A Single Health Care System for a Reunified Germany

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The signing of the German Reunification Treaty on August 31, 1990, ushered in a new era of German history. For the first time in forty-five years, Germany stood as a united nation. As the Berlin Wall fell, the German people rejoiced; but along with the jubilation came confusion and anxiety as questions of merging the two former nations' political, economic, and social systems arose. One of the greatest challenges facing German leaders at that time was the consolidation of the East and West German health care systems. While the East German system of national health service lay in a state of complete disarray, West Germany's comprehensive and compulsory health insurance scheme (commonly called statutory health insurance) ranked as one of the world's best health care systems. Legislators planned to transform the East German system into a social-insurance plan modeled on that of West Germany, but many details remained uncertain as the 16 million citizens of the former East Germany entered the West German health care system on January 1, 1991. (Katz, p. 141) Now, several years later, the success of the reunification of the former East and West German health care systems remains questionable as Germany wrestles with the problem of rising health care costs.

The current German health care system upholds the same basic principles introduced in the social insurance scheme developed by Bismarck in 1883. The initial health insurance system relied on a network of "sickness funds," which are still primarily responsible for coverage in Germany today. Sickness funds are autonomous and self-financed insurance organizations that provide a minimum package of benefits to all members. (Navarro, p. 567) Membership in sickness funds is mandatory for most of the German population, and the sickness funds take a specific percentage of a worker's earnings annually, with employees and employers splitting the premiums. (Roy, p. 1390) Through the sickness funds, most of Germany's citizens have access to a comprehensive set of medical benefits. Thus, the German system manages to provide high-quality medical care to all citizens at a cost the country considers socially acceptable. (Iglehart, p. 508) This ideal of universal access to health care at an affordable cost has guided the evolution of the German health system over the past century; even the health systems that developed in the two new German states after 1945, while drastically different, guaranteed health care to all citizens at a reasonable price. To maintain universal access to health services at an affordable cost after German reunification, numerous reforms had to be implemented in the health system. To fully comprehend the scope of these reforms and their effects on health care, it is necessary to understand the principles that have guided the development of the German health care system since its birth 112 years ago.

Evolution of the German Health Care System

Otto von Bismarck, who unified the disparate German states into a nation, is credited with founding Germany's health care system in 1883; however, the roots of Bismarck's national system of health insurance reach back to the Middle Ages, when sickness funds first developed. In medieval times,

sickness funds were cooperative organizations to which members paid fixed amounts in exchange for cash benefits in time of sickness, injury, or death. (Knox, p. 24) Since medieval medicine had little to offer, cash grants were by far the most important benefit of the sickness funds. As medical knowledge increased through the years, sickness funds began to cover the services of physicians. By the time the German states were unified into a nation in 1871, sickness funds had become the basis of a rudimentary health insurance network.

In an attempt to quell social unrest among workers emigrating to German cities during the Industrial Revolution and to check the growing strength of labor unions, Bismarck proposed a national social insurance system in 1883. The concept of a national social insurance system arose from the principle of social solidarity, which is the belief that nations are obligated to provide a strong network of social benefits to all their citizens. (Iglehart, p. 504) In regard to health care, social solidarity represents a collective agreement to share the risks and costs of a necessary good, which means that the rich subsidize the poor, the healthy support the sick, and workers help the unemployed. (Knox, p. 19) Indeed, social solidarity provided the rationale for the income-related nature of health care financing which Germany adopted in 1883.

The Health Insurance Act of 1883 gave sickness funds the responsibility of providing medical care to all blue-collar workers (Knox, P. 27); however, many Germans were subsequently excluded from the statutory health insurance scheme, such as farmers, self-employed people, pensioners, and civil servants. Revisions of the original law over the years expanded the system to cover all Germans. Under the Health Insurance Act, the sickness funds hired physicians as employees. The numerous conflicts that resulted between doctors and sickness funds eventually prompted sickness funds to turn over the money allocated to fees so that the associated physicians could divide it up among themselves. (Roy, p. 1389)

In 1931, the Weimar Settlement established associations of sickness-fund doctors to negotiate collectively with the sickness funds over reimbursement. Physicians were now organized into a bargaining monopoly against the sickness funds; the balance of power between the sickness funds and physicians had been tipped in the doctors'favor by the Weimar Settlement. (Knox, p. 34) However, the rise of Hitler and the Third Reich soon shattered that balance of power for Hitler stripped both the sickness funds and the physicians' associations of their autonomy and placed the health care system under government control.

