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1 Executive Summary

The part on pensions starts with some information on the structure of pension schemes in Germany and fundamental reform measures implemented in the recent years. Last years` financial development of the statutory (social) pension insurance (SPI, up to now by far the biggest element) was positive – surplus in the budget and the possibility to reduce the contribution rate in the beginning of 2012. But pension adjustment rate remained very low because of several (political decided) factors that cut the link between earnings and pension development. Real pension adjustment rate and real pension benefits were negative not only because of the inflation rate but also because of higher contributions to the social health insurance scheme. Besides already existing factors which influence the pension adjustment rate, an additional element may become important in particular for a comparison of pension benefits and means-tested basic transfer payments to avoid poverty. The adjustment rates of these two types of social benefits are linked to different variables. It is not unrealistic to assume that pension adjustment rates will often be lower and therefore the probability that pensions or pensioners will fall below the poverty line rises. Future poverty in old age has meanwhile become a much-discussed topic. The Federal Ministry of Labour started a "dialogue" with relevant actors on this topic and made accordant proposals. One such proposal is to introduce a new (means-tested?) basic transfer payment for persons with long insurance records in the public and the private schemes as an instrument to cope with the problem of rising poverty in old age. The outcome of this dialogue is still uncertain. Another topic of discussion is the increase of the "standard" retirement age stepwise from 65 to 67, starting in 2012 as well as the adjustment of disability pensions to new rules of old-age pensions. Many critical reports were published on the experiences made with subsidised private pensions that now exist for 10 years. Due to a rising number of insurance contracts it is officially seen as a "success story" though neglecting important negative social and distributional effects. Although fiscal sustainability in particular of the SPI scheme is underlined by model calculations, it remains an open question whether a pension strategy dominated by the development of contribution rates and not benefit levels will be socially (politically) sustainable, too. The final part of the "pension report" deals in particular with the aspects of older workers/pensioners on the labour market and the transition from worker to pensioner.

The health reform GKV-FinG of 2011 has overcome some shortcomings of the previous health reform of 2007. Competition between SHIs has been further increased. Some SHI have even become bankrupt in 2011. However, still SHIs are almost unable to pass on this strong competition to the health providers because there are only few possibilities for selective contracting between SHIs and health providers. Currently, the SHIs receive risk-adjusted per-capita premiums from the health fund. The health fund, in contrast, collects income-dependent contributions from the SHI-insurees, i.e. the purpose of the health fund is redistributing income such that every citizen can afford a social health insurance. From this perspective the SHIs' revenue structure is already optimised.[1] Hence, any further reform of financing health care expenditures will only change intra- and inter-generational income distribution and increase or decrease income redistribution. Nevertheless, further reforms will be necessary in the future to finance growing health care expenditures. Even more important are reforms of how health care is provided. In 2012 the health reform GKV-VStG[2] has mainly addressed the

[1] There might be still ways to optimise the kind of risk-adjustment. But this would not be a fundamental change.

[2] GKV-Versorgungsstrukturgesetz: Law on Health Care Structure.

problem of a shortage of physicians in rural areas. E.g. it has introduced a more flexible remuneration system for general practitioners and resident medical specialists and a more flexible planning of the supply of physicians in the outpatient sector which helps to better identify a local lack or a surplus in the supply of physicians. As a consequence of this reform we expect a reduction of the shortage in the supply of physicians in rural areas in the medium term. However, it is improbable that it will help to reduce health care expenditures. In contrast, it rather increases expenditures because of additional costs for physicians.

In the case of LTC, no reform progress has been made in 2011. However, the debate on reforming LTC has started in 2011 and reforms are expected in 2012. There is a need for expanding the benefits of the LTCI to people with dementia and for increasing benefits according to price inflation to avoid growing poverty of people in need of care. However, the number of payers to the LTCI will diminish in the future. Thus, there will be a financial gap in LTCI – assuming that the economy, on average, will grow as in the past. There are suggestions how to close this gap in the long-term with an optional additional private LTC insurance with capital accumulation and tax subsidies. In the scientific debate other solutions are discussed as well e.g. (i) reducing the benefits for LTC, (ii) increasing the contribution rate to LTCI, (iii) increasing the contributions of high-income insurees, (iv) abolishing private LTCI to strengthen social LTCI.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

Pay-as-you-go financed social insurance has got a better standing in public opinion compared to capital funded schemes which, in former years, have been strongly promoted by many actors.

Important for the recent financial status of social insurance schemes in Germany was a positive economic development that stabilised the revenue basis. The long-lasting low interest rates become more and more a problem in particular for life insurance companies which have to guarantee a minimum interest rate (although this minimum requirement (*Garantiezins*) was and has been once more reduced). In general, the financial crisis is a major reason for pessimistic expectations within the population regarding their own income in old age.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The structure of pension schemes in Germany

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

- mandatory basic pension schemes for different groups of the population as the first tier,

- occupational schemes as the second tier and

- voluntary private arrangements for old-age provision as the third tier.[3]

Germany had no general minimum pension, instead, a means-tested social assistance for all persons below a certain poverty line is provided. Since 2003, however, a new element similar to a *zero tier* exists as part of the pension schemes – a means-tested transfer payment in case of insufficient income for persons aged 65 and older, as well as for disabled persons (*Grundsicherung*). The benefit amount is calculated in the same way as the already existing means-tested social assistance.[4]

Regarding the first tier, social (statutory) pension insurance (SPI) is from a macroeconomic point of view still by far the dominating source of income in old age (at least on average). It covers, in principle, all blue and white-collar workers (including miners[5]), but also some groups of self-employed. It is PAYG-financed with only a very small (in fact inadequate) reserve fund. Financing stems mainly from earnings-related social insurance contributions (paid in equal percentage by employers and employees), but also from federal budget tax revenues.[6] Until recently SPI-Pensions used to be a defined-benefit type of pension. In general, pensions are allocated for insured persons in case of "old age" and disability as well as for widows/widowers and orphans. In addition expenditure for rehabilitation is also available ("rehabilitation before pension").

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

Occupational pension schemes are the *second tier* of the German pension system. These are in general *voluntary* in the *private sector.* A great variety exists in the design of these schemes. Traditionally, pensions were mainly defined-benefit, employer-financed and "capital-funded", but not necessarily linked to the capital market, because the major part of existing pension claims is still based on direct commitments of the employer (*Direktzusage*) and based on book reserves. Mainly for this type of occupational pension claims, a mandatory insurance of employers is in place (Pension Protection Fund, *Pensionssicherungsverein*), covering in case of insolvency of the company pension claims up to certain, but very high limit. However, a shift towards other types of occupational pension arrangement that are linked to the capital market as well as towards being financed mainly (directly[7]) by employees (and no longer employers) and towards defined contribution instead of defined benefit takes place. This is in particular due to a newly obtained right of the employees – introduced in 2001 – to use earnings up to a certain amount to accumulate an occupational pension claim ("earnings

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

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

[5] Here different rules exist as well as a high percentage of tax-financing.

[6] In particular covering those expenditures aims an interpersonal redistribution of income within the scheme.

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

conversion", *Entgeltumwandlung*), without paying income tax and social insurance contributions on this particular amount.

Occupational pension schemes for wage and salary earners in the *public sector* are based on collective agreements. These pensions were in the past linked to the development of the social insurance pensions and to the civil servant's pensions.[8] Meanwhile, this link has been abolished and according to a new collective agreement, there will be a change from defined benefit to defined contribution.

The *third tier consists of* a great variety of *voluntary* capital-funded additional types of savings for old age, some with risk pooling (life insurance), and other without such insurance elements, and some types are tax-privileged. Recent public debates concentrate on those private pensions that fulfil certain requirements (and then will be certified) as a precondition for a subsidy (these are labelled according to the name of the Federal Minister of Labour and Social Affairs at time of implementation: "*Riester Rente*"). One of these requirements is that at least the nominal value of the contribution payment should be guaranteed (zero rate of return). Beside such tax-privileged types of savings for old age many other savings without such subsidies exist, however, it is difficult to say whether these are really destined for old age.

Structural reform

It has been an explicit political goal of the German government to change the pension landscape by shifting the financing of pensions towards private pensions and capital funding. This change should in particular be achieved by reducing PAYG financing by scaling down social pension benefits, as well civil servant's pensions, and giving incentives to save in capital-funded schemes.[9]

Regarding SPI (social pension insurance), target values for the contribution rate have been decided: not higher than 20% up to 2020 and not higher than 22% up to 2030. Several measures have been taken (in particular a redesign of the formula to calculate and adjust pension benefits) in order to realise this in the process of population ageing, resulting among others in a stepwise reduction of the net pension level (i.e. net pension compared to net earnings on average by 2030 by about 25%). The emerging gap in income in old age is intended to be closed by private voluntary, but subsidised pensions. This intention is, however, far from being realised because of inadequate coverage and insufficient amount of savings.

The new German pension strategy has been mainly implemented by pension reform measures in 2001 and 2004.[10] A much debated additional reform measure was and still is the increase of the "standard" retirement age, i.e. when an old-age pension can be claimed without deductions from the full pension. This retirement age will be increased gradually from 65 to 67, starting in 2012 and according to present decisions presumably accomplished by 2029.

Changes within SPI (regarding, for example, the level of benefits and retirement age) will, in principle, also become effective for civil servants' pension schemes. Such schemes exist at the federal level (*Bund*) as well as at the level of the 16 states (*Länder*). In April 2009 the federal

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

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

[10] This is discussed in Schmähl (2011a).

government published its report on public pensions (*4. Versorgungsbericht*), underlining the gradual development towards full capital funding of federal civil servants' pensions.

2.2.2 Debates and political discourse

Financing of SPI

According to model calculations (projections) made by the government[11] and the statutory pension insurance agency, the financial conditions of the SPI scheme in 2011 and in the next 15 years look rather positive. In 2011 there will again be a surplus in the budget which will be even higher than in 2010.[12]. According to the existing rules, the contribution rate in 2012 is reduced from 19.9% to 19.6%, and by 2015 further reductions are expected (2014 and 2015 19.0% each). This in particular is welcomed by the employers' organisations, while trade unions in principle are in favour of a constant contribution rate in order to improve pensions.

Pension adjustment rate

In July 2011 a positive rate of increasing pension benefits has been observed, while in 2010 these benefits remained unchanged in nominal terms. However, based on the new rule prohibiting the reduction of pension benefits in absolute terms (which was eventually caused by different factors of the pension formula as well as an absolute reduction of the average gross wage rate), a process of compensating the effects of not realised negative pension adjustment rates caused in the past years has recently started. This means that in case of a positive adjustment rate resulting from the pension formula, this rate will be cut by 50%, for as long as it is necessary in order to realise the compensating effect. Therefore the adjustment rate resulting from the pension formula was reduced in 2011 by 50% to cover the extra expenditure from the not realised negative pension adjustments. So instead of an adjustment rate of 1.99% (West Germany) pension benefits were only increased by 0.99% (in East and West Germany). This effect will also take place in July 2011, expecting the adjustment rate to be 2.3% in West Germany (instead of 4.6% according to the existing formula). Hence, pension adjustment rates are below the average gross wage adjustment rate and this will further reduce the benefit level of pensions compared to wages.

Additional effects regarding the development of net and real pension benefits

In January 2011, the contribution rate in statutory *health* insurance has been increased from 14.9% to 15.5%. While the *gross* social insurance pension benefit has remained constant in nominal terms from July 2009 to June 2011, the increase of the contribution rate for health insurance reduces *net* pension benefits. In the future, the contribution paid by SPI to health insurance in favour of the pensioners will not be – as in the past – half of the contribution rate. It will (like the employer's contribution rate) remain constant. Therefore, all increases in the health insurance contributions rates[13] will be paid exclusively by pensioners (as well as employees) and will reduce net pension benefits.

The German government also plans to increase the contribution rate for long-term care insurance which is fully paid by pensioners and thus reduces additionally their net pension benefits.

[11] BMAS (2011), Rentenversicherungsbericht 2011, Genzke (2011).

[12] Surplus 2010 2.1 billion EUR, 2011 4.4 billion EUR; see Rische (2011).

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

The increase in consumer prices in 2010 was only 1.1% (compared to 2009). This already reduced *real* pension benefits in absolute terms because of constant gross and sinking net pension benefits. According to the Federal Statistical Office in 2011 consumer prices increased by 2.3%, which is much higher than the pension adjustment rate of about 1% in July 2011. Therefore once more real pension benefits decreased. A general question, however, is whether the general price index gives an adequate picture of price increase for pensioners. Although the existing empirical data is not yet sufficient to prove it, arguments that make the assumption of an even higher inflation rate for pensioners are plausible.[14]

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

The Federal Constitutional Court has recently demanded a change in the adjustment procedure of basic means-tested transfer benefits (relevant also for the basic means-tested benefit for people in old age or with disability, the so-called *Grundsicherung*). In recent years, the development of this transfer payment was linked to the pension adjustment rate between the years of a new income and expenditure survey (*Einkommens- und Verbrauchsstichprobe*), which takes place every five years. The court demanded a change because this link was not seen as adequate (the reasons for this are not discussed here). The government and parliament reacted and the link between the basic transfer payment and pension adjustment rates was abolished.[15] Now the transfer payment is instead linked to the development of a specific price index and average net earnings in the years between the new statistical survey.[16]

If the means-tested transfer payment is adjusted by a higher rate than pension benefits from SPI (because of the specific design of the pension adjustment formula, so that pensions are increasing at a lower rate than earnings), it can make more and more pensioners eligible to claim the means-tested benefit, as otherwise they would fall below the poverty threshold.[17]

Retirement Ages

Although the stepwise increase of the standard *retirement age* (that means the age for claiming a pension without deductions from the full pension) started in 2012, it is still discussed whether this is and will be compatible with the labour market conditions and employment chances for older workers. Above all, trade unions and organisations representing, in particular, older people (*Sozialverbände*) are still fighting against this measure. However, the government had not shown any signs of changing the former decision.

