



From Social State to Welfare State

Empowerment, Individual Responsibility and Effective Compassion

Wilfried Prewo

CNE Health Luncheon
07 June 2005

CNE Health Luncheon with Wilfred Prewo

All Western countries suffer from run-away costs of health, unemployment and pension insurance. Controlling costs by regulation has failed utterly; government administration of social programs has proven wasteful; the age structure is out of balance. The welfare state cannot be sustained. But how to provide a social safety net? In this transcript from the Centre for the New Europe, Wilfried Prewo argues that social security can be made more efficient and should be privatized - without slashing the social safety net.

About the Speaker

Wilfried Prewo is Chief Executive of the Hannover Chamber of Industry and Commerce in Hannover, Germany.

The Hannover Chamber is one of the largest German chambers, with a membership of over 100,000 companies and a staff of 200. Apart from its strong focus on services for its members, the Hannover Chamber is an active pro-market voice in Germany. To this end, Wilfried Prewo writes and speaks frequently on economic and social policy. He has been promoting a privatization plan for the German pension and health insurance systems and, in the case of tax reform, has proposed a revenue neutral flat tax of 20 per cent for Germany.

Prewo was born in 1947. He holds a B. A. from Grinnell College and a M. A. and Ph. D. from Johns Hopkins University. Prior to assuming his current position, he had been working in the private sector as well as, earlier in his career, at the Kiel Institute of World Economics and at the University of Texas at Austin. He is a fellow and a board member of the Centre for the New Europe AISBL.

Stephen Pollard

We are delighted to have with us today Wilfried Prewo, a board member of the Centre for the New Europe, and the author of one of our most interesting and influential pamphlets. One of the areas that we've been most interested in, in terms of healthcare reform and reform more generally to the welfare state in Europe is the idea of medical savings accounts, all kinds of different saving accounts and so on, and a lot of policy wonks talk about this in general terms, and they talk about what a good idea it would be without the specifics. So we were thrilled to publish Wilfried's latest book "From Welfare State to Social State", which goes through not just the general idea and talks about some of the ideas as to why this would be a good thing, but actually puts numbers to it and actually plans a road map which shows how we can move from the current system with all its problems to another type of system, and does it as I say not in the most general terms but actually talks specifics. So I'm going to hand over pretty much immediately to Wilfried.

Wilfried Prewo

Thank you very much for coming here and thank you very much for this introduction. First of all I like it very much if you eat while I'm talking as this keeps your brain cells a little bit subdued and you will not easily detect the mistakes in what I have to say. So, outside I was asked, "Is this a paper or is this a book that you have written?", and Stephen started out by calling it a pamphlet – and this is a very apt description. A pamphlet in the German understanding of a pamphlet is a highly opinionated piece of work and I readily concede that I have a strong opinion as far as healthcare reform is concerned, and this I want to convey to you.

As we all know – and perhaps you all have experiences in your own home countries, and my experience being mostly concentrated on Germany – controlling healthcare cost seems to be the overriding political concern, and controlling costs by government regulation has failed utterly. We have had in Germany more than ten health reforms since the 1970s and each of the reforms was labelled as bringing us closer to containing healthcare inflation. The health payroll tax in Germany healthcare is paid by a tax which is shared 50/50 by employers and employees. It kept rising, it is now over 14% and none of the reforms was able to reduce the health payroll tax over a sustained period of time – and "a sustained period of time" I would say is anything more than five months. The last reform that we had when we had health payroll tax at 14.5% two years ago was supposed to reduce our health payroll tax to 12%; our health payroll tax now in Germany is now at 14.7, so you also see this has not worked.

Now with each of these government failures it is my hope that this will pave the way for new thinking, and especially a fresh look at how we should treat health reform. One of the major misconceptions that we have in politics – and that's also by reform-minded people in Germany – is that they think the health reform debate has to address the issue of revenue, that there is not enough money coming into the system: how do we get more money coming into the system? The problem is not about revenue. The problem is about outlays. The problem is about how can we reduce our total healthcare expense, this is our real problem that we have to address.

