

Peter Ullrich, Stefan Kausch, Sigrun Holze

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**The making of the healthcare self**

State metamorphoses, activation, responsabilisation and red-green alliance's healthcare reforms in Germany

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**Peter Ullrich, Dr. phil. Dr. rer. med. \***

**Stefan Kausch, Dipl. Pol., MA \*\***

**Sigrun Holze, Dr. phil. \*\*\***

**Abstract**

The coalition government in Germany (1998-2005) of the social democrats and the greens instituted several healthcare reform measures marking a paradigm shift and thus setting the direction of reform for subsequent governments' healthcare politics.

Agreeing with governmentality studies perspectives on recent transformations of governing western democracies that have been analysed as ambiguously offering new opportunities (= more freedom) and bringing new disciplinary measures (= more force), it can be shown that many measures are geared towards the activation and responsabilisation of insurants. In doing so, they produce what we call a "healthcare self". This is characterised by a feeling of personal responsibility for one's health, knowledge of options to obtain health, a high degree of reflexivity in health issues and willingness to pay for healthcare costs, because they are seen as an investment in one's own prosperity. This is founded in a moral discourse and an institutional restructuring, which we consider a sign for a basic metamorphosis of the concept of the state into what we call a new state arrangement.

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\* Zentrum Technik und Gesellschaft, Technische Universität Berlin, [ullrich@ztg.tu-berlin.de](mailto:ullrich@ztg.tu-berlin.de)

\*\* Engagierte Wissenschaft e.V., [kausch@engagiertewissenschaft.de](mailto:kausch@engagiertewissenschaft.de)

\*\*\* Universität Leipzig, Klinik und Poliklinik für Urologie, [Sigrun.Holze@medizin.uni-leipzig.de](mailto:Sigrun.Holze@medizin.uni-leipzig.de)

## 1. Introduction

This article analyses the healthcare politics of the German coalition government comprising the Social Democrats (SPD) and the Greens (Bündnis90/Die Grünen) under chancellor Schröder (1998-2005). In this period, we argue, a significant and until now permanent paradigm shift in public health policy was institutionalised, which aims at and results in the creation of a form of subjectification, which we call the *healthcare self*. This healthcare self, which is self-reflexive, well advised in health matters, and informed about the price of health related misbehaviour, reflects changing patterns of government far beyond the healthcare sector.

In recent years significant transformations have been observed in modes of governing, the shape of the state in Western democracies and in the relationship between the governing institutions and the citizens. Generally speaking, one can describe these changes as the production of highly ambiguous policies that generate many new options to choose on the one hand and as such produce more freedom for individuals. On the other hand, disciplinary forces and control strategies complement this picture with authoritarian aspects. These perspectives were especially promoted by the governmentality studies approach (Burchill et al. 1991, Foucault 2007, Foucault 2008, Krasmann and Volkmer 2007, Bröckling et al. 2011, Walters 2012), which analyses the general political rationalities of governing modern societies. It concentrates on the programmatic level and analyses the time and place of the formulation of problems and related political ideas.<sup>1</sup> In analysing contemporary or 'advanced liberal' political programmes it is more and more concerned with the transformation of government into strategies of governing the self or: the transformation into self-government (Rose 1999, Dean 2007). The analysis of subjectivity and subjectification (Esfandiari 2010, Fejes and Nicoll 2008) is the 'other side' of governmentality.

Applied to the field of healthcare politics, the governmentality approach offers an in-depth understanding of recent transformative processes transgressing the borders of standard health policy research attempts (Toth 2010). The politics in this field (other examples can be found in labour market, family, and gender politics) are basically character-

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<sup>1</sup> This also implies that governmentality analyses are mostly counterfactual analyses of possibilities and problematisations within discourses about subjects, not analyses of subjects themselves.

ised by strategies of activating people to feel responsible for their health and take responsibility under the guiding principle of self-care (Ziguras 2004) and disease prevention. To achieve the intended effects, the policies of the making of the healthcare self rely on health advice as well as sanctions like the punishment of those who refrain from prevention programmes. Not only the patients' position is changed in that process, but also the division of labour between institutional levels, where middle or mediating and lower ranks gain in power, which has been labelled the 'new state arrangement'.

