

# Institutionalized Healthcare Reform in Germany? Error Correction or Political Strategy?

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## Abstract

During recent years, German Health Policy has been subject to extensive reform activity. Since the early 1990s, there have been at least seven substantial healthcare reforms and many smaller ones. Against this background, the paper argues that it is more apposite to speak of one “institutionalized reform”, instead of separate reforms. Every single reform seems to be only one step, which in itself does not end the reform process, but which is another step in the direction of the next reform. On the basis of three case studies, the paper argues that there is a basis of one “institutionalized reform” (but to be implemented in small steps) in the reform process for two main reasons: either the reform has been planned badly or planned as a learning system and has to be adjusted to correct deficiencies as they appear, or the new reform is the result of the disability of the actors to achieve the reform they want and a ‘step by step’ strategy is being used to reach the aims after a second or third attempt.

## Zusammenfassung

In den letzten Jahren war in der deutschen Gesundheitspolitik eine umfassende Reformaktivität mit mindestens sieben größeren und zahlreichen kleineren Gesundheitsreformen zu beobachten. Vor diesem Hintergrund argumentiert das Papier, dass weniger von einer Vielzahl von Reformen als vielmehr von einer Art ‘institutionalisierten Reform’ gesprochen werden sollte, die sich dadurch kennzeichnet, dass jede einzelne Reform jeweils nur einen Reformschritt darstellt, der nicht darauf angelegt ist die Reform abzuschließen, sondern vielmehr darauf diese in einem nächsten Schritt weiterzuentwickeln. Auf der Grundlage von drei Fallstudien wird argumentiert, dass eine institutionalisierte Reform (die in vielen kleinen Schritten implementiert wird) entweder damit erklärt werden kann, dass die Reform unzureichend oder als lernendes System geplant wurde, und mit den einzelnen Reformschritten Mängel korrigiert werden, oder damit, dass jede neue Reform das Ergebnis der Unfähigkeit der Akteure ist, die von ihnen angestrebte Reform im ersten Versuch vollständig durchzusetzen, und deren weiteren Bemühungen mittels einer Salami-Taktik in einem zweiten oder dritten Versuch erfolgreich zu sein.

## 1 Introduction

Following the implementation of the current German healthcare reform (Statutory Health Insurance Competition-Strengthening-Act<sup>1</sup>), there have been many comments and newspaper articles criticizing parts of the reform; for example, the central health fund. Critics claim that this section of the reform is incomplete, and that it is, perhaps, designed to be transformed into a system preferred by the next ruling-party. Even though this is an extreme example, we can find countless other instances, in which a reform seems to have been designed in order to be completed by a following reform. So, against this background of broad reform activity in German healthcare poli-

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<sup>1</sup> GKV-Wettbewerbsstärkungsgesetz

cy in recent years,<sup>2</sup> some authors speak of an “institutionalized reform”, without having a clear definition, instead of separate, clearly-defined, reforms. Every single reform seems to be only one step, which is not developed in order to complete the reform process, but is, instead, expected to be advanced to a further stage in the next reform. There are two possible explanations for this: either the reform is planned incorrectly or as a learning system and has to be adjusted, or the new reform is the result of the actors’ inability to achieve the reform they initially wanted, and with a ‘step by step’ strategy, they intend to achieve their aims in a second or third try.

This inability to implement the intended reform can result from the complex veto player structure in the German healthcare system,<sup>3</sup> especially when veto player action is caused not just by the existence of rational winsets<sup>4</sup>, but also by power-political, strategic or vote-seeking and office-seeking reasons. And, if winsets are under-utilized or not established at all, this can make fundamental decisions impossible or unacceptably protracted. According to George Tsebelis, a veto player will make his acceptance of a decision conditional on the existence of a contentual, objective policy winset, which suits his preferences more than the status quo. But, in reality, a veto player often comes to a decision not because of contentual reasons, but because of power-struggle, party political or vote-seeking ones. Veto player exclusion, as far as possible, can be a reaction to reduce the decision-making costs, but very often this will lead into an extension of the implementation costs, where the excluded veto players may develop their power again. (Hence, reforms sometimes do not tend to change policy at first, but to destroy or weaken veto player structures.)

The general aim of the paper is to develop a definition of an ‘institutionalized reform’, in order to assess whether or not there are institutionalized reforms underway in German healthcare policy, and what are the reasons for this. Contemplating the policy process from the view of continuity will help to make the actors’ behavior, as well as policy results, more explainable.

The analysis will consider three different German healthcare reforms. After giving a short historical overview on their development, the position analysis of the involved actors (veto players) will play the main part in verifying the thesis that a reform institutionalization is taking place, and to identify the reasons for this development. Here the focus is primarily on the importance of veto players.

<sup>2</sup> among others: Health Care Structure Act (1993); Act to disburden the contribution in the Statutory Health Insurance (1997); Statutory Health Insurance Reorganization Act (1997/98); Act to Strengthen Solidarity in Statutory Health Insurance (1999); Statutory Health Insurance Reform Act (2000); Act to protect the contribution rate in Statutory Health Insurance (2002); Statutory Health Insurance Modernization Act (2004); Statutory Health Insurance Competition-Strengthening-Act (2007)

<sup>3</sup> compare for detailed information e.g. Alber 1992; Bandelow 1998, 2003, 2005; Mayntz 1990; Döhler/Manow 1995; Busse/Riesberg 2005:37

<sup>4</sup> „The winset of the status quo is the set of policies that can replace the existing one.“ (Tsebelis 2002:21)

“When the status quo is far away from all veto players, its winset is large (policy stability is low). As the status quo approaches one of the veto players, policy stability increases (since the winset of the status quo includes only the points that this veto player prefers over the status quo.” (Tsebelis 2002:22)

## 2 Definition of “institutionalized reform”

Despite the fact that some authors use the term “institutionalized reform” without providing any definition, I want to develop a clear definition, based on the separate meanings of “institutionalized” and “reform”, before I proceed to adopt the full term, “institutionalized reform”, in my paper.

Even if concepts of long term change mention general aims of health care policy in Germany, -- such as the efficiency principle<sup>5</sup>, the change from corporatism to more competition<sup>6</sup> in regulation, as well as financing and service provision and stronger state regulation<sup>7</sup> for reforms (all of which have been established since the 1990s) -- these concepts always mention a change of a universal aim, and not the development of certain reform ideas in many reform steps. These concepts explain the absence of fundamental structural reforms, but not the fragmentation of even small reform aims into different steps.

In trying to find a definition for “institutionalized” against the background of the discourse about institutionalization and institutionalism, a huge field of possibilities opens. In general, institutionalism can be understood as a process of formation or abolishment of institutions, whereupon the question about the definition of institutions occurs. It is not the aim of this paper to give an overview of the discourse, but rather to present the positive and useful aspects for this analysis.

