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Achtung! After 125 Years of Success, The German Health Care System is in Code Blue

MICHAEL NELSON*

I. Introduction

In response to the noose-like financial constraints brought about by the aptly named “Great Recession” that began in late 2007, many countries find themselves attempting to cut costs and reform government spending. While superfluous programs have been cut in various countries without hesitation, others are more difficult, or are simply impossible to discontinue. For the majority of the industrialized countries of the world, health care falls into this latter category. Nevertheless, the need to cut costs has prompted health care reform discussions from China¹ to Wales.² Other countries, for example the United States, desire to improve the health care system that they already have in place. Whatever the motivation, it is common for those charged with the power to make important decisions to evaluate systems that have stood the test of time abroad, with a view towards importation.

Regarded as “one of the oldest universal health care systems in the world,”³ Germany’s health care model is often lauded for its effectiveness and cited as an example for other countries to emulate.⁴ Despite its long history of success, new factors have surfaced that are sending German health care into somewhat of a downward spiral. Looming on the

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1. *China Outlines Plan on Health Care Reform in 2009*, XINHUANET, July 24, 2009, http://news.xinhuanet.com/english/2009-07/24/content_11762276.htm.

2. *NHS Reform*, NHS, <http://www.wales.nhs.uk/sites3/home.cfm?orgid=811> (last visited Oct. 24, 2010).

3. *A Look at Global Health Care Systems*, ANDERSON COOPER AC360°, <http://ac360.blogs.cnn.com/2009/08/10/a-look-at-global-health-care-systems/> (Aug. 10, 2009, 21:16 EST).

4. *But see* Editorial, *Germany’s Hillarycare*, WASH. TIMES, Jan. 15, 2006, <http://www.washingtontimes.com/news/2006/jan/15/20060115-103622-7968r/>; *see also* Posting of Uwe E. Reinhardt, *A German Import That Could Help U.S. Health Reform*, ECONOMIX BLOG, <http://economix.blogs.nytimes.com/2009/07/24/a-german-import-that-could-help-american-health-reform/> (July 24, 2009, 22:55 EST).

horizon for 2011 is an anticipated €11 billion budget shortage in the system.⁵ Because the funding of health care is currently linked to income levels in Germany, there is alarming concern that with their “aging population, the burden on the shrinking work force will rise while the growing number of pensioners with low pension levels won’t pay enough for their health insurance.”⁶ Combined with the impact that the economic downturn has had on the work force and the increasing likelihood that the aging population will push health-care costs skyward in the years ahead, the current situation seems like nothing short of a recipe for disaster.

It is worth noting that Germany’s health care system has operated under a deficit on several occasions (for example, 1982, 1990, 1994, and as recently as 2007) and has gone through a number of reforms, but none of those shortages comes anywhere close to the current estimates for 2011.⁷ As a result, various lawmakers have called for reforms, with some of their plans being more drastic than others.⁸ But “in a country where quality universal health care is considered a basic right, such proposals are extremely controversial.”⁹ Can that basic right be saved? Do the new problems indicate that the oft-cited German model may only work under certain conditions? Or must the system be completely overhauled as Germany faces the reality of these daunting challenges?

II. The German Health Care System

In theory, there are an infinite number of possible health care “models,” but most contemporary systems can be slotted into one of a few categories depending on if: (i) doctors are government employees, (ii) the government simply pays bills, or (iii) if the government removes itself entirely from the health care process. Germany’s system appeals to many analysts because it achieves universal health coverage through the use of “sickness funds” (private sector non-profit insurance companies),¹⁰ thus avoiding the often complained about bureaucratic complexities that government-run health systems go through, like in the United Kingdom.¹¹ That is, in the United Kingdom the lion’s share of doctors are actually employed by the government, which is responsible for paying doctors’ salaries and purchasing their equipment and supplies.¹² Such is not the case in Germany.

5. Andrea Thomas, *Germany Dilutes Health-Care Reforms*, WALL ST. J., July 6, 2010, http://online.wsj.com/article_email/SB10001424052748704862404575350683343738758-lMyQjAxMTAwMDEwNDExNDQyWj.html.

6. *Id.*

7. Volker Amelung, Sherry Glied & Angela Topan, *Health Care & The Labor Market: Learning From The German Experience*, 28 J. HEALTH POL. POL’Y & L. 693, 704 (2003).

8. Vanessa Fuhrmans, *Germany Strains to Fund Health Care for All*, WALL ST. J., Nov. 18, 2009, at A7, available at <http://online.wsj.com/article/SB125849684108252695.html>.

9. *Id.*

10. See Reinhardt, *supra* note 4.

11. Posting of Nate Silver, *Not All Socialist Countries Are Alike*, FIFTYEIGHT: POLITICS DOWN RIGHT, <http://www.fivethirtyeight.com/2009/08/not-all-socialist-countries-are-alike.html> (Aug. 11, 2009, 14:42 EST).

12. *Id.*

A. THE BISMARCK MODEL

Former German Minister for Health, Ulla Schmidt, described Germany's system and its long-standing success as a function of being able to create "consensus building under a form of self-regulation . . . under general government oversight."¹³ She explained that the German "federal government provides a general legislative framework for [its] universal health insurance system . . . [b]ut precisely how to implement it is left to the experts and representatives of the various stakeholders in healthcare . . . hospitals, physicians, dentists and sickness funds."¹⁴ Important choices are not left to bureaucrats outside of the medical profession, but rather, to experts in the field who are far more knowledgeable and medically savvy than their governmental counterparts. Thus, "[n]o political committee can decide whether a new medical procedure should become part of universal coverage or not."¹⁵

Germany is not the only country with universal health coverage that has removed routine medical decisions from the bureaucratic realm. Most countries that do so, however, rely on what are known as single-payer systems "in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private."¹⁶ Countries like Australia, Canada, and Sweden have implemented single-payer systems with some success, but complaints about long wait times, difficult access, medical rationing, and administrative issues are heard with increasing frequency, while the German system, for the most part, has managed to avoid such negative reviews.¹⁷

Germany's health care system dates back to 1883, just over a decade after Otto von Bismarck forged "a disparate collection of kingdoms and duchies into the German Empire."¹⁸ For centuries before Bismarck's ascendancy, medieval craft guilds—groups of blacksmiths, goldsmiths, carpenters, and bakers—had collected and managed "sickness funds" that were distributed to their respective family members in case of injury.¹⁹ "Each guild member paid into a fund to support the families of those who became sick or injured and paid funeral expenses for those who died."²⁰ When Bismarck came to prominence in the second half of the Nineteenth Century, he wanted to discard the sickness fund model in favor of a tax-supported system in which the government could be more directly involved.²¹ Yet, even the "Iron Chancellor," as Bismarck was known, "could not prevail against the funds' powerful and well-entrenched sponsors."²² As a result, a compromise was reached in which the government could prescribe policies, but the sickness funds, as autonomous private parties, would finance and deliver the actual services; a design which

13. Reinhardt, *supra* note 4 (emphasis added).

14. *Id.*

15. *Id.*

16. *Single-Payer National Health Insurance*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.nhp.org/facts/single-payer-resources> (last visited Jan. 27, 2010).

17. David Hogberg, *The Myths of Single-Payer Health Care*, FREE MARKET CURE, <http://www.freemarketcure.com/singlepayermyths.php> (last visited Jan. 28, 2010).

18. Richard Knox, *History of Tinkering Helps German System Endure*, NPR, July 3, 2008, <http://www.npr.org/templates/story/story.php?storyId=92189596>.

19. *Id.*

20. *Id.*

21. RICHARD KNOX, *GERMANY'S HEALTH SYSTEM: ONE NATION, UNITED WITH HEALTH CARE FOR ALL* 23 (1993).

22. *Id.*

still persists today.²³ Interestingly enough, during World War II, Adolf Hitler exported the sickness fund system to the Netherlands, Belgium, and France, and despite the source, the model was so popular that after the war, these countries kept it.²⁴ It is now generally referred to as the “Bismarck Model” to distinguish it from other forms of social health insurance such as the United Kingdom’s National Health Service (NHS).²⁵

B. THE MORE THINGS CHANGE . . . THE MORE THEY STAY THE SAME

As it stands today, the German health care system (GHCS) is largely reminiscent of the scheme that existed over 125 years ago. At the heart of the system is the principle of “solidarity:” everybody is in it together, and nobody should be without health insurance.²⁶ The model is based on mandatory insurance administered by about 200 private non-profit sickness funds²⁷ and regional medical associations.²⁸ The government’s role is generally passive, “providing the statutory framework for the system and stepping in only to resolve crises” or propose necessary reforms.²⁹ Upwards of ninety percent of the population is covered by the private non-profit sickness funds, while the remaining ten percent opt to pay for private for-profit insurance, along with which comes an increased level of care.³⁰

One must qualify to opt out of the non-profit sickness fund system though, and can only do so if they earn above a certain income level or are a civil servant. Solidarity aside, as it stands right now, only Germans making €49,950 (\$72,000) or more per year may opt out of the mandatory non-profit sickness fund plans and into private for-profit insurance coverage.³¹ This is because one is considered affluent enough that such person does not need the safeguard of a sickness fund. As one analyst pointed out, the private for-profit option is “kind of a safety valve for people who want more and can pay for it.”³² Interestingly enough, Germany is only one of two countries (together with Chile) in the Western world that allows “certain socio-economic groups to opt out of an otherwise compulsory

23. *Id.*

24. Posting of Anne Underwood, *Health Care Abroad: Germany*, PRESCRIPTIONS, <http://prescriptions.blogs.nytimes.com/2009/09/29/health-care-abroad-germany/> (Sept. 29, 2009, 17:00 EST).

25. *Id.*

26. Richard Knox, *Most Patients Happy With German Health Care*, NPR, July 3, 2008, <http://www.npr.org/templates/story/story.php?storyId=91971406>.

27. German sickness funds are permitted to advertise their quality and methodology to attract members to that particular fund. However, legislation implemented in 2007 standardized the premium rate for everyone in Germany, eliminating perhaps the biggest decisive factor between funds. Even so, there is competition despite the fact that the businesses themselves are not-for-profit organizations. A combination of competition and legislation has seen the overall number of sickness funds dwindle from around 1,200 funds in 1993, to just over 200 today. See KNOX, *supra* note 21, at 13; see also Interview by T.R. Reid with Karl Lauterbach, Professor of Health, Econ. & Epidemiology at Univ. of Cologne & Member of the German Bundestag, in London, U.K. (Oct. 25, 2007), available at <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/interviews/lauterbach.html>.

28. Byron Done, *Health Care Reform & ERISA Preemption: Can The States Adopt Aspects of Germany’s Health Care System to Achieve Universal Access & Cost Containment?*, 18 HASTINGS INT’L & COMP. L. REV. 745, 748-49 (1995).

29. *Id.* at 748.

30. See Knox, *supra* note 26. Increased level of care includes private rooms, shorter waiting times, and the choice of top doctors. While the self-employed and wealthy must pay for this extra insurance, lawmakers and other civil servants receive it as part of their compensation.

