Pauline Wilbert BSc
Dr. rer. pol. Hans-Christian Vatteroth
Christina Grün BSc
Prof. Dr. rer. pol. Hans-R. Hartweg

Reform of hospital financing: revenue-independent flat rates for acute inpatient obstetrics facilities

Since 2003, hospital services have been remunerated using the G-DRG (German Diagnosis Related Groups) flat-rate remuneration system based on case volumes (Section 17b (1) sentence 1 KHG/Reimbursement Institute 2023). Diagnosis, severity of illness and the operations and procedures performed are entered into the patient classification system for grouping (Reimbursement Institute 2023), along with other parameters where applicable. Although other countries, such as the United Kingdom, Finland and the Netherlands, also use DRG systems, there is a strong performance and volume incentive in Germany compared to othercountries1 . Despite the additional refinancing of care through the care budget introduced in 2020 (Reimbursement Institute 2023), there is no case volume-independent refinancing of necessary provision (Federal Ministry of Health 2023).

>> In Germany, around 98.5% of all births take place in a hospital and 1.5% of births take place outside the hospital, in birth centres or at home (Federal Ministry of Health 2017). Obstetric services are therefore mainly mapped via the DRG system. The aim is to use the DRG system to map the services actually provided depending on the risk profile of the pregnant woman/parturient (Schmidt 2010). Following the introduction of DRGs, there was initially a sharp decline in the number of obstetric departments (IGES Institute 2013). While there were still 1,186 obstetric units in 1991, there were only 672 in 2017 (IGES Institute 2019). This development will be influenced by a variety of factors (Deutscher Bundestag 2018), as the introduction of a new remuneration system will lead to fundamental changes in incentive structures.

Hospitals that are part of the hospital plan and are indispensable for ensuring the provision of comprehensive basic care to the population will receive a supplement in addition to the regular remuneration via the DRG flat rates per case (Section 136c (3) SGB V). This supplement can be used to compensate for deficits that arise due to a lower demand for care. For clinics with obstetrics, the service area is determined by the populated geographical units that are within a 40-minute car journey radius (G-BA 2020). The agreement of the Federal Joint Committee (G-BA 2023) lists 57 locations that receive this award (Federal Ministry of Health 2023).

A distinction must be made between this and further guarantee supplements, whichare paid out regardless of the number of treatment cases for hospitals that are necessary for obstetric care in rural areas, among otherthings2 (Section 5 (2a) KHEntgG/G-BA 2023). Despite these guarantee surcharges, the federal states cited economic deficits, a lack of staff (midwives, doctors, etc.) and quality deficits as reasons for the closure of obstetric wards (Deutscher Bundestag 2018).

As the data from the costing centres only relates to normal beds, the calculation methodology of the flat rates per case was directly questioned. The refinancing of long-stay patients (high-risk pregnancies, etc.) causes a high consumption of resources (Beckmann et al. 2011). The flat-rate payments per case do not do justice to specific services, such as those provided by level 1 perinatal centres (Grüßner/Gembruch 2011).

1: Reform proposal and relevance for obstetrics

To date, the nationally applicable remuneration agreements do not mesh with the state-specific plans. Needs-based, quality-orientated service provision and optimal allocation of patients to care services are not compatible. The reform proposal therefore provides for a link between the remuneration system and hospital planning. The aim is to achieve a uniform definition of care levels, a system of service groups and a reduction in the volume component in favour of reserve financing (Federal Ministry of Health 2022).

In future, hospital care is to be based on uniformly defined care levels throughout Germany. The care mandate of a hospital will be allocated regionally and independently of a hospital location at the level of service groups instead of the previous specialist departments. The individual levels are subject to defined minimum structural quality requirements (Federal Ministry of Health 2022). To this end, 128 defined service groups are prescribed in accordance with standardised national minimum requirements for the provision of services. The service groups are organised in such a way that the treatment within a group requires similar qualifications, skills and technical equipment. Each service group is allocated a standardised proportion of the services provided. This share is intended for the remuneration of staff and technical equipment. The service groups are used to link the level of care described with the provision to be financed. The DRG component, the residual DRG (rDRG), which is reduced by the upkeep costs budget, is intended to reduce the volume incentive and economic pressure.

The future remuneration therefore consists of three components:
rDRG + care budget + retention budget = hospital budget
(Federal Ministry of Health 2022).

