

# INTERVIEW

## Shepherding Major Health System Reforms: A Conversation With German Health Minister Ulla Schmidt

During her tenure with the German health ministry, Ulla Schmidt has overseen major system reforms, balancing social solidarity with fiscal responsibility.

by **Tsung-Mei Cheng** and **Uwe E. Reinhardt**

**ABSTRACT:** Americans looking for role models among foreign health systems may find Germany's, along with the Dutch system, of particular interest. These countries seek to harvest the power of competition among nongovernmental insurers and providers of health care within a unifying regulatory framework aimed at keeping the competition fair and preserving for health care, as much as is possible, Europe's hallowed Principle of Solidarity. In this interview, conducted on behalf of *Health Affairs* by Tsung-Mei Cheng and Uwe Reinhardt, Germany's long-serving minister of health, Ulla Schmidt, explains what ethical and economic imperatives have shaped Germany's health reforms in recent years. [*Health Affairs* 27, no. 3 (2008): w204–w213 (published online 8 April 2008; 10.1377/hlthaff.27.3.w204)]

**Uwe Reinhardt:** Minister Schmidt, let me begin by noting that you are the longest-serving German minister of health. Is that correct?

**Ulla Schmidt:** That is correct.

**Reinhardt:** I take it, then, that you must have many, many battle scars on your back, which is the fate of all ministers or secretaries of health around the world. Perhaps it is because of Tsung-Mei Cheng's famous Fourth Cosmic Law of Health Care, to wit: "Ministers of health anywhere in the Cosmos must have done something bad in an earlier life, or they would not be condemned to be ministers of health in this life."

**Schmidt:** Actually, I have always tried to pre-

vent scars, which makes being minister of health more tolerable. You see, before I became minister of health, and before I was elected to Parliament, I was a special ed teacher and a teacher for oppositional children. I think these are very good prerequisites for surviving as a minister of health, don't you agree?

**Reinhardt:** Did you have any experience working closely with the health system before accepting your portfolio as minister of health?

**Schmidt:** I had had no connection whatsoever with the health care system, nor did I ever yearn to have anything to do with it. So, with my being such a novice, everyone among the interest groups of the health care sector

---

*Ulla Schmidt has been minister of health in Germany since 2001. Tsung-Mei Cheng (maycrein@princeton.edu) is host and executive editor of the International Forum at the International Center, Princeton University, in Princeton, New Jersey. Uwe Reinhardt (reinhard@princeton.edu) is the James Madison Professor of Political Economy at Princeton University's Woodrow Wilson School of Public and International Affairs.*

thought, when I began in my current post in 2001, that I had no clue and therefore would not last, which might explain why initially the interest groups did not bother to form serious strategies for dealing with me. But here we are, six years later.

**Tsung-Mei Cheng:** What was the state of Germany's health system when you started as minister of health in 2001? Did the German public clamor for health reform, or did that call come mainly from health policy experts, politicians of all parties, or sundry interest groups, such as physicians and hospitals?

**Schmidt:** Let me put it like this: In 1998, when Gerhard Schröder won the election—a Social Democratic (SPD) chancellor in a governing coalition with the Green Party and a parliamentary majority—there was a strong call for reform. The prior government had made cuts in the health care system but had also made a number of dubious decisions, such as cutting back on preventive care and rehabilitation where the copays were very high. This had made health care policy a decisive factor in the elections, because voters felt increasingly overwhelmed with problems in health care.

A health reform was introduced in 2000 under then health minister Andrea Fischer of the Green Party. Any major health reform in Germany, however, typically requires approval by a majority in both houses—the First Chamber (the Bundestag or Parliament) and the Second Chamber (the Bundesrat, which represents the states, or *Länder* in German). The Bundesrat, which was dominated by the conservative Christian Democratic Union (CDU), watered down Minister Fischer's 2000 reform to the point that it was no longer truly effective.

I became Germany's minister of health about a year and a half before the then forthcoming federal elections, thus with only half of the term of office of that government remaining. In that period, we were able to enact only small, incremental measures, which did not require the consent of the Bundesrat. There was, however, considerable pressure to adopt a major reform, including a move to integrating inpatient and ambulatory care, which tradition-

ally have been completely separated from one another in Germany. But we envisaged also many other modifications of the existing system. This major reform could be contemplated only after the elections of 2002. One such reform passed in 2004.

