpatient care at a rate fixed at the regional (State) level; payments cover the costs of hospital treatment including physician care, food, and ward accommodations (third class). Semiprivate or private rooms are available to anyone paying for them directly out of pocket, through supplemental sickness fund premiums, or through private insurance policies. In all instances, hospital overhead lost is subsidized by State government funds.

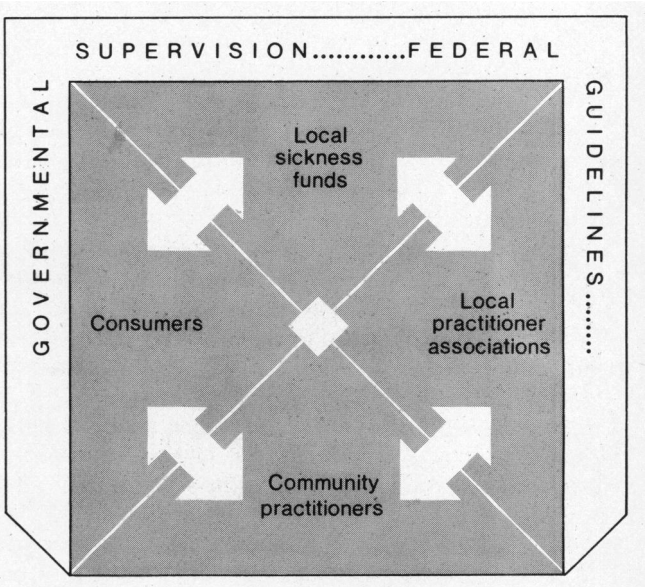
Upon enactment of national health insurance legislation in the 19th century, employer-employee-sponsored sickness funds were authorized to provide medical care directly to beneficiaries. Under the law, the traditional physician-patient relationship that resulted from payment of a fee by the patient to the physician was usurped. Individual physicians were often intimidated by the enormous financial and organizational power of the sickness funds. As a result, there was continuing strife for several decades between the medical societies and the local sickness funds. A 1932 government-mediated compromise restored the traditional physician-patient relationships through establishment of local practitioner associations. In return for safeguarding their professional and financial interests, physicians, through these associations, agreed to negotiate with the consumer-governed sickness funds (*a*) all outpatient fees and (*b*) hours of service.

The arbitration of fee schedules between local practitioner associations and local sickness funds is required by law. Ordinarily, arbitration panels have equal representation from both sides. In case of deadlock, the two parties draw lots to determine which side appoints a chairman who then has the deciding vote. In accordance with this arrangement, physicians have forfeited the right to strike.

Maldistribution of physicians was fairly well controlled before 1960 because sickness funds could withhold payment to physicians in areas having high concentrations of them. According to a Federal court judgment in 1960, the right to engage in sickness fund practice is the prerogative of every qualified physician. Thus, this ruling made it unconstitutional for sickness funds either to limit the number of practitioners or to specify the areas in which they may practice. Although the problem is not serious, this decision led directly to increasing geographic maldistribution of physicians, particularly in rural areas. As a result of the loss of control, there was increasing consumer governance pressure directed toward local practitioner associations to induce physicians to practice in underserved areas. During 1972, only 26 villages in the country had no physician within a 4-mile radius. By that time, the medical societies had permitted some 100 foreign physicians to be licensed as community practitioners in other rural areas. Despite initial resistance by villagers, most of these citizens now willingly accept the foreign physicians.

The schematic representation of the West German health care system, exclusive of hospitalization, reveals how consumers and community practitioners relate to their representative organizations, how the physician-patient relationship is preserved with professional accountability and without government interference, and how government supervision or Federal guide-

The health care system of the Federal Republic of Germany, exclusive of hospitalization



lines overshadow the operational and fiscal aspects of health care delivery between the local sickness funds, the local practitioner associations, and their respective constituencies. Just as community physicians do not have direct access to local sickness funds, consumers do not deal directly with local practitioner associations.

Local practitioner associations are responsible for physician reimbursement and for peer review of unusually high billings. All qualified community practitioners are paid on a fee-for-service basis by 1 of the 17 local practitioner associations. The patient's personal physician retains an official sickness form for 3 months, listing his services and recording his fee for each one. The sickness form is submitted for reimbursement quarterly to the local practitioner association. Because patients are issued new sickness forms only once every 3 months, a change of physician during this time is unlikely, although theoretically possible. Thus, at least in principle, free choice of physician has been preserved. Specialty referrals must be made by one's personal physician unless the patient chooses to pay for the specialist's service.

A record of each personal health care service is stored in a computer for eventual review. Physicians' charges for services, such as consultations, treatments, and laboratory procedures, are compared to norms established from computer data of all the physicians in the local practitioner association. Fee levels may vary according to the qualifications of providers. Similarly, dentists, pharmacists, and opticians undergo computerized review. Despite the effectiveness of policing physician profiles by local practitioner associations, hospital review procedures, conducted separately, have had little effect in reducing markedly prolonged inpatient stays.

