

# **The organizational-institutional transformation of the German Healthcare System: mixing rescaling, privatization, and managerialism**

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## **1. Introduction**

Since the early 1990s, European public health care systems experience dynamic transformation processes. Health care systems have come under the pressure of strong financial constraints, indicating the end of the “golden age” of welfare state policy. Thus, the most important issue at hand is cost control. Various tools have been employed in order to contain rising costs. The broad range of different reform measures can be categorized into three major reform types, namely privatisation, managerialization and rescaling, e.g. the reshaping of the distribution of decision-making authority. In all European health care systems – albeit in different forms and with differing degrees – market mechanisms have been implemented in health care financing as well as in health care provision. Moreover, the upcoming of New Public Management ideas left the health care sector not unaffected, as the notion of ‘managed care’ or the development of sickness funds from bureaucratic ‘payers’ to businesslike competing ‘players’ clearly shows. Finally, decision-making structures have been reorganised in order to overcome reform-obstacles and allow for change.

Germany constitutes no exception in this transformation process – although belonging to the ‘Bismarckian world’. In the literature on welfare state change the Bismarckian welfare state has often been assessed as a ‘frozen landscape’, incapable to implement far reaching regulatory changes: Recent research, however, has put this assumption into perspective and has shown that the Bismarckian welfare states are able to change their welfare regime by rather following an incremental strategy (Palier et al., 2010; Gerlinger, Schmucker, 2009).

In fact, the German health care system has been subject to continual reform efforts and is still subject of a fierce debate. The following case study assesses the impact of the regulatory changes on the German health care system, once considered as the ideal type of a conservative-corporatist welfare state. To start with, chapter 2 expounds what is meant by privatizing, managerializing, and rescaling public health care systems as each of the three reforms trends is a fuzzy concept, which has been understood and defined in manifold ways. While chapter 3 describes *how* privatizing, managerializing, and rescaling have altered the German health care system, chapter 4 delivers assumptions *why* change has taken place. The final chapter outlines the still open research questions.

## **2. Rescaling, Privatization, and Managerialization – Re-Organising Health Care Systems**

The following section introduces what might – after full-coverage has almost been achieved – be considered as the three most important regulatory changes, namely rescaling, privatization, and managerialization. Needless to say, that the differentiation between rescaling, privatization, and managerialization is a purely logical schematization. Governance reforms in health care have produced a great variety of instruments and techniques, which do not always fit into those categories. Moreover, various combinations and refinements of the respective types exist (see also Vrangbaeck 2007). The impact of these regulatory changes are ‘blurring borders between public and private’ (Rothgang et al. 2008) in health care governance. Indeed, the already hazy interplay between of public and private governance in the German health care sector has become blurred even more.

### **Rescaling**

Who has the power and responsibility to decide on the delivery, the financing, and the planning of health services? Over the past decades this question has been answered in Europe in manifold ways. In the post-war period it has been part of the ‘received wisdom’ that a good health policy is characterized by decentralized decision-making authority (Saltman et al. 2007; Saltman 2008: 104). Decentralisation has therefore been on the political agenda, except for those countries which – like Germany – had already had a much decentralised health governance structure with many administrative, managerial, and fiscal decisions delegated to private not-for-profit bodies. With the turn of century, however, this commonly shared believe has been challenged and key functions of health care systems have been centralised, in Germany as well as in other European countries. The renunciation of the idea of decentralisation was driven, as the chapter below will show, from budgetary, legitimacy, as well as from power issues.

Processes of de- and recentralisation in European public health care systems can be described as subsequent ‘reform waves’ (Saltman 2008). This notion, however, should not conceal that these regulative changes entail a broad range of different measures, which are, moreover, related to different parts of the health care system. Decentralisation and centralisation are best understood when considered as the endpoints of a continuum. Slightly altering Vrangbaek’s definition (2007: 45) this paper defines rescaling as the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services either from a higher to a lower level of government or administration, or reverse. Measuring the degree of (de)centralisation requires – amongst others – to take into consideration the scope of decision-making, the provided resources, and – probably most important – the degree of control from higher level.

### **Privatization**

The second major regulatory change, privatisation, has run simultaneously with decentralisation since the late 1980s (Saltman 2008: 104). Some analytical frameworks, such as the seminal one of Rondinelli (1983), consider privatization as a particular form of decentralisation, which is the transfer of authority and power from public to private ownership. This perception, however, is highly contested (Collins, Green, 1994) – for good reasons: Privatization itself can have many faces and can therefore be better understood when treated separately (Collyer 2003; OECD 2003). Contrary to Rondinelli’s framework, this paper distinguishes between a power shift from the public to the private sector and a power shift from the centre to the periphery or reverse (which, by the way, can occur in both the public and the private sphere).

As in the case of ‘decentralisation’ there are considerable differences in the meanings attributed to the term ‘privatization’. Early studies on privatization have depicted privatization as a question of who *owns* assets and have defined privatizing as the sale of public assets. Newer studies on privatization, however, have replaced the narrow understanding of privatization with a wide definition that encapsulates a broad range of different practices. Shifting the balance of the public–private mix towards more private action can encompass different instruments such as *formal* privatisation, where the public authority remains the most important or complete owner of the service, but the supply is taken care of in private structures and legal frameworks, or *material* privatisation, in which case the majority or even entire ownership is transferred from public authorities to private institutions. *Functional* privatisation, a third instrument, is a comparatively new type of privatisation, which has gained in importance with the upcoming of the New Public Management paradigm. It allows public entities to receive assistance from private actors. There is a broad variety of tasks, which the public authorities can delegate to the private sector: In the health care sector this can either be the provision of diagnostic or therapeutic equipment, the construction of a new building or the even the management of the whole hospital. Functional privatisation is based on instruments such as contracting or out-sourcing, or private funding of public services. In some social policy approaches next to formal, material, and functional privatization a fourth type of privatisation is differentiated, namely the risk shift from the whole society/insurance risk pool to the sole individual. Here the differentiation between marketising systems and marketising individuals is introduced and labour market activation policies or the implementation of user fees are included in the privatisation typology (Burchardt 1997; Leisering 2010).

