Introduction: The European Union, the Insurance Industry and the Public-Private Mix in Healthcare

Cyril Benoît, Marion del Sol, Philippe Martin

CHAPTER 1

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1 Introduction

Over the last 20 years, European Union (EU) healthcare policies and their effect on healthcare systems and politics at national level have attracted significant attention from social, legal and political scientists (Anderson 2015, chapter 7; Greer and Kurzer 2016, Mossialos et al. 2010; Steffen 2005; see also Coron 2018). In this domain, treaties are categorical as to

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the limited competencies of supranational provisions, and Member States ostensibly retain power over a number of crucial aspects of their health policies (Vollaard et al. 2016). Unsurprisingly, what research has essentially reported in this broad context is a rather gradual development of EU healthcare policies, with more or less perceptible (and often indirect) effects at national level. Due to its frequently unanticipated nature, such development has typically taken circuitous routes and mainly manifested in two ways: first, by the dissemination of standards and guidelines or through the regulation of certain goods or commodities—knowing that the EU has a number of regulatory prerogatives in relation to vital health products, such as pharmaceuticals (Permanand 2006); and, second, through the court's application of internal market law which, in turn, may affect several segments of health services delivery, policies or rules governing healthcare professionals (Duncan 2002). EU fiscal governance was recently recognized as a "third face" of EU health policy (Greer 2014). Indeed, and after the financial crisis, the EU has gained new powers to enforce budgetary austerity. Through a series of coercive policy recommendations to Member States about the governance of their healthcare systems, fiscal policy became in turn more "rigorous and intimate", provoking significant shifts in healthcare decision-making at national level (Greer et al. 2016).

There is an important segment of the healthcare sector that arguably lies at the crossroads of these three dimensions—in the sense that it is influenced by supranational standards and regulatory provisions, marked by tensions between EU and domestic law and affected by post-crisis regulation—yet it has received very limited attention to date (though see Thomson and Mossialos 2007). It is the private (usually voluntary) health insurance (PHI) industry, a term that refers to the variety of firms offering either or both types of substitutive health coverage (that would otherwise be provided by a national health insurance or system); complementary coverage (for services excluded from or not fully covered by the public purse); or supplementary coverage, which essentially supplies consumers with greater freedom of choice and faster access to care (Thomson and Mossialos 2007). In several EU countries, PHI accounts for a significant share of health expenditure and is even the main provider of care for some benefits. Crucially, it has faced major transformations over the last 30 years, and this as a result of changes in EU law and regulations, often in combination with more or less explicit forms of budgetary constraints or retrenchment efforts at the domestic level.

There is an obvious reason why PHI has largely remained under the radar of scholarship on EU healthcare politics. In effect, it is essentially through a series of directives aimed at governing the insurance industry as a whole that EU law has remodelled PHI. A similar reason arguably accounts for the rather limited interest of students of the public-private mix in healthcare in the study of this issue—a term that we use in the following pages both to describe the combination of public and private actors in health coverage (see Ebbinghaus 2011), but also in health benefits and services delivery (see also Benoît and Coron 2019). As amply documented in the following pages, the potential implications of insurance regulation for the health sector were indeed regularly underestimated or simply disregarded, a statement that applies both to academic research and, critically, to policy-making at domestic level—with policymakers often unaware of the prior effects of EU law and regulation on private health insurers. In turn, this relative ignorance was a source of recurrent mismatches and unexpected effects of policy choices, with a number of implications for the PHI industry. Crucially, this eventually contributed to changing the public-private mix in healthcare.

In an attempt at filling this gap, this collective book gathers a multidisciplinary team of specialists in social policy and the insurance industry. On this basis, our ambition is to provide a broader account of the diverse long-term effects EU provisions had on the private health insurance industry—and their important implications for the political economy of contemporary Welfare States. In this book, we are more formally motivated by three series of research questions. The first relates to the influence of EU law and regulation on the nature and the place of PHI, which contributors intend to prove and to characterize. We are also seeking to determine if and how the effects of these directives and regulations interacted with both the outputs and the outcomes of health policy in several countries (Belgium, France, Ireland and the Netherlands), particularly in a well-documented context of "permanent austerity" (Pierson 1998) and where retrenchment efforts are now firmly entrenched in Welfare State reform (Pierson 2001). Thirdly (and ultimately) our goal is to evaluate if, how and to what extent the interactions between EU law and regulations and health policy at domestic level affected the nature and scope of health coverage in the countries under study.

Overall, the story that we narrate here is that of a growing "decoupling" (Trein 2017) between insurance regulation and health policy, entailing a number of side effects for the private health insurance industry,

for the structure of the public-private mix in healthcare and for the nature of health coverage, yet with contrasting effects from one country to another. At a more conceptual level, such a broad finding might seem quite trivial to readers familiar with existing scholarship on Europeanization (see Graziano and Vink 2007). What we describe is indeed an umpteenth story in which a series of directives are adopted with the explicit aim of harmonizing domestic rules applying to an industry that eventually results, after a conflictual implementation process, in multiple unintended effects due to its interactions with a variety of national institutional dependencies. There are, however, a number of lessons to draw from this seemingly classical conclusion due to the compound nature of the private health insurance industry. Indeed, our findings echo a number of burgeoning debates related to EU influence on health policy on the one hand and to the role played by private providers in social policy at national level on the other. Together, they delineate future research agendas discussed in greater length below.

