

Economization and Marketization in the German Healthcare System: How Do Users Respond?

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Abstract

The focal figure of governance reforms within the German healthcare system is nowadays the “expert patient”. Both, state-driven agendas of user activation as well as market-based healthcare services emphasize self-responsibility, financial stakes and participation of healthcare users. Users act in different contexts as citizens, patients, consumers or community members. Depending on the situation, there is a demand for specific health knowledge and competences (“health literacy”). In order to clarify which healthcare arrangement supports a specific notion of the user, this article is based on a differentiation between economization and marketization processes—both theoretically and empirically. Against this backdrop key questions read as follows: What does the challenge of more choice mean for patients as healthcare consumers? To what extent does the increasing significance help to co-produce and co-finance healthcare, influence patients’ autonomy and agency? Which incentives do users face with regard to cost containment policies? It is argued, that it needs both, a general commitment by users as well as a healthcare system that strengthens users’ agency and provides them equally with opportunities and advocacy.

Zusammenfassung

Nutzer von Gesundheitsleistungen stehen vor einer scheinbar paradoxen Situation: Einerseits sollen sie als “Rationalisierungsagenten“ und ko-produzierende Patienten zu einem verantwortlichen Umgang solidarisch finanzierter Gesundheitsleistungen in der Gesetzlichen Krankenversicherung (GKV) beitragen; andererseits sind Nutzer auf privaten Gesundheitsmärkten aufgerufen im Stile von Konsumenten entsprechend individueller Bedürfnisse in ihre Gesundheit zu investieren. Ausgehend von derartigen multiplen Rollen- und Anforderungsprofilen an Nutzer unterscheidet dieser Beitrag sowohl theoretisch als auch empirisch Ökonomisierungs- und Vermarktlichungsprozesse im deutschen Gesundheitssystem. Im Zentrum der Analyse stehen (mögliche) restriktive als auch autonomieerweiternde Auswirkungen für Nutzer, z.B. hinsichtlich der Krankenkassenwahl, der Teilnahme an einem Disease Management Programm (DMP) oder Individuellen Gesundheitsleistungen (IGeL). Es kann gezeigt werden, dass es zunehmend der Ausbildung individueller Kompetenzen wie Gesundheits(system)wissen, Kommunikations- und Beziehungsfähigkeiten und ökonomischen Sachverstand bedarf, um der steuerungspolitischen Komplexität im Gesundheitswesen als Nutzer souverän begegnen zu können.

1 Introduction

From an historical perspective, the German corporatist healthcare system appeared for a long time reluctant to proceed with any far-reaching reforms. However, since the 1990s the German healthcare system has been targeted by several modernization processes, characterized by pundits as an “incremental reform” (see Gerlinger/Schmucker in this volume). This article scrutinizes two of its key drivers, economization and marketization, arguing that

the two approaches restructure the healthcare system differently and have different consequences for healthcare users' behavior. They share, however, common ground: economization and marketization processes aim at the expert patient as a focal figure. For instance, state-driven agendas of user activation as well as market-based healthcare services emphasize individual responsibility, as well as financial stakes and participation of healthcare users. Simultaneously, there is a differentiation of users' identities, especially against the backdrop of mixed healthcare provision and the establishment of a complementary healthcare market. Users act in different contexts as citizens, patients, co-producers, consumers or community members. In order to do so, there is an increasing need for a specific health knowledge and competence; that means the development of a context-related "health literacy" (Nutbeam 2000).

By analyzing the implementation of economic and market-based elements in the field of healthcare and the differentiation of users' identities—or rather the way they are culturally embedded—this article will give some evidence of opportunities as well as constraints of users' autonomy and self-determination. In the first part, a theoretical distinction between economization and marketization processes within the German healthcare system will be made. Both strategies, superficially viewed as assigned to market principles, stimulate very different users' identities as well as self-governance needs. While an economized healthcare system favors cost containment policies and compliant users above all, the emergence of a healthcare market with various tailored products and services forces users to act as experts on their own behalf, or rather as health consumers.

The second and the third part of the article portray current reforms in the German healthcare system. Illustrative examples of the economization of healthcare (e.g., Disease Management Programs and Diagnosis Related Groups) as well as the marketization of health (e.g., so-called Individual Healthcare Services) will be discussed with a special focus on their consequences for users. The main argument of the fourth part is that ambivalent, and to some extent contradictory, demands emanate from both processes. As it turns out, recent policies are characterized more by controlling users' behavior and bringing them into the service system in order to contain costs than by positive effects such as more choice and user involvement in market-based healthcare arrangements. Finally, the conclusion outlines individual coping strategies for healthcare users in an economized and partly market-based healthcare system and calls for an appropriate supporting environment.

2 Economization and marketization: Two different approaches of a modern health policy

In the field of health policy, it would be a mistake to limit the process of modernization merely to the implementation of market principles. Instead, a variety of different, but related, changes and dynamics that are taking place at the same time have to be taken into account. From a broader perspective

that is related not only to health policy but also to social policy in general, three lines of development are shaping the policy framework:

- First, the reinvention of legitimacy patterns for social policy interventions (Rothgang/Preuss 2008). Efficiency criteria emerging from the paradigm that all social investments must show returns into the future became decisive.
- Second, the adjustment of the notion of citizenship to highlight the active and individually responsible citizen as the modern target of social policies.
- Third, the generation of a political culture and atmosphere that helps to make the revised policy goals and role models for citizens achievable.

Analyzing the particular changes within the healthcare system, according to Kuhlmann (2006, 6), “three arenas of change” can be identified:

- a new self-awareness of professionals who increasingly take over the role of citizen professionals;
- new forms of governance, emphasizing the role of the state as a manager and social investor, and
- the emergence of citizen consumers as a new citizenship model.

Without discussing these theoretical frameworks in detail, one commonality seems quite obvious: the introduction of market-based elements in connection with a more active role of citizens and users. Thus, there are “diverse ways in which citizens engage with policies, which often reflect forms of agency and multiple identities (...)” (Bevir/Trentmann 2007, 3).

