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What Can Massachusetts Learn from The German Health Care System?
Brandeis University
July 9, 2008

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[START RECORDING]

PHILIP JOHNSTON: If you can all take your seats.

Thank you all for coming out on this very tropical morning. I hope the air conditioning is working better than the seats. laughter] I use to be a legislator many centuries ago here, and I can see that the building has not been painted or the furniture replaced since I left, which was 300 years ago.

So my apologies to our guests for that, I hope that one of these days the taxpayers of the Commonwealth will realize that this is an extraordinarily important building and the conditions of the building ought to reflect that. But in any event we are going to do the best we can and it will be cool, we hope and the air conditioning will work and I hope you will be comfortable.

I am Phil Johnston. I am Chairman of the Board of the Mass Health Policy Forum, and again I want to welcome you all and I want to welcome our guests, about whom I will speak in a moment. And I want to thank our principle funder's for the Forum, Blue Cross Blue Shield of Massachusetts, Partners Health Care and Tufts Health Plan. And the co-sponsor of this event is the Tufts Medical School and we are very grateful to Tufts Medical School for its support of this particular program.

And I want to welcome also some of the key folks who are involved in health care and health policy here in this

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building. Beginning with Chris Hager who was the Speaker's key health policy person and use to run this forum and is an old friend of all of ours, and I just introduced her to the Minister as the queen of health reform here in our state.

So, Chris thank you for everything you do and that the Speaker does. And Senator Dick Moore who was the Chairman of the Health Care Committee and former colleague of mine, in the legislature in the Clinton Administration, Representative Cory Atkins who is very much a leader in this area as well. Representative Mary Grant from the North Shore, Representative Alice Wolf of Cambridge leading progressive legislator. And if there are other legislators whom I have missed, just slip me a note and we will make you get introduced.

And I would also like to recognize Stuart Altman, who is if there is any Godfather of health reform in our state and in our country it is Stuart. He has mentored to us all, including Michael Doonan who is our very distinguished Executive Director of the Forum. Jim Hontou is the head of the League of Community Health Centers in Massachusetts and the very distinguished and notorious Robert Stusha [misspelled?] who is one of our leading health advocates in our state.

Ron Preston who was Secretary of Health and Human Services in the Commonwealth during the initial formation of

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health reform, and Celia Wcislo, who is a leader in organized labor and a member of the Connector Board.

As we all know our state has had significant success expanding health care coverage, and the Chapter 58 which was enacted a couple of years ago with bipartisan support at that time makes Massachusetts the still, regrettably the only state in the country that has put into statute a plan for universal health care.

What we are interested in now is how to sustain that program. Sustainability really requires that we now turn the issues of costs and quality and the legislature is working on those two issues as we speak.

Senate President Terry Maurie [misspelled?] has legislation in which has been I think favorably responded to by both branches in the last couple of weeks to deal with some of these issues, and I think it is a consensus that we have to get the most out of our health care dollars.

Our guest of honor, the Minister has had a lot of success leading reform efforts in her home country in the areas of cost containment and quality. This was no easy political feed, because what is inefficiency to some is dinner to others and this holds true on both sides of the Atlantic.

The format today will be an interview between one of our most distinguished health policy experts in our country,

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Professor Uwe Reinhardt and our Health Minister Ulla Schmidt of Germany. Then there will be time, we are going to allow for after we get through the Q&A and that dialogue will leave time for questions.

Let me begin with just brief introductions. First, Ulla Schmidt is a member of the German Bundestag. She has been the longest serving Minister of Health in Germany serving since 2001, and as we will hear has achieved remarkable success with a series of reforms aimed at improving the quality of health care while controlling costs.

From October 2002 to November 2005 she was also responsible for Germany's Social Security System. She graduated from the Open University of Aachen where she studied Psychology and Education and she has been a member of the Social Democratic Party since 1983. I asked her if she was on the right or the left, she said she is on the left, and I said so am I, [laughter] so that is great, and a member of the German Bundestag since 1990. Thank you so much for coming. She did not come directly from Germany she came from Chicago, where she says it is even hotter than it is here.

Uwe Reinhardt, who as many of you know is a native of Germany, has taught at Princeton University since 1968. He is currently the James Madison Professor of Political Economy and the Professor of Economics and Public Affairs. As I indicated

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he is a national and internationally renowned expert on health economics, financing and policy.

He has been and continues to be a top advisor to Congress, to Presidents and to Governors across the country. He has served on the Physician Payment Review Commission, elected to the Institute of Medicine where he served on it's governing council, on the Board of Advisors to the National Institute of Health and he played a leadership role in so many commissions and organizations related to health care that are too numerous to mention. His professional publication list goes on for eons and he is regularly quoted by the national and international press and he is a much sought after speaker.

I well remember when we reminiscing 20 years ago when Michael Dukakis was the Democratic Nominee for the Presidency. Professor Reinhardt and I participated in a wonderful event with the Governor at Princeton University. It seems like last week, but unfortunately it was not. But we are honored to have you here with us as well today Professor. So I will hand it over to Professor Reinhardt and thank you both so much for coming.

UWE REINHARDT: Well thank you very much Phil for this kind introduction. We do go way back. I remember in Washington we had a huge meeting and Governor Dukakis held forth and there was something he said, I disapproved of and it

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turned to the person next to me whom I then did not know and he says did you hear what he just said, how could he say this?