Federal government underlined the fact, that average retirement age has increased in recent years (between 2000 and 2010 - about 1 year for both men and women) and the employment for those between 60 and 64 raised from 20% in 2000 to 41% in 2010.[18] As an additional argument it is now pointed out, that the increasing employment of elderly workers helps to cope with the expected lack of manpower (other sources are seen in the public debate in higher employment rates of women and more migrant workers).

In its report of November 2010 the permanent Social Advisory Board of the German government (*Sozialbeirat*) gave an overview of the arguments in favour and against an increase in retirement ages. The members of the board – mainly representing the trade unions

[14] This is one of the topics not much discussed in Germany regarding the development of pensions during the period after retirement, see Schmähl (2010a).

[15] Gesetz zur Ermittlung von Regelbedarfen und zur Änderung des Zweiten und Zwölften Buches Sozialgesetzbuch vom 24.3.2011, BGBl., Jg. 2011, Teil I, Nr. 12.

[16] The price index has a weight of 70%, the earnings development of 30% for this specific adjustment rate.

[17] More regarding this topic is Schmähl (2011a).

[18] BMAS (2011), p. 70.

and employer's organisations – still have different opinions on this topic. However, they all underline that demographic change will not automatically improve labour market conditions for older workers.[19]

In the public debate it is often not fully recognised, that many – and over time more and more – pensioners retire even before the standard retirement age, thus receiving reduced pension benefits. The number of pensioners who have to bear deductions from the full pension as well as the relative reduction from the pension benefit has remarkably increased. The following Table gives some information on this.

Table 1: Pensions with deductions in Germany

	Old age pensions			
	Men (West)	Men (East)	Women (West)	Women (East)
number of pensions with deductions (%)				
2001	25.3	38.1	28.2	58.5
2010	40.5	43.4	45.1	79.1
reduction of pension benefit (%)				
2010	-17.4	-17.6	-20.6	-22.0

Source: DRV, Rentenversicherung in Zeitreihen, October 2011, pp. 70-71 (in part own calculations).

Whether deductions from the full pension will become even more important in the process of increasing retirement ages depends on numerous factors. The already visible effect should, however, be taken into account when e.g. the adequacy of income in old age is discussed. The focus on a "standard pensioner" with a pension benefit at the "standard retirement age" neglects the heterogeneity that exists in reality.

Changing the conditions for disability pensions

Not only old-age SPI-pensions will become relatively lower over time (because of the decided reduction of the general benefit level and lower individual pension claims). The newly calculated disability pensions are as well based on much lower pension claims expected in the future. In 2001 an average male disability pensioner in West Germany received 38.1 earning points but only 32.6 in 2010 (a reduction by 14.3%, while the pension claims for old-age pensions for male pensioners in West Germany were on average only lower by 3.9%).[20] Here the coalition government plans additional measures, which will be financed by contribution revenue. Among them is the proposal to upgrade earnings in a period before disability takes place if here a reduction in earnings takes place.[21]

Extending mandatory coverage in statutory pension scheme[22]

This is still particularly being discussed in respect of those self-employed persons who are not yet mandatorily covered by one of the existing pension schemes. The question is whether there should only be mandatory coverage in private schemes or also in SPI. There are many

[19] See also several contributions in DRV Westfalen (2011).
[20] Own calculation based on data in Deutsche Rentenversicherung, Rentenversicherung in Zeitreihen, Oktober 2011, pp. 112-116.
[21] For details from the point of view of pension insurance agency see Buntenbach (2011) or Rische and Kreikebohm (2012).
[22] This topic is also discussed in German health insurance (Bieback 2010).

arguments in favour of integrating these persons into the SPI (Fachinger, Oelschläger and Schmähl 2004, Ruland 2010), but the heterogeneity of this group needs special attention (discussed also in Fachinger and Frankus 2011).

There are calculations that an integration of these self-employed persons into the social pension insurance scheme may reduce the contribution rate for several decades (Windhövel et al. 2011). However, the main argument and aim for covering those persons is to avoid insufficient income in old age and poverty in the case of long spells in the earnings career without adequate saving for old age. Obviously, no constitutional restrictions in covering those persons in social pension insurance exist (Ruland 2010), and it seems that the political intention to decide upon activities on this topic is growing. The coalition government, however, is discussing whether there should be an obligation for mandatory coverage in any pension scheme (public or private) or whether these persons should become members of the SPI scheme.[23]

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

Private pensions

In particular life insurance companies have to cope with the long-lasting low interest rates. A major aspect is that life insurance companies have to guarantee a minimum interest rate for new contracts (*Garantiezins*). This rate for new contracts was reduced over time from 2.75% in 2004, to 2.25% in 2007 and 1.75% in 2012. In addition also the surplus interest rate which companies are paying beyond the guarantee interest rate is reduced, and therefore in general the rate of return of private life insurance is decreasing.

Subsidised private pensions

10 years after introducing subsidised private pensions (the so called *Riester-Rente*) a critical discussion took place. It is argued that the official goal of supplementing SPI pensions – to close the pension gap because of declining SPI pension level – is far from being realised.[24] The new pension doctrine established in 2001 and the following years (irrespective of the type of coalition government) has caused – as can be already seen – a number of highly problematic effects regarding social security as well as income distribution.[25]

The costs of private pensions are still discussed, although subsidies exist.[26] It is still complicated for employees to decide which type of pension saving is the best, due to lack of transparency, for example, regarding costs.[27] Also, the rules for taking up a subsidy are not transparent enough, so that persons can simply lose the subsidy because of not reacting in a proper manner. Therefore, in May 2011, the government decided to change at least the specific rule about the necessary own contribution rate to avoid unintended negative effects.

[23] There will be in any case difficult transitory rules to be decided.
[24] Blank (2011).
[25] Discussed in Schmähl (2011b).
[26] Die Ratlos-Rente, in: Tagesspiegel 21/22 April 2011.
[27] See among others Hahn and Neumann (2011).

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

A new proposal to avoid poverty in old age

For a long time it was officially denied that private savings are useless for the person saving. But, if total income remains below the poverty line and means-tested *Grundsicherung* is necessary, then the means-tested transfer payment is lower compared to a situation without private saving, though income in both cases remains the same. Meanwhile this fact can no longer be ignored. As an instrument to avoid poverty, in particular for persons having a long insurance record, the Federal Ministry of Labour proposed in autumn 2011 an additional (also means-tested) transfer payment (*Zuschussrente*) which is higher than the already existing *Grundsicherung*. Among the preconditions for receiving this additional payment is a high number of years of insurance in the SPI scheme as well as a high number of years of private (subsidised) pension saving. In this case the coverage rate for private (subsidised) saving shall be obviously increased.[28] The proposed instrument was very much criticised, among others because of not affecting those groups that need additional income most, e.g. long-term unemployed persons and those working for a long time with (very) low wages. However it still remains unclear whether this instrument will be introduced and under which conditions. In particular the type of financing remains undecided. Such a transfer payment has to be financed from general taxation and not earnings related contribution revenue, if the contribution-benefit link shall not be weakened. But taking the situation of public budget and the increased sum of public debt into consideration (see below), there will be much resistance by the Minister of Finance to give additional money into the SPI scheme. It can, however, be expected, that the coalition government will propose measures which are intended to cope with the problem of future poverty of pensioners. Nothing can be said about its effects yet, because it depends on the conditions of the measures etc. It is quite likely that the government will try to finance such a transfer payment mainly by contributions and not from general taxation.[29]

Still existing differences in pension law between East and West Germany

Twenty years after the German unification differences in rules, in particular also in parameters of the pension formula between West and East Germany still exist. The coalition government announced to come to a solution, however, no decision has been taken yet (some information on this topic was given in the ANR for the year 2009). Although the coalition government had announced its wish to deal with this topic within the current parliamentary period (until 2013), a solution of this complicated topic, which is also often linked to a rather optimistic expectation by actors in East Germany regarding its effect on pension benefits, has been postponed.

It is necessary that any equalisation of rules has to be done in such a way that all elements in the pension scheme which are still different in East and West have to be taken into consideration, as well as the effects for employees and pensioners in both West and East Germany.

[28] Gunkel (2011) gives an overview.
[29] This instrument is e.g. also discussed in Sozialbeirat (2011).

2.2.3 Impact of EU social policies on the national level

Even in 2011 it is obvious that the national pension policy is directly and indirectly influenced by developments at the European level. All types of institutions in the area of old-age security are affected.

Looking at 2011, there seems to be no *direct* effect regarding SPI. How much indirect effect exists, for example by providing arguments for specific decisions and by the process of the OMC, is difficult to say. Life insurance companies and several types of occupational pension schemes are affected by new rules on regulation. Moreover, the need to calculate unisex tariffs is a much debated topic. The European Court of Justice decided on March 2, 2011 that unisex tariffs have to be implemented by the end of 2012.

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

A common position of all relevant actors is that pension policy should remain the responsibility of national authorities, although exchange of information, etc. is highly welcome. Nevertheless, there is some fear of a growing influence of the EU in this area, in particular after the increased role of budgetary aspects. The EU's influence in general and the process of increasing transfer payments between the EU member states in particular have revealed a remarkable sensitivity of this topic in the public debate.

2.2.4 Impact assessment

Increasing the "standard" retirement age

The process of increasing the pensionable age started in 2012 (see above).[30] The next focus in the debate may be on possibilities of (more) flexibility in retirement ages, particularly on combining (partial) pension and part-time work (see for example Kreikebohm 2010). This topic is not new at all but it could now also be a helpful element to overcome opposition against extending working lives. For many years an option for partial pension has existed in Germany, but this has not been a success yet. Reformulating the conditions for taking up a partial pension next to labour income could be a useful element in a strategy to extend the working life and to create options, particularly for those who are not able to work longer on a full-time basis.

The rules on combining pensions and earnings from employment in case of an "early" retirement (prior to standard retirement age) are now once more under discussion. The Federal Ministry of Labour has presented in autumn 2011 (together with its proposal for a special transfer payment for long-time insured persons) some proposals for better combining the two income elements.[31]

Today a rather complicated rule for earnings ceilings while receiving a pension (*Hinzuverdienstgrenzen*) exists. They are linked to the three steps for partial pension (1/3, 1/2 or 2/3 of the full pension). The proposal of the ministry is to introduce individualised earnings

[30] There are also decisions aiming at a reduction of early retirement.
[31] See e.g. Gunkel (2011) for details.

ceilings linked to former individual earnings. This could be an element of more flexibility in retirement and also an instrument for early retirement.[32]

Regarding the extention of working life a higher attention should be paid to preventing illness and disability as well as to developing rehabilitation measures, in order to maintain or to improve the employability of workers and to enable them to stay longer in the labour market, provided that employment opportunities exist.

The special rule for those pensioners with an insurance record of 45 years to retire also in the future at age 65 without a deduction from the full pension – introduced in the political decision process of raising the "standard retirement age" – is often criticised. These persons will get in principal higher benefits from their contribution payments compared to all other insured persons who will be "burdened" by deductions from the full pension in case of "early" retirement before the standard retirement age.

In May 2011 the German Council of Economic Experts (*Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung*) proposed a further increase of the (standard) retirement age beyond 67, linking the retirement age to the increase of life expectancy. According to projections of the Council, in 2045 a retirement age of 68 and in 2060 of 69 is deemed to be necessary (Sachverständigenrat 2011).[33]

Emerging poverty in old-age

All available indicators show that old-age poverty in Germany is *currently* relatively low compared to some other population groups and also in comparison with many other countries. In addition to the indicators for (international) comparisons agreed upon in the EU, an "official" poverty line, which is decisive to become eligible for receipt of specific means-tested social benefits exists in Germany. Since 2003 elderly (65+) and disabled persons are eligible for a specific means-tested benefit, a so-called "basic income in old-age" (*Grundsicherung*; similar to social assistance), which can top up the income up to the (household-specific) poverty line.[34]

In the past, the "dynamic" social insurance pension scheme contributed to a high degree to old-age poverty alleviation. A quite different story is how pensions and pension policy contribute to the objective of reducing poverty in the future. The opposite may be the case. An important effect of the reduction of the net social pension level will be a growing number and a higher ratio of pensioners receiving pension benefits from social insurance which are below the existing means-tested "basic income in old age" in the future. The general decrease of the benefit level works together with effects on the amount of individual pension claims because of unfavourable labour market conditions, e.g. long spells of unemployment for many employees and often low earnings.[35] The coverage and the amount of occupational and private pensions are by far not high enough to compensate the loss in the level of public pensions.[36]

Meanwhile, a public debate about rising old-age poverty in the (near) future has started and the Federal Ministry of Labour presented a proposal to deal with this topic (as mentioned above). But as revealed in the debate, this would not be an adequate element, because main groups of population that may be at risk of poverty will not be affected, for example long-term

[32] See Sozialbeirat (2011) and Rische and Kreikebohm (2012).
[33] In this sense also Clemens (2011) who is employed in the Department of public finance of the German Bundesbank.
[34] Last year's ANR presents data.
[35] See for example Geyer and Steiner (2010).
[36] Hagen (2010).

unemployed and those with low wages.[37] It is an open question what the government will present as a result of the "pension dialogue" which started in autumn 2011. In the beginning this dialogue was named the "government dialogue", but other ministries obviously were not involved, in particular the Ministry of Finance. If the measures agreed on aim at interpersonal redistribution, these might have to be financed from general tax revenue instead from earnings related contribution revenue.

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

Apart from the recent suggestions of the Ministry of Labour several proposals on how to prevent poverty in old age (by measures on the labour market) or to cope with this problem after retirement already exist.[38] Beside the effects on income in old age the consequences for the concept of social insurance should also be taken into consideration.[39] Some proposals – if realised – would increase the degree of interpersonal redistribution within the social pension scheme. Taking into consideration the strain in tax-financed general public budgets as well as a new constitutional rule to limit public debt by a "(public) debt brake" (*Schuldenbremse*), it can be expected that additional redistributive measures in social insurance will not be adequately financed by tax revenues but from earnings-related social insurance contributions. Together with the decreasing pension level, a creeping transformation of the social insurance system will then take place – from a scheme with a relatively close link between contribution payments and subsequent pensions into a redistributive transfer scheme.

