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Preface

In Germany, as in many other developed countries, social security systems are experiencing an era of change. Recent reforms are no longer restricted to mere adaptations, but entail structural changes, especially changes based on privatisation and reorganisation. This process is partly due to internal factors, above all to demographic processes that lead to an aging and shrinking of society. And it is partly the result of external factors, namely the emergence of an European single market and the intensified international exchange of economic factors.

It is still disputable whether this process of reform will affect the core of existing social security systems. A few steps have been taken, others are still required. In this particular situation, it is of utmost interest to gain an overview on the existing systems and how they are being influenced by recent legislative measures.

The following reports aim at informing the English-speaking world about the status quo of, and recent developments in, three branches of German social security: health insurance, long-term care insurance, and pension insurance. The papers were originally written within the framework of a joint German-Japanese project that sought to find out whether, and to what extent, national politics respond differently to comparable demographic changes as far as social security is concerned.

We would like to take this opportunity to express again our thanks for the support we received in carrying through this project, namely to the Univers Foundation and the Institute for Health Economics and Policy, Tokyo.

Ulrich Becker August 2007

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Health insurance

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A. Solidarity, Financing and Personal Coverage

I. Background: The concept of solidarity and social security systems

1. General remarks

Proceeding from the solidary obligation under Roman Law (*obligatio in solidum*[3]), the term "solidarity" evolved via French civil law (*solidarité*[4]) into a social buzzword in post-revolutionary France,[5] one that gradually came to replace the notion of *fraternité*, cultivated during the revolution.[6] The concept of solidarity finally found its way into German social philosophy and theory of the state[7] as a societal principle established by *Lorenz von Stein*[8]. A commitment to solidarity under Roman Law was based on an agreement (*stipulation*[9]) to stand by each other. In the later use of the term, the idea of standing by each other was increasingly detached from a previous declaration of intent: in Catholic social ethics, solidarity was founded on charity;[10] in social philosophy, reflecting the idea of the "nation as the great community in solidarity" (*Ernest Renan*), it rested on nationality.[11]

2. Solidarity and the German constitution

In Germany, the principle of solidarity[12] is in part recognized as a constitutional principle.[13] Given that the German constitution, i.e. the Basic Law [Grundgesetz – GG], does not explicitly mention the term solidarity, the solidarity principle is derived from the entire constitution, from the concept of humanity underlying the Basic Law, or from the social state principle – partly in conjunction with the guarantee of human dignity in

3 *Zimmermann*, The Law of Obligations – Roman Foundations of the Civilian Tradition, 1990, pp. 128 et sqq.

4 *Mauranges*, Sur l'Histoire de l'Idée de Solidarité, 1907, and *Bayertz*, Begriff und Problem der Solidarität, in: *Bayertz* (ed.), Solidarität – Begriff und Problem, 1998, pp. 11-53 (11 et sqq.).

5 *Brunot*, Histoire de la langue française, 1937, p. 669.

6 *Brunkhorst*, Solidarität – Von der Bürgerfreundschaft zur globalen Rechtsgenossenschaft, 2002, p. 9.

7 Detailed *Fiegle*, Von der Solidarité zur Solidarität – Ein französisch-deutscher Begriffstransfer, 2003.

8 See *von Stein*, Die Geschichte der sozialen Bewegung in Frankreich von 1789 bis auf unsere Tage, Vol. III, 1921 (reprint of the original edition of 1850).

9 *Ducos*, Rome et le droit, 1996, p. 108.

10 *Klüber*, Katholische Gesellschaftslehre, Vol. I: Geschichte und System, 1968 pp. 823 et sqq.

11 See also *Bourgeois*, Solidarität, 1896.

12 *Grimm*, in: *Herzog/Kunst/Schlaich/Schneemelcher* (eds.), Evangelisches Staatslexikon, Vol. II, 3rd ed., 1987, col. 3144-3147.

13 *Volkmann*, Solidarität – Programm und Prinzip der Verfassung, 1998, pp. 52 et sqq. and *Kingreen*, Sozialstaatsprinzip im europäischen Verfassungsverbund, 2003, pp. 253 et sqq.

Art. 1(1) GG.[14] The case law of the Federal Constitutional Court [Bundesverfassungsgericht – BVerfG][15] and the social law literature[16] proceed from a solidarity principle under social insurance law that is supposed to organize the natural[17] "solidarity of the citizens with the citizens" by way of redistribution[18]. Solidarity as a principle unfolds its effect under the insurance principle[19] and normally serves to explicate and legitimate social law modifications of civil insurance law, as well as interventions in the basic right of personal liberty under Art. 2(1) GG[20] that occur in social insurance in the form of attempts to rupture insurance-based global equivalence or the obligation to insure.[21]

3. Solidarity in Europe

Part II, Title IV of the Treaty establishing a Constitution for Europe bears the heading "Solidarity". Although this treaty has not been ratified (yet), the chapter also forms part of the EU Charter of Fundamental Rights, which is a mere declaration without legally binding force so far, but at least gives an impression of the common values accepted throughout the European Union.

In some national constitutions of Europe, solidarity is laid down as an express legal norm.[22] In Switzerland, Austria, Italy, Spain, France, Belgium and the Netherlands, the solidarity principle is at any rate invoked to establish and legitimate the institution of social insurance. The solidarity principle, thus the assumption, not only unites the majority of European national constitutions by their shared values, but at the same time constitutes a core principle governing the social insurance systems of Europe.[23]

Solidarity in a more specific sense also plays a role when it comes to the influence of economic basic freedoms (Art. 49 EC Treaty: free movement of services)[24] and of

14 See *Volkmann*, (note 13), pp. 217 et sqq.; for the derivation from the Social State principle, see *Holzer*, Die unterstaatliche Umverteilung – Umverteilung unter Umgehung der Verfassung?, 1977, p. 246, and critically *Becker*, Transfergerechtigkeit und Verfassung, 2001, p. 205.

15 BVerfGE 14, 312 (317); 22, 241 (253); 48, 346 (358); 66, 66 (76).

16 *Kirchhof*, Das Solidarprinzip im Sozialversicherungsbeitrag, in: Sozialfinanzverfassung, Schriftenreihe des Deutschen Sozialrechtsverbandes (SDSRV) – Vol. 35, 1992, p. 65 (pp. 72 et sqq.).

17 *Göbel/Eckart*, Grenzen der Solidarität, Solidaritätsformeln und Solidaritätsformen im Wandel, in: *Bayertz* (ed.), Solidarität – Begriff und Problem, 1998, pp. 463-494.

18 See *Zacher*, Das soziale Staatsziel, in: *Isensee/Kirchhof* (eds.), Handbuch des Staatsrechts – Vol. I, 1987, § 25, no. 85.

19 *Leisner*, Sozialversicherung und Privatversicherung, 1974, pp. 72 et sqq.

20 See *Kingreen*, (note 13), p. 178.

21 For the modifications of the insurance principle, see *Hase*, Versicherungsprinzip und sozialer Ausgleich, 2000.

22 Articolo 2, Costituzione della Repubblica italiana, Principi fondmentali: "La Repubblica riconosce e garantisce i diritti inviolabili dell'uomo, sia come singolo, sia nelle formazioni sociali ove si svolge la sua personalità, e richiede l'adempimento dei doveri inderogabili di *solidarietà* politica, economica e sociale." Or Arts. 2, 45, 156, 158 of the Spanish constitution.

23 *Kingreen*, (note 13), pp. 451 et sqq.

24 See ECJ, Case C-385/99 Müller-Fauré and van Riet [2003] E.C.R. I-4509; Case C-372/04 Watts of 2006 [n.y.r.].

European competition law (Arts. 81 and 82 EC Treaty) on national social security systems. According to the jurisprudence of the European Court of Justice, systems based on solidarity cannot be qualified as undertakings and thus are exempted from the application of competition law[25] – at least insofar as they serve to fulfill their legal tasks.[26]

4. Legal solidarity and social insurance

Solidarity, understood as a legally constituted community for the fulfillment of state-assumed responsibility, is the fundamental requirement for the inclusion of certain persons in specific situations of need and subject to specific risks. In social security law, the solidarity principle manifests itself in an interpersonal redistribution of risk-based burdens within the compulsorily insured community – possibly forming a community (in solidarity) distinguishable from society as a whole[27] (see also 3 (5)). The basis of this "compulsory solidarity" is the obvious need of social protection by socially weaker persons within a (here again: possibly otherwise homogeneous[28]) group of persons.

In this sense, legal (or: legally constituted) solidarity is based on:

- compulsory insurance;
- income-related contributions; and
- benefits not calculated according to contributions, but granted according to need.

II. A concise overview: The German health insurance system

1. Main features of the system

a) A short look back: History of German health insurance

The Health Insurance Act of 1883[29] extended compulsory insurance to almost all workers in industrial undertakings,[30] while the Accident Insurance Act of 1884[31] covered workers in the mining, shipyard, factory, roofing, quarry and well-building indus-

25 ECJ, joint Cases C-159/91 and C-160/91 Poucet et Pistre [1993] E.C.R. I-637; Case C-244/94 Fédération française des sociétés d'assurances [1995] E.C.R. I-4013; Case C-70/95 Sodemare [1997] E.C.R. I-3395; Case C-219/97 Drijvende Bokken [1999] E.C.R. I-6121; Cases C-180/98 to C-184/98 Pavlov [2000] E.C.R. I-6451; Case C-475/99 Glöckner und Landkreis Südwestpfalz [2001] E.C.R. I-8089; Case C-218/00 Cisal/INAIL, [2002] E.C.R. I-691.

26 See ECJ, Case C-136/00 Danner [2002] E.C.R. I-8147; CFI, Case T-319/99 Fenin [2002] E.C.R. II-357; Cases C-264/01, C-306/01, C-354/01, and C-355/01 AOK Bundesverband of 2004 [n.y.r.].

27 See *Rolfs*, Das Versicherungsprinzip im Sozialversicherungsrecht, 2000, pp. 208 et sqq.

28 *Isensee*, Umverteilung durch Sozialversicherungsbeiträge, 1973, pp. 49 et sqq.

29 Gesetz betreffend die Krankenversicherung der Arbeiter [Law on the health insurance of workers] (KVG), dated 15.6.1883, RGBl. 1983, p. 73.

30 This of course should not belie the fact that the law initially benefited only about one-fifth of the gainfully employed and not even one-tenth of the whole population. In particular, workers' family members were not co-insured. Cf. *Hentschel*, Geschichte der deutschen Sozialpolitik, 1983, p.12.

31 Unfallversicherungsgesetz (UVG) dated 6.7.1884 (RGBl. 1884, 69-112).

tries[32]. Still in the eighties of the penultimate century, the group of insured persons was expanded under a series of amendment and extension laws.[33] These laws successively included workers of transport enterprises and of navy and army administration,[34] those engaged in agriculture and forestry,[35] and in building construction,[36] as well as seamen and shipping workers[37]. Further amendments to health insurance law[38] followed a short time later, in 1892, 1900 and 1903, thus again enlarging the group of insurants.

This first phase of social insurance consolidation was followed by the extension of risk coverage to include even more persons. Protection was thus afforded to certain, not yet covered occupational groups, but also to unemployed persons and non-employed family members under family assistance in health insurance.[39] Despite the creation of the Reich Insurance Code [Reichsversicherungsordnung – RVO] in 1911,[40] the individual insurance branches were not unified.[41] In all branches, the insurance obligation for salaried employees remained restricted to an upper earnings limit (health insurance: 2,500 Reichsmark; accident insurance: RM 5,000; invalidity insurance: RM 2,000).

Although the German social insurance system initially played a pioneering role, after which its progress remained in line with developments observed in other European states,[42] it appreciably began to lag behind these developments, especially after World War II. Thus, in other countries, the consequences of the war triggered a phase of overall social solidarization, even in those that did not already have a universalistic system of coverage.[43] For instance, this occurred in France by appealing to national solidarity[44] or in Great Britain through the introduction of the NHS.[45] These movements were no

32 Cf. *Stier-Somlo*, Deutsche Sozialgesetzgebung, 1906, p. 67.

33 Under the laws dated 28.8.1885 (RGBl. 1885, 159) and 5.5.1886 (RGBl. 1886, 132) on the extension of health and accident insurance.

34 Under the law dated 28.6.1885 (note 33). The law on the extension of accident insurance, dated 15.3.1886 (RGBl. 1886, 53), then concerned the welfare assistance granted as a consequence of occupational accidents sustained by civil servants and members of the military.

35 Under the law dated 5.5.1886 (note 33), employees in agriculture and forestry were included in the accident insurance scheme, whereas they were not covered by health insurance until 1911.

36 Law dated 11.6.1887 concerning accident insurance for construction workers (RGBl. 1887, 287).

37 Law dated 13.7.1887 on the extension of accident insurance (RGBl. 1887, 329).

38 Under the amending law dated 10.4.1892 (RGBl. 1892, 379), the law dated 30.6.1900 (RGBl. 1900, 332) and the law dated 25.5.1903 (RGBl. 1903, 233).

39 Regarding the initial possibility for inclusion on the basis of bye-laws, cf. *Peters*, Die Geschichte der sozialen Versicherung, 1978, p. 57.

40 The Reichsversicherungsordnung, dated 19.7.1911 (RGBl. 1911, 509), consolidated the three main pillars of social insurance.

41 Nevertheless, on the approximation of persons covered under health insurance and invalidity insurance, respectively, cf. *Manes/Mentzel/Schulz*, RVO, 2nd Vol., 1912, pp. 16 et seq. These persons, moreover, were now defined according to their occupations, but no longer according to their affiliation with certain enterprises.

42 Cf. *Alber*, Vom Armenhaus zum Wohlfahrtsstaat, 1987, pp. 48 et sqq.

43 Cf. also *Becker*, Staat und autonome Träger im Sozialleistungsrecht, 1996, pp. 107 et seq.

44 Article L 111-1 CSS « L'organisation de la sécurité sociale est fondée sur le principe de solidarité nationale » (JO No. 172 dated 28.7.1999).

45 Introduced under the National Health Service Act (1946).

longer due alone to political class struggle,[46] yet neither in France nor in Italy did they lead to a renunciation of the high degree of organizational fragmentation inherent in their protection systems.[47] At the same time, the configuration of German social insurance remained unchanged, along with its aforementioned restrictions. That, too, is attributable to a politically unique situation, namely Germany's division. After overcoming the early difficulties of reconstruction, this partition led to an emphasis of extremes and made it seem unlikely that an implementation of the standard protection introduced in the East[48] could be enforced.[49]

b) The main principles (or features)

As mentioned, most of the traditional features introduced by the so-called Bismarckian social insurance legislation are still intact today. Of course, there have been changes: While the main task of health insurance was originally to pay sickness benefits, its prime function now is to provide medical treatment. And the way in which the actual provision of benefits is organized and regulated was formed during the first half of the 20th century.

The most prominent and important features of German statutory health insurance are:

- employment-based coverage: the insured population mainly consists of employees (although there is an upper earnings insurance limit, and civil servants have their own system of state-financed reimbursements);
- contribution-based financing (see in detail below, 2 (3) and 3);
- provision of benefits in kind,[50] albeit not by the sickness funds[51] but by independent providers (hospitals, practitioners), the reimbursement of costs to patients being the exception[52];
- administration by different types of self-governed sickness funds, with their own legal personality (see below, 3 (2));
- mix of the public and the private sector (see below, 3 (5)).

46 Cf. above all *Alber*, Vom Armenhaus zum Wohlfahrtsstaat, 1987, p. 164.

47 Cf. *Becker*, Staat und autonome Träger im Sozialleistungsrecht, 1996, pp. 231 et sqq. (France) and 315 et sqq. (Italy).

48 *Ebsen*/*Knieps*, Sozialrechtshandbuch, 2003, C. 14, para. 8; on social protection in the former German Democratic Republic, cf. *Schmidt*, Grundlagen der Sozialpolitik in der Deutschen Demokratischen Republik, in: *Zacher* (ed.), Grundlagen der Sozialpolitik, 2001, pp. 685, 706 and 708.

49 *Stolleis*, Geschichte des Sozialrechts in Deutschland, 2003, pp. 260 et sqq.

50 §§ 2, 11 SGB V.

51 See also § 140 SGB V.

52 See § 13 SGB V.

2. Legal framework

a) Sources of law

aa) Since 1989, statutory health insurance has been laid down in the Social Code V (SGB V), a statute of parliament[53] which partly replaced the RVO.

bb) To be stressed here is that the adaptation of health insurance law cannot be left to the legislator only, as parliamentary procedures will often be too slow and too complicated to ensure quick legal responses. Thus, in most countries, the regulation of the more intricate details is an administrative task that is mostly accomplished via statutory instruments (or regulations). In Germany, another option for dealing with this issue has been implemented. Health insurance management is organized through corporative arrangements (corporatism) under the so-called system of joint self-government [gemeinsame Selbstverwaltung]. An administrative body referred to as the Federal Joint Committee [Gemeinsamer Bundesausschuss] brings together the representatives of sickness funds and providers. Its administrative acts – so-called directives [Richtlinien] – have, according to the jurisprudence of the Federal Social Court, the same force as legal acts.

b) Constitutional background

aa) In Germany, legislative actions are subject to constitutional limitations. Nearly all extensive reforms are reviewed by the BVerfG sooner or later. This is because in Germany access to such constitutional controls has been opened on a wide scale: both via objective procedures such as judicial review of the constitutionality of statutes or administrative acts, and via constitutional complaints which serve to enforce individual constitutional rights embodied in the Basic Law (cf. Art. 93 GG).

bb) In the area of social law, however, the BVerfG seems to have adopted a more cautious stance in recent years. The Basic Law does not acknowledge any fundamental social rights (with but a few narrowly construed exceptions).[54] This is because the constitutional legislators were skeptical of programmatic declarations, at least of those in the form of individual rights. Nonetheless, Art. 20(1) GG deems Germany a "social federal state". This social state principle obliges the legislator on a very fundamental and general basis[55] to configure the legal order in a way that is social – or more precisely, that is also social. Within this meaning, despite all conceptual ambiguity, it is the state's duty to secure decent human existence, to abolish social inequality and to create oppor-

53 Gesundheitsreformgesetz (GRG) dated 20.12.1988 (BGBl. I, p. 2477).

54 See for this category of basic rights *Illiopoulos-Strangas* (ed.), La protection des droits sociaux fondamentaux dans les Etats membres de l' Union europeénne – Etude de droit comparé, 2000.

55 For fundamental remarks on Art. 20(1) GG as a provision governing a state objective, cf. *H.P. Ipsen*, Über das Grundgesetz, 2nd ed. 1964, p. 14; *id.*, Über das Grundgesetz nach 25 Jahren, DÖV 1974, pp. 289, 294 et sqq.; on its content *Scheuner*, Staatszielbestimmungen, in: FS für Forsthoff, 1972, pp. 325 et sqq.

tunities for participation.[56] The duty to avoid social disadvantages thus coincides with the duty to provide for the consequences of social risk occurrence ("vicissitudes of life").[57] Yet this still largely leaves open how social security is to be configured.[58]

Moreover, the basic rights place a number of limits on potential reforms. The guarantee of human dignity (Art. 1(1) GG) thus obliges the legislator to secure an economic subsistence minimum for all inhabitants. The protection of property and of confidence in respect of benefit rights acquired through contributions is inferred from Art. 14(1) GG. In addition, social law also abides by the principle of equal treatment, meaning that any favorable or detrimental amendments must be distributed justly among all those concerned.

cc) The provisions of constitutional law leave a wide margin of constitutive action open to the legislator. It is for this reason that the constitutional complaint brought before the BVerfG by an insurant concerning the limitation of dental prosthesis benefits under the Act to Strengthen Solidarity in Statutory Health Insurance [GKV-Solidaritätsstärkungsgesetz] remained unsuccessful.[59] Nevertheless, a once established compulsory system such as that of statutory health insurance is subject to a lower limit for determining the necessary level of care. Thus, in a remarkable judgment delivered only recently,[60] the BVerfG demands that at least in the event of life-threatening illnesses, all potentially effective benefits must be delivered.[61] Apart from the social state principle, this line of reasoning is attributed to the state obligation to protect "life and physical integrity" (Art. 2(2) GG).

III. Financial burdens and redistribution

1. Introduction

What is there to know (and say) about re-distributive effects? We must largely rely on estimates and theoretical assumptions here because inter-personal and intra-personal equalizations are hard to quantify and depend substantially on individual vocational

56 Cf. more detailed *Zacher*, Das soziale Staatsziel, HStR Vol. 1, 1987, § 25, paras. 27 et sqq.

57 On this citation BVerfGE 28, 324, 375; on accident insurance coverage BVerfGE 45, 376, 387; on sickness insurance BVerfGE 68, 193, 209; on unemployment insurance BVerfGE 51, 115, 125; and on private long-term care insurance BVerfGE 103, 197, 221.

58 On the obligation to cover a basic level of need, cf. *Wannagat*, Lehrbuch des Sozialversicherungsrechts, 1965, Vol. I, p. 224; regarding the current discussion, cf. also *Jäger*, Die Reformen in der gesetzlichen Sozialversicherung im Spiegel der Rechtsprechung des Bundesverfassungsgerichts, NZS 2003, pp. 22 et sqq.

59 BVerfG (Chamber) dated 9.7.2004, 1 BvR 258/04 (under http://www.bverfg.de).

60 See for a critique *Kingreen*, Verfassungsrechtliche Grenzen der Rechtsetzungsbefugnis des Gemeinsamen Bundesausschusses im Gesundheitsrecht, NJW 2006, pp. 877 et seq.; *Huster*, Verfassungsunmittelbarer Leistungsanspruch gegen die gesetzliche Krankenversicherung?, JZ 2006, pp. 466 et seq.

61 BVerfG dated 6.12.2005, 1 BvR 347/98 (under http://www.bverfg.de).

careers. A particular problem impeding the quantifiability of redistribution is that longitudinal comparisons are scarcely possible.[62]

Nevertheless, we would like to give some background information in the form of data on the expenditure of the German health care system (see Tables 1-6).

Table 1: Total health expenditure, 2004

2004 Figures (in m €)	Payers								
	Tax-funded public budgets	Statutory health insurance	Social long-term care insurance	Statutory pension/ retirement insurance	Statutory accident insurance	Private health insurance	Employers	Private households and organizations	Total
Health expenditure total	14,535	131,564	17,587	3,491	3,944	21,112	9,678	32,073	233,983
Investments	5,942	149	0	170	18	158	0	2,605	9,042
Recurrent health expenditure	8,592	131,415	17,587	3,321	3,927	20,954	9,678	29,468	224,941
Prevention/ health protection	2,265	3,513	270	191	943	137	659	1,170	9,148
General health protection	1,392	0	0	0	836	0	0	0	2,228
Health promotion	822	2,091	0	7	23	33	590	1,155	4,721
Early detection/ screening	5	1,074	0	0	0	88	69	15	1,250
Assessment and coordination	46	347	270	184	84	16	1	1	950
Physicians' services	801	42,887	0	575	764	8,989	4,339	5,423	63,779
Nursing/ therapeutic services	3,566	26,023	16,400	1,085	748	2,726	1,700	4,631	56,879
Nursing services	2,969	17,781	16,400	291	491	1,652	1,170	3,001	43,755
Therapeutic services	588	7,647	0	794	257	1,051	517	1,622	12,476
Maternity care	9	595	0	0	0	23	13	8	649
Accommodation/ nutrition	1,224	8,243	0	965	190	1,088	659	5,071	17,440
Goods	660	39,796	306	127	481	4,377	2,247	13,086	61,080
Transport	74	3,056	0	90	154	164	75	86	3,699
Administration	1	7,897	610	287	647	3,473	0	0	12,914
Education	1,789	34	14	0	0	0	0	0	1,837
Research	2,634	7	0	17	0	0	0	0	2,658
Compensation for disabilities, etc.	12,564	342	0	738	229	0	3	1,744	15,620
Income (sick pay, etc.)	2,632	7,049	0	16,468	3,548	1,348	28,016	0	59,060
Total	34,154	138,996	17,601	20,714	7,721	22,460	37,697	33,817	313,158

Source: Federal Statistical Office, Health Expenditure, Wiesbaden 2006.

Explanation to Table 1

In Germany, it is important to differentiate between (1) "health expenditure" as defined and measured by the Federal Statistical Office in accordance with the OECD system of health accounts and (2) expenditure defrayed by the various statutory payers, i.e. especially statutory health insurance (SHI). Compared with the latter, the former (which was reappraised in 2006) notably excludes cash benefits, e.g. sick pay, but also certain expenditure appropriations for education (e.g. allowances for hospitals which maintain nursing schools) and research.

Table 1 illustrates this matrix structure, based on 2004 figures. Of the total health expenditure of € 233,983 million, € 131,564 million (56.2%) was financed by SHI. On the other hand, total SHI expenditure was € 138,996 million, including expenditure on education, training, sick pay, etc. This difference has to be kept in mind when looking at the figures in Table 1.

62 See *Leber*, Risikostrukturausgleich in der gesetzlichen Krankenversicherung, 1991, pp. 80 et sqq.

For the total and insurant-group-related SHI expenditure in Germany, see Tables 2 to 4. Different connecting factors are total expenditure, groups of insured, kinds of benefit, or age.

Table 2: Total SHI expenditure *according to national health accounts definition (i.e. without sick pay, etc.)*

	Total expenditure (in m €)	Thereof: administrative expenditure (in m €)	Share of administrative expenditure (in %)
1995	112,474	6,340	5.64
1996	116,143	6,324	5.45
1997	115,178	6,211	5.39
1998	117,734	6,534	5.55
1999	121,166	6,877	5.68
2000	123,914	6,961	5.62
2001	128,399	7,293	5.68
2002	132,935	7,746	5.83
2003	135,583	7,877	5.81
2004	131,564	7,897	6.00

Source: Federal Statistical Office, Health Expenditure, Wiesbaden 2006.

Table 3: SHI expenditure *according internal financial accounts, 2005 (i.e. including sick pay, etc.)*

	Absolute figures (in 1,000 €)
Hospital treatment	48,959,062
Ambulatory medical treatment	23,095,910
Dental treatment	7,494,501
Dental prostheses	2,433,934
Pharmaceuticals	25,358,432
Non-physician care and medical aids	8,283,644
Sickness benefits	5,867,753
Provident provision and rehab	2,376,192
Social services, prevention, self-help	1,213,467
Other	9,762,609
Total	134,845,504
Other expenditure (without risk structure compensation + risk pool)	808,169
Administrative expenditure	8,155,225
Total expenditure (without risk structure compensation + risk pool)	143,808,898

Source: Ministry of Health, http://www.bmg.bund.de.

Table 4: Healthcare cost shares according to age, 2004

Age	Share of the population (in %)	Share of healthcare costs (in %)
Under 15	14.6	6.0
15 - 30	17.4	7.4
30 - 45	23.7	13.4
45 - 65	26.0	27.8
65 - 85	16.6	36.3
85 and above	1.7	9.1

Source: www.sozialpolitik-aktuell.de.

Health insurance revenue consists of contributions to SHI and tax money. For the different kinds of SHI revenue in Germany (total revenue, member contributions, pensioner contributions and other revenue) and the amounts paid, see Table 5.

Table 5: SHI revenue in Germany (in bn €)

	Total revenue	Member contributions	Pensioner contributions	Other revenue (including tax money)
1995	120.4	94.4	21.5	4.5
1996	124.4	98.1	21.9	4.4
1997	126.2	99.5	22.9	3.8
1998	127.8	100.6	23.6	3.5
1999	131.2	103.3	24.2	3.7
2000	133.8	105.4	24.6	3.8
2001	135.8	106.9	25.0	3.9
2002	139.7	108.4	27.9	3.5
2003	140.8	107.6	29.9	3.3
2004	142.5	106.0	32.3	4.2

Source: Statistisches Taschenbuch Gesundheit, 2005.

Table 6: Public- and private-sector healthcare financing in Germany (in m €)

Third-party payer	2002	2003	2004
Statutory health insurance	132,935	135,583	131,564
Private health insurance	19,453	20,438	21,112

Source: Statistisches Bundesamt, 2006.

2. Sharing of costs between sickness funds

a) Competition, financial autonomy and state regulation of benefit provision

aa) German health insurance bears a remarkable organizational feature not encountered in any other European state: it acknowledges seven different types of sickness funds as third-party payer institutions – which is why it is referred to as a "structured system" [gegliedertes System]. Leaving aside the three special institutions for agriculture, mining and seamen[63], four fund types remain: the AOKs [Allgemeine Ortskrankenkassen], which were previously only one form of local sickness fund; the company-based sickness funds [Betriebskrankenkassen – BKKs]; the guild sickness funds [Innungskrankenkassen – IKKs]; and the substitute funds [Ersatzkassen], whose distinction between blue and white collar workers is of little significance today.[64]

This structural division into fund types can only be explained historically. Back in 1883, with the enactment of the Health Insurance Act,[65] a network of local sickness funds was established.[66] Early company-based sickness funds were set up as factory funds, even prior to the introduction of statutory health insurance, and have been in place as statutory funds since the 1883 Health Insurance Act.[67] Guild sickness funds, dating from medieval trade guilds, upheld the tradition of rendering mutual aid and protection to their members. After entry into force of the 1883 Health Insurance Act, however, they were for a while without legal personality owing to trade law provisions.[68] That changed with the enactment of the RVO. And finally, substitute funds were originally self-help organizations under private law; most of these funds that still exist today had been founded as registered assistance funds by 1911. During National Socialist rule, they were given the status of statutory corporations.[69] Under the Healthcare Reform Act (GRG)[70] of 1989, substitute funds were, in all major respects, placed on an equal footing with the other fund types.[71]

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63 They are entrusted with the administration of "integrated special systems" [*integrierte Sondersysteme*] that take account of the particularities of the respective groups of insurants. This model is also historically embedded in other EU member states, e.g. in French health insurance.

64 §§ 143 et sqq. SGB V.

65 See note 28.

66 Cf. *J. Hahn*, Krankenversicherungsgesetz, 6th ed. 1909, p. 134: "The establishment of local sickness funds, such as municipal health insurance [*Gemeinde-Krankenversicherung*], is a municipal affair. The municipality thus confers its healthcare obligation on the corporately organized funds."

67 They were incorporated into the law because their former legal position as assistance funds did not seem sufficient as regards the dependence of insurant attributes on the specific employment relationship; cf. *Rasp/Meinel*, Kommentar zum KVG, 2nd ed. 1904, p. 243.

68 Cf. *Stier-Somlo*, Deutsche Sozialgesetzgebung, 1906, pp. 44 et sqq., 227.

69 12th AufbauVO dated 24.12.1935 (RGBl. I, p. 1537) as revised by the 15th AufbauVO dated 1.4.1937 (RGBl. I, p. 439).

70 See note 52.

71 Their equal status in terms of care provision by contracting physicians was not established until the adoption of the Structural Health Insurance Act (GSG, see note 75).

The idea behind the different fund types was that they furnished links to the competent insurance institutions. Hence, an occupational link existed for craftsmen in guild sickness funds and for employees in company-based sickness funds, provided these had been set up by the entrepreneur. The remaining insurants came under the competence of the local sickness funds. Substitute funds could be chosen by certain groups of insurants in place of the otherwise competent, so-called primary funds.[72] The Bismarckian health insurance system was thus based on small regional or socio-professionally defined solidarity-based communities. That also explains why a (differing) multiplicity of individual funds, each having a separate legal personality, exists within the four fund types.

In this way, a wide statutory distribution of competence evolved. And because the individual funds were financially autonomous, i.e. could define their own contribution rates within the scope of statutory provisions and under state supervision, the contribution burden became highly differentiated in the course of time.[73] Such differentiation could no longer be adequately explained by the ostensible homogeneity of members insured with an individual fund, so that its justification in light of the constitutional precept of equal treatment (Art. 3(1) GG) had become more than doubtful. Although the BVerfG confirmed the constitutionality of contribution rate differences, thereby referring to the organizational model of statutory health insurance, it dispensed with an extensive review because the legislature had remedied the situation through the enactment of the measures described in the following.[74]

bb) When the legislature introduced the Structural Health Insurance Act [Gesundheitsstrukturgesetz][75] at the end of 1992, providing free choice of sickness funds for insurants and risk structure compensation with effect from 1995/96, it took account of the organizational particularities of the structured system of statutory health insurance.[76] Initially, only little restructuring was necessary. The conventional distribution of competence – previously disrupted only by the limited options in respect of primary and substitute funds – was largely dissolved and replaced by a comprehensive right of choice for insurants. According to the latest amendment, insurants are bound by their choice of sickness fund for 18 months, whereupon they may opt for membership of an-

72 Options for compulsorily insured persons existed in principle only with respect to and from within the receptible substitute funds (§ 183 SGB V, former version) and, on an extended scale, for voluntarily insured persons (§ 185 SGB, former version). Regarding conflicts of competence between the funds under the former law and the obligation to refrain from specifically raising conflict, cf. *F. Kirchhof*, Rechtsstreit gegen die Sozialversicherten statt Wettbewerb zwischen den gesetzlichen Krankenkassen?, VSSR 1992, pp. 165, 174 et sqq.

73 In 1992, for instance, the federal average contribution rate set by the AOKs was 13.46% of earnings below the contribution assessment limit, whereas that of the BKKs was only 11.19%. In addition, regional differences had to be taken into account: in 1992, the highest contribution rate of a regional AOK was 16.8%, the lowest 10.9%; BKK rates ranged between 8.0% and 14.9%; cf. BArbBl. 10/1992, p. 119.

74 Cf. BVerfGE 89, 365, 376 et sqq.

75 GSG dated 21.12.1992 (BGBl. I, p. 2266).

76 Cf. also *Wiegand*, Der Wettbewerb in der Krankenversicherung aus sozialrechtlicher Sicht, BB 1995, p. 94 – alleging that competition is “innately” created.

other fund. As for the funds, they have been subject to the compulsory acceptance of new members, meaning they are not allowed to reject insurants.[77] Consequently, sickness funds can no longer rely on the insurance obligation for the de facto allocation of their members, but must make an effort at being "chosen". Certain exceptions remain, such as the fixed competence of vocationally oriented funds (the social security fund for seamen, the Federal Miners' Insurance Fund, and agricultural sickness funds pursuant to §§ 176, 177 SGB V and § 19 KVLG 1989), on the one hand, and savings clauses in favor of company-based and guild sickness funds, on the other (under § 173 II 1 No. 4, 2nd sent. SGB V).

Competition between sickness funds does not aim to regulate the demand for healthcare benefits and, hence, to contribute to optimum resource allocation. This would require – at least on assuming market mechanisms function that way in the health sector – that insurants were allowed to decide on the scope of benefits, by individually appraising their value, and then to select the best possible cost-benefit ratio to suit their personal needs. The actual aim, rather, is to improve efficiency and thus to mobilize rationalization opportunities within the existing insurance system. The disadvantage vis-à-vis centralized state benefit systems is that more competition is apt to impede steering mechanisms and produce the well-known moral hazard effect, which leads to resource mis-allocation.[78] The major advantage, however, is the – at least basic – connectivity between receipts and expenditures under separate budgets and, consequently, a higher degree of cost transparency.

cc) What are the results of fund competition on the basis of the experience gained in recent years, and what conclusions can be drawn from them?

(1) The total number of sickness funds has declined, from over 1,300 in 1992 to 253 in 2006. Even so, the consolidation process has by no means progressed to such an extent as to threaten the functioning of fund competition. On the contrary, the opened access to many company-based sickness funds has enlarged the number of funds open to choice. All insurants with a right of choice still have sufficient options available to them for all sickness fund types, although the trend toward larger-scale areas of competence is not to be overlooked.[79] There are plans to permit inter-fund amalgamation and, hence, to reduce the number of sickness funds.

(2) On an overall average, contribution rates declined by a good percentage point in the long-range comparison between 1991 and 2000. Since the introduction of the free choice of sickness funds, these rates have now stabilized at a slightly higher level, with only marginal fluctuations. The fact that insurants' total health insurance costs have not fallen must not, however, be equated with a failure of fund competition. These costs are mainly attributable to the high level of benefit expenditure, which in turn is impacted by

77 For details, see § 175 SGB V.

78 More generally, cf. also *Hauser*, Alternative Versicherungssysteme im Gesundheitswesen – ein Versuch lohnt sich, in: *id*. (ed.), Mehr Wettbewerb in der Krankenversicherung, 1984, pp. 7, 9.

79 Whether fund size helps to lower administrative costs (per member) is questionable; for a skeptical view, cf. *Mühlenkamp*, Größen- und Verbundvorteile in der Verwaltung der gesetzlichen Krankenversicherung, ZfB (Zeitschrift für Betriebswirtschaft) 1995, pp. 287 et sqq.

circumstances beyond the realm of competitive relations. It must be borne in mind here that competition between sickness funds applies only to administrative costs, but in no way influences benefit expenditure.

(3) When comparing the contribution rates set by the individual funds, these rates show an overall tendency toward the mean if grouped according to fund types. That is certainly a desired effect as it leads to a balancing of insurants' contribution burdens. Under competitive aspects, too, a trend in this direction poses no problems: a functioning risk adjustment system and the utilization of efficiency reserves would in any case entail a certain degree of approximation, albeit not leveling.[80]

(4) The aforementioned fact correlates with the rising number of statutory health insurance members who make use of their right of choice. Although the total number of changers was comparatively low in the early phase, it has now exceeded original expectations.[81] And when related to the individual funds, this figure has meanwhile reached a magnitude that is bound to have considerable consequences.[82] This development is reflected in the current discussion over the reconfiguration of the risk adjustment system.[83]

(5) Taking a look at administrative expenditures proves of particular interest to the appraisal of competitive effects. Those who thought these expenses would drop erred. One explanation for this could be that employers shifted personnel costs to the company-based sickness funds. But perhaps the rise in some of the funds' administration expenses can be explained more easily by their improved service offer and heightened competition.[84] In that case, however, competition – hailed an efficiency-generating instrument upon its introduction – would have turned out to be counter-productive. Yet a glance at administrative expenditures per member once again reveals an approximation between the fund types. In particular, the company-based sickness funds have "caught up" in this respect. The same holds true for the ratio of administrative expenditures to benefit expenditures. Especially when comparing the different funds, this ratio should not be neglected in accounting for processing and client service costs. In the final analysis, the available figures fail to answer the original question of why administrative expenditures are rising, nor do they indicate whether such a rise is assuming "explosive" dimensions.

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80 The latter has repeatedly been asserted and used as an argument for abolishing the risk adjustment system; on the related discussion, cf. *Cassel/Janßen*, GKV-Wettbewerb ohne Risikostrukturausgleich? Zur wettbewerbssichernden Funktion des RSA in der Gesetzlichen Krankenversicherung, in: *Knappe* (ed.), Wettbewerb in der Gesetzlichen Krankenversicherung, 1999, pp. 11, 27.

81 Still skeptical *Becker*, Gesetzliche Krankenversicherung zwischen Markt und Regulierung, JZ 1997, pp. 534, 537.

82 For further figures, see *Müller/Schneider*, Entwicklung der Mitgliederzahlen, Beitragssätze, Versichertenstrukturen und des RSA-Transfers in Zeiten des Kassenwettbewerbs, AuS 1999, pp. 20 et sqq.

83 See below, III. (6) (c) 1).

84 Thus the earlier presumption by *Oldiges*, Wirkungen der neuen Wahlmöglichkeiten und der neuen Organisationsstruktur in der Krankenversicherung, SF 1996, pp. 112, 115.

b) Risk adjustment system

The risk adjustment system,[85] which provides for extensive financial equalization between the sickness funds, was introduced on 3 January 1994. It was revised by the Law on the reform of the risk adjustment system in statutory health insurance [Gesetz zur Reform des Risikostrukturausgleichs in der gesetzlichen Krankenversicherung], dated 10 December 2001.[86] The twofold task of risk adjustment is to establish equal opportunities between the sickness funds and to avoid risk selection at the expense of the insured. To be noted here is that the legislator has largely repealed the fixed allocation of insurants to individual funds, thus affording options to sickness fund members. The funds are nevertheless essentially bound by statutory provisions to deliver the benefits defined under statutory health insurance. Apart from improving their services, sickness funds must primarily strive to win new insurants by offering lower contribution rates. This, of course, could best be achieved by keeping expenditures low, which is the desired objective in respect of administrative costs, but should not lead to exclusions from benefits. Regarding risk adjustment between the different sickness funds in western and eastern Germany, see Table 7.

Table 7: Risk adjustment in 2003

Sickness funds	West (m €)	East (m €)	Total (m €)	€ per insurant
AOK	8.652	4.501	13.153	512
BKK	-8.031	-1.126	-9.157	-629
IKK	-163	-167	-361	-81
SeeKK	5	-2	3	40
Bundkn	1.178	391	1569	1130
ArbK	-582	-77	-659	-461
AngK	-3.209	-446	-3655	-163

Source: Risikostrukturausgleich: Zahlen, Fakten, Hintergründe 2003/2004, VdAK.

Receipt and expenditure gaps subject to adjustment result from: the level of members' earnings liable to contribution; the number of co-insured dependants (which enter the equation as having "zero" earnings); age and sex distribution; invalidity among insurants; as well as participation in an accredited Disease Management Program (DMP, a criterion since 2002).[87] Simply speaking and leaving aside specific differentiation, all insurants are at first categorized according to the factors of age, sex and invalidity. Total benefit expenditures can then be distributed across these categories, making it possible to determine the average costs incurred by one insurant in each category. In a second step, average benefit expenditures can be correlated to the composition of insurants of a specific fund. This gives an insight into the fund's imputed benefit expenditures and

85 BGBl. I, p. 55.

86 BGBl. I, p. 3465.

87 More detailed *Busse*, Disease Management Programs in Germany's Statutory Health Insurance System – A Gordian Solution to the Adverse Selection of Chronically Ill in Competitive Markets?, Health Affairs 2004, pp. 56-67.

into the contributions it requires for cost coverage. The contribution requirement is in turn compared with the financial power of the fund, which is largely determined by the amount of its members' contributory earnings. If a fund's financial power exceeds its requirements, the excessive amount is paid over to other funds whose financial strength falls short of their needs. The whole procedure serves the purpose of creating and sustaining incentives for economic task fulfillment. That is why actual expenditures are not simply compensated.

The risk adjustment system has only partially been able to perform its intended function of concentrating inter-fund competition for insurants on the efficient use of administrative resources. Given that average benefit expenditures are adjusted, a fund will remain more heavily burdened if its members incur higher costs in comparison to other insurants of the same age and sex. Therefore, criteria should be developed in future that make it possible to record and classify all insurants in terms of morbidity.[88]

3. Sharing of costs between different population groups

a) According to income (upper and lower contribution limits)

aa) There are two different income limits for contribution assessment, an upper and a lower one. They correspond with the earnings limits for compulsory insurance (regarding the upper limit, see more detailed below, 3 (5) (a)).

bb) As for the lower limit, all earnings from employment up to a monthly wage of € 400 (so-called minor employment – geringfügige Beschäftigung)[89] are exempted from health insurance. That means employees who do not earn more than € 400 per month are not covered by health insurance. Consequently, they do not have to pay any contributions. This is different for their employers, who are liable to a contribution rate of 11 percent on minor employment – which, however, is only 5 percent for minor wage earners in private households.[90] This regulation was introduced for labor market reasons and is aimed at making less productive work cheaper. The fact that employers must nevertheless pay contributions is due to a shift from former taxation to the levy of contributions: employers are no longer required to pay taxes on minor employment. In this way, the legislator withdrew funds from the general budget in order to subsidize the social insurance systems. For the number of persons in minor employment in Germany, see Table 8.

88 For more details on the reform, see *Becker*, Rechtliche Fragen im Zusammenhang mit dem Risikostrukturausgleich – unter Berücksichtigung der integrierten Versorgung, VSSR 2001, pp. 277 et sqq.

89 See § 8 SGB IV.

90 See § 249b SGB.

Table 8: Persons in minor employment in Germany

	Total number	Women	Men
June 2004	6,704,923	4,282,992	2,421,931
June 2005	6,680,079	4,248,013	2,432,066
June 2006	6,389,989	4,080,745	2,309,244

Source: Die Minijobzentrale.

b) According to region

First of all, it must be stressed that the above-mentioned risk adjustment system does not differentiate according to regions. This has always been a point of debate.[91] Some hold that this lack of differentiation must be regarded as a violation of the principle of equal treatment laid down in the German constitution (Art. 3(1) GG).[92] However, the BVerfG did not share this view in its recent judgment of 18 July 2005.[93]

But, of course, regional disparities do exist in terms of income structure and thus in the amount of contributions, on the one hand, and in the cost of medical infrastructure, on the other.

Table 9: Risk adjustment compensation between Eastern Germany and Western Germany

Transfer payments from West to East (in m €)		
Year	Transfer of financial power	Transfer of contribution requirements
1999	€ 614	Not done
2000	€ 1.416	Not done
2001	€ 1.528	€ 477
2002	€ 1.773	€ 604
2003	€ 2.178	€ 694
2004	€ 2.300	€ 908

Source: Bundesversicherungsamt, 2006.

The Act to Equalize the Law in Statutory Health Insurance, passed in 1999, standardized the risk structure compensation mechanism for the whole of Germany from 2001. This led to an increase in the transfer of financial resources from western to eastern Germany. On the other hand, the SHI income basis in the eastern part of the country was broadened by adjusting contribution limits, mandatory membership and exemption from co-payment to West German levels. Both measures sought to reduce the high health insurance contribution rates in the East, thereby reducing obstacles to employment and

91 For the pros of regionalization, see *Jacobs/Reschke/Wasem*, Zur funktionalen Abgrenzung von Beitragssatzregionen in der gesetzlichen Krankenversicherung, 1996; for the cons, *Felder*, Regionalisierung, Risikostrukturausgleich und Wettbewerb in der gesetzlichen Krankenversicherung, 1998, p. 12; *Wille/Schneider*, Regionalisierung, Risikostrukturausgleich und Verteilungsgerechtigkeit, in: *Rebscher* (ed.), Regionalisierung der gesetzlichen Krankenversicherung, 1999, pp. 91, 104 et seq.

92 See *Stiebeler*, Zur Verfassungsmäßigkeit des Risikostrukturausgleichs gemäß § 266 Sozialgesetzbuch V, 1995, p. 40; opposing this view, *Gitter*, Grenzen einer Regionalisierung in der Krankenversicherung, in: FS für Zacher, 1998, pp. 201, 207 et seq.

93 BVerfGE 113, 273 et sqq. (2 BvF 2/01).

economic growth. For total risk adjustment payments between eastern and western Germany, see Table 9 above.

c) According to age

aa) Up until the 1990s, there was a special form of financial equalization for Pensioners' Health Insurance (Krankenversicherung der Rentner – KVdR). As health insurance contributions are levied on pension benefits, this line of insurance is considered a separate component of the overall system, with its own insurance obligation and, hence, with an autonomous financing scheme. Owing to the enhanced demand for benefits in older age, an equalization of intergenerational burdens was regarded as necessary if individual pensioner contributions were to remain affordable.[94] For it had long been evident that the proportion of pensioner health benefits would rise relative to total health benefit expenditure.[95] The required financial equalization in favor of the KVdR was therefore not borne by the individual sickness funds and their members, but divided equally among all insurants at large. To that end, pensioner benefit expenditures not covered by pensioner contributions (so-called funding share) were apportioned among all member contributions through the financial equalization scheme (§§ 268 et sqq. SGB V).[96] This independent scheme was abolished with the introduction of the risk adjustment system (see above, III. (2) (b)).

bb) As mentioned, the risk adjustment system equalizes the financial strength of the sickness funds on the basis of standardized benefit requirements, which are determined also by allocating insurants to age groups. The underlying assumption is that, among other things, benefit expenditure per insurant is usually affected by the age of the latter. For the share of selected groups of insured in total requirements, see Table 10.

Table 10: Share of selected groups of insured in total funding requirements Germany in 2003

Age group	Men	Women
0-20	4.9%	4.7%
21-45	7.6%	12.2%
46-65	11.1%	12.3%
66-90+	15.0%	23.2%

Source: Own calculations depending on Risikostrukturausgleich: Zahlen, Fakten, Hintergründe 2003/2004, VdAK.

94 The contribution rate is therefore set at the general average contribution rate of all sickness funds, § 247 SGB V. In 1990, contribution revenues for pensioners and their family members amounted to DM 25,451,159,000 – vis-à-vis benefit expenditures of DM 55,170,975,000; source: BArbBl. 4/1992, p. 107.

95 In 1990: benefit expenditure on pensioners: DM 55,170,975,000; total benefit expenditure: DM 134,273,742,000; source: BArbBl. 4/1992, p. 113.

96 On this development, cf. *Leber*, Risikostrukturausgleich in der gesetzlichen Krankenversicherung, pp. 62 et sqq.

4. Sharing of costs between employers and employees / patients and insurants

a) Contribution rates

The general principle of cost sharing between employers and employees in German social insurance is that they must pay equal contributions. This is still true for statutory old age pension insurance and social long-term care insurance. In contrast, only employers bear the cost of occupational accident insurance, given that this branch of social insurance was introduced to replace the civil law liability of employers.

Quite early on, attempts were made to relieve the financial strain on the healthcare sector. For example, in 1969, continued remuneration in case of sickness was reallocated to labor law.[97] Even so, healthcare expenditure continued to grow substantially in the 1970s.[98] This development led to the enactment of diverse laws between 1977 and 1983, all of which were aimed at cost containment. Most prominent among these were the Health Insurance Cost Containment Act[99] and the Health Insurance Cost Containment Supplementary Act.[100] As these amendments, too, were of only little success, the Healthcare Reform Act was passed in 1988.[101] Among other things, it introduced fixed amounts for drugs and aids, new or increased patient co-payments, the abolition of death benefit for younger persons and its curtailment for older insurants, and the extension of efficiency controls. Notwithstanding all these measures, healthcare spending and, with it, contribution rates kept on rising.[102]

As the present process of reforming social insurance is also aimed at strengthening Germany's international competitiveness and, consequently, at reducing labor costs, the Government has sought ways of altering the distribution of SHI burdens between employers and employees. Thus, in 1997, the First Law on the reorganization of self-government and personal responsibility in statutory health insurance[103] was enacted. One of its prime novelties was the limitation of dental prosthesis benefits to the coverage of fixed amounts. The 1998 Act to Strengthen Solidarity in Statutory Health Insurance[104] brought further benefit curtailments in the area of dental prostheses and orthodontic treatment. With effect from July 2005, insurants have been obliged to pay a special 0.9 percent contribution toward the funding of sickness pay and dental prosthe-

97 Lohnfortzahlungsgesetz [Continued Remuneration Act], dated 27.7.1969, BGBl. 1969 I, p. 946.

98 Cf. *Ebsen/Knieps*, Krankenversicherungsrecht, in: *Maydell/Ruland* (eds.), Sozialrechtshandbuch, para. 15.

99 Krankenversicherungs-Kostendämpfungsgesetz, BGBl. 1977 I, p. 1069.

100 Krankenversicherungs-Kostendämpfungs-Ergänzungsgesetz, BGBl. 1981 I, p. 1578.

101 Gesundheitsreformgesetz, BGBl. 1988 I, p. 2477.

102 See Federal Statistical Office on the Internet: http://www.destatis.de/themen/d/thm_gesundheit.php#Gesundheitsausgaben (as at 10.12.2006).

