NEITHER PARTISAN POLITICS NOR PROBLEM PRESSURE

THE FORCES DRIVING HOSPITAL ORDER TREATMENT PRIVATIZATION IN GERMAN LÄNDER

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Abstract

Privatising prisons is unheard of in Germany, but hospital order treatment in forensic hospitals, a very similar yet more sensitive public task, has been privatized in several Länder over the last ten years. This article – arguably the first one in privatization research – applies the mvQCA method to identify the causes of this rather surprising case of privatization. Whereas neither problem pressure in hospital order treatment itself (as is often discussed in the literature) nor partisan politics can be identified as an explanatory variable, institutions (the Land as the operator of hospital order treatment) can be identified as a necessary condition. Furthermore, hospital order treatment has been privatized in those Länder that displayed comparably high values in two out of three fiscal factors: budget consolidation, investment backlog in the hospitals and the share of Länder hospitals in the overall hospital sector of a Land.

Keywords

Budget Consolidation, Hospital Order Treatment, mvQCA, Party Politics, Privatization,
INTRODUCTION

Privatising prisons is unheard of in Germany and is considered completely unconstitutional (Burgi 2008, p. 65; Dessecker 2008, p. 18), but the closely related field of hospital order treatment (HOT) has been quietly privatized in six out of 16 Länder over the last ten years (Töller & Dittrich 2011). Hospital order treatment is the treatment of criminal offenders with diminished or restricted criminal responsibility due to a mental disorder. To “better and secure” (as the law defines the task) these persons (currently as many as 10,000 in Germany) in specialised and secured psychiatric hospitals is a much more delicate task than to detain persons in prisons because persons remain in the former facilities for longer periods and are subject to more infringements of their fundamental rights (Kammeier 2010). Therefore, in 2012, the Federal Constitutional Court had to address the question of whether the privatization of HOT was constitutional (2BvR 133/10; Grünebaum 2012). This paper does not resolve the question of the constitutionality of privatization but rather addresses the question of why hospital order treatment has been privatized at all—that is, what the causes were for HOT privatization.

According to many authors writing on the subject of hospital order treatment, developments endogenous to HOT over the last 15 years drove privatization. As the number of persons detained in HOT has more than doubled since the 1990s, both operating costs and necessary investments in the construction of new locations have increased. Moreover, growing public sensitivity made the establishment of new forensic hospitals or the extension of existing ones increasingly difficult. Many observers view privatization as a response to these developments based on the commonly held expectation that private operators would complete the task in question “cheaper, faster and better” (Barisch 2010, p. 10) and would contribute a greater volume of investment capital (PWC 2005, p. 8; Willenbruch & Bischoff 2006). In this article, we challenge this functionalist argument, not only because we are generally critical of functionalist perspectives of the world but also because we observed that hospital order treatment was not privatized in isolation in any Land. Rather, forensic hospitals were privatized as subsidiaries of the typically large psychiatric hospitals formerly operated by the Länder (so-called Landeskliniken). Thus, other potential forces driving privatization include partisan politics (the usual suspect with regard to privatization; see Boix 1996; Obinger & Zohlnhöfer 2005; Belke et al. 2007), budget consolidation policies in the Länder (Wagschal et al. 2009), and the institutional settings in which HOT operates. Furthermore, we found that an investment backlog in hospitals and the share of Länder hospitals in all hospitals could also be relevant factors.

Most privatization studies perform regression analyses (e.g., Boix 1996; Obinger & Zohlnhöfer 2005; Belke et al. 2007), but this was not an option for our study because the number of cases (15 Länder) was too small for this method. We found that the use of case studies alone runs the risk of yielding ambiguous results when applied to 15 cases. Therefore, we decided to perform a QCA (qualitative comparative analysis, Ragin 1987), which is ideally suited for situations in which the number of cases (n) is neither large nor small. Because QCA makes it possible to identify the necessary and sufficient conditions that lead to a particular outcome, this tool has been demonstrated to be a particularly useful policy analysis tool in recent years (Rihoux et al. 2011).

This article is relevant and innovative in both substantial and methodological terms. In terms of substance, although there is a wide range of studies on privatization policies both in Germany and
from a comparative perspective, this study is not “more of the same thing” because we consider a case in which, for the first time in Germany, something fundamentally different from telecommunications, electricity, or waste disposal has been privatized. In terms of methods, although QCA has become an established policy analysis methodology, it has thus far been predominantly applied in the fields of social and environmental policy (Rihoux et al. 2011, p. 18), whereas studies on privatization policies have primarily relied on quantitative methods. Based on the literature review in Rihoux et al., our study is one of the first to apply QCA to privatization research (see Rihoux et al. 2011, pp. 60-82). We argue that QCA is useful not only because it is applicable to situations with small-n problems but also because it allows for the identification of combinations of causal factors that accommodate the observation often made in policy analysis: public policies are more often than not the result of complex constellations of factors rather than isolated driving forces.

The remainder of our paper proceeds as follows. In a first step, we present our research design, in which the multi-value QCA (mvQCA) method plays a crucial role (see Cronquist 2005; Cronquist & Berg-Schlosser 2009). Second, we present, discuss, and operationalise our dependent variable, whether privatization has occurred for all Länder. Third, we present, discuss, and operationalise our possible explanatory factors: 1. problem pressure, 2. partisan politics, 3. budget consolidation policies, 4. investment backlog, 5. the share of Länder hospitals of all hospitals, and 6. the institutional environment in which HOT operates. In the next step, we present our data, conduct our analysis, and discuss our results against the backdrop of the cases. Our final section concludes.

