

Healthcare system and reform in Germany

Where is the journey heading?

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- Visiting researcher at the IASU of Goethe University Frankfurt/Main since 2018 (Institute for Occupational, Social and Environmental Medicine)
- Head of the Ethics Committee of the med. specialist society GMDS (Ethical Questions in Medical Informatics, Biometry & Epidemiology)
- Full professor in Healthcare Management and Healthcare Logistics at the Univ. of Trier 2003-2017
- Full professor in Medical Informatics at the University of Bonn 1997-2002
- Member, class "Social Sciences, Law and Economics" of the European Academy of Sciences and Arts since July 7, 2012
- Supervisory Board Klinikum Darmstadt, Academical Hospital Univ. Heidelberg/Univ. Frankfurt/M., since 2013
- Supervisory Board of the Saarland University Hospitals (19.2.2016-15.7.2019)

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EUROPEAN
ACADEMY of
Sciences and Arts



Nov. 22, 2024



COLLOQUIUM ARTS MEET SCIENCES

Date: 11.10.2024 - 31.01.2025

Organisation:

Prof. Violeta Dinescu, Dean Class III

Prof. Dušan Šuput, Dean Class II

PROGRAM-INFORMATION

ZOOM access-link:

<https://us06web.zoom.us/j/84605453615?pwd=7ez4FWNib1QmLe41FXO33ff3hkUShc.1>

Meeting-ID: 846 0545 3615, Kenncode: 639017

ABSTRACTS

11.10.2024: [Velimir Srica](#); [Tassos Bountis](#)

25.10.2024: [Jose Molero Zayas](#); [Anna Rubin](#)

8.11.2024: [Irene Kurka](#); [Ernst Pöppel](#)

22.11.2024: [Andreas J W Goldschmidt](#); [E Andrew Balas](#)

6.12.2024: [Vladimir Scolnic](#); [Monika Czernin](#)

20.12.2024: [Laura Baudis](#)

17.01.2025: [Rami Chahin](#); [Ludwig Tavernier](#)

31.01.2025: [John S Torday](#)



VIDEO

Abstimmung im Bundesrat: Krankenhausreform verabschiedet

Stand: 22.11.2024 22:33 Uhr

Abstimmung im Bundesrat: Krankenhausreform verabschiedet



tagesschau24

Of course, the fact that the hospital reform was passed by the Bundesrat in Germany just today is something very special. Until the very end, many people had expected or hoped: the heads of the federal states to stop the hospital reform.

PUBLICATIONS on this topic:

SERIES

Ethics, health care and economics

Hessisches Ärzteblatt 2020-2024

If you are interested in more detail in what I am saying today, you can view and download a whole series of my publicly accessible publications from the Hessian Medical Journal. Everything is open access.



Krankenhausreform: Neu- oder Fehlstart in die Zukunft der Krankenhausversorgung?

Prof. Dr. med. habil. Andreas J. W. Goldschmidt

PUBLICATIONS on this topic:

SERIES

Ethics,
health care
and economics

Hessisches Ärzteblatt
2020-2024

Ergebnisse aus einem Workshop
mit Oberärztinnen und Oberärzten

der Krankenhausversorgung diskutieren
zu können, wurden eine Gruppe von
nen und -trägern unterschiedlicher Kran-
kenhäuser andererseits. Dabei sollten die

Part: „Hospital Reform“ („Krankenhausreform“)

Hessisches Ärzteblatt 5/2023

**In issue five of last year's paper, I will focus on
the hospital reform as the largest part of the
extensive healthcare reforms in Germany.**

angedachten „Krankenhausreform“ ab
voraussichtlich 2024 um ein grundsätzlich
sehr einfaches Modell einer neuen Kran-
kenhausplanung, das wir auf ein Flipchart
gezeichnet haben und das in groben
Strukturen als Skizze auf ein bis zwei Bier-
deckel passt (Abb. 2 und Kasten dazu).
Die Probleme liegen dann eher im Detail –
bei der Zuordnung von Krankenhäusern

I. Development of the German healthcare system to the present day

Historical overview, starting with the introduction of health insurance for workers under Otto von Bismarck around 140 years ago

1883 - How it all began around 140 years ago
(35 years after the so-called March Revolution)

Legislative Milestones of the 19th century under Chancellor Bismarck

[wikipedia.org: BY-SA 3.0, lizenzfrei]



Otto von Bismarck
(1815-1898)

Health insurance 1883
Accident insurance 1884
Pension insurance 1889

Otto von Bismarck

Otto von Bismarck, the Chancellor under Kaiser Wilhelm the First, is regarded as the founder of the German health and welfare system as we know it throughout the world. It has become a model for many healthcare systems around the world.

Initiative Kaiser Wilhelm I. - Motivation

Impoverishment and Unrest in Europe - Monarchies in Danger

French revolution 1789-1799

Napoleon, self-crowned "Emperor" 1804-1814



Deutscher Bund "March Revolution" 1848/1849



The emperor had great fears of unrest in his own country with regard to Europe. This was very justified if you look at the circumstances and revolutions of the time.



Russia - wars and increasing impoverishment

(which eventually led to the October Revolution of 1917;

Abolition of serfdom (Leibeigenschaft) only in 1914, at the beginning of WW1)

k.u.k. - Austrian-Hungarian Monarchy – last phase 1867-1918

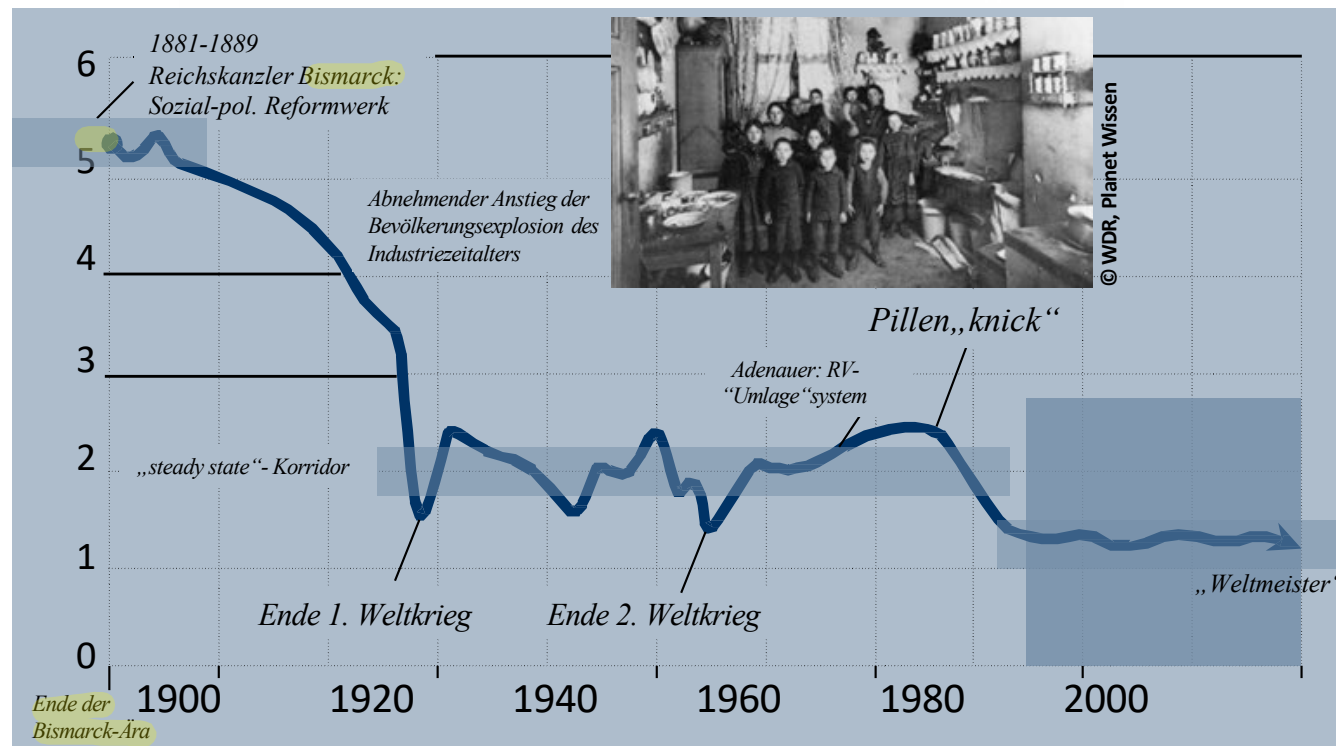
A lot has happened since Bismarck

At the time of Bismarck, there was great poverty among the population throughout Europe. The average number of children at that time was six per woman or couple in Germany.

Changes (exemplary) compared to the 19th century...

