Commercializing German Hospital Care? Effects of New Public Management and Managed Care under Neoliberal Conditions

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Abstract

Market-led reform strategies around the world have given rise to fears of a progressive commercialization of hospital care. The aim of this article is to suggest an analytical framework that might explain the ubiquitous market-led reform strategies and to scrutinize widespread claim that commercialization processes impacts negatively on quality and equality of access. In comparing an ideal type model of commercialized health care with institutional and organizational change the article provides an assessment of commercialization processes in German hospital care. Although there is a newly evolving market-led governance structure in German hospital care commercialization processes have, however, been restricted. While there are strong signs that on a regulatory level the German hospital sector has become successively commercialized, there is insufficient data and research to prove the suspected negative impact on quality and equality of care provision.

Zusammenfassung

Markt- und wettbewerbsorientierte Reformstrategien in den Krankenhaussystemen zahlreicher Industrieländer haben Befürchtungen vor einer kommerzialisierten Krankenhausversorgung hervorgebracht. Dieser Beitrag unterbreitet ein analytisches Interpretationsraster zur Erklärung der internationalen Verbreitung dieser Reformstrategien und versucht die behaupteten negativen Effekte von Kommerzialisierungsprozessen auf Versorgungsqualität und Zugänglichkeit zu untersuchen. Gestützt auf einen Vergleich eines idealtypischen Kommerzialisierungsmodells mit dem institutionellen und organisationalen Wandel im deutschen Krankenhaussystem kommt der Beitrag zu dem Schluss, dass Kommerzialisierungsprozesse in der Krankenhausversorgung bislang noch begrenzt sind. Obwohl ein markt- und wettbewerbsbasierter Umbau des Governancesystems zu beobachten ist und Krankenhäuser zu einem kommerzialisierten Verhalten gedrängt werden, lässt sich aufgrund einer unzureichenden Daten- und Forschungslage bislang nicht empirisch eindeutig feststellen, ob die Kommerzialisierungsprozesse zu einer Verschlechterung der Qualität und Zugänglichkeit der Krankenhausversorgung in Deutschland geführt haben.

1 Introduction

External and internal pressures over the past two decades or so have led to hospital sector reorganization in many countries around the world. The basic thrust has been the implementation of market-led governance reforms and business-type restructuring of public hospitals, although on a different scale and scope in each country (McKee/Healy 2002; Preker/Harding 2003; HOPE/DEXIA 2009; Rechel 2009). These market-led reform strategies have given rise to fears of a progressive commercialization of hospital care (Lister 2005; Mackintosh/Koivusalo 2005; Tritter 2010). The aim of this article is to suggest an analytical framework that might explain the ubiquit-

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ous market-led reform strategies and to scrutinize widespread claim that commercialization processes impacts negatively on quality of care and equality of access. The empirical range of this contribution is limited, applying the analytical framework to a case study of the German hospital sector. The article is arranged as follows: Firstly, I lay out the theoretical foundations of the analytical framework, which situates the concept of commercialization within the transformation processes of modern statehood and the health care state, both contextualized under neoliberal conditions. On the basis of this framework I construct an ideal model of commercialized health care against which institutional and organizational change in the German hospital sector will be assessed. Secondly, I move straight on to describe institutional and organizational change in the German hospital sector, using widely applied analytical frameworks of health care system regulation and some basic empirical indicators and trends describing hospital care. Thirdly, on the basis of the empirical results of the case study, the last section tries to make sense of the changing governance structures and commercialization processes in German hospital care. The newly evolving market-led governance structure in German hospital care displays a complex institutional blend of different forms of governance, so a dichotomous understanding of governance modes is completely unfounded. Commercialization processes have, however, been restrained so far compared with the ideal model of health care commercialization outlined in the first section. The conclusion, finally, sums up the mixed results of commercialization processes in German hospital care. While regulatory efforts to strengthen economization have been pursued and privatization processes precipitated and broadened, the lack of appropriate data and systematic research still makes it difficult to prove any unfavorable impact of commercialization processes at the level of hospital care delivery.

2 The German Health System, New Public Management and the Commercialization of the Hospital Sector

2.1. Beyond False Dichotomies: Governing the Health Care State under Neoliberal Conditions

The analytical framework of the health care state differs from traditional ways of analyzing health care and health policy in the particular status it affords to statehood and statecraft. Statehood and statecraft are general features of health care policy because state involvement—whatever its institutional shape—plays a decisive role in every health care system, and the institution of the state is different from other governance forms like market or corporatism. Basically, the concept of the health care state entails the idea that interaction between health care institutions and state institutions creates multiple areas of conflict between and within both institutional complexes. As a *capitalist state* the modern state affects the development of medical technologies, the regulation of the professions and the framework of collective consumption. As a *welfare state* the modern state influences the way collective consumption is organized and how professions are regulated for

treating patients. As a *democratic state* the modern state is both arena and forum for different material and ideal interests in the health care sector. The political agents of health care institutions and state institutions interact to build a web of policy networks, waiting to be disentangled by health policy analysts (Moran 1992, 1995, 1999, 2000).

In analyzing institutional and organizational change in German hospital care the concept of the health care state serves as a theoretical link from the transformation of statehood in general to regulatory and institutional change in the hospital sector in particular. Statehood in modern capitalist countries has been in a transformation process for years. New Public Management (NPM) has been the most prominent state reform project in the Western hemisphere, affecting both the administration and the provision of public services (Jessop 2002; Pollitt/Bouckaert 2004; Pierson 2007). In Germany, several ideal models and state reform projects developed in the political discourse, ranging from the "Keynesian state" to the recent NPM-like "guarantor state" (Bieling 2009). However, both the transformation of statehood and the political discourse on political models of the state take place within the political and economic context that referring to David Harvey could be termed "the neoliberal condition" (Harvey 2005). Neoliberal conditions frame political decisions and economic processes by, firstly, accepting that the growth of state budgets is restricted through economic globalization processes and, secondly, assuming the superiority of the private sector over the public sector regarding the efficiency and effectiveness of service provision. However, the New Public Management movement insists that the state has a role to play in public service reform (Pollitt/Bouckaert 2004; Pierson 2007; Schedler/Proeller 2007). Although transcending the false dichotomies of market vs. state as asserted in neoliberal economic theory—and therefore providing a much more realistic reform project—the New Public Management movement still adheres to the neoliberal conditions. Further, NPM reforms of statehood under neoliberal conditions might trigger commercialization processes of public services in general and hospital care in particular.[1]

2.2 New Public Management and the Commercialization of Public Services

In Germany, the concept of New Public Management (NPM) was initially associated with the modernization of public administration, in the sense the state's internal structures (Naschold/Bogumil 1998). Here a broader definition of the term is applied, according to which NPM relates to the modernization of the state administration *and* the public service sector, because especially at the municipal level it is practically impossible to draw a clear line between the state administration and the field of provision of public services (including social services) (Harms/Reichard 2003; Czerwick 2007).

[1] It is beyond the scope of this article to describe the web of policy networks generating institutional isomorphism between the modernizing state and the health care state. The following analysis merely tries to make sense of the application of the New Public Management framework to German hospital care.

