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The Recent Healthcare Reforms in Germany –
How does the concept of partisanship explain the positions of SPD and CDU/CSU?

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Abstract

Since the 2000s, several healthcare reforms have been conducted within the healthcare system in Germany. These reforms aimed at decreasing healthcare costs by introducing market processes into public services, among other means. This paper examines the policy preferences and the discourse concerning the reforms of the two dominant parties in German politics, the Social Democratic Party (SPD) and the Christian Democratic Union (CDU/CSU). It aims at revealing why the parties favoured and supported the particular reform policies. The partisan preferences are determined by applying the theoretical concepts of partisanship, power resources theory and a market-oriented power resources approach. This paper utilises the qualitative method of a discourse analysis. The expected preferences of the parties are compared with the political discourse and the policy outcomes regarding market-orientation and strategies of cost containment and recalibration. It can be demonstrated that the SPD repeatedly acted in a way that contradicted the assumed partisan preferences.

Keyword: healthcare reforms, partisanship, power resources, market-oriented reforms, cost containment strategies

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1 Introduction

The healthcare system is a fundamental part of the German welfare state. More than 99 per cent of the German population is insured within the health insurance scheme (BMG 2013c: 113). The total healthcare expenditure amounts to more than eleven percent of GDP, ranking Germany among the countries with greatest expenditures within the OECD and even exceeding the OECD average by about two percent (OECD 2013: 156-157; Oduncu 2012: 328).

Many laws and reforms targeting the healthcare system were introduced by different governments during the last decades. The most extensive reforms aimed at making the financing of the healthcare system more stable and sustainable while preserving its functionality. In addition, a certain trend towards more competition among the health insurance funds is evident in several reforms. Both tendencies, the focus on financial sustainability, as well as on competition can be recognised easily in the official label of the most significant reforms in the 2000s. These reform policies are named the *Act on the Modernisation of the Statutory Health Insurance (GKV[1]-Modernisierungsgesetz)* from 2003, the *Act for Strengthening Competition in the Statutory Health Insurance (GKV-Wettbewerbstärkungsgesetz)* from 2007, the *Financing Act of the Statutory Health Insurance (GKV-Finanzierungsgesetz)* from 2010 and the *Act for the further Development of the Financial Structure and the Quality of the Statutory Health Insurance (GKV-Finanzstruktur und Qualitäts-Weiterentwicklungsgesetz)* from 2014.

The political goal of creating and enhancing competition within healthcare as a typical sector of public service raises further questions concerning the type of market and competition. According to Gingrich (2011), at least six ideal types of markets for public sector marketisation can be identified. These are classified by differentiating between allocation and production dimensions and emphasising either the position of the state, citizens (users) or producers (Gingrich 2011: 10-18).

The time period from the early 2000s to 2014 is not only characterised by alteration within the healthcare scheme but also by recurring changes on the political level. Except the national elections in 2002, each following parliamentary election led to a change in the formation of the government. The Red-Green federal government formed by the *Social Democratic Party of Germany* (*SPD*) and the environmental *Green Party* (*Bündnis 90/Die Grünen*) remained in office from 1998-2005. The grand coalition government of SPD and the *Christian Democratic Union* (*CDU*)/*Christian Social Union* (*CSU*) persisted from 2005-2009. This grand coalition was succeeded by a conservative-liberal coalition formed by CDU/CSU[2] and the liberal *Free Democratic Party* (*FDP*), which lasted until 2013. Since 2013, the

[1] The term *GKV* labels the German abbreviation for *Gesetzliche Krankenversicherung, which* is the German Statutory Health Insurance.

[2] In the following, the term CDU/CSU is used in a standardised form to label the one party-union, which is formed by the Christian Democratic parties in Germany.

present government consists of CDU/CSU and SPD, and represents the second grand coalition in the 21st century in Germany. Overall, four different parties were involved in formation of government within 15 years, which indicates fluent changes in the political sphere.

However, the permanent participation of either the CDU/CSU or SPD illustrates a continuity of the two major political partisan camps in Germany, the Social Democrats and Christian Democrats. Thus, both parties have great significance and responsibility for the design and implementation of reforms targeting the healthcare system.

The SPD as a traditional Social Democratic party represents the political left and established its core constituency among the labour class (Huber et al. 1993), even though there have been shifts in the party's programmatic orientation towards the new middle (Paterson, Sloam 2006: 235-242). The CDU/CSU is seen as a party of the political right with close connections to the capital class. Moreover, the Christian Democratic parties are considered to hold a special position among the conservative parties. They emerged from confessional parties, keeping a more social attitude, while also opening themselves to more social groups of the electorate (Kalyvas, van Kersbergen 2010: 186-191). Nevertheless, SPD and CDU/CSU symbolise the different ideological partisan branches of left and right in the following sections of this paper.

1.1 Research question

The classification of SPD and CDU/CSU as advocates of either labour or capital induces a great interest regarding the effects for the above mentioned healthcare reforms. The trend towards more competition in a previously regulated healthcare system needs to be examined considering the partisanship of the respective government. This raises the main research question, *how do traditional power resource theory and market-oriented partisan preferences help us to understand the justifications of CDU/CSU and SPD for the key healthcare reforms in Germany between 2003 and 2014?* This thesis aims to investigate how the two parties, SPD and CDU/CSU, justified their attitudes towards the most significant healthcare reform policies in Germany during the 2000s. The objective is to understand why the parties carried out the reform policies in their particular way. For this purpose, the discourse of SPD and CDU/CSU is analysed in regard to the theoretically derived expectations of the parties' policy preferences.

1.2 Motivation

The healthcare system is of great significance for the German welfare state. It provides medical treatment and universal access to healthcare for the population. The political question about how to achieve high-quality healthcare with sustainable financing needs to be answered to secure the healthcare system in the future. Therefore, I have a great interest in the healthcare reforms of the last decade. It is also important to understand how the healthcare

structure changed, and who benefited and suffered from these changes. The implementation of cost-reduction measures and competition among health insurances through healthcare reforms is the chosen means to secure the financing of healthcare. The four selected healthcare reforms contained extensive measures targeting and reorganising the functionality of the interaction between health insurance funds, physicians, patients and insured persons. The main objective of all four reforms was to stabilise the financing and secure healthcare quality. A variety of other healthcare related policies were enacted between the time period from 2003 to 2014. Since most of these reforms only addressed minor issues such as pharmaceutical law, hospital reimbursement or care regularities, none of these reforms reached as far as the four selected healthcare reforms.

The role of the parties, above all SPD and CDU/CSU, cannot be underestimated. Both parties are the only ones that provided German chancellors, and dominate politics in Germany. Most of the reforms contain uncomfortable measures and need support across party borders. Thus, it is of great importance that SPD and CDU/CSU cooperate during the decision-making stage. Both parties cooperated for three out of four reforms. Nevertheless, it needs to be examined which party pushed through its own preferences with more success and how both parties justified their position towards the reforms. These circumstances interested me about the significance of partisan preferences for actual policy outcomes. In how far can the SPD leave its mark on reforms that introduce markets into healthcare, or does the CDU/CSU take control of the reform policies? On the other hand, how strong is the impact of budget constraints on the politicians? And does the concept of partisanship help to understand why the policies were designed in their particular manner? Furthermore, it is of high interest whether the reform design actually matches with the expected preferences of the parties. From this, the general direction of future reform outcomes for each party can be inferred.

1.3 Structure of the thesis

This paper is organised in six chapters. The second chapter introduces the policy background. The background section defines several important key terms and illustrates the reasons for rising healthcare costs and the financing deficit of the healthcare system. The section concludes by introducing possible reform options with a focus on market-related reform as well as different reform strategies that are used to characterise the reform policies. The following chapter elucidates the theoretical concepts of partisanship, power resource theory and market-oriented power resources. These are applied in a comprehensive manner to motivate and explain the policy-related preferences of the different parties. The fourth chapter outlines the methodology. For this purpose, the concept of discourse analysis is briefly explained. The following chapter includes the analysis of the political discourse regarding the selected healthcare reforms. This chapter provides more precise information about the reform policies as well as the discourse of the chosen political actors. The thesis concludes by analysing the expected preferences of the parties in relation to their actual statements during the decision-making process.

2 Policy background

2.1 Terms and functionalities within the German healthcare system

The German healthcare system consists of several organisations and institutions that have interacting relationships and are regulated by different laws and acts. In order to achieve a better comprehension of the healthcare reforms examined in this thesis, it is important to elucidate some of these relationships and to explain the role of several institutions in a brief overview. For this purpose, the basic meaning of several healthcare related terms is explained in the following.

The *Statutory Health Insurance* (*SHI*), as the organisational entity of sickness funds, is the central pillar of the German healthcare system. Its purpose is an insurance against financial risks for individuals in case of sickness (BMG 2014a). Thus, it covers the costs for medical treatment and pharmaceuticals according to a predetermined and mostly standardised benefits catalogue. The respective SHI are organised as public corporations and under state supervision (BMG 2014b; Green, Irvine 2001: 53-59). The SHI is financed mainly by contributions from its members and to some extent from federal grants. The membership in the SHI is compulsory for employed people and those who exceed a certain yearly income threshold are also entitled to join the private health insurance (BMG 2014c; Green, Irvine 2001: 54-55).

The *Private Health Insurance* (*PHI*) is the general term for all non-statutory health insurance funds, which provide health insurance for the private market. They are organised as stock companies or mutual assistances and offer differently structured benefits catalogues, depending on individual needs and demands. The financing of the PHI is based on premiums, which are contributed by the insured persons. These premiums are calculated according to several health indicators such as sex, age, medical history and vary in their total sum. (Green, Irvine 2001: 61-63; Gruber, Kiesel 2010: 354; Hofman, Browne 2013: 87-88). All self-employed, *Civil Servants* (*Beamte*) and individuals with a yearly income above a certain *Annual Income Limit* (*Jahresarbeitsentgeltgrenze*) can choose to stay in the SHI as voluntary insured persons or opt out of the SHI and instead join the PHI. Therefore, the PHI is mainly applied by self-employed, civil servants and employed people with a very high income (Green, Irvine 2001: 61-62).

The contribution rate is the main source of revenues for the SHI. It is paid by all employed insured persons who are members in the SHI and their employers. Both parties contribute an equal share (in parity). The current contributions are used to pay for the entire costs of healthcare, which also characterises the German healthcare as a pay-as-you-go system. The particular contribution rate is calculated as a percentage of gross income, with the result that individuals with a higher income pay higher contributions than individuals with lower income in absolute amounts. However, this applies only up to a certain income ceiling

called the *National Income Threshold* (*Beitragsbemessungsgrenze*). The National Income Threshold is determined by the government for each year and ensures that an income above the threshold level is not included into the calculation of the contribution rate (BMG 2014c; Green, Irvine 2001: 54-55).

2.2 The German healthcare system before the reform policies

In the following, the subject of consideration is the German healthcare system at the end of the 1990s. This step back in time is necessary in order to gain a profound insight in the healthcare scheme before the policy reforms were introduced and actually unfolded their effects. In this way, the changes caused by the reforms emerge in a stronger manner and can be analysed more clearly. The German healthcare system is based on several principles such as social solidarity, free choice of physicians and the principles of subsidiarity and corporatism, which are still active.

The principle of social solidarity is applied to the SHI and is summarised with the statement: "The healthy support the sick" (BMG 2013a). The principle specifies that all insured persons have access to the same comprehensive medical treatment and that their contribution rate is not dependent on health indicators such as age, sex or health risks. In addition, most dependants as well as spouses in case of unemployment are covered by family insurance without any surcharges. Furthermore, the catalogue of benefits of the SHI grants full or a high level coverage of services (BMG 2013a; Burkhardt 2013).

Although there are some minor restrictions, basically, all insured persons of the SHI have a free choice of physicians (BMG 2014d). The can freely choose their family physician and also visit each other general physician without a referral. However, it is intended that patients visit the same medical practise again once they choose a particular one to simplify the medical treatment. The patients are free to switch to different doctors.

The principle of subsidiarity puts the responsibility for policies on the smallest political or societal level considering the precondition that these smallest entities have to be capable to carry out such policies. According to the subsidiarity in the German healthcare system, the federal government is not involved in all healthcare related issues. It rather determines the legal structure of healthcare and defines general health objectives to be achieved by the other actors within the healthcare system. These different actors are supposed to follow the principle of self-administration.

The principle of corporatism is, on one hand, given through the representation of certain stakeholders of employers and employees at governing board level of the health insurances. On the other hand, there is a corporatist process of participation and bargaining between healthcare providers such as physician, hospitals, dentists, the pharmaceutical industry and the health insurance funds. Thus, all actors are involved in the decision-making process on the definition of healthcare (Green, Irvine 2001: 53; Giaimo, Manow 1999: 976-78; Busse, Riesberg 2004: 42-45).

In general, the German healthcare system clearly represents the Bismarckian model. This model is mainly characterised by a healthcare insurance system, which is compulsory

and generates its revenues from income-related contributions from the insured persons. Inasmuch, the state is responsible for defining general health objectives and maintaining certain regulations for the involved actors, even though it does not finance the healthcare scheme (Giamo 2001: 350-351; Steffen 2010: 142; Busse, Riesberg 2004: 23-25).

The SHI was founded in the late 19th Century by employees "and in some cases by employers as mutual aid societies" (Green, Irvine 2001: 54) and still plays a key role in the healthcare system. All individuals are free to choose an insurance fund within the scope of the SHI. It covers the health insurance for unemployed persons, students, apprentices, pensioners and naturally employed individuals. More than 87 per cent of the German population is insured in the SHI (GBE-Bund 2015). With the commencement of insurable employment, the employer subscribes the employees as members of the health funds. The members can switch to any other health insurance once a year in accordance to a national established deadline. Insured persons use a personal registered electronic card each time they visit a doctor or hospital. With this practice, instead of individuals directly paying, health funds pay for medical treatments. In turn, insured persons and their employers make their parity contribution from the monthly gross income of the insured persons and according to the contribution rate of the health fund. Within, employees and employers are responsible for about 60 per cent of the total healthcare system's funding. However, there are additional resources that are used to finance the healthcare system. Thus, the state co-finances the system with about 21 per cent from its own budget in order to close financial gaps. Besides, the share of private financing occurring through the PHI aggregates to seven per cent, while patient payments amount to about eleven per cent (Green, Irvine 2001: 54-57).