Adolf Hitler and the National Socialists did not share Bismarck's vision of health insurance as a way to promote political stability and encourage the development of civic spirit without the loss of individuality. (Iglehart, p. 505) Instead, Hitler envisioned health insurance as a means to achieve the Third Reich's goal of a healthy, productive, fit, and racially pure German state. (Knox, p. 34) Once Hitler became chancellor in 1933, he appointed a chief to manage all the sickness funds; this move stripped the sickness funds of their autonomy. Also, the National Socialists barred non-Aryan physicians from treating sickness-fund patients and required that Aryan doctors possess a comprehensive knowledge of eugenic racial theory. (Iglehart, p. 505) Ultimately, the National Socialists succeeded in reducing the power of the sickness funds while strengthening the position of ambulatory care (office-based) physicians not associated with the sickness funds. However, after the fall of the Third Reich, sickness funds regained their central role in the health care system, at least in West Germany.

The division of Germany into two states at the conclusion of World War 11 had dramatic effects on the health insurance system. The Federal Republic of Germany (FRG or West Germany) reinstated the decentralized, largely private system of health insurance that had begun in 1883. Meanwhile, the German Democratic Republic (GDR or East Germany) adopted a strongly centralized, state-operated health care system loosely modeled on the USSR's health insurance system. Needless to say, the merging of these two systems in 1990 has posed one of the major challenges of German reunification.

To fully comprehend the problems encountered in creating one health system for reunified Germany, the structures of the former East and West German health care systems must be considered more closely.

The East German Health Care System

When the Soviets gained control of Germany's eastern sector at the end of World War 11, the health care infrastructure lay in shambles; many physicians had fled west as the Soviet Army swept into eastern Germany. (Knox, p. 242) The situation warranted immediate, decisive action to restore health care services for the citizens of East Germany. The Soviets quickly began rebuilding East Germany's health care infrastructure, for they saw this as an ideal opportunity to prove the superiority of socialist health care over "corrupt" capitalist models. Within months of the war's conclusion, the Soviets had abolished the traditional German separation between hospital and ambulatory care and established a Central Health Administration to preside over the entire health system. A Soviet decree in 1947 eliminated private practice and established a network of ambulatories (primary care centers) and polyclinics (multispecialty outpatient centers); almost all health care workers were now employees of the state and subject to its rigid rules and regulations. (Knox, p. 243) With these actions, the Soviets succeeded in creating a health care system in East Germany that structurally resembled the Soviet Union's system. However, the method of financing the system was much different from that in the Soviet Union.

East Germany maintained the Bismarckian model of universal and comprehensive health care coverage by organizing a single, state-managed health insurance network. Eighty-nine percent of the East German population were insured through the Free German Trade Union, and the other eleven percent (which included the self-employed, members of cooperatives, state employees, and their dependents) were covered by the state. (Knox, p. 243) Like the pre-war sickness funds, the insurance scheme was financed by workers, who contributed ten percent of their gross wages, and by employers, who contributed an equal amount. The state itself guaranteed the fiscal health of the plan and all benefits. Higher-income workers could secure extra benefits for an additional ten percent deduction. Dependents were automatically insured, as well as citizens in retirement or on disability, resulting in nearly universal health care coverage. (Katz, p. 144)

Initially, the East German national health service achieved some successes, most notably in the areas of maternal and child care. Since the East German government's top priority was increasing the labor pool, it was vital for women to bear children to replenish the nation's depleted stock of workers. (Knox, p. 245) Therefore, East Germany's health insurance system included an array of child-centered programs; they included child-care programs at the work site, maternal and child health care initiatives with financial inducements to encourage participation, and school health programs. Additionally, East German parents were offered monthly financial allowances for each child, interest-free housing loans, and a DM 1,000 cash bounty per infant. This birth bounty was paid in installments to expectant mothers who kept their prenatal and postnatal care appointments. (Knox, p. 245) Also, most women had the option of one-year paid maternity leave. (Scharf, P. 17) These programs did not solve East Germany's labor shortage, but they did reduce infant mortality rates and pregnancy-related maternal deaths to levels comparable with those of much wealthier nations including West Germany and the United States. (Knox, p. 249)

