



**THE GERMAN SICKNESS INSURANCE PROGRAMME 1883-1911**  
Its Relevance for Contemporary American Health Policy

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## ABSTRACT

This study describes and analyzes the German Sickness Insurance Programme in the years between its enactment in 1883 and its recodification in 1911, as part of Germany's comprehensive social insurance system. It traces the evolution of health policy between 1883 and 1911 and discusses the impact that this landmark policy had on the well-being of the German population. Although the antecedents to modern German health policy may be traced to the sixteenth century, the period between 1800 and 1911 is a watershed period. The purpose of the study is twofold: 1) to provide a detailed description of the German model for countries<sup>1</sup> without a national health service or national health insurance programme and 2) to study the changing roles of consumers and providers and the effect these changes have on access to care and cost containment, two issues which face policy makers throughout the world.

As a social political analysis, this study explores proximate rather than definitive sources and causes for policy decisions. It attempts to delineate and explicate the issues surrounding the need for and enactment of the German Sickness Insurance Act of 1883: Where did the substantive ideas originate? Were they accepted or challenged? By whom? What is the relationship between policy objectives and policy output? How was quality of life affected?

The infrastructure of medical services on which the programme relied at its inception is described as are legislative precedents for the Sickness Insurance Act of 1883. The operational aspects of the sickness insurance programme (for example, eligibility criteria, benefit design and programme financing) at the time of its implementation in 1884 are detailed. The study then focuses on the evolution of the programme (that is, changes in eligibility, benefit design and provider reimbursement) and the political and social forces which caused those changes. The interplay between consumer and provider concerns, as well as the changing level of organized input into the policy making process from these two groups is highlighted. The study concludes with an analysis of the programme's impact on the German citizenry, their access to health care and health insurance and the programme's ability to contain costs while expanding access. The analysis specifically assesses the impact that changing roles of consumers and providers have on achieving the goals of access and cost containment. The preconditions for effective implementation of a similarly structured programme elsewhere, specifically the United States, are noted.

The limited intervention of the German government in both the financing or administration of the sickness insurance programme as well as its use of a multiple payer system, enhances its political appeal for American legislators and therefore the likelihood that the model could be replicated in the United States.

"There's no single cure for what can never have a single cause."

Aldous Huxley, Island.

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## FOREWORD

The research for this study was done in several countries on two continents. The initial research was done in England. Therefore, the majority of this work involved the use of secondary sources. The resources at the London School of Economics were tapped, as were those at the Ross Institute of the London School of Tropical Health and Hygiene, the University of London Library and the British Library. This is not an all-inclusive listing of the libraries used but it does represent those in which the majority of material from British sources included in the paper, was found.

To augment this research, Professor Brian Abel-Smith of the London School of Economics arranged a research position to study primary sources in Germany. Knowing that a significant portion of the information was historical and dated from before Germany was divided after World War II, the former capital city, Berlin, was chosen.

In Berlin, primary research affiliations were established with two excellent organizations, the Medizinisches Bibliothek (Medical Library) under the direction of Herr Doktor Manfred Stuerzbecher and the Freie Universitaet Berlin. I am indebted to Professor Abel-Smith for the introduction to Herr Doktor Stuerzbecher. Dr. Stuerzbecher in turn arranged for the affiliation with the Freie Universitaet.

At these two institutions all available health, medical and policy oriented journals published between the mid nineteenth century and 1978 were reviewed. Unfortunately, neither of these two resources provided detailed statistical data from the period. Moreover, correspondence from any of the key individuals or groups involved in the development of legislation or the financing and delivery of services under the Sickness Insurance Programme was extremely limited. Newspaper reports from the period between 1883 and 1911 were also not available.

Limited statistical data was available from the Medizinisches Statistisches Amt (Bureau of Medical Statistics) in Berlin. There are several reasons for this. First, the Germans kept limited health related statistical data until the last decade of the nineteenth century. Second and perhaps most

important, the majority of the data had originally been kept at the Charity Hospital in what was East Berlin. Charity Hospital was the hospital and research institute where Rudolph Virchow, a leading nineteenth century clinician, formulator and advocate of the 1883 Sickness Insurance Act centered his activities.

Because Otto von Bismarck's career paralleled the period of this study and because of his involvement in the development of the programme, his personal archives, which are located near Hamburg, were thoroughly researched. All correspondence and news clippings related to domestic policy during the period were collected and translated. While Bismarck was intimately involved in the development of the Social Insurance Programme, which included The Sickness Insurance Act as well as laws relating to Accident (Disability) Insurance and Old Age (Retirement) Insurance, little of the material found in his personal archives related to domestic policy in general and Sickness Insurance in particular. Newspaper clippings found in the archives were slightly more helpful.

Descriptive information and statistical data was also sought from the Universities of Hamburg, Kassel, and Regensburg. Interviews were held in person or by mail and phone with several noted German researchers, including Herr Doktor Manfred Steurzbecher and Professor Florian Tennstedt. In addition, a series of interviews were conducted with Max Kornberg a centenarian who lived through the period.

While the year of research in Germany provided a great deal of information from primary sources, there is a substantial body of information which was expected to exist but was not found. Several reasons are hypothesized for the gaps in available information. It must be remembered that the majority of the data collected from this period on the Sickness Insurance Programme was stored at the Charity Hospital in what was then East Berlin. Most of the large public buildings in Berlin were destroyed during World War II. It is likely therefore that much of the data was destroyed and is no longer available. Unfortunately, access to the archives at the hospital or at the University of Berlin in the former East Germany was not permitted at that time. It was therefore difficult to assess the

availability of that information. With the 1990 reunification of Germany, additional information may now be available.

In an effort to fill in the gaps in available statistical information so that the impact of the legislation on the general health of the population and on the shape of the delivery system could be ascertained, final research efforts culminated in the United States. Some data which was written and published prior to the second World War made its way to American libraries. Secondary sources, such as the books and articles found at the Library of Congress in Washington, D.C., the New York Public Library and the Library of the American Academy of Medical Science in New York City, proved very helpful.

The analysis and writing of this study has evolved over an extended number of years with the kind, insightful and everlasting support of my mentor, Professor Brian Abel-Smith. He has coaxed and prodded and at all times remained a true ally. I am ever grateful.

I am also indebted to my parents, sisters and friends who have read the many drafts and fed my body, mind and spirit with their continued faith in me.

**INTRODUCTION**  
**THE IMPORTANCE OF THE GERMAN SICKNESS INSURANCE PROGRAMME TO**  
**AMERICAN HEALTH POLICY MAKERS**

This paper is about the German Sickness Insurance Programme which was enacted in 1883 and has not been altered significantly in over 100 years. The organization of its delivery system and financing mechanisms, and the limited involvement of government, make it an important example for American policy makers.

The United States is one of the two western industrialized nations which has not enacted a nationwide health care programme for its citizens. Policy analysts and legislators alike rarely look to proven European models when developing legislation for the United States.<sup>2</sup> While no programme could be adopted wholesale from one country to another with a different social, economic and political environment, there are many useful lessons to be learned from the experience of other countries.

Robert Evans, a Canadian writing on lessons Americans can learn from the Canadian experience, states it this way:

*"The point is that by examining others' experience you can extend your range of perceptions of what is possible. Although you cannot borrow our institutions, you can learn from their performance what outcomes are possible, as we learn from your experience. Too often debates over health care policy (in any country) are clouded by spurious allegations of technological determinism, of claims that certain patterns are impossible or inevitable. There are, of course, good sound political reasons for such claims; they distract attention and analysis from possibilities which the claimants find unattractive. They serve as a form of agenda restriction, thereby advancing particular interests...External experience can keep the agenda broader, preventing artificial foreclosure of options."<sup>3</sup>*

More technically, according to the social science literature on cross-national comparisons, an analytical study of the German model for its relevance to American health policy making would be deemed a study of "most similar systems".<sup>4</sup> Nations which are "most similar systems" typically share a broad range of factors including for example, a decentralized programme administration or a historical predilection for or against government intervention. In this case, Germany and the United States share a history of limited direct federal intervention in the provision of health services and the payment

for those services for the majority of citizens. Eligibility in both countries is typically employment-linked. An insurance programme predominates which is administered by third party organizations which collect premiums and reimburse providers. Doctors are largely paid on a fee-for-service basis. Hospitals in both countries are mostly voluntary. There are, of course, differences between the two countries which some would argue negate the "most similar systems" approach to this analysis. Perhaps the most notable difference, other than the fact the German programme was implemented over 100 years ago, is that in Germany, a doctor who cares for a patient in a hospital, is not the same doctor who provides regular primary care to the patient. In America, the doctor will follow a patient to the hospital and will, in most cases, oversee or coordinate his care there.

#### **Access and Cost Containment: Contemporary Health Policy Objectives**

During the last century, access to comprehensive health care services has been a major issue for social policy makers in almost every nation, industrialized or developing. Since 1977 however, the debate has been complicated by double digit inflation in the medical care component of the consumer price index. The focus of policy discussions has shifted to deep-seated concerns about the cost of guaranteed access.

In western Europe, where the issue of access has been addressed through a variety of national programmes, all of which provide nearly universal entitlement to a broad range of health care services, recent cost containment efforts have focused on regulatory strategies.<sup>5</sup> These strategies do not aim to restrict access through the creation of restrictive eligibility criteria. Moreover, they do not attempt to control utilization through the imposition of very large cost sharing requirements. Equitable access continues as a guiding principle in these programmes.

The United States has not implemented legislation guaranteeing access for the majority of citizens to a comprehensive range of health care services. In fact, access to health care services has decreased in the last decade as the cost of purchasing services or health insurance has increased. In 1984, about 35 million Americans were without private or government sponsored insurance. This figure represented a twenty percent increase in the number of Americans without health coverage over

the preceding five year period. <sup>6</sup> As of March 1991, the number of uninsured Americans was reported to be approximately 37.4 million or more than fourteen percent (14%) of the nation's citizenry. <sup>7</sup> The figure is as high as 22.2% in New Mexico. <sup>8</sup> In 1987, nearly 75% of the uninsured were working. <sup>9</sup> In March 1991, only 16.8% of the uninsured were non-workers. Of the remainder, 34.5% were working family heads, 21.2% were other workers and 27.5% were children. <sup>10</sup> While some of the uninsured can pay for services and some receive free care, <sup>11</sup> a 1983 analysis found that people with insurance received ninety percent (90%) more inpatient hospital care and fifty four percent (54%) more ambulatory care than the uninsured. <sup>12</sup> Moreover, in 1985, approximately thirteen percent (13%) of those with private health insurance were underinsured. <sup>13</sup>

At the same time that access to comprehensive health care services have decreased, in part due to efforts to contain increased health care costs, expenditures for health care services in the United States are expected to be \$817 billion in 1992, approximately fourteen percent of the projected gross national product. The \$817 billion figure represents an increase of 10.7% over 1991 expenditures of \$738 billion. <sup>14</sup> What is perhaps more interesting is that medical care expenditures are rising more quickly than costs for other goods and services. Since 1980, medical care costs have risen 130% while costs for other goods and services have risen sixty percent (60%). Adjusting for inflation, medical costs on a per capita basis, measured in 1990 dollars were \$2,687 in 1990 compared with \$2,372 in 1980. <sup>15</sup> As total and per capita costs increase, expanding access becomes more problematic and an approach which is national in scope, more necessary.

### **American Health Policy Initiatives**

In the 1930's, a national health care programme was proposed as part of President Franklin D. Roosevelt's social security package. Unfortunately, that part of the proposal was never enacted. President Harry S. Truman also proposed a compulsory national insurance programme during his tenure. His programme was to be funded through payroll deductions and was to provide medical and hospital care to all citizens regardless of their ability to pay. <sup>16</sup> During the 1960's, a period of revived interest in social policy issues, proposals for a nationwide health care programme were again developed. While a national programme for all Americans was not enacted, significant health

legislation for both the elderly and the poor was passed. Neither of the programmes can be considered to provide comprehensive coverage even to the limited populations which benefit from them.

Medicare, which is a federally administered programme of health insurance for the elderly and disabled, is an insurance programme designed to cover the acute needs of the elderly and disabled. Medicare benefits consist of Part A, Hospital Insurance, which is an automatic benefit to most individuals 65 and over, and Part B, Medical Insurance, a voluntary health insurance programme designed to cover the cost of physician and other ambulatory services. Part A is financed by a nationwide payroll tax. The taxes are placed in the Hospital Trust Fund. Beneficiaries are not required to pay a premium for Part A coverage. Part B coverage is voluntary. Persons eligible for Part A coverage may subscribe for Part B coverage by paying a monthly premium (set annually at 25% of the programme's cost, \$31.80 in 1992) which is deducted directly from their social security check. The premiums for Part B coverage are subsidized by the United States Treasury.

Hospital Insurance covers primarily hospital inpatient care. Once the beneficiary has paid a deductible--\$652 in 1992--Medicare will pay the first sixty days of hospitalization in each spell of illness in full. Beneficiaries who are hospitalized for longer than sixty days pay coinsurance equivalent to one fourth of the deductible--\$163 per day in 1992-- for days 60 through 90. After ninety days of hospitalization, the beneficiary may draw on a lifetime reserve of sixty days during which time the beneficiary is required to pay one half the deductible amount for each day--\$326 per day in 1992. In addition, hospital insurance covers up to 100 post-hospital days in a skilled nursing facility (SNF). Medicare provides full coverage for the first twenty days of care in a SNF. Between the 21st and the 100th day, the beneficiary is liable for a coinsurance amount equivalent to 12.5 per cent of the hospital deductible for each day he spends in a SNF. In 1992, the coinsurance amount--\$81.50 per day--is higher than the average rate for private pay patients in most parts of the country.<sup>17</sup> Given the administrative complexity of filing for Medicare benefits and the rigorous review of eligibility by the fiscal intermediaries of claims filed, many potential beneficiaries of this benefit are discouraged from applying for reimbursement for these services. Finally, Hospital Insurance also provides payment for home health care. Home health care is covered for up to 21 days per illness up to a maximum of 5 days

per week and is not subject to coinsurance. However to be covered, home health care must follow three days of hospitalization for a related illness and require the services of a skilled professional.

After beneficiaries pay an annual \$100 deductible (1992), Medical Insurance (Part B) will pay 80 per cent of "reasonable" charges for medical and health-related services, including payments to doctors, hospital outpatient facilities, and home health agencies. Interestingly, coverage is not provided for preventative health care services including physical examinations and many inoculations. Dental care and optician's services and spectacles are also not eligible for reimbursement. <sup>18</sup>

While hospitals which provide care to Medicare beneficiaries must accept government payment as payment in full, physicians treating Medicare beneficiaries for Part B services may charge beneficiaries an additional amount beyond what the government will pay. Because government reimbursement for health services has risen more slowly than the rate of inflation for medical services, fewer doctors will accept government payment as payment in full (assignment). A 1980 article by Ferry, Newton, and Hackerman, published in the Health Care Financing Review estimates that doctors accepted assignment on only 45.8% of the Part B services delivered in 1975. The percentage of doctors accepting assignment has changed little since 1975. The New York Times reported on March 1, 1992 that *"about half of all doctors have agreed to accept amounts approved by Medicare as full payment for their services"* In the late 1980's Congress enacted legislation which provides doctors with incentives to accept assignment. Immediately after the bill passed, the American Medical Association (AMA) filed a suit to overturn the legislation.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), which took effect in January 1992, set limits on what doctors were permitted to charge Medicare beneficiaries for authorized services. The impetus for this provision of OBRA 1989 was a congressional concern that new Medicare fee schedules for doctors mandated by this law would unfairly shift payment from the government to the beneficiary. To enforce this provision and protect Medicare beneficiaries, OBRA 1989 permits the federal government to impose civil penalties of \$2,000 on doctors who willfully and repeatedly overcharge. OBRA 1989 also stipulates that the doctor may be expelled from the Medicare

programme for up to five years. Unfortunately, enforcement has been lax and overcharging continues.

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In 1978, Medicare beneficiaries retained residual liability for 31 per cent of the cost of Medicare-related services and over 61 per cent for services not covered by Medicare. Clearly, and contrary to popular perception, Medicare is not a comprehensive programme.<sup>20</sup>

In 1988, Congress passed the Catastrophic Coverage Act. The Catastrophic Act as it is now commonly referred to, was designed to protect Medicare beneficiaries from the cost of extended acute and chronic illness. Advocated strongly by Secretary Bowen, the Reagan administration's overseer of federal health programmes, the Act provided for unlimited care in an acute hospital. Beneficiaries paid an annual deductible of \$560 in 1989. Copayments for acute hospital care were unlimited. Benefits for individuals requiring skilled nursing care were significantly liberalized under the Act. One hundred fifty (150) days per calendar year were covered; copayments equivalent to \$25.50 per day in 1989 were required only for the first eight days. Most significantly, no prior hospitalization was required to claim these benefits. Medicare coverage for doctor services were covered up to 100% of reasonable charges once the beneficiary paid the annual Part B deductible of \$75 in 1989 and coinsurance of \$1370. While not covered at all before, the Catastrophic Act was to provide coverage for prescription drugs. This benefit was to be phased in over a four year period beginning in 1990. Also, Home Intravenous (I.V.) Therapy and I.V. Prescription Drugs and Supplies were covered for the first time. Mammography services were also reimbursable. Home Health benefits were extended up to 38 days per illness, 7 days per week and Respite Care was allowable for reimbursement purposes up to 80 hours for chronically dependent persons needing help with at least 2 daily activities. All of these benefits were to be financed by a supplemental premium for all Part A beneficiaries based on federal tax liability.

While strongly supported by both houses of Congress at the time of its enactment, the law came under fire soon after its implementation in January 1989. Only a very small proportion of Medicare beneficiaries actually utilized the new benefits while the majority paid for the benefit. Seemingly, the original bill received popular support because there was not a clear understanding of its

cost and benefits.<sup>21</sup> The wealthier elderly who paid the greater portion of the bill for the programme, quickly mobilized lobbying support through organizations like the American Association of Retired Persons (AARP). They lobbied loudly and relentlessly for the repeal of the law. While there were several proposals to retain certain features of the expanded programme, the law was repealed in its entirety in December 1989. The vociferousness of the attacks against the programme are likely to be felt for some time and will make further legislative changes to the Medicare programme more difficult to achieve in the near future as elected officials struggle to understand what the elderly, a growing part of the voting public, want and are willing to financially support.

In contrast to the Medicare programme, Medicaid is jointly financed by the federal and state governments. The individual states are responsible for programme administration. In enacting the programme, federal legislators set up eligibility<sup>22</sup> and benefit guidelines. Each state was given the latitude to set up specific eligibility criteria and to establish a well defined set of benefits.<sup>23</sup> Consequently, there is significant variation among characteristics of the eligible population and the benefits they receive. There is no dedicated tax which supports the Medicaid programme either on the federal or state level.

In 1969, shortly after its implementation, the Medicaid programme provided coverage to 12.1 million people at a total cost of \$4.4 billion. By 1982, the number of recipients had nearly doubled to 22 million while programme costs had increased nearly 700% to \$29.9 billion. By 1992, Medicaid costs are expected to top \$80 billion.<sup>24</sup> These cost increases unfortunately parallel marked increases in the number of Americans who are uninsured. The number of people who live below the poverty line is at its highest point since the depression.<sup>25</sup> And, while Medicaid has improved the health of some of the poorest citizens,<sup>26</sup> the combination of an increasingly large population living below the poverty line and federal cutbacks to the programme under the Reagan administration means that less than 40% of Americans living below the poverty line in 1983 qualified for the programme. (This compares with 65% in 1976 who qualified.)<sup>27</sup>

Several initiatives at both the state and federal level have been attempted or proposed to make the Medicaid programme what it was originally intended to be, a "social safety net". In the early 1980's, these initiatives focused on redefining eligibility criteria and creating a new minimum benefit level which would be uniformly implemented across the nation. None of these proposals was enacted. More recently, proposals have focused on expanding benefits for specific population groups, for example, pregnant women and children or the developmentally disabled. These initiatives attempt to ameliorate immediate problems, many of which get a good deal of exposure by the press. Large scale attempts to redefine the programme have largely been ignored.

Until the late 1970's, many proposals to establish a national health insurance or service programme in the United States were introduced. However, as the cost of the Medicaid and Medicare programmes dramatically increased, congressional legislators' interest in proposals which called for universal entitlement to health care services for all Americans waned. Moreover, until the late 1980's there had been no groundswell of public support for major health care reform on a national level.<sup>28</sup>

On April 13, 1988, Massachusetts lawmakers passed a bill creating universal insurance coverage for the state. The programme will be phased in by 1992, slowly making insurance coverage available for both the employed and unemployed. Uninsured employed residents will be required to purchase policies at premiums which are earnings-related. Employers have very strong incentives to offer insurance to all employees.<sup>29</sup> The law is an important precedent for future policy discussions. It signifies renewed interest, albeit on a local level, in universal insurance. And, as is often the case (it is true for Germany and Canada among other nations), local programmes may test the waters for future national initiatives.

Interest in a national health care programme designed to insure access to care for all Americans was rekindled during the 1991 senatorial campaign in Pennsylvania. A candidate strongly supported by President George Bush (Richard Thornburgh) was upset by a democratic candidate (Harris Wofford) whose primary campaign issue was access to adequate health care. As a result, each

candidate in the 1992 campaign for the presidency of the United States has incorporated a national health care proposal into his platform of issues.

The national health policy debate during the intervening period (the late 1970's to the late 1980's) focused on mechanisms to control the cost of health care services in general; specifically it has been attempting to limit federal outlays for Medicaid and Medicare. Cost-containment measures originally focused on budgetary restraints and comprehensive health planning ( which included the Certificate of Need (CON) programme to limit capital expenditures for facility construction and purchases of high priced technological equipment). These efforts have been largely abandoned now. With the cost of medical services increasing more than ten percent annually, these cost containment efforts were labeled ineffective.<sup>30</sup>

More recently, national and state legislators have relied on restricting eligibility and increased cost-sharing to control expenditures for government sponsored programmes. The impact of these measures on the poor and elderly has been marked.<sup>31</sup> Infant mortality has increased.<sup>32</sup> The number of elderly who delay early treatment for illness because of their inability to pay deductibles and coinsurance is also growing. When these people finally do get care, their treatment is often more expensive.

The most fundamental change in federal cost containment policy during the 1980's was the Prospective Payment System (PPS). The PPS radically changed the way the federal government pays for hospital services for Medicare beneficiaries. Instead of paying hospitals on a retrospective fee-for-service basis, hospitals are paid a fixed amount per case. The amount is determined by the primary diagnosis; there are 467 diagnostic groupings called Diagnostic Related Groups or DRGs.

The PPS was phased in. Studies using data for the first year of the programme indicated that while the programme had in fact contained costs (largely through a decrease in admissions and length of stay), hospitals with superior management information systems and the resources to utilize those data to control the pattern of admissions and care to patients once admitted, achieved higher profit

margins.<sup>33</sup> As a response, the government is already discussing a DRG freeze, the political viability of which must be questioned in light of the strength of the provider lobbies.<sup>34</sup>

Concurrent with the legislation creating the PPS, the United States Congress enacted legislation permitting Medicare beneficiaries to enroll in Competitive Medical Plans (CMPs). These CMPs are HMOs or prepaid hybrids. All accept the financial risk of providing Medicare beneficiaries with mandated benefits for a fixed fee. The premium paid by the government to the plan is based on the adjusted average per capita cost (AAPCC) for beneficiaries of the same age and sex in the same geographical area. The federal government's contribution is set at 95% of the AAPCC, thereby assuring the government of savings, providing there is not excessive adverse selection or skimming of the healthy into these plans.

Employers, who pay the largest portion of health care costs in the United States next to the government, have also become interested in HMOs as a means to contain the cost of health care while preserving benefit levels, though<sup>35</sup> the majority of employers have opted for increased consumer cost-sharing to contain costs. Nonetheless, there is a definable trend towards HMOs, which place the onus of reducing utilization and costs on the providers rather than consumers. In 1970, only 2.5 million Americans were enrolled in an HMO.<sup>36</sup> By the end of 1988, according to a study by the Group Health Association of America, the national trade organization for HMOs, 32.6 million individuals were enrolled in 614 HMOs nationwide.<sup>37</sup> Membership in HMOs in 1991 was in excess of thirty five million, an increase of seventy five percent since 1985 when membership was just over twenty million.<sup>38</sup>

The American movement toward HMOs is predominantly motivated by the desire of government and employers, the primary payors, to contain costs, not to increase access. Moreover, many leading policy analysts including Alain Enthoven, an advisor to the Reagan and Bush Administrations on health policy and a leading advocate of the competitive model, suggest that costs cannot be effectively controlled without some sort of national programme.<sup>39 40</sup>

The latest effort on the part of policy makers in the United States to contain costs for the Medicare programme is the Resource-Based Relative Value Scale (RBRVS). The RBRVS is the

United States' first attempt to set price controls on services provided by doctors and other providers including physical and occupational therapists, physician assistants, nurse practitioners, nurse midwives, clinical psychologists and clinical social workers. It is the most profound change in health policy since the 1983 implementation of the Prospective Payment System (PPS).

The new payment programme was implemented on January 1, 1992 replacing a system of reimbursement by reasonable charges. The RBRVS fee schedule, also known as the Medicare Fee Schedule, will be phased in over four years. Beginning in 1996, all Medicare services provided by doctors and other ambulatory providers will be paid according to the fee schedule.

The RBRVS is actually comprised of three parts: 1) a physician work component, 2) an overhead component which is exclusive of the cost of malpractice insurance and 3) a malpractice cost component. Each of these three parts is adjusted for location. To determine the actual fee, the sum of the three parts, adjusted for location, is multiplied by a uniform national conversion factor.

The new reimbursement programme was designed not only to contain costs but also to more equitably distribute resources among doctors with different types of practices. Most notably, this system will better compensate general or family practitioners and practices located in rural areas. The new programme includes a massive data collection effort. The Health Care Finance Administration (HCFA) will accumulate nationally coded data on doctors' services. Some are predicting that with this data base and the one which has resulted from the implementation of PPS for hospital payment, the federal government of the United States will seek to bundle payments for all services provided to Medicare beneficiaries. To whom that payment will be made will determine not only the shape of our delivery system but our ultimate ability to control costs. <sup>41</sup>

What type of unified national programme might meet the twin objectives of access and cost containment? How should such a programme be organized? What role will providers, consumers, employers and government play and how will these players influence the design of the programme and hence its outcomes: access to care, the cost of care and the quality of care as well as health status? Should the United States draw on the experience of other western industrialized countries? <sup>42</sup>

## Models for National Health Care Programmes

In the autumn of 1988, three surveys were conducted by Louis Harris and Associates in conjunction with the Harvard School of Public Health. Using the same research instrument, the surveys asked over 1,000 adults in each of America, Canada and Britain what they felt about obtaining medical care services and their views on the performance of their nation's health care system. As Robert Blendon and Humphrey Taylor reported in the Spring 1989 issue of Health Affairs:

*"Of the three nations surveyed, Americans express the greatest degree of dissatisfaction with their health care system. Most Americans (89 percent) see the need for fundamental change in the direction and structure of the U.S. health system. Only 10 percent agree with the statement that "on the whole, the health care system works pretty well." <sup>43</sup>*

In contrast, 27% of the Britons and 56% of the Canadians surveyed agreed with the notion that the system in place in their respective nations, worked "pretty well".<sup>44</sup>

These changes in public opinion coupled with changes in the way America is financing and delivering care to its citizens are, according to Jonathan Weiner of Johns Hopkins University, *"increasing rather than decreasing the relevance of comparative analyses with government sponsored systems (of northwest Europe)".<sup>45</sup>*

Most European health care programmes guarantee access to a wide range of health care services and are able to implement effective cost containment measures. The British programme, the National Health Service, is perhaps the best example of a national health service model. Every British resident is entitled to available health services with relatively modest user fees. The programme is funded mainly through taxation. The government contracts with primary care doctors and pays them directly as independent providers on a capitation basis. Hospitals operate according to established budgets; hospital doctors are, part-time and full-time salaried, though all are allowed some private practice. While funding and overall control of the programme is centralized with the national government, day-to-day management is decentralized to 17 regions throughout England, Scotland, Northern Ireland and Wales.<sup>46</sup> The programme, while one of the broadest in terms of entitlement and coverage in Europe, is also the least expensive.<sup>47</sup> In contrast to health care spending in the United

States which has exceeded twelve percent (12%) of the gross national product,<sup>48</sup> Britain is spending just over one half that amount (as expressed as a percentage of gross national product).<sup>49</sup> This excellent track record is due in large part to the centralization of the financing programme which enables the government effectively to control expenditures. Unfortunately, the high degree of government intervention associated with the programme make it an unlikely model for the Americans to adopt.

Interestingly, in part due to a report published in 1985 by American scholar and policy analyst Alain Enthoven,<sup>50</sup> a series of reforms to the National Health Service with perhaps significant long-term ramifications have been implemented. After attempting to change the managerial structure of the National Health Service based on recommendations made in the Griffiths Report in 1983, the government of Prime Minister Margaret Thatcher came under great pressure from the medical profession. This was not surprising; the reforms called for the implementation of productivity targets. The British medical profession previously enjoyed complete autonomy in service provision in exchange for working within state set budgetary limits. The reforms threatened to alter the balance between the profession and the system's managers. In 1987, the president of the Royal College of Medicine issued a public statement that the National Health Service was at or near ruin. Prime Minister Thatcher was so infuriated that she began the process of change which resulted in a January 1989 White Paper, "Working for Patients". This paper made conclusions and proposals strikingly similar to those laid out by Enthoven in 1985. The White Paper led to the National Health Service and Community Care Act which received approval on June 29, 1990 and was implemented on April 1, 1991. The most striking feature of the Act is that it separates the purchasing of services from their provision. District Health Authorities will be funded according to the needs of their constituencies and will have the ability to purchase services as they see fit. They will contract with providers. Instead of only specifying the amount paid to the providers, (input) the contract will also spell out the expected services to be provided. Medical audits are now mandated.

The new reforms are not designed to alter the fundamental goals of the National Health Service - to provide universal health coverage largely free at the point of delivery to consumers - only to

reallocate resources and decision making. While general practitioners will still be paid via capitation, they will be given stronger incentives to provide preventative care (including immunizations and vaccinations) and will be rewarded financially for doing so. Still the "gatekeeper" to specialist and hospital care, the new law permits general practitioners with more than nine thousand patients to have "practice budgets". In essence this mechanism permits a general practitioner to receive fees for all care provided to his or her patients- something like a mini-HMO. On the acute side, the law permitted the formation of hospital trusts through which hospitals could negotiate for services directly with employees, decide which services to perform and which to contract for and within a total budgeted amount, allocate resources. The changes are too new to evaluate but will surely yield important data to the discussions of organizational design (provider versus managerial and consumer control) and its impact on cost containment and access.<sup>51 52</sup>

The French have adopted a national health insurance model. The French programme is more decentralized than the British National Health Service. The programme is administered by a national system of sickness funds organized on a geographic basis.<sup>53</sup> Compared to the German sickness insurance programme, there are relatively few types of funds or payors. Approximately eighty percent (80%) of French residents belong to a single national fund known as the Regime Generale. The other twenty percent (20%) of the population are insured by smaller funds organized by occupation or employment status, that is, the self-employed. The greater concentration of insureds in a national fund is consistent with the national orientation of the French Programme in comparison to the regional orientation of the German programme.<sup>54</sup> The programme is financed by mandatory payroll contributions which are determined by the government. In the second half of 1991, the employees paid 6.8% of wages while the employer contributed 12.6% of gross payroll. Government subsidies are provided from the general fund and from special taxes.<sup>55</sup> The French generally have freedom to choose their own doctors and while provider fees are negotiated, French doctors may refuse to accept this payment as payment-in-full and may charge the patient more: About 30 per cent do so. Although this may not affect the government's expenditures on the programme, it most certainly affects the cost of health care services in France. Perhaps more importantly, this practice is in many instances a barrier to access for those who do not take out voluntary (private) insurance to cover the difference.

National health insurance in Canada is actually two programmes: prepaid hospital care and prepaid care by doctors and other ambulatory providers. Hospital insurance was legislated in 1957 (the Hospital Insurance and Diagnostic Services Act). Medical care insurance, commonly known as Medicare, was legislated nine years later in 1966 (the Medical Care Act of 1966). Each component programme was designed to be comprehensive in the range of services provided, provide universal access and allow for portability of benefits between provinces. By 1971, all provinces had joined the programme.<sup>56</sup> The programmes are financed jointly by the provincial and federal governments. The provinces are responsible for administration. There is no role for private corporations or other entities in operating the insurance plans. Hospitals are paid according to prospectively determined budgets with only small allowed adjustments for a greater or lesser number of patient days. Doctors' payments are based on fee schedules which are negotiated by medical associations and the provincial government. Most provinces pay between 85-90% of the adopted fee schedule. The doctor has the choice of accepting the government payment as payment in full (assignment), or billing the patient directly for a higher amount.<sup>57</sup>

As a result, Canada's programme, like the French model, is also plagued by uncontrollable costs for doctors' services.<sup>58</sup> Again, this directly affects the consumers' out-of-pocket expenses, not the government budget, but it none-the-less, increases total system costs. As noted on page 20, the problem of "assignment" is also a problem for Medicare in the United States. It is unlikely, given 1) the fact that Canada uses a single payer model in which the government pays for all insurance mandated services and 2) the lack of success of legislation which attempts to control costs (relative to the success of the German Japanese or British programmes<sup>59</sup>), that legislators will look to either the French or Canadian models when constructing an American programme.

The Norwegian government finances Norway's national health insurance programme through taxation. Most providers are paid on a fee-for-service basis. All licensed providers can request reimbursement. Similar to indemnity insurance in the United States, there is no limit to the number of services for which a doctor may be paid and therefore no incentive in the programme for the provider

to control utilization. Like some health insurance plans in the United States, the Norwegian plan requires that coinsurance fees be paid at the point of service delivery, that is, the doctor may charge more than the negotiated rate and collect such monies at the time he delivers the service. While this cost-sharing method does contain costs, the Norwegians place greater reliance on educating the public - consumers and providers alike - to use resources efficiently. This is possible in Norway, largely because it has only slightly more than four million inhabitants and because of strong social values which reinforce the equitable use of limited resources. Obviously, it would be difficult to replicate this model with a great deal of success in a country like America whose 235 million inhabitants have an entirely different value structure.

### **Significance of the German Model**

In contrast to the British, French, Canadian and Norwegian models, the German model is an excellent one for American health policy makers to study. It will appeal to legislators and may be less offensive to doctors.

First and foremost, the programme is government sanctioned, not government sponsored. Federal legislation established it and set up eligibility criteria making insurance compulsory for a large segment of the population. The law also defined a minimum yet reasonably comprehensive, benefit package. The federal government does not finance the programme. While local government does subsidize a small number of people, the majority of revenues are private - collected from employers and their employees. The government also plays no role in organizing the delivery of services. Enrolment of subscribers, collection of premiums, provider contracting, and provider payment is handled by sickness funds. Subscribers and their dependents have free choice of doctors. In short, government intervention is minimal as reflected in the tiny size of the section of the Federal Ministry with responsibility for monitoring the programme. Given the United States' attraction to free market principles, this limited governmental role is important. The organization of the delivery system through sickness funds is significant for another reason. The sickness funds bear a remarkable resemblance to the emerging HMO and HMO hybrids in the United States. The HMOs, like the sickness funds, collect fixed periodic fees, predominantly from employers, and in some cases from

government on behalf of public beneficiaries. The HMOs also use a variety of provider contracting mechanisms. Closed panel HMOs, the oldest model of HMO, salary their doctors. Open panel HMOs, also known as Independent Practice Association HMOs (IPAs) pay doctors on either a capitation or fee-for-service basis. Also similar to the German sickness funds, the HMOs have significantly reduced the paperwork associated with the American indemnity insurance plans. Finally, because of the financial incentive to the HMO to keep people healthy, the HMOs provide coverage for both curative and preventive care. The German funds also provide both types of coverage.

The German model has been successfully copied by the Japanese.<sup>60 61</sup> Like in Germany, the Japanese programme is employment-based. Insurance is compulsory and is provided through multiple insurance funds of which there are more than 1,000. These funds are commonly known as Insurance Societies. Patients have free choice among private doctors and receive hospital care in both private and public hospitals. Moreover, there are standardized reimbursement rates for nearly all doctor and hospital services. Unlike Germany however, negotiations on reimbursement rates include providers, payors (Insurance Societies) and government representatives.<sup>62</sup> Perhaps the most significant difference between the two programmes is that Germany now requires budgeted control of hospital and ambulatory care by doctors which Japan does not. Budgetary controls limit both price and volume (utilization of services) and have more successfully controlled growth in total expenditures for health care where implemented.<sup>63</sup> Doctors are generally paid on a fee-for-service basis in an ambulatory setting and are usually salaried in hospitals. Patients are not responsible for paying deductibles but may pay as much as twenty to thirty percent of the regulated fee as a copayment for services.<sup>64</sup> The insurance programme is otherwise financed by mandatory contributions from employers and employees. Unlike Germany, Japan subsidizes these contributions with general tax revenues.<sup>65</sup>

Japan, compared with Britain, France, West Germany and the USA, has the highest life expectancy, lowest infant mortality, and the fewest deaths from heart disease.<sup>66 67</sup> While surely the Japanese success is determined by the special social and cultural environment of the country, the importance of the model should not be underestimated. It is indeed possible that the United States will try to learn from the Japanese experience with health care systems.

The German model is the oldest example of a national health insurance programme designed to address the major policy issues of access, cost and quality. The original law creating the programme was passed in 1883. The basic components of the programme remain intact today. Durability is important to American policy makers. The programme has succeeded in providing access to health care services to more than ninety percent of the German citizenry at a total cost far below that spent in the United States. Finally, the evolution of the German Sickness Insurance Programme provides an interesting study of the roles of consumers, providers, payers and government and their impact on programme design and outcomes.

For all of these reasons, the German model is extremely important to American health policy today. Little has been written in English about the German Sickness Insurance Programme, the forces which shaped its creation and how it operates. This study focuses on describing not only the policy and its development and evolution but how the German system worked up to 1911. The structured design of the programme has largely remained intact since.

**PART I**

**Roots: Health Policy and Insurance in Germany in the Period Preceding 1883**

## CHAPTER 1 THE NEED FOR HEALTH INSURANCE IN INDUSTRIALIZED SOCIETIES

Our "modern" society has no specific birthdate. For over 250 years however, our environment, and the ways in which we adapt to it, have undergone vast if not fundamental changes. In particular, the 150 years between 1700 and 1850 were critical for technological and social change. These years were marked by three major events, two of which even carry the dramatic label, "revolution": the agrarian revolution, the demographic shift and the start of the Industrial Revolution.

The agrarian revolution was predicated on the introduction of fertilizers, new seed strains, crop rotation and new technology for cultivating the soil. The British have received most credit for these and other early agricultural accomplishments. For example, Jethro Tull, a Berkshire farmer, invented the grain drill in 1701 and in 1731 published his ideas on row cultivation in his book Horse-hoeing Husbandry. Tull traveled through Europe spreading these ideas. A compatriot of Tull's, nicknamed "Turnip" Townsend, also travelled through Europe. As his name implies, he is credited with introducing dutch turnips - a hearty and nutritious crop - to various areas of the continent.

The contributions of France and the German states followed a slower, but nonetheless measurable pace. Justus von Liebig's (1803-1873) work, Chemistry in its Application to Agriculture and Physiology, appeared in Germany in 1840, and proved important in the continued growth of a stable food supply.

The increasing food supply, coupled with new ideas on nutrition and improved sanitation, played a major role in reducing infant mortality and in extending life expectancy. Dramatic changes in mortality rates together with increased life expectancy and higher birth rates were among the primary causes of a sharp upturn in the size of the population and its subsequent rate of growth. These demographic changes, known as the demographic shift, encouraged the transition of European society from an agricultural to an industrial economy. The combination of changing agricultural practices and

a growing population created a labour surplus available to meet increasing demand for workers by the newly developing industrial sector.

The British textile industry signaled the beginning of the Industrial Revolution in the mid-eighteenth century. The continental European nations, however, didn't experience similar industrialization until the next century.

### **The Emergence of Germany as an Industrial Society**

Energy, transportation and communications -- all extremely important for building an adequate infrastructure -- were the first industrial sectors to develop in Germany. This infrastructure proved to be the key to Germany's rapid industrial development between 1815 and 1871.

As the number of industries increased, so did the number of Germans who migrated to industrial centres looking for work. In Essen, home of the Krupp steel works, the labour force expanded from 72 workers in 1848 to 12,000 workers in 1873, a 165-fold increase in 25 years. In Berlin, the largest industrial city, the population swelled from 278,000 in 1849 to one million in 1875.<sup>68</sup>

Rural migrants came to industrialized centres with few resources. Their livelihood depended on their ability to find work quickly. Those who did so, initially the majority of migrants, became dependent on their employer for their well being. Those who did not, became destitute.

The maximum standard of living for working people and their dependents was defined by the employer. An acceptable maximum standard was described as " a sufficiency of good food (preferably with less than a sufficiency of strong drink), a modestly crowded dwelling, and clothing to protect morals, health and comfort without risking improper emulation of the costume of their betters".<sup>69</sup> Obviously, if all this was provided by the employer, the working persons' standard of living was substantially better than his non-working peers.

But did the wages paid by the employer actually provide for this enviable lifestyle? Not if one considers the following examples. A worker in Aachen was paid 2 M for a ten hour work day. In Berlin, the largest industrial city, the average wage was 2.40 M per day. In Breslau, a much smaller industrial centre, the average wage was 1.60 M per day.<sup>70</sup> But what was the mark's purchasing power? In 1908, one mark could buy:

16.6 kg. potatoes or,  
4.1 kg. peas or,  
5.0 kg. cabbage or,  
6.2 kg. red beets or,  
5.0 kg. carrots or,  
2.0 kg. cauliflower or,  
2.0 kg. apples or,  
2.1 kg. white bread or,  
5.3 kg. black bread or,  
1.1 kg. sugar or,  
11.1 kg. skim milk or,  
5.0 kg. whole milk or,  
0.3 kg. butter or,  
1.2 kg. horse meat or,  
0.7 kg. cheap cut of meat or,  
0.6 kg. better cut of meat or,  
0.3 kg. ham or,  
0.7 kg. eggs or,  
6.8 kg. rice or,  
0.3 kg. marzipan or,  
2.0 kg. spinach or,  
2.0 kg. lettuce.<sup>71</sup>

The above figures demonstrate that the actual standard of living was much below the rhetorical maximums envisioned by the employers. Almost half of the average household's income was used to purchase food. In 1907 for example, 42.6% was spent on food, 16.8% on housing, 13% for clothing, 8.4% for furniture heating and light, 6.7 % for miscellaneous "luxury" items, 6.1% for education, 4.2% for health care and sanitation, 1.5% for transportation and 0.7% for household services.<sup>72</sup>

Although the annual incomes of most workers did increase, the increases were below the cost of living in all but seven years between 1870 and 1900. Table A below, illustrates the relationship between real gross income and the cost of living for the years 1870-1900.

**TABLE A**  
**GROSS INCOME AND COST OF LIVING 1870-1900**

<u>Year</u>	<u>Cost of Living</u>	<u>Real Income</u>	<u>Year</u>	<u>Cost of Living</u>	<u>Real Income</u>
1870	83	77	1885	91	89
1871	90	76	1886	89	91
1872	94	80	1887	89	92
1873	104	79	1888	91	93
1874	108	78	1889	95	93
1875	99	86	1890	98	92
1876	99	82	1891	100	91
1877	100	79	1892	99	92
1878	95	83	1893	97	93
1879	93	83	1894	96	94
1880	99	79	1895	95	95
1881	100	78	1896	94	98
1882	98	78	1897	96	97
1883	98	81	1898	99	96
1884	93	86	1899	99	99

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Table A also indicates that Germany's economic expansion was not even. Like most industrial economies, the German economy fluctuated with distinct business cycles. During the downturn of these cycles the number of unemployed workers increased dramatically. For example, during the 1857-58 slump, one third of all workers in the Berlin engineering compounds were out of work. During the 1892 crisis, there were 1.4 to 2.1 million unemployed workers, approximately 6% of the labour force. In contrast, during a period of general prosperity (1887), the unemployment rate was only 1%.<sup>74</sup> However, as the number of persons coming to the urban industrial centres looking for work increased, so did the average unemployment rate. As a result, the impact of an economic recession on the number of unemployed was more pronounced.

The combination of continued substandard living conditions together with little or no job security made life generally miserable for the 19th century working class family. Under these conditions, even the worker fortunate enough to have steady work was unable to save. Without savings or an organized welfare programme, sickness and accident were continuous threats to the worker's only real resource-- his ability to perform manual labour.<sup>75</sup>

Health security then, more than material possessions, became the "luxury" sought by the working class. A fundamental redistribution of wealth would have been necessary, however to meet this demand. Of course, the majority of industrial employers were unwilling to accept such a radical solution.

In 1883, spurred by the growing labour movement which threatened the legislative balance of power held largely by industrial employers and large landowners, the German Sickness Insurance Act (Krankenversicherungsgesetz) was promulgated. As the first of three social welfare programmes designed to insure the working class against the risks associated with illness, accident and old age, the national Sickness Insurance Programme was the first formal, nationwide, government-sanctioned programme intended to facilitate society's adaptation to the industrial revolution.

This study will describe the development of the German Sickness Insurance Act. It will trace the evolution of the national Sickness Insurance Programme between 1883 and 1911 and it will discuss the impact this landmark policy had on the health and well-being of the German population. Finally, the analysis will discuss the relevance of German policy for contemporary American health policymakers. Although the antecedents to modern German Health policy may be traced back to the 17th century, this study concentrates on the watershed period between 1800 and 1911.

As part of the analysis of the German Sickness Insurance Programme, the next several chapters of this paper looks specifically at eligibility criteria, enrollment procedures, benefit design, organization of the delivery system including provider contracting and reimbursement, utilization review and quality assurance, programme administration, programme costs and financing. What mechanisms worked and why? Are they able to be replicated today in the United States?

## CHAPTER 2 HEALTH POLICY AND MEDICAL CARE IN GERMANY UP TO 1883

This chapter traces the early development of German health policy which culminated in the Sickness Insurance Act of 1883. It also describes the infrastructure of health and medical services which existed in Germany prior to the 1883 enactment of the Sickness Insurance Act.

As is the case with most social programmes created through federal legislation, the enactment of the 1883 law served to recognize and codify programmes which had been demonstrated on the local and regional level for quite some time. This chapter discusses three periods in the development of the health insurance programme:

- 1) The period prior to 1848
- 2) 1848 to 1871: The watershed years preceding German unification
- 3) 1871 to 1883: The period following creation of the German Empire.

The information on the provider network (including a discussion of the evolution of clinical medicine, medical education, medical licensure, the number and payment of doctors, hospital services, hospital ownership and payment and the regulation, distribution, payment and use of drugs, pharmaceuticals and medical appliances) which existed at the time the German programme was implemented is provided as a benchmark for other nations planning a similar programme. The discussion on provider support, or lack thereof, for the concept of a national health programme is intended to explain why the programme was enacted with widespread support so soon after the formation of the German nation and approximately 25 years earlier than any other European country.

