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# Structural defects in the health care system in Germany – A consequence analysis for hospitals

*health care; hospitals; scenario technique; soft budget; structure*

*The current health care system, facing a growing pressure for cost reduction and innovation, no longer meets the requirements for an integrated, individual care of patients. In order to examine the structures in detail a „trend-projection", using the method of the scenario analysis was conducted for the German health care system. As a result, one scenario was identified describing a progressive form of regionalised, private-oriented health care structures less as a controlled process but rather as a result evoked from the economic crisis of the public health care system. Consequently, the question arises in terms of the interpretation and the evaluation of the claims made by the trend scenario as well as their impact on the stakeholders.*

## I. Introduction and research question

The health care sector is a political field of high relevance for the citizen. The growing need for integrated, individualised care, also described as personalised medicine, for the patient is caused by a „technology-driven revolution" that is aiming at a truly personalised therapy while being highly efficient from a clinical point of view (Lloyd 2012). However, given the growing pressure for cost-efficiency and innovation, the health care sector does not meet these criteria in its given structures. "The increasing number of available therapies and the steady expanding scope of biomedical knowledge generated are great hopes for the care of patients. Simultaneously, there are new challenges to be faced and resolved as a result of the increasing complexity in clinical decision-making processes…" (Lloyd 2012, p. 2) in which traditional forms of health care supply and the existing planning- and regulation system are stretched to their limits. It seems as if a fully regulated market is just as little not suitable to warrant a sustainable and holistic care for the patient as a non-regulated market. Thus, it appears that the current system in its current structures is not applicable to overcome the challenges, to manage the risks and to take the chances.

In order to examine the assumptions, there was conducted a trend projection for the health care sector in Germany using the method of a scenario analysis (Held 2012). Focussing on the exploration were the changes which determine the transformation processes in the hospital landscape and the ambulant care, in their periphery meaning in the German health care sector, the regions of the hospitals, the local and regional governments and the counties. The result is a trend scenario which describes a progressive shaping of regionalised, corporate sector-oriented health care structures, less as a regulated process but rather as a result from the economic crisis

in the public health care sector. Consequently, the question arises how to perceive and evaluate these trend projections. By performing a consequence analysis, the impacts of the trend scenario are operationalised, the expectations and interest of the stakeholder are analysed and compared within an impact grid. Eventually, making use of the analysis should help to answer the following questions:

- Which impacts does the described trend scenario have on the stakeholder, especially on private and public hospitals as service providers?
- Which factors determine the failure of the state actors being a public service contractor in this scenario?
- Which factors and determinants speak against the idea of letting the market alone regulate the supply of hospital services?

## II. Research methodology

It was ascertained from the results of the trends analysis that health care provision is increasingly becoming an entrepreneurial function involving the acceptance of risk and the necessity of innovation. The more entrepreneurial tasks is faced with, the less the state is in a position to deal with them. Luhmann (1971) recognised the following types of systemic structures provide the preconditions in decision-making. Here, systemic structures represent the operating programs as "conditional programs" or "intended programs", the organisational structure as coordinating in the extreme situation between hierarchy and market, and thirdly, the employees. The study of the structure of the health care system (Held 2014, pp. 47) builds upon an already conducted scenario analysis (Held 2012, pp. 99) which used a multiple set of different research methods (database research, library research and analysis, internet research and contact with respective institutions, interviews with experts, collection of print media and scientific observation – the author worked in different hospitals as an scientific observer from February 2011 until April 2012) in order to be designed. Therefore, the study is based upon a qualitative research design.

With the aim to evaluate the scenario, a consequence analysis, developed as an impact-grid, was accomplished. Because of the fact that the control of politics should be guided by "impacts", an appropriate method to capture "impact" hast do be applied. This was done to enable German public actors to have a solid basis for appropriate policy reactions to the impacts of the predicted trends. As shown below a need arises for a new governance model for health care provision in order to ensure accessible and affordable health care provision for all patients.

In the impact analysis, all relevant projections of the scenario are checked for their impact in the transformation process. To this end, the outcome of the consistency check from the scenario analysis is used. Each of the potential projections is investigated for determining, whether the trend materialises and if so, its major impact.

