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
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Document :	**AEMH 06/030**
Title:	**National Report Germany**
Author :	**VLK**
Purpose :	**Information**
Distribution :	**AEMH Member Delegations**
Date :	**4 April 2006**

AEMH Delegates Meeting 2006 in Bratislava
German Delegation Report

The German delegation is concentrating its report this year on four points which, in the opinion of senior hospital physicians, have been at the centre of political discussion in the German health system during the past year.

1 German legislation governing time spent at work

In its last two annual reports, the delegation outlined the immediate reaction of German legislators to the decision taken by the European Court on 09.09.03 which, it is remembered, confirmed that the hours hospital personnel on-call spend at the work-place are to be deemed as normal working hours. In a remarkably short space of time, German law makers amended the labour laws hitherto in force in our country. The essence of the amendment was to restrict the number of hours worked per day to a strict maximum of 8, and to resolve in unmistakable terms that the time personnel on-call spend at the work-place is no longer to be judged as time off-work. This law, which took effect on 01.01.04, contains the explicit provision however that the amendment may be overridden by contrary decisions reached as a result of union and management negotiation. The legislators granted a two year transitional phase to enable any such decisions to be negotiated, during which time the salary agreements already in force remain applicable. This period has now been extended by a further year to 31.12.06.

This means in concrete terms that German legislators have themselves recognised, regardless of the planned EU Working Hours Regulation revision, that the revised personnel on-call ruling cannot possibly be implemented by 01.01.06. As a consequence, the existing interim period has been extended by a further twelve months, thereby giving management and unions the opportunity to negotiate agreements which are divergent from the in-hospital care regulations. Should these agreements not have been reached by the end of 2006 however, the work-hours legislation will come into force in its unaltered form on the basis of a maximum 8-hour working day.

2 Danger of exclusion from technological progress averted

The German health system narrowly escaped being excluded from technological progress made in the field of international medicine, because of a plan to make legislation at present

only applicable to general practitioners in future also applicable to hospitals. This legislation concerns the diagnostic and therapeutic advantages of new technologies, together with their cost effectiveness and the benefits to be derived from them.

The law applicable to general practitioners at present states that new testing and treatment methods can only be charged to the state health insurance companies if a self-governing body has made pronouncements to the effect that the diagnostic and therapeutic advantages of the new methods are beneficial, and that their cost effectiveness and the benefits of their application are acceptable.

In the field of hospital care however, innovations in international medical technology may be introduced without prior consent. Indeed, their application can only be prevented if tests carried out by the self-governing body have shown that such innovations are not in the interests of the financially viable, expedient and satisfactory care of the patient.

In the autumn of 2005 the committee representing the general practitioners, supported by health insurance companies, began a legislative initiative with the aim of making the regulations governing innovative testing and treatment methods now applicable to general practitioners also applicable to hospitals. This would have meant that in Germany, new testing and treatment methods could only have been applied to in-hospital care after they have become standard methods of practise abroad. The necessary consequence of this action would have been the automatic exclusion of the German health care services from technological progress made in the international field of medical research.

In addition, an explosive socio-political situation would have resulted, given that innovative testing and treatment methods would have been available to private patients, those who pay for health care themselves, much earlier than for patients insured under the state scheme. This would have marked a step in the direction of a two-tier medical system in our country.

Finally however, reason prevailed, and after an exhausting series of negotiations, the Ministry of Health decided that the stringent requirements which govern the use of new testing and treatment methods for general practitioners should not be introduced to hospitals.

3 Attaching over-importance to minimum numbers as an indicator of treatment quality

The German legislator, in an attempt to ensure high quality care in hospitals, has prescribed that what it terms a self-governing body should define a catalogue of services, planned in advance, in which the quality of treatment results depends to a large extent on the number of services performed. Furthermore, the catalogue is to contain minimum numbers applicable to each of the services it lists. Hospitals which do not reach the minimum numbers imposed by the catalogue during the course of one year will thereby not be permitted to charge such services to the state health insurance scheme in the future.