2.3 Rising costs and non-sustainable financing

Healthcare is an expensive good that needs to be financed in a stable and sustainable way in order to keep the healthcare system functional and working. Although the financing of the German healthcare system has a very clear structure, it struggles with sharply increasing costs and decreasing revenues from the contribution rate. Since 1970 the total healthcare costs as a percentage of GDP raised from 6.0 per cent in 1970 to 8.4 per cent in 1980. The share kept stable until 1990 with about 8.3 per cent and increased again up to 10.5 per cent in 2001 (OECD 2014). This data on its own in not meaningful since it does not allow any inference about the evolution of actual costs of healthcare in Germany. Therefore, it needs to be supported by further data. For this purpose, two more indicators, namely total healthcare expenditures and expenditures per capita are examined. During the same time period as above, the German healthcare expenditures per capita rose eight-fold from approximately 340 Euro per capita in 1970 to about 2.570 Euro per capita in 2001. This significant rise of costs per capita is even exceeded by the increase of total healthcare expenditure, which tripled from 20.6 billion Euro in 1970 to more than 63 billion Euro in 1980 and kept increasing to more than 104.9 billion Euro in 1990 and doubled again to above 211.8 billion Euro in 2001 (OECD 2014). Within, there was a ten-fold increase of total healthcare expenditures in 30 years. Accordingly, the German healthcare system is classified as one of the most cost-intensive systems in Europe during the late 1990s while only being surpassed by Switzerland (European Observatory on Health Care Systems 2000: 51-55).

What are the reasons for this sharp rise of costs in the German healthcare system? They can be found in several factors and processes. The technological progress in different fields of medicine and new medical devices or treatments is often accompanied with costly research or developments. Thus, technological growth is one factor for an increase in healthcare costs (Chandra et al. 2012: 647-650; BMG 2013b). Furthermore, the demographic change and subsequently the aging population contribute in part to the rising costs. Elderly people are expected to make use of the healthcare services more often than younger individuals. As a side effect, pensioners have a smaller pension income than during their work life; accordingly, their total sum of contributions decreases by a significant amount once they retire. Therefore, the growing group of elderly people results in a reduction of total contributions to the SHI (BMG 2013b).

Another important process can be identified in the economic systems. After the oil-crisis in the 1970s, many countries including Germany, experienced economic problems followed by periods of austerity. The growing unemployment rate in Germany can be seen as one consequence of this process. Again, a growing share of unemployment among the population leads to decreasing funds for the health insurances. Thus, the number of contributing individuals diminishes while the actual number of insured persons stays the same. In addition, the emerging number of marginal or part time jobs might have a similar effect. The income of such employment relationships performs at a low level. Inasmuch, the sum of contributions to the SHI is lower, either. Furthermore, the unification process of the two German states during 1990-1991 caused new costs for the German healthcare system. The western German model of the SHI had to integrate a great number of additional individuals into the current system as well as the different structures of healthcare institutions in the former eastern Germany. Moreover, the share of labour related wages of the total economies' income diminished in comparison to capital-related income (Schmidt et al. 2010: 469; Busse, Riesberg 2004: 59-60). In case of a healthcare system which is based on the SHI and income-related contributions, this changing ratio leads to a negative trend in revenues even though the general economy might still grow.

Within steadily increasing healthcare costs and constantly decreasing revenues from income-related contributions, the SHI runs the risk to operate with a financial deficit. In order to compensate this financial pressure, the health insurances were forced to constantly increase their revenues. Thus, the average contribution rate rose from 8.2 per cent in 1970 to 11.37 per cent in 1980 and continued to increase to 12.53 per cent in 1990, reaching 13.56 per cent in 2001 (Statistisches Landesamt Baden-Württemberg 2015; Green, Irvine 2001: 55).

Since the SHI contribution rate belongs to the package of additional non-wage labour costs, its rising level has a strong impact on the German economy. On the employers' side increasing non-wage labour costs simply make labour more expensive. Employers have to spend a higher amount of resources for contributions to the social insurance system of each of their employees. Thus, companies are considered to hesitate in employing more or new workers. Furthermore, the employers and management boards argue that such high non-wage labour costs weaken the competitiveness of German enterprises and within the position of German companies in the international market. Both tendencies are expected to create an economic downward trend and therefore foster increasing unemployment, which in turn works against the stability of SHI finances (Giaimo, Manow 1999: 976-977; Carrera et al. 2008: 980-981). The rising level of the contribution rate can result in a loss of purchase power on the employees' side, if there is no wage increase to outweigh the additional burden. A

lower purchase power is supposed to lead to less consumption-related stimulation for the economy. Accordingly, such processes counteract economic growth, which is assumed to foster unemployment and decrease SHI revenues (Carrera et al. 2008: 980-981).

Due to the variety of intense side effects, the option of a dynamic adjusting contribution rate is not considered adequately. The presented arguments against a permanent increase of the contribution rate, as a natural reaction to higher costs and lower revenues, creates a condition in which the scope of action for both, the SHI and politicians, is quite limited. However, the most likely way of approaching the issue is to implement healthcare reform policies that tackle the dilemma characterising healthcare financing in Germany.

2.4 Reform options for healthcare systems

2.4.1 Market-Oriented Reforms

Healthcare reform policies can have very different concepts especially in their design and content. A very important branch of reforms is represented by market-oriented reforms aiming at public service domains. According to Gingrich (2011:7), newly created markets can differ a lot and approach the spheres of "spending, cost sharing, benefits or coverage" in diverse ways. Market-oriented reforms often seek to enhance competition and efficiency within the targeted system, by changing the relationship of costs and power among involved actors, such as the state, users of services and the mostly new private producers of services. Six models of markets are differentiated in a more detailed way by emphasising which of the actors achieves more control (production dimension) and on the other side by scrutinising whether access (allocation dimension) to the market is guaranteed on a collective or individual level (ibid: 3-12).

The category of *State-Driven Markets* is used for introduced markets in which the state keeps the main control about the targeted domain. In this way, the state puts itself in a market overseeing and determining position. The market is primarily seen a tool to increase efficiency, especially cost efficiency. The two models of *Austerity Markets* and *Managed Markets* can be identified within the state-driven markets. The latter does not create opportunities for less efficient producers to pass on the costs to the service users and are thus protecting the users from new costs. Furthermore, managed markets seek to keep a broad and collective access to the service. Austerity Markets involve more stimuli for the service users to request fewer services. This is achieved through privatisation of services, causing a considerable higher level of costs for the individuals or breaking up of access regulations (Gingrich 2011: 12-14).

The second category of *Consumer-Driven Markets* comprises markets, whose implementation emphasises the consumers' choice of service producers and thus creates more incentives for service innovation and improvement. Such markets grant the consumers with free choice of producers or the option to opt out of the system. The funds for the producers are allocated depending on the decisions of the users. Therefore, the service producers are forced to comply with the consumers' priorities for higher service quality which is expected to motivate the producers to compete with each other more. *Consumer-Controlled Markets* and *Two-Tiered Markets* are the two representative models of Consumer-Driven markets. The

former are characterised by an urge to avoid putting more costs onto the service users in order to empower users in weaker positions to make decisions. For this purpose, Consumer-Controlled Markets rely on strong collective public funding of services and pursue to distribute the gains among all consumers. In contrast, by allowing the producers to pass on more costs to the service users, the two tiered markets advantage specific factions of the consumers which are often among low risk, low cost or high income groups of individuals. Furthermore, two tiered markets practice individual cost sharing thus enhancing the individual financial responsibility of the consumers (ibid: 15-16).

In the third category, *Producer-Driven Markets* transfer a great share of market-control in the hands of service producers in order to enable innovation; at the same time reducing the power of users as well as the state. The service producers aim to bring in as many users as possible without having a strong competition for a high quality performance. Those markets emerge out of situations when processes of expanding users' choice or contracting have a lack of clearly set rules or regulations as well as when new service producers can come onto the market and the public inspection performs only at a low level. Thus, new producers have a strong position in the market. Both *Pork Barrel Markets* and *Private Power Markets* are possible models of Producer-Driven Markets. Pork Barrel Markets are characterised by a distinctive collective financing, putting a few service producers in a very profitable market position. The Private Power Markets allow producers to pass a greater share of costs onto the consumers, making the service more expensive for users while reducing the costs for the state (Gingrich 2011: 17-18).

In order to grasp the variety of possible healthcare system reforms beside just the six theoretical archetypes of market oriented reforms, it is necessary to take a look at different kinds of reforms in different countries during recent reform periods. In the early 1990s several countries introduced reforms aiming at more competition and trying to separate the healthcare market in order to open it up for private actors. The United Kingdom's healthcare reforms aimed at enhancing competition as well as market forces. They broke up the previous structure of healthcare service delivery by separating service deliverers and purchasers. In the Netherlands several reforms made efforts to increase efficiency and innovation by strengthening competition among both profit-seeking and non-profit private insurance funds. The insured persons became enabled to choose particular insurance funds, overturning the previous practice of regional dependent distribution of insured persons to insurance funds. In Sweden the government commenced healthcare policies to encourage users' choice and private physicians' activity. The individuals in Sweden were allowed to choose the competent physician freely, while the emergence of private medical practices was facilitated by the politicians and government (Schmid et al. 2010: 460-467; Toth 2010: 82-84).

In contrast to such reforms which ensure competition and more market forces, many reform policies intend to create more regulation and integration within the healthcare system. This can be achieved through inclusion of new or already existing agencies within the healthcare sector, a greater integration of different involved actors forcing them to cooperate more closely or a reduction of the patients' choices. France introduced several policies in the late 1990s to increase integration as well as regulation. General practitioners were empowered to act as gatekeepers in order to prevent patients approaching specialists without a referral. Agencies on both regional and national level were formed to control and plan the healthcare system. A similar process took place in the United Kingdom in the late 1990s. The Blair Labour government introduced several policies targeting more co-operation and collaboration

rather than competition. The new primary care trusts initiated the cooperation between primary care providers, public authorities and hospitals (Klein 1998: 114-116; Toth 2010: 84-86).

2.4.2 Examining strategies for cost containment or recalibration

This paper examines the major healthcare reforms in Germany during the 2000s. For this purpose, the reforms are classified considering two broad dimensions of cost containment and recalibration. The underlying logic of this distinction is that both concepts represent different ways to achieve a stabilisation of the healthcare financing, although they are usually applied in a complementary way (Pierson 2001: 419-429). The two strategies can be identified as direct or indirect outcomes of the service marketisation which is conducted by the reforms.

Cost containment comprises different strategies for decreasing the costs of the healthcare system in a sustainable manner. Such strategies are identified within the areas of the financing structure, competition and simple cuts of benefits. All kind of outsourcing, or cuts of the SHI's catalogue of benefits, is supposed to reduce the expenditures of SHI and decrease the costs of the healthcare system. The competition among health insurances is expected to force SHI to achieve their performance in a more cost-efficient way, which contains their administrative expenditures. Those who are insured, as users of healthcare, also need incentives and opportunities for choosing to switch to more efficiently performing SHI. This way increasing competition is also assumed to decrease the costs of healthcare provision. Finally, changes of the financing structure are applied to make the resource distribution more balanced and efficient, considering the very different socio-economic composition of SHI members. Furthermore, only changes of the financing structure can achieve a decoupling of healthcare costs from non-wage labour costs. Overall, such changes are supposed to create more incentives for healthcare actors, in particular users and health insurances, to act in more resource saving ways.

The recalibration dimension covers initiatives to rationalise or update current procedures or functionalities in order to adjust to "new social needs and demands" (Häusermann 2010: 27). In regards of healthcare reform policies recalibration is applied to integrate new technology or highly demanded treatments into the SHI's catalogue of benefits or to react to recent developments. The integration of recently developed or demanded treatments, such as medical screenings or vaccinations, is necessary for achieving the quality goals of healthcare, while responding to newly articulated needs of the users. Recalibration can also be applied to counteract or steer against undesired trends of inefficiency or even abuse of the healthcare system.

3 Theoretical framework

This chapter applies the theoretical concept of partisanship to deduce the traditional power resources as well as the market-oriented power resources approach to explain and to frame my expectations regarding the preferences of CDU/CSU and SPD.

3.1 Concept of partisanship

The concept of partisanship or partisan politics in welfare state studies refers to parties and their significance for the modern political system of party democracy. It aims to explain why parties behave how they do and for this purpose recognises parties "as representatives of social constituencies mostly defined in terms of industrial classes and as bearers of clear ideological stances for liberal, social-democratic or conservative welfare policies" (Häusermann et. al 2013: 221). The concept of partisanship was substantial influenced and elaborated in the early 1970s by several authors. The analytical study of Hibbs (1977) stated that left-wing parties show a strong tendency towards more redistributional policies and would rather accept higher inflation than growing unemployment. According to Hibbs (1977) this trend can be explained with the different policy preferences of particular social classes, which are generally closely linked to the constituencies of left- or right-wing parties. Borg and Castles (1981) claimed analogous statements about the relevance of right-wing parties for "explaining public policy outcomes" (Borg, Castles 1981: 620). Thus, partisanship refers to both sides of the political spectrum, the left and the right.