#### *Dimensions of privatisation in social policy*

| <b>Dimension</b>   | <b>Possible instruments</b>   |
|--|---|
| Welfare organization<br>(health insurance funds,<br>hospitals, etc.) | Material privatization (private company, shares held by private actors)               |
|  | Partial privatization (through the formation of private subcompanies)                 |
|  | Formal privatization (state company, shares held by the state)                        |
|  | Functional privatization (contracting out, sourcing out, public-private partnerships) |
| Individuals (patient, insured)                                       | User fees, activation policies, private pensions                                      |

### **Managerialism**

(New) Managerialism or New Public Management as a management style has been spread throughout public sector organisations in Anglo-Saxon countries since the 1980s (Pollitt 1993). Germany to the contrary did not open up to NPM-ideas before the early 1990s (Wollmann 1999, Mattei 2009). With regard to NPM reforms, Germany was late-comer – partly because of the German reunification, partly, however, because many of the NPM ideas were already at place in the traditional German welfare governance. A purchaser-provider split, decentralised governance or a sound welfare mix were known from the very beginning of health policy in Germany. Nonetheless, a shift from the welfare state to the managerial state has been identified in the late 1990s, becoming obvious not only in health care, but also in unemployment and pension policies (Rüb 2004).

Managerialism can – to put it simple – be defined as the pursuit of maximum output with minimal input. Managerialism is rooted in economic values: efficiency, cost-effectiveness, competition, entrepreneurship, and progress are the central norms. Managerializing public institutions therefore implies almost always making them more ‘business like’. Managerialism in practice can be

described as a specific organizational arrangement, which heavily relies on the tools and techniques of management science. The classical management cycle consists of the following key-elements: defining objectives, developing and implementing measures, evaluating and improving the measures. Clearly defined and measurable goals as well as standardized practises to reach these goals are crucial as only these allow for critical evaluation. Target-performance comparisons are employed to ensure effectiveness; input-output comparisons are applied to ensure efficiency (Maier et al 2009; Rüb 2004; Edwards 1998).

The managerial ideal is neutral competence which is opposed to ideology and politization. Critics on the 'managerial state', however, denounce the NPM paradigm itself as a ideology (Clark/Newman 1997), as a "seldom-tested assumption that better management will prove an effective solvent for a wide range of economic and social ills" (Pollitt 1993: 1). In fact, one of the main arguments against managerialized public institutions is the threat of depolitization and its negative impacts on democratic accountability. As managerialization goes hand in hand with decentralisation and an increased importance of private actors – here the linkage to the other two reform trends becomes obvious – it may undermine or at least impede political control. Moreover, the New Public Management's faith on scientific management and evidence based management can on the other side of the coin be considered as a profound mistrust in professional self-governance. It undermines, as we will see in the case of hospitals, the professional autonomy of physicians and questions traditional power relations. Finally, with its emphasis on results and outcomes managerialism threatens other components of welfare governance such as participation, member orientation, or voluntarism. Especially in voluntary organizations the introduction of NPM is therefore critically discussed since a trade off between managerialism and voluntarism is expected (Kreutzer/Jäger 2010). This threat, however, should also concern semi-autonomous public institutions such as health insurances or hospitals since their organizational governance structure comprises components like self-administration or the idea of patient participation. Therefore new managerialism can be used by central actors in order to strengthen control over previous autonomous or semi-autonomous actors. It is also possible to consider new managerial actors as an emerging group which play a growing role not only in the implementation of governance reforms but also in the elaboration of reform proposals.

### **3. Reorganising the German Healthcare System – Relief from the Bismarckian Legacy?**

Until recently, Germany has been considered to be the idealtyp of a conservative-corporatist social insurance state (Gerlinger, Schmucker, 2009; Bandelow 2009; Hinrichs 2010). The statutory health insurance funds, which are in the centre of the health care system, insure the main part of the population. Only self-employed, civil servants, and employees with an income above a certain ceiling are allowed to opt out and choose private health coverage. The revenue of the statutory health insurance funds stems mainly from payroll contributions. In line with the idea of 'social partnership', which shapes the industrial relations in Germany, the insured and the employers have for a long time shouldered equal contribution shares. In 2004, however, regulatory changes implemented with the Health Insurance Modernization Act have broken with this general rule (see below).

The German health care system is characterized by a purchaser-provider split. The governance of both financing and health care provision is marked by a strong element of self-regulation. The health insurance funds are organised as statutory corporations under public law: They design their own statutes, and the agency head is appointed by a board consisting of representatives of the employers and the insured. The board members are – as a general rule – elected by the insured and the employers respectively.

With regard to health care provision, there is a strong division between inpatient and outpatient care. In the outpatient sector the *Kassenärztliche Vereinigung*, the mandatory associations of statutory health insurance physicians, is the most important actor and negotiates with the (associations of the) health insurance funds in 'joint self-governance' (*gemeinsamer Selbstverwaltung*). In the inpatient sector self-governing committees are known, too. As the states (*Länder*) are not only heavily involved in hospital financing, but take part in negotiations between purchasers and providers too, the idea of self-governance is in the inpatient sector less pronounced.

The idea of self-governance, however, does not mean freedom from state interference. Despite its fragmented governance structure and a high number of self-governing bodies, German healthcare policy has always been highly regulated by the central government. The policy autonomy of the self-governing bodies remains low: Due to the objective of maintaining equal living conditions embodied in the German constitution, decisions on entitlements and benefit levels of the health insurance funds are for instance made by the federal government. And – as we will see in the following chapters – in the background of cost control efforts the competences of the health insurance funds got restricted even more.

The German health care governance reform trend has started in the late 1980's, early 1990's with the introduction and intensification of competition between sickness funds. The continuity from the Health Care Structure Act in 1992 to the Competition Strengthening Act in 2007 is obvious. The other main reforms of 1997 (Health Insurance Reorganization Act) and 2004 (Health Insurance Modernization Act) also tackle the issue of competition. Therefore our first question is how far have the competition reforms, which mainly concern outpatient care, led to rescaling, privatization and managerialization of the German health insurance system. Then we will analyze the same dimensions for in-patient care.

### **3.1 Health Insurance Funds and outpatient care: the multiple dimensions of competition**

The 1992 Health Care Structure Act (*Gesundheitsstrukturreformgesetz-GSG*) was intended to progressively introduce competition among public health insurance funds – the *Krankenkassen* or 'sickness funds' – by giving statutory insured individuals a free choice among them. As services were not allowed to differ beyond legislatively defined limits, competition for members was based on the level of contribution rate in order to fulfill the main goal of the reform: the stabilization of the contribution rate level (which differed a lot between funds before the reform). At first glance competition leads to decentralization and privatization, but the present health insurance landscape can be more accurately characterized by managerialism and centralization.

