Activating life course policy: social assistance and health insurance in Germany

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Social Assistance and Health Insurance in Germany

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Zusammenfassung

In dem vorliegenden Papier, das im Kontext des Sonderforschungsbereichs „Statuspassagen und Risikolagen im Lebensverlauf“ entstanden ist, werden Veränderungen der Steuerungs- und Interventionsmuster in zwei Systemen der sozialen Sicherung untersucht, die sich entlang unterschiedlicher Strukturprinzipien entwickelt haben: Sozialhilfe und Gesetzliche Krankenversicherung. Die Ergebnisse beruhen insbesondere auf Interviews mit Experten aus der Sozial- und Gesundheitsverwaltung zu zwei verschiedenen Erhebungszeitpunkten in den 1990er Jahren. Im Untersuchungszeitraum läßt sich in beiden Systemen eine Abkehr von passiven, auf Geldleistungen ausgerichteten Interventionsstrategien und ein Bedeutungszuwachs von personenbezogenen Dienstleistungen und stärker handlungs- und verlaufsbezogenen Orientierungen zeigen. Diese Entwicklung kann als institutionelle Annäherung beider Systeme unter dem „Dach“einer stärker aktivierenden Lebenslaufpolitik interpretiert werden.

Summary

This paper builds on results from the Special Collaborative Centre 186 „Status Passages and Risks in the Life Course“ at the University of Bremen and deals with changes in the principles of regulation and intervention within two different institutions of the welfare state: Social Assistance and Health Insurance. The empirical findings are based on expert interviews conducted at two points in time in the 1990s. We find that the traditionally differing structural principles of both systems have been supplemented with new principles of regulation and strategies of intervention in the observation period. Examples are a loss in importance of passive monetary transfers and a new emphasis on personal aid as well as orientation on „time and action“. Thus Social Assistance and Health Insurance obviously converge towards a new model of intervention which we can call „activating life course policy“.

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1. Social Policy and the Life Course

In social-policy research, many scholars maintain that the modern life course was actually "created" by the welfare state (Leisering/Leibfried 1999). One speaks of the institutionalised life course. International comparative political science even claims that there is a specifically German life-course regime constituted by the country's specific formative influences, particularly those of its employment system and welfare state (cf. Allmendinger/Hinz 1998; DiPrete et al. 1997; Mayer 1996; Leisering/Leibfried 1999: 47-53).

Life courses can be described from this perspective as a series of stations and transitions (cf. Heinz 1991). 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. In Germany, 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 employment and careers. Citizens and firms take into account the rewards and sanctions of social-policy regulations in their decision-making and actions which affect the life course.

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. While this system offers security of expectations for people with 'normal' employment or family careers, special institutions of risk management have been established to secure the continuity of biographies in case of less

foreseeable risks like illness or income loss following unemployment or divorce. In this paper we will focus on two of these risk management institutions: Social Health Insurance and Social Assistance.

Social Health Insurance has played and continues to play a pivotal role 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. Physical, mental 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.

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.

The impulses for these debates and reform efforts come not only from demographic trends, but also from the precarious job market and the financial crisis in the health system. 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.

The last safety net in the German welfare state is *Social Assistance*. In the Federal Social Assistance Law (BSHG) which came into force in 1962 Social Assistance was designed to provide mainly support for special needs while the provision of income support for everyday needs was assumed to diminish with economic growth and the further development of the system of social insurance. Until the middle of the 1970s the number of recipients with income support actually remained on a low level. Since the 1980s however, Social Assistance in the form of

income support[1] has gained importance: Before the German reunification the number of recipients in West Germany doubled from about 920,000 in 1980 to 1,830,000 in 1990. In 2000 2,700,000 people received assistance in Germany as a whole, that is 3.3 % of the population. The factors responsible for the increase in numbers of recipients are most prominently rising unemployment, resettlement and immigration, but also high divorce rates together with inadequacies in family burden-sharing and divorce law, as well as budget-cuts in primary realms of social security. Thus, Social Assistance acts as a 'welfare state in reserve' (Leibfried/Tennstedt 1985: 24), as it reflects the failure or shortcoming of labour markets, employment and family policies and the prior social security systems.

