

Health Governance in the Aftermath of Traditional Corporatism: One Small Step for the Legislator, One Giant Leap for the Subsystem?

Nils C. Bandelow

University of Braunschweig (Germany)

Abstract

There is much change happening within outpatient care in Germany. What will be the outcome of these changes? This article analyzes changes in the legal framework and policy impacts concerning the system of organized interests. Subsequently the manifold changes in German regions are analyzed to develop ideal-typical scenarios of the possible future of hierarchy, market, and cooperation in outpatient care governance. It is argued that minor reform compromises are about to lead to major changes of the subsystem.

Zusammenfassung

Im Schatten der öffentlichen Auseinandersetzung um Bürgerversicherung, Gesundheitsprämie und den Gesundheitsfonds wurden wesentliche Veränderungen im System der ambulanten gesundheitlichen Versorgung in Deutschland vollzogen. Wie werden sich diese Veränderungen auswirken? Diese Frage wird auf Grundlage einer Analyse der rechtlichen Neuerungen und der daraus resultierenden Veränderungen im System der organisierten Interessen untersucht. Der Beitrag unterscheidet idealtypische Szenarien zukünftiger Governance-Formen im ambulanten Sektor. Dabei wird deutlich, dass die deutsche Verhandlungsdemokratie oft nur kleine rechtliche Veränderungen als Kompromiss zwischen den gegensätzlichen Interessen zulässt. Diese kleinen rechtlichen Schritte können aber mittelfristig zu einem grundlegenden Wandel des Subsystems führen.

1 Introduction¹

Until the late 1980s outpatient care in Germany was an “ideal-type” of sectoral corporatism (Rosenbrock/Gerlinger 2006: 280). Self-governance and the dominance of large provider associations were the main characteristics of the German outpatient health care governance (Lehmbruch 1988). Public corporations in particular were able to insure privileges for their members by being involved in every decision concerning the range of benefits and prices of outpatient care.

This system has come under increasing political pressure since the first oil crisis in the mid 1970s (Hegelich/Meyer 2008: 130-131). Governments led by both the CDU/CSU and the SPD have argued for sustainable solutions to contain the rising health costs. More than 20 attempts to introduce structural reforms have been undertaken, though most of these only lead to incremental change. The German consensus democracy, the patterns of

¹ I am grateful to Markus Grunenberg, the special issue editors, and the reviewers for helpful comments and suggestions.

semi-sovereignty and the powerful associations worked as efficient veto points in preventing a significant change in the German health system (Altenstetter/Busse 2005).

If the supporters of major reform policy look at the policy outcome there will be little cause for optimism: The proportion of the GDP on health expenditure has risen continuously. The most recent Statutory Health Insurance (SHI) Competition Strengthening Act of 2007 (CSA, GKV-Wettbewerbsstärkungsgesetz), concurred with a further rise of contributions to the SHI (Green/Paterson 2009). Considering the financial and economic crisis that started in 2008 even larger problems in the German health system can be expected.

But there is another side to the German health policy that is revealed when investigating policy output instead of outcome: Despite the failure of sustainable cost containment there have been some considerable changes in the institutional structures. The first major changes were introduced by the Health Structure Act (HAS, Gesundheitsstrukturgesetz) of 1992. The HSA did not overcome the self-governance of the SHI but changed the legal framework of the negotiations significantly (Bandelow 1998: 206-208).

The subsequent attempts of both the former Kohl and Schröder governments hardly continued the structural conversion started by the HSA. So it was up to the grand coalition that came into power in 2005 to take up the dissolution of the power of the associations and to change traditional patterns of negotiations. Both the SPD and the CDU/CSU shared at least the wording of their ideas to strengthen competition within the system even though the parties have totally different views of the problem, the future health system and even the definition of competition (Bandelow/Schade 2009).

At present the structural changes introduced by the latest reform are about to be implemented. There is much change happening within outpatient care. Up to now we can only observe the output and impact of the changes. One has to complete the analysis of the changes that have occurred so far by looking at the long term perspective. What will be the outcome of these changes? This article aims at answering this question by combining the heuristics of the policy cycle with a perspective centered on the protagonists. Referring to the Actor-Centered Institutionalism (Scharpf 1997) it will argue that changes of institutional rules will result in predictable decisions of rational actors. Unlike most applications of the Actor-Centered Institutionalism this observation will not only be used to create models that explain past policy results but to formulate scenarios of future policies.

Part 2 will focus on the changes in the legal framework. Health care policy has already led to major changes within the system of organized interests, especially concerning physicians' associations. These policy impacts will be presented in part 3. Subsequently the manifold changes in German regions are analyzed to develop ideal-typical scenarios of the possible future of hierarchy, market, and cooperation in outpatient care governance.

2 Policy Output: Legal Changes of Outpatient Care Governance

Outpatient care governance underwent several changes during the last decades. After World War II it took many years to re-establish the major elements of the Bismarckian health system. Against some opposition by the social democrats, the early Adenauer government not only re-introduced the separate systems of sickness funds, but also relaunched the corporatist institutions. The most important players within the system of outpatient care became the Associations of Statutory Health Insurance Physicians (ASHIP, *Kassenärztliche Vereinigungen*) that were provided with the full responsibility to guarantee the provision of outpatient services. The ASHIP negotiated with the sickness funds on both the regional and the national levels. On the national level the government refunded the National Committee of SHI-Physicians and Sickness Funds in 1956. The National Committee has increasingly gained authority and became the most important institution within the German health system (Döhler 2002).

During the first decades the governments aimed at providing a system that guaranteed solidarity within the limits of stratification and subsidiarity. This means, that the range of benefits and the proportion of public financed health services grew. Indeed, the solidaristic system still excluded parts of society like civil servants and high-income households. Furthermore, it relied on the separation of societal groups to be insured in different subsystems of the health insurance.

