

**COMPARING HEALTH INSURANCE REFORMS
IN BISMARCKIAN COUNTRIES :
FROM PATH DEPENDENT TO PATH BREAKING CHANGES ?**

DRAFT PAPER

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'A LONG GOODBYE TO BISMARCK?
THE POLITICS OF WELFARE REFORMS IN CONTINENTAL EUROPE'**

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The first aim of this paper is to show that analysing Health insurance reforms in the context of the Bismarckian social protection system re-enforces the idea that “welfare institutions” matter. If the health sector has its own specificities (notably the involvement of the medical professions), we will show that first the health insurance systems share some features with the other social insurances typical of Bismarckian social programmes, and second that the timing and content of the reforms also share some features (from one health insurance system to the other, and from health insurances to other social insurances). Even, if some patterns of change in Bismarckian health insurance system lead to convergent trends between those systems and with national health systems (especially tax financing, managerial transformation and growing State control and regulation), institutional specificities still matter. We will focus our analysis on the role of sickness funds, the most specific Bismarckian institution, in the regulation of health insurance system.

The second aim of the paper is to show the sequencing of reforms in the health insurance sector. As for the other sector and for many national trajectories, four main sequences of reforms can be identified. First, the main reaction to financial difficulties, especially in France and Germany was to increase social contribution rather than cutting benefits. This “before retrenchment” sequence is based on raising social contributions. Second, in the 1980’s, retrenchment were attempted through negotiation with actors highly involved in the system. This first wave of retrenchment is path depend but often lead to a lower level of coverage by public/compulsory health insurance because of growing dereimbursement of health expenses. Third, since negotiated cost control appears insufficient, further (more institutional) reforms are introduced in the 1990’s. They correspond to path shifting changes based on growing direct State intervention in order to curb costs (especially through capped budgets). Previous retrenchment policies also lead to silent privatisation of health insurance because they have diminished the level of public coverage, opening the way for more private insurance intervention. Fourth, the accumulation of the previous changes have enables structural reforms, corresponding to path breaking changes. They have three main aspects : new modes of financing (more taxes, less social contributions), new modes of management with the introduction of performance and competition logics, new organisation of health delivery (especially in the ambulatory sector). Structural reforms seem to lead to some convergence with national health systems but also at the same time to divergent path between Bismarckian systems, since Germany and the Netherlands go for competition among insurance funds whereas France goes for “etatisation”.

These sequences do not necessarily strictly correspond to different periods of time because of the dominant incremental and policy learning logic of the reforms. Some of the institutional reforms started at the same time as the first wave of retrenchment, and path-breaking change have also their origins at the beginning of the 1990’s, even if their structural effects begun mostly visible with the latest reforms (2003 Reform in Germany, 2004 Reform in France, 2005 Reform in the Netherlands). In many cases, the various trends overlap since the 1990’s.

In this comparative analysis, we will mainly deal with France and Germany for two reasons : they represent the two main examples of health insurance systems in Europe and they also have some important differences : the French system is far much centralized and controlled by the State than the German one which represent the most typical Bismarckian case because of its historical origins and the greater autonomy of the sickness funds. Differences are also obvious between the two political systems : presidential and majoritarian democracy in France ; parlementarian and negotiated democracy in Germany (Bandelow, Hassenteufel, 2006). Next to these central cases, will also make some “pointillist” references to the case of

the Netherlands even if the Dutch health protection system is not strictly Bismarckian because of the existence of a first universal compartment, created in 1967, financed by taxes, which mainly includes long term care and mental health care. However, the second compartment has clearly Bismarckian characteristics and represents the bigger part of health risk coverage in the Netherlands. This compulsory health insurance system was created in 1941 for middle and low income people (62% of the population) and covers curative health services (hospital care, physician service, prescription drugs, emergency care etc.).

1. Common features and problems : Health insurances are social insurances

1.1. Main historical characteristics of health insurance systems

In this section, we would like to emphasise the fact that Health insurances have at least as much in common with other social insurances than with National Health systems. Therefore we contrast the two ways Health care can be organised in order to highlight the social insurance traits of health insurance systems.

The history of healthcare systems in the developed countries indicates that at various periods all countries shared similar healthcare objectives (firstly to aid the sick on low incomes, then to guarantee a substitute income for salaried workers suffering from illness and, for Europeans after world War II, to ensure access to healthcare for all) but that they chose different solutions. These differences originate especially from the types of institutions assuming the cost of the demand for healthcare (the role of the State, of the mutual insurance societies and private insurance companies) and from the way in which the healthcare supply is organised (the importance of public hospitals, the role played by general practitioners, etc.) and the way the medical professions developed in the past are organised (the importance of the liberal practice of medicine). These differences also reflect the different priorities held by each system: for some, universal health cover, for others the choice of doctor, the maintenance of liberal medicine and the resilience of insurances.

In Europe, one can find two types of health care systems.

1. **The national health systems** (Sweden, Norway, Denmark, Finland, Great Britain, Italy, Spain, and in part Portugal and Greece) that ensure almost free access to healthcare for all citizens in order to guarantee universal cover for illness. The supply of healthcare is organised mainly by the State and funded by taxes. Some of these systems depend on a highly centralised organisation (as is the case in Great Britain in particular) while others have decentralised their organisation and their management (as is the case especially in the Nordic countries).

2. **The health insurance systems** (Germany, France, Austria, Belgium, Luxembourg, and to a lesser extent the Netherlands and certain countries in Central and Eastern Europe). The supply of healthcare is partially private (ambulatory healthcare, certain hospitals or clinics), and partially public (in particular a proportion of hospital services) and most often guarantees the patient's choice of doctor, as well as the status of the liberal practice of medicine. The expenses arising from the services are mainly assumed by different health insurance funds and financed by social contributions. The French system is centralised while the German one is organised on a regional level (the *Länder*).

The national health systems generally ensure a large degree of equality of access to healthcare and relatively low levels of health spending, but they may provide a questionable quality of

treatment and are known especially for their extremely long waiting lists before access to specialist care is possible. The health insurance systems, in which the supply of healthcare is often plentiful, allows patient choice, comfort and often the quality of care to be guaranteed, but this is most often at the cost of high health spending, and occasionally inequality of access to healthcare.

How do health insurance systems traditionally operate?

In order to stress the importance of welfare arrangements and institutions for understanding the politics of welfare reforms, we will refer to the four main institutional dimension of the health care systems (rules of access, types of benefits, financing and management arrangements) to analyse how Health insurances system operate. We will show 1. how access to the health system is organised, 2. what types of services the latter guarantees, 3. how expenditure on health is financed, and 4. how the entire system is organised and regulated. We will then be able to show that these traits are partly implying the kind of problems and the kind of reforms these systems have been subjected to.

Access.

Who has the right to benefit from the health system? The national health systems are open to all those residing legally within a country, without any particular conditions. The health insurance systems were first intended for employees and their dependents. In Europe, they have been extended to everyone through the implementation of the mechanism of free personal insurance for the most deprived. In Germany and the Netherlands, the richest are not obliged to sign on with a compulsory system of health insurance ¹.

Access to healthcare providers. If countries with a strong Bismarckian tradition have chosen not to go for Public National health systems, it is partly because it appeared important to keep choice and freedom as a central feature of the health care system. Health insurance systems most often ensure quite a large liberty of choice of doctor for the patient, who may go directly to a specialist (accessible via the ambulatory care sector), consult several doctors on the same pathology, or even be admitted directly to hospital (this is the case in France). On the contrary, the majority of national health systems try to control the circulation of patients inside the system. The patient's freedom to choose his or her doctor, appreciated by French or German patients, creates competition between doctors, which can lead to a higher amount of expenditure. Even if "medical nomadism" (the act of changing doctor frequently, of consulting several doctors for the same pathology) is relatively limited, including in systems where there is a completely free choice of doctor, competition between doctors encourages them to write numerous prescriptions in order to satisfy the client and prevent him or her from consulting other doctors (French patients consume twice more drugs than their European counterparts). There is much less possibility of this in the case of the national health systems.

