

The Global financial crisis: A Challenge for the hospital industry

Tanja Klenk, University of Bremen

Paper prepared for the

8th ESPAnet Conference 2010

Social Policy and the Global Crisis: Consequences and Responses

Stream 11.3 Post-crises Health Policies: Challenges and Opportunities

Budapest 2-4 September 2010

Draft version, comments are most welcome

“The Financial Crisis Takes a Toll on Hospitals [...]”, (American Hospital Association 2009);

“Increasing risks instead of increasing rates of return [...]; hospitals have to pay for their usage of new financial instruments like ‘swaps’ [...]”, (Financial Times Germany 2009);

*“Germany’s university hospitals suffer economic crisis”,
(The German University Hospitals Association 2009).*

Messages like these could be found with increasing frequency during the last months. Indeed, the recent capital crisis has severe impacts on hospitals. Inpatient care has developed into a capital-intensive and dynamic market good with funding depending vastly on the capital market. The hospital branch is a branch with high investment needs: Due to technological and demographical developments – medical progress and an ageing society – the investment needs of hospitals have increased tremendously in the past years. At the same time, however, the financial requirements of hospitals are no longer met by public authorities. In Germany, for instance, public subsidies for the inpatient sector declined by 34.48 % during the years 1998 to 2008. Given these developments, the German hospital sector has turned out to become attractive for private investors, the more as the ageing society promises stable growth prospects. Private hospital companies, venture capitalist, financial investors, and strategic investors (medical engineering or pharmaceutical companies) have entered the stage. Public authorities in turn welcomed the new actors as they promised smart solutions for indebted communities withdrawing from funding responsibilities. As a result, the share of hospitals with a private legal form has risen sharply within the past years. Strictly speaking, no other comparable country has privatized as many public hospitals as Germany (Schulten/Böhlke 2009: 97).

This was the situation in autumn 2008 when the recent global economic crisis reached Germany. What impact has the economic crisis had on the inpatient sector? Has the crisis interrupted the processes of corporatization and privatization in the inpatient sector? Can we, like in other parts of public administration, observe a discussion concerning the necessity of a re-nationalization and a return to public ownership in this field as well?

While private investors and hospitals listed at Wall Street are a well known phenomenon in the US for decades, this trend is quite new in Germany. The paper compares the inpatient sector in Germany and the US, enquires if and to what extent we can observe an ‘Americanization’ of Germany in the mentioned respect, i.e. the evolution of a private welfare industry not only delivering healthcare for profit, but with close relationship to the financial market.

The paper is structured as follows: it first briefly portrays the peculiarities of the hospital industry and discusses what ‘politics with markets’ in this field implies. The differentiation between privatizing ownership/provision and privatizing funding is introduced to discuss new vulnerabilities that occur due to a growing intertwining of the hospital industry with the capital market. The paper then recapitulates the evolution of a market-driven hospital industry in the two countries; the main point is that access to capital (and not other reasons, e.g. better performance) explains many of the recent changes in the governance of the hospital industry. As a final step, the paper gives first insights into the impacts of the economic crisis on the inpatient sector and concludes with considerations on the opportunities and risks of a marketized hospital industry in ‘hard times’.

1. Exploring the field of hospital governance

1.1 *Social policy as a policy with markets*

In social policy research ‘de-commodification’, e.g. the establishment of spheres that are sheltered from the logic of markets, has for a long time been regarded as the main feature of welfare policy. It was above all Esping-Andersen (1990) who contributed with his seminal studies to this way of understanding modern welfare states by placing the concept of ‘de-commodification’ at the centre of his welfare regime typology.

In the last decade, however, the notion of social policy as a policy *against markets* has been called into question in the comparative welfare state literature. Recent research has shown that social policy can also occur as a policy *for markets*, i.e. supporting the interests of employers (Mares 2001; Swenson 1991). Even more, social policy can be a policy *with markets*, i.e. a policy that makes use of existing markets or pushes the creation of new markets. Both Taylor-Gooby (Taylor-Gooby et al. 1999) and Nullmeier (2002) coined the term ‘welfare markets’ (Wohlfahrtsmärkte) to describe this type of social policy. Rather than protecting from market forces, social policy in welfare markets relies heavily on private means to deliver public goods.

Welfare markets grew in importance in Germany only recently. The rise of welfare markets is considered to be part of an ongoing transformation of the state in Germany that could be described with the catchwords ‘regulatory’ or ‘guarantee’ state. In social policy – but also in other parts of public policy like telecommunication, energy, or public transport – state provision is replaced more and more by non-state provision. In contrast to a ‘lean state’ a guarantee state is still fairly active. State action is not reduced but altered and shifted from public provision to the regulation of private provision (at least in theory) (Schuppert 2005). The withdrawal of the state from public production became obvious especially in the public utility sector (i.e. telecommunication, transport, energy). In social policy research, the notion of a ‘new regulatory state’ is especially discussed in pension politics against the background of the growing importance of multi-pillar pension systems (Leisering 2010).

What is new in Germany has been well known in the US for decades. According to Neil Gilbert, the US experienced the merging of economic and social markets and the rise of welfare markets at the latest in the 1970s (Gilbert 1983: 3ff.). Since then, proprietary agencies have been

prominently represented in many social service programs, including long-term care, employment training, and particularly the inpatient sector.

This paper discusses the question of whether and to what extent we can observe the rise of a welfare market in the German inpatient sector and whether – in this respect – a convergence with the governance of the US hospital industry has to be stated. Before turning to the case studies, however, we have to clarify what the notion of welfare markets in the case of the hospital industry means exactly. Discussing hospital governance, one has to bear in mind that this field has some strong distinctions from other fields of public administration. What makes hospital governance distinct from any other field of public administration is the important role private institutions have always played. While in other fields of public administration, e.g. electricity, housing, postal administration, and telecommunication, the state has developed from ‘a monopolist producer of public services to the guarantor, enabler, coordinator, and moderator of a complex institutional (or “governance”) setting of public service providers’ over the last decades (Grossi/Reichard 2008: 600), a pluralist institutional landscape has been known in welfare administration from the very beginning of public social policy. Private institutions – not-for-profit as well as for-profit – provided health-care services even before the state stepped into this field and continued to play an important role after health care had become a public responsibility. Inpatient care – as social services in general – is based on a *welfare mix*, namely an articulation of the state, the markets, and voluntary organizations (Powell/Barrientos 2004).

This welfare mix, however, has experienced major changes over time. Drawing the difference between the ‘old’ and the ‘new’ welfare mix is not easy as it is more a matter of degree than of kind. The difference between the ‘old’ mixed economy in the inpatient sector and the ‘new welfare market-like’ hospital governance becomes first and foremost obvious in a changed view of this industry: it is discovered as an untapped market with profit-making potential (Gilbert 1983: 8). Several indicators reveal this growing commercialization of the hospital industry, out of which this paper highlights two: These are, first, an enormous ‘influx of profit-making organizations’ (Gilbert 1983: 8) and, second, a growing intertwining between the hospital industry and the financial markets.¹ It is the latter that provides new vulnerabilities for the hospital industry. The consideration of the hospital industry as an untapped market comes along with shifts in the actor constellations. New actors enter the game: financial investors, venture capitalists, and medical care companies interested in strategic investments have discovered the profit-making potential of the hospital industry.

1.2 *Bringing in the market – paths to a marketized hospital industry*

At their core, welfare markets are about an increased importance of private actors and market forces. Early studies on privatization have depicted privatization as a question of who *owns* assets and have defined privatizing as the sale of public assets. Privatization, however, can have many faces (Collyer 2003; OECD 2003). Newer studies on privatization have therefore 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 and material privatization, contracting or sourcing out, or private funding of public services. Some approaches even differentiate between marketizing systems and marketizing individuals and include labour

1 Another example of the growing commercialization of the hospital industry is ‘isomorphic change’ (Dimaggio/Powell 1983) with the public and the voluntary hospitals mimicking the management practices of the private ones (for the US case: Schlesinger/Gray 2006; for the German case: Wendl 2009),

market activation policies or the implementation of user fees in their typologies (Burchard 1997; Leisering 2010).

