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The Role of Enterprises in Welfare Provision – Enterprises as Producers of Welfare Goods

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1. Introduction

Considerations on corporate action in social policy have (re)gained in importance in recent welfare state literature. The growing interest in the role of enterprises as an explaining variable in welfare state research reflects the insight that business interests are a driving force in social policy development: As social policy – according to the new understanding of the relation between the market and the welfare state – is not necessarily a policy *against* markets but *for* markets, employers do not necessarily represent an obstacle to the expansion of welfare provision.

As argued in the literature on business interests and social policy, employers are for instance concerned about the skills of their workforce and fear the loss of high potentials; they therefore invest in company training schemes, in corporate pension schemes and in measures for the reconciliation between work and family responsibilities, and thus do not hinder but rather enhance the support for social policies. This research has revealed a 'hidden welfare state' and has shifted the focus of social policy analyses to the linkages between industrial relations and social policy.

Taking its starting point in the above-mentioned observations and convictions, the paper nevertheless stresses a somewhat different explanation: It focuses on the role of enterprises not as *employers* but as *producers* of social security products. In doing so, the paper tries to highlight a development which has been neglected by the recent discussion regarding the role of enterprises in welfare provision: the rise of a welfare industry. Due to the ongoing liberalization of the welfare state, companies distributing private pension schemes, running private retirement homes, or managing hospitals have taken on greater significance in welfare state provision.

The authors want to make the point that recent welfare reforms impact the research agenda of social policy research: Both empirical studies and theoretical explanations of corporate (political) action are necessary. The aim of this article is to explore this new research agenda. The article is composed of three major parts. It first reviews the existing literature on the role of employers and private companies in social policy research and singles out their limitation for the analysis of welfare industries. The role of enterprises as producers of social policy is then discussed on the basis of a case study in which the rise of a welfare industry in the inpatient sector in Germany is compared to the development of private hospitals in the US. The third section enumerates desiderata and points out the research questions which have not yet been (sufficiently) addressed in comparative social policy research.

2. Private Enterprises in Social Policy Research

2.1 Labor-market Social Policy Research

In the past, the companies that provided social services as private producers and their branch of the economy, namely the welfare industry, did not feature prominently in social policy research. Social policy studies have primarily been concerned with the risks associated with the labor market, its actors, and its structures. Social policy was perceived as an answer to the social risks arising from the workers' wage dependency. The representatives of capital and labor – employers' associations and labor unions – were perceived as the most important actors in socio-political decision-making processes. The balance of power in labor markets translated into lines of political conflict drawn between social democratic parties on the one side and conservative and liberal parties on the other. The internal structuring of the workforce, for example the differentiation between blue-collar and white-collar workers or the separating line between agricultural, industrial and service industry workers, constituted the background for the respective professional standard of social security. This type of thinking was epitomized in the contributions of the power resource approach (Korpi 1983, Esping-Andersen 1985, 1990) that placed the workers' strength (degree of unionization, number of parliamentary seats and government positions held by leftist parties) in the forefront of explanations of welfare state expansion and maintenance. The power resource approach, as an explicitly actor-centered approach, certainly entailed the opportunity for a closer investigation of the role of employers and enterprises. However, since firms and employers were generally perceived as opponents of the welfare state, they were allocated only a minor role in explanations of welfare state expansion. Attention was more focused on 'labor' and neglected 'capital', so that the analysis of the capital side was not refined to also include the level of the enterprises. If the interests of companies were analyzed, then the focus was solely on the general interests of companies in their role as employers. In spite of the concentration of the power resource approach on the labor-capital conflict, employers and their associations have tended to be neglected in the classical studies.

2.2 From a Labor-Market Centered to a Firm-Centered Social Policy Research

Initially, internal scholarly criticism was not directed towards the lack of attention paid to the employers' side. Instead, the manner in which the state and the institutions of social security were treated in the power resource theory was found to be insufficient. A socio-political analysis in the tradition of sociological and historical institutionalism emerged as a reaction to this neglect of the state('s apparatus) as an independent factor (Skocpol 1992, 1995; Pierson 1994, Thelen 2004). In these studies the emphasis of the role of the state was combined with a concentration on political processes, historical traditions, and institutional inheritances. The accentuation of path dependencies and the predominance of existing institutions initially also served to avoid interpreting the actual modifications to the welfare state as purely a neo-liberal deconstruction. Nevertheless, even though the changes are not just characterized as cutbacks, they cannot be fully understood if the focus is only on describing continuities without being able to name the driving forces of change. Institutionalism became a "second order observation" (Luhmann) in social policy in a way: According to this view, it was no longer the forces of the labor market that directed social policy but the organizations created by the structures and actors of the labor market which with their own weight and state support perpetuate social policy. In view of the retrenchment policy in the 1980s and 1990s these considerations must appear increasingly disconnected from reality. Furthermore, economic factors were excluded from the theory to an extent that stood in grave contradiction to public debates on the welfare state.

Since the 1990s international social policy studies have 'brought the capital back in' (Swenson 1991) social policy research. The varieties of capitalism concept (VOC) shaped the transition from institutionalism to the new political economy of the welfare state. Peter Hall and David Soskice (2001) speak of their approach as a "firm-centered

political economy" that due to the special role of the firms' environment can be described as a firm-centered institutionalism. To achieve the institutionalist view of firms VOC conceives of them as actors operating in coordination networks. In order to improve their economic skills, firms are assumed to provide coordination in five fields: collective labor relations, training, corporate governance, relations between firms, and the relationship of the firm to its employees. In the popular version of the theory, there are precisely two basic types of capitalism: 'liberal market economies', in which coordination is primarily managed by hierarchies or markets, and 'coordinated market economies', in which non-market institutions also contribute to managing coordination. An additional assumption, that particularly affects the version of social policy studies dominated by Esping-Anderson's typology, is that of the correspondence between production regimes and welfare state types. In a nutshell, the VOC literature outbids the typological power of the welfare regime approach in terms of a lower number of typologies by reducing the basic types of social policy from three to two.

