Federalism and the "New Politics" of Hospital Financing

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Abstract

Federalism is commonly regarded as a major impediment to welfare state expansion, yet its role in times of welfare state retrenchment remains unclear. Complex responsibilities shared between the federal government and those of the Länder make German hospital financing an interesting example in this regard. The paper analyses recent reforms in German hospital financing, showing how federal institutions may impede reforms and how resistance is motivated. It describes the historical compromise behind the foundations of hospital regulation and outlines the transformation process in hospital reimbursement, showing how systems of reimbursement and hospital planning have come into conflict. Against this background, attempts by national and Länder governments to solve this conflict are assessed and more comprehensive reform approaches discussed.

Zusammenfassung

Während sehr wohl bekannt ist dass der Föderalismus den Ausbau des Wohlfahrtsstaates erheblich beeinträchtigt hat, wissen wir bisher nur sehr wenig darüber, welche Rolle er bei dessen Um- und Rückbau spielt. Aufgrund der komplexen Aufgabenverteilung zwischen Bund und Ländern bietet die deutsche Krankenhausfinanzierung diesbezüglich ein gutes Beispiel. Der Artikel analysiert die Reformpolitik der Krankenhausfinanzierung in den letzten Jahren und zeigt dabei wie und aus welcher Motivation heraus der Föderalismus auch den wettbewerblichen Umbau hemmt. Nach einem Ausflug in die Entstehungsgeschichte der Krankenhausregulierung wird die wettbewerbsorientierte Umgestaltung der Krankenhausvergütung beschrieben und erläutert, wie dabei zwei völlig unterschiedliche, konfligierende Finanzierungssysteme entstanden sind. Versuche von Länderseite die Diskrepanz zwischen den Finanzierungssystemen zu verringern werden kritisch bewertet und abschließend alternative Reformmöglichkeiten diskutiert.

1 Federalism and Health Care Reforms

In comparative welfare state literature there is consensus that federalism hinders welfare state expansion (Obinger et al. 2005: 3). There is empirical evidence that social policy spending is lower in federal states than in unitary states (e.g. Castles 1999; Huber et al. 1993) and that welfare state development was delayed by federalism (Kittel et al. 2000). Newer research focusing on institutional aspects of federal welfare states to explain the relationship between federalism and low welfare spending draws a more sophisticated picture. Federalism was a major barrier in the phase of welfare state consolidation in federal nation-states where democracy was established at an early stage, but not in federal nation-states where welfare state consolidation preceded democratic consolidation. In the latter, social policy evolved at the national level from the beginning, whereas in the former, social policy was initially the concern of the constituent states, and the bottom-up evolu-

tion of the welfare state was hindered by political structures that produced veto points and limits on the possible course of action (Leibfried et al. 2005: 318ff). Given this important role of federalism in the early days of the welfare state, the question arises whether the "silver age" is equally influenced by federalism. In the literature there is no consensus as to whether federal institutions boost or impede welfare state transformation. The veto player theory would suggest that fragmented interests block reforms and so preserve the status quo. Comparative research findings support this thesis but "as in the era of the 'old politics', much depends on context, including country-specific institutional settings, policy structures and actor constellations." (Leibfried et al. 2005: 332)

Veto player theory has been prominent in explaining the slowness of reform in German health policy (e.g. Rosewitz/Webber 1990; Webber 1988, 1989). Beside corporatist actors and interest groups, the federal council, the Bundesrat, has been identified as a relevant veto player in health policy. Because most health legislation affects the administrative responsibility of the Länder in some way, health reforms usually need approval by the Bundesrat. But the Bundesrat does not always use its veto power, and if it does, decisions are often taken irrespective of party-political majorities (Bandelow 2006: 170). Beside this general reform approach, the influence of federal institutions on health care system restructuring has rarely been researched.[1] Analyzing this interaction the other way round, Gerlinger (2008) concludes that the implementation of competitive governance instruments in health care regulation has changed the relationship between national and state governments. To function optimally, he argues, competition needs a level playing field which must be organized centrally. Therefore regulatory power is centralized and the influence of the states on health policy decreases (ibid: 256).

In the hospital sector competition mechanisms were established through the implementation of a performance-oriented and case-based reimbursement system. The states have blocked other instruments which foster competition, like selective contracting, or weaken the influence of the states, like monistic financing. They bear the ultimate responsibility for adequate supply of hospital care and therefore try to hinder any reform that might make it harder for them to meet this obligation.[2] Thus the states have prevented any regulatory changes in hospital planning and investment. Hospital reimbursement, however, is decided at the national level.[3] In pursuit of low-

[1] Manow (2005) compares changes in welfare spending over time in health care (where there is a federal veto) with pension expenditure (where is no federal veto), and concludes that federal veto points have no influence on welfare state retrenchment in Germany (ibid: 259).

