Paradigmatic Change in Social Insurance Countries?
Assessing Recent Health Care Reforms in Germany, the Netherlands and Austria

Simone Leiber
Institute of Economic and Social Research
at the Hans Boeckler Foundation, Düsseldorf
Simone-Leiber@boeckler.de
www.wsi.de

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Abstract

From an international comparative perspective, it is above all the insurance-based conservative welfare state that is often considered to be in special need of reform. But is the conservative corporate model really as inflexible as many believe? Following the spirit of Paul Pierson’s work, a large amount of today’s research is especially concerned with explaining the high degree of institutional stability of the welfare state. Other authors have criticised this point of view as underestimating the amount of change and have developed mechanisms such as institutional drift, layering, conversion, or exhaustion that bring about “transformation without disruption”, i.e. gradual institutional change that nevertheless has far-reaching effects. In this paper, it will be argued that even this differentiated perspective of institutional change does not place enough emphasis on paradigmatic change that could be classified as transformation with disruption and has recently been observed, also in conservative welfare states. The paper responds to this need for research and investigates the most recent health care reforms in the three “social insurance countries” Germany, Austria and the Netherlands: What changes were made in the reforms and how can they be classified in terms of first, second or third order institutional change? And have the three countries, which due to the similar structural characteristics of their security systems can be assumed to be confronted by similar problems, taken, similar paths in their reforms? In brief, it is the aim of this paper to compare the institutional changes to the three different health insurance systems brought about by current health reforms. It will be shown that the cases examined provide no evidence of inherent “rigidity” in the social insurance model. In addition, it becomes obvious that the German reform of 2006/07 very strongly follows the direction set by the Netherlands. The two countries appear to follow a common “path of regulated competition”, while this path has not been taken by Austria. These developments point towards convergence processes in specific social insurance countries although we simultaneously find increased divergence from other social insurance countries that have not followed this path.
1. Introduction: The Conservative Welfare State in Crisis?

From a comparative international perspective, it is above all the conservative corporatist welfare state (Esping-Andersen 1990)\(^1\) that is regarded as being in special need of reform. Compared to the liberal or social-democratic Scandinavian model, it is often considered least suited to facing the exogenous and endogenous challenges involved in designing social security such as the internationalisation and Europeanisation of the economy, demographic change, structural mass unemployment, changing household structures and new working models (e.g. Esping-Andersen 1996; Scharpf und Schmidt 2000; Pierson 2001). The close coupling of social security with contributions that are dependent on income from employment is characteristic of this type of welfare state and has been criticised as detrimental to employment. As a consequence of the central role of paid employment and social insurance, social rights are closely bound to class and status. The degree of coverage and protection against poverty offered by the security model are therefore very much dependant on the extent to which the society is successful in providing employment (in a standard employment relationship). In respect to gender issues, the conservative welfare state is usually associated with consolidation of the male breadwinner model (e.g. Lewis 1992). Many consider the conservative welfare state model outdated, not only due to its inability to solve problems. It is also attributed little capacity for reform, which makes it incapable of dealing with the aforementioned problems (e.g. Esping-Andersen 1996; Scharpf und Schmidt 2000).

However is the conservative corporatist model, whose ideal is most closely met by the Western European countries of Belgium, Luxemburg, Germany, France, Austria, and – to a lesser extent – the Netherlands\(^2\) really as inflexible as many believe? Slogans such as “reform blockade” and “reform backlog” are very common in the political discourses of these countries. In spite of that, we have recently witnessed far-reaching reforms, particularly in Germany, such as the Riester pension reform of 2001, the Hartz reforms of the Schröder government’s second legislative period, and the family policy of the red-green government and the Grand Coalition (leading to a new parental leave scheme in 2007). These cases involved a break with existing traditions and a “paradigm shift” (for old age security, e.g. Hinrichs 2004; for the Hartz Reforms, e.g. Oschmianski/Mauer/Schulze Buschoff 2007; for family policy e.g. Bothfeld 2005). For France, Palier (2006a: 65) reports an increasing duality

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\(^1\) In spite of all criticism of Esping-Andersen’s typology (for an overview, see e.g. Arts and Gelissen 2002), it is still the reference point for numerous comparative studies of the welfare state.

\(^2\) For the different classification of West European countries in various studies, see the tabular overview in Arts and Gelissen (2002: 149-150).
in the country’s social model, which was originally strongly characterised by the social security principle. This duality was advanced, e.g. through the introduction of the RMI (Reveneu Minimum d’Insertion), a universal means-tested minimum benefit for persons with low income. And last pension reforms of the former ÖVP-FPÖ government in Austria were also rather far-reaching and introduced against fierce protest from the trade unions. Finally, the “Dutch miracle” (Visser/Hemerijck 1997) – cutting edge – was founded on more than just incremental change to the Dutch welfare system and labour market.

Following the spirit of Paul Pierson’s work (1994; 1996; 2000a; 2000b), a great deal of today’s research on the welfare state is especially concerned with explaining the high degree of institutional stability and continuity of the welfare state and the difficulties of socio-political retrenchment following the “golden age” of the 1970s. Recent institutionalist writing criticises this point of view as underestimating the value of change and has developed analytical instruments that bring about “transformation without disruption”, i.e. gradual institutional change that nevertheless shows far-reaching effects (Streeck/Thelen 2005: 4). In this paper, it will be argued that even this differentiated perspective of institutional change does not place enough emphasis on paradigmatic change that could be classified as transformation with disruption, which has recently been observed, also in conservative welfare states. As described above, empirical evidence for this assumption has mainly come from the fields of pension policy, labour market policy and poverty relief. This paper seeks to analyse, whether it can also be sustained for health care. In addition, most of the available comparative studies concentrate on various “worlds of welfare capitalism” or exclusively on either the liberal or the Scandinavian regime. Aside from the illuminating examination of isolated cases (e.g. Palier 2006b, Bleses/Seeleib-Kaiser 2004), the systematic comparative analysis of recent developments in conservative welfare is still in its infancy. 3

This paper seeks to respond to this gap and investigates the most recent health reforms4 in the three “social insurance countries” Germany, Austria and the Netherlands5 in respect to the following questions: What kind of changes were made in the reforms? To what extent can they be classified as paradigmatic change? And have the three countries, which given the structural similarities of their security systems can be assumed to be confronted by similar