In order to conceptualize shifts in hospital governance it is helpful to differentiate between the substitution of public ownership and the substitution of public funding (for a slightly different approach see Aulich/O’Flynn 2007). The table below gives some examples of the different paths to a hospital industry based on market means. Material privatization refers to the sale of public organizations (in this case: hospitals) by government or local authorities to private owners. An alternative to divestment is changes in the legal form to more commercially oriented organizational forms, such as stock companies with the public owners remaining the majority shareholders. Other alternatives to divestment can be partial privatization (dividing the respective organization into several sub-organizations and privatizing some of them) or the purchase of single services formerly delivered by public sector organizations (functional privatization). Concerning the substitution of public funding, borrowing is certainly widespread and anything but a new practice. With the financial liberalization and the development of a broad range of new means of finance – e.g. leasing, just to mention one example – the possibilities of ‘substituting’ public funding through private sources have increased remarkably (Kampe/Bächstädt 2007).²

Bringing in the market – dimensions and instruments of marketizing welfare governance

Dimension	Possible instruments
Substitution of public ownership	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)
Substitution of public funding	Borrowing (debt)
	Outside equity/venture capital
	Leasing, private financing initiatives

Taking these two different dimensions into account allows reflection on the differentiations ‘markets’ have experienced over the past decades (Windolf 2005). ‘The’ market can be differentiated into several ‘sub-markets’, such as the product markets, where *commodities* are traded, and the financial markets, in which the *promise to pay* is traded.³ This paper is not the place to go into details of market theory and the analysis of modern market structures. It is, however, noteworthy that financial markets have gained in importance over the past decades and that this ‘second-order’ market impacts more and more on incidents on the product markets (the first-order markets). This development also impacts on the ‘production’ and proliferation of welfare goods. In social policy research, the increased significance of the financial markets for welfare policy is comparatively well discussed with regard to old-age

2 Sure enough, the differentiation between privatizing ownership and privatizing funding is an *analytical* differentiation in the first place. Empirically there are close ties between the two dimensions, as – for instance – selling stocks to raise new ‘private’ funds requires a private legal form and therefore has to come along with changes in the ‘ownership’ dimension.

3 There is an even more detailed classification possible: these two markets have also developed into several subsystems. In the case of financial markets, for instance, the credit market, the stock market, or the market for derivatives can be distinguished.

provision (Berner 2009; Leisering 2010).⁴ What is neglected in the recent German social policy literature, however, is that financial markets have become a crucial issue for the development of the inpatient sector, too. As costs continue to rise while public subsidies continue to decline and purchaser pressure tightens, hospitals are forced either to economize the budget or to tap new resources to finance the necessary investments. Access to capital – as the case studies below will show – has developed into a major policy issue, which shapes the future of the hospital industry.

1.3 *New vulnerabilities*

The impacts of delivering welfare goods with private means are rather contested. The proponents of privatization claim increased performance with regard to both the quality and the cost-efficiency of provision. Advocates of public provision in turn do not doubt the possibility of increased cost-efficiency in the first place, but question (for good reasons) whether private for-profit companies will pass on the saved costs to public authorities. Moreover, they invoke worsened working conditions for the staff, especially for nurses, maintenance supervisors, cooks etc.⁵

Besides these ‘old’ risks of private provision, new vulnerabilities have emerged due to the growing reliance of hospital funding on the financial markets. As a result of financial liberalization and a changing role of governments in public and social policy, the inpatient sector is more and more intimately embedded in the global economy. Thus, the hospital industry has become more vulnerable to economic turbulence, as the escalating number of hospital closures in the US during the recent economic downturn has demonstrated impressively. Not only do divestment and the sales of public assets diminish the state’s capacity to respond to the shifting demands and needs of the population; the ‘hidden’ privatization coming along with the substitution of direct public funding through revenues raised on the international financial markets curtails the scope of discretion of public actors, too. Privatizing funding allows municipalities or states suffering from a restricted budgetary position to invest in public services that would otherwise be abolished. However, this coping strategy provides only short-term solutions: first, due to debt servicing the total costs increase even further; second, flexibility today is bought at the expense of a restricted future capacity to act as the private financing initiatives are often pegged into long-term contracts. Moreover, as the funding problems are not solved but only shifted into the future, questions of intergenerational justice are raised (AOLG 2004).

The increased intertwining of the hospital industry and the financial markets comes along with changed power constellations in the hospital industry. Hospital planning and hospital renovation depend increasingly on the assessment of financial intermediaries. Interestingly enough, not only the owners of public hospitals but also those of private hospitals are affected by this development: the latter became dependent on the assessment of rating agencies etc., too. In other words, the growing importance of the financial market for hospital funding results in new hierarchical relationships *within* the private sector. The owners of both public and private hospitals experience new restrictions with regard to their management strategies.

4 According to Berner (2009), the welfare market for old-age provision can be subdivided into three different markets: product markets, financial markets, and consultant markets, where expertise is traded.

5 Physicians, however, are in most cases not affected by worsened working conditions, as surveys have shown (Flintrop/Osterloh 2010).

2. The case studies

The following chapters describe the rise of a for-profit hospital industry and the shift to hospital funding based substantially on private financial institutions in a comparative perspective and contrast the developments in Germany with those in the US. Comparing these two welfare regimes means comparing two 'most different' cases. The access to health care, its funding, and the governance of the system vary widely from each other in these two countries. While Germany has nearly universal health coverage, which is mainly funded via contributions and – in the case of hospital care – via taxes, the US is considered to be 'one nation, uninsured' (Quadango 2005). In the US up to now no statutory health-care coverage is known, but a large number of people without access to affordable health care (Obama has not yet reached his goals ...). Admittedly, employer-based health insurance programs play a major role. Moreover, with Medicare and Medicaid there are public programs providing coverage for health care for the elderly and respectively for the poor as the most vulnerable target groups. The treatment costs of Americans, however, who do not qualify for government-provided health insurance programs, who are not provided with health insurance by an employer, or who cannot afford a private insurance scheme, are not covered. As there is no statutory health insurance, hospitals are left with the burden of finding ways to cover indigent care (which all too frequently results in a practice of cream skinning, focusing on lucrative patients, and leaving the poor aside).

In the comparative health systems research, the health governance in the US is considered to be the closest approximation to a private market-driven system (Wendt/Frisina/Rothgang 2009). This does not mean that private for-profit hospitals dominate the hospital industry (quite interestingly, voluntary hospitals supply the major part of hospital beds); moreover, this classification does not imply that there is no regulation at all (quite to the contrary, the regulation of the health-care sector has increased over the past years). Nonetheless, a main feature of the political culture in the US is a negative attitude towards *social political* intervention (Kaufmann 2003: 90). Regulation aims at the prevention of market distortions in the first place (e.g. preventing monopoly structures in the hospital industry) and not at achieving social policy goals.

3. The German case

3.1 Hospital governance in Germany

In today's Germany, the political responsibility for the inpatient sector lies mainly with the federal states (Rosenbrock/Gerlinger 2006).⁶ They are involved in both planning and funding of the hospitals. In 1972, with the so called hospital law becoming effective, systematic hospital planning was introduced. Since then the federal states are obliged to develop hospital plans. The plans contain the number of hospitals considered necessary to secure equal and nationwide access to healthcare in Germany as well as decisions concerning the public investments in these hospitals (Simon 2005).

The funding of the hospitals is based on two different pillars: The public authorities are liable for the investment costs. The health insurance funds, for which regulations lie within the responsibility of the central state, pay the expenses for care provision. This so called 'dual funding system' is intended to warrant both the liquidity of hospitals and necessary modernizations of the structural conditions and medical equipment. Only hospitals which are

6 For a detailed description concerning the task sharing between the national and the federal level in the German inpatient sector see Simon 2000 and Böhm/Henkel 2009.

approved in the public hospital plan are granted access to the 'dual funding system', though. Private ownership, however, provides no obstacles to be listed in the public hospital plan. Hospitals of all ownership types are accepted – as long as they are demand-actuated, capable of high performance at reasonable costs (Bruckenberg/Klaue/Schwintowski 2006: 157). Seen from the perspective of hospitals, being part of the hospital plan is important as it provides a relatively secure base of funding.⁷ Funding from 'outside', either from banks or private investors, has not been absolutely necessary – at least until the 1990s.