### Goals Of German Reforms

**Cheng:** Broadly speaking, what has been the goal of the reforms you have guided?

**Schmidt:** Well, my overarching personal goal as minister of health has been to preserve for Germany's health system the principle of social solidarity, by which we mean that everyone in Germany should have guaranteed access to state-of-the-art medical care and contribute to the financing of this guarantee on the basis of the household's ability to pay. I want to preserve this guiding ethical principle for my grandchildren. At the same time, however, we must be able to afford the health care system as a nation. When expenses skyrocket, the foundation for social solidarity is lost, because people then no longer want to pay premiums based on that principle. Solidarity and affordability of a high-quality health care system therefore are the twin goals of our reform.

**Reinhardt:** I presume that the goal of cost control was the reason for your trying to introduce more competition both among sickness funds and among health care providers in the German system, with the major reform passed in February 2007? How did you manage to combine competition with social solidarity?

**Schmidt:** Let me point out, first, that competition in a health care system may not be compared with competition among automotive manufacturers or those of refrigerators or other goods, as is so often done. Competition in health care must be competition mainly for high-quality medical care, not just cheap care. In other words, we do not want competition in health care based on price and a person's ability to pay. From the insured's and the patient's perspective, we want competition to revolve around the question: "Where do I get good-quality care? Am I taken care of properly by this or that provider? Are these good programs, or are they poor, and could they possibly lead

to a deterioration of my health?”

**Cheng:** So how did you try to inject more competition into Germany’s health system with your 2007 reform?

**Schmidt:** To appreciate what we did, we must go back in history a bit. For many years the German health care system had been so heavily regulated that competition among insurers and providers of care was virtually impossible. The statutory system covers about 90 percent of the German population. All individuals below a fairly high income threshold have to belong to that statutory system. Individuals above that threshold as well as self-employed people and civil servants may opt for private, commercial insurance instead. But millions of Germans who in principle are free to choose a private, commercial insurance carrier have traditionally chosen to seek insurance under the statutory sickness fund as well. Only about 10 percent of the German population is covered by private, commercial insurers.

Until 1996, individuals and families were assigned to one of the many hundreds of statutory sickness funds, depending on their occupation or location. They could not choose among funds. As a result, Germans tended to remain with one sickness fund for life. This brought a static situation in which there developed considerable differences in the premiums paid by Germans for insurance. These premiums have been raised at the nexus of the payroll, as a percentage of the family breadwinner’s gross wages, paid 50 percent by the employer and 50 percent by the employee. Because each fund had to stand on its own financial base, the percentage of gross payroll paid by the insured varied as a function of both the average income level and the demographic composition of the fund’s members. This growing disparity among sickness-fund premiums violated the idea of social equity. So a risk-equalization scheme based on the income, gender, and age of the insured was implemented in 1994.

For their part, the sickness funds could not contract individually with doctors and hospitals. Instead, regional associations of sickness funds negotiated with counterpart regional associations of physicians treating sickness-

fund patients for uniform fee schedules that applied to all sickness funds and physicians. The sickness funds negotiated budgets with each hospital separately, whereupon all sickness funds paid a given hospital the same prices for given services, and so on and so forth. You get the picture.

Beginning with a health reform in 1992, since 1996 Germans were able to choose their sickness fund, but the variance in premium contributions remained, and the sickness funds still could not contract individually with doctors and hospitals for the integrated management of diseases, which became permissible only as part of the 2004 reform. The 2004 reform introduced explicit financial incentives for sickness funds and providers of health care jointly to develop contracts for proper disease and chronic care management, concepts that we Germans actually had picked up in the United States.

### **The 2007 Reform: Price Competition With Social Solidarity**

**Reinhardt:** Turning now to the 2007 reform, I understand that it revolutionizes the way German health care is to be financed henceforth. Can you describe in a nutshell how that is to work in the future?

**Schmidt:** As I already mentioned, until now the sickness funds each collected their premiums from employers or individuals and then turned the funds over on a per capita basis to the relevant regional physician associations (in German, *Kassenärztlichevereinigungen*, or KV), letting these physician associations distribute the funds to individual physicians on a fee-for-service basis on a relative value scale, subject to the total budget at each KV’s disposition.

