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Financial Consequences of Falling Ill

Changes in the German Health Insurance System since the 1980s*

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discussion paper

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Financial Consequences of Falling Ill. Changes in the German Health Insurance System since the 1980s. SP I 2011-209

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Abstract

The incidence of a health risk may result in two different types of financial consequences: the creation of new needs and the loss of savings and/or income to meet those needs. Illness often requires the purchase of medical help. Although in Germany virtually the entire population is covered by statutory or private health insurance, over time these insurance schemes have become less generous as private out-of-pocket payments continue to rise and, in extreme cases, lead to financial hardship and even poverty.

This paper describes the institutional regulations that cover the financial risks of becoming ill and the changes in these regulations since the 1980s. It begins with a structural overview of the German health insurance system, the benefits provided (both in-kind and in-cash) and the evolution of benefits since the 1980s. It then considers the related risk of permanent work-disability and the main institutional means of covering this risk. Here the discussion focuses solely on provisions dealing with loss of income and the changes therein since the 1980s. Aggregate data on short- and long-term illness are then presented to illustrate several effects resulting from changes in institutional rules. The paper concludes with a brief summary of major legislative changes, followed by conclusions and hypotheses about the consequences of occurring risks.

Contents

1 Introduction

The incidence of life risks may result in two different types of financial consequences: the creation of new needs and the loss of savings and/or income to meet those needs. Thus risks generate direct and indirect costs. This is particularly true for the life risk of falling ill. Illness often requires the purchase of medical help. Although in industrialized societies the population is normally covered by public health insurance (the US being a major exception), over time these insurance schemes have become less generous as private out-of-pocket payments continue to rise and, in extreme cases, lead to financial hardship and even poverty.

This paper[1] describes the institutional regulations, which cover the financial risks (the direct and indirect costs) of becoming ill, and the changes in these regulations since the 1980s. It begins with a structural overview of the German health insurance system, the benefits provided (both in-kind and in-cash) and the evolution of benefits since the 1980s. It next considers the related risk of permanent work-disability and the main institutional means of covering this risk. Here the discussion focuses solely on provisions dealing with loss of income and the changes, therein, since the 1980s. Aggregate data concerning short- and long-term illness are then presented to illustrate several effects resulting from changes in institutional rules. The paper concludes with a brief summary of major legislative changes, followed by conclusions and hypotheses about the consequences of occurring risks.

2 The Structure of the German Health Insurance System

Germany's health care system is the archetype of a Bismarckian health care system with Statutory Health Insurance (SHI) as its major structural component. Table 1 shows that about 90% of the population are insured, with most of the remaining population covered by private health insurance. This paper deals primarily with SHI, which insures mainly workers and employees up to an income threshold (€ 3,563, in 2007 - see Table 1), their spouses and children (co-insured without paying contributions (Simon, 2008: 133ff.) and pensioners (those insured by SHI for at least nine tenths of the second half of their employment history). Private health insurance

[1] As part of a series of working papers, produced for the research project "The economic consequences of key life risks in Germany and the US and their evolution since the 1980s" at the Social Science Research Centre Berlin (research unit: Inequality and Social Integration), 2009-2011.

(PHI) covers employees with incomes above the income threshold, as well as the self-employed and freelancers. Civil servants, also an important PHI clientele, account for almost 50% of all PHI-insured with full health insurance. Theirs is a special situation since they, their spouses and children receive a refund from the state (the so-called "*Beihilfe*") for illness-related expenses and need only supplemental insurance contracts to cover remaining costs (Bundesministerium für Arbeit und Soziales (Hg.), 2008b, 770f.; Simon, 2008: 161ff.).

While an exceptionally high proportion of people in the United States are without any health insurance, the figure is normally around 0.2% in Germany (Table 1).[2] A recent health reform, passed in 2007, introduced compulsory health insurance coverage for the entire population. Everyone must have either full statutory insurance (effective 2007) or private insurance (effective 2009), depending on the respective insurance system to which they belong (Bundesministerium für Arbeit und Soziales, 2009; Greß et al., 2009).

2.1 Statutory Health Insurance (SHI)

In-kind Benefits

SHI-benefits are legally defined in the Social Code Book V (the regulatory framework of the SHI system) along with SHI goals and the rules that guide it. Hence, there are only minor differences in the benefit catalogues of statutory sickness funds. SHI adheres to the needs-based principle that the insured have a right to treatments considered necessary. The most important SHI benefits are:

- Health promotion and prevention of disease,
- Medical treatment and psychotherapy,
- Dental treatment and provision for dentures,
- Drugs, surgical dressings, remedies and therapeutic appliances,
- In-patient treatment,
- Medical rehabilitation (Simon, 2008: 133ff.).

[2] An in-depth analysis of people without health insurance reveals, however, that their absolute number decreased from around 400,000, in 1991, to about 196,000, in 2007. The rather high number of Germans without health insurance in the beginning of the 1990s might be explained by German re-unification and the difficulties of people in former East Germany to declare their health insurance status correctly. So this decline is rather a statistical artefact. The number of uninsured reached a low point, in 1995, of about 105,000 but has increased substantially since then (Bundesministerium für Gesundheit, 2009: Tabelle 8.1; Greß et al., 2005: 52ff.).

