

# Per case payment in Germany: all in a mess

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## Abstract

*In 2000, the German government legislated a change to per case payment by DRG, and devolved the responsibility for design to an industry group of hospitals and insurance companies. In June 2002, the industry group formally announced that agreement could not be reached, and the Ministry of Health has consequently taken direct control. We argue that important decisions are consequently being made in haste (with significant risk of errors) and that sole-sourcing of some preparatory tasks (for reasons of time pressure) has disturbing aspects.*

*We suggest three factors that might have contributed to this unfortunate state of affairs. First, Germany did not establish a largely independent research and development program of the style applied in Australia. Second, there was a failure to recognise at an early stage that the industry group was unlikely to reach the consensus required by its terms of reference, if only because of the significant competitive aspects of most elements of the design. Finally, too little was done to address the pervasive culture of mistrust between and among hospitals and insurers. We suggest that there needs to be talk about the process of talking if design work is to be more successful in future.*

## The plan: transition to per case payment from 2003

In May 2000, the German federal government enacted the Statutory Health Insurance Reform Act (GKV Gesundheitsreformgesetz 2000). It specified that payments for nearly all types of hospital inpatient care would have to be made on a per case basis from 1 January 2003, and that cases must be categorised by Diagnosis Related Group (DRG). Per case rates would initially be hospital-specific, but national rates would be introduced over a four-year transition period.

The main aim was to improve control over clinical practice variations, and in particular to eliminate the incentives for over-servicing that were a consequence of payment for itemised services including days of stay. An element of per case payment had been introduced in 1995, but it covered only a small number of well-defined procedure (surgical) case types accounting for less than 25% of hospital budgets.

The task of design and implementation of the new payment model was devolved to an ad hoc industry body termed the Self-Administration Group (the SAG below). Members of the SAG comprised the hospital association (the German Hospital Federation) and the federal associations of the statutory and private health insurance funds.

One of the initial decisions of the SAG was the selection of Australian DRGs (AR-DRG version 4.1) as the basis for classification (Hindle & Lenz 2000). In 2001, the SAG established its own technical support agency, the German DRG Institute (InEK), with the intention that it would conduct research to inform the design process.

The DRG Introduction Act was passed on 1 March 2002 for the purpose of specifying aspects of detail of the new payment model (Bundesgesetzblatt I-27 2002). Inter alia, it specified a more detailed timetable, processes of audit and payment by the health insurance funds, rules for minimum volumes of procedures necessary to result in per case payment by DRG, and processes for data quality control.

Of particular importance here, the Act postponed mandatory participation by one year. Under the so-called 'optional 2003 model', hospitals and insurers could begin in 2003 if they so desired. Thus every hospital would have the right to be paid on a per case basis by DRG, or as before by itemised billing. The SAG was directed by the Federal German government to determine the details of the 2003 model.

## The failure of self-administration

After two and a half years of research and regular meetings, the SAG admitted it could not implement the task it had been given by the Federal government (Rochell & Roeder 2002a). The key formal announcement of failure came from the German Hospital Federation on 24 June 2002, which simply stated that agreement on the structure of the optional 2003 model was "not possible." However, the writing had been on the wall for some time. Deadlines were repeatedly missed, and agreement on even the most neutral of issues often took a surprisingly long time.

There were many technically difficult matters to address. The most general was a lack of precedence. In contrast to the task of Australian state health authorities, the German model required agreement between multiple insurers and large numbers of hospitals with various owners – both government and non-government, and for-profit as well as non-profit. In contrast to models in (say) the United States and Canada, the payment covered both hospital and medical specialist services.

Moreover, the German legislation required the use of a more comprehensive per case payment model than had been previously applied anywhere on a countrywide basis in a single step. Inter alia, it specifically required inclusion of cases that involved expensive implants, high-cost drugs, intensive care, neonatology, surgery of the spinal column, major burns, palliative medicine, and the treatment of chronic diseases. Only a few exceptions (including blood factors, dialysis, and psychiatric care) are defined in the Act. While hospitals and insurers may negotiate other exceptions, they are very tightly limited by the legislation.

However, technical complexity has probably been overstated by many parties. As we noted earlier, there was to be a four-year transition period to price equalisation, and experience in Australia and elsewhere has shown that hospital managers can respond rapidly and intelligently to challenges that are clearly defined and in a stable context.