### **The Period Prior to 1848**

The early Greeks developed two types of institutions: poor houses (Ptochtropheion) and old age homes (Gerontokomeion).<sup>76</sup> In 450 B.C. in what is today Sri Lanka, the first recorded sick house or hospital was founded for the care of both animals and people.<sup>77</sup> From there, the concept of isolation hospitals evolved. Interestingly, isolation hospitals were built more than 100 years before the

notion of infectious disease was understood. These isolation hospitals were used primarily to protect the general population from lepers.

The Church was responsible for shaping early European attitudes towards social welfare policy. The Church created and maintained alms or "public" houses for the sick and poor. In the early part of the nineteenth century, hospitals were institutions with two primary purposes: isolation of the sick from the well and caring for the old and poor. These uses of the hospital had not changed for more than 1,000 years.

Unfortunately, the number of people in need was greater than the Church could support. The feudal rulers of the time did not take it upon themselves to develop social programmes which would adequately fill the gaps. Martin Luther (1483-1546), whose teachings formed the basis for what is today the Lutheran religion, was one of the first major proponents of organized social welfare programmes in Germany. Luther taught that begging was wrong. Instead, he said that all who were able had a duty to work. Those who were unable to work due to illness and were too poor to purchase needed care should be provided with the necessary treatments to restore their health so that they could return to work.<sup>78</sup> Thus, the "right to health" was introduced as an ideological cornerstone for the future German social welfare policy.

No significant action was taken by any "legitimizing authority" to provide health care or other social welfare benefits to the general citizenry for more than two centuries. However, beginning in the sixteenth century, groups of miners began establishing funds called *Knappschaftskassen* that provided basic health and welfare benefits for the fund members and their families. The miners contributed a part of their wages to the fund and the fund made cash grants to needy fund members which covered costs associated with sickness, accidents or disability. Fund revenues were also used to provide cash support to the widows and children of men killed in mining accidents.<sup>79</sup>

The Miners' Funds were supported and managed entirely by the participating workers. The mine owners and employers played no role in this first health insurance programme. Nonetheless,

these early Miners' self insurance funds formed the organizational basis for the German Sickness Insurance Programme which was enacted in 1883 and is still in existence today.<sup>80</sup> They also established an important precedent for the provision of cash payments or sick pay as part of the insurance programme's benefit package.

The first major German social welfare law was enacted on July 1, 1794. Called the Prussian Common Law, it was similar to the English Poor Law. The law is the first example of German government intervention into the lives of the working person. It defined a role for government in two major areas of social policy: welfare and employment.

The new programmes affecting welfare and employment were intended to work hand in hand. First, the law made government responsible for providing employment opportunities for its labour force. Those who did not accept offers of employment were punished. Second, the law established government-supported welfare programmes for those who couldn't work and were in need.<sup>81</sup>

Both the labour and government welfare programmes initiated during the late eighteenth century provided cash assistance to programme recipients. This cash assistance was used to maintain a subsistence level income during periods of unemployment, disability and sickness. Until the mid-nineteenth century, there were few clinical treatments for disease. Hence, there was little need for the government to provide health benefits in lieu of cash or in addition to the cash used for income maintenance. While the sick were treated at home or isolated in hospitals, their families received cash assistance. The German hospital of the early nineteenth century was what today would be called a sanatorium or nursing home.<sup>82</sup> The transition of these institutions to their modern usage began only as new diagnostic and surgical procedures were developed. These techniques required special equipment and special places to house that equipment and operating theatre. The earliest examples of hospital-based diagnostic equipment are x-ray and electrocardiogram machines.

With these developments came both a greater recognition for clinical treatment and an understanding that all sick people shared a similar characteristic which grouped them together in the

new institutions where specialized care was available. Hospitals were now places for the sick, not only the sick poor.

These new hospitals were called either *Krankenhaus* (sick houses) or *Krankenanstalten* (institutions for the sick). They had four functions:

- 1) Protecting the population during an emergency caused by infection, social deviancy and civil or natural catastrophe.
- 2) Providing medical treatment requiring technical apparatus which because of cost or size can only be provided in a central place.
- 3) Supporting families of the sick who can no longer care for the sick in their homes.
- 4) Providing psychological security for the individual that in the event of severe illness, the best medical technology is available. <sup>83</sup>

However, because hospitals existed before the professionalization of clinical medicine and because they were traditionally erected and maintained by municipalities and churches, hospital services in Germany have always been, and today remain, separate and distinct from primary care services. This distinction is an important one, for it has rather large (and negative) implications for the control of hospital admissions and hence, cost containment.

Until the mid-nineteenth century developments in clinical medicine, a medical practitioner was essentially a sanitarian (*Sanitaetspolizei* or *medizinischepolizei*). These "doctors" were hired by the state or municipality and were licensed after passing a special examination called the *Physicatsexam* which could be taken only after the candidate had obtained a doctor's degree and had received his approbation or a regular license to practice medicine. This "regular" license, which was optional for all other doctors at the time, was given by the Medical Board of Examiners at a German university. The legal approbation was given after successful completion of the examination by the Federal Council of the state in which the examination was taken. Most interestingly, this Federal Council could exempt certain individuals from taking the examination and at its discretion, license them.

During the early nineteenth century, these sanitarians were responsible for the prevention of infectious disease, and because that generally meant isolation in a hospital, they were also responsible for overseeing medical institutions. They were known as the medical police.

The medical police were a small elite group. They constituted the only organized medical service. There were however, many more people who practiced medicine. In the pre-1883 era in Germany, no license was necessary for the practice of medicine.<sup>84</sup>

Those who did choose to become licensed were required to have some formal medical education. A doctor's degree was not necessary for licensure or for the practice of medicine. While most doctors who sat for the licensure examination did obtain a doctor's degree to improve their professional standing, the degree was often conferred after the doctor was legally qualified to practice. In fact, licensure requirements in some German states with more rigorous qualifying criteria called only for the potential licensee to have applied to enter a medical course of study at a German university. Most states however, also required proof of at least nine half-year long terms of medical study. Of these nine semesters, two must have been spent in a clinical setting. The examination itself had several parts: anatomy, physiology, pathology, ophthalmology, surgery, medicine, obstetrics and gynecology, and hygiene. The exam in each of these areas had both a written and a practical component. The examination was oral (in German or Latin) and took place before the dean and three to six Fellows of the university, usually after the completion of four years of study. Because the examination as well as the curriculum varied slightly between universities and therefore between the German states, some candidates were also required to write an essay or do practical work as part of the examination. A thesis or dissertation was also required for a doctor's degree. This paper was to be written in German on a scientific subject. Only in Leipzig could the student submit the manuscript; In all other states, between 50 and 100 copies were to be printed. At the Universities of Berlin, Breslau, Griefswald, Konigsberg and Marburg, students had to defend their work publicly.<sup>85</sup>

There were three types of medicaments offered for public sale in Germany: A) prescribed medicines supplied by pharmacies and scheduled on the official price list, B) medicaments in common use supplied without a prescription either by pharmacies or drug stores and C) other medical supplies and appliances which were stocked by both pharmacists and druggists as well as other stores which sold medical supplies.<sup>86</sup>

These items were very important to most Germans in the pre-1883 period largely because they were one of the few "treatments" available. A practitioner of any sort was able to provide a substance to remedy an illness. Only licensed doctors were permitted to prescribe pharmaceuticals (group A above). Whether medicines were prescribed by a doctor or not, most were ineffective. They did however, provide the patient with a feeling that something was being done to help.

Pharmacists were licensed by the federal authorities while pharmacy operations were under the jurisdiction of the states. The federal government through a special advisory panel to the Imperial offices of the (public) Health Department, determined which medicaments required a prescription, and set maximum wholesale prices.<sup>87</sup>

Any person who followed the official curriculum for pharmacists could become a pharmacist. However, because of the extremely strict regulation of pharmacies (which were in part imposed by the existing pharmacy owners themselves) there was a surplus of pharmacists. Many qualified pharmacists served as pharmacy assistants or became druggists.

As noted above, pharmacies were licensed and strictly regulated by the state. The state practice of limiting the number of pharmacy licenses was adopted from an age-old practice. Originally, pharmacy licenses or "concessions" were granted by the Crown. As a matter of interest, a great many licenses were granted to retired military doctors. Once established, the license could be sold or bequeathed. This practice had an enormous impact on the pharmacy business. Obviously it created a monopoly for the service. The government set price ceilings, but the lack of competition among pharmacies allowed charges to stay close to the permitted maxima.<sup>88</sup> Moreover, dispensing fees were

not regulated.<sup>89</sup> As a result, the total cost for a prescription was grossly inflated. The pharmacy monopoly was further strengthened by sections of the penal laws. For example, Paragraph 367 (3) of the Penal Code permitted the medical police to levy substantial fines on any non-authorized individual who dispensed prescription drugs without the appropriate license.<sup>90</sup>

The Pharmacy Ordinances regulated the normal daily operations of the pharmacy. Pharmacies were required to stock adequate supplies of commonly used medicaments. Any drugs prescribed by a doctor which had to be made up were to be prepared correctly and in a timely manner. Furthermore, the pharmacist was required to consult with the prescribing doctor if the prescription called for a dosage which exceeded the norm. As is done today, every filled prescription had to be labeled for its proper use and indicate the name of the patient, the date of the prescription and the name of the dispensing pharmacy. The dispensing fee was uncontrolled and only governed by the pharmacist's discretion.<sup>91</sup>

Drug stores were the only competition for the pharmacies. The legal ability to sell prescription drugs is the primary difference between the two. Drug stores were not permitted to sell prescription drugs. The proprietors of drug stores were known as druggists. Because of the loose licensure requirements for pharmacists, many druggists were pharmacists who did not have a license to own and operate a pharmacy.<sup>92</sup> Prices for non-prescription drugs were fixed by competition, not the government.

Concurrently, (between 1800 and 1835), a great deal of industrial growth occurred in Germany. The railway system was extended throughout the German states. This rapid growth in Germany's industrial strength paralleled the growth in the organized labour movement. In 1834, Friedrich List created the Zollverein or Customs Union which was the first trade organization in which all the German States participated as a national body.

Largely encouraged by the accomplishments of workers in Britain and France, the German workers agitated for laws that would regulate working hours and conditions. One result of this effort

was the Accident Insurance Law (also known as the Nominal Liability Law of 1838) enacted by the Prussian government in 1838. The law made employers nominally liable for accidents to railroad employees who were injured on the job. This was a radical change in policy. No longer were workers entirely responsible for insuring themselves against the risks associated with their jobs. It is also interesting that the government did not manage or fund the new insurance programme directly. Instead, the government used its authority to assign responsibility to another group - the employer. This indirect form of government intervention thereafter was utilized consistently by the federal authorities in the formulation of their social insurance programmes.

Workers were required to prove that the accident was not only job related but that the cause of the accident was related to the employer's negligence. Given the nature of the railroad industry, this type of proof was difficult to obtain.<sup>93</sup>

In 1845, the Prussian government issued the first formal industrial code (Preussische Gewerbeordnung). The code contained many provisions affecting the welfare of German workers. For the first time, a wage earning class was recognized. Perhaps more important in the context of health policy, the law recognized the insurance "funds" as the organizational mechanism to provide social welfare benefits to the labouring classes, not just for employees in select industries. New insurance funds were formed in local areas and at factories. While no distinct set of benefits was mandated, the law did cite the guilds as an example of organizations that provided an adequate range of social amenities for their members. The statute also required employers to contribute towards the cost of an insurance programme. The law did not, however, mandate a fixed rate of contribution for the employer.<sup>94</sup>

In contrast to the 1838 Nominal Liability Law which created an Accident Insurance Programme for railroad employees, the 1845 Code maintained the employee's contribution toward the cost of providing insurance benefits. Management of the funds was shared between employers and employees. This model of shared responsibility both for funding and managing the insurance programme would be employed in the 1883 National Sickness Insurance Programme.

Despite the drawbacks in these early programmes, they laid a strong foundation for German social welfare policy prior to 1848. The government's responsibility for providing welfare support was well established. The organizational foundation for the finance and delivery of health benefits through sickness funds (or what is known in the U.S. as third party insurers) was not only defined but functioning efficiently for a large number of German workers. Moreover, during this period, the government assumed a role in the formulation of social insurance programmes; Instead of directly providing either benefits or insurance, the government elected to authorize programmes which would be funded and managed by employers as well as employees. This released the government from direct fiscal and administrative responsibility for the programmes. By making eligibility for the programme employment-linked, they also narrowed the population who would be eligible for benefits.

Several additional precedents were set in the pre-1848 period, some of which have had a lasting impact on the German programme. The provision of sick pay remains a benefit provided by the programme. Insured separately in the United States, the continued provision of cash benefits has escalated programme costs markedly. The separation of hospital and primary care, as mentioned earlier, is also a precedent which has not been broken and which has contributed to rapidly increasing programme costs.

One notable precedent set during the period has not survived the last century. Unlicensed medical personnel are no longer permitted to practice in Germany as part of the organized medical care system. The forces which catalyzed this change will be explored later in Part III: The Shifting Balance of Power. Another such precedent established during the period which would be tested later is the pharmaceutical monopoly. The sickness funds would attempt to break the hold of this group by dispensing drugs and limiting both the number of prescriptions and types of drugs for which the programme would provide reimbursement. This too is discussed in Part III. Obviously, hospital and ambulatory medical care has changed dramatically over the last 100 years. The relationship of the providers of this care to the entire sickness insurance programme is a major theme of this paper.

## 1848 to 1871: The Watershed Years

Between 1845 and 1854 when the *Gewerbeordnung* was amended, most of Europe from Britain to the Russian border experienced a great deal of social unrest. In the shadow of the Napoleonic era which was marked by relatively progressive social reforms, the workers, supported by many "middle class" intellectuals, requested additional government concessions. These requests became demands as living conditions worsened in rapidly growing industrial centres.

When the German monarchy did not respond, the workers barricaded the streets in protest. The militia was called in and destroyed the barricades. Many workers were killed in what has come to be known as the Revolution of 1848.

Two legislative proposals with relevance to health policy reflected the government's reaction to the 1848 Revolution. Both intended to consolidate or extend government control over the German citizenry. In contrast to earlier policies, these new proposals called for direct government intervention

In late 1848, the government proposed a law that would authorize the formation of "medical courts" (*Ehrengerichten*). The Medical Courts were supposed to protect the material and scientific interests of the clinical practitioner by monitoring the activities of untrained practitioners who, at the time, were legally permitted to provide medical treatment. This public acknowledgement of the socio-economic and scientific rights of the clinician was the first of its kind. It clearly represented the government's recognition of the widespread influence of the Medical Reform Movement which was formed during this revolutionary period, and greatly influenced the development of German health policy. The Medical Reform Movement primarily was comprised of clinically trained practitioners rather than sanitarians. Originally driven by liberal political beliefs, many of these clinicians joined the medical police in order to encourage reform. In so far as the term "medical police" was replaced by "Public Health Service" (*Volksgesundheitsdienst*), they were successful.<sup>95</sup> Otherwise, the public health or preventive health movement and the clinical movement remained distinct. The public health authority continued to be concerned with ventilation, drainage, garbage disposal and other sanitary

measures. While the clinicians, led by Rudolph Virchow, a prominent clinical researcher, contended that medical history or epidemiology controlled the development of society at large, they did not practice preventive or public health medicine as we think of it today. Instead, they used the concept of epidemiology and public health as a way to place themselves into the political mainstream while continuing to practice clinical (curative) medicine. Their objective was to establish a condition of "well-being" for the worker by eliminating his disease, not preventing it from occurring. They aimed to provide clinical treatment to the poor through the formation of a new public health service (oeffentliche Gesundheitsdienst) staffed by clinicians rather than sanitarians, institutionalizing a health insurance programme for workers and organizing a general education programme for the working class.

Like Luther, Rudolph Virchow, who led the Medical Reform Movement, believed health was a right which belonged to all citizens. Virchow viewed the clinician as a vehicle for social change because of his broad exposure in the community. Correspondingly, he defined medicine as a social science with responsibility in the political process. Virchow rhetorically aligned the clinician with the working class, stating that the clinician and worker were mutually exploited by the legitimating authorities. He claimed that clinicians were recognized only during epidemics.<sup>96</sup>

Virchow was influenced by an emerging school of thought called State Socialism. The theories of State Socialism were rooted in the teachings of Frenchmen St. Simon and Fourier and England's Robert Owen. As Adolf Wagner, Professor of Political Economy at the University of Berlin described it, State Socialism represented a new direction in economic thought and mirrored the tenor of recent social and economic legislation in Germany.<sup>97</sup> This new ideology clearly placed the welfare of the community before the welfare of the individual.<sup>98</sup> It was this notion that Virchow and his colleagues used in the formulation of objectives for the Medical Reform Movement.

Members of the Medical Reform Movement viewed the Medical Courts as passive support for their ideas and activities. The Medical Court's authority to monitor untrained personnel was the most attractive feature of the proposal to the doctors.<sup>99</sup>

The second legislative proposal which may be viewed as a reaction to the 1848 Revolution is the *Novelle zur Gewerbeordnung* or Industrial Code Amendments. Enacted on April 3, 1854, the law gave federal authorities permission to establish insurance funds wherever a need existed and where the municipal authorities or factory owners neglected to do so. Though the federal government rarely exercised this authority, the law established a connection between the Federal government and the labour dominated funds that did not previously exist. <sup>100</sup>

Just one week after the amendments to the Industrial Code passed, the government enacted another law with a major impact on the insurance funds. The Miners' Fund Law (*Gesetz ueber die Vereinigung der Berg-, Hutten-, Salinen-, und Aufbereitungsarbeiter in Knappschaften*) was promulgated on April 10, 1854. This law, later to be embodied in the General Mining Law of June 24, 1865, created the modern form of the Miner's Funds. Membership in a fund was made compulsory for all miners. Revenues to support the insurance programme now were to be collected from both employers and employees rather than just from employees. The law required the mine owners to pay at least one half as much as the miners, whose contributions were fixed as a variable percentage of wages. The contributory ratio set forth in the Miners' Fund Law eventually would become the ratio established for the Health Insurance Act of 1883. Employees paid two thirds of the cost of health insurance while employers paid one third. This 2:1 ratio was also employed in setting up committees to select fund managers. preventive services we would con After the enactment of this law, the Miners' Funds were managed by employers and employees again on the two to one principle for managing boards instead of the traditional model of employee self-management. <sup>101</sup>

The Miners' Fund Law effectively "organized" over 80% of the 68,300 miners. While this can be interpreted as a pro-labour gesture, the employers' new role in the funds actually was intended to control organized labour rather than promote it.

The two 1854 laws led to the formation of 5000 new or reorganized insurance funds. <sup>102</sup> The governments of Brunswick (*Braunschweig*) and Saxony (*Sachsen*) went further than the Prussian government and extended the compulsory membership requirement to all workers. <sup>103</sup>

As the number of funds grew, so did their membership and correspondingly, the utilization of health care services. As hospital utilization increased over the century, hospitals were built for separate functions. While most of the hospital were acute or somatic hospitals (Akutkrankenhauser), specialized hospitals (Sonderkrankenhauser) for the care of persons with tuberculosis, psychological disorders, "addiction" diseases and rheumatic illnesses also existed. Special hospitals were also available for those seeking rest and relaxation. These were known as Kurhauser or spas. <sup>104</sup>

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Hospitals were traditionally a public convenience. Most were erected, owned and operated by communes or municipalities. These were generally large institutions. University hospitals fell into this group. The churches (Protestant in the north and Roman Catholic in the south) as well as other charitable organizations also owned and operated hospitals. These were smaller, general purpose hospitals. In rural areas, where the municipalities often did not have the resources to build and support a hospital in their town, several municipalities would build and operate a "regional" hospital (Landeskrankenhauser). <sup>105</sup>

As the use of hospitals became more popular, clinics owned and operated by doctors were developed. (The word clinic (klinik) is a derivative of the word "klein" or small.) These smaller hospitals were status symbols. The clientele were the rich. Privately operated clinics were licensed and regulated by the state. <sup>106</sup>

#### *Political Alignment in Pre-Unification Germany*

The period that immediately followed the enactment of the 1854 laws was one characterized by continued industrial expansion and increased cooperation between the German states. While it was a relatively quiet period for German health policy, it was a period in which the reorganization of the German government began. The political alignment that was associated with the reorganization indirectly affected health policy in the period following unification. Many of the same individuals and schools of thought involved in shaping health policy now became involved with the reorganization. For example, State Socialism, now identified with Bruno Hildebrand, Wilhelm Roscher and Karl Kneis,

all moderate liberals, <sup>107</sup> maintained its theoretical commitment to social change induced by collective action. However, these new theoreticians contended that social change could be brought about without disrupting the existing governmental structure. As such, State Socialism, also known as the Historical School, provided an ideological framework for the institution of social reforms which was acceptable to both moderate liberals and conservatives. <sup>108</sup>

In 1859, Virchow, who remained active in politics after 1848, as well as the other 1848 activists, including Waldeck, Schulze-Delitzsch, Johann Jacoby and Ferdinand Lassalle, established the German National Union. Unlike the new followers of State Socialism, these men who had been influenced by the early theories espoused by State Socialism, believed that the monarchy should be replaced by a strong democratically elected government. This political platform was extremely important. It provided the means for the unification of the working classes and the socialist labour movement. On socialism taking root in the post 1848 period, Lassalle commented,

*"Socialism emerged from the convulsions and ferment of those years with fresh, popular aspirations. It was socialism that remained after the earthquake, the tempest and the fire had passed away. Succeeding events greatly stimulated the new movement. Politically, the working person became free, for the equality of all citizens in the eyes of the law passed from the region of theory to that of fact. The development of industry however, exerted quite a contrary effect, for it perpetuated and increased the economic and social subjugation of the labouring classes. The more the capitalistic system was extended, the more social inequalities multiplied. The law made equal and capitalism made unequal. Thus the position of the labourer became ambiguous. As a citizen and a subject of the state he was perfectly free, sharing the civil rights of the wealthiest; but as a member of the industrial community, he occupied a position which was really dependent and unfree. It was inevitable that this condition of things should be conducive to social discontent and class antagonism".* <sup>109</sup>

Thus, two very different groups that would influence the shape of the post unification government were taking shape. Previously, these two groups had shared some common ideological ground. In regard to most issues, this was no longer the case. While no one political event was responsible for the establishment of the German Sickness Insurance Programme, the conflicts between these groups served as a catalyst for the enactment of the German Sickness Insurance Act of 1883.

#### *Formation of the Progressive Party*

On May 31, 1861, another law that directly influenced the shape of the German Health Insurance Act of 1883 was enacted. As one provision of the German Commercial Code, employers of

shop assistants were required to provide cash assistance during sickness to these employees for up to six weeks per year. While this law would not have an impact on the organization of the health care delivery system for the national insurance programme, it did begin to extend entitlement to workers outside heavy industry. <sup>110</sup>

The next major insurance law was influenced by a new political faction, the German Progressive Party. The law, the Voluntary Association Act of 1867, repealed compulsory enrollment requirements, thereby returning the funds to local control. This move pleased many of the clinical practitioners, who, like Virchow were members of the Progressive Party. The law resulted in a decrease in insurance fund membership which in turn increased the pool of patients for private practitioners. <sup>111</sup>

The Progressive Party was formed as a result of the tenuous bonds holding together the many ideological factions of the German National Union. Led by Rudolph Virchow, the Fraktionchen Junglitthauen broke away to establish the German Progressive Party (Deutsche Fortschrittspartei) in 1861. The Party made eight key points in their first political platform:

- 1) Germany should be unified under the central authority of Prussia;
- 2) A constitution should be developed for the new nation;
- 3) The new nation should have an independent legal system;
- 4) The ministers in the new government should answer to Parliament;
- 5) While there should be a centralized governing authority, local control should be maintained when possible.
- 6) Compulsory civil service should be introduced;
- 7) Existing Factory laws should be revised;
- 8) The military should be retained; defense spending should be minimized during peacetime.

In 1869, the Industrial code was amended again, this time supported by Conservatives and Progressives alike. The new law stipulated that insurance funds were to be under federal rather than regional jurisdiction. While this may seem a reversal of the Voluntary Association Act, it was not. Membership in funds remained voluntary. Local management of the funds continued.

The law, however, did establish federal guidelines for the insurance funds to follow. The most important guideline regarded the provision of benefits. Funds were required to provide a minimum

level of benefits to their members. The provision of additional benefits was permitted at the discretion of individual funds. For example, all funds were required to make continuing disability payments if a worker was permanently disabled. In the case of a worker's death, a disability pension was to be paid to his widow. Children of disabled or deceased workers were provided with cash assistance until they reached the age of fourteen. Medical care, sick pay and money for funeral expenses were all included in the minimum benefit package.<sup>112</sup> This 1869 law also stated clearly that no license was necessary for the practice of medicine. It did state however, that without a license the practitioner was not permitted to use the title of doctor, was restricted from providing inoculations, and was prohibited from advertising or seeking out patients in their homes without an appointment. This law was in force until 1911.<sup>113</sup>

The law represented another attempt at social reform without changing the existing social order. The Socialist Workers Party, the more radical of the socialist factions, opposed the legislation. August Bebel and Karl Leibknecht, two prominent party spokesmen suggested amendments to the law which would give workers freedom to unionize, forbid children under 14 from working, forbid all work on Sundays, establish a maximum ten hour work day and establish factory inspectors who would enforce the other new provisions.<sup>114</sup>

In summary, the period between 1848 and 1871 was characterized by the development and alignment of political parties and interest groups that would shape social policy in post-unification Germany. Health policy reflected this changing and rather unstable environment. Provisions of four out of the six laws promulgated during this period would be incorporated into the 1883 Sickness Insurance Act. One law, the Voluntary Association Act, abrogated provisions of another, the 1854 Mining Fund Law. The Mining Fund Law made enrolment compulsory for miners and many other workers while the Voluntary Association Act repealed this requirement. In contrast to the role government assumed in the laws enacted before 1848, direct government intervention increased. In addition to legitimating the insurance funds and authorizing specific guidelines for the scope of benefits provided and joint employer-employee funding and management, the new laws permitted the federal government to establish funds. While this authority was rarely exercised, it was significant in the light

of the growing conflict between the interests represented by organized labour and those represented by the existing government.

### **1871 to 1883: The Period Following the Creation of the German Empire**

In January 1871, France surrendered to Germany ending the two year Franco-Prussian War. Wilhelm I was proclaimed emperor and the German Empire (Deutsches Reich) officially came into being.<sup>115</sup>

The unification of the German Empire served as a catharsis for the central European transition from the economic and social situation of an agrarian society to that of an industrial society. Indeed, it has been argued that the emergence of the modern German state through the victory in the Franco-Prussian War ushered in the modern era for all western civilization.

The war effort had temporarily eclipsed legislative attention to domestic policy issues. From 1869, the Railroad Funds had actively lobbied for legislation that would increase minimum wages and protect workers from dangerous working conditions. Their efforts attracted a good deal of attention. Soon, the miners and organized factory workers joined the lobbying effort. As early as December 9, 1869, pressure began to grow for a national accident insurance programme.<sup>116</sup> However, until January 1871, no bill was proposed. At that time, Otto von Bismarck, the new Prime Minister (Reichskanzler), introduced the National Accident Insurance Act (Reichshaftpflichtgesetz).

The proposed law was designed to protect railroad, mine and factory workers from death and bodily injury and the financial risks associated with these injuries. The proposed insurance programme protected workers on the job. Miners and factory workers had to be injured or killed at the mine or factory to activate benefits under the programme. Obviously, this stipulation did not apply to railroad employees. In all cases, the worker was required to report an accident and prove that it occurred as a result of his employer's negligence. In the case of a worker's death, the employer, as the liable party, was required to pay for medical care if any was provided prior to death, the cost of burial, and for health benefits and cash assistance for dependents of the deceased worker.<sup>117 118</sup>

The socialist labour movement generally supported the bill. In theory, the law provided workers with insurance against the costs associated with hazardous jobs. It protected their families as well. They were, however, critical of the provision that required the worker to establish proof of employer negligence. They also objected to the eligibility criteria that excluded workers in trade, commerce and agriculture from coverage. Interestingly, these groups were also left uncovered by the Sickness Insurance Act of 1883.

The socialist's criticism of the proof of negligence clause was well founded. In 60% of the accidents that fell under the jurisdiction of the 1871 Law, the question of negligence was unanswered. The Saar industrialist, Freiherr von Stumm put the number of "unsolved" cases at 90%. Lawyers held fast to their position saying that "the majority of accidents were either caused by worker carelessness or through the natural process of the work itself, neither of which was the responsibility of the employer".

119

It is interesting that Bismarck introduced the first piece of social welfare legislation enacted by the German Empire. His memoirs and private papers suggest that he focused his activities primarily on foreign policy and only became involved in social legislation as necessitated by the domestic economic and social situation. For several years, the threat of a direct confrontation with labour on social issues had been growing. Bismarck feared the social unrest that could result if labour's demands were left unmet for an extended period of time. Social unrest threatened to retard economic growth. Bismarck's close relationship to the 1871 National Accident Insurance Act was born out of this fear and the recognition that some government response was necessary. <sup>120</sup>

### *The Depression of the 1870's*

The economic depression which occurred during the early years after unification had been building up for years. It had been delayed by the military build up before and during the Franco-Prussian War. The year 1873, known as the Bubble Era, was a period of active speculation, primarily in French gold. The speculation ended abruptly when the gold market crashed. This crash marked the

beginning of a 22-year span during which periods of prosperity were both rare and short. <sup>121</sup> Of 203 companies founded in 1871, 35 sold off substantial assets, 52 liquidated and 14 went bankrupt. Of 478 companies founded in 1872, 91 liquidated substantial assets, 138 liquidated, and 38 went bankrupt; and of 168 founded in 1873, 22 sold substantial assets, 67 liquidated and 9 went bankrupt. <sup>122</sup> Unemployment increased dramatically. For those still lucky enough to hold jobs, there were substantial wage cutbacks. <sup>123</sup>

During the depression, labour demands on the new government for comprehensive social legislation accelerated. In 1872, the Union for Social Politics was created. Members, influenced by State Socialism, argued that government intervention was necessary to upgrade the welfare of the common citizen. <sup>124</sup> At the same time, industrialists, whose interests were largely represented by the National Liberal Party, lobbied the new legislators to protect their economic interests. Social laws that limited working hours and made employers liable for insurance premiums or the cost of benefits were not on their agenda. Not surprisingly, Bismarck responded by creating a commission to study labour conditions. Despite the extensive inquiries of the labour commission, and Bismarck's interest in Sunday "blue" laws, no comprehensive legislation was proposed. Bismarck explained that his government would not propose such legislation, stating that such an initiative must come directly from labour. <sup>125</sup> But in 1872, labour representation in Parliament was nominal.

Without signs of government cooperation and in the face of continuing high unemployment, labour unrest mounted. Bismarck's government was forced to respond. Existing social legislation was amended. Sunday labour was nominally forbidden. The minimum working age was increased from nine to twelve years. Children twelve to fourteen, were legally permitted to work only six hours per day and children fourteen to sixteen were allowed to work a maximum of ten hours each day. Mothers were allowed three weeks leave following the birth of a child. Factory inspections to enforce these laws were instituted in Berlin and Silesia in 1874. <sup>126</sup> No comprehensive social insurance legislation was proposed, however. And in 1874, when these amendments failed to curb the growth of the organized labour movement, the Bismarck government passed a law forbidding the right to gather, organize and strike.

Each act by either the government or labour precipitated yet another, stronger reaction by the other. In 1875, many of the labour dominated socialist factions united to form the German Socialist Worker's Party (Sozialistische Deutsche Arbeiterpartei).<sup>127</sup> In 1876, Bismarck publicly opposed factory legislation. He reasoned that in a time of high and prolonged unemployment, increased regulation of the workplace would retard the growth of new jobs.<sup>128</sup>

In 1876, possibly as a result of the growing electoral strength of the Socialists and Progressives, The Mutual Aid Fund Law (Hilfskassengesetz) was passed. The legislation was conceptualized by Theodor Lohman (1831-1905), a liberal who would be responsible for developing a good part of the Bismarck government's proposal for a National Sickness Insurance Programme. Lohman was strongly influenced by the early Guilds in which benefits were financed by contributions from guild members and benefit administration also was conducted entirely within the guild. The new law sanctioned funds that provided social welfare benefits on the guild model. The funds, known as Free Funds (freie Hilfskassen), were employee supported and managed. Following the precedent established by the Voluntary Association Act of 1867, membership was voluntary. The law stipulated enrolment procedures, restricted coverage to health and death benefits, and established premium rates.

Bismarck supported the legislation largely because it represented a means to calm labour unrest without either government or management financial commitments. In addition to the preservation of voluntary enrolment requirements and local management of the programme, the law permitted him to maintain his commitment to laissez faire doctrine. The industrialist dominated National Liberal Party, while not thrilled by a law which established the workers unconditional right to legislated benefits, also supported the bill largely because it excused them from a financial commitment and was based on political ideology which they condoned.

The Socialists welcomed the stipulations of the law that allowed employee management of the funds. They were unhappy, though, that the law did not provide the same jurisdiction (that is,

management by employees only) for members of the other 3,961 existing funds that mandated membership for certain classes of workers and were jointly managed by employers and employees. <sup>129</sup>

The calm created by the law was short-lived. Later that year, a federal court decree outlawed the central organization of the Socialist Workers Party. The court decree was upheld in Prussia, Saxony and Bavaria. Not surprisingly, this resulted in the strengthening of the local party organizations as well as the socialist party press.

Between 1871 and 1877 the number of socialists seated in the German Parliament grew from two to twelve. In 1871, they were able to capture approximately three percent of the electorate. In 1877, the percentage increased to nine percent. Of the fourteen parties represented in the parliament (Reichstag), the socialists ranked eighth in terms of the number of representatives. <sup>130</sup> By 1878, it was clear to Bismarck that stronger action was necessary to check the growing power of the Socialist parties.

Until this point, Bismarck had chosen two different ways to cope with social unrest; he promulgated laws that were aimed at destroying his political opposition or laws that were designed to meet some of the demands of organized labour, the primary supporters of his political opposition. In 1878, he chose the former.

On May 11, 1878, two days after the first attempted assassination of Kaiser Wilhelm I, Bismarck introduced a bill to "check Social Democratic excesses". Despite his eloquence and established power base, the proposal was overwhelmingly defeated. However, after a second assassination attempt on June 2, 1878, the Parliament agreed to hear an amended version of the bill.

<sup>131</sup> The bill was not scheduled for a vote until after the October national election.

Bismarck's conservative administration retained its majority control of the government. The "Anti-Socialist Law" was passed on October 17, 1878. The final vote on the measure was two hundred twenty one to one hundred forty nine. <sup>132</sup> Bismarck acknowledged that the law was repressive. He

argued that the measure was necessary to facilitate government sponsored social reform. Two days earlier, Richter, then the Progressive Party leader commented, "*I fear Social Democracy more under this law than without it*".

In 1879, the government's stated commitment to a social insurance programme remained strong. However, there was no clear conception of the policy. This commitment and dilemma is reflected in a statement by Minister Hoffman,

*"The government accepts the theory that the working person who has become incapacitated through age, or in the consequence of his work, should not be a burden upon the public, but should be provided for by other institutions. It is, however, difficult to say how."*<sup>133</sup>

In response, a small group of conservative legislators proposed an insurance programme that would provide medical benefits and cash assistance to the elderly and the indigent. Their proposal did not include a public tax appropriation.

August Bebel, a deputy of the Socialist Party, also advocated a worker's and old age insurance programme. In contrast to the conservative proposal, he suggested an active role for the government. His proposal called for the government to be a direct provider of services; that is, it would be responsible both for financing the programme and negotiating contracts with hospitals and doctors for the provision of services.<sup>134</sup>

Recognizing that compromise was necessary to assure passage of a comprehensive programme, the socialists modified their position. Their support for the programme was based on the following four points:

- 1) Universal coverage for workers and their dependents,
- 2) Coverage means full reimbursement of medical expenses and cash assistance equal to one hundred percent of wages,
- 3) Government and employer paid premiums,
- 4) Worker management of the insurance funds.<sup>135</sup>

The National Liberals advocated a voluntary insurance programme.<sup>136</sup>

It was not until February 15, 1881 that Bismarck delivered his first major speech on comprehensive social and fiscal reform. He said,

*"The end I have in view is to relieve the parishes of a large part of their poor-law charges by the establishment of an institution, having State support and extending to the entire Empire, for the maintenance of old and incapacitated people, just like the institution of accident insurance.*

*A generation may be necessary in order to decide whether the ends I have in view can be attained or should be abandoned, but the way must be trodden and I believe that the parishes, especially those overburdened with poor and under certain circumstances the circuits (Kreise) as well, would experience considerable relief if the poor-law charges were distributed more justly amongst larger unions than now and that they would receive considerable relief, without direct grants in cash, if all persons requiring relief owing to natural causes, as incapacity or old age, were to be received into an insurance institution established by the state." 137*

On March 29, 1881, Bismarck introduced legislation that would establish a national accident insurance programme. The legislation proposed national accident insurance for railway, mine and factory workers—the most active groups in the labour movement. Premiums were to be paid by employers, employees and the federal government. The Socialists immediately proposed that eligibility for the programme be extended to all workers. They further suggested that premiums should be paid entirely by employers. Both the Progressives and the National Liberals called the proposal "a bastard form of socialism, even worse than socialism itself".

On April 2, 1881, in support of the proposed law, Bismarck said,

*"The domain of legislation which we enter with this law deals with a question which will not very soon be removed from the order of the day. For fifty years we have been speaking of the social question. Since the passing of the Anti-Socialist Law, I have been continually reminded by persons in high and official circles, as well as by others in the popular classes, that a promise was then given that something positive should also be done to remove the legitimate causes of Socialism. I have had the reminder in mind to toto die up to this moment, and I do not believe that either our sons or grandsons will quite dispose of the social question which has been hovering before us for fifty years. No political question can be brought to a perfect mathematical conclusion, so that book balances can be drawn up; these questions rise up, have their day and then disappear among the other questions of history; that is the way of organic development".*  
138

In committee, federal appropriations for the programme were rejected. An amended proposal called for employer-employee premium sharing where the employer paid two thirds of the premium and the employee paid the remaining one third. The amended bill was passed by the Reichstag and referred to the Federal Council. The Federal Council tabled the bill. It died there.

On November 17, 1881, Kaiser Wilhelm I made a speech reaffirming the government's commitment to social insurance legislation. The speech is now regarded as the Social Charter for the

German Social Insurance Programme which was enacted later in the decade and is still in existence today. He said,

*" In February of this year, we expressed our conviction that the cure of social ills must be sought not exclusively in the repression of Social Democratic excesses but simultaneously in the positive advancement of the welfare of the working classes. We regard it as our imperial duty to urge this task again upon all the successes with which God has visibly blessed our government if we were able one day to take with us the consciousness that we left to the Fatherland new and lasting sureties for its internal peace and to those needing help, greater security and liberality in the assistance to which they can lay claim. With this intention the draft of an Act upon the insurance of workers against accidents in factories, laid before the allied governments in the previous session will be modified in order to prepare for renewed deliberation upon it. A supplementary bill will be issued for the uniform organization of the industrial sick associations. But those who are disabled from work by age or invalidity have a well grounded claim to greater care from the state than has hitherto been their share. To find proper means for such care is difficult but also one of the highest tasks of every commonwealth which is based on the ethical foundations of Christian national life. The closer the union of the real forces of this national life and their combination in the form of corporate associations, with State protection and State help, will, we hope, render possible the discharge of tasks to which the executive alone would not to the same extent be equal. Yet even in this way, the end will not be reached without considerable expenditure".* <sup>139</sup>

The Socialists responded negatively to the speech and the insurance programme it outlined. Calling it a "Lentil Law" to signify the meagerness of the proposal, they claimed that a law that provided insurance coverage only for emergencies, was unacceptable. The Liberal reaction was also negative. They responded with a counterproposal designed to extend employer liability solely for workers in commerce and industry. Such a measure, they felt, would both check the growth of the Socialist movement and protect private enterprise. This proposal, like its predecessor, was referred to committee and tabled. <sup>140</sup>

On April 29, 1882, the Bismarck government proposed an insurance package that incorporated mandatory sickness insurance and accident insurance. The scope of benefits stipulated for the Sickness Insurance Programme was modeled on the 1876 Mutual Aid Fund Law. The financial model for the programme mirrored the 1845 Industrial Code: joint employer and employee funding and management. In contrast to the most recent laws pertaining to sickness insurance coverage (1876 Mutual Aid Fund Law), the new proposal mandated insurance for all employed labourers and factory foremen earning up to 2,000 M per year. Domestic and agricultural workers were excluded.

As might be expected, the Liberals sharply criticized the proposal. They reacted to both the financial responsibility placed on employers and to the federal government's establishment of eligibility criteria and benefit guidelines. To them, this represented excessive government intervention.

Bismarck in fact did acknowledge the socialistic tenor of the proposal. His rhetoric is illustrative:

*"Many measures which we have adopted of the great blessing of the country are socialistic, and the State will have to accustom itself to a little more socialism yet. We must meet our needs in the domain of Socialism by reformatory measures if we would display the wisdom shown in Prussia by the Stein-Hardenberg legislation respecting the emancipation of the peasantry. That was socialism - to take land from one person and give it to another - a much stronger form of Socialism than a monopoly (which we now create).*

*But I am glad this Socialism was adopted for we have as a consequence secured a free and very well-to-do peasantry, and I hope that we shall in time do something of the sort for the labouring classes. Whether I however, shall live to see it, with the general opposition which is as a matter of principle offered to me on all sides, and which is wearying me, I cannot say. But you will be compelled to put a few drops of social oil into the recipe which you give to the State - how much I do not know... The establishment of the freedom of the peasantry was socialistic. Socialistic too, is every expropriation in favour of railways, Socialistic to the utmost extent is the aggregation of estates- the law exists in many provinces- taking from one and giving to another, simply because this other one cultivates the land more efficiently; Socialistic is expropriation under the Water Legislation etc., where a person's land is taken away from him because another can farm it better; Socialistic is our entire poor relief, compulsory school attendance, and compulsory construction of roads. That is all Socialistic and I could extend the register further; but if you believe that you can frighten any one or call up spectres with the word "Socialism", you can take a standpoint which I abandoned long ago and the abandonment of which is absolutely necessary for our entire Imperial legislation." <sup>141</sup>*

The Socialist Party responded negatively to the proposals saying that "social reforms" would not effect the slightest changes in the political or economic situation of the working classes.

Recognizing, however, that the law stood a good chance of passage, they proposed an amendment to the bill which provided for employee self - management of the funds. This, they believed was an absolute necessity in the light of the Anti-Socialist Law which remained in effect at the time. They saw self - management of funds as a means to circumvent the prohibition against the right to legal association and organizing within the labour movement. The Socialists also objected to the narrow eligibility criteria stipulated under the proposed law. <sup>142</sup>

Both bills were referred to committee but only the Sickness Insurance Act was passed during the session. The Sickness Insurance Act was passed on June 15, 1883 and the programme was implemented on December 1, 1884. <sup>143</sup>

### *The Status of Medical Services and Providers in 1883*

Because hospital services as we know them today were relatively undeveloped in Germany in 1883, primary care services formed the basis of the medical benefits provided by the Sickness Insurance Programme. Primary care services are essentially services provided by doctors in a non-institutional setting. <sup>144</sup> The primary care doctor is usually a general practitioner. He is the point of entry to the medical care system. This was true in Germany in 1883, and is true in HMOs in America today.

The meaning of the loose licensure requirements to the medical care infrastructure in place prior to and at the time of the implementation of the 1883 Sickness Insurance Act is great. It meant that the Germans had in place a significantly large network of primary care providers who practiced the type of medicine provided for by the 1883 law. Moreover, they were geographically distributed. Of course, the areas away from the universities had a preponderance of non-licensed practitioners. This had an adverse impact on the quality but not on the availability of services which was the primary concern of the law.

In 1883, there were approximately 15,100 licensed doctors, a ratio of 3,047:1. <sup>145</sup> The number of unlicensed practitioners is unknown. Prior to 1883 and the enactment of the German Sickness Insurance Act, the majority of practitioners, both licensed doctors and unlicensed practitioners, were paid on a fee-for-service basis. Of course, those employed by the federal, state or municipal government were generally salaried. Some doctors had arrangements with existing sickness funds and were also salaried. Capitation arrangements were less frequent.

In comparison to the average German worker, most licensed doctors were relatively well off. Many came from upper class families who could afford to send them to school and forgo any income

they would have earned during the period of their education. Earnings compared favourably as well, although income was not always regular, due primarily to the relatively small number of persons who could afford to pay for care when they needed it, and the relatively small proportion of the population who were, at that time, enrolled as members in one of the sickness funds. The initiation of the insurance programme held the promise of increasing the available "market" of patients if not guaranteeing a stable income source.

The first professional organization for doctors was formed in 1873. The organization known as the Hartmannbund was dedicated first and foremost to promoting the advancement of clinical medicine. Payment for the new clinical practices was limited by the number of people who could afford it. The professional organization did not oppose the sickness insurance legislation. In fact, the new sickness insurance law promised to lend credibility to clinical practices and de facto, to their profession. Largely because of the newness of the organization and the relatively small number of clinical practitioners, the organization did not actively lobby for or against any of the organizational components of the law. They were pleased with the broad eligibility criteria proposed and satisfied to continue to negotiate payment with the sickness funds for the services they rendered. At the time, the doctors were not concerned with the issue of "freedom of choice" (meaning that a member of a sickness fund is free to select any doctor in the community). This contracting issue was to become the focus of concern for doctors in later years as the funds moved to restrict the number of doctors providing services to fund members in an effort to contain costs.

While the role of hospitals in nineteenth century Germany was very different from what it is today, hospitals in 1883 were used increasingly for advanced clinical practice, most notably for surgical procedures. In 1883 there was one hospital bed for every 545 Germans.<sup>146</sup> There were 2,024 hospitals. This equates to one hospital for 22,349 citizens or a ratio of 1:22,349.<sup>147</sup> As noted earlier, the majority of hospitals were publicly owned and provided acute care services.

Before the 1883 Act, hospital treatment was available to people at rates which were in most cases, below cost. Most often, patients were charged on a per diem basis. Additional charges were

levied for special treatment, including, for example, x-ray treatment. The rates were fixed by the hospital management. Different fee levels were established for different classes of patients in an effort to distribute costs more fairly. Higher rates were charged for persons from out of the area using the hospital. Primarily the municipality, Premium payments are shared <sup>?</sup>almand to a lesser degree, local charitable organizations, subsidized hospital care. <sup>148</sup>

The proposals for sickness insurance which included coverage for hospitalization were probably viewed in a positive manner by the providers of hospital services. Local officials probably viewed the federal legislation which created a private payment mechanism for these services as a way to minimize public subsidies for hospitals. The proprietary operators were supportive because the act provided a greater number of people with the wherewithal to purchase services at their facilities.

Both of these interest groups were most probably disappointed by the outcome. Fund payments to hospitals after 1883 for all fund members were equivalent to the lowest rates charged ordinary working class citizens before the enactment of the Act. And because hospital ownership patterns did not change immediately, local government continued to bear the capital costs associated with owning and operating these facilities. In effect then, local government subsidized the programme. Moreover, the sickness funds severely limited and in many instances prohibited payments to private clinics. This evolving breach between the sickness funds and the providers which followed enactment of the programme will be discussed at length in Part III: The Shifting Balance of Power.

