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This essay will address the particular influence of Germany's social health-insurance system on the constitution of the German life-course model.

Since 1883 health insurance has been mandatory in Germany, at first only for blue-collar workers. Over the years, this social health-insurance system has expanded to cover ever more groups of employees, so that today its various non-profit companies insure nearly 90 per cent of the population against illness. Among the insured are to be found both the employed and the unemployed, as well as their children and spouses, as long as the latter are not gainfully employed. Participation in this social health-insurance system is mandatory up to a certain income, above which it is voluntary. The various para-public health-insurance companies are financed by mandatory monthly contributions deducted from the paychecks of their insured together with matching contributions by employers. Contribution rates are determined by the solidarity principle, not by the principle of equivalence used in private, profit-oriented insurance. The regulatory framework anchored in the Social Law Code stipulates that a board made up of equal numbers of employer and employee representatives administer each of these self-governed health-insurance organisations. Culminating a far-reaching liberal reform of the German social health-insurance system over the past decade, the freedom to change each year from one company to another was introduced in January 1997. These non-profit organisations are thus now competing with one another for members, i.e. for insured persons. Contribution rates range among companies from 9 to 14 per cent of monthly wages or salary. Thus both the insured and employers have a monetary incentive to pick an inexpensive company. The company pays for medical treatment for the insured and their immediate family, and pays sick pay for insured persons who are hindered by illness from going to work for a period of six weeks or more, up to a maximum period of one-and-a-half years. The medical services covered and the level and duration of sick pay are identical among all companies. There is very little room for competition in the form of offering unique or special services.

In what follows, I will present the findings from our research on the subject of "Institutional Regulation in Flux: The Example of Social Health Insurance", conducted in Bremen's Special Research Centre, "Status Passages and Risks in the Life Course". In this research, in which we employed both quantitative and qualitative methods, we interviewed the insured as well as administrative representatives of various health-insurance companies. I will comment on the light which these findings shed on the following issues:

1. Social policy and the life course

2. The reconceptualisation of welfare-state health-care policies in a society characterised by longevity and employment crisis

3. Para-public health-insurance companies' conception of their role in the

German health-care system and in the shaping of the life course

1. Social Policy and the Life Course

The scope of the Northern European welfare state's role in the formation of life courses was characterised by Lord Beveridge as "from the cradle to the grave". In social-policy research, many scholars maintain that the modern life course was actually "created" by the welfare state (Leibfried, Leisering et al. 1995). One speaks of the institutionalised life course. International comparative political science even claims to observe a specifically German life-course regime constituted by the country's specific formative influences, particularly those of its educational system and welfare state.

Life courses can be described from this perspective as a series of stations and transitions. The concept of status passages facilitates the analysis of the interactive process of negotiation between biographical actors and institutions. Time frames, norms and expectations concerning the passages are reciprocally constituted by both sides and structure the transitions. Life courses can be studied particularly well precisely at such transitions from one social status to another. Welfare-state institutions regulate a variety of transitions between life phases and realms, especially those surrounding gainful employment. They prescribe status passages and institutionalise clear caesurae. There are hardly any transitions in the life course which are not somehow framed by social policy: from birth to the status passages into the educational system, into an independent household, the job market, marriage, illness or joblessness and then into retirement. All such transitions are guided by welfare-state institutions. Social-policy framing is not restricted to authorising certain statuses and entitlements or funding these, but also involves organising transitions. Social-policy guidelines help shape life-course regimes primarily by more strongly separating life phases from one another, i.e. by defining and regulating the transitions from one social status to another. They hereby establish social ordering principles. At the same time, individuals as agents in their life course contribute to its organisation as well, making use of the offerings and alternatives of the educational system, for example. Reciprocal, interactive relationships thus exist between individuals and welfare institutions, requiring considerable life-management skills on the part of individuals. Social-policy mandates provide persons, occupational groups and firms with structures and incentives for the organisation of occupational careers and life courses. Citizens and firms take into account the rewards and sanctions of social-policy regulations in their decision-making and actions.

In critical political debates it is often hotly debated whether the welfare state and its institutions further processes of individualisation or act as instances of collectivisation and social control. The empirical findings under discussion here suggest that German social policy has succeeded over the years in protecting individuals against want and the vicissitudes of life and has expanded the options available to them to help them to lead an independent life. Social policy is understood here as a functional precondition of modernity, i.e. of individualisation and the pluralisation of lifestyles (Schmidt 1998). Social policy eases the burden on institutions which traditionally have secured the welfare of

individuals, such as the family, the church or even firms. Welfare-state institutions are interpreted here in the same way as are legal and educational institutions and markets, namely as secondary institutions (Beck 1986). Whereas the older collective institutions, like the family and the church, influenced individual action directly, secondary institutions like those of the welfare state guide individual action indirectly (Leisering 1997). The welfare state has paved the way to an individualisation of social problems by institutionalising individual benefit claims. Both opportunities and burdens can result from this.