In short, we do not believe that complexity has been the main cause of failure to reach agreement. Rather, it appears to have originated in two related features of the German health sector: fear of a significant increase in competition for market shares and profitability, and a culture of mistrust.

The existing model is so highly regulated that competitive risk is minimal for most hospitals and most insurers. Indeed, the rules have encouraged a simple battle between purchasers on the one side and care providers on the other: if one insurer won then they all won, and so on. The idea that insurers and care providers are mutually dependent components of a single production system is not well accepted in Germany.

The new model would present a much higher degree of risk than many parties were prepared to tolerate, and has increased the number of battlefronts. Hospitals that traditionally stood shoulder to shoulder are now more likely to be suspicious of each other in private.

One factor is that there are too many hospital beds, and the new model is obviously intended to encourage efficiency improvements and the closure of hospitals or some of their parts. For example, Australia had 7.1 acute beds per 1000 population in 1987, and this declined by 43.7% to about 4.0 per 100 in 1997. Over the same period, the number fell by only 30% in Germany, from 7.5 to 5.2 per 1000. According to the OECD, Germany had more than twice the number of acute inpatient bed-days than Australia in 1997 (2.1 compared with 1.0 per capita).

Thus the negotiations about the new payment model have frequently involved dispute around technical issues on the surface, when the real battle was about relative profitability and size. Hospitals that privately believed they would gain relative to other hospitals under one type of model were in favour of immediate implementation, whereas the potential losers would argue for delayed implementation – in order to collect more data, prepare more and better computer systems, educate their clinicians, and for whatever other reason might seem plausible.

A similar battle was occurring among the insurers, and therefore coalitions of interest were formed one day and dissolved the next. Given that the members of the SAG were required to act unanimously by its terms of reference, it was hardly surprising that it would fail.

## The Federal Health Ministry takes over

One week after the failure of SAG negotiations became public, the permanent secretary of the Federal Health Ministry announced he would draft an executive order with respect to the 2003 model, and make it available no later than September 2002 (Schaich-Walch 2002). The order would cover essential elements of the 2003 model including DRG definitions and cost weights, and aspects of billing, auditing, and payment. The Ministry argued that this would allow hospitals sufficient time to enter into agreements on per case payment for 2003.

Thus the Ministry has set itself a tight schedule, and is being lobbied by most agencies. Its difficulties are compounded by initiation of the campaign for the federal general election, which will take place on 22 September 2002, and in which the main parties are running neck-and-neck.

The situation is therefore far from comfortable for the Ministry, and it has had to take some hard decisions. First, it decided to contract InEK to provide advice and undertake research as necessary. Second, the Ministry chose to make a set of sole-sourcing decisions in concert with InEK, which have been criticised by some parties on both technical and legal grounds.

One involved contracting a company to construct the mapping between the German procedure classification (OPS) and the Australian ICD-10-AM procedure classification. The same company was contracted to produce the DRG definitions manual. The Ministry claimed this was necessary if only because several attempts at mapping had been made by other groups, and had been found deficient in some way. This appears to be a fair reason for the Ministry's concerns: each of several parties (hospitals, insurers, specialty hospitals, etc) produced its own versions of the mapping tables, and the results were inconsistent – either for reasons of error or (more plausible) for reasons of vested interest. Thus it was wise to specify a single (and presumably more objective) agency. It was less sensible to wait for two years and then to sole-source in a crisis.

The Ministry also contracted a company, without competitive tendering, to produce the DRG cost weights from a variety of data sources including costing studies at 283 hospitals that the SAG had initiated in early 2002. This change was not popular among the hospitals: many of them (including all the university hospitals) withdrew their data from the study. Moreover, most competing companies understandably cried 'foul' – given they believed they were more experienced in cost data analysis than the selected company, and they feared a decline in their competitive position.

The Ministry is bound by national and European Community laws, which are interpreted to require open tendering for the large fees involved. However, it has argued that its actions were justified by the high degree of urgency and the selected contractors' special expertise. Several other companies have indicated they are likely to take legal action, and the Ministry has taken the almost unprecedented step of undertaking to protect the contracted companies from financial consequences – that is, to indemnify them with respect to any damages as a consequence of legal defeat.

The technical challenges for the Ministry and its contractors are far from trivial, since many essential tasks have barely begun or are not yet started at the time of writing. The only essential work that has been satisfactorily completed comprises finalisation of the DRG classification (which is essentially no more than AR-DRG version 4.1), the coding guidelines for 2002 (also modelled on Australian guidelines), and the method of calculation of costs and cost weights and the associated calculation handbook for 2002 (which is available on [www.g-drg.de](http://www.g-drg.de)).

