The impact of hospital privatisation on industrial relations and employees: the case of the Hamburg hospitals

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ABSTRACT

The privatisation of Hamburg’s State Enterprise Hospitals (LBK Hamburg) represents a defining moment in a general trend in the German hospital sector. Carried out in 2005, this privatisation had a far-reaching impact on industrial relations in the hospitals as well as on the working conditions of the employees. These developments cannot only be attributed to the privatisation per se, however; increases in the workloads of hospital workers can also be observed in public clinics. Nevertheless, the deterioration of established collective bargaining procedures and working condition in the privatised clinics have been dramatic, representing an important turning point for hospital employees and their trade union representatives. Drawing on case study research involving interviews with a range of stakeholders, this article describes the privatisation process and its impact on working conditions, employment and industrial relations.

Introduction

No other country has seen more privatisations of hospitals in recent years than Germany, where the share of private for-profit hospitals increased from 14.8 per cent in 1991 to 27.8 per cent in 2006. While during the 1990s only small hospitals in rural areas were privatised, since 2000 this trend has spread to much larger clinics. The privatisation of the State Enterprise Hospitals of Hamburg (LBK Hamburg) in 2005 represented a peak in this development (Schulten 2006). This privatisation has had dramatic impacts on both employment and industrial relations.

Even though it is a particularly large-scale privatisation, the LBK Hamburg privatisation is in many ways typical of hospital privatisations in Germany in general. This article outlines the developments in the German health care sector in general and in Hamburg in particular, which began with changes in the funding system that increased the financial constraints on hospitals. This led the political authorities to increase the autonomy of hospitals, a process which culminated in privatisation. However, the financial constraints have not eased the situation of the hospitals but, on the contrary, continue to grow, with effects that are permanently transferred to the workforce. The article then goes on to describe these
developments in more detail and concludes by reflecting on the implications for the quality of care. It is based primarily on expert interviews, supplemented by information from the scientific literature, case studies, trade union and company information and official statistics.

**Changes in the funding system**
The privatisation of LBK Hamburg can be seen as the result of increasing constraints on hospital income combined with growing autonomy in relation to expenditure. This development is a consequence of changes in the German hospital funding system. This system is based on the so-called ‘dual financing’ system under which while investments are paid for by the federal states, operating expenditures are covered by the health insurance funds. Established in 1972, this system had already run into a crisis by the end of the 1970s as governments struggling with decreasing economic growth and increasing unemployment reneged on their responsibilities for upgrading hospital infrastructure (Simon 2004). From the early 1990s onwards, hospitals were not only struggling to find money for investments but were also increasingly unable to cover their operational expenses. By 1993 the social insurance funds were no longer sufficient to cover full operational costs and the system was changed so that hospitals were reimbursed for the number of days insurance holders spent there. As a result, whereas previously their accounts were automatically balanced, hospitals could in principle now make losses and profits.

This process entered a new stage with the introduction of the Diagnosis Related Groups (DRG) system in 2004. Under this system, treatments are categorised into types and hospitals receive a standard lump sum compensation for each type of treatment regardless of the real cost to the hospital of treating any given patient. The important difference here is that while previously hospitals earned more the longer a patient stayed in the hospital, the situation is now reversed: the earlier a patient leaves the hospital, the more profitable the treatment is for the hospital. The DRG system was intended to increase efficiency and to reduce costs and, at least in theory, to enforce the closing down of inefficient hospitals (Baum und Tuschen, 2000).