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3 But see above all the research programme “The Politics of Reforms in Bismackian Welfare Systems” led by Bruno Palier, see e.g. Palier (2006a); on health care systems in Germany and France Hassenteufel/Palier (2006).
4 In Germany, the research concentrates on the 2006/07 reforms; in the Netherlands, I examined the health reforms that became effective on 1.1.2006 and in Austria, the reforms that took place in 2005.
5 Health insurance in the Netherlands has a second, universally oriented pillar, which provides for long-term care and long-term illness. However, the main pillar of the Netherlands’ health system clearly bears the characteristics of “Bismarckian” social insurance (see also Section 4).
problems, taken similar paths in their reforms (convergence)\(^6\)? Or have the respective countries found different answers and are the systems developing in different directions (divergence)\(^7\)? These questions refer to the analysis of the dependant variable: institutional change\(^7\) to the health insurance systems brought about by recent\(^8\) health reforms. It will be shown that the social insurance models of the cases examined show no evidence of inherent “rigidity”. In addition, it becomes obvious that the German reforms of 2006/07 very strongly follow the direction set by the Netherlands. The two countries appear to follow a common “path of regulated competition” (Hassenteufel/Palier 2006), a path not been taken by Austria. Beyond this, the paper also seeks to discuss first ideas on the question of to what extent new institutionalist theory and the literature on the spread of ideas contribute to understanding these results.

To this end, section 2 below presents the expected degree and causes of welfare state change in Continental systems derived from these two influential theoretical strands of the welfare state literature. Section 3 explains the analytical scheme used to assess the dependant variable – the degree of welfare state change. Section 4 is devoted to describing the main features of the three health systems prior to the recent reforms. Section 5 compares the results of the three reforms and evaluates them on the basis of the presented scheme of analysis. Finally, section 6 discusses the theoretical implications and tasks for future research.

\(^6\) To be more precise, by speaking of convergence in this paper, I mean “sigma-convergence” in the sense of “growing together”, i.e. a reduction in variation between systems regarding particular parameters. On this and further concepts of convergence see Heichelt et al. (2005); for these concepts applied to health care reforms in OECD countries see Rothgang (2006: 305-306).

\(^7\) The concept of institutions used here rests on that of Streeck/Thelen (2005: 10), who define institutions as “formalized rules that may be enforced by calling upon a third party”. The study examines formalised norms and sanctions that can be identified as institutions, as distinct from informal customs and conventions. Policies, such as e.g. health policies, can be considered institutions from this perspective “to the extent that they constitute rules for actors other than for the policymakers themselves – rules that can and need to be implemented and that are legitimate in that they will, if necessary, be enforced by agents acting on behalf of society as a whole” (ibid.: 12).

\(^8\) I am aware that an overall assessment of paradigmatic change in health policy requires long-term observation. In this paper, I provide as much as possible within such limited space including background information on the general reform trends in the three countries in recent years (section 3). Nevertheless, a more in-depth examination of the latest reforms seems justified because there is reason to assume that conservative welfare states are not “blocked per se”, but rather that far-reaching change took place at a later point in time than in other types of welfare state.
2. Theoretical Expectations on Welfare State Change in Continental Europe

Two theoretical strands of the welfare state literature have been particularly vital in recent years when it comes to explaining continuity and change in Western welfare states: new institutionalism and the literature on the spread of ideas. Which expectations can be drawn from this literature in respect to the central topic of this paper: Paradigmatic Change in Continental Welfare States?

New Institutionalism and Welfare State Change

A great deal of welfare state research has been particularly concerned with explaining the high degree of continuity in Western welfare states – even in times of austerity. From this perspective, incremental\(^9\) rather than fundamental change is the general pattern to be expected in welfare states due to the self-reinforcing advantages (increasing returns) of continuous, “path dependent” (Pierson 2000a, 2000b) institutional development for various political and societal interests. This perspective relies – sometimes implicitly – on a punctuated equilibrium model involving long periods of institutional stability interrupted only periodically by more far-reaching change caused primarily by exceptional, exogenous shocks (Streeck/Thelen 2005: 3).

Pierson, together with other path dependency theorists such as, e.g. North (1990),\(^{10}\) assume that lock-in mechanisms connected to increasing returns apply to institutions in general. In his work on the “New Politics of the Welfare State” (2001), Pierson conducts a specific analysis of welfare state change under permanent austerity. He develops a theoretical framework connecting “electoral incentives associated with programmes which retain broad and deep popular support and the institutional ‘stickiness’ which further constrains the possibilities for policy reform” (ibid.: 411). His concept of “institutional ‘stickiness’” here rests on path dependence theory on the one hand, and the analysis of formal and informal institutional veto points on the other.

What is of particular interest within the context of this paper on conservative welfare states, is that path dependence theory would lead us to expect incremental, bounded change across all welfare state types in affluent Western countries, leading to change “in national colours” and

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\(^9\) This does not mean that institutions are generally frozen: “Change continues, but it is bounded change – until something erodes or swamps the mechanisms of reproduction that generate institutional continuity” (Pierson 2000b: 76).

\(^{10}\) For an excellent overview on the course of the path dependency discussion and the underlying mechanisms of path dependency in various studies see e.g. Beyer (2006: chapter 1).
persistent divergence across welfare regimes. Pierson (2001) goes even further and differentiates distinctive reform-dynamics according to the three welfare state regimes of Esping-Andersen (1990): “Different welfare state configurations are the products of complex conjunctural causation, with multiple factors working together over extended periods of time to generate dramatically different outcomes” (ibid.: 429). He expects different reform outcomes, but also distinct politics and key variables to be responsible for the degree of change or stability in each of the three “worlds of welfare capitalism”. While his earlier work focussed mainly on retrenchment, he now takes into account different forms of restructuring: Specifically, rationalizing recalibration\(^{11}\) seems to characterize the changes in the social democratic regime, updating recalibration\(^{12}\) prevails in Continental Europe, while recommodification tends to be the dominant trend in the liberal regime. Finally, cost-containment is a characteristic reform pattern in all three welfare regimes.