According to Monika Csigo, institutions are composed of the following elements:

- they are adaptive on a continuing basis
- they are a guide for order in social relations
- they construct the framework for the actors’ actions
- they define acceptable behavior and are accepted as legitimate
- they translate individual preferences into collective decisions
- they are integrated into hierarchical systems
- they are enforceable by sanctions
- they are affected by history.<sup>8</sup>

From these elements, Csigo defines a political institution as a formal control system, which is integrated into a hierarchical system on a continuing basis, and as a social-normative behavior pattern, which structures the interaction between individuals and politics or the economy.<sup>9</sup>

Thereby, she distinguishes between basic institutions, derivative institutions, organizations and policy-institutions. This paper concentrates on the policy-institutions that focus on problem-solving. These policy-institutions demonstrate principles (policy-core) and precise procedures, and, on this basis, the particular arrangement of a policy field is predicated and the solution to the social problems is developed.<sup>10</sup> Even if the problem-solving func-

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<sup>5</sup> Klinker 2003

<sup>6</sup> Gerlinger 2002

<sup>7</sup> Rothgang 2006

<sup>8</sup> Csigo 2006:65

<sup>9</sup> Csigo 2006:65

<sup>10</sup> Csigo 2006:87

tion is central for policy-institutions, they also have a mediation function, a disciplinary function, a valuation function and, in part, a symbolic function.

In contrast to this definition, the research group “Institutionalisierung internationaler Verhandlungssysteme” (institutionalization of international negotiation systems) understands institutionalism as an agreement on a mutual problem perception and on rules and values of the problem-solving process with a persisting clash of interests and differences in resources of the autonomously negotiating partners.<sup>11</sup>

In conclusion, there seem to be two central aspects: the permanence and the formation of firm (negotiation) structures. Hence, reforms should be called “institutionalized” when permanence is secured e.g. by actors who use the step by step strategy and when negotiations run with a fixed set of actors, firm rules and behavior patterns.

To define “reform” is just as difficult. In general a reform is a process or result of efforts to change (a part of) political institutions, methods or state competences within a political system. One can differentiate between reforms that focus on modernization and course correction, or on a revolutionary system shift with changes in ownership and stakeholder structures, or on a socialistic change with long-running revolutionary implications, which changes the whole structure of the state.<sup>12</sup> The last two kinds of reforms are found less frequently and so the first one is the most common type of reform. This paper is in accord with this definition and adopts it for this analysis.

*So, an “institutionalized reform” should be defined as an “on modernization” and “correction-focused” durable, fragmented process with a fixed set of actors, firm rules and behavior patterns for negotiations on a specific issue. Thereby the action is dominated by modification that tends to have the same direction and holds the same positions and interests, and which avoids any fundamental policy change.*

This general definition can be used for various cases and has to be connected with a specific issue, depending on the policy field. In this case, a policy dimension can be added to the definition that defines the contentual aspect and the direction of impact. This policy dimension will help to identify the beginning and end of an institutionalized reform. The general frame of the beginning and ending will be set by the establishment or abolishment of a fixed set of actors and the possibility of predicting a continuation of the process. After a long-standing absence of action or a fundamental change in actors’ preferences regarding an issue, the process could be considered as completed.

### 3 Set of Actors

Because the analysis takes place in the context of the German healthcare system, the examples as well as the set of analyzed actors are deduced from this policy field, and because the analysis is set against the background of

<sup>11</sup> Pappi/Riedel/Thurner/Vaubel 2004:14

<sup>12</sup> Schmidt 1995:811

the veto player approach, the first actors that will be considered are the institutional and partisan veto players<sup>13</sup>, as long as they are relevant. The institutional veto players in Germany are the German Bundestag (Lower House), consisting of the partisan veto players of the government, the German Bundesrat (Upper House), consisting of the partisan veto players of the majority keeping federal states, and the Constitutional Court. But, because the Constitutional Court is not an active actor in the reforms being analyzed, it should not be included in the set of actors. Instead, some social actors should be included, because although these actors are just put under the heading "other veto players"<sup>14</sup> in the original veto player approach, the inclusion of them is very important, since, especially in German Health Policy, these actors have institutionalized power by their involvement in the self-government body. Therefore, the analysis will be concentrated on the care providers (Leistungserbringer) and cost purchasers (Finanzierungsträger), including representatives of the physicians, hospitals and sickness funds. Furthermore, if necessary, the analysis will consider other social or commercial actors and explain their functions as they appear in the text.

The position determination will be identified from actors' utterances in parliamentary debates, wording of the law, other governmental papers, and official statements and press releases, while the potential of power and the influence will be considered by the acceptance of these demands in the final law.

#### 4 Institutionalized Reforms

The paper analyzes three reforms that were or will be, in all likelihood, adjusted or changed several times. The first reform is the unsuccessful attempt to introduce a drug positive list; the second example will be the Diagnosis Related Groups' Law and its successors; and the last reform is the introduction of a Central Health Fund as part of the Statutory Health Insurance system. Every example was chosen because it presents a certain kind of actors' constellation and results.

##### 4.1 *The (drug) Positive List*

Since the early nineties, there have been several attempts to introduce a drug positive list in Germany. But, until now, such a list, as is common in many other European countries, has not been established.

In 1993, the Health Care Structure Act (Gesetz zur Sicherung und Strukturverbesserung der gesetzlichen Krankenversicherung – Gesundheitsstrukturgesetz) planned to develop a positive list by 1996. However, shortly before its introduction, the Federal Department of Health (Bundesgesund-

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<sup>13</sup> „Veto players are individual or collective actors whose agreement is necessary for a change of the status quo. [...] If veto players are generated by the constitution, they are called institutional veto players. [...] If veto players are generated by the political game, they are called partisan veto players.” (Tsebelis 2002:19)

<sup>14</sup> Tsebelis 2002:35

heitsministerium) cancelled this plan, because other cost containment measures should have been successful enough by themselves. The pharmaceutical industry supported the decision, while there was massive criticism from the sickness funds and the Social Democratic Party (SPD).

In 2000, the Health Care Reform Act (GKV-Gesundheitsreformgesetz) again commissioned the Department of Health to create a drug positive list using a committee of experts. This list was submitted to the German Bundesrat in 2002, where the opposition majority of the Christian Democrats blocked the non-mandatory legislation on a government bill<sup>15</sup> after a sham dispute, because some of the Federal States (Bundesländer), such as Hesse, had major concerns about the positive list. Later, during negotiations about the whole healthcare reform package between the government and the opposition, the positive list was canceled again.

### Main Actors

As well as the classical set of actors, in this case study, the pharmaceutical industry should also be considered, because despite the fact they do not have direct veto power,<sup>16</sup> they do have a lot of influence on veto players, and represent something approximating to (care) providers in this case.

*Government:* In 1992, the government, consisting of the Christian Democrats (Union) and the Liberal Democrats (FDP), included the positive list in the Health Care Structure Act. In 1993, a committee of twenty experts<sup>17</sup> (in the institute for drugs in health insurance<sup>18</sup>) was instructed to develop a list, which should be implemented by an ordinance of the Department of Health. The list should have reduced the expanding costs in the health care system by reducing the quantity of drugs about one third. When the experts had almost finished the list in 1995, the government decided to repeal the reorganization on the basis that, first, other measures already succeeded parts of the targeted aims and, second, the wider public couldn't be convinced of the necessity and, third, that social equity couldn't be avoided.<sup>19</sup> The list would have affected primarily chronically ill and old people, because of the high number of non refundable drugs.