The preconditions for a realisation of benefit claims are provided by the welfare state in the form of resources, competencies, rights and opportunities (Kaufmann 1988). Such resources include for example monetary benefits provided by health-insurance companies in the case of longer-term disability due to illness (sick pay). Individual competencies are strengthened or restored in situations of illness by medical treatment and consultation, financed by the social health-insurance system. Social and labour rights protect the sick worker from dismissal and guarantee him or her appropriate, state-of-the-art medical treatment or rehabilitation. Opportunities for managing such health-related crises are provided by health-insurance companies' service infrastructure, e.g. their counselling services, as well as by medical services covered by their health-insurance plans.

The primary means by which the welfare state has structured the life course in Germany - as well as in Europe generally - has been the pension system. At a closer look, however, one sees what a pivotal role the social health-insurance system has played and continues to play in the institutionalisation of the life course. Policies aimed at ensuring or restoring the health of workers and ensuring their ability to work productively indirectly shape the life course via the institutional framework of the health-insurance system. Life-course policies do not become practically meaningful until benefits are claimed in concrete situations in the firm or in the health-insurance system. Central to life-course policy in Germany has been the guaranteeing of social status through para-public health-insurance companies' financial benefits and medical benefits-in-kind. The concept of the life course has during recent decades increasingly become the subject of public and scientific discourse. Similarly, health has become a public good (public health) and an object of natural-scientific (medical), social-scientific and economic inquiry (Labisch 1992).

If one wishes to investigate the influence of social policies on life courses, or seeks to shape life-courses via social policy, it is necessary to understand the normative life-course conceptions of contemporary institutions and the resulting push-and-pull effects they have on the relevant actors: on citizens, on the medical system so heavily financed by para-public insurers, and on firms. Over the last hundred years in institutions such as pension-, unemployment- or health-insurance as well as the educational system, a conception of the 'normal biography' has gained hegemony both in terms of its empirical prevalence and normative validity. It consists of sequenced life stages: work-free childhood, school attendance, full-time employment, enduring marriage and then retirement at a fixed age.

2. The reconceptualisation of welfare-state health-care policies in a society characterised by longevity and employment crisis

Physical and emotional health underpin the life course. Health can be understood as an individual's ability to successfully manage his or her own needs and expectations, on the one hand, and the demands and imperatives of the external life- and work-worlds on the other. Welfare-state programmes aimed at the restoration of health should, therefore, be based on such a relative conception of individual productivity. A long-term perspective is called for here, namely that of the life course, in which socially and culturally mediated assumptions and interpretations of health, productivity and fitness for work are taken into account.

A connection between health and productivity follows from the fundamental institutional order of market-based societies. The psycho-physical and social dimensions of survival in industrial and market-organised societies are linked to income, and this in turn is tied to gainful employment. Ability to work, in turn, presupposes productive capacity, i.e. health. Health must be seen as a relative entity located between the poles of consummate well-being and serious illness. The concept of 'relative health' serves to express the idea that health is less a physical property than a co-ordination of demands and action-potential. This structural precondition organises the life course with its central phase of gainful employment. The centrality of gainful employment - or, more broadly, of the economy as the sphere organising work - is reflected in the normative and ideological perception of work in the societal orientations of citizens. An end of the work-based society can be diagnosed neither on the level of concrete action nor on the level of consciousness. Only the highly privileged or those who are willing to pay a considerable social, health or existential price can escape the compulsion to work. Even a departure from the world of paid work through no fault of one's own can lead, as we know, to momentous crises in an individual's social, economic and health conditions.

Because employment can be threatened by illness, accident and aging, and because training is prerequisite to individuals' ability to work productively, a range of employment-related welfare-state institutions have been built up in Germany over the last 100 years. The systems of education and vocational training as well as social-insurance institutions aimed at curing illness and cushioning the economic consequences of occupational disability, unemployment and aging are the most significant of these. The social health-insurance system covers 90 per cent of the German population "from the cradle to the grave" with cash benefits and benefits in-kind. Benefits-in-kind occur mainly in case of illness and are provided by doctors or medical facilities. In Germany, most social-policy benefits are predicated on employment, and family dependents are insured through the breadwinner. Benefits are designed to secure the social status of the employed and to facilitate transitions and changes in status.

Welfare-state health services aimed at the maintenance or restoration of individuals' productive capacity over the life course are of contemporary relevance in that the relation between an individual's health and ability to work, which has always been problematic, has in recent years become particularly

precarious.

A historically unique situation has developed in the demography of the Western industrial countries. Germany's age pyramid has been put on its head: in the not-so-distant future more than 40 per cent of the population will be older than sixty years-of-age. Average life-expectancy has more than doubled during the last hundred years. As other countries, Germany too has become a society of longevity.

