



**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
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DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇÃO EUROPEIA DOS MÉDICOS HOSPITALARES
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ΕΒΡΟΠΕΪΣΚΑ ΑΣΟΪΑΪΑΙΑ ΝΑ ΣΤΑΡΣΗΤΕ ΒΟΛΝΗΧΝΗ ΛΕΚΑΡΗ
ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE**

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1. The German **federal elections** for the 19th legislative period are taking place in late **September 2017**. So far, not all parties have submitted their election platforms, so that it is not yet possible to draw any conclusions about the future structure of the German healthcare system. We must wait until the elections are over and any possible coalitions have been formed. The new government programme will most likely become transparent around the end of the year.
2. In the time since the last AEMH Plenary Assembly, we been forced to deal with the effects of the **most recent large-scale legislative project** regarding the healthcare system. The following points are of interest in this context:
 - 2.1 The **anti-corruption law**. The “law against corruption in the healthcare system” came into force in early June 2016, with the intention of preventing bribery and corruption among members of the healthcare profession. In essence, the law states that any member of a healthcare profession that demands, in connection with the performance of their professional duties, a benefit for himself in return for undue favouring of another, shall be punished with imprisonment for up to three years or a fine (elements of corruption). The same applies, mutatis mutandis, if someone offers a member of a healthcare profession a perk in return for undue favouring (bribery).

The problem lies in the fact that the legislator failed to define what constitutes “undue favouring”. Hospitals that hire a fee-based physician, for example, have no way of knowing in which cases the moneys paid the cooperating physician actually correspond to the healthcare services rendered; in other words, when the fees rendered can be deemed appropriate. The legislator left this decision up to jurisprudence. The impact of this is that

an increasing number of hospital operators are uncertain, and — fearing prison terms for corruption or bribery — **are terminating cooperation agreements** or not concluding them to begin with. This is, in the opinion of the German Association of Senior Hospital Physicians (VLK), **counterproductive to patient care**, and requires immediate legal clarification.

2.2 Development of planning-relevant quality indicators

A law has been in force in Germany since early 2016 that stipulates, among other things, that quality indicators should be developed regarding structure-, process- and result-related quality by the end of 2016. **Hospitals that do not meet these quality indicators** — even temporarily — **will not be allowed to use some or all of the applicable treatments as part of their patient care.**

By the end of the year 2016, an initial list of such quality indicators in the areas of gynaecological procedures, obstetrics, and breast surgery, was submitted. This list of so-called “planning-relevant quality indicators” is now to be passed on to the German federal states that are responsible for the planning of the hospital landscape.

Hospitals that fail to meet or do not adequately fulfil these quality indicators **face potentially existence-threatening consequences.** Against this backdrop, the VLK expressed significant conceptual and content-related concerns regarding this submitted list of quality indicators. Among other things, the VLK criticised the fact that avoidable patient hazards were taken as a basis for the lack of care quality in the determination of these quality indicators. In the VLK’s estimation, a high degree of evidence is necessary, particularly for legal certainty. Proving a connection between poor quality of care and potentially damaging events must be scientifically substantiated to a very high degree.

After intervention by the VLK and other associations, this list of quality indicators — initially prepared by a scientific institution — has been revised and reduced accordingly.

In this context, the VLK continues to demand the development of meaningful quality indicators. This, however — according to VLK’s assessment — can only be achieved through the time-consuming creation of indicators for the quality of results.

2.3. Minimum quantities

Since January 2016, a law has also been in force that dictates the creation of a catalogue of plannable services in Germany, with which the **quality of the treatment results is dependent upon the number of provided services**, along with the establishment of minimum quantities for the respective services per physician and/or hospital location.

It is the opinion of the VLK that **minimum quantity guidelines are only useful** and appropriate if they serve **to prevent opportunistic procedures** being performed by providers that do not have the necessary professional, personal and factual competence, on patients receiving complex medical treatment.

If the connection between the quality of the treatment results and the quantity of the services provided is not documented by evidence-based studies, the VLK asserts that this will lead to an **inflationary expansion of the number of minimum quantity guidelines** that have cost reduction as their primary goal rather than quality improvement.

Moreover, forcing a physician to adhere to minimum quantity guidelines is, per VLK's assessment, not appropriate, as it brings with it the risk of the hospital not being compensated for treatments performed thus far if this per-patient guideline cannot be achieved, for example due to unforeseen, long-term absence of the physician (e.g. due to illness).