<sup>15</sup> The German State is a Federal State. Depending on whether the states are affected from changes in national law, their agreement (in the Bundesrat) is needed before the law can become effective. This need for agreement is called "Zustimmungspflichtigkeit". The "zustimmungspflichtige" laws are called mandatory legislation in a government bill, the laws where no agreement from the Upper House is needed are called not-mandatory regulation in a government bill.

<sup>16</sup> Gerd Strohmeier distinguishes between direct and indirect veto players. Direct veto players have actual veto power whereas indirect veto players just have mediate power by influencing the direct veto players. Cf. Strohmeier 2005: 23-26

<sup>17</sup> Prof. Dr. Klaus Quiring; Prof. Dr. Ulrich Schwabe; Prof. Dr. Johannes Köbberling, Prof. Dr. Adalbert Keseberg, Dr. Jürgen Bausch (deputy: Frau Dr. Rieke Alten), Prof. Dr. Ulrich Schwabe, Prof. Dr. Hans Joachim Trampisch (deputy: Prof. Dr. Jürgen Windeler), Prof. Dr. Reinhard Saller (deputy: Frau PD Dr. Karin Kraft), Dr. Karl-Heinz Gebhardt (deputy: Dr. Michael Elies), Dr. Harald Matthes (deputy: Dr. Markus Karutz) und Frau Prof. Dr. Petra Thürmann (deputy: Prof. Dr. Henning Breithaupt)

<sup>18</sup> "Arzneimittel in der Krankenversicherung" (IAK)

<sup>19</sup> Deutscher Bundestag 1995

In 2002, the red-green government, consisting of the Social Democrats and the Green Party (Bündnis90/Die Grünen), was the main mover in the issue of a positive list. In April 2003, it presented a draft (“Entwurf eines Gesetzes über die Verordnungsfähigkeit von Arzneimitteln in der vertragsärztlichen Versorgung”)<sup>20</sup> to parliament. This draft had the objective of securing more transparency, quality and cost-effectiveness in the provision of pharmaceuticals. It aimed at saving public money against the background of increasing drug expenditures and over-, under- and inappropriate supply.

By listing drugs on a positive list, the drug market would be better organized and the relationship between physicians and patients would be simplified by better and easier access to relevant information.. Simultaneously, quality should be improved because only drugs with undoubted beneficial effects, proven by controlled studies, would be allowed on the list. Finally, money would be saved because drugs costing 1,7 billion Euros a year would be excluded from the positive list. This would lead to an effective saving of about 800 million Euros.<sup>21</sup>

Because the government knew about the oppositional position of the German Bundesrat, it transformed the positive list law from a legal regulation -- a mandatory legislation in a government bill --, into a not-mandatory regulation in a government bill, for which the acceptance of the Bundesrat was not necessary; a measure that was not without controversy. Despite this measure, the positive list was never implemented, because the regulation was abolished by the Statutory Health Insurance Modernization Act (Gesundheitsmodernisierungsgesetz).

*German Bundesrat:* In 1995, the red-green opposition unsuccessfully resisted against the repeal of the positive list.

In 2002, there were different majorities in the two German chambers. There was an SPD/Green government, with a majority in the German Bundestag, and the Christian Democrats, with the majority in the German Bundesrat. This gave the Christian Democrats the opportunity to influence the decision about the positive list. For them, the list is dispensable, since it cannot make drugs better or even less expensive, and there is already a functional system established—the negative list. A positive list was considered to be rather bad, because it would deprive some chronically ill patients of accustomed medication, (some of these have to pay for their drugs themselves), and, moreover, the list would have imperiled the existence of many drug manufactures and thereby many jobs. Furthermore, they argued that experience from other countries showed that a positive list would slow down medical progress, and that positive, economic effects were, to a large extent, speculation, because physicians would switch to more expensive drugs, which would obviate any savings.<sup>22</sup> Apart from that, the decision-making about the availability of drugs should be in the hands of physicians and not in those of governmental bureaucrats.<sup>23</sup>

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<sup>20</sup> Deutscher Bundestag 2003a

<sup>21</sup> Deutscher Bundestag 2003a:2

<sup>22</sup> Deutscher Bundestag 2003c; Deutscher Bundestag 2003d

<sup>23</sup> Deutscher Bundestag 2003e

Despite these serious concerns about the positive list, the opposition decided simply to oppose it in the Bundesrat, and not to bring it to a contest, although they had concerns about the legality of handling the positive list as non-mandatory legislation on government bill, which would give the Christian Democrats the opportunity to call for a decision about the correctness at the Federal Constitutional Court.<sup>24</sup> But, obviously, they used another strategy: when the mediation committee negotiated about the whole healthcare reform, the positive list came back on the agenda, and it was sacrificed quickly from the government for the affirmation of the Bundesrat.

*Cost purchaser:* The German Statutory Health Insurance Funds (Gesetzliche Krankenkassen GKV) supported the drug positive list in 1993 as well as in 2002. In 1995, they were unsuccessful in their resistance against the repeal of the positive list. In 2002, they demanded its immediate implementation as a contribution to better quality in drug provision, because a positive list would bring a market adjustment among the 50,000 drugs available in Germany.<sup>25</sup> They failed with their concern again.

*Care provider:* Even though, in 1993, the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung) voted against the positive list, it changed its mind in 2001 and, in general, approved the positive list as an instrument for improvement of quality. The list is appropriate to improve the quality of drug provision and to develop a fact-based drug prescription/use culture in the Statutory Health Insurance area. However, they criticized the detailed arrangements about reimbursement and evaluation that did not meet the standards of the GMA and SHI-authorized physicians. If these requirements are met, the Association sees no alternative to a positive list, in order to secure supply transparency and security for the physicians.<sup>26</sup> Likewise, the German Medical Association (Bundesärztekammer) has officially supported the introduction of a positive list and the Medical Association of Berlin compiled its own list of 600 drugs in August 1995. After the pharmaceutical industry took the case to court, the list was retracted. Since 1999, the Medical Association has pursued no active strategy.<sup>27</sup>

*Drug manufacturers:* According to the influential German pharmaceutical industry association<sup>28</sup>, a drug positive list was not needed and would be counter-productive with regards to quality standards and the German economy. It would also attract criticism under constitutional and European law, as well as from a medical and regional economic policy point of view.

In 1995, the manufacturers prevented the positive list. At the time, a shredded copy of the list was presented to the chairman of the German Pharmaceutical Industry Association (Bundesverband der pharmazeutischen Industrie - BPI), Hans Rüdiger Vogel, after a top level talk to Chancellor

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<sup>24</sup> Levine/Szent-Ivanyi 2003

<sup>25</sup> Arbeitsgemeinschaft der Spitzenverbände der Krankenkasse 2002

<sup>26</sup> National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung) 2001

<sup>27</sup> Medical Association 1999

<sup>28</sup> German Association of Non-Prescription Medicines Manufacturers (Bundesverband der Arzneimittelhersteller BAH), German Association of Research-Based Pharmaceutical Companies (Verband forschender Arzneimittelhersteller (VfA));



Kohl.<sup>29</sup> Furthermore, they tried to develop influence in the German Bundesrat. BAYER pressurized the North Rhine-Westphalian politician Wolfgang Clement, HOECHST the Hessian Hans Eichel and WELLCOME the Premier of Lower Saxony Gerhard Schröder. All of them voted against the positive list in 1995.<sup>30</sup>

In 2002, the critique was maintained. It was pointed out that there was already a functioning system with a complex market admission procedure for new drugs, and that there was also a negative list, which secured high quality and cost-effectiveness in the drug market. Therefore, an additional positive list would be at least unnecessary and, at worst, destructive. The amount of money saved through the inception of a positive list is, in many ways, likely to be negligible. According to them, much more money could be saved by enlarging the negative list, with regard to exiguous disturbances of health, than would be saved by a positive list. And this saving would be more calculable. Furthermore, it must be assumed that, based on worldwide experiences, a positive list would provoke a substitution of excluded drugs through more expensive ones that are on the list. On the one hand, that would lead to even higher expenditures and would be counter-productive, but, on the other hand, it would lead to high losses in sales and profits in the pharmaceutical companies whose drugs are not on the positive list. Sooner or later, this would cost about 17.000 mainly high-qualified jobs, especially in the medium-sized industry sector, and constrain innovations and research.

