

## **Economic demands concerning the management of health enterprises of the future in Germany**

### **Abstract:**

The following article discusses the present situation of the German health service. At the same time it examines the current trends of development. By means of marketing and controlling this contribution has the aim to show the management essential ways of how to succeed the paradigm change in practical experience. The paradigm change is taking place for years now. Therefore the German law-maker has claimed a higher efficiency and set up higher quality benchmarks concerning medical and nursing benefits in combination with economic providing of services and lower fixed costs. New forms of organisation and a rather increasing competition between the service providers have led to the fast progress of differentiating submarkets. However, also growing rates can be recorded. Thus it is essential that the management has to use reliable instruments originating from different areas of business studies, such as marketing, staff management and the different forms of operational and strategic controlling in the fields of proceeds, finance (liquidity planning), medicine, health care. The health care enterprises of the future need to be run steadfastly and market-focused. The enterprises have to think in a business-like manner as far as they want to maintain themselves in the prevailing surroundings of competition. The risk of closure has to become aware by all its participants. Is this a vision? Looking at the many private hospitals companies and their licensors who are responsible for buildings of senior citizens which are partly listed on the stock exchange- realising that they maintain themselves well - the answer is no. More and more the customer or patient is increasingly setting the agenda by an experienced quality level in terms of whether the health enterprise is going to be recommended or not. The service user is setting up the new standards.

**Key terms:** paradigm of the German health care system, controlling, marketing, Diagnostic Related Groups (DRG), private and public owners.

### **The problematic situation of health care policy in Germany**

Since a couple of years the health service of the Federal Republic of Germany has been in a permanent process of change which was induced by its politicians. The capacities which are often cost increasing and oversized in the in-patient area shall be cut. Instead the out-patient sector shall be reinforced. This is a drastical structural change. However, there is no clear concept concerning a health strategy. There are numerous and more or less co-ordinated single measurements in health policy to be found. At the same time there is also a yet but gentle opening of the health care system by market-corresponding elements of competition happening. Both facts are indicating that politics would like to further keep its influence in order to support the in-patient health system. Despite claimed stability of contribution for the service-users of the health insurances

(which are employer and employee's contributions), between politically unwanted cuts in benefits and further financial self-participation of the health and care insured thus politics is trying to find the ideal solution. This, however, will have different effects upon on all concerned economic subjects.

One of the most important reasons is the increasing development of aged people in the population pyramid in Germany. For the year 2050 the "German Hospital Association (DKG)" is forecasting 64.4 million inhabitants in Germany under the pre-condition that approx. 100,000 immigrants will come to Germany every year, in comparison to 81.9 million inhabitants in the year 2000 (Deutsche Krankenhausgesellschaft, 2006:56ff). This would be a decline from round about 17.5 million or 21.4%. This must have a rather negative effect on the financial situation of the health insurance companies and private health insurances.

Furthermore the increasing life expectancies of men and women make a restrictive difference. This trend ventures the prediction that by an increasing life expectancy of 12% of our citizens the health costs will go up considerably. Nevertheless, this is still to happen despite a political claim for stability of contributions. Nevertheless, in 2003 Germany was already in second place by 10.9% of its health costs of the German Gross Domestic Product (GDP) in the comparison to the OECD industrial nations (Deutsche Krankenhausgesellschaft, 2006:66-67). Only the USA (15%) and Switzerland (11.5%) had a higher health expenses than Germany in 2003.

In the analysis of the costs for health care services in 2003 per person in US Dollars Germany is on the fifth rank by 3.005 US Dollars. This is behind the USA (5.711 \$ per person), followed by Luxembourg (4.611 \$ per person), France (3.048 \$ per person) and Belgium (3.044 \$ per person) (Deutsche Krankenhausgesellschaft, *ibidem*). The development of the receivers of benefits "outpatient care" (levels I-III) in the years 1996 (1,162,200) to 2003 (1,279,900) indicates a strongly increasing trend (Verband der Angestellten-Krankenkassen e.V./ Arbeiterersatzkassen-Verband e.V., 2005:91). The trend is concerning also the receivers of benefits "stationary care" (levels I-III) within the years 1996 (384,600) to 2003 (613,300). In opposition, the hospital staff decreased by 5.8% in the comparable time in Germany while the professional group of doctors increased by 19.3% nationwide (Verband der Angestellten-Krankenkassen e.V./ Arbeiterersatzkassen-Verband e.V., 2005:79).

However, the introduction of structures in business management led to an increased effectiveness and profitability than before. Let me give you some examples of structures. They are here cost- and benefit accounting, the management of quality, complaint, operational theatres, purchase, risk and dismissal in combination with each unit of cross-section "controlling" on all decision-making levels. Health care centres in sub- and regional markets are opening up gently. By the introduction of the DRG in the stationary supply sector they are allowing more competition. The construction of health centres can save valuable resources because it activates a lot of synergetic effects. Its protagonists of different lines of added value are often connected cost-effectively by a network.

The unsatisfactory compensation difficulties of the stationary and ambulant health care services allow the conclusion that the present public German health care insurance systems are not able to fulfil the challenges of the future any longer. The reason why the need for qualified health services grows with an increasing age distribution of our society. It will blow up the efficiency of today's legal supply systems. In order to prevent further rationing in health services the German health care policy has to look for new insurance systems (Henke, 07.02.2006).

