Letter from. . . Cologne

Health insurance : the milch cow

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The Germans have always been rather proud of a social security system which not only works well but is also one of the oldest, if not the oldest in the world. It was founded in the 1880s using elements of professional insurance systems which go back much further. But since the general elections last October, some observers think that this system is on the verge of collapse. Remedies will have to be found soon and it looks as if the medical profession will be forced to provide these remedies at their own expense.

I am sure you will not be surprised to hear that the world recession and the oil crisis triggered the threatened collapse but to understand why German doctors may finally be the victims of these events I think that some facts about the system will be helpful. The basic element of German social security is an old age pension insurance scheme. Every employee pays 9% of his salary, limited by a ceiling which is raised every year. The employer pays another 9%. The money is administered at State level for manual workers and at federal level for white collar people. The system is run by representatives of employers and trade unions, without direct interference by the Government. The pensions are calculated by a complicated formula based on the incomes of a pensioner in his active years, but also on the actual average income. Pensions are raised every year, corresponding roughly to the change in incomes in a previous three-year period.

Truth hidden

This system worked well so long as the economy was growing steadily. Since 1974, however, growth has declined and is just recovering slowly. At the same time the number of pensioners has grown, while the number of contributors has decreased, partly because of unemployment (1 000 000) and partly because of the emigration of foreign workers. Everybody has been aware of this for a long time, but in the months before the election nobody was prepared to admit the truth. Walter Arendt, Minister for Social Affairs, Social Democratic Party, pretended that a deficit was unlikely. His liberal partners in the Government promised never to allow contributions to be increased. Only after polling day were the books opened: they revealed that a deficit of 80 billion Deutsche Mark (just under 20 billion pounds sterling) is likely in the 1980s, 100 years after the system was introduced.

Political impossibility

A promise not to raise contributions can be fulfilled only by

a reduction in pensions. This is a political impossibility. The opposition Christian Democratic Union lost the election by a small margin and, beset by internal divisions, have no alternative to offer. A higher federal contribution is also impossible and all parties have promised not to raise taxation. So all politicians, entangled in the web of their promises, are searching the social security system for other sources of money.

Consequently, health insurance looks set to become the politicians' milch cow. The sickness funds have only their own money, provided by employers' and employees' contributions. No State money is used in this system. Employers' and employees' representatives administer the scheme, which varies among the 1500 different funds. Now employers and trade unions are to be made responsible for what the politicians do not want to do themselves: the sickness funds will receive less contributions for pensioners—11% instead of 18% of the pensions. So old age pensions will be funded without raising their contributions; the sickness funds will have to do that instead, the politicians playing the role of Pilate. It is impossible not to call the whole thing "a dirty trick."

Any reason for reform

And this is where the doctors come in. The left wing of the governing Social Democratic Party has long been seeking a way of reforming the health system. Saving money is only a pretext for this. Ambulatory care, whether general or specialist, is provided by doctors who work in their own practices. Their fees, collected from the sickness funds by the panel doctors' associations, are less than 20% of the total expenditure of the sickness funds, so a reduction in them would not help much. Even so, the first draft Bills are aimed at the system of ambulatory care.

Instead of contracts at local or regional level, a pilot contract is to set the limits for the whole Republic, and increases in doctors' incomes are to keep pace with pay rises for other workers. The pilot contract will contain a sum for average prescription costs but if the profession as a whole exceeds the approved limit the surplus will be deducted from the doctors' fees. The fee-for-item of service system would remain in principle but partial reimbursement of fees would be introduced. The fees for "technical" items, especially laboratory tests, are being reduced in any case.

Freedom of choice

But this is only one part. As you may know, the principle of the German system is the strict separation between ambulatory and hospital care: hospital doctors are not usually allowed to provide outpatient care to sickness fund patients (about 90% of the population). This is fundamentally different to the British system, but German doctors working in hospitals as well as in free practice defend this separation. It means that a specialist

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has a freedom of choice: if he does not want to work in hospital, or if the hospital does not offer adequate working conditions, or if there are no posts open for his speciality, he can decide to settle as a free practitioner in his specialty. On the other hand, the patient has freedom to choose a general practitioner or a specialist. There are exceptions: a senior hospital specialist may be allowed to provide outpatient care if no specialist in free practice is available in the region, or if the technical facilities of his hospital are needed for certain diagnosis or treatment. A local committee of doctors and sickness fund representatives adjudicates in such cases.