The rest of this Introduction is organized as follows. In Sect. 2, we start by positioning our research questions and our contribution in the wider literature. We then introduce the main analytical structure permeating the various contributions of the book. Section 3 provides an overview of our research design and case selection process. To understand how the European "matrix" affected PHI and the public-private mix in healthcare, we have undertaken an analysis of its genesis and of its effects at national level, through a comparative analysis of four countries. Section 4 present the contributions to the book, grouped into three parts—the first on the political economy of EU law and regulation related to PHI, the second based on large-n comparisons of the effect of these provisions on PHI and the third part dedicated to in-depth, country case studies. We also reflect in this section on how our findings echo wider debates in the literature.

2 Private Health Insurance in the European Union: Marketization Embraced?

2.1 EU Insurance Law and Regulation as a Potential Vehicle for the Marketization of PHI

This book maps the transformation of the private health insurance industry in the EU over a period of around 30 years, starting with the

debates that led to the passage of "Insurance" directives in 1992. The choice of this point of departure is justified by the ambition of these texts, with the explicit aim of creating a unified legal framework for insurance activities in Europe, in order to facilitate competition between insurers in an increasingly unified Single Market. European integration is pushed a step further some five years later, with the opening-up of a 12-year process of fierce political battles around the reform of solvency rules governing insurance companies, resulting first in the adoption of two directives in 2002 (known as the "Solvency I" system) and, more significantly, of the Solvency II directive in 2009—which finally came into effect in January 2016. Presented as a response by EU authorities to the financial crisis, this text's most explicit goal was to set up a risk-based approach to insurance regulation, involving a number of changes in terms of capital requirements, risk management and governance structures of insurance activities.

As already suggested by this very brief outline of the European policies considered in greater detail throughout the book, PHI was not the principal target of these different texts. Intriguingly, healthcare as a policy matter was not a salient issue in the debates surrounding the building of such a "European government" (Jullien and Smith 2014) of the insurance industry, especially as compared with other life and non-life insurance activities. Part of the reason for that situation lies in the relatively marginal status of PHI in the wider insurance industry in Europe—where in most Member States, a significant share of health expenditure is covered by the public purse. Private health insurance companies are thus typically small or medium sized firms. They are also less financialized than most of the insurance industry. Moreover, they also tend to cover a much more limited array of risks than the dominant insurance companies, essentially circumscribed to health coverage and occupational welfare. In turn, and when the largest insurance firms operating across the continent do offer health-related products of some kind, they rarely constitute the core of these companies' growth strategy.

There is another set of peculiarities of PHI in Europe that explains its rather peripheral position in the industry and, by extension, in regulatory policy agenda. Most private health insurers across the continent are indeed non-profit companies organized along solidarity-based or

democratic principles—meaning that they are usually run by a democratically elected board or by employer and employee representatives, and that they generally use their gains to increase the benefits or the coverage provided to their members. There are historical reasons for that: in many Western European countries (particularly in continental Europe), PHI has developed before the formation of contemporary Welfare States, often as emanations of churches, charities, trade unions or employers' associations. In several countries, various compromises were adopted to integrate these entities after the formation of modern Welfare State institutions, sometimes through the delegation to these entities of all or part of the management of healthcare systems or services, sometimes by providing them with a more minor role. This means that PHI has almost always kept strong ties with or within the Welfare State and by the same token, is usually heavily regulated or even governed at domestic level. As a consequence, the public-private mix in healthcare in Western Europe tends to be integrated into fixed and rigid regulatory frameworks.

EU insurance law and regulation hits this balance. As of 1992, Insurance directives opened up the PHI market to competition, notably to for-profit insurance companies. More importantly, a number of provisions maintaining PHI close to public healthcare systems were considered selective advantages and gradually removed. With Solvency II, private health insurers now have to comply with stricter solvency requirements. They also need to make additional financial provisions and find ways to increase the value of their funds—which, in a broader context of low interest rates, often means searching for further (potentially riskier) diversification benefits (Standard and Poor's 2016). Additionally, this text conveys a more explicit alignment of their governance with for-profit insurance companies and, more broadly, financial firms. In summary, EU laws and regulations, at least formally, seem to induce a growing marketization of PHI—with the openness of the health insurance market to new actors, posing a number of threats for the business model of non-profit entities, with an intensification of (possibly price-based) competition and by potentially paving the way for the increased financialization of the sector.

In this context, tracing the political sources of these formal provisions and determining whether they effectively translated into an actual marketization of private health insurers is the guiding thread of the different

contributions of this volume. Symmetrically, the notion of marketization permeates the three research questions addressed in the following chapters. In determining whether EU law and regulation changed the nature of PHI and if so, how, we are primarily interested in elucidating whether it was in the sense of increased marketization and, critically, with which measurable effects on the industry. By looking at whether and how these same provisions interacted with health policy at domestic level, our motivation is predominantly to evaluate whether it introduced more market logics, behaviours and strategies in the public-private mix in healthcare. The answer to our third question, on how these interactions eventually (re)shaped the nature and scope of health coverage is also driven by a similar concern—do the principles that originally governed the private side of health coverage now resemble more those of a market, as is the case in numerous countries outside Europe?