Starting in 2009, this will change dramatically. Employers and individuals will pay the sickness funds premiums as a uniform percentage of gross wages or income of the individual across all sickness funds. Under an entirely new arrangement, sickness funds will immediately pass those premiums to a central national fund (in German, *Gesundheitsfonds*). These premiums, however, will no longer cover a family’s children, as traditionally they

have. The children's health care, which is part of the coverage without additional charge, and other social services will be covered by tax-financed contributions made by the federal government directly to the central national fund.

From the total national pool of funds collected in this way, the central fund then pays each sickness fund a uniform capitation rate for the people who have chosen that particular fund. That capitation rate, however, is risk-adjusted for age, gender, and some eighty distinct chronic conditions of the insured. Thus, for insured persons with identical demographic and morbidity profiles, each sickness fund gets the same risk-adjusted capitation payment from the central fund. Each sickness fund will then have to make do with the total budget it gets through the risk-adjusted capitation payments from the central fund.

**Cheng:** What if the funds end up with a surplus or a deficit? What then?

**Schmidt:** If the sickness funds spend less than their budgets on their insured, they can offer them a premium rebate or benefits not included in the basic package that must be offered by all statutory sickness funds. The sickness funds also have more flexibility than they have had before in the benefit packages they offer. For example, they can let the insured shoulder more cost sharing on their basic package or accept a gatekeeper model, in order to get the added benefits not in the basic package or to get paid a cash rebate from the sickness funds. They may also offer the insured less cost sharing if the latter join integrated health care under disease management programs.

If, however, the sickness funds spend more than their budgets—run a deficit—they must first try to reduce their spending by guiding their members into gatekeeper models or shoulder higher cost sharing. But if that does not eliminate the deficit, they may charge enrollees who choose them an additional premium, up to 1 percent of the insured's gross wages or income. In that case, however, they must notify their enrollees that they are free to switch to more cost-advantageous, competing sickness funds. For people who cannot afford

that additional premium, the welfare system pays it. In short, we tried to develop in this reform a new element of price competition at a level that does not violate our principle of social solidarity for patients.

Now, as you may have learned on your study tour to Germany, the 2007 reform had many, many other important new provisions whose enumeration unfortunately would take a few hours. For example, while previously prescription drugs were approved for coverage as long as they were effective, henceforth they must be cost-effective as well. Where previously there had been a strict separation between ambulatory and inpatient care and hospitals as a rule did not deliver ambulatory care, now they can. While previously seven different associations of sickness funds had problems finding consensus, henceforth we will have just one national sickness-fund association.

**Cheng:** You mentioned that some 10 percent or so of the German population is covered by private, commercial insurers, whose premiums had been calculated on commercial, actuarial principles. Did the 2007 reform touch this sector as well?

**Schmidt:** It certainly did. Until now, private insurers based their premiums on the age, gender, and health status of the insured at the time of enrollment. Thereafter, premiums could rise as a function of age only. For younger individuals, these premiums included a contribution for a reserve (in German, *Alterungsrückstellung*) for old age, so that premiums would not have to rise as steeply with age. That reserve, however, belonged to the insurer and not the insured. It did not travel with the insured should he or she want to switch to another private insurer. It meant effectively that the individual was locked in for life into one insurance company, stifling competition among them. Under the new law, that reserve travels with the insured, which allows the insured to switch more easily among private insurers and makes competition among them more effective.

Furthermore, we broadened a provision that had forced the commercial insurers to offer policies comparable to the benefit packages

of the statutory system at a so-called *Standardtarif* (after 1 January 2009, the *Basistarif*). The premiums for those policies may vary with age and gender, but not by the insured's health status. The benefit package under the *Basistarif* must be comparable to the basic package in the statutory system, and the *Basistarif* premium cannot exceed the highest comparable premiums under the statutory system. In the past, access to these usually lower-cost policies was limited. Now any privately insured person may switch from whatever private policy they have to this *Basistarif*, and the insurer cannot reject them. Any currently uninsured person who previously had private insurance has that right as well, as do people currently covered by the statutory system on a voluntary basis but free to choose private insurance. This is entirely new and rather controversial.

### Universal Coverage

**Cheng:** When we met you in Germany during AcademyHealth's study tour, you took considerable pride in achieving, with the 2007 reform law, genuine, full universal health insurance coverage for Germany. We were not aware that this had been a problem in Germany. What specifically was prescribed in the 2007 law?

