Solidarity, Financing and Personal Coverage

Ulrich Becker[1]

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

(1) General remarks

Proceeding from the solidary obligation under Roman Law (*obligatio in solidum*[2]*),* the term "solidarity" evolved via French civil law (*solidarité* [3]) into a social buzzword in post-revolutionary France,[4] one that gradually came to replace the notion of *fraternité* cultivated during the revolution.[5] The concept of solidarity finally found its way into German social philosophy and theory of the state[6] as a societal principle established by *von Stein*[7]. A commitment to solidarity under Roman Law was based on an agreement (stipulation[8]) to stand by each other. In the later use of the term, the idea of standing by each other was increasingly detached from a previous declaration of intent: in Catholic social ethics, solidarity was founded on charity[9]; in social philosophy, reflecting the idea of the "nation as the great community in solidarity" (*Ernest Renan*), it rested on nationality[10].

(2) Solidarity and the German constitution

In Germany, the principle of solidarity[11] is in part recognized as a constitutional principle[12]. Given that the German constitution, i.e. the Basic Law [*Grundgesetz* – GG], does not explicitly mention the term solidarity, the solidarity principle is derived from the entire constitution, from the concept of humanity underlying the Basic Law, or from the social state principle – partly in conjunction with the guarantee of human dignity in Art. 1(1) GG[13]. The case law of the Federal Constitutional Court [*Bundesverfassungsgericht* – BVerfG][14] and the social law literature[15] proceed from a solidarity principle under social insurance law that is supposed to organize the natural[16] "solidarity of the citizens with the citizens" by way of redistribution[17]. Solidarity as a principle unfolds its effect under the insurance principle[18] and normally serves to explicate and legitimate social law modifications of civil insurance law, as well as interventions in the basic right of personal liberty under Art. 2(1) GG[19] that occur in social insurance in the form of attempts to rupture insurance-based global equivalence or the obligation to insure.[20]

(3) Solidarity in Europe

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

In some national constitutions of Europe, solidarity is laid down as an express legal norm.[21] In Switzerland, Austria, Italy, Spain, France, Belgium and the Netherlands, the solidarity principle is at any rate invoked to establish and legitimate the institution of social insurance. The solidarity principle, thus the assumption, not only unites the majority of European national constitutions by their shared values, but at the same time constitutes a core principle governing the social insurance systems of Europe.[22]

Solidarity in a more specific sense also plays a role when it comes to the influence of economic basic freedoms (Art. 49 EC Treaty: free movement of services)[23] and of European competition law (Arts. 81 and 82 EC Treaty) on national social security systems. According to the jurisprudence of the European Court of Justice, systems based on solidarity cannot be qualified as undertakings and thus are exempted from the application of competition law[24] – at least insofar as they serve to fulfill their legal tasks.[25]

(4) Legal solidarity and social insurance

Solidarity, understood as a legally constituted community for the fulfillment of state-assumed responsibility, is the fundamental requirement for the inclusion of certain persons in specific situations of need and subject to specific risks. In social security law, the solidarity principle manifests itself in an interpersonal redistribution of risk-based burdens within the compulsorily insured community – possibly forming a community (in solidarity) distinguishable from society as a whole[26] (see also 3 (5)). The basis of this "compulsory solidarity" is the obvious need of social protection by socially weaker persons within a (here again: possibly otherwise homo-

geneous[27]) group of persons.

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

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

2. A concise overview: The German health insurance system

(1) Main features of the system

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

The Health Insurance Act of 1883[28] extended compulsory insurance to almost all workers in industrial undertakings,[29] while the Accident Insurance Act of 1884[30] covered workers in the mining, shipyard, factory, roofing, quarry and well-building industries[31]. Still in the eighties of the penultimate century, the group of insured persons was expanded under a series of amendment and extension laws.[32] These laws successively included workers of transport enterprises and of navy and army administration,[33] those engaged in agriculture and forestry,[34] and in building construction,[35] as well as seamen and shipping workers[36]. Further amendments to health insurance law[37] followed a short time later, in 1892, 1900 and 1903, thus again enlarging the group of insurants.

This first phase of social insurance consolidation was followed by the extension of risk coverage to include even more persons. Protection was thus afforded to certain, not yet covered occupational groups, but also to unemployed persons and non-employed family members under family assistance in health insurance.[38] Despite the creation of the Reich Insurance Code [*Reichsversicherungsordnung* – RVO] in 1911,[39] the individual insurance branches were not unified.[40] In all branches, the insurance obligation for salaried employees remained restricted to an upper earnings limit (health insurance: 2,500 *Reichsmark*; accident insurance: RM 5,000; invalidity insurance: RM 2,000).

Although the German social insurance system initially played a pioneering role, after which its progress remained in line with developments observed in other European states,[41] it appreciably began to lag behind these developments, especially after World War II. Thus, in other countries, the consequences of the war triggered a phase of overall social solidarization, even in those that did not already have a universalistic system of coverage.[42] For instance, this occurred in France by appealing to national solidarity[43] or in Great Britain through the introduction of the NHS.[44] These movements were no longer due alone to political class struggle,[45] yet neither in France nor in Italy did they lead to a renunciation of the high degree of organizational fragmentation inherent in their protection systems.[46] At the same time, the configuration of German social insurance remained unchanged, along with its aforementioned restrictions. That, too, is attributable to a politically unique situation, namely Germany's division. After overcoming the early difficulties of reconstruction, this partition led to an emphasis of extremes and made it seem unlikely that an implementation of the standard protection introduced in the East[47] could be enforced.[48]

(b) The main principles (or features)

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

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

- employment-based coverage: the insured population mainly consists of employees (although there is an upper earnings insurance limit, and civil servants have their own system of state-financed reimbursements);
- contribution-based financing (see in detail below, 2 (3) and 3);
- provision of benefits in kind,[49] albeit not by the sickness funds[50] but by independent providers (hospitals, practitioners), the reimbursement of costs to patients being the exception[51];
- administration by different types of self-governed sickness funds, with their own legal personality (see below, 3 (2));
- mix of the public and the private sector (see below, 3 (5)).

(2) Legal framework

(a) Sources of law

1) Since 1989, statutory health insurance has been laid down in the Social Code V (SGB V), a statute of parliament[52] which partly replaced the RVO.
2) To be stressed here is that the adaptation of health insurance law cannot be left to the legislator only, as parliamentary procedures will often be too slow and too complicated to ensure quick legal responses. Thus, in most countries, the regulation of the more intricate details is an administrative task that is mostly accomplished via statutory instruments (or regulations). In Germany, another option for dealing with this issue has been implemented. Health insurance management is organized through corporative arrangements (corporatism) under the so-called system of joint self-government [*gemeinsame Selbstverwaltung*]. An administrative body referred to as the Federal Joint Committee [*Gemeinsamer Bundesausschuss*] brings together the representatives of sickness funds and providers. Its administrative acts – so-called directives [*Richtlinien*] – have, according to the jurisprudence of the Federal Social Court, the same force as legal acts.