2.2 Marketization: A Multidisciplinary Approach for a Multifaceted Concept

The growth of market forces in the Welfare State or social welfare institutions has been the subject of endless amounts of research over the last three decades. More recently, this topic was examined in closer connection to European integration (Crespy 2017). This book largely builds upon these various contributions. In particular, we draw from these the statement according to which marketization might come with a diversity of institutional features and that it can perform widely different (and sometimes contradictory) functions. This particularly applies to our case, where the provisions of EU insurance law and regulation are capable of generating different marketization paths as they interact with institutional orders stabilized at domestic levels.

This claim also rests on well-established findings reported by the literature on the forging of markets in the Welfare State per se. In an authoritative contribution in the field, Gingrich (2011) identified six ideal types of markets in the Welfare State. Her approach combines the allocation dimension (is the responsibility for access collective or individual?) and the production dimension (who—namely the state, users or producers—has effective control over the market?). The multiple configurations between these two dimensions are capable of generating significant variations in market types, ranging from "austerity markets" (where there is individual

responsibility for access and State control, as in Dutch healthcare markets) to "pork barrel markets" with collective responsibility for access and where producers are in capacity to extract rents (typified in Gingrich's study by the elderly care market in England in the 1980s).

A related feature of marketization is that it is fundamentally multifaceted. It can operate at the level of formal provisions while not necessarily translating into effective practices of firms and organizations. Similarly, there can be marketization when some actors endorse market logics in their strategies and behaviours or when these same logics penetrate their cognitive frames—yet, and crucially, this can be a result (or not) of legal or more explicit political impulses. There may be obvious attempts from political actors to marketize public or private entities' way of operating by changing the institutional rules governing their activities; but for various reasons, an actual market might not emerge at the end as older practices prove enduring (see also Schelkle 2019). These rather familiar statements call for an analytical disambiguation of the different stages and the different processes through which marketization is liable to occur and to draw appropriate inferences from these various possible marketization processes. This motivates the multidisciplinary approach retained in this book, which brings together economists, legal and political scientists. Accordingly, each of our four case studies are drafted by at least two authors from different disciplinary backgrounds, who are addressing our research questions by considering the plural forms marketization often takes in the country under study. This includes its most obvious, formal and policy appearances—typically when there is a number of legal provisions that generate the conditions for the increasing marketization of the private health insurance industry. But marketization is also measured through the lens of the economic strategies and behaviours deployed by the actors exposed to it, principally private health insurers in different countries. Marketization is also envisioned as a possible unexpected outcome of the interaction between EU law and regulation and health policy at domestic level. As such, we also assume that it can be an outcome without necessarily having been a purpose of public policy—as we will see, this particularly applies to significant portions of the interaction between the legal matrix established through EU insurance law and regulation and health policy at the domestic level.

While most studies on marketization have focused on the transformation of Welfare State institutions, this book uses this concept to study a more atypical configuration, since we are essentially considering broad

patterns of marketization through the lens of what happens within the private health insurance industry. In the literature, marketization has indeed often been discussed by authors primarily concerned with the privatization of the Welfare State—with the former phenomenon often seen as eventually leading to the latter, typically through an increase in public spending paralleled with discrete support for market solutions (Jensen 2011). In effect, marketization was often regarded as a particular case of "hidden politics of [Welfare State] retrenchment" (Hacker 2004). Here, we report patterns that differ from these classical accounts for obvious reasons, as the health insurance industry considered throughout the book is private. Yet, and as already suggested, it is not necessarily marketized due to its non-profit commitment, the institutional setting in which it operates and the principles governing its activities. This does not mean that the transformations of this industry never interacted with policies explicitly aimed at privatizing or introducing market mechanisms within the Welfare State. Moreover, and as repeatedly shown in the book, the effects of the marketizations of the private health insurance industry are often amplified by retrenchment efforts at domestic level. Nevertheless, by retaining this case, our ambition with this book is also to depart from the canonical debates around privatization that have dominated a significant body of scholarship on the Welfare State. In so doing, we intend to reflect more explicitly upon the actual practices and logics that lie behind public and private providers in order to appreciate their overall impact on the organization and division of solidarities and the associated power relations within the public-private mix in healthcare.

2.3 Making the Case for the Contingency of Europeanization and its Usages

If EU insurance law and regulation is likely to marketize the private health insurance industry, and possibly a share of the public-private mix in healthcare, by which mechanisms is it likely to do so? In brief, what this book describes is the development of a sizeable legal and regulatory structure for the insurance sector that gradually institutionalizes at domestic level, generating a set of transformative effects affecting the private health insurance industry. In this way, this overall process entails numerous unprecedented interactions with domestic healthcare reform—which, in turn, affects both the public-private mix in healthcare and the nature and scope of health coverage.

We were not, though, expecting to observe automatic effects at play or institutions mechanically colliding with each other here, for two main series of reasons. One is associated with the case under scrutiny. Despite its magnitude and density, EU law and regulation in this domain strikes a richly textured environment, moulded by several decades of reforms that have given the public-private mix in healthcare its current shape in the different countries analysed in this volume. Stated differently, there are a number of interest groups, veto points and more broadly, beneficiaries of past policy choices or compromises that are more than likely to intervene in the course of this implementation process (including private health insurers themselves) and that are more than likely, too, to deflect EU policies from their initial purpose.

