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Country reports on liberalisation and privatisation processes and forms of regulation

Liberalisation, privatisation and regulation in the German healthcare sector/hospitals

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INTRODUCTION

Since the early1990s the German hospital sector has been in an ongoing process of restructuring. The most obvious signs for this are a continuing decline in the number of hospitals and hospital beds and a growing number of hospital privatisations. Concerning the latter there have been two waves of privatisations so far. The first wave started in the early 1990s and following German unification was very much concentrated on east Germany. A second wave started after the year 2000 and has now covered the whole of Germany. The current wave hit its temporary peak with the first privatisation of a university hospital: involving the universities of Marburg and Gießen at the beginning of 2006.

In contrast to the classical network sectors such a post, telecommunication, energy etc. there has been no explicit liberalisation policy regarding the hospital sector. However, the restructuring processes of hospitals in Germany have been highly politically influenced by a fundamental change in the system of hospital financing which generally promotes the economisation and commercialisation of hospital services.

The privatisation of hospitals in Germany is mainly driven by the large budget deficits of public authorities at regional and municipal level. For the latter privatisation has the advantage that they do not have to compensate any longer for the budget deficits of public hospitals and might even gain some money through the sale – with which they can then tackle their own financial problems.

Although not much research has been done so far, the existing evidence suggests that the privatisation of hospitals has had a major impact on working conditions, industrials relations and the quality of hospital services. There are broad concerns that privatisation will lead sooner or later to a deterioration of both working conditions and service quality. Therefore, most privatisation initiatives are confronted with broad local anti-privatisation alliances composed of various stakeholder groups such as trade unions, political parties and other civil society organisations which have tried – in a few cases even successfully – to prevent privatisation. The future of the German hospital sector will therefore continue to be an area of political struggles.

Table 1: Restructuring and privatisation in the German hospital sector – an overview

1984	First privatisation of a public hospital
1993	*Change in the system of hospital financing from the principle of full cost coverage to a system of capped hospital budgets*
since 1993	First wave of hospital privatisations (in particular in east Germany)
1996	*Change of the hospital reimbursement system – based on per-diem fees – to a mixed system based on per-diem and case fees*
since 2000	Second wave of hospital privatisations
2003	*Introduction of a hospital reimbursement system based on diagnosis related groups (DRG)*
2004	Privatisation of the seven LBK clinics in Hamburg
2006	First privatisation of a university hospital (University clinics in Marburg and Gießen)
2006	First acquisition of a German hospital provider by a foreign hospital company (acquisition of the *Deutsche Klinik GmbH* by the Swedish *Capio*)

Source: Own composition.

1. MARKET STRUCTURE

1.1. The German hospital sector – an overview

According the German hospitals statistic there were 2,166 hospitals with more than 530,000 beds in the year 2004 (for the following see Table 2).[1] Since the beginning of the 1990s the hospital capacities in Germany have shown a continuous decline. The total numbers of hospitals fell by about 10% while the number of beds decreased by about 20%. In 2004 there were 6.4 beds per 1,000 inhabitants compared with 8.3 beds in 1991.

There are somewhat more than 1 million employees working in the German hospital sector. This is about one quarter of all employees in the German health sector which in total covers about 4.2 million employees (Rolland 2005: 842; Statistisches Bundesamt 2006b: 41). In comparison to the fall in the number of hospitals, the decline of employment has been relatively moderate. Since the early 1990s the total number of employees has dropped by about 3.6%. Calculated on the basis of full-time equivalents, however, the decline has been more than twice that high, reaching 8%. The latter

[1] The German Federal Statistical Office provides an annual hospital statistic which includes basic data on all hospitals in Germany (see for the most recent issue: Statistisches Bundesamt 2005). There is a legal obligation for hospitals to give certain information on a regular basis, since the hospital statistic is one major source for the national hospital planning. For more information on the structure and the methodology of the hospital statistic see: Rosenow and Steinberg (2002).

indicates an increasing use of part-time and marginal part-time employment in German hospitals.

Table 2: The German hospital sector – key figures 1991 and 2004

	1991	2004	Change 1991/2004
Number of hospitals	2,411	2,166	- 10.2%
Number of beds	665,565	531,333	- 20.2%
Beds per 1,000 inhabitants	8.3	6.4	- 22.9%
Number of employees			
total	1,119,791	1,079,831	- 3.6%
full-time equivalents	875,816	805,988	- 8.0%
Hospital cases	14,577,000	16,801,000	+ 15.3%
Average length of stay	14.0 days	8.7 days	- 37.9%
Average occupancy rate	84.1%	75.7%	- 10.0%
Occupancy and billing days	204,204,000	146,746,000	- 28.2%

Source: Statistisches Bundesamt (2005), own calculations.

Although the number of hospital cases has increased continuously, the average occupancy rate dropped from 84.1% in 1991 to 75.7% in 2004. The main reason for that was a strong decline in the average length of stay from 14 days in 1991 to 8.7 days in 2004. Consequently, German hospitals were faced by a sharp decline in the occupancy and billing days.

1.2. The process of liberalisation and privatisation

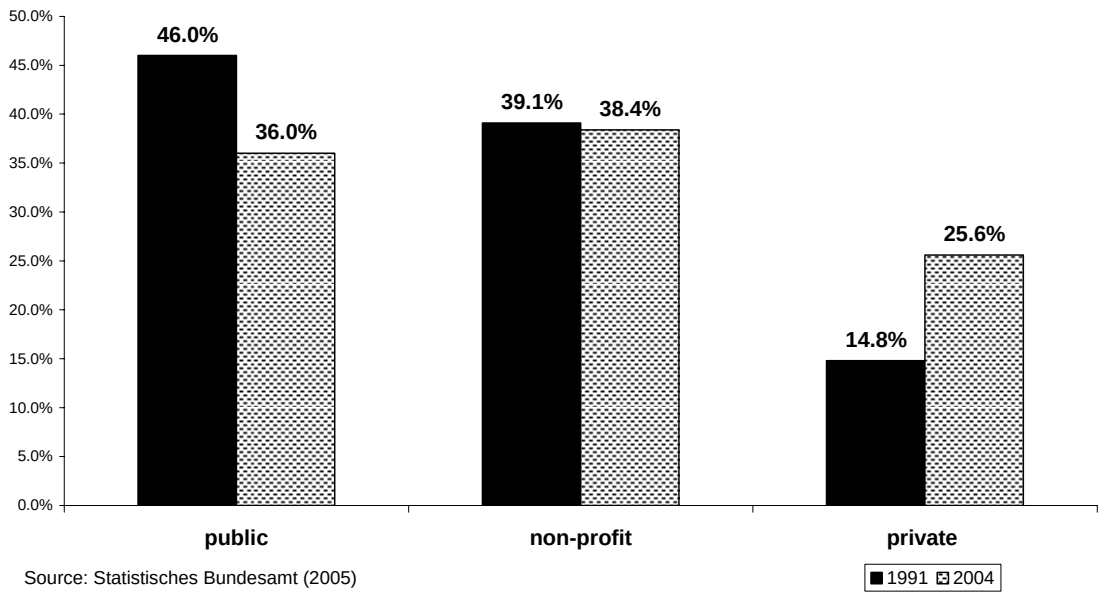
The German hospital sector has always been composed of a certain variety of companies with different ownerships. Beside the public hospitals, which are owned by municipalities, regional districts or the German federal states, there has been a long tradition of non-profit hospitals run by Christian churches and various welfare organisations. For quite a long time there have also been some private hospitals which have mainly covered rather small and specialised clinics. As laid down in the German Social Security Code (*Sozialgesetzbuch*, SGB) only those hospitals receive funding from the state and the health insurance funds which are officially registered within the national hospital plans (Code No. 5, Article 108). According to the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*, KHG) of 1972, however, the state has to respect the variety of ownership and has to make sure that all different groups of hospitals – be they public, non-profit or private – receive sufficient funding (Article 1, Para 2).