103 Erstes Gesetz zur Neuordnung von Selbstverwaltung und Eigenverantwortung in der gesetzlichen Krankenversicherung, BGBl. 1997 I, p. 1518.

104 GKV-Solidaritätsstärkungsgesetz BGBl. 1998 I, p. 3857.

ses.[105] This marked a change in the hitherto solidarity-based equivalence of employee-employer contributions – at the expense of employees.

b) Co-payments

Pursuant to § 28(4) in conjunction with § 61 2nd sent. SGB V, insurants who are 18 years of age and older must pay a consultation fee for every quarter of the year in which they seek ambulatory medical, dental or psychotherapeutic treatment. This fee is currently set at € 10 per quarter. The regulation governing ambulatory benefits is supplemented in accordance with § 61 2nd sent. SGB V for the area of in-patient hospital benefits. Remedies and domestic home care are subject to co-payment of 10 percent of the cost plus € 10 per prescription.

A co-payment limit of two percent of annual gross subsistence earnings is stipulated under § 62 SGB V; it is one percent for persons who are chronically ill. Children are counted as an income-reducing factor. Pensioners and recipients of subsistence aid or basic old-age assistance are entitled to exceptions.

The Federal Government's current draft bill concerning a Law to strengthen competition in statutory health insurance[106] focuses only on the amendment of § 62 SGB V. The bill thereby raises the co-payment limit for chronically ill persons from one to two percent if they were born after 1 April 1972 and failed to participate in regular health checks pursuant to § 25 SGB V, or if they were born after 1 April 1987 and are suffering from cancer and did not undergo any preventive medical checkups required under § 25(2) SGB V. A newly inserted paragraph under § 62(5) SGB V provides that the leading associations of sickness funds are to evaluate exemptions from co-payment with a view to their steering effects, and report their findings to Parliament by 30 June 2007.

5. Sharing of costs between the public and the private sector

a) Scope of compulsory insurance

aa) The present functional division between statutory and private health insurance requires only a few remarks. It is shaped by the selectionist approach taken in the statutory system of provision, which largely precludes self-employed persons from social security coverage of the risk of illness. As for such special groups as civil servants, judges and soldiers, precedence is still given to so-called internalized provision:[107] based on the construct of a special legal relationship, provisions for this category of

105 Gesetz zur Anpassung der Finanzierung von Zahnersatz, BGBl. 2004 I, p. 3445.

106 Gesetz zur Stärkung des Wettbewerbs in der Gesetzlichen Krankenversicherung, BT-Drs. 16/3100; on the Internet: http://www.bmg.bund.de/cln_040/nn_600110/SharedDocs/Gesetzestexte/Entwuerfe/Entw-GKVWSG,templateId=raw,property=publicationFile.pdf/Entw-GKVWSG.pdf) as at 10.12.2006).

107 Regarding systematization, see *Zacher*, Grundtypen des Sozialrechts, in: FS für Zeidler, 1987, pp. 571 et sqq.

persons are left to the state and its provident care duty. Up to this point, the layout of statutory health insurance conforms to the architectural principles of Bismarckian social insurance, a special feature being that not all persons in dependent employment are included in the mandatory scheme. This is because statutory health insurance sets an upper limit for compulsory coverage referred to as the gross annual earnings limit: persons whose salaries exceed this limit are exempt from the obligation to insure (§ 6 I No. 1, VI – VIII SGB V).

Hence, private health insurance does not only assume a supplementary function, namely in offering benefits not covered by the statutory insurance catalogue. Rather, it also possesses a substitutive character, in that coverage for higher-income earners can be provided by private insurers. This idea is often expressed by the somewhat catchy phrase "bipolar insurance constitution".[108] The gross annual earnings limit has also been labeled "peace limit",[109] insinuating a kind of compromise in delineating the range of both insurance forms.

bb) For many years, the gross annual earnings limit was equivalent to the income limit for the assessment of contributions. Since 1971, it had been geared to the income limit for the assessment of pension insurance contributions and amounted to 75 percent.[110] Its annual adjustment by way of statutory order was based on the trend in gross wages and salaries. The Act to Equalize the Law in Statutory Health Insurance placed the limit in the new German states [Länder] on the same level as in the old.

Table 11:

Year	Gross annual earnings limit		Income limit for contribution assessment	
	Old *Länder*	New *Länder*	Old *Länder*	New *Länder*
1975	2,100 DM	—	2,100 DM	—
1980	3,150 DM	—	3,150 DM	—
1985	4,050 DM	—	4,050 DM	—
1990	4,725 DM	—	4,725 DM	—
1995	5,850 DM	4,800 DM	5,850 DM	4,800 DM
2000	6,450 DM	5,325 DM	6,450 DM	5,325 DM
2001	6,525 DM		6,525.0 DM	
2002	3,375 €		3,375.0 €	
2003	3,825 €		3,450.0 €	
2004	3,825 €		3,487.5 €	
2005	3,900 €		3,525.0 €	

Source: PKV, Zahlenbericht [Private Health Insurance Facts & Figures] 2003/2004, www.pkv.de.

108 *Leisner*, Sozialversicherung und Privatversicherung, 1974, pp. 164 et sqq.

109 For example, cf. *Schnapp/Kaltenborn*, Verfassungsrechtliche Fragen der „Friedensgrenze" zwischen privater und gesetzlicher Krankenversicherung, 2001.

110 Since the Zweite Krankenversicherungs-Änderungsgesetz [Second Health Insurance Amendment Act] dated 21.12.1970 (BGBl. I, p. 170); regarding previous development, cf. *Peters*, Die Geschichte der sozialen Versicherung, 1978, pp. 164 et seq.

cc) In 2003, the base value was raised as a one-time measure[111] because an increasing number of persons were opting for private instead of statutory health insurance.[112] It was also decoupled from the limit in pension insurance and is now determined annually by the Federal Ministry of Health.

In February 2004, the BVerfG rejected a constitutional complaint filed by an insurance company against the raising of the compulsory insurance limit.[113] The Court argued that although the upward adjustment at the expense of private health insurers possibly constituted an intervention in their occupational freedom,[114] it was nonetheless justified because it had proved appropriate, necessary and reasonable for sustaining the financial stability of statutory health insurance. An additional criterion was that the business operations of these insurance companies were not unduly affected by the new regulation – at least not in the opinion of the Court.[115]

dd) In Germany, 9.83 percent of the population is fully covered under a private insurance scheme (= insurance of ambulatory and general hospital benefits). Included in this figure are civil servants, judges and soldiers. In 2003, the number of insurants rose by 186,600 (net increase), corresponding to a rate of 2.35 percent,[116] whereas in 2004, the number of insurants rose by only 149,000 persons (net increase).[117] The reason for the decline in the number of persons migrating to private health insurance is the raising of the income threshold for compulsory insurance, from a minimum monthly income of € 3,375 in 2002 to € 3,825 in 2003.[118]

Apart from the more than 8.11 million persons who are fully covered by private health insurance, nearly another 7.9 million have taken out some form of private supplementary protection[119] (approx. 9.6 percent of the population[120]). Even so, full coverage of the sickness contingency remains the chief type of private health insurance in Germany, its share of aggregate premium income amounting to 70.83 percent in 2003[121] and 71.58 percent in 2004.[122]

111 Under Art. 1 of the Beitragssatzsicherungsgesetz [Contribution Rate Stability Act] dated 23.12.2002 (BGBl. I 2002, p. 4637).

112 For substantiation, BT-Drucks. 15/28, p. 11.

113 BVerfG (Chamber) dated 4.2.2004, BvR 1103/03 (on the Internet: www.bverfg.de/entscheidungen/rk20040204_1bvr110303.html.

114 For an overview, see *Becker*, Staat und autonome Träger im Sozialleistungsrecht, 1996, pp. 153 et seq.

115 BVerfG, op. cit., paras. 32 et sqq.

116 PKV, Zahlenbericht 2003/2004, p. 5.

117 PKV, Zahlenbericht 2004/2005, p. 5.

118 PKV, Zahlenbericht 2004/2005, pp. 12/13.

119 Figures from: PKV, Rechenschaftsbericht [Private Health Insurance Report] 2003 (on the Internet: www.pkv.de), pp. 10 and 12.

120 The population in 2003 was reported at 82,531,671; cf. www.destatis.de/download/d/bevoe/31.12.03-werte.pdf.

121 PKV, Zahlenbericht 2003/2004, p. 26.

122 PKV, Zahlenbericht 2004/2005, p. 26.

Table 12: Balance of migration to private health insurance[123]
(accounting balance, not only net increase)

1980	+	108,000
1985	+	145,000
1990	+	198,000
1995	+	85,000
2000	+	176,400
2001	+	213,200
2002	+	232,200
2003	+	208,000
2004	+	167,100

Source: PKV, Zahlenbericht [Private Health Insurance Facts & Figures] 2004/2005, www.pkv.de.

b) Main features of private insurance

aa) Private law approach

In principle, private health insurance functions in accordance with the general rules governing contractual obligations under civil law. The insurance relationship is established by concurrent declarations of intent made by the contracting parties. Its content, too, is subject to the parties' formation of that intent (private autonomy), their scope of action nevertheless being restricted by regulations of insurance law.[124] Disputes between the insured and the insurers are brought before the civil courts under the purview of the Code of Civil Procedure [Zivilprozessordnung – ZPO]. Family members are not included in the coverage of risk on a statutory basis. Generally speaking, they need to conclude a contract of their own, and a separate premium must be paid per insurant. However, according to a judgment of the Federal Court of Justice [Bundesgerichtshof – BGH] regarding § 178a(1) of the Insurance Contract Act (VVG see 2) below) is possible for a spouse to be insured for the account of the other spouse (notably, see § 178a(3), 2nd sent.).[125] The co-insured spouse is thereby not to be regarded as a person at risk under the insurance contract concluded solely in the self-interest of the insurant, but is part of a contract for the benefit of a third party pursuant to § 328 BGB [*Bürgerliches Gesetzbuch* – Civil Code]. The co-insured spouse can claim benefits on his/her own behalf in connection with this contract.[126]

With this approach, two individual funding aspects are brought into line with each other:

- Men and women pay different premiums as a result of "risk-adjusted premium assessment".
- The funding procedure itself is based on the principle of future benefit coverage.

123 In terms of net increase, the number of deaths surpasses the number of births.

124 Cf. bb) below.

125 See BGH NJW 2006, p. 1434, BGH IV ZR 205/04.

126 See BGH NJW 2006, p. 1434, BGH IV ZR 205/04.

bb) Statutory regulation

General safeguards in favor of the insured are set forth in the Law on the supervision of insurance companies (VAG)[127], which was last amended in 2004,[128] not least to implement Community law provisions on the solvency, reconstruction and liquidation of insurance undertakings. Thus the actual commencement of business operations requires a permit, while the operation itself is subject to legal and financial supervision, and to rules on capital resources and investment.[129]

Some statutory provisions moreover deviate from the principle of private autonomy, reflecting the special function of private health insurance. For instance:

The supervisory legislation includes a special provision on substitutive health insurance. Accordingly, there are specific rules for premium calculation; the right of contractual notice of cancellation is restricted, and premium alterations are subject to the consent of an independent trustee.[130] Simultaneously, insurers are obliged to set aside old-age reserves on behalf of every insured person[131] – on the assumption that the demand for many benefits increases with age, necessitating provisions to avoid excessive premium burdens in later life.

The Law governing insurance contracts (VVG)[132] likewise contains a number of special provisions. Accordingly, substitutive health insurance is, as a rule, of unlimited duration;[133] contractually agreed general qualifying periods may not exceed three months; an insured person's newborn child must be admitted without additional risk charges and qualifying periods; and the insured have the right to give contractual notice of cancellation as per the end of every year.[134] Contractual notice by the insurer is ruled out under substitutive health insurance.[135]

Worthy of note, moreover, is the social law provision that pertains to the employer's participation. In the case of compulsorily insured persons, employers and employees share the cost of the contribution; for those voluntarily insured under the statutory scheme, the employer pays a supplement. To avoid the less favorable treatment of private schemes, privately insured employees are also eligible for an employer supplement (§ 257 SGB V).[136] Nevertheless, for private health insurers to qualify for such supple-

127 Versicherungsaufsichtsgesetz – VAG, dated 17.12.1992 (BGBl 1993 I, p. 2).

128 Law dated 21.12.2004 (BGBl 2004 I, p. 3610).

129 §§ 5, 81 et seq., 53c et seq. VAG.

130 §§ 12 and 12b VAG.

131 § 12a VAG.

132 Versicherungsvertragsgesetz – VVG, dated 30.5.1908 (RGBl. p. 263 with amendment); regarding current reform efforts, cf. Abschlußbericht der Experten-Kommission zur Reform des Versicherungsvertragsrechts [Final Report of the Expert Commission on the Reform of Insurance Contract Law], dated 19.4.2004 (http://www.bmj.bund.de/media/archive/667.pdf).

133 § 178a IV VVG.

134 §§ 178c, 178d and 178h VVG; the regulations apply to all health insurance contracts; regarding the right of extraordinary cancellation upon occurrence of the insurance obligation under statutory health insurance, cf. § 178h II VVG.

135 § 178i VVG.

136 Since 1971, cf. *Peters*, Geschichte (note 110), p. 163.

ments, they need to offer a standard tariff, notably to older insurants (§ 257 IIa SGB V). This establishes a link to the benefit catalogue of statutory health insurance and, within a certain scope, to its contribution burden, the aim being to avoid unaffordable insurance premiums in old age.[137]

cc) Provision of benefits

(1) Coverage under statutory health insurance (SHI) is regulated by law, statutory instruments and so-called directives issued by the Federal Joint Committee (including activities of the Institute for Quality and Efficiency of Health Care [Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen]).[138] Basic principles of benefit provision are laid down in §§ 11-18 SGB V, and a catalogue of benefits is set out in §§ 27-43 SGB V. Both must be given concrete substance through the directives and decisions of the above-mentioned institutions. All benefits must be adequate, necessary and efficient.

Under private health insurance (PHI), healthcare benefits depend on a contractual agreement between insurant and private sickness fund. Medical treatment measures must be necessary and adequate.[139] The efficiency of measures is initially of no relevance. There is no budgeting in private health insurance. Nevertheless, in the case of two equally promising measures, the private sickness fund need only pay for the less expensive option.[140]

(2) Under SHI, medical treatment must be performed by providers (medical and dental physicians) who are formally admitted to SHI. They are part of a corporatist negotiating system between the associations of SHI physicians and the associations of sickness funds; this system also decides on provider remuneration. As a result of the present political debate[141] and the Amending Law governing contracting physicians [Vertragsarztrechtsänderungsgesetz][142], the system is due to be modernized in 2007. SHI is then to have fee scales comparable to those of PHI (see below), and budgeting is to be replaced by a new system of control by volume.

Under PHI, physicians conclude individual contracts with their patients. The remuneration of physicians depends on the medical fee scale for physicians [Gebührenordnung für Ärzte] and the fee scale for dentists [Gebührenordnung für Zahnärzte]. All services are listed in these fee scales. Physicians are allowed to multiply the amount of fee charged up to a factor of 3.5 in extremely difficult cases, and 2.3 in difficult cases. For normal cases, the multiplier is 1.8. Abuse of this multiplier system by physicians is said to entail immense expenses for the private healthcare sector.

137 Amendment of § 257 SGB V under the law dated 21.12.1992 (BGBl. I, p. 2266).

138 See *Seeringer*, Der Gemeinsame Bundesausschuß nach dem SGB V, pp. 31 et sqq.

139 See BGH VersR 96, p. 1224; OLG Köln VersR 93, p. 1514; OLG Stuttgart VersR 87, p. 280; OLG Hamm VersR 1982, p. 996; OLG Frankfurt VersR 1981, p. 451.

140 See OLG Köln VersR 1995, p. 1177; BGH VersR 1987, p. 278; BGH VersR 1987, p. 1107.

141 See Eckpunktepapier , p. 4/5.

142 See BT-Drucks. 16/2474.

(3) There are several differences between SHI and PHI in terms of coverage, that is, also as regards the catalogue of benefits. These differences mainly relate to dental and orthodontic treatment; pharmaceuticals and remedies, notably eyeglasses and contacts; patient co-payments; and alternative measures.

Benefits financed by SHI	Benefits financed by PHI
(a) Basic care	
Basic medical treatment is covered; according to the precept of efficiency, this includes only efficient treatment, § 12 SGB V; therefore, budgeting is obligatory, with cost aspects ranking first; obligatory co-payment of € 10 per quarter of the year in which a physician is consulted; some remedies are excluded by law or directive, § 34 SGB V, e.g. remedies for influenza, coughs and colds, or travel sickness; prescription of remedies only according to fixed amounts, §§ 35, 35a SGB V.	All required medical treatment [notwendige medizinische Behandlung][143] is refunded (first level of decision by insurance companies); this is appraised from an objective medical viewpoint[144]; no budgeting; refund of all adequate approved remedies, which the insurant must prove in case of legal dispute[145]; only in unusual individual cases is merely the cheaper of two equally promising measures paid[146] if one of the methods is much more expensive than the other[147]; cost aspects are only of secondary relevance[148].
(b) Dental and orthodontic treatment	
Only basic dental treatment and prophylaxis are covered, but not prostheses, § 28 SGB V; orthodontic treatment is only funded for patients up to the age of 18 and up to 80%, § 29(2) SGB V; no financing of special requests or expensive methods.	100% of the costs of prostheses are refunded (some companies only pay for visible prostheses); implants or special crowns are only reimbursed up to 75-90% according to contract and insurance company[149]; ceramic inlays must be refunded[150]; 85-90% refund of orthodontic treatment.
(c) Optic care	
Optic care is covered only according to a fixed amount, § 33(2) SGB V; co-payment of € 5 per package; only basic eyeglasses, but not frames or contacts, are financed, § 33 SGB V.	Eyeglass frames and hard and soft contacts are refunded – frames up to a maximum amount of € 150.
(d) Hospital care	
Treatment only in certain, easily reachable hospitals; attending physician is assigned by the hospital; shared rooms, with co-payment for television, phone and radio.	Free choice of hospital treatment; free choice among all physicians; treatment by chief physician; twin or single rooms; cost-free use of phone, television and radio.

143 See BGH VersR 1996, p. 1224; OLG Köln VersR 1993, p. 1514; OLG Stuttgart VersR 1987, p. 280; OLG Hamm VersR 1982, p. 996; OLG Frankfurt VersR 1981, p. 451; OLG Bamberg VersR 1979, p. 640; BGH VersR 1978, p. 271.

144 OLG Frankfurt NVersZ 2000, p. 273; BGH ArztR 1998, p. 88; BGH VersR 1996, p. 1224; BGH VersR 1979, p. 480.

145 LG Düsseldorf NVersZ 2000, p. 29; BGH VersR 1996, p. 1224; BGH VersR 1991, p. 987.

146 See OLG Köln VersR 1995, p. 1177; BGH VersR 1987, p. 278; BGH VersR 1987, p. 1107.

147 LG Hildesheim r + s 2000, p. 34; OLG Karlsruhe VersR 1997, p. 562; OLG Köln VersR 1990, p. 612; BGH VersR 1987, p. 278; BGH VersR 1987, 1107.

148 OLG Köln VersR 2004, 631.

149 LG Stuttgart ZM 2005, p. 112; OLG Düsseldorf NVersZ 1999, p. 473; LG Hechingen, dated 7.8.1998, Az 1 O 51/95.

150 LG Stuttgart NJW-RR 1999, p. 1044.

(e) Alternative measures	
Alternative measures are covered only in few cases; according to § 135 SGB V, a funding of alternative measures is only possible if permitted by the Federal Joint Committee; the difference to private health insurance is the need of scientific approval[151]; however, in case of danger to life, alternative measures must be permitted in special cases, according to a recent decision of the BVerfG[152], if there are no prospects for a cure using scientifically approved methods.	Practically[153] approved alternative measures are refunded, e.g. treatment by an official alternative practitioner[154], naturopathic treatment[155] or acupuncture; however, these measures must be required medical treatment appraised as such from an objective medical viewpoint[156]; experimental methods are excluded, i.e. not refunded, e.g. Ayurveda[157], Bio-Resonance Therapy[158], traditional Chinese Phyto-Therapy[159] and ASI-Therapy[160]; however, in case of danger to life, with no other healing prospects, experimental methods must be reimbursed[161]; in such cases, palliative[162], but not necessarily healing[163], measures may suffice; there is a general tendency for courts to accept more and more alternative measures[164].

c) Historical explanation for the present public-private mix

The Health Insurance Act of 1883[165] had already stipulated an upper earnings limit for compulsory insurance. While not pertaining to industrial workers, the limit did apply to the majority of white-collar workers and was set at 6 2/3 marks per day or 2,000

151 BSG MedR 1998, p. 230; BSG MedR 1996, p. 373.

152 BVerfG, dated 6.12.2005, 1 BvR 347/98.

153 In 1993, the Federal Court of Justice decided to abandon the requirement of scientific approval in private health insurance, BGH VersR 1993, p. 957.

154 OLG Düsseldorf VersR 1995, p. 773.

155 Originally, only scientifically approved methods, tested in universities, were accepted, but the constitutional court decided to abandon this jurisdiction; see BVerfG VersR 1993, p. 957. Nowadays all measures with common scientific acceptance are refunded; see *Bach/Moser*, Private Krankenversicherung, § 1 MB/KK paras. 60 et sqq.

156 BGH ArztR 1998, p. 88.

157 OLG Frankfurt VersR 1996, p. 361; but new opinion by OLG Frankfurt in 1999: see OLG Frankfurt NVersZ 2000, p. 273, whereby Ayurveda is required because of its palliative effect.

158 KG Berlin VersR 2001, p. 178.

159 AG Schleiden r + s 1999, p. 124; however, in 2003, OLG Düsseldorf decided to accept traditional Chinese medicine in some cases, OLG Düsseldorf, KHuR 2005, p. 49.

160 LG Göttingen VersR 2001, p. 974.

161 LG Lübeck NVersZ 1999, p. 426 re. enzyme therapy (cancer); KG Berlin VersR 2001, p. 178 re. own-blood therapy (cancer); OLG München VersR 1997, p. 439 re. ozone therapy (AIDS); BGH VersR 1996, p. 1224 re. auto-vaccination therapy (cancer); OLG München VersR 1992, p. 1124 re. ozone therapy (AIDS).

162 OLG München NJW-RR 1999, p. 326; BGH VersR 1996, p. 1224 (1226).

163 LG Heidelberg – 7 S 56/96; BGH VersR 1996, p. 1224.

164 See, e.g., OVG Nordrhein-Westfalen, dated 18.8.2005, Az. 1 A 801/04 (general considerations); OVG Rheinland-Pfalz, dated 16.8.2005 (Petö Therapy), Az. 2 A 10479/05; OLG Düsseldorf, KHuR 2005, p. 49 (traditional Chinese medicine); OLG Frankfurt NVersZ 2000, p. 273 (Ayurveda).

165 Gesetz betreffend die Krankenversicherung der Arbeiter [Law on the health insurance of workers] (KVG), dated 15.6.1883, RGBl. 1983, p. 73.

marks per annum.[166] With the codification of social insurance law through the Reich Insurance Code (RVO),[167] it was raised to 2,500 marks in 1911.[168]

The initial reason for this regulation was that only persons deemed in need of protection were granted health insurance coverage. Employees with earnings above this limit were considered in a position to bridge over sickness-induced, non-productive periods from their own reserves.[169] And later, with the creation of the RVO, physicians were likewise opposed to raising the compulsory insurance limit because that would have narrowed their earnings potential.[170]

Since the introduction of statutory health insurance, the category of insured persons has successively been extended,[171] so that the need-based principle of compulsory insurance has been watered down to some extent. Even so, a widely held view today is that the principle still ought to have some bearing.[172]

d) Institutional competition or solidarity?

Employed persons whose earnings exceed the compulsory insurance limit can opt for membership of statutory health insurance when first entering into employment. If they fail to do so, they have, in principle, forfeited their right to access the system at a later date.[173] The underlying intent is to prevent persons from initially selecting the less costly form of private insurance and then profiting in old age, when benefit needs increase, from social equalization under the statutory system.

Fundamentally, both statutory and private health insurance present options within the respective system, namely in the choice of insurance providers. An interesting phenomenon here is that the statutory insurance system in fact offers more freedom of choice than private insurance. While most statutorily insured persons can choose from among a range of sickness funds after a relatively short term of membership (18 months),[174] switching from one private insurance company to another fails in practice because insurants' old-age reserves are not "portable", that is, cannot be transferred to a new insurance relationship. As a result, concluding a new insurance policy with another company becomes expensive and, hence, economically unattractive.[175]

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166 § 2 b KVG.

167 Law dated 19.7.1911 (RGBl. p. 509).

168 § 165 II RVO.

169 Also cf. *Wannagat*, Lehrbuch des Sozialversicherungsrechts, Vol. I, 1965, p. 246; an extension under the statutes of the insurance institution was thus also out of the question, cf. *Stier-Somlo*, Deutsche Sozialgesetzgebung, 1906, pp. 153, 154. Regarding parallels to the Invalidity Insurance Act, cf. *Köhler/Biesenberger/Schäffer/Schall*, RVO, 1912, Zweites Buch, pp. 6 et seq.

170 Cf. *Hahn*, Handbuch der Krankenversicherung, Erster Band, 1915, pp. 212 et seq.

171 On that development, see *Stolleis*, Geschichte des Sozialrechts in Deutschland, 2003, pp. 101 et sqq. and 154 et sqq.

172 Above all, cf. *Hase*, Versicherungsprinzip und sozialer Ausgleich, 2000.

173 Cf. § 9 I 1 No. 3 SGB V.

174 Namely, since 1996; cf. §§ 173 et sqq. SGB V.

175 On the discussion about changes, cf. *Scholz/Meyer*, Zu den Wechseloptionen der PKV, PKV-Dokumentation 25, 2001; on the more restricted problem of "aging tariffs" (i.e. being bound to cer-

The question is whether this public-private mix should be upheld in the future – that is, whether (1) the whole system should work according to private insurance principles, an option that seems beyond all debate at present; or whether (2) solidarity should be placed on a broader basis. These deliberations are the points of departure for health insurance reforms in Germany.

6. Some remarks on current reform proposals

a) Starting points: Citizens' insurance and per capita premium

For some time now, a fundamental reform of statutory health insurance has been under discussion in Germany. Brought to a point, two reform concepts stand vis-à-vis: the "citizens' insurance" [Bürgerversicherung] and the "premium model" [Prämienmodell]. Both seek to take account of the fact that the existing system of giving higher-income earners a free choice of insurance is felt to be unjust – a circumstance which, however, does not seem to warrant action unless an elimination of the alleged injustice simultaneously promises to strengthen the financial base of social insurance. Citizens' insurance as well as the premium model could impact on the status of private health insurance – the former by substantially reducing, or even abolishing, the possibilities for offering substitutive health insurance, and the latter by intensifying competition, as premiums would likely be subsidized by tax funds.

These reflections are attended by questions relating to their constitutionality.[176] The main issue is whether an extension of the group of compulsorily insured persons is compatible with private insurants' general freedom of action and protection of property, on the one hand, and with the occupational freedom of private insurance companies, on the other. Rulings of the BVerfG have paved the way for the further development of social insurance.[177] A historicizing approach that seeks to "abide by the conventional"[178] is rightly not the demanded course of action. Yet that does not necessarily mean both of the above concepts are admissible.[179] According to the BVerfG, the legis-

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tain tariffs within an insurance company), cf. *Meyer*, Tarifwechsel nach § 178f VVG – Probleme und Perspektiven, in: *Basedow/Meyer/Rückle/Schwintzowski* (eds.), Beiträge zur 12. Wissenschaftstagung des Bundes der Versicherten, 2004, pp. 67 et sqq.

176 Cf., e.g., *Bieback*, Verfassungsrechtliche Aspekte einer Bürgerversicherung, SozSich 2003, pp. 416 et sqq.; *Isensee*, „Bürgerversicherung" im Koordinatensystem der Verfassung, NZS 2004, pp. 393 et sqq.; *F. Kirchhof*, Verfassungsrechtliche Probleme einer umfassenden Kranken- und Renten-„Bürgerversicherung", NZS 2004, pp. 1 et sqq.; *Schmidt-Aßmann*, Verfassungsfragen der Gesundheitsreform, NJW 2004, pp. 1689 et sqq.; *Muckel*, Verfassungsrechtliche Grenzen der Reformvorschläge zur Krankenversicherung, SGb 2004, pp. 583 et sqq. and 670 et sqq.

177 BVerfGE 75, 108, 157 et seq. (Künstlersozialversicherung [social security for self-employed artists]).

178 Thus *F. Kirchhof*, in: *Schulin* (ed.), HS-KV, 1994, § 53, para. 36; concurrently, *Rüfner*, Gleichheitssatz und Willkürverbot – Struktur und Anwendung im Sozialversicherungsrecht, NZS 1992, pp. 81 et sqq.

179 Hence (albeit not without doubt) *Wannagat*, Lehrbuch des Sozialversicherungsrechts, 1965, pp. 224 et sqq.

lature may take account of the fact that a sufficiently large community of insurants is needed to ensure a well-functioning social insurance system.[180] The need to protect the general public from the burden of social assistance benefits is likewise recognized by the Court.[181] By its very nature, this pragmatic approach[182] does not only have the disadvantage of turning a well-established insurance system into a maelstrom that draws ever more persons in its wake. More importantly, such an approach lacks the positive statement of reasons for compulsory membership of a social insurance scheme.[183]

Whether reverting to the criterion of need-based protection[184] will be of any help here is questionable. Correct is that insurance branches must be distinguished according to their respective functions and that a fundamental risk load must be demanded for all insurants.[185] Yet nothing decisive has been gained by affirming this. An unresolved question is how to define "need of protection": is it based on low income,[186] or on the lack of other, more reliable and better attainable security options? Much speaks for the fact that a state dedicated to the common welfare of its people may postulate the aim of rendering sufficient health care to the entire population and of including all inhabitants in the process. That aim can be accomplished just as well through tax financing as through a contribution-based funding system.

b) Current developments

aa) In the Coalition Agreement of 11 November 2005 between the Christian Democrats (CDU) and the Social Democrats (SPD), the parties stress the need for a sustainable and just financing of health insurance.[187] In the face of mounting cost pressure, they declare the importance of a competitive and liberal orientation of the healthcare sector, with stable financial structures. Although the coalition agreement mentions the two parties' hitherto developed, opposing concepts of a "solidarity-based health insurance premium" (CDU/CSU) and a "citizens' insurance scheme" (SPD) as starting points for a common solution, it completely leaves open what such a solution might look like. Ob-

180 At least the existence of a protection system for needy persons as such is certainly required by the social state principle (Art. 20(1) GG); regarding constitutive freedom, cf. BVerfGE 40, 121, 133 et seq.; 48, 227, 234; 98, 169, 204.

181 Thus expressly the BVerfG in its decision dated 15.3.2000 – 1 BvL 16/96 u.a. = NZS 2000, pp. 450, 451.

182 In that regard, the BverfG offers no solution; cf. judgment dated 18.7.2005; BVerfGE 113, 273 et sqq.

183 Cf. also the critique by *Wallerath*, Der Sozialstaat in der Krise, JZ 2004, pp. 949, 960 et seq.

184 Thus the approach taken by *Hase*, Versicherungsprinzip und sozialer Ausgleich, 2000, notably pp. 349 et sqq.; cf. also *Bieback*, Begriff und verfassungsrechtliche Legitimation von „Sozialversicherung", VSSR 2003, pp. 1, 18 et seq.

185 Cf. *Becker*, Verfassungsrechtliche Vorgaben für die Krankenversicherung der Rentner, NZS 2001, pp. 281, 286.

186 *Merten*, Krankenversicherung zwischen Eigenverantwortung und Staatsversorgung, NZS 1996, pp. 593, 595 et seq.

187 Koalitionsvertrag, p. 102, on the Internet: http://koalitionsvertrag.spd.de/.

viously, a compromise could not be agreed upon, but as one wished to get the coalition off the ground, specific details were left out of the coalition agreement.

bb) A so-called cornerstone paper [Eckpunktepapier], dated 4 July 2006, of the joint working group of the Federal and Länder governments on the healthcare reform[188] seeks to substantiate the basic approaches and objectives stated in the coalition agreement, thus laying the foundations for the planned reform. It is thereby agreed that not only the financial basis of the system (income side) should undergo changes, but also the provision of benefits (expenditure side).

The following issues are addressed:

- Ambulant care: improvement of quality maintenance; fee schedule for physicians; admission of individual contracts between sickness funds and physicians.
- Hospital care: reflections on "monistic" funding (i.e. from a single source); certification of rehabilitation institutions.
- Drug provision: flexible price agreements; cost-benefit assessment, etc.; upper price limits.
- Organization and financing (see below).

cc) The Federal Ministry of Health has submitted a so-called working draft,[189] which is alleged by some not to have been cleared with the political leadership. On the other hand, all actors in the healthcare sector were already familiar with the paper after only a few days and engaged in fervid dispute over its contents.

dd) Meanwhile, the draft legislation is being debated by Parliament and the Bundesrat.[190] In February 2007, both Houses took their final vote on the bill, so that the main parts of the law are enacted on 1 April 2007[191]. Other parts will be enacted later. For example, the so-called Health Fund [Gesundheitsfonds] is to become operative in 2009.

c) Alterations of the German system

The main issues focus on the reform of health insurance organization and its financing, including thoughts about the future role of private health insurance. Thus the share of tax-financed revenue flowing to the healthcare system is to be increased; at the same time, competition between the sickness funds is to be enhanced. Additional contractual leeway is to be granted in the provision of ambulatory care as well as for drugs and aids. Moreover, the organization of statutory sickness funds will change as a result of, inter

188 On the Internet: http://www.die-gesundheitsreform.de/gesundheitspolitik/gesundheitsreform_2006/index.html.

189 On the Internet: http://www.gesundheitspolitik.net/06_recht/gesetze/gesundheitsreform/gkv-wettbewerb-ae.pdf (as at: 17.08.2006).

190 BR-Drs. 75/07.

191 Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung (GKV-Wettbewerbsstärkungsgesetz – GKV-WSG), BGBl. I, 2007, p. 378.

alia, proposals to permit inter-fund mergers[192] and fund insolvency,[193] as well as through the introduction of the above Health Fund[194].

aa) Financing is largely to follow the approach taken so far. Nevertheless, the proposed Health Fund is to be set up and managed by the Federal Insurance Agency [Bundesversicherungsamt].[195] The health ministry will then have to fix the contribution rates, after evaluating the findings of an appraisal committee, meaning the sickness funds no longer determine these rates or collect the amounts due.[196] The insurants' risks, which differ among the various sickness funds, will be equalized by means of age- and risk-related allocations from the Health Fund.[197] The Health Fund is thus to replace the hitherto existing system of risk adjustment between the sickness funds.[198] Contribution collection by the sickness funds, as collecting agencies, is to be carried out in future by transfer agencies (authorized agencies). These agencies can be sickness funds, networks, consortia, or sickness fund associations.[199] If the financial requirements of a sickness fund cannot be covered by appropriations from the Health Fund, the respective sickness fund must stipulate in its statutes that a separate additional contribution is to be levied from its members. This amount must not exceed one percent of an insurant's earnings liable to contribution [Kassenindividueller Zusatzbeitrag].[200]

To what extent a premium per insurant will be introduced in addition to an income-based contribution was one of the most disputed points of the reform. It is here that the highly opposing vantage points of the two coalition partners became manifest. One must fear that the proposed compromise will be too complicated to work properly in practice, and it is more likely to impede rather than enforce competition between the sickness funds – also because of plans not to include the additional premium in the future risk adjustment system.

In the face of these various difficulties, the Health Fund will not be launched before 2009.[201] This respite gives rise to the hope that the legislator will be wise enough to "re-reform" the relevant provisions before they ever come into force.

bb) Financing is to be supplemented by tax proceeds in the future. For one thing, the Federal Government will extend interest-free loans to the Health Fund if its liquidity reserves prove insufficient.[202] Moreover, the Government will grant € 2.5 billion[203] to

192 § 171a SGB V, amended version.
193 § 171b SGB V, amended version.
194 § 271 SGB V, amended version.
195 § 271 SGB V, amended version.
196 § 241 SGB V, amended version.
197 § 266(1) SGB V, amended version.
198 § 266 SGB V, amended version.
199 § 28f(4) SGB IV, amended version.
200 § 242(1) SGB V, amended version.
201 § 266(10) and § 272 SGB V, amended version.
202 § 271(2) und (3) SGB V, amended version.

the sickness funds in 2008 as a lump-sum compensation for the performance of non-insurance tasks; in 2009, it will award € 4billion in monthly installments to the Health Fund, with a further increase in the following years up to a maximum amount of € 14 billion.[204] This tax money will be geared primarily to the funding of collective societal tasks, such as the non-contributory co-insurance of children. Subsequently, the subsidy is to rise on a continuous basis. Sickness funds still short of resources after that will have access to possibilities for closing these funding gaps through savings measures (general practitioner fees, fee options, special forms of care provision, additional contributions, etc.).

cc) Competition among sickness funds is to be reinforced in that mergers between different funds will be possible in future[205]; a central agency on behalf of all sickness funds [Spitzenverband Bund] is to be entrusted with the negotiation of basic healthcare guidelines and tariffs.[206]

Both approaches are, in principle, correct.[207] Nevertheless, specific aspects remain open to question (notably, it is not true that larger sickness funds inevitably operate more efficiently than smaller ones). Any intention to replace existing, and well functioning, institutions should be reconsidered carefully. The same holds true for the question whether, and under what prerequisites, sickness funds should be subject to the laws on insolvency. Moreover, it is doubtful whether the aim to strengthen competition actually fits in with the introduction of the Health Fund (see c) above).

dd) Private health insurances are to be upheld alongside full statutory coverage. In any event, the coalition partners were highly at odds on this point of the draft. The new legislation contains the following compromise:

- alignment of the existing private medical fee schedule with the schedule to be created for SHI-contracted physicians;
- portability of old-age reserves to enable insurants to change private insurers in future. Here, however, the treatment of existing insurance contracts is unresolved, and also problematic in legal terms;
- introduction of a basic private insurance tariff (for a basic package of benefits) that is to be made available to all privately insured persons and all persons voluntarily insured under the statutory scheme.

In that way, private sickness funds would be approximated to the statutory funds to such a large extent that differences between them would be obscured even more than between statutory and private long-term care insurance. Such plans are as problematic in terms of constitutional law as they are questionable with regard to regulatory policy.

203 § 221 (1) SGB V, amended version.

204 § 221 (1) SGB V, amended version.

205 § 171a SGB V, amended version.

206 § 91 SGB V, amended version.

207 Previously pointed out by *Becker*, Maßstäbe für den Wettbewerb unter den Kranken- und Pflegekassen, SDSRV 48 (2001), pp. 7 et sqq.

B. Regulating the Provision of Benefits in Germany: Benefit Catalogue, Reimbursement and Quality Assurance

I. Benefit Catalogue and Decision-making

The issue of defining benefit catalogues has recently gained new importance in Germany, as a result of the creation of the new "Institute for Quality and Efficiency". The Institute was designed to support the Federal Joint Committee conducting effectiveness studies for benefit coverage decisions. The Committee and the contractual partners (sickness funds and providers) define the benefit catalogues for the Statutory Health Insurance within the framework of the Social Code Book V (SGB V), Germany's most relevant health care scheme. Unlike other countries, the German federal government limits its regulatory influence to the definition of procedures through which the scope of SHI services is defined. The explicitness of the benefit catalogues varies greatly between different sectors. While benefits in outpatient care are rather explicitly defined, benefit definitions for inpatient care are vague. It is argued that the establishment of the new institute and the development of the DRG system are initial steps towards a more effective and explicit benefit catalogue.

1. Organizational structure and actors involved in the definition of benefit catalogues

A fundamental aspect of the German health care system is the sharing of decision-making powers between the governments of the federal states, the federal government and designated self-governmental institutions. Responsibilities are traditionally delegated to membership-based, self-regulated institutions of payers and providers that are involved in financing and delivering health care. In the largest scheme (which covers 88% of the population), the Statutory Health Insurance (SHI), sickness funds, their associations and associations of SHI-affiliated physicians and dentists are recognized as quasi-public corporations. These corporatist bodies constitute the self-regulated structures that operate the financing and delivery of benefits covered by the SHI scheme within the legal framework of the Social Code Book V (SGB V).[208]

In joint committees of payers (associations of sickness funds) and providers (associations of physicians and/or dentists and/or the Hospital Federation) legitimized actors have the duty and right to define benefits, prices and standards (federal level) and to negotiate horizontal contracts in order to control and sanction their members (regional level). The vertical implementation of decisions taken by senior levels is combined with

208 *Busse/Riesberg*, Health Care Systems in Transition Deutschland. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

strong horizontal decision-making and contracting among the legitimized actors involved in the various care sectors.[209]

Physicians treating SHI-insured patients are organized into 17 regional physicians' associations. The Federal Association of SHI Physicians is responsible for cooperation on the federal level. SHI-accredited dentists are organized the same way as physicians through 17 dentists' associations and the Federal Association of SHI Dentists. The German Hospital Federation is also involved in the decision-making process.

The payers' side is made up of autonomous sickness funds organized on a regional and/or federal basis. They are obliged to raise contributions from their members and to determine the contribution rate necessary to cover expenditures. Their responsibilities include contracting, negotiating prices, quantity and quality assurance measures. Services covered by such contracts are usually accessible to all fund members without any prior approval by the fund, except for preventive spa treatments, rehabilitative services and short-term home nursing care. If there is any doubt, the sickness funds must obtain an expert opinion on the medical necessity for treatment from the Medical Review Board, which serves as a joint institution of the sickness funds.

The most important body for the benefit negotiations between sickness funds and physicians, concerning the scope of benefits, is the Federal Joint Committee. Based on the legislative framework the Committee issues directives relating to all sectors of care. The main body of the Committee consists of nine representatives of the federal associations of sickness funds, nine representatives from provider groups, two neutral members with one proposed by each side, and a neutral chairperson – accepted by both sides. In addition, nine non-voting representatives of formally accredited patient organizations have the right to participate in consultations, and to propose issues to be assessed and decided upon. The directives of the Committee are legally binding for all actors in the SHI scheme. These directives primarily concern the coverage of benefits and assure that SHI services are adequate, appropriate and efficient. The actual criteria for benefit definitions vary largely between sectors and types of catalogues.

2. In-patient curative care

If curative care (i.e. to detect, cure, prevent the worsening, or relieve the discomforts of accompanying diseases) cannot be achieved by ambulatory treatment (§ 39 SGB V), the insured party is entitled to inpatient treatment in accordance with § 27 SGB V. This health care entitlement is linked to a co-payment of 10 Euro per calendar day, to a maximum of 28 calendar days per year (§ 39(4) s. 1 SGB V).

Hospital services are granted in accordance with the care ability of each hospital and with the level of care assigned to each hospital. In each individual case the provision of services needs to be suitable and adequate for the insured. This includes medical treat-

209 *Gibis/Koch/Bultman*, Shifting criteria for benefit decisions, in: *Saltman/Busse/Figueras* (eds.), Social health insurance in Western Europe. European Observatory on Health Care Systems, 2004, pp. 189-205.

ment, nursing care, the provision of pharmaceuticals, cures and therapeutic appliances, as well as board and accommodation.[210]

Hospital care may only be provided in hospitals included in the hospital plan of the respective federal state, in university hospitals or in hospitals that have concluded a service provision contract with the sickness funds (§ 108 SGB V). While the spectrum of services provided by the respective hospitals is indirectly determined by the hospital plan (which also determines governmental subsidies for investments), the reimbursement for the provided services is decided in negotiations between each hospital and the association of sickness funds.

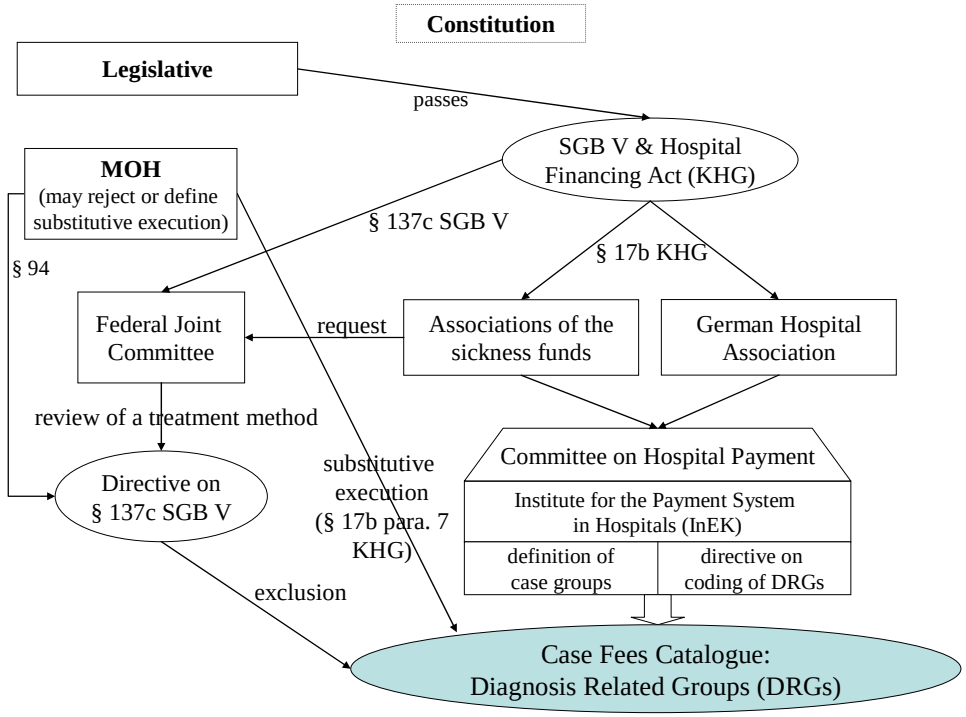

Figure 1: Description of the Case Fees Catalogue and the evaluation of examination and treatment methods[211]

The Federal Joint Committee presides over matters of exclusion of health care services, and/or the evaluation and examination of treatment methods; the Committee handles these matters in response to requests from the federal associations of sickness funds and the German Hospital Federation. The method under examination will be scrutinized as to its suitability to provide adequate, expedient and economical care for the insured persons, with general state-of-the-art medical knowledge taken into consideration. Should the examination reveal that the method does not meet the aforementioned crite-

210 *Busse/Stargardt/Schreyögg/Simon/Martin*, Defining benefit catalogues and entitlements to health care in Germany – decision makers, decision criteria and taxonomy of catalogues. Discussion Paper 2005/5, Technical University Berlin, 2005, http://www.ww.tu-berlin.de/diskussionspapiere/2005/dp05-2005.pdf.

211 Source: *Busse/Stargardt/Schreyögg/Simon/Martin*, Fn. 210.

ria, it may no longer be provided at the expense of the SHI system. In such instances, the Federal Joint Committee issues a corresponding directive according to § 137c(1) SGB V (see Figure 1 above).

Health care services in the framework of clinical studies are not subject to the directive. This means that all health care services that are not excluded by a directive of the Federal Joint Committee may be provided at SHI's expense.

The Reform Act of SHI 2000 demanded the selection and implementation of a case fee system for reimbursement effective as of January 1st, 2003. On June 27th, 2000, the federal associations of sickness funds, the Association of Private Health Insurance and the German Hospital Federation decided to utilize the Australian Diagnosis-Related Groups as the starting base for the development of a German DRG system. On May 10th, 2001, they founded the Institute for the Payment System in Hospitals (*InEK*), which is intended to support the introduction and the further development of the DRG system. The *InEK* is controlled and supervised by the Committee on Hospital Payment, an institution consisting of representatives from the contracting partners (see Figure 1). The matters addressed by the DRG Institute consist of defining the DRG case groups, the maintenance of the DRG-system and its severity classification system, the development of a coding directive and proposals for adapting German modifications of the International Classification of Diseases ICD-10 and the Operating Procedures System (OPS) into the DRG system. The Institute is also responsible for the calculation of DRG Cost Weights and individual adjustments within the DRG system.

As the basis for the new pricing system, a uniform case fee catalogue with fixed payments for services and benefits, valid for the entire Federal Republic of Germany, was developed. The catalogue lists all procedures (services) performed in hospitals in accordance with respective clinical diagnoses. At the same time the DRG system constitutes the catalogue of services and benefits covered by the SHI scheme for inpatient care. The inclusion of new health care services in the DRG system is reflected at the beginning of each year when a new version of the OPS and the ICD-10 becomes available and is linked to a DRG.[212]

The Case Fees Catalogue of 2005 consists of 876 DRGs, of which 33 are not remunerable with a case fee, and an additional list of 71 negotiated extra remunerations. The German DRG system is subdivided into 23 Major Diagnosis Categories, or MDCs, which refer, in principle, to body system or disease aetiology. The MDC-category also defines the first of the four digits of a DRG. The second and third digits of a DRG indicate the respective partition. The partition differentiates between surgical procedures (01- 39), other procedures (40- 59) and medical (conservative) procedures (60- 99) carried out during a hospital stay, thus linking a DRG to benefits provided in a hospital. The fourth digit further subdivides a DRG according to a patient's clinical complexity

212 *Lüngen/Drege//Rose/Roebuck/Plamper/Lauterbach*, Using diagnosis-related groups: The situation in the United Kingdom National Health Service and in Germany, Eur J Health Econom 2004, pp. 287-289.

level, which is comprised of such factors as complexity of secondary diagnoses, cause of discharge and patient gender.[213]

For inpatient services not covered by the DRG system (e.g. new methods of treatment), agreements are made with the hospitals concerned. The local contractual partners have to inform the contract partners at the federal level of such agreements, who may then decide to initiate an evaluation process in order to exclude these new services from the benefit package (§ 137c SGB V; § 6(2) Hospital Payment Act). In principle however, as previously mentioned, all health care services that are not explicitly excluded by a directive of the Federal Joint Committee can be provided at the expense of the SHI.