A second, deeper reason relates to the very process by which EU law and regulation is transposed and implemented. It is indeed widely acknowledged that implementation always involves different sets of actors which, through their mobilizations, interpretations and usages, shape the contours of this overall process—meaning that the same policies or legal provisions can be constructed and used in many different ways (Hay 2007) from one country to another, or even within a single country. This fundamentally implies that transposition always involves "translation" in the broadest sense of the term (Smith 1997). For our research design, a wider implication of embracing such conception is that we expect the outcomes of these transformations under study to be highly contingent, a statement that equally applies to our three research questions.

Stated differently and more generally, we assume here that EU insurance law and regulation should be regarded as creating a number of constraints and opportunities for a large range of actors that are in a position to use tools and resources (possibly offered by European integration itself) to politically shape both the implementation and the likely effects of EU policies—in summary, there is always a range of possible (and possibly multiple) "usages" of Europe in each situation under study (Graziano et al. 2011).

Accordingly, it is through a focus on (individual and collective) actors' political work that the different contributors to this volume grasp and draw inferences from the transformations of the private health industry and the interactions between EU and domestic levels—in particular by paying special attention to the legal, financial, cognitive, political or institutional resources these same actors may possess and actually use to shape this overall process (Jacquot 2008). This is not to suggest that actors and

actions are favoured over institutional factors by the different contributors (see also Exadaktylos and Radaelli 2012 on this distinction). On the contrary, actor-related and institution-related variables are studied in their intimate connection, according to the basic assumption that institutional rules and norms are effective when they actually appear in practices. Institutional or legal factors are thus considered and reported when they are observable and are actual prescriptions for behaviour, and their relative effect is appreciated through the lens of their practices (Itçaina et al. 2016).

3 Research Design and Case Selection

3.1 The Structure of the Book

To approach the transformation of the private health insurance industry under the effect of EU law and regulation—and ultimately, its implications for the public-private mix in healthcare and health coverage—we have organized this book in three parts. Each part corresponds to a specific analytical level and addresses our research questions from a particular angle.

In Part I, two chapters narrate the political genesis of the two sets of European directives that directly affected PHI, namely "Insurance" directives in 1992, then "Solvency I" and "Solvency II" directives in 2009. These chapters focus on the participants and the various motivations of the individual and collective actors involved in the development of this far-reaching European architecture. As such, the two chapters describe the landscape of the government of the insurance industry in Europe. They do so through the lens of the political work undertaken by the various actors that shaped it, with special reference to the regulatory politics at play, and coupled with broadest reflections on the governance of financial services in the EU (see Quaglia 2010).

Part II is also formed of two chapters that consist of large-n studies of the impact of this matrix on private health insurers per se. In 1992, Insurance directives essentially consisted of changes in legal and formal provisions that modified the status and the governance of private health insurers, particularly vis-à-vis the rest of (essentially public) health coverage providers. Thus, the first chapter of this part uses legal methods to appreciate the differentiated impact of EU law in a large set of European countries and healthcare systems, describing a sizeable array of possible (and actual) combinations of public and private provisions. By contrast,

Solvency II mostly concerned a change of the prudential regime governing the daily activities of private health insurers, with likely impacts on the scale of their business model, their strategies and corporate governance. The second chapter of this part thus involves quantitative analyses of the transformations that have affected the private health insurance industry over the recent period.

Part III consists of four in-depth country case studies allowing for the comparison of the different trajectories followed by Belgium, France, Ireland and the Netherlands in this domain. These chapters more frontally address the question of the collision of the EU framework with national (mostly health or social policy-related) political agendas. As such, these chapters not only examine the potential marketization of the private health insurance industry from the perspective of firms, but also from the vantage point of the public-private mix in healthcare. The fifth and last chapter of Part III adopts a more prospective stance, reflecting on the relation between private health insurance, occupational welfare and the distribution of solidarities in the public-private mix in healthcare, also on the basis of national experiences in these domains.

3.2 A Multimethod Perspective

As suggested by this brief outline, the different chapters use a variety of quantitative and qualitative methodologies drawn from the three disciplines participating in the book (economics, law and political sciences). All chapters are formed of a similar empirical bedrock obtained through documentary analysis, systematic content analysis of press releases (including the professional press of the insurance industry), an extensive review of public and organized interests' positions in each policy debate under consideration and when applicable, preliminary expert interviews. This first empirical stage is completed with additional evidence generated through more specific methodologies, depending on the scope and the specific questions posed in each chapter.

Chapters 2 and 3 (first part) mapping the development of EU law and regulation add to this basis a range of semi-structured interviews with key participants in these processes, notably civil servants, staff of European administrative services and directorates, as well as ministerial and European Commission officials. They also rely on second-hand academic sources, mostly on the basis of an extensive review of articles published in actuarial

journals where a variety of stakeholders expressed opinions and shared alternative propositions as these processes were unfolding.