3.2 'Solved' and 'unsolved' challenges

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 2006: 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. In fact, the 'golden age' of the hospital industry has already come to an end in the 1980s. Since then the history of healthcare reforms is one of cost control. Several measurements have been implemented to curb spiraling costs. Amongst others, the rules for the financing of the hospitals' operating costs, which are provided by the health insurance funds, have been fundamentally changed. With the Health Structure Law from 1993, 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.

While the introduction of the DRG system is discussed intensively in both the public and the scientific sphere, a second, incremental change proceeds more or less unnoticed. It concerns the other pillar of the dual hospital funding system, the public authorities' funding of the investment costs. The above mentioned hospital law from 1972 envisaged a need-based funding including the compliance to cover all net costs of hospitals. In 1984, however, the federal states saw off this principle already and switched to 'income-oriented budgeting', or – to put it differently – to an ongoing reduction of the hospitals' investment budget. Public funding has decreased steadily for all ownership types.⁸ As no respective statistics exist, the shortage of public subsidies designated for investments in inpatient care is difficult to quantify. Appraisals, which vary according to interests and concernment, range from 32.4 bn. Euro (in 2005) to 50 bn. Euro (in 2009) (Bruckenberg/Klaue/Schwintowski 2006: 80; Blum/Offermanns 2009).

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, the statutory health insurances,

7 In fact, the share of hospitals being not part of the hospital plan is nominal; only 3% of all German hospitals are excluded from the dual funding system (Ziehe 2009).

8 In 2008, all public subsidies according to § 9 KJG (financial means for investment) amounted to 2.69 bn. EUR; this means a steady decline by -34,48 % throughout at last decade (reference year 1998, see DKG 2009).

in turn, refuse to bear the costs for inpatient care all alone. The hospitals, finally, are afraid that infrastructure funding through the insurance companies will increase their investment backlog even further. Down to the present day all efforts to implement structural reforms with regard to hospital investment have resulted in insufficient solutions.

3.3 The rise of a for-profit hospital industry

Both developments, the turn to income oriented budgeting as well as the turn to prospective payment, have put financial pressure on hospitals. Against the background of the shortcomings of the dual funding system and the failing efforts to reform this system substantially, cities and local municipalities, which are for the most part the owners of public hospitals in Germany, sought their own solutions to be able to cope with the rising expenditures for hospital care. In the 1990s, when the German local municipalities opened up to the NPM paradigm⁹, the 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: Formal privatization (with the public authorities remaining the majority shareholders) as well as material ('real') privatization is juridically¹⁰ possible (Rosenbrock/Gerlinger 2006).

Table 1: Germany, hospital ownership 1991-2008

Year	Altogether (in absolute numbers)	Thereof				
		Public	Thereof		Voluntary	Private
			Public with a private legal form	Public with a 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

9 Germany was a latecomer in terms of NPM reforms, because many of the proposed features like decentralized steering and pluralized ownership were already in place. It was not at least the financial burden of the German reunification which prompted Germany's shift from 'traditional' to 'new' public management finally (Mattei 2009).

10 Another question, however, is the political enforceability of selling public hospitals to private investors. In most cases the process of privatization is accompanied by strong public protests (Greer 2008).

Since the early 1990s, major changes in the German hospital industry can be observed. First, the number of hospitals has constantly declined from 2,411 in 1991 to 2,083 hospitals in the year 2008. Second, the shares of public, private, and voluntary hospitals, which have been stable throughout several decades after World War II, have changed considerably during this time span. The majority of all communities has made use of the new opportunities and has changed the legal form of their hospitals from public to private. Formal privatization is widely used and 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). As a consequence, the Federal Office of Statistics has changed its statistics on hospitals in 2002 and has subdivided the category 'public hospitals' into three different types:

- public law based hospitals without an own legal status,
- public law based hospitals with an own legal status, but dependent on municipal grants,
- and public hospitals based on private law (limited or stock companies).

Besides this, a clear trend to material privatization can be observed. 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. Respectively, the share of public hospitals has declined by half. Interestingly (and similar to the US), voluntary hospitals do not seem to be affected by this trend to privatization. Their share remains more or less stable.

3.4 New actors on the scene: investors in the German health-care market

A closer look at recent shifts in the German hospital market reveals that different groups of private actors are discovering the profit-making potential of this sector. Next to 'traditional' operators of private hospitals investment companies are acquiring more and more public hospitals.

The market for 'real' private for-profit hospitals (with a majority of private owners) is more or less divided between four private companies: Rhön-Klinikum AG, Fresenius-Helios Group, Asklepios Kliniken, and Sana Kliniken AG¹¹ have increasingly obtained an oligopoly status. These hospitals are run as stock companies, but their founding families still preserve a major influence (Stumpfögger 2009).

Concerning investment companies engaged in the hospital industry financial investors can be distinguished from strategic investors. Financial investors almost always have no medical background and are characterized by a pure bottom-line-oriented investment strategy. Their engagement in a hospital is in most cases limited in time: after a time span of two to five years, the acquired object is thought to be resold. While financial investors focus solely on a quick return of investments, strategic investors pursue long-term strategies. Strategic investors are for instance industrial or service companies searching for opportunities to diversify their portfolio. One example of a strategic investor in the German hospital market is the Fresenius AG, which developed from a provider of dialysis products to a highly diversified company running hospitals as well as offering consultancy and producing medical devices (Hesslau/Schmidt 2006).

11 In distinction from the other three enumerated companies the Sana Kliniken AG is run as a stock company, but is not publicly listed; the Sana Kliniken is owned by the German private health insurance companies with the Deutsche Krankenversicherung AG (20.31%), the Signal Krankenversicherung a.G., and the Allianz Private-Krankenversicherungs-AG (13.82%) as the major shareholders (see: <http://www.sana.de/wir-ueber-uns/unser-unternehmen/aktionaere.html>).

3.5 From a dual to a triplex funding system

Next to ownership changes, another fundamental change in hospital governance has taken place, which up to now has not gained the public attention it deserves: the hospitals' dual funding system has developed into a triplex one. The main advantage of the new actors on the health-care scene is their easier access to capital. The revenues of hospitals provided by the health insurances and the public authorities are increasingly complemented by resources acquired on the financial market. Referring to the above introduced table this development can be described as the privatization of funding.

Not only do private for-profit hospitals make use of these new sources of private funding. Hospitals remaining in public custody 'privatize' funding, too. Communities in search for new ways to fill their empty cash drawers highly welcomed new 'creative financing operations', e.g. private financing initiatives or new instruments such as 'cross-border leasing'¹² (for further examples see Kampe/Bächstädt 2007; Ziehe 2009). German municipalities made widely use especially of the latter instrument, considering cross-border leasing as flexible bridge financing to overcome recent budget deficits. Between 1994 und 2004 (when these kinds of contracts were forbidden by the US tax authority) more than 150 communities negotiated CBL contracts, hoping to earn easy money with their debts instead of reducing them. Most of the contracts dealt with the financing of waste management facilities, fairground halls, and public transportation (Höhmnn 2009). Two cities (Leipzig and Dresden, both in the eastern part of Germany), however, applied this innovative funding instrument to tackle financial straits of their municipality hospitals. The CBL transactions of the governorate Chemnitz amount to 189.4 bn. US \$, the 'Chemnitz Klinikum gGmbH' is involved with a sum of 130.7 bn. US \$. In the governorate Leipzig the total amount of CBL transactions account for 2832.3 bn. US \$, the contract with the 'Städtische Klinikum Leipzig St. Georg' comes to 344.4 bn. US \$ (Sächsischer Landtag 2003). The periods of agreement of CBL-transactions are extremely long: in the case of the 'Städtische Klinikum Leipzig St. Georg' the contract covers a period of more than 100 (!) years. Although being a product of the new *flexible* capitalism, innovative funding instruments like CBL are anything but flexible from the perspective of communities. They are *long-term binding* and extremely curtailing the communities' abilities to remain capable of acting.

