Panel

Comparative Health Policy: Foundations, Foibles and Futures

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Marketization of Public Health Services? Comparing Public Hospital Infrastructure Policies in Germany and France via their Instrumentation

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Abstract: Starting from the hypothesis of a ‘marketization’ of public health services in Western states, the paper compares the change of public hospital services in Germany and France between 1990 and 2010. It aims to analyze and comparatively reassess the marketization-hypothesis with regard to the two continental European Bismarckian-style welfare states. We start from an understanding of hospitals as public infrastructures which, for functional reasons and due to the public interest connected to their supply, are not ‘normal’ marketable goods. Based on this premise the democratic constitutional welfare state has a specific responsibility for the adequate supply of social and health infrastructures, which has been differently institutionalized in the two cases under scrutiny. We particularly ask how the German and French states managed the (external) pressure towards marketization of hospital services and it has changed in its role as a welfare state in the course of this process. Drawing from the instruments-approach of policy analysis we develop a framework for a typology-based comparison of health infrastructure provision-strategies in different mature welfare states. We apply the framework to the two cases and present data from document analysis and expert interviews. It is shown that notwithstanding similar market-oriented evolutions regarding the instrumentation of hospital ownership structures, investment and hospital planning, the orientations of German and French public decision-takers about the provision of hospital services diverged over the past twenty years. Public hospital infrastructure policy became more privatized in the German case pointing to a ‘dismantled state’, and it remained widely regulated in the French case hinting to the installation of a market-oriented though ‘dirigiste state’. In the final part of the paper, we suggest a number of possibly explanatory hypotheses regarding the found variance.

1. Introduction

Providing the population with medical care in hospitals is a central element of the social and health public services in Germany and France like in every developed welfare state. Having high quality in-patient medical care facilities at one’s disposal not only constitutes a major public interest in every member country of the OECD irrespective of its classification as a welfare regime (cf. Esping-Andersen 1990), but it can furthermore be considered “an operative precondition for the functioning of modern differentiated societies” (Schneider/Tenbücken 2004, 17) at large. Only where this basic infrastructural condition is met, the welfare state is able to meet its public (health) service functions correctly (cf. Reuter/Zinn 2011). The widely shared understanding of stationary medical care services and hospitals as “infrastructures” in the sense of vital “[...] territorially comprehensive, basic, and enduring material or immaterial support systems” of modern societies (Schneider/Tenbücken 2004, 17) [Translation by the author] has been consequential for the modern national welfare state since its emergence in the late 19th century. It implies a particular responsibility for the state as regards the warranty of supply with an area-wide network of high quality hospitals or stationary health care facilities.

Unlike countries representing the liberal or social democratic welfare regimes, Germany and France as classic paragons of the continental European Bismarckian-style organized conservative welfare regimes used to realize their supply responsibilities jointly with “third actors” (Salamon 2002, 2 and 6) – traditionally the communes, the churches, other charitable actors, and small specialized private providers (doctors). For many years after the Second World War, these actors...
constituted indispensable parties within more or less explicit and intensely regulated and widely stable (“frozen”) public-private supply partnerships characteristic of the German and French hospital systems (cf. Alber 1992). Yet, under the influence of growing external and internal pressures for modernization and market-oriented transformations, these generally change-resistant Bismarckian welfare states have come under reform stress all the more so (Palier/Martin 2008). Since the beginning of the 1990s, scholars of welfare state comparison have witnessed that both the German and the French welfare systems are undergoing processes of restructuring with “liberalization” or “economization” or also “marketization” being the dominant orientation specifically as regards the public social and health services sector (Gerlinger/Mosebach/Schmucker 2009, 146; Götz/Cacece/Rothgang 2009; André/Hermann 2009; Bode 2010, 189). Within the comparative literature on German and French health policy reforms, estimations about the welfare states’ own change have not always corresponded, though. Whereas some have argued that both countries have converged towards the type of a dismantled, liberalized or “privatized” state (cf. Mosebach 2009), others have contended that the national reform tracks have rather diverged, resulting in ‘less state’ in the German case and surprisingly ‘more state’ in the French case (cf. Hassenteufel 2010).

This controversy forms the initial point of this paper. We are specifically interested in the welfare states’ change in the course of the implementation of health services reforms in the two continental European conservative welfare states Germany and France between 1990 and 2010. Particularly, we will be dealing with the questions how the German and French states – being represented by central government and also the governments of the 16 federal regions (Bundesländer) in the German case – managed the (external) pressure towards marketization of hospital services and how they have changed in their role as a welfare state in the course of this process. We start from the thesis that the specific quality of hospitals as infrastructures and the resulting supply responsibility born by the constitutional democratic state puts the national regulator under specific pressure when it comes to market-oriented adaptations of the welfare state; these anyhow emerge differently given the varying institutional foundations of hospital services in different national welfare states. On this basis, we argue that ‘more market’ might thoroughly go along with ‘more state’ in the sense re-regulation or more intense regulation (cf. Vogel 1996).

In terms of concepts, we apply a multifaceted definition of ‘marketization’ and draw from the instruments-approach of public policy analysis (Lascoumes/Le Galès 2004) in order to measure the processes implications for the welfare state. In this context, we use instrument-change as an indicator for welfare state change and develop a framework for a typology-based comparison of national health infrastructure provision-strategies in the two cases under scrutiny. In terms of methods, the paper constitutes a comparative qualitative case study based on document and secondary analysis and the use of data from ten non-standardized expert interviews.

The paper is organized as follows: First, we want to explicate our conceptual approach (2.). Second, we compare the institutional framing and governance

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2 To cite just some of these well-known developments pressing towards liberalizing reforms, we could mention: the international diffusion of the new public management doctrine; the rising demand of national populations for [stationary] medical services; rising health costs due to the medico-technical progress; partly externally (EU, OECD) imposed policies of austerity in mature welfare states.
arrangements in the field of public hospital infrastructure policies in Germany and France (3.). Third, we comparatively analyze the change of the instrumentation of public hospital infrastructure policies in the two cases between 1990 and 2010 and apply the typology in order to document the welfare states’ change (4. and 5.). Finally, we sum up and conclude by presenting a number of hypotheses which might serve as starting points for further empirical analysis on the explanation of variation between the two cases (6.).

2. Policy instrument-change and the ‘marketization’ of public health services

Related to the specific nature of public health services including medical care in hospitals as 'infrastructures' the modern constitutional democratic national welfare states within the OECD-world have always assumed a particular responsibility for the supply of the population with according area-wide network of high quality hospitals or stationary health care facilities. In many welfare states irrespective of their particular regime type, the state for long assumed a large part of this supply responsibility on its own, i.e., in the role of an active producer of public services of all sorts (Naschold 1999). Yet, influenced by rising external and internal stresses for modernization, management-based adaptations of public service organizations and generally liberalizing, market-oriented transformations of the welfare state, national regulators came under pressure to redefine the states’ role as a supplier of these services since the late 1980s.

In countries regularly being affiliated to the liberal welfare capitalist regime type (cf. Esping-Andersen 1990), the states’ reaction was quite clear very early in this marketization process: in the UK with its state organized health system for example, the changing conservative (Thatcher, Major) and Labour (Blair) governments since the 1980s wished to implement the concept of a lean state and privatized all sorts of public services or – in the case of the still state-led national hospital service and NHS-hospitals – implemented efficiency-oriented reforms based on the idea of [economic] performance and on the creation of internal markets (care trusts) (Hope/Dexia 2008, 89; Schölkopf 2010, 116). On the other side, in countries regularly being associated with the social-democratic regime type, especially the Scandinavian countries with their equally state organized health systems, governments wished to retain the strong publicly (central-state; communes) ruled less-competition-driven mode of provision of public social and health services (cf. Alber 1992; Reuter/Zinn 2011; Hope/Dexia 2008, 89). Finally, in countries which are associated with the conservative regime type, namely Germany and France with their Bismarckian-style insurance-based health systems, the national reform strategies and related trajectories regarding public social and health services were less straightforward. And steps towards welfare state reform were often hampered by the specific institutional structures, leaving room for the influence of multiple interest-actors (Palier/Martin 2008, 9). Yet, since the beginning of the 1990s, scholars of welfare state comparison have witnessed dynamic processes of reform of their public social and health service sector, frequently with a competition-oriented and market-creating impetus (Hassenteufel/Palier 2008, 59).