The nature of the benefits. Sick pay is covered by health insurance systems (originally, it was the main purpose of health insurance : to replace income lost because of illness). However, today, most of the health expenditure goes for covering the cost of treatments (70% of health expenditure goes to professionals remuneration). No health system covers the full expenditure on healthcare. The national health systems are those in which the difference between public expenditure and total healthcare expenditure is the smallest. By imposing only

¹ In 2002, it was not compulsory for anyone to join if they earned over €3375 a month in Germany, and €2558 in the Netherlands.

a very limited co-payment (between 14 and 17% of costs in the case of the Nordic or British systems), they offer the most generous assumption of the costs of treatment and thus guarantee the best access to healthcare for all (Cf table 1). In the case of Germany and the Netherlands, the relatively low figures can be attributed in part to the fact that not all the population is covered by the obligatory system. As regards the other countries, there is a proportion of healthcare that is not covered.

Table 1: Proportion of public expenditure in total healthcare expenditure, in 2001.

Germany	74.9%	Italy	75.3%
Canada	70.8%	Japan	78.3% (in 2000)
Denmark	82.4%	Norway	85.5%
Spain	71.4%	Netherlands	63.3%
USA	44.4%	Portugal	69%
France	76%	United Kingdom	82.2%
Greece	56%	Sweden	85.2%

Source, OECD 2003.

In all the healthcare systems in the countries of western Europe, the costs of the most expensive treatments, needed by the most serious illnesses (cancer, cardio-vascular diseases, AIDS, diabetes, etc.) and by long-term illnesses (degenerative disease), is extremely well paid for (the cost of almost all hospital treatment in Europe is met). The cost that these treatments represent is very high and accounts for the majority of health spending. On the other hand, less expensive but more frequent treatments, connected to less serious conditions, treated by community practitioners, are met to a greater or lesser degree depending on the systems. In Great Britain, in Sweden (but also in Germany up until 2003), ambulatory medicine consultations are free. France is the exception for her poor cover of ambulatory healthcare (only 60% of ambulatory treatment is covered by obligatory health insurance). Because of the low levels of reimbursement in out-patient treatment, the French have to rely on their complementary insurance or mutual society to pay for a (growing) part of their healthcare expenditure (almost 13% of the total), in the knowledge that they still have almost 11% of their total expenditure to finance out of their own pocket (High Council, 2003). Complementary insurance is well developed in France: about 85% of French people have a mutual society or complementary health insurance to cover part of the expenses for which they are left to pay; to these we should add the 7% of French have additional cover through the CMU (supplementary low-income health insurance). In comparison, only 1% of Swedes have supplementary health insurance, 11% of British and 25% of Germans (those who are above the threshold of obligatory health insurance and those who wish to supplement their health cover).

Financing.

The financing of the systems. The national health systems favour taxation while the health insurance systems have for a long time favoured social contributions charged on salaries (payroll taxes). When healthcare systems first started up, it seemed logical to fund health insurance expenditure through social contributions charged on salaries, since the main objective was to guarantee sick pay for those who were too ill to work. For example in Germany, the social security contributions for illness represented 14% of the income of wage earners in 2005 (the contributions only cover salaries below €3375, an income ceiling above which insurance is not obligatory). Half of the contributions are paid by the employers, and the other half by the employees. Below a wage of €325, only the employers pay a contribution

of 10%. In France public spending on health is financed by social security contributions paid by the employers (12.80% of gross revenue) and by employees who, apart from CSG, pay a further 0.75% in contributions to finance living allowances. The contributions and supplementary social security contribution for health insurance therefore represent about 18.8% of salaries (to which must be added the contributions for mutual societies or private health insurance, which vary between 2 and 4% of the income of those insured).

The remuneration of the producers of healthcare. In order to ascertain how to distribute the money collected to the different healthcare agents, the national health systems favour an *a priori* financing of the system. Each year they define the total amounts that will be spent on health, and allocate them to the different agents who must manage a budget set in advance. On the contrary, in health insurance systems, ambulatory healthcare is financed *a posteriori* : it is the demand for treatment which comes first, the total amounts spent depending on the doctors' activity and the prescriptions they write: the system works like an open ticket office. This type of financing does not make it possible to control the level of health expenditure. In France and Germany (until recently), countries in which the liberal practice of medicine predominates in the ambulatory sector, most physicians are paid on the base of fee for service in the ambulatory sector. In Sweden, all doctors draw the main part of their income (at least 60%) from salaries. In Great Britain, hospital doctors are on salaries, but general practitioners working in the ambulatory sector, under contract with the NHS, are paid mainly on a capitation basis.

The organisation and regulation of the system – The national health systems are much better in managing to organise the healthcare supply, but this is more limited than in insurance systems. Although it lives mainly off public money, in health insurance systems, the liberal practice of medicine rejects most means of regulation, while this is organised by the public authorities in national health systems.

In national health systems (in northern Europe), ambulatory care is primarily general medicine, most often carried out in groups, in practices in Great Britain, in health centres in Sweden. In these cases primary health centres are often referred to, since other health professionals such as nurses or kinesiologists work alongside the doctors. In France and Germany on the other hand, ambulatory care includes general practitioners and specialists (60% of ambulatory doctors are specialists in Germany, and 49% in France). It is in France and in Germany, countries where numerous specialists are found in the ambulatory sector, that the compartmentalization between ambulatory and hospital medicine is the most marked, with the risks of a lack of coordination, of redundancy or even of contradiction in the treatment already mentioned. The risk of redundancy is all the greater since it is these two countries that offer the highest amount of hospital care. Even if they decreased sharply during the 1990s, the number of hospital beds remains extremely high in Germany (6.4 beds for acute cases per 1000 inhabitants) and in France (4.3)².

Who makes the decisions and regulations? Each type of health system seems to have its own particular model of regulation. The national health systems are strictly regulated by the public authorities alone, national in the British case, predominantly local in the case of the Nordic countries or those of Southern Europe. Their decisions are guided by their concern for ensuring equality of access to healthcare, promoting prevention and savings in the budget.

² It is more limited in the United Kingdom (3.9), the Netherlands (3.5), and relatively low in the United States (2.9) or in Sweden (2.4) (Source: OECD, 2003)

Negotiated regulation. The health insurance systems are based on the negotiation between the managers of health insurance funds and representatives of the medical professions as the German case shows. The relatively united trade union front that German doctors present, the regional Union system of the doctors (who represent them, negotiate the budgets and pay them), the autonomy to set rates and the principle of self-administration by the management and labour have enabled the German system to function on the basis of permanent negotiation. In this framework, the doctors, who assert their identity as liberal practitioners, have agreed to assume some of the responsibility for the management of public money: the doctors' representatives take part in the negotiation of the budget given over to health expenditure, the amount of the fees is adjusted according to the total activity of physicians within this limited budget. The doctors also accept that there should be regulation and control of their practices provided that this is carried by a body made up of doctors and which represents them (the regional doctors' union).

In France the negotiation between sickness funds and doctor's trade unions (*conventions médicales*) also concerns the amount of fees, but it is more controlled by the State (no convention can be signed without the agreement of the State which indirectly participate to the negotiation through the director of the health insurance, nominated by the government).

Regulation by the government. In national health systems, by contrast, the regulation is set in place by the governmental provider of funds. It can take some relatively radical forms: the definition of imposed medical practices subject to control and penalties, limitation of budgets, organisation of short supply. Thus, in Great Britain, the Parliament votes the budget of the NHS and lays down directional guidelines for it, with which the Minister of Health is responsible for ensuring compliance.