#### **3.1.1 Competition and decentralization**

Before the 1992 Reform the statutory health insurance system was already highly decentralized. The over than 1200 sickness funds were mainly organized at the local level (this was especially the case for the local overall sickness funds -AOK- which insured more than 50% of the German population) and enjoyed great autonomy for fixing the level of their contribution rates and for the negotiations with the statutory health insurance physicians organizations (the so-called doctors' unions). This is why in 1992 decentralization was neither an issue nor a goal of the reform. This situation changed with the 2004 Health Insurance Modernization Act (*GKV-Modernisierungsgesetz*) which stimulated, with monetary incentives, the transformation of sickness funds into health care purchasers, enabling them to differentiate the range of services available to their enrollees by selective contracting with networks of local providers and by developing prevention or disease

management programs.<sup>1</sup> The 2007 law reinforced the possibilities given to sickness funds to conclude special agreements with individual doctors or groups of doctors (i.e. not with the statutory doctors' unions) especially concerning integrated care. At the end of 2008 about 6000 contracts in the field of integrated care were signed (Bandelow, 2009: 49). The main outcome of these new contracting possibilities is the growing territorial differentiation of outpatient care depending on different developments of governance patterns and actor constellations within the German *Länder* (Bandelow, 2009: 59). Even if collective agreements with the statutory health insurance physicians still regulate an overwhelming proportion of outpatient care the trend towards the erosion of uniform arrangements is obvious (Gerlinger, Schmucker, 2009: 8).

### 3.1.2 *Competition and privatization*

The link between competition and privatization is not so obvious as it seems to be at first glance. The first reason is that private insurance companies, which insure nowadays around 10% of the German population, are not included in the new competition framework in health care. Competition was introduced between statutory sickness funds but not between them and private insurance companies. Only people earning more than ca. 4000 € monthly, civil servants and self employed people can choose a private insurance instead of a public sickness fund. Even more the private health insurance has been more controlled and regulated with the obligation to implement elements of solidarity and consumer protection. The creation of a basic tariff in 2007, the limitation of premium costs, new rules for cancellation, transferability of old-age provision and the restriction to the freedom of concluding new contracts can be seen as a demarketization process in the private health insurance sector (Böckmann 2009).

The second reason is that privatization has several meanings and dimensions as we explained in point 2. No material or formal privatization has occurred, but privatization level with the growth of user fees can be noticed. This trend begun with the 1988 Health care reform Act, which introduced patients co-payments for pharmaceuticals, hospital inpatient stays, physical therapy and spa cures. It was pursued in 1997 (but the main measures were withdrawn shortly after the change of government in 1998). The privatization of sickness risk coverage has again been more visible since 2004. The Modernisation Act increased the level of co-payment and created a fee of 10 € per trimester and per pathology for certain visits to specialists (if not following a family doctors consultation). Moreover, a voluntary private health insurance is now supposed to cover teeth prostheses, and some benefits are not covered anymore like thermal cure, drugs without prescriptions, sterilizations, medical transports, dental prosthesis and glasses. However, individual health expenses were limited to 2% of annual revenue (1% in the case of chronic sickness). The latest step towards privatization of health risks is directly linked to competition: the 2007 Act allowed sickness funds with financial difficulties to ask their members an extra "health-premium" not exceeding 1% of the annual revenue. Therefore the private share of treatment costs raised from 4.4 percent of total treatment costs in the beginning of the 1990's to more than 10 percent (Gerlinger, 2010: 119).<sup>2</sup>

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<sup>1</sup> The Health Insurance Reorganization Act in 1997 and the „Reform 2000“ already introduced the possibility of pilot projects and of new contracts options for sickness funds in order to improve the cooperation between primary care and inpatient services. But the results were rather limited and disappointing (Bandelow 2009: 48).

<sup>2</sup> In July 2010 the conservative-liberal coalition agreed on a reform proposal which will increase the private share of treatment costs even further. The draft law will be discussed in the German federal cabinet in autumn 2010; the law is expected to become effective in 2011. According to the reform proposal premiums will raise from current 14.9 to 15.5 percent of workers' gross pay. Employers will contribute 7.3 percent while employees contributed the rest 8.2 percent. Moreover, the cap for insurers to charge their clients for extra fees (which is currently set at 8 € per month) will be lifted. The Health Minister Philipp Rösler announced compensation for hardship (via the tax system), the details of the hardship provision, however, are to be decided (<http://www.bmg.bund.de>).

### 3.1.3 *Competition and managerialization*

The introduction of competition in the health insurance system went along with reforms of the internal governance structure of the health insurance funds. To ensure that insurance funds would be as competitive as private companies, their internal organizational structures were to be adapted to those of private companies, as outlined in the rationale of the act: The executive board was therefore professionalized and strengthened by enhancing its autonomy from the board of representatives.

Together with the professionalization of the CEOs of the funds, the number of lay members of the board was reduced, and their main tasks – controlling and advising the executive board rather than intervention in everyday business – were clarified (Felix 2001; Fuchs 1994; Oldiges 1994). The idea was to organize the internal governance of funds as a countervailing system of managers and stakeholders. This idea, however, failed. Although the necessity of clear competencies and further training for the lay members of the board has been considerably stressed in reform discussions, the government has so far not made serious efforts to improve the working conditions of the lay board members by offering special qualification modules or clarifying information and control clauses (Kirch 2006; Paquet 2006). With the executive board becoming more and more professionalized, the maladjustment between executive and advisory board grew: the advisory board with its lay members is in most cases not able to exert effective control.

The effect of both marketisation and managerialization was a functional organizational change of health insurance funds: they developed from ‘payers to players’ (Bode, 2006), adopting practices derived from private business. They more and more conceive their organizations as market players competing for new clients and as enterprises facing business partners and customers. Sickness funds offer special advantages to their members, especially after the 2004 reform which opened up the possibility for sickness funds to design insurance policies more flexibly: with counseling, health checks, packages with complementary insurance, reductions on contributions for enrollee’s participation in health improving activities, refunding of contributions in case of non consumption of reimbursed services health insurance funds make every conceivable effort to improve customer satisfaction and service quality.

### 3.1.4 *Competition and centralization*

Competition between statutory sickness funds was not only thought as a tool to stabilize the contribution level but also as a way to reduce the discrepancy between the contribution rates of the different funds. Those two goals led to a growing centralization of the health insurance system.

First price competition incited funds to merge and slim down their administrative staff in order to reduce their costs. Between 1993 and 2010, the number of health insurance funds has dramatically diminished from more than 1200 to 169. The overall local sickness funds (AOK) were replaced by regional sickness funds at the *Länder* level.