Incomplete work includes the procedure mapping, calculation of the DRG cost weights, and production of the DRG definitions manual (as noted above). It also includes the establishment of a data reporting and processing system within InEK, and finalisation and accreditation of DRG Grouper software.

Work that has barely started includes several analytical tasks, such as validation of the procedure mapping and calculation of thresholds for high length-of-stay outliers. Other more contentious tasks need to be completed, such as precise specification of exclusions from per case payment. The Ministry has attempted to obtain expert

advice, both from within and outside Germany, but there is a widespread view that many important aspects will be based on little more than opinion and guesswork.

And there is more. It is particularly worrying that the political opposition parties most likely to take control if the current government falls in September have announced they would revise the legislation and postpone the introduction of per case payment by DRG. Finally, there is the broader economic context: the financing of the social security system as a whole has been seriously affected by the general economic downturn in Germany over the last two or three years – that has included higher unemployment rates than almost everywhere else in the European Community, and higher than Germany has had in living memory. Hospitals and health insurers would feel under pressure regardless of the chaotic state arising from the DRG legislation.

## Dealing with the uncertainty

There are daily expressions of concern from both the care providers and the insurers. Threats are common, as are warnings of inability to pay or to provide services. Most hospitals and insurance companies are proceeding with their own preparations, but there are obvious problems in terms of a lack of direction. As Neubauer and Kampik (2001) put it, so many elements of the new model are unclear and "... hospitals are having to prepare for the new system like a pilot flying blind with no instruments."

The concern is not restricted to acute inpatient care. Indeed, many people believe the greatest risks relate to unintended and largely unexplored flow-on effects to other parts of the health care system. In comparison to many other countries (Rochell & Roeder 2000) including Australia, Germany has little flexibility in terms of reallocation of funds between sectors – and between acute inpatient, rehabilitation, and outpatient services in particular. There are contractual and legislative constraints, as well as structures and processes that have been designed and operated with the deliberate intention of protection of particular funds.

One example of the claimed dangers relates to psychiatric care. For example, Fritze (2001) argues that the new model will result in the transfer of components of psychiatric care and thus costs to institutions not covered by the DRG system. He also claims that psychiatric inputs (including consultation-liaison services) will be undervalued. Similar points are made by Wrobel & Pientka (2001) with respect to geriatrics.

Another example is rehabilitation. It has been argued that per case payment for acute inpatient care will encourage earlier discharge of patients to rehabilitation, and that this will inevitably lead to higher treatment costs for the same rehabilitation outcomes (Rochell & Roeder 2002b). Rehabilitation providers fear they will be unable to obtain increased payments, and have therefore said they may have no option but to refuse transfers from acute inpatient facilities of patients whom they believe are not ready to begin rehabilitation care.

## Conclusions

It made sense to plan a change towards per case payment by DRG. Many of the obvious inefficiencies (as reflected in longer lengths of stay and higher per case costs than Australian hospitals) are a direct consequence of imprecise methods of definition of episodes of care and the payment incentives for over-servicing.

This said, it was obvious that great care would be needed: the change would be more difficult to make than it proved to be in Australia and elsewhere. In the event, there is every reason to believe that a fundamental change with respect to the annual allocation of 50 billion Euros has been badly managed. There has been no equivalent process to that in, say, Australia – whereby hospitals and purchasers first became familiar with DRG data and the way those data defined performance, transition paths were determined that protected all parties from sudden changes in costs and revenues, research was undertaken to evaluate optional models, and so on.

It is far from easy to understand why this sad state of affairs has arisen, but four factors occur to us. First, there has been no adequate basis for objective and scientific research, in spite of the assurances within the legislation that implementation would be founded on the findings of careful investigation.

Australia was relatively successful in this regard, in that the Casemix Development Program not only provided funding for research and development but also ensured there were many recipients of funding that could at least present different perspectives and at best remove themselves from any sectional interests. The situation in Germany has been quite different. It is not only that the timescale has been shorter. More important, the design and direction of research has been mainly in the hands of the SAG, where sectional and largely commercial interests have sometimes predominated over objective enquiry.

Second, the SAG was always bound to be a poor instrument for the design of change. In particular, the culture of its members was not conducive to open and honest collaboration. For example, many representatives of insurance companies saw their aim as hoping that good ideas were presented by their competitors rather than as contributing to the general good.