The comparative analysis of market-oriented welfare state reforms especially in the cases of the continental European Bismarckian welfare states sometimes is impeded by misunderstandings resulting from a variable use of the sketchy term ‘marketization’. This is associated by some authors first and foremost with
“privatization” of public goods and services (Mosebach 2009), whereas it is associated by others with first and foremost with liberalization and deregulation (Hassenteufel 2010; also: Höpner et al. 2011). Referring to Vogel, who studied the marketization and state change in regard to technical infrastructures, we argue that marketization can include both the privatization of public goods and services and the deregulation of production and service conditions, but also the re-regulation of these conditions which in some cases accompanies the authorization of more private engagement by the national regulator (1996, 3).

To analyze the marketization of public hospital services, we suggest a multi-faceted definition of the term which is sensitive of this span of public policy re-instrumentation related to market-oriented reforms. Furthermore, we propose to utilize the instruments-approach of public policy analysis (cf. Lascoumes/Le Galès 2004) in order to measure the implications of marketization for the change of the welfare state. We define marketization as the politically wanted sometimes protracted process of the re-commodification of former publicly offered or publicly-protected/-funded goods and services by (in-) formally re-labeling them into profitable goods and services and putting a marketable prize to them or leaving price formation completely to the market (cf. Crouch 2009, 879). Marketization thus implies the (re-) instrumentation or change of instruments of the public policies underlying public service production.

Students of public policy instruments and instrument choice have been asking what different governments’ choice and use of instruments tells us about state action and about the states’ role when it comes to the perception of public policy problems and to the realization of public policy goals (cf. Lowi 1966; Salamon 1981 and 2002; Hall 1993; Lascoumes/Le Galès 2004; Howlett et al. 2009). In this context, some have been interested in the question of how instrument-analysis could be used to ‘optimize’ public management and state intervention (Salamon 1981: 256; Howlett et al. 2009, 114). Yet others contended that the instrumentation of public policies helps us to understand the relationship between the state and societal and/or private actors in the perception and solution of public problems as well as the change of this relationship more generally (Hall 1993, 283-287; Lascoumes/Le Galès 2004, 29). Critically against the primarily functionalist perspective, namely Lascoumes and Le Galès have argued that instruments are not politically neutral, but that their choice constitutes a “political gesture” (2004, 358) which expresses a certain form of power exertion, a certain understanding of the states’ authority and/or certain routines of governance as well as the way in public problems are generally perceived by state actors (ibidem.). Based on this argument, one can argue that instrument choice may also be telling about how the welfare state is going to assume its infrastructural supply responsibility in regard to social and health services in the future.

The most basic instruments of state action are rules or laws and public money. Researchers on policy instruments have shown that these can be used in quite different ways or modes associated with command and control-oriented action, or incentives and sanctions-oriented action, cooperation-oriented action, or also liberation and self-regulation oriented action vis-à-vis societal actors (cf. Salamon 2002, 21; Howlett/Ramesh 2003, 92; Lascoumes/Le Galès 2004, 361; Halpern/Le Galès 2011: 57). Roughly, at least four variants of the instrumentation of public services are feasible on this basis:

- first, the direct detailed ruling and/or the public financing of the public function in question;
second, the partly direct framework regulation which deliberately leaves room for a cooperative fulfillment and a shared public-private provision and/or financing of the public function in question;
- third, the indirect regulation which deliberately draws on the private fulfillment and financing of the public function in question e.g. through financial incentives, public information about and observation of the market-like production as well as the setting of basic rules to avert market failure; and
- fourth, the full privatization of a service which implies its deregulation and/or full private financing and, if any, public information about market conditions.

Each of these four variants of instrumentation goes along with a certain pattern or type of state which can be transposed to the field of hospital infrastructure provision (table 1; cf. Lascoumes/Le Galès 2004, 361):
- first, what we will call the direction- or dirigiste state who fulfills and finances the public function in question completely on its own;
- second, the intervening state who fulfills and finances the function in question in cooperation with societal non-profit-oriented and/or private profit-oriented actors;
- third, the guaranteeing state who warrants the provision of the service or good without being directly involved; and
- fourth, the dismantled state who leaves the provision of the good/function, service to private market actors.

How can we use the concept for an analysis of the marketization of public hospitals services and the change of public hospital infrastructure policy as its regulatory basis? In this respect, we first need a clearer understanding of this policy. Public hospital infrastructure policy in the developed welfare states comprises at least four regulatory dimensions or fields in regard to which a differentiated use of the rule- and money instruments is feasible (cf. Hope/Dexia 2008). These are the regulation of 1. hospital supply (and owner) structures; 2. medical treatment and care service financing; 3. investment financing; and 4. the territorial allocation of hospital services. On this basis, the alternative roles of the welfare state in the provision of hospital services look as follows:

Table 1: Instrumentation of hospital infrastructure policy and state-type.

<table>
<thead>
<tr>
<th>Hospital supply (and owner) structures</th>
<th>Dirigiste state</th>
<th>Intervening state</th>
<th>Guaranteeing state</th>
<th>Dismantled state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-production</td>
<td>Full financing (per diem charges)</td>
<td>Full pricing combined with DRG-financing</td>
<td>Full pricing combined with market-based financing</td>
<td>Fully market-based private financing</td>
</tr>
<tr>
<td>Welfare mix</td>
<td>Budgets (combined with DRG-financing)</td>
<td>Flat-rated public financing</td>
<td>Flat-rated public combined with market-based financing</td>
<td>Fully market-based private financing</td>
</tr>
<tr>
<td>Contracting out and PPPs</td>
<td>DRGs (+ price-competition on elective services)</td>
<td>Framework planning performance based (shadow of hierarchy)</td>
<td>Framework planning performance based (shadow of hierarchy)</td>
<td>Material privatization</td>
</tr>
<tr>
<td>Material privatization</td>
<td>Fully price competition</td>
<td>Private allocation decisions</td>
<td>Private allocation decisions</td>
<td></td>
</tr>
</tbody>
</table>

Taking this systematization, we will now turn to the change and the supposed marketization of public hospital service provision in Germany and France. To analyze the change of the instrumentation and the states’ role in public hospital service
provision in the course of hospital infrastructure policy reforms in both countries between 1990 and 2010, we use secondary and document analysis as well as data from on ten explorative non-standardized expert interviews which we carried out with German and French experts of the national health and hospital policies in 2011.

3. Governance arrangements and institutional framing of hospital services

Germany and France share some similarities but are also characterized by a number of differences as regards the institutional framing of and the governance arrangements for the regulation of hospital service provision.

Amongst the correspondences, we can first mention the similar formal foundation. The supply of hospital services is a public function defined by law in both countries. In Germany, hospital infrastructure policy has its legal basis in the German constitution, the Grundgesetz (GG), which says that Germany is a “social state” (Art. 20,1 GG) and declares the “economic protection of hospitals” (Art. 74,1 No. 19a GG) as a function of the state which is attributed to the German Bundesländer. On this general constitutional basis, the German Social Code (SGB) and the federal law on hospitals, the Krankenhausgesetz (KHG), contain more detailed regulations of the related functions. In France, the provision of hospital infrastructure has its legal foundation first in phrase 11 of the still effective preamble of the 1946 Constitution of the Fourth Republic saying that the “protection of health” is guaranteed to every human being standing on French territory. Beyond and adjacent to this, article L6112-8 (part 6, book 1) of the French Code of public health (Code de la Santé Publique) declares: “The state disburses those expenditures which establishments of health care have to bear due to the provision of public services.”

Second, in a wider institutional perspective, Germany and France share same basic characteristics as regards their welfare systems are state. In comparative social and health policy they are classified as continental European conservative welfare regimes with a primarily Bismarckian-style, social-insurance based wage-earner centered organization of solidarity (cf. Palier/Martin, 2008). As has already been mentioned in the introductory part, both in Germany and France, “third parties” play a major role as well for the warranty of social security against the major life risks (social insurances, social partners as actors of social insurance self-government) as well as regarding the production of social and health public services (communes, churches, charitable private actors, private for-profit actors). In the field of hospital services, these actors traditionally have been the communes, the churches, other charitable actors, and small specialized private providers (individual doctors or groups of doctors) who were motivated primarily by professional interests and filled in particular supply gaps on the local or regional level.