## **The German health market**

At the end of the year 2004 there were 64,4 beds available for every 10,000 inhabitants. The average utilization of hospital beds consisted of 75,5 percent in this examined period (in 2003 it were 77,6% ) (Deutsche Krankenhausgesellschaft, 2006:15). Despite the merger of hospitals and an oligopoly of suppliers there were still 2,166 hospitals in Germany in 2004 available (in 1990: 2,447 hospitals and in 2003: 2,197 hospitals). In that year the number of beds in hospitals consisted of 531.333 beds (in 1990: 685.976, in 2003: 541.901 beds) and in facilities for prevention and in rehabilitation centres there 176,473 beds were offered (in 2003: 1,316 rehabilitation centres with 179,789 beds). Also altogether 1,079,831 persons were employed in hospital (in 2003: 1,104,610 persons) so that thus every 29th employee would work in a German hospital (Deutsche Krankenhausgesellschaft, 2006:14).

The cut of capacities has to be emphasized which took place within the time range in the years 1990-2004 and consisted of -154.643 (= -22,5%). There was also a decrease of -281 hospitals (= -11,5%). This trend, too, will continue despite the decreasing days of staying in hospitals (1990: 14,7 days/ 2003: 8,9 days/ 2004: 8,7 days) and days of nursing service (1990: 210,4 Mio/ 2003: 153,5 Mio/ 2004: 146,7 Mio) on one hand and the but increasing numbers of patients on the other hand.

Nevertheless, the average utilization of all hospital beds in Germany in 2004 consisted of only 75,5% (in 2003: 77,6%). This is of a high business management relevance because 24,5% of the mentioned hospital resources are remain unused. However, they are causing uncovered fixed costs in employment. That is too much. These costs lead to a rising change of the break-even-point. (Here the cost curve intersects the curve line of return). Consequently, the area of economicalness or rather the area of profit is either reached by the increasing level of employment or not at all. To prevent a financial disturbing situation, however, also the health enterprises have to work cost-effectively. If the negative values are scored in a long-term run, the enterprises have to take measurements against the situation in forms of capacity adjustments. The adjustments would be of a factual kind. In the worst case it would also have to happen in terms of staff change to prevent problems of financial solvency. Taken from an economical point of view, although these economic measurements are absolutely making sense, they suffer

from extremely problems of imparting concerning the employees. From time to time there is also a problem of imparting concerning the public, too.

### **Former consequences of the paradigm change concerning German hospitals**

It follows that the legislator is intervening in a policy further in the health market. One example: Already in 1995 the hospitals were decreed by the "Bundespflege-satzverordnung" which is a lump sum system of remuneration. The hospitals can calculate their several services individually. The services are offer in a fit-for-the-market-manner. Thus they make profits but also cause losses. The former valide principle for covering one's cost has been abolished. The paradigma chance it was the reason that hospitals had to think entrepreneurially. The legislator forces the hospitals to a company mission/philosophy more suitable for patients and customers. Especially concerning the public hospitals this new approach is still in the process of setting up. And in the millennium in Germany the introduction of the "Diagnostic Related Groups (DRG system)" for hospitals was decided by the law of the so called "Gesundheitsreformstrukturgesetz". Until to January 2009 the hospitals still have time to optimize according to the context of the "convergence phase" their performance offers, their cost and price structures as well as their organizations. This new accounting system leads to a reorientation of all German hospitals and therefore the German health economy. Patients will be dismissed earlier. They are more dependent on support by itinerant private and public care services, health and advice centres, set up itinerant health service providers, shown health centres and advice facilities. Thus new network systems concerning in the comprehensive care sector will be set up and have an impact on the structure of the german health economy. The qualitative demands on domestic care will increase. There will be also new contract partners for the invoice of treatment and care performances (Geise, 2005:394).

The "temporary country case values of the year 2005" represent economic milestones which were determined by the "DRG Institute" for every federal state of Germany. These values should not neither be exceeded nor fall below without suffering from liquidity effective consequences (Tuschen, 2005:242). The basis case values of 13 federal German states contain a range of € 2,564 (in "Mecklenburg-Vorpommern" which is now "West Pomerania") and € 3,122 in Berlin.

The legislator demands of the health enterprises uncover unused economy reserves in the hospitals till now and use them so that they gain positive contributions of variable gross marginal in future. Because when you have uneconomic benefit offers the costs exceed the revenues. The hospitals are living on their assets. They don't allow any substitute investments, leading them straight into insolvency. If the management of the hospital doesn't want to watch such suicidal development idly like this, it must prevent it and immediately dismantle uneconomic problem areas. The German Code of Social Law called "Sozialgesetzbuch V" also follows up these aims when it resolves the until now rigid division of tasks and sectors between ambulant and stationary areas thus allowing its close cooperation. Such structural changes enable a more efficient and more economical

performance offers for health enterprises. These changes contribute to establish their economicalness. Especially in Berlin, this concept is carried out at a terrific rate. This concerns hospital fusions but also the closing of hospitals. Thus the number of available beds for the patients in German hospitals have been decreased by over 154,600 beds since 1990. The time of stationary residence dropped by an average from 14.7 days in 1990 to 8.7 days in 2004 (Deutsche Krankenhausgesellschaft, 2006:24). However, the cut in hospital staff lead to a density of work of the still employed staff.

In February 2007 "German Bundestag" which is part of the German government passed the "GKV law concerning the refreshment of competition". The law claims a considerable financial contribution of German hospitals in order to strengthen financially shattered companies of the legal health insurance. This rescue operation of German hospitals will be limited to January 2009. The main part of this program are: lowering of the minimum hospitals revenues from 40% to 20%, for the rescue operation the total amount 0,5% is deducted for every patient who is insured in the legal health system in the hospital calculation, the education budgets for nursing staff e.g. for the trainees has been negotiated individually by each hospital, the are new standard or basic rates for private insured patients, in the middle of the year 2008 there shall be a organisational reform of the legal health insurances as well as all legal health insurances which until now were united in central associations (Tuschen, 2007:10f.).

