

# **The future of the welfare state: paths of social policy innovation between constraints and opportunities**

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## **Financing healthcare reforms in Bismarckian welfare systems**

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### **The future of the welfare state**

#### **PATHS OF SOCIAL POLICY INNOVATION BETWEEN CONSTRAINTS AND OPPORTUNITIES**

### **8. Financing the welfare state**

#### **FINANCING HEALTHCARE REFORMS IN BISMARCKIAN WELFARE SYSTEMS**

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Social protection can be financed through taxation on labour, capital or consumption. In the European Union, it is actually funded mostly by social contributions on wages paid by employers and employees (including the self employed) and to a lesser extent by general taxes (consumption, household income, capital income and corporate taxes). In 2005, social contributions made up 59.0% of all receipts (PETRASOVA, 2008).

The European average masks major national differences in the structure of social protection funding. The differences are historical and due to the institutional rationale behind social protection systems. Northern European countries, where government funding dominates, are steeped in the “Beveridgian” tradition (in this type of system, it is sufficient to be a resident in need in order to be eligible for social benefits). Other countries are strongly attached to the “Bismarckian” tradition, in which the system is based on the insurance concept (in the form of contributions). However, the difference between European countries is gradually narrowing, with more funding from tax revenue in those countries where it used to be low, on the one hand, and with more coming from contributions in the countries with high levels of government funding, on the other (PETRASOVA, 2008).

Since the mid-1990s, a number of Member States have implemented reforms to their tax systems. These reforms have usually shared the aims of reducing tax burden on labour (particularly at the low to middle end of the pays scale) and of achieving a general reduction in corporate income tax rates (whilst broadening the base). Reforms of indirect taxation have been more diverse. Increases in indirect taxation in some countries were driven by green tax reforms, often as a counterpart to the reduction in the taxation of labour (Eurostat, 2008).

The tax burden on labour in the European Union can be measured by the implicit tax rate on labour employed (ITR on labour). In most of the European countries, social security contributions have a higher impact on the level of the ITR than the personal income tax. On average, in 2006 about two thirds of the overall ITR on labour consists of non-wage labour costs paid by both employees and employers. The ITR on labour grew strongly from the beginning of the early 1970s. This general increase was quite significant in the 1970s, in the

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1980s and the first half of the 1990s. It led to an increase in the weighted EU-15 average ITR from less than 30% (1970) to almost 42% (1997) (ESA79 data, Eurostat, 2008, p.69).

The general long-run trend towards increasing the ITR on labour stopped in the late 1990s. Between 1995 and 2006 the components of the ITR on labour have changed in several Member States: personal income taxation of labour as well as employers social security contributions and payroll taxes have gone down. Some member states have opted for cutting taxes or social contributions for low wage and low-qualified workers. These cuts in social contributions were mostly aimed at granting relief to employers.

Generally, benefits with a strong insurance dimension (old age pensions or unemployment benefits) are predominantly financed by social contributions, while such benefits as family and social exclusion benefits are financed by general government revenues. The financing of health care expenditure varies greatly among member states (European Commission, 2008). In Member States with a stronger Bismarckian emphasis, social health insurance is financed from social contributions<sup>2</sup> while those with a stronger Beveridgian emphasis are tax-based financed.

This paper will focus on healthcare financing reforms in Germany and in the Netherlands, two countries which are attached to the “Bismarckian tradition”. The aim of the recent healthcare reforms in Germany and in the Netherlands was to partially decouple healthcare finances from labour income and to enhance managed competition between insurers. These countries have introduced a central fund to allocate resources to health insurers, mandatory coverage for the entire population, a uniform income-dependent premium determined by government authorities, a community-rated premium determined by health insurers and more instruments for health insurers to contract selectively.

The first and the second parts of this paper will give an overview of the key features of these reforms in Germany and in the Netherlands. The third part will discuss the effects of competition among health insurers (competition that is supposed to lead to greater efficiencies in health care delivery and lower costs) and will analyze the redistributive effects of these new types of financing, as the shift from income linked contributions to nominal contributions clearly affect those on lower incomes more than higher earners. That’s why governments try to minimize negative financial consequences of the reforms by limiting the flat surcharge (in Germany) or through tax subsidies (in the Netherlands).