The key explanatory variable for change in the liberal regime is the concentration of political authority, while in Continental welfare states the ability to form a “new middle” reform coalition and “the vulnerability of centrist reform organizations to ‘poaching’” from competitive organisations (ibid.: 455) are considered decisive. The expectation of different degrees of change in the different regimes is not made totally explicit. According to Pierson, conservative welfare states certainly face the highest adjustment pressures of the three worlds, but political support for the welfare state is also high in these countries and provides grounds for blocking reforms. In contrast, reform pressures are considered more moderate in the two other regimes. However, political support for the welfare state is categorised as high for the social democratic, and moderate for the liberal regime. Thus, according to this scheme, more far-reaching reforms – if there are any – should be expected in the liberal welfare model, while the lowest probability of far-reaching change should be found in the social democratic regime. From this research perspective convergence does not seem likely among the Continental systems, nor across welfare regimes, due to persistent national pathways, (see also Table 1).

In recent new institutionalist writing (Hacker 2004; Streeck/Thelen 2005), this strand of welfare state literature is criticised for its conservative bias and for underestimating the amount of change. From the point of view of these authors, institutional change is differentiated into the mechanisms displacement, layering, drift, conversion and exhaustion. Drift – for example – means the deliberate neglect of the task of adapting institutions to new

\(^{11}\) Reform goals remain the same, but new ideas about how to achieve them are applied.

\(^{12}\) Adaptation to newly recognised needs such as, e.g. changes of typical life courses influencing social insurance, i.e. there is a change of goals involved.
circumstances in spite of changing external conditions (Streeck/Thelen 2005: 24-26, 31). Institutional change occurs quasi **below the surface**. It does not find expression in the form of (legislative) reform, but in the absence of it. With drift and the other mechanisms, the authors point to the far-reaching (long-term) effects even of incremental change.\(^{13}\) In respect to expected convergence, it is important to note that the authors interpret the transformations observed as a common pattern towards liberalisation (ibd.: 4). Despite the crucial importance of this approach for analysing the dependent variable studied in this paper (see also section 3 below) – welfare state change – it gives little consideration to paradigmatic change **on the surface**, which has also been observed recently in Continental welfare states, as e.g. the Riester and Hartz reforms in Germany show.

In addition to the path dependence/historical institutionalist literature, another new institutionalist approach is also highly influential in welfare state debates: the so-called veto point (Immergut 1990) or veto player literature (Tsebelis 1995; 2002). These studies are based on the assumption of rational choice and provide elaborate and at the same time parsimonious frameworks for the explanation of, above all, continuity or “blockage” in welfare states with many veto points, and/or many ideologically distant veto players. New institutionalist writing is usually either based on what Hall and Taylor (1998: 17) termed the “calculus approach”, i.e. rational choice assumptions, or the “cultural approach” emphasising that individual action “depends on the interpretation of a situation rather than on purely instrumental calculation” (ibd.).\(^{14}\) In the cultural approach, the endogenous change of preferences can be captured in the analytical framework. In the calculus approach actors’ interests and preferences are determined exogenously. Recent case study evidence (e.g. Trampusch 2006) shows, that rational-choice institutionalist frameworks reach the limits of their explanatory power where innovative change (in this case the Riester pension reform) takes place in a country that is usually associated with a high number of veto options and reform blockage (Germany), and where at the same time this fundamental change cannot be attributed to an exogenous shock.

In order to capture this kind of reform dynamic (paradigmatic change in countries despite considerable formal and informal veto opportunities) an analytical framework is needed that is able to include endogenous preference change – either by historical institutionalist “sequence-oriented policy analysis” (ibd.; for a similar approach see also Palier 2006a) taking into account feedback effects of different reform stages, and/or by taking into consideration

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\(^{13}\) On small, but system-shifting changes in pension policies, see also Hinrichs/Kangas (2003).

\(^{14}\) Among the “three new institutionalisms” described in the seminal article of Hall and Taylor, rational choice institutionalism relies on the former approach and sociological institutionalism is based on the latter. In contrast, historical institutionalists “are eclectic; they use both the calculus and cultural approaches to specify the relationship between institutions and actions” (Hall/Taylor 1998: 18).
theoretical assumptions on the spread of ideas (on pension reform, e.g. Bönker 2005, see also below).

**Welfare Institutions**

Common to all of the above-mentioned new institutionalist approaches is that they do not provide a fully convincing logic of why we should expect similar reform paths in the Continental systems: “When trying to explain why Bismarckian welfare systems face such enormous challenges, authors usually refer to welfare institutional designs, but when trying to understand why reforms are so comprehensively blocked, they neglect these welfare institutions in their explanations, in favour of broader political factors” (Palier 2006a: 53). While it is possible to find substantial commonalties regarding “broader political factors,” such as e.g. the number of formal veto players or corporatist traditions, either in the social democratic or the liberal welfare regime, this is far less the case in the group of conservative welfare states. If formal veto points or corporatism are to be decisive, it seems difficult to classify e.g. France and Germany as belonging to the same group. For this reason Palier (ibd.; see also Bonoli/Palier 2000) stresses the impact of welfare institutions on the politics of reform. From this point of view, welfare institutions in Continental states with Bismarckian social insurance systems frame the interests and resources that actors can mobilise in the context of welfare reform. Differences in the financing structure are of particular importance in this respect. On this note, contributory benefits are more difficult to cut back than tax financed transfers, because they enjoy a particularly high level of legitimacy. In addition, insurance-based payments are assumed to be particularly defended by organised interests, especially by trade unions; also, the target population of the Continental welfare state was usually strong and well represented, protecting the middle class. Compared with schemes that are targeted to the poor, they are much more important for large parts of the electorate, which makes reforms more difficult. Finally, the management of social insurance in the Bismarckian countries is shared with trade unions which presumably gives them de facto veto power. To sum up, all these common characteristics of welfare institutions in Continental systems are assumed to result in common reform paths in this group of countries (for further details see Palier 2006a: 55-56).

**Welfare State Change and the Spread of Ideas**

In particular the application of the so called “Open Method of Co-ordination” (OMC) to social policy issues in the European Union (EU), but also generally increasing transnational
communication and processes of economic Globalisation have (re-)intensified research interest on such issues as policy learning, policy transfer, diffusion of ideas, framing, or lesson-drawing over the last decades. The diversity of studies is immense, and even a very sketchy overview would go beyond the scope of this paper.\textsuperscript{15} Definitions are not uniform and rather often not made explicit.\textsuperscript{16} This particularly concerns the notion of learning, which is often used without a clearly specifying which actors learn and how, or how to empirically distinguish learning from other potential sources of policy change. This general problem is particularly widespread in the OMC literature, where parallel developments in European aims and national policy measures are often interpreted as “learning from Europe” without specifying the respective transfer mechanism and without taking account of potential alternative explanations (on these problems in relation to the European Employment Strategy, see Hartlapp 2006: 8-12).

