

### Active ageing and European health care systems (WP4): country report Germany

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April 2005

## **WP 4: Active Ageing and European Health Care Systems**

### **Country Report GERMANY**

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# 1 Introduction

What does the concept of “active ageing” imply with regard to health policy and health care? In general terms, active ageing is understood by the OECD (1998) as “...*the capacity of people, as they grow older, to lead productive lives in the society and the economy. This means that they can make flexible choices in the way they spend time over life – in learning, in work, in leisure and in care-giving*”. In the context of health care and health policy, active ageing can be understood as a long healthy life expectancy and as the ability to design one’s life independently even in the presence of an illness.

The following report deals with the health system and health care system in Germany and the way it relates to active ageing. “Health care system” is understood here as the system of medical care which sets in when an illness has already occurred. “Health system”, in turn, encompasses preventive measures which aim at a change of health behaviour, measures which address the physical and social environment (e.g. road safety, food safety and workplace safety) and the accessibility of different spheres of life to all people, also to those ill and with impaired mobility. The broader concept of health system encompasses the idea of “prevention focused on circumstances” versus “prevention focused on behaviour” used in German health policy discussion. “Prevention focused on circumstances” aims at designing healthy living and working conditions. According to EK (2002: 404), this goal goes beyond the scope of health policy alone. In contrast, “prevention focused on behaviour” tries to improve the health status of the population and to diminish morbidity by influencing health behaviour of people (EK 2002: 404-405). Throughout the whole report, issues pertaining both to the broader concept of health system and to health care alone will be raised.

In chapter 2, the demographic features of Germany will be outlined – the age composition of German population, old-age and youth dependency ratio, life expectancy and healthy life expectancy. Chapter 3 deals with the health status of the population. In this chapter, measures related to the concept of “health” as absence of illness or injury will be presented next to measures of self-assessed health status. That way, a concept which belongs to the realm of health care will be contrasted with a concept which pertains to the health system. Chapter 4 deals with the main risks to health. In section 4.1., factors which may cause fatal diseases are described, like smoking prevalence and consumption of alcohol. Section 4.2. then turns to main causes of mortality in Germany and shows age-specific disease patterns. Subsequently, the occurrence of the myocard infarct as one of the most important causes of death in Germany is analysed in more detail.

Chapter 5 turns away from statistics and concentrates on the organisation of health care in Germany and on the functional principles of the health care

system. In this chapter, possible problems inherent in the system are depicted which have been (or will be) addressed by health reforms. Section 5.4. highlights some reform plans and enacted reforms within the German health system from the point of view of the interviewed public health experts. The experts analysed the possible effects of those reforms on active ageing and on older people. Chapter 5.4. deals with the much-debated subject of health care rationing in Germany.

Chapter 6 is the concluding section. It presents the main obstacles and chances for active ageing. This chapter again draws on the interviews.

## 2 Basic demographic characteristics of Germany

Germany is one of the fastest ageing countries in Europe. Today, persons below the age of 20 constitute 21 per cent of the German population, persons aged 20-59 years half of the population and persons aged 60 years and older 24 per cent. According to a prognosis of the Federal Statistical Office, in the year 2050 those relations will shift to 16 per cent, 47 per cent and 37 per cent, respectively (Table 1). The former age pyramid now resembles a pine-tree with a broad trunk, a very broad middle section and a narrowing upper section.

**Table 1: Age structure of German population**

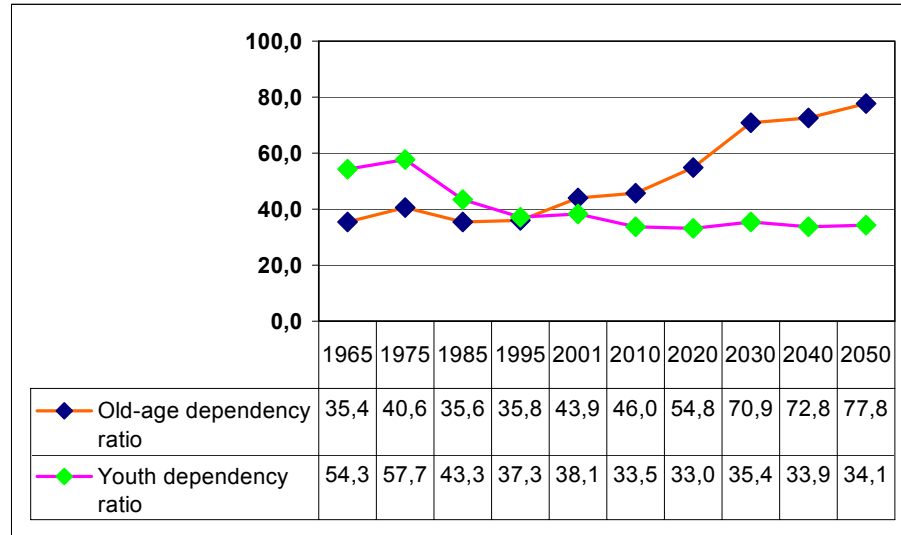
Year	Total (in million persons)	Proportion of persons... (in %)			
		< 20 years of age	20-59 years	60 years and older	
				Total (60+)	80+
1950	69.3	30.4	55.0	14.6	1.0
1970	78.1	30.0	50.1	19.9	2.0
1990	79.8	21.7	57.9	20.4	3.8
2001	82.4	20.9	55.0	24.1	3.9
2010	83.1	18.7	55.7	25.6	5.0
2030	81.2	17.1	48.5	34.4	7.3
2050	75.1	16.1	47.2	36.7	12.1

Source: Statistisches Bundesamt (2003: 31)

From 2010 on: prognosed data

An indicator of population ageing is the old-age dependency ratio. Now, two persons in working age can generate welfare for one older persons. In 45 years, ten younger persons will have to shoulder the “dependency burden” of eight older persons and of three minors (Figure 1).

**Figure 1: Old-age and youth dependency ratio in Germany, 1965-2050**



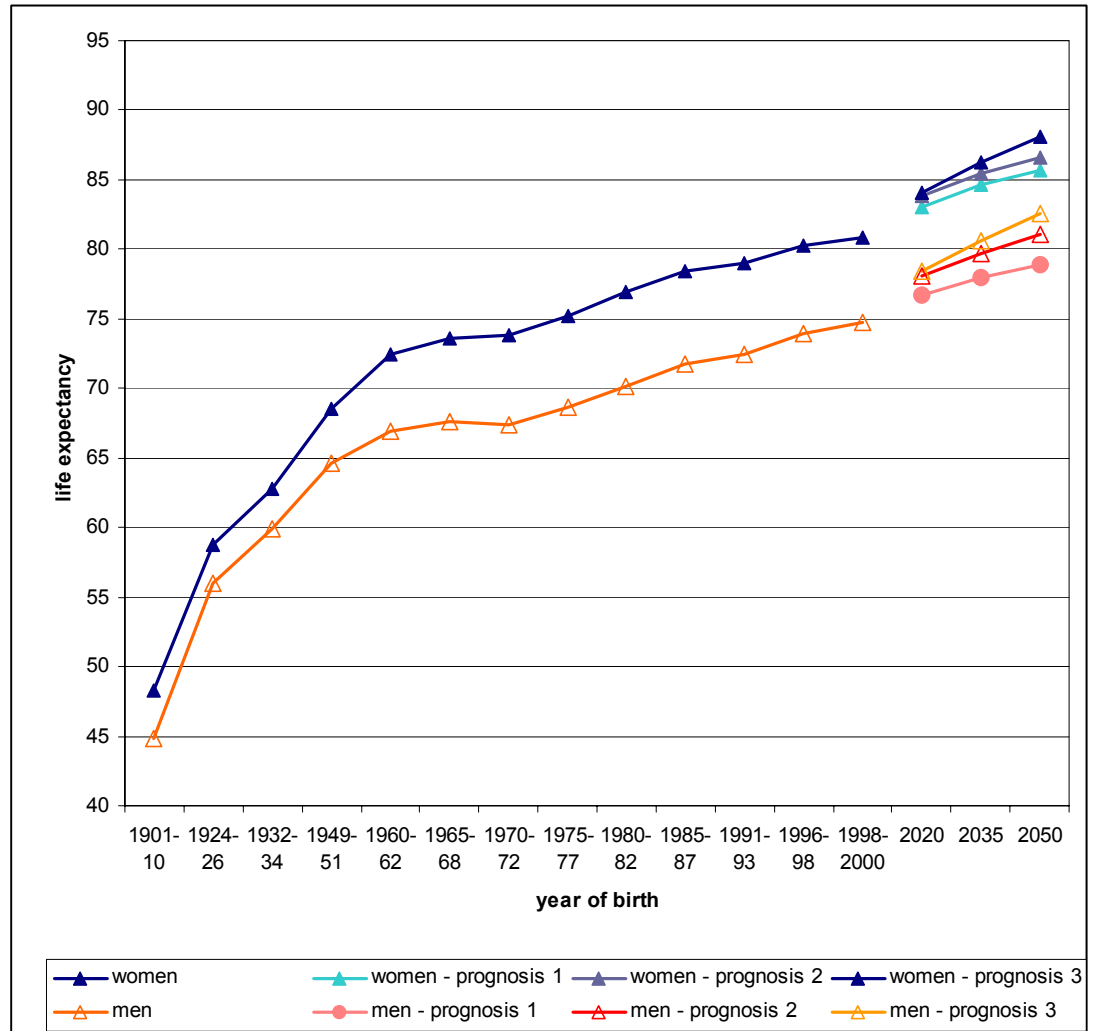
Source: Sommer (2003: 697), Statistisches Bundesamt (2002: 35)