Since the 1980s, there have also been several exclusions from statutorily defined benefits, with notable cuts being:

- Bagatelle drugs (e.g., against colds, motion sickness or laxatives),
- Orthodontic services for adults,
- Death and maternity benefits,
- Prescription-free pharmaceuticals,
- Allowances for glasses (Rosenbrock & Gerlinger, 2006: 105; Steffen, 2008: 57ff.).

However, in addition to cuts, there were also inclusions and extensions of benefits. In 1989, ambulatory, long-term care benefits were introduced into the SHI system and primary prevention benefits augmented. In 1994, long-term care insurance, the so-called "5th pillar" of social insurance, was passed, offering both in- and out-patient, long-term care services (only up to fixed amounts, however).

Since 1977, co-payments for the insured have been gradually extended. Table 2 offers an overview of co-payment evolution in various sectors of the health care system since 1981, showing that co-payments are now required in more and more areas of health care. A notable example is the so-called *practice charge* for physician visits ("Praxisgebühr"), enforced as of January 1, 2004, which introduced a €10 user-fee for the first visit to ambulatory physicians and dentists, per quarter. Further visits to ambulatory physicians are also charged at €10, although for referral patients the fee is waived (Ruckert et al., 2008; Wörz & Busse, 2009: 113). Many existing co-payments have been increased since the 1980s. This twofold expansion of co-payments left its mark on aggregate spending. Based on OECD data, Table 3 exhibits different levels of private health spending in Germany and the USA (private health insurance and out-of-pocket payments[3]) from 1981 to 2007. Regarding Germany, the table illustrates that the share of out-of-pocket payments on total health expenditure increased by about 3 percentage points. The increases in the years 1983, 1997, 1998 and 2004, respectively, are most likely related to health reforms that raised co-payments.

[3] According to OECD health Data private out-of-pocket payments include: "payments borne directly by a patient without the benefit of insurance. They include cost-sharing and informal payments to health care providers; *cost-sharing*: a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received. This is distinct from the payment of a health insurance premium, contribution or tax which is paid whether health care is received or not. Cost-sharing can be in the form of *deductibles*, *co-insurance* or *co-payments*; *co-payment*: cost-sharing in the form of a fixed amount to be paid for a service. *co-insurance*: cost-sharing in the form of a set proportion of the cost of a service. In France and Belgium, "ticket modérateur". *deductibles*: cost sharing in the form of a fixed amount which must be paid for a service before any payment of benefits can take place." (OECD, 2000: 155)

There are exemption rules, however, to protect the insured from unacceptable financial burdens. In general, children under 18 are exempted from co-payments (excluding transport and dentures). Until 2004, exemption rules included both total and partial exemptions from co-payments. Totally exempted were the following:

- those with a monthly gross income below a certain threshold (e.g., €938 in 2002),
- those receiving benefits from designated means-tested programmes and,
- those receiving social assistance benefits or war pensions & living in long-term care facilities (Bundesministerium für Arbeit und Sozialordnung (Hg.), 2002: 152f.).

Partial exemptions relate to pharmaceuticals, remedies, therapeutic appliances, and transportation costs. If, however, one's income surpasses the total exemption threshold, co-payments up to a maximal 2% of gross income are due.

Since January 1, 2004, new exemption rules exist. Everyone (including recipients of means-tested benefits like social assistance and certain pensions) pays 2% of his/her gross income for co-payments, but is exempted from co-payments once medical expenses exceed that amount. People with chronic conditions (in a strictly defined sense) pay 1% of their income for co-payments (Simon, 2008: 74).

Against this background, it seems plausible that financial pressures resulting from co-payments are effectively contained. In health systems research, there is the concept of household catastrophic health expenditure, which measures the share of household income devoted to co-payments. There is no consensus about which portion of household income should be considered catastrophic. Shares of between 5 and 20% are common (Xu et al., 2003; 111f.). In 2003, Xu et al. analysed the portions of household income devoted to private health expenditure[4] in 59 countries and defined a rather high 40% share as the catastrophic health expenditure. The authors concluded that for all German households the catastrophic health expenditure was 0.03% (database: Einkommens- und Verbrauchsstichprobe[5], year: 1993 for comparison: In the USA, the same share was 0.55% (data base: Consumer Expenditure survey, year: 1997).

[4] Health expenditure is here defined as "...all types of health-related expenses incurred at the time the household received the service, including consultation fees, purchase of medications, and hospital bills " (Xu et al., 2003: 113).

[5] A more recent analysis of the same data base for 2005 shows that 11% of all private households have a private expenditure of 5% or more of net income (Bartmann & Busch, 2008).