In the aftermath of the economic crisis of 1973, the ability to finance the system became the major goal of German health policy. To achieve this goal, the cost containment policy that started in the mid 1970s originally extended and deepened the system of self-governance and corporatism. The Health Insurance Cost-Containment Act (HICCA, *GKV-Kostendämpfungsgesetz*) of 1977 established the Concerted Action in Health Care (CAHC). The CAHC intentionally used the name of the tripartite economic Concerted Action that broke up in the same year (1977). Unlike the National Committee, the Concerted Action never became a central institution for outpatient governance. The Concerted Action suffered from the problem of unanimity by having to include a large diversity of interest groups. It never gained enough legitimacy to implement major policy changes (Wiesenthal 1981).

So the cost containment policy originally established sectoral committees of provider associations and sickness funds and strengthened the competencies of these committees. The state supervised these committees and used soft forms of governance to reach their own goals. Negotiations have been the most important type of governance while the governing capacity of the state was limited and there was almost no competition within the system. This strategy was pursued until the end of the 1980s.

Since 1992, there have been different and partly oppositional strategies concerning change of the health policy governance. The Health Structure Act occasionally pursued a strategy that aimed at weakening the traditional negotiation structures. It used several legal instruments of hierarchical steering like cost budgeting and limitation of approved physicians. Additionally,

the HSA was a first step to enable competition by introducing an organizational reform of sickness funds.

After the HSA had been enacted by an informal Grand Coalition, the Kohl government returned to the strategy of strengthening self-governance. The SHI Reorganization Acts of 1997 (GKV-Neuordnungsgesetze) were communicated using the motto “right of way for self-governance” (Bandelow 1998: 219).

Nevertheless the second Reorganization Act already allowed decentralized competition (SVR Gesundheit 2005: 35). By introducing the possibility of pilot projects (article 63 of Social Code Book V) and structure contracts (article 63a of Social Code Book V) a test phase of new supply forms was initiated. Model plans served the development of organization and payment to increase quality and economic efficiency. Sickness funds got the chance to conclude contracts with individual doctors, doctor’s teams or associations of Statutory Health Insurance Physicians. The act used financial incentives to stimulate competition within the medical profession.

The actual effect of the pilot programs has been limited by hurdles that came into force during the implementation phase. In particular the high start-up expenses proved to be an obstacle. Savings could only be reached in the medium term and were often only small and did not immediately go back to the model plan. At the same time the sickness funds aimed at limiting their expenses instead of increasing the quality of services. Therefore most actors would not consider the competitive elements of the 1997 reform as successful (Rosenbrock/Gerlinger 2006: 257).

In spite of these failures the red-green government continued the strategy of the Reorganization Acts. It introduced further contract options in 2000. In contrast to the Kohl government, the green health minister Andrea Fischer not only wanted to increase financeability but also to ensure better quality by changing the governance patterns. The government therefore focused on the idea of integrated care to combine primary with specialist and inpatient services (articles 140a-d of Social Code Book V). Although the implementation still relied on the negotiations between the different types of providers. In the end the results were not very satisfying. The reform enabled some networks of SHI practices but did not overcome the border between inpatient and outpatient care. It thereby demonstrated again the difficulty of introducing considerable changes by relying on the bodies of self-governance and corporatism.

After the replacement of Andrea Fischer with the social democrat Ulla Schmidt, the strategy of the ministry changed. Schmidt increased the pressure to strengthen the state, to enable competition and to overcome traditional patterns of self-governance and corporatism. She first used a policy window in the aftermath of chancellor Schröder’s agenda 2003 speech to mirror the Health Structure Act of 1992: In 2004 she agreed with the oppositional CDU/CSU to introduce the SHI Modernization Act (GKV-Modernisierungsgesetz). The reform has become a perfect example of poor reform communication. Schmidt gave way to the CDU/CSU to introduce a quarterly flat-rate charge of SHI patients for ambulatory treatment. This

treatment fee of 10 Euros is very unpopular and gave the provider groups the chance to attack the reform altogether.

The modernization act also was a significant step in changing health care governance. It extended the legal basis of integrated care and increased the monetary incentives. Additionally, medical care units (Medizinische Versorgungszentren) were allowed (paragraph 95 Social Code Book V) and the threshold between inpatient and outpatient care was lowered (paragraphs 73c and 116b Social Code Book V). So the negotiation system of the Associations of Statutory Health Insurance Physicians not only lost their monopoly but had to face real alternatives. Since 2004, 1,088 medical care units have been established. Most of these units are located in large cities and are under the aegis of office-based physicians (Ärzte Zeitung 30th October 2008).

At the end of 2008, there were about 6,000 contracts in the field of integrated care, although most of these contracts only covered a small amount of money (altogether about 800 million Euros). In contrast to other patterns of single contracts, the future of integrated care still remains unsolved. In 2008 the start-up funding for integrated care ended and experts expected about half of the contracts to be phased out (Ärzte Zeitung 12th November 2008).

The displacement of the traditional corporatist actors and institutions was supplemented with a centralization of decisions relating to the general framework for contracts. The reform of 2004 merged the numerous National Committees of providers and sickness funds to become a Federal Joint Committee (FJC, Gemeinsamer Bundesausschuss). The FJC defines the range of benefits and also decides upon the approval of new sorts of treatment using a cost benefit analysis.

The Federal Joint Committee still is an arena of self-governance and could even be interpreted as a new form of corporatism (Gerlinger 2008). The centralization enabled much more direct control of the health ministry though. In contrast to the situation in the former National Committees, no provider is able to dominate the negotiations within the FJC. The Associations of Statutory Health Insurance Physicians in particular lost influence within the new system. Officially, the ministry is only a legal supervisor, but it takes this supervision quite seriously and is suspected by the members of the FJC of (mis)interpreting its role to become a functional supervisor (according to interviews with representatives of associations that are members within the FJC).

