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Lessons From Unified Germany and Their Implications for Healthcare in the Unification of the Korean Peninsula

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This study investigated the German experience in the transition to a unified health care system and suggests the following implications for Korea. First, Germany could have made use of the unification process better if there had been a good road map. Therefore Korea must develop a well prepared road map that considers all possible situations. Second, Germany saw an opportunity for the improvement of the health care system in the early stage of unification but could not take advantage of it because the situation changed dramatically and they had not sufficiently prepared for it. Korea should take into account the opportunity for improvement of the present health care system, such as the roles of public health and traditional medicine. Thirdly, the conditions f North Korea seem to be far worse than those of former East Germany and also worse than even those of other transition countries. Therefore Korea should design a long-term road map taking as many variables into account as possible, including the different rigid way of thinking and the interrelationship among the social sectors. Fourthly, during the German reunification unexpected factors changed the direction of the events. Korea should have a separate plan for the unexpected factors.

Key words: German unification, Health care system, Korean unification

INTRODUCTION

Germany unified by 1990. On the occasion of the 20th reunification year, surveys and studies evaluated the German experience of reunification and determined it to be, in general, a success [1]. Korea is expecting to face reunification and can learn from the German experience. In this article, German health care transition experiences are investigated [2-4] and their lessons and implications for Korea are presented.

It should be noted that all aspects of the health care system cannot be treated in this article [5]. This paper focuses on the combination of financing sources and health care service delivery, that is, the social security side of health care. And we treat mainly ambulatory care. Secondly, the path dependency and the formative moment are the underlying framework of reference. Path dependency explains why the evolution of a system is governed in fundamental ways by beliefs, choices, and traditions unique to that society [6]. To elucidate the role of path dependency, this article starts at the pre-division German health care system. The formative moment explains how the trajectory of the path can be changed [7]. This change can be achieved by adoption of a new "collective memory" [8]. Collective memories are deliberately created by strategically act-

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ing political leaders in order to further their political goals and ambitions. This article will show that the two transitions of the German health care system in former East Germany were accomplished by the establishment of collective memory by the Soviet Union and then by West Germany.

HEALTH CARE IN PRE-DIVISION GERMANY

The prototype of the pre-division German health care system was formed in the late nineteenth century. Its basis lay in two related statutes: the Edict of the Emperor on German Social Insurance in 1881 and the Law for the Statutory Sickness Insurance for Workers in 1883 [9]. These statutes established the German social insurance system for health care. According to this social insurance system, all economically active people were obliged to obtain coverage by statutory sickness insurance based on conditions defined by law. Workers and employers had to pay a part of their incomes as insurance premiums. The medical services were provided free of charge as benefits in kind.

The pre-division health care system used a negotiation mechanism for its ambulatory care [3,9]. At the beginning, doctors working in a private clinic could treat the insured only on the occasion that one of the many sickness funds allowed for it according to the request of the corresponding physician. But this principle of individual agreements was changed into the corporatist collective bargaining agreement at the request of the doctors. This change in the negotiation mechanism was introduced by the recognition of the Sickness Fund Doctors' Association as a public law institution in 1931. In pre-division Germany, ambulatory care was provided by independent private doctors and inpatient care by local governments, churches, and private owners.

DEVELOPMENT OF HEALTH CARE IN EAST AND WEST GERMANY

East Germany

Overview

When World War II ended in 1945, Berlin was split into three Western Zones and one Eastern Zone by the Allies according to the Potsdam Agreement. The Soviet Union occupied the Eastern Zone, where East Germany, the German Democratic Republic (GDR) (Deutsche Demokratische Republik), was established. Communism was then introduced to East Germany by the Soviet Union. This meant that the healthcare sector was incorporated into the public institutions and all private economic interests were excluded [3]. This change eventually brought about the elimination of physicians' autonomy. However, in the early stage, the physicians still had a voice because doctors' cooperation was urgently needed under the circumstances of a shortage of medical staff and auxiliary personnel and the threat of infectious diseases.