(b) Constitutional background

1) In Germany, legislative actions are subject to constitutional limitations. Nearly all extensive reforms are reviewed by the BVerfG sooner or later. This is because in Germany access to such constitutional controls has been opened on a wide scale: both via objective procedures such as judicial review of the constitutionality of statutes or administrative acts, and via constitutional complaints which serve to enforce individual constitutional rights embodied in the Basic Law (cf. Art. 93 GG).
2) In the area of social law, however, the BVerfG seems to have adopted a more cautious stance in recent years. The Basic Law does not acknowledge any fundamental *social* rights (with but a few narrowly construed exceptions).[53] This is because the constitutional legislators were skeptical of programmatic declarations, at least of those in the form of individual rights. Nonetheless, Art. 20(1) GG deems Germany a "social federal state". This social state principle obliges the legislator on a very fundamental and general basis[54] to configure the legal order in a way that is social – or more precisely, that is *also* social. Within this meaning, despite all conceptual ambiguity, it is the state's duty to secure decent human existence, to abolish social inequality and to create opportunities for participation.[55] The duty to avoid social disadvantages thus coincides with the duty to provide for the consequences of social risk occurrence ("vicissitudes of life").[56] Yet this still largely leaves open how social security is to be configured.[57]

Moreover, the basic rights place a number of limits on potential reforms. The guarantee of human dignity (Art. 1(1) GG) thus obliges the legislator to secure an economic subsistence minimum for all inhabitants. The protection of property and of confidence in respect of benefit rights acquired through contributions is inferred from Art. 14(1) GG. In addition, social law also abides by the principle of equal treatment, meaning that any favorable or detrimental amendments must be distributed justly among all those concerned.
3) The provisions of constitutional law leave a wide margin of constitutive action open to the legislator. It is for this reason that the constitutional complaint brought before the BVerfG by an insurant concerning the limitation of dental prosthesis benefits under the Act to Strengthen Solidarity in Statutory Health Insurance [*GKV-Solidaritätsstärkungsgesetz*] remained unsuccessful.[58] Nevertheless, a once established compulsory system such as that of statutory health insurance is subject to a lower limit for determining the necessary level of care. Thus, in a remarkable judgment delivered only recently,[59] the BVerfG demands that at least in the event of life-threatening illnesses, all potentially effective benefits must be delivered.[60] Apart from the social state principle, this line of reasoning is attributed to the state obligation to protect "life and physical integrity" (Art. 2(2) GG).

3. Financial burdens and redistribution

(1) Introduction

What is there to know (and say) about redistributive effects? We must largely rely on estimates and theoretical assumptions here because inter-personal and intra-personal equalizations are hard to quantify and depend substantially on individual vocational careers. A particular problem impeding the quantifiability of redistribution is that longitudinal comparisons are scarcely possible.[61]
For the expenditure of German health care system, see Tables 1-6.

Table 1 Total health expenditure, 2004

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

Source: Federal Statistical Office, Health Expenditure, Wiesbaden 2006

Explanation to Table 1

In Germany, it is important to differentiate between (1) "health expenditure" as defined and measured by the Federal Statistical Office in accordance with the OECD system of health accounts and (2) expenditure defrayed by the various statutory payers, i.e. especially statutory health insurance (SHI). Compared with the latter, the former (which was reappraised in 2006) notably excludes cash benefits, e.g. sick pay, but also certain expenditure appropriations for education (e.g. allowances for hospitals which maintain nursing schools) and research. Table 1 illustrates this matrix structure, based on 2004 figures. Of the total health expenditure of € 233,983 million, € 131,564 million (56.2%) was financed by SHI. On the other hand, total SHI expenditure was € 138,996 million, including expenditure on education, training, sick pay, etc. This difference has to be kept in mind when looking at the figures in Table 1.

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

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

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

Source: Federal Statistical Office, Health Expenditure, Wiesbaden 2006

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

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

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

Table 4 Healthcare cost shares according to age, 2004

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

Source: www.sozialpolitik-aktuell.de

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

Table 5 SHI revenue in Germany

(in bn €)

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

Source: Statistisches Taschenbuch Gesundheit, 2005

Table 6 Public- and private-sector healthcare financing in Germany

(in m €)

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

Source: Statistisches Bundesamt, 2006

(2) Sharing of costs between sickness funds

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

1) German health insurance bears a remarkable organizational feature not encountered in any other European state: it acknowledges seven different types of sickness funds as third-party payer institutions – which is why it is referred to as a “structured system” [*gegliedertes System*]. Leaving aside the three special institutions for agriculture, mining and seamen[62], four fund types remain: the AOKs [*Allgemeine Ortskrankenkassen*], which were previously only one form of local sickness fund; the company-based sickness funds [*Betriebskrankenkassen* – BKKs]; the guild sickness funds [*Innungskrankenkassen* – IKKs]; and the substitute funds [*Ersatzkassen*], whose distinction between blue and white collar workers is of little significance today.[63]

This structural division into fund types can only be explained historically. Back in 1883, with the enactment of the Health Insurance Act,[64] a network of local sickness funds was established.[65] Early company-based sickness funds were set up as factory funds, even prior to the introduction of statutory health insurance, and have been in place as statutory funds since the 1883 Health Insurance Act.[66] Guild sickness funds, dating from medieval trade guilds, upheld the tradition of rendering mutual aid and protection to their members. After entry into force of the 1883 Health Insurance Act, however, they were for a while without legal personality owing to trade law provisions.[67] That changed with the enactment of the RVO. And finally, substitute funds were originally self-help organizations under private law; most of these funds that still exist today had been founded as registered assistance funds by 1911. During National Socialist rule, they were given the status of statutory corporations.[68] Under the Healthcare Reform Act (GRG)[69] of 1989, substitute funds were, in all major respects, placed on an equal footing with the other fund types.[70]

The idea behind the different fund types was that they furnished links to the competent insurance institutions. Hence, an occupational link existed for craftsmen in guild sickness funds and for employ-

ees in company-based sickness funds, provided these had been set up by the entrepreneur. The remaining insurants came under the competence of the local sickness funds. Substitute funds could be chosen by certain groups of insurants in place of the otherwise competent, so-called primary funds.[71] The *Bismarckian* health insurance system was thus based on small regional or socio-professionally defined solidarity-based communities. That also explains why a (differing) multiplicity of individual funds, each having a separate legal personality, exists within the four fund types.

In this way, a wide statutory distribution of competence evolved. And because the individual funds were financially autonomous, i.e. could define their own contribution rates within the scope of statutory provisions and under state supervision, the contribution burden became highly differentiated in the course of time.[72] Such differentiation could no longer be adequately explained by the ostensible homogeneity of members insured with an individual fund, so that its justification in light of the constitutional precept of equal treatment (Art. 3(1) GG) had become more than doubtful. Although the BVerfG confirmed the constitutionality of contribution rate differences, thereby referring to the organizational model of statutory health insurance, it dispensed with an extensive review because the legislature had remedied the situation through the enactment of the measures described in the following.[73]

2) When the legislature introduced the Structural Health Insurance Act [*Gesundheitsstrukturgesetz*][74] at the end of 1992, providing free choice of sickness funds for insurants and risk structure compensation with effect from 1995/96, it took account of the organizational particularities of the structured system of statutory health insurance.[75] Initially, only little restructuring was necessary. The conventional distribution of competence – previously disrupted only by the limited options in respect of primary and substitute funds – was largely dissolved and replaced by a comprehensive right of choice for insurants. According to the latest amendment, insurants are bound by their choice of sickness fund for 18 months, whereupon they may opt for membership of another fund. As for the funds, they have been subject to the compulsory acceptance of new members, meaning they are not allowed to reject insurants.[76] Consequently, sickness funds can no longer rely on the insurance obligation for the de facto allocation of their members, but must make an effort at being "chosen". Certain exceptions remain, such as the fixed competence of vocationally oriented funds (the social security fund for seamen, the Federal Miners' Insurance Fund, and agricultural sickness funds pursuant to §§ 176, 177 SGB V and § 19 KVLG 1989), on the one hand, and savings clauses in favor of company-based and guild sickness funds, on the other (under § 173 II 1 No. 4, 2nd sent. SGB V).