Demography

Development of the average **number of children** per woman in the German Reich and the former federal territory



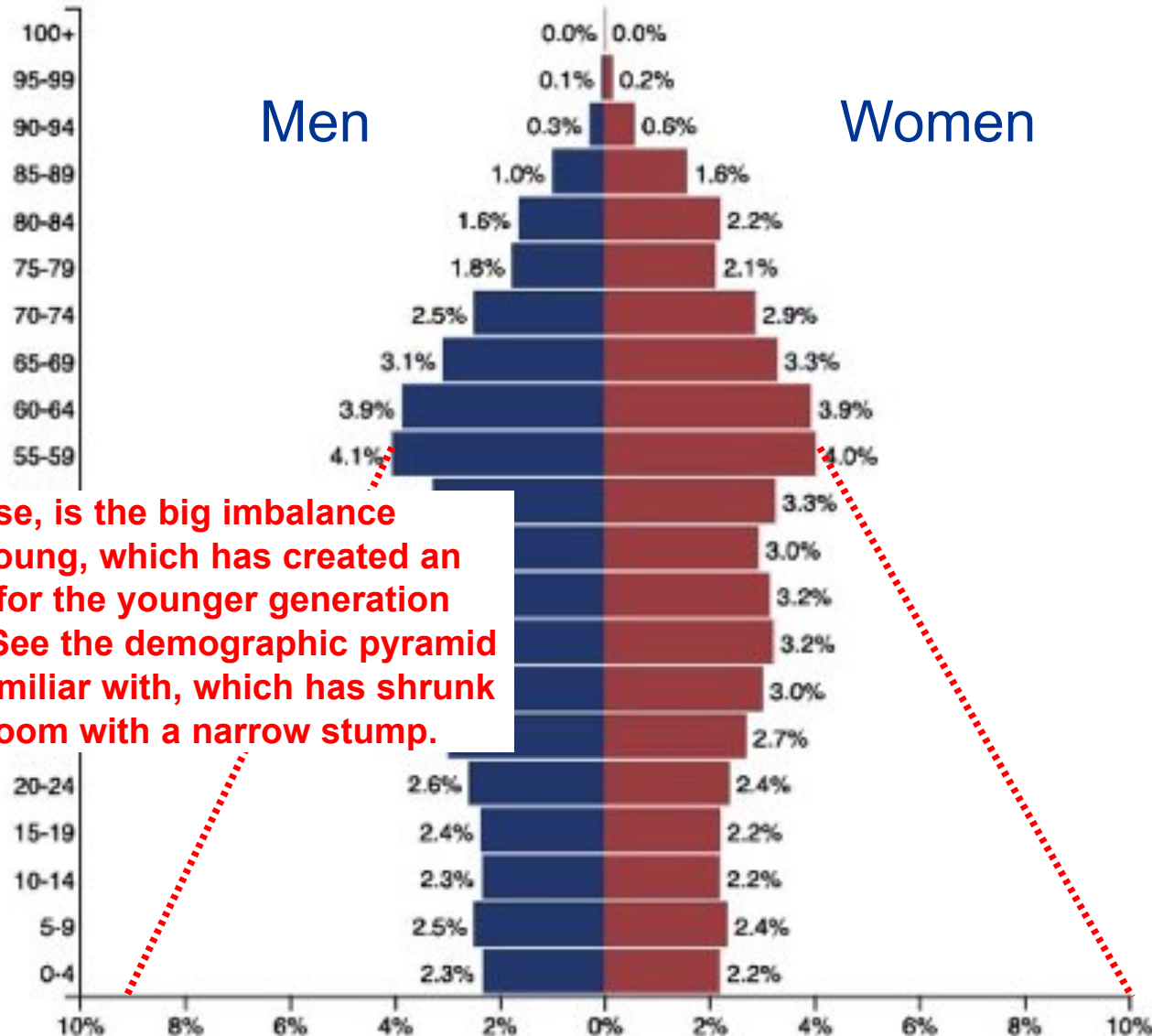
Quellen: (1) Familienwissenschaftliche Forschungsstelle des Statistischen Landesamtes Baden-Württemberg (2001)
(2) Goldschmidt AJW (2004): own research / various sources

**Result
today**

**Germany
2024**

**Population
84,552,242**

demographic
„pyramide“?



The result, of course, is the big imbalance between old and young, which has created an enormous burden for the younger generation with and after us. See the demographic pyramid that everyone is familiar with, which has shrunk more into a mushroom with a narrow stump.

Population-pyramide-Germany-2024_present-state_22Nov2024.pdf

Source / URL: <https://www.populationpyramid.net/de/deutschland/2024/> recall 22Nov2024 15:07 CET

Result at that time

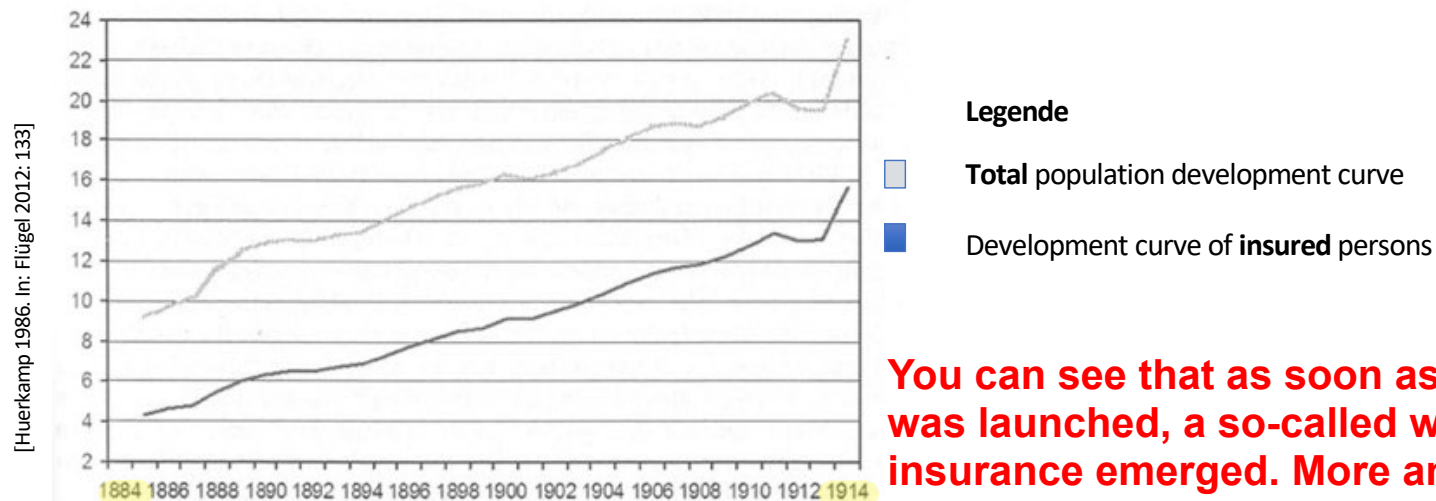
Consequence: Europe-wide exemplary

„ Insurance wave“

According to § 6 of the **Health Insurance Act** of 15.06.1883, this includes:

- “**free medical treatment** and **free remedies** ('Heilmittel'),
- '**Krankengeld**' - **sickness benefit**, but only from the third day of incapacity for work
- and in the amount of half the usual local daily wage ('days off')
- termination of support after 13 weeks at the latest” (Flügel 2013: 132).

'**Versicherungspflicht**' - Initially, this **compulsory insurance** only applied to persons with annual earnings of less than 2,000 marks without their dependents. This changed by the end of the 19th century, so that relatives and other further groups of beneficiaries could be included.



You can see that as soon as the system was launched, a so-called wave of insurance emerged. More and more people were insured free of charge through these health insurance schemes.

Result at that time

And as a result, more and more hospitals were built. Here you can see one of the first hospitals, the catholic Heilig-Geist-Spital in Munich in 1900, and below is the operating theater of the first eye clinic in the later Ludwig Maximilian University.