Healthcare regulation played an important role in the general processes mentioned, because hardly anywhere else self-care seems more perspicuous and convincing. Some of the phenomena concerned have been analysed in a long term perspective by Ziguras (2004). Yet, while he concludes that "individuals are increasingly burdened with impossible responsibilities, unrealisable expectations, escalating anxieties and ceaseless striving" (ibid, p. 13) through a self-care discourse, he only marginally focuses on the role of institutional and welfare state change within this process.

Therefore we will scrutinise several questions combining the three core levels concerned (institutional change, discourse and subjectivity): How is this new subjectification form (the healthcare self) produced? Which incentives, institutional arrangements and discursive strategies have been used in the period concerned to mediate between the governmental level and the subjects? Which rationalities and which political reason are reflected therein? And, finally, what does that indicate concerning the general position of patients in the healthcare system? The reforms newly pose the question, if healthcare is a right or something to be merited through good conduct.

## **2. The German healthcare system**

To understand the change, it is important to understand the structure of the healthcare system in Germany. More than 90 percent of the population are members of one of the many public compulsory health insurance funds (GKV), to which they contribute according to their income. The GKV-System is based on four principles, whose relative weight changed immensely in the period discussed:

- Solidarity: balance of risks, social equalisation; causes complex redistributions between groups (the healthy and the ill, the rich and the poor, the young and the old, people with and without children);
- Personal responsibility: follows the concept of the competitive and performance society; opportunities to take and carry out own decisions and acceptance of responsibility for the consequences
- Hierarchy (“Subsidiarität”): responsibility of local or subordinate institutions before superior institutions/central government
- Justice: a fair relationship between needs and the services provided

Membership of the funds is compulsory up to a certain income level. Employers and employees until recently had to contribute equally. It is also possible to be a voluntary member of public funds for high income insureds, who for whatever reason do not want to be in private health insurance. Persons above a certain income and self employed professionals are free to opt for a private health insurance company. In this system there is a lower degree of redistribution between groups. Tariffs are individually arranged and depend on age, gender and disease situation of the insured and not on income (following the model of actuarial justice). Risk patients (like HIV or cancer patients) may be rejected by the insurance company. In this article we will focus on the GKV system only.

### **3. The red-green government and their healthcare reforms**

After winning the general elections in 1998, the new government of social democrats (*SPD*) and greens (*Bündnis 90/ Die Grünen*) under chancellor Schröder saw its main task in the field of healthcare in rectifying measures of its predecessors that were perceived as undermining the principle of solidarity in the social insurance system. However, the government did not stay in line with this approach. In the literature there are three phases of the red-green healthcare politics (Gerlinger 2003, Holze 2009).

The *first phase* was characterised by the retraction of restrictive measures of the conservative Kohl government, which followed the basic goal of cost containment. Regulations that had privatised health costs, like no claims bonuses and co-payments, were withdrawn in the “law to strengthen solidarity within the compulsory health insurance fund”. There

was, however, one basic assumption that the first red-green reforms shared with their predecessors and that kept guiding other reforms to come: healthcare was seen as too costly, and expenditures should be restricted. All measures to reach that aim were directed at the institutions involved (by restricting or “budgeting” expenditures). This law was followed by a new reform motion, which even though it never passed, first set specific impulses of what later became the new red-green political grammar. Having once more aimed at a stabilisation of expenditures, it focused much more on activating strategies instead of on the negative incentives of the Kohl government healthcare politics. Its cornerstones, as announced by the government, were the focus on disease prevention, health promotion, self help and rehabilitation, deeper integration of inpatient and outpatient care, strengthening the role of the family doctor, improving patients’ rights as a basis for “personal responsibility”, stabilisation of health insurance contributions and improvement of the quality and efficiency of drug-supply. While phase one healthcare politics fulfilled the pre-election promises of strengthening solidarity, it also signalled an ideological shift.