31. *Id.*

32. *Id.*

social health insurance system and switch to a private insurance plan.”³³ Choosing private for-profit insurance coverage carries with it another benefit. If price is more important than quality, qualifying individuals (most often young and successful professionals) can actually save money by opting out of the public system in favor of “bare-bones” private coverage, presumably while keeping their fingers crossed that they will stay healthy.³⁴

To clarify, the GHCS is, in principle, not funded by government taxes, but it is compulsory. All German workers pay premiums of close to eight percent of their gross income to the sickness funds, which their employers then match.³⁵ Whether or not such contribution is actually a “tax” may be an issue of semantics because most economists would argue that the premium is taken entirely out of the workers’ take-home pay.³⁶ Setting aside the current problems, the system is designed so that if one is unemployed, unemployment insurance continues that person’s premiums; if one is poor, the government subsidizes the payments; and when one retires, the public pension fund makes contributions to the sickness funds on their behalf.³⁷ About a decade ago, co-payments were introduced so each doctor visit is now accompanied by a €10 fee.³⁸ Combined with those who opt out of the non-profit sickness funds, this arrangement achieves one hundred percent health coverage—the entire population of Germany.³⁹

C. CONTROLLING COSTS IS KEY

Many observers are impressed by the fact that in terms of gross domestic product (GDP), Germany only spends about ten percent on its health care system, compared with, for example, sixteen percent spent in the United States, and over eleven percent spent in France.⁴⁰ To be fair, the disparity between the percent of GDP spent in Germany when compared with the United States can partly be attributed to the variance between the two countries’ GDPs. Per capita, the United States (\$46,000) ranks eleventh among countries with a population of at least one million, while Germany (\$34,100) comes in at thirty-seventh.⁴¹ Most experts agree that there is a very close correlation between per capita GDP and health spending, so it is not altogether surprising that the United States spends

33. Christian Hagist, Inken Holldorf & Claudia Pütz, *Deductibles in Social Health Insurance Systems: Findings From Germany*, 128 *INSTITUT FÜR FINANZWISSENSCHAFT DER ALBERT-LUDWIGS-UNIVERSITÄT FREIBURG IM BREISGAU* 1 (2005).

34. *Health Insurance: Clear Diagnosis, Uncertain Remedy*, *ECONOMIST*, Feb. 18, 2010, http://www.economist.com/node/15545834?story_id=15545834.

35. Fuhrmans, *supra* note 8. Also, until recently, the GHCS premiums were split evenly between the employer and employee, but recent modifications have seen the employee’s share escalate while the employer’s part has been capped at 7.3%.

36. Underwood, *supra* note 24.

37. *Id.*

38. *Id.*

39. Posting of Niko Karvounis, *What’s New in . . . Germany?*, *HEALTH BEAT BLOG*, <http://www.healthbeat-blog.org/2008/01/whats-new-inger.html> (Jan. 30, 2008).

40. Fuhrmans, *supra* note 8.

41. *The World Factbook Country Comparison: GDP—Per Capita*, CIA, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2004rank.html?countryName=United%20States&countryCode=us®ionCode=na&rank=11#us> (last visited Oct. 24, 2010).

more.⁴² Nonetheless, even when adjusting for income, the fact that Germany has been able to keep the percentage of GDP that it spends on health care consistently low, especially when similarly situated countries cannot, is impressive.⁴³

Perhaps most interesting about Germany's ability to keep costs down is the fact that the Bismarck Model is not exactly "streamlined."⁴⁴ From its interaction with patients' employers, to its constantly changing rules and multiple sickness funds, German health care is quite complex.⁴⁵ Despite its complexity, however, certain aspects of the Bismarck Model are uncomplicated and Germany's incorporation of technology to the process has proven extremely beneficial. Physician compensation is a prime example of Germany's ability to simplify something that is difficult in most other countries.

Each year, doctors' groups, hospitals, and sickness funds negotiate budgets to which the doctors must adhere.⁴⁶ Hospital-based doctors are salaried, and after their salaries have been negotiated, the hospitals pay them for their time and the procedures that they perform.⁴⁷ Office-based doctors negotiate "collective annual budgets" that are individually debited when that doctor sees a patient or performs a procedure.⁴⁸ Note that there is no fund cushion or slush fund—when the money is gone, it is gone—a powerful incentive for doctors to restrain themselves and to not provide excessive or unnecessary care.⁴⁹ The uniform fee schedule, re-negotiated every year, has significant advantages. On the surface, physicians and hospitals do not waste time and money when negotiating rates with each fund/company.⁵⁰ Similarly, sickness funds do not have to investigate or question specific charges because (i) procedures cost the same amount everywhere, (ii) almost everyone has identical benefits, and (iii) the payment rates are uniform.⁵¹

Patient billing, like physician compensation, has also been addressed in an effort to reduce costs. All billing in Germany is done electronically, and citizens are issued cards (like credit cards) that they take to the doctor.⁵² The physician enters a code for his or her services, swipes the card, and receives payment shortly thereafter.⁵³ When a patient goes to the hospital, the hospital produces one bill for all of the patient's care.⁵⁴ There is no flood of paperwork or redundant correspondence to deal with and no questionnaires to fill out to determine if coverage will be denied. As a result, physicians save thousands of man hours, sickness funds have less bureaucratic hoops to jump through, and tons upon tons of paper are conserved—all reducing the final cost to the patient.

42. See Interview by T.R. Reid with Uwe Reinhardt, Professor of Political Econ. & Tsung-mei Cheng, Co-Founder Annual Princeton Conference on Health Policy, in Princeton, N.J. (Nov. 10, 2007), available at <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/interviews/reinhardt.html>.

43. *Id.*

44. Richard Knox, *Keeping German Doctors on a Budget Lowers Costs*, NPR, July 2, 2008, <http://www.npr.org/templates/story/story.php?storyId=91931036>.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. Underwood, *supra* note 24.

51. Knox, *supra* note 44.

52. Underwood, *supra* note 24.

53. *Id.*

54. See Interview by T.R. Reid with Uwe Reinhardt & Tsung-mei Cheng, *supra* note 42.

The simplicity that permeates Germany's method of paying for its citizens' health care, while impressive in its own right, also directly reduces the amount of money spent on administrative costs.⁵⁵ In many countries, administrative costs are a constant problem and only make the price of health care go up.⁵⁶ Every health care system in every country across the globe must deal with them—all that advertising, billing, applicant screening, phone-calling, data entry, record keeping, and other paperwork costs a lot of money.⁵⁷ But by constantly monitoring and tinkering with the health care process, Germany has been able to curtail the amount of money spent on things other than patient care.⁵⁸

All in all, Germany only spends about six cents of every health care dollar on administrative costs.⁵⁹ At the opposite end of the spectrum, the United States spends more than twenty-five cents of every dollar on administrative costs,⁶⁰ and Canada spends around fifteen cents of every dollar on them.⁶¹ Surprisingly though, Taiwan has actually outdone Germany and has achieved a rate of only two cents of every health care dollar spent on administrative costs.⁶² But Taiwan has the benefit of a small island population, and only recently constructed their health system by adopting many ideas from abroad: "like a car that was made of different parts, imported from overseas, but manufactured domestically."⁶³

Clearly, Germany is a very proactive country when it comes to taking advantage of ways to reduce the costs of health care to its citizens. But not all of Germany's methods for doing so rely on simplification and technology. The legal system also plays a significant part in the effort to keep health care costs under control. In that regard, unique medical malpractice laws have reduced the economic strain on the German medical system when compared with other parts of the world.⁶⁴

55. *Id.*

56. See Posting of Uwe E. Reinhardt, *Why Does U.S. Health Care Cost So Much (Part II: Indefensive Administrative Costs)*, *ECONOMIX*, <http://economix.blogs.nytimes.com/2008/11/21/why-does-us-health-care-cost-so-much-part-ii-indefensive-administrative-costs/> (Nov. 21, 2008, 22:34 EST).

57. Deborah Stone, *Single Payer—Good Metaphor, Bad Politics*, 34 J. HEALTH POL. POL'Y & L. 531, 536 (2009).

58. See Knox, *supra* note 18.

59. See Interview by T.R. Reid with Karl Lauterbach, *supra* note 27.

60. *Id.*

61. See Steffie Woolhandler, Terry Campbell & David U. Himmelstein, *Costs of Health Care Administration in the United States & Canada*, 349 NEW ENG. J. MED. 768, 772 (2003); but see James R. Patterson, *A Doctor's View: Bipartisan Thoughts for This Week's Health Care Debate*, OREGONLIVE, Feb. 23, 2010, http://www.oregonlive.com/opinion/index.ssf/2010/02/a_doctors_view_bipartisan_thou.html; see also Adam Oliver, *The Single-Payer Option: A Reconsideration*, 34 J. HEALTH POL. POL'Y & L. 509, 513 (2009) ("On the basis of reported estimates, it is difficult to compare administrative costs across health care systems because one never really knows if like is being compared with like. Moreover, different administrative costs are often cited for the same system").

62. T.R. Reid, *Taiwan Takes Fast Track to Universal Health Care*, NPR, Apr. 15, 2008, <http://www.npr.org/templates/story/story.php?storyId=89651916>.

63. *Id.*

64. Anne-Maree Farrell, M. Stauch, *The Law of Medical Negligence in England and Germany*, Hart Publishing, 2007, *Hardback*, £45, 17 MED. L. REV. 497, 497 (2009) (book review).

D. MEDICAL MALPRACTICE IN GERMANY

Medical liability laws, medical liability insurance, and medical malpractice damage awards have a substantial impact on the costs of health care in any country, regardless of which type of health care system is employed. Advocates of health care reform are quick to point to the negative effects created by medical malpractice litigation in countries where such proceedings are increasingly common.⁶⁵ These commentators contend that litigation over medical liability has resulted in dizzying costs, escalating liability insurance premiums for doctors, a rise in “defensive medicine,” and a general decline in the morale of health care professionals.⁶⁶ On the other hand, countries that have used their legal system to control medical malpractice damage awards have been able to control costs more effectively and do not face the financial hardships that accompany exorbitant insurance premiums.⁶⁷ Germany’s medical liability laws rely on many of the same principles that common law systems do, but there are systemic limitations not found in most common law countries that make sure the system is both equitable and efficient.

Although it is a civil law country, and despite the difference in reputation between medical liability in Germany and elsewhere, the body of laws that govern German medical malpractice shares many similarities with those of Western, common law traditions. In both systems, doctors are subject to similar bodies of rules designed to secure good practice and to reduce the chances that patients will suffer any harm at their hands.⁶⁸ Like almost every other jurisdiction that characterizes medical malpractice as “private law,” Germany uses a “fault-based” approach to liability; that is, there is no liability without fault.⁶⁹ Germans also characterize the presence of fault in a similar manner as most other jurisdictions do, requiring a breach of reasonable care, held by German courts to mean the demonstration of “the standard of care of ‘a respectable and conscientious medical professional of average expertise in the relevant field.’”⁷⁰ Finally, despite the fact that Germany utilizes the *conditio sine qua non* formula to determine if a doctor’s actions caused an injury, its method of determination is actually very similar to the common law “but-for” test.⁷¹

Notwithstanding the numerous similarities shared between the German system and other jurisdictions regarding medical malpractice policies, differences do exist. In both the laws themselves and in the system built to carry out those laws, divergences are present that make the German system unique.

65. Liam Donaldson, Chief Medical Officer, Dept. of Health (U.K.), *Making Amends: A Consultation Paper Setting Out Proposals for Reforming The Approach to Clinical Negligence in The NHS*, DEPT. OF HEALTH (U.K.), 11 (2003), http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060945.pdf.

66. Farrell, *supra* note 64, at 497-98.

67. *Id.* at 500.

