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1 Executive Summary

Although the years 2011-2013 have been characterised by comprehensive political and public debates on pension adequacy and additional measures to avoid poverty in old-age, the reform proposals by the Ministry of Labour could not obtain sufficient support in the government. Pension policies have again been a key topic in the election campaign in autumn 2013 and also after the election in negotiations of the CDU/CSU and SPD for establishing a new coalition government.

Thus, the number and scope of recent reforms has been limited up to now and changes were related to adjustments of certain parameters. Due to the positive labour market development in Germany and high contribution revenue the Government and the Parliament decided in 2012 to reduce the contribution rate of the statutory (social) pension insurance at the beginning of 2013. In principle it could be possible to reduce the rate in 2014 to 18.3%. But it can expected that this will not be realised due to plans to increase pension expenditure and/or to build up some reserve fund. An increase in the retirement age, legislated already in 2007, started in 2012 according the envisaged time schedule.

Due to favourable economic development additional surplus was accumulated in 2013 in the SPI and several proposals on how to use this money for additional pension expenditure already exist. It is an open question which additional measures will be negotiated – details matter a lot, in particular regarding its financing (by contribution or tax revenue) and its volume.

Germany's health insurance system is characterised by the co-existence of a social health insurance scheme and a private health insurance (PHI), both providing comprehensive health insurance. Only a small group of individuals is allowed to choose between private and social health insurance. However, once opted for a PHI, this decision can be regarded as 'once-in-a-lifetime'. Inequality in terms of access to health care is prevailingly discussed with respect to individuals being insured with SHI or PHI.

The public debate especially focuses on expenditures of the SHI because it is predominately financed through labour-income-dependent contributions perceived as a 'quasi-income tax'. Health care expenditures are clearly growing, but with an annual average of 2% per capita between 2000 and 2010 it remains below OECD average. The debate on financing the health care system in Germany as reflected in the election programmes of all parties in summer 2013 focussed more or less on the so-called Bürgerversicherung (universal citizens' health insurance). The parties that are expected to form the new government – and which have different views on the *Bürgerversicherung* - have not yet agreed on halth care policies in the current coalition negotiations.

Social long-term care insurance (LTCI) 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 LTCI and all members of a PHI became members of a private LTCI. The Pflege-Neuausrichtungs-Gesetz (PNG), introduced in January 2013, improved benefits of respite care for persons receiving care allowance. Further reform debates in long-term care focus on financing and the separation between public and private long-term care insurance, the definition for being in need of care and remuneration of nurses.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

Pensions in Germany stem from different sources and are often organised by the occupational status. For a long time now, three tiers of pensions schemes have existed:

- mandatory pension schemes as basis of (in particular) retirement income of different groups of the population as the first tier,

- occupational schemes as the second tier and

- private voluntary arrangements for old-age provision as the third tier.[1]

Germany has no general minimum pensions, but means-tested social assistance for all persons below a certain poverty line. Since 2003, however, a new element (or a zero tier) exists: a means-tested transfer payment in case of insufficient income for persons aged 65 and older, as well as for disabled persons (*Grundsicherung*). The benefit amount is calculated in the same way as the already existing means-tested social assistance.[2]

The most important element of the first tier is the social (statutory) pension insurance (SPI). Main features of this scheme are based on a fundamental pension reform in 1957 when a "dynamic" earnings related pension scheme was introduced, linking pension calculation and pension adjustment on earnings development. It was a defined benefit scheme based on specific targets for the level of pensions, while financing was the dependent variable (employer's and employee's contribution payments and federal grant).

Since 2001 the character of the scheme is changing towards a type of defined contribution scheme where now the benefit level becomes the dependent variable, in particular if the total old age protection landscape is taken into consideration, because part of the former pension level covered by SPI shall now be covered by voluntary (subsidised) private (or occupational) pensions.[3]

The new pension strategy of Germany was implemented mainly by pension reform measures in 2001 and 2004. A much debated additional reform measure is the increase of the "standard" retirement age (mentioned above), decided in 2007. Opposition still comes mainly from trade unions and several "social organizations" (*Sozialverbände*) denying the availability of necessary employment possibilities for older workers. Therefore deductions from the full pension will become more important in case employees cannot work until the (higher) standard retirement age. This effect has to be seen also in the context of a general reduction of the generosity of the scheme as mentioned above.

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1 Information on the structure of Germany's pension schemes and statistical data are included, in particular, in the most recent governmental reports, "Rentenversicherungsbericht 2011", "Alterssicherungsbericht 2008" and "Versorgungsbericht 2009" (the latter focussing on schemes for civil servants and employees in the public sector).

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

3 For details on the new political strategy see Schmähl (2012a)

Changes within SPI (regarding, for example, the level of benefits and retirement ages) will, in principle, also become effective for civil servants' pension schemes. Such schemes exist at the federal level (*Bund*) as well as at the level of the 16 states (*Länder*).

2.1.2 System characteristics

Regarding the first tier, social (statutory) pension insurance (SPI) is by far the dominating element from a macroeconomic point of view, and also as a source of income in old age (at least on average). It covers, in principle, all blue and white-collar workers (including miners[4]), but also some groups of self-employed. It is PAYG-financed with only a very small (in fact inadequate) reserve fund. Financing stems mainly from earnings-related social insurance contributions (mainly paid in equal parts by employees and employers) and also from general tax revenue to cover expenditure aiming at interpersonal redistribution of income within the pension scheme.[5] Pensions were up to recent developments in pension policy of a defined-benefit type. Beside different types of pensions (mainly for insured persons and widows/widowers and orphans) also instruments for rehabilitation exist which are not elements of occupational or private pension schemes. SPI-Pensions for insured persons are paid in case of disability and old-age. Here several retirement ages exist with different effects on the pension amount. The standard retirement age (up to 2011) was 65 for a pension without deductions. Starting in 2012 the standard retirement age will be stepwise increased up to 67 (scheduled for 2029).

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

Occupational pension schemes are the *second tier* of the German pension system. They are mainly pensions for old-age. They are in general *voluntary* in the *private sector.* A great variety exists in the design of these schemes. Traditionally, pensions were mainly defined-benefit, employer-financed and "capital-funded", but not necessarily linked to the capital market, because the major part of existing pension claims are still direct commitments of the employer (*Direktzusage*) and based on book reserves. Mainly for this type of occupational pension claims, a mandatory insurance of employers is in place (Pension Protection Fund, *Pensionssicherungsverein*), covering pension claims in case of insolvency of the company – up to a certain, but very high limit. However, a shift is taking place towards other types of occupational pension arrangement that are linked to the capital market as well as towards arrangements being financed mainly (directly[6]) by employees (and no longer employers) and towards defined contribution instead of defined benefit. This takes place in particular because of a new right for the employee – introduced in 2001 – to use earnings up to a certain amount to accumulate an occupational pension claim ("earnings conversion", *Entgeltumwandlung*), 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 in the past linked to the development of the social

[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.

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

insurance pensions and to the civil servant's pensions.[7] This link has since been abolished. And according to a new collective agreement, there will be a change from defined benefit to defined contribution.

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

2.1.3 Details on recent reforms

Although the years 2011-2013 have been characterised by comprehensive political and public debates on pension adequacy and additional measures to avoid poverty in old-age, the reform proposals by the Ministry of Labour could not obtain sufficient support in the government and pension policies have again been a key topic in the election campaign in autumn 2013 (see more details below).

Thus, the number and scope of recent reforms has been limited and changes were related to adjustments of certain parameters. Due to the positive labour market development in Germany and high contribution revenue Government and parliament decided in 2012 to reduce the contribution rate of the statutory (social) pension insurance (the most relevant element of the German pension landscape) at the beginning of 2013 from 19.6 % to 18.9%.9 An increase in the retirement age, legislated already in 2007, started in 2012 according the envisaged time schedule.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Old-age poverty in Germany is *currently* relatively low as compared to some other population groups. In addition to indicators agreed upon in the EU for (international) comparison, there exists an "official" poverty line in Germany which is decisive to become eligible to receive specific means-tested social benefits. These benefits can indeed prevent poverty. For elderly (65+) and disabled persons a specific means-tested benefit, a so-called "basic income in old-age" ("Grundsicherung"; similar to social assistance), exists since 2003 to top up income below the (household-specific) poverty line.[10]

Indicators defined on the basis of a certain percentage of income achieve higher ratios. The ratio of "people at risk of poverty or social exclusion (65+)" – according to Eurostat (EU-SILC) data – was 15.8% in 2012 (13.9% for males and 17.5% for females), about 4

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

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

[9] Already on January 1, 2012, the contribution rate was reduced by 0.3 percentage points (from 19.9 to 19.6%).