Aside from that, the legality of the process was to be questioned. Usually, measures of the prescription ability of drugs are part of the concurrent legislation.<sup>31</sup> But, in this special process, the government transformed the positive list from mandatory legislation, which requires the approval of the German Bundesrat, into a non-mandatory legislation, where the acceptance of the German Bundesrat is not necessary. This method was regarded as questionable.<sup>32</sup>

### Recapitulation

To return to the initial question of whether there are elements of an institutionalized reform in the German healthcare reform process during recent years, the first case study points to the fact that there are. It becomes obvious that an issue can also be partly institutionalized when it does not become successfully implemented in law. The example accomplishes all criteria of an institutionalization, apart from the one of fragmentation, because this criterion can only take place after an implementation. But, in a generous interpretation of fragmentation, the fact that the positive list is part of the agenda again will be seen as evidence of some kind of fragmentation as well. But, more importantly, the example shows that veto players, even if they have only indirect influence, not only have the power to force govern-

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<sup>29</sup> Jantzer 2006:239

<sup>30</sup> Langbein 2003:142

<sup>31</sup> Art. 74 Abs. 1 Nr. 12

<sup>32</sup> German Association of Non-Prescription Medicines Manufacturers 2003; German Association of Research-Based Pharmaceutical Companies 2003

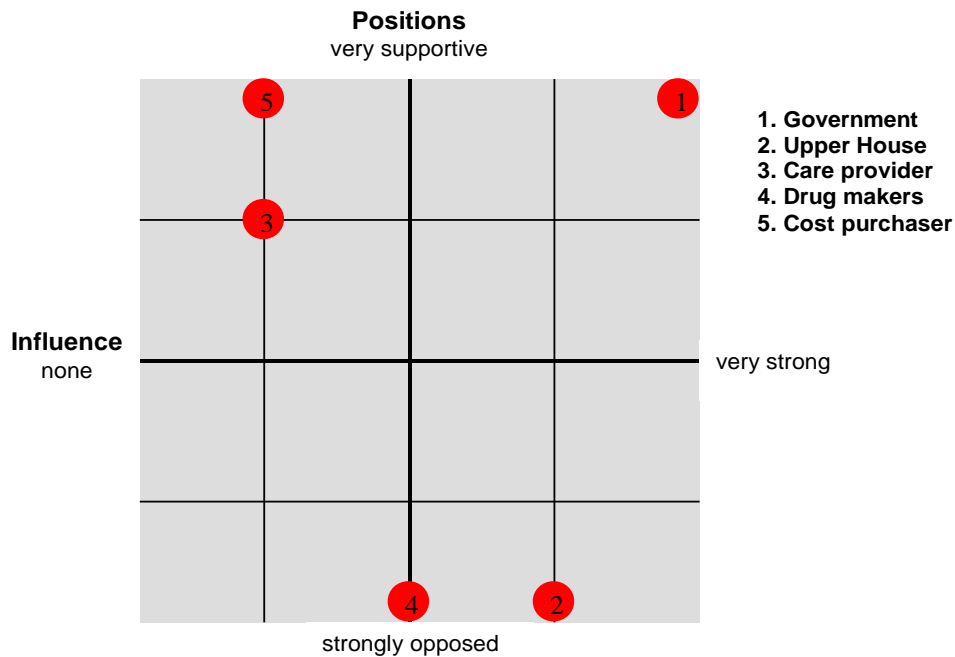
ments to fragment reform plans, but also to relinquish certain ones; although that does not mean that plans are abandoned forever, when they initially fail. In the same way that ideas are adjusted and transformed in a following reform, they can also recur. This fact does not refute the thesis. In fact, it rather supports the assumption that certain blocking veto players provoke the institutionalization. If an issue is not enforceable in one situation, it just follows logically to bring it up at a later time when the conditions might be better. In this example, the positive list is sacrificed in each reform as an accommodation in negotiations, like a power-strategic pledge. But it shows in any case the potential of veto power, which even indirect actors can develop. In this case, the pressure groups of the pharmaceutical industry point out the risks of job losses, less innovations and lower supply security and quality for the patients, which is adapted on some points from direct veto players, such as the Federal States (e.g. Hesse)<sup>33</sup> or parties (e.g. Christian Democrats). These veto players stopped the positive list in the negotiation process, but it can be supposed that they are not completely unaffected by lobbying from the pharmaceutical industry pressure groups.

From the veto players' perspective in general, the non-formation of the positive list is less surprising, because the congruence of the important players is low. So the winset is small anyway, and the cohesion of the actors is too high to make any compromises. Although the Christian Democrats also planned a positive list in their period of office in the early 1990s, they changed their mind even in their own term and took a negative position afterwards. The Social Democrats, however, mainly support the positive list. It is interesting that the self-governing partners, who support the positive list, obviously develop no strong veto power. Hence, it is probably the case that these actors are mainly involved (after the decision process) in the implementation phase, thus with the detailed arrangements and the putting of the laws into effect.

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<sup>33</sup> Robert Koch, Premier of Hesse, and representatives of the pharmaceutical industry (Merz, Homosan, Aventis) announced to blockade the positive list in the Upper House one day before the vote on 22nd May 2003.

Fig. 1. Drug Positive List: Influence and Positions of the Main Actors



Source: Illustration according to Zimmermann 2006 transferred by the author

#### 4.2 German Diagnosis Related Groups' Law (DRG Law)

With the Statutory Health Insurance Modernization Act (Gesundheitsmodernisierungsgesetz) of 2000, the German government initiated the introduction of a new hospital funding system based on the internationally-used Diagnosis Related Group (DRG) system. This implementation of a performance-oriented system of hospital reimbursement was designed to lead to a more transparent health service and thus improve quality and efficiency in hospital care. The reform fundamentally restructures the hospital accounting system, from a payment depending on the length of stay with a retrospective cost-reimbursement basis, to a system based on the kind of disease with a pre-defined case-fee for every diagnosis.

