**Thorsten Schulten**

# GERMANY

## INTRODUCTION

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

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

## 1. THE GERMAN HOSPITAL SECTOR – AN OVERVIEW

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

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

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



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

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

## 2. THE PROCESS OF LIBERALISATION AND PRIVATISATION

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

Since there has never been a public monopoly in the German hospital market, there have been no attempts for an explicit liberalisation policy. However, changes in the social, political and economic framework conditions led to an overall economisation and commercialisation of the health sector, which has promoted an ongoing restructuring process of German hospitals. One of the most obvious signs of this trend has been the growing number of privatisations. Although the first privatisation of a public hospital took place as early as 1984 (cf. Meyer-Timpe 2006), there was not much change in the composition of hospital ownership until the early 1990s. After German unification in 1990 a first wave of privatisations of hospitals took place – mainly in eastern Germany – as part of the transformation process from a former state-socialist towards a capitalist market economy. Since the beginning of the new millennium a second wave of hospital privatisations has started which now covers all regions of Germany.

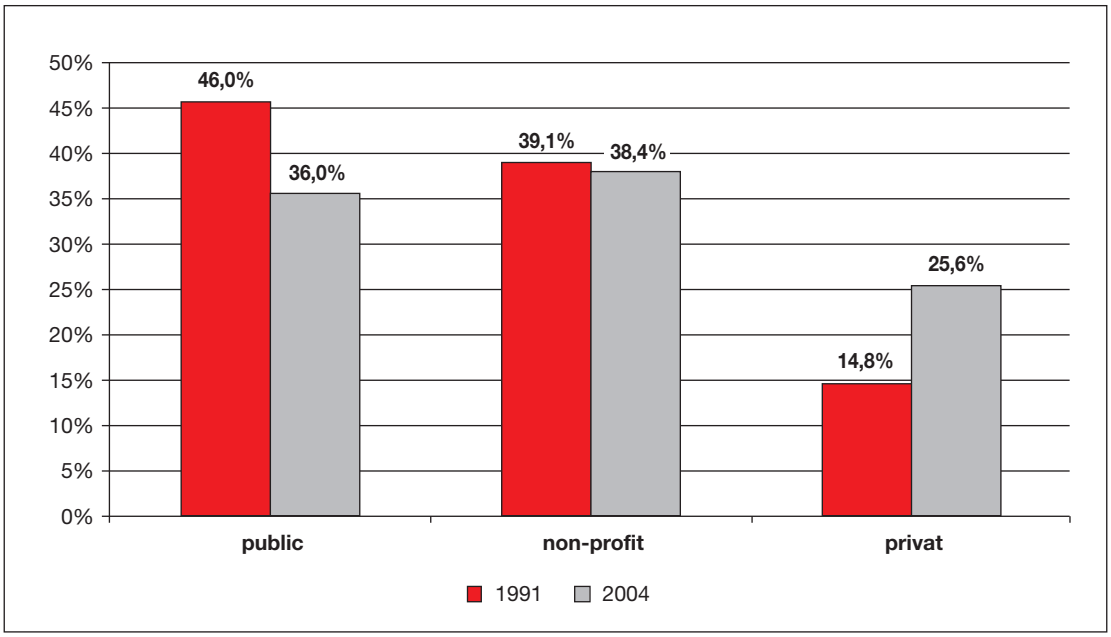
Between 1991 and 2004 the proportion of private hospitals increased from 14.8% to 25.6% (Figure 1). At the same time the share of public hospitals decreased from 46% to 36% while the proportion of non-profit hospitals remained relatively stable. There are also significant regional differences in the share of private hospitals varying from 45% in Berlin to still 0% in Saarland.

Although public ownership has lost its majority regarding the total number of hospitals it still has a dominant position when the numbers of hospital beds are considered. In 2004 a majority of 52.8% of all beds were still provided by public hospitals in comparison to only 11.5% provided by private hospitals (Figure 2). The dominant position of public hospitals becomes even more pronounced regarding the number of employees: Nearly 60% of all hos-



