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1 Executive Summary

This report starts with a short description of the German pension landscape and the fundamental shift that has been taking place because of political decisions in recent years. A ceiling for the contribution rate of the social pension insurance results in a drastic reduction of the benefit level, which is supposed to be compensated by capital-funded pensions (this, at least, is the political wish). This has far reaching consequences for income and income distribution in old age. Growing poverty in old age in the future can be expected. Although the financing of the social pension insurance scheme improved in 2010 compared to the year before, the government tried to reduce some obligations in this field. In 2010, there was no adjustment of social insurance pensions, resulting in decreasing net and real pension benefits. The debate about the already politically decided increase in retirement ages has continued but has lost in power. The topic of increasing flexibility in retirement may receive more attention in the future. An extension of coverage in social pension insurance for those self-employed that are not yet member of a mandatory pension scheme is discussed. Because of a decision of the Federal Constitutional Court, the indexation of the means-tested basic transfer payment for old and disabled persons is no longer linked to the adjustment rate of social insurance pensions. This could be an additional reason for a tendency towards growing poverty in old age in the future. This topic now receives great attention. The government announced that it would establish a governmental commission to deal with this topic, but in May 2011, the government has announced a “pension dialogue” instead of a commission. Although there are some proposals for redesigning the present pension policy, this has not received any political support so far. Public debt, which has grown in particular during the financial crisis, will put public expenditure and, particularly social expenditure, under pressure.

The current health reform of 2010 is an enhancement of the previous reform in 2007. The so-called health fund, which has separated redistributive elements (quasi-taxes) from the financing of health care, remains. But some shortcomings have been overcome. Concerning the extra premium, compensation for low-income insurees is now paid by the health fund instead of the individual social health insurance (SHI), as was the case before. Therefore, for an SHI there is no risk anymore to go bankrupt if it has too many low-income insurees. Although compensations for low-income insurees still does not take into account all kinds of income but only wage income. In the long run, compensations should be better paid out of taxes. What is more, there are still two parallel and incompatible health insurance schemes, the SHI and the private health insurance (PHI). The two systems should converge in the long run. Furthermore, competition between SHIs has been strengthened once again. However, still SHIs are almost unable to pass on this strong competition to the health providers because there are only few possibilities for selective contracting between SHIs and health providers. Moreover, with the GKV-FinG growing health care expenditures will not necessarily result in higher income-dependent contribution rates but in higher extra premiums.

In the case of LTC, substantial progress has been achieved by introducing standardised transparency reports, which make it possible to compare the quality of different nursing homes directly. There is some criticism on the transparency reports. They should be refined in the future. Moreover, there are already signs of a lack of qualified nurses. Measures have to be taken in order to increase the supply of qualified nurses. Otherwise the growing demand for care cannot be satisfied. Finally, there is still no solution on how to make the social LTC insurance financially sustainable. The German government is planning an LTC reform in 2011. If it does not address this issue, the contribution rate for social LTCI will continue to rise.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Pensions

2.1.1 The system's characteristics and reforms

The structure of pension schemes in Germany

Pensions in Germany come from many different sources and are often organised according to the status of groups of people in the labour market. For a long time now, three tiers of pensions schemes have existed:

- mandatory basic pension schemes for different groups of the population[1] as the first tier,
- occupational schemes as the second tier and
- private voluntary arrangements for old-age provision as the third tier.[2]

Germany had no general minimum pension, but means-tested social assistance for all persons below a certain poverty line. Since 2003, however, a new element exists: a means-tested transfer payment in case of insufficient income for persons aged 65 and older, as well as for disabled persons (*Grundsicherung*). The benefit amount is calculated in the same way as the already existing means-tested social assistance.[3] But this transfer payment can now be labelled as part of the pension schemes – like a *zero tier*.

Regarding the first tier, social (statutory) pension insurance (SPI) is by far the dominating element from a macroeconomic point of view, and also as a source of income in old age (at least on average). It covers, in principle, all blue and white-collar workers (including miners[4]), but also some groups of self-employed. It is PAYG-financed with only a very small (in fact inadequate) reserve fund. Financing stems mainly from earnings-related social insurance contributions, but also from federal budget tax revenues.[5] Pensions were up to recent developments in pension policy from the defined-benefit type.

There are other elements that act as first tier for certain groups of the population. Quantitatively important are *civil servant's pension*. They are up to now also PAYG-financed, but are currently in the process of shifting towards capital funding. Other schemes are for *farmers* (PAYG-financed, mainly from tax revenue) and for several *groups of professions* like doctors or lawyers, where the financing is mainly capital-funded.

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1 At least mandatory pension schemes provide old-age and disability pensions as well as pensions for widows/widowers and orphans.

2 Information on the structure of Germany's pension schemes and statistical data are included, in particular, in the most recent governmental reports, "Rentenversicherungsbericht 2010", "Alterssicherungsbericht 2008" and "Versorgungsbericht 2009" (the latter focussing on schemes for civil servants and employees in the public sector).

3 There exists mainly one major difference: in case parents claim social assistance, children are no longer obliged to pay back the whole sum or part of it (depending on their own financial resources), if the own income of children does not exceed EUR 100,000 per year. The maximum transfer payment from this scheme constitutes the respective country-specific poverty line in Germany, which determines eligibility for such means-tested transfer payments. Not only the sum of expenditure but also the number of people receiving this transfer payment has grown remarkably in recent years.

4 Here different rules exist as well as a high percentage of tax-financing.

5 In particular covering those expenditures that are aiming at an interpersonal redistribution of income within the scheme.

Occupational pension schemes are the *second tier* of the German pension system. They are in general *voluntary* in the *private sector.* A great variety exists in the design of these schemes. Traditionally, pensions were mainly defined-benefit, employer-financed and "capital-funded", but not necessarily linked to the capital market, because the major part of existing pension claims is still based on direct commitments of the employer (*Direktzusage*) and based on book reserves. Mainly for this type of occupational pension claims, a mandatory insurance of employers is in place (Pension Protection Fund, *Pensionssicherungsverein*), covering pension claims in case of insolvency of the company – up to a certain, but very high limit. However, a shift is taking place towards other types of occupational pension arrangement that are linked to the capital market as well as towards being financed mainly (directly[6]) by employees (and no longer employers) and towards defined contribution instead of defined benefit. This takes place in particular because of a new right for the employee – introduced in 2001 – to use earnings up to a certain amount to accumulate an occupational pension claim ("earnings conversion"), without paying income tax and social insurance contributions on this part of earnings.

Occupational pension schemes for wage and salary earners in the *public sector* are based on collective agreements. These pensions were linked to the development of the social insurance pensions and to the civil servant's pensions.[7] This link has since been abolished. And according to a new collective agreement, there will be a change from defined benefit to defined contribution.

As *third tier,* there exists a great variety of *voluntary* capital-funded additional types of saving for old age, some with risk pooling (life insurance), others without such insurance elements, and some types are tax-privileged. At the centre of the public debate are those private pensions that fulfil certain requirements (and then will be certified) as a precondition for a subsidy. Among these requirements is the condition that at least the nominal value of contribution payment should be guaranteed (zero rate of return).[8] Beside such tax-privileged types of saving for old age, there exist many others without such subsidies. However, it is difficult to say how much of such savings is for old age.

Structural reform

It is an explicit political goal to change the pension landscape and financing of pensions more towards private (including occupational) pensions and capital funding, in particular by reducing PAYG financing by scaling down social pension benefits, as well civil servant's pensions[9], and giving incentives to save in capital-funded schemes.[10]

Regarding SPI (social pension insurance), target values for the contribution rate were decided: Not higher than 20% up to 2020 and not higher than 22% up to 2030. Several measures were taken (in particular a redesign of the formula to calculate and adjust pension benefits) in order to realise this in the process of population ageing, resulting among others in a stepwise

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[6] Occupational pension claims financed by the employer will mainly be a deferred compensation and, therefore, "indirectly" financed by employees.

[7] Based on the objective that wage and salary earners in the public sector shall, in total, receive benefits from social insurance and supplementary pensions together, according to the level of civil servants' pensions, as a final salary scheme.

[8] Such pensions are called "*Riester pension*", after Walter Riester, who was Minister for Labour and Social Affairs of the federal government at the time of implementation.

[9] In April 2009, the federal government published its report on public pensions (4. Versorgungsbericht). In this report it was underlined that step by step there will be full capital funding of federal civil servants' pensions.

[10] The reform strategy and its effects on pension schemes as well as on pensioners is discussed in Schmähl (2007) and (2011a).

reduction of the net pension level by 2030 by about 25% (a quarter). The emerging gap in income in old age is intended to be closed by private voluntary, but subsidised pensions.

The new pension strategy of Germany was implemented mainly by pension reform measures in 2001 and 2004. A much debated additional reform measure is the increase of the "standard" retirement age, i.e. when an old-age pension can be claimed without deductions from the full pension. This retirement age will be increased gradually from 65 to 67, starting in 2012 up to the year 2029. Changes within SPI (regarding, for example, the level of benefits and retirement ages) will, in principle, also become effective for civil servants' pension schemes. Such schemes exist at the federal level (*Bund*) as well as at the level of the 16 states (*Länder*).

Subsidised private pensions

The costs of private pensions are still discussed, although there exist subsidies.[11] It is still complicated for employees to decide which type of pension saving is best, because often there is a lack of transparency, for example, regarding costs. Also, the rules for taking up the subsidy are not transparent enough, so that persons can lose the subsidy because of not reacting in the right manner. Therefore, in May 2011, the government decided to change at least a specific rule about the necessary own contribution rate to avoid unintended effects. Thus, this requirement will be easier to fulfil.

There is also a debate to give some groups of the population not yet eligible to save in this specific subsidised form the possibility to do this. Whether this will take place depends, to a degree, on the conditions of the federal budget.

2.1.2 Debates and political discourse

Although in 2010 no new reform measures in pension policy were decided or major changes took place, there were debates on several important elements of former decisions, above all the increase of the "standard" retirement age. However, in principle, the strategy for developing pension policy in Germany, i.e. reducing PAYG-financed SPI pensions and increasing the relative importance of capital-funded private (and occupational) pensions, not as a supplement but in part as a substitute for the public pensions, was undisputed by the majority of the political parties[12] and has remained unchanged so far.

Economic, in particular labour market development and the instrument of short-term employment

Compared to 2009, a year of severe economic problems resulting mainly from the financial market crisis and its effects on the "real economy", the economic conditions in 2010 improved much more than expected. Finally, the number of unemployed was 5.2% lower than in 2009, and the number of employees covered by social insurance increased by 1.2% and gross wages by 2.8%.[13]

As an instrument to fight against unemployment resulting from the financial crisis, short-time work was used intensively. Already in the past, existing rules for access, financing and duration of short-time work had been changed several times to give an incentive to companies not to lay off workers. The federal government made it even easier for employers to reduce the amount of working hours without dismissing their employees. This was possible by extending the maximum length of the so-called short-time work benefits (*Kurzarbeitergeld*)

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[11] Die Ratlos-Rente, in: Tagesspiegel 21/22 April 2011.

[12] I.e. neither CDU/CSU, FDP or Green Party, but with the exception of "Die Linke" party. In the SPD, too, there are at least some critical voices.

[13] Bundesministerium der Finanzen April 2011.

from initially six months to a maximum of 12 months at the beginning, and to even 24 months later. If the employer decides to use this measure, the employee receives – as in the case of unemployment[14] – 60% (67% if he or she has at least one child) of the difference between normal and reduced net income by the unemployment insurance agency. Employers benefit from a new regulation. At the beginning, they were compensated for only 50% of the rate that the employer would have to pay for social pension and social health insurance on the short-time work benefit. This compensation was then increased to 100%, starting from the seventh month of short-time work. This reduces labour costs, so that the employer is more likely to keep the employee in the company. The extended period for claiming short-time work benefits of 24 months was originally limited to the end of 2009. Thereafter, the maximum length of the benefit would be back to the "normal" six months only. The compensation for the employer should only be given for short-time work contracts up to the end of 2010. But the government decided already at the end of November 2009 that employers could also claim for short-time work in 2010, but only for 18 instead of 24 months. The compensation for the employer would not be extended, however, beyond the end of 2010, according to an announcement of the federal government in November 2009. But in April 2010, the federal government declared it will once more extend the special subsidy financed by unemployment insurance for short-time work by another 15 months up to March 2012. This was finally decided by the parliament in July 2010. In addition, some other rules, in particular for improving the employment of older workers, were also extended beyond the end of 2010. In general, the instrument of short-time work is looked upon as the most important reason for a development on the labour market that was much less severe than expected.

Because SPI receives contributions also from this short-time work benefit, it stabilised its financing base remarkably. In November 2009, the social pension insurance was expecting contribution revenues in 2009 to be as high as in 2008 and a balanced budget, so that the contribution rate remained constant at 19.9%. For 2010, a *deficit* of nearly EUR four billion was expected in autumn 2009 (while in 2008, there was a surplus of about the same amount).[15] By June 2010 a *deficit* of "only" about EUR 1.3 billion[16] was expected, and by October already a surplus of EUR 1.3 billion. By the end of 2010, a *surplus* of about EUR two billion existed.[17]

Meanwhile, short-tie work became less important as labour market conditions improved. While in April 2009, calculated as full-time equivalent persons, 393,136 workers received short-time work benefits (this was the maximum), in October 2010, it was less than 1/6, namely 63,803.

Reducing the burden for the federal budget by measures affecting social pension insurance

In June 2010, the government, in an attempt to consolidate the federal public budget, decided to shift the financing of some benefits from tax to contribution-financing (i.e. for a number of pension claims that are explicitly aimed at interpersonal redistribution), namely by stopping transfer payments from the federal budget to the social pension insurance for some expenditure, because of special rules resulting from decisions in the process of the German unification. Although this is quantitatively of minor importance, from a distributional point of

[14] The unemployment benefit is limited to a certain number of months, too. Thereafter a means-tested transfer payment is granted.
[15] See Gunkel (2009).
[16] Genzke (2010).
[17] Genzke (2011). Another example on how conditions improved: At the end of January 2010, the federal government expected a decrease in mandatory contribution revenue by 0.7%. But in fact these contribution revenues increased by 2.3% in 2010 compared to 2009.

view it is a problem if such redistributive expenditures are financed by contribution payments, because this weakens the contribution-benefit link.[18]

Another measure to reduce federal expenditure was to cancel contribution payments for those unemployed persons that receive a means-tested transfer payment (*Arbeitslosengeld II*) (volume EUR 1.5 billion per year). In the past, these contribution payments were already reduced. This means that persons receiving this transfer payment get no pension claim. This can be an additional reason for pension benefits after retirement or in case of disability that are too low to finance one's living.

No adjustment of social insurance pensions in 2010

Like in the three years from 2004 to 2006, again no pension adjustment took place in (July) 2010 (which has, of course, from a fiscal point of view a "positive" effect on pension expenditure of SPI). According to the formula for adjusting pensions, and beside the development of average gross earnings, there are two additional factors implemented which aim at a reduction of the pension adjustment rate (the impact on the adjustment rate is about -0.5% to -0.6% per year). Beside these factors, the wage rate (at least in West Germany) became negative. Therefore, the pension adjustment rate would have been negative, amounting to -2.1% in West Germany and -0.55% in East Germany. But because of existing guarantees not to reduce the absolute amount of (gross) pension benefits, the adjustment rate became zero. This was criticised by several actors, such as employers and those who support the structural change in pension policy mentioned above, and even including by the Minister of Economics of the Federal Government.

In July 2011, however, a process will start to compensate the effect of not realised negative pension adjustment: In case of a positive adjustment rate resulting from the pension formula, this rate is cut by 50%, for as long as it is necessary to realise the compensating effect.

Additional effects for the development of net and real pension benefits

In January 2011, the contribution rate in statutory *health* insurance was increased from 14.9% to 15.5%. While the *gross* social insurance pension benefit has remained constant in nominal terms from July 2009 to June 2011, the increase of the contribution rate for health insurance reduces *net* pension benefits. In the future, the contribution paid by SPI to health insurance in favour of the pensioners will not be – as in the past – half of the contribution rate. It will (like the employer's contribution rate) remain constant. Therefore, all increases in the health insurance contributions rates[19] will be paid exclusively by pensioners (as well as employees) and will reduce net pension benefits.

The increase in consumer prices (by 1.1% in 2010 compared to 2009, by 2.1% in February and March 2011 compared to these months in 2010) have already reduced *real* pension benefits in absolute terms because of constant gross and sinking net pension benefits. In spring 2011, the federal government expected an increase in consumer prices by 2.4% for the year 2011.[20] This will be much higher than the expected pension adjustment rate of about 1% only in July 2011.

Adjustment rate of basic means-tested transfer benefits and of social insurance pensions

[18] This is also underlined by the permanent Social Advisory Board of the government (*Sozialbeirat*) in its report of November 2010.

[19] Beside the general contribution rate there can be additional contributions by the different health insurance institutions (*Krankenkassen*), that are also paid only by the insured members.

[20] Bundesministerium der Finanzen, 2011, p. 27.

