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OBJECTIVE TRENDS AND PERCEPTIONS OF HEALTH STATUS IN GERMANY

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ENEPRI Research Report No. 21/August 2006

Christina Felfe*

Abstract

This paper identifies previous trends and future prospects surrounding the health status of the population and the utilisation of health care services, based on data from the German Socio-Economic Panel (1984-2004). Health status and the demand for health care services is examined in conjunction with the following variables: health satisfaction; the degree to which health status hinders the fulfilment of daily life activities; disability and chronic illnesses; and the probability, frequency and duration of hospital stays. The first part of the paper describes the main trends associated with these indicators. Then a further analysis is undertaken with regard to the determinants of health status. For this latter purpose, a sample of about 21,000 persons (aged 16 and older) has been used. The determinants are assessed against two measures of health status: a subjective measure, which is self-reported satisfaction with health, and an objective measure, which is the degree of being hindered by health in daily life activities. An interesting question explored alongside the findings is whether health care expenditures have increased because the overall health of the population has worsened or because expectations have risen.

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1. Introduction

A generous social system is common to all welfare states. Generally they offer a statutory health-insurance system that covers the expenses of medical and dental treatment, pharmaceuticals, hospital visits (inpatient and outpatient) and many other cures, treatments and preventative measures. The down side of these generous health systems is the rising expenditures associated with them. In most industrialised countries, expenditures on health and health care systems have risen tremendously. Conditional on little economic growth, the percentage of health care expenditure as a share of GDP rose from 7.8% in 1997 to 8.5% in 2002.¹

This increase in expenditures stems from, among other reasons, population ageing, rapid advances in medical technology and rising public expectations. In spite of a growing awareness of the importance of prevention and public health, countries spent on average only 2.8% of total health care expenditure on organised public and private prevention programmes.

Governments are under continuous pressure to reconcile economic and health concerns because the public purse funds the bulk of health care spending in most countries. In Germany, for example, an important health care reform was implemented in 2004 with the aim of stabilising the financing of the health care system. Approximately 70 million people (out of a total population of 82 million) are covered by social health insurance; the other 10% have private health insurance. Roughly €230 billion is spent each year on health care services, of which €140 billion goes to the statutory health-care system. Contributions to health care insurance are linked to salaries. At present, employees pay an average of 7.5% of their salary for health insurance coverage, while employers contribute another 6.6% as well as having to pay up to six weeks of wages in the case of illness.² Since this constitutes a heavy burden on labour costs, which results in a less flexible labour market, a further objective is to ensure that burdens are shared and labour costs are reduced. Awareness of past trends in the health status of the population and the use of health care services may foster a better understanding of the factors that have led to rising health care expenditures over the last few years and be a useful a predictor of future developments.

This paper identifies previous trends and future prospects surrounding the health status of the population and the utilisation of health care services in Germany, based on data from the German Socio-Economic Panel (GSOEP) (1984-2004). Health status and the demand for health care services is examined in conjunction with the following variables: health satisfaction; the degree to which health status hinders the fulfilment of daily life activities; disability and chronic illnesses; and the probability, frequency and duration of hospital stays. The first part of the paper describes the main trends associated with these indicators. Then a further analysis is

¹ See OECD (2004).

² See the speech given by Ulla Schmidt at the University of Minnesota on 5 June 2006 (retrieved from http://www.die-gesundheitsreform.de/presse/irb/reden/2006/060606_rede_ulla_schmidt_usa.html?param=st).

undertaken with regard to the determinants of health status. For this latter purpose, a sample of about 21,000 persons (aged 16 and older) has been used. The determinants are assessed against two measures of health status: a subjective measure, which is self-reported satisfaction with health, and an objective measure, which is the degree of being hindered by health in daily life activities. An interesting question explored alongside the findings is whether health care expenditures have increased because the overall health of the population has worsened or because expectations have risen.

2. Descriptive analysis – Past trends

In the last decade health care expenditures outpaced economic growth and thus its reform in order to guarantee financial stability constitutes a major challenge to the German government. An examination of the trends in the health status of the population and the utilisation of health care services during the last two decades facilitates an understanding of the recent problems associated with the health care system and the sources of rising costs. As a first step, this study has undertaken a bivariate analysis of several indicators of health status (health satisfaction, the degree to which health status hinders a person from fulfilling daily life activities, disability and chronic illness) and service utilisation (the probability, frequency and duration of hospital stays) using weighted data from the GSOEP (1984-2003). For this purpose, the average or the prevalence of these indicators is examined, distinguishing among four different periods – 1984-1989, 1990-94, 1995-99 and 2000-03 – as well as different ages, grouped into 10-year intervals.

One main factor that has contributed to rising health care expenditures has been the changing demographic distribution of German society, from a bell- to a fungus-shaped distribution of the population. The change in the age distribution can be found in Table 1. We can clearly see that the percentage³ of young persons (under age 30) has decreased (from 28% in the 1980s to 20% in 2000), whereas the share of elderly persons (over age 60) has increased substantially (from 24% in the 1980s up to 29% in 2000). This changing age distribution is one of the main causes for the rise in health care expenditures and the utilisation of health care services and pharmaceuticals.

Table 1. Population age distribution 1984-2003(%)

Age group	Population 1984-89	Population 1990-94	Population 1995-99	Population 2000-03	Population Total
<20	9	6	6	6	7
21-30	19	19	16	14	17
31-40	16	18	19	19	18
41-50	17	16	16	17	17
51-60	15	17	17	15	16
61-70	12	13	13	15	13
71-80	9	8	8	10	9
>80	3	4	4	4	4
Total	100	100	100	100	100

Source: Author's calculations based on the GSOEP (1984-2003).

