

A Long Farewell to the Bismarck System: Incremental Change in the German Health Insurance System

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Abstract

Germany's health insurance system represents the archetype of the healthcare arrangement generally known as the "Bismarck model". Core elements of this model are the management of healthcare by self-governing corporatist bodies and the funding primarily by income-related contributions, not by taxes. The German health care system has been in a dynamic transformation process since the early 1990s. We currently have a situation where elements of different systems exist side by side. In this contribution we argue that this transformation has already robbed the core elements of the Bismarck system of a great deal of their importance, and that it must be expected that their significance will continue to decline as the reform process progresses.

Zusammenfassung

Deutschland repräsentiert bekanntlich den Archetyp jener Gesundheitssysteme, die gemeinhin als Bismarck-Modelle bezeichnet werden. Zu den Kernelementen dieses Modells zählen die Steuerung des Krankenversorgungssysteme auf dem Wege der Selbstverwaltung und die Finanzierung der Krankenversorgung primär über einkommensbezogene Versicherungsbeiträge, nicht über Steuern. Das deutsche Gesundheitssystem befindet sich seit der ersten Hälfte der 90er Jahre in einem dynamischen Wandlungsprozess. Zurzeit haben wir es mit einer Koexistenz unterschiedlicher Systemmerkmale zu tun. Wir vertreten in diesem Beitrag die These, dass im Zuge dieses Wandels die Kernelemente des Bismarck-Systems bereits erheblich an Bedeutung verloren haben und dass damit zu rechnen ist, dass sie in den weiteren Reformprozess weiter an Bedeutung verlieren werden.

1 Introduction

Germany's health insurance system represents the archetype of the healthcare arrangement generally known as the "Bismarck model". In the decades following its establishment in 1883 it served as the model for numerous other states setting up and designing their own health systems. Nations in continental western and central Europe were first to follow the German example, later joined by countries in Asia and Latin America. Since the collapse of the communist bloc, elements of the German-style health insurance system have come to play an important role in many central and eastern European states. In international comparative research the Bismarck model is identified today as one of three or four classic types of health system (e.g. Wendt 2008). For all the differences of detail, health insurance systems are characterized by the following shared core elements:

- Healthcare is managed by self-governing corporatist bodies, where a distinction must be drawn between self-government of the sickness funds by their members and employers and self-government of healthcare services in the sense of the state delegating to sickness funds and service providers (corporatist partners) the authority to flesh out the details of a broad policy framework (collective negotiations and collective agreements play a central role here).
- Healthcare is funded primarily by income-related contributions, not by taxes.

The health systems of the OECD countries have been in a dynamic transformation process since the early 1990s, and Germany is no exception. Change in the German health system has proceeded at a pace and to an extent that would have been almost inconceivable just a few years ago. We currently have a situation where elements of different systems exist side by side. In this contribution we argue that this transformation has already robbed the core elements of the Bismarck system of a great deal of their importance, and that it must be expected that their significance will continue to decline as the reform process progresses—probably to a point where they will be only a marginal factor in a health system that is fundamentally shaped by other structural elements. Further, we argue that the underlying paradigm shift for system transformation was accomplished in the first half of the 1990s by the Health Care Structure Act that came into effect in 1993, but that since then restructuring has been more a process of progressive incremental change. The decisions of policy-makers are shaped by two factors whose inherent dynamics lead away from core elements of the Bismarck system: a strategic health policy paradigm that strongly prioritizes economic incentives (especially competition mechanisms) and pragmatic problem-solving in situations arising from earlier health policy reforms (“muddling through”).

In the following we will first describe the basic thrust of the health policy transformation, before turning to the aforementioned core elements of the Bismarck system and the reasons why their importance has declined since the early 1990s. In a concluding section on the outlook for the future we explain why the process of sidelining these core elements is likely to continue.