[2] The constitutional principle that Germany is "a democratic and social federal state" (Article 20 of the German Basic Law) gives the state a fundamental responsibility for providing healthcare to the population. While in the outpatient sector this responsibility is delegated to the associations of statutory health insurance physicians, in the hospital sector the federal states are responsible for ensuring capacity meets healthcare needs.

[3] Article 74 (1) (19a) of the German Basic Law provides that "the economic viability of hospitals and the regulation of hospital charges" is subject to regulation by the states only if there is no regulation at the national level.

er insurance contributions, central government has transformed hospital reimbursement through competitive measures over the past fifteen years. This complex nexus of responsibility and heterogeneous interests has produced two different systems within hospital sector regulation. Originally designed to complement each other, hospital reimbursement now contradicts hospital investment financing and planning, and vice versa. Together with other processes that challenge the old system of hospital planning and investment financing, this contradiction endangers adequate supply in the long run.

I begin by describing how the historical compromise behind the Hospital Financing Act (KHG)[4], the foundation of hospital regulation, was arrived at. It is a good example of the way federalism can hinder welfare expansion and how federal mechanisms can be overcome. Then I give a short outline of the transformation process of hospital reimbursement, explain the—at least formally—unchanged system of health care planning and investment financing, and describe some examples of failed reforms. In a second step I show how the two systems—reimbursement and planning—have come into conflict and identify processes that, irrespective of changes to the reimbursement system, challenge the old system of hospital planning and investment financing. Finally, I present the attempts by national and state governments to mitigate the contradictions between the two systems, discuss more comprehensive reform approaches, and draw conclusions.

2 The Hospital Financing Act—A Historical Compromise

After the Second World War hospital care was in crisis: many hospitals had been destroyed or damaged, and suffered from long-lasting underfunding. The fees paid by statutory health insurance were insufficient to cover costs, and providers, generally municipalities and non-profit organizations, had to bear the losses. As a result, hospital infrastructure was inadequate and supply did not meet demand (Simon 2000: 43ff.; Tuschen/Quaas 1996: 4).

In the 1950s, there was consensus among political actors that hospitals needed more funding, but opinions about how to achieve this differed widely. The federal government, in charge of regulating statutory health insurance, held that it was the responsibility of the state to provide hospital care and therefore the states had to finance part of hospital costs to keep contributions low. This opinion was shared by sickness funds (Jung 1985:40). On the other hand, states and municipalities (both hospital-owners) favored monistic financing through health insurance with fees sufficient to cover full costs. But neither side had the power to enforce its favored solution. The Basic Law did not grant the federal government legislative competence; hospital regulation was the exclusive domain of the states. However, in 1954 the federal government enacted a regulation covering hospital charges (PflVO 1954)[5] using authority based on economic law. This regulation lay down that fees must not be cost-covering. The principle that federal law

[4] Krankenhausfinanzierungsgesetz 1972
[5] Pflegesatzverordnung 1954

overrides state law meant that the states were barred from enacting any regulation that would have counteracted this regulation. Diverging interests of different states and federal ministries hindered alternative solutions (Simon 2000: 66–67).

This muddle lasted nearly twenty years, before multiple changes in the social, economic and political environment made reform possible. Firstly, an economic upturn in the late 1960s caused taxes and sickness fund revenues to rise. Secondly, a growing desire for reforms among the population increased the priority of improving hospital care. And thirdly, Christian democrats and social democrats formed a grand coalition between 1966 and 1969, followed by a coalition of social democrats and free democrats (Simon 2000: 69-70). The grand coalition held sufficient majorities in both the Bundestag and the Bundesrat to change the Basic Law and was therefore able to shift responsibilities between the national and state levels. These changes enabled the federal government to co-finance state funding from the federal budget (Art. 91a, 104 GG) and gave federal government authority to regulate aspects of "the economic viability of hospitals and the regulation of hospital charges" (Art. 74 No. 19a GG) (Jung 1985: 41). Whereas these reforms were possible, the grand coalition could not agree upon a hospital reform act because, unlike the social democrats, the Christian democrats did not want national government to take a share in hospital financing and could not accept cost-covering fees. Not until the new government coalition in 1970 conceded to these demands by the states was it possible to tackle hospital finance reform. After some discussion about the national share of investment financing and a promise to respect the states' autonomy in hospital planning, consensus was reached in the conciliation committee in 1972 and the Hospital Financing Act came into force just before the economic downturn of 1974 (Simon 2000: 71-72).

In the end, the state's responsibility for financing was implemented through the dual financing system where investment costs were covered jointly by central government and the states, and only hospital running costs had to be paid by insurers and patients. The Hospital Financing Act also established the statutory responsibility of the states for ensuring hospital capacity, and gave them an instrument with which to accomplish this, in the form of the hospital plan.