From 2010, the data is based on a prognosis.

Whether the rising proportion of persons aged 60 years and older when compared to younger persons will really mean increased “dependency”, rests upon the development of the statutory and the factual retirement age. For the time being, it holds true, as Germans factually enter into retirement at the age of 60.

The life expectancy of the German population is forecasted to rise by 6.3 years for men and 5.8 years for women in comparison to the mean value for the years 1998-2000. According to the medium prognosis (prognosis 2, see Figure 2), by 2050, new-born women will have a life expectancy of 86.6 years, and men 81.1 years.

**Figure 2: Life expectancy at birth, 1901-2050**

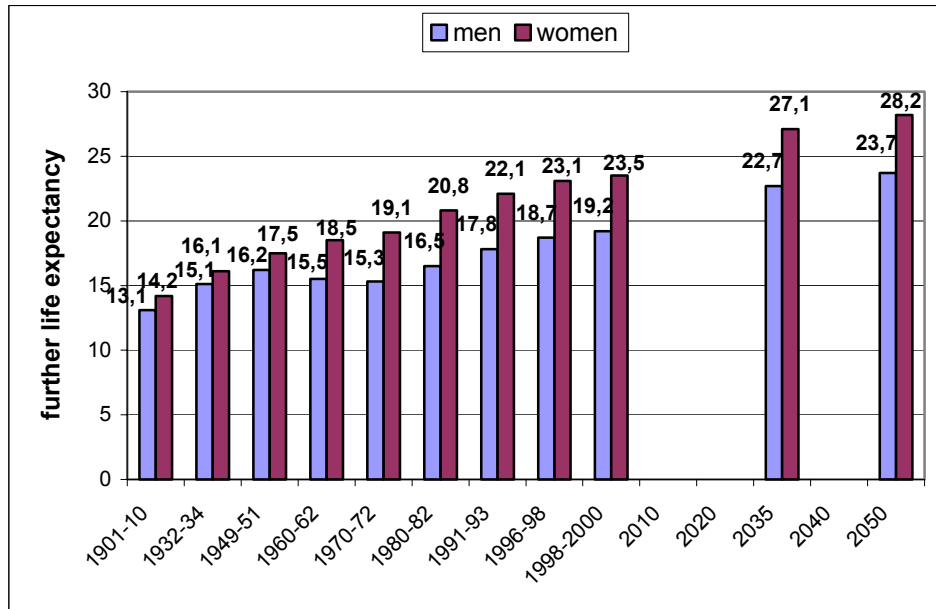


Source: Statistisches Bundesamt (2003: 15)

Till 1932-34: German Reich; till 1985-87: former Western Germany; from 2020 on: prognosed data

The further life expectancy at the age of 60 years will be 23.7 years for men and 28.2 years for women (Figure 3). This means a gain of ten years for men and 14 years for women when compared with further life expectancy in 1901-1910.

**Figure 3: Further life expectancy at the age of 60, 1901-2050**



Source: Statistisches Bundesamt (2003: 16)

Till 1932-34: German Reich; till 1980-82: former Western Germany; from 2035 on: prognosed data

In the context of longer life expectancy, the objective of active ageing policies is to ensure that people who have reached the age of 60 can live longer and be active at the same time – within their own boundaries. To that end, the concept of “healthy life expectancy” is crucial. According to Mayhew/Lee (2004), *“[i]f the gap between HLE [=healthy life expectancy] and general life expectancy (LE) is widening it means that more resources in an economy will be devoted to health and social care than would otherwise be the case. Thus it could be regarded as the antithesis of active ageing since a widening gap would provide an increasing and possibly insurmountable [barrier] to the extent that active ageing is founded on good health.”*

In Germany, males can expect currently 68.3 healthy years, and females 72.2 years. On average, men will spend further 6.8 years in ill health, and women 8.9 years (Mayhew/Lee 2004). Kruse et al. (2003: 27) points to the fact that “active life expectancy” in Germany has risen from the beginning of last century. In line with WHO, Kruse et al. understand “active life expectancy” as an “active lifestyle”, meaning that people carry out daily tasks and construct their everyday life independently. While cohorts born in 1917 had spent one fourth of their lives in inactivity (as measured at age of 67-70 years), male cohorts born ten years later had a balance of 7% more active years, and female cohorts of 4.4% more (Table 2). Due to the constant improvement of education, the quality of medical care and better material and social living and environmental conditions, Kruse et al. reckon with rising share of active years during a lifetime.



**Table 2: Years spent in inactivity by age and sex in former Western Germany**

Birth year cohort	1917	1922	1927
Age group	Years spend inactively as a percentage of all years in life		
MEN			
67-70 years	26,9%	23%	19,45
71-75 years	27%	23%	-
76-80 years	26,9%	23,1%	-
WOMEN			
67-70 years	27,6%	25,4%	23,2%
71-75 years	30,6%	28,8%	-
76-80 years	34,9%	-	-

Source: Kruse et al. 2003: 28, based on Unger (2002)

BmFSFJ (2001: 70) assesses that the gain in life years in the last decades is coupled with a gain in healthy life years. It cites the results of Dinkel's (1999) analysis of microcensus data on subjective well-being for the years 1978-1995. Dinkel states that the birth cohort born in 1919 was healthy for a longer time than birth cohorts of 1907 and 1913. Moreover, 65-70-year-olds surveyed in 1998 were more satisfied with their health condition than people the same age seven years earlier (EK 2002: 400). On basis of this data, BmFSFJ (2001: 70) reasons that risen life expectancy of the German population is, quite contrary to common knowledge, not coupled with a longer period of infirmity of older persons.

### 3 Health status of the population

The Ottawa Declaration of WHO defined in 1986 that "health" as a concept does not only imply the absence of illness but also a health-conscious behaviour, a positive frame of mind and an autonomous lifestyle (Kruse et al. 2002: 7). This definition includes also the ability to cope with drawbacks in life and to gain satisfaction from life even in the case of an illness.

In 2003, 88 per cent of persons aged 50-55 years were healthy and 12 per cent were ill or injured due to an accident. In subsequent age ranges, the proportion

of healthy persons decreases and reaches a low of 72% of healthy persons at the age of 75 years or more (Table 3).<sup>1</sup>

**Table 3: Health status of the population by age group, 1999 and 2003**

Health status (in %) / Age group	Healthy		Ill or injured due to an accident	
	1999	2003	1999	2003
<b>Total</b>	89.3	88.8	10.7	11.2
<b>&lt; 5 years</b>	93.4	93.5	6.6	6.5
<b>5 – below 10 years</b>	95.2	95.3	4.8	4.7
<b>10 – below 15 years</b>	96.6	96.4	3.4	3.6
<b>15 – below 20 years</b>	96.2	95.7	3.8	4.3
<b>20 – below 25 years</b>	93.8	93.7	6.2	6.3
<b>25 – below 30 years</b>	93.4	93.0	6.6	7.0
<b>30 – below 35 years</b>	92.7	92.6	7.3	7.4
<b>35 – below 40 years</b>	92.7	92.6	7.3	7.4
<b>40 – below 45 years</b>	92.0	91.8	8.0	8.2
<b>45 – below 50 years</b>	91.0	90.6	9.0	9.4
<b>50 – below 55 years</b>	88.8	88.3	11.2	11.7
<b>55 – below 60 years</b>	86.0	84.9	14.0	15.1
<b>60 – below 65 years</b>	85.3	85.4	14.7	14.6
<b>65 – below 70 years</b>	82.1	82.6	17.9	17.4
<b>70 – below 75 years</b>	78.9	78.0	21.1	22.0
<b>75+</b>	72.5	72.2	27.5	27.8

Source: Federal Statistical Office, Mikrozensus 2003 (www.gbe-bund.de)

Compared to the year 1999, the health status of the population deteriorated slightly: While in 1999, 88.9 per cent of women of all ages and 89.8 per cent of men were healthy, in 2003 the respective values fell to 88.3 per cent and 89.4 per cent (Federal Statistical Office, Mikrozensus 2003). As of 2003, in the age groups 50 – 54 years and 60 – 64 years, women had a better health condition than men. In the three older age groups, the relation reversed, although the differences were not very pronounced.