Reliable data on internal and external finance lack entirely. The scope of the growing intertwining between the hospital industry and the capital market can only be guessed. The recent credit crunch, however, has revealed that access to capital has developed into a major policy issue of the hospital industry.

3.6 The economic crisis and its impact on the hospital industry

It was in autumn 2008 when the recent financial and economic crisis reached Germany. The crisis started up (if one can specify the beginning of this crisis referring to a single date at all) with the bankruptcy of the influential bank Lehman Brothers Inc. on September 15, 2008. It was

12 Cross-border leasing is a leasing arrangement where lessor and lessee are situated in different countries – in most cases in a European country and in the United States – in order to make use of differences in the tax laws of different jurisdictions. The transaction involves a city selling a public good, such as sewerage facilities, power plants, or municipality hospitals, to an investor. The municipality immediately leases back the asset from the investor, so that it is still a publicly operated service. However, since 2004 cross-border leasing has been effectively eliminated by the passage of the American Jobs Creation Act of 2004 (Pub. Law 108-357), the 'Jobs-Act', which made the vast majority of cross border leases unprofitable (Luksch 2009).

a crisis of the capital markets in the first place, which soon developed into a national crisis of the US economy, and a global economic crisis in what followed.

What has a credit crunch to do with hospitals, once considered to be recession-proof (The Wall Street Journal 2009)? In fact, hospitals were severely hit by the crisis because it affected every single out of the three different pillars of the German hospital funding system. The financial crisis had a strong impact on the two 'traditional' pillars of hospital funding as well as on the new pillar 'innovative funding instruments'. Above all, particularly communities which made wide use of financing instruments, in which banks and financial intermediaries from the US were involved, faced the consequences of the crisis. In the German public media especially the negative impacts of cross-border-leasing contracts gained much attention. The cases of cross-border-leasing described above were in most cases contracted with the US assurances AIG. A bailout plan of the US government prevented AIG from bankruptcy, but not from bad credit ratings. According to the contracts, however, the German communities have to bear the risk for failures of the assurances and their deposited funds. Instead of earning money with their debts, the communities' backlog of debts increased even more. In the pursuit of short-term administrative and budgetary objectives, they destroyed their infrastructure base. The citizens of the respective communities, finally, have to bear the consequences of the risky commercial transactions of their public authorities by paying higher taxes for public services.

The crisis, however, worsened also the budgetary position of those local communities, which were not involved in risky financial transactions. Due to the slackening of the economy the tax revenues have extremely shrunk and the financial room of maneuver, which has been unfavorable anyway, got restricted even more. For hospitals this development implies that one of their most important source of funding – public subsidies for investments provided by the states resp. communities, which has been fraught with problems prior to the crisis – run increasingly dry.

Besides this, the second pillar of the hospital funding system has been affected by the crisis as the budgets of the social insurance funds dwindled. In Germany, as in all conservative welfare states, labor market problems result in immediate financial straits for the social insurance system. As the social insurance funds are financed via payroll defined contributions, their capital decrease when the unemployment rate increases. In other words: just in the moment when due to economic downturn there is an increased need for welfare programs, the social policy resources get restricted.

Finally, hospitals were affected by higher interest rates on credits, lower interest rates for their savings, and less favorable hospital ratings by the banks. During the summer 2009, 12% of all hospitals reported that they experienced these negative impacts of the capital crisis (DKI 2009: 69).

3.6 Lobbying for national grants

The impact of the financial crisis on the hospital industry depends on its reliance on the capital market. It depends, however, also on the question if the government takes positive action and includes the hospital industry in national recovery programs. From the perspective of public policy research, the probably most surprising accompaniment of the recent financial crisis has been the comeback of a 'strong state'. In Germany as well as in the US the economic crisis resulted in a renaissance of a program type which was stigmatized and which progressively lost its political support over the past 30 years: programs of Keynesian government spending. In order to overcome the financial crisis, the German government implemented two economic stimulus programs (Konjunkturpaket I and II). The first program has been voted in by

parliament on December 21, 2008. Only two months later the next package was developed and passed.

Hospitals were not in the focus of the economic recovery programs in the first place and were altogether neglected in the first recovery program. Due to extensive lobbying, however, hospitals became part of the second stimulus program. The hospitals' umbrella organization, the German Hospital Institute (Deutsches Krankenhausinstitut, DKI), made use of the time slot between the first and the second recovery packages and intervened in the political decision making process via intensive issue and information management. The DKI commissioned an expert opinion showing the importance of the healthcare branch for the national economy and the aggregated wealth formation (Prognos 2009). The study made the point that short time investments in the inpatient sector will be an effective means to cope with the financial crisis. The study legitimized public subsidies as recession-busting measures by referring to two arguments: first, subsidizing the inpatient sector means creating sustainable growth, second subsidizing the inpatient sector implies promoting the national economy. The first argument refers to the superiority of investments in the inpatient sector compared to general consumption spending, the second argument positions hospitals against the automotive sector. The automobile industry had been in the focus of the first stimulus program. Due to the very broad formulation of this program, it were not the national manufacturers, but the Asian automobile industry which gained from the scrappage bonus in the first place. Consequently, the crisis management of the German Government received harsh criticism from public media.

Table 3: Economic Stimulus Programs and the Hospital Industry

Konjunkturpaket II in Tausend Euro Stand: September 2009	Bundesmittel (§ 2 i.V.m. § 6 Abs. 1 ZulnVG)	Landes- /Kommunalmittel (§ 6 Abs. 1 ZulnVG)	Gesamtes Fördervolumen (Bund, Länder und Kommunen)	Investitions- schwerpunkt Infrastruktur (§ 3 Abs. 1 Nr. 2 ZulnVG)	Finanzhilfen für Krankenhäuser aus Investitions- schwerpunkt Infrastruktur (§ 3 Abs. 1 Nr. 2a ZulnVG)	Anteil Finanzhilfen für Krankenhäuser an Mitteln für Infrastruktur	Finanzmittel an Universitäts- klinika aus Investitions- schwerpunkt Bildungsinfra- struktur (§ 3 Abs. 1 Nr. 1 ZulnVG)	Gesamtförderung für Krankenhäuser und Uniklinika aus dem Konjunkturpaket II ¹	Anteil der Krankenhaus- gesamtförde- rung am Investitionspro- gramm je Bundesland ²
Baden-Württemberg	1.237.490	412.497	1.649.987	> 433.000	ca. 175.000	k.A.	50.000	ca. 225.000	ca. 14%
Bayern	1.426.630	540.000	1.966.630	715.200	110.000	15%	48.900	158.900	8%
Berlin	474.140	158.000	632.140	221.249	54.156	24%	32.000 ¹	86.156	14%
Brandenburg	342.850	114.283	457.133	153.597	25.000	16%	-	25.000	5%
Bremen	88.450	29.483	117.933	41.277	7.000	17%	-	7.000	6%
Hamburg	229.600	76.533	306.133	107.147	3.000	3%	6.000	9.000	3%
Hessen	718.720	239.573	958.293	570.810	100.810	18%	k.A.	100.810	11%
Mecklenburg-Vorpommern	236.990	78.997	315.987	110.600	48.000	43%	49.700 ²	97.700	31%
Niedersachsen	920.580	307.300	1.227.880	429.450	50.000	12%	41.097 ¹	91.097	7%
Nordrhein-Westfalen	2.133.440	711.147	2.844.587	995.605	170.000	17%	200.363	370.363	13%
Rheinland-Pfalz	468.830	246.000	714.830	k.A.	82.500	k.A.	5.000	87.500	12%
Saarland	128.610	42.870	171.480	56.510	5.000	9%	-	5.000	3%
Sachsen	596.750	198.917	795.667	278.520	ca. 11.800	ca. 4%	k.A.	ca. 11.800	1%
Sachsen-Anhalt	356.230	118.743	474.973	140.616	-	-	k.A.	-	-
Schleswig-Holstein	322.580	110.500	433.080	153.500	28.700	19%	26.500	55.200	13%
Thüringen	318.110	106.037	424.147	118.748	25.000	21%	8.000	33.000	8%
Gesamt	10.000.000	3.490.880	13.490.880	> 4.525.829	ca. 895.766	ca. 20%	467.560	ca. 1.363.308	ca. 10%

Quellen: Landesministerien, Presse- und Informationsamt der Bundesregierung

Vgl. Burmann/Wehner 2010

¹ Bei Universitätskliniken zum Teil nur ungefähre Angaben, da diese Mittel nicht eindeutig einem Topf zuzuordnen sind.

