



# Patient Welfare as an Ethical Standard for Hospital Care

OPINION



# Patient Welfare as an Ethical Standard for Hospital Care

OPINION

5 April 2016

## **Published by the German Ethics Council**

Jägerstraße 22/23 · D-10117 Berlin

Phone: +49/30/20370-242 · Fax: +49/30/20370-252

Email: [kontakt@ethikrat.org](mailto:kontakt@ethikrat.org)

[www.ethikrat.org](http://www.ethikrat.org)

© 2022 Deutscher Ethikrat, Berlin

Title of the original German edition: Patientenwohl als ethischer Maßstab für  
das Krankenhaus

All rights reserved.

Permission to reprint is granted upon request.

English translation: Ehren Fordyce

Layout: Torsten Kulick

# CONTENTS

1	INTRODUCTION AND OUTLINE OF THE PROBLEM .....	7
2	OVERVIEW OF THE HOSPITAL CARE SYSTEM IN GERMANY .....	11
2.1	Structure .....	11
2.2	Financing .....	17
2.3	Joint self-government .....	23
2.4	Legislative activities .....	28
2.5	Conclusions .....	35
3	PATIENT WELFARE AS AN ETHICAL STANDARD .....	37
3.1	Care that enables self-determination .....	38
3.1.1	Self-determination .....	38
3.1.2	Caring-for and care .....	40
3.1.3	Doctor-patient relationship .....	42
3.1.4	Successful communication as prerequisite for care enabling of self-determination .....	44
3.2	Quality of treatment .....	47
3.2.1	Quality model and operationalisation .....	47
3.2.2	Quality measurement .....	50
3.3	Equal access to health services and just distribution of resources .....	52
3.3.1	Patients with special needs .....	55
3.3.2	Conscious use of resources .....	56
4	THREATS TO PATIENT WELFARE: AREAS OF CONFLICT .....	60
4.1	Communication .....	61
4.2	Professional ethos and professional reality .....	64
4.2.1	Physician-based area .....	64
4.2.2	Nursing care sector .....	72
4.2.3	Area of social and therapeutic services .....	78
4.2.4	Hospital management .....	81
4.3	Hospital as organisation .....	83
4.3.1	Management structures .....	84
4.3.2	Clinical ethics committees .....	85

4.4	Advanced training and continuing education of hospital personnel .....	87
4.5	Patient groups with special needs .....	88
4.5.1	Children and adolescents .....	88
4.5.2	Patients of old age .....	92
4.5.3	Patients with typical geriatric illnesses .....	93
4.5.4	Patients with dementia .....	96
4.5.5	Patients with disabilities .....	100
4.5.6	Patients with a migrant background v .....	104
4.5.7	Registered refugees and persons without residency status .....	106
4.6	Resource allocation .....	107
4.6.1	Dual financing in the inpatient sector v .....	109
4.6.2	Ownership structure in the inpatient sector .....	112
4.6.3	(False) Incentives of the DRG system .....	114
4.7	Quality assurance and documentation .....	119
5	SUMMARY AND RECOMMENDATIONS .....	122
5.1	Summary .....	122
5.2	Recommendations .....	125
	REFERENCES .....	133
	ABBREVIATIONS .....	142

# 1 INTRODUCTION AND OUTLINE OF THE PROBLEM

The organisation and financing of hospital care in Germany are ongoing topics of political discussion. Contributing significantly to this are continual challenges, such as the general development of costs in healthcare; advancements in medicine along with the necessity for investments and a continuous adaptation of the medical infrastructure; changed expectations on the part of patients<sup>1</sup>; the interest in participating in an economically attractive growth market; and the demographic evolution in an aging society. While the density of hospitals and the financial structure of the inpatient sector in Germany is overall at a high level in comparison internationally, effects have, nevertheless, emerged through an overriding focus on cost reduction on the part of health insurers and revenue growth on the part of providers, effects that give cause for concern in regard to patient welfare as an essential normative standard. Among other things, volume growth in treatment services may be pertinent to such effects. These offset not only the intended effect of cost reduction, but also lead, just as do reductions in treatment services, to questions about the individual medical justification. Furthermore, the focus on especially profitable treatment procedures is at the expense of other necessary treatment options. The work conditions of the personnel employed in hospitals are worsening due to lack of time and chronic overload, so that the sector's attractiveness for new skilled workers is falling and, in the meantime, there is a shortage in skilled workers.

Such developments have considerable impacts on patient welfare and its normative function as a guiding principle of healthcare. Patient welfare not only involves the physical and

---

<sup>1</sup> In the interest of gender equality this Opinion uses “he/she” or “she/he” alternately.

psychological situation gauged according to medical standards. Central evaluative criteria of whether patient welfare is being ensured also include the quality of treatment, the self-determination of patients as well as justice in terms of access to and distribution of scarce resources. These criteria mark the ethical guiding framework of the inpatient care system.

With the GKV-Versorgungsstärkungsgesetz (Care Provision Strengthening Act)<sup>2</sup> and the Krankenhausstrukturgesetz (Hospital Structures Act)<sup>3</sup>, the German Bundestag agreed in 2015 to reforms that are aimed in an enhanced manner at a profile based on quality criteria. The demand of the Hospital Structures Act to guarantee care that is of “high quality” and “patient-friendly,” focuses on the patient and his/her welfare and ties the future calculation of resources to this standard. Nevertheless, a substantial challenge will consist, as demanded by the law, in defining more closely the criteria for care that is of high quality and patient-friendly and in ensuring their transparency for patients and society.

- » Against this background, the German Ethics Council deems it appropriate to examine hospital care in Germany from an ethical perspective. There are good reasons to focus on the hospital, since this can be viewed as paradigmatic for qualitative developments in the healthcare system and allows one to identify different specific problems:
- » The hospital sector represents, at about 68 billion euros, the largest block of expenses within the expenditures of the statutory health insurance (194 billion euros in total).<sup>4</sup>
- » Hospital treatments are acquiring ever-greater significance, contrary to prognoses up to now. Their number has risen in the years between 2009 and 2014 from 18.2 million

---

2 Gesetz zur Stärkung der Versorgung in der gesetzlichen Krankenversicherung of 16 July 2015 (BGBl. I, 1211).

3 Gesetz zur Reform der Strukturen der Krankenhausversorgung of 10 December 2015 (BGBl. I, 2229).

4 GKV-Spitzenverband 2016, 5, 22.



to 19.5 million, albeit with a decreasing average length of stay.<sup>5</sup>

- >> In the hospital, different actors with varying interests encounter each other in one place: patients and their relatives; doctors, nurses and professionals from psychosocial and therapeutic occupational groups; as well as hospital managers and economists. This gives rise to a high demand for competence in communication, organisation and coordination.
- >> Due to the change in living situation and temporary loss of the familiar domestic everyday world, patients in hospitals are, unlike those in outpatient care, exposed to additional psychological burdens and restrictions in their personal freedom of development.

In the present Opinion, ethical problems are analysed that arise on the level of the hospital, especially from structural conditions defined at the superordinate level of allocation. Hospitals have to provide their care services against the backdrop of political guidelines and under economic demands, which in part have problematic impacts on the decisions of doctors and nurses and hence on patient welfare. The German Ethics Council is aware that it has taken into consideration, given the focus of its reflections on the orientation towards patient welfare in the hospital sector, only a section of a much broader problematics.<sup>6</sup> So, for example, one could in principle also consider more strongly the questions of income and

---

5 Statistisches Bundesamt 2015a, 9. On the basis of the numbers from 2008, the figure of 19.3 million hospital treatments was forecast for the year 2030 (Statistische Ämter des Bundes und der Länder 2010, 11 f.).

6 In its Opinion on “Nutzen und Kosten im Gesundheitswesen – Zur normativen Funktion ihrer Bewertung” (“Medical Benefits and Costs in Health-care: The Normative Role of Their Evaluation”) from 2011, the German Ethics Council has already described the problems that arise in ensuring an adequate patient care on the different levels at which decisions must be taken about the allocation of medical goods. The main focus is on the challenges that arise in the health-care system for the just distribution of resources given their scarcity; this was investigated through the example of the cost-benefit analysis of medications (Deutscher Ethikrat 2011).

financing; the influence of extra-medical factors on people's health status; or even an increase in patient welfare through a greater interchange between the various sectors (outpatient, inpatient, rehabilitative, nursing care, integration support). If these influencing factors were taken into consideration more strongly, the reflections undertaken here on measures necessary for implementing patient welfare would possibly acquire a different emphasis. However, such a comprehensive analysis and assessment would exceed the scope of this Opinion.

With this Opinion, the German Ethics Council presents recommendations for a rigorous orientation of hospital care towards patient welfare.

## 2 OVERVIEW OF THE HOSPITAL CARE SYSTEM IN GERMANY

### 2.1 Structure

Pursuant to Section 107 (1) of the Fünftes Buch Sozialgesetzbuch (SGB V, Fifth Book of the Social Code), hospitals are “facilities which are in the service of hospital treatment or assistance at birth; exist in a medically professional manner under continuous physician-based guidance; have at their disposal diagnostic and therapeutic options corresponding to their public service mandate and work according to scientifically recognised methods; are established to recognise patients’ illnesses principally through medical and nursing assistance, to heal, to prevent their worsening, to alleviate complaints of illness or to render assistance at birth by means of medical, nursing, functional and medical-technical personnel, available at any time; and in which patients can be accommodated and fed”.

In 2014 in Germany, there were approximately 2,000 hospitals with almost 501,000 beds.<sup>7</sup> Of these, 455,496 beds accounted for 1,646 so-called general hospitals, which are, on the one hand, not purely day- or night-clinics and, on the other, not limited to beds for psychiatric, psychotherapeutic, neurologic and geriatric patients.<sup>8</sup> In comparison to other OECD countries (2013), the frequency of general hospitals in Germany (quantity in relation to population) lies in the upper third.<sup>9</sup> A corresponding comparison of hospital bed density shows,

---

7 Of the 1,980 hospitals existing in Germany in 2014, with 500,680 beds, there were 589 operated by public bodies (240,195 beds); 696 by non-profit ones (169,477 beds) and 695 by private ones (91,008 beds) (Statistisches Bundesamt 2015b, 14).

8 Statistisches Bundesamt 2015b, 15.

9 OECD.Stat (<http://stats.oecd.org>) see *Health : Health Care Resources : Hospitals* [2015-11-10]. Long-term care facilities are not included here.

moreover, that Germany disposes of one of the highest capacities in hospital beds.<sup>10</sup>

Hospital treatment is acquiring an ever-greater significance. Essential factors for this are demographic evolution, especially the increasing life expectancy of the population, but also the increasing undersupply in the outpatient sector, particularly in rural areas. The number of hospital treatments rose over the years 2009 to 2014, contrary to prognoses, from 18.2 to 19.5 million.<sup>11</sup> However, the average length of stay sank continuously. It was at 12 days in 1994; 8 days in 2009; and 7.4 days in 2014.<sup>12</sup> Nevertheless, the length of stay per treatment period is at a high level in OECD comparison (2013).<sup>13</sup> However, such numbers can always only be interpreted against the background of, among other things, the interlinking of the inpatient with the outpatient care system as well as with a view to the different possibilities for access to the latter.

The total amount of hospitals in Germany has consistently declined in the last two decades.<sup>14</sup> In the process, the percentages of public<sup>15</sup> and non-profit<sup>16</sup> ownerships have continuously

---

10 OECD.Stat (<http://stats.oecd.org>) see *Health : Health Care Resources : Hospital beds* [2015-11-10]. For a detailed analysis of the inpatient sector in international comparison, see Warschke/Lauerer/Nagels 2015.

11 Statistisches Bundesamt 2015a, 9. On the basis of the numbers from 2008, the value of 19.3 million hospital treatments was predicted for the year 2030 (Statistische Ämter des Bundes und der Länder 2010, 11 f.).

12 Statistisches Bundesamt 2015b, 11.

13 OECD.Stat (<http://stats.oecd.org>) see *Health : Health Care Utilisation : Hospital aggregates* (Variable: *Curative care average length of stay*) [2015-11-10]. The numbers refer to curative care (without rehabilitation, long-term and palliative care).

14 In 1991, there were 2,411 hospitals with 665,565 beds, while in 2014 only 1,980 hospitals with 500,680 beds were still registered (Statistisches Bundesamt 2015b, 14). It should be noted, however, that fewer hospitals are identified as facilities due to the consolidation under one institutional label of formerly independent hospitals.

15 Public hospital operators are, for example, the federal government, federal states, counties, cities and municipalities.

16 Non-profit hospital operators are, for example, churches, charities and private foundations.

decreased in favour of private ones.<sup>17</sup> If in 1991 46.0 percent of hospitals were public, 39.1 percent non-profit and 14.8 percent private, in 2014 only 29.7 percent of hospitals were still public, 35.2 percent non-profit and 35.1 percent already in private hands.<sup>18</sup>

Nevertheless, in 2014 almost half of all beds were in the comparatively large public hospitals (48.0 percent), while non-profits provided 33.8 percent of available beds, private ones 18.2 percent.<sup>19</sup> From an economic perspective, an essential difference between private operators of hospitals and public and non-profit ones is revealed in the designated purpose: “The primary effect of commercial activity [...] is the realisation of profits; the secondary effect, in contrast, the fulfilment of demand.”<sup>20</sup> This is an expression of the constitutionally protected occupational and competitive freedom of the legal operators of private hospitals.<sup>21</sup> Pursuant to Section 5 (1) no. 2 of the Krankenhausfinanzierungsgesetz (Hospital Financing Act)<sup>22</sup>, the participation in general hospital care of hospitals in private ownership requires that these are *for the public benefit* in the sense of Section 67 of the Abgabenordnung (Fiscal Code). Such hospitals are publicly supported if not less than 40 percent of yearly hospital days or calculation days are attributable to patients for whom only rates for general hospital services are charged (see Section 7 of the Krankenhausentgeltgesetz [Hospital Fees Act]<sup>23</sup>, Section 10 of the

---

17 Pursuant to Section 30 of the Gewerbeordnung (Trade, Commerce and Industry Regulation Act) from 22 February 1999 (BGBl. I, 202), last amended through Article 10 of 11 March 2016 (BGBl. I, 396): licensed profit-making enterprises.

18 Statistisches Bundesamt 2015b, 8.

19 Ibid.

20 Thus Eichhorn 1975, 24.

21 Wernick, in: Huster/Kaltenborn 2010, section 16C para. 8 ff.

22 Gesetz zur wirtschaftlichen Sicherung der Krankenhäuser und zur Regelung der Krankenhauspflegesätze of 29 June 1972 (BGBl. I, 1009), revised through the notice of 10 April 1991 (BGBl. I, 886), last amended by Article 1 of the Act of 10 December 2015 (BGBl. I, 2229).

23 Gesetz über die Entgelte für voll- und teilstationäre Krankenhausleistungen from 23 April 2002 (BGBl. I, 1412, 1422), last amended by Article 4 of the Act from 10 December 2015 (BGBl. I, 2229).

Bundespflegesatzverordnung [Federal Ordinance on Hospital Nursing Charges]<sup>24</sup>), i.e., for whom as well no optional services were agreed upon.<sup>25</sup> Publicly assisted hospitals in private ownership thus must take part to a corresponding extent in the general care of statutorily insured patients.

In 2014 bed occupancy was 77.4 percent; in this regard, relatively small differences exist amongst the forms of ownership mentioned. The average bed occupancy was 79.4 percent in public hospitals, 75.7 percent in non-profit ones and 75.6 percent in private ones.<sup>26</sup> Larger differences exist amongst different specialised departments.<sup>27</sup>

The state hospital planning of the German federal states is supposed to ensure a needs-based care. The specialist departments and bed numbers are determined in the public service mandate. This planning of the supply framework and of inpatient capacities is incumbent on the federal states and takes into account various care levels that are not uniformly defined. Roughly speaking, the following classification can be made: primary-care hospitals (in German: *Grundversorgung*) dispose of at least one department of internal medicine or of surgery, without having separate departments for subareas of a specialisation. This last point is also valid for standard-care hospitals (*Regelversorgung*), which, besides internal medicine and surgery, also have, e.g., departments for gynaecology and obstetrics; otorhinolaryngology; or paediatrics. Hospitals that additionally have at least separate departments for trauma and abdominal surgery, radiology and anaesthesiology, and that

---

24 Verordnung zur Regelung der Krankenhauspflegesätze from 26 September 1994 (BGBl. I, 2750), last amended by Article 5 of the Act from 10 December 2015 (BGBl. I, 2229).

25 On this see Genzel/Degener-Hencke, in: Laufs/Kern 2010, section 81 para. 32. 26 Statistisches Bundesamt 2015b, 20.

27 Independent of the operator, specialist departments such as internal medicine (79.9 percent), geriatrics (91.3 percent) as well as psychiatry and psychotherapy (93.5 percent) exhibit higher average bed occupancies; specialist departments such as ophthalmology (64.0 percent), otorhinolaryngology (61.1 percent) or paediatrics (66.3 percent), lower occupancies (Statistisches Bundesamt 2015b, 25).

cover further specialisations, are assigned to specialised care (*Schwerpunktversorgung* or *Zentralversorgung*). Hospitals that are yet further differentiated and correspondingly equipped are classified as maximum-care hospitals (*Maximalversorgung*).<sup>28</sup> The clear assignment of individual hospitals, especially smaller ones, to one of the aforementioned care-levels is increasingly difficult, since many hospitals – in the framework of general departments – operate units that have a specialisation within the respective discipline. The various levels of care correspond to local, regional and supraregional catchment areas.

Generally, the internal organisation of a hospital can be divided into the hierarchically structured areas of medical services; nursing staff; health professions active in the hospital (such as midwives, physiotherapists, ergotherapists, art and design therapists, psychotherapists, curative educators, speech therapists); and social professions (such as social workers and chaplains) as well as the administration including economic controls.<sup>29</sup> Management is incumbent upon an executive body determined by the legal operator – either upon a (commercial) executive manager or director or upon a hospital board of directors (usually the medical director, the administrative director and the director of nursing).<sup>30</sup> By the end of 2014, 1.2 million people were employed in hospitals in Germany – 14.4 percent of these in physician-based service.<sup>31</sup> In comparison to other OECD countries, the number of employees in German hospitals lies somewhat above the average relative to population (2013).<sup>32</sup>

According to the Statistisches Bundesamt (Federal Statistical Office), the amount of full-time positions for medical doctors has developed from 110,152 in 2001 to 150,757 in

---

28 Cf. Nagel 2012, 27 f.; Nagel 2013, 154 f.

29 Cf. Nagel 2013, 151 f.

30 Cf. *ibid.*

31 Statistisches Bundesamt 2015b, 8.

32 OECD.Stat (<http://stats.oecd.org>) see *Health : Health Care Resources : Total health and social employment* [2015-11-10].

2014; in the nursing area, from 331,472 in 2001 to 318,749 in 2014.<sup>33</sup> The nursing staff is composed of fully qualified health and nursing care staff (81 percent), fully qualified health and childcare nursing staff<sup>34</sup> (9 percent) and nursing assistants (4 percent). Approximately 6 percent are miscellaneous care persons, such as geriatric nursing staff.<sup>35</sup> Especially in the event of personnel shortages in the areas of nursing and therapy, a large number of clinics in Germany make use to an increasing extent of so-called “staff leasing” or have outsourced a portion of the personnel into subsidiaries of the hospitals or into employment agencies. The costs for these employees then no longer appear on the list of the respective full-time staff of an occupational group of a hospital, but are carried instead under the budget for material expenses. The total amount of the full-time positions deployed in hospital-based personnel leasing<sup>36</sup> has risen from 14,009 in 2009 to 22,545 in 2014, of which 3,052 full-time positions are accounted for in the physician-based area and 6,487 in nursing.<sup>37</sup>

Given the numbers presented by the Federal Statistical Office, it follows that the numerical relationship of doctors to nurses (including the respective leasing personnel) has sharply changed: If in 2001 there were three nurses per doctor, in 2014

---

33 On the physician-based area: Statistisches Bundesamt 2015b, 12; on the area of nursing: Statistisches Bundesamt 2008, 17; Statistisches Bundesamt 2015b, 26. Under full-time staff, the Statistisches Bundesamt (Federal Statistical Office) captures here the yearly-average number of full-time equivalent employees with a direct employment relationship in a facility, i.e., without full-time position personnel who are administered through leasing procedures.

34 The number of health and paediatric illness nursing staff working in hospitals is consistently declining, from 40,650 in 2002 to 36,900 in 2011 (Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege 2013, 31).

35 Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege 2013, 30.

36 In the count of full-time positions employed in personnel-leasing practices, it is key that the hospital hires extra personnel in the form of temporary employment (or similar) for its services that otherwise are delivered internally in the facility. Personnel from an external company that, for example, took over cleaning in the facility would not be included in this.

37 Statistisches Bundesamt 2015b, 12, 33.



there were only 2.1.<sup>38</sup> The reasons for this are multilayered. The entry into force of the *Arbeitszeitgesetz* (Working Time Act) on 1 July 1994 is central, whereby the widespread practice of 24-hour or even longer working hours for physicians was prohibited and for which an adjustment of the personnel ratios became necessary for ensuring physician-based patient care in hospitals.

## 2.2 Financing

Since 1972 the so-called dual financing of hospitals has taken place on the basis of the Hospital Financing Act. This is valid for all hospitals that are accredited pursuant to Section 108 SGB V for the treatment of both those covered by statutory health insurance and those by private health insurance (so-called self-paying patients). In implementing the welfare state's responsibility for ensuring the availability of certain services (*Gewährleistungsverantwortung*), the Hospital Financing Act integrates by far the largest portion of hospitals into a state planning system with public support of investment costs and legally prescribed financing of necessary operating costs. According to Section 1 (1) Hospital Financing Act, which has remained unchanged since 1972, the immediate purpose of the act is the economic security of hospitals. However, no end in itself is formulated with this; the economic security of hospitals serves rather as a means to the end of a needs-based provision for the sick, at socially acceptable hospital costs.<sup>39</sup> The implementation of this basic concept is shaped by the principle of the diversity of providers. It is prescribed by Section 1 (2)

---

38 The ratios are based on numbers for the physician-based area (Statistisches Bundesamt 2015b, 12) and that of nursing (Statistisches Bundesamt 2008, 17; Statistisches Bundesamt 2015b, 26).

39 On the latter, see BVerfGE 82, 209 (225); moreover, on the basic concept see for example Quaas/Zuck 2014, section 26 para. 3-5 with further references.

sentence 1 Hospital Financing Act. Section 1 (2) sentence 2 qualifies this principle to the effect that, in accordance with the law of the federal states, especially the economic security of non-profit and private hospitals must be guaranteed.<sup>40</sup> In doing so, private hospitals are as a rule operated according to profit-oriented principles.<sup>41</sup> To realise the goals of the law to economically secure hospitals “in order to guarantee a high-quality, patient- and need-based supply of the population with efficient hospitals that are operating in a high-quality manner with individual financial responsibility; and to contribute to socially acceptable care rates” (Section 1 (1) Hospital Financing Act), the federal states must establish state hospital plans. Federal state law regulates the details.<sup>42</sup>

The economic security of hospitals accordingly ensues from two sources: On the one hand, hospitals that have been included into the hospital plans of the federal states are entitled to support through investments by the respective state; on the other, the operational and personnel costs are carried by the health insurance funds. In addition, patients with direct mandatory or voluntary co-payments (hospital co-payment on a daily basis, optional services) contribute to a certain extent to the financing of the inpatient sector. The sums of investment support by the individual federal states differ considerably and in the passage of time have been consistently declining for many years. Additionally, due to the financial shortages of the states, waiting periods of up to ten years are today customary for a binding decision on funding, which moreover then frequently earmarks merely a payment in instalments. This forces many hospitals into the deferral of important building and

---

40 On the privileged treatment of the non-profit and private operators, which cannot – in contrast to hospitals in public ownership, especially municipal hospitals – fall back as a rule on additional operational and investment subsidies, cf. Deutscher Bundestag 1984, 27; further, Quaas, in: Quaas/Zuck 2014, section 25 para. 77 ff.

41 The operator of such a “private health facility” requires a commercial license pursuant to Section 30 of the Trade, Commerce and Industry Regulation Act.

42 Cf. Fleischhauer 2015, 21 f.

investment measures or into alternative credit financing for non-deferrable conditions – such as fire safety, for example – that can lead to an existentially threatening financial situation. Generally, this practice of sluggish and too meagrely occurring support is held responsible for the considerable congestion in investment that has meanwhile come to pass. According to current analyses, the yearly investment needs of hospitals without university hospitals lie at approximately 5.3 billion euros and hence are double that of the investment funds provided by the states.<sup>43</sup>

The 2009 Krankenhausfinanzierungsreformgesetz (Hospital Financing Reform Act)<sup>44</sup> envisaged lump-sum investment payments from 2012, instead of investment financing negotiated and politically decided upon for the given situation (Section 10 (1) Hospital Financing Act); however, this has been inconsistently implemented to this point. A difference needs to be drawn between individual and lump-sum support: the running investment costs of the hospitals are covered via the lump-sum support<sup>45</sup>, while funds in the context of individual support can be provided for larger acquisitions and the furnishing or renovation of whole departments.

The operational costs (material and personnel costs) are borne through the service fees (Section 17 Hospital Financing Act). Till 2003, the principle of cost coverage was valid: The running, actually arising costs were accepted in that daily nursing care rates were invoiced for each day a patient spent in the hospital.<sup>46</sup> Since 2004, the reimbursement of general hospital services no longer occurs through the invoicing of care costs; instead, these are covered in diagnosis-related case-based flat

---

43 Cf. Augurzky et al. 2015, 175.

44 Gesetz zum ordnungspolitischen Rahmen der Krankenhausfinanzierung ab dem Jahr 2009 of 17 March 2009 (BGBl. I, 534).

45 For university hospitals, special financing regulations apply.

46 According to Section 2 Hospital Financing Act, the nursing care rate is the fee that the patient or her/his cost bearer has to pay for the inpatient or day patient services of the hospital and consists of the remuneration for the general hospital services and further costs of the hospital provided that these are not excluded by the act.

rates (diagnosis related groups, DRGs; see below), which include all services for a treatment case (Section 17b Hospital Financing Act). Excluded from the DRGs are services performed in psychiatric and psychosomatic facilities, which are still invoiced according to nursing care rates and for which – pursuant to the objections of the Bundesärztekammer (German Medical Association) and the professional associations against the introduction of a DRG-like financing system – a new fee system is supposed to be introduced, where regional conditions and hospital-specific particularities are supposed to be adopted into budgeting based on case-groups.<sup>47</sup>

For other “special facilities” according to Section 17b (1) sentence 10 Hospital Financing Act, such as palliative care units, for example, the possibility already exists today for agreeing on hospital-specific fee rates. The reimbursement for optional services (for example, accommodation in a single room, treatment by the chief physician etc.) are calculated separately as a surcharge that the patient himself/herself must pay – like in the former system of daily nursing care rates.

The development of the DRG system, its yearly adaptation to changed circumstances, such as medical developments, cost developments etc., as well as further tasks, were delegated through the Hospital Financing Act to the self-governing corporatist bodies (see 2.3) and occur through agreements that are made by the GKV-Spitzenverband (National Association of Statutory Health Insurance Funds) and the Verband der Privaten Krankenversicherung (Association of Private Health

---

47 In the paper “Eckpunkte zur Weiterentwicklung des Psych-Entgeltsystems” (Key Points on the Further Development of the Psych Fee System) of the Federal Ministry of Health of 18 February 2016, the principle of performance orientation and empirical calculation is adhered to; yet, structural particularities of the individual hospitals, such as, for example, the prioritisation of certain diagnosis groups, should likewise be taken into account as well as the respective care levels to which the hospitals are assigned. The basis should initially be the currently valid *Psychiatrie-Personalverordnung* (Psychiatry Personnel Ordinance). Following a transition period, the *Gemeinsamer Bundesausschuss* (G-BA, Federal Joint Committee) should, however, set new minimum standards for future staffing. Home treatment by clinics is supposed to be facilitated.

Insurance Funds) in tandem with the Deutsche Krankenhausgesellschaft (German Hospital Federation). These contractual partners can commission their own “DRG institute” with the work requisite for fulfilling these mandates. The Institut für das Entgeltsystem im Krankenhaus (InEK, Institute for the Hospital Remuneration System) was entrusted with this task (see 2.3).<sup>48</sup>

In DRGs, diagnoses are classified throughout Germany on the basis of different criteria (including the primary and secondary diagnosis as well as procedures) into case groups that are medically and (with respect to the expenditure requisite for this) economically as homogenous as possible. The flat-rate procedure works with a patient classification system (G-DRG system), which is based on the German version of the international diagnosis code (ICD-10-GM) with approximately 15,000 items and an operational and procedural code with approximately 25,000 items. Both code catalogues are published and continually updated by the Deutsches Institut für Medizinische Dokumentation und Information (German Institute of Medical Documentation and Information). The reimbursement for each individual treatment case is based on the primary diagnosis coded according to the ICD code and possible secondary diagnoses as well as the services rendered for this case as coded according to the *Operationen- und Prozeduren-schlüssel* (OPS, German procedure classification). By means of the InEK-certified algorithm, the so-called Grouper, the InEK processes the coded data and ascertains the case groups. After assigning the treatment case to a case group, the applicable case-based flat rate can be ascertained according to a catalogue also published by the InEK.<sup>49</sup> The remuneration due to the hospital for the case-based flat rate is calculated through the multiplication of the so-called cost weight, which expresses the weight of a case group’s costs in relation to the average weight

---

48 Cf. Fleischhauer 2015, 22 f.

49 Cf. *ibid.*, 23 f.

of costs of all cases treated in hospitals, by the base rate, which describes the reimbursement amount for a case with the cost weight of 1.0. After initially agreeing on individual base rates for each hospital, state-specific rates were calculated from 2005. Till 2009, a graduated adjustment (convergence phase) took place to the state-specific price level. Since 2014, a uniform federal base rate is in effect as an orientation factor with a corridor, towards which the state base rates are moving step-by-step (Section 10 (8) Hospital Fees Act). In the calculation of the reimbursement, certain supplemental fees and additional or reduced charges that are listed in the Hospital Financing Act must be taken into account alongside the case-based flat rates. It is evident that the cost accounting according to case-based flat rates is time-consuming and requires special knowledge. Mistakes can have considerable financial repercussions. Many hospitals have hired or had to hire additional personnel for cost accounting according to this system.<sup>50</sup>

Between the operator of a hospital and the health insurance funds, the prospective volume of services of a hospital is negotiated and agreed upon each year in advance as a so-called revenue budget by taking into account the extent of the services rendered and expected changes in services. In the process, the DRGs required from hospitals by the health insurance funds are compared with their public service mandate. Different weights (cost weights) are allotted to different DRGs. From the totality of the DRGs performed yearly in an individual hospital, the so-called case mix can be calculated by adding up their cost weights. The yearly budget of the hospital is then calculated by multiplying the case mix by the base rate. Deviations from the previously agreed-upon volume of services lead to additional or lost revenues. These are taken into account in the following year in a revenue settlement.<sup>51</sup> In order to prevent unfounded expansions of services, the hospitals must pay

---

<sup>50</sup> Cf. *ibid.*, 24.