Second the 1992 Act also introduced compensation rules between sickness funds – the so-called *Risikostrukturausgleich* – which helped to reduce the differences between contribution levels. The last step is, with the 2007 reform, the creation of the Health Fund (*Gesundheitsfonds*), directly linked to the federal state. Payroll contribution rates are now set in a centralized way, with a unified payroll contribution rate for every sickness fund. It means that they lost one of their main competences, which is transferred to the federal state.<sup>3</sup> The Health Fund collects the contributions and taxes financing the statutory health insurance and redistribute it to the different sickness funds following the new compensation rules of the *Risikostrukturausgleich* (taking in account not only age and gender as in the past but also morbidity criteria and the income of insured persons).

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<sup>3</sup> More precisely to the insurance office depending from the health ministry, which manages the Health Fund.

Other aspects of the reforms increased the power of federal authorities. The traditional self-administration of German health care by sickness funds and doctors' unions has progressively been eroded by the growth of state control starting in 1992 (Structural Reform Act). With this reform, the state exerts stronger control over negotiations among sickness funds and unions, as well as over the functioning of these institutions. It can intervene directly if the actors of the self-administrated system do not implement the budget caps for medical activity and prescriptions. The 1992 Act also set spending budgets for outpatient care and drugs prescription.

A further aspect of this trend is the establishment in 2004 of the *Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen* (Institute for quality and economic efficiency in health care) with wide-ranging powers to evaluate the benefit and efficiency of diagnosis and treatment methods. It expanded the weight of scientific expertise, but its autonomy is limited by the fact that it is allowed to assess diagnosis and treatment methods only at the request of the Federal Health Ministry or the Federal Joint Committee, the most important management body in the corporatist arrangements of the statutory health insurance system. Created from the merging of numerous national committees, it is responsible for the implementation of the legislation concerning ambulatory care. Its authority has been expanded to all sectors of the statutory health insurance system in 2004 and it acquired a multitude of new powers. But it is forced to fulfill its responsibilities in a more restrictive frame of action set by the Federal Ministry of Health which reduced its autonomy by professionalizing its members (but less than expected in the original plans) with the 2007 Reform. It also gave the Ministry, as the supervising authority, the right to request additional statements and information when scrutinizing directives (Gerlinger, Schmucker, 2009: 9-10). The centralization of the Federal Joint Committee and of the new federal sickness funds organization<sup>4</sup> enables more control from the Health Ministry (Bandelow, 2009: 49).

The pattern is clear: competition and the creation of new federal institutions led to a growing centralization of the regulation of the German health insurance system which can be characterized as "a transformation towards a state-domesticated competitive corporatism" (Gerlinger, 2010: 130). This trend is less obvious in the hospital sector.

### 3.2 The new governance of the inpatient sector

The inpatient sector experiences major challenges and is subject to an intensive reform discussion. A closer look at the reform discourse in the inpatient sector shows that change is induced by both purposely altered conditions by political actors and factors which lie outside the realm of politics (Schmidt/Möller 2007: 4). With regard to the latter, technical development and demographic changes are considered as the most important catalysts of a changing hospital governance. There is an ongoing trend to a cost intensive high-technology medicine, which not only profoundly changes surgical procedures, but increases healthcare costs tremendously. The increasing demand in inpatient care due to an ageing society contributes to rising healthcare costs, too. The growing demand for cost-intensive inpatient care, however, meets the increasing claim by public authorities to restrain spending.

Hospital financing in Germany is characterised by a pluralistic funding system. Contrary to the outpatient sector, taxes play an important role in hospital funding. The Hospital Financing Act of 1972 introduced a dual financing system: while health insurance funds pay for operating costs and care provision, the investment costs are financed out of taxes from state and federal level. The state governments (*Länder*) are also responsible to set up hospital plans. Only those hospitals which are approved in the hospital plan are eligible for the 'two pillar funding system' and receive tax-based subsidies from the *Länder* and revenues from the health insurance funds. Ownership,

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<sup>4</sup> A new umbrella association of all sickness funds was created in 2007. It took the main competencies of the corporate bodies of the different sickness funds types, which were downgraded to become private associations.

however, does not matter in this respect. Quite to the contrary, in line with the leitmotif of 'subsidiarity', which characterises the German welfare state from the very beginning, the Hospital Funding Act of 1972 is committed to sustain a sound welfare mix. The principle of subsidiarity, though, was above all designed to maintain the tradition of 'free' welfare associations, non-governmental and non-profit organizations delivering social services. Private for-profit hospitals, although being in theory eligible for the two-pillar-hospital system, played until recently only a negligible role in the German hospital industry.

The control of the constantly rising costs has been in the centre of hospital policy since the early 1980s. The first major structural reform, however, was not implemented before 1993. With the Health Structure reform (1992) hospital remuneration through health insurance funds has been restructured: the cost coverage principle was abolished and replaced by legally fixed budgets. In 2002 the introduction of a flat-rate payment system followed, as a second reform step. The states' governments, too, strived to curb spiralling costs. Despite intensive reform discussions, the states were not able to agree on comprehensive regulatory reforms to reorganise the system of hospital investment. Instead, the states pursue pure cost containment policies. The financial means for hospital investment decreased steadily throughout the past decade, bringing about a severe investment backlog.<sup>5</sup>

### **3.2.1 Towards centralization?**

Since almost two decades, there is an ongoing debate about how to cope with the shortcomings of the dual financing system and about how to put hospital funding on a sound financial base. One idea is to replace the dual funding system by a monistic system with the statutory health insurance as the only payer. This reform plan, however, is highly contested: the states and communities fear losing their influence on hospital governance. Up to date, the *Länder* were successful in keeping their competences for planning and funding. Most recently, they demonstrated their veto power in the *Bundesrat* (the second chamber representing the *Länder*) during the law-making procedure of the Hospital Financing Reform Act of 2009 (Böhm, 2009).

Nonetheless, there is a creeping centralisation of hospital governance to observe. The introduction of the flat-rate payment system is a shift of the responsibility for the remuneration of hospitals to the national level since the definition of the diagnosis related groups is made at the federal level and is supposed to be the same for all German hospitals (Böhm, 2009). Like the Federal Joint Committee for the outpatient sector the German Hospital Federation (the umbrella organization for hospitals) has growing responsibilities and defines jointly with the association of statutory health insurance funds the national fee schedules for stationary treatments (Gerlinger, 2010: 128-129). In the background of the growing pressure exerted by the flat-rate payment system on planning and the desire of the Health Ministry to switch to a monistic funding system, the question is how long the states can maintain their competences for planning and funding (Gerlinger, 2008).

