

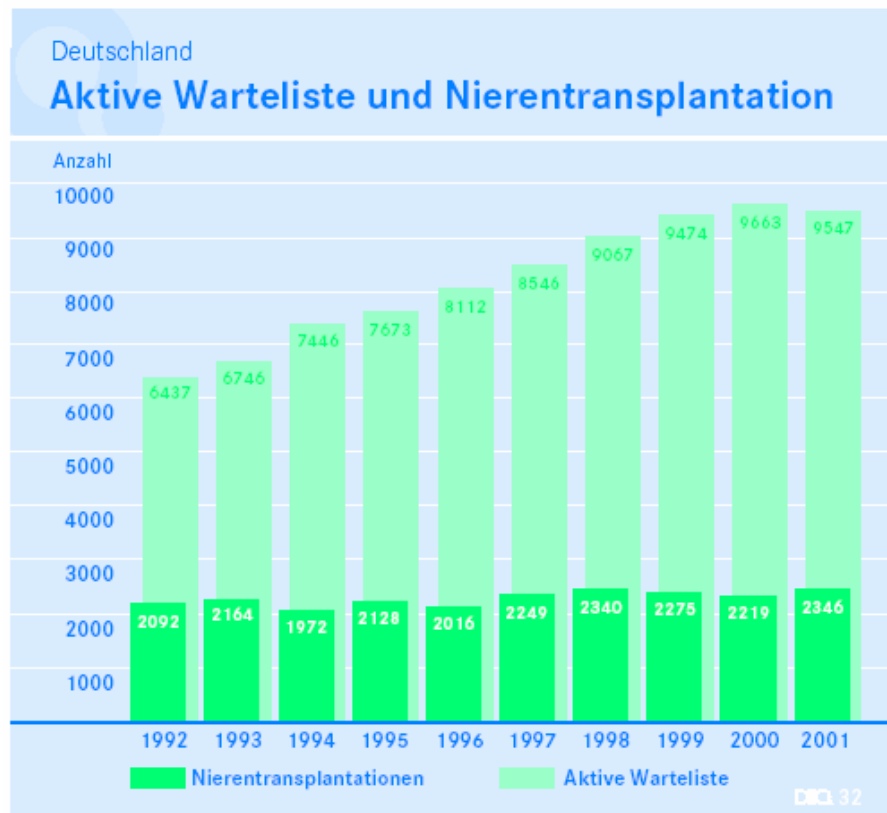
Waiting times & capacities: the German case

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The general feeling is that there are no waiting lists, except for **transplantations** – where it is well documented



Kidney

Waiting times for large centers in 2001:

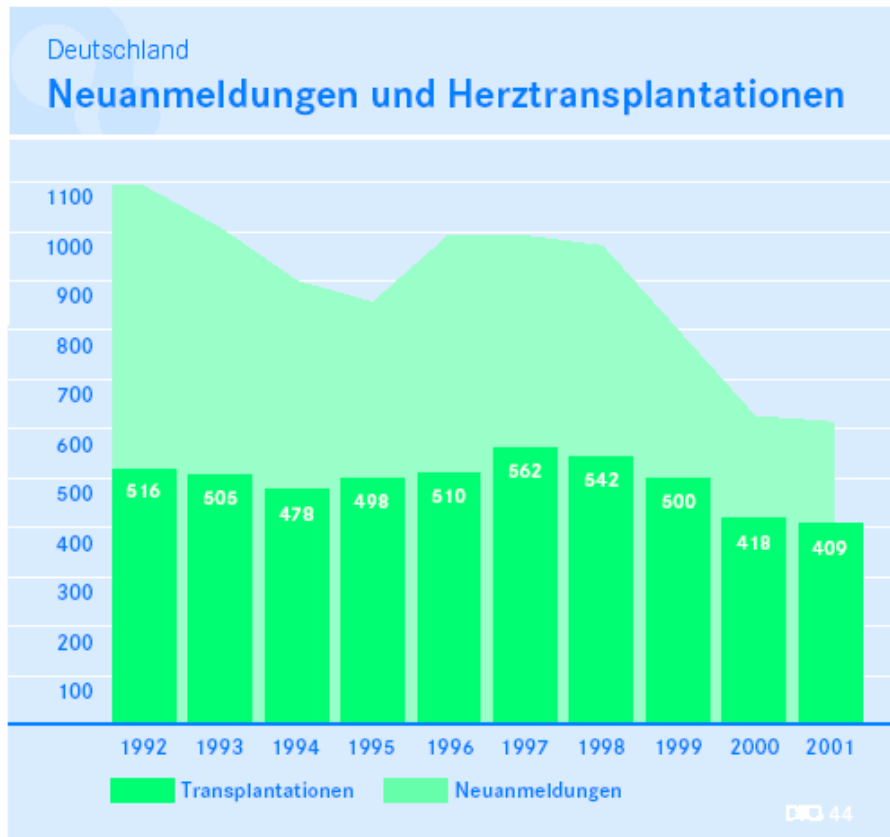
Hannover MH 76/ 51 months*

Cologne Merheim 79/ 46

Berlin Charité 37/ 33

Munich LMU n.a./ 52

* Transplanted patients/ patients on list on 31.12.01



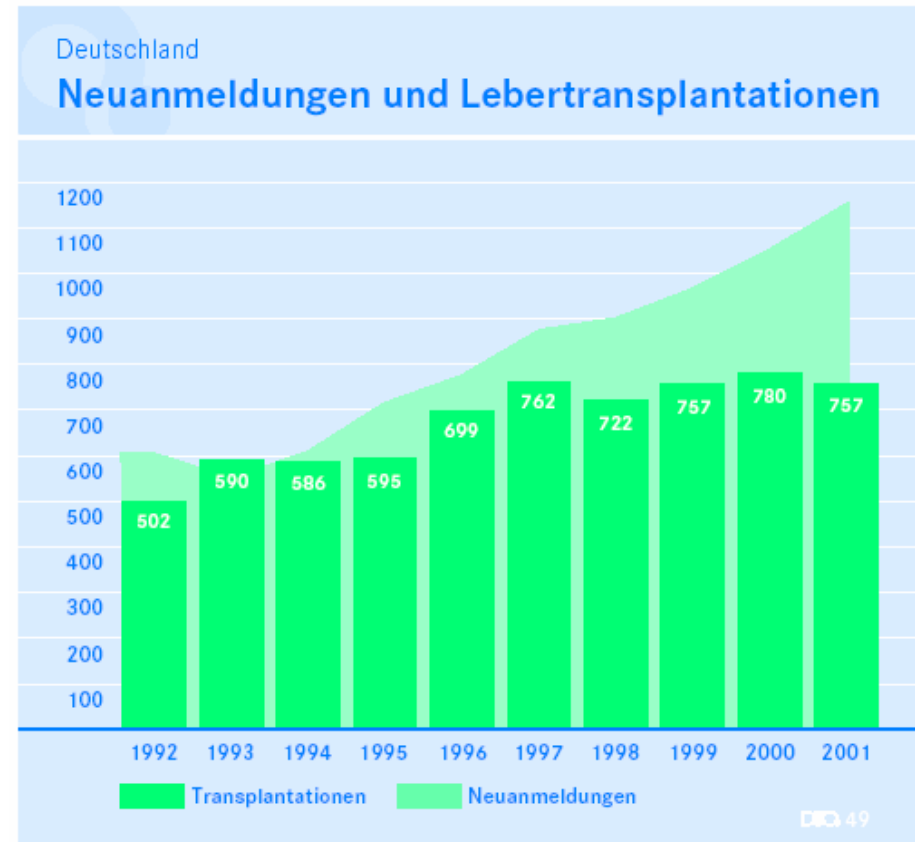
Heart

Berlin DHZ 11/ 8 months*

Munich LMU n.a./ 10

Hannover MH 10/ 17

* Transplanted patients/ patients on list on 31.12.01



Liver

Hannover MH 9/ 8 months*

Munich LMU 4/ 5

Berlin Charité 8/ 6

* Transplanted patients/ patients on list on 31.12.01

Weak evidence on waiting times for elective procedures: Cataract surgery in 2000

(survey of 450 institutions with 926 operating
ophthalmologists)

Average waiting time (self-reported)

5 weeks

(25% < 3 weeks; 25% > 7 weeks)