3. Ambulatory medical care

The provision of medical and dental care must be regulated and secured by agreements between the respective regional physicians' association / regional dentists' association and the regional associations of the sickness funds (§ 72 SGB V). Whereas, in accordance with § 137c SGB V, medical care in hospitals shall be, "adequate, expedient and cost-effective", for ambulatory care, in accordance with § 135 SGB V, the criteria to be applied are "diagnostic and therapeutic expedience, medical necessity and cost-effectiveness". Thus, the inclusion and/or exclusion of health care services from the benefit catalogues differ in the two sectors. In the outpatient sector, a service provided must be proven to fulfil the criteria "expedience, necessity and cost-effectiveness" in order to be included into the catalogue of services and benefits. In contrast to that, health care services in the inpatient sector will only be excluded from the benefit catalogue of the sickness funds if the criteria are proven to be unfulfilled. For this reason, it is possible that the health care services provided in the inpatient sector are not included in the benefit catalogue of the outpatient sector.[214]

Insured persons are entitled to preventive care, detection and treatment of diseases (§ 28(1) SGB V). This entitlement also embraces complementary services by non-physicians and practitioners, provided that they are prescribed by a physician. The legislative authority, however, does not define in detail the entitlements of the insured persons, but regulates the procedures with which the institutions of self-governance and the contractual partners determine the scope of SHI services.[215]

In accordance with § 92(1) SGB V, the Federal Joint Committee issues directives in respect of adequate, expedient and cost-effective medical care for the insured persons.

213 Institute for the Remuneration of Hospitals (InEK) Coding Directive G-DRG Version 2005, http://www.g-drg.de/deutschesdrg/drg_kodier_e.php?m=11.

214 *Niebuhr/Rothgang/Wasem/Greß*, Verfahren und Kriterien zur Bestimmung des Leistungskataloges in der gesetzlichen Krankenversicherung vor dem Hintergrund internationaler Erfahrungen, in: *Niebuhr/Rothgang/Wasem/Greß* (eds.), Die Bestimmung des Leistungskataloges in der gesetzlichen Krankenversicherung, Hans Böckler Stiftung, 2004, pp. 13-96.

215 *Kupsch/Kern/Klas/Kressin/Vienonen/Beske*, Health service provision on a microcosmic level – an international comparison; results of a WHO/IGSF survey in 15 European countries, Institute for Health Systems Research, 2000.

The directives consist of a general part that explains their aim, their users and mentions the corresponding paragraph in the SGB V. After the initial section the directives become more detailed. For example, the Directive on Medical Procedures that regulates the in- and exclusion of benefits in the outpatient sector initially defines the term of a new service and the conditions an evaluation is depended upon. Thereafter, it is stated that the regional physicians' associations, the Federal Association of SHI Physicians and the federal associations of sickness funds have the right to propose services for their inclusion. Then, the criteria for the inclusion of services, the classification of evidence and the decision-making process are described in detail. The services included or excluded through the evaluation process are listed in the annexes.[216]

While the Federal Joint Committee decides on the in- and exclusion of services into the benefit package, the Valuation Committee, which consists of seven representatives of the Federal Association of SHI Physicians and representatives of the federal associations of sickness funds, defines the actual benefit catalogue for the insured, the Uniform Value Scale (EBM). The EBM defines, as an integral component of the Federal Framework Contract – Physicians (BMV-Ä), the scope of medical care to be provided under the SHI throughout Germany. If the Valuation Committee fails to reach a consensus, at least two of its members or the Federal Ministry for Health and Social Security may demand that the extended Valuation Committee in accordance with § 87(4) SGB V, be brought in to resolve a split decision. Resolutions are to be submitted to the Ministry of Health, which, in the event of unresolved objection, may define alternative executions.

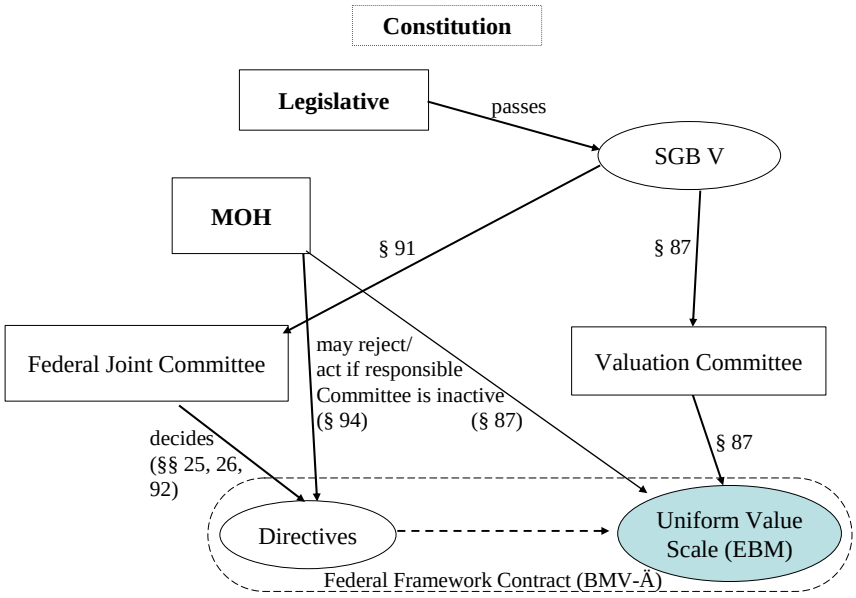

Figure 2: Definition of the Uniform Value Scale in the ambulatory medical sector[217]

216 Federal Joint Committee, Directive for sufficient, appropriate and cost-effective dental prosthesis, 2005, http://www.g-ba.de/cms/upload/pdf/richtlinien/RL-Zahnersatz-2005-12-08.pdf.

217 Source: *Busse/Stargardt/Schreyögg/Simon/Martin*, Fn. 210.

The Federal Framework Contract – Physicians (BMV-Ä) is concluded between the Federal Association of SHI Physicians and the federal associations of sickness funds (§ 82 SGB V). In addition to the scope of health care provided under the SHI, the BMV-Ä regulates participation in ambulatory care, the pertinent aspects of quality assurance, and entitlement to benefits. Thus, the Uniform Value Scale (EBM) and the directives of the Federal Joint Committee are integral parts of this contract. In § 2 of the Federal Framework Contract – Physicians, the description of a service in the EBM is stipulated as a condition for the provision of the respective service. As a result, the Uniform Value Scale (EBM) constitutes the catalogue of services and benefits covered by the Statutory Health Insurance (see Figure 2 above).

The broad structure and the contents of the EBM are stipulated in § 87 SGB V:[218]

- The EBM displays the health care services covered by the SHI scheme and their monetary value in relation to one another in the form of a points system,
- a basic remuneration for general practitioners is defined,
- health care services are grouped into packages of similar services,
- differentiation is being made between the health care services to be provided exclusively by general practitioners and those to be provided exclusively by specialists and
- the respective health care services are assigned exclusively to the groups of specialists that are allowed to provide them.

The EBM-catalogue is structured into 6 main chapters and further sub-chapters. Chapter I comprises general regulations regarding the provision and reimbursement of health care services. Chapters II to IV contain health care services related to different physician groups and/or special criteria. Chapter V contains general health care services provided by most physicians reimbursed with case fees. Chapter VI contains appendices (e. g. a list of services which are already contained in other services and are therefore not reimbursed additionally).[219]

As an appendix to the Federal Framework Contract – Physicians, there is an agreement that applies to care provided by general practitioners under § 73 SGB V. It defines the provision of medical treatments and the early detection of diseases. The definition of individual services to be provided is included in the EBM. In addition to these central agreements, which are uniform for all sickness funds, there are numerous “small” contracts determining the scope of the health care services covered by the SHI scheme.

5. Outpatient dental care

While benefits for ambulatory physician services are legally defined in generic terms only, legislation regulating dental care is much more explicitly detailed in the SGB V.

218 *Schauenburg*, EBM 2000plus – die neue vertragsärztliche Gebührenordnung, Die BKK 2004, pp. 241-242.

219 Federal Association of SHI Physicians, Uniform Value Scale, 2005, http://www.kbv.de/ebm2000plus/EBMGesamt.htm.

One reason for this was that the respective committee of the joint institutions until 2003 failed to provide more explicit definitions.[220] The basic entitlements of the insured to dental care are defined in § 28(2) SGB V: The insured are entitled to prevention, early detection and treatment of diseases of the teeth, the mouth and the jaw. Consequently, only prophylaxis treatments, basic dental care and dental prosthetic services are covered by the sickness funds.[221]

Similar to the definition of benefits for basic medical care, the directives of the Federal Joint Committee broadly define when patients are entitled to a benefit. However, they do not define specific items that have to be included. Therefore, the Dental Valuation Committee, which consists of representatives of the federal associations of the sickness funds and the Federal Association of SHI Dentists, defines the Uniform Value Scale for Dentists (BEMA) (see Figure 3).

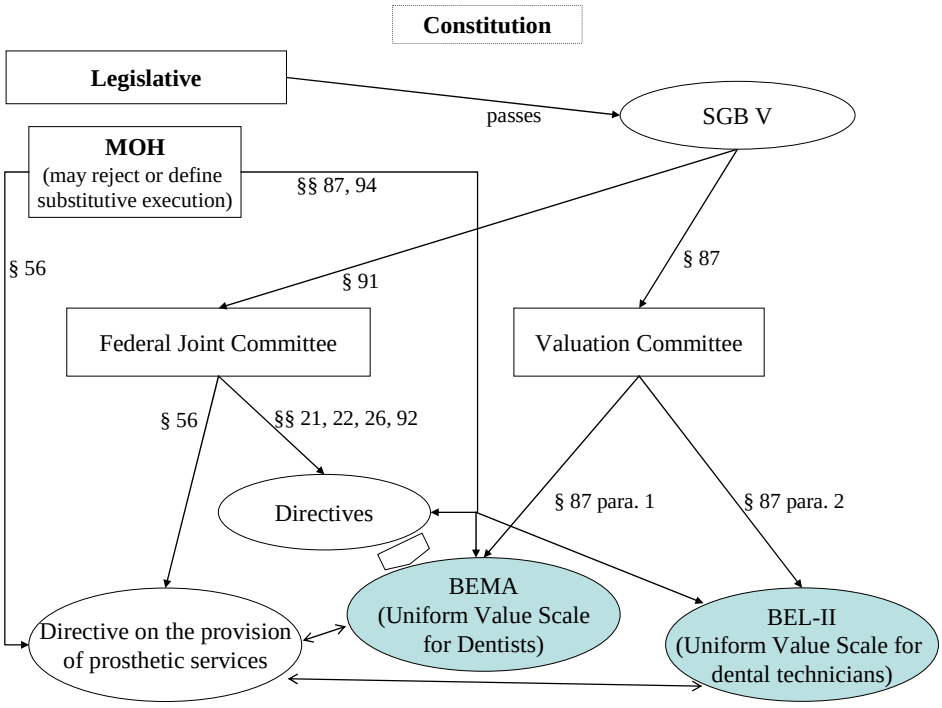

Figure 3: Implicit and explicit definition of the SHI benefit catalogue for dental care[222]

The BEMA lists services that are reimbursed by the sickness funds, thereby explicitly defining the SHI benefit catalogue. The services of dental technicians, producing the material needed for orthodontic or prosthetic services, are listed in a similar framework, the Uniform Value Scale for Dental Technicians (BEL-II) which is negotiated by the same Committee.

220 *Muschallik/Ziermann*, Zukunftsperspektiven der vertragszahnärztlichen Versorgung, Kassenzahnärztliche Bundesvereinigung, 2003.

221 *Tiemann/Klingenberger/Weber*, The System of Dental Care in Germany, Institut der Deutschen Zahnärzte, 2003.

222 Source: *Busse/Stargardt/Schreyögg/Simon/Martin*, Fn. 210.

Orthodontic treatments, except for the treatment of abnormalities, are to begin during childhood and are excluded for insured parties over the age of 18 years (§ 29 SGB V). In order to prevent an over-provision of services, dentists have to prepare a cost schedule that is reviewed by the sickness funds. Prosthetic services are only partially covered by the sickness funds and are therefore defined more explicitly. The insured receive a so called 'subsidy' as a percentage of a "standard" treatment, defined by the Federal Joint Committee in a directive according to § 56 SGB V. The directive currently in force defines a standard treatment for 52 findings. For each standard treatment all reimbursable services of the dentists and the dental technicians are listed separately according to the BEMA and the BEL-II.[223]

Sickness funds usually cover 50% of the standard treatment costs. This share can increase to 70% or 80% if a patient can prove yearly preventive dental checkups in the past five or ten years and the patient's efforts for dental hygiene are observable. Higher payment levels, up to full coverage of the costs of the standard treatment, are only provided for people with a very low income. Patients are free to choose non-standard treatments (§ 55(5) SGB V) or include additional services (§ 55(4) SGB V), however, the amount of sickness funds' payments remains unchanged.

6. Outpatient care performed by non-physicians

The term "Cures" subsumes health care services in Germany that are provided by non-medical practitioners, which include professional, recognized therapists, such as physiotherapists and occupational therapists.[224] The entitlement of the insured to cures can be found in § 32 SGB V. It is limited by co-payments for insured parties over the age of 18 under § 61(3) SGB V.

A further limitation on entitlements is imposed under § 34(4) SGB V, "Excluded Pharmaceuticals, Cures and Medical Aids". The Ministry of Health is entitled to exclude cures from the catalogue of services and benefits covered by the SHI through decrees, with the approval of the Federal Council (Upper Chamber of Parliament). However, a corresponding legal decree does not exist at present.

The scope of services covered by the SHI scheme is explicitly described and regulated by the Directive on Non-physician Care issued by the Federal Joint Committee under § 92 SGB V.[225] The prescription of more cost-effective measures with equal efficacy, e.g. drugs or other therapeutic appliances that achieve the same therapeutic objective, is to be given precedence. The benefits are listed in the directive in connection with an indication. New benefits and/or an extension of the indications for a given benefit

223 Federal Joint Committee, Directive on the Provision of Prosthetic Services, 2004, http://www.g-ba.de/cms/upload/pdf/richtlinien/RL-Festzuschuss.pdf.

224 *Scharnetzky/Deitermann/Michel/Glaeske*, GEK- Heil- und Hilfsmittel- Report 2004, GEK Schriftenreihe zur Gesundheitsanalyse 2004, Vol. 31.

225 Federal Joint Committee, Directive on Care by Non-physicians, 2004, http://www.g-ba.de/cms/upload/pdf/richtlinien/RL-Heilmittel-04-12-21.pdf.

may only be prescribed after the Federal Joint Committee has recognised their therapeutic value and included them into its directive (§ 138 SGB V).

The federal associations of sickness funds and representatives of non-physicians compile a Catalogue of Non-physician Care. The catalogue facilitates the implementation of the directive on Non-physician Care issued by the Federal Joint Committee (see Figure 4) (§ 125 SGB V), which regulates:

- the content, scope and frequency of cures,
- further training measures and quality assurance,
- the content and scope of collaboration between non-physicians and the prescribing SHI physician,
- measures to meet the aim of cost-effectiveness and
- specifications for remuneration structures.

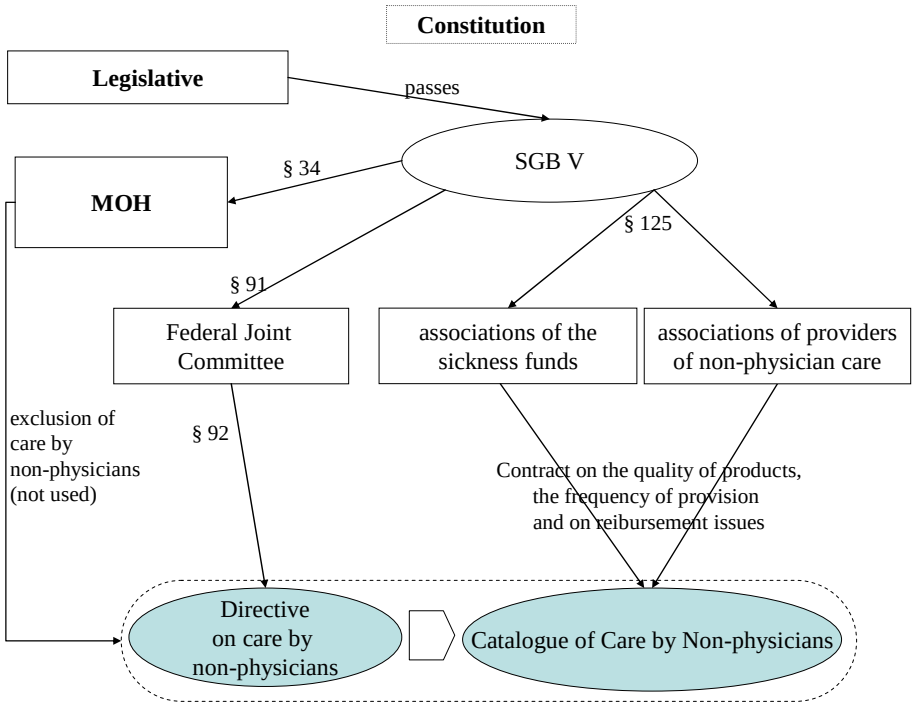

Figure 4: Definition of the SHI-benefit catalogue of care by non-physicians[226]

7. Conclusions

Despite the existence of various catalogues and directives for the SHI scheme, the benefit package is not defined in detail, because the obligation of the catalogues and their explicitness varies largely. Inpatient services not listed in the DRG-catalogue can still be covered by the SHI scheme as long as they are not explicitly excluded by the Directive according to § 237c. Yet in the ambulatory sector only those procedures listed

226 Source: *Busse/Stargardt/Schreyögg/Simon/Martin*, Fn. 210.

in the "Uniform Value Scale" (SHI-EBM) or in the "Uniform Value Scale for Dentists" (SHI-BEMA) are covered as benefits in the outpatient sector.

With the exception of the Catalogue of Non-physician Care, the benefits described in the SHI-DRG, the SHI-EBM, the SHI-BEMA and the SHI-BEL-II are the aggregate results of decisions taken on different levels, and they are not linked to specific indications. The reason for this is that they were originally defined for reimbursement and were not meant to define the SHI benefit basket in full detail. For example, as DRGs aggregate multiple procedures and diagnoses, benefits (medical procedures) provided under one DRG will vary from case to case. Additionally, the patient clinical complexity level of a DRG is determined by diagnoses including co-morbidities, gender and cause of discharge and not on the basis of the actual services provided. Therefore the scope of a DRG is very broad. Conversely the development of a DRG catalogue can also be seen as a starting point towards a more explicitly defined benefit catalogue, and subsequently lead to benefit catalogues where all approved interventions are listed and grouped around the relevant diagnoses.[227]

In the last years strong efforts have been made by the German government to move towards a more explicitly defined benefit basket. The creation of the Federal Joint Committee out of four smaller committees for the different sectors of care can be considered an improvement. The number of issued directives since the inception of the committee supports the assumption that it is more productive than its predecessors. This development suggests that the German health care system is moving towards a more explicitly defined benefit catalogue.[228]

So far the use of cost-effectiveness studies as part of the decision criteria for the inclusion of new benefits is widely lacking. The criteria of 'cost-effectiveness' was only taken into consideration for benefit decisions on medical devices. However, it is likely that it will be considered for other benefits in the future as well. The creation of a supporting institute to the Federal Joint Committee, the "Institute for Quality and Efficiency" in 2004, which increasingly commissions effectiveness studies, was one major step in that direction. Although this will increase the information base for decisions[229], the future impact of the cost-effectiveness criteria on the decision-making process and therefore, on the structure of the health basket, still remains unclear.

227 *Gibis/Koch/Bultman*, 2004, Fn. 209, pp. 189-205.

228 *Schulenburg*, German health care system in transition: The difficult way to balance cost containment and solidarity, Eur J Health Econom 2005, pp.183-187.

229 *Ham/Coulter*, Explicit and implicit rationing: taking responsibility and avoiding blame for health care choices, J Health Serv Res Policy 2001, pp. 163-169; *Henke/Schreyögg*, Towards sustainable health care systems – strategies in health insurance schemes in France, Germany, Japan and the Netherlands, International Social Security Association, 2004.

II. Reimbursement and Price Mechanisms

1. Inpatient curative care (DRGs and others)

With the passage of the Statutory Health Insurance Reform Act of 2000, the German legislature approved the introduction of a new system of reimbursement based on an internationally used system of Diagnosis Related Groups (DRGs). This represents the most significant reform in the German hospital sector since the system of dual financing (state is carrying capital costs) was introduced in 1972. The step-by-step implementation of the new reimbursement system also represents an innovative approach to realising political strategies and legal provisions, as the legislature has defined only the goals and tasks, as well as the time frame and roles of the different players – all very much in the sense of a "learning system"[230]. Difficulties controlling expenditures in the inpatient care sector were the prime motives for fundamentally reforming the old system of hospital services reimbursement[231].

After being extensively amended, § 17 b of the Hospital Financing Act [*Krankenhausfinanzierungsgesetz*, KHG] came into force on 1st January 2000. It defines the fundamental features of the German DRG system for the case-based reimbursement of general inpatient services and day cases of curative care. Pursuant to this section of the Hospital Financing Act, the self-governing bodies at the federal level (i.e. the Federal Associations of Sickness Funds, the Association of Private Health Insurance, and the German Hospital Federation) were required to introduce a reimbursement system based on DRGs that would be "uniform in application, performance-oriented, and case-based" and that would also takes disease severity into account. The self-governing bodies have thus been entrusted with the task of particularising the provisions of the Hospital Financing Act and continually enhancing the German Diagnosis Related Groups system (G-DRG system).

The uniformity in application demanded by the legislature was taken into account insofar as the G-DRG system has been made equally applicable to all patients, regardless of whether they are members of the statutory health insurance (SHI), private health insurance (PHI), or are self-pay patients (§ 17(1) s. 1 Hospital Financing Act). In addition, the G-DRG system applies on principle to all hospitals, insofar as certain services types are not expressly excluded. It also applies to all clinical departments with the exception of institutions or facilities providing services in psychiatry, psychosomatic medicine, or psychotherapy.[232]

On 27th June 2000 the self-governing bodies reached an agreement on the further development of the reimbursement system, approving the use of the Australian Refined DRG system (AR-DRG system) as a foundation for the G-DRG system. The self-governing bodies also agreed that cost weights based on German data should be calcu-

230 *Busse/Riesberg*, Fn. 208, p. 171.

231 *Lüngen/Lauterbach*, DRG in deutschen Krankenhäusern, 2003, p. 2.

232 *Tuschen/Trefz*, Krankenhausentgeltgesetz, Kommentar, 2004, pp. 103-104.

lated for use in the G-DRG (§ 2 Agreement on Remuneration System 2000). The newly founded Institute for Hospital Reimbursement [*Institut für das Entgeltsystem im Krankenhaus*, InEK] provides the organisational structure necessary for the maintenance and further development of the German DRG reimbursement system and is, among its other duties, responsible for calculating cost weights. For deriving DRG classifications, the institute relies on cost and claims data collected in German hospitals. Accordingly, every German hospital is required to provide the institute with hospital-related structural data and case-related claims data on a yearly basis. The case-related cost data are calculated using a sampling of data from hospitals participating in this voluntary data sharing programme.[233]

a) Basic Principles for Valuating DRGs

The new German reimbursement system is based on a patient classification system that selectively assigns treatment cases to clinically defined groups (i.e. DRGs) that are distinguished by comparable treatment costs.[234] In the G-DRG system, the procedure used to assign treatment cases to a DRG is based on a grouping algorithm that uses a variety of criteria from the inpatient hospital discharge data set, such as diagnosis, procedure, clinical severity, co-morbidity and age. As such, DRG assignments are always unambiguous: treatment cases that have identical records are always assigned to only one single DRG.[235]

The German case fee system is characterised by a “top down” approach in which the DRGs are created and calculated using predetermined per-case treatment costs. As part of this “top down” approach, DRGs are created empirically based on pre-existing cost data, although criteria of medical relatedness (i.e. the similarity between different clinical conditions) are also considered to a varied extent. Case grouping in DRG systems gives first priority to economic and only second priority to medical considerations. Essential to the quality and thus the completeness of such a case-based system is the accuracy and scope of the calculation data. For example, cases that are excluded from data collect may not necessarily receive adequate consideration at a later point in time.[236]

A fundamental characteristic of DRG systems is the use of relative cost weights (also known as relative weights or cost weights) to measure resource consumption. The relative cost weights represent the average costliness of a particular DRG as related to a reference value. This reference value is either based on the costs of a reference DRG (e.g. an uncomplicated delivery in the French DRG system) or a weighted average of

233 *Schellschmidt*, Case Mix in Germany: DRG-Based Hospital Payment in Germany, in: *France/Mertens/Closon/et al.* (eds.), Case Mix: Global Views, Local Actions, 2001, pp. 68-70.

234 *Rodrigues*, Origin and Dissemination Throughout Europe, in: *Casas/Wiley* (eds.), Diagnosis Related Groups in Europe, 1993, pp. 17-18.

235 *Lüngen/Lauterbach*, Fn. 231, pp. 51-52.

236 *Rochell/Roeder*, DRG – das neue Krankenhausvergütungssystem für Deutschland, in: Der Urologe 42(4/2003), pp. 471-477.

the per-case costs of the cases included in the cost calculation.[237] Accordingly, cost weights do not express an absolute reimbursement value, but rather only the relative difference between the individual DRGs compared to a reference value.

The case revenue for a particular DRG is generally the product of its relative weight and the base rate (i.e. the monetary value of a relative weight of 1.0). The relative weights used in DRG systems make it possible to quantify the average costs per case in relation to a specific unit of time and according to department, hospital, or region. This involves defining the so-called case mix (CM), which is equal to the sum of the relative weights of all DRGs performed during a specific period of time. The average case weight, or so-called case mix index (CMI), is calculated by dividing the CM by the total number of cases. The CMI is thus equal to the average DRG cost weight for a particular health care facility. With this instrument, it is possible to compare the relative use of health care resources in different facilities.[238] In turn, the complexity-adjusted, hospital-specific DRG revenue per case – otherwise known as the hospital base rate – is calculated by dividing a hospital's total revenues by the case mix.[239] Currently the hospital base rate varies considerable among hospitals in Germany, which reflects historical differences their financing (despite the fact that they offer a similar range of services). For the year 2004, a nationwide base rate of 2,593 € was calculated; the hospital base rate, however, ranged from less than 1,000 € to more than 4,000 €. For most hospitals the base rate ranged between 2,000 € and 3,200 €.[240]

b) The Relevance of Additional and Alternative Remuneration Components

It is the intent of the German legislature that, for each case of treatment, all general inpatient hospital services and day cases provided be reimbursed by means of case fees based on DRGs. Pursuant to §17b(1) s. 12ff of the Hospital Financing Act, additional or alternative reimbursement in supplementation of case fees is only permitted in strictly defined, exceptional cases. Contrary to the original intent of the legislature, however, the total amount of reimbursement for hospital services is currently comprised of a number of different revenue elements, as well as of a variety of surcharges and deductions. In part, these are negotiated on a hospital-by-hospital basis; otherwise, they are set in the context of uniform national standards. The different components of hospital reimbursement in Germany can be seen in Figure 5.

237 Institut für das Entgeltsystem im Krankenhaus, Kalkulation von Fallkosten – Handbuch zur Anwendung in Krankenhäusern – Version 2.0, 2002, pp. 42-44, http://www.g-drg.de/dokumente/kalkhb_v2.pdf.

238 *Fischer*, Diagnosis Related Groups (DRG´s) und verwandte Patientenklassifikationssysteme, 2000, p. 40.

239 *Lüngen/Lauterbach*, Fn. 231, pp. 35-39.

240 *Busse/Riesberg*, Fn. 208, p. 171.

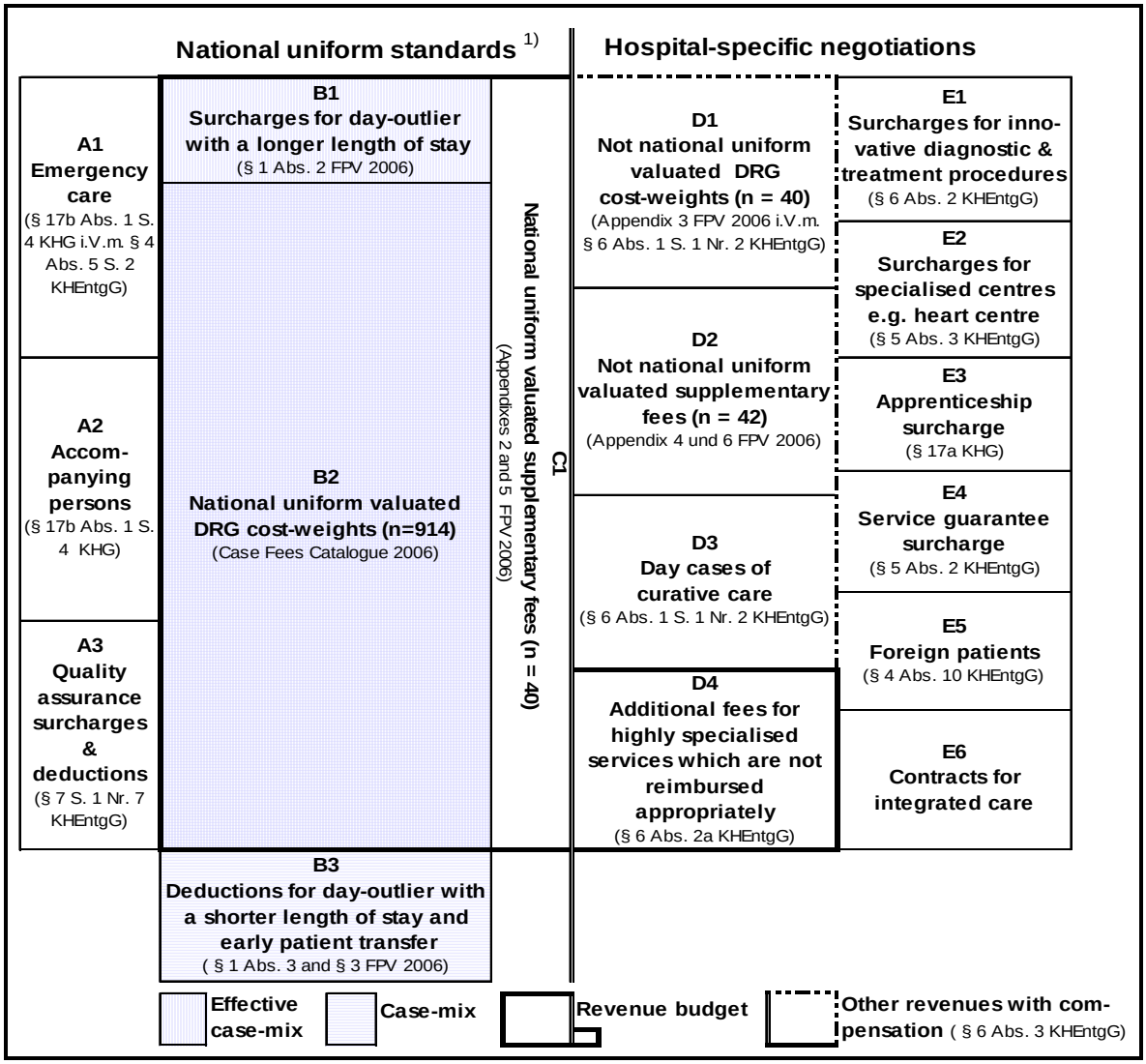

Figure 5: Reimbursement components of inpatient care in Germany (situation for 2006)[241]

1) Exception: classification as a special facility.

The contracting parties in the German system of self-governance in health care are authorised to negotiate reimbursement beyond that covered by DRGs by means of supplementary fees for certain cost-intensive services, service complexes, or medications (§ 17b(1) s. 12 Hospital Financing Act). These supplementary fees are generally calculated by the Institute for Hospital Reimbursement in a uniform manner for all of Germany. From a cost-accounting perspective, providing a definition of supplementary fees represents a step along the way to homogeneous classification. With this approach, it is possible to extract cost outliers receiving special and cost-intensive services from the case

241 Source: *Busse/Stargardt/Schreyögg/Simon/Martin*, Fn. 210, updated by *Busse et al.*, 2005.

groups in question and provide reimbursement for services not included in DRGs.[242] For the year 2005, the number of supplementary fees was increased from 26 to a total of 71. These include 35 supplementary fees whose amounts were fixed by the Institute for Hospital Reimbursement and specified in Appendices 2 and 5 of the Case Fees Agreement 2005 [*Fallpauschalenvereinbarung 2005*, FPV 2005]. The other 36 treatment services were included in the list of supplementary fees that are to be negotiated on a hospital-by-hospital basis pursuant to § 6(1) of the Hospital Remuneration Act [*Krankenhausentgeltgesetz*, KHEntgG].

In addition, pursuant to § 6(1) s. 1 no. 2 of the Hospital Remuneration Act, the contracting parties are authorised in the years 2005 and 2006 to negotiate the reimbursement of services by means of case-based or per diem remuneration. The prerequisite for this is that the service in question "cannot yet be appropriately reimbursed through DRGs or supplementary fees". On this basis, it is also possible, in principal, to negotiate hospital-specific payments pursuant to § 6(1) of the Hospital Remuneration Act for services that would normally be covered by DRGs or supplementary fees. In order to do so, however, it must be proved that the services in question "cannot be appropriately reimbursed" by means of the standard national fees.[243] Although the meaning of "proper remuneration" has not yet been qualified or quantified in more detail, a variety of elements within the G-DRG system (version 2005) are nevertheless affected (Figure 5).

These include, amongst other elements of the G-DRG system, DRGs and supplementary fees that have not been valuated uniformly throughout Germany, and for which hospitals and health insurance funds thus negotiate hospital-specific payments pursuant to § 6(1) of the Hospital Remuneration Act. The number of DRGs that are not remunerable with a case fee has risen from 18 within the G-DRG system of 2004 to a total of 33 in 2005. The abovementioned DRGs were excluded from the Case Fees Catalogue either because the available data pool was insufficient for calculation or the costs were so variable that it was impossible to determine a lump sum. It was also impossible to calculate day cases of curative care or the 36 supplementary fees.[244] Likewise, pursuant to § 6(2) of the Hospital Remuneration Act, it is permissible to negotiate special payments for innovative diagnostic and treatment procedures, although it should be noted in this context that the contractual parties at the federal level issue guidelines that serve as the basis for negotiations at the hospital level.

Furthermore, on the basis of the Second Case Fees Amendment Act [*Zweites Fallpauschalenänderungsgesetz*, 2. FPÄndG], separate supplementary fees for highly specialised services that cannot be properly reimbursed by means of the standard national fees can be negotiated pursuant to § 6(2a) of the Hospital Remuneration Act. In addi-

242 *Roeder*, Anpassungsbedarf der Vergütungen von Krankenhausleistungen für 2006. Gutachten im Auftrag der Deutschen Krankenhausgesellschaft, 2005, pp. 29.30, http://www.dkgev.de/pdf/826.pdf.

243 *Roeder*, Fn. 242, pp. 19-23.

244 *Müller/Häcker*, Ein Baukasten der Vielfalt, ZM-Online 07/2002, p. 38, http://www.zm-online.de/m5a.htm?/zm/7_02/pages2/titel2.htm.

tion, the German Federal Ministry of Health and Social Security made it possible to remove certain special facilities and departments completely from the G-DRG system and finance them through individually negotiated fees.[245]

As can be seen in Figure 5, additional and alternative fees – contrary to the intent of the legislature – play an important role in the Case Fees Agreement 2005 and in further regulations for the reimbursement of hospital services. These fees have become increasingly important because of a lack of sufficient data for calculating certain fees and the limited "appropriateness" of the cost weights currently in use. Due to the various remuneration components, the G-DRG system has become highly complex, leading to an increased need for coordination and a greater potential for conflict in budget negotiations between the negotiating parties.[246] In addition, the fact that various exceptions have considerably limited the scope of the G-DRG system needs to be viewed in a critical light. Indeed, this development is contrary to the transparency and comparability that were originally intended by the legislature. This is particularly true of hospital-specific components, which are determined locally by the negotiating parties.

2. Ambulatory medical care

With the introduction of the EBM 2000plus (*Einheitlicher Bewertungsmaßstab 2000plus*) on 1st April 2005 a new fee schedule for the practising physicians has been established. The EBM describes the various services provided in the individual specialities which can be charged by the SHI physicians. In addition, it also allocates a certain number of points for diagnostic and therapeutic measures (§ 87(2) s. 1 SGB V). EBM 2000plus therefore has the function of a benefit catalogue and is binding for all practising physicians and for the outpatient care of all those insured through the statutory health insurance system (SHI). The EBM criteria and the calculations based on them therefore have considerable influence on outpatient medical care.[247]

The specification of benefits and the relevant valuations are made by the Valuation Committee. This is made up of seven representatives each from the federal associations of sickness funds and the Federal Association of Statutory Health Insurance Physicians (KBV). In accordance with the Social Code Book V (SGB V), the fee schedules should be reviewed regularly to establish that the description of benefits and that the valuations still correspond to the state-of-the-art and the economic efficiency (§ 87(2) s. 2 SGB V). However, the law does not specify any maximum interval between reviews, so that in fact the fee schedule has only been revised irregularly.

Already in 1993 the representatives of the medical profession decided to develop a new fee schedule taking into account the economic requirements of the individual specialities. This was felt to be necessary in particular because the individual items of the

245 *Rau*, Besondere Einrichtungen im ersten Konvergenzjahr, Das Krankenhaus 97(4/2005), pp. 262-264.

246 *Busse/Riesberg*, Fn. 208, p. 175.

247 *Köhler*, Zukunftssicherung für die vertragsärztliche Versorgung, Deutsches Ärzteblatt 97(12/2000), p. 3338, 3388.

EBM at that time had not been reviewed for some 10 to 15 years. However, considerable distortions arose within the framework of the last EBM reform in 1996. Since in particular prices for specialist and technical services were higher than average following the reform, services such as magnetic resonance imaging tended to be provided more frequently than was medically required.[248] In order to eliminate such false incentives and to correct the existing inadequacies in the health services, a thorough reform of the EBM was initiated with the Health Reform Act 2000. The EBM 2000plus was intended to improve the quality and the economic efficiency of the SHI health care by stimulating qualified, cost-effective care. In this context, the basis on which the number of points for the services and the point value are calculated is of particular importance, and also whether these represent a basis for negotiations or for the performance-oriented remuneration for outpatient health services.

Although the new EBM contains elements of quantity control (such as service complexes and time factors), in view of the probable financial consequences it was not possible to introduce a new fee schedule without an effective quantity control strategy. The Statutory Health Insurance Modernisation Act (GMG) requires that the medical profession work together with the sickness funds to develop rules to prevent an excessive expansion of the activities of SHI-accredited physicians (§ 85(4) SGB V). Therefore a limited number of points were determined, up to which services provided by a physician's office would be paid at the regular point value. The limits are group specific, i.e. different groups of specialists have different total numbers of points. The limits are agreed in term of a regular service volume on the basis of the EBM 2000plus. If services are provided above the limit, then the excess is paid at a much lower floating point value. As more services are provided above the limit, the point value sinks even lower, and the lower the payment will be. The aim here, on the one hand, is to provide the physicians with a stable price for a specific quantity of services, and on the other hand to effectively reduce incentives to expand the quantity.[249]

The regular service volume is agreed on *Länder* level between regional physicians' associations and the regional associations of sickness funds. However, the Valuation Committee is responsible for providing key regulations at the federal level. The division of the overall budget that is yearly negotiated between the regional physicians' associations and the regional associations of sickness funds, among the specialist groups and the allocation of the budgets within each specialist group has to take place in accordance with transparent and comparable criteria. The following two points are of particular importance:[250]

- Formation of specialist group budgets to determine the funds available to the specialist group
- Distribution of the funds on the basis of case-number dependent regular service volumes.

248 *Partsch/Held*, Rechnen für Gerechtigkeit, Gesundheit und Gesellschaft 7(11/2004), p. 24, 25.

249 *Partsch/Held*, Fn. 248, pp. 27-28.

250 *Köhler*, Fn. 247, p. 3393.

In order to divide the overall budget, specialist group budgets were formed. A specialist group budget shows the pre-determined proportion of the overall budget at the regional level which goes to the specialist group. This proportion of fees is exclusively reserved for the specialist group in question. These specialist group budgets form the basis for determining the regular service volume of a physician. The regular service volumes, or the appropriate number of points, are derived from the individual number of cases treated by a physician and the average number of points per case of his specialist group.

Regular service volume = No. of points per case x No. of cases treated

The number of cases is the sum of all cases invoiced by a physician's office over the relevant period, as determined by the regional physicians' association (KV). Physician's offices with a higher number of cases therefore have a larger regular service volume than those with fewer cases. However, there are limits because not all cases are treated equally for the regular service volume. For case numbers which are more than 50 percent higher than the average for the specialist group, the number of points per case is reduced by 25 percent. The 200 percent level of average number of cases for the specialist group represents the absolute upper limit for a physician's office. Cases above this level are no longer added to the regular service volume, and are only paid with the floating point value.[251]

The number of points per case is derived from the relevant specialist group budget and the overall number of cases. The number of points per case is therefore the same for every SHI-accredited physician within a specialist group, and expresses a value for the service provided in points. It is calculated by the regional physicians' association (KV) on the basis of the key regulations made at federal level. The specialist group budgets are the central instrument for financial redistribution, because they determine the calculation of the regular service volume of a physician office. The allocation of funds to budgets is intended to ensure funding distribution in accordance with the accounting principles for services specified in EBM 2000plus. This means that the size of budget is determined on the basis of the same data used for the calculation of services under the uniform value scale EBM. Not all services are covered by the concept of the regular service volumes. Such other services are included in a list of exceptions issued by the Valuation Committee. Furthermore, the quantity control by means of the regular service volume in connection with the introduction of the EBM 2000plus is subject to a time limit. The law says that on 1st January 2007, risk-adjusted regular service volumes (*Morbi-RLV*) will be introduced (§ 85 SGB V). From 2007, the medical care services would then be funded by a regulated service volume related to the insured person. An amount of funding will be allocated for every insured individual on the basis of their state of health for the payment of physician's services. Extensive preparations are already underway for this at the federal level. A key point is to develop criteria for the

251 *Schauenburg*, Fn. 218, p. 242.

measurement of morbidity and methods to predict the expected morbidity of an insured individual.[252]

For its calculations concerning the individual services, the Valuation Committee has used a calculated point value of 5.11 eurocent. However, the actual point value is the subject of negotiations between the individual regional physicians' association (KV) and the regional associations of sickness funds. The point value of 5.11 eurocent is appreciably higher than the previously valid point values. Calculations have shown that such a value would not be compatible with stability of health insurance contribution rates.

The consequence of the above is that in some cases the regulated service volumes do not appropriately cover the extent of the services provided. To the extent that medically-unnecessary services are to be cut back this is indeed intentional. However, a more critical view is appropriate for regular service volumes which do not provide (in full or in part) for the provision of medically-necessary services. The Valuation Committee has reacted to this problem by deciding that the regular services volumes must take due account of the extent of services previously provided. According to the new specification, it must be possible to cover at least 80 percent of the previously available services with the regular service volumes. The fixed point value to be determined at the regional level should apply for this volume. It then follows that only 20 percent of the previously provided services will be outside the regular service volumes and will be paid for on the basis of floating point values. This arrangement represents firstly an acceptable compromise between a necessary quantity control and the need to secure the provision of medical care. Secondly it makes clear that only the price structure or the allocation of funds is based on management principles. In this context, all services have been calculated for the first time on the basis of the same principles, so that the weighting of the services with respect to one another is closer to the reality of medical care in Germany than it was in the past. The price level, and thus the prices in individual cases are the result of negotiations and thus orient themselves only to a limited extent to the actual consumption of resources.

In this context, it should be noted that in many cases the calculations could not be based on up-to-date figures. Many details were thus determined through negotiations. For example, the annual physician's working time, the productivity of the physician's work and the resultant valuation of the physician's services were in the end determined by the Valuation Committee. Furthermore, it is not clear how reliable the results of the calculations are regarding the valuated times for the average length of treatment. The Federal Association of SHI Physicians (KBV), representing the interests of its members, has been arguing for an appropriate valuation of services in terms of a realistic practical determination of the times taken. However, various experts claim that the assumed times could not be determined exactly, and that they also represent estimates or the results of the negotiations of the Valuation Committee.

252 *Gass/Gibis/Hess et al.*, Gesetz zur Modernisierung der gesetzlichen Krankenversicherung – Informationen für den Vertragsarzt 2003, pp. 27-29.

3. Dental care

With the introduction of the Reform Act of SHI 2000, a reorganisation and revaluation of the uniform value scale for dental services (BEMA) was required by law (§ 87(2d) SGB V). A revised version of the SHI benefit catalogue started on 1st January 2004. The BEMA defines the content of services that are reimbursed by the sickness funds. It is a fee schedule for dental treatments, but it also contains detailed instructions for each service. Additionally, each service is assigned a certain number of points for reimbursement reasons. The actual compensation of a dental service is the result of the multiplication of the number of points defined by the BEMA and the agreed point value in Euro. The BEMA serves as a reference for the billing of the dental services within the statutory health insurance (SHI). The so called valuation committee decides on the value and the definite content of the reimbursable services. The committee consists of seven representatives of the Federal Association of SHI Physicians and sickness funds and is required by law to revise the status of the dental science and technique regularly even if there is no prescribed time interval.[253]

The point of origin for introducing the basic reform were imbalances of valuation between and within the different service types of the BEMA like teeth preserving services, prevention, prosthetic services and orthodontics. Corresponding economic malfunctions and wrong incentives for the dental service provision had to be changed by the revaluation of the BEMA. After revising the whole system there should be no incentives for a dentist to favour one procedure over another. The reform act of SHI 2000 also requires the valuation committee to create financial incentives especially for dentists regarding preventative care and teeth preserving services (§ 87(2d) SGB V). The intention of the legislation is shared by the Federal associations of sickness funds. But the revaluation of the dental services should be realised by regrouping the funds and without adding expenses by the sickness funds.

a) Working time as an indicator for dental use of resources

The idea of the legislation is to offer a valuation that remunerates the dental services equally no matter which section of dental services is affected. The main criterion for the revaluation of the dental services is the working time. This criteria serves as an orientation for the value based rate of services. As a result of the criteria, the valuation committee carried out an investigation for counting the working time of the dentists. The goal of this research was to expose the time variances for dental services to have a basis for the revaluation. The services described in the BEMA were checked with regard to their over- and underestimation of working time. It was essential for this reason to compare the different numbers of points and the necessary working times which are defined within the BEMA. Another aim of the research was to collect on the one hand the established dental services and on the other hand the services that have not been gathered in

253 *Maibach-Nagel/Prchala*, Dicke Bretter gebohrt, ZM-Online 12/2003, p. 30 (http://www.zm-online.de/m5a.htm?/zm/12_03/pages2/titel1.htm).

the BEMA but are already provided as a routine. The research presumed that the rate of the actual needed input of resources for certain services can be approximately assigned by the working time ratio. As for other qualitative factors like physical and mental burden, quality and qualification requirements are supposed to be equal in all sections of the dental services, and thus do not change the rate of valuation. Concerning the remaining input factors for valuation, dental services like material cost as well as the maintenance costs are not taken into account as it is assumed that every service can be calculated by the working time ratio and a proportional indirect cost surcharge. Those factors are not used to revise the ratio of valuation because they are only affecting the level of valuation and not the cost relation.[254]

b) Data collection

Data was collected from several dental offices in 2001. The KZBV and the federal associations of sickness funds were not able to agree on the fundamentals of design data collection for joint research. The research of the federal associations of sickness funds contained data of the working time in minutes for 40 dental offices, 6 orthodontic offices and 5 offices of oral surgery in 11 different states of Germany. 81 dentists participated in this research and their working time in minutes was measured for 254 days.[255] The KZBV and the orthodontists carried out two different investigations and the results were put together in one survey. Within those investigations 56 dentists in four regions of Germany (Hamburg, Stuttgart, Dresden, and Munich) were observed and 2738 patient treatments were analysed. Every minute of the dental working horizon has been valuated on 267 treatment days.[256]

c) Results of the revaluation

Both investigations were taken into account for revaluating the dental services and this data collection supported the decision making process. Despite the fact that the design of the investigations was different, the results of both surveys are comparable. The results from the survey of sickness funds underlined the assumption of the legislation that several parts of the dental treatments were not reimbursed as the actual resource consumption of dental services.[257]

The remuneration of the teeth preserving and preventative services were found to be too low while the remuneration of prosthetic services was too high. The survey clarified

254 *Marbé/Muschter*, Spitzenverbände der Krankenkassen – Arbeitswissenschaftliche Messung des Zeitbedarfs bei der Erbringung zahnärztlicher Leistungen., 2002, pp. 5-6, http://www.dr-menges.de/IFH-Zeit.PDF.

255 *Stackelberg/Wienefoet*, Neubewertung zahnärztlicher Leistungen steigert Attraktivität zahnerhaltender Maßnahmen. Presseseminar – AOK-Bundesverband, 2003, p. 9, http://www.aok-bv.de/imperia/md/content/aokbundesverband/dokumente/pdf/ presse/ps_bema.pdf.

256 *Müller/Häcker*, Ein Baukasten der Vielfalt, ZM-Online 07/2002, p. 38, http://www.zm-online.de/m5a.htm?/zm/7_02/pages2/titel2.htm.

257 *Prchala* Ein Großprojekt zur Reform der Zahnheilkunde, ZM-Online 07/2002, p. 34, http://www.zm-online.de/m5a.htm?/zm/7_02/pages2/zminhalt.htm.

that dentists earn on average 135 Euros per working hour as measured by all services. Teeth preserving services, which includes individual prevention services, is disbursed on average with 109 Euros per working hour. In contrast, 206 Euros per working hour were earned by dentists for orthodontic services. The results of both surveys have been combined through negotiations. They serve as a foundation for the revaluation of the services in the revised BEMA that have been accomplished by the valuation committee. The number of points of teeth preventing services has been increased on an average by 11.2 percent in the sense of an equivalent remuneration of dental treatment. On the contrary the section prosthetic services number of points per procedure has been decreased by 8.3 per cent and especially the section orthodontic services, which have been decreased by 19.8 percent on average. The section of services for treating periodontosis and periodontitis experienced a decrease of 32.2 percent on average. Furthermore, there were also some new services that were remunerated even though they did not belong to the BEMA catalogue.[258]

d) Conclusion

The revaluation of BEMA is characterized by the fact that during the survey of the separate sections were no data of costs collected. The legislation supports this procedure with the Reform Act of SHI 2000. The regrouping of funds and with this the revaluation of the several services is geared to the dental working time. Therefore the price structure within the BEMA is based on an approximation where the dental working time is a foundation. The actual treatment costs are not considered. The regional dentists association and the association of the sickness funds will decide together on the level of prices which means that they are free to negotiate the point value at the beginning of each year. The economical calculated point value assessed by the regional dentists association is simply an orientation as a start for the negotiations.