At the same time, dynamic poverty research has shown that Social Assistance careers are generally shorter than widely assumed (Leisering/Leibfried 1999). The risk of poverty has proven increasingly to be not confined to one social class, i.e. to an 'underclass', so that one can speak of a "democratization" or "transcendence" of poverty (Leisering/Leibfried 1999: 240). From a life-course perspective, poverty appears as a heterogeneous risk- and life situation calling for highly differentiated institutional risk-management. Moreover, Social Assistance recipients are far more active than widely assumed in independently seeking paths out of Social Assistance. In most cases Social Assistance exerts the function to bridge critical phases or passages in the life course. This is even true for some groups of long-term clients such as lone mothers who have to rely on assistance for some years but who do not "settle in" or loose the ability to find paths out of assistance.

Traditionally, Social Assistance and Social Health Insurance are structured according to different principles. Since the 1990s, however, both institutions have been confronted with rather similar problems and challenges which have induced reforms in the provision of benefits and services (see below). These new approaches to social intervention indicate a convergence of both Social Assistance and Social Health Insurance toward "activating policies".

In the following we will first develop our research questions by briefly comparing the traditional structuring principles and the new challenges in the field of Social Assistance and Social Health Insurance and describe the empirical data of our study. Afterwards we will analyse the old and new patterns of regulation and intervention in both institutions in more detail. Finally we give a conclusion of our main findings.

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1 In the following we use *Social Assistance* only in the meaning of income support or assistance towards living expenses, respectively. The other branch, assistance for special circumstances such as disablement, will not be discussed here.

2. Research question and empirical foundations

If one examines the traditional structuring principles of Social Assistance and Social Health Insurance, we see clear differences in welfare-state arrangements, in the form and design of benefits and in financing principles (see table 1).

Table 1: Traditional structuring principles in Social Health Insurance and Social Assistance

Social Health Insurance	**Social Assistance**
6. Social Insurance	13. Public Assistance
7. Financing by contributions	14. Financing by taxes
8. Solidarity	15. Residuality
	16. Benefits according to need
	17. Help toward Self Help
	18. Individuality
9. Redistribution	19. Redistribution
10. Historically first cash benefits, later services, now almost only services	20. Cash benefits, to a lower degree services with normative priority on personal aid
11. Separation between financing and provision of benefits and services	**21.** Municipal financing and provision of benefits and services with central state regulation
12. Plurality of sickness funds with decentralised structure	

As the basic welfare-state principle we have the public assistance model versus the social insurance model. Social Assistance is financed by taxes whereas the social health insurance is financed by equal contributions of employees and employers. The principles of benefit provision are different: In Social Assistance the principles are residuality (meaning that all other services

For the structuring principles of Social Health Insurance see eg. Alber (1992), Bandeloh (1998). For the principles of Social Assistance see eg. Rothkegel (2000) and according to legal norms Schellhorn (1997).

and benefits must first have been exhausted); individuality (meaning that each application must be individually assessed to determine what cash or other benefits the claimant is entitled to), benefits according to need and help towards self help. Benefit is primarily in-cash but to a limited extent also in-kind benefits and personal services.

Solidarity in Social Health Insurance means benefits according to need (medically necessary benefits). Benefits were historically at first mainly in-cash, later primarily in-kind benefits and services. The benefit type differs as well as the organisational form: Whereas Social Assistance is characterised by mandatory communal responsibility with central-state regulation we have a plurality of sickness funds, with mostly statutorily set benefits.

Today, Social Assistance and Social Health Insurance are confronted by very similar challenges of intervention and regulation. Both institutions have been targets of far-reaching reform proposals in recent years, not least in order to relieve chronically strapped social budgets:

As already mentioned above the number of recipients of Social Assistance has increased in the last decades which means a burden to the municipal finances. In this context, there has been discussion of 'activating measures', in particular with regard to unemployed or employable recipients of Social Assistance, respectively. This suggestion is often associated with the assumption of possible disincentive effects of social assistance on looking for employment and demands for stronger sanctions in the case of client rejection of reasonable job offers.