Competition between sickness funds does not aim to regulate the demand for healthcare benefits and, hence, to contribute to optimum resource allocation. This would require – at least on assuming market mechanisms function that way in the health sector – that insurants were allowed to decide on the scope of benefits, by individually appraising their value, and then to select the best possible cost-benefit ratio to suit their personal needs. The actual aim, rather, is to improve efficiency and thus to mobilize rationalization opportunities within the existing insurance system. The disadvantage vis-à-vis centralized state benefit systems is that more competition is apt to impede steering mechanisms and produce the well-known *moral hazard* effect, which leads to resource mis-allocation.[77] The major advantage, however, is the – at least basic – connectivity between receipts and expenditures under separate budgets and, consequently, a higher degree of cost transparency.

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

a) The total number of sickness funds has declined, from over 1,300 in 1992 to 253 in 2006. Even so, the consolidation process has by no means progressed to such an extent as to threaten the functioning of fund competition. On the contrary, the opened access to many company-based sickness funds has enlarged the number of funds open to choice. All insurants with a right of choice still have sufficient options available to them for all sickness fund types, although the trend toward larger-scale areas of competence is not to be overlooked.[78] There are plans to permit inter-fund amalgamation and, hence, to reduce the number of sickness funds.

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

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

c) When comparing the contribution rates set by the individual funds, these rates show an overall tendency toward the mean if grouped according to fund types. That is certainly a desired effect as it leads to a balancing of insurants' contribution burdens. Under competitive aspects, too, a trend in this direction poses no problems: a functioning risk adjustment system and the utilization of efficiency reserves would in any case entail a certain degree of approximation, albeit not leveling.[79]

d) The aforementioned fact correlates with the rising number of statutory health insurance members who make use of their right of choice. Although the total number of changers was comparatively low in the early phase, it has now exceeded original expectations.[80] And when related to the individual funds, this figure has meanwhile reached a magnitude that is bound to have considerable consequences.[81] This development is reflected in the current discussion over the reconfiguration of the risk adjustment system.[82]

e) Taking a look at administrative expenditures proves of particular interest to the appraisal of competitive effects. Those who thought these expenses would drop erred. One explanation for this could be that employers shifted personnel costs to the company-based sickness funds. But perhaps the rise in some of the funds' administration expenses can be explained more easily by their improved service offer and heightened competition.[83] In that case, however, competition – hailed an efficiency-generating instrument upon its introduction – would have turned out to be counter-productive. Yet a glance at administrative expenditures per member once again reveals an approximation between the fund types. In particular, the company-based sickness funds have "caught up" in this respect. The same holds true for the ratio of administrative expenditures to benefit expenditures. Especially when comparing the different funds, this ratio should not be neglected in accounting for processing and client service costs. In the final analysis, the available figures fail to answer the original question of why administrative expenditures are rising, nor do they indicate whether such a rise is assuming "explosive" dimensions.

(b) Risk adjustment system

The risk adjustment system,[84] which provides for extensive financial equalization between the sickness funds, was introduced on 3 January 1994. It was revised by the Law on the reform of the risk adjustment system in statutory health insurance [*Gesetz zur Reform des Risikostrukturausgleichs in der gesetzlichen Krankenversicherung*], dated 10 December 2001.[85] The twofold task of risk adjustment is to establish equal opportunities between the sickness funds and to avoid risk selection at the expense of the insured. To be noted here is that the legislator has largely repealed the fixed allocation of insurants to individual funds, thus affording options to sickness fund members. The funds are nevertheless essentially bound by statutory provisions to deliver the benefits defined under statutory health insurance. Apart from improving their services, sickness funds must primarily strive to win new insurants by offering lower contribution rates. This, of course, could best be achieved by keeping expenditures low, which is the desired objective in respect of administrative costs, but should not lead to exclusions from benefits. Regarding risk adjustment between the different sickness funds in western and eastern Germany, see Table 7.

Table 7 Risk adjustment in 2003

Sickness funds	West (m €)	East (m €)	Total (m €)	€ per insurant
AOK	8,652	4,501	13,153	512
BKK	-8,031	-1,126	-9,157	-629
IKK	-163	-167	-361	-81
SeeKK	5	-2	3	40
Bundkn	1,178	391	1,569	1,130
ArbK	-582	-77	-659	-461
AngK	-3,209	-446	-3,655	-163

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

Receipt and expenditure gaps subject to adjustment result from: the level of members' earnings liable to contribution; the number of co-insured dependants (which enter the equation as having "zero" earnings); age and sex distribution; invalidity among insurants; as well as participation in an accredited Disease Management Program (DMP, a criterion since 2002).[86] Simply speaking and leaving aside specific differentiation, all insurants are at first categorized according to the factors of age, sex and invalidity. Total benefit expenditures can then be distributed across these categories, making it possible to determine the average costs incurred by one insurant in each category. In a second step, average benefit expenditures can be correlated to the composition of insurants of a specific fund. This gives an insight into the fund's imputed benefit expenditures and into the contributions it requires for cost coverage. The contribution requirement is in turn compared with the financial power of the fund, which is largely determined by the amount of its members' contributory earnings. If a fund's financial power exceeds its requirements, the excessive amount is paid over to other funds whose financial strength falls short of their needs. The whole procedure serves the purpose of creating and sustaining incentives for economic task fulfillment. That is why actual expenditures are not simply compensated.

The risk adjustment system has only partially been able to perform its intended function of concentrating inter-fund competition for insurants on the efficient use of administrative resources. Given that average benefit expenditures are adjusted, a fund will remain more heavily burdened if its members incur higher costs in comparison to other insurants of the same age and sex. Therefore, criteria should be developed in future that make it possible to record and classify all insurants in terms of morbidity.[87]

(3) Sharing of costs between different population groups

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

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

2) As for the lower limit, all earnings from employment up to a monthly wage of € 400 (so-called minor employment – *geringfügige Beschäftigung*)[88] are exempted from health insurance. That means employees who do not earn more than € 400 per month are not covered by health insurance. Consequently, they do not have to pay any contributions. This is different for their employers, who are liable to a contribution rate of 11 percent on minor employment – which, however, is only 5 percent for minor wage earners in private households.[89] This regulation was introduced for labor market reasons and is aimed at making less productive work cheaper. The fact that employers must nevertheless pay contributions is due to a shift from former taxation to the levy of contributions: employers are no longer required to pay taxes on minor employment. In this way, the legislator withdrew funds from the general budget in order to subsidize the social insurance systems. For the number of persons in minor employment in Germany, see Table 8.

Table 8 Persons in minor employment in Germany

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

Source: Die Minijobzentrale

(b) According to region

First of all, it must be stressed that the above-mentioned risk adjustment system does not differentiate according to regions. This has always been a point of debate.[90] Some hold that this lack of differentiation must be regarded as a violation of the principle of equal treatment laid down in the German constitution (Art. 3(1) GG).[91] However, the BVerfG did not share this view in its recent judgment of 18 July 2005.[92]

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

The Act to Equalize the Law in Statutory Health Insurance, passed in 1999, standardized the risk structure compensation mechanism for the whole of Germany from 2001. This led to an increase in the transfer of financial resources from western to eastern Germany. On the other hand, the SHI income basis in the eastern part of the country was broadened by adjusting contribution limits, mandatory membership and exemption from co-payment to West German levels. Both measures sought to reduce the high health insurance contribution rates in the East, thereby reducing obstacles to employment and economic growth. For total risk adjustment payments between eastern and western Germany, see Table 9.