The health market of the Federal Republic of Germany which was until now very much hospital-focused will get a new structure by short stays of the patients in hospitals and in clinics on one side and with a best possible medical and nursing care on the other side, an increase in the resource-saving out-patient treatment as well as new regional-oriented networks of residential medical consultants, pharmacies, out-patient services, health insurance companies, social centres, therapists and further providers in the health service. Nevertheless, in the future the hospital will have an indispensably high importance the market. Especially in research and teaching but also in the supply for the population with equipment of stationary special services.

The pressure of decreed costs and efficiency, however, is new. The management of the hospitals is forced to disclose and implement the potentials of optimization and success as well as the use external services which, for example, cover the pre- and after-stationary area. In the hospitals the shorter time of residence plus the higher imposing of measures of the patients also lead the employees of the social service in the hospital to treat more clients within a shorter time. Two other factors are the growing pressure of time and action plus increasing unfinished work.

A practical way out of the dilemma is the cooperation of external providers of nursing care services, such as centres for social service and nursing within the residential district. Thus the social service of the hospitals becomes time-saving because it is receiving the necessary data. The service can also pass the data on when after-support is necessary. This is saving resources. Taken from a work economical angle it would be making sense. Under the overall control of volunteers as well as specialist coming from university and educational centres the social service of the hospital could improve its

profile by a corresponding prevention concept. Thus the treatment of clients could be guaranteed.

In the focus of political health issues of the legislative endeavour there is still the claim for stable contributions compulsory for all social security payers. The more the increasing development of aged people in the population pyramid has been aggravating the harder the claim in will be to be adhered in the mid and long time run. Due to a growing number of older and old people they will ask more and more for health services of all kind in the next years.

Thus "customers-/ patient-orientation" forced by the market represents a high challenge in the reality. It is necessary to know the interests of providers and consumers. It is necessary to compare them and thus derive a methodically secured statement from it. Looking closer often the questions of the customer-/ patient- orientation are just limited to just the editing of glossy magazines. Often concerning individual clinic is just dealing with to presenting of its special lectures. Another issue is the consultation on the day of dismissal of the patient. However, the health service providers can learn from a equipment which has been approved for decades in the economy. They can systematically to improve their position in the market. They can analyze and focus the interfaces to their customers and suppliers: this is the marketing of service providing.

Unmistakably, in Germany the trend is, however, to further reduce the in-patient care section in favour of the out-patient and semi-in-patient care sections. In addition flexible organizations are further built up. Examples are health care centres and health networks as well as different forms of integrated supply. This situation is in terms of health care and municipal policy. It will contribute to a limitation of the increase of costs. It remains unclear how much the pharmaceutical and the respective industries are going to react. Thus the pharma industry and the pharmacist branche succeeded in keeping the high price level of medicine which is market-inflexible. It remains a vision that prices for medicine will be released and that there will be one real competition between the pharmacies. Class political reasons are not consumer-friendly. They enable the continuation of the convenient situation for the German pharmacists. Plus they are leading to high prices of medicine.

Out of business management, ethical and medical reasons this concerns also the performance hostile of the residential doctors. If the allocated financial budget which a doctor is getting for a quarter or for a whole year is exhausted before reaching the next time period of allocation due to a high emergence of patients the doctor does not get fees for further treatments. For ethical reasons it is possible that the doctor treats a patient free of charge. Thus the doctor performs a service which he rather might not perform. All his fixed and the variable costs wouldn't then be financially covered any longer.

The banning that a doctors are not allowed to offer opened medicine packages to his patients, especially not to poor and needy people just is not making sense in an economical way. These laws lead to the behaviour of patients, doctors or pharmacists that already paid remaining medicine which was already paid by the health insurance has to be thrown away. This is done though the medicine still could be used. Thus valuable medicine which is still useful is just being destroyed.

## **Demands on service marketing**

The benefit of life expectancy, the committed degree of market openness and thus the increasing mutual competition of health enterprises contributes to the fact that more and more also older and aged people represent interesting customers for service providers in the health sector. They should be especially targeted and served with appropriate products matching the age group by the providers (Statistisches Bundesamt, 1998:43).

More and more in the German population the insight is implementing to live a way of life which influencing health in a positive way. This includes a stronger interest in a health-conscious diet, in physical fitness and anti-stress-programms, in active early diagnosis and preventive medical checkups as well as in a changed information behaviour by means of Internet, consumer advice centres and networks. In particular private hospitals but also public run hospitals increasingly have been trying to take this new consumer interests into account by corresponding service offers. Consequently they have been enlarging their product range. Also the spending power as well as the available household income of these interesting consumer layers - "young and middle elderly people" is still high enough. These type of consumer is ready to become an interesting demander for preventional and healthy measurements (like special holidays and to stay at a health resorts).

## **The right service philosophy and service culture**

Hospitals, nursing services, rehabilitation centres, homes for older peoples, set up professions in the health service are service providers. Their product range is mainly of immaterial nature. These service offers are not storable but in personnel, temporal and spatial regard they narrowly connected. Nevertheless they have to be introduced to the interested customer as consumer goods so that can his choice regarding several offers (Ptak, 2000a:5ff.).