The German Sickness Insurance Act of 1883 mandated coverage for prescription drugs. The provision of medical supplies and equipment and unprescribed drugs was covered at the discretion of the sickness funds. Pharmacies were an extremely important player in the provider network. While licensed doctors obviously had prescription privileges, they rarely had dispensing rights. Moreover, only licensed pharmacies could dispense covered medicaments, thus creating a monopoly for the pharmacist. This has a great deal of significance both for the cost of the programme and for the organization of the delivery system (i.e. funds also had to negotiate contracts with pharmacies). <sup>149</sup> In 1883, there were 4,483 licensed pharmacies across Germany- one pharmacy for every 10,264 citizens.

Of all three provider groups, the pharmacists were the most highly organized prior to 1883. They were quite vocal in their support of the legislation, provided it preserved their dispensing monopoly and included prescription drugs as a covered benefit.

In summary, the period between 1871 and 1883 was politically tense. The conservative government led by Otto von Bismarck retained majority control over the Parliament. In spite of oppressive legislation meant to check the growth of the labour-dominated Socialist Worker's Party, the party grew in strength and provided the impetus for legislation creating a national insurance programme. The Sickness Insurance Act, which was enacted in 1883, incorporated selected provisions of laws passed throughout the period from 1848. These legislative antecedents to the Sickness Insurance Act of 1883 are summarized in the chart on page 64.

The provider network which existed in 1883 was extensive but unevenly dispersed. The distribution of all providers was heavily skewed towards urban areas. What impact did this have on the shape of the 1883 legislation? Probably little; the law's advocates were primarily urban dwellers. Their concern was to implement a programme which would provide them with services. Moreover, loose licensure laws for primary care practitioners ensured that outlying areas had access to ambulatory care services, the chief medical benefit mandated by law. Admittedly, the quality of primary care services was uneven; the majority of rural practitioners were unlicensed practitioners. In regard to hospital services, the limited availability of beds (by today's standards) did not hinder passage of the law or greatly affect the quality of medical care available to covered persons. Little importance was attributed to the availability of hospital services largely because hospital care was relatively undeveloped at the time. Today, in western industrialized countries, hospital care is considered to be a vital and necessary part of any comprehensive health care programme. Therefore the number and distribution of hospitals and beds in Germany in 1883 cannot be used to measure another nation's readiness to implement a national health insurance programme. Furthermore, it is unlikely that Americans or citizens of any other western nation would tolerate receiving the majority of their care from unlicensed practitioners. The resistance to the HMO practice of using Physician Assistants or Nurse Practitioners to provide

primary care services to members is evidence of this reluctance. The German provider network could serve as a model for developing nations seeking to implement an insurance programme which is heavily oriented toward primary care. For these countries, the German example of an adequate provider network is an excellent benchmark.

On balance, the German provider network supported the enactment of a national sickness insurance programme. For doctors, most of whom were clinicians, the programme promised to provide them with a means of stabilizing their incomes. Furthermore, the law established the credibility of clinical medicine. Of the doctors who were actively involved in the Medical Reform Movement, many remained active in politics as members of the Progressive Party. The 1883 law affirmed their belief that government should be instrumental in ensuring that all Germans have access to certain social services as a right of their citizenship.

Municipal government, the largest provider of institutional health services, also supported the central government proposals. They believed that the privately financed insurance programme would expand access and reduce the financial burden of the government. Blue Cross, the first American insurance programme, was started by a hospital with the similar aim of reducing its financial risk.

Finally, the legislation was supported by the pharmacy industry, largely because the programme expanded their market. More people would have access to more doctors who wrote prescriptions. In addition, the proposed law did not threaten their monopoly to dispense prescription drugs, nor did it directly cap dispensing charges.

## Legislative Antecedents to the 1883 Sickness Insurance Act

Key Dates	Title	Provisions/Description
July 1, 1794	Prussian Common Law	Similar to English Poor Law. Established government responsibility for full employment and welfare of the poor.
1838	Nominal Liability Law	First Accident Insurance Law; imposed nominal liability for accidents to railroad employees on their companies.
1845	Preussische Gewerbeordnung	First formal industrial code; recognized sickness funds in local areas and factories; required wage laborers to contribute to sickness funds; established joint employee-employer management of funds.
April 3, 1845	Novelle zur Gewerbeordnung	Permitted state governments to establish funds if the factories or municipal authorities did not.
April 10, 1854	Gesetz ueber die Vereinigung der Berg-, Hutten-, und Aufbereitungs-arbeiter in Knappschaften	Legally recognized Miners' funds. Mandated enrollment for all miners; established joint contributory and administrative scheme; established 2:1 (employee-employer) contributory ratio.
May 31, 1861	German Commercial Code	Provided cash assistance for shop assistants during illness for up to six weeks per year.
1867	Voluntary Association Act	Repealed mandatory enrollment requirements.
1869	Amendment to Gewerbeordnung 141	Sickness Funds put under federal rather than regional jurisdiction. Benefits increased and made uniform for all funds.
1871	Reichshaftpflichtgesetz	Accident insurance for railroad, mine, and factory workers; insurance covered costs of medical care and burial for the individual and medical care and cash assistance for survivors.
April 7, 1876	Hilfskassengesetz	Established voluntary funds to provide health and cash benefits to workers; voluntary enrollment; employee funded and managed; employers released from fiscal responsibility to provide benefits to workers who enrolled; enactment paralleled deregulation in industry which Bismarck believed would lead to the creation of new jobs.

**PART II**

**The Sickness Insurance Act of 1883**

The organizational structure of the German Sickness Insurance Programme was based on a well established system of relief funds. The programme's financing was built on a tradition of employer liability and a long history of workers pooling funds to protect themselves and their families from sickness, injury and death. And, it is not surprising that the German government authorized a programme which was national in its scope; laws dating back as early as 1530 established government responsibility for the welfare of its citizens.

But a national programme would not have come about when it did had there not been some strong political motivation to implement one. Chapter 1 showed the growth of the urban working class. It also showed their new awareness of both their need for job security and the role the state could play in assuring it. Together with a politically involved provider network (Chapter 2) which recognized the potential for a new nation to create a comprehensive universal health care programme that would better the lives of the working class, the growth of this class created a good deal of fear among the members of the governing conservative party. This fear and a historical tradition of paternalism served to catalyze the Sickness Insurance Act of 1883.

As the last two chapters suggest, the years leading up to 1883 were tumultuous. The years between 1848 and 1881 were the real watershed. The Sickness Insurance Act of 1883 was enacted with little debate. The law passed on May 31, 1883 by a margin of 216 to 66. (The majority of the dissenting votes came from the Social Democrats and Progressives who saw the Act as a means for the Conservatives to establish control over the labour movement which had a stronghold in the Sickness Funds). The law was promulgated on June 15, 1883 and was implemented on December 1, 1884. <sup>150</sup>

The following chapters describe the German Health Insurance Programme as stipulated by the Sickness Insurance Act of 1883.

### CHAPTER 3 MEMBERSHIP

Prior to 1883, the majority of German citizens obtained health care through direct fee-for-service arrangements with providers or from publicly and privately supported poor houses. Depending upon financial capability, place of residence, and employment status, the quality and quantity of care varied greatly. The enactment of the 1883 law created a more important variable in the availability or affordability of personal health care. The variable was the person's membership in a sickness fund (Krankenkasse).

This chapter describes the criteria for eligibility and the terms for individual and group enrolment in the national Sickness Insurance Programme. Regulations for determining coverage exemptions for pre-existing conditions, waiting periods, dependent coverage and continuation and conversion policies are detailed. The restrictive conditions for voluntary enrolment (age and health status) are set out.

#### Eligibility

At enactment, membership in a sickness fund turned on income level, type of employment and place of residence. The 1883 law required that most workers earning under 2,000 M<sup>151</sup> per year enroll in a fund.<sup>152</sup> The 2,000 M level (equivalent to \$480 or L100) was an income ceiling; those with incomes above that level could voluntarily participate in a fund provided they had previously been insured under the German Workmen's Insurance Programme. (Arbeiterversicherung) The cost of voluntary membership, however, was generally borne entirely by the worker.

Three critical differences in eligibility criteria distinguished compulsory insurance from voluntary insurance. Sickness Funds usually imposed age limits and required voluntary applicants to undergo medical exams. Individuals who were eligible for compulsory insurance on the basis of income

and type of employment were guaranteed membership regardless of age or health status. Further, no income ceiling for voluntary membership was established. <sup>153</sup>

The 1883 law exempted workers employed in agriculture, forest labourers and domestic servants from compulsory coverage, regardless of income level. The exemption of agricultural workers reflects the government's hesitation to obviate the *Gesindeordnungen* or Rural Servants Ordinances enacted in 1810 which obligated employers to provide for their employees when sick. This exemption had strong political support from rural parliamentarians seeking to ensure their dominant yet paternalistic hold on inexpensive labour. Unlike the organizational activities in the cities, the dispersed nature of rural life limited the possibilities for organization and unified action among the affected workers. <sup>154</sup> Moreover, it was a practical impossibility to enforce the provisions of the 1883 law on farmers employing only a few workers.

A similar justification was used to exempt domestics from the compulsory health care system. The German Civil Code made employers responsible for the care of their "property" through the first six weeks of an illness or the expiration of a term of service, whichever came first. It was illegal for the employer to evade liability by discharging a servant during illness. Nonetheless, the employer could deduct the cost of curative treatment from the servant's wage unless the sickness was caused directly by his or her employment. Unfortunately, the law made no provision for adjudication of the servant's claim or enforcement of the employers' fiscal responsibility for health care. This omission not only prevented domestics from receiving care but further delayed investigation into the working conditions or causes of disease and illness facing domestic workers. <sup>155</sup>

The inadequacy of this policy did not go unnoticed. While the Reichstag did not make domestics eligible for sickness (health) insurance, they did favour voluntary enrolment for domestics in the Parochial Funds. <sup>156 157</sup>

In addition to exempting agricultural and domestic employees, the 1883 law made no provision for itinerant workers. An itinerant or casual worker was defined as a worker engaged in

employment for periods of less than one week. The exclusion of agricultural and itinerant workers reflects the 1883 law's differentiation between urban and rural areas. There are several reasons for the industrial-agricultural and urban-rural dichotomy. First, there was a great deal of sympathy among liberal legislators for the plight of the new industrial worker. The more conservative Junkers (landowning, hereditary German gentry) saw the Sickness Insurance Programme as a means of safeguarding productivity. Regardless of the motivation, the law was developed to protect and care for manual labourers who resided in the more heavily populated areas then growing up around factories or transportation centres. Second, as mentioned earlier, urban life was more conducive to collective action by the work force acting in its own interests. The sickness funds which were rooted in unions had expanded rapidly. In contrast, the dispersed nature of rural life limited the possibilities for organized collective action. As before, where funds existed in rural areas, they retained a feudal character centered around the church or poor house.

The self employed were not provided coverage under the stipulations for eligibility in the 1883 Sickness Insurance Act. Either were active military personnel and federal, state and local employees (civil servants).<sup>158</sup>

Although the eligibility criteria stipulated by the 1883 enabling legislation excluded large segments of the German population, it doubled the number of individuals enrolled in sickness funds. In 1880, only 5% of the German population were members of a sickness fund. In 1885, 10% of the population (4.29 million persons) were insured under the auspices of the 1883 law.<sup>159</sup> The majority of those insured were the workers, not their spouses or children. Dependent coverage was a permissive or additional benefit that few funds included in their benefit package in the early years after the 1883 insurance law was enacted.

### **Enrolment and Terms of Membership**

In 1883, an eligible person had little choice between funds; membership was determined according to the place in which a worker lived or was employed. This was binding unless the individual was adequately insured in a Registered Aid Society in which case he was released from mandated

insurance coverage. In that instance, the eligible person paid for the choice by bearing the total cost of sickness insurance himself.

Entitlement to sickness insurance was automatic beginning with the first day of insurable employment. The law required employers to enroll new employees in a sickness fund within three days after employment began. In many areas this was done by notifying the Insurance Office (Versicherungsamt), a jointly run federal and state administrative office.

Once enrolled, state mandated sickness insurance provided first day coverage for all but pre-existing conditions. A waiting period of six weeks could be imposed on voluntarily insured persons, casual workers and members of Miners' Funds. <sup>160</sup>

As noted earlier, under the terms of the 1883 law, dependent coverage was a "permissive benefit" provided at the option of the Sickness Fund. <sup>161</sup> At the discretion of the fund, dependent coverage could be extended to all subscribers or only to those who applied for dependent coverage. Dependents were defined differently in various geographical areas. The following examples illustrate this practice. The specified dependent family members were not subscribers but were "covered" dependents of the insured head of the household:

Bremen: Wife or husband and children, including adopted children

Stuttgart: Wife and children under 14 years.

Dresden: Wife or husband, children and stepchildren under 15.

Leipzig: Wife or husband, parents, grandparents, parents-in-law, and children under 16.

Remscheid: Wife or husband or relative in charge of a household, children or foster children, parents and parents-in-law, and in the case of unmarried members having their own households, the mother or sister in charge.

Essen: Wife, children and other relatives of member by blood or marriage resident with him and wholly or mainly dependent on his earnings, but not a housekeeper or servant. <sup>162</sup>

Dependent coverage was attractive to most subscribers. Where dependent coverage was provided, it was at the expense of all subscribers or was paid by the individual insured as an additional premium. If paid by the individual subscriber, there was no employer contribution for this benefit enhancement. <sup>163</sup> After the turn of the century when there was often both an employment and local fund for the employee to choose between, funds offering this "benefit enhancement" experienced enrollment levels three times greater than funds that did not; only 10% of all funds offered dependent coverage. These funds enrolled 25% of the aggregate membership of all funds. <sup>164</sup> This correlation is highlighted in the following two examples.

In 1911, the aggregate membership in twenty Local Funds was 1,218,048. Membership in twelve of these funds providing dependent coverage was 740,220. Thus, 60.8% of the total membership were attracted to the dependent coverage option in contrast to the 477,828 persons (29.2%) who were members of the eight funds not extending dependent coverage to subscribers.

Of twenty three important Factory Funds (each with greater than 100 members), there was an aggregate membership of 140,223 persons. 86,636 persons, or 61.8% of the total, belonged to eleven funds with dependent coverage compared to 53,517 members (38.2%) who belonged to twelve funds without this benefit. <sup>165</sup>

Coverage lapsed when employment ended. If, however, the worker became sick within three weeks after terminating his employment, health benefits were provided. This applied only to workers who had been insured for at least twenty six weeks in the preceding twelve months or during the 6 weeks immediately preceding termination.

Unemployed workers had the option of continuing coverage as "voluntary members" paying the entire premium for coverage. Thus, the unemployed worker who had been compulsorily insured

because of an income under a prescribed limit, was left to purchase health coverage at his own expense.

Coverage could not lapse while a worker was undergoing treatment for an illness. No premiums were assessed on those workers claiming benefits owing to disability. Further, coverage continued throughout short periods of unemployment (three weeks or less) occurring as a result of changing employers. <sup>166</sup>

If an insured worker voluntarily resigned his job, he too could continue coverage provided he remained in the country, notified the fund executive within one week of his intention to continue coverage, and paid all premiums.

Because the employee co-premium was deducted from his salary and paid by the employer to the fund, there were few instances where mandated coverage lapsed due to premium delinquency. Coverage to voluntarily insured persons however, did lapse if premiums were not paid on two successive paydays. A minimum of four weeks was required to elapse between the first of these days for disenrolment to be effective.

To ensure continuous coverage following termination, full payment of premiums on the day premiums would have been paid had the subscriber remained employed was required. Payment on the proper date was considered formal notification of the intention to voluntarily continue coverage provided the date fell within three weeks of termination. <sup>167</sup>

## **CHAPTER 4 ORGANIZATION OF THE DELIVERY SYSTEM**

The delivery of all mandated and permissive benefits - both medical services and cash assistance-was organized by sickness funds. By granting the labour initiated and dominated sickness funds authority for provider contracting, legislators supporting the 1883 Sickness Insurance Act formally legitimated and permanently institutionalized a role for the funds that dated back to the 1600's.

This chapter will discuss in detail the history and organizational structure of the eight types of sickness funds permitted to participate in the German National Sickness Insurance Programme. Doctor and hospital contracting will be described separately. For each type of contracting, the use of open or selective contracting practices will be discussed as will the method of reimbursement and reimbursement rates for allowable procedures. Federally legislated and fund initiated quality assurance procedures including both grievance procedures and doctor review panels are described. Finally, utilization review mechanisms employed by the funds to contain the growth of health care costs are discussed. A brief analysis points to the early willingness of German legislators to place the burden for cost containment on doctor case managers rather than on the insured "consumer".

### **The Sickness Insurance Funds**

The 1883 Sickness Insurance Act stipulated that sickness funds (Krankenkassen) be responsible for organizing the delivery of services to subscribers and their dependents. The sickness funds, generally were organized by separate trades and occupations, a municipality or a church. The funds, which negotiated contracts with doctors and hospitals, were responsible for claims administration, utilization review and control, and monitoring the quality of services provided. They are the oldest part of the German Sickness Insurance Programme.

The Miners' Funds (Knappschaftskassen) originated in the Harz mountains in the 1500's. These funds were the prototypes for the eight types of funds legislated to organize the delivery of services under the 1883 Sickness Insurance Act. The "Knappschaft" was a group of miners who worked

a particular mine as a partnership. The Knappschaftskassen made monetary grants to needy members, their widows and or surviving children during sickness, temporary or permanent disability, and in the case of death. These original Miners' Funds were supported entirely by contributions paid by the miners. The members were responsible for the collection of revenues and administration of benefits.

Initially, many of the mines in one area united to form one fund. A uniform scale of contributions and benefits was established for members of the fund. For example, anyone seriously injured was paid the equivalent of eight weeks wages. There was however, no uniformity in either benefits paid or revenues collected between funds in different geographical areas. A fund in another area, for instance, did not define a benefit package, declaring that members were to be paid benefits "according to their needs".

Later, the wide variation in the financing and delivery of services to members of the Miners' Funds narrowed. Several major changes occurred in the programme, the most important being that operating revenues were collected from both employer and employee. Employees and employers paid equal premiums. While the co-premium ratios stipulated in the 1883 Sickness Insurance Act were 2:1 (the employee paying the greater share), the joint contributory scheme employed by the Miners' Funds clearly was a model adopted by the nineteenth century national Sickness Insurance Programme. The method for collecting employee premiums also was adopted from this period: contributions to the Miners' Funds were paid entirely by the employer who in turn deducted the employee's premium share from his wages. Compulsory membership was another notable precedent established by the Miners Funds which was incorporated into the 1883 programme. Compulsory membership for all miners was established in 1702, during the reign of Frederick the Great. <sup>168</sup>

The Miners' Funds were predominantly a north German phenomenon. In southern Germany, the area which is now Bavaria, the Catholic Church played a dominant role in organizing welfare programmes for the area's residents. As the forerunner of the Parochial Funds, many local parishes levied a small tax on both common labourers and domestics. This tax was in essence an insurance

premium used to provide both medical care and cash assistance during illness. However, unlike the Miners Funds, eligibility criteria were arbitrary and the delivery of services was inefficient. <sup>169</sup>

The 1883 Sickness Insurance Act permitted the "grandchildren" of the early Miners Funds and Parochial Funds as well as six other types of funds to enroll members, collect premiums, contract with providers for services and monitor the utilization of services and the quality of care provided. Interestingly, of the eight types of funds permitted participation in the national Sickness Insurance Programme, only two were newly created by the 1883 law: District or Local Funds and Contractors' Funds.

The eight types of funds fall into three general classifications: those organized according to a particular trade, occupation or undertaking; those sponsored by municipal government or the church; and those where membership was voluntary rather than compulsory (i.e. enrollees paid the entire premium, and were entirely responsible for the administration of benefits).

Five of the non-voluntary funds fell into the trade or occupation-related classification. The District or Local Funds, most often called Local Funds, were largely for workers of the same trade or occupation or of several trades and occupations in a given geographical area. Normally, these funds were formed by the local commune or municipal government. By petition, the Local Fund could also be initiated by a group of workers. <sup>170</sup> Thus, the Local Fund falls under the trade classification because of the characteristics of its membership and under the municipal classification because the fund is typically initiated by the municipality.

Contractors' Funds (Baukassen) were formed for individual building projects employing more than fifty persons. The general contractor for the job was responsible for organizing the fund. The funds were temporary, lasting only for the duration of the construction project.

The legislators responsible for the 1883 Sickness Insurance Act were aware that some trades ran extremely high risks of occupational illness and accident. Including high risk workers in funds

where the majority of enrolled employees faced no exceptional risk to their health, would necessitate higher premiums for both employers and employees. While the cost differential would be small if the risk was spread across a broad selection of risks, policy-makers chose to isolate the high risk workers thereby insulating the majority of subscribers from any increased cost. In 1883, the employee members of the Contractor's Funds bore the majority of the burden of high premiums. After the Insurance Consolidation Act of 1911, employers in high risk trades were responsible for paying the differential premiums associated with their trade, and as a result were given majority control in fund management.

**The Establishment or Factory Fund (Betriebskassen)** was the third fund which fell under the trade or occupation classification. It was established by employers of fifty or more employees. If the Fund was formed within a factory, all employees of the factory for whom health insurance was compulsory were required to enrol unless they joined a Voluntary Fund and paid the entire premium for services themselves.

**Guild Funds (Innungskassen)**, the fourth type of trade-related fund, were originally recognized by the Imperial Industrial Code. The Guild Funds' members were employees and apprentices of a guild who met the general income criteria for participation in the National Sickness Insurance Programme. As was the case for Factory Fund members, Guild Fund members were required to enrol in the Guild Fund established by their employer unless they chose to enrol in a Voluntary Fund.

The last type of fund that falls under the trade classification, **the Miners' Funds (Knappschaftskassen)** was described on pp.73-74. Unlike the other types of funds, the Miners Funds were only minimally affected by the 1883 Health Insurance Act. Altering the contributory ratio between employees and employers from 1:1 to 2:1 was perhaps the greatest change. Because of their long successful history and acknowledged efficiency in administering a broad benefit package, the Miners' Funds were distinguished from the other funds. The Miners' Funds served as a yardstick against which the achievements of the other seven types of funds were measured.

The Miners' Funds were a model not only for the German national Sickness Insurance Programme. By providing both disability insurance and old age insurance as well as sickness insurance, these funds served as the model for the entire German Social Insurance Programme which included Disability Insurance, Old Age Insurance and Sickness Insurance.

Only one type of fund fell solely into the classification of church or municipally sponsored funds. Labelled **Parochial Funds** prior to 1883 and **Communal Funds** thereafter, the membership of these funds was comprised of those persons for whom enrolment in a sickness fund was mandated but who did not qualify for membership in any of the other statutory funds in the area.<sup>171</sup> Unlike the other funds, the Communal Funds were administered by the commune or municipality. Administration of the health insurance programme was considered part of the commune's regular activities; the establishment of a separate administrative body was not permitted by the 1883 statute. However, the communes were permitted to enrol Communal Fund eligibles in a Local Fund if one existed. In this instance, the Commune was not required to establish a separate fund.<sup>172</sup>

Under the last classification: Voluntary Funds fall two types of funds. The first of these two funds was called a **Voluntary Registered Aid Fund** or a **Mutual Aid Fund** (Ersatzkassen). Similar to the English Friendly Societies, the Mutual Aid Funds, as they were most commonly referred to, were required to comply with the minimum benefit levels established by federal legislators. The regulations for joint administration by employees and employers and shared employer and employee contributions did not apply to the Mutual Aid Funds. A worker who was required by law to join a fund could elect to enroll in a Mutual Aid Fund rather than being assigned to a fund by virtue of his employment. Workers who chose the Mutual Aid Funds were, however, required to pay the entire premium. Individuals who, because of slightly higher incomes, were not required to participate in the national Sickness Insurance Programme were also permitted to join a Mutual Aid Fund.

The first Mutual Aid Fund for Commercial Employees was founded in 1825 in Hamburg. While the funds obviously existed, they weren't legally recognized until the 1876 Imperial Law was passed. This 1876 law encouraged workers to organize themselves into groups in order economically to

provide medical benefits and cash assistance during illness. Establishing the legislative precedent for the 1883 Sickness Insurance Act, the Imperial Law of 1876 was responsible for facilitating the development of many new funds and greatly increasing labour membership in them. In 1876, there were 12,000 funds with over two million members.

The second type of fund falling under the voluntary fund classification was called the **State Registered Fund**. While similar to the Mutual Aid Funds in that enrolment was voluntary, and premiums were paid entirely by subscribers, the administration of benefits was performed entirely by federal bureaucrats. Membership in State Registered Funds was very small.

In all but the voluntary funds, premiums were paid by both employer and employee. Responsibility for the administration of benefits was also shared between employer and employee. While the Sickness Insurance Act of 1883 did stipulate a minimum benefit package, there was a great deal of variation in both premium rates charged and benefits provided by the funds.

#### *Fund Functions*

Similar to the Health Maintenance Organizations (HMOs) in the United States, the German sickness funds were responsible both for underwriting the financial risk associated with providing health benefits and arranging for the direct provision of benefits. Funds had the option of employing salaried doctors or contracting with local doctors. In almost all cases, funds contracted with local hospitals. An individual fund rarely owned and operated its own hospital. (The sickness funds could be compared with third party insurers such as Blue Cross and Blue Shield in America as well. This similarity is greatest with those funds that permitted all doctors to provide services to fund members. However, in contrast to the third party insurers in America, all doctors providing benefits to fund members were required to sign contracts with the funds.)

Like the HMOs, the sickness insurance funds employed comprehensive utilization review programmes to control health care costs. To assure that doctors did not underutilize services and jeopardize the quality of care, the funds developed grievance procedures and doctor review panels.

The 1883 statute provided guidelines for both quality assurance and utilization review. As a consequence, the quality assurance and utilization review procedures employed by the funds were similar. This is not the case for either the contracting process for doctors and hospitals or the reimbursement methods for doctors. Federal law and regulation did not dictate either the form or content of contracts between funds and general practitioners and specialists. Consequently a great deal of variation existed.

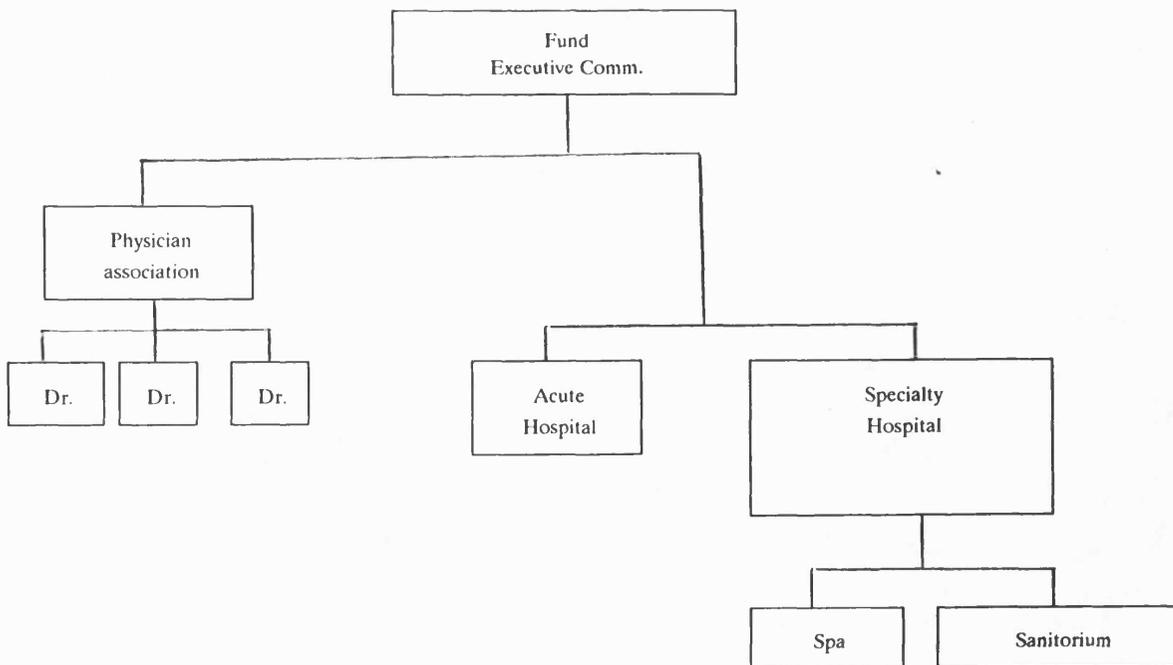
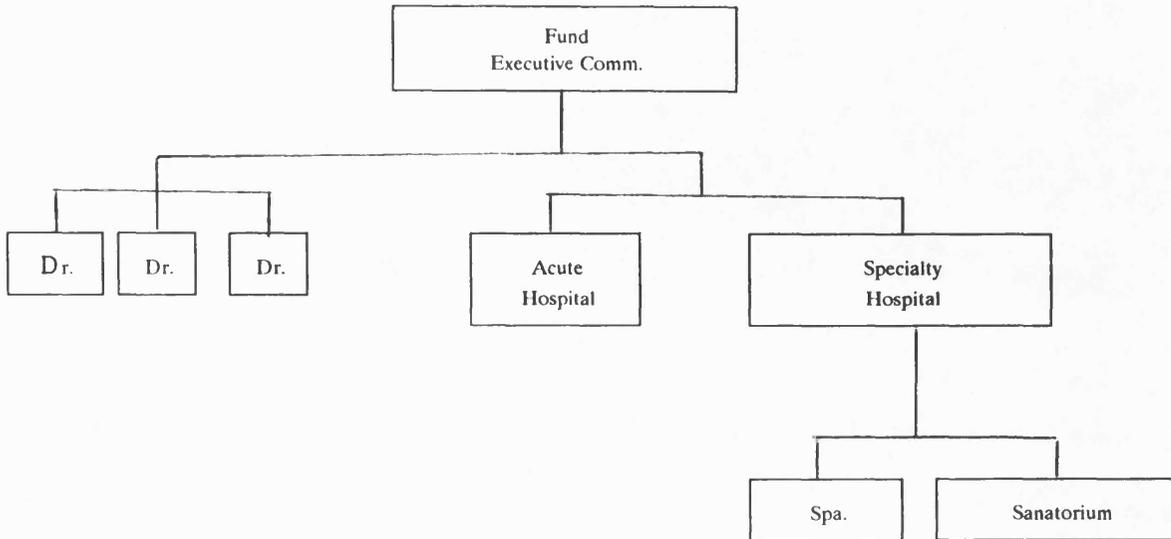
The remainder of this chapter will describe in detail the contracting and reimbursement procedures for doctors and hospitals as well as utilization review methods and quality assurance policies.

### **Provider Contracting and Reimbursement**

The chart below headed "Sickness Insurance Funds: Contracting Options", shows two of the most common models used in fund contracting. As the diagram indicates, funds most often contracted directly with hospitals. However, they also could contract either directly with individual doctors or with a doctor's association which then contracted with doctors who provided the services.

Sickness Insurance Funds

Contracting Options



As the diagram on page 83, *Sickness Insurance Funds: Payment Models*, illustrates, the flow of reimbursement funds was dependent on the contracting arrangements. That is, while hospitals were reimbursed directly by sickness funds, doctors were reimbursed directly or through an association depending on the contracting arrangement.

The lack of federal guidelines dictating contracting and reimbursement procedures is interesting. Perhaps anticipating doctor resistance to the Sickness Insurance Programme, the federal authorities chose to excuse themselves entirely from dealing with the direct providers. Except when arbitration was necessary to conclude a contract, all arrangements for the provision of mandated and permissive services as well as reimbursement were made on a local level between the funds and doctors and hospitals in the funds' service area. In this way, the federal politicians were able to avoid being labelled socialists by the doctors, the majority of whom were members of other more conservative political parties.

#### *Open and Selective Contracting*

In an open contracting arrangement, the fund member was permitted to use any doctor he desired. While doctors were required to contract with a fund, funds with open contracting arrangements permitted doctors to negotiate contracts at any time. This meant that if a fund member came to a doctor requesting services and that doctor did not have a contract, one could be negotiated immediately. In these cases, the doctor was paid on a fee-for-service basis. Fees were based on an established schedule. This established schedule expedited the negotiation process.

In contrast, funds with selective contracting arrangements negotiated agreements with a select group of general practitioners and specialists. Fund members were required to use one of these doctors. This restriction is often known as "Lock-in". In 1883, funds were permitted to contract on either an open or selective basis.

### *Doctor Payment*

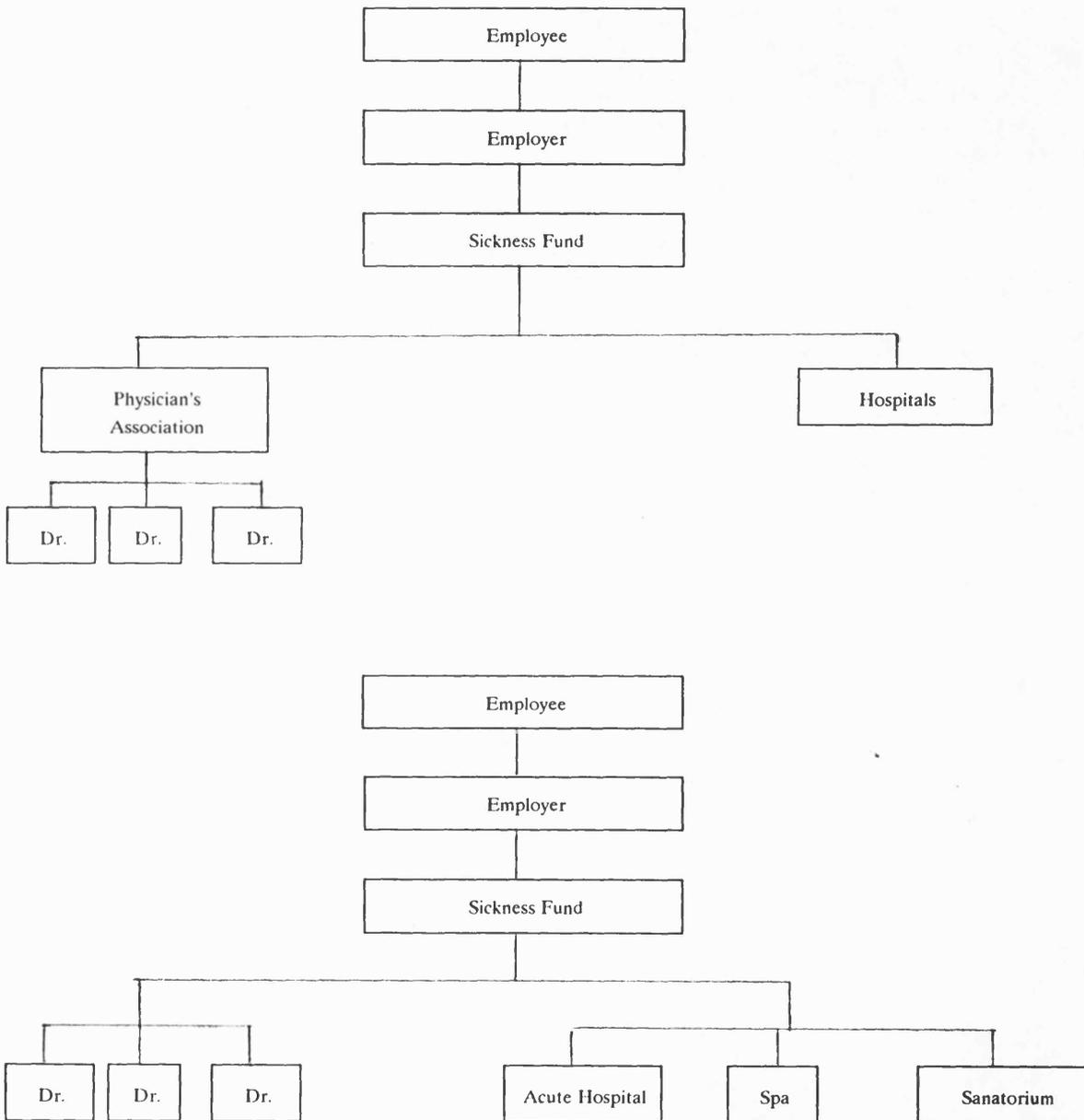
Once again, because federal statute did not prescribe a payment method, a good deal of variation existed in the way individual funds reimbursed both general practitioners and specialists. The chart, "Sickness Insurance Funds:Reimbursement Models", illustrates the money flow between the fund and contracting providers in two principal payment models. Typically, when an open panel model was employed, fee-for-service payment was utilized. In contrast, selective contracting usually went hand in hand with capitation or salary payment.

Fee-for-service payment is a term used to define a payment system that pays doctors a fee for each service provided to a fund member. In most cases the fees followed a schedule set by local federal officials.

Sickness Insurance Funds

Payment Models

Funds Flow



In most instances, the official fee schedule was considered the minimum payment level. Sickness funds could elect to pay at a higher rate and in rare cases a doctor could be paid less than the fees prescribed on the official schedule. In these cases, the reduced fees were generally negotiated during the contracting process.

Capitation payment refers to payments made to doctors for each member for whose outpatient treatment they agreed to be responsible. Depending on the payment model employed by the fund, doctors could receive a capitation fee for his patients whether he provided them services or not or capitation fees collected by the doctors as a group could be paid to individual doctors as fees for services only when they were provided. The capitation fee was generally fixed. Depending on the contract, doctors might receive extra fees for special services provided. When capitation reimbursement was chosen, the fund member was generally allowed to select a different doctor only once each year.

Salary payment was the least common type of doctor payment. A doctor could be a full-time salaried employee or a part-time salaried employee with either a private practice outside of his fund practice or a part time practice for another fund. Several of the largest federation of funds including the Dresden Sickness Fund and several Miners Funds chose to pay doctors on a fixed salary basis. These funds employed doctors on either a full-time or part-time basis. Perhaps the most notable example of a fund that employed full time salaried doctors is the Remscheid Sickness Fund which had salaried doctors on an experimental basis between 1898-1905.

### *Hospital Contracting*

Because all hospital admissions required prior authorization by the appropriate authority acting on behalf of the sickness fund, hospital contracting took a back seat to doctor contracting. In spite of this emphasis on non-institutional care, all funds had contracts with one or more hospitals. (See the chart entitled Sickness Insurance Funds: Contracting Options) Funds often contracted with acute care hospitals, hospitals for special diseases and conditions and spas. Further both the 1883 and 1911 statutes permitted funds to conclude agreements with one or more type of hospital. The law did

stipulate however that funds must contract with all public or philanthropic hospitals who desired such a relationship, that is, requested a formal contract. If they did not request a contract or were not approached for one, they were not reimbursed. The reimbursement terms of the contracts were to be identical. <sup>173</sup> Private clinics did not hold the same advantageous position; they were not granted the right to enter contracts. <sup>174</sup> While it was unusual, a sickness insurance fund or group of sickness insurance funds could erect and maintain a hospital of any kind. <sup>175</sup>

### *Hospital Payment*

Hospitals were paid primarily by sickness funds or privately by individuals who could afford to pay. The very poor were admitted to hospitals if poor law funds agreed to provide payment. <sup>176</sup> Because the majority of hospitals were traditionally constructed, owned and maintained by local communes or municipalities, fees paid by private individuals or sickness insurance funds were paid to government authorities.

As was the case for doctor payment, hospitals could be reimbursed in a variety of ways. Per diem reimbursement, where the per diem payment covered room and board as well as doctor and nursing care, was the most prevalent type of payment to hospitals. Per diem rates varied according to the number of persons in a room, the amount and level of nursing care required, and the type of hospital. Hospital management set rate levels. The number of payment levels varied from city to city. In Hamburg for instance, there were four payment levels ranging from 2 M 50 pf. to 12 M. In Cologne, three levels existed ranging from 3 M to 8 M per person per day. In contrast, in Kiel there were two payment levels: 3 M and 4 M 50 pf. per day.

Sickness insurance funds paid hospitals at the lowest rate. Individuals had the option to purchase greater privacy and amenity by paying additional sums privately. The majority of individuals did not upgrade their care. Utilization figures from 1910 in Hamburg and Dusseldorf indicate that over 90% of the patients treated there were paid for at the lowest payment level. Of all patients in all hospitals, 38% were sickness fund members and 28% were reimbursed by poor law authorities. The

remaining 36% of hospital patients were private pay patients. These figures indicate that a large number of private pay patients also paid the lowest rates for hospital care. <sup>177</sup>

The chart below, "Per Diem Maintenance Charges at Private and Public Hospitals and Clinics", illustrates the difference in minimum charges at publicly owned hospitals and private hospitals. The chart indicates relatively small differences between payments made to public and private hospitals in one town. Perhaps more significantly, they show a wide variation in fees between different localities.

**Per Diem Maintenance Charges at Private Hospitals and Public Hospitals and Clinics**

Town	Public Hospital Charge	Private Hospitals and Clinics
Berlin	3M	3M
Bremen	2M 70pf	2M 68pf
Cologne	2M 50pf	--
Dusseldorf	2M 75pf	--
Dresden	2M 37pf	2M 60pf
Essen	2M 75pf	2M 50 pf
Gera	2M and 2M 25pf	2M 50 pf and 3M 20pf
Leipzig	2M	2M
Munich	3M	2M 80pf and 3M
Remscheid	1M 80pf	-
Stuttgart	2M 20pf	2M 50pf

In addition to the per diem reimbursement for room and board and doctor and nursing care, a hospital typically made additional charges for ancillary services. For example, hospitals billed separately for x-ray treatment, special baths and prosthetic devices. <sup>178 179</sup>

Typically, the hospital, including the medical staff, the nursing staff and administrators, were paid by the local authorities who owned and operated the hospital. There were several exceptions to this. In the first two years following the enactment of the Sickness Insurance Programme in 1883, hospitals did not contract directly with individual nurses. Instead, the hospital contracted with a society or convent. <sup>180</sup> In this case, the hospital made payments to the society or convent which in turn

disbursed such funds to nurses as it thought appropriate. Small hospitals did not pay doctors for the care they provided the poor and indigent. Doctors were expected to provide this care free. At hospitals where this practice was employed, doctors were permitted to charge other paying patients directly for the cost of their care. <sup>181</sup>

The hospital doctor was permitted to have a private practice in addition to his work at the hospital. As a result, the hospital doctor's total income was often higher than the average public employee's. <sup>182</sup>

### **Utilization Review and Quality Assurance**

It was exceedingly difficult to monitor the quality of care provided fund members by unlicensed practitioners. To some limited degree, the funds' ability to contract selectively with providers ameliorated this problem. When appropriate and usually under fairly extreme circumstances, the quality of services provided by unlicensed practitioners came under the scrutiny of the medical courts which had been established in 1848.

Perhaps the most important utilization control mechanism available to the funds as a result of the 1883 Sickness Insurance Act was their right to define sickness and beyond a minimum level of benefits, what treatment was appropriate to restore health. The doctor did not have the right to define care. For example, sickness funds had the unconditional right to forbid a patient from entering the hospital; surgical procedures were limited to those which were required to enable a patient to return to work.

Other utilization review and control mechanisms were not specifically prescribed by the 1883 law. While the number of hospital admissions was an issue and sickness funds were given the right to control them, the services provided in the hospital were still primarily related to isolation. Diagnostic and technology oriented treatments in an inpatient setting would be more of an issue in later years. The number of visits to primary care doctors was also not perceived as a problem immediately following the law's implementation. However, the appliances and number of prescriptions ordered by

a doctor were monitored. Prescriptions were quickly scrutinized by funds largely because dispensing charges were unregulated and with the absence of other forms of treatment, prescriptions were perceived by the consumer to mean the doctor was carefully attending to their needs. Doctors were permitted to prescribe only those drugs which were "listed", that is, drugs which the sickness funds deemed appropriate for the care of their members.

## CHAPTER 5 BENEFITS

Benefit design for the German sickness insurance system originated in the 16th century. At that time, the Miners' Funds, the oldest of the seven types of funds, established cash assistance as a health care benefit for its members to enable them to support themselves and their families during illness. This cash assistance enabled the worker to stay at home, buy food and shelter for his family and regain his health. Later, cash benefits were extended to include cash assistance upon the death of a miner. For members of the funds, cash assistance served as an alternative to alms houses that provided care or, minimally shelter, to individuals without families or the resources to receive adequate care at home. In the absence of medical treatment as we know it today, home care was the "treatment of choice" for the ill.

Clinical medicine evolved slowly until the mid- nineteenth century when rapid advances were made to curb the spread of infectious diseases, surgical procedures became more prevalent, and diagnostic procedures aided by the development of the microscope came into general use. Concurrently, doctors began understanding the causes of bacterial and viral infections.<sup>183</sup> The acceptance by the average citizen of the clinical practitioner was aided by government legislation which created the medical police force who were practitioners responsible for the enforcement of sanitary laws. Slowly, clinical medicine was accepted as a preferred means of treating illness. The Miner's Funds and other local and occupation-based funds began to substitute clinical treatment for cash assistance or otherwise expand cash benefits to include clinical treatment as a benefit of membership. Of course, one of the doctors' primary jobs continued to be certifying illness for the funds before cash payments were made to members.

In 1888, the earliest year following enactment of the sickness insurance programme for which figures are available, cash assistance accounted for 52.7% of health care expenditures while expenditures for clinical treatment made up 47.3% of expenditures. While the 1883 Health Insurance Act specified that both medical services and cash assistance were to be provided to individuals entitled to insurance, the legislation was written loosely, providing sickness funds extremely wide latitude in

the interpretation of obligations to the insured. The Sickness Insurance Act recognized two scales of benefit. The first, "minimum benefits", represented the base level of benefits which a sickness fund was required to provide. In general, this minimum benefit package was always equal to those benefits provided by the parochial authorities or Communal Funds. The legislation specified minimum benefits corresponding to the two types of benefit, medical treatment and cash assistance:

A) Medical treatment for a period of thirteen weeks. Treatment included the provision of drugs, eyeglasses, physical supports and appliances and, of course, medical care required during sickness.

B) Cash assistance including sick pay and death benefits. Sick pay was disbursed from the fourth day of sickness in the form of a daily payment (Sundays and holidays excluded). Sick pay was equal to one half the wages for common day labour and was payable for the same period that medical treatment was provided; that is, thirteen weeks.

Hospital and other institutional care was provided as part of the minimum benefit package. However, such care was permitted only as a substitute for medical treatment and cash assistance.

Additional benefits comprising an expanded benefit package were permitted under the 1883 law. These enhanced benefit packages were defined by the local sickness fund. Although it is not uncommon for legislators to outline a programme, leaving the administrative substance to local jurisdictions or other administrative bodies, the nineteenth century German legislators were ill-equipped to define a programme. No data existed from which to assess the need for care.