In practice, many hospitals accumulated increasing losses as a result of this new financing system. This was because the DRG system uses the average costs of every treatment in the federal state where a hospital is located as the criterion for determining the price the insurance companies have to pay for this treatment. Thus all hospitals that provide the treatment above the average cost accumulate deficits. This is a particular problem for small hospitals that cannot standardise their clinical procedures for many treatments because they occur too rarely. It also creates problems for large specialist hospitals that have to treat very unusual and complicated cases. Ultimately these losses had to be covered by the hospital owners, who, in Germany, were often municipalities. The resulting deficits in municipal budgets opened the way for privatisation (Gröschl-Bar & Stumpföger 2008). Hamburg was no exception in this regard (see Table 1).
Table 1: The most important events leading to the privatisation of hospitals in Hamburg

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1981</td>
<td>Integration of ten public hospitals in Hamburg into a single state enterprise (LBK Hamburg).</td>
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<tr>
<td>1995</td>
<td>Transformation into a legally independent institution (LBK Hamburg AöR).</td>
</tr>
<tr>
<td>late 1990s</td>
<td>Restructuring process within the company.</td>
</tr>
<tr>
<td>September 2001</td>
<td>Change of Government to a conservative/right-wing/neoliberal coalition of CDU, Schill-Party and FD.</td>
</tr>
<tr>
<td>February 29th, 2004</td>
<td>In a referendum 76.8 per cent of voters vote against the majority privatisation.</td>
</tr>
<tr>
<td>January 1st, 2005</td>
<td>Asklepios Kliniken GmbH takes over the management and acquires 49.9 per cent of the shares.</td>
</tr>
<tr>
<td>January 1st, 2007</td>
<td>Asklepios Kliniken GmbH acquires a further 25 per cent of the shares.</td>
</tr>
</tbody>
</table>

Source: analysis by the author

**Increasing autonomy and growing financial pressures**

Changes in the financing system were complemented by a move towards more financial and political independence for hospitals and their managements. After the integration of ten public hospitals into a single state enterprise in 1981, the LBK Hamburg covered almost all public hospitals in the city. In 1995, the government changed the legal status of the ten clinics that made up the LBK Hamburg by transforming the group into a legally and financially independent public-law institution. This triggered a restructuring process, designed to lower the costs, broken down into a series of separate steps. The restructuring plan consisted of three phases known as FIT 1, FIT 2 and FIT 3. The first phase comprised 250 separate individual measures including the closure of one hospital, the merger of two others and the purchase of 50 per cent of another hospital (Seidel-Kwem 2002). The second phase was intended to change the structures and the processes in the hospitals. Here, the main focus was on setting up wholly-owned subsidiaries to take over such functions as cleaning, pharmacy and laundry as well as the concentration of the purchase, training, facility management and logistics departments into separate profit centres and ‘service firms’ on a single site within the organisational structure of LBK. This phase of outsourcing was succeeded by FIT 3 which focused on the modernisation of medical treatments. Structural changes were achieved within the project city hospital and a new initiative (‘Stadtkrankenhaus Plus’) was launched with the aim of optimising medical performance by integrating supply chains and standardising the organisation of key aspects of care. Another initiative, ‘Klinova’, was developed to introduce procedural changes. This project developed measures to change the workflow and reorganise treatments and therapies on an interdisciplinary basis. The goal was to organise the treatment around the patients who

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1 FIT stands for Fortschritt, Innovation und Teamfähigkeit (‘progress, innovation and teamwork skills’).
were no longer to be transferred from one ward to another according to the different fields of expertise but according to the severity of their condition and the degree of intensity of the necessary care. After a phase of intensive care when several physicians from different fields of expertise might be consulted, patients could be transferred to wards where intermediate care involving more standardised treatments was possible. LBK Hamburg also established its own DRG System as early as 1997, thereby becoming the first hospital company in Germany to work with such a financing scheme. According to the former chairman of the hospital group, this was a necessary step towards achieving greater efficiency by introducing more competitive elements into the hospital management.

This did not prevent LBK Hamburg from getting into major financial difficulties, however. These resulted from a decision to reorganise the corporate pension scheme for the workers who were currently employed. Until the 31st of December 2000, all pensions were fully covered by a pay-as-you-go financing system, but after this date, workers who retired were given the option of using a new scheme (Rosenow 2002). This new pension scheme had been established because it was foreseen that the old system would eventually lead to a higher debt than the new one. But for a period both systems had to be paid for at the same time. This increased the financial pressures still further.

