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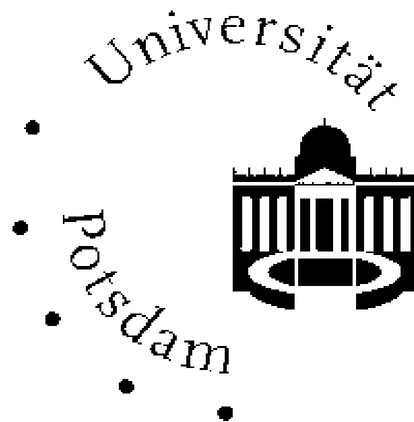
Systematic Change Instead of Curing Symptoms: Coordinating Social and Private Health Insurance in Germany and Beyond



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Systematic Change Instead of Curing Symptoms: Coordinating Social and Private Health Insurance in Germany and Beyond

by

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I. Introduction

Since more than two decades at least in every second or third year after a so-called fundamental or even centennial reform in Germany another reform process has been necessary to combat the ever increasing deficits in the social health insurance system, in the past mainly cured by permanently increasing social security contributions.[1] Since the ancillary wage costs have been driven up and reached a level which cannot be raised without creating further increases in unemployment, measures of cost limitation (baskets of pharmaceutical products, co-payments for pharmaceutical products, hospital expenses, and treatment at a health resort, a newly introduced doctor's practice fee etc.) have been implemented without any substantial and sustainable influence on the mid- and long-term development of costs. Different budgeting methods for the single medical practitioners as well as a new case-based lump sum compensation system for hospital costs have already failed or will prove to be as inefficient as all the other provisions against future cost explosions.

All the innumerable arrangements to cut health costs have had the same cause of defect: the measures were directed against single erroneous trends without taking into consideration the systemic shortcomings of the traditional Bismarckian social health insurance schemes.[2] Therefore the actors within that complex system of quasi-markets, group negotiations and political lobbying have always been able to adapt to the new terms and conditions very quickly, thus exploiting the persisting systemic failure by more and more complex strategic behaviour. The vicious circle in between partial reforms, cost reduction and adaptations of behaviour as consequence of learning by doing is rotating faster and faster. Consequently the trust of the citizen into the political competency for an efficient steering of the public health

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1 For more details see *Henke* (2003).

2 The Bismarckian system is described in detail in *Petersen* (1989); for the systematic shortcomings see *Petersen* (1997).

system is increasingly eroded, thus generating a strongly decreasing acceptance for further partial reform steps. The voter's anger is then directed against the politicians who are obviously unable to implement appropriate solutions, often provoking the political opponents to popular formulas, which often lead to further obstacles against necessary fundamental changes.

Only a comprehensive systemic approach will shed light on the fundamental causes for the excessive cost development within the social health care and insurance systems.[3] Without doubt health goods and services are superior (and overwhelmingly private) goods, and the demand for such services is more than proportionally increasing in the process of general economic growth, so that a certain degree of cost increases are almost natural consequences. What has to be reduced is just the inefficient excessive demand and supply, which is created by the systematic failures within the existing systems. If these systematic failures could be removed, the health sector would play an important role in a modern economic setting and create new jobs, which are currently badly missing to overcome the unemployment situation in many countries. Therefore in chapter II. an actor orientated approach is presented, which is based on the markets involved in the demand and supply processes of the health system. Chapter III. confronts a fully private insurance scheme with the Bismarckian approach of a social health insurance, which is still dominating in Germany. This comparison will make obvious all the misallocations and malpractices, which are discussed in detail in chapter IV. Chapter V. will concentrate on the interplay of public and private health insurance, whilst in chapter VI. the results are concisely summarized.

II. Actors, Markets and Interest Groups in Health Services

In a purely private setting and sufficiently developed market systems there are several markets for health goods and services, which are more or less functioning. Because of the large numbers of actors engaged within the health sector the market structures are comparatively complex.[4] The basic market is the market for outpatients treatments (◊), where the patients are demanders and the medical practitioners and consultants (medical specialists) are the suppliers of medical services (see chart 1). The latter do profit from asymmetric information (or information advantages),[5] which explains a certain market failure. Due to increasing knowledge and experience on the advantages of risk sharing within an insurance membership, private insurance markets are emerging (◊), in which private health insurance companies are offering and selling different insurance contracts to protect the assured persons or insurees (who all are potential patients of the doctors or other suppliers of health goods and services) against individually unbearable risk costs.[6]

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3 A systematic reform approach for the whole social security sector has been developed in a joint project with the Finance Academy at the Russian Federation supported by the World Bank; for more details see *Petersen* (forthcoming). In this research project a blue print for an efficiency orientated integrated tax and transfer reform in transition countries has been presented.

4 This is especially true if health protection is compared to old age security; see, e.g., *Petersen* (forthcoming).

5 For the role of institutional economics and public choice within the health sector see *Petersen/Müller* (1999).

6 In case of sickness two possible risk emerge: (1) loss of income from labour und (2) additional expenses connected with the sickness. In the following the stress is laid upon the problem of the benefits in kind and not on income losses. Both risks can be separately insured within the existing private health insurances.

Chart 1: Market Structures for Health Protection

patients	——	◊	——	medical practitioners, dentists and consultants
assured persons (patients)	——	◊	——	private insurances
patients	——	◊	——	pharmacies
patients	——	◊	——	hospitals
pharmacies	——	◊	——	pharmaceutical industries

In addition to the markets discussed above at least three more markets (◊) do exist in which different health goods and services are traded. In the third market the potential patients can buy pharmaceutical products, which are partly available on doctor's prescription only. Therefore the demand is to a more or less large extent dependent on the decisions of the medical practitioners etc. The market for hospital treatment also partly depends on the doctors decision because except in case of emergency the patients usually are consulting a general practitioner or medical specialist before they are taken into hospital. The last market which is taken into consideration is the market for pharmaceutical products where the pharmacies are the demanders and the pharmaceutical industries the suppliers. Like the basic markets in reality all the markets involved in health protection do have at least partial market failure, which in the past has been the main reason to substitute private markets by political group negotiation systems (see chapter III.).

For generations of politicians and practitioners involved in health policy market failures have been made responsible for social injustice connected with such a system because their main target has always been the classless provision of all citizen with "the necessary" health goods and services (as far as possible at the highest level). At a comparatively low level of technical progress in the medical sector, the *abolishment of the rationing function of the markets* involved could be born by growing populations and real income growth. But the abolition of the scarcity condition in one economic sector has become more and more unbearable in view of decreasing and ageing populations, the slow down in real income growth in the highly developed industrial countries and the rapid technical progress made in the health sector. The political illusions that almost every demand for health goods and services should be financed by the whole society have induced behavioural adaptations on side of demanders and suppliers and created an *entitlement attitude* with harmful consequences for the costs development.

In the contrary, *political rationing* has impaired the trust in the social health care and insurance systems so that parallel private markets have emerged especially since the end of the 60s in the last century, which have made the target of *classless provision a pure political illusion*; even with regard to health goods and services in all countries the demand clearly depends on the individual income situation within the single households as it is the case for all other consumption goods. The lack of market rationing (which would have functioned even by a more or less efficient price system) has been answered by different methods of politically planned rationing methods mentioned above, which overwhelmingly have been without positive impacts on the further cost developments. Therefore this excessive and unrealistic target of the past has to be substituted by a new one: *basic provision of health goods and services* on a

level, which is sustainable for the future, and provides the medical necessary goods and services in accordance with the standards of living within the single societies.