68. MARC STAUCH, *THE LAW OF MEDICAL NEGLIGENCE IN ENGLAND AND GERMANY: A COMPARATIVE ANALYSIS* 4 (2008).

69. *See id.* at 26.

70. *Id.* at 36.

71. *Id.* at 49 (“Under both systems the crucial question is simply whether the defendant’s behavior affected the way things turned out, leading to harm where there would otherwise have been none. In the context of treatment malpractice claims, this means that if the patient’s injury would have occurred anyway, the claim will fail.”).

First, in Germany, medical malpractice arises not in tort, as in common law jurisdictions, but in contract.⁷² This may sound problematic if read from a common law perspective, but it is worth noting that the idea of consideration in the German civil system is not exactly analogous to its counterpart in common law. German contract law provides a higher degree of protection than German tort law. Thus, although it may be an oversimplification as it pertains to medical treatment, a contract can simply be presumed in cases of gratuitous treatment, or treatment of children or incompetent adults.⁷³ "All that is required is that the doctor indicates willingness to treat, and that the patient to be treated."⁷⁴ Another big difference is the standard of proof that applies to this aspect of German litigation.⁷⁵ To find fault, the court "must be overwhelmingly convinced . . . 'in the form of a degree of certainty that silences doubts for practical purposes, even if it does not eliminate them entirely.'"⁷⁶ This standard should sound similar to those trained in a common law jurisdiction, as it is nearly identical to the "beyond a reasonable doubt" standard in common law criminal actions; it is in fact a standard that requires more proof than, say, a "preponderance of the evidence."

There are also many differences in the German system of adjudicating medical malpractice claims that increase the system's efficiency. One such facet is the mostly-European and long-standing German practice known as "loser pays."⁷⁷ That is, the prevailing party in a lawsuit has its legal fees and court costs paid for by the losing party, greatly reducing the incentive to bring frivolous suits in the hope of a quick settlement.⁷⁸ Also, in German civil proceedings, judicial decisions are not made by a jury of one's peers, but rather, the cases are decided by professional judges who tend to be more consistent and less susceptible to being swayed by emotion.⁷⁹ In addition, if damages are to be awarded, such judges use tables prescribing damage awards, sorted by injury, as guideposts to create uniformity.⁸⁰

It is important to note, however, that the damages awarded by German judges would be considered extremely modest when viewed through the lenses of more litigious cultures.⁸¹ Really, it is rare to see any large sums of money awarded to German plaintiffs because punitive damages are not allowed in Germany.⁸² In that regard, the German view is that damages are only for the "reparation of injury and the compensation of resulting losses, while punishment of the wrongdoer is strictly reserved for criminal law."⁸³ Thus, German criminal law has become increasingly important in the regulation of the medical profes-

72. *See id.* at 11.

73. *Id.*

74. *Id.*

75. *Id.* at 65.

76. *Id.*

77. *See generally* Walter Olson & David Bernstein, *Loser-Pays: Where Next?*, 55 MD. L. REV. 1161, 1187 (1996).

78. Dan Slater, *The Debate Over Who Pays Fees When Litigants Mount Attacks*, WALL ST. J., Dec. 23, 2008, at A8, available at <http://online.wsj.com/article/SB122999187816728533.html>.

79. Edith Palmer, *Medical Malpractice Liability: Germany*, L. LIBRARY OF CONG., <http://www.loc.gov/law/help/medical-malpractice-liability/germany.php> (last visited Jan. 29, 2010).

80. *Id.*

81. *See id.*

82. *Id.*

83. Nils Jansen & Lukas Rademacher, *Punitive Damages in Germany*, 25 TORT & INS. LAW. 75, 75-76 (2009).

sion.⁸⁴ While doctors in most other countries only face economic loss in a civil suit, which accompanies high levels of malpractice insurance and increased costs to the patient, there is “a much wider scope, as well as a greater propensity, for criminal prosecutions to be pursued under German law in relation to gross medical error.”⁸⁵

More recently, some outlier cases have provided for extremely high damage awards by German standards, but it must be stressed that these are the exception and not the rule.⁸⁶ A few courts have awarded large sums of money for pain and suffering (again, compensating victims as opposed to punishing perpetrators) for malpractice claims involving newborn babies who, because of negligent medical treatment, suffered severe impairments of both their mental and physical capacities.⁸⁷ This development started in 2001 and has seen awards as high as €500,000 in some cases—a figure that, however, still seems low by some standards.⁸⁸

Perhaps the most unique aspect of the German system of medical malpractice adjudication is the existence of “medical arbitration boards.”⁸⁹ These boards were created in 1975 by a collection of regional medical councils to assist patients “in making good, well-founded claims, while encouraging the abandonment of unmerited claims.”⁹⁰ In practice, the board convenes a panel of three to five members, consisting of one lawyer and two to four doctors, who review the patients’ medical records and affidavits that have been submitted by the patient and defendant doctor.⁹¹ Marc Stauch highlights three principles that have been identified as underpinning the work of these arbitration boards:

The first is that submitting to their adjudication is voluntary. Patients thus remain free to commence legal proceedings straightaway. The doctor, too, is not required to agree to the board’s investigation—though in practice the great majority are happy to do so. Secondly, the proceedings are cost-free to the patient, being financed by the medical councils, with contributions from the relevant hospital authorities (though if the patient wishes to be legally represented, he will need to pay for that). In the third place, the board’s decision as to whether there was a faulty treatment error is not legally binding on the parties. . . . As a rule it takes around 8-14 months for them to reach their decision.⁹²

“Despite the skepticism of claimant lawyers, the available data point to the boards playing a useful role in facilitating settlement of less complex claims and the abandonment of unmerited claims”⁹³ Overall, medical arbitration boards seem to have a reputation

84. STAUCH, *supra* note 68, at 5.

85. Farrell, *supra* note 64, at 498.

86. Jorg Fedtke, *Germany*, in *EUROPEAN TORT LAW* 2004 300, 310-311 (Helmut Koziol & Barabara C. Steininger eds., 2005).

87. *Id.*

88. *See id.* (citing Oberlandesgericht Hamm [OLG Hamm] [Trial Court of Hamm] Jan. 16, 2002, 2002 Versicherungsrecht [VersR] 1163 (F.R.G.); Oberlandesgericht Hamm [OLG Hamm] [Trial Court of Hamm] May 21, 2003, 2004 Versicherungsrecht [VersR] 386 (F.R.G.)).

89. *See generally* STAUCH, *supra* note 68, at 146.

90. *Id.*

91. *Id.* at 146-47.

92. *Id.* at 147.

93. Farrell, *supra* note 64, at 501.

for neutrality; their decisions enjoy high acceptance rates and their presence has contributed to more effective risk management.⁹⁴

In sum, German laws and regulations surrounding medical malpractice liability are very similar to those present in both common law and civil law jurisdictions alike. But certain differences combined with structural hurdles that have been implemented have resulted in less litigation (both merited and frivolous) and have contributed to overall lower health care costs.⁹⁵ Although it is possible that the abhorrence of punitive damages is cultural and cannot be implemented elsewhere, the removing of complex decision making from everyday juries and the advent of medical arbitration boards certainly look ripe for foreign transplantation. Adoption of such ideas present few drawbacks, can increase judicial efficiency, and would reduce costs that invariably trickle down to patients if implemented properly.

III. The €11 Billion Problem

Despite its safeguards and history of success, the costs of maintaining the GHCS have skyrocketed in the past few years.⁹⁶ Exponentially rising medical costs and staggering unemployment levels are projected to leave the system €11 billion (\$13.9 billion) short by the start of 2011.⁹⁷ In addition, Germany's sinking birth rate combined with a rapidly aging population means that this gap will only become more disparate.⁹⁸ The shifting composition of the German population, and the rapidly rising health care costs that accompany it, must be addressed in order for the German non-profit sickness funds to have any shot at financial sustainability.⁹⁹

Modification of the German model is certainly not unheard of though. In fact, since 1980, it has been reformed in one way or another over a dozen times.¹⁰⁰ But as the deficit keeps increasing, some are no longer sure the system is salvageable.¹⁰¹ Those in charge of the country's non-profit sickness funds have gone on record to emphasize that simple premium increases and cutbacks will not solve the problem,¹⁰² but many citizens and lawmakers remain reticent to heed their advice.¹⁰³ That being said, many thought that the German health care system was beyond repair as recently as 2007.¹⁰⁴

94. STAUCH, *supra* note 68, at 148.

95. *Id.* at 130 (noting that although the *number* of claims has risen significantly in Germany since the 1970s, there is no evidence that any sort of "US-style malpractice crisis" will occur there).

96. Fuhrmans, *supra* note 8.

97. *Id.*

98. *Id.*

99. *Id.*

100. Michael Braun, *German Healthcare Reform*, MERCER HEALTH & BENEFITS PERSPECTIVE, May 26, 2009, <http://www.mercer.ie/articles/1346005>.

101. Fuhrmans, *supra* note 8.

102. Editorial, *The Stressed German Model*, WALL ST. J., Oct. 10, 2009, <http://online.wsj.com/article/SB10001424052748703746604574461573950211460.html>.

103. *Health Insurers Warn of System Breakdown*, THE LOCAL, June 30, 2010, <http://www.thelocal.de/money/20100630-28191.html>.

104. See Kyle James, *German Health Care Reform: Mission Impossible?*, DEUTSCHE WELLE, Aug. 3, 2006, <http://www.dw-world.de/dw/article/0,,2117345,00.html>.

A. THE STATUTORY HEALTH INSURANCE COMPETITION STRENGTHENING ACT OF 2007

Even though Germany's leading parties were at loggerheads about how to repair and/or streamline the GHCS for several months throughout 2007, a consensus was reached by April 1, 2007 when the Bundestag, the unicameral German parliamentary body, approved the Statutory Health Insurance Competition Strengthening Act ("the Act").¹⁰⁵ The Act introduced some minor adjustments and structural changes to the funding of the GHCS, intending to make the system more financially sustainable.¹⁰⁶ For example, the Act adjusted the premium percentages paid into the health system by employers and employees to a uniform rate, regardless of location or to which sickness fund a citizen subscribed to (prior to the Act, these amounts differed and as citizens sought to get the best bargain, the economic viability of the system suffered).¹⁰⁷ Another provision of the Act forced for-profit insurance companies that offer private insurance outside of the sickness fund system to also offer the uniform coverage that the sickness funds provide to everyone but at the newly standardized rate.¹⁰⁸ Furthermore, the Act departed from the traditional system of pooling funds by region and created a national "Health Fund" to serve as the central repository for employer/employee contributions.¹⁰⁹ In case of deficits at the national level, the Health Fund would then be supplemented by the Federal government's general tax revenue.¹¹⁰

According to the German government, the purpose behind creating the Health Fund was to pool the flat-rate contributions and then allocate that money to the respective sickness funds based on regional estimates of anticipated health expenditures for the year.¹¹¹ For example, a sickness fund with more patients undergoing cancer treatment would receive a higher allocation of resources at its discretion than a fund with a large amount of healthy young professionals despite each insured payee contributing the same percentage of their respective income.¹¹² The creation of the Health Fund was "intended to offer more transparency and competition among insurers, as well as less bureaucracy."¹¹³ But not all of Germany received the Act with open arms.