Depending on the instruments used in order to avoid old-age poverty, this could therefore be an element which gives a push for changing the structure of the public pension scheme and shift it towards a more interpersonal redistribution by integrating, for example, minimum elements into the scheme. This would take place in a silent process because of the so called "parametric" changes that result into "structural" changes.

How many pensioners will live in households with an income below the poverty line depends, however, not only on the rules set in pension policy and labour market conditions, but also on the structure of households and the income of all its members. It can be expected that the income of married women will, due to increased female labour market participation and pension claims for care responsibilities for children or parents[40] (which is not yet visible in the data), increase in relative terms. Nevertheless, without changes in the pension policy an increase in poverty among the elderly can be expected. This may, as mentioned above, become an important element for political sustainability of pension arrangements.

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

- No further reduction of the general pension level of the social insurance scheme as a core element of a strategy in pension policy.[41] This may preserve earnings-related public pensions providing higher pension benefits than basic means-tested social benefits for people employed on a long-term basis. There are indeed ways to finance a higher pension level. A higher level

[37] Sozialbeirat (2011).

[38] See among others Schmähl (1993), Hauser (2009), Meinhardt (2011), Klumpmann (2011).

[39] See also Bäcker (2011) for different approaches to deal with the problem of poverty in old age.

[40] See Riedmüller and Schmalreck 2012. The expert commission on gender equality (Bundesministerium für Familie 2011a) is demanding more pension claims in case of caring for persons who need long-term care.

[41] At the Party Congress of the Social Democratic Party in December 2011 the left wing of the party was not successful in getting a decision of the party to stop the further reduction of the SPI-benefit level.

of social insurance benefits would reduce the need of high additional private savings that pushes pension costs for private households over the necessary limits to finance the same income in old age mainly from pay-as-you-go financed pensions.[42]

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

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

2.2.5 Critical assessment of reforms, discussions and research carried out

Legitimacy of SPI in the future

In the discussion of increasing retirement ages and preventing poverty in old age critical aspects have already been mentioned as well as effects regarding the general political strategy in the German pension policy that shall not be repeated here. Meanwhile also the BAGSO –an umbrella organisation of a great number of German federations representing actors and person of welfare organisations (*Sozialverbände*) – underlined that SPI must provide pension benefits after a longer earnings period that is clearly above the level of means-tested transfer payments. Otherwise the SPI scheme will lose legitimacy in the future (BAGSO 2011). The expert commission for the first report on gender equality in Germany underlined among others the important role of social insurance. As mainly here measures of social equalisation exist, this "pillar" of the pension scheme should be strengthened.[43]

Fiscal and political sustainability

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

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

[42] This is outlined in Schmähl (2011b).
[43] Bundesministerium für Familie (2011a).

SPI-pension formula

Since 2001 the present SPI pension formula for adjusting pension payments has become more and more complex,. The effects caused by changing demographic or economic conditions are uneasy to understand and difficult to anticipate. Meanwhile, some proposals exist on how to create a formula that is much simpler, but which would have the same effects on contribution rate and benefit level that are intended to be realised by the decided reform measures of the government.[44]

Currently, several proposals are made to end the downgrading of the general pension level, as it will also take place in the years to come. A central element is the design of the pension formula. A rethinking in pension policy is not only argued to avoid poverty but also to reduce the financial burden of private households. One of the effects of the partial shift from pay-as-you-go financing (SPI) to "capital funded" private pensions is a higher overall contribution rate, compared to the contributions necessary to finance a specific level of income mainly from SPI. Recently, some proposals on replacing the former earnings from employment with social pension benefits have been made and these may again become an important objective of pension policy (Schmähl 2011a, Dedring et al. 2010). But until now, no political support for redefining pension policy in Germany can be seen yet.

Subsidised private pensions

10 years after the political decision to create a subsidised private pension, which shall compensate the effect of downgrading public pensions, a critical discussion took place in recent months. Contrary to the rather optimistic view of official representatives, which underline the growing number of saving contracts, empirical research gives a rather pessimistic view regarding its social and distributional effects. These empirical results are far from reaching the original political goals. Papers that give an overview of present knowledge are from Rieckhoff (2011) and Hagen and Kleinlein (2011).

"Crisis", Public debt and pension policy

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

Therefore, the effects of fiscal and political measures to cope with "the crisis" may speed up a process of converting an insurance scheme with a relatively close contribution-benefit link, intended to substitute former earnings and smoothen income and expenditure over the life cycle, into a public transfer scheme with relatively low pension benefits, aiming mainly to avoid poverty in old age or in case of disability.[45]

The European Central Bank (ECB) calculated for the period 2009-2010 an increase in public debt of 12.7% of GDP in Germany (without contingency liabilities that may additionally burden the budget by 8.1% of GDP). According to the German Federal Ministry of Finance the level of the public debt in 2009 was 74.4% of GDP, compared to 64.9% in 2007. From 2009 to 2010 it jumped up to 83.2%[46] underlining the rapid increase.[47] The ECB is (in

[44] See Gasche and Kluth (2011) and Hain, Weprek and Viebrok (2011).
[45] This is discussed in Schmähl (2011a).
[46] BMF (2012), p. 49.

general) anew demanding the governments to take comprehensive reform measures in national pension and health insurance systems in order to reduce the effect of a rising old-age dependency ratio on public budgets, due to negative effects, in particular on economic growth.[48] Additional strain on public expenditure, in particular social expenditure, can be expected.

Although at present the economic development is favourable towards its financing, the future of *public* pension schemes seems to remain gloomy, especially in respect of a strategy to redefine pension policy which has been politically decided at the beginning of the century.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Germany's health insurance system is characterised by the coexistence of a social health insurance scheme (SHI) and a private health insurance (PHI), both providing comprehensive health insurance. In 2010, almost 70 million people were insured under the SHI (BMG 2011c) and roughly 9 million under the PHI (PKV 2011).[49] While health insurance under SHI is mandatory for low- and medium-income employees, high-income employees and self-employed may opt for PHI. With few exceptions, civil servants are also insured under the PHI. The two systems of health insurance fundamentally differ. The SHI is characterised by a largely standardised statutory benefit package, premiums are independent of the individual's health risk and calculated as a fixed proportion of the insuree's labour income, which is 15.5% in 2011. Employers bear almost one half of it and children and spouses with no substantial individual labour income are co-insured without extra costs. In contrast, PHI premiums depend on the individuals' health risk and not on income. The benefit package is subject to an individual insurance contract and co-insurance of family members is not free of charge but requires an additional contract.

Only a small group of individuals is allowed to choose between private and social health insurance. Employees who earn more than 50,850 € per year in 2012 may choose. However, once opted for a PHI, this decision can be regarded as 'once-in-a-lifetime' because (i) switching back to SHI is strongly restricted by law and (ii) when switching between PHIs, risk-premiums are calculated again and they typically increase with age. In contrast, since 1996 there is the option to switch an SHI. Fierce competition between SHIs has led to a constant process of mergers that has reduced their number from almost 1,000 in 1995 to 146 at the beginning of 2012 (Figure 1). The process of mergers has recently gained additional momentum, as mergers of SHIs of different types were allowed by the health reform GKV-WSG[50] in 2007.

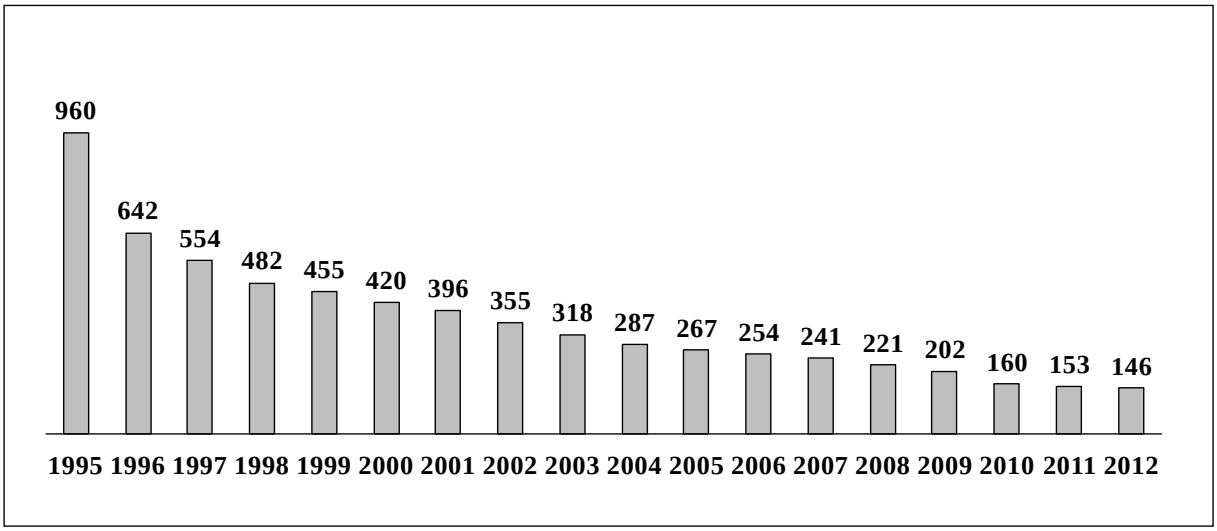
[47] EZB (2011), p. 73 resp. p. 70.

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

[49] Another three million people are covered by special governmental insurance schemes that operate outside the SHI system (KBV 2011).

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

Figure 1: Number of SHIs in Germany (at beginning of each year)



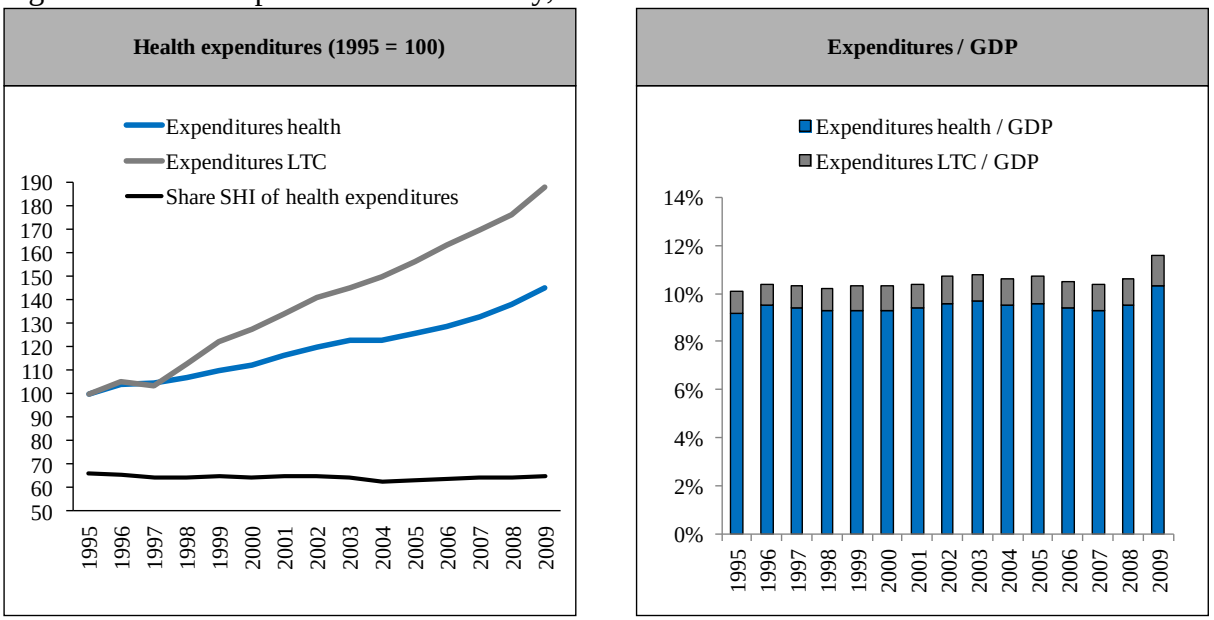
Source: GKV-Spitzenverband (2012).

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

Figure 2 displays total health expenditures[51], their share of GDP, and the share of SHI in total health expenditures from 1995 to 2009. Expenditures for health care and LTC are growing, their share in GDP has increased from 10.1% in 1995 to 10.7% in 2008 and to 11.6% in 2009 due to the large fall in GDP in 2009 which was an exception due to the financial crisis. Expenditures for LTC are faster growing than for health. Although increasing expenditures are most intensely debated with focus on the SHI, the SHI managed to reduce its share on total expenditures by roughly three percentage points during the considered period. This is most likely to be explained by past state interventions aiming at stabilising SHI expenditures.

[51] Deflated by the consumer price index.

