Germany Goes Ahead with Health Vouchers

Wolfram F. Richter*

Introduction

On 1 April 2007 an act became effective which will radically change the German system of health care: the GKV-Wettbewerbsstärkungsgesetz (Social Health Insurance Pro Competition Act; henceforth cited as GKV-WSG). The list of provisions is long and diverse. It includes mandatory coverage for everyone by 2009, extended outpatient care by hospitals, new rules for pricing the services supplied by physicians in free practice and strengthened efficiency requirements for the approval of prescription drugs. Above all, the law changes the contractual relationships between the insured, the suppliers of insurance and the providers of health care services. The reform aims at fostering competition in the health care sector. This dominating objective explains the act's name. From an economic point of view the most interesting provisions are

- granting extended autonomy to the social health insurance (SHI) sickness funds which enables them to contract selectively with the suppliers of health care services
- breaking with a regime under which the sickness funds compete for membership by means of wage-related contribution rates and moving towards competition on the basis of payroll-tax financed vouchers
- obligating private insurers to transfer accumulated premium reserves when an insured switches to another insurance plan.

It is too early to evaluate the reform empirically. The reform is far-reaching and the players in the health care sector still have to adapt to the new rules of the game. Hence it must suffice to describe the relevant provisions and to discuss in non-technical terms the effects that the reform is expected to have.

Some basic features of the German health care system

Even before the reform 99.75 percent of the population was covered by health insurance. The remaining 0.25 percent had fallen through holes in the system which the reform eliminates. In the eyes of Germans their health system excels because of its high standards and unrestricted access to care providers.[1] Until recently queuing has not been a topic. All this may explain that some institutional peculiarities have evolved that external observers may find strange. One such peculiarity is the division of health insurance into public and private spheres.

Almost 90 percent of the population is covered by the public system. Constituent features of the system are mandatory membership and wage-related finance. Membership is compulsory for those wage earners who are not civil servants and whose monthly earnings do not exceed EUR 4,050 in 2009. High wage income earners, civil servants and the self-employed are able to opt for private insurance. Until recently the SHI has been providing full insurance. There has been no real need to buy supplemental coverage. In 2003 only eleven percent of the insured held such supplemental insurance. Under the umbrella of the SHI some 187 independent sickness funds compete for membership. Until 2008 these funds differed primarily by the contribution rate they charged. As differences in benefits were negligible as a result of regulation and competition, one would have expected to observe no noticeable differences in contribution rates. The contrary is true, however, and difficult to rationalize. Just before changing the finance system the contribution rates varied between 13.4 and 16.7 percent. Another peculiarity of the SHI is the provision that not full wages are subject to contribution but only wages up

* Wolfram Richter is professor of economics at the Technical University Dortmund. Email: wolfram.richter@tu-dortmund.de.

[1] According to a survey of the Institut für Demoskopie Allensbach published in August 2009, 64 percent of the population find the performance of the German health care system "good" or "very good".

to a limit ("Beitragsbemessungsgrenze"). Furthermore and as a general principle, employer and employee share the contribution equally. This burden sharing is called parity finance and can be traced back to the very beginnings of social insurance under Bismarck in 1883. As the contributions are income related and not risk related and as the costs of insurance increase with age, demographic change, and the implications of medical technical progress, the SHI is building up sizable future liabilities. The sustainability gap is estimated by Raffelhüschen et al. (2007) to reach the order of 90 percent of GDP.

The premiums of the private insurance are risk related and not community rated. They are calculated with the objective that they would not increase with age if only average health care costs did not increase. Ex ante redistribution works only intertemporally and not interpersonally. A private insurance plan combines pure risk insurance with saving. Before the GKV-WSG became effective, the insured had no right, however, to transfer accumulated savings when switching to another insurance plan. This lack of portability meant a great obstacle to switching and one which increased progressively with age.

