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1 Executive Summary

The first part of chapter 2 describes main developments and the political debate in the area of pensions. Germany's pension system is in a process of fundamental change because of political decisions regarding the structure of public and private, pay-as-you-go financed and funded pensions. This takes place while changes in the labour market - in particular long spells of unemployment in earning careers – affect individual pension claims. This will have severe effects in particular for future cohorts of pensioners. People now become more and more aware of these effects, but a discussion about the strategic decisions in pension policy has not yet really started. Discussed are several topics such as the increase of retirement ages which has already been decided upon, as well as the increasing risk of poverty in old age. Whether or not proposals to react will enjoy political support or gain in political importance is yet not clear. To extend mandatory coverage in particular to several groups of self-employed as well as to adjust still existing differences in the pension calculation between East and West Germany are other topics, but political decisions have not yet been taken. The crisis on the financial markets and its implications on pensions – affecting funded schemes earlier, and directly financed and pay-as-you-go schemes later and in an indirect way via the development of the "real" economy – has not yet become a much debated topic. What can be seen today seems to be only the tip of the iceberg. This may, however, change rapidly.

The second and third part of chapter 2 describe the main characteristics and the development of the health care and the long-term care system in Germany. In addition, it analyses the most recent health care and long-term care reforms and, in doing so, the consequences on the affected parties.

With the introduction of compulsory health insurance as from 1 January 2009, the large number of service providers, the comprehensive catalogue of benefits, and the low level of co-payments, access to health care in Germany can be described as very good.

Unfortunately, the shortcomings on the financing side of the statutory health insurance (SHI) were not eliminated by the GKV-WSG (*Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung).* All five fundamental weaknesses of the financial plan of the SHI remain valid. Among health experts, it is widely accepted that the remaining competitive pricing parameters in the statutory health insurance (additional contributions) are subject to distortions concerning income, morbidity and the family structure in any of the individual sickness funds. This leads to a distorted competition for earners of high incomes, the unmarried, and for healthy persons as these additional contributions become more important.

Progress has been achieved with respect to the Government's target to dissolute the rigid separation between the outpatient and inpatient sector, in particular through the facilitation of selective contracting and the further opening of hospitals for outpatient care. Furthermore, important quality measures were taken with respect to long-term care insurance and more people in need of nursing care can now receive financial assistance.

However, it will be of utmost importance for the next government to improve the financial sustainability of the health care and long-term care system.

2 Status and Development during 2008 and until April 2009

2.1 Pensions

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).

General remarks regarding pension policy and its effects

Germany's pension scheme is undergoing a process of change. Within the scope of the so-called "paradigm shift" in German pension policy it is intended to substitute part of the PAYG-financed social (statutory) pension insurance (SPI) by private (subsidised) capital-funded pensions. This will result in a lower pension level in the social pension insurance scheme. Whether a substitute will be realised keeping pensions at level is – at least for a large part of employees – highly questionable.

The instrument to realise a lower (general) pension level in the social pension insurance scheme is a new pension formula with many "factors" relevant for the calculation, introduced in 2001 and supplemented since 2004. This formula is confusing and by no means transparent. On the other hand, subsidies for private and occupational pensions are intended to compensate for the reduction in the social insurance pension level. Although the Government states that public and private pensions together will allow a "standard pensioner" to keep the pension level as it was in the public pension insurance before the reforms became effective, (in particular those decided upon in 2001 and 2004), this is only about the option to save (if ability to save is sufficient)[1] – and it neglects the fact that this implies a higher financing burden for households if they want to realise the same pension level. Aside from this, to focus on the "standard pensioner" gives a highly optimistic picture, but no adequate information about reality, because

- Arguing on the basis of the "standard pensioner" (average earner with 45 years of contribution payment) neglects the unequal distribution of pension claims even for those insured persons who have long earning (contribution) records.
- It also ignores effects of changes in the pension law affecting individual pension claims (e. g. less years of schooling are taken into account for pension calculation).
- Very little is known about coverage, distribution and the level of supplementary (occupational and in particular private) pensions, which in general, however, is much more unequal than in SPI.

[1] Decisions on additional saving for old age are not easy because – among other things – information by different groups of providers (social insurance, life insurance companies, banks, employers regarding occupational pensions) are difficult to compare (in particular regarding costs and rates of return). Individuals need a sufficient picture e.g. regarding possible "pension gaps". But the evolution of pension law makes it difficult to evaluate one's own position regarding old-age security and to understand what is going on in pension policy. The lack of transparency becomes apparent already when looking at the pension formula in the SPI scheme. From my point of view it is highly necessary to introduce a simple and transparent pension formula.

When calculations for the pension level are provided by the Government for different years they refer to different ages, because the reference retirement age will be increased step by step.

The expectation that despite the fact that the level of statutory public pensions will be considerably lower in the future, a stable pension level will be maintained thanks to increased entitlement to private pensions 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.

(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.

The most recent report on subsidised private pensions quotes explicitly that besides looking at the coverage rate, more attention should be paid on whether or not the amount of individual private pension provision is sufficient.[2]

The now officially used definition of the "pension level before tax", as one of the central indicators in the German debate, gives no adequate information on how much saving will be required to supplement the social insurance pension in order to have income in old age according to its own aspiration level, since the important effect of taxation is not considered. The rules of pension taxation will be changing year by year during the next decades due to fundamental changes in pension taxation policy. It is very difficult for people to estimate the effect of taxation and decide whether it is necessary to accumulate additional savings.

The reduction of the social insurance pension level affects not only old-age pensions but also disability pensions and widow's pensions. Moreover, disability pensions are reduced by "actuarial deductions" from the full pension. Such deductions can also affect old-age pensions if they are claimed before the age when the pension is granted in full (at present 65, gradually increasing to 67, starting in 2012). (See below: retirement age). All information given with respect to the "standard pensioner" (and this is a corner element in the German public debate beside the SPI-contribution rate) assumes, at least implicitly, a pension payment without deductions, i.e. payment starts at the reference retirement age (which, as already mentioned, will change over time). The issue of deductions from full pension due to retiring before the reference retirement age is already highly relevant and will have to be taken into consideration also in the future.[3]

A success story from the point of view of the Government is the increase in coverage in occupational pension schemes due to a continuation of the contribution-free earnings conversion. It must be taken into account here that – in contrast to the usual type of occupational pensions in Germany in former times – financing of this kind of "occupational" pensions is mostly left to employees (and not employers). Moreover, it is a defined contribution scheme, as opposed to a defined benefit scheme. In addition, it is often not

[2] Stolz and Rieckhoff (2008) p. 273.

[3] See Brussig (2007), p. 4.

considered that a growing amount of earnings conversion increases the need for higher contribution rates in several social insurance schemes (due to the fact that the assessment base of earnings for contribution payments is reduced. In social pension insurance a different effect occurs, for the increase in earnings conversion reduces the social pension adjustment rate (and thus also pension expenditure). Therefore, all present (and future) pensioners, whether they used or could not use earnings conversion, have to bear these costs by receiving lower statutory pensions.[4]

Households where social pension insurance benefits make the biggest part of the household income are affected relatively most by the reduction in the general pension level in the social pension insurance. This is (and will be) especially true for pensioners in East Germany, where, on average, occupational and private pensions will for a long time continue to be by far less relevant for the income in old age as in West Germany; this does also go for migrant households.

Projections of pension expenditures in public budgets usually refer only to pension expenditures for the social pension insurance scheme (including miners) and for civil servants, but do not include the costs for tax allowances (for private and occupational pensions) and the special (means tested) social assistance payments for elderly or disabled persons. These means-tested expenditures may increase remarkably in the future when the effects of the political decisions, in particular regarding the level of social pension insurance, and the effects of longer unemployment spells in earnings histories will considerably reduce individual pension benefits.

In its *Alterssicherungsbericht 2008* the Government presents data regarding an overall replacement rate from social pension insurance and subsidised private pensions for future cohorts of pensioners, based on model calculations. But information is missing on how the pension level will develop over time for members of specific cohorts, taking into account stronger effects of income tax on pensions as well as differences in the adjustment of different types of pensions according to wages and/or inflation. Until present, this aspect is hardly being addressed in public debate and no comprehensive studies exist dealing with this topic.

The Government has been underlining for years the necessity of implementing a general pension policy strategy. The sharing of demographically induced financial burdens for pensions is realised in Germany based on the idea of "generational equity", but also by strengthening the link between contribution payments and pension benefits. It is also emphasised by the Government that pensioners with full earning careers should receive pension benefits above social assistance level.

However, conflicts are likely to grow with respect to the already decided measures and the changes in earning lives on the labour market: Even for many persons with a long (full) earning career it will hardly be possible to receive a social insurance pension above social assistance level, because in 2030 even an average earner will need about 35 years of contribution payment if they retire at the age of 67 (about 37 years if retiring at the age of 65). If the pensioner's former earnings were below the average (i.e. below 100%) an even larger number of contributory years will be required to receive a pension above social assistance level. If e.g. earnings were 80% of the average, no lesser than 45 years of contribution payment will be needed.[5] Therefore, even if the contribution-benefit link is close in principle, contributors will perceive that their payment is more like a tax if the pension claim is below

[4] A detailed analysis is given in Schmähl and Oelschläger (2007).

[5] For more details see Schmähl (2008).

or just as high as the social assistance level while persons who never contributed to the scheme will also receive a means-tested transfer payment of that amount.

Regarding private pensions both their costs and the assumptions their calculations are based on are not very transparent. A recent study (Jäger 2008) endeavoured to answer the question at what age a subsidised pension would be higher than the sum of the contributions paid. Calculations of private insurance companies obviously include a high risk premium, so e. g. in a company the study is focused on: Single men would on average have to reach at least the age of 91 before the sum of pension benefits amounts higher than the sum of former contributions.

