

# World champions in hospital privatisation

## *The effects of neoliberal reform on German employees and patients*

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Over the past decade, German hospitals have been privatised at a rate not seen in any other country. In response to massive public-sector debt and the resulting investment backlog, many state and local governments have been privatising hospitals. The most common arguments for privatisation are repeated in a recent study commissioned by the association of private hospital owners (Bundesverband Deutscher Privatkliniken - BDPK) namely that private hospitals manage in a more efficient manner and are economically more successful (Augurzky, Beivers et al., 2009). Indeed, in some cases, private for-profit hospital companies have invested generously and turned inefficient public hospitals into profitable private ones. Of interest to us is the cost of this trend, to workers and patients.

Assertions that privatisation has not undermined the quality of care are highly dubious. In German public opinion, there is broad scepticism about the privatisation of hospitals. While there are very few scientific studies on the effects of privatisation on patients, there are a growing number of local ballot initiatives and other campaigns to fight it. There are widespread fears that for-profit health-care provision would undermine the existing system, which provides universally accessible medical treatment at a relatively high level of quality. Even among physicians, often considered the winners of privatisation, there is scepticism (Bundesärztekammer, 2007).

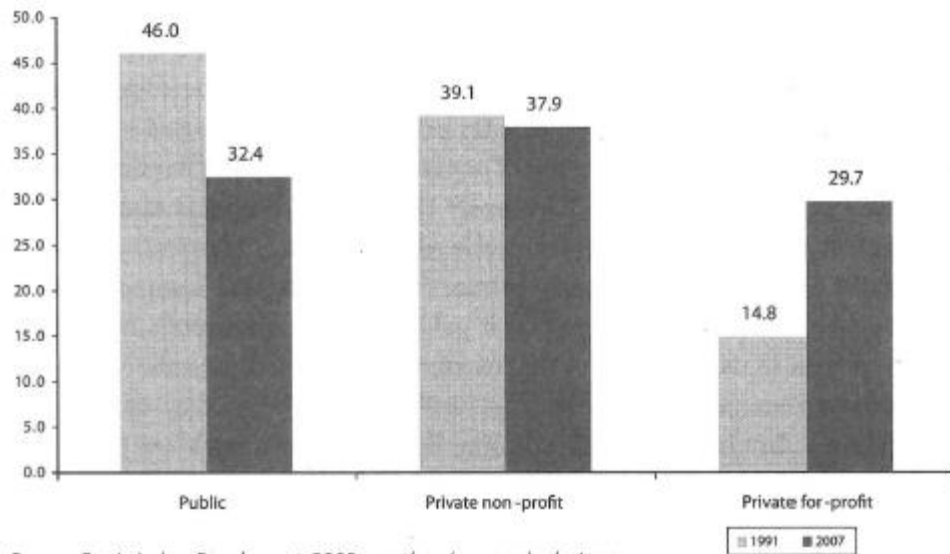
We will argue below that one reason for these problems is the effect of privatisation on employees. Trade unionists and works councils in privatised hospitals have seen a severe deterioration in working conditions (Ver.di Vertrauensleute und Vorsitzende und Mitglieder von Konzernbetriebsräten und Konzern-Jugend- und Auszubildenden-Vertretungen privater Krankenhauskonzern, 2008). Since personnel accounts for about 60 per cent of hospitals' overall costs (Statistisches Bundesamt, 2008b), private for-profit hospitals can only make profits at the expense of employees. These perceptions are supported by the statistics presented in this paper, and trade unions and employees protest — in cooperation with other parts of civil society - almost every planned privatisation.

Drawing on publicly available quantitative data and qualitative interviews, we map out in this paper the trend toward the privatisation of German hospitals. We begin by showing how and why privatisation has proceeded in Germany despite the controversy. Then we examine the effects of privatisation on workers and patients. We will conclude with some implications for policy and practice.

### **The waves of privatisation**

The privatisation of German hospitals has been well documented by the federal statistics office (Statistisches Bundesamt, 2008a) (see Figure 1). From 1991 to 2007 the proportion of private hospitals has almost doubled and has reached nearly 30 per cent. On the other hand the proportion of public hospitals has dropped from 46 per cent to about 32 per cent. Over this time, the proportion of private non-profit hospitals run by the churches and non-profit organisations has been relatively stable.

**Figure 1: Ownership structure of German hospitals, in per cent**



The total number of public hospitals has dropped from 1,110 in 1991 to 677 in 2007. In the same time the number of private hospitals has increased from 358 to 620. This decline in the importance of public hospitals has two reasons: closures of public hospitals and the sale of public hospitals to for-profit hospital chains. This latter process we call material privatisation (see Table 1).

