

# Consumer-Driven Health Care in Germany: A Proposal

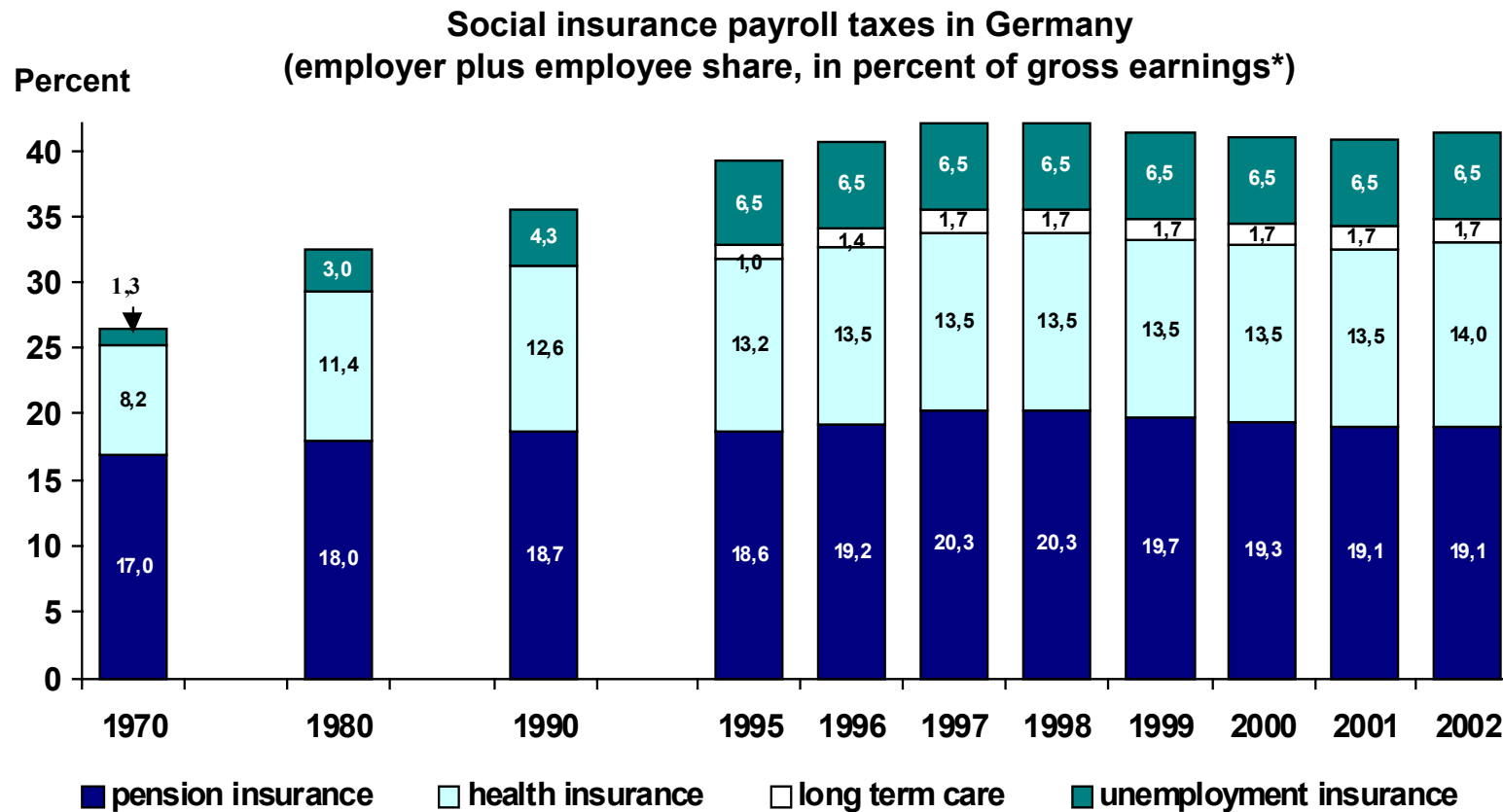
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## The Welfare State and Labor Cost

Whether in the forms shaped by Bismarck in Germany in the 1880s, Roosevelt or Beveridge in the 1930s and '40s, the welfare state seemed to be the model for the maturing industrial society. It was even credited with initiating a virtuous cycle: government pension, unemployment and health insurance provided social stability. With improved health, the work force became more productive; unemployment insurance allowed workers to overcome cyclical and structural slumps without falling through the social safety net; guaranteed pensions meant workers could look forward to retirement. The success of this model made us blind to its basic design flaws.

In countries with a “Beveridgean” health care system, such as the United Kingdom, unemployment, health or pension insurance are financed from general tax revenues. By contrast, Italy, France, and, archetypically, Germany are “Bismarckian” countries, where health care is based on the principle of “social insurance” and predominantly financed by a specific payroll tax; in Germany, it is half borne by employers and employees, and, in 2002, amounts to about 14.0 % of gross wages.<sup>1</sup> In addition, there are payroll taxes for unemployment (6.5%), pension (19.1 %) and long term care insurance (1.7%), bringing the total to about 41 % of wages (**Figure 1**).

**FIGURE 1**  
**COST DYNAMICS IN GERMAN SOCIAL INSURANCE**



\* Percent of gross earnings up to the contribution limit (Beitragsbemessungsgrenze). The contribution limit for pensions and unemployment insurance is € 54,000 p. a., for health insurance it is set at 75 % of that, or € 40,500. For East Germany the contribution limit is somewhat lower.