**Schmidt:** Traditionally, most Germans were employed somewhere and thus automatically got health insurance coverage in the statutory system that way. But in recent years, more and more young people took freelance jobs or were otherwise self-employed. They were not mandated to be insured. Starting on 1 January 2009, however, every German will be mandated to have health insurance for the basic benefit package.

**Reinhardt:** How many uninsured people were there in Germany in 2007?

**Schmidt:** About 200,000.

**Cheng:** Only 200,000? That is only about 0.2 percent of the population. In the U.S., some forty-five million individuals—more than 15 percent of the population—are without health insurance at any point in time, a number that seems to be growing year after year. In addition, millions more Americans have very shal-

low insurance or policies with very high cost sharing.

**Schmidt:** True, that is a small number relative to your numbers, but I feared that this would just be the beginning, that the number of uninsured was growing. Time and again I received letters from people telling me that "I have lost my insurance, have fallen ill, or someone in my family is ill. What can we do? No private insurance company or sickness fund is willing to enroll us anymore." The conservatives resisted and said, "Whoever is not insured, this is their problem." But we were able to adopt the reform to mandate insurance and subsidize premiums when necessary, because this was a major issue for me.

So, as a result of our reform, every German is mandated to have health insurance effective 1 January 2009. For lower-income individuals whose income is below the threshold level that entitles Germans to opt for private insurance, if they wish, the effective date was as early as 1 April 2007. And whenever someone is unable to afford the premium, the sickness fund must lower their premiums. This is how universal insurance on the principle of social solidarity is supposed to work.

**Cheng:** And what happens if someone flouts that mandate and remains uninsured?

**Schmidt:** They face serious disadvantages, since not only do they not have coverage when they fall ill and need care, but they also need to pay premiums retrospectively when applying for insurance too late.

### Individual Mandates

**Reinhardt:** Whether or not to make health insurance mandatory on the individual is a highly controversial issue in the United States. Exactly how does this work in Germany?

**Schmidt:** Suppose a person had hitherto been employed and was insured with a sickness fund under the Statutory Health Insurance system, and then had lost her or his job or had become self-employed for whatever other reason. If that individual had ceased to pay the required sickness fund premiums, she or he would have become uninsured. Traditionally, the sickness fund was not obliged later to in-

sure such people if they sought to return to that sickness fund. Under the new law, that sickness fund is obliged to accept the returning individual.

**Cheng:** But what if these people cannot afford the premium—any premium, whether regular or lowered as you mentioned earlier—charged by the sickness fund?

**Schmidt:** In the Statutory Health Insurance, the premiums are calculated as a percentage of your income anyway, so this problem cannot arise. People without income and the unemployed who receive unemployment benefits will have their health insurance premiums paid by the Federal Agency for Labor or the Welfare Agency. Practically, this means that under the Statutory Health Insurance system in Germany, everyone is treated equally. In the public system, everyone has a health insurance card, and the physician cannot tell whether someone receives welfare or not. Everyone has the same entitlement to receive care based on the card, and the government no longer pays for the care but for the premiums. This is what we mean by “social solidarity.” By contrast, in the United States, you have the Medicaid program for the poor, but physicians then know that these are essentially welfare recipients and that the program will pay them very low fees, which prompts quite a few physicians not to treat Medicaid patients at all.

**Reinhardt:** Yes, this is a delicate subject here. In New Jersey, for example, Medicaid pays a pediatrician \$30 to see a poor Medicaid child on a routine office visit, while commercial insurers pay anywhere between \$90 and \$100 for such a visit. In effect, society is signaling the pediatrician that the social value of his or her professional work is three times as high when applied to a commercially insured child than when applied to a child in Medicaid. Physicians who refuse to treat Medicaid patients have understood that signaling clearly.

**Schmidt:** Private insurers in Germany pay physicians higher fees than are paid by the statutory system as well. But because by far the largest part of the income of health care providers comes from the statutory system, they simply could not afford to reject patients

from the statutory system. If American physicians reject Medicaid patients, they must be able to afford it.

**Cheng:** Going back to the previous example of a previously insured person who becomes uninsured, what if that person had previously been among the 10 percent or so of the German population who are privately insured—that is, not under the statutory system—but for some reason had stopped paying the private insurer’s premiums and lost coverage? Can they now join the statutory system?

**Schmidt:** No, but under the new law they have the right to rejoin their private insurer, which must accept them under the *Basistarif*. The 2007 reform makes provision for assistance with those private insurance premiums as well, if they place an intolerable financial burden on the insured. Then that premium will be reduced. The premium will be cut in half, and if that is still deemed unaffordable, the welfare scheme applies—tax-financed welfare will pay the premium.