**Table 1: The German hospital sector, 1991 and 2007**

	1991	2007	Change 1991–2007
Hospitals	2,411	2,087	-13.4%
Of these			
public	1,110	677	-39.0%
private non-profit	943	790	-16.2%
private for-profit	358	620	+73.2%
Hospital beds	665,565	506,954	-23.8%
Hospital beds per 100,000 inhabitants	832	616	-26.0%
Employees (total)	1,111,625	1,074,883	-3.3%
Employees (Full-time-equivalents)	875,816	792,299	-9.5%
Number of cases	14,576,613	17,178,573	+17.9%
Occupied beds in days	204,204,000	142,893,000	-30.0%
Average length of stay	14.0 Days	8.3 Days	-40.7%
Occupancy rate	84.1%	77.2%	-8.2%

Source: Statistisches Bundesamt, 2008a; authors' own calculations

### Reasons for privatisation

The reasons for these changes can be found in the precarious situation of public budgets and the fundamental change in the financing system of German hospitals (Simon, 2008b). Since the early 1970s there has been a so-called “dual financing system” for hospitals, under

which statutory health insurance funds pay for the operational costs, while the federal states (*Länder*) are responsible for the investments. Since the early 1990s, this system has been reformed several times in order to reduce costs, mainly by linking reimbursements to the diagnoses treated and decoupling them from the operating costs of hospitals.

The first important reform came in the early 1990s, when the principle of full-cost recovery was abolished. Previously, the costs for the hospitals were automatically covered by the health insurance funds. Thus pressures on the hospitals to reduce costs rose dramatically and drastic changes became necessary.

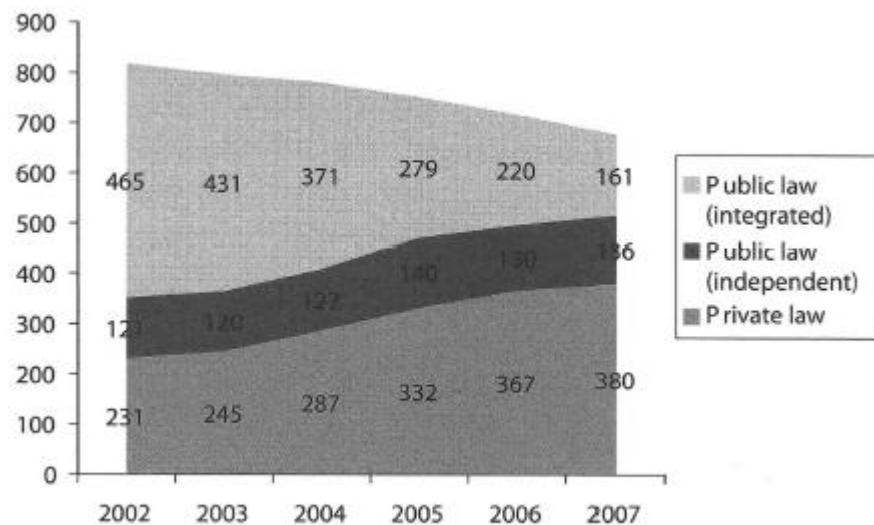
A system of mandatory nationwide case-based reimbursements was introduced in 2004 as the G-DRG-System (German Diagnosis Related Groups). According to this system, treatments are financed on the basis of defined diagnosis and not on time spent in hospital, as they had been before. Prices for each diagnosis are calculated for each *Land* on the basis of average costs in hospitals. This favours hospitals that work with relatively low costs per diagnosis and leads to increased cost pressure on hospitals to reduce their costs. For some companies, it raises the possibility of generating significant profits. This has made hospitals increasingly interesting for private investors and created problems for public-sector owners.

The number of hospitals has dropped by 13.4% since 1991 and the number of hospital beds has declined by 23.8% (Table 1). This has been accompanied by a 10% decline in full-time-equivalent staff. Additionally, outsourcing has become an important factor. Furthermore, the altered incentives of the DRG-System have led to a decline in the average length of stay of almost 50% (Statistisches Bundesamt, 2008a). However, the number of cases has increased by 17.1%. Thus slightly fewer employees treat more cases in a lot less time and the industrial productivity of German hospitals has risen considerably.

Over the next few years the share of private for-profit hospitals is widely expected to rise, to as much as 40% (Bähr, Fuchs et al., 2006). One reason for this shift is that many public hospitals remain inefficient. In 2008, one-third of hospitals operated in the red (Augurzky, Budde et al., 2009) and most of those are public hospitals whose deficits have to be balanced by the local budget of the municipality. From the view of many local governments, the material privatisation of hospitals is an attractive opportunity to rid themselves of these costs.

The lack of investment by the federal states in hospitals further accelerated the trend towards privatisation. Different studies quantify the backlog of needed investments between €20b (Augurzky, Budde et al., 2009), €50b (DKG, 2008 or even €100b (Simon, 2008a). From these privatisations, municipalities hope to receive the needed investment from private investors. Indeed, private hospitals receive more

Figure 2: Changes in legal form, 2002 to 2007



Source: Statistisches Bundesamt, 2008a

investment than public ones (Augurzky, Beivers et al. 2009) because their profitability makes it easier for them to receive capital from private investors. Those higher investments help private for-profit hospitals to improve their competitive position vis-a-vis public hospitals and lead to rationalisation and thus higher productivity.

### Formal privatisation of public hospitals

Intensified competition and cost pressures have led to reorganisations of many public hospitals using structural changes modelled on those of the private companies. One common approach is *formal* privatisation. This means that hospitals run directly by local government departments become fully owned subsidiaries of the states and run under private law. They are still owned by the state, but the decision-making power becomes relatively independent from the political and administrative processes of government.