<sup>51</sup> Cf. Nagel 2012, 51 f.

an additional-volume-deduction<sup>52</sup> on the basis of the revision to the Hospital Fees Act of 2011. Conversely, the rising costs that have led to financial crisis situations in many hospitals have been met through flanking statutory measures, such as the Krankenhaus-Finanzhilfepaket (Hospital Financial Aid Packet) of 2013/2014 and the Hospital Structures Act of 2015, with provision surcharges, tariff adjustment rates and service guarantee surcharges.

The activity-oriented reimbursement pursuant to the DRG is hence not related to the actual costs of a hospital treatment and is supposed to lead to a strong incentive for economic action. Earnings and losses are dependent on whether one succeeds in operating more efficiently than in the calculation of the flat-rate reimbursement. The goal of an economic management of hospitals is already to be affirmed from considerations of justice. Nevertheless, possible false incentives are to be considered in any form of reimbursement (cf. chapter 4).

### 2.3 Joint self-government

Healthcare as a whole in Germany, as well as inpatient care, is extensively entrusted by the legislature to the so-called joint self-government of the health insurance funds as well as of the umbrella organisations for doctors and hospitals involved in the provision of statutory health insurance. In particular, the Gemeinsamer Bundesausschuss (G-BA, Federal Joint Committee) composed of these actors sets secondary law that is directly binding for health insurance funds, for service-providers

---

52 Following the new Hospital Structures Act, this is called fixed-cost degression deduction (*Fixkostendegressionsabschlag*) (Article 2 no. 10h). If, for example, a fictional hospital is now negotiating 21,000 case-mix points with the health insurance funds instead of the hitherto 20,000 points, the additional 1,000 points are allocated with a percentual deduction over several years. The sense of this regulation is to hamper volume increases in the hospital sector. Yet at the same time, growth must also be pre-financed with this.

such as hospitals as well as for the persons insured. In what follows, the most important elements of this joint self-government are outlined.

The at-present 132 public health insurance funds (local health insurance funds, company health insurance funds, guild health insurance funds, substitute funds) form the statutory health insurance, in which about 90 percent of the population overall is insured.<sup>53</sup> Statutory health insurance is a mandatory insurance for wage- and salary-based employees whose annual income falls below a certain limit: the statutory insurance limit or annual income limit. It works according to the principle of solidarity, i.e., the scale of contribution is dependent on income and not on risk and the provision of insurance is not dependent on the scale of the contribution. The statutory health insurance funds form a state association in each federal state and are supported by the legally stipulated umbrella organisation, the National Association of Statutory Health Insurance Funds. The latter is represented on all committees that make decisions on the federal level regarding secondary-law norms for medical- and dentistry-based care of the insured and hence possesses considerable political influence. The SGB V stipulates that the state associations of the various health insurance funds in each federal state jointly form a consortium, the Medizinischer Dienst der Krankenversicherung (German Health Insurance Medical Service), which monitors among other things the necessity of the services borne by the statutory health insurance (Section 278 SGB V).<sup>54</sup>

In contrast to the statutory health insurance, the private health insurances, by which approximately 10 percent of the population was insured in 2013, are not financed through income-related member contributions, but by premiums that are calculated according to the principle of individual risk

---

53 The descriptions following in section 2.3 are based primarily on Fleischhauer 2015.

54 On the duties of the German Health Insurance Medical Service, see Section 275 SGB V.



assessment. In distinction to the statutory health insurance, with private health insurance only the treatment contract with the patient matters for the physician; that is – in contrast to contract doctors – physicians have no contractual obligations vis-à-vis the health insurances and bill their services directly to the patient. On the state and federal level, the interests of the private health insurances are represented by the Association of Private Health Insurance Funds, to which 43 companies belong.

The statutory health insurance funds may only be permitted to perform hospital treatments for their insured members if the hospital is recognised as a university hospital; incorporated into the hospital plan of a federal state; or has entered into a provision contract with a state association of the statutory health insurance funds (Section 108 SGB V). The hospital planning is incumbent on the federal states, which have to establish a state hospital plan and an investment programme. Only hospitals incorporated into the state hospital plan can receive financial support from the state investment programme. In compliance with SGB V, the provision contract obliges the state associations of the statutory health insurance funds to conduct budget negotiations with the hospital operator – these negotiations are about the type and volume of services at hospitals billing according to DRGs, and about nursing care rates at hospitals outside of the DRG system, such as psychiatric hospitals. The agreed types and volumes of service or the nursing care rates apply to all patients of the relevant hospital, thus for those insured by statutory health insurance as well as for privately insured patients. Through pooling of the hospital owners licensed in a federal state, the state hospital associations are formed, which perform legally assigned duties in the relevant committees for self-government. In turn, the state hospital associations form the German Hospital Federation, which represents the hospitals' umbrella organisation at the federal level and among other things discharges duties in self-government assigned by the legislature.

Doctors are obliged pursuant to laws for the healthcare profession to be members in the state chamber of physicians in the respective federal state. The state chambers of physicians have consolidated at the federal level into the Bundesärztekammer (German Medical Association). In each federal state, there is additionally an association of statutory health insurance physicians and an association of statutory health insurance dentists. By law, all doctors or dentists accredited by the statutory health insurance belong to these. They cooperate with the health insurance funds in order to ensure outpatient care of the insured, to distribute the total remuneration and to fulfil important duties in the system of self-government. They must agree on approval of outpatient services provided by a hospital, for instance through an outpatient department. At the federal level, they form the Kassenärztliche Bundesvereinigung (National Association of Statutory Health Insurance Physicians) and the Kassenzahnärztliche Bundesvereinigung (National Association of Statutory Health Insurance Dentists).

Pursuant to Section 91 SGB V, the central committee of self-government is the G-BA, in which the National Association of Statutory Health Insurance Funds, the German Hospital Federation as well as the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Dentists are represented. On behalf of the legislature, the G-BA makes decisions relevant to provision in all areas of medicine by issuing binding guidelines and decisions. The duties and powers of the G-BA concern all provision of medical and dental care borne at the expense of the statutory health insurance. Among other things, the G-BA assesses new medical methods with regard to their diagnostic and therapeutic benefit as well as their medical necessity and economic efficiency. Important duties consist additionally in issuing guidelines on quality assurance for both outpatient and inpatient care; as well as in determining criteria for the indication-based necessity and quality of performed diagnostic and therapeutic services and in defining minimum requirements

for structural, process and outcome quality. The quality guidelines of the G-BA apply uniformly both to those insured by statutory health insurance and to direct payers or privately insured patients.

The G-BA has established a scientific institute, the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (Institute for Quality and Efficiency in Health Care) that is independent and has legal capacity, albeit itself not authorised to take decisions and which the G-BA can commission for research, assessments and the delivery of recommendations. The institute is operated by a private foundation established by the G-BA expressly for this purpose.

In 2009 the G-BA entrusted the professionally independent consulting and research institute Institut für angewandte Qualitätsförderung und Forschung im Gesundheitswesen (Institute for Applied Quality Improvement and Research in Health Care, AQUA Institute) with the drafting of cross-institutional and cross-sector guidelines for quality assurance. Since the regulation has proved impractical pursuant to which the G-BA had to conduct a labourious Europe-wide tendering process at regular intervals for the awarding of these contracts, the legislature resolved in 2014 on the transition to a durable solution and commissioned the G-BA to establish a professionally independent scientific institute, the Institut für Qualitätssicherung und Transparenz im Gesundheitswesen (Institute for Quality Assurance and Transparency in Health Care). This institute was created after the model of the Institute for Quality and Efficiency in Health Care in January 2015.

The Hospital Financing Act empowers the National Association of Statutory Health Insurance Funds, the Association of Private Health Insurance Funds as well as the German Hospital Federation to permit the extensive activities and accountings, connected pursuant to Section 17b Hospital Financing Act with the statutory mandate for further development and adaptation of the DRG system, to be carried out by their own

DRG institute. The InEK has been charged with the execution of these tasks, part of which also includes the accompanying research prescribed by the law.

## 2.4 Legislative activities

On the one hand, hospital law is characterised by complex, partly confusing regulatory structures; on the other, by permanent interventions and readjustments by the legislature as well as by numerous other regulatory bodies. For decades the scene has been determined by federal shifts in competencies, structural debates and financing issues. For the actors of the inpatient care system, this has resulted in a lack of planning security and in uncertain standards for orientation. Until late into the 1960s, the hospital sector in Germany was marked by a structural underprovision of care. Hospitals were deemed the “Cinderella of the *Wirtschaftswunder*”.<sup>55</sup> In this situation, the Federal Government of the time decided on the basis of the so-called Hospital Inquiry<sup>56</sup> to take over responsibility for the economic viability of the hospitals and undertake a fundamental reorganisation of hospital financing. Up to that point, according to the division of competences set out in the Basic Law, the federal legislator has only concurrent authority over social security law pursuant to Article 74 no. 12 GG (old version). Two constitutional revisions have assigned to the Federation, according to Article 74 no. 19a GG (old version), concurrent legislative power for the “economic viability of hospitals and the regulation of hospital charges”.<sup>57</sup> At the same time, the possibility was opened up for the Federation

---

55 Thus aptly Deppenheuer 1986, 30 f.; for a short overview, see Quaas, for instance, in: Quaas/Zuck 2014, section 25 para. 12 ff. Translator’s note: regarding *Wirtschaftswunder*, literally “economic miracle”; term used for the economic boom in Germany in the 1950s and 1960s.

56 Deutscher Bundestag 1969.

57 Translator’s note: English translation taken from [https://www.gesetze-internet.de/englisch\\_gg/index.html](https://www.gesetze-internet.de/englisch_gg/index.html) [2021-01-29].

through Article 104a (4) GG of participating in the financing of investments in hospitals through financial assistance to the states. On the basis of the new Article 74 no. 19a GG, the German Bundestag adopted the Hospital Financing Act of 29 June 1972. Hospital financing was thereby set on two pillars according to the principle of dual financing.<sup>58</sup> The investment support was initially the object of a mixed financing in the sense of a financing shared between the Federation and the federal states. Yet, the limitation of the Federation's legislative power to the economic viability of the hospitals simultaneously made plain that hospital planning still remained a matter of the federal states. With the entering into force of the first Federal Ordinance on Hospital Nursing Charges of 1973, a fully flat-rate system of per diem nursing care rates was introduced.

Essentially, the normative foundations were thereby laid for the threefold division of hospital law: (1) the law of hospital planning on the basis of Sections 6, 8 Hospital Financing Act as well as the state hospital laws enacted respectively by the federal states<sup>59</sup>; (2) the law of hospital financing in accordance with the Hospital Financing Act and the legal ordinances based on it, especially the Federal Ordinance on Hospital Nursing Charges – likewise supplemented through the state hospital laws; (3) the service provider law in the context of the statutory health insurance, namely on the basis of SGB V. Already at the beginning of the 1980s, the so-called politics of cost containment set in, which was complemented from the 1990s by a “structural legislation”. As important stations, the following may be mentioned:<sup>60</sup>

---

58 It is disputed whether and to what extent the applicable constitutional right enables a (largely) monistic financing system. On this, see, for example, Höfling 2007, 293 f.; Kaltenborn, in: Huster/Kaltenborn 2010, section 2 para. 4.

59 On this, see the overview in Stollmann, in: Huster/Kaltenborn 2010, section 4 para. 1, 7 ff.

60 The following descriptions in section 2.4 are based essentially on Tuschen/Trefz 2010, 44 ff.

- » The Krankenhaus-Kostendämpfungsgesetz (Hospital Cost-Containment Act)<sup>61</sup> of 22 December 1981 led to a stronger participation of the health funds and hospital owners in the hospital planning of the states. Investment support was newly regulated through classification of the hospitals into four supply tiers; at the same time, the obligation of the states was laid down to adapt the hospital plans to the development needs of hospital services.<sup>62</sup>
- » Following the change in government in the fall of 1982, a fundamental discussion about the reform of hospital financing began that ultimately led to the Krankenhaus-Neuordnungsgesetz (Hospital Restructuring Act)<sup>63</sup> of 20 December 1984. With the reform, among other things, the mixed financing was eliminated that had applied to that point in the area of investment. From now on, investment aid was solely incumbent upon the federal states.
- » With the Gesundheitsstrukturgesetz (Health Care Structure Act)<sup>64</sup> of 21 December 1992, the principle of self-cost coverage standardised in Section 4 Hospital Financing Act was repealed. According to the revision of the norm, the entitlement to coverage of the anticipated self-costs is replaced by the entitlement to medically performance-based nursing care rates that have to enable a hospital vis-à-vis economic operational management to fulfil the public service mandate (Section 17 (1) Hospital Financing Act).
- » With the Health Care Structure Act in conjunction with the Federal Ordinance on Hospital Nursing Charges of 26 September 1994, flat-rate remuneration elements were introduced for the first time. As a function of the procedure

---

61 Gesetz zur Änderung des Gesetzes zur wirtschaftlichen Sicherung der Krankenhäuser und zur Regelung der Krankenhauspflegesätze (BGBl. I, 1568), repealed by Article 74 of the Act of 14 August 2006 (BGBl. I, 1869).

62 See on this and on the previous, Thomae 2006, 8-13.

63 Gesetz zur Neuordnung der Krankenhausfinanzierung (BGBl. I, 1716).

64 Gesetz zur Sicherung und Strukturverbesserung der gesetzlichen Krankenversicherung (BGBl. I, 2266), last amended by Article 205 of the Ordinance of 25 November 2003 (BGBl. I, 2304).

implemented, case-based flat rates and special fees were agreed between the hospitals and cost-bearers. Depending on the service spectrum of the hospital, the flat rates covered a variously high proportion of the cases handled. Through the flat-rate remuneration, it became possible for hospitals to obtain earnings or losses.

- » With Section 3 of the Beitragsentlastungsgesetz (Contribution Relief Act)<sup>65</sup> of 1 November 1996, a revision was made to Section 17 (3) Hospital Financing Act. The contractual parties were obliged, in order to cut back on misassignments to inpatient care, to lower the hospital budgets for the years 1997 to 1999 by at least one percent overall, and to do so independently from whether actual misassignments to inpatient care were exhibited or could be proved in a specific hospital.
- » The Zweites GKV-Neuordnungsgesetz (Second Statutory Health Insurance Restructuring Act)<sup>66</sup> of 23 June 1997 also brought changes in the hospital area, which retroactively entered into force as of 1 January 1997. As a result, there was a return to a performance-oriented remuneration in the reimbursement of inpatient and day patient hospital services, as had been the case prior to 1995.
- » Following the Bundestag elections of 27 September 1998 and the subsequent change in government, the GKV-Solidaritätsstärkungsgesetz (Statutory Health Insurance Solidarity-Strengthening Act)<sup>67</sup> of 19 December 1998 was enacted at short notice as a so-called interim law to prepare a larger reform and prevent further contribution increases. With its Section 7, a legal limit was prescribed in 1999 on the revenues for inpatient hospital services.

---

65 Gesetz zur Entlastung der Beiträge in der gesetzlichen Krankenversicherung (BGBl. I, 1631).

66 Zweites Gesetz zur Neuordnung von Selbstverwaltung und Eigenverantwortung in der gesetzlichen Krankenversicherung (BGBl. I, 1520), repealed by Article 217 of the Act of 14 August 2006 (BGBl. I, 1869).

67 Gesetz zur Stärkung der Solidarität in der gesetzlichen Krankenversicherung (BGBl. I, 3853), last amended by Article 20 (7) of the Act of 16 July 2015 (BGBl. I, 1211).

- » The GKV-Gesundheitsreformgesetz 2000 (Statutory Health Insurance Reform Act 2000)<sup>68</sup> of 22 December 1999 also effected changes in hospital law. Among other things, integrated care was introduced as an additional form of standard care with the goal of dissolving the sectoral boundaries between inpatient and outpatient care. For the first time, the possibility was created of agreeing contracts between the inpatient and outpatient service providers and the health insurance funds for the care of certain patient groups under fee conditions calculated in a flat-rate manner. Moreover, the health insurance funds were obliged to conduct internal quality assurance.
- » An essentially new orientation was brought by the introduction of a flat-rate payment system through the so-called Fallpauschalengesetz (Case Fees Act)<sup>69</sup> of 23 April 2002.<sup>70</sup> The Fallpauschalenänderungsgesetz (Case Fees Amendment Act)<sup>71</sup> of 17 July 2003 followed, which granted the Federal Ministry of Health greater regulatory powers on the federal level with respect to the contractual parties.
- » On the basis of the GKV-Modernisierungsgesetz (Statutory Health Insurance Modernisation Act)<sup>72</sup> of 14 November 2003, additional financial means were earmarked, among other things, for the improvement of working-hour conditions. Furthermore, integrated care was newly regulated in the SGB V. The consent obligation of the Association of

---

68 Gesetz zur Reform der gesetzlichen Krankenversicherung ab dem Jahr 2000 (BGBl. I, 2626), last amended by Article 3 of the Act of 15 February 2002 (BGBl. I, 684).

69 Gesetz zur Einführung des diagnose-orientierten Fallpauschalensystems für Krankenhäuser (BGBl. I, 1412), last amended by Article 3 of the Act of 17 July 2003 (BGBl. I, 1461).

70 For the hospitals not included in the DRG system, such as the psychiatric and psychosomatic hospitals, the Federal Ordinance on Hospital Nursing Charges applies, with which the daily-equivalent care rates are specified.

71 Gesetz zur Änderung der Vorschriften zum diagnose-orientierten Fallpauschalensystem für Krankenhäuser (BGBl. I, 1461).

72 Gesetz zur Modernisierung der gesetzlichen Krankenversicherung (BGBl. I, 2190), last amended by Article 1 of the Act of 15 December 2004 (BGBl. I, 3445).



Statutory Health Insurance Physicians to a contract for integrated care was abolished and one percent of the total remuneration for outpatient and inpatient services was made available for the financing of projects for integrated care.<sup>73</sup>

- » The Zweites Fallpauschalenänderungsgesetz (Second Case Fees Amendment Act)<sup>74</sup> of 15 December 2004 wanted to confront some deficiencies like the inadequate depiction of the maximum-care provider and to facilitate agreement on supplemental fees. In addition, the InEK was assigned the task of further developing the remuneration system.
- » With the GKV-Wettbewerbsstärkungsgesetz (Statutory Health Insurance Competition-Strengthening Act)<sup>75</sup> of 26 March 2007, changes occurred in the Hospital Financing Act (Article 18), the Hospital Fees Act (Article 19) and the Federal Ordinance on Hospital Nursing Charges (Article 20).
- » Following the introduction and establishment of the DRG remuneration system and the gradual adaptation of the hospital budgets to a state-wide uniform remuneration level, the legal stipulations for the standard operation of the

---

73 Currently there are approximately 5,500 projects for integrated care in Germany, related to extremely diverse patient groups and forms of treatment. Since the list of possible contract partners was also broadened from 2011 by a further legislative change (e.g., operators of outpatient rehabilitation facilities, care facilities and pharmaceutical firms had been included), the projects also differ from one another strongly in terms of their contents, structures and financing forms. Thus, there are, among other things, indication-based contracts (for example, in the area of endoprosthesis), treatment-related contracts (e.g., outpatient surgery) or case-management contracts (transsectoral care). The financing agreements range from budget agreements, to population-related comprehensive lump-sum payments, to case-related flat-rate payments. Only a portion of hospitals participate in integrated care (in 2010, it was 37.1 percent of hospitals according to the "Sondergutachten 2012" [Special Assessment 2012] of the Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen [Advisory Council on the Assessment of Developments in the Health Care System]).

74 Zweites Gesetz zur Änderung der Vorschriften zum diagnose-orientierten Fallpauschalensystem für Krankenhäuser und zur Änderung anderer Vorschriften (BGBl. I, 3429).

75 Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung (BGBl. I, 378), last amended by Article 4 of the Act of 28 July 2011 (BGBl. I, 1622).

DRG remuneration system were adapted from 2009 with the Hospital Financing Reform Act of 17 March 2009.

Since 2009 there have been changes on average every half-year, among others, to the Hospital Financing Act, the Hospital Fees Act and the GKV-Versorgungsstrukturgesetz (Statutory Health Insurance Care Structures Act).<sup>76</sup>

With the Statutory Health Insurance Care Structures Act, in large part having entered into force at the beginning of August 2015, and with the Hospital Structures Act, hospitals once again met with considerable structural changes. Thus, the federal states are supposed to be able to incorporate quality indicators into hospital planning, which in the case of non-achievement lead to reimbursement reductions or suspension from hospital planning. The financing of hospitals' operational costs is supposed to be improved through quality surcharges, emergency care surcharges, service guarantee surcharges, centre surcharges and hospital-specific surcharges. For schedulable procedures, whose quantity can be increased without major difficulties through broadening of indications, a quantity control should occur through the process of physician second opinions and through quality-assurance mechanisms. The investment financing of the federal states should

---

76 Only to be mentioned here are the amendment of Sections 4, 7, 10 and of Attachment 1 of the Hospital Fees Act by Article 8 of the GKV-Finanzierungsgesetz (Statutory Health Insurance Financing Act) of 22 December 2010 (BGBl. I, 2309); the amendment of Sections 10, 17, 17a, 17b of the Hospital Financing Act by Article 6 or, respectively, of Sections 2, 21 of the Hospital Fees Act by Article 7 of the Statutory Health Insurance Care Structures Act of 22 December 2011 (BGBl. I, 2983); the amendment of Sections 17, 17b-d, 18, 28 of the Hospital Financing Act by Article 1 or of Sections 2, 4, 6, 8-10, 19, 21 of the Hospital Fees Act by Article 3 of the Psych-Entgeltgesetz (Psychiatry Remuneration Act) of 21 July 2012 (BGBl. I, 1613); the amendment of Sections 4, 6-10 of the Hospital Fees Act by Article 5a or of Sections 17b, 17c of the Hospital Financing Act by Article 5c of the Gesetz zur Beseitigung sozialer Überforderung bei Beitragsschulden in der Krankenversicherung (Act on the Elimination of Social Overburdening through Contribution-based Debts in the Health Insurance) of 15 July 2013 (BGBl. I, 2423); and the amendment of Sections 4, 8, 14 of the Hospital Fees Act by Article 2b of the Erstes Pflegestärkungsgesetz (First Long-term Care Strengthening Act) of 17 December 2014 (BGBl. I, 2222).

correspond to the average of the funds spent in the years 2012 to 2014. A structural fund endowed with 500 million euros has as its goal the reduction of overcapacities, the stronger concentration of care services and restructurings in non-acute inpatient care facilities. In the years from 2016 to 2018, a nurse staffing development scheme is supposed to strengthen nursing in hospitals with up to 660 million euros. Up to approximately 90 percent of the additional expenditures are supposed to be borne by the statutory health insurance, which can, however, simultaneously expect cost-savings through the quantity control likewise foreseen in the law.

## **2.5 Conclusions**

In summary, this overview shows that the area of inpatient care in Germany represents an extremely complicated construction in operational, financial, structural and legal respects, whose comprehensive understanding necessitates an intensive specialised knowledge that additionally demands continual updating due to the high dynamics of required changes imminent in the system. On the level of the healthcare providers in the medical area, of nursing and of the health professions employed in hospitals, a constantly updated knowledge is demanded about the respectively applicable details of the remuneration system in order to face accounting-related deficits in the documentation of diagnoses or to avoid the provision of – in economic terms – problematic medical services. This requirement appears increasingly determinative alongside a high quality and patient-friendly care. On the systemic level, the manifest necessity of continuous subsequent legal improvements already suggests the assumption that the present system of inpatient care has not so far developed a consistency and stable, self-supporting functionality. Even if improvements have been achieved through legislative activities, it is clear that on the level of the hospitals a medium-term planning security

hardly exists for the individual facilities. Additionally, differing and partially opposing requirements clash in the system of inpatient care and need to be mediated. If one conceives patient welfare as the ethical guiding principle of hospital treatment, the question arises of how this can be represented in the system of inpatient care and which requirements the system must conform to in order to do justice to this guiding principle.

### 3 PATIENT WELFARE AS AN ETHICAL STANDARD

According to Section 107 (1) SGB V, it is the task of hospitals “to recognise patients’ illnesses, to heal, to prevent their worsening, to alleviate complaints of illness or to render assistance at birth”. In accordance with Section 1 (1) Hospital Financing Act, hospital care should be “needs-based” and “efficient”. In 2015 with the Hospital Structures Act, these goals were supplemented by those of being “of high quality” and “patient-friendly”. Even if this poses questions about the precise definition, these supplements still make clear that the treatment quality and observance of the individual needs of the patient are supposed to retain a stronger weight in the future.

In consideration of the general guidelines of the healthcare system, such as the requirement of economic efficiency (Section 12 SGB V) and the stability of contribution rates (Section 71 SGB V), the concept of “patient-friendly care” is predicated on observing the individuality of particular patients and guaranteeing a treatment attuned to their needs; the goal definition of being “of high quality” is likewise predicated on the appropriate medical standard. Both elements can be viewed as essential aspects of an orientation towards patient welfare.

Even if the orientation towards patient welfare appears intuitively plausible as a normative guiding principle of healthcare, the concept of patient welfare is not defined clearly. Patient welfare encompasses dimensions that are objectifiable (medical parameters, accessibility of the service), subjective (treatment satisfaction, consideration of subjective preferences) and inter-subjective (mutual recognition, respect, attentiveness). These often stand in a relationship of tension. With the three ethical criteria outlined in what follows, the orientation towards patient welfare is operationalised in a normative sense. Here, it is a matter of care that enables self-determination; the guaranteeing of good treatment

quality; and the observance of equal access and distributive justice.

Among these criteria for orientation towards patient welfare, care that enables self-determination enjoys precedence and is outlined first, because it rests on the ethically and constitutionally relevant principle of respect for the self-determination of a person: No medical treatment may take place that constitutes an infringement of self-determination. Additionally, treatment quality forms the focus of medical treatments in the inpatient area: to enable a patient's self-determination that is not directed towards high quality and patient-appropriate treatment, would neglect its goal. Since resources are limited, they must be distributed in a just and efficient manner. Inefficient and ineffective resource allocation produces injustice and is hence to be avoided on not only economic, but also ethical grounds. Therefore, allocation considerations intrinsically belong in such ethical reflections; they are a necessary, albeit not sufficient criterion for the attainment of patient welfare.

## **3.1 Care that enables self-determination**

### **3.1.1 Self-determination**

The concept of autonomy denotes the fundamental human ability to draw reasonable considerations on its own account, to exchange reasons for actions with other persons and to make decisions responsibly. This ability distinguishes the human as a morally capable living being. From this, the right to self-determination and personal development is likewise ethically and legally derived, as is the responsibility of the individual for her/his actions, for the convictions that guide him/her in the process, as well as for their imputable consequences.

Assuming that autonomy belongs fundamentally to the human being, self-determination denotes the possibility of realising one's own designs for action and decisions on action.

The realisation of this possibility depends on concrete circumstances. It is related to the place and time of the individual life, as well as to its stage of development. Physical and mental health are also of significance here. At the same time, self-determination is a legal claim that is expressed differently in various legal systems.<sup>77</sup>

The understanding of the patient's self-determination encompasses different aspects. In order to be able to speak of a self-determined decision, a person must have possibilities for action available ("to be able to do otherwise"), among which she/he can choose on the basis of reflections ("to have reasons"). Further, self-determination requires the consciousness of one's own authorship ("I am the one"), the consciousness of which accounts for the imputability of a selected course of action.<sup>78</sup>

To exercise self-determination requires that the person understands the essential aspects guiding his/her decisions according to their nature and consequences. This poses high demands on the communication between doctor and patient when, for example, it is a matter of consent to medical measures, but it also affects the communication between patient and nurse and others employed in the hospital when it is a matter of nursing care and the organisation of the daily routine in the clinic. Moreover, self-determination requires that the patient can assess treatment recommendations or questions regarding the organisation of nursing procedures and can make his or her decision accordingly against the background of her/his life situation and attitudes. Since it is frequently a matter of shame- or fear-filled assessments and decisions, good communication presupposes a high level of empathy and attention, but also knowledge and experience for those employed in hospitals.