In the traditional sense of an scenario analysis and how it was developed for the field of strategic management in enterprises (Fink et al. 2011), the management team of the actual enterprise evaluates chances, risks, strengths and weaknesses resulting from the scenario. Within the frame of a consequence analysis, it derives possible action fields and implementation strategies.

In this case study, however, the research object is the region with public and private enterprises that are integrated in networks. There is not just one actor but many different stakeholders exerting influence and responsibility. As a result, the method must be transferred to a meso-level for which the consequence-analysis with its impact grid is developed. Consequently, the first step is to check the impact on the transformation process of every relevant projection of the scenario. The result can be gained from the consistence-check (Held 2012, pp. 206). Any of the possible projection is examined with the scope to answer the question of whether a trend is likely to occur and if so, how massive the impact was. The evaluation was done by an expert team consisting of doctors, scientists, administrator directives in the health care sector and further experts in a workshop.

Relevant impacts were operationalised into indicators and key figures and measured against their actual data. In a next step, one had to evaluate impacts and expectations of stakeholders in the health care sector which define the measurement criteria for the completion of targets in the sense of the evaluation.

For this purpose, a stakeholder analysis consisting of 23 structured interviews was conducted by asking for the stakeholders' expectations which then were translated into measureable indicators. Finally, the results of the impact analysis and the results of the stakeholder analysis were transferred and merged into an impact grid and then were made visible with the help of a traffic light function. This article focuses on hospitals. On the one hand, there are the expectations of hospitals. On the other hand, the consequences of the trend scenario for the hospitals and the patients are described. In a next step, both aspects are compared. Having performed a consequence analysis for the hospitals the failures of the state actors (public hospitals) and private hospitals are evaluated. By analysing the formal structure (Held 2014, pp. 70) it was possible to determine these organisational forms, to derive factors and major forces for a future structural model serving for the fulfilment of public services, in a next step.

## III. Results and discussion

Next results of the consequence analysis and the structural analysis for the hospitals are described. A more extensive description can be found in further work (Held 2014). Later on, the determinants for the failure of the public hospitals and the private hospitals are portrayed and discussed within the context of the trend scenario and its consequences.

### 1. Consequence analysis for hospitals

All possible trend projections that either supported each other or were mutually dependent were evaluated in terms of whether they are likely to occur and if so whether they would have a significant impact on the stakeholder or not, using a workshop for experts. Subsequently, there were 37 projections left over to be investigated in the impact analysis. In the following step, the projections then can be translated into key indicators which reveal the impacts for the stakeholders and can be measured with its actual values. The values were adopted from the latest sta-

tistics and studies etc. (Behrens 2009; Schmidt 2010; Bundesamt für Statistik 2012; Deutsche Krankenhausgesellschaft 2012). In the following, the stakeholders (SH) are divided into eight groups. All of them are major players. The stakeholders included in the trend scenario were already identified in the scenario analysis. Their influence on the scenario is evaluated according to a three-point scale (high, medium, low) and their interests are identified. Then the impacts and the stakeholders' interests and expectations are contrasted and evaluated. In this paper, only the hospitals are analysed, while a distinction was made between public hospitals and private hospitals.

Afterwards, it is possible to compare the effects from the trend scenario with the interests of the stakeholders using a traffic light function. Eventually, by using the consequence analysis it was possible to describe the effects of the trend scenario on the stakeholders, and therefore to answer the first research question.

Figure 1 shows the expectations of hospitals compared to the effects that have been derived from the trend scenario. It contains a small extract.

| No. | Projection | Indicator | Value |
|---|---|---|---|
| 1 | Danger of bankruptcy | Number of hospital closures per year.<br>Threat of insolvency. | > 35<br>> 11 % |
| 2 | Limited economic and political scope for actions (by local authorities) | Average debt ratio of local authorities.<br>Sovereign debt ratio (debt in relation to GDP). | > 33 %<br>> 80 % |
| 3 | Move from object financing to subject financing (of hospital infrastructure) | Hospital capital expenditure per year.<br>Public discussion on subject financing (amount of articles in the press review compared to previous year). | < EUR 4.5 bn.<br>increase |
| 4 | Increase in regional competition for patients | Number of patients per hospital compared to the previous year or number of cases (average).<br>Establishment of medical care centres (MCCs) in cooperation with the hospitals or hospital owner shareholding in MCC (compared to previous year). | Increase<br>18 million cases/ year<br>> 30 % |
| 5 | Individual optimisation policy of a hospital will become more expensive for the region (micro vs. macro efficiency) | Expenditure of the hospital/region compared to previous year (not incl. inflation).<br>Total household expenditures (health care share of GDP). | hospital individual evaluation<br>> 10.7 % |