2 The Transformation of the German Health System

At the heart of the health policy transformation is the goal of reducing public spending on health and with it the financial burden on employers—whether in the form of taxes or social security contributions—in order to enhance their competitiveness in an increasingly globalized economy. The first efforts to contain costs began as the Fordist growth model expired around the mid-1970s, but these were largely restricted to cautious modification of existing structures (e.g. Rosewitz/Webber 1990; Alber 1992; Rosenbrock/Gerlinger 2006). Efforts concentrated on limiting administrative spending, a moderate shift of treatment costs to patients and minor correc-

tions to the existing regulatory system. A series of cost-containment laws passed after 1977 left the inherited structures of financing, care and regulation largely untouched. The measures adopted in this period included attempts to encourage service-providers to restrict spending through modifications to the reimbursement system and a cautious strengthening of the funding bodies (sickness funds). This era was characterized by an expansion of corporatist regulatory powers with the goal of enabling the collective organizations of sickness funds and service providers to urge their members to contain costs (Döhler/Manow-Borgwardt 1992a). Overall, however, this structurally conservative policy was unable to effectively curb rising contribution rates in the statutory health insurance system (Rosenbrock/Gerlinger 2006: 113–17).

Fundamentally, the existing incentive structures remained unaltered in an environment of revenue-led spending policy. Fee-for-service in the ambulatory sector and the principle of cost-coverage in the hospital sector continued to provide incentives to expand volume, while on the funding side the sickness funds enjoyed a de facto guarantee of continued existence through the largely rigid system of assigning members mostly according to their professional status. Their competition for members was restricted to the minority of members who were permitted free choice of fund (primarily salaried employees and voluntary members; Enquete-Kommission 1990: 358–465). Of course even under these conditions sickness funds strove to avoid increasing contribution rates—but the negative repercussions of increases remained predictable and containable. To that extent these traditional cost-containment policies were characterized by the contradiction between a global goal of stability of contributions and the financial incentives for individual actors.

At the beginning of the 1990s about 90 percent of the population was members of a statutory sickness fund, while the remaining 10 percent had private health insurance and were subject to the principles of the insurance market. The state granted members of the statutory sickness funds almost unrestricted access to healthcare services. The statutory sickness funds were financed exclusively through contributions representing a fixed percentage of the gross wage or salary (until a set upper limit was reached) that were paid in almost equal parts by employers and employees. Non-working spouses and children were (and still are) co-insured without extra charge. At this point funding of the statutory health insurance system was channeled through about 1,100 health funds, most of whose compulsory members were assigned to them automatically, generally on the basis of their professional status (Enquete-Kommission 1990: 358–465). *Care* was based on the outstanding position of office-based doctors. In ambulatory care patients had the right to consult any doctor they chose, whether general practitioner or specialist. Outpatient treatment in hospitals, on the other hand, was permitted only in a few exceptional cases (Simon 2008).

The *regulatory system* at the beginning of the 1990s was characterized by a complex mix of management types (Alber 1992). Each healthcare sector had its own regulatory system with its own particular mix of state, corporatist and free-market elements. Hierarchical state management elements dom-

inated the hospital sector, corporatist elements the ambulatory sector and competitive elements the pharmaceuticals sector (Rosenbrock/Gerlinger 2006).

The German health service was characterized by a legislative framework within which the state delegated far-reaching powers to corporatist management bodies made up of equal numbers of representatives of the sickness funds and the doctors or hospitals (“collective self-government”) to negotiate the details of implementation and regulate price, quantity and quality of services in binding collective agreements (Gerlinger 2002). The state maintained oversight over these associations and institutions, but allowed them a great deal of latitude.

In ambulatory care the collective bodies representing the sickness funds had to negotiate agreements with the regional associations of statutory health insurance physicians, which held the monopoly on representing the interests of office-based doctors. In the hospital sector, on the other hand, the collective bodies representing the sickness funds signed contracts with each *individual* hospital. Here too they had an obligation to contract with any hospital the state health ministry included in the state hospital plan. Through their duty to prepare a hospital plan and their influence on national legislation affecting hospitals the states played a key role in shaping hospital care (Simon 2000).

The sickness funds managed their own affairs through self-government by representatives of employers and members, within a framework set by the state and under state oversight. Among their most important powers was independently setting their own contribution rate.

For years the German health system was regarded as largely unreformable. Various different reasons were cited for this: the power of organized interests in the health system, the necessity to form coalition governments (where the Free Democratic Party, especially, was able to water down or even prevent reforms that would have weakened the position of service providers) and the strong position of the states in the reform process, which above all blocked restructuring of the hospital sector (e.g. Rosewitz/Webber 1990; Simon 2000).

