HSPA Network meeting 2023 in Riga

Germany’s hospital reform

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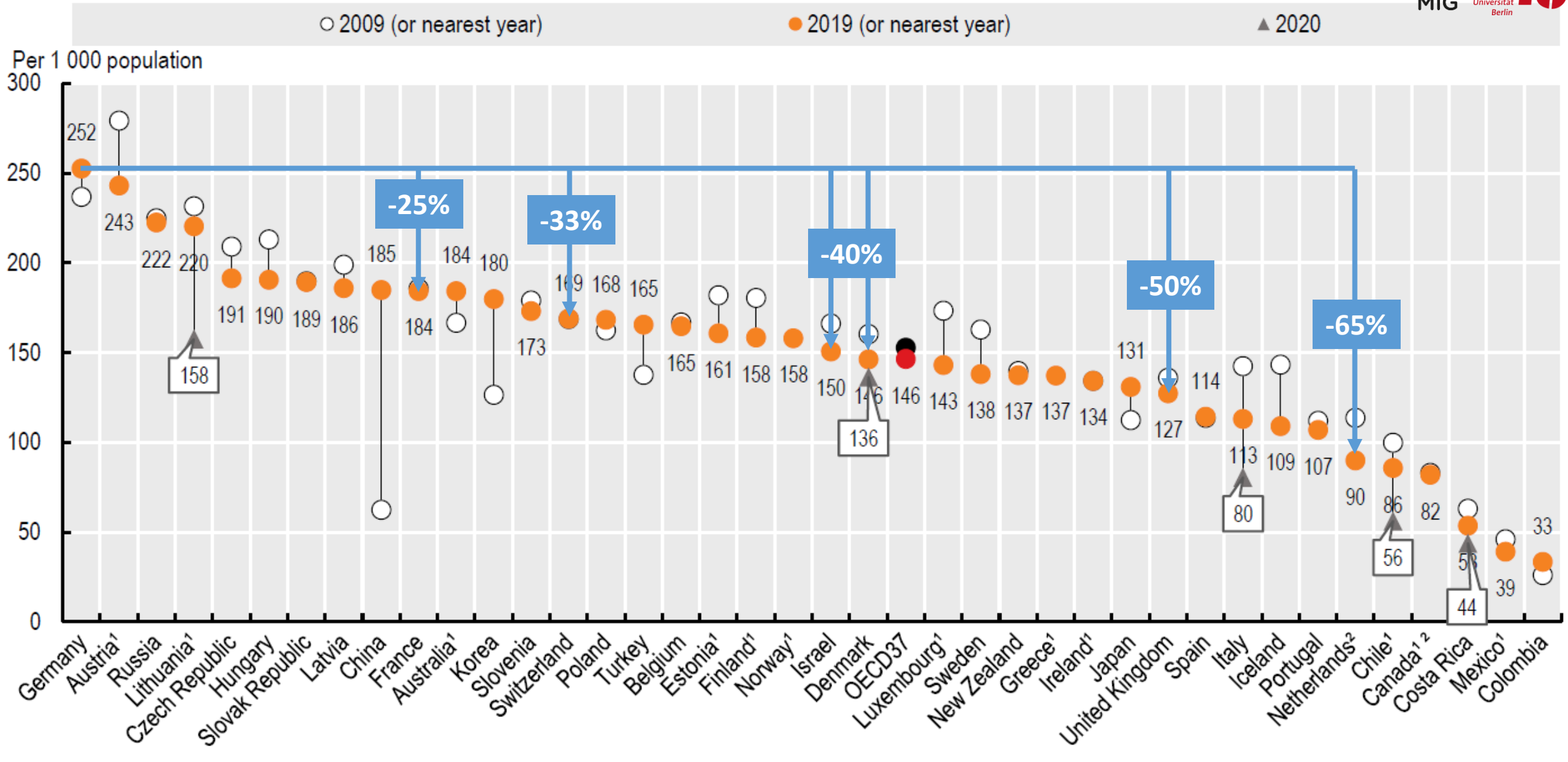
Conflict of Interest