RESEARCH DESIGN

As mentioned above, the aim of this article is to systematically test the causal effect of the above-mentioned factors (in isolation or combination) on whether hospital order treatment is privatized in the Länder. We expect privatization to be the result of a complex combination of factors, in which fiscal considerations with respect to the Länder hospitals as a whole should play a major role.

We derive our causal factors from the literature on hospital order treatment in particular and privatization (and hospital privatization) more generally, and we operationalise these factors for application in our QCA. The use of QCA requires a dichotomous dependent variable, that is, whether a phenomenon (privatization, in our case) is present. Although this condition is given in our case, the operationalisation of a complex landscape of legal and de-facto developments is far from trivial, as will be demonstrated below. This analysis and our considerations regarding the independent variables and the causal mechanisms connecting the dependent and independent variables are based on an extensive study of the secondary literature, primary sources on policy processes in the 16 Länder, and 11 expert interviews.iii

An advantage of the classical QCA, which only accepts dichotomous values (also with regard to independent variables), is that it produces clear deterministic statements, including the combinations of necessary and sufficient conditions under which a particular phenomenon occurs. This Boolean logic appears particularly suitable for our purposes because we expect the combination of factors to be relevant. We should ideally be able to operationalise our
independent variables by disposing of index values or metric data based on thresholds that can be derived from substantial/theoretical considerations. However, because this is not possible for all of our variables, we opt to apply a multivariate QCA, which allows for the identification of one or several thresholds based on the empirical distribution of values and thus the construction of comparably homogenous groups (Cronqvist 2007; Cronqvist & Berg-Schlosser 2009, see below).

OUR DEPENDENT VARIABLE: PRIVATIZATION AND NON-PRIVATIZATION OF HOT

In this paragraph, we will present the dependent variable used in our study, whether hospital order treatment is privatized in each of the 16 Länder. Because the operation and organisation of hospital order treatment are the responsibilities of the Länder, we can observe considerable variation. We first briefly outline developments in this area over the last 13 years to provide a general picture of privatization across time and space. Second, we classify the empirical findings according to the common privatization typologies. Third, we present the operationalisation for our QCA.

Privatization of HOT across Time and Space

HOT privatization began in 2000, when Sachsen-Anhalt transitioned two HOT hospitals to private status (Salus gGmbH - a limited company operating as a public utility). Two years later, Thüringen sold its three HOT hospitals to private for-profit and non-profit operators. In Bremen, the HOT hospital was transformed into a gGmbH in 2004. In the same year, Mecklenburg-Vorpommern changed the operators in two of its three HOT hospitals. In early 2005, Schleswig-Holstein sold its two HOT hospitals to private operators. In 2005, the government of Hamburg sold its HOT hospitals along with the entire complex of Länder hospitals (LBK), despite doubts expressed by the Ministry of Justice. In Bavaria, the government commissioned a study by PWC on the potential costs and benefits of HOT privatization, but after fierce protests by the Bavarian Districts (Bezirke) responsible for HOT, the government ultimately decided against privatization. Brandenburg sold its hospitals to private operators in 2006. In Hessen (the case that was recently argued before the Constitutional Court), HOT hospitals were transformed into a gGmbH (Vitos) that remained a wholly owned subsidiary of the Hessen state welfare organisation (Landswohlfahrtsverband). In spring of 2007, the government of Niedersachsen sold eight of its ten HOT hospitals to various operators (most of which are for-profit) for a total of 107 million Euro.

It must be emphasised that HOT was never privatized in isolation but rather as an aspect of the privatization of Länder hospitals as a whole (Kammeier 2010; Töller & Dittrich 2011). Although there was substantial variation with respect to awareness of decision-makers of the special nature of the task that was meant to be privatized, the common argument was that HOT should not be isolated – in terms of organisation, location, and medical provision – from general psychiatric treatment. Our dependent variable, however, is the privatization of HOT and not of psychiatric hospitals in general.

Types of Privatization

Although privatization clearly occurred in this field (see also PWC 2005, p. 86; Pollähne 2008; Kammeier 2010, Rn 75; BVerfG 122/10), structuring our findings using the common typologies of privatization (e.g., Maurer 2009) proves more difficult than one might expect (Grünebaum 2012,
p. 121). One reason is that one must analytically separate the economic activity of operating the HOT hospital from the legal activity of detaining and treating persons in HOT. Broadly speaking, we found two different varieties of privatization of HOT: in the first, the legal status of hospitals shifted from public to private while the Land remained the owner and thus the operator of HOT. We call this formal privatization or corporatisation. The other form is more complicated: here, hospitals (Land, buildings, and infrastructure) were sold to private, for-profit (or non-profit) operators, which would suggest material privatization, whereas the task of HOT cannot be privatized. However, the operation can be privatized, and governments do this by entrusting private operators with this task (“Beleihung”, Pollähne 2008, p. 152). Thus, we can term this functional privatization, implying that the task itself remains the responsibility of the state, and private operators participate in fulfilling this task (Grünebaum 2012, p. 121; Maurer 2009, p. 5). Thus, in terms of typologies, we identify formal and functional types of privatization.