Within the *private health insurance* schemes *standard insurance packages* have been developed, which clearly define the insurance benefits for income loss, outpatients medical treatment (separated for home or family doctors, medical specialists and dental surgeons), pharmaceutical products (in form of positive lists), and hospital treatment. In individual contracts[7] *full coverage* and different amount of *co-payments* can be arranged, which do have an obvious impact on the health insurance premium. In case of not claiming any insurance benefits the insurees are reimbursed in between 30 to 50 % of their annual insurance premium, whilst all medical costs have to be paid at first be the insuree before he gets reimbursed by his insurance. Consequently the patients do have *full information of the volume, quality and the costs of medical goods and services*. The individual insurance premium for a single male person and full coverage – dependent on the individual risk situation of the insuree – is around 200 EUR a month, which is clearly below the social health contribution in the middle and upper wage scale.[8]

In chart 2 the market relations of chart 1 are represented as arrows, whilst the information channels and mutual influences are drawn as simple lines. Between health insurances, practitioners, dental surgeons, consultants, pharmacists, hospitals, and the pharmaceutical industries *complex networks* of different relations do exist which makes health protection to a multi dimensional organisational problem. The kind, number and intensity of relations are determined by the details of the single health protection system and – as already mentioned above – often quasi markets or political negotiations substitute even all market elements.[9] For the patients the health system – if privately organized or fully socialized – is depicted as a complex organisational structure, whereas the intransparency of the system is further strengthened by the *asymmetric information*, which favours the suppliers in the markets for health goods and services.[10]

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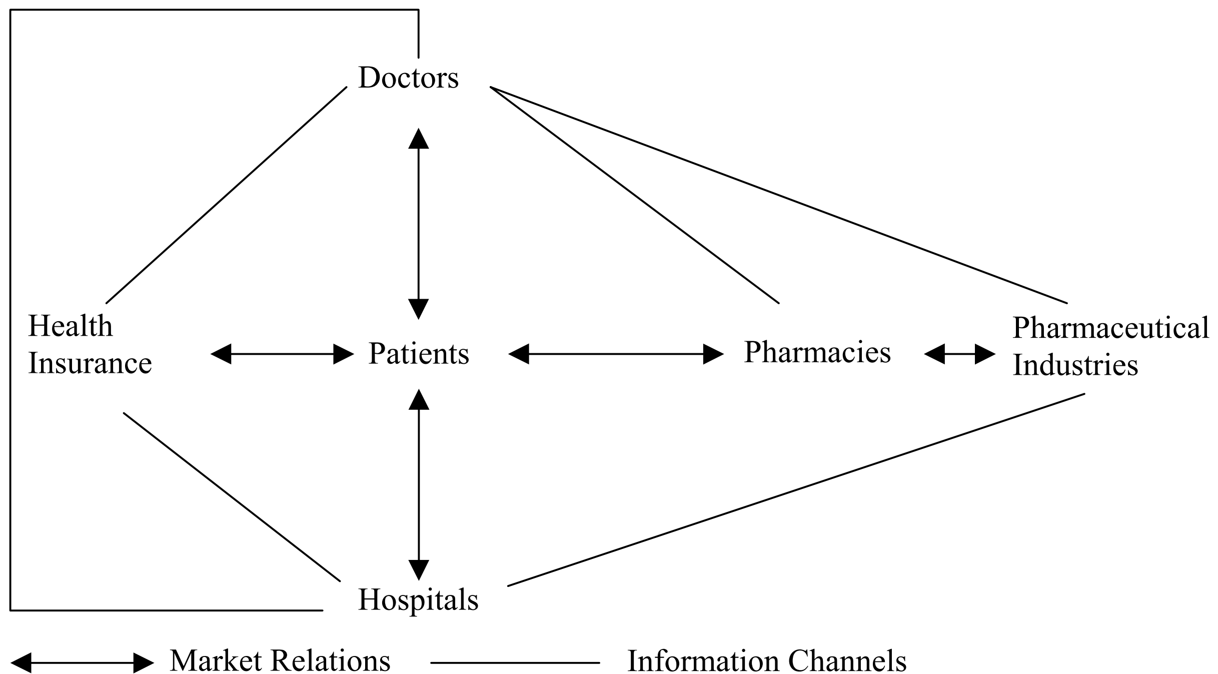
[7] In contrary to the social health insurance in Germany, which co-insures contribution free the family members, in private health insurances each individual family member has to sign an own insurance contract, so that the redistribution in between single and families and men to women does not occur.

[8] If a self-coverage is agreed, the monthly premium is much less depending on the chosen amount; at 600 EUR annual self-coverage the premium is about 130 EUR monthly. For the standard contract and other conditions see, e.g., Hallesche Krankenversicherung auf Gegenseitigkeit: http://www.al-h.de/. The social health insurance contribution in Germany depends on the individual wage. In an average public insurance the premium is 14 %; at the contribution limit of 4.350 EUR monthly in 2004 the maximum contribution is currently 609 EUR per month, one half paid by the employee and employer.

[9] For more detail see *Scheffler* (1997) and *Petersen* (1997).

[10] Because of the information advantages of the supply side in health economics it is often mentioned that Say's theorem holds true, which states that every supply creates its own demand. Consequently the flux of health goods and services heavily depends on the decisions of the suppliers with far reaching consequences for the cost development.

Chart 2: Market Relations and Information Channels in Health Protection



The demand and supply of health goods and services often comes along with *serious ethical questions*. The political standard argumentation is that due to disturbed preferences people systematically under-demand health goods and services or the health insurance itself so that state interventions are clearly justified. This *merit argumentation*[11] is often accompanied by arguments of *relative poverty* so that people cannot afford to pay an appropriate insurance premium. While the latter argument has obviously lost in relevance since the introduction of the Bismarckian insurance scheme about 125 years ago, the former argument is today contradicted by the fact that within the existing social insurance schemes an ever and ever increasing number of insurees demonstrates an obvious over-demand for health goods and services, being one of the most important causes for the excessive cost developments. And this over-demand is economically rational: if the price and the connected rationing mechanism of the market system is abolished it becomes individually efficient to demand from the system as much as possible, while the costs of the *moral hazard behaviour* are distributed to all – especially the well behaving – insurance members.[12]

While in a private insurance setting decisions on the coverage and therefore the rationing of health goods and services are made by the assured persons due to their *individual preferences*, the abolishment of the market mechanisms necessitates a political decision on the coverage extent of the social health insurance system. Sensitive individual decisions on ethical questions are consequently passing into *collective evaluation mechanisms*, which – due to heterogeneous preferences of the people – often do not lead to clear majority solutions. Therefore the *political resistance against any changes* is enormous and often connected with serious losses

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11 For the problems of merit goods see *Petersen* (1993, pp. 144) and health as merit good *Petersen* (1989, pp. 140).

