

Reforming the German hospital system: A paradigm shift in patient classification?

Patient Classification Systems International

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What are the implications of the hospital reform in Germany?

16.8 mio.

Patients are treated in German hospitals per year in round about

1.660 hospitals

The reform aims to reduce treatment costs in hospitals

Quality of service provision should be improved by including

quality indicators

£132.7 bio.
hospital costs arise yearly.

The federal states continue to see no common ground with the federal government [...]. In particular, the 16 ministers have renewed their fundamental criticism of the law's approval requirement, the implementation deadlines and the new remuneration system.

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Planning mechanism shall use Medical Service Groups as planning objects, not only bed capacity as well as medical (specialty) departments



The hospital reform aims for a more balanced distribution of workforce, services and infrastructure

Care is equally accessible for the population

Concentrated and specialised hospital landscape









Quality of care is measurable and comparable

Hospital's management is controllable



Balanced distribution of workforce, services and infrastructure



Hospital staffing capacities are strengthened

High-quality care is provided coordinated at the right time at the right place





The provision of care is financially sustainable



The stakeholder for a successful capacity planning are various



Overarching vision for capacity planning and a capacity plan with defined volumes, planning criteria and planning objects

Ministry of Health, German Hospital Federation, National Association of Statutory Health Insurance Funds, ...

Capacity is distributed and described in a "list". Regional needs specialties in medical supply are included

16 federal states with their political programs

Strategic mission is transferred into small, adjustable variables per hospital, staff and cases can be reallocated based on individual needs per hospital < 1.660 hospitals in different and complex shareholdercombinations



Hospital capacity planning can follow different approaches

Modelling and allocating hospital capacity may follow two different methodological approaches. However, bed-related planning approaches, although still used in many healthcare systems around the world, have limitations.



Bed-related planning approach



- Planning merely based on demand
- Quality aspects are only considered to a very small extent, if at all



- Typical determinants considered for planning: Population size, length of stay, overall hospital frequency, and bed utilization rate
- Planning object: Medical specialties (e.g. cardiology)
- Planning unit: Bed numbers
- Well-established, therefore easy to apply
- Bed numbers do not reflect the actual supply needed and disregard the workforce actually required to take care of the patients



Quality- and demand-oriented approach for capacity planning



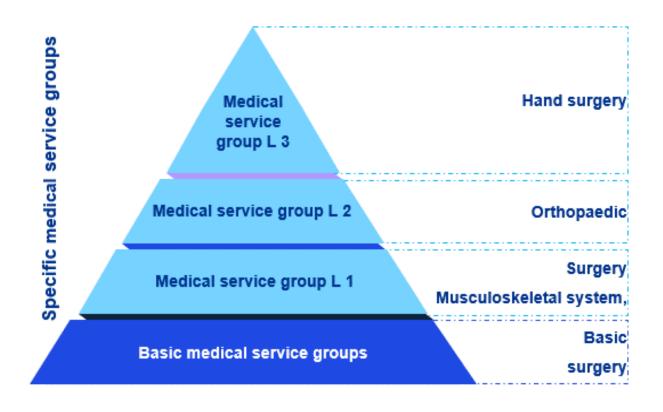
- Planning based on demand <u>as well as quality</u> and performance of the hospitals
- Allow the implementation of minimum quality requirements



- Determinants considered for planning: Typical determinants and specifically designed qualityrelated planning criteria
- Planning object: Medical specialty departments or medical service groups
- Planning unit: Case volumes
- Allows a strategic long-term view and accounts for demand <u>and</u> quality of supply
- At the beginning: Higher effort to implement



Medical service groups can be distinguished between basic and specific service levels

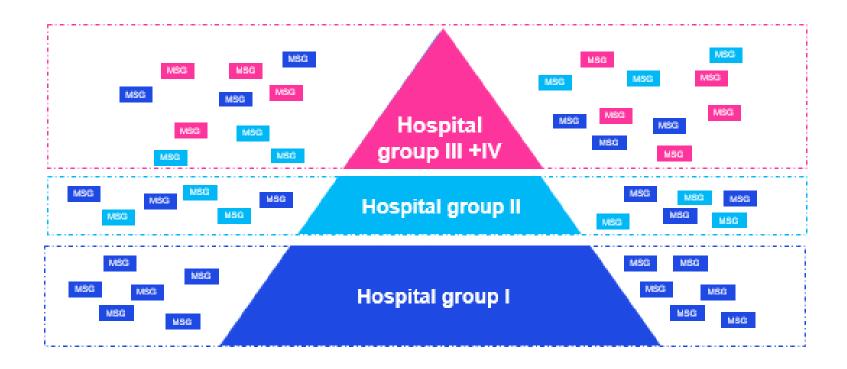


The basic medical service group forms the **foundation for the more specific** medical service groups, resulting in a pyramidical hierarchy of medical service groups.