As Figure 2 shows, over the last five years the number of state-owned hospitals operating under a public legal form has declined by almost two-thirds, while the share of public hospitals run under private law has almost doubled. This change has been caused by the increased competition due to the implementation of the DRG-System. The higher number of potential “veto- players” in the public authorities - i.e. actors who can obstruct rationalisation through the machinery of local government - is viewed as an obstacle under this context. The largest example of such a formal privatisation is the Vivantes Kliniken GmbH in Berlin. The company was founded in 2001 and is the result of a merger of nine city-owned hospitals.

**Table 2: Outsourcing of services in German hospitals between 2004 and 2007**

Sectors	% External (to an external company)	% Internal (to a subsidiary)	Total share (%)
Cleaning	19.5	33.6	53.1
Kitchen	18.4	22.0	40.4
Laboratory	24.0	3.0	27.0
Buying department	11.1	11.6	22.7
Shuttle services	8.3	11.2	19.5
Laundry	17.2	1.5	18.7
Bed preparation	9.1	8.6	17.7
Radiology	9.1	3.1	12.2
Other	10.9	10.2	21.1

Source: Blum, Offermanns et al., 2007

### Functional privatisation: outsourcing

In addition to the material and formal privatisation of entire hospitals, the transfer of functions - mostly support services, rather than direct patient-care functions - into the private sector has played an important role. The outsourced work is either transferred to an external company (“external outsourcing”) or into a newly established subsidiary of the hospital operator (“internal” outsourcing).

According to a survey of the German hospital association, more than 53% of all hospitals have outsourced cleaning services and more than 40% their kitchens between 2004 and 2007 (see Table 2). Increasingly, administrative and medical-technical functions are affected as well. The surprisingly low share of hospitals that have outsourced their laundry operations might be explained by the fact that these services were already widely outsourced before 2004. This has accompanied a decline in employment in these areas since 2001 that has been

estimated to be as high as 41% (Jaehrling, 2007). Another form of outsourcing - involvement of private capital through public-private partnerships (PPP) - is usually used for the financing of the construction of new hospital buildings, which after completion are leased by the public authorities that run the services.

### Ownership structure in international comparison

Unlike other types of privatisation, the rapid material privatisation of hospitals is unique to Germany. Currently, among major western countries only France has a higher share of private for-profit hospitals. However, France's traditionally strong private sector has declined nominally over recent years. Germany, by contrast, surpassed the US in terms of private market share by the end of 2007 (Gröschl-Bahr and Stumpfögger, 2008).

**Table 3: Material ownership in comparative perspective**

	Ownership	Private for-profit sector
Sweden, Denmark	Mainly public	Very few hospitals
UK (2007)	Mainly public	ca. 3% of beds
Poland (2006)	Mainly public	20.6% of hospitals 5.3% of beds
Belgium/ Netherlands (2005)	Mainly private non-profit	Very few hospitals
USA (2004)	Mainly private non-profit	17.0% of hospitals 13.9% of beds
Germany (2007)	Mixed	29.7% of hospitals 15.6% of beds
Austria (2007)	Mixed	21.5% of hospitals 9% of beds
France (2006)	Mixed	37.1% of hospitals 21% of beds

*Sources: national statistics, authors' own calculations*

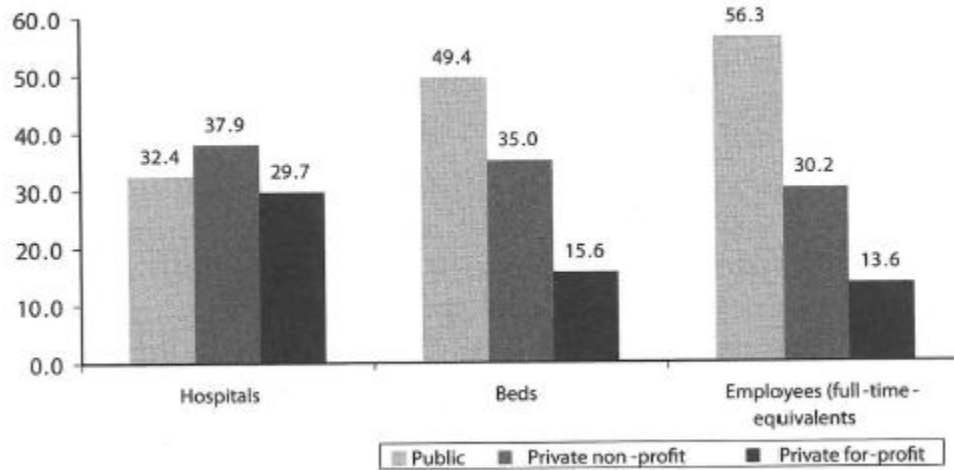
Internationally, there are three different structures of ownership, as Table 3 shows. As in France and Austria, Germany has a mix of different owners. There are public and private for-profit hospitals as well as a large proportion of hospitals that are private, but non-profit. These hospitals are mainly run by churches and welfare associations like the Red Cross and their share is slowly declining. In other countries like the UK, Poland, Sweden and Denmark, hospitals are almost exclusively part of a public health system. The third structure can be found in Belgium, the Netherlands and the USA, where most hospitals are private and non-profit.