² Weitere 4,3 Mio. Euro für die Universität Rostock ohne genauere Angaben.

A survey, conducted by the DKI itself (Deutsches Krankenhausinstitut 2009), stressed not only the contribution of the healthcare branch for the national economy. It showed moreover, that hospitals have, first, high investment needs and, second, the administrative planning capacities to implement and realize their investment projects *immediately*. The latter was required by the government recovery program which supported only those projects which showed near-term effects in the regional economy (DKI 2009). Representatives of the Federal Hospital Federations finally appealed directly to the responsible federal ministers of health to include hospitals in the economic stimulus programs (see for instance KGNW 2009).

The lobbying finally showed positive effects: The second recovery program (Konjunkturpaket II) included a noticeable financial support for the healthcare branch. With regard to healthcare, two recession-busting measures were stipulated: First, the stimulus package contained financial support for the health insurance funds and bulked up their budget. The economic recovery program enclosed, second, a municipality based infrastructure program. The government grants amounted to 4.67 bn. Euro (Deutsche Bundesregierung 2009; Bundeswirtschaftsministerium 2009). The subsidies, however, could only be used for infrastructure measures, especially for sustainable energy solutions. Moreover, hospitals had to compete with other public services, especially schools, kindergartens, public sports grounds etc. The hospitals finally received 1.3 bn. Euro additional benefits. No difference was made with regard to the ownership status, public as well as private or voluntary hospitals could apply for the program and were taken into account. There were, however, huge distribution differences between the different states: While Mecklenburg-Vorpommern invested more than 40% of the economic stimulus package in the hospital industry, Hamburg allocated only a share of 3% to its hospitals. Table 3 shows how the money has been invested.

3.7 A revival of public ownership?

It is of course, needless to say, too early to give a final assessment on the impact of the financial crisis on hospital governance. Venturing a guess, we can expect that the financial crisis will *not* decelerate the pace of privatization, but accelerate the process of privatization even further. The financial straits of the public hospital owners – the communities – have become even more severe due to the financial crisis. Fiscal objectives provide a strong impetus for local authorities to create an environment which encourages the engagement of private actors. Indeed, reducing public budgets and attracting investments are two of most important factors pushing the privatization of provision and funding in the hospital industry. The privatization process is even more fuelled as the enduring financial straits have meant that public hospitals were often starved of capital and it is therefore a strong need to attract investments. Private hospital companies and financial investors, in turn, have already announced to continue their ‘shopping trip’. Germany, with its (nearly) universal health insurance is still an attractive market for both private hospital companies and financial investors as it still provides comparatively secure investment opportunities.

4. The US case

Turning now to the case of the US, it can be stated that both cases share a number of similarities except for two major differences: The turn to a market driven and debt-financed hospital operation mode evolved several decades *earlier*, and the nexus between the capital market and the hospital industry is much *closer*.

4.1 A market driven hospital industry

In terms of ownership, the US hospital market is characterized by a clear dominance of not-for-profit organizations, which have been the major player in the inpatient sector since the 1930s. This notion of steadiness, however, conceals pervasive changes of the hospital industries' profile over time. First, the history of the US hospital market is a history of both growth and decline. The number of hospitals and beds rose steadily throughout the first half 20th century and reached its peak in the mid 1970s. Major developments that shaped the hospital industry in these times were the introduction of hospital insurance in the 1930s, the implementation of the so called Hill-Burton Act in 1946, and – probably most important – the introduction of Medicare and Medicaid in 1965 providing health coverage for the elderly respective the old. The Hill-Burton Act was introduced against the background of failing efforts to establish a universal health insurance. Providing public subsidies and loans to improve the hospital system, the Hill-Burton Act fostered the growth of the healthcare service sector. It was, however, even more the implementation of Medicare and Medicaid which transformed medicine into a high growth business (Marmor et al. 1986: 313). The reimbursement structure at that time allowed hospitals to cover all expenses no matter whether they resulted from medical treatments, administration, labor costs, research, or even interests on borrowed funds, depreciation, and – in the case of for-profit hospitals – return on equity (Gray 1991: 33).

From the mid 1970s onwards, however, hospital care in the US is characterized by falling demand. Both the number of hospitals and beds declined continuously, mainly to the disadvantage of public hospitals. Several aspects contributed to this development: tighter health planning policies, the introduction of prospective reimbursement, and – above all – the invention of 'managed care' practices. Once a builder of hospitals and a purchaser of health services, the federal government began to adopt the role of a regulator from the mid 1970s onwards (Cacace 2010; Lee/Alexander 1999). There was a rising awareness of the necessity of cost containment, and several measures were introduced in order to control the growth of health services now deemed as unbridled and rampant. The Health Planning Resources Development Act from 1974 replaced the former Hill-Burton Act. This act included amongst other things the requirement of state health plans and establishment of Health Service Agencies (HAS) compiling these health plans. An even stronger impact on the growth of the hospital industry had the replacement of cost-based reimbursement by a flat rate payment based on Diagnosis related groups (DRGs) in the Medicare insurance scheme in 1983, though. Besides these changes in the government's health policies, re-adjusted strategies of the employers explain the shrinking size of the hospital industry. It was in the 1990s when the employers, being the financers of the second major tier of healthcare, developed into 'prudent buyers'. As the government's efforts to contain costs did not yield the intended results, they promoted the concept of 'managed care'. Meanwhile, managed care, a diverse set of contractual and management methods used to arrange the financing and delivering of the healthcare services with the aim to control and reduce costs, has become the major medical practice style (Amelung 2007).

The changing regulation of the healthcare system not only had impacts on the size of the hospital industry, but also on the ownership structure. In the long run, the share of the for-profits increased to the disadvantage of public hospitals. It was especially after the extension of health coverage due to Medicare and Medicaid when the importance of for-profit hospitals rose tremendously.

The introduction of Medicare/Medicaid, however, was *not* the date of founding of for-profit hospitals (contrary Mahar 2003: 15). For-profit hospitals – similar like voluntary institutions - can look back on a long history in the US healthcare system and existed long before inpatient care became a public responsibility (Gray 1991: 31). The introduction of Medicare/Medicaid triggered off shifts in the ownership structure *within* the for-profit sector, though. The inpatient sector experienced the ‘coming of the corporation’ (Starr 1982). New actors entered the stage: financial investors. While the early for-profit hospitals were small physician owned facilities, the for-profits became more and more owned by investors with no medical background after the introduction of Medicare/Medicaid. Concerned with acquiring hospitals, developing them into income-maximizing business organizations, and building up hospital chains, they regarded healthcare as a commodity rather than a service. With the given reimbursement rules hospital bankruptcy was virtually impossible, hospital investment provided guaranteed profits and, hence, made this industry an interesting object for investors (Gray 1991).

The coming of the corporation by no means resulted in a ‘triumph’ of the corporation, though. To the contrary, the not-for-profits remained the dominant ownership type. ‘Isomorphic change’ (Dimaggio/Powell 1983) might explain this development, which is so counter-factual to what social policy researcher expected in the 1980s (Starr 1982; Relman 1980). Not-for-profit hospitals have changed their organizational structures and strategies and have adopted corporate practices (Gray/Schlesinger 2002: 82ff.). Similar as the for-profits, not-for-profits strived to obtain a significant market share in a geographic region. They implemented management practices as well and tried to improve their competitiveness through a centralized administration, through mass purchase of supplies and equipment, through sharing of expensive medical technology and through vertical or horizontal integration. Rather than being mission-driven, the not-for-profits of today are market driven, too. Instead of moderating, they rather intensify the ‘marketplace’ character (Lindorff 1992) of US healthcare.