Table 1: Key Dimensions of Health Insurance 1981 - 2007

	1981	1991	2000	2007
Kind of Health Insurance (in % of population)	SHI: 90.3% [a] PHI: 7.5% other: 2.0%[6] without: 0.2%	SHI: 86.2% [b] PHI: 11.0% other: 2.6% without: 0.2%	SHI: 87.0%[c] PHI: 10.1% other: 2.6% without: 0.2%	SHI: 88.1% PHI: 10.6% other: 0.5% without: 0.2% n.a.: 0.6%
Income Threshold for Compulsory Insurance in € (multiple of gross earnings)	1,687 (1.27)	W: 2,493 (1.32) E: 1,150[7] (1.05)	W: 3,298 (1.18) E: 2,723 (1.43)	G: 3,563 (1.69) 3,938[8] (1.86)
Cash Benefits in Case of Sickness	Full wage continuation for 6 weeks Thereafter: 80% of gross earnings (max.: net earnings)	Full wage continuation for 6 weeks Thereafter: 80% of gross earnings (max.: net earnings)	Full wage continuation for 6 weeks[9] Thereafter: 70% of gross earnings (max.: 90% of net earnings)	Full wage continuation for 6 weeks Thereafter: 70% of gross earnings (max.: 90% of net earnings)
Maximum Duration of Benefits	Maximum: 78 weeks within three years			
Contribution Rate (SHI) in % of Gross Earnings	11.8	W: 12.20 E: 12.80 G: 12.36	W: 13.52 E: 13.8 G: 13.54	W: 13.97 E: 13.56 G: 13.90
Source of Financing for Sick Pay: co-share by employees and employers	each with 50% + wage continuation for 6 weeks exclusively by employer	each with 50% + wage continuation for 6 weeks exclusively by employer	each with 50% + wage continuation for 6 weeks exclusively by employer	employee: 0.9% of gross income + wage continuation for 6 weeks exclusively by employer
Contribution Assessment Ceiling (before 2007 in DM) (multiple of gross earnings)	1,687 (1.27)	W: 2,493 (1.32) E: 1,150[10] (1.05)	W: 3,298 (1.18) E: 2,7231.43)	G: 3,563 (1.69)

W = West-Germany, E = East-Germany, G = Germany, [a]1980 [b]1990 [c]1999, n.a. = no answer

Sources: 1981: Alber, 2000: 263 other years: *Kind of Health Insurance:* Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung, 2002: 491, Statistisches Bundesamt, 2008: Tab. 1.1 own calculations. *Contribution rates and income thresholds:* Bundesministerium für Arbeit und Soziales (Hg.), 2008a; Bundesministerium für Arbeit und Sozialordnung (Hg.), 1997 Tables 7.8, Average earnings: Bundesministerium für Arbeit und Soziales (Hg.), 2008b: 428f. and own calculcations, *Contribution rate:* Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung, 2008, *Cash benefits in case of sickness, Financing sources*: Bundesministerium für Arbeit und Soziales (Hg.), 2008b: 101/165/186.

6 Other programmes refer to beneficiaries of public assistance, free health care for the police, the Federal Armed Forces and health care for war pensioners

7 Only the first half-year; the second half-year, 1991, the income threshold for compulsory insurance was 2550 DM in the new states (Bundesministerium für Arbeit und Sozialordnung (Hg.), 1997: Tab. 7.8)

8 For newly insured members of the SHI (Bundesministerium für Arbeit und Soziales (Hg.), 2008a: Tab. 7.8)

9 Between 1996 and 1999, wage-continuation was reduced to 80% (Bundesminister für Arbeit und Soziales (Hg.), 2009).

10 Only the first half-year; the second half-year, 1991, the contribution assessment ceiling was 1.304 DM in the new states (Bundesministerium für Arbeit und Sozialordnung (Hg.), 1997: Tab. 7.8)

Cash Services in Case of Sickness

A separate law regulates wage-continuation in case of sickness. It states that in case of illness employees are entitled to full wage-continuation for up to six weeks. Between June 1, 1996, and January 1, 1999, wage-continuation was reduced to 80% of former gross income.[11] After the initial six weeks, SHI-insured receive up to 78 weeks of sick pay within a three-year period for the same illness (included are the six weeks of wage-continuation). Since January 1, 1997, sick pay amounts to 70% of former gross income (before that: 80%) if the illness continues after the initial six weeks. The employee's income up to the contribution assessment ceiling (e.g. €3,563 in 2007, see Table 2) serves as the basis for calculating sick pay. Furthermore, sick pay may not exceed 90% of former net income. Although it is tax free, it is still subject to contributions for statutory pension and unemployment insurance. These contributions are paid jointly by the insured and the statutory sickness fund (Bäcker et al., 2008,Mielck & Huber, 2005: 588). [12]

[11] However, many collective agreements arranged for full-wage continuation in case of sickness, so that many employees were de facto not affected by this legal change between 1996 and 1999 (Bäcker et al., 2008: 79).

[12] An empirical study based on the German Socio-economic panel revealed that this benefit cut led to an average reduction of net sick pay (i.e. also considering social insurance contributions) of 250 € per sickness episode (Ziebarth, 2009: 332).