In Part II, Chap. 4 assesses the differentiated impact of EU law on private health insurance and its regulation on the basis of a systematic and exhaustive analysis of EU and national legal databases, which roughly consisted of an examination of the national transposition of European directives and the application of European Court of Justice (ECJ) rulings. Chapter 5, on the impact of Solvency II on the private health insurance industry, mobilizes a range of time series analysis techniques based on an original dataset including 23 countries, for a timeframe between 1997 and 2018. It is completed with the identification of specific patterns for the more active countries of the sample, estimated through regression models.

Part III (Chaps. 6, 7, 8, 9 and 10) combines different methodologies, in line with our ambition to identify the diverse forms that marketization might (or might not) take in different countries, as well as to grasp from various angles the broader consequences of the coevolution of insurance law and regulation and health policy. As such, all chapters are informed by an exhaustive review of the legislation produced in the country in question, descriptive statistics and semi-structured interviews with a diverse range of actors, including civil servants and administrative officials, private health insurers and their representatives as well as healthcare professionals. Using data from interviews with representatives of key organizations or players has become quite common in social policy analysis and in political economy, notably for case-oriented studies involving several countries (Ebbinghaus and Naumann 2018). In this part, the combination of different methodologies and data sources more fundamentally allows for a better description of the sequencing of policy decisions and policy change, a crucial point when it comes to evaluating the effects of EU law and regulation on an industry heavily institutionalized at national level.

3.3 Case Selection

While the first part of the book deals with the different pieces of the European regulatory architecture, the second part involves large-n comparisons of its legal and economic impacts on PHI. By contrast, in Part III we address our research questions (especially related to the public-private mix in healthcare and the nature and scope of health coverage) through a limited number of in-depth country case studies. The ultimate goal of these chapters is to characterize causal mechanisms, yet not to identify a

single scheme of linear causality. Instead, our ambition is to uncover traces of causal mechanisms *within* the context of the cases under study (Bennett and Elman 2006), by providing for each case "an accurate picture of causal constellations" (Roger 2013) between a range of intervening variables (such as the prior effects of past healthcare reforms, the mobilization of key veto players or interest groups and the ties that private health insurers might possess in political parties—each providing grounds for various possible "usages of Europe"). As discussed before, we are expecting the outcomes for each case to be highly contingent upon the political work of a number of actors evolving in compact institutional settings. We are also expecting the EU matrix to be subjected to a variety of potential interpretations and framings. As such, we are adopting throughout the book a rather classical approach in healthcare Europeanization, where the goal of the analysis is to understand "how, why and to what extent" this process has taken a given form in the cases under study, assuming that a lot of national specificities are at play from one country case to another (Martinsen 2012).

Our three research questions involve a number of underlying assumptions that do matter when it comes to case selection. Determining whether and how EU law and regulation changed the private health insurance industry obviously requires retaining cases where this industry exists and where it accounts for a significant (which does not necessarily mean large) share of health expenditures. In addition, measuring how the outcomes of this matrix interacted with prior or simultaneous effects of past policy choices is better achieved, we think, through selecting cases where there are some explicit and institutionalized linkages between the public and the private sides of health coverage. Arguably, this same statement equally applies to our third research question, namely whether and how health coverage changed in nature or scope as a result of the interactions between the European framework and health policy at domestic level.

Moreover, an overall expectation underlies these three research questions. We are indeed hypothesising that the institutionalization of the EU framework results in a growing marketization of private health insurers, of the public-private mix in healthcare and, eventually, health coverage. This requires selecting cases where the private health insurance industry is potentially exposed to such a transformation, at least formally—and symmetrically, not selecting cases where it is already marketized. It is noticeable that cases where there exists a fully marketized private health insurance industry are quite rare in Europe. Granted, there are some countries where

there exists a (rather small) market for private health insurance. Yet it generally has no particular institutional linkages with public coverage (this is, e.g., the case in Spain). In accordance with our research questions and hypotheses, we have therefore decided not to include such cases in our country case analysis (see further).

On the basis of these statements, we have retained for our analysis most-similar cases (Seawright and Gerring 2008), to compare the relative effects of factors that we expect to be present in the different cases under study, but crucially, interacting and being at play differently. We combine this approach with a most-likely case selection strategy (Rohlfing 2012), namely by selecting national cases which are most likely to be impacted by EU law and regulation. Here, our ambition is to maximize our chances of observing the PHI marketization process in order to be better able to identify a wide set of different mechanisms—knowing that we expect this process to be an input of EU law and regulation, despite its interaction with other institutional features of healthcare systems that are not directly affected by this initial source of change.

It is on this broad basis that we have retained the four countries under study (Belgium, France, Ireland and the Netherlands), which all comply with this twofold requirement (see Chap. 5 for an extensive discussion). In each of these countries, the share of health expenditure covered by PHI is significant (above 12%). These are also countries where "governments recognize that [PHI] can contribute significantly to social protection" (Mossialos and Thomson 2004) and thus where there exist strong ties between PHI and the Welfare State. Lastly, the private health insurance industry is marked by the presence of a large number of non-profit firms in these four countries, and thus particularly exposed to different forms of marketization. Crucially, there are also for-profit insurance companies offering health coverage in each of these cases, thus allowing an appreciation of the effect of EU law and regulation on these entities, and their potential conflict-provoking effects on "institutionalized relationships" (Jullien and Smith 2008) within the industry.