However, applying these ideal types to the individual cases (real types) poses further challenges. One reason is that there is variation with respect to privatization, not only between the Länder but also within the Länder. A second reason is that to adequately describe the situation in a given Land, one must consider the legal situation (is privatization - formal or functional - legally allowed?) and the factual situation (have hospitals in fact been sold and the task delegated?). We can only consider a situation functional privatization if the majority of hospitals in a Land were sold to a for-profit or non-profit operator.9

Thus, Brandenburg, Hamburg, Niedersachsen, Schleswig-Holstein, and Thüringen are functional privatizers. Bremen, Hessen, and Sachsen-Anhalt are formal privatizers, whereas Berlin, Baden-Württemberg, Rheinland-Pfalz, Saarland, and Sachsen are non-privatizers. Mecklenburg-Vorpommern does not fit in any category. This Land is the only one where HOT has never been exclusively operated by the Land; one out of three HOT hospitals has always belonged to the University of Rostock, a second (Stralsund) was formerly operated by the local administration and was sold to a private operator in 2004, and a third hospital (Ueckermuende) was funded by a private, nonprofit operator in the 1990s, which sold its shares to a private for-profit operator in 2004. Thus, we currently have a mostly private, for-profit operation, but because HOT was never fully public in this case, this Land cannot be considered a privatizer.

**Operationalising the Dependent Variable**

We need a dichotomous dependent variable to conduct our QCA. Beginning from our three types, we can either consider all forms of privatization (whether formal or functional), or we can restrict our definition of true privatization to only include functional privatization. We opted for the second option, and we will briefly explain our reasoning for this choice in the next paragraph.

The crucial aspect of this decision is the implications of privatization for the operation of hospital order treatment. In the case argued before the Constitutional Court referred to above, the claimant argued that due to formal privatization in Hessen, persons infringing on his fundamental rights were not public servants, which was against the constitution. The Grundgesetz (“Basic Law”) stipulates in Art. 33 par. 4 that sovereign duties can, as a rule, only be fulfilled by public servants. This argument, which is very common among lawyers in the debate over HOT privatization, implies that formal and functional privatization essentially have the same effects:
they make non-officials responsible for infringing on fundamental rights (see Grünebaum 2012). This argument, however, misses the point for two reasons. First, prior to privatization and in Länder where no privatization occurred, hospital order treatment was/is not provided by public servants (see BvR 133/10: Rn 122). Second, the German administrative system provides for a broad variety of instruments that, if furnished with sufficient resources, can guarantee the safe and constitutional handling of privatized services in general (for a general note, see Sack 2006) and of necessary fundamental rights infringements in particular.

We consider a different noteworthy argument that was mentioned by the Constitutional Court. Accordingly, the fundamental difference is whether the operator of HOT is the state (irrespective of the legal form) or a for-profit organisation. The Constitutional Court argued that in the case of Hessen, the task of HOT was still in public hands:

“The operator is free from motives and necessities of making profit. Thus there is no surrendering of this task to the powers and interests of private competition which could have an effect on duration of stay or reduction of costs for treatment and care which could be in systematic conflict with either the aim of legal execution or the protection of rights of the persons detained” (2 BvR 133/10: Rn 160bb, translation from German by the authors).

It is unclear whether the profit motive does have an effect on the duration of detention or the quality of care and treatment in functionally privatized HOT because no evaluations are available at present (see Töller & Dittrich 2011: 199). However, we find the argument that there are important differences between for-profit and non-profit operations of HOT most convincing. This is why we do not consider formal privatization and only consider privatization to have occurred when HOT hospitals have been sold to for-profit-operators. Thus, table 1 displays the operationalisation of our dependent variable.

Table 1: Privatisers and Non-Privatisers of Hospital Order Treatment

<table>
<thead>
<tr>
<th>Land</th>
<th>Privatisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baden-Württemberg</td>
<td>0</td>
</tr>
<tr>
<td>Bayern</td>
<td>0</td>
</tr>
<tr>
<td>Berlin</td>
<td>0</td>
</tr>
<tr>
<td>Brandenburg</td>
<td>1</td>
</tr>
<tr>
<td>Bremen</td>
<td>0</td>
</tr>
<tr>
<td>Hamburg</td>
<td>1</td>
</tr>
<tr>
<td>Hessen</td>
<td>0</td>
</tr>
<tr>
<td>Mecklenburg-Vorpommern</td>
<td>--</td>
</tr>
<tr>
<td>Niedersachsen</td>
<td>1</td>
</tr>
<tr>
<td>Nordrhein-Westfalen</td>
<td>0</td>
</tr>
<tr>
<td>Rheinland-Pfalz</td>
<td>0</td>
</tr>
<tr>
<td>Saarland</td>
<td>0</td>
</tr>
<tr>
<td>Sachsen</td>
<td>0</td>
</tr>
<tr>
<td>Sachsen-Anhalt</td>
<td>0</td>
</tr>
<tr>
<td>Schleswig-Holstein</td>
<td>1</td>
</tr>
<tr>
<td>Thüringen</td>
<td>1</td>
</tr>
</tbody>
</table>
OUR INDEPENDENT VARIABLES

We derived our independent variables from the literature on hospital order treatment (especially the argument on “problem pressure” in hospital order treatment) and from privatization research (partisan differences, budget consolidation policy, and institutions are the factors generally considered in this area). When considering the entire complex of hospital privatization as the general context for HOT privatization, we realised that we should also examine the effects of the investment situation in hospitals in the different Ländere and the share of Länder hospitals of all hospitals.

