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ASOCIAȚIA EUROPEANĂ A MEDICILOR DIN SPITALE

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Country Report Germany VLK

COVID-19 care

For the past year, the situation of hospitals in Germany has also been shaped by the care of patients from the corona pandemic. Currently, Germany is in a third wave, but this seems to be slowly subsiding. Since mid-April, the numbers have stagnated at a high level and have been declining slightly for a week with a 7-day incidence at last (02.05.2021) of 146.5 corresponding to a case load of 121,853. Approximately 7% of patients are hospitalized, with a declining trend since the first wave. Currently, about 5,000 of the patients are in the ICU, a good half of them ventilated. Approximately 20,000 are in general wards or in infection wards that have been converted for this purpose. Since the beginning of the pandemic, a good 200,000 COVID-19 patients have been treated in German hospitals, 40,000 of them in intensive care, more than 50 % with ventilation treatment. The regional differences in the load of the hospitals are enormous, corresponding to the different extent of the infection. Increasingly, the great importance of social hotspots with cramped living conditions is crystallizing as a particular catalyst for the occurrence of infections. However, there has been no total overload, and in some cases, it has been possible to take on patients from abroad. Processes and collaborations for patient management in the event of overcrowding at individual sites have been established. Approximately 60% of the patients were treated in the main or maximum care facilities, 40% in the basic and standard care facilities. Currently, about 20% of the intensive care capacity is still occupied by COVID-19 patients. Since the beginning of the vaccination campaign, the age structure of the hospitalized patients has become significantly younger; the average age of intensive care patients is now around 60 years. However, because younger patients have significantly longer lengths of stay in the ICU, there has not yet been a substantial reduction in the burden there. The burden on hospitals and intensive care units has been enormous for more than a year.

According to a recent survey of senior physicians by the VLK, the following assessments emerge: 22% of hospitals continue to be at the limit in terms of intensive care, 53% manage it with considerable restrictions. In up to 50%, the capacity of the higher-level centers is limited, 33% of the hospitals have had to take over patients from there.

Numerous elective procedures had to be postponed maintaining adequate intensive care capacity; for example, scheduled elective procedures decreased by about 15%, but emergencies such as myocardial infarctions and strokes also decreased because patients did not seek out the hospitals. A waiting list for postponed procedures exists at 80% of hospitals, especially the large ones. It is estimated that these waiting lists can be worked off in over 90% in 3-6 months.

By placing them in the highest priority tier, hospital staff have been vaccinated early at over 80%. This important protection for staff health has also led to a decrease in staff absences due to quarantine or infection.

Since the beginning of the pandemic, hospitals have been supported by the government with a total of €10.2 billion in tax revenue to offset the higher costs under COVID-19 treatment and the huge drop in occupancy. In somatic hospitals, this has resulted in a revenue increase of 3.7%, and in psychiatric hospitals, 10.6% in 2020. Additionally, there is a projected revenue shortfall compared to 2019 occupancy. Support measures have now been significantly reduced and will continue for the time being until the end of May 2021.

Post-pandemic perspectives

Due to its high number of hospitals and intensive care units by international standards, Germany was in a comparably favorable starting position. The capacities of intensive care units and ventilation facilities in particular have been increased significantly. The limiting factor was and still is the shortage of personnel, especially in the intensive care units. There are fears of a further thinning out due to fluctuation after the end of the pandemic as a result of the continuing overload.

But even though the hospitals have done their job more than well, there is clear criticism of the existing hospital structure alongside praise for their tireless efforts. The Federal Minister of Health speaks of care that is not in line with demand. Criticism focuses on an allegedly excessive number of small hospitals in particular, and thus a lack of centralization. The aim is also to significantly increase the numbers of outpatient procedures that were previously performed as inpatient procedures. A special feature of this is the so-called double specialist track in Germany, whereby outpatient specialist care is predominantly not provided at hospitals.

The DRG financing concept has also come in for particular criticism. Since it exclusively rewards services rendered, it leads to a considerable volume incentive and economic pressure also on medical decisions. Nursing costs were already removed from DRG financing last year in order to guarantee sufficient nursing staff. This is flanked by additional nursing staffing ratios, which prescribe a minimum key for nursing staffing. Correspondingly, disproportionate cost-cutting efforts are now being made by hospital operators in the medical staff.

The economic pressure is to be countered by taking into account the costs of maintaining the hospital in the DRGs. Investment financing by the federal states has also fallen far short of what is necessary for years. This is a sensitive issue since the states have planning authority for hospitals. The federal government is attempting to undermine this through federal legislation and to push ahead with hospital structural reform through excessive structural requirements and overregulation. This is being fueled by demands from the health insurance funds and their supervisory body, the Medical Service, which intervene significantly in the provision of services and the payment of hospitals through structural and billing audits. Naturally, high quality requirements are the focus of the efforts of physicians, the government and health insurers. In some cases, however, structural and quality requirements are being exaggerated and misused for structural adjustment. In view of an emerging revenue and financial crisis for health insurers in the coming years due to the effects of the pandemic, enormous pressure for change can be expected here after the elections in the fall of 2021.

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