Labour-force participation rates as well as rates of premature invalidity, unemployment and physical disability suggest that in market-oriented industrial societies aging and employment are difficult to reconcile. We have the knowledge and technology to organise work humanely and justly. There are sufficient possibilities for structuring work-demands in ways which are compatible with the decline in an individual's productive capacity over the life course related to his or her age and/or other factors. In spite of this, firms tend to pursue a policy of exclusion of older workers and of those whose productivity has declined, instead of endeavouring to design jobs to match changes in employees' abilities over time as part of a long-term career policy.

A lively debate is raging in Germany on the utility of the country's social and health-policy instruments. The task at hand is to redefine these instruments and to establish a new practice. The impulses for these debates and reform efforts come not only from the demographic trend mentioned above, but also from the precarious job market and a crisis in medicine. The poor job market is relevant because the revenues of social-insurance institutions, foremost those of para-public insurance companies, are tied to wages and salaries. If the number of employed persons decreases, then real incomes decrease as well, and this reduces the revenues of the social health-insurance system. A 'scissor effect' has emerged in which revenues and expenditures drift apart. The crisis in medicine plays a role in the debates on health-care policy reform in that health-care benefits are both theoretically and practically inseparable from clinical medicine. A biomedical conception of illness-episodes prevails in clinical medicine, and the approaches and concepts of acute medicine predominate. The legitimacy and necessity of many physician services, as many medical services generally, have come under fire in recent years, particularly due to pressures of economisation. Medical services nowadays must be able to demonstrate their effectiveness and efficiency, and to hereby justify their utilisation of monetary and human resources.

A society characterised by longevity and by the intensification of the social, organisational and technical rationalisation of work needs to conceive of new ways in which welfare-state health-policy can help maintain and restore citizens' health and thus their capacity to participate in the life course. Medical treatment and clinical rehabilitation no longer suffice to close the growing gap which emerges in the aging process between productive capacity and productive demands. New conceptions of prevention and health-promotion are called for, and have indeed been developed and strategically applied to the life course and to the occupational career.

Existing welfare-state policies are oriented toward short-term episodes, not

longer-term phases of illness, unemployment and poverty. Rooted in a variety of institutions, such policies are carried out in a fragmented fashion and from a short-term perspective. Prerequisite to a reconceptualisation of welfare-state health policy, then, is a reorientation of the concepts of government steering and regulation as well as of normative orientations. Such a modernisation of health policy was begun in recent years. A certain paradigm shift can be observed in social and health-policy discourses, involving a turn from exclusive fixation on illness to an emerging orientation toward health and health promotion. This means replacing the short-term time horizon with a longer-term perspective oriented toward stabilising and organising future life phases and a successful life course. Moreover, in light of current bureaucratic health risk factors resulting from poor case- and disease management and from the low level of compliance and co-operation of the insured, efforts are being made to better incorporate the insured's notions concerning the meaning of their life course. The patient-client can no longer be understood or treated as a passive 'object'. Instead, the services of para-public health-care companies and of the medical system need to focus on citizens' social status and on their need for information, education, interpretation and participation. The welfare state should no longer deal with its clients in a patronising, paternalistic and bureaucratic manner; instead, such contacts should be characterised by a respectful, democratic-participatory tone. The fruits of these reform efforts in the Federal Republic of Germany will now be explored using the example of the social health-insurance system.

3. Para-public health-insurance companies' conception of their role in the German health-care system and in the shaping of the life course

For the reasons mentioned above, a series of laws have been passed in recent years to bring about a modernisation of the social health-insurance system. Because of the newly introduced freedom of the insured to change from one company to another, para-public insurers now compete with one another for members. This places them under more intense economic pressure. The reform legislation also greatly strengthened their position relative to the medical system. Companies now can conduct cost-benefit analyses of and budget medical services, as well as exert influence on the substantive and organisational shaping of these services. The question is whether para-public insurers are perceiving and taking advantage of their new statutory powers and whether the social health-insurance system's hitherto implicit direction and regulation of life courses is now hardening into an explicit policy. The change in the self-understanding of insurers is expressed in their slogan, "from administering to shaping". Indications that the social health-insurance system is on a path of modernisation are to be found in a range of new programs and pilot projects as well as organisational changes which accentuate the service function of insurers above and beyond their traditional role of bureaucratic bill-payers. This is a reaction of the social health-insurance system to changes in the demands and value-orientations of citizens, as expressed in their growing health-consciousness and desire for individual autonomy.