## **I. Health care reform in Germany**

German health insurance is the oldest mandatory national social insurance scheme in Europe. It dates back to 1883, when it was introduced by the parliament under Bismarck. All salaried employees must have a public health insurance. Only public officers, self-employed people and employees with a gross income above € 48 600 may join the private system. This statutory health insurance (SHI) is based on the pay-as-you-go principle and is provided by 248 non-for-profit sickness funds which are the main actors in the decentralized German system. Contributions are income related. Average contributions to finance social health

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<sup>2</sup> In France, social health insurance is financed through social contributions paid by employers and the Generalised social contribution (CSG). Also a tax of legal status, the CSG is exclusively allocated to financing the social security. Its assessment basis covers activity income, replacement income, investment and estate income, and income from certain games.

insurance have increased from 8,2% in 1970 to 14,6% in 2009<sup>3</sup>. About 90% of the persons with health insurance are members of the public system, while 10% are covered by private insurance.

For the provision of services included in the SHI benefit basket, providers get directly reimbursed by the sickness funds. Patients can freely choose a health care provider. However, co-payments for visits to outpatient care providers have been introduced in 2004 (€10 per calendar quarter are payable to the physician visited first in the quarter and to any other physician visited without referral). For hospital care, patients pay €10 per day, for drugs at least €5 and maximally €10 per prescription. Children up to the age of 18 are exempt from co-payments and co-payments may not exceed 2% of the annual gross household income (1% for individuals with chronic conditions) (SIADAT and STOLPE, 2005).

Reforms prior to 2004 mainly aimed at limiting health expenditure growth through sectoral budget caps and increased out of pocket payments (HASSENTEUFEL, 2004). In September 2005, a grand coalition of Christian Democrats and Social Democrats came into power. Facing urgent problems such as the high unemployment rate and the aging of the German society (that lead to decreasing revenues for health insurance funds<sup>4</sup>) and increasing health care expenditures, the government was under pressure to develop a sustainable financing mechanism for health care and attempts to secure long-term financing of health care insurance system. His main objectives are:

- to stabilize or reduce wage related costs
- to promote competition between health insurance funds by urging them to operate in an efficient way.

The Statutory Health Insurance Competition Strengthening Act 2007 has modified the financing scheme. It has established a health fund that collects social contributions and tax revenues (BUSSE et al., 2006). While the governing coalition partners shared the reform goal to decouple healthcare costs more from labour income, the final result has been a difficult political compromise (BODE, 2006 ; VASSELLE et CAZEAU, 2008).

Before A. Merkel was elected as chancellor and built the grand coalition, the SPD wanted to turn health insurance into “citizens' insurance.” Every insurance company – whether private or state-run – would have been required to insure every citizen regardless of risk. There would have been no distinction between private and statutory insurance plans, and no opting out of the system for big-earners, freelancers and civil servants as is currently the case. The insurance fees would have depended on income: the higher the pay, the higher the insurance rate. In the future, wages, salaries and pensions would all have been calculated into the equation as would have been private capital dividends ; however, earnings from rental property would have been excluded. Under the party's plan, all family members without an income would have been co-insured along with the main income-earner.

The CDU/CSU planned on introducing a “solidarity-based health premium.” Every adult would have paid the same constant insurance fee regardless of income. The exact percent would have been altered slightly to take into account lower incomes. The dual system, which requires both workers and their employers to pay a portion of the insurance coverage, would have been kept under the CDU/CSU, but the rate due by the employer would have remained constant. For pensioners, the employer's portion would have been taken out of the retirement

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<sup>3</sup> Since July 2005 an additional contribution of 0,9% is levied on members of social health insurance funds. Deutsche Sozialversicherung Europavertretung. Available at <http://www.deutsche-sozialversicherung.de>

<sup>4</sup> And we musn't forget that the German health care system has come under financial strain because of wage austerity too.

insurance. Insurance for children would have been paid for out of tax revenues. The union planned to increase competition among the various state and private insurance providers.