The VOC-literature has established a new basic understanding of the welfare state and its supporting organizations. It emphasizes the role of the firm as a supporter of the welfare state (Mares 2004). The result of an intense controversy about the influence of business in especially the American history of social policy (Hacker/Pierson 2002, 2004; Swenson 2004a, 2004b) has been the rise of the conception that proposes "capitalists against markets" (the title of Swenson 2002) being one decisive factor behind social policy development and no longer the primarily social democratic, labor union strategy of 'politics against markets'. To restrict the function of the welfare state to be an institution for compensating for market-determined social risks appears to be too narrow. A paramount function of the welfare state is promoting economic growth and at the same time ensuring inclusion in the labor market and the operational production processes (cf. critically Kitschelt 2006, Stephens 2006; in support Soskice 2006, Iversen 2006). Nonetheless, companies according to this understanding are not relevant as individual actors in the VOC-literature, either. They are considered as elements in a network of firm-centered institutions. Furthermore, this network of institutions is dominated by tasks concerning the labor market: the regulation of industrial relations in individual firms, branches, and industries. Consequently, the firm's function as an employer is in the foreground of scrutiny, so that the analysis remains centered on the labor market and does not concern itself with the firm as a provider of welfare goods.

2.3 The Rise of Welfare Industries and its Impact on Social Policy Research

The need to consider firms engaged in the production and sale of welfare goods as important actors on the political stage and to explore their organizational interests and strategies becomes even more urgent with the development of 'welfare markets' (Taylor-Gooby 1999; Nullmeier 2001). The term 'welfare markets', which has been adopted into the social policy language from around the year 2000 onwards, describes the implementation of market mechanisms and competition in welfare provision. There are differing opinions if and to what extent welfare-markets differ from 'normal' markets and if they require – besides 'normal' market regulation, i.e. anti-trust-laws – particular social-policy regulation (Leisering 2008: 65). A minimal definition of welfare markets might be that welfare markets are means to achieve welfare ends with new – hopefully more effective – measures. Welfare markets are considered as a particular promising strategy for welfare state reform; they have become a dominant reform trend which could be observed throughout all welfare regimes and in different social policy fields (albeit with a differing scope). With the creation of welfare markets social policy has indeed developed to a policy *for markets*, however, not in the above mentioned sense. These new market-inducing social policy measures do not only support the employers' interests but go far beyond it by createing completely new fields of business by means of legislation, with new products and new arenas for competition.

A viable market requires private actors which are engaged and compete in this market. The creation of welfare markets therefore comes along with the promotion of welfare industries. In fact, recent welfare state reforms

provide several examples in which the state does not confine itself to regulate private welfare delivery but rather introduces strong incentives for companies to develop and sell but also for consumers to purchase private welfare goods (Nullmeier 2008).

2.3 Demand for a New Research Agenda

Giving a provisional result of a review of recent literature about the role of private enterprises in the welfare state, one can state that there is a need to broaden the social policy research agenda. With liberalization and privatization as a common trend of welfare state reform and the blurring of the boundaries between public and private we have to take private actors into account. The currently most popular approaches in comparative social policy research, Esping-Andersen's 'Worlds of Welfare Capitalism'-typology and the VOC-literature, take private enterprises into account but neglect the heavily divergent interests of private enterprises as employers, producers, and sellers of welfare goods. Recent social policy research on 'welfare markets', in turn, has increased our knowledge when it comes to the creation of welfare markets, and it has provided typologies to classify different forms of regulation and different markets (Berner 2009; Leisering 2008). As a shortcoming of this paper might be conceived that this research is mainly interested in the regulatory *state* and transformations of *public* policy. What is missing is the view on the inside of welfare industries and on the attitudes of the new actors on the scene, the private enterprises providing welfare goods.[1]

3. The Case-Study: Welfare Industries in the German and the US Inpatient Sector

3.1. Case Selection and Research Design

This paper is an explorative case study to start off a research project analyzing welfare industries in Germany and the US. The research design is set up as a most differing case study. In the comparative welfare state research, the US is considered to be the contrast model to the German case. While Germany is one of the pioneers of public welfare policy, the US is deemed as the textbook example of a welfare state laggard: Until the 1930s public social policy programs are rare, and even the programs implemented from the 1930s onwards were in most cases means tested and related with the duty to (search for) work. With regard to health care, private respective employer-based coverage features prominently (Cacace 2007; Döhler 1991). To be sure, there are public programs for targeted groups with Medicare and Medicaid providing health coverage for the elderly respectively for the poor as the most important. Americans, who do not qualify for government-provided health insurance programs, who are not provided health insurance by an employer, or who are unable to afford, however, were without any health insurance. The problem of the uninsured is source of considerable political controversy on a national level since decades. Nonetheless, all efforts to introduce a *universal* health insurance failed (and still do until today). The welfare regime approach classifies the US therefore as a liberal or residual welfare regime (Schmid 2002).

The final aim of the project is to compare the development and the 'inside' of welfare industries in both countries with regard to private pension schemes, private retirement homes, and private hospitals. The following chapters focus on welfare industries with regard to the inpatient sector, whereby the US case is investigated more in-depth since in recent literature the question is raised, if the evolving transformation of the German hospital sec-

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[1] A first step is done by Berner, Leisering, and Buhr (2009), who analyze the welfare market of private pensions in Germany.

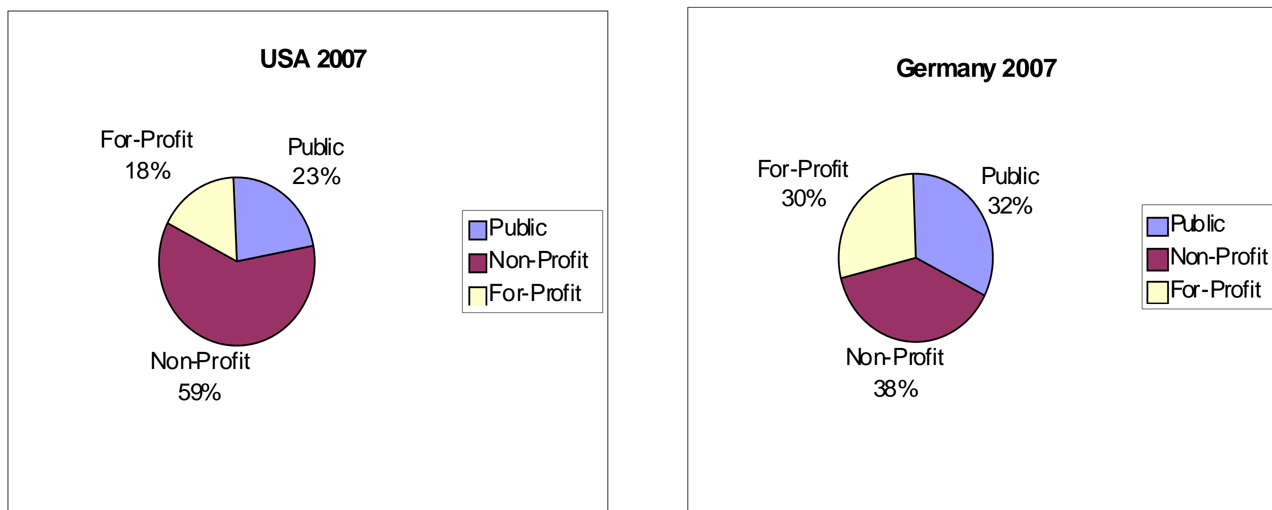
tor is a repetition of what we could observe in the US during the 1980s – with all its negative impact on welfare provision (Eckhardt 2007).

