Steps toward a two-class health system in Germany

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On September 22, the German government passed a resolution on health reform that constitutes a further step toward a two-class system of medical provision. Statutory public health insurance will deteriorate into a scheme offering coverage of only basic requirements, uncertain at that, while many services will be affordable only for high-income earners.

This, the eighth reform in 20 years, will not only lead to deteriorating medical care and increasing costs for the 70 million people in the state's compulsory health system. Philipp Rösler (Free Democratic Party, FDP), the federal minister for health, is also setting the course for the total abolition of this kind of insurance, which originated in the 19th Century.

New regulations concerning contributions to health insurance companies, along with possible additional contributions, undermine the shared (according to income level) and equal (in relation to employer and employee) financing of the compulsory health insurance system.

The contribution rate to the health fund, from which insurance firms receive their money, will rise next year from the current 14.9 percent of the gross wage to 15.5 percent (paid jointly by employer and employee). The former Social Democratic and Green federal government had already abolished the system of equal contributions in order to benefit employers. According to the new regulations, from 2011 the insured will have to pay 8.2 percent and employers 7.3 percent of the total membership rate. From then on, the employer's contribution rate will be "frozen". All future contribution increases will then be financed solely by employees.

The draft law allows statutory health insurance funds to raise the rate of additional contributions, unrelated to the member's income, when they need more finance than that assigned to them by the state health fund. Although the government avoids the term "capitation fee" (a per capita premium), the additional contributions amount to just that. The maximum charge was initially fixed at €75 per month.

An adjustment in line with income will be made only when the "average additional contribution" exceeds 2 percent of the gross income. The additional contribution can also be more than 2 percent for some insured members, if their firm requires a contribution rate that is higher than the average of other firms. Experience shows this will soon be the case for funds with many elderly or low-income members.

Whoever fails to pay an additional contribution should count on being fined. The law permits the health insurance firms to levy a "default surcharge" of at least €30. The highest fine amounts to three-times the additional contribution, i.e., €225.

The unemployed will also have to pay the capitation fee if they receive Unemployment Benefit I, generally for those jobless for less than a year. In the case of recipients of Unemployment Benefit II (Hartz IV), the capitation fees and the income-related adjustments of all insured people will be financed from taxation resources. This will initially be covered by the exceptional €2 billion that the federal ministry for finance has allotted to the state health fund as "reserve liquidity" until 2014.

However, this money may soon be used up. Hence, further state-financed contribution adjustments for the socially disadvantaged will always be subject to the conditional endorsement of the government.

The introduction of the capitation fee is supposed to promote more competition among the insurance firms. According to the neo-liberal FDP health minister, this will lead to savings in state expenditure. But capitation fees have nothing to do with reducing the cost of health care, as experience in neighbouring countries shows.

In the Netherlands, where a switch to financing medical costs via capitation fees was made four years ago, expenditure has increased more than in Germany. Health insurance firms in the Netherlands have reacted to this by raising the capitation fees. In the meantime, about 80 percent of people with health insurance have become dependent on financial support from the state, because they are unable to afford the premiums.

Furthermore, the government's draft law contains hidden cuts for clinics and doctors that will mainly be shouldered by patients and employees in the clinics. Hospital charges will be allowed to increase by only 0.25 percent per year until 2012. The German Hospital Society warns that clinics will face additional expenditure of €1.5 billion, owing to standard wage increases, as well as higher medical and unemployment insurance contributions for their staff. The deficit of €1 billion, arising from the limit placed on charges, corresponds to 20,000 jobs that will have to be cut in the clinics.

Additional fees, claimed by general practitioners and amounting to €500 billion, are to be saved. Rösler intends savings of at least €850 billion in relation to doctors of state insured patients. As expenditure on so-called "extra-budgetary services" is to be reduced, restrictions on health care and rationing of medical services are bound to occur. This is because "extra-budgetary services" include, for example, medical check-ups and early detection screenings, outpatient operations and dialysis. The price increases charged by dentists will be reduced by €20 million in 2011 and by €40 million in 2012.

On the one hand, medically insured people will be fleeced in the name of competition. On the other, they face exploitation from health insurance firms and the pharmaceutical industry. One of Rösler's first official acts was to bring Christian Weber, the former leading lobbyist for private health insurance firms, into his ministry as head of the policy department. Now the private insurance companies can directly cash in on Rösler's personal choice of personnel.

In line with the first stage of the Pharmaceutical Economy Law, the drug industry was obliged to make savings of €2 billion by August 1, by—among other means—increasing manufacturers' discounts from 6 percent to 16 percent. This is turning out to be an absolute sham. Drug producers can count on continued maximisation of profits on new drugs, because—at the request of the pharmaceutical industry—their medical value will be decided in accordance with guidelines set by the government and not, as planned, by the health insurance funds and doctors.

Other regulations, stemming from the Pharmaceutical Economy Law, will also be evaded by producers. Drug manufacturers will not have to grant higher discounts if they lower the prices of their medicines. Some companies increased the prices of their drugs by 10 percent shortly before the new rules came into force, and reduced them by 10 percent shortly after, thereby avoiding having to offer higher discounts.

An investigation carried out by the ministry of health found such price manipulation in relation to 455 drug products sold by 17 different firms. Consequently, Rösler announced that those firms found to be carrying out such practices would have to pay an additional discount of 4.5 percent. However, the new draft law takes no account of this.

According to the current draft law, the next "reform of the health system" is to take place no later than 2012. Far more comprehensive attacks on health care can then be expected. Rösler has set out to do this by launching the capitation fee, to be known as an "additional contribution". The media and leading functionaries in the world of health care are already preparing these attacks.

Jürgen Graalmann, chairman of the AOK insurance company, said that the recent decision to reform health care has "stabilized" it, at least for the time being. He added that, "This breathing-space must now be used for a genuine reform of the whole system", and called for "more competition, not over contributions, but for the best kind of care". The "enormous potential for efficiency in health care provision must be fully exploited", he said.

Spiegel Online commented as follows: "In plain words: Yes to the right of insurance firms to determine contribution rates; but at the same time, cost-cutting till it hurts". The website published another commentary, presenting the current and the previous health care reforms as "great swindles", and drawing the conclusion that the real question was: "Can we afford to prolong life medically at any cost?" Consequently, it is argued, the issue for future health care reforms will be, "how best to distribute limited resources".

The author Sven Böll cited Britain as an example. There the question has already been put and answered. In the British National Health System, a scientific institution checks not only the effectiveness of new medicines, but also how long they extend the patient's life and how much quality of life is gained from them. However, whether the medicine is then authorised depends ultimately on the price: "Because a further year of life of sufficient quality—as concluded by the British institute—will normally cost at most £30,000 (about €35,000)".

Böll remarked that, because this approach "was so drastically reminiscent of the abominable Nazi doctrine 'unworthy life,'" German politicians, in contrast to those in Britain, would only debate the issue on the quiet.

But both the debate and the rationing of medical services have become routine in Germany. Jörg-Dietrich Hoppe, president of the German Medical Association, reported at the start of the year that certain medical services were no longer available for every patient in the country.

"Today, not every cancer patient receives the very expensive cancer medicines", Hoppe told the *Frankfurter Allgemeiner* Sunday newspaper. Owing to budgetary pressure, doctors and hospitals decide which patients it is worthwhile giving expensive individual treatment. Hoppe claimed that, "German health care service is secretly rationed, because there is not enough money available to provide everyone with the optimal therapy. Generally, the patient knows nothing about this".

It should be added that this applies to patients with statutory, but not private, health insurance coverage.