The non-profit sickness fund managers argued that the Act runs counter to the goals set out by the government since it put more power in the government's hands and gave the sickness funds serving the public less ability to compete amongst each other.¹¹⁴ To many, the plan did little to cure the system's ailments in the long term—instead of cutting bu-

105. *Merkel Announces a Deal, Averts a Crisis*, SPIEGEL, Oct. 5, 2006, <http://www.spiegel.de/international/0,1518,440924,00.html>; *Bundestag Passes Controversial Health Care Overhaul*, DEUTSCHE WELLE, Aug. 3, 2006, <http://www.dw-world.de/dw/article/0,,2335651,00.html>.

106. See Diana Ognyanova & Reinhard Busse, *Health Fund Now Operational*, HEALTH POLICY MONITOR, May 2009, http://www.hpm.org/en/Surveys/TU_Berlin_-_D/13/Health_Fund_now_operational.html.

107. See Braun, *supra* note 100.

108. See *id.*

109. See Ognyanova & Busse, *supra* note 106.

110. See *id.*

111. See *id.*

112. *Health Care System & Health Care Reform in Germany*, BUNDESMINISTERIUM FÜR GESUNDHEIT [FED. MINISTRY OF HEALTH], Apr. 15, 2009, http://www.bmg.bund.de/nn_1177806/EN/Gesundheit/gesundheit__node.html?__nnn=true.

113. Ognyanova & Busse, *supra* note 106.

114. See James, *supra* note 104.

reaucracy, it created a whole new one.¹¹⁵ Other Germans echoed such displeasure, highlighting the fact that the government would dictate what level of contribution is required, having assumed full control of the distribution of funds.¹¹⁶ One commentator went so far as to speculate that political lobbying might be behind the reform, noting that very few euros got earmarked for disease prevention when compared with treating the ill, “[D]octors get much more money for treatments. . . . [W]e need a *health care* system, not an *illness care* system.”¹¹⁷

Perhaps the most severe reaction came from the private, for-profit insurance companies after the government made it mandatory for them to offer the state’s sickness fund basic coverage, without the ability to deny membership, in addition to their premium private insurance plans. In a move that is anything but representative of the “solidarity” commonly associated with the Bismarck Model and the German principle of “health care for all,” these private insurance companies filed suit in the Federal Constitutional Court against the government claiming that their constitutional rights of occupational freedom and ownership had been breached.¹¹⁸ With language reminiscent of health care reform opponents throughout the globe, insurers including *Axa* and *Allianz* alleged that such a mandate violated their constitutional rights by “forcing people paying higher premiums to subsidize those who opt for basic coverage at lower premiums.”¹¹⁹ After much deliberation, the Federal Constitutional Court rejected the insurance companies’ arguments and declared that “coherent practicing of the profession of a private health insurer has not become impossible nor has it been made lastingly more difficult.”¹²⁰ The court went on to conclude that forcing for-profit private health insurance providers to offer basic insurance would probably have “no significant impact” on the companies’ business, and if that turned out to be wrong, Parliament may be “obligated to make a correction” to the law.¹²¹

B. PROBLEMS PERSIST

Despite some positive results brought about by the Act in its first few years, the GHCS is still in critical condition. It is possible that the steps taken thus far could have cured Germany’s health care ailments if the global economic downturn had corrected itself more quickly. But as this is not the case, additional reforms are essential. Indeed, this necessity is unsurprising considering that the costs of health care are linked to German citizens’ income levels.¹²² The natural byproduct of the decline in Germany’s economy combined with the corresponding increase in unemployment levels is a contraction of the

115. *See id.*

116. *See The German Health Fund: Patients Fall by The Wayside*, MEDICA, Nov. 20, 2008, http://www.medica.de/cipp/md_medica/custom/pub/content_lang,2/oid,26832/.

117. *Id.*

118. *See* Grundgesetz für die Bundesrepublik Deutschland [Grundgesetz] [GG] [Basic Law], May 23, 1949, BGBl. XII & XIV (Ger.); *see also* Tony Czuczka & Rainer Buerger, *German Health Insurers Lose Top-Court Case Against Basic Tariff*, BLOOMBERG, June 10, 2009, <http://www.bloomberg.com/apps/news?pid=20601100&sid=aKOsWkx5LXo>.

119. *Id.*

120. *Id.*

121. *See id.*; *see also* Bundesverfassungsgericht [BVerfG] [Federal Constitutional Court], June 10, 2009, 1 [BvR] 706/08 (F.R.G.).

122. *See* Thomas, *supra* note 5.

sickness funds' revenues. Making matters worse, the impact on the GHCS's financial situation has been compounded by an increased demand for innovative and expensive drugs and treatments.¹²³

By now, there is an air surrounding the notion of German health care reform that there is probably not a "quick-fix" remedy available. Yet, Phillip Rösler, Germany's newly elected Minister of Health, and a physician by trade, does seem to appreciate the magnitude of the task he has before him.¹²⁴ "I have a clear goal: to establish a new health-care system that works well for 80 million people," he told a German newspaper shortly after he was sworn in in October 2009; however, many were left scratching their heads as to how he thinks he will achieve that.¹²⁵ Some are more optimistic than others, but in the long term, a number of analysts predict that "Germany will . . . be forced to make painful cuts to a system that to many . . . is sacrosanct."¹²⁶

C. CONVERGING ATTITUDES ABOUT DIVERGENT PROBLEMS

Throughout its history, critics have had a great deal of difficulty finding faults with the German health care model and have touted the fact that German citizens seem to hold their health care system in extremely high regard. According to an international survey on health care systems performed by Harvard University in 1990, almost ninety percent of Germans indicated that they were "very satisfied" with the quality, personal control, waiting times, and access to technology that they had within the GHCS.¹²⁷ As recently as 2000, the World Health Organization (WHO) ranked Germany at number 25 out of 191 countries, listing the country ahead of Canada (30), Finland (31), Australia (32), Denmark (34), and the United States (37).¹²⁸ But today it appears that many Germans have changed their minds or would perhaps disagree with the WHO's assessment. As the system's inadequacies have become a more common subject of open debate and the need for reform has become more widely publicized, public opinion about the 125-plus year old Bismarck Model has suffered. Indeed, surveys and polls now paint a less-than-rosy picture of what was once the benchmark for health care models. With the system appearing to be on the brink of disaster, one cannot help but wonder if there were earlier warning signs that some people did not recognize or perhaps, ignored.

By 2009, a study presented in Berlin revealed that sixty-two percent of the population did not have a good impression of German health care services.¹²⁹ Doctors, the ones perhaps most familiar with the details of the GHCS, were even more critical with an astounding eighty-seven percent expressing displeasure when asked about the system.¹³⁰

123. *German Health Insurance Funds Face 4-bil.-Euro Deficit in 2010, Contributions to Rise*, IHS GLOBAL INSIGHT, Dec. 10, 2009, <http://www.ihsglobalinsight.com/SDA/SDADetail17992.htm>.

124. Fuhrmans, *supra* note 8; see also Tristana Moore, *Tough Task Ahead For Germany's First Asian Minister: Health Care Reform*, TIME, Oct. 29, 2009, <http://www.time.com/time/world/article/0,8599,1933169,00.html>.

125. Fuhrmans, *supra* note 8.

126. *Id.*

127. KNOX, *supra* note 21, at 8.

128. World Health Organization [WHO], *World Health Report 2000*, at 152-55 (2000), http://www.who.int/entity/whr/2000/en/whr00_en.pdf.

129. Nancy Isenson, *Study Shows Germans Losing Faith in Health Care System*, DEUTSCHE WELLE, Aug. 3, 2006, <http://www.dw-world.de/dw/article/0,,4546042,00.html>.

130. *Id.*

"More than half of those polled, both citizens and doctors, said that they believed the standard of medical services in Germany had declined in the past few years." Approximately the same number "confessed that they had concerns over whether they would be able to rely on the medical services, standards of treatment and medication in the future."¹³¹ Finally, nearly sixty percent of physicians polled admitted they had thought about leaving the public health sector in favor of a career in private health care or working abroad.¹³² As far as health care reform is concerned, the results are not much better. A survey in 2008 showed that over sixty-six percent of respondents believe that the latest health care and retirement pension system reforms are "headed in the wrong direction."¹³³

But the fact that reform to the GHCS and the policies that contribute to its functioning is a political exercise should not be forgotten. It is not surprising that public opinion of matters related to its reformation is easily swayed. But now, as a growing number of politicians squabble over their theories of reformation, a sense of malcontent towards the myriad lobbyists, medical insurers, doctors' groups, and pharmaceutical companies has become more and more evident.¹³⁴ Such unhappiness is seen most directly in one issue in particular that might have significant ramifications on the future of the GHCS. The growing gap between the quality of care received by for-profit private insurance subscribers versus those who continue to subscribe to the public non-profit sickness funds, has tempered what was once a constant flow of glowing rhetoric for some time now.

The discrepancy between coverage through for-profit private insurance and non-profit sickness funds has grown rather substantially over the years, creating what some say is a *de facto* two-class system.¹³⁵ To many, the "universal" in "universal health care" is becoming meaningless in light of the fact that the financially better-off do, in fact, receive better care—precisely what was not supposed to happen in Germany's welfare state.¹³⁶ The ten percent of the population that chooses to subscribe to private for-profit insurance get their choice of top doctors—including the chief of medicine, if one so desires.¹³⁷ When they go into the hospital, they get private rooms; when they go to the doctor, they get a free cup of coffee and can skip to the head of the line.¹³⁸ These obvious advantages, along with the fact that ten percent or so of the population can simply buy them, is irritating to those not receiving any similar perks—a fly in the ointment of equality.¹³⁹

IV. Exacerbating Factors

When boiled down to its most basic form, the challenges that the GHCS faces are not difficult to grasp. As mentioned above, the simplified version is that a variety of trends

131. *Id.*

132. *Id.*

133. Ursula Zitzler, *Nation-wide Study Gives Bad Grades to Health Care & Pension Policies in Germany—Differences Between East & West*, INNOVATIONS REPORT, Mar. 27, 2008, <http://www.innovations-report.de/html/berichte/studien/bericht-106297.html>.

134. Moore, *supra* note 124.

135. Paul Hockenos, *Is Germany's Health Care a Good Model for The US?*, GLOBALPOST, Oct. 8, 2009, <http://www.globalpost.com/dispatch/germany/091008/germanys-health-care-model?page=0,1>.

136. *Id.*

137. Knox, *supra* note 26.

138. *Id.*

139. *Id.*

have resulted in the amount of money being contributed to health care funding falling short of the amount spent on an annual basis for the treatment of the German population. But why then was the Bismarck Model able to function in Germany for so long? Is it that the current climate is just temporarily incompatible with the Bismarck Model? Were there unique circumstances that allowed Germany to operate a system that would have a hard time functioning elsewhere?