Structural reform in the health system—in the sense of measures to bring about a “redistribution of powers and responsibilities relating to the funding, provision and regulation of medical services” (Webber 1988: 157)—was not initiated until the early 1990s. It was in the subsequent years that health policy developed the dynamism that continues to the present day. This trend can also be observed in many other health systems outside Germany (e.g. Wendt 2008; Blank/Bureau 2007). The sharpening of international locational competition, the rise in unemployment and the ever clearer limits of previous cost-containment policies led to a reorientation in health policy. The predominant justifications for social and health policy shifted from redistribution to efficiency and growth arguments (Rothgang/Preuss 2008). In this context the problem-solving strategies hitherto pursued came to be regarded as increasingly inadequate and the determination grew to make structural interventions in the health system.

This process has been characterized by a quick succession of reform attempts introducing new management instruments that aim to modify the incentives for sickness funds, service providers, fund members and patients. The most important of these are expanding competition between sickness funds, allowing funds to conclude selective contracts, tangibly privatizing treatment costs and increasing the use of prospective forms of remuneration (practice budgets and case fees) (Freeman/Moran 2000).

These new forms of remuneration are of far-reaching importance because they partially or even fully shift the risk of morbidity to the service-provider (e.g. Herder-Dorneich 1994). With prospective remuneration the service provider's profit depends on reducing the actual cost of care below the prospectively agreed fee. Service-providers have two strategies to choose from in response to the new incentives. They can—as the legislation intends—enhance the efficiency of service provision by economically rationalizing their healthcare processes. In many cases this involves downward pressure on pay and increasing the intensity of work. The alternative is to economize on services for patients, perhaps avoiding medically unnecessary treatments. But this approach risks endangering the quality of care, for example when medically necessary treatments are also excluded or patients are asked to pay the full cost of certain services themselves.

The reasons driving this transformation are primarily exogenous factors, changes in the social environment of the health system. Perceived pressure to reduce financial burdens on employers is especially important, along with the perceived weakness and inadequacy of previous reform strategies and the diffusion of New Public Management techniques already applied in other areas into the field of healthcare. Although the relative importance and details differ from country to country, we observe in all state-run and corporatist health systems the introduction of “alien regulatory elements” (Rothgang et al. 2006) and a shared trend to a “regulated market” or “regulated competition” (e.g. Freeman 2000; Saltman 2002).

3 From Corporatist Control to Regulated Competition

The paradigm shift for regulated competition was ushered in by the Health Care Structure Act that came into effect in 1993. The background to this strategy shift in health policy was an accumulation of problems both in the social environment of the health system and within the social health insurance system itself.

The reform introduced a series of management instruments that were either new for the statutory health insurance system or expanded in such a way as to lastingly alter the incentive structures for actors involved in medical care. Two instruments stand out: Firstly, fund members were given the right to freely choose which sickness fund to join, which deprived the funds of their implicit guarantee of existence. A low contribution rate now became the decisive parameter in competition for members. Secondly, the introduction of case fees and individual budgets for reimbursement of medical services shifted the funding risk of treatment to the individual service-

providers. Put simply, the new payment models limited the incentives for service providers to expand volume and in some cases even created incentives to reduce volume within the *individual case* of treatment (Gerlinger 1998).

The heart of the transformation was the establishment of a competition system for healthcare, aiming to establish a regulated market for managed care. So far competition has been largely competition for members between funds. The introduction of free choice of sickness fund was accompanied by a risk structure compensation mechanism to take account of differences in age, gender, number of co-insured family members and number of members receiving invalidity benefits. But because the compensation mechanism did not directly include morbidity indicators it was not very good at fulfilling the purpose for which it was intended, namely to prevent risk selection by the sickness funds. Also it failed to create incentives to improve care of members with chronic conditions, which is particularly expensive (Jacobs et al. 2002). Consequently the risk structure compensation mechanism has been reformed in several stages: in 2002 the sickness funds were granted additional resources for sufferers of particular chronic conditions who sign up for disease management programs and in 2009 eighty especially expensive conditions were added to the mechanism.

This liberalization of the contracting rules was introduced and incrementally expanded in the following period. It affected especially the heart of the corporatist system, the ambulatory sector (Gerlinger 2002). The state expanded the ability of individual actors at the micro-level to shape healthcare arrangements and payment modalities. As the scope granted to individual actors expanded, collective agreements lost in significance. Now sickness funds can—without having to ask for the approval of the association of statutory health insurance physicians—conclude special agreements with individual doctors or groups of doctors covering integrated care, GP-managed care, general practices and ambulatory specialists, disease management programs and pilot projects. Enthusiastic use is being made of these possibilities (Kassenärztliche Bundesvereinigung 2008), even if an overwhelming proportion of care continues to be regulated by collective agreements with the associations of statutory health insurance physicians. But the trend towards further erosion of arrangements made “uniformly and jointly” is obvious (e.g. Kania/Blanke 2000; Noweski 2008).

