Annual National Report 2010

Pensions, Health and Long-term Care

Germany

May 2010

Authors: Winfried Schmähl; Eberhard Wille/Daniel Erdmann

On behalf of the
European Commission
DG Employment, Social Affairs and
Equal Opportunities

Table of Contents

1 Executive Summary

The first section of chapter 2 deals with pensions, starting from the structure of the German pension landscape. The report discusses the present political and economic status, the still ongoing debate on retirement ages, on the development of (public) pension benefits, plans for the abolishment of still existing differences in pension calculation between East and West Germany. Thereafter, the role of private savings as an instrument of old age security is discussed as well as the future development of poverty in old age. Some preliminary findings regarding effects of the economic and financial crisis are mentioned.

The second and third subsections of chapter 2 describe the main characteristics and the development of the health care and the long-term care system in Germany. In addition, the first official results regarding the reform of medical fees (for office-based physicians) are presented. They show that the remuneration of physicians increased at above-average rates from 2007 to 2009. However, the growth rates vary between the 17 SHI-affiliated physicians' associations and between the medical specialist groups.

Last year, the discussion on physician shortages became an important political issue in Germany. According to the representatives of the physicians, Germany suffers already from a severe shortage, especially in rural areas. They fear that the situation might even become worse as soon as currently practicing (older) physicians want to retire. The sickness funds, on the other side, complain about an unequal distribution of the physicians across the country. According to their representatives, the relatively small undersupply problem in certain rural areas could be solved if overcapacities in urban areas were reduced.

Furthermore, the report focuses on the plans of the new government with respect to health care and long-term care. According to the coalition agreement, the coalition parties want to adjust the structure, the organisation, and the financing system of the SHI. As part of these plans, the government wants to fix the employer's contribution rate at 7% of the employee's assessable income. In addition to that, the current health minister wants to introduce a non-income related capitation fee in order to strengthen the financial sustainability of the SHI. However, it is questionable whether a capitation fee will eventually be introduced since one of the three coalition parties, the Christian Social Union, is opposed to this reform.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the previous Year

2.1 Pensions

2.1.1 The structure of the pension schemes in Germany

Pensions in Germany come from many different sources and often are organised according to the status of groups of people in the labour market. For a long time, 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]

In the past, Germany had no general minimum pension, but means-tested social assistance for all persons below a certain poverty line. In 2003, however, a new element has been introduced, i.e. 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 regarded 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-collar 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 of the defined benefit type.

Other elements of the first tier are civil servant's pensions. They are up to now also PAYG - financed, but undergoing a process of shifting towards capital funding. Other schemes are for farmers (PAYG-financed, mainly from tax revenues) or for several professional groups like doctors, lawyers, where financing is mainly capital-funded.

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 still the major part of existing

[1] At least mandatory pensions 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 two recent governmental reports, "Alterssicherungsbericht 2008" and "*Versorgungsbericht 2008*" (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 more 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.

pension claims is 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 firm - up to a certain, but very high limit. However, a shift is taking place towards other types of occupational pension arrangements that are linked to the capital market, as well as towards financing mainly (directly)[6] by employees (and no longer employers), and towards defined contribution instead of defined benefit. This is in particular due to 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 meanwhile been abolished. And according to a new collective agreement there will be a change from defined benefit to defined contribution.

As a third tier, there exists a great variety of voluntary capital funded additional types of saving for old age, some with risk pooling (life insurance), some without such insurance elements, others are tax-privileged. In the centre of the public debate are those private pensions that fulfil certain requirements (and will consequently 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] The "coverage rate" is up to now insufficient to compensate reductions in the pension level of social insurance pensions that are meanwhile implemented [9](see 2.1.7).

Beside such tax-privileged types of saving for old age there are many others without such subsidies. However, it is difficult to tell the share of such savings for old-age.

It is an explicit political goal to change 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 and giving incentives to invest savings in capital-funded schemes.[10]

Regarding statutory social pensions, target values for the contribution rate were decided: No higher than 20% until 2020, and no higher than 22% up to 2030. Several measures were taken (in particular a redesign of the formula to calculate and adjust pension benefits) to realise this in the process of population ageing, resulting amongst others in a stepwise reduction of the net pension level until 2030 by about 25%. The emerging gap in income in old age is intended to be closed by private voluntary, but subsidised pensions. In addition, retirement ages shall be increased[11], starting in 2012 (2.1.3).

---

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, a final salary scheme.

8 Such pensions are meanwhile called "Riester pension", after Walter Riester, who was at that time Minister for Labour and Social Affairs.

9 See for example Oehler (2009), p. 121, Hagen und Reisch (2010).

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

11 Like the age they receive a pension without deductions from the benefit from 65 to 67.

2.1.2 The political and economic current status

2009 was a year without major reform measures in pension policy or major changes, although in autumn 2009 a change of government took place. Superseding the grand coalition between Christian Democrats (CDU/CSU) and Social Democrats (SPD), now the CDU/CSU forms a coalition government together with the liberal Free Democratic Party (FDP). The ministry responsible for pension issues changed from SPD to CDU. However, in principle the strategy for the develpment of pension policy in Germany – reducing PAYG-financed social insurance pensions and increasing the relative importance of capital-funded private (and occupational pensions) - not as an addition but in part as a substitute for the public pensions – has remained unchanged.

2009, however, was a year of severe economic problems as a consequence mainly of the financial market crisis and its effects on the "real economy". But unemployment rates were already high before the crisis.

As an instrument to avoid a further increase in unemployment due to the crisis the previous as well as the new government use extensively the instrument of short-time working. Already existing rules for access, financing and duration of short-time work were changed several times, deemed to give an incentive to firms not to lay-off workers (see for details chapter 3).

One political aim – also of the new coalition government – is to stabilise the contribution rates of social insurance schemes, mainly employer's contributions. Therefore, recently the new Government decided to compensate revenue loss of social insurance contributions on the grounds of the crisis by additional money from tax revenues to health insurance as well as unemployment insurance.

In April 2009, the Federal Government published their report on public pensions for civil servants (*4. Versorgungsbericht*). In this report it was underlined that step by step there will be full capital funding of federal civil servant pensions. In principal, changing rules in social pension insurance are to be implemented for civil servant pension schemes, too, in a manner comparable to what was decidec in social insurance. This, however, needs to be done not only on the federal level but also on the level of the federal states (*Länder*), who are currently responsible for the pensions of their civil servants. Thus, this process has not been finished yet – and there may be differences in the future between the states regarding respective rules.

2.1.3 Ongoing debate on rising the retirement age

For recent years it was often underlined, that employment of older workers as well as average retirement age increased, due to improving conditions on the labour market as well as former politicial decisions, for example the introduction of deductions from the full pension in case of early retirement. It has to be underlined, that only a minority of pensioners changes from employment directly into an old-age pension. And for many employees it is not possible to be employed up to the age for the "full" pension – that means without deduction. In 2007 nearly half of all new retirees are affected by deductions from the full pension.[12]

Regarding *retirement ages* it is still discussed whether the already decided increase of the "full" retirement age (i.e. for entitlement to a pension without deductions from the full pension) – which is planned to be increased stepwise starting in 2012 – is compatible with the labour market conditions and in particular with employment chances of older workers. In

[12] See Brussig (2010).

2010, the Government has to give an assessment[13] whether the increase of retirement ages is still regarded as an adequate measure (at least at that time). Although in particular labour unions are strongly argueing against higher retirement ages, there are no signals from the Government that the former decision will be changed.

Regarding the intended increase in retirement ages and to stay longer in the labour market, much more attention seems to be necessary in the future to prevent illness and disability. And more attention needs to be given also to rehabilitation measures in order to keep or improve the employability of workers, so that they can in principle stay longer in the labour market - if employment opportunities exist.

Amongst other things it is discussed whether disability pensions should also be reduced by deductions from the full pension.[14] Another subject discussed is, that disabled persons do not have the possibility to use subsidised types of private pension savings to compensate the general reduction in the level of social insurance pensions.[15]

As from 1 January 2010, the Federal Employment Agency (*Bundesagentur für Arbeit*) has stopped subsidising partial retirement, i.e. part-time employment prior to retirement (*Altersteilzeit*). The original intention was to create incentives for part-time employment of older employees. In fact, this was mainly used in the following way: Half of the period of partial retirement the employee still worked full time, and, consequently, the second half of the period they would not have to work anymore (*Blockmodell*). The financial incentives that were given by the Federal Employment Agency were often looked at as an incentive for early retirement. This specific subsidy has now been abolished.[16] However, there still exists a sort of subsidy, because if employers increase the wages of these "part-time employees", this amount is not subject to income tax of social insurance contributions.[17]

2.1.4 The development of pension benefits and a new "pension guarantee"

In June 2009, prior to the elections, legislation regarding the *pensions guarantee* (*erweiterte Schutzklausel*) was adopted. This legislation has suspended the current indexation formula and provided that current pension payments will not be reduced, even if the regular indexation mechanism would result in such a reduction due to shrinking wages. This decision was taken as a reaction to possible effects of the financial and economic crisis. It was, however, not clear at the time whether wage development would actually call for such an absolute reduction.It was decided that in case of not realised reductions, this will have to be compensated by lower increases in pension adjustment rates later on. This government initiative was accompanied by severe criticism from the opposition, employer associations, and economists.[18]

Meanwhile, it is a fact that without this type of "guarantee" in July 2010, pensions would have to be cut by 0.4%, because average gross wages were for the first time since 1949 lower compared to the previous year. The main reasons for this development were a high percentage of short-time working with lower wages, and the use of assets accumulated in time accounts and thence a lower number of working hours. Another reason is purely statistical: Since 2009, payments by employers to the costs of private health insurance of their employees have no

[13] The assessment report is legally stipulated and in the future must be published every four years by the Government during the period retirement ages are increased.

[14] This as well as other instruments to deal with the problem of disability pensions that are also reduced by the political decided general reduction of the pension level are discussed in Köhler-Rama et al. (2010).

[15] See Rische (2010).

[16] For a discussion about several effects of this instrument and its evaluation see Knuth (2010).

[17] See Wanger (2009) for details regarding this instrument.

[18] See e.g. Sachverständigenrat (2009), pp. 198.

longer been treated as part of gross wages, but as social insurance contributions. Therefore, average gross wages were reduced by 0.2%.[19]

It is expected that not only in 2010 but also in 2011 no adjustment of social insurance pensions will take place, i. e. *gross* pension benefits will remain constant in nominal terms. The development of the *disposable* income of pensioners or *net* pension benefits can, however, become negative, depending on the evolution of contribution rates to social health insurance (SHI) and long-term care insurance (LTC), and of the income tax burden. Pensioners pay half of the normal contribution rate to SHI (the other half is paid by social pension insurance) and an additional 0.9% based on their pensions. Several sickness funds are now collecting another additional contribution to be paid, as well, only by the insured person (employees and pensioners). This together with reductions in benefits can affect pensioners and in particular those in higher age who need more services and care. The new Federal Government coalition is planning to introduce into LTC also a funded element which will increase ceteris paribus the contribution burden once more. (The effect of the crisis on financial markets has not influenced this political plan.) In addition, the income tax on pensions will be increased stepwise on grounds of already decided and implemented political decisions.

Regarding the future effects of the pension guarantee some doubts still remain in public debate whether the reduction in pension payments will be compensated in the near future by lower pension adjustment rates according to the existing rules.

2.1.5 New rules for splitting of pensions in case of divorce

In September 2009 new rules for the calculation of individual pension claims in case of divorse became effective (*Versorgungsausgleich*). Already in 1977, a splitting of pension claims of both spouses in case of divorce was introduced. Until the introduction of the new rules the following procedure was applied: In case of divorce all pension claims (from different pension schemes, public, occupational, private) accumulated during the period of marriage were divided and compared to the individual pension claims. Normally, women had lower claims when compared to 50% of the claims of both spouses taken together. Then a transfer of claims in favour of the wife took place adding to the existing pension claim in the social (statutory) pension insurance.

According to the new apporach now each type of claim is split separately. Thus, both spouses may now have claims in identical pension schemes. It is no longer the sum of all claims (the calculation of which was based on complex procedures to render different types of pension claims comparable) that is split, but each separte type of pension claim (which may result in additional costs within the pension schemes).[20]

2.1.6 Some plans of the new coalition government

In the coalition agreement of the new Government, references to pension insurance (chapter 8 of the agreement, p. 84) are rather short. The agreement includes the intention to improve the significance of child raising in the old-age security system, to strengthen funded state-subsidised old-age security, in particular for those who cannot yet fully benefit from state subsidies (i.e. the self-employed), to fight poverty in old age by ensuring that lifelong full-

[19] Another effect of this new statistical procedure is that average net wages become lower and therefore increases the net-pension level.

[20] For details see Ruland (2010).

time employed persons receive an income in old-age above the subsistence level, and to equalise pension calculation between East and West Germany.[21]

At least two topics that have already been politically decided are highly unpopular: the increase of the retirement ages and – as mentioned above – the reduction of pension adjustment rates in the years to come in order to compensate the effects of existing different "pension guarantees",[22] which may result in many years of at least very low pension adjustment rates. This will coincide in many cases with private or occupational pensions that are more or less constant over time in nominal terms. In case of rising costs of living, inflation and real income development in the economy this would reduce both the real income and the relative income of pensioners. This topic has, however, up to now hardly been discussed, but it will nevertheless come on the agenda in the future.[23]

2.1.7 Equalising pension calculation in social pension insurance between East and West Germany

Different rules still apply to the calculation and adjustment of social insurance pensions resulting from the process of German reunification, in particular for the two main elements of the German pension formula, i.e. the calculation of individual earning points (*EP*), and the rate of adjustment of the value of earning points (*VEP - aktueller Rentenwert*); VEP is given in Euro per month for 1 EP[24] was linked in principle to the development of (in the beginning) net wages[25] . These different rules were introduced because there was a big difference in (average) wages in East and West Germany when unification took place.