Although East Germany achieved some impressive public health successes in the areas of maternal and child care during the 1950s and 1960s, the 1970s began a long period of decline resulting from limited resources and an ossifying bureaucracy. (Knox, p. 241) Shortages of basic supplies such as sterile syringes, rubber gloves, and intravenous tubing often occurred, even in major hospitals. The nation's largest hospital, Berlin-Buch Hospital, also suffered severe shortages of the high-tech equipment necessary for such specialized procedures as organ transplants, open-heart surgery, and neonatal

intensive care. (Knox, p. 255) The situations in ordinary doctors' offices were even worse. Hartmut Reichwage, a 63-year-old family practitioner who practiced in the GDR, tells of working in an office with outdated medical technology and very limited access to drugs and supplies. He describes working with only "a stethoscope, a microscope for urinary sediment, a blood pressure cuff, an ear mirror - nothing else." (Knox, p. 256) By the time of reunification, the dismal state of the East German health care system contrasted sharply with the successful and efficient West German system.

The West German Health Care System

The Allied forces that controlled the western sector of Germany at World War II's end did not interfere with the health care system since the fundamentals of the system had survived the brutalities and tumult of the Third Reich relatively intact. (Knox, pp. 35-36) The Statutory Health Insurance System (SHI) of pre-war Germany reestablished its roots. The SHI was traditionally characterized by the principles of self-administration, third-party payment, and solidarity; and these principles remained intact in the postwar health care system. (Muller, p. 1658) The principle of self-administration delegated 'the responsibility of financing and providing health care to self-governing and self-regulating institutions (the sickness funds and physicians' organizations), with the federal government providing a legislative framework. (Ade et al., p. 253) The third-party payment system guaranteed that an insured person received the medical attention necessary to treat an illness without having to pay for any services directly; instead, the physician was reimbursed from the sickness fund via the regional physicians' associations. (Muller, p. 1658) The solidarity principle ensured that individuals receive all necessary medical services but contributed only according to their ability to pay; contributions from insured persons were based solely on their income, regardless of sex, age, or health risk. (Ade et al., p. 252) Since the West German health care system was extended to all of Germany upon reunification, sickness funds and physicians' organizations remain responsible for the delivery and financing of health care in Germany today. Thus, the structure of the current German health care system closely resembles that of the former West German system.

The West German health care system is highly decentralized, consisting of approximately 1,300 autonomous statutory sickness funds that insure about ninety percent of the population. The sickness funds can be divided into two groups: 1) primary funds, consisting of local funds, industrial funds, craft funds, rural funds, a sailors' fund, and a miners' fund; and 2) substitute funds, which some blue-collar workers and white-collar workers can join if they earn above a set income ceiling. (Ade et al, p. 253) Membership in the primary funds is determined mainly by place of residence or occupation. (Iglehart, p. 506) The substitute funds, however, are open only to those who qualify for membership; consequently, white-collar workers frequently have the opportunity to choose between a primary fund or a substitute fund. (Ade et al., p. 253) Although the benefits of the two funds are basically the same, substitute funds carry a degree of social prestige since membership is an emblem of higher employment status. Also, substitute funds pay doctors about twice as much as primary funds do; therefore, substitute funds are believed to buy their members better service. (Knox, p. 14)

Sickness fund members can select any ambulatory care physician as their primary physician. Upon visiting the office of their chosen physician, patients give the receptionist or secretary a treatment voucher on which the doctor notes the services provided. Patients receive only one treatment voucher per quarter; during that quarter, patients can only visit the physician who has their treatment voucher. Therefore, sickness- fund members can only visit one physician per quarter, but no limit exists on how many times the patients can visit their chosen physician. If a patient needs to see a specialist, the primary physician must give the patient a referral certificate. At the end of the quarter, primary physicians submit treatment vouchers to their regional physicians' association for reimbursement. No money passes between sickness fund members and their physicians, so in most instances the patients have no idea how much their treatment costs. (Iglehart, p. 508)