Besides these similarities, a number of significant differences appear as regards the governance arrangements particularly underlying the four regulatory fields of hospital service provision. In terms of the regulation of hospital supply (and owner) structures, private actors play a rather diverse role in both systems: whereas in the German

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3 In France, we carried out six interviews with representatives of the national ministry of health (IGAS), of the government funded scientific institute on health policy IRDES and with researchers on public hospital policy, and in Germany, we conducted four interviews with representatives of health administration of different German Bundesländer.
case private (not-for-profit and for-profit) bearers besides public owners take a similar part in the provision of the diverse segments of medical treatment (acute- and emergency maintenance; general maintenance in different segments of treatment; specialized treatment), in France, public and not-for-profit actors traditionally bear the largest part of acute- and emergency treatment and primary health care, while private profit-oriented cliniques traditionally have specialized in specific treatment sectors with a well calculable economic risk (obstetrics; surgery) (Hope/Dexia 2008, 78).

Adjacent to this, the nominal and relative significance of private, for-profit bearers of hospital services as compared to public and private not-for-profit bearers varies between Germany and France (cf. table 2). Whereas in France, the number of private clinics has traditionally been similar to that of state-led or public hospitals (with private not-for-profit providers constituting a minority), this has not been the case in Germany; here private profit-oriented providers of hospital services were in a minority position for a long time and have only recently caught up with public and with private not-for-profit bearers of hospitals services.

Table 2: Stationary health care in Germany and France since 1991

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>France</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>change</td>
<td>change</td>
</tr>
<tr>
<td></td>
<td>in %</td>
<td>in %</td>
</tr>
<tr>
<td>Hospitals*</td>
<td>-14,4</td>
<td>-20,9</td>
</tr>
<tr>
<td>thereof:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>public</td>
<td>-43,2</td>
<td></td>
</tr>
<tr>
<td>private:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not-for-profit</td>
<td>-20,0</td>
<td></td>
</tr>
<tr>
<td>for-profit</td>
<td>+89,6</td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>-16,1</td>
<td>-21,0</td>
</tr>
<tr>
<td>Beds per 10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inhabitants</td>
<td>-26,1</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Schulten/Böhlke 2009; Statistisches Bundesamt (2011); Acker/Denis (1995); INSEE 1993 und 2011; IRDES (2011): Eco-Santé France

Differences in the national governance arrangements equally show up as far as regulatory fields of medical treatment and care service-financing and investment-financing are concerned. Generally, Germany and France differ in their modes of hospital financing overall. Whereas in Germany the system at large rests on the dual-financing principle, i.e. the split of medical treatment-financing (contributions-based by the social health insurance) and of investment financing (tax-based by the governments German Bundesländer), in the French case, it rests on the monist-financing principle, i.e. both treatment services and investment are financed on a contribution-basis out of the social insurances budget (Assurance maladie as health branch of the general Sécurité sociale).

Moreover, in the German case the two financing-related regulatory fields of hospital infrastructure policy have traditionally been affected by states’ federal constitution and the regular corporatist integration of non-state actors into health policy-making. Both federalism and corporatism contribute to a complex multi-actor and multi-level arrangement characteristic of political decision-making and policy implementation. On
the grounds of federalism, the federal government with the health ministry, each of the governments of the 16 constitutional regions, the German Bundesländer, with their health administrations, the standing conference of the health ministers of the Bundesländer, and the communes as owners of most German public hospitals are major actors within of this arrangement. In terms of policy formulation, the governments of the Bundesländer due to their legal competences for planning and hospital investment-financing act as sometimes individual sometimes concerted veto players in all questions concerning the built infrastructure. Moreover, they exert the legal control over the local (communal, church-led, private) hospitals, which are anyhow autonomous in their internal organization and individual service policies. And on the grounds of health policy corporatism, the actually 145 health insurance companies which jointly constitute the German social health insurance system are major interest actors on account of their legal competence for the financing of all kinds of in-patient treatment in hospitals. Based on national framework legislation and placed under the federal health ministries’ control, the health insurance companies unions’ regularly negotiate indemnities for medical treatment with the hospitals’ unions on the level of the Bundesländer since the adoption of the KHG in 1972 (Gerlinger/Rosenbrock 2006, 166-169).

In the French case, in contrast, the traditional fashion of the regulation of hospital service financing was strongly centralized and characterized by hierarchic state intervention. Notwithstanding the monist financing logic, the central state especially since the foundation of the Fifth Republic in 1958 used to intervene especially into investment financing through of direct subventions to public hospital bearers for (re-) construction and equipment. Centralization becomes visible in regard to the actor constellation and structure which makes up the governance-arrangement of hospital infrastructure policy. On its top stands the national health ministry. It not only frequently intervened in financing, but also used to authoritatively steer the planning and territorial allocation of public hospitals. And via the states’ deconcentred authorities (prefecture) in the regions and departments it used exerted a hierarchic supervisory control (tutelle) over the supply of certain many basic public hospital services which were reserved by law to public hospitals and private not-for-profit clinics until 1991. Regional actors have for long played a minor role in decision-taking on and delivery of hospital services. Yet, a noticeable exception are the French mayors who traditionally presided over the administrative boards of the many local hospitals and were therefore deeply implied in the programming of and decision-making on the investment policy of the individual hospital (Kervasdoué 1999; Bras 2009). The centralized character of the governance arrangement finally is illustrated in the role of the French social health insurance, the Assurance maladie. It is a rather weak actor compared to the German health insurance companies and their unions, both in terms of national policy-formulation and regulation of the different fields of hospital infrastructure policy and in terms of the implementation of this policy e.g. via the determination of indemnities for in-patient treatment and care. In France, these prices have traditionally been calculated by the hospitals themselves on the basis of a national framework regulation which has become ever more detailed in the course of the Fifth Republic.

On the whole, irrespective of overall institutional similarities, the state has traditionally played a less dominant role in the German case compared to the French case in the regulation of the different fields of hospital infrastructure policy and the provision of hospital services.
Since the late 1970s both systems more and more came under financial stress caused by rising demands, rising costs related to the ongoing medico-technical progress and by mounting public austerity. By the early 1990s these internal pressures were supplemented by an external pressure for structural namely market-oriented adaptations as the new public management discourse on public service reforms spread internationally and inter-sectorally (cf. Hope/Dexia 2008; André/Hermann 2009; Mosebach 2009). In the following, we analyze how the German and French states – being represented by central government and also the governments of the 16 federal regions (Bundesländer) in the German case – managed the (external) pressure towards marketization of hospital services and how they have changed in their role as a welfare state in the course of this process between 1990 and 2010. For pragmatic reasons we concentrate on only three of the four major interventional fields of hospital infrastructure policy, namely the regulation of hospital supply (and owner) structures, the investment financing, and the planning and territorial allocation of hospital services. We leave aside the financing of medical treatment and care in hospitals as its discussion would at least partly distract the readers’ attention from the net discussion on hospital infrastructure, directing it towards the general debate on performance-oriented health financing and the DRGs.

4. Development of hospital infrastructure provision in the German case

In Germany, the hospital infrastructures did not always belong to the core sample of public services. Until the adoption of the KHG in 1972 the provision (especially in the sense of investment financing) of stationary care services largely belonged to the (most often communal or charitable) hospitals themselves. No formal regulation existed which would allow them to claim the reimbursement of their expenses for construction and equipment vis-à-vis the state or the health insurance funds (Simon 2000). Within this context of non-regulation, many hospitals followed rather conservative investment strategies and deferred necessary investment in the modernization of buildings and equipment. At the beginning of the 1970s experts on stationary health care for the first time argued that German hospitals, due to a generalized policy of non-investment (“investment blockage”), did no longer fulfill the basic standards of modern in-patient health care systems, neither as regards the number of beds and places provided nor as regards the quality of treatment and care (Wiemeyer 1984). In reaction to this devastating report, the German federal government in concerted action with the health insurance funds and governments of the Bundesländer initiated the federal law on hospitals (KHG) which was adopted by the German parliament in 1971 and entered into force in 1972. It was meant to solve the funding problems through the institution of the dual-financing principle and the stipulation of a full public financing of hospitals that fulfilled legally determined medical treatment services. Moreover, with the adoption of the KHG the state, i.e. the federal government and the governments of the, attained comprehensive competences for the regulation of the planning, allocation and financing of public hospital services at large; in short, the state on this legal basis entered the beforehand ‘regulation-free’ zone of hospital infrastructure policy (Leisner 1972). Yet, given the KHGs’ ambitious requirements for the financing of hospital construction, politicians and bureaucrats on all levels of government only awhile held fast to central aim of the law, i.e. the extension and modernization of the German hospital sector. Already in 1975 in the context of the first major economic crisis and recession, the federal government in an evaluation report asserted that on the legal basis of the
KHG a maximal public service provision would evolve which was “not justifiable from a macroeconomic point of view” (Bundestagsdrucksache 7/4530 [1975], 9). Following this fundamental critique, German hospital policy entered a phase of “traditional cost containment” characterized by spending cutbacks from the mid-1970s onwards (Gerlinger/Mosebach/Schmucker 2009, 144). This in turn came to an end at the beginning of the 1990s with the 1992 adoption of the health system structuring law (Gesundheitsstrukturgesetz; GSG) which has been interpreted by different scholars of German health policy as the beginning of a market-oriented restructuring of the German health care system regarding both its ambulatory and its stationary branch (Gerlinger/Mosebach/Schmucker 2009; Böhm/Henkel 2009, 85).