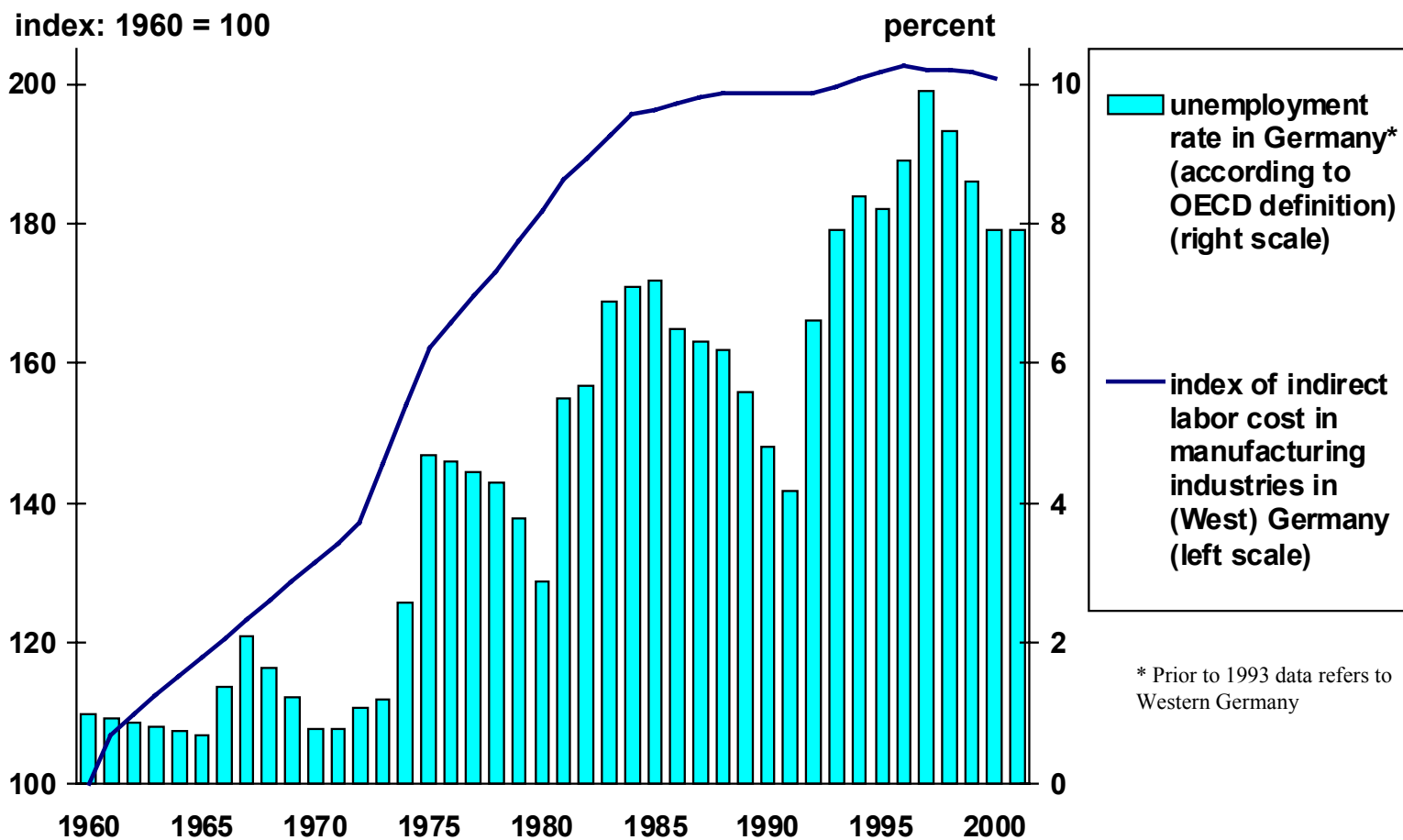
Source: Institut der deutschen Wirtschaft, Köln (IW)

The payroll tax increases labor cost to the employer, with detrimental effects on job creation, and it reduces people's take-home pay. A German plumber must work five hours (at a gross wage of about €13 and net wage of about €8 per hour) to hire a painter for one hour (billed out at a cost of about €40 per hour) and vice versa. Neither of them can afford that. Turning to do-it-yourself is one reaction, and not a problem for society. But it is a problem when more and more unemployed do not seek re-employment, instead supplementing their unemployment benefits with black market income and finding the combined to be higher than their previous net wage. The payroll-tax financed welfare state is the albatross: An increase in social security expenditures requires an increase in the payroll tax, increasing labor cost and, consequently, unemployment. Fewer and fewer employed people have to pay more and for more social security recipients, raising labor cost even further and adding to the job loss spiral (**Figure 2**). The welfare state is hemorrhaging.

Today, globalization exposes the Achilles heel of the welfare state. Given international labor cost competition, the payroll tax can no longer be fully passed on via product prices. The world market is not generous enough to finance the welfare state, let alone the future aging-related cost increases of health care and pensions.

Germany and other countries with public systems of health care can be proud of universal coverage. But these countries are mistaken in believing that government must be the provider of health care. The heavy hand of government has kept market forces at bay. Prices are set in the political arena, and the benefits packages for patients are standardized and also government-defined rather than determined by patients as customers. The performance of the quasi-governmental agencies in providing health care has been dismal when compared with other sectors of the economy.

**FIGURE 2**  
**INDIRECT LABOR COST PUSHES UP UNEMPLOYMENT IN GERMANY**



Source: OECD, Institut der deutschen Wirtschaft, Köln (IW)

The welfare state treats citizens as recipients of entitlements bestowed on them, rather than as sovereign consumers who otherwise can choose among an array of goods and services; with uniform entitlements, there are no incentives to economize. As the payroll tax amounts to pre-payment of all health expenditures, individual use of health care is not related to individual expenditure. Consumer responsibility and choice have no material place.