Due to the high proportion of non-elective interventions, obstetrics is a specialist area with high retention costs. A normal pregnancy cannot be scheduled or postponed. Hospitals must therefore maintain structures, but can currently only receive remuneration linked to actual case treatment. The structures provided are only

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1: The desired reduction in length of stay due to the introduction of the DRG system favours the expansion of inpatient services (Klauber et al. 2020). The incentive to increase volumes has been analysed several times in studies (e.g. RWI 2012/Schreyögg 2014/Reifferscheid et al. 2012/Mostert et al. 2012/ Lüngen and Büscher 2012).

partially refinanced (Schreyögg et al. 2020). Experts are discussing a budget of 60% to be maintained (Federal Ministry of Health 2022). This is intended to ensure the provision of high-quality paediatric and obstetric care across the board and close to home (Federal Ministry of Health 2022).

Methodology

Using qualitative research in the form of semi-structured, guideline-based expert interviews, various employees from clinics in the Rhine-Main region at different levels of perinatological care were included in the analysis. The experts interviewed (E01 to E06) were selected according to their professional experience (<10 years) and their position within the organisation of service providers at different levels of care (see Table 1). This ensures that the data is broadly represented in terms of care levels. Only experts from the specialist area of obstetrics and/or financing were interviewed. Expert E05 is the head of a department specialising in medicine and quality. E06 is the head of a department specialising in hospital financing and fees (see Table 1).

Based on the interviews, the effects of the current remuneration system and the potential and challenges for inpatient obstetrics resulting from the introduction of retention budgets were analysed. In addition, the experts' wishes regarding the remuneration of inpatient care were documented. The interview guidelines used included four topics:

1. general effects of previous remuneration in clinical obstetrics,
2. disincentives,
3. underfunding and comprehensive obstetric care,
4. reserve financing and a final section with the respondents' desire-doutlook3 .

The data and statements obtained in this way were summarised and analysed using the inductive method. This allowed the entire statements to be systematically reduced to the essential content (Mayring 2015). In addition, a cross-question category system was created, which was used to define terms in order to summarise the core statements.

Discussion

The results of the interviews showed that the effects of the DRG remuneration system are perceived by the experts in many different ways.

The length of stay for obstetric cases is described as too short (E01, E02 and E03). This applies in particular to cases with a higher degree of severity. The DRG system does not adequately reflect the case severity (E03). Furthermore, ‚[...] the DRG system [...] does not adequately remunerate the large block of personnel costs [...]' (E03). This includes factors such as the amount of time a midwife spends working with a woman before a vaginal delivery (E01), the 1:1 care required (E02) and the work of midwives on a mother and child ward (E06). E02 describes the increasing number of medical posts, while posts for ‚[...] other staff [...]' were reduced (E02). This is justified by the fact that the wards' case-related surpluses are generated via DRG remuneration and not via the nursing budget (E02). E04 and E06 rule out a fundamental increase in case volumes. Births cannot be planned. However, due to this circumstance, there are no plannable services to counteract the high retention costs and the retention costs incurred in this way cannot be refinanced (E04, E06). This is particularly challenging for level 1 perinatal centres.

Zusammenfassung der wichtigsten Informationen		
Experte	**ID**	**Organisation und Versorgungsstufe**
Experte 01	E01	Freigemeinnütziger Träger mit perinatalem Schwerpunkt
Experte 02	E02	Freigemeinnütziger Träger mit Geburtsklinik
Experte 03	E03	Freigemeinnütziger Träger mit Perinatalzentrum Level 1
Experte 04	E04	Städtisches Krankenhaus mit Perinatalzentrum Level 1
Experte 05/06	E05/E06	Landeskrankenhausgesellschaft, Abt. Medizin und Qualität und Finanzierung

Tab. 1: Summary of the most important information on the interviews.

In connection with the introduction of the DRG system, reference is made to the closures of smaller maternity centres at the time (E01 and E04). However, the points mentioned are not only due to the financing system, but also include corresponding incentives (E02, E04). E02, E03, E04, E05 and E06 consider the guarantee surcharges to be sensible in principle. The aim is to ensure basic care for the population in this way. Attention should be paid to providing care for pregnant women and mothers close to where they live (E04). The time set by the G-BA of 40 minutes by car as the journey time is assessed differently. While E05 sees this as ‚just about reasonable' (E05), E04 judges it to be ‚[...] generous [...] with what is expected of the population' (E04). According to E06, how comprehensive obstetric care is defined depends on what the population wants and reports back to politicians (E06).