It is also worth mentioning that if these four cases are both most-similar and most-likely from the angle of our research questions and assumptions, they are not usually considered as such by comparative research on Welfare States or health policy. If Belgium, France and the Netherlands are all Bismarckian systems to a certain extent, this is not the case of Ireland, classified as a Beveridgian (tax-financed) system. In terms of health expenses, one can also note a significant decrease in the share of health expenditure

covered by the public purse in Ireland and the Netherlands during the period examined, while this share remained relatively stable in Belgium and France. There are, in addition, a number of differences in terms of the status, governance and organization of non-profit health insurers per se from one selected country to another. We expect these second-order differences to provide meaningful insights into the mechanisms accounting for the penetration and effects of EU law and regulation in this domain.

4 The Book in a Nutshell

There are two ways of seeing the story narrated in this book and to envision the answers it provides to our research questions. Readers primarily interested in health policy will find in the subsequent chapters a discussion of the interactions of two trends (marketization and privatization) that arguably stand at the forefront of the debates related to this field, yet that have been subjected to only scant discussion in conjunction with EU influence. Those who are mostly interested in the insurance industry and more broadly, financial services regulation, might also find an interest in reading this volume. Scholars are now paying increasing attention to this sector of prime importance for our understanding of the political economy of contemporary capitalism. Still, the literature has to date mainly focused on large transnational firms and on life insurance, arguably at the forefront of the changes affecting the wider industry (see Graz 2019). Here they will find an analysis of its transformations from a different standpoint, allowing for an appreciation of some of the many side effects associated with the regulatory and industrial changes it has experienced in Europe over the last 30 years. After introducing the different contributions to this book, we return to these questions in a discussion of the wider implications of our findings for current debates on these two broad classes of issues.

4.1 Contributions to the Book

The book opens with Gaël Coron and Marion Del Sol's analysis of the long march towards a unified European government for insurance activities, starting off with the adoption of "first generation" (1973) and culminating with "third generation" Insurance directives in 1992—the latter having constituted a critical juncture for the private health insurance industry in most countries (Chap. 2). Coron and Del Sol particularly insist in this chapter on the proactive role played in this domain by European

Commission services in charge of financial institutions and corporate law, who have made an intensive use of ECJ rulings to advance their own visions and agendas for the sector. More generally, what he describes is a process leading to a twofold trivialization. On the one hand, and as a result of the Commission officials' political work, insurance activities were growingly assimilated to financial services and treated as such, leading to various implications for their regulation in the Single Market. This overall trend was paralleled with a more discrete yet significant trivialization of private (mostly non-profit) health insurance companies, gradually associated with the rest of the insurance activities—notably through Insurance directives in 1992.

In Chap. 3, Cyril Benoît examines the fierce political battles that led to the far-reaching reform of solvency rules governing insurance activities in the EU between 1994 and 2016, with special reference to the private health insurance industry. Focusing on the prudential regime laid down in EU law and regulation, he shows that the adoption of Solvency II in 2009 amplified the movement described by Coron, albeit through a renewed approach. While previous directives were essentially preoccupied with finding common rules to organize competition within the Single Market, Solvency II developed as a more conceptual architecture, with rules, requirements and standards aimed at becoming ingrained in insurers' daily activities. This shift was essentially legitimized as providing greater transparency and safety to financial investors and policyholders. Benoît shows that this transformation is fundamentally more likely to induce major changes for private health insurers (notably non-profit and smaller firms), as their activities have developed using different principles, values and ruling structures.

After a focus in Part I on the sizeable European regulatory infrastructure that developed over the last three decades, Part II starts with an extensive, large-n study of the differentiated implications it may have on PHI in various Member States (Chap. 4). In this regard, Marion Del Sol and Philippe Martin, with a particular focus on the competitive framework created by Insurance directives, arrive at a twofold conclusion. First, EU law and regulation might effectively be considered as a potential vehicle for the increasing marketization of the sector, particularly in those countries where private health insurers are non-profit firms and closely integrated into Welfare State institutions. Yet, and crucially, it should be symmetrically regarded as providing a matrix rather than being a source of vertical integration—as it is actually flexible and open to interpretation,

and as it leaves a wide latitude for national regulation of the PHI industry, including its relation with public providers. As such, one can expect a high degree of contingency and many possible usages of this legal framework in its transposition at domestic level.

In their study of the impact of Solvency II, Philippe Abecassis and Nathalie Coutinet draw a similar conclusion from the vantage point of the insurance industry per se (Chap. 5). It is right, they assert, to expect that EU law and regulation result in an increasing homogenization of private health insurers, in the sense of their growing alignment with the behaviours, strategies and logics already in play in significant segments of the sector. Yet, the pattern suggested by their data is more complex than what this broad-brush picture suggests. Indeed, the financialization of PHI (and notably, mergers and takeovers) does not coincide with the business cycle of the rest of the industry. This does not mean that the impact of EU law and regulation was neutral. Insurance directives provided strong incentives for PHI to develop transnational activities; Solvency II, as it involves stricter solvency requirements, incentivized larger dominant firms to diversify their risk portfolios, leading to alliances with PHI or to the development of health-related products—as the latter are less demanding in terms of solvency requirements. However, this matrix, Abecassis and Coutinet argue, is better understood as providing a basis for various strategies than as an exogenous shock implying a standardised response. For the time period considered, it even appears that national reforms played a more decisive role in providing constraints and opportunities to PHI.

