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<1>The regulatory path to healthcare systems' financialization

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<2>Abstract

The literature has often presented European healthcare systems as being less exposed to the growing dependencies on global finance observed in other areas of social policy. This article explores the sources and dynamics of a regulatory path to healthcare systems' financialization that challenges this depiction. Building on analogies with the case of pension policy, we show that the integration of the private health insurance sector into the European Union financial regulation framework has resulted in perceptible processes of financialization. Notably this manifested in the growing role of financial firms, in non-profit health insurers' adoption of 'financialized' business practices, and eventually, in a noticeable change of their positioning in domestic healthcare reform. After having discussed the theoretical implications, the article provides an empirical illustration of this argument by documenting the implementation of the Solvency II insurance directive by health insurers in France, and describes its more general consequences and implications beyond this case study.

<2>**Keywords**

healthcare, European Union, financial regulation, insurance, financialization

<2>**Introduction**

Recent years have seen a sustained academic attention on the growing interdependences between the global realm of finance and the welfare state. Over

the recent period, such interdependences have mostly grown through the rise of schemes, plans or services in social policy ‘managed by private financial services providers’, generating in turn new business opportunities for financial firms, and the growth of the share of the financial services sector in GDP (Hassel et al., 2019). Often presented as the product of recent politics, various linkages between welfare and finance were detected in diverse, though not in all corners of social policy. Widely documented in this regard are the cases of consumer finance, housing and pension policy (Schelkle, 2012a). There are however important areas that have been largely overlooked so far by the literature where similar developments could well be observed and may have perceptible effects on social policy and its outcomes.

Building on these premises, this article documents and seeks to explain significant changes that have affected a small, yet significant corner of European healthcare systems in recent years. Specifically, we report results from a study on the transformation of private health insurance (hereinafter PHI) in France, a sector that has experienced a discrete – though rapidly increasing – process of financialization. Such process manifests in the growing dominance of financial actors, practices and narratives in the sector (see Cordilha, 2021), with perceptible implications for the structure of healthcare coverage and health policy more generally. Crucially, these changes happened in a system where the share of health expenditures offered through fiscal resources and social contributions has remained stable – in sum, a least likely case of financialization.

While concentrated on France, the findings reported here have broader implications, for reasons discussed throughout the article. One relates to the existence, in all European healthcare systems, of a more or less important private sector providing firms and individuals with healthcare and occupational welfare

coverage and benefits. Another important reason has to do with the main triggering factor in these changes, that we locate in the (supranational) evolutions of the regulatory framework in which private health insurers of the European Union (EU) operate.

Our main conceptual argument is indeed that there exists a close relationship between financialization and regulatory changes in the area of European healthcare. We more particularly establish that the transformation of PHI in France largely results from the adoption of new regulatory provisions through the EU 'Solvency II' directive that was enacted after the global financial crisis. The main goal of this directive, largely inspired by the Basel agreements in the banking sector, was to set out a vast prudential regime for insurance undertakings across the continent. But Solvency II more fundamentally provided insurance companies with incentives towards the financialization of their activities, especially in terms of business practices, corporate governance and strategies. While large and transnational firms were the main and initial target of Solvency II, the text also integrated the smaller, non-profit providers of health insurance and occupational welfare that are found in various European countries – resulting in significant changes for these entities, with measurable implications for their roles and policy stances.

To arrive at this conclusion, we draw inferences from an inductive process-tracing approach. Our main ambition was to substantiate the role of regulation as an important causal path for healthcare systems' financialization, and to detect mechanisms for testing against other cases. To this end, we first collected and analysed qualitatively approximately 2000 public and private documents, secondary sources and press articles to map out actors' positions to uncover the main policy motives behind Solvency II – as well as to detect other potential sources of change of

PHI in France in recent years. Given that part of our argument rests on the consequences of the implementation of Solvency II, we then conducted 16 targeted interviews within two large French health insurance companies selected for their differences – namely, to evaluate the effect of Solvency II by controlling for firm-level specificities.¹ Such a focus on firms allowed us to analyse not only the growth of financialization in the sector – but also why and the extent to which it is sustained.

Overall, our findings suggest that financial logics and imperatives can grow in social policy even when the conditions previously identified by the literature (notably on pension policy) are only partially met. While the argument of a regulatory (and most notably EU) path to financialization has indeed already been advanced for the case of pensions (for example, see Haverland, 2007), we show that similar mechanisms are at play in healthcare but differently, as financialization here rests on less explicit policy motives.