Since there has never been a public monopoly in the German hospital market there have also been no attempts for an explicit liberalisation policy. However, changes in the social, political and economic framework conditions led to an overall economisation

and commercialisation of the health sector which has promoted an ongoing restructuring process of German hospitals. One of the most obvious sign for this has been the growing number of privatisations. Although the first privatisation of a public hospital took place as early as 1984 (Meyer-Timpe 2006), there was not much change in the composition of hospital ownership until the early 1990s. After German unification in 1990 a first wave of privatisations of hospitals took place – mainly in eastern Germany – as part of the transformation process from a former state-socialist towards a capitalist market economy. Since the beginning of the new millennium a second wave of hospital privatisations has started which now covers all regions of Germany.

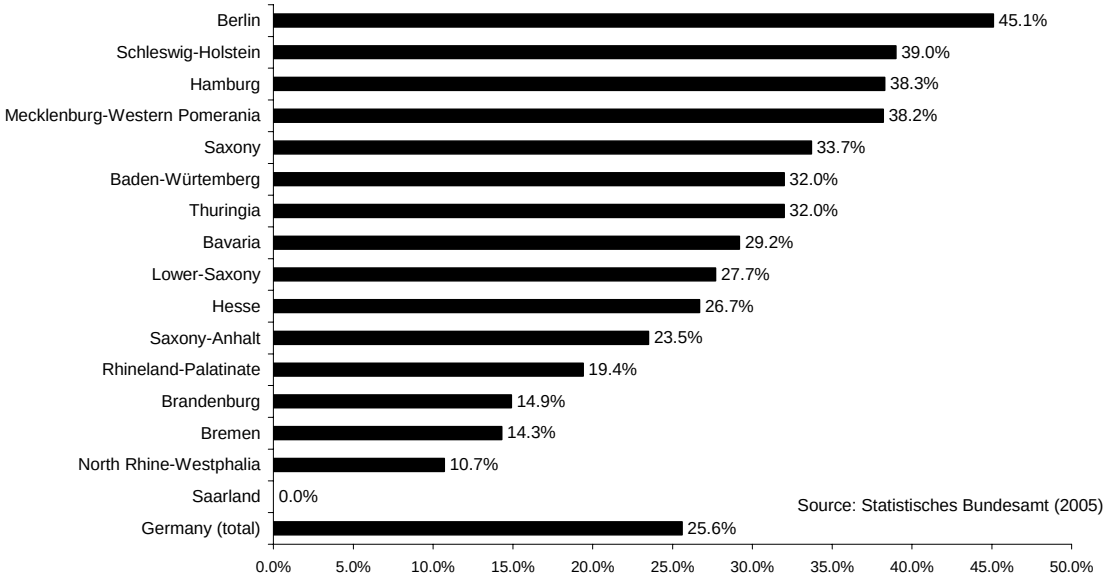
Between 1991 and 2004 the proportion of private hospitals increased from 14.8% to 25.4% (*Figure 1*). At the same time the share of public hospitals decreased from 46% to 36% while the proportion of non-profit hospitals remained relatively stable. There are also significant regional differences in the share of private hospitals varying from 45% in Berlin to still 0% in Saarland (*Figure 2*).

Figure 1: Ownership of German hospitals 1991 and 2004



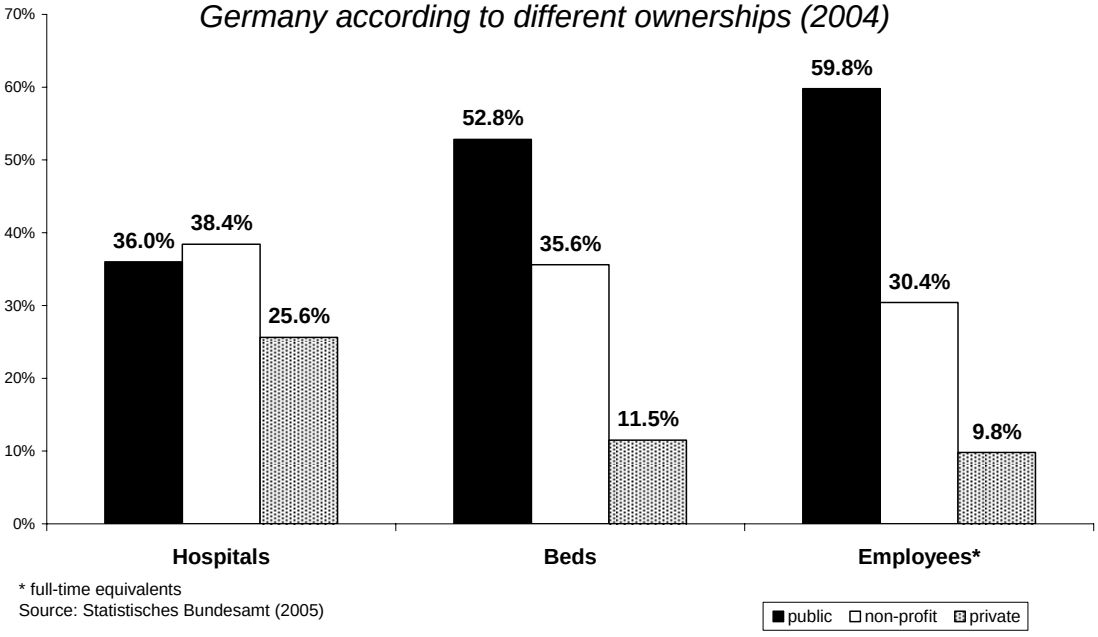
Source: Statistisches Bundesamt (2005)

Figure 2: Proportion of private German hospitals in German federal states (2004)



Although public ownership lost its majority regarding the total number of hospitals it still has a dominant position when the numbers of hospital beds are considered. In 2004 a majority of 52.8% of all beds were still provided by public hospitals in comparison to only 11.5% provided by private hospitals (*Figure 3*). The dominant position of public hospitals becomes even more pronounced regarding the number of employees: Nearly 60% of all hospital workers were hired in public hospitals, while private hospitals still had less than 10% of all employees.

Figure 3: Proportion of hospitals, beds and employees in Germany according to different ownerships (2004)*



So far, the privatisation of German hospital has been a domain of smaller clinics (Strehl 2003). In 2004 more than 82% of all private hospitals had less than 200 beds and more than 63% even provided less than 100 beds. Only about 4% of all private hospitals were larger clinics with more than 500 beds. In contrast to that a majority of 62% of public hospitals were of medium or large size. Nearly one quarter (23%) provided more than 500 beds (Table 3).

Table 3: Ownership and size of German hospitals (2004)*

Size of hospital	public	non-profit	private
< 99 beds	12.4%	15.6%	63.1%
100-199 beds	25.2%	29.4%	19.4%
200-499 beds	38.9%	45.2%	13.5%
> 500 beds	23.5%	9.8%	4.1%
All hospitals	100.0%	100.0%	100.0%

* Only general hospitals.
Source: Statistisches Bundesamt (2005).

While in the past private hospital investors tended to focus on smaller clinics, more recently Germany has been faced by a number of more spectacular cases where larger hospitals have become privatised:

- In July 2001 the private hospital chain *Helios* bought 51% of the shares of the clinic of the city of Erfurt (*Klinikum Erfurt*) which had around 1,121 beds. In November 2002 it also bought the remaining 49% of the shares, so that *Klinikum Erfurt* is now a 100% in the possession of *Helios.*
- In January 2003 *Helios* took over 94.9% of the shares of the clinic of the city of Wuppertal (*Klinikum Wuppertal*) which had more than 1,000 beds.
- In 2004 the private hospital company *Asklepios* bought the main hospital group of the federal state of Hamburg (*Landesbetrieb Krankenhäuser*, LBK) which covered seven clinics with 5,688 beds. The acquisition will become fully effective in 2007 when *Asklepios* will have sold one of the seven clinics as required by the German Federal Cartel Office.
- In January 2006 Germany saw the first privatisation of a university hospital when the private hospital corporation *Rhön Klinikum AG* acquired the university clinics of Marburg and Gießen from the federal state of Hesse. Both university clinics had together more than 2,400 beds.