A. AGING POPULATION

Unlike some of the other factors that are straining the function ability of the GHCS, the make-up of its population is not something that people can simply ride-out or hope to correct. Instead, it is more likely that the demographic shift took a long time to develop and, unfortunately, will take a long time to fix. Most scholars attribute the change in Germany's population structure to a drop in reproduction rates between 1950 and 2000 (from 2.16 to 1.29), combined with a 10.5-year increase in life expectancy.¹⁴⁰ Compounding the problem, experts anticipate low birth rates to continue and a steady increase in life expectancy that will make an aging society even older by 2030.¹⁴¹ Today, the average age in Germany, forty-one (41), is high when compared to similarly situated countries (37.5), but experts predict that in twenty years the country's average age could be driven as high as forty-eight (48).¹⁴² The effects of an aging population put public finances, specifically the funding of health care, under great pressure.¹⁴³ In fact, the effects are two-fold and can be seen on both the expenditure side and the revenue side.¹⁴⁴ On one hand, spending on pensions, housing, and healthcare is almost certain to increase; on the other, the declining labor force means a decrease in revenues from social welfare contributions and taxation.¹⁴⁵ That is, with ever-increasing amounts of state money being spent on various facets of health care and less money being contributed to sickness funds by employed workers, Germany has gotten itself into a massive predicament.¹⁴⁶

B. RISING MEDICAL COSTS

The idea that as technology gets better, quality will increase and price will decrease, is seen very often all over the globe, most notably with mobile phones, computers, televisions, and other electronic devices. Almost everyone, regardless of his or her location, has had an experience of purchasing a new, cutting edge item, only to see it become obsolete—replaced with a better, often cheaper model within months.

But, this common experience does not extend to all sectors of the market place. Most notably, the trend seems to be exactly the opposite in the medical and health care fields.

140. *Individual Country Profile: Germany*, WORLD ECON. FORUM, <http://www.watsonwyatt.com/news/featured/wef/germany.pdf> (last visited Jan. 31, 2010).

141. *Id.*

142. *Id.*

143. Lasya M. Narasimhachari, *Germany's Economics of The Aging—Challenges & Opportunities*, FROST & SULLIVAN: ECONOMIC INSIGHTS, Feb. 2, 2004, <http://www.frost.com/prod/servlet/cif-econ-insight.pag?docid=9990566>.

144. *Id.*

145. *Id.*

146. *Id.*

As an example, consider the fight against heart disease. In the past fifty years, progress has been made slowly, step-by-step, but it has also been wildly successful.¹⁴⁷ In the 1960s, the chance of dying after suffering a heart attack was thirty to forty percent; in 1975, it had been reduced to twenty-seven percent; in 1984, it was nineteen percent; and in 1994, it was about ten percent.¹⁴⁸ Today, the chance of dying after suffering a heart attack is around six percent.¹⁴⁹ But over the same time frame, the cost for treating a heart attack increased steadily from approximately \$5,700 in 1977 to \$54,400 in 2007 (without adjusting for inflation).¹⁵⁰

In most countries health care costs are rising faster than inflation—significantly faster, in fact.¹⁵¹ Yet, just because the prices continue to escalate does not necessarily mean that patients have stopped getting the proverbial bang for their buck. Both doctors and economists have accepted this unfortunate trend because a large amount of money is spent, and necessarily so, trying to discover new and improved techniques to cure the sick.¹⁵² In other words, people who are knowledgeable in the industry believe that such expenditures are important because, while we have spent a lot, we have received a lot in return.¹⁵³ Assuming that these costs will eventually decrease would be foolhardy because there is really no economic data to back that claim.¹⁵⁴ Instead, perhaps now more than ever, doctors must practice restraint when it comes to the amount of tests they order and in selecting the supplies they use, at least in Germany, as discussed above. Nevertheless, all indications point to the fact that health care costs will continue to increase in spite of technological advances, both in Germany and everywhere else in the world.¹⁵⁵

C. THE EFFECTS OF REUNIFICATION WITH EAST GERMANY

Following the fall of the Berlin Wall in late 1989, the German Democratic Republic, more commonly referred to as East Germany, was absorbed into West Germany amid ceremony and festive celebration.¹⁵⁶ For the first time in nearly fifty years, Germany was reunified into one Federal Republic.¹⁵⁷ Clouded by the fanfare, though, was the fact that almost seventeen million people with unique perspectives, traditions, and health problems,

147. David Brown, *A Case of Getting What You Pay For: With Heart Attack Treatments, As Quality Rises, So Does Cost*, WASH. POST, July 26, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/25/AR2009072502381.html?sid=ST2009072600012>.

148. *Id.*

149. *Id.*

150. *Id.*

151. Milt Freudenheim, *Health Care Costs Rise Twice as Much as Inflation*, N.Y. TIMES, Sept. 27, 2006, http://www.nytimes.com/2006/09/27/business/27insure.html?_r=1.

152. Brown, *supra* note 147.

153. *Id.*

154. *National Health Expenditure Projections 2009–2019*, CTRS. FOR MEDICARE & MEDICAID SERVICES (Sept. 2010), <http://www.cms.gov/NationalHealthExpendData/Downloads/NHEProjections2009to2019.pdf>.

155. *Employer Health Costs to Rise in 2011*, REUTERS, Sept. 27, 2010, <http://www.reuters.com/article/idUSTRE68Q3N520100927>.

156. Kirsten Grieshaber, *20 Years Later: Where Germans Stand Without The Wall*, CHICAGO TRIBUNE, Nov. 9, 2009, <http://www.chicagotribune.com/topic/ktl-news-ap-berlinwall1109,0,5226918.story>.

157. *A Short History of German Reunification*, EMBASSY OF THE FED. REPUBLIC OF GER., LONDON, http://www.london.diplo.de/Vertretung/london/en/01/Feste/Tag_der_Deutschen_Einheit/History_of_reunification_seite.html (last visited Oct. 15, 2010).

would soon have new leadership, currency, and access to health care.¹⁵⁸ This access would come without having contributed to the Western Bismarck Model and without any reserves being set aside on their behalf. Thus, as many predicted, the reunification process had its share of problems. These problems were only exacerbated by high unemployment levels in the East and fundamental differences of opinion in how health care should be delivered, forcing German legislators into making extremely weighty decisions very quickly.

The problems with East Germany's age and sex distributions were evident right from the outset of the reunification process.¹⁵⁹ "Two world wars had 'depleted the ranks of working men, resulting in a preponderance of women over men and a worsening dependency ratio of working-age people to children and older people.'"¹⁶⁰ This trend only worsened throughout the years as millions of postwar German refugees escaped to the West, a hemorrhage that was dramatically stemmed by the 1961 construction of the Berlin Wall.¹⁶¹ By the 1970s, East Germany had become "more run-down and rigid . . . [m]orale dropped, coordination declined, and bureaucratic sclerosis set in."¹⁶² Furthermore, the economic gap between the East and West widened considerably during the 1980s.¹⁶³

Immediately after East and West Germany began the process of becoming one sovereign nation with one health care system, the Westerners had to begin a determined effort to "transform both the decrepit physical infrastructure" and the world view of health care personnel in the East.¹⁶⁴ Gloomy and worn-out clinics had to be transformed into "bright, carpeted, computer-equipped private doctors' offices."¹⁶⁵ On average, the 539 hospitals in the East were over sixty years old, and many had "severe structural problems, including leaking roofs, inadequate sewage and sanitation facilities, damaged and dysfunctional heating systems, and dangerously outmoded electrical systems."¹⁶⁶ Overall, the reunification process proved to be an expensive proposition from the West's perspective. Without delay the Federal government launched a comprehensive aid program (Soforthilfeprogramm) of DM 520 million (\$248 million) to provide for the urgent needs of the East (wheelchairs, hearing aids, ambulances, dialysis machines, hospital beds, pharmaceuticals, immediate medical care, etc.).¹⁶⁷ Hospital restoration and construction was undertaken and paid for in a three-part financing program, with DM 20 billion to DM 30 billion (\$9.6 billion to \$14.3 billion) being spent to update the dilapidated facilities.¹⁶⁸

In spite of their monumental efforts and significant tally of expenditures, the incorporation and adoption of West Germany's health care system in the East has not proven as effective as many anticipated. Problems such as low (and decreasing) life expectancy, alco-

158. *Id.*

159. KNOX, *supra* note 21, at 244-45.

160. *Id.* (quoting H.J. von Kondratowitz, *Occupational Health and the Older Worker*, in *POLITICAL VALUES AND HEALTH CARE: THE GERMAN EXPERIENCE* 499 (D.W. Light & A. Schuller eds., 1986)).

161. *Id.*

162. KNOX, *supra* note 21, at 254-55.

163. *Id.*

164. *Id.*

165. *Id.* at 242.

166. *Id.* at 258-59.

167. *Id.* at 259-60.

168. *Id.*

holism, obesity, and mortality from chronic diseases plague the eastern states at rates much higher than in the West.¹⁶⁹ While still requiring significant government subsidies to keep functioning, the health care system, like much of East Germany, has found it hard to measure up to their compatriots in the West.¹⁷⁰ As a result, for the past two decades Germany has struggled to simultaneously bootstrap its eastern states up to western standards while correcting the emerging problems in the health care structure of the "old Federal states."¹⁷¹ The ongoing funding of the East has also led to widespread resentment from westerners who see the costs of bankrolling a section of the population that does not contribute enough resources to the national sickness fund as too great of a sacrifice.¹⁷²

D. ILLEGAL MIGRANTS AND ASYLUM SEEKERS

Another issue complicating the GHCS is the increasing presence of illegal migrants. While a number of other countries also feel the effects of this trend, Germany's problems here, a direct result of their fluctuating policies regarding immigration and asylum, are fascinating. Right now an estimated one million people live throughout Germany illegally, without any personal identity documents, and as a result, have a hard time getting access to health care.¹⁷³ In Germany, one is classified as an illegal migrant if they are a foreigner that entered Germany without a residence permit or visa.¹⁷⁴ These individuals, whether transient, displaced, banished, or simply looking for a better opportunity, find themselves in a precarious position.

The principal problem for those looking to adopt Germany as their new home is that German immigration laws prevent job-seeking immigrants from even entering the country.¹⁷⁵ But in contrast to their straightforward policy against job-seeking immigrants who could poach positions from native Germans, Germany has gone from one end of the spectrum to the other in its reception and treatment of refugees and asylum seekers. Originally, as an attempt to overcome the fascist legacy of the Nazi regime, the 1949 German Constitution boasted one of the civilized world's "most liberal asylum provisions."¹⁷⁶ But after the 1990 reunification of East and West Germany, and in conjunction with the European Union's harmonization of immigration laws, asylum was granted on a much stricter basis. Already having to deal with the influx of generally less-skilled and less-healthy East Germans into the workforce, school systems, and social welfare programs, legislators

169. See Friedrich W. Schwartz & Kurt Buser, *A Tale of Two Germanys*, 331 BRIT. MED. J. 234, 234 (2005), available at <http://www.bmj.com/cgi/reprint/331/7510/234.pdf>; see also Dmitri A. Jdanov, Rembrandt D. Scholz & Vladimir M. Shkolnikov, *Official Population Statistics & The Human Mortality Database of Populations Aged 80+ in Germany & Nine Other European Countries*, 13 DEMOGRAPHIC RES. 335, 346-59 (2005), available at <http://www.demographic-research.org/volumes/vol13/14/>.

170. Stefan Berg, Steffan Winter & Andreas Wasserman, *Germany's Eastern Burden: The Price of a Failed Reunification*, SPIEGEL, Sept. 5, 2005, <http://www.spiegel.de/international/spiegel/0,1518,373639,00.html>.

171. See *id.*

172. Jin Lee, *A Millennium of Hope For Korea: Lessons From German Reunification*, 9 MICH. ST. U. & DETROIT C. L. J. INT'L L. 453, 504 (2000).