In the remainder of this article, we first provide a brief literature review of studies interested in the interdependences between welfare and finance, showing that healthcare constitutes a blind spot in this literature. Next, we provide a brief introduction to Solvency II, before turning to an examination of how it can affect domestic healthcare systems by locating our arguments in a broad comparative setting. In a third section, this mechanism is empirically illustrated through an analysis of the implementation of Solvency II by private health insurers in France. A concluding section summarizes the argument and draws out its implications beyond this case study

<2>Financialization, regulation and European private health insurance

<3>Healthcare systems' 'financialization'

In the broader political economy literature, the term financialization has alternatively served to designate the accumulation regime in which capitalist economies now find themselves; new patterns of development of the modern corporation emphasizing the primacy of shareholder value; and the diverse ways through which finance has affected everyday life through the consumption of mass-marketed financial products (Van der Zwan, 2014). On this basis, students of social policy have usually inferred the rise of financialization when actors from the financial sector were shown to play a greater role in the furniture of social coverage or services (for example, see Wiß, 2019); when formerly non-financial actors in social policy were adopting the behaviours or narratives of the financial sector (for example, see Cordilha, 2021); or when households were encouraged to accumulate assets (like private retirement accounts or home mortgages) to meet their (future) welfare needs (for example, see Hay and Benoît, 2023).

Research has to date essentially concentrated on three domains where the connection between welfare and finance was the most explicit, namely consumer credit (specifically around various 'credit-as-welfare' initiatives, see Mertens, 2017); housing policy (and in particular, policies seeking to make housing affordable, which resulted in the creation of vast mortgage markets, see Schelkle, 2012b); and pension policy (Dixon and Sorsa, 2009). Attention on these areas in the literature is unsurprising. Overall, financialization was indeed revealed to be higher in sectors where there exists a greater propensity for social policy to create and shape markets exploitable by financial firms, namely where its function goes beyond mere compensation for market outcomes (Schelkle, 2012a) – and where financial firms are the most likely to be key proponents of market-based solutions (Naczyk, 2016).

In this context, other corners of social policy were long assumed to be more resistant to the various forms which financialization might take, with healthcare being a major case in point (see, however, Hunter and Murray, 2019; Cordilha, 2021). In Europe, the usually central and persisting role of the state in planning and overseeing healthcare systems (André and Hermann, 2009) was indeed deemed to largely insulate these systems from financialization. It is true however that the existence of a more or less sizeable, sometimes growing private sector in all European healthcare systems could in theory leave room for more market-based logics to diffuse. This is notably the case with private, usually voluntary health insurance. In conservative welfare regimes where its contribution to health expenditures is usually higher (see below), private health insurers are nonetheless mostly small and medium-sized entities providing complementary healthcare coverage and occupational welfare benefits to those offered by social insurance funds or healthcare systems. To anticipate our empirical case study below, this situation holds in the case of France. In this country, PHI covers around 95 percent of the population, accounts for around 14 percent of health expenditure and €37.6 billion in premiums in 2020.² Overall, the fact that PHI usually plays a rather subordinated role, and is essentially constituted of tax-exempted, ‘heavily regulated’ and sometimes non-profit firms, would neatly reduce its exposure to financialization (see Appelbaum and Batt, 2021, for a theoretical discussion). For insurance companies, persistently high levels of compulsory coverage would, in addition to this, make healthcare less profitable than other activities – typically as opposed to pensions where the cumulative consequences of retrenchment have created greater profit prospects for financial firms.

Dispersed yet converging empirical studies have, however, recently reported several symptoms of financialization of PHI in various European healthcare systems. Several countries have for instance witnessed a substantial rise in the market share of for-profit insurance companies. This is notably the case for Belgium in the field of supplementary health insurance, a small segment of the Belgian healthcare system that has been traditionally dominated by non-profit mutual benefit societies (see Assuralia 2018). In France, the market share of banks and for-profit insurance companies has grown faster than those of non-profit providers over the last decade (see below).

Other studies have revealed that strategies and tactics of financial firms were now playing a greater role in the daily operations of private health insurers, and this even where most of them are subjected to extended state regulations. In the Netherlands, for instance, studies have emphasized health insurers' growing concern for their financial credibility, and this is notably due to recent strategies that have resulted in their growing exposure to financial risks – eventually leading to market consolidation and concentration in the sector (see Postma and Roos, 2016). A parallel trend was reported for France (S&P, 2016). Overall, these findings suggest that financialization in healthcare could thus be greater than initially thought.

<3>A neglected path: the (EU) regulatory sources of healthcare systems' financialization

That signs of financialization have been recently found in different European countries is, in itself, unsurprising. Healthcare systems in Belgium, France or the Netherlands indeed face similar dynamics, like an ageing population, rising healthcare costs and, simultaneously, constraints on healthcare budgets. In such a context where public expenditures are at best stagnating (if not decreasing in real

terms), financial firms are ready to step in – and this due to the growing importance they have acquired in other areas of social policy (such as pensions) in recent years. According to this view, financial firms, once established in the healthcare sector, would put strong competitive pressures on non-profit providers that would have no other choice but to conform.