The self-assessment of health status generated other findings. Men and women of all ages felt “not as well/ bad” to a greater extent than was indicated by the presence of an illness or injury. The discrepancy between the felt and the actual health status was highest among older persons. With age, more people perceive their health condition as bad: Whereas on average, 19.7 per cent of

<sup>1</sup> The definition of “illness or injury” is based on the fact whether a person suffers from a chronic illness or from another illness which inhibits him/her in his/her usual daily activities.

women and 16.1 per cent of men had this perception, already one fourth of the 50-59-year-old felt “not as good or rather bad”. (Table 4). Still, two thirds of men and women at the age of 70-79 perceive their health status as “excellent” or “good”.

**Table 4: Self-assessment of health status by age and sex, 1998**

Self-ass. of health (in %) Age group	Women			Men		
	Excellent/ very good	Good	Not as good/ bad	Excellent/ very good	Good	Not as good/ bad
<b>Total (18-79 years)</b>	17.5	62.8	19.7	23.2	60.6	16.1
<b>18-29</b>	31.6	62.6	5.8	44.3	50.6	5.1
<b>30-39</b>	26.8	62.6	10.6	30.2	62.3	7.4
<b>40-49</b>	18.3	64.9	16.8	21.3	66.1	12.6
<b>50-59</b>	10.1	64.9	25.0	11.7	62.7	25.6
<b>60-69</b>	4.3	62.5	33.2	9.3	61.3	29.4
<b>70-79</b>	7.2	58.1	34.7	6.9	61.0	32.1

Source: Robert-Koch-Institut, Bundes-Gesundheitssurvey 1998 (www.gbe-bund.de)

These findings suggest that the objective assessment of health status does not grasp the concept of “quality of life”, which may be impaired by a chronic, albeit not yet perilous illness, by the lack of social contacts or activities which structure the daily life of younger persons, like gainful employment. The perceived health status is a predictor of the usage of medical services, of morbidity and of mortality. According to AOLG (2003: 112), persons of medium or high age who perceive their health status as bad, have a higher mortality risk. According to health policy experts, the question of “quality of life” is however not addressed by the German health care system (see section 6).

Another aspect of perceived health status is the “activity restriction due to physical or mental problems”. Physical and mental troubles can be seen as a first stage of illness and entail costs to the health care system and to individuals (AOLG 2003: 114). Not surprisingly, older persons experience greater difficulties in managing daily tasks due to physical problems (Table 5). Mental impairments which cause coping problems with daily tasks are, in contrast, not directly related to age. Already 13% of men in their twenties and thirties (but only 8% and 6% of women the same age) admit that they “could not work as thoroughly as usual”. There are also other differences between men and women which stick out. E.g., double as much 70-79-year-old men than women reported “I accomplished less than I had intended”. One possible explanation is the shorter life expectancy of men – men aged sixty can expect to live 19.2 more years (Figure 2). This, and the fact that physical and mental impairments accumulate at the end of life probably restricts older men more in their daily activities than older women of the same age.

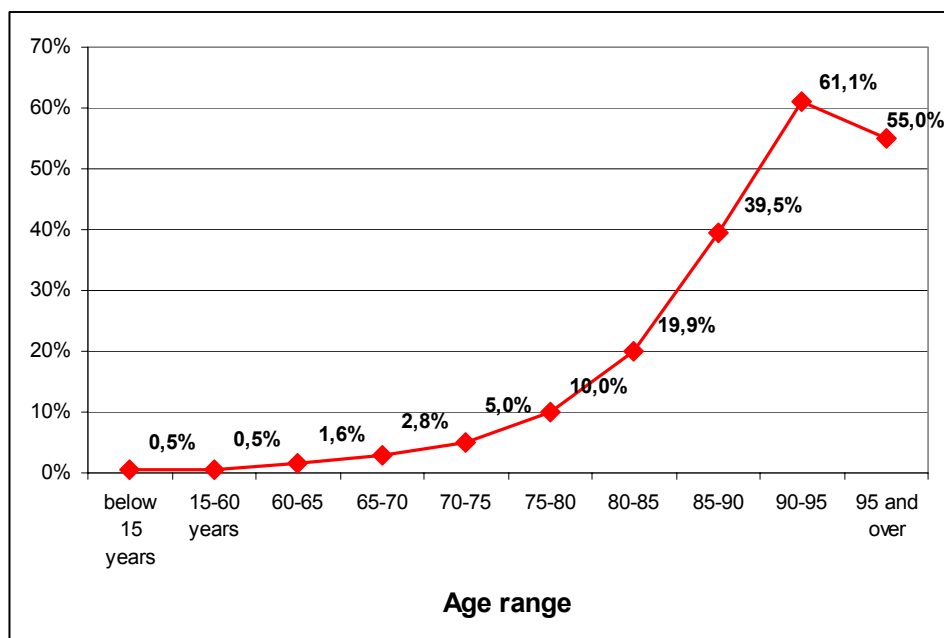
**Table 5: Assessed activity restriction in past 4 weeks due to physical or mental impairments, by age and sex, 1998**

Age group	WOMEN (in %)				MEN (in %)			
	Physical problems							
	I was not able to be active as long as usual	I accomplished less than I'd intended	I was able to do only certain things	I had difficulties with accomplishing what I wanted	I was not able to be active as long as usual	I accomplished less than I'd intended	I was able to do only certain things	I had difficulties with accomplishing what I wanted
<b>18-29 years</b>	9.8	12.5	7.3	11.0	8.1	9.8	5.9	8.5
<b>30-39</b>	12.8	19.6	10.9	13.8	6.1	9.3	4.8	6.9
<b>40-49</b>	14.6	24.2	14.7	17.5	9.6	14.0	9.9	12.6
<b>50-59</b>	24.0	33.0	22.2	25.2	18.8	22.6	16.5	21.7
<b>60-69</b>	27.1	31.5	23.8	23.8	22.7	25.7	21.5	24.0
<b>70-79</b>	37.2	42.3	38.2	33.9	31.5	32.5	30.7	31.4
<b>Total (18-79)</b>	19.6	26.0	18.1	19.8	13.6	16.7	12.3	15.1
	Mental problems							
	I was not able to be active as long as usual	I accomplished less than I'd intended	I was not able to work as thoroughly as usual	I was not able to be active as long as usual	I accomplished less than I'd intended	I was not able to work as thoroughly as usual		
<b>18-29 years</b>	4.8	11.8	13.7	2.9	7.7	8.1		
<b>30-39</b>	6.2	17.4	13.2	3.1	7.9	6.3		
<b>40-49</b>	9.6	18.9	11.5	6.2	10.1	8.1		
<b>50-59</b>	13.4	19.6	13.2	9.8	13.7	12.2		
<b>60-69</b>	10.0	14.7	10.3	10.7	12.4	8.3		
<b>70-79</b>	18.4	23.7	17.4	12.3	12.8	7.9		
<b>Total</b>	9.8	17.4	13.0	6.6	10.3	8.4		

Source: Robert-Koch-Institut, Bundes-Gesundheitssurvey 1998 ([www.gbe-bund.de](http://www.gbe-bund.de))

Another aspect of physical and mental ability is the degree of dependency on long-term care provided by relatives or in professional institutions, which rises with age. Among persons aged 15-60 years, the risk of becoming in need of care is 0.5%. In the age range 75-80 years, the risk rises to 10% (Figure 4). Of people aged 90 and more, more than the half are in need of care. Of those, 147,000 receive care in nursing homes, and 181,000 are cared for by relatives or out-patient nurses (Federal Statistical Office, Pflegestatistik 2001, [www.sozialpolitik-aktuell.de](http://www.sozialpolitik-aktuell.de)).