173. Hardy Graupner & Sean Sinico, *Spotlight Berlin: Illegal Immigrants & The Health Care Dilemma*, DEUTSCHE WELLE, Feb. 26, 2009, <http://www.dw-world.de/dw/article/0,,4056861,00.html>.

174. *Id.*

175. Christian Pross, *Third Class Medicine: Health Care For Refugees in Germany*, 3 HEALTH & HUM. RTS 41, 44 (1998).

176. *Id.* at 41.

feared that by accepting too many refugees, German patriotism would become diluted and too many mouths would have to be fed by the public treasury.¹⁷⁷ Thus, by 1993, asylum awards had diminished considerably as legislation was passed that made life far more difficult for disadvantaged individuals wishing to relocate to Germany.¹⁷⁸

Today, a comparison among European countries reveals that Germany is currently "at the top of the list of hardliners with respect to asylum policies."¹⁷⁹ It is followed by Switzerland, the United Kingdom, and the Netherlands, while France and Sweden have the most liberal policies.¹⁸⁰ Obviously then, when trying to enter Germany, few, if any people, declare that they are merely searching for a new job and want to live in Germany because they would immediately be turned away. Instead they cling to the sliver of hope that they could be granted refuge or asylum if they declare themselves to be in need of humanitarian assistance. But why would someone go through the rigmarole of seeking asylum if he or she were not truly a refugee? One holdover from the generous post-Nazi drafting of the German Constitution may hold the answer: according to German law, any person who is waiting for a ruling on his or her status as a refugee has access to free emergency health care.¹⁸¹ But seeking asylum in Germany is by no means an original idea. At the end of 2003, Germany had the most undecided refugee cases in the entire European Union (EU) (154,000), followed by the Netherlands (45,000), and then Sweden (35,000).¹⁸²

While not wholly unique to Germany, the issues surrounding asylum seekers and illegal immigrants create several problems. First, it invites the opportunity for a transient individual to arrive in Germany, file an application for asylum, take advantage of free emergency care at the expense of those Germans who contribute to the GHCS, and move on.¹⁸³ Others take advantage of the asylum process to immerse themselves in German culture, familiarize themselves with German customs and policies, and then cannot be found once a negative ruling on their asylum application has been made.¹⁸⁴ Finally, others avoid the asylum process completely, instead becoming an illegal immigrant in an attempt to stay off the radar of those concerned with their immigration status.¹⁸⁵ In any event, these problems result in millions of euros being spent on non-contributing patients or illegal immigrants seeking alternative sources of care, or worse, no care at all.¹⁸⁶

Judging by the massive volume of undecided refugee cases in Germany and how other countries pale in comparison, it is clear that Germany remains a very favorable destination for those seeking to improve their lives in one way or another. Obviously Germany can-

177. After reunification there was a rising sense of xenophobia; legislators took advantage to amend the constitution while championing the slogan "the boat is full." *Id.* at 42.

178. *Id.*

179. *Id.* at 44.

180. *Id.*

181. Marie Norredam, Anna Mygind & Allan Krasnik, *Ethnic Disparities in Health: Access to Health Care For Asylum Seekers in The European Union—A Comparative Study of Country Policies*, 16 EUR. J. PUB. HEALTH 285, 285 (2005), available at <http://eurpub.oxfordjournals.org/content/16/3/285.full.pdfhtml>.

182. *Id.*

183. *Id.*

184. Pross, *supra* note 175, at 42.

185. See Veysel Oezcan, *Germany: Immigration in Transition*, MIGRATION POL'Y INST., July 2004, <http://www.migrationinformation.org/Profiles/display.cfm?ID=235>.

186. Graupner & Sinico, *supra* note 173.

not simply close its doors to those who seek refuge behind its borders, but with a looming deficit that continues to balloon, many have become concerned about providing too much treatment for those who are either incapable or unwilling to pay for it.

One solution to this dilemma, albeit not looked upon favorably by everyone, has placed the onus on the doctors and hospitals that are so often called upon to treat illegal migrants.¹⁸⁷ After giving a refugee or illegal immigrant emergency care, doctors and hospitals are among those who can be subject to legal action if they fail to report to the authorities someone thought to be there illegally.¹⁸⁸ Of course, if a person does not have a visa or his or her asylum application was denied, such a report often leads to the deportation of the very person the doctor just treated.¹⁸⁹ This seemingly harsh policy has been widely criticized by doctors' groups and other organizations inside and outside of Germany.¹⁹⁰

Given the constraints that Germany is facing while trying to provide health care for its citizens, coming to a solution that would extend the GHCS's coverage to over a million more people, while desirable, may simply be unworkable.¹⁹¹ Either way, this is an issue that seems to get worse the longer that people refuse to address it. It will be interesting to see if this impending burden on an already burgeoning deficit gets characterized with the public notions of dignity and solidarity mentioned above, or with the recent trend of chastising the subsidization of non-contributors.

E. UNEMPLOYMENT AND THE RECESSION

While the details of the Great Recession are unfortunate and all-too-real for the multitude of people who find themselves in financial difficulty, it is a subject that has been covered elsewhere ad nauseam. It is not the purpose of this comment to get into causes and solutions for the current economic downturn, but this analysis would be incomplete if it failed to mention such a menacing fiscal roadblock. Germany, Europe, and the rest of the world are in dire straits; any rare bit of good news is almost instantly enveloped by the torrent of gloomy forecasts and reports. In 2009, the German economy experienced its largest contraction in the six-decade history of the Federal Republic, with its gross domestic product shrinking by 4.9%.¹⁹² Unemployment in Germany jumped from 7.8% in 2008, to 8.2% in 2009, and is currently at 10.8%—higher than it has been at any time since the fall of the Berlin Wall.¹⁹³ At the same time, leaders throughout Europe are struggling to avert the biggest financial disaster in the euro's eleven-year history.¹⁹⁴

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. Posting of Elisa Jaehner, *Illegal Immigrants in Berlin, Germany May Receive Health Care With Anonymous Insurance Card*, ERBLAWG, <http://www.erblawg.com/illegal-immigrants-in-berlin-germany-may-receive-health-care-without-repercussions-in-the-future/> (Feb. 28, 2009).

192. Nina Koeppen, *Economic Gloom Takes Halt in Germany*, WALL ST. J., Feb. 17, 2010, <http://online.wsj.com/article/SB10001424052748704804204575069223797787134.html>.

193. *The World Factbook: Germany*, CIA, <https://www.cia.gov/library/publications/the-world-factbook/geos/gm.html> (last visited Oct. 22, 2010).

194. *The Spectre That Haunts Europe*, ECONOMIST, Feb. 11, 2010, http://www.economist.com/opinion/displaystory.cfm?story_id=15500695.

Characterizing the infliction of problems by the state of the global economy as “exacerbating” is, admittedly, an understatement. There is no denying that the current recession has wreaked havoc on a number of programs in countries throughout the world, German health care notwithstanding. Because medical costs continue to go up, as discussed above, operating on a deficit is a huge problem.¹⁹⁵ This problem could continue to get worse if measures are not taken soon, as the effects of this recession, if not the recession itself, will be felt for a long time.¹⁹⁶ Identifying what measures should be taken though is far easier said than done. That is, the diagnosis of what is ailing the GHCS is quite clear, but the remedy to make it well again is frustratingly uncertain.¹⁹⁷

V. Uncertain Remedy for a Clear Problem

Considering that the problems surrounding Germany’s health care deficit have been widely broadcast, it is no wonder that over two-thirds of Germans view Germany’s health care reforms as “headed in the wrong direction.”¹⁹⁸ Whether those citizens could describe what the right direction for it to go in may perhaps be a better question. But no one, including current Minister of Health Phillip Rösler, will know the answer for sure until more definitive steps are taken. Some factors, like taxes, will undoubtedly play a role in mending the German health care system. At the same time, other potential moves can be more-or-less ruled out. That is, at this point, it is highly unlikely that the Bismarck Model would be abandoned for a Canadian-style single-payer system. But drastic changes and even cuts to the system, while opposed by many, loom on the horizon.¹⁹⁹

A. TAXES, TAXES, AND TAXES

Someone who is unfamiliar with health care costs and taxation in Germany may not understand why a modest raise in contribution rates would be ineffective, or why doing so is repeatedly referred to as burdensome.²⁰⁰ Seeing an approximation of around 8% (or currently 15.5%, if you take the employer match into account) of employee income going towards German health care, combined with the fact that the rate has not fluctuated much in over three decades, makes it seem like raising the rate a bit higher might be a good solution.²⁰¹ Certainly, Germans do not expect their contribution levels to remain fixed while medical costs are going up, reliance on technology is increasing, and inflation is

195. *Id.*

196. Marco E. Terrones, Alasdair Scott & Prakash Kannan, *Global Recession to Be Long, Deep With Slow Recovery*, INT’L MONETARY FUND, Apr. 16, 2009, <http://www.imf.org/external/pubs/ft/survey/so/2009/res041609b.htm>.

197. *Health Insurance: Clear Diagnosis, Uncertain Remedy*, *supra* note 34.

198. Zitzler, *supra* note 133.

199. Fuhrmans, *supra* note 8.

200. In this case though, the “tax” that would be raised is the fund Contribution Rate, or the “Beitragsatz.” See KNOX, *supra* note 21, at 54.

201. See, e.g., Thomas Gerlinger, *Health Care Reform in Germany*, 6(1) GERMAN POL’Y STUDIES 107, 124-25 (2010), available at <http://www.spaef.com/file.php?id=1188>; see also KNOX, *supra* note 21, at 63; Reinhard Busse, *Disease Management Programs in Germany’s Statutory Health Insurance System*, 23 HEALTH AFFAIRS 56 (2004), available at <http://content.healthaffairs.org/cgi/reprint/23/3/56.pdf>. The Statutory Health Insurance Competition Strengthening Act of 2007 created uniform, flat-rates of contribution—January 2009 at 8.2%, then July 2009 at 7.9% for employees—whereas in 1980, the average rate (depending on income, region, and

rising. But commentators who write about the GHCS tend to only mention health fund contributions in a vacuum and neglect to point out the other encumbrances already placed on German taxpayers.

In Germany, health fund contributions make up one of four deductions that are taken out of employee wages *before* an income tax is levied. Retirement (9.75%), unemployment (currently around 3%), and long-term nursing care (just under 2%) allotments are also immediately deducted from employee wages, and like sickness fund contributions, those amounts are matched by employers.²⁰² As of 2009, Germany uses a progressive income tax system with rates ranging from 15% to 45%.²⁰³ Individual incomes up to €52,152 are taxed between 15% and 42%; incomes between €52,152 and €250,000 are taxed at 42%; and income amounts over those are taxed at 45%.²⁰⁴ In addition, there is a “solidarity surcharge” tax of 5.5% (named because it was implemented to cover the costs of integrating the states of former East Germany).²⁰⁵ Like most other European countries, Germany also has a value-added-tax (“VAT”), currently 19%, that applies to goods and services available for purchase, which is supplemented by an additional sales tax on specific items such as gasoline, alcoholic beverages, tobacco products, tea, and coffee.²⁰⁶ All in all, there are approximately thirty different types of taxes that ordinarily apply to families and individuals, including taxes on inheritances, real estate, and motor vehicles.²⁰⁷

With all of these different costs diminishing the amount of income that is actually taken home, it is no wonder that the current sickness fund contribution rate is already viewed as “expensive” and as a “big chunk of . . . income.”²⁰⁸ In fact, the displeasure of parting with so much of their income has led an increasing number of Germans to misstate their earnings in an attempt to pay less taxes or to avoid paying taxes altogether by hiding money abroad.²⁰⁹ The German Tax Union, consisting of tax collectors and finance officials, estimates that tax evasion may be costing the German government some €30 billion a year in lost revenue.²¹⁰ German officials say the country’s taxpayers have about €175 billion in Swiss bank accounts, or hold about ten percent of Switzerland’s estimated \$1.8 trillion offshore-banking industry.²¹¹ Another €310 billion, officials estimate, has been deposited in Austria, Luxembourg, or the Caribbean.²¹²

German lawmakers are well aware that people are unhappy with the current tax rates. In the most recent round of Bundestag elections, many campaigns made similar promises:

fund choice) was 5.7%, in 1990, it was 6.3%, and in 2000, it was 7%. KNOX, *supra* note 21; *see also* Braun, *supra* note 100.