Parties and their core electorate, their partisans, share mutual interests in societal, economic or political questions. Such "normative commitments" (White, Ypi 2011: 382) between parties and citizens are promoted through active engagement of individuals. Furthermore, these partisans pursue to bring their mutual issues and objectives to the public agenda, in order to have a better chance of being considered during the process of collective decision-making. The term partisanship emphasises these procedures and practices in contrast to the rather representative and administrative form of a party. Then again the close bond between partisans and parties, also distinguishes partisans from other individuals such as intellectuals, social or political activists or scientific experts who strive to influence policies, often without taking position for a particular political party (White, Ypi 2011: 382-383).

Schmidt names "political parties as multi-goal organisations" (Schmidt 1996: 156). They are office-seeking and policy-striving. While parties matter for politics, there is also a strong linkage between the electorate and parties, giving a great importance to the constituency and its political preferences. Thus, when parties are in position to participate or lead the political process of policy-making, they seek to meet the common goals they share with their core electorate in regard to societal, economic or political questions (Häusermann et. al 2013: 224-225, Schmidt 1996: 156).

Some critique on the concept of partisanship is established, considering the challenges parties are facing, in Western democracies, during the last three decades. Mair formulates "the failings of parties" (Mair 2005: 8) and demonstrates that parties are particularly affected by popular withdrawal, the withdrawal of elites and a decrease of programmatic alternatives. Popular withdrawal summarises all the effects of a declining electoral participation, the emergence and rise of electoral instability and high voter volatility, a decline of partisan attachment and a loss of party member or activists (Mair 2005: 8-16). While the diminishing programmatic alternatives, produce party programmes that are very similar in content and almost interchangeable, within originally different parties, the withdrawal of elites leads to a "mutual disengagement of citizens from political parties and of party elites from parties" (Bader 2014: 356). In addition, parties struggle with two more challenges that have the potential to undermine their significance. First, the emergence of possible new social cleavages such as gender or ethno-religious issues open up political space for different or even new social and political movements. This process puts the already existing parties under pressure of how to react and position themselves. Second, the progressive integration into transnational institutions, such as the European Union, holds the potential to shift the focus of parties from national to international politics. The parties can benefit from this process but also run the risk of spending too many resources on either of the two spheres, while neglecting the other one (Bader, Bonotti 2014: 253-254).

Another critical approach on the significant role of parties and partisanship can be seen in the debate around the "New Politics of the Welfare State" (Pierson 2001), which assigns a great responsibility for the weakening of partisan politics to the concept of path dependency. The expansion of the welfare state did not only change social policies but also beliefs and preferences of the electorate, thereby founding new groups within the constituency. The emergence of these groups demonstrates "how policy feedback from previous political choices can influence contemporary political struggles" (Pierson 1996: 151). This change is assumed to reduce the influence of simple partisan politics for policy outcomes, making parties and partisanship less important than partisanship theory suggests.

Furthermore, there are three additional perspectives on partisan politics that can be seen as a critique on the traditional partisanship theory. The first approach argues that the electoral constituency, in particular of left and social-democratic parties, changed during the last decades. On the one side, many predominantly young and well educated middle-class individuals from the heterogeneous group of "sociocultural professionals" (Kriesi 1998: 169) turned to the parties of the political left, forming the constituency of the new left. However many of these voters are assumed to experience different social risks preferences, than the previously typical electorate of the left parties. This trend of attracting new voters to left-wing and social-democratic parties puts the parties into the position that they first have to discover, and then deal with new political issues, in order to keep the support of the gained voters (Häusermann et al. 2013: 228). On the other side, many individuals from the working class gave up their support for political left parties and are progressively attracted by right-wing populist parties. This tendency goes hand in hand with the insider-outsider theory, which distinguishes between the employed as relatively well protected insiders and the unemployed or low-protected low-wage outsiders. The described discrepancy within the working class leads to different interests of both groups (Rueda 2005: 61-62). In a similar way as with the group of the new left, the parties of the political left struggle deciding who to support - the insiders or outsiders. However, the group of insiders, as representatives of the middle,

promise a more stable and rewarding electorate support. Therefore the left parties change and adjust their political agenda to the new electorate group.

The second argument emphasises that parties deal with different political situations and systems. Governments dominated by the political left, are more likely to establish within electoral systems of proportional representation, than majority representation. Hence it matters what kind of institutions or welfare structures a party encounters. In addition, the position of the social-democratic party in the party system itself can have great significance for its partisan perception. This position is determined by whether there are other left, religious (such as Christian democratic) or agrarian parties. All of these parties can cover political issues of the social-democratic party, which has to adjust its political agenda in order to compete for voters (Häusermann et al. 2013: 229-231).

The third approach claims that the party-voter linkage is not only characterised by an ideological link, alongside the social cleavages. Instead it assumes that voters select a certain party due to either programmatic or clientelistic reasons. The client links the vote for a party to the prospect of "direct payments or continuing access to employment, goods, and services" (Kitschelt, Wilkinson 2007: 2). While programmatic voters support a party for the sake of policies it proclaims on its agenda. Depending on the composition of the electorate and the level of the state's bureaucracy, parties can be forced to adopt policies to fulfil clientelistic demands for specific groups, even if they originally sought to implement more universal social policies (Häusermann et al. 2013: 232-234).

Rosenblum (2000, 2008) contributed a profound work to current political theory discussions, countering antipartyism, as well as critique on the partisanship theory, by arguing for the still important role of parties and partisanship within the political arena. Parties are relevant actors for the political work in modern democratic states and have a major role regarding managing "conflicts, nonviolent succession of governments, checking and exposing, competent governing" (Rosenblum 2008: 136). Thus, Rosenblum identifies "regulated rivalry", "governing" and "ethics of partisanship" (ibid: 156) as the three moments of appreciation - an appreciation of parties and partisanship. This leads to a position of "viewing parties as not only occasionally necessary but ordinarily acceptable, useful, even morally desirable features of political life" (ibid. 119). According to Rosenblum parties do still matter and are capable of contributing useful political output in democracies. White and Ypi (2010) developed this approach by identifying a normative, motivational and executive source, being relevant for the political agency. These sources refer to the basic political action, participation and will formation of citizens, their ambition to recognise the political ideals as mutual accomplishments worth to be strived for and the perception of political agency as an institution to protect the political ideals (ibid. 809-813). White and Ypi conclude, that "parties are not only well suited to cultivate these sources of conviction regarding the worth of political agency, but that they respond to the normative, motivational and executive demands in ways that no other type of actor can match" (ibid. 813).

While partisanship can be also recognised as the identification of the electorate with political parties, there are at least two main approaches explaining this kind of identification. The first one emphasises the identity that people identify with in social and political terms. This classification can lead to a distinct group, which accept important group behaviour and rules, while seeing themselves as members of this group. Parties or partisan organisations, among other things, can be connected with a group identity. The second approach focuses on an individual's mind-set towards a particular party. Diverse attitudes towards all kind of

matters can be caused and influenced by various social, economic and political aspects such as ideology, experiences or socioeconomic background. Such attitudes connected to a party are seen as very strong and powerful thus preserving the individual's identification with the party. Both the identity and attitude related approaches can be seen as taking effect at the same time rather than excluding each other (Bartle, 2009: 3-13).

3.2 Traditional Power Resource Theory

In a similar way as the concept of partisanship and partisan politics focus on parties as important actors of political agency, the power resource theory also highlights the significance of parties for particular policy outcomes. It is a theoretical approach that intends to analyse and explain "variation in the size and coverage of welfare states" (Rothstein et al. 2012: 2) and it is mostly applied to examine different developments within the welfare states of the western capitalist world. The traditional power resource theory argues there is a clear relationship between a well organised working class, leading to a high level of political representation through trade unions on the one side, and strong welfare states with a more redistributive character on the other side (Iversen, Stephens 2008: 4; Pontusson, Hyeok Yong 2006: 1-7).

Walter Korpi and John Stephens participated essentially with their work (Korpi 1980, 1983, 1985; Stephens 1979) to develop and complement (Korpi 2006; Huber, Stephens 2001) the theoretical approach of power resources. The power resources itself are perceived "as the attributes (capacities or means) of actors (individuals or collectives […]), which enable them to reward or to punish other actors" (Korpi 1985: 33). These actors are interlinked with each other and their number within a power domain can vary. However, the usage of power resources is connected to costs due to its mobilization and application. Typical power resources within capitalist democracies are identified as capital in the form of funds, control over the means of production and human capital connected to labour, occupational skills and education. These power resources can be linked to the socio-economic class structures of capital and labour, assigning control over means of production respectively monetary funds to the capital class and the ability to organise the human capital into a unified, collective action to the labour class (Korpi 1980: 298, 1985: 33-34).

According to Korpi (1980), the study of different levels of social inequality, as well as equality within western capitalist democracies, is one of the core tasks of welfare studies and makes an analysis of distributive processes in these countries necessary. For this purpose and to explore the interdependencies and mechanisms, the analysis requires a strong focus on the distribution of power resources. In contrast to various previous researches, Korpi assumes that the allocation of the power resources is not stable, uneven or dichotomous but rather varying over time and different countries (Korpi 1980: 297-298). Thus, the control over power resources is identified "to be of central importance for inequality" (Korpi 1980: 298).

The power resource theory is based on the idea that individuals from the working class, such as wage earners and their dependents, are supposed to have an interest in stronger welfare states. This interest is caused by these individuals being more affected by social risks such as unemployment, sickness or parenthood. Therefore they seek a high level of social protection. Furthermore, the different social classes can have diverse class-based norms and

interests and the working class is recognised as having a self-interest in redistribution of wealth through the state (Esping-Andersen 1990; Rothstein et al. 2012: 3-4). The trade unions and social-democratic parties are seen as the natural socio-political partners to address these interests. Thus, trade unions and social-democratic left-wing parties are the two main groups of social and political associations, which can activate and use the power resources of the labour class. Therefore both voter turnouts in elections for social-democratic parties, as well as the level of unionisation among the working class, are recognised as the key features for measuring the power distribution to the labour class. While the impact of trade unions was valued more at the early stage of the theory developing, the role of left-wing parties for mobilizing the labour class in the political sphere received great advocacy in later debates (Korpi, Palme 2003: 427-428; Huber, Stephens 2000). Therefore the share of vote for left-wing parties is seen as the most significant indicator and "displaced trade unions as the primary agents of working-class mobilization" (Pontusson, Hyeok Yong 2006: 5).

Although the traditional power resources approach emphasises the significance of the Social Democratic parties, it is important to mention that Christian Democratic parties also take part in the considerations about welfare state expansion. Recent studies concluded that Christian Democratic parties do not necessarily cut the welfare state but organise the public spending in a different way than their Social Democratic counterpart. The Christian Democrats aim at transfer-oriented welfare policies, which favour families rather than individuals and enhance social fragmentation. Thus, the social structure is maintained rather than refreshed (Allan, Scruggs: 2004: 505-509; Kalyvas, van Kersbergen 2010: 196-198).

The power resources approach for explaining the differently shaped welfare states in the western capitalist world has been challenged and criticized from various positions and perspectives. Mares (2003) argues that companies and employers can have similar preferences to workers or unions, regarding skill protecting social insurances.

The *variety of capitalism* approach (Hall, Soskice 2001) also highlights the significance of for the distribution of income and employment. It states that diverse corporate behaviour creates opportunities for different strategies of social policies, thus being an important factor for the emergence of differently shaped welfare states (Hall, Soskice 2001: 6-17; Soskice 1999: 104-114).

The *quality of government* approach is complementing to the power resources theory (Rothstein et al. 2012: 11). It claims that the actual support for social policies aiming for redistribution or insurance of social risks, is highly dependent on several indicators, characterising the quality of government.

3.3 Market-Oriented Power Resources

The basic idea of the power resources theory is revived by Gingrich (2011), who applies the concept of constrained partisanship for explaining the emergence of public service markets in welfare states. This concept claims that markets in public services vary in the systematical dimensions of service allocation and production. These markets can give control to either the state, users or producers and expose or protect individuals from financial risks (as illustrated in chapter 2.4). The different structures of markets have a great impact on their

distributional character. Thus, the introduction of markets into public services does not automatically advantage individuals with higher incomes over groups of lower-income.

According to Gingrich (2011) this variation in achieved redistribution, enables the left parties to strive for the introduction of markets in the first place. Furthermore, parties of the political left and right have different preferences regarding the introduction of public service markets. On the one side, left parties are supposed to seek for markets that aim to secure the financial sustainability of the welfare state, through collective financing, while integrating lower and higher income individuals. This way, all individuals contribute to the financing according to their capabilities but are granted with the same access to the service.

On the other side, the right parties are assumed to support markets that restrict public services and enhance individual responsibility, thus intensifying the fragmentation between lower and higher income individuals. In this case the financing structure emphasises the individual level thus offering better access for individuals with more resources. These preferences also match with the originally claimed positions of left and right parties towards the scope of the welfare state (Gingrich 2011: 35-42). Following this argumentation, both the parties of the left and the right will introduce market-oriented reforms, but pulling in very different directions.

3.4 Policy Preferences of CDU/CSU and SPD

Following the power resources argument, the influence on political decisions and even more the participation in governments by social-democratic left-wing parties, is a requirement for welfare state expansion. In contrast, more liberal parties and parties of the political right as well as stakeholders of employers are recognised as opponents of welfare state expansion, if not natural supporters of welfare state cutting (Korpi 1980: 306-309). This conclusion has great significance for the expected policy outcomes of healthcare reforms in Germany. The healthcare system is facing serious issues concerning its financing. The simple increase of the healthcare system's revenues, through raising the contribution rate, is considered as a very last option, due to its expected negative outcomes for the programmatic goal of unemployment reduction. Thus, the political actors are confronted with budget constraints driving their willingness to conduct reforms. The market-oriented approach of power resources revives such budget constraints as a situation, in which not only right but also left parties seek for the introduction of markets in public services. The next two sections determine the market models regarding the parties' preferences.