Third, there has been a continuing environment of mistrust. In spite of attempts in Australia's government health sector to separate purchasing from care provision over the last decade, the traditional appreciation of mutual dependence has remained largely intact. Pointless fighting between German insurers and care providers is a more deeply ingrained tradition. As a consequence, the obvious gains for all parties from the proposed changes have seldom been recognised and are proving almost impossible to realise.

Finally, it was probably unwise of the German government to apply the principle of corporatism in this case. The transfer of legally defined rights of governments to corporative self-governed institutions has delivered many benefits in the health care sector in the past (Schwartz & Busse 1996). However, it has often been the case that complicated design tasks that have major implications in terms of the shifting of wealth have been frustratingly difficult to manage. Representatives of the Ministry were able to observe the initial stages of operation of the SAG, and this experience alone should have sufficed to cause it to doubt delegation in this instance. When the Ministry finally realised its mistake, it found itself in a situation whereby political losses seem inevitable.

In total, we see little opportunity to resolve the difficulties in the near future. It will help if some hospitals and insurers proceed anyway, on the basis of doing what seems to be in their collective interest. If so, then the sense of frustration over being under the control of designers they consider incompetent may be replaced by purposeful operation, and evidence of success (or at least the absence of disaster) may encourage others to follow suit.

It would certainly be helpful if the main parties decided to spend a little time talking about the process of talking, along the lines that are illustrated elsewhere in this issue of AHR (Hindle and Natsagdorj 2002). The idea of a single body of representatives of the interested parties is fundamentally sensible: the problem was not that the SAG existed, but rather that it needed to learn a different way of conducting business. We have suggested that it should spend time on this, but thus far have not been able to convince the majority that it is needed.

## References

- Bundesgesetzblatt I-27 2002, Gesetz zur Einführung des diagnose-orientierten Fallpauschalensystems für Krankenhäuser (Fallpauschalengesetz FPG (Official bulletin I-27 2002, DRG Introduction Act). (<http://www.bmggesundheits.de/downloads-gesetze/gesetzlichekrankenversicherung/2000/uebergkv.htm>)
- Fritze J 2001, G-DRG: the German-modified AR-DRG system as a complete case-associated hospital reimbursement system according to section 17bKHG: must it apply to psychiatry? *J Nervenarzt*, vol 72 no 6, pp 479-83.
- GKV Gesundheitsreformgesetz 2000, 22 December 1999 (Statutory Health Insurance Reform Act 2000 (<http://www.bmggesundheits.de/downloads-gesetze/gesetzlichekrankenversicherung/2000/uebergkv.htm>)
- Hindle D and Lenz M 2000, Germany and per case payment using Australian DRGs: a commentary, *Australian Health Review*, vol 24 no 1, pp 136-47.
- Hindle D & Natsagdorj T 2002, Treating organisational illness: a practical approach to facilitating improvements in health care, *Australian Health Review*, vol 25 no 6.
- Neubauer AS & Kampik A 2001, Application of diagnosis related groups (DRGs) in ophthalmology in Germany, *J Ophthalmologie*, vol 98 no 9, pp 900-4.

Rochell B & Roeder N 2000, DRG-based funding systems in Europe, *Krankenhausreport* 2000, Schattauer Verlag.

Rochell B & Roeder N 2002a, DRG Introduction Act (FPG) - Wrong planning?; *ZaeFQ*; , vol 96 no 8, pp527-538.

Rochell B & Roeder N 2002b, A DRG-based future hospital funding scheme: state of implementation and impact in the field of rehabilitation, *J Rehabilitation* (Stuttg), vol 41 no 1, pp 1-9.

Schaich-Walch G 2002, Speech of permanent secretary Mrs. Gudrun Schaich-Walch on 2002-06-28 at the Federal Congress of the German Private Hospitals in Berlin;  
<http://www.bmgesundheit.de/presse/reden01/280602.htm>.

Schwartz FW & Busse R 1996, 'Fixed budgets in the ambulatory care sector: the German experience' in FW Schwartz, H Glennerster & RB Saltman (eds) *Fixing health budgets: experience from Europe and North America*, Wiley England.

Wrobel N & Pientka L 2001, AR-DRG effects on geriatrics in Germany, *J Z Gerontol Geriatr*, vol 34 no 3, pp 176-82.