³ The reference group (100%) is all persons who are older than 16 and living in Germany.

2.1 Trends in health status

Health satisfaction

One popular measure of health status is self-reported satisfaction with personal health. The GSOEP includes the question, “How happy are you with the following areas of your life? Please enter a number on the following scale for each area; if totally happy, enter ‘10’; if totally unhappy, enter ‘0’; if partly happy/partly unhappy, enter a number between these two. How happy are you with: your health?”

This indicator has to be interpreted carefully since it is highly subjective. Yet its analysis gives initial insight into the overall trends in the health of German society. The simple average of the responses by 10-year age intervals is examined across the last two decades, disaggregating these into 5-year periods.

From Figure 1, it is clear that self-reported health status grows worse over the life cycle. Furthermore, it seems that over the last 20 years health satisfaction has become worse at all ages, with satisfaction rising again only recently. One reason for this decline in health satisfaction might be that people in East Germany are generally less satisfied with their health status than those in the West Germany. Since their assimilation into West German society, however, they have perceived their health status as more satisfactory. Observing it from a different perspective we can also see that the percentage of persons who consider themselves satisfied with their health (a value higher than 5) falls over the life course. With respect to the longitudinal change a similar result is obtained: although until the year 2000 the percentage of people who are satisfied with their health continuously declined, recently it has started to rise again (Figure 2).

Figure 1. Trends in health satisfaction, 1984-2003

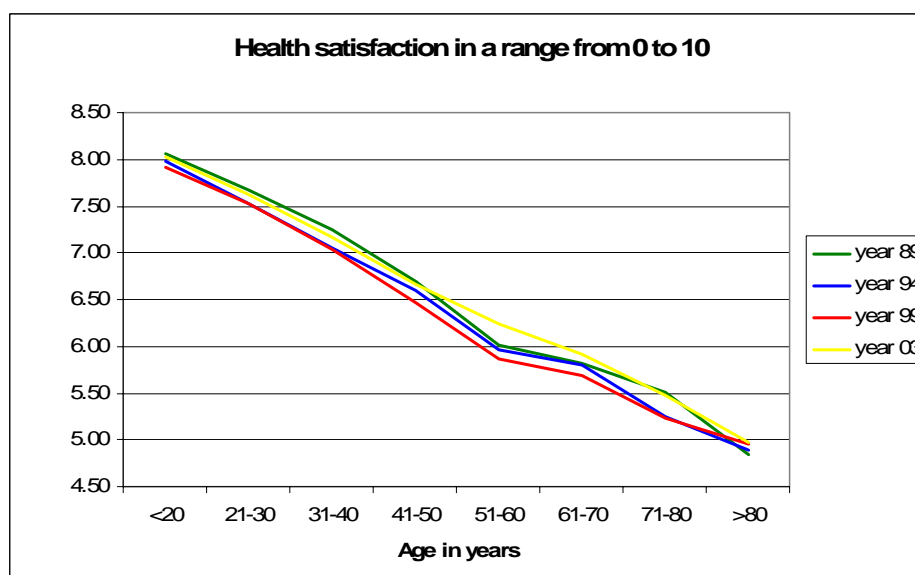
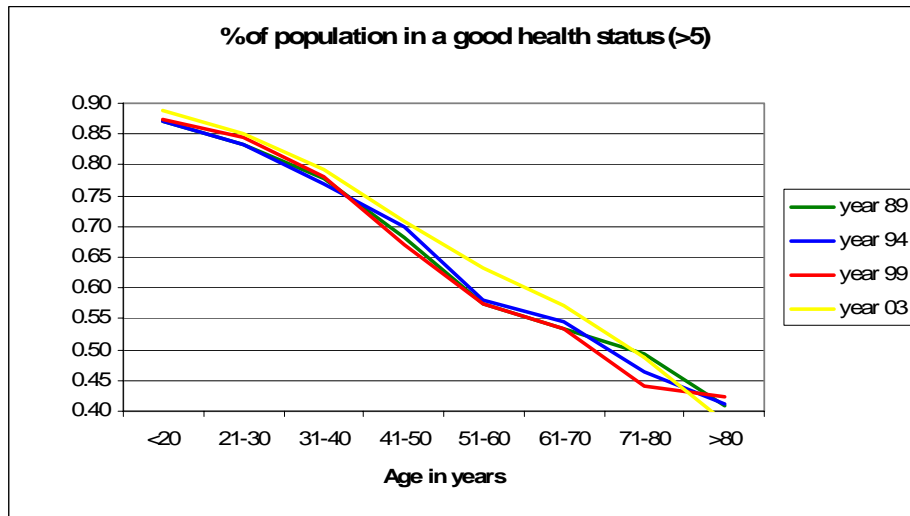
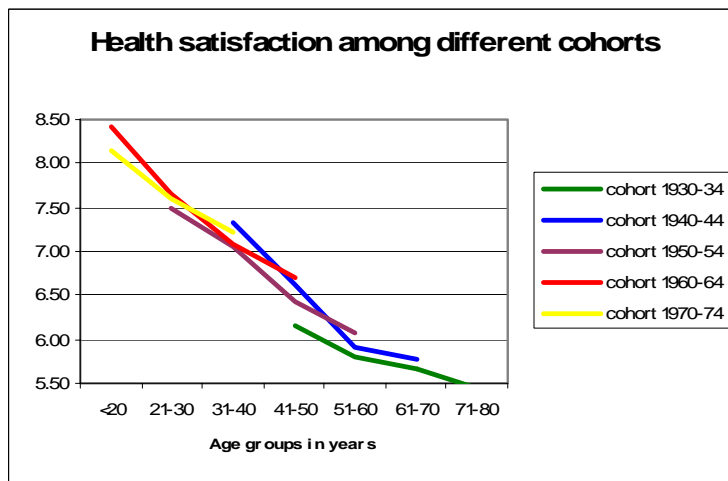