4.1 Supply and owner structures: Privatization of public hospitals

Turning towards the regulation of hospital supply and owner structures first, scholars of comparative hospital policy have identified a trend towards a marketization German hospital services in the form of a massive sell-out of publicly owned hospitals throughout the last 20 years. During this period since 1991 the hospital sector underwent a remarkable change caused by an unprecedented “wave of privatization” especially of local hospitals which contributed to decrease of publicly owned houses of 43,2 per cent (cf. table 2; Schulten/Böhlke 2009, 100-101). Today, the share of privately owned for-profit clinics in the German hospital sector nearly equals that of public hospitals (Schulten/Böhlke 2009, 98). This turn towards more private supply did not happen on the grounds of a clear political strategy neither of the German federal government or the governments of the Bundesländer in their mixed and changing party-political coalitions. Instead, it can be attributed to at least two causes. First, it came about as a side-effect of the communal financial crisis and according austerity policies of many German communes since the late 1980s, and second it was accelerated by the succeeding reforms of medical treatment and care service- and investment-financing adopted by the German legislator since 1992.

To understand privatization of public hospitals, it is first important to know that the question of hospital ownership never was subjected to legal regulation in Germany. The multiple owner structures characteristic of the German hospital sector are the result of long historical evolution; here, especially municipalities have traditionally played and are still playing a strong role as bearers of hospital services. As the German ‘hospital market’ as such was never regulated, the traditionally strong position of public and especially communal owners on this market could in principle always change. Under the comfortable regimes of a full financing of medical treatment services and of nearly complete public compensation of hospital investments, both put in place with the KHG in 1972, the supply and owner structures which were dominated by local public owners and charitable hospitals remained widely stable until 1990. Yet, the German communes in this time began to face a massive budgetary crisis (Bogumil/Holtkamp 2006, 133) with the consequence that many of them started to sell their profitable public facilities like hospitals.

4 The exact number of communal hospitals in Germany is hard to detect as the statistical offices of the federal state and the Bundesländer which are competent for surveying the hospital landscape, only survey the number of publicly owned hospitals without further differentiating between hospitals owned by the respective Bundesland and hospitals owned by its municipalities or counties. Generally, it can rightly be supposed that amongst all public hospitals in Germany, the communal ones have the biggest share.
Equally, by the middle of the 1980s mainstream health political discourse began to identify the all-embracing financing of both of medical treatment and care services and investments as an excessive demand ("cost explosion") on the social health insurances’ and public budgets health policy (Braun/Kühn/Reiners 1998, 21). The "cost explosion"-thesis was indeed shared by the main actors of German health policy – the federal government in concert with the governments of the Bundesländer, the social health insurance funds with their umbrella organizations and the big political parties, the conservative CDU and the Social democrats (SPD). On this basis, political consensus on a first radical reform of hospital financing was easily established. In 1992 the German Bundestag adopted the health system structuring law (GSG) which implied the reorientation of hospital financing policy towards the efficiency goal and the replacement of its instruments (Böhm/Henkel 2009, 85). Instrument change both affected investment- and service financing. In terms of investment, the federal state (Bund) retreated from the compensation of hospital investment leaving this function completely to the Bundesländer. In terms of treatment services, the GSG marked a first step in direction of a performance-oriented financing. It replaced the retrospective full compensation of hospitals on a per diem charge-basis towards the prospective budgeting of hospital services on a mixed per diem- and performance-related basis. This regulated retreat from the full indemnity of in-patient medical services continued in 2000. The social-democrat-green government of Chancellor Gerhard Schröder then adopted a major health reform with which Germany followed the international example of a switch from the duration-based financing system to a diagnosis-related system. German DRGs where introduced stepwise and completely put in place in 2012.

These cost-related instrument-changes in the regulatory fields of hospital financing in turn generated a strong fiscal pressure on the hospitals. In the course of the described reform process especially the small expenditure-intensive local hospitals had to face the challenge of becoming more efficient in order to make up with their budgets. At the same time communal hospital owners were affected by the communal financial crises and were no longer able to maintain expensive hospital services. The privatization wave thus happened against the background of a double-edged health policy- and communal financial crises as a consequence of which many German communes saw the selling of their hospital to private owners as a key to the solution of their financial problems. It must anyhow be stated that besides full organizational privatization also other variants of privatization namely formal privatization, i.e. a change of the legal status of the former public hospital without owner-change, took place. All in all, the provision of hospital services in Germany on this basis saw a ‘marketization by chance’ and the development towards a partly guaranteeing, partly dismantled state in this regulatory field of hospital infrastructure policy during the past 20 years.

4.2 Investment financing

Besides the change of hospital supply and owner structures, scholars on German health policy have reported about a change of the public-private relation also in terms of private actors’ integration and engagement in the financing of hospital investment (Klauber, 2011). At a first glance, this ‘marketization’ tendency can be seen as an effect of the described privatization of the owner structures of the German hospital sector. Private hospitals not only become more important in terms of numbers but are also more important investors than public owners because they normally get access
to the private capitals more easily and are often offered better conditions for loans (Augurzky et al. 2007; Malzahn/Wehner 2009, 113). Yet, private capitals have recently also become more important for investments of public hospitals. This, in turn, can be interpreted an effect of explicit re-regulation and instrument adaptation in this interventional field of German hospital infrastructure policy since the mid-1980s.

Regarding hospital investment financing, the above described developments at the beginning of the 1990s included namely measures of re-regulation of the public funding of public hospital investments. These go into the direction of a stronger market-based mode of hospital capitalization and financing. What had happened to investment regulation? Already during the 1980s, the federal level (Bund) occasionally retreated from its legal duty to bear one third of the state funding of hospital investment which had been concluded in accordance with the Bundesländer – who had to bear the remaining two thirds – in the 1972 KHG. By 1984 in the course of a general revision of the KHG, the federal levels’ de facto retraction from funding was regularized and the competence for hospital investment financing completely handed over to the Bundesländer (Böhm/Henkel 2009, 91) which in turn gained greater sovereignty as regards the regulation of the matter.

After the revision of the KHG in 1984, the Bundesländer specifically enjoyed more autonomy in the then largely decentralized regulation of the funding conditions and the allocation of both of the two legal components of public hospital investment financing, i.e. a legally fixed lump-sum component for smaller investments and a single subsidy component for bigger investments. Being freed from intergovernmental coordination, some Länder, especially the poorer ones, used this situation to follow the central states’ example and conduct a conservative strategy of hospital investment funding. They concentrated on lump-sum subsidizing or even nearly completely retreated from their funding obligations. The new situation facilitated the creeping abandoning of the dual-funding principle and a de facto turn towards a monist financing of both medical treatment and care services and investment out of the social health insurances’ contribution-based budget. Hospitals, especially public ones that wished to invest now often had to make profits in terms of an economical use of the health insurances’ indemnities in order to amount the necessary capitals.

Especially communal hospitals suffered from the thus growing insecurity of their financial condition. As mostly primary care-oriented public establishments they are often too small to work profitably. Therefore, they have problems to get access to the capital market as private banks often deem the loan to communal hospital owners either as too risky or as uninteresting or both. Many German communes, against this background, went for the above described complete privatization, i.e. sale, of their hospital in order to get rid of any financing obligation. And as a number of private, mostly nationally operating medical groups like Rhön Kliniken, Asklepios or Fresenius have discovered the German hospital market in recent years, communes largely do not have problems to find a purchaser (Schulten/Böhlke 2009, 107). Some communes alternatively followed a strategy of inner-organizational reform and formal privatization, i.e. change of the legal status of the still communally held clinic, hoping to get easier access to the capital market (ibidem., 101-103).