Evidence on waiting times for elective procedures: CABG study Munich 1994-96

(days)	1994	1995	1996
SHI-insured (n= 968)	39.5	34.9	22.7
PHI-insured (n= 157)	19.1	19.8	17.2

Evidence on waiting times for
elective procedures:
CABG study Würzburg 1995-97
(n= 906)

“waiting time“ total on average 32.8 days
of which:

coronary angiography – indication with
cardio-surgeon 9.1

+ indication to operation 23.4

(indication to patient consent 10.4

+ consent to operation 13.0)

Statistics of medical societies

Society for Cardio- and Thorax Surgery

CABG

1993 – operated	39,500
waiting on 31.12.	7,468
calculated avg. waiting	69 days
1997– operated	70,000
waiting on 31.12.	7,131
calculated avg. waiting	37 days

Kraft & Elert 1999

Society for Cardiology

Cor. Angiography 1997 avg. waiting time 2 weeks

The topic of waiting for CABG and other coronary procedures has disappeared since the second half of the 1990s

	Diagnostic cardiac catheters	Coronary interventions
1991	214 267	44 528
1992	246 115	56 267
1993	279 882	69 804
1994	357 747	88 380
1995	409 159	109 669
1996	452 016	125 840
1997	478 837	135 925
1998	515 510	153 257
1999	561 623	166 132
2000	594 898	180 336
2001	611 882	195 280

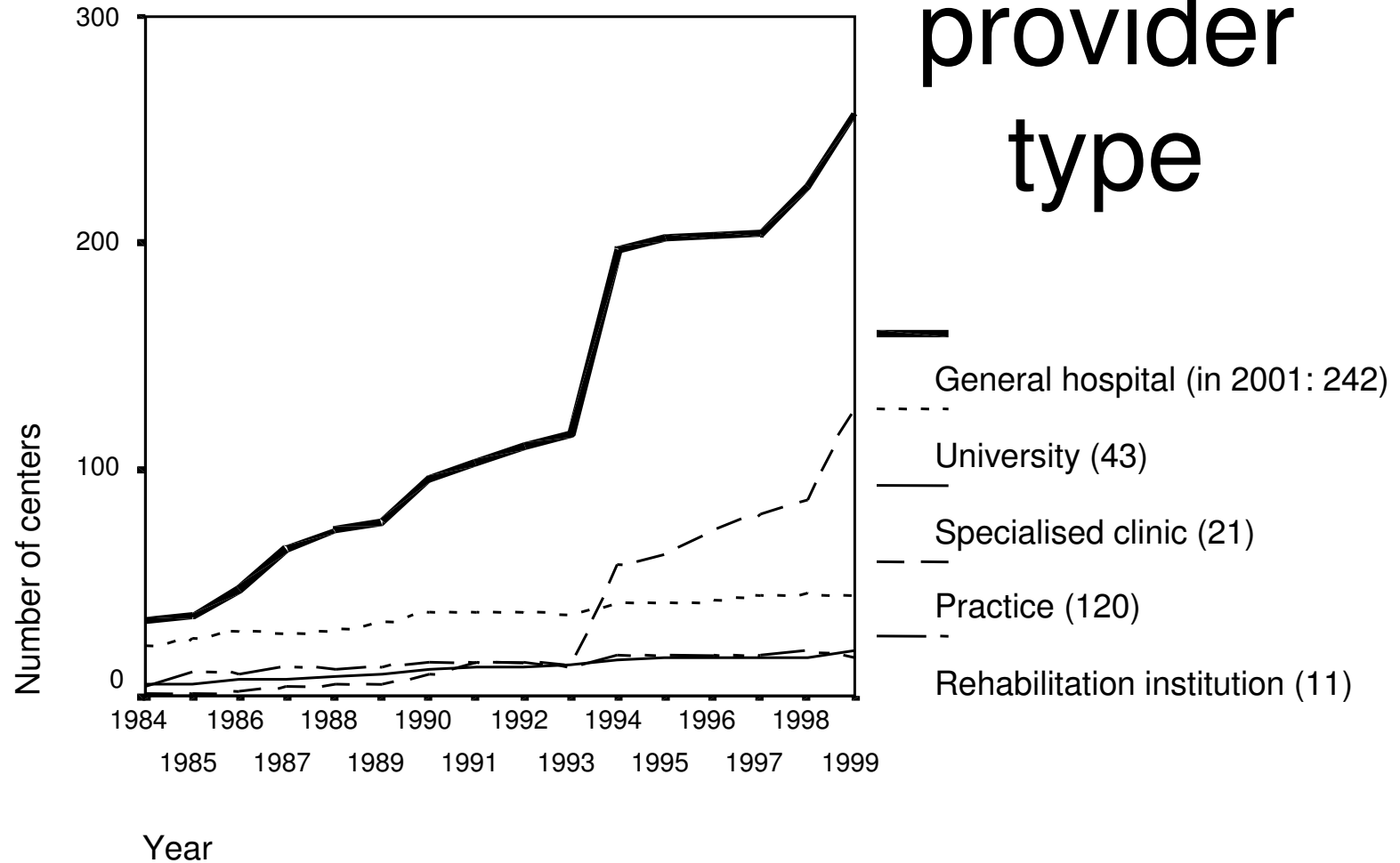
Mannebach et al. 2002 (<http://www.h-wie-herz.de/PDFs/Bericht2001HKLS.pdf>)