One can speak meaningfully of a person's "self" only in relation to other people. One can always understand one's self only in interaction with the respective other. That self-esteem

---

77 Cf. Deutscher Ethikrat 2013, 120.

78 Wunder 2008.

which includes respect of the other demands the recognition of the other as well as respect and attention in contact with that person. From this also arises the limit to self-determination, namely when its assertion would infringe upon the rights of others. In the hospital, in which there are innumerable forms of illness and need and in which, moreover, patients are to be met in increasing number who are cognitively challenged and who can only partially without difficulties make decisions about themselves, the respect for self-determination also includes the expectation to support patients in these situations, to assist them or to restore their competencies for self-determination. Patients who are not capable of consent and are dependent on an authorised representative or custodian, can be involved through corresponding support on decisions. Even if surrogate decisions by authorised representatives or custodians should be necessary, the individual assessment of the patient concerning the determination of his/her respective welfare is of the greatest significance. To respect self-determination also means, moreover, to encourage patients who otherwise can only speak limitedly for themselves or who can no longer speak for themselves to still make decisions in small things such as the organisation of their daily routine.

It is thus insufficient from an ethical perspective to rely on the legally commanded respect of each person's self-determination and not to prevent this person from the exercise of her/his self-determination. Rather, it is ethically imperative to strive for the self-determination of each patient. This is especially clear with respect to vulnerable patient groups (see 4.5).

### 3.1.2 Caring-for and care

The type of attention to patients in the context of medicine and nursing is often described in German with the word *Fürsorge*<sup>79</sup>.

---

79 Translator's note: literally "caring-for", but customarily "care" or "welfare".



Accordingly, the concept is understood in the positive sense as supporting care that recognises a person in his/her individuality and value system. However, some associate with the concept of *Fürsorge* that the doctor or nurse assumes responsibility for the patient without acknowledging that person's own impulses, interests or even possible wishes otherwise. Among doctors or members of other health professions, this attitude, generally identified today as paternalistic, is usually not based on the actor's bad intentions, but rather on the idea of doing the best for the patient. Yet on the patient's side, such behaviour is predominantly experienced as patronising; as ignoring the actual person and her/his own ideas; or even as degrading.

Against the background of the negative connotation of the term *Fürsorge* represented above, the concept of *Sorge*, to a large extent experienced as less charged, is used in this text to emphasise the patient-centred attitude. The concept of *Sorge* in this sense also corresponds to the term "care"<sup>80</sup> used in international literature, which among other dimensions includes: fellow human affection, sympathy, encouragement (towards a still possible self-determination). With this, the patient is offered security and trust, directions (to activities of daily life still possible) and support, but also the provision of care and the assumption of responsibility for the other insofar as this is necessary.

The voice-depriving assumption of responsibility, familiar from the debate around paternalism, also poses an inherent danger to the concept of care. All the more so then, this

---

80 Behind the concept of care, there is a broad debate, whose point of entry is formed by the moral-psychological works of Carol Gilligan. Most care ethics contrast justice and care, a stance that is itself critically discussed in the debate. A further discussion relates to the reproduction in care ethics of classical gender stereotypes; the concentration on the intimate space of the relationship; the close connection of feeling and moral action (and similar objections). However, there are also approaches that conceptualise a "public care ethics" in which the conditions are reflected that a just society needs in order to deliver *Sorge* or *Fürsorge* in the sense of care and to be able to facilitate its realisation in the space of relationships. For a good summary of the feminist-ethical critique of a care ethics, see Jaggar 1995.

requires an examination of the arrangement of respective relationships and the assurance that the other is recognised as a self-competent subject and is encouragingly supported in his/her position as a weakened fellow human being reliant on help. Both aspects are equally important and constitute the concept of a care that enables self-determination.

### 3.1.3 Doctor-patient relationship<sup>81</sup>

In medical ethics, the patient is today viewed in her/his double role as a person needing help and as a “shaping force”<sup>82</sup> to which doctors, therapists and nurses have to adjust when shaping their relationship with the patient. On the one hand, patients confront the doctor or nurse today in a confident and informed manner, with personal responsibility, with rights and duties.<sup>83</sup> On the other hand, the special case of patients in the hospital must always be seen, who, differently from those in outpatient care, are reliant on special help not only due to their illness, but usually also with respect to the special circumstance of being in the unfamiliar situation of a hospital patient. In the event of restricting emotions such as fear and shame or restricted cognitive faculties, he/she needs support in order to make decisions for herself/himself or, as far as possible, to participate in decisions.

---

81 The relationship addressed here also applies, of course, to other relationships between a patient and person offering treatment.

82 Reiter-Theil 2000, 844.

83 The Gesetz zur Verbesserung der Rechte von Patientinnen und Patienten (Act on the Improvement of the Rights of Patients; Patientenrechtegesetz) of 20 February 2013 (BGBl. I, 277) also takes into account this perspective. The doctor-patient relationship is codified in the Patientenrechtegesetz (Patients' Rights Act) as a separate contract. Rights and duties are also extended to the non-physician-based healing- and other health-professions. With the law, the treatment principles developed previously in the jurisprudence are codified. Above all, these include: the requirement for treatment according to the generally accepted professional standards existing at the time of treatment; the entitlement to adequate information and counselling; the requirement for consent to treatment; the requirement for documentation; and the right to access to patient records.

The Patients' Rights Act emphasises a further aspect. According to the law, patients and parties offering treatment are supposed to cooperate. Already prior to the law taking effect, the thought of a duty to cooperate on the part of the patient was discussed. It is frequently understood as a duty of the patient towards compliance in the sense of an observance of rules. In the definition of the World Health Organization from 2001 this meant "the extent to which the patient follows medical instructions"<sup>84</sup>. In today's perspective on the patient as a self-determinedly acting subject, it would be appropriate to follow the concept of adherence. Adherence designates the extent to which the behaviour of the patient corresponds with a jointly arranged therapy concept. With this, it takes into consideration much more strongly the respective individual factors of understanding and of participative possibilities. In contrast to the concept of compliance, the design of the therapy is based on the inclusion of the patient and the support of self-care management.<sup>85</sup>

More than the compliance concept, the adherence concept also takes up the understanding of the patient's health competency. Accordingly, health competency comprises alongside knowledge and motivation, the competency to obtain, understand, assess and implement health information.<sup>86</sup>

In this context, the design of the respective doctor-patient relationship is of great significance, for it positions the health competency of the patient in more or less pronounced ways. In their basic nature, the following statements apply equally to the nurse-patient or therapist-patient relationship. Alongside the paternalistic model that is largely overcome today, the following models are discussed:

---

84 Sabaté 2001, 7.

85 To be understood here under self-care management is the activity of the patient, with which he/she verifies signs and symptoms of an illness's worsening for their significance and initializes measures for avoiding a further worsening, for example, through drawing on professional help.

86 Cf. Sørensen et al. 2012.

- >> the informative model: the patient is provided all information, but the decision is left to him/her in the assumption that she herself/he himself can best assess his/her expectations and values;
- >> the interpretative model: the doctor does not only provide all information, but also questions and counsels the patient regarding her/his values and expectations and, moreover, gives recommendations;
- >> the deliberative model: on the basis of information, counselling and a joint exploration of the health-related values, the patient is encouraged to make a good decision within the framework of the indications posed.<sup>87</sup>

The deliberative model comes closest to what is today's predominantly recommended model of shared decision making. Shared decision making is, however, predicated even more clearly on the equality of doctor and patient and on the negotiation of a decision on the basis of the best possible information and in consideration of the values and expectations of the patient.<sup>88</sup> Shared decision making thus has successful communication as a prerequisite; it entails, among other things, agreements concerning the implementation of the decision; and it underlies the concept of adherence.

### **3.1.4 Successful communication as prerequisite for care enabling of self-determination**

Relationships of patients to their doctors, nurses and therapists rely on successful communication. Communicative competency is an indispensable, key competency of all healthcare professions. Besides communication with the patient, it also includes communication with the people in the environment

---

<sup>87</sup> Klemperer 2003, 14 ff.; Emanuel/Emanuel 1992.

<sup>88</sup> Loh et al. 2007.

of the patient, especially following hospital discharge with those persons who assume major significance in the assuring of therapeutic successes.

Nevertheless, empirical studies substantiate numerous deficits in this area and reveal considerable dissatisfaction on the part of patients.<sup>89</sup> Studies show that information about medical measures is an important factor for patient satisfaction.<sup>90</sup> Deficient communication not only is a cause for patient dissatisfaction, but also leads to a lack of adherence in 19 percent of cases.<sup>91</sup> This important topic and the resulting questions were the object of controversial discussions during the 118<sup>th</sup> Deutscher Ärztetag (German Medical Assembly) in 2015. Hence, in the decision minutes the German Medical Assembly emphasises the central importance of communication in healthcare and issues the urgent call for numerous necessary improvements in this area.<sup>92</sup>

A successful instruction provides the patient initially with the necessary information for her/his decisions in a situation often experienced as a borderline situation.<sup>93</sup> The correct estimation of the patient's needs regarding information is of great significance in this context. Doctors' and nurses' information should, nonetheless, in no way be reduced to a professional ritual at the beginning of treatment. Integral to a care that enables self-determination is, rather, the assurance that the patient has understood the information, as well as the conversation regarding the assessment done by the patient against the background of his/her values and preferences. Additionally, the communication between the person treating and the person being treated is to be understood as a process during the entire duration of treatment. In doing so, the developments on the part of the patient in the course of the treatment phases are also to be taken into account.

---

89 Lahmann/Dinkel 2014.

90 Schoenfelder/Klewe/Kugler 2011.

91 Haskard Zolnierrek/DiMatteo 2009.

92 Bundesärztekammer 2015a, 99.

93 Geisler 2010.

In addition to the content of the conversation, the nature and general framework are also crucial for a successful communication. Virtues and competencies, such as goodwill, honesty, empathy, attention and orientation towards the greatest possible autonomy, should characterise the entire communication process.<sup>94</sup> To preserve confidentiality and to guarantee the necessary attention in certain situations (for example, in conveying a diagnosis of cancer), appropriate spatial, temporal and personnel resources are to be kept available. Through the training of communicative competencies and the provision of useful concepts for a good and goal-oriented conversation, the often limited time available for a conversation can be used much more effectively.<sup>95</sup>

Communication with patients who require special attention can represent a particular challenge. Among these are children and adolescents; elderly patients, with typical geriatric illnesses, with disabilities, with dementia; as well as patients of other ethnic origin, nationality or religious affiliation. In this regard, intercultural treatment situations are often affected not only by language barriers, but also by cultural differences, so that any ethically appropriate decision-making process has to take into account differing moral concepts.

In summary, it can be held that the self-determination-enabling care necessary for patient welfare has as its starting point the respecting and heeding of the patient as a person with individual ideas, wishes, interests, history and rights. To respect the self-determination of the patient and thereby to respect his/her decisions following in-depth information represents the indispensable prerequisite of treatment. Care that enables self-determination also includes encouragement and support when the patient is only limitedly capable of a self-determined decision due to emotions such as fear or shame or because of cognitive limitations. The prerequisite here is always a

---

94 Herbst 2000.

95 Cape 2002.

doctor-patient or nurse-patient or therapist-patient relationship that is sustained by trust and empathy and includes attentive communication, shared decision making and therapy agreements along the lines of the adherence concept.

## 3.2 Quality of treatment

A further benchmark to measure patient welfare is the quality of treatment.

Quality can be divided into objective criteria following medical-scientific perspectives, for example, amelioration or healing of the illness, alleviation of pains and other symptoms, improvement or recovery of functionality in all spheres of life; as well as in subjective criteria, for example, quality of life, patient satisfaction and the accordance of one's own goals with the treatment outcome. The definition of appropriate criteria and methods for measuring quality of treatment represents a major challenge gaining increasing significance for hospitals, since according to the Hospital Structures Act, the reimbursement level for inpatient treatments is oriented perspectively towards quality of treatment.<sup>96</sup>

### 3.2.1 Quality model and operationalisation

Quality measurement and quality assurance in healthcare are predominantly oriented towards the model of structural, process and outcome quality developed by Avedis Donabedian.<sup>97</sup> In this model, all three quality dimensions are associated with

---

<sup>96</sup> Section 6 (1a) of the Hospital Financing Act, newly inserted through Article 1 no. 2 of the Hospital Structures Act, states that the G-BA should now also take the quality dimensions of Donabedian (1966; 1980) – hitherto explicitly mentioned only in Section 136c (1) SGB V – as a basis for quality assurance in hospitals. By decisions of the federal states, however, this can also be excluded and other dimensions introduced.

<sup>97</sup> Donabedian 1966; Donabedian 1980.

the concept of quality of treatment and represent a holistic quality approach. The assessment of the necessity and nature of a treatment concerns all three quality dimensions and is based in many cases on medical rules that are gained empirically, verified statistically and grounded in practical experience. For numerous treatment procedures, evidence-based medical guidelines exist that are developed for the most part by medical expert associations and make the claim of being generally accepted on the basis of statistically verified data and practical experience, to be continually reviewed, and hence to express the current scientifically-grounded medical standard.<sup>98</sup> Subject to medically-grounded deviations in the individual case or to new scientific knowledge, the conscientious observance of these medical standards during treatment in the inpatient area represents a prerequisite for a high-quality treatment. Patients can expect that these standards are adhered to in the hospital, and hospitals must enable, examine and ensure the adherence to these standards in the facility.

However, for many treatment scenarios, especially with rare diseases, no guidelines exist. In these cases and also in all treatment cases with a larger variety of possible treatment options, the treating person must come to a decision on the basis of treatment analogies, inner-departmental agreement and her/his own practical knowledge, and disclose the basis of this decision to the patient. In this respect, these situations require the expertise of physicians and diligence. In some cases, interdisciplinary agreements and the inclusion of special expertises or second opinions are necessary in order to enable a high-quality treatment.

Since the overriding majority of guidelines were not developed for special patient groups, such as elderly and very elderly patients, multimorbid and chronically ill patients with functional limitations (for example, hearing or visual impairment), patients with mild cognitive impairment, diverse forms

---

98 In more detail, Taupitz 2009.



and stages of dementia, patients with various disabilities and patients with rare diseases, the physician is frequently directed here towards decisions that must be made on the basis of the above-mentioned varying sources.<sup>99</sup>

### ***Structural quality***

By structural quality, one understands the quality of resources available, such as spatial conditions, the instrument-based equipment of the hospital, but also the level of training and staffing. For a good quality of treatment, it is necessary that a hospital and its employees only undertake a patient's treatment when

- >> the spatial situation does not hold any special health-endangering risks (e.g., deficiencies in hygiene);
- >> the medical technology conforms to diagnostic and therapeutic needs;
- >> the personnel can be deployed in sufficient number and with the necessary qualifications during the treatment.

As long as the structural quality in a facility does not conform to the specific needs of a patient, the prerequisites for his/her treatment in this facility are not fulfilled.

### ***Process quality***

Process quality is related to the question of how the proper treatment steps are selected (establishing of indications, effectiveness) and how the sub-steps necessary for treatment are constructively organised (efficiency).

To ensure a high quality of treatment, it is important that

- >> the medical indication is established in adequate time according to the current state of medical knowledge and that a treatment is begun only on this basis;

---

99 Aylett 2010.

- >> the individual treatment steps are reasonably organised and unnecessary waiting periods, duplicate examinations or unnecessary examinations are avoided;
- >> the patient is informed during the treatment in an adequate manner and included in decisions.

### ***Outcome quality***

With regard to outcome quality, there are defined indexes for some, but not all parameters. Examples are rates for mortality, complication and bedsores or falls in the hospital. In addition to the physician- and nursing-based assessment, outcomes from patient surveys are also an element of outcome quality. Deficiencies in outcome quality are attributable for the most part to deficits in the structural and process-based prerequisites. It is pertinent to a good treatment quality that

- >> indexes of outcome quality rely on transparency and comparability;
- >> the hospital allows for a constructive error management culture and integrates this into a risk management for the continual improvement of outcome quality.

## **3.2.2 Quality measurement**

The concept of high-quality care in the hospital hence encompasses, alongside the quality of physician- and nurse-based treatment, a variety of structural, equipment-related and procedural communicative aspects, for which, in the future, a large weight is to be attributed on the basis of the Hospital Structures Act adopted in 2015. The major challenge in the newly introduced quality orientation in hospital planning (see 2.4) consists for the G-BA in developing evidence-based and just quality indicators that – as much as possible standardised nationwide – are implementable, measurable, comparable and litigable.

The quality dimensions can be measured with varying degrees of success. While structural quality can be assessed relatively easily by examining whether required material or personnel resources are available, this is markedly more difficult with process quality. For the assessment, analysable data have to exist on individual sub-steps across the entire treatment (also taking into account interfaces to other service providers outside the hospital) with information on points in time. This has existed for only a few sub-areas, such as, for example, the operating room. The largest assessment problems exist with respect to outcome quality. Causes for this are possibly differences between the subjectively felt and objectively verifiable quality, as well as assessments that change in the individual course of treatment or issues regarding the suitable or appropriate point in time for a quality measurement. Finding appropriate indicators for the survey and interpretation of outcome quality poses additional difficulties: Affecting outcome are also the individual health situation of the patient, his/her expectations, previous treatments as applicable, as well as the adherence of the patient during the treatment.

In summary, it can be noted that a high-value treatment in the hospital that includes objective as well as subjective dimensions represents a central criterion for patient welfare. It is connected to the criterion of the self-determined consent of the patient and her/his enablement through care oriented towards self-determination. For a treatment that is of high quality and patient-friendly, a fundamental importance is attached to the medical indication being responsibly provided and correlated to the individual patient. The German Medical Association in its Opinion “Medizinische Indikationsstellung und Ökonomisierung” (Medical Indication and Economisation)<sup>100</sup> also relates the medical indication explicitly to patient welfare, which the Association sees threatened, nonetheless, through increasingly economically defined objectives that enter as

---

100 Bundesärztekammer 2015b.

medically-extrinsic assessment criteria for establishing the indication. Ultimately, the structures and processes required for an indication-appropriate treatment in the hospital are of decisive significance for high-quality treatment outcomes.

### 3.3 Equal access to health services and just distribution of resources

In formal terms, justice means first of all the justified consideration of what is appropriate respectively for each person. From time immemorial, there has been a struggle for the conceptual differentiation of this demand, which is fundamental for human coexistence. Since Aristotle, justice has required some minimum standards that one can describe as formal or universal justice and to which one can ascribe elements of fair procedure, equal treatment of like cases or observance of necessary transparency.<sup>101</sup> The notion of formal justice can be expanded in modernity above and beyond these elements in such a way that equal respect as a person (status equality) belongs to the minimum conditions of a justified and equal consideration of what is respectively appropriate for each person.<sup>102</sup>

People meet under conditions of considerable inequality. Without being able to discuss here even to a limited extent the broad conversation about the necessity and limits of the societal reaction to such social inequalities, it can, nevertheless, be maintained that a broad consensus has been established in this regard that every person should have the fair opportunity

---

101 On the concept of justice in Aristotle, see Book V of the “Nicomachean Ethics”.

102 The principle of *Gleichheit*, in the sense of equality in access to healthcare, is decisively characterised by a basic status equality of all people. It is the expression of the objective-legal dimension of the guaranty of human dignity in Article 1 (1) GG and is underpinned by the general principle of equality before the law in Article 3 (1) GG (cf. Kirchhof, in: Isensee/Kirchhof 1992, section 124, para. 199).

of being able to develop her/his own personality in the context of the given societal circumstances and to participate in social life. Against this background, different needs legitimate differing allocation of resources in order to be able to experience equal opportunities at all.

Further, given conditions of scarce resources, one can hardly dispute that an inefficient and ineffective usage of resources is unjust. The fact that the determination of what ultimately constitutes efficiency and effectiveness is highly controversial does not change the general observation that efficiency and effectiveness oriented economic considerations are elements of justice.

With regard to hospital care, both the access to hospital services and the allocation of services in the hospital are to be looked at in the process. For the concept of *Gleichheit* (equality), which plays a decisive role in the debate over justice, it is suggested to differentiate between equal status in the sense of the basic right (equality) and appropriate consideration of the distinctive features of the individual in the sense of fair treatment (equity).<sup>103</sup>

The criterion of equal status refers in this sense to a status-impartial hospital care. It fundamentally precludes the exclusion of particular patient groups. These principled realisations do not, meanwhile, mean that each individual hospital must guarantee in equal measure the possibility of access for all notwithstanding the economic consequences. Rather, the state bearing responsibility for the guarantee may by all means bundle offerings or more strongly centralise certain care services in order to thus ensure a needs-based hospital care that also benefits the special requirements of specific patient groups. Rules are needed that prevent unjustified discrimination and privileging.

Justice in the sense of fair treatment is manifested in preparing the respectively required health services against

---

103 Satzinger/Werner 2005, 115 ff.

the background of limited resources. This is not a matter of justice in exchange (as in economic life) or of compensatory justice (as in law on damages or criminal law). While the insured are entitled to appropriate healthcare through contributions to health insurance, the nature and extent of the service to be provided are not based on a contributory principle. It is also not a matter of allocating identical shares, as the principle of *Gleichheit* in the sense of equality would suggest. For the services to be provided, what is essential is the need or condition of the patient, whose illness and treatment pose completely individual demands (principle of need). In this context, an unequal distribution of medical resources can also then count as just if it contributes to the equality of life chances, which are unequally distributed through illness and disability.<sup>104</sup>

However, the attempt to achieve a just allocation of resources in healthcare in general, and in the use of hospital services in particular, also reaches its limits when guided by equality, equity and cost-benefit analyses. At some point, under budget constraints, one reaches the point where a conflict between fair opportunities and best outcomes begins to emerge, indeed becomes unavoidable.<sup>105</sup>

What all these issues show is the following: Even the binding nature of strictly generalising criteria, such as status equality, access, sensitivity to opportunity-diminishing discriminations, efficiency and effectiveness does not exclude the necessity of considerations concerning different conceptions of “the good life” and concerning the accompanying conceptions of the human. Such attitudes also have an effect on what is considered just and generalisable. Where such influences are made transparent, public discourse gains.

---

104 Cf. Daniels 2013; Daniels 1996, 191 ff.; exhaustively: Daniels 2008, 29-56. The main argument: “Since meeting health needs promotes health (or normal functioning), and since health helps to protect opportunity, then meeting health needs protects opportunity” (Daniels 2008, 30).

105 Cf. on this and on the following example, Brock/Wikler 2006.

### 3.3.1 Patients with special needs

A special challenge for a status-impartial and discrimination-free hospital care in praxis is represented by all those patient groups that require a special expense in diagnostics, therapy, nursing, accompanying and communication and not infrequently also demand special knowledge and ability to empathise on the part of those offering treatment. In addition to patients with rare diseases, these include above all children and adolescents, elderly and multimorbid patients, people with disabilities and people with dementia, as well as patients with a migration background and the resulting different cultural perceptions and limited language skills.

As a basic principle the hospital must be open to all who need inpatient medical treatment. Nevertheless, these patient groups must, on the one hand, be viewed in a more nuanced way; and on the other, the maxim of providing care close to the patient's residence has to be weighed against the requirement of the respectively best possible treatment. In its Opinion on the UN Convention on the Rights of Persons with Disabilities, the Zentrale Ethikkommission bei der Bundesärztekammer (ZEKO, Central Ethics Committee of the German Medical Association) states, for example, that the principle – laid down in the Convention – of the same quality and same standard for the healthcare of persons with and without disabilities means “equivalent”, not “identical”, “rather a medical care commensurate to the individual need and the life situation of persons with disabilities”.<sup>106</sup> Moreover, the Convention awards to persons with disabilities the health services that are specially needed by them due to their disabilities (Article 25b).<sup>107</sup>

---

<sup>106</sup> Zentrale Ethikkommission bei der Bundesärztekammer 2010, A298.

<sup>107</sup> Gesetz zu dem Übereinkommen der Vereinten Nationen vom 13. Dezember 2006 über die Rechte von Menschen mit Behinderungen sowie zu dem Fakultativprotokoll vom 13. Dezember 2006 zum Übereinkommen der Vereinten Nationen über die Rechte von Menschen mit Behinderungen (Act on the United Nations Convention of 13 December 2006 on the Rights of Persons with Disabilities as well as on the Optional Protocol of 13 December 2006) of 21 December 2008 (BGBl. II, 35).

The inclusion of the most diverse patient groups into the regular treatment offerings of the hospitals thereby stands in a relationship of tension to the establishment of specialised treatment centres in which subject expertise is concentrated, but whose distance from place of residence is often connected to considerable social and psychological burdens for these patients. Because of the special medical knowledge required for the treatment of rare diseases, there is a strong case for concentrating on a few qualified centers. For other groups such as dementia patients or people with disabilities who require hospital treatment for reasons other than their dementia or disability, the perspective of inclusive treatment close to home may be a priority.

### 3.3.2 Conscious use of resources

The principle of justice demands dealing carefully with scarce resources. Against this backdrop, resource reflexivity<sup>108</sup> also acquires a special importance for individual patient treatment as a necessary element of doctors', nurses' and therapists' actions.

In its Opinion on “Nutzen und Kosten im Gesundheitswesen – Zur normativen Funktion ihrer Bewertung” (“Medical Benefits and Costs in Healthcare: The Normative Role of Their Evaluation”), the German Ethics Council examined the benefits and harms of the use of instruments that measure health-related quality of life.<sup>109</sup> It acknowledges as uncontested a meaningful use of such instruments when two competing medical interventions should be checked in terms of effectiveness for one and the same patient. Open for such assessments are not only individual medical therapies, but also the provision of certain apparatuses or structures. In contrast, it did not appear acceptable to the Ethics Council to use such

---

108 On the term, see Rixen et al. 2003, 193.

109 Deutscher Ethikrat 2011.



instruments in order to compare patients or patient groups with one another and hence to play them off against each other. Such a use would, as it were, set people off against each other under the aspect of their “costliness”, and hence treat them ethically and constitutionally in an inadmissible manner as objects only of a calculation. The analysis of the Ethics Council demonstrated, moreover, how dependent such calculations are on often only implicitly conveyed value judgments: Is it, for example, legitimate to assess the life time gained for an older person as inferior to that of a young person, as is sometimes the case?

Independent from such considerations, allocation decisions must not simply be passed on from the macro-level to the meso-level “downwards” and accordingly imposed upon the individual hospital or even the individual physician, who may thereby find himself/herself in a predicament that is incompatible with professional ethical demands. Due to limited medical resources available at the micro-level, the physician would have to make choices between patients and to withhold a promising treatment from one in order to be able to offer it to another.

The ZEKO also warns against such developments. It differentiates between economic efficiency and economisation. Economic efficiency is understood as an allocation of goods and services that is as efficient (economical) and effective as possible and hence serves as an important point of reference for medical action that stands “as such in no way in contradiction to the moral identity of the medical profession”. Economisation prevails, in contrast, “when economic parameters gain an increasing definitional power over individual and institutional action goals beyond their service function for the realisation of genuine medical duties”. The Opinion of the ZEKO turns against such an “economising transformation of medical procedures”.<sup>110</sup>

---

110 Zentrale Ethikkommission bei der Bundesärztekammer 2013a, A1753 f.

Conversely, economic considerations should not lead to an expansion in volumes without sufficient indication.<sup>111</sup> In this respect, the fear exists that certain kinds of treatment would be increasingly performed or omitted in dependence on the respective reimbursement situation. Admittedly, it is disputed whether phenomena such as expansions in volume in the hospital are always verifiable as a direct consequence of introducing the DRGs.<sup>112</sup>

Organisational-structural consequences follow from the deliberations outlined above. In terms of considerations of both effectiveness and efficiency, it appears judicious to strengthen structures of institutionalised assumption of responsibility. For the macro-level of allocation, all fundamental agenda-settings must be institutionally identifiable and politically accountable. On the meso- and micro-level, risk-management systems<sup>113</sup> are to be combined with quality-assurance structures that ensure the systematic identification of misguided developments, to recognise them as potential supply risks and take preventive action.<sup>114</sup> That way, the implementation of resource reflexivity can be ensured.

---

111 One example for the difficulties in verifying such fears is the controversy over the method, available only since 2007, of Transcatheter Aortic Valve Implantation (TAVI), that is, of the minimally-invasive replacement of the aortic valve on the beating heart in older at-risk patients. This method is much more expensive than the traditional operation on the open heart, albeit due to its minimal invasiveness also particularly applicable among older patients who could no longer be exposed to the risk of an operation. What is contested is the rigour of the indication, because the use has increased enormously in the last years (it is estimated that circa 12,000 TAVIs of the worldwide 40,000 have been performed in Germany). Studies reveal a higher death rate following this operation than by the traditional one, which the advocates, however, explain with the higher illness burdens of the patients. Cf. Gotzmann et al. 2011; as well as Tamburino et al. 2011.

112 Schreyögg et al. 2014.

113 Risk management in hospitals takes equally into account legal demands, economic targets, quality standards and patient welfare in order to identify risks at an early stage and to introduce countermeasures or to regulate errors or harms that have occurred. In doing so, it is asked less who is guilty of an error than how an error has appeared.

114 See on this Höfling 2008, 32.

In summary, it can be stated: Justice in the sense of equal access to and just distribution of hospital services includes both the imperative of status-impartial equal treatment (equality) and the precept of fair and in each case individually patient-oriented use of resources (equity). Even if the fundamental allocation decisions are to fall on the responsible political and superordinate levels, economic considerations must also be taken into account on the micro-level, i.e., through the action of the individual physician and the individual nursing staff. Equal access and just distribution signify on the basis of the given scarcity of resources that resource-indifference at one place can lead to the harm of patients at another. From this arises the precept of the resource-reflexive behaviour of all participants, according to which resources in the hospital are to be constantly used effectively and efficiently. Nevertheless, this precept precludes a primarily economic orientation of physician- and nursing-based action, as would, for example, be the case if the use of resources were compared between different patient groups, with the consequence of excluding certain patients or patient groups from a necessary treatment.