The German Association of Senior Hospital Physicians is, together with other institutions, vigorously opposed to this measure and, within the framework of parliamentary legislative procedure, has protested in the strongest possible terms, stating that a strict correlation between the number of services performed and the quality of these services has never been scientifically proved, and that international literature is not able to provide any relevant threshold values. Nevertheless, this ruling has been in practice since 01.01.04, with the result that health insurance companies are naturally attempting to set relatively high threshold values for the different categories of services with the intention of effectively reducing the number of hospitals which are able to offer them, and at the same time considerably reducing their costs.

To date it has been possible to maintain the number of categories affected by the minimum numbers ruling at a very low level, thereby counteracting the threat posed by the ruling of a serious reduction in the number of hospitals offering care in these categories, and of a serious restriction in the balanced spread of hospital care throughout the country.

The following example illustrates the real extent of this threat. Health insurance companies have stipulated a minimum number of 30 planned operations in the case of aneurism of the abdominal aorta. Should this minimum number of 30 operations required by the insurance companies become standard for the 493 hospitals in Germany which at present care for this condition, 85% of them would be forced to abandon such services. The minimum number ruling with a threshold value at this level would necessarily lead to a huge concentration of hospitals performing such operations. Only about 75 hospitals in Germany, those located in densely populated areas of the country, would then be in a position to care for this

condition. The effects of such a ruling on emergency care in the large federal states, as well as on the quality of care for patients living in these areas, would be tremendous.

The German Association of Senior Hospital Physicians, together with the Association of German Hospitals, is at present fighting in the relevant committees of the self-governing bodies against the health insurance companies in order to bring about a departure from what the German Association of Senior Hospital Physicians sees as the ill-fated ruling regarding minimum numbers, arguing that the level of performance aimed at can be achieved by employing other characteristics such as those regarding structural quality and the quality of results. It remains to be seen whether the battle will be won.

4 Shortage of physicians in the German medical system

The Federal German Medical Council and the Federal Association of State Health Physicians have now presented the third phase of their study dealing with age structure and development in the numbers of physicians in the German medical system. This study shows among other things that the average age of general practitioners and hospital doctors continues to increase, a trend which results from the drastic decrease in the percentage of younger doctors. We have now reached a situation in which almost only one in every six practising doctors is under 35 years of age.

At the same time the number of next generation doctors is dropping, despite the fact that the overall number of students starting their studies has, over the last 9 years, remained relatively constant. The total number of medical students however has continued to decline almost continually, as has - over the past 10 years - the number of those completing their studies. The reason for this development can be seen in the constant increase in the numbers of students who prematurely end their studies and those who change subjects.

For general practitioners, this situation is aggravated by the fact that in the near future we will experience a retirement wave of huge proportions, resulting in a drop of 57 000 in the number of general practitioners by the year 2015 from their present number of 118 000.

The study estimates that by 2010 a total of some 40 300 doctors, of which 8 600 are employed in hospitals, will need to be replaced in the German health system. By the year 2015 this number will increase to a total of approximately 74 500, of which 17 200 will be employed in in-hospital care.

This situation is all the more alarming given the urgent need to increase the number of physicians required to deal with the added treatment burden resulting from changes in the morbidity spectrum and the increase in multi-morbidity.

Vacant positions cannot be filled from the pool of unemployed doctors, given that the number of doctors registered as unemployed has been continually on the decrease since 1997. We have reached a point in time where we can speak of over-employment in this area of the medical profession.

The report ends by identifying a noticeable increase in the number of doctors from abroad who have, since 2002, migrated to Germany, particularly from eastern European countries. It is clear that this increased migration is the result of direct recruitment on the part of German hospitals which would not otherwise be able to fill vacant positions, indicating that the German health system is becoming more and more dependent on the import of doctors from foreign countries.