According to the command of the Soviet military administration, the National Ambulatory Medical Institution (polyclinics, outpatient clinics, and workplace polyclinics) was established and integrated social insurance and the establishment of a single sickness insurance fund were promoted. The social insurance and the sickness fund were managed by the newly established trade unions, that is, the Free German Trade Union Federation (Freier Deutscher Gewerkschaftsbund). This federation of trade unions was subordinate to the Socialist Unity Party of Germany (Sozialistische Einheitspartei Deutschlands). Socialist state ideology ruled these institutions.

Almost all hospitals were nationalized (Table 1). One exception was applied to the church-run hospitals. They were protected by the Potsdam Agreement signed in 1945. An initial attempt of East Germany to regulate the church-run hospitals ended in failure. The poor economy had brought about a supply shortage of public medical institutions. On the other hand,

Table 1. Hospital ownership in East Germany: 1960-1989

Year	Total		Public hospitals		Free charitable hospitals		Private hospitals	
	n	Beds	n	Beds	n	Beds	n	Beds
1960	822	204 767	679	189 260 (92.4%)	88	13 523 (6.6%)	55	1984 (1%)
1970	626	190 025	523	176 536	82	12 540	21	949
1980	549	171 895	464	159 828	80	11 711	5	356
1989	539	163 305	462	151 969 (93.1%)	75	11 076 (6.8%)	2	260 (0.2%)

From Beske F, et al. The health care system in Germany. 3rd ed. Koeln: German Dortors' Publisher; 1999 [9].

Table 2. Ambulatory active doctors in East Germany: 1965-1989

Year	Ambulatory active doctors	Population per doctor	Doctors in private practice	Percentage of doctors in private practice
1965	7270	1740	2524	35
1979	10 690	1375	1888	18
1980	16 730	950	863	5
1989	20 840	808	340	2

From Roth H. The transformationsprocess of East German healthcare system: presented by ambulatory care. In: Korean Foundation for International Healthcare. German-Korean symposium for the reunification of health care system in Korea. Seoul: Korean Foundation for International Healthcare; 2009 [3].

the West German sister organization of the East German church-run medical institutions donated goods and state-of-the-art medical equipment, and people came to prefer the East German church-run medical facilities due to their excellence. Moreover, they had the nature of charities and were able to win the people's trust.

The position of the independently practicing doctors was not guaranteed under the new system, and independent practices were forced out of existence after a limited time. Independent and free doctors' organizations were generally prohibited. Measures to eliminate the roles of the independent physicians were taken in several stages. The decisive moment for this was the beginning of the Berlin Wall construction on August 13, 1961 because the concerns about the doctors' escape from East Germany disappeared with it. Forty years after the foundation of East Germany, the transition from the predivision health care system, in which the independent and free doctors were in charge of ambulatory care, to the system in which the state almost entirely managed and supervised ambulatory care, was almost complete (Table 2). In 1948 there were 6978 practitioners in the Soviet occupation zone, but there were only 398 practitioners in East Germany in 1988, and 62% of them were over 65 years old.

East German healthcare in general

East Germany had a policy of providing free medical services for all citizens and realized this plan in its healthcare system [10]. The Free German Trade Union Federation administered the social insurance premiums for sickness insurance and pensions. Social insurance premiums were 20% of gross income and the cost was shared equally by workers and their employers. There was an upper limit to the premium calculation, and people paid nothing other than the premiums. In the case of a budget deficit, the state intervened. Children and spouses were co-insured without any contribution. Family members without jobs could have voluntary pension insurance for 0.50 marks/mo. Freelance professionals such as artists, tradespersons, and pastors were able to obtain health insurance for about 10 marks a month from the State Insurance of the GDR.

All prescribed drugs were free. The importation of drugs from non-socialist countries to East Germany was forbidden until 1985. Ambulatory medical care was carried out in private and state practices, outpatient clinics, and polyclinics. Inpatient care was provided by hospitals and clinics in consideration of population density. There were also specialized hospitals, for example psychiatric facilities. The hospitals were run mostly by counties and districts. A small number of hospitals were run by churches.