3.4.1 Theorising the Policy Preferences of the SPD

In coherence with the traditional power resources argument, a government headed by the SPD, as a representative of the political left, can be expected to strive for only a low level of retrenchment and cutting of the benefits' catalogue within the healthcare system. The party is also supposed to follow simple vote-seeking preferences, motivated by the assumption that the users of healthcare also represent a great part of the party's core electorate (Pierson 2001: 412-413). Thus, it can be assumed, that a Social-Democratic government aims to reduce the

costs of the healthcare system, without putting any new financial burden on these users. The cost reduction can be achieved by making the entire healthcare system more cost-efficient, through market-oriented reforms, which strengthen competitive elements among main actors of the healthcare scheme - the health insurances.

Regarding the introduction of market-oriented reforms, it can be supposed that the political left parties seek to design and implement markets, in which the state or the users acquire a high level of control. This is the case in particular for Managed and Consumer-Controlled Markets. The left wants to prevent a stronger differentiation among citizens, in terms of access to public services. Therefore the left aims for universal and uniformly maintained services, while avoiding measures of individualised allocation of services. Since Producer-Driven Markets in particular reduce the control of the state and expose users to risks of market processes, it is assumed that such market models can hardly be found on the agenda of a left government (Gingrich 2011: 37-44).

How do the expected preferences of the SPD look regarding the identified reform strategies of cost containment and recalibration? Due to the budget constraints, the SPD is expected to support cost containment reform measures but not without restrictions. Cuts of benefits are assumed being barely desired by the SPD (see above). However, the outsourcing of services from the SHI's catalogue to the budget of other institutions, such as the state itself, can be a way to avoid unpopular cuts, while relieving the budget of SHI.

The party can be expected to support the introduction of competition as a necessary core element of a market orientated reform. According to the market preferences of the left (see above) the design of competition is of great importance. Therefore the Social Democrats are expected to favour a market constellation in which users of healthcare, instead of other actors like health insurances, keep the control and are granted with more choice. In addition, the SPD is assumed to aim to prevent and reduce the fragmentation within the market. Hence the party is supposed to oppose regulations that amplify the competition between SHI and PHI and allow more individuals with higher income to opt out from SHI to PHI. Considering these presumptions, the SPD is expected to prefer competition among the SHI to encourage and reward more cost-reducing performance and refuse competition between SHI and PHI or even among the insured persons, the users.

The SPD is expected to endorse changes of the financing structure of healthcare as long as these changes do not put extra costs on the users and in particular on insured persons in weaker economic positions. The Social Democrats are supposed to support changes that strengthen the redistributional character of the healthcare insurance. In addition the party is assumed to strive for maintaining the collective financing of healthcare, which is reflected in income-related contribution rates and the involvement of employers and employees in equal terms.

The SPD is expected to be open for the recalibration of current procedures within the healthcare system. The quality of healthcare can benefit significantly by implementing new treatments and providing more prophylactic measures for the insured persons. It is also expected that the party would welcome steering against unwanted tendencies, such as abuse of medical services. Again, it can be assumed that it is important not to put the greater part of additional costs onto the users of healthcare.

According to the party's preferences, I expect the SPD to legitimise its general support for market oriented reforms and cost containment strategies with the financial constraint of the healthcare system. The stabilising of the finances is the main argument the party can

utilise for justifying measures that could be disapproved by the party's core electorate. In contrast, whenever the SPD can match its preferences with a reform, I expect the party to emphasise that the values of social justice and solidarity are achieved. This goes hand in hand with the collective financing of healthcare by equal contribution rates for employers and employees. The SPD is assumed to highlight redistributional effects and financial relief of the insured persons as a success while appreciating higher burdens on other actors such as the health insurances.

3.4.2 Theorising the Policy Preferences of the CDU/CSU

The reform policy preferences of a government dominated by the CDU/CSU, as a party of the political right, are expected to be different to those of the SPD. According to the power resources theory, the party is supposed to advocate benefit cuts and welfare retrenchment in general, much more than its political counterparts. However, the German healthcare system is characterised by a very high number of individuals being insured within the SHI (GBE-Bund 2015), which also includes a great potential constituency of CDU/CSU. Thus, it is expected that a government headed by CDU/CSU hesitates to introduce purely benefit-cutting reform policies, but rather a package of weakened retrenchment acts, in combination with other measures to reduce the costs of the healthcare system. Similar to the SPD, CDU/CSU is assumed to disapprove of an increase of the contribution rate for generating higher revenues. The party has a close bond to employers and their associations. Therefore, the party agrees that higher non-wage labour-costs are harmful for economic prosperity thus being not conducive for a reduction of unemployment. Hence it can be expected that CDU/CSU also strives for reforms aimed at cost-reduction, through the implementation of more market mechanisms. The preferences of CDU/CSU regarding market-oriented reforms are assumed to be favouring markets, emphasising the individual access under control of either the state, the users or private producers. This is the case for Austerity Markets, Two-Tiered Markets or Private Power Markets. Pork-Barrel Markets can be an opportunity when there is less budget pressure. The parties of the political right favour such markets, in order to enhance a differentiation among the users of the markets and to minimise the expenditures of the state within public services (Gingrich 2011: 12-18).

Several statements regarding CDU/CSU's attitude towards cost containment and recalibration strategies can be made based on those presumptions of the party's preferences towards healthcare reforms. The CDU/CSU, as a party of the political right, is expected to aim to reduce the costs of healthcare and public expenditures for the healthcare system. Therefore, the party appreciates cuts of benefits in a stronger way than the SPD and is further willing to put more costs on the individual users. However, the universal character of healthcare provision and its quality, is expected to remain unchanged by the party, due to the great significance of healthcare for the electorate.

The Christian Democrats are supposed to foster the fragmentation regarding the benefit structure of healthcare (see above). Therefore, the party strives for reform policies that introduce or enhance competition among the health insurances. Furthermore, the possibility for higher income individuals to opt out from SHI to PHI is a significant element of a consumer driven Two-Tiered Market situation. Thus, it can be assumed that CDU/CSU supports competition among the different SHI and in particular between SHI and PHI. Such a

competition is supposed to grant more choices to the users and facilitate switching between SHI and PHI.

The CDU/CSU is expected to endorse a change of the financing structure considering several assumptions. On the one hand, the party is less hesitant to introduce a reform that puts more costs onto users and implements individual elements of financing. On the other hand, CDU/CSU aims to decouple healthcare costs from non-wage labour costs, to relieve the employers in case of rising contribution rates.

The Christian Democrats strive for lower healthcare costs. Thus, the party is supposed to advocate recalibration within the healthcare system, in order to improve current procedures, which can be inefficient and cost-intensive. In addition, the implementation of new or preventive medical treatments is an important element for securing healthcare quality. However, CDU/CSU is expected to aim at assigning more responsibility to the users and again put greater parts of additional costs onto users of healthcare.

According to CDU/CSU's preferences, I expect the party to emphasise the need for reforms due to budget constraints of the healthcare system. When the preferences are met by the reform, the party is assumed to connect its objective of a low contribution rate to the programmatic goal of less unemployment. For this purpose, the party is supposed to endorse financial relief for the employers for decreasing the non-wage labour costs thus being beneficial for the entire economic situation. CDU/CSU is assumed to highlight the personal responsibility of the individuals to act in more cost-efficient ways by taking part in the competition. When the preferences of CDU/CSU are not matched by a reform, I expect the party to call for less redistributional effects in order to encourage insured persons to more cost-efficient behaviour.

4 Methodology

4.1 Discourse analysis

The methodological approach of the thesis focuses on the political discourse related to the respective healthcare reforms in Germany between 2002 and 2014. Therefore, a discourse analysis which examines the spoken and written expressions of the opinions of important political actors who are involved in the policy-making process is conducted.

The discourse itself is used as a term to summarize how the social world is interlinked with sentences and utterances, and how these expressions are arranged and composed in a particular way to form conversation, texts and interactions. It considers language as a tool to inject meaning into conversations (Bryman 2008: 499-501; Jones 2012: 2-7; Wagenaar 2011). These meanings can be examined by performing a discourse analysis, which is seen "as the study of language in use" (Gee, Handford 2012: 1). In this way, a discourse analysis acknowledges the mode of talking, related to the issue of interest, as the subject under investigation. Furthermore, it includes not only linguistic themes such as the framing, general tenor and wording of verbal or written statements but also their inherent meanings. Thus, it reveals and examines how language shapes and affects the discourse as well as the public perception of the examined research issue.

4.2 Material

For this thesis the discourse analysis is supposed to provide relevant information about the preferences of the two political parties during the policy-making process. Therefore, it aims to investigate how the preferences are communicated and justified. For this reason, the analysis is mainly focused on political statements and other semiotics from the leading parties of the incumbent government coalition, when the healthcare reform policies were implemented. This condition is met by the SPD and CDU/CSU. The Act on the Modernisation of the SHI (2003) belongs to the legislative period of a Red-Green coalition of SPD and the Green Party, which was led by the SPD. The Act for Strengthening Competition in the SHI (2007) was enacted by a grand coalition of SPD and CDU/CSU while the Financing Act of the SHI (2011) was introduced by a CDU/CSU-led coalition, consisting of the CDU/CSU and the Free Democratic Party (FDP).

The Act for the further Development of the Financial Structure and the Quality of the SHI (2014) belongs again to a grand coalition of SPD and CDU/CSU. The temporal range of the acts determines the time frame of the analysis to the years 2002-2014, although the majority of the documents are dated very closely to the time of policy-making and decision-taking in the parliament. The analysis utilizes primary sources such as the official

transcriptions of parliamentary debates or discussions as well as written releases like position papers, press releases, coalition agreements or programmes from the parties.

Although all parties - including the parliamentary opposition - contributed to the discourse regarding the reform policies, the analysis considers only the discourse of the SPD and CDU/CSU for each of the reform policies. This is motivated by the leading role of SPD and CDU/CSU within the diverse coalitions as well as the significance of both parties for the German political agenda. It is important to examine the discourse of both parties for all four reforms in a very detailed way, even though the SPD did not support the Financing Act of SHI. This way it can be investigated in how far the discourse of the party changed. It also provides a higher level of comparability of the results.

4.3 Validity and reliability

The thesis research aims at achieving the highest level of validity and reliability possible. The methodological approach of a discourse analysis applies the appropriate tools and mechanisms to identify the actors' discursive behaviour and determines their preferences regarding the healthcare reform policies. The statements from the parties and in particular the parliamentary debates during the bill readings offer a genuine view on how the political actors justify their diverse positions towards the policies. By utilising the discourse of the two parties who led a government coalition during at least one legislative period between 2002 and 2014, it is possible to achieve a high level of comparability of each actor's preferences over time. This enhances the external validity which leads to more credible general statements (Bryman 2008: 376-377). Nevertheless, the level of generalization is limited in terms of the parties and country. The findings of one particular country cannot be generalised to other countries which differ in their partisan settings, party or political systems.

All the used semiotics of the actors are officially released and accessible to the public, which allows other researchers to easily comprehend and replicate the findings. However, the selection of the relevant discourse elements as well as their interpretation can be subject to the personal considerations of the author. This can lead to situational bias and therefore decrease the level of validity and reliability.

5 Analysis

5.1 The four reform policies of the German healthcare system

5.1.1 The Act on the Modernisation of the SHI

On the 26th September 2003 the German Bundestag passed the legislative draft of the Act on the Modernisation of the SHI with 517 votes out of 574. The government coalition parties SPD and Green Party but also the CDU/CSU-faction[3] predominantly voted in favour of the law; however, several representatives from SPD, CDU/CSU and the entire FDP-faction rejected the proposal. The federal council approved the law on the 17th of October 2003. Hence the federal government enacted the law on the 14th of November 2003.

The Act was aiming on reducing the contribution rate for the SHI and further keeping it on a stable level. For this purpose, it introduced several important regulations for the healthcare system, including cutbacks of benefits from the SHI. The SHI was exempted from paying the costs for extraneous benefits such as maternity grant and sickness benefit, which then were covered by tax subsidies. The birth and death grant as well as the subsidy for spectacles were cancelled. Furthermore, patients were obliged to pay higher co-payments for pharmaceuticals and most non-prescribed pharmaceuticals were excluded from SHI catalogue of benefits. In exchange, the act implemented a cap for the administrative costs of the SHI until 2007 which is active as long as the costs would exceed the average administrative expenditures of all SHI by ten per cent. The SHI were committed to publish detailed records about personal and administrative costs on request of their members (Deutscher Bundestag 2003a).

The Act also focused on changing the financing structure of the SHI. The practice fee was introduced in order to enhance the personal responsibility of insured persons and promote a model in which general physicians function as gatekeepers. All insured persons of age had to pay a lump-sum of ten Euro for visiting a doctor or dentist. They were exempted from the fee if the visit was a preventive medical check-up, they visit the same physician during the same quarter or had a medical referral to another physician. Furthermore, only the insured persons and not the employers had to pay for an additional special contribution of 0.9 per cent, which was supposed to be sufficient for dental-care insurance. The act also determined the introduction of an obligatory electronic health card for 2006 in order to enhance transparency and prevent abuse of healthcare services. The insured persons were allowed to

[3] In the following, the term faction is used as a standardised label for the party's faction in the federal parliament (Deutscher Bundestag).

request receipts from their physicians to make the treatment costs more visible and comprehensible. Additionally, the SHI was allowed to offer bonus and reimbursement programmes to the insured persons as a measure to increase health insurance autonomy (Bundesgesetzblatt 2003; Deutscher Bundestag 2003a).

5.1.2 The Act for Strengthening Competition in the SHI

The Act for Strengthening Competition in the SHI was approved by the parliament on the 2nd of February 2007 with 378 votes out of 592. The majority of representatives from the government coalition factions of CDU/CSU and SPD promoted the act, while a minority of these factions as well as the entire factions of FDP, Green Party and Left Party rejected the act. This legislative draft has already been elaborated in cooperation with the federal council and was published in the Federal Law Gazette on the 26th of March 2007.