At the heart of the NPM discourse lies the assumption that establishing competition and (quasi-)markets in areas of public service hitherto furnished by local government or the state leads to greater efficiency, effectiveness and economy (Pelizzari 2001: 57-68 Schedler/Proeller 2006: 51-57). Here a distinction is made between non-market, quasi-market and market competition. Non-market competition functions through internal accounting, benchmarking, performance comparisons, and price competition between public administration units with the goal of minimizing costs (Schedler/Proeller 2006: 195-198). Quasi-market competition aims to reduce costs and boost efficiency through service contracts and delegation of responsibility from administrative units to public service providers as well as internal tendering for public services (Schedler/Proeller 2006: 198-200). Market competition differs from both in that private-sector service providers are involved. Market competition uses the instruments of tendering and contracting-out (make-or-buy, outsourcing) to cut costs and provide services cheaply within publicly determined criteria (Schedler/Proeller 2006: 200-203).

This logic says that in order to realize (quasi-)market competition it is necessary to create a potentially competitive market via privatization, thus engendering a structural "pluralism of supply" in the social services sector—if this does not already exist. Privatization and liberalization processes are thus both a theoretical precondition for the application of NPM concepts in practice and a common side-effect. According to the NPM ideal, the process of privatization would cause the state would lose its role as a provider of services and withdraw to the position of a "guarantor state" overseeing the provision, results and quality of quasi-public services now largely supplied privately but still regulated by the state (Schedler/Proeller 2006: 109-112).

Making the provision of public services more customer- and market-orientated presupposes a maximum of decentralization of decision-making on the part of the service providers, as is normally the case with private services. In order to exert financial control over purchasing and tendering—in an environment where state resources are structurally restricted by neoliberal financial and economic policy—the state relies on the instruments of global budgeting and financial controlling (outsourcing, profit centers, cost centers), which in turn presupposes cost transparency and the introduction of cost accounting in the entities involved (Pelizzari 2001: 57-68; Schedler/Proeller 2006: 165-183).

Commercialization of the public sector

In this context the term commercialization generally refers to reform of the public service sector using management and organization concepts taken from the private sector, in other words following the concept of New Public Management. One example would be the commercialization of the German Post Office (Landgraf et al. 1988). Here I use the term in a broader sense than it enjoys in New Public Management theory, understanding commercialization of the public sector (and thus also of healthcare) to encompass both the emulation by the public sector of private-sector ways of operating

(NPM; often also described as "economization") and also the increasing significance of profit-orientated service providers in the publicly financed sector, including in the whole healthcare system (Mackintosh/Koivusalo 2005: 3-4). So a concept of commercialization combining both aspects means, on the one hand, increasing the importance of achieving a financial profit or the predominance of financial incentive systems for the management and organization of individual (public *and* private) service providers and the welfare system as a whole, and, on the other, a simultaneous reduction in the significance of publicly determined and planned care needs of a defined population group (meaning, in the case of the healthcare system, medically necessary care).[2] Under conditions of progressive commercialization of the public service sector a potential conflict arises between market/competitive allocation of resources and public planning of services. In the NPM discourse this is resolved by the "guarantor state" which guarantees the general conditions for market service provision and plans the financial framework (Pellizarri 2001: 65; Gethmann et al. 2004: 175-178; Schedler/Proeller 2006: 109-112).

Commercialization of public services articulates three relatively autonomous trends in the public sector: (1) privatization of public service organizations, (2) international market liberalization, and (3) the economization of governance through New Public Management. *Firstly*, for a public service to become commercialized service structures and institutions must be economically and organizationally autonomous in order to realize the incentive system of financial surpluses. This can be achieved through *formal* privatization (i.e. by changes in legal status), but under conditions of neoliberal financial austerity formal privatization processes often lead to *material* privatizations, i.e. the sale of public enterprises to private individuals or companies (Pelizzari 2001; Bieling/Deckwirth 2008: 15). As privatization and market liberalization progress this development can lead, *secondly*, to the (potential) *internationalization* of the public service in question, through the application of competition policy and rules (Fritz 2004; Bieling/Deckwirth 2008: 17-24; Huffschmid 2008). *Thirdly*, at the regulatory level, commercializing a public service presupposes that both the governance of the public service sector and the management and organization of service organizations are orientated on market concepts. So the political implementation of quasi-markets or welfare markets and public sector restructuring based on business models are core components of New Public Management reform strategies (Pelizzari 2001; Schedler/Proeller 2006).

[2] The standardization of services (and the formation of markets and prices based on this), the expansion of the wage labour ethos within the respective service sector and the formation of a manifest customer orientation among both service providers and service users are theoretical and real societal preconditions for commercialization and economization processes. In a borrowing from classical political economy, these preconditions are designated commodification processes (Leys 2001: 81-107; Crouch 2008: 101-108). However, it is beyond the scope of this contribution to empirically analyse commodification processes in German hospital care.

2.3. New Public Management, Managed Care and the Commercialization of Hospital Care

Research on the significance of New Public Management in the area of healthcare is still in its infancy, but initial studies do indicate that an emerging international reform discourse on modernizing national health systems is informed by NPM (Pelizzari 2001: 131-141; Lee 2003: 139-147; Lister 2005: 96-121). In the course of this contribution I will draw on NPM concepts and discuss their empirical relevance for describing hospital care trends in Germany (for an earlier attempt see Löser-Priester 2003: 21-54). I begin by considering how the four central pairs of concepts from the NPM discourse should have been anchored institutionally and organizationally in the German hospital sector if the governance of the hospital sector had been restructured according to NPM-based reform strategies.

(1) *Competition and (quasi-)markets*: Competition in markets or quasi-markets presupposes an organizational separation of the service funders or purchasers from the service providers, in other words the implementation of a purchaser/provider model. The corporatist character of the German health service, including its hospitals, makes the statutory sickness funds—as public bodies managing services on behalf of the state—functionally and organizationally the appropriate level for implementing the purchaser function in NPM concepts. But on the other side too there need to be competing private and/or state-run operators that are able to function in a market environment (Schedler/Proeller 2006: 191-213). The hospital operators (public, non-profit and private-sector) represent the provider function in the NPM concept (Schedler/Proeller 2006: 95-109). According to analytical competition models hospitals operate in at least three sub-markets: the treatment market, the service market and the procurement market (Cassel 2002; Klaue 2006a: 5-17). If hospitals and hospital operators are to act competitively in these sub-markets they have to have greater financial and operational autonomy, and formal privatization processes may be needed too (i.e. changes in legal status). But the service funders/purchasers (the statutory sickness funds) also have to be reorganized to make them act according to market principles. To what extent do these conditions exist in the German hospital sector?

(2) *Decentralization and global budget*: The introduction of budgets is intended to make subordinate units of private-sector companies and public administrations provide more effective and efficient services. Especially under the neoliberal conditions of "permanent austerity" of public budgets (Paul Pierson) accepted in the NPM concept, these budgets are presumed to lead to economic use of existing resources. Decentralization of executive and organizational structures, especially separating the funders/purchasers of services from the providers, plays a central role in implementing budgetary control (Schedler/Proeller 2006: 87-95 and 165-189). Sectoral and global budgets can be imposed in the hospital sector to encourage hospital operators' efforts to improve efficiency and foster rationalization processes. Can such processes be identified in the German hospital sector?

(3) *Focus on results and performance*: The NPM concept also promises to improve the quality of results by providing services efficiently to achieve

desired targets. This means the introduction of performance-based reimbursement/payment systems and contractual arrangements for verifying that planned results are achieved (Schedler/Proeller 2006: 131-163). Can such a focus on results and performance be observed in the German hospital sector?

(4) *Focus on quality and customer satisfaction*: NPM promises improved quality of service, and attempts to ensure this by implementing systems that measure the quality of the services provided and pay greater attention to the customer's wishes and interests (Schedler/Proeller 2006: 121-130). Can this kind of focus on quality and customer satisfaction be observed in the German hospital sector?