Since personnel costs account for more than 60 per cent of total hospital costs, the cuts that ensued were mostly at the expense of the workforce. Reductions in employment had started before the privatisation of the hospital. From 1995 to the eventual privatisation on 1st January 2005 the number of employees (measured in full-time equivalents) was reduced from 15,491 to 9,082 (Bürgerschaft 2001; Asklepios 2008). This process took place in the context of trade union negotiations and was accepted by the union, Verdi, and the works council because there were no forced redundancies, the collective agreement for the remaining staff was not affected, co-determination rights were extended, and a right was established for employees to return to public employment in case of privatisation. These concessions from the union did not, however, avert the privatisation process.

The decision to privatisate can be seen as arising from both financial and political causes. Fuel was added to the financial pressure by the fact that the state investments were not sufficient to improve the infrastructure of the hospitals adequately. To make up the shortfall, the hospitals had to draw on their other income from contributions (see Table 2). There was evidently a need for new capital. However it was becoming increasingly impossible to access such capital in Hamburg because of the enormous debts of the company pension scheme whose deficits also had to be met from the contributions which were already overstretched from having to meet the cost of capital investment as well as the running charges.

In addition to this financial pressure, there was also an increase in political pressure to privatise after the change of government in 2001. After 44 years of social democratic rule, the conservatives now led a coalition that had no ideological difficulties with privatisation. As soon as it came into office, this coalition immediately began to push for the sale of shares in the hospital group.
Table 2: Investments in the hospitals of the LBK Hamburg (all sums in million euro)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments from the operating company</td>
<td>16.017</td>
<td>26.209</td>
<td>23.799</td>
<td>27.642</td>
<td>23.954</td>
<td>65</td>
</tr>
<tr>
<td>Investments from the city for infrastructure projects</td>
<td>53.961</td>
<td>36.541</td>
<td>50.986</td>
<td>43.419</td>
<td>36.753</td>
<td>35.297</td>
</tr>
<tr>
<td>Of these (above) lump-sum investments from the city</td>
<td>19,981</td>
<td>19.2454</td>
<td>18.156</td>
<td>18.783</td>
<td>18.530</td>
<td>17.833</td>
</tr>
</tbody>
</table>

Source: (Bürgerschaft 2007a) Note: *2005 was the year in which privatisation took place.

In order to prevent the majority of the shares falling into private hands, the unions and some social movement organisations initiated a ballot against it. They called this initiative ‘health is no commodity’ (‘Gesundheit ist keine War’) with the aim of launching a debate about the increasing market orientation of health policy (Böhlke 2005). For this ballot initiative to be successful it was first necessary to collect 10,000 signatures which gave it an official status (‘Begehren’). This made it possible to move to the next stage, giving the organisers the right to collect signatures for a referendum. This second step required the collection of the signatures of five per cent of voters (about 60,000) within two weeks. Reaching this goal involved a tremendous mobilisation of their members by the unions, and especially Verdi. It was this step, in particular, that succeeded in opening up a high-profile public debate about public services in the city. The result was a victory for the opponents of the privatisation, who achieved an overwhelming success in the third step – the actual referendum, held on February 29th 2004. But, even though 76.8 per cent of voters cast their ballots against the majority privatisation, this did not deter the government from proceeding with it (Greer 2006). As a result, 74.9 per cent of the hospital shares were bought by the Asklepios Kliniken GmbH, later renamed the Asklepios Kliniken Hamburg GmbH (Bürgerschaft 2004).

Asklepios was founded in 1984 in Königstein/Taunus in the state of Hesse and has grown into one of the three biggest hospital companies in Germany and Europe. In 2006 it was operating 74 hospitals in Germany and its daughter company, Pacific Health Group, was operating six hospitals in the United States. Asklepios is also active in Greece, Portugal, Poland, Russia and Romania. According to its own reports, the total turnover of the company in June 2006 was 2 billion euro. Yet until the privatisation of the Hamburg clinics the company was only running small hospitals in rural areas in Germany which, at the time, caused many to question whether it was capable of running the relatively large LBK Hamburg.