While it suggests demand-side similarities, a more careful examination of this trend however reveals (persisting) supply-side differences. In 2019, PHI expenditures in the three examples mentioned above were indeed dissimilar. They were, as a share of health expenditures, twice as low as the OECD average (10 percent) in Belgium (5.1 percent); slightly higher in France (14 percent); and substantially higher in the Netherlands (around 60 percent). Importantly, these patterns have remained stable over the past ten years. Moreover, a review of recent reforms in these countries does not seem to indicate clear or explicit attempts at significantly transforming the role of PHI (for example, see Gerkens and Merkur, 2020; Kroneman et al., 2016). One can detect one important similarity though. During the same period, PHI in these three countries (as in all EU member states) has been more closely integrated with the European rules and regulations of the financial sector, and more particularly of the insurance industry.

Specifically, health insurers have been directly concerned with the implementation of the Solvency II directive, which was enacted in 2009 and finally came into effect in January 2016. The goal of this text was formally to set in place ‘a principle-based approach to the prudential regulation of insurance companies’, with application to ‘all life and non-life insurance undertakings and reinsurance undertakings’ (Quaglia, 2014). But the text was more fundamentally presented as inducing a deep financialization of the insurance industry as a whole, notably due to

the framing of the requirements it imposed (which were more directed towards investors than policyholders) and to the new business practices promoting shareholder value that it introduced (François, 2021).

While it has been rarely hypothesized for healthcare, the existence of a link between EU financial service directives and healthcare systems' change is not necessarily discordant with the findings of the vast literature interested in the relationship between social policy and finance. It suggests that regulation and financialization can grow together through two (possibly interrelated) mechanisms.

The first broadly relates to the comparative advantage transnational market regulations may provide to large and diversified financial firms, at the expense of other domestic actors that build on other principles, business models or organizational structures. Pension policy is a notable case in point. It has been presented as a 'market-making device' for the EU, highlighting 'tensions between supranational regulations and domestic pension systems' as well as between broad social objectives and the commercial interests of financial providers (Hennessy, 2014; see also Haverland, 2007; Schelkle, 2019). Through reshaping existing arrangements and organizing competition between different actors on an equal footing, EU regulations might create various incentives for financial firms to expand in social fields. In turn, they can set the conditions for their development at the domestic level – a first and important aspect of financialization.

The second mechanism links regulation and financialization through the managerial instruments and governance principles (such as having a more technical board staffed with financial skills) regulated actors are required to use in their daily operations. A relationship has indeed been established by studies interested in how regulatory frameworks align the organization and the strategies of non-financial firms

on those of the financial sector. Baud and Chiapello (2015), in particular, have shown that managerial tools and practices imposed by the Basel agreements (largely informed by financial theory) were instrumental in the financialization of small and non-profit banks organized around different principles – leading to a rapid conversion of these firms. This indicates that the financialization of PHI could be a result of firms gradually adopting the routines, strategies and positioning of financial companies as they implement the regulatory provisions entrenched by Solvency II. Such mechanism ostensibly refers to the second dimension of financialization, namely the increasing adoption of financial strategies and narratives by non-financial actors.

Taken together, these contributions thus point to a regulatory path to welfare systems' financialization and, consequently, to the possibility of a more direct relationship between symptoms of private health insurers' financialization and the implementation of Solvency II. Two subsequent consequences can be anticipated from these transformations. One relates to healthcare coverage as provided by these firms, which is expected to change in accordance with the requirements imposed by Solvency II. A second expectation relates to the strategic aims of the same actors, and their policy stances more broadly – that could evolve as they become more closely aligned on the financial sector, possibly challenging established equilibriums within domestic health policymaking. The next two sections provide empirical support in favour of these intuitions.

<2>How (EU) financial regulation might affect domestic healthcare systems

<3>Financialization through regulation? The consequences of Solvency II

Solvency II has been linked with a greater financialization of the insurance industry as whole by a significant amount of contributions. These broad implications, that were already made explicit right from the first meetings of the working groups

convened by the European Commission under the umbrella of the DG Internal Market, in fact largely stemmed from the convergence between insurance and banking regulatory systems that the Commission explicitly sought to achieve through Solvency II.³

In that respect, the text finally adopted replicates the three-pillar approach previously espoused in the banking sector. A first pillar sets the quantitative financial requirements, which are apprehended through the solvency capital requirement (SCR) (that is, the capital an entity should possess to ‘absorb an exceptional shock’); and the minimal capital requirement (MCR), a threshold below which an entity is subject to withdrawal of its insurance authorization. The second pillar broadly encompasses supervisory assessment and corporate governance, notably by defining the methodology for the Own Risk and Solvency Assessment (ORSA) through which insurers identify the risks to which they are exposed and justify their risk management strategies. The third pillar mostly addresses transparency and reporting matters.