| **User (Stakeholder Ia/Ib): Patient** | | |
|---|---|---|
| **Expectations** | **Contribution** | **Indicator** |
| Ia) Optimum medical care | Indirect taxes via health insurance contributions | Health status after therapy (healthy/sick);<br>Duration of stay (days);<br>Number of follow-up treatments;<br>Hospital accessibility; |
| Ib) Optimum social (and pastoral) care | | Satisfaction index (1-5) (questionnaire);<br>Personal care;<br>Cleanliness/hygiene;<br>Quality/amount of food;<br>Operation processes from admission to release; |

| | | |
|---|---|---|
| Ib) Optimum consulting and information | Willingness to provide consulting | Number of consultancies/quality (patient survey). |
| **Service support processes (Stakeholder IIIa/IIIb): CEO/Managing Directors/non-medical staff in hospitals of different ownership/management (hospital management on behalf of the owner)** | | |
| **Expectations** | **Contribution** | **Indicator** |
| IIIa) Reward/recognition/ status<br>Incentives (intrinsic and extrinsic) | Provide optimal conditions for social/medical care | Salaries<br>Incentives<br>Image/Status<br>Review by the owner/board etc.<br>Opportunities for advancement<br>Fluctuation in the administration |
| IIIb) Budget/case numbers/ income | Efficiency | Budget on health insurance<br>"Base rate" given by policy<br>"DRG- relatively weighted"<br>Break-even, positive<br>Operating profit rate<br>Investments generated due to efficiency |
| **Shareholder (Stakeholder VIIIa/b): Private health care companies/private individuals** | | |
| **Expectations** | **Contribution** | **Indicator** |
| VIIIa) Positive margin for investments | Equity<br>Health care operations | Investments per year<br>Earnings/Profit |
| VIIIb) Return/profit for personal drawings | Equity<br>Health care operations | Margin/Profit<br>Profit withdrawals in % |

| **Match between projection (No.) and expectations for Stakeholder I, III, VIII** | | | | | | |
|---|---|---|---|---|---|---|
| No. Projection | **Ia** | **Ib** | **IIIa** | **IIIb** | **VIIIa** | **VIIIb** |
| 1 | green | red | red | yellow | yellow | red |
| 2 | red | red | red | yellow | red | red |
| 3 | green | neutral | neutral | yellow | green | yellow |
| 4 | yellow | yellow | red | red | red | neutral |
| 5 | red | red | red | yellow | red | red |

*Figure 1: Consequence analysis for hospitals*
*Source: Author's compilation*

Supported by this performance measurement system it is possible to examine the impacts of the predicted scenarios periodically. Here, it will be necessary to analyse the scenario in regular intervals (for example every five years) which will get easier due to the fact that the annual impact analysis allows for the determination of an respective trend using key performance indicators.

As a result of the consequence analysis is: from the comparison between the expectations of stakeholders and the trends from the scenario the defects of public hospitals and private hospitals can now be derived. These defects have been identified in the stakeholder analysis by interviews. The interviews were transcribed, coded and analysed applying the qualitative content analysis by Gläser and Laudel (2010).

The defects are described in detail in the trend statements of the scenario analysis (Held 2012, pp. 100). In addition, the defects were confirmed by studies and literature review. In the further

course of the investigation an attempt was made to link the described defects with the structures of public hospitals and the structures of private hospitals. As an outcome, the resulting failures could be described.

## 2. Results: Failures of public and private hospitals

The problems of the German healthcare sector generally and in the sense of Musgrave (Musgrave 1994) perceive "health" as a private good. Its supply in case of an acute sickness can lead to a suboptimal allocation (way of doing and scope) if measured against the societal merits wanted. This is due to distracted preferences of consumers, asymmetric information between provider and consumers and because of the costs of supplying the good in relation to the capacity to pay from many consumers' point of view, and the dependency of consumers on their providers.