When looking for a theoretical framework, appropriate for the analysis of transformative change in the welfare state, the role of “ideas” becomes important where – as mentioned above – traditional rational-choice approaches reach their limits and the endogenous change of preference is to be included in the framework of analysis. Thus, in particular the concept of what Argyris and Schön (1996: 20-22) called “double-loop learning”,\textsuperscript{17} implying a change of actor’s superordinate aims and values due to new information seems a fruitful starting point for analysis in this respect. Far-reaching institutional change can be captured by such an approach. Expectations of this strand of the literature on convergence are not so clear-cut. Presumably, the more the authors believe in best practice solutions, the more they might expect institutions to convergence across countries towards these solutions. Generally, when studying Conservative Welfare states, we should expect countries with structural or organisational similarity to be better suited to learning and adopting solutions from one another (i.e. converge) than from a completely different institutional setting. However, particular paradigms or ideas, as the example of the multi-pillar paradigm in pension policy shows (Bönker 2005), may also lead to increasing similarity across welfare state types under certain conditions.

\textsuperscript{15} For more recent studies on “ideas and welfare state reform” see e.g. Taylor-Gooby (2005); on policy learning e.g. Hall (1993), Bandelow (2003), Bothfeld (2005); on lesson-drawing Rose (1991); on policy transfer e.g. Dolowitz/March (1996, 2000); on diffusion e.g. Knill (2005a); on learning through the OMC, e.g. Zeitlin (2005); for applications to the field of health care e.g. Freeman (1999; 2000a), Greener (2002).

\textsuperscript{16} On differences and overlapping elements of these concepts see e.g. Knill (2005b); for an introductory overview of different approaches to policy learning see Bandelow (2003).

\textsuperscript{17} This is opposed to “single-loop-learning” (ibid.) understood as a change of instruments or measures in order to “better” achieve actor’s pre-existing aims.
The literature often presents power-based and idea-based models of politics as being opposed to one another or mutually exclusive (critically considered by Hall 1993). The concept of learning is frequently associated with (deliberative) problem-solving, while linking the ideas and power perspectives – e.g. in learning in order to maintain power – still seems rather rare. However, Hall (1993: 289-290), points out that:

“power” and “puzzling” often go together. … The competition for power can itself be a vehicle of social learning. … the policymaking process can be structured by a particular set of ideas, just as it can be structured by a set of institutions. The two often reinforce each other since the routines of policymaking are usually designed to reflect a particular set of ideas about what can and should be done in a sphere of policy. But the ideas embodied in a policy paradigm have a status somewhat independent of institutions that can be used …to bolster or induce changes in institutional routines.

Thus, the empirical analysis of how institutions, power struggles, and ideas work together in far-reaching welfare state reform still seems an interesting research task.

3. How to Capture Welfare State Change?

“When is a change big enough to be a system shift? …” (Hinrichs/Kangas 2003), “Country-level comparisons of welfare state change measures: another facet of the dependent variable problem within the comparative analysis of the welfare state” (Kühner 2007) – exemplarily, these titles show that measuring welfare state change, in terms of finding the right quantitative indicators or qualitative categories – is not an easy task and causes lively research debates. When studying the changing role of the state in healthcare systems, Rothgang et al. (2005: 189) distinguish three levels of analysis: financing, service provision, and regulation. In this paper, the focus will be restricted to regulatory level. The paper looks at institutions, not at outcomes, and not (in depth) at discourse.18 As the focus is on very recent health care reforms, it is too early to assess them in terms of outcomes or in terms of quantitative measures of healthcare funding or service provision.

Following the approach of Bonoli and Palier (2000: 338-339), I will differentiate between four basic analysis parameters for social security institutions in order to outline the fundamental institutional principles of the three health insurance systems (Table 2):

- Entitlement rights
- Nature and amount of benefits

18 I.e. no methods, such as e.g. discourse analysis are applied. The level of political discourse is nevertheless taken into account when determining changes in the overall aims of institutions as a means of tracking paradigmatic change.
Structure of the Financing system

Organisation and Management

As the particular interest of the paper is far-reaching change, a second restriction concerns the focus on the degree of change, while omitting a detailed discussion of the direction of change (retrenchment, re-commodification, recalibration etc.). To describe the degree of change, I will rely on the approach of Hall (1993), who differentiated between first, second, and third order change. According to this approach, third order change is given when change occurs in not only the instruments, but also in the higher level goals and the fundamental (regulating) philosophy that gives rise to the policy in a specific field. An extreme example of this in the health area would be a change in the system from comprehensive public coverage through social insurance to the provision of public healthcare only for those who cannot afford their own private insurance (principle of public relief). In the case of second order change, the higher-level goals remain unaltered but the instruments employed to achieve them are changed. For example, an additional tax payment in a system that was previously financed only by contributions can be perceived as such a change of instrument. Finally, first order change involves (level) adjustments made within the context of unaltered goals and instruments, such as increases to the rate of social security contributions. Potential long-term or hidden effects, in the sense of Streeck/Thelen (2005), of what at first sight appears to be incremental changes are also taken into consideration in the case studies.

4. The Health Systems Prior to the Reforms

If one considers an overview of the most important structural characteristics of the health insurance systems in the three countries prior to the recent reforms, a number of similarities can be identified (Table 2). Prior to 2005, all three systems were essentially based on the social insurance principle. This was accompanied by the great importance – compared to the health systems in Scandinavia or Great Britain – of financing through contributions, i.e. wage related payments provided the main source of financing in each of the public health insurance systems. In all three countries, the spouse and children could originally be provided with contribution-free insurance coverage. Since 2001, Austria has limited this contribution-free coverage to spouses who are bound to childrearing or the provision of elderly care. The

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19 Hall developed this scheme in context of his influential approach of social learning. In this paper, the scheme is used as an analytical tool to classify the dependent variable, i.e. the degree of institutional change. The question whether the changes tracked in this study are in fact the results of social learning processes is not studied in depth here (but see some preliminary considerations in the conclusions).