Financing the System

Sickness funds finance health care mainly from payroll deductions and from payments made by employers. The funds calculate annually the amount of money they require for self-sustained operation and then set the rate at which employees and employers contribute. (Iglehart, p. 506) Employees and employers both contribute equal payments to the funds, which are calculated as a percentage of each employee's gross income. The current deduction rate averages a combined 13 percent. Since the sickness funds do not receive additional funding from the government, they must ensure that health care costs in one period do not exceed their revenues. (Ade et al., p. 254)

Once the sickness funds collect the insurance premiums from employees and employers, they turn the money over to the regional associations of physicians, which reimburse the doctors for medical services performed on the basis of the negotiated fee schedule. All doctors who treat sickness-funds patients must be members of a regional association of physicians. These regional associations pay doctors for the care they provide, monitor their patterns of service to patients, and ensure that all sickness fund members have access to ambulatory care. (Iglehart, p. 507)

Regional physicians' associations represent only ambulatory care doctors; other types of organizations represent hospital-based physicians. These two types of organizations exhibit the clear distinction in West Germany between hospital physicians and ambulatory physicians. (von der Schulenburg, p. 1478) More than ninety percent of ambulatory care doctors are prohibited from treating patients in hospitals; likewise, most hospital-based physicians cannot treat patients on an ambulatory care basis. While ambulatory care doctors are reimbursed on a fee-for-service basis through the sickness funds, hospital-based physicians are salaried workers paid by the hospital at a level determined by specialty and seniority. The money needed to pay the salaries of hospital-based doctors comes from each hospital's operating costs. Hospitals receive their operating money from sickness funds while their capital comes mostly from state and local government contributions. (Iglehart, p. 507)

Availability and Quality of Care

As mentioned previously, roughly ninety percent of West Germany's population are covered by the statutory health insurance system. Approximately eight percent of the population have private insurance, and the remaining two percent, which consists mainly of civil servants, are covered by special government arrangements.(Ade et al., p. 253) By law, private insurance is only available to people who earn above a set income ceiling. Since private insurers often reimburse doctors at a higher rate than the SHI, higher income Germans often believe they can "buy" better health care by opting for private insurance. Once people leave the SHI, they may only return if their income drops below the ceiling again. (von der Schulenburg, p. 1474) Some people with high income choose not to participate in the SHI or buy private insurance; these people constitute the 0.5% of the West German population that have no health care coverage at all. (Ade et al., p. 253) Thus, the West German health care system succeeds in providing universal access to health care for those people who want it.

Moreover, the quality of care guaranteed to West Germans by the national health care system far surpasses that of medical services offered in all other western countries. According to Richard Knox, author of Germany's Health System, the standard package of benefits offered by the sickness funds includes:

* unlimited ambulatory physician care, generally without co-payment, including home visits;
* unlimited hospital care, with minor co-payments (for the first ten days);
* maternity care (including household help);

* prescription drugs with limited co-payments;
* medical supplies and devices;
* preventive care;
* family planning services;
* rehabilitative services, including attendants;
* periodic "rest cures" at certified health spas;
* dental care, with co-payments for dentures;
* optical services and eyeglasses;
* ambulance transport. (p. 14)

Dependents of SHI members also receive the same comprehensive coverage. (Ade et al., p. 254) This impressive list of benefits illustrates the high quality of care most West Germans have expected during the postwar era. Furthermore, West Germany has not suffered the shortage of medical equipment, supplies, and drugs that plagued East Germany; obviously this has allowed the standard of health care to be much higher in the West. Citizens of West Germany have also found high-tech care to be easily accessible, for modern medical technology is quite common throughout the country. (Knox, p. 257) Overall, the West Germans have enjoyed comprehensive medical care from a health system that most people consider to be one of the world's best.

Health Care Reforms Prior to Reunification

By the 1980s, West Germany had succeeded in meeting the four objectives that all health care systems strive for: universal access, high quality, free choice of physician, and socially acceptable cost. (Roy, p. 1389) To achieve these high standards of health care, a great deal of consensus and compromise had to occur between the sickness funds and the providers' organizations. The philosophy of consensus and compromise stems from a cultural preference that favors obtaining a compromise before deadlock occurs, a preference that is quite evident throughout German life. (Igiehart, p. 503) However, sickness funds and providers' organizations have not always been able to reach agreements without government intervention.