The DRG Law (Fallpauschalengesetz)<sup>34</sup> was first discussed in 2001, when, after three readings, the parliament made a decision on 14<sup>th</sup> December 2001. It planned (on a voluntary basis) to replace the previous German hospital reimbursement system with the new DRG-based hospital funding system in January 2003. Beginning in January 2004, the change in the reimbursement system would become mandatory for all hospitals, with the exception of psychiatric, psychosomatic and psychotherapeutic hospitals or units. The new reimbursement system was not only intended to cover acute hospital care but also parts of early rehabilitation, palliative and sub-acute care. Due to its economic incentives, the effects of introducing the DRG

<sup>34</sup> Bundesgesetzblatt 2002

system would not only affect the hospital sector but also ambulatory care, nursing and rehabilitation. The law envisaged a budget-neutral phase in 2004, followed by a two-year convergence phase from 2005 to 2006. Beginning in 2007, the DRG system would become normal procedure. The German DRG catalogue 2005 comprised 878 DRGs and 71 supplementary payments. The final Diagnosis Related Groups system was devised and prepared by medical self-governing partners (consisting of representatives from the German Hospital Federation (Deutsche Krankenhausgesellschaft), the German Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung)), which were legally commissioned to develop a DRG-based reimbursement system by 1<sup>st</sup> January 2003 on the basis of the general political and economic conditions as outlined in the DRG Law. In February 2002, the German Bundesrat stopped the introduction of law and the government convoked a mediation committee. The Bundesrat finally accepted the DRG Law on 1<sup>st</sup> March 2002, with some changes regarding minimum case numbers in surgeries and competencies in hospital planning. The German flat-rate reimbursement catalogue got hospitals moving. By the end of 2004, 86 percent of the 1,836 hospitals affected had changed over to the DRG system.<sup>35</sup>

In 2003, the government commenced the amendment of the DRG Law (First DRG Amendment Law)<sup>36</sup>. On 26<sup>th</sup> February 2003, the German Federal Cabinet (Bundeskabinett) approved the draft of the DRG Amendment Law of the Federal Department of Health. The German Bundestag passed the law in the 2./3. reading on 22<sup>nd</sup> May 2003 and the German Bundesrat agreed on 20<sup>th</sup> June 2003. The Amendment Law planned to open the savings clause to performances and specialized institutes, which are not considered in the DRG system, and to extent it for hospital individual paying arrangements. Furthermore, the Amendment Law would strengthen the Department of Health's options for intervention, if the self-governing partners cannot reach agreement, and would adopt reimbursement rules for performances and institutions, which are not appropriately paid within the DRG system.

On 28<sup>th</sup> May 2004, the Federal Cabinet approved the draft of the Second DRG Amendment Law (2. Fallpauschalenänderungsgesetz)<sup>37</sup>, based on a draft from the Federal Department of Health. The law includes, among other things, a prolongation of the DRG introductory phase until 2008. The German Bundesrat delegated the law on 5<sup>th</sup> November 2004 to the mediation committee, where changes regarding the extension of the convergence phase up to five years until 2009 and the introduction of a capping limit for budget losses of one percent were specified, and passed it on 26<sup>th</sup> November 2004.<sup>38</sup>

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<sup>35</sup> The Medical Technology Companies 2005:6

<sup>36</sup> Bundesgesetzblatt 2003: "Gesetz zur Änderung der Vorschriften zum diagnoseorientierten Fallpauschalensystem für Krankenhäuser (Fallpauschalenänderungsgesetz/FPÄndG)"

<sup>37</sup> Bundesgesetzblatt 2004

<sup>38</sup> Deutscher Bundestag 2004b

### Main Actors

Government: For the red-green government, the introduction of the DRG<sup>39</sup> system gave rise to a dramatic change in hospital funding. The performance-dependent payment would be a more effective, modern and open budgeting/charging method. The plan had already started with § 17 of the SHI-Health Care Reform in 2000. With the DRG Law, the hospitals could start with the DRG introduction from 1<sup>st</sup> January 2003 on an optional basis and, after the budget-neutral phase, all hospitals would enter the process up until 1<sup>st</sup> January 2004. The government did not make any plans for the years after 2006, because the new development should be a learning system.<sup>40</sup> The two years from 2004 to 2006 should help to identify problems that should be addressed later. Comprehensive medical care should be secured by the option of agreements about surcharges.

The First DRG Amendment Law was an attempt to adjust the learning system of the DRG. It was intended to reduce especially the emerging blocking potential of the self-governing partners in the decision making process by giving the Federal Department of Health more options to force decisions and by establishing some conciliation instruments. At the same time, the government received more rights to define which medical activities and treatments were included and excluded within the DRG system.<sup>41</sup>

In the Second DRG Amendment Law, the government decided on a new extension of the convergence phase from three to four years, in order to give hospitals involved in intensive care more time to solve their problems.

All these measures are seen as normal adjusting procedures in a learning system and not as a failure of the concepts behind the original law.

*German Bundesrat/Opposition:* The Christian Democrats generally supported the introduction of a DRG system, which they had already partly introduced earlier, giving a 25 percent rate of reimbursement based on treatment group classification, but they had lots of concerns about the detailed implementation. Mainly, they complained about the introduction of the DRGs, because this affected budgeting, since it can provoke price decline, undersupply, floating hospital case values or patients selection under cost benefit aspects. To be more specific, they firstly complained about the short period of time that was scheduled for the introduction of the DRGs and its unrealistic timetable, although the government accepted the proposal of the German Hospital Federation and introduced an optional element. Secondly, they believed that the anchorage of the DRGs in the health system was deficient, because the reduction of the period of hospitalization could be at the expense of the out-patient sector, which was not adequately prepared for that. And thirdly, they thought that the responsibility of the Federal States for guaranteeing provision of services was becoming more and more complex and convoluted.<sup>42</sup> So the Christian Democrats voted against the law in the Bundestag as well as in the Bundesrat. As a result, the government convened a mediation committee. There were disagreements about

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<sup>39</sup> Deutscher Bundestag 2001b

<sup>40</sup> Deutscher Bundestag 2001a:20736B; Deutscher Bundestag 2001c:18474D

<sup>41</sup> Bundesrats-Drucksache 131/03

<sup>42</sup> Deutscher Bundestag 2001a

minimum case numbers, about the safeguarding of coverage in rural areas and concerns about interventions in the hospital planning competencies of the Federal States. In particular, the opportunity for hospitals and insurers to find an agreement for structural changes on their own, would be prohibited. The Department of Health remained defiant in the case of premiums for guaranteeing provision of services (Sicherstellungszuschläge). The Federal States should not have the possibility to define their extent on their own. This measure would secure that inefficient hospitals would not get bonuses, when there are more efficient ones in their proximity.