1.2. Specific problems of health insurance systems

In Health as in other sectors (such as pension or unemployment insurance), institutional differences explain most of the divergent developments. The health care systems of France or Germany on the one hand, and the British or the Swedish ones on the other have been challenged by distinct, if not opposite problems in the last decades. In the U.K. or Sweden, health care is altogether a state service, thus it was relatively easy for the government to control the development of expenditure for health, basically by freezing the budget of the National Health Service. The main problem is: How do you achieve an efficient and adequate health care system with the limited resources the government makes available? In contrast, in France or Germany, the government does not directly control health care expenditures. There are no budgetary limits or freezes, but there is a system of reimbursing health care expenditures first incurred by the insured person. The problem here is an uncontrolled upward trend in health expenditures. The problems confronted by the health care system are at polar opposites: While in the U.K. waiting lists are the key issue, in France or Germany cost containment is on the top of the agenda.

Although they fail to record the best results for the health of their population, the health insurance systems give rise to higher total health expenditure (Cf table 2). Table 2 moreover shows that Sweden is the country where the evolution in health spending between 1980 and 2001 was the best controlled.

Table 2: evolution in health expenditure

	Total health expenditure as percentage of GDP	Public health expenditure as percentage of GDP
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	1980	1990	2001	1980	1990	2001
Germany	8.7	9.9 (1992)	10.7	6.8	7.7 (1992)	8.0
Canada	7.1	9.0	9.7	5.4	6.7	6.9
Denmark	9.1	8.5	8.6	8.0	7.0	7.1
Spain	5.4	6.7	7.5	4.3	5.3	5.4
United States	8.7	11.9	13.9	3.6	4.7	6.2
France	7.6	8.6	9.5	..	6.6	7.2
Greece	6.6	7.4	9.4	3.7	4.0	5.2
Italy	..	8.0	8.4	..	6.4	6.3
Japan	6.4	5.9	7.6 (2000)	4.6	4.6	6.0 (2000)
Norway	6.9	7.7	8.3	5.9	6.4	7.1
Netherlands	7.5	8.0	8.9	5.2	5.4	5.7
Portugal	5.6	6.2	9.2	3.6	4.1	6,3
United Kingdom	5.6	6.0	7.6	5.0	5.0	6.2
Sweden	8.8	8.2	8.7	8.2	7.4	7.4

Source, OECD 2003.

Having shown how important the institutional settings of the Health care systems was for understanding its functioning and problems, we will now turn to the processes of reform in France, Germany and the Netherlands, in order to see how they have coped with their specific problems. We will analyse two types of policies: the cost containment strategies, and the structural changes, each of them being divided into two distinct sequences.

II. Cost containment strategies in health insurance systems from path dependent to path shifting change

Since the beginning of the 1970s, in France, Germany or the Netherlands, health care expenditures increased much faster than the economy grew. As for pension or unemployment insurance, the first main response to this trend has not been retrenchment, but has been to increase social contribution paid to health insurance funds (meanwhile, in National health systems, budget was controlled through rationing services, giving rise to waiting lists). In the 1980s attempt to control cost were launched, but had to be negotiated in Bismarckian countries with the Unions (the Trade Unions and merely the Doctors' Union). In a third step in the 1990's, institutional reforms have been introduced, conducing to a growing State intervention in health insurance systems in order to control costs.

In France, over the years, numerous measures were taken to deal with the financial difficulties of the health insurance funds. On average, every 18 months between 1975 and 1995, a new rescue plan³ was adopted. Typically these plans combine increases in the contributions paid by employees and employers with small cuts. The fact that a financial recovery plan was adopted on average every 18 months in France since the middle of the 1970's underlined its inefficiency over the long term. The comparison between the growth of GDP and that of medical consumption clearly shows that the plans provide short-term results. Two other

³ *Plan Durafour* (December 1975), *plan Barre* (September 1976), *plan Veil* (April 1977 and December 1978), *plan Barrot* (July 1979), *plan Questiaux* (November 1981), *plan Bérégovoy* (November 1982 and March 1983), *plan Dufoix* (June 1985), *plan Séguin* (July 1986, December 1986 and May 1987), *plan Evin* (September 1988 and December 1990), *plan Bianco* (June 1991), *plan Veil* (August 1993) and *plan Juppé* (November 1995).

problems lay behind these plans. The first one is their economic cost: the growth of fees affects the cost of wages for firms in the French economy. It also diminishes incomes and thereby overall consumption. The second one is the social cost: the increase of fees affects the real wage. These plans are therefore very unpopular. In Germany the raise of the contributions was also used by the sickness funds (and not by the State as in France) in order to fight against deficits.

The financial issues are clearly dominating because levels of social contributions are key to competitiveness (See the paper by Philip Manow). Whereas medical expenditures in the Keynesian paradigm were seen as a demand-stimulating motor of economic growth, the social contributions behind these are now seen as a factor impeding competitiveness by adding to production costs. Exemplary of this trend are studies by the European Commission which estimate that an increase in three points of social security contributions leads to an increase of the unemployment rate of one percent (Giaino 2002: 121ff.; Grabow 2005: 57). And on the revenue side, a high unemployment rate is reducing the number of those that contribute while the aging of the population is augmenting expenses. Thus growing deficits became a main factor of reforms. By the early 1990s, increasing social contribution appeared to become an economic dead end in both countries, and attempts were made to limit health insurance expenditure growth and to reduce the deficits of the health insurance funds. But, because of the way health insurances are organised, these retrenchment reforms had to be negotiated.

2.1. The first wave of retrenchment : Negotiated cost containment policies

• Self-administrative regulation in Germany

In Germany cost-containment policies followed the historical pattern of self-administration. Two main explanations can be given here.

The first one is the capacity of the actors engaged in self-administration to take account of the new economic constraints. For the sickness fund the choice was simple: curb costs was the only way for them not to raise level of contributions. The strategy followed by the representatives of the medical profession, especially the Unions of insurance doctors, is very important here. The Unions accepted to participate in cost regulation in the ambulatory sector in order to protect the institutional framework of the policy network. They clearly followed a strategy of political exchange (Rosewitz and Webber 1990): in exchange for short-term economic concessions the Unions obtained the preservation of the institutions of self-administration, of their monopoly on ambulatory care supply, of the fee-for-service payment and their institutional consolidation. The exchange was made between economic (mainly fee-freezes) and institutional goods. These exchanges take place especially when the government threatens to intervene directly in the sector because of the financial problems of the health insurance system.

In 1975–6 Unions signed agreements with the sickness funds including limitation of price rises for medical acts. In 1982 similar agreements froze the incomes of doctors, and in 1985 the Unions accepted to implement ‘global volume envelopes’. In this system, physicians are remunerated on a fee-for-service basis, where each service rendered carries not a fixed monetary value, but a fixed point value. Each trimester the sickness funds distribute a fixed-sum global envelope to the Unions who will then divide the amount of money by the number of treatment points submitted by doctors. Increasing services does not increase expenditure.

This system strengthens the power of the Unions which implement the envelopes and control the individual activity of doctors.

High level of institutionalization allowed the Unions to sign agreements limiting the activity of doctors and involvement in implementing the reforms. The power of the Unions was also strengthened by the health reform law of 1988 because it charged the joint committee (where the federal organization of insurance doctors and the federal sickness funds organizations are represented) to establish the reference prices for drugs, regulating the proliferation of large-scale medical devices, setting standards for medical care and the right to exclude new techniques of diagnosis and treatment from reimbursement through the sickness fund.

The participation of the profession to cost containment gave the Unions legitimacy to refuse direct intervention from the State. Sustained by the Liberal Party (a member of the governmental coalition) they succeeded in 1988 in removing from the health reform project the right given by the sickness fund to employ doctors to control the activity of office-based practitioners and the right for hospitals to accept day-care out-patients; they also preserved the complete freedom in prescribing drugs.