Among the features that were often criticized in the German public debate before the GKV-WSG became effective are the following:

(i) the method of relating SHI contributions to wages with the effect that any increase in health costs pushes up wage costs
(ii) the fact that contributions for SHI are not levied on capital and high wage income
(iii) the coexistence of private and public insurance systems which allows high wage income earners, civil servants and the self-employed to avoid the income redistributive financing of health costs
(iv) the lack of portability of savings in private insurance plans, which makes switching insurance unattractive

In contrast, the following features were seldom the subject of public criticism:

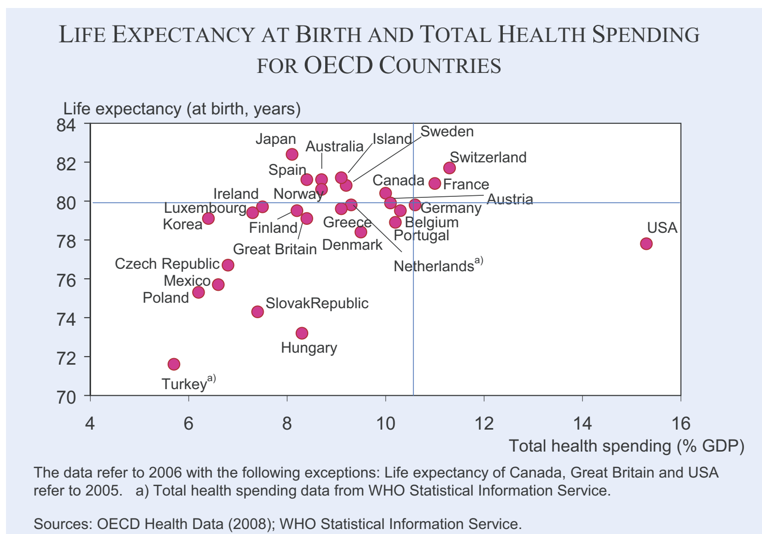
(v) efficiency deficits revealed by international comparisons of health care
(vi) missing options for the insured to choose among different forms of organizing the doctor-patient relationship including managed care

Equity and efficiency deficiencies in German health care

The equity deficiencies are obvious and have been the object of much criticism. The coexistence of two insurance systems which allows privileged groups of individuals to escape the redistributive financing of SHI cannot be rationalized economically. It can only be understood from a politico-historical perspective. Equally unconvincing and inefficient (Breyer and Haufler 2000) is the tradition financing social health costs according to principles of equity which strongly deviate from the principles governing income taxation. The German health care system, however, fares no better with respect to allocational efficiency. There is ample evidence. OECD Health Data 2008 reveal that Germany ranks 4th among OECD countries in health spending if measured as share of GDP but only 18th with regard to life expectancy at birth. The German spending share stands high at 10.7 percent while the average is 9.0 percent. Higher shares are only reached by the US (15.3), Switzerland (11.6), and France (11.1). Life expectancy at birth is 79.0 years in Germany, which is little more than the OECD average of 78.6 years (see Figure).

Afonso (2004) and Afonso and St. Aubyn (2005) analyze efficiency more systematically. They use infant mortality as a second measure of health attainment and they apply Free Disposable Hull and Data Envelopment Analysis. By means of these non-parametric methods they are able to rank 24 OECD

Figure



Life Expectancy at Birth and Total Health Spending for OECD Countries

The data refer to 2006 with the following exceptions: Life expectancy of Canada, Great Britain and USA refer to 2005. a) Total health spending data from WHO Statistical Information Service.

Sources: OECD Health Data (2008); WHO Statistical Information Service.

countries according to the efficiency attained in the production of health. In four different rankings Germany does not appear among the 17 most efficient countries. The computed ranks lie between 18 and 22 depending on which method is applied and on whether the inefficiency is expressed in terms of input or output. Clearly such a disappointing efficiency performance must have reasons. The international comparison is strongly suggestive of the following:

- excessive capacities in acute hospital care: According to OECD Health Data the German number of acute hospital beds stood at 6.2 per 1,000 population in 2006 with an OECD average of 3.9
- uncoordinated competition between hospitals and self-employed specialists in outpatient treatment
- lack of options for the insured to choose among managed and non-managed care

The latter two characteristics are related and in the following discussion they are both meant when referring to the unconstrained right to visit any provider of health care ("free access"). According to a widely held opinion in Germany, generous hospital capacities and unconstrained access to health care providers are highly ranked social achievements. The fact that other countries rely on less generous capacities and on constrained access is no reason to question one's own policies. It is hardly ever acknowledged that the medical benefit may not justify the cost. The economist may find such an attitude strange and ask which specific institutional features explain the growth and preservation of structures suspected to be inefficient by international standards. Some probable answers are presented in the next section.

