ASSOCIATION EUROPÉENNE DES MÉDECINS DES HÔPITAUX
EUROPEAN ASSOCIATION OF SENIOR HOSPITAL PHYSICIANS
EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE
EUROPESE VERENIGING VAN STAFARTSEN
DEN EUROPÆISKE OVERLÆGEFORENING
ΕΥΡΩΠΑΪΚΟΣ ΣΥΛΛΟΓΟΣ ΝΟΣΟΚΟΜΕΙΑΚΩΝ ΙΑΤΡΩΝ ΔΙΕΥΘΥΝΤΩΝ
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇAO EUROPEIA DOS MÉDICOS HOSPITALARES
ASOCIACIÓN EUROPEA DE MÉDICOS DE HOSPITALES
EUROPEISKA ÖVERLÄKARFÖRENINGEN
EVROPSKO ZDRŽENJE BOLNIŠNIČNIH ZDRAVINIKOV
EUROPSKA ASOCIACIA NEMOCNICNÝCH LEKAROV
EUROPSKA UDRUGA BOLNIČKIH LIJEČNIKA
ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ

Document :	**AEMH 09-031**
Title:	**National Report Germany**
Author :	**VLK – Prof Hartmut Nolte – Mr Gerd Norden**
Purpose :	**Information**
Distribution :	**AEMH Member Delegations**
Date :	**22 April 2009**

62nd Plenary Session of the AEMH on 8-9 May 2009 in Brussels

German Delegation Report

The German delegation will limit the scope of its report this year to three leading issues, The Privatisation of Hospitals, The Bologna Case and the Study of Medicine, and Economics and the Profession of the Doctor.

It should be added nonetheless that other important issues have also been the focus of medical policy discussion in the country in the period since the last plenary session took place in 2008. Of these, the ratification of new legislation regarding a reform in hospital financing, the threatening shortage of doctors, and the reorganisation of doctor specialisation are only three.

To turn to the first issues in our report,

1 The Privatisation of Hospitals

In 1990, the year of Germany's reunification, there were 2 207 general hospitals throughout the country, with a total of 616 922 beds.

Of these, 1 043 (47.3%) were state-run, 843 (38.2%) were run by charitable organisations, and 321 (14.5%) were privately-owned institutions.

The number of hospital beds available in 1990 was distributed as follows; 62.8% in state hospitals, 33.5% in those run by charities and 3.7% in private hospitals.

By 2005, the situation looked very different. There were now 1 846 general hospitals, of which 647 (35%) were state-run, 712 (38.6%) run by charities, and 487 (26.4%) were privately-owned.

The number of hospital beds available in 2005 reflected these changes; 51.5% were located in state hospitals, 36.3% in charitable institutions, and 12.2% in private hospitals.

Since 2005 the trend towards hospitals in private ownership - mainly at the cost of state-run hospitals - has continued until today, with the result that throughout the country, 9 private hospital chains today own 341 hospitals with capacities of over 81 000 beds. In 2007, these new, well-known hospital concerns achieved an annual turnover of €8.6 thousand million in Germany alone.

An explanation for this trend can be found in an RWI study undertaken in 2008 on the significance of privately-owned hospitals. This study revealed that as a rule, private hospitals take over state hospitals in which the financial situation is so precarious that state hospital management either will not or cannot continue to bear the financial costs. If this is indeed the case, there will in the near future be a continuation in the wave of privatisation we are witnessing in Germany at the moment. The Institute of German Hospitals reported in their 2008 Hospital Barometer that in 2007, 30% of general hospitals in Germany were running at a loss. Furthermore, the report goes on to predict a marked worsening in the figures for these hospitals in the year 2008.

Clearly, those responsible for private hospital are able to operate them more profitably than is the case with state or charitable institutions. The same RWI study indicates greater labour and manpower productivity in private hospitals, and points to the fact that a considerably lower percentage of total

hospital running costs are spent on personnel than is the case with the private or charitable institutions.

Opponents of privatisation raise the accusation that the source of private hospitals' financial success lies not only in the deliberate selection of patient groups within economically profitable specialist areas of care, but also in low quality performance and exploitation of hospital personnel. These objections are countered by supporters of the trend towards privatisation however, who point to a more efficient organisation, shorter paths in the decision-making process, and the absence of political influence exerted on hospital management in the private sector.

2 The Bologna Case and the Study of Medicine

The Bologna Resolution, signed in 1999 by a total of 29 European Education Ministers, establishes the basis for a wide-reaching reform of the European education system. In this resolution, the signatories committed themselves to an alignment of their respective university systems. The alignment is scheduled be in place by the year 2010.