3.2 Puzzles Arising from the Welfare Regime Approach

The comparative welfare state research distinguishes with public, voluntary non-profit and private for-profit between three different kinds of welfare provision. Conventional wisdom about the 'private nature' of health care in the US – which is supported by the welfare regime approach – would suggest a dominant (at least a prominent) role of private provision in the US (in our case for-profit hospitals). Germany, to the contrary, we are used to associate with a predominance of non-profit provision, be it publicly run or by one of the denominational or other welfare organizations (Schmid 2002: 82 et seq.).

The statistics however reveal another picture. The share of private for-profit hospitals in the US is quite small and accounted for only 18% of all hospitals in 2007. Interestingly enough, it has been even lower during the presidency of Ronald Reagan, the liberal and market-adulatory period per se. In 1985 only 14% of all hospitals were for-profit hospitals. It is quite astonishing that in a country committed to competitive capitalism like the US non-profit hospitals play the major role since the 1930s. Yet, the full extent of the puzzle, however, becomes only clear when we compare the US and Germany. Here the share of for-profit hospitals is today much higher than in the US: In 2007, a third of all hospitals were for-profit hospitals (see diagram 1).[2]

Diagram 1: Comparing a liberal and a conservative welfare regime – Hospitals by ownership



Source: AHA (American Hospital Association); Statistisches Bundesamt/ Deutsche Krankenhausgesellschaft 2009

These short glimpses on the statistics remind us not to draw too fast conclusions from the belonging of certain country to the governance of certain policy field within this country but rather to take closer look in the history of a policy field. This is done in the following chapters.

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[2] The data relate to the national level. There are, however, in both countries huge differences on the federal level with states having a share of private hospitals of more than 50% and such with nearly none (Wörz 2008).

3.3 Welfare Industries in the American Hospital Sector

3.3.1 The Birth of the Modern Hospital – and the Birth of the Proprietary Hospital

In the USA as well as in Germany the forerunners of the modern hospital were cloisters in general and the alms- and pest houses for the larger cities. Both medical and technical progress allowed to transform these simple and charitable caring facilities into complex and technical organizations at the end of the 19th century (for the following see Starr 1982: 145 et seq.). This organizational transformation was accompanied by changes of the typical users of hospitals. With their new treatment modalities hospitals, which had been facilities caring for the oldest, most fragile, and poorest members of society until the middle of the 19th century, now became attractive for well-to-do patients. In the last three decades of the 19th century the request for inpatient care augmented enormously, which resulted in an increase in the number of US hospitals from 178 in the year 1873 to 4,359 in the year 1909 (see table 1).

Due the growing number of well off patients, who could afford to pay their treatments out of pocket, hospitals became less dependent on public subsidies and charitable donations – and they become profitable. The changes in the structure of the typical user in turn resulted in a transformation of the structure of the typical owner. Physicians, though in general being in fierce opposition to corporate enterprises in medical practice, began to launch and run hospitals on a for-profit basis themselves. At the turn of the century proprietary hospitals were quite common. Estimates assume that more than 50% of the hospitals were private hospitals in 1910.[3] The proprietary hospitals run by a (group of) physicians differed considerably from the public as well from the charitable hospitals. While the former were in general very small organizations, frequented first and foremost by well off patients, the average number of beds of the latter two was significantly higher. Their main clientele was primarily the sick poor.

Table 1: Changing Share of the Market Served by Proprietary Hospitals in the US

Year	Total Number of Hospitals of All Types	Number of Proprietary Hospitals	Proprietary Hospitals as a Percent of Total Hospitals
1873	178		
1909	4359		
1910		2441 (est.)	56% (est.)
1928	6852	2435	36%
1941	6358	1584	25%
1946	6125	1076	18%
1968	7137	769	11%

Source: Steinwald & Neuhauser 1970: 819

[3] The share of proprietary hospitals of all hospitals could not be quantified exactly for this time. The AMA started to collect statistics first in 1927. Articles in journals from this period reporting changes of ownership, however, suggest that there was an active hospital market (Steinwald/Neuhauser 1970: 818).

3.3.2 1910-1965: The High Time of the Non-Profit Hospital

The growth of proprietary hospitals, however, calmed down remarkably after 1910 and – as the number of public and charitable hospitals continued to grow – their share within all types of hospitals dropped notably. From (estimated) 56% in 1910 their share declined to 36% in 1928 only to further decrease to only 11% in 1968 (Steinwald/Neuhauser 1970: 819).

The literature provides several explanations for this development: First, the physicians considered proprietary hospitals not as a means to increase their profit but to maintain their professional autonomy in order to not become dependent on commercial intermediaries like private insurance companies. During the first two decades of the 20th century the number of public community hospitals grew considerably, and as they allowed physicians to take care of their patients there was no strong need for physicians to run their own hospitals. Second, and perhaps more important, non-profit hospitals enjoyed several advantages due to their charitable origins as e.g. tax exemptions and charitable immunity from malpractice liability (Starr 1982: 220). Finally, non-profit institutions were not in the focus of the at this time increasing state regulation, and especially anti-trust laws were only loosely applied to non-profit hospitals. The non-profit institutions were indeed the more profitable institutions (Marmor et al. 1986: 322).

In 1928, the AMA (American Medical Association) counted 6,852 hospitals altogether. In 1929, however, the growth of the number of hospitals came to a halt. Due to the ongoing technical and medical progress the costs for a hospital stay had been constantly on the rise during the 1920s and patients were less and less able to pay them out of their means. The physicians and the AMA, their professional association, nonetheless opposed plans to introduce public health insurances, fearing the limitation of their professional autonomy through corporate intermediaries more than insolvent patients. In 1929, the year of the Great Depression, however, the situation culminated. A great part of hospitals faced severe financial problems, which often left them the only solution to declare bankruptcy. In the same year hospitals put different kinds of prepaid hospital plans to the test and they became the prototype upon which the so called 'Blue Cross Plans' were later based.

The founding of Blue Cross, and later of Blue Shield, private non-profit institutions offering hospital respective medical insurances, provided access for patients to secure money funds for those who delivered health care. The hospital industry stabilized and the number of hospitals remained comparatively firm until the end of World War II. The steady line summarizing the total number of hospitals, however, covers structural changes within the inpatient sector: The share of private for-profit hospitals declined further whilst charitable hospitals gained in importance.