Although since 1990 VEP increased much faster in East Germany than in West Germany in accordance with the higher growth rate of average net earnings (which had been for some years the relevant indicator for the development of the pension adjustment rate), the East German VEP is still lower, because it started from a much lower basis in 1990, reflecting the lower earnings level at that time. Since 1998, the progress of catching up in earnings and therefore also in VEP came to a standstill.

The existing difference in VEP (of about 12 percentage points)[26] stimulated discussion in East Germany demanding an equalisation of these values after now 20 years of German reunification. This is supported e.g. by one big trade union (ver.di) as well as by several welfare organisations and linked to the expectation in particular by present and future pensioners in East Germany that pensions in East Germany will be increased compared to the present level. Therefore, a pure redefinition of VEP by recalculating a (weighted) average of West and East VEP without additional costs would not fulfil these expectations.

The problem becomes even more complex because there are also differences in the calculation of EP: Individual earnings in East Germany are in fact being compared to average East German wages (although the statistical procedure looks different and confusing), which are lower then in West Germany. Therefore, a certain sum of earnings in one year will result

[21] See for background and discussion ANR09 Germany, p. 11.
[22] See Rische (2009).
[23] For an analysis see Schmähl (2010).
[24] Since 1 July 2009 the VEP amounts to EUR 27,20 (West Germany) and EUR 24,13 (East Germany).
[25] Meanwhile instead of net wages a complicated formula is used taking into consideration beside average gross wages several factors. The intention to use these factors was to disentangle development of pensions from development of wages. For details see Schmähl (2007).
[26] After the introduction of the DM in the GDR on July 1, 1990, and a substantial upgrading of GDR pensions the difference was around 60%!

in a higher EP in East Germany than in West Germany. This will persist as long as average earnings in the East are lower then in the West.

Without going into detail it can be stated nevertheless that the existing rules are not unfavourable to East German contributors and pensioners. But the lower VEP stimulates a perception in East Germany to be suffering from a disadvantage. Several proposals therefore have been made for a gradual equalisation of the rules with additional costs, to be financed from tax revenues.[27] It is, however, possible to redefine the relevant factos in such a way that this comes without additional costs.

The evaluation of different models depends very much on assumptions regarding the development of wages in East Germany compared to West Germany. Deciding on a specific model has to take into consideration the effects not only for pensioners in East and West Germany but also for contributors. It becomes more and more obvious that looking only on East and West Germany is inadequate because there exist remarkable differences in both regions, also between northern and southern parts in West Germany which are not relevant in the calculation of pensions.[28]

It has to be decided amongst others

- when a redefinition shall become effective;
- whether this is realised gradually in a process of several years or from one year to the other;
- whether this does or does not imply additional costs and
- who shall bear the costs, if applicable.

The final outcome of the political process is not clear as yet.

2.1.8 Saving for private pensions as an instrument to compensate for social insurance pensions loss

Private subsidised pension shall compensate the loss in social insurance pension benefits resulting from the reform measures decided upon since 2001. The Federal Government underlines that despite the fact that the level of social insurance pensions will be considerably lower in the future, a stable pension level will be maintained thanks to increased entitlement to private pensions. In this respect, the Government mentions first and foremost the increasing number of saving contracts. This, however, is hardly convincing, because statistical information on the sum of savings etc. is still lacking.[29] Therefore, the ”official” assumption of such a compensating effect is questionable**:**

(1) The coverage rate regarding subsidised private pensions is actually far below 100%.

(2) It is not known whether those persons who participate in subsidised private pensions do accumulate a “sufficient” amount, namely as much as is necessary to compensate for the loss of social security pension entitlements.

[27] Sachverständigenrat (2008) discusses some fundamental issues linked to some of the existing proposals. See also Winkelbach (2010), Sozialbeirat (2009), and for model calculations regarding a specific proposal of the Sachverständigenrat see Börsch-Supan et al. (2010).

[28] See for data on pensions and income in old-age between the different states (Länder), Frommert (2009).

[29] See Hagen and Reisch (2010).

(3) When the Government mentions the large number of persons in lower earning brackets making use of subsidised saving, this does not say anything about the ratio of such persons/families compared to all persons/families with lower earnings.

There are remarkable differences in costs as well as in net returns. This will – beside different ability and willingness to save – result in a growing income inequality in old age.

In addition, it is questionable whether the subsidies increase savings. In particular neither the percentage of savers in low income households seems to have increased nor their sum of savings.[30] There seems to be substantial "crowding in" in particular by households who can afford saving by only changing the type of saving.[31] In the public debate on this topic is seems to be forgotten that subsidies have to be financed, too.

In general, there is a lack of transparency regarding total income in old age for future pensioners from different sources of income (public, occupational, private).[32] What is needed is a comprehensive (regular) information or at least a possibility to get informed about already accumulated assets or simulated pension benefits (based on relatively simple, but consistent assumptions) at the time of retirement (or even earlier, e. g. in case of disability). Calculations showing the possibility to compensate the loss in social insurance benefits by private and/or occupational pensions are focused on the time of retirement, neglecting the future development (adjustment) of different sources of individual income in the years of receiving pensions. This topic has, up to now, hardly been recognised in the German social policy debate.[33]

2.1.9 Poverty in old age in the future

This topic meanwhile is on the public and political agenda. In the public debate the labour market development, low earnings and changes in the earnings carreer – e. g. with spells of self-employment without mandatory coverage regarding old-age provision are mentioned as reasons for a growth of poverty in old age in the future. The discussion, however, seems to necglect some important reasons for this development: There have been political decisions in pension policy which will result in reduced replacement rates in the social pension insurance. However, compensation for a reduced pension level in the first tier by occupational and/or private pensions (2nd and 3rd tier) will be hardly possible for many employees with low income or long spells of unemployment. In last year's asisp Annual National Report effects of recent pension policies on the social pension insurance scheme as well as for private households were discussed.

Geyer and Steiner (2010) present results of a simulation study taking into account employment patterns and behaviour as well as effects of political decisions. They display considerable effects on pension claims for old age in particular for younger cohorts. The study covers cohorts born in 1937 up to 1971. Disability pensions as well as survivor's pensions are excluded. Results refer to retirement age, i.e. that the development during retirement is not included either. The authors point out a "dramatic" reduction in pension claims in particular for younger cohorts in East Germany resulting from the labour market development as well as from political decisions. For example, average *gross* pension benefits for male pensioners in East Germany will be about 40% lower for the cohorts 1967-1971 compared to cohorts

[30] The result of an econometric study by Corneo et al. (2007). See also Corneo et al (2009).
[31] This is also the result presented by Pfarr and Schneider (2009).
[32] See in particular the extensive debate in Oehler (2009).
[33] Schmähl (2010) deals with this subject.

1942-1946.[34] How *net* pension benefits will develop depends in particular - as already mentioned - on contribution rates in social health and long-term care insurance as well as on the income tax burden. It can be expected that they will all increase in the future and thereby reduce the growth rate of gross pensions.

Eventually, an increased inequality of wages – which are the main source for pension claims and saving for old age – needs to be taken into consideration. Therefore, data based e. g. on average earners neglect an important dimension. The same is true if the conditions *between* different cohorts are analysed but not the remarkable differences *within* cohorts.

Whether income in old age will be sufficient to avoid poverty (i.e. income is above social assistance level) depends, however, on all types of income received – from public, private and/or occupational pensions and from employment income and assets of all household members. It is therefore difficult to say how many persons and households respecitively will require social assistance. But, in addition to the already mentioned scaling down of the general pension level, the conditions for accumulating (individual) pension claims have been unfavourable for many people in recent years, in particular owing to possible long spells of unemployment. During these periods of unemployment not only do people accumulate very low pension claims in social pension insurance, but also no claims in occupational pension schemes or in private insurance schemes are built up.

In the German debate the advantage of saving for old age (even in subsidised schemes) are questioned in particular with regard to persons/households with low income. If social insurance pensions together with private pensions will be below social assistance level, then additional saving will only result in lower social assistance expenditure of local governments but not in higher a income of the saver.

Taking all aspects together, the possibility of a growing poverty rate in old age seems highly realistic. This has meanwhile become a topic of public debate, while during the years of preparing and deciding the fundamental pension reform (implemented since 2001) it has hardly been addressed at all. But there are warnings by actors who are in favour of the new German pension policy[35] not to touch any of these fundamental decisions.

2.2 Health

2.2.1 Overview of the systems's characteristics

Germany has a universal multi-payer system with two main types of health insurance. In March 2010, 69.85 million citizens were covered by statutory health insurance (SHI).[36] At the end of 2009, a further 8.81 million citizens were covered by supplementary private health insurance (PHI).[37] 3.1 million citizens were covered by different specific governmental schemes.[38] Since 1 January 2009, all residents have the legal obligation to hold a health insurance policy. Anyone who has lost their insurance in the past reverts automatically to their previous insurance. This applies both to SHI and PHI. However, a recent newspaper

[34] Pension benefits are compared by discounted values for the basis year 2005 of the study.

[35] Among them the Council of Economic Experts and in particular some of its present or former members.

[36] Bundesministerium für Gesundheit; Monatsstatistik der gesetzlichen Krankenversicherung über Mitglieder, Beitragssätze und Kranke, Monatswerte Januar-März 2010.

[37] Verband der privaten Krankenversicherung; Die wichtigsten Zahlen auf einen Blick; press release, 17 March 2009.

[38] Kassenärztliche Bundesvereinigung; Grunddaten zur vertragsärztlichen Versorgung in Deutschland 2009; 31 December 2009.

article reports that there are still hundreds of uninsured citizens in Germany.[39] This problem might arise for example in the case where currently uninsured persons cannot prove where they were insured in the past. However, these uninsured citizens still receive medical treatment because local authorities cover their medical costs. New official data on this topic will not be available until 2011, when the Federal Statistical Office publishes the new microcensus.

One of the key features of the German health care system is the sharing of decision making powers between the Federal Government, the *Länder*, and authorised civil society organisations.[40] At the national level, the Federal Ministry of Health, the Federal Parliament (Bundestag), and the Federal Council (Bundesrat) are the key actors. The legislature creates the legal framework of the SHI and PHI.

The *Länder* are responsible i.a. for undergraduate medical, dental, and pharmaceutical education, and they are in charge of planning inpatient capacities and financing investments (buildings and large-scale medical technology) in hospitals. However, it is doubted that the *Länder* fulfil this obligation. In 1991, the *Länder* spent EUR 3.6 billion for investments. This subsidy fell to EUR 2.7 billion in 2007 in nominal terms.[41] Due to inflation, the *Länder* funding quota (=fraction of total hospital expenditures) fell from 10.2% to 4.7% during the same period. According to the RWI economic research institute, the cumulative investment gap of German hospitals has grown to EUR 16 billion since 1991.[42] The hospitals, however, fill a growing part of this gap with investments from own resources. These financial measures amount to approximately EUR 7 billion. Hence, it is likely that the actual investment backlog is at EUR 9 billion. Due to the economic crisis, the Government decided to support additional infrastructure investments of the *Länder*. As part of this stimulus package, German hospitals will receive a total amount of EUR 1.3 billion from 2009 to 2011. EUR 350 million of these funds will be allocated to university hospitals.[43] It will be interesting to observe, whether the *Länder* will use this money to close the investment backlog or if they further decrease their normal financial support in order to lower budget deficits.

For the SHI, the medical self-governing bodies formulate and implement in detail which services will be provided and under which conditions. The self-governing bodies are formed by the non-profit sickness funds (SF) and their associations on the purchasers' side, and the SHI-affiliated physicians' associations (Kassenärztliche Vereinigungen), dentists' associations (Kassenzahnärztliche Vereinigungen), and the German Hospital Federation on the providers' side.

A large part of decision-making is realised by horizontal negotiations in joint committees among provider and payer organisations at the federal and regional level (mostly for one *Land*). The Federal Joint Committee (Gemeinsamer Bundesausschuss; G-BA) is the supreme decision-making body of the joint self-administration of SFs, physicians, dentists, psychotherapists, and hospitals. The G-BA determines which medical services are paid for by the SHI. Hence, the G-BA decides uniform requirements for the concrete implementation of the laws that were passed by the Parliament. The G-BA hereby considers the current state of

[39] Schmidt, Michael; Tausende Menschen ohne Krankenversicherung, Schweriner Volkszeitung; 20 March 2010.

[40] The presentation of the characteristics of the German health care system in this report is based mostly on the very detailed report of Busse (2004) which is available in English.

[41] Schwarz, Astrid and Wehner, Christian; Konjunkturspritze für die Kliniken; Gesundheit und Gesellschaft, volume 12, 12/2009, pp. 30-33.

[42] Rheinisch-Westfälisches Institut für Wirtschaftsforschung; "Krankenhaus Rating Report 2009 – Im Auge des Orkans"; December 2009. This result is based on the assumption that 10% of the yearly hospital revenue is needed for investments.

[43] Schwarz, Astrid and Wehner, Christian; Konjunkturspritze für die Kliniken; G+G, vol. 12, 12/2009, p.30-33.

medical knowledge and examines the diagnostic or therapeutic benefit, medical necessity and cost effectiveness of a service that is listed in the catalogue of benefits. In addition to that, the G-BA adopts quality management measures for the inpatient and outpatient sector. The decisions of the G-BA are published on the website www.g-ba.de.