Road to State medicine

The freedom of choice between a hospital career or independent practice is the most important element of doctors' freedom. So it is the main target of attack by those who want to pave the way to State medicine. The present draft Bill will allow hospital doctors to provide outpatient care—under the pretext of saving money. Nobody has proved that this change will be cheaper. But as it is not the hospital doctor but "the hospital" which will provide, in the long run it means that independent practice for specialists will become more and more difficult. The next step will be the installation of complete outpatient departments in hospitals, and for the German doctors the most important element of their freedom will be gone.

The president of the federal panel doctors' association, Dr Hans Wolf Muschallik, has protested to the Chancellor, Herr Helmut Schmidt, who so far has been somewhat taciturn about this dispute despite his nickname "Schmidt-the-lip." Dr Muschallik has said that according to the law, practitioners under collective contract with the health insurance system are not allowed to strike. And their association, being a public corporation, is bound to obey the law, even if they do not like it. But

doctors are able to resign their membership and their contracts and offer their services privately.

Lesson of history

This is not a carbon copy of the action for which the BMA prepared in 1965. Dr Muschallik's predecessor, the late Dr Friedrich Voges, made the same suggestion in 1960 in protest against a Bill promoted by the then Minister of Social Affairs, Herr Theodor Blank. Dr Voges provoked one of the severest clashes in medicopolitical history: Herr Blank retorted, threatening with jail. Dr Voges survived the clash, however, and Herr Blank had to withdraw his Bill: soon afterwards the Minister resigned.

Will history repeat itself? I hesitate to forecast but if history is a guide the next move promises to be quite interesting.

Postscript

Since I wrote this article there have been further developments. You may have read in your newspapers that in some parts of Germany doctors "struck" in protest against the Bill, which has now been approved by the Cabinet and sent to both houses of parliament (one of which, by the way, is dominated by an opposition majority). But to call these actions "strikes" is an overstatement. In parts of Lower Saxony and Bavaria doctors and dentists kept their surgeries closed for one day. But they organised a generous emergency service, so the effect was little different than if 1 May bank holiday had fallen on a Friday. Nevertheless, the new Minister for Social Affairs, Herr Herbert Ehrenberg, was most upset, accusing the doctors of blackmail. We shall now have to await events as the Bill goes through the Bundestag during the next three months.

Hospital Topics

"The cholecystogram is normal" . . . but . . .

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A doctor receiving a report that a patient's cholecystogram was normal would probably give symptomatic treatment with antacids, so long as the results of clinical examination and barium studies of the oesophagus, stomach, duodenum, and perhaps colon, had also proved normal. An unusual response might be to question the validity of the report. The purpose of this paper is to show that patients with gall bladder disease may have apparently normal cholecystograms and to present a series of such patients whose clinical histories have justified elective cholecystectomy.

Patients

This series of 22 patients started in 1968 when I became sceptical of the teaching that fatty or flatulent dyspepsia was not caused by gall stones or gall bladder disease and so would not respond to cholecystectomy. All 22 patients have had at least one oral cholecystogram reported as normal and some have had three cholecystograms over the years. Two patients, one of whom was a doctor, had a 13-year history of symptoms. Fatty meals were usually requested when repeat cholecystography was done. The principal justification for operation was the history, which I often took two or three times before explaining to the patient that the symptoms might be relieved by cholecystectomy, in spite of the apparent normality of the x-ray picture. The patients were often thoroughly disheartened by their symptoms and the reassurances that had given them so little relief, and they usually agreed readily to operation, and accepted that in addition, a full examination of the abdominal viscera was a valuable aid to diagnosis and possible later treatment.

If laparotomy is performed in these circumstances I believe the surgeon should proceed to cholecystectomy and intraoperative cholangiography. The gall bladder may feel and look normal but this

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