Managed care, New Public Management and purchaser/provider models

Managed care is the application of NPM methods and organization to the hospital sector. Managed care concepts give competition and (quasi)markets a major role in the health system (via selective contracting) and also encompass the focus on results, performance, quality and customer satisfaction that are core elements of the NPM concept. The underlying principle of managed care is to (partially) integrate the health service provider and funding functions via individual contracts (selective contracts) between the funders and selected service providers, and thus engender more efficient control of costs and quality (Wiechmann 2002: 49; Amelung/Schumacher 2004: 7).

The managed care literature draws a distinction between managed care instruments (for control of payment and quality) and managed care organization as a special form of contractual coordination between funders and selected service providers (Wiechmann 2002: 50-51; Amelung/Schumacher 2004: 8-9). However, despite a number of similar basic assumptions, New Public Management and managed care differ in that the NPM concept starts from a perspective of a superordinate state engaged in political steering whereas managed care tackles service provision more as a business management question.[3]

The application of New Public Management methods in healthcare and hospital governance and the implementation of managed care instruments and forms of organization in healthcare both culminate in an (international) reform model that is referred to in international comparative health system research as the purchaser/provider model and has come to be propagated as a benchmark (Figueras et al. 2005; Preker et al. 2007). Its constitutive features are theoretically and conceptually similar to those of NPM and managed care. Like the empirical development in other policy fields where NPM concepts for administrative modernization of the state have been im-

[3] These comparable basic assumptions—such as the conviction that competition is superior to state planning processes or the importance of modern management instruments and methods for combining efficiency with quality improvement—can be traced back to shared theoretical foundations. Both concepts are rooted in theoretical approaches from new institutional economics, especially principal agent theory, transaction cost theory and public choice theory (Amelung/Schumacher 2004: 20-38; Schedler/Proeller 2006: 47-57).

plemented (Pollitt/Bouckaert 2004; Pollitt et al. 2007), the realization of this reform model in healthcare and hospitals remains dependant on the political and social balance of forces.

Commercialization of the hospital sector = NPM + managed care + privatization

Under neoliberal conditions (politically enforced) marketization and liberalization of the public hospital sector ultimately lead to (material and functional) privatization and (probably) internationalization processes in and of hospital care. *Material privatization* means the transfer of the ownership of public enterprises to private hands. *Formal privatization processes* on the other hand are the logical and organizational/practical precondition for the greater operative and financial autonomy involved in applying NPM in the hospital sector, without ownership status being affected. *Functional privatization*, which is distinct from both formal and material privatization, covers the manifold forms of partial organizational privatization of services and functions in public and non-profit hospitals, for example through outsourcing and/or public-private partnerships. The objective of functional privatization is to lower operating costs and/or open up additional sources of income to improve the financial situation of the institution (on the different types of privatization see Schneider/Tenbrücken 2004: 18-19; Zech 2007: 14-15; BÄK 2007: 45; Bieling/Deckwirth 2008: 15).

In the field of collective protection against risks of illness the question of *privatization of treatment costs* also plays a role. Here the question is whether hospital treatment is paid for by a collective funder (sickness fund) or directly or indirectly by the individual patient. Privatized treatment costs are those hospital services that patients have to pay for themselves or through additional private insurance policies either because they have been partially or completely removed from the catalogue of treatments provided by the statutory health insurance (SHI) system or because they were never included in it in the first place (Gerlinger/Stegmüller 1995: 155-161; Gerlinger 2004: 501-504).

The balanced and coherent implementation of NPM concepts, the business management strategy of managed care and privatization processes can be regarded as the ideal-case indicators of commercialized hospital care.[4] The politically sensitive issue in commercialized hospital care is the predominance of financial incentives and calculations vis-a-vis the provision of hospital services adequate to meet needs. The following analysis compares the institutional and organizational realities of the German hospital sector with this ideal modeled concept of commercialized hospital care (see Table 1), assessing the degree to which hospital care is commercialized (high/medium/low). Because it is currently difficult to quantify the comparative categories, I will for the time being undertake a heuristic qualitative interpretation, completed where possible with quantitative indicators. In the

[4] Due to lack of relevant data, patterns of internationalization cannot be examined.

last section I will return to the health policy challenge that arises from the contradiction between commercialization and provision of adequate care.

Table 1: Institutional/organizational indicators of commercialized hospital care

		Germany
New Public Management	Competition and quasi-market	**Degree of realization: high / medium / low ?**
	Decentralization and global budget	
	Focus on results and performance	
	Focus on quality and customer satisfaction	
Managed care	New care forms (selective contracts)	
	Payment system reform	
	Quality and cost management	
	Evaluation procedures	
Privatization forms	Formal privatization	
	Material privatization	
	Functional privatization	
	Privatization of treatment costs	

3 Regulation and Care in the German Hospital System[5]

The German health system and particular its hospital care is, in international terms, heavily shaped by the overlapping powers of national and state government that arise from the federal structure of both government itself and the social insurance architecture of the German welfare state (Alber/Schenkluhn 1992; Wendt 2003). Using an analytical model from international health system research, the hospital sector can be further differentiated in terms of financing and care functions (Wendt 2005; Rothgang 2006). When analyzing the regulation of both functions a distinction can be drawn between the institutional anchoring of decision-making jurisdiction *(Entscheidungskompetenz)* and decision-making power *(Entscheidungsmacht)*, to reflect the federal intricacies of German politics and the corporatist structure of the health system. *Decision-making jurisdiction* describes the ultimately constitutional responsibility for fundamental decisions concerning hospital policy that are made directly by government at either national or state level. The alternative term *decision-making power* highlights the way the corporatist arrangements of the German health system, which often finds itself "in the shadow of the state" (Döhler/Manow 1997; Scharpf 2000: 323-335), means that the real decisions on the ground are made in a corporatist framework more or less delegated by the state. This section begins by describing the institutional and organizational changes in the structures and

[5] The empirical analysis describes the regulatory regime and care developments in the German hospital sector at the end of 2008.

regulatory scope of the funding and service provision functions in the German hospital system (3.1.), before outlining the central empirical trends in hospital care and capacity (3.2.).

3.1. Regulatory Structures in Transformation

3.1.1. The Regulation of Financial Allocation

The *regulation of financial allocation* in the hospital sector constitutes a complex web of state-level and corporatist regulation (see Matrix 1). The financing function in the hospital sector comprises on the one hand the funding of day-to-day treatment costs and on the other the provision of finance for building, maintaining and modernizing buildings and other capital equipment. The first "grand coalition" of 1966–69 (Christian Democrats from the CDU and the CSU together with Social Democrats) amended the German Basic Law to include a provision giving national government concurrent legislative powers over "the economic viability of hospitals and the regulation of hospital charges" (German Basic Law, article 74, clause 1, item 19a). On the basis of this constitutional norm the following reformist coalition of Social Democrats and Free Democrats (1969–1974) under Social Democratic Chancellor Willy Brandt increased, for a limited period of time, national government's financial participation in the modernization of the hospitals through the Hospital Financing Act of 1972 (KHG). The details of the standardization of hospital planning, introduced at the same time, were left to the federal states (Simon 2000: 69-82).