The institution of German Sickness Insurance provided the first collective forum for the extraction and collection of medical statistics.<sup>184</sup> The first medical statistics were collected in 1898 from cases occurring between 1894-1896. An analysis was performed and was published in 1899. Since then mortality and morbidity statistics have been collected systematically and published annually.<sup>185</sup> Interestingly, this data collection effort was private. Between 1883 and 1911 the government did not establish a central data collection unit nor did it employ qualified experts to collect utilization,

mortality and morbidity statistics. Rather than basing their policy on fact, policy-makers preferred to define the system in terms of a set of goals. The 1883 legislation had the following objectives:

- 1) To satisfy the care needs of the ill
- 2) To maintain the health of the healthy
- 3) To help realize health legislative political goals of the state and the society. <sup>186</sup>

By basing policy on objective rather than scientific data, the law's proposers were able to accommodate potential opposition from a large group of "doctor legislators" led by Rudolph Virchow. Virchow and his associates argued strongly that with the rapidly changing political environment, the doctor must have the freedom to define treatment. By permitting clinical freedom through a loosely defined set of benefits, the medical profession believed that they would be best able to respond to the needs of the population thereby meeting one of the programme's primary objectives.

### **Medical Benefits**

Although the government definition of medical benefits was broad, as noted earlier, the law permitted the individual sickness funds to establish more succinct provisions and procedures for medical benefits. In most cases, these definitions were established within the contract development and negotiation process with fund doctors. In general the contract provisions related to referral practices and fee schedules. Because of the doctors' insistence on clinical freedom, fee schedules and delivery protocols (i.e. prior authorization requirements) were comprehensive, including the majority of clinical treatments available at the time.

While a good deal of variation existed between the funds both in type of fund and by geographical area (See *Variations in Benefits Among Funds*), ambulatory benefits were extensive. In addition to medical treatment, primary care doctors were permitted to prescribe a large range of appliances and therapeutic treatments including x-rays as well as electro- and hydrotherapy. Perhaps most important to note, drugs were a mandated benefit. Other benefits included an alcohol rehabilitation programme, and limited dental care. Rehabilitation benefits for alcoholics usually took the form of institutional treatment. These benefits were extended by the local authority of the Poor Law Union of each district.<sup>187</sup> While dental care fell under the scope of medical benefits, few funds

provided artificial teeth or contributed to the cost of such appliances. Local Funds were the first to operate dental clinics. More typically, federations of local sickness funds had their own clinics which were equipped and operated at considerable expense (eg. Dusseldorf and Stuttgart).<sup>188</sup>

Surgical procedures were also considered part of medical treatment. Allowable procedures, however, were defined differently by different funds. The funds' definition of allowable surgical procedures turned on their definition of surgical necessity. The original 1883 law established that necessity for surgical procedures would be recognized only if the operation was necessary to enable the patient to return to work. Cosmetic surgery was not paid for by the sickness insurance programme.

The prescription drug benefit differed somewhat from the scope of general benefits defined in the 1883 law. Perhaps in deference to the pharmacies which were strictly regulated, or perhaps in recognition of the need to control prescriptions in order to contain costs, the law allowed sickness funds to reimburse members for only those prescriptions which were listed on authorized drug schedules. Furthermore, members were required to obtain drugs only from those pharmacies with whom the fund had concluded an agreement. In return for a contract, and hence a guaranteed volume of clients, the sickness fund generally received between a 10% and 25% discount from the official government-regulated price list.

#### *Variations in Benefits Among Funds*

Illustrative of the variation in the array of benefits provided among funds are the variations in the regulations for the provision of medical and surgical benefits and the variations among benefits provided to subscribers and dependents. There were three different fund regulations for the provision of medical and surgical benefits. Despite the similar style of the regulations, variation is evident:

- 1) The Leipzig society, with the direction of its executive committee, could contribute up to a maximum per insured person of 75 M per year to the provision of more costly medical requirements including orthopedic instruments and artificial eyes and teeth.

2) The Dresden Society permitted the prescription of wine as a treatment. No more than 300 grams could be ordered in a treatment. In addition the fund permitted the prescription of milk. Milk was fully reimbursed by the fund. The prescription could not exceed one litre per day for not more than six weeks.

3) The Dusseldorf fund permitted reimbursement for dental fillings if it could be shown that they were necessary for the recovery or maintenance of health. Necessity had to be certified by a doctor. <sup>189</sup>

Variation among funds is also evident in their interpretation of the term "appliance". Again, variation existed between different types of funds and different geographical areas. The chart below shows these variations.

#### Variation in the Definition of "Appliance"

Sickness Funds	Definition of "appliance"
Berlin (Book Printers)	*****
Berlin (Siemen's Works)	*****
Berlin (AEG)	Artificial Limbs to max. 50m for any 1 pers.
Berlin (Commercial Employees)	Larger app. to value of 50M/indiv
Dresden (Local)	Larger appliances lent by Fund
Essen (Local)	*****
Cologne (Local)	*****
Dusseldorf (Local)	Larger appliances at executive discretion
Gera (Local)	*****
Leipzig (Local)	Art. Limbs and teeth and others to 75M/pers.
Munich (Local)	*****
Remscheid (Local)	*****
Stuttgart (Local)	*****

The provision of larger appliances as permissive benefits also varied by fund. Where larger appliances were provided, the fund usually specified precisely the type of appliance that could be provided and specified a price ceiling for the total of appliances provided under the benefit. For example, the Berlin Local Sickness Fund for Commercial Employees (with a membership exceeding 126,000 in 1911), provided artificial limbs, appliances for splay-footedness, and corsets up to a maximum cost of 50 M per person. This was in addition to minor appliances. In contrast, the AEG Berlin provided only artificial limbs with the same maximum expenditure limit. The Leipzig Federation

of Sickness Funds had a 75 M per person ceiling on expenditures. They provided artificial limbs, teeth and larger appliances. <sup>191</sup>

When comparing the benefits provided for subscribers as opposed to dependents, the most common variation existed in the duration of benefit periods. The benefit period was usually shorter for dependents and often only covered one half of the cost of the treatment.

### *Hospitals*

Hospital care was provided as part of the minimum benefit package. In the period immediately following enactment, hospital care was considered as an alternative treatment mode either to cash assistance or to care provided by the ambulatory practitioners. Institutional care provided either in a hospital or sanatorium bridged both direct medical care and cash assistance. The 1883 Sickness Insurance Act stipulated that hospital care was to be provided in lieu of ambulatory medical care. Furthermore, sick pay (cash assistance) was reduced when a subscriber was hospitalized. The reduction in cash assistance was justified by legislators as a means to reduce payments intended to provide food and shelter to an individual. Obviously, the individual when hospitalized was being provided with food and shelter. While cash assistance was reduced, a monetary allowance was paid to patients without families and to dependent members of a subscribers family. Labeled "household money", sick pay for hospitalized members with dependents was equal to one half the amount of usual sick pay. At the fund's discretion, household money could be increased to the level of full sickness pay. In addition, funds were permitted to increase the sick pay to single hospitalized subscribers to one quarter or one half the usual sick pay. It should be noted that if a member had no dependents, funds were not bound to pay any cash assistance. While hospital benefits were mandated for all subscribers, hospital coverage for dependents was not mandated. Societies, at their option, were permitted to pay the partial costs of institutional care. Such payments were intended as an equivalent to medical treatment that otherwise would be provided at home. As an example, Koln (Cologne) paid a daily subsidy of 25-75pf. for dependents. <sup>192</sup>

Most hospitals in Germany were acute or somatic hospitals (Akutkrankenhauser). The rest were specialized hospitals (Sonderkrankenhauser) for the care of persons with tuberculosis, psychological disorders, "addiction" diseases, rheumatic diseases and for persons requiring rest and relaxation (Kurkrankenhauser).<sup>193</sup> The majority of acute hospitals were public institutions (oeffentlichen Krankenanstalten). Public hospitals included university clinics (Universitaetkliniken) and Rural Central Hospitals (Landeskrankenhauser). In addition to state and national insurance institutions, clinics run by funds and specialized hospitals (EG: spas, tuberculosis hospitals and rehabilitation centres) formed the second largest group within the acute hospital category. Charitable institutions typically ran general hospitals. Private hospitals did exist.<sup>194</sup> It should be noted that private facilities required a state license in order to contract with a sickness fund.<sup>195</sup>

The majority of German hospitals have traditionally been erected, maintained and administered by communes or municipalities. In rural districts, the Kreis (Rural District) actually built and maintained hospitals with the help of the nearest commune.<sup>196</sup> The Sickness Insurance Act of 1883, which mandated hospital coverage, provided in effect a large subsidy to these local authorities; fund payment covered the cost of treatment or maintenance (room and board). Capital costs, however, were not reimbursed by the funds.<sup>197</sup> While many funds had attempted to make use of private clinics or establish clinics of their own, private hospitals of all sorts tended to have higher charges.

The German hospital has always been, and today remains, a somewhat isolated component of the German health care system. In all but a few instances, hospital care is provided by a salaried staff doctor. There were no attending doctors; the doctor who referred a patient for care essentially left him at the hospital doorstep, relinquishing responsibility for participation in his treatment until the patient was ready for release. While it was permitted, few hospital doctors had private practices.

The separation and distinct roles assumed by ambulatory and institutional providers had implications for both the continuity of care provided the patient and the cost of care to the system as a whole. To address these issues, policy makers established a "case management" system. Case

management, recently revitalized by American policy makers addressing the twin issues of cost and continuity of care, is a series of administrative procedures designed to ensure that the primary care doctor has a rational and effective plan for managing all the care a patient requires to restore his or her health. The 1883 law permitted both primary care doctors and fund administrators to authorize or restrict hospital admissions. Prior authorization protocols were established to facilitate uniformity in admitting procedures among fund doctors. Moreover, the 1883 Sickness Insurance Act granted sickness funds the unconditional right to permit or forbid a patient's hospitalization. <sup>198</sup>

### **Cash Assistance**

Cash assistance was the other major type of benefit provided by the German Sickness Insurance Programme. As an income maintenance mechanism, cash assistance provided for economic welfare when the worker was too ill or otherwise disabled. As noted earlier, cash assistance initially constituted the largest portion of expenditures on services provided by the 1883 legislation. Stipulations of the 1883 Sickness Insurance Act established different types of cash assistance for different types of funds.

For example, the Parochial and Communal Funds were required only to provide cash assistance during illness. The Local and other occupationally related funds were mandated to provide sick pay, maternity benefits, and cash assistance upon the death of a subscriber.

The amount of cash assistance paid also varied by fund. While the Communal and Parochial Funds paid a flat fee to sick members, cash assistance paid by other funds varied by wage class of the worker. Regardless of the type of fund, cash assistance paid as sick pay or maternity benefits was payable at the end of each week. Funeral money was payable upon death.

The benefit period for cash assistance corresponded to the benefit period for direct services. That is, in 1883 basic benefits were extended for a period of thirteen weeks.

Cash assistance or sick pay (Krankengeld) was paid to individual subscribers and covered dependents. Remuneration was made after an initial sickness period of three days at a rate of 50% of the forfeited wage. Sick pay for members of Parochial or Communal Funds was equivalent to one half the average common day labourer's wage. Sick pay for members of other funds varied by the class of worker. Assistance was available as long as medical treatment was being provided. While not required to do so, funds were permitted to pay benefits during the first three days of an illness, on Sundays and holidays. In addition, they were permitted to increase the amount of payment and extend the duration of assistance.

## CHAPTER 6 FINANCE

### Revenues

Both private and public revenue sources funded the German Sickness Insurance Programme. Except for minimal bureaucratic supervision over the programme, federal tax revenues were not used for the provision of health services. This was due in large part to the prevailing theory of laissez faire economics guiding German public policy makers at the inception of the Programme and also due to the desire on the part of labour organizers to retain control over the administration of the sickness funds. Employees and employers were the main contributors to the programme.

The major share of private revenues was paid as premiums by employees for their coverage and the coverage of their dependents and by employers on behalf of those employees working longer than one week in industries for which national Sickness Insurance was compulsory. Charitable contributors existed, though their direct impact on benefit related revenues was negligible. Charitable contributors, including the church and foundations, more commonly provided capital for the construction of hospitals and sanatoria.

Compulsorily enrolled individuals paid only 67% of the total premium due for their insurance. The subscriber's employer paid the remaining 33% of the premium. Three exceptions merit mention: the rate of employer-employee contribution in the Miner's Funds was negotiable. In practice, the employer often paid as much as the employee. The administrative rules governing the Guild Funds also permitted equal employer-employee contributions. In contrast, voluntary subscribers to Mutual Aid Funds (Ersatzkassen) whose incomes were slightly higher, paid the entire premium themselves. Employers whose employees chose membership in a Mutual Aid Fund were required to pay premiums for those employees whose incomes required them to participate in the national Sickness Insurance Programme. The employer paid his premium share to the fund the employee would otherwise have belonged to by virtue of their occupation.<sup>199</sup> This practice facilitated reliable budgeting by the funds.

The contributory scheme of shared employer-employee paid health insurance premiums adopted by policy makers in the 1883 Sickness Insurance Act was patterned after a similar policy originally established by the old Voluntary Funds. The legislature which adopted the first national Sickness Insurance Programme in Germany chose this "private pay" mechanism to minimize state intervention in the programme. Consistent with the laissez faire doctrine, minimal state participation, they said, would ensure that the working person had an incentive to maintain a large measure of personal responsibility over his health and welfare. In addition, legislators recognized that the federal treasury benefited by this contributory scheme. Fiscal responsibility for welfare of the working person, formerly financed largely by the federal and local governments as poor relief, was largely shifted from the public to the private sector. <sup>200</sup>

Premium rates were variable. Although rate setting methodologies differed among the eight types of funds, all of the methods used similar variables. These variables included: a) the scope of the benefit package, b) health status, c) income, and d) the level of occupational risk involved in day to day work.

Today, American health insurance companies which set rates according to these types of variables are said to experience-rate their premiums. This means that they vary premiums according to an individual's or cohort's specific demographic characteristics. Actuaries employed to calculate a rate for a new group insurance contract will collect information on the age, sex, income, and health status of the persons to be insured. They will then compare this information with data from other groups with similar demographic characteristics in the same industrial grouping. With this comparison, they are able to predict the potential utilization of health care services and probable cost of insuring this new group. The rate to be charged the group and the per capita premium assessment are then derived.

In contrast to experience rating, insurance plans that assess the same premium rate for all subscribers receiving the same benefits, regardless of their age, sex, income or health status, are said to community-rate their premiums. Community rating is often associated with Health Maintenance

Organizations (HMO) in America. HMOs typically contract with a selected group of health care providers to supply a defined set of services for a predetermined fee.

Very recently, the Kaiser Foundation Health Plan, one of the oldest, largest and most established of the American HMOs, has begun to use a new rate setting methodology: Adjusted Community Rating. Very simply, adjusted community-rating allows the HMO to assess different premiums for different classes of subscribers. Using the adjusted community-rating methodology, Kaiser is able to share the risk of insuring different kinds of people broadly among one class of persons (EG: all Medicare insured persons). This insulates one class of persons from assuming the cost, either exceptionally high or low, of another class. If placed on a continuum with experience-rating on one end of the scale and community rating on the other end of the scale, adjusted community rating would fall somewhere in the middle. Similarly, if one were to assume that community-rating was the most progressive methodology in terms of risk or income distribution, and experience-rating was the least, adjusted community-rating could be labeled either progressively conservative or conservatively progressive.

While adjusted community-rating is a new concept to American health planners, the methodology certainly is not new. Without labelling it as such, the German Health Insurance Act of 1883 used adjusted community-rating to set premiums. While the Germans employed all the variables associated with experience-rating, legislators established benefit floors and premium ceilings that effectively eliminated a good deal of the variation among experience-rated premiums. Furthermore, because the majority of workers from any one company, or for that matter occupation, who resided in one geographic area belonged to one fund, and because benefit packages were generally set on a fund by fund basis, there was limited variation in premiums due to either benefit differentials or company, within an industry classification.

The level of occupational hazard was also a factor used in determining premium rates. Industrial classifications with unusually high occupational risk of illness were subject to special rate setting regulations. The regulations applied largely to Local Funds, the funds established for

"miscellaneous" trades and undertakings and the Contractors' Funds which were established for special construction projects. These funds were permitted to charge higher rates for those workers who were exposed to a considerable amount of risk. Unfortunately, while such regulations protected other subscribers from exorbitant rates, they placed the burden of payment on the subscriber in the "unhealthy trade" rather than create an economic incentive for the employer to decrease occupational risk. <sup>201</sup>

In addition to establishing maximum wage levels for the assessment of premiums, rates were set for wage classes, not individuals. This procedure more firmly likens the German rate setting methodology to adjusted community-rating.

For each wage class, the premium was levied as a percentage of wages. The enrollee's contribution ranged from 1%-5% of total wages. <sup>202</sup> Unlike flat fee premiums used by American insurance companies which insure against the financial risk associated with treating an illness, the percentage-based, wage-linked premiums were necessary so that cash assistance paid rose commensurately with wages. The maximum daily premium for a worker was 4 M. The employer's contribution was assessed at 50% of the employee's premium.

In all funds except Communal and Parochial Funds average premiums for employees amounted to 2%-3% of wages. The combined employee-employer premiums were not permitted to exceed 6%. <sup>203 204</sup>

In the Parochial and Communal Funds, which assessed premiums according to the recognized local wage rate for common day labour, the average employee-paid premiums amounted to 1%-1.33% of the average wage of the common day labourer. Combined employer-employee premiums could not exceed 3% of the average wage rate. <sup>205</sup>

Table B below shows the mean premium rates for workers in large Local and Factory funds. Table C shows the mean premium rates paid by employers in seven selected industries.

**TABLE B****PREMIUM RATES PAID BY WORKERS IN LOCAL & FACTORY FUNDS****Percentage of Wages****A. Local Funds**

Berlin Fund for Commercial Employees	2.8
Leipzig General Sickness Fund	2.7
Berlin Fund for Machine Builders	3.1
Berlin Fund for Tailoring Trade	2.0
Berlin Fund for Printing Trade	3.0

**B. Factory Funds**

Berlin General Electricity Co. (AEG)	2.5
Berlin Siemens Works (Elec. Works)	2.2
L. Loewe and Co. (machine tools) Berlin	2.33
Royal Porcelain Manufactory	3
Hildebrand and Son (Chocolate)	2
United Cement Works	2
Berlin Municipality	2.66
Great Berlin Tramway Co.	2.66
Berlin Omnibus Co.	2.33
Dusseldorf Pipe and Iron Rolling Works	3
Hohenzollern Locomotive Works, Dusseldorf	2.5
Heinrich Lanz, Motor Car Works, Mannheim	2.66
Waldhof Paper Works, Mannheim	2.66

**TABLE C**

**EMPLOYER PAID PREMIUM RATES IN  
SEVEN INDUSTRIES**

Steel	1.04%
Machinery	.9
Machinery	1.1
Electrical Eng.	1.1
Shipbuilding	.9
Glass	1.9
Cotton Spinning	1.0

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What did the rates mean in terms of actual payments for workers in different wage classes?

Table D which follows, illustrates the weekly payments made by the average industrial worker by wage and wage class at a 2.33% premium rate.

**TABLE D**

**WEEKLY PREMIUM PAYMENTS FOR INDUSTRIAL  
WORKERS**

<b>Class</b>	<b>Wage</b>	<b>Contribution</b>
5	30M	70.0 pf
	27M	62.5 pf
	24M	54.0 pf
4	30M	56.0 pf
	18M	42.0 pf
	15M	35.0 pf
3	12M	27.0 pf
2	9M	21.0 pf
1	6M	14.5 pf

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Table E below, shows the average industrial employer's weekly payment based on a combined employer-employee rate of 3.5%.

**TABLE E**

**WEEKLY PREMIUM PAYMENTS BY EMPLOYERS**

<b>Weekly Wages</b>	<b>Weekly Contribution</b>
30M	35.0 pf
27M	31.0 pf
24M	27.0 pf
20M	23.0 pf
18M	21.0 pf
15M	17.0 pf
12M	14.5 pf
9M	10.0 pf
6M	6.0 PF

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Premium rates had to be fixed so that revenue equaled or exceeded fund expenditures for mandated benefits. Enrollment fees were not permitted.

Both the employer and employee premium shares were paid by the employer to the sickness fund. The employer deducted the employee's premium from his wages. Total payment was made to the fund no later than one day following the day the employee's payroll deduction was made. The employee was not penalized if the employer failed to make the payment on time. The defaulting employer was required to pay all charges incurred in the treatment of his employees during the default period. In addition, the employer could be fined up to 20 M or L 1.00. The regular interval for premium payments varied. The Sickness Insurance Act of 1883 stipulated that payment intervals could not exceed one month. Premiums were waived during sickness.

Each sickness fund was financially independent. Each had its own treasury which collected premiums and paid claims. The funds were liable for the payment of all claims except in three specific cases: in Establishment and Contractors' Funds, participating employers were responsible for any deficits. Communal authorities were liable for deficits incurred by Communal Funds.

### *Voluntary Funds*

There were two types of voluntary subscribers; those individuals with incomes exceeding the eligibility requirements for mandatory coverage who chose to participate in the national insurance programme and those individuals who met the income requirements for mandatory coverage who chose to join a Mutual Aid Fund. All voluntary subscribers paid the entire required premium directly to the sickness fund. As noted earlier, the employer of a subscriber for whom coverage was mandated but who chose a Mutual Aid Fund was required to pay the employer premium on that employee's behalf to the fund in which he would otherwise have been enrolled.

Premiums for voluntary subscribers were calculated on a maximum wage of 6 M per day or 1,800 M per year. This contrasts with the 5 M maximum established for non-voluntary subscribers.

### *Government's Contribution*

Ostensibly, there was no public subsidy for the national Sickness Insurance Programme. While this is largely true on the federal level, it is not true on the local level. Local government was responsible for bureaucratic supervision of the programme. Administrative costs were substantial. These costs were borne by the local authorities. In addition, as noted earlier, local authorities were responsible for making up deficits in Communal Funds which provided coverage to all those for whom insurance was mandated but for whom there was no appropriate alternative fund. In 1909 for example, Hamburg paid over 10,000 M to cover deficits incurred by the Communal Funds. Also, local government subsidized treatment of the insured and uninsured in public hospitals. <sup>210</sup>

## CHAPTER 7 ADMINISTRATION

Unlike the roles assumed by the British, Norwegian and Russian governments in the administration of their national health care programmes, the German government did not play a major role in the day-to-day operation of the Sickness Insurance Programme. In Germany, there was no large centralized bureaucracy. The federal government set guidelines for benefit design and eligibility and defined revenue sources and collection methods. Administration or daily management of the programme was a sickness fund function. The sickness funds defined benefit packages, enrolled members, collected revenues, negotiated and managed provider contracts and processed claims.

This chapter focuses on describing the management structure and administrative functions of the funds. The administrative role assumed by the federal government, albeit small, will be described. The reasons for the lack of a centralized federal bureaucracy will be discussed.

### **Fund Administrative Structure**

The sickness funds were managed jointly by representatives from the insured persons and the contributing employers. The number of representatives selected by each group depended on the percentage of revenues contributed to the fund. Employees selected two thirds (2/3) of the fund managers while employers selected one third (1/3) for all but the Mutual Aid Funds and Parochial Funds. Because revenues necessary to provide benefits by the Mutual Aid Funds were collected entirely from fund members (employees), the membership retained complete administrative control over the Mutual Aid Funds. In contrast, members of the Parochial Funds held no administrative authority. The Parochial Funds were funded entirely by local government. <sup>211</sup>

It is interesting to note that doctors had no role in fund management in the years immediately after the enactment of the Sickness Insurance Act. In contrast to many of the HMOs and other hybrid health plan models springing up in the United States today, none of the German Sickness Funds were doctor organized or controlled. Provider control of the new U.S. plans is motivated by the doctors' or hospital's desire to control not only the fee structure but also provider participation. Prior to the 1883

legislation's enactment, the German providers could not know what impact a nationwide organized insurance programme would have on their practices; the German Sickness Insurance Programme was the first programme of its kind in the world.

The provider role in management did change over the twenty five year period between 1883 and 1911. As the Funds began to implement stringent utilization review and control programmes, the newly emerging professional organizations representing the doctors were successful in negotiating with the funds for professional participation in, and in some cases, control of these activities. After the turn of the century, the professional organizations played an increasingly influential role in fund decisions relating to reimbursement and provider contracting. However, at no time was a defined management role created for them legislatively. This evolution of provider participation in fund administration will be detailed in PART III: The Shifting Balance of Power.

In the early years following the implementation of the programme, the joint management teams had responsibility for defining fund policies and regulations. The executive director of the fund was generally chosen from among the members of the management team. The executive could be either a representative of the contributing employers or a representative of the insured employees.

The Factory Funds were a notable exception. The 1883 legislation gave employer representatives in the Factory Funds the authority to develop fund policies and regulations. This authority permitted them to stipulate that an employer representative chair the executive committee.

<sup>212</sup> This was an important exception for it later paved the way for Bismarck to grant additional administrative power to the employers. By allowing an employer representative to chair the fund's executive committee, Bismarck felt he would be able to quell labour unrest and stem the growth of the labour movement which was centered on the sickness funds during the late 1880's and 1890's.

## **Fund Administrative Functions**

Of the ten administrative functions connected with the Sickness Insurance Programme, the sickness insurance funds were responsible either directly or indirectly for nine functions. The federal government set eligibility criteria and in some instances determined eligibility largely with the assistance of employers. The funds managed all aspects of the programme beginning with enrolment. The fund was directly responsible for designing a benefit package, collecting revenues, negotiating contracts with providers, processing claims, reimbursing providers or provider groups, and maintaining an accurate utilization and cost data base. By the turn of the century, fund management would be indirectly responsible for utilization review and quality assurance, and in some cases, direct reimbursement of doctors. These last three functions were the responsibility of the Confidential Medical Advisor or Confidential Medical Committee. The latter were organized and operated by doctors. In the early years of the Sickness Insurance Programme there was no central medical review organization. Each fund had its own Confidential Medical Advisor or Committee. The utilization review function in particular evolved as a product of the sickness funds' desire to contain costs and the provider reaction to their chosen mechanisms. The next chapter will discuss this evolution in greater detail.

The preceding five chapters described the enrollment process, benefit design, revenue collection, provider contracting and reimbursement and utilization review and quality assurance programmes. The chart below summarizes these activities:

**Fund Administrative Functions  
1883-1911**

- |     |                       |  |
|-----|-----------------------|--|
| 1.  | Eligibility           | <ul style="list-style-type: none"> <li>- Federal government sets eligibility criteria.</li> <li>- Employer and funds must determine eligibility</li> </ul>   |
| 2.  | Enrollment            | <ul style="list-style-type: none"> <li>- Majority of individuals must enroll</li> <li>- Arrangements between employers and funds.</li> <li>- Employer supplies information on new employees.</li> </ul>  |
| 3.  | Membership Management | <ul style="list-style-type: none"> <li>- Funds maintain all records: Send late payment notices, etc.</li> <li>- Record grievances, etc.</li> <li>- Answer inquiries from prospective members</li> </ul>  |
| 4.  | Benefit Design        | <ul style="list-style-type: none"> <li>- Define package including minimum federally mandated benefits and selection of permissive benefits.</li> <li>- Set duration of benefit periods.</li> </ul>   |
| 5.  | Revenue Collection    | <ul style="list-style-type: none"> <li>- Employers collect from employee (payroll deduction).</li> <li>- Funds collect from employers</li> </ul>   |
| 6.  | Provider Contracting  | <ul style="list-style-type: none"> <li>- Funds or legal representatives negotiate directly with individual physicians or through physician association.</li> <li>- Separate hospital contracts (<i>in most cases hospitals contract for attending staff. Funds not involved.</i>)</li> </ul>   |
| 7.  | Claims Processing     | <ul style="list-style-type: none"> <li>- Funds handle provider claims and member claims for medical assistance</li> <li>- Review claims for correct fees, the number of services provided, etc.</li> </ul>   |
| 8.  | Provider Payment      | <ul style="list-style-type: none"> <li>- Funds paid doctors FFS, capitation payments or salary or Funds paid doctor group (most often confidential medical committee) capitation payments. Doctor group paid individual doctors on FFS basis.</li> <li>- Funds paid hospitals per diem and FFS for ancillaries.</li> </ul>   |
| 9.  | Utilization Review    | <ul style="list-style-type: none"> <li>- Funds collect and organize data. Pass to Confidential Medical Committee.</li> <li>- Confidential Medical Advisor or Committee review data, find abnormal practice patterns and take corrective action.</li> </ul>   |
| 10. | Quality Assurance     | <ul style="list-style-type: none"> <li>- Confidential Committees monitor under-utilization.</li> <li>- Confidential Committee fields grievances from patients about organization</li> <li>- Fund Executive fields grievances from doctors about patients.</li> <li>- Confidential Committee fields grievances from doctors about Fund administration.</li> <li>- Fund records member complaints about hospital care.</li> <li>- Federal government may require funds to negotiate new contract if many complaints are logged.</li> </ul> |

### *Administration and the Insured Person*

Insured persons had virtually no administrative responsibilities. Enrolment was automatic for most workers in eligible industries. The employee premium share was paid by the employer by means of a payroll deduction. With the exception of prescription drugs on which a copayment was levied, there were no copayments or other fees paid at the point of service delivery. In contrast to the predominant health coverage in the United States, indemnity insurance, programme participants did not fill out or submit any claims forms. The majority of Germans enrolled in the programme were only responsible for submitting a voucher quarterly to the primary care doctor of their choice.<sup>213</sup> Giving the voucher to the doctor lets both the doctor and the fund know that the doctor was that individual's case manager. Submitting the voucher also triggered capitation fees to that doctor or assured that fees claimed by that doctor (assuming fee-for-service payment) were likely to be for services rendered to that patient. Recent studies in the United States indicate that administrative ease is attracting many Americans, particularly the elderly, to HMOs. HMOs typically do not require members to use claims forms. It should be noted however that most HMOs do require copayments on services at the point of delivery. These copayments are used as an incentive to users to control utilization.

### **Federal Administrative Structure and Function**

The Sickness Insurance Act of 1883 established an Imperial Insurance Office. von Boedicker, a key advisor to Bismarck during the development of the Sickness Insurance Programme, was the first president of the Imperial Insurance Office.<sup>214</sup> In addition to the Imperial or federal office, the federal government, in conjunction with state authorities, established and maintained insurance offices in many regions and localities. These offices were to become more important in the post 1911 era, when they were used largely in the eligibility determination process and in the arbitration of contract disputes.<sup>215</sup> It is especially interesting to note that neither the regional or federal offices were responsible for any centralized planning. While mortality and morbidity figures were collected by the government, these data were not compared to utilization or cost data collected by the funds. As a result, any amendments or adjustments to federal statutes were largely the result of a political rather than "scientific" process.

There are several reasons why the 1883 Sickness Insurance Act did not create a central bureaucracy for the administration of the German Sickness Insurance Programme. Perhaps the most important is that the federal Sickness Insurance Programme evolved naturally from a non-federally authorized yet highly visible and utilized system of labour associations that provided health care benefits and cash assistance to their members. By 1883 these associations were established for almost all industries and in every region of the country. After the enactment of the 1883 Act, the funds were permitted to continue to perform the administrative functions as they had done so efficiently during the previous 100 years. In addition to recognizing the convenience that maintaining the fund administrative mechanism would mean during the transition to a national Sickness Insurance Programme, the federal government recognized that the creation of any centralized bureaucracy would increase the cost of the programme to the federal government. The federal government had managed to avoid contributing service monies and did not desire to expend administrative monies either.

For different reasons, both Bismarck's personal opposition and the labour movement's apprehension limited federal intervention in the Sickness Insurance Programme. While ideologically the Labour Party and its supporters would have encouraged a substantial government role in a national health care programme, they felt strongly that a major federal presence would detract from the benefits a national health programme would bring to the working class. Labour saw no reason why a government that did not contribute towards the cost of providing benefits should have any control over the administration of those benefits. In light of the 1878 Anti-Socialist Law, they also feared federal repression. In 1883, the sickness funds were the only legal organizations where the socialist labour movement could effectively operate.

While the government's direct role in administration of the health insurance programme was limited, the federal, state and local governing bodies did play a role in the administration of public health care programmes. Indirectly, these public health activities impacted the insurance programme and therefore warrant mention here. On the federal level, the government established the Imperial Health Department, headed nominally by the Chancellor but run on a day-to-day basis by a director (who was a lawyer) and staffed with ten "members" (seven of whom were medical professionals), one

veterinarian, two analytical chemists and twenty general staff people. The office had a thirty five member advisory board appointed by the Kaiser. Most important to the insurance programme, one standing committee of the Department was assigned the task of preparing the German Pharmacopoeia. Drugs listed in the Pharmacopoeia were reimbursed by the Sickness Insurance Programme.

In addition to the Imperial Health Department, each state had at least two agencies for managing medical affairs. Known as the Zentralinstanz or Upper Court and the Lokalinstanz or Lower Court, these agencies, and a Medical Commission which served in an advisory capacity, presided over the licensure examinations for doctors wishing to practice medicine. The Commission, also known as the Scientific Deputation for Medical Affairs, was the highest authority in the state for matters of medical jurisprudence.

Finally on the local level, each municipality appointed a Gerichtsarzt (a.k.a. Kreis-physikus, Bezirks-arzt or Oberamts-arzt). This appointed doctor was responsible for the following tasks, many of which deal with the licensure and inspection of providers working in the sickness insurance programme and public health:

- 1) Inspection of pharmacies
- 2) Certification of midwives, nurses and masseurs
- 3) Control of unlicensed practitioners
- 4) Preparation of medical statistics
- 5) Investigation of soil and water supplies
- 6) Prevention of infectious disease
- 7) Control of factory and school hygiene
- 8) Inspection of public and private hospitals, prisons and reformatories
- 9) Inspection of baths and spas
- 10) Control of autopsies and burials. <sup>216</sup>

### **PART III**

#### **The Shifting Balance of Power: Provider, Consumer, Government and Employer Influence on the German Sickness Insurance Programme Between 1883-1911**

## CHAPTER 8

### 1883-1892: INNOVATION WITHOUT REPRESENTATION: Sickness Funds and Consumers Maintain Control

This chapter describes the Sickness Insurance Programme between 1883 the year of its enactment, and 1892, the year during which the first set of amendments to the 1883 Act were passed. The period is interesting in that the balance of power between the providers and the consumers represented through the sickness funds changed little. The amendments largely favored the interests of the sickness funds to contain costs and increase their control over the provider network. The discussion attempts to shed light on several questions: Why could the labour-dominated sickness funds prevail? Were doctors and hospitals interests still aligned with those of the sickness funds? Were their expectations of the programme fulfilled? What issues concerned them? Did federal legislators become involved in mediating between the two parties? Was there a great deal of debate on the 1892 amendments and did their passage serve to create a larger gulf between the parties or unite them?

The Sickness Insurance Act of 1883 dramatically expanded access to health care coverage. Before 1883, only two million Germans had any form of health care coverage. Most of these people were members of one of the many sickness funds which predated the programme. In 1885, only one year after the programme was implemented, 4.3 million Germans were covered. This was 40% of the employed population and 10% of the nation's citizenry.

The workers who were covered by the initial legislation were largely represented in Parliament by the Social Democrats. Interestingly, however, the 1883 Sickness Insurance Act passed without their support. In the final debate on the proposed law, Heinrich Dietz, speaking for the Social Democrats said, "*The law, as a whole and in its parts does not include the demands of the working class*". He complained that many groups of workers were excluded from coverage and opposed the large administrative role given to employers. Labour at the time supported worker self-administration of the funds. <sup>217</sup>

While the Social Democrats publicly opposed the legislation, the party's platform did not mirror the of all the party's members. Popular support for the programme was much more widespread than the public statements by the party suggested. The working class was concerned more with immediate and practical solutions to the problems they faced daily than with a long term struggle to change society. On labour's urging, the Social Democrats accepted the majority control over the programme's operations which the law had granted them and put it to work in their interest. Lenin, seeing popular support, slowly moulded the party platform to more closely resemble labour's position. He called the Sickness Insurance Programme a good interim measure. He suggested that the party accept the programme as "practical" and advocated:

1. Insurance to secure the worker in all cases when his ability to work was threatened or when unemployment and loss of salary threatens well-being.
2. Insurance that was universal, covering all workers and their families.
3. Insurance premiums paid by employers and the state.
4. An insurance programme coordinated by one state agency. The funds should be locally controlled by the workers (self administration). <sup>218</sup>

Other party leaders felt that the 1883 Act was a calculated attempt to control the last remaining bastion of the socialist-dominated labour movement. They suggested that workers leave the compulsory funds where control over the funds' activities was now to be shared with employers.

Between 1880 and 1886, membership in the worker financed and controlled Voluntary Funds increased from 60,000 to 731,943. <sup>219</sup> However, with growing unemployment, the revocation of the Anti-Socialist Law on January 25, 1890, and Bismarck's defeat later in the decade, the working class in all funds, both voluntary and compulsory, turned their attention to finding immediate and practical changes in their work and living conditions. Thus, the labour movement focused its political energy on expanding the minimum benefit package required by the sickness insurance programme.

In many ways, the interest of employers mirrored the desire of the labour movement to retain worker control over their health care programme. The majority of industrial employers in Germany believed that the Sickness Insurance Act of 1883 had the potential to increase productivity by decreasing extended absenteeism due to illness. They also supported this legislation because it had the potential to quell growing labour unrest over poor working conditions. There was, however, a crucial difference in opinion over the issue of responsibility for programme support. The employers were displeased by the adoption of the shared contributory scheme.<sup>220</sup> Like federal policy makers, employers would rather have seen the financial responsibility for the new health care programme rest on someone else's shoulders. Moreover, the employers feared that the new welfare programme would abrogate the employee's responsibility for his own health and would create expectations for increased federally authorized (though not federally funded) welfare programmes, such as an unemployment compensation programme. The employers warned that business contributions under the new Sickness Insurance Programme and any other new programmes would cut severely into their profits, which under other circumstances could be used to provide capital for economic expansion. As mentioned above, one segment of the labour movement favoured a programme which was entirely supported by employer payments.

In contrast to organized labour which represented the majority of the newly eligible population, the provider community supported the enactment of the Sickness Insurance Act of 1883. The providers foresaw no operational problems between themselves and the funds which were given the primary responsibility for administration of the programme.<sup>221</sup> Correspondingly, policy makers considered the relationship between the funds and the doctors so unproblematic that contracting arrangements, payment terms and procedures and a detailed list of covered services were not defined in the legislation or the ensuing regulations which implemented the law.

After the initial implementation of the programme in 1884, the sickness funds contracted with a majority of doctors in any given area and paid them largely on a fee-for-service basis. However, the number of primary care practitioners grew rapidly as did the income of participating doctors.

Beginning in the late 1880's the sickness funds lobbied for an amendment to the 1883 Act which legitimated their right to contract selectively with providers. They argued that the new provisions would enable them to better control costs and thereby ensure access for their members to a comprehensive range of services. The fund leadership also contended that the quality of care could be regulated with control of the provider panel.

Selective contracting fostered cost containment and quality control because the fund could work only with those doctors whose practice style was cost efficient and met the standards the funds established for quality. Moreover, monitoring utilization of a limited number of doctors was certainly easier than monitoring utilization of a large and changing group of practitioners. Selective contracting was also important to the funds because it frequently incorporated capitation reimbursement. Capitation reimbursement meant that a doctor was paid a fixed fee based on the number of members registered to receive his or her care. This fixed fee remained the same regardless of the number of services provided. The doctor therefore had an economic incentive to control utilization. ( Health Maintenance Organizations also use capitation reimbursement where the doctor assumes the risk associated with providing all needed services to members. This incentive controls utilization and cost.)

The 1883 law immediately allowed the sickness funds to negotiate contracts with one or more pharmacies to serve the fund membership. <sup>222</sup> Similar to American HMOs, once these contracts were signed, funds could prohibit members from obtaining medicine from any other pharmacies unless it was an emergency or the member chose to pay for the prescription himself. <sup>223</sup> Though the law did not stipulate it, pharmacists generally gave funds liberal discounts. These discounts varied from ten to twenty percent off officially fixed prices. <sup>224</sup>

Once again, the funds, not the pharmacies, had complaints about the law's provisions for medicaments and their distribution. The funds said that the list of drugs was too comprehensive, that it included "stock medicines" which they could supply at a much lower cost. <sup>225</sup> Also adding to the price, they said, was the continued monopoly of the pharmacies to dispense listed drugs. By

separating both the payment and the distribution from the doctors, there was no financial incentive for the doctors to prescribe drugs economically. <sup>226</sup>

To minimize the economic impact of the pharmacy monopoly, the funds did the following: first, they made sure that all non-prescription drugs and pharmaceuticals were purchased at the lowest cost. Whoever was the lowest cost supplier got the business. This could be either a pharmacy or a drug store. The funds' primary concern was not the members' convenience. Second, the funds monitored both doctors and pharmacies to ensure that only mandated prescription drugs were dispensed, and that prescriptions were appropriate and correctly charged. All non-prescription drugs were to be purchased from the lowest cost provider. Last, the funds purchased and directly distributed bandages, medical appliances and other stock medicaments including medicinal foods. They purchased these items at wholesale cost and minimized their distribution expenses. <sup>227</sup>

The first set of amendments to the 1883 Sickness Insurance Law passed on April 10, 1892. The new law permitted the funds to contract with a selective group of doctors if they chose to do so. They were empowered to determine not only the number of doctors but also the types of doctors to be employed. The prerogative to contract selectively with both a limited number and type of doctors is interesting largely because it evidences not only a very concerted effort on the part of the funds to contain costs by controlling doctors but the continued evolution of clinical practice. Like the primary care network model for HMOs in the United States, the funds wanted to encourage members to use lower cost primary care services rather than more costly specialist services.

The funds had established purchasing procedures for pharmaceutical items which seemed to function adequately. Legislation affecting the pharmacies was not passed until 1894.

The 1892 amendments also extended compulsory health insurance coverage to both men and women engaged in paid employment in the following industries:

- 1) factories and workshops
- 2) mines and quarries
- 3) iron works
- 4) shipping
- 5) inland transportation services (e.g. railways)
- 6) construction
- 7) mechanical trades
- 8) communication (e.g. postal and telegraph services)
- 9) military and naval administration
- 10) trade and commerce
- 11) handicrafts
- 12) office support services (EG: clerks)
- 13) courts and private law practices.

Factory supervisors and foremen as well as shop assistants were eligible for coverage only if they earned less than the maximum income standards of 2,000 M or less per year. The self-employed, active military personnel and state and municipal workers were still not provided with sickness insurance. <sup>228</sup>

Perhaps the most important features of the new law were the amendments granting municipalities the authority to require health insurance coverage for home-workers, agricultural labourers and domestics. Furthermore, municipalities were authorized to extend voluntary membership to any individual with an annual income at or less than 2,000 M.

The 1892 amendments, however, did not result in an immediate or precipitous increase in the number of Germans enrolled in Sickness Funds. Fund membership continued to grow steadily as it had between 1885 and 1892 when the number of enrollees increased from 4,670,959 to 7,342,958. Without these changes, fund growth might very well have leveled to the rate of population increase.

Why did the 1892 law pass? By 1890, the labour movement, represented in the Reichstag by the Social Democrats, had a considerable number of seats. Moreover, the provider community was as yet unorganized.

The 1892 amendments prompted provider concern and may be considered the first catalyst for change in provider attitudes toward the Sickness Insurance Programme. As it was for the sickness funds, the issue of open or selective contracting was an economic issue for the providers. While the

funds viewed contracting as an excellent means of achieving cost containment, the doctors feared that certain new contracting efforts would threaten their economic well-being. No longer did they believe that selective contracting would exclude non-licensed practitioners only.

Physicians favoured "free choice"- a term they hoped would enlist the sickness fund member in support of open contracting. Typically, free choice of doctor is associated with fee-for-service reimbursement. This type of contracting and reimbursement arrangement is similar to the U.S. third-party reimbursement system.

Free choice was crucial to doctors. The 1883 legislation greatly swelled the numbers of persons eligible for medical care. While the funds provided and guaranteed a source of payment for services rendered to these individuals, the doctors feared that the funds could "lock-out" many doctors from caring for these individuals and receiving the associated revenues.

The doctors argued that free choice would promote competition among doctors. The competition, in turn, would contain costs and maintain a high level of quality in the care rendered fund members. They contended that the doctor would spend more time with a patient. Competition would encourage the practice of preventive medicine and discourage hospital admissions. <sup>229</sup>

Regardless of whether the doctor was part of an open or selective contracting arrangement, it should be noted that the 1883 law permitted fund members to purchase services privately on a fee-for-service basis from any doctor. They were not reimbursed for these services.

## CHAPTER 9

### 1893-1904: THE TRANSITION PERIOD: Sickness Fund Efforts to Contain Costs Backfire as the Providers Mobilize their Professional Colleagues

If the financing resources had been unlimited or the funds' authority to contain costs more strictly regulated, provider reaction to the 1892 amendments would have been more positive. As it was, the evolving programme, did not live up to the providers' expectations for greater clinical freedom and a secure and enhanced livelihood. The 1892 amendments threatened the doctors' income security and curtailed their ability to seek out and treat patients. These three issues-- "free choice" (open or selective contracting), the right to self-administration or regulation and payment rates and procedures-- were hotly debated after the late 1880's. This debate and its outcome is the subject of this chapter.

In 1893, the funds' concern with finding a workable solution to rapidly escalating health care costs<sup>230</sup> was reignited. At the suggestion of Dr. Friedrich Landmann, a prominent doctor and socialist speaking at the conference of the Central Organization for Sickness Funds in 1893, the funds established a policy of employing a medical doctor as part of the administrative staff of the fund. This doctor, known as the Confidential Medical Advisor (*Vertrauenarzt*), was responsible for monitoring the utilization practices of the fund doctors. In so doing, the doctor was also responsible for quality assurance, that is, making sure that underutilization did not occur and that unlicensed practitioners were monitored.

While the funds were now implementing several cost containment and quality assurance alternatives, including, for example, limiting the number of contracting doctors and regulating the use of prescription drugs, Landmann strongly advocated for doctor review.<sup>231</sup> He argued that the employment of a doctor (preferably one with the proper political ideology) would be a sign to the fund members that the medical profession was indeed concerned with providing high quality care. The proposal was an important response to complaints that doctors were merely prescription writers. Landmann's proposal also provided a means for the funds to avoid additional conflict with doctors. By suggesting that doctors "police" their colleagues, the doctors retained control over the practice of

clinical medicine. As noted earlier, this was extremely important to doctors at the time. This doctor review position also gave the medical profession the opportunity to control its competitors, the unlicensed medical practitioners. The first doctor review positions were established at Iserlohn, Remscheid, Barmen and Elberfeld in 1894. Thereafter, the number of Confidential Medical Advisors increased rapidly.

The statistics of the Leipzig District Sickness Society indicate that the Confidential Medical Advisors did, in fact, play an important role in utilization control. For example, in 1910, 8,497 persons were referred to the Confidential Medical Advisor for an examination to determine whether or not they were genuinely able to work. Of these 8,497 patients, 111 were later excused from the exam, 1,259 did not keep their appointments and 1,300 persons notified the fund of their recovery prior to the examination date. Of the 5,827 examinations that were completed, 47% of the patients were deemed fit to return to work immediately, 12% were asked to return to work within one week's time, 10% were to be reexamined within a two week period and 31% were declared disabled and therefore unfit to work. <sup>232</sup>

While the doctors did not embrace the new fund policy, they did support the principle behind the policy and recognized its potential positive impact on their practices. As the medical profession grew, so did their demand for self-regulation. Not only did doctors wish to have sole authority to monitor their colleagues; they also wished to select, from among themselves, the individual or group of individuals who would be responsible for utilization review and quality assurance.