The process of privatisation
The first step of the privatisation process was the separation of the LBK Hamburg into two: an operating company called LBK Hamburg New (LBK Hamburg Neu) which
was eventually transformed into a limited liability company (GmbH) and a holding company called LBK real estate (LBK Immobilien). Nearly three quarters (74.9 per cent) of the shares of the former were sold to the new investor, with the first slice of 49.9 per cent of the shared being transferred, together with the management, to the investor on the 1st of January 2005 and the second slice of another 25 per cent two years later. The remaining shares are still in the possession of the city which holds 25.1 per cent of the shares as well as the company’s real estate and pension obligations (Bürgerschaft 2004).

The purchase price was 318.625 million euro. However, only 9.2 million euro was contributed directly up-front by the investor. The huge majority of the purchase price came from loans from LBK Hamburg itself. Since the city had already had to pay compensation payments of 37.8 million euro to the company because of a lack of guaranteed net circulating capital, almost twice the sum that came from the investor to the city has gone in the opposite direction (Bürgerschaft 2008a). One condition that was stipulated by the city in the privatisation of the hospitals was that there should be no forced redundancies if the company reached its ‘Earnings before Interests, Taxation, Depreciation and Amortisation’ (EBITDA) goals (Bürgerschaft 2004). But, even though the Asklepios Kliniken Hamburg GmbH did not reach these goals, no compulsory redundancies have yet been made.

The privatisation did not involve all the hospitals in Hamburg because the federal monopoly and merger division decided that anti-trust laws would prohibit a privately owned hospital company from owning the entire LBK Hamburg. Accordingly, one clinic in Eilbek was sold separately for about 80 million euro to the small private hospital company, Schön-Kliniken. This left LBK Hamburg GmbH with six hospitals, 5,085 beds and 172,429 cases in 2006.

Impacts on employment and working conditions
The trade union and works council representatives we interviewed agreed that there were distinctive aspects to the new strategies adopted by the private investor. First there was something of a reversal of some of the old public hospital management plans, like ‘city hospital plus’. This was associated with a second strategy of passing a lot of the responsibility for non-medical services back to the clinics. Because there was no new hiring for these tasks this meant that administrative work was transferred onto the medical staff. The third distinctive feature was an emphasis on working ‘by the numbers’. According to a union representative, a meeting is held once a week at the Asklepios corporate headquarters in Königstein/Taunus at which the results from all the company’s hospitals are compared and used to set new financial targets for the following week. If a hospital does not reach these targets, the management has to explain why or is seriously endangered. As a result, there has been a very high turnover amongst managers in Hamburg’s privatised hospitals.

One of the first actions of the new LBK Hamburg GmbH was to withdraw from the federal employers’ association and – in alliance with other hospitals in Hamburg – join in the establishment of a new state-wide hospital employers’ association, known as Krankenhausarbeitgeberverband Hamburg (KAH). Unlike the public hospital management, Asklepios did not just put pressure on the wages of non-medical workers.
but also on the medical staff. Almost immediately it was established, the KAH issued a new association directive ("Verbandsrichtlinie") intended to form the basis for all collective agreements with the new employers’ association. This directive proposed lowering the wages of all employees of the privatised hospitals and their subsidiaries by an average of ten per cent, whilst also increasing working hours and reducing the holiday entitlement by an average of ten per cent. Employees already working for the hospital company were still covered by their existing collective agreement, so these new conditions would only be applied to newly hired personnel. The directive had a positive side-effect that was unintended by the management in that, according to the employee representatives we interviewed, it encouraged recruitment to the union because it showed the workers very clearly what the real intentions of the new owner were. The effect was to increase union density immediately from 20-30 per cent to 30-40 per cent.