Politics followed the creeping change towards partly monist, social contribution-based, partly privatized capitalization of public hospitals only recently and only to
some extent. Even though namely the social health insurance funds umbrella organizations and the federal government have started several initiatives towards a reform of the dual-funding principle and a political re-regulation in the direction of the monist principle have existed since the adoption of the GSG in 1992 (Rürup 2008)\(^5\), any real reform of the legal modalities of hospital financing has failed under the opposition specifically of the rich Bundesländer like Bayern and Baden-Württemberg. These adhered to their large regulation competences and political influence as regards hospital services (Böhm 2009). Notwithstanding this opposition of some Länder, more and more German Bundesländer today change over to a legislative adaptation of their respective implementation rules connected to the federal KHG. They not only reduced their funding subsidies to lump-sum grants instead of full grants, but also re-regulated the principles of public financing in the direction of openly allowing the use of public money in support of private capital attraction by the individual hospitals. The effect of this regional re-regulation is, that private loans are nowadays becoming a de facto ‘third pillar’ – besides social contribution-based revenues and public subsidies – of hospital investment financing in Germany (Buckenberger et al. 2006). North Rhine-Westphalia, the biggest German Bundesland in terms of inhabitants, is indicative of this regional change of hospital infrastructure policy instruments and a marketization of hospital capitalization. Here, the Lands’ legislator in 2008 revised North Rhine-Westphalarias’ law on hospitals and concluded that public lump-sum subsidies shall preferably be used by the hospitals “to finance credits”, taken from private banks, for the investment in new construction, or the modernization of buildings and technical equipment (§ 21,5 KHGG). And, according to a senior officer in the Lands’ health ministry, subsidizing loans rather than investments as such “has meanwhile become the rule especially in cases of big investments” (Interview 1).

Altogether, the depicted developments of instrument change via re-regulation indicate a slow changeover towards a ‘guaranteeing state’ in the investment field of hospital infrastructure policy.

4.3 Hospital planning

Finally, in the regulatory field of hospital planning, we equally observe a re-regulation and recent instrument change initiated as well by the federal government as well as by some of German Bundesländer which points to a ‘marketization’. Yet today, it is not quite clear how far the different German Länder will follow the way of strengthening market-based governance-principles which has especially been paved by the Bund through an adaptation of the federal KHG.

In the planning and allocation field marketization relates to a de-regulation of state requirements which concern: the acceptance of an in-patient care establishment – public or private – as a “hospital”, the allocation of hospital beds and places to certain legally pre-fixed planning territories, and also the allocation of medico-technical equipment amongst hospitals within the national territory. Each of these issues may be prescribed in detail by the legislator and the implementing health authorities or it may be regulated in the form of framework rules or even left completely to the market

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\(^5\) One prominent reform model in this context suggested to explicitly factor the hospitals’ investment costs into the calculation of the wage earners’ and patients’ social insurance contributions (Rürup 2008).
and thus to the decision of the individual hospitals who act as competitors of care services on the ground.

In the German case, hospital planning was first regulated in the KHG of 1972 and in specified in terms if implementation in the hospital laws of the Bundesländer. These rules, from their origin, were rather detailed. In the KHG the federal legislator for the first time laid down a definition of the term “hospital” which is valid since then. It is applied in all Bundesländer and refers to the provision of certain basic stationary medical treatment services (e.g. primary care, emergency care, obstetrics, surgery etc.). On this basis, the governments of the German Bundesländer regulate and execute hospital planning within their territories. According to the KHG, they have to fulfill this competency through the regular posting of regional hospital plans. These determine the total number of hospitals in the respective Bundesland, the different hospitals’ location, the medical specializations per hospital site or the allocation of treatment services within the Lands’ territory and the total number of beds and places per site (DKG 2008), the latter being calculated on the basis of the so called Hill-Burton formula. Directly connected to hospital planning is the public funding of hospital investment as the second major hospital policy function of the Bundesländer. Within a certain Land, only those facilities formally admitted as “hospitals” by the Land governments’ health ministry and formally accepted into the Lands’ hospital plan, can get access to the public funding or subsidizing of their investments.

In the past, being accepted into the Bundeslands’ hospital plan was therefore crucial to most hospitals from an economic point of view. In exchange for the access to public investment funding, hospitals accepted the detailed rules of the regional hospital plans. Yet today, this deal loses its acceptance on the sides of private and public hospital owners for three reasons: first, the explained change of the owner structure of the German hospital sector and a growing importance of private for-profit hospitals often owned by big health companies; second, the ever more reduced, flat-rated public investment funding which relates to the increase of the public debt on the national, regional and local levels of government and reduces the attractiveness of public funds for the individual hospital, be it private or public; and third, the changed public discourse on hospital service reimbursement and the changeover to a diagnosis-related, price-driven system of treatment compensation. In this context, the state seems to lose its’ legitimization regarding the detailed regulation of hospital numbers, locations, beds and places. The federal government and the governments of the Bundesländer now see themselves exposed to an increasing pressure of private interest actors like the big private health groups or the German federal organization of private clinics (BDPK). These argue in favor of a change towards framework planning (BDPK 2007) and do not share the skepticism of many Bundesländer, especially the rich ones, that a competition-based system of hospital allocation may satisfy the public interest in a guaranteed, territorially balanced provision of in-patient medical care.

Since 2008, the governments of some Bundesländer and the federal government reacted to this pressure by partly amending their hospital laws with market-friendly rules on the conditions of the public funding of hospital investments and by partly de-
regulating them. In this context, the poorer Länder like North Rhine-Westphalia were amongst the first to reduce the single subsidy component of public hospital investment funding. In 2008, the Lands’ legislator altered the regional hospital law and introduced a *de facto* full changeover of North Rhine-Westphalia towards the less costly system of mere lump-sum subsidies for hospital investment projects. Related to this was the changeover to framework planning and the give-up of a detailed regulation of the number of beds and the equipment per hospital within the regional hospital plan. Additionally, the health authorities of North Rhine-Westphalia now have the possibility to connect the allocation of public flat-rate subsidies to the economic performance of the individual hospital (Winterer 2009). Adjacent to the North Rhine-Westphalian step towards instrument change and de-regulation, the question of future of hospital planning made it on the agenda of federal health policy. In fact, it interfered with the long-standing debate on a change of the federal KHG (Halbe et al. 2010). Following an initiative of the federal health ministry launched in 2008 and which made explicit reference to the North Rhine-Westphalian ‘leader’, the KHG was altered in spring 2009. This law – in default of own competencies of the *Bund* for a detailed regulation of hospital planning on the *Länder* level – never could directly change the Bundesländer’s according rules. Yet, it now contains a passage which suggests to the Länder governments to follow the North Rhine Westphalian example of planning de-regulation. And it also commissioned the Federal Institute on the definition of hospital service fees (InEK) to develop a system of performance-related flat-rate hospital investment fees which could be applied nationwide (§ 10 KHRG).

The transposition of this system into the hospital policies of all German Bundesländer would lead to a de-politization of hospital planning and investment policy in Germany and to a transformation this highly important infrastructural function in terms of the territorial allocation of medical treatment services into an efficiency-base quasi-technical function. Yet, at the moment, such a development remains to be awaited as namely the richer Länder in the South like e.g. Baden-Württemberg, Bavaria or Hesse adhere to the instrument of single subsidy component of investment funding as the main instrument for bigger hospital investments. According to high official in the health ministry of Hesse, they do not want to lose the political steering opportunity in this interventional field of hospital infrastructure policy: “Changing over to a complete flat-rate funding would mean to give up the single subsidy tool which is a crucial instrument for the realization of the different Länder’s specific hospital policy goals” (Interview 2).

