

Health Care Reform in Germany

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Abstract

German health care policy is characterized by a paradigm shift initiated by the enactment of the Health Care Structure Act in 1992. This fundamental change is both affecting in its care structures and its financial and regulatory mechanisms. This transformation is an expression of a paradigm change in health policy initiated during the first half of the 1990s. This paradigm change in health policy increasingly favours the goal of adapting the health care system to the perceived requirements of a globalised economy at the expense of the aim of covering the social life-risk of 'sickness'. Since it began, health policy has proceeded down that chosen development path, generally by means of incremental reforms. In terms of *care structures* the paradigm change involves modernization and rationalization of the provision of medical care. In *financing* it is characterised by a new welfare mix where the financial burden shifts from collective solidarity to individual patients and fund members – while at the same time the employers' share is reduced. In terms of *regulation* the paradigm change is characterised by the implementation of competition-centred structural reforms.

Abstract

Gesundheitspolitik in Deutschland ist gekennzeichnet durch einen Paradigmenwechsel, der mit der Verabschiedung des Gesundheitsstrukturgesetzes 1992 eingeleitet wurde. Mit diesem Paradigmenwechsel gewinnt das Ziel, das Gesundheitswesen an die wahrgenommenen Erfordernisse einer globalisierten Ökonomie anzupassen, gegenüber seiner Funktion, das soziale Lebensrisiko „Krankheit“ abzusichern, zunehmend an Bedeutung. Seitdem bewegt sich die Regulierung dieses Politikfeldes im Wesentlichen recht kontinuierlich auf dem damit eingeschlagenen Entwicklungspfad fort. Dieser Paradigmenwechsel zielt mit Blick auf die *Versorgungsstrukturen* auf eine Modernisierung und Rationalisierung der medizinischen Leistungserbringung. *Versorgungsstrukturen*. Bei der *Finanzierung* ist er zum einen gekennzeichnet durch einen neuen Wohlfahrtsmix, mit dem sich die finanziellen Lasten von der Solidargemeinschaft auf die Patienten und die Versicherten – bei einer gleichzeitigen Entlastung der Arbeitgeber – verlagern. Zum anderen zeichnet sich beim Finanzierungsmodus ein schrittweiser Anstieg

des Anteils der steuerfinanzierter Mittel zu Lasten der arbeitseinkommensabhängigen Versicherungsbeiträge ab. Damit scheint ein Kernmerkmal des Bismarckschen Krankenversicherungsmodells allmählich an Bedeutung zu verlieren. Im Hinblick auf die *Regulierung* ist der Paradigmenwechsel gekennzeichnet durch eine Implementierung wettbewerbszentrierter Struktur-reformen.

1 Introduction

The German health care system is undergoing a process of fundamental change affecting both its care structures and its financial and regulatory mechanisms. This transformation is an expression of a paradigm change in health policy initiated during the first half of the 1990s. At the heart of the transformation is the implementation of competition-centered structural reforms designed to establish a regulated market in the health service and help modernize structures of medical provision that had come to be regarded as inefficient. These reforms have been accompanied by a progressive privatization of treatment costs. This paradigm change in health policy increasingly favors the goal of adapting the health care system to the perceived requirements of a globalized economy at the expense of the aim of covering the social life-risk of “sickness”. Since it began, health policy has proceeded down that chosen development path, generally by means of incremental reforms.

In the following the content of this paradigm change will be brought out in more detail and differentiated from the preceding phase of cost-containment policy (Section 2). Sections 3–5 deal with the effects of this transformation on the care, financial and regulatory structures of the German health care system. Section 6 outlines to what extent the various coalitions that governed between 1992 and 2007 differed in their approach to health policy. Finally I take a look forward at future developments in health policy.

2 Paradigm Change in Health Policy

2.1 Structure-Conserving Cost-Containment Policy

German health insurance is divided into two systems: statutory health insurance and private health insurance. About 90 percent of the population is covered by statutory insurance (generally under compulsory insurance cover), while private insurance—to which only civil servants, the self-employed and high-earning employees have access—covers about 10 percent of the population. Whereas private health insurance is governed by the principles of the insurance market, in the statutory health insurance system the state guarantees members almost universal access to health services, even if these days patients also have to carry considerable charges themselves. Health service financing is accomplished almost exclusively through contributions representing a fixed percentage of gross wages (on the principle of equivalence) and borne in (almost) equal parts by employers and employees. Health service provision is based on the special position of the practicing doctor, generally working in his or her own practice. In the ambulatory sector fund members have the right of free choice of doctor and can consult a specialist directly, but outpatient treatment in hospitals is possible only in exceptional cases. The almost 250 health insurance funds—between which the insured can choose freely—and their umbrella organizations are of primary importance for regulating the system. Within a given legal framework the insurance funds (and their umbrella organizations) conclude contracts with service providers (doctors, hospitals, pharmaceutical manufacturers, etc.). The regulatory system is strongly sectoral differentiated, with each individual sector characterized by its own complex mix of state, corporatist and market management elements. Corporatist elements are strongest in the ambulant sector, state management elements in the stationary sector and market management elements in the pharmaceuticals sector (Rosenbrock and Gerlinger 2006).

Although the German health care system can (still) be relatively clearly classified as a health insurance system in the typology

used in health system research, it turns out to be relatively resistant to simple classification in welfare state typologies, containing as it does pronounced features of the conservative, the universalist and the liberal welfare state models.

During the post-war decades the development of the statutory health insurance system was characterized by an acceleration of the process of ‘double inclusion’ (Alber 1992: 24ff.), in other words the integration of a growing part of the population and an expansion of the range of services covered. During that heyday of Fordism the corporatist/conservative welfare state model became permeated with features of the social democratic welfare state, at least in relation to aspects of social security relating to health (Esping-Andersen 1990). Many contemporaries recognized that the expansive development of spending in the statutory health insurance system was not unproblematic, but any doubts raised could always be dispelled with reference to the continuing high rate of economic growth. At the same time the statutory health insurance system institutionalized and stabilized the demand for health services, which in turn fostered growth in employment in the health sector.

Post-war prosperity not only provided the framework for expanding welfare state services for the case of illness, but also for establishing a system of care characterized by all kinds of inefficiencies. These expressed themselves, for example, in:

- payment rules for practicing doctors (fee-for-service) and hospitals (cost coverage principle), which favored an expansion of provision (Gerlinger 1997; Simon 2000);
- separate institutional responsibility for ambulatory services (the associations of statutory health insurance physicians) and stationary provision (the federal states), which led to a fragmentation of care and reduced the performance of the health care system as a whole;
- the associations of statutory health insurance physicians being given a state-sanctioned monopoly on concluding medical care contracts with the health insurance funds, which led to a structural dominance of the health insurance physicians over the insurance funds.