Table 9 Risk adjustment compensation between eastern and western Germany

Transfer payments from West to East (in m €)		
Year	Equalization of financial power	Equalization of contribution income
1999	€ 614	Not done
2000	€ 1,416	Not done
2001	€ 1,528	€ 477
2002	€ 1,773	€ 604
2003	€ 2,178	€ 694
2004	€ 2,300	€ 908

(c) According to age

1) Up until the 1990s, there was a special form of financial equalization for Pensioners' Health Insurance (*Krankenversicherung der Rentner* – KVdR). As health insurance contributions are levied on pension benefits, this line of insurance is considered a separate component of the overall system, with its own insurance obligation and, hence, with an autonomous financing scheme. Owing to the enhanced demand for benefits in older age, an equalization of intergenerational burdens was regarded as necessary if individual pensioner contributions were to remain affordable.[93] For it had long been evident that the proportion of pensioner health benefits would rise relative to total health benefit expenditure.[94] The required financial equalization in favor of the KVdR was therefore not borne by the individual sickness funds and their members, but divided equally among all insurants at large. To that end, pensioner benefit expenditures not covered by pensioner contributions (so-called funding share) were apportioned among all member contributions through the financial equalization scheme (§§ 268 et sqq. SGB V).[95] This independent scheme was abolished with the introduction of the risk adjustment system (see above, III. (2) (b)).

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

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

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

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

(4) Sharing of costs between employers and employees / patients and insurants

(a) Contribution rates

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

Quite early on, attempts were made to relieve the financial strain on the healthcare sector. For example, in 1969, continued remuneration in case of sickness was reallocated to labor law.[96] Even so, healthcare expenditure continued to grow substantially in the 1970s.[97] This development led to the enactment of diverse laws between 1977 and 1983, all of which were aimed at cost containment. Most prominent among these were the Health Insurance Cost Containment Act[98] and the Health Insurance Cost Containment Supplementary Act.[99] As these amendments, too, were of only little success, the Healthcare Reform Act was passed in 1988.[100] Among other things, it introduced fixed amounts for drugs and aids, new or increased patient co-payments, the abolition of death benefit for younger persons and its curtailment for older insurants, and the extension of efficiency controls. Notwithstanding all these measures, healthcare spending and, with it, contribution rates kept on rising.[101]

As the present process of reforming social insurance is also aimed at strengthening Germany's international competitiveness and, consequently, at reducing labor costs, the Government has sought ways of altering the distribution of SHI burdens between employers and employees. Thus, in 1997, the First Law on the reorganization of self-government and personal responsibility in statutory health insurance[102] was enacted. One of its prime novelties was the limitation of dental prosthesis benefits to the coverage of fixed amounts. The 1998 Act to Strengthen Solidarity in Statutory Health Insurance [103] brought further benefit curtailments in the area of dental prostheses and orthodontic treatment. With effect from July 2005, insurants have been obliged to pay a special 0.9 percent contribution toward the funding of sickness pay and dental prostheses.[104] This marked a change in the hitherto solidarity-based equivalence of employee-employer contributions – at the expense of employees.

(b) Co-payments

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

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

The Federal Government's current draft bill concerning a Law to strengthen competition in statutory health insurance[105] focuses only on the amendment of § 62 SGB V. The bill thereby raises the co-payment limit for chronically ill persons from one to two percent if they were born after 1 April 1972 and failed to participate in regular health checks pursuant to § 25 SGB V, or if they were born after 1 April 1987 and are suffering from cancer and did not undergo any preventive medical checkups required under § 25(2) SGB V. A newly inserted paragraph under § 62(5) SGB V provides that the leading associations of sickness funds are to evaluate exemptions from co-payment with a view to their steering effects, and report their findings to Parliament by 30 June 2007.

(5) Sharing of costs between the public and the private sector

(a) Scope of compulsory insurance

1) The present functional division between statutory and private health insurance requires only a few remarks. It is shaped by the selectionist approach taken in the statutory system of provision, which largely precludes self-employed persons

from social security coverage of the risk of illness. As for such special groups as civil servants, judges and soldiers, precedence is still given to so-called internalized provision:[106] based on the construct of a special legal relationship, provisions for this category of persons are left to the state and its provident care duty. Up to this point, the layout of statutory health insurance conforms to the architectural principles of *Bismarckian* social insurance, a special feature being that not all persons in dependent employment are included in the mandatory scheme. This is because statutory health insurance sets an upper limit for compulsory coverage referred to as the gross annual earnings limit: persons whose salaries exceed this limit are exempt from the obligation to insure (§ 6 I No. 1, VI – VIII SGB V).

Hence, private health insurance does not only assume a supplementary function, namely in offering benefits not covered by the statutory insurance catalogue. Rather, it also possesses a substitutive character, in that coverage for higher-income earners can be provided by private insurers. This idea is often expressed by the somewhat catchy phrase "bipolar insurance constitution".[107] The gross annual earnings limit has also been labeled "peace limit",[108] insinuating a kind of compromise in delineating the range of both insurance forms.

2) For many years, the gross annual earnings limit was equivalent to the income limit for the assessment of contributions. Since 1971, it had been geared to the income limit for the assessment of pension insurance contributions and amounted to 75 percent.[109] Its annual adjustment by way of statutory order was based on the trend in gross wages and salaries. The Act to Equalize the Law in Statutory Health Insurance placed the limit in the new German states [*Länder*] on the same level as in the old.

3) In 2003, the base value was raised as a one-time measure[110] because an increasing number of persons were opting for private instead of statutory health insurance.[111] It was also decoupled from the limit in pension insurance and is now determined annually by the Federal Ministry of Health.

Table 11 Gross annual earnings limit for the SHI

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

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

In February 2004, the BVerfG rejected a constitutional complaint filed by an insurance company against the raising of the compulsory insurance limit.[112] The Court argued that although the upward adjustment at the expense of private health insurers possibly constituted an intervention in their occupational freedom,[113] it was nonetheless justified because it had proved appropriate, necessary and reasonable for sustaining the financial stability of statutory health insurance. An additional criterion was that the business operations of these insurance companies were not unduly affected by the new regulation – at least not in the opinion of the Court.[114]

4) In Germany, 9.83 percent of the population is fully covered under a private insurance scheme (= insurance of ambulatory and general hospital benefits). Included in this figure are civil servants, judges and soldiers. In 2003, the number of insurants rose by 186,600 (net increase), cor-

responding to a rate of 2.35 percent,[115] whereas in 2004, the number of insurants rose by only 149,000 persons (net increase).[116] The reason for the decline in the number of persons migrating to private health insurance is the raising of the income threshold for compulsory insurance, from a minimum monthly income of € 3,375 in 2002 to € 3,825 in 2003.[117]

Apart from the more than 8.11 million persons who are fully covered by private health insurance, nearly another 7.9 million have taken out some form of private supplementary protection[118] (approx. 9.6 percent of the population[119]). Even so, full coverage of the sickness contingency remains the chief type of private health insurance in Germany, its share of aggregate premium income amounting to 70.83 percent in 2003[120] and 71.58 percent in 2004.[121]

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

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

Note: In terms of net increase, the number of deaths surpasses the number of births.
Source: PKV, Zahlenbericht [Private Health Insurance Facts & Figures] 2004/2005, www.pkv.de

(b) Main features of private insurance

1) Private law approach

In principle, private health insurance functions in accordance with the general rules governing contractual obligations under civil law. The insurance relationship is established by concurrent declarations of intent made by the contracting parties. Its content, too, is subject to the parties' formation of that intent (private autonomy), their scope of action nevertheless being restricted by regulations of insurance law.[122] Disputes between the insured and the insurers are brought before the civil courts under the purview of the Code of Civil Procedure [*Zivilprozessordnung* – ZPO]. Family members are not included in the coverage of risk on a statutory basis. Generally speaking, they need to conclude a contract of their own, and a separate premium must be paid per insurant. However, according to a judgment of the Federal Court of Justice [*Bundesgerichtshof* – BGH] regarding § 178a(1) of the Insurance Contract Act (VVG; see 2) below) it is possible for a spouse to be insured for the account of the other spouse (notably, see § 178a(3), 2nd sent.).[123] The co-insured spouse is thereby not to be regarded as a person at risk under the insurance contract concluded solely in the self-interest of the insurant, but is part of a contract for the benefit of a third party pursuant to § 328 BGB [*Bürgerliches Gesetzbuch* – Civil Code]. The co-insured spouse can claim benefits on his/her own behalf in connection with this contract.[124]