### Private hospitals = smaller hospitals?

Although Germany has a long tradition of private hospitals, a qualitative shift in the sector occurred in the early 1990s. In the 1970s and 1980s the private hospitals were exclusively small clinics specialised on lucrative surgeries and treatments. They were not products of privatisation, but were designed and founded as small private clinics. Because of these origins, while the number of material privatisations has increased in the 1990s, private for-profit hospitals still account for a significantly lower share of beds and employees than public hospitals. While public hospitals still have more than 50% of all hospital beds, private for-profit hospitals have just 16%. Even more important is the role of public hospitals for the employees. More than 56% of all employees work in public hospitals and less than 14% in private for-profit

ones (Figure 3).

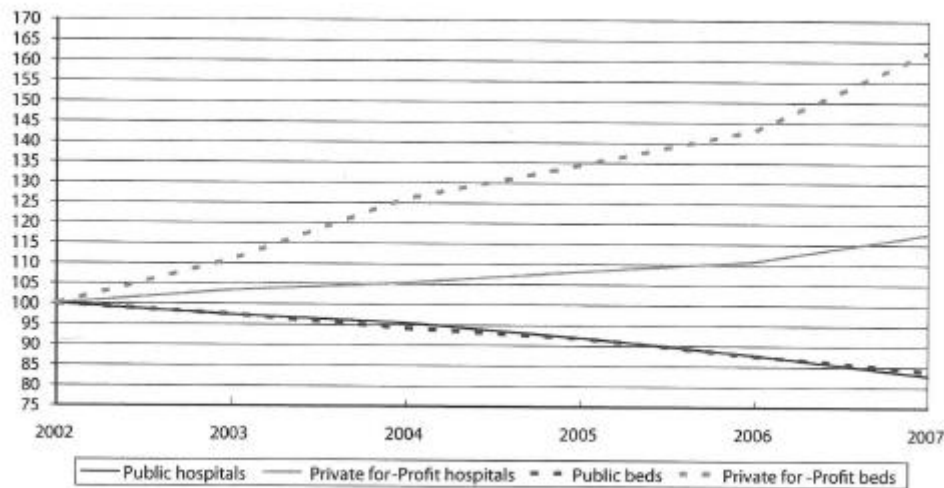
**Figure 3: Ownership structure in Germany by hospitals, beds and employees in 2007 (in per cent)**



Sources: Statistisches Bundesamt, 2008a; authors' own calculations

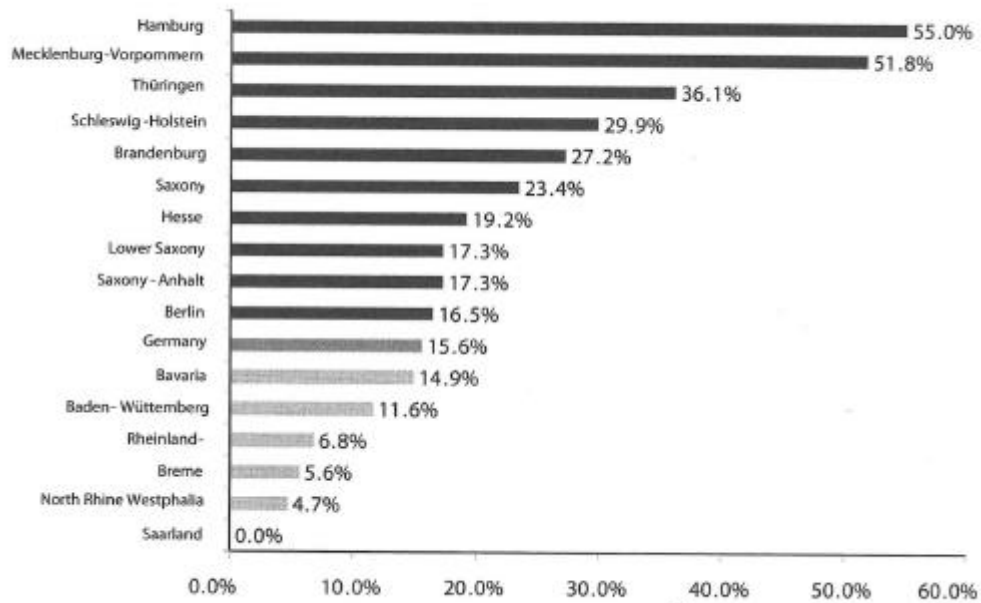
For-profit hospitals, however, have been catching up rapidly in size, especially over the past five years. While the share of private for-profit hospitals has risen by more than 20%, the share of beds in those hospitals has increased by more than 60% (see Figure 4). While the first wave of privatisation predominantly hit small clinics in the area of the former GDR, this more recent wave is affecting larger hospitals in western Germany as well. Most observers assume that this wave will continue through 2010. While the effect of the crises on local government could be eased by the economic stimulus packages of the federal government in 2009, investment from the *Länder* and income from the health insurance funds (and thus income for the hospitals) is forecast to deteriorate further (Augurzky, Budde et al, 2009). Under these circumstances private hospital chains will offer to intervene as investors, and policy makers will find it difficult to reject their offers.