The experts agree with the recommendations of the government commission to promote the formation of centres (E01, E03, E04 and E05). These centres offer the advantage of interdisciplinary medical care. This avoids patient transfers to other locations (even in emergencies) (E01). If specific services are required, patients will also have to accept longer journeys (E04). The prevailing settlement and population characteristics must be taken into account as determinants (E04). Insufficient investment funding from the federal states has led to an investment backlog in hospitals, which means that case-related surpluses have to be generated from DRG payments or other revenues (E02, E03 and E05). Construction measures or measures relating to digitalisation are currently financed from the revenues of other departments in the hospital (E05). As an employee of a hospital with current new construction measures, E02 describes that only ‚[...] marginal [...]' funding is provided (E02). The current separation of operating cost funding and investment funding increases

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2: In the agreement on the list of hospitals pursuant to Section 9 (1a) No. 6 KHEntgG between the GKV-Spitzenverband, the Verband der Privaten Krankenversicherung e. V. and the Deutsche Krankenhausgesellschaft e. V. dated 30 June 2022, all hospitals that receive a guarantee supplement for their obstetrics department, among other things, can be viewed. The supplement is paid out depending on the number of departments maintained. It can vary between EUR 400,000 and EUR 800,000 (GKV-Spitzenverband 2022).

the economic pressure on inpatient obstetrics. In the event of (redefined) reserve funding, this burden could be significantly reduced, particularly in the provision of personnel and technica-lequipment4 (E02, E03, E04 and E05).

The more non-elective interventions are provided within a speciality, the higher the risk that retention costs will not be covered (E04). The volume of obstetric services cannot be influenced (E04). Retention funding offers the opportunity to better map obstetric care economically (E02, E03, E04 and E05). The challenges of reserve funding that may arise, particularly during its introduction, can be summarised in the following three points:

1. the problem of staff shortages will not be avoided by the introduction (E02 and E03). However, the proportion of the reserve budget should be calculated in such a way that the staff in the clinic is adequately utilised (E02) and the level of care is taken into account in the calculation (E02 and E05).
2. which key is used to calculate and distribute the maintenance budget is relevant to perinatal care (E02, E03, E04 and E05), so that at least the actual costs incurred are refinanced (E02).
3. the proportion of DRG revenue that is remunerated via hospital services is to be reduced to 40%. This means that reduced, case-related surpluses can also be expected in future. To date, the DRG share of total hospital revenue accounts for around 75% across all specialities. Following the introduction of a reserve budget, existing external financing must be amortised with the help of reduced financial resources (E03).

E01, E03 and E04 express a further wish for the work of midwives to be adequately reflected in remuneration (E01, E03 and E04), as this time expenditure has not yet been taken into account in DRG remuneration in line with performance (E01 and E03). In addition, tariff increases should be refinanced more quickly and comprehensively (E03).

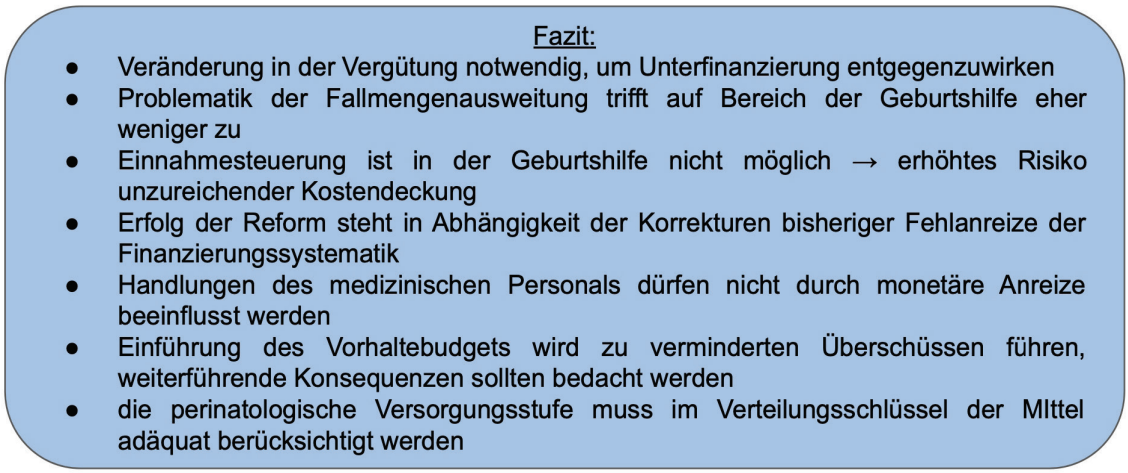


Fig. 1: Conclusion.

Conclusion

This paper should be seen as an exploratory approach to analysing the potential and challenges of reserve financing (see Fig. 1). Despite the utmost cautious neutrality in approaching the question, limiting influences on the results cannot be ruled out. The statements of the experts are heterogeneous in places, so that even in view of the scope of this qualitative research, no representative result can be obtained, but at least a preliminary structuring of the questions that may arise. This means that these assessments and tendencies can also be valuable. Accordingly, extended fields of research could be opened up that can be used for further research. It should also be noted that the Government Commission's proposal had not yet been concretised at the time of writing.