[10] At the end of 2009, in Germany 2.37% of those 65 or older received the above mentioned basic income; 65% of all beneficiaries were women. The beneficiary ratio is higher in West-Germany (2.55% excluding West-Berlin) than in East-Germany (1.05% excluding East-Berlin). The ratio is highest in the three city states: Hamburg 5.28%, Bremen 4.81%, and Berlin 4.68%. In 2011 the ratio for Germany was 2.6%. For a detailed analysis of the "Grundsicherung" Becker (2013).

percentage points below EU-28.[11] For the older elderly (75+) the risk of poverty and social inclusion is lower (13.2%)[12] and the rates are below those in the age group 65+.
The indicator "severe material deprivation" for the age group 65+ gives low rates for Germany and even lower for 75+ which is also different compared to EU-27 average where the old age group gives higher rates.

Median relative income of 65+ as ratio to 0-64 is about 90 and is similar to EU-28 average.

While the pension adjustment rates for West and East Germany on July 1st, 2012 were rather similar: 2.18% (West-Germany) and 2.26% (East-Germany), this was different for July 1st, 2013, namely 0.25% (West) compared to 3,29% (East). This is because of (a) still different wage rates for East and West Germany (which are relevant for calculating the pension adjustment rates) and (b) different factors introduced into the formula for calculating pension adjustment rates which disentangle the rate from wage development.
Beside the lack of transparency of the existing pension (adjustment) formula[13] it is important to underline the fact that the adjustment rates for 2012 and the rate for 2013 in West Germany are below the inflation rate. Therefore the real value of these SPI-pensions benefits is decreasing. The same is true for many types of private savings for old age because of interest rates which are below the inflation rate.
Pensioners are also burdened by a higher contribution rate for long-term care insurance. Here pensioners – in contrast to contribution rates for social health insurance, where half of the rate is paid by social pension insurance – have to pay the full contribution rate themselves.

Future adequacy
As mentioned above, the level of benefits from the statutory pension insurance will be lowered: According to the already decided and implemented measures the net replacement rate in 2030 is expected to be 25% lower than 10 years ago, when the new pension strategy was implemented. To compensate the pension gap a voluntary subsidised private pension was introduced. While in theory the reduced statutory pension level could be compensated by higher private savings, the evolution of the coverage rate and the level of savings do not suggest that this will take place in practice. Beside this the adjustment rate of private pensions is mostly below the pension adjustment in the SPI (nevertheless government assumes in its own projections the same rate as in SPI). There are other factors[14] which show that an increasing – and even a constant - overall benefit level (from SPI and private pensions compared the benefit level of SPI without the reform measures implemented since 2001) seems highly unrealistic and must be based on highly "optimistic" assumptions.

Coverage for different groups of the population (also for men and women) is highly unequal regarding (subsidised) private as well as of occupational pension schemes. Beside the coverage rate also the absolute and relative amount of saving in such schemes differs remarkably.

Beside the indicators for current and future adequacy it seems useful to look at the preconditions in the SPI for a pension that is just as high as the "basic transfer payment" (*Grundsicherung*) that is intended to avoid poverty. This reflects a specific aspect of

[11] Three data sources for Germany (2008) always show a lower ratio for the elderly compared to the average for the total population:
[15] 0 (65+) 15.5 (total) EU-SILC
[12] 0 (65+) 14.4 (total) Microcensus (Statistical Office)
[13] 3 (65+) 14.6 (total) Socio-Economic Panel.
[12] Eurostat database, accessed at 06 November 2013.
[13] Schmähl (2012a) for details.
[14] See e.g. Blank (2011), Kleinlein (2011), Hagen and Kleinlein (2011).

adequacy in a pension scheme that is based on the idea of a relative close link of contribution payment and pension benefit. Today about 27 so called Earnings Points are necessary to receive a (full) SPI-pension (that means at standard retirement age of 65) with just as high as the "basic transfer payment" (that means for example that an "average earner" has to pay contributions for about 27 years; contributors with lower earnings have to pay longer). Taking into account the already decided measures which will reduce the SPI-benefit level as well as the standard retirement age in 2030 35 Earnings Points will be necessary. For those with earnings on average over the whole contribution period 35 years of contribution payment will be necessary. For insured persons with lower earnings even more years of contribution payment will be necessary, e.g. if earnings were only 80% of average then 44 years of contribution payments will be necessary for a SPI-pension just as high as social assistance level. Although such figures do not show how many pensioners will be eligible to receive the means tested "basic transfer payment" (on social assistance level) – because this is based on income and composition of the private household – it clearly underlines the finding that compulsory contributory insurance scheme which often cannot realise a pension to avoid poverty even for those contributors with a large number of working years will in a political sense not be sustainable and the pension not adequate.

A further challenge comes from the fact, that SPI-pensions and the "basic transfer payment" are linked to different indicators during the period of receiving the benefits. The assumption is plausible that ceteris paribus the adjustment rate for the transfer payment will often be higher than the adjustment rate if SPI-pensions. Than the above mentioned problem becomes even more important. Another aspect is whether pensions in periods of low interest rates and increased contributions (e.g. for long-term-car-insurance) will be adequate or whether an expropriation of savers takes place.[15]

2.2.2 Sustainability

A gradual increase of the "standard" retirement age to age 67 started in 2012. It was not linked to the evolution of life expectancy, but increasing life expectancy was a main argument for changing the retirement age. Meanwhile proposals were made that it will become necessary to increase the standard retirement age beyond 67. The effect of a higher retirement age on the contribution rate necessary to finance the budget, however, is modest. One reason is, that insured persons having at least 45 contributory years can still retire at age 65 without deductions from the full pension.[16]

During recent years the employment rate of older workers increased after a long period during which people tend to retire earlier. . E.G. the age specific labour force participation ratio ("*Erwerbstätigenquote*") in the age group of 55-59 was 54% in 1998, but 74% in 2011. Also from age 60 to 65 remarkable changes took place:

Age specific labour force participation ratio (in %)

Age	1998	2011
60	28	59
61	22	51
62	19	45
63	13	33
64	10	27
65	7	14

Data source: Mikrozensus, taken from Noll and Weick (2013). 12.

[15] A topic recently more and more mentioned, see among others Steltzner (2013), Stark (2013).

[16] Employer's organisation again in 2013 proposed to abolish this privilege (Frankfurter Allg. Zeitung 25.7.13).

This development is based on changes on the labour market as well as on decisions to abolish over time several early exit options from the labour market. The figures mentioned above do not reflect the type of employment, e. g. part- or full-time, nor whether this regular employment is covered by social insurance.
The reduction of the contribution rate of the statutory (social) pension insurance at the beginning of 2013 lowers the fiscal burden of employees and employers as well as the federal budget, because a federal grant to the pension insurance is (among other factors) also linked to the development of the contribution rate. A reduction of the contribution rate was possible because of favourable development on the labour market for contribution revenue, while on the other hand the development of pension expenditure was slowed down because of factors implemented in recent years into the pension adjustment formula. Due to the lower contribution rate (which is expected to remain stable until 2016 or even 2018[17]) the financial reserve of the pension insurance will be reduced in 2013 and the coming years.[18] The accumulated financial reserve of the pension insurance stimulated government to discretionary reduction of the grant from general revenues (Bundeszschuß) to the pension insurance and by this violating the existing rule for its development: It will be reduced by 1000 million € in 2013 and 1250 million € each year from 2014 to 2016.[19] This means that more of those pension expenditure, that adequately should be financed by tax revenue because they are aiming at interpersonal redistribution - will instead be financed by earnings based social insurance contributions.
In general, according to present model calculations it is expected that the political decided target contribution rates for SPI (not more than 20% in 2020 and not more than 22% in 2030) will be met.

In the public debate it becomes more and more obvious that not only fiscal sustainability is important (as underlined by many politicians, employers organizations, financial industry and many academic economists) but also – or even more – social respective political sustainability. Here pessimistic expectations concerning future poverty in old age resulting from political decisions as well as changing conditions on the labour market and in earnings histories of employees are meanwhile a driving force regarding proposals for changes in pension policy. But up to the parliamentary election in September 2013 no decision has been taken due to conflicting views even within the ruling coalition parties.

2.2.3 Private pensions

Coverage by private pensions remains below what was and is politically expected after the reduction of the SPI-pension level and for a majority of employees too low to fill the pension gap, that means to realise an overall benefit-level comparable to that of the SPI before the political initiated scaling down of its generosity.

As an instrument to increase coverage some minor changes in existing rules and for better transparency where decided upon in June 2013[20], among them the introduction of standardised information about financial products.

The effects of subsidised private saving for old age – in particular the so-called "Riester-pension" (named after the minister of labour who was responsible for the reform measures decided in 2001) is still a controversial issue.[21]

[17] According to the according to the official medium term respective long term projections published in the „Rentenversicherungsbericht" of the federal government from end of November 2012. – See also from the point of view of SPI Buntenbach (2012) and Viebrok (2013).
[18] Nevertheless it was expected recently that in 2013 no deficit but a surplus of SPI will be realised.
[19] Also the federal grant to social (statutory) health insurance is reduced.
[20] Altersvorsorge-Verbesserungsgesetz (parliamentary decided on June 24, 2013).