For social policy researchers as members of a discipline that, by tradition, invents measures to cure the shortcomings of capitalism and the market economy (Nullmeier 2003, 973), the application of market instruments such as efficiency criteria, standardization and competition in the welfare services sector evokes almost automatically defensive and skeptical reflexes. Hence, with respect to health policies, several publications deal with the interrelations and problems of a marketized healthcare system with regard to solidarity or socio-economic inequalities (e.g. Deppe/Burkhardt 2002; Elsner et al. 2004). Literature that also ascribes positive effects to a partly market-based healthcare system is rarely found among social scientists in the German context. This article argues for a more sensitive analysis of market instruments within the realm of healthcare.

When speaking about market elements in the healthcare system, we do not mean a switch from one system to another, but a limited internal change towards market principles. On a more abstract level, the whole process could be described as the emergence of welfare markets (Nullmeier 2002)—more specifically, a social policy that not only compensates for market effects but produces welfare partly through state-controlled sectoral markets (e.g., care for the elderly).

A careful distinction between the logics of economization and the practice of marketization with regard to their intended effects seems appropriate. While the former aims at better governance of the health sector in terms of a more efficient distribution and application of limited resources, the latter

establishes a competition-based healthcare market alongside a system of supply and demand, which is similar to conventional consumer markets. At first glance, both mechanisms share the pursuit of capital allocation: on the one hand through cost containment (economization); on the other hand through profits generated by commercial healthcare services and products (marketization). But where are the significant differences? First of all, the approaches can be distinguished with regard to the degree to which they attach importance to the state. An economized health policy based on the standardization of healthcare, quality management and an ingenious system of cost control depends on a strong and regulative state, consisting of “elements of centralist steering” (Knappe 2007, 6). By contrast, marketization is reducing the impact of the state by initiating competition between non-profit and for-profit providers, the contracting-out of certain services, or the formation of new kinds of contracts that do not include the state as an actor, e.g., contracts between service providers and users (Clarke 2007, 98). In Germany, the secondary healthcare market offers healthcare services that are excluded from the coverage of the German Statutory Health Insurances (SHI).

Another remarkable difference emanates from the rationale behind the composition of the range of health-related services, therapy treatments, and products to be offered. The paradigm of economization strongly implies a kind of reduction or shortage of healthcare services and medical goods. The state rationalizes its resources or restructures the public healthcare system. Every service, product, treatment or public subsidy is judged according to overarching cost-benefit criteria. Therefore, an economized healthcare system is accompanied by various measures of standardization and managerial rationales in order to homogenize the allocation systems. By contrast, healthcare markets are oriented towards consumer needs. The key principles of marketization are all about more: an expansion and pluralization of healthcare services and products by anticipating as well as creating users’ needs.

Obviously, there is no clear-cut dividing line between economization and marketization; rather it is the process of outsourcing services and cutting social welfare assistance that forces the marketizing of health. Thus, both processes are simply two sides of a reform policy that applies principles, e.g. efficiency and competition, on a sector that was formerly more or less state-driven.

However, the most important distinction concerns the way healthcare users are addressed by both mechanisms. Pointedly, one can say that users are treated as impersonal cost bearers in health arrangements designed under the logic of efficiency. Cost-calculation and containment (as key principles of the healthcare system) and their restrictive effects prevail over the orientation towards individual needs. By transferring the responsibility of health-related costs to the users, economization strategies release the state of its burden. Hence, state policies operate through frameworks and programs that generate cost awareness among users and force them to optimize their consumption of healthcare services and goods in an economical manner. As such, as it will be shown below, the education of users is a key issue. On the

one hand users should avoid expensive medical treatments through healthy lifestyles and appropriate health literacy; on the other hand, they have to internalize a managerial behavior in their dealing with and self-management of costly diseases, e.g., diabetes. To be quite blunt: Non-smoking and non-overweight citizens and patients who co-produce treatments are contributing to a more balanced healthcare budget. They adapt their behavior successfully to overarching systemic constraints that have priority over individual needs and autonomy. Thus, such efforts of individual agency foster the governance principles of economized healthcare systems at large. For this reason, instruments of economization tend to streamline the field of healthcare. They are based on objective criteria of comparison in terms of resource requirements and medical results.

Beyond questions of access and social inequality (see Le Grand 2007, 46–54), the marketization of healthcare increases users' choice to purchase the service or medical treatment that best fits their needs. Patients are empowered as healthcare consumers who seek tailor-made services in a mixed system of public and private healthcare providers. Ideally, they co-design the range of services and products available on healthcare markets according to individual needs and different degrees of health awareness. More choice can be accompanied by more individual sovereignty in terms of opportunities to invest in one's own health. Instead of blaming the healthcare system for being too costly, healthcare markets stress innovations of services and products as engines for economic growth (Rothgang/Preuss 2008, 37). An important precondition for economic success are competent and marketable users who perceive health as an individual achievable "doability" (Kickbusch 2004), something which can at least partly be bought and consumed.

Without evaluating these logics of marketization, one can say that there are stimulus and incentive for participation and self-determination. This can be related to Amartya Sen's agency approach that is based on a "freedom-centred understanding of economics" (1999, 11). According to Sen, markets contribute to the expansion of people's capabilities by equipping them with the freedom to influence or even change their social environment with respect to their "own values and objectives" (ibid, 19). To the contrary, economization processes tend to reduce individual freedom and autonomy by activating citizens for higher systemic reasons. Instead of the most efficient therapy or other hidden potentials for cost containment, a marketized healthcare offers tailor-made solutions for individual cases of illness. Thus healthcare markets have the advantage to adapt the range of medical offerings more quickly according to the differentiation of medicine.