### **Health Care in Germany: A Public System with a Private Fringe**

Any German employee with a **yearly** wage of less than an opt-out level, **which is also the payroll tax contribution limit** (indexed, and in 2002 at **€3,375 per month or €40,500 per year**),<sup>2</sup> must belong to the public health system by becoming a member of a *Gesetzliche Krankenkasse*, commonly referred to as a sickness fund.<sup>3</sup> The payroll tax (**14 %**) is assessed on the wage up to the contribution **limit**. Employees with a wage in excess of that amount may opt out of the public system and obtain private health insurance, or no insurance at all. Close to 90 % of Germans are insured in the public system, about **9 %** have private insurance, and fewer than 1% are uninsured.<sup>4</sup> Those opting out of the public system are automatically freed from the payroll tax, its place then being taken by an actuarially calculated **insurance** premium.<sup>5</sup> Both the opt-out choice and the further choice among competing private insurers are entirely the individual's to make.<sup>6</sup>

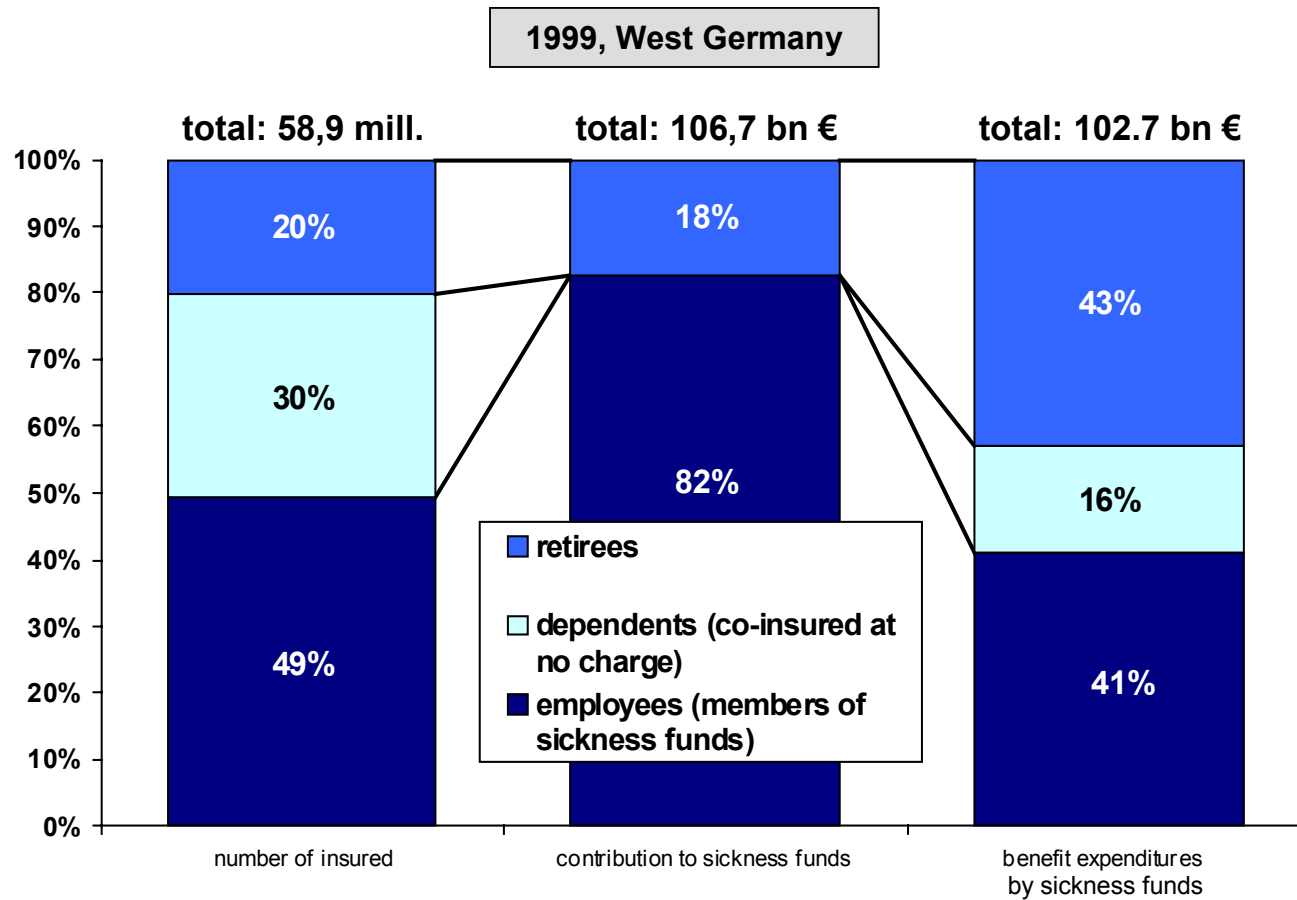
The payroll tax of the public system, **which is** linked to **wage** income alone, entails substantial cross-subsidies from high-income to low-income earners, from singles to households with dependents, from men to women, and, in particular, from the working to the retired generation: The payroll tax contains no old-age provisions, pensioners pay only half **of** the payroll tax rate (as they no longer have an employer) which is assessed

on the (lower) pension benefits rather than previous earnings.<sup>7</sup> Of the average 14 % payroll tax revenue of the employees, about half goes to these cross-subsidies (Figure 3). The private health insurance system, based on an actuarially calculated premium, entails no subsidies of this sort.<sup>8</sup>

Benefits are uniform for all members of the public scheme, regardless of the sickness fund to which they belong. They are generous. With few exceptions, members of the sickness funds freely choose among physicians (most of them in solo practice). However, as free choice of doctors has driven up utilization and outlays, the government has contemplated gatekeeper concepts, under which patients first see a general practitioner before being referred to a specialist.<sup>9</sup>

For those who can opt out of the public system (i.e., with an income above the contribution limit), private insurance offers an attractive alternative. First, for many in this group, the private insurance premium is lower than the payroll tax, which they would have to pay in the public system. This is especially so for younger people with no dependents or small families. Second, while they can limit their coverage to the same benefits as provided by the public scheme, they typically contract for extended benefits (private hospital room, treatment by the chief of service). Third, they receive somewhat preferential treatment, e.g., in setting up an appointment, as doctors can charge them higher fees, often a multiple of what they can bill under the public system. Fourth, administrative costs of the private system are below those of the public system.