Similarly, the social health-insurance system's understanding of its role relative to the medical system has changed. Para-public insurers no longer conceive of themselves as mere financiers of medical services, but rather exert influence on

the quality of such services and assume the role of managers of patient careers (case- and disease management). Health management in the broadest sense now forms an essential point of orientation in insurers' programmatic self-representations. Insurers' new management concepts target medical treatment in the outpatient and stationary sectors as well as prevention and health-promotion in the work-world and in various sectors of the life-world.

The category of "gate-keeper", the function of organisations and decision-makers to grant or deny access to certain status passages and benefits, has by now become a standard category of life-course research. This function of institutions and decision-makers can be supplemented with that of the "*Lotse*", an instructor-guide in welfare-state institutions who elucidates the pros and cons of alternative paths in the life-course and counsels citizens, sometimes even attempting to direct them into specific paths considered either by society or by the institution in question to be desirable. This guiding function is familiar to us from the realm of medical and occupational rehabilitation (Marstedt, Mergner 1993, Müller 1997) as well as from the realm of occupational guidance for secondary school graduates.

In the social health-insurance system, health-promotion and health-education were until recently to be understood as attempts to avert the negative careers of the chronically ill with their undesirable status culminations of early retirement, severe disability and dependence on nursing care, or at least to limit the economically undesirable side-effects of these "careers" in advance. In 1997, such efforts at health promotion by para-public health insurers were restricted to the work-world. Since this statutory change (in Article 20 of the Social Law Code, Book V), insurers have resorted to other measures aimed at redirecting patient flows by creating incentives for the utilisation of "alternative" and "communicative" medicine. This is clearly life-course policy in a very direct sense, going beyond the mere regulation of temporal and material frameworks. Although insurers do not dictate behaviour, in that the insured individual can choose among alternatives, they do establish fairly precise substantive guidelines concerning the directions in which prospective everyday behaviour and lifestyle decisions should be reoriented.

Broadly sketched, there are three types of regulatory mechanisms currently being tested as pilot projects on the German social health-insurance scene:

1. the "primary physician model" and related concepts which aim to augment the role of the general practitioner in place of the specialist as the point-of-entry into the medical system (gatekeeper)

2. the "practice network" model and related projects which endeavour to improve co-operation between outpatient physicians in their treatment of patients and to simplify access to medical services - for example in cases of emergency - and to avoid unnecessary duplicate diagnoses

3. special alternative therapies involving long-standing and increasingly popular unconventional methods which under certain conditions are now being integrated into the service packet of health-insurers (Schulz,

Niedermeier, Veghte, Kahrs 1998).

Further, there are specific instruments such as physician quality circles, reimbursement provisions and modern communication technologies which are partially or fully integrated into one or more of the pilot projects.

Let me now attempt to summarise more generally the elements sketched thus far concerning a changed self-understanding among Germany's para-public health insurers, including the resulting changes in their organisational strategies:

- moving beyond the role of the "third-party payer" to that of an institution which exerts influence not only on the financing of medical services, but also on their nature and quality (consumer-protection function).

- an increasingly critical stance toward the medical system. A prime example is the rising interest in so-called "alternative" therapies as well as the augmentation of the role of the primary physician in the interest of more "communicative" in contrast to "high-tech" medicine.

- development of approaches and strategies targeted at specific population groups on the basis of the analysis of routine health-insurance data. These include projects and concepts for health reporting and for workplace health promotion.

- recognition of structural social change and concomitant changes in health risks and problem-situations. An example of this is the increase in information and counselling services for the insured (Marstedt 1998).

- a greater presence in the "everyday milieus" of the insured. Examples of this are media and materials targeted at schools, sports clubs, firms and self-help groups.

- acknowledgement of the insured as self-confident clients for whom the quality of service is increasingly important. Examples of this are information and counselling services and the greater presence of insurance companies in the mass media as well as a reorganisation of work routines and internal organisational hierarchies.

- increased use of economic controls including quality assurance programs for medical services. Examples of this are projects in the in-patient as well as outpatient sectors.

All the above features suggest a trend, and there is indeed a great deal of evidence to suggest that para-public health insurers are indeed moving towards a stronger role in the health-care system, also in the sense of a greater management of risks in employment careers.

The new steering concepts and regulatory mechanisms of para-public health insurers can be described in two ways which together warrant their characterisation as an augmented, more explicit life-course policy, to the extent

that they exert influence on the routine health and sickness-related behaviour of the insured and of professional organisations and institutions, including firms. First, insurers attempt to target risk groups based on routine health-insurance data. Their services are more problem-oriented. Second, they attempt to exert influence directly or indirectly on realms of medical care which until now have been ineffective or inefficient from a medical standpoint. Influencing processes of chronification of illness stand at the forefront of these endeavours, involving complex measures as well as improved care in the form of case management. The question remains whether para-public insurers' hitherto implicit life-course regulation will in the future be transformed into an explicit, systematic and strategic point-of-departure for their activity.

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