And then Phil said, yes I know I wrote that speech. [laughter]

So I learned to keep my mouth shut. [laughter]

Let me first of all, Minister Schmidt thank you and tell you how honored we are that you would come and join with us to explore this universal problem which we just discussed, Stuart Altman and I that Israel has a somewhat similar scheme to the German scheme, actually introduced some years ago, so these problems are universal.

And let me add, I am personally very honored to be here on this podium with you. We have of course, a dry run, an exercise, an interview last fall which you have here, but then I had my wife SoMae [misspelled?] by my side to give me courage [laughter] and now I am all alone.

I should also mention what a delight it is to talk with Minister Schmidt because she has a sense of humor even more legendary than Stu Altman who is the funniest health economist there ever was. [laughter]

For example, in the interview we will see, I asked about how hard it was to be a Minister of Health and she says, I was a special Ed teacher and a teacher for oppositional difficult children.

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I think these are very good prerequisites for surviving as a Minister of Health. [laughter] And this morning we were discussing the Massachusetts Health Plan whether it will be a success or failure. And it is that saying, success has many fathers, and failures and orphans, but Minister Schmidt modified it and says, success has many fathers and if it is a failure it must be a mother. [laughter] So you can quote that from now on. [Applause] And it was coined in this room.

Now Minister Schmidt you have made quite a few trips to the United States. Probably more than any Minister of Health from Germany that I can remember, and so there must be something about our system, because I looked at your schedule, it is work, work, work, work that fascinates you, or you find instructive. What might that be and can Germany learn from us?

ULLA SCHMIDT: Yes, please let me first thank for the honor to be here and thank you all very much that you spent your time with me and I hope that we can exchange our experience. And because I am so often here you told, I am the longest serving Minister in Germany and therefore have more time than other Ministers to come and to exchange the experience.

But back to your question. It seems to be a easy question, but I think it is not so easy to answer to all what has happened, I think we must, perhaps make a difference. We

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must difference between the health care system or the health care and how you cover health care. And the health care system, I would very much like that more from the experience from Germany came to the United States, not only to Massachusetts, but to the federal level. But when I have a look of how to organize care, than I can learn a lot of it. I am sure that both of our systems are fragmented.

In Germany we have also a fragmentism because we have a separation between out patient and in patient care. Sorry for my English, sometimes I make some mistakes. And we have singular doctors. There is a lack of cooperation between specialists and the primary care or the generalists. And when I am here in the United States last year I visited two Kaiser Permanente and I was very deep impressed how they organized managed care.

How they organized the case management, which role the nurses played. In Germany we have a very high hierarchic system. The doctor said and the doctors seems like to be a golden light. And the special qualities of the nurses are not so integrated as it has to be in a very good pathway for the patient to organize from prevention to rehabilitation. To give the incentives what everybody says can do to change the lifestyle, and what is his part to manage the disease.

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And therefore, I think in those fields where you have a good care in United States, by some insurance companies or I visited the Veterans system, there are very good ideas for us how to organize. And on the other side, to build up the system on the basis of solidarity that could be an experience that we can give to the United States, and we must discuss both things. Those work together because the basis of sustainable finance and the basis to organize affordable health care system with the patient as a partner in the process.

There are two sides, mental and physical. I think the things we could discuss and where we could learn from you. And we have learned because our last reforms were organized due to the experience that we made here in the United States.

UWE REINHARDT: Well that is uplifting for us to hear because I always hear the American health system is broken, it is just broken. Pieces of it are broken, like a car having a flat tire, but the whole thing by and large obviously does inspire. There is a little irony I may take the liberty to remark upon. You said you visited the Veterans Administration and you were impressed how they organized care and do IT.

Now that is the purest form of socialized medicine that there is, but it would serve our veterans and Germany is learning from socialized medicine made in the USA. That is funny. [laughter]

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ULLA SCHMIDT: But there is no problem because a lot of people in Germany said that I would organize a socialized medicine, therefore, I think the arguments against reforms in the health care systems are all over the world equal. Socialized medicine, bureaucratic or in Germany, and in other countries against the constitution.

And therefore, if you know this and you know that it will come, then you must handle and say, put it by side and let us see what is best for the people. And I think a good health care system is one of the most important things to organize and to make true that we want to have human rights and accepted in all areas of life.

Education, access to education and access to health care is one of the most important things, even if you go in other countries to build them up and to make the possibility to have prosperity.

UWE REINHARDT: Now that you mentioned good health care delivery, this state Massachusetts is known for some of the finest care that you can get. In a fact you may have heard yesterday it is a big exporter of research, medical education and of health care itself.

But to Americans this state is now also known as a pioneer in trying to solve this problem of the uninsured, and I have personally been very impressed and spoken highly of it to

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the press. And it reduced the number of uninsured as I [inaudible] cut it in half, only 5-percent are now still uninsured. But to a German the fact that 5-percent of the population is uninsured must still be shocking to hear because I remember in the interview, Mae had asked you why would you worry about 200,000 uninsured and you finally got them insured.

What is it do you think from having seen us and knowing Germany, why do you think it was feasible in Germany, but it is not, we cannot seem to do it. Can you figure it out, I cannot. I mean I can tell you right away I do not know, but is there any idea you have why that is so hard for us, what should we do?