The provider should always come up toward the demander with true, clear and specified information about possible medical and nursing services as well as optional hotel benefit programs. With such a range of the supply groups, for instance the hospital determines the core marketing strategies. These strategies need to be suitable for the market but also on focused on the target group. The potential customer has to be conveyed that he has a clear benefit by choosing our clinic. The offer has to be as different as possible from other providers. It should tell why we are better than our competitors.

One element of a marketing strategy is corporate culture. The committed planning of a corporate culture needs given company philosophy as role model. In this it finds an expression to describe how it perceives its own profile, the management and its employees at following up the market-focused objectives under the observation of value and norm ideas practised in the hospital (Ptak, 2000a:5ff.).

The company philosophy in the hospital will secure a distinctive external identity. It will become an essential system of values for the employees. Thus internal role models and political company principles will be recorded as realistic ideal cases.

Such role models can be oriented towards economical, ethical, ethnic, religious and social targets. This could be for instance patients, providers, the public, questions concerning work scope and individual problem solutions. They will be only then accepted by the employees when the role models of all employees are daily practised. This will also include the executives.

### **Tasks of market research in hospitals**

The hospital market research analyzes the communication and interaction processes between the service provider (health enterprise) and the service recipients (patients or instructors). This happens after previous regional obtained examinations of the demographic structures. The focus here is among other things the question of the patient before, during and after the service process. It is also important to gain the insight of the desired customer- focused behaviour of integration fulfilled by the hospital staff.

Above all the interest lies here on the intensity integration and the quality of the interaction processes. Both can possible essential aims to the **satisfaction research** in the hospital. To build up a high satisfaction degree is surely time-consuming. However, it is essential for a long-lasting and successful position in the market.

Helpful indeed is a working **complaint management**. It just does not only have to record the utterances of dissatisfaction but also to pursue the recognizable operational weaknesses. Another task of a working complaint management is to immediately stop the operational weaknesses and in co-operation with the controlling change them into market opportunities. The individual measurements result in a safeguard marketing concept.

### **Demands on controlling**

Health enterprises and in particular hospitals cannot avoid to implement private-sector and approved business management structures. This could be done in order to be able to work economically and maintain itself as enterprise in the opening market. Thus already approved controlling structures and instruments of the industry of the health economy are adapted (Huch, Lenz, 2005:69f.). Only through this it is possible on the different levels of management to obtain a quick survey of the business management and to take swift measurements of operative control measures then. Both in the private-sector and in non-profit making enterprises of the health sectors indices of economicalness are highlighted.

Both kinds of organisations are only able to exist as long as they are working economically. The ratio of factor uses in money or quantity units (input) to the gained efficiencies in money or quantity units (output), also the "**Economic Efficiency**"-coefficient,



$$\text{Economic Efficiency} = \frac{\text{(Performance-) yield into money units or quantity units}}{\text{(Factor-) costs into money units or quantity units}}$$

is not allowed to sink under "1.0". If the economy coefficient increases over "1.0", profit is already gained. However, the coefficient gives no information about the actual profit height because among other things the operational costs of overheads remain unconsidered. However, the economy coefficient is a reliable decision size on method comparisons and investment invoices and for the appropriate control measurements.

Primarily, it is telling something about the economical technical rationality of the performed or intended efficiency production. In this case it does not matter to which economic system a business belongs to.

In order to recognize a trend in economy the controllers have to judge their indices of economicalness at various times. Then the controllers have to make suggestions to the top management concerning their concluded control measurements. However, the commodity of "public and private health service" always has to be disposable. The corresponding supply capacities of providers of the in-patient health service are respectively classified in the public hospital plans of the German federal states. The supplies are defined according to medical faculties plus the number of available hospital beds. This is based on national promotion. Because this is money from the tax payer the controlling is especially responsible for its economic spending.

Therefore every controlling process is founded on following considerations (Ptak, 2003:15ff.):

1. Absolute following of the **postulate of economicalness** concerning the employment of staff, material and money resources. These may only be used in an efficient and effective way- it is economical and serving the purpose. Hereby the security of the solvency and of the postulate of liquidity. The **postulate of profitability** – as the term already says- gets at profit. Depending on the type of legal business organization - concerning public health enterprises which are obliged to the general public- it should not prevail the situation. Due to their market power profitable enterprises could work by no means uneconomically.
2. It is the **thinking of economicalness** not the profitability thinking which needs to be affirmed on all levels of hierarchy. In addition the thinking of economicalness has to be adapted to all objectives paramount in business. Processes of added-value have to be identified. In complex organization units they need to be coordinated in a way which prevents most of the waste of resources.
3. During the daily work the **customer/ client orientation** and a constant service quality is implemented by the staff. Thus a high customer satisfaction and also strong customer bond can be guaranteed.

4. Primarily, an evaluation of the cost-benefits should find expression in the optimization of all operational measurements. A concentration on operational **core processes** prevents miscalculations concerning operating capital.
5. The until now followed quality of the medical and nursing behaviour is completed by the **quality of the economic behaviour**.
6. This means that the approved **early warning equipment** is accepted by the health economy after a thorough adaptation.

The "**strategic controlling**" – a rather long-term approach- shall help the management during the process of decision making in that respect as in to offer business-/ product fields, new investments in the form of acquisitions of new locations or to search for commitment in new business fields. These targets have to be reduced from the implementation of the level of top-management to the level of manager or team leader.

This principle, however, is always valid: the short to mid-termed applied "**operative controlling** implements the planning specifications of the strategic controlling in a goal-oriented way. One example: a hospital holding company a strategic cost reduction of 5% for the next three years. Every clinic will have to make its contribution. Corresponding six-month-old milestones are stipulated. The individual contribution of accomplishment to the respective milestone then is operative target.