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

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

2) Statutory regulation

General safeguards in favor of the insured are set forth in the Law on the supervision of insurance companies (VAG)[125], which was last amended in 2004,[126] not least to implement Community law provisions on the solvency, reconstruction and liquidation of insurance undertakings. Thus the actual commencement of business operations requires a permit, while the operation itself is subject to legal and financial supervision, and to rules on capital resources and investment.[127]

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

- The supervisory legislation includes a special provision on substitutive health insurance. Accordingly, there are specific rules for premium calculation; the right of contractual notice of cancellation is restricted, and premium alterations are subject to the consent of an independent trustee.[128] Simultaneously, insurers are obliged to set aside old-age reserves on behalf of every insured person[129] – on the assumption that the demand for many benefits increases with age, necessitating provisions to avoid excessive premium burdens in later life.
- The Law governing insurance contracts (VVG)[130] likewise contains a number of special provisions. Accordingly, substitutive health insurance is, as a rule, of unlimited duration;[131] contractually agreed general qualifying periods may not exceed three months; an insured person's newborn child must be admitted without additional risk charges and qualifying periods; and the insured have the right to give contractual notice of cancellation as per the end of every year.[132] Contractual notice by the insurer is ruled out under substitutive health insurance.[133]
- Worthy of note, moreover, is the social law provision that pertains to the employer's participation. In the case of compulsorily insured persons, employers and employees share the cost of the contribution; for those voluntarily insured under the statutory scheme, the employer pays a supplement. To avoid the less favorable treatment of private schemes, privately insured employees are also eligible for an employer supplement (§ 257 SGB V).[134] Nevertheless, for private health insurers to qualify for such supplements, they need to offer a standard tariff, notably to older insurants (§ 257 IIa SGB V). This establishes a link to the benefit catalogue of statutory health insurance and, within a certain scope, to its contribution burden, the aim being to avoid unaffordable insurance premiums in old age.[135]

3) Provision of benefits

a) Coverage under statutory health insurance (SHI) is regulated by law, statutory instruments and so-called directives issued by the Federal Joint Committee (including activities of the Institute for Quality and Efficiency of Health Care [*Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen*]).[136] Basic principles of benefit provision are laid down in §§ 11-18 SGB V, and a catalogue of benefits is set out in §§ 27-43 SGB V. Both must be given concrete substance through the directives and decisions of the above-mentioned institutions. All benefits must be adequate, necessary and efficient.

Under private health insurance (PHI), healthcare benefits depend on a contractual agreement between insurant and private sickness fund. Medical treatment measures must be necessary and adequate.[137] The efficiency of measures is initially of no relevance. There is no budgeting in private health insurance. Nevertheless, in the case of two equally promising measures, the private sickness fund need only pay for the less expensive option.[138]

b) Under SHI, medical treatment must be performed by providers (medical and dental physicians) who are formally admitted to SHI. They are part of a corporatist negotiating system between the associations of SHI physicians and the associations of sickness funds; this system also decides on provider remuneration. As a result of the present political debate[139] and the Amending Law governing contracting physicians [*Vertragsarztrechtsänderungsgesetz*][140], the system is due to be modernized in 2007. SHI is then to have fee scales comparable to those of PHI (see below), and budgeting is to be replaced by a new system of control by volume.

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

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

Benefits financed by SHI	Benefits financed by PHI
(a) Basic care	
Basic medical treatment is covered; according to the precept of efficiency, this includes only efficient treatment, § 12 SGB V; therefore, budgeting is obligatory, with cost aspects ranking first; obligatory co-payment of € 10 per quarter of the year in which a physician is consulted; some remedies are excluded by law or directive, § 34 SGB V, e.g. remedies for influenza, coughs and colds, or travel sickness; prescription of remedies only according to fixed amounts, §§ 35, 35a SGB V.	All required medical treatment [*notwendige medizinische Behandlung*] [141] is refunded (first level of decision by insurance companies); this is appraised from an objective medical viewpoint[142]; no budgeting; refund of all adequate approved remedies, which the insurant must prove in case of legal dispute[143]; only in unusual individual cases is merely the cheaper of two equally promising measures paid[144] if one of the methods is much more expensive than the other[145]; cost aspects are only of secondary relevance[146].
(b) Dental and orthodontic treatment	
Only basic dental treatment and prophylaxis are covered, but not prostheses, § 28 SGB V; orthodontic treatment is only funded for patients up to the age of 18 and up to 80%, § 29(2) SGB V; no financing of special requests or expensive methods.	Not only basic treatment, but 100% of the costs of prostheses are refunded (some companies only pay for visible prostheses); implants or special crowns are only reimbursed up to 75-90% according to contract and insurance company[147]; ceramic inlays must be refunded[148]; 85-90% refund of orthodontic treatment.
(c) Optic care	
Optic care is covered only according to a fixed amount, § 33(2) SGB V; co-payment of € 5 per package; only basic eyeglasses, but not frames or contacts, are financed, § 33 SGB V.	Eyeglass frames and hard and soft contacts are refunded – frames up to a maximum amount of € 150.
(d) Hospital care	
Treatment only in certain, easily reachable hospitals; attending physician is assigned by the hospital; shared rooms, with co-payment for television, phone and radio.	Free choice of hospital treatment; free choice among all physicians; treatment by chief physician; twin or single rooms; cost-free use of phone, television and radio.
(e) Alternative measures	
Alternative measures are covered only in few cases; according to § 135 SGB V, a funding of alternative measures is only possible if permitted by the Federal Joint Committee; the difference to private health insurance is the need of scientific approval[149]; however, in case of danger to life, alternative measures must be permitted in special cases, according to a recent decision of the BVerfG[150], if there are no prospects for a cure using scientifically approved methods.	Practically[151] approved alternative measures are refunded, e.g. treatment by an official alternative practitioner[152], naturopathic treatment[153] or acupuncture; however, these measures must be required medical treatment appraised as such from an objective medical viewpoint[154]; experimental methods are excluded, i.e. not refunded, e.g. Ayurveda[155], Bio-Resonance Therapy[156], traditional Chinese Phyto-Therapy[157] and ASI-Therapy[158]; however, in case of danger to life, with no other healing prospects, experimental methods must be reimbursed[159]; in such cases, palliative[160], but not necessarily healing[161], measures may suffice; there is a general tendency for courts to accept more and more alternative measures[162].

(c) Historical explanation for the present public-private mix

The Health Insurance Act of 1883[163] had already stipulated an upper earnings limit for compulsory insurance. While not pertaining to industrial workers, the limit did apply to the majority of white-collar workers and was set at 6 2/3 marks per day or 2,000 marks per annum.[164] With the codification of social insurance law through the Reich Insurance Code (RVO),[165] it was raised to 2,500 marks in 1911.[166]

The initial reason for this regulation was that only persons deemed in need of protection were granted health insurance coverage. Employees with earnings above this limit were considered in a position to bridge over sickness-induced, non-productive periods from their own reserves.[167] And later, with the creation of the RVO, physicians were likewise opposed to raising the compulsory insurance limit because that would have narrowed their earnings potential.[168]

Since the introduction of statutory health insurance, the category of insured persons has successively been extended,[169] so that the need-based principle of compulsory insurance has been watered down to some extent. Even so, a widely held view today is that the principle still ought to have some bearing.[170]

(d) Institutional competition or solidarity?

Employed persons whose earnings exceed the compulsory insurance limit can opt for membership of statutory health insurance when first entering into employment. If they fail to do so, they have, in principle, forfeited their right to access the system at a later date.[171] The underlying intent is to prevent persons from initially selecting the less costly form of private insurance and then profiting in old age, when benefit needs increase, from social equalization under the statutory system.