For the Social Health Insurance system, enduring budgetary problems have led to proposals for new statutory regulations. Among other things, positive incentives are to be created for sickness funds to optimise health-care provision for the chronically ill through so-called disease-management programmes.

In Social Assistance and Social Health Insurance, institutional change has occurred over the course of the 1990s, the core of which is expressed in altered forms of regulation and intervention. In the process of this change, the heretofore very different structuring and regulatory principles in Social Assistance and Social Health Insurance have become more similar.

The central question of this paper thus is: Are there indications of convergence toward an 'activating life-course policy' in both welfare-state institutions? And if so, what are the features and limits of such an 'activating life-course policy'?

From the introduction of Social Health Insurance in 1884 until about 1920 monetary transfers in case of illness, pregnancy or death were the predominant type (Tennstedt 1976). In 1970, the introduction of statutory wage continuation by employers further reduced the importance of cash benefits in favour of in-kind benefits.

In order to answer these questions, we draw on empirical findings from two research projects of the Special Collaborative Centre 186 'Status Passages and Risks in the Life Course" at the University of Bremen. The first study was on 'Social Assistance Careers between Life-Course Policy and Social Change", the second on 'Life-Course Control via Accident- and Health Insurance".

The empirical bases are document analysis and problem-focused interviews at multiple survey times. In the study on Social Assistance between 1991 and 1993 18 interviews with experts at various levels in Social Assistance agencies were conducted focusing on time and action orientations. Another 20 interviews with experts between 1999 and 2000 in Social Assistance agencies as well as in associations and ministries dealt with similar questions.

In the second project we conducted between 1991 and 1993 40 interviews with experts at various institutional levels focusing the area of rehabilitation. Between 1994 and 1996 another 20 interviews dealt with changes in institutional regulation in the area of 'health promotion and counselling'. In the following research period we also interviewed decision-makers and so called 'leading lights' in 13 sickness funds with the focus on changes in institutional regulation of out-patient care.

These interviews which covered a period of about 10 years make it possible to investigate changes in Social Assistance and Social Health Insurance administration during the 1990s, in terms of both regulatory and interventionist concepts.

In the following we will describe the 'old' and 'new' models of regulation and intervention, first of Social Assistance and then of Social Health Insurance.

3. Patterns of regulation and intervention in Social Assistance

Since 1962, Social Assistance in Germany has been subject to uniform national statutory regulation through the Federal Social Assistance Law (BSHG). Implementation and financing is a local responsibility, however. The structuring principles of public assistance, which evolved historically out of medieval relief, were only partially overcome with the introduction of Social Assistance. Through the present day, Social Assistance is subordinate to other social benefit systems and is characterised by a highly negative public stigma.

3.1 The 'old model': statutory regulation and passive monetary transfers

Already in the 1970s and 80s, inadequacies in the German Social Assistance programme were documented in a variety of publications (cf. Münder 1988). In its institutional set-up and practice, Social Assistance was too passive, statutorily highly over-regulated, insufficiently client-oriented and above all, inadequate in terms of individually-oriented counselling.

In the 1990s, this critique was expanded to include that Social Assistance was too cost-intensive, that it was too problem- instead of resource-oriented and that paths out of Social Assistance were not actively supported. Moreover there was a widespread view in public political discourse that the level of Social Assistance benefits was too high compared to low-income jobs thus reducing the incentive to work.

In sum, we can speak of passive administrative behaviour in the 1970s and 80s and a model of Social Assistance practice which was nearly exclusively based on statutes, rules and procedures. This *passive rule-based and procedurally oriented management model* took into account *neither* time and action *nor* regulatory and interventionist perspectives: Social Assistance was considered to be a local responsibility with minimal potential for influencing recipients' behaviour or for developing innovative policy approaches – and when it did so, then usually in a negative way, i.e. by cutting benefit levels or introducing diversionary or filtering measures.