Matrix 1: Decision-making jurisdiction and decision-making power in the regulation of financial allocation in the German hospital sector

		Decision-making power	
		State	**Corporatist**
Decision-making jurisdiction	**Federal**	*Framework*	Treatment costs
	State-level	Investment costs	*Implementation*

The economic recession of the 1970s made cost-containment in the health system, including the hospitals, a factor of central importance. In place of the undercapacity of the early 1970s, the hospital sector was now treated as a cost factor and cutting capacity was put on the political agenda (Simon 2000: 89-125). Chancellor Helmut Kohl's coalition of Christian Democrats and Free Democrats withdrew national government from the mixed system of investment in the hospital sector through the Hospital Reorganization Act of 1984 (KHNG), but constitutionally speaking the nation-

al level remained the decisive level, and still does. To ensure the economic viability of the hospitals in the following period a new division of powers between national and state government emerged (Böhm 2008; Simon 2008a), guaranteeing adequate revenues from the per diems, where the national level is crucial, while leaving the federal states responsible for financing public investment (§ 4 KHG).

In pursuit of the goal of cutting capacity, the Health Care Reform Act of 2000 (GKV-GRG) proposed a general performance-based case fee payment system for general hospital services (§ 17b KHG), which was then legally regulated by the Hospital Remuneration Act of 2002 (KHEntG) (as part of the 2002 Case Fees Act). The corporatist bodies representing sickness funds and service providers at national and state level played a crucial role in shaping and regulating this new reimbursement system in the hospital sector (Böhm 2008: 46-57; Simon 2008a: 283-305).

At national level the cost weights for the diagnosis-related groups (DRGs) are determined at regular intervals by the Institut für das Entgeltsystem im Krankenhaus (InEK) set up by the corporatist actors (§ 17b Abs. 2 KHG and § 9 KHEntG). The case fees catalogue and other details are fixed annually by the corporatist partners in a legally binding document (the Case Fees Agreement).

The base rates which ultimately determine the "price" of a DRG are set at state level in accordance with the sectoral budget arrangements for the hospital sector. During the convergence phase for the hospital cost structures reflected in the DRG system (2005 to 2009) individual base rates for each hospital are still negotiated at the hospital level between the hospital operator and the involved public funding bodies (§ 11 Abs. 1 KHEntG).

In addition supplements and discounts of various kinds (§ 7 KHEntG Nr. 2–7) can be agreed between the hospital and a working group of public funding bodies under rules fixed at the national level by the corporatist actors (§§ 17a and 17b KHG).

Since the Health Care Structure Act of 1993 (GKV-GSG) the development of spending in the hospital sector has been capped by law at the national level by tying—in different technical guises—the annual increase in statutory health insurance spending in the hospital sector to the rise in revenue of the statutory sickness funds in the previous year (wage base linkage) (Simon 2008b). The slow increase in the wage base since 1995 has intensified the impact of sectoral budgeting by effectively lowering the annual rate of change of the budget of the statutory health insurance system (§ 71 SGB V), causing the annual hospital budget to remain practically static for the past five years (2004–2008) with annual average growth well under 1 percent (nominal values) (Simon 2008b: 16). If the annual growth rate of hospital spending as a whole since the mid-1990s has been structurally higher than the growth rate of hospital spending in the statutory health insurance system, this is due to earmarked funding from national government (for example to ensure adequate psychiatric capacity; see Table 2). The fluctuations in the annual growth rates of hospital spending in the statutory health insurance system result above all from balancing out the previous year's

revenue surplus or deficit in cases where the actual volume of hospital services provided diverged from the planning assumptions.

Table 2: Spending on hospitals (excluding public investment support)

	Total spending on hospitals (Germany)			**Statutory health insurance budget, annual rate of change (%)**		**Statutory health insurance spending on hospital treatment**		
	million Euros	*Change over previous year %*	*Spending as % of GDP*	*West*	*East*	*million Euros*	*Change over previous year %*	*Percentage of total hospital spending*
1992	42,634	-	2.59	-	-	34,948	-	81.97
1993	45,468	6.65	2.68	4.00	16.50	37,188	6.41	81.79
1994	49,103	7.99	2.76	2.40	8.90	40,355	8.52	82.18
1995	51,073	4.01	2.76	0.70	0.40	41,928	3.90	82.09
1996	51,509	0.85	2.75	0.86	1.11	42,569	1.53	82.64
1997	53,213	3.31	2.78	1.30	2.30	43,663	2.57	82.05
1998	54,938	3.24	2.80	1.00	0.80	44,984	3.03	81.88
1999	55,660	1.31	2.77	1.66	0.27	45,227	0.54	81.26
2000	56,426	1.38	2.74	1.43	1.43	46,008	1.73	81.54
2001	57,167	1.31	2.71	1.63	1.63	46,431	0.92	81.22
2002	58,593	2.49	2.73	1.84	1.87	47,692	2.72	81.40
2003	59,193	1.02	2.74	0.81	2.09	48,207	1.08	81.44
2004	60,567	2.32	2.74	0.02	0.71	49,237	2.14	81.29
2005	62,107	2.54	2.77	0.38	0.38	50,689	2.95	81.62

Source: Simon (2007a: 29)

Investment support by the states is tied to a hospital being included in the relevant state's hospital plan (§ 8 Abs. 1 Satz 1 KHG). The states support on application the building of new hospitals and the replacement of long-lived capital equipment (§ 9 Abs. 1 KHG). They also approve on application various structural grants, for example for converting hospitals into nursing homes (§ 9 Abs. 2 KHG), as well as supporting the replacement of short-lived capital goods through lump-sum allowances (§ 9 Abs. 3 KHG). Hospital operators have the option of supplementing the state's public investment support from their own means, although this requires the approval of the state-level bodies representing the sickness funds (§ 8 Abs. 1 KHG). The

situation of state investment support is characterized by a "public investment backlog" that is estimated to amount to up to €30 billion. Funding under the Hospital Financing Act (KHG) fell in real terms by 32.3 percent between 1994 and 2004 (Steiner/Mörsch 2005).

3.1.2. Regulation of Capacity and Services

The *regulation of hospital care* is subject—like financial allocation in the hospital sector—to a mixed system of more state-influenced regulation at the level of the federal states and more corporatist (i.e. state-delegated) regulation at the national level (see Matrix 2). By virtue of its pairing with investment support, regulation of the provision of capacity (market access) is practically fully controlled by the states. The procedure for hospital planning is set out in the respective state laws, which are implemented differently in different federal states and involve the associations of funding bodies and service providers in different ways in the preparation and modification of the state hospital plan (Schwintowski 2006b: 153-161; DKG 2008: 6-11).

State hospital planning is in a process of fundamental reorientation; in many states hospital locations are no longer centrally prescribed by the hospital plan but decentralized in planning conferences involving associations of service providers and funding bodies (for example in Hesse). Additionally, because of the formation of groups and alliances in the hospital sector, decisions about numbers of beds pass de facto to the private, municipal and non-profit hospital groups. This "hands-off" process is known as "framework planning" *(Rahmenplanung)* (Bruckenberger 2006: 86-91; DKG 2008).

In addition to collective framework planning, the state-level bodies representing the sickness funds can also enter into individual care contracts with hospitals outside the hospital plan and terminate these again, although termination requires the consent of the state health ministry (§§ 109 and 110 SGB V). For some time the sickness funds have been trying to acquire the power to make decisions about hospital closures by these means, so far without success. As a consequence the number of hospitals that have an individual care contract with the sickness funds is very small (less than 2 percent of all hospital services; Simon 2008a: 279). By the same token the sickness funds are also required to enter into a collective care agreement with all hospitals included in the plan (obligation to contract).