**Figure 4: Persons in need of care, 2001**  
(in % of persons in given age range)



Source: Federal Statistical Office, Pflegestatistik 2001; [www.sozialpolitik-aktuell.de](http://www.sozialpolitik-aktuell.de)

The health status of the German population is closely connected to retirement behaviour and to the take-up of pensions. Health impairments can evolve into a “partial” or “total” disability and thus necessitate a temporary or final exit from work.

In the years 1960-2002, the percentage of pensions drawn for reasons of disability or a severe handicap as a share of all pensions has decreased markedly. In 1960, disability pensions made up 2/3 of all pensions taken up by women and 60% of those taken up by men (Table 6). In 2002, entries into disability pensions and old-age pensions for the severely handicapped constituted about 20% of men’s pension entries by women and about 30% of women’s pension entries. One obvious reason for this decrease has been the introduction of more strict eligibility criteria. A characteristic development has been the rapid fall of entries into disability pensions by women starting from 1985. This was causally linked to a change in the qualifying conditions which blocked this pathway for women not currently employed (comp. Aleksandrowicz/Hinrichs 2004).

**Table 6: Take-up of disability pensions and old-age pensions for the severely handicapped as share of all pension entries in the years 1960-2002 (Western Germany)**

Year	MEN		WOMEN	
	Disability pensions	Old-age pensions for the severely handicapped	Disability pensions	Old-age pensions for the severely handicapped
1960	60,8%	-	66%	-
1965	48,7%	-	50,1%	-
1970	48,2%	-	45,4%	-
1975	36,9%	2,7%	46%	0
1980	49,4%	15,6%	50%	0,7%
1985	43,9%	12,2%	30,2%	1,1%
1990	36%	10,8%	17,2%	0,8%
1995	32,7%	8,1%	18,3%	2%
2000	24,2%	9,9%	14,8%	3,2%
2002	20,8%	10,5%	14,9%	4,2%

Source: VDR 2003: 55-56

Old-age pensions for the severely handicapped were introduced in 1973.

Chronic illnesses are the most frequent reason for the take-up of a disability pension within the Public Pension Insurance. According to Robert-Koch-Institut (1998, chapter 3.8), the core reason are diseases which are not directly life-threatening and which can be improved with rehabilitative measures. In 1995, 76% of all entries into disability pensions in Germany were necessitated by diseases of the musculoskeletal system and of the connective tissue, by diseases of the circulatory system, by mental disorders and neoplasms. The share of diseases of the circulatory system as a reason for the take-up of a disability pension has dropped between 1982 and 1995, while mental disorders have gained in importance (ibid).<sup>2</sup>

Blue-collar workers run a higher risk of becoming disabled (Robert-Koch-Institut). Disability pensioners have a shorter life expectancy at the age of 65 years. In 1986/1988, male disability pensioners that age had on average a further life expectancy 3 years shorter than that of old-age pensioners, and female disability pensioners – 2.3 years shorter. Robert-Koch-Institut (1998) perceives the long lasting exposure to burdens related to work and social status as a reason for that situation.

What could improve the health status of older people? Courbage (2004: 3) from the Geneva Association pointed to the importance of policies which aim to

<sup>2</sup> Not in all cases is factual disability the reason for pension entry. The pension reform of 2001 introduced the rule that people who are “partially disabled” but cannot find a part-time job on the official labour market, are entitled to a full disability pension. In times of high unemployment, the share of unemployment-related disability pension rises.

improve the labour market participation of older people: *“By being productive longer, elderly persons would stay integrated longer in society, a fundamental promoter of social cohesion and a factor known as primordial to stay in good health, and to limit future spending of our health systems”*. That way, policies which aim at achieving active ageing on the labour market, may also fulfil the objective of active ageing in the health sector, i.e. a longer healthy life expectancy. So far, the trend however goes in the opposite direction, towards lower exit ages (Aleksandrowicz/Hinrichs 2004). Reforms initiated by the Government center on the curtailment of early retirement incentives, which is however only one aspect of this trend. The questions of adequate working conditions, work environment and the different work ability of older blue- and white-collar workers remains to be addressed and solved by the enterprises themselves.

Another aspect related to health behaviour and thus, indirectly, to health status is the educational level of older persons. OECD data adjusted by DIW portrays a trend to higher educational attainment in younger age cohorts. While less than 19% of Germans aged 55-64 have completed tertiary education, in the age cohort 25-34 years, more than 22% have (ZEW et al. 2001: XI, XII). A fewer percentage of older persons than younger persons has also completed secondary level II education (implying a qualification for university entrance or completed vocational education): 76% versus 88%. A higher educational level is closely linked to the ability to make sensible decisions about how to live, what to eat and how to care for one’s health. This poses a chance for improved health behaviour in the next generation of older persons. Hilke Brockmann, a public health expert, arrived at a similar conclusion when analysing micro data of different age cohorts. The ability of the “young old” (as opposed to the “old old”) to explore new things, as well as their better educational level, enables them e.g. to search for the appropriate physician on the Internet and, in general, to invest into new coping-strategies (ActivAge interview, Dec. 2004).

## **4 The main risks to health**

### **4.1 Health behaviour**

An important factor for achieving a longer healthy life expectancy is health behaviour. Smoking, drinking and eating habits and free-time activities like sports play a crucial role. The German Medical Association (*Bundesärztekammer*) defined eight risk factors which may cause coronary heart disease, a stroke, osteoporosis or osteoarthritis. Those risk factors are hypertension, high cholesterol level, smoking, drinking alcohol, early shortage of

oestrogen/low bone density, diabetes mellitus, adipositas and low physical activity level (Kruse et al. 2002: 9).

Smoking prevalence is highest among teenagers, twens and persons in their thirties. 54% of male teens and 48% of female teens smoked as of 1998. Among men aged 60-69 and 70-79, only 18% and 16% smoked; for women this age, the smoking prevalence was 12% and 10%, respectively. The current state is not always a continuation of older persons' earlier habits: Two thirds of men in their fifties and sixties and 76% of men aged 70-79 years had smoked before. Among women of the same age, one third are former smokers (Table 7).

**Table 7: Smokers and persons who had never smoked by age and sex, 1998**

Age range	MEN (in %)		WOMEN (in %)	
	Smokers	Never smoked	Smokers	Never smoked
<b>Total (18-79 years)</b>	37.3	34.5	27.9	56.7
<b>18-19</b>	53.7	45.2	48.4	50.1
<b>20-29</b>	47.4		42.6	
<b>30-39</b>	49.1	32.8	41.0	38.9
<b>40-49</b>	40.1	31.5	30.9	45.5
<b>50-59</b>	31.1	34.4	19.7	63.0
<b>60-69</b>	18.3	33.2	12.0	76.3
<b>70-79</b>	16.3	23.5	10.0	79.4

Source: Robert-Koch-Institut, Bundes-Gesundheitssurvey 1998; www.gbe-bund.de

With regard to daily alcohol consumption, older persons are not more health-conscious than younger persons. If ever, an age pattern is visible in the case of women. Women aged 40-49 years consume the highest amount of beer, wine and spiritualys, while women aged 70-79 drink the lowest amount of beer and wine (Robert-Koch Institut 1998). In the case of men, persons in the age range 30-59 are the heaviest beer drinkers. They consume above 11 grams (= about 0.385 ounces) daily, which is however, according to Robert-Koch-Institut, heavily underreported and does not reflect factual drinking habits. Men aged 70-79 relish wine and consume 5.40 grams (= 0.189 ounces) of it daily, compared to the lowest amount of 2 grams (= 0.07 ounces) drunk by teens and twens.

Older persons are worse positioned with regard to the risk factors "low physical activity" and "overweight". With age, the propensity to physical exercises decreases. While only one third of female twens and one fourth of male twens abstain from physical exercise, already two thirds of the 70-79-year-olds do (Robert-Koch-Institut 1998). Moreover, 45% of persons aged 60 or more are overweight. Older men (60+) are more prone to be overweight – 50% of them have a Body-Mass-Index of 25-29,9, when compared to 35-42% of women the same age (Statistisches Bundesamt 2004). More older persons than younger ones are also affected by adipositas (Table 8). Thus, the risk of older persons to come down with diseases of the circulatory system or with diseases of the muscle-skeletal system is much higher.