## **4 THREATS TO PATIENT WELFARE: AREAS OF CONFLICT**

Patients, the professional groups employed in the hospital and hospital institutions themselves, according to their individual perspective, associate different respective focal points of interest with the target horizon of a “good” treatment. Even if all these actors fundamentally accept the interests of the respective others as justified, desirable or even critical for an appropriate treatment, for patients the focus is generally on a treatment that safeguards their dignity and personal self-determination; for the medical professional groups, it is on the effectiveness of their professional efforts in terms of a best possible treatment outcome; for the economy, the efficiency of the treatment in the sense of a favourable cost-benefit ratio is central; and for the hospital, the economic securing of its own existence or even earnings. These different interests concur at the hospital as a place for treatment and have to be mediated there. In the process, the hospital as meso-level finds itself in a complex dependency on the service providers of the various professional groups that could be described as micro-level, as well as on the social structures and political, legal and economic preconditions and frameworks identified as macro-level.

If one understands patient welfare as the ethical guiding principle of a “good” treatment, numerous developments call attention to the fact that the inpatient care system in Germany is increasingly falling short of this aspiration. At present, the effectiveness and efficiency of the treatment are given priority as outcome parameters in patient-related decisions, whereas other aspects relevant for patient welfare, such as care for the patient or respect for his/her self-determination, for example, are not adequately taken into account. These factors are difficult to operationalise from an economic point of view and can conflict with a primarily economic perspective. Particularly for patient groups with special needs, the aspects of equal access

to treatment services or the just distribution of resources also recede behind criteria of efficiency and effectiveness.

An increasing prioritisation of the economy in treatment decisions is discussed under the concept of the economisation of inpatient care. At different levels of the system, this can lead to ethical conflicts. Thus, those employed in hospitals deplore that the parameters invoked at present for allocation decisions do not adequately take into account the respective professional ethical demands for a treatment oriented towards patient welfare, with the effect that these can scarcely be fulfilled any longer.<sup>115</sup> Other consequences pertain to the equal access to hospital treatment of patients who require a high level of care. The delaying of or a suspension in investments by hospitals is also connected to ethically relevant consequences when, for example, the state does not adequately fulfil its duties as assumed through the dual system of hospital financing. Moreover, the ethical question emerges of to what extent the hospital as social institution and beneficiary of a solidarity-based system must, for its part, put aside efforts at profit beyond the covering of actually arising costs and meaningful investments.

In what follows, areas of conflict are outlined that relate to the three criteria of patient welfare: care that enables self-determination; high quality of treatment; as well as equal access to and just distribution of resources.

## 4.1 Communication

The treatment situation in the hospital and the associated asymmetry of the relationship between practitioner and patient requires not only a fundamental respect for the self-determination of the patient as a person, but additionally the caring enabling of the realisation of her/his self-determination when the latter is limited or hindered by factors such as, for example,

---

<sup>115</sup> Zentrale Ethikkommission bei der Bundesärztekammer 2013a.

fear or cognitive restrictions. There exists a justified claim on the part of the patient, arising from his/her personhood, to the possibility of realising self-determination. According to a modern understanding of medicine, this claim is taken up in the model of an ideal treatment situation where those acting therapeutically work out a treatment concept, in tandem with the patient, individually tailored to him.

It is obvious that an approach oriented towards patient welfare requires certain preconditions. Among these are the time, expertise and practical communicative competency of those employed in the hospital.<sup>116</sup> Communicative competency presupposes not only linguistic capabilities, including the ability for simple language, but also social competency, such as the empathy with the addressees and the readiness to perceive nonverbal signals and messages. Successful communication thus requires not only appropriate knowledge and abilities, but also sufficient personal willingness. Moreover, communication in the hospital is viewed as a highly sensitive area of interaction in which prejudices, reservations and potential for discrimination are displayed. Given the asymmetrical relationship between the practitioner and the patient, the ability and willingness to communicate appropriately is closely related to dealing with patients in a way that is just and enables their self-determination.

In light of the growing pressure for performance, the increasing lack of time and the use of information technologies that ever more strongly define everyday life, the communicative competency of personnel, alongside pure professional expertise, is gaining an ever-greater significance.<sup>117</sup> Next to the communication between physician and patient, nursing staff and patient as well as therapist and patient, the required competency is also related to the communication between supervisors and employees and amongst the representatives of

---

116 Hoefert 2008, 167.

117 Klinkhammer/Krüger-Brand 2015.

individual professional groups. Good communication also has economically relevant effects. Information that is not taken into account in the treatment or becomes lost can lead to problems that are burdensome to all involved (for example, unnecessary or duplicated examinations) onto ones that are severe (for example, information about intolerances; mix-ups). Communicative competency in hospitals therefore assumes a central role in personnel and organisational management as well as in quality management.<sup>118</sup> Also to be pointed out in this context is the necessary communicative competency that doctors and nurses in executive positions require as part of management skills.<sup>119</sup>

Communication also plays a vital role in intercultural treatment situations as part of “intercultural competence”. “Intercultural competence” is identified as a key competence of the 21<sup>st</sup> century and defined as follows: “Intercultural competence describes the competence to interact effectively and appropriately in intercultural situations on the basis of certain attitudes and outlooks as well as specific abilities for action and reflection”.<sup>120</sup> For the daily routine in the hospital, abilities and skills are especially important that, in intercultural treatment situations, enable an ethically appropriate orientation for action and promote reflection on these actions. Among other things, part of this entails cultural knowledge, culturally sensitive communication, avoidance of stereotyping as well as critical recognition and self-reflection.

In order to prevent negative impacts of deficient communication on patient welfare and to improve professional self-perception, it is necessary that the acquisition of communicative competency and intercultural competence becomes a fixed component of the professional training, advanced training and continuing education in the health professions. It is also

---

118 Schaller/Baller 2008.

119 Seffner/Oberschelp 2013.

120 Bertelsmann Stiftung 2006, 5.

essential to create in hospitals the structural and procedural preconditions for a reliable and culturally sensitive communication, the latter, for example, in the form of translators, as well as pastoral care, who are medically knowledgeable and familiar with the German healthcare system and its ethical foundations. For deaf patients, a translation into sign language is correspondingly required.

## **4.2 Professional ethos and professional reality**

With regard to a treatment oriented towards patient welfare, a further area of conflict that arises for the various professional groups employed in hospitals has to do with the respective professional ethos, the associated convictions and goals, and the hospital reality. Contradictions between professional ethos and professional reality can be considered as an indicator for threats to patient welfare.

### **4.2.1 Physician-based area**

For doctors, the widespread approach developed by Tom Beauchamps and James Childress of the “four principles of biomedical ethics” represents an important framework for orientation. Two of these principles, that of beneficence and that of non-maleficence, have already been a basic element of the physician’s ethos since Hippocrates. In contrast, the principle of respect for the autonomy of the patient – at least in its present form and according to current understanding – is relatively new. While the principle of justice holds as a classical tenet of ethics, the authors of this approach, nonetheless, specify it for the area of medical care by posing new priorities.

The principle of autonomy, or of respect for the autonomy of the patient, is directed against the practitioner imposing his/



her will on the patient and is aimed at the enabling of an informed and free patient choice in the treatment situation. The principle of non-maleficence refers back to the classical physician's tenet of *primum nihil nocere*. It demands the tenability of the risks and side effects associated with the intervention and hence requires high qualitative standards and their individual adjustment to the respective situation of the patient. The principle of beneficence designates the physician's duty to prevent illnesses, to heal and to relieve the suffering of the patient. It thus claims the medical principle of *salus aegroti suprema lex*, which traditionally was deemed to be the classical principle of medicine par excellence. The principle of justice focuses on the equal treatment of patients and on a just access to healthcare. Even if their theoretical foundation, the relation of the four principles to one another, and their role and scope in concrete ethical decision-making remain the object of controversial discussion (not treated further here), it is evident that the four principles call for ethical duties on the part of the physician that, in part, find correspondences in law. Thus, the physician must conscientiously and comprehensively inform the patient, as a precondition to her/his self-determined decision, about planned medical measures and their side effects and risks; take the necessary time to do so; and, as applicable, respect the patient's divergent decisions. The risks and side effects associated with the intervention necessitate, in order to heed the precept of non-maleficence, that physicians' actions be supported by adequate competence and experience, as well as the use of a procedure that, as a rule, corresponds to acknowledged quality standards. The determination of a justifying medical indication in observance of the principle of beneficence requires, in addition to medical expertise, an assessment of the individual patient and an adjusting of medical measures to her/his individual life situation. As a demand of the principle of justice, a discrimination-free access by patients to medical treatment requires, among other things, the willingness not to keep patients with special care needs away from treatment and to

distribute the available resources justly. With these demands, the four principles prove to be necessary conditions for securing patient welfare.

Against the background of these principles as a widely respected basis of medical ethics, many doctors working in the hospital increasingly experience the current situation of patient treatment, due to economic parameters that lead to a high pressure and intensification in work and thereby often hamper an appropriate patient treatment, as ethically problematic and scarcely reconcilable with professional self-understanding.<sup>121</sup>

The two normative systems – on the one hand, a medical ethics committed to individual patient welfare; on the other, a market situation characterised by economic criteria – are not in principle opposed to each other. Nevertheless, their differing primary orientations can lead to considerable conflicts. Competition and a resource-conscious supply can by all means be conducive to patient welfare by contributing to restricting medical diagnostics and therapy to a necessary and appropriate scope and to improving, for example, the process-based, structural and outcome quality. This was also one of the goals of the reform of hospital financing, which led to the introduction of case-based payment (DRG). Additionally, the responsible handling of scarce resources is one of the ethical duties of the physician.<sup>122</sup> If, however, a tense market situation in the inpatient care sector compels a competitive struggle over limited resources so that it becomes a question of survival for a hospital or department in a hospital, then the danger exists that third-party interests impeding a treatment oriented to patient-welfare enter into the treatment situation and the doctor-patient relationship. In this case, the normative

---

121 For 81 percent of the chief physicians asked, the economic pressure was appreciable; 45 percent frequently perceived decision-based conflicts between medical and economic objectives; 70 percent saw themselves as restricted in professional practice by economic parameters (Reifferscheid/Pomorin/Wasem 2015, e132).

122 Wopen 2009.

systems of a medical ethics committed to patient welfare on the one hand and of acting primarily in accordance with economic principles on the other hand come into conflict.

With the introduction of the DRGs in the inpatient care area, a billing system was introduced into hospital care that was supposed to serve as a means to a better use of resources in inpatient care. Thus, patients' long duration of hospital stay, which under certain circumstances operated as revenue-increasing in the previous billing system according to daily-equivalent care rates, became in principle unprofitable for hospitals through a billing according to DRGs. Both accounting principles contain ethically problematic incentives with regard to patient welfare: in the first to the extent that an unnecessarily long duration of hospital stay leads to the expectation of economic advantages; in the second, that a medically inappropriately short duration of hospital stay promises economic advantages by allowing for the subsequent treatment of as many additional patients as possible and hence generating revenue from further case-based flat rates in as short a time as possible. From an economic perspective, the danger exists under the framework introduced with the DRGs of discharging the patient too early from the hospital following diagnosis and diagnosis-related treatment. These and other courses of action, such as an expanded indication or a fragmentation of the treatment process, suggest the thesis, well-founded on the basis of empirical studies in the meantime, that the patient under the condition of the current DRG system is perceived less in her/his individual need than as a lump-sum treatment case. This threatens to change the relationship between doctor and patient. For if the case-based flat rates reshape the perspective of the physician towards the patient as an individual and its function changes from a means for accounting to the purpose of treatment, then the important relationship of trust between doctor and patient appears seriously endangered.<sup>123</sup>

---

123 Vogd 2006; Vogd 2014, 58-73; Vogd 2015; Vogd 2016; Feißt/Molzberger 2016; Wolf/Ostermann 2016.

Comparative studies assess quite differently in support of which side it is possible to resolve the conflict between economisation and medicine's self-understanding and what consequences arise from this for employees' working conditions and for patient care. This depends, according to the studies, on factors such as the overall economic situation of the hospital; the involvement of employees in the organisational development; the quality assurance; and the respective type and mission of the hospital, so that the differences between the various hospitals are evident from this.<sup>124</sup> Yet, studies have confirmed that the conflict has not only arrived on the level of direct patient treatment, but has also been clearly exacerbated with the introduction of DRGs.<sup>125</sup>

The ends-means shifting outlined here can have ethically problematic consequences that can be seen especially in the following developments, of which many doctors working in hospitals complain:

- >> Thus, it is often expressed that hospitals had an interest from their own – sometimes economic – perspective in discharging patients from the hospital as soon as possible. This interest is transformed not infrequently, doctors said, into a steady pressure on physicians to accelerate the discharge of a patient out of inpatient treatment at a point where recovery has not been clinically consolidated. In addition, a difficult, laborious and protracted differential diagnosis, as well as complications that delay the discharge of the patient from the hospital, can generate considerable economic pressure on the hospital, which is ultimately exerted on the treating physicians. Compensatory mechanisms, such as short-term discharge and readmission of patients, for example, or their transfer into other hospitals with an already scheduled readmission at a later point in

---

124 Buhr/Klinke 2006.

125 Cf. on this, among others, Marckmann/Strech 2009.

time under another diagnosis (so-called patient carousel or revolving door effect), do not in most cases serve the welfare of the patient and an overall economically sensible and high-quality treatment. In contrast, in bundled payments where different treatment measures are combined into one case-based flat rate, the danger exists that patients are treated within the facility until the complete fulfilment of the payment, even if these measures are not absolutely necessary from a medical perspective.

- » An economically conditioned interest exists to treat mainly patients with particular circumscribed clinical pictures and to avoid the admission of patients with complication-laden illnesses (selectivity of patient admission). This problem manifests itself, for example, in the rejection or deferment of the inpatient admission of patients who exhibit as an additional clinical finding a dementia syndrome, bedriddenness, patients with obligatory isolation due to multiresistant bacteria or the like and hence necessitate a care that is intensive in terms of personnel and costs.
- » It is lamented that as a result of shortening the duration of stay, there are considerable increases in the patient throughput in hospitals and hence the work intensity, and as a result, the time burden for doctors (work intensification), to which personnel structures are only partially attuned. Through both short duration of stay and higher patient throughput, less time is available for the doctor's contact to the patient, whereby a treatment in which individual particularities can be considered is made significantly more difficult.<sup>126</sup>
- » Through its focus on services rendered, the DRG accounting system favours as broadly standardisable interventions as possible and consequently a specialisation in

---

<sup>126</sup> 72 percent of chief physicians surveyed hold the opinion that adequate time to devote to patients is only "seldom" or "sometimes" available (Reifferscheid/Pomorin/Wasem 2014, 5).

such treatments. An incentive is also associated with this to increasingly broaden the medical indication for such interventions. In the opinion of many, the problem of the expansion of treatment numbers (“volume expansions”) can be explained by this, observable for certain types of interventions notably since the introduction of the DRGs.<sup>127</sup> What is more, certain medical fields, such as obstetrics or paediatrics, are not economically attractive for hospitals and are accordingly being dismantled. A discriminatory moment can be associated with such an indirectly system-conditioned complicating of certain patient groups’ access to specialised treatment.

- >> Despite higher standardisation of many treatments and greater possibilities for patients to inform themselves about health questions on their own initiative, the need for communication between doctor and patient is not declining, but increasing. Bases for this are frequently misunderstandings or misinformation on the part of the patient, the rectification of which requires considerable expense in time and communication. In the process, the communication with the patient increasingly has the task of bringing patient-specific treatment findings and the patient’s previous medical understanding into a suitable congruence. Such information and communication are essential conditions for a patient care that enables self-determination. The time available to doctors for these duties in the hospital has for a long time, in the general opinion, no longer been adequate and is being constantly further reduced.
- >> The increasingly extensive documentation duties in the physician sector are also seen as problematic, whose detailedness cannot be justified solely with the welfare of

---

127 39 percent of chief physicians surveyed believed that economic framework conditions in their specialist area lead to superelevated case numbers (Reifferscheid/Pomorin/Wasem 2015, e129, broken down into specialist areas in ill. 2 [e134.]). A popular example for volume expansion is the left cardiac catheterization. Cf. also Schreyögg et al. 2014, 13.

the patient. In the process, the duty to documentation is not criticised as such, but the expense, on predominantly economic grounds, in documentation and time, the latter no longer being available for the actual treatment of the patient. Through this, the evolution from a “talking” to a “documenting” medicine is being promoted.

- » As a subsequent problem, one can observe that young doctors beginning their professional lives internalise the situation sketched as an ethical standard of German hospital medicine. Due to the density of everyday working life and due to hierarchical dependencies, ethical queries are often not brought forward or unanswered. Additionally, hospital specialist departments can scarcely implement an organised and structured continuing education and supervision of young doctors due to the strained personnel situation in the physician sector, which is why tasks are often transferred to young doctors (or have to be transferred) for which they are not adequately prepared. The lack of physicians in the inpatient care area is presently being met, among other things, through the stepped-up recruitment of doctors from abroad, whose deployment, however, can be difficult to shape precisely in a communication- and culturally-sensitive area like the hospital. Furthermore, these doctors are absent from the healthcare in their countries of origin.

Against this background, it should be asked how these requirements of an economically meaningful and resource-sparing action can be brought into harmony with the maxims of an orientation towards individual patient welfare. A prioritising of one or the other side leads in each case to risky intensifications, which can endanger either the quality of care of a hospital or its economic viability. Potential solutions may consist in making visible the justification of the different interests and in bringing about a practice of transparent (i.e., designed according to accepted rules and criteria), always-new negotiation of

the balance of interests in the particular case. In addition to a high communicative competence, this requires suitable structures and temporal resources. The scope for self-configuration for individual specialist departments, already opened today in the context of in-house budgeting, must be adequately financed. Necessary boundaries have to be justified plausibly and transparently.

For the medical profession, it is of considerable significance in this context to be able to make sure, in a structured process, of the ethical bases of its profession. One goal must be to ensure that physicians' actions are oriented towards the individual patient and his/her specific needs. Derived from this, a further goal is to define the quality of the medical treatment adequately from an ethical perspective as well and to name the relevant criteria necessary for this. Additionally, hospital physicians should use their existing organisational structures in order to also incorporate the ethical foundations of their profession effectively into decision-making in (health) policy about the inpatient care sector and hence to responsibly participate in shaping the system level.

#### **4.2.2 Nursing care sector**

As in the physician sector, there is also a field of ethics that is understood as a nursing ethics, in the sense of reflection and assessment of moral questions and problems of nursing practice.<sup>128</sup> In parallel to the differentiation of “medical ethics” from an “ethics in medicine”, an “ethics in nursing” is also spoken of alongside “nursing ethics”, whereby it remains unclear whether and in what sense both concepts differ. Diverse views exist in terms of how far nursing ethics represents a specific professional ethics, since a considerable amount of nursing services take place outside of the nursing profession

---

128 Cf. among others Heffels 2002, 65 ff.



(people who require nursing being cared for in the main by relatives) and nursing ethics can refer both to professional and non-professional nursing practice.<sup>129</sup> Also evaluated in varying ways are the substantive aspects of a nursing ethics as its own field of ethics and the question of a delimitation with respect to a medical ethics understood as physician-based ethics.<sup>130</sup> A justification for a separate nursing ethics is principally seen in nursing's having a separate perspective on patients and on ethical questions in healthcare. Through the particular character of nursing activity, those providing care face specific, ethically relevant constellations of questions and problems. It is therefore argued that those providing care reflect ethically in an independent manner their own practice and must be involved in all important patient-related decisions, not least of all because they often have more precise knowledge about the life situations and wishes of the patients than physicians do.<sup>131</sup> Furthermore, the call for the establishing of nursing ethics as an area of applied ethics is connected to the call for more professional autonomy for nursing as a prerequisite for moral action, and conversely, the establishing of a nursing ethics is understood at times as a mark of nursing's professionalisation. According to another view, medicine and nursing share a common field of action, to which the social mandate also relates and for which a sharp differentiation between a nursing ethics and medical ethics would not be just, even if the specific fields of action of the individual professions, in the course of differentiation and professionalisation, are increasingly clearly contrasted with one another.<sup>132</sup> A listing of maxims for action and attitudes which is based on virtue ethics can be found, for example, in approaches from care ethics. According to this, those providing care should dispose notably of attentiveness, responsibility, competence,

---

129 Lay 2012, 110.

130 Georg/Frowein 1999, 683.

131 Rabe 2009, 68 ff.

132 *Ibid.*, 70 ff.

responsiveness and mindfulness.<sup>133</sup> Such professional-ethical duties are understood as attitudes to be aspired to, which are acquired in the course of one's own professional and personal development according to the model of incremental competence development implemented in today's nursing science.<sup>134</sup>

From the perspective of patients, nurses in the hospital represent a very important professional group for how treatment and contact quality are experienced. Correspondingly, nurses' shortage of time; frequent change in personnel; and the replacing of trained staff through auxiliary staff – precisely for close contact services – play a prominent role in a negative evaluation by patients of hospital services, but also in the self-assessment of nurses.

Personnel reduction in the nursing sector, sinking duration of stay and case increase also lead in nursing to a considerable densification of work.<sup>135</sup> The transfer of less challenging activities, hitherto counted as a core element of the nursing profession, to less qualified auxiliary staff also contributes to this, whereby outputs in the actual nursing profession become even more dense due to the elimination of less intensive work phases.<sup>136</sup> A permanent time pressure has become the norm for many nurses today and impacts nursing performance.<sup>137</sup> This concerns first of all the “invisible” labours such as lending an ear; giving comfort; providing for well-being; also, moreover, prophylactic measures to prevent complications (bed sores, thrombosis, pneumonia, contractures); further as well, activities of basic care, which are being de-individualised; as well, furthermore, as the furnishing of information, the answering of questions and the communication regarding conduct following discharge from the hospital. Concepts such as that of

---

133 Cf. among others Tronto 1993.

134 Benner 2000.

135 Deutsches Institut für angewandte Pflegeforschung 2014.

136 Cf. Friesacher 2015.

137 Heiner Friesacher also speaks here of the “insupportable companion” of nursing work (personal communication).

primary nursing, built on firm assignments of nurses to patients, thus in effect have virtually no place any longer in hospital practice. The present system of inpatient care in Germany appears to foster these developments. Thus, there is empirical evidence that the implicit rationing<sup>138</sup> of nursing services in Germany<sup>139</sup> is especially marked in comparison with eleven other European countries.<sup>140</sup> It is also well known that often employees of home care services and in inpatient care for the elderly complain of the poor care condition of their patients following discharge from the hospital.<sup>141</sup> Among cognitively impaired patients, that element of independence previously still maintained in the practice of life often is no longer present following an inpatient stay, because, due to time pressure, a care that replaces rather than promotes independence was delivered.

A further visible change is the more powerful steering of nursing work by the crosslinking of clinical data with business-management instruments. An example of this is the Therapeutic Intervention Scoring System (TISS)<sup>142</sup>; with this, medical-technical measures can be depicted much better than

---

138 Rationing in healthcare refers to the delimiting allocation of resources according to criteria laid out either openly (explicit) or not openly (implicit) (Deutscher Ethikrat 2011, 22). Cf. on this as well Fuchs/Nagel/Raspe 2009, A555 f.

139 Only 21 percent of nursing service managements are of the opinion that the nursing personnel can always perform all required nursing services; 70 percent think that this is probably not the case; and 9 percent view an adequate supply of care as “not generally” ensured (Reifferscheid/Pomorin/Wasem 2014, 6). 72 percent report frequent conflicts in decision-making in the trade-off between economic efficiency and nursing-based goals (Reifferscheid/Pomorin/Wasem 2014, 4).

140 Zander et al. 2014; Ausserhofer et al. 2014.

141 Personal communication through the nursing scholar Heiner Friesacher.

142 TISS is a scoring system, developed in 1974, for quantifying the cost of nursing of seriously ill patients. Evaluated in the process are measures, such as monitoring, administering of medicines, dressing changes, mechanical ventilation, catheterisation or parenteral nutrition, for example. Psychosocial measures, such as reassuring, talking or removing fear, are not included. Since its introduction, it has become widespread and is meanwhile considered to be an established scoring standard. Following several modifications, the system was reduced in 1996 from its original 76 evaluated measures to 28 (hence as of now TISS-28).

can time-costly nursing work (for example, taking a patient in the arms, having a conversation, taking away his/her fear, handling possible shortness of breath), and this in turn accelerates the decline of nursing in the sense of assistance and care measures oriented toward the whole patient in favour of technical applications and procedures.

The demographically-conditioned, swiftly-growing demand for care also plays a special role, for which the hospitals are only inadequately prepared. Contrary to the foreseeable demand, not only are personnel positions being cut in the nursing sector, but nursing services are also being riskily deskilled through personnel splitting (use of trainees or semi-skilled auxiliary staff).

The situation is aggravated by the fact that more and more, nurses as an occupational group can represent themselves only with difficulty. Nurses are – although the largest occupational group in the hospital in terms of numbers – least represented at management levels. Also, on superordinate levels, developments and standards relevant to nursing are dominated by other interest groups (National Association of Statutory Health Insurance Funds, German Hospital Federation, German Medical Association) and either reduced to cost reduction or locked into profit maximisation.

All these developments lead to nurses increasingly no longer being able to do justice to their ethical principles, which are characterised by a care for and mindfulness towards the patient. Basic nursing approaches are affected, orienting the practice of nursing in a heavily reductionist view of “service provision” rather towards the model of providing definable services for a customer, whereas the aspect of interpersonal and self-determination-supporting attention is made dependent on the availability of possibly residual time resources.<sup>143</sup>

---

<sup>143</sup> 88 percent of nursing management holds the opinion that adequate time for attention to the patient is only “seldom” or “sometimes” available (Reifferscheid/Pomorin/Wasem 2014, 5).

Contributing to this tendency is the fact that the core area of nursing activity is increasingly no longer defined from nursing itself, but from an economic perspective, in that allegedly undemanding activities, which are nonetheless of considerable significance for the self-understanding and the outcomes of the holistic care of a person, are farmed out to cost-saving auxiliary staff. It should be noted that precisely the process- and cooperation-oriented approaches developed by the nursing sector are of special significance for a reorientation in the hospital.

Against this background, it is necessary to evaluate anew the significance of nursing for an identity-endowing development of the hospital and on the whole to afford greater esteem to nursing. With all due caution, since an evaluation of the existing innovation projects for improving the care situation in hospitals in 2011 has yielded no clear outcomes<sup>144</sup>, the following, along with a numerical increase in personnel positions, should particularly be taken into account in the interest of a higher regard for nursing in the hospital:

- >> the ensuring of the self-determination-enabling handling of patients in basic care as well as in treatment care, for which are necessary corresponding specialist expertise, adequate budgets of time for individual patient contact, planning of greater time corridors for handovers, securing of interprofessional ward rounds, a sufficient collegial exchange as well as the carrying out of case conferences;
- >> a greater involvement of nurses in steering processes and management decisions in the hospital (hospital management, management of specialist departments);
- >> qualified nursing experts on the level of the directorates or departmental managements as well as the readiness to implement and ensure scientifically proofed standards of care;

---

144 Cf. Stemmer 2011.

- >> a further differentiation of the nursing care in specialist areas through the acquisition of additional qualifications, with the goal in the future of being able to undertake treatment duties under greater personal responsibility.<sup>145</sup>

Such an altered assessment of nursing care in the hospital and the associated revaluation of the nursing profession are necessary in order to ensure, in the future as well, a high-quality nursing practice for patients through the attractiveness of the profession.<sup>146</sup>

### 4.2.3 Area of social and therapeutic services

In addition to doctors and nurses, such various professional groups work in the hospital as midwives, physiotherapists, ergotherapists, art and creative therapists, psychotherapists, curative educators, speech therapists, social workers and pastoral workers, who are differentiated not only in respect to their position in the clinical context and in their working method, but

---

145 There are reference examples for this in both Great Britain and the Scandinavian countries, where specially trained nursing staff undertake certain medical treatments on their own responsibility.

146 The pilot project “Ausbildung von Arbeitskräften aus Vietnam zu Pflegefachkräften” (Training of work forces from Vietnam into skilled nursing staff) commissioned by the Federal Ministry for Economic Affairs and Technology (today: Federal Ministry for Economic Affairs and Energy) demonstrates one way to counteract the deficit in skilled workers in the area of hospital care. In autumn 2013 for the first time in the context of the project, approximately 100 Vietnamese, who had successfully completed a selection process and language class in their home country, began an elderly care apprenticeship in Germany. The qualification according to German training standards can be reduced to two years if corresponding training requirements from health professions already exist. A comprehensive offer for accompaniment – for example, through mentors and intercultural training – should advance the integration. Since there are limits to the recruitment of skilled workers within Europe, cooperation with non-EU states with large populations and high labor migration can also be advisable in view of the deficit of skilled workers in hospital care. In the process, importance should be attached to dearths in skilled workers not arising in the despatching countries. An oversupply of young skilled personnel in countries like Vietnam allays this danger. The translation of the concept sketched here into hospital care is already in preparation.

also in regard to their work's direction towards a goal. Despite all differences, there is a connecting element: The work of all these people is of great significance for a hospital that strives to take into consideration as much as possible the various physical, psychological, social and spiritual needs of the patient, since only the cooperation of all the occupations in the hospital leads to a holistic perception of the patient as an individual.

In the professional groups mentioned, as among doctors and nurses, engagement with the ethical foundations of their work varies. Depending on the degree of professionalisation of the professions, separate ethics codes are found, but at the least ethical guidelines that are implemented in part in the respective professional code, in part in the professional guiding principles.<sup>147</sup> There are also theoretical reflections in some professions from the area of therapy and social work on the proper ethos, in the sense of a professional ethics. In many professions, there is international and national agreement on ethical principles (for example, social work, midwives, ergotherapy). In most of these disciplines, however, ethical discourses are taking place only recently (at least in Germany), which has to do with the likewise still recent autonomy discussion of the professions. Alongside the recourse to medical-ethical and nursing-ethical discourses, there is ongoing (self-) ascertainment in the therapeutic daily routine about each of the profession-specific values.