Fundamentally, both statutory and private health insurance present options within the respective system, namely in the choice of insurance providers. An interesting phenomenon here is that the statutory insurance system in fact offers more freedom of choice than private insurance. While most statutorily insured persons can choose from among a range of sickness funds after a relatively short term of membership (18 months),[172] switching from one private insurance company to another fails in practice because insurants' old-age reserves are not "portable", that is, cannot be transferred to a new insurance relationship. As a result, concluding a new insurance policy with another company becomes expensive and, hence, economically unattractive.[173]

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

(6) Some remarks on current reform proposals

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

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

These reflections are attended by questions relating to their constitutionality.[174] The main issue is whether an extension of the group of compulsorily insured persons is compatible with private insurants' general freedom of action and protection of property, on the one hand, and with the occupational freedom of private insurance companies, on the other. Rulings of the BVerfG have paved the way for the further development of social insurance.[175] A historicizing approach that seeks to "abide by the conventional"[176] is rightly not the demanded course of action. Yet that does not necessarily mean both of the above concepts

are admissible.[177] According to the BVerfG, the legislature may take account of the fact that a sufficiently large community of insurants is needed to ensure a well-functioning social insurance system.[178] The need to protect the general public from the burden of social assistance benefits is likewise recognized by the Court.[179] By its very nature, this pragmatic approach[180] does not only have the disadvantage of turning a well-established insurance system into a maelstrom that draws ever more persons in its wake. More importantly, such an approach lacks the positive statement of reasons for compulsory membership of a social insurance scheme.[181]

Whether reverting to the criterion of need-based protection[182] will be of any help here is questionable. Correct is that insurance branches must be distinguished according to their respective functions and that a fundamental risk load must be demanded for all insurants.[183] Yet nothing decisive has been gained by affirming this. An unresolved question is how to define "need of protection": is it based on low income,[184] or on the lack of other, more reliable and better attainable security options? Much speaks for the fact that a state dedicated to the common welfare of its people may postulate the aim of rendering sufficient health care to the entire population and of including all inhabitants in the process. That aim can be accomplished just as well through tax financing as through a contribution-based funding system.

(b) Current developments

1) In the Coalition Agreement of 11 November 2005 between the Christian Democrats (CDU) and the Social Democrats (SPD), the parties stress the need for a sustainable and just financing of health insurance.[185] In the face of mounting cost pressure, they declare the importance of a competitive and liberal orientation of the healthcare sector, with stable financial structures. Although the coalition agreement mentions the two parties' hitherto developed, opposing concepts of a "solidarity-based health insurance premium" (CDU/CSU) and a "citizens' insurance scheme" (SPD) as starting points for a common solution, it completely leaves open what such a solution might look like. Obviously, a compromise could not be agreed upon, but as one wished to get the coalition off the ground, specific details were left out of the coalition agreement.

2) A so-called cornerstone paper [*Eckpunkte-papier*], dated 4 July 2006, of the joint working group of the Federal and *Länder* governments on the healthcare reform[186] seeks to substantiate the basic approaches and objectives stated in the coalition agreement, thus laying the foundations for the planned reform. It is thereby agreed that not only the financial basis of the system (income side) should undergo changes, but also the provision of benefits (expenditure side).

The following issues are addressed:

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

3) The Federal Ministry of Health has submitted a so-called working draft,[187] which is alleged by some not to have been cleared with the political leadership. On the other hand, all actors in the healthcare sector were already familiar with the paper after only a few days and engaged in fervid dispute over its contents.

4) Meanwhile, the draft legislation is being debated by Parliament and the *Bundesrat*.[188] In February 2007, both Houses took their final vote on the bill, so that the main parts of the law will be enacted on 1 April 2007. Other parts will be enacted later. For example, the so-called Health Fund [*Gesundheitsfonds*] is to become operative in 2009.

(c) Alterations of the German system

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

als to permit inter-fund mergers[189] and fund insolvency,[190] as well as through the introduction of the above Health Fund[191].

1) Financing is largely to follow the approach taken so far. Nevertheless, the proposed Health Fund is to be set up and managed by the Federal Insurance Agency [*Bundesversicherungsamt*].[192] The health ministry will then have to fix the contribution rates, after evaluating the findings of an appraisal committee, meaning the sickness funds no longer determine these rates or collect the amounts due.[193] The insurants' risks, which differ among the various sickness funds, will be equalized by means of age- and risk-related allocations from the Health Fund.[194] The Health Fund is thus to replace the hitherto existing system of risk adjustment between the sickness funds.[195] Contribution collection by the sickness funds, as collecting agencies, is to be carried out in future by transfer agencies (authorized agencies). These agencies can be sickness funds, networks, consortia, or sickness fund associations.[196] If the financial requirements of a sickness fund cannot be covered by appropriations from the Health Fund, the respective sickness fund must stipulate in its statutes that a separate additional contribution is to be levied from its members. This amount must not exceed one percent of an insurant's earnings liable to contribution [*Kassenindividueller Zusatzbeitrag*].[197]

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

In the face of these various difficulties, the Health Fund will not be launched before 2009.[198] This respite gives rise to the hope that the legislator will be wise enough to "re-reform" the relevant provisions before they ever come into force.

2) Financing is to be supplemented by tax proceeds in the future. For one thing, the Federal Government will extend interest-free loans to the Health Fund if its liquidity reserves prove insufficient.[199] Moreover, the Government will grant € 2.5 billion[200] to the sickness funds in 2008 as a lump-sum compensation for the performance of non-insurance tasks; in 2009, it will award € 4billion in monthly installments to the Health Fund, with a further increase in the following years up to a maximum amount of € 14 billion.[201] This tax money will be geared primarily to the funding of collective societal tasks, such as the non-contributory co-insurance of children. Subsequently, the subsidy is to rise on a continuous basis. Sickness funds still short of resources after that will have access to possibilities for closing these funding gaps through savings measures (general practitioner fees, fee options, special forms of care provision, additional contributions, etc.).

3) Competition among sickness funds is to be reinforced in that

- mergers between different funds will be possible in future[202];
- a leading association on behalf of all sickness funds is to be entrusted with the negotiation of basic healthcare guidelines.[203]

Both approaches are, in principle, correct.[204] Nevertheless, specific aspects remain open to question (notably, it is not true that larger sickness funds inevitably operate more efficiently than smaller ones). Any intention to replace existing, and well functioning, institutions should be reconsidered carefully. The same holds true for the question whether, and under what prerequisites, sickness funds should be subject to the laws on insolvency. Moreover, it is doubtful whether the aim to strengthen competition actually fits in with the introduction of the Health Fund (see c) above).

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

- alignment of the existing private medical fee schedule with the schedule to be created for SHI-contracted physicians;
- portability of old-age reserves to enable insurants to change private insurers in future. Here, however, the treatment of existing insurance contracts is unresolved, and also problematic in legal terms.
- introduction of a basic private insurance tariff

(for a basic package of benefits) that is to be made available to all privately insured persons and all persons voluntarily insured under the statutory scheme.

In that way, private sickness funds would be approximated to the statutory funds to such a large extent (see above, 3 (5)) that differences between them would be obscured even more than between statutory and private long-term care insurance. Such plans are as problematic in terms of constitutional law as they are questionable with regard to regulatory policy.