4. All other outpatient curative care

The term “Cures” subsumes health care services that are provided by non-medical practitioners in Germany. Non-medical practitioners include professional and recognized therapists (e.g. psychotherapists, occupational therapists etc.). The entitlement to cures of insured persons can be found in the fifth section of the “Benefits in Case of Disease“ under Chapter III of the SGB V (§ 32 SGB V).

The scope of services covered by the Statutory Health Insurance is explicitly described and regulated by the Directive on Care by Non-physicians issued by the Federal Joint Committee under § 92 SGB V. The Directive on Care by Non-physicians was amended and came into force on the 1st July 2004. This Directive regulates the prescription of cures under the SHI. The cures listed in the directive in connection with the stipulated indications are services and benefits of the SHI. The federal associations of sickness funds and federal representatives of the interests of the cure providers included

258 *Maibach-Nagel/Prchala*, Fn. 253, p. 30.

a Catalogue of Care by Non-physicians for the implementation of the directive, issued by the Federal Joint Committee, in accordance with § 125 SGB V. This catalogue regulates:

- the content, scope and frequency of cures,
- further training measures and quality assurance,
- the content and scope of collaboration between cure providers and the prescribing SHI physician,
- measures to meet the precept of cost-effectiveness, and
- specifications for remuneration structures.

Actual prices for the remuneration of cures are determined on the *Länder* level between the regional associations of sickness funds and the regional representatives of the interests of cure providers. The actual price for the remuneration of cures comes as a result of negotiations, leading to variations in the price structure within the *Länder*. The Catalogue of Care by Non-physicians solely predetermined the contents of the different services on a federal level.

5. Services of rehabilitative care

The system of rehabilitative care in Germany is highly fragmented. There is no single payer in charge of rehabilitative care benefits or individual benefit categories. Rehabilitative care services thus, comprises one of the many miscellaneous tasks that the various payers of social insurance are responsible for (§ 6 SGB IX). Medical rehabilitation benefits are provided by the SHI, the Statutory Retirement Insurance (SRI), and the Statutory Accident Insurance (SAI). In addition, the SHI only provides subsidiary rehabilitation services, if no other social insurance is responsible (§ 40(4) SGB V).

The decentralized placement of medical rehabilitative services within the social insurance system is followed by different requirements which vary significantly depending on the type and complexity of rehabilitative services. This variety originated from the somewhat different aims of third party payers within the social insurance system. It was required that the framework had to be combined to a clear design and had to be integrated in the Social Code Book as the new Book IX (SGB IX). In addition to the fifth book of the SGB, the ninth book of the SGB is applicable as well. The ninth book of the SGB, which came into force on the 1st January 2001, regulates rehabilitation and the participation of disabled persons. The introduction of SGB IX created a uniform foundation for the provisioning of rehabilitative care services. However, specific accountability and service requirements result from certain laws laid down in different books of the SGB, like for example the SGB V for the statutory health insurance (§ 7 SGB IX).

Medical rehabilitation consists of in- and outpatient rehabilitative care. More than 90 per cent of rehabilitative services are provided for in inpatient facilities. However, there is no list of individual services, like a benefit catalogue in either the inpatient or the outpatient centres. Explicit regulations governing the exclusion or inclusion of services are therefore not stipulated for the field of rehabilitation. In addition explicit regulations

governing the exclusion or inclusion of services are not documented as well. Since no benefit catalogue is available on a federal level; there is no corresponding reimbursement catalogue. 95 percent of the majority of medical rehabilitative services in Germany are financed by the social insurance carriers. In particular, 65 percent of medical rehabilitative services are generated by the SRI. This can be compared to 25 percent by the SHI and 5 percent by the SAI.[259]

The SRI has 95 inpatient rehabilitative care facilities containing 17.000 beds. For this reason, it covers over one third of the inpatient rehabilitative services per year with its own rehabilitative care facilities.[260] The SRI, like all other social insurance carriers, is a public corporation (§ 29(1) SGB IV). Financial management is based on the SRI planned budget. Every rehabilitative care facility of the SRI has its own planned budget where all the receipts and expenditures are taken into account. These budget plans are an attachment of the planned budget of the SRI. By valuating the budgets, which are necessary for the completion of the tasks of the rehabilitative care facilities, financial resources are prospectively determined for the year. The systematic calculation of the actual costs are realized by the use of cost element and cost centre accounting. The identification of annual profit or loss is the most important aspect, but a very detailed overview of the expenditures and receipts are conducted at the same time. In the detailed income statement, the principles of cost effectiveness, thriftiness and completeness have to be borne in mind (§ 69(2) SGB IV und § 13(1) SGB VI). This kind of a reimbursement system is very close to the principle of cost coverage.

The remuneration of rehabilitative services of other providers occurs via daily reimbursement rates. Those rates are equivalent to a per diem remuneration during the length of stay in an inpatient rehabilitative care facility. The day oriented lump sums will be assigned in the yearly proceedings together with the several rehabilitative care facilities. In consideration of the development of costs and services, the reimbursement rates will be assigned mostly on basis of the historical costs. Historical costs are taken into account for future cost plans. It is important for rehabilitative care facilities to give plausible reasons for their personnel costs and other costs during the negotiations of remunerations with the SRI. Therefore, historical costs are used as an orientation for the process of negotiation. It is because of this reason that rehabilitative care facilities are able to generate profits and losses. The SRI demands the disposition of every diagnostic and therapeutic service. The SRI also demands a profit and loss statement, which serves as a foundation for reimbursement rate negotiations. A special listing for the level of the actual service performance is not available and therefore cannot be used for the negotiations. The gathering and reimbursement of single services is seen as too complex from

259 *Burger*, Ökonomische Analyse der medizinischen Rehabilitation – Rehabilitation zwischen sozialpolitischem Anspruch und arbeitsmarktpolitischen Interessen, 1996, p. 22.

260 VDR-Verband Deutscher Rentenversicherungsträger (Federal Association of Retirement Funds), VDR Statistik Rehabilitation, 2003, pp. 17.22, http://www.vdr.de/.

the administrative point of view.[261] The regional associations of sickness funds also include service agreements with several inpatient rehabilitative care facilities and the remuneration on the *Länder* level is made by reimbursement rates. Therefore, reimbursement rates are determined separately for each of the rehabilitative care facilities or are negotiated with regional representatives including the interests of the rehabilitative care providers.

III. Quality Control

1. Inpatient care

Traditionally, personnel, technical and physical capacities, professional self-regulation and the control of technical and hygienic security had been perceived as sufficient to secure quality. The Hospital Financing Act and the Social Code Book outline basic quality requirements of hospitals to be accredited for the hospital plan and to qualify for reimbursement. Quality assurance in hospitals has changed substantially during the last decade, shifting from voluntary activities to obligatory tasks. Requirements for safeguarding quality of processes, and recently of outcomes, have gradually been increased as outlined in the Social Code Book. Quality assurance of processes based on documentation was first introduced in the form of registries in the early 1970s, depending on state legislation concerning registries for perinatal care and general surgical interventions, for example. Later registries for high-tech interventions and the use of medical devices became more common. Their role in actually improving quality of care is not known, however.

In 1996, quality-relevant documentation of case fee procedures, associated with the introduction of prospective case fees, became a task to be negotiated at the *Länder* level. Since physicians' chambers, previously involved in registry quality measures, were initially not involved, negotiations were delayed and implementation was weak. A federal working group for quality assurance, consisting of sickness funds, physicians' associations, hospital organizations, the Federal Physicians' Chamber and the German Nursing Council, sought to improve communication and cooperation in quality initiatives across professional groups and sectors. The working group built an information system on quality projects and organized various meetings, but was dissolved in 2004. Its tasks were delegated to the Federal Joint Committee, where decisions on quality assurance can be linked more closely to more powerful instruments of contracts, regulations and reimbursement.

Since 2000, hospitals have been obliged to run internal management programmes and to negotiate contracts with sickness funds on external quality assurance measures. In addition, the Social Code Book V stipulates that quality be an object of the contracts

261 VDR-Verband Deutscher Rentenversicherungsträger (Federal Association of Retirement Funds), Empfehlungen zur Weiterentwicklung der medizinischen Rehabilitation in der gesetzlichen Rentenversicherung, 1991, pp. 197-209, http://www.vdr.de/.

between purchasers and providers (§137). In the contract, providers are committed to participate in quality assurance measures with special emphasis on documenting quality indicators in a standard way that allows for comparative analysis. An independent institute has been established for the inpatient sector (Federal Office for Quality Assurance), which assists the contract partners in choosing and developing the quality indicators to be monitored and collects the data and presents them in a comparable way. As of now, the contracts oblige the providers to document quality for a set of surgical procedures (such as hip replacement and hip fracture surgery, hernia surgery, cataract surgery) and invasive medical procedures (PTCA, pace-maker implantation). The contract partners are charged by the legislature to further develop the list of areas for which quality documentation should be a contractual requirement. The contract stipulates sanctions for incomplete documentation, that is, for discrepancies between the number of cases claimed for reimbursement and the number of cases documented for quality assurance.[262]

Publication of the results of quality assurance initiatives became obligatory in 2000 for nosocomial infections on an anonymous basis. The benchmarking system with feedback for the participating hospitals and ambulatory surgery institutions is coordinated by the Robert Koch Institute, and is only slowly gaining acceptance. Since 2005, hospitals are obliged by law to include the range and volumes (but not outcomes) of their services on their internet homepages.

Since 2000, hospitals have been encouraged to take part in certification procedures by joint initiatives of associations of sickness funds and various hospital organizations. Two hospital-specific systems of certification combining self-assessment and visitor assessment were developed, based on the EFQM and European quality award system, Cum Cert for religious-based hospitals and KTQ.[263]

Since 2002, minimum services volumes have been legally enacted for selected hospital services. Contract partners, i.e. the associations of sickness funds, the German Hospital Federation and the Federal Physicians' Chamber, were required by law to develop a list of elective services in which there is a clear positive relationship between the volume of services provided and the quality of health outcome. For those services, delivery of a predefined minimum volume will be the condition to become (or to stay) "contractible." Minimum volumes per institution and per individual physician were passed for the surgical treatment of oesophagus and pancreatic cancer as well as for kidney, liver and stem cell transplantations in December 2003. Since 2004, hospitals may only be reimbursed for selected interventions if they can show they have provided the minimum number of these interventions in the previous year.

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262 *Velasco Garrido/Busse*, Förderung der Qualität in deutschen Krankenhäusern? Eine kritische Diskussion der ersten Mindestmengenvereinbarung, Gesundheits- und Sozialpolitik 2004, pp. 10-20.

263 Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen (Advisory Council for the Concerted Action in Health Care), Report 2000/2001: Appropriateness and efficiency, Vol. II: Improving Quality in Medicine and Nursing. Executive Summary, 2001, http://www.svr-gesundheit.de.

2. Ambulatory care

In order to offer special services, mostly invasive procedures or medical imaging procedures, SHI-physicians need to fulfil certification requirements, in addition to being licensed as specialists. This is the case for about 30% of services listed in the Uniform Value Scale. Certification is obtained when the surgeries fulfil minimal technical requirements and the physicians have undergone additional training, defined as a minimal number of cases done under supervision. Organizational requirements are also considered for certification. For example, a binding cooperation agreement with a heart surgery unit within a certain area (measured as time to access) is required to obtain certification for ambulatory PTCA. Specific certificates are required for arthroscopy, dialysis, pacemaker supervision, ultrasound and laboratory testing, for example. The performance of other services not only requires a specific qualification, but also evidence of sufficient experience, indicated as a minimum number of services in the preceding year, for example 200 colonoscopies or 350 PTCAs.[264]

Recertification is needed in order to retain eligible for sickness fund reimbursement for providing special services within the contracts. Recertification requirements are fixed in the contracts and vary depending on the service in question. The different approaches include minimum volumes of procedures done in a year, or case-verification and evaluation of skills (with thresholds for sensitivity, for example). Furthermore, the contracts also include agreements that physicians involve themselves in quality improvement interventions, such as auditing or supervision with significant event reviews. These requirements are defined by the Federal Association of SHI Physicians and are contract items between the sickness funds and the regional physicians' associations.

The reimbursement is further subject to control mechanisms to prevent over-utilization or false claims. A physician may be subject to a utilization review at random or if levels of service provision or hospital referrals per capita are higher than those of colleagues in the same specialty under comparable circumstances. To escape financial penalties, the physician has to justify the higher rates of utilization and referral, which may be due to a higher number of severely ill patients. Utilization review committees and utilization review arbitration committees with an equal number of physicians and sickness fund representatives are responsible for these controls.

264 *Velasco Garrido/Borowitz/Øvretveit/Busse*, Purchasing for quality of care, in: *Figueras/Robinson/Jakubowski* (eds.) Purchasing for health gain, 2005.

C. Health care in an aging society

I. On the demographic processes

German society is aging. This process is not unique,[265] nor is it new,[266] but it has accelerated. Since the beginning of the previous century, life expectancy has increased by about 30 years; it is now just under 75 and 81 years, respectively, and will be prolonged further in future.[267] At the same time, German society is shrinking[268] on account of low fertility rates. According to the Federal Statistical Agency, every third person living in Germany in 2050 will be 60 years of age or older. The (old) age dependency ratio, i.e. the ratio of those over 60 to the working population, is forecast to rise from 44 to 78.[269] And these estimates tend to be on the cautious side.[270]

Table 13: Trends in life expectancy in Germany

	Women	Men
1901/10	48.3	44.8
1924/26	58.8	56.0
1931/34	62.8	59.9
1949/51	68.4	64.6
1960/62	72.4	66.9
1970/72	73.8	67.4
1980/82	76.9	70.2
1991/93	79.0	72.5
2000/02	81.2	75.4
2002/04	81.6	75.9

Source: Statistisches Bundesamt, 2006.

265 Cf. *Pohlmann*, Ageing as a global phenomenon, in: *id.* (ed.), Facing an Ageing World, 2002, pp. 1 et sqq.; Deutsches Zentrum für Altersfragen, Dokumente der internationalen Altenpolitik, 1993; Commission Communication "Towards a Europe for All Ages", COM(99) 221 final.

266 Cf. *Kaufmann*, Die Überalterung. Ursachen, Verlauf, wirtschaftliche und soziale Auswirkungen des demographischen Alterungsprozesses, 1960; *Stolleis*, Möglichkeiten der Fortentwicklung des Rechts der Sozialen Sicherheit zwischen Anpassungszwang und Bestandsschutz, DJT 1984, N, pp. 9 et sqq.; *Birg*, Demographische Wirkungen politischen Handelns, in: *Klose* (ed.), Altern hat Zukunft, 1993, pp. 52, 55 et sqq.; *Wilkoszewski*, Die verdrängte Generation, 2003, pp. 16 et sqq.

267 Statistisches Bundesamt, 10. koordinierte Bevölkerungsvorausberechnung [10th coordinated population projection], p. 14, on the Internet under www.destatis.de (as at: 11.09.2006).

268 See *F.X. Kaufmann*, Schrumpfende Gesellschaft, pp. 48 et sqq.

269 Thus the "mean variant" of the 10th coordinated population projection (note 267).

270 Cf. *Vaupel*, Deutschlands größte Herausforderung, FAZ dated 8.4.2004, p. 41.

Table 14: Trend in the Total Fertility Rate (TFR)

= the average number of children that would be born alive to a woman if she lived to the end of her reproductive years and if she experienced the same age-specific fertility throughout her life that women in each age group experience in a given year or over a period of years.		
Year	Germany	Japan
1993	1.28	1.46
1994	1.24	1.50
1995	1.25	1.42
1996	1.32	1.44
1997	1.37	1.44
1998	1.36	-
1999	1.36	1.40
2000	1.38	1.36
2001	1.35	1.33
2002	1.31	1.37
2003	1.34	1.38
2004	1.37	-

Source: Eurostat, 2006.

Table 15: Age structure in Germany

	Inhabitants in m	Aged under 20	Aged 20 - 60	Aged above 60
1960	73.1	30.2%	52.4%	17.4%
1970	78.1	31.4%	48.8%	20.0%
1980	78.4	28.3%	52.3%	19.4%
1990	79.8	23.1%	56.5%	20.4%
1995	81.8	22.6%	56.4%	21.0%
2000	82.0	21.3%	56.3%	22.4%
2010	83.1	18.7%	55.7%	25.6%
2020	82.8	17.5%	53.2%	29.2%
2030	81.2	17.1%	48.5%	34.4%
2040	78.5	16.4%	48.3%	35.3%
2050	75.1	16.1%	47.1%	36.8%

Source: Statistisches Bundesamt, 2006.

II. Effects of aging on healthcare systems

1. Financial sustainability

aa) It seems to be very difficult to make a prognosis on the development of health care costs, and thus on the costs of the health insurance system, in an aging society. On the one hand, it is quite plausible that the process of demographic aging will lead to

rising costs. On the other hand, we know very well that the costs for an individual insurant reach a peak during the last year of life.[271] It is not clear, though, whether there is also a proportional increase in the previous years.[272] It should be noted that the overall costs of medical treatment for individual insurants depend very much on their state of health, and that this is, at the same time, influenced by environmental and social factors. And of course, technical and medical innovations have a strong impact on the financial burdens of the health insurance system.

bb) Neither the Secretary of Health, the Federal Statistical Office nor the Federal Social Insurance Authority provide any projections on contribution rate and health expenditure development. But some very interesting scientific approaches to this problem do exist.[273] The following description by Postler shows the development of contribution rates according to aging society, on the one hand, and medical progress, on the other.

Table 16: Contribution rate development (allowing for society aging)

Year	Contribution rate (best case) in %	Contribution rate (worst case) in %
2000	13.6	13.6
2010	14.1	14.1
2020	14.7	14.8
2030	15.9	16.1
2040	16.0	16.3
2050	16.2	16.5

Source: Postler, Modellrechnungen zur Beitragsentwicklung in der GKV, 2003, p. 15.

The year 2000 is used as the base year. Concentrating solely on the effects of demographic development, Postler based his calculation on constant amounts of benefits paid for every member, a constant level of compulsorily insured earnings and pensions, and a proportional correlation between both the ratio of persons aged over 60 to pensioners insured under statutory health insurance and the ratio of gainfully employed persons covered under statutory health insurance to the trend in the number of persons capable of gainful employment, as well as between net administrative expenditures and benefit payments. In the best case scenario, the income of insurants will decline by about 16 percent, and in the worst case scenario, by about 23 percent.

271 See, e.g., *Zweifel/Felder/Meier*, Demographische Alterung und Gesundheitskosten, in: *Oberender* (ed.), Alter und Gesundheit, 1996, pp. 29 et seq.

272 See *Rodrig/Wiesemann*, Der Einfluss des demographischen Wandels auf die Ausgaben der Krankenversicherung, ZfgesVersWiss. 2004, pp. 17 et seq., concluding from numbers of the PHI that rising costs have to be expected foremost within the in-patient sector.

273 See *Breyer/Ulrich*, Gesundheitsausgaben, Alter und medizinischer Fortschritt: eine Regressionsanalyse, 1999; Postler, Modellrechnungen zur Beitragsentwicklung in der Gesetzlichen Krankenversicherung, 2003; Henke/Reimers, Zum Einfluß von Demographie und medizinisch-technischem Fortschritt auf die Gesundheitsausgaben, 2004; Fetzer, Determinanten der zukünftigen Finanzierbarkeit der GKV, 2005.

Table 17: Contribution rate development (allowing for society aging and medical progress)

Year	Contribution rate (best case) in %	Contribution rate (worst case) in %
2000	13.6	13.6
2010	15.1	16.3
2020	16.9	20.0
2030	19.7	26.5
2040	21.2	32.0
2050	23.1	39.5

Source: Postler, Modellrechnungen zur Beitragsentwicklung in der GKV, 2003, p. 20

Taking medical progress into account, the calculation shows a 3.5 percentage-point increase in benefit payments per member (with, for the worst case scenario, a 5 percentage-point increase among pensioners). As to the pension level, a fall to 48 percent is assumed. A proportional correlation is presupposed for the ratio of persons aged over 60 to insured pensioners, as well as between the number of persons of employable age and the number of gainfully employed persons covered under statutory health insurance, and between net administrative expenditures and benefit payments.

The other above-mentioned calculations[274] cannot be dealt with in detail here. Given that all of them suffer from more or less great uncertainty, they merit attention not so much for providing new figures as for the simple fact that they put emphasis on the linkage between future expenditure and cost containment policies.[275]

2. Adaptation of the benefit package

a) Introductory remarks

In the face of future demographic changes, an ever more pressing question will be whether and how the benefit catalogue must be adjusted to meet the needs of older persons. Gerontological research shows that supportive and promotional measures are above all necessary to take account of a potential loss of autonomy, but also to maintain self-reliance. Extensive lists of elder policy demands were already drawn up years ago, with reference both to the living environment of older people and to the care and assis-

274 *Breyer/Ulrich*, Gesundheitsausgaben, Alter und medizinischer Fortschritt: eine Regressionsanalyse, 1999; Postler, Modellrechnungen zur Beitragsentwicklung in der Gesetzlichen Krankenversicherung, 2003; Henke/Reimers, Zum Einfluß von Demographie und medizinisch-technischem Fortschritt auf die Gesundheitsausgaben, 2004; Fetzer, Determinanten der zukünftigen Finanzierbarkeit der GKV, 2005.

275 See the so-called "Freiburger Agenda", *Fetzer/Hagist/Höfer/Raffelhüschen*, Gesundheitsreformen im Nachhaltigkeitstest, Initiative Neue Soziale Marktwirtschaft, 2004, pp. 13 et seq. (on the Internet under: www.insm.de/Downloads/Word-Dokumente/Studie_Gesundheitsreformen_im_Nachhaltigkeitstest.doc).

tance benefits required by them.[276] The following seeks only to address two especially topical points relating to health insurance.

b) Preventive measures

aa) Current statutory foundations under SGB V

The statutory foundations governing claims to, and scope of, preventive measures are set forth in §§ 1, 20 to 26 and 33a SGB V. These provisions distinguish according to primary, secondary and tertiary prevention. Healthy persons are the subject of primary measures. Secondary prevention is geared to the early treatment of existing impairments to health in a pre-clinical stage. The third level seeks to prevent a worsening of disease patterns, relapses and sequels.

The law governing primary prevention (measures for general improvements to health and for the reduction of socially induced inequality in respect of healthcare opportunities; occupational health promotion; support of self-help groups) does not only lay down which measures are to be promoted, but also limits the financial resources appropriated to that end (in 2006, € 2.68 were spent annually per insurant, along with an additional € 0.53 toward the support of self-help groups).[277] Consumer and patient counseling services are eligible for separate support (§ 65b SGB V).

Apart from individual and group prophylaxis for children and youths in dentistry (§§ 21, 22 SGB V), entitlements include: general sickness prevention benefits (§ 23 SGB V); benefits specially awarded to mothers and fathers (§ 24 SGB V), comprising allowances for birth control, abortion and sterilization (§§ 24a, 24b); general health checks for disease prevention (§ 25(1) SGB V) and specifically for the prevention of cancer (§ 25(2) SGB V); as well as general check-ups for children (§ 26 SGB V).

The preventive character of medication is regulated under § 33a (7) SGB V as one of the prerequisites for the authorization of prescription drugs.

Pursuant to § 65a SGB V, a bonus is offered for claiming early diagnosis benefits or primary preventive measures.

bb) Reform of preventive measures

Based on preliminary work done in 2004, the government submitted a draft bill for a prevention law on 2 February 2005.[278] The law was adopted by the Bundestag (Lower House) on 22 April 2005 with the votes of the Red-Green majority.[279] But as the bill was rejected by some of the Länder representatives in the Upper House [Bundesrat] on account of its incalculable financial consequences, it was sent to the mediation commit-

276 See *v. Maydell/Schulte*, Generationenbeziehungen und sozialstaatliche Entwicklungen, in: BMFSFJ (ed.), Das Altern der Gesellschaft als globale Herausforderung – Deutsche Impulse, 2001, pp. 225, 236 et seq.

277 See §§ 20(3) and (4) SGB V.

278 BT-Drucks. 15/4671.

279 BT-Drucks. 15/4833; for the discussion in parliament, see Plenarprotokoll 15/173.

tee and could therefore no longer be passed in the previous legislative period. According to the principle of discontinuity, draft bills from a preceding legislative period may not be reintroduced in the new period.

The new Federal Government's coalition agreement of 11 November 2005 re-addresses this issue. Thus it declares that prevention is to be upgraded to form a separate pillar of health care; at the same time, prevention is to come under a general regulation that transcends the individual social insurance branches.[280] Details are left open. Express mention is made only of the aim to improve data acquisition and the recording of disease patterns. In particular, the Government plans to take steps toward the repression of widespread diseases such as cancer and cardiovascular disorders, although it does not mention specific measures to that end.[281]

The cornerstone paper [Eckpunktepapier], dated 4 July 2006, of the joint working group of the Federal and Länder governments on healthcare reform provides further details on a prospective prevention law. Supplementary to the coalition agreement, it places general emphasis on the prime goals of reducing red tape and registering participation in preventive measures. Such participation is to be rewarded with bonuses and considered for out-of-pocket payments on drugs for chronic illnesses. The final version of the new legislation[282] contains various measures for the promotion of prevention[283], e.g. measures for the promotion of occupational health, for the prevention of work-related health hazards, and for the promotion of self-help.

c) Linkage between healthcare and long-term care systems

Geriatric rehabilitation is one such link between the systems of long-term care and health insurance. This form of rehabilitation takes account of age-specific problems in its therapies, a chief aspect being the high frequency of multiple diseases among the elderly. Special therapeutic approaches and forms of treatment thus aim at preventing the need for long-term care.

Previously, geriatric rehabilitation played only a secondary role within the scope of rehabilitation measures under § 40 SGB V. In 2004, however, the leading associations of statutory sickness funds substantiated objectives and benefits for geriatric rehabilitation in a joint framework recommendation,[284] given the obvious significance of these rehabilitation needs in an aging society.[285] According to the cornerstone paper of the

280 Koalitionsvertrag, p. 100.

281 Koalitionsvertrag, p. 101.

282 See BR-Drs. 75/07.

283 See BR-Drs. 75/07, §§ 20-20c SGB V.

284 In 2001, the maximum amount for preventive measures under § 20(3) SGB V was € 181,285,301.76 (on behalf of 70,814,571 insurants) and for measures under § 20(4) SGB V, € 36,115,431.21 (on behalf of 70,814,571 insurants); in 2006, the maximum amount for preventive measures under § 20(3) SGB V was € 188,399,693.24 (on behalf of 70,298,393 insurants) and for measures under § 20(4) SGB V, € 37,258,148.29 (on behalf of 70,298,393 insurants).

285 See *Plate/Meinck*, Ambulante geriatrische Rehabilitation und ihre leistungsrechtliche Einordnung in die gesetzliche Krankenversicherung, Rehabilitation 2005, pp. 215 et sqq.

Federal-Länder working group on healthcare reform, geriatric rehabilitation is to be included in the benefit catalogue of statutory health insurance.[286] With the originally planned insertion of a sub-section under § 40a SGB V into statutory health insurance law, the draft bill was to contain a new separate regulation for geriatric rehabilitation benefits. This approach of incorporating a separate provision was not, however, adopted by Parliament and the Bundesrat[287], as geriatric rehabilitation is now to be included in the standard benefit catalogue. Nevertheless, a novel section under § 37b SGB V will enhance the benefits basket as far as ambulant palliative care is concerned.

286 See Eckpunktepapier, p. 14.

287 See BR-Drs. 75/07.

Long-term care

*Heinz ROTHGANG & Gerhard IGL**

I. The Institutional Setting of Long-term Care

In legal terms, the "need for long-term care" (or "dependency") refers to those people who are – as a consequence of illness or disability – unable to perform the activities of daily living (ADLs) independently for an expected period of at least half a year.

Until the introduction of Long-term Care Insurance (LTCI) in 1994, there was no comprehensive public system for financing long-term care in Germany. Dependent peo-

* We would like to express our gratitude to Dipl. Oec Maike Preuss for her great assistance in drafting this article.

ple or their families had to pay for care services – when they used them at all – out of pocket, with only means-tested social assistance as the last resort for those who had exhausted their assets and could not otherwise afford the necessary formal care.[1] The LTCI Act of 1994 established public long-term care insurance and mandatory private long-term care insurance, which together cover almost the whole population. Members of the public health insurance system become members of the public LTCI scheme, and those who have private health insurance are obliged to buy private (mandatory) LTCI guaranteeing at least as much coverage as the public scheme does. Since all insurance benefits are capped, private co-payments remain important, and means-tested social assistance still plays a vital role, particularly in nursing home care, where about 30 percent of all residents still receive social assistance.[2]

Public LTCI follows the *pay-as-you-go principle*, while private mandatory LTCI is a partially funded scheme. Public LTCI is financed almost exclusively by *contributions*, which are income-related but not risk-related. In the case of those who are employed, employers and employees pay 50 percent each of the premiums,[3] while contributions for the unemployed are paid by unemployment insurance. Since 2004 Pensioners pay the whole contribution themselves. Contributions are calculated as 1.7 percent of gross earnings and accordingly retirement pensions up to an income ceiling of € 3,562.50 per month (2006 figure). Income from other sources such as assets or income from rent and leases is not considered in calculating contributions. The contribution rate can only be changed by an act of Parliament. From 2004 onwards, insured people aged 23 or older who have never been parents have to pay an *additional contribution rate* of 0.25 percent.

Public LTCI is administered by different *LTCI funds*. Since the benefits, as well as the contribution rate, are identical for all funds and all expenses are financed by the sum of all contributions – irrespective of which fund is responsible – there is no competition between these funds.

In contrast to the Japanese Long-term Care Insurance, in Germany, *entitlement* is independent of the age of the dependent person. However, almost 80 percent of all beneficiaries are 65 years old or older and more than 50 percent are at least 80 years old (own calculations based on information from the Department of Health for 2004). The entitlement to claim benefits is based on whether the individual needs help with carrying out at least two basic activities of daily living (bADLs) and one additional instrumental activity of daily living (iADLs) for an expected period of at least six months. Three *levels of dependency* are distinguished depending on how often assistance is needed and

1 See also Pabst and Rothgang, 2000 for the situation before LTCI was introduced.

2 At the state level, the "Länder" (in other words, the 16 provinces with different legislation) are responsible for subsidizing the building and modernization of nursing homes, thus reducing private co-payments and social assistance expenditure.

3 The employers' part is tax-free. In order to compensate employers, 15 out of 16 provinces abolished one bank holiday. In Saxony, no bank holiday was abolished and thus employers bear a contribution rate of 0.35 percentage points and employees bear 1.35 percentage points.

how long it takes a non-professional care-giver to help the dependent person (see Table 1).[4]

Table 1: Definition of Dependency

	Level I:	Level II	Level III
Need of care with basic ADLs	At least once a day with at least two bADL	At least thrice a day at different times of the day	Help must be available around the clock
Need of care with instrumental ADLs	More than once a week	More than once a week	More than once a week
Required time for help in total	At least 1.5 hours a day, with a least .75 hours for bADL	At least 3 hours a day with at least 2 hours for bADLs	At least 5 hours a day with at least 4 hours for bADLs

Source: § 15 SGB XI.

The LTCI benefits are set by law. Beneficiaries (and their relatives) may choose between different benefits and services. It is important to note that this *choice* is up to the beneficiaries and not to care managers, state agencies or long-term care insurance funds. The LTCI benefits are for home care, day and night care, and nursing home care. People in *home care* can choose between in-kind benefits for community care and cash benefits. Cash benefits are given directly to the dependent person, who can choose to pass the cash on to a family carer. However, there is no obligation for the dependent person to do so, and the use of cash benefits is at the beneficiary's discretion – given that care-giving is guaranteed. Community care is provided by both non-profit and for-profit providers. Up to certain ceilings (see Table 2), their bills are covered by LTCI funds. Cash and in-kind benefits may be combined, i.e. if only x% of claims for in kind benefits are realized, 100-x% of the cash benefits claims are still available.

Table 2: Amount of LTCI Benefits (Major Types of Benefits)

in Euro per month	Home care		Day and night care	Nursing home care
Level	Cash benefits	In-kind benefits	In-kind benefits	In kind benefits
I – moderate	205	384	384	1,023
II – severe	410	921	921	1,279
III – severest	665	1,432	1,432	1,432
Special cases		1,918		1,688

Source: §§ 36-45 SGB XI.

Table 2 contains the respective amounts of money for the most important types of benefits, as laid down in the Code Book regulating LTCI (*Sozialgesetzbuch, 11. Buch (SGB XI)*). As the table shows, in-kind benefits for home care are about twice as high as cash benefits; while day and night care is of equivalent value to in-kind benefits. In

4 Of course, there are also less dependent people who do not qualify for LTCI benefits. According to a representative survey conducted in 2002, apart from about 2 million recipients of LTCI benefits, there are about 3 million older people who needed help, mainly with iADLs, but do not qualify for LTCI benefits (Schneekloth and Leven, 2003, p. 7).

level I and II, benefits for nursing home care are higher than for home care. Only in level III benefits for all types of formal care are the same. The latter was aimed at preventing a shift towards nursing home care as a result of the introduction of LTCI.

If a family carer is on vacation, the LTCI will cover the expense of a professional carer for a period of up to four weeks – up to a ceiling of € 1,432. This is a benefit in its own right but is weighted against other claims for home care. There is also a small grant for special aids, and the insurance funds offer courses for non-professional carers. LTCI funds pay the pension contributions of informal carers,[5] who are also covered by accident insurance without having to pay contributions. In general, all benefits are capped or given as lump sums.

LTCI funds provide benefits that, in general, are not sufficient to cover the costs of formal care at home (see Rothgang, 2000) or in a nursing home. In a nursing home only care expenses are co-financed by LTCI funds up to a certain ceiling (see Table 2). As Table 3 reveals, LTCI benefits are even insufficient to cover average daily rates for care costs. Since residents have to pay for board and lodging (so-called "hotel costs") out-of-pocket, co-payments are quite substantial, particularly as an average monthly amount of about € 376 for investment costs is to be added (Schneekloth 2006: 29). These "investment costs" cover the annuities resulting from building or modernizing nursing homes. They are partly (and decreasingly) financed by the provinces ("Laender"). Uncovered costs have to be paid by the nursing home residents themselves.

Table 3: Average Monthly Rates for Nursing Homes, LTCI Benefits, Co-payments in 2002

in €	(1)	(2)	(3) = (1) + (2)	(4)	(5) = (1) - (4)	(6) = (3) - (4)
Level of care	care costs	board and lodging	daily rate (investment excluded)	LTCI benefits	co-payments, care costs only	Co-payment, care and hotel costs
Level I	1,172	738	1,910	1,023	149	887
Level II	1,558	738	2,296	1,279	279	1,017
Level III	1,979	738	2,717	1,432	547	1,285

Source: Daily rates from the peak organization of the general local sickness funds (*AOK Bundesverband*).

There are no regulations concerning *how benefits are adjusted* by the federal government. Until the time of writing, benefits have never been adjusted, not even for inflation, while prices for nursing home care, to give one example, have gone up by 10 to 15 percent. Consequently, the purchasing power of LTCI benefits has been declining.

Laender have the responsibility for financing *investments* in premises for long-term care services. Regulations vary greatly among the 16 provinces. Some Laender directly finance investments in nursing homes, while others only provide subsidies for dependent older people living in nursing homes who rely or would otherwise rely on social

5 The amount of contributions differs according to the level of dependency of the person cared for and the time spent caring. Contributions to pension funds require a minimum of 14 hours of care work a week. The minimum contribution paid is equivalent to 26.7 percent of the contribution paid for a full-time employee with average salary, while the maximum is 80 percent of this amount.

assistance (*Pflegewohngeld*). In order to help East Germany to "catch up" with the former West Germany, however, from 1996 to 2003 a special program was set up funding an investment worth up to about 500 million Euro a year in the former East Germany. The central government covered 80 percent of this amount as long as the respective region provided the remaining 20 percent share.

With respect to *regulation*, LTCI funds are the most important actors in the field. They are responsible for contracts with care providers (including admission to the market), prices (for in-kind care), and cash benefits. The Medical Review Board (*Medizinischer Dienst der Krankenversicherung* or MDK) perform the assessment to determine whether an individual is entitled to benefits. For private LTCI, Medicproof, a private company, carries out this task.

II. The Provision of Care

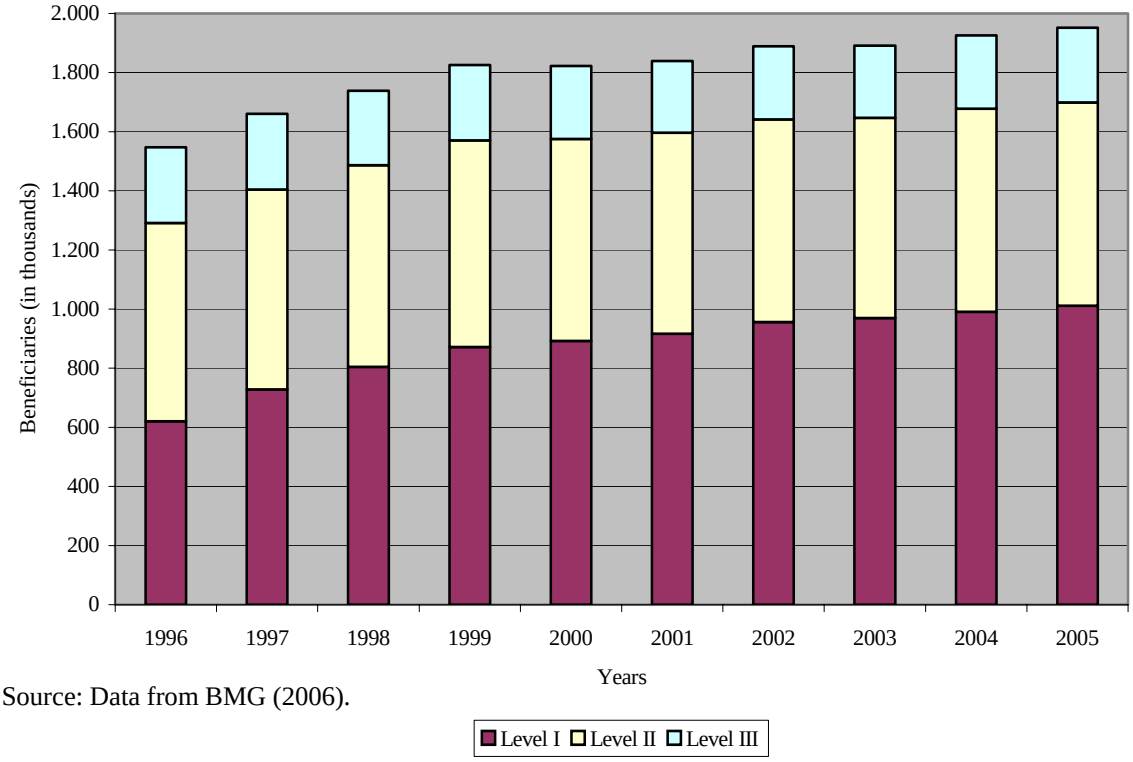
Families are the main providers of informal long-term care. Formal care is provided by public and private (profit and non-profit) care providers in private households (home care); day and night care centers and nursing homes. One of the innovations of the LTI Act is the beneficiary's opportunity to choose between different care arrangements and respective benefits. Therefore, it is interesting to take a close look at the development of these arrangements.

1. The Current Situation

Between 1997, the first year when the LTCI system was fully operating, and 2005, the *number of beneficiaries* increased by about 291 thousands, which equals about 36,000 per year on average. There has been a slight but steady growth of the number of beneficiaries, but no "explosion".

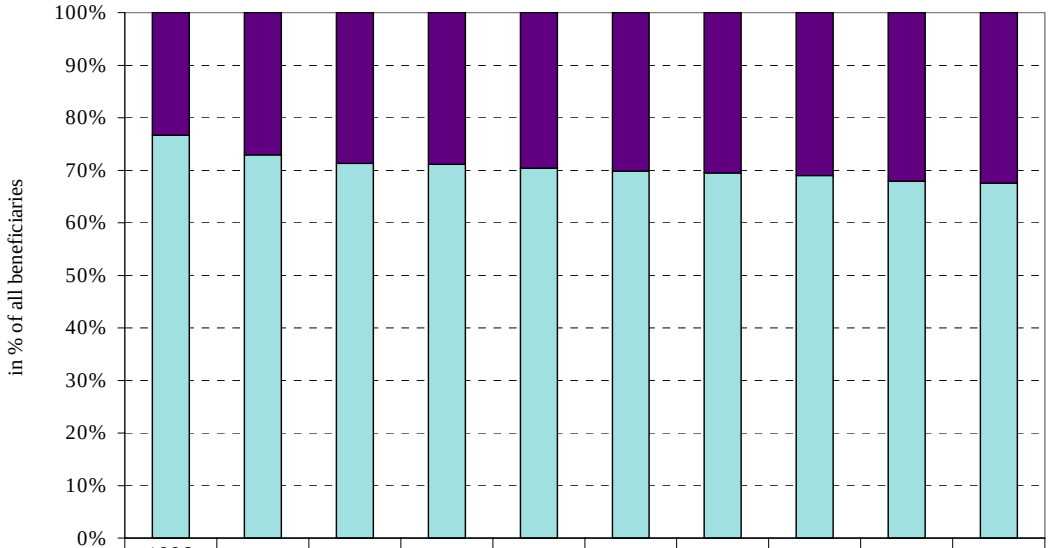
The highest growth rates occurred in the early years of the system when the population still had to get used to their claims. An annual growth rate of 2 percent was exceeded just once in the last six years (Figure 1). However, a gradual shift in care arrangements towards formal care is also contributing to raising expenditures (Figures 2 and 3).

Figure 1: Number of public LTCI Beneficiaries



Source: Data from BMG (2006).

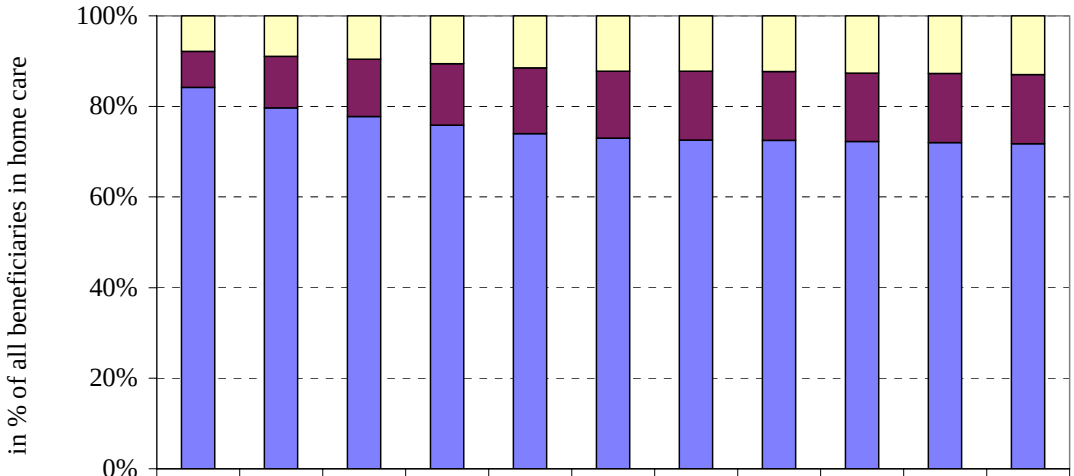
Figure 2: Share of Dependent Persons in Home Care and Nursing Home Care



	1996 (last 6 months)	1997	1998	1999	2000	2001	2002	2003	2004	2005
nursing home care	23,3	27,1	28,7	28,9	29,6	30,1	30,5	31,0	32,1	32,5
home care	76,7	72,9	71,3	71,1	70,4	69,9	69,5	69,0	67,9	67,5

Source: Data from BMG (2006).

Figure 3: Beneficiaries in Home Care



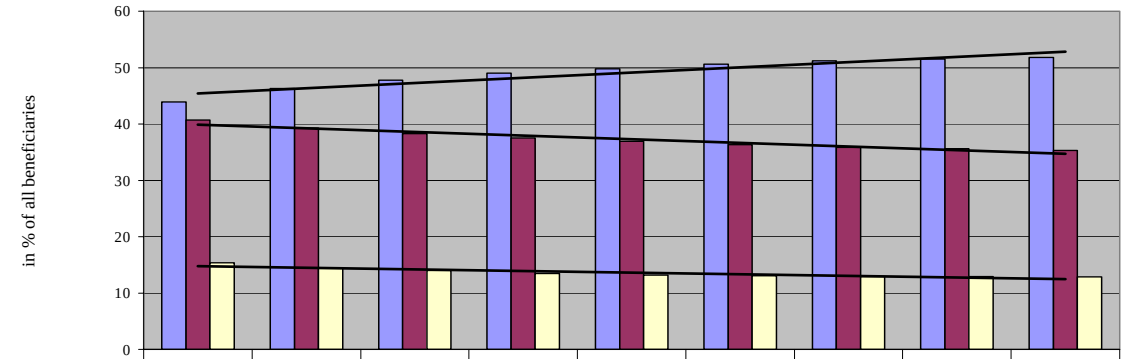
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
in kind benefits	7,9	8,9	9,6	10,6	11,5	12,2	12,2	12,3	12,6	12,7	13,0
combination	7,9	11,4	12,6	13,5	14,5	14,8	15,2	15,2	15,1	15,3	15,3
cash benefits	84,3	79,6	77,8	75,9	74,0	73,0	72,6	72,5	72,2	72,0	71,8

Source: Data from BMG (2006).

There is a clear trend towards formal care in Germany over time. In public long-term care from 1997 to 2005 the share of dependent people in nursing home care has increased from 27.1 to 32.5 percent (Figure 2). At the same time, in home care the share of those who choose cash benefits has decreased from about 78 to 72 percent (figure 3). So, while about half of all dependent people are still cared for without the involvement of professional carers, over time this quota has fallen from 56.7 to 48.5. This drop of 8.2 percentage points clearly indicates the *growing involvement of formal care services* in care-giving.

With respect to the *levels of dependency*, Figure 4 reveals that the share of dependent people who fall under level I is growing, whereas the share in both level II and level III has declined. The same picture holds for those who are newly classified. The share of those assessed in level I has been growing from 55.1 percent in 1997 to 66.2 percent in 2004 (own calculation based on MDS 2006: 10). Thus, the growing share of people in level one is not an effect of distinct survivor rates according to levels of dependency. Since the share of the very old (those aged 75 and over) among the beneficiaries has not decreased but rather has slightly increased, this is likely to be the effect of tighter assessments by the MDK and tighter assessment rules for level III based on court jurisdictions.

Figure 4: LTCI beneficiaries according to level of dependency

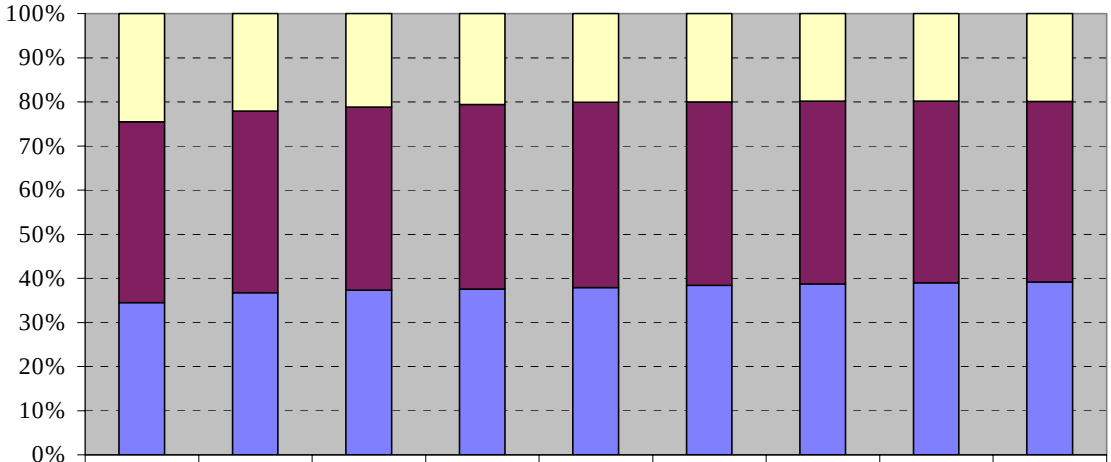


	1997	1998	1999	2000	2001	2002	2003	2004	2005
Level I	43,9	46,3	47,8	49,0	49,8	50,6	51,2	51,5	51,8
Level II	40,7	39,3	38,3	37,5	36,9	36,3	35,8	35,6	35,3
Level III	15,4	14,5	14,0	13,5	13,2	13,1	12,9	12,9	12,9

Source: Data from BMG (2006).

Even more puzzling is the growing share of beneficiaries in nursing home care classified in level I (Figure 5). The LTCI Act states a preference for home care over nursing home care. Correspondingly, benefits for nursing home care must only be granted if home care is "impossible," which was thought to be the case for dependent people in level III and partly in level II, but only rarely in level I. Thus, it was expected that there would only be a small and decreasing share of moderately dependent people in nursing homes.

Figure 5: LTCI beneficiaries in nursing home care according to level of dependency



	1997	1998	1999	2000	2001	2002	2003	2004	2005
Level III	24,5	22,1	21,1	20,6	20,1	20,0	19,8	19,8	20,0
Level II	41,0	41,2	41,5	41,8	42,0	41,6	41,4	41,2	40,9
Level I	34,5	36,7	37,4	37,6	37,9	38,4	38,8	39,0	39,2

Source: Data from BMG (2006).

As the choice of a certain care arrangement depends on several facts the reasons for the shifts in dependency levels among dependent person in nursing homes are also multiple. One reason, however, is the benefit structure. For those in level I, benefits for nursing home care are much higher than for home care (Table 2), while co-payments on the other hand are smaller than for those in levels II or III (Table 3). Thus, there are incentives for beneficiaries who may not always need that degree of care to choose nursing home care, particularly for those in level I. As these incentives become common knowledge the observed shift in structure might be expected.

Three-quarters of all main carers are female. Table 4 provides an overview of the *relation of family carers to the dependent people they care for*. As the table shows, intra-generational care by spouses or partners has decreased over the last decade from 37 percent in 1991 to 28 percent in 2002, while the share of other groups among main carers on the other hand is fairly stable, with the exception of sons whose share among carers has more than tripled. Today, 42 percent of carers are sons, daughters or daughters-in-law of the dependent elderly, which highlights the importance of inter-generational care and also the vulnerability of the care system to the fact that the ratio of children to the dependent elderly is declining.