The Christian Democrats did not reject the First DRG Amendment Law, but still had major concerns, mainly because of a non-appropriate DRG mapping and the non-inclusion of the European adjudication regarding working times and its influence on the DRGs. Moreover, the tight timetable, the non-consideration of advanced training, the cut backs in the rights of the Federal States, the deficient savings clause, the growing excessive bureaucracy and mostly the wish for 100 percent coverage by the DRGs, were/are (still) problematic.<sup>43</sup>

In the debate about the Second Amendment Law, the Christian Democrats were not internally in agreement about the problems of the DRG system. The parliamentary group of the German Bundestag wanted to maintain the convergence phase as originally planned - or even to shorten it --, while the German Bundesrat wanted to lengthen it to five years. The States particularly feared for university medicine and its financial provision. And they stressed that the option of agreeing to prospective excess volumes for emerging medical technologies and an appropriate and fair compensation mechanism for service volumes that were below or above predictions for high-quality medical technologies with proportionately high material costs, were of the utmost importance during the convergence phase. In addition, a rapid incorporation of innovative medical technologies into the DRG system must be guaranteed.<sup>44</sup> In general, the States and the parliamentary opposition continue with their criticisms as with first Amendment Law.<sup>45</sup>

*Care provider:* From the German Hospital Federation's point of view, caution was advised because many of the general conditions could not easily be implemented into the reality of German hospital practice. They asked for three things: firstly, for a longer convergence phase and frame set for introducing DRGs in Germany and, secondly, for an unlimited savings clause, to permit hospitals to make their own individual regulations of payment for rare diseases, special cases and problems beyond the DRG system. And finally, they asked for a hospital internal evaluation procedure, which would guarantee the provision of services by evaluating the hospital itself, and not by a comparison with other hospitals' performances - because the efficiency of a hospital results from all its treatment areas and not just from the comparison of single treatment areas. Otherwise, the law would cause a reduction in quality instead of an improvement in the quality of care. Moreover,

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<sup>43</sup> Deutscher Bundesrat 2003a; Deutscher Bundestag 2003b

<sup>44</sup> Deutscher Bundesrat 2004a; Deutscher Bundesrat 2004b; Deutscher Bundesrat 2004c

<sup>45</sup> Deutscher Bundestag 2004a

the interfaces between the hospital sector on the one hand and other areas of care on the other would be put to a real test of endurance.<sup>46</sup>

The Medical Association had mainly the same concerns. They wished for a convergence phase of five years and a fair mapping of performances in the DRG system, with a good savings clause for an additional and alternative funding of performances and institutions. Moreover, they pointed out the problem of the missing financing due to the shift from in-patient care supply to out-patient care supply, and wanted the costs for advanced training to become part of the payment.<sup>47</sup>

*Cost purchaser:* The German Statutory Health Insurance Funds supported the law, but had major concerns about the capping limit for budget losses, the exclusion of certain treatments from the DRG system, and the perpetuation of the hospital individual remaining budget. They pointed out that those measures could pervert the DRG price system, because they would maintain the combined system and yet still support inefficient hospitals. The same effect could result from the responsibility for guaranteeing provision of services, if that means that every hospital should be maintained, even if there is no need. Altogether, such measures could be dangerous for contribution rate stability.<sup>48</sup> Moreover, they had concerns about the restrictions on their self-government.

### Recapitulation

The example of the DRG law is completely different from the first one. It fulfills the criteria of an institutionalized reform—durability, fixation of the actors set and negotiation rules—perfectly, but the several amendments do not seem to be part of a veto player blocking strategy. In fact, it seems to be a normal adjustment process to correct problems in a learning system. Nevertheless, it is an example for an institutionalized reform. But the institutionalization is not caused by the veto players but, rather, by a learning process. The adjustments affected mainly time extensions in the convergence and introduction stages, as well as the coverage rate of the system. The reasons for the veto players' low blocking activity may be that their positions were not fundamentally different. Hence, the DRGs were an integral part of the negotiations, but never ran the risk of being rejected as a principal. This fits with the veto player perspective, where a relatively large winset can be found. Almost all actors supported the DRG system and criticized only the detailed implementation. Whether this criticism was fact-based or sometimes just power-political is debatable. For example, the tight timetable for the introduction may have been unrealistic, even in the eyes of the government, but was nevertheless established to avoid the impression of supporting the opposition point of view.

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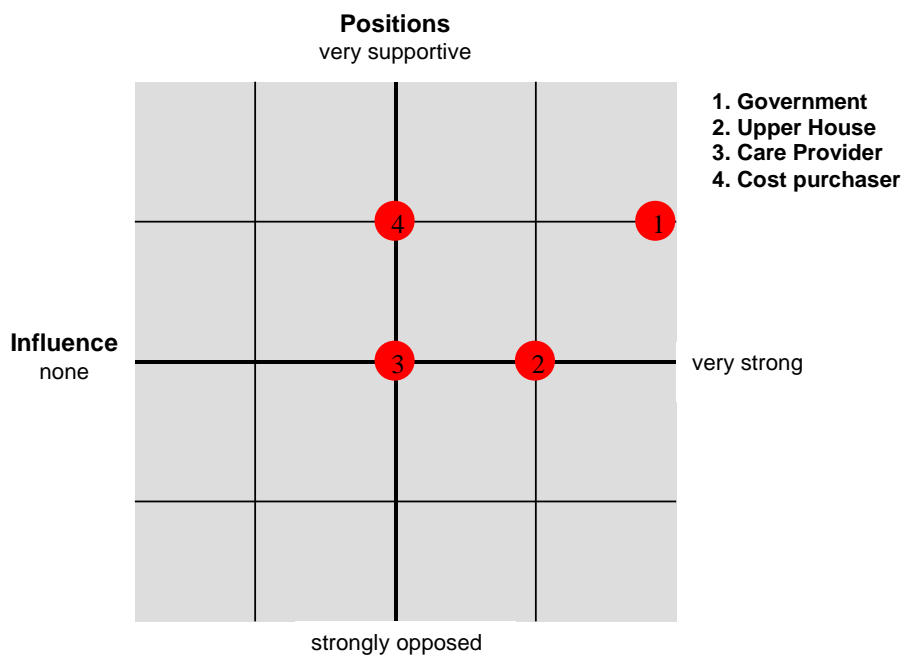
<sup>46</sup> German Hospital Federation 2001

<sup>47</sup> Medical Association 2003

<sup>48</sup> Spitzenverbände der Krankenkassen 2002; Spitzenverbände der Krankenkassen 2003; Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen 2004; Spitzenverbände der Krankenkassen 2004

An interesting aspect is that, although the self-governing partners were involved in the detailed planning of the DRG system, they could not develop their own veto power. Because they could not agree on a catalogue, the government, on several occasions, used the substitute performance (Ersatzvornahme) to set up the catalogue. This measure stopped the blockade but did not decrease the conflict potential and only solved the problem temporary.

Fig. 2. German Diagnosis Related Groups' Law: Influence and Positions of the Main Actors



Source: Illustration according to Zimmermann 2006 transferred by the author

#### 4.3 Central Federal Health Fund

After the elections in September 2005, a grand coalition of Christian and Social Democrats came into power, which forced the parties to cooperate and to integrate two very different healthcare reform concepts: the Citizen Insurance Scheme (Bürgerversicherung), favored by the Social Democrats and developed by the Rürup Commission<sup>49</sup>, and the Flat-rate Premiums (Gesundheitsprämie), favored by the Christian Democrats and developed by the Herzog Commission<sup>50</sup>. Without cooperation, the parties risked a standstill in health policy, which again would not be accepted by the voters.

<sup>49</sup> Bundesministerium für Gesundheit und Soziale Sicherung 2003; The Rürup Commission also developed a Flat-rate Premiums model, but the Christian Democrats mostly refer to the Herzog Commission.