During the 1970s and 1980s, the West German government had to intervene in the largely private health insurance system. In an attempt to combat soaring health care costs, the government implemented a series of reforms aimed at containing costs. The first of these reforms, the Health Care Cost Containment Act of 1977, codified the cost control goals while maintaining the principle of social solidarity and establishing stability in the payroll deduction rate. The law also created the Uniform Evaluation Standard to eliminate unrestricted negotiations of physicians' service budgets between the sickness funds and the physicians' associations. The Uniform Evaluation Standard defined the schedule of charges for medical services and their relative point values so that all physicians could be reimbursed at the same rates for the same services. (Ade et al., pp. 8-9)

Further cost increases and a declining economy caused the government to implement additional cost containment acts in 1981 and 1982. The reforms included decreases in dental coverage, the number of hospital beds, and the allowed length of stay for childbirth. Also, price freezes were established for medications and medical appliances, and co-payments were instituted for some items. (Roy, p. 1391) In response to rising hospital fees, the Federal Hospital Payment Regulation of 1986 introduced prospective budgets to the sickness funds and hospitals for their approval, along with arbitration of disagreements. (Roy, p. 1391) As physician expenditures continued to grow, the West German government implemented an expenditure cap in 1987 to limit the growth in physician spending to the increase in the average German wage. (Ade et al., p. 9) The most drastic reforms of the statutory insurance system came with the Health Care Reform Act of 1989. These reforms doubled the minimum

contributions required of voluntarily insured (wealthy) patients and introduced the concept by which the patient pays up front and is reimbursed (in an attempt to increase the patient's sensitivity to costs). Furthermore, patient co-payments were increased for prescription drugs, dental prostheses, spa visits, and hospitalization. (Roy, p. 1391)

These reforms effectively controlled health care expenditures, for West Germany came the closest of all western countries during the 1980s to limiting increases in health care spending to a rate equal to the growth of its national income. (Iglehart, p. 503) But the greatest challenge of cost containment for the West German health care system loomed ahead, as reunification in 1990 introduced the 16 million citizens of the former East Germany into West Germany's health insurance network.

Unifying the Two German Health Care Systems

The reunification of Germany in 1990 revealed the dismal state of the former GDR's socialist health care system. In order to avoid social chaos in the Eastern states, a new health insurance system had to be erected quickly. Many people from both sides of the fallen Berlin Wall believed that Germany should preserve in the unified health care system some of the Eastern health care values and institutions that had worked well. However, the West German government decided to completely abolish the East German system and replace it with the West German system.

The plan for health care reunification was outlined in two treaties between the GDR and the FRG prior to reunification. Article 21 of the Treaty of May 18, 1990, between the GDR and the FRG establishing monetary, economic, and social union stated: The German Democratic Republic shall introduce all necessary measures to adapt its health insurance law to that of the Federal Republic of Germany. (Press and Information Office of the Federal Government, p. 21)

Also, Article 22 of that treaty mandates the GDR to "move towards the range of services offered in the Federal Republic of Germany with private providers..." (Press and Information Office..., p. 22) Furthermore, the Reunification Treaty of August 31, 1990, Article 33, stated: It shall be the task of legislators to create the conditions for effecting a rapid and lasting improvement in in-patient care in [East Germany] ... and for bringing it into line With the situation in the remainder of the federal territory. (Press and Information Office.... p. 84)

The provisions of these two treaties arranged for the West German health care system to extend its coverage into the Eastern states while the former East German system was dismantled.

