The Status Quo of Senior Hospital Physicians

Welcome to Berlin.

Thank you for bringing the sun with you.

Allow me to say a few words about our current political situation before I talk about the situation of senior hospital physicians and hospitals in Germany. We are experiencing a frightening brutalization of political discourse, the likes of which we have never seen before. In the context of the European election campaign, there have been physical attacks on Members of the European Parliament in recent days, resulting in injuries in Dresden and, the day before yesterday, on the former Lord Mayor here in Berlin. There is great horror at this. But you could have seen it coming after the statements made by the right-wing AFD party in the parliaments became increasingly aggressive. It is reassuring that the suspected right-wing youths were quickly caught. But it prompts us, as well as other medical organizations, to make a clear and unequivocal commitment to the values of our democracy, against right-wing extremism, anti-Semitism and xenophobia. We stand for democracy, tolerance and humanity, especially in view of German history.

The role of senior hospital doctors in the turmoil surrounding hospital reform

Senior hospital doctors bear medical responsibility for inpatient care in Germany. They are not bound by instructions in their medical decisions. Within the framework of their employment contract with the hospital operator, however, they are employees of the hospital and not formally senior staff. This has advantages such as protection against dismissal but restricts their freedom of decision in many important matters such as staff recruitment, personnel planning and staffing. As a rule, they have a non-tariff employment contract with various forms of participation in income from revenues from patients with private or supplementary insurance when providing personal services. Running an outpatient practice at the hospital is possible in many cases but is usually limited to privately insured patients.

In addition, a share of income is generated through the achievement of target agreements. We assume that around two thirds of senior physicians have concluded target agreements. The targets should focus exclusively on issues relating to quality, organization, staff management and patient satisfaction. Length of stay is also a popular target, albeit not uncontroversial. Economic targets to increase performance are prohibited by law, but still occur. This is also since in the tense economic situation of hospitals, the already enormous economic pressure has increased further. Together with the German Medical Association, we operate a so-called coordination office to which colleagues can turn in the event of problems. This does not mean acting economically and using resources carefully. A rule of thumb applies: "As long as economic thinking serves to implement an indicated measure as economically and effectively as possible, it is required. The Rubicon is crossed when economic thinking to increase revenue influences the medical indication and the resulting medical action."

The head physician is responsible for the specialty of his department and its medical staff. For overarching issues such as quality assurance, M&M conferences, hygiene, hospital planning and

negotiations with health insurance companies, there is also a medical director, often elected alternately from the ranks of the chief physicians.

They are the supervisors of the employed senior physicians and assistant physicians in their field. In large disciplines and departments, there are additional divisions, e.g. into departments in which the respective head of the department in cardiology is responsible, for example, for rhythmology with ablations or interventional therapy. Together with the senior physicians, they are responsible for the further training of doctors. Depending on the size of the clinic, they may or may not be involved in on-call duties, the specialist background service. There are different rules for professors at the university, who have significantly more rights as directors of their clinic.

Hospital structure reform

As the Association of Senior Hospital Doctors (VLK), we represent the interests of senior hospital doctors in Germany. In this function, we support health policy at federal and state level on interdisciplinary issues relating to inpatient care.

Hospitals have a central constitutional role in the provision of services of general interest. We consider it to be one of our most important tasks to ensure that these services are needs-based, effective and of high quality with appropriate framework conditions for patients and employees. Fulfilling this is a Herculean task in the face of major financial bottlenecks in hospitals due to inflation, wage increases and staff shortages. Structural problems in hospitals therefore make reform imperative. The number of hospitals is very high by European standards, with over 50% of hospitals having fewer than 150 beds. The concentration of complex interventions in specialized facilities is incomplete. The financing of operating costs exclusively via DRGs has led to an increase in the volume of services. In contrast, there are no waiting times.

The government has appointed several experts to a commission, which has been given the task of making proposals to safeguard and improve the quality of treatment, guarantee comprehensive medical care and reduce bureaucracy and economization. All these goals have our full support, but the way to achieve them and the radical changes proposed - the Minister of Health, Lauterbach, speaks of a revolution - do not. To quote Georg Büchner's famous <Danton's Death>, one could say: "This revolution is eating its hospitals."

Financial situation of the hospitals

According to the current hospital barometer of the German Hospital Institute, over 80% of hospitals are in financial difficulties and even at risk of insolvency, as their increased operating costs due to inflation and tariff increases are not offset by an increase in the state prime rate. The Minister is deliberately thwarting a solution in order to catalyse hospital closures and mergers through extreme economic pressure. We call this a cold structural adjustment. We are calling for an adjustment of revenues to be made immediately and to take effect retroactively for 2024. The strategy of driving forward changes to hospital structures through sustained financial pressure on hospitals, including insolvency, is already jeopardizing the quality of patient care. The resulting cost-cutting measures - including for medical staff - are critical to the provision of care.

Future hospital planning

In future, hospital planning is to be based on performance groups (like interventional cardiology) that are allocated to or taken away from hospitals. Depending on the services, the structural requirements are very high. Switzerland follows a similar principle.