Table 1: Economization and marketization: features and consequences for users

Economization	Marketization¹
<ul style="list-style-type: none"> - dominance of cost containment policies (<i>reductive thinking</i>) - cost-benefit analysis as a key instrument - outsourcing of services and goods - transfer of financial responsibilities to users; cost-sharing policies - self-optimizing in terms of efficiency <p>Risks:</p> <ul style="list-style-type: none"> - new paternalism initiated by economic reasons - loss of autonomy, systemic conditioning (self-control) 	<ul style="list-style-type: none"> - competition among public and private providers - new quality awareness - demand-oriented (individualized/tailor-made) range of offerings - increase of users' choice / opportunities for social investment - exertion of voice on social markets <p>Opportunities:</p> <ul style="list-style-type: none"> - gains of users' sovereignty - self-determination and participation alongside individual needs <p>Risks:</p> <ul style="list-style-type: none"> - inequalities of competences and purchasing power - cutting of SHI benefit catalogue

However, it would be wrong to favor the marketization of healthcare in general without constraints and risks. As Table 1 indicates, mechanisms of economization and marketization can be distinguished along two central aspects: First, do users or patients have a choice with regard to healthcare services and medical treatments? Likewise, one can ask whether health arrangements are primarily designed to satisfy systemic or users' demands. Second, a key question concerns the way and the overarching aim of users' involvement: the actual space for manoeuvre, the realization of individual claims with respect to health, and the institutional design in which users' participation is embedded. Taking both aspects together it seems obvious that the difference between economization and marketization is not simply about the implementation of cost-benefit analysis versus an increase in users' choice. Their voice and the institutional instruments to exert influence are crucial as well. According to Albert O. Hirschman's (1970) classic *Exit, Voice, and Loyalty. Responses to Decline in Firms, Organizations, and States*, exit (the option to abandon a company or to choose an alternative service provider) and voice (interest articulation by citizens and consumers) are at their best when they institutionally combined. Instead of a simple ei-

¹ The following features of marketization are merely necessary preconditions but do not constitute a full-fledged healthcare market. The latter is marked by additional *hard criteria* such as private legal forms, a clear for-profit orientation among healthcare providers and complete freedom of contract.

ther—or, the strength of both mechanisms depends on a skilful institutional design that allows “voice functions as a complement to exit, not as a substitute for it” (1970, 35). Thus, a partly marketized healthcare system provides at least the possibility of a better involvement of users in the designing and delivering of health-related services—provided the marketization of health is accompanied by a careful balance of exit and voice instruments.²

Summing up the essence of this part, three aspects are central to the analysis of current reforms in the German healthcare system. First, the application of market elements within the realm of healthcare requires a differentiation regarding intended policy goals. Despite their parallel appearance and conceptual intertwining, economization and marketization processes have to be distinguished. Second, different user consequences and role models emanate from both processes. An economized healthcare system conceives citizens and patients in the first place as cost bearers that need to be governed economically, whereas in healthcare markets users might have more agency—provided they co-design the range of offers according to their individual needs. Third, to be effective, the voice of citizens and patients is dependent on appropriate institutional designs that safeguard both the freedom of choice among healthcare providers and medical goods as well as involvement in the governance and the production of services.

Against the backdrop of these theoretical distinctions, the next part examines examples for economization processes in the German healthcare system.

3 Processes of economization: examples from the German healthcare system

Obviously, the restructuring of healthcare along economic criteria is not a typical German phenomenon: “Health care is a key arena of the modernization of welfare states” and cost containment functions as a “strong policy driver” (Kuhlmann 2006, 1–2). However, the tools applied by policy makers to reach this overarching goal promise an improvement of healthcare services and medical performances through measures of standardization and quality management. Hence, the search for more efficiency is accompanied by various attempts to increase individual satisfaction with healthcare. Healthcare users could expect better service and quality-tested medical treatments through the establishment of managed care centers and well-coordinated therapy systems. Despite these promises in terms of quality and reliability, increasing the profitability of healthcare remains the primary goal of the restructuring process (Kühn 2004, 29). Generally speaking, the structural change within the German healthcare system can be summarized by the introduction of new financing instruments. By budgeting clearly defined out-

² Le Grand (2007, 38) argues in a similar direction as Hirschman, even though he values “user choice” and “provider competition” as more important than ordinary voice instruments. Nevertheless, the merits of voice are included in his “choice and competition model” which is—through a better structure of incentives to providers—more likely to deliver high-quality services efficiently and equitably as well as in a responsive fashion.

puts through flat compensation fees, professionals and hospital managements adapt themselves to cost-reducing incentives. In contrast to the former system, the responsibility for health expenses shifts from the Statutory Health Insurances (SHI) as the main cost bearer towards healthcare providers. Office-based physicians, healthcare professionals and hospitals get used to covering all their costs with a preliminary fixed budget. Wasting of resources, e.g., through lavish and inappropriate methods of treatment, as a strategy to increase one's income does not pay off anymore (Bauer 2006, 20).

In the following new financing instruments and corresponding measurements of quality management will be introduced with special attention towards the theoretical features of economization.

3.1 Disease Management Programs (DMPs)

As elements of “managed care”-approaches (among others, Kühn 1997) DMPs closely combine requirements for cost effectiveness with those of quality optimization. Depending on one's perspective, DMPs give priority to quality management or cost containment. The advantages for patients, especially for chronically ill persons, are quite obvious. DMPs as structured programs of treatment provide a well balanced provision of medical care that fits exactly to specific diseases.³ According to the German Ministry of Health, acute worsening of the patient's condition and long-term consequences should be prevented in the first place; therefore DMP treatments are regularly checked with regard to effectiveness, security and benefit (BMfSG, http://www.die-gesundheitsreform.de/glossar/strukturierte_behandlungsprogramme.html; 27.3.08). The managerial logic of DMPs—most apparent through steady attempts of process optimization and patient control—represents the economic side of the new management approach. Healthcare providers contract with chronically ill persons, who agree to various voluntary self-obligations required by their diseases, e.g., training programs or precautionary measures. Once again the improvement of patients' compliance serves different goals: On the one hand, affected persons are forced to increase their individual competence to cope with their diseases in order to realize a better quality of life; on the other hand, standardized programs facilitate broad evaluations in terms of efficiency. Resources which had been spent in former times for uncoordinated treatments by uncooperative healthcare providers should be saved, and doctor hopping should be prevented.