Table 2: Co-payments in the SHI since 1981

	1981	1982	1988	1990	1992	1993	1996	1st half 1997	2nd half 1997	1998	1999	2000	2003	since 2005
Ambulatory medical treatment				0	0	0	0	0	0	0	0	0	0	10,- €
Pharmaceuticals														5-10 €
Per pharmaceutical	0.75 €	1,- €	1.50 €											
with reference price				1.50 €	1.50 €									
without reference price				0	0									
Up to 15.3 € in price						1.50 €								
Price >15.3 to 25.6 €						2.60 €								
Price over 25.6 €						3.60 €								
Small pack (N1)							1.50 €	2.- €	4.60 €	4.60 €	4.10 €	4.10 €	4.-€	
Medium pack (N2)							2.60 €	3.10 €	5.60 €	5.60 €	4.60 €	4.60 €	4.50 €	
Large pack (N3)							3.60 €	4.10 €	6.60 €	6.60 €	5.10 €	5.10 €	5.-€	
Conservative dental treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	10.- €
Dentures	40%	40%	50%	35-50%	35-50%	35-50%	35-50%	35-50%	35-50%	100% above fixed sum	35-50%	35-50%	35-50%	35-50%
For persons born after 1978								100%	100%	100%				
Orthodontic treatment				0-20%	0-20%	0-20%	0-20%	0-20%	0-20%	0-20%	0-20%	0-20%	0-20%	0-20%
Transportation to and from medical facility	2.60 €	2.50 €	10.20 €											
In-patient stays or emergencies				10,20 €	10.20 €	10.20 €	10.20 €	10.20 €	12.80 €	12.80 €	12.80 €	12.80 €	13.- €	10.- €
Ambulatory treatment				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
In-patient stays (per day)		2.60 €	2.60 €	2.60 €	5.10 €	5.60 €	6.10 €	6.10 €	8.70 €	8.70 €	8.70 €	8.70 €	9.- €	10.- €
Preventive spa or in-patient rehabilitation (per day)		5.10 €	5.10 €	5.10 €	5.10 €	5.60 €	6.10 €	12.80 €	12.80 €	12.80 €	12.80 €	8.70 €	9.- €	10.- €
Remedies and therapeutic appliances, home health-care und non-physician care (e.g. physiotherapy)				10%	10%	10%	10%	10%	15%	15%	15%	15%	15%	10% plus 10.- € per prescrip-tion

Source: modified according to Alber, 1992: 60; Busse, 2000: 48; Busse & Riesberg, 2005: 92: 92; Gericke et al., 2004: 7; Verband der Ersatzkassen, 2010

Table 3: Private Health Expenditure in Germany and the USA since 1980

Private Expenditure on health in % of total expenditure on health																													
Year	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Germany	21.3	21.3	21.8	22.7	22.6	22.6	22.4	22.5	22.8	24.0	23.8	N/A	18.5	19.3	19.2	18.4	17.8	19.2	19.9	20.2	20.3	20.7	20.8	21.3	23.0	23.0	23.2	23.1
Change to previous year (%)		0.0	2.3	4.1	-0.4	0.0	-0.9	0.4	1.3	5.3	-0.8			4.3	-0.5	-4.2	-3.3	7.9	3.6	1.5	0.5	2.0	0.5	2.4	8.0	0.0	0.9	-0.4
USA	59.2	59.3	60	59.9	60.4	60.7	59.9	59.6	60.9	60.9	60.8	59.3	58.1	57	55.6	55.1	55	55.3	56.5	56.9	56.8	55.8	55.9	56.1	55.7	55.6	54.8	54.6
Change to previous year (%)		0.2	1.2	-0.2	0.8	0.5	-1.3	-0.5	2.2	0.0	-0.2	-2.5	-2.0	-1.9	-2.5	-0.9	-0.2	0.5	2.2	0.7	-0.2	-1.8	0.2	0.4	-0.7	-0.2	-1.4	-0.4
Private Insurance in % of total expenditure on health																												
Germany	5.9	6	6.2	6.4	6.2	6.5	6.3	6.4	6.4	7.2	7.2	N/A	7.4	7.8	7.7	7.7	7.5	8	8	8.2	8.3	8.4	8.5	8.7	9.1	9.2	9.2	9.3
Change to previous year (%)		1.7	3.3	3.2	-3.1	4.8	-3.1	1.6	0.0	12.5	0.0			5.4	-1.3	0.0	-2.6	6.7	0.0	2.5	1.2	1.2	1.2	2.4	4.6	1.1	0.0	1.1
USA	27.8	28.3	28.9	29.2	30.1	20.4	29.4	29.6	31.2	32.6	33.3	33.1	32.9	33	32.6	32.6	32.6	32.5	32.9	33.6	34.3	34.5	35.1	35.5	35.6	35.6	35.3	35.2
Change to previous year (%)		1.8	2.1	1.0	3.1	1.0	-3.3	0.7	5.4	4.5	2.1	-0.6	-0.6	0.3	-1.2	0.0	0.0	-0.3	1.2	2.1	2.1	0.6	1.7	1.1	0.3	0.0	-0.8	-0.3
Private Insurance per capita, US-$ at 2000 PPP rates																												
Germany	102	109	109	114	116	127	123	130	137	146	151	N/A	164	169	175	182	185	197	203	212	221	229	237	246	252	261	266	272
Change to previous year (%)		6.9	0.0	4.6	1.8	9.5	-3.1	5.7	5.4	6.6	3.4			3.0	3.6	4.0	1.6	6.5	3.0	4.4	4.2	3.6	3.5	3.8	2.4	3.6	1.9	2.3
USA	561	600	646	687	744	790	794	840	948	1055	1147	1191	1239	1286	1297	1326	1355	1380	1445	1526	1611	1704	1837	1953	2012	2063	2098	2144
Change to previous year (%)		7.0	7.7	6.3	8.3	6.2	0.5	5.8	12.9	11.3	8.7	3.8	4.0	3.8	0.9	2.2	2.2	1.8	4.7	5.6	5.6	5.8	7.8	6.3	3.0	2.5	1.7	2.2
Out of Pocket-Payments in % of total expenditure on health																												
Germany	10.3	10.1	10.3	11.3	11.4	11.2	11	10.8	11.1	11	11.1	N/A	10	10.4	10.5	9.7	9.5	10.3	11	11.2	11.2	11.5	11.4	11.7	13.1	13	13.3	13.1
Change to previous year (%)		-1.9	2.0	9.7	0.9	-1.8	-1.8	-1.8	2.8	-0.9	0.9			4.0	1.0	-7.6	-2.1	8.4	6.8	1.8	0.0	2.7	-0.9	2.6	12.0	-0.8	2.3	-1.5
USA	23.5	22.7	22.3	21.9	21.9	22.1	22.3	21.7	21.1	20	19.4	18.2	17.2	16.2	15.1	14.6	14.4	14.7	15	14.8	14.5	13.8	13.5	13.2	12.9	12.7	12.3	12.2
Change to previous year (%)		-3.4	-1.8	-1.8	0.0	0.9	0.9	-2.7	-2.8	-5.2	-3.0	-6.2	-5.5	-5.8	-6.8	-3.3	-1.4	2.1	2.0	-1.3	-2.0	-4.8	-2.2	-2.2	-2.3	-1.6	-3.1	-0.8
Out of Pocket-Payments per capita, US-$ at 2000 PPP rates																												
Germany	179	182	182	203	213	219	218	218	235	224	233	N/A	220	226	238	232	234	256	279	290	299	315	318	330	366	370	384	384
Change to previous year (%)		1.7	0.0	11.5	4.9	2.8	-0.5	0.0	7.8	-4.7	4.0			2.7	5.3	-2.5	0.9	9.4	9.0	3.9	3.1	5.4	1.0	3.8	10.9	1.1	3.8	0.0
USA	474	481	498	514	540	574	604	616	644	647	668	656	647	632	601	596	600	623	658	673	683	683	704	727	732	738	731	743
Change to previous year (%)		1.5	3.5	3.2	5.1	6.3	5.2	2.0	4.5	0.5	3.2	-1.8	-1.4	-2.3	-4.9	-0.8	0.7	3.8	5.6	2.3	1.5	0.0	3.1	3.3	0.7	0.8	-0.9	1.6