<sup>50</sup> Kommission „Soziale Sicherheit“ 2003



The Citizens Insurance Scheme included plans to levy contributions to healthcare insurance to all citizens, according to their ability to pay (including privately insured citizens) and to levy according to all types of income (e.g. income from rent, capital investments, etc.). These measures would broaden the calculation basis of contributions and retain the income redistribution part of the health insurance system. In contrast, the Flat-rate Premium Model specified the same contribution premium for every insured, regardless of income and health status, and aimed at compensating individually for illness and aging. Thereby, contributions to Statutory Health Insurance would be partially decoupled from employer labor costs and income redistribution should be shifted to the tax system (i.e. by subsidizing the health premiums of the poor).

The grand coalition's working group on healthcare reform discussed the Health Fund Model (*Gesundheitsfonds*) as part of a package of measures to secure the long-term financial sustainability of the German healthcare system. An early version of the funding model was developed by the scientific advisory council of the Ministry of Finance in 2005. Later, the health fund, which combines aspects of the citizens insurance scheme and the flat-rate health premiums scheme, found increasing acceptance from policy makers, but was strongly debated between and within the political parties and among health experts, trades unions, sickness funds, etc. especially in its detailed design.

The envisaged health fund would draw on employer and employee contributions, as well as on tax revenues. From 1<sup>st</sup> January 2009, a unitary contribution rate of 15.5 percent<sup>51</sup> would be paid by all insured members of the statutory health insurance. The contributions would be paid to the sickness funds and transferred by them to the Health Fund. Additionally, the Health Fund is funded with tax money. The sickness funds will receive a flat rate out of the fund for each insured person, which is corrected by risk structure compensation (*Riskiostrukturausgleich*)<sup>52</sup> for those insured with higher risks. The risk structure compensation should made the competition between sickness funds fairer, because it pays a compensation for higher costs of 80 defined diseases.

If the funds have higher expenditures, they would be entitled to raise an additional risk-adjusting premium (*Zusatzprämie*). On the one hand, funds that operate efficiently may refund parts of the contribution payments to their members or offer additional benefits, but, on the other hand, excess costs would be covered by charging an additional premium to their members.

### Main Actors

*Government:* The Government working group on the healthcare reform, consisting of Social and Christians Democrats, seemed to agree on the gen-

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<sup>51</sup> set by the national government

<sup>52</sup> The risk structure compensation is reformed by the health care reform of 2006. Previously the compensation was paid directly from one sickness fund to the other. With the introduction of the health fund it becomes his task to pay the compensation to the funds.

eral idea of a health fund, but was divided about the detailed design of the fund. The main contentious issues were the integration of private health insurers and employer contributions.

To be more specific, the Christian Democrats generally agreed to the health fund idea, but demanded the retention of the plural system of statutory and private health insurance, as it was stipulated in the coalition paper. Moreover, they wanted to freeze employer contributions in order to stabilize labor costs. Nevertheless, parts of the Christian Democrats also rejected the fund. The Bavarian Christian Democrats (CSU), especially, accentuated their critique and concerns.

The left wing of the Social Democratic Party opposed the health fund model, especially the idea of freezing employer contributions and the allowing of sickness funds to charge an additional premium if the funds cannot survive on the flat-rate premiums they receive from the fund, and they demanded the integration of private health insurers into the new health fund.<sup>53</sup>

*German Bundesrat:* Some Christian Democratic, as well as Social Democratic actors from the Federal States (especially Bavaria), rejected the health fund and wished to enforce a convergence clause<sup>54</sup>, because the wealthier southern states would have to pay more into the new health fund, since contributions to the fund would be based on personal income. Those living in the poorer (mostly) east German states, where unemployment averages more than 16 percent, would pay considerably less. This convergence clause was rejected by the left wing of the Social Democratic Party.<sup>55</sup>

*Cost purchaser:* Sickness fund representatives opposed the health fund. They argued that the bureaucratic effort would be much too high. The costs for the money transfer from the sickness funds to the health fund, and back again, would be huge. Although the contributions would be distributed in a different way, there would be no real change in the funding system of the statutory health insurance, but many new problems. The sickness funds would lose the financial responsibility due to flat rate contributions. On the one hand, the additional premium would increase the competition for "healthy insured" with a higher income, in that a restriction of 1% of the contribution related income is provided for. Consequently, in absolute terms, the sickness funds receive more money from the additional premium when they have more higher-income members. On the other hand, the risk structure compensation will increase the competition for "insured with risked structure compensation defined diseases", because the sickness funds receive more money from the health fund for those insured. Both developments are unsolicited, because both would worsen the provision. Firstly, the

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<sup>53</sup> Although the private health insurance is not part of the health fund the convergence with the sickness funds is increased by introducing a constrain to offer a basis rate and an obligation to contract.

<sup>54</sup> Through the "Convergence clause" the contributions in 2008 in a particular State (adjusted by the demands and need to make compensatory payments due to the risk structure compensation and increased by the obligatory contribution income) are compared with the allocations from the Federal Health Fund. If the difference between the two is more than € 100 million then the allocations to the sickness funds for the insured in that state are adjusted accordingly up or down.

<sup>55</sup> Focus 2008

incentives to offer prevention measures for the diseases of the risk structure compensation and, secondly, the optional and service activities for the insured would be reduced to save costs or raise more money.

Private health insurers also opposed the health fund model. They claimed that keeping the current pay-as-you-go system would not make the German healthcare system viable in the long-term. They rejected the idea of integrating privately insured persons into the fund<sup>56</sup> and the enforcement to offer a base rate (Basistarif) with obligation to contract (Kontrahierungszwang). Only the first demand was successful.

*Care provider:* The representatives of the care provider opposed the health fund, mainly because the financing level would not be good enough to secure a patient-oriented healthcare. The German Medical Association called the financing elements of the reform - the fund - an experiment, which is not reliable for the future. The National Association of Statutory Health Insurance Physicians deplored the reduction of the financial autonomy of the sickness funds by the state through the loss of the responsibility for the premium rate and the reduction of the capital. Physicians associations, such as the Hartmannbund or the Marburger Bund, and the German Hospital Federation, claimed that the fund would not solve any of the financing problems of the health system but, instead, create new restraints or strengthen old revenue structures. Instead of broadening the calculation basis of contributions of the statutory health insurance, the contributions would stay income-related. Moreover, the cost control efforts of the sickness funds would intensify the mistrust and patronizing of the care provider.<sup>57</sup>