In 1894, the Prussian government passed a law which had a major effect on the pharmacy monopoly. Pharmacy licenses could no longer be sold or bequeathed. In the event of the death of the licensee, the license reverted to the state which could grant a new license to the pharmacist of their choice. This meant that the government, not the industry controlled the monopoly. Pharmacies established before 1894 were not affected. <sup>233</sup>

The 1894 law is interesting because, like the 1892 amendments which controlled services provided by doctors, it aimed to regulate supply in order to contain costs. And, while each law created a reaction among the provider group to which it applied, the impact of the 1892 amendments was more marked on the doctors.

Selective contracting and the imposition of formal utilization review mechanisms caused a great deal of concern among doctors. The number of practitioners had increased markedly, and now the funds would limit those who could treat the growing number of persons who were enrolled in one of the funds. Moreover, the competition among doctors to participate as fund providers gave the funds new leverage to negotiate discounted fee-for-service rates, capitation payments or salary doctors. This threatened not only the doctors' their social standing but also the livelihood of many practitioners. There was also concern over the new utilization practices. Even before the enactment of the Sickness Insurance Act of 1883, doctors, through the Aerztevereinbund, the only professional organization to predate the Sickness Insurance Programme, had fought against outside regulation of their profession. While they were unsuccessful in preventing the enactment of a law creating a governmentally controlled "medical court" or watchdog agency, they were successful in gaining significant representation on, and therefore control of, these agencies.<sup>234</sup> The doctors were not as alarmed by this law as they were over the move by the sickness funds. As noted earlier, they viewed the government's creation of provincial medical courts as a tacit recognition of the role of the clinical practitioner in society.<sup>235</sup> They saw the fund efforts as direct interference in the practice of their profession.

In response, a group of doctors formed the Berlin "Free Choice" Association of Doctors.<sup>236</sup> As the name implies, this group was primarily concerned with assuring open contracting provisions for their members with the funds. The Aerztevereinbund (Doctor's Union) continued to advocate primarily for the right to self-regulation.

In 1896, the government again went on the offensive. This time they created a central committee for the provincial medical courts. The stated function of the central committee was to coordinate communication between the federal Minister for Medical Affairs and the courts. It so

happened that in this case, the creation of a central agency did not result in greater regulation of the profession. In fact, while communication did flow more smoothly, it did so more slowly, thus making new policy development a more lengthy process and enforcement more difficult. Nonetheless, the government action made the doctors more wary.

Two years later, in 1898, Friedrich Landmann proffered another proposal. This time he suggested that the system could be more cost efficient if the funds limited the number of hospital admissions, specialist referrals and prescriptions to norms derived from the average of the past three years experience. He also proposed that funds dispense drugs directly and organize providers to ensure 24-hour, 7-day per week care. The proposals were originally implemented in Barmen. Those fund doctors who refused to support the plan were fired and replaced by those who would. For the first time since the Sickness Insurance Programme's implementation in 1883, the doctors went on strike.

The strike in Barmen lasted eight days. The government stepped in and mediated between the parties until a contract more acceptable to the doctors was negotiated. This was the first time that the government took an active role in the delivery of services. In effect, the government intervention legitimated the issues the doctors had raised.

Landmann's plan was introduced elsewhere and met with a similar response. By the end of 1898, a national call was made for all doctors to terminate their contracts with the sickness funds.

In January 1899, during the nineteenth legislative session, Boffe, Minister for Spiritual, Educational and Medical Affairs, proposed additional legislation for the medical courts (Ehrengerichten). He proposed that one new court be formed for each of the existing chambers. The new court was to be composed of three licensed doctors and a government appointed administrator. The new group's proposed purpose was to settle doctor patient disputes and arbitrate medical malpractice claims. The proposal gave the court the ability to fine any doctor who refused to appear before the court. The new court also would be able to issue warnings and reprimands and suspend a doctor from practice. The law further proposed the establishment of a federal medical court. This

federal agency was to be headed by the Director of the Medical Department of the Ministry for Medical Affairs. Finally the new courts were to be financed by the collection of fines levied on the errant doctors. <sup>237</sup>

Rudolph Virchow's speech in the Haus der Abgeordneten (lower house of Parliament) is not only a good practical analysis of the Bill but mirrors the reaction of most doctors. Summarizing his two major points, he stated that the legislation was poor because the new courts would no longer be used primarily for exposing quacks. He said that the new government agency would have the ability to usurp the doctor's clinical freedom. In making his case, he condemned the government's evidence that such a court could be effective. He noted that of the 265 cases between 1887 and 1897 which could have come before the court should it have existed, 160 were dismissed for insufficient evidence, 32 warnings were issued and 45 licenses were suspended. <sup>238</sup>

Virchow also vehemently opposed the provision of the bill which called for the new court to be financed by the collected fines. He argued that the fines collected by the old courts were used to support needy colleagues and their families.

The law was passed. Together with increased pressure on the doctors by the funds to control utilization and contain costs, it resulted in the formation in 1900 of a new medical union, the Verband der Aerzte Deutschlands (Union of German Doctors). This new organization was more commonly known as the Leipziger Verband. The group was formed with the sole and expressed intent to protect the economic and professional rights of doctors. <sup>239</sup> In 1903, the Leipziger Verband merged with the Aertzvereinsbund. The official name of the strengthened organization was the Verband der Aerzte Deutschland. It was commonly known as the Hartmannbund. The new union was aggressive. They lobbied actively to make legislators aware of their concerns and supportive of their positions.

In the first years of the new century, shortly after the formation of the Hartmannbund, the funds (where approximately 10 million people were now enrolled) and the doctors remained polarized on the three issues: free choice (selective contracting), self regulation and payment. In 1903, local

chapters of the Hartmannbund began to organize strike funds. The first two major strikes were in Leipzig and Cologne. During the strike, the doctors refused to treat fund members. Forced to recognize the doctors as an organized interest group, a pattern of reconciliation evolved.

The fund and doctor negotiating teams agreed on four models for doctor contracting:

- 1) unrestricted free choice or no restriction on the number of doctors who could participate in the fund's programme,
- 2) contracting with the doctors association and allowing members free choice of doctor within this group,
- 3) contracting with a limited group of doctors selected by the fund and allowing members free choice among them and
- 4) funds employing doctors and assigning each member to the doctor in his area.<sup>240</sup>

Most often a compromise was found. The majority of funds contracted with a group of doctors that included the majority of practitioners in the area. This is often known as the open panel model and corresponds to option 2, Organized Free Choice or option 3, Limited Choice. An open panel of doctors is also the most widely accepted contracting practice for consumers and doctors participating in HMOs in the United States. The open panel generally is associated with the IPA or Independent Practice Association model.

The negotiating teams also addressed payment issues and resolved that five payment models were possible:

- 1) Fee-for-service payment. As noted earlier fee-for-service payment is a payment method that pays doctors for the services they provide. The fee schedule was generally considered the minimum level of payment.

2) Capitation fees to individual doctors. This reimbursement method entailed paying doctors who contracted with a sickness insurance fund a fixed fee per assigned member each year. Depending on the fund, capitation fees could be augmented by extra fees for special services.

3) Capitation payments into a pooled fund. Similar to option 2, capitation payments were paid on behalf of each fund member. However, the payments were made to the group representing the contracting doctors, not directly to the doctor. If the physicians so desired, extra fees for special services provided could also be directed to the pool. The funds in the pool were then divided among the doctors according to the number and intensity of services provided. Capitation fees paid by the fund to the doctor pool were based on membership figures calculated by taking the mean of the monthly average membership figures for each quarter. As a rule, doctors received quarterly payments. Services for which payment generally was not pooled included obstetrical services, night and emergency visits and care for members of other sickness insurance funds.

4) Per case payment. This method of reimbursement was uncommon. With this type of arrangement a fund would pay doctors directly for all benefits associated with an entire spell of illness. Interestingly, pooled doctor funds were often distributed on a per case basis rather than on a fee-for-services basis. The per case reimbursement method was less complicated.

5) Salaries. As noted earlier, funds could pay salaries to doctors for part time work with fund members or employ doctors on a full time basis. <sup>241</sup>

In general, contract negotiations over issues of provider payment were often polarized between doctors who advocated fee-for-service payment and funds who were strong proponents of salary or capitation payment. As early as 1874, nine years before the enactment of the German Sickness Insurance Programme, a professional platform calling for fee-for-service payment appeared in the medical press. Fee-for-service payment was important to doctors for two primary reasons. The first reason was economic. Doctors felt that fee-for-service payment would maximize income. The larger the revenue pool available for doctors, the greater the number of doctors who could be supported. This, they argued, was extremely important in providing adequate care to the German

citizenry. Second, doctors argued that fee-for-service reimbursement was crucial for guaranteeing that quality and appropriate care would be rendered. According to the doctors, fee-for-service permitted the profession the latitude to define sickness and its treatment. The doctors argued that they and they alone would decide on the appropriate treatment and the doctor should be guaranteed payment for it.

This desire to control the treatment or plan of treatment for a patient has been mimicked by American doctors until very recently. Doctors, who control approximately eighty percent (80%) of the health care dollars, are now being told that their utilization practices will be monitored to control costs. In the United States however, insurance company managers or health plan administrators who often have financial management backgrounds are involved in utilization review committees in addition to doctors.

The funds' leadership, on the other hand, argued that capitation and salaried reimbursement permitted greater latitude for doctors to define sickness and treatment. In contrast to fee-for-service reimbursement, where doctors were often paid according to a schedule that clearly stated which treatments would be reimbursed and at what rate, capitation or salary reimbursement arrangements did not tie the doctor to any written schedule or treatment plan for disease. Capitation allowed the funds to predict and control their expenses.

Capitation payments which were distributed from a pool to participating doctors were the most widely accepted form of doctor payment. Funds favored this method largely because capitation payment permitted efficient budgeting. Liabilities could be calculated in advance. Doctors also favored this method. They were free to pay themselves on either a fee-for-service or per case basis.

Most of the doctors opted for a combination of organized free choice (i.e. contracting options two or three) and pooled capitation fees distributed by the doctors (payment model three). This was acceptable to the funds because it enabled them to fix a budget and limit their risk. By paying the

doctors capitation fees, regardless of how they chose to distribute them among themselves, they placed the financial risks associated with excess utilization on the doctors.

The Hartmannbund was also able to influence the fund's utilization review and control practices. They argued that the confidential medical advisor should be selected from their membership because of their expertise in medically related matters. <sup>242</sup>

The number of strikes confined to local areas continued to increase. With each strike, the medical profession slowly gained strength. Increasingly, doctors associations played a dominant role in both the contract negotiation process and in paying member doctors. The government, in an effort to keep the programme, which was by now a deeply entrenched component of German domestic policy, functioning, became a driving force in establishing a means to solve disputes before the programme could be further interrupted. The government's mechanism of choice was usually arbitration between the parties.

Disputes between the funds and pharmacies arose on a number of occasions. By the early twentieth century, individual sickness funds had instituted cost-containment measures to limit drug expenditures. Several funds, most notably the Stuttgart Federation of Sickness Funds appointed a doctor to examine all prescriptions and inform doctors when their prescription patterns exceeded norms. Similar to the data and triggers used by Professional Standards Review Organizations (PSRO) in the United States to monitor doctors utilization patterns, the Stuttgart doctors organized a committee of general practitioners, specialists and other doctors to prepare a set of instructions for "the economical prescription of drugs".

Similar to the doctors' strikes the pharmacies withheld services from fund members. For example, in Cologne, the pharmacies negotiating contracts with the sickness funds refused to dispense prescriptions unless they were paid for in cash. They placed this limitation on the funds in order to establish a better bargaining position for the "free choice" of pharmacies. The dispute in Dusseldorf was over the supply and charges for non-listed drugs and other medical appliances. As did the doctors,

the pharmacists were able to negotiate a reasonable settlement with the sickness funds outside of the legislative process. One notable agreement was reached between the United Sickness Funds of Frankfurt-an-Main and the Local Apothecaries Association. The pharmacists were successful in securing an open -panel contracting arrangement. The funds were permitted under the terms of this agreement to supply dressings, surgical tools and medical and dental appliances. The funds were also able to negotiate a full 25% discount on stock drugs, a 40% discount on elixirs and tinctures, a 20% discount on "external use" preparations and a 50% discount on drugs containing ferromanganese and peptone fluids. In return, the fund agreed to purchase all listed drugs at the full retail price. The pharmacy permitted the fund with a discount for timely payment and agreed not to charge fund members more than they charged non-fund members. Finally, the agreement contained a binding arbitration clause which protected both sides from a strike. <sup>243</sup>

The 1883 law permitted funds to contract selectively with one or more hospitals in their areas. <sup>244</sup> The reaction of hospital providers to the Sickness Insurance Programme however, was different from the reaction of the doctors and pharmacies. This is largely because the majority of hospitals were owned and operated by government rather than the private sector which dominated the pharmacies and doctors. In most cases funds had to contract with the publicly owned and operated facility to serve their members because it was the only hospital available. Because of this monopoly, hospitals could raise their rates, although as noted earlier, there was not a large financial incentive to do so because it meant they would shoulder more bad debt. As the number of hospitals increased, funds did contract with selected hospitals which provided them with advantageous rates. While this could have been a problem for the large publicly owned teaching facilities which needed the volume of patients to operate efficiently, there were no major disputes between hospitals and sickness funds.

In 1904, another set of amendments to the 1883 Sickness Insurance Act was enacted. Of the stipulations of the new law, perhaps the most important were those which institutionalized a dispute resolution mechanism between the funds and providers. Arbitration was to be used to resolve these disputes prior to any disruption of service-- that is, when a strike was threatened. It is not surprising

that this mechanism was chosen by the legislators. As was the case when the 1883 law was promulgated, the legislators looked to institutionalize an established practice.

The 1904 legislation also extended the duration of benefits, both medical treatment (including the provision of drugs, eyeglasses, physical supports and appliances) and cash assistance to 26 weeks. No change was made in the revenue collection mechanism; the shared employer:employee contributory scheme was maintained.

Total programme expenditures rose 17.34% and per capita expenditures increased 12.11% between 1903 and 1904, the largest single annual increase prior to the Insurance Consolidation Act of 1911. While it is logical to assume that this increase can be attributed to the newly enlarged benefit package, benefit enhancements like this one did not have a major effect on cost increases for the system as a whole. Most illnesses terminated before the end of the thirteen week period. In Leipzig for example, 96% of all illnesses terminated and employment resumed within thirteen weeks. At least a part of the increase likely was attributable to changes in the ability ( or lack thereof) of the funds' to effectively control utilization patterns.

In contrast to the rather vocal role of both the consumer as represented by the sickness funds and the doctors and pharmacies, employer criticism of the shared contributory scheme subsided by the turn of the century. Employers were able to pass their share of the cost of the sickness insurance programme on to the consumer in increased costs for goods and services. According to a report published for the St. Louis Exhibition of 1904<sup>245</sup> by the Imperial Insurance Office entitled, "The German Workingman's Insurance as a Social Institution", the employers' financial burden was largely offset by increased labour efficiency due to less sickness and better attendance in the workplace.

A representative opinion of the employers, mirroring the above sentiments, can be found in the following comments by Herr E. Schmidt, a prominent representative of the tobacco industry and member of the Reichstag. At the annual meeting of the German Tobacco Manufacturers Association on November 24, 1907, he said:

*"I am convinced that when the social legislation was introduced, and for the first time the large contributions for sickness and later for old age and infirmity insurance had to be paid, many of us groaned. Today, however, these contributions, which occur every year, are booked either to the general expenses account or the wage account for they are in fact a part of wages. They are naturally calculated as part of the cost of production and eventually appear in the price of goods, though perhaps not to the full extent in times when business is slow. In any event, it is certain that it is hardly possible to speak of these insurance contributions as constituting a special burden on industry, for if you regard the sum so paid not as a percentage of wages, but of the year's turnover, it does not exceed 1/2%. In calculating the cost of goods, that is the extent of the expense which must be absorbed. That is so small a sum that it is neither right nor just to make a noise about it and pretend that we can no longer pay it if our working people are awarded increased benefits by new insurance legislation. Speaking honestly, as one employer to another, I am of the opinion that the investment in these insurance contributions is not a bad one."*<sup>246</sup>

## CHAPTER 10

### 1905-1911: PROVIDER DOMINANCE IS ESTABLISHED: Few Disputes While Legislators Move to Codify Changes Motivated by Providers

The period between 1905 and 1911, when the Insurance Consolidation Act was promulgated, was a period of relative tranquility compared to the prior period. The provider community maintained its tight organization. The government cooperated with them to insure that the Sickness Insurance Programme would continue to function.

This chapter looks not only at the political environment but at the evolving infrastructure for services, in an effort to describe the environment in which legislators began the process to recodify the laws governing the provision of not only sickness insurance but also old age and disability (accident) insurance into a more organized social welfare system.

#### *Impact on the Provider Network*

The implementation of the German Sickness Insurance Programme had a dramatic effect on the numbers of doctors, hospitals and pharmacies. In all cases the number of providers dramatically increased.

The number of primary care practitioners more than doubled. The ratio of these practitioners to population was nearly halved. In 1883, there were 15,100 practitioners and in 1906, there were 31,346. In 1883, the practitioner to population was 1:3,047 and in 1906 it was 1:1,952.<sup>247</sup> The increase is not due only to an increase in the number of trained and licensed doctors. In fact, during the twenty five year period between 1883 and 1911, the medical curriculum was tightened. An additional year of study was required.<sup>248</sup> More importantly, a doctor's degree was made a precondition of licensure. The increase is largely due to an increase in the number of unqualified practitioners who participated in the programme. Of the approximately 30,000 practitioners in 1906, between 12,000 and 13,000 were unqualified practitioners.<sup>249</sup> It was not until the Insurance Consolidation Act in 1911 that licensure was mandated for provider participation in the programme.

A less dramatic but certainly marked increase in hospital beds also occurred. 1,777 new hospitals were erected, bringing the number up to 3,801 hospitals nationwide. This meant that in 1906, there was one hospital for every 16,095 citizens. This is a significant decrease from the 1:22,349 ratio noted in 1883. A more important indicator of the increased availability of hospital services is the bed to population ratio. This ratio was significantly reduced between 1883 and 1906 from 1:545 in 1883 to 1:275 in 1906.<sup>250</sup>

Who owned the new hospitals? In contrast to the pre-1883 period, sickness funds began to construct and operate hospitals. While, they did so to control their operating costs (charges equaled cost and in contrast to using non-affiliated hospitals they could control utilization in their own hospitals), construction costs remained high. Because of these high capital costs and the funds' ability to negotiate relatively advantageous rates with public hospitals, hospital ownership remained largely in the hands of local government.

It is unlikely, therefore, that new financing was the primary impetus for new hospital construction in either the public or private sector. Instead, public lack of concern over the availability of this increasingly valuable and increasingly popular service pushed local and state authorities to construct new hospitals.

Despite the strict regulation of pharmacy licenses, the number of pharmacies increased by 38% between 1883 and 1906. This is deceptive: the ratio of pharmacies to population improved less than 4%. In 1883, there was one pharmacy for every 10,264 people. In 1906, the ratio was 1:9,885.<sup>251</sup>

In summary, the Sickness Insurance Act of 1883 caused the provider network to expand. Whether the network's expanded capacity drove enrolment or increased enrolment drove expansion of the network is unclear. Regardless of the cause, the result was a dramatic increase in access to and availability of medical services to the German population.

### *Provider Reaction*

In two years, 1910 and 1911, 1,022 conflicts between sickness funds and doctors and their associations were recorded. Of these, 921 were settled in favour of the doctors. Clearly, by 1911, the profession, now represented by an organization of almost 24,000 members (95% of the licensed doctors in Germany), had wrested a great deal of control over the operation of the Sickness Insurance Programme. <sup>252</sup> Their continued impact on the evolution of the Sickness Insurance Programme is demonstrated by their ability to wrest control over many of the organizations originally designed in the 1890's to control them and their practice patterns.

For example, by 1910, the medical profession had won the authority to choose and monitor confidential medical personnel. <sup>253</sup> In almost all cases, Confidential Committees were formed which supplanted or worked together with the individually employed Confidential Medical Advisor. The committees were generally established by an agreement between the local sickness funds and the local medical associations. For example, the Confidential Committee for the Leipzig Local Sickness Fund consisted of twelve members who were elected every two years from among the fund's doctors. All twelve members were elected by the fund doctors. The election of new members to the committee typically took place in the last month of each two year period. A written vote was taken. Four substitutes were elected. The twelve members selected in turn elected a chairman and vice chairman. Six members and a chairman or vice chairman formed a quorum. Resolutions were adopted by a simple majority. In the case of a tie, the chairman cast a vote.

Meetings were convened at the chairman's discretion. Urgent matters coming before the committee were to be settled within one week, if at all possible. The minutes of the meetings as well as all resolutions were recorded. The sickness funds provided clerical assistance.

Specifically, the Confidential Committees were asked to examine prescriptions for drugs, appliances, baths and recreation. The doctors were asked to ensure that repeat prescriptions were filled in the original bottles and that unpatented medicines were not used. The committee was also

asked to monitor closely the number of disabled members each doctor attended and the duration of disablement. Again the committee was asked to report any abnormal practice patterns to the fund.

When upon examination of a practice, the committee found serious problems, it was permitted to penalize the doctor by reducing his remuneration. In addition the committee was required to send a written reprimand to the doctor. If the physician did not respond both to the decreased reimbursement levels and two warning notices, the committee could suspend the doctor's fund privileges for up to twelve (12) months. The doctor was entitled to a hearing on the matter prior to suspension. If the doctor had been temporarily suspended twice, the Confidential Committee could ask federal arbitrators to revoke permanently the doctor's fund privileges.

Complaints made either by patients or by the fund administration about a particular doctor's professional conduct were also directed to the Confidential Committee. In such cases the necessary documentation was to be supplied to the committee within one week. The committee reviewed the materials and communicated their opinion to the doctor. The fund was not permitted to terminate a contract with a fund doctor without having first completed this grievance process.

Physician's complaints about the fund were also reported to the Confidential Committee. After review, the committee's opinion was to be reported to the doctor and the fund's executive director. Doctor's complaints about patients were to be reported to the executive director. If the executive failed to address the problem appropriately, the doctor could present the matter to the Confidential Committee.

Where the Confidential Committees could not reach a suitable resolution to a grievance, Conciliation Committees were formed by the fund to mediate between the parties.<sup>254</sup> Arbitration was used as a last resort to settle disputes that both the Confidential and Conciliation Committees could not. Arbitration committees contained representatives of the fund, doctors and also independent third parties.<sup>255</sup>

While members of the fund were assured quality doctor care both through the complex grievance procedure and the utilization review programme, fund members did not have the same opportunity in regard to hospital care. Members could make a formal written complaint to the fund if they felt inadequate hospital care had been rendered to them. If the problem was not resolved satisfactorily, the fund member could appeal to a federal supervisory authority. A federal representative was required to look into the matter. If he found the complaint to be justified, the fund could be required to contract with other hospitals in the area for services to fund members.

Despite this success with the funds, the doctors were unable to legislate, and thereby institutionalize, any changes in the programme until 1911. The following section details the changes encoded in the Insurance Consolidation Act.

**PART IV**

**The 1911 Insurance Consolidation Act**

Expanded access and lengthened duration of benefits were the primary results of the legislation which was enacted between 1883 and 1911 when the Insurance Consolidation Act was promulgated. Until the recodification in 1911, no major legislative steps were taken to institutionalize the changes in contracting procedures, licensing and payment of providers which were forced by an increasingly organized provider community. The following sections describe the legislative stipulations which firmly established not only these new mechanisms but the role of the profession in shaping future health policy. There are sections which describe membership and its impact on access; organization of the delivery system (including sections on licensure, provider payment, contracting and utilization review and control mechanisms); benefits (including a look at the portion of total benefit monies used for medical treatment and cash assistance); finance (including a discussion of programme costs and revenue collection mechanisms); and administration (including a short description of changes in fund administration and federal administrative oversight of the program).

### **Membership**

The 1911 Insurance Consolidation Law (RVO) retained the scope of eligibility criteria established by the 1883 law and 1892 amendments; eligibility turned on income and type of employment. The minimum income level for compulsory coverage for factory supervisors and teachers increased to 2,500 M. <sup>256</sup> The 2,000 M ceiling applied to all other workers. No consideration was given to the modest inflationary trends of the previous 28 years. <sup>257</sup>

Insurance was extended to many non-industrial and professional workers. Most notably, service workers, including domestics, fell under the law's jurisdiction. The following list specifies the other groups granted eligibility for sickness insurance:

- 1)domestics
- 2)shop assistants and apprentices
- 3)factory supervisors
- 4)actors and musicians
- 5)teachers and tutors
- 6)merchant seamen

With these additions, sickness insurance covered the majority of wage earners regularly employed in industry, commerce, and service. A total of approximately five million persons joined the ranks of the mandatorily insured.<sup>258</sup> Itinerant workers employed for periods of less than one week continued to be ineligible for insurance.<sup>259</sup> Lawmakers justified this exclusion on the basis of the high administrative cost associated with enforcing employers to notify state officials of the temporary employment. Notification by employers was the trigger for enrollment in a sickness fund.

By 1910, approximately 21.5% of the population were covered by the original legislation. In 1913 following the enactment of the Insurance Consolidation Act of 1911, 25% of the population (13.9 million) was covered by the state authorized insurance programme.<sup>260</sup> And by 1914, 15.6 million persons had insurance coverage through the programme.<sup>261</sup> The 1910 and 1913 figures include dependents. The following chart documents this gradual, fairly steady and substantial increase in insurance coverage between 1885 and 1910:

### Membership of Funds 1885-1910

Year	Avg. No. of Persons Covered	Percent of Population
1885	4,670,959	10.0
1886	4,944,212	10.5
1887	5,220,782	11.0
1888	5,790,431	12.0
1889	6,557,336	13.5
1890	7,018,483	14.3
1891	7,342,958	14.8
1892	7,342,958	14.8
1893	7,574,942	14.9
1894	7,756,686	15.1
1895	8,005,797	15.4
1896	8,443,049	16.0
1897	8,865,685	16.6
1898	9,325,722	17.1
1899	9,742,259	17.6
1900	10,159,155	18.1
1901	10,319,564	18.1
1902	10,529,160	18.2
1903	10,909,288	18.6
1904	11,418,446	19.2
1905	11,903,794	19.7
1906	12,451,183	20.4
1907	12,945,242	20.9
1908	13,189,599	20.9
1909	13,385,290	21.5
1910	13,954,973	21.5

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#### *Out of Area Coverage*

Prior to 1911, coverage was limited to insured workers residing in Germany. The Insurance Law of 1911 permitted the German Chancellor to conclude reciprocal agreements with any other nation for the provision of health care to German nationals residing abroad. Correspondingly, foreign nationals of countries with which an agreement existed and who resided in Germany were fully covered under the German Sickness Insurance Programme. No distinctions were made between German nationals and foreigners.

Reciprocal agreements varied from nation to nation. The extent of coverage was limited by (1) the provisions of the 1911 Law, (2) the laws of the nation in which the German expatriate resided and

(3) the length of employment outside Germany. Under all circumstances the employer was obligated to continue to contribute a co-premium towards the employee's health coverage.

### *Voluntary Insurance*

The 1911 law made several changes in the eligibility criteria for voluntary participation in a sickness fund. Persons earning above 2,500 M per year and below 4,000 M per year could elect voluntary membership; those earning above 4,000 M per year could no longer be covered by an insurance fund.<sup>263</sup> The medical profession viewed the institution of maximum income limits on voluntary membership as a step in the right direction, but would rather have seen a 3,000 M per year limit instead of the 4,000 M per year ceiling. Doctors complained that their remuneration from the funds rarely increased. Therefore, the increase in the maximum income level for statutory membership, provided less opportunity for them to have private pay patients.<sup>264</sup> Moreover, doctors claimed that it was impossible to determine exactly when a worker's income exceeded 4,000 M per year.

In summary, those eligible within the income criteria for voluntary membership in a sickness fund included persons in the following types of employment:

- 1) Employees of the scheduled groups normally covered who were not liable for statutory insurance coverage.
- 2) Members of an employer's family working in his business without a formal contract and without remuneration.
- 3) Tradespeople who didn't regularly employ workers or who employed no more than two individuals (the self-employed).
- 4) Women who had been legally insured but who had left employment on marriage.

The actual proportion of voluntary membership to prescribed membership is difficult to ascertain. However, based on the following statistics, an average of 8% of all fund membership in 1910-1911 was voluntary.

	<b>Compulsory</b>	<b>%</b>	<b>Voluntary</b>	<b>%</b>	<b>Total</b>
Berlin Sickness Fund (1911)	927,451	92.5	75,563	7.5	1,003,014
Leipzig Local Fund (1910)	168,948	92.4	13,950	7.6	182,898
Dresden Local Fund (1910)	104,310	87.4	15,109	12.6	119,419
Munich Local Fund (1910)	119,175	92.7	9,368	7.3	128,543
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	1,319,884	92.0	113,990	8.0	1,433,874

### **Organization of the Delivery System**

#### *The Sickness Insurance Funds*

The 1911 Insurance Consolidation Law aimed to combine small and inefficient funds. Both the Communal Funds and Contractors Funds disappeared. Henceforth, the majority of Local Funds were reconstituted. Called General Funds (Allgemeine Ortskrankenkassen-AOK), they became the major fund in the Sickness Insurance Programme. General Funds organized after 1911 were not limited to formation around a trade or occupation. However, industry specific Local Funds organized before 1911 could maintain their identity. The creation of these new funds without dissolution of the old enabled workers to choose between funds.

These Local Funds were required to maintain a minimum of 250 subscribers. Within 6 months after the enactment of the 1911 law, the remaining Local Funds were required to upgrade their minimum benefit package so that they were equivalent with the package provided by the General Fund in the area.

Factory and Guild Funds which predated the 1911 law were now subject to minimum membership requirements. For all Factory and Guild Funds except those connected with agriculture and inland navigation, a minimum of 100 members was required. The funds for agricultural workers

and employees of the inland navigation industry were authorized under the national Sickness Insurance Programme with a minimum of 50 members.

New Factory and Guild Funds required a minimum of 150 members to be certified. Because of the pivotal role intended for the new General Funds, certification of the Factory, Guild and Local Funds was continued only if their existence did not threaten the General Funds from maintaining a membership of at least 1,000.

The Miners' Funds were exempted from minimum membership requirements. In fact, the 1911 law again noted these funds for their exemplary record of high quality and efficient service.<sup>265</sup>

In addition to the General Funds, the Insurance Consolidation Act of 1911 authorized the formation of Rural Funds (Landkassen). The Rural Funds were designed to include agricultural workers, domestics and any other groups designated by the federal insurance authorities. Employers and employees shared responsibility for the administration of benefits. However, in contrast to other funds, the administrators were chosen by the municipality, not by the insured members and their participating employers.<sup>266</sup> Mutual Aid Funds as certified prior to April 1909 were permitted to continue to provide benefits as long as fund membership numbered 1000 or more. Given these minimum membership requirements, these funds, known as Ersatzkassen, were the only real competitor for the general funds (AOK). Moreover, because the 1911 Law prohibited the formation of new Mutual Aid Funds, the membership in the existing funds continued to grow.

Membership in more than one statutory fund was prohibited. However, membership in both a statutory and voluntary (Mutual Aid Fund) was allowed. While all eligible workers were required to enrol in a sickness fund, eligibles could refuse fund services and purchase services privately on a fee-for-service basis.<sup>267</sup>

The chart on the following page, "The Sickness Funds", shows the types of funds that were recognized by the 1883 Law and the 1911 Law. The membership and payment requirements as well as the administrative structure of each fund are summarized.

### The Sickness Funds

1883	Membership Requirements	Contrib. Scheme	Admin.	Comments
Stat. Funds	All must meet 2000 M (L100) income crit.			
Local	Elig. turns on trade or geo. loc.			
Guild	Guild members and apprentices req. to join.	2:1	2:1	Formed by workers or municipality
Contractor	Temp. membership lasting as long as project	2:1	2:1	
Communal	For those mandated persons not eligible for other funds	2:1	Commune	Former Parochial Funds
Voluntary Funds				
Mutual Aid	Those who chose not to join employment related funds	Member pays all	Membership	Age limits, health screening used in determining elig. Cash Assistance could be used to pay for the private provision of medical benefits
State Regis. Mutual Aid			Federal Officials	

1911	Membership Requirements	Contrib. Scheme	Admin.	Comments
Stat. Funds	All must meet 2000 M (L100) income crit except teachers and factory supervisors at 2500 M (L125).			
Local	Min. 250 members	2:1	2:1	No new funds permitted to form.
General		2:1	2:1	Major type of fund post 1911 not required to form around trade
Guild	Minimum 100 members	2:1	2:1	New funds required to have min. 150 members.
Factory	Minimum 100 members	2:1	2:1	New funds required to have min. 150 members
Rural	For domestics and agri. workers	2:1	1:1	Administrators chosen by Municipality.
Miners	No miners membership requirements	2:1	2:1	
Voluntary Funds				
Mutual Aid	Min. 1000 Members	Member pays all	Membership	Only real competition to general funds.

### *Provider Contracting*

The 1911 Insurance Consolidation Act radically altered the sickness funds' ability to control costs through selective contracting. Selective contracting provisions for all three major provider groups: doctors, hospitals and pharmacies, were outlawed.

The 1911 law provided licensed practitioners with two primary means of maintaining control over their livelihood and their practice patterns. First and foremost, the law made it nearly impossible for a fund to refuse a contract with a doctor who was represented by a medical association. Contract negotiations were held between these organized associations of practitioners and the fund management. If no agreement could be reached between the parties, the matter was sent to arbitration. Practically, this meant that few funds were willing to go to the expense of time and money to exclude a particular doctor from the association's contract.

Second, the law stipulated that only licensed doctors, those who had completed their education and the licensing examinations, could be paid for services provided to fund members. The large number of unlicensed practitioners who had been permitted to participate in the programme up to this point, were now excluded. This effectively meant that the licensed doctors or clinicians, a smaller number of persons, shared a rather large pot. Their financial situation improved considerably as a result. <sup>268</sup>

The Insurance Consolidation Law also prohibited selective contracting with most hospitals. It stipulated that funds must pay hospitals for services they render fund members regardless of whether or not the hospital contracts with the fund, provided, that the services are provided under the same terms of the funds contracts with other hospitals. It should be noted that this provision only applied to publicly owned and operated or charitable hospitals and not to private clinics. <sup>269</sup> While the private clinics would have liked "free choice", they were a minority. Moreover, it was unlikely that the negotiated rates would have been acceptable to them.

The 1911 Insurance Consolidation Law mandated that pharmacies give sickness funds a discount on listed drugs. The law also fixed maximum prices for non-listed drugs and medical appliances. The provision of the 1911 law which prohibited funds from selective contracting with pharmacies, was the only change which benefitted the pharmacies. The law said that funds which contract with selected pharmacies must allow any other pharmacy that met state licensing requirements to provide the same services on the same terms as those defined in agreements with contracting pharmacies. <sup>270</sup>

#### *Utilization Review and Quality Assurance*

The 1911 Act firmly instituted the Confidential Medical Committees as the group which had oversight responsibility for monitoring both utilization and quality. The Confidential Medical Committees were controlled by the medical profession. In most cases, the Confidential Medical Committees replaced the Confidential Medical Advisor. Where it did not, the Committee worked closely with and often selected the advisor.

The Committees monitored utilization by monitoring trends in prescriptions for drugs and appliances, hospital utilization and certification of disability. The Committees also handled complaints from doctors or patients. When the Committee did not resolve the conflict, it was referred to regional Conciliation Committees.

Perhaps the most important provision of the 1911 law which related to utilization control and quality assurance was Paragraph 368Abs. 2 RVO which stated clearly that the primary care doctor had a monopoly on care as the central agent for authorization of goods and services in the health care system. <sup>271</sup> The provision made it virtually impossible for a fund to propose contract provisions which rigidly imposed utilization and review mechanisms outside of the mechanisms employed by the Confidential Medical Committees. Moreover, the change in the law gave doctors what they wanted-- the ability to define clinical treatment and be paid by the national programme for the services they deemed appropriate.

## **Benefits**

### *Reclassification and Further Enumeration of Minimum Benefit Levels*

The 1911 Act systematized the benefits provided through the development of new benefit classifications. There were four categories of benefits:

- 1)Sickness benefit (Krankenhilfe)
- 2)Maternity benefit (Wochenhilfe)
- 3)Funeral benefit (Sterbegeld)
- 4)Family benefit (Familienhilfe)

The categories applied both to medical benefits and cash assistance.

The Act maintained mandated coverage for sickness benefits for twenty six weeks. It also permitted funds to extend benefits for a period of up to one year. In addition, with the patient's consent, the insured person could elect to substitute home health care for one quarter of his sick pay. Household money for the dependents of hospitalized subscribers became a formal benefit equal to one half the amount of the usual sick pay. At the fund's discretion, household money could be increased to full sickness pay. (A discussion of the 1911 law as it pertained to sick pay, death benefit and maternity benefits, follows in the next section on cash assistance.)

The 1911 Act extended the duration of postnatal benefits to eight weeks. However, to claim benefits, women must have been insured at least six months during the year preceding confinement. It should be noted that the duration of benefit could be reduced to four weeks for women members of Rural Funds who did not come under the jurisdiction of the Industrial Code Classifications, that is, those in agriculture or domestic service. Permissible benefits included treatment in a maternity home where the insured could claim half the usual maternity pay when she had dependents. Those who were nursed at home were entitled to a similar stipend. Either of the two of these benefits were permissible as a substitute to maternity benefits. Additional benefits provided by funds could also include surgery or midwifery assistance during birth to insured wives or women subscribers.

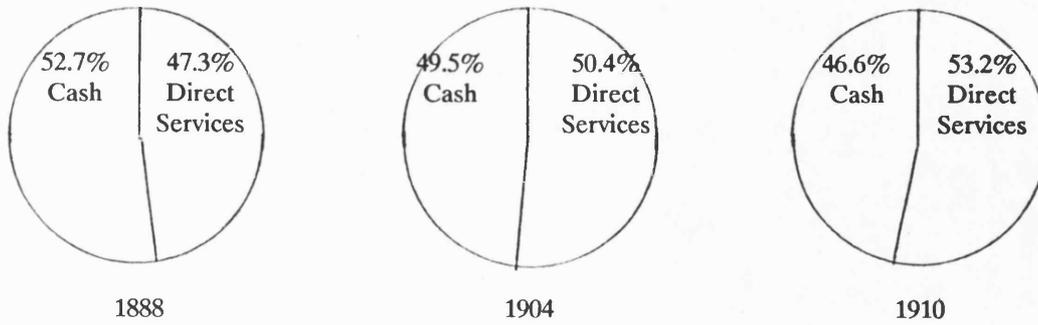
While confinement was not considered an illness and did not establish a claim to sickness benefits, pregnant women or women in confinement could claim sickness benefits if an illness occurred. The sickness pay received during that time would be in lieu of maternity benefits. Women who were fund subscribers for at least six months prior to their pregnancy could receive sickness pay for six weeks in the event of disability due to pregnancy, in addition to medical and midwifery services provided by the funds and maternity benefits payable after delivery.

Death benefits paid to subscribers or dependents in Local and other occupation-related funds included a payment to cover the cost of burial as well as limited support for the deceased's survivors. Burial was paid in full. This payment was made directly to the undertaker. The remaining payment was made to the deceased's household. If there were no claimants, remaining death benefits reverted to the sickness fund.<sup>272</sup> As a permissive benefit, funds could pay two thirds or one half the normal death benefits upon the death of a dependent. If the dependent had insurance from another fund, the benefits payable were reduced by the amount of funeral money the deceased received from the fund to which he or she subscribed.

#### *Cash Assistance*

Expenditures on the German Sickness Insurance Programme corresponded to the two major types of benefits provided: direct medical services and cash assistance. The balance of expenditures for cash assistance and direct services slowly shifted over the thirty year period. This shift parallels the development and acceptance of clinical medicine as well as increased access to health care services resulting from the Sickness Insurance Act. In 1910, direct services accounted for 53.2% of total expenditures while 46.8% went toward providing cash assistance.<sup>273</sup> These are aggregate figures for all funds providing benefits under the national Sickness Insurance Programme. The three charts below show the shift in expenditures between the two types of benefits.

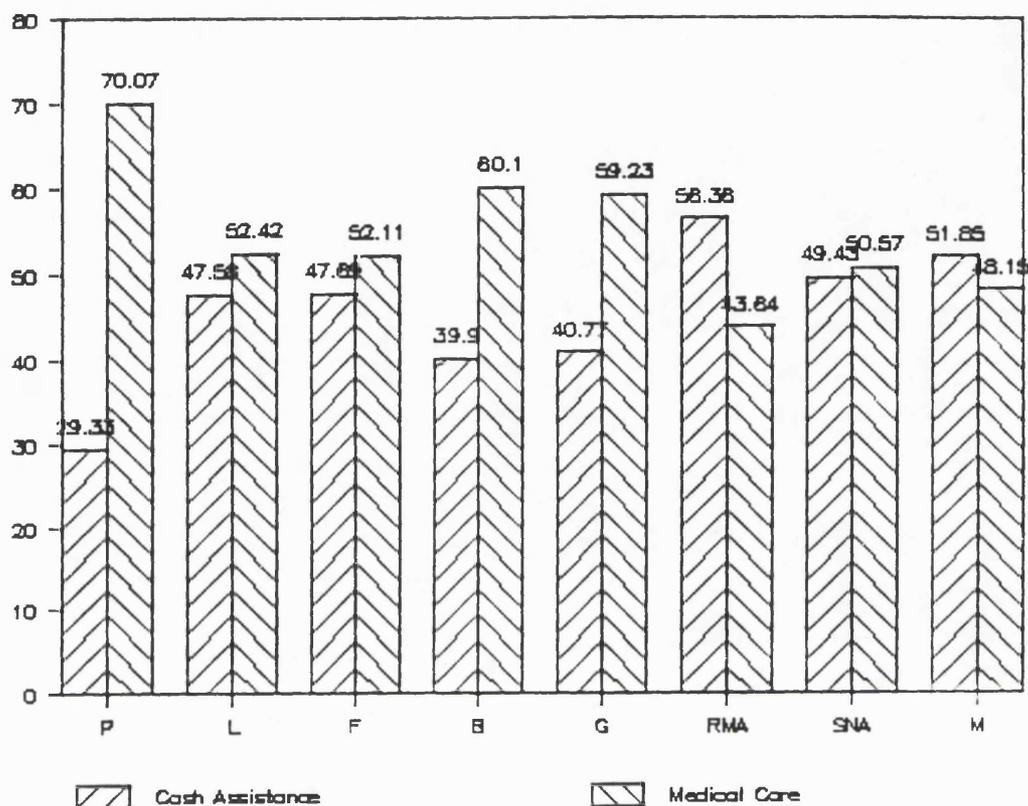
### Expenditure by Benefit Type



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These graphic presentations depict the situation that existed for the system as a whole. The distribution of expenditures by benefit type for each type of fund, shown in the chart below indicates that substantial variation existed between the funds. This differential reflects the variation in benefit packages provided by the several types of funds.

Cost by Benefit Type and Fund  
1910



P: Parochial Funds  
L: Local Funds  
F: Factory Funds  
B: Building Funds

G: Guild Funds  
RMA: Registered Mutual Aid Funds  
SNA: State Mutual Aid Funds  
M: Miners' Funds

Of all eight types of funds, the Miners' Funds clearly provided the most generous benefit package. Per capita expenditures for both medical benefits and cash assistance totaled 40.32 M in 1910, 29% more than the Factory Funds, which provided the second most generous benefit package, and 196% more than the Parochial Funds which had the leanest package. Table F shows the actual expenditures for each of the eight types of funds providing direct services and cash assistance in 1910. The distribution of expenditures by the types of service also are listed.

**TABLE F**  
**FUND EXPENDITURES FOR BENEFITS IN 1910**

Funds	<u>DIRECT SERVICES</u>			<u>CASH ASSISTANCE</u>		<u>TOTAL</u> Marks
	<u>Medical Treatment</u> Marks	<u>Medicine</u> Marks	<u>Hospitals &amp; Others</u> Marks	<u>Sickness Pay</u> Marks	<u>Misc. Benefit</u> Marks	
Parochial	4.18	2.20	3.15	4.06	0.01	13.60
Local	5.44	3.69	3.64	10.41	1.23	24.41
Factory	7.88	4.81	3.50	13.42	1.49	31.10
Building	7.07	3.34	7.87	11.60	0.54	30.42
Guild	5.26	2.96	5.42	8.78	0.62	23.04
Reg. Mutual	4.93	4.69	1.96	11.70	0.68	21.96
State Mut.	4.27	3.10	1.73	7.67	1.24	18.01
Mining	5.83	4.58	9.14	19.77	1.10	40.32

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Debate on the Sickness Insurance Act of 1883 indicates that cash assistance was considered a form of social protection to insure members of the population and their families who were covered by the insurance programme that illness would not financially destroy the family. In contrast, the Insurance Consolidation Act of 1911 defined more clearly when sick payments were to be paid. The new law replaced the term "Erwerbsunfaehigkeit" (the inability to earn a livelihood) with "arbeitsunfaehigkeit" (the inability to work). Inability to work presumed that an insured person was unable to work or unable to work without the risk of worsening his condition.<sup>278</sup> The 1883 legislation seemed to consider cash assistance a form of income maintenance, whereas in 1911 it was intended to be short term disability pay. At least this was the legislative intent.

The 1911 Insurance Consolidation Act retained the basic character of the 1883 law with respect to sick pay. Basic benefits were payable from the fourth day of an illness at one half the basic wage rate. Again the duration of cash assistance corresponded to the duration of medical treatment, which, in this case, was a maximum of twenty six weeks. While the twenty six week benefit period represented the maximum payable for any spell of illness, the law stipulated that a twenty six week benefit period for cash assistance was allowable only once during each calendar year. Thirteen weeks was the maximum benefit period allowed for a second illness during the same year. The new law also contained provisions restricting sick pay when an insured person received benefits simultaneously from more than one fund. In that case, benefits were coordinated to insure that workers' would not receive cash assistance exceeding their normal daily wages. Like the 1883 law, first day coverage and payment over Sundays and holidays was a permissive benefit. The 1911 law did however stipulate that such payments could only be made when sickness lasted more than one week, ended fatally or was caused by an accident occurring at work. Finally funds were also permitted to pay one half the sickness pay to hospitalized subscribers without dependents.

After 1911 there was the tendency for sickness funds to abolish waiting time for entitlement to sick pay. For instance in 1899, only 18% of the funds had no waiting period. In 1910, the figure was 23.9%. In 1899 a two day required waiting period was required by 1.9% of funds. In 1910, that proportion had increased to 2.4%. These increases corresponded accordingly to a drop in the number of funds registering more than a two day wait, that is, 80.6% in 1899 and 73.7% in 1910.

Utilization of the sick pay benefit increased between 1883 and 1910. For 1,956,635 cases of sickness in 1885, 27,854,226 days of sickness were reported. Over the 26 year period ending in 1910, 92,582,319 cases totaling 1,679,553,045 sick days were counted. The following chart shows the number of cases of sickness and the corresponding number of days of payment for each year between 1885 and 1910.