202. *Social Security Programs Throughout the World: Europe, 2004: Germany*, U.S. SOCIAL SECURITY ADMIN. OFFICE OF POL’Y, <http://www.ssa.gov/policy/docs/progdesc/ssptw/2004-2005/europe/germany.html> (last visited Oct. 24, 2010).

203. *Paying Taxes in Germany*, HOW TO GERMANY, <http://www.howtogermy.com/pages/germantaxes.html> (last visited Mar. 3, 2010).

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. Knox, *supra* note 26.

209. David Crawford, Vanessa Fuhrmans & Deborah Ball, *Germany Tackles Tax Evasion*, WALL ST. J., Feb. 7, 2010, <http://online.wsj.com/article/SB10001424052748704197104575051480386248538.html>.

210. *Id.*

211. *Id.*

212. *Id.*

"more money in the pockets of workers."²¹³ If taxes are lowered, one party declared, Germany "will increase tax revenues by providing more incentive to work and boosting growth."²¹⁴ In any event, analysts seem to agree that raising premiums or contributions would only be a short-term solution.²¹⁵

B. REHAB OR MAJOR SURGERY?

The multi-faceted problems plaguing the German health care system are not likely to be solved by any simple solution. It would undoubtedly be preferable to return the sickness funds to sustainable levels while making as few changes as possible. Practically speaking, it would save a great deal of confusion, explanation, and public outcry if the current system could remain intact or only slightly altered. But while the goal is a simple cure for the maladies that are ailing the GHCS, thorough analysis has failed to diagnose the problem as requiring anything less than extensive treatment. Indeed, any desire to delay corrective action must be tempered by the reality that a few slight changes may only *reduce* the impact of problems that are creating such a large deficit.²¹⁶

For example, addressing the ten percent of the population currently subscribing to for-profit private insurance plans outside of the non-profit sickness fund system could be a step in the right direction for Germany's health care deficit. Other issues aside, those ten percent divert a significant amount of money away from the sickness funds that are charged with paying for the medical needs of the less affluent and the elderly. Also, mandating that the whole population contribute to the non-profit public health funds could urge a return to the aforementioned ideal of solidarity. If their contributions were added to the public coffers, one would think that the impending deficit might not be so ominous. But eliminating private insurance options alone will not by itself solve Germany's problem, and it may not be fair to characterize an attempt at doing so as a "slight adjustment."²¹⁷ Is what is good for the goose, good for the gander, or is beauty in the eye of the beholder? Given the choice between calling it a slight modification or a wholesale change, one would think that some 8.2 million people being forced back into the non-profit sickness funds would characterize it as the latter.²¹⁸

Finding measures that can reduce costs while increasing revenues are key to the survival of the GHCS. There is no doubt that the burgeoning shortage of funds and unfavorable population trends in Germany, if left alone, will cause this problem to get worse before it gets better. Refusing to make difficult yet appropriate changes now may result in similar or worse problems in the not-so-distant future. To ensure that Germany retains its universal health coverage, Phillip Rösler, the Minister of Health, and his compatriots in the Bundestag will have to delve deeper, and quite possibly, design a whole new system.²¹⁹

213. Tristana Moore, *Fight Over Tax Cuts Looms for Merkel*, TIME, Sept. 29, 2009, <http://www.time.com/time/world/article/0,8599,1926644,00.html>.

214. *Id.*

215. See Fuhrmans, *supra* note 8.

216. See Braun, *supra* note 100.

217. *Id.*

218. See Verena Schmitt-Roschmann, *Germany Preparing for New Health Care Reform*, BUS. WEEK, Feb. 24, 2010, <http://www.businessweek.com/ap/financialnews/D9E2KEA81.htm>.

219. *Id.*

1. *Per Capita Adjustments*

Despite warnings from a number of sources, a mixture of intra-governmental disagreement and criticism from party constituents has hampered Rösler's efforts, essentially preventing the wholesale changes that seem so necessary. Those monitoring the situation have resigned to the fact that Germany will only see "watered down health-care reform . . . with higher fees and only small spending cuts instead of the sweeping overhaul promised in last year's election campaign."²²⁰ At this point, Rösler has only implemented two modifications to the GHCS, while a third, more controversial alteration, waits in the wings.²²¹ Nevertheless, despite the divisive nature of his decisions as it pertains to at least the first two changes, the disheartening observations mentioned above appear to be spot-on.

With the €11 billion deficit as the clear target, Rösler and his commission increased statutory co-payments for medical services from one percent to two percent of employees' income and also raised the contribution levels to the National Health Fund from 14.9% to 15.5% of workers' gross pay.²²² Much to the chagrin of the voting public, however, has been the one-sided focus of the reform and the lack of willingness to spread the burden of increased contribution levels more equitably. That is, the employers' share of the 15.5% has been capped at 7.3% while employees will have to pay an additional 0.6% (from 7.6% to 8.2%) of their gross wages to reach the new target.²²³ It is not surprising then that the third adjustment to the GHCS also targets each individual who is a member of the sickness funds.²²⁴ This time it is in the form of imposing an additional monthly per capita premium of €29 for all sickness fund members beginning in 2011.²²⁵ Critics have been quick to point out that this new per capita emphasis is a step in the wrong direction because the newly raised contribution levels seem likely to "burden workers, low income-earners, pensioners and students."²²⁶ But Rösler has stood firm and made clear the government's position that, at least for now, any "inevitable spending increases will be financed by additional contributions from those insured."²²⁷

Interestingly, inspiration for the imposition of a per capita fee came from the managers and coalitions of the sickness funds themselves.²²⁸ Although no number is statutorily imposed, German law allows the sickness funds to charge customers extra fees when they run out of the money allocated from the national Health Fund for each member.²²⁹ Of course, in years past, the money from the Health Fund has been sufficient to cover the

220. Thomas, *supra* note 5.

221. Patrick Hassenteufel & Tanja Klenk, *The Organizational-Institutional Transformation of the German Healthcare System: Mixing Rescaling, Privatization, & Managerialism*, (Sept. 2010) (unpublished paper prepared for 8th ESPAnet Conference 2010), http://www.espanet2010.net/en/386.file/p_Hassenteufel%20Klenk%20Espanet%202010.pdf.

222. *Id.*

223. *Id.*

224. *Id.*

225. See *Germans Flout Extra Health Insurance Fees*, THE LOCAL, Aug. 17, 2010, <http://www.thelocal.de/money/20100817-29199.html>.

226. *Critics Savage Rösler's Health Reform Plan*, THE LOCAL, July 7, 2010, <http://www.thelocal.de/politics/20100707-28337.html>.

227. Thomas, *supra* note 5.

228. See *Germans Flout Extra Health Insurance Fees*, *supra* note 225.

229. See *id.*

costs that the funds must pay to doctors and hospitals for their subscribers' care; however, in early 2010, several sickness funds began to appreciate how bleak the financial situation had become and realized that the day they would run out of money was approaching with great pace.²³⁰ Taking advantage of their ability to do so, "more than a dozen [sickness funds] began charging their members [additional] fees, which top[ped] out at €37.50 per month."²³¹ The genesis of the €29 nationwide imposition of a per capita premium for every sickness fund came about after millions of members of those sickness funds either refused to pay, or switched sickness fund membership in order to avoid the charge.²³² Undeterred by the public's reaction, Rösler envisions the per capita premium as another vehicle to chip away at the shortage of funds.²³³ If his plan is successful, efforts to avoid the fees will be futile, because they will be mandated by the German government and will apply to every sickness fund across the board.²³⁴

As could be expected, the new contribution adjustments have been blasted by opposition parties, unions, and insurers "as a failure to tackle the deep problems with the health system that would burden the poorest."²³⁵ Wolfgang Steiger, general secretary of the Economic Council of the Christian Democratic Union party poignantly pointed out that "[p]umping more money into the health system may help plug holes in the short run, but the long-term use in securing the sustainability of German health care is zero."²³⁶ But with a complete overhaul meeting intense resistance from lawmakers and the general public, some view short-term answers as extremely important until a better plan can be concocted.²³⁷ Doris Pfeiffer, head of the Association of Statutory Health Insurers recently noted that Germany's "whole [health care] system is teetering and could collapse."²³⁸ "The [sickness funds'] situation is dramatic," she continued, "this year the . . . funds are standing on the edge of the abyss. . . [n]ext year, they will take a step even closer."²³⁹

2. *What About a Transplant?*

Could Germany possibly conclude that the best course of action is to adopt another commonly used universal health system? Would it be effective for the government to take more complete control of the medical needs of their people, like the NHS does in the United Kingdom? Conversely, what about removing itself from the process a bit more, like the governments in Sweden or Canada have done with their single-payer systems? Advocates of either scheme would probably support such moves, but given Germany's unique problems, doing so would not be advantageous.

Germans have learned from experience that physicians, dentists, and hospital owners are more qualified to implement health care and know more about the costs involved than

230. *Id.*

231. *Id.*

232. *See id.*

233. *See id.*

234. *Id.*

235. *Critics Savage Rösler's Health Reform Plan*, *supra* note 226.

236. Thomas, *supra* note 5.

237. *See id.*

238. *Health Insurers Warn of System Breakdown*, *supra* note 103.