The "**process controlling**" of individual projects and functional areas of the enterprises is profile networked with both levels of controlling. Examples are marketing, materials logistics management, financial management, human-resources management, operational social affairs among others. Thereabouts arisen costs will be analyzed and assigned to the cost and activity accounting. This is for instance the calculation of the DRG, which records the costs of a complete treatment case or the increase value controlling for the production of medicine or of medical aids. Here all accrued costs of the complete increase value-added chain are included (these include all processes and all costs from the original product of raw materials to the costs of transportation up to disposal costs) (Ptak, 2003:22ff.).

Summing up, it can be said, that all processes which can be quantified and judged with the approved controlling instruments are controllable. Already for this reason no enterprise – even the smallest ambulant company- can do without controlling. Furthermore only the controlling in the health system on the and further developing free market gives an up-to-date impression on the economical situation of health enterprises.

## Staff Controlling in the health care service

### *Deviation analysis*

Because of diverse actions it has turned out to be expedient, to calculate these actions according to their extent of time, to give a brief summary and to grade the patients in their need of permanent nursing. At the same time every patient will be categorized according to a specific dependency factor of accomplishment. Another factor will be a special average expenditure of energy assigned in minutes. The planning of size and contents of nursing will be related to the number and the qualification of the staff. Therefore it is advisable to tend the deployment of nursing staff not just to the number of patients but also to the nursing expenditure in respect to time. A not too complex system for the conclusion of the patient category will enable the nursing service then a disposition at short notice for the necessary nursing action per nursing unit.

The first task of staff controlling in the nursing service it is now then to determine daily the necessary scale of nursing action as the estimated value. The new value has to be compared with the actual value and with the actual staff on each individual medical war. In addition a possible extension and lack of covering concerning the estimated and the real value needs to be stated. Values deviating from the target together with proposals concerning the counter control of human resource management need to be reported to the nursing service. Correspondingly, this then has to decide accordingly. It also has to ensure the implementation and decision. At all times, however, the following principles, applies: **“No Staff-Controlling without deviation analysis”** under the observation of more quantitative as well as qualitative targets. Both analyses serve the precise controlling of nursing processes.

At the same time the quantitative range of the deviation analysis is determined by indices of economicalness. The qualitative range is determined by degrees securing the target of nursing quality. Within the quantitative range very quickly the monetary effects of goal deviations become clear. They compel to launch counter-controlling actions the quickest possible. The deviation analysis within the range of the nursing quality security covers, however, for possible occurring during the nursing process. However, they can and will also have a medium-termed influence on indices of economicalness.

Thus it results in then the following exemplary operational sequence of the work of Controlling in the nursing service:

- ✓ Following the form the controller collects the status quo of the patients in the morning. This is done together with the simplified examined degrees of dependence of the patients concerning nursing actions.
- ✓ By the admission, dismissals and changes concerning the dependence during the period of controlling the controller checks the changes for time requirement of nursing action on the individuals ward or nursing units. The controller also determines the target requirement for the nursing service.
- ✓ Then the controller compares with the in service present nursed patient. Thus results a minus value. Per ward this minus value is daily available under the

special consideration of the time factor concerning the admission and dismissal of patients (deviation analysis).

- ✓ The time over and under cover revealed by the deviation analysis in combination with measurement proposals will be communicated by the controller to the management of the nursing service. One example is the immediate transfer of a nurse into nursing unit which is lacking workforce because the ward is not utilized or it is the opposite situation.

By this method fixed staff costs can be proportioned. Furthermore the dangers of fixed non-necessary costs as a result of non-employment can be minimized and a better economicalness of the nursing service can be established. However, also in seasonal peak times the progressive personnel costs caused by overtime extra pay need not be accepted as mayor force. In this case a proportion of the staff costs could be reached for instance caused by subcontracted workers, by stand-in pools or by accounts for annual flexible time.

### *The analysis of fluctuation*

The second task of the staff controlling in the nursing service is the analysis and the examination of the cause of reason why the fluctuation rate is so extraordinarily high in the nursing rang. Studies show that no other occupational group stays such a short time in the job.

$$\text{Rate of Turnover} = \frac{\text{number of dismissal during a periode}}{1\% \text{ of the average number of employees}}$$

In order to reveal the causes of fluctuation it is necessary to determine not just the whole rate for the entire hospital but for the individual nursing units and the deviations for the average fluctuation. There are many reasons for fluctuation. The reasons might be situated in a rather personal area but it also could be also an area in business. The personal reasons (marriage, pregnancy, disablement, retirement, among others) can hardly be defused in contrast to the reasons in business. The reasons in business are for example, strain in cause of staff shortage, unsatisfactory service forms and service work schedules, additionally difficulties for getting holidays, especially difficult patients, a bad working atmosphere, lacking leading qualities of the supervisors.

The following counter measures would be possible: motivation increase by more variety in the daily service, more satisfying work with more connection towards the individual patient, more flexible job deployments, part-time jobs, equally distribution of gravely ill patients, to limit or do avoid totally freer systems of service schedules, inclusion of the holidays into the personnel requirement calculation, so in case of holiday utilization no additional charges arise in the nursing unit. The management of the nursing service has to personally initiate and implement these counter-measures.

Great care should be taken at the selection of executives, their education and their development. Evidently, a lack in leading qualities often causes frictions in the daily work-life and thus a bad working atmosphere. For that purpose belong in particular deficits at the managing of coordination of interests, during the cooperation of other occupational groups (especially with doctors) and the motivation of subordinate employees.