Figure 2: Health Expenditures in Germany, 1995-2009

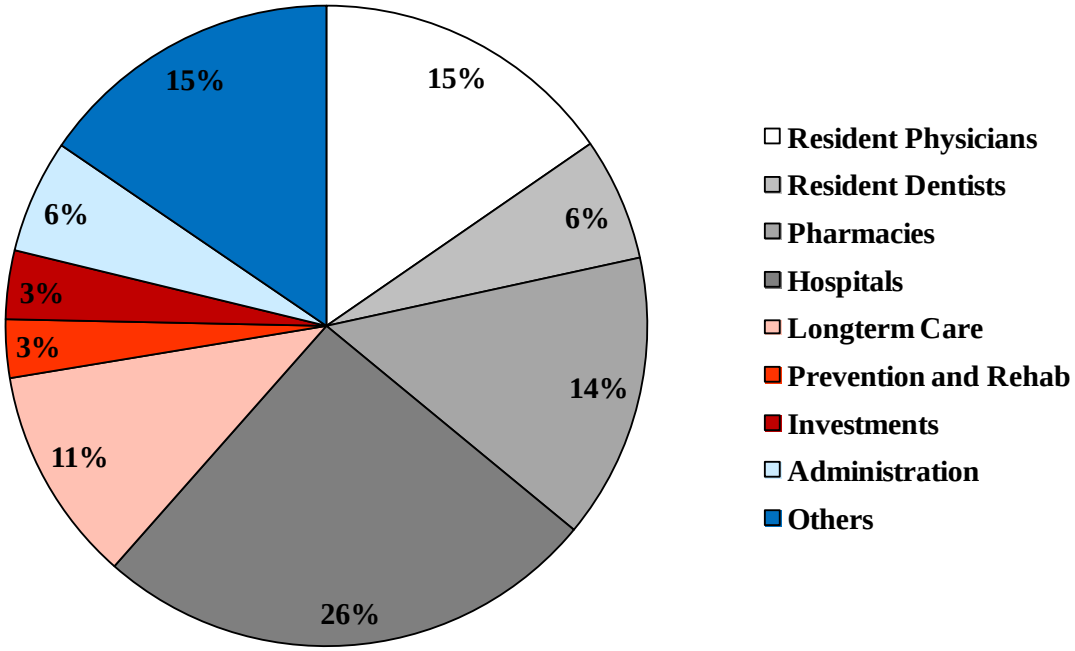


Source: BMG (2011c) and own calculations.

Figure 3 displays the structure of health care expenditures. Hospitals account for the largest share, which may explain why they are often considered the prime candidate for further cost reduction interventions. Nevertheless, resident doctors – taking general practitioners, specialists[52] with own practices, and dentists together – account for a share in expenditures of comparable size. Pharmacies (including pharmaceuticals) account for another 14%.

[52] In Germany, specialists not only work in hospitals but also in the outpatient sector.

Figure 3: Distribution of Health Expenditures in Germany, 2009



Source: Statistisches Bundesamt (2011a) and own calculations.

Until 2009, SHIs competed mainly[53] via their contribution rates, which were set individually by each SHI. This has been changed by the GKV-WSG in 2007. Since 2009, there is a uniform contribution rate fixed by the federal government. In 2011 it amounted to 15.5% of wage income. It is collected by a general health fund which redistributes its revenues to the individual SHI with allocation of funds depending on the risk profile of each SHI's enrolee. In consequence, the contribution rate is no longer an element for price competition. Yet, the SHIs are allowed to charge income-independent extra premiums if allocations from the health fund turn out to be insufficient for covering expenditures. Moreover, SHIs which spend less than they receive from the health fund may grant refunds to their insurees. The introduction of extra premiums has strongly increased competition between SHIs. In an empirical study Schmitz and Ziebarth (2011) find that the reform has led to a sixfold increase in an individual's switching probability.

In 2011 the health reform GKV-FinG[54] has introduced a mechanism to the SHI to adapt to future increases in health expenditures. Furthermore, it aimed at reducing an expected financial gap of the SHI in 2011 of around 10 billion €. Therefore, it was accompanied by several other regulatory interventions. The main changes of the GKV-FinG are the following (Augurzky 2010). First, it raised the general contribution rate to the health fund from 14.9% in 2010 to 15.5% in 2011, increasing revenues for the health fund by roughly 6 billion €. Second, it has frozen the part of the contribution rate paid by employers to 7.3%. Thus, further

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

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

increases of health care expenditures will lead to higher extra premiums paid by the insurees. Moreover, the government can increase the contribution rate paid by the insurees, which amounts to 8.2% in 2011.

Third, a compensation for insurees with low income was introduced. Until 2010, the extra premium was restricted to 1% of wage income, which was a disadvantage for SHIs with many low-income insurees. The new compensation takes place when the average extra premium over all SHIs exceeds 2% of wage income of an insuree. Most importantly, this compensation is paid by the health fund instead of the individual SHI. Therefore, elements of income redistribution have been removed from individual SHIs to the health fund which is an improvement to the previous system. In order to finance growing compensations due to growing extra premiums in the future, additional tax money will be provided to the health fund. What is more, it is not the individual extra premium of an SHI which is relevant for compensation but the average extra premium over all SHIs. Thus, the incentive to change from an expensive to a less expensive SHI remains also for low-income insurees. Both innovations are essential to make competition work in the presence of a cap on extra premiums. In sum, with this reform the economic incentives for insurees and for SHIs are equal to those of a system with full income-independent premiums and tax compensations for low-income insurees. Fourth, the general annual price increase for hospitals has been cut to 0.9% in 2011 and to roughly 1% in 2012. Thus, hospital expenditures for SHIs will increase less in these years than usual.

In addition to the GKV-FinG the AMNOG[55] aimed at reducing expenditures for pharmaceuticals. It is in line with previous reforms, aiming at capping costs, such as the GKV-ÄndG[56], which was passed in parliament in July 2010. Yet, the GKV-ÄndG introduced explicit measures to reduce costs, most importantly a mandatory discount of 16% on pharmaceuticals and freeze of prices of pharmaceuticals until 2013. In contrast, the AMNOG has introduced mechanisms of how prices of pharmaceuticals are determined. In Germany, pharmaceuticals have been subject to a system of reference pricing since 1989 (Augurzky et al. 2009). While producers are free in setting prices for any pharmaceuticals, the SHI reimburses costs only up to a reference price. Patients have to bear the price difference for any drug whose price exceeds the reference level. This sets strong incentives to producers not to set prices above the reference price.

However, until recently reference pricing only applied to generics and therapeutic substitutes, i.e. drugs that are already established. In contrast, newly invented drugs are excluded from reference pricing. In consequence, for such innovative drugs the SHI has to reimburse the full price, which is unilaterally set by the producer. It does not come as a surprise that high costs for newly invented pharmaceuticals are a matter of concern for the SHI. Exactly this issue is addressed by the AMNOG, which obliges producers to verify the additional medical value of an innovative pharmaceutical. If the producer fails to do so – compared to already existing drugs and therapies – even innovative drugs that use new active pharmaceutical ingredients are subject to reference pricing. Yet, even if an additional benefit exists, AMNOG does no longer allow for unilateral price setting by the producer. Rather, prices are subject to negotiations of the producer and the SHI. Indeed, in 2011 expenditures for pharmaceuticals sank by 2.8% or 800 million € (ABDA 2012).

[55] Gesetz zur Neuordnung des Arzneimittelmarktes: Law on the Re-organisation of the Market for Pharmaceuticals.

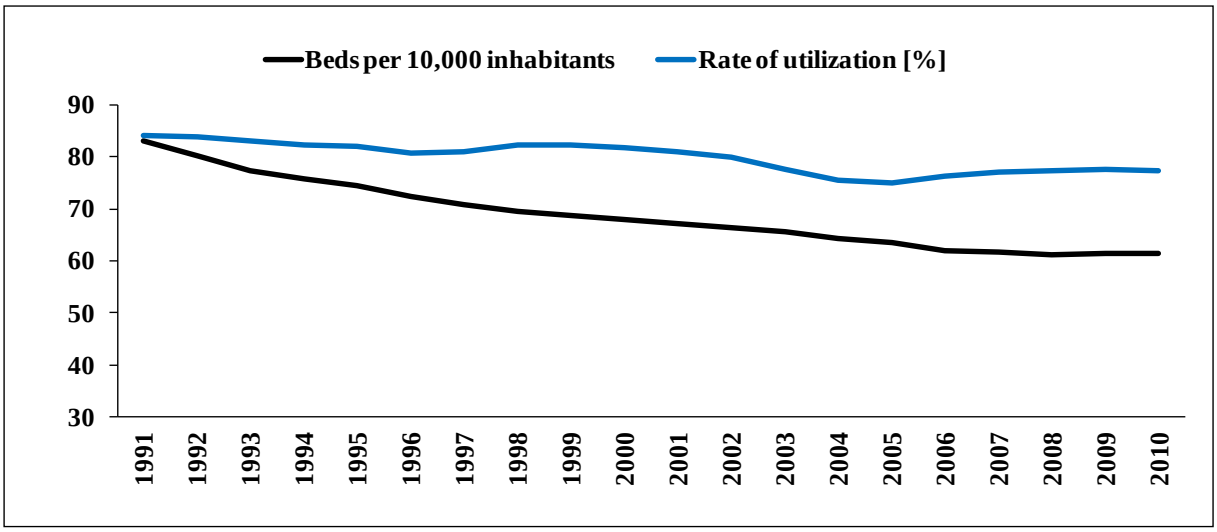
[56] GKV-Änderungsgesetz: Law on the Change of the SHI.

Access to health care

The health reform GKV-WSG of 2007 has largely eliminated the problem of individuals lacking any health insurance cover. Yet in Germany, even before this reform, this problem has never been a widespread one. Not only has the reform introduced the legal obligation to buy health insurance, it also guarantees that failing to pay premiums will not automatically result in the loss of health insurance cover. Hence, the number of individuals lacking any health insurance cover – apart from non-legal residents – is very low (Gress et al. 2009). However, inequality in terms of access to health care is frequently discussed with respect to individuals being insured with SHI or PHI. Since general practitioners and outpatient specialists are allowed to charge much higher prices from PHI patients, privately insured patients are often assumed to be first-class consumers. Empirical evidence suggests that waiting times are shorter for this group of individuals (Lüngen et al. 2008, Schwierz et al. 2009). However, there is also the presumption that PHI-patients get too much unnecessary medicine. Nevertheless, except for organ transplantations, no official waiting lists exist for medical services. In general, health inequality is likely to be less severe than in other industrialised countries.

Regarding the per-capita number of hospital beds for curative (acute) care in Germany, it is among the highest in the world (OECD 2011). In 2009, Japan was the only OECD country for which the OECD reported a higher number than for Germany, i.e. 8.1 compared to 5.7 beds per 1,000 inhabitants, while European countries such as the Netherlands (3.1), France (3.5) and Belgium (4.2) exhibited much smaller figures. Obviously, access to inpatient care is high in Germany. This holds true, although the number of beds is on a constant decline for several years – but also the length of stay in hospitals. Nevertheless, Augurzky et al. (2011b) argue that substantial excess capacities still exist with respect to hospital beds in Germany. Figure 4 displays the number of curative and psychiatric beds and their occupancy rate for 1991 to 2010.

Figure 4: Curative beds per capita and occupation rate in Germany, 1991-2010

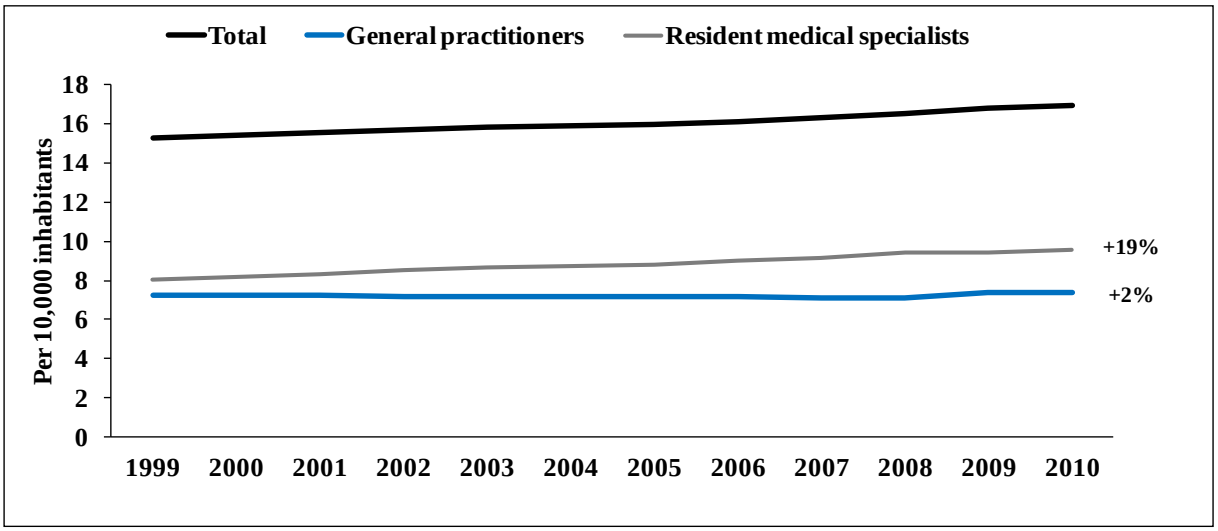


Source: Statistisches Bundesamt (2012).

While the number of hospital beds is high in Germany, the number of general practitioner is rather low. But that of medical specialists is relatively high and has constantly grown in recent years. This might reflect the fact that, in Germany, medical treatment occurs more often in hospitals or by resident medical specialists than in other OECD countries. This raises the

question of excess capacities, as in Germany treatment by medical specialists is provided through both the inpatient and the outpatient sector. Figure 5 displays the number of general practitioners and resident (outpatient) medical specialists per 10,000 inhabitants.[57]

Figure 5: Number of resident physicians in Germany, 1999-2010



Source: BMG (2011c) and own calculations.

2.3.2 Debates and political discourse

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

The discussion on shortages in rural areas has led to the GKV-VStG[58] that has come into effect in January 2012. It addresses various different issues (Augurzky and Beivers 2012), e.g. sustainable provision of outpatient medical services in rural areas, a more flexible remuneration system for general practitioners and resident medical specialists, innovative medical treatments, a reform of administrative structures, more options for SHIs to differentiate in competing with other SHIs, and more restrictions in founding larger outpatient units with employed general practitioners and resident medical specialist. Halbe et al. (2012) intensively discuss the new Law on Health Care Structure.

The following are examples from the GKV-VStG:

- More flexible planning of the supply of physicians in the outpatient sector[59] which helps to better identify a local lack or a surplus in the supply of physicians.

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

[58] GKV-Versorgungsstrukturgesetz: Law on Health Care Structure.