Almost all studies on the German hospital sector estimate that the privatisation process will continue in the future and will also include larger clinics. For example, a study made by the economic research department of the Allianz Group has predicted that in the year 2020 the proportion of private hospital will increase from 25% at present up to 40% (Hess 2005: 11). Other studies have estimated that the share of private hospitals might even grow to 50% (Sal Oppenheim 2001; Schmidt et.al. 2003). Regarding

university hospitals a study by the Dr. Wieselhuber & Partner Consultancy estimates that in the year 2015 about 23% of all hospital clinics will have been privatised and further 29% will be organised through public-private-partnerships (Dr. Wieselhuber & Partner 2006).

1.3. Major private hospital companies

The ongoing restructuring of the German hospital sector has led to the emergence of some major private hospitals companies (Table 4). Among them there is a group of four large corporations including *Asklepios, Rhön-Klinikum, Fresenius and Sana Kliniken* which combine already nearly one third of all private hospitals. Since all of these four companies are following a strategy of continuous expansion they are expected to acquire a much larger market share in future. Thereby, the restructuring of the hospital sector does not only include privatisations but also mergers and acquisitions among private hospital companies. The largest takeover of a private hospital so far took place in October 2005 when the medical care company *Fresnius* bought the private hospital chain *Helios Kliniken.*

Table 4: Major private hospital companies in Germany 2005

	Number of hospitals	Number of beds
Asklepios Kliniken GmbH	37	11,027
Rhön-Klinikum AG	37	10,717
Fresenius ProServe GmbH including	36	11,738
Helios Kliniken GmbH *Humaine Kliniken GmbH*	*23* *5*	*8,981* *1,470*
Sana Kliniken GmbH & Co. KGaA	29	5,600
Paracelsus-Kliniken Deutschland GmbH	16	2,386
MediClin AG	10	1,382
Ameos Holding AG	8	1,812
SRH Kliniken AG	6	2,487
Dampf Holding AG	4	1,277
Medigreif GmbH	4	616
Deutsche Klinik GmbH	4	418

Source: Bruckenberger et.al. (2006: 61).

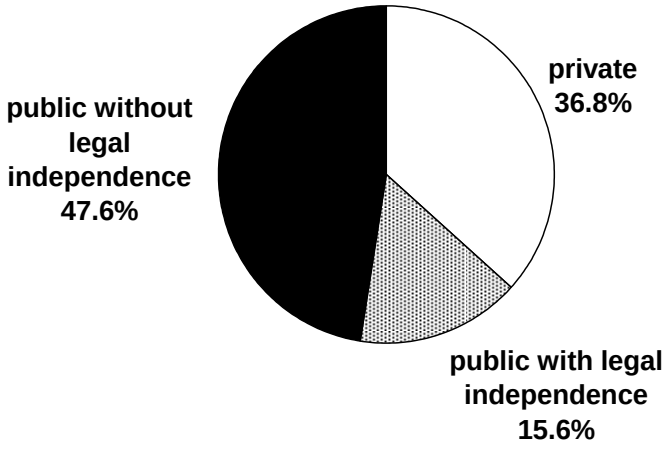
The German hospital market is so far almost exclusively dominated by German companies. However, since privatisation and restructuring will continue this might also attract more foreign healthcare companies to the German market. A first major acquisition made by a foreign company took place in August 2006 when the Swedish

healthcare company *Capio* announced a takeover of the *Deutsche Kliniken GmbH* which is one of Germany's largest private hospital companies (Capio 2006).

1.4. Organisational changes within public hospitals

The restructuring of the German hospital sector did not only lead to a growing number of privatisations but also had a major impact on the structure and management of the remaining public hospitals. Many public owners have started far-reaching organisational changes by introducing specific management tools (outsourcing, process optimisation, financial controlling/cost control, specialisation, group purchasing, standardisation, benchmarking etc) which are quite common in the private sector. In many cases the organisational restructuring went along with changes in the legal form of public hospitals. In 2004 almost 37% of public hospitals had adopted a private legal form and became, for example, a limited corporation (*Figure 4*). Such a "formal" privatisation was usually also a precondition for a later "material" privatisation. There existed a further 16% of the public hospitals which had a public legal form but were at the same time legally independent of public administration. Only less than half of the public hospitals have remained under the full control of their public owners.

Figure 4: Legal form of public hospitals in Germany (2004)



Source: Statistisches Bundesamt (2005)

In 2005 the managers of municipal hospitals founded a new interest organisation (*Interessenverband kommunaler Krankenhäuser*, IvVK) which wants to defend the principle of public ownership against privatisation by making municipal hospitals more economically efficient. In order to create more efficiency it demands a hospital management which is free of "political influence", so that the public hospitals become more or less able to function like their private competitors (Tissen 2005).

1.5. Drivers for privatisation

The reasons for the growing number of privatisations in the German hospital sector are manifold. On the one hand there are more general reasons such as changes in the overall political and economic framework conditions. On the other hand there are some more specific reasons which have to do with changes in the regulation of the German healthcare system and the system of hospital financing and their impact on the financial situation of public hospitals.

Among the more general reasons there is first of all the difficult financial situation of most public authorities in Germany which often have to deal with large debts and high budget deficits (Table 5). At the end of 2005 the total public debt of all German municipalities ran to 83.8 billion euro while there was a public deficit of 2.3 billion euro. The financial situation of the German federal states was even worse with a total debt of 468.2 billion euro and an annual budget deficit of 24.1 billion euro.

Table 5: Financial situation of German federal states and municipalities in 2005

	Budget deficit	Total debt
Federal states	24.1 billion Euro	468.2 billion Euro
Municipalities	2.3 billion Euro	83.8 billion Euro

Source: Statistisches Bundesamt (2006c); Bundesministerium der Finanzen (2006a, 2006b).

There are many reasons for the ongoing crisis of public finances: it is partly caused by the consequences of German unification as well as by a relatively weak economic performance, persisting high unemployment and increasing social welfare payments during the 1990s. Moreover, it is also caused by a certain fiscal and tax policy in Germany which in recent times has favoured tax cuts – especially for companies and groups with higher incomes. This policy has further contributed to maintaining the weak economic performance of the German economy and has undermined the tax income of public authorities (Truger 2004).

Although the crisis of public finances is rooted in political decisions, it is usually treated as a "constraint" for political action. Against that background the German federal states, which according to the German Hospital Financing Act have the main responsibility for the hospital planning and the financing of hospital investments, have been less and less active in fulfilling their tasks. For many years they have not provided sufficient financial resources for hospital investments (Bruckenberger 2005). Various studies have estimated that the current backlog of necessary investments in hospitals amounts to around 30 billion euro (Augurzky et.al. 2004, Bruckenberger 2005, Hess 2005).

Moreover, since the German hospital financing system does no longer guarantee full cost compensation, many German hospitals have not been able to finance their operational business. According to figures provides by the German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG) more than one third of German hospitals had a negative annual balance sheet in 2004 (Deutsches Krankenhausinstitut 2005: 62).