The other reason for continuity in health-insurance policy making is that the Social Affairs Ministry favored self-administered regulation. The ministerial bureaucracy historically contributed to the strengthening and centralization of health and welfare organizations. This ‘sectorial policy paradigm’ (Döhler 1993) was not changed for cost-containment policies. On the contrary, the State tried to extend self-administered regulation in the hospital sector (Döhler and Manow-Borgwardt 1992) where it has no direct intervention tools: hospital are financed at the *Länder* and local levels. During the 1980s more power was allocated to the sickness funds and the hospital associations were upgraded. It was clearly an attempt to regulate this sector through collective bargaining between highly institutionalized actors, as in the ambulatory sector. The strengthening of the Unions and of the joint committee clearly belongs to the same strategy.

Cost-containment policies did not change the patterns of sectoral regulation. The success of the political exchange strategy of the Unions, relying on their high level of institutionalization and their capacity to aggregate the interests of the whole profession, preserved the main components of asymmetric corporatism favoring physicians in the health-policy network.

In France the negotiation of cost containment policies was more difficult because of the lower institutionalisation of doctors and conflicts between physician trade-unions (Hassenteufel 1996).

- *The difficulties of negotiated regulation in France*

In the 1980 conventional negotiation, the Minister of Social Affairs tried to impose a ‘global volume envelope’, like in Germany, in order to link the growth of expenditure in ambulatory care to economic growth. This goal was accepted by the sickness fund (CNAM) which then negotiated it with the medical unions in exchange for the creation of the so-called ‘sector 2’ (*secteur 2*). Doctors in this sector can charge higher fees than those reimbursed by the sickness funds. The difference is paid directly by the patient. Only one medical union, the FMF— mostly specialists from large cities who were most favored by this sector—accepted this system. The CSMF, the biggest union, was clearly against it. Because of this opposition the global volume envelope was never implemented. It disappeared in the 1985 convention.

Consequently the only thing left to the State for regulating in the ambulatory sector was the level of contributions (as described above) and levels of reimbursement. Doctors could thus decide (and raise) their level of activity and in a fee-for-service system this meant a direct raise in their income. The regulation of total expenditure in the ambulatory sector was therefore ineffective.

Another consequence, however, is that the fee freeze we have described above affects only doctors in 'sector 1', who are mainly generalists. The creation of 'sector 2' increased the income disparity between specialists and generalists. This was one of the main reasons leading to the creation of a generalist's union, MG France, in 1986... a further increase in the fragmentation of representation.

After the 1988 presidential election the new government, headed by Michel Rocard, tried to introduce a new way to regulate costs, based on greater involvement of health producers, especially doctors in the regulatory system. The government wanted to negotiate the regulation, as in Germany. This strategy also corresponded to a reorientation of regulation from a financial logic to a medicalized logic, based on medicalized evaluation of therapeutic activities. The change in health-cost regulation is not only the consequence of the limits of financial and administrative regulations. It can also be related to strategies followed by sickness funds and health producers. Medical regulation is the first to give the possibility of strengthening their position in the health-policy network (Ravoux 1994). In market-oriented or administrative regulation the sickness funds are marginalized; on the contrary their position is central in a medicalized regulation for, at least, two reasons. First it requires bargaining with the health producers, especially with doctors in the ambulatory sector. Second, because of their technical capacity in controlling medical activity, the funds are absolutely necessary for implementation. To the health producer, especially doctors, this type of regulation appears less constrictive than administrative regulation based on rigid financial norms.

The attempt to change the logic of regulation was at its clearest in the ambulatory sector. In the negotiation of the new *convention*, beginning in Spring 1989, Claude Evin followed a strategy based on a political exchange with the generalists, especially the new union MG France, a union awarded formal 'representative' status by the State and consequently admitted to formal participation in the negotiation. The political exchange on the one side provided for the closure of 'sector 2' and the creation of incentives for patients to consult a generalist before a specialist (in order to limit uncontrolled access to specialists which was seen as very costly). It also provided for prospective budgeting of costs in the sector. This attempt failed, however, because of the opposition of the other actors involved in the negotiation, the other doctors' unions and the sickness funds, which preferred to negotiate with their traditional partners: the CSMF and the FMF.

This failure led to another negotiating strategy based on the main union, the CSMF. The new ministers of Social Affairs and Health (the government changed in April 1991) was in favour of fixing a national rate of growth in health expenditure, based on economic conditions, medical progress and demographic evolution. This strategy led to very vocal opposition among the medical unions, fearing a 'global volume envelope'. This fear was explained by agreements in three other sectors containing annual global volume envelopes: liberal nurses, private *cliniques* and biologists (Tabuteau 1991). This opposition led to two large demonstrations by the medical profession in June (80,000 people in the streets) and November 1991 (200,000 persons).

An agreement was signed in October 1992 between the CNAM and the CSMF. This agreement replaced the national fixed rate of growth with ‘aims’ or targets (*objectifs*) that placed fewer restrictions on each doctor’s activity. It also contained the notion of ‘medical references’ (*références médicales*) based on therapeutic norms and norms of prescriptions. The application of these references supposed a new instrument of evaluation: the ‘coding’ of medical acts (*codage des actes*). This agreement is the basis of the health-insurance law, voted in December 1992 (Brocas 1993), also creating professional regional bodies for doctors (*unions professionnelles régionales*), which would implement this medicalized regulation.

A second step on the way to medical regulation was accomplished with the new *convention* signed in October 1993. An objective of cost growth was fixed (3.4 per cent) as were 24 ‘categories’ for medical references. If a doctor did not conform to these therapeutic norms he could be penalized. Sixty-five references were adopted by ministerial decree in March 1994, 147 in February 1995. The agreement also created the ‘*dossier medical*’ for elderly patients: to have one doctor centralize all medical information on a given patient in order to control medical consumption.

But these changes are limited. The main point is that doctors cannot be penalized automatically, individually or collectively, if the aimed fixed rate is overshoot. The ‘obligatory medical references’ (*références médicales obligatoires*) do not concern all medical acts (mostly acts of general medicine, which explains the opposition to the convention by MG France) and the coding is rather difficult to implement. The same can be said for the ‘*dossier medical*’. It only concerns patients over 70, and its creation in fact entails new expenses. The 1993 *convention* also includes fee increases linked to the respect of the objectives in curbing expenses. Finally the second sector is not regimented and the ‘*dossier medical*’ does not institute a gate-keeping in the use of ambulatory care, these being other reasons why the generalist’s union MG France did not sign the *convention*. Only two unions signed it: the CSMF and the SML, representing between themselves barely half of the physicians. At the first elections for the newly created regional medical bodies (*unions régionales de médecins*) in April 1994 the CSMF received 39 per cent of the votes of all doctors; MG France 33 per cent (59 per cent in the electoral body for generalists); the SML 14 per cent; and the FMF 7 per cent (10 per cent in the electoral body for specialists, 5 per cent in the electoral body for generalists). These electoral results show that the implementation of medical regulation in the ambulatory sector is not easy, especially because of the opposition of MG France, a union which is highly representative of the GPs who will need to be convinced to play a central role in any reform that genuinely hopes to be successful.

In both countries these patterns of regulation have not been enough to curb health expenditure significantly. This is the reason why new cost-containment policies have been experimented since the beginning of the 1990s, more relying on direct State intervention than on collective negotiation. They correspond to path shifting change.

2-2. State intervention and cost containment policies

Health insurance reforms in the 1990s are clearly linked to failures in the past and introduced fixed budget in order to contain cost in a more constrained way.

In this trend, The Netherlands were pioneer. The budgeting logic was already introduced in the Netherlands in the 1980’s. In 1983 the open-ended hospital reimbursement system was replaced by a global budgeting system for hospital’s operating expenses. In 1984 the scope of

the general budgeting system was extended to all other inpatient-care institutions. Acquisition of expensive technologies were also restricted, fees and salaries were limited and a complex system for planning the development of hospital facilities and the geographical distribution of specialists was launched (Harrison, 2004 : 135). At the end of the 1980's the Government also tried to introduce global expenditure caps for medical specialists with fee reduction in case of excess. In the 1990's medical specialists payments were progressively integrated to the hospital budgets. In 2000 a legal basis was provided for integrating the fees for hospital specialists into the hospital budget. Since then the medical specialists have to negotiate their fees with the hospital management and no longer with the health insurers (Shut, Van de Ven, 2005 : 63). And in 1996 the Drug Prices Act enabled the State to impose price limits for the prescription drugs covered by the health insurance system.