Further, it becomes evident that the state and the corporatist system in its current structure are not capable of promoting a societal wanted degree of supply. The health care sector is a dynamic one and is leaded by innovation in the pharmaceutical science, bio-chemistry and medicine technology. The main claims worked out in the present study, and which should be investigated in further empirical work, are the following.

Innovation and competition are fundamental elements which transform the health care sector into a health care economy. Notably, this is positioned diametrically opposed to the state's public services. The health care sector is characterised as:

- High specialisation of knowledge and division of labour.
- Great need for capital especially due to high research and development costs. Innovations are outsourced to therapies (clinical studies).
- Specialisation in service provision and therapy (personalised medicine).
- Establishment of private enterprises which are expanding players along the whole possible value chain of the health care sector focussing exclusively on profitable regions.
- Personalised therapies that need a focus on patients and regional oriented processes in terms of service provision resulting in a faster demolishment of current service structures, which are local and focused on doctors rather than patients.

The German health care system is characterised by the following group of actors: (1) The state defining laws and regulations and being the important financier for hospital infrastructure, (2) organisations and corporations of the public law as so called indirect administrations (health insurances and associations of statuary health insurances physicians), (3) contract physicians (not in hospitals) and hospitals that form a corporatist community together with health insurances and the associations of statuary health insurances physicians. The fourth actor is the medical and medical-technology and pharmaceutical enterprises and its representatives. The health care system forms a system of corporatist leadership trough self-administering corporations. The central element of this constellation of actors is the joined self-government of the health insurances and doctors, hospitals and pharmaceutical enterprises. Physicians commit patients to treatment and also care for the supply of the pharmaceuticals. The result is that there is no chance for a flexible market for service provision, because there is global budgeting and "cata-

logue accounting" (accounting in accordance to diagnostic related groups) for the health care providers which in turn prohibit competition. As for the statutory health insurances, there is a simple product offer where prices do not vary from the quality of the health care services. In this system there is no price signal for the patients. According to the standard literature in health economics this leads to a moral hazard situation. Insured people with full cost-coverage plans tend to overuse health care services because their insurance fees are decoupled from the consumption of health services.

As a consequence, there is a collective overstress of the health care system, which can be exploited like a "good of the commons" (Görlinger et al. 2012, p. 22). Despite the looming of the limits of the current planning and regulation system, as it is shown in the scenario analysis and measured from the effects, the German health care system still also follows the rules for German regional development and regional planning. The law for the financing of hospitals (Krankenhausfinanzierungsgesetz (KHG)) engages the federal states to do hospital planning (Krankenhauspläne (§ 6 KHG))) with the aim to secure an adequate supply of health care services through effective, independent and economic hospitals (Moersch 2009, p. 9).

The governmental hospital planning does a spatially allocation to central locations regarding three levels of provision. Considering the levels of supply, a hospital plan determines the hospitals needed for an adequate supply in line with the centrality of the location, number of beds and semi-residential beds and specialty. This form of hospital planning is regarded as a leftover of the "old planning" taking into account fundamental reforms of the health care system. It originates from the defending of the state responsibilities for the hospital planning (Böhm 2008, p. 70) but as well as the ambulant supply from a spatial perspective, it more and more becomes subject to pressure. This is because a permanent adjustment of the health care system, through health care reforms (Görlinger et al. 2012, p. 41) that aim for more competition by simultaneously maintaining a solidary financed primary care, also tends to a dissolution of supply regions for the benefit of regionally forming health care regions that are based on economic principles (Urban 2001, p. 10; Böhm 2008, p. 7).

This was worked out within the scenario analysis and was described in the trend scenario (Held 2012, pp. 217). Out of this and also from the types of formal structure (program, organisation or communication and employees) it is possible to examine the defects and their reasons (Held 2014). The compensation system is the greatest of the defects. Central incentives for the earnings increase of the health care providers are an increase of the services and the prices per services. Compensation systems which refund single services are in danger to set economic incentives that also lead to the provision of services that are without any medical necessity (Hildebrand 2012). Here, health insurances and health care providers rival each other, the first having an interest to sink costs and the other to increase their services. The consumer/patient however only has a marginal role to play as he/she is the object of the services. For this reason, an economic, rational allocation cannot be successful. In addition, the compensation follows the sectoral separation of the service provision domains which leads to further problems. In a system where each single service is refunded, it is economically plausible to provide as many services as possible on one's own even if other health care providers are better qualified or can charge less for their services. In a budgeted-sectoral system it is the other way round: Here, it gets interesting to outsource services into another sector even if this sector produces with hig-

her costs. Domain selfishness in medical centres, hospitals and even in single stations is the tangible effects. To conclude, one must say that the first determinant is a wrong incentive system in the form of a compensation system.