### **3.3.2 Material, functional and formal privatization in the hospital industry**

While with respect to the rescaling of hospital governance only subtly changes are to detect, a clear trend to privatization is perfectly obvious. Both the introduction of DRGs as well as the shrinking resources for hospital investment have fostered considerable changes of the welfare mix in the hospital industry. In order to cope with increasing financial pressure, cities and local communities, which are for the most part the owners of public hospitals in Germany, have welcomed

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<sup>5</sup> In 2008, all public subsidies according to § 9 KHG (financial means for investment according to the *Krankenhausfinanzierungsgesetz* (Hospital Financing Act) amounted to 2.69 bn. EUR; this means a steady decline by -34,48 % throughout at last decade (reference year 1998, see DKG 2009).

market solutions. Hospital laws have been changed: municipalities, formerly only allowed to run their own hospitals under public law, nowadays have an enlarged scope of organizational forms: Material ('real') privatization as well as formal privatization (with the public authorities remaining the majority shareholders) and 'functional' privatization are now juridical possible (Rosenbrock/Gerlinger 2006).

Thenceforth, material privatization has developed to an important reform measure. While in 1991 only about 15% of all hospitals were private for-profit hospitals, their share has meanwhile doubled: 30.6% of all hospitals operated on a private for-profit basis in the year 2008 (see the table below).

**Table 1: Germany, hospital ownership 1991-2008**

| Year | Altogether<br>(in absolute numbers) | Thereof |                                     |                                    |           |         |
|------|-------------------------------------|---------|-------------------------------------|------------------------------------|-----------|---------|
|      |                                     | Public  | Thereof                             |                                    | Voluntary | Private |
|      |                                     |         | Public with a<br>private legal form | Public with a<br>public legal form |           |         |
| 1991 | 2 411                               | 1 110   | -                                   | -                                  | 943       | 358     |
| 1992 | 2 381                               | 1 062   | -                                   | -                                  | 950       | 369     |
| 1993 | 2 354                               | 1 023   | -                                   | -                                  | 950       | 381     |
| 1994 | 2 337                               | 987     | -                                   | -                                  | 949       | 401     |
| 1995 | 2 325                               | 972     | -                                   | -                                  | 944       | 409     |
| 1996 | 2 269                               | 933     | -                                   | -                                  | 929       | 407     |
| 1997 | 2 258                               | 919     | -                                   | -                                  | 919       | 420     |
| 1998 | 2 263                               | 890     | -                                   | -                                  | 920       | 453     |
| 1999 | 2 252                               | 854     | -                                   | -                                  | 930       | 468     |
| 2000 | 2 242                               | 844     | -                                   | -                                  | 912       | 486     |
| 2001 | 2 240                               | 825     | -                                   | -                                  | 903       | 512     |
| 2002 | 2 221                               | 817     | 231                                 | 586                                | 877       | 527     |
| 2003 | 2 197                               | 796     | 245                                 | 551                                | 856       | 545     |
| 2004 | 2 166                               | 780     | 287                                 | 493                                | 831       | 555     |
| 2005 | 2 139                               | 751     | 332                                 | 419                                | 818       | 570     |
| 2006 | 2 104                               | 717     | 367                                 | 350                                | 803       | 584     |
| 2007 | 2 087                               | 677     | 380                                 | 297                                | 790       | 620     |
| 2008 | 2 083                               | 665     | 384                                 | 281                                | 781       | 637     |

Source: Statistisches Bundesamt 2008

Next to purchase hospitals completely, new forms of public-private partnerships have evolved. An example for 'functional privatization' is the trend to contract out the management of public hospitals to private companies. Some private hospitals such as the Sana Kliniken GmbH have specialised in this kind of business. They offer public owners "encompassing services for all non-medical tasks in a hospital" (<http://www.sana.de/wir-ueber-uns/unser-unternehmen.html>) and run public hospitals on the base of a management contract. Unfortunately, empirical data to assess both the range of functional privatization and its impact on health care performance lack entirely and research is needed (Mosebach 2009).

In the case of formal privatization, finally, *private* law is used to re-organize *public* services. The legal form of a hospital is changed, but public authorities remain nonetheless the majority shareholders. In the past years, the share of public hospitals run under private law has risen significantly: In 2008, 57.7 % of all public hospitals operated under private law (Statistisches Bundesamt Deutschland 2008). Formal privatization gives hospitals their own legal personality and as a result

a greater autonomy in day-to-day operations. Moreover, formal privatization allows for 'de-administration', e.g. the replacement of bureaucratic organizational structures with a more commercial management. Thus, managerialism and entrepreneurial leadership occurs not only in private for-profit hospitals, but also in (functionally and formally privatized) public hospitals, as we will see in the following section in more detail.

### 3.2.3 Managerialization of hospital governance

The managerialization of organizational hospital governance has been pressed ahead in particular with the introduction of DRGs. The reorganisation in the wake of the introduction of DRGs goes far beyond the introduction of new hospital reimbursement practices. While hospital reimbursement under the 'old' cost compensation-model was a comparatively simple procedure – a fixed price has to be multiplied with the duration of stay – reimbursement on the basis of DRGs requires a developed information system documenting detailed information on diagnosis, treatments, duration of stays etc. From the perspective of the hospitals the invention of DRGs not only meant a tightening of cost pressure, but also a considerable increase in administrative complexity, as the following examples show.

- *Process and logistic-management:* In the aftermath of the introduction of DRGs process and logistic management have become a crucial aspect of hospital governance. In order to respond to cost pressure and efficiency demands hospitals not only reorganize their financial reporting, but also their internal work flow and their relationships to external suppliers. Standardizing – for instance by organizing care along pre-defined 'care paths' – and centralizing – for instance by establishing centralized purchasing – are considered as best practise.
- *'Admission'-management:* Process and logistic management includes also the management of the flow of patients. The introduction of DRGs can be regarded as a shift from a supply-driven to demand-driven remuneration of the hospital sector. Influencing demand has therefore become important for hospitals, especially for the bottom-line oriented amongst them. The introduction of DRGs came along with the evolution of a new management task, e.g. admission management. In order to secure a steady flow of patients, hospitals try to establish close relationships to important gate keepers such as emergency doctors and – even more important – office based practitioners of the outpatient sector who make out over 50% of the hospital referrals. Different instruments are applied: besides the above mentioned and by recent health care reforms fostered integrated care arrangements, hospitals offer professional development or even (illegal) financial incentives to secure the steady flow of patients into their operating theatres. While in other countries – especially in the US health care system – such 'patient feeder systems' (Lindorff 1992: 26) are known for long time and have been steadily perfected, admission management in Germany is a new and still underdeveloped management field. Against the background of augmented competition, however, it is expected that hospitals will establish respective divisions and increase their efforts (Behar/Wichels 2009). Overcoming the borders between the inpatient and outpatient sector is for sure a necessary precondition for any improvement of health care provision in Germany. Close business relationships between office-based doctors and hospitals, however, create also new moral tensions for physicians and involve the danger of monopolized health care structures, as the US case shows impressively (Churchill 1999).
- *Quality-Management:* The introduction of DRGs, thirdly, has altered the requests for quality management. Quality management in hospitals has already become obligatory with the health care reform 1988. This reform, however, proved to be with no effects. As a next reform step, the health care reform 2000 introduced external and comparative quality assessments which are conducted by a newly established agency for quality assurance. Finally, the Cases Fee Act 2002 (Fallpauschalen-Gesetz, FPG) introduced biannual standardized quality reports which the hospitals