The *second phase* was characterised by minor corrections and new signs of a policy change. All measures implemented still focussed on institutional regulations of the insurance system (drug budgets, risk compensation between health insurance funds). But efforts to privatise healthcare cost came from several sides, also from within the government.

The *third phase* has been labelled “the re-privatisation of the risks of illnesses” (Holze 2009). It was part of chancellor Schröder’s “Agenda 2010”, probably the most extensive programme of dismantling the welfare state<sup>2</sup> in the history of the Federal Republic of Germany (Deppe 2005). Its core principles for the health sector—all aimed at restricting social security contributions and costs—were the restriction of services, the furtherance of competition, the broadening of personal responsibility and co-payments, standardisation of quality checks, the end of equal healthcare contributions of employers and employees, and tax-financing of specific services. The respective law (Compulsory Health

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<sup>2</sup> One has to keep in mind that the dismantling thesis reflects the view of healthcare fund insurants who clearly lost previously granted rights and funding options, while at a general level one can observe not a dismantling but a re-structuring of the logic of state inventions (cf. Lessenich 2008 and section 4).

Insurance Modernisation Law, German: “Gesundheitsmodernisierungsgesetz”, GMG) contains most of the instruments analysed in detail in the following section.

Eventually, the red-green reforms were in line with their predecessor’s in some elements and went partly well beyond them, focussing mainly on economic interests, as symbolised in buzzwords like “cost explosion”, “ballooning costs”, “Germany as business location”. Regarding the patients, the reform aimed at dealing with the three core elements: patient autonomy (strengthening patients’ rights, prevention and health promotion), options for patients’ decisions, and privatisation (individualisation of risks and co-payments) (Holze 2009). These reforms were both the requirements and the techniques for the formation of the healthcare self.

#### **4. Measures**

##### *4.1. Positive incentives and choice options: diversification of tariffs*

Aware of the psychological disadvantages of negative incentives, the red-green reforms have given patients many new opportunities to choose between care options and payment models. Since 2004 compulsory health insurance funds have been able to offer insurants a variety of new care and payment models, by which they have inserted functional elements of market oriented private insurance into the public system. Very important in this regard was also the introduction of “innovative care programmes”.

So called *Disease Management Programmes* (DMP) were introduced in 2002 to better coordinate care for chronically ill patients suffering from diabetes, breast cancer, asthma, and COPD. The aim was to improve patient care and save money through a systematic (‘structured’) attendance of these newly defined special risk groups coordinated by the family doctor and oriented toward up-to-date guidelines of the best disease management which a board of experts has to agree upon. The family doctor is supposed to be strengthened as a ‘gatekeeper’ and patient guide. This shall avoid extravagance caused by patients visiting too many doctors on their own or by avoidable sequela and comorbidities. Resulting from phase three of the health reforms, compulsory health insurance funds can give

financial incentives for participating in DMPs (reduction of co-payments, practice fees or insurance contributions).

The so-called *family doctor centred care programme* has similar functions. Insurants taking part in these programmes obligate themselves (against the former principle of free choice) to always visit their family doctor first (exceptions are cases of emergency and visits at the gynaecologist's, eye specialist's, and paediatrician's) who then decides whether a specialist should be seen or not. The government calculated immense savings. Patients can receive bonuses in return.