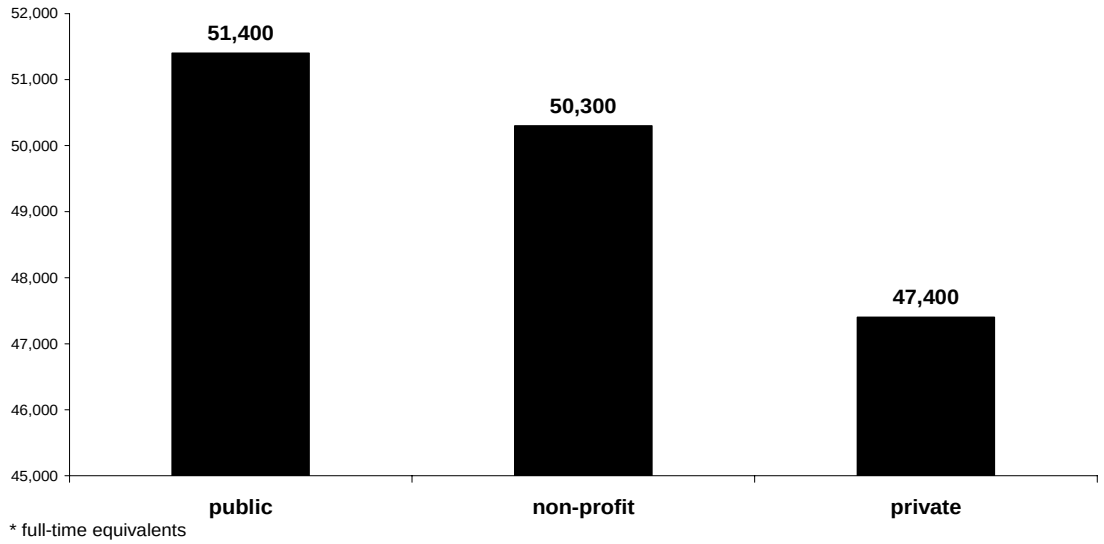
The municipal employers association (*Vereinigung der kommunalen Arbeitgeberverbände*, VKA) had even claimed that nearly 50% of all public hospitals were in the red (VKA 2006). The financial losses of the public hospitals have to be taken by their public owners which are often themselves in serious financial difficulties.

Against that background the privatisation of hospitals might be attractive for public authorities for several reasons (Brunckenberger 2005; Hess 2005): First, the sales revenues might help to reduce the public debt. Secondly, the public authorities are no longer responsible for balancing the financial deficits of the hospital. Moreover, they can shift at least part of the costs for necessary investments in the hospitals to private investors.

In comparison to public hospitals private hospital companies are claimed to have several competitive advantages (Hess 2005). First, they have much easier access to private capital markets in order to organise the financial resources for necessary investments. Secondly, private hospital companies are often able to organise their operational business in more efficient ways. They have, for example, the opportunity to realise better economics of scale and synergy effects through the close cooperation of different clinics within the private hospital chain.

Thirdly, private hospital companies maintain that they have much lower labour costs, because they are not covered by the relative "expansive" collective agreements of the public sector but have either their own company agreements or are not covered by any collective agreement at all. In 2004 the average costs per employee in private hospitals were 47,400 euro in comparison to 51,400 euro in public hospitals (Figure 5). Since labour cost amount to nearly two thirds of the overall costs in German hospitals (Statistisches Bundesamt 2006a), the differences in pay and other labour costs create a major competitive advantage for private hospital companies.

Figure 5: Average costs per employee in German hospitals in 2004 (in Euro)*



* full-time equivalents
Source: Statistisches Bundesamt (2005, 2006a), own calculations

1.6. The European dimension

So far, the European Union has no explicit policy on hospital services. The organisation and provision of hospitals is the full responsibility of the EU Member States. As pointed out in Art. 152 (5) EC (Treaty establishing the European Community) "community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care." However, the currently dominating economic policy of the European Union has implicitly a more or less strong influence on the development of hospital services in Germany.

First of all, the EU Stability and Growth Pact (SGP) determines a European macroeconomic regime which strongly constrains the possibilities for public economic policy and investments. In order to fulfil the SGP's limits for public budget deficits German public authorities have followed a rather restrictive fiscal policy and have increasingly used privatisations to solve budget problems. The European economic policy regime also put pressure on the German national social insurance systems whose financial deficits make a significant contribution to the overall public deficit (Urban 2003: 52ff.). In order to bring down the cost of the public health insurance system, for example, since the mid-1990s the German government has made one reform after another including major reforms of hospital financing (see below chapter 2.1). Finally, the development of the German hospital sector has been influenced by the EU liberalisation policy in other sectors which has promoted the general concept of privatisation as an efficient and advantageous policy strategy.

In recent years there has been a growing juridical and political debate on whether or not the German system of hospital organisation and financing is in agreement with European competition law (for an overview see: Bruckenberger et. al. 2006; Rinken and Kellmer 2006). In particular, there is a strong criticism coming from private hospital companies in Germany on the common practice according to which public authorities regularly compensate the financial deficits of public hospitals. In January 2003, the private German hospital company *Asklepios* sent a complaint to the European Commission in which they argued that this practice created an unlawful discrimination of private hospitals and had to be seen as a prohibited form of state aid according to Art. 86ff. of the EC Treaty. In May 2004, *Asklepios* brought the case before the European Court of Justice (ECJ), after the European Commission had failed to take a decision on the complaint (Official Journal of the EU C 210/16-17, 7.8.2004). The ECJ has taken no decision on that case yet. However, if the European Court agreed with the viewpoint of *Asklepios*, this would have a major impact on the German hospital sector and would definitively promote further privatisations.

The European Commission has regarded health services as "services of general interest" where the application of the EU competition law should be subject to some restrictions (European Commission 2004). In its "Altmark decision" from July 2003 the ECJ define some relatively restricted conditions under which public authorities are allowed to compensate for deficits of public companies (Rinken and Kellmer 2006: 5). However, from a legal point of view it is still unclear if theses criteria have alsoto be used for

public hospitals. In 2005 the European Commission published a draft decision in which it proposed somewhat less restricted conditions for deficit compensation in public hospitals. According to the European Commission

> "Hospitals … entrusted with tasks involving services of general economic interest have specific characteristics that need to be taken into consideration. In particular, account should be taken of the fact that at the current stage of development of the internal market, the intensity of distortion of competition in those sectors is not necessarily proportionate to the level of turnover and compensation. Accordingly, hospitals providing medical care, including, where applicable, emergency services and ancillary services directly related to the main activities, notably in the field of research … should benefit from the exemption from notification provided for in this Decision, even if the amount of compensation they receive exceeds the thresholds laid down in this Decision, if the services performed are qualified as services of general economic interest by the Member States." (European Commission 2005: 5)

Depending on further juridical clarifications and decisions of the ECJ and the European Council on the treatment of services of general interest and hospital services in particular the European level might have a much stronger impact for the restructuring of the German hospital sector in future.

2. REGULATION

Healthcare services differ fundamentally from free-market commercial services. This has to do with the nature of health or sickness which "as a whole cannot get the character of a commodity" (Deppe 2003: 3). The health care system creates a special social relationship which needs social protection and cannot be regulated only by the market. The reasons for this are manifold:

- "Health is an existential good. It is a use value, which is in our societies collective and public – similar like the air we breath, drinking water, education or traffic and juridical security.
- It is not possible to decide being without sickness – like with commodities for consumption.
- The patient does not know when and why he or she will become sick, by which sickness he or she will suffer in the future. Sickness is an event which cannot be regulated individually. It is a general life risk.
- The demand of a patient for medical aid is primarily not specific. At first the competence of an expert defines and specifies it. There is a relevant difference between the competence and information of a physician and a patient. And the physician has a big discretionary power for indications, diagnostic and therapeutical decisions.
- Over this the patient is in a position of insecurity, weakness, dependency, need in combination with anxiety and shame" (ibid., see also Deppe 2002).

All in all the health care system is a prominent example for the theory of market failure. Since the market is not able to provide sufficient and universal services, these have to be guaranteed by the state. Accordingly "the German health system continues to be more state-regulated than almost any other economic area and largely removed from the allocation mechanism of the market" (2002 German Hospital Report quoted from Bruckenberger et. al. 2006: 219). There is a complex system of state regulation which determines the provision, planning and financing of hospitals.