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

- Right of participation of the federal states in the discussion of planning the supply.
- The physicians' regional associations get more rights to buy physicians' licences in order to reduce a local surplus in the supply. In contrast, in regions with a lack of supply prices for medical services can be increased locally.
- Physicians do not have to live anymore in the city of their workplace. That means that they can live in an urban area with excess supply but work in a rural area with a shortage of supply.
- Physicians in hospitals and in rehabilitation clinics can also participate in the provision of outpatient services if there is a local shortage of supply.
- Delegation of physicians' duties is promoted.
- For highly specialised services in case of special or seldom diseases the law creates a new sector of so-called specialised outpatient treatments which can be offered by resident medical specialists as well as by hospitals.
- Innovations can be better tested in the future in order to evaluate their costs and benefits.
- SHIs get more instruments to differentiate in the highly competitive market of SHI.
- Founding larger outpatient units[60] with employed general practitioners and resident medical specialist is restricted to physicians and hospitals and a physician must be its medical director. Furthermore, stock corporation are not anymore allowed to found such a unit.

A still disputed issue is the so-called selective contracting of SHIs and providers of health care services. Typically, all SHIs contract together with all health care providers. Individual contracts between an individual SHI and an individual provider are not possible. This has been criticised as a severe barrier to competition. Although selective contracting has been permitted to a very limited degree since 2009, economists argue in favour of such contracts becoming the rule rather than the exception (Göbel and Wolff 2012). Yet, sometimes it is argued that the market power of large funds will lead to inefficient results if selective contracting becomes common. Moreover, the Association of Statutory Health Insurance Physicians, which negotiates collective contracts for resident physicians, argues that quality of treatment may deteriorate. See Paquet (2011) for a comprehensive discussion.

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

The general political debate about financing the health care system in Germany focussed on two alternative models for financing the SHI, i.e. (i) the so-called *Bürgerversicherung* (universal citizens' health insurance) and (ii) the so-called *Gesundheitsprämie* (per-capita flat-rate insurance) has been quiet in 2011 but will again be an issue in 2013 when there are general national elections. The first alternative is characterised by including the entire

[60] "Medizinische Versorgungszentren".

population and abolishing PHI and by contributions that depend not only on labour income but also on capital income. The second model is characterised by a uniform income-independent per-capita premium which is accompanied by a compensation of the low-income insurees such that they are able to pay the premium. All major parties currently in opposition, i.e. the social democrats (SPD), the Green Party, Die Linke party, as well as the trade unions are in favour of the first option. The political parties currently in power, the Christian democrats and the Liberals, back the reforms implemented by the GKV-FinG. However, prior to entering the government, the Liberals insisted on a more prominent role of private health insurance, while the Christian Democrats pleaded for the *Gesundheitsprämie* at the time. The latter is still advocated by the majority of economists.

Another debate is whether extra premiums to health funds should be allowed to differ regionally. This is advocated by health economists (Augurzky et. al 2010), in order to accommodate regional variation in preferences for health care and not to distort competition between health funds that operate nationally and others that operate at a regional level. Regional variation in contributions is also advocated by the Christian Democrat Party (CDU). Moreover, health economists stress that in the long run the German health insurance system needs to overcome the duality of SHI and PHI in order to establish an integrated, competition-oriented and more efficient system (Augurzky et al 2010). Implementing such an integrated system is regarded as a difficult task, since the rights of the privately insured have to be considered. The reform of the Dutch health insurance system of 2006, which has managed to integrate PHI and SHI, is sometimes regarded as a blueprint for the German case (Wasem 2010). Others do not see an advantage in the Dutch system (PKV 2010).

2.3.3 Impact of EU social policies on the national level

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

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

The EU general competition law represents another example for EU policies having an impact on national health policy, as in Germany, several health-related markets are exempted from general competition regulation, which might conflict with EU law. Yet, since the European Court of Justice approved exceptional rules for pharmacies in Germany in 2009, the expectation of EU law pushing the German health system towards more competition has largely vanished. Moreover, there is an ongoing discussion at the EU level about whether public owners of hospitals, e.g. municipalities, are allowed to cover deficits of their hospitals.

Since non-public hospitals do not have this advantage, there is a distortion of competition. In essence, however, health policy is still nationally oriented.

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

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

2.3.4 Impact assessment

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

The immediate impact of the financial crisis and, more recently, the euro crisis – and the policy measures taken in order to cope with the crisis – on the health system seems to be heterogeneous. On the one hand, the federal government has put additional tax money into the health fund after the financial crisis in order to stabilise the health system and to even reduce the general contribution rate to 14.9% until 2010. For the insurees, the financial crisis had no negative impact on the access to health care or on individual health costs. Neither does the euro crisis show negative effects on the German health care system. On the other hand, there is empirical evidence that economic downturns, and in particular job insecurity, directly exert detrimental effects on individual health (Knabe and Rätsel 2010). Since the overall economic situation in Germany in 2011 was very good and the health care reform GKV-FinG has come into effect in 2011, there was even a considerable surplus in the health fund which amounts to an expected 4.4 billion € (Focus Money online 2012). In February 2012 there is a public debate on how to use the surplus of the health fund: (i) reduce tax subsidies to the health fund, (ii) reduce the current contribution rate of 15.5%, (iii) save the surplus, or (iv) give it to health care providers. However, it is very improbable that the surplus will remain in the future – not only if the euro crisis persists but also because of increasing health care expenditures.

With respect to financial long-term sustainability, only limited progress has been made by the GKV-FinG through mitigating the dependence of the SHI on aggregate labour income. Nevertheless, demographic change, shifting the balance of net-contributors and net-recipients

in the SHI, still represents the major challenge to the health system. Moreover, as to health care personnel, the number of medical students has been decreasing in recent years (Kopetsch 2007). In conjuncture with regional heterogeneity in regional provision of health care services, this might result in shortages of health care supply in some regions. This problem is, however, not unique to the health care sector but reflects the fact that ageing societies will experience a relative decrease in labour supply. Although it is too early to assess the impact of the current reform GKV-VStG which has come into effect in 2012, as a consequence of this reform we expect a reduction of the shortage in the supply of physicians in rural areas in the medium term. However, it is very improbable that it will help to reduce health care expenditures. In contrast, it rather increases expenditures because of additional costs for physicians.

2.3.5 Critical assessment of reforms, discussions and research carried out

Since the public and scientific debate about the reform of financing the health care system in Germany has focussed on the controversy of *Bürgerversicherung* and *Gesundheitsprämie*, the GKV-FinG has first and foremost been debated in the light of these general concepts (ifo 2010), with a special focus on the question of whether and to what extent the reform meets their major objectives. In this debate economists have often argued (Augurzky 2010) that a reform of financing the SHI should achieve five objectives simultaneously: (i) the health premium should not depend on labour income, (ii) strong competition between SHIs, (iii) redistribution of income within the SHI should be based on all kinds of income of the insuree, not just on labour income, (iv) compensation of the low-income insurees should not distort competition between SHIs, (v) the duality of SHI and PHI should be abolished.

The "*Gesundheitsprämie*" achieves all of these objectives except for (v), although PHI would hardly be competitive in the world of the "*Gesundheitsprämie*". The GKV-FinG represents a step into this direction. With respect to (ii) and especially (iv) the GKV-FinG corrects a serious shortcoming of the health reform GKV-WSG of 2007, as compensation for low-income insurees is now carried out at the level of the health fund instead of at level of the individual SHI. Thus, compensation no longer distorts competition among SHIs. Among many health economists the GKV-FinG is also considered as a step into the right direction with respect to (i). Though contributions to the SHI remain income-dependent, any future increase in health expenditures might be financed by per-capita extra premiums. However, the GKV-FinG fails to make progress towards (iii) and (v). In the long run, the system might develop into the direction of the Dutch system.

In other words, currently, the SHIs receive risk-adjusted per-capita premiums from the health fund. Thus, leaving the accumulation of a capital stock in the PHI aside, SHI and PHI do not differ fundamentally with respect to how their premiums are calculated. While the PHIs collect their risk-adjusted premiums directly from their insurees, the SHIs collect them from the health fund. The health fund, in contrast, collects income-dependent contributions from the SHI-insurees, i.e. the purpose of the health fund is redistributing income such that every citizen can afford a social health insurance. From this perspective the SHIs' revenue structure is already optimised.[61] Hence, any further reform of financing health care expenditures will only change intra- and inter-generational income distribution, e.g. integrating PHI into SHI, building a capital stock, or increase or decrease income redistribution. Since it is very improbable that the current surplus of the SHI will remain in the future – not only if the euro

[61] There might be still ways to optimise the kind of risk-adjustment. But this would not be a fundamental change.

crisis persists but also because of increasing health care expenditures – financing problems might soon arise again.

Finally, the current reform GKV-VStG addresses many important challenges in the local provision of health care. It contains some helpful adjustments. However, many details are still open and have to be clarified ex post. The lawmaker did not have the courage to become more concrete. What is missing are strong elements to overcome the separation of the inpatient from the outpatient sector – mirrored in two different remuneration systems and budgets. Neither do we see any approach to combine the planning of the local supply of inpatient and outpatient health care. There is also a need to define national minimum requirements concerning minimum provision of regional health care, e.g. maximum distances to the next hospital. If regions themselves defined minimum requirements they would establish a rather generous definition because financing them would be national. Finally, the reform shows a certain tendency in favour of the outpatient physicians.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

The social and private long-term care insurance (LTCI) were introduced on 1 January 1995 as a compulsory insurance to cover a portion of long-term nursing care costs. All persons insured by SHI were automatically assigned to the social LTCI and all those insured by PHI to a private LTCI. In 2011, according to the Federal Ministry of Health, 69.5 million citizens were covered by social LTCI and according to the association of PHI 9.6 million citizens by a private LTCI (in 2010). In 2009 the social and private LTCI bore roughly 50% of residential and 54% of home care (in kind) costs (Statistisches Bundesamt 2011a). Thus, the LTCI is often referred to as a "part insurance cover".

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

There are three different arrangements a recipient can choose from: care allowance, home care (in kind), and residential care. Care allowance refers to so-called informal care, i.e. the person in need of care receives only monetary support, typically lives at home and is looked after by close relatives. Home care (in kind) means that a professional care provider visits the recipient regularly at home. The provider is directly payed by the LTCI, only additional services are paid by the person in need of care. Residential care refers to either short-term or long-term stay in a nursing home. Home care (in kind) and residential care are referred to as formal care. In 2009 2.34 million people received benefits from social or private LTCI, thereof 1.07 got care allowance, 0.56 for home care in kind and 0.72 for residential care. The number has risen considerably by 16% or by 1.5% per year between 1999 and 2009. At the same time total expenditures of the social LTCI have grown from 16.3 to 20.3 billion €, i.e. by 24% in total or by 2.2% per year.

The LTCI distinguishes between three levels of care with increasing severity of care. In level I extensive care of at least 90 minutes per day is needed. People in level II (severe care) are in need of at least 180 minutes of care per day, and in level III (most severe care) recipients need at least 300 minutes of care per day. If the need for care exceeds level III by far, it is possible

to apply for further assistance. The level of care is formally assessed by an independent Medical Review Board of the Statutory Health Insurance Funds (MDK) for the social LTCI and by an equivalent body for the private LTCI. The LTCI pays the benefits according to the level of care but irrespective of the price for the actual goods and services. Thus, the person in need of care has to bear the difference between the price and the benefit of the LTCI.

Between 1996 and 2007 there was no change in the nominal amount of the benefits. However, due to general price inflation the nominal amount had gradually lost its real value. Monthly benefits have been increased for the first time by the reform PfWG[62], with higher increases for home care and care allowance to strengthen both types of arrangements in comparison to residential care ("*care at home before residential care").* Table 1 gives an overview of the benefits of LTCI in the years 1996 to 2012 by kind of care arrangement and by level of severity. There are no differences in benefits between social and private LTCI. From 2014 onwards benefits will be assessed every three years and possibly adjusted to keep up with the general price inflation.

Table 1: Benefits of LTCI in € per month

	1996-2007	2008	2009	2010	2011	2012
Residential care						
Level I	1,023 €	1,023 €	1,023 €	1,023 €	1,023 €	1,023 €
Level II	1,279 €	1,279 €	1,279 €	1,279 €	1,279 €	1,279 €
Level III	1,432 €	1,451 €	1,470 €	1,510 €	1,510 €	1,550 €
Home care (in kind)						
Level I	384 €	402 €	420 €	440 €	440 €	450 €
Level II	921 €	951 €	980 €	1,040 €	1,040 €	1,100 €
Level III	1,432 €	1,451 €	1,470 €	1,510 €	1,510 €	1,550 €
Care allowance						
Level I	205 €	210 €	215 €	225 €	225 €	235 €
Level II	410 €	415 €	420 €	430 €	430 €	440 €
Level III	665 €	670 €	675 €	685 €	685 €	700 €

Source: Bundesministerium für Gesundheit (2011a).