Figure 2. Percentage of people who are satisfied with their health, 1984-2003



It is interesting to note not only the development of health satisfaction over the years but also the differences in health satisfaction among the cohorts. For this purpose, five groups of cohorts have been created, consisting of persons born between 1930-34, 1940-44, 1950-54, 1960-64 and 1970-74, which are compared at certain ages. Thus it has been possible to compare groups who are the same age at different points in time. In other words, at age 41-50 for example, the following three cohorts can be compared: persons born in 1930-34 who are aged 40-50 in the years 1970-84, the cohorts born in 1940-44 who are aged 40-50 in the years 1980-94 and last the cohorts of those born in 1950-54 who are aged 40-50 in 1990-2004. Figure 3 shows the results.

Figure 3. Changes in health satisfaction among cohorts



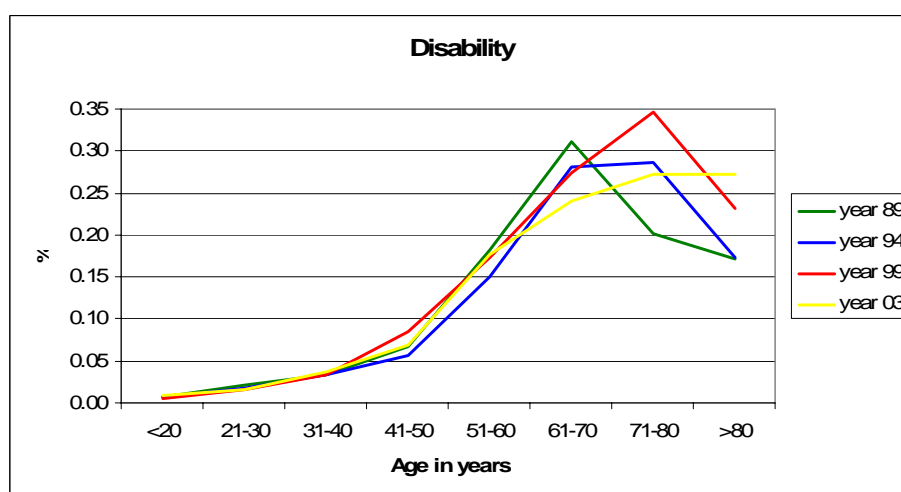
There is a visible upward trend among the cohorts, especially if the trend in health satisfaction among the younger cohorts is projected to older ages. In other words, it seems that younger cohorts are more satisfied with their health, which might be the result of better preventative measures as well as improved health care services and quality of life.

Disability

A more objective indicator of health status contained in the GSOEP is the degree of disability, which is prompted by the question, “Have you been officially certified as having a reduced capacity to work or of being severely handicapped?” Again we look at the average degree of disability (measured in percentages) and make distinctions among eight age groups and four periods of years.

The degree of disability shows a clear deterioration among the older age groups (Figure 4). At these ages, however, we can also observe the strongest improvement over time. Nevertheless, data arising from this question need to be interpreted carefully, as the question itself provokes several caveats: while until 1998 the question put an emphasis on the reduced capacity to work, from 1999 onwards the order of the question changed and the legally attested degree of disability in general was asked first. This might explain why on the one hand we can observe a peak around the age of retirement and on the other hand the smoother curve for the age groups from 2000 onwards.