**FIGURE 3**  
**HIDDEN CROSS SUBSIDIES IN GERMAN PUBLIC HEALTH CARE\***



\* In addition to the cross-subsidies for retirees and dependents (co-insured at no extra charge) that are shown here, there are also cross-subsidies from high income to low income earners, and males to females.

Source: Deutsches Bundesministerium für Gesundheit, own calculations.

The private system, although it covers only a 9% fringe of Germans, is a powerful competitor of the public system. The cornerstone is the opt-out mechanism offering a continuous exit option to higher income earners, coupled with the exemption from the payroll tax.<sup>10</sup> If the private insurance option in Germany were not substitutive, but complementary, i.e., if its coverage were only available without payroll tax relief, this competitive effect would vanish.

### **Increasing Government Intervention Has Worsened the Situation**

With uniform benefits and a payroll tax not actuarially determined, the public system amounts to prepaid care. Patients behave like the patrons of an eat-as-much-as-you-can restaurant. The sickness funds are prohibited from giving rebates to prudent users of health care, and they impose no penalties for abuse.

Doctors, dentists, pharmacists, and hospitals as providers do not compete for the customers' business, but render their services. Reimbursement of doctors in the public system is by fee-for-service according to a relative point system,<sup>11</sup> in which a specific procedure is assigned a point value, which is then translated into a monetary fee. The point scale is negotiated between the sickness funds and the providers as represented by the associations of doctors or dentists. Doctors send their fee claims to their physicians' association which, as a clearing house, settles with the sickness funds. Public patients never see a bill.<sup>12</sup>

The system does not reward the providers for outcomes, but for utilization. Hospitals bill for public patients on a per-diem basis; the longer they stay, the higher the bill. To recoup the cost of expensive treatment, hospitals keep their patients longer than necessary.<sup>13</sup>

These inefficiencies are reflected in soaring costs: The payroll tax for health care rose from 8.2% of gross wages in 1970 to 14% in 2001. Over the last twenty years, there has been increasing government intervention in order to contain cost, but all measures have, instead, resulted in further cost increases. Some examples:

- Generous fees in ambulatory care caused the number of doctors to increase continuously. At the end of 2000, Germany had 358 doctors per 100,000 inhabitants<sup>14</sup> (as compared to only 162 in 1970). To cut costs, the fee points doctors can charge for individual treatments were lowered in value. Result: diagnostic inflation, a growing volume of billed treatments, each at lower individual cost, but at rising cost in sum.
- Budgeting was introduced, with regional and sectoral budgets for ambulatory, stationary, dental care and pharmaceuticals. One result: When the budget was exhausted, by October or November, some dentists closed their offices except for emergency care, regular care being deferred to the next year.
- The physicians' association has monopoly power to negotiate for all providers of ambulatory care, and the hospitals' association for stationary care providers. The public health system cannot negotiate with individual doctors or hospitals or select groups of them. Monopolization on the provider side prevents the introduction of cost-saving concepts.
- In the past, hospitals had little incentive to optimize. If they decreased their cost, their per-diem was reduced; if they raised their cost, they documented it and got a higher per-diem reimbursement. Per-diems are negotiated between hospital associations and sickness funds. Sickness funds demand shorter hospital stays, a cut in the number of hospital beds, or cooperation

among hospitals. But the cost savings that can be extracted in a non-market, politically influenced duopolistic setting will always be limited; and the transaction costs of collective bargaining are high.

- Ambulatory and hospital care have been strictly separated, allowing no competition between them and preventing the exploitation of synergies.
- Ancient guild-like rules are preserved. For example, a pharmacist may only own one pharmacy. Pharmacy chains or mail-order pharmacies are outlawed.

### **The Consumer Model: Efficiency and Equity**

Good health is a basic need and in the public interest. There should be universal access to it. But German politicians are mistaken in believing that health care must be provided by the government. Clothing, housing and food also fill basic needs; and we do not want anyone, out of poverty, to be without clothes, shelter or food. Yet clothing, housing and food are organized differently from health care. We do not have the government outfitter from which we obtain the one size fits all coat; we do not have the central quartermaster that provides standardized housing; nor do we eat the same menu in the people's canteen. Clothing, housing and food are provided in the marketplace, in which a huge variety of competing suppliers face discriminating consumers. Government and private charities step in only as providers of last resort. In the case of health care, however, many still believe that the goal - universal access to health care - requires a unitary, **government plan.**

Applying the principles of the market economy to health care—and to social security in general—would unleash a vast potential of efficiency gains. However, particularly in the European environment, distributive issues must be considered in health