The incentives given for 'innovative care' are based in wider regulations on bonuses, refunding, and cost sharing. Compliance bonuses have a tradition going back to the Kohl government (dental prostheses co-payment lowered for regular check-up participants) but are now widely used incentives in all sectors. The GMG law allowed the compulsory health insurance funds to pay bonuses for taking part in the programmes mentioned above, for enrolling in special tariffs (see 2-3), employer provided preventive measures, check-ups, screenings and health promoting behaviour and training programmes. This has resulted in the emergence of a large sector which delivers training programmes and courses on subjects such as healthy food, back exercises, relaxation, and conducting smoking cessation. Most insurance funds pay for the bulk of the expenses and give rewards for having taken part. The new tariff models rendered possible by the law are the following:

1. The law allows patients to observe a tariff that guarantees paybacks in case they had no claims on the health insurance fund (except check-ups and screenings). So it is in their financial interest to not see the doctor in case of an illness, because their expected payback would then be at stake.
2. Patients can opt for a reimbursement model. Those taking part in this have to pay for the doctor's services directly - like those being insured with a private health insurance company (those in compulsory health insurance have to hand their insurance card and pay practice fees and co-payments, but not the medical service as such). They are only refunded afterwards by their insurance fund. Refunding



only applies for the services that are insurance standards. Optional services have to be funded by themselves.

3. Bonuses and contribution refunds can also be given for those who agree to a deductible. This is beneficial for those who expect to make only infrequent use of these services (for voluntary members in public insurance funds only)

All the models have one thing in common: insurants have the chance to be financially better off by doing something they are normally not obliged to do or for taking the risk of high personal expenditures in case of an unexpected illness. Further risks that are no longer covered by default, like costs for glasses and certain prostheses, can be privately insured. Therefore, compulsory health insurance funds can offer their insurants additional contracts.

#### *4.2. Negative incentives: cuts, co-payments and medical practice fees*

Although the central task of the 2004 reform was to achieve the financial goals through strengthening competitive elements and personal responsibility as shown above (cf. Holze 2009), there were also forthright cuts. Services that compulsory health insurance would not pay for in the future included funeral and birth expenses, sterilisation, glasses and lenses, and transportation costs. The reform also constituted the end of equal health-care contributions for employees and employers, which was at the heart of the German social insurance system. The cuts and the restrictions have at the same time given rise to IGeL services (“individual healthcare services”), which physicians can offer in their practice. They are not considered as essential and have to be paid for by the patients. Despite these severe cuts, the most prominently discussed issue in public discourse was the so called “practice fee”. Since GMG was introduced, all patients have to pay a 10-€fee for each quarter of a year in which they see a doctor and another 10 € for seeing a dentist. The same sum has to be paid for visiting a medical specialist without a referral by the family doctor. The coalition also raised the sum and the length of payments for stays in hospitals and rehabilitation centres. Cures, drugs, remedies and adjuvants have to be co-financed by the patients at 10 % (partly with one-time fees per prescription, partly with lower and upper co-payment limits; for details see Holze 2009). It is remarkable that

medical check-ups not leading to treatment were excluded from the practice fee. The red-green government had not yet introduced measures to directly discipline people who would not observe preventive demands. Yet, such measures followed under their sequel, the grand coalition of conservatives (CDU) and Social Democrats (SPD).

#### 4.3. *Prevention law*

“Every citizen shares responsibility for his/her own health” (Ulla Schmidt, health secretary)<sup>3</sup>

The general shift from cure to prevention, which can be observed in many western countries (Mathar and Jansen 2010, Ullrich 2009, 2010), has been a principal idea of the period addressed. Consequently, the Schröder government tried to bundle this in the “law to fortify healthcare prevention”. It aimed at the upvaluation of prevention and establishing it as a fourth pillar of the healthcare system next to cure, attendance/care and rehabilitation (Rosenbrock 2010). Notably, this was planned with a strictly individualised focus. Its aims were to strengthen primary prevention, to ensure its financing by social insurance carriers, to expand setting approaches (“life-world approaches”), to establish a generally binding set of concepts of disease prevention for healthcare. Additionally, a foundation was to be installed that would be responsible for the definition of mandatory aims, quality management, and evaluation of prevention.