The probable institutional reasons for inefficiency

German hospital capacities are the result of government planning. Noteworthy are the following characteristics. First, deficient capacities are established when the local number of beds falls short of the countrywide average. In doing so one ignores the fact that a filled bed need not be one needed. Yet Romer's Law suggests that a "built bed is a filled bed" (Kopetsch 2006). Secondly, the employed method of hospital finance enables political deciders to externalize costs. The method is called dual finance and it implies that only the cost of infrastructure is borne by the local state while the variable cost of utilization is covered by the health insurances of the beneficiaries of medical treatment. The insurers, however, have no right to restrict utilization. Free access to health care providers includes the free choice of hospitals. As a result the variable hospital costs are spread uniformly across the country while the benefits are regionally concentrated. There is no regional equivalence of costs and benefits. Instead, providing hospital beds is a policy by which a state is able to externalize costs. This is the most plausible explanation for apparent excess capacities. It would however not suffice just to grant the insurers the right to restrict access to hospitals. Much depends, as is argued below, on the insurers' incentives to improve efficiency.

Up to 2008 the competition among SHI sickness funds was strongly distorted. The reason is the use of distortive instruments (Wissenschaftlicher Beirat 2004). The funds did not compete in prices but in wage-related contribution rates. The result was that the insured with low incomes paid only a fraction of the costs of their own insurance demand. Parity finance implied a further halving. The employer bore half of the costs although having no say in selecting the insurer. It was as if the demand for insurance were subsidized, with the rate of subsidization being the larger the smaller the income earned. Only very high income earners were effectively taxed. But those earners tend to be households with less elastic demand. Under such rules, the economist would expect sickness funds to compete primarily by expanding the benefit package. As all funds faced the same incentives one would expect to observe benefit packages dominating the market that were inefficiently generous from a social perspective.

The lack of managed-care options can be rationalized along such lines. One only has to interpret the free access to health-care providers as a marginal expansion of benefits. According to this rationalization sickness funds did not offer insurance plans with constrained access because demand was expected to be weak. Whether this is true or not, it is striking for an economist to observe that 187 competitors today – and even more in the past – choose not to differentiate the benefit packages they offer. Market competition which brings about no diversity is extremely unusual. It has pathogenic features and calls for explanation. The competing rationalization widely suggested refers to the narrow scope of choice sickness funds have when offering health services. More than 95 percent of the benefit package would be pre-

determined by regulation (Buchner und Wasem 2003). This attempt at rationalization ignores, however, that the organization of the patient-physician relationship does offer significant scope of choice. The German government even legalized the possibility for sickness funds to offer gate-keeping plans with the GKV-Reform 2000 (SHI Reform Act 2000). However no fund took advantage of this opportunity (Greß et al. 2004). Obviously it must have been unattractive business. The government reacted by putting the screws on. After 2004 funds were obliged to offer optional gate-keeping plans. Such plans require the insured to enrol with a specified general practitioner who then serves as a gatekeeper. The result is that specialist care is only granted following referral. At least this is the rule. Greß et al. try to rationalize the sickness funds' reluctance to offer such plans voluntarily by questioning expectations that gate-keeping effectively results in cost savings or an improved patient-physician relationship. The international evidence would be inconclusive and any cost savings proven in the private health-care insurance sector would most probably result from self-selection. In contrast, I prefer to explain the traditional non-existence of gate-keeping plans in Germany by the systematically distorted demand for health insurance.

The competing models in the German reform debate

In November 2002 the German Minister of Health and Social Security, Ulla Schmidt, instructed a commission of experts to work out proposals for achieving financial sustainability for the social security systems. The commission was referred to as the "Rürup-Commission" after the commission's chairman. With respect to SHI, the commission did not agree on just one model of finance. Instead, it presented two competing models which became known thereafter as the Citizens' Insurance Scheme (Bürgerversicherung) and Flat-Rate Health Premiums (pauschale Gesundheitsprämie).[2] Essential features of the Citizens' Insurance Scheme are:

- non-discriminatory and mandatory inclusion of all citizens in one single system
- finance by means of a proportional tax levied on all income up to a joined limit

By contrast, Flat-Rate Health Premiums require

- maintaining the division between private and social health insurance
- financing SHI by fund-specific premiums that are paid by the insured without differentiating according to income or health-care risk
- enforcing portability of the savings accumulated in private health insurance plans