Further development of the healthcare system in Germany up to modern times (2 v 2)

[Städtisches Klinikum München]



Das Heilig-Geist-Spital in München
(1900)

- **Subscription contracts or hospital insurance** (= allotment contracts) for journeymen, servants and assistants (**until** the introduction of compulsory **general** insurance)
- General **increase in hospitals**, consolidation of the overall system

- **Financially precarious situation of the hospitals** persisted; what helped: charity of individuals and public donations

[Städtisches Klinikum München]



Aseptischer OP-Saal in der Augenklinik der LMU
(ca. 1900)

- It was only as a result of Bismarck's legislation that **the number of hospital beds rose** from 24.5 per 10,000 inhabitants (1877) to 69.0 (1913)
- The cost regulation of outpatient medical care, which was also linked to the social laws, gave rise to a **conflict** that is still open today: that of the **license to practice medicine** ('**ambulante Medizin**') (e.g. Leipzig doctors' strike of 1905)

Result at that time

Further development of the healthcare system in Germany up to modern times (2 v 2)

- 1931: So-called “Weimar Republic”
- Foundation of the Association of Statutory Health Insurance Physicians ('Kassenärztliche Vereinigung', KV)
- Creation of the KV treatment monopoly
- 1955: Statutory health insurance physician law ('Kassenarztrecht') → Sectoral structures have been consolidated through the safeguarding mandate ('Sicherstellungsauftrag')
 - In-patient-doctor-system ('Belegarztwesen')
 - Authorizations / Empowerments ('Ermächtigungen')

In 1931, during the so-called Weimar Republic, the Association of Statutory Health Insurance Physicians (KV) was founded. This resulted in a monopoly by doctors in private practice, which has led to drastic changes in the entire healthcare system to this day. In 1955, the so-called "Kassenarztrecht" (law on statutory health insurance physicians) came into being, which „separated“ the sector from hospital care in terms of both „patient treatment and financing“.

Social market economy: “Prosperity for all”

„Awakening“
60 years ago
(approx. 20
years after
the Second
World War)



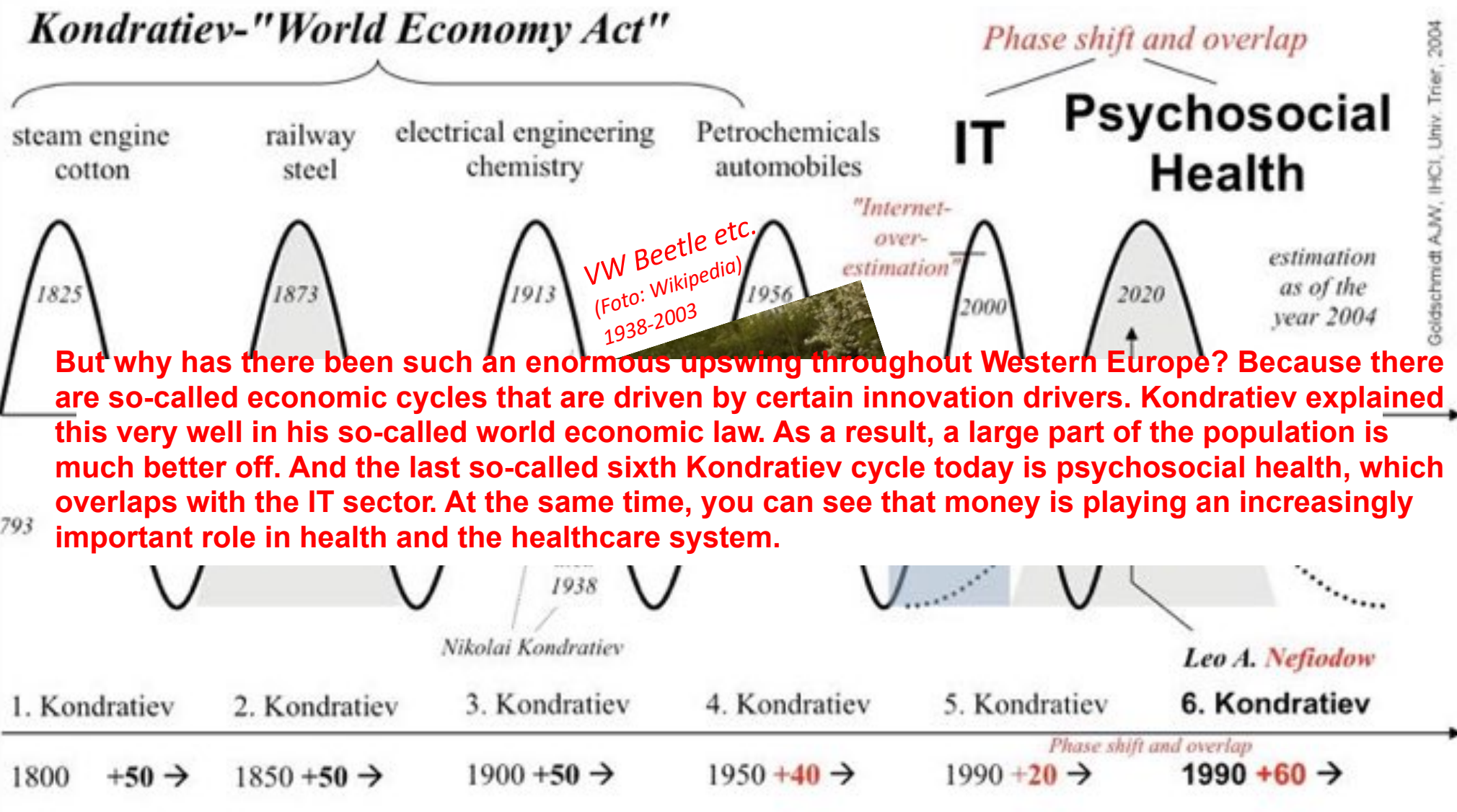
Just a few years after this episode, the social market economy under Chancellor Ludwig Erhardt led to an almost legendary economic upswing in Germany and the whole Europe.

Ludwig Erhard (*1897, †1977). „Führer des deutschen Wirtschaftswunders“, Bundeskanzler 1963-1966, Bundesminister 1949-1963.
Foto: Capital 11/2023, S. 103

Ludwig Erhard (*1897, †1977), “father of the German economic miracle”,
Federal Minister of Economics 1949-1963, Federal Chancellor 1963-1966

Nikolai Kondratiev: Anti-Marxist theory about 1920's; empirical study UK/USA
Josef Schumpeter: Definition of a "Kondratiev"-Unit
Leo A. Nefiodow: 6th Kondratiev "Psychosocial Health"

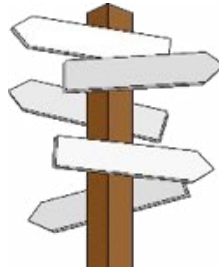
"applicable" to a national economy in general,
not applicable to all participants in a "market"



URL: https://en.wikipedia.org/wiki/Kondratiev_wave#/media/File:Kondratiev-waves_IT_and_Health_with_phase_shift_acc_to_Goldschmidt-AJW_2004.jpg

Result:

Money is playing an increasingly important role in health



This is why many previous reform efforts have failed.
This is because there are many things to consider, such as:

Reform is necessary.

But: Where does the **reform confusion** came from ... instead of answers?

How is the German healthcare system **organized** and **managed**?

How much **money** is needed in the healthcare sector?

Why is there less and **less money** available?

How is money **distributed** in the healthcare system?

key^s

What are the most important **factors and forces** influencing the **reimbursement** of services? („Erstattung von Gesundheitsleistungen“)