## Disease Management In Germany

**Reinhardt:** On our recent study tour to Germany, we Americans were impressed by how seriously Germany now takes disease management. Specifically, we were very impressed that through its recent reform, the German government called for paying sickness funds extra for implementing formally approved disease management programs.

**Schmidt:** Yes, we provided for financial incentives for disease management contracts that are formally approved and binding on insurers, physicians, and patients. The incentive for patients to participate is lower copays, because we want them to be healthier. Physician payments under these contracts are higher because those who participate do more than others, including coordinating the care. Before we introduced disease management, the sickness funds could have done much more for the chronically ill, but they did not do so because they felt that doing more would be expensive to them—that they might attract more chronically ill people by treating them well but not get adequately compensated for that effort.

**Cheng:** Have you evaluated your new disease management programs?

**Schmidt:** Yes. We built in a requirement for formal evaluation of these programs. This is the first time in Germany that we have been able to quantify improved health among those participating in these disease management programs compared with those who are not. We were encouraged to find that we are moving in the right direction.

### Formal Technology Assessment

**Reinhardt:** During AcademyHealth's study tour, we met with the president of the so-called Joint Federal Committee [JFC; in German, the *Gemeinsamer Bundesausschuss*, or G-BA], which was established by federal law as a formal association of the various stakeholders in health care in Germany and was endowed by law with the authority to issue binding regulations for the German health system. We in the U.S. are now hotly debating whether we should have a formal technology assessment body and where it should be housed, within the federal government or outside government, as an agency akin to our Federal Reserve system. We found the consensus-building German approach to this problem instructive and possibly a role model for the U.S.

**Schmidt:** This is the approach we prefer in Germany—consensus building under a form of self-regulation, but under general government oversight. The federal government provides a general legislative framework for our universal health insurance system. But precisely how to implement it is left to the experts and representatives of the various stakeholders in health care. No political committee can decide whether a new medical procedure should become part of universal coverage or not. We feel that this should be left to the experts who, in our case, are hospitals, physicians, dentists, and sickness funds. The Joint Federal Committee also has patient representatives as well, so that patients can be heard, too. The JFC, for example, makes the final decision about whether a new medical treatment should be covered by the universal access/universal coverage system or not. Since

the most recent health care reform in 2007, the JFC must meet in public sessions and must publicize their discussions, final decisions, and so on. It is our experience that the decisions rendered by the JFC are widely accepted, including by patients. Generally, we then have no additional problems.

**Cheng:** Does the JFC have the research capacity to support its coverage decisions with scientific data—that is, a technology assessment group?

**Schmidt:** Yes. Associated with the JFC is our newly established Institute for Quality and Cost Effectiveness in the Health Care System, going by the German acronym IQWiG. The establishment of this technology assessment institute goes back to 2004, when we said that we wanted an independent institute for quality and cost-effectiveness assessment in the health care system. Upon request by the JFC to evaluate a particular technology or product, the IQWiG submits recommendations to the JFC without, however, itself making any coverage decisions. This institute is also tasked with translating medical research results into simple language, so that the IQWiG also serves as an independent information portal for patients.

**Reinhardt:** How quickly is new technology introduced in Germany? We often hear, in the U.S., that Europeans are slow to adopt new medical technology.

**Schmidt:** Not so. Indeed, there is most likely no other country where innovations become part of universal coverage as quickly as in Germany. Actually, in the United States there are more regulations and restrictions for health care manufacturing companies through Medicare/Medicaid than we have in Germany. Without those restrictions, those two public programs in the U.S. would not be able to fund their expenditures, either. And when we speak privately with these corporations, we discover that there seem to be more price discounts in the programs in the U.S. than we have in Germany through the publicly negotiated discount contracts with the sickness funds—through price negotiations and other means.

## Reference Pricing For Drugs

**Reinhardt:** Germany did invent the reference pricing system for drugs—that is, the system under which sickness funds will cover in full the cost of an adequate, relatively low-cost drug in a therapeutic group aimed at the same medical condition and leaving patients to pay out of pocket the full difference between this so-called reference price and the price charged by pharmacies for a higher-cost drug in the same therapeutic group. Do I see this correctly?