Figure 4. Trends in disability, 1984-2003



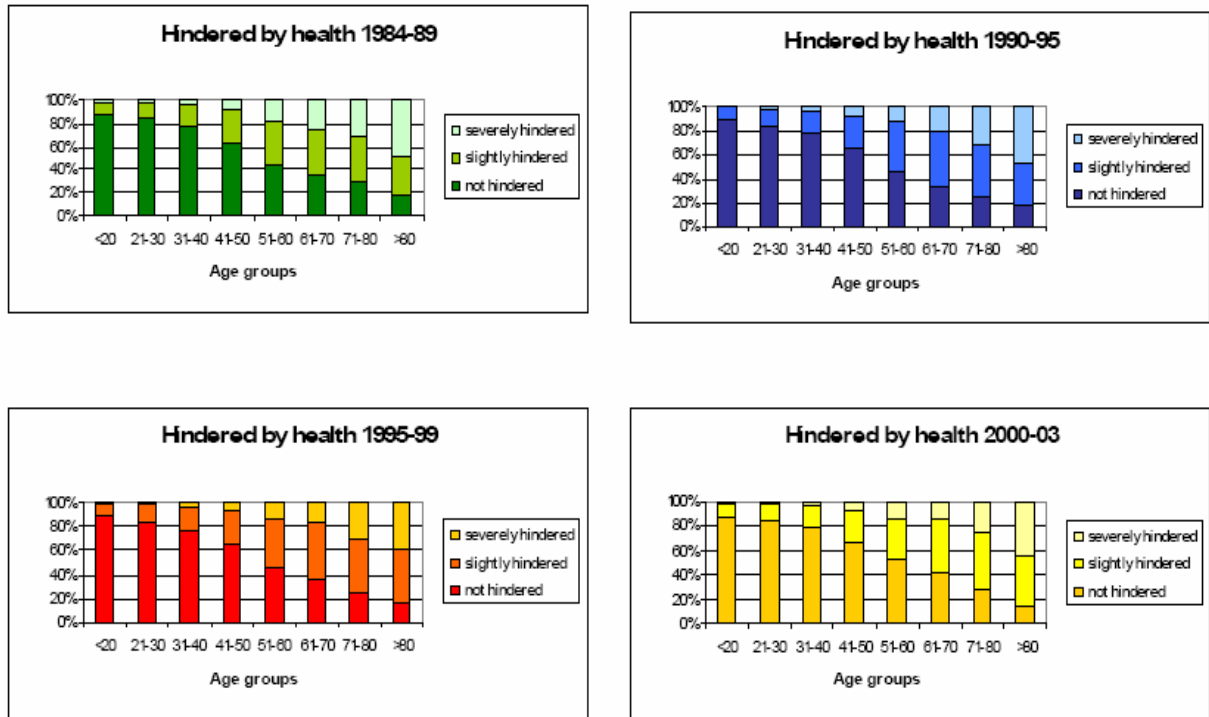
Hindered by health

A further, rather objective measure of health status is provided by the question about the ability to fulfil daily life activities, in other words if one is hindered by the condition of health in doing his/her activities in the household, job or education and to what extent. The answers are classified into three groups: 1) not at all, 2) slightly and 3) to a great extent.

In Figure 5 we can clearly see that with advancing age people suffer more from their health status. Since this question is general with respect to all areas of daily life there is no observable break around retirement age – in fact an increase can be detected. Comparing the years reveals that in each time period the respondents are less hindered in fulfilling their daily activities, particularly from age 40 to around 70. The decomposition of the category ‘hindered by health status’ into three groups (those who are not at all hindered, those who are somewhat hindered

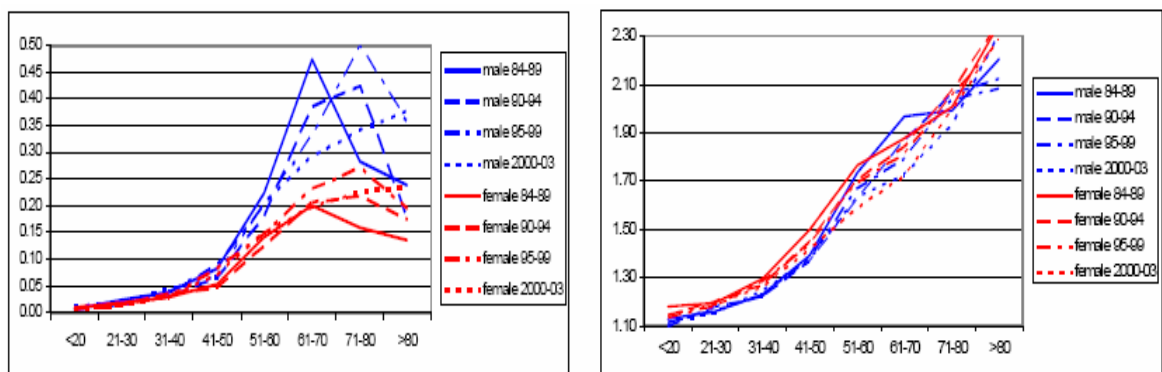
and lastly those who are fully hindered), shows that the improvement is owing to a decrease in persons who are strongly hindered by their health status, while the group size of slightly hindered persons did not change much.

Figure 5. Trends in 'hindered by health status', 1984-2003



It is also interesting to look at gender differences for the two measures, disability and hindered by health, since the latter is not work-related, to determine whether men and women are affected equally (Figure 6).

Figure 6. Disability (right panel) and hindered by health (left) for men and women during 1984-2003



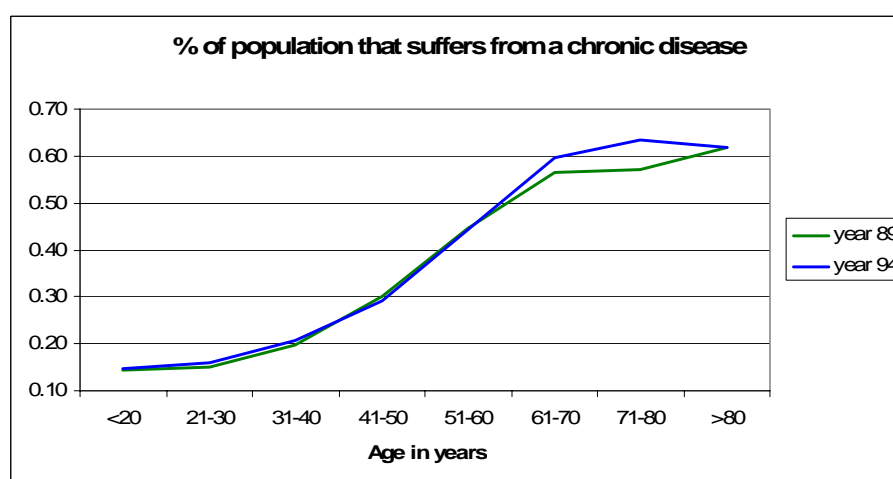
Once more it is confirmed that disability may be job-related. First, there is no observable break around retirement age for women, while the curves for men show a peak. Second, men have a

greater likelihood of having a disability, whereas there seems to be little difference if any for women, other than a higher degree of being hindered in daily life activities.

Chronically ill

Recently, health problems related to chronic diseases have gained more attention. The GSOEP only gathered data on chronic diseases during the first 10 years of the survey, however, so we only have some initial insight as to how this indicator has evolved. Nevertheless, a slight trend can be observed during this period (Figure 7).