4.2 A debt-financed hospital industry

In the context of this paper, which likes to highlight the impact of the recent financial crisis on the inpatient sector, one factor fostering the marketplace character is of special interest, which is the growing reliance of the hospital industries’ funding on the capital market. In the aftermath of the introduction of Medicare/Medicaid, private equity markets have beaten other sources of funding. This can not only be traced back to the fact that Wall Street discovered the health industry as a profitable business and that the share of publicly traded for-profit hospitals augmented. The introduction of Medicare/Medicaid increased the nexus between the hospital industry and the capital market *irrespective* of the ownership type. While in former times expansions and renovation projects were financed with capital provided by the Hill-Burton Act, philanthropic grants, and retained earnings, which were reinvested into the organization, from the late 1960s on debt became the preferred solution in order to finance expansion and renovation plans. A combination of several factors fostered this development. As described above, hospital costs were fully covered under the reimbursement rules of the late 1960s – including the costs for interests on borrowed funds. This allowed hospitals to go on a ‘borrowing spree’ (Getzen 2007: 289). In the light of the promise of the steady flow provided by Medicare and Medicaid, investors, in turn, were willing to borrow. Special tax-advantages designed for the not-for-profit hospitals supported this shift to debt-financed inpatient care. The Nixon administration encouraged the not-for-profits to debt financing by introducing tax-

exempted hospital bonds which investors could buy without paying state, federal, or local taxes. As other sources of healthcare capital have dwindled, notably philanthropy, internal reserves, and government grants, tax-exempt debt has become the principal source of capital (Gershberg/Grossman/Goldman 1999). This new access to capital soon replaced older ways of financing investments, and hospital borrowing rose from under 100 million US \$ in 1960 to 2.6 bn. US \$ in 1977 (Getzen 2007: 287).

The shift to debt financing had two impacts: First, while being involved more and more in financial transactions, not-for-profits had to become bottom-line orientated, too. Due to increasing interest payments, they had to make profits to meet the demands of their lenders. Second, the hospital industry in its entirety became dependent on business trends and experienced the game of demand and supply.

In fact, the hospital industry had to face tighter markets soon: With the government and the employers becoming prudent purchasers, restricting reimbursement practices and making increased use of 'managed care' contracts there was soon an oversupply with regard to both hospitals and beds. Investors revised their expectations and treated hospital debt as a risky business – with the effect that access to capital became even more difficult, interest costs rose and the financial straits of hospitals grew.

The story line of the development of the hospital industry from then on is well documented and can quickly be summarized: Hospitals were stuck in a vicious circle: In order to clear debts they had to remain in the competition game and had to maximize their profits. Due to falling demand and oversupply, the possibilities to increase profits, however, were curtailed. Instead of growing by constructing new hospitals, mergers and acquisitions took place. Consequently, the hospital industry has experienced a phase of concentration and consolidation, which reached a peak in 2006, but which still endures up to the present day. In 2006, the hospital giant Hospital Corporation of America (HCA) was acquired by an assembled group of private equity companies including Bain Capital, Kohlberg Kravis Roberts, and Merrill Lynch Global Private Equity. The group of investors, taking advantage of relatively cheap borrowing cost, acquired HCA for over 30 bn. US \$ and claimed to have fulfilled the biggest-ever leverage buyout (NY Times 25/7/2006).

4.3 The credit crunch and the US hospital industry

The case of HCA is only one paradigmatic example for the development the financial markets in general experienced within the last decade: In the years before the crisis, the behavior of lenders changed noticeably. Innovative but increasingly risk-taking financial intermediaries – investment banks, banks, insurers, and others – developed increasingly complex financing products. Debts of diverse groups of borrowers were combined, different forms of risk were remixed, packages of loans were insured against delays of payment and were resold to investors. Rating agencies and loan holders, though, considered all these innovative financing instruments as very safe investments – until the puffy bubble burst in autumn 2008 (Moore et al. 2009).

Credit was unrealistically easy to obtain and unrealistically cheap, and the hospital industry being no exception to other branches – see the example of HCA –, used more and more of it. Compared to Germany, the US hospital industries' reliance on the capital market is much more advanced. Thus, the financial health of the hospital industry was affected by recent financial crisis to greater extent. According to a survey conducted by the American Hospital Association

(AHA 2009) hospitals experience both severe losses in investment income and difficulties in finding new sources of capital. The hospitals' access to external sources of capital is severely constrained as regards tax-exempt bonds as well as equity. Nine out of ten hospitals report that access to capital provides difficulties and that they face a liquidity crisis.

In addition problems on the revenue side arose: A remarkable reduction in philanthropic contributions is to state. Moreover, insurance companies put financial pressure on hospitals by increasing their scrutiny on claims they receive and by delaying payments. Finally, with the financial markets in turmoil and the economy in decline the number of unemployed increased, which implies an increase in the number of uninsured. The lost of employment goes in most cases hand in hand with the lost of health coverage as the unemployed cannot afford private health insurance for them and their families. Thus, hospitals expect increases in charity care, declines in volume and drops in elective procedures. Their response to the financial crisis is to curtail expenses and to postpone investments in facilities and improved services.

Similar to Germany, the US Government enacted bailout plans and economic stimulus packages to overcome the financial crisis. Already in 2008 under the presidency of Bush the so-called *Emergency Economic Stabilization Act* was enacted. While this act focused primarily on the stabilization of the financial sector, the *American Recovery and Reinvestment Act* of 2009, passed under the presidency of Obama, had more the character of a government spending program in the Keynesian tradition. The rescue plan accounted for 787 bn. US \$ and included next to federal tax cuts, an expansion of unemployment benefits and other social welfare provisions, domestic spending in education, healthcare, and infrastructure. In the field of healthcare the plan contains financial support for Medicaid (86.6 bn. US \$) Medicaid and 24.7 bn. US \$ to provide a 65%-subsidy of healthcare insurance premiums for unemployed individuals.¹³

As well as in the German case, however, the Government rescue plans only provide short time solutions: The applied measures cushion the negative impacts of the financial crisis, but provided no sound solutions to make primary healthcare independent from the turbulences in the financial markets in the long run.

5 Conclusion

The German hospital sector has experienced major ownership changes only recently. The share of for-profit hospitals (hold by either public or private owners) has risen sharply within the past years. These changes in the ownership structures have gained much attention in current public and social policy research (Böhlke et al. 2009), where it is discussed if we can observe an 'Americanization' of the hospital industry, namely the convergence to a liberal or private welfare regime (Wörz 2008; Eckhardt 2006).

It is, however, not only the 'coming of the corporation' (Starr 1982), but also the turn to a debt-financed hospital industry which suggests the assumption of an 'Americanization' of the hospital industry. Hospital funding in both countries is increasingly based on means raised on the financial markets. And both private as well as public hospitals have to make recourse to more or less risky financial instruments in order to finance investments.

Germany as well as the US has undergone a growing intertwining between the hospital industry and the capital market. In the US, however, this development is much more advanced

¹³ For more date related to the ARRA and information how and where the recovery funds spent see <http://www.recovery.gov>.

than in Germany. Moreover, while the question of how to maintain unrestricted access to the capital market shaped the US inpatient sector for several decades, tapping financial sources from the financial market has developed to a crucial subject of hospital management in Germany only recently.

Besides the similarities – a growing importance of both for-profit hospitals and capital market funding –, major differences between the hospital industries in the two nations remain, though. These differences between a country with nearly universal health coverage and ‘one nation, uninsured’ (Quadagno 2005) become obvious first and foremost in questions of access and indigent care, which poses severe problems in one country, but not, however, in the other (see also Wörz 2008, 2009).