In particular for life insurance companies it becomes more and more difficult to fulfil the minimum requirement of a minimum interest rate because of the low interest rates on capital markets. Life insurance companies have to guarantee for new contracts a minimum interest rate which was already reduced overtime: from 4% to 2.75% in 2004, 2.25% since 2007 and now 1.75% since 2012. For all contracts the average minimum guarantee is, however, higher than 1.75%. German government bonds, for example, meanwhile only could deliver a rate of return below this rate, and the costs have to be covered by the insurance companies. To realise a higher rate of return might imply to include assets of higher risks.[22] Insurance companies now discuss to redesign guarantees.[23]

2.2.4 Summary

Looking at strengths and weaknesses of German pension arrangements and topics to be decided in the near future, several points can be highlighted:

- Although fiscal sustainability of the SPI-scheme from a present day perspective seems not be the central topic in the political debate, proposals regarding changes within the SPI scheme for old age pensions as well as disability pensions to prevent poverty in old age in the future already exist;
- abolishing the still existing differences in pension law (in particular in the pension formula) between West and East Germany;
- redesigning the pension (adjustment) formula, at least making the formula more transparent
- looking for adequate measures to avoid poverty in old age and to realise a benefit level in SPI for employees with longer working history to realise a pension benefit above the social assistance level;
- future development in the supply of adequate jobs for elderly workers in the process of increasing the retirement age for receiving a pension without a deduction from the full pension (which is 0.3% per month of early retirement) and to increase the effective retirement age in the process of demographic change;
- how to increase coverage in private and occupational schemes to compensate pension loss in SPI (if this remains as until now politically decided) and how to realise adjustments of private and occupational pension benefits over time, in particular in periods of inflation and real economic growth.

2.3 Reform debates

There are still different rules for calculating the adjustment rates in SPI for West and East Germany. The different pension adjustment rates in 2013 for West and East Germany will stimulate a debate about abolishing these differences which still exist more than 20 years after German unification. 4 years ago the ruling coalition parties had announced their willingness to solve this problem, but nothing was decided until the parliamentary election in September 2013. Regarding the distributional effects of equalisation measures this will among others depend on the fiscal effects, with or without additional expenditure.

In general it is necessary to make the pension formula much more transparent as it is today, because since 2001 several additional "factors" (aiming at a reduction of the benefit level) were integrated into the formula and contributed to unnecessary complexity.

[21] For different oppinions see Deutsches Institut für Wirtschaftsforschung (2012).
[22] Effects oft he financial crisis on pension schemes is discussed in Schmähl (2012b).
[23] See e.g. Frankfurter Allgemeine zeitung, 23.8.2013, "Neue Garantien dürfen nicht zu kompliziert sein."

An even more important topic is, how to cope with the risk of increasing poverty in old age. In the past, the "dynamic" SPI scheme contributed to a high degree to old-age poverty alleviation. A quite different story is how in the future pensions and pension policy will contribute to the objective of reducing poverty. An important effect of the reduction of the net social pension level (together with effects for individual pension claims by unfavourable labour market conditions, long spells of unemployment for many employees) will be a future growing number and a higher ratio of pensioners receiving pension benefits only from social insurance which is below the existing means-tested "basic income in old age".[24] Coverage and the amount of occupational and private pensions are by far not high enough to compensate for the loss in the level of public pensions.[25] After the election to the Federal Parliament (Bundestag) of September 22nd, 2013, it can expected, that a new coalition government will decide on measures to deal with this topic, because CDU/CSU, SPD and the Green Party all made proposals how to cope with and to avoid this problem.

One important factor for low pension claims in case of unemployment is the fact that beside low or no claims for the period of unemployment also often earnings after unemployment is much lower compared to former earnings. And during periods of unemployment no claims for occupational pensions are accumulated and the possibility to save for old age is rather limited.
How many pensioners will live in households with an income below the poverty line depends, however, not only on the rules set in the pension policy and labour market conditions, but also on the structure of households and the income of all members of a household. It can be expected that the income of (married) women will, due to increased female labour market participation and pension claims for care responsibilities for children or parents (which is not yet visible in the data), increase in relative terms. Nevertheless, without changes in the pension policy an increase in poverty among the elderly can be expected (which may, as mentioned above, become an important element regarding political sustainability of pension arrangements).
Meanwhile, a public debate about growing old-age poverty in the (near) future has started. Political parties presented different models on how to prevent poverty in old age. The effects are often much criticised[26] but what will be the answer of the next government is still unclear. Some of the meanwhile presented plans would increase the degree of interpersonal redistribution within the social pension scheme and thus change the mix of insurance and transfer elements in the SPI scheme. Taking into consideration the strain in tax-financed general public budgets as well as a new constitutional rule in Germany to limit public debt by a "(public) debt brake" ("Schuldenbremse"), it can be expected that additional redistributive measures in social insurance will not be adequately financed by tax revenues but from earnings-related social insurance contributions. Together with the decreasing pension level a creeping transformation of the social insurance system will then take place – from a scheme with a relatively close link between contribution payments and (later) pensions into a redistributive transfer scheme, e. g. by integrating for example minimum elements into the scheme. The topics of avoiding poverty in old-age, equalizing West and East German pension rules and making the pension formula much more transparent will remain on the agenda for the next parliamentary term as well as the discussion on how to introduce mandatory coverage for those groups of self-employed persons who are not yet members of any mandatory pension scheme.[27]

[24] See for example Geyer and Steiner (2010)
[25] Hagen (2010)
[26] See among others Schmähl (1993), Hauser (2009), Meinhardt (2011), Bäcker (2011), Suchy and Nürnberger (2012), Dünn and Stosberg (2013).
[27] But it can be expected that these self-employed persons will have the possibility to choose between several ways for protecting them from poverty in old age either in a public or a private scheme.

After the election to the German federal parliament (Bundestag) in October 2013 negotiations started between CDU/CSU and SPD to build a new coalition government. Regarding the pension policy the parties in their recent proposals have similar views on some areas (i.e. disability pensions; upgrading pensions for those with a long insurance record but low pension claims). CDU/CSU in particular proposed to increase the pension claims for „mothers" with children born before 1992.
Already at the beginning of the coalition negotiations it became obvious that all 3 parties do not want to reduce the contribution rate which would theoretically be possible (by a reduction of another 0.6 percentage points to 18.3%) because of the favourable economic conditions, but instead to increase pension expenditure or to accumulate a higher reserve fund in the SPI for some time. The present rules for a necessary reserve in SPI will therefore be changed.
What will be the result of this process of how to spend the money cannot yet be answered. Taking into account the fact that all parties as well es trade unions, employer organisations and SPI were in favour of improving conditions for disabled pensioners (also as a measure to avoid poverty in old age) it can be expected that an agreement will be easy to realise. It can also be expected that something will be done to improve low pensions of persons with long insurance careers and for women with children. Here, financing will be the crucial topic, in particular how much to finance from contribution revenue and from tax revenue.
Several proposals exist on improving flexibility in the process to change from work to retirement and will also be a topic of the negotiations. There are, however, no signals that a rethinking regarding the general pension level is intended. Therefore the topic of how to avoid poverty in old age will remain on the agenda.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The health care system in Germany is regulated in the Social Code Book V (Sozialgesetzbuch, SGBV). 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 including the federal association of social health insurance funds and the federal associations of healthcare providers (i.e. physicians, dentists, psychotherapists and hospitals). These organisations are members of the Joint Federal Committee (Gemeinsamer Bundesausschuss, G-BA), which is the highest decision-making body in Germany.

Before the Health Care Structure Act (HCSA) of 1993 came into force, employees covered under social health insurance (SHI) were restricted in the choice of their sickness funds (SF). In contrast, the HCSA allowed from 1996 onwards employees to switch an SHI. Fierce competition between SHIs has led to a constant process of mergers that has reduced their number from almost 1,000 in 1995 to 134 at the beginning of 2013 (GKV-Spitzenverband 2013). The process of mergers has gained additional momentum, as mergers of SHIs of different types were allowed by the health reform GKV-WSG[28] in 2007.

3.1.2 System characteristics

Germany's health insurance system is characterised by the co-existence of a social health insurance scheme and a private health insurance (PHI), both providing comprehensive health

[28] GKV-Wettbewerbsstärkungsgesetz: law to strengthen competition between SHIs.

insurance. In 2012, around 70 million people were insured under the SHI (BMG 2013) and roughly 9 million under the PHI (PKV 2012). While health insurance under SHI is mandatory for low- and medium-income employees, high-income employees and self-employed may opt for PHI. With few exceptions, civil servants are also insured under the PHI. The two systems of health insurance fundamentally differ. The SHI is characterised by a largely standardised statutory benefit package, premiums are independent of the individual's health risk and calculated as a fixed proportion of the insuree's labour income. Employers bear almost one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. In contrast, PHI premiums depend on the individuals' health risk and age. The benefit package is subject to an individual insurance contract and co-insurance of family members is not free of charge but requires an additional contract.