ULLA SCHMIDT: It is difficult for me to say that, but I think when I follow the discussion I had here in the United States, it maybe that from a European perspective or from the U.S. perspective, there is another peeling of the role of the state. In the European culture we base our social policies on the basis that the states have to organize or justify anti-quality.

One of our basis and principle and values are that everybody in our country have had the same choices, but you know also in the United States to have the same choices by right is not to have them in practice and to organize that

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those who are poor that those who have more difficulties as others that those who have maybe they are in the wrong family.

No children can decide in which family they will be born. And that the choices you must have could not depend to your family or to the areas where you grow up if nothing else. And therefore, in the European community the state play an active role than in the United States because come from Europe to the United States.

They not only leave the Europe because they are poor, they have no chances. Also lot of will be independent and do not have a state and therefore, you have a different culture this is the one thing. The other thing is that I feel that in the last discussion a lot, even the Minister of Health tell me there is a skyrocketing of the costs and the skyrocketing of uninsured is a problem and a challenge in the United States.

And the change, the change is also in Germany. It was never a question when I was young that all are insured in Germany, because you have an individual mandatory to be insured. But the economy and the globalization it changed the business, the big companies are not there, that what was for me. Without any question, my generation go to school had a good education and then you have a good working place. And a lot of them was very sure that you have to work at place up to you go to retiring.

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It is not for this generation and the younger generation because companies go down. You have small companies, and when you look at the United States well for a long time it was also that the people has a job, they were insured, and this changed. And if you have an insurance by a company and hired the people and they go to the next and meanwhile, you have a diabetes you are underinsured.

And therefore the number of those who are insured by the companies is decreasing. The number of those who have no insurance is increasing, and the number, not to forget of those who are underinsured is decreasing and I read from Krukman [misspelled?] he wrote a book and he said, that the cost for the insurance company to organize reselection. Meanwhile, by \$80 billion is a lot a money you can treat the people for.

And therefore, to organize a system with no reselection as you do in Massachusetts and I think you do here a very big step forward, and I hope that it will be a blueprint for the discussion also on the federal level to organize a system that guarantees care for everybody, treatment and not a system as you have that if I have problems with my stomach, I have to go to the emergency, it is too expensive.

You have to organize an infrastructure that is too expensive, perhaps for a [inaudible] or other things that must be treated and therefore, I think we have to organize it and it

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will change in the United States, maybe it will be difficult. I am sure you will not find a reform that with one step all problems are solved, it could not work.

Because you have the enemies in each place you go. It is in Germany too. It is health care and reforms, it is after the reform it is before the next reform. And you can only organize it step by step, you see where a problem, you must solve them, but you must, not a net.

And the 200,000 that you mentioned who are uninsured in Germany they were uninsured because they have in the private sector we have 10-percent who are private insured and that they could not pay because of [inaudible] of the small business or so. And after two months the insurance company put you out and if you have a raise, you could not come back.

And therefore last year we said everybody has to be insured and every company has to insure. And if they do not pay, they have to look that they get the money, but not that they people are not treated and I think if we do not do so, we affect 200,000 and 300,000, 400,000. It is an increasing number in the changing of the biographies and also in the job market.

UWE REINHARDT: I think this point of culture of course is important in when this country was founded all the empire

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loyalists were sent to Canada and that is why Canada has universal health insurance. [laughter]

ULLA SCHMIDT: Yes.

UWE REINHARDT: And all the rebels stayed here, and that is why we do not have it, I guess. But I must say I was very impressed in the interview Mae asked you what has been the goal of the reforms you have guided in Germany, and you said my over arching personal goal as Minister of Health has been to preserve for Germany's health system the principle of social solidarity.

I want my grandchildren to be guided by this ethical principle. And we were in Taleana at the World Health Organization meeting for Europe and that is pretty much the standard in Europe and I think at some point maybe we in America ought to discuss this principle and put it into the vocabulary of the health reform debate. And you just had an eloquent explanation of what Europeans mean by that. It is not socialism at all.

ULLA SCHMIDT: No.

UWE REINHARDT: Nor is it government medicine at all. It is really the principle, when in trouble we help each other. We are one nation. So thank you for that. We had already –

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ULLA SCHMIDT: Perhaps let me say, I think that sometimes in the discussion in the United States, they are not really open –

UWE REINHARDT: Honest.

ULLA SCHMIDT: Honest, because in many cases, there is also solidarity. When you look at Medicare, Medicaid, CHIP, other emergencies and in a country with this constitution, also a constitution to guarantee individual rights, everybody knows that it is not correct that anybody has not had the chance to go to the doctor because he is poor. And when you have a look at the expenditures, then you must see that at the moment my information is about 50-percent of all of the costs are paid by the state, by taxes.

And therefore it is an increasing number and what you have to discuss is how can you organize it better? Because the system you have that is not really free from solidarity, cannot say so. It is not free. But you organize it in a way that you could not make also a cost management. And a management for a good health care, because you pay for this, you pay for this, you pay for this and you pay for this.

But there is no framework how to organize it. And if you have this in your background and you see that today there is many money that is invested, but is it always in the right distribution and [inaudible] it is best, best for the patient.