We defined the timeframe for our data by operationalising the independent variables according to the period defined by our dependent variable: the first observable privatization occurred in 2002, and the most recent was in 2007. Based on the premise that a causal factor must exist prior to its possible effect, we constructed, as a rule, our independent variables from 2001 to 2006. There are, however, some exceptions to this rule. Regarding problem pressure, we had to use data from 2006 because there were no other data. With regard to the party compositions of Länder governments, we considered the period from 2001 to 2006 for those Länder that did not privatize. For Länder that did privatize, we only used data prior to privatization because including data after privatization would necessarily distort the results. The indicator for investment backlog available in the literature is a long-term indicator covering the years from 1973-2004. Regarding the share of Länder hospitals in all hospitals, we decided to use data from before the wave of privatization; thus, we adopted 2000 as a reference point.

Problem Pressure

The literature on hospital order treatment pays little attention to privatization. Where it does, considerations regarding the causes of privatization are made implicitly, if at all, based on some sort of commonly applied theory. Accordingly, HOT was privatized – against a backdrop of a sharp increase in the number of persons detained in HOT and the corresponding rise in costs – to obtain access to investment capital for new buildings and to have private operators fulfil the task in a more cost-effective manner (e.g., PWC 2005, p. 8; Willenbruch & Bischoff 2006; Barisch 2010, p. 19, for a general note, see Zohlhäfer & Obinger 2005, p. 5). It is certainly not possible to depict the full complexity of the development of hospital order treatment using quantitative parameters alone. However, the massive rise in the number of persons that are detained in HOT according to §63 StGB (e.g., from 2724 in 1994 to 6287 in 2008, Kammeier 2010, Rn A 69) is commonly considered the core of the problem. This rising number can be expressed through the prevalence rate (the number of persons in HOT per 100,000 inhabitants), which rose from 3.9 in 1994 to 9.1 in 2008 for Germany as a whole (Kammeier 2010, Rn. A 69), although there is substantial variation across the Länder (Traub & Weidmann 2008, p. 596). The rise in prevalence rates is the result of both a growing number of persons sent to HOT by the courts each year and more restrictive criteria for being released from HOT (Kammeier 2010, Rn A 68-69). This development has produced problems for existing HOT hospitals, most of which were overcrowded regular work becoming increasingly difficult (PWC 2005, p. 54; Strohm 2008, p. 182). Establishing new HOT hospitals not only required investment capital that the Länder lacked in periods of austerity but also provoked increasing public resistance in local communities (Strohm 2008, p. 175). Moreover, the Länder were confronted with increasing operating costs but had no ability to influence this
development as such because both committing persons to and releasing them from HOT is in the hands of courts (Pollähne 2008, p. 143; Kammeier 2010, Rn A 65).

Based on the above, we find that prevalence rates are a suitable indicator of problem pressure. Particularly high prevalence rates produce comparably high operating costs and require financial and organisational efforts to ensure that this large number of persons is cared for and secured. We use prevalence rates for 2006 because there are no data for all Länder available for earlier years. Even for 2006 (and currently), there is no database for all Länder. The data set provided by the Federal Statistics Agency only covers data for the Western Länder (DESTATIS 2007), and another data set contains data for all Länder except Baden-Württemberg and Bavaria (Jaschke & Oliva 2010). We constructed our data by combining the two (contacting the Länder statistics agencies in cases of deviation) data sets (see table 2, Column 1). If problem pressure is a driving force, we should be able to confirm the following hypothesis:

**H1: Länder with relatively high prevalence rates should have privatized HOT, whereas Länder with low prevalence rates should not.**

**Partisan Politics**

The well-known theory of partisan difference holds that parties differ in their programmatic positions on specific policies (for reasons of deep-rooted ideology and vote-seeking) and that once they form a government, these parties not only attempt but also tend to succeed in implementing their policy preferences (e.g., Hibbs 1977). Although the truth of this theory substantially depends on policy sectors, privatization policies, in particular, were formerly strongly influenced by party positions because the preference for or against public companies and extensive public tasks differed substantially along left and right cleavages (e.g., Boix 1997; Belke et al. 2007, p. 218-219). Currently, there seems to be a partisan effect on privatization within the OECD (Belke et al. 2007, p. 237). Some authors find that in the context of the European Union, the party effect is diminishing (e.g. Obinger & Zohlnhöfer 2005, p. 18-20). This means that the effects of partisan difference need to be analysed in this study.

We examined the party compositions of Länder governments between 2001 and 2006 and coded them as follows: when a left-wing government (SPD, Grüne or PDS/Die Linke) was in power over the full period, we code this as 0. When conservative parties (CDU/CSU, FDP) were in government throughout the entire period, this is coded 2. We coded a grand coalition, or an SPD/FDP-coalition, as 1 (see table 2, column 2). In cases where there was change of government, we considered this a window of opportunity for privatization once a conservative government (as defined above) had been in power for at least a year, which we therefore also coded as 2.

