A cross-country comparison of health insurance: the United States and Germany

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Abstract

This paper compares the healthcare systems in the United States to those in Germany, and examines in particular the effectiveness of managed care against universal care. Focus is made on the methods to contain increasing costs in healthcare expenditures in both countries, and a several suggestions are made as lessons learned from each system.

Introduction

Health insurance is, for many, a critical component of medical intervention, primarily because physician and hospital care is expensive, an ironic reflection of the public's desire for specialized care, state-of-the-art technology, and high quality drugs. The financial support that insurance can provide is the safety blanket for all those who take insurance, and the 'crisis' that President Richard Nixon spoke of in 1969[i] is due, in part, to the need for many to weigh adequate medical care against the affordability of such care. Despite the availability of advanced care in the United States, the healthcare system faces much criticism because of the lack of universal coverage, the aspect of profit-making through managed care, increased premiums, and, in general, its disjointed and fragmented nature that leaves so many people dissatisfied. By comparing the existing system to that of another country, namely Germany, one may be able to suggest certain improvements in order to alleviate the current situation.

Table 1. *Side-by side comparison of health insurance systems in the United States and Germany*[1]

	United States	**Germany**
Name	None, in particular; Social Security	*Gesetzliche Krankenkassen, Krankenversicherung* (GKV)
Applicants	'Gainfully occupied' persons	Universal for employed persons, pensioners, student
Coverage	Voluntary, with special programs for state and local government employees	Universal and mandatory for earnings up to €47,250 and includes spouse, children up to 18 (25 if student). Voluntary for German citizens abroad and foreign citizens residing in Germany. Coverage for unemployed.
Benefits	Based on individual programs	Sickness: 100% up to 6 weeks Maternity: 100% 6 weeks before and 8 weeks after childbirth
Insured's expenses	6.2% of income, 1.45% to Medicaid	9.75% of income, including long-term care benefits
Employer's expenses	6.2% of payroll, 1.45% to Medicaid	Average of 6.65% of earnings, 0.85% for long-term care
Available programs	Medicare, Medicaid	*Privatkrankenkasse* (PKV)
Premiums	Based on age, gender, health	Based on income
Supervision	Department of Health and Human Services, Centers for Medicare and Medical Services	Federal Ministry of Health, Federal Insurance Institute, state-government and sickness funds
Qualifications for pension	65-years old must have had 10 years of qualifying prior coverage- payouts depend on insured's lifetime earnings up to age 62, excluding 5 years with lowest earnings.	65-years-old and must have had 5 years of qualifying prior coverage- payouts depend on insured's lifetime earnings scaled on average earnings of all contributors.
Number of uninsured	Approximately 16% or 44.8 million	Approximately 0.2%[2]

[1] "Social Security Programs Throughout the World" <http://www.ssa.gov/policy/docs/progdesc/ssptw/2006-2007/europe/germany.pdf>

[2] "Highlights on Health in Germany" http://www.euro.who.int/document/e88527.pdf

Table 2. *Side-by side comparison of health insurance systems in the United States and Germany*[3]

	United States	**Germany**	**OECD Average**
Healthcare spending share of GDP	15.3%	10.7%	9.0%
Spending per capita (adjusted for purchasing power)	$6401	$3287	$2759
Spending per capita increase per year between 2000 and 2005	4.4%	1.3%	4.3%
Real GDP Growth (2007 Fourth Quarter Estimates[4])	2.1%	2.4%	2.6%
Government and public sector funding percentage	45.1%	76.9%	72.5%
Private insurance share	37%	10%	Approx. 25%
Physicians per thousand	2.4	3.4	3.0
Acute care hospital beds per thousand	2.7	6.4	3.9
Nurses per thousand	7.9	9.7	8.6

[3] "Social Security Programs Throughout the World" <http://www.ssa.gov/policy/docs/progdesc/ssptw/2006-2007/europe/germany.pdf>

Approaching the Issue

The approach to healthcare is radically different between Germany and the United States, most conspicuously by the fact that health insurance in Germany is almost entirely universal, and the only criteria for eligibility for the most fundamental of insurance systems are residency status and employment. The United States employs a system that is divided into private insurance (where employer-based insurance is the largest constituent, at 59.7 percent) and government-based insurance, where participation in Medicaid or Medicare is approximately equal, at about 13 percent of the total population. Approximately 16 percent of the population (or 44.8 million people) of the United States is uninsured, as compared to 0.2 percent in Germany[5]. Given the nature of employment-based insurance, the most unexpected, perhaps, is that the majority of the uninsured in the United States are white, between 25 and 34, have families, and have a household income between $25,000 and $50,000[6]. With no explicit regulation and employer costs, the small firms to which these uninsured generally belong are less likely to provide health insurance coverage[7]. This has also been shown to be the case in Germany, though since substitute funds are available for small and medium-sized firms, the uninsured tend to be the self-employed.