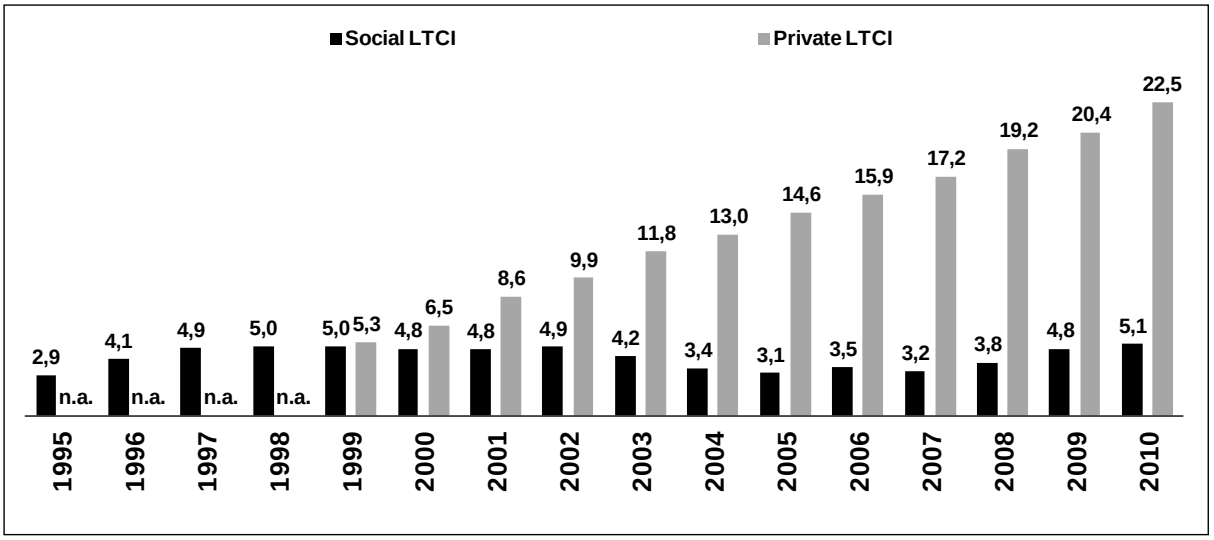
The average price e.g. for a place in a nursing home at level II was 2,800 € per month in 2009 (board and lodging included). However, the prices for nursing homes vary considerably across Germany (e.g. Augurzky et al. 2011a or Mennicken et al. 2010). The LTCI benefit at level II was 1,279 € or 46% of average total costs. If the person is unable to pay the difference between price and LTCI benefit, first-grade relatives are required to step in. If their support is still not sufficient, social welfare covers the remaining amount of money. Currently, social welfare covers on average 12% of all costs (Statistisches Bundesamt 2011a). Due to the high out-of-pocket payments (for persons without support by social assistance), there is an incentive to demand services with a good relationship between price and quality.

The contribution rate to the social LTCI was stable at 1.7% of wage income until 2008. In the immediate years after the introduction of the social LTCI, contributions exceeded expenditures and capital was accumulated up to 5 billion € until 1998 (Figure 6). Yet, given rising expenditures, from 2003 on, its capital stock was reduced. With the reform PfWG it increased to 1.95% in general and to 2.20% for insured without children. Employers and

[62] Pflegeweiterentwicklungsgesetz: Law on advancement of LTC.

employees pay half of the premium, pensioners pay the full premium themselves. Therefore, from 2008 on, capital stock has been growing again. In contrast, the capital stock of the private LTCI has increased steadily to above 22 billion € in 2010. Since current data are only available for 2010, it is not possible to make any statements about recent developments in 2011 or 2012. However, there are signs that capital reserves have begun to diminish (Augurzky et. al 2011a).

Figure 6: Capital reserves of the social LTCI in billion €



Source: Bundesministerium für Gesundheit (2011a) and PKV (2011).

Between January 2010 and December 2011 there were no relevant political reforms concerning LTC on the national level, only small changes in legislation in some federal states. In January 2012 a new legislation for employees caring at home came into effect. Employees with a family member in need of care at home are allowed to reduce their working hours to a minimum of 15 hours per week for a maximum of two years. Their employers can add up the reduced salary by half of the difference between old and new salary with an interest free credit from the *Kreditanstalt für Wiederaufbau*. Afterwards, the employee has to work full-time until the credit is payed back (Deutscher Bundestag 2011).

However, reforms of the financing structure of LTCI are necessary due to the ageing of the population and, thus, rising demand for LTC. In 2050 4.4 million people are expected to be in need of care. Hence, the gap between expenditures of and contributions to the social LTCI is growing. Without reforms the contribution rate would have to rise from 1.95% to around 4.4% in 2050 in order to close the gap (Häcker, Hackmann and Raffelhüschen 2010).

2.4.2 Debates and political discourse

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

- reduction of bureaucracy for LTC providers,
- improvement of the compatibility of work and informal care by relatives,
- increase the attractiveness for the occupation of elderly care nurse,
- standardising the different kinds of training for elderly care nurses on the one hand and for hospital nurses on the other,
- improvement in the assessment of quality of care,

- reform of the definition of being in need of care, especially concerning people with dementia who, currently, might not be considered in need for care if they do not have physical handicap, and
- implementation of an additional, mandatory, individualised LTCI with capital accumulation.

So far, the government has only taken small steps along these lines. Even though the government had announced 2011 as the "year of care" and intended to present a first draft of an LTC reform before summer 2011; in November 2011 only a small paper presenting key points for the forthcoming reform of the LTCI was published by the Federal Ministry of Health (Bundesministerium für Gesundheit 2011b). The first draft was finally presented in January 2012 *(*"*Pflege-Neuausrichtungsgesetz*"[63]). The objectives of the coming reform are mostly in line with the coalition agreement. Care allowance and home care shall be further strengthened. Furthermore, the government wants to improve medical care for people in need of care and support rehabilitation measures to avoid or at least to postpone the need of care. The definition of being in need of care shall also be redefined and goods and services especially for people with dementia shall be raised. In return, the government plans to increase the contribution rate to the social LTCI by 0.1 percentage points from January 2013 on in order to finance the additional expenditures especially for people with dementia. This might raise roughly 1.1 billion € for the social LTCI. However, these plans do not give an answer on how to finance the strong increase in demand for care in the years to come. Therefore, as a further element, the government wants to implement an additional optional private LTCI supported by tax deductions.

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

The social democrats (SPD) want to abolish the private LTCI and enlarge the social LTCI to all citizens without exceptions – according to models that plan an integration of SHI and PHI. They also want to broaden the income basis to which contributions to the social LTCI refer. Currently, contributions depend on wage income only. Capital income is not taken into account. The plans of the Green Party are similar. Moreover, they explicitly want to strengthen the collective capital reserve of the social LTCI by increasing the contribution rate and, thus, save money for future expenditures. The party DIE LINKE ("the left") is also in favour of abolishing the private LTCI and broadening the income basis for contributions. Moreover, it wants to considerably expand benefits of the social LTCI.[64]

Furthermore, there are scientific contributions to the current debate. Schmähl (2010b) as well as Rothgang (2011) call for attention to the fact that the introduction of an additional, individualised LTCI with capital accumulation would increase the burden for the payers for a very long time period without reducing the contributions to the current pay-as-you-go social

[63] Law on redirection of LTC.
[64] See webpages of the parties mentioned.

LTCI. Furthermore, insurances based on capital accumulation also incur the capital market risks which have to be taken into account. Beyond that, Rothgang (2011) discusses the implementation of a social LTCI for all citizens, which will be much easier in LTC than in the health care market, because assessments of and benefits from the social and private LTCI are nearly identical. An immediate introduction of a social LTCI for all citizens would result in an additional capital stock of around 4 billion €, mostly because the private LTCI currently benefits from a better demographic and risk structure.

Hackmann, Moog and Raffelhüschen (2011) argue in favour of a "benefit gap", i.e. no benefits are granted in the first year(s) of being in care, but without changes in benefits in the following years. The idea is that small risks, i.e. the costs of the first year(s) of being in care, are to be beard fully by the insured while large risks, i.e. costs of being in care for an unknown length of time, by the insurance. Häcker, Hackmann and Raffelhüschen (2010) showed that the future financial liabilities of the social LTCI would diminish considerably with such a "benefit gap", though not completely. By introducing a benefit gap of one year, the contribution rate to the social LTCI would only increase to 3.8% – instead of estimated 4.4%. If the benefit gap would be extended to even three years the contribution rate would remain stable at 1.95% for all years to come. Hagen and Lamping (2011) discuss the advantages and disadvantages of pay-as-you-go and capital cover systems as the different financing options for LTCI as well as broadening the number of insurees by abolishing the private LTCI. They conclude that, because LTCI is an existential good and financing of LTCI is not suited for experiments, (1) the pay-as-you-go system should be sustained and (2) the social LTCI should cover all citizens.

Another issue in the current debate is the validity of the quality assessment with "school marks" in the transparency reports for nursing homes. There are 82 standardised items in five dimensions to be assessed by ratings: (i) care and medicine, (ii) interaction with people with dementia, (iii) social assistance, (iv) board and lodging, (v) interviews of the people in need of care. These reports make nursing homes directly comparable. However, only few refer to outcome quality while most of them are about structural and process quality. Generally, transparency reports are criticised because equal weighting of all marks makes it possible to compensate bad marks in care by good marks in service. There are no knockout criteria for bad outcome quality, and most of the indicators are criticised to measure only the quality of documentations. See Hasseler and Wolf-Ostermann (2010) or Weibler-Villalobos and Röhrig (2010) for a more detailed discussion.

Finally, an intensive public debate on the current and expected lack of qualified nurses is going on (Afentakis and Maier 2011). While financing the growing demand for care is the most important issue, another one, almost as important, is how to provide LTC. Since LTC is very labour-intensive more demand for care means an increasing demand for personnel. Providers already report difficulties in finding qualified personnel. The problem might intensify in the medium term. Several measures are discussed to alleviate it: (i) increase attractiveness of the job of a nurse, (ii) immigration of qualified nurses, especially from outside Europe (RWI 2011).

2.4.3 Impact of EU social policies on the national level

Concerning the open method of coordination (OMC), Germany has organised three peer reviews so far, one of them in the area of LTC, held in Murnau, Germany, in October 2010 (see Leichsenring 2011), on quality in residential care facilities. This topic is a concern in all EU member states and at the EU level. Nine other member states joined the peer review. The

German experience stimulated a lively debate and prompted participants to present their experiences. The debate came to the following agreements or conclusions: minimum standards are needed for long-term residential care and compliance should be monitored. External quality management systems involve internal quality management systems. The introduction of such systems requires participative leadership, human resource management, training and lifelong learning. Moreover, transparency of quality can stimulate performance-based pricing of nursing homes. Finally, modernisation of nursing homes entails openness to other parts of the care chain. The relationship between health services and social services needs further discussion. Some countries' perspectives on LTC are more health-oriented, while others are more focused on social services.

In October 2011, the GVG[65] organised an event in Berlin about the future demand for nurses in LTC with guests from Austria and the Netherlands, sharing their national experiences. The Council of the European Union commented in its recommendation on the National Reform Programme 2011 of Germany only very briefly on LTC: The budgetary strategy for 2012 and beyond should be followed, while maintaining a growth-friendly consolidation course by enhancing efficiency in LTC (European Commission 2011).

2.4.4 Impact assessment

The financial crisis has not had an impact on financing of LTC in Germany, neither does have the current euro crisis an effect. However, concerning private investors, there seems to be a reduced interest in investment in nursing homes. Due to some overcapacities of nursing home places in these years, there was no problem for the provision of nursing home care. In 2011 waiting lists are unknown. Furthermore, since the German economy is expected to remain growing, negative effects on social LTCI in the medium term are not expected. Additionally, the value of accumulated capital in the private LTCIs has grown significantly more in 2010 (PKV 2011).

Looking forward, there is a need for expanding the benefits of the LTCI to people with dementia and for increasing benefits according to price inflation to avoid growing poverty of people in need of care. However, the number of payers to the LTCI will diminish in the future. Thus, there will be a financial gap in LTCI – assuming that the economy, on average, will grow as in the past. In politics, currently there are suggestions how to close this gap in the long-term with an optional additional private LTC insurance with capital accumulation and tax subsidies. In the scientific debate other solutions are discussed as well e.g. (i) reducing the benefits for LTC, (ii) increasing the contribution rate to LTCI, (iii) increasing the contributions of high-income insurees, (iv) abolishing private LTCI to strengthen social LTCI.

Another important issue is the provision of formal (home care or residential care) and informal care (care allowance) and the principle "care at home prior to residential care", which meets the demand of elderly people, who would like to stay at home while receiving benefits from LTCI (BMVBS 2011). Currently, the majority of people in need of care receives care allowance and is looked after by family members or receives home care (in kind). The typical scenario is that children at the age of 50 to 65 years care for their parents at the age of 80 and above. Since the generation between 50 and 65 years belongs to the so-called baby boomers, their number will increase in this decade. Therefore, there might be an increasing potential of informal care by family members. However, once the baby boomers will reach the age of 80 themselves, beginning around 2025, family members will become rare and a huge

[65] Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.

number of professional nurses will be necessary. This might result in waiting lists for people in need of care. Yet, there is already a substantial lack of nurses in 2011. In order to increase the number of nurses, measures are already necessary in the short run, e.g. concerning wages and the attractiveness of the job in general, which, however, puts further pressure on costs of care.

Finally, efficiency of the provision of care plays an important role in the public debate as well. For the assessment of efficiency, quality of care has to be measured. To this end, transparency reports have been introduced in Germany in 2009. However, the validity of the transparency reports has often been criticised, which should lead to a continuous improvement process (GKV-Spitzenverband 2011). In any case, the transparency reports will not be given up because they are valuable for people looking for professional care. With the development of external and internal quality management tools, a learning process with regard to quality is starting. Moreover, external institutions like the MDK control quality of nursing homes once a year – much more often than before the introduction of the transparency reports. In sum, competition between nursing homes based on transparent quality measures as well as annual controls by the MDK should lead to an increase in quality in the medium term.

2.4.5 Critical assessment of reforms, discussions and research carried out

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

Furthermore, benefits of the LTCI cannot be increased to the full extent as discussed with a redefinition of being in need of care without changes in the financing of LTCI (BMG 2009). Raising benefits for people with dementia are expected to be financed by the above mentioned increase of 0.1 percentage points to the contribution rate. For any other increase in benefits convincing financing concepts are still missing. An optional private LTC insurance with capital accumulation is unlikely the solution, because experiences with the private pension insurance[66] show low uptake rates for large parts of the population. However, at the end of the day, society has to bear the costs of the underinsured. The introduction of a benefit gap, as discussed by Häcker, Hackmann and Raffelhüschen (2010) would be an arguable measure. In our opinion, the parallel system of social and private LTCI has no rational justification and should, therefore, be questioned. Furthermore, in order to keep welfare expenditures for people in need of care who are unable to bear the co-payment for LTC services under control, the "basic care package" cannot include "luxury" services, e.g. single rooms.