Besides the above mentioned reasons two further factors help to explain the dominant position of non-profit hospitals: First, Blue Cross resp. Blue Shield, being themselves non-profit institutions, promoted first and foremost the founding of non-profit hospitals. There were close personnel relationships between the non-profit insurers and the non-profit hospitals, constituting what later has been called the 'American Health Empire' (Ehrenreich & Ehrenreich 1971; Döhler 1991: 349). Second, Blue Cross brokered higher reimbursements rates for inpatient care in non-profit hospitals compared to the reimbursement rates for-profit hospitals received. Due to these discriminative practices the proprietary hospitals become even less profitable and their share declined down to 11% in 1968 (Steinwald/Neuhauser 1970: 819).

The Hill-Burton Act, which became effective in 1946, marks the next important chapter in the history of hospitals in the US. As all efforts to introduce a national health insurance failed, the Democratic Government under President Truman passed the Hill-Burton Act which provides public subsidies and loans to improve the hospital sys-

tem.[4] The Hill-Burton Act strengthened the position of public hospitals compared to charitable hospitals – for the simple reason that they accessed the public subsidies quicker than the voluntary institutions (Marmor et al. 1986: 325).

In summary, the time span from the Great Depression until the 1960s can be characterized as the high time of non-profit (be it public or charitable) institutions in the health sector.[5] Contemporaneous literature even arrived at the question whether proprietary hospitals would vanish completely and draw the conclusion that in general the role of proprietary hospitals "*is more complementary than competitive with respect to the non-profit sector*" (Steinwald/Neuhauser 1970: 830). History, however, took another turn: In the following years a corporatization and industrialization of the health sector could be observed. The 1970s were the advent of what Arnold S. Relman later called the 'industrial medical complex' (1980).

3.3.3 The Making of a Hospital Industry

The Hill-Burton Act fostered the growth of health care deliverers, especially the growth of short-term general hospitals – however, not in the by the government intended way. Due to poor federal regulatory mechanisms, the process of growth was unchecked and did not fulfill the expectations. Regional inequalities with regard to access did not diminish but even got worse.[6] Moreover, the publicly sponsored facilities did not provide the 'reasonable volume' they agreed to furnish for those residents in the facility's area who needed care but could not afford the treatment.

Inequalities with regard to health coverage worsened as plans to introduce Universal Health Coverage continued to fail. Even though the coverage of the employees and their families improved due to the labor unions' success in negotiating non-wage benefits[7], the poor and elderly remained as the most vulnerable groups. After his land sliding success during the elections in 1964 and having a majority in both the House of Representatives and the Senate, President Johnson began to put his vision of a 'Grand Society' into practice with the health insurance for the elderly as its centerpiece. In 1965, Medicare and Medicaid, two programs providing health coverage for the elderly respectively for the poor, were enacted.

One of the – unintended – effects was that the inpatient sector became attractive again for corporate investors: The introduction of Medicare and Medicaid *"transformed medicine into a virtual gold-mine for commercial non-profits as well as for-profit enterprises"* (Marmor et al. 1986: 313). Under Medicare and (to a certain extent) Medicaid hospitals were reimbursed on a cost-plus basis in these times, meaning that the more a hospital spends the more it could charge either the government or the health insurers (Lindorff 1992: 33). The growth of private (profit and non-profit) health insurance either through employer-based contracts or Medicare and Medicaid provided a

[4] Money was designated to the states to achieve 4.5 beds per 1,000 people. The states allocated the available money to their various municipalities, but the law provided for a rotation mechanism, so that an area that received funding moved to the bottom of the list for further funding.

[5] Non-profit institutions had a predominant position with regard to both financing and delivering. For the development of the former, which is not subject in this paper, see for instance Hacker 2004.

[6] The money by the federal government was only provided in cases where the state and local municipality were willing and able to pay an equal amount to the federal grant or loan, so that the federal portion only accounted for one third of the total construction or renovation cost. The states and communities were also required to prove the economic viability of the facility in question. This excluded the poorest municipalities from the Hill-Burton program; the majority of funding went to middle class areas.

[7] Since World War II and the Korean War, when the wages were frozen and non-wage benefits were the only means to increase the workers' remuneration, unions considered health insurance as an important component of collective bargaining. The number of insured persons increased from thirteen million in 1940 to over 100 million in 1955. With this enormous growth in health care coverage private insurers achieved to increase their market share from 30% in 1940 to 52% in 1960 (Marmor et al. 1986: 326).

secure flow of funds into the health industry. And the gold-mine even became richer with the subsequent amendments of the Social Security Act. The amendment of 1972, for example, brought the treatment of end-stage renal disease under Medicare funding.[8] Existing branches of the health industry like hospitals, nursing homes, and home care prospered. In addition, completely new markets evolved which were especially constituted by private enterprises.[9] "Everybody grew fat in this period", and for private companies engaged in the health care sector it was almost impossible to fail (Lindorff 1992: 22-23).

3.3.4 Corporatization, Concentration, Integration: The Evolution of the 'Medical Industrial Complex'

"*The industrialization of episodic medicine was not the original intent of the market idealist of the early 1970s* […]" (Starr 1982: 443). This is might (perhaps) be the reason, why a critical discussion about the impacts of the rise of welfare industry started comparatively late: Neither policy makers nor scientists expected a corporatizised health industry to evolve. It was not before the presidentship of Ronald Reagan with its paradigm shift to a neo conservative and liberalized (social) policy when the industrialized health care provision become subject of social policy research. From the 1980s onwards critical voices stated a "social transformation of American Medicine" and warned against the "coming of the corporation" (Starr 1982) or even saw a "new medical industrial complex" already evolved (Relman 1980). What exactly made the authors bother about the development of health care governance?

The steady flow of funds had led to an enormous expansion of the health care industry in general. The non-profit institutions remained predominant but the for-profit institutions caught up. In addition to the increased share of for-profit institutions – and perhaps even more important – far reaching changes *within* the for-profit sector could be observed. The single owned, small, and specialized proprietary hospitals were replaced by corporate owned, large hospital chains or hospital networks. The organizational behavior of these multi-hospital chains differs distinctively from the earlier type of proprietary hospitals. Decision making in hospitals was now shaped by investors who were not only striving for the well-being of patients and for their employees but also (or possibly even more) for their shareholder. Organizational growth became an end in itself while medical aspects or social policy criteria, e.g. equal access to or quality of care, shaped the organizational strategy only to minor degree.