If partisan difference had an impact, we would find the following hypothesis confirmed:

**H2: Länder with conservative governments should have privatized HOT, whereas Länder with leftist governments should not.**

However, we would not exclude the possibility that a grand coalition, or an SPD/FDP-government, could opt for privatization.
Budget Consolidation Policy

Budget consolidation policy is not, as some authors suggest, a direct response to serious levels of public debt (e.g., Obinger & Zohlnhöfer 2005, p. 5, 19; Belke et al. 2007, p. 27). Rather, the strength of budget consolidation policy was found to generally be independent of the level of public debt (see Wagschal et al. 2009, p. 30). How does privatization in general relate to budget consolidation? Privatization is always an easily implemented budget consolidation strategy because, compared to tax increases or spending cuts, it produces few distributional conflicts. Privatization can contribute to budget consolidation in two ways. First, “selling off the family silver” (Zohlnhöfer & Obinger 2005) brings in fresh money, although it is not possible to consolidate the budgets of some Länder (e.g., Bavaria) using privatization revenues (Wagschal et al. 2009, pp. 123; 136). For instance, in Lower Saxony (Niedersachsen), the sale of Länder hospitals yielded 107 Mio Euro. Second, privatization can aid in the elimination of costly tasks (Obinger & Zohlnhöfer 2005, p. 5).

Wagschal and his colleagues analysed Länder budget consolidation policies and their successes as a dependent variable, which allows us to use these data when analysing budget consolidation policies as an independent variable in our study. The authors provide a consolidation indicator\textsuperscript{vii} for each Land from the years 1992 and 2006, which is then contrasted with the data on the average for all Länder. We summed the data for the years 2001 and 2006 (in cases where privatization took place up to the year before privatization) and then divided them by the number of years. These data (see table 2, column 3) provide a clear picture of which Länder implemented strong or weak budget consolidation policies in the years in question. If budget consolidation was a relevant driving force of HOT privatization, we should be able to confirm the following hypothesis:

\textit{H3: Länder with strong budget consolidation policies should have privatized HOT, whereas Länder with weak budget consolidation policies should not.}

Investment Backlog in (Länder-)hospitals

Our view that the intensity of budget consolidation policies are a possible driving force of privatization is based on the assumption that privatization allows revenues to increase and expensive tasks to be eliminated. This argument applies to the privatization of hospitals. However, the financial situations of individual hospitals could make a difference, particularly with respect to investment. In general, the Länder are obliged to finance hospitals based on § 8 par. 1 of the hospital finance act (KHG) adopted in 1972. However, they comply with this obligation to very different extents. Länder investment in hospitals has declined continuously since 1993 (Bruckenberger 2005, p. 5). Investment (or the long-term lack thereof, termed investment backlog) is argued to be an important driver of hospital privatization.\textsuperscript{viii} Ultimately, the need for investment accumulated over many years is so substantial that only private investors are believed to be able to raise sufficient funds to keep the hospital in operation (Bruckenberger 2005, p. 33). We use an indicator that is commonly applied in the literature to operationalise this factor. This indicator is available for all Länder and should equally apply to Länder hospitals and other (mostly local) hospitals. The values displayed in table 2, column 4 present the investment backlog (estimated accumulated investment demand per bed calculated from 1973-2004, Bruckenberger
2005, p. 20, table 19). If investment backlog were a driving force of HOT privatization, we should obtain support for hypothesis 4:

**H4: Länder with particularly high investment backlogs in their hospitals should have privatized HOT, whereas Länder with average investment backlog levels should not.**

This hypothesis, however, is based on the assumption of limited rationality on the part of political actors. Even if for-profit operators of hospitals were interested in reducing (and were able to reduce) investment backlog, the Länder do not ultimately eliminate their statutory obligation through privatization. The only gain they can achieve is not having to spend money on short notice. Either the private investor borrows the money in the financial market and the Land repays the loans with interest over a number of years, or the Land regularly compensates the operator for overhead in addition to the maintenance costs for each person detained in HOT.

**Share of Länder hospitals**

The above considerations suggest that the relative share of Länder hospitals of all hospitals may influence how urgent Länder governments consider the problem of financing “their” hospitals. Based on the official list of all hospitals (DESTATIS 2000), we calculated the relative share of Länder hospitals of all hospitals. If this share had an effect on privatization, the following hypothesis should be confirmed:

**H5: Länder with particularly high shares of Länder hospitals in all hospitals should have privatized HOT, whereas Länder with relatively low shares should not.**

**Institutions**

As in most other policy fields, institutions are expected to have an influence on privatization policies, such as by situating groups of actors, the actors’ strategies, and patterns of interaction between actors (Obinger & Zohlnhöfer 2005: 7-8). In our case, the institutional factor relates to the non-trivial fact that one can only sell the things one owns. This means that privatization as a means of raising revenues for budget consolidation is only possible if the Land is the owner of the Länder hospitals. This is not the case when the Länder hospitals (including HOT) are operated by so-called higher municipal associations (höhere Kommunalverbände, see Mecking 1994), which also own the hospitals. This is the case in Bavaria where the Districts (Bezirke) are responsible for HOT, in NorthRhine-Westphalia where two regional associations (Landschaftsverbände) are responsible for HOT, and in Hessen where the Land welfare association is responsible for HOT. It possible that these Länder could also privatize HOT (for a discussion on Bavaria, see PWC 2005). However, because the Land does not own the hospitals, one major motivation for privatization – the opportunity to raise revenues for the Land budget – is not relevant. Moreover, these municipal associations have much to lose in case of functional privatization and thus can be expected to agitate against privatization (as occurred in Bavaria in 2005). In table 2, column 6 we coded cases in which a municipal association was responsible for HOT as 0 because we expect that this would hinder privatization, whereas the absence of a municipal association responsible for HOT was coded 1. If these contentions were correct, hypothesis 6 would be confirmed:
**H6: In Länder where a municipal association is responsible for operating the Länder hospitals (including HOT) instead of the Land itself, no privatization should occur.**

**DATA, ANALYSIS, AND RESULTS**

In this section, we will first present the data produced by operationalisation described above. Second, we will conduct the QCA and present our results. Third, we will discuss these results against the backdrop of our cases.