Figure 7. Chronic illnesses, 1984-2003



While the prevalence of chronic illnesses rises over the life course, in the 1990s an upward trend for the population can be detected in comparison with the 1980s. This increase was particularly strong (around 10%) for persons older than 65. Unfortunately, we do not have information about the last 10 years, so we cannot draw any further conclusions.

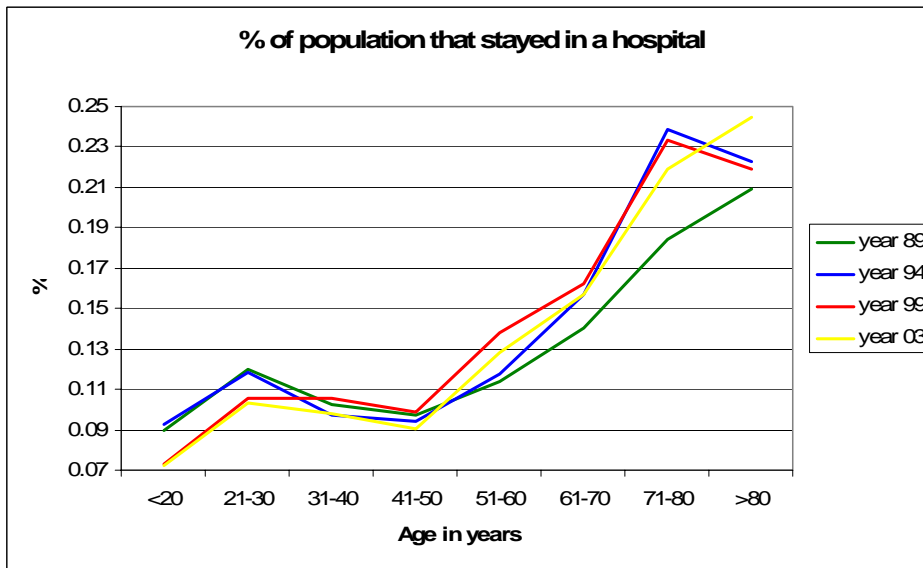
2.2 Trends in the utilisation of health care services

An additional explanation for the increase in health care expenditures could be a possible rise in the use of health care services. Trends in the utilisation rates for health care services are described in this section. It is interesting to see whether the rates of usage have risen and thus caused health expenditure to grow, or if the opposite is true, and utilisation has remained equal or even declined and an increase in costs may be responsible for the rise in expenditures. An increase in the costs of health care could stem from several factors, among them better technology, more expensive pharmaceuticals and so forth. In this section the prevalence, frequency and duration of hospital stays are examined as well as the incidence of doctor visits.

Hospital stays

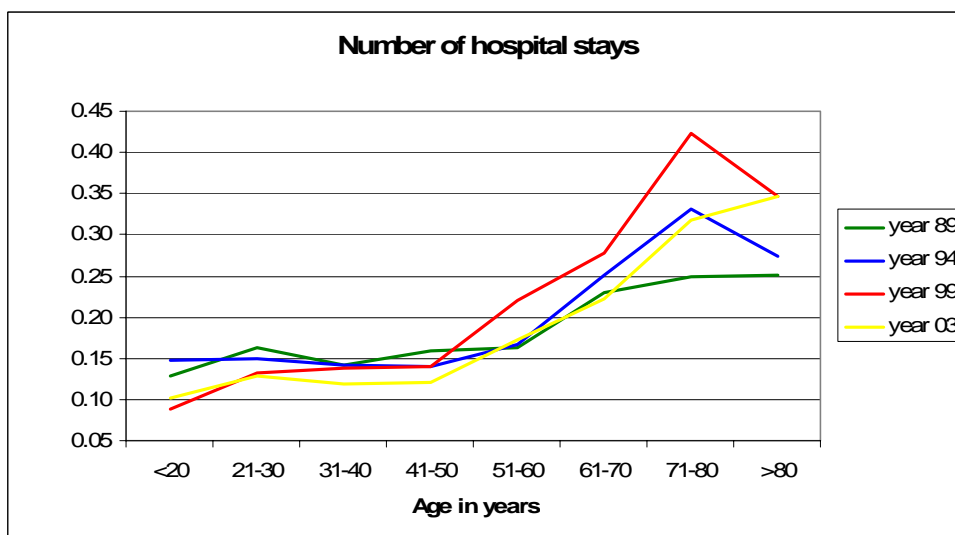
With respect to the utilisation of health care services, the GSOEP provides information about the probability of a hospital stay during the last calendar year. Figure 8 shows the percentage of persons visiting a hospital during a calendar year.

Figure 8. Probability of hospital in-takes, 1984-2003



We can see that the number of people visiting a hospital has risen during the first 15 years, particularly among those over age 45. Only recently has a slight decrease taken place (Figure 9). The peak around the ages of 20-30 is related to motherhood, as women in this age group stay in a hospital more often. This relationship reverses at older ages, when men are more likely to visit a hospital. This trend is confirmed looking at the average number of hospital stays during one calendar year. The related question in the GSOEP is “How often have you been in a hospital for at least one night during the last calendar year?”