Thus, DMPs seek both cost control and cost transparency and could be labeled as instruments for the recording of chronic diseases with respect to managerial rationales. Do the promised gains of quality for patients really justify the dominant cost-benefit analysis? An accurate answer causes mixed feelings: Opponents have to appreciate that DMPs are constructed as per-

³ In Germany, DMPs cover the following diseases: breast cancer, diabetes mellitus I and II, coronary heart diseases, chronically obstructive respiratory diseases, and bronchial asthma.

manent learning systems that flexibly adapt themselves to patients' needs and medical improvements. Consequently, a dynamic process of refinement and verification brings DMPs up-to-date despite the fact that they are standardized programs. So far, evaluations have been confirmed that DMP-subscribers benefit from a more coherent medical provision than non-subscribers (Graf 2008). The unsolved question remains whether patients are systematically involved in the adjustment of DMPs. The crucial point is whether the users' voice is valued to the same extent as economic interests. Does the orientation to patients' needs prevail in conflict situations, such as an increase of health expenditures as a result of users' recommendations to already existing DMPs? In the face of the enormous degree of self-management and compliance accompanied by DMPs, solutions that are not efficiency-oriented seem rather unlikely. Instead, voice mechanisms promoted by DMPs primarily serve for an optimal management of one's disease and therefore nourish a fundamental ambiguity: DMPs aim at cost containment and a better quality of life for chronically ill persons. Thus the ambiguity of DMPs emanates from the fact that patients participate not only in order to improve their health but contribute as well as co-producers to the overall success of this specific tool of standardization.

3.2 *Diagnosis Related Groups (DRG)*

Concerning allocation systems within hospitals, patients' co-producing does not play a role. Diagnosis Related Groups (DRGs) subdivide patients into "clinically defined groups of treatments with extensively harmonized medical costs" (Rutz 2006, 53). Hence, the development of classificatory systems that allow a flat rate reimbursement for individual cases (Oberender et al. 2002, 215) is a key feature of DRGs. The amount of reimbursements for providers depends on the degree of severity of the medical diagnosis.⁴ Through the creation of homogenous, many covering more than one illness, DRGs intend to cover only costs that actually took place. On top of that, the performance-related categorization of expenditures for patients affords a better comparison of hospitals regarding the investment of resources and medical results (Rutz 2006, 54). Since its implementation in the German healthcare system in 2004, the economic and medical design of the DRG-system has been redefined several times in order to improve the contribution of resources alongside the costs-by-cause principle.⁵ However, the overall scope of differentiation of the system is quite limited. Cost effectiveness prevails as the new paradigm (Schulte-Sasse 2004, 67). Nevertheless, DRGs provide also advantages for healthcare users—despite their clear-cut orientation toward efficiency criteria. By making comparative analysis in terms of efficiency and medical quality easier, DRGs provide patients with more information at their fingertips and therefore facilitate their choice of hospitals.

⁴ DRGs are categorized by "objective medical criteria such as the main diagnosis, key facts for operation (surgery or non-surgery), age, sex and birth weight" (Rutz 2006, 53).

⁵ Therefore, the classification of DRG-systems takes place by labeling them according to different generations.

In sum, DRGs are conceived as financial incentive tools that initiate competition on the macro-level of healthcare systems. Patients can benefit from better quality emanating from a higher profitability of business-like organized hospital management. Other gains of influence, e.g., choice through provider competition alongside users' needs or voice mechanisms, are not accompanied by DRGs.

3.3 Evidence-based Medicine (EbM)

As pointed out in the previous sections new financing instruments draw their legitimacy by raising the general standards of healthcare. They do not primarily refer to their formal goal of cost effectiveness. Thus, as a precondition for DMPs and DRGs, verifiable quality criteria that represent the state of the art of modern healthcare need to be established. Evidence-based Medicine (EbM), consisting of quality-tested guidelines for medical diagnoses and therapies, is described as “the use of the best external, scientific evidence with regard to healthcare decisions for individual patients” (Oberender et al. 2002, 216). Consequently, it is very important for patients' autonomy as well as their knowledge-based choice among diagnostic and therapeutic treatments to what extent EbM is covering the range of medical opportunities. Furthermore, other key questions are which institutions are formulating and evaluating EbM and do patients themselves participate.⁶ From a more fundamental point of view, EbM's demand to be based on objective and neutral information makes it necessary to balance contradictory aims: namely, the unbiased disclosure of medical knowledge, including all available sources and methods (Schmacke 2005, 124), and the effort to streamline healthcare services with an eye to efficiency criteria and best-practice approaches (Kuhlmann 2006, 212). Concerning the strengthening of users' voices, the potential of EbM is at least ambivalent. On the one hand, the democratization and pluralization of medical knowledge might contribute to new bonds between professionals and healthcare users based on partnerships and shared decision making. On the other hand, EbM that is generated only by professionals can replicate the “knowledge-power knot” (ibid.) to the benefit of well-established healthcare providers.