### 4.4 Conclusion: Hospital infrastructure policy in the German case

The increased strength of private for-profit hospitals, the renunciation from the full financing of technical and constructional hospital infrastructure and the turn towards a co-financing of private loans, and also the increasing pressure towards leaving structural investment decisions to the hospital owners instead of regulating them in detail – when we finally outline the described adaptations of the instruments of German hospital infrastructure policy, the conclusion is that in the German case much points to a change towards a ‘guaranteeing state’ in this field of public policy-making. It is important to notice, that we can find an only partly regulated passage towards the market as some instrument adaptations (like the privatization of communal hospitals) did not happen on the grounds of political decision-taking.
5. Development of hospital infrastructure provision in the French case

Unlike in the German case, the provision of hospital services became a public function on the authority of the state already during the 1940s. With the adoption of the hospital law of 1941 and the establishment of the general social insurance, Sécurité sociale, in 1945, the French central legislator set up the basic institutions for the implementation of this public service promise still in the era of the Fourth Republic. In 1958, following the foundation of the Fifth Republic, its first government adopted the so called Debré-decrees on hospital reform and established the foundations of a public hospital infrastructure policy. In the years and decades thereafter, especially the hospital reform law of 1970 which introduced hospital planning as a state function, the hospital reforms of 1991 and 2003 (“Plan Hôpital 2007”) which touched upon every single regulatory field of hospital infrastructure policy, and, most recently, the hospital reform law of 2009, loi HPST, went along with important changes of this policies’ instrumentation. As will be shown in the following, the mentioned reforms of the different branches of French hospital infrastructure policy did not result in a marketization of public hospital services which was as distinct as in the German case. And, market-making measures in France more than in Germany, originated in pre-defined strategies of the central governments to enhance the French hospitals’ competitiveness; this in turn was often put in place through re-regulation and a fortification of the state as a ‘hospital market’-regulator.

5.1 Supply and owner structures: (nearly) unchanged co-existence of public and private hospitals

In contrast to Germany, a ‘hospital market’ in the strict sense does not exist in France as hospital owner structures are subjected to state regulation. The owners of public hospitals in France – first and foremost the municipalities like in the German case – do not have the option of material privatization, i.e. a sale of their establishment to a private owner with the aim that it may continue to operate as a hospital. According to article L 6148-1 of the French Public Health Code (Code de la Santé Publique, CSP), which was included into the Code by the hospital reform law of 1970 (Hope/Dexia 2008, 80), public hospitals must not be sold to private owners and must be considered timeless in their function as public infrastructures:

“In accordance to the rules of article L 3111-1 of the General Code on Public Properties, public hospitals and publicly owned facilities of in-patient medical care with an own legal personality are not for sale and do not become time-barred (…)” (Translation from French by the author)

This rule, though, does not say anything about the real share which public hospitals and private – not-for-profit or for-profit – clinics have in the provision of in-patient medical treatment and care services in France. As measured by the total number of establishments, public (local, regional, state-owned) hospitals and private for-profit

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7 The Debré-decrees have their name not from Michel Debré but from his father, the politically engaged medicine Robert Debré.

8 The full name of the loi HPST which came into force at 23 of June 2009 is “Loi Hôpital, Patients, Santé et Territoires”.
clinics have a quasi-equal stake in the French hospital sector, whereas private not-for-profit clinics are in a minority position (cf. Table 2). Considering the number of beds and places, public hospitals are – like in Germany – the most important carriers of stationary medical services. In the year 2004, they ran about two thirds of the total number of beds (Hope/Dexia 2008, 76 and 78).

The aspect that in France private for-profit clinics relatively early (compared to Germany) had a strong position within the national hospital landscape dates back to the time between the 1940s and 1970s. During this period, the number of private clinics expanded due to a vague of private investments made by individual free practitioners and/or groups of physicians who founded predominantly small private clinics. These in turn – other than in Germany – specialized in the most profitable treatment segments like surgery or obstetrics very early (Hope/Dexia 2008, 77-78). By 1970 this private expansion came to an end and the then established public-private share of the French ‘hospital market’ has remained almost stable until today (Bouinot/Péricard 2010, 37). What explains this remarkable difference to the German case where – as we have seen above – private for-profit-oriented hospital owners have gained enormously in their share of the national ‘hospital market’ only since the beginning 1990s?

In contrast to Germany, the French central governments by 1970 began to vest the state with specific instruments for the regulation of the national hospital landscape or ‘market’. Indeed, French hospital infrastructure policy in its field of supply control could be seen at least in parts as an exercise of hierarchic market regulation since that time. This manifested itself, first, in the formal protection of the public segment of the hospital market by the French legislator through the institution not only of the cited prohibition of a sale of public hospitals in 1970, but also of the legal construct of a ‘Public hospital service’: the execution of this service was nearly exclusively reserved to public hospitals (plus private not-for-profit clinics upon request) and served as an expression of the French welfare states’ guarantee to supply the population with a range of important in-patient medical treatments. Furthermore, on the basis of the same 1970 law on hospital reform, both public and private hospitals were subjected to a regime of hospital planning. Since 1971 the operation of hospitals (public and private) was put under the control of the central states’ regulator, the ministry of health, which as a consequence led to a massive slow-down of the expansion of private clinics. In 1991, the regulated delimitation of the private sectors’ share in the French ‘hospital market’ continued. By this time, many of the small specialized clinics had to close due to productivity problems or the difficulties of its owners – individual physicians – to find a successor (Tanti-Hardouin 1996). In many cases, a handful of big (international) clinic groups like Générale de Santé or Clininvest-Capio who had begun to enter the private segment of the French hospital market (Mosebach 2009, 56) incorporated these little facilities into their clinics structures. These in turn took a short run before jumping into the French hospital sector since the late 1980s irrespective of the narrow state control over hospital supply. Indeed, the international clinic groups by that time began to outrun the states’ own spending capacities and massively invested in the private segment of the hospital sector. The health ministry and the French legislator reacted to this development with re-regulation. In 1991, parliament adopted a hospital reform law on the basis of which the Health ministry concluded a “national objective on quantities” (beds and places) for the private provision of hospital services with the French Federation of private hospitals in 1992. Additionally private clinic owners were
constrained in a number of other ways (e.g. introduction of the public authorization of investments) in exchange for a formal opening up of the Public hospital service to their participation and the possibility to use public funds for their investment projects (Hope/Dexia 2008, 78).

Today, it is not quite clear whether the creeping restructuring process will continue. The situation of high public debt and also a strong indebtedness of the Sécurité Sociale, and the background of the European financial crises might force the French central state into a tightened austerity regime and strengthen the private hospitals. Yet, whether the regulation of the French hospital market is going to be released in the near future is a matter of mere guess, especially against the background of recent political change. We thus observe a regulated delimitation of the ‘market’ rather than its (free or state-planned) expansion. As far as the regulatory field of hospital supply and owner structures is concerned, a marketization French hospital services can therefore not be detected and a persistence of the ‘intervening state’ can be concluded. In the following section, we will yet see a ‘marketization-turn’ in the regulatory field of investment financing.

5.2 Investment financing

According to a “monist” logic of hospital financing, French hospitals are compensated by the social health insurance (Assurance maladie) both for the provision of medical treatment and care services and for investments in the construction and modernization of equipment. Thus, the wage earners’ contributions to the health branch of the Sécurité Sociale are in principle intended to deliver the totality of the financial resources necessary for the fulfillment of the hospitals’ functions. Yet in practice, the French central state used to intervene into this scheme of a single-funded financing of hospital services especially during the first decades following the foundation of the Fifth Republic. Between 1958 and the mid-1980s, in accordance with President Charles de Gaulles’ and his successors’ strategy of hierarchically planned modernization of the French state, the different national governments directly subsidized the expansion namely of the public hospital sector. During this period the health ministry proposed a tax-financed program of all-embracing investment funding upon request to public hospitals. At the same time, the ministry only exerted a lose control over the individual hospitals’ spending policies. Especially the many small local hospitals benefited from this control practice which can be explained in parts by the fact that the mayors had a strong say in their hospitals’ administrative boards and at the same time were often important political players on the national scene as elected members to the Assemblée Nationale and/or the Sénat (Bras 2009).

The widely uncontrolled extension of public hospitals which resulted from this centralized financing strategy – together with the parallel expansion of the private clinic sector – led to an excessive supply of stationary medical treatment and care services. So the health ministry by 1985 decided to withdraw nearly completely from the direct funding (Bouinot/Péricard 2010, 38) with the consequence that French public hospitals, especially the small local ones offering services of primary health care, were confronted with growing investment problems. They not only faced the states’ retreat from construction financing. Also, alike the German communal hospitals, they had to manage a reform of the social health insurance system of the indemnifying of medical treatment and care services which was put in place by the
French legislator in 1983 and stipulated budgetary shortcuts. This overall modified financing condition added to a situation of investment blockage in the public hospital sector by the end of the 1990s (Bouinot/Péricard 2010, 40). French public hospitals then encountered an investment gap of up to 14 billion euros according to different expert’s reports which were published on the topic since 1998 (Cour des Comptes 2008, 146; Bouinot/Péricard 2010, 40).