Peer review of abnormally high fees and income (50 percent above the norm) triggers examination of both the physician's charges and his performance. A committee of the local practitioner association performs the review with consumer representatives from the board of the local sickness fund sometimes in attendance. Failure of a physician to justify the cost, quantity, or quality of service could result in a warning, withholding part or all of the reimbursement, a fine, or even loss of authorization to participate in the local practitioner association. Those whose incomes are in the top 3 percent are automatically reviewed annually; corrective action is only occasionally necessary. Recourse to the courts is the ultimate expression of consumer dissatisfaction. Although the incidence of malpractice litigation has increased slightly, the number of new cases is not significant enough to indicate widespread consumer discontent.

A medical control service, comprising a special group of physicians, is used by the local sickness funds. These physicians employed by the sickness funds are often requested to re-examine a sick person who had been certified previously by community practitioners to be incapable of work. In this way, the consumer's privacy is assured; no personal health information goes beyond the medical profession.

Professional Organizations

In addition to the local practitioner associations, there is a national coordinating body of the 11 State medical societies. This body is responsible for licensure, registration, specialty certification, physician conduct, and discipline for any breach of ethical or moral conduct. In 1973, each State society had a graduated dues structure ranging from about $25 to more than $300 per year, part of which is used to support the national coordinating body, whose members are often viewed as the elder statesmen of the medical profession.

Another physicians' organization, the 30,000 member Association of German Physicians, is growing in popularity, prestige, and membership. It is composed of both community- and hospital-based physicians but its policies are dominated by the political and economic interests of community practitioners. It seeks representation on its governing council from all age groups in the physician community, not just from elder statesmen of the medical profession. It has published monographs advocating group practice, continuity of care, and medical education oriented to the delivery of patient care. Despite these progressive views, the association is strongly committed to fee-for-service and adamantly opposed to salaried practice.

A third important organization of physicians, the Marburgerbund, has a membership of 30,000 hospital-based physicians. There are also some 20 specialty professional groups and a few other specialized societies.

Administration of Local Sickness Funds

National health insurance in the Federal Republic of Germany is completely decentralized. From 1883 to 1972, the number of local sickness funds dropped from 22,000 to 1,751. Each one is responsible for (*a*) employing its own administrative staff, (*b*) setting its own health insurance rates within certain limits, (*c*) collecting premiums through payroll taxes, (*d*) contracting for the provision of needed services with local practitioner associations, (*e*) paying officially determined hospital rates, and (*f*) balancing its own budget.

Federal law defines the basic medical benefit package, thus establishing the basis for setting the premium rate which in 1972 averaged 8.25 percent of taxable income. In addition to a legislated step increase in the taxable income level in 1973, the average premium rose to 9.01 percent (*8*). Despite statutory efforts to establish a maximum taxable income level, health insurance premiums are not rigidly controlled. Maximum premiums can be adjusted upward by government regulation upon the request of the sickness funds. The funds have additional flexibility in rate setting by offering supplementary benefits within legally defined limits.

The national federation of sickness funds is legally

responsible for negotiating the fee schedule for more than 1,000 health services with the national organization of local practitioner associations (*9*). Each local sickness fund then negotiates a contract with its local practitioner association and is able to adjust its premiums for regional variations in costs. Lump-sum payments are made in advance on a quarterly basis by each of the local sickness funds to the practitioner associations, with retroactive adjustment for any excess or deficit. Qualified physicians submit their billings to their local association and are paid a fee for each personal health service provided. In this way, the patient receives comprehensive primary and specialty medical care including laboratory and X-ray services from community practitioners without co-payments or deductibles. Dental treatment is similarly provided, although a prior estimate for expensive dental work and for dentures is required to be submitted to the local sickness fund. However, co-payments are made for drugs, eyeglasses, dentures, and other prostheses.

Private Health Insurance

Although comprehensive coverage under private health insurance in West Germany has declined as statutory insurance has grown, private coverage to supplement medical care benefits and to increase cash sickness payments has steadily risen (*10*). Moreover, some 50 private health insurance firms, under government supervision, vie with sickness funds for the enrollment of a relatively small number of voluntarily insured persons. This arrangement permits many in the upper-income groups eligible for private insurance to choose between paying premiums either to a local sickness fund or to a private insurance company. In one form or another, private insurance is available to the entire population and contributes substantially to approximately 20 percent of the physician's income that is derived from private practice.

Discussion and Conclusions

Any study of the role of consumers under national health insurance must not only include a description of the health care system, but should also identify national and local forces contributing to changing patterns of health care. For example, in the Federal Republic of Germany two well-publicized concerns about the health care system are public demand for greater emphasis on early diagnosis and preventive care and for containing the rising costs of health care. Local newspapers and consumer-oriented magazines regularly feature these issues.