Furthermore, the conflicts between purely medical considerations, the contribution of resources and actor-related competences and interests need to be considered (Rosenbrock/Gerlinger 2004, 223). Insurance companies, for instance, are very interested in the degree of medical differentiation of DRG-systems. Those providers that represent clients with bad risks (such as advanced age and multi-morbidity) clearly benefit from a weak degree of differentiation; to the contrary, health insurance companies with a relatively

⁶ With respect to the German healthcare system, the Federal Joint Committee (G-BA) and the Institute for Quality and Efficiency in Healthcare (IQWiG) are mainly involved in the invention of EbM guidelines. Newman and Kuhlman (2007, 105) stated that users are still treated as *objects* instead of a possible *source of inspiration* for the direction and innovation of health care.

young and healthy clientele seek for a refinement of DRG-systems (Rutz 2006, 80).⁷

3.4 Institute for Quality and Efficiency in Healthcare

Since 2004 the standardization of medicine and quality management has been accompanied by recommendations of the national Institute for Quality and Efficiency in Healthcare (German abbreviation: IQWiG). Established as a publicly financed institute “beyond the classical corporatist arrangement” (Kuhlmann 2006, 64), the IQWiG has the task to improve and monitor public health in Germany. The range of activities of the IQWiG, such as benefit analysis of pharmaceutical products, assessment of DMPs and EbM guidelines, is documented by the German Social Code Book V (SCB) (§ 139a/3). Contracting authorities of the IQWiG are exclusively public institutions, e.g., the so-called Federal Joint Committee (Gemeinsamer Bundesausschuss [G-BA])⁸ as well as the German Ministry of Health. The latter emphasizes on its webpage IQWiG’s obligation to guarantee a “reliable provision of evidence-based medical knowledge for policy-makers and citizens” (http://www.die-gesundheitsreform.de/glossar/institut_fuer_qualitaet.html, 28.3.08). Hence, in addition to carrying out research on evidence assessment, it is IQWiG’s goal to strengthen users’ autonomy through “high-quality evidence-based information (...) produced on a large scale” (Bastian et al. 2009, 185). In 2007, IQWiG’s power to create transparency within the healthcare system was improved significantly. By law (§§31, 35a and 139a, SCB), the cost-benefit analysis of drugs was permitted, which facilitates users’ choice and at the same time forces pharmaceutical providers to enter more into a user-friendly competition. However, there remains skepticism concerning the objectivity and the overall patient-centeredness of the IQWiG. Critics argue that the “physician-centred and bio-medically biased” (Kuhlmann 2006, 65) institute is just reproducing the imbalance of power and voice between healthcare providers and users. Patient organizations as well as self-help groups play a minor part in the process of generating neutral medical knowledge; they have the right only to give recommendations—provided they are members of the Federal Joint Committee (G-BA) (Newman/Kuhlmann 2007, 106).

In conclusion, the tools and institutions invented for the economization and standardization of healthcare in Germany are far from patient-centred. Cost-control and containment prevail over attempts to enhance citizens’ and patients’ opportunities to choose among healthcare providers or participate

⁷ Since 1994 these structural inequalities have been compensated within the German Statutory Health Insurances (SHI) by adjustment payments via a so-called *Risikostrukturausgleich* (RSA).

⁸“The paramount decision-making body of the self-government is the Federal Joint Committee (G-BA). The G-BA has been institutionalized as a legal entity under public law. It has wide-ranging regulatory powers which are laid down in Volume Five of the Social Code Book that governs statutory health insurance. (...) Since 2004 national groups representing patients were given the right to file applications and to participate in the consultations of the G-BA.” (<http://www.g-ba.de/institution/sys/english/>, 13.01.09).

in the governance of healthcare. One can find merely indirect stimuli towards improvements in the health-literacy or sovereignty of users. In a long-term perspective more transparency in medical results and healthcare in general, as well as the refinement of DMPs, supports the development of expert patients who are able to make their own choices. On the other hand, there remain profound doubts regarding incremental patient education: After all, the complementary and alternative medicine as a potential source of patients' autonomy and self-determination is highly underrepresented within the German healthcare system. In addition, the institutional design of the described instruments does not strengthen users' voice substantially.

The next part deals with elements of marketization in the German healthcare system. Do they combine choice and voice in a way that increases users' impact on health policy? Preliminary assessments are based on illustrative examples.

4 Marketization processes: examples from the German healthcare system

In the following, elements of users' choice and service provider competition that potentially strengthen users' sovereignty and autonomy are examined. Starting from the idea that "a new generation of patients" with "individual perspectives on diagnostic and therapeutic decisions" (Kuhlmann 2006, 160) is ready to take more responsibility for its own health, the opportunities for health consumerism and participation have a positive image. At first glance, the marketization of healthcare creates greater choice as well as opportunities for a modern and tailor-made healthcare provision than a corporatist and/or economized healthcare system. However, empirical facts from the German healthcare system bring market enthusiasm down to earth. Three examples of marketization of healthcare and health insurance support a more ambivalent picture: The increase and the acceleration of competition among healthcare providers are not automatically synonymous with an empowerment of users who are shaping the healthcare market by exerting their voice. Instead, new risks emerge from a marketized healthcare system—partly because of an inappropriate institutional design that fails to combine choice, real competition, and voice and partly because of a lack of knowledge and information among users to apply their new market power.

4.1 Healthcare insurance: choice among providers and tailor-made tariffs

Since 1997, insurants have been able to choose a provider within the German system of Statutory Health Insurances (SHI). Until now, this moderate injection of choice into an otherwise very bureaucratic complex has not equipped insurants with a considerable market or consumer power. Furthermore, the degree of difference among SHIs is not very distinctive. Despite an opening to the market, the spectrum of membership rates has been very limited. Since the introduction of the health fund in 2009, membership rates have been standardized but provide SHIs with the opportunity to

charge small additional amounts (Gerlinger et al. 2008, 108). A real competition with strong incentives for insurers to change their provider has not been developed yet. Space for competition and manoeuvre merely results from the offer of so-called bonus programs, the extension and provision of additional health information for citizens, and the inclusion of complementary and alternative medicine (CAM) in the catalogue of benefits. However, the freedom to choose an insurance company is likely to change the landscape of SHIs in the long run: Especially insurers with good risks are more willing to change their insurance company (Lauterbach/Wille 2001), and SHIs are increasingly undertaking mergers to strengthen their market power.