Ulla Schmidt survived as health minister when the red green government was replaced by the second formal Grand Coalition in 2005. She still followed the strategy of weakening the actors and institutions of the traditional corporatist system. On the federal level, the Grand Coalition continued to strengthen state control. The changes on the regional level are much more difficult to evaluate, as the latest reform eliminated old structures without determining the new system.

In January 2007, the Amendment to the Law Governing the Professional Activities of Physicians in General Practice (Vertragsarztrechtsände-

rungsgesetz) enabled new forms of contracts. It became much easier for physicians to work at multiple places and to employ other physicians.

The main health reform act of the Grand Coalition was the Competition Strengthening Act (CSA), enacted in April 2007. Like the Modernization Act, the CSA was a disaster in public communication. The public only was aware of the financial reform. The parties have bound themselves to the apparently incompatible concepts of citizens' insurance (SPD) and health premium (CDU). Bargaining between the party leadership of both partners led to the health care fund (Gesundheitsfonds, Richter 2005), which looked like a sell-out that did not serve either of the goals of both parties.

Even though it did not receive much public attention, civil servants used the public controversy concerning financial issues to introduce major changes of health care governance (Bandelow/Schade 2008). While the act of January 2007 strengthened regional pluralism, the CSA—despite its name—did not directly enable competition but continued the centralization of the system. The FJC especially has become professionalized and now includes professionals appointed by the Ministry of Health. The number of other members was reduced and the former corporate bodies of the health insurances were downgraded to become private associations. Their competencies were mainly given to a new SHI umbrella association of all sickness funds.

The health care fund also contributes to the centralization. While up to the end of 2008 each sickness fund could decide on its respective contribution rate, there will be a single rate valid for all sickness funds. The rate is actually set by the ministry. The sickness funds are allowed to raise an additional contribution or to pay a refund to those insured dependent on their respective balances. In contrast to the different contribution rates, the additional contribution is quite visible for those insured (who have to bear it on their own, while the employers are released from paying more than 7.3 percent of the base rate salary). So the health fund might increase the pressure on the sickness funds to achieve financeability in the long run.

In total, there are changes towards both more competition and more state. The results are appropriately described as a 'regulated health market' by Böckmann (2007). Similar developments also can be found at other Bismarckian health insurance systems as in France and the Netherlands (Hassenteufel/Palier 2007). At the federal level, the health ministry became the central actor with an advanced legal supervision and enlarged intervention authority. At the regional level single health insurances play a significant role to implement the federal measures.

At present, there are still different possible paths for the future of German health governance. Although the changes of the legal framework and the increasing pressure of financeability already caused significant changes in physicians' associations that will be evaluated in the next chapter.

3 Policy Impact: Actors and Goals in the new German Outpatient Care Policy

As shown above, legal changes enabled new patterns of contracts between suppliers and sickness funds at the regional level. The regional Associations of Statutory Health Insurance Physicians lost their monopolies. The new legal framework intended to give sickness funds a stronger position for negotiations with the physicians. They can now close contract with single suppliers or supplier groups. The physicians reacted to these changes by reorganizing their interests within new associations and cooperatives. At the same time, the traditional associations have to redefine their role within the new framework. As a consequence, one can observe several exciting developments in the intermediation of physicians' interest.

The best known and by now most successful new cooperative is the MEDI group which was founded by former officials of a southern ASHIP as a parallel organization to the corporate bodies. The more than 12,000 physicians and psychotherapists that are organized within MEDI are companions of the MEDI GmbH. Starting with Baden-Wuerttemberg the MEDI cooperatives have succeeded in founding new organizations in several federal states and at least partly reach high organizational degrees. By now, MEDI groups exist in Bavaria, Berlin, Brandenburg, Hesse, Mecklenburg-West Pomerania and Rhineland-Palatinate, associated are practise networks in North Rhine-Westphalia.

MEDI belongs to the most radical associations within the new system. The cooperatives aim at completely replacing the system of the corporative bodies at the regional level. For that purpose they use the paragraphs 72a and 95b of the Social Code Book V. These articles specify the chances for competitors to take over the responsibility for guaranteeing provision of services from a regional ASHIP. If more than 70 percent of the physicians within a medical specialty, a region or a federal state deliberately resign from their approval as ASHIP members, the responsibility for the services passes on to the sickness funds.

The self-image of MEDI is to be a multidisciplinary, democratically legitimized community of office-based physicians that follows espousing conservative values and structure-conservative beliefs. The cooperation strives for both a political and economic mandate to negotiate the interests of its members. It supplies and organizes individual contracts with sickness funds by using the legal framework of regional competition (Rübsam-Simon 2005).

MEDI follows the core belief that only practice networks will be able to protect office-based physicians against the dominant demand power of the sickness funds. The practice networks need stable internal contracts to guarantee high income for their members in spite of the legal attempts to weaken physicians' negotiation position.

While MEDI is quite successful in southern Germany, other physicians' cooperatives have been founded that have more influence in northern federal states. Especially in Lower Saxony and Schleswig-Holstein these "Ärztegenossenschaften" have already reached sufficient membership to negotiate

for individual contracts with sickness funds (Ärzte Zeitung 22nd September 2008). In 2008, the federal association of these Ärztegenossenschaften claimed that they have nearly 15,000 members in total.

Beside the corporative bodies and the newly emerged cooperatives there are several established and new associations that organize the interest of German physicians. The largest of these associations within outpatient care is the traditional Hartmannbund. The Hartmannbund is the oldest German physicians' association. Its predecessor Leipziger Verband was founded in 1900. It organizes physicians of all sectors but concentrates on office-based physicians. About two thirds of its nearly 40,000 members work in outpatient care. The Hartmannbund is a very traditional lobbying group and still defends core features of the old system. In contrast to MEDI, it has for a long time avoided taking part in single negotiations with health care funds.