12 For a description of moral hazard see *Petersen* (1989) and *Petersen/Müller* (1999, pp. 65).

in popularity. Hence, principally necessary adaptations are shifted into the future so that the coming generations are cumulatively burdened with the failures of the past.[13]

In a Beveridgean health care system like in the UK almost all the suppliers in chart 1 and 2 are socialized within the state sector. Because such a system principally produces long waiting queus due to political rationing decisions on cost intensive surgery, in the social health insurance systems the contributions have been permanently increased before rationing was implemented. In a formal sense within the social insurance scheme doctors and pharmacists as well as the pharmaceutical industries are private, while the social health insurance and the hospitals are predominantly part of the public sector. In any case the price mechanism has been substituted by a *publicly steered mechanism of cost coverage*, with overwhelmingly fatal consequences not only for economic efficiency but also for equality of opportunity.

Partial market failures (disturbed preferences on side of the assured, asymmetric information on side of the suppliers, oligopolistical structures within some markets and local monopolies due to advantages of scale and scope) have been used as justifying causes for a more or less complete socialisation of the health sector. But due to different forms of market failure and the insecurity of the insurance funds in case of unregulated insurance markets, political decisions in the past were often made against markets and in favour of state intervention. A whole theory of *private insurance failure* has been developed, which consist of problems of relative poverty, adverse selection, moral hazard, risk infection, long term insecurity of private funds etc.[14] While in private systems at least a certain insecurity of insurance funds necessitates state regulation, but never can exclude all capital risks, in social insurance and care systems strong *interest groups* emerge, using their collective power for *rent seeking* purposes, thus more and more exploiting the public systems. Doctors, dentists and pharmacists associations, organisations of the pharmaceutical industries and the public hospitals have been developed, which all are involved as interest groups in producing the costs to be born by the public. The insiders of the system do have much better information than the politicians as outsiders so that cost pressures are a built-in phenomenon. Hence, the *political risks* of public steered systems today are to be evaluated much higher than capital risks which might be involved within private insurance schemes. For decades it has been politically neglected in the traditional social policy that social insurance systems as well as care systems are confronted with just the same problems as discussed for private schemes or even worse: the problems are more serious creating structural deficits which make the systems unsustainable.

III. Private and Social Health Insurance in a Simple Model

With regard to the health protection system not only precautions for a possible income loss have to be made but also additional expenses for health goods and services have to be financed. In a private health insurance setting as mentioned above an individual health insurance contract would determine the possible reimbursement of the assured person for such health expenses. Then the individual person has chosen a certain coverage (full or partial) that is in accordance with an equivalent actuarially fair insurance premium. The level of the benefit in kind corresponds to the individual preferences.

In social health insurance and care systems the level of the benefits in kind secured by the social health protection system has to be determined by political decisions. While in the first phases of the social health protection systems a full coverage on an optimal level was striven

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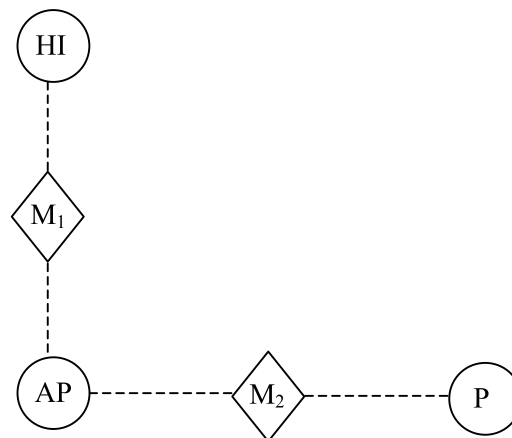
13 For details on the public choice approach to tax and transfer reforms see *Petersen* (2000).

14 For details see *Schönbäck* (1980) und *Petersen* (1989).

for, the misconstructions within the systems as well as the permanent expenditure pressure have forced social politicians to several reforms in which the full coverage was stepwise reduced. These reductions have often met the resistance of the beneficiaries as well as of the interest groups being involved (associations of physicians, pharmacist, pharmaceutical industry etc.). Therefore, the necessary reform process is getting along only in a very draggling way.

What are the main misconstructions within the health protection system? The comparison of a private health insurance with the basics features of the German health insurance can shed some light on the main problems. Chart 3 and 4 contrast cum grano salis a private health insurance as a market system with the current regulatory mechanism in place for social health insurance, whereby, for the sake of simplicity, the above mentioned interrelated markets (see chart 1 and 2) are neglected.[15]

Chart 3: Private Health Insurance as a Market System



Source: Herder-Dorneich (1980, p. 37).

In the model of private health insurance we have three bargainers: the assured person (or patient), AP, as demander of health goods and services (here: outpatient physicians' services[16]), the physicians (or practitioner), P, as supplier of health goods and the health insurance companies, HI, as supplier of health insurance policies (cost coverage). Two markets connect these bargainers: market 1, M_1, for insurance services, and market 2, M_2, for health services. Without going into detail[17], it should be noted that the assured person, AP, directly demands health services from the physician, P, and pays in real market prices. The receipts, which the assured person obtains from the physician, comprise the quantity and quality of health services as well as the single prices. Consequently the assured person has full information on the services and the connected costs.[18] The assured person then passes on the receipt to his health

[15] The most important source for such presentations is *Herder-Dorneich* (1980).

[16] In private health insurances the insurance contracts are predominantly separated in four kinds of health goods and services: 1. Outpatient physicians' services, 2. dental treatment, 3. hospital expenses, and 4. the replacement income in case of sickness. In these entire contract details different levels of coverage can be agreed upon dependent on the individual risk preferences of the assured person.

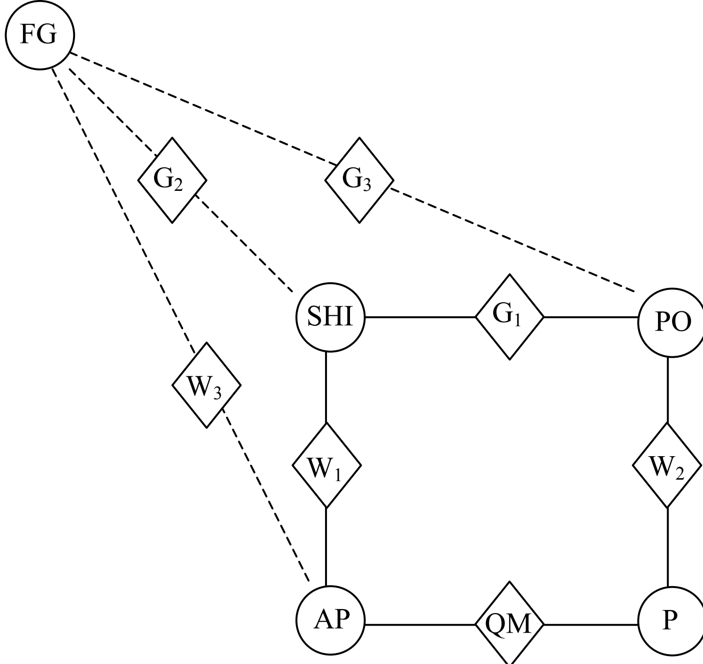
[17] See *Petersen* (1989, pp. 142).

[18] Information on the quality of health services can be derived if the doctors would be evaluated by patients, insurances or independent organisations; in the current systems such evaluations are predominantly non existing.

insurance, HI, which reimburses the assured. Hence, the assured persons have the full sovereignty of consumption with regard to the choice of insurances and the physicians, and they have full information on prices and services, so that a clear cost consciousness does exist.