The current health fund has been implemented by the grand coalition on January 2009. It draws on employer and employee contributions as well as on tax revenues (to help fund insurance of children). Contributions and tax revenues flow directly into the health fund and are no longer paid to health insurers. The government sets a uniform contribution rate for all insurers while social insurers set it independently until the reform goes into effect (Commission des comptes de la sécurité sociale, 2007). Sickness funds and private health insurances receive a flat rate out of the fund for each insured person and are entitled to additional risk-adjusting payments if they insure many old or sick persons. Funds that operate efficiently may refund part of the contribution payments to their members or offer additional benefits. Excess costs may be covered by charging a nominal premium from their members (up to 1% of gross income) (LISAC et al., 2008).

So far, sickness funds have competed mainly via contribution rates, which they have been free to determine. Now there is a unitary contribution rate set by the Government. With price competition limited to the extra premium or the refund, sickness funds now have to compete through the development of new insurance plans and tariffs. For example, they are required to offer gatekeeping and disease management programmes (DMPs) to their members. Funds are free to develop deductible health plans where the insured – in return for contribution refunds – pay a certain amount of health care costs out of their own pockets (KAUFMANN, 2009).

To reduce the effect of rising healthcare expenditure on labour costs, contributions from the federal budget to the central health fund will be gradually increased (to compensate insurers for the free co-insurance for children). However, there may be some doubt as to whether the reform will actually materialise in view of the see-saw policy changes with respect to general budget contributions to the social healthcare system in the recent past (budget contributions have been reduced substantially in 2007 compared to 2006) (BRANDT, 2008).

## **II. The Dutch health care reform**

For many years, Dutch health insurance for basic care services consisted of a two-pillar system. One pillar consisted of the social health insurance system for people in the lower income brackets<sup>5</sup>, and the other pillar was the voluntary private health insurance system for people with higher incomes. In 2006, the Dutch government implemented radical market reforms and the two pillars fused into one mandatory national health insurance system executed by private insurers. The key idea of the market reforms is to increase efficiency by promoting more competition on the health insurance market as well as on the health care provider market (COHU et al., 2006 ; VASSELLE et CAZEAU, 2008).

In 2006, the government introduced a basic benefit package that is mandatory for all Dutch citizens. All citizens have freedom of choice in choosing their health insurer. Consumers are able to choose from a variety of different options. They can choose between benefits in cash and benefits in kind. They are able to choose voluntary deductibles (up to € 500 per year) and receive premium discounts in return. All insurers are required to accept all applicants and an insurer must charge the same premium for the same coverage (community rating). Risk selection is not allowed. Children up to the age of 18 are insured without any costs attached. The Dutch government implemented a risk equalization system that compensates health

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<sup>5</sup> The income threshold was set at € 30 000 in 2005.

insurers for predictable differences in their medical expenditures (the development of the risk equalization system dates back to 1991 in the social insurance system) (DOUVEN et al., 2006).

All citizens, except children under 18, must pay (BUSSE et al., 2006):

- a nominal premium directly to their health insurer. Community-rated premiums differ among health insurers. The idea being that consumers discipline health insurers by voting with their feet if they are not satisfied with the performance of their health insurer ;
- an income dependent contribution, levied by the tax collector, to the Health Insurance Fund (HIF). The HIF also receives contributions from the government (for example for expenditure on children under eighteen). The HIF reimburses this money, after applying risk equalization, to the health insurers (DOUVEN et al., 2006).

While the financing system was also present in the social health insurance system before the reforms, the size of the nominal premium was much smaller than the size of the income dependent contribution. Under the new health care system the law requires that 50% of all expenditures must be paid by income dependent contributions and 50% by nominal premiums. This implied a significant rise of the nominal premium for people in the lower income brackets from about 390 euros in 2005 to about 1050 euros in 2006. The increase in nominal premiums resulted in a loss of spending power of the lower income groups and therefore the government now compensates more than five million citizens with monthly income-dependent subsidies. Moreover, the dutch government tried to minimize negative financial consequences for private households by raising old-age pensions and by increasing allowances for families with children. Nevertheless, 20% of households lost some purchasing power after the reform (GREß et al., 2007).