**Table 8: Body-Mass-Index by age group, 2003**

Age range	BMI < 18.5 (underweight)	BMI = 18.5-24.9 (= normal weight)	BMI = 25-29.9 (= overweight)	BMI > 30 (= adipositas)
18-19 years	9.4	75.6	12.3	2.6
20-24	7.0	72.5	16.5	4.0
25-29	4.0	64.6	24.7	6.7
30-34	2.6	59.7	29.7	8.1
35-39	2.3	56.5	31.3	9.8
40-44	1.6	51.9	34.8	11.7
45-49	1.4	45.7	38.3	14.5
50-54	1.3	40.2	42.2	16.3
55-59	1.1	37.5	44.1	17.3
60-64	0.8	35.7	45.1	18.3
65-69	0.9	32.0	47.0	20.1
70-74	0.9	33.5	46.5	19.2
75+	2.8	45.1	40.1	12.0
total	2.3	48.4	36.3	12.9

Source: Statistisches Bundesamt 2004, Mikrozensus 2003

## 4.2 Mortality causes

Germany experiences “*slightly worse female mortality than the average*” (Mayhew/Lee 2004). The percentage of mortality due to external causes (industrial injury, road accidents) is lower than the average for all countries. This is due to “*moderately low rates of all different kinds of accident rather than one specific category such as road accidents*” (Mayhew/Lee 2004). Occurrence of deaths due to circulatory diseases is above the average, with standardised mortality ratios (SMR) for males and females of about 110. Mayhew/Lee (2004) point to the fact that “[c]irculatory diseases... [are] frequently attributed to life styles, including diet, levels of exercise, and tobacco consumption.” In the case of cancer, Germany has a below average SMR for men and a SMR slightly higher than the average for women. As a percentage of all causes of deaths, malignant neoplasm ranges in Germany slightly above the average for the 10 countries in the case of women and slightly below average in the case of men (Mayhew/Lee 2004).

Older persons are affected to a greater extent by diseases, especially by diseases of the circulatory system, of the metabolic system, of the muscle-skeletal system and by malignant neoplasm. Below, the overall tendencies in

mortality in Germany are delineated. Next, some disease patterns which affect older people will be presented. In the age groups 5-14 years, 15-24 years and 25-34 years, injuries and poisoning are the most common causes of death. They accounted for 50-75 per cent of all male deaths and 30-55 per cent of female deaths in 1995 (Federal Statistical Office, Todesursachenstatistik 1995, in Robert-Koch-Institut 1998). In the age range 35-44, malignant neoplasm, circulatory diseases and metabolic diseases gain in importance. In the age group 55-64, malignant neoplasm accounted for almost 50 per cent of female mortality and about 38 per cent of male mortality as of 1995.

Between 1980 and 2000, the average age of death due to most diseases has risen. Patients with circulatory diseases die on average at the age of 80 years, while 20 years ago, they died on average at the age of 76.6 years. Persons with diseases of the respiratory system also die on average 4.5 years later than in 1980 (Table 9). On the one hand, the increased average age of death is a sign of higher medical standards and, in the case of "infectious and parasitic diseases", improved vaccines. On the other hand, the risen average age of death from certain diseases could also imply that multimorbidity is increasing. The latter assumption is however contradicted by findings from the Microcensus and from the German Socio-Economic Panel, which show that in the last decades, the share of life years spent in activity and the subjective well-being has risen (comp. chapter 2).

**Table 9: Average age of death by disease, 1980-2000**

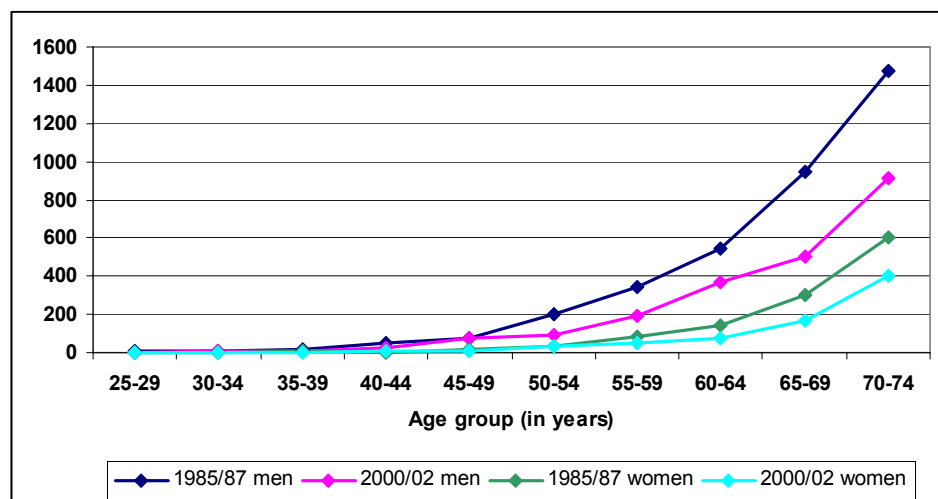
DISEASE (ICD-9)	1980	1985	1990	1995	2000
All diseases	71.8	73.3	74.0	74.6	75.5
Infectious and parasitic diseases (001-139)	62.6	66.9	65.4	64.0	71.2
Neoplasms (140-239)	69.6	70.3	70.7	71.1	71.5
Endocrine, nutritional, and metabolic diseases and immunity disorders (240-279)	72.6	73.7	75.0	76.5	77.7
Disorders of the blood and blood-forming organs (280-289)	70.9	72.3	73.7	74.9	75.1
Mental disorders (290-319)	58.5	60.6	61.0	62.7	61.4
Diseases of the nervous system and sense organs (320-389) (in 2000, only "diseases of the nervous system")	60.0	64.1	69.4	72.0	73.7
Diseases of the circulatory system (390-459)	76.6	77.7	78.6	79.3	80.3
Diseases of the respiratory system (460-519)	74.6	76.7	77.8	78.3	79.1
Diseases of the digestive system (520-579)	67.7	69.4	69.5	69.5	70.7
Diseases of the genitourinary system (580-629)	74.3	75.5	76.5	78.4	79.7
Diseases of the skin and subcutaneous tissue (680-709)	71.5	75.3	77.0	78.7	78.8
Diseases of the musculoskeletal system and connective tissue (710-739)	74.0	74.0	76.7	77.0	75.6
Symptoms, signs and ill-defined conditions (780-799)	70.3	69.9	68.2	70.4	70.9
Injury and poisoning (800-999)	52.2	54.6	56.3	56.0	57.4

Source: Federal Statistical Office, Todesursachenstatistik; [www.gbe-bund.de](http://www.gbe-bund.de)

Only such illnesses are listed which affect people aged 50 or more years.

On the example of the myocard infarct, the development of the mortality of men and women at two points in time can be shown. The disease accounted for 9 per cent of male deaths and 8.6 per cent of female deaths as of 2002 and thus is the 2<sup>nd</sup>, resp. the 3<sup>rd</sup> most important cause of death (Federal Statistical Office, [www.destatis.de/basis/d/gesu/gesutab20.php](http://www.destatis.de/basis/d/gesu/gesutab20.php)). Mortality and morbidity due to heart attack has fallen between 1985/87 and 2000/02 for men and women alike (Figure 5). An exception are younger age groups. Also, the mortality and morbidity due to heart attack for women is much lower than for men. While in 2000/02, the mortality ratio for men due to heart attack in the age group 60-64 years was 368 per 100,000 of population, for women it was only 80 per 100,000 persons.

**Figure 5: Mortality due to heart attack by age and sex (rates per 100,000)**



Source: KORA Herzinfarktregister Augsburg des GSF-Forschungszentrums für Umwelt und Gesundheit; [www.gbe-bund.de](http://www.gbe-bund.de)

The data refers to Augsburg which was chosen as a showcase.

The myocard infarct and other diseases of the circulatory system affect the elderly much more than younger persons. They accounted in 1995 for more than one fourth of deaths in the age range 55-64 and more than half of deaths of 75-year-olds and older persons (Robert-Koch-Institut 1998). The standard mortality ratios were higher in Eastern than in Western Germany but they are also sinking more rapidly in the newly-formed German states (ibid).