Thus Controlling does not just have to prepare fluctuation analyses with the reasoning of causes as well as suggestions of conclusive counter measurement controlling to the nursing management but it has to be absolutely to monitor the effects of the measures.

### ***The analysis of absence***

Down-times are times of absence. They cause fixed idle costs which go together with liquidity outflows. Therefore they have to be minimized. In many times high rates of absence often indicate to a later similar high rate of fluctuation. The causes match. Either the members of staff want to evade an overstrain in the job or they are extremely dissatisfied with the job. In any case a thorough cause analysis of time of absences should prevent later terminations causing possibility even greater problems. In the first step the rate of absence should be figured out for the nursing unit.

$$\text{Proportion of Time of Absence} = \frac{\text{time of absence of during a periode}}{1\% \text{ targeted work during a periode}}$$

In order to evaluate such kind of calculated rate, it needs to be analyzed by recording the times of absence separately in regard to their cause (Ptak, 1999:19ff.). This way it becomes obvious whether we are talking here about controllable times of absence like for example as a result of holidays, further education and training or whether it is not a controllable time of absence due to for instance illness (job-caused illness and job-independent illness) but also. However, whether it is a clear question of absence. Looking at the cause research for absence the controlling has to divide between reasons which are depending on the individual and are operational and thus type of reason is influenced (operational excessive demands as well as not enough challenge, strain, unfavourable working atmosphere) and individually private—conditioned reasons which cannot be influenced by the enterprise.

These differentiations reveal the multilayeredness the problem of down-time and absence. They also clarify, however, that not all causes are controllable by the executives and supervisors. The counter-measures of controlling, however, should aim at the supposedly changeable causes. After conscientious determining and analysis of the reasons of absence this has to suggest corresponding alternatives of measurements.

## **The Controlling in staff planning in the health care section**

Regarding the sensitive staff situation in the nursing service - especially the problematic nature of fluctuation and times of absences - great significance must be attached to controlling in the area of staff planning. The Controlling has to determine, whether and to which extent personnel planning is operated, it has to demonstrate possible deficits and has to suggest measures for the dismantling of deficits. At the same time it uses comparisons between target and real situations, therefore we are talking here in terms of deviation analyses.

The guidelines of the target for the staff planning supply the operational objectives of the hospital and the specialized divisions or the functional units. Out of the objectives result the planned accomplishment as well as the criteria for quantity and quality of the necessary nursing staff.

The target profiles of demands have to be contrasted with the profiles of skills and suitability of the present members of staff. This serves the purpose to identify possible agreements and differences (deviation analysis). Most of the time they will deviate from each other so that a need of action consists in the adjustment of the actual values with the target values. Therefore the management of the health care has two alternatives: either already present suitable members of the staff are adapted by educational and training course measures for future profile of demands or the therefore suitable members of the staff are acquired on the external operating job market.

After clarifying the substantiated program of accomplishment as a quality component of staff planning the quantitative elements of staff planning would be to be specified. These are:

1. The **staff planning** with the question about the necessary requirement profiles for the fulfilment of the program of accomplishment. A suitable measure would be the introduction of a planning of accomplishment program.
2. The **planning of the need of a position** with the question of how many members of the staff need which when qualifications. As a measure there is a qualitative appropriation and a time limit for the staff need.
3. The **plan filling vacancies** asks: Can the job positions be filled by members of the staff –with or without a measurement of further education or do new external employees to be won?
4. The **planning of staff acquirement** has to answer the question, how to win the necessary co-workers by a correct timing. Here the following measures quite handy: In-plant recruitment advertising, advertisements, head hunting, enticement.
5. The **planning of staff development** with the question about the kind and intensity of the necessary education and further education of members of the staff for the fulfilment pf the accomplish programme. The necessary measures are tangible education programs tending to future profiles of requirements.

6. The **planning of personnel placement** asks: Who for the purpose of exact and real task scheduling among the members of the staff when and where used in order to avoid excess of authority.
7. The **shedding of staff planning** concerning the reconcilable with a welfare state division of not any longer needed staff has the following questions:
  - ✓ which positions are omitted?
  - ✓ which staff cannot be employed any longer?
  - ✓ is there a chance for this group to be retrained or do they have to be diminished?

Efficient measures could look like this: the development of alternative models of curricula, the allowance of retraining helps, the support during the process of finding a new job. Thus the concept of planning is provided. It has to refer to a specific time amount. This can be at short notice (until 1 year), medium-termed (1 - 3 years) or long-termed (3 - 5 years). Now the decisive criterion to be examined would be the question of costs with the all elements of staff planning influencing staff planning expenditure. Another factor would be the thus connected financial planning under certain postulates of **economicalness, rentability and liquidity**. Often that can lead to corrections in the personnel planning. Staff expenditure planning asks for substantiated costs which are caused by the new concept of planning. It suggests the following measures for solving the problem: The recording of personnel expenditure within all staff planning elements consideration of time horizons (short-termed, medium or long-termed) in co-ordination with the financial and budget controlling.

It is the task of controlling to accomplish the presented steps of planning steps itself or to arrange these. In any case the controlling has to show the respective need of measure to the hospital service. Controlling also has put pressure on the implementation. Thus controlling as an initiator symbolizes the introduction and realization of staff planning in the health care in commitment.