**Figure 4: Change of the number of hospitals and beds under different ownership since 2002**



Sources: Statistisches Bundesamt, 2008a; authors' own calculations

**Figure 5: Market share of private hospitals in beds in the federal states in 2007**



Source: Statistisches Bundesamt, 2008a

The trends described above proceeded unevenly in different *Länder*. In the “new” states in eastern Germany, the share of private for-profit hospitals is relatively high, partly due to privatisation and partly due to a weaker tradition of church-run provision. In addition, the share of private hospitals is especially high in western *Länder* where especially large privatisations have taken place. Hamburg does not have any public hospitals besides the university hospital and Hessen has privatised two of its three university hospitals. However, generally the share of private for-profit provision in large western *Länder* is significantly lower than average.

### **Oligopolisation of the hospital sector**

The privatisation of hospitals has led to the rapid growth of a few hospital chains. The German hospital market is dominated by four major companies. Two of them are the largest hospital companies in terms of revenue and three in terms of employees. The companies are the Rhön Kliniken AG, the Helios-Kliniken-Group, the Asklepios Kliniken GmbH and the Sana Kliniken AG.

The major German hospital companies are former family businesses that were founded and dominated by individual physicians. The only exception is the Sana Kliniken AG, which is run by a group of private insurance companies. The founders of Asklepios, Rhön and Helios play a major role in the management of these companies. Recently, this has changed a little due to the purchase of Helios by Fresenius SE in 2005 and the withdrawal of the founder of Asklepios in early 2008.

Overall, the basic structure of the German for-profit hospital landscape remains stable. Attempts from private equity funds to enter the market, like the British firm APAX’s bid via the Swedish health-care company Capio, remain exceptional. However, the resale of private hospitals to other private companies and private equity funds will probably increase over the next years (Schmidt, 2003; Bähr, Fuchs et al., 2006). The largest private hospital owners in other countries are more closely tied to financial markets (Stumpfögger, 2007) and the need for massive investment may undermine the governance practices of these companies.

**Table 4: Germany's large for-profit chains**

	Hospitals	Employees	Turnover (in Mio. €)	EBIT* (in Mio. €)
Germany				
Rhön-Kliniken AG	45	26,887	2,025	157.5
Helios Kliniken Group (Fresenius SE)	56	30,043	1,841	162.2
Asklepios Kliniken GmbH (2006)	72	36,000	1,649	69
Sana Kliniken AG	33	16,338	946	49.9
Europe				
Générale de Santé (France)	196	22,900	1,651	ca.160**
Capio (Sweden)	100	14,150	1,229	no info.

\* EBIT = Earnings before interests and taxes

\*\* The numbers for Générale de Santé are projections based on data for the first half-year (81.3 Mio €) in 2007.

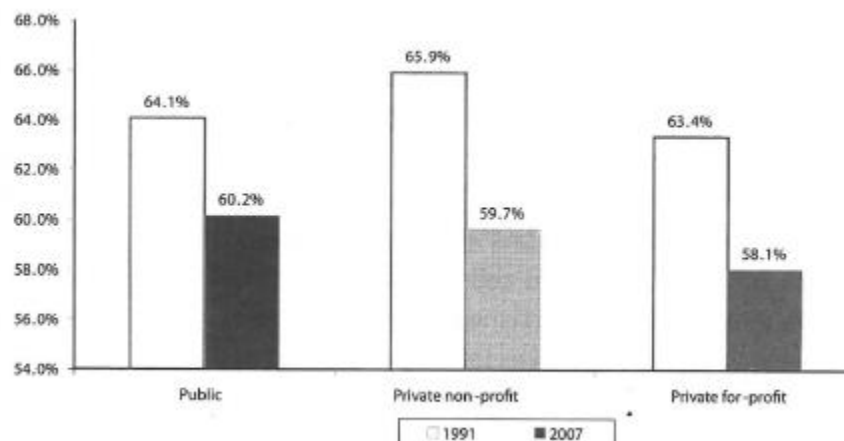
Sources: Stumpfögger, 2007; Handelsblatt on 10/10/2008; annual reports of the companies

### Competition on labour costs instead of quality

The competition that was created with the abolition of full-cost recovery and the implementation of the DRG-System has been further intensified due to the increasing importance of the private hospital companies. Besides paying for the operating costs and investments in their hospitals, private companies have to generate a profit for their owners. Since the DRG-system provides only limited scope for hospitals to influence their income, profit has to result from cost reductions.

According to the federal statistics office, the share of personnel (labour) costs in 2007 was 61.6% (2008b). For managers, labour costs are an obvious source of potential savings, and there are several possible ways to reduce them. The major hospitals (those with more than 500 beds) have reduced their share of labour costs since the early 1990s regardless of their ownership. However, the largest reduction has happened in private for-profit hospitals (see Figure 6).

**Figure 6: Share of labour costs in hospitals with more than 500 beds in 2007**



Sources: Statistisches Bundesamt, 1993; Statistisches Bundesamt, 2008b; authors' own calculations



Table 5 shows the collective bargaining landscape in German hospitals. Private for-profit hospitals derive major cost advantages from signing collective agreements at the level of the hospital, if they sign any agreement at all (Augurzky, Beivers et al., 2009). Usually, immediately after the privatisation, private for-profit companies try to reach a new collective agreement (Gröschl-Bahr and Stumpfögger, 2008) and break away from the federal collective agreement for public services (TVöD) that is perceived as “too inflexible” (Neubauer and Beivers, 2006). Hence, 85.7% of the employees of public hospitals (excluding physicians) are getting paid according to the federal agreements, compared to just 14.1% of their colleagues in private for-profit ones. In the latter, 20.3% have a collective agreement at the hospital level and 24% do not have a collective agreement at all.