The broad, underlying goal of Solvency II was to set up a ‘risk-based’ approach to regulation. The holistic approach taken by this directive is thus ‘not just about capital’, but implies a more fundamental ‘change of behaviour’ – in the words of Thomas Steffen, chairman of the European Insurance and Occupational Pensions Authority (CEIOPS 2007). It is essentially due to the broad orientation of the regulatory tools and instruments that accompany these provisions that Solvency II has been presented as involving an increasing financialization of the European insurance industry and this on two related dimensions that echo the mechanisms described in the previous section.⁴

The first relates to the clear incentives that are induced by the risk-based orientation of Solvency II. To reduce their probability of failure (a critical requirement of Solvency II), insurance companies (as well as banks providing insurance services) are strongly encouraged to grow in size and to diversify both the range of benefits they provide and their investment incomes. This constitutes a powerful incentive for firms to reduce their exposure to risky businesses (such as life insurance), typically through expanding in 'safer' areas (with healthcare being a case in point).

The second dimension more directly concerns firms and their everyday activities. It relates to the introduction of various business practices based on 'financialized valuation' (Chiapello, 2020) of insurance undertakings – accompanied by a dedicated 'financial vocabulary of motive' (Van der Heide, 2022). This notably manifests in how capital requirements should be calculated with respect to the provision of the SCR. Solvency II notably requires the use of current market values for assets and liabilities ('fair value accounting') instead of the price at which they were initially purchased, namely 'book values'. When there is no actual market for certain assets or liabilities (and this is notably the case for technical provisions, which are part of the liabilities), the value is obtained through summing a best estimate of technical provisions and a risk margin. The practical consequence of this is that substantial parts of an insurer's activity are now marketized and categorized as assets or liabilities even where it was previously not the case – and that a financial perspective now prevails in the regulator's appreciation of a firm's solvency (François, 2021).

Another, though related dimension of financialization associated with Solvency II appears in the considerable extension of the conceptions of risks and risk exposure that accompanies the implementation of the directive. The capital needed under

Solvency II should indeed reflect virtually all the quantifiable risks to which an insurance company could be exposed. Various risks, ranging from the brutal collapse of stock markets to a rapid increase in longevity or a natural disaster, now have to be factored into every decision taken by an insurance company in its activities. More importantly, these various provisions pave the way for extended (and arguably, more aggressive) risk management strategies into the direct relations between insurers and their customers.

Overall, it is because of these changes that Solvency II was perceived as largely embracing shareholder value. The directive itself explicitly takes an investor's viewpoint, and allows profit margins to be readily and easily deduced by looking at the various risks to which an undertaking is exposed. This is also reflected in disclosing procedures (third pillar), that are explicitly based on the rules and conventions of financial reporting. Solvency II is thus not just a mere reform of a given sector – but also a (regulatory) vehicle likely to deepen its financialization (François, 2021).

<3>When (financialized) modes of financial regulation intrude on healthcare systems Solvency II emerged well beyond the realm of domestic healthcare systems – and during the two decades that preceded its final enactment, its potential implications for these systems were not fully foreseen by policymakers, both at the EU and domestic levels. This is largely due to the fact it was primarily envisioned as a framework for life and non-life (re)insurance undertakings conceived as financial services. In effect, the making of the reform ostensibly involved large and transnational insurance companies as well as countries concerned with protecting their financial systems such as France, Germany and the UK. The latter, in particular, played an instrumental role in the adoption of some of the text's core concepts. In her extensive

analysis of Solvency II, Quaglia (2011) has shown that the UK was indeed a ‘pace setter’ during the negotiations. By constructing alliances with the Commission and large transnational companies, its representatives were able to diffuse various norms and principles of their domestic model of insurance regulation (including ‘targeted risk-sensitive solvency requirements’, ‘dual capital requirements’, ‘the possibility of using firms’ internal models’ and a ‘non-zero failure approach’) to other European countries – where regulatory requirements were more often based on a ‘rule-based approach’, ‘no market disclosure’, a ‘zero-tolerance of failures’ and a largely more limited use of financial instruments (Quaglia, 2011).

Solvency II was thus not only a source of increasing financialization of the insurance industry, but also of diffusion of core regulatory principles from countries with pre-existing financialized conceptions of insurance regulation (like the UK) to other varieties of capitalisms. But the same diffusion also happened at the sectoral level, as before Solvency II the business model and the degree of financialization of large insurance companies (such as Allianz for Germany or Axa for France) were already similar to those of most companies operating under the British regulatory regime. Consequently, the text also constituted an extension of these ways of operating to the many small and medium-sized insurance companies found in different European political economies, now formally subjected to the same requirements.