Again the shifts in hospital-ownership (between and within the sectors) cannot be explained by referring only to one single factor. A nexus of different events and developments rather has caused the evolution of the medical industrial complex.

From mid 1970s onwards, there was a rising awareness for the necessity of cost containment. Several measures were introduced to contain the rapidly spiraling costs and to control the inflationary growth of the health care sector brought about by the enactment of Medicare and Medicaid:

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[8] The funding of dialysis through Medicare not only increased the number of patients. Moreover, it caused a profound change of the medical treatment methods: before the enactment, over 40% dialyses were home-based, after the enactment however a rapid increase of centre- respective hospital-based dialysis could be observed (Relman 1980: 965).

[9] Besides the market for long-term haemodialysis programs the market for hospital emergency-room services provides an interesting example. Most third-party payer reimbursed services in hospital emergency rooms at higher rates than the same services rendered in the private offices of physicians and, thus, offered incentives to invest in hospitals.

- *Enhancing health planning:* The Health Planning Resources Development Act from 1974, which replaced and adjusted the former Hill-Burton Act, included amongst other things the requirement of state health plans and establishment of Health Service Agencies (HAS) compiling theses health plans
- *Improving quality:* Already in 1972 peer review organizations (Professional Standards Review Organizations, PSROs) were set up to cut costs, to minimize abuses by checking on the need of applicants for care, and to monitor the care provided in the publicly funded programs
- *Introducing new forms of provision:* The HMO Act, which became effective in 1973, subsidized health maintenance organizations, expecting that the concept of 'managed care' would lower health costs.
- *Changing the funding*: In 1983 Medicare replaced cost-based reimbursement by a flat rate payment based on Diagnosis related groups (DRGs).

In fact, the enumerated measures, implemented in order to enhance equality of access, quality, and contain costs, had (unanticipated) side-effects: They strengthened the position of the corporate-owned for-profit-hospital chains and fostered the concentration of the hospital market. Dwindling sources of public funds made the hospitals search for new financial sources and they found them at the capital market. The newly introduced regulation measures in turn supported the process of concentration and horizontal integration. DRGs, health planning, and other regulatory measures require a fully developed administrative apparatus, which exceeds the capacities of a free-standing hospital (irrespective of which ownership). To become member of a hospital chain was one solution for hospitals to discharge their physicians and nurses from the administrative burden (Döhler 1991: 356).

Table 2: Hospitals by ownership in the US 1980-2004

	public				Voluntary				private			
Jahr	KH	%	B	%	KH	%	B	%	KH	%	B	%
1980	1778	30,5	209	21,1	3322	57,0	693	70,1	730	12,5	87	8,8
1985	1578	27,5	189	18,9	3349	58,4	708	70,7	805	14,0	104	10,4
1990	1444	26,8	169	18,2	3191	59,3	657	70,9	749	13,9	101	10,9
1995	1350	26,0	157	18,0	3092	59,5	610	69,9	752	14,5	106	12,1
1998	1218	24,3	139	16,5	3026	60,3	588	70,0	771	15,4	113	13,5
1999	1197	24,2	136	16,4	3012	60,8	587	70,7	747	15,1	107	12,9
2000	1163	23,7	131	15,9	3003	61,1	583	70,8	749	15,2	110	13,3
2001	1156	23,6	132	16,0	2998	61,1	585	70,8	754	15,4	109	13,2
2002	1136	23,1	130	15,9	3025	61,4	582	71,0	766	15,5	108	13,2
2003	1121	22,9	129,1	15,9	2984	61,0	575	70,6	790	16,1	110	13,5
2004	1171	22,7	127,6	15,8	2967	60,3	568	70,3	835	17,0	113	13,9

Source: National Centre for Health Statistics

Besides the state, another important actor in the health care market namely the employers fostered the privatization and concentration of the health care industry. In the early 1980s the employers got seriously annoyed about the dramatic increase of health costs and forced the health insurance companies to provide a range of health plans with clearly defined budget constraints. To satisfy these demands, private insurers developed a huge range of interventionist strategies and tools such as selective contracting with networks of providers (PPOs or IPAs), prior authorization of non-emergent hospital admissions, aggressive review of lengths of hospital stay, and the formation of HMOs etc. In fact, the implementation of 'managed care' and 'health plans' had already been facilitated by the Nixon administration in 1973; but a significant rise of managed care did not happen until the 1980s when large, influential employers put pressure on insurance companies (Schlesinger/Gray 2006: 388). The rise of

managed care not only increased the insurance funds' efforts to contain cost but converted the health industry into a highly competitive market.

The described developments (which are by no means claimed to be a comprehensive description of health policy of these times) for sure do not explain the evolution of the medical industrial complex to the full extent. Nevertheless, they make obvious the most important point: It was not solely market forces but the interaction of public and private action, of (poor) state regulation and of employers being 'prudent buyers', which put together fostered the evolution of a medical industrial complex (see also Stevens 2008: 478).

3.3.5 US-Hospital Governance Today: Non-Profits Remain Dominant

In the 1980s, Arnold Relman (1980) and other researchers feared that investor-owned hospital chains might finally triumph over non-profit hospitals. It was expected that hospitals would increase their market power through (friendly or unfriendly) acquisition, horizontal and vertical integration, diversification and concentration (Starr 1982: 429). "*It is certain that there is something in the nature of the corporate beast that requires it to grow in order to remain viable on its own terms*" (Wohl 1984: 49).

Indeed, for-profit hospitals applied all these strategies: They acquired new hospitals, they merged and created large chains, they enlarged their business portfolio and invested in other medical branches like hospice management, home care etc. as well as in non-medical branches, e.g. in real estate or hotel management. Moreover, they created so called "patient-feeder" systems by integrating other institutions of the 'health production chain' in their network, e.g. health insurance companies or free-standing emergency rooms, in order to secure a constant supply with patients (Lindorff 1992: 26). For-profit hospitals applied typical private business practices like advertising and marketing, they 'skimmed the cream' and gave affluent patients the preference (not to say they practiced patient dumping at the expense of public hospitals, ibid., 19). Nonetheless, the predicted triumph of the for-profits has not come true: Non-profit hospitals still continue to dominate the inpatient sector.