The link between cost containment policies and State intervention is also obvious in France and Germany.

. The 1996 Reform in France

This reform, adopted in 1996 stemming from the so-called 'Juppé Plan', gave new institutional tools to the State in order to increase its control over the whole health insurance system. It is the case in the hospital sector where regional state agencies were created. They have undertaken the previous powers of the sickness fund. In the ambulatory sector the scope of the collective bargaining between sickness funds and doctors organisations has been reduced and the State can, since 1996, replace the social partners when the latter are not able to reach an agreement. The 1996 reform also obliged Parliament to vote every year a national health spending objective (ONDAM), which sets target financial limits on health insurance expenditures. With this reform the government can also more easily adopt cost containment every year, because it is now a constitutional obligation and because the Parliament is in France strongly controlled by the government. Since 1997 most measures for health care were adopted through this way. It also means the dominance of the financial issues in health care.

The 1996 French reform is a consequence of a policy learning process. Three main failures of previous cost containment policies had been identified in several public reports on the health insurance system since the beginning of the 1990's :

- *The lack of constraints on doctors* which the reform addressed by introducing global budgets for the reimbursement of doctors with financial penalties if the fixed rate for budget increases was overstepped.
- *The limits of hospital budgets.* The need to restructure the supply of hospital beds (reduction of the number of beds, changing from short stay to long stay beds ...) had often been mooted. The reform addressed this by creating regional hospital agencies in order to implement this restructuring.
- *The lack of control by the State* which is why the reform extended State power in the health insurance system with the vote in Parliament of national health spending objective (ONDAM and greater intervention in the negotiation of collective contracts between doctors' organisations and the health insurance funds).

In a second sense, policy learning also means the progressive elaboration of solutions through cumulative processes and the gradual introduction of these solutions. In the French case, since the beginning of the 1990s, many reports have been published on this subject: the Moreau report on European health systems (1990), the Lazar report on ambulatory care (1991), the Health report 2010 (1992), the 'White paper' on the health system (1994), the Dewulder report on hospitals (1995), etc.. A 'repertory of solutions' was elaborated through this conceptual

work, prepared mainly by made by state experts (i.e., senior civil servants). This is the reason why the ‘Juppé Plan’ could be formulated so quickly. Once the political decision to undertake a reform of Social Security had been taken, it was possible to select from the measures included in the reports. Two other aspects also need to be underlined. First, the 1996 reform is also based on an expert’s report carried out for the Gaullist party (RPR) before the 1986 elections. At that time, Alain Juppé (Prime Minister from 1995 to 1997) was in charge of the elaboration of the RPR’s political programme. Second, two main aspects of the 1996 reform correspond to a generalisation of measures taken over the preceding years. This is especially the case for budgeting : the 1996 reform imposed the annual vote of national health spending objective (ONDAM) for every sector of the health insurance system (ambulatory and hospital care). It is important to remind that hospital budgets were already introduced in 1983 and that numerous attempts to introduce global volume envelopes in the ambulatory sector did not succeed because of the of the opposition of doctor’s unions, as we have seen.

• *The Seehofer Reform (1992): the end of German self-administration?*

In Germany the health system reform of 1988 (Blüm reform) did not have the expected effects on the financial situation of the health insurance system. In 1990–1 the average growth of health costs was 5 per cent and in 1991 the health insurance system again showed a deficit of 5.5 billions Deutschmarks. A new reform seemed necessary in the context of German unification and a structural law on the health system was voted at the end of 1992.

Many structural changes were decided in order to curb health expenses.

1. The hospital financing system was completely reformed from a per-bed, per-day basis to global budgets based upon standard illness categories. These budgets would not be permitted to increase more than average German wages from 1993 through 1995.
2. The activity and number of physicians became restricted: the overall body of doctors was given a strict aggregated prescription budget of 24 billion DM (the amount of prescriptions in 1991); the global volume envelope for physician reimbursement was maintained (since 1989 the Unions had been trying to negotiate its abolition); the number and type of physicians who could practice within each regional division was limited.
3. The State would exert a stronger control on negotiations between sickness funds and Unions, on the functioning of these institutions and obtained the right to intervene directly if the actors of the self-administrated system did not implement the law.

This has been seen as a major reform (Wilsford 1994), the departure from past practice being underlined by the weakening of the position of the medical profession in the health policy network, and the results achieved regarding the financial situation of the health insurance system (in 1993 the excess was of 10.2 Billion DM, 2.1 billion DM in 1994). The extent of this reform has in most cases been explained by factors external to the policy network.

The government faced a growing fiscal crisis because of the costs of German unification and the recession. The high level of German wage costs made it necessary to curb the evolution of health insurance contributions paid by employees and employers. The reform was supported by the whole government, even the Liberal Party which traditionally defended the interests of physicians and those of the pharmaceutical industry.

The political strategy followed by the new health Minister Horst Seehofer was clever and successful. This case is a good example of a policy learning process: Seehofer was state secretary under Blüm (Minister of Social Affairs) and experienced the failure of the health-

insurance reform of 1988. Seehofer negotiated with the main opposition party: the SPD (social democrats). He took their claims into account (especially the centralization and strengthening of the sickness funds). As a result the SPD backed the reform. This allowed the approval of the law by the second Chamber, the Bundesrat, which has a veto power on this topic (because hospitals are a *Länder* prerogative) and where the SPD had the majority. It also allowed Seehofer to outmanoeuvre the Liberal Party (FDP).

But neither of these reforms were successful in the long-term. In France health expenses grow again very fast and the deficit still grew. The target of the national health spending objective (ONDAM) were only reached in 1997, but never the years after. These budgets were ineffective because of the failure of sanction mechanism (Hassenteufel 2003). Doctors lead a successful juridical battle against penalties, which were finally abandoned. Since 1996 the health expenditure have always been exceeding the budgets without any sanction against doctors. More, in 2002 GP went on strike for higher fees (20 euros). The raise of fee was accepted by the new Minister of Health, at a time were the deficit of the health insurance system was already growing !

During summer 2004 a new law on health insurance (“Dousté Blazy reform”) was voted by the Parliament in a context of a huge deficit of the health insurance system (10,6 billions euros in 2003, 11,6 billions in 2004; 8,3 billions expected for 2005). This last reform was accepted by the main physician trade union (the CSMF). It is not very surprising because this law embodies no new constraint for doctors (for their activity, for prescriptions or for installation) and gives specialists the right to get higher fees when patients go directly to them, without being addressed by a GP. The main effort is asked to patients because of raising co-payments and taxes. This evolution is also clear in the German case where the last Reform in 2003 (Hassenteufel 2004) introduced patient co-payment for medical consultation in ambulatory care and at the same time planned the end of regional budgets for doctors (which not yet implemented).

The last reforms show the progressive erosion of the logic of cost containment which is progressively leading to a logic of silent privatisation. A new common trend is going on: the reduction of the coverage by the compulsory health insurance, leading to a silent privatisation of the non acute care

2.3. Consequences of the cost-containment measures : silent privatisation

One of the main consequences of the introduction of health expenses control instruments is the reduction of the health risk coverage. In France, the public coverage of health expenditures has clearly decreased between 1980 and 2003, from 79.4 per cent to 75.5 per cent, because of the reduction of reimbursement rates for patients and of the creation of direct patient co-payments for health care services (creation of the hospital flat rate in 1982, patients contribution for medical consultation, drugs and medical analysis). The silent privatisation process of health risks is obvious in the French case: more and more people cannot afford paying their health expenses in France and around 150 000 people have no health insurance at all. This is why the Juppé Plan included the idea of the creation of universal medical coverage. This measure was not implemented immediately, but was taken up again by the Jospin government: the universal health coverage (*Couverture Médicale Universelle*) was created at the end of 1999. It can be analysed as a change in the public of the health insurance policy: Not only workers have the right to be insured for health risks but every person residing lawfully in France, irrespective of their employment status or their contribution

record. In 2003 complete CMU coverage was made available to about 2% of the population, who benefited from a basic package of health services.