There are various reasons for these developments. Generally, there was rather little pressure to create more efficient health-care structures in view of steadily rising insurance fund revenues. Furthermore, a slew of inefficient structural elements, especially the contractual monopoly held by the associations of statutory health insurance physicians, was rooted in the political elites' unwillingness—for clientelist political reasons—to challenge established structures.

These characteristics point to a special feature of the health care system within the social security system as a whole. Management of the statutory health insurance system—unlike the pensions insurance system and large parts of the unemployment insurance system—is not 'only' about social redistribution or covering particular life risks but also involves managing personal services that represent a significant branch of the economy. Thus efforts to influence health policy take place in arenas where large numbers of actors are active, often organized in powerful associations each with their own interests and strategies. These include state actors (national and state governments), corporatist and para-state actors (health insurance funds, associations of statutory health insurance physicians, medical associations) and private actors (doctors, hospitals, the pharmaceuticals industry and not least, of course, patients).

A strategic reorientation in health policy set in during the mid-1970s, as the end of the 'brief dream of everlasting prosperity' loomed into sight (Lutz 1984). The drastic rise in unemployment and a slowing of the dynamic economic growth rates of the post-war decades led political and administrative decision-makers to make cost containment the most urgent goal of health policy (Rosewitz and Webber 1990). Since then the declared aim has been that health insurance spending should cease to exert upward pressure on wage costs, in order to avoid weakening Germany's international competitiveness.

Until the early 1990s these cost-containment policies left the existing incentive structures for actors basically unaltered, and structural reform of the health care system—measures that would have involved a 'redistribution of competencies and responsibilities with respect to the financing, provision and regulation of

medical services’—was not undertaken (Webber 1988: 157). Incentives either promoted an expansion of the volume of services or at least failed to lead the actors to effectively restrict the provision, financing or take-up of services in their own financial interests. To that extent this traditional cost-containment policy was characterized by the contradiction between the global goal of keeping the level of contributions stable (or restricting spending) and the provision of financial incentives for the individual actors. On the part of the service providers it was the instruments of funding and payment (especially the cost coverage principle in stationary provision and the fee-for-service system in the ambulatory sector) that provided strong incentives for quantitative expansion. A largely rigid system of allocating members to funds gave the health insurance funds a de facto guaranteed existence. Even under these conditions the funds attempted to avoid raising the level of contributions, but that said, the negative effects of any increases on the fund itself were limited.

2.2 Paradigm Change in Health Policy: The Transition to Competition-centered Structural Reforms

A really fundamental change in health policy did not come about until the first half of the 1990s. The background was an accumulation of problems both in the social environment in which the health system operated and within the statutory health insurance system itself: the sharpening of international economic competition, the recession and the accompanying increase in unemployment that followed the reunification boom, and a strong increase in spending in the statutory health insurance system. At the same time the failure of the 1989 Health Reform Act (Gesundheitsreformgesetz) (trumpeted as the ‘reform of the century’) clearly showed the limits of traditional cost-containment policy (e.g. Perschke-Hartmann 1994: 203ff.). In such a situation, the solutions that had been pursued up until then were increasingly perceived as inadequate, and the determination to make structural changes in the health system grew.

The Health Care Structure Act of 1992 (Gesundheitsstrukturgesetz) initiated the far-reaching transformation that was to be

pursued in subsequent years—sometimes with different emphases—in ‘stage three’ of the health reform in 1996/97 and in the reforms of the SPD/Green coalition of 1998–2005 and the ‘grand coalition’ (CDU/CSU/SPD) that followed it, and still characterizes health policy at the beginning of this century. In this process a series of management instruments were introduced that were either new for the statutory health insurance system or were expanded in such a way that they permanently altered the incentive structures for the actors:

- Competition between funds created by giving members a free choice of fund. This meant that the funds lost their guarantee of existence. The level of contributions became the decisive parameter in competition for members, and from this point on every increase in the rate was tied to the threat of loss of market share (e.g. Stegmüller 1996).
- The introduction of fixed fees and practice budgets for remunerating service providers. In the ambulatory sector doctors’ pay still follows the fundamental principle of fee-for-service, but the trend towards quantitative expansion has been restrained by the introduction of budgets (Gerlinger 1997). In the stationary sector the Health Care Structure Act (Gesundheitsstrukturgesetz) initiated the transition to a fixed fee system independent of the length of time spent in hospital. This realignment of the payment systems shifted a considerable share of the financial risk of treating the sick onto the individual service provider, both in the ambulant and stationary sectors. Fixed fees reverse the financial incentives for providing services. The way for a service provider to increase income is no longer through quantitative expansion but by minimizing the service provided in each individual case, because profitability now results from the difference between the theoretical fixed fee and the actual cost of treatment.

A shift towards privatization of treatment costs. This came initially with ‘stage three’ of the health reform in 1996 and 1997 and—after a brief interlude during the first legislative period of the SPD/Green coalition (1998 to 2002)—continued in the health

reforms of 2004 and 2007 (Gerlinger 2002; Gerlinger et al. 2006).

- Generally these measures have been accompanied by sectoral budgeting, or the statutory definition of upper spending limits for ambulatory and stationary treatment and drugs, etc.
- At the same time lawmakers have given the health insurance funds more freedom in contractual matters. In particular, their options to conclude contracts with individual groups of doctors (rather than exclusively with the associations of statutory health insurance physicians as the regional monopoly representation of practicing doctors) were expanded. In this way the funds were to be put in a position to set in motion the desired modernization of care structures and to force service providers to improve efficiency and quality (from ‘payer’ to ‘player’).

All the aforementioned management instruments share the characteristic that they create an incentive for individual actors to pursue their own financial interests via the goal of limiting spending and quantity. In this way it was hoped to create coherence between global health policy goals and individual patterns of behavior in the provision, financing and take-up of services. This involves a new dimension of economization of the health service, a new fundamental orientation that typifies the paradigm change in health policy. Including the patients in this system of financial incentives (something initially done only by the CDU/CSU and FDP) reflected the conviction that it was no longer possible to provide a comprehensive range of services for fund members without asking them to shoulder part of the costs directly, and furthermore that this was not desirable anyway, for overarching political reasons.