Whether income in old age will be sufficient to avoid poverty (i.e. above social assistance level) depends, however, on the types of income received altogether – from private and/or occupational pensions, from the spouse or from other assets. It is therefore difficult to say how many persons 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 will people accumulate very low pension claims in social pension insurance, but also no claims in occupational pension schemes or in private insurance schemes will be accumulated. And the value of private pensions in the aftermath of the financial crisis cannot be estimated today because what can be seen now is only the tip of the iceberg. Also its effects for the social pension insurance is unclear and will depend in particular on the future development of the labour market (earnings development, employment and unemployment respectively). If the rate of average (gross) earnings becomes negative, this would according to the existing pension formula – ceteris paribus – make the pension adjustment rate negative, too, i.e. the absolute amount of pension payments would be reduced. To avoid this reduction of pension benefits the federal Government decided (in a very quick decision process) on 6 May of this year to integrate an additional factor into the (already highly complicated) pension formula. If this new rule comes effective – that means an absolute reduction in pension benefits will be avoided – this effect will be made good in coming years. It can be expected that pension benefits will only be increased at very low rates in the near future (also because of effects of a suspension of other factors in the pension formula, see below).

Taking all the above mentioned aspects together, the possibility of a growing poverty rate in old age seems highly realistic.[6] This has, by now, become a topic of public debate, while during the years of preparing and deciding upon the fundamental pension reform (since 2001) this topic has hardly been addressed at all. Trust into the public pension scheme has been undermined in recent years to stimulate private saving for old age and to get support for the new strategy in the pension policy.

[6] In 2003, a new needs-based *Grundsicherung im Alter und bei Erwerbsminderung* (pension supplement in old age and in cases of long-term reduced earning capacity) took effect which differs from social assistance mainly in terms of a reduced obligation of family members (in particular children) to pay back social assistance payments their parents received. 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.

Suspending a factor for reducing the pension adjustment rate

As already mentioned several factors are included in the pension formula that in principle reduce the pension adjustment rate compared to the development of wages. For 2008 and 2009 one of these factors (stimulating the increase of contributions to private subsidised pensions in order to compensate for the reduction in the pension level of social pension insurance) has been suspended. Therefore, the adjustment rate was and will be a bit higher than otherwise. This decision was attacked by employers' organisations and by some advisors for breaking the rule – however, neglecting that in recent years the old rule was broken radically. The effect of the suspended factor shall be made good in 2012 and 2013.

Contribution rate in social health insurance and its effect for pensioners

In 2009, superseding the so far varied contribution rates to social health insurance schemes (SHI) a universal contribution rate was introduced. This will have some effect on the amount paid out as individual pension because pensioners have to pay 50% of the universal contribution rate (which will often differ from former contribution rates), but are burdened, in addition, by an extra 0.9% (alike employees), introduced to reduce the employer's contribution burden. This is based on the same argument as the shift towards private pensions: Non-wage labour costs are too high – an argument that is from an economic point of view less important than stated in the political discussion (this is discussed in Schmähl 2007a and 2009).

Employment of elderly workers

In April 2008 some new rules focussing on older workers were decided by Parliament, among them the possibility for workers aged 50 plus to receive unemployment benefits for an extended period of time (while this had been reduced a few years ago)[7], and to subsidise employers if they hire workers who have severe problems in the labour market. Also a change in statistics was introduced: Persons aged 58 plus who are able to work, but are unemployed and have received means-tested social assistance for at least 12 months will not be taken account of in statistics as unemployed persons.[8]

A specific problem regarding old age security is the obligation for persons receiving the above mentioned means-tested transfer payment to take up pensions as early as possible. For claiming a pension before the "normal" (reference) retirement age at least 35 years of insurance are needed, but the pension benefit is reduced by 0.3 % per month of early retirement. However, those persons who have contributed to insurance for a smaller number of years may retire at the "regular" retirement age, without deductions. – For the general debate on retirement ages see below.

[7] 15 instead of 12 months for workers aged 50 to 54; 18 months for persons 55-57 years of age (unchanged); 24 instead of 18 months for people 58 plus.

[8] A critical debate can be found in Dietz et al. (2008).

Topics under discussion

Increasing the retirement age

In 2007, it was decided to increase the age for entitlement to the full pension (i.e. without deduction) gradually from 65 to 67, starting in 2012. In 2029, this process shall be finished. Also the minimum retirement age will increase to 63. Therefore, the maximum of deductions in case of early retirement will be 14.4% (4 x 3.6%). In 2010, the Government will deliver a report concerning the employment of elderly workers including an estimation whether or not the increase of the retirement age shall remain as decided. The criteria for evaluation are, however, rather vague (Schmähl 2007b).

The effect of an increase of the reference retirement age (to receive a full pension) on the development of pension expenditure and the necessary contribution rate is relatively small, in part depending on a special rule for those pensioners that already have 45 years of (compulsory) insurance in their insurance record: They will have the possibility to retire at the age of 65, still without deductions.[9] In 2030, when the process of increasing the retirement age has become fully effective, the contribution rate in the social pension insurance is estimated to be (only) 0.5 percentage points lower.[10]

The increase of the retirement age (for full pension entitlement) has been under attack in particular by trade unions, arguing that there is a lack of employment opportunities for elderly people and therefore they will be mostly forced to retire earlier and encounter deductions from the full pension. This, however, should be seen in combination with the overall reductions in the pension level. A debate about the retirement age will be intensified during the coming months prior to the parliamentary elections in September 2009. The focus of the debate will be on the general rules as well as on possibilities for flexible retirement.

From my point of view, changes in the retirement age (as well as measures to avoid poverty in old age, see below) should not be discussed as isolated topics, but in particular the combined effects with the general trend in pension policy (in particular the reduction in the pension level of about 25%) should be taken into account.

The future development of poverty in old age

As a result of the political decisions to reduce the pension level of the social pension insurance, the unequal possibilities to compensate this by private pension provision (although this can be subsidised) and the effects of the labour market development (in particular in terms of unemployment), poverty in old age will see an increase in the future if things remain unchanged.[11] Meanwhile, different proposals have been published how to cope with this problem, mainly suggesting topping up (under specific conditions) “low” SPI-pensions,

[9] GVG (2006), p. 12-14. Kaldybajewa and Kruse (2006).

[10] Deutsche Bundesbank (2008) mentions that because of an increase in life expectancy in the future an additional increase of the retirement age seems justified.

[11] Bieber and Stegmann (2008) give information about data on present poverty in old age. Riedmüller and Willert (2008) discuss in particular the *Alterssicherungsbericht 2005* of the Federal Government and underline the risk of poverty in old age and that subsidising private pensions is in particular favourable for households with stable and high incomes. Taxation will burden more and more pensioners in the long run. They criticise that the Federal Government does not draw any conclusions regarding future poverty in old age and the increasing social inequality in its report.

mainly financed from tax revenues (see e.g. *Sachverständigenrat 2008*). This is, however, closely linked to the future role of the social pension insurance (SPI) compared with other tiers of the German pension scheme, because realising an increase of low pensions while the general pension level is being reduced (until 2030 by about 25% according to political decisions already taken) can change not only the scope but also the structure and design of the SPI. It may become more of a tax-transfer scheme and less an insurance scheme with a relatively close link between contribution payments and pension benefits (Schmähl 2008). This discussion was, however, avoided up to now by politicians in Germany, arguing, on the contrary, that the effects of the pension reforms will leave pensioners better off. Not only the crisis of financial markets – which makes obvious the risks of funded pensions that are intended to replace to some degree social pension insurance –, but also an enhanced understanding of long-term effects of the present pension policy within the population may result in a feeling that it is the strengthening of the pay-as-you-go financed SPI which is necessary, and not a process to undermine it even more. Until present, this has not been much articulated but may become more important in the (very) near future[12]. However, a change in pension policies – at least for the moment – cannot be expected to be realised by the present or possible other coalition governments and would be against the will of influential pressure groups.

Extension of coverage in the social pension insurance

Proposals to extend coverage are not new, but the topic received more attention in 2008 in particular from trade unions and several welfare organisations, favouring an *Erwerbstätigenversicherung*, that means a mandatory insurance for all persons who earn income from work, either as employee or self-employed (*Erwerbstätigenversicherung 2007*). Several groups of people are in the focus of such proposals:

(a) Economically active persons that have so far not been covered by any mandatory pension scheme. These are several groups of self-employed as well as employees with earnings below a certain threshold (*Geringfügigkeitsgrenze*), that means below a minimum income for access to social insurance coverage.

(b) Integration of persons who are already covered by compulsory insurance – such as civil servants and several groups of self-employed – into the social pension insurance.

While (a) in principal could be implemented relatively quickly, (b) would require a more long-term project, not only because of already accumulated pension claims in other schemes, but also due to legal issues (in particular regarding the status of civil servants).

While (a) is primarily proposed to reduce the risk of poverty in old-age, (b) is mainly motivated by increasing the basis for collecting revenues from contribution payment.[13]

This is also the case when an increase of the upper ceiling of the assessment base for contribution payment (*Beitragsbemessungsgrenze*) is proposed – often in combination with proposals for extended coverage.

[12] Meanwhile the important trade union of the metal industry (*IG Metall*) is in favour of a higher pension level in the SPI and a higher contribution rate compared to present conditions.

[13] Some analyses and calculations are in Prognos (2008).

There seems to be a growing political interest for mandatory coverage for those groups of self-employed that are now not covered by one of the existing schemes.[14] It will then have to be decided whether these persons shall be covered by social pension insurance or whether they shall be obliged to enter into e.g. a life insurance contract. In case of the second alternative a severe political problem would exist in explaining employees why they are not allowed to opt out of social pension insurance and choose other types of old-age insurance. (In times of a severe crisis of the financial markets this may not be as attractive as before when the public debate was framed to compare only rates of return of the PAYGO-financed SPI and private capital funded schemes without discussing different risks).

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

Different rules still apply for the calculation and adjustment of SPI 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 EUR per month for 1 EP.

Although since 1990 VEPs increased much faster in East Germany than in West Germany in accordance with the higher growth rate of average net earnings (which were 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 the time. Over the past years, the progress of catching up in earnings and therefore also in VEPs came to a standstill.

The existing difference in VEP (of about 12 percentage points)[15] stimulated discussion in East Germany demanding an equalisation of these values 20 years after the German reunification. This is supported e.g. by one big trade union (*ver.di*) as well as by several welfare organisations. It is expected by those, who propose such an equalisation, that pensions in East Germany will increase compared to the present level. Therefore, a mere redefinition of VEP by recalculating a (weighted) average of West and East VEP without additional costs would not fulfil the expectations.