Table 4: Main Carer of Dependent People in Private Households

Share in %	1991	1998	2002	Change 1991-2002
Sex				
Male	17	20	27	+ 10
Female	83	80	73	- 10
Relation of Carer to Dependent Person				
Husband or (Male) Partner	24	20	28	- 9
Wife or (Female) Partner	13	12		
Mother	14	11	12	- 2
Father	0	2	2	+ 2
Daughter	26	23	26	0
Son	3	5	10	+ 7
Daughter-in-law	9	10	6	- 3
Son-in-law	1	0		- 1
Other Relative	6	10	9	+ 3
Neighbor / Friends	4	7	8	+ 4
Residence of Main Carer				
Co-resident	78	73	62	- 16
Separate Household	22	27	38	+ 16

Sources: Schneekloth and Potthoff, 1993, 126; Schneekloth and Mueller, 2000, 52; and Schneekloth and Leven, 2003: 19.

With respect to formal care, the LTCI Act triggered an *expansion of capacity*. In both nursing home care and home care, the number of providers doubled between 1992 and 1997. But these official figures should not be over-interpreted. As residential homes for the elderly were re-founded as nursing homes and as former informal help systems

(such as those organized by churches) transformed themselves into formal care providers, there are no valid time-series data showing the exact expansion of capacity before and after the LTCI Act. Table 5, therefore, concentrates on the development from 1999 onwards, for which reliable data exists. While the number of providers and the overall capacity of nursing home care (measured by the number of beds) are still growing an even increasing pace, the picture is more complex for home care. The number of providers grew slightly between 1999 and 2005**,** while the number of employees grew considerably. Obviously, this must reflect a process of concentration. Table 5 also reveals changes in staff structure as the number of part-time employees has grown while the number of full-time employees even decreased. Overall, from 1999 to 2005 – which is after the end of the initial boom in the establishment of new providers – the capacity in home care has still been growing, but at moderate pace.

Table 5: The Capacity of the Formal Care Sector

	Home Care			Nursing Home Care	
	Number of Providers	Employees	Full-time Employees	Number of Providers	Number of Beds
1999	10,820	183,782	56,914	8,859	645,456
2001	10,594	189,567	57,524	9,165	674,292
2003	10,619	200,897	57,510	9,743	713,195
2005	10,977	214,307	56,354	10,424	757,186
1999-2001	-2.1	3.1	1.1	3.5	4.5
2001-2003	0.2	6.0	0.0	6.3	5.8
2003-2005	3.4	6.7	-2.0	7.0	6.2
1999-2005	1.5	16.6	-1.0	17.7	17.3

Source: Data from Federal Bureau of Statistics.

2. Projections

In the future, the *number of dependent people* can be expected to grow and care arrangements can be expected to change. According to the most recent population forecast from the Federal Office of Statistics, the number of people aged 65 or older and 80 or older will grow by 45 percent and 111 percent respectively until 2040 (own calculation based on Federal Office of Statistics 2006). Since these are the age groups with the highest dependency rates, the number of dependent people will also increase. Projections based on constant age-specific and sex-specific dependency rates show growth rates of between 50 and 80 percent. Assuming a decline in age-specific dependency rates (as assumed, for example, by Jacobzone et al, 1998) yields much lower, but still considerable growth rates (Table 6).

Table 6: Projections of the Number of Dependent People

Assumption about Age-specific Dependency Rates	Growth in Number of Dependent People until 2040	Source
Constant	50-75%	Hof, 2001
Constant	60%	Dietz, 2002
Constant	60%	Rothgang, 2002b
Constant	80%	Ruerup–Commission. 2003
Declining	45%	Rothgang, 2002b

Source: Own depiction.

As demonstrated above, over the last decade formal care has partly begun to substitute family care. A further *shift to formal care* can be expected to occur in the future due to at least four factors. First, for demographic reasons alone, the ratio of potential care-givers to dependent elderly will be declining: Firstly the share of widowed dependent elderly will decline as the war generation is gradually replaced by post-war generations, so there will be more spouse carers. The latter, however, is unlikely to balance the former. Second, female labor market participation is likely to increase, which will increase the opportunity costs of care-giving for women. This is reinforced by the fact that future female cohorts will be better educated and may earn higher wages than their mothers and grandmothers. Third, care potential will be declining because the share of single households among the elderly is expected to grow (Alders and Manting, 2003; Hullen, 2003; and Mai, 2003). Finally, as surveys reveal, the moral obligation to care for dependent parents is gradually vanishing. This has been partly reinforced by the introduction of the LTCI, which explicitly regards long-term care as the responsibility of society as a whole, thus making clear that it is (no longer) a purely family obligation. Projections therefore assume a shift towards formal care, which could either lead to more nursing home care, to a strengthening of formal home care or a combination of both.

3. Labour Market Issues Concerning Formal and Informal Care

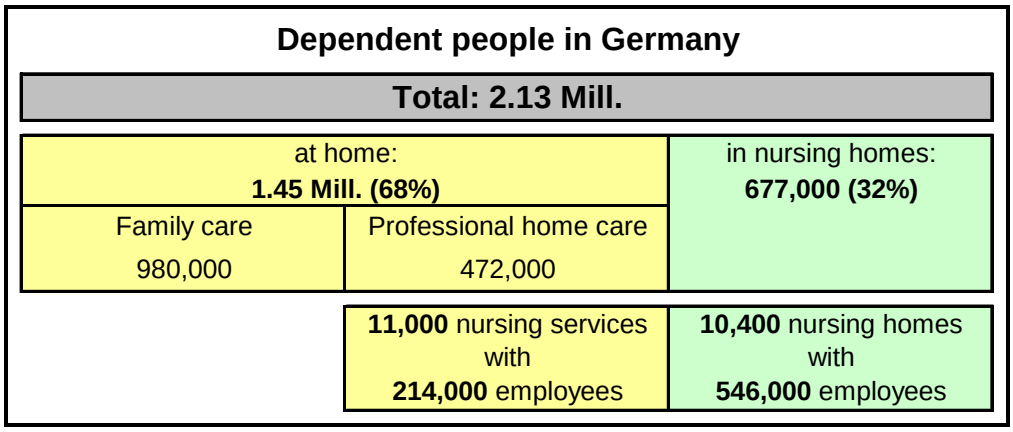
a) Care Workers in Germany

The situation on the German labour market for care workers is highly influenced by changes in the demographic structure of the German population. The ageing society will increase the demand for care provision while the number of people available to provide this care will decrease.

By the end of 2005 about 2.13 Million people are requiring care. 46 percent are cared for exclusively by relatives, friends etc. without professional assistance. Another 22 percent are cared for at home with professional carers as part of the care arrangement. In total 1.45 million dependent people are cared for at home. Another 32 percent are living in nursing homes. Even people requiring high levels of care are mostly cared for at home. So, nearly 51 percent of LTCI beneficiaries in level III are attended at home (Federal Statistical Office (2007), own calculations). Most care-givers in Germany, pro-

fessional and non-professional, are women. In the professional care sector we find 85.5 percent women (Federal Statistical Office 2007, own calculations), while in the informal sector 73 percent of all caregivers are female (Schneekloth 2005: 77).

Figure 6: Long Term Care in Germany, end of 2005



Source: Federal Statistical Office (2007).

There is, however, a trend towards professional care and towards nursing home care (see section II.1). The number of dependent people living at home and receiving just cash transfers provides an indicator for the number of people receiving no formal care. Because in-kind benefits have a higher monetary value than cash benefits, it can be assumed, that people choosing cash benefits do not utilise formal care at all. They may, however, employ home-helpers from the grey and the black market.

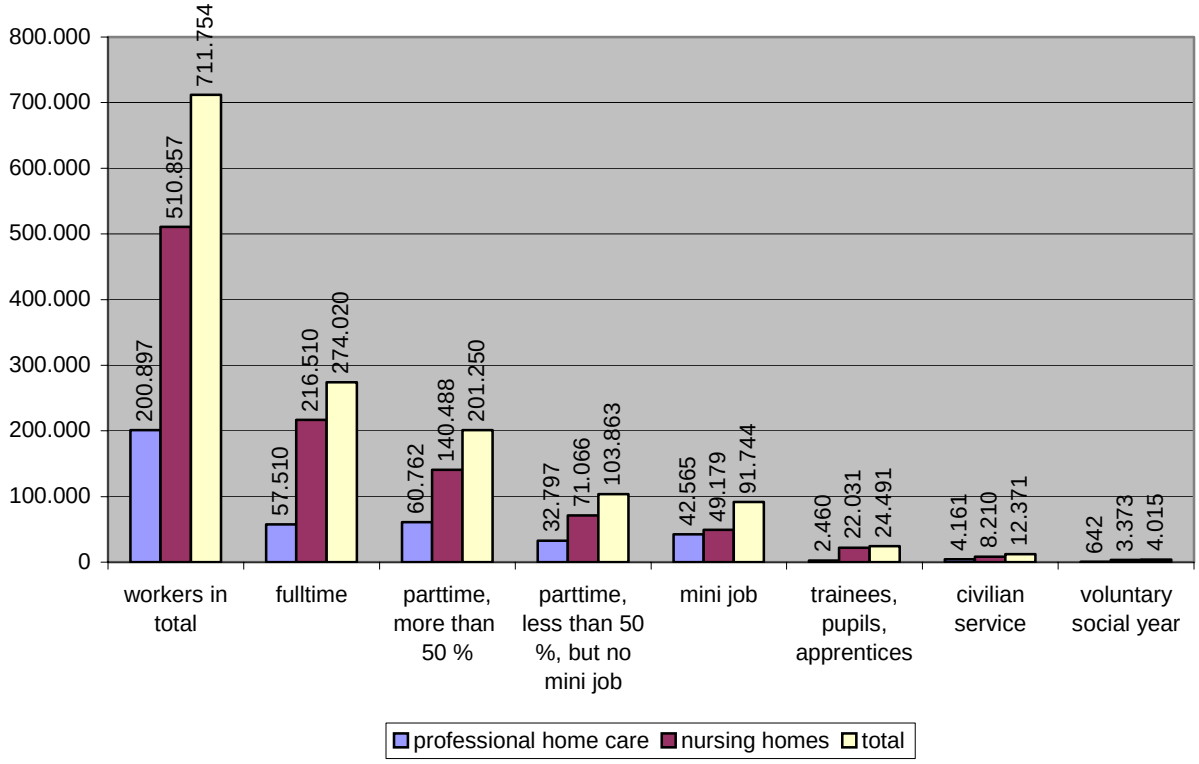
The above mentioned trends towards formal care could be a first result of the decreasing informal care potential. Even though the compatibility of informal care-giving and occupation in the formal labour market has been improved since the introduction of the LTCI, most main caregivers are not able to continue their jobs unchanged. 51 percent main caregivers did not work when starting care-giving, 21 percent gave up their jobs or reduced working hours. Only 26 percent of main caregivers could continue their jobs (Schneeklooth 2005: 79). Looking at the time spent with caring, these data is no surprise: According to Schneekloth, the weekly time spent for caring in private households averages 36.7 hours, with a range from 29.4 hours for people with in level I and 54.2 hours for elderly in level III (Schneeklooth 2005: 78). In professional care various types of qualifications exist in the German care market (see appendix for an overview).

b) Labour conditions for care workers

The breakdown of the absolute number of professional care workers is yielded by the figures depicted in Figure 7. According to these data 42.4 percent of jobs in nursing homes are fulltime jobs. In professional home care, the largest parts of jobs are part-

time jobs as well. Only 28.6 percent of professional home carers are working fulltime. 46.5 percent have part-time jobs, not included 21.2 percent mini jobber (Figure 8).[6]

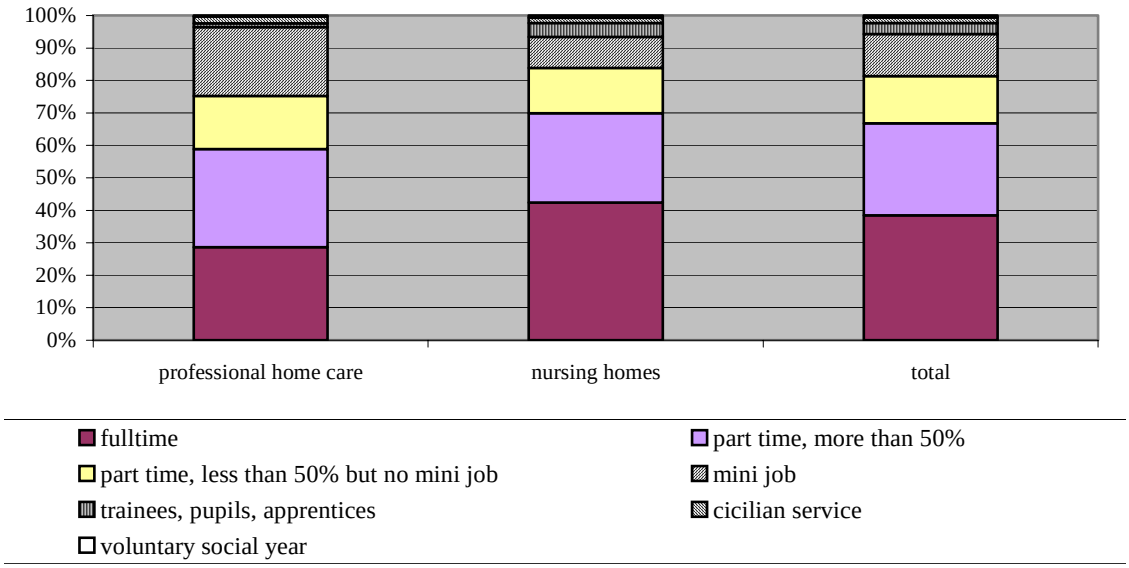
Figure 7: Number of professional care workers in Germany (15-12-2003)



Source: Own depiction based on data from Federal Statistical Office (2005a).

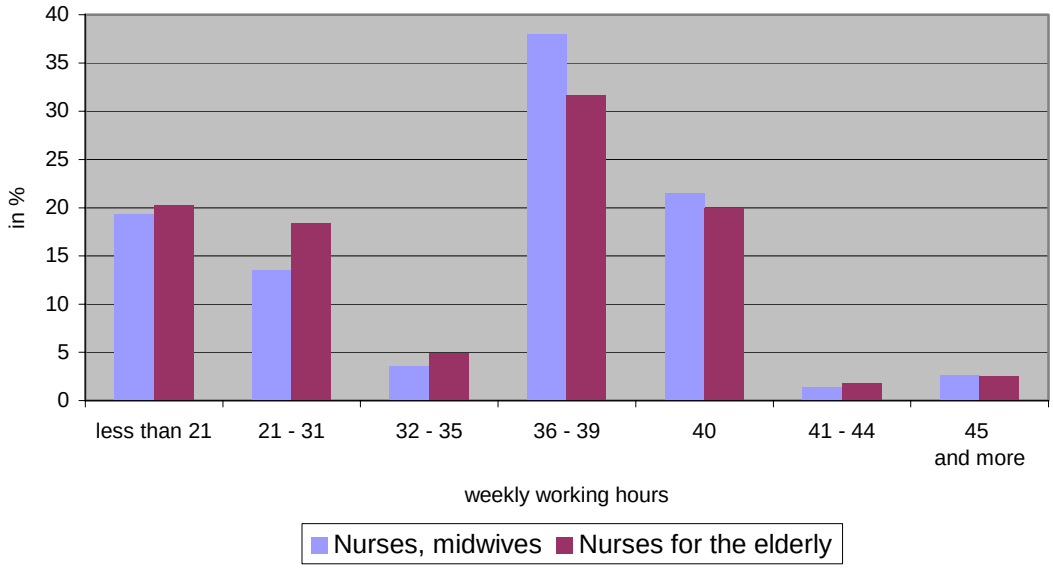
6 The term “mini job” in Germany refers to jobs with wages up to € 400 monthly. These jobs are freed of income taxes and social contributions for the employee.
The civilian service is an alternative to compulsory military service, which young men in Germany generally have to accomplish after school (www.zivildienst.org). The voluntary social year is very similar and can also be used as an alternative to the military service, but according to its voluntariness it is open for young women, too (§ 10 ZDG = Zivildienstgesetz).

Figure 8: Care workers in Germany by type of employment in %



Source: Own calculations, own depiction, based on data from Federal Statistical Office (2005a).

Figure 9: Weekly Working Hours of Professional Carers



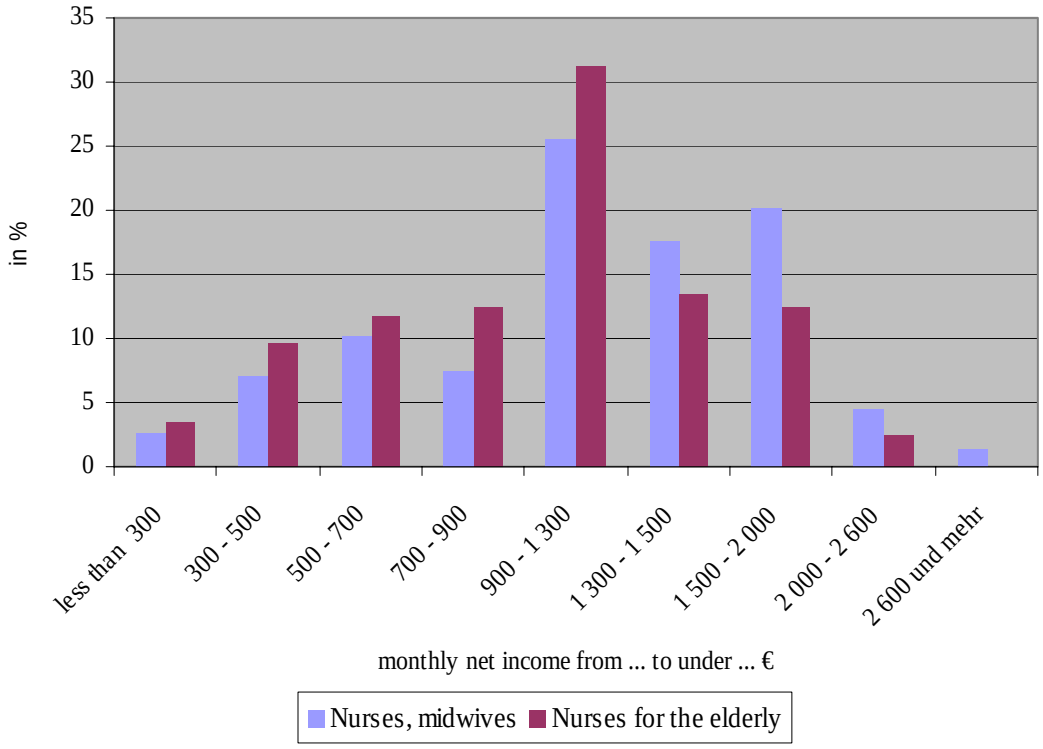
Source: Own depiction based on data from Federal Statistical Office (2005b).

In March 2004 the Federal Statistical Office (FSO) collected the following data applying the working conditions of nurses for the elderly. Figure 9 reveals a significant amount of part time work; with only 25 percent of nurses for the elderly are working 40 hours per week or more. The health situation of care workers is often worse than in

other working sectors, which could be a main cause for preponderant part time jobs in care (Delta Lloyd 2006: 17).

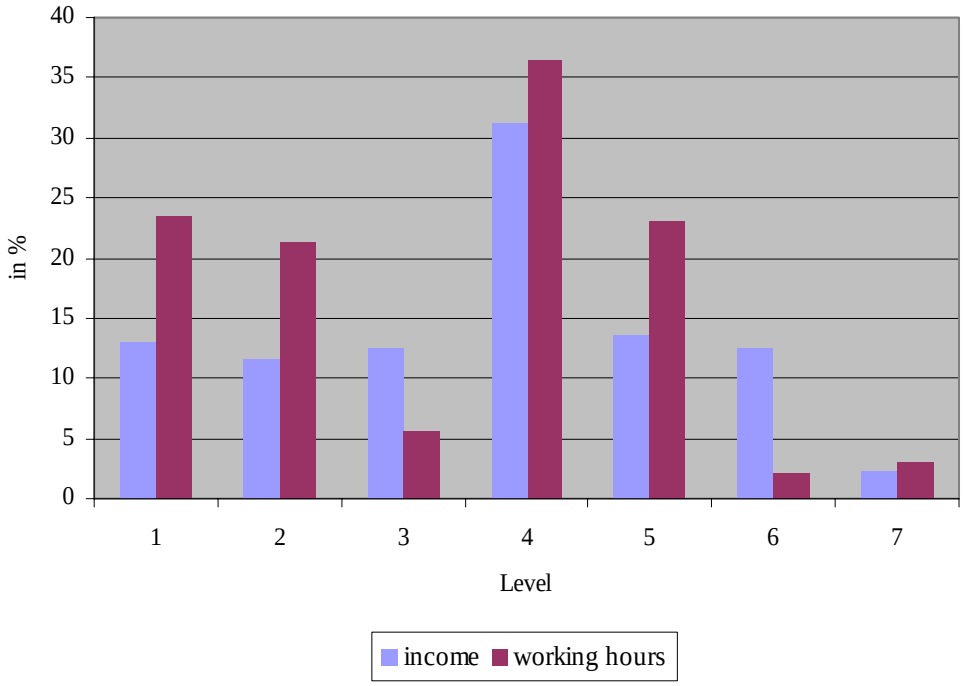
These findings correspond to the data presented in figure 10. The data pertaining to the income situation of nurses reflects in large parts their working hours (see figure 11). In contrast, nurses not specialised on care for the elderly and midwives face a broader range in income, but in average they all earn between 900 and € 1,300 monthly.

Figure 10: Monthly Net Income of Professional Carers



Source: Own depiction based on data from Federal Statistical Office (2005b).

Figure 11: Income and working hours from nurses for the elderly



The "levels" are defined as:

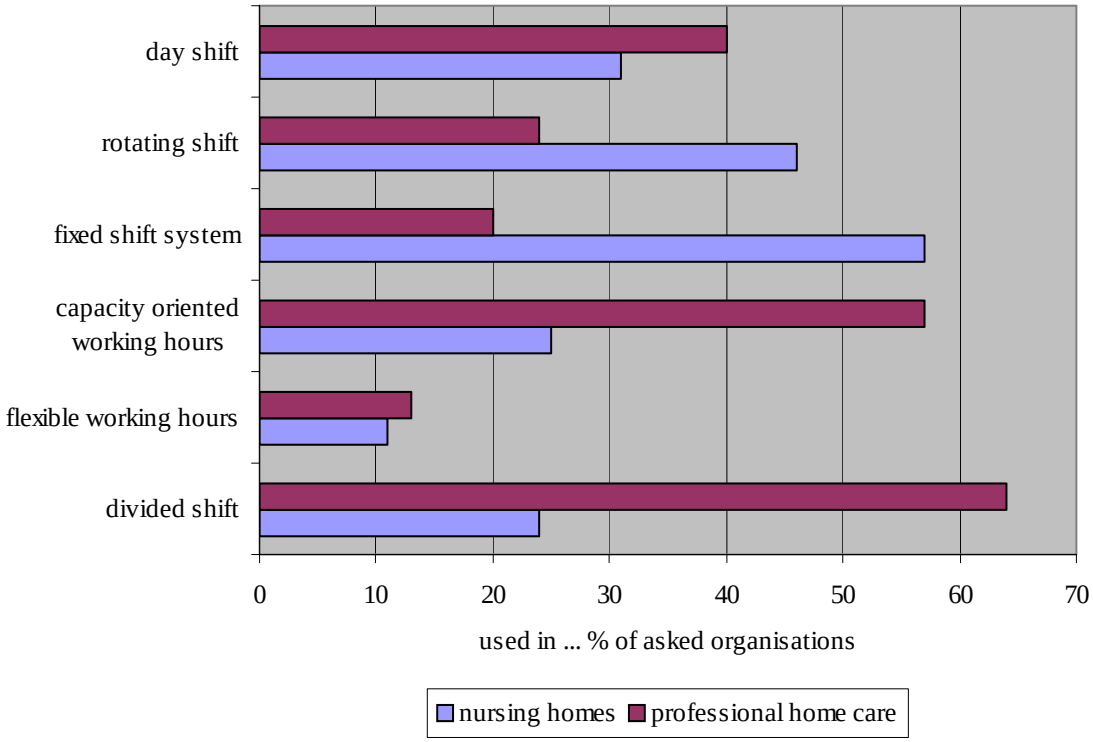
	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7
Net income per month	Less than 500	500 – under 700	700 – under 900	900 – under 1,300	1,300 – under 1,500	1,500 – under 2,000	2,000 and more
Working hours per week	Less than 21	21-31	32-35	36-39	40	41-44	45 and more

Source: Own depiction based on data from Federal Statistical Office (2005b).

Literature about professional care work mentions the extraordinary stress and strain related to this working sector. Especially the shift systems and unsteady volume of work are core points of criticism (Landenberger/Ortmann 1999; Robert Bosch Stiftung 1992). Concerning the shift systems we observed a key difference between working conditions in home care and nursing homes. In home care the divided shift is the most common working system. Divided shift means, workers have to work two times a day with a longer break of a few hours in the middle. This situation is not surprising, looking at the work, which is done by home carers. Often they will support the dependent elderly in the morning: helping them with getting up, washing and dressing and the second time most dependent need help is the evening.

In nursing homes the fixed shift system is most common. Most special nurses occupy nursing homes work only night shift, while other nurses work in early or late day shift.

Figure 12: Working Schedule Systems



Source: Own calculations and depiction based on data from Federal Statistical Office (2005b).

The introduction of LTCI in Germany enabled dependent people to spend some money for informal care. Receiving cash benefits, they are free to use them e.g. as allowance for their informal caregiver. Most caregivers are partners or children of the care recipients (see section II.1). The share of caring sons among main-caregivers has been rising from 1991 to 2002 from 3 percent to 10 percent. Parents are the main caregivers for younger dependent people (Schneekloth 2005: 77).

Most caregivers are 55 years old and older. In this state of life, they often have a tight relationship to their family and more time available then in earlier years, as their children are grown up and/or they are already retired. These factors are important in explaining the great willingness to care in Germany (Schneekloth 2005: 76 f.). To predict future trends in development of informal care it is important to rely on changes affecting these determinants.

c) Future of Care in Germany

Combining demographic projections and age- and sex-specific care probabilities the number of future LTCI beneficiaries can be estimated. According to a respective projection model, developed by Rothgang (2002: 2 ff.), until 2040 the number of beneficiaries will rise to 2.5 – 3.3 millions, depending on different assumptions concerning age-specific morbidity and population development. These calculations are based on the “9.

koordinierte Bevoelkerungsvorausberechnung" of the German Federal Statistical Office (FSO), published in July 2000. One reason for the great variance is that the FSO gives data about four different scenarios of population development. These scenarios assume different rates of migration and mortality. A second reason is the consideration of specific assumptions about morbidity. Previous developments indicate that age-specific morbidity has been declining and will continue to decline (Rothgang 2002a: v ff.). In one scenario, therefore, the age-specific morbidity remains constant over time, while in the other scenario a decreasing morbidity is assumed.[7]

Table 7: Number of Beneficiaries (in thousands)

year	scenario 0	scenario 1	scenario 2
constant age specific morbidity			
2020	2,429	2,469	2,480
2030	2,638	2,713	2,734
2040	2,883	2,983	3,022
decreasing age specific morbidity			
2020	2,170	2,206	2,217
2030	2,313	2,381	2,401
2040	2,500	2,590	2,628

Source: Own depiction based on Rothgang (2002): v ff.

In order to project the development of professional care a constant relation between utilisation of professional care and number of professional carers is assumed. 1998 nearly 400,000 persons worked as carers for the elderly. These 400,000 people represent 300,000 full-time jobs. With this manpower, they cared for about 700,000 dependent people in nursing homes and private households (Rothgang 2002a: S. 80 f.). In 1998, we had 220 full-time equivalents in home care and 372 in nursing home care for each 1.000 dependent people. In combination with the projection of the number of dependent people, it is possible to project the future need of professional care. Figure 13 shows this chart for growing significance of professional care. Until 2040 the need for professional carers can be expected to grow between 70 percent and 130 percent.

7 More precisely, the deferral of morbidity for half a year is assumed with every year that life expectancy rises.

Figure 13: Demand for care workers for the elderly (assuming increasing utilisation of formal care)

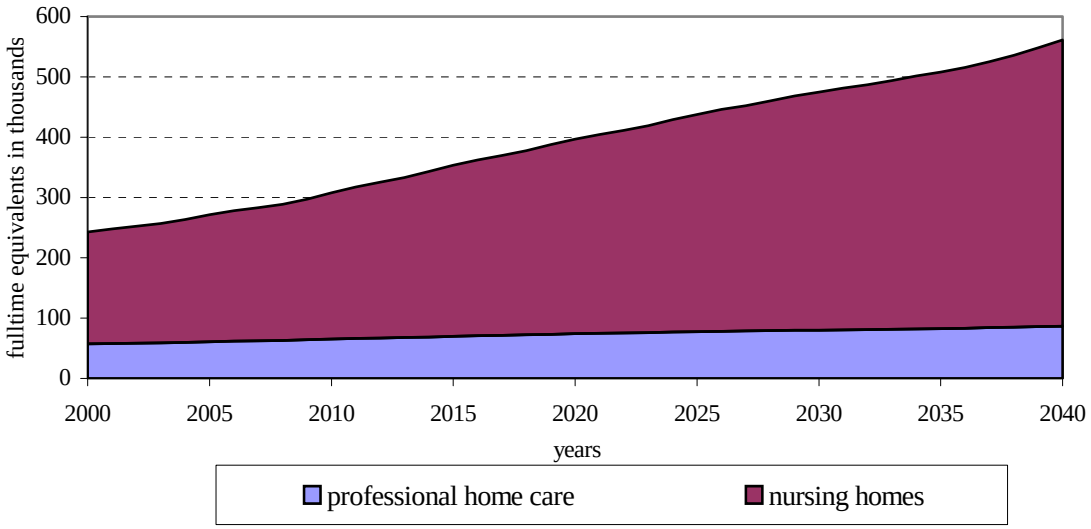
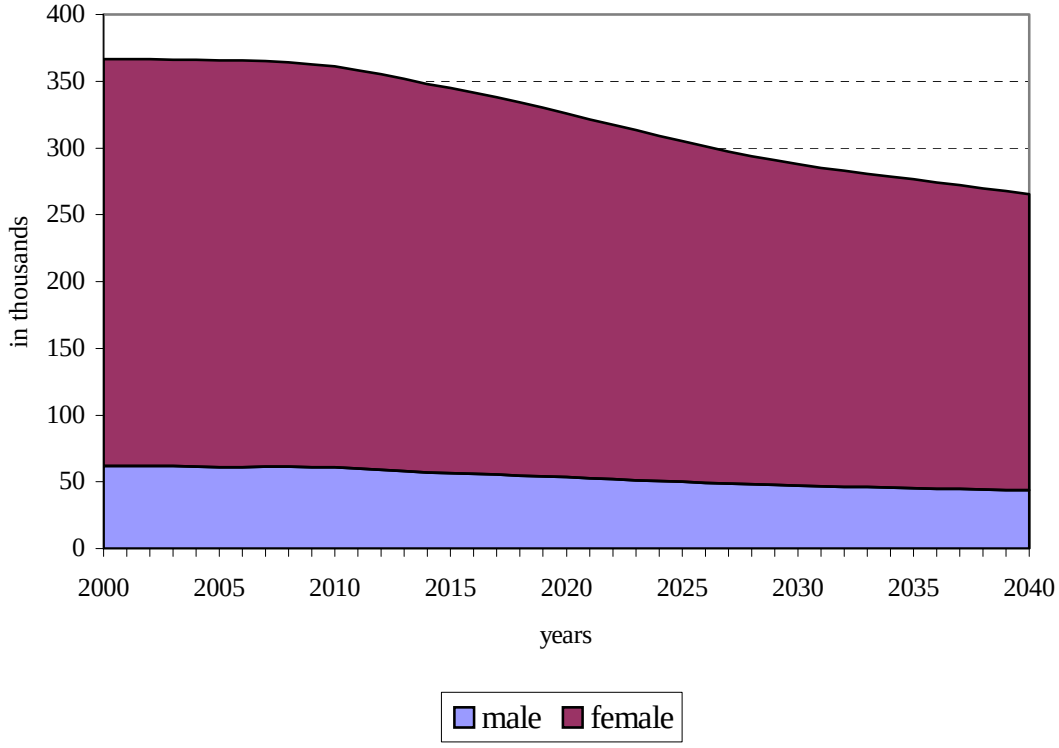


Figure 14: Projected number of care workers for the elderly



On the other hand the care potential will decline (Figure 14). Assuming that for both sexes the share of people working in long-term care will remain constant for each age bracket, from 2000 to 2040 the number of professional carers is going to decline by about 100,000 from 366,000 to 265,000. The validity of this model is limited due to the

high number of estimates, but the trend is clear: in the long run we will face a workforce shortage in care (Rothgang 2002a: 81 ff.). For guarantying the continued existence of a sufficient care workforce it is necessary to create new incentives for making care work more attractive. One possibility could be the reform of education systems.[8]

Facing the fact, that less than 40 percent of jobs in care are fulltime jobs with accordingly low income, working in care sector is not attractive. Possibilities for a career are low, the income is low and not sufficient differentiated. Besides the unattractive working times, matched with the great stress revealed with this kind of jobs, combined with sunken reputation in society, working in professional care becomes more and more unattractive (Delta Lloyd 2006: 17).

The education of care workers in Germany (see section II: 4.3.5) is divided into education of nurses, nurses for the elderly, midwives etc. In other European countries, we do not find this separation. In writings of Landenberger and Ortmann (1999) or the Robert Bosch Stiftung (2001) we find pleadings for changing the system of educating care workers in Germany. They favour a solution of a universal, basic common training for all care workers with the possibility to specialise on different key issues.

4. Current Problems and Proposed Solutions

a) Reforming Market Regulation for Care Provision

Although recent debates on a reform of LTCI are centered on financing issues, some reform issues relate to market regulation and to the benefit structure. While some debates have already led to changes in the institutional structure, most center on future reforms.

With respect to *market regulation*, two issues have dominated the debate – the relationship between competition and planning on the one hand and the mechanisms by which remuneration for nursing homes is determined on the other hand.

Competition and Planning. While *competition* between health insurance funds was introduced in the early 1990s, there is no competition among LTCI funds. All funds offer identical benefits and require an identical contribution rate and have identical contracts with providers. Moreover, an equalization scheme guarantees that all expenses are covered by all contributions. Hence, in effect, all funds are just “branches” of one LTCI. Competition is among (contracted) providers for contracts with dependent people and their families, who choose not only among different providers of services, but also between different care arrangements, in other words, between buying formal care or relying on the help of family or friends only. The choice between cash benefits and in-kind benefits enhances this make-or-buy decision for each household. As each use of formal services implies a reduction in claim to cash benefits, there is an implicit co-payment

8 For detailed discussions see publications of the Robert Bosch Stiftung (1992, 2001) or Landenberger and Ortmann (1999).

for all service use, which prevents over-utilization of services due to moral hazard behavior and produces some price elasticity of demand.

The intensity of competition in these circumstances heavily depends on how much access providers have to the market. The LTCI Act tried to intensify competition by stripping public and private non-profit providers of all of the privileges that they had had traditionally. Moreover, the LTCI Act entitles every provider that fulfils certain formal criteria to a contract with the LTCI funds – irrespective of whether the LTCI funds or a government agency think an additional provider is needed. Since benefits are capped and providers do not assess beneficiaries' entitlement to benefits, oversupply was not regarded as a possible problem for the system.

At the provincial level, however, this was seen differently. Laender governments restricted their subsidies for investment costs to those nursing homes that they regarded as "necessary." Without public subsidies, the daily rates were higher, putting the nursing homes that did not receive subsidies at a disadvantage. Even worse, municipalities and provinces denied granting social assistance if dependent person were to go to a nursing home that did not receive public subsidies for investment costs – in extreme irrespective on overall costs of the nursing home. Thus, the market was effectively closed to newcomers. However, following a ruling from the Federal Court of Social Law in 2001, regulations of this kind have been abolished or are about to be abolished. Today therefore, provinces have reduced their planning activities and are giving way to competition of providers.

Remuneration of Nursing Home Care. Daily rates for nursing homes are set as a result of a bargaining process between LTCI funds and social assistance agencies on the one side and the providers on the other side. Rates are differentiated according to three classes that by and large follow the three levels of dependency. Recently, this *system of pricing* has been challenged on three counts.

First, the legitimacy of the *bargaining system* has been questioned. Funds negotiate with providers over rates for care costs although they only finance benefits that fall well below those rates. Furthermore, they are also responsible for negotiating rates for room and board, although they never finance this part of the rates and are thus not affected by the results of negotiations. This also applies to municipalities, which negotiate on behalf of residents of nursing homes who never receive any social assistance. Funding agencies thus negotiate only as advocates for their clients without being (fully) affected by the results of the negotiations. Therefore, some experts are now advocating in favor of introducing market pricing in those regions with sufficient supply of providers. As residents of nursing homes are captive consumers, it would, however, be vital to implement regulations to protect them from abrupt rises in rates if this road was to be followed. Similar regulation already exists for rented flats. Furthermore, a maximum rate would have to be fixed for recipients of social assistance, for example, based on the average rate. For those users not eligible for social assistance, the co-payment resulting from capped benefits would act as an incentive against ex post moral hazard.

Second, the *unit for pricing* has been challenged. Since only three classes exist, there is a lot of heterogeneity within each class. Thus, nursing homes must charge the same

rate for people needing very different amounts of care. Even if the number of classes were to be increased to five as in Japan, the problem would still exist. In order to solve this problem, rather a classification system such as the US Resource Utilization Group System could be implemented, which distinguishes among 44 classes of dependent people with similar needs. Alternatively, the notion of paying a comprehensive rate could be abolished and dependent person would pay for board and lodging and could then buy certain service packages (*Leistungskomplexe*) such as bathing and morning toilet. In this case, the distinction between formal home care and nursing home care would have been abolished.

Third, the *process of price negotiations* itself is being questioned. Although prospective budgeting is used, in practice the costs incurred by each nursing home in the past still influence what daily rate for the next period it can achieve in the negotiations. Therefore, striving for efficiency is discouraged. Efficiency incentives could only be introduced if the rate is identically fixed for all nursing homes in a given region, e.g. based on the average costs of all nursing homes in this region.

Although the pricing system has been questioned, for example, in a recent report from the province of Northrhine-Westfalia (Landtag NRW, 2005), respective reforms are unlikely to be adopted in the near future as other questions are regarded as more pressing.

b) The Structure of Benefits

There are two major issues currently being discussed with respect to the structure of benefits: the introduction of additional benefits for dependent people with dementia and the equalization of benefits for formal home care and those for nursing home care. The so-called Ruerup Commission (the commission for achieving financial sustainability for the social security system) (2003) made suggestions about both of these issues, which were picked up in a reform bill that was prepared in the winter of 2003/04. However, the reform proposal was shot down as a whole by the former German chancellor, Gerhard Schroeder, who felt that his pension and labor market reforms had caused enough trouble for his government at that time. Therefore, he decided to postpone any LTCI reform that would lead to additional spending and thus require the population to make more sacrifices in order to finance it. So it was not the content of the reform but rather its timing that put an end to this reform initiative. Currently, however, the grand coalition has started a new attempt for reform, which includes both elements, the equalizing benefits for formal home care and nursing home care as well as additional benefits for people with dementia.

Benefits for People with Dementia. By now, all political parties and all experts agree that in LTCI *people with dementia* are discriminated against. Dependency is defined only with respect to ADLs without taking into account the particular needs of people with dementia. Consequently, many people with dementia do not qualify for LTCI benefits or receive benefits for moderate dependency (level I) even though they need

supervision around the clock. From 2002 onwards, additional benefits for dependent people with dementia in home care were introduced as a first step towards solving this problem. These benefits are earmarked for day and night care, respite care, or related services. However, the maximum annual amount to be spent on those additional services was set at a mere € 460. This low ceiling may be the most important reason why in 2003 only 30,000 people applied for this specific benefit out of an estimated 400,000 people who were assumed to be entitled to it (BMGS, 2004). So while the government originally expected an additional € 250 million to be spent on this benefit, in 2003 only € 13.4 million were spent.

The most straightforward way to resolve the problem would be to change the (legal) concept of dependency and establish a definition that is not based on ADLs and physical needs alone. As the fiscal consequences of such a bold move are difficult to calculate, this has not yet been seriously discussed among politicians. In November 2006, however, a new expert body was founded, which should look into that and develop a new legal concept of dependency. In the short run, however, politicians rather favor a more modest solution. The current plans aim to increase the additional benefit to € 1,200 per year and entitle all people suffering from dementia even if they are not entitled for LTCI benefits.

Equalizing Benefits for Formal Home Care and Nursing Home Care. Another element of the failed reform of the winter of 2003/2004 was the attempt to *equalize benefits* in formal home care and nursing home care. The starting point of the proposal is a reversal of a perverse incentive in the current benefit structure. In levels II and III, benefits for nursing homes are much higher than benefits for formal home care, thus creating an incentive in favor of nursing home care, particularly in level I where – generally speaking – nursing home care is least necessary. This incentive would be abolished if benefits were the same for formal home care and nursing home care. There would be another advantage of such equalization. Today, each care arrangement must be categorized either as nursing home care or as home care. Alternative care arrangements such as small groups of dependent people living together in a flat suffer from the legal restrictions caused by this dichotomy. Equal benefits for all types of formal care would help to reduce such restrictions.

The fiscal effects of this equalization, however, would depend on how the benefits were equalized. If these were achieved simply by cutting benefits for residential care, this can be expected to lead to a decline in LTCI expenditures, but also to an increase in the number of recipients of social assistance. Making moderate cuts in benefits for nursing home care, while at the same time increasing benefits for professional home care, on the other hand, would have unclear fiscal consequences. A rise in the benefits for formal home care would be an incentive for recipients of (low) cash allowances to rather choose the increased in-kind benefits. Thus a partial substitution of cash allowances by formal home care could happen, which would cause an increase in LTCI spending. Current reform proposals, nevertheless, opt exactly for such a move with increasing benefits for formal home care and decreasing benefits for nursing home care.

c) Quality Issues

aa) Situation before the LTC-Act

Quality in the field of LTC was not really an important issue before the enactment of the LTC-Act in 1994. Before this time, only the residential home authorities (Heimaufsicht) had a look on quality of LTC in nursing homes. But the quality inspected was less the quality of care and nursing, but more the structural quality (above all construction requirements, room size and equipment, staff qualification). Beyond those structural quality requirements there were no further standards as regards personal care itself. The legal framework did not contain those requirements in a detailed, but only in a very general manner. As the residential home authorities are organized on the Laender level, sometimes on the level of local authorities, quality requirements considerably varied. There was no nationwide common understanding of those requirements. Quality requirements were not controlled by federal courts, so that a nationwide binding interpretation of those requirements was not given.

bb) Situation after the LTC-Act

This situation changed with the enactment of the LTC-Act. The insurance bodies have now the duty to control the quality of LTC service benefits. The inspection of quality is entrusted to the Medical Review Board (Medizinischer Dienst der Krankenversicherung – MDK), a body, which has large empowerments of inspection of quality not only in the sickness insurance field, but since the LTC-Act also in the field of LTC. The different MDK bodies are de facto, not legally, covered by an umbrella body, the Federal Medical Review Board (Medizinischer Dienst der Spitzenverbaende der Krankenkassen – MDS). The MDS is empowered, together with other bodies on the national level, to formulate guidelines and common rules for quality of LTC. Thus, for the first time in Germany, nationwide rules for quality requirements are established. Nevertheless, there is sometimes still a broad range of discretion on quality requirements for the different MDK bodies.

Nursing homes are now submitted to two kinds of quality inspection: by the residential home authorities and, too, by the MDK bodies if the nursing home delivers LTC-services to recipients of LTC under the LTC-Act. These inspections are sometimes not coordinated – despite statutory requirements of coordination for the two bodies.

The MDK bodies are also entrusted with the assessment of the care needs of LTC-recipients. But this assessment is restricted to the needs covered by LTC-benefits, such are above all the activities of daily life (ADL). A broader assessment of all the needs of a dependent person is under discussion, but not yet enacted. An advisory board of the Ministry of Health has now (since November 2006) the task to work on this topic.

The entire quality assurance scheme provided by the LTC-Act has only effects on professional care service delivery in the field of home care as well as in the field of nursing home care. The quality control of family care given by family members or volunteers is organised in a different manner: recipients of the home care allowance – a kind

of lump sum depending on the degree of dependency (see also section 0 – table 2) – are obliged to have a professional counselling by a provider of formal care every six months for persons in dependency level I or II, and once within a period of three months for persons with the highest degree of dependency (level III). As the majority of dependent persons choose the care allowance (see section I.1), a great difference of quality can be stated in the field of home care depending either on professional or on informal care delivery.

cc) Evolution of the legal framework for quality assurance after the LTC-Acts

Assessment by Medical Review Boards

The initial assessment of dependent people is entrusted to the MDK-bodies (see section 4.3.2). This assessment does not only relate to the degree of dependency but extends to the possibilities of rehabilitation of the person in need, the housing facilities (accessibility for handicapped persons). The MDK may have a look into medical documents and ask persons and services contributing to care services delivery.

It is important to know that the MDK-bodies are not only composed by physicians, but also by professional nurses and members of nursing-related professions.

Quality management by providers

LTC-service providers are legally bound to take care of LTC-quality ("assurance and development of care quality"). Points of reference for LTC-quality are laid down in rules established by the LTC-insurance bodies and their national and Laender associations. As all LTC-providers are to follow the lex-artis-rule (state of the art of medical and care knowledge) this rule is the principal guideline for LTC-service quality. The problem is that there is not, as in the medical field, a widespread common knowledge in the field of LTC compared to the medical field. Such, the state of the art in the field of LTC is not a generally accepted and generally known rule. There are, for the moment, only three national standards which are accepted as nationally consented care standards.

Providers are obliged to apply a series of internal quality management systems (documentation on care delivery, internal preventive check systems and so on). These requirements are laid down in the Guidelines for Quality Control (Qualitaets-Pruefungsrichtlinien - QPR).

Disclosure of service-related information

Services are legally bound – by the LTC-Act as well as by the Residential Home Act (Heimgesetz – HeimG) to disclose any information connected to structural and procedural quality and results of quality. This information is not only to be given at the beginning of an enterprise, but has to be delivered regularly.

Ombudsman system, etc.

Up to now there is no national or Laender ombudsman system. But some cities and other local authorities provide informal possibilities for complaints of cared and caring persons.

dd) Evolution in fact

Generalities

We have to state that the introduction of LTC-Insurance was the reason to introduce quality assurance in the field of LTC for the first time. Before this time, quality of LTC-services was neither a legal topic nor an issue which was of practical concern in the field of LTC.

Evaluation on the consumer side

Consumers are more and more sensitive for care quality topics. But this sensitiveness is more orientated to so-called care-scandals ("Pflegeskandale") than to the every-day delivery of care. The German Government is eager to provide more information on care quality topics. It has organized a Round Table LTC (Runder Tisch Pflege), which was established in four work groups. Two of those work groups dealt with quality in home and institutional care, one with de-bureaucratism, and one with a Charta of the Rights of Persons in Need of LTC. This Charta does not create new rights, but it consists in a collection of all the fundamental rights (constitutional rights and freedoms), the rights in the different Acts (LTC-Act, Residential Homes Act, Social Assistance Act, Sickness Insurance Act etc.). This Charta was presented in public in September 2005 and is published. LTC-service providers are invited to engage in the realisation of the rights laid down in the Charta.

Change of the attitude of service-providers

Service providers, soon after the enactment of LTC-Insurance, felt the necessity to act in the field of quality. On the one hand, legal requirements obliged them to do so; on the other hand, they were afraid of too much regulation stemming from public authorities. Especially the associations of charities (Freie Wohlfahrtspflege), but also the associations of private for profit nursing home enterprises engaged in quality activities. Nearly each association has now a special quality certificate, which should reflect the own quality policy, the aims and the ideology of the enterprise. These quality certificates obliged the service providers to an own quality management. On the other hand, the diversity of quality certificates gives no transparency for the consumer.

Quality policies at the service providers' management level are still not yet entirely satisfying. A report from 2004[9] edited by the Federal Medical Review Board for example testifies serious problems of quality assurance.

ee) Qualification and training of professional care workers

Services and institutions of LTC under the LTC-Act have to be managed under the steady control of a professional care worker (Pflegefachkraft). This professional care worker must have a training as nurse (hospital nurse), old person's nurse (Altenpfleger) or as children's nurse (Kinderkrankenschwester).

9 1. Bericht des Medizinischen Dienstes der Spitzenverbände der Krankenkassen (MDS) nach § 118 Abs. 4 SGB XI – Qualität in der ambulanten und stationären Pflege, November 2004.

The training and the legal statute of professional care workers is laid down for (hospital) nurses in the Act on Sickness Care, and for old person's nurse in the Act on Old persons' Care, the two acts being federal acts. These professions are licensed professions which means that a person may only be entitled to designate him or her as nurse, old person's nurse or children's nurse when he or she was trained conforming to the rules established by these Acts.

The Acts describe the goals and the content of the training, the licensed schools for training. The training is practical and a theoretical training of three years and ends with a state exam.

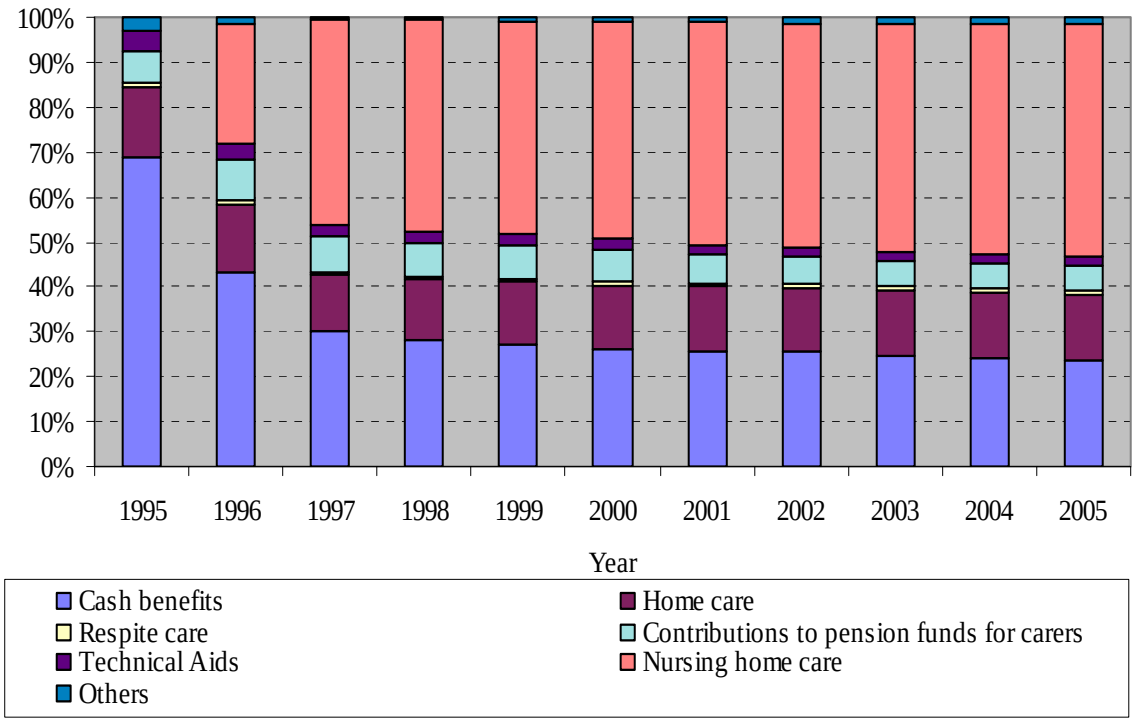
III. Expenditure, Contribution and Balance Sheet

In the above sections some trends concerning care arrangements were analysed. Adding information about contribution allows us to analyse the fiscal situation of the system as a whole. After giving an account of the past and present situations (section III.1), results of some projections are presented (section III.2), thus laying ground for the discussion of reform debates and proposals in section III.3.