**Cases of Sickness and Corresponding Days of Sickness 1885-1910**

<b>Year</b>	<b>Cases of Sickness</b>	<b>Days of Sickness</b>	<b>Avg.Days/Case</b>
1885	1,956,635	27,864,226	14.24
1886	1,874,302	28,962,927	15.45
1887	1,895,040	29,590,454	15.61
1888	1,932,554	32,116,110	16.62
1889	2,211,617	36,155,685	16.34
1890	2,627,124	42,002,835	15.99
1891	2,616,433	43,948,953	16.80
1892	2,699,091	46,405,474	17.19
1893	3,037,372	50,120,082	16.50
1894	2,719,175	47,380,530	17.42
1895	2,943,159	50,301,640	17.09
1896	3,001,684	51,461,851	17.14
1897	3,220,802	55,577,087	17.26
1898	3,262,194	57,374,993	17.59
1899	3,780,811	65,198,471	17.24
1900	4,023,421	70,146,991	17.43
1901	3,983,898	72,446,146	18.18
1902	3,930,639	73,124,529	18.60
1903	4,177,280	77,603,490	18.58
1904	4,642,679	90,051,510	19.40
1905	4,848,610	94,715,219	19.53
1906	4,834,108	94,573,327	19.56
1907	5,406,076	104,883,006	19.40
1908	5,701,180	111,924,654	19.63
1909	5,561,006	112,190,311	20.17
1910	5,704,429	113,459,544	19.89
1885 to 1910 (26 years)	92,582,319	1,679,553,045	18.14

While there was a greater frequency of sickness of men, perhaps due to the greater number of male labourers in high risk occupations, the charts below indicate that the average duration of sickness was longer among female subscribers. The figures in the charts below have been aggregated for all funds except Miners' Funds.

**Average Number of Days of Sickness per 100 Members**

<u>Year</u>	<u>Male Members</u>	<u>Female Members</u>
1900	658.1	670.0
1901	696.5	674.5
1902	687.6	670.8
1903	695.3	720.4
1904	762.1	822.9
1905	775.9	821.9
1906	728.6	804.7
1907	788.7	833.1
1908	836.6	860.7
1909	820.8	835.5
1910	781.0	853.2

**Average Number of Days Per Case of Sickness**

<u>Year</u>	<u>Male Members</u>	<u>Female Members</u>
1900	17.0	20.1
1901	17.8	20.9
1902	18.2	21.3
1903	18.1	21.9
1904	18.7	23.2
1905	18.7	23.5
1906	18.5	24.1
1907	18.5	23.4
1908	18.9	23.5
1909	19.4	23.8
1910	18.0	23.9

The chart above also indicates that from 1904 through 1910 the average number of days of sickness for male members remained relatively stable while the number of days per case of sickness per female member increased. The Imperial Statistical Office (ISO) attributed this to the 1903 amendments that extended the duration of benefits from thirteen to twenty six weeks, a benefit which the ISO concluded was more advantageous to women than men.

The 1883 law stipulated that funds providing maternity benefits could extend cash payments for three weeks. The amount of payment depended on the fund and ranged from one half to three quarters of the daily wages. <sup>281</sup> In 1892, the duration of maternity benefits was extended to 4 weeks. Six weeks were allowed after 1903, and in 1908, the total duration of maternity benefits was extended to eight weeks, of which six weeks had to be used subsequent to delivery.

Prior to 1911 the extension of maternity benefits by funds was limited. The Parochial and Communal Funds most often did not extend the benefit. Factory Funds and Local Funds were the most generous with this benefit.

In 1910, the following percentages of female workers in seven urban funds and federations received maternity benefits. The amount paid (average sum) is noted in each case. The average among all funds was 6 M 50 pf. per week.

	<u>Number of Women Who Received Mat.</u>	<u>Percentage of Female members</u>	<u>Amount Paid</u>
Leipzig General Fund	3671	6.4	38M 90pf
Berlin Printers Fund	410	5.8	59M 8pf
Berlin Tailors Fund	2911	5.2	41M 50pf
Dresden General Fund	2550	5.0	38M 58pf
Munich General Fund	3469	6.9	40M 33pf
Frankfurt General Fund	1504	5.8	46M 50pf
Berlin General Fund	2546	5.8	41M 33pf

## Finance

### *Programme Costs*

In the 25 years between 1885 and 1910, expenditures by the German National Sickness Insurance system for direct services and cash assistance increased over 600%.<sup>283</sup> The average annual rate of increase in total expenditures for this period was only 8.03%. These increases, due in large part to increasing enrolment, were offset by revenues collected as premiums from employers and employees. Perhaps more interestingly, the annual cost per person enrolled in the German programme increased only 125% in 25 years. Moreover, during five of these years (1887, 1894, 1896, 1902, 1906) the per capita cost actually decreased. Nevertheless, total expenditures for health care decreased only in the year 1894. The chart below shows the actual increase in total expenditures and per capita expenditures per year for each year from 1885 through 1910. The chart also contrasts the annual rate of increase in total expenditures with the annual rate of increase in per capita expenditures.

The great disparity between the rate of increase for per capita and total expenditures cannot be attributed simply to changing medical technology, increasing benefits and/or higher reimbursement rates for providers. Clearly, changes in medical technology did occur during this period. Also, the legislative amendments described previously document the increased duration of benefit periods, and with the advent of professional organizations for doctors, one would expect an increase in remuneration for practitioners.

### Cost of Health Care Benefits

Year	Total Expenditures (Marks)	Cost Per Person (Marks)	Annual Rate of Increase in Total Expenditures (%)	Rate of Increase In Cost Per Person (%)
1885	52,785,868	11.22	****	****
1886	59,004,876	11.93	11.83	5.66
1887	61,217,448	11.72	3.74	-1.76
1888	67,917,540	11.72	10.94	0.00
1889	77,609,952	11.83	14.27	0.93
1890	91,733,381	13.07	18.19	10.48
1891	97,938,723	13.33	6.76	1.98
1892	103,983,397	13.99	6.17	4.95
1893	112,115,146	14.80	7.82	5.78
1894	109,263,892	14.08	-2.50	-4.86
1895	115,034,824	14.36	5.28	1.98
1896	119,899,974	14.20	4.22	-1.11
1897	131,715,503	14.85	9.85	4.57
1898	140,029,447	15.01	6.31	1.07
1899	159,470,508	16.36	13.88	8.99
1900	174,012,063	17.12	9.11	4.64
1901	182,368,109	17.67	4.80	3.21
1902	186,042,373	17.66	2.01	-0.05
1903	200,795,839	18.40	7.93	4.19
1904	235,620,162	20.63	17.34	12.11
1905	255,803,589	21.48	8.56	4.12
1906	266,553,033	21.40	4.20	-0.37
1907	301,296,469	23.27	13.03	8.73
1908	329,311,015	24.96	9.29	7.26
1909	337,644,505	25.22	2.53	1.04
1910	355,732,905	25.49	5.35	1.07

Note: Figures are aggregated for all funds and are exclusive of administration costs.

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Actually, the slow rate of growth in per capita expenditures compared with the significantly larger increases in total expenditures indicate that increased participation in the programme is primarily responsible for the growth in total expenditures. This hypothesis is logical in light of the rapid growth in the percentage of the population covered by the programme. Shortly after enactment in 1885, 10% of the population was enrolled in a sickness fund. By 1910, 21.5% of the population was enrolled. <sup>285</sup>

A direct relationship appears to exist between per capita expenditures and enrolment. The Parochial Funds, which provided the leanest benefit packages, had only 12% of total system-wide enrolment in 1910. In contrast, the broad scope of benefits provided Local and Factory Fund members, attracted 77% of total enrollment. (Note: These calculations exclude the Miner's Funds.) Expenditures for the three major types of services comprising the direct service benefit-- Physicians Services, Medicine and Appliances, and Hospital Care-- rose steadily between 1883 and 1910. Table G, below, depicts this trend. The table was compiled from data for all funds excluding Miner's Funds. The figures include services provided by general practitioners, specialists and dentists as well as all costs incurred in treating dependents and accident victims for as many as 13 weeks.

**TABLE G**  
EXPENDITURES BY BENEFIT TYPE: 1888-1910

Year	Medical Treatment		Medicine & Appliances		Hospital Care	
	M.	pf.	M.	pf.	M.	pf.
1888	2	32	1	84	-	-
1889	2	38	1	91	-	-
1890	2	55	2	16	-	-
1891	2	60	2	16	-	-
1892	2	74	2	31	1	50
1893	3	0	2	49	1	63
1894	3	5	2	39	1	63
1895	3	8	2	41	1	67
1896	3	12	2	38	1	71
1897	3	23	2	48	1	78
1898	3	32	2	51	1	81
1899	3	49	2	68	1	95
1900	3	60	2	73	2	6
1901	3	69	2	72	2	14
1902	3	80	2	70	2	16
1903	3	99	2	83	2	31
1904	4	47	3	0	2	59
1905	4	75	3	10	2	73
1906	4	90	3	8	2	79
1907	5	22	3	31	2	98
1908	5	49	3	52	3	18
1909	5	70	3	55	3	33
1910	5	85	3	69	3	47

Per capita expenditures for cash assistance were displayed in the table on page 152. As noted in Chapter 5, **Benefits**, the amount of sickness pay received by each subscriber varied according to his premium contributions and his weekly wages.

Although cost increases during the early years of the programme were largely attributable to changes in eligibility criteria and the resultant growth in enrolment, comparatively large increases in per capita expenditures predominated in the years after the turn of the century. This can be attributed to the increased power of the medical profession, which thwarted efforts by the funds to control costs through 1) selective contracting, 2) payment programmes which shifted risk to providers and therefore contained costs to the funds and 3) strict utilization review and control mechanisms.

#### *Revenue*

As originally proposed, the Insurance Consolidation Act of 1911 would have changed the employer-employee contributory scheme from a ratio of 1:2 to 1:1. This change from the original legislation was supported by large employers who hoped to gain a greater degree of control over the administration of the funds. The Labour Party (SPD) however, opposed the proposed change, fearing diminished labour representation and loss of administrative control. The change was also opposed by small employers who feared the additional fiscal responsibility the change would necessitate. The proposal was dropped before the law was passed.<sup>287</sup>

Total revenues collected from all employers and employees in 1910 were 397,965,391 M of which 268,132,704 M were collected from employees and 129,832,687 M from employers. The Insurance Consolidation Act of 1911 increased the total cost to employees from 268,132,704 M to 308,324,000 M. Total premiums paid by employers increased from 129,832,687 M to 149,928,000 M.

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Table H below, breaks down the total revenues paid by employers and employees in 1910 by type of fund. Note that for all funds (including the Guild Funds but excluding Miners' Funds), in which there is a shared premium, the ratio of premiums paid by employers to those paid by employees

is 2:1. Premium payments are shared almost equally between employees and employers enrolled in the Miner's Funds.

**TABLE H**  
**PREMIUM PAYMENTS BY EMPLOYERS AND EMPLOYEES IN 1910**

<b>Funds</b>	<b>Contributions of Employers (Marks)</b>	<b>Contributions of Workpeople (Marks)</b>
Parochial	7,542,758	15,096,911
Local	64,620,347	131,371,376
Factory	34,880,095	70,492,644
Building	188,215	377,887
Guild	2,773,023	5,634,818
Registered Aid	---	23,947,884
State Aid	---	691,210
Mining	19,828,249	20,519,974
<b>Total</b>	<b>129,832,687</b>	<b>268,132,704</b>

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The 1911 Insurance Consolidation Act also stipulated that employers pay the entire additional premium required for coverage of persons in high risk trades or occupations. <sup>290</sup>

#### **Administration**

In 1911, with the passage of the Insurance Consolidation Act, the federal government and the employers were successful in wresting back a greater degree of management control of the funds. The 1911 law stipulated that the fund executive and other top managers of the fund be elected by the majority of both the insured employees and employers. Supporters of the change claimed that it would "stop abuses of a party political nature which had formerly occurred in some local funds as long as the majority principle was in effect". Because of this stipulation, the labour supported SPD voted against the Insurance Consolidation Act. <sup>291</sup>

By 1911, the majority of doctors practicing for funds were reimbursed from a pool of money created by the funds. These monies were dispersed by the doctor's association directly to the practicing

doctors. Also by 1911, the doctor's associations had gained authority for selecting and operating the committees that performed both utilization review and quality assurance. While these doctor's groups operated separately from the fund administration, many direct ties were maintained. Most notably, the fund administration provided operating revenues to the review organizations that performed utilization review and quality assurance.

The Insurance Consolidation Act also established federal and state level administrative bodies to oversee the Sickness Insurance Programme. Their staff included, among others, arbitrators who specialized in resolving disputes between funds and providers.

**PART V**

**Changes to an Established Framework:  
Health Policy in Germany Between 1912-1990**

## 1912 to 1932: Conflict and Change through the end of the Weimar Period

The 1911 Insurance Consolidation Act came into force for sickness insurance on January 1, 1914.<sup>292</sup> Between the time the law was enacted and implemented however, another major precedent-setting piece of legislation was enacted. Despite the additional rights the Insurance Consolidation Act promised to grant to doctors, particularly in the area of contracting with sickness funds, the doctors, through the growing medical associations, most notably the Hartmannbund, continued to agitate for professional autonomy and control over their work conditions.

In 1913, it was announced that the doctors were planning a general strike. The government stepped in again to mediate a settlement between the sickness funds and the doctors. These negotiations resulted in the historic Berlin Agreement. Perhaps more than the Insurance Consolidation Act of 1911, this agreement significantly altered the role of the profession in the delivery of care to the German citizenry.

### *The Berlin Agreement*

The Berlin Agreement recognized the Hartmannbund, the largest and most militant of the professional associations as *the* contractual partner of the sickness funds. The agreement established a review committee composed of doctors and representatives of the sickness funds whose responsibility it was to regulate the admission of doctors to sickness fund practice. To that end, the agreement further decreed that there should be a specified ratio of fund doctors to insured persons. That ratio was established at not less than 1:1,350 for each fund in 1913 (the ratio was not less than 1:1,000 insured persons where family members or dependants were also to be treated). In addition, the review committees also were given the right to arbitrate conflicts and formulate the terms of contracts between the doctors and the funds.<sup>293 294</sup>

In effect, the Berlin Agreement went a great way towards the elimination of the direct provision of ambulatory health services by the sickness funds. To the extent that sickness funds continued to employ doctors, the funds ability to contract with a few cost conscious providers was eliminated. The stipulation of the doctor patient ratio not only gave the doctor greater control over

practice patterns but also made it easier for the growing number of practitioners<sup>295</sup> to enter practice and be paid by the insurance programme. Not surprisingly, the status and responsibilities granted to the Hartmannbund by the Berlin Agreement increased the membership of the doctors' association. By 1919, 90% of all doctors were members.<sup>296</sup>

In the years immediately following the Berlin Agreement, disputes between the sickness funds and doctors decreased. However, the doctors demand for higher remuneration by the sickness funds continued. While official payment levels had been established earlier, the funds routinely paid doctors at discounts to these official rates. The doctors wanted the minimum payment levels to be equivalent to the official fee schedule.

Perhaps because of World War I, there were few major disputes between the funds and the doctors during the war years. There were no major legislative changes enacted during this period. In fact, in contrast to the years preceding the war when doctors gained significant strength in shaping health policy, the war allowed the labour movement and hence, the sickness funds, to regain some level of influence in the government. As the war dragged on, the military administration worked with labour in order to ensure the cooperation of the workers. Domestic legislation enacted during or immediately after the war recognized the labour movement, the workers' right to freedom of association and collective bargaining.<sup>297</sup> Specifically with regard to the sickness insurance programme, two pieces of legislation were enacted and implemented which recognized the special circumstances of the war. In December 1914, the wives of insured servicemen became entitled to maternity benefits. And, in April of the next year (1915), a second law was enacted to extend the same coverage to the wives of all servicemen.<sup>298</sup>

At the end of the first world war, the German monarchy was replaced by a parliamentary democratic republic. The Weimar Republic, created with the signing of the constitution on August 11, 1919, was to last until 1933. During that time, domestic policy reflected the fact that the social insurance programmes, of which sickness insurance was a part, were to be maintained by the state. What changes were made to the programmes, were dictated far more by the prevailing economic

conditions of the country as a whole than by special interest groups whether they be the sickness funds or the doctors.

In the post war period between 1919 and 1923, the German economy experienced a period of high inflation and unemployment. Policy changes in the first years of this period largely reflected the demands of the labour movement. For example, an eight hour work day was legislated as was a law which required larger employers to employ the handicapped. In regard to health policy, a 1919 law, extended maternity benefits to all insured women. <sup>299</sup>

While there was a doctor's strike in 1920, it did not result in any identifiable change in policy. However, tension between the funds and doctors escalated in 1923. In late 1923, two new laws were implemented, only one of which addressed the relationship between the funds and the doctors. In October 1923, the Insurance Consolidation Act of 1911 was amended to include the provisions of the Berlin Agreement of 1913 which was to expire by the end of that year. None of the additional changes lobbied for by the doctors (for example, minimum payment levels) were incorporated. The doctors were unhappy with this development and went on strike the following month. The strike ended in January 1924 in most places but lasted until June in Berlin where the association of sickness funds had set up special clinics staffed by salaried doctors. <sup>300</sup>

The other law passed in 1923 was called the Reichsknappschaftsgesetz or Miner's Fund Law. The law was enacted in an attempt to organize the services and administrative practices of the Miners' Funds. At the end of the world war, there were 110 separate Miners' Funds, governed not by federal but by state law. The new law created a national association for the Miners' Funds.

Between 1924 and 1929, a period which Zollner refers to as the stabilizing period, there were no pieces of legislation relating to sickness insurance passed. This period which was marked by high growth rates in the economy and currency reform did however, produce several other important legislative initiatives. For example, in 1924, the existing poor relief system was reformed. The old, largely state or local programmes were consolidated into a federally regulated social assistance

programme. In 1927, landmark legislation was introduced which created an unemployment insurance programme. Both of these initiatives reflect not only a rapidly deteriorating economic situation in Germany but the end of the transition of Germany from a rural agricultural society to an urbanized wage earning society. The social welfare nature of both laws also reflect the continuing influence of the labour movement in the policies created by the Weimar government.

The following three years, the period between 1929 and 1932, was one characterized by an economic crisis which was more marked in Germany than in other countries. By the winter of 1931-1932, approximately 33% of the German workforce was unemployed (6 million persons).<sup>301</sup> As government revenues declined and federal deficits increased, the government undertook a series of legislative initiatives which had a substantial impact on the social insurance programme. Between 1930 and 1932 a number of emergency regulations were implemented. The majority of these, reduced benefits for the insured by instituting fees or copayments for services. The sickness funds were not allowed to grant benefit coverage which exceeded the minimum statutory levels. Beneficiaries were required to pay a small fee when seeking care; this fee was paid to doctors to certify that the patient was in fact, sick and therefore entitled to benefits both in-kind (medical care) and perhaps more importantly given the economic crisis, cash payments. To further discourage the insured population from claiming sick pay benefits, one of the emergency decrees implemented during this period declared that cash benefits would no longer be paid from the onset of illness. These benefits were now only to be claimed from the fourth day. The last change in legislation relating to benefit levels passed during this period instituted a copayment of 50 pf. for each prescription. This charge was in addition to a 10% coinsurance requirement implemented in 1923, also in response to inflationary pressures.<sup>302</sup>

The reduction in benefits for sickness insurance together with similar reductions in the other social insurance programmes had a dramatic impact on the German social welfare system. From 1930 to 1932 the real expenditures for social insurance actually decreased for the first time in the history of the programmes from 4,400 million RM in 1930 to 3,300 million RM in 1932.<sup>303</sup> Also by 1932 the number of sickness funds serving the 19 million citizens then covered had shrunk to 6,662.<sup>304</sup> The majority of insured persons (62%) were now members of a Local Fund.<sup>305</sup> Interestingly, by this time

the sickness insurance programme was supported not only by the labour movement but by employers who recognized that without the programme, the economic responsibility for the provision of benefits of the social insurance programmes would fall solely to them.

Not surprisingly, shrinking revenues to the funds and the resultant benefit cutbacks created new tension between the funds and the doctors who were concerned about their already shrinking levels of remuneration. A decree passed in July 1930 permitted the sickness funds to employ a utilization control panel. Essentially, the panel's job was to give second opinions and otherwise check doctors' utilization patterns and consequent expenditures. At the time the law was implemented, there were over 1,000 doctors serving in a utilization review capacity for the sickness funds. To pacify the expected reaction of the doctors to the new statute, a provision of the law reduced the required doctor patient ratio from the not less than 1:1,350 stipulated by the Berlin Agreement of 1913 to not less than 1:1,000. Still, the doctors were concerned that the government might soon introduce a law requiring the sickness funds to employ doctors directly.

At a medical congress held in 1931, the doctors formulated a series of demands primary among which was the assurance by the sickness funds of a minimum income level for doctors regardless of the economic condition of the funds. The result of lobbying efforts by the doctors was a 1932 law which once again shifted the balance of power towards the doctors. First, the ratio of doctors to insureds was further reduced to not less than 1:600. Perhaps more significantly, selective contracting was all but eliminated by a provision of the law which established regional medical associations (Kassenaerztliche Vereinigungen) which were empowered to 1) sign contracts with the sickness funds on behalf of doctors providing services to fund members and 2) establish a fee schedule and distribution system for prescription drugs and medicines. With regard to the doctors demand for minimum guaranteed remuneration, the statute instituted a capitation payment for each member. While the sickness funds guaranteed that a capitation payment would be made, they were not required to guarantee any minimum payment to an individual doctor. Finally, the law established that to work for a sickness fund a doctor must be certified by a board composed of equal numbers of doctors and insurance fund representatives. These changes or more importantly, the concepts they embody--self

administration, guaranteed remuneration and free choice or the ability to control the provision of ambulatory services through the medical associations--are features of the programme that have shown great tenacity. <sup>306</sup> These features exist in today's programme. <sup>307</sup>

### 1933 to 1945: The Impact of National Socialism

While the government, through its various decrees institutionalized a far more powerful role for the doctors during the post war period, the expanding number of persons covered by the sickness insurance programme and the programme's continued strong identification with the labour movement and socialist doctors led to continuing conflicts between the doctors and the funds. The relationship of the doctors' associations and hence many individual practicing doctors themselves, to the changing political climate, is an interesting one. Between the parliamentary election held on May 20, 1928 and March 5, 1933, the National Socialist Democratic Workers Party (NSDAP or Nazi party) increased their share of the total vote from 2.6% to 43.9%. <sup>308</sup> What is perhaps less well known is that the NSDAP which had paid special attention to attracting the doctors during the period from 1924-1930 as earnings fell and fears of socialist medicine increased, succeeded in their efforts. Proportionately more doctors joined the NSDAP than did the members of any other profession. They were "rewarded" in late spring 1933 by the Ministry of Labour's issuance of two new regulations which prohibited communists, non-Aryans and socialists from practicing medicine for local sickness funds. As a result, by 1938, largely through the efforts of doctors in local or regional medical societies, the majority of doctors who favoured sickness funds with independent delivery systems, <sup>309</sup> were eliminated either through forced emigration or death. <sup>310</sup> In 1933 alone this law affected 2,800 doctors or approximately 8% of all doctors practicing for funds. <sup>311</sup>

The NSDAP later consolidated control over the sickness funds by replacing fund members who acted in an administrative capacity with loyal party members known as "old fighters" who were among the first 100,000 to join the Nazi Party. <sup>312</sup> In this action, approximately 10% of the sickness funds employees were dismissed. <sup>313</sup> The Reconstruction Act of 1934 and several auxiliary decrees passed between 1932 and 1942, completely eliminated local management of the funds by individuals appointed by the members and their employers. <sup>314</sup> The Party also sanctioned the closing of fund

owned and operated clinics and ambulatory care centers in a 1933 law which permitted the closure of "uneconomical" centres. As Donald Light states,

*"Uneconomical was defined as taking business away from more private physicians than they replaced. For example, if one physician in an ambulatory center took away business from four other physicians, the center was deemed uneconomical."* <sup>315</sup>

The NSDAP was responsible for legislation which finally recognized doctors as a profession under German law. This law was backdated to 1932. At approximately the same time the regional medical associations, which were acting as collective bargaining units for the doctors, were united into a national organization with which the sickness funds were required to conclude a contract. This finally wrested control over the delivery of services from the funds and made it nearly impossible for them to control utilization and costs. The sickness funds were relegated to the role of premium administrators.

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In 1942, two new statutes were enacted which extended benefits and reorganized the method of collecting premiums from the insured for all types of social insurance. Benefit periods were made unlimited and maternity benefits were granted for six weeks before and after the birth of a child. The latter benefit improvement was funded by the federal government or Reich Regierung. In regard to premium collection, the sickness funds were given the responsibility of collecting contributions not only for sickness insurance but also for pensions and unemployment insurance. The entire contribution was deducted directly from the insured's wages. <sup>317</sup>

In short, the period between 1933 and 1945 can be summarized as another period of consolidation. There was administrative consolidation and consolidation of professional control over the finance and delivery of health care services. While the federal government's control over fund administration would end after the second World War and the original administrative framework for the programme would be reinstated, gains made by the doctors including the legalization of the profession and the unification of the "bargaining unit" would have a lasting impact on the programme.

## **1946-1990: Health Policy and the Sickness Insurance Programme in the Post War Period**

At the end of the second World War, the German economy was in substantial disarray and the need for services by a ravaged population whose numbers included over eight million refugees was monumental. Moreover, there was no German governing entity; legislative and executive power was in the hands of the allied military authorities. The allies left the system of social insurance in place and took decisive action only to abolish the rulings of the NSDAP. For example, Jewish and socialist doctors were once again permitted to practice for the funds and the NSDAP members who had been given executive positions were removed from office. In March 1946, the Allied Control Council approved in principle to standardize the social insurance programme in the occupied territories but never moved to create legislation to implement any reforms.<sup>318</sup> In the British zone, an attempt was made to implement a system similar to that in Britain but was unsuccessful.<sup>319</sup> As a result, to the extent that funds permitted, the system which was in place prior to the war was maintained. The German leaders of the time were not desirous of seeing major changes instituted with regard to social policy. De facto, this meant that those groups who had benefitted from the Nazi period, that is, the doctors who were granted professional status, were, as previously mentioned, allowed to retain this very important right.

The German state was rebuilt slowly over the period from 1945 to 1949. Regional governments were allowed to be formed in 1946-1947. In 1948, the leaders of the regional or state governments (Laender) were given the authority to form constituent assemblies which would be the basis for a new federal government. In May 1949, this group enacted the Grundgesetz or Basic Law which allowed the creation of the new German parliament or Bundestag. In the autumn of 1949, the first Bundestag was elected and West Germany (the Bundesrepublik Deutschland or BRD) was created. East Germany (the Deutsche Demokratische Republik or DDR) was created at about the same time.

Before discussing the evolution of the sickness insurance programme in the two post war Germanies, it is important to note the one law passed by the Economic Council in the British and American sectors on June 17, 1949, shortly before the elections. This law, known as the Social

been cut in the latter years of the war due to a lack of funds. The restoration of benefit levels applied to all forms of social insurance, not just the benefits covered by the sickness insurance programme. Perhaps more importantly, the payment and administrative "split" between employers and employees was changed. Contributions and administrative representation became shared on a 50:50 basis. Formerly, in the majority of funds, the employees paid two thirds (2/3) of the premium for insurance coverage and consequently, had a right to elect two thirds (2/3) of the administrative panel.

#### *Overview of the East German Health Care System*

Because the system of health care services developed in East Germany after the war is divergent from the programme of sickness insurance in Germany prior to 1945 and the programme maintained in West Germany, it will only be briefly described here. The balance of this study will be devoted to the "continuation" of the programme in the West Germany.

The East German health care system embodied many of the principles originally conceived by Virchow and other clinical reformers of the nineteenth century. Lenin encapsulated these principles in a speech on health care policy at the Fifth All-Russian Congress of Soviets in 1918. He stated his belief that the provision of health care services is a state responsibility and that it should be a right of each citizen to receive such services without cost. Lenin also said that a health care system should be unified and centrally administered and that public health depends on citizen involvement. Finally, he stated his belief that preventive care and health promotion be primary objectives of the system. Thus in contrast to the programme entrenched in the West, clinical intervention and promoting the medical profession were not focal points of the programme. As early as 1946, the Central Health Administration or Centralverwaltung fuer Gesundheitswesen, was formed to *"redress the maldistribution of professionals, plan and control the production and distribution of medications and pharmaceuticals, regulate health education and social hygiene, oversee industrial health care, orchestrate the treatment of venereal disease and tuberculosis and supervise the collection of statistics on diseases"*.

The public health problems caused by insufficient food supply and the burgeoning population, prompted the Central Health Administration to create what became known as Central Offices for Hygiene for each population center of 20,000-30,000 persons. These offices, staffed by a doctor and a team of "disinfectors", vaccinated the population against typhoid and maintained shelters for those seriously ill with typhoid, tuberculosis, malaria and spotted fever.<sup>321</sup> Similar offices or clinics were established for the control of venereal disease. This state organization of care marked the beginning of the end of the doctors' independent control over the provision of ambulatory care services.

Other changes formally changed the role of the doctor in the East German health care system. The German Doctors' Association was dissolved and professional associations were prohibited. Most notably, the separation between ambulatory and hospital care was eliminated. Clinics for the provision of ambulatory care services became affiliated with hospitals. Prior to reunification in 1990, the majority of these clinics were no longer affiliated with hospitals yet they provided a means of transition to a state-controlled system for health care delivery. Needless to say, these changes did not please the majority of the doctors and thousands emigrated to the West. Consequently, the East German system relied proportionately more on paraprofessionals (nurses and medical assistants). Similarly, East Germany used proportionately fewer specialists and more general practitioners.<sup>322</sup>

The East German health care system also had two special programmes for maternal and occupational health which are worthy of mention. Not surprisingly, the East Germans set up these programmes as models for their own citizens as well as to demonstrate to other nations their commitment to preventive health care and to show the results of a programme which was planned and administered by the state.

In the late 1940's and 1950's in East Germany, it was very important for women to work (the male workforce had been depleted by the war and by the exodus of citizens to the West). At the same time, it was deemed important for these same women to bear children. The East German government instituted a rich array of benefits to maintain the health and productivity of their female childbearing population and to encourage these women to reproduce. The system promised job security to women

who had children and provided not only health care services but income maintenance during maternity leave. From the second trimester, pregnant women were not to be subjected to any health risks and were not to work overtime or night shifts. Paid pregnancy leave began six weeks prior to the expected date of delivery and extended to up to one year after the birth of the child. Moreover, the state offered financial incentives to encourage couples to have more than one child. Mothers received a one time payment of 1,000 M after the birth of her first child. Additional financial incentives were provided for seeking postnatal care for both mother and child. For women under 26 years of age, home improvement loans were also provided which included provisions for forgiveness of this debt as more children were born were also provided. The maternal and child health care programmes are credited with the marked decline in both maternal and infant mortality rates. Infant mortality in East Germany decreased from 72.2 per thousand in 1950 to 12.1 per thousand in 1980. Both the infant and maternal mortality rates were lower in East Germany in 1980 than in West Germany.<sup>323</sup> Not surprisingly, the child and maternal health programmes are provided through the state run clinics most of which are located in close proximity to child care centers or kindergartens.

Similarly, the East German health care system focused on occupational health through the establishment of on-site clinics to serve the needs of the workers. These programmes largely implemented preventive health programmes and provided health education as well as providing first aid treatment and ambulatory care for workers who became sick on the job. The clinics, which were numbered in the thousands, were required (under the terms of union contracts) also to analyze patterns of accidents and illness among the workers at the work site. As with the maternal health care programme, the programme for occupational health and safety was first instituted by the state as an incentive for workers to stay in East Germany and not emigrate to the West. It was also designed to be a model of a state controlled system which provided comprehensive preventive oriented care.

While it was a heavily beauracratized system, the East Germans provided health care to their citizens at half the cost (defined as a percentage of the gross national product) of the West Germans and if the infant and mortality statistics are indicative, with comparable and perhaps better results.

## *West Germany*

Unlike the East Germans, the West Germans kept the system which mimicked that established by Bismarck. There was a division between ambulatory and hospital care and a finance and delivery system organized through sickness funds. However, the doctors continued to look for increasing control and autonomy and higher remuneration. The politically active doctors influenced the laws of the early post-war period. The major concessions achieved by the medical profession include provisions in laws which prohibited 1) sickness funds from delivering services directly or running clinics without the approval of the local medical association, 2) occupational or public health doctors from providing any treatment other than emergency care or first aid and 3) doctors from organizing group practices without the permission of the local medical association. All of these statutory changes were designed to strengthen the medical associations. As in the past, the doctors also pressed to reduce the number of doctors trained and certified for practice in order to increase their economic security.<sup>324</sup>

The laws which codified these structural changes to the sickness insurance programme were not the first to be enacted by the new government. In autumn 1949, the first legislative session passed 52 laws designed to reduce the fragmentation in the social insurance programme created in the period between 1945 and 1949. These laws were intended to standardize practices in the states (Laender) and adapt the programmes to rapidly changing economic conditions where wages and hence, revenues to support the programmes rose markedly. Average wages increased 80% between 1948 and 1953.<sup>325</sup>

The Establishment Laws (Errichtungsgesetze) which codified the structural changes noted above as well as others related to self-administration of medical practice by the doctors, were enacted in the new decade. On May 1, 1952, the Federal Office of Employment and Unemployment Insurance (Bundesanstalt fuer Arbeitsvermittlung und Arbeitslosenversicherung) was created. While the organization had no direct impact on the sickness insurance funds, its creation meant that administrative oversight for labour-related issues became a federal rather than state responsibility. This structure mirrored that of the pre-war (Weimar) period.

In 1953, the Social Court Law (Sozialgerichtsgesetz) was passed. It meant that legal decisions regarding social insurance were to be handled by a special legal jurisdiction. A special three step process was implemented. Again, this was important because it reestablished the independence of the administrative bodies governing the social insurance laws. <sup>326</sup>

In terms of its impact on the sickness insurance programme, the Insurance Doctors Act of 1955 was by far the most important piece of legislation enacted as one of the Establishment Laws. This Act formally established the Associations of Insurance Doctors at the state level. They were formed as corporations under public law. <sup>327</sup> These corporations were responsible to the sickness funds in each state for the provision of all medical services to insured persons and their dependents. The law laid down principles for the admission of doctors to practice for the sickness funds. The medical associations were to guarantee care in exchange for all payments from the sickness funds to insurance practice doctors. <sup>328</sup>

Each doctors' association in each state was an independent self-governing body. All licensed doctors in the state were members, including those certified for insurance practice and those who were not. Each association had a paid administrative staff financed by the doctors at a rate of approximately 2-3% of fees paid. The separate state associations were members in turn of the Federal Insurance Doctors Association, headquartered in Cologne. <sup>329</sup> The law was significant because it recognized that all doctors, not only those certified for insurance practice could be members of the administrative body which handled the doctors' insurance practice. By 1959, just prior to the enactment of a new law which once again reduced the ratio of doctors to insured persons (not including dependents), this time to 1:500, there were 37,000 doctors practicing for the sickness insurance funds out of a total of 42,000 independent practitioners. <sup>330</sup>

To be admitted for insurance practice, a doctor 1) had to have served an apprenticeship as an assistant to a doctor in private practice for a sickness fund and 2) had to satisfy certain criteria of an admission committee comprised of representatives of both the sickness funds and the doctor's association. The criteria of the committee included proof of professional ability, the number of years

in practice, a review of the applicant's experience as an assistant and the applying doctor's knowledge of local conditions. Because of these criteria and the restrictions on the number of doctors allowed to practice for the insurance funds, the average age of a doctor entering sickness fund practice was 40 years. <sup>331</sup>

Each doctor admitted to practice with the sickness funds was assigned a geographical area in which to practice. The doctor was permitted to practice outside the area but patients utilizing services of a doctor from outside his assigned area were responsible for paying extra charges associated with that care. The doctor was required to treat all insureds and dependents who came to his office during regular office hours and to make house calls when necessary. Unlike under a capitation system, the insured or dependent was entitled to seek care at any time from any sickness fund doctor in his area. A patient simply presented a treatment form or voucher demonstrating his eligibility for treatment under the sickness insurance programme. The same form afforded the doctor a means by which to claim payment. Sickness fund members received forms from the funds or their employers. Each insured person and his dependents was entitled to one form each quarter. While the member was legally entitled to free choice of practitioner, the system for handling forms, that is, eligibility and doctor payment, suggests that changing doctors more than one time per quarter or during a spell of illness was unusual. If treatment for an ailment continued past one quarter, the member was required to present another form to the doctor providing care.

After the implementation of the 1955 law, any complaints by patients about a doctor or the care they received from a doctor went directly to the doctors' association and not to the sickness fund. The doctors' association was responsible for establishing a grievance procedure and a system of penalties. Doctors had the right to appeal a decision by the association to the State Social Services Tribunal. In addition, the patient had the right to seek civil court remedies and to change his or her doctor.

The 1955 Act retained for the sickness funds their ability to budget medical costs. The amount to be paid to the doctors' association for the treatment of all fund members for the year was established

via negotiations between the fund and the doctors' association. In general, these negotiations strived to allow the fund to fix its costs while providing for adequate compensation for the services to be provided. Federal law only stipulated that the sickness funds pay an amount which is 1) related to the number of insureds to be treated, 2) the average level of utilization and 3) variation in wage rates and hence total revenues available to the sickness funds. The variation in budgeted payments between the two organizations was therefore de facto adjusted for changes in the cost of living. The amount of payment by the sickness funds to the doctors' associations could also be made on a payment per case or payment per service basis in addition to the modified capitation method described above. Generally speaking, the system seemed to work without major controversy when there were adequate revenues available to the sickness funds.

The doctors' associations paid individual doctors from the remuneration pools received from the sickness funds. Payments to individual doctors were based on the quantity of services performed, not on the number of treatment forms submitted or persons treated per quarter. Doctors were paid according to a federally established fee schedule known as the Official Tariff of Fees for Registered Doctors and Dentists. This official tariff was promulgated in January 1953 by the Federal Minister for Economic Affairs. The 1953 tariff actually represented the reenactment of the Prussian Tariff of Fees, commonly known as the "Preugo" which was enacted in 1925 and was itself patterned after a fee schedule implemented in 1896. The fee schedule of 1953, which provided for minimum fee levels identical to those established in 1896, was adjusted upward by 33 1/3% in 1957. While the amount of payment was based on the official tariff and may seem low to the reader, it should be remembered that the size of the remuneration pool from the sickness funds did increase over this time period which, in turn, permitted increased compensation to the doctors. In the past, the total funds available to pay doctors for their work was insufficient to pay out all the claims made. Therefore, the tariff or fee schedule really established proportionate payments to doctors for differences in the level of services provided. It should also be noted that there was only one fee schedule for doctors. There was no distinction in payment between the general practitioner and the specialist although there were some services which normally, only specialists would perform. Doctors submitted claims quarterly to the doctors associations. The treatment form for each patient treated during the quarter also was required

to be submitted with the claim. Typically, the doctor was required to submit this paperwork to the payment office of the doctors association within ten days after the end of the quarter. There were penalties for late submission of claims. <sup>332</sup> Hogarth describes the following distribution process which was adopted in Hesse and is an example of the procedures used at the time:

- "(a) claims by individual doctors are priced according to the Official Tariff;*
- (b) claims in respect of unduly large numbers of cases are scaled down according to an arithmetic formula;*
- (c) claims are examined to ensure that they are not excessive or extravagant, and may be reduced when necessary;*
- (d) certain prior charges are met from the total remuneration "pool";*
- (e) the total volume of claims-checked, reduced if necessary, and scaled down under the formula-are set against the balance in the pool available to meet them, and the payments due to individual doctors are adjusted according to the ratio between the two totals;*
- (f) total payment to individual doctors which exceed certain "ceiling" amounts are automatically reduced." <sup>333</sup>*

With the exception of the Insurance Doctor's Act of 1955, the decade of the 1950's saw little reform of the sickness insurance programme or accident insurance programme relative to the major revisions to the pension system. On October 29, 1957 after the election victory which re-elected him, Chancellor Adenauer declared, *"Social reform shall be continued. Apart from amending some of the deficiencies which have come to light in legislation so far, the reform of sickness and accident insurance primarily will come under consideration"*. He went on to say *"social reform cannot be exhausted by developing social security institutions based on solidarity. The federal government is determined to promote self-help and private initiative in every way and...to prevent the country from sinking to the level of an all-embracing welfare state"*. <sup>334</sup> In 1959 a proposal which incorporated these aims was introduced by the government. It was followed by the introduction of legislation in January 1960. The proposed law, known as the Sickness Insurance Amendment Bill, called for patient copayments for some medical treatments and for prescriptions as well as the payment of doctors on a direct fee-for-service basis. Clearly, the proposed amendments were designed to shift the cost of services to the patient and away from the employer or government who paid for those eligible but not enrolled through their employment. In regard to the change in payment for doctors, the proposed amendments were an acknowledgement of the power of the profession and the successful lobbying efforts of its newly formed and recognized central organizing bodies. The cost sharing provisions of the bill, which the government stated were designed to correct inappropriate utilization were also proposed to offset the

cost of new benefits including coverage for physical examinations every three years for those over 40 years and extending the duration of coverage from 26 to 78 weeks in each three year period.

The bill called for the following payments: 1) a flat payment of 1.50 DM for each service provided and recognized on the official tariff, 2) a sliding scale co-payment for prescription drugs ranging between 1 DM and 3 DM, 3) a charge of 1 DM to 3.30 DM per day for care in a hospital. In regard to the hospital payment, the fee was reduced to 1.50 DM when a hospital stay exceeded six weeks. A maximum payment for each spell of illness was to be established by each sickness fund which by federal stipulation could not be less than 15 DM and finally, charges were to be waived for those earning 200 DM or less per month.

In regard to payment of the practitioner, (in addition to the legislative institution of fee-for-service payments by the associations to doctors), the proposed law called for the federal association of doctors to negotiate the remuneration pool with the sickness funds thereby greatly strengthening the power of the profession to control the total amount of remuneration for services. Perhaps of greatest significance to the profession, the proposals also called for the elimination of restrictions on the number of practitioners allowed to practice for the sickness insurance funds.

The Minister of Labour introduced the proposals on behalf of the government and stated in his introduction that the three main elements of the bill, cost-sharing, direct fee-for-service billing and the elimination of restrictions on the number of doctors practicing for sickness funds, were inseparable. He granted leeway in debate only on the level and form of the cost-sharing provisions.<sup>335</sup> Interestingly, when the proposals were made public, both the sickness funds and doctors protested vociferously against the proposals.

The doctors organized rallies as did the labour unions. Both groups were against the cost sharing provisions and blamed the government for "mistrust" of their utilization of the services authorized by the programme. The doctors were concerned that the newly legislated provisions would discourage utilization and therefore reduce their level of payment. They also objected to having to bear

the administrative burden of collecting the new fees from patients. The labour unions declared their opposition to the new charges and threatened demands for higher wage rates to compensate for the reduction in real income. In the Parliament, the Sozialistische Partei Deutschland (SPD) rejected the plan. Given this, the proposals did not have sufficient support for passage and a vote was delayed until 1961, the end of the legislative session. <sup>336</sup>

In March 1960 however, a Federal Constitutional Court found that the restriction by the sickness insurance programme of the number of doctors to be permitted to contract with the sickness funds was not in keeping with the constitutional right of all Germans to have the freedom to select their profession and place of work. <sup>337</sup>

In 1962, another legislative proposal to reform sickness insurance was proposed. Similar in its content to the 1960 proposal, it too lacked the necessary support for enactment. Finally, in October 1963, the new chancellor, Ludwig Erhard, withdrew the government's proposal. He then called for a commission of social inquiry to review the sickness insurance programme which in essence meant that no new reforms were to be proposed in the near term future. <sup>338</sup>

The commission published its report in 1966. The report, for the first time, included an economic analysis of the sickness insurance programme which enabled the development of a national social budget. The first social budget was presented to the parliament in 1969. The recession of 1964-1969 was coming to an end and a new law, the Wage Continuation Payment Law (Lohnfortzahlungsgesetz), was passed. This new law allowed both wage and salary earners the right to collect their full salary for up to six weeks of illness. <sup>339</sup>

In April 1970, the new government, a "Social Liberal Coalition" led by the SPD, issued its "Social Report of 1970". This report described the issues facing social programmes and identified the need for reform and extension of benefits. The issuance of the report was followed by the establishment of four commissions, one of which was dedicated to reviewing the sickness insurance programme. The commission's work led to the enactment of several laws during the early and mid-

1970's. In December 1970, another Further Development Law (Weiterentwicklungsgesetz) was enacted, this time to permit voluntary enrolment in a sickness insurance fund to all employees regardless of income level. The law also extended coverage for physical examinations aimed at early diagnosis of disease. This was important because for the first time, the German programme turned its attention to focus on health protection, not sickness treatment. In 1972, a law extended insurance coverage to farmers, the self-employed and their dependents and persons who received old age assistance. The law provided for coverage of medical treatment only and did not permit the payment of sick pay. In December 1973, the Law on Improved Benefits (Leistungsverbesserungsgesetz) was enacted. This law provided for home help during hospitalization and sick pay for people caring for an ill child. The law also abolished any time limit for payment of hospitalization benefits. In June and August 1975 two laws were promulgated which extended coverage to students and authorized payment for medical advice on contraception, sterilization and abortion. <sup>340</sup>

During the late 1960's the number of hospital-based doctors had increased. As a result, hospital utilization and costs also escalated. The trend for increased utilization of costly services coupled with a decline in revenues to the sickness insurance funds led the government to declare a cost explosion in late 1974. The government called on all parties involved with the programme to help it find a solution. By 1976, the average contribution rate had risen to 11.3%, up from 8.2% in 1971. A number of legislative proposals were considered but none were enacted by the end of 1976. The Cost Containment Act (Kostansteigerungsgesetz) was passed in June 1977. It called for setting maximum payments for prescription drugs, fixed price, selective contracts for pre-inpatient diagnosis and post hospital treatment, the establishment of a "Concerted Action" in the health service and the taking into account of aggregate wages in determining remuneration pools from the sickness insurance funds to the doctors' association. <sup>341</sup> The 1977 law was important for a number of reasons. First, it represented an acknowledgement by the government of the relationship between 1) the service providers, most notably the doctors 2) the cost of care and 3) action on the part of the government to control the profession and the overall cost of the programme. In fact, when there were doctors' strikes in protest, public opinion shifted so that doctors were viewed as earning too much for a "public servant" and as being too greedy. <sup>342</sup> Second, the "Concerted Action" meant the formation of a National Health

Conference attended by all the major parties associated with the Sickness Insurance Programme including the sickness funds, health care providers (hospitals, doctors, dentists and pharmacies), employers, labor unions, and representatives of the provincial and Federal governments. The inclusion of the governmental representatives is important; the federal government had formerly shied away from such participation, particularly when the subject to be discussed was cost control. While a seven person administrative committee was to meet monthly, a full conference was scheduled two times per year. The group was mandated to provide annual health policy recommendations and to establish guidelines for cost ceilings for each part of the health care system. The guidelines were just that- non-binding recommendations. However, when costs substantially exceeded the suggested limits in any one part of the system, it was clear to all parties that discussion of measures to bring that segment under control were needed. In effect, the conferences, held regularly, provided another subtle form of peer review and control. <sup>343</sup>

Amendments to the 1977 Cost Containment Act were passed in 1982 and 1983. The 1982 law increased charges to the patient for prescription drugs while at the same time publishing a list of drug comparables. In 1983, a Supplementary Budget Act was passed which introduced copayments for the first fourteen days of a hospital stay (5 DM) and for rehabilitation in a spa (10 DM per day) and prescription drugs (2 DM per drug). <sup>344</sup> Together these two measures were intended to reduce costs by encouraging the consumer to select the lowest cost alternative and through copayments, discourage some utilization.