4 Waning Influence of Self-governing Corporatist Partners

The Federal Joint Committee plays a singular role in the system of corporatist structures. It is the most important management body in the corporatist arrangements of the statutory health insurance system. The Federal Joint Committee is responsible for concretizing legislation concerning ambulatory care in the statutory health insurance system. Its most important responsibilities today include issuing directives to ensure adequate, appropriate and efficient healthcare for fund members (§ 92 Abs. 1 SGB V), as well as evaluating the benefit and efficiency of all diagnosis and treatment methods

provided at the expense of the sickness funds, which gives it considerable potential to shape and influence the catalogue of treatments provided by the statutory health insurance system. The Federal Joint Committee is made up of equal numbers of representatives of sickness funds, doctors and patients, plus three impartial members (although the patients' representatives have no voting rights). The state exercises legal supervision over the decisions of the Federal Joint Committee, whose directives are submitted to the Federal Ministry of Health and Social Security, which has two months to object. If the Federal Joint Committee fails to issue a directive on time, the Federal Ministry of Health can issue it itself. The Committee's directives automatically become part of the federal collective framework agreements and the state-level agreements between the bodies representing sickness funds and office-based doctors. This means they are immediately binding on all involved, including doctors and fund members.

The history of the Federal Joint Committee can be traced back to the 1920s. It has undergone considerable change since the second half of the 1970s and again, more strongly, since the second half of the 1990s (Döhler/Manow-Borgwardt 1992b, Urban 2001). In the process, its importance has grown considerably, with expansion in both the spheres it covers and in its powers within them. On the one hand, its remit was expanded in 1989 to include the "substitute funds" (*Ersatzkassen*) and its authority extended in 2004 from ambulatory care to all sectors in the statutory health insurance system. On the other, it has acquired a multitude of new powers within the fields it covers: it became responsible in 1997 for assessing the benefit and efficiency of all diagnosis and treatment methods covered by statutory health insurance and in 2007 for quality control in all sectors. This list of new powers is by no means exhaustive (Döhler/Manow-Borgwardt 1992a, 1992b; Urban 2001).

These developments could be seen as a strengthening of corporatist control (and thus of one of the central pillars of the Bismarck model) but that would be a very superficial interpretation. Instead there were other parallel processes at work that considerably curtail the scope of decision-making in the Federal Joint Committee. The state has set an increasingly restrictive financial framework for the statutory health insurance system. This is especially clear in the policy of setting spending budgets, which has been in force since 1993 for important categories of service, and in three decades of increasingly restrictive interpretation of the basic principle of stability of contribution rates. The decision—in the 2007 Health Reform—to abolish the right of sickness funds to set their own contribution rates and transfer this prerogative fully to the state represents the logical conclusion of a long-term trend. The scope for action—and that means above all the scope for financial redistribution—granted to sickness funds and service providers has steadily shrunk. The Federal Joint Committee has expanded its remit, but it is forced to fulfill its responsibilities in an ever more restrictive frame of action.

Beyond that the government—specifically the "red/green" coalition of Social Democrats and Greens and the Social Democrats in their "Grand Coalition" with the Christian Democrats—has made repeated attempts since

the beginning of this decade to curb the influence of the collective bodies representing sickness funds and doctors in the Federal Joint Committee on the assessment of the benefit and efficiency of medical treatments. The background to this is the charge that the collective bodies make these decisions not purely on the basis of scientific findings but allow themselves to be strongly led by their own interests. If that were the case, the decisions of the Federal Joint Committee would be suboptimal from the perspective of rationality and the goal of efficient care. The government continued its efforts to reduce the influence of the collective bodies on such decisions in the 2004 Health Reform, which established an Institute for Quality and Efficiency in Health Care (IQWiG) with wide-ranging powers to evaluate the benefit and efficiency of diagnosis and treatment methods. The 2007 Health Reform originally proposed reducing the autonomy of the Federal Joint Committee by curtailing the powers of the collective bodies to appoint members and altering their status: in future the collective bodies were only to have the right to propose candidates rather than appoint members, and the members were to become full-time employees of the Federal Joint Committee rather than employees of their respective collective body. Many observers saw this as a step towards transforming the Federal Joint Committee from a corporatist self-government entity into a state regulatory authority.