The payers' side is composed of currently 169 quasi-public sickness funds for SHI insured persons (about 69.8 million insured persons; 51.3 million contributing members plus their dependants) and 46 private insurance companies. Since the SFs cover approximately 90% of the population, the main focus of this report will lie on the SFs. The SFs are public bodies, financially and organisationally independent. The principle of solidarity (equal benefits for all insured persons regardless of income or morbidity) and the principle of benefits in kind (Sachleistungsprinzip) are the fundamental structural principles of the SHI.

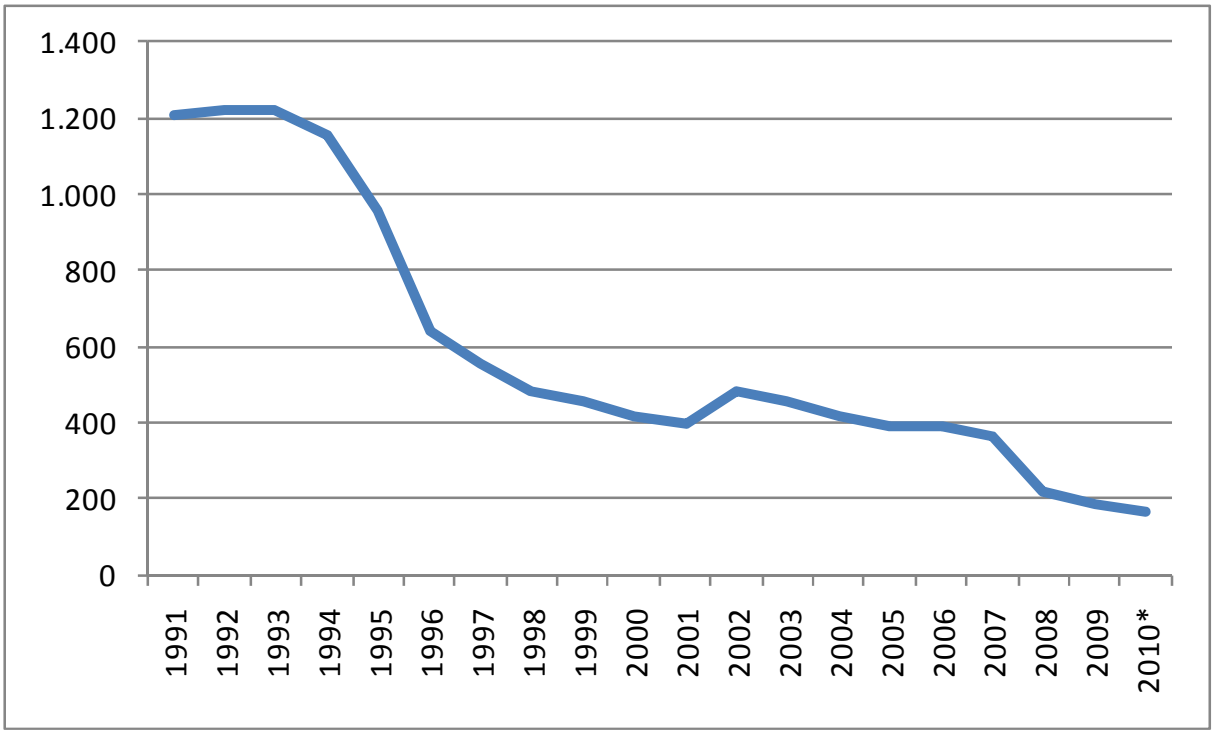
In March 2010[44]:

- 35.5% of all SHI members were insured at one of the 6 substitute funds;
- 33.9% were insured with one of the 14 general regional funds (*Allgemeine Ortskrankenkassen*, AOKs);
- 19.1% were covered by one of currently 130 company-based sickness funds (BKKs);
- 7.9% were covered by one of the 9 guild funds (IKKs) and
- 3.6% were covered by SFs for farmers (9) or for miners (1)

Before the Health Care Structure Act (HCSA) of 1993 came into force, employees were restricted in the choice of their SFs. The HCSA lifted this restriction which led to an increase in competition between SFs, which were then forced to work more efficiently in order to offer low contribution rates and thereby attract new contributors. Since many SFs (especially general regional funds) were very small at that time, a lot of SFs merged into bigger SFs that operated at federal or *Länder* level in order to lower costs (especially administration costs). The total number of SFs has decreased significantly since then (cf. figure 1). Until recently, mergers between SFs were only allowed between SFs of the same type. Since the 2007 health care reform (*Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung; GKV-WSG*) became effective, SFs have been allowed to merge irrespective of the type of SF they belong to. The *Techniker Krankenkasse* (TK), a substitute fund, caused quite a stir when it merged with *IKK-Direkt*, a guild fund on 1 January 2009 to become Germany's largest SF at that time (currently 7.2 million insured persons). Since 1 January 2010, the substitute fund *Barmer GEK* is Germany's largest sickness fund with currently 8.6 million insured persons. It arose out of a merger as well.

[44] Bundesministerium für Gesundheit; Monatsstatistik der gesetzlichen Krankenversicherung über Mitglieder, Beitragssätze und Kranke, Monatswerte Januar-März 2010.

Figure 1: Number of sickness funds in Germany 1991-2010



*) March 2010;

Source: Gesundheitsberichterstattung des Bundes; BMG (2008, 2010), diagram by author

2.2.2 Structure and development of specific health care branches

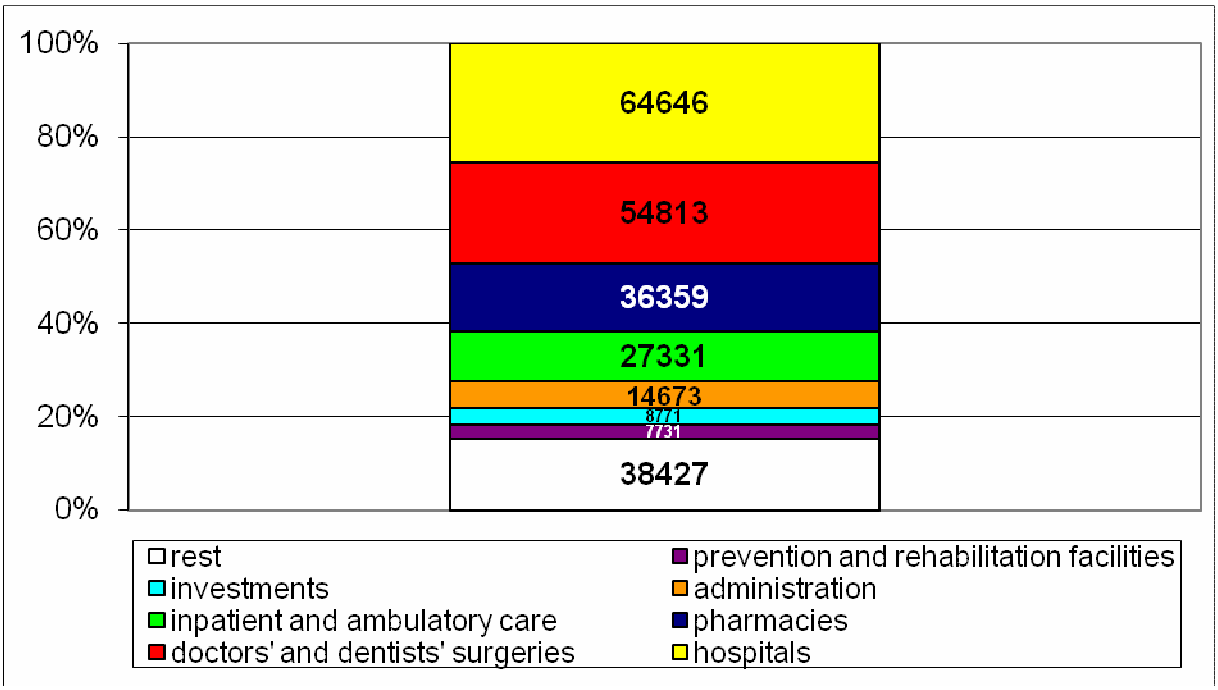
According to OECD Health Data 2009, Germany spent 10.4% of its 2007 GDP on health.[45] This was (behind the USA, Switzerland and France) the fourth highest rate among OECD members. However, this figure should not be overemphasised since Germany had to bear high costs due to the reunification for the last twenty years.[46] Hence, total expenditures on health per capita are a more meaningful variable in the case of Germany. According to OECD Health Date 2009, total expenditures on health were at USD 3,588 per capita (USD purchasing power parity) in 2007. This is only the tenth highest value among the thirty OECD member countries. This shows that the relatively high share of GDP spent on health in Germany is rather the result of the country's relatively weak economy than of high expenditures on health.

Figure 2 illustrates how health care expenditures are distributed on the individual branches of the health care system. Thereby, the y-axis depicts the percentage of total expenditures of the branches that are named in the figure legend. Total expenditures in million Euro of a branch are mentioned in each bar.

[45] 10.5% of ist 2008 GDP according to national statistics (www.gbe-bund.de).

[46] Total gross costs of the reunification process (including social transfers, costs related to an improvement of the infrastructure, and subsidies for companies from 1990 to 2009) are estimated to lie between EUR 1.3 – 1.6 trillion.

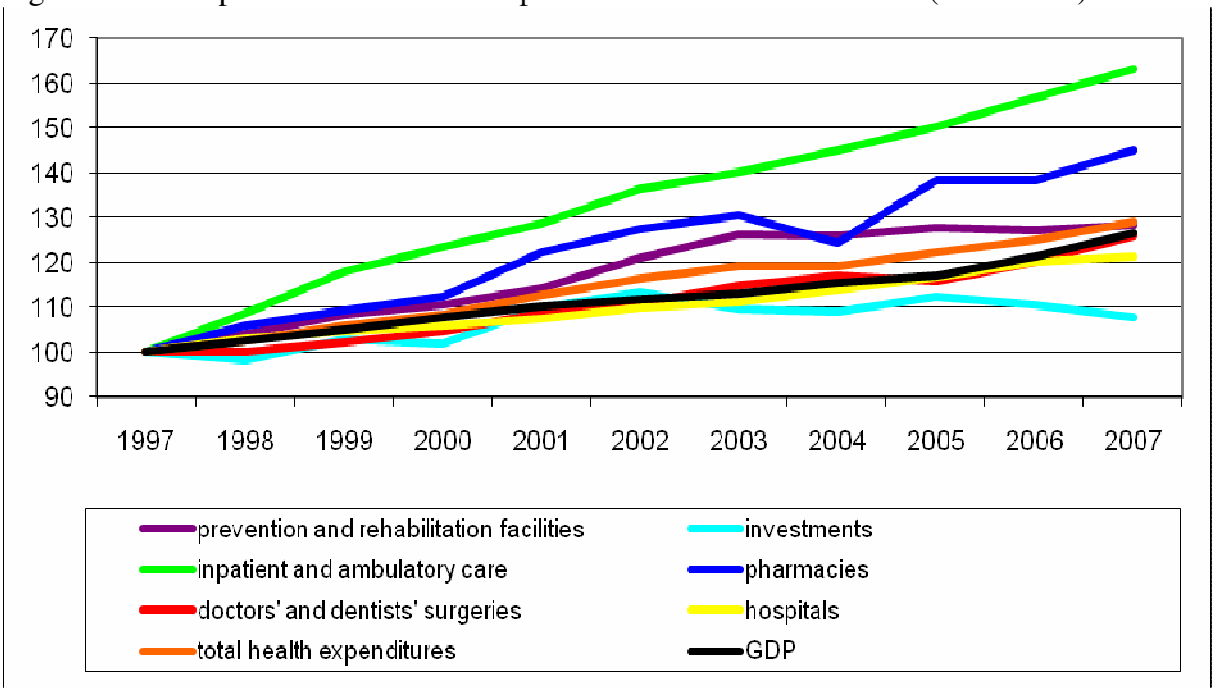
Figure 2: Structure of health care expenditures in 2007



Source: Statistical Yearbook 2009, diagram by author

As it is shown in figure 2, 25.6% of health care expenditures are allotted to the hospital sector. With EUR 64.6 billion, the hospital sector is therefore the largest branch of the German health care system, followed by the mostly single doctors' and dentists' offices. The importance of the health care sector for the German economy can also be displayed by looking at employment. According to OECD data, 4.4 million people were employed in the German health care system and in social branches in 2009. Because of the demographic trend and the medical-technical progress it can be assumed that the number of employees in the health care and long-term care sector will further increase in the future. The development of health expenditures of selected health care branches between 1997 and 2007 is shown in figure 3.

Figure 3: Development of health care expenditures of selected branches (1997-2007)



Source: Statistical Yearbook 2009, diagramme by author; 1997 = 100%

Expenditures for inpatient and ambulatory care, for prevention and rehabilitation facilities, and for pharmacies grew faster between 1997 and 2007 than total health expenditures and GDP (cf. figure 3). Due to demographic change, the number of cases for nursing care and hence expenditures for long-term care are expected to increase at above average growth rates in the future as well.[47]

During the same period expenditures for the hospital sector, for surgeries and for investments grew by smaller rates than total health expenditures (and GDP as well). Due to the relatively low growth rates, private practitioner organisations advocated for higher budgets. Finally, the budget for surgeries was significantly increased from 2007 to 2009 which narrowed the gap between the relatively small growth rates of this branch and the growth rate for long-term care expenditures.