In comparison with the model of social health insurance (see chart 4), two other (groups of) bargainers are added: First, the physicians' organisation (or association), PO, is an institution which is responsible for the distribution of the total amount of insurance revenue[19] provided by the social health insurance, SHI, for physicians' services to the individual physician. Second, the federal government social politicians, FG, who have the main responsibility for the insurance coverage as well as the budgets. In addition, the market relations within the private insurance model are replaced by electoral systems, $V_1 – V_3$, and a medical card (or voucher) system (often called quasi market, QM), which is the entrance key to the health services. The term quasi market is somewhat misleading because neither information on medical services nor on the costs of services are given to the assured persons. It is rather a voucher or purchase permit system which on the part of the assured creates the illusion that health services are zero priced – with all the well-known negative consequences for allocation. Furthermore the assured persons do not get any information about the quantity and quality of health services generated by the physicians, so that a real control mechanism of the physicians' supply is badly missing. Consequently the billing fraud is becoming a frequent problem. In case of such a misconstruction the differences between a Bismarckian insurance scheme and the Beveridgean health care system diminish in the course of time and both systems become more and more inefficient.

Chart 4: Steering Mechanism of a Social Health Insurance



Source: Herder-Dorneich (1980, p. 35).

As consequence of the increased number of bargainers, the network of relationships between them becomes much more complex. The insurance market, M_1, is replaced by the election of

[19] Simply expressed the total revenue results as average social health insurance contribution multiplied with the number of assured persons within the single insurance.

membership representatives[20] to the health insurance, V_1, and an electoral process, V_2, is also implemented between the physicians, P, and the physicians' organisation, PO. The relation between the social health insurance, SHI, and the physicians' organisation, PO, is regulated by group negotiations, N_1, and corresponding group negotiations, N_2, take place between the federal government, FG, and the social health insurance, SHI. The general elections for the federal parliament, V_3, are an expression of the relation between the federal government, FG, and the assured persons (or voters), AP. Last but not least the group negotiations, N_3, between the federal government, FG, and the physicians' organisation, PO, have to be mentioned.

With regard to *public choice* theory, all bargainers have massive *self-interests*, which impair, at least partially, the overall efficiency of a market economy. Because the assured continue, as a result of their strategy to maximize individual utility, to obtain high-quality medical services at the most favourable insurance premium, and because there is a lack of information on the services supplied by the physicians and the corresponding costs, *cost consciousness is inevitably reduced*. Since the medical card system creates false information and illusions, the propensity to moral hazard behaviour is increased. In comparison with a private insurance system that consists of several competing private health insurances perhaps in an oligopolistical structure, a mandatory health insurance system covers a much larger membership. Because the costs of moral hazard are distributed among all members, at least in the beginning, the per capita costs of moral hazard for the individual member in the social insurance system is lower than in a smaller private health insurance. Hence, the possible individual profit is high; the individual cost-benefit analysis demonstrates that moral hazard is profitable as long as it does not become a general phenomenon.

Therefore, to rely solely on quasi markets or on the introduction of some market elements into the social insurance system might currently be the only feasible strategy, but it remains a strategy of curing symptoms. It is quiet obvious that political group negotiations are instruments, which may be popular with social scientists, but what is created instead of the alleged market failures of private insurance markets are *political failures, governmental failures, electoral paradoxes, bureaucratic failures, etc.* Causal therapy would involve strengthening the insurance markets by providing efficient regulation and by subsidising the insured individuals who would otherwise be hit by adverse selection because of a bad personal risk structure. The latter problem is an important task of a socially orientated market economy that directs its support to the really poor within the societies.

In practice pure market systems as described by chart 1 do not exist. Since some decades in almost all countries the private insurance schemes are more or less efficiently regulated.[21] The regulations range from *competition control* via cost and *price control* to insurance *funds security* and *funds policies*. For several insurance branches *reinsurance programmes* have been implemented to assure the funds of the insurees against the bankruptcy of single insurances. All these measures have contributed to a strongly increasing safeness of mature private insurance schemes so that today the security situation of the private scheme often seems to be much more promising than of the public ones, the latter especially threatened by the gloomy demographical prospects.

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[20] The employees (via the trade unions) and the employers both have 50 % of the representatives within the social insurance system.

[21] In Germany the insurance control has been recently merged with the bank control within one institution, the *Bundesanstalt für Finanzdienstaufsicht*; for details on the historical development of banking and insurance control see http://www.bafin.de (Wir über uns: Geschichte).

IV. Misallocation and Malpractice in Social Health Care and Insurances

In the following chapter the current malaise within the health service systems of two countries will be shortly summarized. The UK is chosen as example for an inefficient care system, while Germany presents the problems within an inefficient social health insurance. The chapter closes with some remarks on the intertemporal problems also involved in health economics.

IV.1. The UK Health Care System

The Beveridgean type of social protection has grown out of the poor relief, which was exemplified in the early pension legislation of Britain (1908).[22] Today a comprehensive state administered social protection system covers almost the entire population. While the care components are mainly tax financed, the social insurance components are financed from contributions, which partly allow for income-related benefits.[23] The National Insurance Fund (NIF) is the core institution of the social insurance system, which is financed by compulsory contributions based on current income and paid by most workers and employers.[24] The system covers the pension insurance, unemployment insurance, accidents insurance as well as sickness and maternity benefits. The contributions raised by the NIF are distributed on the single insurance branches. Additionally the NIF receives a public grant from the budget, which is about 10 to 15 % of the total expenses.[25]

The NIF contributions are paid as part of the income tax, following the pay as you earn approach (withdrawal or source tax). In case of the existence of occupational pension schemes, only reduced contributions to the NIF are paid (so-called contracting-out). For private old age protection, the total NIF contributions apply. The NIF then transfers the contributions, which are above the reduced contributions to the private pension insurance. For the NIF contributions four different contribution classes exist (see chart 5).

Chart 5: Contribution Classes for the NIF

Contribution Class		Description
Class 1	-	Paid by people who work as employed earners and their employers
Class 2	-	Paid by people who are self-employed
Class 3	-	Voluntary contribution by people who wish to protect their entitlement to the state pension and do not pay enough national insurance contributions in another class
Class 4	-	Paid by those whose profits and gains are chargeable to income tax. These are normally paid by self-employed people in addition to Class 2 contributions

Source: Inland Revenue (2003, p. 2).

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22 Before similar models were introduced in Scandinavia, e.g., in Denmark 1891. See for more details *Baldwin* (1997, pp. 4).

23 See *Europäische Kommission – Beschäftigung und Soziales – Missoc* (2002) under http://europa.eu.int/comm/employment_social/missoc/2002/org_de.pdf.

24 See *Schmidt* (2002, p. 166).

25 See *Inland Revenue* (2003, p. 48).

In class 1 the British "standard" employee is assured. Above the income threshold the employers' contribution rate is 12.8 % and the employees rate 11 % of the earned wage (see chart 6). For contracted-out workers the employers contribution is reduced to 9.3 %. Below the threshold no contributions are raised and the employer is not assured. For wages in the range of the lower limit (5,805.80 Euro)[26] and the threshold (6,691.75 Euro) contributions are still zero, but an assurance does exist; the contributions for the self-employed are also represented in chart 6.