**Data and Multi-Value QCA**

Based on the above steps to operationalise our independent variables, we present the following data in table 2. Column 1 displays the values for prevalence (PREV) in 2006. Column 2 presents the data on the partisan difference (PD) between 2001 and 2006 for positive cases up to the year before the privatization. Column 3 displays the intensity of budget consolidation policy (BCP). The values for investment backlog (IB) are shown in column 4. Column 5 presents the share of Länder hospitals of all hospitals (SH). Finally, in column 6, the existence of an institutional restriction (INST) is coded 0.

**Table 2: Values of Independent Variables**

<table>
<thead>
<tr>
<th>Land</th>
<th>1 PREV</th>
<th>2 PD</th>
<th>3 BCP</th>
<th>4 IB</th>
<th>5 SH</th>
<th>6 INST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baden-Württemberg</td>
<td>5.09</td>
<td>2</td>
<td>1.67</td>
<td>-3.4</td>
<td>3.29</td>
<td>1</td>
</tr>
<tr>
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<tr>
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<td>1</td>
<td>2.4</td>
<td>14.29</td>
<td>1</td>
</tr>
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<td>Brandenburg</td>
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<td>2.2</td>
<td>-1.2</td>
<td>7.41</td>
<td>1</td>
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<tr>
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<td>-0.4</td>
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<td>2.83</td>
<td>-3.7</td>
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The only dichotomous variable is that representing institutional restrictions, which are either present or not (column 6). To begin with the more difficult cases, partisan difference (PD) is represented using three ordinal expressions. For budget consolidation policy (BCP), we employed a constructed index, and prevalence rates (PREV), investment backlog (IB), and the share of Ländere hospitals are represented by metric values.

Based on these data, we performed an mvQCA, which allows for the use of non-dichotomous data. Beginning from the distribution of metric values, we arranged the cases into n groups with similar values. Calculations are performed on the basis of the ordinal values of these groups (Cronqvist 2007, Cronqvist & Berg-Schlosser 2009, p. 73). Thus, we meet the methodological requirements of QCA without arbitrarily setting a threshold for dichotomisation (Vink & Van Vliet 2009, p. 268).

We converted the four variables from metric values into multi-value variables using TOSMANA software. The precise manner of conversion depends on the distribution of the variable’s values. Because we obtain statistical outliers in some cases, it appears more reasonable to employ several groups instead of two dichotomous groups. Different solutions were more sensible for the different variables depending on the distribution of values.

The values for prevalence (PREV) are distributed quite equally (see table 2, column 2); thus, dichotomisation is not particularly difficult. TOSMANA assigned the value 1 to all Ländere with a prevalence rate above 9.96. Regarding the values for budget consolidation (BC), Sachsen, with its extremely high budget consolidation value, is an outlier (see table 2, column 3). Here, it is sensible to distinguish between three groups: non-consolidators (BC=0), consolidators (BC=1, threshold 2.02), and strong consolidators (BC=2, threshold 3.75). The same applies for investment backlog (IB): the values are distributed rather equally, except for North-Rhine-Westphalia (see table 2 column 4). If we dichotomised based on these data, NRW would constitute a group of its own, with all of the other Ländere in a second group. In contrast, a categorisation using five groups (of which only three really apply) yields two groups of similar size for the other Ländere (0 and 1, threshold at -0.7), and NRW alone is given a value of 4 (threshold at -10). Finally, the data on the share of Ländere hospitals were the most difficult to translate into mv-QCA-compatible data. In the three city-states of Berlin, Bremen, and Hamburg, this share is extremely high, which makes grouping these values with those obtained for the other Ländere quite difficult. Thus, we opted for four groups that accommodate the given distribution of values: the threshold for group 1 (non-city Ländere with a high share of Ländere hospitals) is 5.91.

Table 3: Thresholds for mvQCA

<table>
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<th>Variable</th>
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<td>PRIV</td>
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<tr>
<td>PD</td>
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<tr>
<td>BC</td>
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<tr>
<td>IB</td>
<td>-0.7 -3.8 -6.9 -10</td>
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<tr>
<td>SH</td>
<td>5.91 11.02 19.64</td>
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Table 4: Truth Table

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<th>Land</th>
<th>1 PREV</th>
<th>2 PD</th>
<th>3 BC</th>
<th>4 IB</th>
<th>5 SH</th>
<th>6 INST</th>
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<tr>
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</tbody>
</table>

Presentation of Results

For those cases with privatization=1, the TOSMANA analysis generates five different combinations of explanatory factors for five Länder (which are indicated at the beginning of each line):
Accordingly, each Land exhibits a different combination. However, there are clear initial and general results. As expected, no HOT privatization occurred in Länder with institutional restrictions. Thus, INST=1 (the absence of institutional restrictions) can be identified as a necessary condition for privatization, but it is not a sufficient condition because there are seven Länder that did not privatize despite lacking any restrictions. However, especially in the cases of Hessen and Bavaria, this restriction seems to be decisive because privatization should have occurred according to the values of the other variables. Thus, hypothesis 6 has been confirmed.

Both values for the prevalence rate (PREV) (1 and 0) are found in cases with privatization and those without. In four out of five cases of privatization, no substantial problem pressure was present; thus, hypothesis 1 (which we had regarded critically from the outset) is clearly falsified.