On 1 March 2009, the *National Association of Statutory Health Insurance Physicians* (KBV) published the first official results regarding the reform of medical fees (for office-based physicians) which dates back to a ruling of the *extended assessment board* (Erweiterter Bewertungsausschuss) in 2008. According to the KBV, the remuneration of the approximately 150,000 SHI-physicians and psychotherapists increased from EUR 13.78 billion in the first half of 2007 to EUR 15.47 billion in the first half of 2009 (+12.2%).[48] Thus, this increase is considerably higher than average salary increases for employees in Germany (+3.1% from the second quarter of 2007 to the second quarter of 2009).[49] This comparison shows that the remuneration of physicians was not affected by the economic crisis whereas salary increases of employees were relatively low due to the economic crisis. However, not all physcians and psychotherapists benefit to the same degree from this increase. The growth rates vary between the 17 SHI-affiliated physicians' associations and between the medical specialist groups. The remuneration grew particularly strong in Eastern Germany (+20.1%

[47] Augurzky et al. (2007); Krankenhaus Rating Report 2007.
[48] N.N.; Honorarreform – Großes Plus reicht nicht für jeden; Deutsches Ärzteblatt vol. 107 (issue 9), A 374-375
[49] Federal Statistical Office (2007-2009): Fachserie 16 Reihe 2.1.

from 2007 to 2009), whereas the growth rates in the old *Länder* were significantly smaller (+10.9%). However, the low increases in Baden-Württemberg (+2.0%) and Bavaria (+0.9%) are also associated with specific so-called general practioner models, which led to an adjustment of the SHI fee sharing. Hence, the 'real' growth rates are greater than the statistic indicates. Nethertheless, the data shows that one of the key goals (alignment of remuneration between East and West Germany) was achieved.

Similar income fluctuations can be observed among the different types of specialist groups. Thus, the remuneration of internists (without subspecialty) increased by 88.0% and that of neurologists by 21.3%. The average rate of increase amounted to 14.2%. The remuneration of e.g. general practitioners (+10%), surgeons (+5.9%) grew at below average rates and orthopaedic surgeons and radiologists suffered even a loss of 3.0% and 1.5%, respectively.

In recent years, mainly hospital doctors stood in the spotlight of public interest. They fought succesfully e.g. for an independent trade agreement for hospital doctors and for higher salaries. In 2010, the physician labour union *Marburger Bund* negotiates with the *Municipal Employers' Association* (Vereinigung kommunaler Arbeitgeber) a new trade agreement. The physician's side claims, inter alia, a five percent wage increase and a better pay for night shifts. On 8 April, 2010, the physicians eventually aborted the negotiations after five bargaining rounds. First strikes of the hospital doctors started on 17 May 2010.[50]

2.2.3 Access to and quality of health care

It has been pointed out earlier in this text that despite the legal obligation to hold a health insurance policy, there are still citizens without health insurance in Germany. However, the current Parliamentary State Secretary Daniel Bahr (Free Democrats) emphasises in a response to a parliamentary inquiry of Martina Bunge (Left Party) that no updated official figures exist on this subject.[51] The number of people who have no health insurance is extrapolated from surveys executed by the Federal Statistical Office every four years. The latest survey is from 2007. For that year, the Federal Statistical Office quantifies the number of people who are not covered by health insurance at 196,000. Updated data will not be available until the release of the next micro-census in 2011. However, it can be shown that the 2007 health care reform led to a significant reduction of the number of uncovered citizens by refering to statements of the SHI and PHI, respectively.

The number of so-called returnees is part of the monthly statistics of the SHI. In February 2010, 109,038 members have already been returned to one of the SFs because of the new regulation (§ 5 paragraph 1, point 13 Social Act V). Taking into account the average number of non-contributory co-insured spouses and children, it is expected that a total of around 153,000 people have obtained an insurance cover in the SHI. The PHI recorded an inward flow of 53,000 people that were previously not insured.

Besides the fact that every German citizen has the right and the obligation to hold a health insurance policy, broad access to service providers is guaranteed. This can be shown, e.g. by Germany's acute care bed density. This ratio (8.2 hospital beds per 1,000 inhabitants in 2007) is one of the highest in the world (average of 27 reporting OECD countries: 5.4).[52] German patients can also rely on a high number of service providers in other medical sectors. According to OECD data, there were 3.5 practicing physicians per 1,000 inhabitants in Germany in 2007 compared to the OECD average of 3.1. Germany also had slightly more

[50] See press release of 8 April 2010 and 17 May 2010 on www.marburger-bund.de.
[51] Bundestag-Drucksache 17/1108, question nr. 58, 19 March 2010.
[52] OECD Health Data 2009; own calculation.

practising nurses, at 9.9 per 1,000 inhabitants, than the OECD average of 9.5 per 1,000 inhabitants. Because of the large number of service providers, waiting lists (except for the organ transplant system) are virtually unknown in Germany. In addition, the high number of providers, in conjunction with comprehensive demand planning, is the reason for (almost) blanket coverage of medical benefits in Germany.

Nethertheless, last year, attention was drawn on existing and predicted physician shortages from different stakeholders. Neither the representatives of the SFs nor those of the physicians dispute that shortages already exist in certain (rural) ares of Germany. However, this can not disguise the fact that physicians and sickness funds disagree on the actual dimension of this problem.

The SFs consider the unequal distribution (in particular of the office-based) physicians across Germany as the main problem. According to a press release of the *National Association of Statutory Health Insurance Funds* (GKV-Spitzenverband), launched on 6 April 2010 (see www.gkv-spitzenverband.de), an excess of 20,000 office-based physicians in urban areas exists, whereas there is a shortage of only 800 physicians in rural areas. However, this position is strengthened by the fact that more than 90% of all planning regions were officially oversupplied at the end of 2008. Mutatis mutandis, they advocate a reduction of excess capacities in urban areas in favor of an increase of the number of physicians in rural areas. In order to further strengthen their argument, the SFs accentuate the fact that the total number of practising physicians in Germany grew from 244,238 in 1991 (a year in which overcapacities in the medical sector were debated) to 319,697 in 2008 (+30.9%).[53] During this period, the number of practicing physicians in the out-patient (+38.6%) as well as in the in-patient sector (+27.8%) increased both at high rates.

The representatives of the physisians confront this argumentation with the following two points. Firstly, they classify the problem of insufficient supply in rural areas as more serious than the SFs acknowledge. On 3 January 2010, several newspapers (e.g. "*Welt*", "*Ärzte Zeitung*") reported that 3,620 office-based physicians are already missing in Germany. They rely on a publication of the KBV.

Secondly, they assert that the need for physicians has increased in recent years. The German Medical Association (GMA) launched an interesting article on 21 April 2009. It explains their point of view why Germany needs more physicians even though the number of physicians rose by more than 30% since 1991.[54] The author of this article identifies four reasons which shall explain this paradox:

Firstly, the medical-technical progress leads to an increase of demand. In Germany, medical-technical progress often leads to an improved outcome through increased resource utilisation (e.g. the number of employed physicians). From an economic point of view, the ratio of resource utilisation to medical outcome is crucial for an evaluation of the economic efficiency. Hence, medical-technical progress definitely increases the demand for physicians but it is not totally clear whether it actually increases the need of physicians since the money spent for additional equipment and physicians might have been used more effectively for other (cheaper) innovations.[55]

---

[53] Gesundheitsberichterstattung des Bundes (www.gbe-bund.de).

[54] German Medical Association; "Ärztemangel trotz steigender Arztzahlen – ein Widerspruch, der keiner ist"; 21 April 2009 (retrieved from www.bundesaerztekammer.de/page.asp?his=0.5.33.7123 on 13 April, 2010).

[55] For further information on the difference between the concepts of "need" and "demand", see ADVISORY COUNCIL for the Concerted Action in Health Care; Appropriateness and Efficiency volume III; overuse, underuse and misuse, 2001.

Secondly, the demographic change in Germany leads to an increase of the number of older persons. In 1991, only 20.4% of all inhabitants (80.3 million) were sixty years old or older. In 2008, more than a fourth of the population (82.0 million) was already that old. Since older people need more medical treatment on average than younger people, demographic change leads *c.p.* to an increasing need for physicians.

Thirdly, the feminisation of the medical profession leads *c.p.* to an increasing number of physicians. In 1991, only 33.6% of all practicing physicians were female. This number rose to 41.5% in 2008. Since more than 60% of all current medical students are female, the fraction of female practicing physicians will further increase in the future. According to the microcencus, the number of hours worked is lower for female than for male physicians (58.9% of the interviewed male physicians but only 36.8% of the female physicians reported that they work more than 40 hours per week). If this relationship remains constant over time, an increasing fraction of female physicians leads to an increasing need of physicians (head count).

Forthly, the author argues that due to a reduction in working hours, the same total amount of working hours has to be allocated on more heads. It is argued that today young physicians are not willing to work as long as physicians in the past used to do. In addition to that, the law (§ 3 of the Working Hours Act [Arbeitszeitgesetz]) regulates that employees are, in principal, not allowed to work more than 48 hours per week. The author even claims that, as a result of the reduction of working hours per capita, the total amount of working hours decreased from 2000 to 2007 by 1.6%. However, the methodology of the underlying calculation is questionable which is why further studies on this topic would be desirable.

In conclusion, the arguments of the GMA are reasonable in general. However, the physicians neither address the topic of exisiting overcapacities in urban areas nor feasible improvements in productivity. Hence, they tend to overestimate the need of physicians. This shows that more and most notably independent research regarding this topic is necessary.

The current health minister, Phlipp Rösler (Free Democrats) caused quite a stir, when he presented his ideas regarding critical shortages of physicians in rural areas in an interview on 4, April 2010 (*Frankfurter Allgemeine Sonntagszeitung*). He suggests that future medical students should not primarily be admitted to medical school because of their final school exam grades but because of their performance in selection interviews performed by the universities. His critics argue e.g. that such a system would further increase bureaucracy costs. In addition to that, his administration is not in charge of student admission (*Länder* jurisdiction).

Only one day after this interview, Rösler suggested the introduction of a so-called "Landarztquote" (quota for country doctors). This would imply that applicants, who are willing to commit themselves for a few years as a country doctor, should get preferred access to medical school. The reaction on this suggestion was rather positive even though it is not clear how this quota should be implemented. Such a quota already exists for physicians that want to work for the Federal Armed Forces. Prior to his political engagement, Mr. Rösler worked inter alia as a physician for the Federal Armed Forces.

The stakeholders know that one of the main challenges regarding supply of health care services in rural areas is to attract physicians to those regions. A study of scientists from the University of Leipzig shows that salary is not the only (but a very) important parameter with respect to the practice establishment of young physicians. The scientists describe their main results as follows: "Additional net income to compensate the disutility of a rural practice as compared with an urban practice was EUR 9,044/months (USD 11,938). Yet, nonmonetary

attributes such as on-site availability of childcare and fewer on-call duties would decrease the additional income required to compensate the disutility of a rural practice."[56]

In conclusion, even though there are rural areas with problems securing a sufficient number of physicians, access to health care providers is still at a very high level in Germany. Furthermore, the level of co-payments is – as compared to international standards – at a low level. According to Article 62 Social Act V, the level of co-payments is limited to 2% of annual household income and just 1% for chronically ill patients. This measurement is a further instrument to safeguard the citizens' ability to afford health care.

Quality of health care is a high priority in Germany. Care providers, for instance, are legally obliged to implement quality management systems. Moreover, physicians are obliged to pursue continuing medical education. The Institute for Quality and Efficiency (IQWiG), which was founded in 2004, performs health technology assessments for drugs and procedures. In addition, many hospitals voluntarily get quality certificates to prove that they fulfil specific quality standards. In 2002, minimum volume requirements were introduced for a number of complex procedures such as prosthetic knee replacement in order to ensure that health care providers had the necessary experience. The reimbursement of the treated cases is thereby linked to performing at least the required minimum number of operations.

2.2.4 Financial sustainability

As already mentioned above, Germany spent 10.4% of its 2007 GDP on health. Therefore, cost containment is one of the government's main objectives for reforming the health care system. The government introduced health care reforms in the past that led to relatively constant expenditures on SHI benefits, as a percentage of GDP (from 6.3% in 1995 to 6.1% in 2008).[57] But if expenditures on benefits are related to assessable income, one recognises that this ratio increased over time (from 13.3% in 1995 to 14.9% in 2008).[58] From this juxtaposition, it is clear that the core problem of SHI does not lie on the spending but mainly on the financing side. The SHI is mostly funded by compulsory contributions on wages and retirement pensions. The employer contributes 7.0% of the assessable income and the employee contributes a further 7.9%. In addition to that, the government granted a further EUR 7.2 billion in 2009 (EUR 15.7 billion in 2010[59]). Originally, the federal grant should have been much lower (EUR 4.0 billion in 2009 and EUR 5.5 billion in 2010). Initially, the grant was intended as a lump sum in order to cover the SHI-expenses for extraneous insurance benefits (versicherungsfremde Leistungen). However, additional resources have been made avaiable in order to support the economy and to alleviate the negative impact of the economic crisis on the SHI-budget.

SHI's current financial plan has five key weaknesses. Firstly, it is sensitive to cyclical changes in the economy. In periods of an economic downturn, unemployment and early retirement rise which weakens the financing base of the SHI. Secondly, the revenues are growing slowly due to low wage increases, an increasing importance of revenues that are not

[56] Günther et al.; The Role of Monetary and Nonmonetary Incentives on the Choice of Practice Establishment: A Stated Preference Study of Young Physicians in Germany; Health Service Research vol. 45, issue 1, pages 212-229; 2009.