The collective bargaining process itself was, as a result, distinctly confrontational. Verdi organised ten warning strikes and the negotiations extended over more than 18 months from November 2005 to June 2007 before an agreement could be reached. Several employees and their representatives remarked that they were surprised by how many of their colleagues supported these strikes over such a long period, especially because of the pressures on them resulting from the dependency of their patients. The negotiations took so long because, on the one hand, the employers were unwilling to give in to Verdi’s demand to return to the nationwide collective agreement whilst, on the other, Verdi was unwilling to give this demand up. There were long discussions over the possibility of compromising by settling for an agreement that, whilst technically not part of the national agreement, was at least based on it, a possibility that both parties resisted for a long time. The management claimed that such an agreement would not be financeable whilst Verdi thought that it would weaken their position in future negotiations. However eventually an agreement was reached to base the salary grades and wages on the nationwide collective agreement for the public services and to rule out forced redundancies. In return the unions agreed to forego a one-off payment for 2006 that was included in the national agreement and accepted a reduction of 0.5 per cent in the increase in the compensation for services rendered. The collective agreement with the hospital employers’ association of Hamburg (Tarifvertrag für den Krankenhausarbeitgeberverband Hamburg e.V., TV KAH) was signed on the 14th of June 2007. Its provisions included a 38.5 hour week, 26-30 days of holiday and continuity with the old wages until new rates came into effect. The works council members view this agreement as a possible sign that Asklepios is becoming less confrontational and prepared to co-operate more closely with the unions and the works councils. They believe that Asklepios was impressed by Verdi’s ability to organise warning strikes in the Hamburg hospitals. This was a new experience for the company, because in the small clinics they were used to running in other parts of the country it is a lot more difficult to mobilise a sufficient number of union members to achieve an effective strike.

This agreement applies to direct employees, leaving the employees of subsidiary companies outside its scope. Asklepios increased pressure on these workers by founding a new service company in which there is no new collective agreement with

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2 The amount of holiday entitlement depends on the age of the employee.
Verdi. Because there is a national sector-level minimum wage agreement for cleaning workers, Asklepios is obliged to pay at least 7.87 euro per hour for the employees in this category, but the kitchen workers have had to accept coverage by randomly chosen agreements that have been signed by the food and restaurant workers union (NGG) in different sectors. As a result of this pressure, the old employees who were transferred to this company accepted the abandonment of Christmas bonuses. The employees of the laundry service firm, TeXIG, had to accept a new collective agreement that was signed by a small organisation, DHV, that is not accepted as a union by the German Federation of Trade Unions (DGB). According to a union representative, the wages in this agreement are about 6.5 per cent lower than in the old one. Verdi was, however, able to safeguard the existing standards for the other former employees because for them the existing collective agreement is still valid until a new one is signed.

Doctors have their own trade union, the Marburger Bund, which negotiated an independent agreement with the KAH as early as May 2006, more than a year before the Verdi agreement was signed.

Competition between unions has consequences for the management’s adherence to these agreements. Since the works council members in most clinics are from Verdi, the company pays more attention to compliance with their collective agreements than it does to the agreements signed with the Marburger Bund. According to a doctor we interviewed, the domination of the works council by members of Verdi gives the management an opportunity to deny some doctors access to the grade on which they should be paid according to their collective agreement. There are also problems with obtaining correct reimbursement for overtime work and stand-by duties. The only exception is at the AK St. Georg clinic, where the works council is led by members of the Marburger Bund.

These strategies of the new owner have changed the working conditions of other employees as well, but their experiences have been different. The situation of administrative workers and researchers (who designed and implemented many of the changes introduced under the old public hospital regime) has deteriorated dramatically since the privatisation. For other non-medical staff the situation has been perceived as one of continuous decline, both before and after the privatisation. Some administrative personnel who had held positions of rather high responsibility in the public hospitals became, in their own words, ‘paid pedestrians’ as soon as the privatisation took effect. They were assigned to offices, but had no function and had to sit at their desks all day without any work. This method was chosen by the company to put pressure on these workers to leave because it had been agreed that there would be no forced redundancies. These enforcedly idle workers were regularly invited to talk with the management about their prospects and asked whether they wanted to leave the company voluntarily or not. Not surprisingly, this led to a relatively high number of these staff exercising their right to return to other public sector employment.