The 1977 Law, as amended, did not address the issue of rising hospital expenditures. Policy makers changed their focus and in a series of laws promulgated and enacted between 1982 and 1986, changed the way hospitals had been paid. The Hospital Cost Containment Act which was introduced in 1982 stipulated that hospitals negotiate the daily per diem charge for their services with representatives of the sickness funds. In addition, on the state level, associations of sickness funds and associations of hospital were responsible for the development of a state hospital plan for services. Finally, this statute extended the Concerted Action to cover issues related to inpatient hospital care. <sup>345</sup> In 1984 a law was introduced (which would be implemented in 1986) which required hospitals to establish flexible

budgets. Formerly, hospitals had been paid a fixed, all-inclusive per diem charge. Now, the sickness funds which financed more than five percent of a hospital's patient days could participate in the hospital's budgeting process. The budgets were to be based on facility specific historical expenses, likely future expenses and be comparable to similar expenses for comparable hospitals in their geographic region. This form of budget now incorporated the impact of varying occupancy levels and lengths of stay. Once an overall budget had been set, the budget was used to derive a new per diem charge. If utilization was higher than anticipated and the hospital made more income than originally budgeted, the hospital was allowed to retain twenty five percent of the surplus. If, on the other hand, the hospital's occupancy was lower, the hospital was required to cover twenty five percent of the loss.

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Hospital reform continued in 1985 with the Hospital Financing Act. Federal funding for capital investment in hospitals was now to be limited to those institutions which were accredited. Similar to most other aspects of the German programme, states defined the criteria for accreditation. In general, the criteria became tougher. Prior to the enactment of this legislation, the establishment of investment criteria was a task shared by the federal and state governments. Equally notable, the sickness funds were now given permission to contract selectively with hospitals by cancelling contracts with inefficient providers of inpatient services. This had not been allowed since the Insurance Consolidation Act of 1911 had been implemented. Practically, however, few contracts were cancelled for fear of losing competitive position. Contracts were only cancelled on the state level, which effectively meant that the hospital was forced to close. Because of negative public reaction to hospital closures, this only happened in five instances between 1985 and mid-1990. In addition, two hospital departments closed. Similar to the Certificate of Need Law (1973 Health Care Cost Containment Act) in the United States which allowed states to set limits on new construction and the purchase of high cost medical equipment, the German states were given the right to control a hospital's decision to purchase expensive specialized equipment. Unfortunately, the law did not regulate doctors' ability to purchase such equipment which resulted in individual doctors and groups purchasing equipment and locating it near hospitals. <sup>347</sup>

The Federal Hospital Payment Regulation of 1986 fostered new data collection efforts at hospitals. With a view toward cost-per-case pricing, hospitals began collecting demographic statistics as well as diagnosis, specialty and length of stay information.<sup>348</sup> This law also permitted some new payment flexibility. Special rates were now paid for both high and low cost services including for example, obstetrics (low cost) and neonatal intensive care (high cost). In addition, special payments were permitted for high cost items such as pacemakers.<sup>349</sup>

In 1987, a flexible budgeting programme was introduced for doctors. Under the old system, the federal government set tariffs for each of 2,500 services. Each service was assigned a number of points to determine its relative value. The sickness funds then negotiated the value of each point. Under the new system, the level of overall expenditures was based on the number of insureds and the average earnings to be contributed. This resulted in a lower value per point; the more points there were, the lower the value of each. Between 1987 and 1988, point values fell approximately 10%. Since 1971, relative earnings for German doctors have dropped considerably. In 1971, a German doctor earned approximately 6.5 times that of the average worker. In 1988, the figure was 3.5.<sup>350</sup>

Legislation passed in late 1988 was designed to address rapid cost increases in yet another part of the system: pharmaceuticals. A Transparency Commission was formed to publish new information on the price of drugs. Additional changes designed to alter prescription patterns of doctors were incorporated into the Health Reform Act of 1989.<sup>351</sup>

Further increases in expenditures in the mid-1980's coupled with increasing unemployment, resulted in the employee contribution rate for health insurance to jump from an average of 11.3 percent to an average of thirteen percent. A series of reforms designed to further restrict the growth in expenditures was encapsulated in the Health Reform Act of 1989.

The Health Reform Act of 1989 has been described as the most important piece of comprehensive legislation since the Insurance Consolidation Act of 1911.<sup>352</sup> In addition to containing costs, the law provided coverage for some selected new benefits. New benefits included coverage for

preventive care. Free examinations for people over thirty five years of age are now reimbursable as are routine dental examinations twice per year for those twelve to twenty years of age. Respite care is now provided for families providing care to the long-term chronically ill. In 1989, the sickness funds paid for four weeks of vacation for caregivers and beginning in 1991, the benefit was extended to include a 400 DM per month stipend for caregivers or 750 DM per month for professional nursing services. <sup>353</sup>

In regard to cost containment, drug copayments were increased from 2 DM to 3 DM per drug. The hospital daily copayment charge was doubled to 10 DM per day. The conditions exempting some patients from these charges were revised. Requirements designed to encourage providers to be more cost efficient included the establishment of fixed prices for drugs based on the lowest cost that would not jeopardize supply. The price schedules were to be introduced in three stages and were designed to encourage the use of the least costly alternative, usually a generic brand. Once a drug was covered by the list, the copayment would be dropped. Doctors could continue to prescribe drugs not on the list and with a higher cost, but the patient was liable for the difference in cost. By limiting reimbursement to less costly alternatives, it was hoped that patients would exert influence on doctors to prescribe generic brands and that the doctors themselves would pursue more cost-efficient practice patterns.

Improved coordination of inpatient and ambulatory care was encouraged. Demonstration projects assessing the viability of payment by diagnosis, similar to the Diagnostic Related Group (DRG) payment mechanism in the United States seem to be more successful in providing the impetus for these new relationships. Patient oriented incentives for reducing utilization are now also allowed. Sickness funds were encouraged to provide rebates of one month's premiums to patients who submitted no new claims. This and other ideas were to be tested scientifically for a five year period to determine their effectiveness. To improve quality, new quality assurance programs were to be introduced for doctors practicing in ambulatory or institutional settings. No method was stipulated. Among other aspects of the law was the encouragement of State governments to slow the number of doctors being trained in medical schools. <sup>354</sup>

The Health Care Reform Act has had a measurable impact on the German Sickness Insurance Programme. The series of reforms encoded in the Act did contain national expenditures for health care services. Expressed as a percent of GNP, the sickness funds spent 5.52 percent in 1988. In 1989, the amount was more than ten percent less: 5.00 percent.<sup>355</sup> Cost containment was accomplished both by increased price controls (mostly for pharmaceuticals) and by the institution of incentives for reduced utilization. Perhaps most interesting, the burden of controlling use of services was placed primarily on the consumer. Consumer copayments again increased for pharmaceuticals and hospital care. Health policy makers continue to state their concern that cost sharing at the point of service delivery will create a barrier to access. However, copayments have increased fairly dramatically since 1977.<sup>356</sup> Secondly, the Health Care Reform Act of 1989 strengthened the ability of sickness fund administrators to oversee practice patterns. While seemingly these measures increase the power of the consumer and the sickness funds, it is interesting that providers, who perhaps can have the most impact on utilization patterns, were largely unaffected by the 1989 reforms. The ability to determine their practice patterns and hence define sickness treatment has remained sacrosanct.

Concern over costs has continued as expenses have continued to increase and acknowledgement grows that the West German system shifted its legitimacy from one based on the health needs of society to one based on the miracles of medical science and the supremacy of the physician as a figure of authority, expertise and prestige. Debate has continued over means to control costs by altering doctor practice patterns through a modernization of the organizational structure of the sickness funds. The post-war period in West Germany was a period of continued consolidation of power by the profession to achieve administrative control and financial stability. The era was punctuated by the acknowledgement of that trend and a movement to reverse some of the negative effects. Clearly, it will take much effort and likely a great deal of time to alter the balance of power so firmly entrenched after a slow but strong evolution over more than 100 years.

### *Health Care in a Reunited Germany*

In October 1990, East and West Germany were reunited. The first elections have been held and now the new members of parliament must begin to address a plethora of issues facing them. As the monumental task to reunite the two Germanies unfolds, the merging of the two health care systems which are ideologically different and which hence, organize and provide services in a different manner, will likely be a priority of domestic policy. Policy makers will have to address not only practical issues like the distribution, organization and adequacy of health care services throughout the nation but the underlying framework for the social policy on which these legislative initiatives will be based. No doubt, the medical profession will have a loud voice in these discussions.

**PART VI**

**Lessons From the German Experience**

The purpose of this chapter is to draw conclusions from this paper's description of the German Sickness Insurance Programme. It evaluates the German programme's impact on access and cost containment - the two major themes in current health policy and planning and briefly compares health status in the pre- and post-programme eras. The chapter continues with discussions of the peculiarities of the German model and similarities between the German system in the period between 1883 and 1911 and the evolving American national health care system. It concludes that the German experience over the past century holds valuable lessons for American health care planners today.

### **A Century of Modern Health Care in Germany Summarized**

#### *Roots*

Enabling legislation which created a compulsory sickness insurance programme in Germany was passed by Otto von Bismarck's government on June 15, 1883. Bismarck advocated the legislation believing that it would, at least in part, pacify the growing and increasingly vocal socialist-oriented labour movement. These workers, who had moved from rural to urban areas as the industrial revolution came to Germany, experienced a marked change in life style and a great deal of economic and physical insecurity. Away from their families and communities who cared for them and supported them when illness or accident prevented them from working, these workers now had no health protection and no means of income maintenance. Bismarck's objective was to establish a government-sponsored and operated system so that workers would look to the state, not to labour unions or the Social Democratic Party for assuring their welfare.

Bismarck's plan was also deeply rooted in the Hegelian notion of a strong state as well as a long-standing Prussian tradition of governmental responsibility for the citizenry's health, a fairly comprehensive plan for which can be dated to 1766 when J.P. Frank outlined a programme of individual and group health care services supported and administered by the state. Frank's proposals were embraced in 1848 by a group of politically active clinicians, including Rudolf Virchow, who called themselves the Medical Reform Movement. Although the revolution of 1848 failed (and with it the idea of a state-run health care establishment), the period between 1848 and 1883 included several important pieces of health-related legislation on sanitation, the responsibility of employers for their

workers' care (notably miners and domestics), and the firm establishment of worker mutual aid funds as a means to administer existing health insurance programmes.

The speed of German industrialization, the social problems and unrest it and the demographic shift wrought, a political value system which embraced the notion of a strong state and "provider state", and the historical governmental support for social medicine only partly explains why Germany enacted a national sickness insurance programme in 1883. All of these facts are necessary preconditions. The catalyst, however, was the unification of the German States in 1871.

The ten year period following unification was one of consolidation. While many laws were adopted from long-standing traditions, policy needed to be codified. The Sickness Insurance Act was the first of three major pieces of social welfare policy to be enacted during the 1880's. Together, the three laws for health, accident, and old age insurance formed the backbone for domestic social policy in Germany today.

#### *The 1883 Act*

The chancellor's proposal for a nationally financed and state-administered programme was opposed both by employers, who wanted a more limited role for government, and by labour, which preferred a system of worker-administered funds not unlike the mutual aid or voluntary societies which had existed in Germany since the 1500's.

The 1883 legislation represented a compromise between the state welfare and mutual aid approach. Bismarck succeeded in his goal of creating a national insurance programme, yet failed in his aim to have it state-run. Instead, the programme was administered by employer-worker managed sickness funds. This alliance between the worker and employer also meant that "social protection" would not be the sole domain of labour. This was no less important to Bismarck.

The 1883 act, which was implemented on December 1, 1884, linked eligibility for coverage to employment. Insurance coverage was mandated for employed workers and factory foremen earning up to 2,000 M per year. Including dependents, some 4.6 million Germans were now insured. Insurance

was provided through sickness funds typically organized by industry. Enrolment of the employee in a sickness fund was automatic. Coverage of dependants was optional. Those earning more than the minimum required for compulsory enrolment could enrol voluntarily. Payment for the insurance coverage was shared between the employee and employer. Typically, the employee paid two-thirds of the cost, while the employer paid one third. The state stipulated a minimum benefit level which included two distinct benefit types: cash payments or sick pay and medical services, including care by a doctor in and out of the hospital, hospitalization, and pharmaceuticals and some medical appliances.

The 1883 enabling legislation only established guidelines for eligibility and benefits. The specific definition of benefits, methods for contracting with and paying providers, as well as systems for assuring quality and monitoring costs were all left to the discretion of the individual sickness funds. Contracting and reimbursement arrangements varied widely. Some funds contracted with a small number of doctors to provide services on a full-time basis to fund members (selective contracting). Typically, these providers were salaried. Other funds permitted all local providers to serve members (open contracting). Doctors were reimbursed on a capitation or fee-for-service (FFS) basis. A hybrid method, which was to become the most popular reimbursement method, also existed: pooled capitation payments distributed on a FFS basis to doctors by doctors' associations according to the services provided by the individual doctors. Hospitals were paid a negotiated per diem rate to cover the cost of room and board and care by in-hospital doctors. Pharmacists, the most highly organized segment of medical professionals at the time, were paid for formulary drugs on a negotiated discount basis from an established fee schedule. Dispensing charges were additional and were unregulated.

The sickness funds were managed by a combination of employer and employee representatives according to the proportion of revenues the two parties contributed--again typically two thirds by the employee and one third by the employer.

Thus, the German Sickness Insurance Programme evolved on a regional basis. Consumers, employers and providers, through the insurance funds, defined the system. The federal government and employers largely were not responsible for initiating substantive changes in the programme.

Instead, the state, through new legislation, acted to (1) expand the guidelines for coverage and benefits it set down in 1883, or (2) reacted to marked shifts in the balance of power among the parties.

*Amendments to the 1883 Act: The Shifting Balance of Power*

There were no amendments to the 1883 laws until April, 1892. Still, a great deal transpired in the first ten years which would shape the programme. By 1888, approximately 11% of the population was enrolled in a sickness fund. By 1886, enrolment in mutual aid funds, which were strongly supported by the Social Democrats, had reached 731,943--an increase of over 1200% since 1880. Of the benefits provided, 52.7% were cash, while 47.3% were for medical care. In 1883, there were 15,100 licensed doctors (3,047:1), and an unknown number who practiced (legally) without formal training or license. There were 2,024 hospitals and a bed to population ratio of 1:545. There were 4,483 licensed pharmacies, or one pharmacy for every 10,264 citizens.

With the exception of pharmacists, the provider community in 1884 was not organized. Hospitals were predominantly state<sup>357</sup> or church owned and operated. Although formed in 1873, the Aertzevereinbund, the only formally organized professional organization for doctors, was small, and as a professional "union" played virtually no role in the debate culminating in the 1883 Act. Doctors however did play a role in advocating universal access to health services for workers. They did so as politicians, not as medical providers.

Because of their lack of organization, and because individual doctors had voices which were heard in the debate, and lastly, because the programme promised the allocation of additional monies for their services, the providers, as an organized group, said little and had little input into the law; their interests were not acknowledged. There was no definition of what constituted appropriate medical care; no requirement for licensure, no provisions for methods of reimbursement or minimum income standards, no complaint or dispute resolution procedures, and no means for representation of provider interests in the management of sickness funds. The doctors who aligned themselves with the funds and the goals of the labour movement saw their practices and influence increase. The majority of freely practicing doctors did not share their enthusiasm. Their market share and the wealth, power,

and prestige which it promised did not increase. In one area, four fund doctors treated one quarter of the area's residents, while 45 others contended for the remaining three quarters. Moreover, the funds served as a basis for growth of the Social Democratic Party, which did not represent the doctors' interests. The doctors became not only alarmed, but interested in shaping the programme.

In 1892, the Sickness Insurance Amendment Act was passed. The law extended coverage to additional classes of workers, increased the duration of maternity benefits, and most importantly, gave the sickness funds the expressed right to contract selectively with any number and type of doctors which they, the funds, defined.

In 1893, in concert with the dominant role which the consumer-run funds had assumed and not outside the purview of their largely socialist providers, Dr. Friedrich Landmann, speaking at the Conference of the Central Organization for Sickness Funds, proposed a mechanism for cost-containment and quality assurance. He suggested that funds hire a doctor (preferably one with the proper ideology) to police the number and quality of services provided members. While intended to police doctors' practice patterns, the institution of "the confidential medical adviser" was the first legitimated management position established for doctors in the national insurance system. The first doctors were hired in 1894, and the system spread rapidly thereafter.

In 1898 in Barmen, Landmann again proposed to make the system more efficient by limiting the number of hospital admissions, specialist referrals, and prescriptions to norms calculated on the past three years' experience, dispensing drugs directly through funds, and organizing providers to ensure access to 24-hour, 7-day per week care. Those doctors who refused to support the plan were fired and replaced. For the first time, doctors went on strike. The Barmen strike lasted eight days, until the government stepped in and assisted in negotiating a contract more acceptable to the doctors. This governmental intervention represents the first acknowledgement by the state of the medical profession and its role in the health insurance system.

When introduced elsewhere, the plan met similar resistance. Late that year (1898), a national call was made for all doctors to terminate contracts with the sickness funds. Shortly thereafter (formally in 1900), an organization of doctors called the Leipziger Verband (LV) was formed. In 1903,

the LV merged with the Aerztevereinbund. Now known as the Hartmannbund, the group organized strike funds to provide their membership with support during the nearly 200 strikes they declared annually against sickness funds which they accused of unfair contracting practices. By 1904, when the next set of amendments to the 1883 Act were promulgated, over fifty percent of the approximately 30,000 doctors in Germany were members of the Hartmannbund.

The 1904 amendments, the last major changes before the 1911 Insurance Consolidation Act, extended the duration of benefits from thirteen to twenty-six weeks. A formal grievance and complaint resolution system was instituted which provided for fair redress for both consumer and provider.

#### *The 1911 Insurance Consolidation Act*

Debate on the 1911 Insurance Consolidation Act, which solidified the social partnership of consumer, employer, state, and provider for health, accident, and old-age insurance, began several years before the legislation was passed. The debaters this time included an additional participant--the provider. The 1911 law did expand coverage so that nearly twenty-five per cent of the population was insured. This figure included dependents who remained voluntarily covered. The majority of other stipulations however served to check consumer power and legitimate the medical profession. Selective contracting was prohibited, voluntary enrolment in funds by persons whose income exceeded the levels for compulsory enrolment was limited, unlicensed providers were prohibited from reimbursement by funds, doctors assumed responsibility for utilization review and quality assurance through what was now known as the confidential medical committees, doctors were given the responsibility and right to direct patient care (the fund management was forbidden to do so), and finally, the necessity for hospital contracts was eliminated--any and all hospitals could provide services to fund members.

#### *Health Policy Changes Between 1912 and 1990*

Even prior to the implementation of the Insurance Consolidation Act of 1911, another precedent setting piece of legislation was enacted which further consolidated the control of doctors over the sickness insurance programme. Called the Berlin Agreement, it recognized the Hartmannbund,

the predominant German medical association, as the contractual partner of the sickness funds. This law established a committee of doctors and representatives of the sickness funds to be in charge of admitting new doctors to fund practice, instituted ratios for the number of doctors and members of each fund (to be not less than 1:1,350) and stopped funds from directly providing ambulatory care services. In part because of the success of the Hartmannbund's lobbying efforts which resulted in the Berlin Agreement, membership in the doctor's association increased to 90% of all practicing doctors by 1919.

The period from 1914 through the early years of the Weimar Republic, saw labour and the sickness funds regain some influence over the sickness insurance programme in specific, and social welfare legislation, in general. In part, these gains were a product of changed domestic circumstances including World War I (where labour support was crucial to the national effort) and deepening economic problems.

In 1914, 1915 and 1919, a series of laws extended maternity benefits first to the wives of insured servicemen, then to the wives of all servicemen and finally to all insured women.

In 1923, the Insurance Consolidation Act was amended to formally incorporate the provisions of the Berlin Agreement. While seemingly a move which favoured the medical profession, the doctors struck later that year in opposition to the law because it did not address their request to codify minimum remuneration levels. Also in 1923 the Miner's Fund Law (Reichsknappschaftsgesetz) was passed. This law created a national association of the 110 separate miners' funds formerly governed by state, not federal law.

Continued deterioration in the economy, increased labour influence and the continued needs of a society transitioning from an agricultural to industrial base, prompted two very important pieces of domestic legislation. In 1924, a national social assistance programme was legislated to consolidate the existing system of poor relief. In 1927, a national unemployment programme was instituted to help cope with a rapidly rising percentage of unemployed workers.

By the early 1930's the unemployment rate was as high as 33%. Consequently, fund revenues dropped. The government legislated that funds adhere to federally established minimum benefit levels, institute copayments and fees for services and stipulate that sick pay be paid only from the fourth day of an illness. For the first time since 1883, real expenditures decreased as did the number of sickness funds. Expenditures dropped 25% between 1930 and 1932 to 3,300 million RM from 4,400 million RM. Sixty two percent of the insureds now belonged to Local Funds. In 1930, funds were once again allowed to use a utilization control panel although this time, it was primarily for second opinions and to put a check on the volume of services provided.

Employers now wholeheartedly supported the sickness insurance programme because without it, they would face a greater financial commitment to keep their workforce productive. The doctors were increasingly agitated. To quell any unrest, the government permitted the doctor to patient ratios to drop from not less than 1:1,350 to not less than 1:1,000. In 1931, at a medical congress, the doctors again pressed for assurance of minimum income levels regardless of the financial status of the sickness funds.

In 1932, a series of reforms clearly acknowledged their influence by 1) again reducing the ratio of doctors to insureds to not less than 1:600, 2) permitting regional medical associations to conclude contracts with sickness funds, 3) forcing the sickness funds to guarantee capitation payments (but not a minimum income level) and 4) requiring certification of a board of representatives of the doctors and funds, to practice for a sickness fund. These changes marked a period to last for nearly four decades, during which providers (primarily doctors) would have greater influence on health policy than the consumers or sickness funds.

The Nazi period which lasted from 1933 until the end of World War II in 1945, was marked by several notable changes in the sickness insurance programme. Only one change would prove to last beyond the end of World War II.

The doctors had a great deal of influence during the Nazi period. Proportionately more doctors joined the NSDAP than any other profession. The most significant and only lasting change to the sickness insurance programme was actually legislated in 1932 when the national medical association

became the doctors' bargaining unit. Because this provided the doctors with yet more control over the provision of authorized health care services, the sickness funds became, in essence, third party administrators, handling the collection of employer and employee contributions (premiums) and paying the medical association and other provider groups. In 1933, the Nazis prohibited communists, non-Aryans and socialists from practicing medicine and forced the closure of clinics owned and operated by the sickness funds. In a further blow to the sickness funds, the Reconstruction Act of 1934 replaced independently appointed administrators with loyal NSDAP members. Finally in 1942, benefit periods became unlimited and maternity benefits were extended to six weeks pre- and post-delivery. These additional maternity benefits were funded by the federal government, not by employer and employee contributions. The 1942 law also provided that the sickness funds collect contributions for pensions and unemployment insurance as well as for sickness insurance. The administrative consolidation which occurred during the Nazi period ended after the war however, the consolidation of professional control (that is, the unification of the medical association as a bargaining unit) lasted.

East and West Germany were created in autumn 1949. In June 1949 however, the Social Insurance Adjustment Law was passed which 1) restored benefits lost prior to or during the war and 2) established that employers and employees would now contribute equally to the sickness insurance programme. The 50:50 contributory scheme is still used today.

East Germany did not preserve the sickness insurance programme. Instead, a national health care programme evolved looking strikingly similar to the one Rudolf Virchow envisioned. The East German programme was characterized by central administration, prevention and health promotion, public health clinics and the elimination of the separation between ambulatory clinics and hospitals. Moreover, eligibility was not employment-linked; health care was a right for all East Germans. Early on, the doctors' association was dissolved. Many doctors emigrated and the East German programme whether by default or intention came to rely on paraprofessionals and general practitioners, rather than specialists, to provide the majority of care. Notably, infant mortality in East Germany was reduced from 72.2 per 1,000 live births in 1950 to 12.1 per 1,000 live births in 1980. This was lower than

the infant mortality rate in West Germany. Furthermore, the East Germans provided care at roughly half the cost of the West German programme.

In West Germany, in the early 1950's a series of laws known as the Establishment Laws were enacted. In short, these laws further strengthened the medical profession by stipulating that 1) funds not deliver services directly or operate clinics without approval of the medical association, 2) occupational and public health medicine be limited to the provision of emergency or first aid services and 3) that no group practices be formed without permission of the medical association.

The most significant of the Establishment Laws was the Insurance Doctors Act of 1955. This law stipulated that the state doctors' associations incorporate. They were to be legally responsible for the provision of all medical services to insureds and their dependents in exchange for all payments by sickness funds to the doctors' associations. Further, all doctors were to be members of the association whether they had a sickness fund practice or not. Criteria for admission of a doctor to fund practice were established and all patient complaints were to bypass the funds and go directly to the doctors' associations. The sickness funds were still allowed to negotiate with the strengthened provider organizations in an effort to budget costs.

The only other law pertaining to the sickness insurance programme to pass in the 1950's, again provided for the doctors. In 1957, the official fee schedule was increased thirty three and one third percent. While a seeming victory for the doctors, it was the first adjustment in the fee schedule since 1896.

While no new laws affecting the sickness insurance programme were enacted until 1969 when the Wage Payment Continuation Law (Lohnfortzahlungsgesetz) was passed, the period was marked by a number of proposals designed to dramatically increase the power of the doctors. In 1960 and 1962, laws were proposed to shift more of the health care costs to the consumer, eliminate restrictions on the number of doctors practicing for sickness funds and pay doctors directly on a fee-for-service basis. While these government proposals show the strong power of the newly centralized medical associations,

neither the doctors, labour or the consumers supported them. The proposals were withdrawn and a commission formed to study the sickness insurance programme.

Laws passed in 1970, 1972, 1973 and 1975 generally extended eligibility (access) and benefits. The 1970 Further Development Law permitted voluntary enrolment by all employees regardless of income level and permitted reimbursement for physical exams. In 1972, coverage was extended to farmers, the self-employed and their dependents and persons receiving old age assistance. In 1973, the Law on Improved Benefits allowed for payments for home help during hospitalization, sick pay for people caring for a sick child and abolished time limits on payment for hospitalization. In 1975, two laws were passed to extend coverage to students and provide family planning services including contraception, abortion and sterilization.

While benefits and eligibility were extended, costs were exploding. In 1971, the average employee contribution rate was 8.2%. By 1976, it had reached 11.3%. A series of crucial laws were passed between 1977 and 1990 designed to control costs. These laws are significant because they used price and later budget controls rather than provider-based utilization review and control to slow the growth in expenditures. Also new was the role the government played in the programme.

The Cost Containment Act of 1977's (Kostansteigerungsgesetz) most important feature was the establishment of the Concerted Action. The Concerted Action was to provide annual health policy recommendations and to establish guidelines for cost ceilings. The Concerted Action formally recognized the relation between providers, the cost of care and governmental action in cost control. Interestingly, the doctors struck following the enactment of this law, but for the first time since the turn of the century, there was no public support for them.

1982 and 1983 amendments to the Cost Containment Act increased copayments for hospitalization and drugs. As such, these measures were designed to contain costs by discouraging consumer overutilization of services.

Important hospital reforms were enacted in 1982, 1984 and 1985 to contain hospital costs which, still distinct from the provision of ambulatory services, had been rising quickly. The Hospital Cost Containment Act of 1982 allowed hospitals to negotiate per diems with sickness funds and called for the development of state hospital plans prepared by state associations of sickness funds and hospitals. The 1984 Act, implemented in 1986, allowed hospitals to establish flexible budgets. Importantly, sickness funds with more than five percent of patient days were permitted to participate in the budget process. The budgets were to be based on historical and projected expenses as well as costs of geographically comparable facilities. This was a very important first step towards the establishment of price and volume controls. The 1985 Hospital Financing Act limited federal funds for capital investment in hospitals and for the first time since 1911, permitted sickness funds to selectively contract with hospitals.

The Health Care Reform Act of 1989 is considered to be the most sweeping legislation since the Insurance Consolidation Act of 1911. In addition to recognizing the importance of preventive care, this law further controlled costs by addressing those parts of the sickness insurance programme where costs had largely been unchecked. Drug copayments were increased and a series of incentives for use of the least costly drugs were implemented. In addition, the sickness funds were once again allowed some utilization review privileges in an attempt to foster better quality control.

In summary, the period between 1912 and 1990 was largely one during which the doctors gained many important concessions. However, as costs dramatically escalated, government stepped in to check the system albeit this time, with price and budget controls which, in contrast to the utilization review and control programmes employed by the sickness funds in the 1890's, created a new role for government and did not directly place the onus for cost containment, solely on the doctors.

#### **Accomplishments of the German Sickness Insurance Programme**

Today, more than one hundred years after the implementation of the German National Sickness Insurance Programme, over 90% of the (West) German population is covered by comprehensive sickness insurance<sup>358</sup> at a cost of approximately 8.2% of the GNP.<sup>359</sup> With the

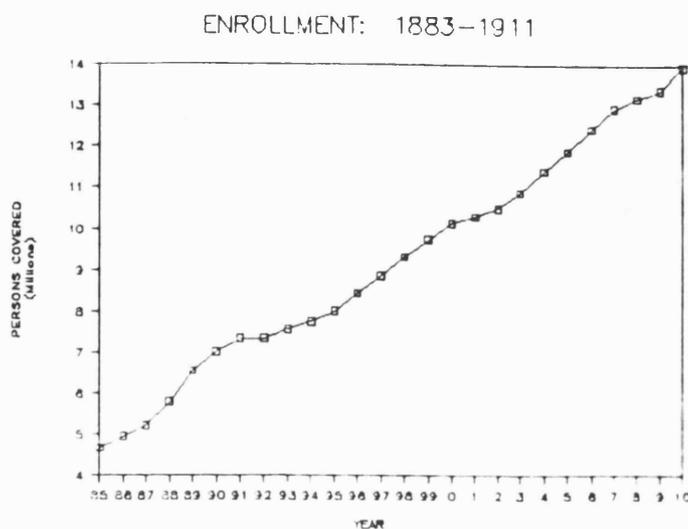
exception of the Nazi period, the delivery and financing mechanisms which were codified in 1883 and revised in 1911 have been in constant service,<sup>360</sup> and still form the foundation of the programme.<sup>361</sup>

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Why has the system been so tenacious? One principal reason stands out: the model evolved slowly over a period of more than 300 years; the financing, delivery, and administrative systems are the product of a dynamic process designed by the people to respond to their own needs in a changing technological and social environment. Seen in this context, it is easier to understand why the German Sickness Insurance Programme represents a social programme which is an outstanding model for health care delivery and financing programmes in other countries.

#### Access

In 1880, only five percent of the German population was enrolled in a sickness fund. The 1883 Act dramatically expanded access to insurance for the general population. In 1885, shortly after the implementation of the national programme, 4,670,959 Germans - ten percent of the population - were members of a sickness insurance fund. In 1910, before the Insurance Consolidation Act extended coverage to domestics, actors, teachers, etc., the number of persons enrolled in the programme equalled approximately 21.5 percent of the population. In 1913, after the 1911 amendments were implemented, a quarter of the German population had guaranteed access to comprehensive health care services.<sup>363 364</sup>



The 1883 and 1911 laws established two very important policies regarding access to health care services. First, they assured entitlement of the majority of working people <sup>365</sup> to insurance that both covered the costs associated with the treatment of an illness and protected them from loss of income due to that illness. Second, and perhaps more notable, the laws defined the government's responsibility for the medically indigent, those who are retired or unemployed and who do not have the resources to purchase insurance or health care services.

As a result of these important precedents, less than one percent of all German citizens directly pay for health care services today. Forty-two percent of the population are either compulsory or voluntary subscribers to a sickness fund (31% are compulsory, 11% are voluntary). Forty percent are insured as dependents. Another fifteen percent are enrolled as retirees or unemployed workers or their dependents. <sup>366</sup> Only three percent of the population purchase private insurance. <sup>367</sup>

#### *Cost Containment*

Perhaps one of the most important findings of this research is the direct correlation between increased costs and increased enrolment. While medical technology did change and doctors developed professional organizations which sought higher pay for their members, these factors did not have a significant impact on total programme expenditures between 1883 and 1911. Cost increases were largely the result of increased enrollment. The funds, which organized the delivery of services were able to contain the cost of services adequately. There are two reasons for this: 1) during the early years of the programme stringent utilization review and control mechanisms were implemented and 2) the medical profession was not organized and until the first decade of the twentieth century, had little power to override the utilization controls many of which restricted their practice patterns and hence, income.

The sickness funds began exploring a variety of cost containment measures as early as 1887. Interestingly, and in contrast to options currently being considered by American policy makers, benefit cutbacks and changes in eligibility criteria that would have curtailed access were not seen as preferred solutions to the perceived problem. Instead, a programme of utilization review and control was

implemented by the Germans. This type of cost containment programme is receiving a great deal of attention in the United States today. In spite of the fact that all evidence suggests that utilization review and control did contain the growth of health care costs in Germany in the late nineteenth century, similar programmes are only now being adopted widely in American HMOs and in some innovative indemnity insurance plans. The new growth in the popularity of this cost containment technique may be attributed in part to computers that make managing data easier.

Utilization review and control are intelligent and effective cost containment measures. They place the onus of cost containment on the primary care doctor, the person who controls the use of the majority of health care services. In the German system, the primary care doctor is the gatekeeper of the medical system.<sup>368</sup> He controls access to hospitals. The sickness fund administrators who sought the cost containment measures recognized this and decided that because the sickness fund controlled the purse strings for at least a good portion of the doctors practice, the sickness fund could effect some control over expenditures without restricting eligibility or cutting back benefits.

The notion of risk assumption is not widely discussed in the German literature. As noted earlier, the assumption of financial risk by a doctor serves as an incentive to control utilization and contain costs. Under fee-for-service payment, doctors are paid for all services provided and therefore have no incentive to limit utilization. Utilization review of fee-for-service practitioners can be effective. However, this method is less agreeable to doctors. The control comes from an external authority. Where an economic incentive exists for a doctor to control utilization, as in capitation payment, the doctor controls his own utilization practices for his own benefit. Capitation payments to a pool from which funds are disbursed on a fee-for-service basis may involve various levels of risk assumption by doctors. If the capitation payments into the pool are fixed, (that is, the payment is flat and no other monies are forthcoming from the fund), doctors will be paid on a fee-for-service basis only up to the financial limits of the pool. However, if the fund pays capitation payments into the pool to minimize administrative costs and allows doctors to be paid for all services rendered without regard to the pool resources, the doctors are assuming no risk. If pool resources should be depleted in these cases, the

fund would be responsible for either adding funds to the pool or paying doctors directly on a fee-for-service basis.

While utilization review in America is considered most important in controlling the utilization of hospital inpatient services (the most costly component of health care expenditures), the technique of monitoring doctor practice patterns in Germany between 1883 and 1911 was most often used to control pharmaceutical prescriptions and cash allowances.

Perhaps one reason why the validated German utilization review and control mechanism has not received sufficient attention from contemporary policy makers is because it does not control hospital utilization in Germany. In Germany, primary care and hospital care are separate. There is essentially no link between the two save the fact that they are both a type of medical care. Most German hospital doctors are staff doctors. Except in rare cases, they do not have a private practice.<sup>369</sup> Correspondingly, primary doctors may not attend their patients in the hospital. Consequently, the system only has leverage over hospital admissions. There is no control over length of stay or the intensity of services provided.

This lack of financial, clinical and administrative coordination between primary care and hospital services has dramatically increased costly hospital utilization. In fact, the ratio of inpatient care to ambulatory care exceeds that of the American fee-for-service model, which is often thought to be the highest in the world.<sup>370</sup> In contrast, the American HMOs have strong links between primary and inpatient care. The HMO managers are responsible for expenditures in both settings. Where possible HMOs set up incentives for providers to practice cost efficiently, emphasizing preventive care and early treatment of potentially acute problems. While some critics argue that these techniques may lead to a lower quality of care, studies to date do not support this hypothesis.<sup>371</sup>

In recognition of 1) increased costs, 2) the difficulty of reinstating rigorous utilization review and controls on doctors and 3) the dissociation between primary and hospital care, German policy makers have recently resorted to budget controls. The budget controls implemented in the last several years first set limits for hospital spending and now have been extended to ambulatory (doctors') care. While the German programme has, in effect, long worked with modified price controls (which have

taken the form of negotiated rate between the doctors' associations and the associations of sickness funds) budget controls set limits on both price and volume (utilization). The budget controls in place for all hospital and doctors services authorized by the German sickness insurance programme have proven effective in slowing the growth in health care spending. However, because the budget controls do not apply to all authorized services (for example, prescription drugs), cannot address the introduction of new and costly treatment modalities or address the increased need for care by an aging population or the AIDs epidemic, all pressure for increased spending has not been relieved. And, in contrast to utilization review and control, budget controls do not monitor the appropriateness of services (quality or efficiency). New price controls on and incentives for proper utilization of drugs were encapsulated as part of the Health Care Reform Act of 1989. This law also provided sickness funds with the latitude to once again oversee practice patterns in an effort to monitor quality.

In America, policy makers have recently introduced a fee schedule for paying doctors who provide covered services to Medicare beneficiaries. This is a major shift from a strictly market-based system. However, because the programme, known as the Resource Based Relative Value Scale (RBRVS) only applies to a part of the population, it is possible that doctors will shift the costs of care from one payer to another, in this case, the more generous one. If payments for all services and for all payers are standardized, price controls will function more effectively. Once again however, they do not control utilization and therefore are suspect if systemwide cost containment is the objective. Price controls also do not monitor quality.

### *Health Status*

The health status of the German population improved dramatically between 1870 and 1911. Life expectancy increased from 35.58 years in 1871 to 55.97 years in 1910. During the same period, infant mortality dropped 32.5%. In 1870 the infant mortality rate was 252.7 per 1,000 live births. In 1901, the rate was 202.3 and in 1910, 170.5. <sup>372</sup>

There are several possible reasons for these positive changes. During this twenty five year period, there was extensive economic growth which reduced poverty and bettered living conditions.

Improved sanitation and access to uncontaminated water curbed the spread of some infectious diseases. Many important advances were made in clinical medicine. An understanding of disease pathology evolved quickly and new surgical procedures were developed. Important to this discussion, comprehensive health insurance made these advances and general health care services available to the average citizen.

A 1936 study indicated that there was a positive correlation between access to comprehensive health care and health and fitness of the general population. The report prepared by Dr. Reichert of the Berlin based Reichsaerztekammer, compared the military fitness of men in different areas of the country where the extent of coverage varied. "Coverage" variables included both the number of persons insured and the extent of benefits. <sup>373 374 375</sup>

A stronger argument for the programme's positive and direct impact on health status can be made if one compares the change in infant mortality statistics in Germany and Britain between 1883 and 1910. British exposure to advances in clinical and preventive medicine was not identical but certainly similar to Germany's. But in 1910, Britain was only on the verge of implementing a national health insurance programme.

While Britain's infant mortality rate in 1883 and 1910 was lower than Germany's, Germany's infant mortality rate declined more significantly. In 1883, the rate of infant mortality in England and Wales was 137 infant deaths under one year old per 1,000 live births. In Scotland the rate was 119 per 1,000 live births. This compares with the German rate of 232 per 1,000 live births in 1883. In 1910, Germany's rate was 162 compared to 105 in England and Wales and 108 in Scotland. This means that Germany's rate declined more than 30% compared to decreases of 23% in England and Wales and only 9% in Scotland. While no conclusive evidence exists, the national health care programme may have contributed to this exemplary improvement. <sup>376</sup>

The German achievement is important. First, the programme achieved one of its primary objectives: it improved the quality of life for the average citizen by providing them with health, and thereby income, security. Perhaps more important is the implication for this finding for health policy development in both western and developing countries debating national programmes today. The

finding suggests that countries that implement a national programme that guarantees access to comprehensive health coverage have the potential to improve the health status of the population.

### **Peculiarities of the German Model**

There are several aspects of the German model which set it apart from programmes adopted by other European countries. Perhaps most important, the German Sickness Insurance Programme reserved only a very small role for government. The impact of this limited state intervention on programme costs has significance for policy analysts.

The institution of a sickness insurance programme in Germany with limited state intervention is easy to understand. Precedents for the programme were set hundreds of years before implementation of the Sickness Insurance Act of 1883. The earliest sickness funds were established by workers for workers in the 1500's. Germany was feudal at that time. Remember also that Germany was not a united nation until 1871, only twelve years before enactment of the legislation which created the programme. Accordingly, there was no federal government to intervene until that time. The state governments which preceded the founding of the nation did not play a major role in operating comprehensive social welfare programme's before 1871.

While Bismarck sought to use the sickness insurance programme as a means of social control, he did not advocate government financing or administration of the programme. While the workers represented by the social democrats would have favoured federal programme financing, they advocated strongly to maintain the established decentralized administrative model. Given this, it was unlikely that a German programme established in 1883 could have given government administrative control.

Unlike Britain, where residency establishes entitlement to health benefits, eligibility for the German programme is employment-linked. Moreover, eligibility as well as contributions are income-related. Like the limited role established for government, these aspects of the programme evolved naturally from the insurance programme organized through sickness funds which predated the 1883 Act.

Employment-linked eligibility is important because it is a barrier to access. While the Germans do make provisions for covering the unemployed, the young and the old, their "safety net" does not guarantee universal coverage in the same way that eligibility determined by residency does.

Also peculiar to the German system of determining eligibility is a maximum income criterion. This criterion effectively excludes higher income workers from compulsory participation in the programme. This feature of the programme also predates 1883. It was maintained not because of labour advocacy but because doctors wished to protect a segment of their market which provided them a way to increase their income. Today, because over 90% of the German population is insured, it has little effect on either access to services or doctor's income. While this eligibility criterion could be seen as an additional barrier to access, until the cost of purchasing health services dramatically escalated in the period after 1911, most of the people excluded under this provision could pay for services on an out-of-pocket basis.

Income-related contributions are not unique to the German model. While contributions are not collected by the government as in a tax financed system, taxes, like the German premiums are assessed as a percentage of income. As in the German system, dedicated or undedicated taxes are often capped.

Income-related contributions are significant because they serve as a means of distributing income and risk. The cost of health insurance is borne more heavily by those with greater means. By pooling these contributions, the risk of providing health services as well as paying for them is spread over a broader cross section of the population. Of course, health service models which provide universal coverage and are centrally administered do a better job at spreading these risks.

The employment and income-related features of the German model are important to policy makers who seek to develop systems based on the premise that health care is a right. Unemployment and income-related eligibility criteria may create barriers to access or continuous coverage. These gaps may be bridged by some form of social assistance programme which pays the premium. In Germany, premiums are paid by government unemployment or pension programmes for the unemployed and for aged retirees respectively.

The German model can also be differentiated from other European programmes by the participation of employers in programme administration. Before 1883, depending on the industry and therefore the fund, employers often played a part in both programme financing and administration. Consistently, when they financed a portion of the programme, they also were involved in administration. The 1883 law stipulated that for all but the voluntary Mutual Aid Funds, employers pay one third of the total premiums due for their employees and by virtue of this contribution, had one third of the total votes in determining fund management practices. The Insurance Consolidation Act of 1911 extended their management role.

Why is this important? It is significant politically. It means that a party which controls the purse strings but by and large was not directly impacted by the programme (in terms of the health care services they received) had a large say in making decisions which impacted workers and providers. It is particularly meaningful because the Sickness Insurance Act of 1883 left the detailed definition of benefits to the sickness funds. Given the broad authority of the employers especially after the implementation of the 1911 Law, this could adversely affect access to needed health care services.

#### **Similarities Between the German Programme 1883-1911 and the Evolving American System**

The German Sickness Insurance Programme is a national sickness insurance programme for the employed and unemployed and the old and young.<sup>377</sup> It is a contributory social insurance programme. America, unlike most other western European nations, has no counterpart.

Medicare, the federal health insurance programme for the elderly and the disabled is the most similar to the German Sickness Insurance programme. While the federal government does contract out claims processing and quality assurance functions, the government underwrites the programme. Neither the providers or the intermediaries accept any financial risk associated with the provision of medical benefits to eligible beneficiaries. Doctors and until recently, hospitals, are reimbursed on a fee-for-service basis. Medicaid, which is jointly funded by the federal and state governments and administered by the states, is a public health assistance programme for the poor. Like the Medicare

programme, the Medicaid programme generally has been a cost reimbursement programme where the government retains the financial risk for the provision of services.

In the last ten years American legislators, policy analysts and tax payers have searched frantically for solutions to alarming increases in health care expenditures. Federal legislation to regulate provider reimbursement to contain costs has been unsuccessful.<sup>378</sup> In the wake of the failure of the regulatory programmes, federal and state governments have resorted to eligibility restrictions and benefit reductions. This has contained the growth of government expenditures but has increased the amount of unreimbursed care which is cost shifted to the paying patients. Total nationwide expenditures, that is, costs to the private sector as well as government have soared. Because employers are the largest private payer for health care services, they too have become an active and outspoken party in the battle to contain health care costs while assuring access to health care services.

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It does not appear that America is ready to implement a national health insurance programme or form a national health service at this time. American policy makers continue to favour a decentralized insurance system where eligibility is linked to employment. However, given the current political environment in America, it is likely that the Medicare and Medicaid programmes will continue and that the government will play a major role in shaping health politics.

At the moment, a great deal of attention is being given to Health Maintenance Organizations (HMO) and their potential to contain costs. Like the German sickness funds, the HMOs arrange for the direct provision of health care services and accept the associated financial risk. The HMOs bear similarity to the sickness funds during the 1883-1911 period in their provider contracting and reimbursement arrangements, and their quality assurance and utilization review programmes. The most important similarity however, is that the HMOs provide financial incentives for providers to practice cost efficiency.

HMOs will contain costs only if 1) consumers have free choice of insurer, 2) the HMO can selectively contract with providers and dismiss them if they do not practice in a cost efficient manner and 3) if financial incentives for reducing utilization can be instituted.<sup>380</sup> It is important to note that the

German programme has changed markedly since its inception in regard to selective contracting and utilization controls. The Insurance Consolidation Act of 1911 severely curtailed the funds' ability to selectively contract with providers. Since 1932, doctors have had the absolute right to practice for any fund; the fund contracts do not prohibit the doctor from providing services to members of other funds. And, while originally consumers could chose to enroll voluntarily in a Mutual Aid Fund or employer-related fund (remember that there was no choice between funds for employees of a firm; each employer or occupation group sponsored a fund), de facto this choice was difficult because of the higher contribution required from the enrolee. Therefore, competition between funds which would serve to reduce premium levels was really non-existent. Finally, and most important, the German system is not structured so that incentives to control utilization of the most costly services, that is, hospital and specialty care, can work; there is no integration between providers of these services and primary care providers.