Prior to the elections to the German Parliament in 2005 all parties committed to the objective of a fundamental health care reform. While Social Democrats and the Green Party decided to support the Citizens' Insurance Scheme, the Christian Democrats recommended a combination of traditional wage-related contributions and Flat-Rate Health Premiums. As the elections did not bring about clear majorities, the Social and Christian Democrats decided to form a grand coalition. This however meant a deadlock for the promised health reform. In this critical situation the Wissenschaftlicher Beirat beim BMF (2005) came up with a third reform model which was previously proposed by Richter (2005). The model requires

- maintaining the division between private and social health insurance
- maintaining wage-related contributions at such a rate that allows the sickness funds of the SHI to finance average health spending
- stopping competition in fund-specific contribution rates and switching to competition in marginal (positive or negative) premiums.

With one exception, to be discussed below, this model became the blueprint for the reform enacted by parliament in 2007. In the public debate the model is named the "fund model" or the "health fund" for short. The name is derived from the idea that insured individuals no longer pay their contributions to the specific health fund they select but to a fictitious fund from which the selected fund receives risk-related but not income-related premiums. The contribution rate members of the SHI have to pay on wages was fixed uniformly at 15.5 percent from 1 January 2009 and at 14.9 percent from 1 July 2009 onwards. Hence the contribution rate is no longer a competitive instrument. The sickness funds compete instead with prices for marginal quantities. This means that they charge flat marginal premiums if the funds they receive from the health fund are insufficient to cover costs. Vice versa, the sickness funds may pay out surpluses in equal euro premiums if their budget allows them to do so. In economic terms the competition in wage-dependent contribu-

[2] See Commission (2004).

tion rates has been replaced with an income-independent price competition at the margin.

A more standard way to understand the new competition is by referring to vouchers. It is as if each member enrolled in the SHI receives a voucher in return for contributing. As the rate of contribution is uniform and no longer fund specific, the contribution is an effective payroll tax. The aggregate value of the issued vouchers equals the revenue generated by the payroll tax. The value of an individual voucher is an equal share after correcting for the expected risk of health costs. The vouchers entitle their holders to join the health plan of their own choice. If the value of members' vouchers allows the sickness fund to make a surplus, the fund may distribute it to members in flat payments. In case of a deficit, the fund must ask members to pay an extra flat marginal premium. At least, this is the rule. In contrast to the original proposal, the legislator introduced the one-percent cap ("Überforderungsklausel"). According to this one-percent cap, contributors to the SHI cannot be asked to pay more than one percent of their liable income if the extra marginal premium exceeds EUR 8. Additionally, the insured members have the right to terminate the health plan and to enrol in a competing one if the insurer charges an extra marginal premium or increases an extra premium.

Tax-financed voucher competition is a way of redistributing income without distorting the demand for health services. As the insured keep all the savings, they have a strong incentive to seek out plans that provide care economically. The idea is clearly not new and even not new for health care. The first proposal for health care based on vouchers was made by Enthoven (1978). The most recent proposal is one by Kotlikoff (2007). See also Kotlikoff and Burns (2004, 169).

Assessing the reform

The GKV-WSG is a reform which I believe is moving into the right direction. Whether it has moved far enough is debatable. Problematic is the continued division of public and private insurance. Political barriers were too high to overcome this division. There were also fears that closing private health insurance plans would be unconstitutional. As far as the SHI is concerned the reform's provisions are, however, essentially positive.[3] The change to voucher competition and the extended contractual autonomy granted to the sickness funds are definite improvements. It is still too early to ascertain the beneficial effects on competition. The sickness funds still have to learn to use their new freedom. In the past they confined themselves to collecting members' contributions and to distributing them to the health service providers according to rules which were largely exogenous. In particular, they pushed no managed care-like innovations. As has been argued before, market pressure did not support any moves in this direction. This has now changed due to the new rules enacted by the GKV-WSG.[4] The reform has legalized deductibles, and sickness funds now offer plans that include them. First sickness funds try to attract members by promising to distribute surplus revenue. Furthermore, the funds have started to use their competencies to provide managed care. In particular, funds have started to negotiate with health care providers on the organisation of outpatient care. Finally, funds are now offering gate-keeping plans. A first important step towards restricting the access of the insured to health care providers has been undertaken.