**Schmidt:** The original concept came from the Netherlands, but Germany was the first country to introduce it on a national level for its Statutory Health Insurance system, which covers about 90 percent of the population.

**Reinhardt:** Reference pricing is anathema among American pharmaceutical producers, although in effect it is a marriage of social solidarity with the power of market forces. If truth be told, the industry seems to fear the power of those market forces. Is reference pricing controversial among German drug manufacturers as well?

**Schmidt:** It certainly is. Until our recent reform, reference pricing for drugs applied to generics only—that is, to products with the same chemical composition. Now the therapeutic groups for reference pricing include on-patent brand-name drugs as well. The JFC puts comparable drugs into therapeutic groups. The national association of sickness funds then sets the reference price, which is reimbursed by the sickness fund. Because German patients hate making copayments for drugs, the manufacturers of rival brand-name drugs then have little choice but to lower their prices to the reference price, if they want to preserve sales volume.

After the recent health reform, one well-known American drug manufacturer did not lower the price of its on-patent drug for a certain therapeutic group, and consequently 90 percent of its market for that drug collapsed. As it turned out, no one in Germany was any sicker because of it; patients just switched to other medications in the therapeutic group.

It should be emphasized here that the on-

patent drugs involved here are so-called me-too drugs. It does not involve truly novel products—that is, for which there is no comparable medication on the market. But whoever is engaged in producing me-too drugs must be aware ahead of time that their product will be subject to reference pricing.

## Ban On Direct-To-Consumer Drug Advertising

**Cheng:** There is one other difference between the U.S. and Germany that we discovered during our study tour to Germany last fall: namely, that you do not permit direct-to-consumer advertising for drugs and medical devices in Germany. What is the reasoning behind that policy in Germany?

**Schmidt:** You are right. Direct-to-consumer advertising is prohibited. Prescription drugs are not items such as candy or shirts for men, which come at different prices. Prescription drugs require medical advice. I cannot get them in a pharmacy here without a prescription. So why do I need advertisements for something someone else has to prescribe? The physician has adequate training and knows which medication is effective because of its active ingredient. For this reason, there is no room for advertisement for prescription drugs. As minister of health, I do not want that someone can go to the pharmacy to purchase statins. The person first needs to be examined to determine whether there really is an elevated cholesterol level. And the person needs advice about medication therapy, because it could be different from what she or he imagines. If all of us knew what is best for us, we would no longer need any physicians. Then we could all be our own physician, but I do not believe that this would work.

## Long-Term Care

**Reinhardt:** Another subject we were very interested in in Germany was long-term care [LTC]—specifically, Germany's long-term care insurance. Would it be a possible model for the U.S.?

**Schmidt:** In 1995 we introduced long-term care insurance, which is mandatory for all Ger-

mans. After a ten-year debate, it was made part of the Statutory Health Insurance system. Long-term care insurance in Germany is now part of the country's social insurance system. It is financed by fairly small, payroll-based premiums, like in Statutory Health Insurance. It now reimburses on three levels—I, II, and III, depending on the intensity of care required.

The second issue, which also relates closely to our concept of human dignity, was as follows. Before we had LTC insurance, many individuals who needed care all of a sudden became dependent on the state—this in spite of the fact that they had been independent for all of their lives, earned an income, had some savings and retirement benefits that they would have been able to live on. But they were unable to obtain home care and then had to move to an institution. Becoming dependent on the state had an impact on their sense of dignity because, just as in the U.S., they had to give up all of their property, even though they had been independent for all of their lives. But only once you are indigent, then you receive state support and a bit of spending money. In Germany, 80 percent of nursing home residents—because such an institution is more expensive—all of a sudden, at the end of their lives, became welfare recipients, as the welfare system is needed to finance their costs for care either entirely or partly. So we decided to prevent this. Also because of the individual dignity of having your own income while insurance provides additional funds. Today, only 25 percent depend entirely or partly on the welfare system, compared to 80 percent before. And furthermore: whenever someone does not provide for the future, even where there is mandatory insurance, tax money will be needed to help out. So which approach provides more dignity? Hence, we concluded that a system of social insurance that entitles the person to benefits is a better safeguard of human dignity and a person's need to remain independent. Better than to say: eventually, you will not be abandoned. In the U.S. as well, no one ends up abandoned because the state pays for Medicaid, for example, but first you must have used up all of your income. And then you

become a supplicant, which no one likes to be. Some individuals are unable to avoid this because they have no opportunity left to go it alone. But there are many who have always succeeded independently, and they do not want to become supplicants at the end of their lives. For this reason, I think we are doing the right thing.