3 Reform and Structural Continuity in Hospital Funding

3.1 Reimbursement Reforms

Until 1993 the level of payment for hospital treatment was set in negotiations between each hospital and the sickness funds, following the principle of cost-coverage: on the basis of the hospital's cost and service structure a prospective budget was negotiated at a level sufficient to cover the operating costs of a properly managed, efficient hospital. Per diem rates were set at the same level for all treatment days regardless of what care or treatment

was actually provided.[6] Despite the principle of cost-coverage hospitals still had the possibility of making a surplus or loss, because the sickness funds reimbursed only the agreed rates rather than the actual costs.

Because of its inherent incentive to extend the period of hospitalization and continuously rising per diem rates, this reimbursement system had come under criticism.[7] The German government, following the principle of keeping social security contributions stable, no longer felt able to accept costs in the hospital sector rising faster than the incomes on which contributions were based, and used this to justify making structural alterations to the reimbursement system in the Health Care Structure Act of 1993 (GSG). The principle of cost-coverage was identified as the "fundamental structural defect" (Deutscher Bundestag 1992: 67), which the act abolished and replaced with a performance-based reimbursement system (Tuschen/Quaas 1996; Busse/Riesberg 2005).[8]

A mixed system involving a basic per diem, department per diems, procedure fees and case fees was introduced on a voluntary basis on 1 January 1995, before becoming mandatory from 1996.[9] In this transitional system 20 to 25 percent of hospital services were reimbursed via case fees and procedure fees,[10] while the rest was covered by a single basic per diem for the whole hospital (to cover non-medical and non-nursing activities) in combination with a department per diem for department-specific medical and nursing costs.. This transitional reimbursement system was merely a stepping stone on the way to a comprehensive performance-based system. It established the rudiments of a case fee system on the basis of which a comprehensive case-based reimbursement system could be built.

With the Health Care Reform Act of 2000 the decision for a new, performance-based hospital reimbursement system was reached,[11] and the Case Fees Act (FPG)[12] in 2002 then introduced the new system based on DRGs (diagnosis related groups). In 2003 hospitals could apply the new reimbursement system for the first time. By 2004 all hospitals had to introduce it, although implementation was—like in 2003—budget-neutral (while accounting was conducted using DRGs the hospital's budget continued to be

[6] The per diem rates were arrived at by dividing the total budget by the number of hospital days to be provided during the period, which was also negotiated. They only became part of the negotiations in 1985. Previously they were fixed by the health ministries of the federal states (Veith 1988: 93).

[7] The costs during the last days of the stay are generally lower, as a rule less than the per diem, for which reason there was an incentive to keep patients longer in hospital than medically necessary.

[8] Simon (2000) differs, asserting that the Health Care Structure Act only modified the principle of cost-coverage rather than abolishing it.

[9] The new reimbursement model was enacted by the Health Care Structure Act of 1993 but not implemented until the National Ordinance on Hospital Rates of 1995.

[10] Whereas case fees were designed to cover all the costs of treating a case, procedure fees were paid in addition to the basic per diem and a reduced department per diem

[11] With the exception of psychiatric and psychosomatic facilities, which are to receive their own separate case fee system starting in 2013. Certain other "special facilities" (departments and sometimes whole institutions) whose services cannot (yet) be properly reimbursed through the DRG system are temporarily exempted from the system (§ 17b Abs. 1 S.15 KHG).

[12] Fallpauschalengesetz 2002

negotiated on the basis of its actual costs). A six-year convergence phase began in 2005, during which the individual hospital base rates are being gradually brought closer to the average state base rate.[13] Fundamentally, the payment for treatment is calculated by multiplying the cost weight of the relevant DRG by the base rate. The DRG cost weights are calculated by the corporatist bodies at the national level, whereas during the convergence phase the level of the base rate, and thus the price of the service, is still negotiated between hospital operators and sickness funds. Once the convergence phase has been completed there will be a single state-level base rate, negotiated between the state-level corporatist bodies. The goal is to have a single standard price in order to realize the principle of "equal pay for equal service". So in future there will be a standard national base rate, which will emerge after a five-year convergence phase starting in 2010 that will bring the state base rates into a corridor of -1.25 and +2.5 percent below and above the national base rate.[14]

The DRG system was introduced in order to allow competition among hospitals in a regulated environment. It alters the incentive structures for hospitals in such a way as to encourage them to pursue the goals of efficiency and cost reduction in their own interest. In the DRG system price is determined not by supply or demand but by negotiations between the corporatist bodies. The organizations representing the sickness funds and the hospital operators negotiate the prices of hospital treatments via the base rate, whereby the sickness funds try to keep the price as low as possible while the hospitals strive to increase it, at least to a level that covers costs. The price negotiated in the DRG system is a fixed one that applies to all hospitals.[15] It represents—like a market price—an upper cost limit for hospitals. In the long term hospitals whose costs are higher than the revenue they receive from case fees will have to attempt to reduce their costs; otherwise they will make losses and have to reduce the range of services they offer (Sachverständigenrat 2007: item 455). So the DRG system creates an incentive to expand services whose costs are less than their case fee and conversely to cease services that cost more than the fee. This should lead to treatment being offered only by efficient hospitals.[16]