The expert interviews which were conducted by us at the beginning of the 1990s largely confirmed the aforementioned inadequacies of the Social Assistance programme. At the same time, upon closer examination, Social Assistance appeared already at the beginning of the 1990s to *no longer* constitute a uniformly problematic system in terms of its institutional set-up and administrative policy. Beside a *traditionally paternalistic and strongly rule-oriented case worker type*, who focused on supervisory and disciplinary tasks, features of a *service-oriented case worker type* began to emerge. For the latter, service, counselling and a client-orientation

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However, if there really is a „poverty trap" which keeps people in permanent receipt of assistance is not yet empirically proved (cf. Gebauer et al. 2002).

This means e.g. that it did not systematically differentiate between short term and long term receipt of Social Assistance and did not aim at influencing the behavior of clients.

represented central institutional action orientations. The *temporal dimension*, however, continued to play *no* significant role for either case worker type at the beginning of the 1990s. Rather, the image of the 'long-term claimant' prevailed in case workers' minds. As a result, the modes of interaction and contact with clients were accordingly undifferentiated, as were the measures which were supposed to facilitate Social Assistance exits, above all welfare-to-work (*Hilfe zur Arbeit*).

3.2 The 'new model': activating administration, incentive systems and counselling

Since the middle of the 1990s, a "*new look"* can be observed in German Social Assistance administrators' estimation of their ability to influence clients' behaviour. The motives for this are hard to identify. Besides *budgetary constraints*, the ideas of 'new public management' (cf. KGSt 1993; Brülle/Reis 2001; Trube 2001) has had a strong influence on Social Assistance administration since the mid-1990s. Social Assistance administration has undergone a *three-fold institutional change*, characterised – mostly indirectly – by *changed time and action-orientations*. An activating administration is developing, wherein Social Assistance makes more use of economic incentive systems and makes greater attempts to affect individual behaviour via counselling. In our analysis of the last round of interviews (1999/2000), we have found confirming evidence for the existence of all three of these lines of development.

Activating administration

The new concepts being employed include *entry counselling, planning assistance, case management* as well as *projects designed to improve institutional co-operation*. These new concepts (cf. Kontz 1999; Bertelsmann Stiftung et al. 2002) are always oriented strongly toward diverting claims or shortening the duration of claims by activating clients' financial and action resources, or those of third-party actors, e.g. social service agencies.

Economic calculation and incentive systems

Since the mid-1990s, we have witnessed not only the implementation of new *internal administrative* economic regulatory instruments in the form of the German variant of new public management, but also the laying of the foundations for a more strongly '*intensively formative Social Assistance policy*' with the reform of the BSHG (Federal Social Assistance Actor

Legislation) in 1996. The most prominent example is the welfare-to-work measures, which are conceived as payment of a kind of credit-advance on future benefit savings. A further example of this new administrative understanding are the growing efforts to calculate the effects of workfare-measures. Other examples of this '*activating administrative policy*' are the introduction of individual wage subsidies and the calculation of 'potential savings' in Social Assistance to be achieved through the expansion of debt counselling and the resultant furthering of Social Assistance exits.

Individual counselling

Our findings from the 1999/2000 interviews clearly suggest that over a decade, Social Assistance administration in Germany has come to focus more strongly on individual problem-constellations and Social Assistance 'career' trajectories in their assistance and counselling efforts. This can be described as an *actively-formative service orientation*, which, however, remains normatively strongly paired with traditional disciplining and paternalistic elements.

The limits of activating intervention are apparent. They are evident not only in the continuation of high case-loads (120 to 150 clients by case worker), but also in case workers' lack of professionalisation. To achieve the desired intensification of activating and counselling intervention, a professionalisation offensive is required. In order to furnish case workers with the necessary competencies in communication and interaction, either a fundamental professional reorientation of Social Assistance is necessary which more strongly incorporates elements of social work; or the academic training of case workers must be significantly enhanced to include psychological and communication-related elements, specifically devoted to tasks facing Social Assistance case workers. Yet in our interviews, we found *no* evidence that such reforms were translated into day-to-day practice.