In the first year (2006), about 20% of the dutch population switched health insurer. The dynamics of consumer mobility was driven primarily by low-priced group contracts. In 2006, many people switched from an individual contract to a group contract as health insurers are allowed to offer premiums discounts for group contracts (the discount is capped at 10% of a similar individual contract) (DOUVEN et al., 2006). Health insurers started a premium war and tried to attract customers by offering low-priced contracts, in particular by discounts on group contracts (premiums of these contracts were offered below the break-even price). As a result of this price competition in 2006 and 2007 health insurers incurred annual losses of about 2% of total premium revenue on the offering of basic health insurance (DNB, 2008). Since 2007 insurers started to cut operating costs, premiums converged and switching rates dropped to about 4%. In 2006 and 2007, the annual increase in per capita total health expenses was around 4% (WYNAND et al., 2009).

Although consumers may choose between 41 individual health insurers, market concentration has increased considerably since the implementation of the reform. The health insurance market is dominated by four conglomerates of health insurers. These four conglomerates have a joint market share of 80%. However, until now health insurers hardly seem to have used their newly acquired opportunities for selective contracting. There are several reasons for this reluctance of health insurers to engage in managing care. One of these reasons is the limited availability of high-quality information. Insurers often do not have sufficient information to selectively contract with good-quality providers. A second reason may be that health insurers do not have enough bargaining power to obtain favourable contracts with hospitals. Hospitals exert market power, especially in those regions where the number of hospitals is small. A third reason is the fear of a loss of reputation if they restrict consumer choice to a limited network of preferred providers. Both provider and consumer organizations are critical about restrictions on free provider choice. If better performance indicators were available, insurers

would become more inclined to offer preferred provider plans. The real test of the reform is still to come (WYNAND et al., 2009).

### III. Competition and redistributive effects

Some key features of the healthcare reform in Germany look similar to the dutch system: the introduction of a central fund to allocate resources to health insurers, mandatory coverage for the entire population, more options for consumers to choose from (including voluntary deductibles), a uniform income-dependent premium, a community-rated premium determined by the insurers health-based risk adjustment and more instruments for health insurers to contract selectively. But the separation of social and private health insurance remains in Germany (GREß et al., 2007). In all cases, the ultimate goal of the reform is to promote more competition on the health insurance market as well on the health provider market (ENTHOVEN, 1993; LEGAL, 2009)

The price signal for competition in these new systems will come from the community-rated premium in the Netherlands and from the possible surcharge that german insurers will have to levy (those who will not be able to cover the costs with the payments they receive from the central health fund). The key idea is that competition will increase efficiency (SIADAT and STOLPE, 2005). But introducing competition into the healthcare market is not without risks, as it may threaten redistribution from good to bad health risks:

- the switching rates of persons who are chronically ill may be lower. These bad risks are not entitled to a discount as it is rare they are covered by group contracts and they don't opt for a voluntary deductible ;
- health insurers can also compete with different supplementary insurance packages and these packages are a tool for risk-selection (as group contracts can be). In the swiss insurance system, holding a supplementary insurance contract substantially decreases the propensity to switch<sup>6</sup>, except when the individual assesses his/her health as “very good” (Dormont et al., 2009).

But financing healthcare through community-rated premiums is also antiredistributive as individuals with low income are hit much harder by a flat fee than wealthier individuals. Flat fees alone are regressive (HONEKAMP and POSSENRIEDE, 2008). The shift from income linked contributions to nominal contributions clearly affect those on lower incomes more than higher earners. That's why governments try to minimize negative financial consequences of the reforms by limiting the flat surcharge (in Germany) or through tax subsidies (in the Netherlands). In that sense, the Tinbergen rule is fulfilled : two instruments (flat fee<sup>7</sup> and tax subsidy or ceiling) are used to achieve two targets (competition and redistribution).

According to the OECD (BRANDT, 2008), the price signal is too weak in Germany as the flat surcharge cannot exceed 1% of members' income subject to contribution charges. This ceiling does not encourage low income earners to switch. Brandt proposes to increase the flat surcharge in Germany to make a more significant price signal and to enhance price

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<sup>6</sup> If we take the Swiss example, insurers cannot operate risk selection for basic contracts and they have to charge uniform rates. But their provision of supplementary contracts, free of all constraints, enables them to operate risk selection, since it is rare for an insured person to choose two different insurers for these two types of cover. And there is very little switching, since nonstandardized supplementary contracts are very hard to evaluate and compare.