The Federal Constitutional Court demanded a change in the adjustment procedure of basic means-tested transfer benefits (relevant also for the basic means-tested benefit for people in old age or with disability, the so-called *Grundsicherung*). In recent years, the development of this transfer payment was linked to the pension adjustment rate between the years of a new income and expenditure survey (*Einkommens- und Verbrauchsstichprobe*), which takes place every five years. The court demanded a change because this link was not seen as being adequate (the reasons for this are not discussed here). Government und parliament reacted and the link between the basic transfer payment and pension adjustment rates was abolished.[21] Now the transfer payment is linked to the development of a specific price index and average net earnings in the years between a new statistical survey instead.[22]

If the means-tested transfer payment is adjusted by a higher rate than pension benefits from SPI (because of the specific design of the pension adjustment formula, so that pensions are increasing at a lower rate than earnings), it can be that more and more pensioners are eligible to claim the means-tested benefit, as otherwise they fall below the poverty threshold.

Retirement Ages

Regarding *retirement ages* it is still discussed whether the already decided increase of the "standard retirement age" (that means the age for claiming a pension without deductions from the full pension), which that is supposed to start stepwise in 2012, is compatible with the labour market conditions and employment chances of older workers. Above all, trade unions and organisations representing, in particular, older people (*Sozialverbände*) have been fighting against this decision. However, the government has never shown any signs of changing the former decision. This became obvious in the answer of the federal government to questions raised by the party "Die Linke" in parliament.[23] In 2010, the government had to give an assessment on whether the increase of retirement ages was still regarded as an adequate measure. This report[24] stated clearly that from the government's point of view this remains *necessary*, due to demographic ageing (and in order to improve well-being, to realise equity between generations and to enhance the international competitiveness of Germany) and *acceptable,* due to the positive development for older workers on the labour market so far and due to the fact that it will increase the income situation of future pensioners.

The permanent Social Advisory Board of the German government (*Sozialbeirat*) gives an overview of the arguments that are used in the German discussion in favour and against an increase in retirement ages in its report of November 2010. The members of the board – mainly from trade unions and employer's organisations – still have different opinions on this topic. However, they all underline that demographic change will not automatically improve labour market conditions of older workers remarkably.

Extending mandatory coverage in statutory pension scheme[25]

This is particularly being discussed in respect of those self-employed persons who are not yet mandatorily covered in one of the existing pension schemes. The question is whether there should only be mandatory coverage in private schemes or also mandatory coverage in SPI. There are many arguments in favour of integrating these persons into the SPI (Fachinger, Oelschläger and Schmähl 2004, Ruland 2010). But the heterogeneity of this group needs special attention (discussed also in Fachinger and Frankus 2011).

[21] GesetZ zur Ermittlung von Regelbedarfen und zur Änderung des Zweiten und Zwölften Buches Sozialgesetzbuch vom 24.3.2011, BGBl., Jg. 2011, Teil I, Nr. 12.
[22] The price index has a weight of 70%, the earnings development of 30% for this specific adjustment rate.
[23] BT-Drs. 17/2271, 23.6.2010.
[24] Bundesministerium für Arbeit und Soziales, Aufbruch in die altersgerechte Arbeitswelt, 2010.
[25] This topic is also discussed in German health insurance (Bieback 2010).

There are calculations that an integration of these self-employed persons into the social pension insurance scheme may reduce the contribution rate for several decades (Windhövel et al. 2011). However, the main argument and aim for covering those persons is to avoid insufficient income in old age, avoiding poverty in the case of long spells in the earnings career without adequate saving for old age. Obviously, there exist no constitutional restrictions in covering those persons in social pension insurance (Ruland 2010), and it seems that the political intention to decide upon activities on this topic is growing.

Such an extension of coverage of the SPI, focused only on special groups of self-employed who are not mandatorily covered, seems to be a realistic approach. However, it is sometimes argued that *all* persons working in Germany should become a member of the social pension insurance, i.e. civil servants, too. This would create a lot of transitional problems (also of additional financing burden) and does not seem to be a realistic (political) proposal, even in the medium term.

Deductions from the disability pension in the social pension insurance scheme

Given that old-age pensions are reduced in case of claiming the pension benefit before the "standard" retirement age, it was often expected that it could become more attractive to claim a disability pension (in particular after a period of unemployment) if there is no deduction from the full amount of this benefit. Therefore, a gradual deduction was introduced in 2001, and from December 2003 a maximum of 10.8% (0.3% per month) was introduced when claiming disability pension before the age of 63. In case of claiming the benefit before the age of 60, "only" the 10.8% deduction is made. There was a dispute among different "*Senats*" of the Federal Court for Social Security (*Bundessozialgericht*) about whether this deduction also for pensioners who are not 60 yet is compatible with the constitution. The Federal Constitutional Court (*Bundesverfassungsgericht*) decided in January 2011 that the rule is compatible with the German constitution (*Grundgesetz*).

Beyond this special law case, the decision of the court is insofar interesting as it makes some remarks regarding the limitations if pension claims are negatively affected by political decisions, i.e. if the financing situation of the SPI is improved, measures that reduce pension claims are permissible from a constitutional point of view, if the changes are linked to an element which is causal for the financing situation. This illustrates (once more) that the constitutional restrictions for politically decided reductions in pension claims are rather low. This gives government and parliament a multitude of possibilities for decisions that negatively affect pension claims in SPI, although, in principle, such claims (at least those claims accumulated by own contribution payments) are looked upon as individual property.

Still existing differences in pension law between East and West Germany

Twenty years after the German unification there still exist differences in rules – in particular also in parameters of the pension formula – between West and East Germany. The coalition government announced to decide about a solution for this issue; however, no decision was taken by spring 2011. Some information on this topic was given in last year's NRP. It is necessary that any equalisation of rules has to be done in such a way that all elements in the pension scheme that are still different in East and West have to be taken into consideration, as well as the effects for employees and pensioners in West and East Germany. This has also been underlined by a representative of the Ministry of Labour (Flecken 2010).

2.1.3 Impact of EU social policies on the national level

It has become more and more obvious that national pension policy is directly and indirectly influenced by what happens at the European level. All types of institutions in the area of old-age security are affected.

Looking at 2010, there seems to be no *direct* effect regarding SPI. How much indirect effect exists, for example by providing arguments for specific decisions and by the process of the OMC, is difficult to say. Life insurance companies and several types of occupational pension schemes are affected by new rules for regulation. Moreover, the need to calculate unisex tariffs is a much debated topic.

Many organisations have responded to the questions set out in the Green Paper towards adequate, sustainable and safe European pension systems from July 2010 (among them was also a statement of the GVG). In many organisations this stimulated reflections on central topics of pension policy, as well as on developments that take place at the European level and its relevance at the national level for different institutions. Amongst other issues, the rules of Solvency II and how appropriate they are for life insurance companies and occupational pension schemes are discussed intensively.

A common position of all relevant actors is that pension policy should remain the responsibility of national authorities, although exchange of information, etc., is highly welcome. Nevertheless, there is some fear of a growing influence of the European level in this area.

But also the influence of the European level in general and the process of increasing transfer payments between EU countries in particular have revealed a remarkable sensitivity in the public debate.

2.1.4 Impact assessment

Higher "standard" retirement age

A decision on increasing the pensionable age has already been taken (see above).[26] It might be possible that another debate will flare up about possibilities for (more) flexibility in retirement ages, particularly about combining (partial) pension and part-time work (see for example Kreikebohm 2010). This topic is not new at all but it could now also be a helpful element to overcome opposition against extending working lives. For many years an option for partial pension has existed in Germany, but this has up to now not been a success story at all. Reformulating the conditions for taking up a partial pension next to labour income could be a useful element in a strategy to extend the working life and to create options, particularly for those who are not able to work longer on a full-time basis.

The effect on the financing situation of the SPI is rather modest. It is expected that the contribution rate will be about 0.5 percentage points lower in 2030, compared to the conditions without increasing the retirement age. However, in the public debate the financing argument (fiscal sustainability) is often mentioned as decisive.

Regarding the intention that many employees should stay in the labour market longer, much more attention seems to be necessary to prevent illness and disability as well as to develop rehabilitation measures, in order to maintain or to improve the employability of workers and to enable them, in principle, to stay longer in the labour market, providing employment opportunities exist.

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[26] There are also decisions aiming at a reduction of early retirement.

The conditions for older workers in the labour market are still not favourable, despite improvements during the last years. The recent positive development of the labour market, but also the institutional changes in social security (among them ending early retirement possibilities), are seen as causes for this development (Walwei 2010).

Emerging poverty in old-age

All available indicators show that old-age poverty in Germany is *currently* relatively low compared to some other population groups and also in comparison with many other countries. In addition to indicators agreed upon in the EU for (international) comparisons, there exists an "official" poverty line in Germany, which is decisive to become eligible for receipt of specific means-tested social benefits. These benefits can indeed prevent poverty. For elderly (65+) and disabled persons a specific means-tested benefit, a so-called "basic income in old-age" (*Grundsicherung*; similar to social assistance), has existed since 2003 to top up income below the (household-specific) poverty line.

At the end of 2009, 2.37% of those 65 or older received the above mentioned basic income in Germany; 65% of all beneficiaries were women.[27] The beneficiary ratio is higher in West Germany (2.55% excluding West-Berlin) than in East Germany (1.05% excluding East-Berlin). The ratio is highest in the three city states: Hamburg 5.28%, Bremen 4.81%, and Berlin 4.68%.

Indicators defined on the basis of a certain percentage of income achieve higher ratios. The ratio of "people at risk of poverty or social exclusion (65+)", according to Eurostat (EU-SILC) data, has increased in Germany since 2005 and was 16% in 2009 (13.8% for males and 18% for females). Three data sources for Germany (2008) always show a lower ratio for the elderly compared to the average of the total population:

15.0 (65+) 15.5 (total) EU-SILC

12.0 (65+) 14.4 (total) Microcensus (Statistical Office)

13.3 (65+) 14.6 (total) Socio-Economic Panel.

The indicator "severe material deprivation"[28] for the age group 65+ gives low rates for Germany (in 2009 2.5% on average).

In the past, the "dynamic" social insurance pension scheme contributed to a high degree to old-age poverty alleviation. A quite different story is how pensions and pension policy contribute to the objective of reducing poverty in the future. The opposite may be the case. An important effect of the reduction of the net social pension level will be a growing number and a higher ratio of pensioners receiving pension benefits from social insurance which are below the existing means-tested "basic income in old age" in the future (together with effects on individual pension claims by unfavourable labour market conditions, e.g. long spells of unemployment for many employees).[29] Coverage and the amount of occupational and private pensions are by far not high enough to compensate for the loss in the level of public pensions.[30] Meanwhile, a public debate about rising old-age poverty in the (near) future has started. The present coalition government announced to establish a governmental commission to deal with this topic, which for many years had been a non-issue. But by May 2010, this commission still did not exist.

[27] Data taken from Bieber and Stegmann (2011).
[28] All indicators, and in particular this one, must be considered very carefully – a topic not to be discussed here.
[29] See for example Geyer and Steiner (2010).
[30] Hagen (2010).

One important factor for low pension claims in case of unemployment is the fact that, apart from low or no claims for the period of unemployment, earnings after unemployment are often much lower compared to former earnings.

There exist already several proposals on how to prevent poverty in old age.[31] Some would increase the degree of interpersonal redistribution within the social pension scheme. Taking into consideration the strain in tax-financed general public budgets as well as a new constitutional rule to limit public debt by a "(public) debt brake" (*Schuldenbremse*), it can be expected that additional redistributive measures in social insurance will not be adequately financed by tax revenues but from earnings-related social insurance contributions. Together with the decreasing pension level, a creeping transformation of the social insurance system will then take place – from a scheme with a relatively close link between contribution payments and subsequent pensions into a redistributive transfer scheme.

Depending on the instruments that will be used to avoid old-age poverty, this could, therefore, be an element which helps to change the structure of the public pension scheme and shift it towards more interpersonal redistribution by integrating, for example, minimum elements into the scheme.

How many pensioners will live in households with an income below the poverty line depends, however, not only on the rules set in pension policy and labour market conditions, but also on the structure of households and the income of all members of a household. It can be expected that the income of married women will, due to increased female labour market participation and pension claims for care responsibilities for children or parents (which is not yet visible in the data), increase in relative terms. Nevertheless, without changes in the pension policy an increase in poverty among the elderly can be expected. This may, as mentioned above, become an important element in respect of political sustainability of pension arrangements.

In respect of measures to prevent poverty in the future, three additional topics are worth being mentioned here again:

- No further reduction of the general pension level of the social insurance scheme as a core element of a strategy in pension policy. This may preserve earnings-related public pensions providing higher pension benefits than basic means-tested social benefits for people employed on a long-term basis. There are indeed ways to finance a higher pension level. A higher level of social insurance benefits would also reduce the need for high additional private savings that pushes pension costs for private households over the necessary limits to finance the same income in old age mainly from pay-as-you-go financed pensions.[32]

- Integrating all those self-employed persons into the SPI that are not covered by a mandatory pension scheme. This would also help to reduce the danger of rising old-age poverty.

- Subsidies for occupational and private pensions should be targeted more at people with low incomes.

[31] See among others Schmähl (1993), Hauser (2009), Meinhardt (2011).
[32] This is outlined in Schmähl (2011b).

2.1.5 Critical assessment of reforms, discussions and research carried out

Demand for redesigning pension policy again

Regarding SPI, an upper limit for the contribution rate was politically fixed: The contribution rate must not be higher than 20% up to 2020 and not higher than 22% up to the year 2030. Several measures (in particular a redesign of the formula to calculate and adjust pension benefits) were taken to realise this. In the process of dealing with population ageing, a ceiling for the contribution rate, and by this the introduction of a "revenue-oriented expenditure policy", has the result of a gradual reduction of the "standard net pension level"[33] by about 25% by 2030. The emerging gap in income in old age is intended to be closed by private voluntary, but subsidised pensions. Reality, however, differs remarkably from this political objective.

An important effect of the scheduled reduction of the net social pension level together with effects for individual pension claims by unfavourable labour market conditions, e.g. long spells of unemployment for many employees, will be a growing number and ratio of pensioners in the future receiving only a pension benefit from social insurance that is below the existing means tested "basic" transfer payment (*Grundsicherung*).

Model calculations show that **fiscal sustainability** can be increased by already politically decided (and mainly already implemented) measures. From a present-day perspective, fiscal sustainability of the public pension schemes can be realised in the long term. Whether **political (social) sustainability** can also be realised was not much politically discussed and is highly questionable, especially taking into account already decided measures that will among other things reduce the "generosity" of the scheme remarkably and increase poverty. The increase in public debt that took place in the process of coping with the "crisis" will be an important political argument for a reduction of public (in particular social) expenditure. But meanwhile, however, a broad public debate has started, particularly on the adequacy of the future development of pensioners' incomes.

Taking into account that a central political aim in Germany is to stabilise the contribution rates of social insurance schemes, above all employers' contributions, and that, on the other hand, the new constitutional "public debt brake" is in place, considerable pressure on social expenditure can be expected when a balanced public budget is supposed to be realised in the long term. This will result in an additional burden for private households and make it much more difficult to finance one's living in old age, also because of reduced benefits, for example in the social health insurance and long-term care insurance schemes. The growth rate of public expenditure will be reduced and rising expenditure in case of an ageing population will be more and more financed by private households directly. This may become a severe political challenge and underlines the necessity to look not only at the development of fiscal but also social and political sustainability.

Measures to cope with the multiplicity of effects resulting from the banking and financial crisis, which are either already implemented or will be based on future political decisions, will reinforce, but not change, the political strategy of the new pension policy in Germany. Although up to now, single anti-crisis measures directly affect pension schemes only moderately, in my judgement long-term structural changes are most important. These, at least, may fundamentally change the present structure of the core element of Germany's pension system, the social (statutory) pension insurance, and, thus, the "pension landscape" in

[33] That is the ratio of a pension benefit based on 45 „Earnings Points" (which can be the result of 45 years, earning in this period just average gross earnings) to average net earnings of all employees.

Germany may distribute risks and costs of old-age protection in a different way among major actors (state, companies, private households).

If the inflation rate rises as a medium or long-term effect of the different "rescue measures" during the crisis, in particular because of the explosion of public debt in many countries, especially real income in old-age will be damaged. The main reasons for this are – ceteris paribus – (1) that the adjustment rates of social pension insurance will remain relatively low and below general earnings or income development because of the existing rules to adjust public pensions and (2) private or occupational pensions are often constant over time in nominal terms.

Therefore, the effects of fiscal and political measures to cope with "the crisis" may speed up a process of converting an insurance scheme with a close contribution-benefit link and intended to substitute former earnings and to smooth income and expenditure over the life cycle into a public transfer scheme with relatively low pension benefits, aiming mainly to avoid poverty in old age or in case of disability.

It is argued (by those who supported the new pension policy) that the financial crisis gives no argument for a fundamental revision of the pension reform implemented in 2001(see for example Börsch-Supan and Gasche 2010). But there are other effects and arguments that support the proposal to say farewell to the "new German pension policy" (Schmähl 2011), in particular because of its effects on pensioners' income and the danger of increasing poverty in old age in the future.