Dispute between the federal states and the federal government over hospital planning

Historically, there are around 1,700 hospitals in Germany, with only a slight downward trend. The federal government would like to drastically reduce this number, some even speak of halving it. However, according to the German constitution, the federal states have planning authority over hospitals. The federal government in person of minister Lauterbach here in Berlin would like to seize this because he fears that the federal states and their local authorities will only close a few sites for political reasons. The federal states, on the other hand, argue that they need exceptions to the structural criteria for the performance groups in order to ensure comprehensive care if hospitals do not fully meet them, but are necessary to ensure care. We fear that even facilities that currently provide high-quality services and contribute to the security of care will go offline as a result of the government's radical approach. This threatens to turn the provision of care under structural but justifiable restrictions into a lack of care. This is already the case in some federal states. Regional knowledge of the supply situation is a basic prerequisite for such decisions and justifies the role of the federal states in purely operational terms.

Number of performance groups and allocation

The number of performance groups is highly controversial. Originally, the experts called for 128, similar to Switzerland, but now 65 has been agreed. However, this is causing problems in many areas, as the aim is to regulate not only planning but also payment. Decisions on the allocation of sites must be transparent and made by the federal states, not the federal government. This is one of the main points of contention. Consultation with the scientific societies is difficult, as particular interests naturally come to light.

Minimum volume

At the last moment, the experts on the government commission introduced minimum quantities figures for the performance groups. This is explicitly not only about quality and preventing occasional interventions, but also about streamlining structures through high hurdles. In the planned form, they create a false incentive for increases in performance in the event that the required minimum volume is not met. A softening of indications is then pre-programmed in order to clear the hurdle. The performance incentive is far greater than with the previous DRG billing system, as it is no longer just about individual cases, but about an entire perfomance group. This counteracts all efforts to eliminate disincentives to expand services in the context of de-economization.

Limits of volume should therefore be abolished in this setting. Otherwise, corridors need to be defined that exclude both hospital-specific fluctuations in case numbers and systematic disadvantages for regions with low case numbers due to their population, and that weaken the disincentive to increase services at the limits of volume. For each minimum volume, there must be scientific evidence as to when and to what extent the quality of treatment improves. Such evidence exists for many, but by no means for all interventions.

Minimum numbers of medical staff ("provision of a constantly available specialist standard") must not lead to clinics or staff being overstretched. The structural feature introduced in the context of complex intensive care treatment: "Outside of attendance times (regular working hours), a specialist with the additional qualification of intensive care medicine must be available to the patient within 30 minutes" can no longer be met on a regular basis, even for maximum care providers. This jeopardizes the existence of intensive care units that are essential for the provision of care. The structural requirements must therefore now also permit on-call arrangements outside regular working hours. On the one hand, this means that the possible times for background services - in particular for specialists with additional qualifications - are significantly longer, while on the other hand, permanent on-call duty for these highly specialized doctors leads to a considerable fluctuation out of inpatient care.

Reducing bureaucracy

Reducing bureaucracy should be a key objective of the reform law. It is repeatedly mentioned in the text, but there are no concrete regulations for its implementation. Instead, a number of proposals, such as the mandatory reporting of staffing levels or the review of new quality criteria (structural requirements) for service groups by the Medical Service, lead to a massive increase in bureaucracy. Specifically, the inspection intervals of the medical service must be extended to at least 3 years. The coexistence of various uncoordinated regulations exacerbates the situation. The reduction of bureaucracy must be given a high priority, as it offers the only short-term opportunity to significantly relieve the burden on our staff and enable more patient care activities.

Reserve financing

Planned reserve financing aims to significantly reduce the economic pressure on medical decisions. 60% of revenues are to be paid in advance for the provision of structures and staff. In its present form, however, it does not meet this objective, neither for small hospitals nor for large clinics. The regulations with a performance corridor of plus/minus 20% lead to a false incentive for underperformance in the lower range and delays the adjustment of remuneration in the event of increases in performance. However, the latter are absolutely necessary to compensate for shifts in the number of cases due to the intended centralization of complex services and must also be counter-financed in a timely manner. This leads to a decrease in services and the creation of waiting lists.

Financing the reform

The reform itself is to be paid for by a transformation fund of 50 billion euros over 10 years. The federal states and the health insurance funds are to each pay half. They are demanding that the federal government contribute at least one third. The outcome of the dispute is completely open.

Outpatient surgery

Outpatient surgery is performed much less frequently in Germany than in other countries. This is due to poor payment in the past and a lack of outpatient follow-up structures. However, we have been able to increase the number of outpatient procedures by around 30% through numerous

measures such as hybrid DRGs and expect this figure to rise even further. There is a lot of discussion here on topics that may sound familiar: What can be done on an outpatient basis and who and where should it be done? The patient's wishes must be taken into account, as well as comorbidities, a doctor's reservation and social circumstances. None of this can be taken for granted in our system.

Outlook

You will understand that we are very concerned about this situation. We are also in favour of a reform with a substantial structural improvement in addition to greater effectiveness. However, it is completely unacceptable that such a large-scale experiment should be launched without a comprehensive care concept, without prior needs analysis and without an impact assessment, as is now the case. We are looking forward to the political wrangling between the federal and state governments or between Ministers Lauterbach and Laumann. We are looking for orientation in the revolution for continued good patient care.

Thank you very much!

PD Dr. Michael A. Weber, President of the Association of Senior Hospital Doctors