In the process of passing the reforms these original plans were watered down. The IQWiG's autonomy from the Federal Joint Committee was limited by permitting it to assess diagnosis and treatment methods only at the request of the Federal Health Ministry or the Federal Joint Committee. And in the end only the three impartial members became full-time employees of the Federal Joint Committee, not the representatives of the doctors and sickness funds. The right to appoint members of the Federal Joint Committee also remained with the collective bodies. But despite these modifications both reform acts ultimately strengthened the influence of instances other than the collective bodies on the definition of benefit and efficiency of medical treatments: one by expanding the weight of scientific expertise; the other by strengthening the influence of the state executive in the form of the Federal Ministry of Health. The 2007 Health Reform also gave the Federal Ministry of Health, as the supervising authority, the right to request additional statements and information when scrutinizing directives. Some observers see this as a step from legal to technical supervision—which would expand the ministry's possibilities to intervene.

For the future of corporatist regulation this would suggest that decisions about the benefit and efficiency of medical treatments could theoretically also be made without the involvement of the affected collective bodies. Even the state's dependence on medical and care-related expertise is plainly no guarantee for the lasting survival of corporatist arrangements in the health system.

Finally, since 2004 bipartisanship in the Federal Joint Committee has also been weakened. Previously, apart from the impartial members, the Federal Joint Committee comprised only representatives of doctors and sickness funds. In 2004 patients' representatives were added, although they attend only in an advisory capacity. This alteration reflects the government's fear

that the prevailing incentives might sometimes lead doctors and sickness funds to reach agreement at the expense of the patients. Even without voting rights the presence of the patients' representatives increases the pressure on doctors and sickness funds to justify their decisions.

Like the mechanisms of shared self-government by doctors and sickness funds, self-government by members and employers *within* the sickness funds has also been considerably weakened since the beginning of the 1990s. Until 1992 each sickness fund had a board of management which made all the significant decisions for the sickness fund. Equal numbers of representatives of employers and members served on the board, which was chosen by a meeting of elected delegates, also with equal representation of employers and fund members. In 1993 the self-governing structures of the sickness funds underwent a comprehensive restructuring under the slogan of so-called "professionalization"—also as part of the aforementioned Health Care Structure Act. Under the new system a supervisory board elects a full-time board of management to serve for six years. This new full-time board is granted extensive powers to run the day-to-day operations of the sickness fund (including, especially, negotiating care contracts with service providers). The remit of the supervisory board—as the organ where members and employers are equally represented—is now restricted to questions of a more elementary nature including, in particular, questions concerning the statutes (e.g. decisions about providing extra treatments not required by law) and—until the end of 2008—setting the fund's individual contribution rate. This formal weakening of self-government was amplified by a real loss of power emanating from the outlined reform processes. For example a fund's scope to set its contribution rate was considerably curtailed by the restrictive framework ordained by the state and the constraints of competition. In the end, with effect from 2009, the government also withdrew even the formal right of funds to set their own level of contributions.

5 The Declining Significance of Wage-based Contributions

Contribution rates in the statutory health insurance system have been rising for decades. In public discussion this trend is often discussed in terms of a "cost explosion" in the health system. In fact, the development of spending turns out to be relatively undramatic in reality. Neither the nominal spending trend nor the development of the contribution rate in the statutory health insurance system say anything about the share of economic value consumed by health insurance. The decisive variable here is spending on treatment in the statutory health insurance system as a share of GDP (the value of goods and services produced in a year). Examining that indicator since 1970 shows that a steep rise in spending in the statutory health insurance system—in absolute and real terms—was observed only between 1970 and 1975. This was largely a consequence of the expansion of both the catalogue of treatments provided by the statutory health insurance system and the number of people covered by the system. Since 1975 spending in the statutory health insurance system has largely kept step with overall economic growth. In the

western states of Germany it has remained relatively constant since then at just over 6 percent of GDP (although it must be remembered that over this period co-payments have jumped and numerous treatments have been removed from the catalogue). Variations in the contribution rate and health spending as a share of GDP have more to do with cyclical economic trends and the associated variations in revenue than with changes on the spending side. Although total expenditure for health care represents 10.6 percent of GDP for the Federal Republic of Germany as a whole (OECD 2008), the figure is considerably higher in the eastern states (the former East Germany) than in the west above all because unemployment is higher there and growth weaker, and as a result per capita GDP is significantly lower. The rise in contribution rates is due in the first place to changes on the revenue side:

1. The wage share, the share of GDP taken by wages and salaries, has been falling since the mid-1970s. So growth in the wage base, the incomes on which contributions to the statutory health insurance system are raised, has fallen behind economic growth (e.g. Kühn 2001; SVR 2003, vol. I). If the incomes relevant to contributions had kept pace with productivity (GDP per working person) in western Germany, the statutory health insurance system would have had €18.2 billion more revenue in the western states (and €22 billion for the country as a whole). With these revenues the spending of the statutory health insurance system in 2000 could have been covered with a contribution rate of 11.6 percent (instead of 13.5 percent). That would have put the contribution rate at the level of the early 1980s (SVR 2003, vol. I: 69).
2. In the past the state has repeatedly misused the statutory health insurance system as a “piggy-bank” (“Verschiebebahnhof”), reducing transfers from the pension and unemployment funds into the statutory health insurance system or burdening the statutory health insurance system with extraneous responsibilities—and costs—in order to reduce the federal subsidy required by the state pension funds and the Federal Employment Agency and thus reduce the level of national debt. The statutory health insurance system, which ultimately means the contribution-payers, has had to make up the difference.
3. Since the 1970s the statutory health insurance system has seen heavy migration of members to private insurance schemes. The balance of migration since 1975 amounts to a loss of about five million members. This worsens the financial situation of the statutory health insurance system because these members previously paid high contributions and exhibit a below-average risk of morbidity.

Numerous experts agree that the current funding system is in need of reform. But this diagnosis comes with very different perceptions of the problem and different proposed solutions (BMGS 2003). Some are primarily interested in relieving employers of health insurance costs, which will probably continue to increase in future. Their main argument is that the employer’s contribution to statutory health insurance represents a component of wage costs, so rising insurance contributions mean rising wage costs. This is a disadvantage in tough international competition and endangers jobs, they say, so the level of contributions to the statutory health insurance

system should be separated from wage costs. This perspective culminates in the demand for a flat-rate insurance contribution independent of the level of income (*Kopfpauschale* or *Gesundheitsprämie*), a concept favored by the Christian Democrats and their allies. Others are primarily interested in eliminating the inequalities that currently exist in the funding and insurance system. Their core arguments are, firstly, that having separate statutory and private systems cannot be justified in terms of social policy, because it exempts the better-off from contributing to the system of mutual solidarity. Secondly, they say, the funding of the statutory health insurance system is unfair because contributions are raised only on wages and salaries but not on other forms of income. This perspective leads to the call to include all citizens in a solidarity-based insurance system and expand the types of income on which contributions are raised to include areas that have not hitherto played a role (e.g. interest and investment income). Such a system (*Bürgerversicherung*) has been proposed in different versions by the Social Democratic Party, the Greens and the Left Party.

Both proposals are driven by a desire to separate health insurance contributions from wage costs. The *Kopfpauschale* focuses on this aspect while with the *Bürgerversicherung* it is secondary to the question of fairness, but also important in its own right and explicitly cited by the Social Democrats and Greens to back their reform concepts. One strategy for lowering non-wage labor costs, which is compatible with both models, is to fund the health system more strongly out of taxation. Tax-financing of social services in the age of globalization is generally seen as more competition-friendly than direct financing via income-related insurance contributions.

The preference for expanding the taxation-financed share of social services also shows through in the most recent health reforms. In coming years the tax-funded federal subsidy for the statutory health insurance system will be increased step by step. This subsidy, initially funded by an increase in tobacco duty, was introduced in 2004, and amounted to €4.2 billion by 2006. Funding of the federal subsidy through tobacco duty stopped in 2007. Instead, since the 2007 Health Reform, the statutory health insurance system has received a federal subsidy not funded by any specific tax increase. At €2.5 billion in 2007 it was initially less than the 2006 subsidy, but will increase to €14 billion by 2012, which would correspond to nearly 10 percent of total statutory health insurance system spending in 2006. In view of the economic recession triggered by the global financial crisis the German government decided in January 2009 to accelerate the increase in the tax-funded share. This made it possible to reduce the contribution rate to the benefit of employers and employees, which should boost spending and investment and make a contribution to overcoming the economic crisis.