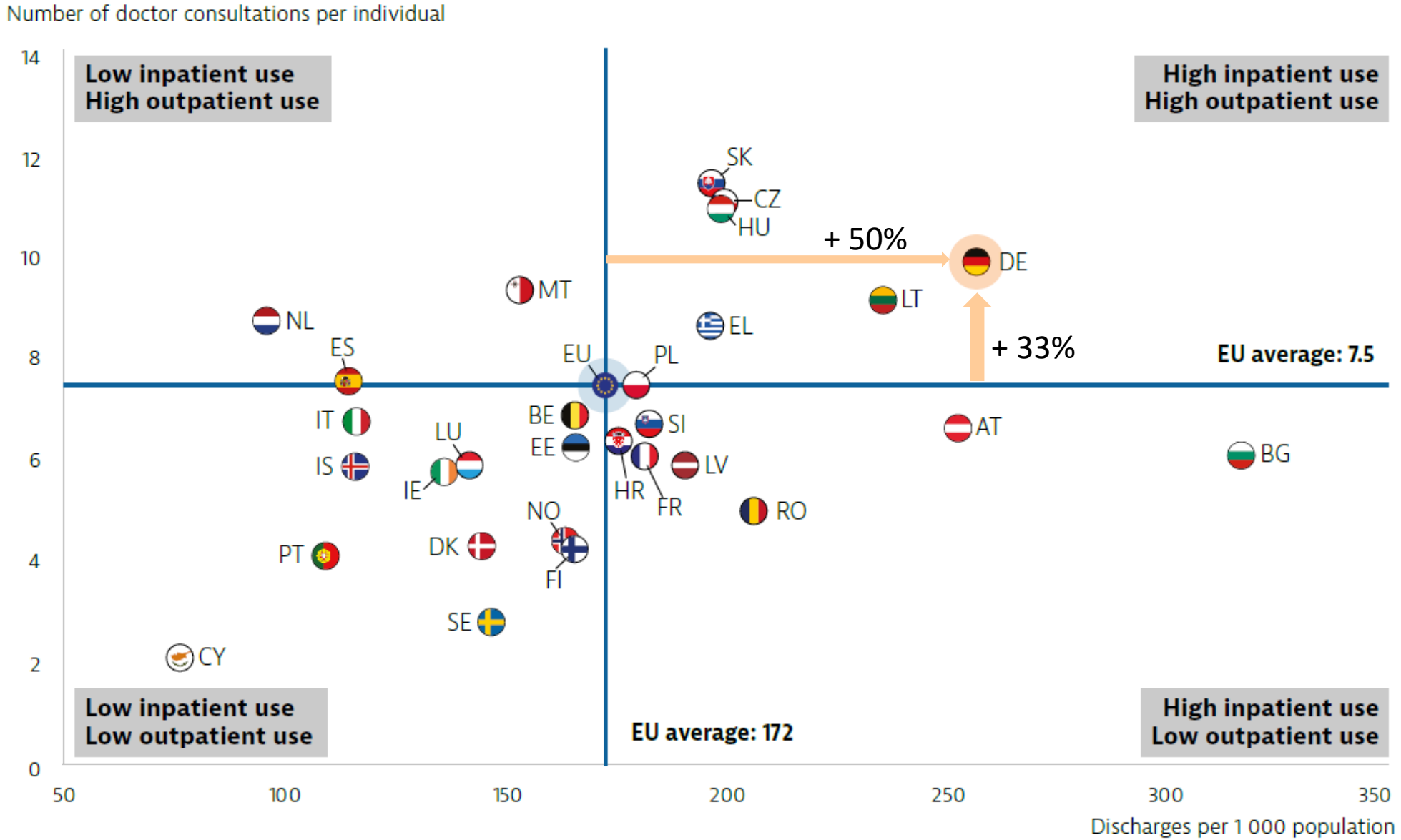
I am a member of the “Government Commission on Modern and Needs-based Hospital Care”, and within that commission a leading person in drafting the reform proposal discussed here. I am therefore not neutral.