The problem becomes eve 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 gives a higher EP in East Germany than in West Germany This will remain 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 for East German contributors and pensions. But the lower VEP stimulates a perception in East Germany to be suffering from a disadvantage. Therefore, proposals for a gradual equalisation of the rules imply additional costs to be financed from tax revenues.[16] It

[14] Old-age security of self-employed is analysed in detail in Fachinger et al. (2004); regarding not yet covered self-employed Ehler and Frommert (2009).

[15] 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%!

[16] Sachverständigenrat (2008) discusses some fundamental issues linked to some of the existing proposals.

seems that before the parliamentary elections in September 2009 no clear decision will be taken, but the topic will remain on the agenda. Decisions will have to take into consideration the effects for pensioners as well as for the contributors in West and in East Germany.

2.2 Health

Germany has a universal multi-payer system with two main types of health insurance. In 2008, 70.25 million citizens were covered by statutory health insurance (SHI),[17] and 8.62 million citizens by supplementary private health insurance (PHI).[18] Slightly more than 3 million citizens were covered by different specific governmental schemes.[19] 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 to their previous insurance. This applies both to SHI and PHI.

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.[20] At the national level, the Federal Ministry of Health, the Federal Parliament (Bundestag), and the Federal Council (*Bundesrat*) are the key actors, responsible to set 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. According to the RWI economic research institute based in Essen subsidies fell from EUR 4.7 billion in 1992 (in 2006 prices) to EUR 2.7 billion in 2006.[2122] The institute further estimates that EUR 18.8 – 23.4 billion would be required to remove the investment backlog in the hospital market.[23] Due to the financial and economic crisis, the Government decided to support additional infrastructure investments of the *Länder*, e.g. modernisation of hospitals with up to EUR 3.5 billion. The relatively small amount of money that will eventually be spent on hospital modernisation makes obvious that the investment backlog will not be significantly decreased by this measure.

For the SHI, corporatism is mainly represented by the non-profit sickness funds (SF) and their associations on the purchasers' side, and the SHI-affiliated physicians' associations (*Kassenärztliche Vereinigungen*) and dentists' associations (*Kassenzahnärztliche Vereinigungen*) on the providers' side. Physicians who want to treat SHI-insured patients are organised in regional physicians' associations, based on obligatory membership and democratically elected representation. There is one physicians' association in every *Land,*

17 Bundesministerium für Gesundheit; Kennzahlen der gesetzlichen Krankenversicherung 1998 bis 2007; 1. bis 4. Quartal 2008; March 4, 2009.

18 Verband der privaten Krankenversicherung; PKV-Geschäftszahlen 2008; press release, 25 March 2009

19 Kassenärztliche Bundesvereinigung; Struktur der Krankenversicherung in der Bundesrepublik Deutschland 2007; last update 2007.

20 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.

21 Arbeitsgemeinschaft der Obersten Landesgesundheitsbehörden (Hrsg.), Umfrage der Arbeitsgruppe für Krankenhauswesen der AOLG, presented by the German Hospital Association (DKG), 2008.

22 Rheinisch-Westfälisches Institut für Wirtschaftsforschung; Krankenhaus Rating Report 2008; March 2008.

23 According to a press release of the German Hospital Association (DKG) on 8 April 2007, the DKG estimates that the investment backlog amounts for EUR 50 billion. However, this number must be highly doubted since the estimation was published by a special interest group.

with the exception of North Rhine-Westphalia which has two physicians' associations. In addition, the federal physicians' association (*Kassenärztliche Bundesvereinigung; KBV*) and the federal dentists' association (*Kassenzahnärztliche Bundesvereinigung; KZBV*) represent the providers' interests at the federal level. 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 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. Furthermore, the G-BA adopts quality management measures for the inpatient and outpatient sector.

The payers' side is composed of currently 201 quasi-public sickness funds for SHI insured persons (about 70 million insured persons; 50.1 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 2009[24]:

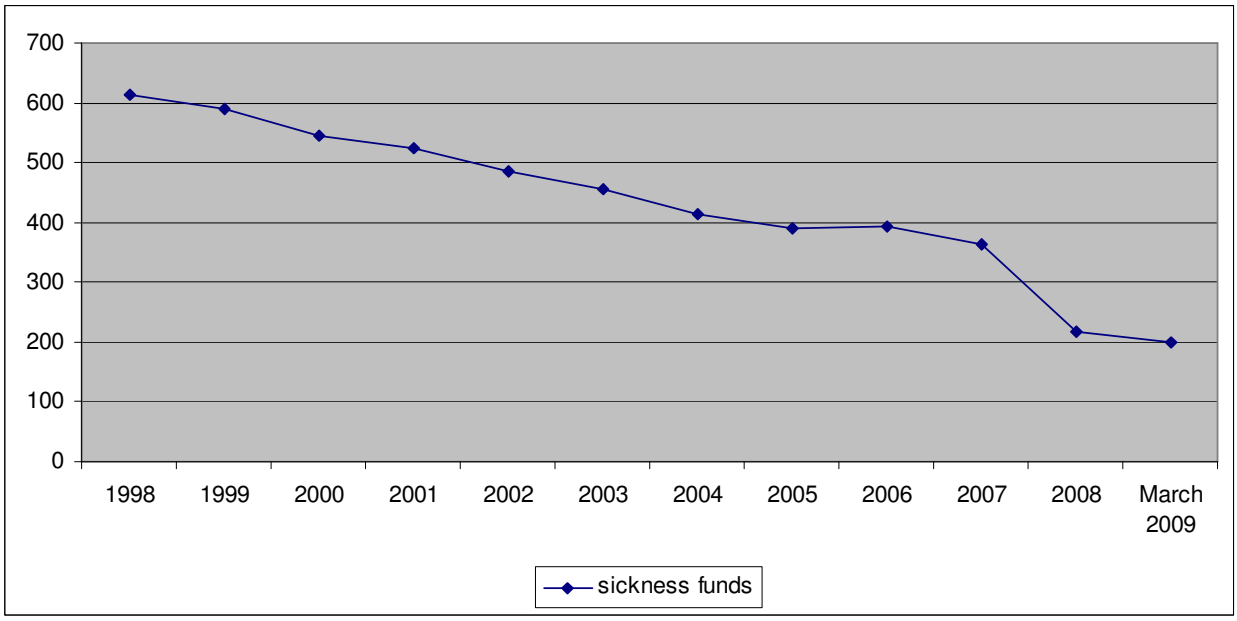
- 33.8% of all SHI members were insured with one of the 15 general regional funds (*Allgemeine Ortskrankenkassen*, *AOKs*);
- 35.0% were insured at one of the 8 substitute funds;
- 19.6% were covered by one of currently 154 company-based sickness funds (*BKKs*);
- 7.9% were covered by one of the 14 guild 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, therefore, led to an increase in competition between SFs, which were then forced to cut costs and 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). During the past years, mergers mainly occurred between company-based SFs. Until recently, mergers between SFs were only allowed between SFs of the same type (e.g. between AOKs or between BKKs, etc.). 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*

[24] Bundesministerium für Gesundheit, Monatsstatistik der gesetzlichen Krankenversicherung über Mitglieder, Beitragssätze und Kranke, 2 April 2009.

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 with currently 7.2 million insured persons.

Figure 1: Number of sickness funds in Germany, 1998-2009

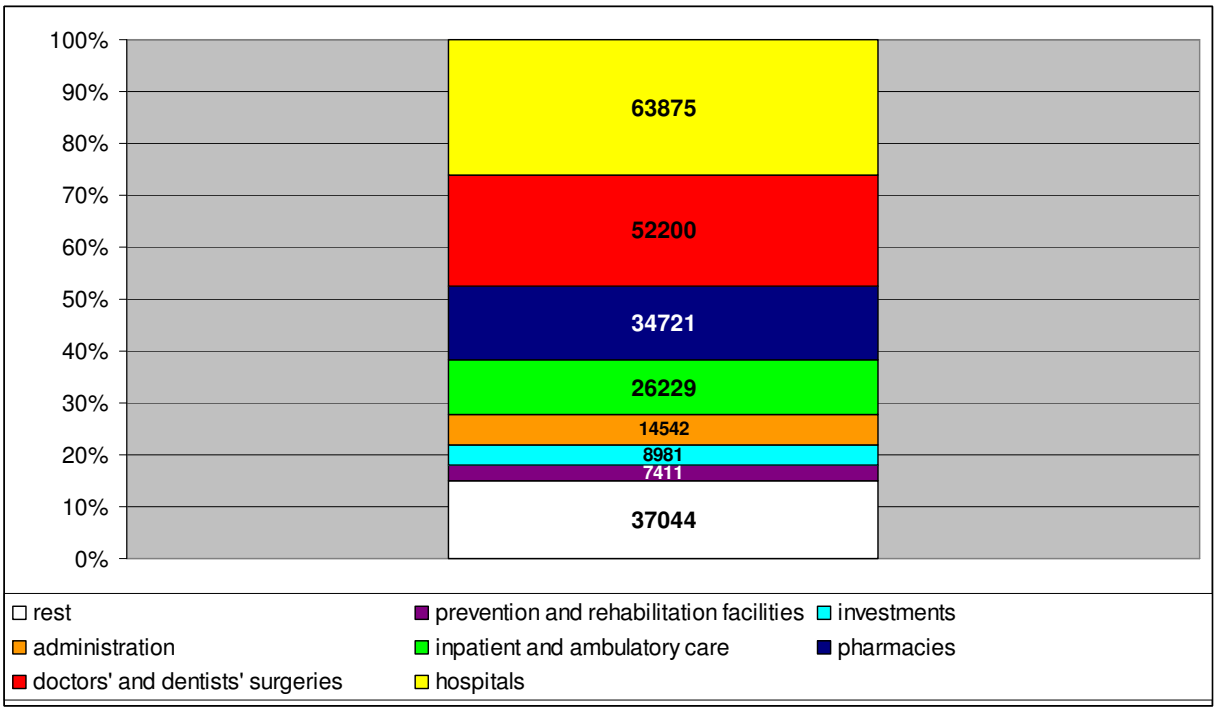


Source: BMG (2008, 2009), diagram by author

Structure and development of specific health care branches

According to OECD Health Data 2008, Germany spent 10.6% of its 2006 GDP on health. This was the fourth highest rate among OECD members. 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 EUR of a branch are mentioned in each bar.