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And this discussion I think is necessary all through the United States of America, what can we do that each dollar is better invested today. And then you have a lot where you can build up and you do it in Massachusetts, we have seen that there are problems and you will have problems also in the future. But you must solve them, you have another basis and you can solve them.

UWE REINHARDT: I guess that is one way to put it. In Europe they have organized solidarity and we have disorganized solidarity. In the U.S. there is a big debate and I guess it will not come, but it was an issue in the primary campaign between Senator Clinton and Senator Obama of whether the state should have the right to mandate individuals to buy health insurance. Now you clearly do that.

ULLA SCHMIDT: It is because I think the state have the duty. It is not the right. I think it is a duty. Therefore we need a state, we need a state to organize society. If we all live as individuals maybe, but nobody won. And everybody in each state you will find rules and I think to organize a state or a society where everybody has the same rights, and everybody has the same duties. Also in the family they have rights and duties. It one side only have rights and the other the duty, it does not work. Not in the long-term. It happened, but it is not what we want.

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And therefore, I think if you have a state and if you have a Democratic framework of a state, then in our constitutions say this must be a framework based on the solidarity base. And we have good experience with social state and it is not that the state has to go in everybody's life, but if you want to have sustainability financed health care system, you must organize it because it only works if the healthy pay for those who are sick, if the young pay for the elderly.

If the elderly has only to pay for the elderly, they could not pay because you never have so much money for all people that everybody could pay what is [inaudible]. And it is not so that young people say, oh how nice, I would pay for the elderly. No, it is not so that the healthy say, oh we nice, could I spend more money for those who are sick.

And therefore you have to organize it and I think we have in 125 years of our health insurance companies and the mandatory health insurance company, we have good experience that everybody has the same risk to get sick. And if you are really sick, it is so expensive that only few people earn so much money that they can pay it out of the pocket. You need the other that stand for you. And my experience is that people stand for people is the best sustainability.

You know your experience with the house crisis and finance market, it is not always the best and sure, but that

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those who can pay for those who need it that will be the long time the best you can organize.

UWE REINHARDT: I had to smile a little bit when you mentioned in a family people have duties and responsibilities.

ULLA SCHMIDT: In a good family.

UWE REINHARDT: In a good family. [laughter] Well maybe ours was not. [laughter] Because when our children became –

ULLA SCHMIDT: Do the duty –

UWE REINHARDT: I obey, I do obey. But our teenagers had many, many rights and duties. They have kind of a view which is what people say, no one has the right to mandate me to have insurance, but those very people if they got hit by a truck or were very sick, do believe that by virtue of living in America they have a right to get life saving health care from Massachusetts General or anyone.

And that reminds me of a teenager, I think that is what Americans mean when they say we are a young country.

[laughter] Actually much older than Germany. Germany is 71 maybe, and we just had 232nd birthday, so we are an old country, but we think young, [laughter] and this in health policy. Which I once made a list, and I would like to ask you whether Germans are like that.

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You ask Americans, make me a list. What do you really want from a health system? Here is the list. The latest technology and much of it, proven or not.

ULLA SCHMIDT: Yes.

UWE REINHARDT: Complete freedom of choice of therapy by patient and doctors, called patients rights, no rationing ever, low taxes, and low insurance premiums, that is all.

[laughter]

Now are Germans like that?

ULLA SCHMIDT: Yes, it is human. In Germany too, you know if therefore, I am not the most famous Minister in our country, as a Health Minister you are not because when they talk to me they say, I want a free choice of doctors. I want the best medicine buys, I want the newest drugs whether it is [inaudible 00:35:12] if it costs too much money. I want to have good hospitals, I want to have a good prevention, I want to have a good rehabilitation and I want to reduce my contributions.

I think that it is human being, therefore, you have to face it, but you may not stop to organize the way forward, and that is what health care reform means that you have to fight against all things. You never find the doctors.

I saw a discussion here in the United States where Hillary Clinton tried to make a health care reform. They want

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stuff that you can have the free choice of your doctor, the same in Germany. They want bureaucracy, social medicine and all the factors and it will be too expensive, the increasing costs. And so the accruements are all the same, because a lobby is very, very important and the lobby of the pharmaceutical industry above all.

And therefore, and they had the good influence in the press. They had a good influence because they can play with the feeling of the people with their fears, with their hopes, and therefore, I think the people are not so different in the United States and in Europe. I wish all the best for locals.

UWE REINHARDT: I guess maybe the main difference is Germany's Minister of Health is a former special Ed teacher. [laughter] Our Minister of Health is not and does not know how to deal with these people.

Those of us who do international research are always amazed by some statistics. Our population is still young, 12.6-percent of the population is under 65, that will grow, but we are still young, and will be forever the youngest OECD. In Germany it is 19.8-percent over, closer to 20-percent already now, you have no uninsured. Yet in purchasing power parity according to the OECD data, you spend half per capita what we spend on health care.

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So, as an American you ask yourself, how can you do this? Do you ration by the queue, do you have low tech medicines so you do not have drug eluting stents for example. Do you have low health status, do people die earlier? What is going on, how can this –

ULLA SCHMIDT: They die later.

UWE REINHARDT: You die later. So what would you tell an American how that is?