The major flaws of the current system – and this just doesn't hold for healthcare, it also holds for other welfare systems, unemployment insurance and especially pension or social security – the primary problems are that, number one, the citizens are being treated as recipients of an entitlement that is bestowed on them by a benevolent, seemingly benevolent government. Government is not benevolent; people are benevolent because they bestow their taxes on their government and so rather than viewing citizens as recipients of an entitlement given to them by their government, we should think of citizens being consumers or customers of healthcare services who, like in other markets, like among other products and services, can chose among an array of goods and services and of different producers and providers. That is I think the basic argument of those that argue for consumer driven healthcare reform. Put the consumer into the driver's seat, don't put him into the luggage compartment but put him in the driver's seat, give him the keys and tell him where he should go.

Number two, a government provided system inevitably will see to it that entitlements will be uniform across the board; with a government programme there is always “government issue”, there is always “one size fits all”. Critics of consumer driven healthcare proposals have always said, “Well this is fair, you have to give everybody uniform entitlements because healthcare is a basic need”, to which I tend to answer: Well, clothing is also a basic need so why don’t we give everybody like they did in Mao’s China: a blue suit. And also food is a basic need, then how come we have fast food and we have fancy restaurants as in Brussels, and none of our socialists are complaining about that; also, living quarters are a basic need, we don’t want anybody to have to live in the streets but it well accepted that some people live in a small apartment and some people live in a large mansion, this is all accepted, everybody gets what he pays for.

In all of these things, clothing, food and general living conditions, it is all agreed in Western European countries I think that at least there should be some kind of a minimum, a minimum level below which the government may step in with welfare programmes. This is not something that I attack but what I readily accept.

Another major mistake is that we think that security and welfare programmes, when provided by government, can only be provided by some kind of monopoly scheme. There cannot be just uniform entitlements but also there has to be a monopoly provider of these services. I still remember twenty years ago when the chambers of commerce – I run the chamber of commerce in Hanover, Germany – when we argued in a German telecommunication deregulation debate that we should have competition. At that time the German post office, the postal ministry of course like in many other countries was running the telephone company and everybody said, or the critics said, “Well, this is a natural monopoly, I don’t think anybody in this room still would think that’s a reasonable argument”, but at that time it was seemed to be an argument that 95% of knowledgeable people agreed to. Luckily times have changed for the telecom industry and I think there is also hope they will change for the health industry.

Finally, and this comes more in to play with pension reform, the major flaw of our welfare programmes is that they build on the false assumption that there is a generational contract that is being adhered to, and that society generates and raises its offspring to the necessary strength in order to preserve the demographic permit. There is an old calendar story, you know these calendars that on the back side or front side they have some stories that you read each week or each day that gives you a motto and something to think about. In the early 19th century there was a German writer who gave this calendar story:

A peasant was walking home from town carrying three loaves of bread and another stranger was meeting him and said, “Well, farmer why don’t you give me one of your loaves of bread, you’ve got three, that’s surely more than you need”.

He said, “No, sorry, I can’t give you one because I need this one for my parents, they have raised me and they have brought me up and I am inheriting the farm from them. I have to look after them in their old age, and the second one I need for myself”.

“Oh, then you can give me the third one?”

“No, sorry I need the third one for my children so they grow up and when I’m old they will also support me in my old age.”