2.1. Provision, planning and financing of hospitals

The basic regulation for the provision, planning and financing of hospitals is laid down in the German Social Security Code No. 5 (*Sozialgesetzbuch*, SGB 5) and in the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*, KHG). The responsibility to provide sufficient hospital services lies with the governments of the German Federal States (*Länder*). According to Article 6, Para 1 of the KHG the federal states are obliged to produce and regularly update a hospital plan, which details the provision of hospital-based medical care in the respective state. Contents and methods of hospital planning are determined at federal state level and differ substantially among states. As laid down in Article 7, Para. 1 of the KHG the ministry responsible within the federal state has to work out the hospital plan under participation and consultation with the regional associations of German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG) as well as with the regional health insurance funds.[2] In recent years the federal state administrations have also increasingly involve consulting firms and research institutes in the planning process (Busse and Riesberg 2004: 105). As Article 1, Para 2 of the KHG determines, the hospital plan has to guarantee a structure of hospitals with different ownership, i.e. not only public but also non-profit and private hospitals have to be considered in the hospital plan. As a result of Germany's basically regional system of hospital planning the number of hospital and hospital beds in relation to the population show significant differences among the federal states (Deutsche Krankenhausgesellschaft 2006).

The payment of hospitals in Germany is organised through the so-called dual financing system which was introduced in the early 1970s (Busse and Riesberg 2004: 165ff.). All operational costs which include cost for medical services and accommodation as well as personnel costs are covered through reimbursement contracts between hospitals and the health insurance companies, whilst longer-term infrastructure investments are to be financed by the federal states. Only those hospitals which are listed in the federal state's regional hospital plan are entitled to participate in the dual financing system. In fact, 97% of all clinics and roughly 80% of all private hospitals belong to the hospital planning scheme (Hess 2005: 2f.).

[2] For a description of the different content, methods and institutional arrangement of hospital planning in the various federal states see: Deutsche Krankenhausgesellschaft 2006.

Table 6: Hospital planning and financing in Germany

Regulation	Actors
Hospital planning	Governments of Federal States under participation of regional health insurance funds and hospital providers.
Hospital financing (Investment costs)	Governments of Federal States in consultation and negotiations with hospital providers
Hospital financing (Operational costs)	Health insurance funds in negotiation with hospital providers

Source: Own composition.

Since the early 1990s the German system of hospital financing has been confronted with rising problems and difficulties (for an overview see: Simon 2000, 2001). On the one hand the hospitals have had to deal with an increasing investment backlog since most federal states did not provide sufficient financial resources for investments because of their own growing budget problems. This investment backlog has been identified as one major driver for the privatisation of public hospitals (see above chapter 1.5). On the other hand the mode of compensating the operational costs through the health insurance funds has been challenged by various legal changes which finally led to fundamental transformation from a system of full cost coverage to a system of capped hospital budgets.

Until the end of 1992 all operational expenditures had to be financed by the social health insurance funds, so that it was not possible for hospitals to make deficits. The actual remuneration was mainly done through per-diem charges where each day's treatment per patient was compensated at a flat rate, irrespective of the individual treatment input required. In the 1980s, however, this system of hospital financing became increasingly accused of creating "incentives to keep patients in hospital for longer than medically necessary to increase the occupancy rate of the oversized bed capacities" (Hess 2005: 4).

With the adoption of the Health Care Structure Act of 1993 (*Gesundheitsstrukturgesetz*) hospital spending was capped. The annual growth of reimbursement for individual hospitals was restricted to the annual rise in the health insurance funds' revenue, irrespective of the services actually provided. At the same time the principle of full cost coverage became abolished and, for the first time, hospitals were allowed to make profits or deficits (Busse and Riesberg 2004: 168). In 1996 the reimbursement system based on per-diem fees was replaced by a mixed payment system which included per diem fees as well as case fees which covered the costs of a patient's entire hospital stay.

The changes in the hospital financing system were aimed at putting considerable rationalisation pressure on hospitals in order to provide more efficient and cost-saving health services. Indeed, the new forms of hospital financing set in motion a far-reaching restructuring process of the German hospital sector – of which the most obvious results are the reduction of the number of hospitals and hospital beds (including the close down of hospitals), the reduction in the average length of stay and a growing number of privatisations (see chapter 1.1 and 1.2).

However, until the end of the 1990s all these developments did not result in a decrease of the overall spending on hospitals which on the contrary has continued to rise (Simon 2001: 15). In 2000 the German Federal Government decided on an even more fundamental change to the hospital financing system by the introduction of a German Diagnosis Related Group (G-DRG) system which was mainly based on the existing Australian DRG-System (Baum and Tuschen 2000, Simon 2002, Busse and Riesberg 2004: 171ff.). The introduction of the DRG system started in 2003 and – after a transitional period – is planned be fully operational from 2009 onwards. That basic notion of the DRG system is that very case should be reimbursed by a uniform flat-rate determined by a DRG irrespective of the concrete treatment and the actual corresponding costs of an individual hospital.

It is widely expected that the full introduction of the DRG system will further promote the ongoing restructuring process of the German hospital sector. According to a study by the Allianz Group Economic Research Department the new DRG system "brings greater transparency and keeps up the rationalization pressure, particularly for those hospitals whose costs per case are above average. … But even institutions operating at below-average costs have a strong incentive to continue cutting expenses, since the difference between in-house costs per case and the case-based lump-sum remuneration remains as their operating profit" (Hess 2005: 6). One major consequence of the DRG system will be a further reduction of average patient's length of stay, since "the logic behind case fees calls for ideally short hospitalization periods" (ibid.). This will have further organisational consequences for the hospitals which more and more will split their business between core inpatient care and the supplementary outpatient care.

Moreover, the growing rationalization pressure coming from the DRG system will lead to a further concentration in the hospital sector. The Allianz study estimates that in 2020 the number of hospital and hospital beds will have dropped to 20% (ibid.: 11). According to a recent study by McKinsey, about one third of all German hospitals will not be able to operate without financial deficits under the conditions of the new DRG system (McKinsey 2006). Considering this, McKinsey expects a further restructuring in the German hospital sector including the closing down of hospitals, new mergers and further privatisations. The politically instigated change in the German hospital financing system could therefore be identified as one further major cause for the ongoing process of restructuring and privatisations in the German hospital sector.

2.2. Restructuring of hospitals and German competition law

Since the growing number of mergers and takeovers, the German hospital sector has become more and more confronted with the German competition law. On 11 March 2005, the Federal Cartel Office (*Bundeskartellamt*) prohibited for the first time the takeover of two public hospitals in the district of Rhön-Grabfeld by the private hospital company *Rhön-Klinikum AG* in order to prevent a dominant position of a single hospital provider in a certain regional market (Monopolkommission 2006). Only two weeks later, on 29 March 2005, the Federal Cartel Office also prohibited *Rhön* from acquiring

the municipal hospital of the city of Eisenhüttenstadt. In April 2005 the Cartel Office accepted the acquisition of majority shares in the public hospital group *LBK Hamburg* by the private hospital company *Asklepios* only under the condition that *Asklepios* will further sell one of the seven *LBK* hospitals.

In its justification of its decisions the Cartel Office recognised the particular status of hospitals and made clear that it is not against privatisations in principle. As the president of the Cartel Office has stated:

> "The Bundeskartellamt is fully aware of the special social-law regulations under which hospitals operate. In view of the difficult financial situation of many hospitals and their owners the Bundeskartellamt wholly welcomes the fact that also private investors can use their financial and management resources to restructure the German hospital system. In the recent past the Bundeskartellamt has thus cleared a large number of hospital takeovers. Private hospitals' opportunities for expansion are only restricted if they result in considerable competition problems in the markets affected. Hospital takeovers must not lead to market dominance. Moreover it would be a most contradictory situation if companies were to use the possibilities of private-sector economic activity on the one hand, but refused to be controlled by competition on the other. Particularly in this difficult phase of co-existence between public-law planning guidelines and market-economy control mechanisms it is of decisive importance not to cement dominant positions held by private groups of companies." (Bundeskartellamt 2005)

The affected private hospital company *Rhön* has made an appeal against the decision of the Cartel Office at the Higher Regional Court (*Oberlandesgericht*) (which have not yet passed a final judgement). At the same time the regional government of the Rhön-Grabfeld district asked the Federal Ministry of Economics to give a special permission (*Ministererlaubnis*) for the takeover.[3] In May 2006, however, the Ministry rejected this demand and confirmed the decision of the Cartel Office (Ministry of Economics 2006).