have to place since 2005 at the disposal of the health insurance funds (§ 137, 3 SGB V). The associations of the health insurances funds in turn are expected to publish these reports completely and unmodified and to make the results of the reports available for the general public (Tiemann/Schreyögg/ Wörz/ Busse 2010: 61ff). The standardized quality reports should provide information for both medicines and patients and enable them to compare hospitals and to consider quality aspects in the planning of hospital stays. The effectiveness of the current quality management concept, however, is critically discussed. Empirical studies have shown that the expressiveness of the quality reports is very limited (Schellschmidt/Lütticke 2005): The reports are too complex and are overloaded with technical terms. The German hospital quality reports are readable only for those patients who dispose of above-average communicative skills (Friedemann/Schubert/Schwappach 2009).

To sum it up: privatization and NPM-ideas have reshaped hospital governance. To cope with increased cost pressure, public owners have opened to different types of privatization. Furthermore, hospitals have changed (or are on the way to change) their management routines and planning processes fundamentally, as these short glimpses on recent reorganisation processes have shown. In terms of health performance, the impact of managerialization remains still unclear and empirical research is needed. In terms of power distribution, however, it is obvious that the reforms had severe impacts on the role of the employees whose working conditions have deteriorated tremendously, especially those of the medical and non-medical staff. Concerning the professionals, the administrative reforms not only question their claim to leadership. Moreover, under the pressure of the new administrative tasks the professionals have become themselves managers, spending more and more time on documentation and controlling duties at the expense of the time they could concentrate on the treatment of patients. Hospitals try increasingly to counteract this negative impact of the DRGs system with the introduction of new jobs: 'Medical controllers' and the 'DRG assistants' shall relieve the professionals from their administrative burdens. This further differentiation of the medical profession, however, is only at its early stages.

#### **4. Explaining change: from economic to political factors**

Most scholars stress the impact of economic dimensions in the reform process of the German Health system. As we already noticed since the end of the 1970's cost containment is the main issue in German health care policies because health care expenditures increased much faster than the economy grew. As for pension or unemployment insurance, the first main response to this trend has been to increase social contribution paid to health insurance funds. During the 1980s, increasing social contribution appeared to become an economic dead end because it threatens the competitiveness of German products and the location of economic activity in Germany because of growing personal costs. Therefore the main motive for reforms was to relieve employers from the financial burden of health insurance contribution. The cost of the reunification process of the two separate parts of Germany accelerated the pressure on reforms in the early 1990's and explains the adoption of the Structural Act in 1992. Like in most of the OECD health systems financial constraints have led to the desire to improve both equity and efficiency of health care delivery (Cacace et al. 2008). It helps to explain the transnational diffusion of policy tools like market mechanisms, new public management principles, quality evaluation and new financing systems (especially DRG's in the hospital sector).

But looking only at economic factors of health care reform is misleading because they are not able to explain the difference of contents in the transformation of European health care systems: these policy instruments have been adapted to specific national contexts. This translation process, in the sense used by Campbell (2004), was done by policy actors sharing not only interests but also re-

form programs. In the German case it is possible to identify a “programmatic coalition” (Hassenteufel and al., 2010) believing that the improvement of the efficiency and equity of the health care system relies not only on economic tools but also on a greater autonomy of the state towards corporatist interests (especially doctors but also the social partners managing the sickness funds) seen as the main obstacle to structural reforms. This programmatic coalition is composed of two main categories of actors: political actors (the Minister of health<sup>6</sup>, the state secretaries for health, the health policy spokespersons of the leading political parties, the health ministers of some *Länder*, members of the parliamentary health commission) as well as the so-called political civil servants (*politische Beamte*) at the top of the federal health administration, appointed at the discretion of the Health Minister.<sup>7</sup> There is a great continuity in the reform process since the structural reform of 1992, prepared at the end of the 1980’s by a parliamentary commission for the structural reform of the health insurance system composed of parliamentarians and experts (the *Enquete Kommission Strukturreform der gesetzlichen Krankenversicherung*). This commission can be considered as the matrix of the reform ideas. In it, we find the actors who subsequently play an important role, like Franz Knieps, member of the staff of this commission and then head of the Health Insurance Department of the Health Ministry from 2003 to 2009; Klaus Kirschner, head of the commission and then of the health commission in the Bundestag; and Horst Seehofer, member of the commission and then minister of health from 1992 to 1998. This programmatic coalition had a clear reform program, combining competition among sickness funds and regulation by the state. Progress toward these goals was slowed in the 1990’s because of German unification, which reinforced the established institutional pattern of the health insurance system, but returned to the top of the health agenda after 2000.

The two most important reforms of the last twenty years, in 1992 and in 2003, were negotiated by the two main political parties (SPD and CDU-CSU). The most recent reform, voted in 2007, was prepared and decided by a bipartite commission in charge of elaborating a new reform project, composed of 16 political actors coming from the Parliaments and the *Länder* belonging to the two parties of the governmental coalition. It is also important to note that members of the German parliamentary social and health commissions have won substantial autonomy from interest groups (Trampusch 2005). The autonomy of this programmatic (and rather political) coalition is limited by the fact that they are not involved directly in the implementation process (where self administration still plays a great role). Doctors are excluded from the decision process since 1992, however. Finally, expertise was institutionalized through the creation in the mid 1980’s of the Expert Committee for the evaluation of the health system (“*Sachverständigenrat zur Begutachtung der Entwicklung des Gesundheitswesens*”), which has a role in agenda setting and the framing of the policy debate on health care, and sometimes prepares policy decisions (Brede, 2006: 441).