Figure 2: Structure of health care expenditure in 2006

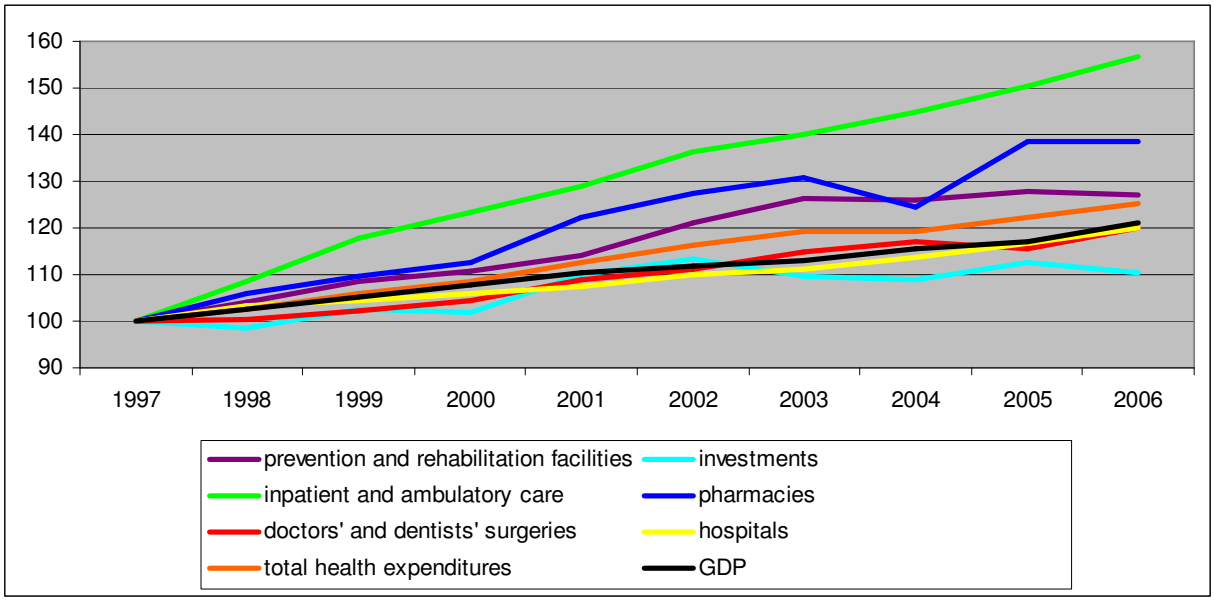


Source: Statistical Yearbook 2008, diagram by author

A share of 26.1% of health care expenditures is allotted to the hospital sector. With almost EUR 64 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 Health Data 2008, 3.8 million people, and thus almost every ninth employee, were employed in the German health care system.[25] Because of the demographic development and the medical-technical progress it can be assumed that the number of employees in the health care system will further increase in the future. The development of health expenditures of selected health care branches between 1997 and 2006 is shown in figure 3.

[25] In 2005 (latest update).

Figure 3: Development of health expenditure of selected health care branches (1997-2006)



Source: Statistical Yearbook 2008, diagram by author; 1997 = 100%

Expenditure for inpatient and ambulatory care, for prevention and rehabilitation facilities, and for pharmacies grew faster between 1997 and 2006 than total health expenditures and GDP (cf. figure 3). Due to the demographic development (and hence an increased demand for long-term care) expenditures for long-term care are expected to increase at above average growth rates in the future as well (especially outpatient care).[26]

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, hospital and private practitioner organisations advocated for higher budgets. Finally, the budgets for hospitals and surgeries were significantly increased in 2008 which narrowed the gap between the relatively small growth rates of those branches and the growth rate for long-term care expenditures.

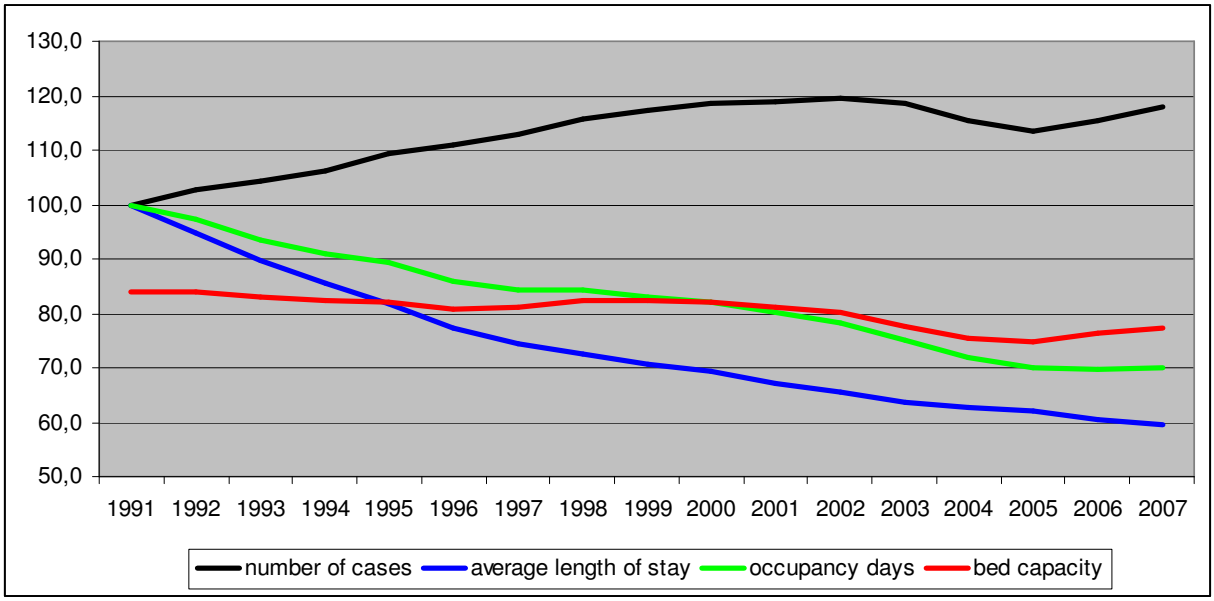
At the meeting of the extended committee for the rating of panel doctors‘ services (*Erweiterter Bewertungsausschuss*) on 17 March 2009, a new projection for the development of total medical fees was submitted by the institute of the committee. According to this projection, total SHI medical fees for mainly office-based physicians will increase by EUR 3.5 billion in 2009 compared to 2007. This increase is the result of a reform of medical fees. An allowance in Euros instead of points and the adoption of the morbidity risk by the SFs are the crucial aspects of this reform. Since 1 January 2009, physicians receive fixed Euro-cent values per service. Prior to this reform, physicians did not know the actual equivalent of their work. The doctor’s fee was subject to a complex distribution scheme and it took up to six months to work out the precise remuneration. Hence, the medical fee reform leads *ceteris paribus* to more transparency, but might also increase health expenditures significantly in the future.

[26] Augurzky et al. (2007); Krankenhaus Rating Report 2007.

On 3 April 2009, only a few days after the Hospital Financing Reform Act (*Krankenhausfinanzierungsreformgesetz, KHRG*) took effect, the German Hospital Society (DKG) and the SHI-umbrella association (*GKV-Spitzenverband*) signed an agreement about how wage increases in the hospital sector shall be financed in 2009. Due to the KHRG and the mentioned agreement, an additional EUR 1.1 billion will flow to the hospitals.

There is broad agreement that efficiency reserves should be used in order to cut costs in the first place before rationing measures are taken. Hence, all involved parties are forced to increase efficiency of the health care system.[27] This development can be described best by studying the hospital sector. Even though the number of treated cases increased from 14.6 million in 1991 to 17.2 million in 2007,[28] the number of beds was heavily reduced during this period. In 1991, there were 665,565 hospital beds and in 2007, only 506,974 of them were left. This diametrical development was only possible due to a massive decline of the average length of stay (from 14.0 days in 1991 to 8.3 days in 2007). The strong decrease overcompensated the increased number of cases which means that bed capacity (drop from 84.1 % in 1991 to 77.2 % in 2007) and the number of patients' occupancy days (drop from 204.2 million to 142.9 million) fell as well. This development can be seen in figure 4.

Figure 4: Development of cases, average length of stay, occupancy days, and bed capacity between 1991 and 2007



Source: Federal statistical office (2008): Fachserie 12 Reihe 6.1.1, diagram by author; 1991 = 100% for number of cases, average length of stay, and occupancy days

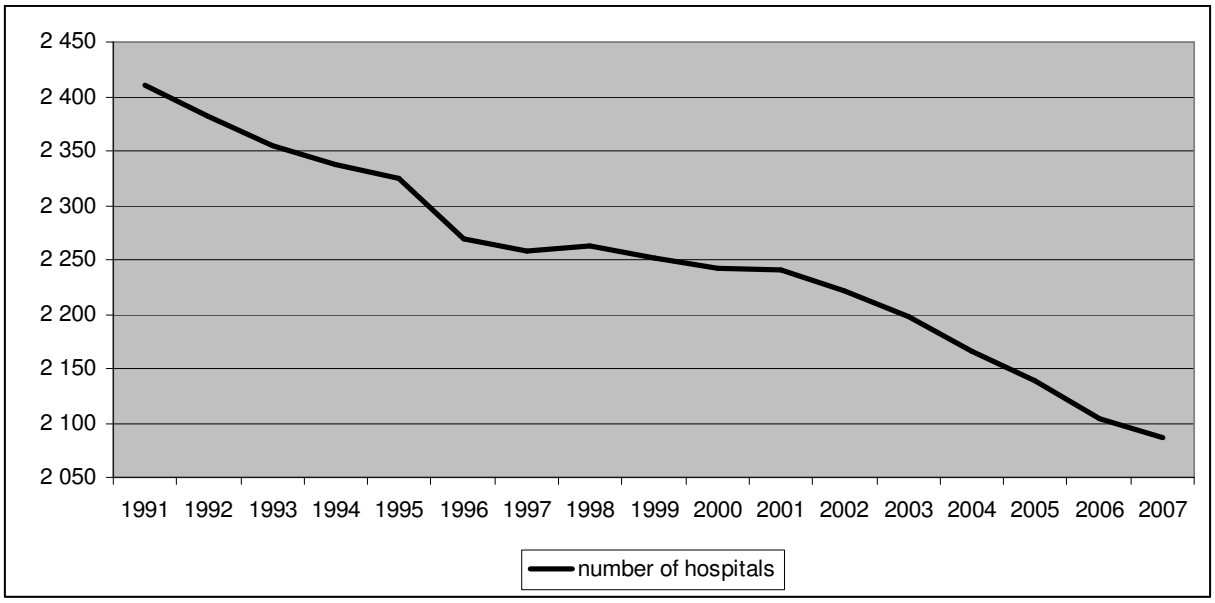
Additionally, the upheaval in the hospital sector becomes apparent by showing the decrease of the number of hospitals in the market and the ownership structure. Figures 5 and 6 illustrate this development. In 1991, one year after the German reunification, there were 2,411

[27] According to a lately published RWI study, the SHI could save up to EUR 9.8 billion if all efficiency reserves were used (cf. Augurzky et al (2009); Effizienzreserven im Gesundheitswesen).