II. What are the current challenges of health in Germany?

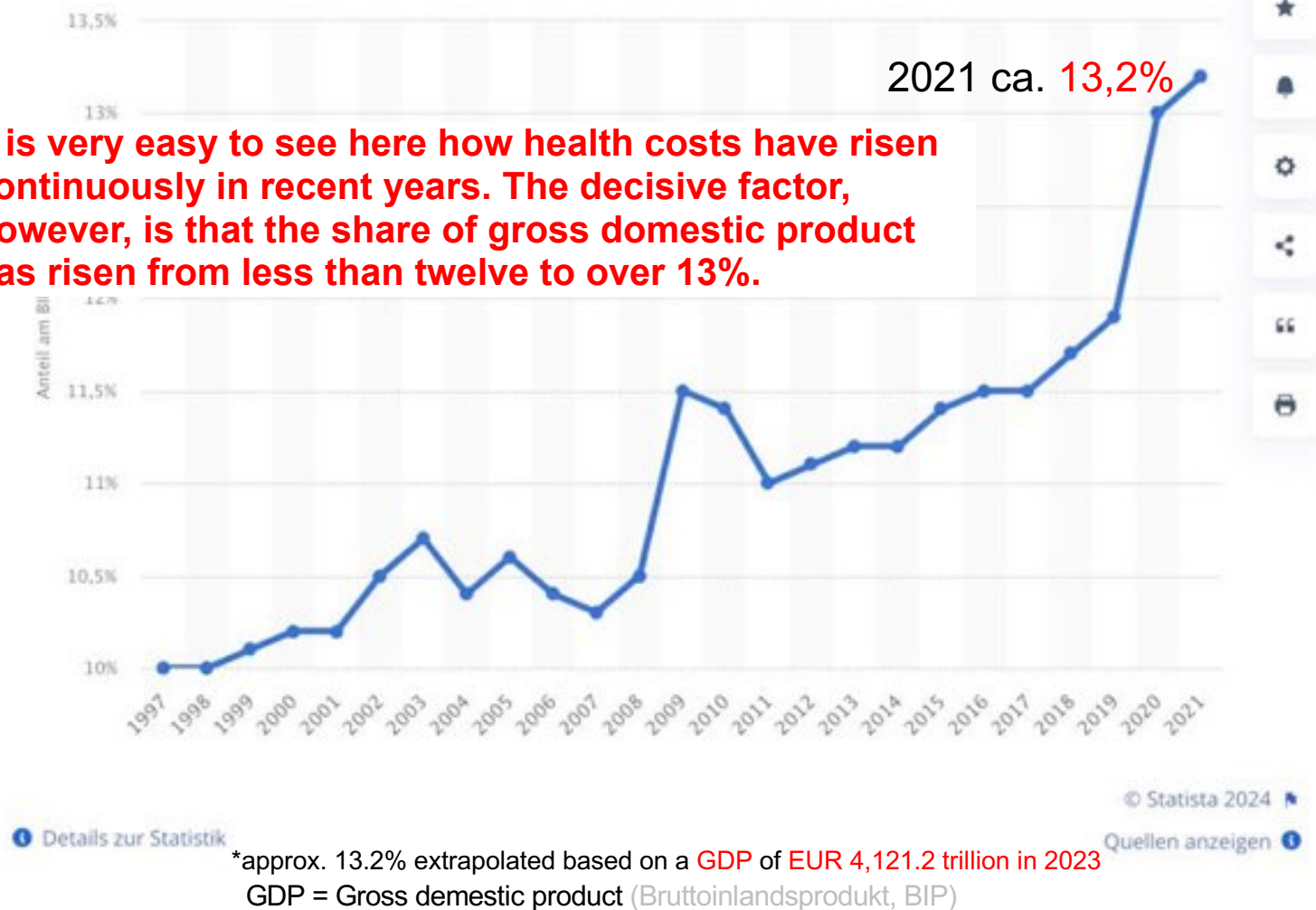
“The cause of all (?) evil”

An unimaginable amount of money is at stake

Share of healthcare expenditure in GDP in Germany 1997 to 2021

Corresponds to **544 Bio. Euro** in 2023*

It is very easy to see here how health costs have risen continuously in recent years. The decisive factor, however, is that the share of gross domestic product has risen from less than twelve to over 13%.



“The cause of all (?) evil”

An unimaginable amount of money is at stake

Share of healthcare expenditure in GDP in Germany 1997 to 2021

Corresponds to **544 Bio. Euro** in 2023*

Healthcare „market“
as portion of GDP
„Health economy“
(GKV-/PKV-insurances,
OOP/OTC, import/export)

= ca. 100 bio. Euro?

Hospitals 141 bio. Euro GKV

13,2%

We are talking about €544 billion in 2023,
of which €141 Bio. was needed for
hospitals alone. Exclusively at the
expense of patients with statutory
health insurance.

[Details zur Statistik](#)

*approx. 13.2% extrapolated based on a GDP of EUR 4,121.2 trillion in 2023

GDP = Gross domestic product (Bruttoinlandsprodukt, BIP)

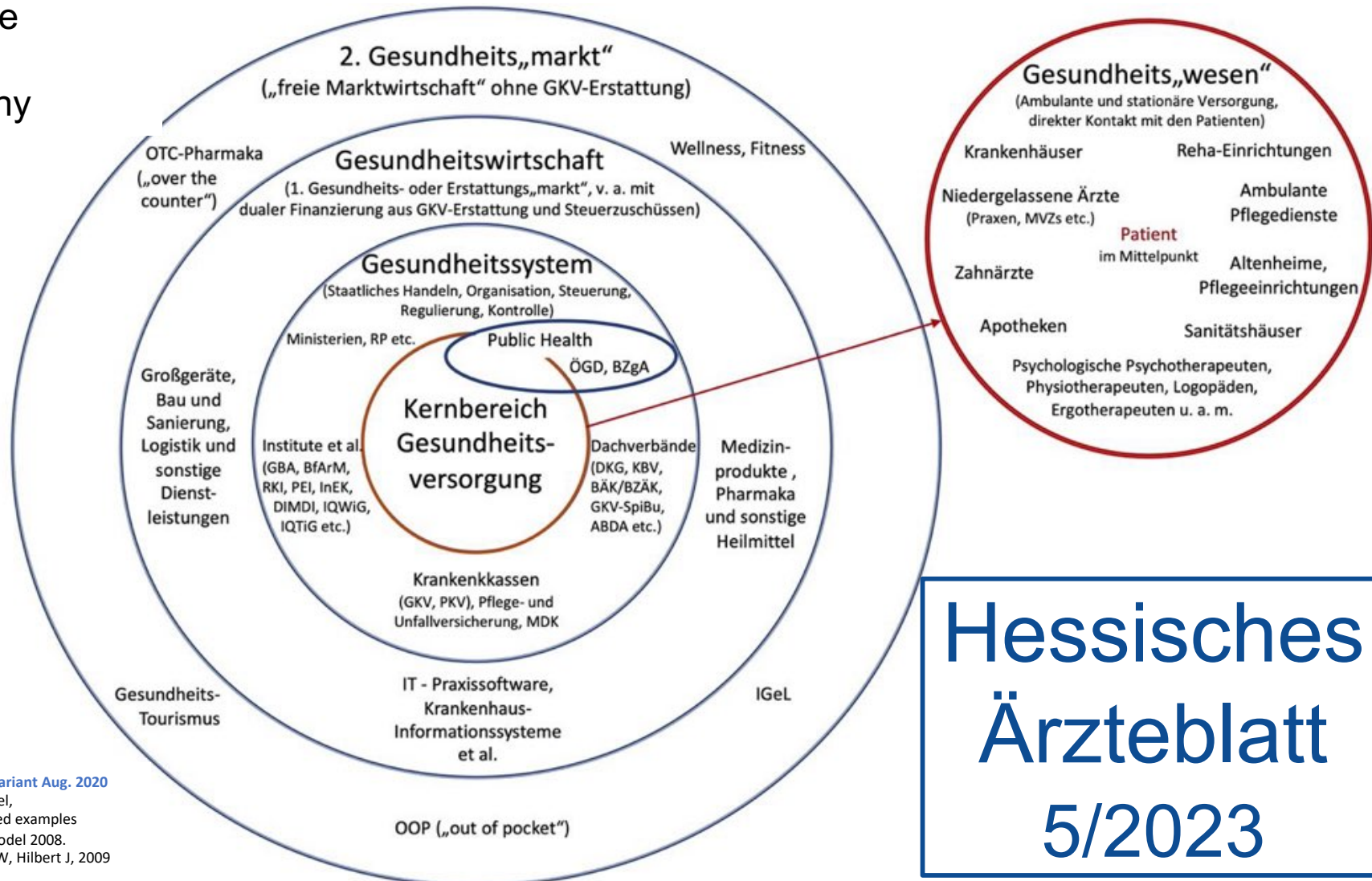
© Statista 2024
[Quellen anzeigen](#)

Taming the system in Germany („Zähmung“)



Organization and
structure
Healthcare
system
in Germany

„healthcare onion“



Goldschmidt AJW: [Own Variant Aug. 2020](#)
of a simplified onion model,
Modifications with selected examples
based on the IAT onion model 2008.
Compare Goldschmidt AJW, Hilbert J, 2009