## 5. Outlook

On the whole, the German healthcare sector has undergone major regulatory changes. Each of the three key regulatory reform trends in health policy – rescaling, privatization, and managerialization – has affected the governance of the system, altering thereby this welfare state, that once has been the ideal type of a conservative-corporatist welfare state, into ‘something uncertain else’ (Lamping, Rüb, 2001). As a result of simultaneous centralization, privatization and upholding old structures features of different systems currently coexist side by side. Therefore “the emerging

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<sup>6</sup> Three factors give the health minister a central role: the *Ressortprinzip* (autonomy for each ministerial administration), the creation of a Ministry of Health separate from the Ministry for Social Affairs since 1991 and the longevity of two ministers: Horst Seehofer, minister for health from 1992 to 1998 and Ulla Schmidt, minister for Health from 2001 to 2009. All the important reforms during this period were adopted under their ministerial mandate.

<sup>7</sup> Their careers are less purely administrative: a growing number of the political civil servants in the health sector come from the staff of political parties or from the sickness funds.

regulatory model can be characterized as state-domesticated competitive corporatism" (Gerlinger, 2010: 136). The reform projects of the new Ministry of Health (coming from the Liberal party) seem to follow the same "regulatory mix" pattern combining more state control (for cost containment) and more competition (between sickness funds).

The paper has shown *how* and *why* the German health care system has changed. We know, however, still very few about the effects these changes have had on the overall performance of the system. Sure enough, there is a huge literature on healthcare system performance and studies such as the OECD 2009 report give information on the quality and the outcome of different healthcare system types. But yet, if changes in the overall performance of a system are to be observed, can they be traced back to regulatory changes? Or have other factors, such as medical progress or demographic changes, more explanatory power? Further research is needed to evaluate the impact of regulatory reforms and to assess their influence on the performance of healthcare systems.

## References

- Bandelow, Nils (2009): "Health Governance in the Aftermath of Traditional Corporatism: One Small Step for the Legislator, One Giant Leap for the Subsystem", *German Policy Studies* 5 (1): 3-20.
- Behar, Benjamin; Wichels, Reinhard (2009): „Einweisermanagement in Gesundheitsnetzwerken – Ein schmaler Grad zwischen Kooperation und Wettbewerb“, in: Amelung, Volker E.; Sydow, Jörg; Windeler, Arnold (Hg.) (2009): *Vernetzung im Gesundheitswesen – Wettbewerb und Kooperation*, Stuttgart: Kohlhammer, 349-358.
- Böckmann, Roman (2009): "The private health insurance: demarketisation of a welfare market?", *German Policy Studies* 5 (1): 119-140.
- Bode, Ingo (2006): "Fair funding and competitive governance. The German model of health care organization under debate", *Revue Française des Affaires Sociales* 2-3: 183-206 (English version).
- Böhm, Katharina (2009): "Federalism and the New Politics of Hospital Financing", *German Policy Studies* 5 (1): 99-118.
- Brede, Falk (2006): „Politikberatung in der Gesundheitspolitik“, in: Falk, S.; Rehfeld, D.; Römmele, A.; Thurnert, M. (Eds.): *Handbuch Politikberatung*, Wiesbaden: VS, 436-448.
- Burchardt, Tania (1997): *Boundaries between Public and Private Welfare: a typology and map of services*. London: LSE.
- Cacace, Mirella; Goetze, Ralf; Schmid, Achim, and Rothgang, Heinz (2008): Explaining Healthcare System Change. Paper presented at the 4th International ESPA-net Expert Conference, University of Aalborg.
- Campbell, John (2004): *Institutional Change and Globalization*. Princeton: Princeton University Press.
- Clarke, John; Newman, Janet (1997): *The Managerial State: Power, Politics and Ideology in the Remaking of Social Welfare*, Thousand Oaks, CA: Sage.
- Churchill, L. R. (1999): "The United States Health Care System under Managed Care: How the Commodification of Health Care Distorts Ethics and Threatens Equity", *Health Care Analysis* 7 (4): 393-411.
- Collyer, Fran M. (2003): "Theorising Privatisation: Policy, Network Analysis, and Class", *Electronic Journal of Sociology* 7 (3).
- Collins, C.; Green, A. (1994): "Decentralisation and primary health care: some negative implications in developing countries", *International Journal of Health Services* 24 (3): 459-475.
- DKG (2009): Deutsche Krankenhausgesellschaft - Aufgaben und Ziele. [http://www.dkgev.de/dkg.php/cat/23/aid/2/title/Aufgaben\\_und\\_Ziele](http://www.dkgev.de/dkg.php/cat/23/aid/2/title/Aufgaben_und_Ziele), 10. August 2009 (last access: 22. Februar 2010).
- Edwards, David J. (1998): "Managerial Influences in Public Administration", *International Journal of Organization Theory and Behavior*, 1 (4).
- Felix, Dagmar (2001): "Verwaltungsrat und Vorstand in der gesetzlichen Krankenversicherung – Aufgaben und Befugnisse", in: Schnapp, Friedrich E. (ed.): *Funktionale Selbstverwaltung und Demokratieprinzip – am Beispiel der Sozialversicherung*, Frankfurt a. Main: Peter Lang, 43-64.