Ambulatory care

The polyclinics were the main outpatient facilities of the East German public health system [11]. Polyclinics could be independent or belong to a company or be tied to universities. A polyclinic had more than 4 specialist departments, special dispensaries, and counseling centers. The specialist departments of the polyclinic provided ambulatory care. The polyclinics bundled outpatient care in various medical specialties under one roof. The polyclinic doctors were government employees and supported by nurses and other support staff, who were also public service personnel. The organization of a polyclinic is different from the concentration of independent individual practices, which are concentrated for organizational or economic reasons. The establishment of polyclinics meant the expansion of centralism in healthcare. Over time, the number of physicians in private practice steadily decreased, while the number of employed physicians in polyclinics and in state practice increased. In East Germany, people did not visit a family doctor but a polyclinic when they had smaller injuries, infections, or chronic diseases. Due to the concentration of many disciplines and the affiliation with facilities like radiology services and laboratories, a fairly high quality of medical care was possible in the polyclinic. Some polyclinics even possessed beds in a partial or pre-inpatient area and facilities for outpatient surgery.

Exceptions to the polyclinic principle were recognized specialists in private practice, especially in the larger cities. They occasionally held a venerable title such as Medical Officer

(Obermedizinalrat). A substantial number of dentists held their own private practices. Although they were under pressure to join the state system, it was relatively gentle, and they were able to resist.

State practices and state dental practices were also a part of East German ambulatory care [12]. In these institutions there were one or more doctors along with staff and employees. They earned a negotiated salary. Most of these practices were professionally and disciplinarily subject to a polyclinic. However, this did not mean that the polyclinic could influence the quality of their medical care. This form of ambulatory care continued to grow because in East Germany doctors could not open new private practices. The only exception was to inherit a parent's private practice. Therefore medical graduates could start work only in the public health system or in a parent's practice.

West Germany

Unlike in the Soviet occupation zone of East Germany, there were no fundamental changes in the West German health care system after World War II. The pre-division health care system was largely restored.

Table 3. Timeline of German unification and health care integration

Year	Events in general and in the health care system
1972. 12	Basic Treaty (Grundlagenvertrag)
	Reconciliation and rapprochement of East and West Germany
1974. 4	Health Agreement (Gesundheitsabkommen)
1989. 11	Fall of the Berlin Wall
1990. 3	First free election in East Germany and new government
1990. 5	State Treaty for Monetary, Economic, and Social Union (Staatsvertrag zur Waehrungs-, Wirtschafts- und Sozialunion)
	Article 22 on health care system
1990. 7	Law for Restructuring of the State Ambulatory Health Care, Veterinary System, and Pharmacy System (Gesetz zur Umstrukturierung des staatlichen ambulanten Gesundheitswesens, Veterinaerwesens und Apothekenwesens)
	Important prerequisites for privatization
1990. 8	Unification Treaty (Einigungsvertrag)
	45 Articles, including articles on health care system
1990. 8	Hospital Financing Act (Krankenhausfinanzierungsgesetz)
1990. 9	Health Insurance Establishment Act (Krankenkassenerrichtungsgesetz)
1990. 9	Health Insurance Contract Act (Krankenkassen-Vertragsgesetz)
2000. 1	Law on Legal Harmonization of Statutory Health Insurance (Gesetz zur Rechtsangleichung in der gesetzlichen Krankenversicherung)

Concluding Remarks on the Pre-unification Period

After 1945, two opposing health care systems emerged in East Germany and West Germany, that is, a centralized health care system in East Germany and decentralized self-governing health care system in West Germany. Until the 1970s, the health care system in East Germany was evaluated as positive. But due to under-financing, personnel shortages, and lack of access to modern equipment, the health care system in East Germany began to fall behind the standards of western industrialized countries after the beginning of the 1980s. According to the Statutory Sickness Insurance Modernization Act of 2004, West Germany self-evaluated its health care system as positive in general, but saw drawbacks in quality that did not correspond to the cost, and the lack of information for patients. In sum, the East German health care system primarily faced the problem of developing countries, that is, a lack of sufficient resources, and the West German health care system had the problem of the western industrialized countries, that is, quality improvement and wider possibilities of choices.