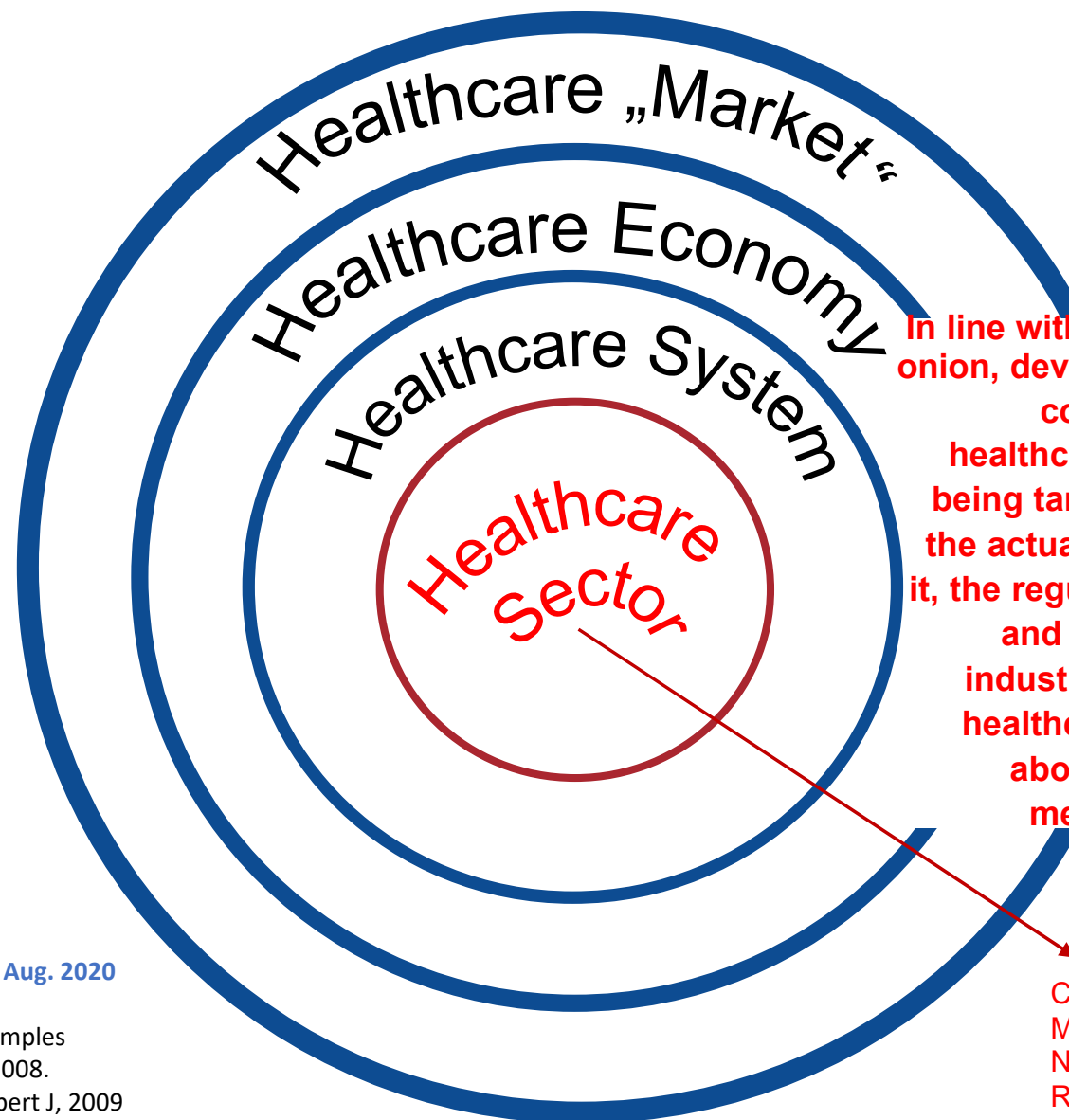
Hessisches
Ärzteblatt
5/2023

Taming the system in Germany („Zähmung“)

„healthcare onion“



Organization and
structure
healthcare
system
in Germany



In line with this model, a healthcare onion, developed teamwork with my colleague Josef Hilbert, the healthcare system in Germany is being tamed. At the center we see the actual patient care and around it, the regulating healthcare system and above that the healthcare industry and above that the free healthcare market. You can read about this in the publication I mentioned at the beginning.

Core area of direct patient care
Medical diagnosis and treatment
Nursing Care, Pharmaceuticals,
Rehabilitation etc.

Simplified

Goldschmidt AJW: **Own variant Aug. 2020**
of a simplified onion model,
Modifications with selected examples
based on the IAT onion model 2008.
Compare Goldschmidt AJW, Hilbert J, 2009

Numerous more or less **new challenges** for the healthcare system in Germany (**disproportional trends**)

New diseases, old illnesses are back

Drug **shortages** (“Arzneimittelengpässe”)

Increase in **antibiotic resistance**

Lack of skilled workers, especially in rural areas

Migration challenges (more patients, old diseases ...)

Expensive **medical advances**

Delayed progress in digitization

“**Copper wire** instead of fiber optics”

About **1,700 Acute Care Hospitals** of about 1,900 Hospitals (i. E. 1,874 in **2023**)

-> 1,900 minus 500 = about 1,400; excluding psychiatric clinics, pure day and night clinics and those that do not have contracts with the health insurance funds

-> 1,400 plus 300 = **1,700**; Including corporate alliances that have several locations

With **emergency level 2 or 3** = **1,100**

-> 425 of which with at least 10 intensive care beds with ventilation facilities and cardiac catheterisation measuring stations

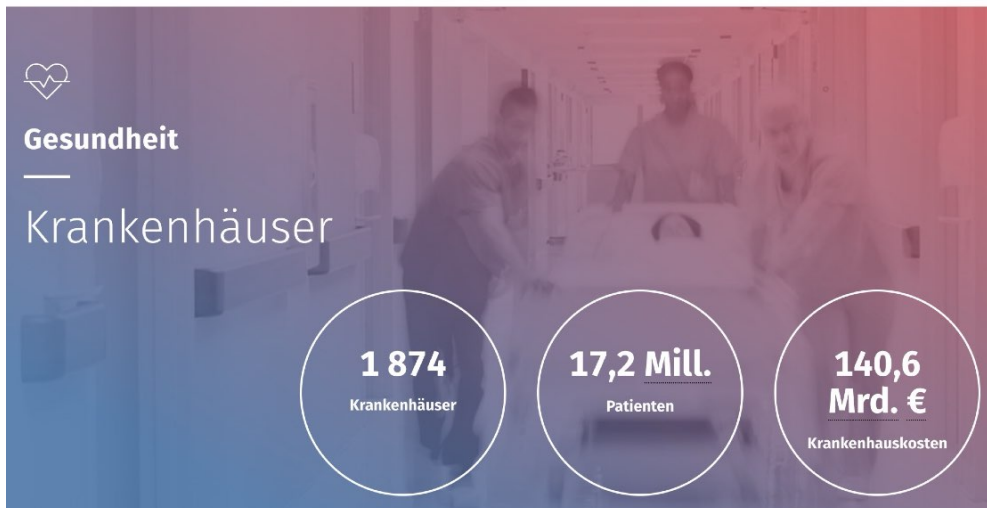
Number of **inpatients** treated in hospital **17,2 Millionen**

-> (2019 before COVID-19-Pandemie 19,4 Millionen)

Total bed **occupancy rate** of **71.2 %** ("Auslastung der Betten")

Hospital Cost (GKV) **140,6 Bio. Euro**

DI STATIS
Statistisches Bundesamt



Hospitals in Germany

Source/URL: https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Krankenhaeuser/_inhalt.html - Recall 22. Nov. 2024 07:08

Quelle: Busse R (Zitat/Auszug aus): Hoffmann A, Koch M: Interview mit Busse R und Raab E: Zukunft der Krankenhäuser Streitgespräch. Stern 4/2023, 19. Jan. 2023, S. 100-104

*)

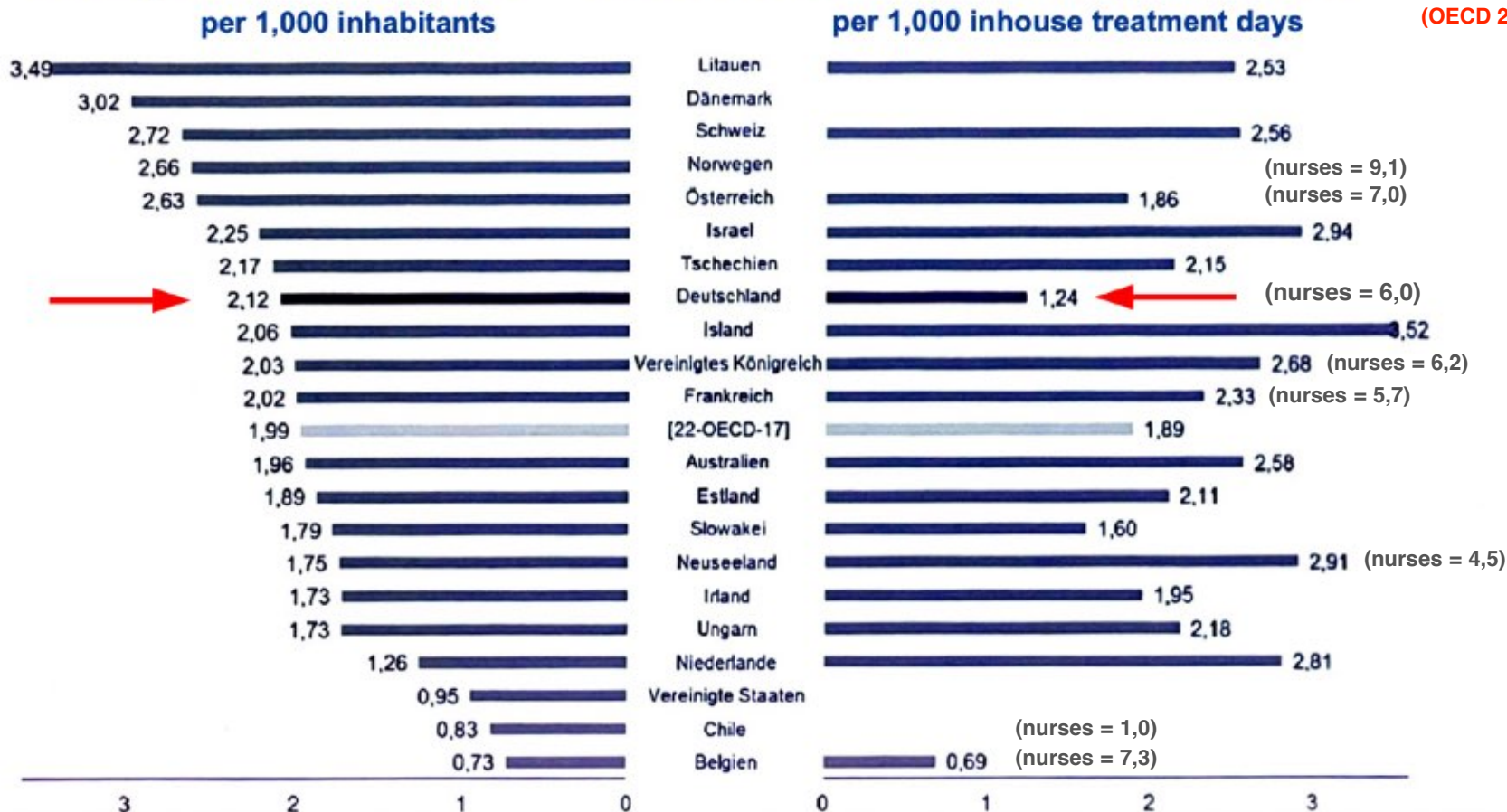
Diese Annahme bezieht sich auf eine Analyse mit 1.697 Standorten, davon 425 mit GBA-Notfallstufe 2 oder 3.