According to the experts, there is a consensus regarding the need for a change in the remuneration of inpatient services. The underfunding of maternity clinics perceived by the experts is partly due to the current financing system. This is the reason for the current health policy legislative initiative. The scope and impact of the reform will depend on whether the disincentives of flat-rate payments per case that have been identified to date can be corrected in accordance with the DRG classification (Schreyögg 2020). Financing in the context of retention costs, especially for specialist areas with a high proportion of unplannable cases, as is the case in obstetrics, is more than challenging.

The possibility of hospitals controlling their income accordingly is rather limited and there is a high risk that obstetric hospitals will not be able to cover their costs sufficiently. Hospitals are currently compensating for such inadequate remuneration and financing by increasing the number of cases, among other things. An increase in the number of cases is less of a problem in obstetrics from a health policy perspective that is geared towards conserving scarce resources. In order to ensure the safety and well-being of mother and child, aspects of the quality of care should also be considered. Medical staff should not be induced to behave in a certain way by monetary incentives.

In principle, the plan to introduce a proportion of the costs of care to be financed for essential services in order to relieve the economic burden on hospitals can be supported. The approach of taking into account different levels of perinatological care and providing for minimum structural requirements for the distribution of financial resources seems to be heading in the right direction. The guarantee surcharges that have been paid to date, which were introduced as part of the Hospital Structure Act, can be seen as an anticipation

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3: In order to check the comprehensibility and completeness of the interview guide, a trial interview was conducted in advance (Döring/Bortz 2016)

4: With regard to a three-shift system, at least three midwives, one paediatrician in the neonatal intensive care unit, one nurse in neonatology, two anaesthesiology specialists, one nurse in anaesthesia, two nurses in the operating theatre, one assistant doctor responsible for the delivery room with advanced training and one senior obstetrician must be present per shift in a level 1 perinatal centre (E04).

of the financing of maintenance costs, which should be embedded in the new regulatory framework in future. The fact that the proportion from which hospitals can generate case-related surpluses will be reduced by the introduction of the retention budget will not only affect obstetrics wards in future, but also other hospital service areas. This means that hospitals will tend to have less room for manoeuvre, which could lead to resentment about the reduced degree of freedom. <<

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Authors' statement

The authors have analysed the data and interpreted the results without financial support. They declare that there are no conflicts of interest.

Citation

Wilbert et al.: „Reform der Krankenhausfinanzierung: erlösunabhängige Vorhaltepauschalen für akutstationäre Einrichtungen der Geburtshilfe", in: „Monitor Versorgungsforschung" (06/23), S. 62–67. http://doi.org/10.24945/MVF.06.23.1866-0533.2565

Pauline Wilbert BSc ORCID: 0009-0001-4732-2328
ist Absolventin des Studiums der Gesundheitsökonomie (BSc) an der Hochschule RheinMain in Wiesbaden. Ihre Bachelorthesis schrieb sie zum Thema der Vorhaltefinanzierung in der stationären Geburtshilfe.
Kontakt: Pauline.Wilbert@icloud.com



Dr. rer. pol. Hans-Christian Vatteroth ORCID: 0009-0006-4480-2090
hat als Bank- und Diplomkaufmann langjährige Leitungserfahrung in den Bereichen des Krankenhauses, Medizinischer Versorgungszentren sowie stationärer und ambulanter Pflege. Er ist Lehrbeauftragter an der MSH Medical School in Hamburg. Weitere Lehraufträge hatte er in der Vergangenheit an der FOM, Hochschule Fresenius und der IU. Er ist Geschäftsbereichsleiter der Referats Krankenhausfinanzierung und Entgelte der Hessischen Krankenhausgesellschaft e.V. Kontakt: Hans-Christian.Vatteroth@hkg-online.de



Christina Grün BSc ORCID: 0009-0005-2648-8213
studierte an der Fachhochschule Gießen-Friedberg Allgemeine Betriebswirtschaftslehre mit den Schwerpunkten Wirtschaftliches Gesundheitswesen und EDV/Betriebsorganisation. Nach verschiedenen Stationen im Krankenhaus- und Krankenkassenbereich, insbesondere im Bereich der Versorgungsplanung und Qualitätsmanagement/Patientensicherheit, ist sie Geschäftsbereichsleiterin Medizin und Qualität bei der Hessischen Krankenhausgesellschaft e. V. Kontakt: Christina.Gruen@hkg-online.de



Prof. Dr. rer. pol. Hans-R. Hartweg ORCID: 0000-0002-5218-5508
ist Professor im Fachbereich „Wiesbaden Business School" der Hochschule RheinMain. Dort betreut er den Studiengang „Gesundheitsökonomie (B.Sc.)" und kümmert sich um aktuelle Fragen der Versorgungsforschung.
Kontakt: Hans.Hartweg@hs-rm.de