20 See e.g. Freeman (2000b: 32-50); Döring et al. (2005).
uppermost goal of all three systems was to provide comprehensive care without rationing and to secure living standards through wage replacement payments, i.e. maternity and sickness benefits. In fact, earlier reforms in all three countries followed a logic of cost containment and resulted in the reduction of services and the increase of private cost sharing (see also Section 5). Nevertheless the public systems still offered a level of security that was well above a basic, subsistence security.

In addition to these basic structural similarities, there were also important differences between the three countries. For example, the Netherlands’ social security system was constructed in two pillars. Alongside the social health insurance, which guaranteed acute care (regulated by the Health Fund Act/ Ziekenfondswet/ ZFW), there was also insurance for long-term care (regulated by the Exceptional Medical Expenses Act/ Algemene Wet Bijzondere Ziektekosten/ AWBZ). The latter was mandatory for the entire population (universal insurance principle) and covered so-called “serious risks” such as, e.g. stationary care and rehabilitation with a duration of over a year, long-term care and psychiatric treatment. It covered not only some of the areas that have been covered by separate long-term (elderly) care insurance in Germany since 1995 but also some areas that are covered by the German public health insurance (Gesetzliche Krankenversicherung/ GKV).21 The AWBZ insurance was financed entirely by contributions paid by the insured, without employer contributions (collected via the employer or paid with income tax). In 2005, the rate of contribution amounted to 13.45 % of taxable income (Greß et al. 2006: 8).

The ZFW insurance was introduced by decree by the occupying power during the Second World War, along the lines of the German model, which accounts for the similarity in its basic structure, which has been retained to the present. There were however, important differences between the details of the German GKV, the ZFW in the Netherlands, and the Austrian public health insurance.

Firstly, the systems differed in respect to the mandatory definition of the insured group. In Austria, the level of coverage went particularly far in the direction of compulsory insurance for the entire labour force since – in contrast to Germany – various groups of self-employed workers were integrated as early as the end of the Second World War.

In 2004, 97 % of the approximately 8 million Austrian inhabitants were integrated into the public health system (Tálos/Obinger 2006: 221). The self-employed were also included in the

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21 In the Austrian system, long-term care is integrated into the public health insurance system however, it is financed through tax.
ZFW in the Netherlands. However, this applied only up to a certain income threshold for compulsory insurance, which didn’t exist in Austria. Employed and self-employed persons whose income exceeded this threshold were forced to leave the system and to insure themselves privately. In Germany, insured workers with an income above the compulsory insurance threshold also have the option of transferring to a private health insurance (PKV). In contrast to the Netherlands, it is also possible to voluntarily remain in the public insurance system on condition that the person has been insured in this system for a specific period of time. Thus, in Germany there was competition between the private (PKV) and public (GKV) systems to attract those with high incomes and who on average represent better health risks, while this market segment was clearly separated in the Netherlands. While in Austria the PKV was essentially limited to the provision of supplementary insurance, the field of full health insurance was shared by private and public health insurance providers in the German and Dutch systems.

However, here there were also important differences in detail between the Netherlands and Germany: For example, private health insurance companies were subject to much stronger legislation in the Netherlands than in Germany as they were forced to offer standard tariffs with services similar to those of the public system in addition to calculated risk premiums. Private insurance companies in the Netherlands were obliged to enter contracts, i.e. they were not permitted to refuse those with poor health risks. The transfer between different providers of private insurance contracts was also possible and was made easier by the fact that the Dutch private health insurance was based on a cohort-specific pay-as-you-go system and didn’t accumulate a reserve for old age. Members of private health insurance also had to participate in financing the ZWF. Financial equalisation was used to balance out the higher proportion of older insured persons in the public system. In addition, service providers’ fees had become almost equal under the two systems so that there were only minor differences in the status of those insured (Greß et al. 2006: 9, 15). This meant that the difference in supplying care for those with private and public insurance (“two-class system”) carried less weight.

A further difference between the three countries lies in the relative combination and weighting of financing sources. Prior to 2005, all three systems were financed primarily through member contributions, whereby the contribution rates varied greatly. In Austria, the contribution level was set according to the respective professional status group; the employer share was greater for white-collar workers than for blue-collar workers (for details, see Döring et al. 2005: 56). The employee and employer contributions were almost equal in both
Germany and Austria. In some cases, the contributions paid in Austria lay approximately 50% below those paid in Germany. In 2000 the average rate in Germany was 13.57%, while in Austria it varied between 6.4% (farmer) and 9.1% (self-employed), depending on the status group. For blue-collar workers, it lay at 7.9, for white-collar workers at 6.9% (Hofmarcher/Rack 2001: 33). However, the health costs carried privately by households and the tax component of health spending in Austria was significantly higher than in the other two countries (Table 2). Finally, the special feature of the ZFW in the Netherlands lay in that it was financed by a mixture of income dependent contributions (6.75% employer contribution, 1.7% employee contribution) and premiums that were independent of income and not paid directly to the individual insurance companies but into a general fund. In 2005, the average premium was 350 Euro per annum (Greß et al. 2006: 9).

The public health insurance in the three systems also differed in terms of organisation and management. In both Germany and Austria, these functions lay in the hands of the social self-administration, though they did not have equal levels of competence. For example – in contrast to Germany prior to 2006 – in Austria, the contribution rates for the public system were set by federal legislators rather than the health insurance funds themselves. The State also had more influence on the system in the Netherlands. Until 2001, the social partners had greater involvement in the management of health insurance funds (ziekenfondsen). Since then, the Central Steering Committee (College voor zorgverzekeringen, CVZ) has been made up of nine independent members who are selected by the Minister of Health (Exter et al. 2004: 16).

The main organisational principle of health insurance funds in the Netherlands and Germany was competition, based on a free choice of social insurance fund, while in Austria membership of a particular health insurance fund was assigned according to the location of the company where the insured was employed.

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5. Current Health Reforms in Social Insurance Countries: Degree of Change, Convergence or Divergence?

In this section, I will describe the changes brought about by recent health reforms in the three countries. The comparison clearly illustrates above all the parallel development between the German and Dutch situations.