THE PROCESS OF GERMAN UNIFICATION AND HEALTH CARE INTEGRATION

Overview

The following table gives a timeline of German unification and health care integration (Table 3).

Developments in East Germany Early in the Unification Process [3]

At the end of 1989, the crisis in the East German health care system was escalated, particularly due to personnel shortages. The last East German Minister for Health and Social Welfare demanded, among other things, an increase in salaries and in material and financial resources for health care. For example, he proposed that government spending for the Department of Homeland Security and the National People's Army should be reallocated to health and social policy. On 1 March, 1990 there were significant increases in salaries in the East German health care system. Early in the reunification process, East Germany took the perspective that they had their own achievements in the field of health and social policy that deserved to be preserved, and especially saw the exclusion of commercialization from health care as a historic achievement.

The Early Perspective of West Germany [3]

Until the 1970s, discussions about alternative forms of organization of ambulatory care were considered to be almost illegitimate in West Germany. At the beginning of the 1970s, however, demands for reform of West German health care were increasing. Alternative forms of organization have been proposed. For example labor unions criticized the private practices of physicians because they no longer met modern medical standards. It was proposed that medical-technical centers be established and they should be non-profit corporations with salaried physicians. There, all elaborate diagnostic procedures for the doctors of a region should be performed. In the context of the scientific and political debate about the crisis and reconstruction of the German welfare state and particularly in the discussion on competition in health care, the monopoly of the sickness fund doctors' associations was questioned again more intensively. In these debates, politicians and experts of West Germany considered at least some social institutions and social benefits of East Germany to be possible models for necessary reforms of West Germany. Therefore, it was not surprising that after the collapse of East Germany many health policy experts from both sides developed proposals for reform of the East German health care system, but not by an unmodified transfer of West German structures.

Policy Turnabout Under Adverse Circumstances [3]

The initial position of both East and West assumed a mid- and long-term process of reunification. However, it was soon revealed that the timeline for reunification made by the two German governments would not be feasible because of the rapid fall of the East German economy and continually growing emigration of East German residents. Thus, the reunification of Germany had to be planned and carried out under time pressure. During the negotiations on the first State Treaty (May 18, 1990), the negotiating partners agreed on the exact plan for the transformation of the health care sector within only a few weeks. First, a chamber system for doctors, dentists, and pharmacists would be established, and the freedom of medical practice for doctors and other health professionals would be introduced. This meant a departure from the previous East German state health care system and acceptance of essential elements of the West German health care system. Secondly, it was also emphasized that polyclinics, which had been a key pillar of citizen-friendly ambulatory care and the powerful structures of company health care as well as the close connection between inpatient and outpatient care, should be preserved. However, this idea of mixing the two systems and incorporating some positively viewed elements of the East German social system in a new common welfare state was rejected. This means that the West German negotiators' positions were enforced. The main reasons for the takeover by the West German health care system were time pressure and the fear that controversial political discussions and social confrontations could endanger the enterprise of "German Unity". In addition, the vast majority of people also believed that the West German welfare system had proven itself overall successful and that a mixture of both systems could be doomed to failure. The effect of inertia of the West German institutions and traditions also played a role. There was also fear that the process of adaptation of the East German economy to the free market conditions would be complicated and the government and economy of the unified Germany could be overloaded if the East German decommercialized system were combined with the high standards of the West German welfare state.

The following table summarizes the negotiation phases of the health care integration according to time, subjects, and contents (Table 4).