Source: OECD Health Data 2009

2.2 Private Health Insurance

While SHI benefits are basically the same, there are different models of full health insurance in PHI. It is, thus, up to the individual to arrange a suitable benefit package. Prior to 2007, there was no obligation to obtain private health insurance since the majority of German workers were insured through SHI. Those not covered by SHI – civil servants, the self-employed, free-lancers – could contract voluntarily with private insurers if desired. Since the 2007 mandate, however, everyone is obligated to have health insurance, which means those uninsured by SHI must now buy private insurance to comply with the new law (see Sec 2, above).[13]. To obtain private health insurance, applicants must first undergo a risk assessment to identify pre-existing conditions. If conditions exist, the insurer might charge risk premiums or make exclusions from the insurance policy. Insurance premiums are risk equivalent and depend on one's health condition, sex and age at the time the policy is concluded. Since premiums are risk equivalent, they increase with applicant age and are usually higher for women than men. For employees, the premium is subsidized by the employer at half the contribution rate of SHI. Under PHI, there is no free insurance for unemployed husbands or children as in SHI; therefore, family members must be insured separately (Simon, 2008: 164ff.).

For wage-continuation in case of sickness, self-employed PHI-insured must conclude a separate, wage-continuation insurance agreement. Depending on the agreement, wage- continuation varies in terms of benefits and duration. In case of sickness, civil servants receive full wage-continuation which, in principle, is unlimited. There is also, however, the possibility of moving those in need into early retirement (http://de.wikipedia.org/wiki/Entgeltfortzahlung im Krankheitsfall accessed on January 27, 2010). In addition to full health insurance, PHI also offers complementary insurance products. These, however, account for only 20% of PHI income from premiums (Simon, 2008: 161).

[13] Since 2007, PHI-insured have a legal right to the so-called "standard tariff". The standard tariff for PHI means in essence that the benefit catalogue must be the same as in SHI. Premiums may not be higher than the contribution rate in the SHI (Simon, 2008: 168).

3 Becoming Permanently Work Disabled

In institutional terms, the risk of becoming permanently work disabled is predominantly[14] covered by Statutory Pension Insurance (SPI). The working paper on pensions also deals with disability pensions, which is why verbatim overlaps exist with this paper. Here, the main institutional features as well as changes in the disability pension system are presented along with aggregate data on disability pensioners. Pensions are provided if someone is either fully - or partially - work disabled (Bundesministerium für Arbeit und Sozialordnung (Hg.), 1998: 285). Given that an important reform took effect in 2001, the pre- and post-reform situation is herein described (if not otherwise stated, what follows is based on: Bundesministerium für Arbeit und Sozialordnung (Hg.), (1998: 285ff), Bundesministerium für Arbeit und Soziales (Hg.), (2008b: 305ff.), Ebbinghaus; Viebrok, (2004).