[28] Federal Statistical Office (2008): Fachserie 12 Reihe 6.1.1.

hospitals. The number of hospitals decreased by 13.4% and declined to 2,087 facilities in 2007. The main reasons for this development are mergers and acquisitions and only to some extent real closings of hospitals.

Figure 5: Number of hospitals (1991 – 2007)



Source: Federal Statistical Office (2008): Fachserie 12 Reihe 6.1.1, diagram by author

The number of beds decreased from 1991 to 2006 by 23.8%. This sharp decline can be explained by the efforts of planning authorities to reduce excess capacity and raise efficiency. Although there have been severe cutbacks in hospital beds, Germany still has a very high density of beds compared to other highly developed countries. According to OECD Health Data 2008, Germany still had the third highest hospital bed density in 2005 among OECD countries (6.4 acute care beds per 1,000 inhabitants compared to an average of 3.9 beds per 1,000 inhabitants for all 27 OECD countries where data was available).

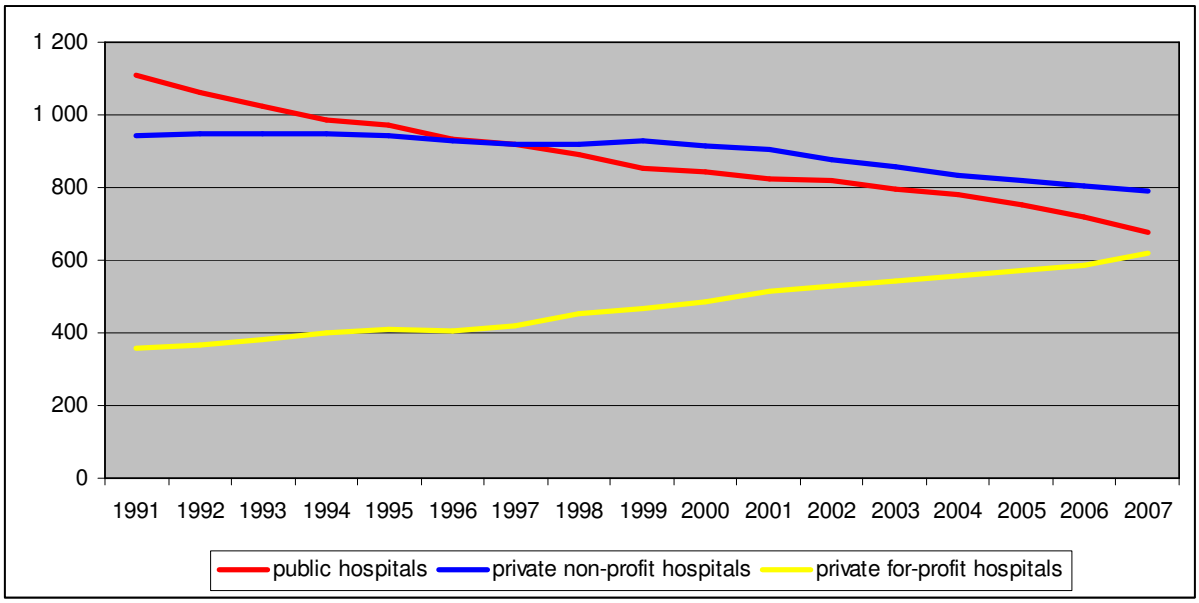
Despite the massive decline of the average length of stay, acute care patients in Germany stay in hospital longer than in other countries. According to OECD Health Data 2008, the average acute care patient stayed 8.7 days in hospital in 2005 (only Japanese patients stayed in hospital longer). The country with the lowest average was Denmark with 3.5 days. In the opinion of the Advisory Council on the Assessment of Developments in the Health Care System (*Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen; SVR-G*) the explanatory power of international comparisons, however, is limited, e.g. because of the heterogeneous separation between acute care, ambulatory care, inpatient care, and rehabilitation. Nevertheless, the high bed density and the low occupancy rates indicate – according to the SVR-G – that over-capacities exist in the German hospital sector.[29]

Figure 6 shows that private operators gained in their market share in the German hospital market in recent years. This increase can be explained mainly by takeovers of public hospitals by private for-profit hospital chains. This rapid increase of the importance of private for-profit

[29] SVR-G; Kooperation und Verantwortung: Voraussetzungen einer zielorientierten Gesundheitsversorgung; 2007.

companies is another indicator for the existence of efficiency reserves in the German hospital sector. The number of private non-profit hospitals (*freigemeinnützig*) has also decreased, but due to the general decline in inpatient facilities, they were able to keep their market share between 38% and 40%, and thus relatively stable.

Figure 6: Ownership structure of hospitals



Source: Federal Statistical Office (2008): Fachserie 12 Reihe 6.1.1, diagramme by author

Access to and quality of health care

It was one of the main goals of the current health minister, Ulla Schmidt, to guarantee access to health care to every legal resident. The most recent health care reform, therefore, stipulates that all legal residents have the legal responsibility to hold a health insurance policy. Anyone who has lost their insurance will revert to their previous insurance. This applies –as already mentioned – both to SHI and PHI.

Besides the fact that Germany's hospital bed density ratio is one of the highest in the world, 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 2006 compared to the OECD average of 3.1. Germany also had slightly more practising nurses, at 9.8 per 1,000 inhabitants, than the OECD average of 9.7 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 blanket coverage of medical benefits 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.

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.

Financial sustainability[30]

As already mentioned above, Germany spent 10.6% of its 2006 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 6.0% in 2007). But if expenditures on benefits are related to assessable income, one recognises that this ratio increased over time (from 13.3% in 1995 to 14.6% in 2007).[31] 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 funded by compulsory contributions on wages and retirement pensions. The employer contributes 7.3% (this rate will be lowered to 7.0% on 1 July 2009) of the assessable income and the employee contributes a further 8.2% (will be lowered to 7.9%).

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. Because of the current financial and economic crisis, more information about this topic can be found in chapter 3 of this report. Secondly, the revenues are growing slowly due to low wage increases 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 at the compulsory insurance income threshold.[32]

These fundamental weaknesses of the SHI are broadly accepted among health politicians. All relevant parties have their own reform concept and it is the common goal of all parties to reduce the burden on wages by widening the financing basis of the SHI. Nevertheless, there are major differences between the competing concepts which will be briefly presented in the following:

The social democrats (*SPD*)[33], the green party[34] (*Bündnis 90/ Die Grünen*) and the party "the left"[35] (*Die Linke*) advocate the all citizens' health insurance scheme (*Bürgerversicherung*). The basic idea of this scheme is to include all citizens with all sorts of income (up to a certain

30 Several recent adjustments regarding financial sustainability of the SHI are mentioned in chapter 3.

31 Bundesministerium für Gesundheit: Kennzahlen der gesetzlichen Krankenversicherung 1994-2006, 1.-4. Quartal 2007, June 26, 2008; Statistisches Bundesamt: Deutsche Wirtschaft 2. Quartal 2008, 2008; Bundesministerium für Gesundheit: Arbeits- und Sozialstatistik, Bundesarbeitsblatt, KJ 1, KM 1, KV 45, 2008.

32 EUR 48600 in 2009.

33 SPD; Hamburger Programm – Das Grundsatzprogramm der SPD, October 2007.

34 Bündnis 90/ Die Grünen; Die Patienten stark machen – Grüne Gesundheitspolitik, Broschüre 16164; February 2009.

35 Die Linke; Programmatische Eckpunkte; March 2007.

income threshold) into the financing system of the SHI. In such a system, public servants, self-employed, or wealthy citizens could not opt out of the SHI any longer. According to the proponents of the *Bürgerversicherung*, this shall lead to more social justice and higher revenues for the SHI. Consequently, further increases of the contribution rate and additional rationing measures might become dispensable.

The conservatives (*CDU/CSU*) advocate a capitation fee scheme (*Solidarische Gesundheitsprämie*)[36]. In contrast to the just described concept, the CDU/CSU-model is a proposal that affects only the SHI. Hence, this scheme allows for a continuation of the separation between SHI and PHI. The other important distinction to the *Bürgerversicherung* is that - in principle - every member of the SHI pays the same absolute amount of money. However, no member shall be supposed to contribute more than 7% of his or her personal income. In addition to the member's salary, casual earnings, return on interest and income from rent are taken into account. This makes obvious that even in this scheme, income verification has to be carried out (but at a significantly lower degree than it would be the case if the *Bürgerversicherung* were introduced). In addition to that, the contribution rate for the employer shall be fixed to a certain percentage point of the member's gross income. This cap of the employers' contribution shall prevent a further increase of the indirect labour costs which would weaken the firms' international competitiveness. The conservatives argue that the SHI should not be misused to pursue redistribution goals.[37]

The free democrats (*FDP*)[38] favour a health insurance system with more private elements. They argue that due to demographic changes, old age provision should be accumulated. Even though there are important differences between the concepts of the CDU/CSU and the free democrats, it is very likely that a consensus between these positions can be reached if these parties were to build a coalition government.

Unfortunately, the current coalition between conservatives and social democrats was not able to eliminate the shortcomings on the financing side of the SHI. Hence, the future health insurance system depends largely on the composition of the next coalition government. However, there were considerable changes due to the *GKV-WSG* with respect to the financing system. The most visible modification was the introduction of a uniform contribution rate of 15.5% on 1 January 2009. Even though the SFs continue to collect contributions, all contributions are now centrally pooled by a new national health fund (*Gesundheitsfonds*), which allocates resources to each SF based on a risk-adjusted capitation formula. The new capitation formula takes into account morbidity from 80 chronic and/or serious illnesses in addition to gender, invalidity, and age. If the national health fund covers less than 95% of the expenditures of the SHI in any given year, the contribution rate must be adjusted by the Government.