4. Health care in an aging society

(1) On the demographic processes

German society is aging. This process is not unique,[205] nor is it new,[206] but it has accelerated. Since the beginning of the previous century, life expectancy has increased by about 30 years; it is now just under 75 and 81 years, respectively, and will be prolonged further in future.[207] At the same time, German society is shrinking[208] on account of low fertility rates. According to the Federal Statistical Agency, every third person living in Germany in 2050 will be 60 years of age or older. The (old) age dependency ratio, i.e. the ratio of those over 60 to the working population, is forecast to rise from 44 to 78.[209] And these estimates tend to be on the cautious side.[210]

Table 13 Trends in life expectancy in Germany

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

Source: Statistisches Bundesamt, 2006

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

*The average number of children that would be born alive to a woman if she lived to the end of her reproductive years and if she experienced the same age-specific fertility throughout her life that women in each age group experience in a given year or over a period of years.

Year	Germany	Japan
1993	1.28	1.46
1994	1.24	1.50
1995	1.25	1.42
1996	1.32	1.44
1997	1.37	1.44
1998	1.36	-
1999	1.36	1.40
2000	1.38	1.36
2001	1.35	1.33
2002	1.31	1.37
2003	1.34	1.38
2004	1.37	-

Source: Eurostat, 2006

Table 15 Age structure in Germany

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

Source: Statistisches Bundesamt, 2006

(2) Effects of aging on healthcare systems

(a) Financial sustainability

(1) It seems to be very difficult to make a prognosis on the development of health care costs, and thus on the costs of the health insurance system, in an aging society. On the one hand, it is quite plausible that the process of demographic aging will lead to rising costs. On the other hand, we know very well that the costs for an individual insurant reach a peak during the last year of life.[211] It is not clear, though, whether there is also a proportional increase in the previous years.[212] It should be noted that the overall costs of medical treatment for individual insurants depend very much on their state of health, and that this is, at the same time, influenced by environmental and social factors. And of course, technical and medical innovations have a strong impact on the financial burdens of the health insurance system.

(2) Neither the Secretary of Health, the Federal Statistical Office nor the Federal Social Insurance Authority provide any projections on contribution rate and health expenditure development. But some very interesting scientific approaches to this problem do exist.[213] The following description by *Postler* shows the development of contribution rates according to aging society, on the one hand, and medical progress, on the other.

Table 16 Contribution rate development (allowing for society aging)

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

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

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

by about 16 percent, and in the worst case scenario, by about 23 percent.

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

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

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

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

The other above-mentioned calculations [214] cannot be dealt with in detail here. Given that all of them suffer from more or less great uncertainty, they merit attention not so much for providing new figures as for the simple fact that they put emphasis on the linkage between future expenditure and cost containment policies.[215]

(b) Adaptation of the benefit package

(1) Introductory remarks

In the face of future demographic changes, an ever more pressing question will be whether and how the benefit catalogue must be adjusted to meet the needs of older persons. Gerontological research shows that supportive and promotional measures are above all necessary to take account of a potential loss of autonomy, but also to maintain self-reliance. Extensive lists of elder policy demands were already drawn up years ago, with reference both to the living environment of older people and to the care and assistance benefits required by them.[216] The following seeks only to address two especially topical points relating to health insurance.

(2) Preventive measures

(a) Current statutory foundations under SGB V

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

The law governing primary prevention (measures for general improvements to health and for the reduction of socially induced inequality in respect of healthcare opportunities; occupational health promotion; support of self-help groups) does not only lay down which measures are to be promoted, but also limits the financial resources appropriated to that end (in 2006, € 2.68 were spent annually per insurant, along with an additional € 0.53 toward the support of self-help groups).[217] Consumer and patient counseling services are eligible for separate support (§ 65b SGB V).

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

The preventive character of medication is regulated under § 33a (7) SGB V as one of the

prerequisites for the authorization of prescription drugs.

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

(b) Reform of preventive measures

Based on preliminary work done in 2004, the government submitted a draft bill for a prevention law on 2 February 2005.[218] The law was adopted by the *Bundestag* (Lower House) on 22 April 2005 with the votes of the Red-Green majority.[219] But as the bill was rejected by some of the *Länder* representatives in the Upper House [*Bundesrat*] on account of its incalculable financial consequences, it was sent to the mediation committee and could therefore no longer be passed in the previous legislative period. According to the principle of discontinuity, draft bills from a preceding legislative period may not be reintroduced in the new period.

The new Federal Government's coalition agreement of 11 November 2005 re-addresses this issue. Thus it declares that prevention is to be upgraded to form a separate pillar of health care; at the same time, prevention is to come under a general regulation that transcends the individual social insurance branches.[220] Details are left open. Express mention is made only of the aim to improve data acquisition and the recording of disease patterns. In particular, the Government plans to take steps toward the repression of widespread diseases such as cancer and cardiovascular disorders, although it does not mention specific measures to that end.[221]

The cornerstone paper [*Eckpunktepapier*], dated 4 July 2006, of the joint working group of the Federal and *Länder* governments on healthcare reform provides further details on a prospective prevention law. Supplementary to the coalition agreement, it places general emphasis on the prime goals of reducing red tape and registering participation in preventive measures. Such participation is to be rewarded with bonuses and considered for out-of-pocket payments on drugs for chronic illnesses. The final version of the new legislation[222] contains various measures for the promotion of prevention[223], e.g. measures for the promotion of occupational health, for the prevention of work-related health hazards, and for the promotion of self-help.

(3) Linkage between healthcare and long-term care systems

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

Previously, geriatric rehabilitation played only a secondary role within the scope of re habilitation measures under § 40 SGB V. In 2004, however, the leading associations of statutory sickness funds substantiated objectives and benefits for geriatric rehabilitation in a joint framework recommendation, [224] given the obvious significance of these rehabilitation needs in an aging society.[225] According to the cornerstone paper of the Federal-*Länder* working group on healthcare reform, geriatric rehabilitation is to be included in the benefit catalogue of statutory health insurance.[226] With the originally planned insertion of a sub-section under § 40a SGB V into statutory health insurance law, the draft bill was to contain a new separate regulation for geriatric rehabilitation benefits. This approach of incorporating a separate provision was not, however, adopted by Parliament and the *Bundesrat*[227], as geriatric rehabilitation is now to be included in the standard benefit catalogue. Nevertheless, a novel section under § 37b SGB V will enhance the benefits basket as far as ambulant palliative care is concerned.

[1] The author wants to thank Mr. Benno Quade for his contribution to the remarks on solidarity, Dr. Matthias Knecht for his assistance in preparing this text and organizing the project, and Esther Ihle for her help in translating parts of this text and in correcting its English version.

[2] Zimmermann, The Law of Obligations – Roman Foundations of the Civilian Tradition, 1990, pp. 128 et sqq.

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

[4] Brunot, Histoire de la langue française, 1937, p. 669.

[5] Brunkhorst, Solidarität – Von der Bürgerfreundschaft zur globalen Rechtsgenossenschaft, 2002, p. 9.

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

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

8 Ducos, Rome et le droit, 1996, p. 108.

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

10 See also Bourgeois, Solidarität, 1896.

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

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

13 See Volkmann, (note 12), pp. 217 et sqq.; for the derivation from the Social State principle, see Holzer, Die unterstaatliche Umverteilung – Umverteilung unter Umgehung der Verfassung?, 1977, p. 246, and critically Becker, Transfergerechtigkeit und Verfassung, 2001, p. 205.

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

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

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

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

18 Leisner, Sozialversicherung und Privatversicherung, 1974, pp. 72 et sqq.

19 See Kingreen, (note 12), p. 178.

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

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

22 Kingreen, (note 12), pp. 451 et sqq.

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

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

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

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

27 Isensee, Umverteilung durch Sozialversicherungsbeiträge, 1973, pp. 49 et sqq.

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

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

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

31 Cf. Stier-Somlo, Deutsche Sozialgesetzgebung, 1906, p. 67.

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

33 Under the law dated 28.6.1885 (note 32). The law on the extension of accident insur-

ance, dated 15.3.1886 (RGBl. 1886, 53), then concerned the welfare assistance granted as a consequence of occupational accidents sustained by civil servants and members of the military.