Currently, several proposals are made to end the downgrading of the general pension level, as it will also take place in the years to come. This is not only argued to avoid poverty but also to reduce the financial burden of private households compared to the contributions necessary to finance a specific level of income in old age from (reduced) social pension insurance and (increased) private saving, compared to a comparable level with a different mix of income – more from social pensions and less from private pensions. The role of replacing former earnings from employment with social pension benefits will again become an important objective of pension policy (Schmähl already 2001 and most recently 2011, Dedring et al. 2010). But up to now, no political support for a redefinition of pension policy in Germany can be seen.

Public debt and pension policy

The European Central Bank calculated for the period 2009-2010 an increase in public debt in Germany of 12.7% of GDP (without contingency liabilities that may additionally burden the budget by 8.1% of GDP). The level of the public debt in Germany was 73.4% of GDP in 2009, compared to 64.9% in 2007. This underlines the rapid increase.[34] Not for the first time, the ECB is (in general) demanding that governments take comprehensive reform measures in national pension and health insurance systems to reduce the effect of a rising old-age dependency ratio on public budgets, because of otherwise negative effects, in particular on economic growth.[35] Additional strain on public expenditure, in particular social expenditure, can be expected. Beside the public debt and its increase during the crisis, the sudden change in energy policy that the German government announced after the dramatic experience in Japan will also increase costs for public and private households.

In May 2011 the German Council of Economic Experts (*Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung*) proposed a further increase of the

[34] EZB (2011), p. 73 resp. p. 70.
[35] In an ECB-Discussion paper it is argued, that starting around levels of 70-80% of public debt to GDP it has an "deleterious impact on long-term growth", Checherita and Rother (2010), p. 4.

(standard) retirement age beyond 67 by linking the retirement age to the increase of life expectancy. According to projections of the Council, in 2045 a retirement age of 68 and in 2060 of 69 is deemed to be necessary (Sachverständigenrat 2011).

Considering such aspects together, and although at present the economic development is favourable towards its financing, the future of *public* pension schemes seems to remain gloomy, especially in respect of a strategy to redefine pension policy compared to the path that was politically decided at the beginning of the century.

2.2 Health Care

2.2.1 The system's characteristics and reforms

The health insurance system

Germany's health insurance system is characterised by the coexistence of a social health insurance scheme (SHI) and a private health insurance (PHI), both providing comprehensive health insurance. In 2010, 69.8 million people were insured under the SHI (BMG 2011) while 8.9 million were insured under the PHI (PKV 2011).[36] While health insurance under SHI is mandatory for low and medium-income employees, high-income employees and self-employed may opt for PHI. With few exceptions, civil servants are also insured under the PHI. The two systems of health insurance fundamentally differ. The SHI is characterised by a largely standardised statutory benefit package, premiums are independent of the individual's health risk and calculated as a fixed proportion of the insuree's labour income, which is 15.5% in 2011. Employers bear almost one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. In contrast, PHI premiums depend on the individuals' health risk and not on income. The benefit package is subject to an individual insurance contract and co-insurance of family members is not free of charge but requires an additional contract.

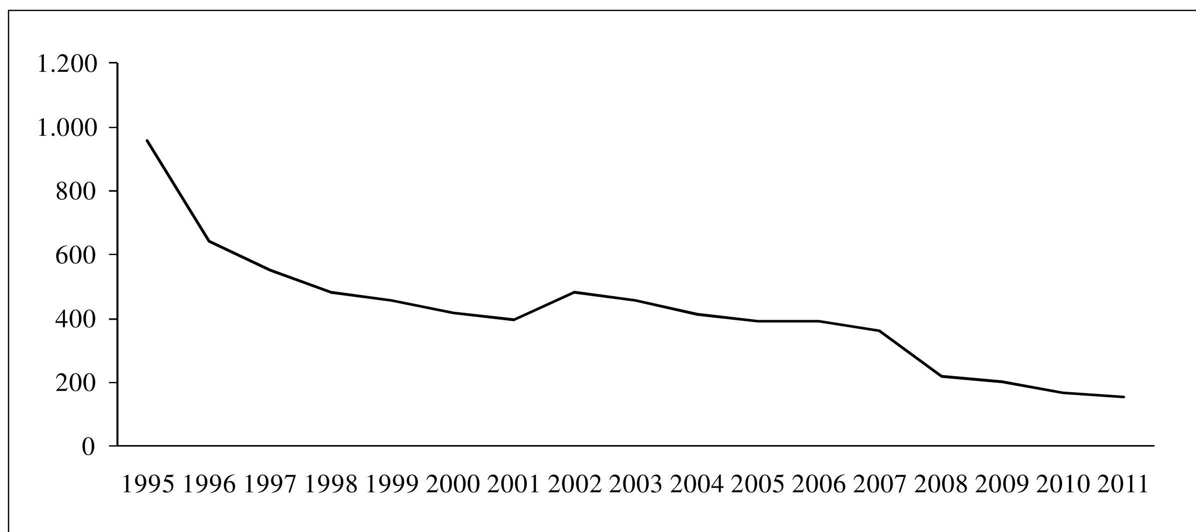
Though SHI and PHI fundamentally differ, a recent reform (*GKV-Wettbewerbsstärkungsgesetz, GKV-WSG*), which came into force in 2007, forced both systems to converge to a small degree. On the one hand, SHI nowadays is allowed to offer so-called elective insurance contracts that may include deductibles, which are a typical feature of health insurance contracts under the PHI. On the other hand, the reform forced private health insurers to offer a so-called basic insurance. It is similar to health insurance provided by the SHI in terms of both benefits and premiums: premiums may not depend on individual health risk and are equivalent to the maximum contribution under the SHI.[37]

Only a small group of individuals is allowed to choose between private and social health insurance. Employees who earn more than EUR 49,500 per year in 2011 may choose. However, once opted for a PHI, this decision can be regarded as 'once-in-a-lifetime' because (i) switching back to SHI is strongly restricted by law and (ii), when switching between PHIs, risk-premiums are calculated again and they typically increase with age. According to PKV 45 major private insurers offer comprehensive health insurance cover in 2010. In addition, 31 small and very small private insurers exist, often just locally active and providing only supplementary insurance for people insured under the SHI. Supplementary private health insurance is widespread in Germany. For 2009, the association of private health insurers reports roughly 16 million supplementary contracts held by individuals insured under the SHI.

[36] Another three million people are covered by special governmental insurance schemes that operate outside the SHI system (KVB, 2011).
[37] Except for welfare recipients.

Traditionally, a very large number of SHIs existed in Germany. In the past, SHI was often provided at a local or company level. Only few SHIs operated at the national level. Specific groups of insurees were directly assigned to certain types of insurers (Tamm et al, 2007). Yet, this has changed dramatically after 1996, when free choice of SHI and the option to switch an SHI was granted. Fierce competition between SHIs led to a constant process of mergers that has reduced their number from almost 1,000 in 1995 to 150 at the beginning of 2011 (Figure 1). The process of mergers has recently gained additional momentum, as mergers of SHIs of different types were allowed by the GKV-WSG.

Figure 1: Number of SHIs in Germany, 1995-2011



Source: BMG (http://www.gbe-bund.de) and GKV (2011).

Until 2009, SHIs competed mainly[38] via their contribution rates, which were set individually by each SHI. This has been changed by the GKV-WSG. Since 2009, there has been a uniform contribution rate which is set by the federal government; in 2011, it amounts to 15.5% of wage income. It is collected by a general health fund which redistributes its revenues to the individual SHI with allocation of funds depending on the risk profile of each SHI's enrolee. In consequence, the contribution rate is no longer an element for price competition. Yet, the SHIs are allowed to charge income-independent extra premiums if allocations from the health fund turn out to be insufficient for covering expenditures. Moreover, SHIs which spend less than they receive from the health fund may grant refunds to their insurees. How to deal with low-income insurees who cannot afford this extra premium has been subject to a harsh public debate. While health economists have stressed the argument that switching to an SHI which does not charge extra premiums is the best option to avoid them (e.g. Augurzky et al., 2010), rendering any further measures for protection of low-income households superfluous, the GKV-WSG introduced an income-related cap on extra premiums of 1% of income. The difference of the extra premium and this cap bears the individual SHI. This has been criticised as a severe distortion of competition. SHIs with a high share of low-income insurees may be forced to charge even higher extra premiums for wealthy individuals in order to raise the required financial means. Yet, this renders these SHIs less attractive to high-income individuals who, then, might switch to another SHI.

[38] To a limited degree there is also competition by benefits. Though under the SHI the benefit package is largely standardised by law, some so-called elective benefits exist for which it is up to the SHI to include them or not. In terms of total expenditures the share of such benefits is very small, yet for some insured certain elective benefits may still be crucial for the choice of an SHI.

After a new federal government had taken over in 2009, a further health reform immediately came onto the political agenda. The so-called *GKV-Finanzierungsgesetz* (GKV-FinG, Law on Financing the SHI) was passed at the end of 2010. It has an incremental character in that it has removed discrepancies of the former reform GKV-WSG. Its main objective was to introduce a mechanism to the SHI to adapt to future increases in health expenditures. Furthermore, it aimed at reducing an expected financial gap of the SHI in 2011 in the region of EUR 10 billion. Therefore, the GKV-FinG was accompanied by several other regulatory interventions, most importantly the 'Law on the Re-organisation of the Market for Pharmaceuticals' (*Gesetz zur Neuordnung des Arzneimittelmarktes*, AMNOG) aimed at reducing expenditures for pharmaceuticals.

The main changes of the GKV-FinG are the following (Augurzky 2010): Firstly, it raised the general contribution rate to the health fund from 14.9% in 2010 to 15.5% in 2011, increasing revenues for the health fund by roughly EUR 6 billion. Secondly, it froze the part of the contribution rate paid by employers to 7.3%. Thus, further increases of health care expenditures will lead to higher extra premiums paid be the insurees. Moreover, the government can increase the contribution rate paid by the insurees, which amounts to 8.2% in 2011.

Thirdly, a compensation for insurees with low income was introduced. Previously, the extra premium was restricted to 1% of wage income, which was a disadvantage for SHIs with many low-income insurees. The new compensation takes place when the average extra premium over all SHIs exceeds 2% of wage income of an insuree. This compensation is paid by the health fund instead of the individual SHI. Therefore, elements of income redistribution have been removed from individual SHIs to the health fund which is an improvement to the previous system. In order to finance growing compensations due to growing extra premiums in the future, additional tax money will be provided to the health fund. What is more, it is not the individual extra premium of an SHI which is relevant for compensation but the average extra premium over all SHIs. Thus, the incentive to change from an expensive to a less expensive SHI remains also for low-income insurees. Both innovations are essential to make competition work in the presence of a cap on extra premiums. In May 2011, the first SHI (City BKK) became insolvent and had to close, which shows that competition has, indeed, become stronger than intended. In sum, after this reform the economic incentives for insurees and for SHIs are almost equal to those of a system with full income-independent premiums and tax compensations for low-income insurees.

Fourthly, the general annual price increase for hospitals has been cut to 0.9% in 2011 and to roughly 1% in 2012. Thus, hospital expenditures for SHIs will increase less in these years than in 2009 and 2010. Furthermore, administrative costs of SHIs are frozen at their 2010-level. Some measures addressed expenditures for outpatient care. In addition to the GKV-FinG, the government addressed the problem of increasing expenditures for pharmaceuticals with the AMNOG in 2010. It is, in line with previous reforms, aiming at capping costs, such as the *GKV-Änderungsgesetz* (GKV-ÄndG), which was passed in parliament in July 2010. Yet, the GKV-ÄndG introduced explicit measures to reduce costs, most importantly a mandatory discount of 16% on pharmaceuticals and freeze of prices of pharmaceuticals until 2013. In contrast, the AMNOG introduces mechanisms of how prices of pharmaceuticals are determined.

In Germany, pharmaceuticals have been subject to a system of reference pricing since 1989 (Augurzky et al. 2009): while producers are free in setting prices for any pharmaceuticals, the SHI will reimburse costs only up to a reference price. Patients have to bear the price difference for any drug whose price exceeds the reference level. This sets strong incentives to producers not to set prices above the reference price. However, until recently reference

pricing only applied to generics and therapeutic substitutes, i.e. drugs that are already established. In contrast, newly invented drugs are excluded from reference pricing. In consequence, for such innovative drugs the SHI has to reimburse the full price, which is unilaterally set by the producer. It does not come as a surprise that high costs for newly invented pharmaceuticals are a matter of concern for the SHI. Exactly this issue is addressed by the AMNOG, which obliges producers to verify the additional medical value of an innovative pharmaceutical. If the producer fails to do so – compared to already existing drugs and therapies – even innovative drugs that use new active pharmaceutical ingredients are subject to reference pricing. Yet, even if an additional benefit exists, AMNOG does no longer allow for unilateral price setting by the producer. Rather, prices are subject to negotiations of the producer and the SHI.

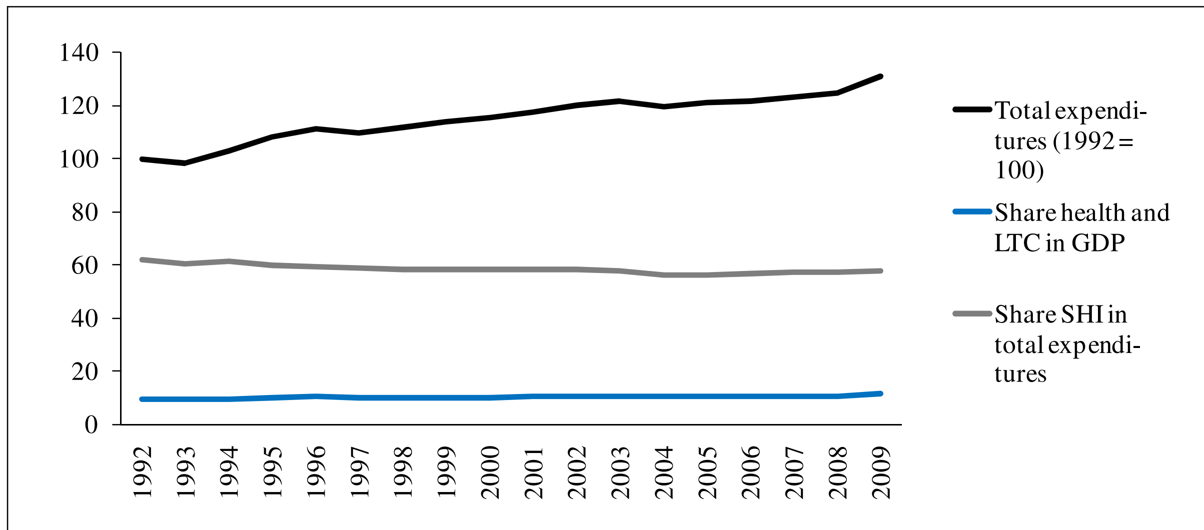
Health care expenditures

In Germany, increasing health care expenditures are a matter of public concern like in many industrialised countries. The public debate especially focuses on expenditures of the SHI because it is predominately financed through labour-income-dependent contributions perceived as a 'quasi-income tax'. Hence, the classical dilemma of keeping tax burden low while offering high quality und comprehensive health care service applies to the SHI. According to the Federal Statistical Office (Statistisches Bundesamt 2011a) in 2009, total expenditures on health care amounted to EUR 278 billion, of which the SHI bears 58%. Other social insurance schemes bear another 10.3%, the PHI 9.3%, public authorities 4.9% and employers 4.2%. Private out-of-pocket payments amount to 13.5% of total health expenditures.

Figure 2 displays total real health expenditures,[39] the share of health cost in GDP, and the share of SHI in total health expenditures for 1992 to 2009. Real health care expenditures are clearly growing, its share in GDP has increased from 9.6% in 1992 to 10.5% in 2008 and to 11.6% in 2009 due to the large fall in GDP in 2009. Although increasing expenditures are most intensely debated with focus on the SHI, the SHI managed to reduce its share on total expenditures by roughly five percentage points during the considered period. This is most likely to be explained by past state interventions aiming at stabilising SHI expenditures.

[39] Deflated by the consumer price index.

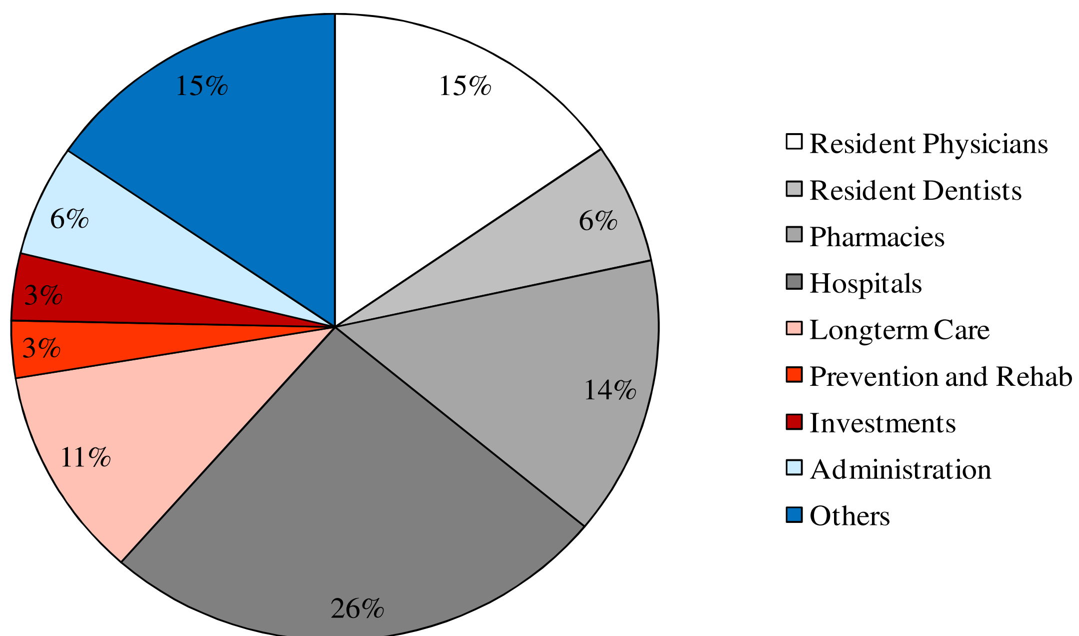
Figure 2: Health Expenditures in Germany (expenditures in 1992 = 100), 1992-2009



Source: BMG, 2011 (http://www.gbe-bund.de) and own calculations.