The act implemented fundamentally changes to the financing structure of the healthcare system. From the 1st of January 2009 the contribution rate of the SHI was determined by law at 15.5 per cent, from which employers contribute 7.3 per cent and employees 8.2 per cent. At the same time all contributions to the SHI from employers, employees and tax subsidies were directed and gathered in the *Healthcare Fund* (*Gesundheitsfond).* The Healthcare Fund redistributes the resources to the health insurances paying only a lump-sum for each insured person of the insurance. However, the risk structure compensation scheme was also adjusted to the Healthcare Fund and determined the allocations to the SHI on several health indicators such as age, sex or morbidity of the respective members. The SHI was also committed to offer more bonus and reward programmes to their members in order to encourage preventive medical check-ups. Several services were integrated into the catalogue of benefits such as parent-child-cures and vaccinations. In case, health insurances could not pay all their expenditures from the distributed funds, they were allowed to charge an additional contribution up to one per cent of the insured persons' gross incomes. In exchange, insured persons were offered a less complicated procedure to switch health insurance featuring a special right of cancellation and were allowed to switch from the SHI to the PHI after exceeding the Annual Income Limit for three years in a row. These measures were supposed to strengthen the competition among the SHI, thus encouraging the SHI to perform more efficient (Bundesgesetzblatt 2007; Deutscher Bundestag 2006b).

Furthermore, the performance-based remuneration for physicians was introduced, making the payment structure for physicians more transparent and comprehensible. All citizens were obliged to join a health insurance scheme, either the PHI or the SHI. This regulation also includes all citizens who were previously refused to re-enter the insurance scheme by the health insurances (Bundesgesetzblatt 2007).

5.1.3 The Financing Act of the SHI

On the 12th of November 2010 the parliament passed the Financing Act of SHI with 305 out of 558 votes. The factions of the government coalition of CDU/CSU and FDP approved the legislative draft while it was rejected by representatives from the oppositional

parties SPD, Green Party and Left Party. The act was approved by the federal council on the 17th of December and enacted on the 22nd of December 2010.

It introduced further changes of the financing structure of the healthcare system. The contribution rate was raised from previously 14.9[4] to 15.5 per cent. The employers' share was raised from 7.0 to 7.3 per cent and the employees' share was increased from 7.9 to 8.2 per cent. The contribution rate of employers was frozen at the determined value of 7.3 per cent while further rising healthcare costs were supposed to be financed through additional contribution from the employees. The amount of this additional contribution was not income related nor capped at one per cent of the insured person's income anymore. Instead, the act implemented a social compensation in case the average additional contribution was exceeding two per cent of the income. The administrative costs of the SHI in 2011 and 2012 were frozen at the level of 2010. The time period for the opportunity to switch from the SHI to the PHI after exceeding the Annual Income Limit was lowered to one year. All these measures were supposed to further stabilize the financing of the SHI, hence securing the healthcare system for the future. At the same time, the competition among the SHI and the PHI was enforced based on the assumption that the SHI was encouraged to achieve a more efficient performance. The separation of the contribution rate of employers and employees was meant to decouple healthcare costs from non-wage labour costs. This was expected to secure and strengthen the business location of Germany (Bundesgesetzblatt 2010; Deutscher Bundestag 2010d).

5.1.4 The Act for the further Development of the Financial Structure and the Quality of the SHI

The Act for the further Development of the Financial Structure and the Quality of the SHI passed the Bundestag with the votes of the coalition factions of CDU/CSU and SPD on the 5th of June 2014. Although the minority factions of Green Party and Left Party rejected the act, it was not a roll-call vote. Since the law did not have to pass the *Federal Council* (Bundesrat), it could be already enacted and announced on the 21st of July 2014.

The former implemented crucial changes in the financing structure of the SHI. The contribution rate of employers and employees in parity was re-established, cancelling the additional special contribution of 0.9 per cent from the Act on the Modernisation of the SHI in 2003. Thus, the basic contribution rate was set to 14.6 per cent, from which employers and employees both contribute 7.3 per cent. Additionally, the lump-sum additional contribution of the insured persons to the SHI was cancelled. Instead, health insurances were only allowed to charge an income-related additional contribution from the insured persons when it aimed to offset the shortfall in revenues. Moreover, the social compensation linked to a relatively high bureaucratic burden was given up as well as the opportunity for the SHI to pay a bonus to their members. In case a health insurance charged an additional contribution or increased an already existing additional contribution, the insured persons were entitled to use a special right of termination that shortened the notice period of the current contract from 18 to only

[4] The general contribution rate was decreased to 14.9 per cent (employers 7.0, employees 7.9) by a government resolution on the 1st of July 2009.

two months. The health insurance was even obliged to inform each of its members about the opportunity to switch to a cheaper insurance using the special right of termination. These regulations were expected to make it easier for insured persons to switch to more efficient and cheaper SHI while it also enhanced the competition among the SHI (Bundesgesetzblatt 2014; Deutscher Bundestag 2014b).

Furthermore, the act established a new scientific and independent institute for securing quality and transparency in the healthcare system. The latter was supposed to start working in 2015; covering tasks of quality monitoring and submitting proposals to strengthen quality or transparency within the healthcare system (BMG 2014e).

Table 1. Reform Policies and Strategies of Cost Containment and Recalibration

		Cost Containment		
Reform	Recalibration	Cut of Benefits	Competition	Financing structure
Act on the Modernisation of the SHI (2003)	- Charge of a practice fee - Physicians as gatekeepers	- Cancellation of childbirth and death grant - Exclusion of non-prescribed pharmaceuticals from SHI-catalogue - Increase of additional charges for pharmaceuticals	- SHI are forced to cap administrative costs per member at max. 10 % - Management's salary records & administrative costs have to be published	- Introduction of a practice fee
Act for Strengthening Competition in the SHI (2007)	Catalogue of benefits extended by several treatments (vaccinations)	-	- Health insurances can charge an additional contribution - Distribution ratio of revenues from Healthcare Fund rewards more efficient working health insurances	- General Healthcare Fund effective in 2009; - Contribution rate is set at 15.5 % (from 2009) - Health insurances can charge an additional contribution considering certain limitations
Financing Act of the SHI (2010)	-	-	- Income threshold (SHI) only requires to be exceeded 1 year (previously 3 years) for being legitimated to switch to PHI - Health insurances are bound to keep administrative expenditures for 2011/2012 on same level as in 2010	- Health insurances can set amount of additional contribution without limitations - Social compensation is introduced in case additional contribution exceeds 2 % of gross income - Contribution rate is increased to 15.5 %; Share of employees (7.3% + 0.9 % special contribution) is alterable while employers' share is fixed (7.3 %)
Act for the further Development of the Financial Structure and the Quality of the SHI (2014)	-	-	Insured persons get special right of cancellation in case of SHI charges or increases additional contribution SHI must notify their members about special right of cancellation and the opportunity to switch to a health insurance with lower charges	- Contribution rate is set to 14.6 %; both employees and employers contribute the same rate of 7.3 % - Charge of additional contribution must be income-related - Cancellation of social compensation

Notes: This table depicts the reform policies and identified strategies of cost containment and recalibration. The table is adapted from Häusermann (2010): 102-103.

Sources: Bundesgesetzblatt 2003; Bundesgesetzblatt 2007; Bundesgesetzblatt 2010; Bundesgesetzblatt 2014.

5.2 The discourse of SPD and CDU/CSU

5.2.1 The discourse on the Act on the Modernisation of the SHI

The following section outlines the discourse of the different involved parties during the legislative process of the reform acts mentioned above. Both SPD and CDU/CSU recognised the need for the reform in order to rebalance the healthcare financing structure while also preventing a rise in the contribution rate. The SPD highlighted that many policy measures were regrettable but were the inevitable result of budget constraints and intense negotiations. The CDU/CSU emphasised its optimism that the reform could achieve its objective to decrease the costs. The additional burdens for the insured persons were justified as unfortunate but necessary and the patients were asked to demonstrate more personal responsibility.

Initially, the discourse on the Act on the Modernisation of the SHI in 2003 is assessed; starting with statements from the SPD as the government-leading party before turning to CDU/CSU as the main oppositional party.

The SPD recognised the continuing need for reform of the healthcare system already in the coalition agreement of the 15th legislative period, which was published by the Red-Green coalition on the 16th of October 2002. It clearly called for "more quality and more competition in healthcare" (SPD, Bündnis 90/Die Grünen 2002: 53). Furthermore, the agreement attempted to put general physicians into the position of gatekeepers while it also aimed at a higher level of transparency and patients' personal responsibility (ibid: 54-56). Thereby, the SPD was the home party of the incumbent German chancellor Gerhard Schröder as well as the leading party of the government coalition. Thus, the former was centrally involved in the planning and designing process of the legislative draft. In March 2003 the government declaration from Schröder pointed out the need for reform of the German healthcare system and suspected a big share of the costs to be caused by inefficiency. Therefore, Schröder outlined a forthcoming reform that required the cooperation of all parties in the parliament and stated that "competition needs to be allowed and encouraged by the state to reduce incrustation of healthcare structures" (Deutscher Bundestag 2003b: 2490). In June 2003 the SPD and the Green Party presented an early legislative draft of the "Act of the Modernisation of the Healthcare System" (Deutscher Bundestag 2003a: 1), which again acknowledged the need to reform the healthcare system due to financial pressures and outdated structures. Among other reform measures, the draft contained the implementation of a practice fee of 15 Euro per quarter year (ibid.: 6). However, as a result of the negotiations between the government coalition and CDU/CSU and controversies within the SPD, the final draft suggested only 10 Euro per quarter.

During the second and third bill reading in the parliament in October 2003, Klaus Kirschner claimed that the final Act on the Modernisation of the SHI was the result of an extensively debated cross-party consensus which ensured quality and economic performance of the healthcare system. Nevertheless, Kirschner, who represented the SPD in the *Committee of Health and Social Security* (Gesundheitsausschuss) of the Bundestag, saw "no reason for euphoria" (Bundestag 2003c: 5466) emphasising the additional burden for the insured

persons. In the same manner, Gudrun Schaich-Walch, vice-chairperson of the SPD faction, emphasised that the three cooperating political parties took a great responsibility to maintain the solidaristic principle of the health insurance while cutting several services which are considered to be non-insurance benefits. In this way, it would be possible to achieve a stabilised contribution rate which was a primary target of the reform (Deutscher Bundestag 2003c: 5458-5459). The SPD acknowledged that the maintenance of the welfare state in the future is tied to the question of funding. The practice fee as a financial burden on users was seen as a controversial but necessary element. Accordingly, health minister Ulla Schmidt from the SPD declared at the according party-conference in November 2003 that "Social Democracy is not determined by a practice fee of ten euro per quarter year" (SPD Parteivorstand 2003: 458).

How did CDU/CSU perceive the Act on the Modernisation of the SHI? Before CDU/CSU joined the negotiations with the government coalition about a mutual legislative draft, the party criticised the legislative proposal of the Act of the Modernisation of the Healthcare System for being too paternalistic and bureaucratic, handing in its own proposal for a "liberal and humane healthcare system - think and design health policy in a new way" (Deutscher Bundestag 2003e) in June 2003. In this proposal, the Christian Democrats questioned the attainability of the government coalition's goal of lastingly lowering the contribution rate and claimed that the implementation of a practice fee will decrease the accessibility of specialist physicians, thus leading to a lower quality of healthcare (Deutscher Bundestag 2003e.: 4-6). In the further discourse, CDU/CSU clarified its willingness to cooperate with the government coalition to find a compromise solution which could be supported by all involved parties. During a parliamentary speech in June 2003 the party's chairperson Angela Merkel underlined the need for a reform and mutual goals such as a low contribution rate and a good quality of healthcare. Furthermore, she demanded a fair procedure for the negotiations but offered the "will to jointly enforce everything that we jointly can enforce" (Deutscher Bundestag 2003d: 4204).

After negotiations with the SPD and the Green Party, the CDU/CSU approved the proposal of the mutual Act on the Modernisation of the SHI. In August 2003 Wolfgang Zöller, health policy spokesperson of the CSU and vice chairperson of the Committee of Health and Social Security, pointed out that the reform could potentially decrease the contribution rate and non-wage labour costs. Zöller also emphasised the significance of keeping negotiated promises (Die Zeit 2003). Consequently, within the parliamentary debate of the second and third reading in September 2003, various CDU/CSU speakers supported the legislative draft as an opportunity to settle the financial issue of the healthcare system. Thus, the reform aimed at "securing [affordable] healthcare for everyone" (Deutscher Bundestag 2003c: 5473). Moreover, CDU/CSU claimed that its participation prevented the implementation of a "governmental healthcare system" (ibid.: 5469) by the Red-Green coalition. Furthermore, cuts of benefits and additional burdens for insured persons were justified as unfortunate but necessary and an obligatory part of a - sometimes painful - compromise. However, Zöller referred to a strengthening of the patients' position in the healthcare system and argued that "personal responsibility of patients means much more than just an increased financial burden" (ibid.: 5460).

5.2.2 The discourse on the Act for Strengthening Competition in the SHI

How did CDU/CSU and SPD perceive the Act for Strengthening Competition in the SHI in 2007? Both parties appreciated the elements of competition among SHI. The CDU/CSU considered the attempts to decouple non-wage labour costs from rising healthcare costs as a success. The party emphasised that no cuts of benefits were implemented, thus justifying the reform to be a good deal for the insured persons. The SPD highlighted the new Healthcare Fund and the reintegration of all citizens into health insurance in a positive manner. The party justified the policy as an achievement of Social Democratic politics. To begin with, how did CDU/CSU justify its position towards the act? Subsequently this section assesses the position of the SPD.