ULLA SCHMIDT: I mentioned it before. I am deeply convinced that the fact that we organize a system on a solidarity basis, with guarantee, access to treatment for everybody, and access from prevention to rehabilitation for everybody. And that is built up that people have, not only access to treatment, but on the state of the art. And that what they had paid due to their ability they could pay through the income.

And if you have a system, if we implement disease management program, everybody could take part if you had a disease that you had to manage it. And then you have the possibility to manage care for all, and to manage costs. You may never forget that the –

UWE REINHARDT: The readiness.

ULLA SCHMIDT: The readiness for solidarity depends to affordability.

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UWE REINHARDT: Depends on health care being –

ULLA SCHMIDT: Depends on health care being affordable.

There are two sides and we have the chance that our insurance companies could make contracts with doctors. When we introduced the DIG system in the hospital, we do it in all hospitals in a same way. You can set incentives for maybe to save money, and you can set incentives by the patient to invest in prevention, maybe financial incentives or so.

And therefore Germany, when you have a look at the health care system, you have four systems who are very expensive and spend a lot of money as is the United States, France, Germany, Switzerland. Sometimes we are the second place or the third place countries for spend. Between 11 to 12-percent of the GDP, but the United States 17-percent of the GDP. The life expectancy in our countries are higher than in the United States.

But when you have a look at preparateur [misspelled] spending, then we are about \$3,300 Euro preparateur and the United States more than \$6,000, not Euro. And I think that the way to cut the skyrocketing of the costs here is to organize a health care system with an individual mandate to be insured. And then you can offer what you have as an experience for managed care and for better care to all the people and then the

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costs will reduce, because of the emergencies [inaudible] and not before and not after that to be clear.

UWE REINHARDT: This brings me to the health reform you got legislated against all odds last year. There were several reforms, but that one is often said to be revolutionary in the way you reorganized the financing and I wonder if you could explain a little bit to this audience what it was you did and why that is revolutionary in the German context.

ULLA SCHMIDT: Yes, it is one of the parts of the socialized medicine and the socialism that flew in Germany. But we have 90-percent of our people are insured in the Statutory Health Insurance Fund. And up to now the Health Insurance Fund has set up their contribution between all there is a risk management and also in management about the differences of the income.

Our people pay a percentage to an income up to \$40,000 Euro a year. Less money pay less who earn more money pay more. It is a good system because you do not need taxes to organize a social justice in this system. But we have 215 statutory health insurance companies, and everybody has the right to choose the company he or she wants.

So there is no risk select. Even if you are in a treatment for breast cancer and you say I want to change my company. They have to take you and you can go from one company

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to another. And therefore you need a risk management because it is possible that in one company that most of the elderly people or most of the chronically ill people and so.

And what we have up to now was not so efficient as I want because you have a difference from the cheapest company to those who has a expensive between 5-percent, that is for one for who had \$1,000 Euro a month, \$50.00 Euro a month have not had paid by the employer, employees. And therefore, I say we must have a better range because it is also human and other people, I could not change my insurance company, and now they would not take me. They have the right, but they do not feel that they have really the right or other things.

Now everybody goes to the same doctors, to the same hospitals, have the same rights for all what is covered. And therefore, we say must organize it better. If our health insurance companies should more invest in competitive over quality. Best programs, best quality and so, then we must have equal conditions for all. And so we said, it is okay that everybody is paid the same percentage of the income. Maybe at the moment it will be 14-percent, 7-percent employers, 7-percent for the employees.

And then we review this money that a company get the money they need for approximately to organize the healthcare system.

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UWE REINHARDT: The risk adjustment.

ULLA SCHMIDT: Risk adjustment that means that those company where more elderly people are insured. They get more money than those who are more young people. We have now make a risk management that is due to the morbidity with the 80 most expensive sick with diseases and then we think that it will work so that the company get the money they need in an average and then they can work.

And then I think that I would have a better opportunity to organize good care. Those companies who had good investment in prevention or disease management or other things they will save money and then they can pay premium to the people who are insured there, and get their money back.

And those who are not so affected, they had maybe to ask for additional payment, but this may not more than 1-percent of the income of the people who are insured. And we hope that with this fund we can organize better that in all areas of Germany, also in those where the income is lower than in others. We have the money to organize a good health care for the people and it would be more justice for all. This is ideal before.

UWE REINHARDT: I think to my mind that really is a way to combine social solidarity and bring in elements of competition in private sector ingenuity which makes it so

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different from what one thinks it is. It is not government medicine at all.

ULLA SCHMIDT: No. We only say that the contribution rate for the future, but not as we like because before the insurance company, the experts at other they have looked at what is the need for 2009, and what is the need, and therefore we say, how many money we need? And in the fund we also will have an increasing rate of taxes the first time.

Our health insurance system had a lot of duties for families and for children and so they do not pay anything. And therefore we say it is better to pay taxes for it and in the fund also in additional every year \$1.5 billion Euro more on taxes and then you can organize it. I am sure that it would work better than the old system because the right spread in the contribution was not -

UWE REINHARDT: The variation -

ULLA SCHMIDT: The variation of the contribution.