This is not true of American HMOs today. The HMOs provide strong financial incentives to primary care doctors who direct all the care for patients, to control hospital and specialist utilization. This has been effective not only in controlling costs but in insuring that care is coordinated and some continuity among providers is achieved.<sup>381</sup> While it is argued that these incentives on utilization adversely affect quality of care because doctors are skimping, there is little research to date which supports this notion.<sup>382</sup>

Selective contracting has been used by commercial insurers in their indemnity insurance products, by government for public entitlement programmes and by HMOs. This practice has also been extremely effective in controlling costs. Lastly, while consumers do not have a free choice to enrol in any health plan and have their employer pay all or some portion of the premium, they are free to enrol in any insurance programme provided they pay. Moreover, federal law states that all employers with 25 or more employees, must offer an HMO if that HMO has met federal qualifying criteria and requests the employer to offer the HMO plan to employees. Where a significant number of HMOs and traditional indemnity insurance plans are offered, significant competition largely based on pricing exists.<sup>383</sup>

Provider resistance to HMOs exists and is growing as HMO enrolment increases and the HMO concept proves its ability to contain the growth of costs while maintaining benefit levels.<sup>384</sup> Approximately 14% of the American public is currently enrolled in an HMO.<sup>385</sup> The remainder of the population has indemnity insurance coverage through an employer, pays privately for indemnity coverage, has Medicare or Medicaid or is uninsured. The ability of HMOs to maintain these seemingly effective cost controls will be tested in over the next decade. Here too, American policy makers can learn from the German experience. The next several paragraphs highlight the structural similarities between the German sickness funds and the HMOs.

#### *Open or Selective Contracting*

The German system permits both open and selective contracting. As noted in Chapter 7, Organization of the Delivery System, both the doctors and many enrollees favoured open contracting while sickness fund administrators favoured selective contracting largely because it enabled them monitor doctor practice patterns more easily. While computers make it easier to monitor the practice patterns of a large number of doctors, the issue of open or selective contracting is hotly debated in America. This is so because the provider contracting practices determine the enrollees' choice of provider.

In the past, HMOs have required a member to choose a doctor who contracts with the plan once annually or semi-annually. Members who voluntarily agreed to be part of the HMO agreed to this practice. In contrast, the Medicaid programme which has only recently begun to enrol recipients in HMOs, has always stipulated that programme recipients be allowed free choice of doctors. HMOs cannot budget and assure their fiscal viability if a member can choose to disenrol at any time. Thus, the free choice or "lock-in" issue has become a stumbling block in the government's effort to use this cost containment programme. Currently, legislation is being considered which would permit the recipient to choose a doctor only once every six months. Demonstration programmes across the country are now testing the efficacy of this cost containment programme.

### *Provider Reimbursement*

Like the early sickness funds, the HMO's pay doctors and hospitals in a number of ways. Physicians can be salaried, paid a capitation fee or paid on a fee for service basis. Hospitals are paid per diem or fees for services provided. In contrast to the similarity the HMOs have to the early sickness funds, the American indemnity insurance carriers reimburse almost entirely on a fee-for-service basis.

### *Utilization Review and Control*

The German Confidential Committees are very similar to doctor review panels utilized by HMOs. While the Confidential Committees lacked the computer support of their modern counterparts, they defined and measured appropriate practice according to a set of prescribed utilization norms. Today, the review panels programme these norms into their computer system. When the utilization data is run, the computer triggers a check on any doctor who exceeds or falls under the norms. The latter check is to assure that enrollees get quality care and that the doctor does not underutilize services.

American doctors have resisted utilization review and control until recently. It is now recognized that American doctors control the utilization of approximately eighty percent of the health care dollar. These doctors are now being asked or told that their utilization practices will be monitored to control costs. Utilization review is an integral part of all HMOs and all doctors who contract with an HMO tacitly agree to its use.

While the German Confidential Committees usually excluded fund administrators, the American panels include insurance company managers or health plan administrators who often have financial management backgrounds.

### *Administration*

The insured German health care consumer, had few administrative responsibilities to fulfill in order to access services provided by the Sickness Insurance Programme. Premiums were deducted

directly from their paychecks by the employer. Perhaps more importantly, the consumer made no payments at the point-of-service and had no claims forms to fill out. Providers practicing on a fee-for-service basis were responsible for keeping track of the services they provided fund members and they (the doctors) dealt directly with the fund managers to receive payment for their services.

The majority of American HMOs, as a means to differentiate themselves from the indemnity insurers, do not require their members to use claims forms. In many markets, it has been a marketing advantage for the HMO as they compete with indemnity insurers for members. Like the German sickness funds, the enumeration of services provided to consumers by doctors and other health care professionals is the responsibility of the professional. The consumer is responsible only for showing their HMO identification and paying any copayments at the time they see the provider.

The claims forms systems used by the majority of commercial insurers with indemnity style programmes in the United States and by the Medicare programme have been troublesome for many consumers. Because of the long lead time necessary to secure reimbursement from the insurer, many providers have asked consumers to pay for services up front and work with the insurance company to reimburse for their outlay. In the worst instances, this has meant that some people have delayed needed care. This particularly applies to the elderly who largely live on fixed incomes. At best, it has placed a substantial and time consuming burden on consumers.

### **Implications for the American Health Care System**

Clearly, the German Sickness Insurance Program between 1883 and 1911 encapsulated solutions to the twin problems of access and cost containment. And, it appears that the American HMO which bears a close resemblance to the German sickness fund, addresses these same issues - albeit at a different time and in different economic and social conditions - in a similarly successful manner.

In the period following 1911 and to the present, costs of the German system have skyrocketed. Why? The marked increase in per capita costs after the turn of the century (in contrast to the largely stable per capita costs prior to that time) may be attributed, at least in part, to the increased pressure

from doctors to restrict the use of stringent utilization control practices and increase payments for services. <sup>386</sup> And, because the strikes during that period threatened the "life" of the programme, the government's intervention effectively legitimated the doctor's demands. The parties influencing the organization of medical care, and hence the long-term cost of the programme, changed significantly. The period between 1883 and 1911 illustrates the complex interaction of political values and action between the state, the consumer, and the providers. By 1911, with the enactment of the Insurance Consolidation Act, the fundamental bases for cost containment-- selective contracting, free choice of insurer and financial incentives for risk assumption by providers (established best via capitation payment or salaried providers)-- were virtually eliminated.

What lessons can the American policy maker learn from the German experience?

Comprehensive universal health insurance can be an integral part of an income security system without incurring uncontrollable expenditures. It can be organized via third party entities like HMOs which organize and administer the delivery of services to consumers. Eligibility, enrolment and payment for the majority of the population can be employment-linked and government can maintain a relatively small role in both the finance and administration of the programme. However, the German experience also suggests that 1) utilization controls instituted and controlled by the fund are necessary to control costs and that 2) doctors in particular but other providers as well, will actively challenge these measures and seek to reform them in a manner which more readily conforms them to their objectives. The German doctors sought to provide the consumer with free choice of provider, not free choice of insurer. They largely rejected financial incentives which would have made it economically unappealing for them to provide consumers with any of the more complicated and costly new medical treatments available. In short, the doctors sought the latitude to define sickness and its treatment under the Programme. The German government gave them this right.

A unified and organized medical community with the desire to impact policy, and the balance of the conflicting interests between the consumer and provider determines whether the costs to a national sickness insurance programme are contained. Herein lies the lesson for U.S. policy makers. Providing broad or universal access to health insurance does not necessarily lead directly to skyrocketing costs. The mechanisms Landmann proposed in the 1890's did work.

To date, American HMOs have used utilization review and control mechanisms effectively to control costs. And while no national effort by consumers or legislators to promote a national insurance programme has had the political clout to produce viable legislation, the providers-- doctors, hospitals, pharmacies and others-- have shown that they are well organized and can sustain political pressure through their impressive and well financed lobbying efforts. On a host of health-related legislative measures they have defended their economic self-interest and professional autonomy.<sup>387</sup> Clearly, for the HMOs to maintain their cost effectiveness, consumers, insurers and the government alike must carefully monitor provider interests and concerns and shape compromises which prevent concerted work actions (strikes) on the one hand and maintain the fundamental integrity of utilization control mechanisms on the other. This is a difficult task.

Because of its 100 long years of experience it would seem both logical and appropriate for American policy makers to take a closer look at the German model for examples of general system design, practical operating mechanisms and the impact changing roles of the players--consumers, insurers, providers and government-- can have on the outcome.

Unfortunately, until recently most American analysts have overlooked this important resource. There is relatively little descriptive material written for the English reader on the period between 1883 and 1911, the period during which the fundamental basis for the programme was established. This study is intended to begin to fill this gap.

- <sup>1</sup> Other than the United States, this refers primarily to developing countries. Switzerland has comprehensive health insurance in many cantons, if not the nation as a whole.
- <sup>2</sup> This evidenced by the relatively few articles written on European models in English and published in American health policy periodicals.
- <sup>3</sup> Robert G. Evans, "The Spurious Dilemma: Reconciling Medical Progress and Cost Control", Health Matrix, Vol.IV, Spring 1986, No.1, p.26.
- <sup>4</sup> A. Przeworski and H. Teune, The Logic of Comparative Social Inquiry, John Wiley and Sons, New York, 1970; T. Marmor, Political Analysis and American Medical Care, Cambridge University Press, 1983, Ch. 9, pp.165-166; D. Light, "Values and Structure in the German Health Care Systems", Milbank Memorial Fund Quarterly, Vol. 63, No. 4, 1985, pp.615-616.
- <sup>5</sup> B. Abel-Smith, "Who is the Odd Man Out?: The Experience of Western Europe in Containing the Costs of Health Care", Milbank Memorial Fund Quarterly, Vol. 63, No.1, Winter 1985, pp.1-17.
- <sup>6</sup> K. Schwartz, The Urban Institute, quoted in the Wall Street Journal, June 3, 1986, p.62.
- <sup>7</sup> Health Care Spending Control: The Experience of France, Germany and Japan, GAO, November 1991, p.2.
- <sup>8</sup> Washington Post Health, January 14, 1992, p.5.
- <sup>9</sup> G. Willensky, "Viable Strategies for Dealing with the Uninsured", Health Affairs, Spring 1987, pp.33-46.
- <sup>10</sup> Census Bureau, Employee Benefit Research Institute, as reported in The New York Times, February 3, 1992, p.1 and p.8.
- <sup>11</sup> A 1984 article by J. Feder, J. Hadley and R. Mullner, "Falling Through the Cracks: Poverty, Insurance Coverage and Hospital Care for the Poor, 1980 and 1982", published in the Milbank Memorial Fund Quarterly (Vol.62 (4)), indicated that while the number of uninsured persons had increased, the amount of charity care provided was essentially unchanged. This is not surprising; many hospitals had fulfilled their Hill-Burton obligations and others (primarily after the 1983 implementation of the Prospective Payment System (PPS) lacked the resources to assist those requiring unreimbursed care.
- <sup>12</sup> K. Davis and D. Rowland, "Uninsured and Underserved: Inequities in Health Care in the United States", Milbank Memorial Fund Quarterly, Volume 61 (2), p.76.
- <sup>13</sup> P.J. Farley, "Who are the Underinsured?", Milbank Memorial Fund Quarterly, Volume 65 (1), p.28.
- <sup>14</sup> The New York Times, January 9, 1992, p.1 and p.10.
- <sup>15</sup> M.W. Schwartz, "Assessing the Investment Climate", July 5, 1991, p.1-2.
- <sup>16</sup> David McCullough, Truman, Simon and Schuster, New York, 1992, pp.473-474.
- <sup>17</sup> Private rates for skilled nursing care were higher only in the Northeast. Moreover, Medicare coinsurance rates exceeded private rates regardless of the ownership of the institution, be it proprietary, voluntary non-profit or government. National Center for Health Statistics, March 27, 1987.
- <sup>18</sup> All figures for Medicare payment rates are from The Medicare Handbook, U.S. Department of Health and Human Services, Health Care Financing Administration, 1992.
- <sup>19</sup> The New York Times, March 1, 1992, p.1. and p.22.
- <sup>20</sup> L.S. Katzmann, "Health Care and the Elderly: Issues and Alternatives", unpublished, 1983.
- <sup>21</sup> A public opinion survey of those over 65 years of age conducted by the American Association of Retired Persons revealed that prior to the law's implementation, 65% of those asked favoured the new programme's implementation.
- <sup>22</sup> Eligibility for Medicaid generally means that one must be blind, disabled, old (over age 65) or a member of a single parent family with children under 19 and that one must have an annual income below a state prescribed limit.
- <sup>23</sup> A state's latitude to set benefit levels must fall within an extensive list of sanctioned benefits which federal law permits states the option of providing the whole range or a portion thereof.
- <sup>24</sup> Restructuring Medicaid: An Agenda For Change, The National Study Group on State Medicaid Strategies, Washington, D.C., January 1983.
- <sup>25</sup> Restructuring Medicaid: An Agenda For Change, *ibid*.
- <sup>26</sup> See for example, K. Davis, "Inequality and Access to Health Care", The Milbank Memorial Fund Quarterly, Vol. 69 (2), 1991, pp.253-273.
- <sup>27</sup> Medicaid: Today and Tomorrow, Perspectives, Medicine and Health, McGraw Hill, March 14, 1988.

- <sup>28</sup> K. Wing, "American Health Policy", Case Western Reserve Law Review, Vol. 36, No.4, 1986, p.612.
- <sup>29</sup> The New York Times, 4/13/87, p.1.
- <sup>30</sup> Medical Benefits, The Medical Economics Digest, 3/15/85, p.1.
- <sup>31</sup> D. Rogers, R. Blendon, T. Moloney, "Who Needs Medicaid", New England Journal of Medicine, Vol.307, No.1, pp.13-18, 7/1/82.
- <sup>32</sup> L. Katzmann and B. O'Brien, "A Pro-Competitive Model for a Statewide Health Insurance Program: The Oregon Proposal", Conference on Alternative State and Local Policies, Washington, D.C., 1/83.
- <sup>33</sup> Steven H. Sheingold, "The First Three Years of PPS: Impact on Medicare Costs", Health Affairs, Vol. 8, No.3, Fall 1989.
- <sup>34</sup> Washington Report on Medicine and Health, McGraw Hill, 6/24/85, Vol.39, No.25, p.3.
- <sup>35</sup> New York Times, Tues. 7/9/85, p.D2; Forbes, 8/27/84, pp.138-148; "Enough is Enough", Forbes, 9/10/84, pp.109-112.
- <sup>36</sup> Health Maintenance Organizations, Bernstein Research, New York, 1/84 and Health Maintenance Organizations: Overview and Outlook, Dean Witter Reynolds, Inc., New York, #696, 4/22/85.
- <sup>37</sup> Group Health Association of America, "National Directory of HMOs 1989", Washington, D.C., 1989 as reported in Health Affairs Vol.8, No.4, Winter 1989, p.125.
- <sup>38</sup> US Department of Commerce, Prospective Payment Assessment Commission. A Health Affairs article by Marsha R. Gold (winter 1991, p.190) stated that HMO enrolment was 36.5 million at the end of 1990.
- <sup>39</sup> A. Enthoven, Consumer Choice Health Plan, Addison-Wesley Publishing Co., Massachusetts, 1980.
- <sup>40</sup> Robert J. Blendon and Humphrey Taylor, "Views on Health Care: Public Opinion in Three Nations", Health Affairs, Vol. 8, No. 1, Spring 1989.
- <sup>41</sup> Lawrence S. Goldberg, Washington Commentary: A Perspective on Health Care, Deloitte and Touche, Washington, D.C., November 27, 1991.
- <sup>42</sup> See discussion in J.P. Weiner, "Primary Care Delivery in the United States and Four Northwest European Countries: Comparing the "Corporatized" with the "Socialized", The Milbank Memorial Fund Quarterly, Vol.65, No. 3, 1987, p.427.
- <sup>43</sup> R. Blendon and H. Taylor, op cit., p.151.
- <sup>44</sup> R. Blendon and H. Taylor, *ibid.*, p.151
- <sup>45</sup> J.P. Weiner, "Primary Care Delivery...", op cit., p.427
- <sup>46</sup> J. P. Weiner, "Primary Care Delivery...", *ibid.*, p.429.
- <sup>47</sup> The Economist, 4/28/84, pp.17-19.
- <sup>48</sup> Health care spending equalled 12.3% of the gross national product in 1990. Health Care Spending Control: The Experience of France, Germany and Japan, U.S. General Accounting Office, GAO/HRD-92-9, November 1991, p.3.
- <sup>49</sup> P. Day and R. Klein, "Britain's Health Care Experiment", Health Affairs; Fall 1991, p.40.
- <sup>50</sup> The report, entitled "Reflections on the Management of the National Health Service" was first made to the Nuffield Provincial Hospitals Trust in London in 1984 after Enthoven spent one month studying the National Health Service at the invitation of Gordon McLachlan. The written findings were published in 1985.
- <sup>51</sup> P. Day and R. Klein, *ibid*, pp.39-59.
- <sup>52</sup> A. Enthoven, "Internal Market Reform of the British Health Service", Health Affairs, Fall 1991, pp.60-70.
- <sup>53</sup> U. Reinhardt, "Can the United States Learn from Foreign Medical Insurance Systems?", Hospital Progress, 11/78, pp.60-67.
- <sup>54</sup> Health Care Spending Control, op cit., p.28.
- <sup>55</sup> Health Care Spending Control, *ibid.*, p.33.
- <sup>56</sup> Malcolm G. Taylor, The Canadian Health Care System 1974-1984.
- <sup>57</sup> T. Allison, "National Health Insurance in Canada", The Health Insurance Association of America, Washington, D.C., 1977.
- <sup>58</sup> B. Abel-Smith, "Global Perspective on Health Service Financing", p.3.
- <sup>59</sup> E. Neuschler, "Debating the Canadian System: A Response from the Author", Health Affairs, Fall 1991, p.238.
- <sup>60</sup> B. Abel-Smith, *ibid.*, p.4.

- 61 Japan Economic Institute, No. 25A, July 5, 1991, p.2.
- 62 Health Care Spending Control, op cit., p.4.
- 63 Health Care Spending Control, *ibid.*, p.54.
- 64 Health Care Spending Control, op cit., p.5, and Naoki Ikegami, "Japanese Health Care: Low Cost Through Regulated Fees", Health Affairs, Fall 1991, p.91.
- 65 Health Care Spending Control, *ibid.*, p.6 and p.33.
- 66 The Economist, op cit., pp.17-19.
- 67 N. Ikegami, op cit., p.88.
68. E.J. Hobsbawm, The Age of Capital, Abacus Publishers, London, 1975, p.251,p.248.
- 69 E.J. Hobsbawm, *ibid.*, p.256
70. J. Hadrich, "Bismarck und die deutsche Krankenversicherung", Gesundheitspolitik, Vol.11, 1969, p.26.
- 71 F. Tennstedt, "Krankenversicherung" Handbuch der Sozialmedizin, Band 3, Ferdinand Enke Verlag, Stuttgart, 1976, p.386.
- 72 F. Tennstedt, *ibid.*, p.386.
- 73 J. Kuczynski, "Die Geschichte der Lage der Arbeiter unter dem Kapitalismus", Materialistische Wissenschaft, Bank III, Berlin, 1962, p. 302.
- 74 Unemployment, as mentioned before, regularly followed business cycles which even the most skilled workers couldn't dodge. In Berlin's engineering compounds, one third of all workers were out of a job in the 1857-58 slump. During the 1892 crisis, there were 1.4 to 2.1 million unemployed workers (roughly 6% of the labor force). In 1885, there were six million industrial workers and in 1913, 10.8 million unemployed workers. This is in contrast to 1887, a period of general prosperity when there was only a 1% unemployment rate. Hobsbawm, op cit., p.258; KSV-Zelle Medizin, p.46; F. Tennstedt, op cit., pp.385-386.
- 75 While the church and other charitable organizations provided limited assistance to those in need, demand far exceeded available resources.
- 76 Schaeffer and Blohmke, Sozialmedizin, Thieme Verlag, Stuttgart, 1978, pp.308-310.
- 77 Hovind, Seminar on the Norwegian Health Care System, International Summer School, Oslo, Norway, Lecture 7/23/80.
- 78 R.R.A. Burgess, "The Roots of our Social Attitudes and Their Change in the Sixteenth Century"; Society for the Social History of Medicine, Bulletin 18, 6/76, pp.13-16.
- 79 W.H. Dawson, Social Insurance in Germany 1883-1911, T. Fischer Unwin, London, 1912, pp.4-5.
- 80 Note that funds for commercial workers were established in 1825. These funds were a model for the joint financing and administration included in the Sickness Insurance Act of 1883.
- 81 W.H. Dawson, Bismarck and State Socialism: an exposition of the social and economic legislation of Germany since 1870, Swan, Sonnenschein and Co., London, 1891, p.93.
- 82 Note that in the U.S. both old sick people and old poor people are housed together in a nursing home. Medicaid, which fully covers care in a nursing home, is often the only way that an older poor person can be assured adequate housing, heat, food, recreation and of course, health care.
- 83 Schaefer and Blohmke, *ibid.*, p.311.
- 84 Licensure became mandatory for practice in the national Sickness Insurance Programme after implementation of the Insurance Consolidation Act of 1911. See page 146. Licensure is an important measure of professionalization. It establishes the authority of certain medical practitioners while effectively eliminating or subordinating (to their authority) others.
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- 86 W.H. Dawson, Medical Benefit Under the German Sickness Insurance Legislation, Parliamentary Papers 1912-1913 Session, Vol.78 Cd.6581, p.18.
- 87 W.H. Dawson, *ibid.*, p.18.
- 88 I.G. Gibbon, op cit., p.134.
- 89 W.H. Dawson, (Medical Benefit), op cit., p.7.
- 90 W.H. Dawson, (Medical Benefit), *ibid.*, p.19.
- 91 W.H. Dawson, *ibid.*, pp.18-19.
- 92 I.G. Gibbon, op cit., p.18.
- 93 W.H. Dawson, Bismarck and State Socialism: an exposition of the social and economic legislation of Germany since 1870, Swan, Sonnenschein and Co., London, 1891, p.93.

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- 98 W.H. Dawson, *ibid.*, p.3.
- 99 Section 29 of the Begründung for the Entwurf des aertzlichen Ehrengesetz from October 24, 1848 discussions on the Reformen der Preussischen Medizinal Verfassung. In Akten stuck No. 29, Haus der Abgeordneten. (Rep, 84a. No.101 Geheimes Staatsarchiv).
- 100 KSV-Zelle Medizin, Gesundheitswesen im Klassenkampf, Oberbaum Verlag, Berlin, 1973, p.61.
- 101 W.H. Dawson (Social Insurance) op cit., pp.4-5.
- 102 Two thousand of these were reorganized guilds.
- 103 A. Ashley, The Social Policy of Bismarck, Longmans, Green and Co., 1912, p.49.
- 104 Schaefer and Blohmke, *ibid.*, p.317.
- 105 Schaefer and Blohmke, *ibid.*, p.310.
- 106 I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, p.170.
- 107 G. Lichtheim, Imperialism, Praeger Publishers, Inc., USA, 1971, p.64.
- 108 A. Ashley, op cit., p.3 and p.42.
- 109 F. Lassalle, in "German Socialism and Ferdinand Lassalle" as noted in Dawson pp.33-34.
- 110 W.H. Dawson (Social Insurance) op cit., p.6.
- 111 A. Ashley, op cit., p.49.
- 112 A. Ashley, *ibid.*, p.47.
- 113 "The Medical Profession in Germany", *ibid.*, pp.1197-1198.
- 114 KSV-Zelle Medizin, op cit., p.65.
- 115 Fragen an die deutsche Geschichte, Deutscher Bundestag Verwaltung Presse und Informationszentrum, Referat Oeffentlichkeitsarbeit, Bonn, 1979, pp.205-207.
- 116 W. H. Dawson, (Bismarck and State Socialism) op cit., p.94.
- 117 W.H. Dawson (Bismarck) *ibid.*, p.94 and KSV-Zelle Medizin, op cit., p.67.
- 118 Today, survivors' pensions are paid from the day of death of the insured as a result of an industrial accident or disease. Pensions are payable to widows until her death or remarriage. Orphans pensions are also payable to all children of a deceased insured for as long as they would have been able to claim support as a dependent. D. Schewe, K. Nordhorn, and K. Schenke, Social Security in the Federal Republic of Germany, 1970, p.156. According to the representatives of the Allgemeine Ortskrankenkasse, sickness insurance benefits for dependents of deceased workers expire one month after the death of the insured worker.
- 119 KSV-Zelle Medizin, *ibid.*, p.67.
- 120 A. Ashley, op cit., p.41.
- 121 W.H. Dawson, (Bismarck) op cit., pp.37-40 and F. Tennstedt, "Sozialgeschichte der Sozialversicherung", Handbuch der Sozialmedizin, Ferdinand Enke Verlag, 1976, p.385.
- 122 W.H. Dawson, *ibid.*, p.159.
- 123 Wages would decrease until they hit a low when the miners' salary was noted as having halved. F. Tennstedt, *ibid.*, p.385.
- 124 Frederick List is also credited as a pioneer of the German Historical School. His Zollverein in 1834 was the first real movement towards unification of the German states to the creation of a strong protective centralized state. However, the principle of the Zollverein was to abolish duties within the German territories and induce free trade and individualism, a policy responsive to the immediate political stimuli. Gustav Schmoller, a member of the Historical School, later perfected these ideas.
- 125 W.H. Dawson, (Bismarck) op cit., p.103.
- 126 W.H. Dawson, Rede ueber die Soziale Frage, 1872, pp.8-9.
- 127 KSV-Zelle Medizin, op cit., p.58.
- 128 A. Ashley, op cit., p.44.
- 129 KSV-Zelle Medizin, op cit., p.68.
- 130 W.H. Dawson, op cit., p.44 and W.H. Dawson, Social Insurance in Germany 1883-1911, T. Fischer Unwin, London, 1912, p.11.
- 131 W.H. Dawson, (Social Insurance) *ibid.*, p.11.
- 132 W.H. Dawson (Bismarck) op cit., p.44.

- 133 W.H. Dawson, *ibid.*, p.110.
- 134 W.H. Dawson, *ibid.*, p.110.
- 135 KSV-Zelle Medizin, *op cit.*, pp.64-65.
- 136 J. Hadrich, "Zur Diagnose der sozialen KV", Gesundheitspolitik, Vol.1, p.44.
- 137 Bismarck, as quoted in Dawson (Bismarck), *op cit.*, p.112.
- 138 Bismarck, as quoted in Dawson, *ibid.*, pp.112-113.
- 139 Translation compiled from quoted material in Ashley, p.51 and Dawson (Bismarck), *op cit.*, pp.114-115.
- 140 W.H. Dawson (Bismarck), *ibid.*, p.115.
- 141 W.H. Dawson (Bismarck), *ibid.*, pp.63-64.
- 142 KSV-Zelle Medizin, *op cit.*, p.89.
- 143 W.H. Dawson (Bismarck), *op cit.*, p.116. It is interesting to see that a bill on work conditions was proposed parallel to the amendments passes on January 15,1885. This indicated the government's willingness to compromise to gain support for its primary legislation.
- 144 D. Hicks, Primary Health Care, Department of Health and Social Security, London, 1976, p.1.
- 145 W.H. Dawson, Social Insurance in Germany 1883-1911, T. Fisher Unwin, London, 1912, p.10.
- 146 I.G. Gibbon, *ibid.*, p. 167.
- 147 I.G. Gibbon, *ibid.*, p.167 and W.H. Dawson, *op cit.*, p.206.
- 148 I.G. Gibbon, *ibid.*, pp.165-167.
- 149 W.H. Dawson, *ibid.*, p.17.
- 150 P. Kohler and H. Zacher, The Evolution of Social Insurance 1881-1981, St. Martins Press, New York, 1982, p.26.
- 151 All references to currency are denoted according to German law of the period. Between December 4, 1871 and November 14, 1923, the currency was known as the Mark (M). Each Mark was equivalent to 100 pfennig. On November 15, 1923, the currency became known as the Rentenmark (RM). Shortly thereafter, on August 30, 1924, the currency was renamed the Reichsmark (RM). It was not renamed the Deutsche Mark until June 20, 1948. Bernd Sprenger, Das Geld der Deutschen, Geldgeschichte Deutschlands von den Anfängen bis zur Gegenwart, Paderborn, 1991; Herbert Rittmann, Deutsche Geldgeschichte 1484-1914, Munich, 1975 and Herbert Rittmann, Deutsche Geldgeschichte seit 1914, Munich, 1986.
- 152 I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, p.2.
- 153 The last difference was controversial, generating a strong reaction from the medical profession. Doctors claimed that permitting those whose income exceeded the limits for statutory membership to enrol in a sickness fund would erode their private practice and income.
- 154 W.H. Dawson, Social Insurance in Germany 1883-1911, T. Fischer Unwin, London, 1919, p.24.
- 155 Please note once again that neither this legislation or the government policy accounts for attempts to ameliorate bad working conditions or gross negligence (which in all likelihood existed).
- 156 It can be said that such a move actually signifies the acceptance of a slave trade- the marketing of a human being. It also must be seen as a move which benefited and was probably the resultant response to pressure from the employer.
- 157 Dawson, *op cit.*, pp.23-24.
- 158 W.H. Dawson (Medical Benefit), *op cit.*, pp.23-24.
- 159 F. Tennstedt, Sozialgeschichte der Sozialversicherung, Ferdinand Enke Verlag, Stuttgart, 1976.
- 160 Dawson, *ibid.*, p.32.
- 161 Dependent coverage became a mandated benefit for certain insured members during the first World War. Soziale Sicherung in der Bundesrepublik Deutschland, Bericht der Sozialenquete-Kommission, W. Kohlhammer GmbH, Berlin, 1964, p.202 and D. Schewe, K. Nordhorn and K. Schenke, Social Security in the Federal Republic of Germany, 1970, p.124. Family Insurance was initially instituted in July 1930 and enhanced in 1945. Die Versicherungspflicht in der Krankenversicherungs, Georg Albrecht, Asgard Verlag, Bonn Bad Godesberg, 1<sup>st</sup> edition, 1971 and Hundert Jahre Gesetzliche Krankenversicherung: im Blick der Ortskrankenkassen, Hans Tuns, Verlag der Ortskrankenkasse, Bonn, 1983.
- 162 W.H. Dawson, *ibid.*, pp.9-10.
- 163 Detlev Zollner in The Evolution of Social Insurance, P. Kohler and H. Zacher, St. Martins Press, New York, 1982, p.28. Zollner also notes (p.32) that in 1900, only eleven of the 201 sickness funds providing dependent coverage charged supplementary premiums.
- 164 F. Tennstedt, Sozialgeschichte der Sozialversicherung, Ferdinand Enke Verlag, Stuttgart, 1976, p.388.

- 165 W.H. Dawson, op cit., p.10.
- 166\*Today, any worker who collects unemployment insurance is insured. The premium is part of unemployment benefits.
- 167 W.H. Dawson, *ibid.*, pp.42-43.
- 168 A. Ashley, The Social Policy of Bismarck, Longmans, Green and Co., 1912, pp.46-47. Note: While the 1702 law was a Prussian law, it should be remembered that many Prussian Laws were used as models for Reich laws after the unification of Germany in 1871.
- 169 W.H. Dawson, Bismarck and State Socialism: an exposition of the social and economic legislation of Germany since 1870, Swan, Sonnenschein and Co., London, 1891, pp.91-92.
- 170 In 1883, the Local Funds might also include Building Works Funds formed ad hoc for special works of construction owing to exceptional risks incurred in their temporary nature.
- 171 A. Ashley, op cit., pp.60-61.
- 172 I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, pp.8-9.
- 173 Post 1911, hospitals did not require contracts but without one, they would receive the lowest reimbursement rate paid by the fund.
- 174 W.H. Dawson, *ibid.*, p.163. Note on Private Clinics: The Munich Society and Munich Doctor's Association for Free Choice had concluded agreements not only for free choice of domiciliary medical attendance but also for free choice of institutions included in the list of the Doctor's Association.
- 175 W.H. Dawson, (Social Insurance) op cit., p.58.
- 176 W.H. Dawson, *ibid.*, p.63.
- 177 I.G. Gibbon, op cit., p.37.
- 178 W.H. Dawson, op cit., p.9.
- 179 It is necessary to remember that only a small part of the population was covered by insurance at that time so that the varying private payments in effect applied to many, if not most, of those in hospitals created classes among the sick.
- 180 Schaeffer and Blohmke, Sozialmedizin, Thieme Verlag, Stuttgart, 1978, p.320 and I.G. Gibbon, op cit., p.169.
- 181 This may be the first institutionalized example of cost shifting. In America today, hospitals are passing the cost of providing indigent care as well as the difference between charges and government reimbursement for Medicare and Medicaid patients to paying patients in the form of higher rates. These higher rates are paid by insurance companies who in turn pass the increases as higher premiums on to employers who are the purchasers of the majority of health insurance policies.
- 182 I.G. Gibbon, op cit., p.169 and Schaeffer and Blohmke, op cit., p.318.
- 183 W.L. Langer, Political and Social Upheaval 1832-1852, Harper and Row, New York, 1969, pp.542-543.
- 184 I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, p.70.
- 185 W.H. Dawson, (Social Insurance) op cit., p.200.
- 186 T. Kraemer, Gesundheitsstatistik als Grundlage der Gesundheitsplanung, p.319. Note that at least the first of two of these objectives are identical to objectives of HMOs in America. This is significant because indemnity insurance plans which still predominate do not provide services to maintain health. Unfortunately, many preventive services we would consider important today were not covered by the funds.
- 187 W.H. Dawson, (Social Insurance) op cit., p.168.
- 188 W.H. Dawson, (Medical Benefit) op cit., p.7.
- 189 F. Tennstedt, "Sozialgeschichte der Sozialversicherung", Handbuch der Sozialmedizin, Ferdinand Enke Verlag, Stuttgart, 1976, p.387.
- 190 W.H. Dawson, *ibid.*, p.8.
- 191 W.H. Dawson, *ibid.*, p.8.
- 192 W.H. Dawson, *ibid.*, pp.164-165.
- 193 Schaeffer and Blohmke, Sozialmedizin, Thieme Verlag, Stuttgart, 1978, p.317.
- 194 Reiners and Volkholz, Das Gesundheitssystem in der BRD, VSA, Hamburg, 1977, pp.121-123.
- 195 I.G. Gibbon, op cit., p.170.
- 196 I.G. Gibbon, *ibid.*, p.165.
- 197 I.G. Gibbon, *ibid.*, p.167.
- 198 W.H. Dawson, (Medical Benefit) op cit., p.4 and p.8.
- 199 W.H. Dawson, (Social Insurance), op cit., pp.39-40.

- 200 A. Ashley, The Social Policy of Bismarck, Longmans Green and Co., London, 1912, p.56 and p.58.
- 201 W.H. Dawson, (Social Insurance) *ibid.*, pp.47-48.
- 202 W.H. Dawson, (Social Insurance) *ibid.*, pp.210-211.
- 203 A. Ashley, *op cit.*, pp.61-62.
- 204 In 1911, wages could be assessed up to 6s. per day.
- 205 This was abolished after 1911.
- 206 W.H. Dawson, (Social Insurance), *op cit.*, p.220.
- 207 W.H. Dawson, (Social Insurance), *ibid.*, p.214.
- 208 Culled from figures in H.N. Bunbury, Lloyd George's Ambulance Wagon, Methuen and Co., Ltd., London, 1957, p.86 and W.H. Dawson, (Social Insurance), *ibid.*, p.221.
- 209 W.H. Dawson, (Social Insurance), *ibid.*, p.212.
- 210 I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, p.5.
- 211 W.H. Dawson, (Social Insurance), *op cit.*, p.6.
- 212 W. H. Dawson, (Social Insurance), *ibid.*, pp.73-74.
- 213 U. Reinhardt, "Can the United States Learn from Foreign Medical Insurance Systems?", Hospital Progress, 11/78, p.64.
- 214 L. Horbach, Manpower Studien in Gesundheitswesen, p.42.
- 215 W.H. Dawson, (Social Insurance), *op cit.*, p.32.
- 216 "The Medical Profession in Germany", British Medical Journal, 6/3/1905, pp.1197-1204.
- 217 W.H. Dawson, Bismarck and State Socialism: an exposition of the Social and Economic Legislation of Germany since 1870, Swan Sonnenschein and Co., London, 1891, p.83.
- 218 KSV-Zelle Medizin, Gesundheitswesen im Klassenkampf, Oberbaum Verlag, Berlin, 1973, pp.64-65.
- 219 KSV-Zelle Medizin, "Gesundheitswesen im Klassenkampf", Oberbaum Verlag, Berlin, 1973, p.90.
- 220 R. Hay, "Employers and Social Policy in Britain: the evolution of social welfare legislation", Social History, No. 4, January 1977, p.440.
- 221 Licensure issues continued to concern them. This concern was mitigated by the Medical Courts instituted in 1848 largely as a result of lobbying by the Medical Reform Movement. Leaders of the Medical Reform Movement were the most vocal doctors in 1883.
- 222 W.H. Dawson, (Medical Benefit), *op cit.*, p.7.
- 223 W.H. Dawson, (Social Insurance), *op cit.*, pp.89-90.
- 224 I.G. Gibbon, *op cit.*, p.136.
- 225 W.H. Dawson, (Medical Benefit), *op cit.*, pp.19-20.
- 226 W.H. Dawson, (Medical Benefit), *ibid.*, p.4.
- 227 W.H. Dawson, (Medical Benefit), *ibid.*, p.20.
- 228 Dawson, *op cit.*, pp.23-24.
- 229 In regard to discouraging hospital admissions, the reader should remember that primary care physicians do not have hospital privileges. Hospital staff physicians treat patients in hospitals. Therefore, there is an economic incentive for the physician to treat the patient in his office as long as possible.
- 230 Doctors wrote an inordinate number of prescriptions for fund members. I.G. Gibbon, *op cit.*, pp.168-169.
- 231 I.G. Gibbon, *ibid.*, p. 108 and p.125.
- 232 I.G. Gibbon, *ibid.*, p.117.
- 233 W.H. Dawson, (Medical Benefit) *ibid.*, p.8.
- 234 Gesetz Np. 9205, Verordnung, betreffend die Einrichtung einer aertzliche Standesvertretung vom 25. Mai 1887.
- 235 V. Navarro, "Political Power, the State and their Implications in Medicine", URPE, Vol. 9, No. 1, Spring 1977.
- 236 W.H. Dawson, (Medical Benefit), *op cit.*, p.16.
- 237 Entwurf eines Gesetzes betreffend die aertzlichen Ehrengerichte das Umlagerecht und die Kassen der Aerztekammern- Haus der Abgeordneten, Aktenstück, No. 29.
- 238 Begründung der Entwurf des aertzlichen Ehrengerichte, Aktenstück No.29.
- 239 This notion of the use of the professional association to safeguard economic and professional security is discussed by Parry and Parry in The Rise of the Medical Profession, Croom Helm, London, p.84.

- 240 The word conciliation refers not only to the process of reconciliation, but also to the committees which bear that name, although they were not necessarily one and the same.
- 241 W.H. Dawson, Medical Benefit under the German Sickness Insurance Legislation, Parliamentary Papers, 1912-1913 Session, Vol. 78, pp.12-14.
- 242 I.G. Gibbon, op cit., pp.228-229.
- 243 W.H. Dawson, (Medical Benefit), *ibid.*, pp.39-40.
- 244 However, if a philanthropic or public hospital requested a contract, the fund was required to grant it.
- 245 This refers to the World's Fair in St. Louis, Missouri, USA, in 1904.
- 246 W.H. Dawson, (Social Insurance) op cit., translated, p.235.
- 247 F. Sardemann, "Wer soll und wer darf Arzt werden?", Aerztliche Mitteilungen, January 13, 1911.
- 248 I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, pp.63-64.
- 249 I.G. Gibbon, *ibid.*, pp.35-36.
- 250 I.G. Gibbon, *ibid.*, p.167 and W.H. Dawson, (Social Insurance) op cit., p.206.
- 251 W.H. Dawson, (Social Insurance), op cit., p.206.
- 252 I.G. Gibbon, op cit., pp.126-127.
- 253 The evolution of doctor's focus, from a focus on the social political relevance of their practice to a focus on payment and control issues for their profession- is discussed in detail in Chapter 11: Impact of the Sickness Insurance Act.
- 254 "Parties" could be individual doctors, fund members, funds or professional associations. Leipzig, Frankfurt and Wurtemberg had model conciliation committees. For more information, see Gibbon, op cit., p.116 and Dawson, op cit., p.36.
- 255 I.G. Gibbon, *ibid.*, p.131.
- 256 Dawson, *ibid.*, pp.24-25.
- 257 It is important to note that in real terms, the increase to 2,500 M represented a decrease; the average earnings had nearly doubled between 1883 and 1913, D. Zollner in The Evolution of Social Insurance, P. Kohler and H. Zacher, St. Martins Press, New York, 1982, p.38.
- 258 Dawson, *ibid.*, pp.26-27.
- 259 Dawson, *ibid.*, pp.22-23.
- 260 F. Tennstedt, op cit., p.387.
- 261 Kohler and Zacher, op cit., p.31.
- 262 W.H. Dawson, (Social Insurance) op cit., p.91.
- 263 W.H. Dawson, *ibid.*, pp.29-30; also I.G. Gibbon, Medical Benefit in Germany and Denmark, P.S. King and Son, London, 1912, p.2.
- 264 I.G. Gibbon, *ibid.*, p.67.
- 265 W.H. Dawson, op cit., p.36.
- 266 I.G. Gibbon, op cit., p.9.
- 267 W.H. Dawson, Social Insurance in Germany 1883-1911, T. Fischer Unwin, London, 1912, pp.37-38.
- 268 Kohler and Zacher, The Evolution of Social Insurance, St. Martins Press, New York, 1982, p.37.
- 269 W.H. Dawson, (Medical Benefit), op cit., p.163.
- 270 I.G. Gibbon, op cit., pp.135-136.
- 271 Reiners and Volkholz, op cit., pp.115,116,125.
- 272 W.H. Dawson, (Social Insurance), *ibid.*, p.62.
- 273 W. H. Dawson, Medical Benefit Under the German Sickness Insurance Legislation, Parliamentary Papers, 1912-1913 Session, Vol. 78, Cd. 6581, p.14.
- 274 W.H. Dawson, (Social Insurance) op cit., p.97.
- 275 W.H. Dawson, (Medical Benefit) op cit., p.14.
- 276 W.H. Dawson, (Social Insurance) op cit., p.98.
- 277 W.H. Dawson, Social Insurance in Germany and Denmark 1883-1911, T. Fischer Unwin, London, 1912, p.98.
- 278 W.H. Dawson, (Social Insurance), op cit., p.53.
- 279 W.H. Dawson, (Social Insurance), *ibid.*, pp.94-95.
- 280 W.H. Dawson, (Social Insurance) *ibid.*, p.52.
- 281 A. Ashley, The Social Policy of Bismarck, Longmans Green and Co., London, 1912, p.62.
- 282 W.H. Dawson, (Social Insurance), op cit., p.61.

- 283 W.H. Dawson, (Social Insurance), *ibid.*, p.97.
- 284 T. Kraemer, Gesundheitspolitik als Grundlage der Gesundheitsplanung, p.319.
- 285 W.H. Dawson, (Social Insurance) *op cit.*, p.91.
- 286 W.H. Dawson, (Medical Benefit) *op cit.*, pp.14-15.
- 287 W.H. Dawson, (Social Insurance) *ibid.*, p.38.
- 288 W.H. Dawson, (Social Insurance), *ibid.*, p.237.
- 289 W.H. Dawson, (Social Insurance), *ibid.*, p.99.
- 290 W.H. Dawson, (Social Insurance), *ibid.*, p.48.
- 291 Detlev Zollner in, The Evolution of Social Insurance 1881-1981, P. Kohler and H. Zacher, St. Martins Press, New York, 1982, p.39.
- 292 D. Zollner, *ibid.*, p.38
- 293 Zollner, *ibid.*, D. Light, "Values and Structure in the German Health Care Systems, Milbank Memorial Fund Quarterly, Vol. 63, No.4, Fall 1985, pp.621-622; J. Hogarth, The Payment of the Practitioner, Pergamon Press, London, 1963, p.211.
- 294 The stipulated doctor to patient ratios are significant. The imposition of these ratios meant that more doctors would be admitted to fund practice. This reduced the control sickness funds could exercise further because for example, in some funds where the number of doctors would now increase, it would make review of utilization patterns more difficult.
- 295 From 1876 to 1900 the number of doctors had increases by 50%, Zollner, *ibid.*, p.37.
- 296 D. Light, *op cit.*, p.622.
- 297 D. Zollner, *op cit.*, p.41.
- 298 D. Zollner, *ibid.*, p.42.
- 299 D. Zollner, *ibid.*, pp.42-43.
- 300 D. Zollner, *ibid.*, pp.47-48.
- 301 D. Zollner, *ibid.*, p.43.
- 302 D. Zollner, *ibid.*, p.46; J. Hogarth, *op cit.*, p.211.
- 303 D. Zollner, *ibid.*, p.46.
- 304 J. Hogarth, *op cit.*, p.212.
- 305 D. Zollner, *op cit.*, p.47.
- 306 D. Zollner, *ibid.*, p.48.
- 307 It should be noted that several laws passed during the 1980's have, in effect, reduced provider remuneration. Total monies to the funds and hence the providers are once again budgeted. The budgeted amounts are based on changes in the economy and fixed premium rates. If budgeted expenditures decrease, so will payments to doctors. There has in fact been a marked decrease. See page 185 for additional discussion.
- 308 D. Zollner, *ibid.*, p.43.
- 309 This refers primarily to funds which salaried doctors.
- 310 D. Light, *op cit.*, p.623.
- 311 D. Zollner, *op cit.*, p.54.
- 312 D. Light, *ibid.*, p.623.
- 313 D. Zollner, *op cit.*, p.53.
- 314 D. Zollner *ibid.*, p.53.
- 315 D. Light, *op cit.*, p.623.
- 316 D. Light, *ibid.*, p.624.
- 317 D. Zollner, *op cit.*, pp.54-55.
- 318 D. Zollner, *ibid.*, p.58.
- 319 J. Hogarth, *op cit.*, p.212.
- 320 D. Light, *op cit.*, p.629.
- 321 D. Light, *ibid.*, p.630.
- 322 D. Light, *ibid.*, pp.633-634.
- 323 D. Light, *ibid.*, pp.635-636.
- 324 D. Light, *ibid.*, pp.625-626.
- 325 D. Zollner, *op cit.*, p.53.
- 326 D. Zollner, *ibid.*, p.60.
- 327 D. Zollner, *ibid.*, p.61.
- 328 J. Hogarth, *op cit.*, p.213.
- 329 J. Hogarth, *ibid.*, p.225.
- 330 J. Hogarth, *ibid.*, p.226