Figure 5.19. **Hospital discharge rates, 2009, 2019 and 2020**



1. Excludes discharges of healthy babies born in hospital (3-10% of all discharges). 2. Includes discharges for curative (acute) care only.
Source: OECD Health Statistics 2021.

Figure 9. There is high use of both inpatient and outpatient care in Germany

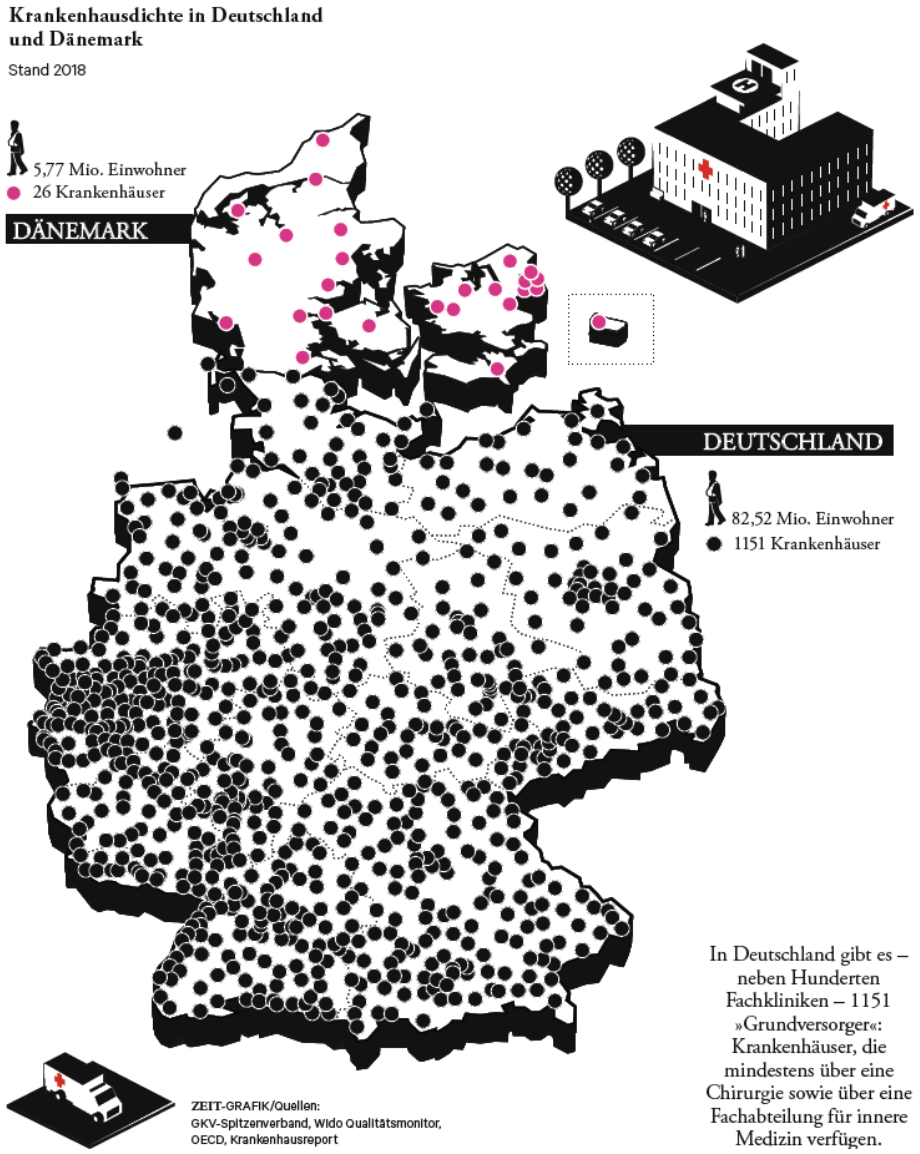


Note: Data for doctor consultations are estimated for Greece and Malta.
Source: Eurostat Database; OECD Health Statistics (data refer to 2016 or the nearest year).

