
Perspective

Germany's Health Care System: It's Not The American Way

by Uwe E. Reinhardt

From an American perspective, Germany's health care system represents a nettlesome challenge. Americans now spend 14 percent of their gross domestic product (GDP) on health care, while Germany spends less than 10 percent. Yet, for all that heavier spending, the U.S. health care system has never managed to provide all Americans with secure, portable health insurance. Evidently, for many low-income Americans without health insurance, the system now rations health care by income and ability to pay.

By contrast, Germans of all ages have long enjoyed fully portable health insurance that provides what is effectively first-dollar coverage for a very comprehensive package of benefits. Furthermore, unlike U.S. patients, who increasingly find their choice of doctor and hospital limited through the technique of managed competition, German patients still enjoy completely free choice of provider at the time illness strikes. In cross-national opinion surveys conducted by the Louis Harris organization in conjunction with the Harvard School of Public Health, both German patients and physicians express relatively greater satisfaction with their health care system than their American counterparts express with their system.¹

The relatively low level of health spending in Germany is all the more remarkable, because Germany's population is so much older than America's: 15.5 percent of the German population is age sixty-five or older, compared with 12.2 percent of Americans.² In fact, the United States will attain Germany's current age structure only in the year 2020.

In their paper on the German health care system published in this volume, Klaus-Dirk Henke, Margaret Murray, and Claudia Ade describe Germany's current attempt to control the cost of its health system through top-down global budgeting. One would think that this analysis would be of great interest to U.S. policymakers, who also are deeply concerned over rising health costs. Indeed, about a year ago, as our debate on health system reform went into full swing, I published a similar analysis in another journal, also in the hope of informing U.S. policy making.³ But our tortur-

ous reform debate during the past year or so has convinced me that papers of this genre may be only vaguely relevant to the American context, and mainly to the Medicare and Medicaid programs. It turns out that Americans really are quite different from Germans, in at least two important respects.

First, Germany's system is almost elegant in its simplicity. That is probably no historical accident. Germans appear to understand the trade-off between the operational simplicity of a system and its fairness and efficiency in each particular instance. Apparently, the German people and the politicians who represent them value administrative simplicity and accept regulations that make sense on average. The party discipline inherent in Germany's parliamentary system makes it relatively easy to design, legislate, and implement coherent policies—including inherently controversial cost control programs—without the myriad of contradictory amendments that so often complicate U.S. public policy. As has become apparent in the public deliberations of the Physician Payment Review Commission (PPRC), to impose top-down global budgeting of the German variety upon the extraordinarily complex American health care system would quickly beget an administrative nightmare.⁴

Second, the ethical precepts driving German health policy differ substantially from those driving American policy. Germans, along with other Europeans and Canadians, view health care as part of the cement that binds a people sharing the same geography into a genuine nation. All social classes in Germany thus are made to share the same health care system. About 90 percent of the population gains access to that system through one social insurance scheme that is administered by some 1,000 fiscally independent, semiprivate sickness funds operating under the constraints of a federal statute. Only about 10 percent of the German population has private commercial insurance, but they share the same health care delivery system and merely enjoy more amenities.

Under Germany's statutory insurance scheme, premiums are based on ability to pay. With the financial burden of illness fully socialized in this way, the system inevitably would be subjected to top-down global budgeting, including controls on price and volume. Germany's clear social ethic, to which all political parties still pledge explicit allegiance, makes the global budgeting described by these authors politically acceptable.

The United States never has had a one-tier health care system, and, as the recent debate on health reform in Congress has demonstrated, the United States never will have a one-tier health care system. A working majority of the politicians representing Americans in the policy arena evidently view health care as essentially a private consumption good of which low-income families might be accorded a basic ration, but whose

availability and quality should be allowed to vary with family income. This view lends official sanction to the following three-tier system: (1) Tier I for the low-income uninsured: a system of public hospitals and clinics that rations health care severely through constraints on capacity.⁵ (2) Tier II for the insured, broad middle class: a system of competitive, integrated private health plans budgeted on a per capita basis, with limited choice of providers and with varying degrees of tacit rationing. (3) Tier III for the Medicare population and the moneyed elite: the traditional, open-ended, free-choice fee-for-service health care system with little or no rationing of care.

The bottom tier will be globally budgeted through annual appropriations by legislative bodies. The middle tier will be effectively budgeted as well, albeit through negotiated, prepaid annual capitation payments. Finally, the top tier will remain open-ended, as it is now, and thereby will be able to avoid rationing. The nation's moneyed elite would never accept anything less for itself. When members of Congress warn us darkly about the prospect of "rationing," they are not thinking about the bottom tier nor, I suspect, about the second tier. They have in mind mainly the upper tier.

We must leave for study by political scientists the question of whether this politically preferred vision for American health care faithfully reflects the independent preferences of the grass roots, or whether it is being foisted on an unsuspecting grass roots by a small, powerful policy-making elite that knows how to manipulate grass-roots "preferences" through skillfully structured information and misinformation. Whatever the case may be, however, Germany's current approach to cost control holds few practical lessons for this emerging three-tier system. The ethical principles driving German health policy just do not square with the American way.

NOTES

1. R. Blendon et al., "Satisfaction with Health Systems in Ten Nations," *Health Affairs* (Summer 1990): 185-192; and R. Blendon et al., "Physicians' Perspectives on Caring for Patients in the United States, Canada, and West Germany," *The New England Journal of Medicine* (8 April 1994): 1011-1016.
2. See Organization for Economic Cooperation and Development, *Aging Populations: The Social Policy Implications* (Paris: OECD, 1988), Table 6.
3. U.E. Reinhardt, "Global Budgeting in German Health Care: Insight for Americans," *Domestic Affairs* (Winter 1993/94): 159-194.
4. See in this connection the PPRC's annual reports to Congress, 1993 and 1994.
5. As if to illustrate the political acceptability of such a bottom tier, Gail R. Wilensky, a frequently quoted consultant to Republican legislators, recently told the *National Journal* that "for people who can't afford [health insurance] coverage, the government might set up a separate system of health maintenance organizations or public health clinics." See J. Kosterlitz, "Going Halfway," *National Journal* (16 July 1994): 1668. It is not clear whether she intended this bottom tier to be a permanent solution, but it can be taken for granted that it would be at the hand of the U.S. Congress.