4. Patterns of regulation and intervention in Social Health Insurance

Today, Social Health Insurance provides 90 per cent of the population with all necessary care in case of illness. Its core tasks consist in *financing* health-care benefits, which are to a large extent statutorily prescribed. These benefits are provided by a strongly segmented and in part privately

In the field of assistance for disabled persons there have also been attempts to strengthen competition between institutions since 1996 (see Rothgang 2003).

organised health-care system. The question of which benefits are provided in specific cases is not decided by sickness funds, but by the medical system. Yet, there are also realms of action which go beyond the mere administration of funds. Prevention, rehabilitation and health promotion are such fields of action. They were successively added to the palette of Social Health Insurance benefits since the 1970s. Since the 1990s another non-administrative field of action has been developed by sickness funds: They conduct pilot projects for reorganising out-patient care .

On the basis of the development in these areas, a parallel study has explored changes in the patterns of institutional regulation by sickness funds.

4.1 The 'old model': administering receipts and expenditure for the health care system

The patterns of intervention which we call the 'old model' are well described in the empirical findings discussed by Gerd Marstedt and Ulrich Mergner (Mergner 1993, Marstedt 1998). The focus of that research was sickness fund behaviour in the field of rehabilitation.

Despite statutory and financial degrees of freedom, sickness funds' institutional behaviour in the field of rehabilitation can be characterised as predominantly reactive gate-keeping. Although active and far-sighted risk-management were commended by the experts interviewed as desirable from a health-care policy perspective, the great majority of sickness funds did not pursue patterns of regulation or intervention which incorporated dimensions such as a time or action, e.g. they did not allow for patient careers or influencing clients' behaviour.

Sickness funds were for example found to have conducted no systematic analysis of the rehabilitation process, no systematic controls of costs, quality and efficiency and no active regulation of the volume of rehab-applications through targeted information campaigns. The sickness funds have had no strategy for the legally required co-ordination of the various rehab-providers; and to have limited their activity to that prescribed in legal norms, internal organisational regulations and external medical expertise concerning what is 'medically necessary'.

The patterns of regulation sketched here can be interpreted against the background of the Social Health Insurance system's routines and traditions. The prevailing patterns of intervention were based on the model of a government agency and administration with the task of distributing the

contributions of the insured while exercising only a merely formal control of benefit entitlements. These norms of action were transferred to the realm of rehabilitation, even though sickness funds in principle had far more freedom of action here than in the set of legally required benefits.

4.2 The 'new model': restructuring health care through health promotion and managed care

The example of health promotion can be used to sketch – briefly and in broad-brush strokes – several changes in the pattern of institutional regulation within the Social Health Insurance system.

Whereas traditional sickness funds largely were reacting to benefit claims, health promotion required them to develop their own benefit offerings and then to communicate these actively to the insured. The insured could no longer be perceived merely as passive 'applicants' and 'benefit recipients', but became target groups of different preventive strategies of intervention. The associated patterns of institutional regulation needed to be oriented toward the specific risks, problem-constellations and health needs of the insured and thus took into account the perspective of the life course.

Health promotion placed a myriad of new life course advising demands on the training and skills of administrative staff in sickness funds, e.g. with regard to informing and counselling the insured in health-care matters, analysing data or conducting health reporting. The vocational training programme completed by most sickness fund workers to this day – that of the 'social-insurance specialist' focussing on financial aspects – has been revised and enhanced. Existing personnel have been supplemented by academically trained specialists to plan and evaluate the new health promoting policies.