That was the generational contract and that contract being an intra-family contract, that contract worked. It worked for century and of course that contract fell apart because our societies became modern; we industrialised and we separated the place where we lived with our families, over generations, from the place where we worked. And as a result of that, in response to that the early proponents of the modern welfare state – Bismarck in Germany and Beveridge in the UK installed a new system that is saying we have to see to it that people, old people that no longer live with their children that are now working because of initialisation they have to work in a different town where the parents live, we have to see to it how old people are being taken care of and we also have to see to it that the young people will be able to support that. So in Germany in the late 19th century we started the payroll tax system and the Bismarck – essentially at that time, to give credit to Bismarck – the German payroll tax system had a very, very strong funding basis, and in Germany it was easy to do it on a funded scheme because you got retirement benefits when you were 65 – and life expectancy in Germany was about 65 at that time. It was a funded system, the funds then were depleted during world war one and there was again a build up of funds and those funds were again depleted in the German hyper inflation of 1923-24, so, also one lesson: never entrust government to build up a fund, a government’s building up funds is as realistic as asking a dog to keep a supply of sausages that you give him to keep in inventory.

Now this system of course no longer works. It no longer works because of various reasons, but just if you look at global competition you know that it has exposed the modern welfare state. We no longer can command the prices in world markets that are generous enough to finance it. Payroll taxes, again to give you the German example, are now about 42% of wages in Germany: about 14.5% for healthcare, 19.5% for pensions, 6.5% for unemployment insurance and 1.7% for our old age care insurance system, which is also payroll tax financed. So we have a total of 42% that you have to add on to direct wages and that certainly is not sustainable because we cannot get the prices in world markets that would allow us to keep going. As a result, jobs are lost to other countries – Eastern Europe and China are prime examples – and this initiates a vicious cycle: As jobs are lost there is less money coming into the payroll tax finance systems, there are more beneficiaries, more recipients, and there are fewer people that are paying into the system. And those fewer people that pay into the system have to pay more – and also demographically, for increasingly higher numbers of people have to pay more money, and for more people initiating the next spiralling inflation around on payroll tax increases. As a result the welfare state sucks up the savings that we would need in order to invest and grow into the information age and as I said it’s the albatross around our neck, it pulls us down.

Now as bleak as it is, I think it is also easy and this is for me, this was the miraculous thing when I worked on this: I thought, “this is such a huge problem you cannot solve it”, but it is a problem that I think is exceedingly easy to solve. I didn’t find the magic trick; on this I just learned from the countries, from the concepts in Singapore, where they have medical savings accounts, and from the very lively debate in the 1980s and 1990s in the US about “medical savings accounts” at that time (in the US they are being re-christened as “health savings accounts”). These are the concepts that I just took and said, can we apply them to our Western European model? And here I start with a basic presumption that maybe for

Americans would not be number one but for us in Europe would be number one and that is, we not only have to look for an efficient system but we also have to look for an equitable system, we have to look for a system that is politically palatable that you can sell politically where the first argument that will be thrown at you is not, "some people will be worse off" but "where you can show under such a system nobody loses?". Nobody has to lose, everybody has the chance to be as well off at the start as before.

And so let me outline the various steps, we take the money that is currently being spent on behalf of each individual on his healthcare, on his unemployment care, on his pension insurance. We take in Germany we take the payroll taxes that the government and the various health, unemployment and pension agencies are collecting from people, and in countries that have a system like the UK where the systems are paid out of general tax revenues, we take the money that the government is collecting through these tax revenues and we split that up, and I will tell you in a minute how we split that up and we deposit that into what I called social savings accounts which are vested in the individual. Now how would this work? How would we divide it up? Because some people, as I say in Germany it's the payroll tax or in the UK it's paid out of a VAT or income tax revenue, so some people depending on their income would be paying more into the systems than they would be taking out of the system. This is what we call redistribution and in order to preserve the rule that nobody should lose, we have to preserve the current redistributive situation, I'm not saying that the current redistribution is good or is bad, I just take it as given and we said somebody should be able tomorrow to buy the same health services, the same level of unemployment insurance, the same level of pension insurance as is currently bestowed on him by the government.