The decision of the Cartel Office became widely criticised by legal experts (Bruckenberger et.al. 2006) as well as by private hospital companies. There is an apprehension that if the Cartel Office's ruling becomes final "it would basically throw private clinic chains' expansion strategy into doubt. Since cost-cutting measures have potentially reduced the rate of return on public-sector hospital takeovers, private operators are increasingly looking to the synergetic effects of regional concentration of their capacities" (Hess 2005: 10). However, it remains to be seen if the German competition law will really become an instrument to limit hospital privatisations.

[3] According to Article 42 of the German competition law (*Gesetz gegen Wettbewerbsbeschränkungen*, GWB) the Federal Ministry of Economics has the possibility to cancel a decision of the Cartel Office and could give a planned merger or acquisition for general economic reasons a special ministerial permission.

3. ROLE OF THE STATE AND OTHER STAKEHOLDERS

3.1. Role of the state

The public authorities at various levels (national, federal state, municipalities) have been the major social actor which has pushed for the ongoing restructuring process of the German hospital sector. In changing the framework condition of hospital financing the state has strongly promoted tendencies towards an economisation and commercialisation of heath care services. Against that background the initiatives for privatisations of hospitals have usually been taken by the state at regional or municipal level, driven by significant budget problems of the public authorities.

However, the issue of the privatisation of hospitals is still very much contested amongst Germany's major political parties. While the Christian Democratic Party (*CDU*) and the Liberal Party (*FDP*) are usually very much in favour of privatisations, the Left Party (*Linkspartei*) is usually against it. A more ambiguous role has been taken by the Social Democratic Party (*SPD*) and the Green Party (*Bündnis 90/Die Grünen*). As members of municipal governments in some cases they have actively supported hospital privatisations. In other cases when these parties have been in opposition they have often battled against privatisations.

In general the behaviour of the state is becoming more and more ambiguous. On the one hand the state is responsible for providing sufficient and universally accessible hospital services for all citizens, irrespective of their economic "rationality". On the other hand with its promotion of privatisations and its new regulation on hospitals the state increasingly has introduced the market logic and the imperative of profitability into the provision of hospital services which might have far-reaching consequences for other stakeholders.

3.2. Role of other stakeholders

Considering the attitude of other stakeholders such as hospital employees, regional citizens and patients there is a broad scepticism towards privatisations of hospitals. In recent years there has been almost no major privatisation of a hospital which has not been faced by a strong resistance coming from various stakeholder groups. For example, when the federal state government of Hamburg announced the sale of the *Landesbetrieb Krankenhäuser* (LBK), which covered seven clinics with 5,688 beds, a broad anti-privatisation alliance was formed including regional trade union organisations, political parties and altermondialist groups such as Attac (Greer 2006). Under the slogan "health is not a commodity" the alliance launched a broad political campaign against the privatisation and collected more than 100,000 signatures which forced the Hamburg government to hold a referendum (*Volksentscheid*) on that issue in February 2004. While 65% of the people entitled to vote had actually participated in the

referendum, nearly 77% of them had voted against the privatisation (Hansestadt Hamburg 2004). Although a broad majority of the people of Hamburg have shown their disapproval with the privatisation the Hamburg government finally sold the *LBK* to the private hospital company *Asklepios*.

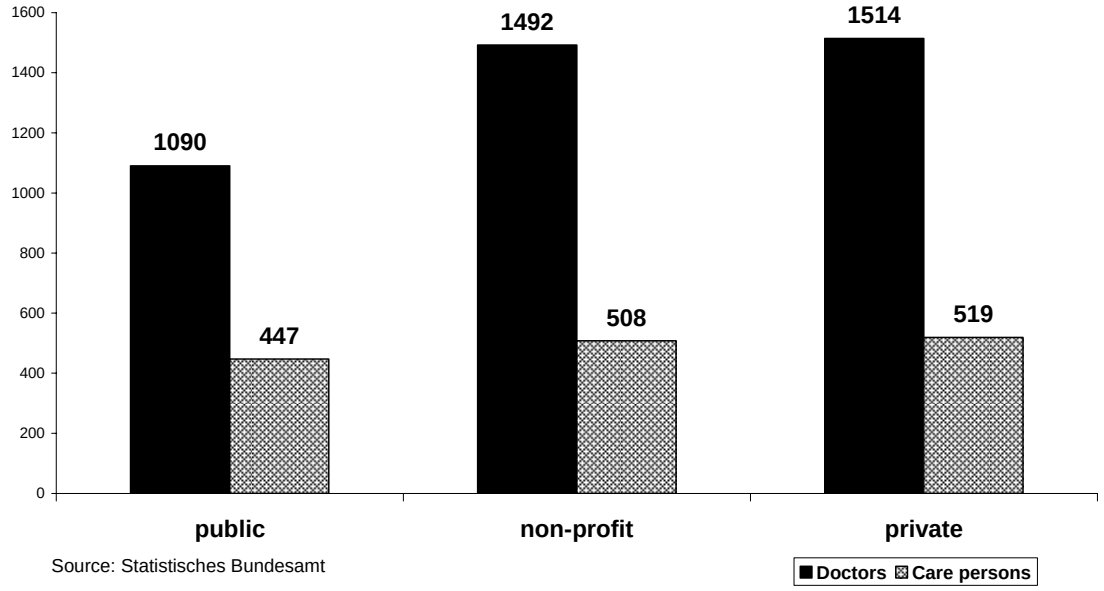
A strong resistance coming from trade unions and many other civil society organisations also developed during the first privatisation of a university clinic at the Universities of Marburg and Gießen in 2005 and 2006 (http://www.attac.de/klinika/). Most of the anti-privatisation initiatives have so far not been able to prevent the actual privatisation. There are, however, some exceptions: In 2002, for example, a planned privatisation of the *Heinrich-Braun-Krankenhaus* in the city of Zwickau was rejected in a referendum (*Bürgerentscheid*) by a majority of more than 80%. The public authorities are legally bound to the results of the referendum – at least for a period of three years. More recently, in autumn 2006, the local public authorities had to give up their plans for a privatisation of the *Elblandkliniken* in Meissen, which is a public clinic with around 800 beds. Prior to this a local anti-privatisation alliance of trade unions, political parties and other organisations had collected more than 33,000 signatures on a petition for a referendum (*Bürgerbegehren*) against the privatisation (Anderson 2006).

In most cases the anti-privatisation initiatives are led by the local trade union organisations, as, in particular, the Unified Services Union (*Vereinte Dienstleistungsgewerkschaft*, ver.di) which is by far the largest union in the German health care sector. The strong resistance to the privatisation of hospitals coming from the German trade unions are based on the assumption that privatisations would worsen the working conditions of the employees and would threaten jobs. Although there are almost no studies which have compared working conditions of public and private in detail, there are some indicators which support these assumptions. First of all, private hospitals claim to have lower labour costs than their public competitors (see chapter 1.5). This is partly a result of the fact that the public hospitals are still mostly covered by the general collective agreements for the public sector while private companies either have company agreements or no collective agreement at all. Besides lower wages, on average private hospitals also seemed to have a higher wage dispersion so that employees in the lower wage grade earned less and employees in the higher wage grades earned more than their colleagues in public hospitals (PLS Ramboll Management 2004). The increasing competition between public and private hospitals also had an effect on the development of the traditional collective bargaining system in the public sector. In recent years the whole system has been affected by some fundamental changes which also had a strong impact on collective bargaining in public hospitals (for the general trends see: Dribbusch and Schulten 2006, for the hospitals see: Wendl 2006). For example, public hospitals often use the “threat of privatisation” to push for employees’ concessions on pay and working conditions.