Although the law was not passed in the end (not because of disagreement on the guiding ideas, but for financial reasons and bickering over responsibilities between administrative branches), a basic agreement across political camps and professional status groups was established: the consensus that there is a lack in prevention in Germany and that a corresponding law for improving health and reducing costs is an indisputable necessity. Both aspects are tied together, as can be seen in the stated main potential of prevention:

“Quality of life, mobility and productivity can be sustainably improved and otherwise necessary costs of illnesses can be reduced through effective and efficient prevention”

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<sup>3</sup> Ulla Schmidt, [http://www.die-praevention.de/presse/reden\\_beitraege/dokumente/05-03-08\\_interview\\_aachener.html](http://www.die-praevention.de/presse/reden_beitraege/dokumente/05-03-08_interview_aachener.html), 2008

(BMGS 2004). In the law's explanatory statement, the basic assumptions of the authors about health in society become apparent. All preventive measures are understood as being connected with economic interests (productivity, efficiency, costs) and dependent on individual health *consciousness* and behaviour. Individual responsibility for one's own health is defined as both a basis as well as an intended effect of prevention: "On the basis of personal responsibility of each person, the measures and services of the law strengthen the awareness for a responsible way to manage one's own health. This includes one's own behaviour and the social environment" (BMGS 2004).

Although the law intended to strengthen setting approaches and took into consideration "social environments," this does not go beyond the primarily individual focus. Taking into consideration social environments only means valuing them as a peripheral condition for successful access to those who should be convinced of healthier *lifestyles* and whose personal responsibility should be promoted: "With such measures people can be reached where they live and work. These measures are useful to strengthen many people's health awareness and to show opportunities to act in their specific life-world. In this way people not easily accessible as target groups can also be included in preventive measures" (BMGS 2004). However, social environments are – contrary to all knowledge of medical sociology (Naidoo and Wills 2003) – not understood as independent factors that influence health chances.

#### 4.4. *Electronic health card*

One core element of the GMG law was the electronic health card (Decker and Grave 2010). The health card was also the first among the government's several "eGovernment" projects aiming at consequently digitalising administration (Engemann 2002, Decker 2005). It was taken up under the leading role of the ministry of the interior (sic!) in cooperation with the ministries for finance, economy and health. The card is intended to function as a kind of ID card legitimising the insurant with a photograph, personal data and – most importantly – the electronic signature. It contains a programmable micro chip that enables the system to change the card's functions. Among those to be implemented are several data storage functions (the electronic prescription to displace paper prescriptions, a set of medical data of the patient for cases of emergency, information on chronic

illnesses and intolerances to medication). A central feature to be applied in a later phase is the so called electronic medical record. The card will give the patient access to an extensive file that contains his/her full medical history. Its equivalent data-access-condition is the doctors', dentists' or psychotherapists' 'healthcare professional card'. The full system's structure seems to be more significant than the storage functions mentioned. Unlike prescriptions and emergency data, the patient record and the (in the future completely paperless) communication between healthcare professionals about the patient will be stored in a "telematic" data network. All medical professionals and insurance funds will have access to all data that are not locked by the patient on purpose (not to mention the providers with access to the back-end system).

This system is aimed at coordinating optimal and integrated treatment and care and avoiding costs caused by double prescriptions, printed documents and the like. The government explicitly stated that the card aims at empowering patients by enabling them to access their own data and thus giving them more control over the processes related to their health: "The health card aims at improving quality of treatment, increasing transparency in healthcare and providing the patients with the opportunity to more strongly participate in the treatment process" (Bales 2005).

The guiding ideas of cost efficiency through control of the patients by healthcare professionals, the control of the professionals through patients, empowerment, self monitoring—all this reflects current governmental techniques and their legitimising discourses that do not necessarily need disciplining force to come into effect, because they are mediated and solicited by rational self-interest.