[13] Originally a convergence phase of just three years was envisaged. Fears that this would lead to "considerable disruption in the hospitals landscape (DKG 2004), to the detriment especially of the maximum care hospitals, led to a two-year extension introduced through the 2nd Case Fees Amendment Act of 2004 (2. FÄndG). At the end of 2008 it was decided to extend the convergence phase by a further year to relieve the financial pressure on the sickness funds (Deutscher Bundestag 2008b).

[14] Convergence will merely bring base rates into a corridor until research has clarified why state base rates differ so widely. Should the research show that hospitals in different states have comparable cost structures, state base rates will be brought in line with a single national base rate between 2015 and 2019. (§ 10 Abs. 13 KHEntgG)

[15] The base rate is currently negotiated at state level, so the price is identical for all hospitals within a state. Later, when the base rate is negotiated nationally, there will be uniform national prices for all German hospitals.

[16] Of course in reality the ramifications of the DRG system are a good deal more complex than this outline of the competitive function of DRGs might suggest, and as a result the competition mechanism described is not always able to take full effect in real situations.

3.2 Investment Financing and Hospital Planning

3.2.1 General Points on Investment Financing and Hospital Planning

The responsibility of the states for adequate supply does not mean that the states themselves have to provide hospital services, but merely that they must create a suitable framework that allows the various hospital operators to provide their services at a level that meets the need (Simon 2008: 66 and 250f).[17] To this end each state—on the basis of a needs analysis—prepares a hospital plan detailing the number of hospitals required to care for the population together with their location and facilities. The legal framework for hospital planning is laid down at the national level by the Hospital Financing Act, but division of responsibilities and details concerning implementation are governed by the respective state hospital laws, which explains the sometimes considerable variations in form and amount of detail of hospital plans between individual federal states.

State hospital planning in Germany is intimately bound up with investment support. Only those hospitals that are included in the hospital plan have the right to receive investment funds from the state. Inclusion in the hospital plan automatically entitles a hospital to treat patients from the statutory health insurance system, because the sickness funds are legally required to conclude care contracts with all hospitals included in the plan (contract implied in law under § 109 SGB V)[18]. A hospital that is excluded from a state's hospital plan can nonetheless gain admission to treat patients from the statutory health insurance system. In this case the hospital has to conclude a contract with the state-level sickness fund organizations (§ 109 Abs. 1 SGB V). Of the 1,791 general hospitals in Germany with a total of 468,169 beds, 1,512 are in the hospital plans (414,931 beds), 34 are university hospitals (42,965 beds), and only 93 (7,492 beds) have a care contract outside the plan, while 152 (2,781 beds) have no care contract at all (Statistisches Bundesamt 2008). So hospitals outside the plans are a negligible factor.

The Hospital Financing Act lists different categories of investment financing. Construction and fitting out of new hospitals is funded on application if the hospital is included in the hospital plan and is part of the investment program (§ 9 Abs. 1 Nr. 1 KHG). The replacement of capital equipment with an average life of more than three years is also supported (§ 9 Abs. 1 Nr. 2 KHG). Funding is also provided for, amongst other things, depreciation on capital equipment, start-up and restructuring costs for internal reorganization, and costs arising through closure or conversion (§ 9 Abs. 2 KHG). The aforementioned categories require itemized applications by the respective hospital, while minor building work and the costs of replacing short-lived capital equipment are covered by an earmarked annual lump sum that the hospital can spend as it decides (§ 9 Abs. 3 KHG). The specific arrangements and the size of the lump sum differ from state to state.

[17] But the final responsibility remains the state's, so if private-sector, non-profit or municipal operators fail to supply adequate capacity the state would ultimately have to provide the services itself (Simon 2008: 251).

[18] Sozialgesetzbuch V (volume V of the German Social Code)

3.2.2 Structural Continuity

State hospital planning and investment support as described above, were established in 1972 by the Hospital Financing Act and have changed little in their regulatory structure since then. Probably the most important modification was the switch from investment funding shared by national and state government to financing solely by the states, which occurred with the Hospital Reorganization Act that came into force in 1985. The basic principles of dual funding and state hospital planning have survived since their introduction. Although both have long been the subject of heated controversy, they exhibit astonishing structural continuity. Repeated attempts have been made to erode the principles of dual financing and hospital planning or to abolish them in favor of a monistic financing and planning system, but as the following examples show these have thus far come to naught.