Figure 3 displays the structure of health care expenditures. Hospitals account for the largest share, which may explain why they are often considered the prime candidate for further cost reduction interventions. Nevertheless, resident doctors – taking physicians and dentists together – account for a share in expenditures of comparable size. Pharmacies (including pharmaceuticals) account for another 14%. Hence, it does not come as a surprise that the recent reform AMNOG aims at reducing costs for pharmaceuticals in order to stabilise health expenditures.

Figure 3: Distribution of Health Expenditures in Germany, 2009

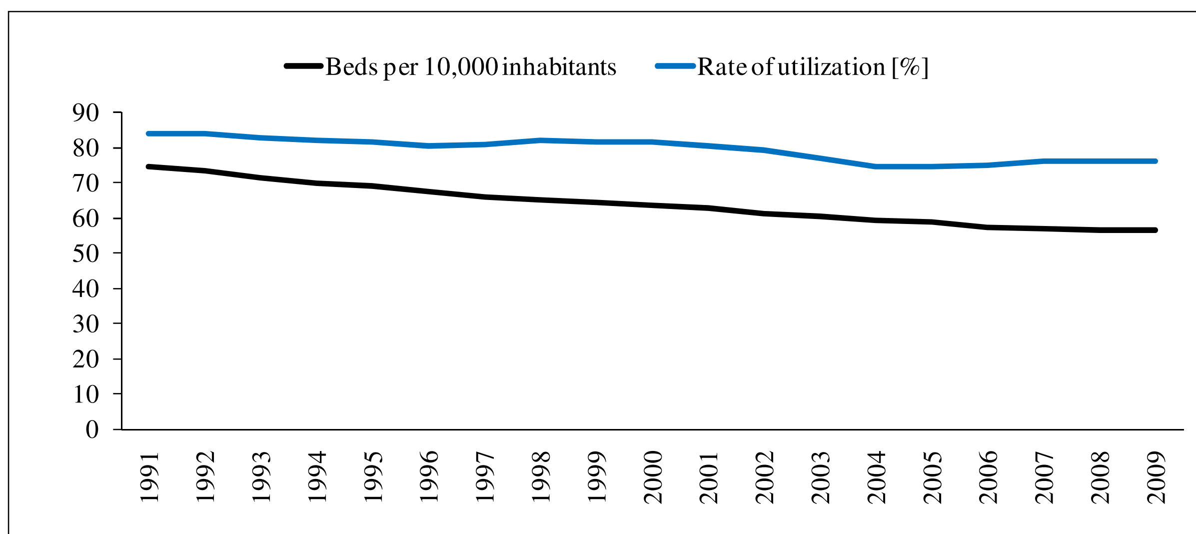


Source: StaBuA (2011) and own calculations.

Access to health care

The per-capita number of hospital beds for curative (acute) care in Germany is among the highest in the world (OECD 2010). In 2008, Japan was the only OECD country for which the OECD reported a higher number than for Germany, i.e. 8.1 compared to 5.7 beds per 1,000 inhabitants, while European countries such as the Netherlands (2.9), France (3.5) and Belgium (4.3) exhibited much smaller figures. Obviously, access to inpatient care is high in Germany. This holds true, although the number of beds is on a constant decline for several years – but also the length of stay in hospitals. Nevertheless, Augurzky et al. (2010b) argue that substantial excess capacities still exist with respect to hospital beds in Germany. Figure 4 displays the number of curative beds and the occupation rate for 1991 to 2009.

Figure 4: Curative beds per capita and occupation rate in Germany, 1991-2009

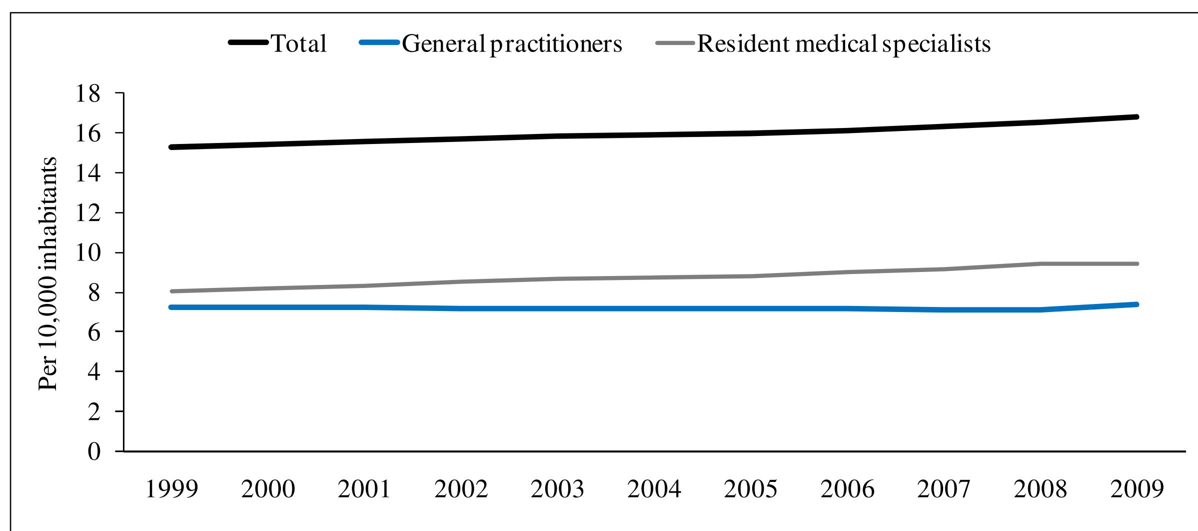


Source: BMG, 2011 (http://www.gbe-bund.de) and own calculations.

While the number of hospital beds is high in Germany, the number of general practitioner is rather low, but that of medical specialists is relatively high and has constantly grown in recent years. This might reflect the fact that, in Germany, medical treatment occurs more often in hospitals or by medical specialists than in other OECD countries. This raises the question of excess capacities, as in Germany treatment by medical specialists is provided through both the inpatient and the outpatient sector. The increase in per-head general practitioners is less distinct but still present in the data. Figure 5 displays the number of general practitioners, resident (outpatient) medical specialists and overall resident medical professionals per 10,000 inhabitants where the latter is the sum of the former two.[40]

[40] Note, that only resident medical professionals are considered that are allowed to medicate SHI insurees and for this reason have registered with the 'Association of Statutory Health Insurance Physicians' (*Kassenärztliche Vereinigung*). Moreover, only *resident* physicians are considered, i.e. physicians working in hospitals are not included in these figures.

Figure 5: Number of resident physicians in Germany, 1999-2009



Source: BMG, 2011 (http://www.gbe-bund.de) and own calculations.

2.2.2 Debates and political discourse

Because of severe regional differences in the number of resident medical professionals (Felder and Tauchmann 2009), there is a discussion about insufficient availability of general practitioners in rural areas. It is unclear whether there is a general lack of practitioners in Germany or whether there is a lack in rural and an over-supply in urban areas (e.g. Schmacke 2006, Klose and Rehbein 2011). Some initiatives aim at making practicing in the countryside more attractive. Günther et al. (2010) carried out research on what makes young health professionals choose where to locate.

The discussion on shortages in rural areas has led to a recent legislative initiative that is currently discussed. For the planned 'Law on Health Care' (*Versorgungsgesetz*), several measures are proposed in order to guarantee sufficient supply of medical services in all regions. In detail, federal states may in their own rights take measures to improve local supply, if the regular system[41] fails to guarantee sufficient supply. Services of outpatient care may be remunerated at a higher price in regions that exhibit under-supply. Moreover, in such regions, hospitals may be allowed to offer services which regularly are provided by resident physicians. Yet, the proposed law is still disputed, in particular between the federal government and the federal states (Preusker 2011). Another regional issue of health reform is whether extra premiums to health funds should be allowed to differ regionally. This is advocated by health economists (Augurzky et al 2010), in order to accommodate regional variation in preferences for health care and not to distort competition between health funds that operate nationally and others that operate at a regional level. Regional variation in contributions is also advocated by the Christian Democrat Party (CDU).

The general political debate about the health care system in Germany has focussed on two alternative models for financing the SHI, i.e. (i) the so-called *Bürgerversicherung* (universal citizens' health insurance) and (ii) the so-called *Gesundheitsprämie* (per-capita flat-rate insurance). The first is characterised by including the entire population and abolishing PHI and by contributions that depend not only on labour income but also on capital income. The second model is characterised by a uniform income-independent per-capita premium which is

[41] In Germany, the Association of Statutory Health Insurance Physicians is responsible for managing the supply of facilities for outpatient care.

accompanied by a compensation of the low-income insurees so that they are able to pay the premium. All major parties currently in opposition, i.e. the social democrats (SPD), the Green Party, Die Linke party, as well as the trade unions are in favour of the "*Bürgerversicherung*". The political parties currently in power, the Christian democrats and the Liberals, back the reforms implemented by the GKV-FinG. However, prior to entering the government, the Liberals insisted on a more prominent role of private health insurance, while the Christian Democrats pleaded for the *Gesundheitsprämie* at the time. The latter is still advocated by the majority of economists.

Moreover, health economists stress that in the long run the German health insurance system needs to overcome the duality of SHI and PHI in order to establish an integrated, competition-oriented and more efficient system (Augurzky et al 2010). Implementing such an integrated system is regarded as a difficult task, since the rights of the privately insured have to be considered. The reform of the Dutch health insurance system of 2006, which has managed to integrate PHI and SHI, is sometimes regarded as a blueprint for the German case (Wasem 2010). Others do not see an advantage in the Dutch system (PKV 2010).

Another heavily disputed issue is the so-called selective contracting of SHIs and providers of health care services. Typically, all SHIs contract together with all health care providers. Individual contracts between an individual SHI and an individual provider are not possible. This has been criticised as a severe barrier to competition. Although selective contracting has been permitted to a very limited degree since 2009, economists argue in favour of such contracts becoming the rule rather than the exception. Yet, sometimes it is argued that the market power of large funds will lead to inefficient results if selective contracting becomes common. Moreover, the Association of Statutory Health Insurance Physicians, which negotiates collective contracts for resident physicians, argues that quality of treatment may deteriorate. See Paquet (2011) for a comprehensive discussion.

2.2.3 Impact of EU social policies on the national level

There is some scepticism in the Member States with regard to the surveillance and assessment of national reforms in health and LTC. The open method of coordination (OMC) as a voluntary exchange of experience helps with discussion and tries to improve the provision of social services. Its voluntary character increases its acceptance. Since 2004, there have been eight peer reviews on average in the area of social protection and social inclusion, but only few in the area of health and LTC. In this area, Germany has organised three peer reviews so far, two of them in the area of health about cost containment in the pharmaceutical sector and about ensuring a functioning health care system in regions with declining and ageing populations.

With respect to the most intensely debated issues of health policy, such as financing the SHI and the role of PHI, EU policies are typically regarded as of marginal importance in the national health system. Nevertheless, EU policies play an indirect role. An example is the European Working Time Directive, which made what had previously been common practice in German hospitals inconsistent with EU law. Some more health-focused EU regulations, such as The Directive on the Application of Patients' Rights in Cross-Border Health Care, are rather at the margins of the debate on health policy in Germany.

The EU general competition law represents another example for EU policies having an impact on national health policy, as in Germany, several health-related markets are exempted from general competition regulation, which might conflict with EU law. Yet, since the European Court of Justice approved exceptional rules for pharmacies in Germany in 2009, the expectation of EU law pushing the German health system towards more competition has

largely vanished. Moreover, there is an ongoing discussion at the EU level about whether public owners of hospitals, e.g. municipalities, are allowed to cover deficits of their hospitals. Since non-public hospitals do not have this advantage, there is a distortion of competition. In essence, however, health policy is still nationally oriented.

In contrast, the EU antidiscrimination directive requiring unisex premiums for insurances may serve as a controversial example that may result in a distortion of the competition among health insurers. Since health expenditures for women are higher than for men on average, unisex premiums in the PHI lead to distortions in the risk profile of the insurers. If there is an imbalance in the distribution with respect to the number of men and women in the pool of the insurees of a PHI, e.g. predominance of women, the insurer faces the risk of insolvency because its average premiums are lower than its average expenditures. In contrast, unisex premiums in the SHI do not pose this problem because of the risk equalisation scheme between different SHI. If an SHI has too many female insurees, it receives compensation from other SHI with fewer female insurees. A private health insurer with unisex premiums, in contrast, must either avoid acquiring female insurees or increasing the unisex-premium to the former level for women. Hence, higher premiums for PHI and less effort to acquire female insurees in the PHI are expected.

Finally, the EU strategy EUROPE 2020 addresses health issues at several points. Most importantly: (i) health is listed among the core fields of R&D and innovation policies and (ii) better access to health is called for in order to reduce health inequalities. Although it is ambitious to identify impacts of a strategy launched just one year ago, the German government has indeed intensified its efforts in stimulating health-related research and has issued a new master plan on this issue (BMBF 2010).

2.2.4 Impact assessment

Assessing the impact of health policies on the health system and health outcomes is not trivial, as identifying such impacts requires disentangling the effects of various sources of such indicators. Moreover, such impacts may materialise with a substantial time lag. Nevertheless, for some relevant issues reliable empirical evidence is available, while for others the impact of health policies appears to be obvious.

The immediate impact of the financial crisis – and the policy measures taken in order to cope with the crisis – on the health system seem to be heterogeneous. On the one hand, the federal government put additional tax money into the health fund in order to stabilise the health system and to even reduce the general contribution rate to 14.9%. For the insurees, the financial crisis had no negative impact on the access to health care or on individual health costs. On the other hand, there is empirical evidence that economic downturns, and in particular job insecurity, directly exert detrimental effects on individual health (Knabe and Rätsel 2010).

The health reform of 2007 is likely to have largely eliminated the problem of individuals lacking any health insurance cover. Yet in Germany, even before this reform, this problem has never been a widespread one. The GKV-WSG not only introduced the legal obligation to buy health insurance, it also guarantees that failing to pay premiums will not automatically result in the loss of health insurance cover. Hence, the number of individuals lacking any health insurance cover – apart from non-legal residents – has been substantially reduced (Greß et al. 2009) since 2007. However, inequality in terms of access to health care is frequently discussed with respect to individuals being insured with SHI or PHI. Since resident physicians are allowed to charge much higher prices from PHI patients, privately insured patients are often assumed to be first-class costumers. Empirical evidence suggests that waiting times are

shorter for this group of individuals (Lüngen et al. 2008; Schwierz et al. 2009). Nevertheless, except for organ transplantations, no official waiting lists exist for medical services. In general, health inequality is likely to be less severe than in other industrialised countries.

With respect to financial sustainability, limited progress has been made by the most recent health reform through mitigating the dependence of the SHI on aggregate labour income. Nevertheless, demographic change, shifting the balance of net-contributors and net-recipients in the SHI, still represents a major challenge to the health system. As to health care personnel, the number of medical students has been decreasing in recent years (Kopetsch 2007). In conjuncture with regional heterogeneity in regional provision of health care services, this might result in shortages of health care supply in some regions. This problem is, however, not unique to the health sector but reflects the fact that ageing societies will experience a relative decrease in labour supply.

2.2.5 Critical assessment of reforms, discussions and research carried out

Since the public and scientific debate about health care reform in Germany has focussed on the controversy of *Bürgerversicherung* and *Gesundheitsprämie,* the GKV-FinG has first and foremost been debated in the light of these general concepts (ifo 2010), with a special focus on the question of whether and to what extent the reform meets their major objectives. In this debate economists have often argued (Augurzky 2010) that a reform of financing the SHI should achieve five objectives simultaneously: (i) the health premium should not depend on labour income, (ii) strong competition between SHIs, (iii) redistribution of income within the SHI should be based on all kinds of income of the insuree, not just on labour income, (iv) compensation of the low-income insurees should not distort competition between SHIs, (v) the duality of SHI and PHI should be abolished. The "*Gesundheitsprämie*" achieves all of these objectives except for (v), although PHI would hardly be competitive in the world of the "*Gesundheitsprämie*". The GKV-FinG represents a step into this direction. With respect to (ii) and especially (iv) the GKV-FinG corrects a serious shortcoming of the health reform of 2007, as compensation for low-income insurees is now carried out at the level of the health fund instead of at level of the individual SHI. Thus, compensation no longer distorts competition among SHIs.