Cost containment

Healthcare systems in both nations have as their common goal to provide affordable, adequate, high quality care to patients in need, and inherently associated with it is the need to consider the means to fund such programs. In the United States, a market system is employed, allowing for competition among healthcare providers in an attempt to create self-regulation and cost containment. With Social Security taxes levied on employer and employee alike at a comparable rate in Germany and the United States, *financing* government expenditures is not nearly as large a concern as it is the control of *reimbursement* to the 'healthcare consumers'.

An integral part of the system in the United States is the use of *managed care* systems, which

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[4] OECD Economic Outlook No. 81 - Statistical Annex Tables
<http://www.oecd.org/document/61/0,3343,en_2825_32066506_2483901_1_1_1_1,00.html>
[5] "Highlights on Health in Germany" http://www.euro.who.int/document/e88527.pdf
[6] http://www.census.gov/prod/2007pubs/p60-233.pdf

transfer the financial burden of care to the physician through the use incentives to provide sufficient and adequate, but not excessive, care for the patient's needs. These incentives, however, run the risk of allowing the physician to compromise care by associating the physician's income with the care provided – for example, a physician might not recommend costly but necessary specialized care because of limits imposed on managed care contracts. Managed care organizations may, in addition, cap the utilization of specialized services in order to encourage careful selection of the most critical patients to accessing such advanced treatment. While it can be claimed that under most programs consumers have the freedom to choose a primary care physician of their choice (with certain limitations) or at least the managed care organization of their own choice, it is still clear that the quality and extent of physical care is weighed against the cost of paying for it, and by restricting practices as well as availability of resources (such as the choice of eligible doctors), the managed care institution has an uneasy stake in the health and well-being of the insured.

The United States performs particularly poorly in regulating prescription drug prices, as powerful lobbying groups have managed to restrict imports of cheaper alternatives from abroad, even though programs such as the Medicare Part D help offset some of the costs.

Relative Advantages and Disadvantages

The national health insurance system in Germany has been widely lauded as one of the world's most successful programs, in that it has been able to maintain relatively stable healthcare expenditures (when compared to inflation) while providing comprehensive, universal healthcare in which the government plays an integral part by administrating and monitoring the system but does not, in general, directly finance it. Germany is currently fourth in OECD countries for highest expenditures as a share of GDP on healthcare, at 10.7 percent as opposed to the 9.0 percent OECD average and the United State's 15.3 percent, which is a larger share than any other industrialized nation[8], and outstripped GDP growth by 0.9 percent. The increase in healthcare spending annually from the year 2000 to 2005, however, was a full 3 percentage points lower than the OECD average, at 1.3 percent, demonstrating the relative

[7] 30 percent to 40 percent of the uninsured, are, perhaps evidently, are the result of a *loss* of a job. http://www.statecoverage.net/pdf/coverage.pdf

[8] "Health, United States, 2006" http://www.cdc.gov/nchs/data/hus/hus06.pdf

effectiveness of cost-containment measures despite high costs.

The key establishment of Germany's national health insurance is the use of a non-profit 'sickness fund' (*Gesetzliche Krankenkassenvergleich*, or GKV), participation and contribution to which is mandatory for all non-self-employed citizens whose annual income is within a specified limit (47,700 euros[9]), as well as students.

To be fair, Germany's healthcare system is not without problems of its own, as rising healthcare costs have plagued employer and employee alike through rising premiums while sickness fund resources are often in deficit- the disparity between the young and rich, who can opt out of the mandatory contributions for the GKV, and the self-employed, who can rarely find solace in the premiums they must pay for private insurance, is particularly evident precisely because of the dual public/private system that Germany employs. Indeed, since the statutory health insurance (SHI) system incorporates costs for insuring all dependents of the policy holder, and because private health insurance use flat premiums that are fixed for the age bracket in which the individual first enrolled, private insurance is inherently more popular for the young and healthy, the very people who could be instead helping to fund the sickness funds.

Both Germany and United States face the same issues with regards to maintaining control over rising healthcare costs, a growing elderly population, and the need to provide the healthcare that patients need, among many others. What sets private insurance apart from universal healthcare, then, is the methods with which such costs are distributed and allocated. Premiums in the United States may be based on *community rating*, where costs are independent of health risk, or on *experience rating*, where premiums are proportional to the expected payouts for the particular individual. Germany's SHI system and wage-based (community-rated) insurance is inherently redistributive in that the healthy take less advantage of the same costs paid, while the chronically sick benefit. This is also a form of cross-subsidization, where funds are distributed from one social status (such as age or health) to another in such a way to, ideally, balance out. While both payment methods are in practice in Germany (SHI for the former, private insurance for the latter), private insurers in the United States are far less willing to take the risks involved with community rating, and mandating its use on a state level forces

[9] "The social insurance systems in Germany" <http://www.schnur-partner.de/schnur/opencms/html/de/health_en/index.html>

private health insurance programs to raise their premiums for everyone.