Next, the efficiency of the provision of LTC can still be increased. First, there is still a lot of bureaucratic ballast that makes the system less efficient. Second, competition between

[66] The so-called Riester-Rente in Germany.

providers is still weak. There are considerable regional price differences in residential care, which cannot be explained by quality differences and labour costs alone. Transparency of quality may induce more competition between nursing homes, thus mitigating price differences in the future. Yet, the criticism on the ratings for nursing homes has to be taken seriously. Although we highly advocate standardised transparency reports, they must be improved to meet international standards. Moreover, we would also suggest creating an independent institution that gives the ratings in the transparency reports by transforming the MDK into an independent organisation.

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

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

In Germany several attempts were taken to promote active ageing in particular through designing the transitional period at the end of the working career and the beginning of the retirement phase. The possibility to combine work and pension benefit before the "standard" retirement age (early retirement) exists already for quite a long time. The rules, as mentioned above, are rather complicated. In principle some potential of making the transition into retirement more flexible is available, though this instrument was not at all a success yet.

Meanwhile a rethinking in some areas of the business community seems to take place. This is linked to the demographic development and a (already present, but in particular for the future expected) lack of qualified manpower. This already seems to change the process of recruitment by firms[67] and is also supported by the Federal government which tries to communicate examples of good practice etc.[68] The assumption of lower productivity of older workers seems to become less influential. However, beside social protection rules changes in collective wage and labour agreements, in particular focussed on measures to further qualify older workers, should become elements of a comprehensive strategy of extending working life without implicating inadequate retirement income.[69]

2.5.2 Participation in society

In general, an important precondition for participation of elderly persons in society is an adequate income. As already pointed out above, there is a trend towards decoupling (public) pensions from general income development. Private and occupational pensions often are not adjusted during retirement. In addition, contribution rates to health and long-term care insurance are growing for pensioners as well as additional out of pocket payments in case of illness and long-term care. Therefore, a gap between the need for income and the availability of income seems to become bigger and bigger in old age. An integrated policy perspective taking into consideration not only pensions and taxation, but also development in the health

[67] See e.g. some few case studies reported in Wagner (2011).
[68] See e.g. Bundesministerium für Familie (2011b).
[69] For a broader perspective see a report published by Bundesministerium für Familie (2006), chapter 2.

and long-term care area as well as a representative cost of living index is necessary. This should become a corner stone for developing chances for participation of older persons in society. Often older persons are seen as an economic factor, though in this case an adequate income in old age is crucial.

The Federal Ministry of Family Affairs, Senior Citizens, Women and Youth supports several model programmes, e.g. together with local administration and many organisations, for comfortable conditions in living arrangements to improve possibilities for participation in society.[70] In addition, even elderly people are explicitly invited to participate in the "federal volunteer service" *(Bundesfreiwilligendienst)* where they can be active in social, ecological, cultural or other projects.[71] Pension claims are normally not coupled with such an engagement, with the exception of unsalaried long-term care under certain conditions.

2.5.3 Healthy and autonomous living

In Germany, most of the people in need of care live at home. In 2009 2.34 million people received benefits from social or private LTCI, thereof 1.63 million (70%) lived at home and received formal or informal care. 0.56 million people lived in a nursing home, almost 60% of them in a single room. Both home helpers and support at home are included in the LTC benefit basket. Roughly half of the costs are carried by the LTCI. Furthermore, there is a clear political priority to provide support for home care as opposed to institutional care. This priority is reflected by benefits that are more strongly rising for home care than for institutional care. Furthermore, there are special offers and benefits for the elderly in public transportation and public institutions. Thus, we expect that the large majority of the elderly live rather autonomously.

However, currently the LTC system does not focus on prevention to avoid or delay the dependency of care because the payers for rehabilitation and prevention are the SHIs while payer for LTC is the LTCI. This means that SHIs carry the costs of rehabilitation and prevention while the LTCI receives the "profit". The reform of LTC planned in 2012 intends to improve upon this situation. However, we think that the political efforts towards rehabilitation and prevention to avoid or delay the dependency of care will be low and the need for improvement will remain in the future.

[70] See for some examples http://www.bmfsfj.de/BMFSFJ/aeltere-menschen.html (Date of access 12.2.2012).

[71] See for further details http://www.bundesfreiwilligendienst.de/der-bundesfreiwilligendienst.html (Date of access 12.2.2012).

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3 Abstracts of Relevant Publications on Social Protection

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

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

[L] Long-term care

[R] Pensions

[R1] BMAS (2011), Bundesministerium für Arbeit und Soziales, Rentenversicherungsbericht 2011

This (annual) report of the Federal government gives empirical information on statutory (social) pension insurance and in particular model calculation on the future development within the medium term (next 5 years) as well as for the next 15 years. The development of the (necessary) contribution rate is outlined. In an annex additional empirical information is given.

[R2] Gasche, Martin; Kluth, Sebastian (2011), Auf der Suche nach der besten Rentenanpassungsformel, Universität Mannheim (mea discussion paper 241-2011).

Hain, Winfried; Weprek, Andrea; Viebrok, Holger (2011), Bewährte Rentenformel in neuem Gewand – ein Vorschlag für eine vereinfachte Anpassungsformel- , in: Deutsche Rentenversicherung 3/2011, pp. 234-249.

Both papers discuss the possibility to make the pension formula more transparent without changing its effects regarding the development of contribution rate and benefit level.

[R3] DRV Westfalen (2011), Deutsche Rentenversicherung Westfalen, Dokumentations- und Forschungsstelle der Sozialversicherungsträger (eds.), Sieht die Rente alt aus? – Positionen zur Rente mit 67, Münster (o.J., 2011)

In this booklet different papers in particular on the increase of the (standard) retirement age are publishes, giving different perspectives and evaluation.

[R5] Blank, Florian (2011), Die Riester-Rente: Ihre Verbreitung, Förderung und Nutzung, in: Soziale Sicherheit 12/2011, pp. 414-420.

The paper gives information about the subsidised private pension, the structure of the subsidies, who used this possibility to save during the last 10 years, what tells us data on number of contracts and what empirical information is lacking.

[R5] Hagen, Kornelia; Kleinlein, Axel (2011), Zehn Jahre Riester-Rente: Kein Grund zum Feiern, in: DIW Wochenbericht 47/2011, pp. 3-14.

A critical evaluation of the subsidised private pension, pointing e.g. on high costs, low rates of return and the fact, that a high age is necessary for those who use this instrument, when they want to receive a positive return from their saving activities.

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

Critical evaluation of up to now published research on the subsidised private pension and outlining what type of knowledge and empirical information is lacking.

[R5] Dedring, Klaus-Heinrich; Deml, Jörg; Döring, Diether; Steffen, Johannes, Zwiener, Rudolf (2010), Rückkehr zur lebensstandardsichernden und armutsfesten Rente, *WISO Diskurs*, Friedrich Ebert Stiftung, Bonn, 2010.

The authors criticise present German pension policy outlining negative effects and argue in favour of a strategy that aims at a pension that avoids poverty and makes it possible to protect the standard of living also in old age.

[R5] Hahn, Christoph; Neumann, Dirk (2011), Verbraucherschutz bei Riesterverträgen – Probleme und Lösungsvorschläge, in: Soziale Sicherheit 12/2011, pp. 421-425.

A critical evaluation of the subsidised private pension from a customers point of view, outlining e.g. lacks in transparency, and discussing effectivity and security of contracts.

[R5] Kumpmann, Ingmar (2011), Politikoptionen gegen Altersarmut, in: Deutsche Rentenversicherung 4/2011, pp. 291-303.

The paper gives an overview of different options to avoid poverty in old age, focussing on the employment phase (earnings and employment as precondition for pension benefits) as well as possibilities to deal with the problem after retirement.

[R5] Ruland, Franz (2011), Rente mit 67 und Zuschuss-Rente – aktuelle Fragen der Rentenpolitik, in: DRV Westfalen (2011), pp. 59-68.

The paper discusses in particular new proposals of the Federal Ministry of Labour for a new instrument to avoid poverty in old age for those persons that have a long career in the public and the private pension schemes.

[R5] Schmähl, Winfried (2011b), Die Riester-Reform von 2001 – Entscheidungen, Begründungen und Folgen, in: Soziale Sicherheit 12/2011, pp. 405-414.

In this paper the history of the pension reform of 2001 and its effects on income distribution, the increasing costs for financing adequate pension benefits and the effect of the statutory pension scheme – that seems to be transformed radically into a transfer scheme focused on avoiding poverty in old age but not more on income smoothing and a close contribution-benefit link – are regarded.

[R5] Schmähl, Winfried (2011a), Quo vadis "Gesetzliche Rentenversicherung"? – Eine Zwischenbilanz zehn Jahre nach einem grundlegenden "Paradigmenwechsel" in der deutschen Alterssicherungspolitik. In: Deutsche Rentenversicherung 3/2011, pp. 216-233.

This is an extended version of Schmähl (2011b) dealing in detail with arguments for the reform strategy that was implemented in 2001 and further developed in particular in 2004 and its outcome regarding social policy and income distribution.

[R5] Sozialbeirat (2011), Gutachten des Sozialbeirats zum Rentenversicherungsbericht 2011 (29.11.2011).

This annual report deals with the model calculations of the Rentenversicherungsbericht (see above [R1]) and in particular with recent proposals of the federal ministry regarding poverty in old age, disability pensions and how to combine work und pensions better.

[H] Health

[H4] Arentz, Christine (2011), Medizinisch-technischer Fortschritt im Gesundheitswesen: Zentrale Kosten-Nutzen-Bewertung ohne Alternative? Otto-Wolff-Institut Discussion Paper 01/2011, Universität zu Köln.

Technical progress in medicine: cost-benefit evaluation without alternative?

The paper discusses rules for competition in the health care market. As long as there is no fully competitive health care system, it is too early to argue that technical progress in medicine automatically increases costs and that rationing is necessary. The author argue that first efficiency of the system has to be improved.

[H4] Augurzky, B. and H. Tauchmann (2011), Less Social Health Insurance, More Private Supplementary Insurance? Empirical Evidence from Germany. Journal of Policy Modeling 33 (3): 470-480.

Less Social Health Insurance, More Private Supplementary Insurance? Empirical Evidence from Germany

Based on individual level data from Germany, we analyse the effect of changes in the compulsory benefit package of the social health insurance on the demand for supplementary private insurance, employing a difference-in-differences approach. The focus is on the exclusion of dental prostheses from the benefit package in 1997 and its re-inclusion in 1999. Individuals born prior to 1979 serve as control group because only the young were affected by the reform. No significant effect on the demand for supplementary health insurance is found. Thus, the notion of clients making informed choices about their health insurances' coverage is not supported.

[H1] Augurzky, Boris; Felder, Stefan; Van Nieuwkoop, Renger; Tinkhauser, Alois (2012), Soziale Gesundheitswirtschaft – Impulse für mehr Wohlstand, WISO Diskurs, Friedrich-Ebert-Stiftung, Bonn.

Social health care industry – stimulus for more wealth

Within the framework of a computational general equilibrium model the authors forecast the German economy to 2030. The model contains 69 industries, nine representative households, social insurances, government, and foreign countries collectively. The number of younger people will decrease and that of older people strongly increase. Given technical progress in the health industry of 0.5% p.a. and 1.0% in the rest of the economy, a growth in demand per age class of 2.0% p.a., the GDP in the health industry will continue to grow until 2030 by 50% or 2.2% per year. In the remaining industries it will grow by 15% or 0.7% annually. In sum, the authors expect an increase of total GDP by 19% or 0.9% p.a. Moreover, the number of employees will shrink from 40.3 million to 35.3 million. Due to the increase in GDP health care expenditures can still be financed in 2030. However, the contribution rate to the health fund will increase to 22%.

[H4] Beske, Fritz and Brix, F. (2011), Solidarische, transparente und bedarfsgerechte Gesundheitsversorgung im demografischen Wandel durch Priorisierung und Rationierung - Begründung und Vorschläge, Kiel 2011.

Solidary and transparent health care system in the context of the demographic change by prioritisation and rationing – arguments and suggestions

The gap between resources for the health system and expenditures of the health system is increasing. A hidden (implicit) rationing would be the worst answer to this gap. In contrast, the author recommends a transparent and publicly discussed way to reduce services (explicit rationing). Moreover, he criticises that new products are added to the benefit package of social health insurance but old one are not removed. The author suggests several measures to reduce costs in the SHI.

[H4] Drösler, Saskia; Hasford, Joerg; Kurth, Bärbel-Maria; Schaeffer, Marion; Wasem, Marion and Wille, Eberhard (2011), Evaluationsbericht zum Jahresausgleich 2009 im Risikostrukturausgleich, report for the Ministry of Health.

Evaluation of the risk-adjustment scheme of SHI

This report analyses the effects of the risk-adjustment scheme of the SHI in Germany of the year 2009 when the former scheme based on age and sex was extended by 80 diseases. Focus is on the accuracy of the new risk-adjustment scheme. The report also assesses various reform options and whether there are ways to manipulate risk-adjustment payments. The authors conclude that the accuracy of the risk-adjustment scheme has increased compared to the former one. Considering morbidity in the risk-adjustment scheme has improved covering health care expenditures on the level of the individuals, groups, and at the level of the SHIs. A reduction of 80 diseases to 50 or 30 would also reduce accuracy. Though, there is still room for improvement especially in case of diseases with high lethality and pronounced multi-morbidity.

[H4] Glaeske, Gerd (2011), Patientenorientierung in der medizinischen Versorgung, Vorschläge zur Weiterentwicklung und Umgestaltung unseres Gesundheitswesens, WISO Diskurs, Friedrich-Ebert-Stiftung, Bonn.