The Hartmannbund is mirrored in several ways by the NAV-Virchowbund that was founded by a fusion of a physicians' association from the old federal republic with a strong partner from eastern Germany. The NAV-Virchowbund has about 20,000 members. Its opposition toward the new contractual system is not as radical as the position of the Hartmannbund. In contrast to the Hartmannbund, the NAV-Virchowbund agreed upon a general cooperation with MEDI and the Ärztegenossenschaften at the federal level to prepare joint contracts on the basis of articles 73b and 73c (Ärzte Zeitung 1st July 2008).

Both the Hartmannbund and the NAV-Virchowbund are facing rising competition of associations that organize specific groups of physicians. The biggest of these associations are the German Association of General Practitioners (GAGP, Deutscher Hausärzteverband) that has about 23,000 members and the Professional Association of German Internists (PAGI, Berufsverband Deutscher Internisten) with some 25,000 members. Both associations contribute to the rising conflict between general practitioners and specialists. The conflict is a continuing issue within the corporate bodies and sometimes also reaches the new cooperatives.

Beside the PAGI there are several smaller associations of specialists. Fifteen of these smaller associations have founded a federal umbrella association of specialists (Spitzenverband Deutscher Fachärzte) in 2008 that competes with both the GAGP and the PAGI. In contrast to the PAGI, the members of the new umbrella associations only represent office-based physicians and do not want to include hospital-based specialists (Ärzte Zeitung 7th May 2008).

Generally the policy of cost containment has led to a fragmentation of physicians' associations. Beside the general fragmentation of interest one can observe a pluralization of actors and interests. There are increasing differences between the regions. For example, MEDI and the GAGP cooperate in some regions while they compete in others. In Baden-Wuerttemberg, both associations have worked together and jointly have won a major contract with the local sickness fund. The contract has included 3,055 practitioners and more than 600,000 insured people up to July 2009 (Ärzte Zeitung 28th July 2009). A similar contract was signed by MEDI, the GAGP and the

Company Health Insurance Fund in Baden-Wuerttemberg (Ärzte Zeitung 23rd June 2009).

At the same time, MEDI face sharp criticism from other physicians. Though they have not only been able to compete successfully against the local ASHIP, they also dominate their competitor at the same time. At the last elections of the assembly of SHI-physicians (Vertreterversammlung) in Baden-Wuerttemberg MEDI only missed very narrowly a majority on its own. As MEDI cooperates with the GAGP it is very difficult for their opponents to use the public corporation as a real alternative against MEDI.

Competition between MEDI and the GAGP is based on different general goals of both associations within the new system: While MEDI aims at dismantling the traditional system, the GAGP wants to save and improve the income of general practitioners. So they disagree when it comes to the question whether the specialists should be integrated into the selected contracts with single sickness funds. MEDI needs the support of specialists to establish itself as a real alternative to the Associations of Statutory Health Insurance Physicians. Therefore it wants to use paragraph 73c of the Social Code Book V (special medical outpatient care) to enlarge the basis of existing contracts that were only negotiated for general practitioners on the basis of paragraph 73b (Ärzte Zeitung 28th July 2008).

In Bremen, in contrast, the GAGP is negotiating for a single contract with the local sickness fund on the basis of paragraph 73b without including any partner (Ärzte Zeitung 10th November 2008). The Berlin GAGP cooperates with several local physicians' associations (excluding MEDI) and has just agreed upon a 73b-contract (Ärzte Zeitung 3rd August 2009).

Aside from Baden-Wuerttemberg, Bavaria and Rhineland Palatinate are the main strongholds of the development to build alternatives to the corporations. In Bavaria, both MEDI and the GAGP have organized a "Korbmodell" to return the approval to the SHI. It turned out that it was quite difficult to reach the required proportion of 70 per cent of all doctors of a federal state, a region or a specialist group (Ärzte Zeitung 23rd June 2008). Only if this proportion is achieved can the supervisory authority decide that the provision of services is no longer guaranteed by the ASHIP and can transfer the responsibility to the sickness funds. Obviously, it is very difficult for competitors of the corporations to win enough direct support even in southern Germany.

Therefore other associations work together with the ASHIP in Bavaria. In 2008, a special Bavarian coalition was built of the ASHIP, the Hartmannbund, the PAGI and some local physicians' networks to win a contract with the local sickness fund under paragraph 73b (Ärzte Zeitung 24th September 2008).

While in Baden-Wuerttemberg MEDI opposes the ASHIP-system, it cooperates with the ASHIP in Rhineland-Palatinate. As in Baden-Wuerttemberg, MEDI is involved in the guidance of the corporation. In contrast to the southern neighbors, MEDI in Rhineland-Palatinate only organizes about 1000 physicians and therefore still lacks the basis for a confrontation against the ASHIP. Indeed, even in Rhineland-Palatinate MEDI discusses ways to oppose the ASHIP-system (Ärzte-Zeitung of 6th February 2008).

In the other federal states varying alliances can be observed. In Hessen the conflict between general practitioners and specialists dominates the assembly of the ASHIP. At the same time, the assembly tries to avoid separate contracts of its members with single sickness funds.

In Lower Saxony, Hartmannbund, the Net Alliance Southern Lower Saxony (Netzallianz Südniedersachsen) and the Ärztegenossenschaft have agreed upon joint negotiations with the sickness funds. Even though the ASHIP is not a member of this group yet, the associations are much more open to include the corporation into single contracts than in southern Germany.

Most of the northern and eastern federal states have changing confederations of associations that usually include the regional ASHIP. On the federal level, MEDI, the federal association of the Ärztegenossenschaften and the NAV-Virchowbund have built an alliance for negotiating outpatient care. The National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung, NASHIP) has been hampered by the conflict between general practitioners and specialists for a long time.