### Recapitulation

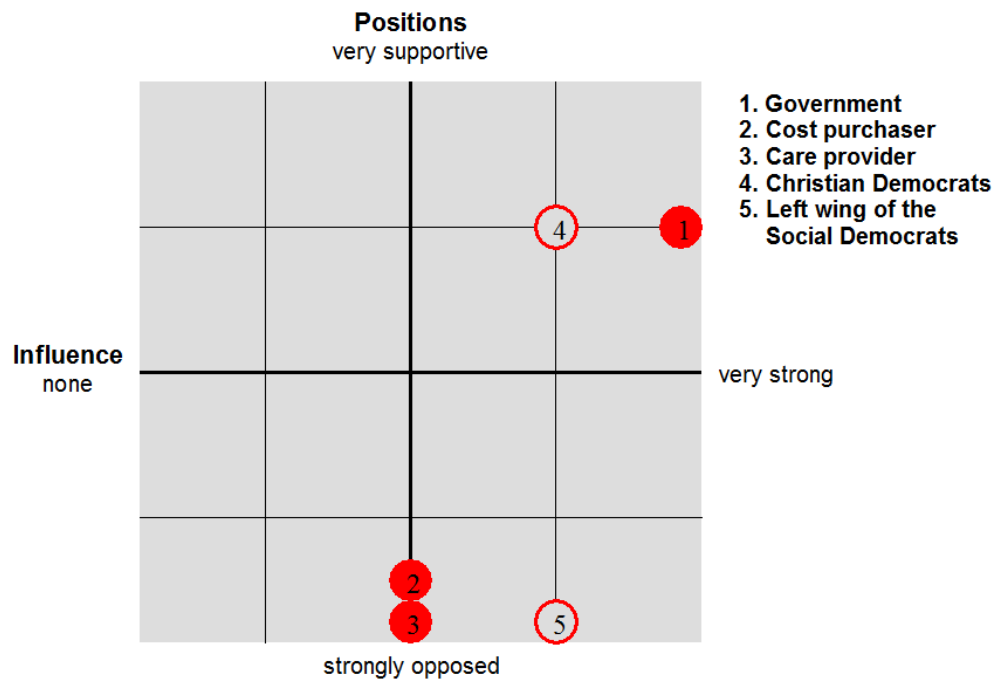
The last example centered primarily on the beginning of an institutionalized reform, in which the health fund introduction seemed to be the first step. The health fund is a compromise between two different concepts of statutory health insurance funding. Ultimately, it is neither what the one coalition party wants, nor the other. But, because both parties want to sustain the possibility of changing the fund into their concept if they win the next election, it is not surprising that the health fund has the potential to be transformed into a citizen's insurance scheme as well as a flat-rate premium system. On the one hand, with the health fund there are equalizing contributions and a widening of the financial basis through the increase in finance coming from general taxation (which supports the concept of "Citizens' Insurance"), and, on the other hand, there is relief given to the factor "work" as well as there being a first step in the direction of a "premium model" due to the introduction of the additional premium (thus implementing an element of the "Flat rate Premium model"). Therefore, it cannot be assumed that the health fund in its current form will survive a long time, and will inevitably be adjusted

<sup>56</sup> Spitzenverbände der gesetzlichen Krankenkassen 2006a; Spitzenverbände der gesetzlichen Krankenkassen 2006b

<sup>57</sup> German Hospital Federation 2006; Marburger Bund 2006; Hartmannbund 2006; National Association of Statutory Health Insurance Physicians 2006; Medical Association 2006

sooner or later. So the health fund example shows the immense influence even a small number of veto players can develop. Because the two coalition parties cannot agree on one concept, they find a compromise that seems to be not even planned to be kept for a longer time, but gives the best position for a change. It is, therefore, not surprising that the general feedback from all the other actors is bad, because the health fund concept exhibits all the characteristics of a short-time compromise. The interesting fact is that all these other actors obviously have no major influence on the result. But, actually, that is not surprising, because a grand coalition is theoretically the most powerful form of government, since it eliminates the Bundesrat as well as a functional opposition as veto players, and by that a lot of indirect working actors as well. Indeed, can be noticed that social actors like trades unions, employers, representatives of the sickness funds and care providers were excluded from the negotiation process as far as possible. It can be argued that, in view of the fundamental conflicts between the two coalition parties, the different positions of these actors were already included in the party ones, but seeing the consistent rejection of the health fund, this is obviously not the case. Therefore, the exclusion seems to be an active measure to reduce the decision-making costs. Instead, the conflict focused on the two coalition partners. The opposition does not come from the other parliamentary parties but from different factions inside the coalition parties. Furthermore the congruence between the two concepts was low, but the cohesion of the veto players, especially in the Social Democratic Party, was low as well. This would argue against the original concept of Tsebelis, which describes low cohesion as a good condition for fundamental change. Obviously some others factors play a role. Strong leadership and the habit of the other parties to interact as opponents, and by that as combative instead as consensual veto players, could have had a stake in the result.

Fig.3. Central Federal Health Fund: Influence and Positions of the Main Actors



Source: Illustration according to Zimmermann 2006 transferred by the author

## 5 Conclusion

Considering the question as to whether there have been institutionalized reforms in certain parts of German healthcare policy, there is an absolutely positive answer for the case studies analyzed here. But it is contestable that it can be extrapolated from these results, the conclusion that there is an institutionalized reform overall. On the one hand, it can be argued that a general institutionalization must consist of many small institutionalized reforms, and that it emerges from that. The paper follows this argument, particularly because more examples can be found for almost every healthcare issue, which would show an institutionalization in the defined way. On the other hand, it may be an unacceptable generalization to infer from single reform issues to a general trend, because there are examples for closed reforms<sup>58</sup> as well. This concern can only be addressed by additional, more comprehensive and representative research.

But, if we proceed on the results from the case studies where institutionalized reforms take place, the following question arises: what are the reasons for this development? The veto player approach has been chosen as a possible explanation, because German healthcare policy is a prime example for the involvement of many veto players. The results show that there are veto

<sup>58</sup> e.g. negative list (introduction 1989 Health Care Reform Act); freedom of choice between statutory health insurance (introduction 1993 Health Care Structure Act)

player-influenced reforms as well as normal adjusting processes and it is not always distinguishable which aspect is more important. Normally, it is a mix of power-strategically and contentual reasons that lead the actors to a reform adjustment. Both aspects seem to have a similar influence. Although there is a slight relationship between the number of veto players and the extent of a reform, surprisingly, the number of veto players does not appear to be the principle factor. As we see in the case studies, a closed fundamental reform does not follow automatically from a low number of veto players. Tsebelis set two other variables, congruence and cohesion, which should be considered. In the last example, only two veto players, the parties of the grand coalition, were active, but a working durable compromise was not established. On the other hand, there are many veto players included in the DRG Law and its follow ups, and, although there are several adjustments necessary as well, the abolishment of the concept in general was never up for debate. Against this background, the congruence regarding an issue seems to be a more important factor than the number of veto players. Nevertheless, the likelihood of obtaining such congruence decreases with an increasing number of veto players, and so the exclusion of veto players is a normal action in the solution-finding process, especially when the congruence is low. But, sometimes, the excluded actors just develop their power in a later phase—in the implementation. If they can influence the interpretation of the decision they still belong to the veto players. This is obviously applicable to the cost purchaser and care provider. At first sight, it seems to be that these traditional actors lose power. They are, apart from formal statements, excluded from important reform processes or put under pressure by the state, if they do not provide the requested results. Actually, these actors have only a minor influence on the legislative process. That does not mean that they have no influence at all, because they mainly develop their influence at the implementation phase. They achieve an institutionalization of the reform process, not by a rejection, but rather by a delay in the implementation and the forced revision. Interestingly, it appears that the government, through the use of its extra veto powers and the broadening of its control competencies, wishes to "soften" this development. This gives more veto power to the parties and to all actors who have influence on them—even if these actors are economic actors whose influence is otherwise low.

The paper does not involve any evaluation as to whether an institutionalized reform is good or bad, but rather tries to identify the development itself. If an institutionalization is an efficient way to eliminate veto player blocking potential or to improve normal adjusting processes, has to be part of further research. The conclusion of this paper is the definition and identification of institutionalized reforms in German health policy, which results from a combination of error correction and power-political strategies.

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