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22 In the current German reform terminology, this principle is referred to as a “small per capita premium”.
5.1 The Austrian Health Reform 2005

Several reforms have taken place in Austria in recent years in spite of the population’s comparatively high satisfaction with the health system (see e.g. European Social Survey 2004/05), the almost universal insurance coverage, a relatively high standard of care and low contribution rates. These reforms aimed, on the one hand, at financially consolidating the system and on the other at improving the quality of care (for a description of the system’s development since 1955 see e.g. Bittner 2005). Similar to Germany, the public system in Austria also had to battle with financing problems, which was primarily due to the deterioration of gross wages and salaries. While spending developed in parallel to the GDP, the wage ratio and consequently the most important source of revenue remained below this development (Tálos/Obinger 2006: 222). As in Germany prior to 2003, this problem of insufficient income was above all met with cost constraint measures. For several years, Austria has been among the leaders when it comes to private cost participation, e.g. by certification and prescription fees or diverse forms of cost sharing (see also Table 2: out-of-pocket payments). This applies especially to the self-employed, public servants and farmers, who must usually carry 20 % of their treatment costs as a patient’s contribution. In addition, the aforementioned reforms attempted to increase efficiency and effectiveness through improved interface management in the health system and a performance oriented financing of hospitals (e.g. per case-based lump sum allowances) and to establish a broader income basis, above all in the financing of hospitals, by increasing the share financed through tax. Overall, these reforms can be classified as gradual changes in which the system’s uppermost goals and structural principles (also the sometimes extreme status group differences) are not fundamentally altered.

The health reforms of 2005 did not deviate greatly from this pattern. In 2005, the costs to be carried privately were gradually increased once again. Further, additional funds flowed into financing the system through another increase to the contribution rate, an increase in the contribution assessment ceiling and additional income from tobacco tax. The health system’s organisation and the financing of hospitals were also restructured in the course of these reforms. The aim of the reforms was to significantly improve both quality assurance and preventative nature in the system. To this end, a Federal Health Agency (Bundesgesundheitsagentur) and State Health Funds (Landesgesundheitsfonds) were established with the expectation of optimising manageability and improving efficiency (for details see Gaugg 2005). Finally, the electronic insurance card (e-card) was introduced.

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23 On the individual measures, see Tálos/Obinger 2006: 222-224; Döring et al. 2005: 57-58.
throughout Austria in 2005. This replaced the sickness certificate and in the long term is intended to take over functions such as the electronic transfer of diagnosis (Tálos/Obinger 2006: 224).

5.2 The Health Reform in Germany in 2006/07
As early as the 70s, the German health system was subject to constant change, which above all aimed at cost containment and stabilising the GKV contribution rate. As in Austria, this policy found expression primarily in increases to the contribution rates, the outsourcing of specific services and an – initially moderate – direct contribution to costs for private households. An expansion of this strategy “the revenue-oriented expenditure policy” can be identified from the beginning of the 1990s. If the management and service provision structures (e.g. the contractual relationship between the insurance funds and service providers) had remained largely untouched until then, they were subjected to striking changes by the Health Care Structure Act/Gesundheitsstrukturgesetz (1992) and the GKV Modernisation Act/GKV-Modernisierungsgesetz (2003). At the same time, the privatisation of health costs was pursued to an extent that was previously unknown (for details see e.g. Gerlinger 2004).

Indeed, on conclusion of these reforms, political parties of diverse orientation were in agreement that further reform was necessary. In the election campaign of 2005, far-reaching structural changes to the German health system were discussed under catch phrases such as the “citizens’ insurance” (Bürgerversicherung) and the flat rate “per capita premium”. Measured against this, the changes that the grand coalition adopted were less far-reaching. The most significant elements can be summarised as follows:

A legal obligation for all citizens to take out insurance was introduced.

The separation of the PKV and GKV was retained. The possibility of transferring provisions for old age to a new contract simplifies the change of service providers within the PKV system. Previously, the change of service provider was associated with high losses for the insured and was therefore rarely practiced. The PKV is obligated to enter contracts – similar to until recently in the Netherlands – and to introduce a basic tariff offering the same level of services as the GKV without risk assessment. The asymmetric competition between the two parts of the system, the GKV and the PKV, which systematically contributed to the erosion of the GKV income from contributions in the past, was not altered.

In the future, the GKV is to be financed through a new central organisation (Health Fund). The insurance will continue to be financed through income-related employee and employer contributions. The contribution rates are now set by legislation and as such limit the freedom
and scope of social security self-management. The reform intervenes in the relationship between the State and the health insurance funds. An adjustment to the contribution rates must take place at the latest when 95% of the health fund’s expenses can no longer be covered by the fund’s resources.

Payments from the fund to the health insurance funds are made as a fixed premium for each insured person and are complemented by risk adjusted supplements. Should this sum be insufficient, the health insurance funds can demand additional contributions – either income related\(^{24}\) or as a fixed sum (“small per capita premium”) from the insured. Should the health insurance funds generate a profit, they are permitted to repay part of the fund capital to the insured. The competition between health insurance providers should then take place via these premiums and no longer via the contribution rates. Competition between health insurance funds is also further encouraged by the expansion of tariffs that make more options available to the insured (like e.g. cost-sharing tariffs, reimbursement tariffs, or family physician tariffs).

In the long term, the contribution-free insurance of children is to be financed through tax income. Since the Government was unable to agree to a further tax increase,\(^{25}\) this process will occur in stages over the long term (as a first step 2.5 billion Euro in 2007 and 2008). For the period that follows, it has been determined that the share covered by tax will be increased to approximately 14 billion Euro. However, how this is to be financed has not yet been clarified. At the same time, the income from tobacco tax amounting to 4.2 billion Euro is to be cancelled so that contrary incentives have been set here. In order to overcome short-term financial difficulties, a further rise in GKV contributions is expected when the health fund is implemented in 2009.

In addition to these changes, numerous individual measures have also been decided upon, including measures that affect the provision of services and contractual structures. They aim to achieve a new regulation of doctors’ remuneration, to increase the quality of prophylactic measures (e.g. further development of integrated care) and to save costs (e.g. the negotiation of discounts between pharmacies, health funds and the pharmaceuticals industry). The organisation of health insurance funds is also to be restructured by easing the fusion of different types of health insurance funds and the development of a central umbrella organisation.

\(^{24}\) Under the condition of a free choice of social insurance provider, income-related additional contributions are considered to deter high income earners (with lower health risks). Therefore, it is not very likely that any health insurance fund will introduce them.