OECD/European Observatory on Health Systems and Policies (2019), *Germany: Country Health Profile 2019*, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels

The German hospital sector I

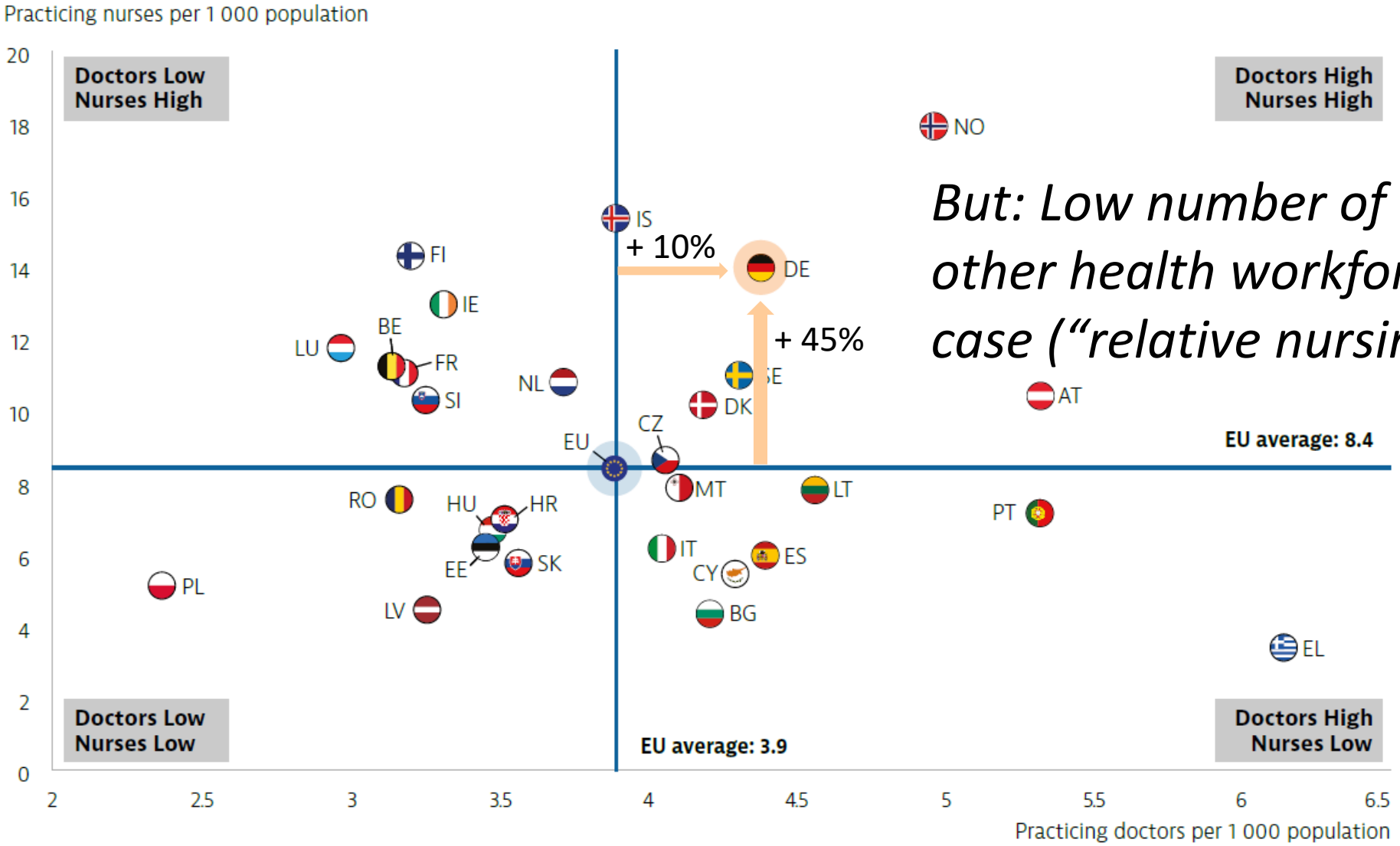
- Not only high number of inpatient cases,
- but also in terms of hospital numbers and beds (also +50% vs. EU avg.)
- Chicken or egg? High bed numbers → high case volume, or … ?
- High case numbers are seen as due to high reliance on DRG payments,
- but -15% since pandemic (= total 2019 utilization of 850 of 1700 hospitals), leading to financial problems of hospitals