However, most of the French population, the cost of health which is not covered by the public system is increasing. The 2004 reform again raised co-payment for patients : 1 euro annual growth of the hospital flat rate until 2007, new one euro patients contribution for medical consultation, dereimbursement of drugs. The global level of patient co-payment were raised to 30% for medical consultation, to 20% for hospitalisation, and to 40% for drugs. The French situation is characterized by a rather high (and increasing) level of complementary insured people (over %) and a high level of users charge to total health expenditure (over 11%).

In Germany, this trend has also been more visible with the reform in 2003, which increased the level of co-payment and created a fee for patients in the ambulatory sector. Hospital fee went up to 10 Euro, 10% of drugs have to be paid by patients, and a fee of 10 € per trimester and per pathology for certain visits to specialist (if not following a family doctors consultation). Moreover, a voluntary private health insurance is now supposed to cover for teeth prostheses, and some benefits are not covered anymore like thermal cure, drugs without prescriptions, sterilizations, medical transports, dental prosthesis and glasses. However, individual health expenses were limited to 2 % of annual revenue (1 % in the case of chronic sickness). At the same time concerns have recently been raised over an increasing number of uninsured people, with estimations ranging from 80 000 to 300 000 people, mostly jobless people who are not eligible to the unemployment insurance and owners of small business (Greß and al. 2006).

In the Netherlands the last reforms also excluded several benefits from the sickness fund scheme.

The cost containment policies and privatisation trend follow the historical pattern of health insurance system but at the same time the reforms adopted since the mid 1990's lead to structural changes which are partly blurring the difference between health insurance and national health systems.

3. Structural changes : toward new health care systems in Bismarckian countries?

The structural changes introduced by the reforms adopted in the last decade follow convergent patterns with national health services but they do not abolish all the Bismarckian aspects of health insurance systems, especially the role of the sickness funds. With the recent developments, differences among Bismarckian health insurance systems appeared, France going toward 'Etatistation' when Competition oriented Reforms are implemented in Germany and the Netherlands.

3.1 Convergent trends with National Health Service systems

It is justified to characterize a structural some of the change occurring since the 1990's because they follow a convergent trend with National Health Service Systems, especially the British one (Hassenteufel, 2001). This trend is obvious for the three following patterns.

1. Financing of public health expenditures by taxes

Inasmuch as healthcare systems no longer restrict their cover to those with jobs (and who therefore pay contributions), and health spending today mainly funds health treatment (with no connection to income from employment), it seems more appropriate to finance the expenditure through taxation. One structural reform of health insurance systems is to change their mode of financing, from social contribution to taxation. This has gone relatively far in France, especially since in 1998, most of the social contribution paid by the employees have been replaced by a general tax on revenue. Since, 1998, the French pay a specific tax of 5.25% for health insurance on all their income from salaries and capital (3.95% on retirement pensions, unemployment benefits and living allowances). This tax, called CSG (*Contribution sociale généralisée*), funds approximately 30% of expenditure on healthcare. The pharmaceutical industries pay a tax on their sales and advertising expenditure. The taxes on tobacco and alcohol (representing most of the cost of these products) are allocated to the general Social Security system and account for 3.4% of its revenues.

The health expenditures are financed only 8.4% by taxation in Germany but it was raised in the 2003 Reform : cigarette prices were raised by one euro per packet to enhance financing by taxes and wage compensation in the case of sickness is no longer taken charge of by the employer but by contributions of employees. Taxes (especially on tobacco) are supposed to cover expenditures deemed not to conform to the actuarial foundations of the health insurance system (the so-called “*versicherungsfremde Leistungen*”). And the sickness funds receive cross-subsidies from social security schemes covering old age and unemployment risks (Altenstetter, Busse, 2005 : 124).

Even more important the central debate on the future of health insurance in Germany concerns its financing. In considering reform proposals, one can see that both parties are trying to defect the system of an insurance financed by payroll taxes. The concept of the SPD, the so-called “*Bürgerversicherung*” (citizens insurance), places all citizens under the same health system, thereby ending the distinction between public and private health insurance schemes and broadening the financing base by including all incomes. This system would in fact be close to that of a tax-based one, since all citizens would be covered as such and financing in turn would be levied on all sorts of incomes. In the model envisaged by the CDU, which is called “*Kopfpauschale*” and copied from Switzerland, every person would have to pay a flat rate contribution to the health system of about 160 to 200 € per month. In this conception, the idea of progressively taxing incomes is limited to the tax system, in which progressiveness should be strengthened accordingly (Grabow 2005). Thus, both projects are departing from an insurance-based system. They therefore include a change of policy paradigm. As opposed to the idea of health insurance as being earned by prior contributions, the SPD is envisaging that entitlement to health care would be given to all the citizens, access to the health system being the same for the entire population and paid for by tax-like contributions. The CDU is envisaging a system in which every person would pay the same amount for being covered. Both proposals thus differ from an insurance that is based on work-related contributions. The new governmental coalition between CDU-CSU and SPD tries to elaborate a compromise between the two conceptions. A bipartite commission was created in April 2006 with the duty to propose a new financing system before the summer.

These change are even more obvious in the Netherlands because of the introduction of flat rate contribution for every insured, with financial help of the State for low incomes. The State has also the charge of insuring children.

2. The managerialisation of the hospital sector

In France the managerialisation process of the hospital sector begun with the 1991 law. The purpose of the law was to make hospital regulation take into account the real activity of hospitals. With this reform each hospital's budget was to depend upon an evaluation of its activity and its prospective development, both negotiated with the State. The autonomy of hospitals was to be improved, especially for financial loans and inter-hospital co-operation..

Since the beginning of the 1990s, two new tools for evaluation were introduced: the 'Programme of medicalised information Systems' in order to evaluate the activity of each hospital and to introduce payment systems based on diagnosis related groups (Letourmy 1995); and 'medical references' for ambulatory care, containing therapeutic norms and norms of prescription. The 1996 Reform clearly promotes and generalises the introduction of evaluating therapies in the health insurance system with the creation of a National Agency for Accreditation and Evaluation in Health (ANAES). So, the promotion of competition mechanism, partly inspired by British reforms is based on changes at the level of public policy instruments. They have been introduced to increase economic and medical efficiency (Robelet 1999) and to make competition work, especially between hospitals.

The new dominance of managerial paradigm in the French health insurance policy has lead to significant changes. As a consequence of the search of efficiency competition has been promoted in every sector of the health care system (Hassenteufel *et al.* 2000). In the hospital sector regional agencies were created (*Agences Régionales d'Hospitalisation*). They have to distribute budgets between hospitals. Those budgets are based on the evaluation of the performance of every hospital. The regional agencies have also the right to close inefficient hospitals after an accreditation enquiry. These changes have led to the rise of 'managerialism' amongst hospital directors (Pierru 1999) and doctors, an obvious sign of increasing competition between health care producers.

The same evolution occurs in Germany. The financing system of hospitals changed in 2000 with the introduction of flat rate reimbursement for hospitals (it was also the case in 2005 in the Netherlands). Since then fees are reimbursed after the evaluation of diagnostic and treatment rather than length of stay. A number of measures in the 2003 Reform tried to increase efficiency of the health sector without directly altering modes of financing. A Center for quality in health was established in order to diffuse therapeutic norms and evaluation tools especially for drugs (checking which medicine is most efficient and has the best price / effect ratio).