For example, back in 1977 a government white paper proposed departing from the principle of dual financing. The hospital operators themselves, the draft of the Health Insurance Cost-containment Act proposed, should contribute 10 percent of new build costs and 5 percent of replacement costs, in order to increase the economic efficiency of the investment procedure. Hospital operators would have been able to recoup the costs through the per diems, while the state-level sickness fund organizations would have gained greater influence over the states' hospital planning. Both these proposals were rejected by the state governments in the Bundesrat (Simon 2000: 96–98).

With the Health Care Reform Act of 2000 the German government attempted to introduce a monistic hospital financing and to reduce the states' hospital planning to a skeleton. But this was again blocked by the states, which refused to approve the act in that form in the Bundesrat (Tuschen/Quaas 1996: 37).

Despite many attempts to erode or abolish the dual financing system and weaken the powers of the states in hospital planning, both have survived to this day. The actual inroads into the dual hospital funding system have been minor, mainly because the opportunities opened up have remained largely unused by those involved. Because deviations from the plan require the approval of the state health ministries, hospital planning also remains at least formally largely in the hands of the states.

The main argument cited against dual financing is that those who make the investment decisions are not those who have to bear the ensuing costs, and that this leads to inefficiencies. The states are accused of basing investment decisions not solely on economic criteria but allowing themselves to be led by political and budgetary considerations.[19] This, it is said, creates overcapacity, inefficiency and high running costs, which then have to be borne by the sickness funds. Under monistic financing, by contrast, investment and running costs would be financed from a single source, which

[19] In fact, explicit political decisions about distribution of resources are at the heart of the hospital planning system (Sachverständigenrat 2007: item 455), with the aim of ensuring needs-related care that could not be realized by allocation purely through the market.

would lead to more efficient allocation of funding, it is claimed (e.g. Felder et al. 2008; Hermann 2007; Neubauer 2003).

The states are responsible for ensuring hospital capacity. But in order to do so they need to have sufficient powers, which they would largely lose under a monistic financing system. The states would no longer be able to make investment decisions; depending on the details of the monistic system this prerogative would pass to the sickness funds and/or the individual hospitals. But without the power to decide the use of investment funds, hospital planning would lose its teeth because the states would no longer have any financial incentives with which to persuade hospitals to comply with the plan (Sachverständigenrat 2007: item 518). Thus under monistic financing the states would lose all their instruments for ensuring capacity, while still remaining responsible for it. Another reason for the states' unwillingness is that under monistic financing they would still have to supply the funds for investment, for two reasons: firstly, the states have a fundamental obligation to provide public services, while, secondly, funding investment solely via health insurance contributions would increase ancillary wage costs, which is currently politically unacceptable. A third important reason why the states have resisted giving up their powers is rooted in the economic significance of hospitals. As employers and purchasers of goods and services, hospitals are an important economic factor largely independent of economic up and downturns. Therefore investment decisions are also structural and economic policy decisions, which the states are eager to retain control over.

4 Conflicts and Challenges in Hospital Funding

4.1 Challenges for Investment Financing and Hospital Planning

So in the field of hospital planning and investment financing there has been little reform at the formal level of regulation and legislation. Although formally almost nothing has changed in the dual system of financing and hospital planning, in reality in recent years there have been numerous developments that have undermined or at least challenged it (Ebsen 2007; Kortevoß 2007; SVRG 2007; Rüschmann et al. 2004; Bruckenberger 2003; Neubauer 2003; Stapf-Finé/Polei 2002).

- The dual system is most strongly endangered by the states themselves, through inadequate provision of investment. For a long time the states have been providing ever smaller funds for investment support. In the western states investment support has been declining since the early 1980s, and funding in Germany as a whole has been falling in absolute terms since 1993 (Simon 2008: 281). In the past ten years (1997 to 2007) investment funds under the Hospital Financing Act have declined in real terms by 34.3 percent, with itemized funding shrinking by 41.6 percent and lump-sum funding by 19.9 percent (DKG 2008: 65–66). The hospital investment rate more than halved between 1991 and 2006 from 11.1 percent to 4.9 percent (DKG 2008: 73), while experts regard a figure of at

least 10 percent to be necessary (ver.di 2008: 5).[20] Continuous underinvestment has created an investment backlog of billions in the hospitals: widely diverging estimates of the exact amount range from €12 billion upwards to €50 billion (Rürup 2008: 16). Because the switch to reimbursement through case fees and the specialization demanded by increased competition make increased investment necessary (AOLG 2004: 3), hospitals sometimes have no alternative other than to fund investment out of operating costs, which leads to the creeping expansion of quasi-monistic financing. In 2004 €850 million from operating costs was already being spent on investment, representing a share of 20.4 percent of total investments. It is believed that this amount has now grown to a billion Euros annually (ver.di 2008: 6). In 2002, before the introduction of DRGs, Neubauer already estimated own funds channelled to investment to be four billion Euros annually (2003: 77). He even states that "quasi-monistic financing" is already de facto reality in many federal states (ibid: 86).