The health ministry reacted to this problem with an – in the French context – atypical change of the instrumentation public hospital investment funding which is example for a strategic re-regulation of French hospital infrastructure policy. In 2002, the then newly elected conservative government of Jean-Pierre Raffarin adopted a comprehensive hospital reform, the “Plan Hôpital 2007”. With this reform, the state turned to a market-based, but anyhow state-controlled system of hospital investment financing in 2003. The investment part of the “Plan Hôpital 2007” was regulated in the government decree on “simplification of the organization and functioning of the health system”\(^\text{10}\). Essentially, this decree for the first time maintained the participation of private actors in the financing of public hospital investment and opened up the individual public hospitals’ investment projects for public-private-partnerships.

In more detail, the health ministry scheduled a strategy towards the reduction of the mentioned investment gap which featured two elements: the first was a capital reserve of 1.93 billion euro charged off the social health insurances’ budget in order to directly promote hospitals’ investment projects within a period of the coming 20 years. In contrast to past direct subsidies of the state, the capital reserve should be used – like in the German case – for the public bidding of loan guarantees and should thus allow the individual hospitals to take up loans at private banks (Cour des Comptes 2008, 148-149). This innovative instrument was combined with a second element, namely the informal pre-arrangement of the bank loans amounting to about 4 billion euros calculated on a total capital need of 6 billion euros for a first set of 1.000 investment projects in the cases judged most urgent by the central health ministry. To raise this capital, the national health administration negotiated with three big banks familiar with the financing of public investment projects, the Dexia Crédit Local, the Société Générale and Crédit Agricole. These three banks acted as loan givers for the near-term of the first investment projects (Interview 7).

To ensure the fast realization of its strategy – a lapse of five years was envisaged for the accomplishment of the 1.000 modernization operations of the “Plan Hôpital 2007” –, the health ministry installed a system of arm’s-length-implementation control. Generally, in accordance with the French Code on Public Health, public hospitals have to raise an individual service and investment project each year which explains their annual budgeting. Both plans must be accomplished in agreement with the states’ health authorities on the regional level, the regional hospital agencies (Agences regionals de Santé, ARS). To rapidly and effectively implement the investment feature of “Plan Hôpital 2007”, the health ministry complemented this system of state tutelage already in place by the establishment of a specialized authority on the central level, the so called MAINH, meant to assist the regional

\(^9\) With the 1983-reform of the hospitals’ reimbursement of in-patient services, the French central legislator replaced the system of retrospective per diem charges by a system of prospective global budgeting of the hospitals.

\(^{10}\) Ordonnance 2003-850 du 4 septembre 2003.
health agencies in the appraisal of the hospitals’ projects. On the grounds of this new structure, the states’ ARS acted as controllers of projects and bank loan conditions and also actively promoted the implementation of hospital investment schemes based on public-private-partnerships. The general idea behind this was to mobilize another 4 billion euros of private capitals in the course of the implementation of the “Plan Hôpital 2007” so that the plan would finally raise 10 billion euros in total (Bouinot/Péricard 2010, 40-41).

The investment part of the “Plan Hôpital 2007” was a great success. Indeed, it was as great that the originally envisaged 10 billion euros of total investment capital were reached within the short lapse of only five years. However, instead of the originally envisaged 1.000 modernization operations many more French hospitals – mostly public but also private – took up loans in reference to the “Plan Hôpital 2007”. Therefore, by 2008 the projects initiated within the reach of the states’ investment strategy amounted to nearly 16 billion euros (Bouinot/Péricard 2010, 42). The consequence of this success was that the risk for the individuals’ projects increased as the originally planned 100 per cent public guarantee of the hospitals’ loans melted to an only 43-per cent guarantee. The French health ministry recently reacted to this situation with another round of further re-regulation: a new hospital investment scheme (“Plan Hôpital 2012”) was launched already in 2007 (Bouinot/Péricard 2010, 43), and the health ministry endowed the regional ARS and the MAINH with even greater control competencies allowing them to directly intervene into the individual hospitals’ investment projects and restrict them – if necessary. All in all, the explained reform marks the interesting case of a market-oriented reform of hospital investment policy on the grounds of stronger regulation and under the reinforced control auspices of the state which is confirmed in its role as ‘intervening state’.

5.3 Hospital planning: From traditional to modern Jacobinism

Hospital planning policy started in France with the adoption of the first hospital reform law since the foundation of the Fifth Republic in December 1970. In contrast to the German case, French hospital planning as defined in this law and the regulations of the years thereafter – especially the laws and decrees issued most recently adjacent to the “Plan Hôpital 2007” – is exemplary for a ‘more state rather than less’-strategy of the French health authorities which aims at the regulated optimization in terms of cost efficiency and better quality of the hospital service offer to the population.

With the adoption of the hospital reform law of 1970 the central state reacted to the above-mentioned evolution of an excessive supply of beds and in-patient care places in public and also private hospitals during the first decade of the Fifth Republic. Differently to the German hospital law of 1972, the French hospital reform law was a rather weak planning instrument as it did not combine planning and public investment funding. It introduced the so called Carte sanitaire which served a double end. First, it was an instrument for the systematic documentation of the in-patient treatment services offered in France and of number of public hospitals and private clinics within the national territory. Second, the Carte sanitaire was a regulatory instrument applied to Public hospital service (Service public hospitalier) which was equally brought into being with the law of 1970 and integrated all public hospitals as well as not-for-profit clinics on request and under the condition that they were admitted by the health

11 Loi n° 30-1318 du 31 décembre 1970.
ministry. In terms of its function as a regulatory tool, the *Carte sanitaire* was originally intended to become an authoritative instrument for the territorial allocation of public in-patient medical services based on the Hill-Burton-Formula (see footnote 5). Yet, as its use on the grounds was left to the prefect as general representative of the central state within the *Département* (i.e. on the county level), and not to a specialized authority, the *Carte sanitaire* was not very effective. In particular, it failed as an instrument to reduce the excessive supply of hospital beds. Even though under the regime of the *Carte sanitaire*, a number of small (mostly local) hospitals were forced into new cooperative structures, the so called *syndicats interhospitalières*, it remained a stub sword.

A policy reform to correct the weakness of the *Carte sanitaire* as major planning policy instrument was only initiated in 1991 in the context of massive criticism being passed on the public hospital sector. In 1991, the French legislator passed a new hospital reform law\(^{12}\) which can be seen as an example a re-regulation of hospital services in the regulatory field of planning and allocation. At the beginning of the 1990s, the restricted access to the Public hospital service which had for long worked as a protective shield of the public sector against the private clinics did no longer fulfill its protective function. Indeed, public hospitals by that time had a bad reputation in the media and public discourse. They were presumed to be outdated in their equipment, expensive and slow-going in their services and were generally suspected to provide worse quality than private clinics. To this situation, the health ministry reacted with the initiation of a hospital reform which was aimed at strengthening the efficiency of public hospitals and ameliorating their quality and competitiveness in respect to private clinics.

The 1991-law modified the instruments of hospital planning created in 1970 in two ways. First, as has already been mentioned above, it opened up the Public hospital service to the participation of private for-profit clinics and finally recognized their irrecoverable role for the provision of public hospital services in France at large. Yet, at the same time, it subjected private clinics to the states’ authoritative planning regime and regulated the beforehand relatively free developement of private clinics by introducing a number of legal restrictions related to the construction of private houses (Hope/Dexia 2008, 78). Second, it introduced a new regional planning scheme, the *Schéma regional d'orientation sanitaire* (*SROS*), which in contrast to the *Carte sanitaire* not only refers to a quantitative planning rationale one but also to a qualitative one. The *SROS* which completely replaced the *Carte sanitaire* in 1996 was designed to take into account the medical needs of the population within a given planning region. According to the idea of the French health regulator, the medical needs and demands of the population shall become the primary criterion for the territorial allocation of stationary medical services in the future (Mossé/Verdier 2002, 4; Hope/Dexia 2008, 115-116). The functionality of this new planning instrument very much depends on the collection of detailed epidemiological knowledge; yet, this was not easy to acquire for the central states’ health administration. Therefore, a decentralization of hospital planning was the logical consequence. Yet, this restructuring of the hospital infrastructure governance arrangement overall which was indeed implemented between 1996 and 2009, was not a step towards a reduction of the central states’ influence on the provision of public hospital services but on the contrary went along with a legal strengthening of the central regulators’ position.