The German healthcare system provides for cost containment through an entirely different method: at the federal, state and local level, annual negotiations take place between healthcare providers and payer groups (such as sickness funds) over budgeting and policies, while simultaneously providing for quality control and checks over effective cost containment. In addition, physicians, who must belong to regional associations (*Kassenartzliche Vereinigungen* or KVs) in order to treat sickness fund members, are paid as a result of additional negotiations made with sickness funds over payouts. Germans under the SHI pay minimal co-payments while physicians are paid for the services they've provided.

Conclusion

Evidently neither healthcare system is without flaws. Employer-based private insurance, upon which most Americans are dependent, presents an incalculable risk when it comes to the loss of a job, and infrastructures such as Consolidated Omnibus Budget Reconciliation Act (COBRA) may still mean costly and unaffordable premiums. An aging population in either country puts significant strain on government financing for high-risk, high cost patients, and while in Germany this can be offset to some degree by co-payments and contributions from lower-risk patients, the multiple-tiered system in the United States restricts civilian contributions to the government to Social Security tax.

Clearly the approach to cost-containment by relegating health insurance to a market system compromises the system's ability to adequately provide care in the face of rising costs. Clearly the availability and use of advanced, specialized care –in a nation whose wealthy population can afford it – have not translated to an appropriate rise in better health among the masses. What, then, can the United States learn?

- **Pluralism and stringent eligibility requirements inevitably exclude some portion of the population.** Government financing through taxation alone cannot support the funding of healthcare for the unemployed and the chronically ill.
- **Community rating is inherently redistributive but will never work for private insurers in a competitive market** as the necessity to make a profit while providing

attractive premiums cannot overcome the risks involved with level premiums for both high-risk and low-risk policy holders.

- **Complexities in the system steer the focus away from the actual providing of care.** While Germany's healthcare system is by no means simple or perfect, it does have just one eligibility requirement, and it does highlight the government's desire to prioritize its population's welfare.

Perhaps the issue is fundamentally sociological – the American individualist attitude comes at an expense when dealing with the unhealthy, the unemployed, the poor and the uninsured. The dissatisfaction at paying into a profit-making institution whose payouts are not guaranteed breeds the sort of negativity that demonizes doctors through lawsuits and allows for fraud. The '*social solidarity*' that Germans abide by takes it for granted that the advantaged provide for the disadvantaged, and also ensures a relatively swift agreement on yearly contract negotiations on the state and federal level.

While further, more detailed analysis is necessary on the topic, it seems unlikely that the debate on healthcare will ever subside, however, until a genuine effort is made by the government to indicate that it prioritizes its citizens' ability to access affordable and adequate care and that it is willing to pursue all available options to enact upon those while keeping costs under control.

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Figure 9. Personal health care expenditures, by source of funds and type of expenditures: United States, 2004

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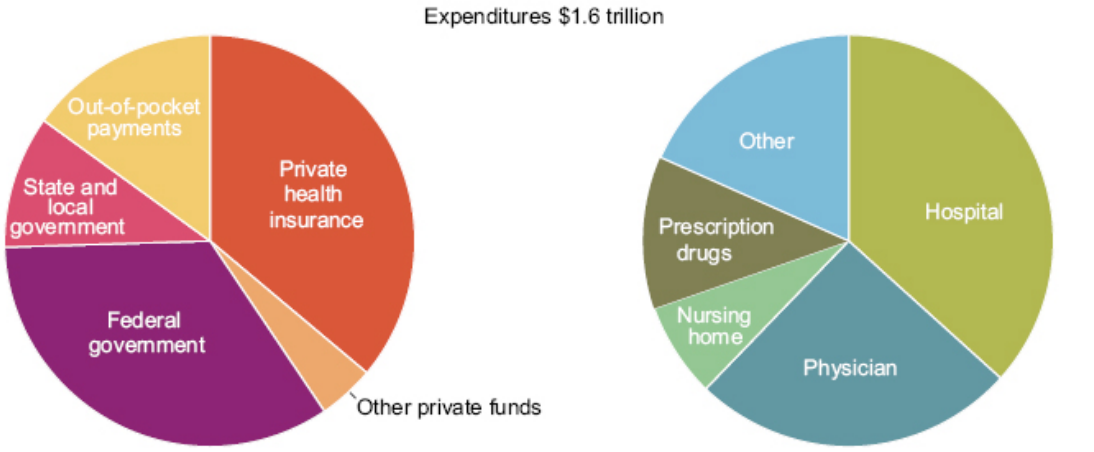

NOTE: See data table for data points graphed and additional notes.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Accounts.

Source: "Health, United States, 2006". U.S. Department of Health and Human Services.
http://www.cdc.gov/nchs/data/hus/hus06.pdf

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[i] "*We face a massive crisis in this area; and unless action is taken, both administratively and legislatively, to meet that crisis within the next 2 to 3 years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country*."
Source: http://www.presidency.ucsb.edu/ws/index.php?pid=2121