Chart 6: NIF Contributions and Assessment Limits

Class	Contributions		Assessment Limits
	Employees	Employers	
Class 1	- Wage below threshold: no contributions - Wage above threshold: **12.8 %** (Contracted-out: **9.3 %**)	- Wage below lower limit: **no insurance** - Wage between lower limit and threshold: **0 %** (but assured) - Wage between threshold and upper limit: **11 %** (Contracted-out: **9.4 %**) - Wage above the upper limit: **1 %**	- Lower limit: **5,805.80** €/ year - Threshold: **6,691.75** €/ year - Upper limit**:** **44,863.00** € / year
Class 2	- Lump sum contribution (2002): **2.90 €/ week**		Negligible income limit: 5,836.25 €/ year
Class 3	- Lump sum contribution (2002): **9.93 €/ week**		No limit, volutary contribution
Class 4	- **8 % of profits** above the lower and below the upper limit - **1 % of profits** above upper limit		Lower limit: 6,691.75 €/ year Upper limit: 44,863.00 € /year

Source: Inland Revenue (2003, pp. 7 and 2003 a, pp.13) and Adams/Kaplan (2002, pp. 9).

Non-contributory benefits and transfers in kind are financed from the general tax revenue and dependent on specific personal circumstances. The National Health Service (NHS) provides universal health care, which is financed form tax revenue and the NIF. Because the whole social insurance (NIF) is financed by an overall contribution, a separation on the single branches is not possible.

The UK health protection system is a tax financed public health care system in which all the UK residence participate. Even the supply side (practitioners, consultants, pharmacists, hospitals, etc.) is part of the public sector,[27] so that the remaining quasi-markets within the social health insurance approach (see chart 1 and the surrounding text above) are abolished. In contrary to the transfers in kind, which are covered by the National Health System (NHS), the cash benefits (sickness benefits, maternity benefits, and benefits in case of occupational disea-

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[26] The amounts have been converted from GBP to Euro with an exchange rate 1 GBP = 1.45 Euro.

[27] Since 1998 experiments with alternative models are made, in which personal medical services (PMS) are supplied on the base of local contracts between Local Health Authorities and licensed doctors. For details see *Europäische Kommission – Beschäftigung und Soziales – Missoc* (2002) under http://europa.eu.int/comm/employment_social/missoc/2002/uk_part2_de.htm.

ses) are born by the National Insurance Funds (NIF).[28] The private health insurance system is limited to upgrade insurance. Because of increasing *waiting times and queues* especially for high quality medical treatment, *private upgrade insurances* have become more popular; in 1996 about 9 % of the UK population were assured in an private upgrade health insurance.[29]

The remunerations for the doctors are negotiated between the government and representatives from the doctors associations; the NHS administers the public hospitals. The expenses for medical services are financed by the general tax revenue (about 80 %); the remaining 20 % are mainly financed by the NIF. Principally the choice of the home doctor is free but the doctor himself has to agree; the home doctor is the key-person who regulates the access to the consultants as well as to the hospitals. The medical treatment of doctors and within the hospitals is without any personal co-financing. For dental treatment of the General Dental Service a co-financing does exist. The NHS covers 80 % of a course of dental treatment expenses up to 522 Euro. For pharmaceuticals the co-financing is 8.85 Euro for each prescribed item.[30]

The sickness cash benefits are partly paid by the NIF. The Short-term Incapacity Benefit (IB) applies for self-employed and unemployed people. For employees only the Statutory Sick Pay (SSP) applies if they have reached the lower earning limit of the NIF. Before sickness benefits are paid, there is a waiting period of three days. The SSP is paid by the employer in case of illness lasting at least 4 consecutive days up to a maximum of 28 weeks. The standard rate is 90.19 Euro per week (or about 390.83 Euro per month). The IB and family additions are financed by the NIF. The IB is paid in two rates: the lower rate of 76.26 Euro per week applies for first 28 weeks; the higher rate of 90.19 Euro applies thereafter. If the person is over pension age, the weekly amount is 101.14 Euro per week. For spouses over the age of 60 or adult caring for dependant children the additional benefit is 47.20 Euro per week, for the first child 14.07 Euro and for each other 15.89 Euro.[31] The short-term IB applies for 52 weeks maximum; then it is replaced by a long-term incapacity benefit. All these benefits are due to the income tax.

Compared to the much more generous social health insurance cash benefits in Germany[32] and other European countries,[33] the *British system is obviously basic security orientated*. Due to the high co-financing of pharmaceutical items, the waiting period of three days until the SSP und IB are paid, and the comparatively low sickness benefits, the UK population is obviously much less pampered by the social network and has therefore much stronger incentives for protection measures to be decided on in primary responsibility. In view of the poor protection levels and partly enormous queues for high quality medical treatment, the system still finds acceptance, obviously because from the very beginning it has *promised less than many social insurance schemes did*. However, discussions on the reform of the NHS are highly on the agenda.

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[28] For more details see *Petersen* (forthcoming).

[29] See *Jakubowski/Busse* (1999, p. 122).

[30] An annual (or 4 months) prescription prepayment certificate can be bought which offers considerable savings to those who need regular medication. The cost of the certificate is 46.26 Euro for 4 months and 127.02 Euro for one year. For further details see *Europäische Kommission – Beschäftigung und Soziales – Missoc* (2002) under http://europa.eu.int/comm/employment_social/missoc/2002/uk_part2_de.htm.

[31] See ibid.

[32] The German sickness benefit, paid for the first six weeks by the employers, is 100 % of the last wage before sickness; the expenses of the employers are 4 to 6 % of the payroll.

[33] In *Petersen* (forthcoming) a comparison for four European countries is presented.

IV.2. The German Social Health Insurance System

The social health insurance system is not a unitary institution but consists of local, companies, guilds, agricultural, professional, etc. insurances and the so-called compensation cashes, which are self-administrative entities of public law (like all the social insurances). Since some years the number of the existing insurances decreased to 420 in the year 2000 (see table 1). The membership is compulsory for all blue-collar workers and for white-collar workers with a wage below the income limit for the legal obligation to insure (see table 2). Above that limit employees are free to choose self-coverage of health risks or to assure within private health insurances. Self-employed and employees above the income limit can be voluntarily insured in one of the above mentioned insurance types while some special prerequisites apply. Since recently the compulsory members are free to choose their preferred insurance from the basket of the existing mandatory health insurances, so that since 1996 a certain *competition between the mandatory health insurances has been introduced*.

Table 1: Social Health Insurance

Specification	**Unit**	**1998**	**1999**	**2000**
Single insurances	Number	483	459	420
Members (incl. pensioners) [1]	1 000	50 686	50 927	51 036
Receipts [2]	EUR mn	127 750	131 203	133 808
Expenditure [2]	EUR mn	127 473	130 918	133 740

[1] Average of 12 monthly values.
[2] Excl. risk structure compensation scheme.