Disability Pension until 2001

Until 2001, there were two kinds of disability pensions: *occupational* and *general disability*. *Occupational disability* applied to workers earning less than half the normal earnings of a healthy person with similar training and equivalent skills due to infirmity or disability. The *general disability pension* was for people no longer able to work or unable to earn more than a minimum income (http://ec.europa.eu/employment_social/missoc/2000/d_part5_en.htm, accessed on 01.07.2010). Initially, both pensions were given strictly on medical grounds; however, court decisions granted a partial pension to those not fully fit to work so that, de facto, labour market considerations also played a role. The amount of the *general disability pension* was conceptualized to fully replace wage - as in an ordinary, statutory old-age pension - while the *occupational disability pension* was considered a partial pension with a pension type factor of 2/3 (an ordinary pension has a pension type factor of 1). In both cases, contributions by the insured were supplemented as if the insured had worked until their 60th birthday, but with the time between 55 and 60 counted as only 2/3 rather than a full five years. Until 1996, pensions could be accumulated with other earnings without limit and not uncommon to find that a pensioner's total earnings were higher than during working life. After 1996, upper limits were introduced - e.g. in 2000, the limit was €322 per month (http://ec.europa.eu/employment_social/missoc/2000/d_part5_en.htm, accessed 01. 07. 2010), (Bundes ministerium für Arbeit und Sozialordnung (Hg.), 1998: 285/288).

[14] There are, however, other systems which cover this risk, e.g. statutory accident insurance, special pension for civil servants, or pensions due to the Federal War Victims Relief Act. These are not considered in this paper (for more details, see e.g.: Rehfeld, 2006).

In 1985, qualifying requirements tightened considerably. Since then, three years of employment within the last five years prior to retirement must be shown (previously, it was five years of contributions). The reform primarily affected women, owing to their significantly lower contribution records, and led to a strong drop in females receiving disability pensions (Jacobs et al., 1991: 188f., Kaltenbach, 1986: 359).

Disability Pension after 2001

Two aspects of the dual pension system for *occupational* and *general disability* were criticized: First, that SPI must bear both labour market and disability risks; and, second, that *occupational disability insurance* is a pension only for people who are very privileged anyway (Deutscher Bundestag (Hg.), 2000).

In 2001, a different kind of two-tiered disability pension (*partial* and *total disability pension*) was introduced. A *total disability pension* is granted people unable to work three hours a day; a *partial pension* to those unable to work longer than six (Bundesministerium für Arbeit und Soziales (Hg.), 2008b: 305ff.; Wollschläger, 2001: 277f.).[15] The benefit amount was also cut since actuarial reductions (as found in the *general old-age pension scheme*) were introduced along with the reform. The reductions amount to 0.3% (up to a maximum of 10.8%) for every month prior to age 63. Also since the reform, supplemented contributions between 55 and 60 are now considered at full value, unlike prior to 2001 (see above). Because of that, the actual benefit reduction for the *total disability pension* compared to the former pension type lies between 3.3% und 10.8% (Bundesministerium für Arbeit und Soziales (Hg.), 2008b: 310f.; Wollschläger, 2001: 282f.). In addition, the *partial disability pension* amounts to only 50% of the full pension (compared to the 2/3 of the former *occupational pension*).

Table 4 shows that both types reduced the number of new pensioners and the average entry-age into disability pensions. The decreasing numbers might indicate that disability pensions are used to a lesser degree as a means of early retirement, or that qualification requirements became somehow more restrictive (although not necessarily reflected in statutory regulations). It is more plausible that the declining numbers of disability pensioners are due predominantly to a healthier workforce and the decreasing age of new entrants than a change in the spectrum of disability illnesses (see Appendix Table 2 for details). As somatic diseases have declined, incidences of mental disorders have risen. Such disorders typically occur in younger age-groups than somatic diseases, thus lowering the entry-age.

[15] Owing to the concept known as "protection of legitimate expectations", those 40 years old and insured prior to January, 2001, receive a partial-disability pension if able to work in the general labour market but unable to work more than six hours in a position corresponding to their qualifications (Wollschläger, 2001: 283).

Table 4: Average Early Retirement Age and Number of New Pensioners

Year	Men		Women	
	Number of new pensioners	Average early retirement age	Number of new pensioners	Average early retirement age
1980	150,421	55.8	265,433	56.2
1985	142,729	57.1	85,938	57.6
1986	129,029	57.7	66,595	59.0
1987	130,278	56.3	64,573	59.2
1988	134,918	54.4	63,440	57.7
1989	136,899	53.7	64,130	54.3
1990	134,755	53.8	63,198	52.6
1991	128,054	54.0	58,536	52.8
1992	132,663	54.0	62,770	52.6
1993*	170,800	54.3	100,741	51.3
1994	186,563	53.0	107,921	51.0
1995	184,286	52.7	109,701	50.9
1996	175,066	52.6	104,602	50.8
1997	165,581	52.4	98,622	50.5
1998	149,522	52.3	87,523	50.3
1999	137,390	52.3	80,797	50.5
2000	131,781	52.2	82,301	50.3
2001	119,868	51.7	80,711	50.0
2002	102,795	51.1	73,304	49.5
2003	100,479	50.7	73,882	49.2
2004	96,600	50.4	72,860	49.1
2005	91,356	50.5	72,604	49.2
2006	89,186	50.5	70,529	49.3
2007	89,435	50.5	72,080	49.3

* From 1993 East and West German data (before that: West Germany only)

Source: Deutsche Rentenversicherung Bund, 2009; Deutsche Rentenversicherung Bund (Hg.), 2007