Suppose somebody in Germany pays a health payroll tax of 400 euros. He is 29 years old, single, and a private insurance premium for him in Germany would only be 200 euros. So with this 400 euros, so 50% is taken away from him currently and given to other people. Who receives it? Well, number one, pensioners. The pensioners being old of course have higher health expenses than younger people and they only pay a payroll tax on the basis of their pension income and not on the basis of their active income, so they receive a high subsidy in the system. There are also cross subsidies in Germany between households with two income earners, where husband and wife are both earning incomes in the German case both have to pay the payroll tax, whereas if one does not work only the other one pays the payroll tax but both are insured, so there is redistribution in that. But it doesn't matter: just take the whole pot and divide it up and say that 29 year old keeps paying his 400 euros health payroll tax for the time being, and he gets 200 because 200 is enough for him to buy insurance to cover 100% of today's benefits at today's cost. And say the pensioner who only pays in 200 but has expenses of 600, he gets 600 because 600 is what he needs in order to buy today's benefits at today's cost. Does this work? Well it adds up to the same total number.

We currently do this redistribution scheme, we do it, we do invisibly to us, we do it behind the screen. There's the screen of the sickness funds, there's the screen of the unemployment insurance system, there's the screen of the pension insurance system. They don't let us look behind this screen and show us what this redistribution scheme is. All we have to do is individualise the collective redistribution and transfer system, individualise it and show it to people. So in the day and age of computers this is an easy task to do. In fact it is being done in Germany between individual collectives we have individual sickness funds that you can

say, "I want to go to this sickness fund, I want to go to that sickness fund", they all have uniform benefits that they give you and if there is one sickness fund that has more higher risk people, older people, more people with lower incomes, there is a risk equalisation scheme between the sickness funds so all that we would be doing is we would extend the equalisation scheme to everybody and we would individualise it.

So mathematically it would be an easy operation financially. Administratively it would be very easy to do it. It would lead however to a very lively political discussion because the 29 year old would see and realise he is paying 400 in and only getting 200 out. It would open his eyes, but I think in a democracy, people have a right to being informed, don't they? That would be the debate that we would have and I think we should be able to withstand the debate that would come forth. Currently people sense that they are paying more in than they get out, or that they are getting out more than they pay in; there's a certain dissatisfaction or satisfaction with this system depending on which side you are on. So we do that, we give everybody the money that he needs to buy today's benefits at today's cost and the result is no fresh money, no additional money, no additional tax money is needed, and everybody can buy today's insurance level at today's cost.

And then we come to step two. You do not have to buy all of today's entitlements, you only have to buy a minimum, you only have to cover yourself in healthcare for what we would call "catastrophic coverage". We want everybody to be covered when he goes to hospital, faces a high bill that could easily put him into dire financial straights. We want everybody to be covered for chronic diseases, but why can't I opt to pay for my eye exam myself in return for a lower premium? Why don't I have the option to pay for my normal doctor visits myself in return for a lower premium? Now we don't force anybody to pay for his eye exams, we don't force anybody to pay for his doctor visits, we don't force anybody to pay for his dentist, we just give everybody the option to just reduce themselves to a minimum level of benefit. Where should the minimum level be in the European understanding? I think it should be there. The cost of covering that out of your pocket yourself would make your welfare case because society would not gain anything if somebody would save on his insurance premium and then when it gets serious he would go to the state and say, "dole out some money, I need a welfare cheque" – that we don't want.

Now a system like that, a system that would give people the option – not force them but give them the freedom to pay things out of pocket – would certainly result in very discriminating consumers. That's one reason why the professional associations of German doctors, not individual German doctors that I've talked to but their associations, don't like my proposal, because people are no longer patients that have to be patient. People, "patients", will be discriminating consumers and they will ask tough questions to their providers, as we do when we buy a car, as we do when we buy other services, as we do when we get a hair cut we tell the barber that we don't like it if we don't like it.