Higher levels in the pyramid involve a higher level of complexity and required specialization with regards to e.g., training and medical equipment.



These service level will be reflected in the service level of hospitals leading to reshaping the hospital landscape





Executing a capacity planning based on medical service groups consists of detailed sub steps

Standardized care pathways and expert committees can support hospital networks in precise planning when applying for regional capacity.

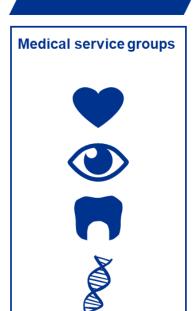
Define planning objects

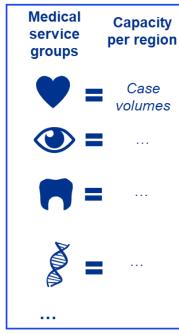
Define total capacity per planning object per region

Define planning criteria

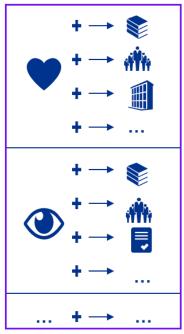
Assign planning criteria to planning objects

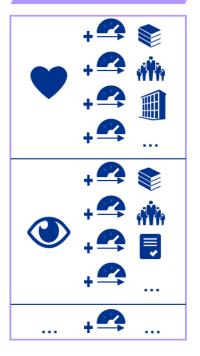
Set thresholds per planning criteria of each planning object





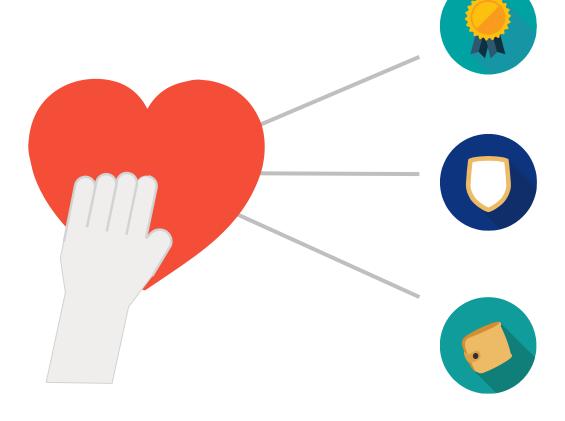








The new reform aims to incentivize quality and optimize incentive structures in hospital planning



Improving quality of care

Set quality standards, e.g., minimum volumes, will need to be maintained.

Securing existence of hospitals in rural areas

Improving cooperation between hospitals and other healthcare facilities and strengthening care in rural areas to prevent further hospital closures

Less bureaucracy for hospitals

Relieving hospitals of bureaucratic burdens and improving working conditions for medical personnel



In a nutshell, the reform will lead to various adjustments for the German hospital market

Reimbursement based on DRG

Capacity planning based on demand with beds as planning objects

Hospital planning on federal state level

Focus on profitability

DRG + contingency budget based on service levels

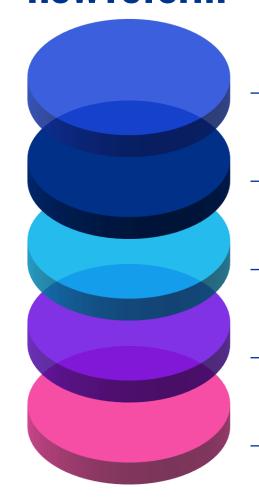
Number of cases per medical service group

Taking (federal) cross-border patient movement into consideration

Focus on quality



Several uncertainties arise about the implementation of the new reform



Data requirements for qualitative measurements

From DRG data to service groups

Forming of service groups

Uncertainties about the development of costs for patients

Improvements in the provision of care in rural areas still unclear

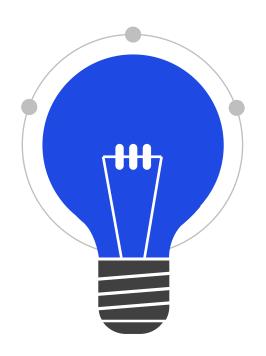


Discussion

What is the impact of implementing medical service groups for patient classification?

Which disincentives we can expect from this reform?

Other countries in Europe considering a similar capacity planning approach, would it be suitable for your region?



Which support/measures are required to make this reform successful, e.g., for service provider?



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