---

<sup>147</sup> For example the following general or ethical guidelines: Deutsche Gesellschaft für Psychologie/Berufsverband Deutscher Psychologinnen und Psychologen 2005; Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie 2013; Deutscher Bundesverband für Logopädie 1998; Deutscher Hebammenverband 2011; International Confederation of Midwives 2014; Deutscher Verband der Ergotherapeuten 2005; Deutscher Fachverband für Kunst- und Gestaltungstherapie 2000; Deutsche Gesellschaft für Erziehungswissenschaft 2010, to which the curative educators also refer; Deutscher Berufsverband für Soziale Arbeit 2014, on which the Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen (German Association for Social Work in Health Care) also draws; code of ethics of pastoral care professionals by Rosenberger et al. 2009, which is also discussed in clinical pastoral care. See also the international and interreligious project "Medizinethik in der Klinikseelsorge" (Medical ethics in clinical pastoral care) at the Goethe University Frankfurt.

In social work, as in the ethics of nursing (see 4.2.2) as well, an ethics can be taken up that emanates from a care practice as a practised basic conviction. In this, encouraging action and mindful attention (care) do not stand alongside other action processes; rather, they have their place within the processes themselves. A crucial aspect resides in the goal of an increasing autonomy in action, i.e., the enabling of self-determination, being achieved precisely when differentiating support and joint action are defined through mindful attention and encouraging action.<sup>148</sup> Against this background, the therapeutic and social professions in the hospital have a special significance with regard to care that enables self-determination.

Given this, the fields of conflict identifiable for nursing are also related, in respectively specific ways, to nearly all of the other non-physician-based health professions employed in the hospital. It is frequently argued that due to the shortening of patients' duration of stay in the hospital, certain services can hardly be applied in a meaningful way, such as physiotherapy or speech therapy, whose outcomes correlate strongly with a continuity of the treatment concepts and the person treating. This problem relates first of all to the fact that through the intensive diagnostics and therapy called for by the shortest possible duration of stay, the units of time necessary for treatment by the non-physician-based health professions are scarcely available any longer. Additionally, due to the increased patient throughput, barely enough time is available for an individual-specific, patient-friendly treatment. Since these professions also rely strongly on an intensive communication with the patient by having to practice methods of self-treatment with the patient, adequate time plays a huge role. Ultimately, this problem concerns the transition of treatment to the outpatient sector, which often does not function or is associated with temporal or conceptual disruptions.

---

<sup>148</sup> Cf. Conradi 2013, 12.



A special problematic applies to social services and pastoral care. The social services complain that in the time provided, in many cases a sustainable social network cannot be formed for certain patients, so that patients are frequently discharged from the hospital into a hardly manageable situation of having to care for themselves. Pastoral care is dependent on an intensive communication with the patient, scarcely ensurable under present circumstances. Even if its outcomes are largely shut off from a parameterisation and operationalising, it can still deliver an essential contribution to a care that enables self-determination and a suitable treatment in terms of a subjective patient satisfaction.

#### 4.2.4 Hospital management

The actions of management personnel in the hospital direction or administration, who are trained in business administration and health economics, are of decisive significance for a high quality and self-determination-enabling hospital care. Even though codes of honour for managers exist – for instance, oaths that are sworn by the graduates at business schools and which oblige them to ethical conduct<sup>149</sup> – there is to date no established ethical self-concept comparable with that of the medical and nursing professions which would be applicable as a code of conduct in the health sector. Generally, recourse can be made instead to demands on the management<sup>150</sup> within social organisations: Although hospitals are assigned to various forms of ownership (public, non-profit, private) and sometimes geared towards profit, the portion of solidarity-based

---

149 Cf. Cabrera 2003.

150 The questions of the “management” (*Leitung* in German) or “leadership” (*Führung*) are dealt with in the international literature under the term leadership, which has also already been partly introduced in the German discussion, yet does not apply here despite the somewhat broader perspective associated with this.

financing and – not least – the constitutive goal of hospitals refer to their character as social organisations.

Management is to be understood as an organisation-related function that consists especially in ensuring and shaping the mutual relationship, on the one hand, of structural conditions and, on the other, of individual as well as collective action. In awareness of this reciprocity, goals and tasks of the organisation are developed. The handling of mistakes is also part of this. Especially for social organisations and organisations funded by the community, it seems natural to require top executives to balance economic with social interests and claims. Consequently, economic reductionism in managing a hospital should be no option for the professions mentioned.

Management and administration of the hospital face the conflict of having to maintain an economically sustainable balance between the treatment services, provided in the hospital in a patient-friendly manner, and the revenues thereby achieved. In doing so, the securing of the economic foundations of the hospital represents an ethical obligation insofar as the hospital serves as a healthcare facility for all the people in a specific geographical catchment area and not least also as an employer for numerous persons. But also the securing of the ethical foundations of the treatment of patients is ultimately of crucial significance for the existential security of a hospital. Due to the doctor-patient relationship, in which they are not involved, management and administration are precluded from intervening directly into medical decisions. Nevertheless, indirect, less obvious possibilities of influence on the treatment of patients exist, for example through cuts in the finance budget of hospital departments or via the supervision that in most cases exists of hospital management over doctors, nurses and employees of other professional groups, in that contract cancellations can be brought into play or carried out in the event of a performance of treatment that is not in conformity with the economic goals of the hospital management. However, exerting influence in such ways is opposed to the idea of providing health services

cooperatively such that each professional group contributes its competence and places trust in the various competencies of the other professional groups thereby as a whole representing the hospital's level of competence to the public. It is hence evident that in the interest of an adequate treatment of patients, a structured, continual, transparent and fair communication is necessary between the management and administration as well as the members of the professional groups employed in the hospital. In doing so, it is a matter above all of reflecting on and adequately taking into account the ethical bases of patient treatment and the ethical obligations of the different professional groups. For this, in addition to the necessity of a special communicative competence, the management of a hospital must also have at its disposal sufficient knowledge in the health professions and the processes established here, including their ethical implications. This specific qualification profile can be secured principally through the completion of additional training, for example in economics and medicine or nursing, and a sufficient professional practice in both fields, which should be part of the qualification standard.

### **4.3 Hospital as organisation**

In addition to professional-group-specific ethics relating to the responsibility of the occupation – i.e., doctor, nurse or official in the hospital management or administration – vis-à-vis the patient, an organisation that takes into account an ethically-reflected, framework-providing order and patient welfare is necessary in the complex system of a hospital with its multitude of interacting actors. Tied to this is the assumption of being able to stabilise and, as the case may be, supplement individually internalised values through incentives for (morally) desired action and cooperation between individual actors. Possible concepts relate, for example, to the recognition and taking into account of different stakeholders' interests or to the

assumption of social or civic responsibility. Codices, mission statements, commissions or training courses can be of use for implementation. Many of the fields of conflict affecting the professional groups correspond to structures of organisational ethics within the hospital. These concern in particular the possibility for transparent and professionally competent decisions on the level of the hospital management and also structures of an ethically appropriate decision-making process.

### 4.3.1 Management structures

The competence of a hospital manifests itself not only in a positive economic balance sheet. Repeatedly, the failure to establish transparent and participatory decision structures<sup>151</sup> is pointed to as an organisational-ethical deficit with regard to the treatment of patients in the hospital. The demand for a treatment oriented towards patient welfare necessitates that the management of a hospital integrates the departmental competences of all the professional groups employed in the hospital. For this, structures are necessary that enable a sanction-free professional communication on an equal basis between management and hospital professional groups and that are additionally suited to making transparent the criteria upon which decisions are made. The latter is also indispensable for an authentic public image of the hospital vis-à-vis patients. Such participatory management structures can also ensure in particular that core areas of diagnostic, therapeutic and nursing action are not defined primarily through economic considerations.

This involves both the levels of direct and individual patient treatment and the designing of the processes at the wards and above and beyond these the mid- and long-term planning decisions of the hospital. In particular, the relationship must be transparent between the earnings performance of a hospital

---

<sup>151</sup> In more detail: Kroboth/Heller 2010.

and the possibility that the business management has influence on physicians' treatment and nurses' support of patients. A departmentally inclusive management structure in the hospital that brings together business management, physician management and nursing management on equal footing and unencumbered by employment-law possibilities of sanction, can represent a suitable model in order to also structurally replicate an interdisciplinary perspective towards patients. To ensure transparency, it is also conceivable to establish committees in the hospital that function as counselling and communication offices and mediate as necessary between management and employees.

The self-determination of the patient is also specifically related to the handling of her/his personal and health-related data. With the introduction of hospital information systems in which all treatment data are stored and viewable, new challenges are posed in regard to an adequate protection of these data from access by unauthorised persons, but also in relation to the scope of data that those providing treatment and other hospital employees can view respectively. To this effect, clear rules and technical requirements must be created that on the one hand ensure adequate data protection, but on the other also guarantee efficient treatment procedures in an interdepartmental and intersectoral manner. In the process, a conflict can exist between the justified interest of the patient in the protection of her/his personal data and the necessary, rapid exchange – associated precisely with complex treatments – of treatment data by individual attending persons.

#### **4.3.2 Clinical ethics committees**

The conceptions of patients and their relatives concerning a patient-friendly hospital treatment are linked to the expectation that the hospital personnel is competent to arrive at ethically-reflected and adequate decisions in difficult treatment

situations. This expectation relates first of all to every hospital employee involved in patient treatment, but also especially to a well functioning clinical ethics committee. With the exception of the federal state of Hessen<sup>152</sup>, the composition and tasks of clinical ethics committees are not set by law.<sup>153</sup> As a rule, they have the task, among other things, of organising and carrying out ethical case conferences for consultations in individual treatment cases; but moreover, of offering counselling for ethically relevant questions that can arise on different levels in the hospital. This may include the development of ethical guidelines for the hospital, ad hoc counsellings or the organisation of continuing education for hospital employees in the realm of clinical ethics, for instance; in more exceptional cases, however, also a participation in determining the strategic orientation of the hospital.

Clinical ethics committees are, admittedly, far from established in all hospitals in Germany. Not infrequently, they are only established for the purpose of the acquisition of certain certifications that, among other things, require precisely a clinical ethics committee. Often, clinical ethics committees are viewed merely as additive elements that are not structurally integrated into the practice of doctors and nurses. Disinterest and ignorance may be the cause for this; more and more, however, it is suggested that a structured engagement with ethical questions and the training desirable for this, as well as membership in a clinical ethics committee, would represent an untenable time burden under the current general conditions in the hospital. Additionally, establishing and integrating a clinical ethics committee into patient treatment requires the application of time and finance resources whose return can be represented in economic parameters only with difficulty. In

---

152 Section 6 (6) of the Zweites Gesetz zur Weiterentwicklung des Krankenhauswesens in Hessen (Second Act on the Further Development of the Hospital Sector in Hessen) of 21 December 2010 (GVBl. I, 587).

153 On tasks and quality, see Vorstand der Akademie für Ethik in der Medizin 2010; Zentrale Ethikkommission bei der Bundesärztekammer 2006.

addition, a certain mistrust by the management can arise vis-à-vis a structured ethics work in the hospital, since professional monitoring is feared with the clinical ethics committee or an additional, clandestine decision-making organ is presumed, which might have the effect of being a disruptive element.

As a result of such fears, representatives of the hospital management are not infrequently placed in clinical ethics committees, which as a rule does not favourably affect the independence of the decisions of the clinical ethics committee. In principle, clinical ethics committees would be suited to detecting ethically relevant problems in the hospital; to work out possible solutions; and above all to create a communicative interface between the clinic management and the employee level. Nevertheless, members of clinical ethics committees in German hospitals currently often complain of minimal regard and appreciation in institutions. Yet, examples of quite successful work can also be posed against this, in which the meaningfulness of this instrument is in principle confirmed. Precisely for involvement in strategic discussions about the hospital's development and in the interest of a transparency for management decisions, an independent advisory committee can be of advantage that stands to the side of the clinic management and whose mission exists in examining decisions in view of patient care; in taking up impulses from the institution and putting them forward to the clinic management; and in offering advice in case of controversies. Whether this function can or should be observed by a clinical ethics committee or by another committee depends upon the circumstances in the respective hospital.

#### **4.4 Advanced training and continuing education of hospital personnel**

A qualitatively and quantitatively appropriate advanced training and continuing education of the hospital personnel is an indispensable precondition for providing treatment

corresponding to medical standards. The limited financial situation of many institutions and the thin personnel coverages caused by this may represent reasons for the facility either not offering or reducing its own advanced training and continuing education courses for medical personnel; or for employees having to be kept from corresponding external events or having to eschew participation in order not to endanger patient care in their facility due to their absence. While the state chambers of physicians demand annual proof of a set quota of advanced training hours from each doctor in the hospital, the choice of such advanced training events is not thematically determined. In the nursing sector, such requirements do not exist; advanced training takes place on a voluntary basis. In the interest of ensuring a good treatment, facilities or facility owners with a certain spectrum of treatment offerings should therefore guarantee that advanced training courses corresponding to this spectrum are available; and care should be taken that employees can attend these courses.

## **4.5 Patient groups with special needs**

### **4.5.1 Children and adolescents**

According to statements by the Gesellschaft der Kinderkrankenhäuser und Kinderabteilungen in Deutschland (Society of Children's Hospitals and Paediatric Departments in Germany) and the Deutsche Gesellschaft für Kinder- und Jugendmedizin (German Society of Pediatrics and Adolescent Medicine), since 1991 almost every fifth paediatric department has been closed; 4 out of 10 beds in inpatient paediatric and adolescent medicine have been eliminated.<sup>154</sup> In 1991, there

---

<sup>154</sup> On the numbers in this and the following paragraph, see the press information of the German Society of Pediatrics and Adolescent Medicine from 11 April 2014: [http://www.dgkj.de/service/meldungsarchiv/meldungen/2014/presseinfo\\_rettet\\_die\\_kinderstation](http://www.dgkj.de/service/meldungsarchiv/meldungen/2014/presseinfo_rettet_die_kinderstation) [2015-09-28].



were 440 departments for paediatrics, with 31,708 beds; in 2013, there remained 364 departments with 19,199 beds. The number of departments for paediatric surgery shrank from 99 to 80. As a result of this development, nationwide supply is decreasing. According to the recommendations of the professional associations for paediatric and adolescent medicine and the Deutsche Akademie für Kinder- und Jugendmedizin (German Academy for Paediatrics and Adolescent Medicine), a paediatric clinic or a department for paediatric and adolescent medicine should be reachable for the patient at a maximum in 40-minutes travel time or 30-km driving distance. Accordingly, departments should not be at a greater distance from one another than 80-minutes travel time or 60 km. Partly, these parameters are already no longer being achieved. In spite of the demographic development, however, the amount of children who need inpatient care has not declined, but rather has remained relatively constant.

In comparison to adult medicine, departments for paediatric and adolescent medicine must serve a considerably more differentiated range of services. While on average approximately 200 flat rates for different kinds of cases are used in adult-medicine departments, the service spectrum of a paediatric clinic encompasses 400 to 500 DRGs. A portion of these DRGs is not child-specific, but derives from adult medicine. In general, a markedly higher amount of care is incurred among children of a young age; additionally, longer conversation times with relatives; a greater expense in time during examinations (for example, during x-rays); as well as a psychosocial support, in particular also during chronic illnesses. The personnel costs in paediatric clinics account for approximately 80 percent of the total costs of treatment and to that extent lie almost 30 percent higher than those in comparable adult medicine. Since rare diseases are frequently detected in the initial years of life, many such cases are attended to in paediatric and adolescent medicine. Indeed, children with rare diseases frequently require expensive care; moreover, in such cases, due to

the modest sample size, there is rarely a specific appropriately calculated case-based flat rate. In addition, hospital treatment of children occurs whenever possible in outpatient care; yet, the remuneration of outpatient interventions lies significantly below the inpatient remuneration rate. Furthermore, and not least of all for psychological reasons, an inpatient stay for children is reduced to the shortest possible time, whereby the lower limit for the duration of stay is fallen short of in approximately 25-30 percent of inpatient treatments, which is associated with high reductions in the hospital's revenues.

According to the German Society of Pediatrics and Adolescent Medicine and the Society for Children's Hospitals and Paediatric Departments in Germany, a further problem is manifested in the high fixed costs in paediatric clinics, which are not taken into account in the DRG remuneration system. Whereas about 25 percent of the budget in adult medicine is set for the continual availability of inpatient care services, the share in paediatric clinics for these contingency costs lies at up to 40 percent of the budget, because the percentage of predictable services in inpatient paediatrics accounts for only about 20 percent and the emergency quota through acute illnesses is very high at 50 percent. In consequence, it is frequently necessary in hospitals to cross-subsidise the inpatient treatment of children and adolescents from adult medicine.

On the basis of the acute risk that paediatric clinics and departments close for financial reasons, the German Medical Association, the German Society of Pediatrics and Adolescent Medicine, and the Society for Children's Hospitals and Paediatric Departments in Germany started the information campaign "Rettet die Kinderstation!" (Save the paediatric ward!), which points to the nationwide threats to hospital care of children and adolescents and demonstrates possible solutions.

The comparison to adult medicine and the obvious impact of the goal of savings in the healthcare system onto the personnel- and cost-intensive area of paediatrics raises the question of how far it is justified to set children through case-based

flat rates in a market-oriented finance system in competition with adults for limited resources. Justice in healthcare is considered above all in terms of a discrimination-free equal access to the healthcare system and in terms of an equality of medical care, i.e., of a just distribution of resources. Like any citizen, children also have a right to a qualified medical care. If one observes the consequences of the closing of paediatric departments and children's hospitals in the form of longer journeys and distance from residence, longer waiting times, unfamiliar doctors and nurses, it can be stated that these factors, while not altering the right of children to medical care, do nonetheless alter the conditions under which children can take advantage of this right.<sup>155</sup> Whereas these factors as far as adults are concerned – at least as a rule and to a certain extent – are not considered as unacceptable, in the case of children doubts exist in this respect based on their developmental stage: children are not self-determined like adults; they cannot themselves perceive their rights; and they have other needs, since they cannot behave in the same manner as adults in relation to the aforementioned conditions. Children thus can rightly expect from state institutions a particular kind of assistance, which may also warrant relieving children from an unmediated competition with adults for scarce goods in healthcare.<sup>156</sup>

A solution to the problem sketched here could consist in the factors characterising paediatric and adolescent medicine – such as children's extremely short duration of stay in hospitals or a comparatively quite costly nursing and psychological care – being taken into account in an adequate way, i.e., in a cost-covering manner within the DRG system. With this, the unmediated impact of the competitive situation would at least be alleviated, even though this would not in principle be abolished. The latter could be achieved if paediatric and adolescent medicine were uncoupled completely from the

---

155 Cf. Wiesemann/Lenk 2006, 49.

156 Cf. *ibid.*, 53.

case-group remuneration system of adult medicine, and either a child-specific DRG system or other modes of accounting for inpatient paediatric and adolescent medicine, such as per diem nursing rates, were introduced. The ongoing closing of specialist departments for paediatric and adolescent medicine in hospitals for financial reasons represents, in any case, an extremely problematic development in light of justice.

#### **4.5.2 Patients of old age**

In many hospital departments, more and more elderly and aged patients are found. To the question of who may be considered old, different answers are given. The disciplines of biology, sociology and psychology each use different criteria in this regard. According to the definition of the World Health Organization, someone may be considered old who has completed the 65<sup>th</sup> year of life. Admittedly, calendar age is ostensibly of little help in determining whether someone belongs to the group of the elderly. As a general indicator, it may be valid that elderly people require increasingly more time for the details of everyday life. Initially, this additional demand is compensated for by learned efficiency strategies and experience; only later then does the increased need for time become evident. As a rule, no objective assessment as a disease is assigned to physical limitations determined by age. In old age, illnesses can emerge for which an elevated age is not causal (for example, the development of a colon tumour). Even so, people in old age become ill more frequently; many illnesses are associated with age (for example, a femoral neck fracture); and both the symptoms of illness and dealing with the illness by those affected can be associated in a complex way with age-related limitations.

In a hospital medicine oriented towards economic and temporal efficiency, these circumstances can acquire considerable significance for elderly individuals who need to be treated

within the hospital. Healing processes in old age last longer for physiological reasons. Often, elderly patients can scarcely conform communicatively to the tightly clocked everyday routine in the hospital (for example, due to hearing impairment, longer periods of reflection, slower articulation and the necessity for explanation of unfamiliar terminology during the medical history interview). Additionally, elderly people can often not satisfy the requirements of hospital daily routine procedurally (for example, in independently seeking out diagnostic specialist departments in the hospital). They hence require special aid and increased attention in time and personnel. On the part of the hospital, this is expressed in longer lengths of stay, increased need for personnel and prolonged process workflows. The additional time that elderly persons need, can prove to be a disadvantage for the hospital from an economic perspective. Moreover, medical trade-offs arise differently for elderly patients than younger ones, for instance, in regard to a greater restraint in invasive therapies and procedures due to a generally rising risk of such interventions as age increases, albeit as a result of which the remuneration for the hospital may diminish. Furthermore, a medical treatment oriented towards the elderly has to carry out a paradigm change from deficit orientation (elimination of health deficits) to a resource orientation (use and support of the capacities present in the elderly patient), which likewise requires an intensified attention in terms of personnel. Against this background, the treatment of elderly patients in the hospital is often not profit-making. These circumstances can lead to a tendency of impeding access to hospital medicine for elderly individuals.

### **4.5.3 Patients with typical geriatric illnesses**

The geriatric patient is characterised by his/her multimorbidity, the need for multiple-drug therapy, the chronification of illnesses, immobility syndrome and functional disturbances

that often negatively affect one another. Added to this are psychosocial factors, usually associated with the somatic problems of the elderly patient. All these factors must be taken into account during the hospital treatment of the elderly person.

Only since the mid-1980s in Germany has geriatric medicine come closer to the professional standards already prevalent in other countries, which were at least ten years ahead in this regard. Out of a “prospectless custodial-medicine”<sup>157</sup>, a holistic and functionally oriented treatment concept has developed that also applies rehabilitative methods at an early stage in complement to acute care for geriatric patients. Acute geriatrics unites the concurrency of acute medicine and rehabilitation. Yet, this early-rehabilitative approach leads to it being difficult to sharply separate the services provided in acute treatment from those provided in rehabilitation. As a result, in the current situation, geriatric/early-rehabilitative complex treatment is carried out and billed not only in hospitals with a care provision contract pursuant to Section 109 SGB V on the basis of Section 39 SGB V, but also in rehabilitation clinics with a care provision contract pursuant to Section 111 SGB V on the basis of Section 40 SGB V. This situation, heterogeneous less from a medical than mainly from a health-insurance law perspective, leads in the DRG accounting system, also applicable for geriatric medicine, in the care provision contract in some federal states to the result that each phase of illness of a geriatric patient is differentiated according to its acuity. If, for instance, according to the criteria of the care provision contract of the federal state of Lower Saxony, the capability of rehabilitation arises following an acute treatment for a geriatric patient, then there is a switch to “Section 111”; if this phase is again interrupted, for example, by an acute pneumonia, then there is a switch back to “Section 109” until capability for rehabilitation is once more attained. The critique is made that thereby the real occurrences of service for the patient – who

---

157 Borchelt 2004, 2.

notices nothing of all this, because she/he remains continually in the same bed and is treated by the same team at the same ward – are completely veiled. If afterwards only one respective care area is evaluated and adduced for the remuneration negotiations, then a contorted image arises in regard to both the case numbers and spectrum of performance.<sup>158</sup> Such systematic contortions with regard to a patient group to be categorised as particularly vulnerable can give grounds, against the background of the system of accounting according to case-based flat rates, for a grave problem of justice. In this regard, urgent need for the development of adequate solutions is perceived.<sup>159</sup>

In addition to these problems in the structure of care, questions also arise with respect to a just consideration of geriatric patients within the case groups. Allocation takes place mainly on the basis of the primary diagnosis and the co-morbidity or the degree of complexity. In doing so, cognitive limitations in terms of a dementia or an incipient dementia, which are frequently to be encountered precisely among geriatric patients, prove particularly problematic in regard to a cost-covering treatment. The complaint is made that the high care requirements and the necessary, considerable additional expenditures among the patients affected are not modelled adequately, i.e., with cost coverage, in the case-based flat rates for dementia as either a primary or secondary diagnosis. Additionally, the desirable goal of an integrated care of geriatric patients in the hospital can scarcely be attained under the given circumstances already due to the aforementioned reasons of age-associated functional restrictions. Moreover, the problems connected to a fragmentary care in the inpatient and outpatient sector are posed with special sharpness amongst geriatric patients, particularly those with dementia. Not least, it is to be asked how the last phase of life and dying in the hospital can be arranged

---

158 Ibid., 4 ff.

159 Schulz/Kurtal/Steinhagen-Thiessen 2008; Fügen 1996; Sections 108, 109, 111 SGB V.

with dignity among geriatric patients and how this can be modelled in an accounting system according to case-based flat rates.

In summary, it can be stated that elderly patients and geriatric patients in the hospital are in need of special expenses, which find expression immediately in an intensified attention by personnel. These patients have a right, as do all other patients, to be treated adequately in the solidarity-based health insurance system. Their treatment cannot be oriented towards the criteria valid for younger patients, because as a rule a changeable and often not entirely unambiguous image is already yielded through the frequently non-linear course of illness or due to multimorbidity, and hence the presence or the end of the necessity for inpatient hospital treatment as prescribed in law can only with difficulty be determined unequivocally. In addition, in comparison with younger patients, specific health problems come to the fore with the frequent appearance of dementia-related changes. This poses the question of how these patient groups can be justly considered in an accounting system according to case-based flat rates, which in principle sets various patient groups in competition against one another.

One solution could consist in supplemental fees being earmarked for certain complex multimorbid disease patterns and in providing a billable personal nursing support for elderly patients in the hospital, which can be activated as needed. This support would then likewise have to be financed via special DRGs.

#### **4.5.4 Patients with dementia**

For patients who have to be treated in hospital due to a somatic illness and at the same time suffer from an already established dementia or one only then diagnosed in the hospital, considerable problems often arise. The Deutsche Alzheimer Gesellschaft (German Alzheimer's Society) laments that the



general hospitals are hardly prepared for suitable modes of dealing with dementia patients, and it recommends its members to carry with them during hospital admission pre-prepared information sheets about existing abilities and particularities.<sup>160</sup> Yet often during admission, according to the Society, neither the degree of dementia-related illness nor the exact profile of the still existing capabilities, self-determination competences and particularities was registered. The consequences were incapacitating care that ignores the still existing potentials for independence; as well as treatments and measures given without communication, which confuse those affected even more than the already alien situation. Capabilities that still existed at home were quickly unlearned and could be recovered following the hospital stay only arduously. Yet, the majority of difficulties in dealing with patients arose in the course of the hospital stay less due to cognitive limitations, but usually due to certain modes of behaviour, such as wandering around, shouting or permanent questioning, whose meaning and causes were often unrecognised. Also lacking was knowledge about the correct strategies for adequately handling such modes of behaviour without the use of psychotropic drugs.<sup>161</sup>

For the situation of those in the hospital who are ill with dementia, the following problems are mentioned, to which the hospital would need to react:

- >> cognitive impediments that complicate coming to an understanding and make uncertain the descriptions of symptoms on the part of the patient and his/her feedback on effects and side-effects of medications,
- >> alien environment and altered daily routine as well as unfamiliar procedures and actions that can trigger, among other things, fear, resistance or aggression,

---

160 Cf. Deutsche Alzheimer Gesellschaft 2013; Deutsche Alzheimer Gesellschaft 2015.

161 Teschauer 2014; Teschauer 2015.

- >> deficient opportunity for diversion, occupation and movement, which can lead, among other things, to tension and anxiety,
- >> absent reference persons, who are familiar with the particularities of the patient.<sup>162</sup>

Additionally, a terse and functional communication, often associated with demands or reprimands, can lead to further problems. Alongside the aforementioned calls for help – aimless wandering, physical or verbal aggression and screaming fits –, further frequently mentioned types of challenging behaviour displayed as a reaction to the opaque world of the hospital consist in delusions, apathy or disinhibition. In hospitals, which are adjusted neither structurally nor in terms of personnel to these special patient groups, the result is overtaxing of personnel, inadequate treatment (for example, medical restraint) and ultimately also the rejection of such patients.

These problems possess a special brisance if one brings to mind the predicted growth rates in the area of elderly and very elderly patients and their risks of simultaneously falling ill with dementia. Thus, according to calculations by the Federal Statistical Office, the proportion of hospital patients over 80 years of age in 2020 will be 19.5 percent and 20.7 percent in 2030; the proportion of hospital patients from 60-80 years, 35.6 percent in 2020 and 41.7 percent in 2030.<sup>163</sup> The prevalence rates for those suffering from dementia in acute care hospitals are given differently depending on age group reference.<sup>164</sup> Whereas one prospective study for Germany arrives at 28 percent of hospital patients over 60 years of age in acute hospitals as suffering from dementia<sup>165</sup>, an international study indicates a percentage rate of 18 percent of all hospital patients over 65 years of age.<sup>166</sup>

---

162 Teschauer 2015, 15.

163 Statistische Ämter des Bundes und der Länder 2010, 15.

164 Pinkert/Holle 2012.

165 Trauschke/Werner/Gerlinger 2009, 386.

166 Arolt/Driessen/Dilling 1997, 208.

For this large and, in the future, growing group of patients with dementia, it is necessary to create appropriate conditions in order to be able to adequately treat and care for them in the hospital while protecting their dignity and remaining possible self-determination.<sup>167</sup>

In addition to the introduction of an improved early diagnostics through corresponding screening procedures, primarily to be demanded are better admission conditions in the hospitals, during which particulars of the patient are systematically asked for from relatives and the state of existing competences for self-care and possibilities for self-determination are conveyed. Furthermore, the processes in admission procedures should be expedited, and the possibilities for rooming-in of relatives should be extended.<sup>168</sup> Courses of instruction for personnel are also necessary, in which specialist knowledge about dementia is communicated, but also abilities in communication are trained and problematic standard situations (for example: a patient suffering from dementia is wandering around in the hospital or tears indwelling cannula out of the veins) are thematised through best-practice examples.<sup>169</sup> The goal in doing so is also to reduce the stress experienced by nursing staff in caring for patients with dementia in the hospital.