4 Major Statutory Changes since the 1980s, Summary and Hypotheses

Regarding the life risk illness and its regulation, two dimensions appear significant: The share of people without health insurance, and the content of the benefit package – including its scope and ability to protect against loss of income. [16] We have seen that the percentage of people without health insurance has remained low and rather stable since the 1980s (about 0.2% of the population). In legal terms, no one is without health insurance, owing to an April, 2009, statutory mandate obligating everyone to be insured. In this respect, there is no privatisation of a collective risk. Things are more complex, however, when it comes to the content of the benefit package. Table lists the most important health care reforms and their respective economic consequences and shows that they often include increased co-payments or the exclusion of benefits. These increases surely lead to higher financial burdens for households (documented aggregately in Table 2). It is a well-known fact that health expenditure is highly concentrated on a minority segment of the population (the "rule of thumb" being that in any given year roughly 20% of the population generates about 80% of the health expenditure). This means that exemption rules are extremely important since people with high health expenditures (and simultaneously confronting serious illness) would soon be financially swamped without them. In 2004, exemption rules were changed such that complete exemption from co-payments was no longer possible.[17]

Health care reforms, however, were not limited to just cuts and increased co-payments. There were notable benefit extensions, as well – especially concerning long-term care. In 1994, long-term care insurance was passed, alleviating financial problems in such cases. For example, an analysis with panel data showed that having a household member in need of long-term care in 1993 significantly increased the risk of becoming impoverished. This was not observed, however, in the years following implementation of long-term care insurance (Grabka & Frick, 2010: 9/11).[18]

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16 The topic: "In what ways do upper budget limits of health care providers (hospitals or doctor practices) lead to implicit rationing (see e.g. Brockmann, 2002) and a privatisation of health care risks?" is beyond the scope of this paper. While it can be mentioned, it cannot be analysed.

17 Hit hardest by these changes are recipients of social assistance. While they could be exempted totally from co-payments before 2004, they have had to spend up to 2% of their income on co-payments since then.

18 Important to remember is that insurance benefits for long-term care have upper limits, i.e. above a certain level, people must pay services out of their own pockets. This makes it plausible that the financial consequences of needing long-term care can often be more severe than the consequences of being ill.

Risk of illness also affects indirect costs. Here immediate as well as middle- and long- term consequences can be distinguished. While there was a brief interval between 1996 and 1999 in which sickness benefits during the first six weeks of illness were reduced to 80% of former income, the measure was subsequently revoked and full wage benefits restored. In contrast, sick pay was permanently reduced to 70% (instead of 80%) of former gross earnings. The most severe benefit reductions affected *partial disability pensions*, which constitute only half (instead of formerly 2/3) of a *full disability pension*. As shown in Appendix Table 1, the average payment for *partial disability pensions* declined by more than 25% in real terms, whereas the cuts for *full disability pensions* were less severe. The changes in the illness spectrum reinforce this trend since mental illnesses have become more important and occur normally at an earlier stage of life. The consequence is that those affected must rely on cash transfers for a longer period. The following hypotheses can be formulated from this description of changes for the micro-analyses.

Hypotheses for the Micro-Analyses

1. The economic consequences of illness are shaped much more by indirect than direct costs, since direct health care costs are effectively covered by health insurance.
2. The share of people with chronic health problems and resultant disability receiving means tested benefits increases since the 1980s (course B increases over course C – Figure 1).
3. Incomes of disability pension recipients were higher in the 1980s and 1990s than in the 2000s (due to regulation changes, concerning additional earning when receiving benefits, and the direct cuts in 2001).

Figure 1: Ideal Typical Employment Transition Paths in Case of Sickness

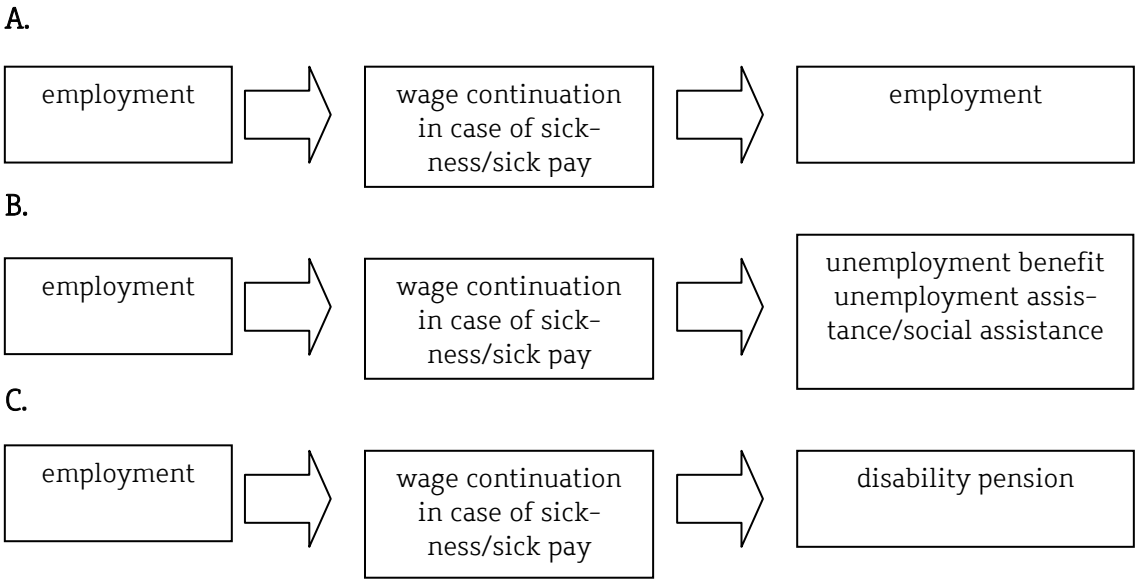

Table 5: Most Important Legislative Measures with Economic Consequences in Case of Ill Health (1980-2007)