In the coalition agreement with the SPD in November 2005, both parties already stated that the quality of the German healthcare system, its medical performance and financial stability needed to be secured for the future (CDU, CSU, SPD 2005: 102-103). In a common benchmark paper with its coalition partner from July 2006, the CDU/CSU explained several reform issues. Thus, the financing structure of healthcare needed to be reformed and competitive elements among the SHI as well as regularities concerning the remuneration of physicians needed to be enhanced. CDU/CSU and SPD motivated the reform in reference to the varying healthcare quality standards across the country and inefficient use of financial resources (CDU, CSU, SPD 2006). Further on, in various press releases from 2006, the CDU/CSU claimed that the reform policy was far-reaching and trend-setting by securing health insurance for every citizen and enhancing competition and transparency within the healthcare system (CDU/CSU-Fraktion im Deutschen Bundestag 2006a). While supporting the act proposal, Zöller emphasised that "further cuts of benefits are unjustifiable" (CDU/CSU-Fraktion im Deutschen Bundestag 2006b) and consequently were not incorporated into the reform proposal considering the already introduced profound measures from the Act on the Modernisation of the SHI in 2003 (CDU/CSU-Fraktion im Deutschen Bundestag 2006c). Moreover, the CDU/CSU-faction's health policy spokesperson Annette Widmann-Mauz highlighted the efforts of the reform. Thus, it aimed to improve transparency and competition within the healthcare system and attempted to partly decouple non-wage labour costs from healthcare costs. Thereby, she was supported by Hans-Georg Faust, the vice chairperson of the Committee of Health and Social Security from the CDU/CSU who pointed out the reform's aim to further improve and secure a high level of quality of the German healthcare system (CDU/CSU-Fraktion im Deutschen Bundestag 2006d; Deutscher Bundestag 2006a: 5989-5990).

In further parliamentary debates, Zöller mentioned necessary measures such as more competition among healthcare actors, the performance-based remuneration of physicians and a middle term reduction of non-wage labour costs in order to achieve those goals (Deutscher Bundestag 2006a: 5973-5975; Deutscher Bundestag 2007a: 8011-8013). Furthermore, CDU/CSU justifieed the reform as a response to critics on the legislative draft from the parliamentary opposition as well as physicians' and health industry's associations (CDU/CSU-Fraktion im Deutschen Bundestag 2006e). CDU/CSU claimed to "consider the established structures" (Deutscher Bundestag 2007a: 8040) during the negotiations of the reform and accused the opposition of providing "no answers for the outstanding issues" (Deutscher Bundestag 2007b: 7500). During the second and third reading of the bill, different

statements of representatives such as Widmann-Mauz and Zöller depicted the party's eventual support for the reform and its positive impact on competition and transparency (Deutscher Bundestag 2007a) while being "addressed to the patients and insured persons" (Deutscher Bundestag 2007a: 8011).

How did the SPD perceive the Act for Strengthening Competition in the SHI? Basically, the SPD claimed that the act included every citizen into the insurance scheme and achieved a fair balanced competition among the SHI and the PHI while maintaining the solidaristic financing of healthcare in Germany. For this purpose, the party saw the need for a reform policy already in the beginning of 2006 stating that "solidarity stays the fundamental element" (SPD Parteivorstand 2006: 5). With Ulla Schmidt as a health minister, the party endorsed the legislative draft of the Act for Strengthening Competition in the SHI at various occasions. The SPD depicted the reform as beneficial to insured persons and patients. Thus, various party representatives pointed out that the reform policy provided health insurance for each citizen. In contrast to previous healthcare reforms, the act contained no plans for a cut of benefits instead, it placed more value on preventive treatments (Deutscher Bundestag 2006a: 5968; Deutscher Bundestag 2007a: 8018-8019). Carola Reimann, the health policy spokesperson of the SPD-faction, claimed that "benefit reductions mostly affect the weak and poor [...] and are no solutions for Social Democrats" (Deutscher Bundestag 2006a: 5981).

In the further discourse between October 2006 and February 2007, the SPD highlighted the eponymous basic principle of the reform - the strengthening of competition among health insurances. The party stated that the reform and the Healthcare Fund terminated the competition among SHIs for members with lower health risk indicators. Instead, the act strongly encouraged SHIs to compete with each other through an appropriate catalogue of benefits combined with an efficient administrative body. Insured persons were assumed to switch to more efficient health insurances while being rewarded with bonus programmes (Deutscher Bundestag 2006a: 5980-5981; Deutscher Bundestag 2007a: 8007-8008). According to Peter Friedrich, a member of the Committee of Health and Social Security, the reform was "creating more competition on the correct side" (Deutscher Bundestag 2007a: 8041). Furthermore, Schmidt stated that "we do not need 250 [statutory] health insurances nor seven national associations of statutory health insurance with seven executive boards" (Deutscher Bundestag 2006a: 5970). The SPD-faction defended the reform proposal against critique from other already mentioned (political) actors in the healthcare system and in particular from the parliamentary opposition. Thus, the opposition's critique on the reform was considered to be "contradictive in itself" (Deutscher Bundestag 2007a: 8041) and groundless; moreover, counterproposals did not become "more valid by repeating them" (Deutscher Bundestag 2006a: 5991). Finally, representatives of the SPD affirmed that constitutional concerns have been considered by the ministry's law department and various court decisions. Hence, discussions on constitutional concerns were irrational (Deutscher Bundestag 2007b: 7489; 7497).

5.2.3 The discourse on the Financing Act of the SHI

Starting with the CDU/CSU and continuing with the SPD, how did both parties justify their preferences towards the Financing Act of the SHI? The CDU/CSU appreciated the changes of the financing structure and recognised great attempts to relieve the employers and

economy from more burdens. The reform was justified because it promoted cost-efficient behaviour of insured persons and SHI, as well as tackled the financial deficit. In contrast, the SPD condemned most reform measures as unjust for individuals with lower or middle incomes and as enforcing a three-class healthcare system? The party disapproved of the policy and in particular the non-income related additional contribution as a "capitation fee".

In October 2009 CDU/CSU considered a further healthcare reform with the goal to create and promote an innovation friendly, performance-focused and future-securing financed healthcare system. Moreover, the coalition agreement with the FDP stated financing and competition as prominent features of such a policy (CDU, CSU, FDP 2009: 84-87). During the governmental declaration in November 2009, the federal chancellor Angela Merkel declared that there was a need for a "stronger decoupling of non-wage labour costs from healthcare costs than today" (Deutscher Bundestag 2009: 36). In September 2010 the legislative draft of the Financing Act of the SHI was introduced; it depicted the initial point of further intense discussions in the parliament. The CDU/CSU stressed that the SHI's estimated financial deficit in 2011 was about nine billion Euro and thus justified a strong need for action. Various party representatives declared that "this deficit needs to be sorted out first" (Deutscher Bundestag 2010a: 6476) with the "participation of all healthcare [actors]" (Deutscher Bundestag 2010b: 7866). Furthermore, the CDU/CSU claimed that the opposition and in particular the SPD had no elaborated and economically tested alternative concept. Instead, the Christian Democrats argued that the opposition propagated untrue accusations and suggested that the critique was mostly unfounded (Deutscher Bundestag 2010a: 6469-6471; 6478-6480).

Furthermore, Dietrich Monstadt from the Committee of Health and Social Security argued that "the SPD does not remember its own actions" (Deutscher Bundestag 2010c: 7470) while the vice chairperson of the CDU/CSU-faction Johannes Singhammer stated that "once [referring to the last legislative period] the SPD acted responsibly and was part of the decision-making" (Deutscher Bundestag 2010a: 6460). Finally, the Christian Democrats announced that by setting a default value for the employers' share of contribution rate, the reform policy was an important step to decouple healthcare costs from non-wage labour costs. "This is just, [...] because it ensures jobs and brings more people from unemployment to employment" (ibid.: 6460). For insured persons, exactly calculated additional contributions were more comprehensible than a percentage of wage. Consequently, there would be "a whole new willingness to switch" (ibid.: 6473) to health insurances with lower rates but the same catalogue of benefits. Thus, the introduction of unlimited additional contributions and a social compensation for low-income individuals allowed even more competition among the SHI.

How did the SPD perceive the Financing Act of the SHI? In the first half of 2010 the Social Democrats already accused the government coalition and their healthcare reform ambitions of following an unsatisfactory agenda of clientelism. The party claimed that the coalition "primarily aims on unburdening the employers" (SPD-Bundestagsfraktion 2010b) and "make[s] the insured persons pay the bill alone" (SPD-Bundestagsfraktion 2010a). The chairperson of the Bundestags-faction Frank-Walter Steinmeier declared that the reform plans were a disaster; since as the reform would mostly affect individuals with low and middle incomes, it would be unsocial (ibid.). The SPD referred to the status of the healthcare system after the SPD participation in government until 2009 and called for a *Citizens Insurance* (Bürgerversicherung) that would aim to integrate members from the PHI into the SHI (SPD-Bundestagsfraktion 2009). Inasmuch, the SPD explicitly refused to accept the proposal of the

Financing Act of the SHI for various reasons. The expected changes to the contribution rate were seen as the "beginning of the termination of financing in parity" (SPD-Bundestagsfraktion 2010c) and show how the coalition intended to "cash up pensioners and low-income individuals" (Deutscher Bundestag 2010b: 7872). Carola Reimann, chairperson of the Committee of Health and Social Security, criticised the competition elements of the reform as to the advantage the PHI. Thus, it would not tackle "unequal treatment of PHI and SHI members which is a major issue of the healthcare system" (Deutscher Bundestag 2010a: 6481).

Furthermore, the SPD doubted the effectiveness of the stimulus for especially older people to switch the health insurance. The SPD perceived the additional contributions as a partial introduction of a *Capitation Fee* (Kopfpauschale) although the CDU/CSU denied that they pursued this project any longer (Deutscher Bundestag 2010a: 6477-6478). The SPD announced that the regulation for the elective reimbursement of healthcare treatment costs for member of SHI marks the starting point for a "three-tier-system of healthcare" (SPD-Bundestagsfraktion 2010d). This change was further seen as a hidden gift to the physicians to cash up additional services considering that the "average rate of reimbursement for the members of SHI is just at 50 per cent of the costs" (Deutscher Bundestag 2010b: 7860). The spokesperson of the SPD in the Committee of Health and Social Security Karl Lauterbach accused the coalition of pursuing "clientele politics for employer associations and the PHI" (Deutscher Bundestag 2010a: 6468) and complained about the PHI being excluded from additional burdens. The vice chairperson of the SPD-faction Elke Ferner summarised the critique of the SPD by stating that the "reform proposal shows the true attempt to break the welfare state with a wrecking ball" (Deutscher Bundestag 2010a: 6457).

5.2.4 The discourse on the Act for the further Development of the Financial Structure and the Quality of the SHI

How did firstly the CDU/CSU and secondly the SPD justify its position towards the Act for the further Development of the Financial Structure and the Quality of the SHI? Both parties revealed their contentment about the elements of further competition among the SHI, and the creation of more incentives to perform more cost-efficiently. The CDU/CSU regretted the cancellation of the non-income related additional contribution but justified its support as a necessary trade-off for the political compromise. The party was satisfied with lower contribution rates in order to foster economic growth. In contrast, the SPD was pleased with the cancellation of the lump-sum additional contributions. The party recognised the reform measures as socially compatible. The SPD stated that the policy did not reach far enough and justified it as a political compromise with trade-offs for both sides.

In December 2013 the coalition agreement between CDU/CSU and SPD announced several changes concerning the financing of the healthcare system (CDU, CSU, SPD 2013: 59) due to the expected consequences of the demographic change (CDU/CSU-Fraktion im Deutschen Bundestag 2014). Accordingly, the legislative drafts from April and May 2014 emphasised the "positive development of the SHI finances in the last years" (Bundesrat 2014: 1) while also estimating that "the yearly healthcare expenditures of the SHI will exceed the yearly revenues of the Healthcare Fund" (Deutscher Bundestag 2014a: 1) in the future. The Christian Democrats appreciated the reduction of the contribution rate as a relief for insured

persons and the continuous fixed determination of the employers' rate at 7.3 per cent since the healthcare costs would remain decoupled from non-wage labour costs. According to health minister Hermann Gröhe this regulation promoted growth, prosperity and consecutive employment by "preventing additional [financial] burden through increasing non-wage labour costs" (Deutscher Bundestag 2014c: 2867).

Furthemore, the health policy spokesperson of the CDU/CSU-faction Spahn regretted the abolition of the lump-sum additional contributions and highlighted that compromises require a "working-together of both sides" (ibid.: 2874). In exchange, the CDU/CSU was satisfied with the introduction of the income-related additional contribution by the SHI. It was supposed to encourage the SHI to invest in even more efficient administrative processes in order to "avoid losing members to competitors" (ibid.: 2884). The party emphasised the exceptional right to terminate the charge of additional contributions for members of the SHI; setting the "price competition at the level of the amount of additional contributions" (Deutscher Bundestag 2014c: 2881). Further on, various party speakers claimed that the reform also provided appropriate measures to increase and monitor the quality of healthcare. The parliamentary state secretary Widmann-Mauz claimed it introduced an "independent and scientific institute" (Deutscher Bundestag 2014d: 3373) that could secure quality and transparency in the healthcare system. Accordingly, it should provide precise information about faults and inefficiencies within the healthcare scheme. Moreover, the CDU/CSU accused the parliamentary opposition of being inactive and emphasized their own actions (ibid.: 3381).

How did the SPD perceive the Act for the further Development of the Financial Structure and the Quality of the SHI? As the coalition partner of CDU/CSU, the SPD basically shared the goals of the mutual coalition agreement. Besides, the SPD also highlighted the need for a reform in order to secure the financing of the SHI in the future and to enhance competition among the SHI (Bundesrat 2014: 1-3; Deutscher Bundestag 2014a: 1-3). The abolishment of the "unspeakable [...] capitation fee" (Deutscher Bundestag 2014d: 3379)was a declared goal of the Social Democrats. The SPD considered lump-sum based additional contributions as being a "small capitation fee" (SPD-Bundestagsfraktion 2014a).