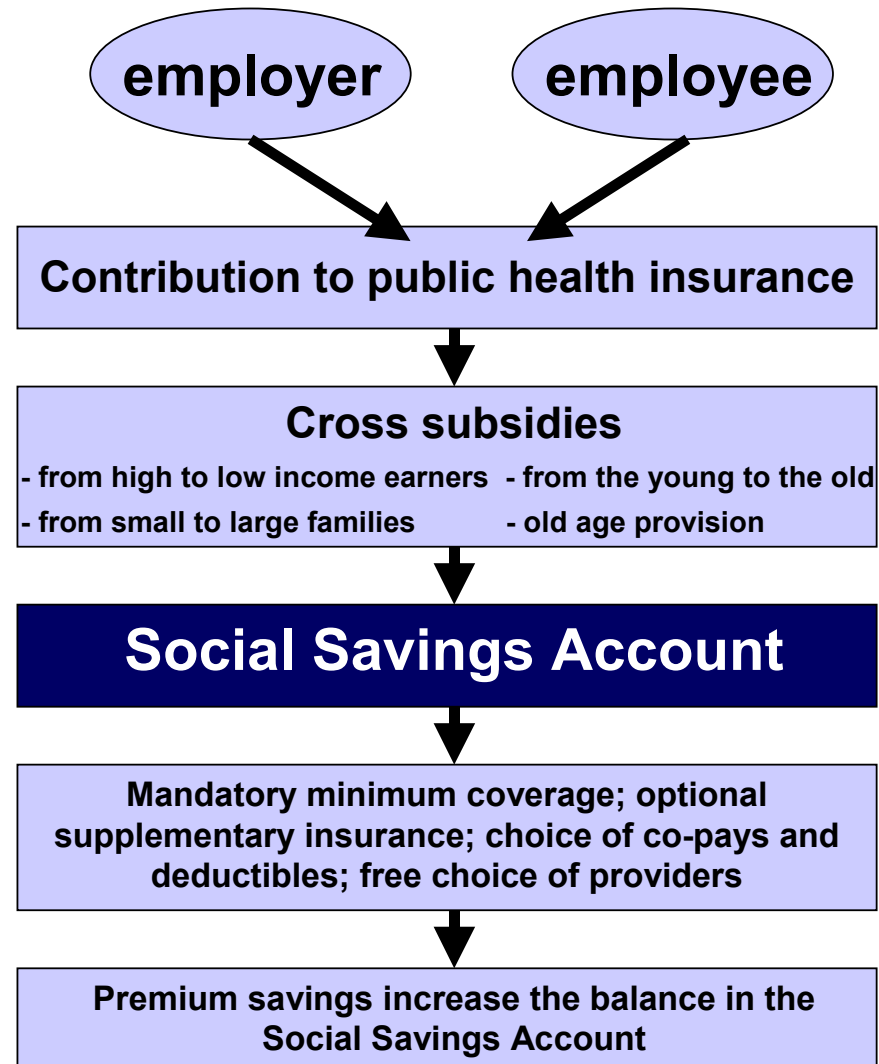
care reform. Access to care must be affordable for all. Therefore, the guidelines for health care reform must be efficiency *and* equity. While government should not provide health care, it should provide a framework for achieving universal coverage in a market system.

Universal coverage is not merely a social issue; it makes good economic sense. It is cheaper, for society, to make universal coverage a goal embedded in the policy framework rather than neglecting it and procuring health care for the indigent outside the market framework, through government welfare programs. Finally, from a practical point of view, market-oriented health reform stands no chance of even getting a hearing in the political arena if it does not address equity.

In reconciling efficiency and equity, the cornerstones of consumer-driven health care are financial empowerment and individual responsibility: Every individual would get the money required to buy today's level of health benefits. Everyone would then be allowed to decide what level of benefits they would purchase - so long as he met a minimum standard. The savings from restraint will be theirs to keep. The reform steps would be:

**(1) Empowerment, fairness and finance:** Empowerment requires, first of all, purchasing power in the hands of the individuals that enables them to finance their choice. To this end, we deposit the money that is currently spent on behalf of each individual's health insurance into a Social Savings Account<sup>15</sup> (SSA; **Figure 4**) which is vested in the individual. Taking the current social transfers as a given which must be preserved, each individual, with the same money as is currently spent on their behalf, would be allowed to buy the same benefits as today (nobody loses).

**FIGURE 4**  
**THE SOCIAL SAVINGS ACCOUNT - HEALTH**



Technically, there are two steps: We start by depositing the payroll tax of individuals (employer and employee share) in their SSA. In the second step, the individual SSA's must be corrected for current cross-subsidies (implicit solidarity transfers). Lower income earners, large families, or pensioners typically have a payroll tax falling short of an actuarially calculated premium and are subsidized by high income earners, singles, or couples with two incomes and no children, who typically pay more than their cost (**Figure 3**).

Strictly adhering to the no-loss rule, assume that these transfers are to be preserved: Consequently, those of the first group will have amounts added to their own SSA deposits, while the second group will have corresponding amounts deducted; both will then have an SSA balance that is sufficient to buy current benefits at full actuarial value. Nobody - government, employers, employees - has been made worse off.

No fresh money is needed. All we do is making current transfer payments explicit. Currently, they take place within the sickness funds, behind a veil and unobserved by the individual.

- (2) **Safeguard and choice:** Allowing the beneficiaries to evolve from recipients of an entitlement to buyers of a service requires giving them the option of buying health care from providers of their choice and also, within limits, of buying less (or more) than current benefits and opting for a co-payment or deductible or a combination of both. There should be limits to choice, since otherwise carelessness might produce a welfare case. The community would gain nothing, if an individual were not insured against catastrophic illnesses and, in the worst case, became a burden to society. To be on the safe side, mandatory coverage could go beyond catastrophic illnesses and include most ambulatory care beyond a sizeable annual deductible. But there is no

need to dictate full dental coverage or to disallow people from opting for a co-payment.