In 2004 competition among healthcare insurance companies was enhanced by the right to sign selective contracts with healthcare providers. Thus, insurance companies that negotiate specific contracts with pharmaceutical companies or managed care providers can improve their efficiency (Rothgang/Preuss 2008, 38). As a result of the health reform 2007, insurance companies are encouraged to offer special tariffs, e.g., optional gate-keeper systems, managed care proceedings or DMPs. On top of that, insurers can choose a cost-sharing or contribution refund system. All in all, insurers are forced to act as empowered consumers who choose their insurance coverage according to individual health needs, e.g., cheaper cost-sharing model or a more expensive model that includes for instance exclusively chief physician treatment.

The marketization of healthcare insurance so far has not empowered users remarkably. The public still perceives health insurance providers more as business companies than as patients' advocates or service providers (Kuhlmann 2006, 223). Hence, to date, claims to become more patient-centred and responsive, e.g. through the establishment of call centers that provide illness-related knowledge and expertise, have failed (Braun 2007).

4.2 The emergence of a private healthcare market: Individual Healthcare Services

Since 1998, health services that are excluded from the list of services covered by the Statutory Health Insurances (SHI) could be purchased as Individual Healthcare Services (German abbreviation: IGeL). IGeL consists of cosmetic and preventive treatments and all other healthcare services that are still excluded from the SHI benefit catalogue but might be included in the future (Windeler 2006, 19). In accordance with market rules, an ultimate list of IGeL services does not exist. Offerings are oriented to healthcare users' demands and needs (Zok 2004, 1–7). A key feature of Individual Healthcare Services is that they are neither medically necessary nor based on compelling reasons.⁹

According to a study of the WidO-Institut (press release, 10.7.07), a think tank of a big German healthcare insurance company, the demand for IGeL

⁹ This encompasses various products and services that are categorized under artificial terms such as *comfort, lifestyle or wellness medicine* but also supplementary treatments such as eye pressure measurements for glaucoma patients, ultrasound treatments, or diabetes provisions.

in Germany increases. Between June 2006 and May 2007, around 18 million insureds of the SHI have consumed individual healthcare services. The estimated annual turnover of IGeL amounts to one billion Euros. The formal requirements for the consumption of IGeL have not been observed systematically. Hence, often contracts between physicians and patients were missing just as the issuing of an invoice has not been a natural course of action (*ibid.*). A significant impact of the marketization of IGeL concerns the relationship between physicians and patients. Contradictions emerge given the fact that the former are pushed into new roles. To a certain extent, physicians are locked in the conflict between providing a professional assessment of medical treatments in terms of quality and appropriateness, and offering such treatments commercially in response to tempting benefits or financial incentives (Tonkens/Kremer 2006, 129–31). Finally, one can say, that Individual Healthcare Services force patients to take over the role of clients and consumers during their visits to doctors' offices. With regard to the German case, the pluralization of healthcare-related services and products has equipped users with more choice; nevertheless, it is based on an "inadequate information of potential buyers" (Windeler 2006, 22). Quite apart from the challenge to strengthen users' voice and resistance when it comes to the sale of supplementary health services, there is an increasing need for information, transparency and quality assurance on private healthcare markets.

4.3 Marketization of pharmaceutical provision

Patients' status as consumers becomes most apparent in the provision of pharmaceuticals and the individual consumption of medicines. By discussing three processes of transformation in this field the insidious change of roles will be verified.

The first process concerns the growing importance of self-medication—defined as the purchase of drugs that are not available by prescription ("over-the-counter" drugs) and/or just pharmacy medicines on one's own initiative (Zok 2004, 2). In 2004 the turnover resulting from self-medication amounted to 4,63 billion Euros, or 45 percent of all drugs sold in pharmacies (Bundesverband der Arzneimittel-Hersteller, [BAH], 2005). The business with self-medications has been boosted by a law that took effect in 2004 and excluded non-prescription drugs from the list of products covered by the Statutory Health Insurances (SHI) (Zok 2004, 2). According to polls, the willingness to carry out self-medication depends on wage and education and is intensified by an increasing individual awareness of health issues, the wish to practice prevention, and the influence of autonomous self-help groups (Emnid 2003). Hitherto, there is hardly any evidence that patients exert their consumer sovereignty on pharmaceutical markets. The comparison of costs, which has been possible since the abolition of price fixing in 2004, still remains an exception (Zok 2004, 7).

Second, a change in the distribution of medicines has consequences for customers and consumers. The abolition of the ban to distribute medicine via mail-order in 2004 has been a turning point from which a competition on

prices emanated (Vogel 2008, 22). If the market share of mail-order pharmacies and internet pharmacies increases further, there will be new opportunities for the marketing of drugs. At the same time, the advocacy and steering functions of ordinary pharmacies diminish. For this reason, users increasingly face the challenge to distinguish on their own the subtle advertising strategies of the pharmaceutical industry from neutral facts. At the same time, there is the potential that rising competition between different forms of pharmacies will contribute to quality improvements (Etgeton 2008, 59). However, in any case, there is a need for advocacy and support by health insurance companies and customer services.

Third, strong incentives for medicine users to ask for pharmaceutical products with low prices stem from the Medicine Provision Efficiency Law (Arzneimittelversorgungs-Wirtschaftlichkeitsgesetz, AVWG) passed in 2006. The regulation encourages users to act as price-conscious consumers by abolishing co-payments for medicines only available by prescription—provided the medication is 30 percent cheaper than the average of all offers from a certain group of active substances.

5 Preliminary summary: Attempts toward healthcare consumerism in Germany

The previous examples represent competition within the German healthcare system, which provides choice for users and healthcare consumers. Accordingly, attempts toward fostering health consumerism exist in Germany, however, with special characteristics (Kuhlmann 2006, 224; Newman/Kuhlmann 2007). Significant for the German case is that the narrative of the health consumer was not used to challenge the power of healthcare providers (Newman/Kuhlmann 2007, 102). Reasons for this might be the cultural embeddedness of the free choice of medical practitioner as well as health self-determination in general. Users' room for manoeuvre—although quite limited—results from reforms that aimed at cost containment, such as various financial incentives for users.