Sie bezieht nur Standorte ein, die im Jahr 2020 insgesamt mindestens 100 stationäre Fälle (nach den berichteten Hauptdiagnosen) behandelt haben. - Augurzyky B: Folgeabschätzung des Reformvorschlags der Regierungskommission vom 6.12.2022. Pressekonferenz, Berlin, 13. Febr. 2023: Vebeto Folie 14

Hospital doctors - International comparison

OECD 2022: hospital doctors

(OECD 2018: hospital nurses)

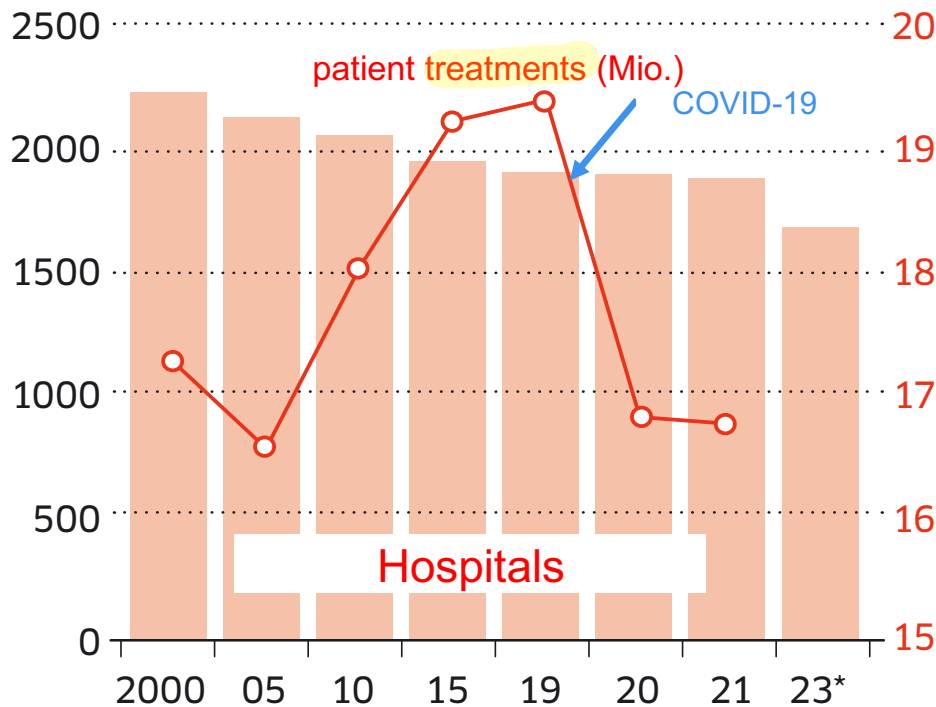


Quelle: SVR (2023) auf Basis von OECD (2022)

Reason: Sector separation and therefore (a) wrong distribution of health professionals, and (b) too many hospital treatments -> (c) too many hospitals?

Germany

Less hospitals, less treatments

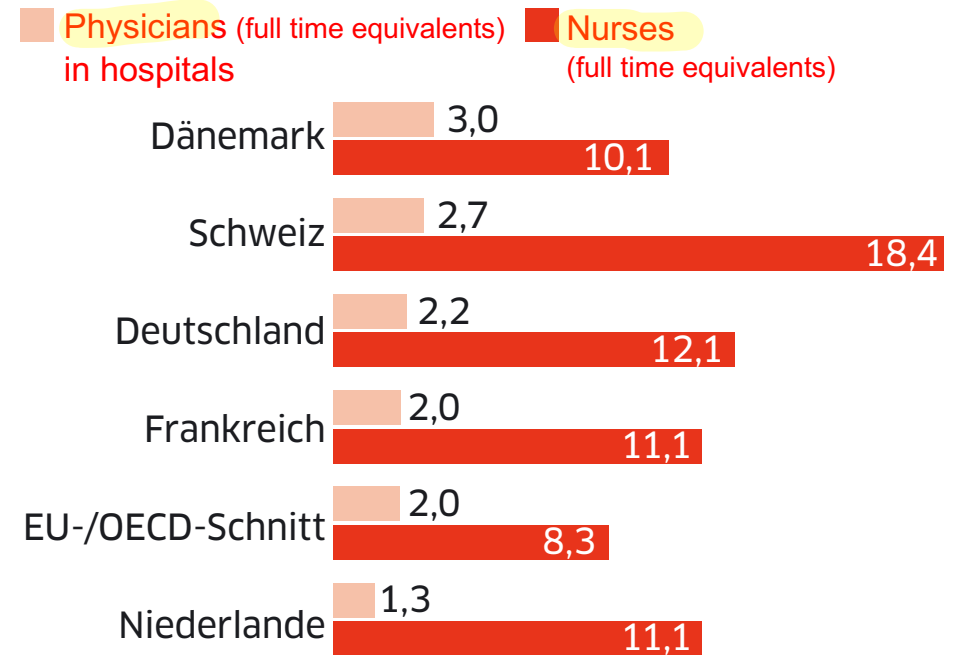


* Stand: Anfang des Jahres; **Quelle:** Destatis, DKG

Europe

Comparisons

(acc. to 1.000 inhabitants)

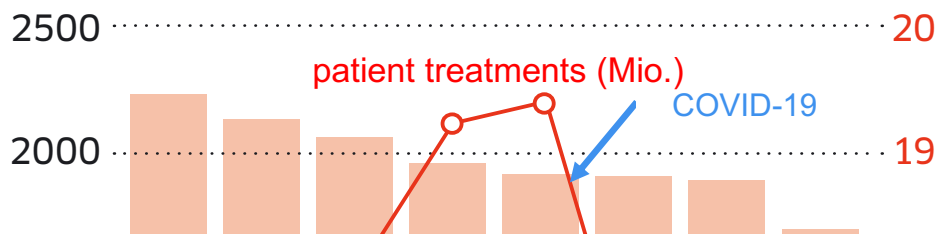


Quelle: OECD und SVR (2023)

17.2.2023 / WirtschaftsWoche 8

Germany

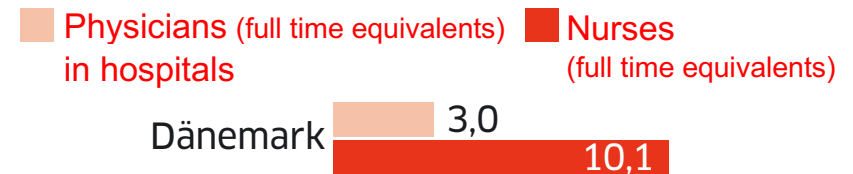
Less hospitals, less treatments



Europe

Comparisons

(acc. to 1.000 inhabitants)



The histogram on the left shows that the number of patient **treatments** in hospitals increased sharply between 2005 and 2019 in particular. With the outbreak of the COVID-19 pandemic, this number fell massively and has since stabilized again at a low level.