Under current legislation the state tax-funded subsidy will become a permanent component of the funding of the health system. It has been supplemented in 2009 by additional contributions to be paid by fund members alone which may rise to a share of 5 percent of sickness funds' total expenditure. The structural pillar of the Bismarckian system—funding through contributions based on gross earnings, shared equally by employers and employees—is being supplemented by new elements. Funding of the statutory

health insurance system is turning into a mix where state subsidies and individualized funding components enjoy growing importance (Gerlinger et al. 2008).

6 Self-government Squeezed between Competitive Control and State Centralization

During the late 1980s and early 1990s the German state was held to have capitulated on health reform, and the results of the first fifteen years or so (1977-1992) of attempts to reform health policy confirm that assessment. The actual impact of reforms failed to live up to expectations, because proposals were watered down during the discussion process or at the latest when they were implemented. By the end of the 1980s the health system was regarded as highly reform-resistant.

However, since then the state has overcome these obstacles to act as the “architect of political order” in the health system (Döhler 1995), and set in motion the transformation processes outlined above. One of the main thrusts of this turn in health policy has been the privatization of costs and risks. But it would be misplaced to reduce health policy to this aspect. Political leaders, despite sometimes having rather close ties with the interests of service providers, have turned out to be quite willing to enter into conflict with doctors, hospital operators and drug companies. To some extent this was inevitable: placing an excessively one-sided burden on fund members and patients would have exposed the parties in power to great legitimization risks. The health system differs from other parts of the social security system such as pension schemes and large parts of the unemployment benefits system in that it is not “only” about monetary redistribution or social protection against particular life risks, but also encompasses the management of personal services in an important branch of the economy. This opens up more strongly than in other areas of social security the opportunity to pursue the goal of restricting spending not only by cutting the provision of services but also by rationalizing their production, in other words by involving the service providers. This structural singularity is probably one reason why the field of health policy has so far been less affected than other areas by the prevailing privatization trends.

A “big bang” solving all the problems for good has not occurred in Germany. Rather, even in the transformation processes since the early 1990s, reform plans have been delayed, weakened and watered down. Nonetheless, the Health Care Structure Act of 1992 can be identified as a historic turning-point that was quickly followed by a multitude of fine-tuning measures. One prominent feature of health reform has been the search for (provisional) solutions in individual fields rather than attempting to deal with everything at once. This process has inevitably increased the complexity of political control and management of the health system. The decision to pursue competitive transformation incrementally was partly a function of the complexity of the object of regulation, but also served to keep the number of opponents of reform within limits. Health policy certainly bears traits of “mud-

dling through” but to reduce it to that would be to overlook the strategic calculation of the political elites.

But can this regaining of the state’s ability to actively fashion the control and management of health systems really be characterized as a new primacy of politics? Such an interpretation, shared by many experts, would imply that in reorganizing the health system the political elites really have demonstrated a greater willingness to enter into conflict with powerful interest groups, even in cases where these belong to their own clientele. Here parallels can also be observed with the reforms in other health systems. In Switzerland and the Netherlands too, the service providers—especially the bodies representing doctors and drug manufacturers—number among the bitterest opponents of the health reforms (e.g. Bandelow 1998; Hartmann 2002; Rosenbrock/Gerlinger 2006), because state regulation is designed to strengthen primarily those actors from whom the political elites expect effective constraints on spending and increases in efficiency. Clientelist bonds may not become meaningless under these circumstances but the organized particular interests in the health system can no longer depend on political decision-makers taking account of them. Nonetheless, the concept of the primacy of politics would appear to us to be misleading for two reasons. For one thing it ignores the way clientelist interests—especially on the side of the service providers—continue to play an enormous role in the shaping of health systems and represent an obstacle to the rationalization of system structures. For another it disregards the fact that this transformation process is driven primarily by *economic* motives and goals. The most important motive for the transformation process is to relieve employers of the financial burden of health insurance contributions, and health system restructuring aims to strengthen the role of economic incentives in demand for and supply of goods and services in the health sector.

The reduction of state intervention in the health systems that certain observers called for or expected (e.g. Oberender et al. 2006) has not occurred in Germany. Although we can speak of the state retreating from health policy in the sense that it has expanded the options of individual actors at the micro-level—above all by freeing sickness funds from the obligation to contract with service providers and granting funds and their members opportunities to individualize financing conditions—the emerging health market is still fundamentally a politically constituted market.