From the conservative/liberal perspective this radical privatization of treatment costs was also conceived as an instrument that would help to develop growth potential in the health sector and boost employment (from ‘cost factor’ to ‘growth sector’). For this development was intended to bring to the health sector the moneyed demand that had previously been denied it through the way the statutory health insurance system tied spending to income from employment (e.g. Sachverständigenrat 1997).

3 Provision of Care: Structural Modernization and Implicit Rationing

One of the aims of introducing the aforementioned management instruments was to modernize the structures of medical care, which according to numerous experts suffered from considerable inefficiencies. In international comparison the German health care system is costly—the world's third most expensive in relation to gross domestic product, with a share of 10.9 percent in 2004 (OECD 2006)—but demonstrates only an average quality of treatment with respect to numerous epidemiologically relevant diseases (e.g. Sachverständigenrat 2002). Alongside the remuneration structures, two other core features of the care system count among the most important reasons for this lack of efficiency: firstly, the small role played by the general practitioner as the first port of call in case of illness and as coordinator of care processes, and secondly the fragmentation of care structures—the rigid barriers between ambulatory, stationary, nursing and rehabilitative care—which is reflected in numerous deficiencies of communication and coordination. As a consequence, the quality of treatment remains less than ideal and additional costs arise (Sachverständigenrat 2002). Accordingly, in health policy, lawmakers' efforts have aimed above all to strengthen the position of the general practitioner and to expand the possibilities for creating integrated (inter-sectoral) forms of health care. In international comparison this policy can be characterized as an attempt to catch up with modernization developments under specifically German conditions. The health systems of numerous other capitalist states demonstrate a head start over Germany with respect to the development of health-care structures.

Lawmakers hope to achieve this modernization of health-care structures by strengthening the rights of the health insurance funds and their umbrella organizations in relation to the associations of statutory health insurance physicians. The state assigned to the latter the task of ensuring the provision of ambulatory care for statutory fund patients, for which they were granted a regional representational and contractual monopoly in dealings with the health insurance funds and their umbrella organizations. In the

past the associations of statutory health insurance physicians have used this monopoly to prevent the modernization of health-care structures (Rosewitz and Webber 1990), because this would have harmed the interests of the specialists who dominate the associations of statutory health insurance physicians, and it would also have undermined the monopoly of practicing doctors in this field and hence the general exclusion of hospitals from ambulatory care.

Since 1996/97 the options for health insurance funds to conclude care contracts with willing groups of doctors without the approval of the associations of statutory health insurance physicians have been increased step by step. In the meantime a large number of contracts have been concluded in this field. They have not, however, to date fulfilled the expectations of increased efficiency that had been placed upon them (Tophoven 2002). For one thing, these specific forms of health care remain for the moment of quantitatively small significance, for such forms of provision account for less than 10 percent of spending on ambulatory health care. The overwhelming share of services continues to be provided under the conventional regime and managed through collective contracts with the associations of statutory health insurance physicians. One important factor behind this development is that, owing to the distorted incentives of competition (see Section 4.2), the health insurance funds have to date shown relatively little interest in such forms of provision. But a glance at those new forms of provision that have been implemented in practice also shows that the expectations of cost savings (and often of quality improvement too) have failed to be fulfilled.

Fairly quickly after the Health Care Structure Act (Gesundheitsstrukturgesetz) introduced free choice of health insurance funds, it became clear that the competition between funds that this choice created was leading to various distortions that ultimately threatened to call into question the functioning of the whole statutory health insurance system and its public legitimacy. Of outstanding importance here are the funds' own interests created by the competition regime. In order to create a level playing field between funds, the introduction of free choice of health insurance fund was accompanied by a system of financial com-

pensation between the funds known as the 'risk adjustment scheme'. This was intended to balance out the different risks of the health insurance funds that resulted from the composition of their respective clientele in terms of income and a number of spending-related factors (age, gender, number of non-paying family members covered). Because, however, this scheme took no account of the morbidity of fund members, the specific competition regime introduced into the statutory health insurance system created an incentive for funds to compete first and foremost by selecting 'good risks', in other words focusing on healthy individuals. The most expensive 10 percent of fund members, in terms of hospital treatment, sickness benefit and medicines, account for about 80 percent of spending on services (Winkelhake et al. 2002). If a health insurance fund succeeds in keeping the proportion of this group in its membership as low as possible it can by this means achieve far greater cost advantages over its competitors than it could by, say, creating more efficient health-care structures. The health insurance funds had no interest in establishing and advertising innovative care structures for the chronically sick, because this would have exposed them to the risk of attracting the expensive patients from other health insurance funds. So one reason why they held back from introducing the modernization of forms of care called for by health policy was that these could have turned out to represent a competitive disadvantage for them.

In view of these distortions a new reform of the competition regime was unavoidable. Accordingly, in 2002 a revision came into effect that was intended to direct the interest of the health insurance funds and the financial resources of the statutory health insurance system towards improving provision for the chronically sick. Since then health insurance funds that participate in 'disease management programs', which are designed to offer medical best practice for a number of selected chronic diseases, receive (through the risk adjustment scheme) additional funds for each member who signs up for these programs. As a consequence of this rule, the health insurance funds now offer their members numerous such programs. All the same, integrated medical care remains underdeveloped in Germany, and it has become evident

that transforming the structures of medical provision is a long-term undertaking.

When it comes to provision of care, however, it is not only the creation of innovative care models that is of interest, but also the question of the impact of budgets and fixed fees as management instruments for service provision. Budgets and fixed fees are a response to the experience that without administrative instruments for limiting spending doctors tend to expand diagnosis and therapy without medical grounds.

There are now a number of indications that this consideration of financial utility is also having an impact on the creation of new financial incentives, and that the introduction of new forms of remuneration leads to rationing in the everyday practice of health care. Patients are denied services, especially where the prescription of medicines and remedies (e.g. massages) is involved; treatments are postponed to the next quarter; and patients are refused admission to hospital or are transferred to other institutions without medical necessity (e.g. Simon 2001; Braun 2002). Although the extent of this development cannot be quantified exactly, the available data shows that this is by no means a negligible phenomenon. Although insurance fund members continue to enjoy an almost universal legal entitlement to health care in case of illness, the rationing of medical care has effectively hollowed out that right, at least in certain sectors. Patients who have been denied care either have to do without it or bear the costs privately. The new financial incentives for service providers and the increase in charges (Section 4) have led to a situation where the welfare mix has shifted further towards privatization of costs.