- The states' inadequate funding not only undermines their position and their favoured model of dual financing, but also encourages the advance of privatization. Insufficient investment funding from the states is one of the main reasons why municipal councils sell their hospitals to for-profit hospital operators. Budget constraints leave local authorities unable to make up the investment deficit caused by the states, practically forcing them to sell their hospitals to private operators. An obligation to make necessary investments is often part of the deal (Simon 2008: 283). Private operators are not dependent on the states' investment financing because they can raise funds on the capital markets. Private investment funding also has the advantage, compared to public investment support, that it can be deployed flexibly, independently and without excessive red tape.
- The planning autonomy of the states has been curbed in recent years by court rulings. Applying competition law to the hospital sector has had a particularly strong impact on hospital planning. Although this is extremely controversial (e.g. Bruckenberger et al. 2006), the Federal Cartel Office has forged ahead with strict merger controls in the hospital sector. To date the Federal Cartel Office has investigated more than fifty mergers (Böge 2008), and in the meantime rejected some.[21] In a case concerning a Federal Cartel Office decision to prevent a merger, the Higher Regional Court in Düsseldorf issued a clear verdict giving competition law priority over hospital planning law.[22]

[20] The hospital investment rate is calculated by dividing the investment support provided under the Hospital Financing Act by the total hospital spending of statutory sickness funds and private health insurers.

[21] For example see Federal Cartel Office decisions B10-123/04, B10-109/04, B10-161/04, B3–1002/06.

[22] "Rather, the merger control rules represent a legal requirement that can affect the implementability of planning goals. Thus seen, the implementation of hospital planning is subject to its acceptability under monopolies and mergers law" (Higher Regional Court,

- The German health system is characterized by a strict and fundamental separation between ambulatory and hospital care. But in recent years the divisions between the sectors have become increasingly porous, which undermines state-level hospital planning (Ebsen 2007: 117). The task of ensuring capacity observes the old sectoral divisions, with the states responsible for the hospital sector while the associations of statutory health insurance physicians ensure there is adequate ambulatory capacity. In most cases the states have no planning powers for the newly emerging intersectoral arrangements such as integrated care or outpatient surgery in hospitals.[23]

4.2 Conflict between State Planning and Competitive Allocation

The greatest challenge for hospital planning, however, is the change in the reimbursement system to performance-based case fees. The basic principle of case fees is controlling provision through the reimbursement system, which stands in stark contradiction to planned management of hospital capacity based on need. The introduction of DRG reimbursement leads to specialization among hospitals (Lüngen/Lauterbach 2002: 94; Roeder et al. 2004: 703). The competition mechanism causes operators to cease providing unprofitable services and specialize instead in profitable ones.[24] The enhanced cost accounting that comes with DRGs tells hospitals precisely which services are profitable and which are not. The specialization tendency is amplified by the economies of scale which become possible through specialization (Lüngen/ Lauterbach 2002: 95; Rüschmann et al. 2004: 126). Empirical data from the United States on the introduction of DRGs confirms the specialization tendency (Eastaugh 1992 cited in Lüngen/Lauterbach 2002: 94).[25] From the perspective of quality and efficiency, increasing specialization of hospitals is to be welcomed. But specialization can also become a problem if it endangers coverage. In the DRG system decisions about providing a service are made largely on the basis of cost accounting data rather than need, which can lead to a situation where particular services are no longer offered in a region. Under conditions of competition no hospital can continue providing loss-making treatments. So if a hospital is unable to provide particular services at a profit, it will stop providing them at all, even if the state hospital plan stipulates otherwise. The state has no authority to force a hospital to provide particular services, leaving the hospital plan powerless in the face of the economic incentives of case fees. Under competitive conditions the hospital plan is unable to guarantee capacity (Leber et al 2008: 83).

Düsseldorf, VI-Kart 10/07 (V) of 8 October 2008, quoted from Bruckenberger 2008). The verdict is still subject to appeal.

[23] This is not the case with outpatient hospital treatment for rare diseases, highly specialized services and conditions with unusual courses (§ 116b Abs. 2 SGB V), where the law insists on ambulatory treatment being included in the hospital plan.

[24] See above.

[25] The lack of research in this field means it is impossible to gauge the degree of specialization in Germany.

As just described, the DRG system has made a mockery of hospital planning, but conversely hospital planning and the practice of investment support also hamper the competitiveness of the reimbursement system. Hospital planning hinders free access to the market by tying admission to treat members of the statutory insurance schemes (who make up almost 90 percent of patients; Simon 2008: 119) to inclusion in the hospital plan. This gives the hospital plan the role of a "licence to bill" the insurers. Leber et al. even surmise that without this "market access via licence trading" private operators would build many more new facilities rather than taking over existing ones (2008: 83).