What happens with the savings, what happens if you opt for deductible and have a lower premium? You should not be able, in our example, to just take it out and consume it. You should be able to leave it in your social savings account. You can use it for any type of social insurance purpose, you can use it if you have amassed a nice deposit in your social savings account, you could use it say the next year when you have to pay a deductible, or suppose you have amassed a nice deposit in your social savings account and then you go to your

insurance company and say I can opt for a higher deductible or a higher co-pay because I have this money in my savings account and I don't have to take it out of my other household spending money. And this would of course give added fuel to the consumer driven concept. Also you should, as I said, be able to buy it for any other social insurance purpose and this is may be where I have to divert from health care. Nobody of us seriously believes that the total level of healthcare expenses will be radically lowered because we have innovation in healthcare and this innovation comes at a price and above all we all get older we are aging societies and aging societies are expensive societies as far as healthcare is concerned and therefore I do not know whether the savings that we will get from a consumer driven healthcare model will leave us a lot of money left over at the end, but what I know is consumer driven healthcare models certainly will be much less expensive than our current government run models.

Now in other cases we will have real money left over, for example, in unemployment insurance. In Germany unemployment insurance is 6.5%, again 50% paid by employer and 50% by the employee. On the other hand, about one third of unemployed people in Germany are unemployed for more than three months, so in Germany we have a lot of search unemployment, that is people voluntarily or quasi-voluntarily get unemployed and then only once unemployed they look for a new job. Suppose we would do the following: If you opt for a three month co-pay, that's the first three months when you are unemployed, you get no unemployment insurance benefits because you've said "three months, I've saved that much, I've saved it up I can get by for three months" and you pay a much lower premium, maybe it would only be 3% or 4% instead of 6.5, he would amass 2.5% per month of his pay cheque in his social savings account and what would he use that for? Ideally he would use it for a funded pension to build up a funded pension provision. So this brief example shows you how the health insurance, pension insurance, unemployment insurance or other social insurance systems can be linked together, and it can help us in overcoming the problems that our demographically problem ridden pension system will be facing in the future.

I've mostly stressed the health issue because the health issue I think is the most difficult, it's the most controversial. It may be the most complicated issue; you know talking about unemployment insurance and a co-pay, that's easy, but I wanted to address the rather more difficult issue, the health case, and try to show you how it can be done how it can be made to work. Now Stephen said in the beginning that this was a little road map what I've provided, and I did it simply for the reason that in the German debate – but I presume it's the same in other countries. It is no longer sufficient now to say we want a market driven model instead of the state run model but I think also in order to get a hearing in the political arena you have to show how we get from here to there and this is what I wanted to try to provide. Of course because I wanted to do that, I had to take specific German numbers. I do it within the German institutional system and had to do it – I think that somebody who works in Belgium, somebody who works in France, somebody who works in Denmark, he can try to do the same thing for his or her country; I don't know enough about the French system or the Danish system in order to do it. I've always realised when other people have written about other countries' health models it was always wrong, it was always easy to write mistakes because government regulation is far more rapid than Darwin's evolution and so you will always have made a little mistake or little oversight, and if you do that you easily open up yourself to criticism. This is why, simply because I am German and live in

Germany, I've picked the German system but I'm convinced you can easily apply the idea to other countries. Thank you very much.

Stephen Pollard

Thank you very much for that Wilfried. If we open it up to questions and comments and so on, people feel free. You don't have to ask a question, if you have a criticism or praise or question or a comment then please feel free. If you perhaps just say who you are and where you're from as well when you do that. Who would like to go first?

Eline van den Broek (Netherlands)

Thank you very much for your presentation, it was very nice as your book is. I have been working on the implementation of the reforms in the Netherlands and tiny successes there, but there are many, many questions that politicians ask me that I personally can't answer, so I'm going to try a couple. Maybe you have answers, so I can go back and answer the questions. First of all you don't elaborate on the transition period and I think it's quite crucial, the transition period from the current system to an SSA system. How much time do you think governments need, is it just simply transferring the money from the government to the SSA? Is it as simple as that, or how much time do they need? That's the first question.