Consequently, users' new role as healthcare consumers is not really reflected at the institutional level, e.g., through the co-governance of healthcare providers, but rather through indirect implications in market arrangements. Recent modernization processes force patients inevitably to become experts on their own behalf. As a result, consumer sovereignty turns into a key capability—comparable with other competences like the co-production of one's own health through a high degree of compliance. Apparently, these changes provide both opportunities and risks. The promises of choice are accompanied by new requirements of transparency and information. Modern key competencies such as health-related knowledge and the ability to voice are preconditions for effectively dealing with healthcare providers. Otherwise, potentials for self-determination and autonomy turn into financial risks and health threats—as is the case when it comes to uninformed consumption of Individual Healthcare Services.

If patient orientation and consumer voice become political aims, there will be a necessity to expand offers of user information and education. In Germany, especially the institutional devices to combine the mechanism of choice with users' voice are underdeveloped. The following part recapitulates the mixed consequences for multiple users' identities stemming from economization and marketization processes and compares them with users' actual disposition, behavior and needs.

6 Ambivalent consequences for multiple users' identities

In the subsequent paragraphs, the main interest of this article—the different implications of economization and marketization processes—will be related to the targets of social policy. It will be argued that users face progressively more ambiguous messages emanating from modern governance approaches in the healthcare system. Individual room for manoeuvre depends on particular healthcare arrangements, different competencies, and health literacy. For this reasons users are forced to develop multiple identities. They are challenged to find a balance between role models such as citizens, patients, consumers, co-producers or members of a certain community (Ewert 2009).

As it was argued above economization and marketization processes pursue rather different policies, especially if it comes to the agency role of users. By summarizing the codes of conduct, the demands and consequences for users' autonomy will be illustrated. Finally, some remarks on a more abstract level will be made by referring to the cultural embeddedness of the described changes, namely through the emergence of a "health society" (Kickbusch 2006) in which a blurring of traditional boundaries and new demands on citizens take place.

Instruments of economization are all about reduction, rationalization, control and standardization; consequently, cost containment, cost-benefit analysis, and a harmonization of allocation systems are of utmost importance. They concede merely an abstract and impersonal role to users, perceiving them as cost bearers that need to be managed by managerial rationales and competition-based systems or financial incentives (Rüb 2003, 269). Particularly when economization policies were accompanied by calls for more self-responsibility of the recipients of services, the introduction of co-payments has been pushed forward.¹⁰ However, an economized health policy triggers indirect effects that shape individual lifestyles and habits in terms of health. Instead of co-designing the healthcare system and their instruments, healthcare users seem to be locked in a given and demanding framework. Economization processes tend to restrict users' autonomy by forcing them to optimize their behavior according to efficiency criteria. On top of that, patients should consider the financial implications of their illnesses and are expected to internalize awareness and responsibility for accruing costs. This limited view of users as rational decision-makers in a system denies different (civic) ambitions of healthcare users a priori.

¹⁰ This has been the case in Germany by charging medical registration fees (so-called *Praxisgebühr*) or by curtailing the list of services covered by the SHI.

Instruments of an economized and standardized healthcare system such as DRGs and EbM have an indirect impact on users. Without responding to patients as co-producers, they fundamentally change the way users are conceived by the system. In addition to gains in quality, the central effect of these mechanisms is to compartmentalize all parts of the healthcare system, including users, in order to make them comparable for economic analysis. For instance the competitiveness of hospitals depends on the possibility to evaluate its work performed precisely. Thus, DRGs are the necessary precondition for private capital expenditures (Schulte-Sasse 2004, 166).

What evidence can be sorted out with regard to marketization? First of all, strategies of marketization rely on the market power of users. Therefore, a marketized healthcare system naturally mirrors socioeconomic inequalities (Clarke/Newman/Westmarland 2007, 249). However, the activation of users' abilities to take advantage of healthcare markets requires more than mere financial resources. Users have to adopt a new kind of behavior that deviates explicitly from their former status as passive recipients of services. According to Nullmeier (2002, 973) "marketability" becomes a "social category" that has to be transferred into a "market sociality" in order to realize an individual "liberation to the market". What are the characteristics of a "market-related self-forming" (*marktbezogene Selbstformung*) (Nullmeier 2004, 498)? To a certain extent the development of a non-civic behavior is asked for. Users are encouraged to become familiar with market rules such as short-term-orientation, flexibility, mobility, and the ability to cope with risks (*ibid.*). Healthcare users' individual responsibility and marketability depend on appropriate knowledge, consumer sovereignty, quality awareness, and the ability to voice their individual preferences.

Not surprisingly, these role models do not fit with reality. As the example of Individual Healthcare Services illustrates, contradictions and shortcomings arise from the clash of very different logics. The opportunity to invest in one's health by choosing among additional services and treatments makes IGeL a clearly customer-orientated market offer. Users are explicitly addressed as consumers enabled to purchase services according to their desires rather than to medical necessities. The change of roles means that physicians partly act as entrepreneurs, whereas patients become primarily customers. Even though this logic fits well with the marketplace, there are strong conflicts regarding hitherto existing physician-patient relationships. The principle of medical care clashes with pecuniary interests of professionals providing commercial services. The peril of manipulation by market-savvy physicians holds especially true, if one bears in mind that, within the realm of healthcare, choices are seldom made by oneself. There are, instead, very sensitive cooperative and trusting procedures "based on co-production or discussion models" (Greener 2007, 198).

Both examples, DMPs and IGeL, emphasize user involvement and health literacy as key concepts of modern healthcare systems. Nevertheless, in their consequences for healthcare users they differ significantly. One can argue that in DMPs the shift of responsibility towards chronically ill persons is somewhat marked by deprivation in terms of autonomy and self-determination. Anyhow, in order to avoid the most serious consequences of

the disease and to hold treatment expenses down, patients commit themselves to compliance. How far individual ideas, needs and preferences are realized in DMPs depends on patients' competencies and the particular physician-patient relationship.