The figure on the right shows that Germany employs a relatively large number of **doctors** per capita. In relation to 1000 inhabitants, about 10% more than in France and the EU average, but significantly more than in the Netherlands, which are listed at the bottom, but much less than in Switzerland and Denmark, as can be clearly seen above.

Germany also employs a disproportionately high number of **nursing staff**. Only Switzerland has more per capita. Or per 1000 inhabitants. However, it should be noted that the number of patients in hospital per nurse or doctor is significantly higher than in our neighboring countries.

If the available staff were better distributed across fewer larger hospitals, with correspondingly fewer patients who actually require treatment in hospital and not on an outpatient basis with a GP, this ratio would also be similar to that of our European neighbors.

In principle, we have **enough staff**, at least by European standards. However, this may be **incorrectly distributed**.

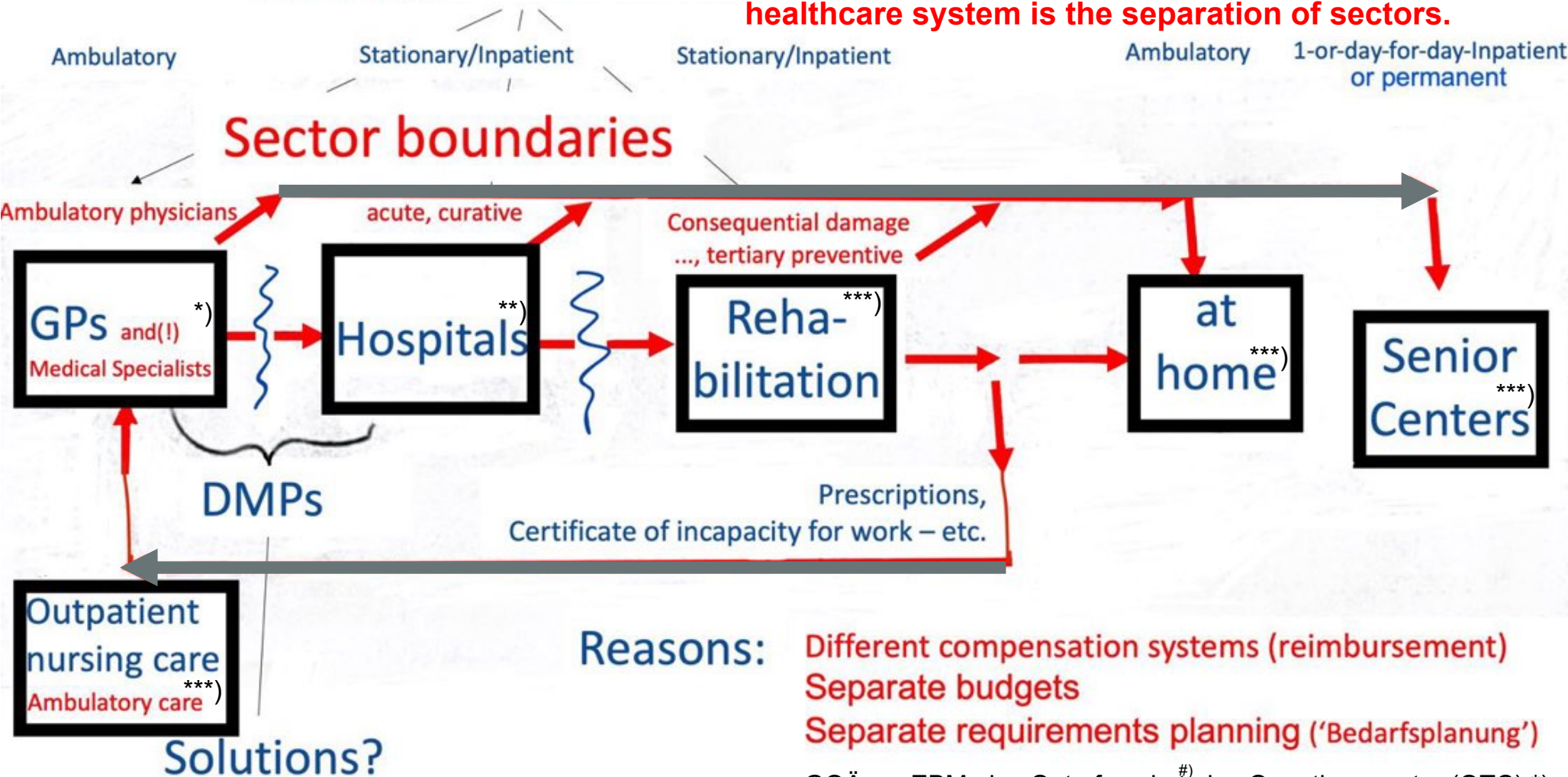
Main problem

sector separation

in-house vs. ambulatory / in-patient vs. out-patient

Wastage (,Verschwendung')

As I mentioned at the beginning of my presentation, one of the biggest problems in the German healthcare system is the separation of sectors.



Reasons:

Different compensation systems (reimbursement)
Separate budgets
Separate requirements planning ('Bedarfsplanung')

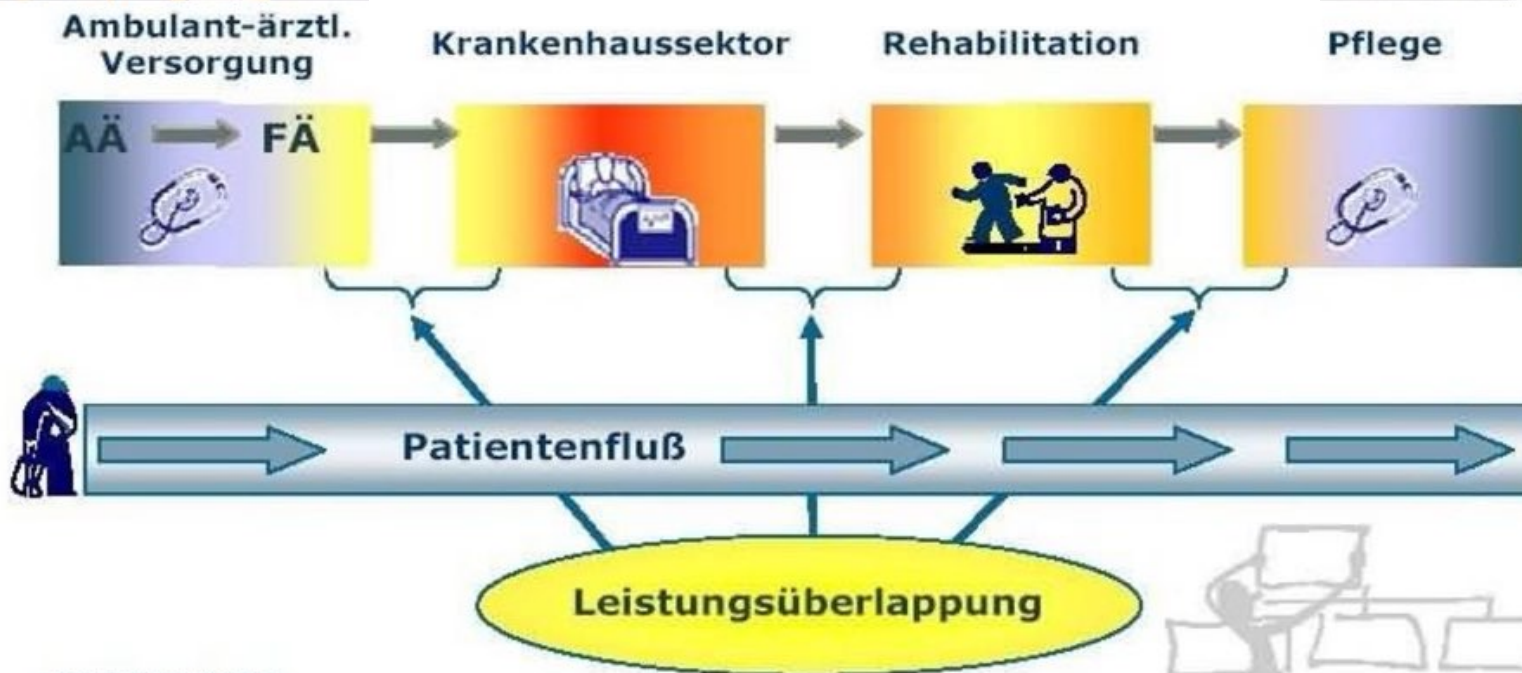
GOÄ vs. EBM plus Out of pocket^{#)} plus Over the counter (OTC) *)
DRGs vs. GOÄ vs. EBM plus Out of pocket ...**)
Completely other: Reha, Senior Centers, Ambul. nursing care, ...)