Matrix 2: Decision-making jurisdiction and decision-making power in the regulation of hospital care in the German hospital sector (market access/capacity and form/quality of services)

		Decision-making power	
		State	**Corporatist**
Decision-making jurisdiction	**National**	*Framework*	Form/quality of services
	State-level	Market access/capacity	*Implementation*

Regulation of the form and quality of services is codified in social law in volume V of the German Social Code (SGB V) as part of the catalogue of treatments provided by the statutory health insurance system. Hospital services are generally fully or partially inpatient services (§ 39 SGB V), but of limited duration and tied to referrals; they may also include pre-admission and/or post-discharge phases (§ 115a SGB V). Outpatient treatment in hospitals was previously practically unknown but is increasing (§ 115b SGB V). Hospitals can also participate in new forms of care, especially integrated care which enables sickness funds to organize and coordinate a group of health care providers from different care sectors through selective contracting (§ 140a–d SGB V). Further, hospitals can participate in structured treatment programs for the chronically ill (disease management programs, § 137f SGB V).

Since the Statutory Health Insurance Modernization Act of 2004 (GKV-ModG) hospitals have also been able to participate directly in GP and specialist care as operators of health centres. The provision of ambulatory treatment by hospital doctors (§ 116 SGB V) or whole departments of a hospital (§ 116a SGB V) is permitted where an underprovision of GPs and office-based specialists has been identified. Furthermore, certain approved hospitals are entitled to provide highly specialized services and treat rare diseases and conditions with unusual courses, "if and to the extent defined in the state hospital plan, on application by the hospital operator, and taking into account available capacity of GPs and office-based specialists" (§ 116b Abs. 2 Satz 1 SGB V). The Joint Federal Committee, as the central organ for the collective self-government of service providers and sickness funds at the national level, develops the catalogue of highly specialized services, rare diseases and conditions with unusual courses (cf. § 116b Abs. 4 SGB V).

The form and quality of services are regulated in different ways, with the national level of the corporatist self-governing bodies playing a special role (especially the German Hospital Federation, the collective bodies representing the sickness funds and the Association of Private Health Insurers). However, the importance of the Federal Ministry of Health in regulat-

ing form and quality of services has grown in recent years (Gorschlüter 2001: 13-24; Schwintowski 2006a: 124-132; Böhm 2008: 57-62).

The concrete service contracts at the level of the individual hospital are negotiated between the hospital itself and a working group of public funding bodies (including the statutory sickness funds). A hospital included in the hospital plan has the right to a care contract with the sickness funds (Böhm 2008: 53-57). Only in the case of integrated care do direct individual contracts between (groups of) funders and the hospital operators play the central role. These contracts can deviate from the requirements of the Hospital Financing Act and the Hospital Remuneration Act concerning reimbursement schemes and quality measures (cf. § 140b Abs. 4 SGB V); furthermore, hospital doctors or departments involved in such contracts can expand their scope of care towards ambulatory care services if the hospital has concluded an integrated care agreement with an ambulatory specialist's practice (§ 140b Abs. 4 Satz 3).

The introduction of a reimbursement system based on diagnosis-related groups through the Health Care Reform Act of 2000 and subsequently the Case Fees Act of 2002 (FPG) placed a legal requirement on service providers to guarantee a high quality of service. Since then doctors, hospitals and rehabilitation facilities have been obliged to set up internal quality management systems and have to participate in external quality assurance measures (Böhm 2008). Regulation of the quality of treatment has successively passed to the self-governing structures of service providers' and funders' associations and is now subject to the directives of the Federal Joint Committee, the central corporatist body of the sickness funds, doctors and hospitals at national level. The Federal Joint Committee has two subcommittees responsible for ensuring and developing quality control in the hospital sector. The subcommittee on external hospital quality control is responsible for regulating both internal systems of quality management in single hospitals and joint quality improvement schemes between hospitals (cf. § 135a Abs. 2 SGB V). The second subcommittee is responsible for "other hospital quality control" duties concerning, for example, the regulation of reimbursement reductions for hospitals that do not apply quality measures. Further, under these regulations hospitals have to publish a structured quality report every two years, with any objections put to a state-level arbitration procedure by representatives of service providers and public funding bodies (cf. § 137 Abs. 1 Nr. 5 u. 6 SGB V). The Joint Federal Committee also took over "the agreements on quality control concluded before 2004 by the self-governing partners" (Brenske et al. 2005: 169). Since the introduction of the DRG system, hospitals have been required to achieve a specified minimum number of cases for particular diagnoses as a precondition for being permitted to continue offering those particular treatments. The idea behind this is that as the number of cases grows, the treatment or intervention becomes routine and the frequency of errors is reduced. However a state may also decide to allow deviation from the national minimum volume rule in order to safeguard local provision of hospital services.

3.2. Development of Services and Capacity

3.2.1. Privatization and Concentration Processes

The responsibility to ensure adequate hospital care through investment support and hospital planning is assigned by the Hospital Financing Act—as already outlined—to the states. Paradoxically most states neither own nor run any significant number of hospitals, nor have they ever done—with the important exception of the maximum care teaching hospitals attached to various universities where most medical research is also conducted. In certain federal states state-run psychiatric hospitals also play a role, although these—like other hospitals—have in the recent past come under heavy privatization pressure (Ver.di 2002ff).

The power to decide about hospital privatizations lies with their operators, primarily local authorities and non-profit organizations, who have, however, only a weak influence on hospital policy. The fundamental neoliberal slant of fiscal and economic policy and the recurring financial crises of municipal budgets have produced waves of privatizations. If we examine the ownership structure of hospitals from a historical perspective we find that most are owned either by local authorities or by religious and non-religious non-profit organizations. But since the 1990s both these groups have come under pronounced privatization pressure. In the late 1980s and early 1990s numerous municipal and non-profit hospitals were converted into private legal forms in a trend that continued into the next decade too (Dahme et al. 2005: 93-103; Zech 2007: 26-30; Jakobi 2007: 92-99).

Not only has the number of publicly owned hospitals fallen from 817 in 2002 to 717 in 2006 (Statistisches Bundesamt 2008: Tab. 1.4.); the number in public ownership with private legal status increased over the same period from 231 to 367. The number of hospitals without independent legal status has fallen especially strongly (2002: 465 of 586 publicly owned hospitals; 2006: 191 of 297). This formal privatization was followed—from the late 1990s onwards and especially after the German economy entered a phase of stagnation during the era of red-green coalition government (Social Democrats and Greens; 2001–05)—by a new wave of material privatizations of municipal and non-profit hospitals. This significantly increased the number of private-sector hospitals in Germany (see Table 3).

From 1992 to 2006 the number of private-sector hospitals in Germany increased by 58 percent from 369 to 584. In terms of the number of beds, however, the record of the private sector hospitals is not quite as impressive—even if recent years have seen the first privatization of a public maximum care hospital (LBK Hamburg) and in 2005 even a university hospital in Hesse (Marburg-Giessen, formed through the fusion of two previously separate teaching hospitals). The total number of beds has fallen by about 6.5 percent from a little over 547,000 (2002) to just under 511,000 (2006), while the private-sector proportion of total hospital beds rose during the same period from 8.9 percent (48,615 beds) to 13.6 percent (69,574 beds), representing a 43.1 percent increase in the number of private-sector beds (Statistisches Bundesamt 2008: Tab. 1.4.). At the same time the introduction

of the DRG reimbursement system under conditions of budgeting led to a steady decline in the average length of stay in hospital (with an opposing rise in the number of cases treated) (see Table 3).