In addition to corporations, old associations and new cooperatives, the hospitals are about to emerge as players in outpatient care in some regions. The legal status of hospitals' outpatient care is a very controversial topic. Some large hospitals refuse participation in single contracts, while others already have applied for them. So it is quite difficult to find a general pattern of the new actor constellation in outpatient care. But the new institutional rules and the rational interest of the major corporatist actors allow us to formulate ideal-typical scenarios and to predict their respective policy outcome.

4 Future scenarios of outpatient-governance and their consequences

Originally, the introduction and strengthening of competition in outpatient care aimed at increasing financeability. Competition was believed to be an instrument to improve efficiency and thereby contain health costs. During the process of formulating the SHI-CSI the financeability and competition have been discussed in separate arenas. While financeability became a topic of the party leadership, the strengthening of competition has been negotiated by specialists and civil servants. In contrast to the party leadership, the specialists have not primarily followed the goal of financeability but are interested in guaranteeing the quality of health services much more. At the same time, the specialists of both large parties have agreed that the power of interest groups has to be reduced. This should apply both for the power of sickness funds and of health service providers like physicians (Bandelow/Schade 2008).

The policy outcome of the new system depends crucially on recent and further decisions by both politics and subsystem actors. Up to now, there are still a huge number of partly inconsistent patterns in different regions (Jacobs 2007: 335). Idealtypically, one can distinguish four possible developments. First the traditional system with a strong position of regional Associ-

ations of Statutory Health Insurance Physicians could continue to exist. Much more likely is another development that will lead to a replacement of the old monopolies of corporations by new monopolies of single associations in each region. The “third way” is the official goal of plural competition with several providers working for a better quality of services. Fourthly, it is possible that the sickness funds focus on different groups of insured people.

Continuing Dominance of the ASHIP System

There is some evidence that the Associations of Statutory Health Insurance Physicians will be able to maintain their dominance in spite of the formal increase of competition: The contract competition still is restrained by the problem to get uniform guidelines for the payment of standard benefits in inpatient and outpatient care (Hess 2007: 987). The legislator admits selective contracts only if exhaustive services are guaranteed. The ASHIP could remain in some regions as the only suppliers who can give this guarantee in their contracts. The introduction of disease management programs (paragraph 137f of Social Code Book V) strengthened the position of the ASHIP as they used to be the only competitor to be able to realize an exhaustive registration of patients (SVR Gesundheit 2005: 34). Besides, it is difficult to persuade physicians to abandon the ASHIP interest. As discussed above, the attempt to win enough support against the ASHIP within the general practitioners in Bavaria has failed up to now.

This first scenario is consistent with a traditional self conception of the sickness funds. Within this way, the sickness funds only use single contracts to supplement the supply of the ASHIP. They would not compete with each other for special services but would avoid any strategy that restricts the free choice of doctors. So not only the ASHIP but also the sickness funds would resist significant changes.

New Monopolies

The latest policy decisions in particular have increased the probability of a general change of actors within the system without a real change of basic structures. The SHI has already given patients a general right to register for a primary physician gatekeeper model. So every sickness fund is forced to find partners for primary physician contracts. The payment of these contracts is cut from the overall remuneration for medical services.

The replacement of the monopoly of the ASHIP will not necessarily enable real competition. There is still the chance that a situation emerges with only one large association or group of allied associations that are able to provide exhaustive services in a region.

In an extreme case, the new monopolies would lead to a situation that strengthened the power of service suppliers ever further than within the old system. Previously the ASHIP was faced with only a few associations of sickness funds that were able to cooperate. So the monopoly on the supply side could have been balanced by the powerful demand side. The new struc-

tures will strengthen the competition between single sickness funds. The new monopolies could use this situation to negotiate different services with different sickness funds. They thereby might negotiate increases of physicians' benefits that have never been intended by the legislator. If one looks at the latest development of physicians' income, one can already find some evidence for the thesis of stronger instead of weaker physicians' associations. They were able to negotiate an increase of payments for outpatient care in different regions between 2.5 per cent and 8.6 per cent in 2009. Indeed, there is no relation between the respective organizational structure of physicians' associations and the amount of regional increases in benefits visible so far (Ärzte Zeitung 27th October 2008).

Nonetheless, the legislator itself has already paved the way for the new monopolies. Under pressure from the Bavarian state government, paragraph 73b of Social Code Book V was changed in 2008. The governing Bavarian party, the CSU, has followed the pressure of the German Association of General Practitioners in the run-up to the state elections to include a new requirement for any association that is allowed to apply for single contracts under this article. The new regulation is part of the Act to Develop the Organizational Structures of Sickness Funds (ADOSSF, GKV-Organisationsstruktur-Weiterentwicklungsgesetz) that passed Bundestag and Bundesrat in October and November 2008, respectively. So the artificial monopoly of the GAGP has been backed not only by the CSU but also by the SPD even though critics belong to nearly all major parties (Ärzte Zeitung 7th July 2009). Up to 30th June 2009, every sickness fund had to agree on a contract with an association that meets the requirement. As a requirement, the association has to represent 50 per cent of the general practitioners in the region. Neither pediatricians nor internists have been included in the definition of general practitioners. Therefore competitors of the GAGP will have little chance to participate in this sort of contract.

Within this scenario the sickness funds also face changes. In contrast to the ASHIP, free associations like the GAGP do not have the responsibility for guaranteeing provision of services. So the sickness funds will gain this responsibility. This will increase the pressure on small sickness funds to merge with larger partners. It is also possible that regional monopolies of associations develop in partnership with the local sickness funds. So even within pluralist competition we will have less than the currently 186 sickness funds in future (Ärzte Zeitung 13rd August 2009)

Pluralist Competition

The third scenario describes the actual policy goal of the legislator: the establishment of a pluralistic competition around the highest-quality supply. Health specialists of both large parties still believe that they could approach this goal by the recent measures.