The Consumers Union, an organized consumer group, advocates optimal health security; but it directs most of its activities toward new issues and thus has little to do with the statutory health insurance plan. In 1973, it was lobbying against easy access to self-medication, poor-quality medical goods and supplies, and the use of potentially dangerous food additives, and in favor of health education, environmental improvement, and food inspection with attention to its nutritional value (*11*).

In recent years, both the German Federation of Trade Unions and the Confederation of German Employers' Association have prepared policy documents for future direction in health care policy (*12,13*). The trade unions are a strong and forceful voice for the consumer; they have publicly expressed concern about many aspects of the medical care system, particularly about preventive medicine, early diagnosis, occupational health, rehabilitation, the high cost of drugs, and the need for continuing professional education. The Confederation of German Employers Association has also taken a strong positive public stance on these and other health care issues.

The Ministry of Labor and Social Affairs, which is responsible to the German parliament for overseeing national health insurance matters, has vigorously endorsed programs for health care for all the people consistent with the state of technological progress. The Ministry recently conducted a survey to determine consumer satisfaction with a trial program directed toward early diagnosis and preventive care: the results showed that consumers do place great emphasis on preventive measures (*14*). This finding has reinforced recent legislative action to continue to provide financial incentives to promote health maintenance as a personal health service to be provided by physicians.

A 1973 review of all social security programs concluded that despite the steady increase in the percentage of older Germans, the rate of per capita expenditure on behalf of beneficiaries of the sickness funds had risen more rapidly in the past 5 years than per capita payments to beneficiaries of the old age and survivors social insurance program. This happened because both the level and the percentage of taxable income for old age and survivor benefits are fixed by law, while only the level of the taxable income applicable to sickness funds is legislatively mandated. The percentage of taxable income going to health care can be adjusted simply by regulation and has been permitted to rise as sickness fund expenses have increased. In 1973, it was considered necessary to budget the rate of increase in the total national expenditures for health care for the next 5 years. These expenditures were expected to rise even more rapidly than the percentage rise in either the old age and survivor benefits or the gross national product (*15*).

Awareness of the escalating health care costs is causing political reaction from all three German political parties, and they continue to press the Ministry of Labor and Social Affairs for explanations of these rising costs. On the one hand, hospital costs have not responded to review procedures, and escalating costs outside the hospital can be attributed partly to the absence of barriers to the number of physician-office visits in an aging society; these factors have gradually tended to increase the demand for personal health services over

the years. On the other hand, the fee-for-service payment mechanism both inside and outside the hospital continues to provide strong incentives for practitioners to promote utilization of their own services. Numerous attempts by local sickness funds to control costs have met with only limited success.

Although health insurance in West Germany is closely supervised by the government, the practice of medicine is comparatively free of government constraints. The ever-increasing costs of medical care, however, are throught not to be subject to the checks and balances that usually prevail in industrialized societies. There is growing concern that the supply and demand for medical care is out of balance, with physicians primarily influencing both supply and demand, thereby increasing the cost of medical care. One possible adjustment for this imbalance is by income negotiation of fixed-fee schedules to the satisfaction of both parties, that is, between groups of providers and consumers as a variation on the flexible fee schedule used by physicians before national health insurance. Another possible adjustment is by development of competitive delivery systems designed to contain costs appropriately.

If national health expenditures continue to exceed insurance income in the Federal Republic of Germany, an intrusion on professional performance might recur. Short of increasing governmental constraints, West German officials could consider (*a*) further reduction in the number of local sickness funds so that negotiations between consumers and providers would be on an equal footing, (*b*) expansion of hospital services to include ambulatory care which might stimulate competition with community practitioners in the hope that it will lead to cost containment, (*c*) demonstration of reduced hospitalization through annual capitation payments to selected groups of hospital practitioners resulting in significant savings to be used to maintain competitively high-income levels for participating chiefs of services compared to those remaining in fee-for-service practice, or (*d*) restoration of the continuity of care by community practitioners who could then maintain primary responsibility for patients when hospitalized if these practitioners would agree to accept capitation-per-annum instead of fee-for-service payments (*16*).

Despite obvious satisfaction with consumer participation in health financing systems in a number of countries, this pattern has met with only limited success in controlling the rising cost of health care (*17,18*). Knowledge of the satisfaction with elected consumer participation in health care financing in an industrialized country such as West Germany could very well influence public support for such a role in the United States under whatever financing mechanism is eventually adopted by the American Congress. Although the two countries do not have identical health care systems, the Federal Republic's long experience with consumer participation under national health insurance provides several object lessons for health planners in the United States and for the American medical profession as well.

Among those lessons to be learned are (*a*) that elected consumer participation in development of policy for the sickness funds has provided almost 100 years of stability and satisfaction seldom found in health financing schemes of other industrialized countries, (*b*) that the medical profession has been a vital force in shaping health care policies under national health insurance, (*c*) that social insurance uniquely among other West German social institutions has survived the disruption of the fabric of German culture in two World Wars, and (*d*) that there is growing consumer demand for preventive care even under national health insurance.

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