Individuals, not a third party, control the Social Savings Account deposit. They can buy the full current benefits or as little as the mandatory level or opt for full benefits minus a co-payment or deductible. The corresponding premium savings are a major deterrent to “gaming the system”, or moral hazard. It will not be necessary to police socially unacceptable behavior by means of bureaucratic control, as is often suggested.

Analogous to mandatory automobile liability or optional collision insurance, the insured would choose among competing providers of health care, and this will unlock a vast efficiency potential on the supply side. Compared with the current situation in Germany, this will be an even greater source of savings than the elimination of moral hazard on the demand side.

- (3) Savings to keep:** The premium savings resulting from having chosen a more efficient provider or from less-than-full coverage will be the individual’s to keep. Instead of only making hollow appeals for prudent behavior, the call for self-responsibility must be monetized, if we really want a response to this call. Whoever buys prudently should retain the fruits. The savings will augment the SSA balance.

Unspent balances cannot be withdrawn for consumption purposes. The individual can only draw on them either for expenses not covered, e.g., a deductible, or for other social security purposes, such as nursing care or additional old age insurance.<sup>16</sup>

- (4) Institutional reform:** Finally, the Social Savings Account may be managed by current sickness funds. There are pragmatic reasons for this: They and the sizable body of their employees would fight the new system, tooth and nail, if they were to

have no role and were simply to be abolished. The German public health system alone has over 143,000 administrative 2001 employees, a formidable force; there is no need to become their enemy. We should give these institutions the opportunity to also evolve into a competitive provider. If they change successfully, all the better. However, there must be no monopoly care-taker of the SSA. If an individual sickness fund, for example, offers to manage the account, it would do so in competition with others. Individuals decide where to do their SSA banking.

### **Quality and Price**

The empowerment model improves health care and reduces its cost. Since everybody may choose their provider—e.g., insurance or capitation-based HMO, fee-for-service plan or managed care - everybody gets a plan that, in their judgment (not some politician's) serves them best. Innovative models can be freely offered. And since, beyond mandatory coverage, everyone can determine the extent of coverage, each person will spend the money in those areas that he desires, a lesser dental plan for a private hospital room, for example. Value is in the eye of the beholder. Nobody should have to pay for a plan or for extra coverage that they do not need.

To use our metaphor again: We replace the fixed-price, unitary food-plan, monopoly eatery with highly varied, fiercely competing restaurants. There are those with table cloths, flower arrangements and extensive wine lists; and there are the family restaurants, the chains, and the serve-yourself cafeterias. Instead of a unitary diet, each restaurant allows the customer to choose from an exhaustive menu and to compose his own order. Only a minimum diet (mandatory coverage) is prescribed. The previous unitary plan is also included in the offering as one among many. Which restaurant arrangement would you prefer?

Whatever level of benefits we choose, it will become available at the least cost, since everyone will try to preserve their - their own and valued - SSA balances, spending only as much as necessary. Waste caused by careless (not cost-conscious) use, will be eliminated, since health, while affordable, will no longer be perceived to be free.

Imprudent individual behavior is no longer externalized, shifted onto the community of all insured. Unnecessary visits to doctors will vanish. A patient will not embark on an odyssey visiting specialist after specialist without regard for cost, but will consider the cost of duplicate exams and lab tests. He will ask his doctor and, first of all, himself, whether he has to return for a follow-up visit after his nose stops running. He will no longer ask the doctor to give him a sick leave slip for a week, when his tennis elbow aches on Monday morning.<sup>17</sup> Self-payment of small bills that fall under a deductible would relieve the insurer of substantial administrative cost; hence, the premium cutback would be more than the actuarial value of the deductible. Likewise, and in return for a lower premium, an insurer could ask the insured to submit bills for reimbursement only quarterly or semi-annually, or when the total has exceeded a set amount.

On the supply side, consumer choice would, above all, bring about an efficient and competitive structure. Today, doctors and hospitals spend an inordinate amount of energy in figuring out how to extract additional remuneration out of the public health system. In the empowerment model, they will compete for the patient's business and strive to offer alternative, better or less expensive services. Benefits and prices will be market-determined, not bureaucratically dictated or negotiated between supplier and provider cartels. Health care will no longer be structured along guild-like professional or corporatist rules. Why should, for example, the fee-for-service physician practice be the only or dominant form of providing ambulatory care? Why should there be no multi-specialty group practices? Why should ownership of a pharmacy be limited to one per

pharmacist, chain or mail-order pharmacies be forbidden? Cost decreases can be achieved in a service-industry. We do not take sides - for or against managed care, for or against traditional pharmacies, for or against public hospitals, for or against fee-for-service-practices, for or against group practices. We leave this choice to the consumer. Different plans entail advantages or disadvantages for the individual and will come at different prices.

Overall, health care costs may or may not decrease in absolute terms, as aging and technological advances tend to push costs up. But whatever the total costs, they will be at the minimum for the level of care desired by society and markedly below the cost trend of the current system.

### **Criticism and Objections**

The empowerment model puts the patient, as a consumer, on a level playing field with the suppliers. Critics in Germany have raised the following objections:

*(i) Patients lack medical information to make sound judgments.*

Patients are not medical experts. But: Do you have to be an automotive engineer or a computer expert when buying a family car or a home computer? When the car breaks down, we do not need to self-diagnose the problem and prescribe the repair (therapy). We order the outcome. We know from our own or others' experience where we can expect the best service, whom we can trust, where we get our money's worth. When we make the wrong choice and are disappointed, we will remember and not repeat that mistake. The parallel to health care is obvious. Not possessing the same information as a medical expert seemingly puts us at a disadvantage. But in the empowerment model, our distinct advantage is that we can take our business elsewhere.