[57] According to the Federal Ministry of Health (Vorläufige Rechnugsergebnisse der GKV nach Statistik der KV 45; 1.-4. Quartal), the quota jumped from 6.1% in 2008 to the current level of 6.7%. This high increase is due to the the economic downturn in 2009 (5% decline of GDP in 2009).

[58] Bundesministerium für Gesundheit: Kennzahlen der gesetzlichen Krankenversicherung 1994-2007, 1.-4. Quartal 2008; Federal Statistical Office, Fachserie 18 Reihe 1.4, last update: February 2010.

[59] Subject to Drucksache 17/507; Sozialversicherungs-Stabilisierungsgesetz – SozVersStabG; 25 January 2010.

subject to social insurance contributions, and a growing proportion of pensioners. Thirdly, it produces adverse effects to employment because of the unilateral burden on wages and thus on labour. Fourthly, it lacks transparency as a result of the fragmented redistribution between the different branches of social security. Fifthly, it has adverse effects on distribution because it discriminates against wage earners and two-wage-earning families and leads to distortions in the choice of a health insurance type at the compulsory insurance income threshold.[60]

The ANR 2009 deals with the 2007 health care refom in detail which is why this report focuses on the projects of the new government (coalition between the Christian Democrats, Christian Social Union and Free Democrats). These projects can be found in chapter III, subsection 9 of the coalition agreement.[61]

Due to the medical-technical progress and demographic change, the coalition parties want to adjust the structure, the organisation, and the financing system of the SHI. On page 86 of the coalition treaty, it is mentioned that the contribution rate for employers will be frozen at the current level. The employer's contribution rate is currently at 7.0% of the employee's assessable income. Therefore, this scheme aims at decoupling the non-wage labour costs from health care costs in order to increase the competitiveness of German companies against international competition. However, the opposition parties complain that future rises in health care costs are then to be borne solely by the members of the SHI.[62] This objection is not entirely true since the employer would have to contribute a fixed portion of the employee's assessable income. Hence, if the assessable income of the employee rises, the employer's contribution increases, too.

In the long run, employees shall contribute a non-income-related fee. The introduction of a capitation fee would lead *inter alia* to the following improvements:

- elimination of the SHI funding dependency on the labour market which is sensitive to cyclical changes in the the economy,
- increase in financial sustainability due to the separation of health care provision and the current low-growth financing basis,
- greater resistance to the demographic structure of the population because retired persons and employees would pay the same fee,
- elimination of distortions in the case of wage and income increases,
- decrease in the marginal tax and contribution ratio for middle-income earners,
- equal treatment of all income by broadening the assessment basis,
- greater transparency and efficiency of the redistribution effects.

Initially, the Christian Democrats as well as the Free Democrats favored the capitation concept.[63,64] However, especially the Christian Social Union, the third coalition party, is reluctant to change the financing system of the SHI in such a way. The current party leader

[60] EUR 49,950/year in 2010.
[61] Koalitionsvertrag zwischen CDU, CSU und FDP; Wachstum. Bildung. Zukunft.
[62] Deutscher Bundestag; Plenarprotokoll 17/5; 12 November 2009; p. 275.
[63] CDU/CSU; Reform der gesetzlichen Krankenversicherung – Solidarisches Gesundheitsprämien-Modell vom 15 November 2004.
[64] FDP; Programm der Freien Demokratischen Partei zur Bundestagswahl 2009, beschlossen auf dem Bundesparteitag vom 15.-17. Mai 2009 in Hannover.

Horst Seehofer, a former federal health minister, considers the capitation fee as anti-social. In 2004, he even resigned from his post as deputy party leader after the party congress delegates approved the capitation fee by a large majority. This specific constellation complicates the introduction of a capitation fee.

In such a system, each member of the SHI would contribute a lump sum payment. There is still no official information concerning the envisaged premium level. The new governmental commission for a sustainable and socially balanced funding of the health care system will focus on these issues and make suggestions refering to the design of the premium.

At first sight, high wage recipients would pay less and low wage earners would pay more than today. Hence, social adjustments for low-income earners would be necessary in order to compensate them for higher SHI contributions. The required tax subsidy for this purpose is estimated at EUR 14 to 35 billion annually. This change in the financing scheme shall be financed by increasing tax revenues for which mostly high income earners would have to come up for since the income tax has no ceiling (in opposition to the SHI contribution). Therefore, it is possible that a capitation fee leads to increasing tax and contribution payments for high income earners. However, it is too early to finally declare winners and losers of the reform since the design of the SHI financial plan has not yet been determined. The current health minister also stressed the fact that the change of the funding mechanism towards a capitation fee will only be accomplished in small steps. This measure shall increase the acceptance from the population for the capitation fee.

The government also wants to simplify the transfer of an SHI-insured person into a private health insurance company. In the future, an employee will therefore only have to exceed the annual compulsory insurance income threshold once (instead of three times) in order to become a member of a private health insurance company. From an economic point of view, the adherence to the prohibition on third party- and multiple ownership of pharmacies (Fremd- und Mehrbesitzverbot) and the intended limitations for incorporated companies to own medical care centers (Medizinische Versorgungszentren; MVZ) in particular must be evaluated critically. In Germany there are about 21,000 pharmacies, which are all owned by pharmacists. In addition to this restrictive regulation, each pharmacist may have only three more additional pharmacies. This approach thus prevents the formation of chains and the dispensing in supermarkets or department stores and therefore inhibits competition which could lead to a reduction in expenditures on drugs.

The coalition agreement also announced changes to the design of the morbidity oriented risk adjustment scheme (morbiditätsorientierter Risikostrukturausgleich; Morbi-RSA), which shall be reduced to the "necessary minimum" (see p. 86 of the coalition agreement). So far it is not clear what is meant hereunder which also holds true for the announcement of regional differentiation possibilities in the design of the SHI contribution rates.

The reduction of pharmaceutical expenditure is another main goal of the health minister. The minister wants to achieve this objective by using short-term measures as well as structural changes in the pricing mechanism of new pharmaceuticals. On 26 March 2010, the Federal Ministry of Health released a list of cornerstones in order to achieve this goal.[65] The most relevant short-term measures consist of an increase of the compulsory rebate for certain drugs from 6% to 16% and the prohibition of price increases until 21 December 2013. These measures represent a strong intervention in the design freedom of companies and may thus reduce the producers' innovativeness. In addition to this, both measures do only apply to sickness funds. This means that pharmaceutical expenditure may still increase for members of a PHI which *c.p.* leads to distortions of competition between the two health insurance types.

[65] http://www.bmg.bund.de/gesundheit

The cornerstones also specify structural changes that are likely to cause savings for the SHI in the medium term.

According to the plan, pharmaceutical companies will still be allowed to set prices for innovative drugs in the future. Some commentators already described this as a victory for pharmaceutical companies since some political parties[66] advocated fixed prices for new drugs. However, the ministry of health intends to reduce the firms' market power by forcing them to price negotiations with the sickness funds. According to this plan, the pharmaceutical company will be required to present the advantages of the new drug, *inter alia* it will have to show, whether an additional benefit of the drug compared to standard therapy exists or not.

Based on these investigations, the Federal Joint Committee initiates a benefit assessment of the drug, which should be available no later than three months after its approval. The assessment should in particular determine for which patients/ diseases an additional benefit exists and whether it competes with similar (already accredited) drugs. If the assessment leads to the detection of an additional utility of a drug, the pharmaceutical company will have to negotiate a discount on the selling price with the National Association of Statutory Health Insurance Funds within one year. If no compromise is found, the price will be determined by an arbitration board. Individual contracts between sickness funds and the pharmaceutical companies shall also be allowed.

In order to restrict the financial burden of the members of the SHI and to guarantee excellent medical treatment to the patients, benefit assessments represent a useful approach in order to determine prices of pharmaceuticals. In general, even the *Association of Research-Based Pharmaceutical Companies* (vfa; lobby organisation of the research-based pharmaceutical companies) endorses this approach. The IQWiG publishes the current version of the "methods" used in order to assess, *inter alia* the benefit of new drugs on its website (www.iqwig.de). At the beginning of 2010, the board of directors of the IQWiG decided not to renew the contract with Peter Sawicki, the current director of the institute. His contract expires at the end of August. The (official) main reason for his dismissal was an affair related to the company cars driven by Mr. Sawicki. However, it is also argued that his dismissal was the result of political pressure of the new coalition government. According to the coalition treaty, the coalition parties want to "reassess" the institute's work in order to "improve the acceptance" of the institute's decisions. It is generally assumed that the new director will be more industry friendly than Mr. Sawicki.

2.2.5 Long-term care insurance

Social long-term care insurance (SLCI) was introduced on 1 January 1995 as a form of compulsory insurance to cover a portion of long-term nursing care costs (often referred to as "part insurance cover"-principle). All members of the SHI automatically became members of the SLCI. All members of a PHI became members of a private long-term care insurance (PLCI). According to the Federal Ministry of Health, 69.90 million citizens were covered by SLCI and 9.25 million citizens by (PLCI).[67]

Expenditures for long-term care are limited depending on the level of nursing care required. If a person that is in need of care has to spend more money, he or she has to pay the difference by him- or herself. In total, 2.25 million legal residents draw benefits from one of the two

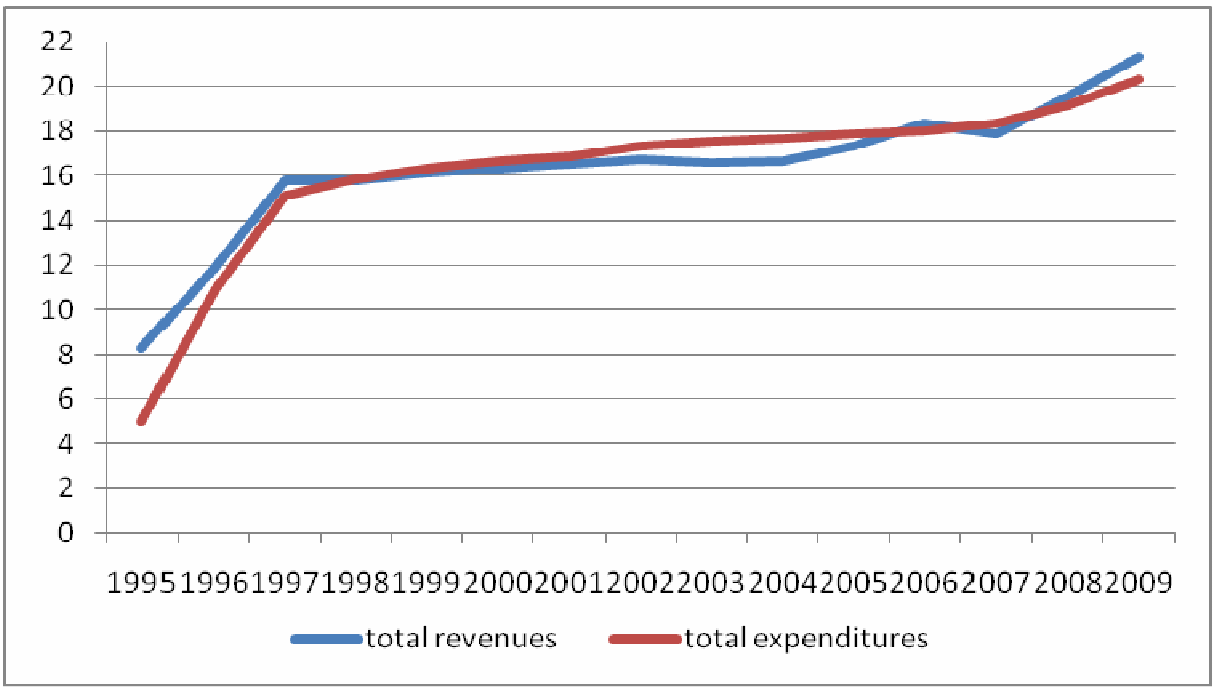
[66] The Social Democrats recommended fixing prices of those pharmaceuticals that are considerably more expansive than in the rest of Europe (see Bundestag Drucksache 17/1201; 24 March 2010).

[67] Bundesministerium für Gesundheit, Zahlen und Fakten zur Pflegeversicherung, July 2009.

long-term care insurance schemes in 2009; 1.53 million persons outpatient care and 0.72 million inpatient care.

Due to the fact that more and more persons receive benefits from SLCI, total expenditure is growing (cf. figure 4). In order to provide the long-term care insurance with a sufficient amount of financial resources, the collection of contributions began on 1 January 1995, whereas the first benefits could be drawn only from 1 April 1995. Since then the long-term care insurance provided benefits for home care. Since 1 July 1996 benefits for inpatient care were also provided. Hence, it is no surprise that the long-term care insurance finished the first two fiscal years with a surplus. Since 1997 total revenues and total expenditures were pretty similar. This was only possible due to several increases of the contribution rate and fixed nominal benefits. On 1 July 2008 the contribution rate was increased again, from 1.7% to 1.95% (for persons without children 2.2 %).

Figure 4: Total expenditures and total revenues of long-term care insurance in billion EUR



Source: Federal Ministry of Health (2010)

The impact of the most recent long-term care reform can be - generally speaking - described as follows: On the one hand, it led to important improvements for people in need of care and their relatives. On the other hand, it led to an increase of the contribution rate of 0.25 percentage points which leads to an increase of non-wage-labour costs. In accordance with *the Long-term Care Development Act* (*Pflege-Weiterentwicklungsgesetz*), long-term nursing care funds, as well as SFs, must set up long-term care bases. The task of these bases is to inform patients and their relatives about their rights and obligations. In addition to that, it supports patients and their relatives by coordinating help programmes and networking health care facilities. Furthermore, most benefits will be increased gradually until 2012.