There is also reason to criticize the reform. A major weakness is the introduction of the one-percent cap ("Überforderungsklausel"). With this clause the legislator aimed at sheltering insured individuals with low incomes from financial distress. The need to shelter has however rightly been disputed (Sachverständigenrat 2006). Insured members have the right to terminate membership and to enrol in a different plan if the fund charges an extra marginal premium or increases an existing one. In all such cases the insured can simply switch to a more favourable plan. The government only has to ensure that there are always funds making a surplus. Additionally, the truly needy – for example the recipients of social aid – are not required to contribute to SHI. The contributions are paid for them by the competent authority. The one-percent cap has also been criticized for reintroducing a distorting effect on competition among sickness funds. This criticism is valid, as the cap has the effect of shifting premium obligations from low-income to high-income members. The implication is that a fund may risk losing all its high income members if it is obliged to charge an income-

[3] For a more critical assessment see Sachverständigenrat (2006) or Carrera et al. (2008).

[4] Some evidence of increased competitive pressure is indicated by the increased propensity of sickness funds to merge. The number of independent funds has declined by 14 percent from 218 to 187 just during the last twelve months.

related extra payment. This results in distorted competition (Sachverständigenrat 2006).[5]

Another critical point is that the particularism of the German länder has prevented policy makers from finding a way to reduce excess capacities in acute hospital care. The dual financing of hospitals has not been abolished and the sickness funds have not been granted the right to contract selectively with hospitals. The German länder only agreed in a follow-up act ("Krankenhausfinanzierungsreformgesetz") to coordinate their future hospital investments.

The parts of the GKV-WSG dealing with private insurance are also problematic. The only positive aspect is the obligation for private insurers to offer plans promising the same benefits as the SHI. This is a first step towards overcoming the separation of private and social insurance. Problematic is however the obligation to transfer premium savings when switching to another plan. This is problematic because it is not clear how to comply with this obligation without triggering adverse selection. The problem originates in the so-called collective risk of premiums. The most important factor of this risk is technical progress in health care. This factor implies that future health costs can only be forecast with great uncertainty. The practice is to update premium calculations only ex post, at the time when increased costs have effectively materialized (Nell and Rosenbrock 2008). As this updating goes along with increased information about individual health risks, it implies to some non-negligible extent ex-post redistribution instead of ex-ante insurance. The positive side of the lack of portability of premium savings is that it effectively prevents low risk individuals from escaping redistribution. It thus shelters redistribution against market forces. More than anything else, redistribution is the government's business, and legislators misperceive their job if they simply require private insurers to enable portability of insurance premiums without prescribing how to distribute future health costs among individuals with different health histories.

Comparing the enacted reform with the competing reform proposals

The strengths as well as the weaknesses of the GKV-WSG are best assessed when comparing the enacted reform with reform proposals that have been dismissed by policy or that have been enacted by other countries.[6] The proposals that figured most prominently in the German reform debate were the Citizens' Insurance Scheme and Flat-Rate Health Premiums. As has been argued before, the Citizens' Insurance Scheme's primary focus has been on equity. All Germans should have indiscriminate access to the same health plans, and all health costs should be financed according to the principles applied to income taxation. Such an objective is certainly not without merit. However, the concept as such would not contribute to increased efficiency in the health care sector. After having introduced voucher competition, the Citizens' Insurance Scheme is therefore a more appealing model. The competition in tax-financed vouchers ensures that income distribution has no distorting effect on insurance demand. Only under such circumstances is it justifiable to raise the question of equitable finance. There is, no doubt, much appeal to the idea that all goods and services which are provided by the government and from which no individual can be excluded for technical or ethical reasons should be financed according to the same set of distributive principles.

Most German health economists have been strong promoters of Flat-Rate Health Premiums. They argued mainly by referring to the labour market. Flat premiums would make it possible to fight unemployment and to disconnect health costs from labour cost. The flaw in the proposal was that it ignored the ensuing distributive conflict when wage-related contributions are replaced with wage-independent premiums. Such a reform would only be politically viable if income effects were compensated. If however all income effects are perfectly neutralized, little or even nothing is gained with respect to labour supply incentives (Haufler 2004; Buchholz 2005). The only change would be that the distortions induced by payroll tax rates would be replaced with distortions induced by increased income tax rates. Nothing would change effectively if the overall incidence of contribution payments and taxation were considered sacrosanct. The health-fund reform proposal is the obvious result when acknowledging this.