Assessing the likely effects of Solvency II on healthcare systems is not an easy task, as the role of PHI varies considerably, sometimes between countries that conventionally belong to the same categories. While it for instance essentially provides a greater choice of providers or superior accommodation in the UK, it plays a much greater role in Ireland – two countries that are generally referred to as liberal

welfare states. What is clear, though, is that voluntary, private and usually non-profit insurers are usually more important in Continental and Southern European countries.

This, in part, is explained by historical legacies. Conservative European healthcare systems founded upon a national or statist health insurance system (namely the vast majority of them, see Böhm et al., 2013) largely built on existing insurance schemes organized along corporatist principles, that served as a basis for the creation of sickness funds or similar institutions. While most of these private insurers were integrated or disappeared as a result of the formation of modern welfare states, some continued to offer complementary benefits to those offered by the statutory social insurance funds. In countries such as Belgium, PHI providers play a dual role: they are not only in charge of the statutory healthcare system, but as 'private' providers they also offer complementary or supplementary-like benefits. While the statutory side of their activities is excluded from Solvency II, their complementary activities are considered as insurance under European law and should in principle comply with the directive. Crucially, the strong level of institutional integration between the statutory and the complementary sides of the Belgian healthcare system suggests that the implementation of Solvency II could have important side effects on the whole structure of the public–private mix.

Yet the question of the likely implications of Solvency II is also a matter of political agency, however. In several countries, recent reforms towards the partial privatization of healthcare systems have generated a perceptible increase in the demand for PHI – and, as such, of the share of the system possibly exposed to Solvency II. PHI providers in the Netherlands, which account for all primary and curative care since the 2006 Health Insurance Act, are a relevant example. As Dutch regulations demand health insurers to align their capital management and pricing

strategies, their technical results and their risk profile are likely to be negatively perceived under Solvency II – with some companies at risk of facing a withdrawal of their insurance agreement. Different trends, yet with similar consequences, are noticeable in Southern Europe. In recent decades, healthcare (formerly organized along corporatist principles) in most of these countries has been gradually integrated through the creation of national health services (see Ferrera, 1996). But the demand for PHI has recently increased following austerity measures adopted during the Great Recession. In Portugal, a prolonged underfunding of health services has, for instance, induced the rise of PHI plans in the country, with around 25 per cent of the population now covered. At the same time, and while the sector comprises several non-profit companies, tax deductions for insurance premiums were substantially reduced (Sagan and Thomson, 2016).

While there is thus considerable variation regarding the likely effects of Solvency II on healthcare systems, it thus appears as possibly substantial. In the next section, we illustrate that claim by providing an in-depth examination of the implementation of Solvency II by private health insurers in France, a relevant case-study for three interrelated reasons. First, dominant private health insurers in France (*'les mutuelles'*, namely mutual benefit societies) share numerous properties with other health insurers elsewhere in the continent. Specifically, they are non-profit firms, organized around 'principles of solidarity between their members, who participate in the governance of the business' and are primarily focused in healthcare and occupational welfare plans (European Parliament, 2011). Second, they have historically dominated the field of PHI, with a (now decreasing) market share of more than 50 percent in 2019. Last, they are closely integrated into the national health insurance system and are heavily regulated. In sum, the case under scrutiny involves

actors that operate at a distance from the financial principles of Solvency II; their role within the healthcare system is significant; and they are closely within the French healthcare system.

<2>The financialization of private health insurance

<3>Turning financial firms into health insurance providers... and turning non-profit health insurers into financial firms

We have argued in the previous section that the implementation of Solvency II could induce a financialization of private health insurers on two important dimensions. The first is linked to the clear incentives the text provides towards growth in size and diversification of insurance undertakings, which could in turn result in the growth of financial firms in the sector – at the expense of pre-existing providers of health insurance. The second relates to the business practices it introduces, and more specifically, the new tools based on financial valuation it requires firms to use.

At the time of implementing the directive, mutual benefit societies clearly differ from the rules and principles associated with Solvency II. As in other countries where the state ‘holds regulatory powers in healthcare but grants privileges for the financing and provision of health services to societal actors like sickness funds’ (Böhm et al., 2013), mutual benefit societies emerged on a professional or a regional basis long before the formation of the French welfare system and persisted after its foundation. In 1947, a law recognized their role by granting them the right to participate in co-payments for treatments and services within the statutory healthcare system. In a context where funding by the national health insurance system has ceased to increase and has somewhat declined over the last 30 years, they have gained in importance – and ever since, their development has been continuously encouraged by policymakers through a range of tax credits and incentives (Benoît and Coron,

2019). In addition, mutual benefit societies have historically participated as trustees of the State through managing on its behalf the healthcare coverage of civil servants, and prospered in occupational welfare by offering schemes covering industrial accidents and incapacity.