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\(^{12}\) Loi n° 91-748 du 31 juillet 1991.
Decentralization was put in place through the adoption of three important rulings between 1996 and 2009: the decree on hospitalization reform of April 1996, the decree on the simplification of the health systems’ organization of September 2003 as planning-related part of the “Plan Hôpital 2007” in 2003 and, most recently, the hospital reform law, “Loi Hôpital, patients, santé et territoires” (Loi HPST), of June 2009. Altogether, these three rulings were further steps towards the re-regulation of hospital capacity allocation and towards an increase of the central states’ intervention power. They set up a close and straight control structure based on chain of inter-level contracts which reached from the central health ministry down to the regional level of governance and which enabled the states’ authorities on the ground to implement the governments’ policy objectives as regards the allocation of hospital services – both public and private.

The 1996-decree first erected new specialized public hospital authorities on the regional level, the regional hospital agencies (Agences regionals hospitalières, ARH). These were attributed the competency to establishment a regional hospital plan in accordance with the multi-annual national SROS. The agencies should therefore consult the affected actors within their reach (hospitals, clinics, the health insurance offices, communes, etc.) and systematically collect knowledge about the medical needs in the region. The 2003-decree changed of the ARH into regional health agencies (Agences regionals de santé, ARS) thus widening the control competencies of these bodies. The implementation of the SROS was now put on the basis of the individual hospitals’ and clinics’ annual service and investment projects. Since 2003, each hospital and clinic must schedule such a project in accordance with the regional SROS. The individual project in turn must be authorized by the ARS and constitutes the basis for the conclusion of a formal service contract between the states’ regional authority and the hospital or clinic. Finally, the 2009 HPST-law coupled the SROS and hospitals’ and clinics’ projects with the public financing of investments. Only those investment projects conform to the aims of the regional SROS have been authorized for public funding within the reach of the “Plan Hôpital 2012”.

All in all, the reregulation of hospital planning went along with the installation of a narrow system of state control and thus more state for the sake of an efficient high-quality offer of hospital services to patients. Today, the third generation of SROS is on its way to implementation. Whether the system works, is hard to judge for the time being. Particularly, a top-down implementation of the SROS is neither feasible nor has it ever been intended by the health ministry. And yet, the rather intended partnership-like implementation of the plan on the basis of contracts concluded between the national health ministry and the regional ARS as well as between the states’ representatives in the ARS, the local representatives of the Social health insurance as the paying authority, the hospitals and the communes and counties holds a lot of conflicts (Interview 8). Anyhow, what should be stated here is that in terms of hospital planning as one regulatory field of hospital infrastructure policy, France – unlike Germany – rather stroke a state-oriented path during the last years. And given that the regional ARS do not to hesitate to sanction hospitals and clinics (e.g. by forcing them into fusions or service cooperation) which won’t respect the states’ planning and investment objectives or which are not able to produce the service cost and quality objectives purported by the SROS, some commentators even spoke of a return to a “jacobine” steering mode of the state (Bouinot/Péricard 2010, 79).
5.4 Conclusion: Hospital infrastructure policy in France

Adherence to the traditional defense of a privatization of public hospitals as public infrastructures, turn towards private market-based financing of hospital investments yet coupled to a reinforced control power of the states’ health authorities over the investment projects, and strengthening of the detailed planning and control of the territorial allocation of hospital services but also reduction of the public hospitals former privileges – if we take a concluding glance at the change of the French hospital infrastructure policy between 1990 and 2010, we get a diffuse picture of the states’ role at least to some extent. Partly, we find the traditional model of the intervening or even dirigiste state reaffirmed, and partly we observe the passage towards the model of the guaranteeing state. Yet overall, the change of instrumentation of the French hospital infrastructure policy over the past two decades does not point to a decrease in intensity of state intervention but rather to an adaptation of regulation in the light of changed policy objectives of the state.

6. Changing the welfare states’ role in the provision of hospital services – Germany and France compared

In an overall perspective, the described developments point to a meaningful change of the instrumentation of hospital infrastructure policy both in Germany and France within the last two decades from 1990 to 2011. For both cases we saw modifications in all of the three dimensions of this policy analyzed here, the regulation of hospital supply and owner structures, of hospital investment and of hospital planning. The changes of instrumentation which, here, served as indicator in order to document the modifications in the welfare states’ perception of infrastructural responsibilities in the social and health public service sector differed in both cases and in each of the three policy dimensions. Anyhow, we can sum up a general tendency as regards the alteration of the states’ role. In Germany, the welfare state stepped back from the provision of hospital infrastructure, leaving more room for private actors and private action. In the German case, privatization goes hand in hand with de- and with re-regulation and a reduction of public money spending resulting in a general tendency towards a guaranteeing state. In France, in contrast, the state kept or even strengthened its already strong interventionist role. However, at the same time, it started to cooperate more intensely with private actors in some areas and to act as a competitor in the market himself in other areas. In the French case, the retention of the public good and of a strong public responsibility for hospital services goes hand in hand with re-regulation resulting in a general tendency towards a confirmation of the intervening state.

These tendencies accumulate from the instrumental developments in the three policy dimensions under scrutiny here. In terms of the regulation of supply structures, first, a privatization by chance supplemented by the maintenance of the traditional non-regulation of the hospital-market in Germany. This contrasts with a retention of the legally protected role of public providers of hospital services, yet supplemented by a re-regulation of the hospital-market (reduction of public providers former privileges) in the French case. Focusing upon the spending of public money on hospital investments, second, a privatization of financing and reduction of direct state subsidies in exchange for a turn towards indirect public guarantees on private bank loans can be observed in both cases. However in Germany, this went along with the non-regulation of the hospitals’ loan-taking and investment-policies whereas in
France the state strongly intervened into these policies both through new regulation and bargaining (arranged financing partnerships between banks and hospitals selected for modernization). Finally looking at hospital planning, third, we find a deregulation or cutback of planning requirements in the German case where more and more Bundesländer leave the allocation of infrastructure and thus services to the market and the hospitals’ ‘performance’ as competitors. In contrast we observe a detailed re-regulation of hospital service allocation in the French case where the existing public planning system with its allocation rules based on quantitative needs has been completed by rules based on qualitative service needs of the population.

How can we explain the changes? And what do we learn from them? It was the main purpose of this article to comparatively explore the marketization of public hospital services in the conservative welfare regimes Germany and France and to reassess the widespread assumption of a marketization of social public services in regard to the two cases. Therefore, we can only formulate some tentative, hypothetic answers to these questions in the concluding stages of this article.

In Germany and France the general orientation of public policy makers regarding the provision of hospital infrastructures went in the direction of ‘more market’. Under this point of reference being shared in both cases, we scrutinized instrument change in two similar cases as far as the understanding and general institutional organization of the welfare capitalism is concerned, but yet in two dissimilar cases in terms of the understanding of the state as such, the state-society-relationship and the states’ overall organization (decentral-corporatist vs. centralist-pluralistic). On the grounds of these varying normative and institutional conditions, the shared market-orientation was turned in ‘more market’ simply in the German case, and ‘more market plus more state’ in the French case in the course of the revised processes of public hospital infrastructure policy (re-) formulation and implementation between 1990 and 2011. Summing up these observations, we propose to do further research on the following three hypotheses which might explain the variation in the market-oriented modification of the states’ role in Germany and France: First, marketization constitutes an internationally shared orientation for public policy reform which anyhow plays out very differently from state to state even in similar cases of the organization of welfare capitalism. Second, institutions matter in order to understand variation in the national implementation of the marketization-orientation; they constitute national filters of the internationally diffusing trend towards the marketization of public services. Third, how the marketization orientation reflects on the welfare states’ public service role depends on the traditional framing of the relationship between state and societal actors. The role tends to become stronger in a traditionally hierarchical state and it tends to become reduced in a traditionally cooperative state.

What do we learn from the observed changes? Generally, the market-oriented restructuring of the states’ role in the provision of hospital infrastructure and the related medical treatment and care services actually under way not only in the two cases under scrutiny here but in many European states (cf. André/Hermann 2009) is often related with an increase in uncertainty on every level concerned with the service delivery, from the hospital owners and providers to the doctors and employees and to the patients and citizens (Bode 2005). Summing up the insights we have gained from the study of the German and French cases here, we can conclude that the welfare state yet has a choice of how to react to the rising pressure of the markets. At the moment no one really knows how the modification in the public-
private-relationship will affect the former state-guaranteed security in the provision of the material or immaterial support systems vital for modern capitalist societies. What seems to be clear though is an increase in the functional insecurity of modern welfare states possibly going along with an increase in social uncertainty and a decrease of democratic choice differently allocated amongst the members of national societies. The management of uncertainty may arise as the new great challenge of the post-industrial welfare state.

Literature