Among many health economists the GKV-FinG is also considered as a step into the right direction with respect to (i). Though contributions to the SHI remain income-dependent, any future increase in health expenditures might be financed by per-capita extra premiums. However, the GKV-FinG fails to make progress towards (iii) and (v). In the long run, the system might develop into the direction of the Dutch system.

2.3 Long-term Care

2.3.1 The system's characteristics and reforms

The social and private long-term care insurance (LTCI) was introduced on 1 January 1995 as a compulsory insurance to cover a portion of long-term nursing care costs. All persons insured by SHI were automatically assigned to the social LTCI and all insured by PHI to a private LTCI. According to the Federal Ministry of Health, 69.8 million citizens were covered by social LTCI in 2010, and according to the association of PHI, 9.6 million citizens were covered by a private LTCI.

In 2009, the social and private LTCI bore roughly 50% of residential and 54% of formal outpatient LTC costs (Statistisches Bundesamt 2011a). Thus, the LTCI is often referred to as a "part insurance cover". Table 1 gives an overview of the benefits of LTCI in the years 2007

to 2012 by kind of care arrangement and by level of severity. There are no differences in benefits between social and private LTCI. Between 1996 and 2007, there was no change in the nominal amount of the benefits. However, due to general price inflation the nominal amount had gradually lost its real value. Indeed, in 2000, the LTCI bore 55% of residential and 59% of formal outpatient care. The reform in 2008 (*Pflegeweiterentwicklungsgesetz*) increased the monthly benefits for the first time.

Table 1: Benefits of LTCI in EUR per month

In € per month	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Formal, residential						
Level I	1,023	1,023	1,023	1,023	1,023	1,023
Level II	1,279	1,279	1,279	1,279	1,279	1,279
Level III	1,432	1,451	1,470	1,510	1,510	1,550
Formal, outpatient						
Level I	384	402	420	440	440	450
Level II	921	951	980	1,040	1,040	1,100
Level III	1,432	1,451	1,470	1,510	1,510	1,550
Informal						
Level I	205	210	215	225	225	235
Level II	410	415	420	430	430	440
Level III	665	670	675	685	685	700

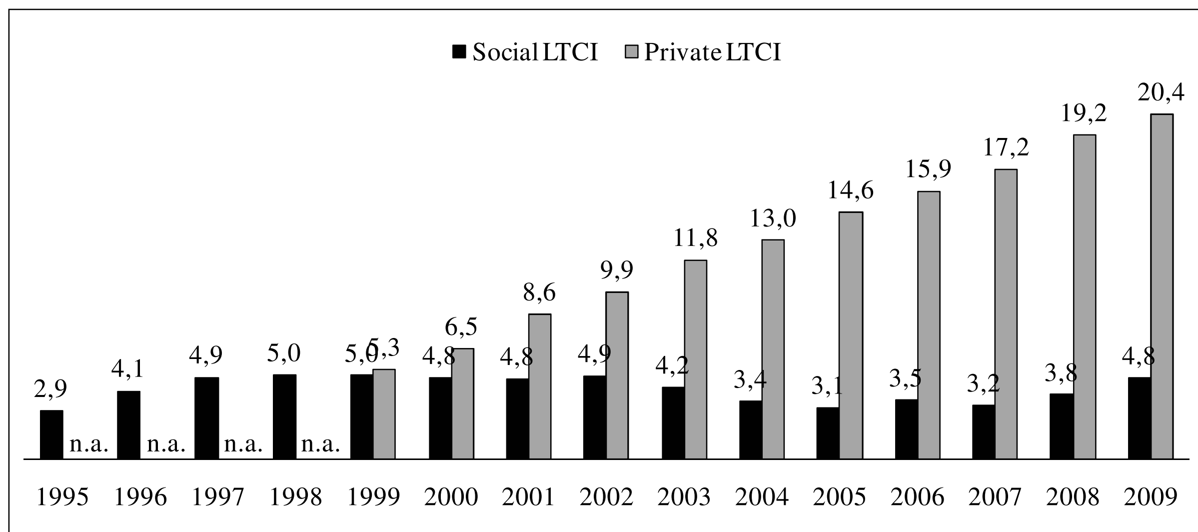
Source: Federal Ministry of Health 2011

The LTCI pays the benefits according to the severity of need of care (Level I = low, Level III = high) but irrespective of the price for LTC. The person in need of care has to bear the difference between the price for care and the benefit of the LTCI. E.g. the average price for a place in a nursing home at Level II was EUR 2,800 per month in 2009 (board and lodging included). The LTCI benefit was EUR 1,279 or 46%. However, the prices for nursing homes vary considerably across Germany (Augurzky et al. 2009). If the person is unable to pay the difference between price and LTCI benefit, first-grade relatives are required to help financially. If their support is still not sufficient, social welfare covers the remaining amount of money. Currently, social welfare covers 12% of all costs on average (Statistisches Bundesamt 2011a). Due to the high out-of-pocket payments (for persons without support by social assistance), there is an incentive to demand services with a good relationship between price and quality.

In 2009, 2.34 million people received benefits from social or private LTCI, thereof 1.07 million for informal care, 0.56 million for formal outpatient care and 0.72 million for residential care. The number has risen considerably by a total of 16%, or by 1.5% per year, between 1999 and 2009. At the same time, total expenditures of the social LTCI have grown from EUR 16.3 to 20.3 billion, i.e. by 24% in total or by 2.2% per year. In the years after the introduction of the social LTCI, contributions exceeded expenditures and capital was accumulated up to EUR 5 billion until 1998 (Figure 1). Given rising expenditures, from 2003 on, capital stock was reduced. The capital reserves of the private LTCI, however, have increased steadily to above EUR 20 billion in 2009.

The contribution rate to the social LTCI was stable at 1.7% until 2008. With the LTC reform *Pflegeweiterentwicklungsgesetz,* the contribution rate increased to 1.95% in general and to 2.20% for insurees without children. Employers and employees pay half of the premium, pensioners pay the full premium. Therefore, since 2008, capital stock has been growing again.

As current data are only available for 2009, it is not possible to make any statements about recent developments in 2010 or 2011. However, there are signs that capital reserves will begin to diminish soon (Häcker, Hackmann and Raffelhüschen 2010). There is, therefore, a need for a further reform in respect of the financing of the social LTCI, which is expected for 2011.
Figure 6: Capital reserves of the social LTCI in EUR billion



Source: Federal Ministry of Health 2011 (http://www.bmg.bund.de/pflege/zahlen-und-fakten-zur-pflegeversicherung/zahlen-und-fakten-zur-pflegeversicherung.html).

In 2009, there were 11,634 nursing homes and 12,026 outpatient services. 40% of all nursing homes were private-for-profit, 55% private-not-for-profit and 5% public (Statistisches Bundesamt 2011b). In the outpatient care, even 62% were private-for-profit, 37% private-not-for-profit and 2% public. The market shares (measured in number of patients) are slightly lower for private-for-profit providers because they are smaller on average. Overall, the German market is dominated by private providers.

One important aspect of the *Pflegeweiterentwicklungsgesetz* was the introduction of so-called "transparency reports", which include "„school grades", i.e. ratings assessing the quality of a nursing home in various dimensions. The reports' structure is standardised and, thus, identical for all nursing homes. They are directly comparable, making them a useful tool for patients and their relatives to compare different nursing homes.

Between January 2010 and April 2011, there were no political reforms concerning LTC at the national level, and only small changes in legislation in some federal states. Due to the ageing of the population and, thus, rising demand for LTC – by 2050 4.4 million people in need of care are expected – the gap between expenditures of and contributions to the social LTCI will grow. Without reforms, the contribution rate would have to rise from 1.95% to around 4.4% in 2050 (Häcker, Hackmann and Raffelhüschen 2010). To avoid this burden for the payers, further reforms of the LTCI are necessary.

2.3.2 Debates and political discourse

In 2009, the new German government announced a reform of LTC in its coalition agreement (Koalitionsvertrag 2009):

- reduction of bureaucracy for LTC providers,
- improvement of the compatibility of work and informal care by relatives,
- increasing the attractiveness of the occupation of elderly care nurse,

- standardising the different kinds of training for elderly care nurses on the one hand, and for hospital nurses on the other,
- improvements in the assessment of quality of care,
- reform of the definition of being in need of care, especially concerning people with dementia, who currently might not be considered in need of care if they do not have a physical disability,
- implementation of an additional, mandatory, individualised LTCI with capital accumulation, and
- adjustment of LTCI benefits to general price inflation.

So far, the government has not taken any initiatives along these lines. In 2010, it concentrated on reforms of the SHI. However, the government has announced 2011 as the "year of care" and intends to present a first draft of an LTC reform before summer. The draft is supposed to include the following issues: improvements for people with dementia, measures to reduce the lack of skilled nurses, better assistance for relatives, and reduction of bureaucracy. However, the government has not yet commented on a financial reform of LTC and on the redefinition of being in need for care, which might induce additional annual costs of EUR 3.6 billion (BMG 2009). It remains unclear as well whether an additional, mandatory, individualised LTCI with capital accumulation is still under discussion.

A position paper of the coalition parties CDU and CSU (CDU-CSU 2011) points into the direction of the coalition agreement: implementation of an additional capital accumulation, redefinition of being in need of care, priority to outpatient instead of residential care, establishment of an independent organisation that controls LTC suppliers instead of the current organisation *MDK* ("medical service of the social health insurances") that is dependent on the social health insurances, adjustment of LTCI benefits to general price inflation, standardising the different ways of education of nurses for the elderly and hospital nurses, improving the legal framework for informal care at home, special help for people with dementia, improving medical care of people in need of care, and strengthening the principle "rehabilitation before care".

The Social Democrats (SPD) want to abolish the private LTCI and enlarge the social LTCI to all citizens without exceptions, in accordance with the models that plan an integration of SHI and PHI. They also want to broaden the income basis to which contributions to the social LTCI refer. Currently, contributions depend on wage income only. Capital income is not taken into account. The plans of the Green Party go in the same direction. Moreover, they explicitly want to strengthen the collective capital reserve of the social LTCI by increasing the contribution rate and, thus, save money for future expenditures. The party Die Linke ("the left") is also in favour of abolishing the private LTCI and broadening the income basis for contributions. Moreover, it wants to considerably expand benefits of the social LTCI.[42]

Furthermore, there are scientific contributions to the current debate. Schmähl (2010) calls for attention to the fact that the introduction of an additional, individualised LTCI with capital accumulation would increase the burden for the payers for a very long time period without reducing the contributions to the current pay-as-you-go social LTCI. Furthermore, insurances based on capital accumulation also incur the capital market risks, which have to be taken into account. Häcker, Hackmann and Raffelhüschen (2010) argue in favour of a reduction of benefits of the LTCI in that no benefits are granted in the first year(s) of being in care ("waiting time"), but without changes in benefits in the following years. The idea is that small risks, i.e. the costs of the first year(s) of being in care, are to be borne fully by the insurees while large risks, i.e. costs of being in care for an unknown length of time, by the insurance. They show that the future financial liabilities of the social LTCI will diminish considerably, though not completely. By introducing a waiting time of one year, the contribution rate to the

[42] See homepages of the parties mentioned.

social LTCI would only increase to 3.8% – instead of the estimated 4.4%. If the waiting time would be extended to three years, the contribution rate could remain stable at 1.95% for all years to come.
Another issue in the current debate is the validity of the ratings in the transparency reports for nursing homes. There are 64 different ratings, of which, however, only few about outcome quality and most of them about structural and process quality. Equal weighting of all ratings makes it possible to compensate bad ratings in care by good ratings in service. There are no knock-out criteria for bad outcome quality. See Hasseler and Wolf-Ostermann (2010) for a further discussion. Moreover, LTC providers argue that the institution MDK, which gives the ratings, is not independent, as it is part of the organisation of the SHIs.
Finally, an intensive public debate on the current and expected lack of qualified nurses is going on. While financing the growing demand for care is the most important issue, another one, almost as important, is how to provide LTC. Since LTC is very labour-intensive, more demand for care means an increasing demand for personnel. Providers already report difficulties in finding qualified personnel. The problem might intensify in the medium term. Several measures are discussed to alleviate it: (i) increase attractiveness of the job of a nurse, (ii) immigration of qualified nurses, especially from outside Europe.

2.3.3 Impact of EU social policies on the national level

Concerning the open method of coordination (OMC), Germany has organised three peer reviews so far, one of them in the area of LTC, held in Murnau, Germany, in October 2010 (see Leichsenring 2011), on quality in residential care facilities. This topic is a concern in all EU member states and at the EU level. Nine other member states joined the peer review. The German experience stimulated a lively debate and prompted participants to present their experiences. The debate came to the following agreements or conclusions: minimum standards are needed for long-term residential care and compliance should be monitored. External quality management systems involve internal quality management systems. The introduction of such systems requires participative leadership, human resource management, training and lifelong learning. Moreover, transparency of quality can stimulate performance-based pricing of care homes. Finally, modernisation of care homes entails openness to other parts of the care chain. The relationship between health services and social services needs further discussion. Some countries' perspectives on LTC are more health-oriented, while others are more focused on social services.

2.3.4 Impact assessment

Looking back, the financial crisis in 2008 and 2009 has not had an impact on financing or LTC in Germany. However, concerning private investors, there seems to be a reduced interest in investment in nursing homes. Due to some overcapacities of nursing home places in these years, there was no problem for the provision of nursing home care. Furthermore, since the German economy has recovered quickly, negative effects on social LTCI in the medium term are not expected. However, the value of accumulated capital in the private LTCIs has grown less in 2009 than in former years.

Looking forward, there is a demand for expanding the benefits of the LTCI to people with dementia and for increasing benefits according to price inflation to avoid growing poverty of people in need of care. In contrast, the number of payers to the LTCI will diminish in the future. Thus, there will be a financial gap in LTCI – assuming that the economy grows as usual. In politics, there is no debate on how to close this gap in the long-term, but only on how to close it in the short-term. In the scientific debate different solutions are discussed: e.g. (i) reducing the benefits for LTC, (ii) increasing the contribution rate to LTCI, (iii) increasing

the contribution of high-income insurees, (iv) abolishing private LTCI to strengthen social LTCI, (v) introducing a mandatory additional private LTC insurance with capital accumulation.

Another important issue is the provision of formal and informal care. Currently, the majority of people in need of care are looked for by family members. The typical scenario is that children at the age of 50 to 65 years care for their parents at the age of 80 and above. Since the generation between 50 and 65 years belongs to the so-called baby boomers, their number will increase in this decade. Therefore, there might be an increasing potential of informal care by family members. However, once the baby boomers will reach the age of 80, beginning in the 2030s, family members will become rarer and a huge number of professional nurses will be necessary. However, already in 2011 there is a substantial lack of nurses. In order to increase the number of nurses, wages and the attractiveness of the job in general have to increase, which puts a further pressure on costs of care.

Finally, efficiency of the provision of care plays an important role in the public debate. For the assessment of efficiency, quality of care has to be measured. To this end, transparency reports have been introduced in Germany in 2009. There 64 standardised items in five dimensions to be assessed by ratings: (i) care and medicine, (ii) interaction with people with dementia, (iii) social assistance, (iv) board and lodging, (v) interviews of the people in need of care. These reports make nursing homes directly comparable. However, the validity of the transparency reports has been criticised. They might be refined in the future. However, they will not be given up because they are valuable for people in need of care looking for professional care. With the development of external and internal quality management tools, a learning process with regard to quality starts. Moreover, external institutions like the MDK control quality of nursing homes once a year – much more often than before the introduction of the transparency reports. In sum, competition between nursing homes based on transparent quality measures as well as annual controls by the MDK should lead to an increase in quality in the medium term.

2.3.5 Critical assessment of reforms, discussions and research carried out

There is no doubt that the financial situation of the social LTCI is not sustainable. The question is how to close the financial gap in the future. In my view, the burden of closing the gap has to be distributed among all relevant groups: the wage earners, the pensioners, the people in need of care, and the providers of LTC. An increase of the contribution rate to social LTCI is inevitable. However, the large rate of 4.4% expected by 2050 is unacceptably high and burdens pensioners and especially wage earners, who will have to pay higher contributions to other social insurances and taxes as well. However, current pensioners could carry a somewhat larger part of the growing burden because they have profited from the introduction of LTCI in 1995. A stronger increase in contributions for insurees with a high income raises quasi-taxes and makes working in Germany less attractive. Since Germany needs highly-qualified immigration on the one hand, and has to avoid a corresponding emigration on the other, quasi-taxes for high income should only be raised moderately. However, the parallel system of social and private LTCI has no rational justification and should, therefore, be abandoned.

Furthermore, benefits of the LTCI cannot be increased to as large an extent as might be expected from a reform of the definition of being in need of care. If benefits for people with dementia are to be expanded, other benefits have to be reduced in return. The introduction of a waiting time, as discussed above, would be an arguable measure. Moreover, in order to keep welfare expenditures for people in need of care who are unable to bear the co-payment for

LTC services under control, the "basic care package" cannot include "luxury" services, e.g. single rooms.