Only a small group of individuals is allowed to choose between private and social health insurance, for example employees who earn more than 52,200 € per year. However, once opted for a PHI, this decision can be regarded as 'once-in-a-lifetime' because (i) switching back to SHI is strongly restricted by law and (ii) when switching between PHIs, risk-premiums are calculated again and they typically increase with age. Until 2009, SHIs competed mainly[29] via their contribution rates, which were set individually by each SHI. This has been changed by the GKV-WSG in 2007. Since 2009, premiums are fixed by the federal government (15.5% of wage income in 2013). It is collected by the general health fund (*Gesundheitsfonds*) which redistributes its revenues to the individual SHI with allocation of funds depending on the risk profile of each SHI's enrolee. In consequence, the contribution rate is no longer an element for price competition. Yet, the SHIs are allowed to charge income-independent extra premiums if allocations from the health fund turn out to be insufficient for covering expenditures. Moreover, SHIs which spend less than they receive from the health fund may grant refunds to their insurees. The introduction of extra premiums has strongly increased competition between SHIs (Schmitz and Ziebarth 2011). However, given the large surplus of the general health fund and the individual social health insurance companies in 2011 and 2012, none of the SHIs charges extra premiums in 2013. At the end of 2012 the SHI's reserves (including the health fund) amounted to 28 billion € (BMG 2013).

3.1.3 Details on recent reforms

In 2011 the health reform GKV-FinG[30] has introduced a mechanism to the SHI to adapt to future increases in health expenditures. First, it raised premiums to the health fund to the above mentioned 15.5%, increasing revenues for the health fund by roughly 6 billion €. Second, it has frozen the part of the contribution rate paid by employers to 7.3%. Thus, further increases of premiums will only be paid by the insurees. Third, a compensation scheme for insurees with low income was changed (*Sozialausgleich*). Until 2010, the extra premium was restricted to 1% of wage income, which was a disadvantage for SHIs with many low-income insurees. The new compensation scheme comes into effect if the average extra premium over all SHIs exceeds 2% of wage income of an insuree. Most importantly, this compensation is paid by the health fund instead of the individual SHI. Therefore, elements of income redistribution have been removed from individual SHIs to the health fund which is an improvement to the previous system. Due to the high surplus of the SHI, the average extra

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

[30] GKV-Finanzierungsgesetz: Law on Financing the SHI.

premium in 2013 has been zero. In order to finance growing compensations in the future, additional tax money will be provided to the health fund.

Moreover, the individual extra premium of an SHI is not important for compensation, but only the average extra premium over all SHIs. Thus, insurees in need only get compensated up to the average extra premium. If their SHI charges a higher extra premium, insurees have to bear the difference. Hence, the incentive to change from an expensive to a less expensive SHI remains also for low-income insurees. In sum, the economic incentives for insurees and for SHIs are equal to those of a system with full income-independent premiums and tax compensations for low-income insurees. Fourth, the general annual price increase for hospitals has been cut to 0.9% in 2011 and to roughly 1% in 2012. Thus, hospital expenditures for SHIs have increased less in these years than usually.

In addition to the GKV-FinG the AMNOG[31] aimed at reducing expenditures for pharmaceuticals. It is in line with previous reforms, aiming at capping costs, such as the GKV-ÄndG[32], which was passed in parliament in July 2010. Yet, the GKV-ÄndG introduced explicit measures to reduce costs, most importantly a mandatory discount of 16% on pharmaceuticals and a freeze of prices of pharmaceuticals until 2013. In contrast, the AMNOG has introduced mechanisms of how prices of pharmaceuticals are determined. In Germany, pharmaceuticals have been subject to a system of reference pricing since 1989 (Augurzky et al. 2009). While producers are free in setting prices for any pharmaceuticals, the SHI reimburses costs only up to a reference price. Patients have to bear the price difference for any drug whose price exceeds the reference level. This sets strong incentives to producers not to set prices above the reference price.

The GKV-VStG[33] came into effect in January 2012. It addresses various different issues (Augurzky and Beivers 2012), e.g. sustainable provision of outpatient medical services in rural areas, a more flexible remuneration system for general practitioners and resident medical specialists, innovative medical treatments, a reform of administrative structures, more options for SHIs to differentiate in competing with other SHIs, and more restrictions in founding larger outpatient units with employed general practitioners and resident medical specialists. Halbe et al. (2012) intensively discuss the new Law on Health Care Structure.
There has been no major health reform in 2013, only a few smaller amendments. In January 2013 the PsychEntgG[34] was introduced: Remuneration rates for psychiatric and psychosomatic cases are switched towards daily-based lump sums. The new system starts with a budget-neutral introduction period (2013-2017) with voluntary participation of the psychiatric facilities' in 2013 and 2014. From 2015 on participation will be compulsory for all psychiatric facilities. In 2017 a five-year lasting convergence period will start. Moreover, given the large surplus of the general health fund, the government has decided to (i) reduce tax subsidies to SHI by 2.5 billion Euros to 11.5 billion Euros in 2013 and (ii) to abolish the so-called "practice fee" (*Praxisgebühr*), a co-payment of 10 Euro paid once in a quarter by every patient visiting an outpatient practitioner. Furthermore, the KVBeitrSchG[35] reduces the interest rate for premiums due of insurees. Outstanding premiums became a problem of the

[31] Gesetz zur Neuordnung des Arzneimittelmarktes: Law on the Re-organisation of the Market for Pharmaceuticals.
[32] GKV-Änderungsgesetz: Law on the Change of the SHI.
[33] GKV-Versorgungsstrukturgesetz: Law on Health Care Structure.
[34] PsychEntgG - Gesetz zur Einführung eines pauschalierenden Entgeltsystems für psychiatrische und psychosomatische Einrichtungen: Law for the introduction of a flat-charge remuneration system for psychiatric and psychosomatic facilities
[35] KVBeitrSchG - Gesetz zur Beseitigung sozialer Überforderung bei Beitragsschulden in der Krankenversicherung: Law for the removal of excessive demands with oustanding premiums in health insurance

GKV-WSG of 2007. The GKV-WSG had eliminated the problem of individuals lacking any health insurance cover[36]. However, failing to pay premiums did not automatically result in the loss of health insurance cover, i.e. insurees could easily build up a significant amount of debts with high interest rates. Additionally, in 2013 and 2014 German hospitals receive in sum 1.1 billion Euros funding as a compensation for their increasing personnel costs. The economic situation of the hospitals has worsened considerably in 2011 (Augurzky et al. 2013).

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The health reform GKV-WSG of 2007 has largely eliminated the problem of individuals lacking any health insurance cover. Hence, the number of individuals without health insurance – apart from non-legal residents – is very low (Gress et al. 2009). However, inequality in terms of access to health care is frequently discussed with respect to individuals being insured with SHI or PHI. Since general practitioners and outpatient specialists are allowed to charge much higher prices from PHI patients, privately insured patients are often assumed to be first-class consumers and empirical evidence suggests that waiting times are shorter for this group of individuals (Lüngen et al. 2008, Schwierz et al. 2009). Nevertheless, except for organ transplantations, no official waiting lists exist for medical services. Even though there is some evidence for a correlation between social deprivation and health status (Kuznetsov et al. 2012), this issue does not receive much attention in Germany.

Regarding the per-capita number of hospital beds (including beds in mental and other speciality hospitals) in Germany, it is among the highest in the world (Kumar and Schoenstein 2013). In 2010, Japan (13.6) and Korea (8.8) were the only OECD country with a higher number than Germany with 8.3 beds per 1,000 inhabitants. Except for Austria (7.6) other Western European countries such as Belgium and France (both 6.4), Switzerland (5.0) or the Netherlands (4.7) show much smaller figures. Obviously, access to inpatient care is high in Germany. This holds true, although the number of beds is on a constant decline for several years. Concerning the number of hospitals per inhabitant, Germany also shows quite high figures due to its numereous small hospitals. Augurzky et al. (2013) argue that excess capacities still exist with respect to the number of hospitals in Germany. For providing and securing area-wide access to inpatient services, many, especially the smaller hospitals, seem redundant.

In Germany a total free choice of hospitals by patients is not intended. In general, a hospital admission has to be ordered by a practitioner. The practitioner has to suggest two nearby and adequate hospitals. The respective laws regulating hospital stays, § 73 and § 92 of Social Code book V, do not explicitly define the criteria “adequate” and “nearby”. So, within these limits, the patient and the practitioner together can choose two hospitals that comply with both requirements. In case of emergency admissions, the above mentioned restrictions do not apply.

In the primary care sector, on the one side the number of general practitioners is rather low. On the other side, medical specialists with their own practices are relatively common and have constantly grown in recent years. This might reflect the fact that, in Germany, medical treatment occurs more often in hospitals or by specialists with own practices than in other OECD countries. This raises the question of excess capacities, as in Germany treatment by medical specialists is provided through both the inpatient and the outpatient sector. There are no regulations restricting access to either general practitioners or medical specialists in the

[36] Yet, even before this reform, this problem has never been a widespread one in Germany.

outpatient sector, however, some SHI provide premium discounts if insurees always visit a general practitioner first.