Figure 9. Frequency of hospital in-takes, 1984-2003

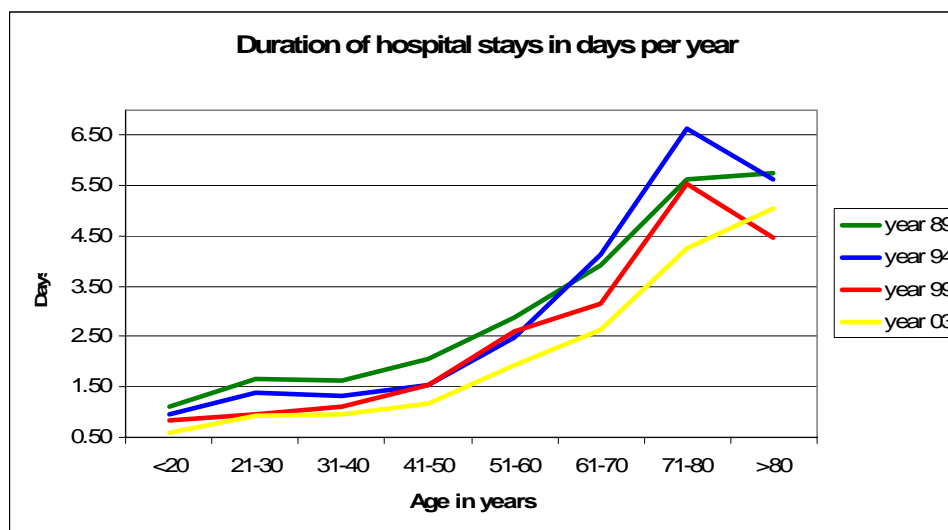


Up to 2000, a strong upward trend took place, especially during the late 1990s and for persons over age 45. Since 2000, the average number of hospital stays per year has declined. One interesting feature may concern the East–West contrast, particularly for the elderly. In the first years after reunification (in the 1990s), older persons in the East went to the hospital less frequently, which might explain the peak in the lines for the 1990s. This difference disappeared, however, as is observable today in the smoothed graph for 2000-03.

Duration of hospital stays

When looking at the utilisation of hospital services it is not only important to consider the frequency with which people visit a hospital but also the duration of their stay. The results for the average duration of hospital stays, measured in days per year, can be seen in Figure 10. While the number of stays per year has increased during the last two decades, the duration per stay has steadily declined (except for elderly persons in the early years of the 1990s). In line with the decrease in the prevalence, frequency and duration of hospital stays since 2000, the overall rate of hospital usage has fallen in the last five years.

Figure 10. Duration of hospital stays, 1984-2003

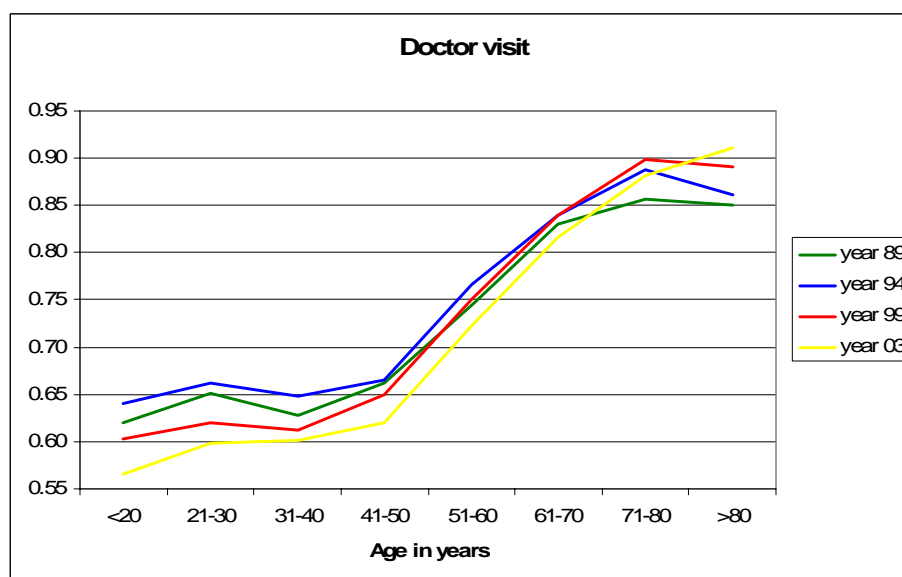


Visits to the doctor

In addition to hospital stays, visits to the doctor should also be taken into account when describing the use of health care services. The GSOEP provides information concerning whether an individual has visited a doctor during the last year. Using this information the percentage of persons who visited a doctor at least once in the last year can be calculated.

From Figure 11 we can see that the percentage of persons going to a doctor has fallen over the last two decades, except during the early 1990s, which again can be explained by the different behaviour pattern of persons living in East Germany. This decline has taken place across all age groups, but particularly for younger persons. Such a result could indicate two different things: on the one hand it may be the case that young persons are healthier nowadays; or on the other hand it could imply that they are less likely to undertake preventative medical examinations. In the latter case it may be that severe illnesses are not discovered or are done so at a much later stage, and thus the associated treatment may be more intense and more expensive.

Figure 11. Percentage of people visiting the doctor, 1984-2003



3. Multivariate analysis – Objective status vs. subjective perceptions of health

After having described the recent trends in health status, it is necessary to identify its determinants. Knowing the determinants of health status, of both objective health status and its subjective perception, allows the design of a more targeted policy and thus the opportunity to cut costs. In this section a multivariate analysis is undertaken to identify the determinants of health status using two different measures: a subjective indicator, which is satisfaction with health, and a more objective one, which is the degree to which an individual is hampered when fulfilling daily activities. The descriptive analysis above has shown that the previous trends for these indicators moved in opposite directions – while the subjective perception of personal health status worsened during 1984-2000 and only recently improved, the individuals observed in each time period were less hindered in their daily life, which indicates an improvement in the general health status of the population. Knowledge about the determinants of the two measures and their comparison may identify those who have increasing expectations and those who really are in a worse health condition.