Next, the efficiency of the provision of LTC can still be increased. Firstly, there is still a lot of bureaucratic ballast that makes the system less efficient. Secondly, competition between providers is still weak. There are considerable regional price differences in residential care, which cannot be explained by quality differences and labour costs alone. Transparency of quality may induce more competition between nursing homes, thus mitigating price differences in the future. Yet, the criticism on the ratings for nursing homes has to be taken seriously. Although I highly advocate standardised transparency reports, there should also be room for improvement in the reports. Moreover, I would also suggest creating an independent institution that gives the ratings in the transparency reports by transforming the MDK into an independent organisation.

Notwithstanding, it is indispensable to make the job of a nurse more attractive. However, this will increase, once more, the costs of LTC and the gap in financing care. Moreover, other industries will react in increasing the attractiveness for their jobs as well. In the end, I suppose that – although necessary – increasing attractiveness alone will not help to close the lack in qualified personnel. Therefore, it is also essential to implement a rigorous immigration system in order to acquire qualified nurses.

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Pension Policy" is Necessary), *ZeS-Arbeitspapier* 1/2011, Zentrum für Sozialpolitik, Universität Bremen, 2011.

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STATISTISCHES BUNDESAMT (2011b), Pflegestatistik 2009, Pflege im Rahmen der Pflegeversicherung, Deutschlandergebnisse, statistical overview, February 2011, Wiesbaden, Germany.

TAMM, MARCUS; TAUCHMANN, HARALD; WASEM, JÜRGEN and GREß, STEFAN (2007), Elasticities of Market Shares and Social Health Insurance Choice in Germany: A Dynamic Panel Data Approach, *Health Economics* 16 (3), pp. 243-256, journal article, March 2007.

THIEDE, REINHOLD (2011), Riester-Rente: Verteilungswirkungen der Zulagenförderung, *RVaktuell* 3/2011, pp. 71-78.

WALWEI, ULRICH (2010), Arbeitsmarktchancen Älterer – empirische Befunde und Perspektiven, in: *DRV* 2010, pp. 421-433.

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WINDHÖVEL, KERSTIN; FUNKE, CLAUDIA and MÖLLER, JAN-CHRISTIAN (2011), *Fortentwicklung der gesetzlichen Rentenversicherung zu einer Erwerbstätigenversicherung*, Düsseldorf, 2011.

3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R5] BIEBER, Ulrich and STEGMANN, Michael (2011), Aktuelle Daten zur Altersarmut in Deutschland in: Deutsche Rentenversicherung 1/2011, pp.66-86.

"Actual data on poverty in old age in Germany"

Data from different sources are presented that are relevant when talking about poverty in old age.

[R5] BÖRSCH-SUPAN, Axel and GASCHE, Martin (2010), Zur Sinnhaftigkeit der Riester-Rente, mea Discussion paper 197-2010, Mannheim.

"Why the Riester-pension makes sense"

The authors underline their position that the subsidised private pension is necessary also after the financial crisis.

[R3] BUNDESMINISTERIUM FÜR ARBEIT UND SOZIALES (2010), Aufbruch in die altersgerechte Arbeitswelt– Bericht der Bundesregierung gemäß § 154 Abs. 4 Sechstes Buch Sozialgesetzbuch zur Anhebung der Regelaltersgrenze auf 67 Jahre

"Departure towards a world of labour fair for all ages"

The report of the government gives data on labour markets for older workers and arguments why an increase in the "standard" retirement age from 65 to 67 is necessary and has positive effects.

[R5] DEDRING, Klaus-Heinrich; DEML, Jörg; DÖRING, Diether; STEFFEN, Johannes and ZWIENER, Rudolf (2010), Rückkehr zur lebensstandardsichernden und armutsfesten Rente WISO Diskurs, Bonn.

"Return towards a pension securing the standard of living and avoiding poverty"

The authors point out negative effects of the present pension policy and argue in favour of changing the pension policy, discussing several instruments in realising this.

[R2] FACHINGER, Uwe and FRANKUS, Anna (2011), Sozialpolitische Probleme bei der Eingliederung von Selbständigen in die gesetzliche Rentenversicherung. Friedrich Ebert Stiftung (WISO Diskurs), Bonn, Februar 2011.

"Integrating self employed persons in the social pension scheme – problems from a social policy point of view"

The paper discusses problems for integrating different groups of self-employed persons into the social pension insurance.

[R5] FLECKEN, Hans Ludwig (2010), Wie stellt sich die Bundesregierung die Umsetzung eines einheitlichen Rentenrechts in Ost und West vor?, in: verdi (ed.), Workshop: 20 Jahre Rente im vereinten Deutschland, Berlin, pp. 37-48.

"Which plans have the government for realising identical rules in pension law in East and West?"

The author, a high ranking official of the Ministry of Labour and Social Affairs, outlines different proposals on how to realise common rules in social pension insurance for pensioners in East and West Germany, eliminating transitory rules implemented in the process of German unification.

[R3] GASCHE, Martin (2011), Ist die Rente mit 67 ein Rentenkürzungsprogramm? Auf die Sichtweise kommt es an, Wirtschaftsdienst 1/2011, pp. 53-60.

"Is a pensionable age of 67 a programme to cut pensions?"

Different points of view are discussed when looking at the effects of a higher „standard" retirement age on the income position of workers.

[R5] HAAK, Carroll (2011), Das angesparte Altersvorsorgekapital aus Riester-Verträgen: Eine empirische Auswertung auf Basis der Befragung „Individuelle Altersvorsorge 2009" in: DRV 1/2011, pp. 105-116.

"Capital for old age from Riester-contracts"

Gives some information on how much capital during the first years of subsidised private pensions was accumulated.

[R5] HOCKERTS, Hans-Günter (2010), Abschied von der dynamischen Rente – Über den Einzug der Demographie und der Finanzindustrie in die Politik der Alterssicherung in: Ulrich Becker, Hans-Günter Hockerts, Klaus Tenfelde (Hrsg.), Sozialstaat Deutschland – Geschichte und Gegenwart –, Bonn, pp. 257-286

"Goodbye to a dynamic pension"

The author describes the process of focusing the German debate in pension policy on demographics and the role of the financial industry.

[R5] RIECKHOFF, Christian (2011), Wohin steuert die Riester-Rente? – Stand der Forschung, Kritik der Ergebnisse und zukünftiger Forschungsbedarf, DRV 1/2011, pp. 87-104.

"Where is the Riester-pension heading?"

The author analyses several research papers dealing with the subsidised private pensions and points at several shortcomings in research up to now.

[R2] RULAND, Franz (2010), Ausbau der Rentenversicherung zu einer allgemeinen Erwerbstätigenversicherung? in: Ulrich Becker, Hans-Günter Hockerts, Klaus Tenfelde (Hrsg.), Sozialstaat Deutschland – Geschichte und Gegenwart –, Bonn, pp. 297-312.

"Extending social pension insurance into a general scheme for all persons gainfully employed?"

The author gives arguments for integrating in particular several groups of self-employed into social pension insurance and discussed also whether this is compatible with the German constitution

[R1] SACHVERSTÄNDIGENRAT ZUR BEGUTACHTUNG DER GEAMTWIRT-SCHAFTLICHEN ENTWICKLUNG (2011): Herausforderungen des demografischen Wandels. Wiesbaden, May 2011.

Retrieved from: http://www.sachverstaendigenratwirtschaft.de/fileadmin/dateiablage/Expertisen/2011/expertise_2011-demografischer-wandel.pdf on 14th June 2011

"Challenges of demographic change"

This expertise analyses the impact of demographic aeging on products- and financial markets, the production capacities, the labour market and public budgets. It includes projections of public expenditures on pensions, health, unemployment and education/family policies in 2060.

[R5] SCHMÄHL, Winfried (2011a), Von der Ergänzung der gesetzlichen Rentenversicherung zu deren partiellem Ersatz: Ziele, Entscheidungen sowie sozial- und verteilungspolitische Wirkungen – Zur Entwicklung von der Mitte der 1990er Jahre bis 2009]-, in: Eberhard Eichenhofer, Herbert Rische, Winfried Schmähl (eds.), Handbuch der gesetzlichen Rentenversicherung SGB VI (HDR, Kap. 6), Köln (Luchterhand), pp. 169-249.

"From supplementing social insurance towards partial substitute – objectives, decisions and social and distributional effects"

The author describes the political process within two decades in developing a new strategy in pension policy by reducing social insurance pensions and substituting this income loss in part by subsidised private pensions, including occupational pensions. Relevant effects from a social policy point of view and regarding income distribution are outlined.

[R5] SCHMÄHL, Winfried (2011b), Warum ein Abschied von der „neuen deutschen Alterssicherungspolitik" notwendig ist, ZeS-Arbeitspapier 1/2011, Zentrum für Sozialpolitik, Universität Bremen.

„Why saying farewell to the "new German pension policy" is necessary"

Starting with the effects of the new pension policy in Germany the author outlines an alternative strategy which will, instead of substituting social pensions, supplement them by private pension provision and points at several instruments that could realise this.

[R3] SOZIALBEIRAT (2010), Gutachten des Sozialbeirats zum Rentenversicherungsbericht 2010

Retrieved from http://www.sozialbeirat.de/files/2010__11__29__gutachten__rentenversicherungsbericht__2010.pdf on 14th June 2011

„Report of the Social Advisory Board"

The annual report discusses in particular different positions of social partners regarding the increase of the „standard" retirement age.

[R5] THIEDE, Reinhold (2011), Riester-Rente: Verteilungswirkungen der Zulagenförderung RVaktuell 3/2011, pp. 71-78.

"Riester-pension: Distributional effects of subsidies"

The author presents data that shows that the subsidies for private pensions are favouring in particular low-income earners and families.

[R4] WALWEI, Ulrich (2010), Arbeitsmarktchancen Älterer – empirische Befunde und Perspektiven, in: Deutsche Rentenversicherung, S. 421-433.

"Chances on the labour market for elderly people – empirical facts and perspectives"

The author gives empirical facts on the situation of older workers on labour markets.

[R2] WINDHÖVEL, Kerstin; FUNKE, Claudia and MÖLLER, Jan-Christian (2011), Fortentwicklung der gesetzlichen Rentenversicherung zu einer Erwerbstätigenversicherung Düsseldorf.

"Developing social pension insurance as a scheme for all gainfully employed persons"

The report presents information, based on model calculations, when integrating additional groups of the working population into the social pension scheme, either those not yet covered mandatorily or those who are now members of another scheme.

[H] Health

[**H3**] BECKER, Bettina and UEBELMESSER, Silke (2010), Health Insurance Competition in Germany – the Role of Advertising, *Schmollers Jahrbuch* 130(2), 169-194. http://www.atypon-link.com/DH/doi/abs/10.3790/schm.130.2.169

"Health Insurance Competition in Germany – the Role of Advertising"

In the 1990s, competition among public health insurance funds ('SHIs') was introduced in Germany. As one means of competition, free choice of initial health funds and subsequent switching between them was made available to all insured. Since then, the number of funds has decreased substantially, and funds have had to engage in competitive strategies to remain in the market. In this paper, the authors want to analyse the funds' advertising activities in the face of the changed competitive environment. This has not been possible to date due to a lack of data. They use two new datasets to get a first insight into the potential effects of competition on funds' advertising strategies; one of the volume and cost of advertisements and one of their contents. Our results suggest that competition has been associated with an increase in the amount of advertising. As to the adverts themselves, the authors find that there

was a decrease in the share of advertisements of a 'general' content in favour of advertisements of a more 'fund-specific' content. The data therefore indicate that once the market was open to switching of funds by the insured, funds' advertising efforts changed to differentiating their own perceived strengths from those of competitor funds. These observations allow them to draw some tentative conclusions about the relevance of (attempts of) risk selection by health funds via advertisements and about the general success of the pro-competitive legislation.

[**H1; H2; H4**] BREYER, Friedrich (2010), Gesundheitspolitik, *Vierteljahreshefte zur Wirtschaftsforschung* 79 (1), 44-55.
http://www.atypon-link.com/DH/doi/abs/10.3790/vjh.79.1.44

„Health Policy"

Federal Health Secretary Rösler deems a reform of the wage-related contribution system in the German social health insurance (SHI) his most important project for the next 4 years. Indeed such a reform would greatly enhance competition in the GKV system. However, other topics are equally important for efficiency, quality and sustainability of the German health care system: more freedom of contract for SHIs, a better design of co-payments to control health care demand, better methods for evaluating new pharmaceuticals, more competition in private health insurance, and the procurement of more organ transplants through introducing the presumed consent rule. Finally, Germany needs a broad social debate on the benefit package of social health insurance to secure long-term sustainability of the system.

[H5; H6] GRESS, Stefan and MANOUGUIAN, Maral-Sonja (2010), Health Care System Change and the Cross-Border Transfer of Ideas: Influence of the Dutch Model on the 2007 German Health Reform, *Journal of Health Politics, Policy and Law* 35(4), 539-568.
http://jhppl.dukejournals.org/cgi/content/abstract/35/4/539

"Health Care System Change and the Cross-Border Transfer of Ideas: Influence of the Dutch Model on the 2007 German Health Reform"

To increase understanding of the cross-border transfer of ideas through a case study of the 2007 German health reform, this article draws on Kingdon's approach of streams and follows two main objectives: first, to understand the extent to which the German health reform was actually influenced by the Dutch model and, second, in theoretical terms, to inform inductively on how ideas from abroad enter government agendas. The results show that the streams of problem recognition and policy proposals have not been predominantly influenced by the cross-border transfer of ideas from the Netherlands to Germany. The Dutch experience was taken into consideration only after a policy window opened by a shift in politics in the third, the political, stream: the change of government in 2005. In many respects, the way Germany learned from the Netherlands in this case sharply contrasts with an image of solving policy problems by either lesson-drawing or transnational deliberation. Instead, the process was dominated by problem-solving in the sphere of politics, i.e. finding a way to prove the grand coalition was capable of acting.

[**H2; H4**] LISAC, Melanie, REIMERS, HENKE, Klaus-Dirk and SCHLETTE, Sophia (2010). Access and Choice – Competition under the Roof of Solidarity in German Health Care: an Analysis of Health Policy Reforms since 2004. *Health Economics, Policy and Law* 5, 31-52.
http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=6851252
"Access and Choice – Competition under the Roof of Solidarity in German Health Care: an

Analysis of Health Policy Reforms since 2004"

This paper analyses the influence of recent German health care reforms, the Statutory Health Insurance Modernisation Act 2004 and the Statutory Health Insurance Competition Strengthening Act 2007, on different dimensions of access and choice. More specifically, the authors look at and discuss the effects of these policies on the availability, reachability and affordability of health care as well as on their impact on consumers' choice of insurers and providers. Generally, patients in Germany enjoy a high degree of free access and a lot of freedom to choose, partly leading to over- and misuse of health services. Concerning choice of insurers, one result of the analysis is that in the statutory health insurance system, the introduction of a greater variety of benefit packages will develop into an additional parameter of choice. In contrast to that, insurees more and more accept certain restrictions of choice and direct access to providers by enrolling into new forms of care (such as gatekeeping-, disease management- and integrated care programmes). However, they might benefit from better quality of care and more options for products and services that best fit their needs.

[H5] MENNICKEN, Roman , AUGURZKY, Boris, ROTHGANG, Heinz and WASEM, Jürgen (2010), Explaining Differences in Remuneration Rates of Nursing Homes in Germany, Ruhr *Economic Papers #215*
http://en.rwi-essen.de/publikationen/ruhr-economic-papers/319/

"Explaining Differences in Remuneration Rates of Nursing Homes in Germany"

Remuneration rates of German nursing homes are prospectively negotiated between long-term care insurance (LTCI) and social assistance on the one side, and nursing homes on the other. They differ considerably across regions, while there is no evidence for substantial differences in care provision. This paper explains the differences in the remuneration rates by observable characteristics of the nursing home, its residents and its region, with a special focus on the largest federal state North-Rhine-Westphalia, in which the most expensive nursing homes are located. The authors use data from the German Federal Statistical Office for 2005 on all nursing homes that offer full-time residential care for the elderly. They find that differences in remuneration rates can partly be explained by exogenous factors. Controls for residents, nursing homes, and district characteristics explain roughly 30% of the price difference; 40% can be ascribed to a regionally different kind of negotiation between nursing homes and LTCI. 30% of the raw price difference remains unexplained by observable characteristics.

[H2; H4] PUHANI, Patrick A. and SONDERHOF, Katja (2010), The Effects of a Sick Pay Reform on Absence and on Health-related Outcomes, *Journal of Health Economics* 29(2), 285-302.
http://www.sciencedirect.com/

"The Effects of a Sick Pay Reform on Absence and on Health-related Outcomes"

The authors evaluate the effects of a reduction in sick pay from 100 to 80% of the wage. Unlike previous literature, apart from absence from work, they also consider effects on doctor/hospital visits and subjective health indicators. The analysis also adds to the literature by estimating both switch-on and switch-off effects, because the reform was repealed 2 years later. The authors find a 2-day reduction in the number of days of absence. Quantile regression reveals higher point estimates (both in absolute and relative terms) at higher quantiles, meaning that the reform predominantly reduced long durations of absence. In terms of health, the reform reduced the average number of days spent in hospital by almost half a day, but they cannot find robust evidence for negative effects on health outcomes or perceived liquidity constraints.