## 5 Health care provision

### 5.1 Players on the health policy arena<sup>3</sup>

Health policy in Germany takes place in the fields of in-patient care, out-patient care, rehabilitation, long-term care, and health promotion (including occupational safety and health). The federation is responsible for the legislation in those areas, while the federal states participate in the legislative process through their veto power in the Bundesrat – the first chamber of the German Parliament – and are responsible for the administration of health care institutions. The main player at the federal level is the Ministry of Health and Social Security.

The Public Health Insurance is the core institution of the German health care system. Almost 90 per cent of the population are insured in public health insurance funds (*Krankenkassen*). Those are divided along regional, occupational and firm criteria. After the introduction of free choice of health care funds, those divisions have lost in importance (Robert-Koch-Institut 1998). Public health insurance funds are public bodies with a self-government organ consisting of representatives of the insured and of employers. The contribution to the public health care funds is financed in equal parts by employees and employers.<sup>4</sup> The contribution rate ranges between 12.9 and 14.7 per cent of gross income up to a certain ceiling. Persons which earn above that threshold can opt out of the public health insurance fund and join a private fund. In private insurance funds, the premium is calculated on the basis of such criteria as age, sex and previous illnesses.

The interrelations between public health insurance funds and the suppliers of health services in in-patient and out-patient care are regulated in Social Law Book V. As an element of the corporatist character of German health care, professional associations are involved in the provision of medical service. In in-patient care, the health insurance funds, patients, general practitioners (GPs) and dentists, Associations of CHI (compulsory health insurance) Physicians and Associations of CHI Dentists are intertwined in a complex “web of contractual relationships” (Sauerland 2002: 345-346). The Associations of CHI Physicians and of CHI Dentists (*Kassenärztliche* and *Kassenzahnärztliche Vereinigungen*) are obliged, together with health-care funds, to guarantee the supply of

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<sup>3</sup> This section draws predominantly on Robert-Koch-Institut (1998) and Sauerland (2002).

<sup>4</sup> Starting in 2007, insurance of certain treatments, e.g. of dental prostheses, will be paid by the employees alone.

physicians in whole Germany. They also function as interest representations of physicians and dentists.

The network of connections in out-patient care is, according to Sauerland (2002: 346), less complex, due to the missing intermediary between hospitals and health insurance funds on the one hand and the patients on the other hand. Out-patient care is regulated on federal state level. In the process of drafting “hospital plans”, hospitals are represented on regional level by Hospital Associations. Here, however (differently than in the case of in-patient care), the federal states are obliged to guarantee the appropriate number of hospitals.

Health clinics and rehabilitative facilities provide rehabilitative and preventive services in the forefront or after a hospital treatment. The financial responsibility for rehabilitative measures is borne by the carriers of public accident insurance (*Berufsgenossenschaften*) in cases of accidents which occurred at work, by the public health insurance funds in the case of pensioners, and by the public pension insurance carriers in other cases, in order to prevent early retirement. Out-patient care is provided by general practitioners (GPs) and dentists.

Health protection is provided by regional health authorities (*Gesundheitsämter*), by the labour inspectorate (*Gewerbeaufsicht*), by carriers of accident insurance and by health insurance funds commissioned by firms to carry out health management measures (see Aleksandrowicz/Hinrichs 2004 for examples).

Other important players in the health policy network in Germany are welfare agencies. The six umbrella organisations Arbeiterwohlfahrt, Zentralwohlfahrtsstelle der Juden in Deutschland, Diakonie, Caritas, Paritätischer Wohlfahrtsverband and Deutsches Rotes Kreuz are, a.o. functions, carriers of nursing homes and in-patient nursing care. As another actor on the health policy arena, the Expert Council for the Assessment of the Development of Health Care (*Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen*) was appointed – under a different name - in 1985 by the Ministry for Health and Social Affairs. The council analyses the development of health care, their medical and economic effects and develops proposals how to solve the problem of supply shortages and excess supply. Up to date, the Council issued 13 expertises.

## **5.2 Functional principles of the German health care system**

One of the functional principles of the German health care system is the division between in-patient and out-patient care. Another principle is the institutional separation between statutory health care insurance and long-term care

insurance<sup>5</sup>. The separation does not exist in organisational terms, as both sectors of the German health system are administered by the same carriers.

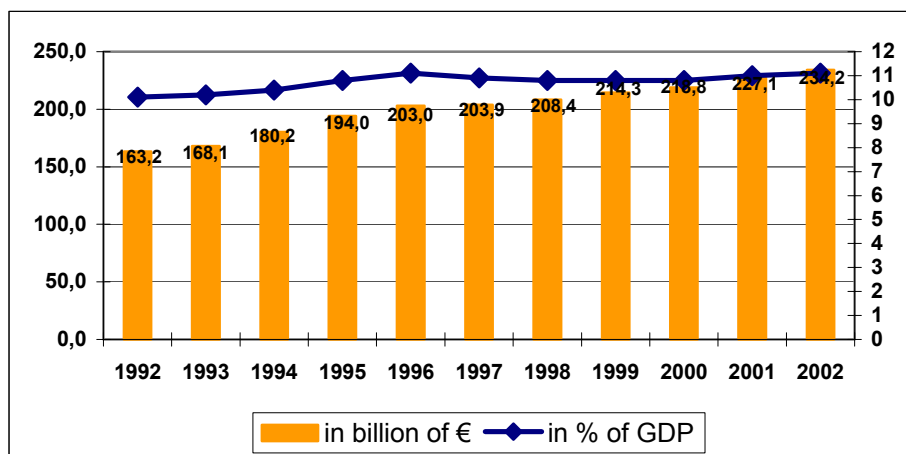
Those two functional principles of the German health care system are regarded by experts as possible sources of problems. The expert commission “Demographic Change”, which issued several expertises between 1994 and 2002, regarded the strict division between in-patient and out-patient care as “structural deficit” which impairs the financial transparency and the flow of information between those two sectors (EK 2002: 406-407). As a result, GPs and physicians working at hospitals use different treatment with regard to the same patient. Moreover, the lack of cooperation between both categories of physicians is made responsible for a slower spread of newest medical knowledge to each doctor’s surgery. GPs also seldom participate in further vocational qualification. Following Lauterbach (2001), the expert commission (EK 2002: 407) assesses that “[u]p to date, health care in Germany is characterised by high variance with regard to therapy, a fragmented care, concentration on acute care and insufficient transparency of the quality of care, accompanied by a high input of financial resources.”

The spending on health care in Germany has steadily risen between 1992 and 2002. This is true both in absolute and in relative terms. In 1992, 163.2 billion € were spent on health care, and ten years later, the spent sum amounted to 234.2 billion €. The percentage of GDP spent on health care rose by 1 per cent, from 10.1 per cent to 11.1 per cent (Figure 6). The expert commission “Demographic change” pointed out that Germany occupies the third position with regard to health spending as a percentage of GDP (EK 2002: 395). At the same time, the quality of health care places Germany only in the “higher medium range” (SVR 2001: 20). According to experts, the same is true with regard to survival ratios for the common chronic illnesses like diabetes mellitus, breast cancer, myocard infarct, stroke and cancer of the intestine (EK 2002: 396).

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<sup>5</sup> Statutory long-term care insurance was introduced in 1994 and is regulated in Social Law Book XI. From 2005, due to rising pressure on funding, child-less persons have to pay a higher contribution amounting to 0.25% on top of the regular 1.7% of gross earnings.

**Figure 6: Spending on health care in Germany, 1992-2002**



Source: Federal Statistical office, Statistisches Jahrbuch 2004, [www.sozialpolitik-aktuell.de](http://www.sozialpolitik-aktuell.de)

The decimals are preceded in Continental manner with a comma and not a full stop.

The members of the expert commission argued that structural and treatment deficits of the German health care system become most evident in the case of chronically ill persons. The German health care system concentrates too much on acute treatment (EK 2002: 407), to the detriment of prevention. According to members of the Expert Council for the Assessment of Development of Health Care, the division between in-patient and out-patient health care generates double costs, problems with coordinating medical treatment and problems of quality control (SVR 2003: 84).

As a solution to the “structural deficit”, the concept of “integrated health care” was introduced within the Public Health Insurance. This concept aims at coordinating treatment provided by in-patient and out-patient care facilities and the provision of drugs and medical appliances. Patients can participate in model projects in integrated care offered by their respective health funds. An example is the cooperation between the GP, the specialist, the hospital and the rehabilitative facility on the treatment of a patient with a heart surgery ([www.barmer.de](http://www.barmer.de)).