Source: Statistisches Bundesamt (2002)

Table 2: Overview on the Basic Parameters of the Social Insurance Scheme 2003

Income limit for the legal obligation to insure

Health insurance	Old States	New States
Year	45,900.00 Euro	45,900.00 Euro
Month	3,825.00 Euro	3,825.00 Euro
Day	127.50 Euro	127.50 Euro

Contribution assessment limit

Health and old age care insurance	Old States	New States
Year	41,400.00 Euro	41,400.00 Euro
Month	3,450.00 Euro	3,450.00 Euro
Day	115.00 Euro	115.00 Euro
Pension and unemployment insurance	Old States	New States
Year	61,200.00 Euro	51,000.00 Euro
Month	5,100.00 Euro	4,250.00 Euro
Day	170.00 Euro	141.67 Euro

Contribution rates

	Old States	New States
Branches of social insurance		
Pension insurance	19.5 %	19.5 %
Health insurance	11.9 % to 15.7 %	11.9 % to 15.3 %
Old age care insurance	1.7 %	1.7 %
Unemployment insurance	6.5 %	6.5 %
Students contributions		
Health insurance	45.67 Euro	45.67 Euro
Old age care insurance	7.92 Euro	7.92 Euro

Wage limit for negligible part-time employment

Month	325.00 Euro	325.00 Euro

Source: Bundesministerium für Wirtschaft und Soziales (2003).

Compared to the social pension insurance, the large number of much smaller social health insurances creates an *adverse selection problem* for the single insurances because in some of them bad risk cases are concentrated. With the purpose to avoid negative consequences for single insurances, risk sharing or equalisation schemes have been implemented (*risk structure compensation scheme*).

The single social health insurances have due to their different risk structure different costs, which are also expressed in *different contribution rates*. The actual contribution rates are in the range from 11.9 % for the most favourable and 15.7 % in the most expensive insurance (see table 2).[34] These contribution rates are applied until the contribution assessment limit is reached, which is 75 % of the social pension insurance contribution assessment limit. The maximum contribution is then between 4,926.60 Euro in the most favourable and 6,499,80 Euro in the most expensive social health insurance. *Non-working family members (spouse and children) are contribution-free insured*.[35] As in case of the social pension insurance contribution, the employee and employer pay half of the contribution, respectively. Principally the single insurances have to balance their budgets by contribution adaptations in due time. Therefore contribution revenue (receipts) and expenditure are almost balanced (see table 1).

The benefits from the social health insurance are mainly medical services (transfers in kind) and sickness benefits. Law independently from the actually paid contribution defines about 95 % of all medical services. The comprehensive catalogue comprises all necessary medical treatment from ambulant treatment of physicians and dentists to hospital treatment on a comparatively high level.[36] With different cost abatement laws co-payments for the assured were introduced. For pharmaceuticals, hospital treatment and especially for dental treatment (dental prosthesis) as well as eyeglasses the co-payments are partly defined in absolute and partly in relative terms.[37] But generally the patients do not get any information about the quantity and quality of medical treatment they have demanded, abstained from any price or cost information (see chart 1 and the surrounding text above).

People in old age who were in need of care were only very limited assured in the social health insurance and often got into the social aid system due to the high care costs. Therefore in 1995 old age care insurance was invented and implemented as a mandatory system for all citizen older than 18 years. Even the self-employed and government officials are compulsory members. Therefore, this social insurance scheme has with 71,3 million members in 2000 the largest number of persons insured of all existing social insurance systems (see table 3). Citizen with income above the limit for the legal obligation to insure have to procure an old age care insurance contract with their private health insurance.

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[34] The actual contribution rates are to be found under http://www.abc-der-krankenkassen.de/template.php3?page=alphabetinc.php3&id=1.

[35] The income dependency (instead of a risk orientation as in private insurance schemes) and the contribution-free co-insurance of family members are re-distributive measures, which currently are seriously discussed.

[36] For details see http://www.abc-der-krankenkassen.de/gesetzlicheLeistungen.htm.

[37] See http://www.abc-der-krankenkassen.de/zuzahlungen.htm.

Table 3: Social Old Age Care Insurance

Specification	Unit	1998	1999	2000
Number of persons insured	1 000	71 458	71 545	71 319
Recipients of benefits	1 000	1 738	1 819	1 822
- domiciliary care	1 000	1 227	1 275	1 261
- residential care	1 000	511	544	561
Receipts	EUR mn	16 083	16 318	16 543
Expenditure	EUR mn	15 823	16 352	16 674

Source: Statistisches Bundesamt (2002)

The contribution rate in the old age care insurance is constant since 1996 with 1.7 % up to the contribution assessment limit of the social health insurance (see table 2). The maximum annual contribution is 703.80 Euro, again divided between employee and employer. While in the first years the old age care insurance has made a surplus, until recently deficits have been run, so that contribution rate increases as in the social health insurances are likely.

The need of care is defined in detail by the law; different grades of care are differentiated. In the first grade daily care is supported by transfers in kind up to 383.50 Euro or in cash to assisting relatives up to 204.50 Euro per month. In the highest third grade the amounts are 1,431.60 Euro and 664.70 Euro, respectively. Due to the high monthly costs of old age care in nursing homes of often much more than 3,000 Euro per month, even in case of an average pension payment both, the transfer in kind and the pension are not high enough to pay for the nursing costs. Then the maintenance obligation of the relatives becomes effective or in case of poverty the social aid system has to come into effect.

Because a large part of the German population is compulsory assured in the social health insurance system (clearly about 90 %), the assured persons in the *private health insurance* system are overwhelmingly *self-employed and government officials*. The latter do have an own health care system, which principally pays for 50 % of the medical expenses; usually the other 50 % are assured by quota-contracts within the private health insurance system.[38] Naturally the private health insurances have *risk-orientated premiums* for the individual members (differentiated for male and female, age, individual risk situation, age at inception date, etc.) including lifetime individual accounts for the *old age accruals*. In spite of the regulations in other European countries, in case of insurance change the accruals are expired. This regulation interferes the competition between the single health insurances. However, discussions on possible changes in the regulation have begun. The private health insurance market has an oligopolistical structure. The opening with regard to the common European market has strengthened the competition and additionally improved the risk structure within single insurances. As mentioned above, the contract usually consists of four parts: ambulant treatment of physicians, dental treatment, hospital treatment, and replacement income. *All measures to avoid moral hazard are used*. In each part of the contract a certain retained amount can be arranged that

[38] Both can by application also become members of the social health insurance as far as their income is below the limit for the legal obligation to be assured or before they have been employees with mandatory membership.

reduce the insurance premium. Moreover, premium reimbursement is implemented, which also reduces the premium dependent on the length of the period (number of month or years, partly with progressive reimbursement) in which no benefits have been claimed. In case of high risks additional premiums are applied. The in former times possible debarment in case of high risks is today overwhelmingly avoided because such practices have undermined the trust of the assured into the private insurance scheme.

In Germany the *private health insurance is bound to the price system of the social health system*, thus reflecting the problems and inefficiencies involved in that scheme. The medical services are systematically higher priced as in the social health insurance by a multiplier system, which is dependent on the complicacy of the single medical treatment. In the coming reform of insurance regulation also separate price negotiations between the private insurances and the physicians (or physicians' association) have to be reconsidered.