3.2.2 Quality and performance indicators

Quality in hospital care is a topic of growing awareness for both, the public and policy makers. Hence, during the last decade new regulations regarding transparency and quality in health care were introduced making Germany a leader in the OECD ranking. The most important part is the so-called "external quality assurance" according to §137 Social Code book V: from 2003 (with 2005 being the first reporting year on 2004 data) onwards all German hospitals are obliged to publish every second year a so called "quality report", which is submitted to the Joint Federal Committee. The first reports only included information on structural quality regarding staffing levels, technical equipment and the like. In 2007 (referring to the reporting year 2006), the first outcome measures for i.a. hip or knee replacements and coronary artery bypass grafting were published in these reports. Depending on the diagnosis or procedure, the quality indicators vary across outcomes or process measures. The reports as such are publicly available on the internet, but there are also a number of different providers offering aggregated data in consumer information portals. Patients can compare results for hospitals by diagnosis or procedure and by geographical area (Cacace et al. 2011, Kumar and Schoenstein 2013).

The AQUA-Institut für angewandte Qualitätsförderung und Forschung im Gesundheitswesen (AQUA institute for applied quality improvement and research in health care), mandated by the Joint Federal Committee, is responsible for the development of new and the improvement of existing indicators. Before results get published, the performance of individual hospitals is compared to national benchmarks. Depending on the results, hospitals are obliged to formally comment on their results and – if applicable – have to take necessary steps to improve their performance (Kumar and Schoenstein 2013).

The German health expert council (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen) discusses quality indicators in general in their special expertise 2012. They stress the importance of external quality assurance for the in-patient sector, but criticise the lack of quality assurance in the outpatient sector. The council recommends focusing on population-orientated and sector-comprehensive quality indicators (SVR 2012). Pay-for-performance approaches are discussed as well (Veit et al. 2012, SVR 2012).

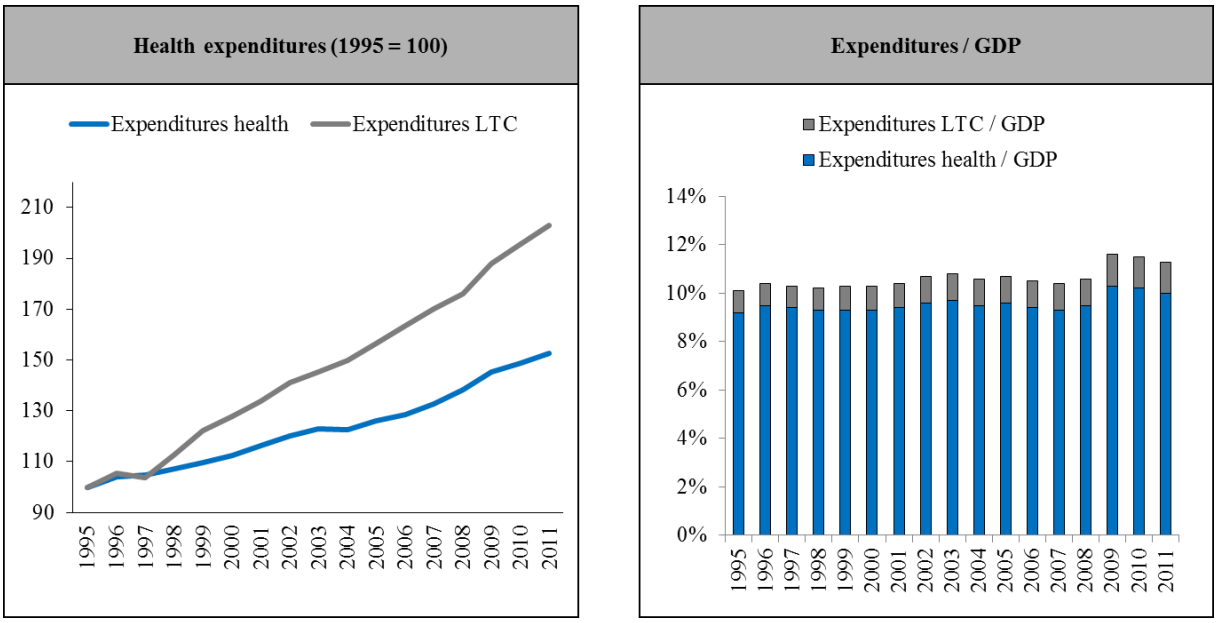
3.2.3 Sustainability

In Germany, increasing health care expenditures are a matter of public concern like in many industrialised countries. The public debate especially focuses on expenditures of the SHI because it is predominately financed through labour-income-dependent contributions perceived as a 'quasi-income tax'. Hence, the classical dilemma of keeping tax burden low while offering high quality and comprehensive health care service applies to the SHI. Total expenditures on health care amounted to 294 billion €, of which the SHI bears 57% (Statistisches Bundesamt 2013). Other social insurance schemes bear another 10.5%, the PHI - 9.4%, public authorities - 4.8% and employers - 4.3%. Private out-of-pocket payments amount to 13.7% of total health expenditures.

Figure 1 displays total real health expenditures in health and long-term care (LTC) and their share of GDP from 1995 to 2011. Health care expenditures are clearly growing, i.e. in total nearly by 53%. Expenditures in LTC have more than doubled between 1995 and 2011. However, the increase in health care spending of an annual average of 2% per capita between 2000 and 2010 is below OECD average. Shares of the GDP expenditures in health and LTC have increased in total from 9.6% in 1992 to 10.5% in 2008 and to 11.6% in 2009 due to the

large fall in GDP in 2009 which was exceptional due to the financial crisis. In 2011, the share regarding GDP has slightly fallen to 11.3%, with 10% in health and 1.3% in LTC. Although increasing expenditures are most intensely debated with focus on the SHI, the SHI managed to keep its share on health expenditures roughly constant by around 64% during the considered period. The general health fund (Gesundheitsfonds) and the individual social health insurance companies have realised in 2012 a further increase in their already large surplus. This is most likely to be explained by past state interventions aiming at stabilising SHI expenditures.

Figure 1: Expenditures in health and long-term care



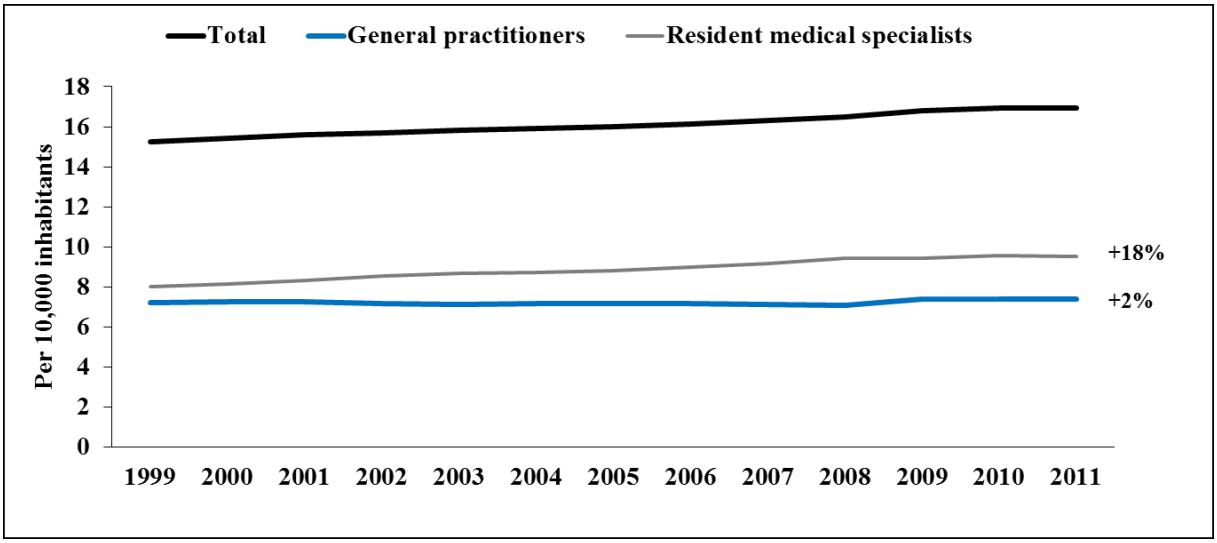
Source: Statistisches Bundesamt (2013) and own calculations.

There has been an on-going discussion about insufficient numbers of general practitioners in Germany. The German Council of Science and Humanities (Wissenschaftsrat 2012) comments on the discussion by pointing out that it is important to distinguish the reasons for the expected demand for practitioners. On the one side, demand is triggered because practitioners retiring have to be replaced. On the other side, demand may increase due to changes in health services and due to the ageing population with an increased risk of multi-morbidity. So far, demand for resident practitioners has been fully met and the Wissenschaftsrat also does not see empirical evidence for a general shortage of medical practitioners[37], especially because there has been a slow increase in resident practitioners which stagnated in 2011 (Figure 2). However, because of severe regional differences in the number of resident medical professionals (Felder and Tauchmann 2011), there may be a lack in some rural and an over-supply in urban areas (Schmacke 2006, Klose and Rehbein 2011). Some new initiatives aim at making practicing in the countryside more attractive. Günther et al. (2010) carried out research on what makes young health professionals choose where to locate.