In this context of close integration with the statutory healthcare system, their business model and their organization markedly contrast with that of stockholding insurance companies. Mutual benefit societies are indeed led by an executive board elected by its members, with each member being formally granted the right to vote or to be elected to head the organization. In line with their 'democratic' principles, these non-profit, usually small and medium-sized entities mostly grow in capital through an increase of their members and limited investment incomes.

Due to the de facto monopoly enjoyed by mutual benefit societies (as well as the poor profitability of health insurance given the generous social benefits provided under the statutory healthcare system), financial firms have traditionally disregarded health insurance. It is on those latter aspects that one can identify a first series of effects linked to Solvency II, that led to an unprecedented development of financial firms in PHI – without, importantly, this being directly linked to some policy choices at the domestic level. Figure 1 plots the annual percentage change of net earned premiums by mutual benefit societies, provident institutions (that is, non-profit insurers also exposed to Solvency II, though mostly involved in occupational welfare and pension plans) and financial firms (banks and insurance companies) over the last ten years.

<Insert Figure 1 near here>

It shows that since Solvency II came into force in 2016, financial firms have continuously grown for the time period considered at a much higher rate than mutual

benefit societies and provident institutions – with the exception of 2020–2021, which is largely explained by mutual benefit societies' greater exposure to the consequences of the COVID-19 pandemic, that explains both the decrease and the surge observed for that period. Insurers now account for about a third of the PHI market in France. This stark increase is a direct effect of the implementation of Solvency II, that has pushed financial firms to search for further diversification benefits that are less demanding in capital than their riskier (typically life insurance) activities – particularly in a context of low-interest rates (S&P, 2016). While most of these providers are stockholding insurance companies (like Axa, Allianz or Swiss Life), banks have also started to develop in this segment.⁵

In the same time, mutual benefit societies have struggled with the implementation of Solvency II. For the same reasons it favoured diversified financial firms, this regulatory framework contributed to making two defining features of their business model appear problematic. One is linked to the very limited diversification of their products, as most mutual benefit societies focus almost exclusively on healthcare and occupational welfare – a situation likely to be considered as 'riskier' under Solvency II, particularly as most operate in a single country. Another aspect of their activities deemed as problematic relates to the fact that, as non-profit entities, mutual benefit societies typically use their gains to improve the benefits provided to their members or to increase their coverage. As it tops up the capital burden through SCR and MCR, Solvency II requires that they make additional provisions or find ways to increase the value of their funds.

This twofold challenge led to an unprecedented rise of financial transactions in the sector, essentially through mergers and acquisitions or strategic alliances between mutual benefit societies (Abecassis and Coutinet, 2021). Overall, the

various mergers and acquisitions in the context of the implementation of Solvency II resulted in the formation of large groups made up of different entities, with the group level now in charge of overseeing compliance with prudential requirements (Interview 13). As a result of these various financial transactions, the market is now heavily concentrated, with only 40 groups possessing 90 per cent of all premiums collected by all mutual benefit societies according to the most recent (2019–2020) figures.

Interview data confirms the importance Solvency II has as the main driver of this process, which was anticipated during the negotiations that preceded the enactment of the directive and has been reinforced ever since. In the course of these years, mutual benefit societies tried, but largely failed, to resist the pressures of European integration. During the negotiation, the French government (as were also its German and British counterparts) was essentially preoccupied with preserving the interest of its main domestic insurance companies. Lacking the resources to meaningfully participate in these debates, mutual benefit societies' representatives were unsuccessful in their demands for a softer framework, and only the smallest insurance undertakings were eventually excluded from Solvency II (Quaglia, 2011). Mutual benefit societies then focused their lobbying efforts on more technical aspects, essentially around health insurance volatility under Solvency II calibrations – while preparing for implementation of the text, which was perceived as inevitable.⁶

The implementation of Solvency II was also associated with perceptible changes in terms of corporate governance. Indeed, the directive demands that the effective administrators of insurance undertakings, just as for other financial firms, be 'fit and proper' (namely considered as 'reputed', 'experienced', 'professionally qualified' and 'knowledgeable' so that they can act as 'prudent' managers).⁷ Yet members of the elected board of mutual benefit societies, who usually are not

professional insurers, are unlikely to possess such competences and abilities. In parallel, the four 'key functions' of Solvency II, that are, respectively, the risk management, compliance, audit and actuarial functions, had to be put in place. To cope with the sizeable range of technical provisions associated with each function, mutual benefit societies massively recruited actuaries trained in modern financial theory and risk management (Interview 13). As a result of this twofold change, the situation that now prevails in mutual benefit societies is either one where the elected members simply endorse the decisions formulated and presented to them by 'fit and proper' actuaries in charge of the key functions (Interview 11), or adopt a more explicitly 'financialized' approach to their role. In this second instance, one can observe their increasing participation in the evaluation of ORSA reports and more broadly, in financial reporting activities which are now crucial tasks demanded of the effective administrators of insurance undertakings (Interview 7).