Using a sample of roughly 21,000 people,⁴ an ordinary least square regression has been run controlling for the impact of the following variables: personal variables such as age, age squared, gender and education (measured in years of schooling); marital status (five dummies for married, which is the omitted group, single, separated, divorced or widowed); and origin (which can be either West or East Germany). Furthermore, socio-economic variables have been used such as job, described by its prestige (using the Wegener scale of the magnitude of job prestige from 0 to 200) and income after subsidies and taxes, along with the type of health insurance (public or private). Dummies for the years, grouped into five years, and a variable indicating the cohort (1930-70) have also been included. The dependent variable of satisfaction with health has been scaled from 1 (very unsatisfied) to 10 (very satisfied). The degree to

⁴ The size of this sample is significantly smaller than those presented in the first section. This is owing to missing values for certain variables, especially income, job prestige and type of insurance.

which one is hindered in fulfilling daily life activities ranges from 1 (not hindered at all) to 3 (completely hindered). The results can be viewed in Table 2.

Table 2. Regression results for health status

	Health satisfaction	Hindered by health
Age	-0.07 (-11.26)**	-0.07 (5.43)**
Age squared	0.00 (8.80)**	0.00 (-0.82)
Female	-0.15 (-10.16)**	-0.15 (-9.08)**
West Germany	0.07 (3.69)**	0.07 (1.59)
Education (in years)	0.02 (3.82)**	0.02 (8.74)**
Separated	0.19 (3.44)**	0.19 (5.11)**
Divorced	0.00 (0.09)	0.00 (0.26)
Widowed	0.10 (1.95)*	0.10 (2.06)
Single	-0.02 (-0.67)	-0.02 (1.72)
Children	0.01 (0.67)	0.01 (1.25)
Ln job prestige	0.05 (2.09)*	0.05 (2.27)**
Ln income	0.09 (5.55)**	0.09 (4.98)**
Private insurance	0.02 (0.85)	0.02 (2.13)**
Cohort	0.00 (-0.29)	0.00 (0.69)
Year 1990-94	-0.07 (-2.04)*	-0.07 (-1.67)
Year 1995-99	-0.14 (-3.02)**	-0.14 (-1.07)
Year 2000-03	-0.13 (-2.21)**	-0.13 (-1.01)

Note: The absolute value of z statistics are in parentheses; *significant at 5%; ** significant at 1%

Source: Author's calculations based on the GSOEP (1984-2003).

As the bivariate descriptive analysis has clearly indicated, health status worsens for older ages. Both the level of satisfaction with health and the degree of being hindered seem to grow worse with old age. Yet, while the negative effect on health satisfaction becomes smoother at older ages, the degree of handicap rises monotonically.

The multivariate analysis gives a better idea about the impact of gender on health status. Although women are generally less satisfied with their health status as observed in the descriptive analysis above, being female also has a significant impact on the degree of being hindered. Furthermore, geographical origin seems to have an effect on health status, significantly so with regard to perception. Citizens in West Germany seem to be more satisfied with their health status. Nevertheless, origin does not have a significant effect on the degree of being hindered. This result is interesting, as it seems that East Germans perceive their health status to be worse even if their daily life is not more affected by their health condition than that of West Germans. The result of the coefficient for marital status is surprising, given that separated and widowed persons seem to be in better physical shape than their married counterparts. It could be the case that they have fewer family duties and care more about their physical conditions.

Economic variables such as human capital (represented by education) and a better job with respect to both its prestige and its income seem to have a significantly positive impact. A higher level of education and a better job could influence health status in several different ways. First, well-educated individuals may be more conscientious about their health and thus take more care, as well as undergo preventative medical check-ups more often. In a decomposition of the probability of receiving medical care with respect to education, it can be confirmed that individuals with higher education (especially at younger ages) visit a doctor more frequently.

Second, a better job may be less physically demanding and thus have less severe physical consequences. Disentangling the effect of job quality shows that occupations associated with more prestige seem to have fewer negative effects on the degree of disability. Individuals with a better job are also less likely to stay in a hospital, which may stem from fewer accidents at work. Finally, another way in which a better job may affect health status is the amount of income it brings. A higher salary may enable people to afford better health services, in terms of both prevention and care. Individuals with higher income (above €3,700 gross income per month) can opt out of the statutory health insurance system and participate in a private plan. Private health insurance facilitates access to higher quality health care services and pays for more treatments, health care products and medications. In the regression above we can see that the presence of private insurance seems to significantly affect the degree to which a person is hindered by his/her health. Yet while the privately insured seem to be less hindered by their health status they do not seem to perceive a better health condition. This finding could indicate that these individuals have higher expectations about their health.

Before concluding, it is important to look at the time effect, in terms of both years and cohorts.⁵ The coefficients of the different year groups studied show the same pattern already observed in the bivariate analysis: health status has worsened over the last two decades and only recently do people perceive it to be better even if it did not improve significantly. Interestingly, the cohort does not seem to be important with regard to an objective assessment of health status but has a

⁵ In a regression where year dummies and an indicator of the cohort are included, the effects are not significant. Separate regressions, however, in which one of these two is omitted, show significant effects.

negative impact on its perception. These results indicate that younger cohorts have higher expectations and thus believe their health to be worse even in the absence of objective indicators.