In contrast, the expansion of choice by IGeL aims at market-mimicking consumer participation—a challenge that, at present, definitely asks too much of the mainstream of German healthcare users. In addition, it is noteworthy that against the backdrop of economization and marketization processes, role models of physicians need to be reshaped as well. Economic restraints, rationalized medicine and likewise financial incentives resulting from IGeL have an impact on the interaction with patients. Currently, a strategic and heterogeneous role model, given preference to self-determination and individual responsibility, gives physicians a license to distance themselves from patients' medical conditions (Kühn 2005, 23). Instead, self-inflicted contributions to illnesses through risky and unreasonable lifestyles come to the fore (Dietrich 2006, 15).

Finally, there are additional tractive forces for users to develop an appropriate handling of health questions and knowledge beyond the tools of economization and marketization that have just been discussed. Nowadays the significance of health has extended beyond the medical, mostly curative, sector. According to Kickbusch (2007, 151), this change could be described as follows: "Health moves out of the expert medical system into the context of everyday life and everyday behavior and becomes ever more open to social rather than medical definitions and constructions." This new environment attempts to reconcile the commodification of health with claims of empowerment and a promotion of health (as it is stated in the Ottawa Charta from 1989) instead of concentrating on illness. Health decisions have become a daily challenge for multiple users' identities: Citizens are encouraged to contribute to healthy environments, for instance, by abandoning smoking. Insurance companies activate their clients to change their lifestyles in order to prevent costly diseases in the future. Patients learn that their state of health or convalescence depend much on their willingness to act as co-producers, whereas health consumers are faced with the challenge to differentiate between their own needs and the increasing number of medical services and products available on healthcare markets. Health touches users' identity as community members in families and also in social areas where the promotion of health is of special importance such as in self-help groups or in similar community networks in which users receive support when chronically ill. All these changes contribute to the way health is culturally perceived and embedded in modern society. Furthermore, they reinforce governance approaches that activate healthcare users. This, however, takes place in the name of economization or marketization.

7 Final remarks

What can be concluded from this article with regard to the guiding research interests? Instead of recapitulating the major findings, this final part at-

tempts to formulate some recommendations for a healthcare system that strengthens users' agency and provides them equally with opportunities and advocacy.

First of all, there is a need for a real change of perspective. Even though almost every actor in the German healthcare system claims to be patient-centred and user-friendly, there is a lack of drivers bringing this promise to life. Cost-containment policies clearly dominate the discourse by generating an atmosphere in which policy makers and healthcare providers reduce the term "user involvement" to cost sharing by patients or other personal contributions that relieve corporatist actors in the German healthcare system financially. Less creative inventiveness exists regarding the extension of users' choice and voice. As the cases for marketization indicate, there have been efforts at "making services fairer and more responsive" (Greener 2007, 197). However, the given examples illustrated that the degree of responsiveness merely concerns the access and the quality of healthcare. Voice, defined as users' power to co-govern the provision of healthcare, is rarely developed and even ignored. For instance, the case of Individual Healthcare Services points out that both professionals and patients often do not have the capabilities to negotiate a shared decision that reflects patients' needs. Even worse, IGeL equips professionals to take advantage of patients' medical ignorance. Thus, the expansion of choice has to be linked more effectively with tools that safeguard the participation of citizens, patients and consumers. Along this vein, relatively new institutions, e.g. petition boards or ombudsmen in hospitals (Schaeffer/Dierks 2006, 74), have to be further developed. Positive effects might also emanate from the strengthening of patient, self-help and customer groups in the governance of the German healthcare system. Currently, these actors play only an advisory role in the Federal Joint Committee (G-BA), even though this is remarkable progress compared to the past (see Etgeton 2009, also: Heberlein 2005; Köster 2005).

Both processes of economization and marketization suffer from the technocratic grasp on users. Until now the development of a supporting culture that helps to exert autonomy and sovereignty is still worthy of improvement. Despite several promising approaches like the patient university in Hannover (Dierks 2009; Dierks/Seidel 2009) or the flourish of independent advice centers and guidebooks for patient consultation (Schmidt-Kaehler 2007), a cultural shift towards user empowerment has not taken place. In particular, joint efforts are necessary for the integration and cooperation of the very pluralistic field of advocacy groups (Schaeffer/Dierks 2006, 85). This encompasses also the improvement of professionals' competencies to advise patients in their choice among healthcare providers and solutions. The search for tailor-made choices depends on users' abilities to express their needs. Here, agency in terms of health requires skills to cooperate and communicate with intermediaries. These demanding preconditions for applying modern tools in the health sector or struggling through the maze of options indicate a new source of social inequality: expert patients are nowadays not only dependent on financial resources but also on specific knowledge and social and cultural capital—the capability to interact with profes-

sionals, to voice one's needs and to maintain personal autonomy despite strong and sometimes contradictory behavioral demands.

However, beyond the skills that enable users to behave adequately in DMPs or to shop competently on healthcare markets, there is the need for something else. Surely, the recognition of multiple users' identities that acknowledges also the existence of hyphenated terms, e.g. citizen-consumers (Clarke et al. 2007) portrays complex realities better than the former one-dimensional approaches did. With regard to the German case, one can criticize that the fairly technocratic transformation from passive into active users took place without a clear delineation of their role as citizens. Thus, rationalities such as solidarity, creativeness, especially in a sense of "democratic experimentalism" (Unger 2004), but also civic disobedience and the ability to be critical are more or less denied. In view of the framework of an economized and marketized health policy, there is some evidence that these might be rationalities and capabilities to assert additional claims, such as demands for autonomy that withstand standardized coping or cost containment strategies or the evaluation of healthcare services in terms of quality and user-friendliness. Strengthening users' agency primarily depends on the importance a certain policy attaches to their role as citizens and community members. Obviously, within such a personal and sensitive matter as health, these identities and role models clearly outreach any other characteristics.

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