ASSESSING HEALTH CARE IN UNIFIED GERMANY

Health Care Transition: Upside

In 2009, the Epidemiological Department of the Robert Koch Institute in Berlin presented an investigation report [1,4]. This report demonstrated to what extent the former East Germany has caught up to the medical standards of the West in the past 20 years. The life expectancy, morbidity, and structure of health care and its use by the population have already aligned themselves largely with the former West Germany 20 years after the fall of the Berlin Wall. The Robert Koch Institute evaluated the transformation of the health care system as a success because most of the health problems identified shortly after the reunification have disappeared. For example, the life expectancy of East German women in 2006 had increased by 6.2 years compared to 1990, coming up to the West German level of just under 83 years old. The life expectancy of men was 76 years old in 2006, at 1 ½ years under the West German level.

West Germany supported the upgrading of infrastructure in the eastern part through an immediate aid program [2]. Through it, the problem of the shortage in health care could be miti-

Table 4. Overview of the negotiations on health care integration

When	Who	What
1990. 1	Representatives of the Federal Insurance Office of West Germany and the social security of workers and employees of East Germany	Neither the creation of the social union nor the German unification was on the agenda
1990. 1-3	East and West German government and health policy experts	Initial position of both countries assumed a mid- and long-term process of unification
		Many health policy experts from both sides developed proposals, which provided for the reform of the East German health care system but were not an unmodified transfer of West German structures
1990. 3-5	East and West German government	New East German government decided on the fastest way toward unification according to Article 23 of the German Basic Law because of the rapid fall of the East German economy and continually growing emigration of East German residents
		The idea, to mix two systems and to take over some positively viewed elements of East German social system in a new common welfare state, was rejected by West Germany
1990. 5-9	East and West German government	A series of laws were enacted, which brought about a departure from the previous East German state health care system and acceptance of essential elements of the West German health care system

gated.

It was also thought that the negative relationship between patient and physician under an autocratic health care system could be transformed to a trust relationship by securing the physician's independent status [4].

However, those who interpret the German transformation as a success also point out that it was only possible because Germany was under relatively good conditions compared to countries formerly in the Soviet sphere of influence, for example, in Central and Eastern Europe and Central Asia [4]. These other countries had hoped that they could transform their systems to those like the West, but the transition took place under very difficult conditions and has certainly not reached completion. The main reason why these countries were not successful is that the way of thinking formed over a long period of time cannot be changed quickly, and in addition, health care is only one of many areas that require change. Therefore it has been thought that foreign aid will be necessary for the health care transition of former Soviet countries with difficult conditions.

Health Care Transition: Downside

Although the one-sided adoption of the West German health care system has generally been accepted, differing opinions remain. The most common alternative opinion is that the transformation process was driven too quickly and the incorporation of the good components of East German health care, although desirable, was thus impossible [3]. For example, polyclinics with public or semi-public characteristics are considered to be a health care component that could have been expanded into community health care centers for ambulatory care.

CONCLUSION: IMPLICATIONS FOR KOREA

The German Experiences of the Transition of the Health Care System Suggest Implications for Korea

First, it should be noted that Germany could have made the reunification process more effective if there had been a well prepared roadmap. The reunification happened unexpectedly. Therefore, it is necessary for Korea to develop a well prepared roadmap that sufficiently takes into account all possible situations.

Second, it is recommended that the roadmap take the opportunity to improve the present health care system. Germany saw this opportunity in the early stage of the reunification process. However, they could not take advantage of the opportunity because the situation was changing dramatically and rapidly, and they had not prepared for it sufficiently. Korea, however, could use the reunification process for the improvement of the health care system if they prepare for it well. For example, the role of public health and traditional medicine in health care system could be the subject.

Thirdly, the conditions of North Korea seem to be far worse than those of the former East Germany and also worse than even those of Eastern and Central Europe. Therefore, Korea should design a long-range roadmap and consider as many

factors as possible as an integrated whole, including the different and more rigid way of thinking in the North and the interrelationship among the social sectors.

Fourth, during the German reunification there were unexpected factors that changed the direction of the events. Therefore, it is recommended to have contingency plans for unexpected outcomes.

CONFLICT OF INTEREST

The authors have no conflicts of interest with the material presented in this paper.

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