These converging statements are followed in Part III by in-depth country case studies. Cyril Benoît and Marion Del Sol (Chap. 6) first consider the case of Belgium, where the "public" side of health coverage is delegated and organized around non-profit private health insurers, namely mutual benefit societies—and as such is excluded from the perimeter of EU insurance law and regulation. Over the last two decades, and as a result of various governmental attempts at reducing health expenditure, mutual benefit societies nevertheless developed and managed on their own a variety of complementary coverage, initially without any formalized legal boundaries. This situation was challenged during the 2000s by for-profit insurance companies seeking to penetrate the market. In this context, they used both Insurance and Solvency II directives in their search for supranational support, in order ultimately to challenge the position of mutual benefit societies. In turn, the latter responded by working politically to secure their position at domestic level. As a result of these political

struggles, a reform adopted in 2010 reinforced several features of the Belgian public-private mix by safeguarding the position of mutual benefit societies for complementary coverage. But this same reform also opened the supplementary side of health coverage to competition and aligned it with EU provisions, thus marketizing a share of the public-private mix in Belgium—with recent figures suggesting that this new pillar is now rapidly expanding.

Mutual benefit societies might also be found in France, as explained by Gaël Coron, Thomas Houssoy and Cyril Benoît in their contribution (Chap. 7). Historically, however, their activities were circumscribed to the complementary share of health coverage, where they have to compete with other non-profit entities and (increasingly) for-profit insurance companies. What has happened in the country, Coron, Houssoy and Benoît argue, is an early and manifold marketization process of private health insurers as a result of the application of EU law and regulation—but decisively, this trend was markedly reinforced and shaped by a series of policies adopted at national level. Indeed, over the last 20 years, successive French governments have tried to increase health coverage without expending the share already covered by the public purse. This strategy ostensibly involved private health insurers in achieving several governmental objectives, yet the prior effects of Europeanization on these entities were poorly acknowledged by policymakers. As such, the many consequences associated with the rise of a "European-driven" market now increasingly conflict with a "State-driven" market.

While Europeanization was associated with greater marketization of the public-private mix in healthcare in Belgium and France, this has initially not been the case in Ireland, as argued by Pascale Turquet and Philippe Martin in their contribution (Chap. 8). In this "two-tiered" system, private health insurance duplicates public coverage by offering additional benefits and services such as access to private hospitals. While there is competition on the PHI market in Ireland in application of EU legal provisions, the Irish government succeeded in maintaining strong regulation of the sector due to the important role it plays in the provision of care. This was notably achieved through an exemption of (semi-public) non-profit firms from compliance with Insurance directives and through a risk-equalization scheme. However, this initial compromise was increasingly contested in the 2000s, with new entrants on the market trying to use European provisions to challenge the position of their competitors. This also coincided with debates on whether Voluntary Health Insurance

(VHI) Healthcare, the non-profit leading firm of Irish PHI market, should comply with solvency requirements. These turbulences were amplified by the consequences of the financial crisis, which significantly raised the cost of insurance policies over the last few years.

Turquet and Martin then turn to an examination of the case of The Netherlands, a country where health policy has been market-oriented since the beginning of the 1990s. The system is now characterized by managed competition between health insurers, and the government only retains regulatory and supervisory prerogatives (Chap. 9). In this country, EU law and regulation was thus not the only—or the main—source of marketization. In addition, there seems to be no contradiction between the latter's most market-like dimensions since similar features are arguably in play in the Dutch healthcare system. However, and crucially, Turquet and Martin show that it does not necessarily mean that Europeanization has had no effect on the country. Solvency rules on insurance activities as well as the degree of openness of the market (in close relation to the policies pursued by the Dutch Central Bank) notably constituted major issues, with collateral implications for the public-private mix in the course of recent years.

In the last contribution to the book, Thomas Houssoy, Marion Del Sol and Philippe Martin adopt a more prospective stance by reflecting on some additional repercussions of the transformations observed in the previous chapters (Chap. 10). In the four countries under study, PHI is now more marketized than it was at the beginning of the 1990s, even if the shape and the very reasons for the development of health insurance markets differ from one country to another. What are the specific implications of such changes when PHI turns out to be acquired at corporate level, and thus becomes part of occupational welfare? More precisely, how do firms and trade unions behave in such marketized environments when they become purchasers of private health coverage? What are the related implications of their choices for the distribution of solidarities within the public-private mix? After a discussion of the many ramifications of these questions (which ostensibly resonate with the literature on pension reform and the pillarization of social protection), Del Sol, Martin and Houssoy consider the French case, viewing it as a quasi-natural experiment. Indeed, while once limited in scope, corporate PHI grew significantly in this country after a reform in 2013, which introduced an obligation for employers to provide their workers with a PHI scheme. Crucially, it came into force in

an environment already reshaped in the sense of a greater marketization of PHI by prior reforms.