UWE REINHARDT: But we hope this will be a success and we a mother with the success. But I have tons more questions, but I think it will be nice to have the audience ask questions if they have them. I am sure they do. This is Massachusetts after all. [laughter]

So why do we not throw open the floor at this point to anyone. There is a mic there. Is a portable mic? Ask the

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second question. I have always noticed the first is so hard because it is embarrassing.

Okay, here comes the second question. [laughter]

MALE SPEAKER: Thank you very much for this very enlightening presentation. One of the problems that we have identified and I am certainly interested in hearing what the situation is in Germany. Is that the issue of our universal coverage in Massachusetts has only heightened another problem which we have in Massachusetts, which is universal access. There are inadequate primary care physicians to see all the patients that are now a newly insured.

In fact, I was recently speaking to a colleague that runs a volunteer clinic in the Western part of the state who told me that all of the patients that they have been seeing for years that are now insured are actually coming back to the free clinic where they are now continuing to use those services because they cannot find primary care physicians.

And most of us know that anyone that has looked into this knows that the more robust your primary care system, the better the health outcomes, the less expensive the care and I am wondering what the status is in Germany with respect to the availability of primary care?

ULLA SCHMIDT: It is not really a problem in Germany because we have increasing number of physicians. But they are

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not always on the right place where we need them. In the big cities you have too much physicians, you have hospitals with too much physicians, and you have rural areas and we have problems to find physicians who will be there and will be there in the primary care.

We had made a lot of reforms to set incentives. Next year we will implement a new fee schedule for the doctors because we want that it is possible to give more money to the doctors who go in a region where the underserved and less money for those who go in the regions where it is over served.

We are a free state. Sometimes when I go to the Eastern part of Germany, from the former GD Air then they say yes you can say then they had to go there. I say no we are now a Democracy, [laughter] and it does not work because everybody is free to go where they want. And we can only send incentives.

I said to our state governor, well invest in scholarships and then we can say we pay for you. And you say if you have finished your study then I will go for five years or so in an area where you want. I am deeply convinced that a lot of them will stay there because they find families, they find friends. And we discussed such incentives. It is not the number of the doctors, but the doctors in the rural area where we need them.

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UWE REINHARDT: By the way we did this in 1976, Brian Biles [misspelled?] a National Service Corp. We have such a system that we pay their tuition and then they can work off that debt by practicing so -

ULLA SCHMIDT: And they do not have to pay -

UWE REINHARDT: Have it back. If you want some experience will be able to help you.

Another question, sir!

MALE SPEAKER: Minister Schmidt, I wonder if you can tell us, in the course of your reforms some providers probably have made less money because of some of the reforms, what has been the response of the German provider community. What have you done politically to try to make that more palatable, or has that not been a problem?

ULLA SCHMIDT: There is a problem, but not all who think is a loser is a real loser. And you have a lot of doctors and physicians that come from a very, very high level. And you will have discussion about how to be on this high level and that what was the '80s to be a physician it is like to bring money. It is the same like to bring money and it does not work in a society with more and more elderly people.

And also the medical achievement and progress that comes to the price. It in the '80s it was easier because you do not have such expensive treatments as today. The fight

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against cancer and other things, dementia are what we have, transplantations and other things. They are very expensive, but the medical progress make sure that you can give it to the patient and make their life better.

And therefore, the money you can spend, could not grow in the same way, and therefore doctors today in Germany they are not close to those that have less money, or low income. But you can in a political way do something because they had also new chances and every doctor can go and take the chance with new contracts, with more cooperation, with more organizing a new way. You have doctors that are against every IT or other things. And who move can also be a winner by the reform, who do not move, you cannot take them.

UWE REINHARDT: But this problem of printing money of course, we have that too, and our government dealt with this by for the Medicare program by putting essentially a budget telling the doctors, here is the total budget of what we want to spend for Medicare beneficiaries for physicians and it gets adjusted over time, cost of practice and so on. And if you exceed the budget, we will later on cut your fees retroactively and because of that, we are now looking as a fee cut of 10-percent, but what is often overlooked the volume was enormously the [inaudible 00:57:55].

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If you actually plot on a graph Medicare spending per beneficiary for physicians, that has been growing at 6-percent per year in the last decade. So you have this problem always, and I think that too is the human condition. Fee for service will always have it. So we have that in common as well.

But you mentioned these expensive drugs, and this came up last night we were talking about, Avastin, Urbatux, these biological specialty drugs. What it really means you are buying quality adjusted life years at enormous prices. And those prices will soon exceed \$100,000, \$200,000, \$300,000 per life year, and at some point society has to say, is there some upper price limit where we say no, this does not make sense. How does Germany deal with this? We do not know how at the moment.

ULLA SCHMIDT: Yes it is a problem. In some countries they cut the prices, but in our constitution it is not possible to cut prices because industries is free to set the prices. But what we want to do and I am sure that it is really necessary that you have a real cost effectiveness proof. Today you have a lot of new drugs that go into market after licensing. The prices are 300-percent more than other drugs, but not the need and usefulness for the people and for the treatment of the patient.

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And we want a system that we said, okay you can go in through the market after licensing but our institute of quality and efficiency in the health care system will have a look at the studies and then they will give us the assessment. Is it really more usefulness for the people or not, and are the costs in a real relation to this, and then the insurance companies can make or shake with the pharmaceutical industry about the price.