Public Health experts have a lot of objections against this idea though. First of all, there is doubt if competition really could lead to quality. Competition would only produce incentives towards better quality if the demand side of the market was able to distinguish different levels of quality (Wille

1999: 131; Hajen/Paetow/Schumacher 2000: 52-53; Lungen/Lauterbach 2007: 292). As patients usually are not able to evaluate the medical quality of services, competition could produce opposite incentives. Service suppliers might try to reduce costs, as this is the only thing everybody could easily overlook (Rosenbrock/Gerlinger 2006: 243).

Furthermore, there are general problems of competition within the health sector like the *uno actu* principle (Herder-Dorneich 1979: 119). So it is not only unclear if there will be any competition within future outpatient care but also to which outcome competition might lead.

The role of the traditional corporate bodies within this scenario remains unclear. It is still legally contested whether the ASHIP is allowed to apply for contracts on the basis of paragraph 73b in all regions (Ärzte Zeitung 2nd October 2008). Additionally, not all ASHIP actually want to take part in the new competitive game. While in some regions—for example in Bavaria—the ASHIP joined a coalition that applied for a contract, the ASHIP in other regions—like Schleswig Holstein and North Rhine—even warned that the disadvantages may actually outweigh the benefits for those who take part in selected contracts (Ärzte Zeitung 22nd August 2008; KVNO 2008). Furthermore there is an internal problem. The ASHIP being made up of corporate bodies, are not able to work as independent competitors. They are much more an arena for the conflict between the different groups than an actor themselves. Each competitor has the chance not only to compete for better services than the ASHIP but also to dominate the ASHIP assembly. So if an association or a group of associations wins a dominant position within a region it will usually also be able to win a majority of seats within the ASHIP.

The strategy of the sickness funds will be a customer-oriented one in which the insured can be persuaded that they will gain a better service, prices and/or quality by single contracts. Up to now, single contracts still lack quality gains as aimed by the legislator. Pluralist competition will only be successful if sickness funds find strategies to win new policy holders by promising better quality because of single contracts. For example they could promise shorter waiting periods or offer special checkups for their members. Single funds have already promised to follow this strategy (Ärzte Zeitung 28th July 2009).

Like the others scenarios, pluralist competition will be accompanied by a further reduction of sickness funds. But there will be several funds with different quality strategies in each region. The risk remains that we will face the development of more expensive funds offering better quality on the one hand (competing with the private health insurance). On the other hand there might be insurance funds for people who cannot offer additional contributions and get worse treatment than today.

Fragmentation by Specialization of Sickness Funds

The fourth ideal typical scenario is based on a possible development of the strategies of the sickness funds. Opposite to the other scenarios, it does not start with a possible development within the organizational structure of phy-

sicians' associations. On the contrary, it looks at the demand side of outpatient care.

The new system could lead to incentives for sickness funds to specialize on specific groups of insured people and patients. This would have significant effects on the whole system. The sickness funds could develop political strategies instead of economic strategies to improve their respective competitiveness. The framework for this sort of strategies is provided by the new morbidity related risk adjustment scheme (morbidityorientierter Risikostrukturausgleich). Sickness funds that have a high proportion of insured members with a specific illness would profit if this illness is factored in the compensation scheme. So they might use political influence instead of strategies to improve quality.

There has already been such a strategy of sickness funds when the list of 80 diseases to be listed in the scheme was decided. The local sickness funds were able to formulate a coalition with the Barmer Ersatzkasse which is the largest substitute fund. The Barmer mirrors the insured structure of the local sickness funds with a delay of about three years. Therefore they have similar interest structures and have been successful in changing the original approach of the scientific advisory council of the federal insurance office (interview federal peak association of sickness funds).

For the supply side, this scenario is a special case of pluralist competition. Specialists' associations might cooperate with special sickness funds, but they will not have a monopoly as they lack the legal protection that has been described in the second scenario.

Evaluation

The different scenarios have been introduced as ideal types and the future development will be characterised by elements of several or all types at the same time. In addition regional differences are also possible. The legislator will have decisive influence which of these types will gain most weight (Schmidt 2009: 32). Legislation can decide on the overall remuneration for medical services, on hurdles to join the market for private providers and on the risk adjustment scheme and thereby frame the competition.

All scenarios have waived the special relationship between the SHI and the private insurance companies. The grand coalition left this problem for its successors. Private insurance companies could actually influence the future of the SHI if they were completely or at least partly integrated into the system.

5. Outlook

The traditional corporatist system of German outpatient care was characterized by the sectoral negotiations of corporate bodies and the dominance of office-based physicians over the bargaining power of sickness funds. Until the cap of the remuneration for medical services in 1993, the corporate bodies had the control over services and payment for the whole outpatient care. Quality was only assured by hierarchical governance that was not di-

rectly included in the most powerful arenas of the system. The latest reforms and in particular the SHI-CSI contribute to a general change of this system.

Originally, the political measures were motivated by the aim to improve financeability and to cut expenses. The employers' contributions in particular should have been limited to improve international competitiveness of the German industry. Since the late 1990s this goal has been supplemented with rising efforts to ensure quality of health services.

Both the idea of financeability and the aim to guarantee quality should be reached by increasing competition within the system. Even though, the political decisions have not been able to guarantee competition yet. While the grand coalition was not able to agree upon major changes toward a sustainable financial system the small changes of structural rules have already lead to major changes of actors and constellations and are about to create one giant leap for the policy outcome.

There are different developments of governance patterns and actor constellations within the regions. On the basis of the present developments four ideal typical scenarios have been distinguished to describe the possible future of outpatient health governance.