What can be concluded from these brief glances at the development of ownership in the inpatient sector in the two countries? What the case studies have shown is that capital access explains much of the current attractiveness of for-profit medicine and corporate restructuring. An unintended consequence, however, is that a once recession-proof industry has become vulnerable for financial and economic crises. These facts remain largely unspoken and unheeded in public and social policy research, though. The consequence which should be drawn with regards to public and social policy research is that research interested in privatization and in ‘politics with markets’ not only needs to focus on legal forms, but also on the mix of funding resources to answer the question by whom a certain organization is owned or by whom it is run. The lesson to be learned from a more political point of view is, that the impacts of a hospital industry with close ties to the financial markets on access, quality, and costs need to be discussed. The answer to financial pressure in inpatient care should *not* be to grant unconstrained access to the capital market (the way the U.S. have chosen). Healthcare should be rather considered as a public good which is financed by public means, including both the expenses for running a hospital and for investment projects in order to make the necessity of external funding via the capital market superfluous.

References

- AHA (2009): Report on the Capital Crisis: Impact on Hospitals. <http://www.aha.org/aha/resource-center/Statistics-and-Studies/studies.html>, 10. August 2009.
- Amelung, Volker E. (2007): Managed Care. Neue Wege im Gesundheitsmanagement. Mit 17 Fallstudien aus den USA, Großbritannien und Deutschland. Wiesbaden: Gabler.
- Arbeitsgemeinschaft der Obersten Landesgesundheitsbehörden (AOLG) (2004): Ergänzende / alternative Finanzierungsformen zur Krankenhausfinanzierung der Länder. Bericht der Arbeitsgruppe Krankenhauswesen der AOLG an die 14. Sitzung der Arbeitsgemeinschaft der Obersten Landesgesundheitsbehörden am 11./ 12. November 2004 in Berlin - Kreuzberg Vorlage Berlin, Bremen, Hamburg, Hessen, Nordrhein-Westfalen, Sachsen-Anhalt, Thüringen Erfurt, 29. Oktober 2004.
- Aulich, Chris; O'Flynn, Janine (2007): John Howard: The great privatiser? Australian Journal of Political Science 42 (2), 365-381.
- Berner, Frank (2009): Der hybride Sozialstaat: die Neuordnung von öffentlich und privat in der sozialen Sicherung. Frankfurt/Main: Campus.
- Blum, Karl; Offermanns, Matthias (2009): Krankenhäuser zwischen Innovations- und Kostendruck. Die stationäre Versorgung seit dem Jahr 2000. Das Krankenhaus 101 (4), 295-302.
- Böhlke, Nils; Gerlinger, Thomas; Mosebach, Kai; Schmucker, Rolf; Schulten, Thorsten (Ed.) (2009): Privatisierung von Krankenhäusern. Erfahrungen und Perspektiven aus Sicht der Beschäftigten. Hamburg: VSA.

- Böhm, Katharina; Henkel, Rüdiger (2009): Krankenhausplanung und Krankenhausfinanzierung im Wandel. In: Böhlke, Nils; Gerlinger, Thomas; Mosebach, Kai; Schmucker, Rolf; Schulten, Thorsten (Ed.), *Privatisierung von Krankenhäusern. Erfahrungen und Perspektiven aus Sicht der Beschäftigten*. Hamburg: VSA, 83-96.
- Bundesministerium für Wirtschaft und Technologie (2009): Umweltprämie, download unter <http://www.bmwi.de/BMWi/Navigation/Wirtschaft/Konjunktur/Konjunkturpaket-2/umweltpraemie.html>, (Abruf am 22. Februar 2010).
- Burchardt, Tania (1997). *Boundaries between Public and Private Welfare: a typology and map of services*. London: LSE.
- Burmann, Simone, Schwarz, Astrid & Wehner, Christian (2009): Konjunkturspritze für die Kliniken. *Gesundheit und Gesellschaft* 12(12), 30-33.
- Bruckenberg, Ernst; Klaue, Siegfried; Schwintowski, Hans-Peter (2006): *Krankenhausmärkte zwischen Regulierung und Wettbewerb*. Heidelberg: Springer-Verlag.
- Cacace, Mirella (2010): Wandel von Governance-Strukturen im amerikanischen Gesundheitssystem: Beschreibung und Erklärung anhand der Neuen Institutionenökonomie. Frankfurt/Main: Campus, i.E.
- Collyer, Fran M. (2003): *Theorising Privatisation: Policy, Network Analysis, and Class*. *Electronic Journal of Sociology*. 7(3), 25pp.
- Deutsche Bundesregierung (2009): Die Konjunkturpakete. Wir bauen Zukunft. Download unter: <http://www.konjunkturpaket.de/Webs/KP/DE/Investitionen/investitionen.html> (Abruf am 22. Februar 2010).
- DKG (2009): Deutsche Krankenhausgesellschaft - Aufgaben und Ziele. http://www.dkgev.de/dkg.php/cat/23/aid/2/title/Aufgaben_und_Ziele, 10. August 2009 (Abruf am 22. Februar 2010).
- Deutsches Krankenhaus Institut (2009): *Krankenhaus Trends. Kurzfristige Investitionsmaßnahmen der Krankenhäuser im Jahr 2009. Erhebung Januar 2009*. Düsseldorf.
- DiMaggio, Paul J.; Powell, Walter W. (1983): *The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields*. *American Sociological Review* 48 (2):147-160.
- Eckardt, Martina (2006): Die Entwicklung des Krankenhausmarktes in den USA. In: Jürgen Klauber; Bernt Peter Robra; Henner Schellschmidt (Ed.), *Krankenhaus-Report. Schwerpunkt: Krankenhausmarkt im Umbruch* Stuttgart: Schattauer, 49-63.
- Esping-Andersen, Gösta (1990): *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.
- Flintrop, Jens & Osterloh, Falk (2010): Privatisierung von Krankenhäusern. Die nächste Welle kommt bestimmt. *Deutsches Ärzteblatt* 107 (17), 686-689.
- Gray, Bradford (1991): *The profit motive and patient care: the changing accountability of doctors and hospitals*. Cambridge, Mass. [u.a.]: Harvard University Press.
- Gray, Bradford H.; Schlesinger, Mark (2002): *Health*. In: *The State of Nonprofit America*, edited by L. M. Salamon. Washington D.C.: Brookings Institute Press.
- German University Hospitals Association (2009): *Germany's university hospitals suffer economic crisis*, EUROPEAN HOSPITAL online, download under: <http://european-hospital.net/en/article/6331.html>.
- Gershberg, Alec Ian, Grossman, Michael & Goldman, Fred (1999): *Health Care Capital Financing Agencies: The Intergovernmental Roles of Quasi-Government Authorities and the Impact on the Cost of Capital* NBER Working Paper Series, Vol. w7221.
- Getzen, Thomas E. (2007): *Health Economics and Financing*: Wiley.
- Gilbert, Neil (1983): *Capitalism and the Welfare State*. New Haven: Yale University Press.
- Greer, Ian (2008): Von sozialen Bewegungen lernen: Ein Impuls für deutsche Gewerkschaften. *WSI-Mitteilungen* 61 (4): 205-211.
- Grossi; Giuseppe; Reichard, Christoph (2008): *Municipal corporatization in Germany and Italy*, in: *Public Management Review* 10 (5): 597-617.
- Hesslau, Uwe & Schmidt, Christian (2006): *Der Krankenhausmarkt im Umbruch. M&A-Strategien privater Investoren im Markt*. In: Frank Keupe, Häfne, Michael & Glahn, Carsten Von (Eds.), *Der*