The German Alzheimer's Society assumes that a change in attitude is required in the overall system of the hospital in order to better cover the needs of the group of dementia patients. Mentioned in this as essential options for action for the further

---

167 For the field of "dementia-sensitive hospitals", we refer readers to the programme "People with Dementia in Hospitals" of the Robert Bosch Stiftung (<http://www.bosch-stiftung.de/content/language1/html/37166.asp>[2016-02-22]); for the field of "barrier-free hospitals" (where it is a question of barriers both architectonic and communicative), to the Stiftung Gesundheit Fördergemeinschaft (<http://www.stiftung-gesundheit-foerdergemeinschaft.de> [2016-02-22]).

168 Deutsche Alzheimer Gesellschaft 2013, 16.

169 Cf. on this, among others, the programme "DEMIAN – Promoting positive everyday experiences for people with dementia", which was developed in the Institute for Gerontology at the University of Heidelberg in the years 2004 to 2010. Cf. also Berendonk et al. 2011.

development of a hospital into a “dementia-sensitive hospital” are:

- >> adaptation of the milieu and processes on a ward to the needs of persons with dementia,
- >> involvement of relatives and helpers,
- >> instruction and advanced training of personnel,
- >> provision of opportunities for activity and movement.<sup>170</sup>

It should be emphasised that along with the conveying of specialist knowledge and confidence in action for reducing fear, it is also a matter of a change in terms of a basic positive attitude vis-à-vis dementia as illness and the person affected by dementia, a change that neither demotes her/him into being a child, nor sees him/her as a pure nursing case. This change requires the ability for empathy among individual employees, but also the willingness to perceive more strongly the emotional communications of those affected than the cognitive ones.<sup>171</sup> Furthermore, an essential precondition for the further development of a hospital into a dementia-sensitive hospital is guaranteeing that the time that must be spent for the individual patients is adequate. Whether the care of hospital patients affected by dementia occurs better through beds integrated into the various specialist departments or in an interdisciplinary ward in which a dementia-friendly milieu can be created through an entire package of measures and additional structurings of the day, has not as of yet been conclusively resolved.

#### **4.5.5 Patients with disabilities**

Patients with disabilities and their relatives frequently complain that in hospitals they are either turned away or treated

---

<sup>170</sup> Teschauer 2015.

<sup>171</sup> On this, see in more detail: Deutscher Ethikrat 2012.

with so little expertise that they have to switch into clinics far from their place of residence.

Moreover, it is reported that many hospitals demand<sup>172</sup> that the person with disability be accompanied by an additional person during the hospital admission, independent of the patient's self-competence, and that they offer no possibility of becoming acquainted with the relevant ward prior to admission so as to undertake necessary precautionary measures for the period of the stay.<sup>173</sup> A systematic and adequate evaluation of the capabilities for self-care and of specific support-needs following admission is often omitted, it is also reported, and that this leads both to a partial oversupply and incapacitating care and to an undersupply through omission of necessary aid.<sup>174</sup> In its Opinion on the UN Convention on the Rights of Persons with Disabilities, the ZEKÖ states: "People with disabilities have the experience of being met with impatience in reaction to the extra time and expense that they occasion (for example, when they need more time to dress and undress or need special communication aids)".<sup>175</sup> It is further criticised that communication in the hospital is tailored to competent patients. However, for patients with articulation problems; patients who need more time for answers; or patients who make themselves understood non-verbally, neither the time necessary for this nor the expertise exists.<sup>176</sup>

For dealing with persons with disabilities, the principles and statements of the UN Convention on the Rights of Persons with Disabilities can hold as a foundation (see 3.3.1). The convention ascribes to persons with disabilities not only the "same" health treatment as to non-disabled persons, but also the healthcare services that are required specially by them due to their disabilities (Article 25 b) and those that serve their

---

172 Lachetta et al. 2011, 143.

173 Budroni et al. 2006, 127.

174 Forum selbstbestimmter Assistenz behinderter Menschen 2007.

175 Zentrale Ethikkommission bei der Bundesärztekammer 2010, A298.

176 Schmidt 2010.

“habilitation and rehabilitation” (Article 26) in order to reach a very high degree of independence as well as full and equal participation.

Against the background of the requirements of equal access and just distribution, the conflicts for the hospital can be outlined through three questions:

- >> How within the hospital, against the background of growing economic pressure, can the self-determination be guaranteed for persons with disabilities who need assistance in self-determination due to their cognitive limitations?
- >> How, among persons with disabilities for whom the disability is not the reason for the current hospital treatment and for whom the direct treatment of symptoms associated with the disability does not necessitate a specialised care, can the medical and nursing care be ensured in terms of the patients’ inclusion within the framework of the hospitals’ regular treatment offering?
- >> How can an adequate balance be struck between the comprehensive care of persons with disabilities in general hospitals (a kind of generalising of the offerings for the special needs of this patient group) and the specialising of certain hospitals on the treatment of specific subgroups who, as in the case of certain genetic syndromes, for example, require a high expertise?

A process of realisation in relation to these questions is only slowly occurring. To this point, there are only a few programs for needs-based treatments, mostly financed by foundations, but also by individual federal states.

Approaches must take into account that persons with disabilities require a care and treatment during an inpatient hospital stay that poses special demands on both nurses and doctors. Diagnosis, therapy and care are associated with additional expense and effort, and they require particular specialist knowledge and particular communicative competencies by nurses as

well as doctors. Amongst the symptoms to be concretely treated, complex interactions can sometimes also arise that further complicate diagnosis, treatment and care.<sup>177</sup>

In this context, the Ärztekammer Berlin (Berlin Chamber of Physicians) advocates for a “barrier-free hospital”. They assert that while building-related conditions as well as equipment with technological assistive devices correspond widely to the requirements for barrier-free accessibility in the majority of hospitals, there is a lack in terms of barrier-free communication and of assistive systems that facilitate, especially for persons with sensory disabilities, a very high degree of independence as well as the preserving their self-reliance and self-determination during the stay in hospital.

In order to improve the care of persons with disabilities within the hospital, the disability-related professional associations have proposed the concluding of a target agreement pursuant to Section 5 of the Bundesgleichstellungsgesetz (Federal Act on Gender Equality) between the German Hospital Federation and the associations of people with disabilities.<sup>178</sup> With this, the deficit in binding descriptions of organisational methods and processes for the care of patients with serious and multiple disabilities within the hospital should be rectified; a better professional training and continuing education of physician-based, therapeutic and nursing personnel ensured; binding quality standards established; and an admission- and transition-management agreed upon that is geared towards the needs of this group. Great need for action exists regarding additional financing for the care of persons with disabilities in the hospital and in terms of a new legal regulation of personal

---

177 In 2014 in Munich, the German Ethics Council already was guided by these baseline conditions during its Bioethics Forum on “People with Disabilities – Challenges for Hospitals”. Participants raised demands for an improvement of the care of persons with disabilities in the hospitals, but also for the creation of specialised centres that not only provide for complex diagnoses and treatments, but also can undertake an advisory function for the hospitals. See <https://www.ethikrat.org/en/bioethics-forum/people-with-disabilities-challenges-for-hospitals> [2016-02-22].

178 Cf. among others Roser/Budroni/Schnepf 2011.

hospital assistance, which should be placed at the ready in a needs-based manner to all persons with disabilities from the point of a defined need for assistance on.<sup>179</sup>

#### 4.5.6 Patients with a migrant background

About 16.5 million people with a migration background live in Germany, which corresponds to a population percentage of 20.5 percent.<sup>180</sup> In densely populated areas, it is often the case that 30 to 50 percent of patients at hospital wards possess a migration background. On the basis of these demographic circumstances, intercultural treatment situations are part of the daily work in numerous German hospitals. Linguistic and cultural barriers, but also different moral concepts regularly lead in the process to various difficulties and ethical conflicts. Such a situation not only impairs access to an adequate provision of healthcare in the hospital, but also poses new challenges for practitioners in the hospital.

Linguistic barriers play a crucial role in the mis-, under- and overtreatment of patients with a migration background in the hospital. Often, patients from other cultural areas do not speak German; professional interpreters are only available in rare cases.<sup>181</sup> To overcome difficulties of understanding, accidental interpreters are frequently enlisted. During such interpreting

---

179 Pursuant to the Gesetz zur Regelung des Assistenzpflegebedarfs im Krankenhaus (Act on the Regulation of Assistive Nursing Needs in the Hospital) of 30 July 2009 (BGBl. I, 2495), persons with disabilities are entitled to bring into the hospital their familiar nurses as nursing assistance if they employ their nurses in the so-called employer model, which, however, only very few persons who need nursing and obtain services from nursing insurance do. Most of those affected receive nursing care as an outpatient service or while living in a nursing home and hence fall out of the current statutory regulation. A change in the law, which the disability representatives and equal opportunities commissioners of the federal states are also seeking, would integrate persons with disabilities who receive outpatient care services or care within a facility.

180 Statistisches Bundesamt 2014, 38.

181 Cf. Barkowski 2008.



activities, deficient linguistic competence frequently leads to mistranslations, omissions or censoring. In order to compensate for possible gaps in communication, additional examinations are often conducted, which would have been avoidable with adequate communication and which require additional financial and personnel resources.<sup>182</sup> These constellations not only make difficult an adequate and quality-assured hospital treatment, but simultaneously also throw up grave ethical and legal problems. For communication deficits of this kind, which often remain unremarked or elude monitoring, impede the required patient information and thus do not allow the patient to give an informed consent in a self-determined manner.

Additionally to the difficulties of understanding, cultural barriers also impede access to and use of health services in the hospital. Under cultural barriers are to be understood, on the one hand, misunderstandings about decisions and actions of the patient that are characterised by cultural value conceptions, alien to the practitioners, and often appear little comprehensible to those offering treatment. On the other, during the implementation of medical measures, a culturally-stamped intense feeling of shame or the observance of certain religious duties, such as the compliance with dietary rules, can represent a challenge for both the persons offering and receiving treatment.<sup>183</sup>

Varying moral evaluations of medical measures are not rare experiences in the hospitals of value-pluralistic societies. Nevertheless, there are moral attitudes by patients from other cultural areas that are ascribable to specific cultural value convictions. Examples for this are decisions within the family of the patient about whether this person should be informed of the diagnosis of a malignant and incurable cancer; the request for maximal therapy, even in medically futile situations, by reference to religious arguments; or the influence

---

182 Bioethik-Kommission des Landes Rheinland-Pfalz 2010, 87.

183 Zuckerman et al. 2002; Ilkilic 2002; Ilkilic 2006; Sattar et al. 2004.

of traditionally-characterised hierarchical structures on the decision-making, for instance, when the husband decides for the wife.<sup>184</sup> Underlying such claims are moral attitudes that are strange to the local culture, or of a different significance to those ethical principles familiar in medical ethics, such as the principle of respect for patient autonomy. Ethical conflicts about interests and decision-making in clinical daily life are often especially complex and hence a challenge for hospital employees.<sup>185</sup>

#### 4.5.7 Registered refugees and persons without residency status

The high number of refugees who have come to Germany for roughly a year poses the question, among others, of the conditions for the treatment of these persons in German hospitals. Moreover, according to estimates, at least 500,000 to a million people reside in Germany without valid residency papers (so-called *sans papiers*), which include persons residing illegally in Germany as well as refugees before they have been registered. Even if regulations<sup>186</sup> exist in principle for the treatment of these patient groups, numerous questions relate to their

---

<sup>184</sup> Cf. Ilkilić 2008.

<sup>185</sup> Cf. Ilkilić 2014.

<sup>186</sup> See on this Zentrale Ethikkommission bei der Bundesärztekammer 2013b; Resolution of the 109<sup>th</sup> German Medical Assembly 2006 (printed paper VII-11): “Unzureichende medizinische Versorgung von Menschen ohne legalen Aufenthaltsstatus” (Inadequate medical care for people without legal residence status) ([http://www.bundesaeztekammer.de/arzt2006/data/anhang\\_a/topo7\\_11\\_E\\_END.pdf](http://www.bundesaeztekammer.de/arzt2006/data/anhang_a/topo7_11_E_END.pdf) [2016-03-02]). See on the healthcare of asylum seekers (examination and care in institutions for initial admission, care and treatment of psychological illnesses and traumas, demand for qualified personnel, inclusion of linguistic and intercultural aspects, improvement of data and research) the 2015 brief statement “Zur Gesundheitsversorgung von Asylsuchenden” (“Healthcare for Asylum Seekers”) by the Nationale Akademie der Wissenschaften Leopoldina (German National Academy of Sciences Leopoldina), the Deutsche Akademie der Technikwissenschaften (National Academy of Science and Engineering) and the Union der deutschen Akademien der Wissenschaften (Union of the German Academies of Sciences and Humanities).

practical implementation.<sup>187</sup> In the context of the present Opinion, this problem area can only be mentioned, but not treated in more detail due to its complexity, which can be ascribed not least to the high number of persons affected and which additionally involves questions about the accordance of international-law, constitutional-law and social-law principles.

## 4.6 Resource allocation

It is uncontentional that society has an interest in a generally accessible, high-quality medical care at the most up-to-date state of medicine, life science and technology. This is not only in the interest of patients, but also in the interest of those not acutely affected by illness. For these latter can be sure, in case of an illness, of being able to make use as quickly as possible of a high-quality medical care. In many cases, this demand arises unforeseen and acutely so that so-called “reserve capacities” must be held out. Inpatient institutions thus have the character of an *option good*, that is, the mere existence of a system of inpatient care already endows a benefit to the members of the society. This option-good character is particularly evident in the areas of emergency care and disaster care as well as in intensive care.

---

187 In this context, the questions to be handled would be, for example, to what extent it can be justified against the background of obligations according to international law (for instance, the International Covenant on Economic, Social and Cultural Rights of 1966 or UN Resolution 48/104: Declaration on the Elimination of Violence against Women of 1993) that in the Asylbewerberleistungsgesetz (Asylum Seekers Benefits Act) (Sections 4, 6), the treatment of registered refugees within the first 15 months of their stay is limited to acute illnesses and pain conditions, whereas for example the treatment of a war traumatised patient, which is urgent for many of these patients, is not allowed; further, that the access of these persons to medical care is regulated in many federal states by the director of the accommodation facilities, who are usually not medically competent. For persons without valid residency papers, it ought to be examined how a hospital treatment can be enabled that protects medical confidentiality in terms of prolonged protection of secrecy, for example through the instrument of an anonymous health insurance certificate that has been introduced in some states.

In addition to the undisputed benefit of medical services for society, it has to be taken into account that the public resources that are invested into the inpatient sector are high and limited. Thus, questions of funds distribution as well as efficiency and effectiveness automatically arise. But also, through alternative structures and organisational measures, resources may be gained and redistributed. A societal decision must be made, therefore, to what extent funds are expended for inpatient care. In inpatient care, the determination of the total capacities occurs in the context of the demand planning by the federal states and hence in the framework of the political decision-making process. The available number of beds also always has an influence on the amount of treated cases and hence services.<sup>188</sup> For the question of whether an existing facility can be economically operated under the given framework conditions and how many cases and what services it must deliver for this purpose, the financing of the inpatient sector above all is of crucial importance, in addition to its size and structure.

Decision-making about the economically efficient and socially just allocation of scarce medical resources takes place at different levels.<sup>189</sup> Initially, one has to determine how much funding will be allocated to the healthcare sector as a whole, i.e., what portion of the national income is to be used for healthcare purposes.

Determining such a monetary upper limit for the healthcare system – a certain restriction at the macroeconomic level is contained in the principle of contribution rate stability (Section 71 SGB V) and in the requirement of economic efficiency (Section 12 SGB V) – necessarily entails allocation decisions at the downstream levels. If the limited means are supposed to

---

188 Cf. among others the so-called Roemer's Law: "in an insured population, a hospital bed built is a filled bed" (Shain/Roemer 1959, 71); see also Sauerland 2002, 84 ff.

189 An example for an inefficient allocation between the sectors of healthcare is the shifting of care from practice-based doctors to emergency departments in hospitals. An indicator for this shift taking place is the strong increase in outpatient emergency care by hospitals.

be efficiently and effectively used on all levels, this serves the purpose of preventing undersupply, oversupply and missupply. For this, the form of financing for the inpatient sector can make an essential contribution.

In addition, the interrelation between investments in the building and technical infrastructure (invested capital) and operating costs is important for considering the respective consequences. By way of example, a new building structure may generate lower energy costs, or employees may be able to care for more patients without additional burden given functional arrangement and meaningful area sizes than given long transport distances or too cramped ward sizes. Private hospital owners deploy more capital (“fixed assets”) per euro of revenue than do the public and non-profit operators. The rate stands at 71 cents by the private owners, 70 cents by the public and 58 cents by the non-profit.<sup>190</sup> If the public and non-profit operators thereby have fewer funds at their disposal in order to, for example, change process-hindering building structures through corresponding investments, replace outdated medical technology or reduce high energy- and maintenance-costs, then a greater demand arises to use personnel and material resources.<sup>191</sup>

#### 4.6.1 Dual financing in the inpatient sector

Hospital financing in the dual model (see 2.2) has long been criticised. Originally the issue was problematised from the side of the health insurance funds arguing that this form of

---

<sup>190</sup> Cf. Augurzky et al. 2015, 162.

<sup>191</sup> For the calculation of the DRGs, hospitals currently report their cost and performance data on a voluntary basis to the InEK. So far, the private hospital chains do not take part in the calculation. By law, the InEK should be empowered to call on hospitals to participate. Should data from the private hospital chains enter into the calculation of the DRGs in this way, the described interrelation between invested capital, i.e., investments, and operating costs is to be taken into account.

financing created overcapacities in the inpatient sector. The background to this critique is that the federal states only have to render investments, whereas the insurance funds have to cover the running operating costs. Due to the shortage of funds in the public budgets, however, it can be observed for some time now that the hospital investments are lagging behind the development of expenditures in the healthcare system. Thus, expenditures by the statutory health insurance in the period from 2002 to 2013 increased by approximately 40 percent, whereas the states' investments in the inpatient sector fell in the same period by roughly 15 percent.<sup>192</sup> Meanwhile, an investment backlog estimated at several billion euros is spoken of in the hospital sector (see 2.2). The conversion to a monistic system of financing "from a single source", as the Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (Advisory Council on the Assessment of Developments in the Health Care System) recommends<sup>193</sup>, has thus far failed on the question of how and in what amount – also given consideration of the investment backlog – the institutions receive the additionally necessary financial resources.<sup>194</sup> Additionally, the influence of the federal states would be reduced in a monistic system<sup>195</sup>, yet they would still have the mandate to ensure inpatient care. Nevertheless, one can of course also address the issue of the investment backlog in such a way as to ask whether the number of existing hospitals is necessary. On multiple occasions, the Advisory Council on the Assessment of Developments in the Health Care System has connected the question of the methodical reduction of overcapacities to the demand for a necessary reform of the investment financing.<sup>196</sup> In this

---

192 See [http://aok-bv.de/gesundheitsversorgungsbereiche/krankenhaus/index\\_11287.html](http://aok-bv.de/gesundheitsversorgungsbereiche/krankenhaus/index_11287.html) [2016-02-23].

193 Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2014, number 512; Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2012, number 337.

194 Cf. Preusker 2010, 302.

195 Cf. fn. 58.

196 Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2014, number 264.

case, the limited investment budget could be more efficiently distributed to a smaller number of remaining hospitals. Comparative figures from countries at a similar level to Germany in terms of national economy, such as the Netherlands, Denmark or Sweden, suggest that this path of efficiency enhancement should also be considered for the improvement of the hospital infrastructure.<sup>197</sup>

In addition to the general underfinancing in investments, there is also the problem of considerable differences in the investment activities of the individual federal states. This has already led to marked disparities in the provision of inpatient services for the population in different states. As a result, the current hospital financing has been contributing to inequality in an area that is of outstanding importance for the life situation of those affected. Although the quantity of inpatient care in Germany can be considered as very good in an international comparison (see 2.1), it cannot be excluded in the mid- to long-term that an undersupply will occur in the inpatient area, especially in sparsely populated rural regions. For this purpose, the Advisory Council on the Assessment of Developments in the Health Care System has recommended, in addition to determining the medical specialties that are indispensable for a comprehensive primary care, to define corresponding minimum accessibility criteria (preferably travel times, rather than distances) and to support hospitals that are

---

197 The international comparison, especially to countries in Europe whose national economies are structured in a like manner, shows that Germany, despite declining capacities, still disposes of an above-average number of beds and hospitals (with in part questionable facilities). While according to data from 2014, the Netherlands reserves 4.7 hospital beds per thousand residents and Denmark just 3.4 beds, the number in Germany was 8.3 beds per thousand residents (<http://www.indexmundi.com/g/r.aspx?v=2227&l=de> [2016-02-23]). The aforementioned reduction in beds, running at 15 percent in the last two decades in Germany, also stands in contrast to the 27 percent reduction in the old EU-15 countries. With regard to duration of stay and hospital cases, Germany lies above the average of the old EU-15 countries. On this and further numerical data, according to which the international comparison also suggests further questions on the outcome quality of German hospitals, cf. Geissler/Busse 2015.

vital for the provision of healthcare services in sparsely populated areas through service guarantee surcharges.<sup>198</sup>

In this connection, the question arises of whether the supply planning, primarily oriented towards the quality of treatment, should rather follow the current goals of a location-based planning or those of an accessibility-based<sup>199</sup> planning, whereby patient-welfare oriented arguments are to be found for both given targets. Simultaneously, the question arises of whether hospital planning and the financing of the facilities should take place more strongly according to uniform federal criteria and whether the financing should be regulated in a cross-state manner.

#### 4.6.2 Ownership structure in the inpatient sector

For several years, a significant transformation with regard to the structures of hospital ownership can be detected in Germany (see 2.1), whereby the privately-operated facilities have evolved from a “niche product” to a significant provider of healthcare.

Empirical studies show that private facilities exhibit a higher measure of economic efficiency than municipal and non-profit ones. Various factors may be causal in this regard. In addition to a higher targeted capital investment and faster decision-making of the facility, a success-oriented management, lower personnel costs as well as better possibilities for outsourcing certain services are mentioned.<sup>200</sup> Private

---

198 Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2014, number 263.

199 If one focuses particularly on the means of bed reduction and hospital closings, the possibly longer travel distances can be offset (especially in emergency care) through more capacities in air rescue, given the perspective of both medical effectivity and healthcare-economic efficiency.

200 Augurzyk/Beivers/Gülker 2012, 13 f., 21-26, 38-42.



providers are frequently accused of “cherry-picking”<sup>201</sup>, that is, concentrating on the lucrative cases, while not serving cost-intensive areas.<sup>202</sup>

To what extent this allegation is justified on the whole, remains contested in the literature.<sup>203</sup> Thus one study on hospitals in private ownership shows that the severity level of the illness as well as the age of patients in private hospitals is not lower than in public or non-profit institutions.<sup>204</sup> This fact taken by itself, however, is still not evidence that private institutions assume the same breadth of care as public hospitals. Speaking against the assumption of a comparable breadth of care by private operators is the fact, for example, that private facilities offer cost-intensive accident and emergency departments in markedly smaller measure than public or non-profit ones do. Yet, emergency and acute medicine represents not only a cost-intensive and economically unprofitable area of day patient or inpatient care, but also is essential and indispensable for the healthcare of the population.

In general, a specialisation of institutions on certain therapies is medically and economically sensible. Institutions can operate at the current state of technology and medical knowledge, especially for schedulable surgeries. In particular for smaller institutions, specialisation is an appropriate strategy in order to assert themselves in an increasingly competitive environment. This holds true for all forms of ownership. Also, in

---

201 Cf. Brütigam/Kruse 1992. With regard to private hospitals, one must differentiate between hospital chains and individual facilities. That certain hospitals pursue an economically motivated selection strategy cannot be ruled out. Conversely, however, this is also valid for hospitals under other forms of ownership.

202 For other hospitals in the surrounding area, this implies that they, in contrast, focus on emergency care or on providing putatively not economically attractive services in order to ensure supply. High contingency costs and lower effects of scale with correspondingly lower efficiency are associated with this.

203 With respect to age and type of insurance (statutory versus private), data analyses on patients cared for show no abnormalities related to the totality of private providers (Augurzky/Beivers/Gülker 2012, 28).

204 Augurzky/Beivers/Gülker 2012, 28-31.

hospital groups in public or non-profit ownership, concentration strategies can be noticed that likewise create the frame for a high-quality care.

An increasing specialisation within the hospital landscape appears unproblematic in terms of health politics as well as ethics so long as the necessary reserve capacities are ensured and supported financially in an adequate manner by the public authorities for the cost-intensive intensive-care and emergency wards; the increasingly sidelined fields such as gynaecology, obstetrics and paediatrics; as well as the treatment of rare diseases. In many regions, however, the comprehensive or quickly accessible ensuring and adequate financing of emergency capacities meanwhile represents a considerable problem.

#### **4.6.3 (False) Incentives of the DRG system**

In the existing DRG accounting system, those hospitals are working in an economical way whose average costs for a treatment case lie below the remuneration of the diagnosis-oriented case-based flat rates. Particularly institutions that have specialised in certain disease patterns and therapeutic procedures fulfil this condition. These institutions are able to raise their case numbers in these areas and hence to operate profitably to a high degree. In principle, scarce public funds are supplied to that use that endows the largest medical benefit. Nevertheless, there are treatment fields in which the DRGs are from experience insufficient to cover the accruing costs. These include, among others, the specialist departments for paediatric and adolescent medicine as well as the care of multimorbid elderly patients (see 4.5.1 to 4.5.4).

The goal must be to ensure cost-adequate forms of financing for all treatment cases, whereby one also has to examine under what conditions cases, case groups or patient groups are to be financed outside the case-based flat rates.

A remuneration system oriented towards patient welfare can in substance be based on case-based flat rates as long as one can expect that certain typical treatment situations, taking into account the above-mentioned criteria, could be adequately described through standardised variables and that these could be implemented into flat-rate remunerations. Standardising of such situations saves effort and costs. Nevertheless, any clinical treatment can lead to resources being necessary that go far beyond the planned standards. Moreover, innovative treatments, especially in high-performance medicine, acquire entry into the DRG system sometimes only after years of preparations. This applies especially with regard to multimorbid elderly patients, patients with rare diseases and in emergency care. To standardise such situations for their part appears of limited meaning due to the need for an extensively fanned-out differentiation.

Building on the provision of Section 17b (1) sentence 10 of the Hospital Financing Act on “special facilities”, one possible solution could consist in expanding the possibility of agreeing upon hospital-specific remuneration rates for case groups, in which the complex individual treatment situation is settled on the basis of actually arising costs. With a remuneration system based on case-based flat rates and, in parallel to that, an individualised remuneration system, cost-intensive necessary reserves, i.e., the maintenance of accident and emergency departments<sup>205</sup> in rural areas, could be decoupled from the case-based accounting system. In doing so, nevertheless, clear criteria for the possibility of agreeing upon such hospital-specific remuneration rates have to be defined, including a limitation

---

<sup>205</sup> The outpatient emergency care of the statutory insured is not paid by the DRG system, but remunerated via case-related honorariums according to the uniform valuation standard of the Association of Statutory Health Insurance Physicians. Nevertheless, here as well the problem exists of a possible underfinancing, since the flat rates for outpatient emergencies are not cost-covering and have to be cross-subsidised through other income. The average treatment costs here lie in part markedly above the corresponding reimbursement rates (cf. Haas et al. 2015, 11 f., 38 f., 48 f., 61 f.).

to indications and diagnosis groups on the basis of externally verifiable rationales. It should be ensured thereby that the intended savings effects of the DRG system are not cancelled out. Such a system could encourage the willingness as well to treat patients with complex and resource-intensive pre-existing illnesses (for example, dementia, infections or colonisation with multidrug-resistant organisms) within the hospitals.

The remuneration criterion of rendered physician-based services that has so far primarily been taken into account in the DRG case-based flat rates system, can be seen as in need of review; this criterion, measured for instance in the escalations in case numbers and reduced durations of stay, can without question set incentives for ethically problematic actions. That is, the remuneration system lays emphasis strongly on action and use of active measures, whereby incentives for superfluous, doubled and hence unnecessary measures can also arise that additionally burden the patient. A study commissioned by the National Association of Statutory Health Insurance Funds, Association of Private Health Insurance Funds and German Hospital Federation and presented in 2014 was, however, able to find no unequivocal evidence for or against a volume expansion in the hospitals based solely on economic motivation. Too many effects had influence on the evolution of services: morbidity and mortality, medical progress, patients' expectations, changed lifestyle habits or also changing interactions with outpatient care and the demographic effect. Nevertheless, the authors summarise the results thus: that while with acute services like acute heart attack, the admission behaviour was not changed, with other acute services, such as vascular diseases, the changed case numbers were to be ascribed to a changed coding-behaviour or other treatment pathways; with plannable services or services in areas with unclear evidence, such as spondylosis, however, the case numbers had changed as a consequence of the DRGs.<sup>206</sup> Still, the authors emphasise that

---

206 Schreyögg et al. 2014, 13.

the data available to them permit no conclusion about whether the changes in case numbers were medically indicated or not. The study also notices a connection between rising costs among unchanged DRGs and declining case numbers<sup>207</sup> as well as declining case numbers in the event of declining DRG weights without supplemental remunerations and case-number increases in the event of the possibility of supplemental remunerations<sup>208</sup>. The pendulum effects between DRG evolution and case-number trends appear at least demonstrable for certain diagnosis areas, although the question cannot be answered whether these developments go beyond the medically advisable or necessary.