\(^{25}\) A 3% increase in VAT was introduced at the beginning of 2007.
5.3 The Dutch Health Reform of 2006

The health reform that became effective in the Netherlands on 1.1.2006 was the result of a discussion and negotiation process that extended over several years and required several attempts at implementation (Greß et al. 2006: 12-16). The reform affects above all the ZFW System; the AWBZ remained unchanged. The reform restructured the ZWK System as follows:

The coexistence of the GKV and PKV in this pillar of the Dutch health system was discontinued. The ZFW was restructured into a form of “citizens’ insurance” for the provision of acute medical care (i.e. there is a general obligation for all citizens to have this insurance). The financing of this citizens’ insurance is based solely on private health insurance companies. The health insurance funds in the ZFW System were privatised through the reform, but at the same time subjected to a framework of special State regulations (including the obligation to enter contracts and the provision of a basic tariff).

Similar to Germany, the insured were provided with more options in terms of cost sharing or reimbursement tariffs.

50% of the finance for the ZFW System now comes from a per capita premium that is independent of income. This financing source has been significantly expanded. In order to avoid causing undue financial stress, the State takes over payment of this premium for the needy and draws the necessary funds from tax income. It has been demonstrated that approximately 60% of all households in the Netherlands are entitled to a tax-financed health subsidy (Greß et al. 2006: 20). The income-related contribution of up to 6.5% is levied on various types of income (including income from capital assets). Contributions based on income derived from employment are financed by the employer.

5.4 Comparison

How is extent of the investigated changes in the three countries to be classified? Comparison revealed the following: In Austria reform was largely confined to first order institutional changes according to the definition provided in section 3 – with the exception of organisational and management structures (second order change). An incremental transformation has occurred, which, above all, increased the citizens’ direct participation in costs. However, the fundamental principles of the Austrian social security model in respect to health were not altered by the reforms of 2005 or previous reforms.
In contrast, in the Netherlands one could even speak of third order change if one takes into account the following modifications to the system: Status group differentiation and financing primarily through income-based contributions, both characteristic of the Bismarckian Social Security Model, have now been abandoned. 50% of the finance is derived from per capita premiums. The income threshold for compulsory insurance was dispensed with and the ZFW insurance was transformed into a mandatory universal citizens’ insurance, which can be interpreted as a new principle in the system’s insurance goals. Due to the simultaneous abrogation of the former GKV this model rests exclusively on private companies, which are embedded in a dense network of State regulations and operate in competition with one another. The new cost-sharing tariffs – which on their own could be classified as second order change – fit into this broader picture of a shift towards a radical market model. All in all, these changes represent a break with at least three fundamental traditions of the Bismarckian social insurance: finance by income-based contributions (now per capita premiums); (co-)management by social partners (now private companies under state regulation); a historically developed patchwork of different insurance obligations for different status groups (now universal, mandatory citizens’ insurance). Thus, this reform can be classified as a radical shift away from the “paradigm of social insurance”.

The German case is most difficult to classify and lies somewhere between the other two countries. In the German reform process, the discussions around the concept of “citizens’ insurance” versus “a per capita premium” prior to the 2005 federal elections created expectations of comprehensive structural reform. The pressure to compromise experienced by the Grand Coalition, which has governed since Autumn 2005, hindered this on significant issues such as substantial financing of the GKV through tax income and the integration of the GKV and PKV into a single health insurance system. The reform here was confined to gradual first order (e.g. the degree of financing from tax) and second order change (e.g. general basic tariff and the transferability of reserves for old age as new PKV instruments). All in all, the reform provides for a series of new instruments and consequently for second order changes. These occur primarily at the organisational and management levels of the health system, the centre of which is envisaged to be the health fund in the future. The break with Bismarckian traditions does not go as far as in the Netherlands. Nevertheless, the legal obligation for all citizens to take out insurance, the per capita premiums (although still smaller than in the Netherlands), as well as the new cost sharing tariffs point in a similar direction.
6. Conclusions and Research Perspectives

When comparing recent health reforms in the three countries, we see processes to which first (Austria), second (Germany) or third (Netherlands and perhaps even Germany) order changes are central. As such, the cases examined here provide no evidence of inherent “rigidity” in the social security model of the conservative welfare state. This is particularly true if one considers that through institutional layering (Streeck/Thelen 2005), first and second order reforms, e.g. the proposed health fund in Germany, could cause significant long-term changes to the system that are not yet clearly visible. These might include, for example, a shift in the power relationship between the health insurance funds and the State, or – as some German health economists expect – a decrease in service provision quality due to distorted competition between the sickness funds.26

Notable in the comparison of the three countries is also that the German reform of 2006/07 very strongly follows the direction set by the Netherlands, even if this has not yet been pursued to the last consequence. The step in the direction of integrating the GKV and PKV is not complete, however the fund model accompanied by a “small per capita premium”, which is now being pursued in Germany, is markedly similar to the now “old” system used in the Netherlands prior to 2006. The two countries appear to follow a common “path of regulated competition” (Hassenteufel/Palier 2006) based on a market-like organisation of the health system. This path has not been taken by other social insurance countries such as Austria or France to date (on developments in France see ibd.). These developments point towards convergence processes in some social insurance countries and simultaneously, increased divergence from countries that do not follow this path.

To what extent do new institutionalist theory and the literature on the spread of ideas contribute to understanding these results? Comparison of the expectations derived from different strands of the literature (as described in section 3) on the three empirical cases allows the following preliminary conclusions (Table 1): First, an explanatory framework that includes paradigmatic change, not just change as a reaction to exceptional, exogenous shock, seems best suited to explaining the observed developments. Neither in the Netherlands nor in the German health reform – the two cases with far-reaching change – were exogenous shocks of any importance. Second, the theoretical framework should be able to account for diverging reform paths (for health care: Germany and the Netherlands versus Austria and presumably France) among conservative welfare states. Taking these two pre-conditions into account,

26 The legislative framework, as it stands, disadvantages health insurance funds with many low income earners or beneficiaries of public assistance.
none of the approaches presented in the first five columns of Table 1 seems adequate because they expect the Continental welfare states to display incremental change and/or predict convergent reform paths. In contrast, those approaches that are able to capture endogenous preference change – historical institutionalist sequence analysis and some strands of the “ideas literature” – might be a fruitful starting point for analysing the causes of transformative welfare state change. On this note, Greß et al. (2006: 12-15) stated on the Dutch reforms of 2006, that they were facilitated among other things by a sequence of previous reform attempts made over several years, leading step by step to an approximation of the public and private health insurance. In contrast to Germany, the institutional structure of private health insurance shortly before the fundamental reform in 2006 – such as, e.g. a cohort-specific pay-as-you-go system and service providers’ fees almost equal to those of the public system – finally made an integration of the private and public insurance systems much easier.