The trend scenario and also the expectations of the stakeholders show that health care provision more and more develops into an entrepreneurial exercise with acceptance and management of risks and a necessity for innovation, while the state and the corporatist system in terms of health care planning- and warranty are trying to combine social political and entrepreneurial tasks. The more entrepreneurial tasks there are, the less the system is prepared to manage both challenges. Here, Luhmann's (1971) perception applies which claims that system structures and its formal structures operate as decision premises and that they can be used for organisational analysis. System structures at this are effective program as conditional- or as intention program, the organisational structure as a form of coordination or communication (here in the extreme form between hierarchy and market) and derived from that the personnel and its values. The corporatist system fails being the entrepreneur and manager determined through its organisational structures (hierarchy) and the conditional program that can be described as the second and third determinant, leading to the fact that the state and the members of the corporatist system do not underlie any competition, thus cannot "perish".

The factual force that establishes itself in the market is stopped with the implementation of rules, guidelines and laws as described earlier with the example of the compensation system. Kornai (2009) has analysed this phenomenon by using the example of the health care system in Hungary and he labelled it the „soft budget constraint (SBC) syndrome" versus "hard budgets". He states: "The appearance of a SBC in the hospital sector is not peculiar to Hungary, or the post-socialist region. It is propensity that necessarily appears in all regions including modern, democratically governed capitalism, where state ownership, state regulations, and state financing have a necessarily great role to play. Furthermore, it reproduces itself, retreating but resurging after a time." (Kornai 2009, p. 133).

The effects of this system guideline can be described as follows:

- The enterprises develop somewhat of a "begging mentality". They know that they have the support from the state (Held 2014, p.75). The economy as the mayor force gets suspended (principle of scarcity).
- Soft limitations for budget distort competition. Because of the fact that the state secures the maintenance, enterprises can act comfortable. Innovation, optimisation and product development are no longer decisive for their survival (Held 2014, p. 91).
- The support of permanently deficit enterprises cost vast sums.
- Because of a missing commitment of the enterprises, there are also profitless investments that are realised (Dewatripont-Maskin-modell) (Dewatripont/Maskin 1995).

All effects described by Kornai, can also be unveiled for the German health care system. Through interviews with experts and the scientific observation the same defects were detected (Held 2014, pp.130). Soft limitations for budget which lead to a suspension of the economy in the public hospitals are the fourth determinant. Results are deficiencies in the health care system that lead to entropy of the system. The term "deficiencies" does not mean there is a lack of something generally, rather it is a term we find in logistics (Jünemann 1989, p. 18). There is not the correct amount of goods or services available at the right time, at the right place and in the

adequate quality. Therefore, deficiencies in the health care mean an under-coverage of the actual need of goods, deficiencies in services and economic resources, a gap in supplies of goods and services, a gap in supplies of material and equipment, deficiencies in productivity (Held 2014, pp. 70).

The significance of an under-coverage of goods and services becomes evident if one looks at the waiting time in hospitals (DKG 2012), or if one takes into account that integrated, personalised supply is only available in a central-location-system. Further, there is only a more and more fragmentary supply offered in rural areas, which is not enough to offer all citizens the best possible supply with optimal prices. A planning of locations for hospitals in line with accessibility of primary care simply is not satisfactory. It is not possible to evaluate if ten or 20 minutes to access the next hospital for the primary care is good or bad, because a benchmark is missing. It would be more needful to provide a service catalogue and guarantee its contents (e.g.: n-days to get to the next specialist, n hours to get to the emergency doctor, n minutes to get in touch with the next doctor for example via an emergency hotline, n minutes resource-availability) which however is not possible within the given structures.

A further significance of a deficiency is that the optimal production factor is not encouraged, e.g. input of material and manpower but rather one uses what is in place. This can be observed in hospitals. Deficiencies stimulates hoarding. Deficiencies cause an excess effort of operative administration and mislead to a neglect of perspective questions towards economic development.