4 Financing: Privatizing the Risk of Sickness and Moving Away from Wage-based Contributions

Since the mid-1970s health policy reform has focused on cost containment in the health service, and more specifically, on holding down the employers' contributions to the statutory health insurance system. One of the most important instruments used by the various national governments to pursue this goal is the priva-

tization of the costs of illness, which have since then been raised in countless smaller steps and a few large ones. Here too, the pace of change has accelerated since the mid-1990s and led to a considerable increase in the private share of treatment costs. In 1991 the volume of charges for treatment in the statutory health insurance system amounted to the equivalent of €3,300 million or 4.4 percent of spending on treatment in the statutory health insurance system (Pfaff et al. 1994); somewhat more than a decade later, in 2002, the figure had already reached €9,800 million or 7.3 percent of spending on treatment (Statistisches Bundesamt 2004). The Statutory Health Insurance Modernization Act (GKV-Modernisierungsgesetz) that came into force in 2004 (see Rosenbrock and Gerlinger 2006) raised charges significantly yet again. Charges now amount to 10 percent of total treatment costs, with a defined upper and lower limit for each service and a limit on the total charges to be borne by a member in any one year. This means that the total amount paid in charges must have increased significantly yet again (Pfaff et al. 2003). And this does not even include the treatments that have been officially excluded or the probably considerable volume of treatments informally refused (see Section 3.2), which members now have to pay for in full themselves.

Finally, with the 2007 Health Reform another privatization mechanism came into effect for the statutory health insurance system. Health insurance funds have now been given the possibility of offering lower contributions to those members who are willing to accept a share of treatment costs themselves or who have made no use of their health insurance in the preceding year. In this respect lawmakers have introduced core elements of private health insurance into the statutory health insurance system and gone far beyond the previous practice of gradually—and altogether relatively moderately—rising charges.

The justification for this privatization mechanism was that it would increase citizens' own sense of responsibility for their health, because greater participation in the costs would give them more incentive to lead a healthy life. A similar measure also affects chronically sick patients who did not take part in the screening programs for the condition in question before they fell ill or

whose personal behavior has a negative effect on their treatment. In these cases the standard cap on charges does not apply, and these patients have to contribute up to 2 percent of their household income in charges. Overall there is a visible trend for the responsibility for avoiding and dealing with illness to be given to the individual and for behavior defined as inappropriate in health terms to be punished financially.

Alongside increased charges, the exclusion of medical services from the catalogue of publicly funded treatments is another instrument of cost-containment policy. Overall, though, this plays rather a small role in Germany. Where services have been excluded in the recent past these were mostly either monetary benefits (e.g. death benefit), treatments whose medical usefulness was regarded as dubious or services relating to health problems that are not classified as illness. The path of excluding whole treatment categories (e.g. dental prosthetics)—that was discussed for a time and has indeed been taken in other countries—has not so far been followed in Germany.

Furthermore, members of the statutory health insurance funds have to bear a growing share of spending not only as patients but also as members. The 2004 Health Reform also marked the end of the principle that members and their employers bore an equal share of statutory health insurance contributions. Since 2005 employers have been exempt from the contributions for sickness benefit and dental prosthetics, and these are paid in full by the community of members. This measure affects about 6 percent of overall spending in the statutory health insurance system.

But these changes are unlikely to mark the end of the transformation of the financing system. Instead, far-reaching changes are in the pipeline that will shake the very foundations of Germany's health care system architecture, which dates back to Bismarck's era. From the perspective of supply-side economic policy, the core problem of the current financial construction is that rising spending by the statutory health insurance system impacts directly on wage costs through the employer's contribution. This is regarded as a structural disadvantage in international economic competition. Therefore, since the beginning of this decade, the demand for statutory health insurance system spending to be

completely decoupled from wage costs has gained strongly in importance. It is proposed that this decoupling be accomplished through the introduction of a flat-rate contribution (Rürup-Kommission 2003). Under this system health insurance would in future be financed solely through an insurance contribution having no relationship to income, which would be the same for all members. The employer's contribution would fall away completely and the poor would have to be subsidized to a certain degree out of taxation. This model is supported by the CDU and the CSU, while the SPD, the Greens and the Left Party categorically reject a flat-rate contribution model. Instead they call for the introduction of a 'citizens' health insurance' that would include the whole population in a single health insurance system and would take account of income from capital, interest and other sources when calculating contributions, as well as income from employment. However, this model too would diminish the importance of income from employment as a source of finance for the health service. When presenting their reform proposals, both the SPD and the Greens make a point of pointing out that their model of a citizens' health insurance would also reduce the pressure on wage costs. In the 2007 Health Care Reform the parties of the grand coalition agreed to introduce a so-called Health Care Fund (Gesundheitsfonds) which can be regarded as a kind compromise between these two concepts. The Health Care Fund (Gesundheitsfonds) aims at postponing any far-reaching reform of the financing system to the next parliamentary term and implies the employers' share of the contribution rates temporarily to be frozen.

5 Regulation: More Competition, More State, a Different Corporatism

Jens Alber pertinently characterized the German health care system as a 'system of complex multiple management' (Alber 1992: 157). The regulatory regime is distinguished by strong segmentation and by the individual sectors (ambulant care, stationary care, pharmaceuticals, etc.) each having its own regulatory system in-

volving a specific mix of state, collective self-regulation (corporatist) and free-market elements. Corporatist elements are of particular significance here; indeed, the ambulant sector is one of the best examples of a corporatist management model. At least until the early 1990s cost-containment policy was in fact characterized by attempts to strengthen corporatist management instruments as a whole (e.g. Döhler and Manow 1992 and 1997). For a long time lawmakers saw integrating the sectoral associations as a suitable instrument for successful cost-containment. In this connection corporatist management elements were also expanded in other sectors, above all the hospital sector.

5.1 Liberalization of Contract Law—the Importance of Collective Contractual Arrangements Declines

The paradigm change during the first half of the 1990s outlined at the beginning led to a complex and fundamental transformation of the regulatory system—a transformation that has since then progressed as an incremental but clearly identifiable process of change. Since then this transformation has been pursued—albeit with differing emphases—quite consistently under all the different governing coalitions.