[H1; H4] SCHREYÖGG, Jonas, GRABKA, M.M. (2010), Copayments for Ambulatory Care in Germany: a Natural Experiment Using a Difference-in-difference Approach, *European Journal of Health Economics* 11(3), 331-41.
http://www.springerlink.com/content/ut5121252871u291/

"Copayments for Ambulatory Care in Germany: a Natural Experiment Using a Difference-in-difference Approach"
In response to increasing health expenditures and a high number of physician visits, the German government introduced a copayment for ambulatory care in 2004 for individuals with statutory health insurance (SHI). Because persons with private insurance were exempt from the copayments, this health-care reform can be regarded as a natural experiment. The authors used a difference-in-difference approach to examine whether the new copayment effectively reduced the overall demand for physician visits and to explore whether it acted as a deterrent to vulnerable groups, such as those with low income or chronic conditions. The authors found that there was no significant reduction in the number of physician visits among SHI members compared to the control group. At the same time, the authors did not observe a deterrent effect among vulnerable individuals. Thus, the copayment has failed to reduce the demand for physician visits. It is likely that this result is due to the design of the copayment scheme, as the copayment is low and is paid only for the first physician visit per quarter.

[L] Long-term care
[L] ARNOLD, R., ROTHGANG, Heinz (2010), Finanzausgleich zwischen Sozialer Pflegeversicherung und Privater Pflegeversicherung. In welchem Umfang ist ein Finanzausgleich aus Gründen der Gleichbehandlung notwendig? In: Göpffarth, D.; Greß, S.; Jacobs, K.; Wasem, J. (Hrsg.): Jahrbuch Risikostrukturausgleich 2009/2010. Von der Selektion zur Manipulation? Heidelberg: Medhochzwei Verlag. S. 65-94.

"Financial compensation between social and private LTCI"

In 1996 both the social and private LTCI were introduced. People insured by the SHI were assigned to the social and people insured by the PHI to the private LTCI. Within each LTCI there are elements of risk and financial redistribution. However, there is no compensation between the social and private LTCI. This paper analyses whether there is a need for such compensation and, if so, to which extent, based on the prerequisite that everybody should participate in the redistribution of risk and income. Since privately insured have, on average, a higher income than insurees in the social LTCI, there should be an income redistribution of EUR 1 billion per year in favour of the social LTCI, i.e. EUR 120 per privately insured and per year. Moreover, expenditures of the privately insured are, on average, lower. Hence, there should be compensation in favour of the social LTCI in the region of EUR 885 million per year, which might decrease in the future.

[L] AUGURZKY, Boris, MENNICKEN, Roman, RÖHRIG, Bernd und WEIBLER-VILLALOBOS, Ursula (2010), Do Higher Remuneration Rates Result in Better Quality? Evidence from nursing homes in Rhineland-Palatinate, Gesundheitsökonomie & Qualitätsmanagement 6/2010, 292-298.

Professional long-term care is of growing importance in Germany. There is substantial regional variation in remuneration rates of nursing homes. So far it remains unclear whether higher remuneration rates lead to better quality of care. This paper analyses the relationship of nursing home quality and the average care costs. The authors include as controls the size and the ownership of the nursing home as well as regional differences. The results show that higher remuneration rates are positively correlated with better structural conditions (equipment and head of nursing home) and a better quality management. However, there is no

association with outcome quality. Obviously, better structural conditions and better quality management do not result in providing better quality of care.

[L] BERLIN INSTITUT FÜR BEVÖLKERUNG UND ENTWICKLUNG (2011), Demenz-Report, Wie sich die Regionen in Deutschland, Österreich und der Schweiz auf die Alterung der Gesellschaft vorbereiten können, report, Berlin Institut für Bevölkerung und Entwicklung, February 2011, Berlin, Germany.

"Report on dementia"

The report gives a thorough overview of the illness of dementia in Germany, Austria and Switzerland. There are roughly 1.3 million people with dementia in Germany, 130,000 in Austria and 120,000 in Switzerland. By 2050, their number will be more than double in Germany, but the number of relatives who may care for people with dementia will reduce substantially. There are noteworthy regional differences, some regions face severe challenges and have to look for solutions. The authors point out that more money is not the only solution but also increasing the awareness for dementia in the public: people with dementia can have a normal life if the neighbourhood is aware and prepared.

[L] BMFSFJ [=Bundesministerium für Familie, Senioren, Frauen und Jugend] (2010): Wohnen für (Mehr)Generationen. Gemeinschaft stärken – Quartier beleben. Rostock: Publikationsversand der Bundesregierung, August 2010, Berlin.

"Living for more generations"

Most of the elderly want to participate actively in social life and keep contacts with the younger generation. This report presents 30 examples where more than one generation live together in one area.

[L] HÄCKER, Jasmin, HACKMANN, Tobias, and RAFFELHÜSCHEN, Bernd (2010), Pflegereform 2010: Karenzzeiten in der Sozialen Pflegeversicherung, Discussion paper, Forschungszentrum Generationenverträge, no. 46, July 2010, Freiburg, Germany.

"Waiting times in the social LTCI"

As current research, as well as current data, reveal, the German long-term care insurance (LTCI) is expected to run a deficit in 2012. Additionally, further expenses will be incurred due to the newly conceptualised definition of long-term care needs – in future, five instead of three care levels are to meet the needs of LTC patients. In order to account for the demographic turbulence ahead, the German LTCI is in urgent need of a broad reform. The paper suggests a reasonable transition from the current pay-as-you-go system to a partly funded strategy, thereby accounting for the burden each generation is confronted with. With the help of generational accounting, the authors demonstrate that a certain waiting period (Karenzzeit) until LTC benefits are granted achieves an intergenerational balance. This reform proposal stems from the analysis of the length of stay in LTC.

[L] HÄCKER, Jasmin and HACKMANN, Tobias (2010), LOS(T) in Long-Term Care: Empirical Evidence from German Data 2000-2009, Discussion paper, Forschungszentrum Generationenverträge, no. 43, May 2010, Freiburg, Germany.

Using microdata, i.e. representative samples of 114,403 German long-term care dependants (LTCDs) observed from 2000 to 2009, the authors give a comprehensive insight into the length of stay (LOS) in long-term care (LTC). Furthermore, this paper evaluates the effects of

longevity on the LOS, thus revisiting the debate on the validity of the competing theories of compression or expansion of morbidity in LTC. The analysis finds significant effects on the LOS when age is controlled for, thus rejecting the time-to-death hypothesis. However, controlling for assessment level suggests an improved health status of LTCDs over time, thus supporting the time-to-death hypothesis. An analysis of the mortality rates of LTCDs is to give insight into the opposing results. But the regression of mortality shows a divergence in the development of mortality rates for different disability levels. This is evidence to suggest that the "improved" health status in LTC is not only due to actual changes in the health status, but also a consequence of political meddling.

[L] HACKMANN, Tobias (2010a), Arbeitsmarkt Pflege: Bestimmung der künftigen Altenpflegekräfte unter Berücksichtigung der Berufsverweildauer, in Sozialer Fortschritt, 59(9), p. 235-244.

"Who will Nurse in the Future? A Calculation of Prospective Long-term Care Professionals with Particular Reference to Job Duration"

As a result of an expected increase of 170% in the number of persons who will need formal long-term care and as a result of an anticipated decrease in the labour supply of 40% by 2050, one challenge for the future nursing labour market will be to find enough professional nursing staff. Building on this insight, this paper specifies different supply and demand factors that influence the existence and extent of future nursing shortages. Based on the relationship between these factors, a supply and a demand function for nursing staff will be calculated separately in a time-series framework. Separating the effects of an increase in demand of formal long-term care from those associated with the decline in the labour supply, the model shows an increase in the number of nurses working in the long-term care sector of 30% by 2050. This will lead to an acute shortage of nurses. In this context, special attention should be given to prolonging the job duration of nurses.

[L] HACKMANN, Tobias (2010b), Entwicklung der professionellen Pflege vor dem Hintergrund des demografischen Wandels, in: Nienhaus, A. (Hrsg.): *Gefährdungsprofile - Unfälle und arbeitsbedingte Erkrankungen in Gesundheitsdienst und Wohlfahrtspflege*, Hamburg, 96-112.

"Development of professional care against the background of demographic change"

The number of people in need of care will probably increase from 2.3 million in 2007 to 4.4 million by 2050. This paper estimates the corresponding need for and supply of nurses and whether increasing the length of stay in the job of a nurse can help to reduce the gap between the need for and supply of nurses. Currently, the length of stay in the job is around 8.4 years. In contrast, hospital nurses stay 13.7 years in their job. If the length of stay of nurses for the elderly increased from 8.4 to 13.7 years, the additional need for nurses would be 15 to 48% lower – depending on scenario assumptions.

[L] HEINICKE, Katrin and THOMSON, Stephan L. (2010): The Social Long-term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives, ZEW Discussion paper no. 10-012, Mannheim, Germany.

This paper describes the social LTCI in Germany. Based on a short review of the history of long-term care organisation and the preceding laws in Germany, the implementation of the LTCI as a self-standing pillar within the system of social insurances in Germany and its set-up

with regard to eligibility criteria, service provision and financial budget are presented. Since social LTCI is a universal, contribution-financed insurance, the ageing society and the corresponding shifts in the number of persons in need of care and the number of persons potentially providing informal care are challenges for its sustainability. Seven recently suggested reform options are discussed in the paper showing potential pathways to a sufficient provision of care services in the future.

[L] KEESE, Matthias, MENG, Annika, and SCHNABEL, Reinhold (2010), Are You Well Prepared for Long-term Care? – Assessing Financial Gaps in Private German Care Provision, Ruhr Economic Papers 0203, September 2010, Essen.

The development of expenditure for care services is one of the most intensively debated topics in public. However, studies calculating financial provision gaps only focus on the macro-level implications for the compulsory care insurance. In contrast, this paper examines the individuals' micro-level perspective. They authors use survey as well as regional and national statistical data to calculate expected individual costs of long-term care on a very detailed care arrangement and care level basis. Afterwards, they compare these costs with the individuals' total wealth. In their most conservative policy scenario, the results show that about a third of statutorily insured individuals will have to face a financial care provision gap. Among homeowners, an even higher share will have to liquidate the main residence. The privately insured are affected to a somewhat lower extent. In both groups, the situation will become much more severe if the development of public transfers does not keep up with future increases of long-term care costs. Furthermore, regression analyses show that provision gaps are more frequent among statutorily insured individuals, females, and individuals in single households.

[L] MENG, Annika (2010), Long-term Care Responsibility and its Opportunity Costs, Ruhr Economic Papers 0168, February 2010, Essen.

This paper analyses the relationship between long-term care provision and the average individual wage rate. In addition, the effects of the number of hours spent on caregiving on the probability of employment as well as on the number of hours worked are examined. Data from the Survey of Health, Ageing and Retirement (SHARE) of 2004 and 2006 is used to analyse caregiving effects on the European labour market. Descriptive statistics show a positive correlation between hours of care and the wage rate for those working. In the regression analysis, sample-selection models combined with instrumental-variable estimation are used to estimate the causal effects of hours of care on wages. The results illustrate that care for parents has a large negative impact on the individual's wage rate. Test results show that controlling for sample selection is reasonable. Finally, the probability of employment is only decreased in the female sample. Although the hours worked are not significantly affected.

[L] MENG, Annika (2010), The Impact of Demographic Change, Co-morbidity and European Care Policies on the Choice of Care Arrangement, Ruhr Economic Papers 0224, November 2010, Essen.

Recent literature on long-term care looks at the substitutability of informal and professional home-based care arrangements. Other factors that influence the utilisation of informal care instead of formal care have been ignored in conditional analyses so far. However, regressors that represent demographic change and the development of co-morbidity are of crucial

interest to forecast the future choice between different care services. Therefore, the author uses SHARE data from 2004, as they contain rich information on illnesses, health limitations, and health behaviour. She estimates bivariate and multivariate probit models to identify the determinants of different care arrangements, namely informal care, professional home-based care, or a combination of both types, as well as living in a nursing home. Unobserved factors that affect all forms of care arrangements simultaneously can be accounted for. Moreover, she uses data on European long-term care expenditure to examine the effects that public spending has on the choice of care arrangements. Simulations of different scenarios of demographic change illustrate that the developments in frailty are decisive for the future care market structure.

[L] MENNICKEN, Roman, AUGURZKY, Boris, ROTHGANG, Heinz, and WASEM, Jürgen (2010), Explaining Differences in Remuneration Rates of Nursing Homes in Germany, Ruhr Economic Papers No. 215, Essen.

Remuneration rates of German nursing homes are prospectively negotiated between long-term care insurance (LTCI) and social assistance on the one side, and nursing homes on the other. They differ considerably across regions, while there is no evidence for substantial differences in care provision. This paper explains the differences in the remuneration rates by observable characteristics of the nursing home, its residents and its region, with a special focus on the largest federal state North-Rhine-Westphalia, in which the most expensive nursing homes are located. The authors use data from the German Federal Statistical Office for 2005 on all nursing homes that offer full-time residential care for the elderly. They find that differences in remuneration rates can partly be explained by exogenous factors. Controls for residents, nursing homes, and district characteristics explain roughly 30% of the price difference; 40% can be ascribed to a regionally different kind of negotiation between nursing homes and LTCI. 30% of the raw price difference remains unexplained by observable characteristics.

[L] MÜLLER, R.; UNGER, R.; ROTHGANG, H. (2010): Wie lange Angehörige zu Hause gepflegt werden. Reicht eine zweijährige Familien-Pflegezeit für Arbeitnehmer? In: Soziale Sicherheit, 59, 6-7, S. 230-237.

"How long do relatives care for their family members in need of care?"

The Federal Ministry for Family, Senior Citizens, Women and Youth plans to introduce a so-called family care time for employees. During the time of LTC of a relative, the employee receives the right to work part-time. The family care time should last up to two years. This paper analyses the typical length of family care based on three empirical studies. They find out that after one year 50% of all men and after two years 50% of all women and 61% of all men are not cared for anymore at home. Hence, two years of "family care time" would be enough.

[L] ROTHGANG, Heinz, IWANSKY, Stephanie, MÜLLER, Rolf, SAUER, Sebastian, UNGER, Rainer; BARMER GEK Pflegereport 2010, Schwerpunktthema Demenz und Pflege; November 2010, Schäbisch Gmünd, retrieved from http://www.zes.uni-bremen.de/homepages/rothgang/downloads/2010_BarmerGEK-Pflegereport.pdf.

"BARMER GEK LTC Report 2010"

The report gives a review of LTC politics in 2009 and 2010, analyses public and official data as well as data of the SHI BARMER GEK in order to study the dynamics of LTC careers. In 2010, there is a special focus on dementia and LTC. The report finds that the prevalence rate for LTC has remained quite stable in recent years, but that there are large regional differences

in the average prevalence rate, and that increasing life expectancy increases length of stay in LTC, and that the prices for LTC are lower in East Germany. Concerning dementia, the authors state that the number of people with dementia is growing, that a third of all men and half of all women will be dement in the course of their life, that people with dementia typically are in need of care and need LTC longer and more intensively than people without dementia. Finally, the report works out political reform options.

[L] ROTHGANG, Heinz (2010): Social Insurance for Long-Term Care: An Evaluation of the German Model, in: Social Policy and Administration, 44, 4, S. 436–460.

After fifteen years of existence, Germany's long-term care insurance shows both successes and weaknesses. The latter led to the 2008 reform, which concentrated on quality improvements, care management and careful adjustments of benefits. While attempts to improve quality and care management contain promising elements, new rules for adjustment are disappointing. This is also true for the issue of future financing, as the modest increase in the contribution rate, which is part of the reform, only buys time. Thus, the next round of reform is already in the making, marking the scheme as a system of permanent reform. As Germany is one of the most clear-cut examples of social insurance, the assessment of this scheme and its recent reform also allow us to draw some general lessons for the design of long-term care social insurance schemes.

[L] ROTHGANG, Heinz (2010b): Gerechtigkeit im Verhältnis von Sozialer Pflegeversicherung und Privater Pflegepflichtversicherung, in: Das Gesundheitswesen, 72, 3, S. 154–160.

"Justice in the relation between social and private mandatory long-term care insurance"

The Long-term Care Insurance Act of 1994 introduced two branches of long-term care insurance (LTCI), namely the social LTCI and a mandatory private LTCI. Both branches together cover almost the whole population. Insurees of the social LTCI, however, have a higher age-specific dependency ratio. Furthermore, social LTCI covers a higher share of elderly people. Therefore, per capita expenses are twice as high as in private LTCI - even if benefits for civil servants directly financed out of the public purse are taken into consideration. Moreover, on average members of private LTCI have higher incomes. If organised according to the principles of social LTCI, private LTCI could, therefore, operate with a contribution rate that is only one third of the rate necessary in social LTCI. Being assigned to social LTC, thus, creates a considerable disadvantage for the insurees that cannot be justified. Fairness considerations, therefore, demand reform. The most simple, but politically most difficult, reform option is to abolish the dualism of social and private LTCI and create an integrated system for the whole population instead. If this is not possible, at least a risk equalisation scheme should be introduced, which equalises the risk structure concerning the expenses and – if possible – also the income side.