Accordingly, Lauterbach proclaimed the rejection of non-income-related additional contributions and the integration of income-related additional contributions "as a step towards more solidarity in our healthcare system" (Deutscher Bundestag 2014d: 3375). Although the SPD considered income-related additional contributions to be more fair, the party was not satisfied with the persisting fixed determination of the employer's contribution rate. In addition, the SPD strived for an upheaval of the SHI's financing through a Citizens Insurance (ibid.: 3375-3376). However, various party speakers stated that cooperation in a coalition requires negotiations, making "compromises necessary" (Deutscher Bundestag 2014c: 2877) and makes the deferment of several goals unavoidable. Furthermore, the Social Democrats emphasised that the reform policy was supposed to promote solidarity; thus, an revenue compensation for the SHI will be introduced within the risk structure compensation scheme for the SHI. It strengthened the position of the health insurance funds with a low-income member structure. Thus, the income compensation scheme enhanced the competition among SHI while also supporting members (Deutscher Bundestag 2014c: 2872; SPD-Bundestagsfraktion 2014b). Moreover, the SPD was in favour of introducing an independent institute for securing quality and transparency in the healthcare system. Accordingly, it is supposed to collect and examine data in order to find weak points and elaborate on solutions.

The prevention of unnecessary expenditures and procedures from healthcare actors such as hospitals was a main objective (Deutscher Bundestag 2014c: 2883). Overall, the SPD strongly supported the Act for the further Development of the Financial Structure and the Quality of the SHI and promoted it.

5.3 Discourse Analysis

This section analyses and discusses the reform policy related discourse of both SPD and CDU/CSU. For this purpose, the positions and justification of the parties are examined considering the expected policy preferences of the parties.

5.3.1 Discourse Analysis of the Act on the Modernisation of the SHI

The first analysis scrutinises the discourse related to the Act on the Modernisation of the SHI by the SPD, followed by CDU/CSU.

The Act on the Modernisation of the SHI contained a couple of measures that were aimed at reducing healthcare costs through cost containment strategies. While several benefits such as death and birth grants were cut from the SHI catalogue, others like maternity grant and sickness benefit were outsourced and financed by the state. The competition among SHI was increased in a rather slight level. The SHI were obliged to cap administrative costs until 2007 and publish records of their administrative expenditures. Nevertheless, the opportunities for users to switch between SHIs were not enhanced. The financing structure was changed by implementing the additional special contribution of 0.9 per cent as well as the practice fee of ten euro. Both measures placed additional costs for healthcare onto users. The practise fee regulated the access on an individual level and was supposed to establish and strengthen a gate-keeping function of general physicians in order to lower the cases of self-referrals. It was claimed that such gatekeepers and fees could be helpful in decreasing the number of - from a medical perspective - unnecessary and expensive visits of specialist. From this perspective, both concepts were intended as recalibration strategies to change an unwanted behaviour of the users.

According to the applied theories of power resources and partisanship as well as the derived policy preferences of the Social Democrats, most measures of the Act on the Modernisation of the SHI were designed in a way that does not fit to the expected party preferences. The strategies for cost containment and recalibration burdened the insured persons with extra costs and even emphasised individual levels of healthcare financing. Moreover, the introduction of an additional special contribution just paid by employees removed the parity in the financing of SHI between employers and employees. However, the outsourcing of benefits by shifting the financing from SHI to the state's budget matches the preferences of the SPD for a strong state. The slightly enhanced competition among SHI is also in favour of assumed SPD preferences. Overall, the reform did mostly not meet the preferences of the party, although the SPD was essentially involved in its design and implementation.

In the political debates the SPD stressed that the reform is necessary due to the in-deficit financing of health care and inefficiencies within healthcare structures. The party recognised the budget constraints and the need to act in responsibility to secure the future financing of the German healthcare system. The driving force was the reduction of healthcare costs while also preventing a further rise in the contribution rate. Therefore, the party accepted the reform as inevitable and claimed that Social Democracy is not defined by these individual measures. However, various speakers of the SPD acknowledged that the reform contains many deep cuts for the insured persons and expressed their regret about it. Furthermore, the party highlighted the reform being a product of very intense negotiations with CDU/CSU and declared that political compromises necessitate making unpleasant decisions. Overall, the SPD approved the reform and was crucially involved in its implementation and justification even though most of the reform contents were in conflict with the expected party preferences.

In how far did the reform meet the preferences of CDU/CSU and how did the party justify its position? According to the theoretical considerations of this thesis, the Christian Democrats are supposed to endorse expenditure reducing reforms including cutbacks of healthcare benefits in a considerably stronger way than the SPD. Moreover, CDU/CSU is assumed to aim at reducing the financial burden of employers and being less hesitant to put more costs on the individual users. The party is expected to prefer market reforms, which stimulate the competition among health insurances while requesting more personal responsibility and choices for the insured persons.

The applied cost containment strategies had great potential for cost-saving effects by putting more personal responsibility and direct costs onto insured persons. The introduction of a practise fee even strengthened the individual dimension of healthcare access while gatekeeping physicians were supposed to counteract inefficient processes. Although CDU/CSU indeed advocated higher co-payments for each medical treatment, those kinds of recalibration measures fit the party's preferences. Moreover, the additional special contribution for employees relieved the employers and was an initial step to decouple healthcare cost and non-wage labour costs. Nevertheless, the financing of services by the state instead of the SHI is not in the interest of the party. The implemented elements of competition were rather marginal and do not match CDU/CSU preference for more competition. Overall, the reform policy of the Act on the Modernisation of the SHI matches the expected policy preferences of CDU/CSU in most cases. Thus, it can be assumed that the party enforced most of the reform measures.

In the political discourse CDU/CSU highlighted the significance of their participation in the decision-making process for averting a strongly criticised reform proposal from the government coalition. Hence, the party announced confidently that the Act on the Modernisation of the SHI can achieve its main objective of lowering and stabilizing the contribution rate to SHI without creating more bureaucracy. Although the party doubted the compatibility of the practise fee with a guarantee for high healthcare quality, the introduction of new financial burdens on users was appreciated as unfortunate but necessary. Representatives of CDU/CSU demanded more personal responsibility of healthcare users even beyond the reform measures. Although the reform mostly matched the assumed policy preferences, the Christian Democrats took great efforts to actually justify their support for the reform.

5.3.2 Discourse Analysis of the Act for Strengthening Competition in the SHI

The next section scrutinises the discourse related to the Act for Strengthening Competition in the SHI by the government leading party CDU/CSU, followed by the government coalition partner SPD.

The Act for Strengthening Competition in the SHI comprised of different measures to reform the healthcare system. The greatest changes were conducted regarding the financing structure and competition. The introduction of the Healthcare Fund as the main institution for pooling and redistributing health insurance contributions to the SHI changed the financing structure and strengthened competition at the same time. On the one side, it ended the structural advantages for SHI with a higher-income and lower-risk member structure, hence encouraging SHI to work more efficiently and achieve their performance goals with similarly structured revenues. On the other side, the SHI had to pay all expenditures from the Healthcare Fund's allocations and were obliged to charge an additional contribution up to one per cent of the insured persons' gross income in case they needed more funds. This additional contribution was supposed to put more costs onto individual users of healthcare if they were hesitant to switch to other SHI with lower or no additional contributions. The opportunity for higher-income individuals to opt out to PHI was subject to the condition of exceeding the Annual Income Limit for three consecutive years. Furthermore, the general contribution rate was determined by law at 15.5 per cent, from which employers had to pay 0.9 per cent less than employees. Instead of cutting services, the reform added several services such as vaccinations to the SHI's catalogue. In addition, the reform paved the way for all citizens to re-join a health insurance scheme even if they had been rejected previously. These kind of slight recalibration measures were supposed to enhance health quality among the population and did not put any extra costs onto users.

In how far do the reform measures match with the expected preferences of CDU/CSU? The implemented strategies for cost containment enhanced the competition between the SHI but also between SHI and PHI. The SHI had to compete with each other for new members regardless of their medical history or income. The users were granted more choices to switch health insurances to punish inefficient performance, thus enhancing the competition. Moreover the insured persons faced a risk of bearing higher individual costs in case they did not carry out their personal responsibility. The change of the contribution rate further developed a different contribution structure between employers and employees in favour of the employers. The recalibration measures were supposed to improve healthcare quality and meet the party's preferences. Overall, all of the reform actions matched with the expected preferences of CDU/CSU. Therefore, I expect that the party to endorsed the policy in the discourse.

In the political discourse the party stated that further reforming of the healthcare system was necessary for securing healthcare quality and sustainable financing. For this purpose, various party speakers emphasised the significance of the Act for Strengthening Competition in the SHI for more competition and a new, rather efficient financing structure. The party highlighted its satisfaction with the advancing decoupling of healthcare costs from non-wage labour costs. In addition, CDU/CSU appreciated the secured healthcare quality and presented the inclusion of all citizens into health insurances without any cutbacks as a great achievement and claimed the reform was made for the insured persons. The reform policy

matched the expected policy preferences of the Christian Democrats. They, in turn, expressed their satisfaction with the reform and justified the measures as being necessary to secure the healthcare system.

In how far did the reform meet the policy preferences of the SPD? The Healthcare Fund integrated another redistributive element to the healthcare financing without putting more costs on users. In contrast, the unequal general contribution rate and in particular the additional contribution rate disadvantaged insured persons and paved the way for putting more costs on the users. Therefore, the party preferences were only met partly regarding the financing structure changes. The SPD was supposed to support the enhanced competition between SHI, which granted the users with more choices and control. But it was assumed to oppose a competition that also enhances the fragmentation of healthcare, which is represented by the stronger competition of SHI and PHI. Overall, the policy preferences of the Social Democrats are only met partly by the Act for Strengthening Competition in the SHI. Thus, I assume that the party revealed an indecisive attitude in the discourse.

However, the political discourse of the SPD was characterised by a positive attitude towards the reform. The combination of the reintegration of all citizens into healthcare insurance, enhancing the competition among SHI in a SPD-favoured manner and having no cutbacks was seen as the result of Social Democratic work. The party appreciated the implementation of the Healthcare Fund and expected the SHI to work even more efficiently while competing for all individuals and not just for the ones with lower risks or higher incomes. The SPD recognised the healthcare system as securing solidarity through the reform measures and passionately defended the policy against oppositional critique. Although the expected preferences of the SPD were only matched partly, the party strictly endorsed the reform in the political discourse.

5.3.3 Discourse Analysis of the Financing Act of SHI

The following section examines the preferences and discourse regarding the Financing Act of SHI from CDU/CSU as the government-leading party and then SPD as an oppositional party.

The reform did not enact any cutbacks of healthcare services nor recalibration measures. Instead, the focus was on the remaining cost containment strategies regarding financing structure and competition among health insurances. The general contribution rate was reset from 14.9 to 15.5 per cent and employers had to contribute 7.3 per cent and employees 8.2 per cent. The employers' share was frozen at this value and it was determined that only the employees would pay for rising healthcare costs in the future. They were charged a non-income-related additional contribution that was set only by an SHI that demanded more funds. This way, the reform clearly intended to put extra costs onto individual users while again relieving the employers. However the choice was still granted to the users to switch to another SHI or PHI to avoid extra costs. The insured persons were allowed to switch to PHI after exceeding the Annual Income Limit for only one year. The administrative costs of SHI were frozen for the next two years. All these measures were supposed to enhance the competition between SHI and PHI and encourage SHI to perform more efficiently. The costs of this competition were not put onto users but the system fragmentation between SHI and PHI was intensified.

How did the reform match with the expected policy preferences of CDU/CSU? The reform again emphasised the personal responsibility of insured persons to switch to cheaper SHI or PHI in order to avoid higher costs. Furthermore, the competition was strengthened within the fragmented structure, offering more options for higher-income individuals. This way more choices were granted to the users. These measures match the CDU/CSU preferences. The changes in financing structure aimed at decreasing the non-wage labour costs. These were decoupled from rising healthcare costs by freezing the employers' share. In contrast, the insured persons had to bear extra costs introduced by the new lump-sum additional contribution. Overall, these reform measures matched with the expected preferences of the Christian Democrats. Therefore, I expect that the party to strictly supported the reform in the parliamentary debates.

The party welcomed the new additional contribution for insured persons as well as the fixed value for the employers' share as great achievements. These measures were appreciated as making labour cheaper, thus decreasing unemployment and giving more incentives to insured persons to switch to a better performing or cheaper SHI. CDU/CSU recognised the urgent need to reform the healthcare system in order to decrease financial pressure on it. The party criticised other political actors, in particular the SPD, for not taking the responsibility to act. Overall, CDU/CSU expressed its contentment with the reform policy, which matched the expected preferences of the party. The reform was justified as solving the estimated deficit of the healthcare system.

In how far did the Financing Act of SHI meet the expected preferences of the SPD? The changes in financing structure continued to disadvantage the insured persons and reduced the redistributive character by introducing a non-income-related additional contribution. Thus, the reform placed more costs on the individual healthcare users. This contradicted the expected policy preferences of the SPD. The enhanced competition between SHI and PHI increased the fragmentation within the healthcare system. At the same time, the SHI also had stronger competition with each other in order to encourage more cost-efficient performances. Thus, the competition strategies did partly not match the expected preferences of SPD. Overall, the party's preferences were mostly not met by the Financing Act of SHI. For this reason, I assume that the SPD vehemently disapproved the act in the discourse.