From an organizational perspective, these important shifts led to a growing problematization of a number of activities of mutual benefit societies in the 'terms of investment, capital return and risks' (Chiapello, 2020). Due to the important prerogatives they gained in the daily supervision of the implementation of Solvency II core principles, actuaries were more particularly able to diffuse a number of conventions regarding how to manage an insurance undertaking. Specifically, these professionals are now more directly in charge of 'pricing and the creation of new products', that are now envisioned in combination with capital requirements, the 'calculation of best estimates, SCR and MCR' thresholds demanded by Solvency II (Interview 14). In this context, the constant need to generate returns that are higher than the amount initially invested (and to justify initiatives that may deviate from this 'actuarial convention' in Chiapello's parlance) puts strong pressures on the very

principles on which mutual benefit societies have built their activities. Unlike financial firms, these entities have indeed historically refused to base contributions on the risks to which individuals are exposed, but instead on broad redistributive principles – meaning that in practice, ‘high incomes pay for lower incomes, active [individuals] pay for retirees, and childless couples pay for larger families’ (Interview 16). Under Solvency II, solidarity between policyholders should however not be primarily based on broad social values, but on capital. In this context, one can observe a gradual attenuation of these pricing strategies and an increasingly prevalent ‘risk-based’ approach, similar to what prevails in other kinds of insurance companies (Interview 9) – particularly as the latter’s search for further diversification benefits puts strong competitive pressure on mutual benefit societies.

<3>Mutual benefit societies and their new policy stances

As expected, the implementation of Solvency II eventually resulted in a growing financialization of PHI in France, that notably manifested in the growing importance of financial firms in the sector, in the introduction financial valuation practices and in the diffusion of new conceptions of risks and risk exposure within these organizations. Most of our interviewees recognize that broad ‘cultural’ differences persist between financial firms and mutual benefit societies – but that in terms of ‘operational management’, the implementation of Solvency II has rendered them more alike (Interview 4). This distinction between the ‘cultural’ and the ‘operational’ suggests that Solvency II does not necessarily modify the broad set of ‘mutualist’ values, but the managerial tools that accompany the directive and the principles they represent place strict restrictions on the ability to translate these values into practice.

Due to their role within the French healthcare system, the financialization of mutual benefit societies has had practical implications beyond the insurance sector,

to encompass the provision of healthcare as a whole. The above discussion has already shown that they were less keen or capable of maintaining broad mechanisms of solidarity between their members, and that they were increasingly adopting the same pricing strategies as stockholding companies. Other evidence suggests that mutual benefit societies are also becoming significantly less redistributive. Since the implementation of Solvency II, one can indeed observe a substantial rise in the administrative charges of PHI policies in France, which have now surpassed that of the statutory, national health insurance system – a rise that, importantly, cannot be linked to an increase of PHI plans over the same period (Figure 2).

<Insert Figure 2 near here>

If this increase can also be partly attributed to a broad rise in the fiscal burden over PHI plans, it largely results from the implementation of Solvency II, particularly as the text generated additional regulatory costs – ranging from the need to hire financial experts and actuaries or to rely on external expertise to cope with financial reporting requirements (Interviews 8 and 9). As a result, the return for policyholders (namely the ratio between their contribution and the benefits effectively received) is only at 65 per cent, meaning that a smaller share of insurance costs effectively translates into actual care or benefits.

The evolutions associated with Solvency II, however, also modify the policy landscape, and this on two important aspects – both of which could have longer-term implications for stabilized equilibriums within the French healthcare system. The first is linked to health policy per se, where mutual benefit societies have recently adopted policy stances that markedly contrast with their historical positioning. This is particularly manifested in the recent debates over the development of managed care organizations (MCOs) in France. MCOs are networks of healthcare professionals,

providers or facilities used by private health insurers for risk management and cost reduction purposes (see Benoît and Coron, 2019; Gay, 2021). Until recently, only stockholding companies were relying on such arrangements, which were fiercely opposed by mutual benefit societies for the threats they pose to fair and equal access to care. However, large mutual groups which formed after the implementation of Solvency II, not only started to develop their own MCOs – in 2014 they also successfully lobbied the Socialist government to obtain the right to modulate their rates and levels of reimbursement to incentivize their members to consult primarily healthcare professionals affiliated to their networks. While it essentially affects the provision of benefits on which the share of private coverage has always surpassed that of the statutory one (as in hearing aids, dental and optical care), the shift in mutual benefit societies' positioning is not neutral – particularly as MCOs have been praised as an important managerial and financial innovation by several governmental entities, including the French Competition Authority.