3. The reorganisation of ambulatory care

Today, in the majority of systems of health coverage based on social insurance, which guarantee great freedom of choice for the patients, it is contemplated that the movement of patients within the system should be controlled more like in the national health services, both to limit ineffective expenditure and to improve the monitoring of the patient and the coordination of treatment. Thus it is sought to make the general practitioner (the Germans speak of the "family practitioner") play the role of "referring doctor" (who must be seen before any other consultation of a specialist), to have a medical file circulated that is shared between all those involved in treatment, to institute healthcare channels or networks (teams of practitioners brought together by the same insurer, for example). The implementation of these

new practices represents a restriction on the freedom of choice and, often, a more important role for the general practitioners. These considerations provoke strong resistance from both patients and specialists.

In France the 1996 Reform gave the possibility for GP's to be gate-keepers for patients who agree to contract with them (*médecins référents*). This system was replaced by an other in 2004 (*médecin traitant*) in order to make GP's the drivers of patients in the health system. All French insured person have to choose their main GP. It will cost them more if they consult a specialist directly without being addressed by their main GP.

In Germany the 2003 Reform developed the system of the "family doctor", who takes the role of piloting the patient towards specialists. It also gave the possibility to create medical centers instead of individual cabinets and in order to promote cooperation between doctors and other health professionals. Another aim of this reorganization of the health sector is to increase prevention.

In the Netherlands the sickness funds have the right to create health networks and day-out hospitals.

But these evolutions have not lead to a complete convergence between health insurance and national health service systems. Some institutional specificities are still remaining especially the role of the sickness funds.

3.2. Health insurance systems between competition and State control

Competition for German and Dutch Health insurance Funds.

A major trend of reform since the 1992 "Seehofer Reform" is the strengthening of sickness funds. The regional concentration of the funds was favoured in order to reduce their fragmentation (the number of local sickness funds were to be reduced from 268 to 30); the risks were redistributed, through financial compensations between funds, in order to diminish the discrepancies in health-insurance contributions, and all funds were allowed to bargain together at the regional level.

The Reform also introduced competition between health insurance funds by giving insurants the freedom of choice between them. As services were not allowed to follow under a legislatively fixed limit, price competition should incite funds to compete by merging and sliming down their administrative staff. The sickness funds have increasingly become under the influence of orientations derived from private business (Bode 2004). They conceive their organizations as market players racing for new members and as enterprises facing business partners and customers. Sickness funds offer more and more special advantages to their members, especially after the 2003 Reform : counseling, health checks, package with complementary insurance, reductions on contributions for enrollees participation to health improving activities, refunding of contributions in case of non consumption of reimbursed services ...

The 2003 reform was also a first step in the transformation of sickness funds in health purchasers. They have the possibility to differentiate the range of services available to their enrollees by selective contracting with networks of local providers and by developing prevention or disease management programs. The current reform projects in Germany concern new possibility of contracting with single providers. The 2006 law on drug provision

already allows sickness funds to negotiate special prices with producers of pharmaceutical and to provide their members with cheaper drugs.

Changes since the mid 1990s can be subsumed under an attempt to render the insurance system more efficient while guarding its essential features. The health reform in 2003 did not differ much from this logic; it inscribed itself in the “Agenda 2010” and its overall aim to reduce contributions without abolishing the assurance system or its corporatist functioning. But the competition logic is still growing : the current reform proposal imply measures that will broaden inter-fund competition, maybe even between sickness funds and private insurers.

In the Netherlands, competition between insurers was also developed in two main steps : the Simon Plan in 1991 and the Reform of 2005. Regulated competition was progressively introduced for the second and the third compartment of health insurance because of the lack of incentives for efficiency and innovation in the prevailing health insurance system (Schut and Van de Ven : 65-67). The starting point of the structural transformation process was the market oriented model of managed competition developed by the Dekker Commission (appointed by the Government) in 1987. This model was progressively introduced since the beginning of the 1990’s by the successive center-right and center-left governments. In 1991 in the compulsory health insurance systems, enrollees, like in Germany, became the right to choose their fund. The 2005 Reform abolishes the difference between compulsory and private insurance in the second compartment; it means that competition is extended to the whole second compartment. Sickness funds and private insurers receive the power to negotiate the price, quality and volume of hospital treatments and to selectively contract with health care providers. In order to make competition work an adequate system of risk adjustment was developed, based on age, gender, region, disability, employment status, pharmacy costs groups and since 2004 on diagnostic cost groups.

Etatisation in France.

In France another strategy was followed : the strengthening of the State. This "etatisation" of the French health insurance system is often underlined (Hassenteufel, Palier 2005). This evolution can be linked to the growing role of state experts. In the French case, since the beginning of the 1980's we can observe the constitution of a group of senior civil servants, specialised in health insurance policies and occupying strong positions (especially in the cabinets of the Ministry of Social Affairs and of the Prime Minister) (Hassenteufel and all. 1999). They played a growing role in the decision making process as the Juppé reform clearly showed (Hassenteufel 1997) but also for other important decisions: the global budget for hospitals, hospital performance evaluation, global volume envelopes, therapeutic norms for ambulatory care, hospital management ... This new “Welfare elite” wants to rise the efficiency of the health insurance system trough the strengthening of the State.

The 2004 Reform followed this trend by creating the national union of sickness funds (UNCAM) directed by a high civil-servant, nominated by the government. The director is now leading the negotiation with the different medical professions and has the power of nominating directors of local sickness funds. But, even with this growing control by the State sickness funds still play a regulating role (but less than in Germany) in the health insurance system.

The political factors behind the differences.

These differences can first be explained by political factors. In Germany the most important reforms were adopted together by the two main political parties (SPD and CDU-CSU) as we have seen for the 1992 Reform. It same political strategy was followed in 2003 (Hassenteufel 2005). It will be also the case for the next reform announced for autumn 2006 because the SPD and the CDU-CSU are governing together at the federal level since autumn 2005. Negotiation between the main political parties also played an important role in the Netherlands. It is not the case in France where the political responsibility for reforms is taken by one political party, confronted to electoral blame as the example of the gaullist party (RPR) shows. The electoral defeat of the party of President Chirac in 1997 (after the dissolution of the National Assembly) is often, with other reasons, attributed to the anger of doctors against the Juppé reform. This explains why this party (now called UMP) since it returned to power in 2002 has treated doctors rather smoothly by raising their fees after the 2002 strike and by abandoning constraining aspects of cost containment policies for doctors in the 2004 Reform.

Another explanation is the difference between policy advisers in health policy. Non medical expertise (especially economic) expertise is playing a growing role in reforms. It is one important aspect of the decline of the health care State (Moran, 1999). In France expertise is dominated by the State. The high civil servants, forming a new policy elite, as we have seen, were not been formed in Universities but in the “grandes écoles”. They have less links to academic expertise and to international debates. The situation is rather different in Germany (Döhler, Manow, 1996) and in the Netherlands were academic expertise (especially economic and in public health) play a growing role and has strong links with international organisations. This expertise is more internationalised than in France, which partly explains that more policy transfer of competition mechanism, inspired by foreign examples has occurred. The international diffusion of market tools in health care has more impact in Germany and the Netherlands than in France. Academic experts, especially health economists, are embedded in the health policy networks, especially in Germany as the example of Karl Lauterbach (main adviser of the of Health Minister Ulla Schmidt, professor for health economics after a PHD at Harvard University) show. In Germany expertise in health insurance policy was institutionalised through the creation in the mid 1980’s of the Expert Committee for the evaluation of the health system (“Sachverständigenrat zur Begutachtung der Entwicklung des Gesundheitswesens”). In the Netherlands the first proposals for regulated competition were made in 1986 by a government-appointed committee headed by W. Dekker, chairman of the board of Philipps Corporation. The 1991 and 2005 reforms are clearly inspired by these proposals. And the current Reform debate in Germany often refers to the Dutch system.