IV.3. Current Discussions: Intertemporal Perspective and Fundamental Change

Since the health protection is more a problem where cost coverage can predominantly be organised within one period, the PAYGO approach is even appropriate for private insurance schemes. But because the health expenditures heavily depend on the age of the assured persons, in the health insurance – like in the pension schemes – an *intertemporal problem of risk sharing* does exist. In a private insurance scheme the increasing costs for the older assured are reflected in a special fund financed from the premiums, which have been paid during the active phases of live. The private health protection is then at least partially protected against increases in live expectancy as long as such increases are projected correctly. In the social health protection systems such an intertemporal mechanism is badly missing, so that the *demographic changes will also have gloomy consequences for social health insurance* as well as care systems. Already in the last two decades in the German example the expenses for retired persons have been increased more than double as strong as the expenses for the general health insurance.[39]

Fundamental changes within the social health protection systems are in the discussion; on the one hand the financing by wage-related contributions has been substituted by *per capita premiums* (as in the case of Switzerland). Consequently such a reform would mitigate the problem of the ancillary wage costs (non-wage labour costs). But without a reform of the expenditure side on the other hand, no clear reduction of the wage extra costs can be reached. A *catalogue of basic health services* must be defined in which the coverage is limited to the really necessary sickness expenses.[40] This catalogue has to be guaranteed to every member of the society. In case of poverty the catalogue has to be supplied in form of transfers in kind, or alternatively, this catalogue is supplied by private health insurances. Then the social aid recipients would get their risk orientated personal insurance premium paid by the social aid system. In case of cost free insurance periods they also would profit from the repayment of premiums so that even in this group a better cost control and incentives for decreasing health expenses are given. For all employed persons the insurance premiums for that basic health care would be income tax free, so that all groups of the society would have the same mini-

[39] See *Institut der deutschen Wirtschaft* (2003, p. 5).

[40] See, e.g., *Sowada* (2000).

mum health care.[41] Additional health services then have to be insured by insurance contracts guaranteeing higher coverage levels.

V. Interplay of Public and Private Health Insurance: Lessons for Countries in Transition

The basic lines and problems of social health protection systems have already been discussed above. Our analysis has made clear that the current social health insurance as well as the health care systems is fundamentally faulty constructed. The only possible reform perspective is causal therapy because curing symptoms has already failed in the past. As far as social health insurance schemes are taken into consideration, only the introduction of market elements could overcome the current malaise of permanent cost explosions. Market elements on the one hand consists of *clear cost signals for the assured* connected with better *control mechanisms of the medical supply*, e.g., detailed information for the assured on the quantity, quality and prices of health goods and services. On the other hand the introduction of market elements have to deliver the *correct incentives* which would steer the assured demand for health goods and services much more efficiently. As far as the institutional setting is taken into consideration, the question has to be answered if all that elements could better be organised within a private insurance scheme, because only in such a scheme a sufficient extent of necessary competition can be secured which is always necessary for price control.

A fundamental and comprehensive health protection reform has to solve two tasks: First such a reform should secure the framework for a long term optimal allocation of public expenditures for health protection; second – and perhaps more important – is the necessary reformulation of the role of the societies solidarity and the role of the state with regard to their responsibilities connected with health protection. Hence, it becomes more and more clear that even the West European countries are unable to guarantee the highest possible quality and quantity of health goods and services in the sense of a sufficient coverage for every citizen with all technical possible, expensive medical services. Demographic change, ageing and the badly lacking incentives for an economically demand for medical services intensify the financial pressures.

The social politicians being interested in re-election overwhelmingly stick to a guaranteed full coverage for every citizen and deny any unequal treatment regarding the access to medical services. Often they almost swear to the classless society with regard to medical services, thus impairing the scarcity conditions which are fundamental for every economic system. If any rationing is refused, there are no chances for the introduction at least of some market elements. If rationing by the price system is rejected, as the real existing socialism has proofed, waiting queues are the outcome, as can be easily observed as consequence of the UK health care system. Then, step-by-step, private parallel markets for health care services emerge in which the unsaturated demand meets a sufficient supply, partly at relatively high costs.[42]

If the rationing mechanism of markets as consequence of the mechanism of relative prices is abolished, the scarcity condition is switched-off in that sector, one and perhaps the main reason for the permanent cost explosions that are only prolonged by curing symptoms instead of causal therapy. The classless society just for one sector is as an illusion as for the whole

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41 For the integration of the tax and transfer system see *Anton/Brehe/Petersen* (2002), *Petersen/Rose* (2003) und *Petersen* (2003a, 2003b, 2003c, and 2004).

42 In many transformation states, or even already in socialistic times, the health care systems were not able for a sufficient supply of medical services, so that on illicit markets (or below the tables) medical services were traded.

society. With regard to consumption possibilities for “ordinary” goods and services, the differentiated income class society is at least in market economies accepted since generations, thus creating the necessary incentives for the supply of effort. The emergence of private markets is expression of the consumers’ sovereignty, which is obviously suppressed in the social protection systems. The ban of private medical service markets would be a clear offence against a market economy and is a clear interference into the constitutional rights. Even in view of the current discussions in Germany that medical services for a basic coverage should be only supplied by social health insurances,[43] such change would be a clear step backwards to an increased interventionism of the state and even worsen the current situation.

One important argument for a justified and well-dosed state intervention is the general interest of the public on a sufficient state of health and on the existence of satisfying precautions in case of sickness. As important is the individual interests of the citizen with regard to their own health situation. Due to the consumers’ sovereignty, the general interest of the public can only justify complementary and accompanying measures of social protection if the individual precautions are not secured in a sufficient way. However, many medical services are indispensable to life. In case of need, any refusal of such services would jeopardise the physical existence of the affected people. Therefore, in the European setting it is out of question that *vital medical services are made available*, independently from the needy individuals ability to pay for such services. The health protection for the persons in need has to been overtaken by the state, following the justice of needs concept (or the solidarity principle).[44]

In the health protection scheme the justice of needs concept can be expressed in two demands: First the identification of *basic security services* in the medical sphere has to be limited to that services which are indispensable for life. Obviously this identification is connected with ethical reasoning, with individual as well as social norms, and the technically possible medical services. Because even in such an important service sector, *a permanent breach of the general scarcity conditions cannot be accepted without endangering the existence of the whole economic system.* Therefore, the identification of the really necessary medical services is a permanent task for the societal discourse that finally influences the voting behaviour of the citizen. The second demand is connected with the principle of *subsidiarity*, which states that in the very first instance the responsibility even for such basic and important health good and services is with the individual. Society and state should concentrate their care on those who are unable for individual health protection. If free rider behaviour is a frequent and individuals who are principally able for protection in self-responsibility do not care, a *mandatory obligation for health protection could be legitimate*.[45]

The identification of the basic catalogue of the medical goods and services is a complex task that can be only solved by politicians, physicians and economists in an interdisciplinary approach, e.g., done in official ethical commissions. The volume and structure of such a catalogue has to be permanently adapted to the technical standards as well as to the economic possibilities. In that identification process the highest possible extent of transparency should be striven for. Economics and health economics have developed a real bundle of criteria, which

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[43] The *Rürup commission* currently discusses such ideas. For the results see http://www.soziale-sicherungssysteme.de/download/index.html.

[44] For a detailed discussin of the concepts of justice of ability and justice of needs see *Petersen* (1993) and *Petersen/Müller* (1999).

[45] But one should be fully aware that alleged free rider behaviour is often a pure interest group argument to press the whole population into mandatory systems because only a comprehensive system secures solidarity. Comprehensive, monopolised systems mean on the one hand the largest possible political impact for the lobbyists, and on the other hand the necessity of permanent political interventions from the social politicians. Both impacts are overwhelmingly counterproductive; for details see *Petersen* (2000).

allow a classification in basic and upgraded health services.[46] Here the criteria of the medical exigency, the medical effectiveness, and the cost criteria are just to be mentioned.