Another innovation of the *Pflege-Weiterentwicklungsgesetz* is the expansion of quality assurance. The approved care institutions are obliged to take measures to maintain their quality and to implement a quality management regime. In addition, outpatient and inpatient care facilities will be audited every year without notice. However, the *Medical Review Board of the SHI funds* (MDK) requires already to tighten the standards of these quality reports. In particular, the grading system is considered to be misleading, as even nursing homes with

severe deficits in some important fields may be awarded with good grades if they show good performance in other areas.

The SLCI is funded just like the SHI – on a pay-as-you-go basis. As a result, the long-term care insurance exhibits the same five fundamental weaknesses as the SHI which were previously described. The negative effect of the demographic change on the financial sustainability is particularly strong for the SLCI. It is assumed that contribution rates for the SLCI will sharply rise in the future if the government sticks to the pay-as-you-go (PAYG) funding principle (cf. Haecker (2007), p.124). This is the reason why the current government decided to introduce an additional contribution based on the funding principle. In such a system, young insured persons build reserves, which can then be used in old age for nursing expenses. The introduction of the funding principle thus makes a contribution to maintaining the financial stability of the SLCI. According to the coalition agreement between the Christian Democrats and the Social Democrats (SPD), the introduction of the funding principle in the SLCI was already a goal of the previous government.[68] In the end, however, it failed to establish the funding scheme. Therefore, it will be interesting to see whether the present government will implement this reform or not.

For about 800,000 employees in the elderly and outpatient care, a nationwide minimum wage shall be introduced this year. A commission appointed by the Federal Ministry of Labour recently recommended minimum wage floors for nursing assistants of 8.50 euros in West and 7.50 euros in East Germany.[69] Minimum wages are a controverse topic in German politics. In principal, the current government disapproves of nationwide uniform minimum wages. However, the commission was already appointed by the former government and hence approved by the Christian Democrats. The Federal Minister of Labour and Social Affaris, Mrs. von der Leyen (CDU) already announced a quick regulatory implementation of the decision. Due to the projected additional demand of nurses, whereas the working population is projected to decrease in the future, future increases of wages for nurses at above average rates are likely.

3 Impact of the financial and economic crisis on social protection

In 2009, many countries in the world experienced a severe economic setback. The German economy, highly integrated into the world economy, suffers the full effects of the global downturn. According to the Federal Statistical Office, German real GDP decreased by 5% in 2009. However, the outlook for the economic development of Germany was even worse since an even stronger slump and an explosive increase in unemployment were forecasted. Fortunately, these fears have been proven wrong. Overall, the labour market was surprisingly robust given the economic development (increase of unemployed people from 3.27 million in 2008 to “only” 3.42 million in 2009).[70] This was mainly due to the reduced hours compensation scheme (Kurzarbeitergeld).

The public social insurance system is mainly funded by compulsory contributions on wages (in case of SHI and SLCI) as well as social (statutory) pension insurance (SPI). Hence, the

[68] Koalitionsvertrag zwischen CDU, CSU und SPD, November 11, 2005, p. 91.

[69] Federal Ministry of Labour and Social Affairs; Einigung der Pflegekommission auf einen Mindestlohn; press release; 25 March 2010.

[70] Federal Employment Office; Geschäftsbericht 2009; February 2010.

number of employees contributing to the social security system (more specifically the number of full-time employees), and the development of the average assessable income are important figures with respect to the capability of the social insurance schemes to cover current expenditures. Both, employment (full-time employees) and wage growth rates decreased because of the economic crisis. This led to a weakening of the financial basis of the social insurance.

Compared to several other countries, Germany's pensions in general seem at least up to now not so much affected by the financial crisis. One reason is the still high ratio of PAYG pensions, another reason is that because of existing regulations insurance companies and pension funds invested only a relatively low percentage of assets in equities, compared to countries like Australia, Ireland, UK, the Netherlands.[71] But Germany's pension schemes have been suffering from the crisis.

PAYG schemes like social pension insurance are affected via the "real economy", the development of employment, and unemployment and earnings respectively. This was already mentioned above (2.1.2), along with for exemple a "pension guarantee" to protect pensioners from negative average gross wages. Lower contribution revenues as well as lower pension adjustment rates due to a low development of earnings affect the pension scheme as well as recent and future pensioners. As yet, no higher contribution rate has become necessary in social pension insurance and the frail earnings development had insofar only a limited effect in recent years on pension adjustment rates because (a) of the obove mentioned guarantee, that pensions shall remain at least constant in nominal terms, and (b) because the factors included in the pension adjustment formula (that are intended to reduce pension adjustment rates) have not become fully effective.[72] It will depend on the (future) effects on the real economy, who will be affected (in particular by unemployment) and how strong. It is in principle difficult to isolate "the crisis" as a causal factor for employment and earnings development.

The Federal Government made it easier for employers to reduce the amount of working hours without dismissing their employees. This was possible by extending the maximum length of the short-time allowance (*Kurzarbeitergeld*) – that formerly had been six months – to 12 months in the beginning, and now even to a maximum of 24 months. If the employer decides to use this measure, the employee receives – similar as in case of unemployment[73] - 60% (67% if he or she has at least one child) of the difference between the regular and the reduced net income from unemployment insurance funds. In addition to that, the employer benefits from other regulations. The employer is now allowed to cut up to 50% (since 1 July 2009 even 100% after six months of reduced hours compensation) of the rate that he or she would have to pay for social insurance if the employee works within the reduced hours compensation domain.This reduction further reduces labour costs, so that the employer is more likely to keep the employee in his or her company.The Federal Employment Agency fully covers this loss in social insurance revenues, which is one of the reasons why SHI and SLCI revenues did not fall dramatically in 2009. The extended period for claiming short-time allowance for 24 months was originally limited to the end of 2009. Thereafter, the maximum length of the benefit would be as the former "normal" six months only. The compensation for the employer should only be given for short-time working contracts up to the end of 2010. The Government decided at the end of November 2009 that employers can also in 2010 claim

[71] See e.g. OECD Pension Markets in Focus, No. 6, October 2009, data for 2008, cited by Yermo (2010), p. 6.

[72] Börsch-Suppan et al (2009a), however, talk about "massive" effects for contributor and pensioners in the short as well medium term (that means within the next 10 years).

[73] The unemployment benefit is limited to a certain number of months, too. Thereafter a means-tested transfer payment is granted.

short-time working, but only for 18 instead of 24 months. The compensation for the employer shall, however, not be extended beyond the end of 2010 – so at least according to the decision of the Federal Government of November 2009. But in April 2010, the Federal Government extended once more the special rules (the subsidy financed by unemployment insurance) for short-time working by another 15 months - until March 2012.

In general, this instrument is considered an important reason for an evolution on the labour market that has been, up to now, much less severe than expected. In 2009, there was a stagnation of employment and only a relatively small increase in unemployment, although economic activity had decreased by 5%. A major reason is seen in the flexiblity of working time, not only through short-time working, but also by other instruments geared towards making working time more flexible, based for example on collective agreements or by using time accounts (paid time off banks).[74]

For 2009, on average about 1.1 million workers received short-time allowance by reducing to around one third of their normal average working time.[75] Because social pension insurance receives contributions also from this short-time money it stabilises at present its financing base remarkably. In November 2009, social pension insurance was expecting a contribution revenue for the whole of 2009 as high as in 2008, and a balanced budget, so that the contribution rate has remained constant at 19.9%. For 2010, however, a deficit of nearly EUR 4 billion was anticipated in autumn 2009 (while in 2008 there was a surplus of about the same amount).[76]

The losses of capital-funded old age provision are most severe for those persons with high assets and in particular for elderly persons who have less possibilities to compensate these losses compared to younger cohorts (at least in principal).[77]

Life insurance companies have to guarantee at least an interest rate of presently 2.25% (3.25% as until end of 2003; 2.75% as until end of 2006). Beside lower rates of return, the present low interest rates on capital markets for assets can become a problem for insurance companies in the future. On top of the guaranteed interest rate life insurance companies granted a surplus interest. This will be reduced or become zero and therefore expectations of pensioners may turn out to be too optimistic and give them less money to live upon.

Regarding occupational pension schemes the loss is greatest for those who have invested in shares. For certain schemes based on book reserves (direct pension commitment of the firm) there exists the pension protection fund (*Pensions-Sicherungs-Verein - PSV*) covering pension claims in case of insolvency of a firm (see also 2.1.1), financed by contribution payments of the member firms. In 2009, the number of cases of insolvency increased and the PSV was confronted with a sum of damages of about EUR 4 billion, resulting in a contribution rate of 0.142% – the highest ever (this is, however, distributed over several years, resulting in 0.082% at the end of 2009, in order not to burden the firms' liquidity too heavily). Nearly 10,000 persons affected by insolvency of their firms are covered.[78]

What will be the effect on the real economy of the crisis taking into account all the measures already implemented for "umbrella" (rescue) instruments, to save banks (directly) and insurance companies (indirectly), and now by granting credits for Greece - measures financed

[74] See Sachverständigenrat (2009), pp. 260.
[75] Fuchs et al. (2010), p.3.
[76] See Gunkel (2009).
[77] Börsch-Supan et al (2009) give estimates on loss in financial assets – on average 4.3%, for assets in old age security by only 2% - however with an unequal distribution of losses between households.
[78] For details see Hoppenrath (2010) as well as the report of the PSV for 2009.

mainly by public debt? What will be the effects of "exit" strategies? There will be tremendous pressure on public expenditure in general and social security expenditure in particular.

The present crisis undermined the confidence in capital funded elements in pension policy. But since many years the confidence in PAYG-financed social insurance was willingly undermined to better sell private products. There exists a high degree if uncertainty regarding employment and income. Trust can get lost very quickly but needs a long time to be rebuilt.

Recent developments in particular in the EU and regarding the Euro stimulated already reports in Germany's mass media that reflect growing critical opinions in the population because of the hughe amount of (possible) transfers linked to the rescue measures at first to cope with challenges from the crisis of world wide financial markets and now with challenges in particular within the Euro-zone of the EU. Even within the process of German unification there was and is some debate about the limits of solidarity. This may become more and more a topic of public debate regarding solidarity within the EU and the distribution of responsibility for political decisions on the national and European level.

In the field of health care, however, the negative impact of a reduction of the number of employees on the financial situation of the SHI is less severe than for example for the public unemployment insurance (PUI). This derives from the fact that the PUI contributes a large part of the premiums that were previously paid by the dismissed members to the SHI. In principle, the PUI pays 80% of the member's last contribution during the first 12-18 months of unemployment.[79] If the SPI/SHI member remains unemployed for a longer period the social insurance receives (on average) a much lower contribution. Therefore, the SPI and SHI experience severe financial problems regarding revenue if the job market remains weak for a medium or longer period. In 2009, the national health care fund already reported a deficit of EUR 2.48 billion.[80] The Federal Ministry of Health estimates that the SHI will generate a deficit of EUR 7.9 billion in 2010. This is due to the forecasted unfavourable development of SHI revenues and rises in expenditures at the same time.

In order to guarantee a stable introduction of the new national health fund, the Federal Government granted an interest-free loan to the national health fund in the amount of the money gap that was caused by recession. Initially, it was envisaged that the loan had to be paid back until 31 December 2010. Under the influence of the recession, the Government decided to extend this phase until the end of 2011.

This measure leads to more (short-term) financial stability in the SHI, because SFs do not have to worry about high budget deficits due to the current economic crisis. The loan is therefore part of the reason why the sickness funds were able to generate a surplus of EUR 1.1 billion in 2009.

Furthermore, the Federal Government decided to increase the subsidy for the new national health fund to EUR 7.2 billion in 2009 and to EUR 15.7 billion in 2010. The purpose of this increased subsidy was to lower the uniform contribution rate from 15.5% to 14.9% and to safeguard the financial stability of the sickness funds in 2010 as well.[81]

Moreover, the Government decided to support additional investments of the Länder and municipalities in education and infrastructure. The Federal Government grants financial aid to

[79] § 232a I Social Code Book V.

[80] Due to other revenues, the sickness funds, however, generated a surplus of EUR 1.1 billion in 2009. Hence, the SHI generated a net loss of EUR 1.4 billion in 2009.

[81] The PHI does not receive direct financial support. However, the old age provisions of the PHI and PLCI increased by EUR 10 billion in 2009 (total old age provisions at the end of 2009: EUR 144 billion).

the Länder in the amount of EUR 10 billion.[82] As part of this stimulus package, German hospitals will receive a total amount of EUR 1.3 billion from 2009 to 2011. EUR 350 million of these funds will be allocated to university hospitals.[83]

In conclusion, the setback in economic activity and the decrease of the number of employees (full-time employees) subject to social insurance contributions led to declining SHI revenues. The German Federal Government committed itself to cover the SHI financing gap, caused by recession, with an interest-free loan and will cover approximately 50% of the forecasted SHI deficit in 2010. Hence, the measures taken by the Government in order to tackle the crisis with respect to social security lead to more stability in the short run. However, the government deficit as well as government debt rose to a new all-time high. According to calculations of the German Central Bank, government debt[84] rose to EUR 1.76 billion (73.2% of German GDP) in 2009. The government bound itself to lower government deficits by law. Hence, it is questionable whether the government will be able to subsidise the social insurance system in the future to such an extent.