As of the mid-1990s, notwithstanding all justified scepticism concerning whether these reforms would lead to real health benefits for the insured, the above-described changes could be interpreted as early stages of a new institutional self-understanding of the Social Health Insurance system, i.e. as a clear departure from the previous model of 'financial administration for the medical system'. Still – as has been observed with regard to Social Assistance administration as well – these innovations were by no means universal or introduced simultaneously in all sickness funds.

A strong impulse for these new patterns of intervention was given by the introduction of individuals' free choice of sickness funds and thus competition among funds for members. This pushed funds toward a service and customer orientation. Yet this new orientation found expression more in 'modern' public relations than in substantive health promotion strategies. The partially justified reproaches of sickness funds' 'abuse' of health promotion for marketing purposes and to attract low-risk members led ultimately to it being statutorily sharply reduced. Yet the 'end' of health promotion did not slow the changes in institutional regulation – as we found out in our expert interviews.

Since the mid-1990s, new regulatory concepts and models for out-patient care have been pursued by a significant number of organisations in the Social Health Insurance system. The substantive focus of these models has been on projects which have developed new co-operative and networked structures of service delivery. Examples of this are physician networks, case- and disease-management projects. In addition, there have been pilot projects in new treatment methods, in particular in the field of alternative medicine, as well as a small number of projects in quality assurance.

The patterns of regulation and intervention by sickness funds are thus clearly no longer limited to the administration of the costs of illness. Rather, they aim to assume a partnership role with the medical system in shaping the substance, quality and structure of health care provision. Contractual arrangements are made with service providers to increase the quality of out-patient care. The insured are offered health-care alternatives. Counselling and support services are designed to guide the insured through the health-care system so as to avoid negative illness 'careers'. Just as in the field of health promotion, the new forms of intervention indicate a stronger reference to the life course, e.g. they intend to exert more influence on the behaviour of the insured population. Moreover, they are bringing about a renewed wave of professionalisation within sickness funds: nurses, doctors, pharmacists and public health specialists are being hired in large numbers, and administrative staff are receiving further training to enable them to become case managers.

The prime motive for this development, revealed in our study, has been the goal of sickness funds to achieve more economic efficiency and rationality in the health-care system over the middle and long-term. Closely linked to this are motives such as competition for the most attractive and effective models of health-care provision, as well as issues of quality and customer service.

After the red-green coalition came to power in 1998 health promotion was re-introduced in a modified form.

In our interviews it also became clear that the new concepts for health-care provision entail not only promise, but a series of health policy risks as well: We observe a tendency toward disintegration and a lack of transparency, for different sickness funds or sickness-fund types develop their 'own' models and hereby proceed not co-operatively, but in isolated fashion. The establishment of quality in terms of 'evidence-based medicine' goes hand-in-hand with a tendency toward the bureaucratisation and de-individualisation of medical care, which can bring disadvantages for the insured. Individual sickness funds' short-term business considerations (e.g. normative cost-profiles, prescribed budgets and risk-selective marketing strategies) tend to divert their attention away from social and macro-economic concerns, and hereby exacerbate existing social and health inequalities.

In a broader interpretation we can see a changed self-understanding among Germany's Social Health Insurance, including the resulting changes in their organisational strategies and the effects on the life course: The sickness funds are 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). They are adopting 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. We can see 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. There is 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 which intend to create a health consciousness especially concerning anti-smoking.

We can observe an 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.

The new steering concepts and regulatory mechanisms of Social Health Insurance 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 areas of medical care which until now have been ineffective or inefficient from a medical standpoint.

5. Conclusion: Convergence and divergence in Social Assistance and Health Insurance – Are there signs of a qualitative-activating life-course policy?

In summary, Social Assistance administration on the one hand is no longer based on a *passive monetary transfer function*, but – to put it in contemporary terms – on comprehensive '*activating time and action-related institutional resource management*'. An activating administration, economic calculation and incentive systems, and individual counselling and supervision constitute the core elements suggesting institutional change toward an activating life-course policy in Social Assistance. At the same time, however, the limits of such activating intervention are clearly evident. The Social Health Insurance systems on the other hand are making increasing use of their limited powers of discretionary and formative action. In the process, they appear to be walking a tightrope between bureaucratic traditions on the one hand, and management strategies reduced to cost-cutting on the other.