- M&A-Prozess. Konzepte, Ansätze und Strategien für die Pre- und Post-Phase. Wiesbaden Gabler, pp. 62-86.
- Höhmnn, Ingmar (2009): In der Schuldenfalle. Die Mitbestimmung 55 (1/2):16.
- Hood, Christopher (1995): Contemporary public management: a new global paradigm? *Public Policy and Administration* 10 (2): 104-117.
- Kampe, Dieter M.; Bächstädt, Karl-Heinz (eds.) (2007): Die Zukunft der Krankenhaus-Finanzierung: private Investitionen, staatliche Investitionen. 1972-2010. Wegscheid WIKOM.
- Kaufmann, Franz-Xaver (2003): Varianten des Wohlfahrtsstaats. Der deutsche Sozialstaat im internationalen Vergleich, Frankfurt/Main: Suhrkamp.
- KGNW – Krankenhausgesellschaft Nordrhein-Westfalen (2009): Krankenhäuser trägerneutral am Konjunkturprogramm beteiligen. Düsseldorf.
- Lee, Shou-Yih D.; Alexander, Jeffrey A. (1999). Consequences of Organizational Change in U.S. Hospitals. *Medical Care Research and Review* 56 (3): 227-276.
- 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.
- Luksch, Petra (2009): *U.S.-Cross-Border-Leasing-Transaktionen deutscher Kommunen: ein Beitrag zum Recht der öffentlichen Sachen*. Berlin: Duncker & Humblot.
- Mares, Isabela (2001): Firms and the Welfare State: When, why, and how does Social Policy matter to Employers? In: Peter A. Hall & Soskice, David (Eds.), *Varieties of Capitalism. The Institutional Foundations of Comparative Advantage*. Oxford: Oxford University Press, 184-212.
- Marmor, Theodore R.; Schlesinger, Mark; Smithy, Richard W. (1986): A new look at nonprofits: Health care policy in a competitive age. *Yale Journal on Regulation* 3 (2): 313-349
- Mattei, Paola (2009): *Restructuring welfare organizations in Europe: from democracy to good management?* Basingstoke Palgrave Macmillan.
- Moore, Keith; Coddington, Dean; Byrne, Deirdre (2009): The long view. How the financial downturn will change health care. *hfm Magazine* 2009 (1 (January)): 56-65.
- Nullmeier, Frank (2002): Auf dem Weg zu Wohlfahrtsmärkten? In: Werner Süß (Ed.), *Deutschland in den neunziger Jahren. Politik und Gesellschaft zwischen Wiedervereinigung und Globalisierung*. Opladen: Leske & Budrich, pp. 269-281.
- OECD (2003): *Privatising State-owned Enterprises. An Overview of Policies and Practices in OECD Countries*. Paris: OECD.
- Prognos (2009): *Makroökonomische Auswirkungen zusätzlicher Investitionen im Krankenhausbereich im Jahr 2009. Studie im Auftrag der Deutschen Krankenhausgesellschaft*. Basel.
- Powell, Martin; Barrientos, Armando 2004: Welfare regimes and the welfare mix, in: *European Journal of Political Research* 43: 83–105
- Quadango, Jill (2005): *One Nation Uninsured: Why the U.S. Has No National Health Insurance*. Oxford: Oxford University Press.
- Rosenbrock, Rolf; Gerlinger, Thomas (2006): *Gesundheitspolitik. Eine systematische Einführung*. Bern: Hans Huber.
- Sächsischer Landtag (2003): *US Leasing-Geschäfte von Land, Kommunen und Unternehmen der öffentlichen Hand in Sachsen*, Drucksache 3/7806.
- Schlesinger, Mark; Bradford, H. Gray (2006): Nonprofit Organizations and Health Care: Some Paradoxes of Persistent Attention. In: Powell, Walter W.; Steinberg, Richard (Eds.): *The Nonprofit Sector: A Research Handbook*. New Haven: Yale University Press, 378-414.
- Schmidt, Christian; Möller, Johannes (2006): Katalysatoren des Wandels im deutschen Krankenhausmarkt, in: Jürgen Klauber; Bernt Peter Robra; Henner Schellschmidt (Ed.), *Der Krankenhausreport. Schwerpunkt: Krankenhausmarkt im Umbruch*. Stuttgart: Schattauer, 3-19.
- Schulten, Thorsten; Böhlke, Nils (2009): Die Privatisierung von Krankenhäusern in Deutschland und ihre Auswirkungen auf Beschäftigte und Patienten. In: Nils Böhlke, Gerlinger, Thomas, Mosebach, Kai,

- Schmucker, Rolf & Schulten, Thorsten (Eds.), *Privatisierung von Krankenhäusern. Erfahrungen und Perspektiven aus Sicht der Beschäftigten*. Hamburg VSA, 97-123.
- Schuppert, Gunnar Folke (2005): *Der Gewährleistungsstaat – modisches Label oder Leitbild sich wandelnder Staatlichkeit?* In: Gunnar Folke Schuppert (Ed.), *Der Gewährleistungsstaat – ein Leitbild auf dem Prüfstand*. Baden-Baden: Nomos, pp. 11-52.
- Simon, Michael (2005): *Das Gesundheitssystem in Deutschland: eine Einführung in Struktur und Funktionsweise*. Bern: Huber.
- Simon, Michael (2000): *Krankenhauspolitik in der Bundesrepublik Deutschland. Historische Entwicklung und Probleme der politischen Steuerung stationärer Krankenversorgung*. Wiesbaden: Westdeutscher Verlag.
- Starr, Paul (1982): *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry*. New York: Basic Books.
- Statistisches Bundesamt Deutschland (2008): *Gesundheit. Grunddaten der Krankenhäuser. Fachserie 12 Reihe 6.1.1*. Wiesbaden.
- Stumpfegger, Niko (2009): *Wenn die Gründerzeit zu Ende geht*. In *Privatisierung von Krankenhäusern. Erfahrungen und Perspektiven aus Sicht der Beschäftigten*, edited by N. Böhlke, T. Gerlinger, K. Mosebach, R. Schmucker and T. Schulten. Hamburg: VSA.
- Swenson, Peter (1991): *Bringing Capital Back in, or Social Democracy Reconsidered: Employer Power, Cross-Class Alliances, and Centralization of Industrial Relations in Denmark and Sweden*. *World Politics* 43(4), 513-544.
- Taylor-Gooby, Peter; Larsen, Trine; Kananen, Johannes (1999): *Market Means, Welfare Ends: the UK Welfare State Experiment*. *Journal of Social Policy* 33(4), 573–592
- The Wall Street Journal 2009: *Recession Now Hits Jobs in Health Care*, 12. April 2009.
- Wendl, Michael (2009): *Eine neue »innere Landnahme« – Wie öffentliche Krankenhäuser zu kapitalistischen Unternehmen werden*. In: Böhlke, Nils; Gerlinger, Thomas; Mosebach, Kai; Schmucker, Rolf; Schulten, Thorsten (Ed.): *Die Privatisierung von Krankenhäusern in Deutschland und ihre Auswirkungen auf Beschäftigte und Patienten*, Hamburg: VSA, 220-244.
- Wendt, Claus; Frisina, Lorraine; Rothgang, Heinz (2009): *Health Care System Types. A conceptual framework for comparison*, in: *Social Policy & Administration* 43 (1): 70-90.
- Windolf, Paul (2005): *Was ist Finanzmarktkapitalismus?* In: Paul Windolf (Ed.), *Finanzmarktkapitalismus. Analysen zum Wandel von Produktionsregimen*. Wiesbaden: VS, pp. 20-57.
- Wörz, Markus (2009): *Unterschiedliche Träger von Krankenhäusern in den USA*. In: Böhlke, Nils; Gerlinger, Thomas; Mosebach, Kai; Schmucker, Rolf; Schulten, Thorsten (Ed.): *Die Privatisierung von Krankenhäusern in Deutschland und ihre Auswirkungen auf Beschäftigte und Patienten*, Hamburg: VSA, 66-80.
- Wörz, Markus (2008): *Erlöse - Kosten - Qualität: Macht die Krankenhausträgerschaft einen Unterschied? Eine vergleichende Untersuchung von Trägerunterschieden im akutstationären Sektor in Deutschland und den Vereinigten Staaten von Amerika*. Wiesbaden: VS Verlag für Sozialwissenschaften.
- Ziehe, Manja (2009): *Innovative Finanzierungsinstrumente im Krankenhaus: Vergleich von Finanzierungsmöglichkeiten zur Umsetzung von Investitionsprojekten in kleinen und mittleren gemeinnützigen Krankenhäusern in Deutschland anhand eines Fallbeispiels: sind derzeit propagierte innovative Finanzierungslösungen eine echte Alternative?* Frankfurt/Main: Peter Lang.

Contact Details

Centre for Social Policy Research
 University of Bremen
 Dr. Tanja Klenk
 Parkallee 39
 28209 Bremen, Germany
 Tel. + 49 421-218-4370
 Mail: tklenk@zes.uni-bremen.de