- Friedemann, J.; Schubert, H.-J.; Schwappach D. (2009): „Zur Verständlichkeit der Qualitätsberichte deutscher Krankenhäuser: Systematische Auswertung und Handlungsbedarf“, *Gesundheitswesen* 71 (1): 3-9.
- Fuchs, Harry (1994): „Aufgaben, Handlungsgrundlagen und -instrumente. Der Verwaltungsrat in der GKV nach der Selbstverwaltungsreform des GSG“, *Soziale Sicherheit* 43 (8): 249-253.
- Gerlinger, Thomas (2008): „Wettbewerbsinduzierte Unitarisierung. Der Wandel der Bund-Länder Beziehungen in der Gesundheitspolitik“, in: Scheller, Henrik; Schmid, Josef: *Föderale Politikgestaltung im deutschen Bundesstaat. Variable Verflechtungsmuster in Politikfeldern*, Baden-Baden: Nomos, 242-263.
- Gerlinger Thomas (2010): „Health Care Reform in Germany“, *German Policy Studies* 6 (1): 107-142.
- Gerlinger Thomas; Schmucker, Rolf (2009): „A Long Farewell to the Bismarck System: Incremental Change in the German Health Insurance System“, *German Policy Studies* 5 (1), p.3-20.
- Hassenteufel, Patrick; Smyrl, Marc; Genieys, William; Moreno, Javier (2010): „Programmatic Actors and the Transformation of European Health Care States“, *Journal of Health Politics, Policy and Law* 35 (4): 509-530.
- Hinrichs, Karl (2010): „A Social Insurance State Withers Away. Welfare State Reforms in Germany – or: Attempts to Turn Around in a Cul-de-sac“, in: Palier, Bruno (Ed.) (2010): *A Long Goodbye to Bismarck? The Politics of Welfare Reform in Continental Europe*. Amsterdam University Press, 45-72.
- Kirch, Peter (2006): „Selbstverwaltung im Gesundheitswesen: Strategische, strukturelle und inhaltliche Neuausrichtung notwendig“, *Soziale Sicherheit* 55 (2): 58-60.
- Kreutzer, Karin; Jäger, Urs (2010): „Volunteering Versus Managerialism: Conflict Over Organizational Identity in Voluntary Associations“, *Nonprofit and Voluntary Sector Quarterly* online first, published on May, 21<sup>st</sup>, 1–28.
- Lamping, Wolfram; Rüb, Friedbert W. (2001): From the Conservative Welfare State to „Something Uncertain Else“: German Pension Politics in Comparative Perspective. University of Hannover, Centre for Social and Public Policy, Discussion Paper No. 12. Hannover.
- Leisering, Lutz (Ed.) (2010 (forthcoming)): *The New Regulatory State. Regulating Private Pensions in Germany and the UK*, Palgrave.
- Lindorff, Dave (1992): *Marketplace Medicine. The Rise of the For-Profit Hospital Chains*. New York: Bantam Books.
- Lütticke, Jürgen; Schellschmidt, Henner (2005): „Qualitätsberichte nach § 137 SGB V - Bewertung und Vorschläge zur Erweiterung“, in: Klauber, Jürgen; Robra, Bernt-Peter; Schellschmidt, Henner (Eds.): *Krankenhaus-Report 2004*. Stuttgart: Schattauer, 197-212.
- Maier, Florentine; Leitner, Johannes; Meyer, Michael; Millner, Reinhard (2009): „Managerialismus in Nonprofit Organisationen“, *Kurswechsel* (4): 94-101.
- Mattei, Paola (2009): *Restructuring welfare organizations in Europe: from democracy to good management?* Basingstoke Palgrave Macmillan.
- Mosebach, Kai (2009): „Commercializing German Hospital Care? Effects of New Public Management and Manged Care under Neoliberal Conditions“, *Germany Policy Studies* 5 (1): 65-98.
- OECD (2003): *Privatising State-owned Enterprises. An Overview of Policies and Practices in OECD Countries*. Paris: OECD.
- OECD (2009): *Health at a Glance 2009*, Paris: OECD.
- Oldiges, Franz Josef (1994): „Vorstand und Verwaltungsrat in der GKV. Eine Antwort auf Harry Fuchs“, *Soziale Sicherheit* 43 (8/9): 308-311.
- Paquet, Robert (2006): „Ansatzpunkte für eine Reform der GKV-Selbstverwaltung“, *Soziale Sicherheit*, 55 (2): 61-65.
- Palier, Bruno (Ed.) (2010): *A Long Goodbye to Bismarck? The Politics of Welfare Reform in Continental Europe*. Amsterdam University Press.
- Pollit, Christopher (1993): *Managerialism and the Public Services. Cuts or Cultural Change in the 1990s?*, Oxford: Blackwell Business.
- Rondinelli, D.A. (1983): *Decentralization in developing countries. A review of recent experience*. Staff Working Paper 581, Washington, D.C. World Bank.
- Rosenbrock, Rolf; Gerlinger, Thomas (2006): *Gesundheitspolitik. Eine systematische Einführung*. Bern: Hans Huber.

- Rothgang, Heinz; Cacace, Mirella; Frisina, Lorraine; Schmid, Achim (2008): "The Changing Public/Private-Mix in OECD Healthcare Systems", in: Seeleib-Kaiser, Martin (Hg.): *Welfare State Transformations in Comparative Perspective: Shifting Boundaries of 'Public' and 'Private' Social Policy?*, Houndmills, Basingstoke: Palgrave, 132-146.
- Rüb, Friedbert W. (2004): „Vom Wohlfahrtsstaat zum „manageriellen Staat“? Zum Wandel des Verhältnisses von Markt und Staat in der deutschen Sozialpolitik“, in: Czada, Roland; Zintl, Reinhard (Eds.): *Politik und Markt. PVS-Sonderheft*, Wiesbaden: VS, 256-299.
- Saltman, Richard B. (2008): "Decentralization, re-centralization and future European health policy", *The European Journal of Public Health* 2008 18(2):104-106.
- Saltman, Richard B.; Bankhauskaide, Vaida; Vrangbaek, Karsten (eds.) (2007): *Decentralisation in Health Care. Strategies and Outcomes*, Berkshire: Open University Press.
- Schmidt, Christian; Möller, Johannes (2007): „Katalysatoren des Wandels im deutschen Krankenhausmarkt“, in: Klauber, Jürgen; Robra, Bernt-Peter; Schellschmidt, Henner (eds.): *Der Krankenhausreport 2006. Schwerpunkt: Krankenhausmarkt im Umbruch*, Stuttgart: Schattauer, 3-19.
- Statistisches Bundesamt Deutschland (2008): *Gesundheit. Grunddaten der Krankenhäuser*. Fachserie 12 Reihe 6.1.1. Wiesbaden.
- Trampusch, Christine (2005): "From Interest Groups to Parties: The Change in the Career Patterns of the Legislative Elite in German Social Policy", *German Politics* 14 (1): 14-32.
- Tiemann, Oliver; Schreyögg, Jonas; Wörz, Markus; Busse, Reinhard (2010): „Leistungsmanagement in Krankenhäusern“, in: Busse, Reinhard, Schreyögg, Jonas, Tiemann, Oliver (Hg.): *Management im Gesundheitswesen*, Berlin: Springer, 47-76.
- Vrangbaek, Karsten (2007): "Towards a typology for decentralisation in health care", in: Saltman, Richard B.; Bankhauskaide, Vaida; Vrangbaek, Karsten (eds.): *Decentralisation in Health Care. Strategies and Outcomes*, Berkshire: Open University Press, 45-62.
- Wollmann, Hellmut (1999): „Politik- und Verwaltungsmodernisierung in den Kommunen: zwischen Managementlehre und Demokratiebot“, *Die Verwaltung* 32 (3): 345-375.

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