In order to safeguard financial stability of the SHI/ SLCI in the long run, structural reforms on the financing side have to be performed. This will be an important task for the new Federal Government.

[82] The *Länder* provide a further EUR 3.3 billion for the same purpose as part of their own economic stimulus packages.

[83] Schwarz, Astrid and Wehner, Christian; Konjunkturspritze für die Kliniken; Gesundheit und Gesellschaft, volume 12, 12/2009, pp. 30-33.

[84] This number includes federal debt, debt of the *Länder,* debt of the municipalities, and that of social insurance.

References

AUGURZKY et al. (2009); Krankenhaus Rating Report 2009.

BÖRSCH-SUPAN, Axel et al. (2009a), Auswirkungen der Finanzkrise auf die Gesetzliche Rentenversicherung, ihre Beitragszahler und ihre Rentner, mea studies 09, Universität Mannheim.

BÖRSCH-SUPAN, Axel et al. (2009a), Auwirkungen der Finanzkrise auf die private Altersvorsorge, MEA Diskussionspapier 193-09, Universität Mannheim.

BÖRSCH-SUPAN, Axel et al., Ein einheitliches Rentensystem für Ost- und Westdeutschland: Simulationsrechnungen zum Reformvorschlag des Sachverständigenrates, Perspektiven der Wirtschaftspolitik 2010, pp. 16-46.

CORNEO, Giacomo et al. (2007), Erhöht die Riester-Förderung die Sparneigung von Geringverdienern? Retrieved from http://www.wiwiss.fu-berlin.de/institute/finanzen/corneo/dp/Riester_CKS.pdf.

CORNEO, Giacomo et al. (2009), The Riester scheme and private savings, Schmollers Jahrbuch 129, 321-332.

FROMMERT, Diana (2009), Bundesländer im Vergleich, RVaktuell, pp. 291-297.

FUCHS, J. et al., Die Spuren der Krise sind noch länger sichtbar, IAB-Kurzbericht 3/2010.

GEYER, Johannes, & STEINER, Viktor (2010); Künftige Altersrenten und der Wandel der Erwerbsbiografien – Eine Mikrosimulationsstudie für Deutschland, Deutsche Rentenversicherung 1/2010 ,S. 34-47.

GEYER, Johannes, & STEINER, Viktor (2010), Public Pensions, Changing Employment Patterns, and the Impacts of Pension Reforms across Birth Cohorts: A Microsimulatioon Analysis for Germany, IZA Discussion paper.

GUNKEL, Alexander (2009), Perspektiven der Finanzen der gesetzlichen Rentenversicherung, DRV-Schriften Bd. 87, S.5-15.

HAGEN, Kornelia, & Lucia REISCH, A. (2010), Riesterrente: Politik ohne Marktbeobachtung, DIW Wochenbericht Nr. 8 2010, S. 2-14.

HOPPENRATH, Martin (2010), Bewährungsprobe für den PSVaG in Zeiten der Finanz- und Wirtschaftskrise, Betriebliche Altersversorgung, S. 111-117.

KÖHLER-RAMA, Tim, & LOHMANN, Albert, & VIEBROK, Holger (2010), Vorschläge zu einer Leistungsverbesserung bei Erwerbsminderungsrenten aus der gesetzlichen Rentenversicherung, Zeitschrift für Sozialreform, 56. Jg., S. 59-83.

KNUTH, Matthias (2010), Altersteilzeit weiterhin fördern, aber umgestalten, Institut Arbeit und Qualifikation Universität Duisburg-Essen (IAQ-Standpunkt) 01/2010.

OEHLER, Andreas, Alles "Riester"? Die Umsetzung der Förderidee in der Praxis, Gutachten im Auftrag des Verbraucherzentrale Bundesverbandes, Bamberg 2009.

PFARR, Christian, & SCHNEIDER, Udo (2009), Demand inducement, crowding in and the German Riester pension scheme, MPRA (Munich Personal RePEc Archive).

PSVaG (2010), Bericht über das Geschäftsjahr 2009, Köln.

RISCHE, Herbert (2010), Die Absicherung des Erwerbsminderungsrisikos – Handlungsbedarf und Reformoptionen, RVaktuell, 1/2010, 2-9.

Herbert RISCHE (2009), Die Alterssicherung in der neuen Legislaturperiode, DRV – Schriften Bd. 87, S. 33-45.

RULAND, Franz (2010), Das neue Versorgungsausgleichsrecht für Betriebsrenten, Betriebliche Altersversorgung, S. 131-139.

SCHMÄHL, Winfried (2007), Dismantling an Earnings-Related Social Pension Scheme – Germany's New Pension Policy, Journal of Social Policy 36 (2): 319-340.

SCHMÄHL, Winfried (2010), Die wachsende Bedeutung der Dynamisierung von Alterseinkünften für die Lebenslage im Alter, Wirtschaftsdienst. 90. Jg., S. 248-254.

SACHVERSTÄNDIGENRAT (2009): Jahresgutachten 2009/10. Die Zukunft nicht aufs Spiel setzen. http://www.sachverstaendigenrat-wirtschaft.de/gutacht/ga-content.php?gaid=55%20&node=a.

SOZIALBEIRAT (2009) , Gutachten des Sozialbeirats zum Rentenversicherungsbericht 2009, published together with the Rentenversicherungsbericht 2009 of the Federal Government, http://www.sozialbeirat.de/files/sozialbeirat_gutachten_2009_1.pdf.

WANGER, Susanne (2009), Altersteilzeit: Beliebt, aber nicht zukunftsgerecht, IAB-Kurzbericht 8/2009.

WINKELBACH, Martin (2010), Stand und Hintergründe der Vereinheitlichung des Rentenrechts – Modelle der Rentenangleichung, RVaktuell 2/2010, D. 56-62.

BUNDESMINISTERIUM FÜR GESUNDHEIT, Zahlen und Fakten zur Pflegeversicherung, July 2009.

BUNDESMINISTERIUM FÜR GESUNDHEIT: Kennzahlen der gesetzlichen Krankenversicherung 1994-2007, 1.-4. Quartal 2008; Federal Statistical Office, Fachserie 18 Reihe 1.4, last update: February 2010.

BUNDESMINISTERIUM FÜR GESUNDHEIT; Monatsstatistik der gesetzlichen Krankenversicherung über Mitglieder, Beitragssätze und Kranke, Monatswerte Januar-März 2010.

BUNDESMINISTERIUM FÜR GESUNDHEIT; Monatsstatistik der gesetzlichen Krankenversicherung über Mitglieder, Beitragssätze und Kranke, Monatswerte Januar-März 2010

BUNDESTAG-DRUCKSACHE 17/507; Sozialversicherungs-Stabilisierungsgesetz – SozVersStabG; 25 January 2010.

BUNDESTAG-DRUCKSACHE 17/1108, 19 March 2010.

BUNDESTAG DRUCKSACHE 17/1201; 24 March 2010.

BUSSE; Health care systems in transition: Germany; 2004.

CDU/CSU; Reform der gesetzlichen Krankenversicherung – Solidarisches Gesundheitsprämien-Modell vom 15.11.2004.

DEUTSCHER BUNDESTAG; Plenarprotokoll 17/5; November 12, 2009; p. 275.

FDP, Programm der Freien Demokratischen Partei zur Bundestagswahl 2009, beschlossen auf dem Bundesparteitag vom 15.-17. Mai 2009 in Hannover.

FEDERAL EMPLOYMENT OFFICE; Geschäftsbericht 2009; February 2010.

FEDERAL MINISTRY OF LABOUR AND SOCIAL AFFAIRS; Einigung der Pflegekommission auf einen Mindestlohn; press release; 25 March 2010.

FEDERAL STATISTICAL OFFICE (2007-2009): Fachserie 16 Reihe 2.1.

GERMAN MEDICAL ASSOCIATION; Ärztemangel trotz steigender Arztzahlen – ein Widerspruch, der keiner ist; 21 April 2009 (downloaded from http://www.bundesaerztekammer.de/page.asp?his=0.5.33.7123 on 13 April, 2010).

GESUNDHEITSBERICHTERSTATTUNG DES BUNDES (www.gbe-bund.de).

GÜNTHER et al.; The Role of Monetary and Nonmonetary Incentives on the Choice of Practice Establishment: A Stated Preference Study of Young Physicians in Germany; Health Service Research vol. 45, issue 1, pages 212-229; 2009.

KASSENÄRZTLICHE BUNDESVEREINIGUNG; Grunddaten zur vertragsärztlichen Versorgung in Deutschland 2009; 31 December 2009.

KOALITIONSVERTRAG ZWISCHEN CDU, CSU UND FDP; Wachstum. Bildung. Zukunft.

KOALITIONSVERTRAG ZWISCHEN CDU, CSU UND SPD, 11 November 2005.

N.N., Honorarreform – Großes Plus reicht nicht für jeden; Deutsches Ärzteblatt vol 107 (issue 9), A 374-375.

OECD HEALTH DATA 2009.

RHEINISCH-WESTFÄLISCHES INSTITUT FÜR WIRTSCHAFTSFORSCHUNG; Krankenhaus Rating Report 2009 – Im Auge des Orkans; December 2009.

SACHVERSTÄNDIGENRAT FÜR DIE KONZERTIERTE AKTION IM GESUNDHEITSWESEN; Bedarfsgerechtigkeit und Wirtschaftlichkeit; Band III; Über-, Unter- und Fehlversorgung; expertise 2000/2001.

SCHMIDT, Michael, Tausende Menschen ohne Krankenversicherung, Schweriner Volkszeitung; 20 March 2010.

SCHWARZ, Astrid, & WEHNER, Christian; Konjunkturspritze für die Kliniken; Gesundheit und Gesellschaft, volume 12, 12/2009, p.30-33.

VERBAND DER PRIVATEN KRANKENVERSICHERUNG; Die wichtigsten Zahlen auf einen Blick; press release, 17 March 2009.

4 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

[R1; R2] OEHLER, Andreas (2009), Alles "Riester"? Die Umsetzung der Förderidee in der Praxis, Gutachten, Bamberg

The practical implementation ob subsidzed private pension products in Germany are analysed, underlining a lack of transparency, including the interaction of public and private pension provision.

[R1; R4] GEYER, Johannes, & STEINER, Viktor (2010), Public Pensions, Changing Employment Patterns, and the Impactz of Pension Reforms across Birth Cohorts: A Microsimulatioon Analysis for Germany, IZA Discussion paper

The impact of changing employment patterns and pension reforms on the future level of public pensions across birth cohorts in Germany in analysed in this paper. The analysis is based on a rich dataset that combines household survey data from the German Socio-Economic Panel Study (SOEP) and process-produced microdata from the German pension insurance. A microsimulation model is developed which accounts for cohort effects in individual employment and unemployment and earnings over the lifecycle as well as the differential impact of recent pension reforms. Cohort effects for individuals born between 1937 and 1971 vary greatly by region, gender and education and strongly affect lifecycle wage profiles. The largest effects can be observed for younger cohorts in East Germany and for the low educated. Using simulated life cycle employment and income profiles, gross future pensions across cohorts are projected taking into account changing demographics and recent pension reforms. Simulations show that pension levels for East German men and women will fall dramatically among younger birth cohorts, not only because of policy reforms but due to higher cumulated unemployment. For West German men, the small reduction of average pension levels among younger birth cohorts is mainly driven by the impact of pension reforms, while future pension levels of West German women are increasing or stable due to rising labor market participation of younger birth cohorts.

[R1; R5] CORNEO, Giacomo, & KEESE, Matthis, & SCHRÖDER, Carsten (2009), The Riester scheme and private savings, Schmollers Jahrbuch 129, 321-332

Questions the expectation that subsidised private saving for old age increases savings in particular of low-income households, based on econometric analysis.

[R1; R5] SCHMÄHL, Winfried (2010), Die wachsende Bedeutung der Dynamisierung von Alterseinkünften für die Lebenslage im Alter, Wirtschaftsdienst. 90. Jg., S. 248-254

Underlines the increasing importance of adjustment (dynamic) of income in old age from different sources for living conditions in old-age. This becomes even more important because dynamic public pensions will be reduced and information on the development of private and occupational pension benefits during retirement are hardly existing. This is up to now a neglected topic.

[R2] BÖRSCH-SUPAN, Axel et al., Ein einheitliches Rentensystem für Ost- und Westdeutschland: Simulationsrechnungen zum Reformvorschlag des Sachverständigenrates, Perspektiven der Wirtschaftspolitik 2010, S. 16-46.
"A uniform pensionsystem for East and West Germany"

Discusses results of a proposal to unify the German pension system by the Council of Economic Advisors. Based on a simulation study the effects largely depend on the assumption of average wages in both "part". As most realistic case the authors assume that the wage in the East remain a constant fraction of average wage in the West over time, there will be only minor effects on the contribution rate and pension benefits in nominal terms. In all other cases different types of redistribution would take place.

[R5] HAGEN, Kornelia, & REISCH, Lucia A. (2010), Riesterrente: Politik ohne Marktbeobachtung, DIW Wochenbericht Nr. 8 2010, S. 2-14

Although Federal Government mentions the subsidised private pensions as a success story the empirical base for this evaluation is still lacking.