1. The Current Situation

While beneficiaries predominantly choose cash benefits, public LTCI funds spend more on nursing home care due to higher per capita benefits for this type of care. Over time, the proportion of LTCI spending on nursing home care is even increasing (Figure 15). This demonstrates once again the past and potential future fiscal effects of a shift in utilisation towards nursing home care.

Figure 15: Structure of expenditure on benefits

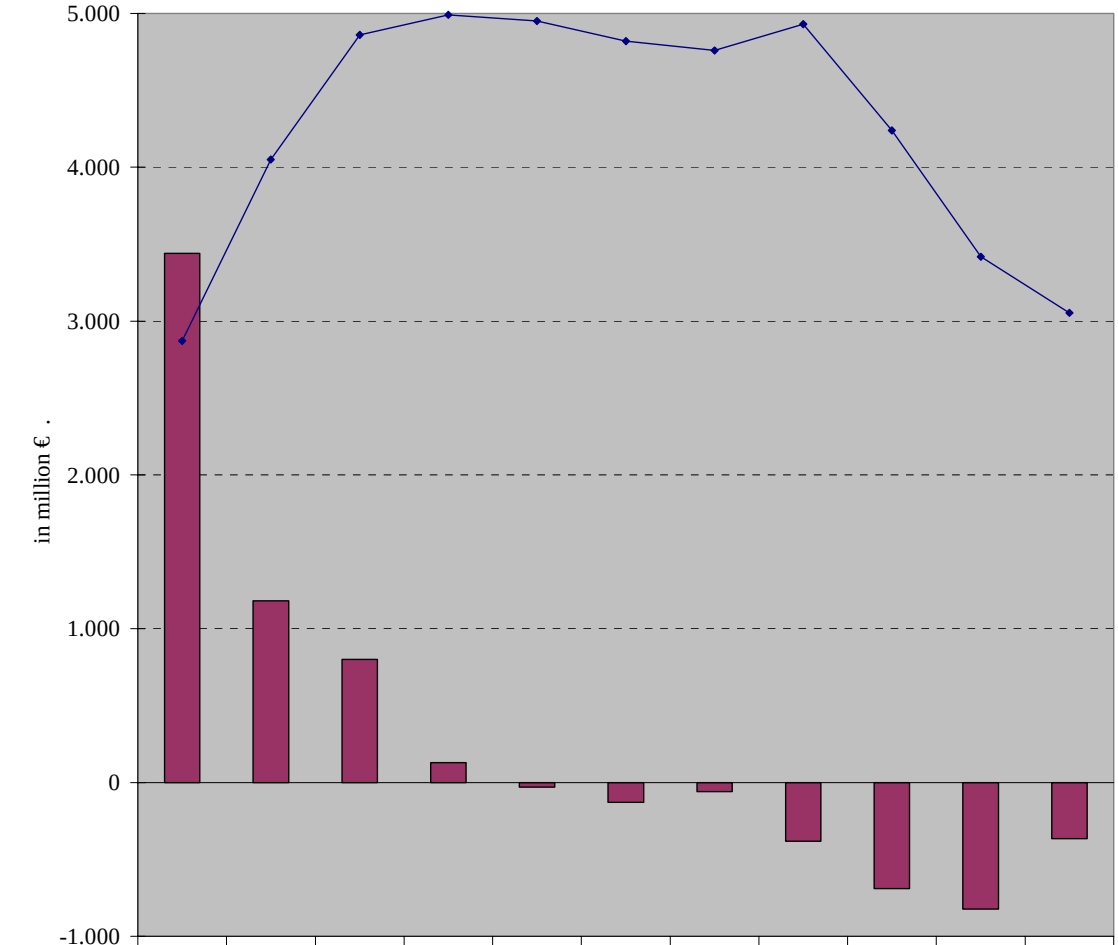


Source: Data from BMG (2006).

Most important for the sustainability of the long-term care insurance system, however, is the *balance sheet*. As Figure 16 demonstrates, this balance has been deteriorating constantly from high surpluses in the beginning to considerable deficits lately. Current deficits can be met by money in the reserve fund, which was mostly accumulated in the first three months of public LTCI, when only contributions were paid but no benefits were granted, and which was further filled by the considerable surpluses of 1996 and 1997.[10] The deficits of 2003 and 2004 however, started to drain this reserve fund. Without the additional contributions for those without children in 2005 the deficit would have been above € 1,000 million.

10 In 1995, a loan of € 560 million was given to the central government, which paid it back without interest in 2002.

Figure 16: Balance sheet of public LTCI

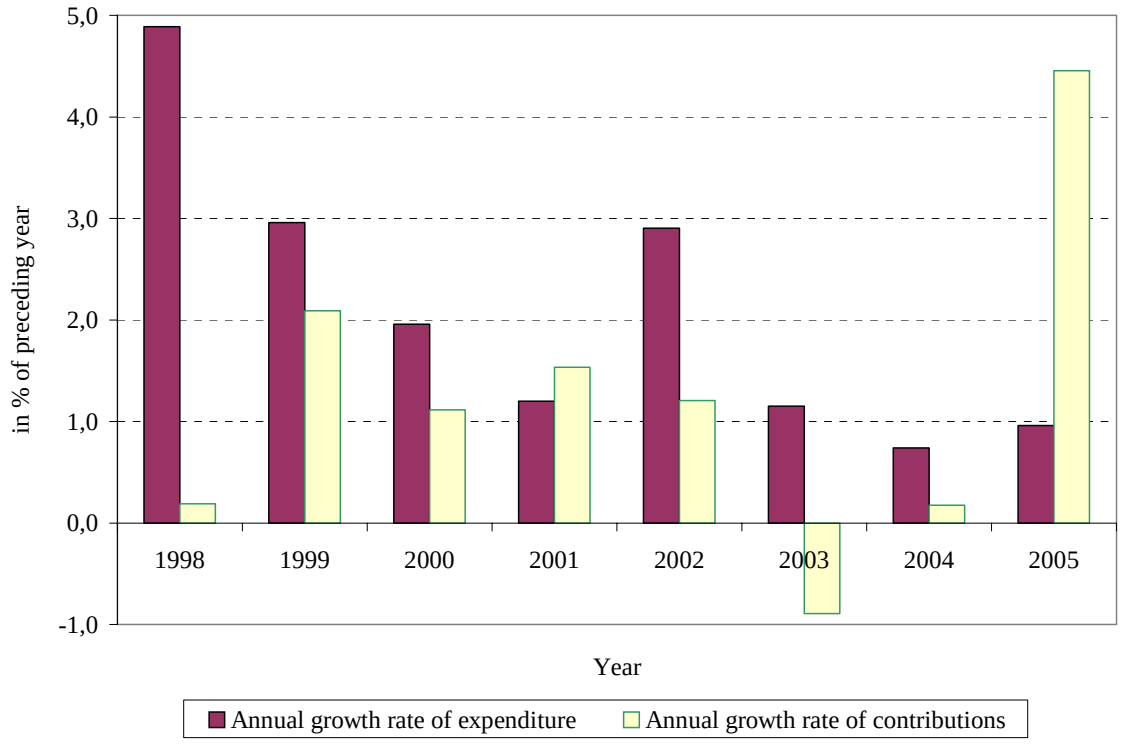


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Balance	3.440	1.180	800	130	-30	-130	-60	-380	-690	-823	-365
Liquidity	2.870	4.050	4.860	4.990	4.950	4.820	4.760	4.930	4.240	3.417	3.054

Source: Data from BMG (2006).

In order to explain this development, it is useful to look at annual growth rates for contributions and expenditure, which are given in Figure 17. In every year except 2001 and – due to the introduction of the additional contribution rate for the childless – in 2005, the expenditure growth rate for expenditure was higher than the growth rate for contributions. Not that the growth rates for *expenditures* were extraordinary high. Since 2000, this growth rate has exceeded 2 percent only once, and from 1997 to 2004, the geometric mean was a mere 2.0 percent.

Figure 17: Growth Rates of Contributions and Expenditure



Source: Own calculations, based on data from BMG (2006)

The actual deficit has rather been caused by disappointing growth rates for *contributions*. From 1997 to 2004, the average annual growth rate of nominal (sic!) conributions was 0.8 percent (geometric mean). This is even far below inflation which was on average about 1.3 percent per year for this period of time. In 2003, contributions actually declined and in 2004, they remain practically unchanged. Thus, growth rates of conributions have been much lower than had been projected by government agencies and researchers alike.

Both of these developments – the moderate growth rates for expenditure and the disappointing growth rates for contributions – need to be explained. The only *moderate growth of expenditures* has been due to two major factors: First, the insurance system is based on a comparatively tight definition of dependency (see Rothgang and Comas-Herrera, 2003), and entitlement for LTCI benefits is based on a rigorous assessment by the Medical Review Board preventing any *ex ante* moral hazard, which might have been expected if service providers were to make these assessments. Revision of the assessment guidelines that aimed to reduce regional variations in assessment results and court jurisdictions actually even reduced the number of claims that were approved. Second, all benefits are capped and have not been adjusted since 1995, not even for inflation. So, while the assessments have prevented any explosion of the number of beneficiaries, the benefit caps have controlled expenditure per beneficiary. Of course there is a "price" to be paid for cost containment of this kind: First, the tight definition of dependency has

meant that people with dementia are entitled to LTCI benefits only insofar as they need help with the activities of daily living as the assessment does not evaluate or take into account their general need for supervision. Second, due to the benefit caps, there is still a large amount of out-of-pocket payments, which is unusual for the traditional German social insurance system. Moreover, the number of persons in need of long-term care who depend on social assistance is still high and much higher than had been anticipated when the LTCI act was passed. Finally, the fact that the benefits have never been adjusted in a decade has caused the purchasing power of LTCI benefits to decline, which will eventually lead to a de-legitimization of this branch of social insurance. This is why it is simply not feasible to continue to control costs by capping benefits but never adjusting their value.

The *slow growth of contributions* is partly an effect of certain (social) policies. Certain changes in social law have reduced contributions either explicitly or implicitly. For example, in 2000 the federal government reduced contributions for the unemployed, which have to be financed by the unemployment insurance, because, at that time, it was beset with fiscal problems, while the LTCI had considerable assets. Similarly, the introduction of so-called mini-jobs and midi-jobs, that is jobs earnings up to € 400 and € 800 a month respectively, reduced the amount of contributory income to the LTCI funds as these workers are exempt from making regular contributions. This effect is likely to become yet more noticeable as normal jobs are increasingly transformed into mini-jobs. Something similar is happening to the old-age security system. Recent legislation is aiming at the partial substitution of (mandatory) public schemes by (voluntary) private schemes. In the course of this legislation federal government has introduced new opportunities for sacrificed compensation which reduced the amount of contributory income. A general feature of social policy over the last decades has been that the problems in one branch of the insurance system have often been resolved at the expense of others. As for the existing reserve fund, the LTCI has been used as a melting cow for other branches of social security. In addition, LTCI contributions have suffered from the general trends that have affected all branches of social security, namely the reduction in the number of jobs that are subject to social insurance contributions, cyclical and structural unemployment, and low (if any) rises in wages and pensions.

Thus, it is an irony of history that LTCI financing is in trouble despite successful cost-containment because of inadequate contributions, partly caused by social policy regulations aimed at solving problems in other branches of social security.

As mentioned before, the capped benefits are insufficient to cover even the assessed needs of a dependent elderly. Consequently, *private financing and social assistance* still play an important role in financing long-term care (Table 8).

Table 8: Sources of Funding for Long-term Care (own estimates relating to about 2001)

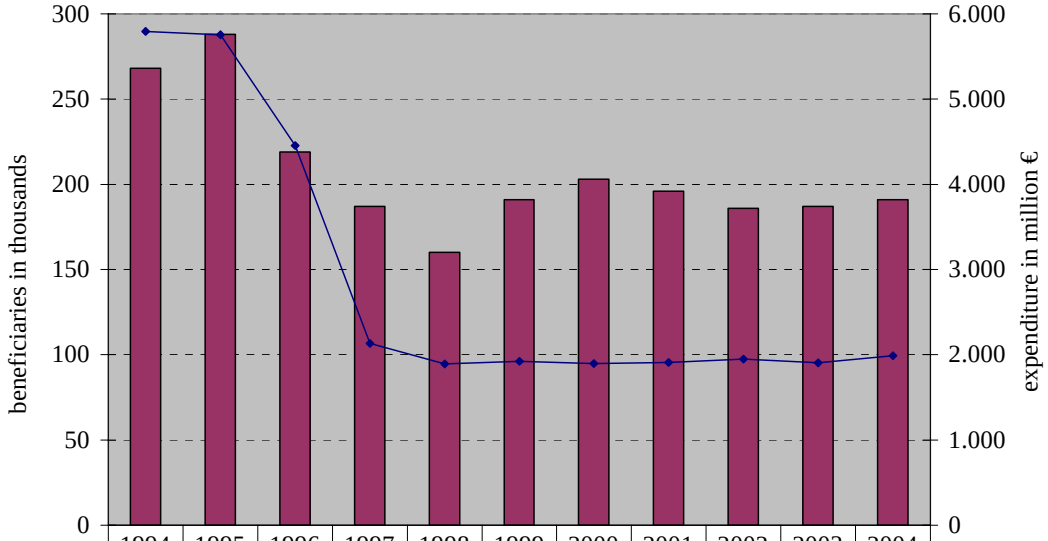
Source of Funding	In million Euro	As % of Public / Private Spending	As % of All Spending
Public Funding	24,230	100	75
Public LTCI*	17,360	79	60
Private Mandatory LTCI*	0,520	2	2
Social Assistance	2,900	13	10
Investment Financing*	1,070	5	4
Public Accident Insurance	0,080	0	0
Out-of-pocket Private Funding** on:	7,220	100	25
Nursing Home Care	5,050	70	17
Home Care	2,170	30	7
Total	29,160		100

Notes: *Cash allowances are included, **Estimated.

Source: Rothgang and Comas-Herrera, 2003, 159 ff.

According to the figures in Table 8, about one-quarter of all funding is out-of pocket, and another 10 percent comes from means-tested assistance. About 80 percent of public funding and 60 percent of all funding comes from LTCI, highlighting the fiscal importance of this system for LTC.

Figure 18: Social assistance for nursing home care: Number of beneficiaries and expenditure



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
beneficiaries	268	288	219	187	160	191	203	196	186	187	191
expenditure	5.796	5.755	4.453	2.133	1.894	1.923	1.895	1.910	1.948	1.905	1.988

Source: Data from BMG (2006)

Social assistance expenditure on nursing home care nowadays is less than one-third of what it was in 1995. The number of beneficiaries has also dropped considerably, but still is about two-thirds of the 1995 figure (Figure 18). Thus, the introduction of LTCI

has not been as successful in terms of the number of beneficiaries as it has been in terms of reducing the fiscal burden on municipalities**.**

2. Projections

Projections can be made concerning the expenditure of public LTCI funds and the contribution rate. Due to demographic changes, both the number of beneficiaries and the funds' expenditure levels can be expected to increase by about 1.2 to 1.5 percent per year. Due to the above mentioned shifts in care arrangements, an additional rise in expenditure of up to 0.5 percent per year can also be expected. If we assume that benefits are going to be increased by about 2 percent per year, this adds up to a 4 percent growth rate per year in expenditure, which simply cannot be financed if the contribution rate remains constant.

Table 9: Projected Contribution Rate in 2040

Projections	Adjustment according to	Source
1.6 – 2.1	Inflation	Rothgang, 2002a
3.6 – 3.9	Average wages and salaries	Rothgang, 2002a
3.0	(Average wages + inflation) / 2	Ruerup-Commission, 2003

Table 9 contains the results of some projections on the contribution rate that all assume rising real wages but differ with respect to the assumed adjustment rule. As long as benefits are adjusted only for inflation, the current contribution rate will more or less suffice albeit with deteriorating purchasing power. However, as soon as we assume that an adjustment will be made (partly) according to wages, the contribution rates are projected to rise.

3. Current Problems and Proposed Solutions

The current deficit of LTCI funds is the starting point for most reform debates, which therefore tend to revolve around fiscal issues. The adjustment of benefits is one issue that is rarely missed out of any proposal. In order to fund such adjustments, two different kinds of proposals have been made: radical reforms and reforms within the current system. We consider each of these in turn in this section and then discuss whether any of these proposals are likely to be implemented and whether they would solve the problems at hand.

a) Adjustment of Benefits

There is a general consensus that LTCI benefits must be adjusted if the system is to survive. This could be done more or less regularly at the discretion of politicians or by

the introduction of an adjustment mechanism, which would guarantee an automatic adjustment according to some pre-agreed formula. Given what is known about other branches of social security, only an adjustment mechanism will yield a regular adjustment. Since future economic development is always hard to project, adopting any system with a fixed adjustment rate of X percent per year is doomed to fail as the rate is likely to be considered either too high or too low depending on the prevailing economic situation. Therefore, any formula should relate to such macroeconomic indicators as inflation or the rise in average (nominal) gross wages. Assuming that wage increases in the care sector are similar to those in the rest of the economy and assuming further that in the long run wages are the major determinate of the price of labor-intensive care services, adjusting benefits according to the rise in average wages seems to be the perfect indicator if their purchasing power is to be maintained.

b) Radical Reform

Three main radical reforms that have been suggested are to integrate LTCI and health insurance or to abolish LTCI in favor of either a tax-funded system or a (mandatory) funded private insurance scheme.

Integrating LTCI and Health Insurance. The suggestion to abolish the separate LTCI and integrate long-term care into health insurance is as old as the insurance system itself. Recently it has been discussed (favorably) by the Enquete Commission (2002) and (less favorably) by the Ruerup Commission (2003). Advocates emphasize the fact that elderly people suffering from multi-morbidity would be better off when receiving integrated care under this arrangement. Today, e.g. sickness funds have no incentive to grant rehabilitative measures that could reduce dependency because the expenses of long-term care are financed by all of the funds together, while the expenses rest with the individual fund. On the other hand, integrating LTCI and health insurance has dangers and disadvantages as well. Given the relative weight of both areas for example in terms of finance, most likely long-term care issues would be dominated by health issues. Even today, the long-term care divisions within the LTCI funds are rather weak and after any integration, this domination would be likely to increase. The same applies on the service side. As highlighted by Ikegami and Campbell (2002: 721 f.), in an integrated system, medical doctors tend to predominate over nurses, with the result that terminal care is over-medicalized and rehabilitation is under-medicalized. Most important, however, the crucial role of the family in providing long-term care is likely to be ignored if health funds were to manage long-term care as well.

The introduction of competition among LTCI funds would be a more moderate solution to the lack of incentives for funds to care for dependent people. As a consequence, the contribution rate could no longer be legally fixed, and each fund would be able to set its own rate. As is well known from the experience of the health insurance system, introducing competition also requires the introduction of a risk-equalization scheme.

However, neither option is likely to be implemented in the next reform, because such schemes are inevitably complicated and as such tend not to be vote-winners. Moreover, the administration seems to be overloaded with complicated reforms in the health care area already.

Replacing LTCI with a Tax-financed System. During the discussions leading up to the LTCI Act, policymakers also discussed a means-tested tax-financed system but ultimately dismissed this alternative. Recently, one member of the Ruerup Commission started the discussion again, but the proposal was dismissed within the Commission. As all major parties favor an insurance system, the replacement of LTCI by a tax-financed system seems extremely unlikely.

Switching to a Funded (Private) System. Switching to a funded private system has mainly been suggested by those economists who generally favor funded systems. Basically, they have suggested two variants of this idea. First, among others, the Kronberger Kreis (Donges et al, 2005), a group of conservative economists, has suggested completely switching the whole population at once. Alternatively, the Council of Economic Advisers (2005) advocates a cohort model in which only those born after 1950 switch to a private funded system while older people remain in the traditional social insurance system. As the older generation cannot bear the financial burden of their own insurance by themselves, they have to be subsidized by the younger generations. Any kind of switch towards a funded system would transfer future burden into the present and would necessitate enormous increases in contributions since benefits for the elderly would have to be financed at the same time as capital stock would have to be built up (double burden). Moreover, this move would not solve the system's current fiscal problems but in fact would increase its actual problems. Therefore, only the small Liberal Party (*Freie Demokratische Partei*) advocates such a policy, which means that a switch of this kind seems very unlikely in the near future.

Introducing a Mandatory Supplementary Funded System. To avoid an unacceptable high double burden, some have advocated a hybrid system that combines public LTCI with a mandatory supplementary funded system. Basically, the existing LTCI would remain untouched – with nominally fixed benefits, which could be financed at the present contribution rate. To compensate for the declining purchasing power of these benefits, each person would be obliged to buy private supplementary insurance. According to a proposal of the peak organization of private insurance companies the benefits of this insurance would be set at whatever level would be necessary to fill the gap caused by missing adjustment in public LTCI.[11] The monthly premium would be € 8.50 per

11 The proposal assumes a proper adjustment of LTCI benefits of 2 percent per annum, and the mandatory supplementary insurance to fill the gap between this proper benefit and the nominally fixed LTCI benefits. Benefits for the supplementary system can therefore be calculated as:
Bsup = (1,02t – 1) * Bpub,
with Bsup denoting the benefits of the supplementary system, Bpub the (nominally fixed) benefits of the public system, and t the number of years after the introduction of the supplementary system.
After 35 years, the benefits for the supplementary insurance would be as high as those of the public LTC.

person. It would be neither income-related nor risk-related. Each year, the premium would rise by € 1. In the long-run the funded system would become dominant and the pay-as-you-go-system would loose relevance.

This model would avoid dramatic rises in premiums and has no legal pitfalls as everyone remains in the existing system. In the long run, however, it would put a considerable burden on low-income households, which would suffer from the phasing out of income-related premiums. Furthermore, administrative costs would be fairly high as another system would have to be built up for – initially – comparatively very low benefits and premiums. Finally, the co-operation of both insurance systems would have to be secured, which might prove difficult, because supplementary insurance benefits would be low immediately after the introduction of this scheme but would grow continuously until they were higher than the benefits from public insurance.

c) Reform within the System

Beside these radical reforms, there are several options for making reforms within the system, in other words reforms that neither abolish public LTCI nor supplement it with an additional system that would eventually dominate public LTCI, but rather concentrate on changing the parameters of the existing financing system.

Tax-financed Subsidies or Contributions to the Insurance System. Both pension insurance and health insurance receive tax-financed subsidies or contributions that are fed into the system. In the current health care reform the increase of tax-financing is even one of the core issues. Obviously, this raises the question of whether something similar is possible for LTCI. However, making tax-financed subsidies to insurance systems needs to be justified. Particularly in pension insurance, the justification centers around the idea that the insurance scheme also provide benefits that are not linked to the social risk covered but rather refer to public policies (as family policies) and should therefore be financed out of the public purse. With respect to LTCI, it could be argued that insuring children without contributions is a kind of family policy that should be tax-financed. Accordingly, tax-financed subsidies to LTCI or tax-financed contributions for children could be justified. Since children produce about 5 percent of all public LTCI expenditures, it might be reasonable to expect the public purse to contribute the same amount. Of course, this could only be one small part of any fiscal reform.

Additional Contributions for Pensioners. Current pensioners have gained windfall profits when LTCI was introduced as a pay-as-you-go system. This fact can be used as a rationale for introducing an additional contribution for pensioners as has been suggested by the Ruerup Commission. Such an additional contribution would in effect counteract this initial “present” from the elderly. As windfall profits are the smaller the younger the cohorts are, the justification for a pure additional contribution for pensioners will vanish over time as younger cohorts enter pension age. To compensate for this, the introduction of an additional contribution for pensioners could be combined with compulsory savings in a private funded pillar of the old-age security system for the younger. This

would enable them to pay the additional contribution once they become pensioners themselves. In effect, an extra element of funding would be introduced without the need to introduce a supplementary LTCI, and – contrary to other proposals for introducing funded bits of the system – immediate cash flow is guaranteed from the pensioners' additional contribution.

As normative justification is possible and the potential fiscal effects are substantial, this could be an important element in any financing reform. Unfortunately, pensioners have recently already been subjected to cuts in their pensions. Therefore, any additional LTCI contributions from pensioners must been discussed against the background of social policy in general and old-age security policies in particular.

Raising the Contribution Rate. The easiest way to raise additional funds, however, is simply to raise the contribution rate. This can be done without much administrative effort and will yield additional revenue at once. Even when the system was first introduced, the Bill admitted that there would be increases in the contribution rate. A moderate rise could not harm the country's economic performance and would hardly affect the labor market, particularly if it were combined with a freeze on the employers' contribution.

If any rise is moderate, fiscal effects would be limited as well. Nevertheless, a moderate rise in the contribution rate could be introduced as part of a sensible package deal. For ideological reasons, however, this is unlikely to happen. As all major parties agree that social security contribution rates must be reduced, the persistence of the current rate of 1.7 percent has become a kind of dogma.

Citizens' Insurance (Buergerversicherung). The Social Democratic Party (at least its left wing) and the Green Party both favor transforming the existing long-term care (and health) insurance into a citizens' insurance (*Buergerversicherung*).

The concept is based on two elements: First, all citizens should be part of one insurance system. When implemented, this principle would mark the end of a separate mandatory private LTCI. Second, contributions should be based on all sources of income, not just on income from gainful employment (and derived benefits as benefits for the unemployed and pensions). Both elements combined would increase horizontal justice as all types of income would become contributory and it would also increase vertical justice as high-income groups would participate in redistribution without being able to opt out. The combined insurance would also attract additional revenue equivalent to an increase in the contribution rate of up to 0.2 to 0.5 percentage points. There are, however, administrative and legal problems connected with both elements and only the former element is favored by the Council for Economic Advisers and other more conservative groups. Thus, there is a small chance that the whole population would be forced to enter the public system if this were combined with a radical reform of public LTCI.

IV. Discussion

In this paper current debates with respect to the provision of care and to fiscal questions have been reviewed. As has been demonstrated, today, care-giving relies very much on family care-givers. Due to demographic reasons as well as socio-demographic and cultural changes the relative family care potential, i.e. the number of potential care-givers per person in need of long-term care, is declining. Respectively, even in the last decade a decline in family care-giving could be observed. A shift from informal to formal care, however, requires an increased workforce in formal care-giving. Respective projection show instead that even if the share of people who take up care-giving as a profession remains constant the need for carers will increase while the supply will decrease leading to a huge gap. Thus, a higher recruitment is asked for – but unlikely given low payment and unattractive working conditions. Since neither family care can prevail in its current role nor can formal care take over, "*mixed care arrangements*" are the only possible solutions (cf. Döhner / Rothgang 2006). This implies that families open up for supporting services and professional providers accept a new role as partners of families and source of advice rather than as hands on carers.

Mixed care arrangements also require that formal care becomes *more flexible*. By now dependent elderly can only choose among about two dozens service packages *(Leistungskomplexe).* If formal care providers and informal carers are to work together more closely these arrangements have to be liberalized. A current experiment with care budgets and case managers who help spending the budget in the most effective and efficient way, hint towards possible solutions.

New care arrangements can also be found in *new forms of care services and housing* in such settings which are not especially arranged for people in need of LTC-services but which are created generally for older persons. These different forms are sometimes difficult to distinguish. Some of them have experimental character, some of them are only to be found in some regions, and some of them are fostered by national institutions. The following list is therefore by no means exhausting:

- *Housing at home with care services ("sheltered housing at home")*
  In order to stay in the traditional environment services are provided at home. The older person may contract with service providers which may be organized by the home owner enterprise or which may be independent from the home.
- *Sheltered housing*
  Sheltered housing offers autonomous dwelling in apartments specially equipped for the needs of older persons. There are community facilities and offers of services. Usually an emergency call service is provided. This concept is more common in cities than in the rural situation. The legal situation (see above) is rather sophisticated and often not clear for the older persons.
- *Self-organized collective projects*
  Self-organized collective projects of housing in an apartment house have develo-

ped in the last 20/30 years. There are integrated forms of living with different groups of dwellers of more generations in order to offer mutual help.

- *Village for older persons*
  In the model of a village for older persons (Altendorf) dwellings are constructed in a separate area. All kinds of services are provided in the village so that there is no need of moving out of the village in the case of need of such services.
- *Joint residences*
  In joint residences groups of older persons in need of LTC get the necessary services by home care services and are therefore considered as a home care setting. Those groups may live together in an apartment or in a house.
- *House communities*
  House communities have been developed in order to give an alternative to traditional nursing homes. Those communities are conceived like institutional care, but people live together in joint residences groups and have common structures, above all a common kitchen.

These arrangements may differ with respect to the situation of decision of the beneficiary, the form of service provision, or the degree of service provision. Quite regularly they lie, however, somewhere in between institutional and home care. In order to foster such arrangements the equalization of benefits for formal home care and those for nursing home care would be one step in overcoming the segmentation between these forms of care-giving.

With respect to *quality of care*, we firstly have to state that there is no all-over concept of quality assurance or quality management, but there are some important guidelines as regards responsibilities of service providers to produce quality and as regards controls. Since the last ten years, quality assurance was legally based and developed above all on legal grounds. The practice of service providers and of the associations of service providers was to bypass (or: to outrun) in some way the legal requirements by constructing their own quality certificates which should serve as a substitute for the legal requirements. These various forms of certificates are not useful for consumer purposes: they are not transparent; they do not explain which quality for which reasons is certified; they have no explanations on the means of quality management of service providers. Secondly, notwithstanding these efforts in the field of quality (which is considered to be an important issue), there is one great fault in this system of quality assurance: The LTC-Act as well as the Residential Homes Act start from the idea that there are quality standards and rules of the state of the art of delivering LTC-services which just should apply. The truth is that there are only very few nationwide recognised and accepted quality standards which may fulfil the state of the art criteria. Such, the important contents of quality, the description of different standards of qualities, is not available. But there is a variety of quality standards which do not fulfil the internationally accepted criteria of compliance within the professional group and of evidence based nursing (EBN). This, thirdly, leads to the necessity to create an institutional basis to develop LTC-quality standards. This institution or centre has to be independent from political influence, has to integrate the professionals in the field of LTC-care, the care

services, cared and caring persons and the financing bodies. The aim is to provide an independent, neutral, scientifically and professionally based knowledge on how to create quality in the field of LTC. One of the problems still not solved in a convenient manner is how to support and improve the quality of care by family members with regard to mixed care arrangements. Notwithstanding the fact, that the LTC-Insurance bodies are obliged to offer free training courses especially for volunteers and caring family members, the take up of these possibilities is not satisfying. One reason may be, that caring family members are too busy in care giving, that there is no spare time for these courses.

Recently *fiscal questions* tend to dominate the debate. Due to demographic changes, the number of dependent elderly will continue to increase over the next decades. Although it might be possible to influence the speed of this increase by prevention and rehabilitation and although the fiscal effects of reduced dependency rates are considerable, respective policies for long-term care are not on the political agenda. Political debates rather center on how to cope with increased numbers of dependent elderly. Generally speaking there are three remaining options to deal with demographic change: First, the eligibility criteria could be tightened in order to moderate the expected increase in the number of beneficiaries. Second, individual benefits and/or remuneration for providers could be cut. Third, sources for additional revenue might be discovered and exploited.

In Germany even today, *eligibility criteria* are tighter than in Japan (Campbell, 2002) or in other countries (Rothgang and Comas Herreras, 2003). Moreover, the number of beneficiaries is growing at a moderate pace, and on average the assessed level of dependency is even declining. A recent report concludes that the declining level of assessed dependency is due to tighter eligibility assessments as there is no evidence that the real level of dependency is decreasing (Landtag NRW 2005: 457, own translation). Therefore, there is little room to make even tougher assessments in the future.

Cutting real benefits has been the predominant policy of the last decade. Since benefits are nominally fixed, this policy of real cuts has been executed smoothly simply by not adjusting the benefit caps. Although there has hardly been any protest against this practice in the past, it seems impossible to continue this policy forever. Too many commissions and reports have brought up this issue, and by now the deteriorating real purchasing power of LTCI benefits is being discussed in the media. *Cuts in remuneration* of service providers would not reduce LTCI expenditure as the latter just depend on the fixed benefits (Table 2). Reduced remuneration would, however, increase the purchasing power of LTCI benefits and thus ease the pressure for adjustments. On the other hand, cuts in remuneration could make formal care benefits more attractive to beneficiaries and thus reduce the extent to which they choose – cheaper – cash allowances. So this could even increase LTCI expenditure.

In a nutshell, real cuts in LTCI benefits are no way to deal with fiscal problems as this strategy has been used exhaustively during the last decade. Cutting remuneration of care providers does not help either, as they do not affect LTCI spending directly and

might even lead to a shift in utilization patterns that increase LTCI expenditure. In recognition of this, recent debates about reform have concentrated on the final option – identifying *new sources of revenue*.

Radical reforms are unlikely to be adopted as the political costs would be enormous, and the system is too small (and unimportant) to make it worthwhile to start a public relations campaign on this. This is why *solutions within the system* or solutions that combine new elements with the existing system are more likely.

The obvious way to deal with the fiscal crises, in other words, to increase the contribution rate, cannot be done for ideological reasons. The *citizens' insurance* is favored by one of the partners in the grand coalition but loathed by the other. Thus, a *supplementary privately funded system* seems to be a feasible option as it is ideologically sound (funded private insurance) without causing too much opposition as the initial additional financial burden would be too small to engender much conflict.

All in all, after more than one decade of existence the German long-term care insurance can show several successes, but also some failures and problems: At least *five major successes* have to be mentioned: First, due to the introduction of a public LTCI that followed the pay-as-you go principle, immediate benefits were available to those who were eligible. Second, family care was strengthened, particularly through the introduction of cash benefits and contributions to pension insurance for family carers. Third, the fiscal burden on municipalities was lifted as social assistance spending for dependent people declined by two-thirds. The number of recipients of social assistance was reduced by one-third, which is less than was promised but is still a success. Fourth, the LTCI Act triggered an expansion of capacity in the formal sector and improvements in the quality of care. Finally, attempts to control costs were quite successful.

On the other hand, the system suffers from several *failures and problems*. First, there are the structural problems of service provision. The quality of care is still not satisfactory, alternative care facilities (such as assisted living) are developing only very slowly, there is too little rehabilitation for dependent elderly, there are still breaks in the chain of care between institutions (hospitals, nursing homes, and rehabilitation facilities), and there is no case management to overcome this. Second, there are those problems that could easily be solved if more funding was available. For example, the narrow concept of dependency leads to the neglect of communication needs in general and the particular needs of people with dementia. Tight budgets cause understaffing in nursing homes, and the nominally fixed benefits of the LTCI have caused their purchasing power to decline. Finally, the faltering revenue in particular has caused the public LTCI to incur increasing deficits, which are at the heart of all current reform debates.

Based on this account at least three *lessons* can be learnt from the German experience: First, cash allowances can help to stabilize family care and thus expenditure on long-term care. More than half of all dependent people are cared for without the involvement of any professional carer. Although the data clearly reveal a trend towards formal care, there can hardly be any doubt that cash allowances moderated this trend. Moreover, future care arrangements will inevitably be a combination of formal and in-

formal care. The opportunity to combine cash and in-kind benefits has opened the way to such arrangements. Second, it is possible to control costs. The German system has been quite successful at this, mainly by capping benefits and by having an institution that is independent from providers assessing the eligibility of potential beneficiaries. However, this strategy of effecting real cuts through nominally fixed benefits cannot be applied forever as it causes the purchasing power of the benefits to decline, which will sooner or later de-legitimize the whole system. Finally, even successful cost control is not sufficient to stabilize the system unless a steady growth in revenue can be guaranteed. It must be regarded as an irony of history that the German system is financially unbalanced despite its success in cost-containment simply because of its faltering revenue.

Appendix: Professional Care Workers in Germany

Qualification	Qualification (German term)	Workers in			therefore females (%)			therefore females (%)		
		Prof. home care	Nursing homes	∑	Prof. home care	Nursing homes	∑	Prof. home care	Nursing homes	∑
state-approved nurses for the elderly	staatl. anerkannte/-r Altenpfleger/-in	31,757	110,208	**141,965**	87.5	85.6	**86.0**	27,787	94,338	**122,125**
state-approved geriatric nurse	staatl. anerkannte/-r Altenpflegehelfer/-in	4,816	14,662	**19,478**	91.6	91.6	**91.6**	4,411	13,430	**17,842**
registered nurse	Krankenschwester, -pfleger	61,233	55,348	**118,581**	88.8	89.9	**89.3**	56,151	49,758	**105,909**
auxiliary nurse	Krankenpflegehelfer/-in	9,678	18,994	**28,672**	91.4	90.5	**90.8**	8,846	17,190	**26,035**
nurses for children	Kinderkrankenschwester, -pfleger	5,360	3,587	**8,947**	98.0	97.3	**97.7**	5,253	3,490	**8,743**
Orthopedagogist	Heilpädagoge/-in	93	375	**468**	79.6	79.5	**79.5**	74	298	**372**
occupational therapist	Ergotherapeut/-in	265	4,202	**4,467**	90.2	88.1	**88.2**	239	3,702	**3,941**
other education in not medical healing occupation sector	sonst. Abschluss im Bereich der nichtärztl. Heilberufe	2,945	3,480	**6,425**	92.8	87.2	**89.8**	2,733	3,035	**5,768**
social pedagogist / social worker	sozialpädagogischer/-arbeiterischer Berufsabschluss	1,311	6,411	**7,455**	78.0	77.1	**77.3**	1,023	4,737	**5,760**
other	Familienpfleger/-in mit staatl. Abschluss	2,136	1,567	**3,703**	97.3	95.2	**96.4**	2,078	1,492	**3,570**
	Dorfhelfer/-in mit staatl. Abschluss	138	158	**296**	98.6	89.9	**94.0**	136	142	**278**
	Heilerzieher/-in, Heilerziehungspfleger/-in	653	2,080	**2,733**	82.8	79.9	**80.6**	541	1,662	**2,203**
	Heilerziehungspflegehelfer/-in	200	538	**738**	58.0	70.8	**67.3**	116	381	**497**
care specific degree from university or university of applied sciences	Abschluss einer pflegewissenschftl. Ausbildung an einer Fachhochschule oder Universität	557	1,397	**1,954**	60.7	65.7	**64.3**	338	918	**1,256**
other care-specific profession	sonstiger pflegerischer Beruf	19,420	33,681	**53,101**	93.2	92.6	**92.8**	18,099	31,189	**49,288**
Menschen	Fachhauswirtschafter/-in für ältere Menschen	1,051	1,575	**2,626**	98.3	92.0	**94.5**	1,033	1,449	**2,482**
other degree on domestic economy	sonstiger hauswirtschaftlicher Berufsabschluss	4,014	21,631	**25,645**	97.7	87.3	**88.9**	3,922	18,884	**22,806**
other degrees	sonstiger Berufsabschluss	35,895	121,835	**157,730**	83.9	79.3	**80.3**	30,116	96,615	**126,731**
still in vocational training / without degree	noch in Ausbildung / ohne Berufsabschluss	17,375	109,395	**126,770**	67.4	83.3	**81.1**	11,711	91,126	**102,837**
	∑	**200,897**	**510,857**	**711,754**	**86.6**	**84.9**	**85.5**	**174,579**	**433,718**	**608,297**

Source: Federal Statistical Office (2005a), own calculations.

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Normative issues concerning statutory pension insurance in Germany

Bernd Baron von MAYDELL

I. Outline of the German pension system

1. Structure of the system

The central old-age pension system in Germany was established as social insurance at the end of the 19th century[1] and until this day chiefly covers employees[2]. The system provides parallel coverage of invalidity and old age, although invalidity was originally in the foreground. Civil servants and the self-employed have their own pension schemes[3]. In the following, the main emphasis is placed on employee social insurance. Social insurance is geared to earned income, which forms the basis for the amount of both contribution payments and benefits. In that respect, it constitutes a uniform system. Social insurance pensions may be augmented by supplementary occupational pension benefits and private forms of retirement provision (see I.7. below).

2. Basic character of the statutory pension system

As a branch of social insurance, the statutory pension system has the function of replacing prior earned income. Given that contributions and benefits are oriented to the income earned throughout entire working life, the system is not designed for the award of a basic pension. This strict reference to income is nevertheless somewhat attenuated by the selective recognition of creditable periods during which specific, statutorily defined activities were carried out (training, parenting periods, military service, etc.).

According to the insurance-based equivalence principle, statutory pension insurance cannot guarantee a minimum pension. If the awarded pension does not suffice to secure the necessities of life, the subsidiary, tax-financed social assistance scheme is called upon to intervene.

3. Unit of pension benefits

The link to earned income requires that pension benefits be related to the individual insured and not his or her household. As far as the prerequisites are fulfilled, several persons living together in a household can be entitled to the receipt of social insurance pensions. The varying needs of one- or multiple-person households are not taken into account upon determining benefit amounts[4].

1 For details on the history of pension insurance in Germany, cf. *Fisch/Haerendel* (eds.), Geschichte und Gegenwart der Rentenversicherung in Deutschland; see also www.bmas.bund.de.

2 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, para. 1.

3 *Battis*, in: *Cramer/Förster/Ruland* (eds.), Handbuch zur Altersversorgung, pp. 117 et sqq.

4 Regarding basic principles of pension insurance, cf. *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, paras. 12 et sqq.

4. Coverage

Statutory pension insurance originally covered only low-income employees[5]. In the course of time, it was extended to all employees as well as other groups of persons, such as self-employed persons with low earnings and craftsmen. Up until this day, however, the system does not provide universal coverage as self-employed groups and civil servants have their own pension schemes[6].

5. Regulation and level of benefits

Pension benefits awarded in the event of old age, invalidity and death (to the survivors) depend on the length of the insured period and on the level of compulsorily insured earnings on which contributions were paid. Contribution-free periods are accounted for on a narrow scale.

The pension received by an average earner after 45 years of coverage (net standard pension) amounted to 69.1 percent of net average income in 2002, after deduction of health and long-term care insurance contributions[7].

6. Regulation and level of contributions

Contributions are calculated on the basis of earned income. Since 1 January 2003, the contribution rate has been fixed at 19.5 percent, half of which is borne by the employer and the employee respectively. Contributions are levied only up to the income limit for the assessment of contributions which is index-linked to the increase in average earnings. The income limit for the assessment of contributions was set at €63,000 a year for western Germany in 2006[8].

7. Additional pension schemes

Statutory pensions can be augmented by occupational pension benefits and/or private forms of retirement provision, notably life insurances. Such supplementary schemes do not come to bear in all cases as they are not mandatory. Consequently, a large proportion of employees receive no additional pension.

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5 *Döring*, in: *Fisch/Haerendel* (eds.), Geschichte und Gegenwart der Rentenversicherung in Deutschland, pp. 169 et sqq. (169).

6 Detailed in *Cramer/Förster/Ruland*, Handbuch zur Altersversorgung; Roth, ZRP 2004, 154 et sqq.

7 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, para. 2 with further substantiation; figures can also be found at www.deutsche-rentenversicherung.de (Nov. 2006); *Steinmeyer*, RdA 2005, 345 et sqq. (345).

8 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, para. 1.

Benefits received under occupational pension schemes and through private provision moreover vary substantially in terms of amount.

The state promotes additional provision for old age. That applies in particular to personal forms of retirement provision backed by the so-called "Riester" incentives (named after the former Federal Minister of Labor and Social Affairs). These incentives are geared to the establishment of fully funded private pensions which are to compensate for the lowering of the statutory pension level. Yet these "Riester" pensions are not obligatory[9].

II. Avoiding poverty in old-age

1. The problematic nature of poverty lines

Every social insurance system, and especially pension insurance, aims to protect people from poverty[10]. How poverty is to be defined and assessed is, however, dealt with in different ways on both the international and national level.

As far as the individual is concerned, old-age pensions serve to secure the necessities of life in old age. The necessities of life differ according to living conditions. With respect to very simple living conditions, they are defined in terms of money, the level of which may be taken as the poverty threshold. Under German social assistance law, the poverty line is assessed this way[11].

On the international level, nominal income limits are of little significance, with economic and living conditions differing from country to country. That is why relative indicators are used, making the median a point of reference and fixing the poverty line as a percentage thereof (e.g. 40 or 50 percent). Occasionally, however, in countries with very high average incomes, a relatively high personal income may already fall below the poverty line.

2. Other minimum limits regarding old-age provision

Besides securing the necessities of life, other circumstances may also speak for benefits and services not falling short of certain limits, a fact which especially applies to contribution-based pension schemes.

9 On the so-called Riester-Rente, cf. *Öchsner* (eds.), Riester-Rente; *Richter*, IStR 2006, 429 et sqq.; *Zermin*, Handbuch Altersvorsorge, pp. 21 et sqq.; *Blomeyer*, NZA 2001, 913 et sqq.

10 On family poverty, cf. *Borchert*, in: *Boecken/Ruland/Steinmeyer* (eds.), Sozialrecht und Sozialpolitik, pp. 109 et sqq.

11 On prevention of poverty, see *Lenze*, Staatsbürgerversicherung und Verfassung, pp. 203 et sqq.

(1) In order to find acceptance, a pension scheme mainly financed via contributions paid by the insured, as is the case in Germany, must ensure that an equivalence ratio between benefits and contributions is maintained and that the total amount of contributions does not exceed the total amount of benefits[12]. Consequently, the minimum pension level is predefined, although it may be hard to fix in terms of amount.

(2) The difficult financial situation of old-age social protection can result in a lowering of the pension level, which has also been the case in Germany[13]. Consequently, the pension of a retiree who earned an average income during a long working life may be just above or on a par with the social assistance level, or even fall short of it. This seriously challenges the credibility and acceptance of contribution-based insurance systems, given that equivalent retirement earnings can also be reached without paying contributions[14]. Querying the purpose of paying contributions will entail a further erosion of contribution-based systems through attempts to avoid or minimize contribution payment. This again calls for the imposition of limits to counteract the decline of pension levels, without being able to fix exact amounts beforehand[15].

3. Structure and function of the present statutory pension system

As pointed out in the introduction (I.), standard old-age protection was established as a pension insurance system for employees, with contributions oriented to earned income and benefits depending on the amount and duration of contribution payment. Such systems are not designed for the award of guaranteed need-based basic pensions. Individual measures taken to modify the insurance principle in terms of "justice of needs" will not alter this general statement.

The pension is to assure the standard of living[16]. This is only possible, however, if at least an average income was earned and working life was not interrupted. On account of changing employment behavior, this objective is nevertheless often not achieved today.

In addition, the burden resulting from demographic developments is not only borne by those paying the (higher) contributions but also by those receiving the (lower) pensions under the newly amended pension formula[17]. A declining pension level poses the risk of pensions no longer sufficing to cover the necessities of life. In such cases, social assistance is called upon to provide a primary benefit in the form of a need-based pen-

12 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, paras. 29 et sqq.; *Färber*, in: *Fisch/Haerendel* (eds.), Geschichte und Gegenwart der Rentenversicherung, pp. 333 et sqq.

13 *Steinmeyer*, RdA 2005, 345 et sqq.

14 See *Schmähl*, BKK 2005, 312 et sqq.; *Schmähl*, in: BfA (eds.), Gesundheits- und Alterssicherung 2004, pp. 1 et sqq.

15 See *Heinze*, ZRP 2004, 275; *Roth*, ZRP 2004, 154 et sqq.

16 See *Köbl*, in: *Boecken/Ruland/Steinmeyer* (eds.), Sozialrecht und Sozialpolitik, pp. 321 et sqq., taking orphans' pensions as example.

17 *Steiner*, NZS 2004, 505 et sqq.

sion supplement in old age and in the event of reduced earning capacity (see II. 7. below).

4. Elements involving a modification of the insurance principle

As pointed out above, statutory pension insurance does not provide a basic old-age benefit. According to the insurance principle, irregular and low incomes increasingly lead to only low qualifying periods. To counteract this trend, the insurance principle has been subjected to a number of modifications which allow for vested rights to accrue even in periods of lacking or low income.

Prime examples of such periods are:

(1) periods with no or only low earnings during which social benefits are received, children are raised or unpaid home nursing care is provided; contributions are paid by a third party, i.e. by the social insurance institutions (e.g. the employment offices) or the federal government (for child-raising periods)[18];

(2) specific non-contributory periods due, for example, to vocational training and education or events of war; these are credited as contribution-free periods when calculating the pension and thus raise pension entitlements and subsequent pension payments[19];

(3) low-income periods of women; in the past, this led to the introduction of the so-called minimum income pension which upgraded actual earnings where they were too low to reach a certain pension level[20]; this regulation was valid until 1991, after which it was restricted in terms of time and subject matter, so that it is no longer relevant for a basic pension.

5. Claims for minimum protection in old age

Numerous suggestions have been made for a form of minimum protection within the scope of statutory pension insurance[21]. Other propositions call for the entire reorganization of old-age protection by way of a mandatory pension insurance for all citizens (*Staatsbürgerversicherung*) that could be complemented by personal forms of old-age provision[22]. The Swiss system is often cited in this context. It is characterized by rela-

18 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, paras. 38 et sqq.; *Meyer/Blüggel*, NZS 2005, 1 et sqq.; *Karuth*, Kindererziehungszeiten in der gesetzlichen Rentenversicherung; *Kirchhoff/Kilger*, NJW 2005, 101 et sqq; *Berghahn*, FPR 2005, 508 et sqq.

19 *Meyer/Blüggel*, NZS 2005, 1 et sqq. (2 et sqq.).

20 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, para. 43.

21 *Kreikebohm*, in: Lexikon des Rechts, Sozialrecht 11/535.