The (formal and material) privatization processes are also associated with an organizational restructuring of the German hospital sector that can be described as a "conglomeration trend". Under the increasing economic pressure exerted by continuing sectoral budgeting on the one hand and the costs associated with implementing the DRG system (specialization and cost-cutting) on the other, hospital operators have been transferring individual hospitals into hospital groups, hoping to maximize rationalization gains and improve their market position in Germany's increasingly specialized hospital sector. Alliance-forming processes involve all types of operator and have fundamentally altered the contours of the German hospital system. It is to be expected that the horizontal integration processes brought about by alliance-building and mergers will be accompanied by vertical integration processes joining up different fields of healthcare. Vertical integration corresponds to the core idea of integrated care, namely, the realization of a trans-sectoral care chain (Dahme et al. 2005; Jakobi 2007; Wörz 2008).

A new, innovative form of privatization of core hospital functions, finally, is project-related cooperation between public hospitals and private companies (functional privatization), for example in the provision of large-scale diagnostic and therapeutic equipment through public-private partnerships (Gerstlberger/Schneider 2008: 59-63) and in the outsourcing of all kinds of management tasks to private agencies (controlling, cost accounting, financial management, marketing). However there are not yet any systematic empirical studies of these new forms of privatization that could be used to assess improvements or deteriorations in hospital procedures. Other hospital functions that can be classified more as ancillary services (catering, portering, building services, cleaning services) have been subject for much longer to organizational outsourcing and privatization processes. Like the privatization processes of core functions, we can distinguish here between formal, material and functional privatization processes (Leonhard/Völpel-Haus 2002; Löser-Priester 2003; Zech 2007).

Table 3: Selected data on German hospitals, 1992–2006

	Hospitals by type of operator (index and proportion)							Hospital sector	
	All	*Public*		*Private non-profit*		*Private for-profit*		*Cases treated*	*Length of stay*
	1992=100	*1992=100*	*%*	*1992=100*	*%*	*1992=100*	*%*	*1992=100*	*Days*
1992	100.0	100.0	44.6	100.0	39.9	100.0	15.5	100.0	13.2
1994	98.1	93.0	42.2	99.9	40.6	108.7	17.2	103.5	11.9
1996	95.3	87.9	41.1	97.8	41.0	110.3	18.0	108.0	10.8
1998	95.0	83.8	39.3	96.9	40.7	122.8	20.0	112.5	10.1
2000	94.2	79.5	37.6	96.0	40.7	131.7	21.7	115.3	9.7
2002	93.3	77.0	36.8	92.3	39.5	142.8	23.7	116.4	9.2
2004	91.0	73.5	36.0	87.5	38.4	150.4	25.6	112.2	8.7
2006	88.4	67.5	34.1	84.5	38.2	158.3	27.8	112.4	8.5

Source: Statistisches Bundesamt (2008: Tab. 1.1. and Tab. 1.4.); own calculations

3.2.2. New Forms of Treatment and Care

Two new forms of care in the hospital sector have joined the traditional and still common collective contract arrangements: integrated care based on individual contracts with the sickness funds (§140a–d SGB V), and the possibility of running a health centre, which allows hospitals to become directly involved in GP and specialist care. The possibility of connecting the two new forms—health centres and integrated care—through individual contracts opens up potential to improve the integration of the different spheres of care, which is the core policy goal of managed care concepts.

Empirical analyses of the reality of care show two things: Firstly, the number of integrated care contracts has risen steadily since their introduction in 2000 and especially since the first round of start-up funding following the enactment of the Statutory Health Insurance Modernization Act of 2004 (GKV-ModG). By 31 March 2007 there were 3,498 contracts between sickness funds and service providers with a volume of €611 million (approx. 0.4 % of spending by the statutory health insurance system in 2007), whereby about half the contracts had just a single sickness fund as contracting party on the funding side (2007: 45.9 percent). Hospitals were involved in 57.2 percent of all integrated care contracts, either alone or with other service providers (doctors, rehabilitation clinics) (BQS 2007).

Secondly, in the second quarter of 2008 hospitals were involved in 402 health centres (36.9 percent), whereby the proportion of health centres tied to hospitals has risen continuously since the introduction of these new service providers (KBV 2008a). Major private and public hospital operators in conurbations have gone into the health centre sector in a relatively big way and have announced further expansions (Deutscher Bundestag 2007: 8; Grether 2008a). According to a recent representative survey by the Bundesverband der Medizinischen Versorgungszentren e.V. (BVMVZ) only 28 percent of health centres in Germany have contracts for integrated care

(which do not necessarily involve hospitals). Therefore, the extent to which hospitals have allied themselves with health centres through contracts for integrated care remains unknown. Furthermore, sickness funds do not have any great interest in health centres, because the survey found that 88 percent of health centres had no special contact with the sickness funds (Müller/Köppl 2008: A2501).

Competition effects of the new forms of care

Ultimately, behind the new structures of integrated care and health centres we find different constellations of competition. *Firstly*, integrated care has increased the proportion of selective contracts, and with it competition in the treatment market. *Secondly*, from the perspective of hospitals and hospital groups, health centres can serve as (potential) focal points to attract admissions under conditions of budget-driven consolidation of the hospital market. *Thirdly*, the growth of health centres in GP and specialist care does not actually represent competition where these (often smaller) health centres are in thinly populated rural areas. In this case health centres function more as new instruments for overcoming shortages in ambulatory care. *Fourthly*, larger health centres made up exclusively of formerly office-based specialists compete in the field of GP and specialist care just as much or just as little as office-based doctors organized in individual, shared or collective practices did before the introduction of health centres. Taken as a whole, though, both the expansion of selectively contracted integrated care schemes and the combination of integrated care contracts on the one hand with the organizational integration of office-based doctors within health centres on the other has increased the plurality of providers and the intensity of competition in the treatment market. This is true even though sectoral budgeting policies in the hospital sector continue to foster the establishment of oligopolies or even (local) monopolies. Integrated care and the establishment of health centres for GP and specialist care have certainly already shaken up Germany's healthcare and hospital systems. But we are still waiting for systematic studies on the competition effects of the new networks on hospital care.

Diverging opinions on health centres

Different healthcare actors have very different evaluations of the health centres. Sickness funds are skeptical or even indifferent because the regional associations of statutory health insurance physicians continue to have a major say in approving health centres. However, there are regional and fund-specific differences (Müller/Köppl 2008: A2501-A2502). The national Association of Statutory Health Insurance Physicians fears above all that the involvement of private capital could lead to a "commercialization of the medical profession" (Flintrop/Korzilius 2008; KBV 2008b: 7). The relationship between the associations of statutory health insurance physicians and

health centres is—as the BMVMZ-survey demonstrates—accordingly strained (Müller/Köppl 2008: A2501-2502).

The German government's opinion of the health centres on the other hand is unclear, characterized as it is by ignorance (all the official data comes from the national Association of Statutory Health Insurance Physicians, whose information is publicly accessible) and indifference towards possible risks to proper care. In its response to a written question by the Left Party group in the Bundestag the government states that it sees "no threat to the provision of care" in increasing involvement of private hospital chains in the founding of health centres (Deutscher Bundestag 2007: 9). Nor does it hold fears about profit-motivated hospital admissions to be relevant as long as all involved adhere to the "proper relationship between ambulatory and hospital care" (Deutscher Bundestag 2007: 9). But the government apparently has no facts on which to base these opinions, because in its response to the written question it admits that it possesses no evaluations of the efficiency of treatment in health centres in comparison to office-based doctors nor is it informed about the flow of funds to the health centres from the statutory health insurance system (Deutscher Bundestag 2007: 6). This contrasts both with prescriptive concepts of admissions marketing as an important remedy for securing the economic viability of the hospitals and with the empirical turn towards precisely such admissions management practices identified in the hospital management literature (Ament-Rambow 2008: 21). Since the written question, further growth in health centres run by private and public hospital operators in conurbations and headline-grabbing "admissions scandals" where hospitals (it was claimed) paid "bounties" to referring specialists would appear to call into question the government's optimistic perspective (Grether 2008b).