[H] Health

[H1] AUGURZKY, Boris et al.; Krankenhaus Rating Report 2009 – Im Auge des Orkans; rwi Materialien; 2009
"Hospital Rating Report 2009 – in the eye oft he stom"

For the current edition of the hospital rating report, data has been improved again, which enable additional analysis compared to earlier versions of the report. The number of examined annual financial statements rose to almost 550. They include a total of 832 hospitals. The report analyses the effects of the Hospital Reform Act (Krankenhausfinanzierungsgesetz), the second economic stimulus package and the likely consequences of the economic crisis on the economic performance of hospitals. The report investigates the investment activities and puts the calculation of the investment backlog on a sound foundation. On the basis of 17 million cases, patient flows are examined and the importance of foreign patients is looked at. A specially developed model for regional population forecasts is used for the first time.

[H1] BARMER GEK; Arztreport 2010; Viele Patientenkontakte, wenig Zeit; January 2010; retrieved from http://www.barmer.de/barmer/web/Portale/Versichertenportal/Presse-Center/Pressemitteilungen/100119_20PK_20Arztreport/content_20Arztreport.html
"A lot of patient contacts, little time"

The paper shows that the number of medical treatments continues to rise. The study examines data on outpatient care of 1.7 million insured persons and is hence one of the most detailed studies in this field of research.

[H1] KLUSEN, Norbert; The German Health Care System in an International Context; Techniker Krankenkasse; 8 September 2009; retrieved from http://www.sph.umich.edu/hmp/glc/pdfs/Klusen%2008%20Sep%202009%20Lecture%20070909.pdf

Gives an overview of the German health care system from a perspective of one of the biggest sickness funds (Techniker Krankenkasse)

[H1] RAFFELHÜSCHEN, Bernd; MOOG, Stefan; Ehrbarer Staat? Gesundheitsprämien und Rentenindexierung auf dem Prüfstand der Generationenbilanz; Stiftung Marktwirtschaft; 10 november 2009; retrieved from http://www.stiftung-marktwirtschaft.de/wirtschaft/themen/generationenbilanz.html
"Reputable State? Capitation fees and indexation of pensions – audited with respect to the generation balance"

According to this study, the introduction of a capitation fee would reduce the sustainability gap of the SHI by 25%.

[H1; H2; H3; H4; H5; H7] SACHVERSTÄNDIGENRAT ZUR BEGUTACHTUNG DER ENTWICKLUNG IM GESUNDHEITSWESEN; Coordination and Integration – Health Care in an Ageing Society; september 2009

The 2009 report focuses inter alia on generation-specific health care against the background of demographic change, special requirements for children and adolescents, special care requirements for elderly and old people. The Council thus fulfils its mandate formulated in § 142 Para. 2 of Social Code Book V, i.e. to identify priorities for the elimination of health care deficits and existing overuse, as well as ways and means of further developing the health care sector, taking into account the financial framework conditions and existing efficiency reserves.

[H3] BUNDESÄRZTEKAMMER; Ärztemangel trotz steigender Arztzahlen – ein Widerspruch, der keiner ist; 2009
"Physician shortages despite of an increasing number of physicians – a contradiction that is none."

The author of this article identifies four reasons which shall explain this paradox: Firstly, the medical-technical progress leads to an increase of demand. Secondly, the demographic change in Germany leads to an increase of the number of older persons. In 1991, only 20.4% of all inhabitants (80.3 million) were sixty years old or older. In 2008, more than a fourth of the population (82.0 million) was already that old. Since older people need more medical treatment on average than younger people, demographic change leads c.p. to an increasing need for physicians. Thirdly, the feminisation of the medical profession leads ceteris paribus to an increasing number of physicians. In 1991, only 33.6% of all practicing physicians were female. This number rose to 41.5% in 2008. Since more than 60% of all current medical students are female, the fraction of female practicing physicians will further increase in the future. According to the microcencus, the number of hours worked is lower for female than for

male physicians (58.9% of the interviewed male physicians but only 36.8% of the female physicians report that they work more than 40 hours per week). If this relationship remains constant over time, an increasing fraction of female physicians leads to an increasing need of physicians (head count). Forthly, the author argues that due to a reduction in working hours, the same total amount of working hours has to be allocated on more heads. It is argued that today young physicians are not willing to work as long as physicians in the past used to do. In addition to that, the law (§ 3 of the Working Hours Act [Arbeitszeitgesetz]) regulates that employees are, in principal, not allowed to work more than 48 hours per week. The author even claims that, as a result of the reduction of working hours per capita, the total amount of working hours decreased from 2000 to 2007 by 1.6%.

[H3] GÜNTHER, Oliver et al.; The Role of Monetary and Nonmonetary Incentives on the Choice of Practice Establishment: A Stated Preference Study of Young Physicians in Germany; Health Service Research 45:1 (February 2010), p. 212-229.

The study aimed to quantify the preferences of young physicians for different attributes relevant to practice establishment in Germany. Qualitative in-depth interviews of 22 physicians were conducted to identify relevant practice attributes. Based on this information, a questionnaire was developed containing a discrete choice experiment comprised of a ''best–worst scaling'' (BWS) task. It was mailed to a representative sample of 14,939 young physicians who were close to making a decision regarding practice establishment. Regression analysis was used to estimate utility weights quantifying physicians' preferences for practice attributes. Qualitative interviews identified six attributes: ''professional cooperation'',''income", "career opportunities of the partner", "availability of child care", "leisure activities,'' and ''on-call duties.'' For the BWS task, 5,026 returned questionnaires were analysed. Results indicated that a change in income led to the largest utility change compared with changes in other attributes. Additional net income to compensate the disutility of a rural practice as compared with an urban practice was 9,044h/months (USD 11,938). Yet, nonmonetary attributes such as on-site availability of childcare and fewer on-call duties would decrease the additional income required to compensate the disutility of a rural practice. The results offer quantifiable information about young physicians' preferences in establishing a practice. It can assist health policy makers in developing tailored incentive-based interventions addressing urban–rural inequalities in physician coverage.

[H6] SCHWABE, Ulrich (ed.); PAFFRATH, Dieter (ed.); Arzneiverordnungs-Report 2009: Aktuelle Daten, Kosten, Trends und Kommentare; September 2009, retrieved from http://www.springerlink.com/content/978-3-642-01079-8.

"Pharmaceutical prescription report 2009: updated data, trends and comments"

The report is one of the latest books on pharmacology in German-speaking countries. It is intensively reviewed every year and it is an important decision support for physicians. For the past 25 years, it analyses the reasons for the increase of pharmacy expenditures of the SHI. The report is based on 723 million prescreptions that were issued by 135,388 physicians in 2008. Drugs that came on the market in 2009, are assessed pharmacologically and therapeutically. For the first time, prescriptions of vaccines are analysed.

[L] Long-term care

[L] ROTHGANG, Heinz et al.; GEK-Pflegereport 2009; November 2009, retrieved from https://www.gek.de/presse/informationen/archiv/2009-11-18.html.

> *German citizens are not only living longer, they also stay healthy for a longer time. According to the GEK Pflegereport 2009, the number of people needing long-term care increased. Between 2000 and 2008, however, the age-specific risk of becoming a case for nursing care, dropped by 1% for men and by 3.6% for women. The increased level of care can therefore be soley explained by the ongoing demographic change. The study also detects regional characteristics in nursing care, e.g. that there are significant regional differences in the remuneration structure and distinctions with respect to the level of provision of special physicians in nursing homes.*

[L] RUNDE, P. et al.; Pflegeaufwand und Mitteleinsatz; september 2009 and RUNDE, P. et al; AOK-Trendbericht Pflege II; Entwicklungen in der häuslichen Pflege seit Einführung der Pflegeversicherung, august 2009; retrieved from http://www.aok-bv.de/presse/pressemitteilungen/2009/index_01874.html.

"Nursing requirementsand long-term care expenses" and "trend report II; development of home care since the introduction of the SLCI"

> *Scientists of the University of Hamburg show that the increasing number of long-term care patients is mainly due to the longer periods patients are in need of nursing care and hence the resulting longer payments of SLCI benefits. The study points out that there is a trend towards more self-determined living for people in need of long-term care. At the same time, these patients have to adjust to a longer nursing duration. A key finding of the study is that patients with low income are more likely to receive long-term care at home because they have to organise their care more often all alone. In addition to that, they often do not have enough financial resources for convalescence. They also demand less nursing supplies and living adjustments. Another trend: There is a growing number of citizens that are economically active and in need of long-term care.*

5 Important institutions

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

Address: Rohrbacher Str. 12, 69115 Heidelberg
Phone: +49(0)6221-137178 0
Fax: +49(0)6221-2421 0
Webpage: http://www.aba-online.de

Aba is an association of occupational pension scheme providers in Germany. Its tasks includes the provision information, 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 gives also an overview of statistics and the various statistical sources for occupational pension schemes.

Bertelsmann Stiftung – Bertelsmann Foundation

Address: Carl-Bertelsmann-Str. 256, 33311 Gütersloh
Phone: +49(0)5241-810
Fax: +49(0)5241-81681396
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
Phone: +49 (0) 3018 527-0
Fax: +49 (0) 3018 527-1830
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
Phone: +49 (0) 18 88 441 - 0
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 bills, 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
Phone: +49(0)221-9242 8105

Fax: +49(0)221-9242 8107
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 literacy (http://www.wiwi.uni-muenster.de/dia/). 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)
Phone: +49(0)30-897 89 249
Fax: +49(0)30-897 89 119
Webpage: http://diw.de

DIW is one of the five large economic research institutes in Germany. It is focused on applied economic 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
Phone: +49(0)30 -39801 0
Fax: +49(0)30-39801 3000
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
Phone: +49(0)211-47051 17
Fax: +49(0)211-47051 19
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 are 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
Phone: +49(0)30-260740 0

Fax: +49(0)30-7854350
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 aim 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
Phone: +49(0)621-181 1862
Fax: +49-621-181 1863
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 Aging Society and SHARE, an EU- and NIA-sponsored project which constructs a longitudinal Survey on Health, Aging and Retirement in Europe.

Forschungszentrum Generationenverträge (FZG) – research centre inter-generational contracts

Address: Albert-Ludwigs-University Freiburg, 79085 Freiburg
Phone: +49(0)761-203 2354
Fax: +49(0)761-203 2290
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
Phone: +49(0)30-206288 0
Fax: +49(0)30-206288 88
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. It responsibilities include to conclude framework contracts and remuneration agreements for in-patient, out-patient 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
Phone: +49(0)22899-64381 21
Fax: +49(0)22899-64389 96
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 hazard, 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-Insitute and the Federal Office of Statistics (Statistisches Bundesamt) under the political liability of the Federal Health Ministry (Bundesministerium für Gesundheit).

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

Contact person: Dr. Sibylle Angele, Managing Director
Address: Hansaring 43, 50670 Cologne
Phone: +49(0)221-912867-0
Fax: +49(0)221-912867-6
Webpage: http://www.gvg-koeln.de

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 develop 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
Phone: +49(0)40-340576 0
Fax: +49(0)40-340576 776
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 the 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
Phone: +49(0)211-7778 0
Fax: +49(0)211-7778 120
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
Phone: +49(0)89-9224 0
Fax: +49(0)89-985369
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 fouces 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
Phone: +49(0)30-23080 90
Fax: +49(0)30-23080 911
Webpage: http://www.iges.de

IGES is a private R&D institute for health and health care based in Berlin, Germany. It´s main foci are: German statutory and private health insurance systems, current legal conditions affecting health and health care, out-patient and complementary services, the day-to-day reality of care in both out-patient and in-patient 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
Phone: +49(0)221-4981 401
Fax: +49(0)221-4981 406
Webpage: http://www.insm.de

INSM promotes for 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
Phone: +49(0)2241-9382 0
Fax: +49(0)2241-9382 35
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 the array of medicine (case-related groups, coding guidelines, cooperation with institutions, bodies and organisations) and the array of economy (costing).

Institut für Weltwirtschaft – Institute for the World Economy

Address: Düsternbrooker Weg 120, 24105 Kiel
Phone: +49(0)431-8814 1
Fax: +49(0)431-85853
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)
Phone: +49(0)345-7753 700
Fax: +49(0)345)-7753 820
Webpage: http://www.iwh-halle.de

The Halle Institute for Economic Research (IWH) was founded on January 1st, 1992 and is also one of the six large economic research institutes in German. A 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
Phone: +49 - (0)221 - 35685 – 0
Fax: +49 - (0)221 - 35685 – 1
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 Essen)

Address: Hohenzollernstraße 1-3, 45128 Essen
Phone: +49(0)201-81 49 0
Fax: +49(0)201-81 49 200
Webpage: http://www.rwi-essen.de

The RWI Essen 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
Phone: +49(0)611-752 390
Fax: +49(0) 611-752 538
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
Phone: +49(0)228-99 441 2294
Fax: +49(0)228-99 441 4915
Webpage: http://www.svr-gesundheit.de

The Advisory Council´s task is to provide a survey at an interval of two years concerning the analysis of developments in the health care system, with special regards to cost effectiveness and to new, further 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
Phone: +49(0)3018-527 4333
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, has been giving 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 institution of the AOK

Address: Rosenthaler Str. 31, 10178 Berlin
Phone: +49(0)30-34646 2393
Fax: +49(0)30-34646 2144
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 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
Phone: +49(0)621-1235 01
Fax: +49(0)621-1235 224
Webpage: http://www.zew.de

The ZEW includes inter alia a research unit on Labour Markets, Human Resources and Social Policy, 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
Phone: +49(0)421-218 4362
Fax: +49(0)421-218 7540
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
Phone: +49(0)30-4005 0
Fax: +49(0)30-394937 39
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 programs in the field of primary and secondary prevention, disease management for chronic disease and, telematics in the health care sector.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(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