[L] Weber, Roland (2010), Die Zukunft der sozialen und privaten Pflegeversicherung – Anmerkungen aus aktuarischer Sicht, ASta Wirtschaft- und Sozialstatistisches Archiv 4: 43-72, Springer, 23 February 2010.

"The future of social and private long-term care insurance"

The pay-as-you-go social LTCI will have to deal with existential problems caused by the demographical changes in the German society. The research of the different concepts for the future of LTCI shows that all discussed concepts are not bringing a satisfying result to deal with the financial problems of the social LTCI. In the concept of this paper of collective

financing of the demographic effect, the increased contributions to social LTCI should be collectively absorbed by the coverage capital. The concept is stable with respect to demographical changes and has a balancing effect. For this reason, it is possible to put the social LTCI on a firm financial footing.

4 List of Important Institutions

Arbeitsgemeinschaft für betriebliche Altersversorgung e.V. aba – German Association for Company Pension Schemes

Address: Rohrbacher Str. 12, 69115 Heidelberg
Webpage: http://www.aba-online.de

Aba is an association of occupational pension scheme providers in Germany. Its tasks include the provision of information and contribution to national and international political discussions on the further development of occupational pensions, and it offers training, conferences and workshops focused on occupational pension schemes. It publishes the journal Betriebliche Altersversorgung which informs regularly on legislative developments and political discussions in the area of occupational pension schemes in Germany. On its website, aba also gives an overview of statistics and the various statistical sources for occupational pension schemes.

Bertelsmann Stiftung – Bertelsmann Foundation

Address: Carl-Bertelsmann-Str. 256, 33311 Gütersloh
Webpage: http://www.bertelsmann-stiftung.de/

Bertelsmann Stiftung's main research fields are demographic change, education, economics and health care.

Bundesministerium für Arbeit und Soziales (BMAS) – Federal Ministry of Labour and Social Affairs

Address: Wilhelmstraße 49, 10117 Berlin, Germany
Webpage: http://www.bmas.de

The BMAS is responsible for the issues labour market policy, employment, labour promotion, labour law, occupational safety and health. Also, the BMAS is responsible for the pension and accident insurance, the social security statutes (SGB), prevention and rehabilitation as well as for the system of labour courts and jurisdiction of the social courts.

Bundesministerium für Gesundheit – *Federal Ministry of Health*

Address: Am Propsthof 78a, 53121 Bonn
Webpage: https://www.bmg.bund.de

The Federal Ministry of Health is responsible for a variety of policy areas, whereby its activities focus predominantly on the drafting of laws, ordinances and administrative regulations. Moreover, by means of prevention campaigns, the Federal Ministry of Health seeks to improve the population's health. All in all, the sphere of activities pursued by the Federal Ministry of Health can be condensed into the areas of health, prevention and long-term care.

Deutsches Institut für Altersvorsorge (DIA) – German Institute for Old-age Security

Address: Lindenstr. 14, 50674 Cologne
Webpage: http://www.dia-vorsorge.de

The DIA is a private research institute focused on promoting private pensions in Germany. Specific attention is given to financial). Shareholders of the DIA are the Deutsche Bank AG, the Deutsche Bank Bauspar AG, the DWS Investment GmbH, and the Deutscher Herold AG.

Deutsches Institut für Wirtschaftsforschung (DIW) – German Institute for Economic Research

Address: DIW Berlin, Mohrenstraße 58, 10117 Berlin (Mitte)

Webpage: http://diw.de

DIW is one of the five large economic research institutes in Germany. It is focused on applied economics research and policy advice. Research topics include household composition, occupational biographies, employment, earnings, health and satisfaction indicators. They also host the German Socio-Economic Panel Study (SOEP), which offers microdata for research in the social and economic sciences. SOEP is a representative longitudinal study of private households in Germany.

Deutsche Krankenhausgesellschaft (DKG) – German Hospital Federation
Address: Wegelystraße 3, 10623 Berlin
Webpage: http://www.dkgev.de

The DKG is the association of hospital providers. It represents the interests of the German hospital sector and publishes on health care issues. Overview statistics on the hospital sector are accessible on their website.

Deutsches Krankenhausinstitut (DKI) – German Hospital Institute
Address: Hansaallee 201, 40549 Düsseldorf
Webpage: http://www.dki.de

The DKI, an institute of hospital providers, is concerned with research, policy advice and training in the hospital sector.

Deutsche Rentenversicherung – German statutory pension insurance scheme
Address: Berlin, several regional administrations, see webpage
Webpage: http://www.deutsche-rentenversicherung-bund.de/; http://www.deutsche-rentenversicherung.de/

The German statutory pension insurance scheme is the main administrative body of the statutory pension insurance in Germany. It maintains a research unit which is funding research projects in the area of pensions and rehabilitation (Forschungsnetzwerk Alterssicherung - http://forschung.deutsche-rentenversicherung.de) including a statistical research unit Forschungsdatenzentrum der Rentenversicherung (FDZ-RV) providing administrative micro data.

Deutsches Zentrum für Altersfragen (DZA) – German Centre of Gerontology
Address: Manfred-von-Richthofen-Strasse 2, 12101 Berlin-Tempelhof
Webpage: http://www.dza.de

The German Centre of Gerontology is an institute for scientific research and documentation in the fields of social gerontology and aims to evaluate, process and disseminate information about living conditions in old-age and the challenges of an ageing population for society and social policy. The major shareholder of the DZA is the Federal Ministry for Family, Senior Citizens, Women and Youth.

Mannheimer Forschungsinstitut Ökonomie und Demographischer Wandel – Mannheim Research Institute for the Economics of Ageing
Address: University of Mannheim, 68131 Mannheim
Webpage: http://www.mea.uni-mannheim.de

MEA is a research institute and part of the Faculty of Law and Economics, Department of Economics of Mannheim University. MEA evaluates micro and macroeconomic aspects of demographic change and is organised in four research units: Old-Age Provision and Savings Behaviour; Economics of Health and Life Expectancy; Macroeconomic Implications of an

Ageing Society and SHARE, an EU- and NIA-sponsored project which constructs a longitudinal Survey on Health, Ageing and Retirement in Europe.

Forschungszentrum Generationenverträge (FZG) – Research Centre Inter-generational Contracts

Address: Albert-Ludwigs-University Freiburg, 79085 Freiburg
Webpage: http://www.vwl.uni-freiburg.de/fakultaet/fiwiI/fzg

FZG, a research institute at Freiburg University directed by Bernd Raffelhüschen, focuses on the financial sustainability of social security system, fiscal policies, generational accounting, labour market and demography, health and long-term care.

Gesetzliche Krankenversicherung Spitzenverband (GKV) – Central Association for Statutory Health Insurance

Address: Mittelstraße 51, 10117 Berlin
Webpage: https://www.gkv-spitzenverband.de

The National Association of Statutory Health Insurance Funds is the newly established central association of the health insurance funds at federal level. Its responsibilities are to conclude framework contracts and remuneration agreements for inpatient, outpatient and dental care, to support the health insurance funds and their subnational associations in carrying out their tasks, to represent the interests of statutory health insurance at federal level in joint self-government with the health care providers (e.g. in the Federal Joint Committee) and vis-à-vis the Federal Ministry of Health, to decide on fundamental technical and legal questions of the contribution and reporting procedure in social insurance, to set reference prices for medicines and therapeutic appliances, as well as maximum amounts for medicines, to define requirements for remuneration negotiations and medicine agreements at "Land" level, to contribute to the design of telematics in the health care system, to define principles for prevention, self-help and rehabilitation.

Gesundheitsberichterstattung des Bundes (GBE) – Federal Health Monitoring

Address: Graurheindorfer Straße 198, 53117 Bonn
Webpage: www.gbe-bund.de

The Federal Health Monitoring is based on existing data and systematically collects scattered information from the multitude of institutions in the health sector. The data is harmonised in a way that a comprehensive picture of the entire health sector is painted: framework condition of the health care, health situation, health behaviour und health hazards, health problems and diseases, health care, health expenditures, costs and financing of the health care. The GBE is a mutual task of the Robert-Koch-Institute and the Federal Office of Statistics (Statistisches Bundesamt) under the political liability of the Federal Ministry of Health (Bundesministerium für Gesundheit).

GVG Gesellschaft für Versicherungswissenschaft und -gestaltung e.V. – Association for Social Security Policy and Research

Contact person: Sylvia Weber, Managing Director
Address: Hansaring 43, 50670 Cologne
Webpage: http://www.gvg.org

GVG is an association of institutions from all areas of social security: the statutory and private insurance providers; the associations representing the various actors of the social security sectors; administrative bodies and academic research. Committee meetings offer an opportunity for "off-the-record" exchanges of views between the social security sector's key players. GVG arranges information exchange and develops joint positions. GVG is also

engaged in international cooperation and carries out studies and research projects in the field of social security for third parties.

Hamburgisches WeltWirtschafts Institut (HWWI) – The Hamburg Institute of International Economics

Address: Heimhuder Straße 71, 20148 Hamburg
Webpage: http://www.hwwi.org

The Hamburg Institute of International Economics (HWWI) specialises in the early recognition and interdisciplinary analysis of key economic, societal and political trends. The HWWI's profile is made up of four research programmes, in which it acts in a scientific and consultancy capacity: Economic Trends, Hamburg and Regional Development, World Economy and a Migration Research Group.

Hans Böckler Stiftung – Hans Böckler Foundation

Address: Hans-Böckler-Straße 39, 40476 Düsseldorf
Webpage: http://www.boeckler.de

The Hans Böckler Foundation carries out research and provides scholarships on behalf of the DGB, the Confederation of Trade Unions. The Foundation is concerned with the following main areas – social dialogue, labour markets, employment and institutional change, income distribution and social security, industrial relations and collective bargaining policy and research on macroeconomic linkages and economic trends.

ifo Institut für Wirtschaftsforschung – ifo Institute for Economic Research

Address: Poschingerstr. 5, 81679 München
Webpage: http://www.cesifo-group.de/portal/page/portal/ifoHome

The ifo Institute is one of the five large economic research institutes in Germany and focuses on business cycle analyses and surveys, public sector, social policy and labour markets, human resources and innovation, industry branch research, environment and transportation, international trade and foreign direct investment, as well as international institutional comparisons.

IGES-Institut – IGES Institute

Address: Friedrichstraße 180, 10117 Berlin
Webpage: http://www.iges.de

IGES is a private R&D institute for health and health care based in Berlin, Germany. Its main focuses are: German statutory and private health insurance systems, current legal conditions affecting health and health care, outpatient and complementary services, the day-to-day reality of care in both outpatient and inpatient situations, legislative and registration procedures for health-related technology, the decision-making structures of the individual market participants and the market strategies of industrial and business suppliers.

INSM - Initiative Neue Soziale Marktwirtschaft – Initiative New Social Market Economy

Address: Gustav-Heinemann-Ufer 84-88, 50968 Cologne
Webpage: http://www.insm.de

INSM promotes market-based reforms in Germany mainly in the fields of economic policy, employment policy, social policy, collective bargaining policy, and educational policy. INSM is financed by Arbeitgeberverbände der Metall- und Elektro-Industrie, the employers' associations in the metal and electronic industry.

Institut für das Entgeltsystem im Krankenhaus (InEK) – German Refined - Diagnosis Related Groups

Address: Auf dem Seidenberg 3, 53721 Siegburg
Webpage: http://www.g-drg.de

The InEK is concerned with the development, implementation and administration of the G-DRG-System (German-Diagnosis Related Groups-System), the new compensation of universal hospital payments system (according to §17b hospital financing law). The fields of work are within the area of medicine (case-related groups, coding guidelines, cooperation with institutions, bodies and organisations) and the area of economics (costing).

Institut für Weltwirtschaft – Institute for the World Economy

Address: Düsternbrooker Weg 120, 24105 Kiel
Webpage: http://www.ifw-kiel.de

The Institute is one of the six large economic research institutes in Germany (so-called blue list institutes) and concerned with seven research areas: the global division of labour, knowledge creation and growth, the environment and natural resources, poverty reduction, equity and development, monetary policy and market imperfections, financial markets and macroeconomic activity and reforming the welfare society.

Institut für Wirtschaftsforschung Halle – Halle Institute for Economic Research

Address: Kleine Märkerstraße 8, 06108 Halle (Saale)
Webpage: http://www.iwh-halle.de

The Halle Institute for Economic Research (IWH) was founded on 1 January 1992 and is also one of the six large economic research institutes in Germany. Special focus was given to the observation and scientific analysis of the transformation processes in the New Lander of Germany as well as in Central and Eastern Europe. However, this perspective broadened over time towards analysing the general process of economic change. Today, this relates to global integration and its linkages to national societies.

Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen – Institute for Quality and Efficiency in Health Care

Address: Dillenburger Str. 27, 51105 Cologne
Webpage: http://www.iqwig.de

The IQWIG is an independent scientific institute that investigates the benefits and harms of medical interventions for patients. They regularly provide information about the potential advantages and disadvantages of different diagnostic and therapeutic interventions.

Rheinisch-Westfälisches Institut für Wirtschaftsforschung (RWI)

Address: Hohenzollernstraße 1-3, 45128 Essen
Webpage: http://www.rwi-essen.de

The RWI belongs to the blue list institutes. Focal points of the research include analysis of labour markets, population and health; migration, integration and education. Particular attention is also paid to the diagnosis and forecasting of the German economy and those of leading developed countries, as well as to structural changes within the economy.

Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung – The German Council of Economic Experts

Address: Statistisches Bundesamt, 65180 Wiesbaden
Webpage: http://www.sachverstaendigenrat-wirtschaft.de

The German Council of Economic Experts (Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung) is an academic body which advises the German government and parliament on economic policy issues. It is the council's duty to analyse the current economic situation and its likely development and also to investigate ways and means of concurrently ensuring - within the framework of the free market economy - price stability, high employment, external equilibrium, plus steady and adequate economic growth. In line with its legal mandate, the council compiles and publishes an annual report (in mid-November) as well as ad-hoc special reports in order to address particular problems or in response to a request from the government.

Sachverständigenrat zur Begutachtung der Entwicklungen im Gesundheitswesen – Advisory Council on the Assessment of Developments in the Health Care System

Address: Rochusstraße 1, 53123 Bonn
Webpage: http://www.svr-gesundheit.de

The Advisory Council's task is to provide a biennial survey concerning the analysis of developments in the health care system, with special regards to cost effectiveness and to new possible developments.

Sozialbeirat – German Social Advisory Council (GSAC)

Address: Bundesministerium für Arbeit und Soziales
Finanzielle Grundsatzfragen der Sozialpolitik
Geschäftsstelle Sozialbeirat
Referat I b 2
Wilhelmstr. 49, 10117 Berlin
Webpage: http://sozialbeirat.de

The German Social Advisory Council (GSAC) is the governmental advisory group for the legislative bodies and the federal government on issues related to the statutory pension insurance. The Social Advisory Council's main task is to submit an expert opinion stating its views on the Federal Government's Pension Report. Over and above the regular cooperation between the Social Advisory Council and the Federal Ministry of Labour and Social Affairs, which has been in place for several decades, the Social Advisory Council, within its legally defined responsibilities, gives ad-hoc advice to the federal government on specific questions arising in the context of new legislation in the field of the statutory pension insurance.

Wissenschaftliches Institut der AOK (WidO) – Scientific Institute of the AOK

Address: Rosenthaler Str. 31, 10178 Berlin
Webpage: http://www.wido.de

The Wido was founded in 1976 and is the research institute of the Federal Association of the AOK (Allgemeine Ortskrankenkassen). The research topics are linked to the basics and problems of the statutory health insurance and its related areas.

Zentrum für Europäische Wirtschaftsforschung (ZEW) – Centre for European Economic Research

Address: Zentrum für Europäische Wirtschaftsforschung GmbH,
L 7,1 D-68161 Mannheim
Webpage: http://www.zew.de

The ZEW includes a research unit on labour markets, human resources and social policy, and is mainly focused on labour market issues but also carries out research on the economic effects of social protection institutions on the labour market.

Zentrum für Sozialpolitik – Universität Bremen (ZeS) – Centre for Social Policy Research

Address: Universität Bremen
Zentrum für Sozialpolitik
- Barkhof -
Parkallee 39, 28209 Bremen

Webpage: http://www.zes.uni-bremen.de

ZeS is an interdisciplinary research institute at the University of Bremen and deals with all fields of social policy such as old-age security, labour market, poverty, family, education, gender, health care and comparative welfare state research.

Zentralinstitut für die kassenärztliche Versorgung (Zi) – Central Research Institute of Statutory Health Insurance in Germany

Address: Herbert-Lewin-Platz 3, 10623 Berlin

Webpage: http://www.zi-berlin.de

The research and studies of the Central Institute, which is financed by doctors' associations in the ambulatory sector, focus on the ambulatory health care sector, health economics and cost-effectiveness analysis in ambulatory care, health services research, conception and evaluation of programmes in the field of primary and secondary prevention, disease management for chronic disease and, telematics in the health care sector.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en