Indeed, the SPD refused the changes in the financing structure and claimed it was not socially compatible and disadvantaged people with lower or middle incomes. The non-income-related additional contribution was perceived as the introduction of a capitation fee and strictly opposed by the party. The SPD criticised the competition related strategies for strengthening the position of PHI against the SHI instead of equalising it. The party depicted a future healthcare system as a three-class system in which wealthier individuals would be provided with higher healthcare quality than the rest of the population. Overall, the SPD perceived the reform as a threat to the welfare state and strongly refused to support it. This fits to the expected policy preferences of the party.

5.3.4 Discourse Analysis of the Act for the further Development of the Financial Structure and the Quality of SHI

The next section scrutinises the discourse and party preferences related to the Act for the further Development of the Financial Structure and the Quality of SHI by the government leading party CDU/CSU, followed by the government coalition partner SPD.

The reform policy conducted crucial changes in the financing structure of SHI. Both the additional special contribution of 0.9 per cent as well as the lump-sum additional contribution were cancelled, setting the contribution rate for employees at 7.3 per cent. Thus, the insured persons were relieved from extra costs and the general financing of healthcare was again equalised between employers and employees. The fragmentation was reduced by decreasing the contribution rate for employees hence giving fewer incentives to switch to PHI for reasons of cost-avoidance. The SHI were allowed to charge an income-related additional contribution with a more redistributive character from the insured persons only in case they needed more funds. This way the act created the opportunity to put additional costs onto users in a more collective way compared to the lump-sum additional contributions of the Financing Act of SHI in 2011. However, the competition among SHI was enhanced by granting a special right of termination to the insured persons in case SHI charged or raised the additional contribution. The SHI were obliged to inform their members about the opportunity to switch to another and cheaper SHI. Moreover, the social compensation for insured persons with lower income was cancelled and the SHI were not allowed to pay out bonus to its members anymore. Thus, the reform provided the users with greater incentives to avoid the additional costs and encouraged the SHI to operate more cost-efficient. The users were again granted the choices to act self-responsible. There were no more cutbacks or recalibration measures enacted.

How did the Act for the further Development of the Financial Structure and the Quality of PHI meet the expected policy preferences of CDU/CSU? The reform enhanced the competition among SHI while slightly decreasing the fragmentation. The insured persons with higher income were provided with fewer financial incentives to switch to PHI. However, the general regularities that made switching to PHI less complicated were still kept in force. Furthermore, the insured persons were granted choices and more incentives to actively avoid extra costs. Therefore, these measures matched the expected preferences of CDU/CSU only partly. The financing structure was changed in favour of the insured persons by cancelling several additional costs. Nevertheless, the employers did not have to bear any extra costs continuing the policy of the Financing Act of SHI. Although CDU/CSU was supposed to prefer an individual to a collective cost structure, the party was assumed to appreciate the additional contribution for the users in order to encourage them exercising more personal responsibility. Again, the party's preferences were only met partly. Thus, while the reform did not adhere to the expected preferences of CDU/CSU, it was not completely contradictive to their stance. Therefore, I expect that CDU/CSU perceived the reform in an indecisive way.

Various CDU/CSU representatives regret the cancellation of the lump-sum additional contribution and emphasised that making compromises often requires trade-offs. On the other side the party was highly satisfied with the reductions of contributions in general as well as the fixed contribution rate for employers. The party declared that lower contribution for healthcare are fostering the economy. CDU/CSU appreciated the further developments of competition among SHI. Moreover, the party announced that the additional contribution in

combination with the right of termination creates a price competition based on the additional contribution. Thus, the SHI was assumed to be strongly encouraged to operate more cost-efficiently. Although the reform did not meet the party's preferences, the Christian Democrats perceived the reform being necessary to counteract estimated rising healthcare costs in the future. The attitude of CDU/CSU was surprisingly positive.

In how far did Act for the further Development of the Financial Structure and the Quality of SHI match with the expected preferences of the SPD? The cancellations of both the additional special and additional contribution as a lump-sum relieved the users and weakened the cost-related incentives for higher-income individuals to switch to PHI. Thus, the fragmentation of the healthcare system was slightly decreased. The implemented additional contribution was redesigned by substituting the lump-sum element with an income-related structure. Hence, the extra costs were redistributed among individuals with different income levels, strengthening the redistributive and collective character of the SHI's financing structure. Therefore, the measure targeting the financing structure mostly matched with the expected preferences of the Social Democrats, even though the party is assumed to oppose extra costs on the users. The enhanced competition granted more choices to the users. Insured persons were allowed to switch faster and less complicated to more cost-efficient SHI in case of rising additional contributions. The SHI had to outline the costs for their members more transparently and faced the risk to lose members in response of rising additional contributions. Nevertheless, insured persons that were hesitant or not used to carry out the personal responsibility were burdened with extra costs. The changes of the competition among the SHI matched the assumed preferences of SPD rather more than CDU/CSU. Overall, the reform mostly adhered to the expected policy preferences of the Social Democrats. Thus, I assume that the SPD appreciated the reform in a stronger way than CDU/CSU.

How did the party perceive the reform in its political discourse? The SPD emphasised its contentment about the cancellation of the lump-sum additional contribution, which was perceived as a small capitation fee that disadvantaged lower-income individuals. Moreover, the Social Democrats highlighted that the healthcare system becomes more just. The SPD also appreciated the enhanced competition among the SHI and declared the income compensation for SHI within the risk structure compensation scheme as a key measure for a socially fair competition. Nevertheless, the party articulated critique on the reform for not going far enough and still preventing the employers to contribute a greater share to healthcare financing. The SPD announced that main objective has to be to change the entire healthcare structure by introducing the citizen insurance. However, the party justified the reform for being a compromise of the government coalition thus the result of negotiations and trade-offs for both sides.

Although the reform mostly matched the expected policy preferences of the SPD, the party partly criticised the reform for being too reluctant. The Social Democrats even justified their support for the reform. Therefore, the SPD expressed its satisfaction with the Act for the further Development of the Financial Structure and the Quality of SHI not in a particular stronger way than CDU/CSU.

6 Discussion and Conclusion

This chapter puts the central statements of the previous sections into context with the findings of the analysis. This way, the findings of the analysis can be discussed in order to conclude the final statements of this paper.

The organisational level of the German healthcare system is fundamentally determined by the interaction of SHI, PHI, hospitals, physicians and insured persons. Several laws and principles regulate and control the access and terms of healthcare. The German population is covered by health insurance that relates to medical treatments. The greatest share of the health insurances' revenues is borne by the insured persons, either through income-related contributions from both employers and employees (SHI) or premium-based payments (PHI).

The costs of healthcare in Germany sharply increased during the last decades. The share of healthcare costs in relation to the GDP rose from six per cent in 1970 to more than ten per cent in 2001, while the total healthcare expenditures increased ten-fold during this time period. The revenues and costs of the healthcare system were unbalanced and led to a deficit for the SHI. This paper identifies various reasons for this situation. The technological progress increased the price for healthcare and the aging population needed more extensive medical treatments. Moreover, the period of economic austerity after the oil crisis in the 1970s hampered economic growth and prosperity. Growing unemployment in turn undermined the financial pillar of healthcare by reducing the revenues for SHI.

The healthcare system was in need of reform, which aimed to rebalance healthcare financing without depressing the economy by increasing the contribution rate. This would also increase the non-wage labour costs, thus increasing labour costs and hamper the struggle against unemployment. However, the decrease of unemployment is the programmatic objective of both dominating parties in German politics, SPD and CDU/CSU. Thus, other reform policies had to be considered.

This paper introduces several possible reform options with a strong focus on market-oriented reforms. It examined the different options for public service markets and what the consequences for insured persons as users of such markets would look like. Moreover, the strategies for cost containment and recalibration are elucidated and identified regarding the reform policies. The healthcare reforms are substantially designed by political actors. Therefore, the preferences of the SPD and CDU/CSU concerning the different markets and reform options needed to be examined.

For this purpose, the theoretical concept of partisanship is applied as a foundation for the traditional and market-oriented power resource theory. These theoretical frameworks provide profound information about what to expect about the preferences of the political left and right regarding welfare state retrenchment and expansion. The traditional power resource theory emphasises the significance of Social Democratic parties for welfare expansion and right parties for welfare cutbacks. However, this position does not explain why the SPD substantially participated in the decision-making process of reforms that implemented more market mechanisms within the healthcare system. The theoretical idea of market-oriented

power resources introduces different market types and explains the policy preferences of the typical partisan camps, which I linked to SPD and CDU/CSU. According to Gingrich (2011), the left parties do not hesitate to implement market mechanisms into public services to counteract budget or quality issues. However, left parties prefer to assign control within the market to the users or the state, maintain a more universal level of access to the service and aim at achieving a collective financing structure. In contrast, the right parties favour allocating more control to private producers of services and amplifying the fragmentation among individuals within the service structure. The Right is expected to seek lower public expenditures and is less hesitant to put more costs onto users.

The main analysis section of this paper scrutinises the political discourse of SPD and CDU/CSU in relation to the selected healthcare reforms. According to the theoretical considerations of this thesis, the SPD is expected to support market-oriented reforms in order to enhance competition among SHI forcing health insurances to increase cost-efficiency. The party is supposed to disapprove of both extra costs on the users and a growing fragmentation of the benefit structure. The SPD is assumed to seek measures that maintain or strengthen the redistributional character of healthcare.

In contrast, the Christian Democrats are supposed to endorse expenditure reducing reforms including cutbacks of healthcare benefits in a considerably stronger way than the SPD. Moreover, CDU/CSU is assumed to aim at reducing the financial burden of employers and being less hesitant to put more costs on the individual users. The party is expected to prefer market reforms, which stimulate the competition among health SHI and between SHI and PHI, while requesting more personal responsibility and choices for the insured persons.

The expected party preferences are utilised to draw a line between the reforms and the parties' discourse. For this purpose, the reform acts are examined considering the strategies for cost containment and recalibration.

The discourse analysis of this paper presents interesting findings. In the political discourse the Social Democrats supported the Act on the Modernisation of the SHI as well as the Act for Strengthening Competition in the SHI, although the former policy was mostly and the latter one partly in conflict with the expected preferences of the party. Although the party was involved in designing the reforms, both policies put more costs on insured persons. The competition elements were so small that they did not outweigh the extra burden for the users.

The SPD strongly rejected the Financing Act of SHI in its discourse and acted as expected, since the reform mostly contradicted the party's preferences. On the other hand, the Act for the further Development of the Financial Structure and the Quality of SHI matched mostly with the SPD's preferences. The party expressed its satisfaction with the policy but endorsed it in a weaker way than CDU/CSU. Overall, the SPD supported two reforms it was not expected to but disapproved of one reform as expected. The fourth policy was endorsed in a weaker way than assumed.

The Christian Democrats expressed their contentment with the reform policies of the Act for Strengthening Competition in the SHI and the Financing Act of SHI and justified their support due to the budget constraints of the healthcare system. Both reform policies actually matched the expected preferences of CDU/CSU. The party acted as assumed.

However, CDU/CSU took great efforts to justify its endorsement of Act on the Modernisation of the SHI, although the policy mostly met its preferences. Finally, the party expressed its satisfaction with the Act for the further Development of the Financial Structure and the Quality of SHI. This is an unexpected outcome, because the reform adhered the least

to the party's expected preferences and even the SPD criticised the act. Overall, the CDU/CSU supported four reforms, all of which adhered to its preferences in most cases. The party justified its position in two cases much stronger than expected.
How can these findings of at least partly contradicting discourse and party preferences towards the reforms be explained?

The parties utilised the discourse to justify their support for the healthcare reforms, even in cases when the reform measures actually matched the party's preferences. It can be stated that by justifying instead of purely endorsing a reform the parties do not intend to refuse the policy. The justification could rather be seen as a strategy to explain and legitimise each particular reform in order to follow vote seeking preferences and avoid the electoral blame for unpopular political decisions.

The reforms were designed in a way that mostly matched with CDU/CSU preferences. Even though the party kept on justifying its support, the endorsement actually fit to the expected preferences in most cases. The SPD had contradictive preferences for the markets in three out of four reforms. The Social Democrats participated in the government coalition when two of those three reforms were enacted. Why did the expected preferences not meet the policy outcome? Why did the SPD – at least in two cases - support healthcare reforms that do not fit to their expected partisan preferences? The concepts of partisanship and power resources cannot answer this question sufficiently, since the SPD actually had access to the political power resources.

The budget constraints related to healthcare could have a greater impact on the parties than estimated. The parties shared the assessment that the deficit in financing determined the need for reforms. In this regard, it can be of great importance that the SPD was part of the government and also needed to prove its capability to act and take responsibility, even accepting that the introduced measures could contradict the party's core preferences. Nevertheless, a minority of SPD representatives in the parliament rejected the Act on the Modernisation of the SHI and the Act for Strengthening Competition in the SHI. The party was partly divided due to the essential reform measures. It can be considered that the party needed the parliamentary support from CDU/CSU in order to conduct the reform project. It is not the only instance that the SPD accepted the support from CDU/CSU to enact path-breaking reforms, considering the cross-party alliance for the Hartz labour market reforms. Overall, the budget constraints could have such overwhelming effects on the SPD that considerations of partisanship were weakened. Furthermore, the programmatic shift of the Social Democrats towards the new middle could be seen as more advanced than this paper assumed. In such a case, it would be necessary to reconsider the theoretical classification of the SPD as a traditional Social Democratic party.

Further research could focus on applying the same research method of discourse analysis with a different welfare area. These areas could be seen in labour market, family or pension policies and the discourse could be oriented on the main political actors as well. Another research could be conducted by utilising the same method and policy area on a different country, which healthcare system is similar to the German one. For this purpose, the healthcare reforms in the Netherlands appear to be an appropriate study subject. Finally, a very similar study set-up could be conducted while concentrating on the discourse and policy preferences of other important actors. These actors can be seen in employers, trade unions or the other parties in the federal parliament. This way, the gaps that are unintentionally left by this thesis, could be filled.

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