Regarding working conditions the existing evidence indicates that work in private hospitals seemed to be more intensified and stressful than in public clinics (PLS Ramboll Management 2004; Rehm 2006). On average private hospitals have far less staff to provide for a given number of patients than their public competitors. In 2004 a

doctor working for a private hospital had on average 1,514 beds in his care while his colleague at a public hospital had only 1,090 beds (*Figure 6*). A care person in a private hospital was responsible for 519 beds in comparison to 447 beds covered by a care person in a public hospital. The relation of staff and patients in non-profit hospitals fell somewhat in between public and private clinics.

Figure 6: Number of beds to be cared by a full-time employed doctor or care person in 2004



Source: Statistisches Bundesamt

Considering the effects that hospital privatisations had on employment in the majority of cases, the public authorities and the new private owners made an agreement that secured jobs in the privatised company for a certain period of time. For example, when in January 2006 the *Rhön Klinikum AG* acquired the university clinics of Marburg and Gießen it had to accept a job guarantee for all permanent employees until 2010 (Hessischer Minister für Wirtschaft und Kunst 2006). However, less than half a year after the takeover *Rhön* announced its plan to reduce up to 15% of the staff at the university clinics – mainly through lay-offs of employees with no permanent contracts (Ärztezeitung, 2 May 2006). In a mid-term perspective the privatisation might accelerate the general trend towards a reduction of employees in German hospitals.

Regarding the effects of hospitals privatisations on the quality of health care services there are no detailed studies available. However, there are some studies which have analysed the consequences of the growing economisation and commercialisation of hospital services which have mainly been pushed through the new system of hospital financing but have also been enforced by the growing number of privatisations (see for example: Simon 2001, Kühn 2003, Kühn and Klinke 2006). There is a broad concern that the increasing economic pressure will influence the hospital services in such a way that the treatment of patients will increasingly follow not only medical but economic

criteria (Deppe 2002, 2003). For example, since the new hospital financing systems promotes a shorter length of stay, there is a strong financial incentive for hospitals to check out patients as early as possible with a danger of 'bloody check outs" (Kühn 2003: 7). Since private hospital companies tend to create clinic networks with a greater specialisation of certain clinics, patient associations have raised concern that particularly in rural areas patients might have to travel much longer distances in order to get certain treatment (Deutsche Gesellschaft für Versicherte und Patienten 2005). To sum up, the privatisation of hospitals might encourage the general trend towards a "commodification" of hospital services (Attac Marburg 2005).

4. OUTLOOK

If the current trends in the German hospital sector continue, as is expected by most experts, there will be a continuous decline in the number of hospitals as well as a growing number of hospital privatisations. These developments will have a significant impact on both working conditions and industrial relations, as well as on the quality of hospital treatment. Much more research is therefore needed to get a more detail picture of the differences in the functioning and organisation of public and private hospitals.

There is, however, no automatism, which determines the future development of the German hospital sector. On the contrary, the recent restructuring of hospitals in Germany are the results of political decisions which follow an economic philosophy which currently dominates the system and according to which liberalisation and privatisation of public services are associated with more efficiency. In particular, in the health care sector there are many doubts that this association will materialise. As a result, hospital privatisations will continue to be confronted with anti-privatisation alliances composed of various stakeholders, so that the future development of hospitals in Germany will depend on the outcome of these political and social struggles.

REFERENCES

Anderson, Peter (2006): Krankenhaus-Verkauf ist gekippt, in: Sächsische Zeitung, 6 October 2006.

Attac Marburg (2005): Kommodifizierung und Privatisierung der Krankenhäuser in der BRD, Manuscript, [http://www.attac.de/marburg/cms/?id=Thema.Privatisierung.Krankenhaeuser].

Augurzky, Boris, Sebastian Krolop, Andreas Liehr-Griem, Christoph M. Schmidt and Stefan Terkatz (2004): Das Krankenhaus, Basel II und der Investitionsstau, RWI-Materialien No. 13, Essen: RWI.

Baum, Georg and Karl-Heinz Tuschen (2000): AR-DRG – Die Chancen nutzen. Überlegungen zu den ordnungspolitischen Rahmenbedingungen des neuen DRG Entgeltsystems, in: führen und wirtschaften in Krankenhaus (f&w) Vol. 17 (5), 449-460.

Bruckenberger, Ernst (2005): Privatisierung der Krankenhäuser. Eine Alternative zum Investitionsstau, Ms. (Version: 24 March 2005) [www.bruckenberger.de].

Bruckenberger, Ernst, Siegfried Klaue and Hans-Peter Schwintowski, (2006): Krankenhausmärkte zwischen Regulierung und Wettbewerb, Berlin et.al.: Springer.

Bundeskartellamt (2005): Bundeskartellamt prohibits hospital merger for the first time, Press Release from 11 March 2005.

Bundesministerium der Finanzen (2006a): Eckdaten zur Entwicklung und Struktur der Kommunalfinanzen 1996-2005 [http://www.bundesfinanzministerium.de].

Bundesministerium der Finanzen (2006b): Einnahmen und Ausgaben der Länder im Jahr 2005 (vorläufiges Ergebnis) [http://www.bundesfinanzministerium.de].

Busse, Reinhard and Annette Riesberg (2004): Health care systems in transition: Germany. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Capio (2006): Capio Press Release from 21 August 2006.

Deppe, Hans-Ulrich (2002): Kommerzialisierung oder Solidarität. Zur grundlegenden Orientierung der Gesundheitspolitik, in: Hans-Ulrich Deppe and Wolfram Burkhardt (eds.), Solidarische Gesundheitspolitik. Alternativen zur Privatisierung und Zwei-Klassen-Medizin, Hamburg: VSA, 10-23.

Deppe, Hans-Ulrich (2003): Neoliberalism, Health and Managed Care – A View from Europe, Paper presented in Rio de Janeiro/FIOCRUC, 26 March 2003, Ms. [http://www.opas.org.br/servico/arquivos/Sala5302.pdf].

Deutsche Gesellschaft für Versicherte und Patienten (2005): Fehlentwicklungen in stationären Einrichtungen des Gesundheitswesens, Papers for a Press Conference on 25 October 2005 in Berlin.

Deutsche Krankenhausgesellschaft (2006): Bestandsaufnahme zur Krankenhausplanung und Investitionsfinanzierung in den Bundesländern (Stand: Januar 2006), [http://www.dkgev.de/pdf/1047.pdf].

Deutsches Krankenhausinstitut (2005): Krankenhausbarometer Umfrage 2005, Düsseldorf [http://dkg.digramm.com/pdf/967.pdf].

Dribbusch, Heiner and Thorsten Schulten (2007): The End of an Era: Structural Changes in German Public Sector Collective Bargaining, in: Peter Leisink, Bram Steijn and Ulke Veersma (eds.), Industrial Relations in the New Europe. Enlargement, Integration and Reform, Cheltenham: Edwrad Elgar.

Dr. Wieselhuber & Partner (2006): Hochschulmedizin 2015 – Eine vergleichende Studie für Deutschland, Österreich und die Schweiz, München.

European Commission (2004): White Paper on services of general interest, Brussels, 12.5.2004, COM(2004) 374 final.

European Commission (2005): Draft Commisison Decision of [.] on the application of Article 86(2) of the Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest [.], Brussels, /07/.2005.

Greer, Ian (2006): Social movement unionism and social partnership in Germany: the case of Hamburg's hospitals, Ms, October 2006.