In political discourse, the division between health care and long-term care insurance was criticised. In summer 2003, there were several proposals how to reform the long-term care insurance which was regarded as pressing due to growing numbers of older persons in need of care. One proposal was to merge both insurances. This proposal was criticised as health care insurance provides comprehensive cover, and long-term care insurance grants only limited cover (see e.g. *Handelsblatt*, August 8<sup>th</sup>, 2003: “Pläne zur Pflege stoßen auf Ablehnung”). Lastly, the problem of rising costs approaching long-term care insurance was solved by imposing a higher premium on childless persons.

### 5.3 Health care reforms, reform plans and their effects on older people and active ageing

Within the ActivAge project, four health policy experts were interviewed in November-December 2004. They voiced opinions on the effectiveness of latest or planned health care reforms and on the assessed effects upon older persons and the process of active ageing. According to Bernard Braun, a public health scholar at the Centre for Social Policy Research in Bremen, the reforms focus too much on the curtailment of expenditure and on the reduction of the premium. As a result, the quality of the service is neglected. Although the Law on the Modernisation of the Public Health Care Insurance (GMG) of 2003 included impulses for the improvement of health care, e.g. the focus on prevention, Braun believes that actual implementation is contingent on the budgetary position: *"... [I]t is clear for everyone that in the health care system, the main focus is on health and not on money, but every time,... [t]here was something fantastic in it [=in the law], but the main thing was about stabilising the contribution rate".*

An expert from a public health insurance fund also criticised the overt focus on costs and revenues in the German health care system while neglecting the expenses. According to the expert, in-patient health care generates one third of all expenses of his company. He thinks that those services could be made cheaper and better at the same time, if thoroughly analysed. Analogously, Hilke Brockmann from the University of Bremen sees "the control of costs" as the guiding principle in the current health policy debate in Germany. Prevention and quality assurance are, in her opinion, second order goals. Active ageing is not a goal at all in German health policy. If ever, Brockmann concluded, active ageing is interesting for the health system and the German welfare state in general as a means to cut costs – eg. by increasing the retirement age.

Recently, a draft of a "prevention law" has been presented by the Government. According to the planned law, 250 million € per year shall be provided by social insurance carriers (pension insurance, accident insurance, health insurance and long-term care insurance; the unemployment insurance backed off from this plan) for preventive measures. The money shall be used for the prevention of illnesses, the propagation of a healthy way of living (with the help of dietary courses, quit-smoking campaigns, training on back exercises...). One of the envisaged goals is to bring back older persons their mobility and thus save costs for early retirement and work incapacity pensions (*taz*, February 2<sup>nd</sup>, 2005, article by Ulrike Winkelmann). The innovative character of the bill lies in the realisation that prevention is a task for the whole society and not a task that should be shouldered by the health care insurance carriers alone. The "setting approach" is another novelty, whereby target groups shall be addressed at their respective environments, e.g. at school, in their neighbourhood. The interviewed representative of a health fund thinks that this approach is not



sufficiently put into practice as of today. He regards it as important that pupils in socially underprivileged neighbourhoods are informed about healthy food so that they can spread the knowledge to their parents.

In line with the opinion of the health fund representative, Rolf Rosenbrock from the Expert Council for the Assessment of the Development of Health Care views the bridging of social inequalities which have an impact on health as one of the functions of the planned law. He pointed to the statistical insight that persons which belong to the „upper fifth part“ of the population (with regard to educational status, occupational status and income), have a life expectancy which is seven years longer than that of persons who belong to the „lower fifth part“ (*Ärzte-Zeitung*, Nov. 22<sup>nd</sup>, 2004, article by Christiane Badenberg). Besides of persons with a low social status, the unemployed, pupils and migrants are regarded as target groups for prevention and information campaigns. Rosenbrock however criticises that the containment of social inequalities plays only a marginal role in the bill on prevention (*Ärzte-Zeitung*, Nov. 10<sup>th</sup>, 2004).

Gerd Glaeske, professor at the Centre of Social Policy Research (ZeS) in Bremen argues in line with the previously mentioned experts: *“I have to change the circumstances around the persons, shall he change his behaviour as well”*. As important circumstances, he regards working and living conditions, mobility, road safety, new forms of housing (eg. intergenerational living), and shopping conditions. According to Glaeske, many health measures address only the “middle strata”, to the detriment of socially underprivileged persons, who are often poor women. The task to change the circumstances around those people cannot be accomplished by health funds alone, he added, as it is a societal task.

Health is for Glaeske closely related to educational status. *“Educational options and health options are in my opinion closely interrelated... In this respect, we [= the Germans] are disadvantaged in a twofold manner [due to the bad results in the Pisa test]. To a certain extent, we have bad health chances closely linked to social status, and educational chances equally dependent on social status. Due to the concurrence of both circumstances, a big barrier towards good health emerges.”*

What effects will the passed reform measures have on older persons? For Bernard Braun, negative effects outweigh positive ones. He holds that the GMG will impair the living conditions of older persons as they are the main users of health services and will be forced to lay out a rising amount of money on them. Due to increased health expenses, older persons will have less disposable income they can spend on self-dependent activities which improve active ageing – travelling, membership in associations and others. Braun is also skeptical about the use of the Prevention Law for older people. He noticed that the prevention debate focuses on younger people. He regrets that the idea to direct prevention at the 50-year-olds in order to contain the incidence of e.g.

dementia at the age of 70 and 80 years, has not yet gained popularity. Furthermore, Braun sees potential problems in the implementation of the Prevention Law as he fears that the “*central theme of the German health system, the question of financing*” will overshadow all endeavours to bring the law into life. The small chances of success he associates with the prevention law result also from the low incentives for health funds to invest in preventive measures. He fears that the expected benefits from preventive measures which only become visible in the long run, will be outweighed by the threat that younger members of the health funds will make use of the exit option.

“Integrated care” (see chapter 5.2. for explanation) is a measure which Bernard Brauen, in turn, views as positive for older persons. He gave an example of patients with hip replacements. Usually, patients are released from the hospital after surgery but there are no provisions taken to prevent accidents at home. Often it happens that the hip prosthesis is fractured on the first visit to the washroom and has to be replaced. Due to integrated care, it will be possible for health funds to contract services with all providers. That way, it will be possible to coordinate the release from the hospital with the reconstruction of the flat so as to make it accessible for persons with impaired mobility.

Gerd Glaeske sees more positive aspects in the recent health care reform. The levying of a “surgery fee” (*Praxisgebühr*) on each visit to the doctor’s will, on the one hand, reduce the function of the health care system to the provision of health services. Older people often visit the doctor’s in order to have social contact, Glaeske explained. Moreover, “*as soon as I have contacted the medicine, the medicine has started to fiddle about me*” and the patient is prescribed unnecessary drugs and undergoes unnecessary treatment. On the other hand, Glaeske added, the surgery fee bears the risk of overburdening older persons. This contradicts the principle of solidary redistribution which is the foundation of social insurance.

The interviewed press officer from the health fund pointed to the expected gains from the “Morbi-RSA” planned for 2007. “Morbi-RSA” is a mechanism which will balance the costs between all public health funds and thus favour those health funds which have more older and ill members than others and thus have to bear higher costs. Currently, only age and gender are regarded in this balance of costs, but the health status is ignored. Due to Morbi-RSA, the expert said, health funds will be able to concentrate on their core clientele – ill persons and chronically ill persons – and will not have to concern themselves with attracting young, healthy members.

## 5.4 Discussion on health care rationing in Germany

After the postulation of a junior politician in summer 2003 not to finance hip joint prostheses for older patients, a controversy on the pros and cons of health care rationing ensued. The politician in question said, *"I don't think it's fair if 85-year-olds receive hip replacements at the cost of all insured"* (taz, August 8<sup>th</sup>, 2003). He argued that in former times, older patients used to go on crutches. A lively debate ensued, long enough to feel the summer slump. How much truth is in the then awakened fear of older people that they might receive worse medical treatment than they need?

The German Society for Geriatrics informed on a conference in autumn 2003 that health care rationing is not a fear of the future but is already taking place in some sectors of the health care system. E.g. some GPs abstain from medicinal treatment of dementia patients, although this could spare nursing care. Geriatric doctors often experience that drugs prescribed by them are later abandoned by GPs due to high costs. Another observation reported by taz (Nov. 11<sup>th</sup>, 2003) is that older patients are put on a waiting list when they want a first contact to a GP, while younger patients are admitted without this procedure. A disturbing effect of that practice is that older women are diagnosed with breast cancer much later than younger women.