A third explanation is the change of power relationship between actors. It mainly explains greater change in Germany than in France because the German Reforms since 1992 tried to give more power to the sickness funds and to erode the monopoly of the doctor’s Unions. A structure of bigger and fewer health insurance funds was also meant to increase negotiating power towards the trade unions of practitioners. In strengthening health insurance funds, their natural interest (higher health costs mean higher expenses for these) to prevent health costs from rising got more influence in reference to practitioners for which rising health expenditure mean rising incomes. It is important to remark that the government tried to strengthen the corporatist system by reestablishing a balance of power, instead of abandoning it (Hassenteufel 2005; Giaimo 2002). At the same time monopoly of the unions over the ambulatory sector was eroded: day out-patient care in hospitals was allowed and the sickness funds would have the right to open ambulatory care centres and now medical centres.

One should also mention that deputies members of the social and health commissions won autonomy from interest groups (Trampusch 2005). Political actors (the Minister of health, the state secretaries for health, the health policy speakers of the leading political parties, the health ministers of some länder, deputies members of the health commission) are playing a greater role in the health policy decision process, as the creation (in April 2006) of a bipartite commission in charge of elaborating the new reform project, composed of 16 political actors coming from the Parliaments and the länder belonging to the two parties of the governmental coalition, recently showed.

Conclusion:

Up to now continental health insurance systems remain Bismarckian because of the limits of institutional changes (they are still financed mainly by social contribution, managed by Health insurance funds, delivering public and private health care). The main explanation is the incremental strategy followed, especially in the German and the Dutch case in order to introduce structural change. Those change are embedded in the existing institutions. The aim of the reforms is more to change the logic of institutions than changing the institutions themselves. We can say that the observed institutional transformation correspond to what Kathy Thelen has called “conversion” (Thelen, 2005). This explains how structural change occur without change of the system. It corresponds to a growing hybridisation of Bismarckian health insurance systems with both logic of universalization through the State and growing market logic based on regulated competition. Another limit of reforms is the power of doctors, which still plays an obstacle to reorganize ambulatory care as the French and the Dutch case show. In France the last elections for the doctor’s professional Unions (in May 2006) gave a clear victory to the organisations opposed to the 2004 reform. It shows the fragility of the structural transformation process in France, especially the transformation of the ambulatory care.

References

- Altenstetter C., Busse R., (2005), ‘Health Care Reform in Germany : Patchwork Change within Governance Structures’, *Journal of Health Politics, Policy and Law*, 30 (1-2), p. 121-142.
- Bandelow N., Hassenteufel P. (2006), ‘Mehrheitsdemokratische Politikblockaden und verhandlungsdemokratischer Reformeifer : Akteure und Interessen in der französischen und deutschen Gesundheitspolitik’, *Kölner Zeitschrift für Soziologie*, forthcoming
- Bode I. (2004), ‘Die Regulierung des Gesundheitssystem in Frankreich und Deutschland : Ähnliche Debatten, aber unterschiedliche Reformperspektiven’, in W. Neumann (ed.), *Welche Zukunft für den Sozialstaat ? Reformpolitik in Frankreich und Deutschland*, Wiesbaden, Verlag für Sozialwissenschaften, p.87-118.
- Brocas, A-M. (1993) ‘La maîtrise des dépenses dans le secteur de la santé après la loi du 4 janvier 1993’, *Droit social*, 3, p.235–43.
- Döhler, M. (1993) ‘Ordnungspolitische Ideen und sozialpolitische Institutionen’, in Czada, R. and Schmidt M. (eds) *Verhandlungsdemokratie, Interessenvermittlung, Regierbarkeit*, Opladen: Westdeutscher Verlag, p.123–141.
- Döhler, M. and Manow-Borgwardt, P. (1992) ‘Korporatisierung als gesundheitspolitische Strategie’, *Staatswissenschaft und Staatspraxis*, 1, p.64–106
- Döhler M., Manow P., (1997), *Strukturbildung von Politikfeldern*, Opladen, Leske+Budrich

- Giaimo, S. (2002), *Markets and Medicine. The Politics of Health Care Reform in Britain, Germany, and the United States*. University of Michigan Press.
- Grabow, K. (2005), 'Fighting with Goliath: The Reform of the Public Health Care Insurance Scheme in Germany, its Potential to Increase Employment and Alternative Models of Reform', *German Politics*, 14 (1), p. 51-73.
- Greß S., Walendzik A., Wasem J. (2006), 'Hartz IV und gesetzliche Krankenversicherung-Nichtversicherte als gesellschaftliches Problem', *Sozialer Fortschritt*, 55, forthcoming
- Harrison M. (2004), *Implementing Change in Health Systems. Market Reforms in the United Kingdom, Sweden and the Netherlands*, London, Sage.
- Hassenteufel P. (1996), 'The medical profession and health insurance policies: a franco-german comparison', *Journal of European Public Policy*, 3(3), p.57-74.
- Hassenteufel P. (1997), *Les médecins face à l'État, une comparaison européenne*, Paris, Presses de Science-Po, 1997.
- Hassenteufel P., (2001), 'Liberalisation through the State. Why is the French Health Insurance System Becoming so British ?', *Public Policy and Administration*, 16 (4), p.84-95.
- Hassenteufel P., (2003), 'Le premier septennat du plan Juppé : un non-changement décisif', in De Kervasdoué J. (ed.), *Carnet de santé de la France 2003*, Paris, Dunod, p.122-147.
- Hassenteufel, P. (2005), 'L'accélération des transformations du système d'assurance maladie allemand', in Bourgeois, I. (ed.), *Le modèle social allemand en mutation*, Cergy, Travaux et Documents du CIRAC, p. 121-132.
- Hassenteufel, P. / Palier, B. (2005), Les trompe-l'œil de la « gouvernance » de l'assurance maladie. Contrastes franco-allemands. *Revue française d'administration publique*, n° 113, 2005, p. 13-28.
- Hassenteufel P., Bachir M., Bussat V., Genieys W., Martin C., Serré M. (1999), *L'émergence d'une "élite du Welfare" ? Sociologie des sommets de l'État en interaction. Le cas des politiques de protection maladie et en matière de prestations familiales*, research report, M.I.R.E.
- Hassenteufel *et al.* (2000) 'La libéralisation des systèmes de protection maladie européens. Convergence, européanisation et adaptations nationales', *Politique Européenne.*, 2, 2000, p.33-46.
- Letourmy, Alain (1995) 'Les formes économiques de la régulation des dépenses de santé en France: le gaspillage négocié', in MIRE (ed.) *Comparer les systèmes de protection sociale en Europe*, vol 1, Paris: Imprimerie Nationale, p.323-60
- High Council, 2003
- Moran, M., (1999), *Governing the Health Care State*, Manchester, Manchester University Press.
- Palier, B. (2004), *La réforme des systèmes de santé*, Paris, P.U.F.
- Pierru F. (1999) 'L'hôpital-entreprise : une self-fulfilling prophecy avortée', *Politix*, 46,
- Ravoux, V. (1994) 'La maîtrise médicalisée de l'évolution des dépenses de santé : contribution à l'analyse d'un concept', *Droit social*, 6, p.578-85.
- Robelet M. (1999) 'Les médecins placés sous observation. Mobilisations autour de l'évaluation médicale en France', *Politix*, 46,
- Rosewitz, B. and Webber, D. (1990) *Reformversuche und Reformblockaden im deutschen Gesundheitswesen*, Frankfurt, Campus
- Shut F., Van de Ven W. (2005), 'Rationing and competition in the Dutch health-care system', *Health Economics*, 14 (1), p.59-74.
- Tabuteau, D. (1991) 'Les nouveaux mécanismes de maîtrise de l'évolution des dépenses de santé', *Droit social*, 11, p.815-822.
- Trampusch C. (2005), 'From Interest Groups to Parties : The Change in the Career Patterns of the Legislative Elite in German Social Policy', *German Politics*, 14 (1), p.14-32.

Wilsford, D. (1994) 'Path dependency or why history makes it difficult but not impossible to reform health care systems in a big way', *Journal of Public Policy*, 14 (3), 1994.