If the capitation is insufficient to cover the needs of a SF, this specific SF is allowed to demand its members for additional contributions. This additional contribution can either be in the form of a flat rate fee (up to EUR 8 per month without income verification) or be income-related. The income-related contribution is limited to 1% of the assessable income of the member (hardship clause). If a SF generates a surplus, it may grant refunds or additional services to its members.

[36] CDU; Grundsatzprogramm der CDU Deutschlands: "Freiheit und Sicherheit", December 2007.
[37] Having said that, the CDU/CSU approves redistribution but only if the income tax is used for this purpose.
[38] FDP; Beschluss des Präsidiums der FDP, July 2006.

The national health fund, and thereby the new uniform contribution rate, took away the dominating competition parameter from the SFs. The competition will thus inevitably shift to the specific optional benefits of the SFs and the additional contributions. Such a system could increase the intensity of competition between the SFs due to the uniform contribution rate of the employer. The achievement of this objective, however, is being hampered by three problems. Firstly, persons with low incomes and wages have little incentive to switch SF because of the 1% hardship clause. Moreover, this scheme causes significant fiscal problems for those SFs with a large fraction of low-income members if the capitation is insufficient to cover their costs. They are then forced to compensate for the shortfall by further increasing the supplementary contribution rate, which will further deteriorate their competitive position.[39] Secondly, the amount of the additional contribution also depends on the family structure of the SF members. This derives from the fact that children and non-working spouses of a SF member are non-contributory insured. Thus, the amount of the additional contribution of a SF member will also be determined by the proportion of non-contributing family members in relation to the total number of insured members of this SF. Thirdly, the amount of supplementary contribution depends also on the morbidity structure of the members of a SF. It is envisaged that up to 5% of the expenditures on benefits can be funded by additional compensations without providing a morbidity structure compensation for them. Hereby, a competitive advantage, inevitably, arises for SFs with a high proportion of healthy members. Hence, incentives for risk selection arise.[40]

In May 2008, the consulting company *Accenture* published a survey[41] among SFs and private health insurance companies on the future challenges of the health insurance market. The aim of this survey was to find out, how the SFs and private health insurance companies respond to the 2007 health care reform. More than two thirds of the SFs assume that the reforms on the financing side strongly affect the propensity of the SHI members to switch SFs. The representatives of the SFs expect that more members will leave SFs if they ask for a higher contribution fee (via the newly introduced additional contribution fee) in comparison to the old financing scheme with individual contribution rates. Approximately two thirds of all asked representatives even believe that more low-income earners are willing to switch between SFs compared to the old ruling.

Besides all criticism, the *GKV-WSG* also led to improvements. It is now easier for SFs to contract providers directly and to negotiate rebates with pharmaceutical companies or to procure medical aids. Additionally, SFs are allowed to offer their members special rates (deductibles, reimbursement of costs). Moreover, mergers between different types of SF are now allowed. On 1 January 2009, the *Techniker Krankenkasse* and the *IKK-Direkt* made use of this regulation to become Germany's largest SF.

These reforms imply that more purchasing power was given to the individual SF. By contrast, the private health insurance companies were forced to offer a social premium (*Basistarif*). In this scheme, the services offered have to be comparable to the catalogue of services of the SHI and the insurance premium must not exceed the highest SHI contribution rate. In conclusion, the SHI gains more rights that are typically associated with private companies whereas the PHI gains more social elements. Therefore, there has been a convergence of these two systems. Moreover, hospitals are allowed outpatient treatment to patients with serious

[39] Igel, Christian and Schaufler, Thilo M., Der neue Zusatzbeitrag als Wettbewerbsparameter, Dienst für Gesellschaftspolitik, 9-2006, 24 August 2006.

[40] Rürup, Bert, Gesundheitsökonomische Grundlagen und Defizite des Gesundheitsfonds, Recht und Politik im Gesundheitswesen, 3-2008, 2008.

[41] The survey was scientifically supported by Prof. Ulrich and Prof. Wille.

illnesses such as AIDS or multiple sclerosis. Higher quality of treatment for those patients and more efficient structures will be the likely consequences of this reform.

2.3 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, 70.36 million citizens were covered by SLCI and 9.25 million citizens by PLCI.[42] An overview of the catalogue of benefits is given on the website of the Federal Ministry of Health. In table 1, two main kinds of benefits are presented.

Table 1: Extract of the catalogue of benefits of the German long-term care insurance

		Level 1 of nursing care required (low level of care required)	Level 2 of nursing care required (high level of care required)	Level 3 of nursing care – very high level of care required (hardship case)
Home care	Non-cash benefits for nursing care; up to EUR per month until the end of 2009	420	980	1470 (1918)
	Allowances for nursing care; EUR per month until the end of 2009	215	420	675
Inpatient care	Allowances for nursing care; EUR per month until the end of 2009	1023	1279	1470 (1750)

Source: Federal Ministry of Health

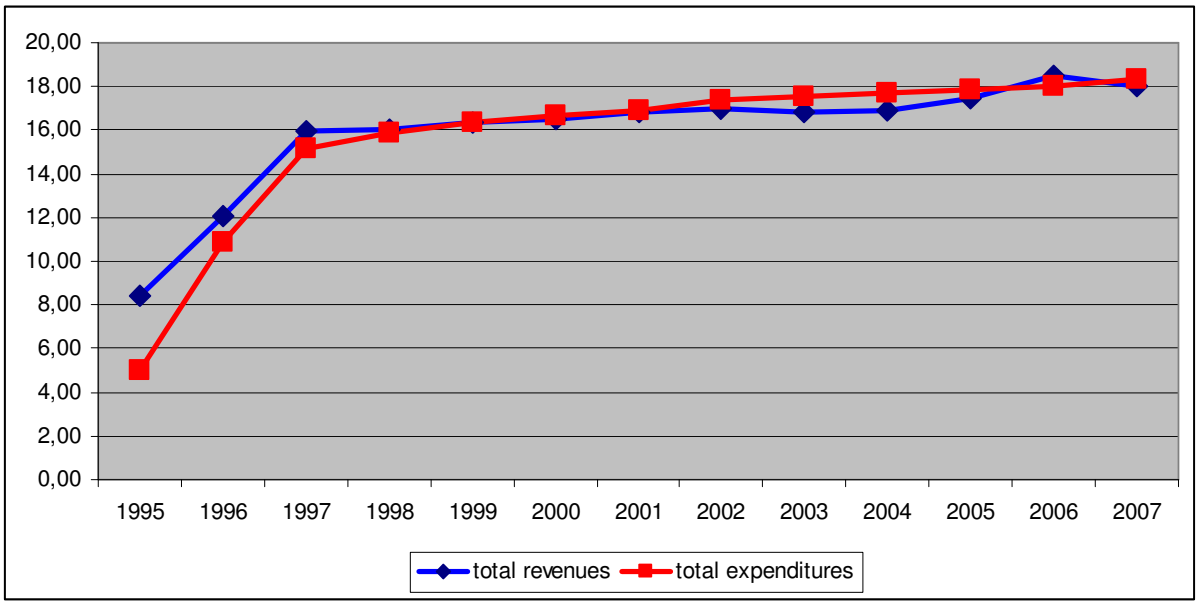
Expenditures for long-term care are limited depending on the level of nursing care required (cf. table 1). If the person that is in need of care has to spend more money, he or she has to pay the difference by him- or herself. In total, 2.17 million legal residents draw benefits from

[42] Bundesministerium für Gesundheit, Zahlen und Fakten zur Pflegeversicherung, January 2009.

one of the two long-term care insurance schemes; 1.46 million persons outpatient care[43] and 0.71 million inpatient care.[44]

Due to the fact that more and more persons receive benefits from the long-term care insurance, total expenditure is growing (cf. figure 7). 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 %).[45]

Figure 7: Total expenditures and total revenues of long-term care insurance in billion EUR



Source: Federal Ministry of Health (2009)

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. In accordance with the Long-term Care Development Act (*Pflege-Weiterentwicklungsgesetz*) of 2008, 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.

[43] 58.6% of them fall into level 1 of nursing care required, 31.8% fall into level 2, and only 9.6% fall into level 3.

[44] 40 % of them fall into level 1 of nursing care required, 40 % fall into level 2, and 20 % fall into level 3.

[45] Due to demographic changes, experts forecast further increases of the contribution rate in the future (cf. Deutsche Bank Research 2009).

Furthermore, the financial support for people with significantly reduced every-day living skills (such as dementia patients or mentally ill people) were increased from EUR 460 per year to up to EUR 1,200 (basic amount) and up to EUR 2,400 (increased amount), respectively.

Another important 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.

The long-term care insurance is funded just like the SHI – on a pay-as-you-go basis (*Umlagefinanzierung*). As a result, the long-term care insurance exhibits the same five fundamental weaknesses as the SHI which were previously described.

Originally, in the coalition treaty the governing parties have agreed to add elements of the funding principle in order to overcome some problems related to the demographic change. These elements, however, have not been and most likely will not be introduced within the current term. However, in Parliament, the Free Democrats (*FDP*) advocate for a transition from the currently PAYG scheme to a funded system (*Kapitaldeckung*).[46] The other two opposition parties (the greens and the left party) advocate a system where all legal residents belong to a public long-term insurance. In such a financing scheme, all sorts of income would be subject to long-term insurance contribution (*Pflege-Bürgerversicherung*). Hence, depending on the outcome of the upcoming elections for the Bundestag, the long-term care might gain more elements that are typically associated with a market system (coalition between the conservatives and the free democrats) or more social elements (if government led by the social democrats).

3 Impact of the Financial and Economic Crisis on Social Protection

At the end of 2008, many countries in the world experienced a severe economic setback.[47] The German economy, highly integrated into world economy, suffers the full effects of the global downturn. Leading economic research institutes and the Government forecast a decline in real GDP of 6% in 2009.[48]

It is obvious that such an intense economic setback has negative affects on the job market. 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 number of employees contributing to the social security system 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 and wage growth rates decrease because of the economic crisis. This leads ceteris paribus to a weakening of the financial basis of the social insurance.[49]

[46] Antrag der Fraktion der FDP (BT-Drs. 16/7491).