2001 data

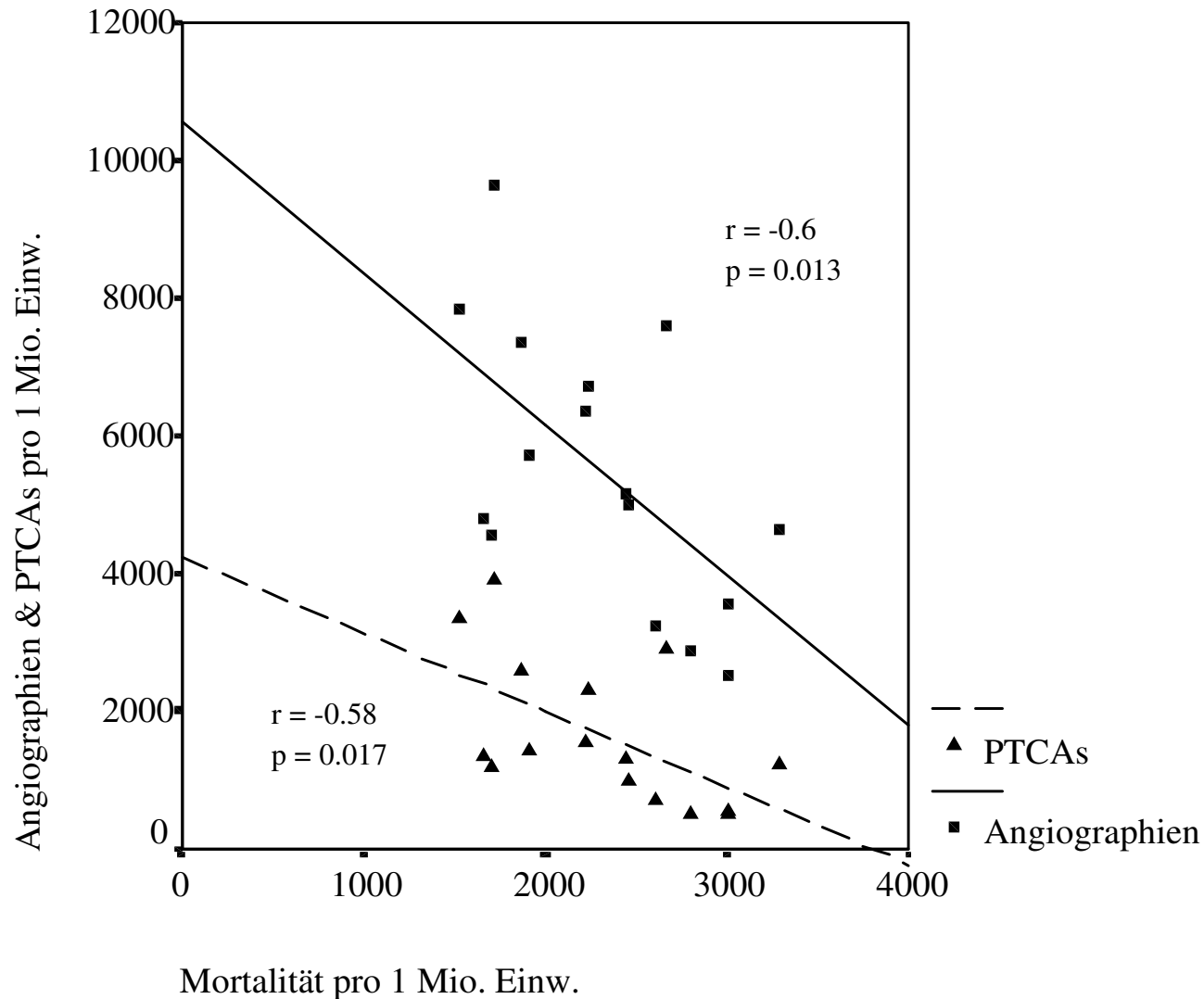
Mannebach et al. 2002

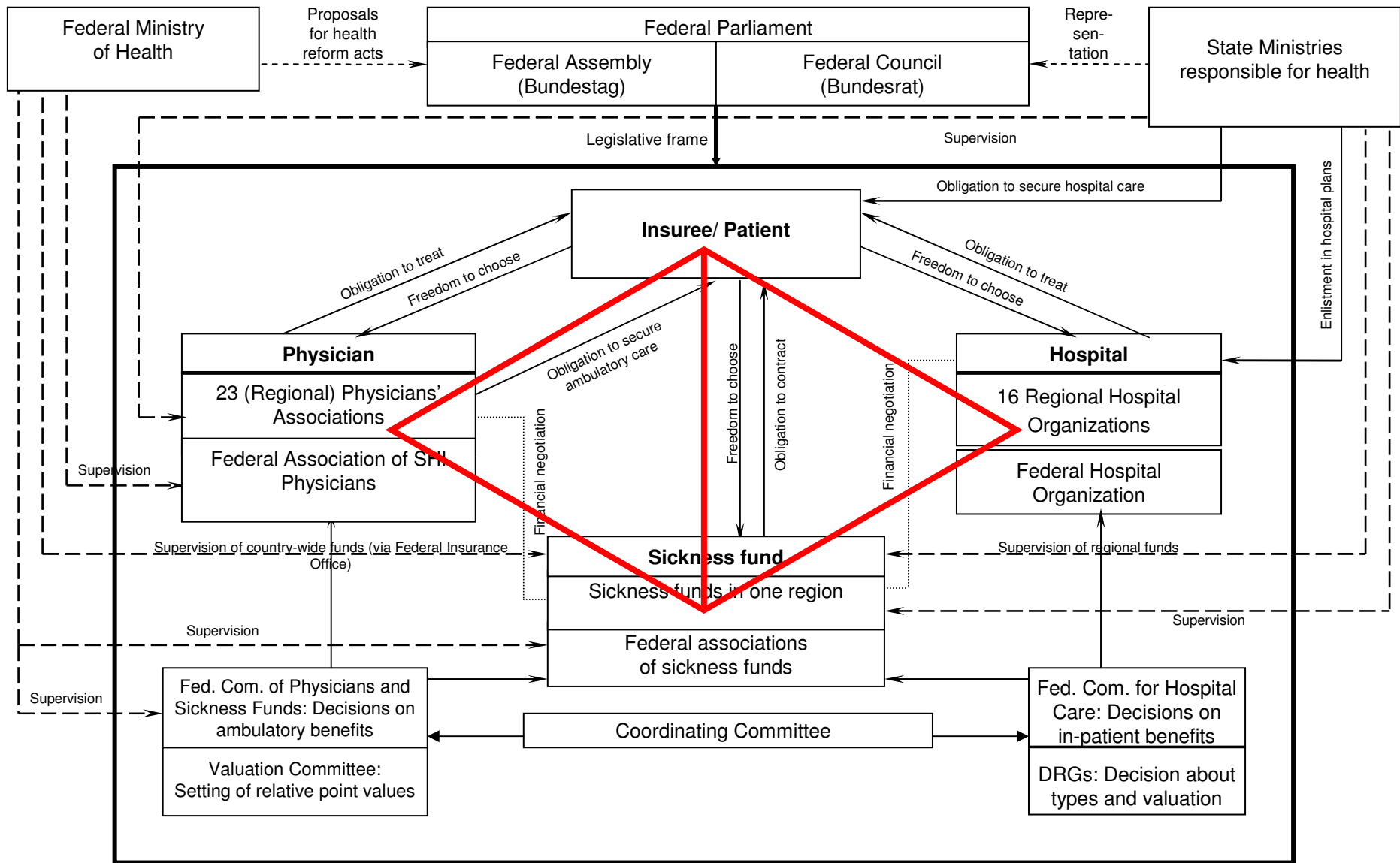
Land/ state	Diagnostic procedures (D)			Coronary interventions (I)			Relation D: I
	Centers	Number	per 100000	Centers	Number	per 100000	
Baden-Württemberg	53	67 897	6 50	46	24 031	2 30	2,83
Bayern	61	89 441	7 38	57	27 562	2 27	3,24
Berlin	18	24 005	7 08	16	10 922	3 22	2,20
Brandenburg	10	13 144	5 07	10	4 731	1 82	2,78
Bremen	5	8 481	1 273	5	2 920	4 38	2,90
Hamburg	13	22 022	12 94	11	7 509	4 41	2,93
Hessen	36	49 868	8 25	33	20 474	3 39	2,44
Mecklenburg-Vorpommern	6	14 877	8 29	5	4 466	2 49	3,33
Niedersachsen	45	50 303	6 39	31	12 538	1 59	4,01
Nordrhein-Westfalen	123	154 781	8 61	93	45 136	2 51	3,43
Rheinland-Pfalz	17	25 938	6 44	15	8 439	2 09	3,07
Saarland	4	10 260	9 57	4	5 096	4 75	2,01
Sachsen	14	33 485	7 48	11	9 472	2 12	3,53
Sachsen-Anhalt	10	16 033	6 02	10	4 025	1 51	3,98
Schleswig-Holstein	13	16 026	5 79	10	4 194	1 51	3,82
Thüringen	9	15 321	6 24	8	3 765	1 53	4,07
SUM (Fed. Rep. Germany)	437	611 882	7 46	365	195 280	2 38	3,13