Regarding the country-specific recommendation to "continue the growth-friendly consolidation course through additional efforts to enhance the efficiency of public spending on health care and long-term care", the National Reform Programme addresses the situation of the SHI in 2013 as quite comfortable.

Figure 2: Number of resident physicians in Germany, 1999-2011

[37] This assessment does not apply to the long-term care sector (see also next chapter).



Source: KBV (2012) and own calculations

3.2.4 Summary

The health care system in Germany is regulated in the Social Code Book V (Sozialgesetzbuch, SGBV). 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. Germany's health insurance system is characterised by the co-existence of a social health insurance scheme and a private health insurance (PHI), both providing comprehensive health insurance. Only a small group of individuals is allowed to choose between private and social health insurance. However, once opted for a PHI, this decision can be regarded as 'once-in-a-lifetime'. Inequality in terms of access to health care is prevailingly discussed with respect to individuals being insured with SHI or PHI.

Regarding the per-capita number of hospital beds (including beds in mental and other speciality hospitals) in Germany, it is among the highest in the world. In the primary care sector, on the one side the number of general practitioners is rather low. On the other side, medical specialists with their own practices are relatively common and have constantly grown in recent years. Quality in hospital care is a topic of growing awareness. Hence, during the last decade new regulations regarding transparency and quality in health care were introduced, making Germany a leader among OECD countries. In Germany, increasing health care expenditures are a matter of public concern like in many industrialised countries.

The public debate especially focuses on expenditures of the SHI because it is predominately financed through labour-income-dependent contributions perceived as a 'quasi-income tax'. Health care expenditures are clearly growing, but with an annual average of 2% per capita between 2000 and 2010 it remains below OECD average.

3.3 Reform debates

The debate on financing the health care system in Germany as reflected in the election programmes of all parties in summer 2013 focussed more or less on the so-called Bürgerversicherung (universal citizens' health insurance). The so-called Gesundheitsprämie (per-capita flat-rate insurance) as an alternative model has received no attention. The Bürgerversicherung[38] is characterised by including the entire population and abolishing PHI. In addition, advocates of the Bürgerversicherung also want to extend the tax character of SHI

[38] The Gesundheitsprämie is characterised by a uniform income-independent per-capita premium which is accompanied by a compensation of the low-income insurees such that they are able to pay the premium.

contributions in that the contributions not only depend on earnings but also on capital income and that higher contributions are to be paid by people with higher incomes. All major parties that were in opposition until the national election, i.e. the social democrats (SPD), the Green Party, Die Linke (the left party), as well as the trade unions are in favour of this concept. At the time of writing of this report, no decision has yet been made within the current coalition negotiations between CDU/CSU and SPD. A recent evaluation assessing the economic consequences of introducing a Bürgerversicherung concluded that the GDP would not be higher, but even lower after its introduction (Augurzky und Felder 2013).

The political parties in power during the last election term, the Christian democrats and the Liberals, back the reforms implemented by the GKV-FinG. The CDU also wants to improve access in rural areas with telemedicine. This is in line with a recent initiative of the federal health ministry, which introduced an eHealth strategy to investigate ways of including telemedicine applications in practice.

Still heavily discussed is the fact that the number of hospital patients is increasing more rapidly than the demographic change would suggest (RWI 2012). This might be because of technical progress in medicine or because of a demand that is induced by the suppliers. Indeed, the German DRG system financially rewards the number of cases and, moreover, since hospitals' output prices rise less than hospitals' input prices (costs) and prices are fixed by law, hospitals try to increase their revenues by treating more patients. The question is how to adapt the remuneration system such that the incentive to increase the number of patients is reduced (Kumar and Schoenstein 2013). Politics will address this question in 2014.

Especially the abolishment of the "practice fee" has been criticised (DGGOE 2012). Co-payments can drive behaviour. While indeed the old "practice fee" showed no impact on e.g. the number of patient-physician contacts in the outpatient sector, a chance was missed to reform the co-payment system. The introduction of a co-payment leads typically to a large public outcry. Once introduced, it could have been refined instead of abolished. It is obvious that a co-payment paid only once every quarter during the first outpatient visit can hardly influence further outpatient visits in the same quarter. However, paying an even smaller "visiting fee" on every outpatient visit might have reduced the high number of patient-physician contacts in Germany (on average around 17 per year). Moreover, the practice fee produced additional revenues for SHI of around 2 billion Euros, which was a relief for contribution payers. It was not discrimination against the socially disadvantaged because total co-payments in the German health care system are capped at 2% of income (1% for chronically ill patients).

4 Long-term care

4.1System description

4.1.1 Major reforms that shaped the current system

Social long-term care insurance (LTCI) 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 LTCI. All members of a PHI became members of a private LTCI.

4.1.2 System characteristics

In 2013, according to the Federal Ministry of Health, around 70 million citizens were covered by social LTCI and roughly 9 million citizens by a private LTCI (in 2011). There are no differences in benefits between social and private LTCI (BMG 2013). Premiums for social LTCI are independent of the individual's health risk and calculated as a fixed proportion of the insuree's labour income, which is 2.05% in 2013. Insurees without children have to pay 2.30%. Employers bear almost one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. In contrast, private LTCI premiums are not connected with income, but with premiums of private PHI.

In general, there are three different arrangements a recipient can choose from: care allowance, home care (in kind), and residential care. Care allowance refers to so-called informal care, i.e. the person in need of care receives only monetary support, typically lives at home and is looked after by close relatives. Home care (in kind) means that a professional care provider visits the recipient regularly at home. The provider is directly paid by LTCI. Residential care refers to either short-term or long-term stay in a nursing home. Home care (in kind) and residential care are referred to as formal care.

The LTCI distinguishes between three levels of care based on the severity of the health condition. In level I extensive care of at least 90 minutes per day is needed. People in level II (severe care) are in need of at least 180 minutes of care per day, and in level III (most severe care) recipients need at least 300 minutes of care per day. If the need for care exceeds level III by far, it is possible to apply for further assistance. Furthermore, the beneficiary is supposed to be in need of care for at least six months prior to the application of care allowance. The expected time in need of care and the level of care is formally assessed by an independent Medical Review Board of the Statutory Health Insurance Funds (MDK) for the social LTCI or by an equivalent body for the private LTCI.

4.1.3 Details on recent reforms in the past 2-3 years

In January 2012 a new legislation for employees caring at home came into effect (*Familienpflegezeitgesetz – FPfZG*[39]). Employees with a family member in need of care at home are allowed to reduce their working hours to a minimum of 15 hours per week for a maximum of two years. Their employers can top up the reduced salary by half of the difference between old and new (reduced) salary with an interest free credit from the *Kreditanstalt für Wiederaufbau*. Afterwards, the employee has to work full-time until the credit is paid back (Deutscher Bundestag 2011). In January 2013 less than 150 people applied for a credit (Deutscher Bundestag 2013). Even though these figures do not take all potential employees into account, the uptake has to be considered as very low.

The Pflege-Neuausrichtungs-Gesetz[40] (PNG), introduced in January 2013, improved benefits of respite care for persons receiving care allowance. If the informal carer gets sick or takes a vacation/holiday, LTCI pays benefits for up to four weeks of respite care or short-term residential care, but not more than 1,550 € once a year. The beneficiary of care allowance even gets half of it during times of respite care or short-term residential care. However, the informal carer had to take care of the recipient for at least six months prior to application. The PNG further strengthened care allowance and home care by (1) raising benefits for people with dementia, and (2) introducing "domestic support" (*häusliche Betreuung*). Now, people with dementia can receive benefits, even if they are not eligible for care level I or they get additional benefits in care levels I and II. Domestic support refers to inter alia communication or activities for maintaining social contacts. Furthermore, people in need can now expect

[39] Gesetz über die Familienpflegezeit: Law about family care time.
[40] Pflege-Neuausrichtungs-Gesetz: Law on redirection of LTC.

improved and faster services when applying for benefits from LTCI. To finance the additional expenditures resulting from the PNG the contribution rate to the social LTCI has been raised by 0.1 percentage points to the above mentioned 2.05% (2.30%). Last but not least, with the PNG an additional optional private LTCI subsidised with a maximum of 60 € per year has been introduced.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The LTCI pays the same fixed benefits according to the level of care but irrespective of the price for the actual goods and services. Thus, the person in need of care has to bear the difference[41]. If recipients cannot pay the total difference out of their income or other assets, or with the help of their children or near relatives, social assistance (Support for care - Hilfe zur Pflege, § 61 ff. SGB XII) has to step in and pay the remaining difference. Additionally, social assistance has a broader definition for being in need for care. Even persons with a temporary impairment, i.e. less than six months, or with less need for support than set in care level I can apply for Hilfe zur Pflege (Rothgang et al. 2012).