Hansestadt Hamburg (2004): Volksentscheid: Senat stellt fest, dass die Vorlage der Initiatoren angenommen wurde, Press Release, 9 March 2004.

Hess, Werner (2005): Hospitals walking a tightrope between reform pressure and financial straits, Allianz Group/Dresdner Bank Economic Research Working Paper No. 49, 25 July 2005, [http://www.allianz.com].

Hessischer Minister für Wirtschaft und Kunst (2006): Privatisierung des Universitätsklinikums Gießen und Marburg, No. 2/2006, Wiesbaden: Ministry for Economcis.

Krukemeyer, Manfred G. (2004): Structural problems in the German hospital system, in: Central European Journal of Public Health Vol. 12 (3), 161-165.

Kühn, Hagen (2003): Ethische Probleme der Ökonomisierung von Krankenhausarbeit, in: A. Büssing and J. Glaser (ed.), Dienstleistungsqualität und Qualität des Arbeitslebens im Krankenhaus, Göttingen et. al.: Hogrefe, 77-98.

Kühn, Hagen and Sebastian Klinke (2006): Krankenhaus im Wandel, in: WZB-Mitteilungen No. 113, 6-9.

Löser-Priester, Ingeborg (2003): Privatisierung öffentlicher Krankenhäuser und Partizipation der Beschäftigten, Frankfurt a.M.: Mabuse.

McKinsey (2006): Krankenhausreform weitgehend ausgereizt, Press Release from 2 May 2006.

Meyer-Timpe, Ulrike (2006): Schmerz ist selten Privatsache, Zeit-Online 22 June 2006, [http://zeus.zeit.de/text/online/2006/26/privatisierung-krankenhaeuser].

Ministry of Economcis (2006): Keine Ministererlaubnis im Fall Landkreis Rhön-Grabfeld/ Rhön-Klinikum AG, Press Release 22 May 2006.

Monopolkommission (2006): Sondergutachten zum Zusammenschlussvorhaben der Rhön-Klinikum AG mit dem Landkreis Rhön-Grabfeld, Bonn, [http://www.monopolkommission.de/sg_45/text_s45.pdf].

PLS Ramboll Management (2004): Geschäftsmodelle privater Konzerne im Krankenhaussektor, unpublished Manuscript.

Rehm, Fabian (2006): Krankenhäuser zwischen Ökonomisierung und Privatisierung, in: Z. Zeitschrift Marxistische Erneuerung Vol. 17, No. 66, 83-93.

Rinken, Alfred and Oliver Kellmer (2006): Kommunale Krankenhäuser als Instrumente sozialstaatlich-kommunaler Daseinsvorsorge im Europäischen Verfassungsverbund, in: Die Verwaltung Vol. 39 (1), 1-28.

Rolland, Sebastian (2005): Krankenhäuser in Deutschland 2003, in: Wirtschaft und Statistik No. 8, 838-848.

Rosenow, Christiane and A. Steinberg (2002): 10 Jahre bundeseinheitliche Krankenhausstatistik, in: Wirtschaft und Statistik No. 5, 383-391.

Sal Oppenheim (2001): Neues Vergütungssystem beschleunigt Privatisierung – Sal Oppenheim-studie zur Entwicklung des Krankenhaismarktes in Deutschland. Press Release, 1 October 2001.

Schmidt, Christian, Thomas Gabbert, Florian Engler, Florian Fischer, Jochen Breinlinger O'Reilly and Johannes Möller (2003a): Investoren im Gesundheitsmarkt, in: Deutsche Medizinische Wochenschrift No. 128, 1551-1556.

Schmidt, Christian, Thomas Gabbert, Florian Engler and Johannes Möller (2003b): Krankenhausmarkt im Umbruch – Welche Kliniken profitieren von der aktuellen Situation? in: Gesundheitsökonomie & Qualitätsmanagement 8, 294-299.

Simon, Michael (2000): Krankenhauspolitik in der Bundesrepublik Deutschland, Opladen/Wiesbaden: Westdeutscher Verlag.

Simon, Michael (2001): Die Ökonomisierung des Krankenhauses. Der wachsende Einfluss ökonomischer Ziele auf patientenbezogene Entscheidungen, Wissenschaftszentrum Berlin für Sozialforschung (WZB) Veröffentlichungsreihe der Arbeitsgruppe Public Health P01-205, Berlin: WZB.

Simon, Michael (2002): Das neue DRG-Fallpauschalensystem für Krankenhäuser. Kritische Anmerkungen zum Konzept einer ‚Steuerung über den Preis', in: Hans-Ulrich Deppe and Wolfram Burkhardt (eds.), Solidarische Gesundheitspolitik. Alternativen zur Privatisierung und Zwei, Klassen-Medizin, Hamburg: VSA, 145-158.

Statistisches Bundesamt (2005): Grunddaten Krankenhäuser 2004, Fachserie 12, Reihe 6.1.1, Wiesbaden: Statistisches Bundesamt

Statistisches Bundesamt (2006a): Kostennachweis der Krankenhäuser 2004, Fachserie 12, Reihe 6.3, Wiesbaden: Statistisches Bundesamt

Statistisches Bundesamt (2006b): Gesundheit – Ausgaben, Krankheitskosten und Personal 2004, Wiesbaden: Statistisches Bundesamt.

Statistisches Bundesamt (2006c): Finanzen und Steuern, Schulden der öffentlichen Haushalte 2005, Fachserie 14, Reihe 5, Wiesbaden: Statistisches Bundesamt.

Strehl, Rüdiger (2003): Privatisierungswelle im deutschen Krankenhauswesen? in: Michael Arnold, Jürgen Klauber and Henner Schellschmidt (eds.) Krankenhaus-Report 2002, Stuttgart: Schattauer, 113-129.

Tissen, Wolfgang (2005): Kommunal oder privat: Wohin tendieren die Krankenhausunternehmen, Interview with Wolfgang Tissen, in: Das Krankenhaus No. 8, 648-649.

Truger, Achim (2004): Rot-grüne Steuerreformen, Finanzpolitik und makroökonomische Performance – was ist schief gelaufen? in: Arne Heise, Eckhard Hein and Achim Truger (eds), Finanzpolitik in der Kontroverse, Marburg: Metropolis, 169-208.

Urban, Hans-Jürgen (2003): Europäisierung der Gesundheitspolitik? Zur Evolution eines Politikfeldes im europäischen Mehrebenen-System, WZB Discussion Paper der Arbeitsgruppe Public Health SPI 2003-303.

VKA (Vereinigung der kommunalen Arbeitgeberverbände) (2006): Hintergrundinformationen zum Tarifkonflikt zwischen der VKA und dem Marburger Bund, VKA Presse Release, 27 June 2006.

Wendl, Michael (2006): Verteilungskämpfe im Krankenhaus, in: Sozialismus Vol. 33 (9), 27-31.

Websites

Association of Municipal Hospitals, (Interessenverband kommunaler Krankenhäuser, IvVK), http://www.ivkk.de/.

Association of Private Hospitals, (Bundesverband Deutscher Privatkliniken, BDPK), http://www.bdpk.de/bdpk.php/cat/1/title/Home.

Federal Ministry of Health Legal Sources for the German hospital sector, http://www.bmg.bund.de/cln_041/nn_600124/DE/Gesetze-und-Verordnungen/zu-Krankenhaeusern/zu-krankenhaeusern-node,param=.html__nnn=true.

Federal Statistical Office, Data on the German Health Care System (including the German Hospital Statistic), http://www.destatis.de/themen/d/thm_gesundheit.php.

German Association of Insurants and Patients, (Deutsche Gesellschaft für Versicherte und Patienten, DGVP), http://www.dgvp.de/.

German Hospital Federation, (Deutsche Krankenhausgesellschaft, DKG), http://www.dkgev.de.

Unified Services Union (Vereinte Dienstleistungsgewerkschaft, ver.di), Section for the Social and Health Care Sector, http://gesundheit-soziales.verdi.de/.