Wilfried Prewo

The transition itself takes a millisecond but preparing for the transition takes time in terms of writing the software and doing the previous institutional change. For example the sickness funds in Germany all know that on average a 29 year old costs them – they have statistics about that – and so we can easily say, as 29 year old he needs say 200 euros a month to buy an insurance system for the current benefits and then they know we have a 29 year old named Mr Meyer; he pays 350, and then we have a 29 year old unemployed who pays nothing, but the unemployment agency pays for him 100; we have a 29 year old Mr Zimmerman who is a young banker and he pays at the top, 450 euros at the maximum roughly. So they all know that, so you just have to write the programme that for the guy who pays in 450 you deposit 200 into his account; the guy that pays 350 you deposit 200 into his account; the guy that only pays in 150 you deposit 150 into his account plus another 50 to bring him up to the same level. And basically you would have to have a purely age rated system, ideally you might also have a difference between female and male, although that will probably no longer be allowed under the EU discrimination directive, so you might have a unisex insurance premium. Insurance companies can handle all that. Now what you would have to do is you would have to bring the sickness fund agencies – they are public workers, they are quasi-government workers – you have to bring them up, you have to school them, you have to bring them up to the knowledge level where they can operate like a private insurance company. So the transition is in preparing, but then you throw the switch on, say, the 31st December and you switch over from this system to the new system and then you have it. You will then have of course a longer, in a sense, a transition period; people will say “well, in the beginning I'll start out a little conservative I don't know what kind of co-pay...” People have different risk levels; this will take a few years until people are adjusted but I think people are much quicker than government believes people are, they are a little bit more mature than sometimes we are presumed to be or judged to be by our governments. So I think the transition is in preparing and it's just technical. It's basically technical work.

Question from audience

Thank you for your speech; this is the praise part not the insulting part. Just a reflection maybe to add concerning the cost of the heavy equipment that is necessary for the really heavy treatment in today's healthcare: If I get a brain tumour I basically have got, and correct me if I'm wrong, but basically I've two alternatives, death excluded, and that is surgery or that is radio therapy which is the most expensive you can have today. To me it seems like the system today, where lots of equipment of this type is installed in parts of Europe and the United States where the waiting lists are still heavy and it costs tax payers an enormous amount of money, maybe that could be replaced by a system where you actually instead of waiting one year with the risk for your life could just get a plane ticket paid by your insurance company and go to say Malaysia, or maybe Atlanta, which is one of the most well equipped places in the world.

Also, in the same case you are running the risk in a socialised system of having the doctor who is of course the expert saying that "no, I recommend surgery which is far more costly and far more dangerous", saying that "no, I think we recommend surgery in this case", for one reason, it will give him an experiment to use in his dissertation. Just a comment, thank you.

Wilfried Prewo

Well I'll make a comment on that, I think. I'm not saying that this proposal is [unclear] and a cure for all our problems or misjudgements, I cannot say that. But in the current system when you don't pay anything – and in the German case the patient doesn't even see the bill at the hospital or the doctor, but writes and presents it to the sickness fund. In the current case the doctor tells the patient, "let's do the most expensive thing" or "do you want the lesser expensive thing?". When you don't pay anything and don't see the bill you always say, "Doctor you take the most expensive routine, because you believe the most expensive is the best". I'm not saying that you will not do that in another system but you might be more discriminating and if you look at people's behaviours in countries where people have to pay some money out of pocket, more people in countries where people have to pay something out of pocket invest time in educating themselves about what medical procedures should be done, I'm not saying that they then become medical experts but they go on the Internet, they have an exchange with other patients with same diagnosis and exchange very frequently. If you look at, in the US it's very wide spread; in Germany very few people are doing it because they're saying, "well I'll just go to the hospital because everything is taken care of and being paid for". Another thing, in Germany people have said, "but that's not for a major disease, it's just for a minor treatment". People in Germany have said, well, then people don't brush their teeth anymore if we don't pay the dentist.