Up to now the beneficiaries of the reform are actors that belonged to the weakest groups of the traditional systems: local sickness funds, general practitioners and their largest association (GAGP), health service providers in eastern Germany and even some consumer groups profited from the reforms introduced by the social democratic health minister Ulla Schmidt. The traditional physicians' associations were originally completely opposed to the political measures. The previous system of regional collective negotiations guaranteed a formally free choice of doctors within the SHI system. This freedom of choice was one of the most important demands of physicians' associations (Naschold 1967). The latest reforms depart from the idea of freedom of patient choice. Officially it is aimed at replacing it with more freedom for those insured and associations' contract choice (Le Grand 2003), but up to now it is unclear who will have more choices in the future.

Nonetheless, some new cooperatives and even traditional physicians' associations have already taken part in the new governance strategy. They have discovered the new system as a way to ensure higher income for the participating groups. Up to now, especially actors with close links to governing parties can use the new system for their own interests. For example the local sickness funds used their traditional partnership with the SPD, while the general practitioners in Bavaria have been successful in exploiting their relations with the CSU for their own interests.

Even though the latest act, the ADOSSF of 2008, already entails some major decisions, some elements concerning the future still remain open. Paragraph 73b of Social Code Book V in particular has been criticized by many interest groups and academic observers. In contrast to paragraph 73c, it might have privileged single associations in a way that is not legitimized by the goals of financeability and quality (Cassel 2008). As both major articles seem to follow different beliefs one has to expect that the legislator will at least change one of them again soon. It is even possible that changes will be forced by a legal judgment as the association of internists (PAGI)

has already decided to sue for a change in the paragraph 73b (Ärzte Zeitung 3rd November 2008). However future party politics decide these questions, the most interesting lesson is that minor reform compromises are about to lead to major changes of the subsystem. The causation between the belief systems of legislators and the final policy outcome can not only be indirect but also different from any impression gained by focusing only on policy output. Policy analysts therefore should differentiate their theoretical lenses by clarifying whether they aim to explain output, impact, or outcome.

References

- Altenstetter, Christa/Busse, Reinhard, 2005: Health Care Reform in Germany: Patchwork Change within Established Governance Structures, in: *Journal of Health Politics, Policy and Law* 30/1-2, 121-142.
- Ärzte Zeitung (online version) 6th February 2008: Geteiltes Echo auf BKK-Hausärztervertrag.
- Ärzte Zeitung (online version) 7th May 2008: Neuer Dachverband soll Fachärzte besser vertreten.
- Ärzte Zeitung (online version) 23rd June 2008: Hausarztverein Nürnberg hält Korbmodell für passé.
- Ärzte Zeitung (online version) 1st July 2008: Neuer Verband soll Verträge nach 73b aushandeln.
- Ärzte Zeitung (online version) 28th July 2008: Fachärzte drängen auf Sonderverträge nach § 73 c.
- Ärzte Zeitung (online version) 22nd August 2008: Kollateralschaden durch Hausarztvertrag?
- Ärzte Zeitung (online version) 22nd September 2008: Ärztegenossen setzen auf Verträge mit den Kassen.
- Ärzte Zeitung (online version) 24th September 2008: Anbieterkoalition für AOK-Hausarztvertrag.
- Ärzte Zeitung (online versions) 2nd October 2008: Bayerns Hausärzterverband bestreitet der KV die Vertragskompetenz für § 73b.
- Ärzte Zeitung (online version) 27th October 2008: Aufatmen in Nordrhein, Zahnknirschen im Südwesten.
- Ärzte Zeitung (online version) 30th October 2008: Immer mehr medizinische Versorgungszentren.
- Ärzte Zeitung (online version) 3rd November 2008: BDI-Spitze: Gang vor den Kadi beschlossene Sache.
- Ärzte Zeitung (online version) 10th November 2008: Bremer Hausärzte streben AOK-Vertrag an.

- Ärzte Zeitung (online version) 12th November 2008: Für IV-Verträge schlägt die Stunde der Wahrheit.
- Ärzte Zeitung (online version) 23rd June 2009: Hausarztvertrag mit Betriebskrankenkassen im Südwesten ist unter Dach und Fach.
- Ärzte Zeitung (online version) 7th July 2009: Monopol des Hausärzteverbandes missfällt Gesundheitspolitikern.
- Ärzte Zeitung (only version) 28th July 2009: Selektivverträge als Motor der Versorgung.
- Ärzte Zeitung (online version) 28th July 2009: Südwest-AOK setzt auf vitalen Hausärzte-Vertrag.
- Ärzte Zeitung (online version) 3rd August 2009: Bei Berliner Hausärzten steht der Südwesten Pate.
- Ärzte Zeitung (online version) 13rd August 2009: Da waren es nur noch 186 – Kassen im Fusionsfieber.
- Bandelow, Nils C., 1998: Gesundheitspolitik: Der Staat in der Hand einzelner Interessengruppen? Opladen: Leske + Budrich.
- Bandelow, Nils C./Schade, Mathieu 2008: Die Gesundheitsreform der Großen Koalition: Strategische Erfolge im Schatten des Scheiterns, in: Fischer, Thomas/Kießling, Andreas/Novy, Leonard (Hrsg.): Politische Reformprozesse in der Analyse: Untersuchungssystematik und Fallbeispiele. Gütersloh: Bertelsmann, 85-144.
- Bandelow, Nils C./Schade, Mathieu 2009: Konsens im Dissens? Parteipolitische Konflikte in der Gesundheitsreform der Großen Koalition, in: Paquet, Robert/Schröder, Wolfgang (Hrsg.): Gesundheitsreform 2007: Nach der Reform ist vor der Reform. Wiesbaden: VS Verlag für Sozialwissenschaften, 58-76.
- Böckmann, Roman, 2007: Von der Selbstverwaltung zum regulierten Gesundheitsmarkt. PoliThesis. Diskussionspapiere des Instituts für Politikwissenschaft und der Graduate School of Politics (GraSP). Münster: Westfälische Wilhelms-Universität.
- Cassel, Dieter et al., 2008: Vertragswettbewerb in der GKV. Möglichkeiten und Grenzen vor und nach der Gesundheitsreform der Großen Koalition. Bonn: BdO.
- Döhler, Marian, 2003: Gesundheitspolitik in der Verhandlungsdemokratie, in: Gellner, Winand/Schön, Markus (Hrsg.): Paradigmenwechsel in der Gesundheitspolitik?. Baden-Baden: Nomos. 25-40.
- Gerlinger, 2008: Health Care Reform in Germany, in: German Policy Studies. Special Issue "From Bismarck to Conservative Universalism? The Politics, Problems, and Prospects of the German Welfare State" (to be published).