While the plan for health care reunification appeared straightforward, complexities arose as the West German government discovered the East's crumbling health infrastructure. Medical technology in the East was far below West Germany's accustomed standards. Additionally, most of the East's hospitals had severe structural problems, including leaky roofs, inadequate sewage and sanitation facilities, dysfunctional heating systems, and dangerously outdated electrical systems. (Knox, p. 259) To bring the East's hospitals up to the standards of the West, the estimated cost was $20 billion (Iglehart, p. 1756); a much higher price was projected to completely remake the East's health care system according to Western standards. West Germany's first step in 1990 was the immediate aid program, which allocated DM 520 million ($248 million) to begin upgrading the East's failing health infrastructure. (Knox, p. 259) A more ambitious effort, termed "Soaring East," was introduced in 1990-91. It directed DM 5 billion ($2.4 billion) toward restoring and rebuilding hospitals and facilities for the elderly and disabled. Furthermore, a three-part financing program, proposed in 1993 and begun in 1995, will funnel DM 2.1 billion ($1 billion) annually to Eastern hospitals for the next decade. (Knox, p. 260) These government financing programs were aimed primarily at upgrading the East's health care infrastructure after

reunification; the next step was to organize the new financing and service-delivery systems in the East.

To finance the expansion of West Germany's health care system to the East, approximately 200 new statutory sickness funds were established in the Eastern states. These new sickness funds were modeled after West German funds both in benefits and premium levels; the premiums were initially set at 12.8 percent of gross wages, split equally between employer and employee. (Katz, p. 146) Government officials expected the new funds to have less income than the older funds in the West because of lower wage rates and higher unemployment rates in the East. To account for this discrepancy, residents of the former GDR received benefits only up to the billing rates of their local doctors, whereas the citizens of the Western states enjoyed benefits that covered any appropriate doctor, whether in the East, the West, or other countries. Although this rule stemmed from the financial goal of keeping expenditures in line with predicted fund income, it prevented an immediate collapse of the former GDR health care infrastructure. Because East Germans could not afford to pay the higher prices of West German physicians, they could not leave their own health care delivery system. (Katz, p. 147) Surprisingly, the new sickness funds had a surplus at the end of 1991 of DM 2.7 billion ($1.3 billion). The principal reasons for this surplus were that residents of the former CDR have fewer dependents than Westerners and also use their health care services less frequently. (Knox, P. 264) Thus, creating a new system of financing health care coverage in the former GDR turned out to be a relatively simple task. On the other hand, reorganizing the service-delivery system resulted in quite a struggle.

Very few physicians of the former East Germany were private practitioners. The state had employed the majority of the doctors to work in hospitals or polyclinics. This arrangement presented a unique problem to the health care reunification process, for the West German system relied mainly on private practitioners. To completely convert the Eastern system to Western standards, the polyclinics had to be dismantled in favor of private practices. The fate of polyclinics - multispecialty groups of salaried physicians working in conjunction with public health workers, social workers, physical therapists, psychologists, and other personnel - became a center of controversy. (Knox, p. 267) At the time of reunification, ninety percent of East German physicians supported polyclinics, as did most of the public. Many people argued that polyclinics should be preserved in the East's new health care system as an alternative practice mode because of their administrative efficiencies as well as the medical benefits of interdisciplinary groups. (Knox, p. 268)

Unfortunately, West Germany's government gave into the demands of providers' associations, who feared that polyclinics would end their monopoly over ambulatory care services, and ordered the polyclinics to be dismantled over a five-year period. (Knox, p. 269) Thus, physicians once employed by the state-run polyclinics had to set up private practices if they wanted to continue offering medical care. The transition of physicians from state employees to private practitioners presented numerous difficulties. To set up private practices, the doctors had to lease or purchase medical equipment, hire staff, and rent office space, things they never did previously as employees of the East German state. (Iglehart, p. 504) Western banks readily loaned money to Eastern doctors, which facilitated the conversion. Also, the Western physicians' associations coached their Eastern colleagues in all facets of the transition. Because of these measures, the conversion to private practice occurred rapidly; within the space of two years, East German medicine was transformed from an almost completely salaried, state-run enterprise to an entirely private, fee-for-service model. (Knox, p. 270) Physicians of the former GDR rapidly adjusted to the new method of health care delivery, with their greatly increased salaries being an added bonus.