Well in Switzerland, where the dentist is not covered by the social insurance system, it has been proven that people have better teeth than in Germany. Although some people in Switzerland even speak a language that sounds like German, ethnically they are not so different from them and so why would that be? So it just shows that I think that there is more self interest if you pay a little bit out of pocket, just as like when we need new tyres we read the car magazine saying which tyre has tested best as a snow tyre, as an all season what ever and so on, and I think we would take more care, invest more time in gathering information about the best healthcare than otherwise. I'm not saying we will always be making the right decisions, we may not.

Question from audience

I have a question for Wilfried concerning an idea that I very much believe in. Personally you totally sold me when it comes to your ideas which I totally believe in but of course I realise that we live in Belgium and the system that was proposed once several years ago, I think is should be ten or twelve years ago, was by the guy who is now a prime minister. Well he proposed a system of social security which included also a proposition or proposal concerning healthcare and well a lot of the things he proposed were very much going in the direction that you propose. Now in Belgium we have the tradition of coalition governments, some people are pleading for the separatist but I don't think that if Flanders would become independent a lot of things would change. So my question is how do you see it's possible in real life to convince the government or to convince the people that your system is indeed the best. So my question comes down to this, how do we do it in practice and not stick to theory? That's my question.

Wilfried Prewo

Both democracies, the EU and the US, are imperfect, but what we have is two things: What we see in countries like the United States is we have a gradual acceptance of consumer driven healthcare ideas. We started out with a debate of medical savings account like people like John Goodman National Centre of Policy Analysis in Dallas about twenty years ago, and at that time people like him where considered lunatics then they found and realised that this is being practiced in Singapore, though I said of course Singapore is quasi-fascist state government and so "can't do that" and then gradually in the political process – and that is interesting – there were other ideas like one called a Health Reimbursement Account or Arrangement, HRA, and other ideas, and that had flaws because senators, representatives didn't understand this. For example one flaw of these other arrangements was that money that was not spent by the end of the year that you saved because you opted for a co-pay would be lost unless you spent it at the end of the year so everybody had to go out in December and get designer prescription glasses or something like that in order to deplete his account.

And now the political process has learned. In the health savings accounts that the US got in the end of 2003 together with the Medicare reform, there's no longer a "use it or lose it" provision but the money will stay in your account. It will also stay tax free and you can take it out when you retire and you take it out tax free, so you are receiving a taxable benefit only if you take it out before you retire and you consume it for a vacation – then you have to pay income tax plus a 10% tax penalty, which I think is okay, it's an incentive to keep it there. So politically things catch on, I'll give you another example: Flat tax. I made a flat tax proposal during 1995 or 1996. I was considered a lunatic and currently talking about a flat tax in Germany is absolutely okay, we now have a previous German supreme court justice Professor Paul [unclear] who went back to teaching law; German supreme court justices are not appointed for life. He is making a very detailed proposal, he is writing a new tax book for Germany, so he's doing all the nitty gritty detailed work and it takes, unfortunately it takes time, we're not a dictatorship and I don't believe in benevolent dictators.

Question from audience

First of all I wanted to thank you for your excellent presentation. It was geared both on a political level because you highlighted the different political issues and on the technical

level, giving us already a hint on how one could make it possible. As we are in Brussels and we are all busy with Brussels regulatory issues I wonder if you think it is desirable, positive, interesting to have some essential guidelines issued by the institutions and these independently from the future of the institutions for structuring these kind of policies because you guess that if you go for considering health as a consumer product, consumer good, then you would need some kind of standards, you would need a kind of internal market and you need some standards. So do you see any role centralised at the Brussels level?