4 Commercialization of German Hospital Care?

4.1. Changing Governance of the German Hospital Sector: On the Relationship between Competition, Corporatism and the State

The (social) governance of the German hospital sector finds itself in a process of transformation. Although the governance debate assumes opposition between the modes of competition, corporatism and state, the development of hospital policy and the societal management of the hospital sector shows—certainly since the introduction of DRGs—a *simultaneous* increase in the importance of all three modes of governance—in accordance with the analytical framework of the health care state.

Firstly, competitive conditions in the hospital sector have expanded, with competition concentrated above all in the treatment market—between different hospitals and between hospitals and alternative service providers (on the competition concept in the health system see Cassel 2002; Mosebach 2006a). However, reform concepts focusing on a purchaser/provider model controlled by the sickness funds have been slow to take hold in the hospital sector because the funds are still under an obligation to contract with all

hospitals included in the state's hospital plan. Competing "integrated healthcare companies" could potentially come into being through integrated care contracts and the establishment of health centres (Bruckenberger et al. 2006a), but strict budgeting in the hospital sector means that massive competition between hospitals and integrated healthcare companies is not to be expected, especially in rural areas. However, particularly in densely populated areas with a greater range of treatments and services the new possibility for hospitals to provide outpatient care and the establishment of health centres operated by hospitals has created the potential for trans-sectoral competition. Instead of the purchaser/provider model supported and pursued by the sickness funds (demand-led competition between service providers for contracts with (competing) sickness funds) a more supply-driven mode of competition between hospitals and integrated healthcare companies appears to be becoming established in the conurbations. But this raises yet unresolved issues of competition law: the German Federal Cartel Office believes this form of concentration of care structures in the hospital sector is subject to German competition law and has consequentially stopped a number of hospital mergers because of the danger of abuse of market power (Bundeskartellamt 2004; Monopolkommission 2008). Critics of this application of competition law to the public hospital sector argue that the concentration processes ensuing from the introduction of the DRG reimbursement system were politically intentional—to cut back excess capacity in the hospital sector—and that German competition law should not be applicable to the hospital sector (Klaue 2006b: 175-182; Bruckenberger et al. 2006b: 203).

The potential significance of another expression of competition in the treatment market has also increased: extra services paid for privately by or for (higher-earning and/or privately insured) domestic and foreign hospital patients, especially in a situation where publicly funded hospital services remain strictly budgeted and hospital operators are looking to open up new sources of additional income. By contrast competition between hospitals for patients with statutory insurance (the treatment market) remains relatively weak, because free choice of hospital remains relatively restricted, given that a referral by an office-based doctor is required (Bruckenberger et al. 2006a). However, at the hospital level the importance attached to "admissions management" (something of a euphemism for the acquisition of additional high-revenue patients) is growing—not just in propagandistic terms but in very real terms too. But information on this is largely anecdotal, since there are as yet no empirical studies on the importance of economically motivated admissions management.[6]

Secondly, the importance of the self-governing corporatist bodies in regulating the German hospital sector has grown steadily, as the above description of the regulatory system has shown. Not only do the corporatist bodies remain responsible for the continuing development of the DRG reimbursement system, but in most states the negotiation of state-level hospital plans

[6] In early September 2009, during the review phase, the issue of illegal bonuses for referring patients surfaced as a major news issue, in advance of the Bundestag elections on 27 September 2009.

is (despite the introduction of state-level framework planning) still characterized by negotiation between representatives of public funding bodies and service providers to fix locations and capacity. Finally, underlining the historic institutional significance of corporatism in the German health system, the Federal Joint Committee is responsible for quality control at the national level. The strategy observed here is not only "corporatism", but a centralization and professionalization of the corporatist structures. This applies above all to the strengthening of the Federal Joint Committee's role and powers in regulating treatment in the hospital sector. This centralization and professionalization of the self-governing corporatist structures is an outcome of the interaction of political strategies of national government (especially the responsible ministerial bureaucracy) seeking to strengthen the role of state actors in decisions in the health system with the corporatist bodies' rejection of state intervention in their realm of management (which they often criticize as "bureaucratic interventionism" and "the road to socialized medicine").

As that would suggest, it is the case that, *thirdly*, alongside the increasing role of competition and the growing importance of corporatist arrangements, the possibilities for state intervention in the hospital sector have also expanded noticeably. The growing use of the threat of execution by decree where the corporatist partners are unable (or unwilling) to reach agreement—for example the introduction of the first case fees catalogue by decree during the launch phase of the DRG system—shows that state actors at the national level, despite the intricacies of federal politics and the corporatist tradition in the German system, are able to wield great regulatory power. Here the state, especially the ministerial bureaucracy at the Federal Ministry of Health, has attempted to push through very determined competition concepts (Simon 2000). So state actors at the national level have been central agents in the progressive transformation of the health system and in particular of the hospital sector in the direction of competition (Böhm 2008). The history of political control in the hospital sector shows that increasing competition and indeed even corporatization processes have taken place not only "in the shadow of the state" but in fact require the state's unique institutional capacity to make and enforce decisions (Döhler/Manow 1997; Scharpf 2000; Benz 2001).

An antagonistic understanding of the three central forms of governance in the hospital sector fails to recognize the changes in the specific configuration of societal management there. While increasingly competitive or competitive-corporatist control at the national level stands in a certain contradiction to state-level hospital planning, where the state still plays an important role, the increasing role of hands-off framework planning in defining capacity seems to suggest that this contradiction has not gone unnoticed (Rüschmann et al. 2000; Bruckenberger 2006). Here too, regardless of any antagonistic perspective, a (partial) withdrawal of the state or a change in its role in state-level hospital planning can be identified—among other things in order to make hospital planning compatible with increasingly competitive conditions in the treatment market—but the state still retains broad potential powers to intervene to ensure adequate hospital capacity. Whether they are used remains a question for future research, for so far there have been no

empirical studies dedicated to this tension between competitive resource allocation and state-level hospital planning.

4.2. Commercialization of Hospital Care: Institutional and Organizational Characteristics

The analysis of the regulatory and care structures using the categories described at the beginning (see Table 1) allows us to assess the progress of commercialization processes in the German hospital sector (see Table 4). With respect to the economization of hospital sector management through NPM, the effect in Germany has been moderate. Competitive processes have grown, as has the focus on results and performance; the latter above all through the introduction of the performance-based DRG reimbursement system. The implementation of managed care concepts has thus far concentrated above all on instruments, whereas the expansion of new forms of treatment and care based on individual contracts is still limited (managed care organizations). While formal and material privatizations have increased in the German hospital sector, detailed information about functional privatization processes is currently not available.