### **Operational demands on health care enterprises**

Today the demands on health and social enterprises are changing with high speed. New health and social laws are enacted in increasingly shorter intervals. The realization of the G-DRG accounting system has been already running for at least two years. It will still need approximately three more years. The realization of the innovations and the thus connected requirement of training staff and the financing of these training measures take time. Traditional job outlines and traditional contents change or run out. New professions come up bringing new profiles. Examples are the medical controller, the encoders, in counselling, in the growing academically education in the nursing professions, the case manager, the accommodation managers. At the same time there are trends moving towards an increasing knowledge specialization in the respective job. They all prove that there is a changed speed happening now in the health and social services. Thus the demands for interdisciplinary forms, team players, a constant learning as well as

the capacity to think in networks and a profound knowledge of business management and jurisdiction.

The "**system for indices of liquidity**" is regarded as a the central equipment of control and controlling. Occuring imbalances between payment deposits and paying also in a financial plan for the future outs then these are most significant warning signs then. In that case they should trigger immediate cause analyses. This cash forecast system informed the management, if the enterprise is still able to fulfil all their obligations to pay every time. Similar significant is the "**cash-flow**".

It reveals whether and to which extent an enterprise achieved surpluses by its accomplishments. These are not needed for purposes of the reinvestment in its process of accomplishment. However, they are needed when there is a non-distribution of dividends to the capital investor taking place in order to redempt outside capital. Thus it will strengthen the base of the owner's own capital by self-financing. By the help of cash-flow the economic power of an enterprise can be reliably judged (Ptak, 2001:21ff.).

By the "**working-capital**" indicator it is possible to identify short-term liquidity risks. However it would be identified without the exact periode allocation, it could just recognized by tendency. This indices would have to be completed by analyses of the deadline of the liquidity dates concerning the degree of covering investment. The degree of covering investment concerns the relationship between capital (stockholder's equity and long-term outside capital) available in the long run or for an indefinite period bound fortune (non current asset, long-term equity holding and loan demands). By the postulate of the period congruent financing of the fortune which is financed on the long-term the degree of covering investment quotient should drop below "1.0". If this would happen parts of the in the long run bound fortune would be financed by short-term outside capital, for example short-termed liabilities, bills payable).

However, this could lead to a sudden illiquid situation at termination of the short-termed outside capital. Because the long-term investments generally cannot transfer into the re-money stage as short-termed (Schröder, 1996:5f.). From the frequency of capital transfer the amount of operational business capital and also the use intensity of the fortune inventory can be judged (Ptak, 2001:21ff.).

- ✓ Independent of their maintenance health and social enterprises are organized increasingly under a form of civil law. When they are in need health and social enterprises can be recognized as charitable organizations. Nevertheless, they have the following things in common.
- ✓ Everybody has to economize with scarce financial resources. This forces them to a permanent consideration of a cost-benefit-analysis and to a setting up of entrepreneurial priorities and targets. These have to be converted into strategic and operative plans of enterprises, finances, liquidity, staff, quality and marketing.
- ✓ The **total costs** in German hospitals consist of staff costs to 67.1% and to 32.9% for material costs (Deutsche Krankenhausgesellschaft, 2006:43f.). Therefore it has to be taken into account that staff costs are fixed costs which must be earned from expense ratio among others from DRG. If this doesn't turn out well, liquidity problems arise. They can endanger the existence of the complete business. Health



enterprises which do the accounts according to DRG therefore have to give priority of their company planning to a strict orientation of proceeds. Especially when they want to keep a continuing high medical and nursing quality.

- ✓ They cover needs directed by others or market-conform need of the population. An example are political determined aims of welfare. The needs will be either defined by political programs or they will be based on the own entrepreneurial risk.
- ✓ For liquidity preservation and security of competitiveness the German hospitals need an increasingly outside capital within the next years. However, the obtaining of operating supplies loans and of long-termed investment credits put higher demands on the capital looking health enterprises according to the "Basel II agreement". The examination of credit rating as well as the thus concerned equity capital that determine the credit price. Thus the credit institutions include even more trade-specific "additional factors" into the assessment of credit. Examples among others are the deviation of the individual base case value of the corresponding country base case value, the proportion of the choice accomplishment, the extent of legal liability cases, the image, several values of quality (Schmitz, 2006:45ff.).
- ✓ The operational efficiency as well as the work effectiveness of the employees shall be optimized to avoid waste and thus destroying of capital (Gehrmann, Müller, 1999:39f.).
- ✓ As suppliers they are working in an opening market for social and health economic services. Until now the market was steered predominantly by the state. Looking at the valid consideration system lumped together for hospitals (DRG which were introduced for the hospitals as of 2004) it can be recognized. Legally, it is among other manifested in the DRG case flat rates' catalogue and in the ordinance of the federal hospital and nursing charges (Tuschen, Quaas, 2001:109).
- ✓ They need a modern, on business oriented business-management-system which has the newest subject and management knowledge at disposal. Furthermore a system which is able to lead the business conform with the market, that is customer focused, in a way that the existence of the business remains safeguarded particularly under the liquidity postulate (Brauns, 2000:42).
- ✓ The process of "**market opening**" ordered by the legislator in a relatively short time also the welfare associations (DPWV, Diakonische Werke, Caritasverband Deutschland, Deutsches Rotes Kreuz, AWO) to the specification of its market competences. In such cases the enterprise concepts should be nationwide. However they should be always be worked out professionally and put into practice under the special consideration of the regional situation of competition. Especially in clinics specialists different faculties are often working in side by side in a lack of communication. Or there they are insufficiently informed. Approved control instruments, like a comprehensive report system or a system of controlling, can help to avoid these defects.