Wilfried Prewo

That's a difficult question for me, difficult to answer because the healthcare systems are still mostly in the national domain. Now what we are doing, what we do get, and where maybe what you are suggesting would be even welcome, is that all our national health care systems now face problems that are second round effects of free-trade in services. For example, Germans go to Hungary to get their teeth fixed; this is an intensive industry in Hungary. You have German speaking dentists because they have their Austrian/Hungarian tradition; some of them went to medical school in Vienna, and so Germans go there and get new teeth for one tenth of the price of what they would have paid in Germany, and so that has of course effects within Germany. We always thought that a medical service is a non tradable good, you can only consume it locally. So what we get in Hanover, we get lots of patients at our medical school hospital from England that are bypassing the waiting lines on, say, hip replacements and the like, so since we are getting a European trade in medical services we are also getting questions that affect the finances of our healthcare systems – and maybe that way something in the direction of what you suggested could come in, but hopefully if we get something central, hopefully it will be a pro-market, a central directive. I don't know whether something like that exists.

Health Consumer Powerhouse

I come from a part of Europe where we can only dream about having to choose among insurances, even more talking about medical savings accounts – that seems like very, very far away. But what I know of the German system if I understand it correctly, the insurances that you actually can choose among, they actually are then making deals with hospitals and suppliers, which means that if you choose a specific insurance you know that you can go to this or that hospital or this or that position – is that correct? – and if so, do you see any trends that, because when we talk about this in our part of the world they actually say and you can't have insurance because they would say that we don't want diabetics, we don't want people with high blood pressure, we don't want that type or another of a disease state and if I look around among my friends I don't know anyone who hasn't got the DNA for either asthma, breast cancer, diabetes, high blood pressure or rheumatism. Sooner or later everyone will get any of these more or less chronic diseases. And do you see any trends in Germany that the insurances start specialising in chronic disease areas to attract these type of customers for this large customer base if you manage, say, to get all the diabetics in Germany as your customer?

Wilfried Prewo

First of all, the way the German system works, about 90% of our population are in the sickness fund, payroll tax finance system, not 100%. 10% of Germans have private insurance, they are outside that system. Anybody in Germany can go and get the necessary

– anybody can go to the doctor for care that he wants to get to as long as that doctor's registered with a public healthcare system which holds true for, I'd say about 95% of German physicians. And anybody can go to the hospital, typically the hospital in his town where the hospitals in his town, that he needs to go to except for say the doctors at the hospital will determine "we can take a patient that needs a hip replacement, and we can take a patient that needs a coronary bypass or we sent him to this hospital because they have free capacities". So, otherwise there is not a general restriction that you can only go, whatever you have, to hospital A or to hospital B. We will see in Germany a specialisation of hospitals because we have changed our hospital remuneration system to DRG's and this will lead to some specialisation; one hospital will more specialise in orthopaedic surgery, another one will do more coronary work and so on. By and large, the hospital or your doctors in Germany are not being restricted. The government wants to do it, the sickness funds want to do it, they believe, but they should have studied the US experience, they believe that managed care is a cure-all and it can tremendously save cost. Well if you look at managed care in the United States it can, for a few years, contain cost and then you get the problems later on. So by and large we don't have that problem in Germany, our problem is more ideological. Our current government, the social democrats and the greens, and this is now their program for after the next election, they say we want to have citizen insurance. Citizen insurance is two lies in each word, it's not for citizens but it's for subjects and it's not insurance but it's provisions and they want everybody like in England, like in a national health service, to pay into this system and not only pay some income taxes but also based on rental income, on capital income and so on; and on the other side of the spectrum the Christian democrats want to have more of a Swiss style system where you would have a [unclear] fee for everybody, this would then not be an actuarially calculated premium, they want a fee of 169 euros for everybody, for every adult, husband and wife, working or not working and then would allow then within balance but probably in the beginning very, very restricted balance to have very limited co-pays. So we're getting a lively debate now on what is the right system in Germany. One proposal is terrible; the other proposal goes maybe 50% in the right direction

– end of transcript –

Centre for the New Europe AISBL
Rue du Luxembourg 23
Brussels 1000 Belgium
+32 (0) 2 506 40 00

www.cne.org