The precise causes of this development remain to be analyzed, but the following aspects might contribute to the explanation:

- The growth of the share of for-profit hospitals is limited as there is only a limited number of attractive acquisition candidates (Bazzoli 2004: 899). What has not been taken fully into account in the 1980s is that for-profit hospitals are themselves not interested take over *every* single hospital. Private investors will most likely selectively invest in markets with a strong payer demand. Therefore, corporate action in the health care sector concentrates on distinctive regional areas, which especially holds true for the US where due to the low coverage rate many regions are characterized by a poor payer mix. This fact explains not only the continued existence of public and voluntary hospitals but at the same time also the huge differences with regard to the regional dispersion of private hospitals.
- In order to face the challenge of for-profit hospitals acquiring others and competing between each other, non-profit hospitals have changed their organizational structures and strategies and have adopted corporate practices (Gray/Schlesinger 2002: 82 ff). They have implemented management practices and try to save costs through a centralized administration, mass purchase of supplies and equipment, and sharing of expensive medical technology. Similar as the for-profits, non-profits strive to obtain a significant market share in a geographic region by vertical or horizontal integration. The non-profit hospital field of today is as concentrated as the for-profit sector.
- Finally, the funding of investor-owned facilities is more fragile compared to that of voluntary institutions. Scandals can curtail growth. The stock markets are highly sensible for this kind of organizational failure and a company might be forced to sell off or close down facilities due to its declining stock value (as the case of the

‘Humana Corporation’ has shown in the mid 1990s). Indeed, with the shift to investor ownership the hospital market has become a highly dynamic and feverish market which is characterized by acquisitions and resales, by conversions from a non-profit to a for-profit legal form, and back again (Gray/ Schlesinger 2002: 76-77).

Even though non-profits remained dominant medicine has become a ‘marketplace’ (Lindorff 1992). Since the non-profits adopted for-profit strategies and became ‘hybrids’, they rather intensified than moderated the marketplace character. Having a health care industry without a universal health insurance, however, has severe impacts on the equal access to health care, its quality, and costs. It is a well known fact in social policy research and must not be proved here again: The US ranks relatively low on customary health-status indicators but is at the same time nonetheless one of most expensive systems in the OECD-world (Cacace 2007: 5; Stevens 2008). Private welfare companies might be more efficient, but they have to content the greed of gain of their stakeholders, which is why cost benefits are rarely not passed along to patients.

What conclusions can be drawn from this case study in terms of future social policy research? First, due to the rise of welfare industries, social policy research has to take businesses as political actors into account. The history of other industrial sectors (such without reference to the welfare state as automobiles for instance as well as such with reference to the welfare state as pharmaceuticals) has shown that concentrated industries are likely to use their financial and political power to gain control over public governance. For social policy research it is essential, therefore, “to know what these companies are, how they developed, how they operate” (Lindorff 1992: 29, 30). Second, as welfare provision has become a capital intensive and highly dynamic market good, social policy research has to deal with capital markets and to investigate their impact on social policy. The need to take a closer look at corporate action in social policy becomes even more urgent since not only market like and liberal welfare regimes as the US but also ‘conservative’ welfare regimes experience the evolution of welfare industries as the following chapter on the German case exposes.

3.4 The German Case

3.4.1 Private Hospitals in a Conservative Welfare State

The history of private hospitals in Germany shares communalities as well as differences with the US. As in the US, private hospitals in Germany are known since the evolution of the modern hospital. First private hospitals were founded in Germany around 1830 by both physicians and medical laypersons who were interested in disseminating new ‘healthier’ lifestyles. Throughout the 19th century, private hospitals were in general very small organizations with most of them with no more than 50 beds and offering only a few clinical services.[10] Similar to the US, these early proprietary hospitals were exclusively frequented by affluent patients who were concerned to maintain the social distance to the poor masses crowding the public and voluntary hospitals (Shorter 1996).

Despite their long tradition, the role of private hospitals in the German inpatient sector is still rather unresearched (Wörtz 2008: 147). Moreover, longitudinal analysis is hampered by several changes of the statistical bases (Simon 2005: 189). Until the 1930s the share of private for-profit hospitals is difficult to assess as statistics are only partly available and apply different typologies of public, private for-profit and private non-profit hospitals. In 1933, the share of private and voluntary hospitals in the inpatient sector was almost equal (Spree 1996: 61). The private hospitals, however, provided only a fractional amount of the number of beds within the inpa-

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[10] Most of the proprietary hospitals were specialized in dietetic therapy, tuberculosis or nervous diseases (Shorter 1996: 325).

tient sector. It can therefore be assumed (as there is a significant lack of research) that private hospitals remained first and foremost small specialized clinical centers and played only a minor role in the general health care provision. This guess is also supported by the fact that during the years of the Weimar Republic the idea of 'subsidarity' became a main feature of the German welfare state. Since then voluntary institutions are considered as an important pillar of welfare provision and have therefore access to public subsidies. After World War II, private as well as voluntary hospitals were on the decline in the German Democratic Republic (GDR) whereas, right to the contrary, the idea of subsidiary still played an important role and became established by law in the Federal Republic of Germany (FRG) in 1984. Here, the major share of hospitals and beds were provided by public and voluntary institutions, while private for-profit hospitals played a tangential role (Wörtz 2008: 148).

In todays Germany, the political responsibility for the inpatient sector lies mainly with the federal states. Since 1972, they are obliged to conduct hospital planning. The funding of the hospitals is based on two different pillars: Both the states and the health insurance funds contribute to the funding of those hospitals which are approved in the public hospital plan. While the public authorities are liable for the investment costs, the health insurance funds are paying the expenses for running the hospital. In Germany, a country with a statutory health insurance, there were only low incentives to establish private hospitals, which are not approved by the public hospital plan (and, hence, are not granted access to the funds of the statutory health insurances). In 2000 a share of only 0.5 % of all hospital beds were provided by hospitals being not part of the hospital plan (Simon 2005: 205). While these hospitals have to rely on the financial solvency of their patients, the system of dual financing provides a relatively secure funding for the 'plan-hospitals'. Contrary to the US, financing via the capital market has played only a minor role – at least until the 1990s.

3.4.2 The 1990s: The Turn to Market-based Governance in the Inpatient Sector

As in the US, the growth of the health care sector came to an end in the mid 1970s when the era of cost containment polices began. It was however not before the 1990s that structural reforms have been implemented. In the context of welfare industries, three reforms are of particular importance:

- First, the abolishment of the cost coverage principle ('Selbstkostendeckungsgesetz') within the Health Structure Law (Gesundheitsstrukturgesetz) in 1993,
- second, the introduction of a flat-rate payment system (Diagnostic related groups) in 2003/4,
- and, finally, the introduction of the concept of 'integrated health care' (§ 140 a-d SGB V) – the German way of managed care – which comes along with the idea of 'selective contracting'. [11]

These reforms – accompanied by a strong backlog of investments into the hospital sector by the federal states[12] – had severe impacts on welfare governance in the hospital sector and have changed the share of public, private, and the voluntary hospitals.