<sup>7</sup> The surcharge in Germany and the community-rated premium in the Netherlands

competition. A substantial increase would also raise the need to protect lower income earners from financial hardship, which is done through tax subsidies in the Netherlands. But these subsidies reduce the price signal for lower income groups and restrict or distort effective competition among health insurers (competition that is supposed to lead to greater efficiencies in health care delivery and lower costs). Redistribution is hardly compatible with competition. Then if continued health care inflation pushes up the nominal premium, it can be difficult to contain increases in tax subsidies. There seems to be no way around an equity-efficiency trade off when competition is used as a tool to attain more cost-efficiency in healthcare and there is no example of a country that has addressed both problems in a satisfactory way (BRANDT, 2008).

Nevertheless, if subsidies are not tied to changes in the flat fee (which, given the trend of increasing healthcare costs, can be expected to rise), they are likely to decline in relation to total individual health care payments. This situation would lead to less redistribution from rich to poor, as the subsidies to the poor are more likely to come under attack and could be more easily reduced than the level of redistribution within an income-related financing structure. In times of economic slow down, general tax revenue, which are used to pay subsidies, may easily be redirected towards other government expenditures (HONEKAMP and POSSENRIEDE, 2008). Switzerland experiences these problems with its system of flat premia combined with subsidies for low income earners (BILGER, 2008). The swiss experience is characterized by an imperfect competition in the health sector and an unclear bookkeeping system of health insurers. That is why the constant increases in health premiums cause troubles to middle and low income households (DE JONG and MOSCA, 2006).

In time of economic slow down, the basic mandatory benefit package is likely to be reduced or co-payments rates to be risen and the private health insurance to develop (supplementary or complementary insurance). Co-payments are virtually absent from the basic insurance package in the dutch system but the benefits package of compulsory (statutory) insurance is accompanied by a controversial system of co-payments in Germany (in response to the rise in healthcare expenditures, user charges have increased under the Statutory Health Insurance Modernization of 2004). But co-insurance is regressive in terms of income since it takes a larger proportion of low incomes than from high incomes. It also lessens the redistributive effect from healthy to sick people as these people suffer from higher health expenditure, which they have to pay themselves as a result of co-insurance.

For example, private insurance performs a complementary function within the French system: private insurers cofinance spending on medical goods and services. They meet all or part of patients' health costs which are not covered by social security. In reality, complementary insurance has over the years become a kind of safety valve in France, allowing adjustments to be made to the state system rather than a way of compelling those covered by social insurance to share collective responsibility (TURQUET, 2004).

But this system is unfair as premiums are set on the basis of actuarial rates (i.e. Risk-rated): the level of premiums charged is based on age or on health status and insurers are allowed to cherry-pick the "good risks" (KAMBIA-CHOPIN et al., 2008). 85% of the French population currently have complementary cover (20% of the German population). Because private complementary insurance was not available to everyone, it was judged necessary to introduce universal health cover (*couverture maladie universelle*, or CMU), which came into effect from 1 January 2000. There are two parts to this: basic CMU and complementary CMU. Complementary CMU provides free complementary insurance to any one normally resident in France, if their financial means do not exceed a level set by decree and this inevitably produces threshold effects.

That is why an assistance system called *aide complémentaire santé* (ACS) has been set up in January 2005. The objective of this financial aid is to help people who have an income just below the threshold enabling them to benefit from universal complementary health coverage (CMUC) to obtain complementary health insurance coverage. The analysis of the contents and price of the complementary health insurance contracts demonstrates that subscribing households, even after having benefited from the ACS, are still contributing considerable sums with respect to their total income. The system currently leaves beneficiaries paying almost 60% of the price of the contract, which represents around 4.5% of their annual income. This is an overhead which is much higher than that borne on average by other insured households, despite the fact that they choose cheaper contracts (FRANC et PERRONNIN, 2007).

All in all, decisions on what mandatory health insurance reimburses (and at what rate) are likely to depend largely on how far the health spending deficit can be controlled. If it persists, it is a fair bet that private insurance would develop, strengthening the tendency described above towards inequalities. Tax or social subsidies for the least well-off will not then be enough to eliminate these inequalities. But tax incentives are the mechanism generally used to increase the scope of private services and insurance and reduce that of basic social protection.

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