Independent from the influence of the respective form of remuneration, the medical profession is increasingly discussing the avoidance of medically unnecessary measures.<sup>209</sup> In this sense in 2015, the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (Association of the Scientific Medical Societies in Germany) also initiated the discussion “Gemeinsam klug entscheiden” (“Choosing wisely together”), which follows up on the international initiative “Choosing wisely” and is aimed at working out “don’t-do recommendations” for unnecessary and even damaging services.<sup>210</sup>

Against this background, the remuneration of medical diagnostics and of the observation of a patient without performing of a subsequent treatment service should be more strongly accentuated, target-oriented and better remunerated in the

---

207 Ibid., 80.

208 Ibid., 93.

209 In this context, Michael Hallek from the Deutsche Gesellschaft für Innere Medizin (German Society for Internal Medicine) gives his view in a press release from 24 February 2015 thus: “Many medical interventions also imply a burden for the patient. [...] As doctors it is not only our duty to treat, but also to omit treatments if they do not benefit the patient or could even harm him” (<https://idw-online.de/de/news626239> [2015-09-28]). Moreover, a press release by the German Society for Internal Medicine from 9 July 2015 states: “Services that have been proven to be of no benefit for the patient should be identified and omitted” (<https://idw-online.de/de/news634544> [2015-09-2015]).

210 Richter-Kuhlmann 2015.

DRG catalogue. This could occur through the introduction of a separate and adequately financed “observation” procedure. In the event, for example, of a questionable medical indication, a physician’s decision for watchful waiting would be released from an economic sanctioning.

In addition, the phenomenon of segmenting the treatment of multimorbid patients into several individually accountable hospital stays, each supported by one respective diagnosis, needs to be dealt with through changes within the DRG system. Package solutions are conceivable in which in the individual case, several parallel diagnoses could be consolidated into a superordinated DRG. In addition, a remuneration structure oriented towards patient welfare should in case of need lead strictly to the placing of a patient into a better suited and specialised facility, even if a part of the treatment could be conducted in the emitting hospital, which could be achieved by tying the relevant DRGs to certain qualifications and equipment levels of facilities for the defined case groups. A remuneration structure that promotes a further reduction of durations of stay to a critically short space of time and supports the expansion of case numbers is going in the wrong direction. Likewise, a prolongation of the inpatient stay with the goal of a DRG reimbursement without deductions and above and beyond the medically necessary may not occur.

A further problem, which affects especially university hospitals and facilities with a comprehensive service mandate, is the treatment of rare diseases. These facilities, due to their service mandate, cannot withdraw from non-profitable areas and are obligated to provide services for cases involving rare diseases. In cases in which hospitals – be it maximum-care hospitals or ones of other service levels – assume the treatment of rare diseases, it needs to be examined whether the financing of these facilities must be supplemented alongside a price-based system by a corresponding basic financing of the contingency costs. This could be achieved, for example, through sufficient service guarantee surcharges.

## 4.7 Quality assurance and documentation

A central instrument of external quality assurance in hospitals is the quality report, thus far prepared by the AQUA Institute on behalf of the Federal Joint Committee (G-BA).<sup>211</sup> The most recent report comes from the year 2013. Both in the guidelines of the G-BA and in the quality report, it is set out, among other things, how to deal in a “structured dialogue” with negative deviations of a hospital with regard to defined medical parameters.

External quality assurance in the hospital is not comparable with the approach in the *Elftes Buch Sozialgesetzbuch* (Eleventh Book of the Social Code) and with the role described there of the German Health Insurance Medical Service in quality controls in inpatient nursing facilities, since scientifically established outcome-criteria exist for quality-management criteria in the hospital sector. The valuation factors that underlie these criteria are defined and introduced through diverse medical professional societies.

None of the involved medical professional societies has to this point raised objections to the AQUA quality report so that one ought really to think that no objections or complaints are raised from the hospital area as well, i.e. from those to be audited. Yet considerable critique is expressed precisely on the part of the hospitals and many doctors. Thus, among other things, it is criticised that the survey is limited to numerically detectable criteria, in which “soft” factors such as the subjective satisfaction of patients play hardly any role. Nursing is generally not covered in an adequate manner. Of the currently 30 service areas, only one relates to nursing, and this solely in regard

---

<sup>211</sup> Pursuant to Section 137 b SGB V, the G-BA is responsible for the conceptual implementation of the quality assurance obligations of healthcare service providers. See on this the Richtlinie über Maßnahmen der Qualitätssicherung in Krankenhäusern (Directive on Quality Assurance Measures in Hospitals) of 15 August 2006 (BAnz., 6361), last amended on 16 April 2015 (BAnz. AT 2015-08-06 B2).

to pressure sore prevention. Furthermore, it is criticised that the outcome success criteria for the service areas, published by some health insurance funds, has led to premature comparisons between facilities, without integrating the respective starting conditions (for example, composition of the patients). There are also multiple complaints about the considerable expense of time that is associated with the surveys. It is striking that these objections are not promoted publicly on the part of the professional societies and associations and not passed on to the AQUA Institute.

Against the background that the issue of quality assurance (improvement in quality, comparability and increase in transparency for the user) is beyond dispute, quality assurance in the new Hospital Structures Act is declared to be an integral part of hospital planning and the awarding of resources. Thus, additional payments and deductions are introduced for good or insufficient quality, whereby the question of the parameters for the determination of quality will arise in an intensified manner.

The AQUA Institute has taken up the already long-existing critique of the current process and suggested improvement of the communication between the healthcare providers and audit authorities in order to shape the facility comparisons fairly and in a convincing way. Further, more longitudinal observations should be initiated. It is also planned to introduce patient surveys and attain an improvement in the cost-benefit ratio.<sup>212</sup>

Patient surveys for quality assurance are of great significance, precisely against the background of the goal to ensure patient welfare. To be considered, therefore, are patient surveys not only related to treatment experiences and treatment outcomes, as currently suggested by the AQUA Institute for individual service areas, but also surveys related to the subjective quality of life of the patient during the hospital treatment,

---

212 Cf. Institut für angewandte Qualitätsförderung und Forschung im Gesundheitswesen 2014, 238-244.



to the treatment process and, where appropriate, to the as yet unfulfilled need for information.<sup>213</sup> Additionally, in future quality-survey instruments, nursing and its standards should not only be taken more strongly into account in the existing service areas, but nursing should also be operationalised as a separate service area.

In particular the physician-based area, but also nursing in the hospital, is increasingly burdened with obligations for documentation, whose scope and detailedness additionally burden the already scarce resources of time. Obviously, this form of documentation is principally necessary for the continued development of the accounting system. To the extent that the benefit of this documentation is questionable for the individual patient and that the documentation demands a considerable additional effort and attentiveness on the part of doctors and nurses that then diminishes attention for the patient, the question arises of an appropriate compensation for this provision of services as well as of the development of digital technical solutions for a sweeping simplification of the documentation.

---

213 How important objectifiable survey instruments are for the surveying of patient satisfaction is shown by the 2012 survey by the AOK and other health insurance funds, according to which 83 percent of patients indeed expressed predominantly high satisfaction with the care in the hospital, yet the representativeness of the survey is not given, and hence its explanatory power is not sufficient (Weisse Liste/Barmer GEK/AOK 2012, 2).

## 5 SUMMARY AND RECOMMENDATIONS

### 5.1 Summary

#### *Chapter 1: Introduction and outline of the problem*

For decades, the organisation and financing of hospital care in Germany have been topics of a controversial political discussion. Persistent challenges contribute to this, such as the general development of costs in healthcare; further developments in medicine with the necessity for investments and a continuous adaptation of the medical infrastructure; changed expectations on the part of patients; the interest in participating in an economically attractive growth market; and the demographic evolution. It is striking that in this discussion an orientation towards patient welfare as determinative normative guiding principle for hospital care has so far not been placed explicitly in the foreground. In conjunction with this finding are distressing developments in hospital medicine, such as, for example, volume expansions or reductions in treatment services; the concentration on particularly profitable treatment procedures at the expense of other necessary treatment offerings; as well as, in the meantime, problematic labour conditions for the personnel employed in the hospital.

With the GKV-Versorgungsstärkungsgesetz (Care Provision Strengthening Act) passed in 2015 and the Krankenhausstrukturgesetz (Hospital Structures Act), the latter with the demand to ensure a care that is “of high quality” and “patient-friendly”, the German Bundestag takes into consideration once more in an intensified manner the patient and her/his welfare and ties the future calculation of resources to this superordinate standard. The challenge remains, meanwhile, as demanded by the statute, of determining the criteria for this standard in more detail and of making them transparent for patients and society.

Against this background, the German Ethics Council deals in the present Opinion with hospital care in Germany and, in doing so, poses patient welfare in the centre as normative guiding principle. In the process, the German Ethics Council is aware of the systematic and methodological difficulties that are connected with focusing considerations of patient welfare on hospital care as merely a single segment of the extremely complex total system of healthcare provision in Germany. Nevertheless, the problematic developments in hospital medicine in Germany appear to make such considerations necessary.

### ***Chapter 2: Overview of the hospital care system in Germany***

A survey of the structure, financing and legal framework already shows that the segment of inpatient care itself also represents a complicated construction that has thus far not developed any sufficient stability, which is shown in the obvious necessity of continuous statutory improvements. Even if improvements have been attained through legislative activities, medium-term planning security hardly exists for the individual hospitals. Additionally, the normative reference points of the previous system of inpatient care are not unambiguously identifiable.

### ***Chapter 3: Patient welfare as an ethical standard***

The ethically grounded orientation towards patient welfare can be operationalised by means of three criteria: care for the patient that is sustained by the enabling of his/her self-determination; a good quality of treatment; as well as the just distribution of resources available for inpatient care.

Care that enables self-determination has as its point of departure the respect and consideration of the patient as a person with individual ideas, wishes, interests, an individual history and with individual rights; and it is connected to the concept of adherence and the model of participatory decision-making in the doctor-patient relationship, or respectively in the nurse-patient and therapist-patient relationship.

Consequently, it presupposes a successful communication that must be tailored to the patient in content, in manner and with respect to the general framework and which finds its aim especially in a concept of informed and self-determined consent on the part of the patient.

The treatment quality encompasses objective as well as subjective elements; the former refer to possibilities and requirements of the medical sciences, the latter to the satisfaction of patients with the treatment. Quality measurement and quality assurance are oriented towards the model of structural, process and outcome quality. In a treatment that is of high quality and patient-friendly, treatment quality also finds expression particularly in the medical indication being established responsibly, in relation to the individual patient.

Justice in the sense of equal access to hospital services and their just distribution includes both the imperative for status-impartial equal treatment (equality) and the imperative for fair and in each case individually appropriate use of resources (equity). On the basis of the preexisting scarcity of resources, both calls for justice point to their effective and efficient (economical) use. The call for a resource-reflexive conduct in the hospital must not lead, however, to an economic alteration of physicians' actions, nor that of nurses and therapists.

#### ***Chapter 4: Threats to patient welfare: areas of conflict***

With a view to the three criteria determining patient welfare, ethically relevant areas of conflict can be identified within hospital treatment in Germany and possible solutions named. In the foreground of patient-related decisions, the effectiveness and efficiency of the treatment currently stand first and foremost as outcome parameters. As a result, the other criteria relevant for patient welfare – care that enables self-determination and equal access to treatment services – retreat in practice into the background.

The resulting areas of conflict concern especially the increasingly lacking possibilities for an adequate interpersonal

communication in the doctor-patient relationship, or respectively that of nurse-patient and therapist-patient, including intercultural treatment situations, as well as the increasing difficulty for the professional groups employed in the hospital of being able to put into practice their respective professional-ethical duties. Likewise, it is proving increasingly difficult to ensure an equal access to hospital services and their just distribution, especially for patient groups with special needs. This applies in different ways to children and adolescents, patients in old age, with typical geriatric illnesses, with dementia, with disabilities or patients with migration background.

On the basis of this analysis, the German Ethics Council submits the following recommendations.

## 5.2 Recommendations

### 1. *Ensuring a better communication*

- a) For a communication in the hospital that is oriented towards patient welfare, the legislature and the self-governing corporatist bodies should ensure that time and organisational expense is correspondingly taken into account in the provisions for remuneration within the DRG system.
- b) Within the scope of focusing on quality, which is required by the Krankenhausstrukturgesetz (Hospital Structures Act), instruments should be developed with which communication is transparently documented. The documentation should include both conversations with the patients and interprofessional ward rounds and case conferences. In the process, with regard to the documentation guidelines, it should be ensured that the amount of effort remains reasonable.
- c) For reasons of equal treatment and the ensuring of an informed, self-determined decision, the legislature should figure in the case-based accounting system the costs for a necessary professional translation in the context of an

intercultural treatment situation as well as a translation into sign language for deaf patients.

- d) To assure the quality of communication in the hospital, the communicative competence of all those employed in the hospital should systematically be strengthened and cultivated through regular professional training, advanced training and continuing education. In doing so, intercultural competence should also be imparted, which is characterised by knowledgeable ability about other cultures and understanding of their moral concepts.
- e) The German courses and profession-relevant language exams already introduced into practice for non-German-speaking doctors and nurses by several medical associations should be comprehensively introduced and made mandatory.

### ***2. Assurance and improvement of management qualification***

In the filling of physician and nursing executive positions in the hospital, not only the respective professional core competence should be vital in the future, but also qualified knowledge in economics, ethics, management and law. In a similar manner, executive hospital managers should also dispose of basic knowledge in medicine and nursing in addition to their economic expertise. For this, corresponding advanced-training offerings, which also include the acquisition of practical experience, have to be developed or refined.

### ***3. Improvement of the nursing situation in the hospital***

- a) The Federal Ministry of Health should provide for a sustainable improvement of the nursing situation in hospitals. So for hospitals, nursing personnel ratios as a function of ward and department sizes should be developed and implemented that are oriented towards the number of patients to be tended to and their illnesses or care needs. In doing so, the specific spectrum of duties of the nursing, physician and other therapeutic services in the respective area of expertise is necessarily to be taken into account including

times, for example, of handover, interprofessional ward rounds and case conferences.

- b) Moreover, minimum quotas for fully qualified nursing staff, differentiated according to specialist departments, should be established and made transparent, and their observance should be subject to a regular review. Deviations from these targets should be made transparent for patients and referring physicians.
- c) In this context and bearing in mind the current deficit in fully qualified nurses on the labour market, new qualification models should be developed and promoted with which, for example, doctor's assistants can receive in-service training to become nursing staff.
- d) In the interest of improving the quality of a patient-welfare-oriented nursing, conditions should be purposefully promoted that guarantee as far as possible a personnel continuity in nursing and that avoid methods of pooling staff positions.

#### ***4. Minimisation of false incentives in the remuneration through case-based flat rates (DRGs)***

The German Ethics Council recommends to the legislature and self-governing corporatist bodies the following measures for a patient-welfare-oriented reshaping of the DRG system:

- a) In order to minimise false incentives for premature transfer or releasing of multimorbid patients with several existing medical treatment requirements, the possibility should be created of billing without time delays or economically motivated transfers the necessary treatments as separate DRGs. Synergy effects should lead to corresponding deductions. Alternatively, the consolidating of several relevant DRGs should be made possible in the form of a package solution related to the individual case or in that of a superordinated new DRG.
- b) As regards patients for whom the actually arising costs cannot be realistically depicted through case groups – such as

with certain very elderly patients, patients with rare diseases, patients with severe infections or with ones caused by multi-resistant bacteria, but also patients with special care needs, patients subject to involuntary commitment or patients with special behavioural problems – new agreement options should be created, as already existent in isolated cases, for supplemental payments or other additional remuneration elements. As the basis for this, the already valid Section 17b (1) sentence 10 of the Krankenhausfinanzierungsgesetz (Hospital Financing Act) on “special facilities” can be adduced, which would have to be expanded to these case groups and bound to clear criteria for delimitation to verifiably substantiated indications and diagnosis groups.

- c) Complementary to the second-opinion process already stipulated in the Hospital Structures Act for certain operations able to be planned with a lead-in time (elective surgeries), remuneration models should be developed and tested in order to avoid unnecessary operations and procedures, so that they do not offer incentives only for conducting a measure, but also for its justified omission. For this purpose, an “observation” procedure could be newly introduced for certain diagnosis areas, for example, which receives its own remuneration assessment in order to relieve the physician’s decision for watchful waiting from economic sanction. The payment of such a DRG would have to be bound in each case to a particular medical rationale, an observation of the patient through repeated examinations and the in-depth conversation with the patient.
- d) To avert treatments in hospitals insufficiently equipped or not qualified for such, the relevant DRGs should be linked to certain qualifications and equipment levels of facilities, alongside the new minimum-volume regulation in defined case groups. The aim of this regulation should be to prevent hospitals from rendering such services in these cases.
- e) For the financing of the treatment costs in inpatient psychiatry and psychosomatics, a payment system should be



developed on the basis of the Federal Ministry of Health's key points paper of February 2016, which guarantees long-term a staffing that is sufficient and commensurate to the hospital-specific needs and that takes into account the diversity of treatment courses for the same diagnosis and the individually extremely diverse life circumstances that play a major role for the course of the illness and therapy with psychiatric and psychosomatic patients. Forms of cross-sectoral care should be facilitated by linking inpatient and outpatient services.

#### **5. Expansion of quality assurance structures**

- a) To improve the quality of treatment and bundling of expert knowledge, a programme at the federal level should promote disease-pattern-oriented organisational models in German hospitals in the form of establishing multidisciplinary centres, which so far have existed only on a quite modest and professionally limited scale. In addition to the treatment centres for persons with disabilities already made possible by law, the creation of centres for geriatric patients would be necessary.
- b) The obligations for documentation prescribed by law should be simplified with the goal of freeing up more time for the care of patients. Models making use of digital assistance, among other things, should be developed and tested to this end. At the same time, however, enhancements in the documentation of communication (interprofessional communication, communication with the patient, communication quality) and of the "soft" factors of care (conversation, attention, contact) should be developed and tested. For the development and assessment of such documentation procedures, corresponding financial resources should be made available.
- c) The legislature should strengthen measures aimed at introducing a uniform documentation and quality assurance in the inpatient and outpatient area in order to design the

processes in the hospital more effectively and efficiently, to simplify the cooperation between both sectors and to reduce duplication of examinations to those cases where a rigorous medical indication exists for a renewed diagnostics.

- d) Furthermore, the federal legislature should examine whether, in the framework of the federal states' demand planning in the hospital sector, the existence of a clinical ethics committee or equivalent structures, or the intention to establish such in the facility, should be made a precondition for the licensing of a hospital. Moreover, possibilities for an organisational-ethical counselling are to be created, to which the members of the hospital management can have recourse. Depending on the circumstances, an internal clinical ethics committee or external counselling is suitable.

## **6. *Special patient groups***

- a) To ensure the appropriate hospital care of children and adolescents, specific DRGs should be worked out and implemented for these age groups. A prerequisite for this is the creation as rapidly as possible of a statistical basis established on strictly paediatric data that permits a modelling into strictly paediatric DRGs. Until that point, a remuneration corresponding to the actual costs should be ensured through sufficiently high service guarantee surcharges. Alternatively, taking inpatient paediatric and adolescent medicine out of the current system of case-based flat rates and remunerating them according to daily-equivalent nursing care rates to be negotiated should be examined.
- b) In line with the inclusion goals of the UN Convention on the Rights of Persons with Disabilities, possibilities for supplemental payments should be provided that take into account the specific needs of persons with disabilities and the associated additional expenses in order to prevent hospitals from refusing to treat these patients.
- c) To improve the treatment in hospitals of persons with disabilities, it is recommended to expand the Gesetz zur

Regelung des Assistenzpflegebedarfs im Krankenhaus (Act on the Regulation of Assistive Nursing Needs in the Hospital) of 2009 in such a way that persons with disabilities who receive in-kind benefits or live in a nursing home also have access to the service of additional assistance in the hospital.

- d) For the barrier-free redesign of hospitals that are suited for this, a subsidy programme should be established with federal financial resources. Additionally, accessibility for persons with disabilities should be taken up in the framework criteria for hospital planning.
- e) For the high-quality and patient-friendly care within the hospital of persons with disabilities, the framework for the federal states' hospital planning should include designating selected regional hospitals for ensuring the care of persons with disabilities and equipping them correspondingly in material and personnel terms.
- f) For the group of patients affected by dementia who are treated in the hospital, a subsidy programme of the federal government should be established for the creation of dementia-sensitive structures in general-care hospitals, with which advanced training and continuing education of personnel for the appropriate handling of those suffering from dementia as well as organisational and construction-related remodellings are made possible. For an adequate treatment of patients with dementia, it is additionally recommended to adapt the remuneration level appropriately to the effort for the treatment of patients with dementia in the hospital.

### ***7. Systemic framework***

- a) Transparent criteria should be developed and tested for a hospital planning oriented primarily towards patient welfare in the sense laid out by the German Ethics Council, and it should be examined to what extent the fulfilment of these criteria can be adduced and made mandatory as a necessary prerequisite for a licensing of hospitals under the state hospital plan pursuant to Section 108 Fünftes Buch

Sozialgesetzbuch (Fifth Book of the Social Code), and, in place of a thus far predominantly practised rolling forward, as a condition for the continuation of the licensing of hospitals.

- b) The Federal Government and the states should develop and introduce nationwide standards for hospital planning in order to minimise the presently existing differences and duplicated structures for hospital care in the federal states. This does not exclude, where appropriate, a reduction in the number of existing hospitals. In this context, a suitable ratio of close-to-home, or quickly reachable, inpatient care and specialised centres with expanded treatment offering should be determined, in accordance with patient welfare with participation of patient representatives and with consideration for the medical specialties that are indispensable for a comprehensive basic care.
- c) It is further recommended that the problematics of the link between the inpatient and outpatient sector be systematically analysed and evaluated once more from the special perspective of patient welfare in the sense posed by the German Ethics Council with respect to healthcare in general and the hospital in particular, and that solutions be worked out and implemented.
- d) The Gemeinsamer Bundesausschuss (Federal Joint Committee) should integrate expertise from the field of ethics into its work. This could be done, for example, by establishing a multidisciplinary ethical advisory body composed of relevant experts.

## REFERENCES

- Arolt, V.; Driessen, M.; Dilling, H. (1997): The Lübeck General Hospital Study. I: Prevalence of psychiatric disorders in medical and surgical inpatients. In: *International Journal of Psychiatry in Clinical Practice*, 1 (3), 207-216.
- Augurzky, B. et al. (2015): Krankenhaus Rating Report 2015. Bad Bank für Krankenhäuser – Krankenhausausstieg vor der Tür? Heidelberg.
- Augurzky, B.; Beivers, A.; Gülker, R. (2012): Bedeutung der Krankenhäuser in privater Trägerschaft. Essen.
- Ausserhofer, D. et al. (2014): Prevalence, patterns and predictors of nursing care left undone in European hospitals: results from the multicountry cross-sectional RN4CAST study. In: *BMJ Quality & Safety*, 23 (2), 126-135.
- Aylett, V. (2010): Do geriatricians need guidelines? In: *BMJ*, 341:c5340. DOI: 10.1136/bmj.c5340.
- Barkowski, M. (2008): Mein Blut tut weh. Interkulturelle Implikationen beim Dolmetschen im Krankenhaus. In: *MDÜ*, 54 (2), 41-43.
- Benner, P. (2000): Stufen zur Pflegekompetenz. From Novice to Expert (3<sup>rd</sup> ed.). Bern.
- Berendonk, C. et al. (2011): Biographiearbeit in der stationären Langzeitpflege von Menschen mit Demenz. Potenziale des DEMIAN-Pflegekonzepts. In: *Zeitschrift für Gerontologie und Geriatrie*, 44 (1), 13-18.
- Bertelsmann Stiftung (ed.) (2006): Interkulturelle Kompetenz – Schlüsselkompetenz des 21. Jahrhunderts. Thesenpapier der Bertelsmann Stiftung auf Basis der Interkulturellen-Kompetenz-Modelle von Dr. Darla K. Deardorff. Gütersloh.
- Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege (ed.) (2013): Gesundheitssektor Krankenhaus. Zahlen – Daten – Fakten. Hamburg.
- Bioethik-Kommission des Landes Rheinland-Pfalz (ed.) (2010): Gesundheit und Gerechtigkeit. Ethische, soziale und rechtliche Herausforderungen. Mainz.
- Borchelt, M. (2004): Gewachsene Strukturen, beschleunigter Wandel und divergierende Interessenlagen zur Geriatrie: Anatomie eines scheinbaren Widerspruchs. [http://www.geriatrie-drg.de/Public/Docs/Geriatriestrukturen\\_13022004.pdf](http://www.geriatrie-drg.de/Public/Docs/Geriatriestrukturen_13022004.pdf) [2016-02-22].
- Bräutigam, H. H.; Kruse, K. (1992): Die Lifestyle-Klinik. In: *Zeit Online*, 1992-06-12. <http://www.zeit.de/1992/25/die-lifestyle-klinik> [2016-03-08].
- Brock, D. W.; Wikler, D. (2006): Ethical issues in resource allocation, research, and new product development. In: Jamison, D. T. et al. (ed.): *Disease Control Priorities in Developing Countries* (2<sup>nd</sup> ed.). Washington D.C., 259-270.
- Budroni, H. et al. (2006): Behinderte Pflegewelten. In: *Pflege aktuell*, 60 (3), 122-127.
- Buhr, P.; Klink, S. (2006): Qualitative Folgen der DRG-Einführung für Arbeitsbedingungen und Versorgung im Krankenhaus unter Bedingungen fortgesetzter Budgetierung. Eine vergleichende Auswertung von vier Fallstudien. Berlin.

- Bundesärztekammer (ed.) (2015a): 118. Deutscher Ärztetag. Beschlussprotokoll. [http://www.bundesaerztekammer.de/fileadmin/user\\_upload/downloads/pdf-Ordner/118\\_DAET/118DAETBeschlussprotokoll20150515.pdf](http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Ordner/118_DAET/118DAETBeschlussprotokoll20150515.pdf) [2015-09-06].
- Bundesärztekammer (ed.) (2015b): Medizinische Indikationsstellung und Ökonomisierung. [http://www.bundesaerztekammer.de/fileadmin/user\\_upload/downloads/pdf-Ordner/Stellungnahmen/Stn\\_Medizinische\\_Indikationsstellung\\_und\\_Oekonomisierung.pdf](http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Ordner/Stellungnahmen/Stn_Medizinische_Indikationsstellung_und_Oekonomisierung.pdf) [2016-02-22].
- Bundesministerium für Gesundheit (ed.) (2016): Eckpunkte zur Weiterentwicklung des Psych-Entgeltsystems. [http://www.bmg.bund.de/fileadmin/dateien/Downloads/P/Psych-Entgeltgesetz/160218\\_Eckpunkte\\_Psych-EntgeltG\\_II\\_Version.pdf](http://www.bmg.bund.de/fileadmin/dateien/Downloads/P/Psych-Entgeltgesetz/160218_Eckpunkte_Psych-EntgeltG_II_Version.pdf) [2016-03-02].
- Cabrera, A. (2003): Oh Manager, Schwöret! In: Handelsblatt Online, 2003-07-18. <http://www.handelsblatt.com/unternehmen/management/gastbeitrag-oh-manager-schwoeret/2259928.html> [2016-03-08].
- Cape, J. (2002): Consultation length, patient-estimated consultation length, and satisfaction with the consultation. In: British Journal of General Practice, 52 (485), 1004-1006.
- Conradi, E. (2013): Ethik im Kontext sozialer Arbeit. In: EthikJournal, 1 (1), 1-19.
- Daniels, N. (2013): Justice and access to health care. In: Zalta, E. N. (ed.): The Stanford Encyclopedia of Philosophy (Spring 2013 Edition). <http://plato.stanford.edu/archives/spr2013/entries/justice-healthcareaccess> [2016-02-22].
- Daniels, N. (2008): Just Health. Meeting Health Needs Fairly. Cambridge.
- Daniels, N. (1996): Justice and Justification. Reflective Equilibrium in Theory and Practice. Cambridge.
- Depenheuer, O. (1986): Staatliche Finanzierung und Planung im Krankenhauswesen. Eine verfassungsrechtliche Studie über die Grenzen sozialstaatlicher Ingerenz gegenüber freigemeinnützigen Krankenhäusern. Berlin.
- Deutsche Alzheimer Gesellschaft (ed.) (2015): Patienten mit einer Demenz im Krankenhaus. Begleitheft zum "Informationsbogen für Patienten mit einer Demenz bei Aufnahme ins Krankenhaus" (4<sup>th</sup> ed.). Berlin.
- Deutsche Alzheimer Gesellschaft (ed.) (2013): Menschen mit Demenz im Krankenhaus. Auf dem Weg zum demenzsensiblen Krankenhaus. Berlin.
- Deutsche Gesellschaft für Erziehungswissenschaft (ed.) (2010): Ethik-Kodex der Deutschen Gesellschaft für Erziehungswissenschaft. [http://www.dgfe.de/fileadmin/OrdnerRedakteure/Satzung\\_etc/Ethikkodex\\_2010.pdf](http://www.dgfe.de/fileadmin/OrdnerRedakteure/Satzung_etc/Ethikkodex_2010.pdf) [2016-02-22].
- Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (ed.) (2013): Ethik-Leitlinien der DGPT. [http://www.dgpt.de/fileadmin/download/DGPT\\_Ethik\\_Leitlinien\\_Stand\\_20130927.pdf](http://www.dgpt.de/fileadmin/download/DGPT_Ethik_Leitlinien_Stand_20130927.pdf) [2016-02-22].
- Deutsche Gesellschaft für Psychologie; Berufsverband Deutscher Psychologinnen und Psychologen (ed.) (2005): Ethische Richtlinien. [http://www.bdp-verband.org/bdp/verband/clips/BDP\\_Ethische\\_Richtlinien\\_2005.pdf](http://www.bdp-verband.org/bdp/verband/clips/BDP_Ethische_Richtlinien_2005.pdf) [2016-02-22].
- Deutscher Berufsverband für Soziale Arbeit (ed.) (2014): Berufsethik des DBSH. Ethik und Werte. Berlin.
- Deutscher Bundestag (ed.) (1984): Beschlußempfehlung und Bericht des Ausschusses für Arbeit und Sozialordnung (11. Ausschuß). Bundestagsdrucksache 10/2565. <http://dip21.bundestag.de/dip21/btd/10/025/1002565.pdf> [2016-02-17].