Table 4: Institutional/organizational indicators of commercialized hospital care in Germany (high/medium/low)

		Germany
New Public Management	Competition and quasi-market	Medium
	Decentralization and global budget	Medium
	Focus on results and performance	Medium
	Focus on quality and customer satisfaction	Medium
Managed care	New care forms (selective contracts)	Medium
	Payment system reform	High
	Quality and cost management	High
	Evaluation procedures	Low
Privatization forms	Formal privatization	High
	Material privatization	Medium
	Functional privatization	n.a.
	Privatization of treatment costs	Medium

Formal privatization and decentralization processes have been strengthening the financial and operational autonomy of the hospitals since the early 1990s, in the process enabling competition-orientated behavior. The potential for competition in the German hospital sector is relatively high because of the historical legacy of plurality of healthcare providers (munici-

pal, non-profit and private-sector hospital operators). The actual degree of competition differs according to sub-market:

(1) The *treatment market* (where hospitals compete for patients) is still clearly characterized by weak competition, because the requirement for a referral still restricts the freedom of choice of patients with statutory insurance. But with respect to privately insured and self-pay patients it would seem that competition is increasing, not least as a function of shrinking revenues from the statutory health insurance system. Also the expanding practice of admissions management and the still limited but growing field of hospital-linked health centres suggest that in the hospital market, too, competition for customers (patients) will be of increasing importance.

(2) Competition in the *service market* (where hospitals compete for contracts with sickness funds) has been strongly pushed by health policy and through the introduction of individual contracts between hospitals and sickness funds for integrated care. It also corresponds best to the NPM ideas of efficiency-increasing competition; so far, however, change has been limited here. As one component of the state's indirect resource management, the sickness funds would be predestined for anchoring NPM ideas, but it has not so far been possible to strategically consolidate the purchaser/provider model in their dealings with the hospitals (with the exception of integrated care). The expansion of selective contracting in the hospital sector (with and without global budgets) beyond the limited integrated care schemes has failed repeatedly, most recently in the latest hospital reform (Mosebach 2009).

In contrast to the implementation of competition processes, the *focus on results and performance* promised in the NPM concept has clearly had a greater impact in the German hospital sector. A performance-based DRG reimbursement system designed to encourage hospitals to enhance efficiency has been established, leading to specialization and a reorganization of the hospital sector and resource allocation. But it remains unclear to what extent this has improved hospital care, for although required by law, evaluation research into the effects of the DRG systems has not yet been conducted (Simon 2007b: 42).

The *focus on quality and customer satisfaction* has also clearly grown in the hospital sector, at least as far as the institutionalization of external and internal quality control systems by the Federal Joint Committee is concerned. But the connection between quality management and customer orientation in the sense of transparency of treatment for patients remains unproven despite concerted efforts. The biennial quality reports are, according to the latest research, neither generally comprehensible nor accessible to a broader segment of patients (Geraedts 2006; Friedemann et al. 2009). So a focus on quality and customer satisfaction has only been established to a limited extent in the German hospital sector. However, the increasing orientation on privately insured patients and self-paying customers can certainly be understood as customer orientation (in the economic sense) (on the conceptual differences between customer orientation and patient orientation see

Mosebach 2006b: 11-19). Customer orientation is therefore closely linked to an increasing privatization of treatment costs in the hospital sector and a differentiation of hospital services and hotel services in pursuit of affluent, high-income patients (on the differentiation strategy see Ament-Rambow 2008: 22-23).

At the *business organization level of hospital care* (in the sense of managed care concepts) payment reform has made a clear mark in cost management and the organization of treatment. Business management of costs and treatments is of increasing importance to both hospitals and funds (Fleßa/Weber 2006; Moos/Brüggemann 2006). Formal quality management requirements (in the sense of establishing internal and external quality control systems as described above) are also fairly strict at the operational level in hospitals, but there are not yet any independent evaluations of the quality of integrated care forms and managed care concepts in Germany. This deficit results especially from the fact that integrated care contracts are not accompanied by evaluation research with the objective of publishing quality indicators. The red/green coalition (of Social Democrats and Greens) plainly assumed that with legal minimum standards managed care forms would automatically meet high standards of quality (Deutscher Bundestag 2005: 8). This official government view has not recognizably changed, because no additional requirements have been introduced with respect to external quality evaluation of integrated care contracts.

The "permanent austerity" (Paul Pierson) of *neoliberal financial and economic policy* expresses itself in hospital policy on the one hand through increased cost-containment in the publicly financed hospital sector achieved through budgeting and on the other in the chronic recurring crises of municipal and non-profit budgets.[7] As well as fostering formal processes of privatization of public hospitals—in order to make hospital operators financially and operationally more autonomous and better able to cope with the cost pressure—material privatizations of (public) hospitals and functional privatization processes have also increased considerably, especially in a context of falling public investment spending on hospitals in the hospital plan. Individual hospitals and hospital operators have increasingly responded to the constant background of "permanent austerity" and sectoral budgeting of public hospital spending by opening up new sources of income. Of special importance for healthcare seems to be the expanding role of privatized treatment costs, from which many hospitals are attempting to profit by setting up separate private treatment facilities for foreign and domestic private patients (self-payers or patients with private insurance or private supplementary insurance) (Braun 2004; Ament-Rambow 2008; Brenner 2009).

[7] Although some economists argue that the German government has opted for a more Keynesian fiscal and economic policy during the recent economic recession, this anti-recession programme is limited in scope and duration and is neither sufficient to support long-term growth driven by domestic demand nor capable of altering the export-led foundations of the German economy. Consequently, municipal fiscal crises and the post-crisis balancing of state budget deficits through expenditure cuts are expected to prolong the neoliberal conditions.

5 Conclusions: Profit or Need?

The analysis presented here plausibly suggests that financial incentives are playing a growing role in the German hospital sector. Monetary incentives have clearly been strengthened by the establishment of the DRG system, and have led to operational reorganization of hospital care. The importance of private-sector hospital operators has also expanded considerably and the strategy of tapping additional revenue by attracting privately insured and self-pay patients has become more important for all hospital operators (privatization of treatment costs). Further, cost-optimizing care structures has become the central goal of hospital care management reorganizations. Finally, there are empirical indications that the increased prevalence of economic targets for medical and nursing activity in the hospital sector and the higher intensity of work brought about by this is associated with possible negative consequences for the care of hospital patients (Braun/Müller/Timm 2004; Buhr/Klinke 2006; Simon 2008b).

Together with the dissemination of competition models in the German hospital sector (treatment market, service market, group-building), these processes of NPM-driven economization and privatization create a potential conflict with the objective of equal access to high-quality hospital care adequate to meet needs, thereby potentially degrading the functioning of the collectively funded system of medically necessary hospital care for all social classes. However, it has not been possible here to give a definitive (empirical) answer to the question whether resource allocation increasingly conducted according to competition-driven considerations of cost and profit stands in contradiction to adequate need-based provision of hospital services. The goal of this study was to assess whether a process of commercialization is under way in German hospital care. The comparison of an ideal model of commercialized health/hospital care with the regulatory and service reality produced mixed results. While there are strong signs that on a regulatory level the German hospital sector has become successively commercialized, there is insufficient data and research to prove the suspected negative impact on quality and equality of care provision (incidentally, this also means that the opposite effect—of improving service quality through market-led reforms—is also undetectable for the time being). Therefore, it remains for further political science *and* health science research to investigate more closely the contradictory relationship between competition-driven resource allocation and state planning of services in the hospital sector under neoliberal conditions. For this the need-based ideal provision of hospital services would have to be compared at the level of indications and conditions with the care realities determined by the cost and profit calculations of funders and providers of hospital services. Only then would it be possible to determine with certainty whether hospital care in Germany has become commercialized.

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