- Green, Simon/Paterson, William E., 2009: Last Orders? Semisovereignty and the Crisis of Cost Containment in the Grand Coalition, in: Miskimmon, Alister/Paterson, William E./Sloam, James (eds.): Germany's Gathering Crisis: The 2005 Federal Election and the Grand Coalition. Basingstoke: Palgrave (to be published).
- Hajen, Leonhard/Paetow, Holger/Schumacher, Harald 2000: Gesundheitsökonomie. Strukturen – Methoden – Praxisbeispiele. Stuttgart/Berlin/Köln: Verlag W. Kohlhammer.
- Hassenteufel, Patrick/Palier, Bruno, 2007: Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems, in: Social Policy & Administration, 41/6, 574-596.
- Hegelich, Simon/Meyer, Hendrik, 2008: Konflikt, Verhandlung, Sozialer Friede: Das deutsche Wohlfahrtssystem, in: Schubert, Klaus/Hegelich, Simon/Bazant, Ursula (Hrsg.): Europäische Wohlfahrtssysteme. Wiesbaden: VS Verlag, 127-148.
- Herder-Dorneich, Philipp, 1979: Soziale Ordnungspolitik. Mit neuen Strategien gegen Steuerungsdefizite. Stuttgart: Verlag Bonn Aktuell.
- Hess, Rainer, 2007: Der Stellenwert der gemeinsamen Selbstverwaltung auf Bundesebene nach dem GKV-WSG, in: Ulrich, Volker/Ried, Walter (Hrsg.): Effizienz. Qualität und Nachhaltigkeit im Gesundheitswesen. Festschrift zum 65. Geburtstag von Eberhard Wille. Baden-Baden: Nomos, 985-993.
- Jacobs, Klaus, 2007: Alles bloß Etikettenschwindel? Der künftige Kassenswettbewerb nach der Gesundheitsreform der Großen Koalition, in: Ulrich, Volker/Ried, Walter (Hrsg.): Effizienz. Qualität und Nachhaltigkeit im Gesundheitswesen. Festschrift zum 65. Geburtstag von Eberhard Wille. Baden-Baden: Nomos, 325-341.
- KVNO 2008: Kassenärztliche Vereinigung Nordrhein: Selektiv-Verträge vereinzeln den Arzt und bedrohen das Arzt-Patienten-Verhältnis, in: KVNO aktuell online, Ausgabe April 2008.
- Le Grand, Julian, 2003: Motivation, Agency, and Public Policy. Of Knights and Knaves, Pawns and Queens. Oxford: Oxford UP.
- Lehmbruch, Gerhard, 1988: Der Neokorporatismus der Bundesrepublik im internationalen Vergleich und die "Konzertierte Aktion im Gesundheitswesen", in: Gäfgen, Gérard (Hrsg.): Neokorporatismus und Gesundheitswesen. Baden-Baden: Nomos, 11-32.
- Lüngen, Markus/Lauterbach, Karl W., 2007: Wettbewerb im Gesundheitswesen, in: Ulrich, Volker/Ried, Walter (Hrsg.): Effizienz. Qualität und Nachhaltigkeit im Gesundheitswesen. Festschrift zum 65. Geburtstag von Eberhard Wille. Baden-Baden: Nomos, 279-293.
- Naschold, Frieder, 1967: Kassenärzte und Krankenversicherungspflicht. Zu einer Theorie der Statuspolitik. Freiburg: Rombach.

- Richter, Wolfram R., 2005: Gesundheitsprämie oder Bürgerversicherung? Ein Kompromissvorschlag, in: Wirtschaftsdienst 85/11, 693-697.
- Rosenbrock, Rolf/Gerlinger, Thomas, 2006: Gesundheitspolitik. Eine systematische Einführung. Bern: Verlag Hans Huber.
- Rübsam-Simon, Ekkehard, 2005: „Es ist Krieg“. Der gesundheitspolitische Kommentar. www.buschtelefon.de/artikel/1132606918t65.pdf [visited 05.02.2008]
- Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen [SVR Gesundheit], 2005: Koordination und Qualität im Gesundheitswesen. Jahresgutachten 2005. Bundestagsdrucksache 15/5670. <http://dip.bundestag.de/btd/15/056/1505670.pdf>. [visited 05.02.2008]
- Scharpf, Fritz W., 1997: Games real actors play: Actor-centered institutionalism in policy research. Boulder: Westview.
- Schmidt, Ulla, 2009: Gesundheitspolitik im Widerschein der Interessen – Ein Rück- und Ausblick, in: Bandelow, Nils C./Eckert, Florian/Rüsenberg, Robin (eds.): Gesundheit 2030 – Qualitätsorientierung im Fokus von Politik, Wirtschaft, Selbstverwaltung und Wissenschaft. Wiesbaden: VS Verlag für Sozialwissenschaften, 29-33.
- Wiesenthal, Helmut, 1981: Die Konzertierte Aktion im Gesundheitswesen. Ein Beispiel für Theorie und Politik des modernen Korporatismus. Frankfurt a. M./New York: Campus.
- Wille, Eberhard, 1999: Auswirkungen des Wettbewerbs auf die gesetzliche Krankenversicherung, in: Wille, Eberhard (Hrsg.): Zur Rolle des Wettbewerbs in der gesetzlichen Rentenversicherung. Baden-Baden: Nomos, 95-156.