- Deutscher Bundestag (ed.) (1969): Bericht der Bundesregierung über die finanzielle Lage der Krankenanstalten in der Bundesrepublik. Bundestagsdrucksache V/4230. <http://dipbt.bundestag.de/doc/btd/05/042/0504230.pdf> [2016-02-17].
- Deutscher Bundesverband für Logopädie (ed.) (1998): Berufsordnung der LogopädInnen. [https://www.dbl-ev.de/fileadmin/Inhalte/Publikationen/0009\\_b\\_berufsordnung.pdf](https://www.dbl-ev.de/fileadmin/Inhalte/Publikationen/0009_b_berufsordnung.pdf) [2016-02-22].
- Deutscher Ethikrat (ed.) (2013): Die Zukunft der genetischen Diagnostik – von der Forschung in die klinische Anwendung. Berlin.
- Deutscher Ethikrat (ed.) (2012): Demenz und Selbstbestimmung. Berlin.
- Deutscher Ethikrat (ed.) (2011): Nutzen und Kosten im Gesundheitswesen – Zur normativen Funktion ihrer Bewertung. Berlin.
- Deutscher Fachverband für Kunst- und Gestaltungstherapie (ed.) (2000): Ethische Grundsätze für Kunst- & GestaltungstherapeutInnen im DFKGT. [http://www.dfkgt.de/download\\_doc.cfm?doc\\_UUID=45DFC7A1304875DA97AA CE32519E4F4B&](http://www.dfkgt.de/download_doc.cfm?doc_UUID=45DFC7A1304875DA97AA CE32519E4F4B&) [2016-02-22].
- Deutscher Hebammenverband (ed.) (2011): Leitbild des Deutschen Hebammenverbandes (1<sup>st</sup> ed.). Karlsruhe.
- Deutscher Verband der Ergotherapeuten (ed.) (2005): Ethikkodex und Standards zur beruflichen Praxis der Ergotherapie. <https://www.dve.info/fileadmin/upload/pdf/infotehke/Ethik.pdf> [2016-02-22].
- Deutsches Institut für angewandte Pflegeforschung (ed.) (2014): Pflege-Thermometer 2014. Eine bundesweite Befragung von leitenden Pflegekräften zur Pflege und Patientenversorgung von Menschen mit Demenz im Krankenhaus. Cologne.
- Donabedian, A. (1980): Explorations in Quality Assessment and Monitoring. Vol. 1: The Definition of Quality and Approaches to Its Assessment. Ann Arbor.
- Donabedian, A. (1966): Evaluating the quality of medical care. In: The Milbank Memorial Fund Quarterly, 44 (3, part 2), 166-203.
- Eichhorn, S. (1975): Krankenhausbetriebslehre. Theorie und Praxis des Krankenhausbetriebes, vol. I (3<sup>rd</sup> ed.). Cologne.
- Emanuel, E. J.; Emanuel L. L. (1992): Four models of the physician-patient relationship. In: Journal of the American Medical Association, 267 (16), 2221-2226.
- Feißt, M.; Molzberger, K. (2016): Die Praxis der Zahlen im Krankenhausmanagement. Fakt oder Fetisch? In: Bode, I.; Vogd, W. (ed.): Mutationen des Krankenhauses. Soziologische Diagnosen in organisations- und gesellschaftstheoretischer Perspektive. Wiesbaden, 119-142.
- Fleischhauer, K. (2015): Die Regulierung der medizinischen Versorgung in Deutschland. Normsetzung und Normen in der gesetzlichen und in der privaten Krankenversicherung – Eine Einführung. Berlin.
- Forum selbstbestimmter Assistenz behinderter Menschen (ed.) (2007): Ich muss ins Krankenhaus ... und nun? Dokumentation der Kampagne 2006/2007. Berlin.
- Friesacher, H. (2015): Wider die Abwertung der eigentlichen Pflege. In: Intensiv, 23 (4), 200-214.
- Fuchs, C.; Nagel, E.; Raspe, H. (2009): Rationalisierung, Rationierung und Priorisierung – was ist gemeint? In: Deutsches Ärzteblatt, 106 (12), A554-A557.

- Füsgen, I. (ed.) (1996): Der ältere Patient. Problemorientierte Diagnostik und Therapie (2<sup>nd</sup> ed.). Munich.
- Geisler, L. S. (2010): Das ärztliche Gespräch – eine vernachlässigte Aufgabe. In: Bruchhausen, W.; Hofer, H.-G. (ed.): Ärztliches Ethos im Kontext. Historische, phänomenologische und didaktische Analysen. Bonn, 99-112.
- Geissler, A.; Busse, R. (2015): Stationäre Kapazitätssteuerung im internationalen Vergleich. In: Klauber, J. et al. (ed.): Krankenhaus-Report 2015. Schwerpunkt: Strukturwandel. Stuttgart, 13-22.
- Georg, J.; Frowein, M. (1999): Pflegelexikon. Wiesbaden.
- GKV-Spitzenverband (ed.) (2016): Kennzahlen der gesetzlichen Krankenversicherung. [https://www.gkv-spitzenverband.de/media/grafiken/gkv\\_kennzahlen/kennzahlen\\_gkv\\_2015\\_q4/GKV\\_Kennzahlen\\_Booklet\\_Q4-2015\\_300dpi\\_2016-03-10.pdf](https://www.gkv-spitzenverband.de/media/grafiken/gkv_kennzahlen/kennzahlen_gkv_2015_q4/GKV_Kennzahlen_Booklet_Q4-2015_300dpi_2016-03-10.pdf) [2016-03-23].
- Gotzmann, M. et al. (2011): Transcatheter aortic valve implantation in patients with severe symptomatic aortic valve stenosis – predictors of mortality and poor treatment response. In: American Heart Journal, 162 (2), 238-245.
- Haas, C. et al. (ed.) (2015): Gutachten zur ambulanten Notfallversorgung im Krankenhaus – Fallkostenkalkulation und Strukturanalyse. [http://www.dkgev.de/media/file/19401.2015-02-17\\_Gutachten\\_zur\\_ambulanten\\_Notfallversorgung\\_im\\_Krankenhaus\\_2015.pdf](http://www.dkgev.de/media/file/19401.2015-02-17_Gutachten_zur_ambulanten_Notfallversorgung_im_Krankenhaus_2015.pdf) [2016-03-23].
- Haskard Zolnierok, K. B.; DiMatteo, M. R. (2009): Physician communication and patient adherence to treatment: a meta-analysis. In: Medical Care, 47 (8), 826-834.
- Heffels, W. M. (2002): Pflegeethik als Verpflichtung zur Wahrnehmung personaler Verantwortung der Pflegenden in funktionalisierten Handlungsfeldern der Pflege. Dissertation. Gerhard-Mercator-Universität Duisburg, Fakultät für Gesellschaftswissenschaften. <https://duepublico.uni-duisburg-essen.de/servlets/DocumentServlet/Document-5219/heffelsdiss.pdf> [2016-02-22].
- Herbst, U. (2000): Pflegeberufe. In: Korff, W.; Beck, L.; Mikat, P. (ed.): Lexikon der Bioethik. Vol. 3: Pe-Z. Gütersloh, 19-22.
- Hoefert, H.-W. (2008): Einbindung von Patienten in den Behandlungsprozess. In: Hoefert, H.-W.; Hellmann, W. (ed.): Kommunikation als Erfolgsfaktor im Krankenhaus. Heidelberg, 151-170.
- Höfling, W. (2008): Zukunftsfragen des Krankenhauses im Gesundheitsgewährleistungsstaat – vom Krankenhausrecht zum Krankenhausregulierungsrecht. In: Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen (ed.): Das Krankenhaus im Gesundheitsgewährleistungsstaat. Stuttgart, 17-34.
- Höfling, W. (2007): Vom Krankenhausrecht zum Krankenhausregulierungsrecht. In: GesundheitsRecht, 6 (7), 289-294.
- Huster, S.; Kaltenborn, M. (ed.) (2010): Krankenhausrecht. Praxishandbuch zum Recht des Krankenhauswesens (1<sup>st</sup> ed.). Munich.
- Ilklic, I. (2014): Interkulturalität in der Ethikberatung. In: Coors, M.; Grützmann, T.; Peters, T. (ed.): Interkulturalität und Ethik. Der Umgang mit Fremdheit in Medizin und Pflege. Göttingen, 101-111.
- Ilklic, I. (2008): Kulturelle Aspekte bei ethischen Entscheidungen am Lebensende und interkulturelle Kompetenz. In: Bundesgesundheitsblatt – Gesundheitsforschung – Gesundheitsschutz, 51 (8), 857-864.



Ilklic, I. (2006): Begegnung und Umgang mit muslimischen Patienten. Eine Handreichung für die Gesundheitsberufe (6<sup>th</sup> ed.). Bochum.

Ilklic, I. (2002): Der muslimische Patient. Medizinethische Aspekte des muslimischen Krankheitsverständnisses in einer wertpluralen Gesellschaft. Münster.

Institut für angewandte Qualitätsförderung und Forschung im Gesundheitswesen (ed.) (2014): Qualitätsreport 2013. Göttingen.

International Confederation of Midwives (ed.) (2014): International Code of Ethics for Midwives. [http://www.internationalmidwives.org/assets/uploads/documents/CoreDocuments/CD2008\\_001 percent20V2014 percent20ENG percent20International percent20Code percent20of percent20Ethics percent20for percent20Midwives.pdf](http://www.internationalmidwives.org/assets/uploads/documents/CoreDocuments/CD2008_001%20V2014%20ENG%20International%20Code%20of%20Ethics%20for%20Midwives.pdf) [2016-02-22].

Isensee, J.; Kirchhof, P. (ed.) (1992): Handbuch des Staatsrechts. Vol. V: Allgemeine Grundrechtslehren. Heidelberg.

Jaggar, A. M. (1995): Caring as a feminist practice of moral reason. In: Held, V. (ed.): Justice and Care. Essential Readings in Feminist Ethics. Boulder, 179-202.

Klemperer, D. (2003): Wie Ärzte und Patienten Entscheidungen treffen. Konzepte der Arzt-Patient-Kommunikation. Berlin.

Klinkhammer, G.; Krüger-Brand, H. E. (2015): "Mut zum Beziehungsaufbau". In: Deutsches Ärzteblatt, 112 (21-22), A966-A972.

Krobath, T.; Heller, A. (ed.) (2010): Ethik organisieren. Handbuch der Organisationsethik. Freiburg.

Lachetta, R. et al. (2011): Erleben von Menschen mit geistiger Behinderung während eines akutstationären Aufenthaltes. Eine systematische Literaturübersicht. In: Pflegewissenschaft, 14 (3), 139-148.

Lahmann, C.; Dinkel, A. (2014): Ärztliche Gesprächsführung – eine hohe Kunst. In: MMW – Fortschritte der Medizin, 156 (special ed. 2), 84-87.

Laufs, A.; Kern, B.-R. (ed.) (2010): Handbuch des Arztrechts (4<sup>th</sup> ed.). Munich.

Lay, R. (2012): Ethik in der Pflege. Ein Lehrbuch für die Aus-, Fort- und Weiterbildung (2<sup>nd</sup> ed.). Hannover.

Loh, A. et al. (2007): Patientenbeteiligung bei medizinischen Entscheidungen. Effekte der Partizipativen Entscheidungsfindung aus systematischen Reviews. In: Deutsches Ärzteblatt, 104 (21), A1483-A1488.

Marckmann, G.; Strech, D. (2009): Auswirkungen der DRG-Vergütung auf ärztliche Entscheidungen: Eine ethische Analyse. In: Zeitschrift für medizinische Ethik, 55 (1), 15-27.

Nagel, E. (ed.) (2013): Das Gesundheitswesen in Deutschland. Struktur, Leistungen, Weiterentwicklung (5<sup>th</sup> ed.). Cologne.

Nagel, E. (ed.) (2012): Die gesundheitliche Versorgung in Deutschland – eine kurze Einführung. Cologne.

Nationale Akademie der Wissenschaften Leopoldina; Deutsche Akademie der Technikwissenschaften; Union der deutschen Akademien der Wissenschaften (ed.) (2015): Zur Gesundheitsversorgung von Asylsuchenden. [http://www.leopoldina.org/uploads/tx\\_leopublication/2015\\_Gesundheit\\_Asylsuchende\\_01.pdf](http://www.leopoldina.org/uploads/tx_leopublication/2015_Gesundheit_Asylsuchende_01.pdf) [2015-03-01].

- Pinkert, C.; Holle, B. (2012): Menschen mit Demenz im Akutkrankenhaus. Literaturübersicht zu Prävalenz und Einweisungsgründen. In: Zeitschrift für Gerontologie und Geriatrie, 45 (8), 728-734.
- Preusker, U. K. (2010): Lexikon des deutschen Gesundheitssystems (3<sup>rd</sup> ed.). Heidelberg.
- Quaas, M.; Zuck, R. (ed.) (2014): Medizinrecht (3<sup>rd</sup> ed.). Munich.
- Rabe, M. (2009): Ethik in der Pflegeausbildung. Beiträge zur Theorie und Didaktik. Bern.
- Reifferscheid, A.; Pomorin, N.; Wasem, J. (2015): Ausmaß von Rationierung und Überversorgung in der stationären Versorgung. Ergebnisse einer bundesweiten Umfrage in deutschen Krankenhäusern. In: Deutsche Medizinische Wochenschrift, 140 (13), e129-e135.
- Reifferscheid, A.; Pomorin, N.; Wasem, J. (2014): Umgang mit Mittelknappheit im Krankenhaus – Rationierung und Überversorgung medizinischer Leistungen im Krankenhaus? Executive Summary. University of Duisburg-Essen, Chair of Healthcare Management.
- Reiter-Theil, S. (2000): Patientenethik. In: Korff, W.; Beck, L.; Mikat, P. (ed.): Lexikon der Bioethik. Vol. 2: G-Pa. Gütersloh, 842-844.
- Richter-Kuhlmann, E. (2015): Mut haben, etwas nicht zu tun. In: Deutsches Ärzteblatt, 112 (44), A1810-A1811.
- Rixen, S. et al. (2003): Zum rechtlichen Schutz der Patientenautonomie in der ressourcenintensiven Hochleistungsmedizin: Vorschläge zur Neustrukturierung des Aufklärungsgesprächs. In: Medizinrecht, 21 (4), 191-194.
- Rosenberger, M. et al. (2009): Ethikkodex professioneller Seelsorger. In: Stimmen der Zeit, 227 (7), 447-458.
- Roser, J.-M.; Budroni, H.; Schnepf, W. (2011): Abschlussbericht zum Projekt Entwicklung einer Zielvereinbarung zur barrierefreien Krankenhausversorgung von Menschen mit Mehrfachbehinderungen. [http://www.barrierefreiheit.de/tl\\_files/bkb-downloads/Projekte/barrierefreies\\_krankenhaus\\_mehrfachbehinderung/endausschlussbericht\\_barrierefreies\\_krankenhaus\\_bvjn\\_uwh\\_2011\\_druckfassung.pdf](http://www.barrierefreiheit.de/tl_files/bkb-downloads/Projekte/barrierefreies_krankenhaus_mehrfachbehinderung/endausschlussbericht_barrierefreies_krankenhaus_bvjn_uwh_2011_druckfassung.pdf) [2016-02-22].
- Sabaté, E. (2001): Adherence to Long-Term Therapies: Policy for Action. <http://www.who.int/chp/knowledge/publications/adherencerep.pdf> [2016-03-07].
- Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (ed.) (2014): Bedarfsgerechte Versorgung – Perspektiven für ländliche Regionen und ausgewählte Leistungsbereiche. Gutachten 2014. Bern.
- Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (ed.) (2012): Wettbewerb an der Schnittstelle zwischen ambulanter und stationärer Gesundheitsversorgung. Sondergutachten 2012. Bern.
- Sattar, S. P. et al. (2004): Patient and physician attitudes to using medications with religiously forbidden ingredients. In: Annals of Pharmacotherapy, 38 (11), 1830-1835.
- Satzinger, W.; Werner, A. (2005): Gerechtigkeit im Krankenhaus – Mutmaßungen über Maßstäbe aus der Patientenperspektive. In: Krukemeyer, M. G.; Marckmann, G.; Wiesing, U. (ed.): Krankenhaus und soziale Gerechtigkeit. Stuttgart, 111-158.

- Sauerland, D. (2002): Gesundheitspolitik in Deutschland. Reformbedarf und Entwicklungsperspektiven. Gütersloh.
- Schaller, B.; Baller, G. (2008): Der Zusammenhang zwischen guter Kommunikation und Qualität. Konsequenzen für eine erfolgreiche Unternehmensstrategie. In: Das Krankenhaus, 100 (2), 140-142.
- Schmidt, C. (2010): Die Situation von Patientinnen und Patienten mit geistiger und mehrfacher Behinderung im Krankenhaus aus Sicht des Krankenhauses. In: Bundesverband evangelische Behindertenhilfe (ed.): Patientinnen und Patienten mit geistiger und mehrfacher Behinderung im Krankenhaus – Problemlagen und Lösungsperspektiven. Dokumentation des Symposiums am 4. Februar 2010. Berlin, 39-49.
- Schoenfelder, T.; Klewer, J.; Kugler, J. (2011): Determinants of patient satisfaction: a study among 39 hospitals in an in-patient setting in Germany. In: International Journal for Quality in Health Care, 23 (5), 503-509.
- Schreyögg, J. et al. (2014): Forschungsauftrag zur Mengenentwicklung nach § 17b Abs. 9 KHG. Endbericht. <http://www.g-drg.de/cms/content/download/4861/38231/version/2/file/Endbericht+zum+Forschungsauftrag+gem.+percentC2+percentA7+17b+Abs.+9+KHG+percent28Druck+percent29.pdf> [2016-02-22].
- Schulz, R. J.; Kurtal, H.; Steinhagen-Thiessen, E. (2008): Rehabilitative Versorgung alter Menschen. In: Kuhlmeier, A.; Schaeffer, D. (ed.): Alter, Gesundheit und Krankheit. Bern, 334-351.
- Seffner, S.; Oberschelp, K. (2013): Führung kann man lernen. In: Deutsches Ärzteblatt (Ärztstellen), 110 (46), 2-4.
- Shain, M.; Roemer, M. I. (1959): Hospital costs relate to the supply of beds. In: Modern Hospital, 92 (4), 71-73.
- Sørensen, K. et al. (2012): Health literacy and public health: a systematic review and integration of definitions and models. In: BMC Public Health, 12:80. DOI: 10.1186/1471-2458-12-80.
- Statistische Ämter des Bundes und der Länder (ed.) (2010): Demografischer Wandel in Deutschland. Issue 2: Auswirkungen auf Krankenhausbehandlungen und Pflegebedürftige im Bund und in den Ländern. Wiesbaden.
- Statistisches Bundesamt (ed.) (2015a): Diagnosedaten der Patienten und Patientinnen in Krankenhäusern (einschl. Sterbe- und Stundenfälle) 2014. Subject-matter series 12 series 6.2.1. Wiesbaden.
- Statistisches Bundesamt (ed.) (2015b): Grunddaten der Krankenhäuser 2014. Subject-matter series 12 series 6.1.1. Wiesbaden.
- Statistisches Bundesamt (ed.) (2014): Bevölkerung mit Migrationshintergrund – Ergebnisse des Mikrozensus 2013. Subject-matter series 1 series 2.2. Wiesbaden.
- Statistisches Bundesamt (ed.) (2008): Grunddaten der Krankenhäuser 2006. Subject-matter series 12 series 6.1.1. Wiesbaden.
- Stemmer, R. (2011): Zur Situation der Pflege im Krankenhaus. In: Pflege & Gesellschaft, 16 (4), 293-372.
- Tamburino, C. et al. (2011): Incidence and predictors of early and late mortality after transcatheter aortic valve implantation in 663 patients with severe aortic stenosis. In: Circulation, 123 (3), 299-308.

- Taupitz, J. (2009): Bindungswirkung von Standards im Gesundheitswesen. In: Möllers, T. M. J. (ed.): Geltung und Faktizität von Standards. Baden-Baden, 63-106.
- Teschauer, W. (2015): Menschen mit Demenz im Krankenhaus. Präsentation beim Berliner Tag der Patientenfürsprecher am 16. März 2015. [http://patientenbeauftragter.de/images/pdf/20150316\\_Vortrag\\_Dr\\_Teschauer.pdf](http://patientenbeauftragter.de/images/pdf/20150316_Vortrag_Dr_Teschauer.pdf) [2015-10-17].
- Teschauer, W. (2014): Demenz im Akutkrankenhaus – Gute Wege sind bekannt aber kaum beschritten. In: Alzheimer Info, 1/2014, 1-2.
- Thomae, H. (2006): Krankenhausplanungsrecht. Köln.
- Trauschke, T.; Werner, H.; Gerlinger, T. (2009): Zur Diagnostik und Häufigkeit von demenziellen Erkrankungen. Eine prospektive Untersuchung im Alltag einer geriatrischen Klinik (PAOLA-Studie). In: Zeitschrift für Gerontologie und Geriatrie, 42 (5), 385-390.
- Tronto, J. C. (1993): Moral Boundaries. A Political Argument for an Ethic of Care. New York; London.
- Tuschen, K. H.; Trefz, U. (2010) Krankenhausentgeltgesetz. Kommentar mit einer umfassenden Einführung in die Vergütung stationärer Krankenhausleistungen (2<sup>nd</sup> ed.). Stuttgart.
- Vogd, W. (2016): Das Missverstehen des Ökonomischen. Oder vom Sündenfall falsch verstandener Rationalitäten im Krankenhaus. In: Bode, I.; Vogd, W. (ed.): Mutationen des Krankenhauses. Soziologische Diagnosen in organisations- und gesellschaftstheoretischer Perspektive. Wiesbaden, 281-307.
- Vogd, W. (2015): Arranging medical and economical logics. Investigating the influence of economic controlling in an internal medicine department. In: Knudsen, M.; Vogd, W. (ed.): Systems Theory and the Sociology of Health and Illness. Observing Healthcare. Abingdon; New York, 103-127.
- Vogd, W. (2014): Götter in Grau. Über das gestörte Verhältnis zwischen Arzt und Patient. Hamburg.
- Vogd, W. (2006): Verändern sich die Handlungsorientierungen von Krankenhausärzten unter den neuen organisatorischen und ökonomischen Rahmenbedingungen? Ergebnisse einer rekonstruktiven Längsschnittstudie. In: Sozialer Sinn, 7 (2), 197-229.
- Vorstand der Akademie für Ethik in der Medizin (2010): Standards für Ethikberatung in Einrichtungen des Gesundheitswesens. In: Ethik in der Medizin, 22 (2), 149-153.
- Warschke, F.; Lauerer, M.; Nagels, K. (2015): Die stationäre Versorgung in Deutschland im internationalen Vergleich. Bern.
- Weisse Liste; Barmer GEK; AOK (ed.) (2012): Ergebnisse aus der Befragung zum Krankenhausaufenthalt. Stand: Dezember 2012. [https://www.aok-gesundheitspartner.de/imperia/md/aokbv/presse/pressemitteilungen/archiv/2012/umfrageergebnisse\\_121218.pdf](https://www.aok-gesundheitspartner.de/imperia/md/aokbv/presse/pressemitteilungen/archiv/2012/umfrageergebnisse_121218.pdf) [2016-02-23].
- Wiesemann, C.; Lenk, C. (2006): Gesundheitsökonomie und Pädiatrie: Ethische Aspekte. In: Gerber, A.; Lauterbach, K. W. (ed.): Gesundheitsökonomie und Pädiatrie. Stuttgart, 48-54.

- Wolf, J.; Ostermann, A. (2016): Von der Organisation der Pflege zur Pflege der Organisation. Ein neuer Typus der Pflegedienstleitung im Krankenhausmanagement. In: Bode, I.; Vogd, W. (ed.): Mutationen des Krankenhauses. Soziologische Diagnosen in organisations- und gesellschaftstheoretischer Perspektive. Wiesbaden, 165-183.
- Woopen, C. (2009): Der Arzt als Heiler und Manager – Zur erforderlichen Integration des scheinbar Unvereinbaren. In: Katzenmeier, C.; Bergdolt, K. (ed.): Das Bild des Arztes im 21. Jahrhundert. Berlin; Heidelberg, 181-194.
- Wunder, M. (2008): Demenz und Selbstbestimmung. In: Ethik in der Medizin, 20 (1), 17-25.
- Zander, B. et al. (2014): Implizite Rationierung von Pflegeleistungen in deutschen Akutkrankenhäusern – Ergebnisse der internationalen Pflegestudie RN4Cast. In: Das Gesundheitswesen, 76 (11), 727-734.
- Zentrale Ethikkommission bei der Bundesärztekammer (2013a): Ärztliches Handeln zwischen Berufsethos und Ökonomisierung. Das Beispiel der Verträge mit leitenden Klinikärztinnen und -ärzten. In: Deutsches Ärzteblatt, 110 (38), A1752-A1756.
- Zentrale Ethikkommission bei der Bundesärztekammer (2013b): Versorgung von nicht regulär krankenversicherten Patienten mit Migrationshintergrund. In: Deutsches Ärzteblatt, 110 (18), A899-A903.
- Zentrale Ethikkommission bei der Bundesärztekammer (2010): Die neue UN-Konvention für die Rechte von Menschen mit Behinderung als Herausforderung für das ärztliche Handeln und das Gesundheitswesen. In: Deutsches Ärzteblatt, 107 (7), A297-A300.
- Zentrale Ethikkommission bei der Bundesärztekammer (2006): Ethikberatung in der klinischen Medizin. In: Deutsches Ärzteblatt, 103 (24), A1703-A1707.
- Zuckerman, M. et al. (2002): Determinants of women's choice of obstetrician/gynecologist. In: Journal of Women's Health & Gender-Based Medicine, 11 (2), 175-180.

# ABBREVIATIONS

<b>AQUA Institute</b>	Institut für angewandte Qualitätsförderung und Forschung im Gesundheitswesen (Institute for Applied Quality Improvement and Research in Health Care)
<b>BAnz.</b>	Bundesanzeiger (Federal Gazette)
<b>BGBI.</b>	Bundesgesetzblatt (Federal Law Gazette)
<b>BVerfGE</b>	Entscheidungen des Bundesverfassungsgerichts (Decisions of the Federal Constitutional Court)
<b>DRG</b>	diagnosis related group
<b>G-BA</b>	Gemeinsamer Bundesausschuss (Federal Joint Committee)
<b>GG</b>	Grundgesetz (Basic Law)
<b>GKV</b>	Gesetzliche Krankenversicherung (statutory health insurance)
<b>GVBl.</b>	Gesetz- und Verordnungsblatt (Law and Ordinance Gazette)
<b>ICD</b>	International Classification of Diseases
<b>InEK</b>	Institut für das Entgeltsystem im Krankenhaus (Institute for the Hospital Remuneration System)
<b>para.</b>	paragraph*
<b>SGB V</b>	Fünftes Buch Sozialgesetzbuch (Fifth Book of the Social Code)
<b>TAVI</b>	Transcatheter Aortic Valve Implantation
<b>TISS</b>	Therapeutic Intervention Scoring System
<b>ZEKO</b>	Zentrale Ethikkommission bei der Bundesärztekammer (Central Ethics Committee of the German Medical Association)

\* In the original German citations, “Rn.” (Randnummer, or literally “number on the margin”) refers to the practice of numbering paragraphs in the margin of many German legal opinions. Here, “Rn.” is translated as “para.”

## Members of the German Ethics Council

Prof. Dr. med. Christiane Woopen (Chair)  
Wolf-Michael Catenhusen, former State Secretary (Vice-Chair)  
Prof. Dr. theol. Peter Dabrock (Vice-Chair)  
Prof. Dr. iur. Jochen Taupitz (Vice-Chair)

Prof. Dr. med. Katrin Amunts  
Constanze Angerer, former President of Munich Regional Court I  
Prof. Dr. med. Frank Emmrich  
Dr. med. Christiane Fischer  
Prof. Dr. phil. habil. Dr. phil. h. c. lic. phil. Carl Friedrich Gethmann  
Bischof Prof. Dr. theol. Martin Hein  
Prof. Dr. med. Dr. phil. Thomas Heinemann  
Prof. Dr. iur. Wolfram Höfling  
Prof. Dr. (TR) Dr. phil. et med. habil. İlhan İlkilic, M. A.  
Prof. Dr. med. Leo Latasch  
Auxiliary Bishop Dr. theol. Dr. rer. pol. Anton Losinger  
Prof. Dr. iur. Reinhard Merkel  
Herbert Mertin, former Minister of Justice in the State of Rhineland-Palatinate  
Prof. Dr. med. habil. Dr. phil. Dr. theol. h. c. Eckhard Nagel  
Dr. phil. Peter Radtke  
Ulrike Riedel, lawyer, former State Secretary in the State of Saxony-Anhalt  
Prof. em. Dr. iur. Edzard Schmidt-Jortzig, former Federal Minister  
Prof. Dr. theol. Eberhard Schockenhoff  
Prof. Dr. med. Elisabeth Steinhagen-Thiessen  
Prof. Dr. iur. Silja Vöneky  
Prof. Dr. med. Claudia Wiesemann  
Dipl.-Psych. Dr. phil. Michael Wunder

## Office

Dr. rer. nat. Joachim Vetter (Head of Office)  
Dr. theol. Katrin Bentele  
Carola Böhm  
Ulrike Florian  
Steffen Hering  
Christian Hinke  
Petra Hohmann  
Christian M. Jolibois  
Torsten Kulick  
Dr. Nora Schultz