Deficiencies in the health care sector lead to a delay of renewal and modernisation investments (e.g. investment bottleneck) and also to a lengthening of the transition of scientific, technical renewals (e.g. therapy, medicine, innovative equipment) (Held 2012, p. 160). Results and insights of scientific studies which are directly produced within therapy are reserved for those patients who are treated in medical centres' (www.kompetenznetze-medizin.de). Deficiencies cause extra hours and slack time simultaneously. A lot of doctors feel overburdened. One out of four works around 80 hours a week with unforeseeable consequences for the patient. "More than 48 working hours per week, in three out of four cases of hospitalists, are increasingly becoming a risk factor for patients" (www.n24.de). Deficiencies further cause a tendency towards a self-supply of the health companies and inhibit the creation of rational relationships in terms of division of labour (Held 2014, pp. 95; Phöhler 2010). Market and competition-based elements (fifth determinant) are introduced with the market however being unable to function with all its rules (Böhlke et al. 2009). What are missing are real prices, market players and concrete buyers for the services offered, and to be able to choose between them respectively, thus actual competition. The competition that is created through the compensation system is not going into the right direction. It is not healthiness as such that is being promoted but rather sickness. One could speak of a "fight" for patients (Held 2012, pp.147).

One can conclude that the survival of the current public health care sector does not depend on efficiency, innovation and effectiveness, because the financial funds are not limited (financing through debts). 19 % of all public hospitals are bankrupt if measured and assessed by economic criteria, 51 % make losses (www.dki.de; DKI 2012), to which all university hospitals belong to (www.vdek.com). The reason for it can be found in the principle of scarcity which is the basic principle for economic behaviour but which is non-existent in this case (SBC). Alternatively,

this system also means that social working potential is lying idle while needs are not met pleased. Available work (because there are unlimited needs e.g. research, gain of insights, care, education, prevention, art and culture) is present, but it is not paid for at the moment meaning that a lot of products, goods and services are excluded from the market – a fact which was already absorbed from the economy and the economic theory and was discussed under the term “shared value” as a new concept for the industry and the corporate sector (Porter/Kramer 2011).

As for the governmental regulation system, the regulation of the market also shows its limits. Major force of the market economy is the utilisation of capital while all other forces are subsidiary. According to Schumpeter and aimed at market realisation, each innovation is based upon this fundamental drive. The utility of a product is determined by the buyer on the market and is individual and concrete at any time. Economical thinking and behaviour are the fundaments of the market economy. The public sectors' major force in the utilisation of capital indirectly leads to the satisfaction of individual needs (what can be stressed, weakened or is manipulable respectively through marketing). Even less distinct and far weaker than the focus on a direct satisfaction of individual needs, there is the possibility of the public sector to focus on societal needs (e.g. sustainability, health care etc.). Although societal responsibility is accepted as a strong image-factor for private enterprises, it is not a major force as such compared to the efficient utilisation of capital. The extreme value of the corporate sector, being based on the maximisation of the realisation of capital, eventually is the product of limited personal needs (market saturation), limited availability of resources which allows the production for market-adequate prices. Strive for efficiency leads to a progressive edging of people aside from the value creation process (not because of reasons of rationality).

## IV. Conclusions

According to Schumpeter, innovation is an entrepreneurial task. Innovation has to bring up new products, services or methods which eventually are successfully implemented in a market (Müller-Prothmann/Dörr 2009, p. 7). Research and development in medicine have changed in respect to their positioning within the value chain. They significantly appear in the form of clinical studies and become "personalised medicine". As a premise, there is a need of changes with regard to current structures. Personalised therapy requires the conclusion of all available methods, systems, information and data surpassing sector boundaries. Given structures, however, are not appropriate for it (e.g. doctors horde their patients data thus one can speak of a war for patients, there generally is much competition between doctors and between hospitals). Innovation if perceived as personalised medicine cannot be offered from a single doctor, because he/she simply is not in the position anymore to offer defined services in line with scientific state of the art knowledge. There would be a need to integrate the doctor in service networks as there generally is a need for interdisciplinary networks of doctors and scientists. Notably, even single medical care centres’ (MVZ`s) are not adequate any longer. The knowledge of a single doctor is dated after five years, therefore he/she cannot be innovative anymore. In case, the patient is aware of that and will not go to a single doctor any longer. Innovative therapies as a premise for the avai-

lability of personalised therapies are only realisable in region with managed interdisciplinary and linked structures. Innovation realises itself as a service and needs service management structures similar to other industries (mobility as a service, cars, public means of transport are secondarily products).