Principally the individual insurance approach is the most comfortable alternative for social market economies, even if most of the existing health insurance systems follow – due to the above-mentioned historical reasons – quite another approach. The premiums are fully orientated to the individual risk. Changes in the risk situation have then consequences for the future premiums. The intertemporal risk sharing necessitates individual funds for the old-age, which should be clearly defined and transformed to a competitive insurance in case that the assured will change into another insurance.[47] The problem of *adverse selection*, which does exist in all insurance schemes, can be easily solved by a *subsidisation of the part of the premium*, which is above the standard risk for disabled people, and in case of poverty the full premium could be transferred as mentioned above. Poverty and disability are clearly defined facts while only in case of psychological diseases some problems of identification remain, which are also creating problems within the current institutional settings. Hence, an efficiently regulated private health insurance scheme with a basic insurance and a upgrade insurance is able to overcome all the limitations of private insurance schemes mentioned above if the problems of relative poverty and adverse selection are solved by premium grants for the concerned groups of assured persons.

Naturally such a health protection reform needs a certain trust in the regulative powers of the government as well as in the efficiency and justice of the connected market solutions. Even in the Western European countries often such trust is badly missing – in spite of the obvious failures of the existing systems. Whether the introduction of a private health insurance system would be the silver bullet in the direction of a social market economy, for a transition period even a social insurance scheme might be a system which is only political feasible. This is especially true if the change form a publicly administrated care system has to be organised.[48] But if such an interims solution is striven for, *the decisive elements of a well indicated catalogue of basic health services as well as the necessary steering mechanisms for the demand of health services and the control of the supply side have to be integrated into such a model*. Then the future switch to a private scheme would be far easier because the basic market elements have already been integrated with the interim reform step.

Beside the health insurance problem, a specific problem of old-age care has been identified in Germany during the mid 90s of the last century. The answer has been a new social insurance scheme: the old-age care insurance as mentioned above. Principally the old-age care problem would not have been a problem at all if the social health insurance scheme would follow the funding approach for the old-age people as it is in the case of private health insurance. The old-age care insurance therefore is the consequence of a falsely constructed social health insurance, so that in an efficient private setting there is no pride of place for such an insurance branch.

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[46] See, e.g., *Sowada* (2000, pp. 55).

[47] In Germany these funds are lost in case of an insurance change that creates a trap against any change and impairs the competition between the insurances.

[48] In the Polish example a social health insurance has been introduced; for details see *Sowada* (2000). Because of similar constructive failures as in the Germany this system has recently come under enormous pressures.

VI. Summary: The Necessary Steps to a Fundamental Reform

Summarizing all arguments in a nutshell, the clear diagnosis is: the social health care and insurance schemes are sick of too much political intervention and heavily infected by interest group influence. These fundamental failures can only be overcome if the cobweb of supply-dominated influences and lobbying of the involved association is substantially pushed back. The design of a modern mix of public and private health insurances has to be so efficient that permanent political interventions become redundant. In the German case that would mean fundamental reforms within the private insurance schemes as well as within the social health insurance system.

Private Health Insurance:

- More *efficient regulation* of the insurance system by independent control of costs and premiums (like in case of the audit courts).
- *Transfer of old age accruals* in case of insurance change from the old to the new health insurance to strengthen the systems competition.
- *Reinsurance* of the funds for the old age accruals to limit capital risks.
- *Segregation of the negotiations* on medical fees and hospital expenses of the private health insurances from the collective bargaining process of the social health insurance system.
- *Direct contracts* in between the private health insurances, the doctors (physicians) and the hospitals.
- *Quality inspections* by the private health insurances for doctor's and hospital's performance including a free information policy.
- *Abolishment of competitive restrictions* for doctors and hospitals.

Social Health Insurance:

- Combating the asymmetric information in favour of the supply side by giving clear *information of medical attendance* and the *costs of medical treatment and pharmaceutical products* to the patients.
- Combating moral hazard behaviour of the patients by introducing the steering mechanisms of the private insurance schemes, especially *voluntarily agreed co-payments* and *premium refund* in case of no claims against the insurance within the insurance period.
- Combating rent seeking and principal agent problems by *eliminating excessive interest group influence* (that is to say to diminish or even abolish the influence of the physicians association mentioned in chart 2 and to increase the competition within the pharmacies and pharmaceutical industries sectors).
- *Eliminating* health goods and services with predominantly *cosmetic character* (large parts of dental treatment)
- Improving the knowledge of the population an health *policies and individual health provision*.

- Improving the knowledge of the population with regard to the *functions of insurance schemes* (i.e., the insurance service is the release from an individually often unbearable risk but not the occurrence of the risk assured).
- Implementation of *quality controls* for doctors and hospitals.
- Stepwise intensification of *competition in between the social health insurances*.
- Introducing an *appropriate health insurance size* to avoid problems of adverse selection on the level of the single insurances (merging process between single and also to small insurances).
- Introducing *per-capita-premiums* instead of wage related contributions.[49]

These likely incomplete list of measures would strengthen the social as well as the private health insurances. The remaining problems would be how to combat adverse selection and poverty within such a mixed system. In a fully privatised system the so-called bad risks and people in relative poverty would get a grant for the additional risk premium or a premium subsidy for the poor so that they would remain above the poverty line. Similar measures have to be implemented if the current wage-orientated contributions would be substituted by per-capita-premiums within the social health insurances. Such a switch would not reduce the total systems cost, which is only possible if the above mentioned additional spending cuts are implemented. But the combined effect of such measures would be the separation of wages from the health insurance premium and a remarkable decline in ancillary wage cost, thus improving the employment conditions for labour compared to capital.

Obviously is the necessity for fundamental reforms much more pronounced than the willingness of social politicians to present a courageous draft law to the public. But the long lasting debates on the cumulating problems within the social protection systems have already had some positive impacts beside the half-hearted reforms of the last years, which could be taken as reason for a more optimistic foresight. On the one hand some social health insurances are rethinking their business strategies and discussing the access to the private health insurance market. On the other hand the private health insurances in Germany very recently have developed an internal strategic paper which discusses a standard tariff. Such a tariff could be opened even for compulsory insurees in the social health insurances, while the costs could be born by a collective funds of the private insurance scheme.[50] Whatever the outcome might be – the front lines are already at least partly dissolved; if courageous but stepwise reforms would also promise the existing social health insurances a prosperous future, the resistance of the old pressure groups could be overcome to the advantage of all: the citizen as well as the employees within the health sector which certainly will play an important role in a modern service society.

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[49] Per-capita-premiums would reflect the average risk of an assured individual in the social health insurance; therefore a reform in direction of such premiums would be the prerequisite for a future change to a fully privately based insurance scheme. The in Germany also discussed citizens insurance (Bürgerversicherung) comprising the whole population (in addition to the current system the government officials and the self-employed people) would only cure the symptoms via a revenue increase, which at the same time is connected with increasing entitlements against the social health insurance. The outcome would be an almost total monopolisation of the social insurance system and the end of an independent private health insurance system with harmful consequences for efficiency.

For details see *Breyer* (2003) and http://www.buergerversicherung-aktuell.de/index00.html.

[50] See *Der Spiegel*, Nr. 6, 2.2.04, p. 17; but in a press release the *Verband der privaten Krankenversicherung* has denied the existence of such a paper, see http://www.buergerversicherung-aktuell.de/index00.html.

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