Between 1996 and 2007 there was no change in the nominal amount of the benefits. Hence, due to general price inflation the nominal amount has gradually lost its real value. Monthly benefits have been increased for the first time by the Pflege-Weiterentwicklungsgesetz[42] (PfWG) in 2008, with higher increases for home care and care allowance to strengthen both types of arrangements in comparison to residential care ("care at home before residential care"). From 2014 onwards benefits will be assessed every three years and possibly adjusted to keep up with the general price inflation.

On the supply side the German market is dominated by private providers. In 2011, there were 12,354 nursing homes and 12,349 home care providers. 41% of all nursing homes were private-for-profit, 54% private-not-for-profit and 6% public (Augurzky et al. 2013). In home care even 63% of providers were private-for-profit, 36% private-not-for-profit and 1% public. Market shares (measured in number of care recipients) are slightly lower than these figures for private-for-profit providers because they are smaller on average. Concerning investments, there seems to be a reduced interest in building new nursing homes. Due to some overcapacities of nursing homes in recent years, there were no problems in providing nursing home care. Waiting lists are unknown. However, providers already report difficulties in finding qualified personnel, which lead to an intensive public debate about the lack of qualified nurses (see e.g. Afentakis and Maier 2011, Schulz 2012, Augurzky et al. 2013). Several measures are discussed to alleviate it: next to general measures such as increasing (i) the number full-time employments or (ii) women's employment, (iii) attractiveness of the job of a nurse, and (iv) immigration of qualified nurses, especially from outside Europe, are discussed as well (RWI 2011, IEGUS, RWI, RUB and Arbeitgeberverband Pflege 2012).

4.2.2 Quality and performance indicators

For the assessment of efficiency, quality of care has to be measured. To this end, the so-called transparency reports for formal care have been introduced in Germany in 2009. Both, home care providers and nursing homes are yearly audited by the MDK – much more often than before the introduction of the transparency reports. The MDK rates every institution with 82

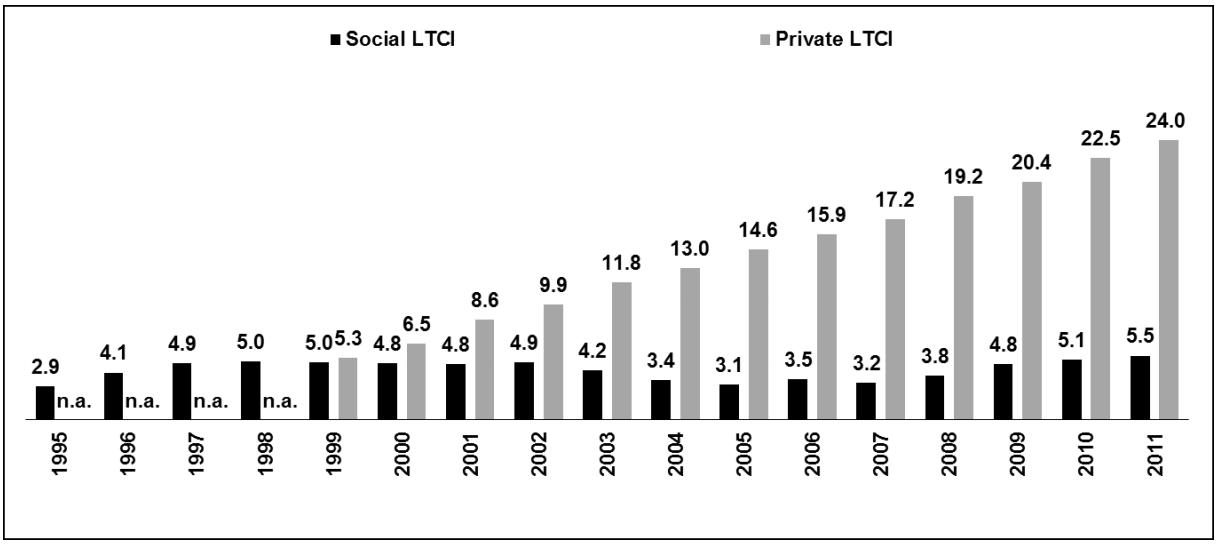
[41] In 2011 the social and private LTCI bore roughly 50% of residential and 54% of home care (in kind) costs (Statistisches Bundesamt 2013). Thus, the LTCI is often referred to as a "part insurance cover" (Rothgang et al. 2012).

[42] Pflege-Weiterentwicklungsgesetz: Law on advancement of LTC.

standardised items in five dimensions: (i) care and medicine, (ii) interaction with people with dementia, (iii) social assistance, (iv) board and lodging, (v) interviews of the people in need of care. However, only few items refer to outcome quality while most of them are about structural and process quality. Generally, transparency reports are criticised, because equal weighting of all items makes it possible to compensate "bad quality" in care by "good quality" in other services. There are e.g. no knockout criteria for bad outcome quality, and most of the items are criticised to measure only the quality of documentation[43].
However, with the development of external and internal quality management tools, a learning process regarding quality started. In sum, due to the competition between providers based on transparent quality measures as well as annual controls by the MDK quality of care already shows slight improvements (MDS 2012).

4.2.3 Sustainability

The financial crisis has not had an impact on financing LTC in Germany; neither does the current euro crisis. Furthermore, since the German economy is expected to remain growing, negative effects on social LTCI in the short term are not expected. The value of accumulated capital in the private LTCIs has grown significantly in 2011 (PKV 2012) and social LTCI gained a surplus of 100 million Euros raising its capital reserves to 5.5 billion Euros.
Figure 1: Capital reserves of the social LTCI in billion €



Source: Bundesministerium für Gesundheit (2013) and PKV (2012).

In 2011 2.5 million people received benefits from social or private LTCI, thereof 1.18 received care allowance, 0.58 - home care in kind and 0.74 - residential care. The number has risen considerably by 24% or by 1.8% per year between 1999 and 2011. At the same time total expenditures of the social LTCI have grown from 16.3 to 22.0 billion €, i.e. by 35% in total. Due to an ageing population, demand for long-term care is expected to increase significantly in the following decades. Estimates for people in need for care range from 3.17 million to 3.37 million in 2030 (Augurzky et al 2013). In 2050 around 4.4 million people are expected to be in need of care (Häcker, Hackmann and Raffelhüschen 2010).

[43] See Hasseler and Wolf-Ostermann (2010) or Weibler-Villalobos and Röhrig (2010) for a more detailed discussion.

4.2.4 Summary

Social long-term care insurance (LTCI) 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 LTCI and all members of a PHI became members of a private LTCI.

In 2013, around 70 million citizens were covered by social LTCI and roughly 9 million citizens by a private LTCI (in 2011). There are no differences in benefits between social and private LTCI. In general, there are three different arrangements a recipient can choose from: care allowance, home care (in kind), and residential care. The LTCI distinguishes between three levels of care based on the severity of the health condition. The level of care is formally assessed by an independent Medical Review Board of the Statutory Health Insurance Funds (MDK) for the social LTCI or by an equivalent body for the private LTCI. The LTCI pays the same fixed benefits according to the level of care but irrespective of the price for the actual goods and services. Between 1996 and 2007 there was no change in the nominal amount of the benefits. Hence, due to general price inflation the nominal amount had gradually lost its real value. In 2011, 2.5 million people received benefits from social or private LTCI, thereof 1.18 got care allowance, 0.58 for home care in kind and 0.74 for residential care. The number has risen considerably by 24% or by 1.8% per year between 1999 and 2011. Due to an ageing population, demand for long-term care is expected to increase significantly in the following decades.

On the supply side the German market is dominated by private providers. In 2011, there were 12,354 nursing homes and 12,349 home care providers. Due to some overcapacities of nursing homes in recent years, there were no problems in providing nursing home care. Waiting lists are unknown. However, providers already report difficulties in finding qualified personnel, which lead to an intensive public debate about the lack of qualified nurses. For the assessment of efficiency, quality of care has to be measured. To this end, the so-called transparency reports for formal care have been introduced in Germany in 2009. Both, home care providers and nursing homes are yearly audited by the MDK – much more often than before the introduction of the transparency reports. The financial crisis has not had an impact on financing LTC in Germany; neither does the current euro crisis. Furthermore, since the German economy is expected to remain growing, negative effects on social LTCI in the short term are not expected. However, the question remains how the strong increase in demand for care in the years to come is supposed to be financed.

4.3 Reform debates

The manifesto of the Christian democrats (CDU/CSU) is in line with earlier positions and the recent reform of LTCI by the PNG. The CDU/CSU wants to change the definition of being in need of care and improve conditions for informal carers. The implementation of the additional optional private LTCI by the PNG is supposed to increase self-responsibility regarding the individual risks for LTC. CDU/CSU intended to keep private and social LTCI separate.