[34] Under the law dated 5.5.1886 (note 32), employees in agriculture and forestry were included in the accident insurance scheme, whereas they were not covered by health insurance until 1911.

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

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

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

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

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

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

[41] Cf. Alber, Vom Armenhaus zum Wohlfahrtsstaat, 1987, pp. 48 et sqq.

[42] Cf. also Becker, Staat und autonome Träger im Sozialleistungsrecht, 1996, pp. 107 et seq.

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

[44] Introduced under the National Health Service Act (1946).

[45] Cf. above all Alber, Vom Armenhaus zum Wohlfahrtsstaat, 1987, p. 164.

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

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

[48] Stolleis, Geschichte des Sozialrechts in Deutschland, 2003, pp. 260 et sqq.

[49] §§ 2, 11 SGB V.

[50] See also § 140 SGB V.

[51] See § 13 SGB V.

[52] Gesundheitsreformgesetz (GRG) dated 20.12.1988 (BGBl. I, p. 2477).

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

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

[55] Cf. more detailed Zacher, Das soziale Staatsziel, HStR Vol. 1, 1987, § 25, paras. 27 et sqq.

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

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

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

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

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

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

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

63 §§ 143 et sqq. SGB V.

64 See note 28.

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

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

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

68 12th AufbauVO dated 24.12.1935 (RGBl. I, p. 1537) as revised by the 15th AufbauVO dated 1.4.1937 (RGBl. I, p. 439).

69 See note 52.

70 Their equal status in terms of care provision by contracting physicians was not established until the adoption of the Structural Health Insurance Act (GSG, see note 74).

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

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

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

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

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

76 For details, see § 175 SGB V.

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

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

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

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

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

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

83 Thus the earlier presumption by Oldiges, Wirkungen der neuen Wahlmöglichkeiten

und der neuen Organisationsstruktur in der Krankenversicherung, SF 1996, pp. 112, 115.

84 BGBl. I, p. 55.

85 BGBl. I, p. 3465.

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

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

88 See § 8 SGB IV.

89 See § 249b SGB.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

107 Leisner, Sozialversicherung und Privatversicherung, 1974, pp. 164 et sqq.

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

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

110 Under Art. 1 of the Beitragssatzsicherungs-

gesetz [Contribution Rate Stability Act] dated 23.12.2002 (BGBl. I 2002, p. 4637).

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

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

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

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

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

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

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

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

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

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

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

122 Cf. bb) below.

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

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

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

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

127 §§ 5, 81 et seq., 53c et seq. VAG.

128 §§ 12 and 12b VAG.

129 § 12a VAG.

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

131 § 178a IV VVG.

132 §§ 178c, 178d and 178h VVG; the regulations apply to all health insurance contracts; regarding the right of extraordinary cancellation upon occurrence of the insurance obligation under statutory health insurance, cf. § 178h II VVG.

133 § 178i VVG.

134 Since 1971, cf. Peters, Geschichte (note 109), p. 163.

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

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

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

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

139 See Eckpunktepapier , p. 4/5.

140 See BT-Drucks. 16/2474.

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

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

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

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

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

146 OLG Köln VersR 2004, 631.

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

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

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

150 BverfG, dated 6.12.2005, 1 BvR 347/98.

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

152 OLG Düsseldorf VersR 1995, p. 773.

153 Originally, only scientifically approved methods, tested in universities, were accepted, but the constitutional court decided

to abandon this jurisdiction; see BVerfG VersR 1993, p. 957. Nowadays all measures with common scientific acceptance are refunded; see Bach/Moser, Private Krankenversicherung, § 1 MB/KK paras. 60 et sqq.

154 BGH ArztR 1998, p. 88.

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

156 KG Berlin VersR 2001, p. 178.

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

158 LG Göttingen VersR 2001, p. 974.

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

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

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

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

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

164 § 2 b KVG.

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

166 § 165 II RVO.

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

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

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

170 Above all, cf. Hase, Versicherungsprinzip und sozialer Ausgleich, 2000.

171 Cf. § 9 I 1 No. 3 SGB V.

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

173 On the discussion about changes, cf. Scholz/Meyer, Zu den Wechseloptionen der PKV, PKV-Dokumentation 25, 2001; on the more restricted problem of “aging tariffs” (i.e. being bound to certain tariffs within an insurance company), cf. Meyer, Tarifwechsel nach § 178f VVG – Probleme und Perspektiven, in: Basedow/Meyer/Rückle/Schwintzowski (eds.), Beiträge zur 12. Wissenschaftstagung des Bundes der Versicherten, 2004, pp. 67 et sqq.

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

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

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

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

178 At least the existence of a protection system for needy persons as such is certainly re-

quired by the social state principle (Art. 20(1) GG); regarding constitutive freedom, cf. BVerfGE 40, 121, 133 et seq.; 48, 227, 234; 98, 169, 204.

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

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

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

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

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

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

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

186 On the Internet: http://www.die-gesundheitsre-form.de/gesundheitspolitik/gesundheitsre-form_2006/index.html

187 On the Internet: http://www.gesundheitspoli-tik.net/06_recht/gesetze/ge-sundheitsreform/gkv-wettbewerb-ae.pdf (as at: 17.08.2006).

188 BR-Drs. 75/07.

189 See BR-Drs. 75/07, § 171a SGB V.

190 See BR-Drs. 75/07, § 171b SGB V.

191 See BR-Drs. 75/07, § 271 SGB V.

192 See BR-Drs. 75/07, § 271 SGB V.

193 See BR-Drs. 75/07, § 241 SGB V.

194 See BR-Drs. 75/07, § 266(1) SGB V.

195 See BR-Drs. 75/07, § 266 SGB V.

196 See BR-Drs. 75/07, § 28f(4) SGB IV.

197 See BR-Drs. 75/07, § 242(1) SGB V.

198 See BR-Drs. 75/07, § 266(10) and § 272 SGB V.

199 See BR-Drs. 75/07, § 271(2) und (3) SGB V.

200 See BR-Drs. 75/07, § 221 (1) SGB V.

201 See BR-Drs. 75/07, § 221 (1) SGB V.

202 See BR-Drs. 75/07, § 171a SGB V.

203 See BR-Drs. 75/07, § 91 SGB V.

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

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

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

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

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

209 Thus the "mean variant" of the 10th coordinated population projection (note 207).

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

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

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

213 See Breyer/Ulrich, Gesundheitsausgaben, Alter und medizinischer Fortschritt: eine Regressionsanalyse, 1999; Postler, Modellrechnungen zur Beitragsentwicklung in der Gesetzlichen Krankenversicherung, 2003; Henke/Reimers, Zum Einfluß von

Demographie und medizinisch-technischem Fortschritt auf die Gesundheitsausgaben, 2004; Fetzer, Determinanten der zukünftigen Finanzierbarkeit der GKV, 2005.

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

[215] See the so-called “Freiburger Agenda”, Fetzer/Hagist/Höfer/Raffelhüschen, Gesundheitsreformen im Nachhaltigkeitstest, Initiative Neue Soziale Marktwirtschaft, 2004, pp. 13 et seq. (on the Internet under: www.insm.de/Downloads/Word-Do-kumente/Studie_Gesundheitsreformen_im_Nachhaltigkeitstest.doc)

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

[217] See §§ 20(3) and (4) SGB V.

[218] BT-Drucks. 15/4671.

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

[220] Koalitionsvertrag, p. 100.

[221] Koalitionsvertrag, p. 101.

[222] See BR-Drs. 75/07.

[223] See BR-Drs. 75/07, §§ 20-20c SGB V.

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

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

[226] See Eckpunktepapier, p. 14.

[227] See BR-Drs. 75/07.

Ulrich Becker (Director of the Max Planck Institute for Foreign and International Social Law)