**Table 5: Collective bargaining coverage**

	Public	Private non-profit	Private for-profit
Federal collective agreement for public services (TVöD/TV L)	85.7%	8.1%	14.1%
Collective agreements on company level	3.1%	-	20.3%
Other collective agreements	10.7%	17.3%	41.6%*
Special regulations for church-run hospitals	-	73.6%	-
No collective agreement	0.5%	1.0%	24.0%

\* Includes the collective agreement with the CGB-member DHV.

Source: Blum, Offermanns et al., 2007

The largest group of employees in the private for-profit hospital companies have a collective agreement signed by the Bundesverband Deutscher Privatkliniken (BDPK - Federal association of German private hospitals) and the Deutschen Handels-und Industrieangestellten-Verband (DHV). The latter is a member of the Christian federation of trade unions (CGB) that opposes the German federation of trade unions (DGB) and signs agreements more closely aligned with the demands of the employers. In many other for-profit hospitals, there is a framework collective agreement that may cover certain terms and conditions of employment, but does not cover salaries. Thus the real proportion of employees in private for-profit hospitals that do not receive a wage that is secured by collective agreements is higher than the numbers in Table 6 suggest.

The erosion of collective bargaining is one trend that may be reversing itself. Over the past few years, public-sector trade union Ver.di has been quite successful in reaching collective agreements with the major hospital chains that contain wages, similar to the federal collective agreement for public services (Gröschl-Bahr and Stumpfögger, 2008). According to the Association of German Hospitals (DKG), about nine per cent of hospitals have signed so called “emergency collective agreements” that allow a temporary reduction of wages by ten per cent (Blum, Offermanns et al., 2007). The majority of those hospitals, however, are public and the purpose of these clauses is to keep them under the TVöD.

The reduction of costs is an important objective of outsourcing, and the reduction or freezing of wages is the usual result. Outsourcing usually leads to a situation where employees either have no collective agreements or significantly worse agreements than before. In particular the workers with assignments that are not directly linked to the patients often have to accept worse agreements than their colleagues (Jaehrling, 2007). According to internal union sources, cleaning personnel for example usually drop to the minimum wage for their sector, which is about 30% lower than the respective wage in the TVöD. Employees of the temporary work agencies established by some private and public hospitals are also paid significantly lower wages. This division of the workforce seems to harm the position of the core staff as well.

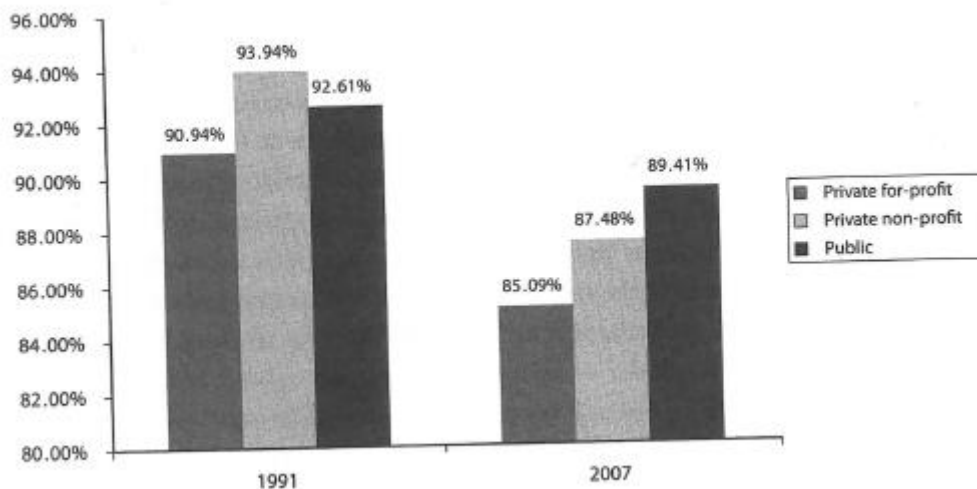
Table 6 shows how privatisation has affected the pay of various occupational groups. In 2007 the average cost per full-time-equivalent in private for-profit hospitals was four per cent lower than in public hospitals. Hence there is not just a lower share of the workers secured by collective agreement but a general wage drift. Wages of doctors in private for-profit hospitals are slightly higher, while those of employees in technical, functional and special services are much lower. The wages of nurses, the largest group of hospital workers, are nine per cent higher in public hospitals.

	In euro			Personnel costs of the private for-profit hospitals in % of the public hospitals
	Public	Private non-profit	Private for-profit	
Physicians	89,926	91,213	91,217	101
Administrative services	48,195	47,827	48,203	100
Clinical personal	30,192	29,059	28,847	96
Med.-techn. Services	45,684	45,123	43,451	95
Supply services	35,585	35,107	33,493	94
Techn. Services	46,540	47,436	42,753	92
Functional services	47,868	47,074	43,494	91
Nursing services	47,746	46,163	43,628	91
Special services	54,481	51,998	45,951	84
<b>Total</b>	<b>53,401</b>	<b>52,769</b>	<b>51,272</b>	<b>96</b>

Sources: Statistisches Bundesamt, 2008a; Statistisches Bundesamt, 2008b; authors' own calculations

These changes have widened pay inequalities between occupational groups, with nurses and medical technical staff hit especially hard. As Figure 7 shows, the average wage of a nurse in a private hospital was just 85.1% that of all employees, down from 90% in 1991. This trend has been much slower in public hospitals, where the average wage of a nurse in relation to the overall average dropped from 92.6% to 89.4%.