In particular, the close similarity of the Dutch and German reform paths draw our attention to the cross-border transfer of ideas. At first sight, it might be tempting to tell a story of good-practice-solutions – potentially even promoted by exchange through the Open Method of Coordination – “travelling” from the Dutch model into the German reform process. However, as mentioned above, parallel policy developments alone are not sufficient to conclude that learning in the sense of deliberative problem-solving has taken place; and the emergence of new European soft law instruments does not automatically mean that they have an effect on national policies. Anyone who is familiar with the latest German health reform discussion (and my expert interviews confirmed this) will agree that the new European Union health policy instruments in the realm of the OMC had nothing to do with the decisions taken. Rather than by deliberation, the whole process was very much driven by the power struggle and search for compromise of the two political parties in the Grand coalition. The government had to be successful in bringing together two contradicting concepts – citizens’ insurance and the per capita premium – in order not to endanger its future. Although there were many expert commissions and scientific opinions, the actual decisions were negotiated by a small circle of politicians, and no researcher was actually in favour of the final politically-negotiated compromise.

This raises the interesting question of how and why the “idea” of the health fund, which already existed in the Netherlands, – but independent of the Dutch model (interview notes) – was brought into the political debate by the German economist Wolfram F. Richter (see

While these seem to be rather obvious points, the literature on the Hartz reforms in Germany related to the European Employment Strategy shows that it is not self-evident (for a critical review see Fleckenstein 2006).
Spiegel 2006; Richter 2005) and later taken up by the scientific advisory board of the German Ministry of Finance, of which Richter is a member. It goes beyond the scope of this paper to explain this in detail. However, this case provides the opportunity to learn more about how ideas might be used as a power resource and how – as suggested by Hall (1993) – powering and puzzling are intertwined. Further research needs to verify whether a linkage of historical institutionalist approaches with theoretical frameworks on the spread of ideas are generally able to account for institutional change in Continental health systems.
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Table 1: Theoretical Expectations and Empirical Results on Welfare State Change in Continental Europe (CE)

<table>
<thead>
<tr>
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<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent variable</td>
<td>Incremental</td>
<td>Incremental, if many veto points</td>
<td>Incremental for Continental Europe</td>
<td>Incremental, but far-reaching effect</td>
<td>Paradigmatic change among common reform patterns</td>
<td>Paradigmatic change among common reform patterns</td>
<td>Paradigmatic change and incremental change with far-reaching effects found</td>
<td></td>
</tr>
<tr>
<td>Degree of expected welfare state change in CE</td>
<td>No (but persisting similarity)</td>
<td>No (political institutions are more important than welfare institutions)</td>
<td>Yes</td>
<td>Yes, towards liberalisation</td>
<td>No</td>
<td>Yes (some strands of this research)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convergence in CE?</td>
<td>No</td>
<td>No (political institutions are more important than welfare institutions)</td>
<td>No</td>
<td>Yes, towards liberalisation</td>
<td>No</td>
<td>Yes (some strands of this research)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convergence across welfare regimes?</td>
<td>No</td>
<td>No (political institutions are more important than welfare institutions)</td>
<td>No</td>
<td>Yes, towards liberalisation</td>
<td>No</td>
<td>Yes (some strands of this research)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: own compilation; \(^1\) Pierson (2001: 455)
### Table 2: The Care Health Systems before 2005

<table>
<thead>
<tr>
<th>Entitlement Rights</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Austria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>Mandatory social insurance for employees and coequal groups up to an upper income limit</td>
<td>ZFW: mandatory social insurance for employees and coequal groups up to an upper income limit; self-employed</td>
<td>mandatory social insurance for employees and coequal groups; self-employed</td>
</tr>
<tr>
<td><strong>Nature and Amount of Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public services</strong></td>
<td>Benefits in kind aimed at comprehensive service provision based on individual needs</td>
<td>Benefits in kind aimed at comprehensive service provision based on individual needs</td>
<td>Benefits in kind aimed at comprehensive service provision based on individual needs</td>
</tr>
<tr>
<td><strong>Wage replacement benefits</strong></td>
<td>Cash benefit aimed at securing the living standard</td>
<td>Cash benefit aimed at securing the living standard</td>
<td>Cash benefit aimed at securing the living standard</td>
</tr>
<tr>
<td><strong>Structure of the Financing System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Financing of public health care</strong></td>
<td>Mainly contributions</td>
<td>Mainly contributions</td>
<td>Mainly contributions</td>
</tr>
<tr>
<td><strong>Employers’ share</strong></td>
<td>Almost equal to employees’</td>
<td>ZFW: almost equal to employees’</td>
<td>Almost equal to employees’</td>
</tr>
<tr>
<td><strong>Insurance of family members</strong></td>
<td>Contribution-free</td>
<td>Contribution-free</td>
<td>Children contribution-free, spouses only when involved in the provision of care</td>
</tr>
<tr>
<td><strong>Public share of total health expenditure (2003)</strong></td>
<td>78 %, thereof: 10 % (State) 68 % (social insurance)</td>
<td>63 %, thereof: 3 % (State) 60 % (social insurance)</td>
<td>70 %, thereof: 21 % (State) 49 % (social insurance)</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Payments for healthcare as share of total health expenditure (2003)</strong></td>
<td>10 %</td>
<td>8 %</td>
<td>15 %</td>
</tr>
<tr>
<td><strong>Importance of Private Health Insurance</strong></td>
<td>Relevant, above all, for employees above the upper income limit for mandatory insurance, self-employed, and civil servants</td>
<td>Relevant, above all, for employees above the upper income limit for mandatory insurance</td>
<td>Above all, additional insurance, not full value insurance</td>
</tr>
<tr>
<td><strong>Organisation and Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organisational structure of insurance funds</strong></td>
<td>Social partners/ self-management</td>
<td>Since 2001 mainly governed by the State</td>
<td>Social partners/ self-management</td>
</tr>
<tr>
<td><strong>Organisational principle of insurance funds</strong></td>
<td>Competition</td>
<td>Competition</td>
<td>Non-competitive</td>
</tr>
</tbody>
</table>

Source: own compilation; ¹ OEDC Health Data 2006