Table 2: Selected new regulatory principles and patterns of intervention in the 1990s

New regulatory principles	Social Assistance	Social Health Insurance
Regulatory goals	Efficiency, effectiveness, client orientation	Efficiency, effectiveness quality, ability to compete
Framework conditions or organisational form	Intercommunal comparison (benchmarking)	Freedom of choice for insured persons; competition among sickness funds
Service principle	citizen/client orientation, 'customer service, 'quality'	'customer service'
Prevention principle	'preventive help'	health promotion

Pattern of intervention	co-operation and networking, individual counselling, 'planning assistance', 'case management'	co-operation and networking as well as integrative service-delivery concepts (managed care, case management, disease management ...)
Professionalisation strategy	management competency, counselling competency	health-science / medical competency; management competency

In table 2 we have summarised the essential new regulatory concepts and patterns of intervention in Social Assistance and Social Health Insurance during the 1990s.

If we compare the new principles and patterns of regulation in both institutions we can identify divergent and convergent developments which affect the life course:

Areas of divergence

22. '*Quality*' is assuming a more prominent role in Social Health Insurance discourse, whereas in Social Assistance it is only marginal to the 'new model'.

23. The '*interests of the insured*' are (for now) of less concern to sickness funds in their new patterns of regulation and intervention than are the interests of clients to the Social Assistance administration. Social Assistance offices are concerned not only with improving their public image, as is to some extent the case among the competing sickness funds, but also with developing – since the early 1990s – fundamentally new and intensified policies. Examples of this are welfare-to-work (*Hilfe zur Arbeit*), support for debt counselling and improved service offerings.

24. The need for more *professionalised* management and a thoroughly altered personnel policy was faced by both institutions. Yet sickness funds have given more weight to this than have Social Assistance offices.

Areas of convergence

25. Both in Social Assistance and in Health Insurance, we observe, in addition to markedly *heterogeneous* implementation of 'new management' concepts, a very heterogeneous understanding of forms of client-related intervention. A uniform basic counselling concept cannot be discerned. We have found a mix of administrative cultures, composed of traditional-bureaucratic and modern service orientation.

26. 'Time' and 'action' are new and central points of policy orientation in both institutions, as is particularly exemplified by prevention policies aimed at influencing client behaviour.

27. Both institutions strongly support *integrated service-delivery approaches*, the aim of which is to improve the collaboration of social, medical and economic benefits and services through new forms of 'risk management'.

28. In both institutions, we see an increase in the importance of forms of intervention aimed at influencing client behaviour, such as counselling, information and education. In such measures, the individual coping forms and action resources of clients have moved more prominently into the foreground. In both institutions, a 'mediating' or 'channeling' function (pilot function) has emerged, resulting in case workers in the Social Assistance or Social Health Insurance systems referring individual clients to third-party entities. This reveals the limits of specialisation and the need for integrated, co-ordinated service offerings.

29. In both welfare-state institutions, we clearly see the outlines of a life-course policy with formative and strategic steering elements, as are inherent in interventions aimed at altering individual behaviour. Both Social Assistance offices and sickness funds exert direct influence on individual processes of coping and hopefully overcoming the risks of poverty and illness respectively. They not only frame the life course, but participate as active partners in the shaping of it through specific constellations.

30. The *social policy model of 'activation'* is well-developed in both institutions.

The question of whether a *qualitative*-activating life-course policy exists cannot be answered unambiguously, as old and new patterns of regulation and intervention overlap. Great importance is accorded by both institutions to ‘cost-cutting’ and image maintenance. Yet we also see clear indications that in recent years greater normative weight has been given to the ‘quality’ of social benefits and services. Thus we suggest that on the horizon of institutional change in Social Assistance and Social Health Insurance a ‘qualitative-activating life-course policy’ is indeed emerging.

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