However, for many other non-medical staff the privatisation simply meant continuity in a process of deterioration that has started much earlier. For example,

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3 210 administrative employees on executive grades (190.6 in full-time equivalents) declared that they wanted to exercise their right to return to the public service (Bürgerschaft 2007b).
one teacher in the educational centre for health workers (‘Bildungszentrum für Gesundheitsberufe – BZG’) described how the centralisation of the training system within the LBK, which took place as part of the restructuring process in the late 1990s, had increased the workload of training staff immensely, despite the fact that the number of trainees declined from 1,300 to approximately 1,000. First, some tasks like scheduling and accompanying students to the wards were taken away from the teachers and the number of class hours rose; later, these tasks were given back to the teachers but the number of class hours remained the same. The decline in student numbers was used to justify job reductions. According to this teacher, this strategy was also sometimes enforced by the public hospital management with the tactic of making teachers into ‘paid pedestrians’ like the administrators described above. This technique for encouraging people to leave therefore predated the takeover of management by Asklepios and could be said to have been an adaptation of old practices, rather than a new invention by the company after the privatisation.

The medical staff, too, had already experienced the processes that took place before the actual privatisation as a loss of responsibility. Before the management of the new LBK Hamburg centralised the administration, doctors played an active role in most of the hospital planning and a considerable degree of autonomy was exercised by each hospital. Strong patterns of co-operation had grown up between different departments within each hospital and this was sometimes ripped apart ‘overnight’ when the restructuring took place. This obviously had a major impact on doctors’ working conditions. Asklepios promised to give some autonomy back to the doctors and thereby gained the support of some of them during the debate about privatisation. But after the management was handed over to Asklepios, although the clinics did indeed regain some of their autonomy, the responsibilities were not transferred back to the doctors but to new management structures.

For nurses, one of the most important changes in work organisation after the privatisation was the introduction of a ‘3-2-1 key’ designed to control staffing levels. This specified that three nurses should work in the early shift, two in the late shift and one in the night shift in every station. According to the works council members, there are always trainees within this key team and sometimes the staffing levels fall short even of this minimal ‘3-2-1’. This has led to a huge increase in the workload. One nurse who had exercised her right to return to public service employment told us that she had done so because she ‘could not leave work every night with a bad conscience’. She explained that it was physically impossible to respond to all the patients’ demands for help during the night shift. Other nurses complained that it is impossible for them to feed or even just look after the patients adequately because the work intensity is so high. This is a development that can be observed in all privatised hospitals.

This situation has probably led to an increase in the number of sick days taken off by staff. A member of the works council told us that, even though no precise numbers are available to prove this, it can be measured indirectly because Asklepios replaces sick employees with temporary workers. According to this informant, over the last two years payments to temporary employment agencies have increased significantly. He argued that from this it can be deduced that the number of sick days has risen proportionally.
Another complaint from both management and employees was that the amount of bureaucratic work had grown considerably since privatisation. One nurse we interviewed said that some head physicians spend so much of their time on documentation that they do not treat patients anymore. This trend towards increasing the amount of reporting and monitoring is aggravated by the way the DRG system is implemented. Increasingly, the most important indicator of efficiency used by the company is the so-called ‘case mix index’. This is the average of the relative cost of the treatments and provides information about the effort that is necessary for each patient. Since the higher the effort is per patient the higher the cost is, it is lucrative for the hospitals to increase their case mix index by, for instance, changing the main and subsidiary diagnoses that are recorded. Hence, it is obviously beneficial for the company to train doctors how to figure out the diagnosis that will produce the highest profit. This development cannot be blamed simply on privatisation. The DRG System has been implemented in all hospitals in Germany regardless of whether or not they are privatised.