4. Conclusions

The aim of this paper is to throw some light on the recent increase in expenditures on health care and health care systems in industrialised countries. As discussed earlier, the increase in expenditures is explained by, among other reasons, rapid advances in medical technology, population ageing and rising public expectations. In addition, an analysis of past trends in health status and the use of health care services may extend our understanding of the factors that have led to rising health care expenditures over the last few years and be a useful predictor of future developments.

In this paper past trends and future prospects for health status and health-care service utilisation have been studied using the German Socio-Economic Panel (1984-2004). From the first part of the paper (a purely descriptive analysis) the following insights can be gained. While health satisfaction did improve across the cohorts, in general it has grown worse over the last two decades (with the exception of a slight increase since 2000). Yet objective measures point to a better state of physical health among the population nowadays: people seem to be less disabled or hindered by their health. The only slight upward trend visible is for chronic diseases, which may not necessarily be owing to a worse health status of the population but rather improved knowledge and better diagnosis. These results alongside those of health satisfaction could suggest that although people perceive a worse health status, in reality it may have improved.

With respect to the utilisation of health care services our analysis shows the following results: while the probability and frequency of hospital stays has increased, the average duration of stay has declined. Furthermore, the number of hospital stays per year has fallen slightly since 2000. This finding indicates that over the last few years, people have drawn less upon health care services. The decrease in the number of doctor visits over the last two decades confirms this. The reduction in doctor visits points to two other trends: although it may be that on average people are healthier and thus have less need to visit a physician, it could also be the case that people are less likely to attend preventative check-ups. The rise in health care expenditures despite the lower rates of health-care service utilisation may stem from rapid advances in technology and thus more expensive treatments and associated products. The fact that people seem to undertake preventative check-ups less frequently may have the consequence that severe illnesses are discovered at a later stage, with the eventual treatment being more costly.

Thus in any plans for health care reform it may be important to encourage people to pursue preventative health care more actively. In addition, controls placed on the costs of health care services and pharmaceutical products may help to rein in excessive expenditures.

The multivariate analysis clearly indicates that women suffer more from their health status than men. This finding may be related to motherhood and less physical strength in general; yet it could also be the result of a more sensitive perception of health status. Higher education seems to be linked to improved physical condition, reflecting that more knowledge and prevention affect health status positively. Better working conditions also seem to affect health status in a positive way. Therefore, the government should guarantee educational advertising as well as the regulation of working conditions. Two reforms, implemented in 1997, took into account the importance of improving working conditions: one reform introduced some regulation of safety at the workplace and another one did the same for overtime.

The greatest challenge, however, seems to be associated with changes in the age distribution of the population. The so-called ‘ageing society’ is the biggest problem the government faces. In order to help meet this challenge, the promotion of educational advertising and preventative health care aimed at limiting exposure to health risks is essential.

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The European Network of Economic Policy Research Institutes (**ENEPRI**) is composed of leading socio-economic research institutes in practically all EU member states and candidate countries that are committed to working together to develop and consolidate a European agenda of research. **ENEPRI** was launched in 2000 by the Brussels-based Centre for European Policy Studies (CEPS), which provides overall coordination for the initiative.

While the European construction has made gigantic steps forward in the recent past, the European dimension of research seems to have been overlooked. The provision of economic analysis at the European level, however, is a fundamental prerequisite to the successful understanding of the achievements and challenges that lie ahead. **ENEPRI** aims to fill this gap by pooling the research efforts of its different member institutes in their respective areas of specialisation and to encourage an explicit European-wide approach.

ENEPRI is composed of the following member institutes:

CASE	Center for Social and Economic Research, Warsaw, Poland
CEE	Center for Economics and Econometrics, Bogazici University, Istanbul, Turkey
CEPII	Centre d'Études Prospectives et d'Informations Internationales, Paris, France
CEPS	Centre for European Policy Studies, Brussels, Belgium
CERGE-EI	Centre for Economic Research and Graduated Education, Charles University, Prague, Czech Republic
CPB	Netherlands Bureau for Economic Policy Analysis, The Hague, The Netherlands
DIW	Deutsches Institut für Wirtschaftsforschung, Berlin, Germany
ESRI	Economic and Social Research Institute, Dublin, Ireland
ETLA	Research Institute for the Finnish Economy, Helsinki, Finland
FEDEA	Fundación de Estudios de Economía Aplicada, Madrid, Spain
FPB	Federal Planning Bureau, Brussels, Belgium
IE-BAS	Institute of Economics, Bulgarian Academy of Sciences, Sofia, Bulgaria
IER	Institute for Economic Research, Bratislava, Slovakia
IER	Institute for Economic Research, Ljubljana, Slovenia
IHS	Institute for Advanced Studies, Vienna, Austria
ISAE	Istituto di Studi e Analisi Economica, Rome, Italy
NIER	National Institute of Economic Research, Stockholm, Sweden
NIESR	National Institute of Economic and Social Research, London, UK
NOBE	Niezalezny Osrodek Bana Ekonomicznych, Lodz, Poland
PRAXIS	Center for Policy Studies, Tallinn, Estonia
RCEP	Romanian Centre for Economic Policies, Bucharest, Romania
SSB	Research Department, Statistics Norway, Oslo, Norway
SFI	Danish National Institute of Social Research, Copenhagen, Denmark
TÁRKI	Social Research Centre Inc., Budapest, Hungary

ENEPRI publications include three series: Research Reports, which consist of papers presenting the findings and conclusions of research undertaken in the context of ENEPRI research projects; Working Papers, which constitute dissemination to a wider public of research undertaken and already published by ENEPRI partner institutes on their own account; and thirdly, Occasional Papers (closed series) containing a synthesis of the research presented at workshops organised during the first years of the network's existence.



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