At the centre of this transformation stands the establishment of a competition regime in the health service, one could also say: a regulated market aiming to establish managed care. This competition was initially (and is still largely) limited to the health insurance funds, which compete for members who are allowed to freely choose their fund. Whereas the individual funds have been competing for members since the mid-1990s, until recently they were only allowed to regulate their relations with the service providers via collective contracts. They were able to conclude health-care contracts with practicing doctors only at the level of their particular association of health insurance funds,¹ or even ‘uniformly and jointly’ (to quote the applicable legal provision) with all the other health insurance funds. Their contractual partners in ambulatory health care were the associations of statutory

¹ There are seven different types of statutory health insurance fund, with an association (umbrella organization) for each at national and state level.

health insurance physicians, which held a contractual and representational monopoly, and in the stationary sector the individual hospital, which had a right to a health-care contract, which the associations of health insurance funds again could only conclude 'uniformly and jointly'. For that reason the health insurance funds called for a liberalization of the contracting regime that would allow them to conclude and terminate specific care contracts with individual service providers or with groups of providers. In short, the competition situation was also to be extended to the care providers in their relations with the health insurance funds. The health insurance funds also saw this as the precondition for getting the politically desired modernization of care structures under way. In particular the monopoly of the associations of statutory health insurance physicians had long been a thorn in their side in this connection.

In the ensuing period precisely this liberalization of the contracting regime was initiated and continued in incremental steps, in particular in the core field of corporatist order, the ambulatory sector (Gerlinger 2002). In growing measure the state has turned to individual actors at the micro level and expanded their room for maneuver in care provision and remuneration. Collective contracts have lost in significance as the alternatives for individual actors expand. This is especially clear in the aforementioned possibility for the health insurance funds to bypass the associations of statutory health insurance physicians when concluding contracts concerning particular care provision projects. Via this route health insurance funds can today conclude contracts with individual groups of doctors (for integrated care, GP cover, disease management programs, pilot projects and health centers) without the approval of the associations of statutory health insurance physicians; and they have made real use of this possibility. Although the overwhelming majority of care continues to be regulated through collective contracts with the associations of statutory health insurance physicians, there is an unmistakable trend towards a further loss of importance for such arrangements. The Statutory Health Insurance Competition Strengthening Act (GKV-Wettbewerbsstärkungsgesetz) that came into effect in

April 2007 now provides a general option for health insurance funds to diverge from collective contractual agreements.

This erosion of collective contractual competence affects not only the doctors' associations, but also the fund side. Here the possibilities for individual funds to conclude selective contracts with doctors have been deliberately expanded. As they are given these freedoms, the funds are no longer regarded as pillars of a statutory health insurance system based on principles of collective solidarity, but as competing economic agents—perhaps integrated in a public-sector framework but acting essentially rationally. To that extent the enhanced position of the single fund as a management instance amounts to a relaxation of the collective contractual framework, a step that is only consistent in the logic of competition. Here it becomes clear at the same time that lawmakers assign a key role to the statutory health insurance system when it comes to tapping rationalization reserves.

5.2 Expansion of State Intervention

The establishment of a competition regime in the health service is associated, as already hinted at above, with an expansion of state intervention in the health service. This intervention is characterized by the following features:

1. In its management efforts the state makes increasing use of wide-ranging and detailed procedural management. By abolishing and creating institutions, changing procedural and decision-making rules and setting financial incentives the state can equip individual actors with resources for action and/or alter their constellation of interests and thus increase the likelihood that the desired decisions will be taken in the relevant subsystem. As such, the state operates as the architect of political order in health policy (Döhler 1995). This applies in particular to the institutions of self-management in the statutory health insurance system.

2. The state sets an increasingly restrictive financial framework for the statutory health insurance system. This becomes especially clear in the budgeting of spending, which has applied to important categories of treatment since 1993, and in the principle of stability of contribution rates, which has come to be defined

increasingly narrowly over the course of the past three decades.² When the state (in the 2007 Health Reform) abolished the health insurance funds' right to set their own contribution rates and took that power entirely for itself, this marked a radical turning point in terms of the distribution of formal legal authority, but with respect to the real autonomy of the health insurance funds it merely represented the logical conclusion of a long series of developments. Thus the leeway—and here that means above all the scope for financial distribution—of the health insurance funds and care providers will become even smaller. Although this trend began when cost-containment policies were first introduced, until the early 1990s there was considerable scope for distribution, which was taken advantage of, especially in post-negotiation revisions.

3. Lawmakers have subjected the statutory health insurance system and its actors to an increasingly dense network of statutory regulations. These are largely such provisions as regulate the modalities of the market regime—defining the rights and responsibilities of the actors in a system that is increasingly shaped by financial incentives and fixing the limits of their power to act. These rules are intended to ensure that their activities in the new

² In the Health Insurance Cost-Containment Act of 1977, the first major cost-containment act, lawmakers were still prescribing that, when agreeing overall remuneration, health insurance funds and associations of statutory health insurance physicians should among other things '*take into account* the expected development of the average revenue base of the involved health insurance funds, the practice costs and the working time required for statutory health insurance doctors' activities and the type and extent of medical services, to the extent that they are based on a legal or statutory expansion of treatment' (§ 368f para. 2 of the Reich Insurance Code) (Reichsversicherungsordnung). Taking these criteria into consideration, the national associations of the health insurance funds and the national Association of Statutory Health Insurance Physicians were to 'submit once a year a joint *recommendation* for appropriate change in overall remuneration' (§ 368f para. 4 of the Reich Insurance Code) (Reichsversicherungsordnung). The gradual intensification of these provisions undertaken during the 1980s and 1990s culminated in the requirement in the 2000 statutory health insurance reform passed by the SPD/Green coalition that the remuneration agreements must ensure 'that contribution rate increases are *excluded*' (§ 71 para. 1, Social Security Code V—emphasis added.) (Fünftes Sozialgesetzbuch).

competition regime are compatible with the political reasons for creating the market: keeping contribution rates stable, making sure members receive all necessary medical services and increasing the efficiency and quality of care as far as possible. In this way perceived distortions are to be corrected and anticipated distortions avoided.³ The German experience with earlier health reforms and a glance at health reforms abroad supply an abundance of useful examples for identifying such distortions. This necessity—of accompanying the process of creating a market with state re-regulation (Vogel 1996; Majone 1997; Lütz and Czada 2000)—is not restricted to the legal framework, but also encompasses state supervision.⁴

This intention—namely to prevent service providers succumbing to the temptation to cut costs even if this entails quality deficits and rationing—becomes especially clear in the legal enhancement of quality control. Before the Health Care Structure Act (*Gesundheitsstrukturgesetz*) came into force there were no provisions at all for quality control in health insurance law. Since then such provisions have gradually found their way onto the statute books, eventually forming a dense regulatory network. On top of this came a much more comprehensive concrete set of regulations for collective self-management prepared on behalf of the legislature, also on the basis of the aforementioned act of parliament. By 2006 the number of valid regulations had already grown to such an extent that the parties of the grand coalition agreed ‘to debureaucratize existing rules and to concentrate on the essentials’ (CDU et al. 2006: 4). Here the enhancement of

³ Such distortions can, for example, involve hospitals concentrating on selecting good risks, doctors refusing medically necessary care or hospitals discharging patients prematurely.