And I think that it is the only way. I am sure and the pharmaceutical industry must learn it, that no health care system of the world can pay for the price that they ask at the moment, and no health care system can do it with more and more in the individual therapies or in the biological medicine. We get older and older and the risk to get a cancer, the risk of dementia is growing. More people are at the 80 years, 90 years and 100 year. In Germany our President they congratulate for the 100th birthday for the people. Last year, 10 years ago at 15 it was 400, last year 4,000 and in 2025 it will be 45,000.

But it is also in the United States people live longer and the risk to get a disease is greater and the costs of the very expensive drugs is not only for those who become new disease, but only you can, the life expectancy will grow and the number of those who have to be treated grow. And therefore, the pharmaceutical industry have the best profit for

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the next years because we need the drugs and we have to have negotiations with them about fair prices. It could be one of the most important things to people.

UWE REINHARDT: This incidentally, we are wrestling with that issue in the U.S. and we are indeed going to Germany and England to study how they do it to see whether we can learn, and at least collaborate with you. So there you are way ahead of us. Madam.

FEMALE SPEAKER: If I could just make a quick comment on that. I am aware of some very new ways in which drug development is occurring that involves virtual pipelines. One of my very good friends was President of the TB Alliance that was part of the Gates Foundation and they are now aligning parts of products for drug development in various parts of the world where they are uniquely qualified to do a particular segment of drug development and testing. And so that could be the way of the future to generate international competition to bring prices down, to make such drugs more affordable.

But the question that I was going to raise is. What is Germany doing about the undocumented population? You certainly have guest workers which you acknowledge perhaps more readily than we and is this part of your 200,000 uninsured or not? Is the undocumented illegal migrant worker population part of that 200,000 uninsured or not and what are you doing to address

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their needs, because of course they serve as sources of communicable disease for others. There is naturally the human misery aspect and all of these things.

ULLA SCHMIDT: Yes, maybe there are more because they live illegal and you have no numbers. How many people really live illegally in your country? And if this is a problem because if you are illegal you cannot be insured, and all the rights you have, you have for the people who live legally in the country.

But illegal people can go to the doctors, but it is the question, who pay for it? In others countries in Europe and Spain or Portugal for instance with the state system the state pay for it. Because people go to the hospitals, go to the doctors. In our system it is more difficult and it is a problem for me because the health insurance company also pay only pay for the people who are insured by them.

And therefore, we have a discussion about maybe people who are illegal go to the doctor, they fear, they could and a lot of physician they treat them without getting money for it.

But people fear because they not sure even the doctor or the hospital will announce it, maybe to the state or ask for money by the social security, by the welfare system, and then they are fear that they are put out.

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This is a real problem and we have in the last Presidency of the Portuguese European Presidency it was one of the main issues. How can we organize in Europe to guarantee that also people who are illegal there have the same access to treatment as those who are legal there?

And we have not solved the problem until now, but it is in my mind and in the discussion with my colleagues, how can we do it, and how can we give them a little bit more security that they do not feel the state. If they go to the doctor, it is a problem.

UWE REINHARDT: When you raise your question, could you speak a little louder so the translators can hear.

FEMALE SPEAKER: Alright, thank you. Can you hear this? Thank you very much for a wonderful conversation.

I would like to ask a question about the role of the insurance funds in Germany and contrast it with the United States. What was the historical role of the health insurance funds? I ask because this is often a point of controversy in this country, where the insurance industry is more attuned to commercial insurance and distributing risks and aligning risks and costs, whereas it might be different to distribute costs unrelated to risks.

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And so my question is there a difference? Is the role of the insurance funds in the insurance companies different and are there historical reasons for that? Can we learn something?

ULLA SCHMIDT: Maybe when you have a look at the historical story of our health insurance companies that it was built up by Bismarck 125 years before. But it was first one of the self help organization of workers, and when you have a look at what Bismarck built up, maybe a lot to do with your Medicaid because the health insurance system was built up for the workers, and not for the treatment by beginning but that had organization.

If a worker was ill and sick that they get money from the insurance company for the family that they can live, because you do not have social benefits as today. And then you have the money for sickness, cash benefits if you are sick, and then it started for the treatment that you can go to the doctors.

And therefore, our traditional as health insurance company AOC [misspelled?] for the worker. And then it grow and grow, you get the insurance company for those who were employers, you have difference. For up to the '90s, you have difference.

The workers are in this, the employer there and then you have difference due to the profession for technical people

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or for the automobile industry or other things more. And then we organize it step by step that you have now have a system that is for all people who are insured by the fund, by our statutory fund can choose every insurance company, that every insurance company can merge. I think it has to do with your Medicaid, for poor people to make sure that they are not hungry if they are sick.

UWE REINHARDT: I think the distinction you wanted to make was between blue collar workers who had to be in their sickness funds that tended to be company tied or local. And then you had white collar workers. When I was an apprentice in Germany it was white collar office worker, I could choose the [inaudible] I chose, which was nationwide. We have a gentleman here from it.

And the idea was that somehow there was a difference, but there really was not. It is a little bit like the first class section on the Luftanza [misspelled?] from Frankfurt to Hamburg, the same seat. So I asked what am I paying for here, [laughter] and he said, oh you should feel better. [laughter] So the white collar, we are not really much different, but they were nationwide.