	Health Insurance
1980s	**Cost Containment Addendum Act 1981** (Kostendämpfungs-Ergänzungsgesetz) Increase in co-payments for pharmaceuticals, introduction of co-payment for orthodontic treatment and medical transportation. Introduction of a maximum for the reimbursement of dentures 80%. **Supplementary Budget Act 1982** (Haushaltsbegleitgesetz 1983) Increase in co-payments for pharmaceuticals, surgical dressings, remedies and glasses. Introduction of co-payments for rehabilitation treatment. Exclusion of various bagatelle drugs (e.g. laxatives) **Supplementary Budget Act 1983** (Haushaltsbegleitgesetz 1984) Consideration of single payments (e.g. vacation pay) for social insurance contribution payments, inclusion of sick pay into the social contribution payments for unemployment and pension insurance (this de facto reduces the net amount of sick pay). **Health Care Reform Act 1988** (Gesundheitsreformgesetz) Introduction of home-based, long-term care benefits; increases in co-payments for pharmaceuticals, hospital stays, orthodontic treatment and remedies and therapeutic appliances; introduction of hardship clauses in relation to co-payments; introduction of cost reimbursement principle, reduction of death benefits
1990s	**Health Care Structure Act 1992** (Gesundheitsstrukturgesetz) Increases in co-payments of pharmaceuticals, exclusion of orthodontic treatment benefits for adults. **Long Term Care Insurance Act 1994** (Pflegeversicherungsgesetz) Introduction of a new social insurance pillar, for both out- and in-patient long- term care benefits **Health Insurance Contribution Rate Exoneration Act 1996*** (Beitragsentlastungsgesetz) Reductions of benefits for rehabilitative care, reduction of sick pay from 80% to 70% of the last gross income, cut of sickness fund allowance for glasses frames; **First and Second Statutory Health Insurance Restructuring Acts 1997*** (Erstes und Zweites GKV-Neuordnungsgesetz) Increased co-payments for pharmaceuticals, medical aids, ambulance transportation, and dentures (partially lowered in 2010), introduction of a new hospice care benefit

2000 - 2007	**Act to Strengthen Solidarity in Statutory Health Insurance 1998** (Solidaritätsstärkungsgesetz) This law primarily revoked measures introduced by the former government (with Health Insurance Contribution Rate Exoneration Act 1996, and First and Second Statutory Health Insurance Restructuring Acts 1997) **Statutory Health Insurance Reform Act of 2000 (1999)** (Gesetz zur Reform der gesetzlichen Krankenversicherung ab dem Jahr 2000) Increases in health promotion benefits, introduction of a new benefit for people with severe psychiatric illnesses, provisions that make it harder to change from SHI to PHI in old age. **Retirement Savings Act 2001** (Altersvermögensergänzungsgesetz) Indexation of sickness benefits after one year in line with pension indexation (before that in line with inflation), therefore effectively a reduction of indexation **SHI Modernization Act 2003** (GKV Modernisierungsgesetz) Introduction of a user charge of €10 for the first contact with ambulatory physicians and dentists, increases in co-payments: basic rule: 10% of costs, minimum: 5€ maximum 10€, new regulation of hardship clauses; introduction of special contribution for the insured (0.9% of gross income); higher contributions for pensioners, **SHI Competition Strengthening Act 2007** (GKV-Wettbewerbsstärkungsgesetz) Introduction of compulsory health insurance coverage for the entire population (as of 2007 for SHI and as of 2009 for PHI)

* Several provisions of these acts were revoked by the succeeding government and are not listed in this table. For more, see: Alber, 1986; Busse & Riesberg, 2004; Steffen, 2008

Appendix

Appendix Table 1: Average Payments for Disability Pensions (Men and Women)

	Average payment in €			
Year	for partial disability	for complete disability	for partial disability	for complete disability
	in current prices		in 2000 prices	
1980	297	321	-	-
1985	369	478	-	-
1990	476	647	-	-
1993*	542	675	487	607
1994	531	694	490	641
1995	535	704	502	661
1996	546	714	520	680
1997	537	719	521	698
1998	536	721	525	707
1999	548	733	540	723
2000	547	738	547	738
2001	479	724	489	738
2002	419	722	433	747
2003	398	715	416	747
2004	379	696	402	739
2005	368	686	399	743
2006	361	676	397	744
2007	359	662	404	745

* From 1993 both East and West German data

Source: Deutsche Rentenversicherung Bund (Hg.), 2009: 106, values deflated with the consumer price index Bundesministerium für Arbeit und Soziales (Hg.), 2008a: Table 6.1

Appendix Table 2: Distribution of Selected Major Diagnostic Categories for Disability Pensions

Year	Main Diagnostic Category (%)				
	Skeleton/ muscles or connective tissue	Heart and circulatory diseases	Mental illness	Neoplasms	Metabolism and digestion
1985	25.0	30.7	10.9	9.1	5.9
1990	29.7	23.9	12.0	9.7	5.2
1995*	28.9	18.2	24.2	10.4	5.3
2000	25.4	13.3	22.8	13.5	4.9
2005	18.1	11.0	23.5	14.5	4.3
2007	16.2	10.5	23.9	14.5	4.1

* From 1995 East and West German data (before: West Germany only)

Source Deutsche Rentenversicherung Bund, 2009: 88f.

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