A study on health-care rationing in hospital care was conducted by Hilke Brockmann from the University of Bremen in 2002 during her occupational activity at the Max Planck Institute for Demographic Research. As a starting point, Brockmann challenged the common knowledge that older persons generate higher costs. With her research, she proved that the last few years before death produce high costs and that health services for older persons are often rationed. Analysing data from the biggest public health insurance fund in Germany, Brockmann found out important differences between the treatment of deceased and surviving patients and between men and women. One finding was that hospital expenses for deceased patients are falling with age starting from the age of 60. In contrast, expenses for surviving patients are rising between the age of 50-70 years in the case of men, resp. 50-80 years in the case of women and sink afterwards until reaching a stable level at the age of 95 years (Brockmann 2002: 605-606). In the case of oldest old patients, expenses for surviving and deceased patients become more equal with age. To rule out the possibility that the falling expenses have to do with the respective disease the patients suffer from, Brockmann controlled for the type of diseases, but the effect remained the same: *"[O]lder patients generally receive less costly treatment than younger patients who suffer from the same disease. This age-discriminating pattern is particularly evident for surviving patients and non-surviving women"* (Brockmann 2002: 601).

What are the implications of those results? In an interview given for the weekly *Parlament* (Nov. 22<sup>nd</sup>, 2004: 16, interview carried out by Ulrike Baureithel), Brockmann pointed to the importance to carry out a similar analysis with the help of time series data: *“If it would crop up that chronologic age has little to do with health expenses, then the discussion on demographic ageing would lose much of its dramatic air.”* In the ActivAge interview, the social scientist specified that social norms on age, the low willingness of family members to care for an older patient and the central character of the age and gender category in a medical history are possible sources of ageism and health care rationing. She regards the common association of “old age” with “frailty” as the decisive argument doctors resort to when they forbear an invasive treatment with regard to an older patient. Brockmann contradicts this argument: *“My thesis would be... that chronologic age is a very weak indicator... of physical constitution. Some people might well be “past it” at the age of 80 but others might not.”*

Gerd Glaeske from ZeS appraises those findings and Brockmann’s conclusions critically. Reducing the extent of invasive treatment with regard to older patients is not a matter of rationing, he argues, but a matter of appropriateness, a matter of *“[w]hat is still appropriate with regard to the given age and diagnosis.”* He misses this point of view in the German discussion on health policy. On the one hand, the question of appropriateness of a given treatment helps to preserve the dignity of the older person, Glaeske explicated. On the other hand, it helps to cut costs. The second aspect dominates the discussion in the U.K., Glaeske reminded, but in his eyes, it is of no importance in Germany at date, as there are still enough monetary resources in the German health care system.

## **6 Barriers and opportunities to active ageing connected to the health system in Germany**

The experts named barriers and opportunities to active ageing which can be grouped in the following categories: medical, economic, institutional, cultural, biological and political.

*Barriers related to the medical profession:* These were strongly emphasised by Gerd Glaeske. He recognised several functional principles in the German health care which endanger active ageing. One of those barriers is the “medical appropriation” or “medicalisation” of the old age. Older people are prescribed drugs which reduce their activity and make them more compliant. At the basis of this practice, the belief lies that old age in itself is a permanent status of illness. Another failure Glaeske finds with the medical profession is the lack of geriatric know-how. He sees this deficit as a reason why “age-deviant” behaviour is immediately perceived as symptomatic of an illness.

Another medical barrier was named by Bernard Braun. He regrets that “quality of life” is not a goal within the German health care system. Services regarded as “essential” from the medical point of view are defined very narrowly, he argues. This results in the rejection of services to older and chronically ill patients which are not necessary for their survival but which would improve their quality of life and enable them to live independently. As an example, Braun named the low standard of pain therapy in Germany.

A *biological barrier* to active ageing can be seen in the lower-than-average position of Germany with regard to life expectancy and life years lost<sup>6</sup> when compared with other EU and OECD countries (EK 2002: 395-396). At the same time, the average life expectancy within Germany for cohorts born in the last one hundred years has risen (comp. [Figure 2](#)), as well as the proportion of active years ([Table 2](#)). This side of demographic change can be therefore seen as a clear *biological chance* for active ageing. In political and media debate, however, the rising share of older persons is always depicted as a negative development. Hilke Brockmann thus argues: Demographic change implies, first and foremost, that people stay healthy for a longer time, and not that multimorbidity rises.

*Political barriers:* Bernard Braun pointed to one-sidedness of the political debate which overly emphasises performance and effectiveness. This sticks out in the discussion on reforms to the social security systems, where “old age dependency ratio” and “financing problems” are frequent catchwords. This results in a disregard of old age-specific qualities. In contrast to France, Spain and Sweden, the public health scholar recognises in Germany a specific “militant attitude” towards older persons, argues Braun.

Hilke Brockmann spoke about the *economic barriers* to active ageing which channel action not only in the health system, but also on the labour market. The current cyclical downturn leads to the perception of old age as an “expenditure trap”. This perception could be reversed if older persons would make a higher contribution to the financing of health systems, argues Brockmann. This, in turn, would constitute an *economic chance* for active ageing. In contrast, Bernard Braun perceives the “surgery fee” (chapter 5.3) which already now affects older people disproportionately as an *economic barrier* to active ageing. Due to increased health expenses, older people will lack money for self-dependent activities which lay outside the sphere of health and illness, he argues.

The experts associate the chances for active ageing with the succession of generations and with related *cultural changes*. The press officer from a health fund holds that the cohort of the 60-70-year-olds is much more interested in active life, of which a health way of living is an integral part, than older cohorts.

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<sup>6</sup> The OECD definition counts as “life years lost” all life years of persons who died before completing their 70<sup>th</sup> year (EK 2002: 395).

They have the material resources and the will to travel, to participate in political life and to take responsibility for themselves. The health expert observes also a tendency to claim better services in long-term care. On the long run, this will lead to a higher degree of professionalisation in long-term care but will also make higher demands on individual participation in the financing of those services, he believes. Also the improved educational attainment of younger age cohorts poses a chance that the next generation of older people will have better understanding how to live healthy (chapter 3). Gerd Glaeske stressed the importance of education for identifying and implementing “health options”.

Expert commissions hold that an *institutional barrier* is the separation between in-patient and out-patient care (chapter 5.2). This division is not only made responsible for high costs, but also for deficient quality of care, especially with regard to chronically ill persons. However, an *opportunity* to reverse this situation has already arisen in the form of “integrated care” set into practice in some public health insurance funds (chapter 5.2).

Gerd Glaeske perceives *institutional opportunities* for active ageing. He notices a trend to open up platforms where the elderly can interact with younger persons or lead a more independent life. He perceives a rising demand for new forms of housing, following the model of a generationally-mixed households other than the traditional family. The scholar sees however deficits in other spheres, e.g. no age-specific options for participation in the field of sports.

Expert commissions have for a long time stressed the importance of preventive measures for a longer, healthy life (see e.g. EK 2002: 405, SVR 2001: 25ff). In this respect, the planned prevention law will enhance the *opportunities* for active ageing. The Federal Ministry for Health and Social Affairs stresses on its website the importance of prevention in old age<sup>7</sup> and has commissioned the Federal Association for Health with an expertise on the means to recover lost mental and physical capacities in old age. The association recommends rehabilitative measures and “activating care” to achieve this goal. Bernard Braun, however, holds that prevention measures focus on the middle-aged generation instead of taking into account the young old as well (chapter 5.3).

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<sup>7</sup> <http://www.bmgs.bund.de/deu/gra/themen/praevention/altern/index.php>.

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#### Internet Resources

[www.gbe-bund.de](http://www.gbe-bund.de) (Federal Health Reporting)

[www.sozialpolitik-aktuell.de](http://www.sozialpolitik-aktuell.de) (information on social policy fields)

[www.destatis.de](http://www.destatis.de) (Federal Statistical Office)

[www.bmgs.bund.de](http://www.bmgs.bund.de) (Federal Ministry for Health and Social Affairs)

[www.bmfsfj.de](http://www.bmfsfj.de) (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth)

#### Expert Interviews:

Dr. Bernard Braun, Centre for Social Policy Research, University of Bremen



Prof. Dr. Hilke Brockmann, Graduate School of the Social Sciences, University of Bremen

Prof. Dr. Gerd Glaeske, Centre for Social Policy Research, University of Bremen

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