GERMAN REFORM A MODEL FOR U.S.

A Reply to Thomas Weil

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The 1993 German Health Reform Plan represents one of the few examples of consensus legislation agreed on by the ruling conservative-liberal coalition and the major opposition party (the Social Democrats). Its aim is both cost containment—the short-term objective—and fundamental reform via structural changes, mainly on the supply-side—the long-term objective.

The 1993 plan's goal was to stabilize what is generally viewed as a good system, ranking high in overall efficiency and distributive justice. The structural reforms were introduced to eliminate waste and redundancies; several measures emphasizing effectiveness and quality are yet to be implemented.

Thomas Weil's evaluative summary ("The Germans must be doing something right") emboldens me to state some similarly straightforward conclusions. The basically right decisions shaping the German health insurance and healthcare system were made long ago:

- To introduce well-nigh universal coverage
- To provide health services on the basis of need, not ability to pay
- To implement the social insurance principle on the financing side (i.e., to levy a contribution rate based on the employed members' income—irrespective of their individual health risk or the number of dependents also covered by the single payment—and to have the employer carry half the contribution burden)
- To provide an advanced standard of healthcare to all (and *not* a minimal or basic standard, to be supplemented by optional private health insurance packages)
- To provide health services in kind, without consumers' payments at point of utilization (i.e., via third-party payments from the health insurance funds)

I have restated the fundamental or strategic design principles of the German healthcare system because they are, in my judgment, the basis for the system's successes commented on by international observers. Most other mechanisms used for steering this system (which Weil describes very well) would not produce the same effects when transplanted into another country. My major message therefore is: If the United States were willing to apply similar design principles for its impending reforms, the country would in all probability obtain a more efficient and equitable healthcare system.

INTERESTING ELEMENTS OF REFORM

I am aware that the reforms likely to be chosen will not embrace fully the German or the Canadian model of healthcare. Therefore I shall comment on individual features of the 1993 German Health Reform Plan that may be of practical interest to U.S. health reformers. Since Weil has admirably and succinctly stated their major features, I shall focus only on elements that I see in a slightly different light than Weil, or that, to my mind, require further emphasis.

Insurance Fund Deficits A major concern of policymakers in spring of 1992—at the outset of deliberations leading to the 1993 plan—was the foreseeable increase in the deficit of public health insurance funds. Their overall expenses were growing at twice the rate of their revenues. Correspondingly, the stability of contribution rates was threatened precisely during the two years leading up to federal and state elections. Such increases of the contribution rates are highly unpopular, imposing burdens on employers, lowering employees' disposable income, and lowering pension increases.

The ruling conservative-liberal coalition had to do something about the impending deficits. They

obtained the support of the opposition Social Democrats by agreeing to put into effect many of the measures of structural reform advocated by Germany's Council of Health Advisors and also by the Social Democrats.

Payment Rate Freeze The "freeze" in provider payments put into effect by the 1993 plan was not an "absolute freeze" but a relative one. The respective budgets are allowed to grow at a rate that cannot be higher than that of employees' incomes (the wage bill).

Hospital Reforms Hospital reforms were included in the 1993 plan for several reasons. First, because hospital spending accounts for roughly one-third of overall health spending, any attempt at cost containment that left out the hospital would have been bound to fail.

More important, however, the division of labor between the hospitals and the other health and social services providers created a number of inefficiencies. It raised barriers between in- and out-of-hospital doctors, encouraged duplication of medical technology, and discouraged integration of general hospital and rehabilitation services. Excessive average length of stay in hospitals was another factor necessitating hospital reform.

One of Weil's points needs a twofold clarification. First, Germany had already instituted a prospective budgeting system for its hospitals—tied to the projected volume of patient days for the coming year—before the 1993 plan. However, this system was based, on the whole, on past per diem costs. Second, the transition to the new system (described by Weil in detail) will take place far more rapidly than the decade he indicated.

Constraining Costs I agree with Weil that the single-payer system as such does not lead to effective cost containment. Rather, to my mind, it is the ability to constrain providers' expansionary drive that leads to cost containment. And budgeting provider payments is only one of several possible ways of implementing such constraints.

Risks of Overfunding I am much less concerned about the risks of underfunding when total health spending is set by government mandate than the risks of overfunding when no mechanisms are in place to constrain spending. A large share of health spending evidently does not lead to a commensurate decrease in morbidity or increase in longevity (both of which evidently are determined mainly by other factors).

Prescription Caps The federally mandated cap on drug prescriptions and the liability of doctors (and of the pharmaceutical industry) for overruns thus far have had a striking effect on physicians' prescribing behavior, creating savings that have exceeded the targets set by the 1993 plan. In this point I disagree with Weil's view that the cap "by itself has limited effect in reducing health costs."

Limiting Supply of Physicians I am far less sanguine than Weil about the potential of enrollment restrictions as an instrument to limit the supply of doctors. Many Germans study medicine outside Germany and return to Germany thereafter for medical practice. Moreover, under the terms of European unification, doctors from other European countries could, under certain conditions, practice in Germany. A stringent policy curtailing the number of medical students is thus likely to discriminate against German citizens to the benefit of others.

Effect of Competition Many Germans are skeptical about the benefits likely to arise when competition for members among health insurance funds increases. They fear that different packages of health benefits (which are likely to go hand in hand with different contribution rates) will in the end lead lower-income individuals to receive lower-quality healthcare. Thus one of the major positive effects of the historical German system—utilization mainly on the basis of need—is threatened in their view. Only the future will tell whether their fears are justified.

A Model for Reform

Among the most informative parts of Weil's paper are his answers to the fundamental question, How are the Germans able to produce more desirable results at substantially lower costs than the Americans (particularly in the hospital sector)? I believe that his explanations are of considerable use to German policymakers.

But I would still like to pose the provocative question, Even if Germans are doing something right in the healthcare field, why should they not try to do it still better? The 1993 German Health Reform Plan is one answer to this question.

And if many Americans are convinced that they are doing something wrong in the healthcare field, why should they not try to learn from other countries' successes—and failures—as well? I believe that the 1993 German Health Reform Plan may provide some points of departure for such an exercise. □