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

**Figure 1: Ownership of German hospitals 1991 and 2004**

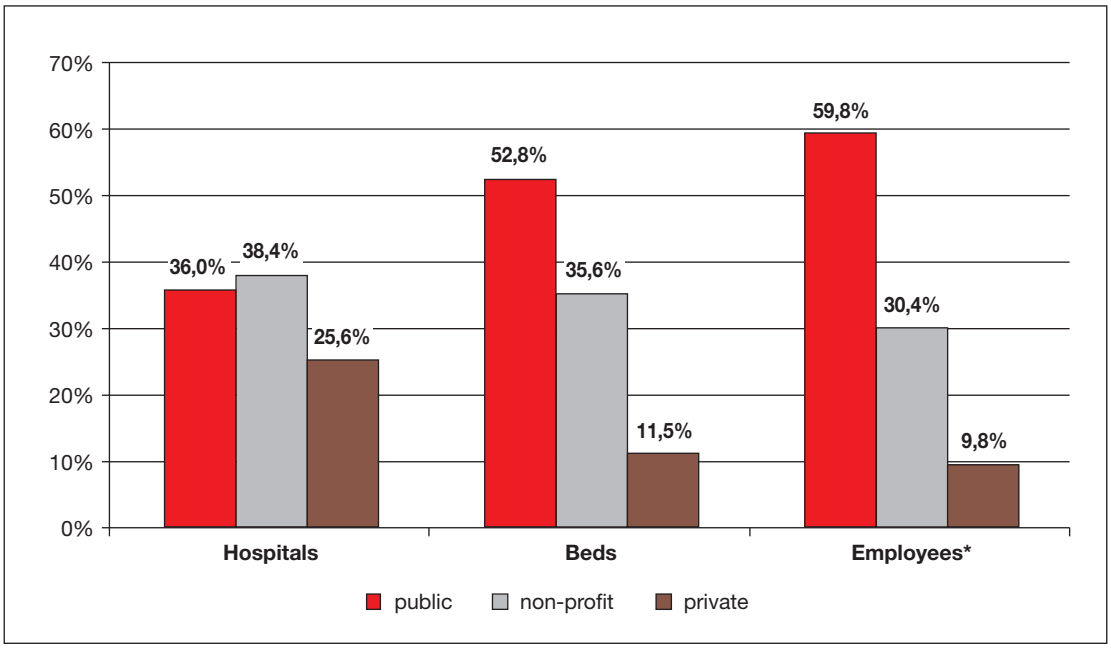



Source: Statistisches Bundesamt (2005)

pital workers were employed by public hospitals, while private hospitals still had less than 10% of all employees.

So far, the privatisation of German hospitals has been the domain of smaller clinics (cf. Strehl 2003). In 2004 more than 82% of all private hospitals had less than 200 beds and more than

**Figure 2: Proportion of hospitals, beds and employees* in Germany according to different ownerships (2004)**




* full-time equivalents
Source: Statistisches Bundesamt (2005)

**Table 1: Ownership and size of German hospitals (2004)***

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

* Only general hospitals
Source: Statistisches Bundesamt (2005)

63% even provided less than 100 beds. Only about 4% of all private hospitals were larger clinics with more than 500 beds. In contrast to that a majority of 62% of public hospitals were of medium or large size. Nearly one quarter (23%) provided more than 500 beds (Table 1).

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

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

Almost all studies on the German hospital sector estimate that the privatisation process will continue in the future and will also include larger clinics. For example, a study carried out by the economic research department of the Allianz Group predicts that by 2020 the proportion of private hospitals will increase from currently 25% up to 40% (cf. Hess 2005, 11). Other studies estimate that the share of private hospitals might even grow to 50% (cf. Sal Oppenheim 2001; Schmidt et.al. 2003). Regarding university hospitals a study by Dr. Wieselhuber & Partner Consultancy estimates that in 2015 about 23% of all hospital clinics will have been privatised and further 29% will be organised through public-private-partnerships (cf. Dr. Wieselhuber & Partner 2006).



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

## 2.1 Major private hospital companies

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

The German hospital market is so far almost exclusively dominated by German companies. However, since privatisation and restructuring will continue this might also attract more foreign healthcare companies to the German market. A first major acquisition made by a foreign company took place in August 2006 when the Swedish healthcare company Capio announced the takeover of Deutsche Kliniken GmbH, which is one of Germany's largest private hospital companies (cf. Capio 2006).

## 2.2 Drivers for privatisation

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

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

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

Although the crisis of public finances is rooted in political decisions, it is usually treated as a "constraint" for political action. Against that background the German federal states, which according to the German Hospital Financing Act have the main responsibility for hospital planning and the financing of hospital investments, have been less and less active in fulfilling



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

their tasks. For many years they have not provided sufficient financial resources for hospital investments (cf. Bruckenberger 2005). Various studies estimate that the current backlog of necessary investments in hospitals amounts to around 30 billion euro (cf. Augurzky et.al. 2004; Bruckenberger 2005; Hess 2005).