*(ii) Patients are not mature.*

There are many critics that hold the individual not mature enough to be a wise shopper of health services, when offered the option of a sizeable deductible, even when limited by an annual cap of, for example, \$4,000. This is grotesque. Each owner of a car bears the cost of a tune-up, an inspection, tires, and depreciation. These costs easily add up to \$4,000 annually. We certainly hold every car owner, rich or poor, responsible for these costs. We even hold the individual mature enough to buy a car and decide whether he wants to buy, on top of mandatory liability coverage, collision insurance; for a small new car, this is a risk of at least \$10,000.

*(iii) People will save themselves sick.*

In striving to save money and increase the SSA balances, the individual would, critics claim, cut down on necessary medical services. This is a serious argument. But there are ways to prevent consumers from skimping on necessary purchases. First, the forced savings concept of the SSA prevents the individual from using their SSA balances for a vacation or a car purchase. Second, deductibles and co-payments can be structured in such a way that they offer incentives for preventive care. For example, there are insurers which waive the deductible if the patient has had a routine check-up. Finally, preventive care related to catastrophic illnesses would be included in the mandatory package.

*(iv) Young people will underinsure themselves.*

Young and healthy people may restrict themselves to the mandatory package and buy a frugal plan. When they get older, they may realize that switching to a more extensive and comfortable plan is very expensive, since actuarial rates will then be much higher.

This argument is valid, but: Those that decided on a minimum plan in their earlier years have saved a lot. Their SSA balances allow them, as they become older, to step up

to a more expensive plan or to cover extra benefits out of their balances. Or they have, instead of additional health coverage, bought more life insurance or invested in a house or other assets on which they can fall back, if necessary. And: The minimum mandatory coverage is the back-stop that prevents a drop to welfare levels.

*(v) Optional coverage has no effect on hospital expenses.*

Hospital care takes the largest slice of the health cost pie. Since hospital care is in the mandatory package, how would the empowerment reform save money in this area?

In the case of hospital care, there is little moral hazard on the demand side: Nobody wants to undergo unnecessary surgery or stay in the hospital for excessive periods. There is, however, considerable waste on the supply side. Hospital stays in Germany, for example, can and - in a competitive system - would be shortened. Rather than banding together in hospital associations and trying to extract reimbursement increases from the sickness funds, hospitals will focus on the patient. They will specialize in services, where they excel and, where they are not up to par, form alliances with other providers, merge, and outsource.

It is interesting that most criticism received so far focuses on the adequacy of mandatory coverage and views a cut in benefits as the major source for premium savings. This is wrong. There would be tremendous savings even if we set mandatory benefits at today's level and (only) allowed people to pick their provider and opt for co-payments or deductibles. Ten years ago, the same critics warned that deregulation of postal and telecom services in Germany would lead to poorer service and higher cost, especially for households. The opposite happened. And just one year ago, they claimed that EU electricity deregulation will drive up the cost to households. As deregulation has just started, households are already swamped by lower price offers from competing utilities.

**Conclusion: Simple, Radical, Social**

In a consumer-driven model of health care, efficiency is achieved by privatization, individual responsibility and freedom of choice on the demand side and by competition on the supply side. The patient evolves from a passive recipient to an active buyer. Equity is guaranteed by financial empowerment of the individual and a no-loss rule; mandatory minimum insurance would preserve the safety net.

Market-oriented health reform is a must as we enter the information age. Unlike in the machine age, when structural reform, e.g., in the textile or auto industries, came in discrete steps with long periods of “rest” in between, structural change now is ongoing. This requires continuous and fast adaptation. Markets react quickly and often even anticipate change. Government only reacts when severe damage has been done. With new and revolutionary drugs coming onto the market, speed of government approval is already a pressing issue. If, on top of a drug’s safety approval, government wants to take time out to deliberate whether to include it from remuneration under the public health system or not, progress will be slowed down, and the needy patient is victimized. In the information age, time is not just money, but the deciding factor.

Second, individual needs and preferences are becoming more and more heterogeneous. Standardized government health plans are “mass” oriented, built on the premise that everybody has the same needs or that individuals are unable to articulate their needs, and so we ended up with one-size-fits-all. This was the mass solution for the machine age. Today’s citizens no longer are illiterate, the tools of the information age allowing them to articulate their needs and the providers to meet them, better and better every day. Government is only good at government issue. One-size-fits-all government health plans, dinosaurs of the machine age,<sup>18</sup> have had their day.

The proposed empowerment reform does not slash the social safety net. It is radical in the sense of a root-change - abolishing the welfare state -, but it neither axes benefits nor institutions. It allows the individual to evolve from a passive beneficiary of entitlements into an active and sovereign consumer of social insurance products, and it forces current monopoly providers to become innovative competitors.

The empowerment reform is social, because it adheres to the no-loss rule. Nobody loses except for those that abuse the system. Access to care is guaranteed and the quality of health care is, at the very minimum, preserved. Its cost goes down.

Finally, the empowerment reform is simple, because it can be financed, because it can build on current institutions and, above all, because it builds on people's ability to decide responsibly while also, as a back-stop, having a safeguard against individual errors.

Simple, unfortunately, is not easy. Empowerment reform is difficult. It faces the powerful opposition of the paternalistic guardians of the welfare state,<sup>19</sup> whose status would melt like snow in spring once we are empowered to act with self-responsibility. We have accepted this custodial structure for too long; the welfare state has corrupted our minds, many of us having become insecure, doubting that we can decide for ourselves. Building self-confidence towards individual responsibility is the most difficult task.