Each of these chapters comes with its own conclusions and series of responses to our research questions. Additionally, we think that the book in itself generates further insights on two broader debates in the literature that are worth briefly introducing before allowing the reader to enter into the many complexities of the relationship between private health insurance and the European Union.

4.2 Understanding the Presence of Financial Firms in Social Policy

The various conclusions raised in the aforementioned chapters explicitly echo a wider controversy in the political economy literature. Political economists have indeed long debated whether and why capital—often equated with employers—tended to express support for or oppose social protection (see Hall and Soskice 2001). More recently, scholars have argued that our understanding of "capital" should also include financial firms, since as potential competitors of social insurance, they can reasonably "be expected to be key proponents of retrenchment" to become integral participants of social coverage (Naczyk 2013). The book provides this burgeoning literature with additional accounts on why financial firms—here insurance companies—might have an interest in prospering in social protection or policy, particularly in a more protected and less lucrative market, as health insurance undoubtedly is.

Admittedly, and by paving the way for a removal of some of the barriers that integrated PHI into the Welfare State, EU provisions considerably eased access to this market to other (essentially for-profit) insurance companies. One can note that their presence increased in the four countries for the period under study, but crucially, this was not as a result of an explicit (or an implicit) European political agenda—as health insurance, as shown in Chap. 2, was a theme of particularly little importance during the debates surrounding Insurance directives. In a similar vein (and more fundamentally) several chapters of the book argue that this also has to do with the incentives created by Solvency II, while the goal of this text was initially to strengthen regulation and improve regulatory standards. What is described in the following pages is that by imposing stricter requirements, EU provisions created a very powerful incentive for for-profit insurance companies to diversify, notably on more secured markets such as healthcare (see

Chaps. 2, 3 and 4). As such, the presence of insurance companies (and their demands, as exemplified by the case of Belgium, for government to facilitate their access to the health insurance market—see Chap. 6) also appear to be a side effect of an overall increase in regulatory requirements.

Put differently, an apparent consolidation of regulatory demands for the wider industry here resulted, at least in some of its segments, in increasing pressures and financialization. This does not necessarily contradict the finding reported by studies identifying more explicit attempts by financial companies to gain access to social protection, and country case studies in Part III provide evidence of more direct and more classical forms of interest group politics. But this arguably provides a set of additional factors of the formation of the structure of opportunity that shape financial firms' behaviours and motivations in this domain—as we highlight how social protection might be unintentionally affected by wider transformations of financial services regulation. A similar statement arguably applies to related debates on the financialization of social protection. Here also, we report, especially in Chaps. 3, 4 and 7, an increasing financialization of health insurers, notably non-profit insurance companies. And here again, we show how it is an outcome (and to some extent a side effect) of the stricter solvency requirements demanded by Solvency II. In our view, such findings should invite political economists to pay greater attention to multilevel changes and unexpected outcomes of past regulatory choices when they seek to understand why and how there is a rise of financial firms or financialization in social protection.

4.3 The EU and the Shifts in the Public-Private Mix in Healthcare

As already suggested at the beginning of this Introduction, the literature on EU healthcare politics has essentially focused on the propensity of Europeanization to diffuse a number of (notably regulatory) standards, to alter health services delivery and policies through the application of internal law and to stimulate budgetary austerity—three features largely exhibited in the case of PHI. This book hopefully helps to make another aspect more explicit, which complements rather than disputes the already known faces of EU healthcare politics as documented in the literature. This aspect relates to how Europeanization contributes to the reshaping of the public-private mix in healthcare in two ways, amply discussed in Chaps. 6, 7, 8 and 9. Firstly, it can introduce competition within the sector (or facilitate

competition where it already exists), together with the alignment of non-profit and for-profit providers. Secondly (and less noticeably), because Europeanization might result in an institutional decoupling between PHI and Welfare State institutions. This, in turn, renders public and private coverage more sealed off from each other. In addition to modifying the nature of health coverage, such reconfiguring might also affect the scope of health policy (as illustrated by the case of France studied in Chap. 7). As a result, Europeanization here is not necessarily "shifting the public-private mix" (Seeleib-Kaiser et al. 2012), but rather reinforcing its institutional (and possibly financial) sedimentation. This latter statement will certainly sound familiar to those who know the literature dedicated to the political economy of pension reform and policies, where scholars are accustomed to speaking in terms of pillarization and multi-pillar structures—and where they are accustomed, too, to studying marketization in close connection with privatization in broad "multi-pillar" settings (see Ebbinghaus 2015). There are a number of issues involved when the public-private mix in healthcare is analysed in the language of pillars, as discussed in Chap. 10. But we strongly think that there is something to be gained from keeping a watchful eye over some similar transformations arguably at play between the two sectors, in close connection with the role of the EU and, more broadly, Europeanization. We also believe that this holds true even if, in stark contrast with pension reform, the changes that are described here are mostly unintended outcomes of the interactions between various EU and national policy choices, and are not (or not yet) part of an explicit political agenda to combine pillarization with various forms of privatization and marketization of the public-private mix in healthcare. Yet some critical outcomes (that prominently include marketization, a segmentation of coverage and growing presence of financial firms) are now changing both sectors, which are arguably at the crossroads of national "growth regimes" (Hassel and Palier 2020).

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