Moreover, since the German hospital financing system does no longer guarantee full cost compensation, many German hospitals have not been able to finance their operational business. According to figures provided by the German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG) more than one third of German hospitals had a negative annual balance sheet in 2004 (cf. Deutsches Krankenhausinstitut 2005, 62). The municipal employers association *(Vereinigung der kommunalen Arbeitgeberverbände,* VKA) even claim that nearly 50% of all public hospitals were running deficits (cf. VKA 2006). The financial losses of the public hospitals have to be covered by their public owners, who are often them-selves in serious financial difficulties.

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

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

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

## 2.3 The European dimension

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



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

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

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

The European Commission has regarded health services as "services of general interest" where the application of the EU competition law should be subject to some restrictions (cf. European Commission 2004). In its "Altmark decision" of July 2003, the ECJ defines some relatively restricted conditions under which public authorities are allowed to compensate for deficits of public companies (cf. Rinken and Kellmer 2006, 5). However, from a legal point of view it is still unclear if theses criteria also apply to public hospitals. In 2005 the European Commission (2005, 5) published a draft decision in which it proposed somewhat less restricted conditions for deficit compensation in public hospitals. Depending on further juridical clarifications and decisions of the ECJ and the European Council on the treatment of services of general interest and hospital services in particular the European level might have a much stronger impact on the restructuring of the German hospital sector in future.

## 3. PROVISION, PLANNING AND FINANCING OF HOSPITALS

The basic regulation of the provision, planning and financing of hospitals is laid down in the German Social Security Code No. 5 *(Sozialgesetzbuch,* SGB 5) and in the Hospital Financing Act *(Krankenhausfinanzierungsgesetz,* KHG). The responsibility to provide sufficient hospital



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

services lies with the governments of the German Federal States *(Länder).* According to Article 6, Para 1 of the KHG the federal states are obliged to produce and regularly update a hospital plan, which details the provision of hospital-based medical care in the respective state. Contents and methods of hospital planning are determined at federal state level and differ substantially among states. As laid down in Article 7, Para. 1 of the KHG the ministry responsible within the federal state has to work out the hospital plan under participation of and in consultation with the regional associations of the German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG) as well as the regional health insurance funds.[2] In recent years the federal state administrations have also increasingly involved consulting firms and research institutes in the planning process (cf. Busse and Riesberg 2004, 105). As Article 1, Para 2 of the KHG determines, the hospital plan has to guarantee a structure of hospitals with different forms of ownership, i.e. not only public but also non-profit and private hospitals have to be considered in the hospital plan. As a result of Germany's essentially regional system of hospital planning, there are significant differences among the federal states regarding the number of hospitals and hospital beds in relation to the population (cf. Deutsche Krankenhausgesellschaft 2006).

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

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

Until the end of 1992 all operational expenditures had to be financed by the social health insurance funds, so that it was impossible for hospitals to make deficits. The actual remuneration was mainly done through per-diem charges where each day's treatment per patient was compensated at a flat rate, irrespective of the individual treatment input required. In the 1980s, however, this system of hospital financing became increasingly accused of creating "incentives to keep patients in hospital for longer than medically necessary to increase the occupancy rate of the oversized bed capacities" (Hess 2005, 4).

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



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

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

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

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

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

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



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

as one further major cause of the ongoing process of restructuring and privatisations in the German hospital sector.

### 3.1 Restructuring of hospitals and German competition law

Since the growing number of mergers and takeovers, the German hospital sector has become more and more confronted with the German competition law. On 11 March 2005, the Federal Cartel Office *(Bundeskartellamt)* prohibited for the first time the takeover of two public hospitals in the district of Rhön-Grabfeld by the private hospital company Rhön-Klinikum AG in order to prevent a dominant position of a single hospital provider in a certain regional market (cf. Monopolkommission 2006). Only two weeks later, on 29 March 2005, the Federal Cartel Office also prohibited Rhön from acquiring the municipal hospital of the city of Eisenhüttenstadt. In April 2005 the Cartel Office accepted the acquisition of majority shares in the public hospital group LBK Hamburg by the private hospital company Asklepios only under the condition that Asklepios goes on to sell one of the seven LBK hospitals. In its justification of its decisions the Cartel Office recognised the special status of hospitals and made clear that it is not against privatisations in principle (cf. Bundeskartellamt 2005). The affected private hospital company Rhön has made an appeal against the decision of the Cartel Office at the Higher Regional Court *(Oberlandesgericht)* (which has not yet passed a final judgement). At the same time the regional government of the Rhön-Grabfeld district asked the Federal Ministry of Economics to give a special permission *(Ministererlaubnis)* for the takeover.[3] In May 2006, however, the Ministry rejected this demand and confirmed the decision of the Cartel Office (cf. Ministry of Economics 2006).