Figure 7: Nurses' pay in relation to the average wages of all employees



Source: Statistisches Bundesamt, 1993; Statistisches Bundesamt, 2008b; authors' own calculations

to 89.4%. Generally, nurses in private for-profit hospitals earn just 91.4% of the wages earned by their colleagues in public hospitals (Statistisches Bundesamt, 2008b).

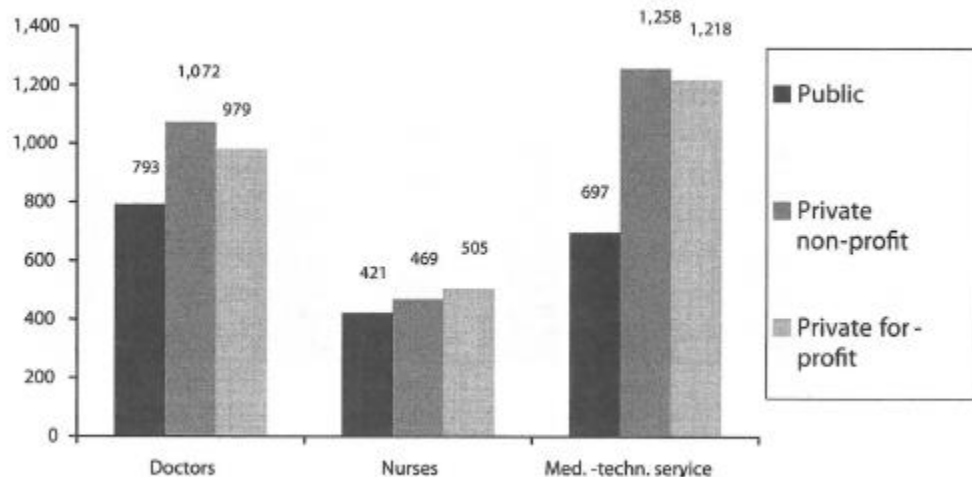
### Effects on working conditions

Competition on the basis of labour costs does not only take place through downward pressures on wages. According to trade unionists and works council members, the intensification of work has also increased at private hospitals. This has negative effects on both employees and patients. One major indicator, the ratio of number of patients to the number of staff, has deteriorated sharply (Ver.di Vertrauensleute und Vorsitzende und Mitglieder von Konzernbetriebsräten und Konzern-Jugend- und Auszubildenden-Vertretungen privater Krankenhauskonzern, 2008).

Compared with the public hospitals, the staff-to-patient ratio is especially low in private for-profit hospitals. According to the federal statistics office, the number of occupied beds that one member of staff had to look after is considerably higher than in public hospitals. This applied across all professional groups (see Figure 8).

Since small hospitals cannot be compared with larger hospitals (they offer different services that require different personnel), here we compare only hospitals with more than 500 beds. In 2007, in a private for-profit hospital a physician had to care for almost 25% more occupied beds than his colleague in a public hospital. Each nurse in private for-profit hospitals had to care for more occupied beds as well and this discrepancy was even greater in medical- technical services (Statistisches Bundesamt, 2008a).

**Figure 8: Occupied beds in days per full-time-equivalent in hospitals with more than 500 beds**



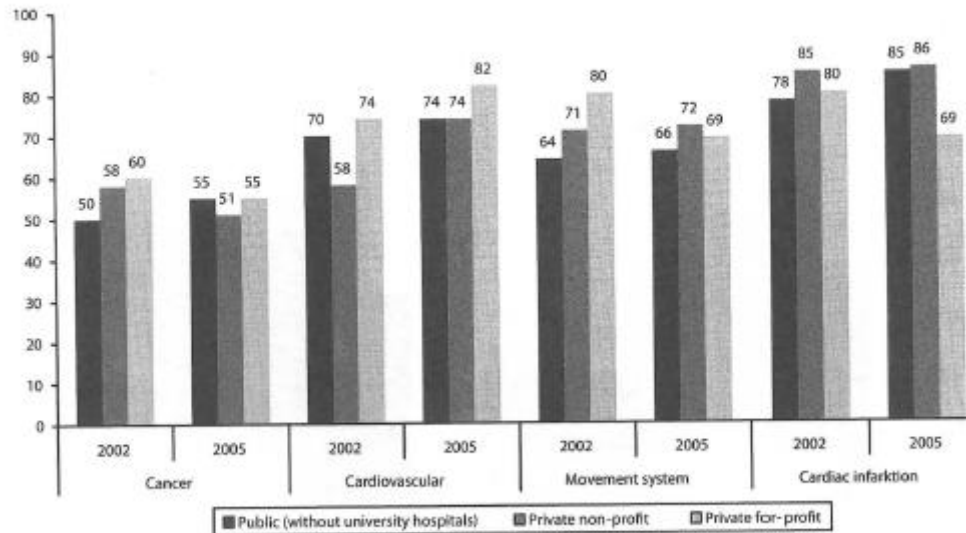
Sources: Statistisches Bundesamt, 2008a; authors' own calculations

### Effects on the quality of care

The hospital sector is facing a politically driven imperative to economise that is self-reinforcing and self-amplifying. Numerous international studies indicate that the quality of care is declining, with a decreasing number of personnel and a focus on economic success. In the USA, for example, there is a clear correlation between mortality rate and ownership. In for-profit hospitals it is higher than in non-profit hospitals (Devereaux et al., 2002). According to a recent study by the Harvard School of Public Health, patients surveyed assessed all quality criteria to be worse in private for-profit hospitals (Jha, Orav et al., 2008). These studies suggest a strong correlation between patient satisfaction and the number of nurses.