Furthermore, the dual hospital financing system produces distortions of competition, both between hospitals and between the ambulatory and hospital sectors. Investments have a direct impact on the level of operating costs, so hospitals that received more investment in the past enjoy a competitive advantage today over those that received less. The transition to a uniform national pricing system will further exacerbate this situation, because levels of investment vary considerably between states. Unlike the hospital sector, service providers in the ambulatory sector have to finance their investment out of treatment fees, which causes a distortion in the relative prices between the two (Rürup 2008: 8).

The aforementioned distortions of competition caused by state investment support highlight a fundamental problem. A level playing field is required in order to avoid unfair competition and resulting inefficiencies. So the starting conditions have to be defined and regulated nationally. But the federal states are responsible for hospital planning and investment support, leading to sometimes very large structural differences between the hospital markets of the individual states. This could become a serious problem in the transition to a single national base rate.

It is also important for hospital operators to be able to make decisions quickly and independently, in order to be able to respond quickly in a competitive environment (Sachverständigenrat 2007: item 455). That does not square well with the central planning frame of the hospital plans, where certain factors are fixed for years ahead. Additionally, the procedures for awarding public investment funding involve a great deal of red tape, which consumes time and resources (ibid.**)**.

Another important precondition for functioning competition is for economic subjects to be largely free to decide how funds are spent. State investment support shifts financing decisions to a level independent of the economic subject, where decisions are made not purely on the basis of economic rationality, but also taking other goals into consideration. This argument points again at the general problem of conflicting objectives between the two systems, discussed above. Whereas hospital planning is justified by normative objectives like need-satisfaction and equal access, competitive hospital reimbursement pursues exclusively efficiency gains.

4.3 Notes on the pursued goals of hospital financing

Hospital reimbursement arrangements and the hospital planning and investment support system share the ultimate aim of ensuring that the treatment needs of the population can be met. But the Hospital Financing Act of 1972 also pursued two additional goals: securing the economic viability of hospitals and ensuring socially acceptable per diems (§1 KHG). Which of these goals should be given priority was and still is controversial (Simon 2000: 74). The history of the Hospital Financing Act clearly suggests that the government was primarily pursuing the goal of providing adequate need-based care. At that time this was endangered by underfunding, which is why the government undertook reform in the first place—because economic viability is a precondition for adequate care. The goal of socially acceptable per diems was subsidiary to these two objectives (Simon 2000: 75f). The goals of the Hospital Financing Act have remained unchanged to this day, but the weighting of the goals has shifted towards the goal of socially acceptable per diems. Investment support and the principle of cost-coverage ensured the economic viability of the hospitals (and thus adequate care), but endangered the goal of "socially acceptable per diems", which is why they were abolished and replaced by case fees. The latter were designed to prevent any further expansion of volume and spending and thus to ensure that contributions remained stable (Deutscher Bundestag 2001). Not until the Case Fees Act of 2002 was the goal of stability of contributions anchored in the Hospital Financing Act (§ 17 Abs. 1 KHG), but ever since 1988 sickness funds and service providers have been required to observe the principle of contribution stability in their agreements on reimbursement of services (§ 71 SGB V).[26] Reimbursement is thus principally governed by economic considerations, whereas hospital planning and investment financing primarily pursue the aim of providing the population with adequate hospital capacity.

4.4 Resolving the Contradiction

The government has, as described above, persistently attempted to abolish the dual financing system in favour of a monistic system in order to resolve the contradiction between the two systems. It has sought to do this by subsuming investment financing into the competitive system of hospital reimbursement, and when these efforts failed it tried at least to mitigate the contradiction. The states have also responded to this situation by—at least to some extent—attempting to adapt their hospital planning to the new circumstances.

In order to maintain adequate hospital capacity even under conditions of competition the Case Fees Act provided for structural supplements for hospitals that cannot supply at DRG-prices but are necessary for comprehensive coverage, to be agreed between sickness funds and hospital operators as part

[26] The goal of stability of contributions represents a tightening of the goal of socially acceptable per diems, because it fixes the level of contributions at the current rate, whereas a "socially acceptable" level is historically negotiable.

of the overall negotiations on treatment fees. But so far the possibilities offered by structural supplements have remained largely untapped. Insurers have adopted a very rigid stance against the structural supplements, and the hospitals are unwilling to take recourse to legal action. In any case, the law here is very vaguely formulated (Deutscher Bundestag 2008a: 5). The states have the right to define by decree the conditions under which structural supplements are to be paid, and in case of disagreement the state health ministry's decide whether the supplements are due (§17b Abs. 1 KHG; § 5 KHEntG). This means that the states do have an instrument—albeit a weak one—for fulfilling their responsibility to ensure adequate capacity. The structural supplements do not negate the contradiction in the system, but they could help to mitigate its effects if the states would make use of them.