[5] One equally has to criticize legal provisions capping marginal premiums paid by sickness funds to members. The maximum amount of feasible premiums is made a function of the contribution paid by the individual member to the health fund. Hence maximum negative and positive premiums are related to the member's income and contribution payment, which should not be the case.

[6] Because of a lack of space it is not possible to assess all those proposals that have only been discussed among experts without any serious chance of legal enactment. One such proposal implies the full liberalization of premiums (Zweifel und Breuer 2003). Another noteworthy proposal targets accumulating capital within the SHI (Henke et al. 2002).

It focuses on improved marginal incentives and it leaves the distribution of income largely unchanged. The primary objective is to eliminate the distortions in health care demand and to leave labour market incentives as they are.

The promoters of Flat-Rate Health Premiums often refer to Switzerland, where such flat premiums had been introduced in 1996 (Leu et al. 2008). Whether Switzerland can serve as a good example for efficiency in health care is however not clear. Life expectancy is admittedly high; it is even the second highest in the OECD. Yet health spending as a share of GDP equally ranks second (Figure 1). However this may be interpreted, Switzerland does not excel by an obvious efficiency lead. This may be surprising given that the method of financing health costs is basically non-distorting and it clearly calls for an explanation. Leu et al. (2008, 150) list various deficiencies, the most critical of which is that too little autonomy is granted to the insurance companies. Swiss insurers are not entitled to contract selectively with the providers of health services nor are they entitled to negotiate fees. Hence their method of financing would allow them to pass on efficiency gains to the insured but they lack the legal competence to generate any. Health maintenance organizations (HMOs) enjoy more autonomy (Leu et al. 2008, 114). There is even some evidence that this autonomy pays off. Depending on the study the cost reductions achieved by Swiss HMOs are in the order of 20–37 percent even after controlling for self-selection of individuals in good health. The share of the insured enrolling in HMOs is however still rather small. It amounts to roughly 15 percent of the managed care market, which accounts for just over 12 percent of the insured Swiss population. A true obstacle is that the maximum premium reductions HMOs can pass on to the insured are limited by law.

Apart from Switzerland, the Netherlands is often cited as an example of successful health care reform (Enthoven et al. 2007; Greß et al. 2007; Stoelwinder 2008). Technically speaking the Dutch method of finance can be seen as a combination of tax-financed vouchers and Flat-Rate Health Premiums. About 50 percent of total expenditures is financed by income dependent contributions (Leu et al. 2008, 74). 5 percent is a government subsidy and 45 percent is financed by flat premiums which in 2007 amounted to EUR 1,144 on average. The flat premiums must be the same for every insured member under the same health plan, but they can vary among insurers. Hence the demand for insurance can be considered to be undistorted. As the reform was not enacted until 2006 it is still too early to evaluate the reform's success empirically. There is however one critical issue that policy makers should watch carefully. This issue is market power in the demand for insurance. About 57 percent of the insured have signed collective contracts which offer discounts of up to 10 percent and which are negotiated between the insurers on the one side and the employers or trade unions on the other side. There is good reason to believe that such collective bargaining is more of an obstacle than a help for the development of efficiency-enhancing managed care. Managed care is still in is infancy in the Netherlands (Leu et al. 2008, 17) and it might be unduly difficult to market the efficiency gains of managed care if such plans have to compete with collectively negotiated plans.

A tentative outlook

According to Richter's proposal (2005) the switch to voucher competition in the German SHI should only be the first stage of a more fundamental reform in health care and its finance. At the second stage the payroll-tax finance should be integrated into the general system of taxation. This second part of the reform would then offer a good opportunity to redesign the roles of private and public insurance. The Netherlands had to meet similar challenges years ago and they have showed how to overcome them. From an economist's point of view there is hardly any reason why public and private insurance companies should not compete for insurance demand on an equal footing. Whether for-profit or non-for-profit companies better serve people's needs can only be determined by market outcome. Insurance plans with risk-rated premiums, which characterize private insurance, will under no circumstances lose importance. They will only be limited to supplementary insurance plans. In the long run most Germans will find themselves signing up for two plans: one is tax financed and it only covers health care to an extent specified by experts to be basic.[7] The other plan is risk-rated and it covers non-basic health care. To prevent such a system from suffering unduly from adverse selection, however, all relevant information about individual health costs must be made available to the insurer with which the individual wants to sign up a supplementary plan.

[7] Even now experts decide on what is included in the benefit package offered by SHI. So this part is no change.

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