239. *Id.*

bureaucrats do.²⁴⁰ Simply put, abandoning the Bismarck Model in order to put more control in the government's hands would do nothing to assuage Germany's predicament.²⁴¹ At the other end of the spectrum, some countries' single-payer systems have been given glowing reviews at one time or another. But most observers contend that the positive aspects of single-payer systems—lower administrative costs and streamlining coverage—come at the expense of rampant bureaucracy, medical rationing, depressed innovation, and decision making by non-medical professionals.²⁴² As should be evident at this point, Germany already has low administrative costs and confusion as to who gets what coverage is a non-issue. Germany has worked hard for a long time to achieve the advantages of a universal health care system without having to pry decision-making away from experts in the medical field.²⁴³ Despite its current problems, abandoning what they have learned in the past 125-plus years to mimic systems that were spawned off of its own, especially in light of its unique situation, would not be a worthwhile endeavor.²⁴⁴

3. *Utilization of Private Insurance*

Although it has since fallen out of favor, one option that may still be revived involves giving for-profit private insurance companies a larger role, despite the inherently public nature of universal health care and the Bismarck Model.²⁴⁵ Once the "major component" of the ruling parties' coalition, Rösler and other members of the Free Democrat Party (FDP) planned on avoiding anything involving the adjective slight and seemed headed for the more drastic change end of the field.²⁴⁶ Their plan, which has since been shelved due to intra-governmental squabbling, would have initiated a departure from the traditional system of bankrolling the sickness funds.²⁴⁷ Ultimately, Mr. Rösler and his FDP partners envisioned the establishment of a basic coverage scheme for everyone that could then be augmented through the purchase of additional private insurance.²⁴⁸ In their model, health care would be funded more strongly with taxpayers' money and contributions would be based less on the income levels of subscribers.²⁴⁹

In the FDP plan there would still be universal per capita contributions, presumably lower than the amount taken with the current contribution percentages, but they would only provide a basic level of coverage.²⁵⁰ Patients would then pay additional premiums, independent of their work situation, with the government assisting the poor.²⁵¹ The FDP believes this would "unshackle health-care costs from labor costs by freezing the amount employers pay into the system and shifting from income-based contributions toward a flat-rate [per capita] health insurance premium."²⁵² Advocates of the FDP plan are con-

240. See Reinhardt, *supra* note 4.

241. See Oliver, *supra* note 61.

242. See Hogberg, *supra* note 17; see also Stone, *supra* note 57.

243. See Knox, *supra* note 18.

244. See *id.*

245. See Fuhrmans, *supra* note 8.

246. See *id.*

247. See Thomas, *supra* note 5.

248. See Fuhrmans, *supra* note 8.

249. See Thomas, *supra* note 5.

250. See Fuhrmans, *supra* note 8.

251. See Schmitt-Roschmann, *supra* note 218.

252. See Fuhrmans, *supra* note 8.

vinced that it would help reduce labor costs and would yield a more sustainable foundation for the GHCS.²⁵³ But the plan fell apart after another party "vetoed the planned income-independent component."²⁵⁴ In their eyes, and in the opinion of other opponents, the FDP plan would really only benefit businesses and high earners.²⁵⁵ Also, many characterized the FDP plan as a decided shift toward a "'two-class health-care system.'"²⁵⁶ Critics noted that "[p]atients with serious illnesses insured on the basic plan would end up financing a disproportionate share of their health care on their own, the antithesis of the Bismarck Model."²⁵⁷

Mixing private, profit-seeking insurance companies into the universal health system would be a new experience for Germany, but Germany would certainly not be the first to do so. That being said, the emergence of private health insurance in the public non-profit system would not necessarily require pulling the plug on the Bismarck Model.²⁵⁸ Private health insurance is used in a variety of countries in a variety of manners:²⁵⁹

In America . . . [and] the Netherlands . . . [private health insurance] provides primary coverage for those not on government schemes. In Australia, Britain, Ireland and New Zealand, private insurers duplicate the coverage of state-run health systems, usually offering perks like better service or shorter queues. In many countries, notably France, complementary private cover is used to top up official schemes, for example by covering out-of-pocket payments.²⁶⁰

Like Germany, these governments want to stimulate private insurance competition in the hope of solving recurring problems afflicting their national health care systems: soaring costs, problems with accessing care, and deficiencies in innovation.²⁶¹ They wish to improve their citizens' wellbeing "without tearing more holes in tattered public finances."²⁶² So far, the evidence suggests that relying on private insurance may be helpful in some respects, but on the other hand, it cannot solve every problem and may even be making some of them worse.²⁶³

There is evidence that leaning on private insurance to help control costs could lead to even more money being spent on health care. As private insurance grows to meet the demands of the public, "it will call forth extra resources . . . [in] helping to relieve the strain on state health-care systems."²⁶⁴ Advertising, adapting to the processes of the new system, and growing to meet the demand of millions of Germans that wish to supplement their basic coverage are all reasons that health care costs could increase under the Rösler/FDP plan. Although it may have to wait, it would be interesting to see if Germany's history of success in keeping costs down could experience some degree of growing pains if the FDP

253. *See id.*

254. Thomas, *supra* note 5.

255. *See* Fuhrmans, *supra* note 8.

256. *Id.*

257. *Id.*

258. *See Health Insurance: Clear Diagnosis, Uncertain Remedy*, *supra* note 34.

259. *See id.*

260. *Id.*

261. *See id.*

262. *Id.*

263. *See id.*

264. *Id.*

reforms are ever implemented. They have quite obviously ruffled some feathers though and it is unclear if a compromise is a realistic possibility or if their plan has flat-lined.²⁶⁵ Despite the apparent overwhelming necessity, opponents of making wholesale changes to the GHCS, at least in the way that the FDP proposed, may rest easier knowing that less drastic measures are being explored. As one lawmaker in the Bundestag so succinctly stated when asked about his opinion of the FDP plan, “[it is] not a model for Germany.”²⁶⁶

4. *Alternative Therapy*

Officially, Rösler and seven other legislators make up a commission responsible for drafting and putting forth whatever reform will be made to the GHCS, but that has not stopped other observers from having their two cents on the matter.²⁶⁷ One viable alternative to the per capita adjustments and the FDP proposal is known as the “Freiburg Agenda.”²⁶⁸ The men who formulated the Freiburg Agenda did so in light of the fact that Germany’s population makeup has rendered the current health model problematic, as discussed above.²⁶⁹ Hoping for reformation, the Freiburg Agenda is a three-part plan that, if implemented, is hoped to produce a sustainable health care system.²⁷⁰

First, the plan removes dental care from the public plan and leaves it to private insurance companies.²⁷¹ Second, a €900 deductible per patient would be imposed for outpatient care and pharmaceuticals.²⁷² Finally, in order to harness soaring medical costs, hospitals would be forced to negotiate for contracts transparently—by introducing price competition.²⁷³

It is interesting to note that the Freiburg Agenda and Rösler’s FDP plan both involve concerted efforts to include private insurance companies in the statutory non-profit sickness fund system. How long that will preclude more serious investigation as to each plan’s real viability is another question left for a different day. In any event, both plans propose cutting benefits that have been provided for a long time but are now becoming cost-preventative, instead of increasing fees and premiums to mount a piecemeal attack on the huge health care deficit.

The Freiburg Agenda is an interesting attempt to account for Germany’s health care problems, but it relies heavily on projections and variables that could change significantly throughout the years. Also, demanding “genuine competition” between hospitals sounds good in theory, but in practice, it would be far easier said than done.²⁷⁴ Thus, the Frei-

265. See Schmitt-Roschmann, *supra* note 218.

266. *Id.*

267. *Id.*

268. See Stefan Fetzter & Bernd Raffelhüschen, *Zur Wiederbelebung des Generationenvertrags in der gesetzlichen Krankenversicherung: Die Freiburger Agenda* [Reviving the Statutory Health Insurance Contract Between Generations: The Freiburger Agenda], 6(2) PERSPEKTIVEN DER WIRTSCHAFTSPOLITIK 255 (2005).

269. See *id.*; see also Bernd Raffelhüschen, Professor of Fin., Univ. of Freiburg, F.R.G., Speech at IAAHS-Colloquium in Dresden, Germany: Health Care Reform in Germany (Apr. 27, 2004) (presentation available at <http://www.actuaries.org/IAAHS/Colloquia/Dresden/Raffelhueschen%20presentation.pdf>).

270. See Fetzter & Raffelhüschen, *supra* note 268.

271. See *id.*

272. *Id.*

273. *Id.*

274. *Id.*

burg Agenda is close to, if not just as, controversial a plan as the one originally brought forth by the FDP. That being said, it would be fascinating to see if the Freiburg Agenda would actually cut costs and how members of the German public would react to its consideration.

With all of the complaints, opinions, options, plans, and reforms hovering around the GHCS, at least one thing is certain—the public will not receive the changes without complaint.²⁷⁵ Most of the time, Germans are very proud of their time-tested health model but they have a history of resisting proposals to modify it.²⁷⁶ Declaring reforms as unpatriotic or “not for Germany” is unsurprising. In the past, “[s]imilar protests have [successfully] broken the government’s will to push for overhauls. . . .”²⁷⁷ Worried about losing votes, some politicians have refused to take responsibility for altering the system’s structure.²⁷⁸ But now that Germany faces a crushing €11 billion deficit,²⁷⁹ it is almost shocking that minor alterations are finding more traction than the sweeping reforms that try to attack the root of the problem. Delaying inevitable changes that are crucial to the system’s functioning may prove to be extremely costly.

VI. Conclusion

Despite an unreceptive public and temporary gridlocks in the Bundestag, proponents of Germany’s Bismarck Model can take solace in the fact that it has been reformed, despite opposition, more than a dozen times in the past. More drastic steps than those being called for now have been taken in the past. But the German public cannot have its cake and eat it, too. When the numbers do not add up, attacking a reduction of benefits as “unpatriotic” is ridiculous. In fact, it is quite the opposite. Allowing the GHCS to collapse in a heap of deficit and complacency would be the real tragedy.

So what bearing does this information have on the GHCS in general and on the Bismarck Model? Well, as far as universal health models go, it is a good one as evidenced by its effectiveness over the past 125-plus years. But when a population shrinks and its average age soars, the Bismarck model suffers. When a large number of people take advantage of the system’s perks but many less contribute to its funding, the system’s once efficient operations grind to a halt. Whether a person is on pension, in the country illegally, or simply unemployed, and there are not enough people to underwrite the health care costs of a country, then the Bismarck Model and universal health care in general simply do not work. Thus, transplanting the GHCS abroad might be problematic, especially where illegal immigration problems and unemployment issues exist. Instead, the system is most successful in smaller countries with homogenous populations and low unemployment rates that keep their average age below forty. Thus, it is unsurprising that the Bismarck Model has had such success in countries like Belgium, the Netherlands, and Switzerland.

Countries that do not need to import an entire health system can still learn a lot from the GHCS; many of the GHCS cost-cutting techniques do not depend on the Bismarck Model. Replicating the German practice of electronic billing, medical malpractice re-

275. See Fuhrmans, *supra* note 8.

276. *Id.*; see Moore, *supra* note 124.

277. Fuhrmans, *supra* note 8.

278. *Id.*

279. *Id.*

form, government oversight, and utilization of non-profit insurance companies are all effective methods for reducing the health care costs that are skyrocketing around the world. Attention to detail, constant modification, and concentration on administrative costs are also helpful lessons provided by the German experience.

It is interesting to observe the wild variance of both action and rhetoric surrounding German health care and the idea of universal health care in general. Many tout the dignity and solidarity of a people that look out for their own and share health care costs evenly. Others are angered at the idea of subsidizing the cost for someone who refuses to look out for him- or herself. Some have looked at the access to health care in Germany and think that the GHCS has all the answers, while others have seen the innovation and quality in countries without universal health care, like the United States for example, and wondered if that instead is the best solution. Nevertheless, the advent of private insurance's involvement in Germany is fascinating and especially relevant, considering the ongoing health care debate in the United States. Ironically, "[i]f the trend in the U.S. over the last several years has been toward more of a European-style system, the trend in Europe is toward a system that looks more like the U.S."²⁸⁰

Obviously, neither system is perfect yet both have aspects that appeal to one group of citizens or another. The most effective model, given the recent population trends in industrialized western societies, probably lies somewhere in the middle. Rösler's FDP plan comes extremely close to this middle ground so it will be interesting to see if he is able to fully implement his ideas. If successful, history could repeat itself, and we may see others following the German lead on health care once more.

280. Michael D. Tanner, *Universal Health Care Not Best Option*, CATO INST., Feb. 23, 2009, http://www.cato.org/pub_display.php?pub_id=10011.