⁴ This can be clearly seen in the example of disease management programmes (see Section 3.1). Here there was concern to avoid the financial incentives for establishing disease management programmes being used by the health insurance funds to establish cheap programmes of inferior quality. For that reason the law prescribed minimum standards for such health insurance fund programmes and obliged the funds to have the associated contracts approved by the German Federal (Social) Insurance Authority. Similar mechanisms can also be identified in other fields of medical care.

quality control was about more than the goal of counteracting undesirable responses to financial incentives. Furthermore it also took account of the growing pressure to ensure efficient allocation of resources as funding restrictions tighten, not least with respect to minimizing the legitimization risks associated with resource limitation.

5.3 The Transformation of Corporatism

Liberalizing the contracting regime significantly diminished the importance of corporatist management. The most important actors at the meso-level, the associations of statutory health insurance physicians and the national and state associations of health insurance funds, have until now negotiated collective contracts for the management of medical care under a representational monopoly granted by the state. But this level is increasingly losing influence to the micro level, where medical care contracts are concluded as individual contracts between single health insurance funds and groups of doctors, with both sides acting as rational self-interested economic agents according to the incentive structures on offer. The result is a pluralization of actors in the contracting regime—among the health insurance funds and among the doctors. On the doctors' side it is the sectoral physicians' associations—first and foremost the associations of general practitioners—that gain most in importance as contractual partners for the health insurance funds for agreements concerning particular forms of care. Alongside these, a growing role is played by local and regional groups of doctors who are open to innovation, for example as contractual partners for testing pilot projects. To that extent, the erosion of corporatism that has already been identified in other fields of social policy (Rhodes 1998; von Winter 2004; Trampusch 2006) is also found in the health service.

With regard to the statutory health insurance system, however, it would be wrong to speak of, or indeed to call for the end of corporatism. On the contrary, we find that even after the transition to competition-centered structural reforms, state health policy still clings to corporatist regulatory structures. Hence powers

are still delegated to centralized management bodies made up of equal numbers of representatives of the associations (health insurance funds and doctors), which collectively negotiate binding decisions to address particular problems within a framework set by the state (Gerlinger 2002). This trend can be seen particularly clearly in the way the most important body in the collective self-management system, the Federal Joint Committee (Gemeinsamer Bundesausschuss) (composed of equal numbers of representatives of health insurance funds and of doctors, as well as three independent members) has developed. After its role had already expanded during the transition to cost-containment (Döhler and Manow 1992), this body's influence grew still further during the 1990s transformation of health policy outlined above (Urban 2001). The Federal Joint Committee (Gemeinsamer Bundesausschuss) now possesses comprehensive powers to issue binding guidelines for almost all fields of ambulatory medical care (§ 92 of Social Security Code V) (Fünftes Sozialgesetzbuch). Additionally, it also has the job of assessing the benefit and effectiveness of all existing and planned treatments paid for by the funds. Thus it ultimately defines the scope of the catalogue of treatments provided by the statutory health insurance system. At the beginning of the decade this body's purview, which had until then been restricted to the ambulatory sector, was extended to encompass the whole spectrum of medical care, creating what has now become a 'trans-sectoral negotiating mechanism' (Döhler 2002: 33).

As well as representing an expansion of the powers of the Federal Joint Committee (Gemeinsamer Bundesausschuss), the step of including the stationary sector also reflected the changing role of the umbrella organizations of the hospitals—the German Hospital Federation and the state hospital federations. Since the 1980s a considerable volume of management responsibility has been transferred to them (Döhler and Manow 1992) without them to date having been granted the status of a public corporation and without membership in these bodies having been made compulsory for hospitals. The hospital federations have a statutory responsibility in various fields to conclude binding collective agreements with the funds' associations at the respective nego-

tiating levels. (Rosenbrock and Gerlinger 2006). At the state level, together with the health insurance fund associations, they run joint boards of arbitration that make binding decisions in cases of dispute. At the national level the most important task of the German Hospital Federation is defining—jointly with the associations of statutory health insurance funds—the national fee schedules for stationary treatments and adapting these to the latest advances. This task is of decisive importance for establishing a functioning remuneration system (the system is currently undergoing a fundamental overhaul).

In a field so heavily influenced by free-market transformation, it might seem strange that centralist corporatist arrangements have survived so tenaciously—indeed, it must be said, even increased their influence in some respects. It has already been explained above why creating a market calls for a high degree of political (re-)regulation. What remains to be clarified in this connection is why the state continues to delegate regulatory powers to centralized corporatist bodies. Here the following aspects are significant:

1. Numerous management tasks demand a high degree of expertise, which in many cases is available in the participating associations but not in the responsible ministerial bureaucracies or in the political parties. This applies, for example, to determining the benefit and efficiency of medical treatments, to defining quality standards for medical care, to the economic assessment of medical procedures and to economic aspects of care processes. To that extent the state is forced to rely on the knowledge accumulated in the associations when it comes to the nitty-gritty of health service management.

2. In the industrialized capitalist states the right to appropriate medical care is at the heart of the respective welfare state cultures, and counts virtually as a kind of civic right: ‘Health care matters. [...] Being able to go to the doctor is one of the hallmarks of citizenship in most advanced industrial countries’ (Freeman and Moran 2000: 35). In Germany, too, the principle of a right to comprehensive medical care also enjoys broad approval (Ullrich 2000, 2001; Wendt 2003). Restrictions on public funding of health services thus entail considerable legitimization risks

for the governments concerned. Such legitimization risks can be reduced by delegating decision-making powers to bodies such as the aforementioned Federal Joint Committee (Gemeinsamer Bundesausschuss) because these bodies generally operate outside the glare of publicity and are generally less sensitive to legitimization risks than parties, governments and parliaments. Hans-Jürgen Urban (2001) shows that the expanded role given to the Federal Joint Committee (Gemeinsamer Bundesausschuss) in 1997 (reviewing and defining the treatment catalogue) was directly connected to the previous failure of efforts by the CDU/CSU/FDP coalition to remove certain treatments from the statutory employer/employee funding system. Another factor is that decisions of the Federal Joint Committee (Gemeinsamer Bundesausschuss) are generally made with reference to scientific evidence. Mobilizing the resources of science makes it easier to legitimize decisions to remove treatments from the funding list and to make these decisions appear not to be political.