### **Good Results With Lower Per Capita Spending**

**Reinhardt:** Let me now ask you to help us Americans with the answer to a riddle. According to widely recognized statistics collected and published by the Organization for Economic Cooperation and Development [OECD], Germany now spends only about half as much per capita (about \$3,200 in 2005) in purchasing power parity dollars, than does the U.S. (\$6,400 in 2005), even though Germany has a much higher fraction of the population over age sixty-five (19.8 percent versus 12.6 percent) and full comprehensive and universal health insurance coverage. Yet one does not hear of the long queues to physicians and hospitals that are common in some countries—for example, the United Kingdom and Canada—and, as you have told us, in many instances Germany makes new medical technology available to patients even faster than does the U.S. How is this possible?

**Schmidt:** You are right; we do have comprehensive insurance coverage in Germany. In practice, everything that is medically needed is covered—prevention, outpatient and inpatient care, participation in medical progress, prescription drugs, medical products, compensation for sick days, and children's care are covered without additional premiums paid by the family, and we have comparably small copays. In addition, we cover ergotherapy, psychotherapy, dental care, and dental prosthetics.

**Cheng:** So, then, how can German health spending per capita be so much lower than ours in the United States? Where is the magic here?

**Schmidt:** First, because we do not have any uninsured in Germany, we do not have to rely

as heavily as you do in the U.S. on expensive emergency room care. Second, related to universal insurance coverage, is that Germans get timelier interventions, which often avoids more expensive postponed tertiary care. Finally, our insurance system is structured so that we can bargain and act collectively, within an overall constraint set of general economic conditions. Insurers and providers bargain over prices and budgets collectively, and, as we have discussed earlier, we solve many regulatory problems through discussions among stakeholders under the aegis of the JFC.

**What Can Germany Learn From The United States?**

**Reinhardt:** Finally, I would like to pose a rather delicate question to a European minister of health visiting the United States. Imagine that you are giving a lecture at a German university, such as Humboldt University or the Freie Universität in Berlin. Your topic is the American health care system as you have perceived it in your several visits here. What are the positive aspects of our system that the Germans might be able to learn from, and what are the negative ones Germany should avoid? What would you tell those German students?

**Schmidt:** There is much to be learned from the U.S. such as investment in research, including medical research, and the quick transfer of research results into practice, including health care delivery. But also the close contact between science and application. We are now working on this in Germany as well, but there is much to learn. We also have learned much from your systems of managed care. We agree with you that healthy individuals and patients alike must take greater responsibility for their health by being better informed about how to manage their health and how best to treat their illnesses—what you can contribute yourself, and how you can coordinate your effort with the health care system.

I have also learned that in the U.S. there is much less of a rigid hierarchy in many areas of the health system, especially under managed

care, but also in many other areas of U.S. health care. There is less of a rigid hierarchy between physicians and other nonmedical professions and more of an effort to work as a team and to coordinate work, because there is the recognition that everyone has something to contribute to the process of health care. We also can learn quality control from the U.S., because of the growing emphasis on transparency here, especially transparency on clinical outcomes.

To my mind, the main problem of the American health care system is its fragmentation and the reportedly growing number of uninsured. I have been told that to be uninsured does not mean that such people go without any health care at all, because they can go into the emergency departments of hospitals. But everyone in the U.S. also agrees that this is not an efficient way to provide health care. Without universal health insurance, it is difficult to provide timely, cost-effective health care, continuity of care, and transparency on quality and outcomes.

**Cheng:** Minister Schmidt, it has been a privilege to sit for this interview with you. On behalf of the two of us, the editors of *Health Affairs*, and its readers, I would like to thank you for being so kind as to make time for this interview and to be so frank and illuminating throughout. Now my last question: Did we leave something out that you consider important?

**Schmidt:** I was happy to sit for the interview. And I do not think we skipped important aspects of our health care system, although there is, of course, only so much one can cover in an interview.

.....  
*The authors thank Birgit Cobbers, Franz Knieps, Birte Langbein, and Ulrich Tilly, all of the German Federal Health Ministry, for their assistance with the transcript; Ursula Weide for translating the original transcript from German into English; and the Commonwealth Fund for its financial assistance with the translation and transcription.*