In all, the poor working conditions in the private hospital have provoked some 1,960 employees into taking up their right to return to public service after the privatisation, a right that was negotiated when the hospitals changed their legal status in 1995. The sale contract between the city and Asklepios forced the company to pay up to 15 million euro compensation for these returnees (Bürgerschaft 2004). However, since the city has no hospitals anymore these employees have had to be redeployed and paid for in new jobs in other parts of the public sector. According to the opposition in the Hamburg parliament, the cost of their wages will amount to 74 million euro a year (Bürgerschaft 2007b). The city government has therefore tried to decrease their numbers by several means. Most important of these was an attempt to deny the right to return to the public sector for employees of the subsidiaries (as opposed to direct employees of Asklepios). At the time of writing, 357 employees of the cleaning and laundry companies who wanted to return to public sector employment were involved in a legal dispute with the city, with the government claiming that the subsidiaries were not part of the LBK Hamburg anymore so the workers had forfeited this particular right. Victory for the government in this case would mean that the number of returnees could be reduced to 1,541 employees. This would still mean that Asklepios has to pay 9,733.94 euro per employee (Bürgerschaft 2007b) but this is probably significantly lower than the amount of money that would otherwise have to be spent on redundancy payments. Thus this is a rather lucrative way to reduce the number of employees still further.

The privatisation of the Hamburg hospitals did not just have an impact on the employees but on the patients as well. The consumer advice centre in Hamburg has reported a dramatic increase in complaints from patients over recent years. This is reflected in a patient survey carried out by a leading health insurance company. Apart from one, all the hospitals in the city run by Asklepios received the lowest ranking (Techniker Krankenkasse, 2007). The works council members are convinced that there is a direct connection between this low level of patient satisfaction and the poor working conditions of the hospital workers.
Conclusions

It can be concluded that the various health reforms enacted in Germany over the last decade have played a major role in bringing about the privatisation and liberalisation of the hospital sector in general and LBK Hamburg in particular. The restructuring process and, in part, the privatisation of the clinics, can be traced back to changes in the hospital financing scheme at the federal level. The lack of investment by the state further influenced the shift towards a market orientation. However, it is difficult to correlate every step of the liberalisation and privatisation processes with specific developments in the hospitals, because the economic pressures underlying these reforms also affect the public clinics.

The restructuring process in the hospitals that took place in the 1990s had already brought about significant changes and these change processes continued with the 2005 privatisation. Every single step in this process led to an increase in the workload, an overall drop in employment and a deterioration in working conditions. The total number of employees has shrunk from 15,491 in 1995 to around 8,800 in 2006 (full-time equivalents). During the same period, according to union representatives, the number of cases has actually increased marginally (by 4 per cent) and the average duration of stay has decreased by forty per cent. It can therefore be concluded that about forty per cent fewer employees now have to treat the same number of patients forty per cent faster. Most of this enlargement of the workload has taken place in the public hospitals and privatisation on its own neither stopped nor started this development. However, the implementation of the ‘3-2-1 key’ and the growing amount of bureaucratic work to increase the case-mix index has nevertheless created additional stresses for those who have to work under the new private management.

The impact of privatisation on industrial relations has, if anything, been even greater. While the public LBK Hamburg had strongly supported the principle of co-determination and encouraged works council members to provide ideas for the development of the hospitals, the new management did not talk to union representatives at all for several months. Instead, they terminated several agreements with the unions, abandoned the employers’ association and established a new one that immediately presented a directive that attacked wages, holiday entitlements and the working time agreements of the employees and then founded a new non-unionised service firm that competed with other subsidiaries that were bound by collective agreements.

The purchase of LBK Hamburg is still one of the most disputed privatisations in Germany. The way that the city government ignored the results of the referendum was a particular cause of indignation. This was exacerbated by the structure of the sale contract and the manner in which the company dealt with its employees and their representatives. The unexpectedly high number of returnees to the public sector further weakened the legitimacy of the privatisation. And the declining quality of care provides yet another source of grievance. It is not surprising, then, that there is wide agreement with the views of the vice chairman of the general works council that the privatisation has been ‘completely unsuccessful’ (Bröcker-Lindena 2007).

Notwithstanding this opposition, it seems likely that these trends will continue and perhaps even accelerate. The financial and political motives that have underpinned
the changes in the governance of German hospitals continue to accumulate and some studies suggest that the proportion of hospitals owned by private hospital chains might increase to as much as 40 per cent in the near future (Bähr, Fuchs et al. 2006).

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