The paradigm change outlined at the beginning has subjected corporatism in the health care system to a multi-dimensional transformation. Firstly, on the meso level it has undergone a process of erosion, and its management functions are increasingly being replaced by competition relations at the micro level. Secondly, it is becoming increasingly centralized, and thirdly, as a centralized form of corporatism, it is being subjected to increasingly tight state controls. Fourthly, its role is becoming largely restricted to the function of elaborating the details within a given competition framework that is in the process of being established in the health service. This development can best be characterized as a transformation towards a state-domesticated competitive corporatism.⁵ With reference to the period up to the mid-1990s, Döhler and Manow still had good reason to assert that the state was pursuing a policy of corporatization, “at whose heart was the attempt to solve the cost problem by expanding the collective contract-making powers of insurance funds and service provid-

⁵ The concept of ‘competitive corporatism’ was coined by Martin Rhodes (Rhodes 1998 and 2001). Hans-Jürgen Urban introduced it into the sociological debate on health policy (Urban 2001 and 2005).

ers” (Döhler and Manow 1997: 119). But precisely this no longer applies since the passing of the Health Care Structure Act (Gesundheitsstrukturgesetz). Since then the state has assigned this function to competition, while corporatism is primarily given the task of supervising this free-market transformation of the health service.

6 Coalitions: “Conservative/Liberal”, “Red/Green”, “Grand Coalition”

After the Health Care Structure Act (Gesundheitsstrukturgesetz) set out the new course, health policy fairly consistently pursued this path (Rosenbrock and Gerlinger 2006). The specific composition of the national governing coalition was not irrelevant for the particular slant of health policy, but the new governments that took office in 1998 and 2005 made no major U-turns. This was partly due to the strong influence of the associations in leveling party-political differences and to the necessity to reach compromises that is inherent to the German federal system. Over and above those factors, we also find that over the past fifteen years there has been fundamental agreement on the basic tenets of health policy between the different parties of government.⁶ This consensus encompasses the central goals (stability of contribution rates, increasing efficiency) and the management instruments of health policy (competition, remuneration reform in the hospital sector)—in other words the core elements of the paradigm change of the early 1990s.

Nonetheless, health policy has not been free of intense controversy. The degree to which individual patients should be made to bear part of their treatment costs themselves was especially controversial, at least for a time. In 1997 the CDU/CSU/FDP coalition (the ‘conservative/liberal coalition’) implemented far-reaching privatization measures that were largely rescinded by the SPD/Green coalition (‘red/green’) immediately after it took

⁶ This applies least to the FDP, whose calls for complete privatization of the health insurance system rather overshadow its specific proposals for reforms *within* the statutory health insurance system.

office. The SPD and the Greens initially pursued a strategy of tapping unexploited efficiency reserves by modernizing health-care structures and contracting arrangements, hoping that this would allow contribution rates to be held down while still maintaining a comprehensive catalogue of treatments. However, when it became apparent during the SPD/Green coalition's second term of office that structural reforms would not—at least in the short term—lead to cost savings and at the same time rising unemployment was causing significant increases in contribution rates, the coalition decided in 2003 to accept proposals for raising charges.⁷ The distribution of seats in the second chamber, the Bundesrat, made it necessary to conduct negotiations to find a compromise with the CDU/CSU, and in the course of these the proposals were expanded considerably. The outcome was that in the 2004 Statutory Health Insurance Modernization Act (GKV-Modernisierungsgesetz) not only were charges increased heavily, but the system of employers and employees each bearing an equal share of statutory health insurance contributions was abandoned in the employers' favor (Gerlinger 2003).

Furthermore, differences can also be found between the respective coalition partners (SPD and Greens on the one hand, CDU/CSU and FDP on the other) in the details of their concepts for competition. Strong competition rhetoric can be found in the policy statements of all the parties, but the SPD and the Greens also emphasize the integration of care providers in a competition regime and consequently the necessity to give the health insurance funds autonomy in contractual arrangements, while the conservatives and the liberals stress the possibility of allowing fund members to pick and choose between a range of different levels of coverage and tariffs. In practice, though, the CDU/CSU and

⁷ However, as well as representing a response to specific considerations of health policy, this reorientation was also an expression of a general shift in attitudes towards the welfare state within social democracy. This can be generalized as a turn from state responsibility for social welfare to individual responsibility, both in policy statements and in real political action (Seeleib-Kaiser 2002; Egle et al. 2004). Even the Greens display a certain distance towards welfare state programs and are for that reason sometimes called a 'new party of the middle class' (Haas 2003).

the FDP have often watered down or opposed proposals to expand the use of selective contracts (Gerlinger 2003).⁸ To that extent the alignments typically found in most other fields of policy are reversed in health policy. Whereas conservatives and liberals normally campaign for deregulation and more competition, in the case of the health care system they are rather restrained when it comes to including health-care providers in competitive arrangements. However, in matters of competition these are differences of degree rather than of principle.

Another difference consists in the SPD/Green coalition's strong focus on improvements in the quality of care and in its great willingness to further this end by issuing statutory regulations and creating para-state institutions.⁹ Conservatives and liberals, on the other hand, tend to leave quality assurance to the selective behavior of patients. Finally, between 1998 and 2005 the SPD/Green coalition worked to strengthen patients' rights and to enhance the role of preventive medicine and health promotion; these concerns were not at the top of the CDU/CSU's list of priorities but the initiatives were ones they were able to give their approval to.

A new and very fundamental conflict has appeared since the beginning of this decade with respect to the overall shape of the insurance and financing system, with the opposing models of the flat-rate contribution and the citizens' health insurance scheme (see section 4). The 'grand coalition' was unable to resolve this

⁸ The reasons for this are to be found in political ideology and clientelist considerations. Offering different levels of coverage and tariffs is an expression of the principle of subsidiarity, while the slower expansion of competition mechanisms to include relations between funds and doctors is a mark of political proximity to the interests of doctors.