The German hospital sector II

- Intransparent and unstructured, “planning” by states on location, departments, beds – but no planning or transparency on what hospitals provide (and no notion of a “general hospital”)
- Where measured, high variability of quality, because every hospital can do whatever it wants:
  - stroke unit not required to treat stroke,
    and even if existing, stroke units are not required to be certified,
  - angiography unit not required for acute myocardial infarction,
  - 50% of cancer patients receive their treatment in hospitals without a certified cancer center
- Less than 10 conditions are more regulated through the necessity to achieve certain minimum volumes (e.g. preterm newborns <1250g)

Figure 9. Germany has comparatively high numbers of physicians and nurses for its population



But: Low number of nurses (and other health workforce) per inpatient case ("relative nursing shortage")

Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

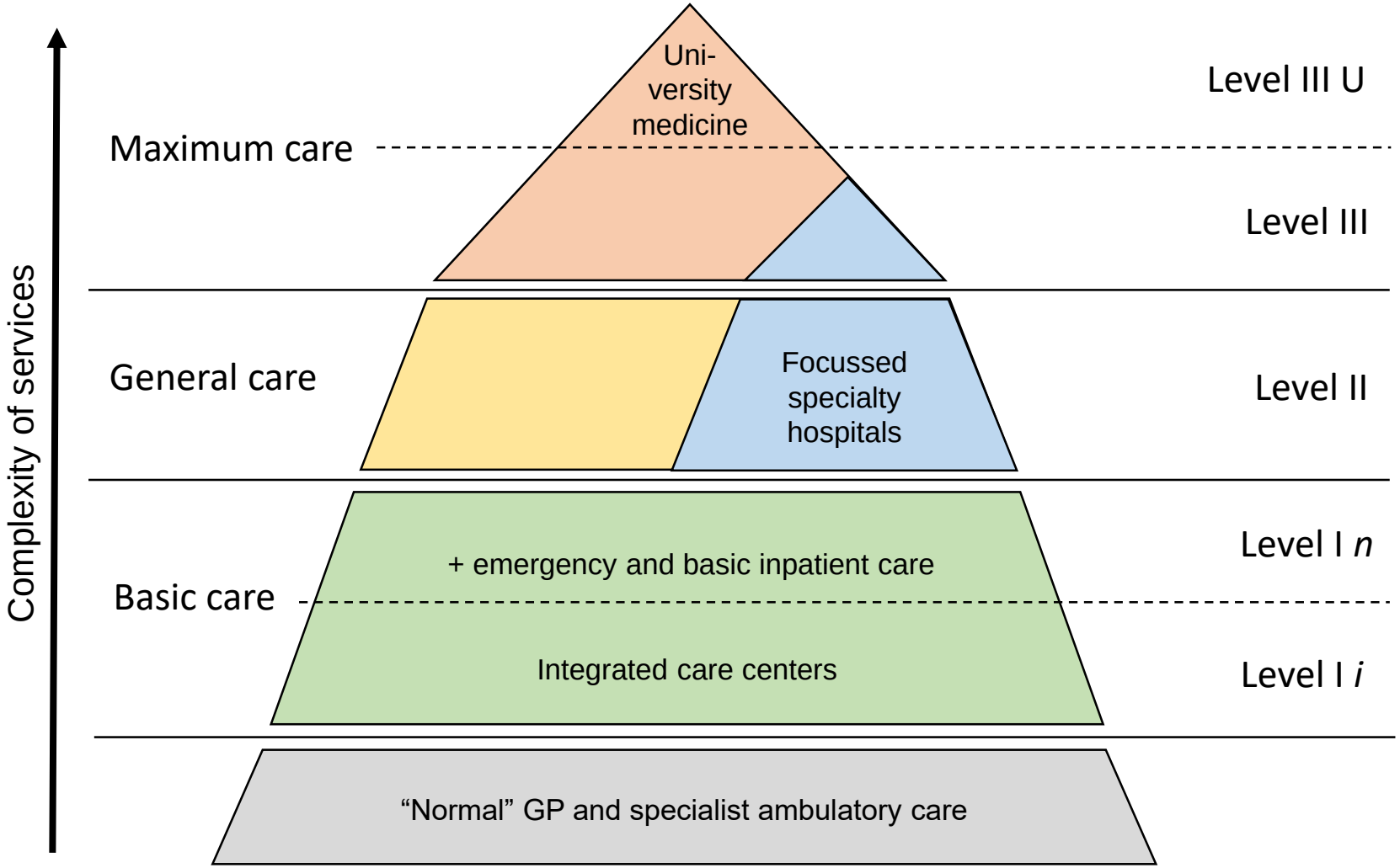
OECD/European Observatory on Health Systems and Policies (2021), *Germany: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels

Post-Corona, a Government Commission on Needs-based and Modern Hospital Care is tasked to propose wider reforms

Reform proposal drafted by Commission and presented by Minister of Health in December 2022 included three main elements (acknowledging that neither more money nor more personnel will be available):

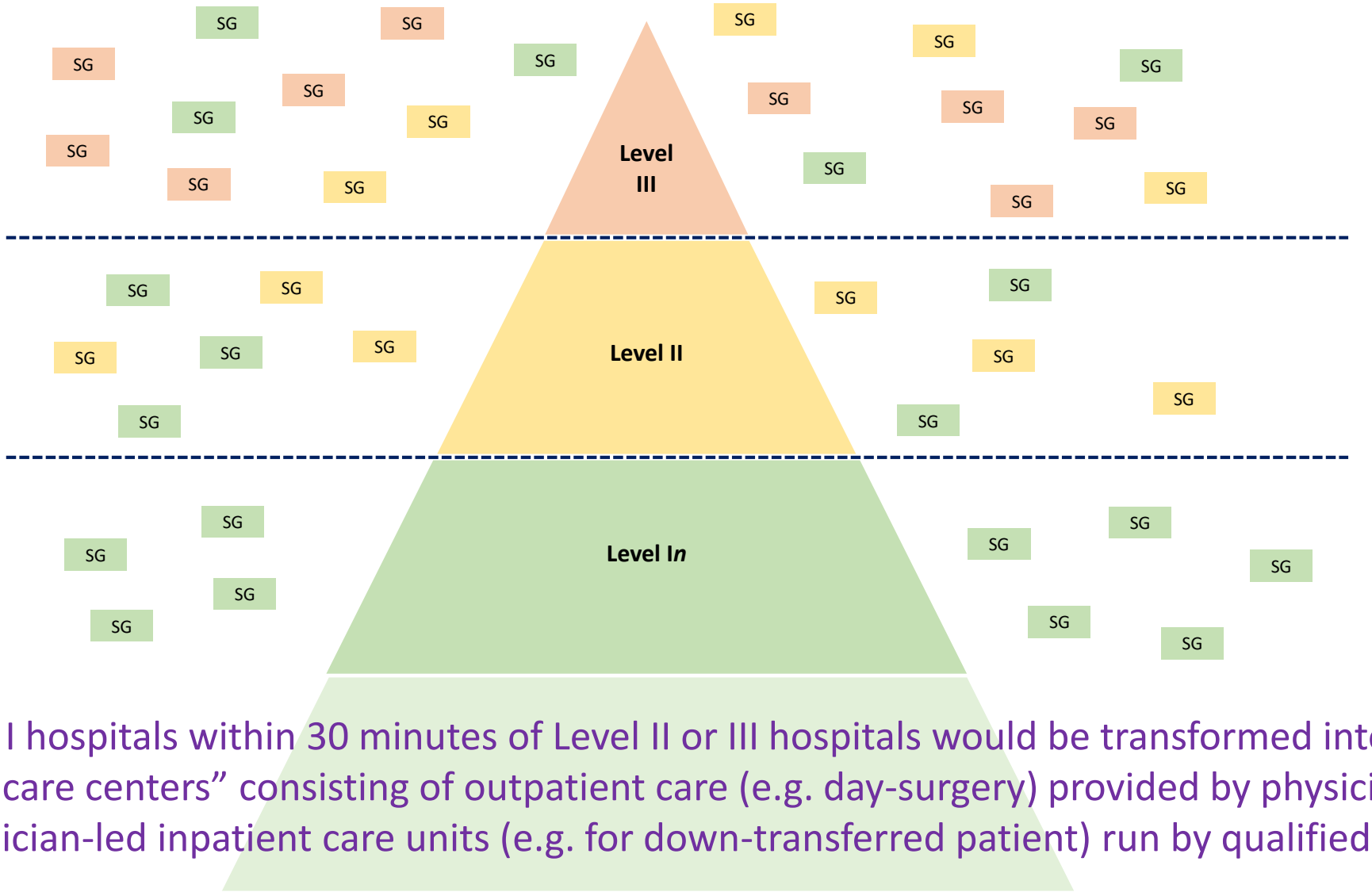
1. Hospitals are placed on three levels, defined by e.g. physician availability out of hours, size of intensive care
2. Services are grouped into “service groups” (“SG”; wider than DRGs, narrower than specialties), with a certain minimum level required and specific requirements fulfilled (e.g. stroke unit to treat stroke)
3. Financing: DRG component reduced to 60% in favour of budgets per service group to reduce incentive to provide unnecessary services