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

## 4. OUTLOOK

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

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



*Sozialpolitik in Diskussion, Band 5/2007: Seiten 37–49*

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

## REFERENCES


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

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

*Augurzky,* Boris und Sebastian *Krolop* und Andreas *Liehr-Griem* und Christoph M. *Schmidt* und Stefan *Terkatz* (2004), Das Krankenhaus, Basel II und der Investitionsstau, RWI-Materialien Nr. 13, Essen.

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

*Bruckenberger,* Ernst (2005), Privatisierung der Krankenhäuser. Eine Alternative zum Investitionsstau; www.bruckenberger.de.

*Bruckenberger,* Ernst und Siegfried *Klaue* und Hans-Peter *Schwintowski* (2006), Krankenhausmärkte zwischen Regulierung und Wettbewerb, Berlin.

*Bundesministerium für Wirtschaft und Technologie* (2006), Keine Ministererlaubnis im Fall Landkreis Rhön-Grabfeld/Rhön-Klinikum AG, Pressemitteilung, 22. Mai 2006.

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

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

*Bundesministerium der Finanzen* (2006b), Einnahmen und Ausgaben der Länder im Jahr 2005; http://www.bundesfinanzministerium.de.

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

*Capio* (2006), Capio Press Release 21 August 2006.

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

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

*Deutsche Gesellschaft für Versicherte und Patienten* (2005), Fehlentwicklungen in stationären Einrichtungen des Gesundheitswesens, Paper released for a press conference 25 October 2005 in Berlin.

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

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

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

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

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

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

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

*Hansestadt Hamburg* (2004), Volksentscheid: Senat stellt fest, dass die Vorlage der Initiatoren angenommen wurde, Pressemitteilung, 9. März 2004.

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

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

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

*Kühn,* Hagen (2003), Ethische Probleme der Ökonomisierung von Krankenhausarbeit, in: *Büssing,* Andre und Jürgen *Glaser* (Hg.), Dienstleistungsqualität und Qualität des Arbeitslebens im Krankenhaus, Göttingen, 77-98.

*Kühn,* Hagen und Sebastian *Klinke* (2006), Krankenhaus im Wandel, in: WZB-Mitteilungen Nr. 2/113, 6-9.

*Löser-Priester,* Ingeborg (2003), Privatisierung öffentlicher Krankenhäuser und Partizipation der Beschäftigten, Frankfurt am Main.

*McKinsey* (2006), Krankenhausreform weitgehend ausgereizt, Pressemitteilung 2. Mai 2006.

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

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

*PLS Ramboll Management* (2004), Geschäftsmodelle privater Konzerne im Krankenhaussektor, unveröffentlichtes Manuskript.

*Rehm,* Fabian (2006), Krankenhäuser zwischen Ökonomisierung und Privatisierung, in:. Zeitschrift Marxistische Erneuerung, 17. Jahrgang, Nr. 66, 83-93.

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

*Rolland,* Sebastian (2005), Krankenhäuser in Deutschland 2003, in: Wirtschaft und Statistik Nr. 8, 838-848.

*Rosenow,* Christiane und Anke *Steinberg* (2002), Zehn Jahre bundeseinheitliche Krankenhausstatistik, in: Wirtschaft und Statistik, Nr. 5, 383-391.

*Sal Oppenheim* (2001), Neues Vergütungssystem beschleunigt Privatisierung – Sal Oppenheimstudie zur Entwicklung des Krankenhausmarktes in Deutschland, Pressemitteilung, 1. Oktober 2001.

*Schmidt,* Christian und Thomas *Gabbert* und Florian *Engler* und Florian *Fischer* und Jochen *Breinlinger-O'Reilly* und Johannes *Möller* (2003a), Investoren im Gesundheitsmarkt, in: Deutsche Medizinische Wochenschrift, Nr. 128, 1551-1556.

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

*Simon*, Michael (2000), Krankenhauspolitik in der Bundesrepublik Deutschland, Opladen/ Wiesbaden.

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

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

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

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

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

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

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

*Tissen,* Wolfgang (2005), Kommunal oder privat: Wohin tendieren die Krankenhausunternehmen, Interview mit Wolfgang Tissen, in: Das Krankenhaus, Nr. 8, 648-649.

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

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

*Vereinigung der kommunalen Arbeitgeberverbände* (2006), Hintergrundinformationen zum Tarifkonflikt zwischen der VKA und dem Marburger Bund, Pressemitteilung, 27. Juni 2006.

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