⁹ One expression of this was the creation of the Institute for Quality and Efficiency in Health Care in 2004. The SPD and Greens originally planned this as a state institution and only as a result of consensus negotiations with the CDU and CSU was it placed largely under the remit of the collective self-management system and the health insurance funds. At the same time it is undeniable that the first steps towards liberalizing contractual arrangements were taken 1998 under Health Minister Horst Seehofer. Although clientele ties persist, the pressure of cost containment has tended to fracture the alliance between the CDU/CSU and doctors.

conflict in the 2007 Health Reform (Gerlinger et al. 2006). Although the final decision has been postponed until the next legislative period, in the form of the Health Fund an institution has been created that can be used at a later date—depending on the majority in the Bundestag—to ease and accelerate the introduction of one of the two models.

Overall the 2007 Health Reform displays much continuity with respect to the preceding health policies. The competitive autonomy of the health insurance funds has been expanded yet again, as is evident, for example, in the aforementioned scheme to offer all members the option of tariffs with an own-risk clause and/or a no-claims bonus or in allowing funds to deviate from collective contractual arrangements. By transferring the right to set the level of contributions from the funds themselves to the Federal Ministry of Health (Bundesministerium für Gesundheit) the reform at the same time strengthens the state's influence on health policy. Furthermore, the reform pushes forward the centralization of corporatist arrangements by replacing the existing seven national associations of statutory health insurance funds with a single joint national association. Finally, the 2007 Health Reform also contains a trend towards privatization of treatment costs. Although it does not provide for any more services to be excluded from coverage or for any further increases in charges, the introduction of more flexible tariffs along with the establishment of the Health Fund will in the medium term further increase the financial burden on fund members and patients and reduce costs to employers.

7 Summary and Outlook

The enactment of the Health Care Structure Act (Gesundheitsstrukturgesetz) ushered in a paradigm change in German health policy during the first half of the 1990s. Since then policy in the field of health has largely followed the trajectory defined in that act. The change is leading to a radical transformation of the health service, affecting both its care structures and its funding and regulatory mechanisms. The heart of the reform is the

establishment of a specifically German version of the regulated market that builds on the institutional idiosyncrasies of the German health service. The paradigm change can be characterized as a transition to competition-centered structural reforms. Relations between health insurance funds, care providers and patients/fund members are being restructured through an expansion of free-market elements. In the course of this transformation the incentives for the participating actors are being reconfigured so that their individual financial interests in the provision, funding and take-up of medical services lead them to support the goal of restricting spending. On the demand side this process is accompanied by a forced privatization of treatment costs.

This fundamental shift in strategic health policy has its roots in the efforts of the political elites—especially in the political parties—to adapt the health care system to a new economic environment. Their actions are guided by the dogma of neo-classical economics, according to which globalization and intensified international economic competition make it necessary to lower production costs, business taxes and ancillary wage costs. This reorientation was triggered by a confluence of general processes (the worsening economic situation and a resulting significant rise in contribution rates to the statutory health insurance system) and processes specific to the field of health policy (the failure of successive attempts to contain costs by means of traditional, structurally conservative policies). As a result of this change of strategy the goal of adapting the health care system to fit the perceived requirements of a globalized economy has increasingly gained in importance over its function of protecting against the social life-risk of ‘sickness’. The change can be understood as the sectoral expression of the shift from the ‘Keynesian welfare state’ to the ‘Schumpeterian workfare state’ (Jessop 1994) or a transition from a Fordist to a post-Fordist regulatory system (e.g. Hirsch 1995).

In terms of care structures the paradigm change involves modernization and rationalization of the provision of medical care. In financing it is characterized by a new welfare mix where the financial burden shifts from collective solidarity to individual patients and fund members—while at the same time the employers’

share is reduced. In the financing system there is also a trend towards gradually increasing the share of funding provided through taxation and reducing the contributions based on income from employment. Here one of the central features of the health insurance model dating back to its introduction under Bismarck appears to be losing its importance. In terms of regulation the paradigm change is characterized by the implementation of competition-centered structural reforms. At the micro level the state is expanding the possibilities for individual actors to conclude health-care contracts, while at the meso level the powers for health funds and doctors' associations to impose collective contracts are being successively undermined. At the same time the remaining corporatist regulatory instances are becoming increasingly centralized, hence changing the function of corporatist arrangements; their purpose is now primarily to flesh out the details of competition within a framework laid down by the state and to supervise the establishment of the new system.

Parallel to this process an expansion of state intervention is also occurring, where the state uses the instruments of procedural management to shape the interests and resources of subsidiary actors, in order to direct their actions in the self-managed system towards the achievement of state management goals. With the same intention the state is imposing increasingly tight controls on the actors in the corporatist management bodies, especially where the financing of the statutory health insurance system is concerned. The emerging regulatory model can be characterized as state-domesticated competitive corporatism.

What can be said about the future development of health policy? The most controversial question in coming years will be the shape of the financing and insurance system. In the long term it will probably not be possible to fund the statutory health insurance system through contributions based on income from employment—especially if individuals with high incomes and below-average treatment needs migrate to the private health insurance system and are thus able to escape from participating in collective financing of health costs. For this reason a far-reaching reform of the financing and insurance system will probably be unavoidable. The form this takes will depend above all on the

political majorities after the next Bundestag election. In view of the German political system's in-built necessity to find compromises it is unlikely that either of the two opposing models will be implemented in its pure form. Here too, the path of gradual change will probably be taken. In this connection it is conceivable that a convergence of the statutory and private health insurance systems could occur, by introducing elements of the financing mechanisms of each system into the other—a course for which some of the ground has already been prepared by the most recent reform (Gerlinger 2007). Whether or not this occurs it can be assumed that the share of statutory health insurance funding provided by contributions based on income from employment will continue to fall, probably accompanied by a rising share of funding through taxation.

Apart from this fundamental question, it can be assumed that the existing trends in health policy will continue in coming years: competition mechanisms and options for concluding individual contracts between health insurance funds and doctors will probably be expanded; the state will formulate the rules of competition and ensure that they are observed, not least in order to limit the legitimating risks for the governing parties; the state will also continue to place restrictive (probably increasingly restrictive) financial conditions on the statutory health insurance system; corporatist arrangements will be subject to further centralization (in particular, the different categories of health insurance fund will probably disappear in the foreseeable future because they are superfluous under conditions of competition between funds); and finally the costs of treatment will continue to rise disproportionately (compared with the Gross Domestic Product) and will probably be shifted further onto the shoulders of patients and fund members. If we were to describe the development of the health care system in the categories of Esping-Andersen's welfare state typology, one could say—in a word—that features of the liberal model will gain considerably in importance in the German health service.

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