There are no German empirical studies on the effect of lower staff-to-patient ratios on the quality of care that compare private and public hospitals. However, there are surveys by the statutory insurance funds that indicate a worse quality of care for their customers in private hospitals (Braun and Müller, 2006). The major complaint was that patients were discharged home too early. Compared to an earlier

**Figure 9: Improvement or cure of diseases according to the patients in %**



Source: Braun and Müller, 2006

survey in 2002 this sentiment has increased in public hospitals as well, but at a lower level. Overall, the perception of the quality of treatment was worse in private for-profit hospitals than their public-sector counterparts. However, the private non-profit hospitals received the best results.

Regarding the results of treatment, patients in public hospitals have seen an improvement in their hospitals in all the main disease categories. All of these statements indicate obvious trends. Especially compared with the survey in 2002, the experiences in private for-profit hospitals show a similar tendency. However, in three out of four diagnoses, patients in private for-profit hospitals claimed lower rates of improvement and healing than in 2002. Unlike public and non-profit hospitals, private for-profit hospitals have seen a deterioration and it is probable that higher work intensity is one reason (see Figure 9).

### The future of German hospitals

Against a background of financial and economic crisis, most observers expect further waves of privatisation over the next few years. The negative effect of the crisis for the hospital sector has been buffered by the federal government's economic stimulus packages. However, in 2010 the situation in most hospitals will probably become worse (Augurzky, Beivers et al., 2009). The fiscal problems of the state and local governments will make it less and less likely that they will finance deficits or increase investment in public hospitals. For the major private hospital chains, this represents a major opportunity for future acquisitions. Rhön-Kliniken AG, for example, has decided to raise €500m in capital to buy more hospitals (*Handelsblatt*, 5 July 2009).

However, there is broad public scepticism about the trend toward privatisation. In a 2008 survey, 63 per cent of the population thought that hospitals should be public and just six per cent thought all hospitals should be private (DBB, 2008). Already, there have been several cases of mass protests against hospital privatisation, some of which involved ballot initiatives for a referendum (Mittendorf, 2008). Some of these have helped to prevent the purchase; and usually when the referendum was unsuccessful it was for procedural reasons, not because

a majority of the population voted in favour of the privatisation. Most of these initiatives have included a broad alliance of trade unions, physicians, social movement organisations, local politicians and local organisations (Böhlke, Greer and Schulten, 2009). There is little reason to believe that this protest will abate any time soon.

In the upcoming debate, the main question will be whether marketisation and the introduction of competition are appropriate means to organise health care. Despite the problems described above, the federal association of private hospitals (BDPK) does not hesitate to demand even more cost-cutting, since the hospital sector has become a lucrative business. They have continued to ask for more deregulation, including the abolition of hospital planning by the *Länder* (BDPK, 2007).

Because of price setting and other regulations, it is still the case that the hospital sector in Germany is not a free market (Bruckenberg, Klaue et al, 2006). It is obvious that a "hospital market" differs from classic markets in several ways that make a purely capitalistic organisation impossible. Health is existential and cannot be abandoned or boycotted. The "customer" cannot withdraw from a service that does not satisfy his or her needs or autonomously decide which service is necessary. There are thus asymmetries of power and information between patients and health-care professionals. As a collective good, health-care provision is a basic right for every person that in many countries may not be withheld from anyone; in Germany this right is grounded in article 2, section 2 of the Basic Law. For these reasons, health systems are regulated relatively strictly (Deppe, 2002).

High-quality hospital care costs money, which in Germany comes from taxes and insurance contributions. Due to the way the industry is structured, corporate hospital profits are not accumulated due to the workings of a free market but rather extracted from society using political processes of reforms. The German Association of Community Hospitals (IVKK) has argued along these lines and added that in health care profits are an extra cost with little or no benefit, and should therefore be abolished (IVKK, 2008).

Private hospital chains have two main advantages in the German healthcare industry as it is currently structured. First, they have significantly lower personnel costs and a more intense exploitation of employees. Private for-profit hospitals pay below the collective agreement and have lower staff-to-patient ratios. It is the task of trade unions to fight for equal conditions across the sector. Second, because private for-profit hospitals receive pure investment, they enjoy advantages in terms of productivity. It is the responsibility of the public authorities to increase the level of investments in the public sector to counterbalance this structural disadvantage.

The advantages enjoyed by private for-profit hospitals reflect failures of public policy that have produced a shift of power to private owners. For many social and economic reasons (Weizsäcker, Orav et al, 2005), trade unions, civil society and political parties on the left should, and will, continue to resist the trend toward privatisation.

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