## Result

The patient as a customer, the client or even the "consumer in the position of a first-served" will be able to choose services and provides more freely. If this is true may be doubted since still the health and social markets are adjustly state-regulated. Also the public investors have to organize their deposit in order to run a health enterprise according to the principles of economicalness. This means that the management has to run a company always by the economic minimal principle. Because on the long run no investor is able to keep a business in deficit unchanged on the market.

However, the until now protected health and social sectors are changing very quickly into an open market. These circumstances forces all carefully budgeting social enterprises in Germany to constantly check their cost centres for unnecessary expenses. This need to be done in order to prevent hustling costs. In context of the product politics they will increasingly diversify as well as to deliver or obtain whole systems. This way the function of controlling takes up an economic existential significance for health service providers of any type. And eventually, the marketing will have to examine the growing self-confidence of the consumer and patients, especially in the part of proper information and communication policy of the social enterprises.

Neither the hospitals nor the medical out-patient and nursing services withdraw from this politically intended change. Not even then if they are owned by the "Diakonie", "Caritas" or the public authorities. The reason is that they are going to compete with each on the health market henceforth.

## References:

Brauns, H.-J., 2000, "Wohlfahrtsverbände: Gemeinnützige Oligopole oder Wettbewerber am Markt?" *Soziale Arbeit, Zeitschrift für soziale und sozialverwandte Gebiete*, Heft 2/ 2000. Pp. 42-48.

Deutsche Krankenhausgesellschaft 2006, *Zahlen, Daten, Fakten 2006*. Düsseldorf.

Gehrmann, G. & Müller, K., 1999, *Management in sozialen Einrichtungen, Handbuch für die Praxis Sozialer Arbeit*. Regensburg und Bonn.

Geise, St., 2005, "Marketing in der Pflege" Pp. 354-394 in: *Management und Betriebswirtschaft in der ambulanten und stationären Altenpflege* edited by Loffing, C. and Geise, S., Bern.

Henke, K.-D., 07.02.2006, "Die gesetzlichen Krankenkassen privatisieren", *Frankfurter Allgemeine Zeitung*.

Hentze, J. & Huch, B. & Kehres, E., 2005, *Krankenhaus-Controlling, Konzepte, Methoden und Erfahrungen aus der Krankenhauspraxis*, vol. 3. Stuttgart.

- Huch, B. & Lenz, I., 2005, "*Operatives Controlling im Krankenhaus*" Pp. 69f. in *Krankenhaus-Controlling*, vol. 3 edited by Hentze, J. et. al. Stuttgart.
- Ptak, H., 1998, "*Managementoptimierung im Krankenhaus durch Controlling*" Pp. 16-28 in *Wirtschaftspraxis, Verwaltungspraxis, Wirtschaftswissenschaften*, vol. 2 edited by Hellstern, G.-H. Kassel.
- Ptak, H., 1999, "*Das Personalcontrolling im Krankenhaus als funktionsbereichsbezogenes Controlling*", Pp. 12-28 in *Management im Gesundheitswesen*, vol. 1 edited by Ptak, H. and Reinhart, M. Berlin.
- Ptak, H., 2000a, "*Ökonomische Optimierungsmöglichkeiten für Gesundheitsbetriebe durch Marketing-Mix*" Pp. 3-22 in *Management im Gesundheitswesen*, vol. 3 edited by Ptak, H. and Reinhart, R. Berlin.
- Ptak, H., 2000b, "*Zur Marktorientierung von Dienstleistungsunternehmen des Gesundheitswesens*", Pp. 2-3 in *Management im Gesundheitswesen*, vol. 3 edited by Ptak, H. and Reinhart, R. Berlin.
- Ptak, H., 2001, "*Strategieleitende Steuerung marktorientierter Gesundheitsunternehmen durch Kennzahlensysteme*" Pp. 11-33 in *Management im Gesundheitswesen*, vol. 5 edited by Ptak, H. and Reinhart, M. Berlin.
- Ptak, H., 2003 "*Controlling als zentrales Managementinstrument in der Gesundheitswirtschaft*" Pp. 14-32 in *Management im Gesundheitswesen*, vol. 10 edited by Ptak, H. and Reinhart, M. Berlin.
- Schmitz, H., 2006, "*Fremdkapitalbedarf und Basel II zwingt Klinken und Banken zum Handeln*" Pp. 45-48 in *Führen & Wirtschaften im Krankenhaus*, vol. 1. Melsungen.
- Schröder, E., 1996, *Modernes Unternehmens-Controlling*, vol. 6. Ludwigshafen.
- Statistisches Bundesamt/ Gesundheitspolitische Berichterstattung des Bundes 1998, *Gesundheitsbericht für Deutschland*. Stuttgart.
- Tuschen, K. H. & Quaas, M., 2001, "*Bundespflegesatzverordnung, Kommentar mit einer umfassenden Einführung in das Recht der Krankenhausfinanzierung*" vol. 5. Stuttgart/ Berlin/ Köln.
- Tuschen, K.-H., 2007, "Gesundheitsreform 2007, Auswirkungen auf die Krankenhäuser", *Führen & Wirtschaften im Krankenhaus*, Heft 1/ 2007. Pp. 10-11.
- Tuschen, K.-H., 2005, "DRG", *Führen & Wirtschaften im Krankenhaus*, Heft 3/ 2005. Pp. 18-22.
- Verband der Angestellten-Krankenkassen e.V. (vdak)/ Arbeiter-Ersatzkassen-Verband e.V., 2005, *Ausgewählte Basisdaten des Gesundheitswesens*. Siegburg.