## ENDNOTES

1. The health payroll tax may vary among the so called sickness funds, depending on their current financial needs. The other payroll taxes are uniform across Germany and vary only over time. The unemployment payroll tax has been constant over the last several years, albeit at a high level of 6.5%. The pension payroll tax has declined nominally from 20.3% in 1998 to 19.1 in 2002, because the pension system now receives revenues from a new energy tax. Without that, it would stand at around 22% in 2002.
2. The contribution limit for the health payroll tax is set at 75% of the pension and unemployment payroll tax contribution limit, the latter being set at €4,500 per month for 2002.
3. Sickness funds, though, is a misnomer, since they are financed in a pay-as-you-go scheme. Although they may have a temporary surplus or deficit, there are no funds or reserves for old-age provisions and the like.
4. Statistisches Bundesamt, *Statistisches Jahrbuch 2001*, Wiesbaden 2001, p. 62. The sickness funds are authorized to levy the payroll tax. The amount varies among the sickness funds from 11.2 to 15.3% (Januar 2002), with an average of 14% levied on the gross wage income up to €40,500 per year. Other income sources such as dividends or rental incomes play no role in determining the individual contribution. Half of the payroll tax is paid by the employer, half by the employee. Since 1996, employees have been able to switch from one sickness fund to another, leading to some rate competition between the funds. There are risk equalization payments between the funds to compensate for differential risk structures in their membership (age composition, household size etc.). With identical benefits packages across the funds, rate competition is limited.

5. Typically, the employer also pays half of this premium, up to the payroll tax share that he would pay if the employee were to stay in the public system. Thus, an employer can only gain if his employee opts for private insurance.
6. The social safety net sees to it also that the privately insured do not lose health coverage: In the case of a job change, portability of insurance is assured, since the individual, not his employer, is the insured. In the case of a job loss, the unemployed will not lose his coverage, his and his employer's contribution being picked up by the unemployment insurance. Apart from that, if an individual once has decided to opt out of the public system, he would not be able to rejoin it at a later stage.
7. Non-working spouses or children, as dependents, are insured at no extra cost in the public system, whereas in a household with two earners, both would pay the payroll tax. Consequently, a worker with several children and a non-working spouse pays the same payroll tax as a single worker with the same gross wage. Yet, both households enjoy the same benefits for all household members.
8. Therefore, any decision to opt out of the public system for premium-financed private insurance must be irreversible. Otherwise some of the privately insured would revert back to the public system once they retire or have several children or other household characteristics that would allow them to benefit from such subsidies.

Among those that earn more than €40,500 per year and qualify for opting out of the public system, this is of particular interest to younger people with few or no dependents. Their private insurance premium can be considerably less than their payroll tax. On the other hand, employees with a non-working spouse and two or more children might not opt out when their income starts exceeding the opt-out

level at, say, age 45. The private health insurance for a 45-year-old with dependents may well exceed the payroll tax. This explains why not all of the 23% of Germans that qualify for opting out actually do so. In fact, about 40% of them (9% of the total) do exercise the option. However, the fact that the majority stays in the public system is no testimony at all to the public system's quality. Opting out has, simply, come too late for 60% of this group, because only few young employees earn more than €40,500 per year and can opt out when it really would pay. In light of this, it speaks well for the private option that about 40% of those eligible do exercise it.

9. For the privately insured, there are no limits as to choice of physician. Private insurers cover the full range of benefits available in the public system and, in most cases, some extras in ambulatory and hospital care. In the future, this gap will probably open further, as the sickness funds have imposed budget caps on hospitals and doctors.
10. The decision to opt out need not be made immediately when the employee's salary starts to exceed the opt-out level. It can be made anytime thereafter. This means that the employee earning beyond the threshold level continuously weighs the private option. This exerts substantial competitive pressure on the public system. A high income earner leaving the public system typically is an employee who, over his life cycle, is a net payor into rather than a net recipient from the public system's social transfers. No sickness fund wants to lose such members. It will want to do everything to keep them. However, preferential treatment is impossible, as sickness fund benefits are uniform. Improving benefits in order to keep higher income earners requires improving them for all members and implies higher costs for all, the brunt of which, again, is borne by the high income net payors. Needless to say, sickness funds view this as a dilemma.

11. The scale consists of points for different procedures. With the introduction of budgeting, each point no longer has a fixed, but floating monetary value. For example, if the aggregate of doctors in a given region submitted more point claims than previously and their regional budget was not increased, the money value of each point had to decrease.
12. Private patients are billed directly by the doctors, the patients being reimbursed by their insurance companies, higher for otherwise identical services.
13. There are now efforts to move to a DRG-based remuneration system.
14. Statistisches Bundesamt, *Statistisches Jahrbuch 2001*, Wiesbaden 2001, p. 444.
15. In spirit, this reform proposal is a cousin to Medical Savings Accounts as we know them from the United States or Singapore. But the institutional arrangements are tailored to conform to countries that, like Germany, have a payroll-tax financed system and want to retain universal coverage and portability. For the proposal of Medical Savings Accounts in the United States, see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington: Cato Institute, 1992).
16. With respect to additional old age provision, the SSA is an important key to pension reform and helps solve the looming demographic crisis of pay-as-you-go pension systems: Unspent SSA balances can be used to gradually build up a fully funded pension system, while still honoring pension claims of those that have paid into the current schemes. See Wilfried Prewo, "From Welfare State to Social State—Empowerment, Individual Responsibility and Effective Compassion," Centre for the New Europe, Brussels, October 1996.
17. This example underlines that reforming both sick-leave and health policies entails synergies.

18. Cf. Michael Rothschild, "Why Health Care Reform Died," *The Wall Street Journal*, September 22, 1994.
19. In particular, labor unions which have institutionally guaranteed seats on the boards of the sickness funds.