## **5. Subjectivity and New Rationalities of Governing**

### *5.1. The production of the healthcare self*

The electronic health card stands *pars pro toto* for the ambivalent new political grammar as we construe it. Decker has accordingly examined the telematic system behind the card from a governmental studies perspective as what he called a "panoptic fantasy" (Decker 2005), as a structure that allows for the extensive control of patients and forces them to

evaluate their own health situation, behaviour, data and their implications. For Decker, this is primarily the effect of the panoptic principle of the unequal distribution of visibility (Foucault 1979). The knowledge that – given a panoptic situation – you are potentially under surveillance all the time (in the telematic system: all the centrally stored data), combined with the insecurity about the intensity of actual surveillance, Foucault argues, functions as an incentive to incorporate the (expected) logic of the surveillance agents by the ones who are under surveillance, resulting in self monitoring. Especially in the preventionist environment, which makes prevention the guiding principle in more and more areas of life (Ullrich 2009, 2012), the knowledge of actual or feasible surveillance will have a self-disciplining effect. The constant awareness that non-compliance and “misbehaviour” (missed check-ups, untreated high blood pressure etc.) can be detected, may lead to extensive reasoning concerning health related behaviour and possibly to more conformity.

The panoptic arrangement reflects the programmatic foundations of the modern liberal capitalist societies, which are based on an economic rationality (Foucault 2007). This entails that the individual is expected to calculate rationally in questions dealing with his/her body. This is what modern governmentality is about - the objectification of subjects, the structurally individualised making themselves and their bodies the object of governmental reasoning.

While Decker focussed more on the indirectly repressive and disciplining aspects of objectification/subjectification in connection with the card, Ullrich (2009) also stressed the productive and activating aspects, because it is not only conformity that is produced by fear of material or symbolic loss through illness. The system also aims at empowering people. Patients will have access to their personal health and illness related data. And they will be enabled to decide which personal data will be accessible by which healthcare professional (although patients will have no influence on which data are stored in the system, Decker and Grave 2010). The card with its multiple functionalities also produces new forms of knowledge (at least for those who can handle the technology). The card is thus a device in normalising patients as “co-producers of quality health care” (Bopp 2000).

Disciplinary functions and activating or freedom-based arrangements work hand-in-hand to add to the production of the healthcare self. The obverse of the card's empowerment potential is the necessity to take the chance offered. Those who cannot or will not take it will pay for it. Elderly, poor and less educated people for example will be at a disadvantage because of the high technical demands. Those who do join in will find their role changing from a patient seeking help and advice to a patient managing his/her own health – considering advantages and disadvantages of health related behaviour, studying diagnostic findings, pondering usage rights of their personal data. The same ambiguity is a fundamental characteristic of the red-green reforms, the prevention programmes, the disease management programmes and the educational appeals for healthier living. They can be empowering (as more prevention can result in better health), distribute knowledge (through coordinated care, setting approaches) and capabilities (training). Yet, at the same time, they change the subject's thinking and implicitly give the people new tasks.

Backed by a discourse on ballooning costs and a need for more rational, market-based solutions, they consist of direct financial incentives, strategies of empowerment and a “new moral regime” (Mathar and Jansen 2010) emphasising responsibility and accountability for oneself and the society. The accompanying media discourse, that was not part of our study has been characterised as such: “While until recently [...] the single individual was the focus of healthcare, now the individual citizen is subordinate to the benefit and welfare for society” (Müller 2006). Under these circumstances we see a new patient at the horizon, whose emergence almost all patient-related aspects of the red green healthcare reforms have contributed to. In line with the analysis of the “enterprising self” (Bröckling 2005), we call this the healthcare self. The healthcare self modelled as an ideal type in the Weberian sense is the subjectivity of a patient who has learned to manage her/his health by:

- Being exposed to a political and moral discourse on health and the crisis of healthcare
- Acquiring quasi-expert knowledge on a wide range of tariffs and treatment programmes, health related technical infrastructure
- Choosing from offered opportunities

- Reasoning about health related behaviour and lifestyle, creating awareness of one's own biography of illness and health by using the information on the electronic health card
- Feeling responsible for his/her own future performance, considering that (financial) outcomes depend on personal behaviour and conditions
- Accepting the family doctor as the key regulator for diagnosis, therapy and rehabilitation
- Paying for former non-commodity benefits.