Political control in the health system is characterized, firstly, by the state holding on to a large part of its existing regulatory powers. The definition of the catalogue of treatments, the reimbursement of services and capacity planning all remain the responsibility of the state, although liberalization at the micro-level is gradually turning this into a looser planning framework. The establishment of market-based incentives is accompanied by the introduction or persistence of implicit or explicit budgets.

But beyond that, the establishment of competitive relations in the health system produces numerous new fields of activity for state control. The financial incentives for individual actors require sophisticated management systems in order to ensure that their activities in the new competitive order are compatible with the political goals for which the market was created.

This primarily means setting conditions to regulate the modalities of the market constitution (specifying the rights and obligations of the actors in a system of operations increasingly shaped by financial incentives and defining the limits of their activities): contributions should be kept down if possible; fund members should receive all necessary medical services; the efficiency and quality of care should be improved where possible. Detected disincentives (e.g. cream-skimming or rationing of services) need to be corrected by these means and anticipated ones avoided. So the creation of a market must be accompanied by a far-reaching process of state re-regulation (e.g. Vogel 1996; Majone 1997; Lütz/Czada 2000). The outcome is that the law enmeshes the health system in an ever-tightening web of legal regulations.

Thus in the course of the transformation process we can also identify a centralization of regulatory powers and a trend towards standardization of the legal framework for developing the health system. Existing regional differences lose in significance as does the role of the states in health policy. The centralization of regulatory powers progresses insidiously, partly intentionally driven by the government, partly an unintentional consequence of incremental reforms (Gerlinger 2008). One symptom of centralization is the establishment and expansion of the Federal Joint Committee, which is being transformed into a “trans-sectoral negotiating machinery” (Döhler 2002: 33); another, since 2000, is the national standardization of conditions for reimbursement of services in ambulatory and hospital care (Gerlinger 2008). But probably the most important step towards centralizing regulatory powers came with the 2007 Health Reform, which withdrew with effect from 1 January 2009 the right of the sickness funds (now about 210) to set their own contribution rates and transferred it to national government.

7 Summary and Prospects

Over the past fifteen years the structures of the German health insurance system have changed tangibly. The core elements of the Bismarck system continue to exist and seen as a whole continue to dominate: the German health system is certainly still recognizably a health insurance system. But its Bismarckian features are not as predominant as they once were. Market-oriented management reforms play a growing role in the control of health-care processes, and the state intervenes more strongly than ever in the statutory health insurance structures, appropriating a series of important management powers for itself. In the course of this process the scope for self-government—both the self-government of the sickness funds by employers and members and the collective self-government of the health system by funds and service providers—is tangibly squeezed between market and state. The possibility to conclude selective contracts is increasingly fraying the system of collective agreements. Healthcare is increasingly governed by market mechanisms, with the state pursuing re-regulation to bring the interests and powers of the actors into line with the politically defined goals of competition. Corporatist control is considerably diminished, especially at

the meso-level. At the micro-level it is increasingly being replaced by competitive elements, at the macro-level by state planning frameworks. At the national level corporatist bodies are still important (the GKV-Spitzenverband representing all the sickness funds, and the Federal Joint Committee), but they operate in an ever-tighter state corset and are active predominantly in fields where management knowledge of the immediately involved actors is relevant for regulation. A health system controlled by the market has no need of collective corporatist agreements.

At the same time the weight of taxes in the funding of health insurance has increased considerably, even if it is still of secondary significance. Increasing the share of taxation in the financing of the statutory health insurance system meets with broad approval among the political parties, albeit for disparate and differently weighted reasons. One argument is that global competition requires that wage costs be decoupled from health insurance costs, another that considerations of fairness mean that other types of income should be taken into account when calculating contributions to the statutory health insurance system. A third argument is that the conjunction of a high base level of unemployment, labor market deregulation (more jobs below the threshold for social security), the low level of increases in wages and salaries, and the migration of fund members to private insurers makes funding solely on the basis of wages and salaries increasingly unviable.

The weight of taxation in health funding is likely to continue to increase, regardless whether this is justified by the supposed requirements of global competition or because it is deemed to be fairer. Equally, the role of collective agreements and corporatist self-government will continue to shrink. Spectacular moves are unlikely because of the magnitude of the legitimation risks they bear for the political actors. The inescapable farewell to the Bismarck system has begun, even if it is likely to be a long drawn-out process.

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