FEMALE SPEAKER: Here in the U.S., sometimes coverage of mental health services and medical services can be very different. And companies and insurers sometimes have to make

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decisions of whether to limit mental health services to keep costs down. And I was wondering how Germany has structured their mental health services when compared to their medical services?

ULLA SCHMIDT: It has a lot to do with the private system. Our private insurance company they may do a risk selection. If you are sick and you want to be insured they do not take you. But the statutory health insurance, they do not know any risk selection. It does not matter if you are very sick or not, if you are old or not. You have to be insured and therefore, for the health insurance companies we have a framework.

The state by law it is laid down in law what is the medical need. The medical need from the right of access to prevention after rehabilitation. The ambulatory sector and the hospital sector and other things, also medication. All is paid, all medication who is prescribed you get the money for it. You have to pay additional payment.

In our system you have to pay one times in a quarter, \$10 Euro processing fee, and you have to pay with all you get a minimum of \$5 Euro maximum \$10 Euro, but not more than 2-percent of your income or if you are chronically ill, not more than 1-percent of your income, after that you are free.

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And you can only do it in this statutory health insurance company. If it is a private, it is only a thing between you and the insurance company, how you organize your contract. You can say I will pay \$5,000 a month or I will pay the first \$10,000 or \$20,000 or I will not be insured for the dentist or so. In our health insurance companies, all included. Dentists and all, mental health, all is included.

UWE REINHARDT: So that the distinction between mental health care and other health care is not so -

ULLA SCHMIDT: It is no -

UWE REINHARDT: And I think that was part of, they do not do that, it is all the same.

Madam.

FEMALE SPEAKER: Thank you. I too have enjoyed the conversation this morning.

UWE REINHARDT: Closer in.

FEMALE SPEAKER: I too have enjoyed the conversation this morning. [laughter] I wanted to get some understanding of your experience in dealing with a big problem that we have here in the United States. One that we are dealing with in Massachusetts and that is health care and health inequities. Particularly, those based upon race and ethnicity.

I am sure through all your visits here, you are very much aware of the differences in the burden of disease in

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health care treatment and also in health outcomes for particularly black people and Latino's, as well as other people of color. So just wanted to hear what you had to say about that. Thank you.

ULLA SCHMIDT: I think this is a problem that all societies are facing. It is not in the right all people in Germany who are insured have the same right. It is also a question of education, if you know your rights. It is a question in Germany of the language.

We have a high percentage of people with a Turkish background, and you have a lot of people who live in Germany that do not speak the German language, and then it is they do not have the same rights. They go to the physician, but they do not understand them, or they do not know what are their rights.

And therefore, I think it is not only I think of the health care system, it is I think of the education before school that you invest to learn a language and that you try to overcome social inequities. Equity is one of our values, but we discuss often of it, about it because it is not in the everyday life that inequity is also guaranteed for all.

And therefore, we have now making a survey for the chances of children and the youth, how they can grow up and what are their healthy chances and it is change, because one-

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third our children have not same opportunities for a healthy life than other.

It depends to the family and it depend if you are in a family with a migrant background. We want to change it. We make now an action plan to invest and to support the chances for all children to have the same chances of a healthy life. And I think that this are the steps to overcome the barriers also in the mind of those who are physicians or the possibilities they have.

It is the same problem with the elderly care. Elderly people who live in Germany who do not speak the German language, they often thought before that they would go back to their country when they are elderly, but they do not. They stay because their society and their family are there. And we now look for people who speak for example, this Turkish language, that you have a care for them and they can understand what are their wishes, what are the needs.

And therefore, health policy is not only the policy for the health care system it has to be integrated in family policy, in social policy, in the rights in the working place and also in the guarantee of the human rights for all.

And in the public, internal affairs, and this is also I think the problem you cannot only [inaudible] repair the health care system and reform there, you must take it as a task for

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the whole society and to work step by step that this will overcome.

UWE REINHARDT: The issue, *The New England Journal of Medicine* just had an article a couple of months ago. It was May I think, 2008, where it showed the socio economic link between health status and the income in 22 European countries. So you have this problem there to. But then you have ethnicity or race over laid or coveted. I think we all have a lot to learn from each other in that regard.

PHILIP JOHNSTON: Thank you so much, both of you. Are they not wonderful? Thank you so much. [Applause]

And Minister Schmidt was concerned that her English was not as good. I said it was spectacular. People could understand you very well. {Applause}

Hopefully we will be having some changes in this country in the next few months. And we hope this country will join the rest of the world in providing high quality affordable health care for every American.

Thank you all for coming. Thanks to Professor Reinhardt and Minister Schmidt for participating. Thanks so much professor for coming from Princeton and Minister Schmidt for coming all the way from Germany by Chicago.

UWE REINHARDT: I just want to add and thank the Massachusetts Health Policy Forum for sponsoring this, you are

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the Chairman, Michael Doonan in the back, [inaudible] facing is the Executive Director and Stuart is on the Board. I am sure you had something to do with this, like with everything that happens in America.

Somebody at some point should write a book, The Quotations of Ulla Schmidt because I marked down one more. It is the old Roman, [Speaking in foreign language] to err is human, but you told us [Speaking in foreign language] [laughter], To be crazy is human. [laughter] Thank you very much. [Applause]

[END RECORDING]