With the growing financial straits of the public authorities the need for new financial sources became urgent. In this situation, changing the legal form has been considered the preferred solution. All federal states have changed their hospital laws during the 1990s. Communities, formerly only allowed to run their own hospitals

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[11] Integrated Care (Integrierte Versorgung) has been introduced with the health care reform in 2000 (§ 140b SGB V). One of the main aims of this kind of 'managed care' is to overcome the borders between the inpatient and the outpatient sector, which are especially in Germany very prevalent (Amelung 2007).

[12] In the years 1998 to 2008, the public subsidies according on the 'Krankenhausfinazierungsgesetz (KHG)' declined about 34.48% (DKG 2009).

under public law, nowadays have an enlarged scope of organizational forms: Formal privatization (with the public authorities remaining the majority shareholders) as well as material ('real') privatization is juristically[13] possible.

Meanwhile, the majority of communities has made use of the new opportunities and has changed the legal form of their hospitals from public to private. The share of public hospitals run under private law has risen significantly: In 2006, 51.2 % of all public hospitals ran under private law (Bölt 2009: 253). Besides this, a clear trend to material privatization can be observed. Within the last 15 years the number of public hospitals declined to the advantage of private hospitals. In 2007, 30% of all hospitals operated on a private for-profit basis (see table 3). Interestingly (and this is similar to the US), voluntary hospitals seem not to be affected by this trend to privatization. Their share remains more or less stable.

Table 3: Germany, Hospital Ownership 1991-2007

	public				voluntary				private			
Year	H	%	B	%	H	%	B	%	H	%	B	%
1991	996	46,0	367	61,4	838	38,7	207	34,6	330	15,2	24	4,0
1995	863	41,5	320	56,7	845	40,6	213	37,6	373	17,9	32	5,7
1996	831	40,7	307	55,6	835	40,9	212	38,3	374	18,3	34	6,1
1997	818	40,5	305	56,3	820	40,6	205	37,9	382	18,9	32	5,8
1998	788	38,8	295	55,3	823	40,5	202	37,9	419	20,6	36	6,8
1999	753	37,4	287	54,3	832	41,3	204	38,6	429	21,3	38	7,1
2000	744	37,1	284	54,2	813	40,6	201	38,3	446	22,3	39	7,4
2001	723	36,2	277	53,6	804	40,3	198	38,4	468	23,5	41	8,0
2002	712	37,5	272	54,2	758	39,9	188	37,4	428	22,6	42	8,4
2003	689	36,9	266	53,1	737	39,5	187	37,5	442	23,7	47	9,4
2004	671	36,7	256	52,3	712	39,0	180	36,7	444	24,3	54	11,0
2005	647	35	250	51,5	712	38,6	176	36,3	487	26,4	59	12,2
2006	614	33,9	238	50,3	692	38,3	171	36,2	503	27,8	64	13,5
2007	587	32,8	230	49	678	37,9	168	35,8	526	29,4	71	15,1

Source: Statistisches Bundesamt, Deutsche Krankenhausgesellschaft 2009; own calculation

The former public owners are replaced either by investors with strategic interests, for instance medical engineering or pharmaceutical companies in the search for new sales markets, or by financial investors without a close relationship to the inpatient sector (Lohmann 2007: 42). Table 4 presents the key figures of the ten most important private companies in the German (short- and long-term) inpatient sector. With regard to the short-term hospital sector, the four wholesale buyers Rhön-Klinikum AG, Fresenius-Helios Group, Asklepios Kliniken and the Sana Kliniken AG increasingly obtain an oligopoly status. They have in common that their organizational behavior is expansive, but they vary with regard to their expansion strategies. Fresenius Medical Care for instance is a strategic investor with medical engineering as its core business. While Fresenius Medical Care relies on vertical integration, the Sana Kliniken AG rather focuses on the operating businesses and tries to increase its market

[13] Another question, however, is the political enforceability of selling public hospitals to private investors. In most cases the process of privatization is accompanied by strong public protests (Greer 2008).

share by concluding management agreements for public hospitals. Moreover, all companies differ with regard to their main regional area and try to specialize in different medical indications.

Table 4: Important private companies in the German inpatient sector

Company	Volume of Sales (Milliarden €)	Employees	Hospitals	Beds	Publicly owned
Asklepios Kliniken	2.3	36000	71 (2008, acute)	21000	no
Rhön-Klinikum AG	2.13 (2008)	33679 (2008)	48 (2008)	14828 (2008)	yes
Helios Kliniken	2.12 (2008)	23533 (2008)	57 (2008)	13733 (2008, acute)	yes (via Fresenius)
Sana Kliniken	1.06 (2008)	16500 (2008)	37 (2008)	8200 (2008)	no
MediClin	0.45 (2008)	1936 (2008, acute)	8 (2008, acute)	1377 (2008, acute)	yes
Paracelsus	0.3 (2007)	5102 (2007)	18 (2008)	2257 (2008)	no

Source: Ärzteblatt, 17. 3.2009

Not only the absolute number of private hospitals has increased within the last 15 years, private hospitals today also provide an increased share of hospital beds. Nonetheless, there still remains a significant difference between the number of private hospitals and the number of private beds indicating that private hospitals in most cases are still comparatively small hospitals. The case of the Rhön-Klinik AG, however, indicates changes in the expansion plans of private investors. Today, they seem to consider themselves also capable to run large university hospitals. In 2005, the Rhön-Klinik AG has acquired the university hospitals of Gießen and Marburg which has been (as a preparatory step for the acquisition) merged only six months before (Bähr 2007).

The German hospital market is still a nationalised market. The buyout and commercial exploitation of the German inpatient sector remains in the hands of a few large domestic providers so far. Having built up close relationships to political actors as well as to responsible actors of public and voluntary hospitals, they possess advantages with regard to information and lobbying, which makes market entry more difficult for foreign actors lacking this knowledge (Wettke 2007: 31). Nonetheless, foreign hospital operators as well as financial investors have serious interests in entering the German market as both the German aging society and a – compared to international standards – relatively good economic viability of hospitals promise a stable growth forecast. With the entering of the Swedish hospital operator *Capio* a first bridgehead has been seized from which further progress can be made. It can be expected that the internationalization of the German inpatient sector will advance in the near future. The Swedish private hospital chain *Capio,* which has been founded in 1993, pursues – according to its own webpage – a 'pan-European' strategy. As the possibilities to grow are limited in its home country, Capio decided to cross frontiers and acquire property in other European countries in the mid 1990s.[14] In August 2006, Capio finally entered the German market and acquired the 'Deutsche Kliniken GmbH'. The example of Capio not only shows the beginning internationalization of the German hospital market but also its growing dynamic.