[47] E.g. OECD; Quarterly National Accounts (GDP), last update: fourth quarter 2008.

[48] Projektgruppe Gemeinschaftsdiagnose; Im Sog der Weltrezession – Gemeinschaftsdiagnose Frühjahr 2009, April 2009.

[49] The Federal Ministry of Health estimates that a by one percentage point lower increase of the average assessable income leads to a shortfall of EUR 1.5 billion for the SHI. In addition to that, the Ministry

However, the negative impact of a reduction of the number of employees (and hence an increasing unemployment rate) 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 SPI and the SHI. In principle, the PUI pays 80% of the member's last contribution during the first 12-18 months of unemployment.[50] If the SPI/SHI member remains unemployed for a longer period the social insurance receives (on average) a much lower contribution.[51] Therefore, the SPI and SHI experience severe financial problems regarding revenue if the job market remains weak for a medium or longer period.

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 so called reduced hours compensation (*Kurzarbeitergeld*) for a limited period of 12 to 18 months.[52] If the employer decides to use this measure, the employee receives 60% (67% if he or she has at least one child) of the difference between his normal and his reduced net income by the Government. In addition to that, the employer benefits from a new regulation. The employer is now allowed to cut 50% 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.

Labour market problems can, in addition, affect expenditures of SPI if the number of early retirees increases. The effects on revenue as well as expenditure can be expected to increase in the near future, depending on how much the financial crisis affects the "real economy".

Besides these indirect effects of the financial crisis funded pensions are directly affected. However, until now, only the tip of the iceberg can be seen. SPI is hardly affected because only relatively small reserve funds are accumulated. Life insurance companies and pension funds suffer already from low interest rates or even loss of capital. Exact figures are not available as yet, nor data concerning the effects on the income of pensioners, due to a lack of cohort-specific data and of different groups of the population regarding the structure of their assets and sources of income.

What kinds of measures have been implemented by the Government in order to tackle the crisis? In autumn 2008, the Government's effort was to stabilise the financial market. One of the first measures taken in this sense was to grant the financially stricken Hypo Real Estate Group (HRE) a EUR 50 billion guarantee.[53] On 5 October 2008, the Federal Government announced a full guarantee for all savings in Germany that are part of the German deposit protection system.[54]

In order to stabilise the financial market, the Stabilisation Act (*Finanzmarkt-stabilisierungsgesetz*) came into effect on 17 October 2008. The main part of this act was the formation of a so-called bank rescue fund (*Banken-Rettungsfonds*). This fund is allowed to spend up to EUR 80 billion in order to buy toxic assets from financial institutions or to take a

estimates that a loss of 100,000 contributing SHI members leads to a shortfall of EUR 0.323 billion for the SHI. These estimates are published in table KF08Bund (last update: 4 March 2009).

50 § 232a I Social Code Book V.

51 In 2009: EUR 129.54 per month and member according to § 232a Social Code Book V in conjunction with § 18 Social Code Book IV and § 246 Social Code Book V.

52 Verordnung über die Bezugsfrist für das Kurzarbeitergeld vom 26. November 2008, BGBl. I S. 2332.

53 Federal Ministry of Finance, press release, 6 October 2008. This first guarantee was split among private companies and the Federal Government.

54 Federal Government, Die Sparer sind geschützt, 6 October 2008.

stake in such a company. In addition to that, the fund is allowed to grant guarantees up to EUR 400 billion to financial institutions.[55] These early measures aimed at avoiding a breakdown of the financial system and the resulting consequences on the real economy.

In order to support the real economy and thereby securing employment, the Federal Government approved two economic stimulus packages. The first one was approved on 5 November 2008. The "Employment Guarantee and Stability Act" (*Gesetz zur Sicherung von Beschäftigung und Stabilität in Deutschland*), also known as the second economic stimulus package, came into effect on 2 March 2009.

Since the Social Insurance Schemes are primarily funded by compulsory contributions on wages, the economic stimulus measures indirectly lead to a stabilisation of its revenues. Due to space restrictions, the focus of this paper will lie on the aspects of the stimulus measures that directly affect the health care system, because specific decisions are implemented here.

On 1 January 2009, several crucial parts of the 2007 health care reform changing the financing system of the SHI took effect. Since 1 January 2009, members of a sickness fund (SF) and their employers have to contribute 15.5% of the employee's assessable income. Even though the SFs continue to collect contributions, all contributions will be centrally pooled by a new national health fund (*Gesundheitsfonds*), which allocates resources to each SF, based on a risk-adjusted capitation formula (cf. chapter 2). Due to the addressed changes on the financing side of the SHI, SFs see themselves confronted with insecurity regarding their financial situation in 2009.

In order to guarantee a stable introduction of the new national health fund, the Federal Government announced to grant 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 financial stability in the SHI, because SFs do not have to worry about high budget deficits due to the current economic crisis. The financial burden for SFs is limited since the Government loan will be free of interest and does not have to be paid back until the end of 2011.

Furthermore, the Federal Government decided to increase the subsidy for the new national health fund from EUR 4 billion to EUR 7.2 billion in 2009 and from EUR 5.5 billion to EUR 11.8 billion in 2010. The purpose of this increased subsidy is to lower the uniform contribution rate from 15.5% to 14.9%, which will take effect on 1 July 2009. The benefits of this reduction are split evenly among employees and employers, totalling a decrease of 0.3% each. The employers then contribute 7% (currently 7.3%) of the assessable income and employees contribute a further 7.9% (currently 8.2%).

Moreover, the Government decided to support additional investments of the *Länder* and municipalities in education and infrastructure. The Federal Government grants financial aid to the *Länder* in the amount of EUR 10 billion.[56] At least EUR 5 billion shall be used prior to 31 December 2009 in order to set a growth stimulus as soon as possible. The remaining financial aid will be granted if the investment project starts earlier than 31 December 2010. EUR 3.5

[55] According to a press release of the institution that is responsible for the stabilisation of the financial market (Finanzmarktstabiliserungsanstalt) of 3 March 2009, financial institutions requested EUR 294 billion up to that point. EUR 178 billion have already been granted as guarantees and EUR 19 billion as equity capital.

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

billion shall be spent for infrastructure projects, e.g. modernisation of hospitals. At this moment, however, it is not certain how much additional money will be spent in order to modernise hospitals due to this measure.

In conclusion, the setback in economic activity and the expected decrease of the number of employees subject to social insurance contributions will lead to declining SHI revenues. The macroeconomic development, however, cannot be fully adapted to the SHI, since e.g. the PUI pays a large part of the member's last contribution in case of unemployment. The German Federal Government committed itself to cover the SHI financing gap, caused by recession, with an interest-free loan. This measure yields more planning reliability for the SFs. 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. In order to safeguard financial stability of the SHI/ SLCI in the long run, however, structural reforms on the financing side have to be performed. This will be an important task for the next Federal Government.

Regarding social pension insurance it was already mentioned above that the Government has declared to protect pensioners from the impact of an absolute reduction in (average gross) earnings on individual pension benefits (as a result of the pension indexation formula) by integrating an additional element into the formula. Whether such a negative earnings development in 2009 will actually take place and would affect the pension adjustment rate will only be known in March or April of 2010, when statistical data regarding the development of earnings in 2009 will be available. There are up to now different assumptions regarding earnings development by research institutes and by the Government. The Government assumes that there will be no such negative development, however, they quite recently decided (May 2009) – i.e. some months before parliamentary election – upon a protective measure, not only for 2010, but as a general rule for the future, which ensures that, in fact, there will be no reduction of pension benefits in absolute terms. This decision will hopefully act as a stimulus and trigger a (very much required) relaunch of the debate on the pension formula.

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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.

[R1] BUNDESMINISTERIUM FÜR ARBEIT UND SOZIALES (2008), Rentenversicherungsbericht 2008

(Yearly)Report on pensions by the Federal Ministry

The report is focused in particular on the financing situation of SPI and gives model calculations for medium term and for the next 15 years. These projections show that the target values for the contribution rate as well as the pension level (before tax) will be fulfilled.

[R1] BUNDESREGIERUNG, Vierter Versorgungsbericht, Berlin (8 April 2009) *Fourth report on provision of pensions for civil servants*

In April 2009 the Government published its 4th report (to be presented every 4 years) on pensions for civil servants and its future development as well as for supplementary pensions for employees in the public sector that are covered by SPI.

[R1] DEUTSCHE BUNDESBANK, Perspektiven der gesetzlichen Rentenversicherung in Deutschland, Monatsbericht April 2008, S. 51-76

Perspectives for SPI

Mentions among others that in times of further increase of life expectancy a additional increase of the retirement ages may be adequate.

[R2] EHLER, J./FROMMERT, D. (2009): Für eine Pflichtversicherung bei Selbstständigkeit ohne obligatorische Alterssicherung, in: Deutsche Rentenversicherung, S. 36-57

In favour of mandatory coverage of self employed
It is argued that such a mandatory coverage should be within the SPI scheme.

[R2] Erwerbstätigenversicherung: Rente mit Zukunft. Gemeinsames Konzept des Sozialverbandes Deutschland, des Deutschen Gewerkschaftsbundes, der Volkssolidarität Bundesverband, Berlin 2007

Proposals for a comprehensive coverage of the total working population

[R2] PROGNOS (2008), Fortentwicklung der gesetzlichen Rentenversicherung zu einer Erwerbstätigenversicherung (Studie im Auftrag der Hans –Böckler-Stiftung), Basel, Oct. 2008 „*Further development of the statutory pension insurance towards an insurance for all employees“*

Presents data and calculations for extending coverage.

[R2] SACHVERSTÄNDIGENRAT ZUR BEGUTACHTUNG DER GESAMTWIRTSCHAFTLICHEN ENTWICKLUNG, Jahresgutachten 2008/09 (published Nov. 11, 2008)

Council of Experts to review economic development: Yearly advisory opinion

Discussion of possibilities to introduce equal rules for pension calculation in East and West Germany

[R2] TNSINFRATEST (2008): Situation und Entwicklung der betrieblichen Altersversorgung in Privatwirtschaft und öffentlichem Dienst 2001-2007 – Endbericht -, München *Report on the situation and development of occupational pensions in the private and public sector*

This report gives a broad overview and detailed on the results of surveys on the coverage of occupational pensions carried out by TNS infratest on behalf of the German Ministry of Labour between 2001 and 2007. The survey relies different sources (survey among private employers, data collection in pension funds, life insurance companies and administrative data). A follow-up survey for 2008 is under way.

