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Financing of hospitals: the bad German example

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One year after the controversial vote, the law Hospital, patients, health, territories (HPST) starts to come into force. Efficiency and profitability are henceforth the keywords of hospital management. Each hospital initially must above all balance its budget. However the budget is given since 2009 only by the "tariff of the diseases dealt with and the medical acts carried out". It is the application of "tariffing by activity" (DRGs-T2A). A country in Europe already carried out this change for the financing of its hospitals: Germany.

As in France, the number of hospital and beds of hospitalization in Germany, knew a significant reduction in the last decade, but all the sectors of hospitalizations were not touched in equal way: if between 2004 and 2008 the number of public hospitals of acute care passed from 671 to 571, on the other hand private clinics saw their number growing from 444 to 537. Whereas in 1991 the public hospitals constituted 46 % of all hospitals, they were not more but 32 % in 2009, while the private establishments, passed from 15 % to 30,6 %, and the non-profit private hospitals passed from 39 % to 37,5 %. Until the end of 1990, privatization related to primarily small hospitals but since 2000 large public hospitals, in particular the Teaching Hospitals, were concerned. Thus, the hospitals of Hamburg were sold in 2005, the amalgamated Teaching Hospital of Giessen and Marburg was it in 2006.

Before the DRG system, the financing of the hospitals in Germany was ensured by a dual system: operating expenses were the burden of the Health insurance with a system of fixed day prices, investments were the burden of the Länder. The application of DRGs, at the place of fixed prices, put in bankruptcy the majority of public hospitals: the 2008 report of *Krankenhaus Rating Report* announced that in 2008 a third of the hospitals wrote red figures. The deficit was estimated at 2,2 billion euros. As in France, the essential part of hospital expenditures representing personnel costs (65 %), economies were massively carried out on this expenditure: the staff costs represent now only 60 % of the expenses. Generally, the workload of the employees is higher in the private sector compared to the public: more beds per employees (+30 % per doctor). At the same time, the average duration of stay was lowered (10 days in 1998 to 8 days in

2008), intensifying the workload accordingly. The staff shortage is a cause of general dissatisfaction of patients.

DISSATISFACTION OF PATIENTS, DISSATISFACTION OF HEALTHCARE PROFESSIONALS

In addition the wages in hospitals are not fixed any more by tariffs of the public service, but in each hospital, widening the grid of the wages for HC workforce. All health employees saw their wages decreasing while passing in the private sector except doctors heads of units and their assistants having management functions. It should be pointed out that these modifications of remuneration and working conditions involved a "historical" strike, the first for thirty years, of doctors in public and communal hospitals. Worse still, since a couple of years the departure of the hospital doctors to Switzerland, Scandinavia and in private cabinets has caused a true shortage in hospitals. This exile and this shortage also start to touch the non-medical workforce.

Resistance to privatization is now increasing in the population: in 2004, a referendum in Hamburg delayed one year the sale of the hospitals, 77 % of the voters having expressed against the sale. Collectives "*Gesundheit ist keine Ware* " (health is no merchandise) were created. Because for the patients, the dysfunctions are numerous: in addition to staff shortage, the reduction in duration of stays and the premature exits are the cause of re-hospitalisations all the more encumbering the emergencies units which then takes place in a different hospital than the one of the first stay (because of the risk that the second stay "is not remunerated" because depending on the first stay). Thus, one attends an explosion of transfers from hospital to hospital (+50 % between 2001 and 2006). Lastly, the DRG does not seem effective to control the costs: the health expenditure per capita is very close in France and in Germany (3601 dollars per annum in France, 3588 in Germany, according to OECD in 2007) and, if the public expenditure of health drops in Germany (passing from 79 % of public expenditure to 77 % between 2000 and 2007), the direct participation of households is in rise: passing from 11 % to 13 % of participation in the expenditure over the same period.

Source of dissatisfaction for patients, source of dissatisfaction for the HC workforce, the new procedure of the German hospitals thus seem to have brought a clear benefit and crescent only to the shareholders of the private sector of health. Why is it necessary that France follows this example?

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