At first glance, partisan difference seems to have an effect in conjunction with other factors because only Schleswig-Holstein privatized while having a leftist government. A conservative government (HH, NS, TH) or a grand coalition (BB) was in power in three of the Länder that engaged in privatization. However, if we examine the non-privatizers, we find a variety of party compositions – including conservative ones – in government: conservative in SL, BW, and SA (PD=2, SL, B) and governments with CDU or FDP participation (PD=1) in HB and RP. Thus, partisan differences did not have an impact, and hypothesis 2 is rejected.

If the lack of institutional restrictions is a necessary condition for HOT privatization to occur and neither partisan politics nor problem pressure has an impact, what are the factors that account for the privatization or lack thereof of HOT? Our focus is now on the three fiscal variables that remain: budget consolidation (BC), investment backlog (IB), and the share of Länder hospitals (SH) (see table 3, columns 3 to 5). At first glance, all five Länder privatized exhibit different patterns: in BB, all variables take the value of 1; NS displays strong budget consolidation (BC=1) and strong investment backlog (IB=1); and in HH, there is no hospital investment backlog, but there is a combination of strong budget consolidation (BC=1) and a high share of Länder hospitals (SH=1). TH exhibits a significant investment backlog (IB=1) and a large share of Länder hospitals (SH=1). There is, however, one common denominator across these different patterns: those Länder that display high values in at least two out of the three fiscal variables privatized (BB, HH, TH, and NS). This confirms our assumption that different combinations of factors led to privatization, and hypotheses 3, 4, and 5 cannot be confirmed in isolation.

However, Schleswig-Holstein (SH) is the only privatizer where this combination of at least two fiscal variables does not fully apply. SH exhibits a lack of institutional restrictions (as a necessary
condition) and a significant investment backlog (IB=1), yet neither budget consolidation (BC=0) nor the share of Länder hospitals (SH=0) are above average. Given our other results, privatization in this case demands further explanation, which we will attempt to provide below.

By examining non-privatizers, we confirm our assumptions. There are essentially two groups: Länder with positive values in at least two fiscal factors but having institutional restrictions (BY and HE), which accounts for the lack of privatization; and Länder with only one positive value in the fiscal variables (HB, BW, BE, RP, SAA and NRW) or none (SL), which confirms our findings that HOT privatization coincides with positive values in at least two fiscal factors (and the lack of institutional restrictions). Again, we have one atypical case: Sachsen (SA) exhibits substantially above-average levels of budget consolidation, relevant investment backlog, and a high share of Länder hospitals. Thus, it should have privatized HOT but did not.

**Discussion of Atypical Cases**

Our mvQCA analysis of the causal factors of HOT privatization produced a number of instructive results. However, two out of 15 cases do not appear to be fully consistent with these results. Due to the case orientation inherent to the QCA methodology, we will now examine these two atypical cases in greater detail to clarify their relevance for our explanations.

According to our results, Sachsen should have privatized HOT. If we examine this case in greater detail, we find that our results are confirmed, in a certain way. In Sachsen, Länder hospitals have been privatized since 1998, as our results would suggest, but Länder hospitals that include forensic departments were exempted from privatization. This was because the Sachsen government “holds the position that hospital order treatment is a sovereign duty which should remain in public hands” (interview with the Government of Sachsen 2012).

What does the analysis reveal about the case of Schleswig-Holstein, which displayed no institutional restriction and a high investment backlog combined with low budget consolidation and a low share of Länder hospitals and yet privatized HOT? First, we find our observation confirmed that HOT was privatized as a component of the general privatization of Länder hospitals to ensure that HOT was not isolated from general psychiatric treatment (see SH Landtag, Drs. 15/3424:4). Concerning the motivations for privatising Länder hospitals, the government states, “The aim of privatization is to generate additional private capital for necessary investments in hospital facilities. Privatization occurs to compensate for changes in public investment, which will no longer be available at the level previously provided” (Schleswig-Holsteinischer Landtag, Drs. 15/3424: 4, authors’ translation from German). This self-perception conforms to our finding that SH exhibits a substantial investment backlog in the hospital sector. A closer examination of the case further reveals that budget consolidation considerations played a major role in the decision to privatize in spite of the fact that the index displays budget consolidation values far below average prior to 2006. In 2001, SH had the third highest deficit per capita (6.626 €) of all non-city-Länder. That SH faced an urgent need for budget consolidation (without, however, arriving at effective budget consolidation measures) is demonstrated by the fact that no other Land had such a substantial discrepancy between the announced and implemented budget consolidation measures (Wagschal et al. 2009, p. 71). However, due to the economic structure, the revenue situation was precarious while spending was at a relatively low level. Thus, “selling
off the family silver” played a more significant role in attempts to consolidate the budget than elsewhere (Wagschal et al. 2009, pp. 265, 269). This information suggests why the government commission on administrative reforms, which had initially suggested (only) formal privatization of Länder hospitals, ultimately opted to sell the hospitals and delegate the task of HOT to for-profit operators, which generated revenues of nearly 50 Mio Euro (Landesregierung SH 2004).

CONCLUSION

Although the privatization of prisons is considered unconstitutional, hospital order treatment, a very similar and yet more delicate public task, has been privatized in several Länder over the last ten years. This paper sought to identify the causes of this rather surprising case of privatization. For the reasons outlined above, we only considered cases of functional privatization, where hospitals were sold and the task of HOT was entrusted to for-profit (and non-profit) operators, as “real” privatization. We addressed the question of causality using mvQCA, which appeared to be an ideal method given the medium n of 15 Länder, and we expected to be able to identify necessary and sufficient conditions and combinations of causal factors as opposed to regression analyses.