1 Finally a clear level-structure for German hospitals …



Source:
Regierungskommission
Krankenhaus

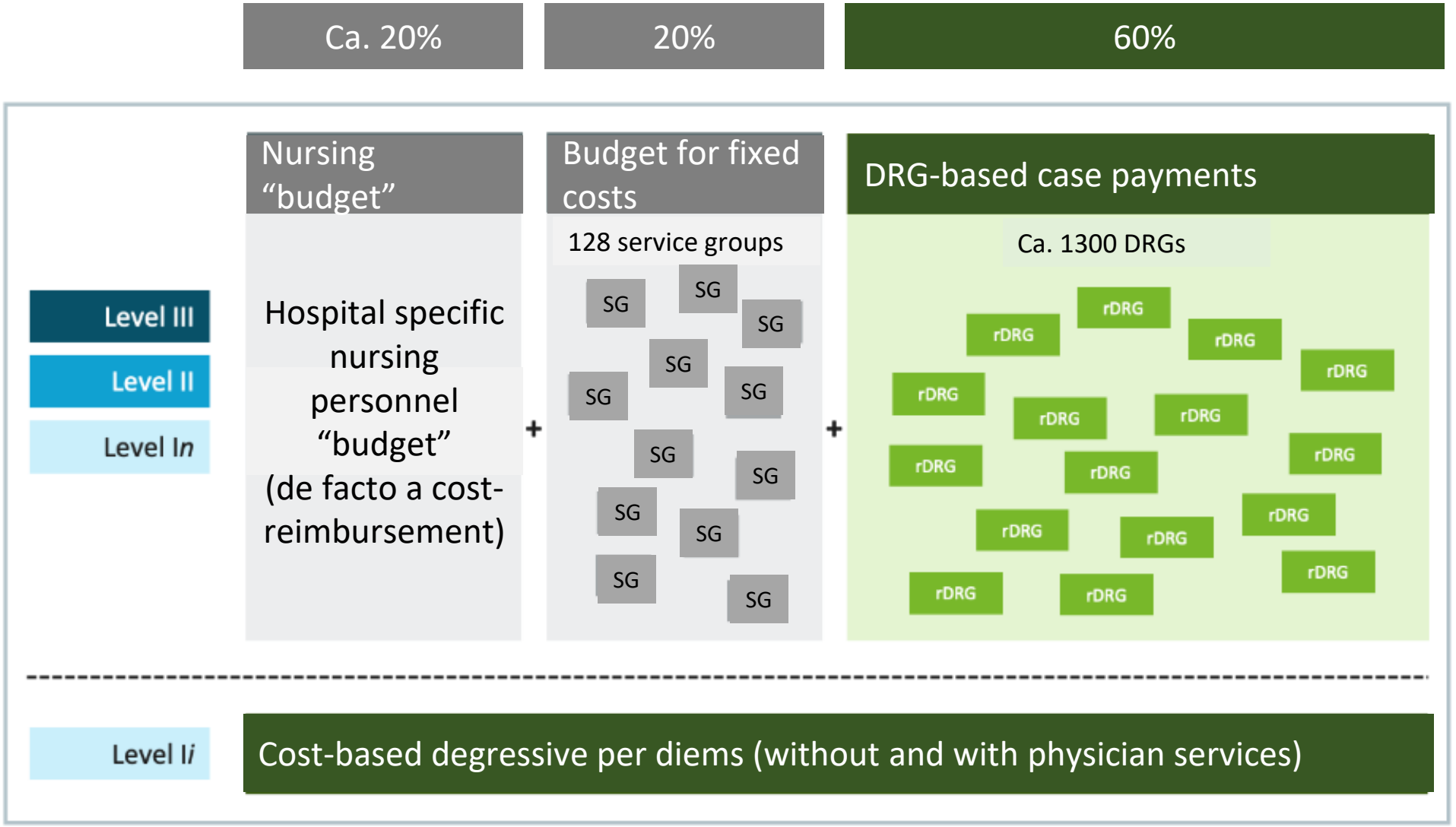
2 … with hospitals only allowed to treat patients they are equipped and staffed for



Level I hospitals within 30 minutes of Level II or III hospitals would be transformed into "integrated care centers" consisting of outpatient care (e.g. day-surgery) provided by physicians and general, not physician-led inpatient care units (e.g. for down-transferred patient) run by qualified nursing staff

Source:
Regierungskommission Krankenhaus

3 Rebalancing reimbursement further away from reliance on DRGs



Nursing "budgets" have been in use since 2020 to stimulate the employment of nurses;
rDRG = residual DRG, after deduction of ca. 40% for nursing costs and fixed costs

Source:
Regierungskommission Krankenhaus

What has happened since December?

- Trilateral negotiations (fed. MoH, government parties in parliament & 16 state MoH) started in January
- States' reaction officially positive, but opposing core parts of reform: levels: "not justified to regulate this uniformly", too many SG with too many requirements: "I need exceptions which I can define myself", only financing was approved (with 40% budget and 40% DRGs)
- Agreement on corner pieces (service groups, financing, Level Ii) in July
- "Author group" of fed. MoH and three states working over the summer, first draft reform bill available in September (long phase-in until 2030)
- Agreement in trilateral negotiations expected later this year, legislative procedure in first quarter of 2024

My resumee

- Lost opportunity because the main avenue, to classify hospitals and to close or transform (into integrated care centers) the unnecessary ca. 50% of hospitals, is not used
- That hospitals will be better off if the same amount of money is allocated to them based on different rules, is an illusion!
- States and hospitals are hoping for more money to cover deficits – but (1) this is not necessary and (2) not realistic: tax money is scarce (Ukraine, increasing interest on public debt …), and increasing health insurance contributions with federal elections in 2025 not a good idea
- We have to wait until bankrupt hospitals really close down!