14 Today the company owns over 100 health care organizations in Sweden, Norway, Denmark, Finland, UK, Greece, Switzerland, France, Spain, and Portugal. Capio is Europe's most diversified private hospital operator. Its core business is the inpatient sector, but in addition the company offers diagnostic, laboratory and further services. Capio employed 14,500 people in 2005 and made a turnover of 1.35 Mrd. Euro (http://www.deutsche-klinik-gmbh.de/ueber-uns/capiogruppe/).

In November 2006, only three months after its new buyout, Capio has in turn for its own part become an interesting object of venture and has been acquired by private equity investors (APAX Partners / Nordic Capital).

Next to privatization and (beginning) internationalization, a third reform trend could be observed: This is the growing importance of hospital chains and hospital networks. The share of hospitals belonging to a big network with more than five hospitals is about 17%. Taken also the smaller networks into account, an estimated third or even half of all hospitals belongs to a network (Wörz 2008: 154). While the general trend to (formal or material) privatization is mainly a result of increased financial difficulties of the public owners, the trend to concentration, which takes places in the public as well as in the private and voluntary field, has its roots first and foremost in the introduction of concepts of managed care. With the introduction of 'integrated health care' the health insurance funds have obtained the possibility to negotiate directly with providers. Normally, prices, quality, and quantities of health care provision are negotiated between the according umbrella organizations of the health insurances and the hospitals and are the same for all funds and providers within a certain regional area. In the context of 'integrated care', however, insurance funds are allowed to agree upon flexible contracts with single hospitals – with the latter being in the weaker negotiation position as integrated care is not only considered as means to improve quality but also as a means for cost containment. In this regard, the concentration process and the building of large hospital chains can also be regarded as one out of several defense measures of hospitals to re-strengthen their negotiation power with regard towards the funding side (Amelung et al. 2007: 10).

To sum it up: Recent health care reforms have promoted the rise of a welfare industry in the German inpatient sector. As the hospitals no longer – or at least not necessarily the same amount – get the funding they need to finance their day to day business and to keep their facilities up to date from public institutions, the need for new forms of financing became urgent. Changing the legal form (either through formal or material privatization) is regarded as one solution to tap new financial resources. Besides the growing reliance on the capital market, the transformation of the inpatient sector can be described with the catchwords (beginning) internationalization and concentration. It remains to be seen whether Germany experiences the same development the US has undergone 20 years ago: the growth of a new industry and "*the transition of the practice of medicine from a science and art […] to a boardroom activity in pursuit of shareholder profits*" (Wohl 1984: 2).

4. Conclusion

The starting point of the paper were two observations: first, nowadays welfare goods are more and more delivered on welfare markets, thus, private companies have become an important actor in the (social) political arena. Second, the currently most prominent welfare state theories, Esping-Andersens' regime-approach and the VOC-literature, reveal their limitations especially when it comes to the analysis of the inside of welfare markets and the role of private enterprises. The regime-approach pays its main attention to the role of 'labor' in welfare state policy thereby neglecting the role of the 'capital'. The VOC-literature in turn has brought the capital back into social policy research, disregards in doing so, however, the differing roles 'capital' plays in welfare provision. The VOC approach considers companies only as employers who probably purchase welfare goods for their employees. Besides these purchasers, however, there are private enterprises producing and selling welfare goods. Until today, little is known about these latter businesses.

Taking the case of private hospitals as an example, the second part of the paper has deeper immersed in the question about the role of private companies selling welfare goods. The empirical findings again point out the restrictions of the regime approach. On the one hand the share of private for-profit hospitals in the US, a country committed to competitive capitalism as hardly any other, is surprisingly small. Non-profit hospitals, especially voluntary, but also public hospitals still play a major role. On the other hand, the amount of private for-profit hospitals in Germany is higher than in the US (on the national level). Even if the aim of the paper is not to push

on the 'collapse of the worlds' (Schelkle 2008) in the comparative welfare state research it wants to make the point that comparative exploration of policy fields instead of whole nations can be considerably more fruitful.

Taking a closer look on the history of private hospitals in Germany and the US it can be observed that changes have taken place not only with regard to the welfare mix, e.g. when it comes to the relationship between public, private, and voluntary provision. The case studies have, moreover, revealed profound changes *within* the private hospital market. The rise of welfare industries (which has started in Germany only lately but which has taken place in the US at latest since the 1970s) has come along with a replacement of single ownership hospitals by huge multihospital chains raising questions of monopoly power in welfare provision in both countries. Moreover, the production of welfare goods became increasingly dependent on capital market conditions. It is this trend of corporatization and – as its impact – of growing dependence of social policy from the international financial markets on which this article wants to put special emphasis.

The attractiveness of welfare markets in recent welfare state reform is in the literature in most cases explained with the shared belief in the superior effectiveness of private ownership compared to public or voluntary ownership. This case study however highlights another reason: It is the easier access to the capital market which makes the private companies so attractive for welfare state reformer. Irrespectively, if private ownership is really the more efficient and effective governance form (a question, which is still debated controversially in organizational theory), privatization can relieve the financial burden of public authorities as organizations running under a private legal form can tap new financial sources. It would however mean to carry coal to Newcastle, if one recapitulates the financial events these days, that problems in welfare provision arise especially when Wall Street enters the welfare market and when the logic of financial markets, which are not sensible for social policy aims, rule welfare industries. Investors not only have yield expectations, investor-capital is also free-floating. It transforms welfare provision into a feverish market with acquisitions and resales, openings, and foreclosures, conversions from non-profit to for-profit etc.

The rise of welfare industries challenges the common typologies in welfare state research. Ownership matters, indeed. However, the customary typology of public, private, and voluntary governance is not sufficient at all, as it does not allow to take variants of private ownership and especially the impact of the financial market on welfare provision also theoretically into account. Further differentiations *within* the private sector are necessary as private actors enter the stage in different roles: as single owners of companies, as managers of multi-facility chains, or as partners in financing. The latter can either be strategic investors, taking a long view and investing for the long term. Or they can be financial investors, being solely interested in an increased profit (indifferent in which product market). Companies can either be small enterprises or huge vertically and horizontally integrated conglomerates, they might be dependent from the capital market or not.

Being an explorative case study, the paper does not claim to have delivered an in-depth study on welfare industries. Its findings have rather revealed the demand for a new research agenda. In order to understand recent shifts in welfare governance and their impacts on welfare provision, a social policy research attended to private companies as political actors is needed.

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