It becomes obvious that this new self is a real manager of her/his health.

### 5.2. *New State Metamorphosis*

From a governmentality studies perspective which analyses new subjectification processes, this form of government can be seen as creating spaces and power regimes of freedom (Rose 1999), through which – by managing his/her individual health – the subject is in a very basic way made *responsible*. In the case analysed here, this “government of freedom” (Parton 1999) is characterised by its efforts for the production of techniques that activate and make responsible, thus having a deep impact on the construction of a healthcare self. However, these techniques can also be analysed within a wider framework that pays attention to a metamorphosis of the state.

This metamorphosis of state regulations cannot simply be analysed as a reduction of state activities (Lessenich 2008), even though material benefits of the healthcare system for patients have been reduced, like other demands patients could have formerly made to the state's social security institutions and thus risks are being privatised. They rather have to be seen as a change within the state's areas of activity (e.g. investment in infrastructures for data collection and control while privatising medical service costs). And they are modifications of the power structures between administrative institutions, a new configured mid-range level and the (self-) regulated subjects.

From a state perspective the central role of the family doctor is symptomatic. Within his realm, the doctor has a relatively influential position for several decisions concerning the

patients' bodies. Within this realm, autonomy for the doctor as mid-level regulator between the patient and the wider healthcare system is created. This space is, on the one hand, produced by the governing institutions; on the other hand, it shifts power relations from a national level to every local point of intersection between the healthcare system and the subjects using it. Connected with the implementation of the integrated care (“integrierte Versorgung”) reform, the establishment of an interrelated system between in-patient and out-patient care institutions, family doctors, medical specialists and rehabilitation centres (Holze 2009), a new net of (power) relations is created.

At the same time the family doctor functions as a gatekeeper for the patients, who are confronted with this disciplinary institution that authoritatively guides the subjects through the healthcare system. This disciplinary approach is crossed by its functional replication on an even lower level that is described by the subjectivity of the healthcare self as above. Equipped with techniques to handle this disciplinary realm (prevention, fitness, care for health etc.), the healthcare self patient will find it full of opportunities. And he/she will be equipped with the respective knowledge. Again, freedom is produced and governed at the same time.

We observe similar modes of government in the restructuring process of the health insurance funds. The GKV functions in a way like the family doctor. The realm for their action and responsibilities in the healthcare sector is also constructed by the national government. Within this legal space the funds have a relative autonomy to regulate their tasks.

To establish the healthcare self, these funds organise programs for insurants in the name of prevention, activation and responsabilisation. Training courses, bonus tariffs, and the creation of risk groups are some among the various facets in line with the political grammar of the state institutions and the funds at the same time. These programs function again as ambivalent techniques to regulate the patients' behaviour; for some they may be authoritarian modes of government, especially if the affected person finds her-/himself in one of the “risk groups”; for others (or the same person under different circumstances), these techniques act as freedom-space producers, because of the multiple possibilities to choose one's individual healthcare behaviour. Here again the healthcare self finds one of its sources.



Yet it needs to be highlighted that the state in these particular examples has not disappeared, nor are the state institutions the same as before. We can observe a metamorphosis where the state disaggregates and re-aggregates on different levels of regulation instances, amongst which the national level is only one power node among others. And the power relations are organised in a new way between the national level, the strengthened mid-level or local institutions (family doctor, healthcare funds) and the subject (the healthcare self), of which the latter two are more and more autonomous or obligated to self organisation – within the boundaries set by the state. This is what we can call a new state or a new state arrangement (Gales and Scott 2009, Kausch 2008: 93-105).

## 6. Conclusion

On a macro level, the observed changes in healthcare, as in other policy fields, signify a transformation *within* welfare states that change their character on a principal level. We have demonstrated that the character of state interventions changed from a mode of guaranteed, greater solidarity-oriented provision to state interventions that focus on activating citizens, who are supposed to feel responsible for their wellbeing, and to mid-level regulators, who become relatively autonomous agents, both acting in heteronomy. Yet this perspective should not make one forget that this nevertheless also implies changes on the distribution of life chances and severely impacts on social inequality.