Patient orientation in the health care system, suggestions for the advancement of the German health care system

It is unclear whether the current German health care system is able to reflect changing patients' needs. The question is how to reform the system such that patients' needs can be better taken into account. Since not all providers offer the same quality the author argues in favour of pay for performance. In particular, costs and benefits should to be considered much more than it is the case today. To this end, more research is necessary.

[H1] Kifmann, Mathias; Roeder, Kerstin (2011), Premium Subsidies and Social Insurance: Substitutes or Complements? Research Paper No. 2011/01, Hamburg.

Premium Subsidies and Social Insurance: Substitutes or Complements?

Premium subsidies have been advocated as an alternative to social health insurance. These subsidies are paid if expenditure on health insurance exceeds a given share of income. This paper examines whether this approach is superior to social insurance from a welfare perspective. The authors show that the results crucially depend on the correlation of health and productivity. For a positive correlation, they find that combining premium subsidies with social insurance is the optimal policy.

[H3] Roll, Kathrin; Stargardt, Tom; Schreyögg, Jonas (2011), Effect of Type of Insurance and Income on Waiting Time for Outpatient Care, hche Research Paper No. 2011/03, Hamburg.

Effect of Type of Insurance and Income on Waiting Time for Outpatient Care

This paper analyses the impact of type of insurance, income, and reason for appointment on waiting time for an appointment and waiting time in the physician's practice in the outpatient sector. Data were obtained from a German patient survey conducted between 2007 and 2009. The authors differentiated between GP and specialist and controlled for socioeconomic, structural, and institutional characteristics as well as interactions between type of insurance and control variables. The results reveal that private health insurance plays a significant role in faster access to care at GP and specialist practices. Access to care is also highly influenced by the reason for an appointment. They also found that increased income had a negative effect on waiting time in practices and on waiting time for an appointment in GP practices. Whether inequalities in access to health care also impact overall quality of treatment needs to be investigated in future research.

[H4] Schmitz and Ziebath (2011), In Absolute or Relative Terms? How Framing Prices Affects the Consumer Price Sensitivity of Health Plan Choice, Ruhr Economic Papers #304, Bochum, Dortmund, Duisburg, Essen.
How Framing Prices Affects the Consumer Price Sensitivity of Health Plan Choice

The paper provides field evidence on (a) how price framing affects consumers' decision to switch health insurance plans and (b) how the price elasticity of demand for health insurance can be influenced by policymakers through simple regulatory efforts. In 2009, in order to foster competition among health insurance companies, German federal regulation required health insurance companies to express price differences between health plans in absolute Euro values rather than percentage point payroll tax differences. Using individual-level panel data, as well as aggregated health plan-level panel data, the authors find that the reform led to a sixfold increase in an individual's switching probability and a threefold demand elasticity increase.

[L] Long-term care

[L] Arentz, Christine; Läufer, Ines and Roth, Steffen, Zur Reform der Pflegeversicherung: Einstieg in ein nachhaltiges und wettbewerbliches System. Wirtschaftsdienst. 91(2): 115-120.
"*On the reform of LTCI: Introducing a sustainable and competitive system*"

The Federal Ministry of Health proposes a reform of LTCI which affects both, the financing as well as the benefit side of LTCI. The authors suggest to add an insurance with capital accumulation to the current pay-as-you-go LTCI.

[L] Colombo, Francesca, Llena-Nozal, Ana, Mercier, Jérôme, Tjadens, Frits (2011), Help Wanted? Providing and Paying for Long-Term Care, OECD Health Policy Studies, OECD Publishing.

This book examines the challenges countries are facing with regard to providing and paying for long-term care. With populations ageing and the need for long-term care growing rapidly, this book looks at such issues as: future demographic trends, policies to support family carers, long-term care workers, financing arrangements, long-term care insurance, and getting better value for money in long-term care.

[L] Häcker, Jasmin, Hackmann, Tobias and Raffelhüschen, Bernd (2011a), Pflegereform 2010: Karenzzeiten in der Sozialen Pflegeversicherung, *Zeitschrift für die gesamte* Versicherungswissenschaft, 100(3): 347-367.

"*Benefit gaps in the social LTCI*"

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

[L] Häcker, Jasmin, Hackmann, Tobias and Raffelhüschen, Bernd (2011b), Soziale Pflegeversicherung heute und morgen - mit nachhaltigen Reformen aus der Krise, May 2011, Deutsches Institut für Altersvorsorge, Bonn.

"*Social LTCI today and tomorrow – with sustainable reforms out of the crisis*"

The number of people in need of care will double in the next decades in Germany. The current pay-as-you-go financing of the social LTCI will not be able to compensate the financial downturn. This report discusses other sustainable options.

[L] Häcker, Jasmin and Hackmann, Tobias (2011), LOS(T) in Long-Term Care: Empirical Evidence from German Data 2000-2009, Health Economics (forthcoming).

Using microdata, i.e. representative samples of 114,403 German long-term care dependants (LTCDs) observed from 2000 to 2009, the authors give a comprehensive insight into the length of stay (LOS) in long-term care (LTC). Furthermore, this paper evaluates the effects of longevity on the LOS, thus revisiting the debate on the validity of the competing theories of compression or expansion of morbidity in LTC. The analysis finds significant effects on the LOS when age is controlled for, thus rejecting the time-to-death hypothesis. However, controlling for assessment level suggests an improved health status of LTCDs over time, thus supporting the time-to-death hypothesis. An analysis of the mortality rates of LTCDs is to give insight into the opposing results. But the regression of mortality shows a divergence in the development of mortality rates for different disability levels. This is evidence to suggest that the "improved" health status in LTC is not only due to actual changes in the health status, but also a consequence of political meddling.

[L] Lüngen, Markus and Paschke, Ellen (2011), Was muss getan werden, um Pflegebedürftigen zu helfen? Und was nicht?, *Wirtschaftsdienst 2011*, 10, 668-670.

"*What has to be done to support people in need of care? And what not?*"

In comparison to other social insurances the LTCI does not suffer from increasing prices. In contrast, the relative price for "one unit of care" decreased when compared to other sectors. However, especially in LTC a sufficient wage for nurses and improved working conditions are essential for high quality care. Additionally, there is no doubt about the future financing problems in LTCI and shortcomings of benefits, especially for people with dementia. Hence, being in need of care needs to be redefined, access to 24 hour care at home, improvements in training for nurses and increases in wage for nurses need also be discussed.

[L] Raffelhüschen, Bernd and Vatter, Johannes (2011), Pflegereform: Ausgangspunkt und Weichenstellung, *Wirtschaftsdienst 2011*, 10, 664-667.

"*LTC reform: Starting point and setting the course*"

Social LTC was introduced with four major flaws: (1) The first cohort of recipients has received LTCI benefits as a present, because they never paid any contributions. (2) LTCI paid for this present with an implicit credit, because everyone contributing to LTCI receives the right for benefits. It is evident that current contribution rate is insufficient to finance future demand. (3) The LTCI breaks with the principle of participation equivalence (*Teilhabeäquivalenz*), i.e. there is no linear relationship between contributions and benefits (as in pension or unemployment insurances). Benefits are fixed for all, while contributions are dependent from wage. This leads (4) to distortions in the employment sector, especially in the low income sector.

[L] Rotärmel, Olga (2011), Die Pflegeversicherung: Finanzierungsoptionen angesichts des demographischen Wandels und weitere zukünftige Herausforderungen**,** In: Wege zu einem nachhaltigen Krankenversicherungssystem in Deutschland. Göttingen: Cuvillier.

"LTCI: Financing options in the light of demographic change and other future challenges"

The author discusses the advantages and disadvantages of pay-as-you-go and capital cover systems as the different financing options for LTCI with a special focus on demographic change.

[L] Rothgang, Heinz; Iwansky, Stephanie; Müller, Rolf; Sauer, Sebastian; Unger, Rainer (2011), BARMER GEK Pflegereport 2011, Schriftenreihe zur Gesundheitsanalyse, Band 11, Asgard-Verlag, St. Augustin. http://www.zes.uni-bremen.de/ccm/cms-service/stream/asset/?asset_id=7059365

"*BARMER GEK long-term care report 2011*"

The report gives a review of LTC politics in 2010 and 2011, analyses public and official data as well as data of the SHI BARMER GEK in order to study the dynamics of LTC careers. In 2011, there is a special focus additional support for people with restrictions in their activities of daily living.

[L] Rothgang, Heinz (2011): Solidarität in der Pflegeversicherung: Das Verhältnis von Sozialer Pflegeversicherung und Privater Pflegepflichtversicherung, in: Sozialer Fortschritt, Heft 4-5/2011: 81-87.

"*Solidarity in long-term care: the relationship between social and private long-term care*"

Social and private long-term care insurances are both obliged to the principle of solidarity. However, private LTCI has advantages in its income and risk structures. The differences between both insurance types are not balanced, i.e. there is no solidarity between both types of insurance, only within both types. To achieve solidarity for the whole LTCI, either a new insurance including all insurees or a system of financial compensation needs to be developed.

[L] Rothgang Heinz; Arnold, Robert; Wendlandt, Katharina; Sauer, Sebastian; Wolter, Annika (2011): Berechnungen der finanziellen Wirkungen verschiedener Varianten einer Pflegebürgerversicherung, Gutachten aus dem Zentrum für Sozialpolitik im Auftrag der Bundestagsfraktion Bündnis90/Die Grünen, Universität Bremen. http://www.gruene-bundestag.de/cms/pflege/dokbin/393/393744.gutachten_pflegebuergerversicherung.pdf

"*Calculations of the financial consequences for different options of a "Pflegebürgerversicherung*""

The financial consequences of "Pflegebürgerversicherung" with the following characteristics are discussed: Obligatory social LTCI for everyone, contributions according to all kinds of income, raising the income limit of LTCI for assessment of contributions to the income limit of the pension insurance, and finally splitting of contributions for couples. A "Pflegebürgerversicherung" meeting these prerequisites could immediately drop contribution rates by 0.4 percentage points and the contribution rate would be ceiled to a maximum of 3.2% in the future.

[L] RWI – Rheinisch-Westfälisches Institut für Wirtschaftsforschung (2011), Faktenbuch Pflege – Die Bedeutung privater Anbieter im Pflegemarkt, report, September 2011, Essen, Germany.

Factbook LTC – The relevance of private providers in the LTC market

The report describes the LTC market in Germany and discusses the special characteristics of private-for-profit providers of LTC in comparison to not-for-profit providers. 40% of all nursing homes and 62% of all home care providers are private-for-profit. The main difference is that private-for-profit providers use private capital for which they have to pay an interest rate. On the one hand, this is a disadvantage because part of the annual profit is extracted from the providers. On the other hand, a considerable amount of private capital is at the providers' disposal for the purpose of investments. Furthermore, the factbook shows that, on average, private-for-profit providers offer the same quality of care as the other providers and have a lower price level.

[L] SVR – Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung (2011), Demografischer Wandel: Herausforderung für die Wirtschaftspolitik, Wiesbaden. http://www.sachverstaendigenrat-wirtschaft.de/fileadmin/dateiablage/Expertisen/2011/expertise_2011-demografischer-wandel.pdf
"*Demographic change: challenges for economic policy*"

The report of the German council of economic experts compares the development of costs for LTC with German GDP. The service sector (and the demand for labour) is supposed to grow stronger in the future to meet rising demands for LTC. Even though health and long-term care projections are subject to a higher uncertainty than the e.g. development of pensions, rising costs have to be expected in the following decades.

4 List of Important Institutions

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

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

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

Bertelsmann Stiftung – Bertelsmann Foundation

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

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

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

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

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

Bundesministerium für Gesundheit – *Federal Ministry of Health*

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

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

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

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

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

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

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

Webpage: http://diw.de

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

Deutsche Krankenhausgesellschaft (DKG) – German Hospital Federation

Address: Wegelystraße 3, 10623 Berlin

Webpage: http://www.dkgev.de

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

Deutsches Krankenhausinstitut (DKI) – German Hospital Institute

Address: Hansaallee 201, 40549 Düsseldorf

Webpage: http://www.dki.de

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

Deutsche Rentenversicherung – German statutory pension insurance scheme

Address: Berlin, several regional administrations, see webpage

Webpage: http://www.deutsche-rentenversicherung-bund.de/; http://www.deutsche-rentenversicherung.de/

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

Deutsches Zentrum für Altersfragen (DZA) – German Centre of Gerontology

Address: Manfred-von-Richthofen-Strasse 2, 12101 Berlin-Tempelhof

Webpage: http://www.dza.de

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

Mannheimer Forschungsinstitut Ökonomie und Demographischer Wandel – Mannheim Research Institute for the Economics of Ageing

Address: University of Mannheim, 68131 Mannheim

Webpage: http://www.mea.uni-mannheim.de

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

Behaviour; Economics of Health and Life Expectancy; Macroeconomic Implications of an Ageing Society and SHARE, an EU- and NIA-sponsored project which constructs a longitudinal Survey on Health, Ageing and Retirement in Europe.

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

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

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

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

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

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

Gesundheitsberichterstattung des Bundes (GBE) – Federal Health Monitoring

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

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

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

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

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

players. GVG arranges information exchange and develops joint positions. GVG is also engaged in international cooperation and carries out studies and research projects in the field of social security for third parties.

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

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

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

Hans Böckler Stiftung – Hans Böckler Foundation

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

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

ifo Institut für Wirtschaftsforschung – ifo Institute for Economic Research

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

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

IGES-Institut – IGES Institute

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

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

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

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

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

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

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

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

Institut für Weltwirtschaft – Institute for the World Economy

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

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

Institut für Wirtschaftsforschung Halle – Halle Institute for Economic Research

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

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

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

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

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

Rheinisch-Westfälisches Institut für Wirtschaftsforschung (RWI)

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

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

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

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

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

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

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

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

Sozialbeirat – German Social Advisory Council (GSAC)

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

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

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

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

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

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

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

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

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

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

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

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

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

Address: Herbert-Lewin-Platz 3, 10623 Berlin

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

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

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

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