A second policy implication of Solvency II relates to the broader institutional changes that have accompanied the implementation of the directive. Formerly supervised by a special committee attached to the Ministry of Health and Social Affairs, since 2010, mutual benefit societies are regulated by a Prudential Supervision and Resolution Authority along with stockholding insurance companies. Operating as an independent entity within the Bank of France, it oversees as part of the Solvency II framework the various (and notably, financial) operations of mutual benefit societies. As a result, these actors formerly placed under the responsibility of social ministries' authority are now more closely integrated to the central bank's policy agenda. In particular their important reserves of capital accumulated over the years make them important targets for the pursuit of the Bank of France's financial

stability objectives. Once very similar to the sickness funds around which the national health insurance system in France were originally built, mutual benefit societies are thus not only closer to financial firms in organizational terms: they are also increasingly detached from the healthcare system to which they were previously exclusively anchored.

<2>Conclusion

In this article, we have provided evidence of signs of private health insurers' financialization in diverse European healthcare systems, and hypothesized a relationship between these changes and the transformation of European financial services regulation. Using the case of France, we have argued that the implementation of Solvency II could be associated with the growing role of financial firms in healthcare, to the adoption by health insurers of 'financialized' business practices and, eventually, to perceptible transformations of their positioning within their own healthcare system.

Overall, the regulatory path to healthcare systems' financialization that we revealed entailed three series of direct consequences for social policy in our case. First, it significantly transformed the typical actors involved in PHI, now dominated by financial firms and large market-oriented health insurers – that are crucially less redistributive than the statutory healthcare system, in part due to the consequences of regulation itself. Second (and as a result), it modified long-standing equilibriums in healthcare policymaking due to the conditions and incentives induced by the new regulatory requirements. Third, it more broadly connected a significant segment of the healthcare systems to other objectives and imperatives unrelated to those of the healthcare sector per se (as notably revealed by the growing involvement of the Bank of France in the sector).

While likely to be subjected to significant variation across countries, we believe that this argument holds true beyond the case of France. In the Netherlands, for instance, Solvency II has been explicitly recognized by the central bank as posing systemic threats for the healthcare system as a whole given the importance of risk equalisation within the sizeable PHI sector in this country (KPMG, 2020) – an issue that health insurers are likely to solve through deepening their financialization. In Belgium, mutual benefit societies that are in charge of the statutory healthcare systems battled with the European Commission and the representatives of financial firms to avoid implementing Solvency II for the complementary side of their activity. But a 2010 reform opened the field of supplementary health insurance to competition and aligned it with EU provisions, thus subjecting a share of the public–private mix in Belgium to Solvency II – with recent figures suggesting that for-profit insurance companies now cover more than half of the Belgian population under this segment (Assuralia, 2018). It thus seems that the various implications of Solvency II on domestic healthcare systems have thus yet to be fully grasped.

The findings reported here more broadly open two important areas for future research. One directly relates to the relationship between healthcare systems and finance, that Solvency II arguably reinforced – for implications that are likely to be perceptible not only for private health insurers per se, but in terms of their strategies, interactions with policyholders and attitudes in healthcare policymaking. On another aspect, we have also revealed the existence of a largely overlooked area of EU influence on domestic healthcare systems that shares obvious similarities with pension policy. There seems to be, however, an important difference with the case studied in this article. Most reforms documented by existing research on pensions and pension policy were indeed explicitly targeting this industry, often with the clear

ambition of turning savings into investment through financial services providers. As the focus of Solvency II is not specifically on healthcare, the process by which the directive has induced transformations of PHI seems, from that vantage point, to be of a different nature. Indeed, the financialization of private health insurers is clearly not an outcome explicitly sought by this text – much more, it seems to be the result of a mismatch that exists between the underlying logics and principles that are introduced by the directive, and the way of operating of private health insurers in several EU member states.

<2>Notes

1 More information about these data is provided in the Appendix.

2 Here and throughout, the numbers cited on the French health insurance market are those of the Directorate for Studies, Assessment and Statistics (DREES, Ministry of Health), <https://drees.solidarites-sante.gouv.fr/publications-documents-de-reference/panoramas-de-la-drees/la-complementaire-sante-acteurs>.

3 European Commission (2002).

4 See François (2021) for a fuller introduction to Solvency II.

5 *L'Argus de l'assurance*, April 2022.

6 *L'Argus de l'assurance*, March 2014.

7 See EIOPA (2013).

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