[R4] DIETZ, M. et al., <<Jüngste Arbeitsmarktreformen: Schöne Aussichten für ältere Arbeitnehmer?>>, IAB-Forum 1/08, pp. 70-75

Most recent reforms on the labour market for elderly workers

[R4] WALTERMANN, Raimund (2008): <<Alternde Arbeitswelt – Welche arbeits- und sozialrechtlichen Regelungen empfehlen sich?>>, in: NJW, H.34, 2008

What should be proposed in labour and social law in the light of an ageing workforce?

[R5] RIEDMÜLLER, Barbara & WILLERT, Michaela (2008): <<Die Zukunft der Alterssicherung. Analyse und Dokumentation der Datengrundlagen aktueller Rentenpolitik>>, Hans Böckler Stiftung

Analysis of official statistics and reports regarding income of the elderly

[R5] BUNDESMINISTERIUM FÜR ARBEIT UND SOZIALES (2008), <<Alterssicherungsbericht 2008>>

"Report on old age security" by the federal ministry (every four years)

Giving an overview of the different tiers and presents model calculations for replacement rates

[R5] JÄGER, Klaus (2008): <<Wer profitiert von den staatlichen Subventionen der Riester-Rente?>> Versicherungswirtschaft , p. 1874ff

"Who gains from susidies for Riester-pension?"

Analysis for one life insurance company at what age a contributor will at least receive as much pension benefits as the sum of his contribution payments

[R5] SCHMÄHL, Winfried <<Die Gefahr steigender Altersarmut in Deutschland – Gründe und Vorschläge zur Armutsvermeidung>>, in: Antje Richter u. a. (eds.), Dünne-Rente – Dicke Probleme, Frankfurt a. M. 2008, pp. 37-58

"The risk of increasing poverty in old age"

Debates the effects of recent pension reforms and underlines its important consequences fort he pension scheme itself, the increase of income inequality and of poverty in old age.

[R5] Ulrich STOLZ, Christian RIECKHOFF, Förderung der zusätzlichen Altersvorsorge für das Beitragsjahr 2005 durch die ZfA, in: RVaktuell 9/2008
"Subsidies for private pensions in 2005"

Gives statistical information.

[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

[H1-H7] ADVISORY COUNCIL ON THE ASSESSMENT OF DEVELOPMENTS IN THE HEALTH CARE SYSTEM; <<Cooperation and Responsibility – Prerequisites for target-oriented Health Care>>, Report for 2007, 2007

In addition to cooperation between the health care professions, the 2007 report focuses on integrated health care, the hospital system, the quality and safety of health care, and primary prevention in vulnerable groups. The Council thus fulfils its mandate formulated in Section 142 Para. 2 of Book V of the German Social Security Code (SGB V), i.e. to identify priorities for the elimination of health care deficits and existing overuse, as well as ways and meansof further developing the health care sector, taking into account the financial frameworkconditions and existing efficiency reserves.

[H3] AUGURZKY, Boris and TAUCHMANN, Harald, <<Less Social Health Insurance – More Private Supplementary Insurance?>>, Ruhr Economic Papers, no. 46, May 2008

This paper uses individual level data to analyse the effect of changes in the compulsory benefit package of the German statutory health insurance scheme on the demand for private supplementary insurance. In particular, the authors aim at measuring the effect of excluding dentures from the benefit package in 1997 as well as the effect of re-including them in 1999.Adifference-in-differences estimator is used. Individuals born prior to 1979 serve as control group because only the young were affected by the reform. Their results do not exhibit any significant effects on the demand for supplementary health insurance. Thus, the hypothesis that clients do make informed choices about their health insurances' coverage is not supported.

[H1] AUGURZKY, Boris; TAUCHMANN, Harald; WERBLOW, Andreas; FELDER, Stefan; <<Effizienzreserven im Gesundheitswesen>>, RWI Materialien Heft 49, January 2009, expertise by order of *Initiaitive Neue Soziale Marktwirtschaft (INSM)*
„Efficiency reserves in the health care system"

The authors of this empirical study conclude that the SHI could save up to EUR 9.8 billion p.a. if all efficiency reserves were used.

[H5] WISSENSCHAFTLICHR BEIRAT BEIM BUNDESMINISTERIUM FUER WIRTSCHAFT UND TECHNOLOGIE; <<Mehr Wettbewerb im System der gesetzlichen Krankenversicherung>>, in: Dokumentation Nr. 556, editor: Bundesministerium fuer Wirtschaft und Technologie, 2006

„More competition in the statutory health insurance"

This paper presents reform options regarding the SHI. It mainly advocates more price competition between sickness funds, more selective contracting, and lower hurdles for sickness fund members to switch to another sickness fund.

[H4] CASSEL, Dieter; EBSEN, Ingwer; GREß, Stefan; JACOBS, Klaus; SCHULZE, Sabine; WASEM, Juergen*;* <<Weiterentwicklung des Vertragswettbewerbs in der gesetzlichen Krankenversicherung - Vorschläge für kurzfristig umsetzbare Reformschritte>>; expertise by order of the WIdO, July 2006

„Further development of contract competition in the statutory health insurance"

This expertise presents reform options regarding the SHI contract competition (Vertragswettbewerb). It discusses selective contracting in Germany and presents reform options that can be realised immediately.

[H6] INSTITUT FUER GESUNDHEITS- UND SOZIALFORSCHUNG (IGES); CASSEL, Dieter; WILLE, Eberhard; WISSENSCHAFTLICHES INSTITUT DER AOK (WIdO); <<Steuerung der Arzneimittelausgaben und Stärkung des Forschungsstandortes für die pharmazeutische Industrie>>; expertise by order of the Federal Ministry of Health; June 2006

This expertise includes an empirical analysis of the evolution of pharmaceutical costs of the SHI, an analysis of the impact of legal regulations on the pharmaceutical market, an empirical review of the pharmaceutical research activities; and a regulatory assessment of the pricing mechanisms in the SHI pharmaceutical market

[H1] RÜRUP, Bert; INSTITUT FUER GESUNDHEITS- UND SOZIALFORSCHUNG (IGES); DIW ECON; WILLE, Eberhard; <<Effizientere und leistungsfähigere Gesundheitsversorgung als Beitrag für eine tragfähige Finanzpolitik in Deutschland>>; expertise by order of the Federal Ministry of Finance; publication in the near future

The expertise examines how the competition and antitrust regulations in the health care sector can be applied in order to reduce potential inefficiencies. Hereby, the emphasis lies on the competition between the care providers. Furthermore, it discusses the potential repercussions arising from the application of competition law and antitrust law on the scope of the sickness funds.

[H1] RÜRUP, Bert; WILLE, Eberhard; <<Finanzielle Effekte des vorgesehenen Gesundheitsfonds auf die Bundesländer>>; expertise by order of the Ministry of Health; January 2007

The expertise analyses the monetary impact of the introduction of the national health fund on the regional (at the Länder *level) distribution of financial recources. The authors hereby forecast that the disadvantages for Hessen, Baden-Württemberg and Bavaria are less severe than expected in the past.*

[H5] BERTESLMANN STIFTUNG; << Gesundheitsmonitors der Bertelsmann Stiftung. Neue Versorgungs- und Versicherungsformen in der GKV: Wer kennt sie und wer nutzt sie?>>; Gesundheitsmonitor 2 2007; 2007

The article describes the new methods of treatment and insurance schemes in the SHI which came along with the GKV-Modernisierungsgesetz. Furhtermore, it studies and illustrates the policyholders' awareness and use of these new possibilities.

[H3] SCHWIERZ, Christoph; AUGURZKY, Boris; FOCKE, Axel; WASEM, Jürgen; << Demand, Selection and Patient Outcomes in German Acute Care Hospitals>>, Ruhr Economic Papers, no. 74, October 2008

In times of peak demand hospitals may fail to deliver the high standard of treatment quality that they are able to offer their patients at regular times. To assess the magnitude of these effects, this study analyzes the effects of low staff-to-patients ratios on patient outcomes empirically. The authors use the variation of patient admissions over time as a proxy for varying staff level. Further, they control for within diagnosis unobservable variation in severity across days with as opposed to days without excess demand. They find that when this variation is ignored in the regression framework, the effect of demand on outcomes is biased upwards. The reason is that when demand is high more patients with a higher unobservable frailty are admitted to the hospitals. After having controlled for this selection of patients, excess demand does not negatively affect patient outcomes.

[H1] WASEM, Jürgen; BUCHNER, Florian; WILLE; Eberhard; <<Umsetzung und empirische Abschätzung der Übergangsregelungen zur Einführung des Gesundheitsfonds (§ 272 SGB V); expertise by order of the Federal Government; April 2008

The expertise gives an empirical estimation of the impact of the transition rules affecting the introduction of the new national health fund (§ 272 Social Code Book V).

[L] Long-term care

[L] DEUTSCHE BANK RESEARCH; <<Deutsche Pflegeversicherung vor massiven Herausforderungen>>; Demografie Spezial, Aktuelle Themen 442; March 2009

This paper gives an overview about the challenges the SLCI is confronted with. Furthermore, the authors estimate the likely consequences on the contribution rate for the SLCI. They conclude that the contribution rate will rise from 1.95% today to at least 3% in 2050 or at most up to 7 %. At the end of the paper, propositions for more efficiency and more intergenerational justice regarding the financing system are presented.

[L] WILLE, Eberhard; IGEL, Christian; <<Die soziale Pflegeversicherung: ein Pflegefall?>>, Mannheimer Vorträge zur Versicherungswirtschaft, February 2007

The article gives an overview about the characteristics and the development of the Social long-term care insurance in Germany. Furthermore, it reveals the main differences between SHI and SLCI. Additionally, it contains a forecast of the development of revenues and expenditures and concludes with reform options for the SLCI.

5 List of 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 co-operation 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.

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.