We were able to generate clear and instructive results. First, neither problem pressure (H1) nor partisan politics (H2) had an effect on the decision of whether to privatize HOT. Second, the lack of institutional constraints (H6) is a necessary condition for privatization. Where higher municipal associations are responsible for HOT (in NRW, Hessen, and Bavaria), no privatization occurred, irrespective of the values of the other variables. Third, given this necessary condition, Länder that exhibit a combination of at least two out of three fiscal independent variables (strong budget consolidation (H3), substantial investment backlog (H4), and a high share of Länder hospitals (H5)) did privatize (NN, HH, TH, NS). The only atypical case here is Schleswig-Holstein, which, according to these findings, should not have privatized. Fourth, Länder that did not privatize either failed to meet the necessary condition (see above) or did not exhibit positive values in more than one of the three fiscal factors (BR, BW, BE, RP, SL, SSA). According to this, Sachsen is another atypical case because it should have privatized HOT.

Using these necessary and sufficient conditions, we are able to unambiguously explain 13 of 15 cases. An in-depth examination of the remaining two cases helps to reduce the difficulties that the two atypical cases produce for our explanation: Sachsen (as we expected) privatized Länder hospitals but deliberately excluded those with forensic departments. In Schleswig Holstein, as our data suggested, a substantial investment backlog was one reason for privatization, and the pressure for budget consolidation was another. Due to a number of peculiarities, however, this was not reflected in the data on budget consolidation at that time.

Thus, the forces driving the decision to privatize hospital order treatment were – in the broadest sense – of a fiscal nature: budget consolidation (often accompanied by a general review of public tasks), a substantial hospital investment backlog, and a high share of Länder hospitals of all hospitals made the general problem that Länder hospitals posed for Länder governments even more dramatic. There could be no clearer evidence that HOT privatization had nothing to do with hospital order treatment itself.
Our results should allow for some cautious predictions: Länder that have thus far refrained from functionally privatising HOT will not do so in the near future if (following the logic of path dependency) they have engaged in formal privatization (see the discussion above on BR, SAA, and BE, where Länder hospitals other than those for HOT were formally privatized) or if there are institutional restrictions (NRW, BY, HE). In the other Länder, future privatization would be likely if a dependent variable that thus far had been negative became positive; hence, at least two variables would take positive values. As neither investment backlog nor the share of Länder hospitals can change in the short run, this could only apply to budget consolidation policy. If stricter budget consolidation policy were implemented in Baden-Württemberg or Rheinland-Pfalz, the privatization of Länder hospitals (and of HOT as a component of these organisations) would be likely to occur, unless they were to opt for the Saxonian Model and deliberately exempt Länder hospitals with forensic departments from functional privatization.

We see the innovation of our article in two aspects, substantial and methodological: First the paper identified the causal factors of HOT privatization. It rejected the common hypotheses of partisan difference and problem pressure and instead emphasised the role of both institutions and fiscal considerations. Second, being one of the first studies to apply QCA to the field of privatization research, it has demonstrated that QCA is a useful method for privatization research more generally not only because it is applicable to situations with small-n problems but also because it allows for the identification of combinations of causal factors.

The article further demonstrates that policy making might well be a problem-solving activity, but it often remains unclear which problems are at stake. The privatization policies examined here were designed to solve fiscal problems and not those inherent to HOT, as is often suggested in the literature. A significant amount of further research remains to be done to identify the effects of this surprising case of privatization.
REFERENCES


ENDNOTES

1 We work with 15 instead of 16 Länder because we had to exclude Mecklenburg-Vorpommern (see below).
2 Eleven interviews were conducted between 2010 and 2012. Interviewees were ministerial officials (seven out of eleven) from various Länder, a legal expert, a head of a HOT hospital, and two consultants working in this field. Four persons were interviewed personally, five via telephone, and two by writing.
3 On these data, see Pollähne 2008, p. 146, and Töller & Dittrich 2011.
4 Länder with atypical cases of privatization (i.e., where it is legally possible to privatize and one or few of many hospitals have been sold to private operators, such as in North-Rhine-Westphalia) are not considered privatizers. In Niedersachsen, not all but a majority of hospitals with HOT have been privatized; thus, it is counted as a privatizer.
5 There are, for example, the entrustment contract and other agreements on staff and quality control between private operators and ministries, the usual legal and professional statutory supervision procedures by the ministry, and the participation of the ministry in personnel policies, advisory councils, and ombudsmen.
6 For a critique of this argument, see Pollähne 2008, p. 149; Kammeier 2010, Rn A 77.
7 This indicator includes, among others, the level of primary balance as a percentage of gross domestic product (GDP) and the level of and trend in public debt (Wagschal et al. 2009, pp. 52-58).
8 Over the last ten years, the situation of hospitals in Germany has changed as in no other European country (see Klenk & Reiter 2012). Formerly public hospitals have been sold to for-profit and non-profit operators. Currently, the share of for-profit operators is 33.1% (DESTATIS 2012).
9 We employed a threshold-setting mechanism based on a cluster function that arranges groups based on the average-linkage method (see Cronqvist 2007, p. 9). The thresholds are displayed in table 3.