Thus far, the reunification of Germany's health care system seems to be a success. Expansion of the West German system to the new Eastern states occurred quickly; three-quarters of the population of the Eastern states had comprehensive coverage by June 1991. (Knox, p. 263) Unfortunately, the hasty decisions made during the transition period eliminated some beneficial characteristics of the East

German system. For example, the strong emphasis on maternal and child health and preventive care, the hallmarks of the former East German system, should have been adopted into the unified system. Furthermore, the dismantling of the polyclinics eliminated an opportunity to increase the cooperation of in- and outpatient care which might have resulted in a reduction of hospitalization time. (von der Schulenburg, p. 1480) In retrospect, legislators might have missed an opportunity to improve Germany's health care system by eliminating these features of the East German system. However, these oversights are understandable, for the government was more concerned with the economic burden of health care reunification.

Health Care Reforms Since Reunification

For the two decades prior to reunification, West Germany attempted to regulate rising health care costs with cost control interventions. The overriding goal of the cost containment policies was to keep the average rate at which employers and employees pay premiums to the sickness funds consistent with increases in workers'wages and salaries. In essence, the West German government had declared that it had reached the limit in the proportion of the gross national product it wanted to allocate to health care. (Iglehart, p. 1751) Instead of reducing benefits or increasing patient cost-sharing requirements, the government imposed tighter controls on physicians' fees and hospital budgets. These cost containment measures had proved very effective during the 1980s in restraining the growth in medical expenditures to a rate approximately equal to the growth rate of the economy. (Iglehart, p. 1752) However, German reunification greatly increased health care expenditures. Reform of the system was once again needed to combat rising medical care costs. The first reform attempt involved replacing the expenditure-cap mechanism (established in 1987) with an expenditure-targeting mechanism. The expenditure-targeting mechanism targeted physicians' expenditures toward a yearly growth rate instead of capping the growth in physician payments each quarter by the growth in income of the sickness-fund members that quarter. The expenditure-cap mechanism limited growth in physician payment during 1992, but the increase was still greater than the growth in income per sickness-fund member. (Ade et al., p. 10) Clearly, something more needed to be done to control health care spending.

At the end of 1992, the German government passed a major health care reform package that introduced further cost control measures and made fundamental structural changes in the health care network. The package, referred to as the 1993 Health Care Reform Act, was designed to limit overall expenditures through control of the volume as well as the price of physicianservices and pharmaceuticals. (Ade et al., p. 11) Also, the law removed the limits on choice of sickness fund for certain population groups and established a financial risk equalization scheme; this allowed the sickness funds to compete against one another for members. Furthermore, the law reformed the hospital payment system. (Ade et al., p. 11) In an attempt to lessen the sharp distinction between ambulatory care and hospital care, the reform law allowed hospitals to provide outpatient care prior to hospitalization, and office-based physicians to perform certain operations outside hospitals (von der Schulenburg, p. 1478); this was the first major attempt to reform structural aspects of the German health care system.

The 1993 Health Care Reform Act contained special provisions for the new Eastern states. Growth in physician expenditure was allowed to increase by a greater percentage in the former GDR than in the Western states. (Ade et al., p. 12) Also, the Health Care Reform Act simplified the process of private capital investment in Eastern hospitals. Legislators hoped that private capital would help upgrade the East's technologically and physically inferior hospitals. (Ade et al., p. 261)

The 1993 Health Care Reform Act went into effect on January 1, 1993, and the effects were seen almost immediately. While health care costs during the first half of 1992 had risen by 11 percent relative to the previous year, expenditures in the first six months of 1993 decreased 2.7 percent from the previous year.

(Muller, p. 1660) Finally, Germany seems to have found an effective solution to the problem of rising health care costs.

Concluding Remarks

Through its turbulent 112 year existence, the German health care system has succeeded in providing universal access to medical services at a socially acceptable cost. In the ongoing battle against rising health care costs, Germany has already implemented many reforms to its system. Two more reform packages are in the works, one for 1996 and the other for the year 2000. Hopefully these two laws will be as successful as the 1993 Health Care Reform Act in stabilizing health care expenditures without trimming benefits. Prior to reunification, the citizens of West Germany enjoyed one of the most comprehensive health insurance systems in the world. Many people doubted that the system would survive the reunification process. However, the health care system "transplant," while not necessarily the best course of treatment, seems to have been successful. The patient readily accepted the "transplant" and is recuperating nicely. The long-term success of the operation remains to be determined, but the prognosis is optimistic.

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