Development of catheter units by provider type



Correlation between coronary angiographies and PTCAs with cardiovascular mortality by region (1996)





Statutory health insurance today

Regulation & planning

Sectorisation of health care delivery

- state-run public health service: decreasing as many activities (immunizations, screening ...) have moved to ambulatory sector
- office-based ambulatory care: powerful and still growing with full range of specialties
- hospitals concentrating on inpatient care (no regular out-patient departments)
- plus rehabilitation etc.

General differences in planning, regulation and financing 1

- Benefits: A = decided jointly by physicians and sickness funds, H = not explicit
- Capacity planning & accreditation: A = jointly by physicians and sickness funds, H = by states

Medical training is not planned (merely limited according to university capacities); specialist training is by apprenticeship under the supervision of the physicians' chambers (no set number of training positions)

General differences in planning, regulation and financing 2

- Reimbursement: A = according to uniform fee schedule but depending on overall utilization, H = -2002/03 mainly by per-diems, differing from hospital to hospital (from 2003/04 DRGs) under negotiated activity-based target budget
- Co-payments: A = none, H = EUR 9/ day (for up to 14 days per calendar year)

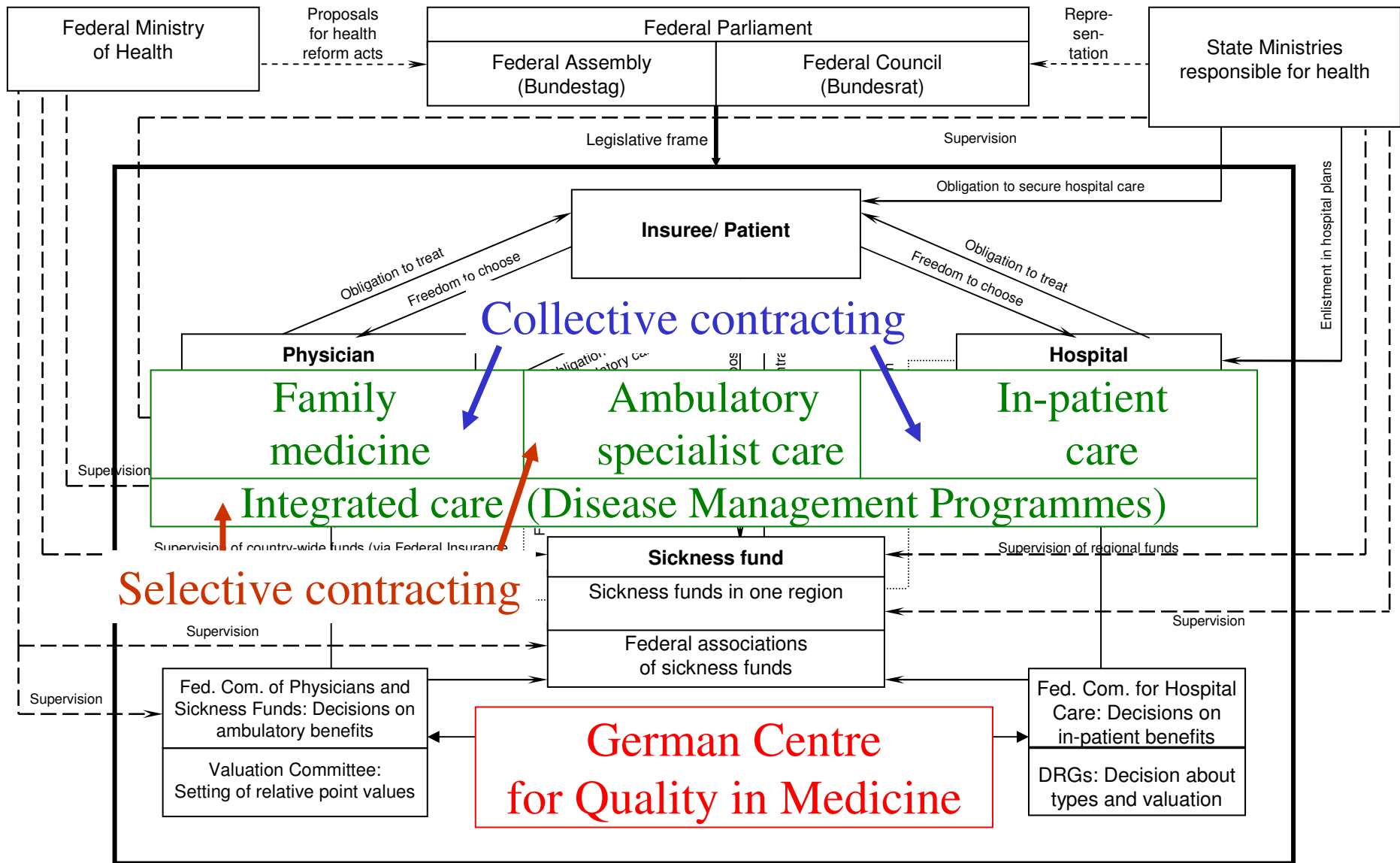
The exception to the rule: Ambulatory surgery (§115 SGB V)

- Benefits: uniform catalogue, decided tri-laterally by physicians' associations, sickness funds and hospital organization – separates into three categories: usually ambulatory (e.g. cataract), ambulatory or inpatient (e.g. finger amputation), usually inpatient but exceptionally ambulatory (e.g. coronary angiography)
- Capacity planning & accreditation: all respectively qualified physicians and hospitals
- Reimbursement: according to uniform fee schedule – specific fee + anaesthesiology + special supplements

Incentives are clearly stronger for ambulatory physicians to provide ambulatory surgery – but hospitals have entered the market:

	1995	1997	1999	2001
Cases in hospitals x 1000	117 (96)*	171	219	259 (00)
Expenditure - in million EUR	18	43	84	131
- of total hospital expenditure	0.05%*	0.1%	0.2%	0.3%

* In ambulatory sector: ca. 5 mio. cases; 300 mio. EUR = 1.5% of exp.



Proposed Health Care System “Modernisation“ Act 2003

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