All the measures and tariffs enable insurants to influence their healthcare costs through rewards for 'positive' behaviour or through restricting one's own claims against insurance funds. People who opt for one of the new tariffs will be responsible for their physical wellbeing more than ever before. The administrative call for reducing costs is delegated to the patients themselves and the mid-level regulators. It is clear that these tariff models, the new co-payments and the practice fee accelerate the privatisation of health risks and prioritise the rich, the young and thus the healthy over the rest of the insured. The consequence is increasing inequality in the healthcare sector and an acceleration of the process of change from social to actuarial justice (Schmidt-Semisch 2000), from solidarity to reciprocity (Leitner and Lessenich 2003). It is also clear that co-payments, which are irrespective of income, strain the poor more than the rich. Re-distribution from the

bottom to the top is also supported by the end of equal contributions of employers/employed.

All this is rendered possible through a new grammar in healthcare politics, which has allowed the establishment of new discourses and new institutional arrangements, and is subsumed here under the label “the new state”. The help and opportunities offered, the advice and guidance given, and the moral as well as financial pressure inflicted upon help and prevention deniers all contribute to the subjective legitimacy of this new arrangement.

These trends are part and parcel of general transformations of western democracies. It is noteworthy that they were often initiated by social democrats in government. Programmatic in this regard was the Blair-Schröder-Manifesto (Blair and Schröder 1999), which stated: “People rightly demand high-quality public services and solidarity for all who need help – but also fairness towards those who pay for it. All social policy instruments must improve life chances, encourage self-help and promote personal responsibility.” New Labour in the UK was the trendsetter for the German Social Democrats (Merkel et al. 2006, Unger et al. 1998). Their “rights-and-responsibilities” rationality was implemented in Germany through the so called “Agenda 2010” and also the healthcare reforms. Yet, the essence of the political programme we analysed was continued and even strengthened by subsequent governments under the leadership of the conservative chancellor Angela Merkel, who found the field discursively well prepared for new cuts, restrictions and activation strategies, although with new stress on direct cuts and new compulsory payments. The grand coalition lead by her made several screenings or consultation on the screening programme compulsory (e.g. breast cancer prevention programme). Non-compliance can double the amount to be annually paid by chronically ill patients. This is accompanied by a discourse asking if risk takers (like snowboarders, smokers etc.), should be excluded from health insurance services. Other milestones in the following Merkel government healthcare reforms were the definite end of equal payments by employers/employees through additional healthcare contributions for employees only and tax funded support for the healthcare system, the further implementation of the health

card<sup>4</sup> and steps to substitute the former system, in which contributions to the healthcare-funds still depended on income, with a *per capita* contribution.<sup>5</sup>

The new arrangement, as introduced under the red-green alliance, aims at restricting guaranteed demands by replacing them with self-activating individual responsibility. It is clear that these transformations are in conflict with the idea of health provision as a human right, which is acquired by birth and not by good behaviour.

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<sup>4</sup> Much later than proposed the card is now being widely distributed, although with strictly reduced functions for the starting period.

<sup>5</sup> The most significant new measure in this respect was the introduction of an additional monthly insurance fee for patients of needy insurance funds, which is irrespective of income and comes with no complementary payment by the employer. Yet, in November 2012, the Coalition of Conservatives (CDU) and the Liberal Party (FDP) decided to withdraw the 10-€practice fee in 2013. The decision had been pushed forward by the Liberal Party. In return, the CDU got their demand for the so called “Betreuungsgeld” (“childcare money”) accepted. It will be given to mothers, who raise their children under the age of three at home instead of utilising childcare institutions. This logrolling shows that the rationalities behind political decisions are not always coherent. The slight turn now becoming visible is nevertheless no paradigm change.

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