With the latest reforms of 2008 the government hoped to eliminate the conflict between hospital reimbursement and investment financing. The original draft of the Hospital Financing Reform Act would have shifted investment financing to performance-based investment allowances and allowed itemized funding only under special circumstances. But resistance on the part of the states made it impossible to introduce compulsory investment allowances, so the law as enacted gives the states the possibility to choose between the two investment funding models (§10 KHG). Agreeing the basic structures for uniform national investment weightings is the task of the corporatist bodies. Here the varying investment needs of different hospital services have to be taken into account, for example whether a service is labor- or material-intensive. This couples investment financing directly to service provision and produces a "system-congruent harmonization with the uniform national modalities for funding operating costs in the DRG system" (Deutsche Bundesregierung 2008). Tying investment support to the services provided restructures investment financing into a competition-based system, but at the price of almost complete separation of hospital planning and investment financing. The right to receive investment funding may still be tied to inclusion in the hospital plan, but investment allowances no longer permit investment to be directed according to planning criteria. This is likely the reason why the states resisted compulsory introduction of investment allowances.

In order to respond to the conflict between reimbursement and planning, some states have adapted their hospital planning in recent years to fit the changing circumstances. They have reduced the depth of detail of the hospital plan and make greater use of morbidity- and performance-based planning variables (Roeder et al. 2004: 703; Simon 2008: 276, Sachverständigenrat 2007: item 481). Some states have also tried to take account of the increasing provision of outpatient services by hospitals. "Framework planning" can ameliorate the fundamental conflict but not eliminate it, because even scaled-back supply planning conflicts with competition-based allocation.[27]

To eliminate the inherent conflict between hospital reimbursement and investment financing, one of the systems would have to be adapted to the

[27] The term "framework planning" *(Rahmenplanung)* crops up frequently in discussion of the required reforms of the macro-level structure, but there is no consensus as to what it should actually entail.

other. Restructuring investment financing to make it competition-based would require the complete separation of investment financing from the responsibility to guarantee capacity. Investment could then be financed through performance-based investment allowances, whereby—contrary to widespread belief—it is irrelevant who provides the funding; what matters is that investment financing is adapted to competition and harmonizes with the system as a whole. Guaranteeing capacity should definitely remain the responsibility of the states. The proposal to transfer this duty to the sickness funds is exceptionally problematic in a competitive environment, because they would be confronted with contradictory incentives and there would be a danger that the objective of adequate capacity would be sacrificed for the sake of keeping contributions stable. The states could ensure adequate hospital capacity either through structural supplements (over which they would, unlike the present situation, have to have full authority) or through states or local authorities supplying the missing facilities needed for hospital care. However, in such a system it would no longer be at all possible to plan the range of services offered. The states would be limited to monitoring provision of services and responding with remedial structural measures if a problem arose.

An alternative solution would be to create a new incentive system concentrating on social rather than economic targets. But given the road currently taken and the current social climate this will probably have to remain a utopia.

5 Conclusions

Examining the role of federalism in the "silver age" of the welfare state, it becomes apparent that federalism is an important factor in the restructuring of hospital regulation.

Most literature focuses on the veto position of the states and how this hinders reforms. In the hospital sector the states often used their veto power to block reforms, thereby hindering a comprehensive competition-led transformation of hospital regulation. And it is due to their veto position that the formerly coherent hospital financing system is now split into two conflicting parts. But reforms have had an impact on the power of the states. Step by step responsibility for remuneration has shifted to the national level. Also, and even more significantly, the states' old instruments of hospital regulation have become more and more powerless. In a competitive environment they are no longer appropriate to secure adequate supply.

Given this constellation of problems, simply blocking further competition-led reforms seems a very simplistic and backward-looking response. To overcome their predicament, the states would have had to take action and implement countervailing reforms. Granted, they only possess limited legislative competence, but there are other ways to intervene too. They could increase their hospital investment budgets, or put pressure on central government to improve the instrument of structural supplements or to implement other coverage-securing instruments. The states have only lost their

influence on hospital supply, not their veto power over certain federal matters (Gerlinger 2008: 260). But such policies need concerted action and that is hard to find among the states because their interests are quite diverse and their votes are often influenced by party politics. The states' resistance to reform represents the lowest common nominator among them, because it is easier to agree on what they do not want than on what they do, as various discussions in the conference of state health ministers have shown.

As described above, there seems to be no solution for integrating the two different systems of hospital funding the near future. Fragmentation of responsibility and, most notably, diverging interests between federal government and the states represent obstacles to coherent reforms. While the states want to safeguard adequate supply, federal government—with stable contributions high on its agenda—is trying to make the system more efficient by introducing competitive allocation instruments and capping spending. This conflict of interests merely mirrors the more fundamental contradiction between adequate supply and competitive allocation. To be adequate, supply must be determined by the needs of the population, whereas in a competitive environment supply decisions are made by the hospital based on economic considerations, more or less irrespective of needs.

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