In contrast, the social democrats (SPD) have advocated in the election campaign to abolish the private LTCI and enlarge the social LTCI to all citizens without exceptions – according to models that plan an integration of SHI and PHI ("Bürgerversicherung"). They also want to increase premiums paid by employers and to broaden the income basis to which contributions to the social LTCI refer. Currently, contributions depend on wage income only. Capital income is not taken into account. Furthermore, the SPD also intended to change the definition for being in need of care. Additionally, nurses are supposed to receive higher incomes and a better reputation. The plans of the Green Party have been similar. Moreover, they intended to

increase the income threshold of which premiums for LTCI are dependent and abolish the free co-insurance of spouses with no substantial individual labour income. The "left party" (Die Linke) has also been in favour of abolishing the private LTCI and broadening the income basis of contributions.

There are only a few scientific contributions to the current debate. Rothgang (2012) argues in favour for the implementation of a social LTCI for all citizens. Lüngen (2012) estimates the costs of changing the LTCI from a part- to full-insurance cover to be about 13 billion €. In June 2013, the Federal Ministry of Health published a report about redefining being in "need of care" prepared by an expert circle (BMG 2013b). Instead of three levels, the LTCI should distinguish five different levels. The assessment for being in need of care should be completely changed. The new assessment tool should measure impairments in eight modules such as mobility, cognitive and communication skills or coping with disease related requirements. The often criticised assessment with minutes per day should be abolished altogether.

However, the question remains how the strong increase in demand for care in the years to come is supposed to be financed. Without further reforms capital reserves will diminish quickly in the future (Augurzky et al. 2013). The optional private LTCI is insufficient as insurance companies are not allowed to perform a medical risk assessment. With nearly everyone allowed to join, insurance premiums are expected to be high. Given that non-subsidised insurances with medical risk assessment already exist in the market, a substantial risk selection can be expected. Furthermore, as the additional insurance is voluntary, the uptake is expected to be insufficient. Hence, it will be very unlikely that a voluntary additional private LTCI closes the expected financing gap.

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Annex – Key publications

[Pensions]

DÜNN, SYLVIA, STOSBERG. RAINER (2013), Vom "Rentendialog" zum Entwurf des Alterssicherungsstärkungsgesetzes – die Reformdiskussion 2011 bis 2013, Deutsche Rentenversicherung, 139-154

"*From a "pensions-dialogue" to a draft of a law – The debate on pension reform 2011-2013"*
This article gives an overview over the various phases in the pension reform debate, initiated by the federal ministry to introduce into the social insurance pension scheme elements in favour of persons with a long insurance career but low earnings, a proposal that was heavily criticised. A final political decision was not taken up to the end of the parliamentary term in September 2013.

DEUTSCHES INSTITUT FÜR WIRTSCHAFTSFORSCHUNG (ED.) (2012), Riester-sparen: kontroverse Sichtweisen aus Wissenschaft, Politik und Wirtschaft, Vierteljahreshefte zur Wirtschaftsforschung, 81. Jg., 02.2012

"*Riester-Saving: Controversial views from academic, politic and economic industry*"
This special edition of the journal gives a broad based overview on goals and effects of subsidised saving for old-age as it was introduced in 2001. Authors in favour of the new element as well as critics are represented in a volume of about 280 pages. In the centre are aspects like transparency, costs, rate of return, effects on income distribution and whether it compensates the pension gap resulting from scaling down social insurance benefit level

[Health]

[H] Augurzky, B. und S. Felder (2013), Volkswirtschaftliche Kosten und Nebenwirkungen einer Bürgerversicherung. RWI Materialien 75. RWI.

*Economic costs and adverse effects of the Bürgerversicherung (*universal citizens' health insurance)

In this report, the authors evaluate the economic consequences of introducing a Bürgerversicherung. The results of an equilibrium model indicate that the German GDP would not be higher, but even lower after the introduction of a Bürgerversicherung.

SACHVERSTÄNDIGENRAT ZUR BEGUTACHTUNG DER ENTWICKLUNG IM GESUNDHEITSWESEN (2012), Wettbewerb an der Schnittstelle zwischen ambulanter und stationärer Gesundheitsversorgung, report, retrieved on 1 September 2013, from: http://dip21.bundestag.de/dip21/btd/17/103/1710323.pdf

Competition at the interface between outpatient and inpatient health care

The German health expert council discusses quality indicators in general in their special expertise 2012. They stress the importance of external quality assurance for the in-patient sector, but criticize the lack of quality assurance in the outpatient sector. The council recommends focusing on population-orientated and sector-comprehensive quality indicators.

VEIT C, HERTLE D, BUNGARD S, TRÜMNER A, GANSKE V, MEYER-HOFMANN B. Pay-for-Performance im Gesundheitswesen: Sachstandsbericht zu Evidenz und Realisierung sowie Darlegung der Grundlagen für eine künftige Weiterentwicklung. Ein Gutachten im

Auftrag des Bundesministeriums für Gesundheit, 2012. BQS Institut für Qualität & Patientensicherheit (Hrsg.). Düsseldorf. 2012.

Pay for performance in health care. Progress report on realisation and evidence as well as description of the basis for its future development.

The report gives a systematic overview about pay-for-performance (p4p) in the national and international context. For Germany all identified pay-for-performance projects are discussed in more detail. Furthermore, the report summarises the results of workshops and answers to questionnaires of different German stakeholders regarding p4p measures.

[Long-term care]

AUGURZKY, B., C. HENTSCHKER, S. KROLOP UND R. MENNICKEN (2013), Pflegeheim Rating Report 2013 – Ruhiges Fahrwasser erreicht. Hannover: Vincentz Network.

Nursing home rating report 2013. Reaching calm waters.

The report gives an overview about current demand for and supply of professional as well as informal long-term care in Germany. All analyses including price levels for nursing homes are provided at the district level. The report includes estimates for future regional demand. Furthermore, the current credit standing for a subsample of nursing homes is assessed by providing estimates for the probability of default within one year.

BMG – BUNDESMINISTERIIUM FÜR GESUNDHEIT (2013), Bericht des Expertenbeirats zur konkreten Ausgestaltung des neuen Pflegebedürftigkeitsbegriffs, report, 27 June 2013, Berlin, Germany.

Report of the expert committee on concrete corporate structure of the new definition of need for long-term care

In June 2013, the Federal Ministry of Health published a report about redefining being in "need of care" prepared by an expert circle. Instead of three levels, the LTCI should distinguish five different levels. The assessment for being in need of care should be completely changed. The new assessment tool should measure impairments in eight modules such as mobility, cognitive and communication skills or coping with disease related requirements. The often criticised assessment with minutes per day should be abolished altogether.

HACKMANN, TOBIAS (2012), Arbeitsmarkt Pflege: Bestimmung der künftigen Altenpflegekräfte unter Berücksichtigung der Berufsverweildauer, In: Sozialer Fortschritt 2012, Vol. 61, No. 2-3: 47–49.

Labour Market and LTC: Calculating the Headcount in Long-Term Care and Job Tenure

Compared to other approaches the present article is the only one that presents a comprehensive labour market model that includes both a supply- and a demand-side function. A time-series approach is used and is tested for validity by standard empirical tests. A comparable approach to model the supply side of the long-term care labour market, using the same quality standards as in the present article, cannot be found in the existing literature. Future projections of personnel requirements should focus on refining the method of the presented model and on improving the quality by including other high comprehensive data sets. As Simon suggests, the existing approach could usefully be extended to cover other health care sectors, if the available data improve accordingly. By enlarging the focus, the

substitution of other care jobs from different health-care sectors could be considered in the model as well. From today's perspective the presented model can be seen as a suitable concept for modelling future labour demand as it leads to highly significant results.

LÜNGEN, MARKUS (2012a), Vollversicherung in der Pflege: Was sie bringen und was sie kosten würde, In: Soziale Sicherheit 12/2012.

Full-insurance cover in LTC: how much will it cost and what are the benefits

In case of being in need of care substantial costs arise. According to recent studies total costs of care for the elderly sum up to around 42,000 € (84,000 €) for me (women) until end of life. Only around half of these costs are reimbursed by LTCI due to its design as part-insurance cover. What are the benefits and how much will it cost to switch to a full-insurance cover? This report discusses the answers to these questions.

ROTHGANG, HEINZ; MÜLLER, ROLF; UNGER, RAINER; WEISS, CHRISTIAN AND WOLTER, ANNIKA (2012), BARMER GEK Pflegereport 2012, Schriftenreihe zur Gesundheitsanalyse, Band 17. Asgard-Verlag: Siegburg.
Long-term care report 2012.

The report gives a review of LTC politics in recent years, analyses public and official data as well as data of the SHI BARMER GEK in order to study the dynamics of LTC careers. In this report, estimates for the total costs of care from the onset of being in need for care until end of life are given. The results show substantial differences between men and women with women bearing double the costs of men (84,000 € compared to 42,000 €).

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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