22 *Lenze*, Staatsbürgerversicherung und Verfassung.

tively high basic pensions financed via contributions paid by all citizens (without any contribution assessment limit), and includes a mandatory occupational scheme[23].

Whether the German constitution calls for minimum pensions to be paid out under the statutory pension scheme is disputed[24]. The securing of basic needs in old age is grounded in the welfare state principle and in the protection of human dignity under Art. 1 of the Basic Law [*Grundgesetz* – GG]. The constitution does not, however, declare the form in which such state protection is to be provided. Hence, it need not necessarily take the form of standard old-age pensions (statutory pension insurance) but can also be rendered by social assistance serving as a "risk absorber".

It is moreover debated whether pension adjustments (to price trends) and/or income developments are protected under the constitution. The Federal Social Court (*Bundessozialgericht*) dealt with the problem in its decision of 31 July 2002[25], referring in particular to the guarantee of property under Art. 14 GG and the personal freedom of making one's own provisions under Art. 2 GG, as well as to the principle of equity under the rule of law. The Court held that the guarantee of property entails the constitutional right of pensioners to the protection of their entitlements against inflation, without taking account of future sources of income[26]. Were the Federal Constitutional Court (*Bundesverfassungsgericht*) to endorse this view, pension cuts would no longer be possible, thus guaranteeing a certain minimum level. Art. 14 GG is also invoked when comparing total contribution payments with total pension payments. Here again, legal clarification is still missing.

6. Securing the pension level through personal forms of old-age provision

The supplementing of statutory pensions by company pension plans (2nd pillar) and private forms of retirement provision (3rd pillar) has been a longstanding goal of social policy – one that has partly been achieved. In Germany, the Act on retirement asset formation [*Altersvermögensgesetz*] of 26 June 2001[27] provides for state-aided, capitalized private pensions to compensate for the lowering of the pension level in the years to come[28]. With that in mind, the government has created specific incentives to promote the "Riester" pension, a non-obligatory private pension named after the former Federal Minister of Labor and Social Affairs. Accordingly, only insured persons who opt for this scheme will be able to offset the lowering of the pension level. Notwithstanding the

23 *Schmid*, in: *Cramer/Förster/Ruland*, Handbuch zur Altersversorgung, pp. 1153 et sqq.

24 *Heinze*, ZRP 2004, 275 f.; *Roth*, ZRP 2004, 154 et sqq.

25 Ref.: B 4 RA 120/00 R.

26 Regarding this decision, cf. *Lenze*, NZS 2003, 505 et sqq.; regarding future pensions, cf. BVerG, Urteil vom 28. 2. 1980 = BVerfGE 53, 257 (289 et sqq.); BSG, Vorlagebeschluss vom 16. 11. 2000 – B 4 RA 3/00 R.

27 BGBl. I, p. 1310; *Steinmeyer*, in: *Boecken/Ruland/Steinmeyer*, (eds.), Sozialrecht und Sozialpolitik, pp. 683 et sqq.

28 See *Ruland*, NZS 2002, 505 et sqq. (506).

wide-ranging state incentives, notably for persons raising children, people with low incomes who are particularly in need of pension supplements are often unable to draw on this kind of private provision[29].

7. The role of public assistance in the statutory pension system

Under the German old-age pension system, comprising a large number of different individual schemes, some persons or groups of persons are not covered at all. In such cases, social assistance serves as a safety net of last resort to these persons. According to the insurance principle, the standard (statutory) pension insurance for employees only provides a sufficient pension if a certain amount of contributions have been paid over a certain period of time. Interrupted or low contribution payments will thus affect the ultimate pension received. As a result, pensions are sometimes even lower than social assistance rates. If poverty in old age is to be prevented, these pensions must be supplemented by some form of public assistance[30].

In the past, the number of people on supplementary benefits was rather low. In 1999, for example, only about 184,000 pensioners out of 14 million received assistance towards living expenses[31]. Even when including an estimated number of unreported cases where needy persons failed to claim their entitlement (hidden or "shamefaced" poverty), it can be said that pension insurance in the past largely achieved its aim of avoiding poverty in old age. Owing to the problems now facing old-age protection, the situation will change and social assistance will assume increasing importance with respect to supplementary benefits[32].

Social assistance, originally known as "welfare" (*Fürsorge*), was regulated in the Federal Social Assistance Act [*Bundessozialhilfegesetz* – BSHG) and comprehensively conceived on behalf of the entire population. It used to be divided into assistance towards living expenses and assistance in special circumstances. Benefits were need-based and thus subject to a means test with a view to the applicant's assets, income and maintenance claims.

Before the pension reform of 2001[33], the general provisions of social assistance legislation, notably those concerning assistance towards living expenses, also applied to pensioners. Hence, pensioners could only claim benefits to supplement their pensions if their children were not under any obligation to pay maintenance on their behalf. To avoid these cases of "shamefaced" poverty and to improve the situation of those who

29 *Von Maydell*, in: Münsterische Sozialrechtsvereinigung e. V. (eds.): Reformen in der privaten und betrieblichen Altersvorsorge pp. 1 et sqq.; *Richter*, IStR 2006, 429 et sqq.; *Zermin*, Handbuch Altersvorsorge, pp. 21 et sqq.

30 *Lenze*, Staatsbürgerversicherung und Verfassung, pp. 203 et sqq.; 224 et sqq.; 461.

31 *Ruland*, in: *von Maydell/Ruland* (eds.), SRH, C 16, paras. 255 et sqq.

32 *Zermin*, Handbuch Altersvorsorge, pp. 311 et sqq.; *Blomeyer*, NZA 2001, 913 et sqq. (914 et sqq.).

33 On the reform of pension insurance, see *Ruland*, NZS 2002, 505 et sqq.; *Lenze*, NZS 2003, 505 et sqq.; *Ruland*, NJW 2001, 3505 et sqq.

lack sufficient protection in old age, an Act on need-based pension supplements in old age and in the event of reduced earning capacity [*Gesetz über eine bedarfsorientierte Grundsicherung im Alter und bei Erwerbsminderung*] was introduced on 26 June 2001[34]. This act underwent several modifications before it was incorporated into §§ 41 - 46 of Book Twelve of the Social Code [*Sozialgesetzbuch* – SGB XII], which comprises the legislation on social assistance[35]. The objective of this new law is to cover the minimum needed to maintain a socially acceptable standard of living in old age and in the event of disabilities via an independent social security scheme on behalf of persons with insufficient income and savings. The new benefits are similar to social assistance in many ways but also show new features. One novel element concerns the provision on assets and maintenance claims (§ 43 SGB XII). Unlike the former social assistance rule, there is no recourse to a claimant's children or parents for maintenance if their annual income does not exceed €100,000. Recourse to children or parents is therefore now to be the exception. The declaration that the income of persons liable to pay maintenance will presumably not exceed the €100,000 limit also contributes to this fact. Here, the principle of social assistance law has been substantially altered by being assigned lower priority. Consequently, the pension supplement in old age and in the event of reduced earning capacity could well turn into a general instrument of minimum old-age protection in the course of further reform, thus emancipating itself further from social assistance law[36].

The old-age pension reform of 2001 mainly focused on (1) pension adjustments, (2) state incentives for private forms of retirement provision, (3) the revision of old-age protection for women and (4) the implementation of basic protection[37].

In this connection, the survivors' pension was amended by introducing a child-raising aspect. Accordingly, surviving dependants who reared children are awarded a supplement of two earning points for the first child and one earning point for each additional child (§ 78a [1], sent. 1 SGB VI). The surviving spouse's other income in excess of an exempt amount is deducted from the widow's or widower's pension. The exempt amounts are linked to the current pension amounts and thus indexed, mainly to prevent a deterioration in the old-age protection of women who raised children. As a consequence of this reform, many widows and widowers who raised several children and whose spouse died after 2001 are better off than those subject to the previous law.

Another novel feature is that widows or widowers who were married for less than a year are not granted a survivors' pension. The refutable presumption is that if the mar-

34 BGBl. I, p. 1310; *Kötter*, FPR 2004, 689 et sqq.; *Mayer*, ZEV 2003, 173 et sqq.; *von Koppenfels-Spies*, FPR 2003, 341 et sqq.

35 See *Schellhorn*, in: *Schellhorn/Schellhorn/Hohm*, Kommentar zum SGB XII, Teil A: Einführung; *Schellhorn*, in: *Boecken/Ruland/Steinmeyer* (eds.), Sozialrecht und Sozialpolitik, pp. 595 et sqq.

36 *Schnitker/Grau*, NJW 2005, 10 et sqq.; *Flanze*, NZA-Beilage 2006, 21 et sqq.; *Klemm*, NZA 2006, 946 et sqq.

37 For details, see *Ruland*, Rentenversicherung nach der Reform – vor der Reform, NZS 2001, 393 et sqq. (396 et seq.).

riage lasts less than a year it was arranged with the intention of claiming a survivors' pension (§ 46 [2a] SBG VI).

III. The family and the pension system

1. Family status in the statutory pension system

The statutory social insurance system providing standard old-age security to employees, which is at the center of this paper, focuses on the individual rather than on the family or household. This also holds true for the other areas of old-age protection. Consequently, the obligation to insure as well as contributions and benefits are not in any way connected to whether the person concerned is married, must take care of a partner or children, or lives in a household with other persons.

Within the framework of statutory pension insurance, the criterion of marriage does not become significant until the marriage is dissolved, entailing pension rights adjustment (*Versorgungsausgleich*), or until one spouse dies and leaves behind dependants entitled to support, notably children and/or the other spouse entitled to survivors' pension (*Hinterbliebenenrente*). In this context, one must ask whether pension rights adjustments and survivors' pensions need to be based on effective marriage or whether cohabiting partnerships may be considered valid for raising claims[38]. The Civil Partnership Act [*Gesetz über die eingetragene Lebenspartnerschaft* – LPartG] of 2001, as amended on 1 January 2005, largely places these partnerships on an equal footing with marriage[39], provided they meet the legal requirement of registration. In particular, pension rights adjustment is applicable to this type of partnership (§ 20 LPartG). The term marriage or family has thus been extended considerably in this respect[40].

2. Maintenance adjustments following divorce and pension benefits

a) Maintenance regulations during marriage

While married, both partners have the obligation to provide maintenance, i.e. they are obliged to contribute to the shared livelihood[41]. The statutory insurance pension is also part of the income to be used for this purpose. If one spouse's statutory pension is

38 *Hohnerlein*, FPR 2001, 49 et sqq.

39 See *Kemper*, FPR 2003, 1 et sqq.

40 See *Kemper*, FPR 2003, 1 et sqq.; *Epple*, FPR 2005, 305 et sqq.; *Reinecke*, FPR 2001, 56 et sqq.; *Hohnerlein*, FPR 2001, 49 et sqq.

41 § 1353(1), sent. 2 BGB.

the only source of income, it must be used to defray the joint cost of living, while possibly requiring a supplement from the public assistance program.

The gainfully employed spouse is not legally obliged to provide in advance for the old-age security of the partner who is not gainfully employed but managing the household. The situation is different in the event of separation as from the moment divorce procedures are pending before court. In this case, § 1361 of the German Civil Code [*Bürgerliches Gesetzbuch* – BGB] requires precautions for old age through the provision of maintenance (also after the divorce, according to § 1578 [3] BGB). Proposals to create such an obligation to provide for old age during an existing marriage have not yet been taken up by the legislature.

b) Maintenance after divorce

After a divorce, the obligation to provide maintenance to the former spouse may continue and is based, respectively, on need and earning ability (§ 1569 BGB), but not on the degree of guilt for failure of the marriage. An obligation to provide maintenance becomes particularly relevant in cases of childcare requirements, old age, sickness, infirmity or unemployment (§§ 1570-1573 BGB).

Thus all income, including social insurance pensions, must be considered for the assessment of need and earning ability. Where a former spouse has no income[42], while the other receives an old-age pension, this may lead to an obligation to pay maintenance if one of the above preconditions exists. If the person obliged to provide maintenance dies, no further maintenance payments are made. An earlier law required that in such cases a so-called alimony / widow's pension be paid by the social insurance fund – though under very stringent conditions – in order to replace these maintenance claims. The introduction of pensions rights adjustment entailed the termination of this alimony / widow's pension.

c) Apportionment of assets and liabilities in the event of divorce

If a marriage is dissolved, an apportionment of assets and liabilities usually takes place and depends on the respective matrimonial property regime. Where no agreement has been made stipulating, for example, a separation of property, the statutory matrimonial property regime in the form of equalization of accrued gains will prevail, whereby the assets acquired by each of the two spouses during their marriage are summed up and half of the difference is assigned to the partner who acquired less assets during the marriage (§§ 1363, 1378 BGB). Old-age pensions and vested rights to such pensions are not subject to the equalization of accrued gains, but to pension rights adjustment (see also III.3. below).

42 See *Berghahn/Wersig*, FPR 2005, 508 et sqq. (509 et sqq.).

3. Pension rights adjustment – pension splitting

a) The function of pension rights adjustment

Pension rights adjustment (*Versorgungsausgleich*) on divorce provides for the equal division of vested benefit rights acquired by the two spouses, corresponding to the equalization of accrued gains from the asset growth. At the same time, the economic situation of the spouse entitled to pension adjustment – most often the wife – is to be improved in old age or in case of disability. This is deemed necessary if the economically dependent spouse received maintenance during the marriage and would thus have been entitled to survivors' pension upon death of the other spouse. In the event of divorce, a claim to maintenance exists only in special cases of need and is discontinued if the former spouse obliged to provide maintenance dies. Upon retirement or in the event of disability, the surviving former spouse is left to rely on her own old-age security claims, these being low if she did not pursue a regular gainful employment, say, because of parenting responsibilities[43]. These pensions can therefore be increased through pension splitting on divorce. Hence, pension rights adjustment does not only have an equalization function, but also one of rendering support[44].

b) Basic structures of pension rights adjustment

Pension rights adjustment was not gradually developed according to court rulings, as in Japan, but was instituted by the legislator as a new legal arrangement under the First Marital Law Reform Act of 1976, which entered into force on 1 July 1977. Pension rights adjustment is intended to achieve the equal participation of both spouses in benefit entitlements acquired in the course of their marriage for the purpose of securing maintenance in old age and times of reduced earning capacity[45]. It is determined in the divorce proceedings before the family courts, which assess the vested benefit rights acquired during the last period of marriage, make them comparable and sum them up. The adjustment of vested rights under statutory pension insurance is also referred to as splitting, meaning that units of value equivalent to the vested adjustment rights are deducted from the statutory pension account of the person obliged to provide adjustment and credited to the account of the person entitled to receipt[46].

Different forms of adjustment are required by law for other types of vested rights.

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43 *Karuth*, Kindererziehungszeiten in der gesetzlichen Rentenversicherung; *Berghahn/Wersig*, FPR 2005, 508 et sqq.; *Kirchhoff/Kilger*, NJW 2005, 101 et sqq.

44 Regarding the basic structure, see *von Maydell*, FamRZ 1977, 172 et sqq.; for a contemporary view, cf. *Bergner*, NJW 2006, 2157 et sqq.; *Brudermüller*, NJW 2006, 3184 et sqq.

45 Detailed in *Creifelds*, Rechtswörterbuch, pp. 1515 et sqq.; BVerfG, NJW 2006, 2175 et sqq.; BVerfG, NJW 2006, 2177 et sqq.; for further details, cf. *Ruland*, in: *Boecken/Ruland/Steinmeyer* (eds.), Sozialrecht und Sozialpolitik, pp. 575 et sqq.

46 See BGH, FPR 2003, 439 et sqq.; BGH, FPR 2003, 238 et sqq.

In particular cases where rights to adjustment have not yet become non-forfeitable, an immediate adjustment at the time of divorce is not possible. Therefore, aside from the aforementioned value-based adjustment, pension rights adjustment governed by the law of obligations has been provided for. The latter is not applied until the benefit rights have become due and payable claims. The entitled person then has the right to an adjustment claim under the law of obligations amounting to the adjustment value. Should the benefit right cease due to the death of the obligor, the claim to adjustment under the law of obligations is likewise legally terminated. This shows that the adjustment under the law of obligations is weaker than the adjustment of benefits under public law in the form of splitting.

c) Problems with the implementation of the legislative concept

In principle, the legislative concept is reasonably self-critical and consistent. Vested rights to benefits are divided between the spouses like property rights. In practice, however, the implementation of this concept is fraught with considerable difficulties which have led to numerous corrections by the legislator, frequently on the basis of objections from the Federal Constitutional Court[47].

A chief reason for the complexity of pension rights adjustment is that it includes all vested rights under the old-age security system, notably on account of the constitutional principle of equal treatment under Article 3 GG. In view of the diversity of the various parts of the old-age security system as regards standard and supplementary protection, this stipulation creates innumerable problems for both the evaluation and division of vested rights, not to mention the inclusion of foreign vested rights[48].

Other difficulties arise from the fact that pension rights adjustment is associated with a particular point in time – the end of the marriage[49]. Even if the adjustment decision ensues at a later date, it cannot be ruled out that vested rights and entitlements develop differently than was projected at the time of decision-making. This again leads to the necessity of correcting such decisions, which is an extremely difficult process[50].

Differentiating between static and dynamic (index-linked) vested rights has proven to be particularly problematic because indexation is linked to greatly differing issues (developments in wages and salaries, prices, etc.). Moreover, it is uncertain whether an accepted index-linked increase will actually occur, as was shown in the last few years for statutory pensions where the expected wage and salary rises governing indexation did not take place[51].

47 See *Bergner*, NJW 2006, 2157 et sqq.; *Bergner*, NJW 2005, 2751 et sqq.; *Brudermüller*, NJW 2006, 3184 et sqq.; BVerfG, NJW 2006, 2175 et sqq.; BVerfG, NJW 2006, 2177 et sqq.

48 *Schmeiduch*, NZS 2006, 240 et sqq.; concerning changes: BGH, NJW-RR 2006, 2 et sqq.

49 *Brudermüller*, NJW 2006, 3184 et sqq. (3185).

50 BGH, FPR 2003, 439 et sqq.; BGH, FPR 2003, 238 et sqq.

51 *Bergner*, NJW 2005, 2751 et sqq. (2753).

Due to complications in calculating and executing pension splitting, a growing number of cases are being left to pension rights adjustment under the law of obligations. The latter, however, is in many respects less favorable than the value adjustment under public law in the form of splitting. Under the law of obligations, the person entitled to the adjustment must ensure collection, thus being forced to deal with the obligor for years and perhaps even decades. Furthermore, this form of adjustment expires upon death of the obligor.

Adjustment under the law of obligations is a legal arrangement under family law, with social law-related elements. Therefore, family law and social law should be aligned with each other seamlessly to that end. Yet this is not always the case. For example, the adjustment may as an exception be rendered by means of a capital sum, most often leaving the recipient with no economically meaningful way of using this amount in terms of social security law. Hence, this person's only alternative is to resort to private life insurance.

d) Continuous reform process

The difficulties outlined above, albeit only briefly, have the effect of subjecting the statutory provisions governing pension rights adjustment to a continuous reform process. This again further enhances complexity and is the very reason for the failure to achieve the just equalization of rights sought by such continuous refinement.

It could therefore make sense to seriously consider the further development of those features which would permit simplified adjustment. Accordingly, very small amounts of vested rights might then be ignored. In addition, more scope for personal arrangements could lead to decisions providing a just solution in individual cases. However, discussion about a basic reform has not yet reached its conclusion in Germany[52].

4. Valuation of unpaid family work in the statutory pension system

a) Point of departure

As the statutory pension system is based on worker and employee contributions and therefore does not provide a basic pension, it is inevitable that any unpaid family activity will have negative effects on the amount of old-age pension received. These adverse effects predominantly impact women who, even today, still perform most of the family work in terms of child raising and household management. For this reason, a separate old-age security system for women has been on the social policy agenda for decades[53].

52 *Ruland*, NZS 2001, 393 et sqq.; *Lenze*, Staatsbürgerversicherung und Verfassung; *Ruland/Dünn*, NZS 2005, 113 et sqq.; for further figures, cf. *Flanze*, NZA-Beilage 2006, 21 et sqq.

53 *Ruland*, FamRZ 2001, 129 et sqq.; *Mascher*, SozSich 2001, 89 et sqq.; *Ruland*, NJW 2001, 3505 et sqq. (3508); *von Maydell*, Die Neuordnung der sozialen Alterssicherung der Frau.

Nevertheless, in spite of an immense array of reform proposals, the crucial issues remain unsolved, although they have been mitigated by a series of measures. One approach towards remedying these adverse effects is to consider family work in terms of social insurance law (see III.4.b) below) and to link special prerequisites governing statutory pensions to family issues (see also III.4.c) below).

b) Crediting of family care periods under statutory pension insurance

In this context, the periods spent raising children are of particular significance. A maximum of one year is credited for births that occurred before 1992, while three years are allowed for births after 1992 (§§ 56, 249 I SGB VI)[54]. This compulsory insurance period is triggered by the fact that parenting occurred. It begins following the month of birth and ends after 12 or 36 calendar months, respectively. If several children were raised at the same time, the insurance period for the second and each additional child is extended by the number of calendar months during which these children were simultaneously cared for. The parenting period is recognized only for children brought up in Germany and for mothers or fathers normally resident here. The citizenship of the child or the parents is of no significance. In principle, this insurance period is credited to the mother unless the parents jointly decide to have the periods assigned to the father. Multiple insurance periods result if parenting periods coincide with other contributory periods[55].

The contributions for parenting periods are funded by the federal budget (§ 177 SGB VI)[56]. These amounts are currently calculated as if the beneficiary had received an average income during the three years in question, i.e. one point of the personal income index is credited per year. Thus, starting from 1 July 2003, one year of parenting increases the statutory pension amount by €26.13 per month[57]. The beneficiary's own contributions during the parenting period are additionally credited up to the contribution ceiling, i.e. they do not decrease the value of the parenting period. Hence, the legislator has opted for the additive solution. The parenting periods are in every respect considered equal to mandatory contributions. They are moreover taken into account for the qualifying period so that a woman who was not gainfully employed and has raised two children since 1992 will receive an age-related statutory pension for this reason alone.

Aside from parenting, an additional activity leading to statutory social insurance credits is care-giving, even if it is rendered outside the family. Caregivers are insured by virtue of the law (§ 44 SGB XI). This coverage is contingent upon care given to a person entitled to benefits from statutory or private long-term care insurance. The care may not be rendered on a commercial basis and must comprise at least 14 hours per week

54 *Hirsch*, in: LPK-SGB VI, § 56, paras. 3 et sqq.; *Hirsch*, in: LPK-SGB VI, § 249, paras. 3 et sqq.

55 See *Rolfs*, NZS 1998, 551 et sqq.; *Karuth*, Kindererziehungszeiten in der gesetzlichen Rentenversicherung.

56 *Reinhardt*, in: LPK-SGB VI, § 177, para. 2.

57 This factor is adjusted along with the pension; see *Ruland*, GK-SGB VI Einleitung, para. 172.

within the home area of the person in need of care. Care-giving is not, however, considered a commercial activity merely because the care recipient hands over a part or all of his/her care allowance to the caregiver. Insofar as caregivers past retirement age are exempt from insurance because they receive a full old-age pension or a civil service retirement pension, this is likewise applicable to care-giving periods. It follows that a pension recipient who takes care of her elderly husband cannot acquire additional vested rights to statutory pension payments.

The accumulation of care-giving and contributory periods is limited only by the fact that caregivers cease to be insured as such once they are regularly and gainfully employed for more than 30 hours per week. In cases where a caregiver looks after several persons, this may result in multiple insurance up to the contribution ceiling. If several caregivers jointly attend to one person, they are insured proportionally (§ 166 [2], sent. 2 SGB VI)[58].

c) Statutory pension insurance benefits in relation to family circumstances

The family circumstances of an insured person can also be of relevance to statutory pension insurance since specific family-related conditions may have a bearing on certain benefit cases. The most important example here is survivors' pension, although its significance is decreasing due mainly to the inclusion of other income sources in its calculation. Parenting periods nevertheless remain significant for the amount of survivors' pension[59].

A further family-related insurance case is the so-called child-raising pension introduced under the First Marital Law Reform Act. Spouses divorced after 30 June 1977 who did not remarry receive a child-raising pension after the death of their former husband or wife for the period during which they raised their own child or a child of the divorced spouse, provided the general qualifying period of 60 months was completed before the death of the divorced spouse (§ 47 SGB VI)[60].

5. Result: transitional situation

The current legal situation as regards the significance of the family in social insurance matters is to some degree transitional in nature. On the one hand, there is the tendency to create and develop separate old-age security schemes for spouses, for example based on pension rights adjustment, parenting periods, etc. On the other hand, key insurance benefits are still linked to the status of the spouse, above all survivors' pen-

58 *Reinhardt*, in: LPK-SGB VI, § 166, paras. 4 et sqq.

59 *Karuth*, Kindererziehungszeiten in der gesetzlichen Rentenversicherung; *Berghahn/Wersig*, FPR 2005, 508 et sqq.; *Kirchhoff/Kilger*, NJW 2005, 101 et sqq.

60 *Quinten*, in: LPK-SGB VI, § 47, paras. 2, 4 et sqq.

sions. Undoubtedly, these programs will continue to exist side by side in the near future[61].

61 See also *Lenze/Zuleeg*, NZS 2006, 456 et sqq.; *Steiner*, NZS 2004, 505 et sqq. (506); *Schmähl*, in: *Fisch/Haerendel* (eds.), Geschichte und Gegenwart der Rentenversicherung, pp. 351 et sqq.; *Döring*, in: *Fisch/Haerendel* (eds.), Geschichte und Gegenwart der Rentenversicherung, pp. 169 et sqq.; *Ruland*, in: *Cramer/Förster/Ruland* (eds.), Handbuch zur Altersversorgung, pp. 935 et sqq.

Sustainable pension systems in times of structural changes in demography, economy and society – Objectives, arguments and effects of the new German pension policy

Winfried SCHMÄHL

I. Introduction

Current pension policy in Germany as it has been realised since 2001 by the red-green coalition government – which was in power from autumn 1998 to autumn 2005 – can be characterised as a paradigm shift. One of the objectives is to realise sustainable pensions and intergenerational equity. Sustainability is focused on "fiscal sustainability". Whether this will also be politically sustainable over time may be questioned because the new pension policy paradigm will affect old-age security arrangements in Germany remarkably – the role of different institutions as well as income in old age.

Germany's pension system is facing many challenges. There are not only structural changes in demography, household composition, in the economy and, in particular, in the employment system, but also problems resulting from political decisions. For example, since a long time public pension schemes have been an instrument for labour market policy (early retirement options) resulting in higher expenditure and contribution rate. Also a new possibility for employees to opt out with part of their earnings from social insurance contribution payment to finance claims in an occupational pension scheme ("earnings conversion") reduces contribution revenue in the social pension insurance

scheme and requires, ceteris paribus, a higher contribution rate. German unification also necessitated a higher contribution rate. Regarding the international environment, in particular decisions from the European level are influential, such as decisions by the European Court of Justice, but especially political decisions like the introduction of the Maastricht stability criteria, which put public budgets under pressure. The new "open method of coordination" on EU-level may become highly influential for decisions on national pension policy, the level of expenditure as well as the design of the schemes, in particular the role of private versus public, pay-as-you-go (PAYGO) financed versus capital-funded schemes.

This paper is structured as follows: it starts with a brief outline of the pension schemes in Germany as they were designed in 1989 (based on the fundamental pension reform of 1957 introducing a dynamic earnings-related pension). The focus will be mainly on the earnings-related (not flat-rate) social pension insurance. It is quantitatively by far the most important part of pension provision in Germany, covering the majority of employees and even part of self-employed persons (2.). In particular this scheme will undergo a fundamental transformation, if the present strategy in pension policy will not be changed in the near future. The reasons for the pension reform debate in recent years will be illustrated by a few examples (3.). The new political pension strategy of the (red-green coalition) government, the dominating objectives and major instruments to implement it in 2001 and 2004 are outlined. In order to fully understand the "paradigm shift", it is compared to the approach existing before (4.). In addition to the measures already implemented, it will be outlined what the new government of the "Great Coalition" of the Christian and Social Democratic Party (which came into power in autumn 2005) is planning. In general, the new strategy in pension policy – which started after the turn of the century by the former coalition government – will remain effective.

This paper does not attempt to explain the political process resulting in the decisions. The main focus is on possible (long-term) effects of a new strategy in pension policy. Major effects are discussed, focusing on changes of the "pension landscape" in Germany, the objectives to be realised by different elements of the pension schemes in Germany as well as effects on the type of the social insurance scheme and effects of the new pension policy on income distribution (5.)

II. An outline of the structure of pension schemes in Germany

In Germany, three tiers (often labelled as "pillars") of old-age security have existed since a long time:

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

Regarding the *first tier, social (statutory) pension insurance* is by far the dominating element. It covers in principle all blue- and white-collar workers (including miners) but also some groups of self-employed.[1] It is PAYGO-financed. The dominating source of revenue is from contributions paid in equal parts by employees and employers. Some revenue is also from the federal public budget, in particular covering those expenditures that are aiming at an interpersonal redistribution within the scheme. In 1999 nearly 93 percent of those persons covered by mandatory first tier schemes were members of social pension insurance. In 2003 about 79 percent of total pension expenditure was from this scheme (see Overview 1). This was 11.2 percent of GDP (see Overview 2). Social insurance pensions are (at least on average) by far the most important source of (monetary) income in old age in Germany (see Overview 3). It is not surprising that this scheme is in the centre of the political debate in times of adapting pension schemes to changing conditions.

Overview 1

Expenditure of Different Pension Schemes:
– Germany 2003 –

Pension scheme	in % of total pension expenditure
social pension insurance	79
civil servants pensions	10
old-age pensions: farmers	1
old-age pensions: professions	1
occupational pensions	
private sector	6
public sector	3
total	100

Source: Bundesregierung (2006a), p. 89.

1 The rules for miners as well as for self-employed differ from the general rules relevant for employees. Civil servants have a separate scheme, financed from public budgets.

Overview 2

Structure of Official Social Budget
– Germany 2003 in % –

	in % of social budget	in % of gross national product
social pension insurance	32.5	11.2
old-age security farmers	0.5	0.2
old-age security professions	0.3	0.1
occupational pensions		
private sector	2.2	0.8
public sector	1.2	0.4
pensions in total	41.6	14.4
health insurance	19.6	6.7
long-term care insurance	24.	0.8
accident insurance	1.5	0.5
promotion of labour	10.0	3.4
others	24.9	6.8
total	100.0	32.6

Data are preliminary

Source: Bundesministerium für Gesundheit und Soziale Sicherung (2005a), table I-4.

Overview 3

Sources of (Gross) Income of Persons 65 years or older
– 2003 in € –

Type of Income	all persons	couples		single men		single women	
		West	East	West	East	West	East
social pension insurance	66	57	89	60	87	68	95
other pension schemes	21	26	2	26	5	22	2
others (e.g. labour and capital income,transfer payments)	13	17	9	14	8	10	3
total	100	100	100	100	100	100	100

Source: ASiD03, Bundesregierung (2006b), p. 25.

Many of the basic elements to be found in the German *social pension insurance* date back to the end of the 19th century like

- not covering the total population in this scheme (although by far the majority of all employees),[2]
- the organisational structure (several regional schemes for blue collar workers and one scheme for white collar workers),[3]
- linking pensions[4] to number of years of insurance[5] and individual earnings (this link became much stronger after a major reform in 1957),
- financing above all from social insurance contributions based on gross earnings (wages and salaries) and paid in equal parts by employers and employees, but also from taxes (from the state budget),
- financing on a pay-as-you-go (PAYGO) basis in principle, although up to 1957 officially capital funding was the guideline.[6]

The dominating objective of social pension insurance (up to the year 1957) was to avoid poverty in old age, but was for a long time not sufficient to save in general employees from poverty. In 1957 a real paradigm shift took place by implementing an earnings-related pension aiming at a replacement of former earnings (to a certain extend) and thereby realising income and consumption smoothing over the life cycle – in particular when retiring (as well as in case of disability and also in case of the death of the (male) spouse), see below.

Supplementary occupational pension schemes, the *second tier* of the German pension system, are in general voluntary in the *private sector.* A great variety exists in the design of these schemes. About 50 percent of all employees are covered; coverage is very unequal according to the branch and size of the firm. Pensions are mainly defined benefit and employer-financed. Occupational schemes in the private sector are based on capital funding (Schmähl 1997, Deutsche Bundesbank 2001).

During the nineties, a decline in occupational pension arrangements took place by giving less favourable conditions for new employees or by closing schemes for newly hired employees. It can be assumed that – among other reasons – (employer-financed) occupational pensions became less important as an instrument of attracting qualified employees because of high unemployment. Collective agreements were an exception in the private sector,[7] quite in contrast, for example, to the Netherlands. After the "2001 reform" (see below) this has been in a process of change.

2 Coverage was extended over time, even covering some groups of self-employed.

3 This divide ended in autumn of 2005, after having discussed this several times since more than 50 years.

4 No lump sum payments in contrast to many private life insurance contracts.

5 Beside years of employment and paying contributions also some other periods are counted as insurance years.

6 Already in the late 19th century this became necessary to finance pensions for those already old (or disabled) and not waiting about 40 years until capital accumulation has taken place. Economic crisis and inflation as well as – later German unification in 1990 – made pay-as-you-go financing necessary.

7 This has existed in the building industry and for employed journalists.

After the introduction of the social pension insurance (in 1889), voluntary occupational schemes (which existed in some big companies even before the start of the social pension insurance) became a *supplement* to social insurance pensions, mainly in bigger companies. That means that a number of employees receive also an occupational pension beside a social insurance pension.[8] While there exist some tax privileges[9] for occupational pensions, additional private saving for old age was not *specifically* subsidised by taxes or transfer payments up to the year 2001.

Occupational pension schemes for wage and salary earners in the *public sector* are based on collective agreements. These pensions were fully integrated with the social insurance pensions – that means that a reduction in social insurance pension will be compensated by higher supplementary pensions. Wage and salary earners in the public sector shall receive benefits from both types of pensions which are targeted at the level of civil servants' pensions, a final salary scheme. After the "2001 reform", trade unions and public employers agreed upon a new collective contract that will abolish this integrated approach. It will disentangle the supplementary pension from the development of the first tier schemes – i.e. from the development of civil servants' pensions (and its replacement rate) as well as social pension insurance. It will also be changed from defined benefit to defined contribution.

As *third tier* there exists a great variety of *voluntary* capital-funded additional types of saving for old age, some with risk pooling (life insurance), others without such insurance elements, some types are tax-privileged. Empirically, it is very difficult to identify which part of the private saving is for old age.

A fundamental change in pension policy took place in 1957 regarding the aim of the social pension insurance as well as the distributional objective. This reform was the basis for the development for several decades. Social insurance pension no longer should be only an additional element for financing one's living, a scheme being mainly focused on the objective to avoid poverty in old age. Now it should *replace* to some extent *former earnings* (according to the number of years of insurance as well as wages earned on average during the whole earnings span) and *linking pensions to the development of average (at the beginning: gross) earnings of all employees* – not only at time of retirement but also during all the following years ("dynamic pension"). The (social insurance) pension claims – based on the relative amount of individual earnings[10] – were accumulated in individual pension accounts. The link between (individual) contributions and pension benefits became much stronger, for example by abolishing a flat-rate element in the pension formula that existed since 1889. The Federal Constitutional Court decided later that pension claims based on (own) contributions are assets that are protected by the constitution. This general opinion of the Constitutional Court, however, gives no firm restrictions for political changes. However, often measures to reduce pen-

8 In tendency: the higher social insurance pension, the higher is the occupational pension.

9 Those differ according to the type of occupational pensions; but exact information on the amount of tax loss is still lacking.

10 That means: individual gross earnings (up to a ceiling) were compared to average gross earnings of all insured employees during all the years of insurance.

sion claims were focused on those elements that are not or only to a relatively small degree based on former contribution payments, but are mostly transfer payments (or elements within the pension claim based on interpersonal redistribution).

Since 1957, the pension scheme has been adapted several times to changing conditions in economy and demography and because of differences in direct tax and contribution burden of employees and pensioners.

The borderline between the second and the third tier became more and more blurred over time because of using models of deferred compensation, financed only by employees.[11] Several collective agreements were tailored to maximise net labour income by avoiding tax and social insurance contributions on that part of labour income which is deferred for old-age security. The "2001 reform" introduced a *right* to the employee to use earnings up to a certain amount without paying income tax and social insurance contributions (the latter is at present limited up to the year 2008).[12] New subsidies for voluntary old-age provision were also introduced.

If we are looking at the financing method (PAYGO versus funding) in Germany, according to the official "Social Budget" of the federal government about 90 percent of all pension expenditure were PAYGO-financed in 2003 (79 percent social pensions, 10 percent civil servants pensions, financed from general public budgets, 1 percent pensions for farmers). Less than 10 percent of all pension expenditure came from occupational pensions (see once more Overview 1).

Taking into consideration private pensions, which up to now are not integrated in the official "Social Budget", as a rough estimate 10 percent of total (public and private) pension expenditure are from the third tier and capital funded (it is, however, difficult, to give exact numbers for private saving for old-age purposes). Pension schemes for professions are also capital funded. So about 80 percent of total pension expenditure are based on PAYGO financing and 20 percent on capital funding. It is now an explicit political goal of the "2001 reform" to change the ratio of PAYGO versus funding – which can be estimated at about 80:20 today – towards more private pensions and capital funding. Some economists propose a ratio of 60 percent PAYGO-financed pension expenditure and 40 percent based on capital funding, in particular by reducing the expenditure level of PAYGO-financed schemes.

Germany had no general minimum pension. If household income was lower than a certain amount, means-tested social assistance could be claimed. Even if also those persons are included who may be eligible for social assistance but do not claim it, then even pessimistic estimates state that no more than about 4 percent of pensioners have an income below the social assistance level.[13] Looking at the "poverty rate" as measured

11 The support of the individual employer or even on a branch of industry, for example, is by negotiating group insurance contracts with a life insurer resulting in better conditions compared to individual contracts.

12 This is up to now limited until the year 2008. But several (influential) actors are supporting the demand to retain this possibility.

13 It can be expected that a high percentage of those people not claiming social assistance in old age would only receive a relatively small additional benefit; Becker and Hauser (2005).

by the number of persons claiming means-tested social assistance for financing one's living, this rate is under average for "aged" persons (age 65 or higher): In 2002, for example, the ratio of persons claiming social assistance for the total population in Germany was 3.3 percent, for the "aged" 1.3 percent, a ratio that has been relatively stable during the last years. In 1969 – as an example for West Germany – this ratio for the total (West German) population was only 1.2 percent, but for the "aged" above average (1.5 percent for men, 3.1 percent for women).

The 2001 pension reform introduced two new elements into the German pension system. The first one is a *means-tested transfer payment in case of insufficient income for persons age 65 and older as well as for disabled persons*. The benefit amount, however, is calculated in the same way as means-tested social assistance. But there is one major difference: in case parents claim social assistance, children are obliged to pay back the whole sum or part of it (depending on their own financial resources). This often was mentioned as a main reason for not claiming social assistance. This obligation of children was abolished in case of the new means-tested benefit, if the own income of children does not exceed € 100.000 per year. By introducing this means-tested transfer payment e.g. for aged persons Germany now has an additional tier within the pension system which can be labelled as a floor.[14]

The second new element is a *subsidy for contributions into a private pension scheme* that fulfils certain criteria. This approach – subsidising private pensions – was labelled as the "heart" of the 2001 pension reform by government.[15] There exist, however, other tax privileges for some types of private saving and occupational pensions. Therefore, one can distinguish between two different elements of the former third tier (voluntary saving for old age), one with targeted subsidies for private pensions and one without. There is now a tendency to reduce incentives for saving for other purposes and to concentrate incentives on saving for old-age pensions.

For a long time, mainly social pension insurance was in the centre of the German public debates about social security, in particular its expenditure level and the financing burden linked to it. Recently – after measures to reduce the generosity of the social pension scheme – a debate about the financing of (social) sickness insurance got a prominent role in the public debate. Also long-term care insurance is on the political agenda, however, its quantitative dimensions are much smaller. Pension and sickness (including long-term care) insurance are – regarding its quantity – the two dominating parts in the German social security scheme. This becomes obvious when looking at the Social

14 There was a long debate on how to introduce such an element. Originally government wanted to integrate such a tax finance transfer payment into the social pension insurance. There was a lot of resistance against this approach because of the fear of a mix of contribution- and tax-financed elements within the social pension insurance. On the other hand, government did not want to change for example rules within social assistance for older persons, which would have been an easy way. Therefore, in fact such a change took place, but the official political rhetoric was that this is quite different compared to means-tested social assistance. The two institutions got different names. But meanwhile this was silently merged with social assistance.

15 Such pensions are meanwhile called "Riester pension", after Walter Riester, who was at that time minister of labour and social affairs.

Budget (which does at present not cover private pensions as well as private sickness insurance): more than 63 percent of expenditure of the Social Budget are belonging to these branches (see once more Overview 2), that means nearly 22 percent compared to GDP.

III. Major arguments for pension reform in the German debate

In the eighties of the last century as well as in the nineties following German unification, debates on further reform measures in particular regarding the PAYGO-financed social pension insurance – and to a minor extent also civil servants' pensions – were based on demographic and economic projections showing an increasing future economic burden of social security: increasing expenditure, rising taxes and contribution rates as well as an increase in non-wage labour costs. Labour costs became a highly important topic in the public debate, mainly focused on assumed negative effects regarding competitiveness. This had two dimensions, a national one – competitiveness of the official sector compared to shadow work activities – and one focused on international competitiveness of the German industry. Despite the fact whether and how far the assumed effects are empirically well-founded or not, the arguments were and are highly important in the political debate.

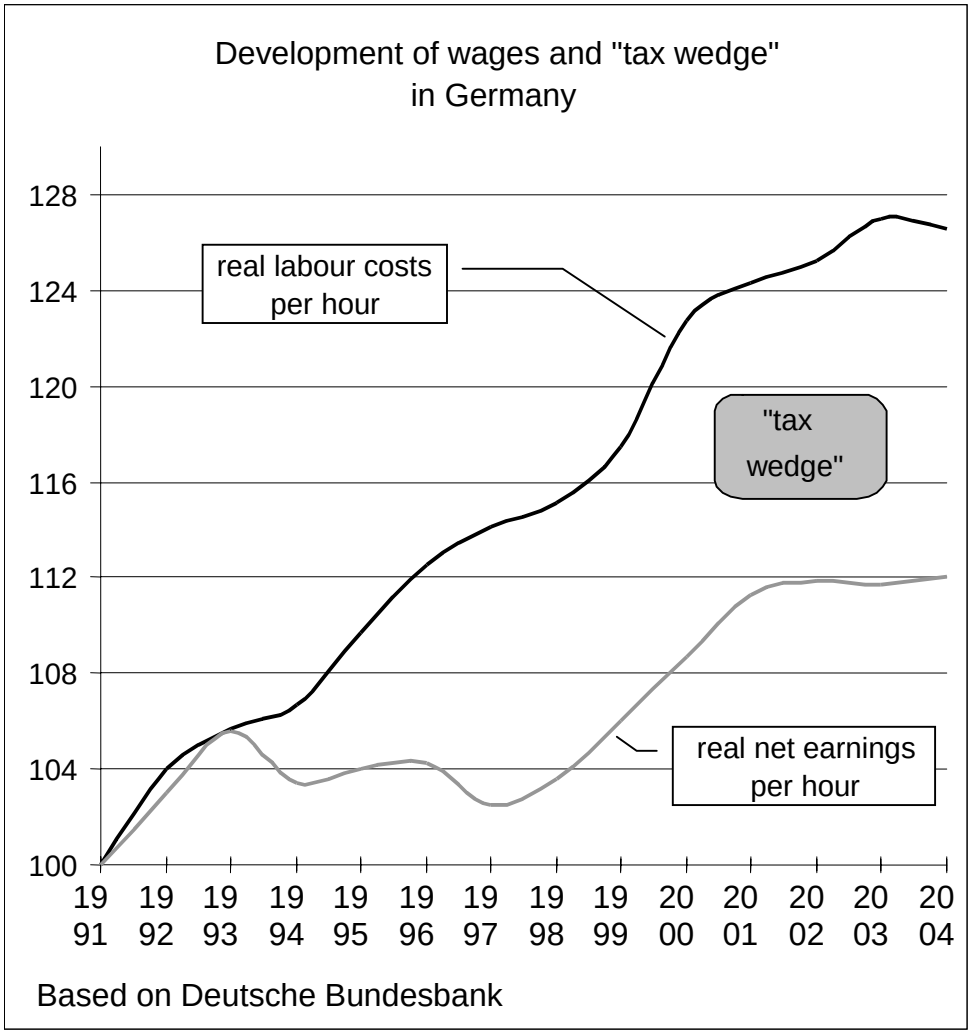
Regarding labour costs, in particular employer's contribution to social insurance as part of non-wage labour costs are in the centre of the debate. Often it sounds as if these contribution payments are the only reasons for high and increasing non-wage labour costs. However, they are only part of labour cost –of course not negligible, but their weight is mostly overemphasized in the debate. Employers' contributions in 2004 (in the production sector of the German economy) amounted to about 16 percent of total labour costs in West Germany and 17 percent in East Germany.[16] For competitiveness, however, not only wage costs, but all costs compared to productivity are relevant (beside other factors). Although the government has declared since many years that a reduction in non-wage labour costs is high on the (political) agenda, political decisions often resulted in an increase of contribution rates to reduce the tax-financed federal public budget.[17]

Often the rising difference between total labour costs – which are an important factor for decisions of employers – and net wages of employees are compared, the difference is labelled "tax wedge". Overview 4 gives some impression (in real terms) of what has taken place during recent years in Germany since 1991, comparing real labour costs per hour and real net wages per hour.

16 In absolute terms wages in East Germany were 66 percent of those in West Germany. A detailed discussion is in Schmähl (2006a).

17 See for example decisions for the "Haushaltsbegleitgesetz 2006" (for details see Schmähl, 2006a, p. 9-10).

Overview 4



However, such a comparison overlooks that contribution payments may be linked to claims (even relatively close), especially for social insurance pensions, where the level of individual monetary claims is linked to the level of individual contribution payments (respectively wages the contributions are levied upon).[18] Insofar it is decisive in particular for future development, whether contribution payments are in fact more like a price for insurance claims or whether they get more and more the character of a tax. This can influence behaviour of workers as well as trade unions and the wage setting behaviour. (This will be discussed later as well as the question which part of pension expenditure should be financed by taxes instead of wage-related contribution payments.)

18 In contrast to health insurance in Germany where expenditure are mostly transfers in kind, which are not income-related.

Already in the past, several changes within the system of social pension insurance took place to adapt the scheme to changing conditions. For example in 1989, it was projected that contribution rates for West Germany will rise to more than 36 percent until 2030. That means a doubling of the contribution rate compared to the rate that existed at that time. The reform measures decided in 1989 were expected to reduce the "necessary" contribution rate in West Germany to 27 percent instead of 36 percent (in 2030). In 2000 the projections (being the basis for political decisions of the 2001 pension reform) showed an increase of the contribution rate from 19.3 percent (2000) up to "only" 23.6 percent in 2030 – for meanwhile unified West and East Germany.[19]

Regarding the demographic outlook, projections of the federal government are based on demographic scenarios of the Federal Statistical Office.[20] Central assumptions are:

- an increase in life expectancy (on average, i.e. at birth) from 2002 to 2030 of about 2.5 years
- fertility will remain low as it is today of on average 1.4 children per women
- net migration of 200.000 per year.

Regarding economic assumptions, among others things

- real growth of the economy of 1.7 percent per year on average up to 2030, however, decreasing in the long run because of a shrinking potential of labour (after 2020 real growth rate 1.4 percent per year).[21]

Beside demographic effects influencing the potential number of workers there is, however, assumed a remarkable increase of the labour force participation of women and older workers up to 2030 to a level which already exists today in Scandinavian countries or in the Netherlands.

Concerning social pension insurance, changes in the structure of employment have a remarkable influence on the financing conditions, the contribution revenue as well as – later – the expenditure because of changes in pension claims linked to individual contribution payments.

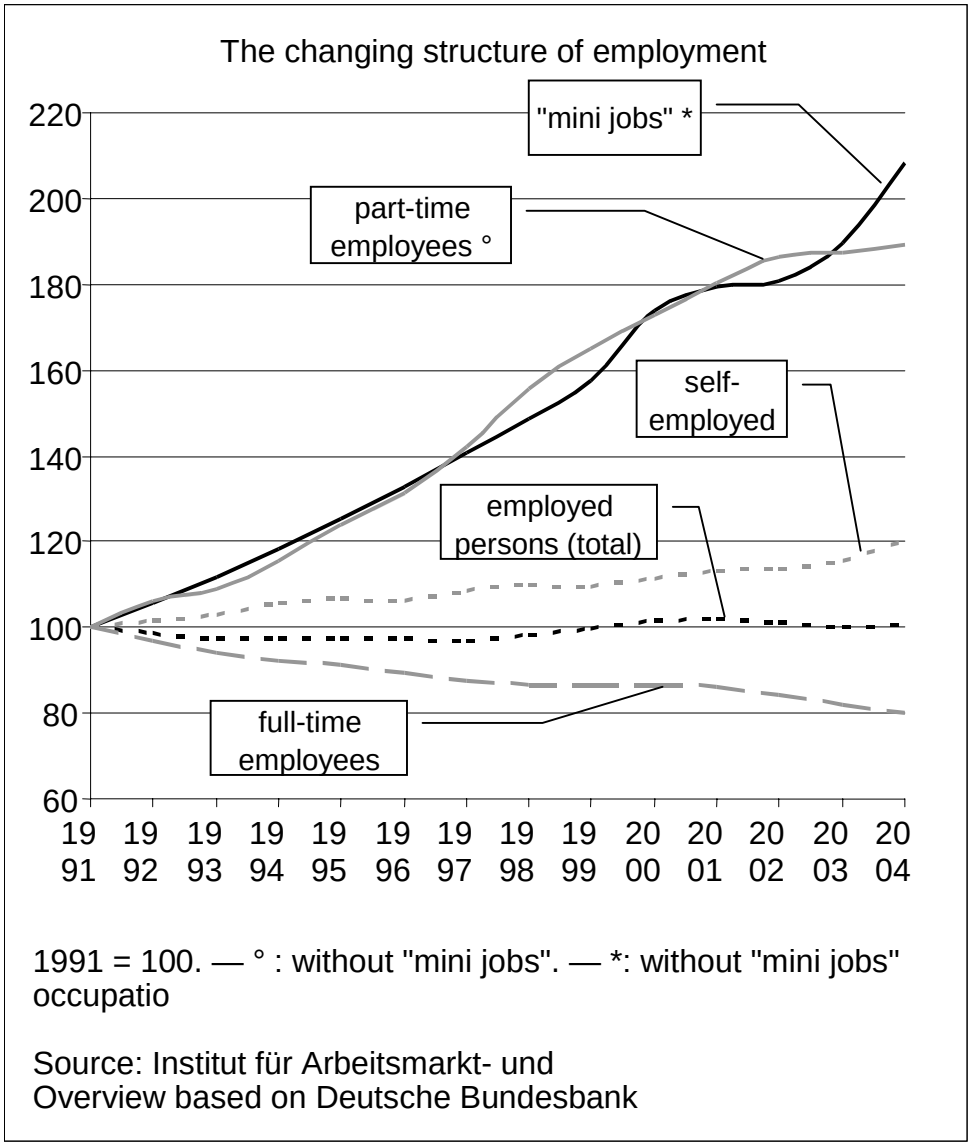
As Overview 5 clearly demonstrates for the period of 1991 up to 2004, the number of full-time employees decreased remarkably (these are mostly employees covered by social insurance), while part-time employment and (mainly) not covered so called "mini jobs" (i.e. employment below a certain amount of wages, the floor) increased in absolute as well as relative terms.