The analysis has shown that the private hospital groups are the only players having the necessary innovation resources and also the necessary market pressure to be innovative. But, the negative consequences of the dominance of these private corporations have been described. Government hospitals are arrested in their structures. An outdated planning model, the soft budget constraint, the corporatist system of organisation and lack of entrepreneurship are the main causes of the defects in public hospitals. All elements described tend to cause an erosion of the corporatist, organised health care sector on its way to classical bankruptcy and towards a private system within the scope of service provision while preserving the model of a solidary health insurance financing. Here, the state keeps on disappearing from investment financing of the hospitals. The employer‘s contribution regarding health insurance, locked up through the political decision-makers, allocates the rising costs to the insurant even greater.

Simultaneously, the growing offer of direct and chargeable health care services is only partly paid by the insurance. Step by step, the patient becomes the financier of the health care system subsequently leading to a point where he/she is a player and customer in the health care market, thus puts pressure on the system himself. The patient becomes the subject rather than being the object which means that he/she is put in the position is able to make decisions rather than being the object of other stakeholders' actions. More and more active patients demand for:

- Transparency of information towards the players (information about doctors in the Internet and rankings of hospitals) and focus on needs.
- Transparency of performance/quality (therapy → cost/benefit evaluation).
- Cost and efficiency transparency therapy → benefit/cost evaluation).

It becomes evident that working competition requires the same basic premises for all players. Therefore, they have to be set and must be applied nationally (antitrust law).

On the contrary, a supply that fits the needs must be oriented on the differing social and local/regional needs, thus requires a decentralised management (Böhm 2008, p. 74). The central question, subsequently, is how the three principles (1) an efficient and market-oriented organised health care sector, (2) the social principle of balance of the public services in the health care sector (3) and the local/regional reachability of the health care services are organised and linked with each other. General problem solving will only occur if management in the health care sector orientates itself on the principles of "hard budgets". „The entry of non-state companies and private capital must be combined with reinforcement of government regulation and control." (Kornai/Eggleston 2001, chap. 7) "The way must be opened for the entry of non-state forms of ownership, among other reasons because there are improved changes of hardening the budget constraint on private business. It is desirable to have supply-side competition in the hospital sector." (Kornai 2009, p. 133) A first problem-solving scenario for the German regional health care supply was worked out (Held 2014), which has the citizen being a shareholder as its central point. Here, the market in the form of a privately organised health care service provision is the mean (coordination tool) and a union or a stock company stands as the medium. The following basic principles determine this scenario.

- Health is not a common good; supply of health care is a service.
- The patient transforms from being the object into being the subject (transparency/service/quality/costs).
- Replacement of soft budget constraints (SBC) of the central planning with „hard budgets".
- Industrialised service structures (customer care, delivery, resource management) (Held 2012, pp. 234).

The concrete forming of this model like for example the forming of public governance, civil governance, the relations of distribution demands need further evaluation, research and discussion.

Zusammenfassung

*Bärbel Held; Strukturdefekte im Gesundheitswesen in Deutschland – Eine Konsequenzanalyse für Krankenhäuser*

*Gesundheitswesen; Krankenhäuer; Soft-Budget; Struktur, Szenario-Analyse*

*Dem zunehmenden Erfordernis an integrierter, individualisierter Versorgung für den Patienten bei wachsendem Kosten- und Innovationsdruck wird das Gesundheitswesen in seiner derzeitigen Struktur nicht gerecht. Unter Anwendung der Szenarioanalyse wurde eine Trend-Projektion im Gesundheitswesen vorgenommen. Diese beschreibt eine fortschreitende Ausprägung von regionalisierten, privatwirtschaftlichen Gesundheitsstrukturen, weniger als kontrollierten Prozess, sondern als Ergebnis der wirtschaftlichen Krise des öffentlichen Gesundheitssystems. Folglich stellt sich die Frage nach der Interpretation und Auswertung des Trendszenarios sowie deren Auswirkungen auf die Beteiligten.*

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