The basis of the reform is, among other things, the creation of a two-tier university degree system, the bachelor degree and the master's degree. Access to a master's degree course will depend on the successful completion of a bachelor degree course, which in turn must last a minimum of three years. Since the signing of the statement in 1999, a total of 46 European countries have now adopted the resolution.

Although the implementation of the Bologna Case in Europe is clearly inevitable, there is controversy in Germany as to whether the two-tier system is suitable in the study of medicine. The 111th German Doctors Conference in 2008, after discussion with all expert medical committees, formally rejected the introduction of the new measures in the study of medicine, committing itself to maintaining the standardised study of medicine which terminates in the German State Examination.

The German Association of Senior Hospital Physicians also clearly rejects the implementation of the Bologna Case in the case of medical degree courses. The stance taken by the VLK can be summed up in the six following points:

1 The subject of medicine must remain a standardised course of study in which the subject is dealt with in its entirety. A bachelor's degree does not represent a final qualification which can form the basis of a future career in medicine.

2 The present shortage of doctors and the threat that this shortage will continue into the future is a result of both the drop-out rate and the high percentage of graduates who decide not to enter clinical medicine. This shortage can be resolved only by increasing the number of university places, by quality improvement in the study of medicine, and by making the doctor's profession more attractive. Account must be taken here of blanket-coverage availability of university courses in all Federal States.

3 Restricting access to a master's degree course in medicine by making admission dependent on the grade achieved at bachelor level, a measure foreseen by the project, is not an adequate criterion on which to base the pursuance of a student's medical studies in the master's degree field.

4 A binding, standardised examination, conducted on a federal level and independent of the individual medical faculties, is indispensible to the medical profession. A master's degree in medicine is not compatible with the requirements imposed by the state examination as stipulated in the regulations governing a doctor's right to practise.

5 Promoting mobility of students, doctors, and members of other medical professions by means of cross-European core curricula, coupled to the mutual recognition of qualifications obtained, is a desirable measure.

6 Students must continue to have the opportunity to conduct scientific research during their studies with a view to obtaining a doctorate degree on graduation, and not only at such time as their master's degree course has been completed.

3 Economics and the Profession of the Doctor

A doctor's duty to the patient is at the forefront of hospital work. This duty is embedded in an economic framework which makes necessary the implementation of entrepreneurial measures with regard to organisation and hospital management, then in hospitals too, the maxim that a patient should be cared for in an environment which best corresponds to specific requirements, on the most economic and patient-oriented basis possible, is just as valid as elsewhere.

The comprehensive catalogue of responsibilities hospital must face is therefore governed by the categorical requirements of cost reduction and cost saving, not least because the demand for in-hospital care can barely be met given the financial means at its disposal, even after the last rationalisation measures have been mobilised.

In light of this situation, senior hospital physicians - in their capacity as guarantors of high-quality, sufficient, patient-oriented and humane medical care, and at the same time as those responsible for respecting the limits imposed by tight budgets - face a genuine challenge. It is their responsibility to find the medically correct and economically acceptable path which lies between both that which is necessary and affordable, and the demands placed by actual medical requirements and the constant drive for a greater degree of rationalisation.

This challenge has led the VLK to draw up *Guidelines for the Senior Consultant* which includes the following statement:

In light of the increasing importance of financing in the areas of in- and out-patient care, the senior consultant must think and act in global economic terms.

Medical progress and a concentration of services demand structured organisational forms. The rational employment of material and personnel require from senior consultants, in addition to the medical excellence essential to their profession, organisational and above all financial skills. Given the legislation governing hospital financing and hospital expenditure, it is essential for senior physicians to know the rulings this legislation contains, as well as to understand how the repercussions of changes in statistical values, case-mix index and normative national values affect the departmental budget as well as the budget of the hospital as a whole, and how to integrate these financial considerations into the responsibilities of his work as a physician.

It follows that the senior physician must possess detailed knowledge of questions arising in the areas of hospital and human resource management, of health policy and economics, in addition to his professional expertise. Should such knowledge be lacking, he must be prepared to attend regular training and refresher courses in order to acquaint himself with these subjects and keep abreast of new developments.

In this way, the senior physician becomes a recognised expert and partner in management discussions, a necessary objective in order to create – in dialogue with the hospital finance managers - the best possible conditions not only for qualified patient care, but for the financial success of the hospital as a whole.