19 To evaluate such contribution rates it should be taken into consideration that German unification increased the contribution rate in pension insurance by about one percentage point. This will continue for a long time.

20 The so called 10th coordinated population projection.

21 Bundesregierung (2006b), p. 13.

Overview 5



Between 1991 and 2004 the number of full-time employees decreased by nearly 6 million persons (5.9), while the number of part-time employees as well as "mini jobs" increased by 2.7 million each[22]. The number of self-employed also increased (0.7 million) – many of them are not covered by social insurance.[23]

If we look at employees covered by social insurance, a change also took place from full-time to part-time employment (Overview 6). But even the number of both together decreased (here for the period of 1993 respectively 1999 up to 2004), while the number

22 These are numbers referring on to those "mini jobbers" that are not working in this type beside another regular employment contract (which is also possible). Mini jobs can replace employment covered by social insurance, for this is often done in companies which can split up easily the working load.

23 A detailed analysis of old-age security of self-employed is given in Fachinger et al. (2004).

of mini jobs increased. It can be expected that to some extent full-time jobs or jobs covered by social insurance are split into several mini jobs without (full) coverage in social insurance.

Overview 6

year	employees covered by social insurance *) in 1000			mini jobs **) in 1000
	full-time	part-time	total	
1993	25 454	3 142	28 596	
1999	23 805	3 678	27 483	3 658
2004 p	22 213	4 311	26 524	4 803
change 1993 bis 2004	- 3 241 (- 12.7 %)	+ 1 169 (+ 37.2 %)	- 2 072 (- 7.2 %)	
change 1999 bis 2004	- 1 597 (- 6.7 %)	+ 639 (+ 17.2 %)	- 959 (- 3.5 %)	1 145 (+ 31,3 %)

data: June of the respective year

p = provisional

*) i.e. without civil servants, self-employed and helping family members

**) without mini jobs beside another occupation

Source: Bundesministerium für Gesundheit und Soziale Sicherung (2005b); Deutsche Bundesbank (2005), p. 19.

These developments result in an increase in the pensioner ratio (number of pensioners compared to the number of contributors) and – assuming a constant pension level – in the need for higher financial resources in this area from contribution payments or taxes, because in the PAYGO-financed pension scheme former pension claims are based much more than today on full-time employment, while today contribution financing is to a higher percentage from part-time employment (or there is a lack of contributors or contribution revenue because of employment not covered by social insurance).

An important factor for expenditure increase in the pension scheme was that on average pensions were received and paid for an increasing number of years. While in West Germany in 1960 the average duration of receiving a pension was 10.1 years and 12.1 years in 1980, it was already 15.4 years just before German unification, resulting from a policy of early retirement (that was supported by politicians, trade unions and labour organisations) based on several instruments (Schmähl 2003c). Meanwhile – in 2003 – this time-span was 16.8 years in unified Germany (16.7 in West Germany, 17.0 in East Germany). Such an extension of the period for receiving a pension is an increase in the generosity of the scheme, in particular, if there are no reductions from the full pension because of the extended period of receiving the pension (as it was the case for a long time in the social pension insurance).

The expected effects of population ageing on social security in particular stimulated proposals for radical reform mainly in old-age security. To overcome the "crisis" of the PAYGO scheme the by far most important measure was seen in shifting pension ar-

rangements towards capital-funded private pensions.[24] Many economists, actors in the financial market, politicians and mass media recommended a strategy of rolling back the Welfare State[25] because of its assumed negative economic effects. Capital funding – some economists declared – is dominating PAYGO financing in nearly all aspects.[26] Therefore, it was argued that a shift towards funding will improve the well-being of the population – at least in the long run – in particular because of a higher rate of return.[27]

The public debate about the coming "demographic crisis" and nearly daily reports in the mass media prepared the ground for a major paradigm shift based on a broad informal coalition of actors aiming at a reduction of the public PAYGO-financed social pension insurance scheme by substituting it in part by private capital-funded pensions. The actors involved had different motives: the minister of finance, who became a major player in the pension policy arena, is particularly interested in reducing the burden for public budgets and public debt in line with the Maastricht convergence criteria of the European Union. Lower contribution rate also means lower federal grant to social pension insurance, because part of the grant is linked also to the development of the contribution rate of the pension scheme. Many mainstream economists are arguing in favour of only minimum protection which should mainly avoid poverty in old age by interpersonal redistribution. Pension provision above this level should remain a voluntary decision of the individual according to individual preferences, giving more choice. Employers' organisations are in favour of a reduction of the PAYGO public scheme because of lower contribution rates and non-wage labour costs. The actors of the financial market – like banks, pension funds, insurance companies – are of course highly interested in a reduction of public PAYGO schemes to attract a higher percentage of the growing amount of pension money in an ageing population.

The political debate was finally framed by the new government which came into power in autumn 1998: a contribution rate of about 24 percent in 2030 in social pension insurance as it was the result of projections would be economical unbearable and would burden the younger generations too much. "Intergenerational equity" as well as "sus-

24 For a detailed description of the coming "crisis" because of the population ageing see Wissenschaftlicher Beirat (1998), which is an Advisory Group of Scientists for the Federal Ministry of Economics. For a discussion of these findings see Schmähl (1998a) and regarding the financing methods in general Schmähl (2000). It is for example obvious that not only PAYGO but also capital-funded schemes will become more expensive in the process of demographic ageing, especially if life expectancy is increasing.

25 Economic consequences are analysed by Atkinson (1999).

26 For example Neumann (1998), also Siebert (1998).

27 Advocates of a remarkable shift towards funding do not focus anymore mainly on assumed positive economic effects like a higher saving rate, increased investment and economic growth – arguments which were intensely debated and sometimes questioned and empirically not convincing (Schmähl 1998b). The debate is instead primarily focused on higher rates of return of funded schemes. These calculations often are neglecting differing costs for different amounts of saving as well as transition costs when substituting PAYGO by capital funding. These calculations are only for old-age pensions in case of private capital funded schemes, while in the social pension insurance also disability pensions and expenditure for rehabilitation are financed which reduces the rate of return.

tainability" became widely used catchwords in the political debate.[28] The development of the social insurance contribution rate became the decisive indicator. Therefore, cuts in the pension level were regarded as unavoidable. To compensate such cuts regarding income in old age, additional private saving would become necessary: The "stick" was the cut in public pension level and the "carrot" was a subsidy for private pension saving. During the boom period of the stock market this shift towards capital-funded pensions appeared to be very attractive and with low risk.

The permanent public debate about sustainability of the social pension insurance was stimulated also by the political decision to reduce the already low minimum reserve requirement (liquidity reserve) of the scheme to finally only 20 percent of pension expenditure of one month! Just little differences between projected and realised economic variables cannot be adequately compensated by the reserves. In the public debate such short-term fiscal aspects were mixed up with long-term structural aspects, questioning in general the ability of this scheme to survive. Together with other reasons this eroded the confidence into the scheme remarkably (Rische 2006).

IV. A paradigm shift by the 2001 pension reform

To illustrate why and how the reform measures decided in 2001 can be labelled as a "paradigm shift" it is useful to outline the main characteristics of the social pension insurance scheme as it existed at that time.

1. Main elements of the existing scheme before the reform

On November 9, 1989 (the same day when the Berlin Wall came down) a major pension reform act was decided in parliament and became effective in 1992 ("1992 pension reform"). It was adapting once more to changing conditions the scheme that had been implemented by the major pension reform act of 1957. In 1957 a dynamic, earnings-related pension scheme was introduced, linking pension calculation and regular pension adjustment to gross earnings. The 1989 reform measures tried to cope with the challenges of demographic ageing by using several instruments to reduce the growth rate of pension expenditure, e.g. by increasing the retirement age and linking pension adjustment to the development of average *net* earnings. These measures were based on a clear distributional objective: pensioners with a specific amount of pension claims (a certain number of Earnings Points, see 4.2.1) always should be entitled to a pension benefit equivalent to a specific percentage of actual average net earnings of all employees. This should not only be realised at the time of retirement but also during the whole phase of receiving a pension benefit. Linking the development of individual pensions to the de-

28 This framing of the public debate in Germany and the focus on "fiscal sustainability" and "intergenerational equity" is discussed in Schmähl (2005a).

velopment of the growth rate of average *net* earnings was an important instrument to realise the explicit distributional objective: a constant net pension level (pension compared to net average earnings). This underlines the character of the social pension insurance as a defined benefit scheme. The benefit level was the exogenous variable, financing (the contribution rate as well as the grant from the federal budget to pension policy) was the endogenous (dependent) variable. Linking the development of pension benefits to average net earnings reduced pension expenditure compared to a link to average gross earnings (as it was the concept of the formula introduced in 1957). This effect, however, only occurs as long as there is an increase of direct taxes and social insurance contributions (in relative terms). This was expected to be the case in the future.[29]

To characterise the social pension insurance, it has to be underlined that this earnings-related scheme realises a relatively high degree of intertemporal income redistribution over the life cycle, i.e. a relatively close contribution-benefit link. This allows to smooth income and consumption possibilities over time. The *whole insurance period* is taken into account for calculating pensions. Meanwhile, there has been a development in several countries (for example in Sweden and Austria) to consider not only some, but (in tendency) all years of insurance when calculating a pension. Individual pension claims of the insured person from earnings or credited in case of some other activities (like child care) are accumulated in the German social pension insurance scheme within an *individual account*.

Income and consumption smoothing over the life cycle is the main distributional objective of the social pension insurance scheme and not primarily avoiding poverty. For pensioners – at least for those with a longer insurance record – the pension shall be sufficient to maintain during retirement to a certain specified percentage the level of living that was financed before retirement from earnings.

To sum up main objectives and characteristics of the German pension schemes prior to the reform that was decided in 2001:

(a) regarding social pension insurance:

- an explicit distributional objective of the PAYGO financed scheme: the individual pension should be a fixed percentage of average net earnings (the percentage depending on the accumulated sum of pension claims), the benefit (pension) level being the independent (exogenous) variable – a defined benefit scheme;

29 The new pension adjustment formula was one element within a concept to construct the social pension insurance scheme according to a self-regulating mechanism, Schmähl (1993). The new adjustment formula was seen as an important instrument to reduce the future development of pension expenditure. In addition, it was also decided to introduce a deduction from the full pension in case of early retirement. This did not exist before and gave remarkable incentives to early retirement in the past and increased the contribution rate of the PAYGO scheme. It was planned to phase-in the deductions from the full pension beginning in 2001, during a period of more than 10 years. The level of the deduction (3.6 % per year of retiring before the reference retirement age, that will be age 65 in the near future), however, is too low to eliminate the incentive for early retirement. In 1996 – beside other measures – it was decided to start the phasing-in of these deductions already in 1997 (and not in 2001) and not within ten but only five years; Schmähl (1999b).

- a constant pension level (compared to average net earnings) over time by linking the development of pensions to the development of average net earnings; this is realised for new pensioners at time of retirement as well as for all pensioners during the phase of receiving a pension ;
- financing (by social insurance contributions and federal grant) is the dependent (endogenous) variable;

(b) regarding occupational and voluntary private pensions:

- capital funded occupational pensions being a *supplement* to social insurance pensions (financing by employers was dominating, pensions were mainly of the defined benefit type; occupational pensions in the private sector are voluntary, based on collective agreement in the public sector);
- voluntary private saving for old age (for example by life insurance contracts) was another supplementary instrument.

2. The 2001 pension reform – the new strategy in pension policy

The *2001 reform* changed several of the above mentioned characteristics of the social pension insurance scheme:

- The contribution rate became the dominating objective, the benefit level now is the dependent (endogenous) variable.
- Employees now have a right of "earnings conversion". Collective agreements regarding occupational (firm-based) pensions are favoured; financing by employees will become dominating instead of employer-financing of occupational pensions.
- Subsidised private saving became explicitly a *substitute* to social pensions, although officials labelled it still as "supplementary".
- Capital funded private schemes shall *substitute* PAYGO financed social insurance pension partially.
- A major instrument to reduce expenditure and the benefit level in social pension insurance to realise the intended shift towards private pensions was a change of the pension (adjustment) formula. Additional changes in disability and widow(er)s' pensions were also decided (Schmähl 2001a, 2003a).

a) Changing the pension adjustment formula to reduce the benefit level

Changing the formula for adjusting pensions affects all pensioners, those who claimed a pension in the past as well as those who will claim it for the first time in the future. It affects insurance pensions (retirement and disability) as well as survivors' pensions (for widow(er)s and orphans).

The calculation of the individual (insurance) pension is based on two elements:

- sum of individual *Earnings Points* (*EP*) the insured person accumulates during his/her whole life. In case of covered employment the Earnings Point of an employee in one year is the ratio of individual gross wages to average gross wages of all employees. If an employee just earns the average amount of earnings, he gets one *EP* in this year, if he/she earns only half of the average, he/she gets 0.5 EP etc. There is also a crediting of Earnings Points for activities like child caring, caring for frail elderly, in case of unemployment[30] and even for some non-contributory periods like schooling. At time of retirement the sum of Earnings Points of the whole insurance period is accumulated and multiplied by a second factor,
- *actual pension value* (Aktueller Rentenwert", ARW) which gives the value in DM (now in Euro) per month of one *EP*.

If the pension is claimed before the age of a full pension, the full pension is reduced by 3.6 % per year.

The growth rate of ARW is the rate for adjusting those pensions which were calculated in the past. Therefore, all pensioners with the same sum of *EP* have an identical pension benefit irrespective of the year of retirement.

For a so-called standard pension with *EP* = 45, the target value of the pension according to the rules implemented in 1992 was 0.7 multiplied by average net earnings. A lower (higher) number of *EP* gives proportional lower (higher) pension benefit.[31] The 1992 reform linked – as mentioned above – the growth rate of ARW (pension adjustment rate) to the growth rate of average *net* earnings,[32] and the ratio of (individual) pension to net average earnings remains constant over time for all pensioners.

In 2001, the new government abolished the link of ARW to net average earnings. The main reason was that an intended reduction in income tax and shifting the tax burden more towards indirect taxes (VAT and ecological tax) would increase the growth rate of net earnings compared to gross earnings. Because of the net adjustment formula then also the pension adjustment rate, pension expenditure and the need for additional revenue would increase.

The pension adjustment formula, as it was introduced in 2001, is no longer based on the development of average *net* earnings but on average *gross* earnings (like in the 1957 pension reform in principle) and the contribution rate only of social pension insurance[33]

30 Here other institutions are paying the contribution.

31 It has to be mentioned that this pension level is not the replacement rate, because the pension is based on the average of relative earnings over the whole earnings span and not linked to last earnings. Only in case of an identity of last earnings of the employee and his/her average relative earnings position over the insurance period, this also gives information about the replacement rate.

32 This, however, is a simplified version. Since pensioners pay themselves contributions to health and long-term care insurance the effect of these contribution payments had to be eliminated in the pension adjustment formula. For a detailed discussion of the net adjustment formula see Schmähl (2001a).

33 These two elements of the pension formula had already been proposed by the author about 20 years ago instead of the net adjustment formula. The main idea for this was that the pension formula should only take into account such factors, which are direct elements of the social insurance pension

as well as a *fictitious* contribution rate for saving in private pensions. This rate is not the empirical saving rate for private pensions but a rate the government will subsidise in case there is saving in certain (certified) types of private pensions. This factor was introduced in 2002 at 0.5 % and will be increased in eight steps to 4 % up to 2008. By increasing this factor, the development of ARW – and by this the adjustment rate for public pensions – will be reduced as well as the benefit level for all present and future pensioners. This clearly demonstrates that the new (subsidised) private pension is intended to be a *partial substitute* for public pensions. Present pensioners and employees near retirement age cannot compensate for the loss in public pensions by additional private saving for old age.[34] The new formula was intended to reduce the standard pension level (pension based on 45 EP) from 70 per cent to 64 per cent compared to average net earnings.[35]

Beside this *general* reduction of social insurance pensions by redefining the pension formula in case of old age as well as of disability, additional measures were adopted to reduce *disability pensions* and *widows'/widowers' pensions* as well as pension claims in case of (long-term) unemployment. These measures are affecting certain groups of the population in addition to the general reduction of the benefit level.

Regarding "disability pensions" there existed two different types prior to the 2001 reform:
Pensions in case of (general) disability and pensions because of vocational disability.[36] The first one was like old-age pensions to replace former earnings if the insured person was not able to work regularly (or could not earn more than a specific amount) because of health conditions. Therefore, this pension was calculated on the same level as old-age pensions, while in case of vocational disability it was assumed that the insured person was able to earn some money; therefore the level of these pensions was 1/3 lower and

scheme, gross earnings and the contribution rate to social pension insurance. If pensions become more costly (for example because of demographic ageing) this will not only burden employees (and employers) by a higher contribution rate, but pensioners as well by a reduction in the pension adjustment rate. In 1999, this formula was introduced again into the public debate by the Social Advisory Council of the German government on pension policy (the author was chairman of this Council from 1986-2000), Schmähl (1999a). The government finally adopted in principle this proposal, but added an additional element.

34 A short remark seems interesting regarding the original version of the paradigm shift government had in mind. In May 2000, it was proposed that for future pensioners the PAYGO-financed public pension should be reduced by half of the amount of a private pension which employees in principle could realise if they were saving 4 % of their earnings. This reduction of the public pension should take place irrespective of the fact whether and how much the employee was in fact saving for such private pensions. This approach would have changed the social pension insurance into a system of partial income testing based on the assumed possible amount of a private pension. During the reform debate this was substituted by integrating the fictitious contribution rate for private pensions into the pension formula.

35 Government, however, redefined net earnings by considering the voluntary private contribution like a mandatory levy which reduces net earnings. It was finally decided in parliament that the standard pension shall not fall below a certain percentage of redefined earnings. This was a compromise especially with trade unions.

36 For details see Verband Deutscher Rentenversicherungsträger (2002) and Viebrok (2003).

being a supplement to labour income. However, there existed a special "protection" regarding the type of work that was looked upon as "reasonable" (in principle the occupation or one that was related to it). If such a job was not available on the labour market the insured person received the (generally) higher disability pension.

This was changed into a disability pension with taking into account individual income. Relevant now is how many hours somebody is able to work – regardless of the type of work. That means that in principle all occupations are "reasonable". Decisive now is how many hours the insured person is able to work. If he/she can work 6 hours or more per day no disability pension is granted. If he/she can work 3 up to 6 hours a partial disability is paid (as a type of allowance), while in case of less then 3 hours the full disability pension is paid.

Regarding widow's/widower's pensions, it is linked to the amount of the pension of the deceased spouse. Before 2001 this was in principle 60 percent (but taking into account certain types of own income of the widow/widower). This percentage was reduced to 55 percent and all other types of income are now taken into account. However, if the widow/widower has children, then Earnings Points are granted: for the first child 2 Earnings Points, for all other children one Earnings Point. For all those couples having been married since 2001 (and born 1962 or later) they can choose whether they opt for this widow's/widower's pension or for a split of the pension claims the two partners earn together (a technique used also in case of divorce).

b) Additional decisions in 2004

Only two years after the decision on "the most important reform of the century" – as it was labelled by supporters – the government established a new ad hoc commission to work out proposals for a "sustainable development" in social security. Because economic conditions, in particular on the labour market, did not develop as expected, the contribution target (20 percent in 2020) runs the risk of not being realised. This as well as short-term financial problems again stimulated a reform discussion. In particular, the Green Party favoured a new commission which should deal with demographic consequences for social security.[37]

The report of the "sustainability commission"[38] proposed several additional measures to reduce expenditure and to distribute financial burden between present and future contributors and pensioners. One of the measures proposed is a gradual increase of the retirement age for receiving the full pension (from age 65 to 67) and of the earliest age of retirement (from age 62 to 64) over a period of more than 20 years (one month extra

37 However, there had been an intensified research on this topic since many years, e.g. by an Enquête-Commission of the Federal German Parliament (Bundestag), which published a final report in spring 2002 after 10 years of work (Enquête-Kommission (2002)) – work that was obviously little recognised by those politicians who now made political pressure to take up the topic again in the political debate via the new commission.

38 The commission (named "Rürup-Commission" after its chairman) published its report in 2003 (Nachhaltigkeitskommission 2003).

per calendar year), to react to increasing life expectancy.[39] This proposal was, however, not realised by the red-green coalition government, while the new coalition government of Christian- and social-democratic parties (established in autumn 2005) announced to realise this in the future. The acting minister of labour announced meanwhile to present a draft bill up to the end of 2006.

Another proposal by the commission was adopted by the government in 2004, namely to introduce an additional "sustainability factor" into the pension (adjustment) formula. This factor is defined as a (standardised) ratio of pensioners to contributors (pensioner ratio, system dependency ratio), reflecting among other things changes in demography and labour market participation, but also changes in the coverage by the social pension insurance scheme. If the ratio increases, this will reduce the development of the "actual pension value" (ARW) and by this in general the benefit level. However, this "sustainability factor" is multiplied by another factor (α); α at present is set at 0.25. This number is chosen in such a way that the projected contribution rate of the pension scheme[40] is just as high as the contribution objective (2020 not above 20 percent, 2030 not above 30 %). This underlines that the definition of the "sustainability factor" as such is not decisive, but shall give the impression of a well-defined element.[41]

The pension formula as it is implemented is already now lacking transparency.[42] This will increase in the (near) future, if another additional "factor" – as it is already announced by the coalition government – is introduced into the formula (see below).

V. Some effects of recent reform measures

1. Reducing the benefit level

Regarding the effects of these reform measures, one has to take into consideration the *general* pension level, the *individual* pension claims, the *net income* of pensioners, the *contribution rate* and the *total financing burden* for old-age provision as well as *income distribution* in old age and the *fundamental features in particular of the social pension insurance*. This becomes obvious mainly in a long-term perspective.

Regarding the *net* pension benefit, (direct) taxes and contribution payments are relevant. Here, also changes took place: the income tax on pensions will be increased

39 For a general discussion of life expectancy and retirement ages as well as a concrete proposal to integrate this into the pension scheme see Schmähl and Viebrok (2000).

40 Together with other assumptions regarding demographic, economic and institutional development.

41 Börsch-Supan et al.(2003) discuss several modifications of additional elements to be introduced into the pension formula for reducing pension expenditure. Börsch-Supan was one of the members of the sustainability commission.

42 Government in addition redefined the calculation of average gross earnings which influences also the development of ARW.

gradually[43] and the contribution rate in long-term care insurance now burdens in full the pensioner (while before half of the contribution was paid by social pension insurance on behalf of the pensioner as in case of health insurance).

Regarding the *individual* pension claims, it is decisive, how much claims can be accumulated during the working life from employment as well as in case of other circumstances (like caring for children) or "social risks" (like unemployment).[44] The high unemployment rate and the increase in long-term unemployment will reduce individual pension claims in the future remarkably. How long has an employee in principle the possibility to stay in the labour market? Will it be possible to remain employed up to the age, where the full pension is paid without any deduction? Labour market conditions are (beside e.g. health conditions) relevant in particular.

To illustrate some aspects in case of unemployment, two employees (*A* and *B*) are compared (Overview 7). Both employees started with identical earnings, but while employee *A* is continuously employed, the working career of employee *B* is interrupted by unemployment. The contribution payment of the unemployment agency to pension insurance is based on the unemployment benefit which is linked to the employee's former earnings. According to the ratio of unemployment benefit to average earnings a pension claim is created during the period of unemployment.[45] If employee *B* finds a new job, his earnings may be lower compared to the earnings of employee *A*, who was continuously employed. Therefore, also the pension claims of employee *B* from gainful employment will be lower compared to *A*.[46] Therefore two effects work together resulting in lower pension claims of *B*: because of lower claims based on the unemployment benefit and on lower earnings after the unemployment period.[47] If, for example, an unemployed person has exhausted the maximum length of unemployment benefit and is not employed again, he may receive a means-tested transfer payment. The maximum length of this contribution payment was reduced in 2006 to 12 months (18 months at maximum only for those 55 years and older). If thereafter, a means-tested benefit is claimed, the pension claim in this case is at present 1/6 EP and shall be reduced (according to announcement of the new coalition) to 1/12 EP. That means that if someone needs this means tested benefit for 3 years, his/her pension claim is as high as the claim an average earner gets within 3 months. This illustrates how unemployment can reduce

43 Only a certain percentage of social insurance pensions (like private life insurance pension) were taxable income. This percentage will be gradually increased up to 100 percent. On the other hand employees will be able to deduct step by step a higher percentage of their contribution payments from taxable income.

44 These effects are compared to private pension schemes in Schmähl (2005c).

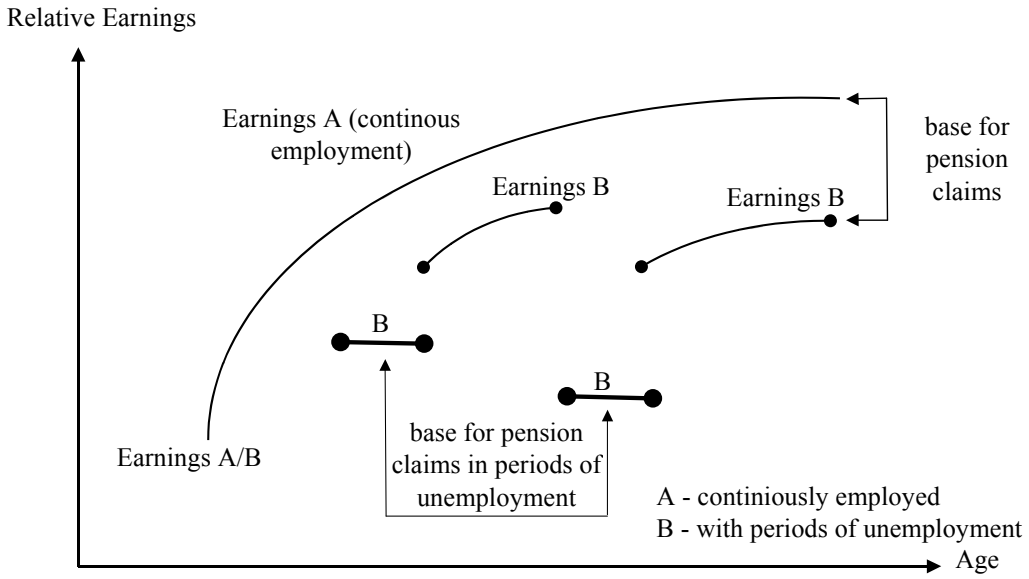
45 Pension claims in the social pension insurance in Germany in case of employment (covered by social insurance) are based on the relative amount of earnings, i.e. individual earnings compared to average earnings of all employees during a particular year.

46 If there is no further interruption earnings of B may approach over time the earnings level of employee A.

47 If there is another spell of unemployment, the unemployment benefit and therefore also the pension claim is even lower because of the reduced earnings level of B after the first period of unemployment (see Overview 5).

the individual sum of EP and therefore the individual pension benefit – beside the general reduction of the pension level.[48] All this demonstrates very clearly that unemployment can remarkably reduce the public pension claims an individual can accumulate during his working life. [49] But nevertheless, periods like unemployment or illness as well as disability are taken into account in *public* but not in private or occupational pension schemes. The more individual or occupational pensions replace public pensions the lower is the compensation-effect in case of illness, unemployment or disability which the public scheme provides.

Overview 7: Earnings-profile without and with periods of unemployment



Source: Schmähl (2005c).

In case of earlier retirement deductions reduce the monthly pension benefit. Early retirements may be a voluntary decision or an effect of labour market conditions. Even today the effect of unfavourable labour market conditions influence pensions (beside the low pension adjustment rate according to low earnings increase): In 2004, in West Germany 24 percent of all new pensioners retired after unemployment or a specific part-time rule for older workers, in East Germany even 55 percent. The deductions from the full pension were on average around 14 percent (that was on average € 175 less per

48 The development in health and long-term care insurance is also highly relevant regarding the question whether income in old age will be adequate to cover costs of living and in how far the level of living (at least) during the last phase of the working life can be maintained. Here the benefit level is reduced, too, and it is necessary to spend more money in case of illness, not to speak in case of residential care for frail elderly.

49 In Germany, all the years from the beginning of employment (even some years of schooling) up to the year when the employee retires are taken into account for pension calculation.

month) for West and East Germany. The effect of deductions can be expected to increase in the future even without the planned increase of the "normal" retirement age (for a pension without deductions) from 65 to 67.

Looking at the effect for income in old age, the general reduction in the pension level as well as the effect of changing conditions (on the labour market, in other areas of social security, in taxation) have to be taken into account.

The reduction in the pension level *in general* is closely linked to the concept of the social pension insurance scheme. A few figures shall substantiate this. The intended scaling down of the pension level – sooner or later – will transform this pension scheme fundamentally.[50] If we assume that all the changes, which were politically decided from 2001 to 2004, were already fully effective today, then the pension of an insured person with 45 EP (which is often a point of reference in the German debate) would not be 70 percent of average net earnings anymore (as was the dominating distributional objective of the "1992 Pension Reform Act"), but only 52 percent – in case the pension is claimed at the "standard retirement age" (65 or even 67 in the future). A pension of € 1000 then would be only € 750.[51]

How can this affect the fundamental feature of the German social insurance scheme? This becomes evident if one takes into account, how many pension claims are necessary to receive a pension benefit that is just as high as means-tested social assistance, which is about 40 % of average net earnings. At present, about 25 EP are necessary, but about 35 EP will be needed in case of a general reduction of the benefit level to 52 percent.[52] That means, somebody who earned during his working life on average just as much as average earnings, has to pay contributions for about 35 years of insurance. Who earns less, e.g. only 86 (75) percent of the average, has to pay contributions for 40 (45) years

50 For a detailed analysis see Schmähl (2003a and 2004).

51 In the German debate there is some confusion regarding the definition of pension levels. Government decided to reformulate the definition of „net earnings" by regarding the voluntary saving for private pensions in certain subsidized types as if it is a mandatory duty (tax or social insurance contribution). Therefore, net earnings become lower and the pension level becomes higher (pension level defined as pension compared to net earnings). In addition, the tax treatment of pensions as well as of earnings changes over time: pensions will be taxed heavier and earnings less by deducting social insurance contribution payments more from the income tax base.

52 Parliament decided in 2004 that the two factors in the pension formula described above shall not become fully effective, if they would reduce the absolute amount of the pension benefit (negative adjustment rate). This becomes relevant, if the annual growth rate of average gross earnings is below (about) 1.3 % – as is already the case for the pension adjustment in 2006. Therefore, it is now demanded by many actors that those cuts should be compensated later by lower adjustment rates as calculated from the formula. For formulas of such additional factor see Bomsdorf (2005) and Gasche (2005). The new coalition announced already that such a procedure will be implemented. Therefore, the full effects of the already politically decided changes are taken into account in the following. Whether, however, several years of no pension adjustment and a reduction in the real value of pension benefits will be accepted politically or even by decisions of courts has to be seen. For example the Federal Court on Social Affairs (Bundessozialgericht) recently decided that pension adjustment has to compensate at least the inflation rate (Sodan 2005: 565).

to receive a pension just as high as means-tested social assistance – a benefit that can be claimed without any provision (saving, contribution payment) for old age.[53]

Today, about two third of all women and about one third of men have less than 35 EP. Even if we assume an increasing female labour force participation rate, the picture will not change fundamentally. If we take the labour market conditions of the past into consideration as well as changes in the institutional rules for accumulating pensions (for example the number of pension claims credited for periods of schooling that were reduced radically in recent years), we can expect that – even after long periods of contributing to the social insurance scheme – a remarkable percentage of pensioners will only have pension claims hardly above or even below the social assistance level. This would undermine fundamentally the political legitimacy and public acceptance of a scheme that intends to realise an insurance principle and a close link between (at least relative) individual contribution payments and (relative amount of) pension benefits. Even the federal government underlined this as an important objective of their reform. If the outlined development takes place, it will have (additional) negative incentives for contributors to finance such a scheme.

Meanwhile the "official" rhetoric is to say that the earnings-related social pension insurance cannot anymore finance the "standard of living" of pensioners, it can be no more than a "basic pension". However, it is not mentioned, what this will mean in reality: a basic pension that is *above* the social assistance level will not be realised by many of the pensioners – even if they have a long working career.[54] This becomes even more relevant, if the full pension (without deductions) can only be claimed at age 67 and the labour market conditions do not change fundamentally. Then a growing number of pensioners will have deductions from their full pension in addition to the lower general pension level and the effect of (an increasing number of) unemployment spells in their insurance record.

2. Shifting of burden and risks

A shift of financing burden from public budgets directly to private households takes place as well as a shift of burden (as well as of risks) from employers to employees. In

53 If the retirement age for the full pension is increased up to 67, but retirement still takes place at 65, then an "average earner" with 45 EP has a pension level of only about 48 % of average net earnings (and an average earner then needs more than 37 years to receive a pension just as high as a (full) social assistance benefit). – Some actors (like the present chairman of the German Council of Economic Advisors, Bert Rürup) argued, that the ratio of pensions to social assistance will not be changed because social assistance will be reduced by the same percentage as the pension level. Then, however, social assistance hardly could anymore be an instrument to fulfil its objective, namely to avoid (income) poverty.

54 Federal government nevertheless declares: The pension of an average earner with a normal working life will also be much higher in the future than the level of "basic insurance" (that is the means-tested transfer payment in case of old age or disability); see Federal Ministry of Health and Social Security (2006), p. 17.

addition, the total financing burden of private households will be increased compared to the previous pension mix because of the transition costs resulting from (partial) substituting PAYGO financing by capital funding.

The 2001-reform measures already showed this: a contribution rate of 24 percent in the social pension insurance scheme was calculated for 2030 without the reform, the implemented measures are expected to reduce the contribution rate to 22 percent. However, employees are expected to save 4 percent of their earnings in private schemes to realise a benefit level comparable to the old rules. The total contribution rate in 2030 then would be 26 percent instead of 24 percent. However, now 15 percent have to be paid directly by employees and 11 percent by employers, instead of 12 percent each.

A lower social insurance contribution rate reduces the burden for the federal budget because federal grant is also linked to the development of this rate. Additional burden for the federal budget, however, results from subsidising private (as well as occupational) pensions.

The shift towards more private capital-funded pensions – which are at least today mainly fixed nominal amounts – and the increasing income tax on pensions can reduce the real value and the relative amount of pensions compared to general income development as well as compared to former (dynamic) social insurance pensions during the period of receiving pensions . On the other hand, the age-specific risk of illness or even need for long-term care and the need for income to cover costs linked to these risks increases with age.

It also has to be considered that within the social pension scheme several social risks (like unemployment) or social relevant tasks (like caring for children) are taken into account, but not in private pension schemes. A reduction in the generosity of the social pension scheme reduces therefore also the effects of such redistributive (and mostly tax-financed) elements. If they are looked upon as being important, then the question remains how this should be realised. If private pension schemes become mandatory – as has been discussed in Germany for some time, in particular if private saving seems to remain too low –, it could be possible that private schemes have to take over such redistributive tasks.[55]

3. Effects on income distribution

The new German strategy in pension policy affects the distribution of income of different cohorts, of men and women, families with children and single households.[56] In principle, younger cohorts gain by the measures already implemented. However, the effect is very small, at maximum an increase in the rate of return by the 2001 reform (compared to the previous scheme) of less than 0.2 percentage points, for example, for

55 This can already be seen in that part of mandatory long-term care insurance in Germany that is managed by private insurance companies.

56 For a detailed discussion see Schmähl (2003b), Himmelreicher and Viebrok (2003), Viebrok et al. (2004).

those born in 2010 and retiring (at age 65) in 2075. These findings are based on calculations of the Bundesbank, referring for example to an average earner with 45 years of insurance, two children, retirement at age 65 and receiving a pension for 15 years and then a widow's pension for additional 5 years. These calculations show that for younger cohorts the rate of return will increase while for older cohorts it is the opposite effect. However, the difference in the rate of return with and without the 2001 reform measures is at maximum less than 0.2 percentage points. The "break even point" where cohorts will be positively affected is around birth cohorts of 1975. For those born later the effect – measured by the rate of return – will be positive, however slowly increasing and – as already mentioned – at maximum less than 0.2 percentage points for those born around 2010 – that means retiring at 2075 or even later. This hardly can be taken as a convincing argument in favour of the reform.[57]

Persons with high income gain by tax subsidies for private pensions because of the progressive income tax schedule. From a social-policy point of view, one could argue that if private pensions are subsidised, this should be focused on those in the low and middle income brackets. This becomes especially important when taking into consideration, that persons with low income may not have enough money to save in these subsidised types of saving. There is even a remarkable percentage of German households (at present about nine per cent) that cannot even meet their financial liabilities (their obligations to pay back the accumulated debt although they already reduced their living conditions). If they have some money left, it is preferable for them to reduce the debt instead of saving for old age in subsidised forms.

It is neglected in the present public discussion that fiscal incentives have to be financed, too. If tax expenditure for incentives to save are financed mainly by indirect taxes (like VAT or tax on petrol etc.), all households, including households with low income, have to finance the incentives, while not all households are able to profit from the subsidies. Households with many children are burdened relatively high by indirect taxation.

Concerning the development of saving, it is on open question whether and how much additional saving can be expected. Based on the experience of former attempts to stimulate saving,[58] there are severe doubts that the new financial incentives will increase total saving. It can be expected that there will often be a mere substitution within different types of saving, from non-subsidised to subsidised types or towards higher subsidies.[59]

It can be expected that income inequality in old age will increase. This can be the effect of:

- different participation in private pension funds as well as in
- different amounts of saving, but also in

57 For more information see (Schmähl 2003b).

58 See Börsch-Supan and Essig (2002: 93).

59 Deutsche Bundesbank (2002) offers some reflections on this topic.

- different net rates of return[60] and as an effect of
- labour market conditions, interruptions in the working career and
- less equalising measures realised by social pension insurance. Such equalising effects (for example by crediting pension claims in case of unemployment, child care etc.) will be eroded because of the smaller role of this benefit as income source in old age.

The interaction of changes in the rules for public and private pensions, the increase in – often long term – unemployment (unemployment spells in individual careers), changes in rules in case of unemployment (shorter duration of unemployment benefit as well as reduction in the pension claims in periods after receiving unemployment benefits and receiving a means-tested transfer payment) as well as an increase in inequality of wages that can be seen in Germany since a number of years,[61] are reasons for growing income inequality in old age.

Even today there are rising inequality regarding pension payments. This is shown in Overview 8: Gini-coefficient – as an indicator of inequality – of pension payments from social insurance is increasing for newly calculated pensions. In addition if we compare Gini-coefficient of newly calculated pensions with the "stock" of all pensions in a certain year, it is also obvious that over time inequality is rising.

Overview 8

Gini-Coefficient Old-age Pensions Social Pension Insurance Germany								
Year	New pensions in year …				All pensions in year …			
	Men		Women		Men		Women	
	West	East	West	East	West	East	West	East
1995	0.288	0.112	0.387	0.159	0.258	0.387	0.387	0.190
2000	0.306	0.132	0.391	0.160				
2005	0.346	0.157	0.403	0.202	0.273	0.143	0.369	0.187

Source: Original data from pension insurance, own calculation

Present pension policy will obviously affect the structure and design of pension schemes in Germany as well as living conditions of the elderly in the future. The effects of the new strategy in pension policy on income distribution in old age (which will become more unequal) and in particular on (income) poverty (which can be expected to

60 For example a recent study on life insurance contracts showed that the amounts received after 30 years of paying premiums could differ by about 30 % depending on the life insurance company, Frankfurter Allgemeine Zeitung, 18.8.2006 (Teurer Fehlgriff).

61 See for example Gernandt and Pfeiffer (2006), Kohn (2006), Dustmann et al. (2006).

grow in the future)[62] will stimulate the question of *political* sustainability – even if the social pension scheme seems to be *fiscally* sustainable.[63]

4. Further structural change

The present political strategy in pension policy is supported by the vast majority of political parties, by employer organisations, trade unions, banking and insurance companies and their organisations, newly established lobby groups financed in particular by employers' and industrial organisations (Lampert 2005) and by mainstream economists. It is not surprising that this strategy is not disputed at all in the media. The new strategy and its main elements can meanwhile be labelled as the *new pension orthodoxy* in Germany. Regarding social pension insurance it will cause a fundamental change in the dominating objective, from income and consumption smoothing of an earnings-related scheme with a strong contribution-benefit link back to the objective of avoiding poverty in old age – as it was the starting point of the scheme at the end of the 19th century.

A pressure towards further reducing *public* PAYGO pensions can be expected from the European level. One of the influencing factors are the Maastricht stability criteria, the demand for reducing public debt as well as to balance the public budgets. Arguments for this are the sustainability of fiscal policy in general and of pension policy in particular as well as the goal of intergenerational equity. The main instrument to realise this is seen in reducing PAYGO financing.

Another influencing factor coming from the European level is linked to the process of an "open method of co-ordination" in pension policy for EU member states. Decisions on common goals in pension policy and on a set of indicators will be the basis for a process of benchmarking of national pension policies. This benchmarking will depend on the decision which indicators will be chosen as being relevant. Taking into account the important role of the ministers of finance in the EU, it may happen that for example indicators like the percentage of public pension of GDP will become decisive in the process of evaluating different pension arrangements in the member countries. It is obvious that the ministers of finance are particularly looking at the "burden" for public households, not as much at the "burden" for private households in case of a shift from public budgets to private households and by this from PAYGO to capital funding. This process may become a highly important factor (by "blaming and shaming") in the national pension debate and may influence the mix of pension schemes on the national level (Schmähl 2002).

In Germany, those types of occupational pensions (in the private sector) that are based on book reserves (internal financing) – direct commitments by employers – are

62 This is analysed in detail in Bundesregierung (2006c), Schmähl (2005b), Viebrok et al. (2004).

63 A comprehensive evaluation of the effects of pension policy will also have to take into account other economic effects such as the negative incentives for saving and employment in the official labour market in particular for persons with low wages because of the growing probability to be affected by means testing either in case of unemployment or in old age.

under high pressure, too. Changing accounting standards and activities of rating agencies push the financing of occupational pensions towards the capital market.

Regarding occupational pensions in the public sector, there, too, is a shift from PAYGO financing towards capital funding. And also in civil servants' pension schemes in the level of states as well as on the federal level capital funding shall substitute PAYGO financing. We can see a "victory" of capital funding (and its supporters) nearly in every part of German pension schemes. Whether the expectations linked to this approach will come true, that is another – and open – question.

Although private pensions as a substitute for public pensions are voluntary at present, the topic of *mandating* private (or occupational) pensions will be on the political agenda at least in case of a low participation rate of employees in the new possibilities for saving (in certified pension products or in using the possibilities via collective agreements). Mandating may be based on industry-wide collective agreements (quasi-mandating like in the Netherlands) or by law (like in Switzerland).

While Germany today still is a country with an *earnings-related* public pension scheme as first tier (aiming at income smoothing over the life cycle) and with *voluntary* funded pensions (for example as a second tier of supplementary occupational pensions), it seems realistic to assume not only a changing mix of the schemes and of financing methods, but also a change in the division of tasks between public and private schemes: a shift in the public first tier towards primarily avoiding poverty, while a mandated second tier shall take over some income replacement. The "basic (social) pension" (as it is labelled very often now) may even become a benefit similar to the already existing means-tested scheme in case of old age or disability or will be merged with this scheme, because a general flat-rate pension (adequate to avoid poverty in old age!) would be much too costly.[64] The pattern of a low PAYGO-financed public pension and a mandatory second tier can be seen in countries like the Netherlands or Switzerland. The development in these countries is often mentioned in Germany as being an attractive model for pension policy especially by those actors aiming at an extended capital-funded part of pensions.[65]

In Overview 9 a stylised picture is given, showing "typical" combinations in a typology of first and second tier pension arrangements. It is not unrealistic to assume that Germany will change its position in this matrix, if the present strategy in pension policy remains effective (as it looks like at present).

64 The chairman of the German Council of Economic Advisors, Bert Rürup, recently proposed to calculate widow(er)'s pension no longer on the pension claim of the deceased husband but purely on means testing.

65 For example, it is neglected in the German debate that in the basic tier (AHV) in Switzerland the aim of avoiding poverty is realised much less compared to the earnings-related social insurance pension in Germany. Meanwhile also some former socialist countries established such a combination of two mandatory schemes. This is in line with a strategy the World Bank is proposing worldwide (World Bank 1994), although now with some modifications depending on country-specific conditions.

Overview 9

Combinations of mandatory first tier and second tier pension schemes			
mandatory 1st tier (PAYGO-financed		2nd tier (capital funded)	
		voluntary	mandatory by law or collective agreement
not income-related flat rate means-tested low pension level dominating objective: avoiding poverty in old age			X 1)
income-related	defined contribution		X 2)
dominating objective: income and consumption smoothing over life cycle	defined benefit	X 3)	

Examples:

1) The Netherlands, Switzerland, Australia

2) Sweden, Latvia, Poland

3) United States, Germany

If such a development takes place, this would be quite the opposite direction in Germany than in many other countries, where a low and insufficient first tier is supplemented by a mandatory second one. Germany now reduces its public first tier, which will become insufficient for many groups of the population. To realise a sufficient replacement level in old age, a mandatory second tier would then be added. If this takes place, the existing subsidies for private pensions have to be changed, too, because otherwise it would become much too costly for public budgets.

According to the present "Zeitgeist" and the remarkable influence of some actors on public pension policy, expectations were created that the increase of financial capital would be the decisive factor for coping with the challenges of an ageing population for social security, namely in pensions, but also in health care and long-term care. This is based on the assumption that an increase in financial capital (liquidity) does also result in an increase of real capital and productivity. This assumption, however, may be questioned. Beside this it can be argued that for future economic development in a country like Germany financing of human capital will be decisive in particular.[66] If this is a realistic assumption, subsidies should be focused more on investment in human capital (including further training of the growing number of older workers) instead of financial capital (private capital-funded pensions). This could become an important precondition

66 For a theoretical discussion see Kemnitz and Wigger (2000).

to realise high productivity and income.[67] Structural changes like those resulting from population ageing and its effects for social security can then better be coped with, as net income will increase despite unavoidable higher provision for old age because of the changing age structure.

Germany's pension policy seems to be beyond a crossroad at present. However, the long-term costs of the new development do not seem to be adequately realised in the public debate. During the last century, Germany introduced two important elements of pension policy – social insurance at the end of the 19th century and the dynamic earnings-related pension with a close contribution-benefit link for income and consumption smoothing over the life cycle in the middle of the 20th century. It seems that social insurance in Germany is on a way back towards its founding period in the late 19th century when the public scheme was an element to avoid poverty in old age. The dismantling of the earnings-related pension scheme and its partial replacement by private pensions will have considerable effects on income distribution in old age but also on incentives to contribute to pension schemes. The long-term costs of this strategy seem to be neglected compared to assumed benefits from a lower social insurance contribution rate and the expectation of higher rates of return from capital-funded pension schemes. However, as long as the political decisions that were taken remain unchanged Germany's old age security will pass through a radical transformation.

Although there seems to be no influential political power at present to change the development that has been introduced politically since 2001, I do not share the opinion of the ruling political parties and many actors that there was and is no alternative.[68] In a report to the German federal government by a commission of the federal government, some corner stones and guidelines of an alternative approach are outlined.[69] This approach favours the idea of a close link between contribution payment and pension claims realising pensions, that are –for those with a relatively long earnings career – well above the poverty line (respectively means-tested social assistance). Then also an increase of the "normal" retirement age – which is much debated in Germany at present – can be accepted, even if retirement takes place earlier. Germany has – compared to many other countries – at present relatively low labour force participation rates of the elderly (see Overview 10). This is in part due to a long lasting strategy of political parties, employers' organisations as well as trade unions to support early retirement. To change retirement behaviour, however, also a bundle of additional measures is needed beside changes in social security. A specific problem is linked to the group of employees with low qualification. To discuss this is beyond the scope of this paper.

67 "... a country's economic growth is closely tied to the human capital of its population. Countries that invest heavily in educating their citizens are also those that tend to experience high economic growth following such investments." Becker et al. (2003).

68 For example Lamping and Rüb (2004: 170) state: "Our main argument is that the government had run out of policy options and no plausible concepts were available for an internal solution within the existing pension scheme."

69 Bundesregierung (2006c), Schmähl (2005b), (2006b).

Overview 10

Labour Force Participation Rates 2004 – in % –						
age group	55-59			60-64		
country	E	U	I	E	U	I
Germany	*61.3*	*9.7*	*29.1*	*25.3*	*3.2*	*71.6*
Sweden	78.1	3.4	18.5	57.8	3.8	38.4
Norway	74.8	1.0	24.2	54.2	0.5	45.4
Switzerland	77.5	2.3	20.2	50.0	2.1	47.9

E = Employed and Self-employed

U = Unemployed

I = "Inactive" at Labour Market

Source: Europäische Arbeitskräftestichprobe 2004

Finally it should be mentioned, that a policy approach in old-age security cannot be concentrated on pension schemes (their financing, the benefits and taxation), but has to take into account additional elements that are relevant (decisive) for real income position in old age. This includes politically determined developments like social security rules in case of illness and long-term care, in particular how much from the individual budget elderly persons have to finance. This is highly relevant because in health and long-term insurance as well, there is a tendency towards more privatising respectively to reduce the level of public activities. However, public – as well as academic – debates are highly fragmented. An integrated view in old-age security is missing. The "reform" measures are debated mostly irrespective of their cumulative effects on the individual/household level. The notion of "reform" in Germany at present is not seen as a chance, but more as a danger. What social security should also realise, a fee-paying for security, is more and more missing in the perception of the public. Therefore, "sustainability" should not – as it is done today – be focussed in public expenditure and its financing, but should be viewed in a much broader sense, trying to realise "political sustainability". This, however, needs a policy approach that is far more comprehensive than usually.

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