^{#)} OOP -> „IGeL“, „GOÄ – „Gebührenordnung für Ärzte“, EBM – „Einheitlicher Bewertungsmaßstab“

**Kostenexplosion
im Gesundheitswesen
zwischen 1980–2005**

**sector separation
-> „cost explotion“**

My former colleague from the University of Cologne, Karl Lauterbach, then became Minister of Health. I was at the neighboring university in Bonn at the same time. At that time, he also told my students about the sector separation and the associated cost explosion.

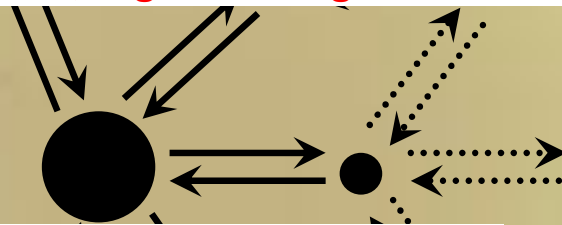


nach Prof. Lauterbach

Chance: New patterns of healthcare

Ring and star-shaped ...

Due to the major challenges mentioned above, the healthcare reform will essentially reorganize healthcare provision. Here we see the model of a new, logistical organization.



Of course, none of this is written anywhere in the law, but it cannot be solved in any other way, as was shown in a major competition for model healthcare in Germany. We also took part in this competition and won a prize.

HealthCare Management Instituts an

"Comprehensive healthcare provision is at risk, especially in rural areas," says Professor Andreas J. W. Goldschmidt ...
Project: "eHealth and Health Care Logistics Trier+" ...

2008 (Price of Ministry of Research)

Success for Trier team

Healthcare system of the future: Rural doctors, local centers and mobile care up to the last mile



Future healthcare in the countryside

Demography, economy and rural exodus:

- The distances are getting longer
- Focal points are distributed
- Acute care is being centralized
- Everything is on the move or is being moved.

Enabler:

Digitization (Telematics, eHC/eGK)



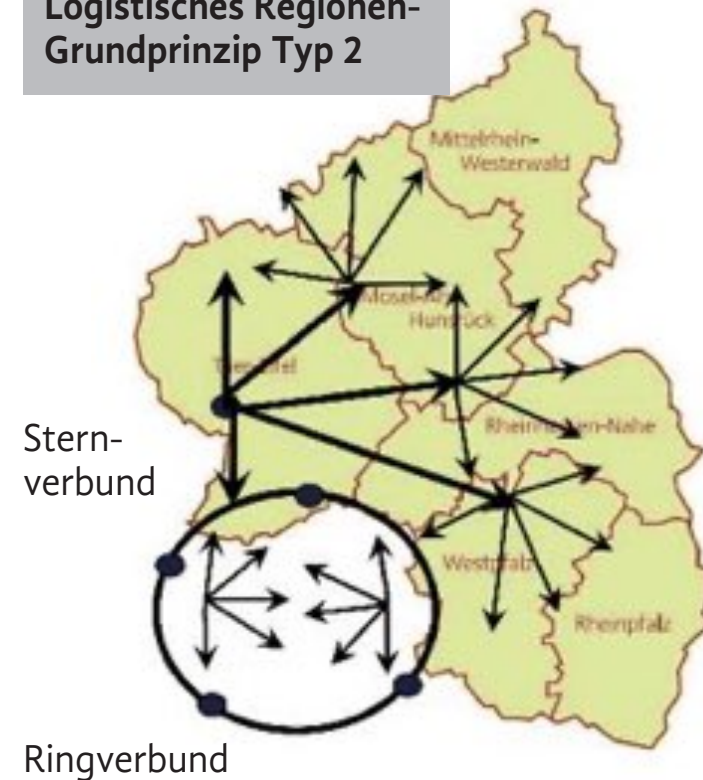
There are medium-sized hospitals within a medium distance that cover the most important specialties such as surgery, internal medicine, gynecology, obstetrics and one or two other specialties.

Smaller hospitals will primarily be converted into integrated centers with outpatient care. From there, patients with serious illnesses will be referred to medium-sized or larger hospitals.

Patients will have to travel longer distances for treatment or to be transported to clinics for emergency medical care. The municipalities will organize themselves and, for example, use school buses or other buses for new routes for patients.

Logistisches Regionen-Grundprinzip Typ 1

Logistisches Regionen-Grundprinzip Typ 2



Logistic Principles Ring and star-shaped ...

Hessisches Ärzteblatt 2/2020: 90

III. Current status of hospital financing in Germany

- (a) **Increasing gap** between **cost** increases for personnel and material resources and **refinancing** via contributions
- (b) **Insufficient** financing for hospital **construction** and **refurbishment** by the *federal states*
- (c) **Liquidity** bottlenecks lead to more and more **insolvencies**
- (d) **lack** of financial support **to bridge the gap** until reforms by the federal government via taxes take place

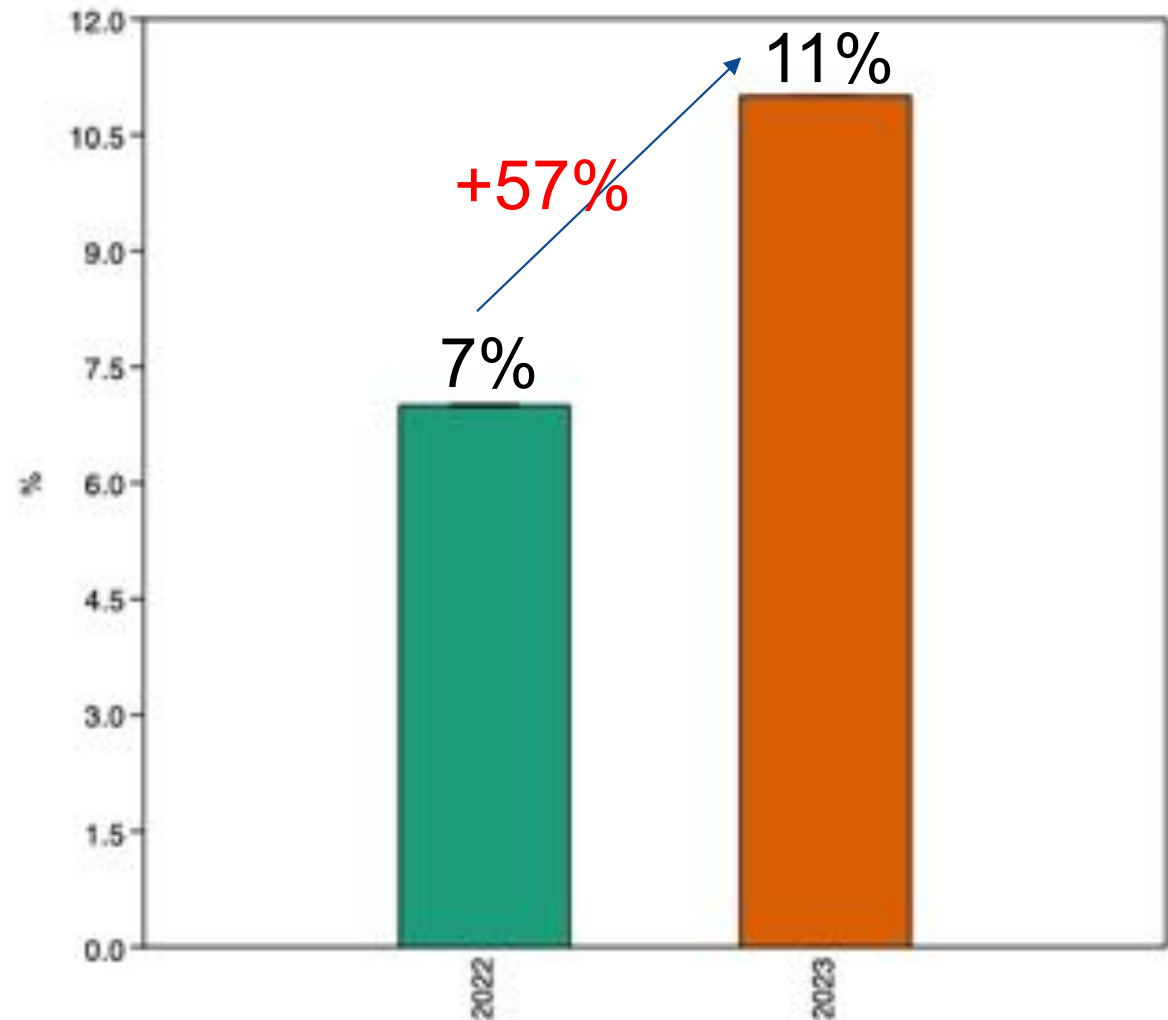
EBIT

„Red results“

Risk of
insolvency

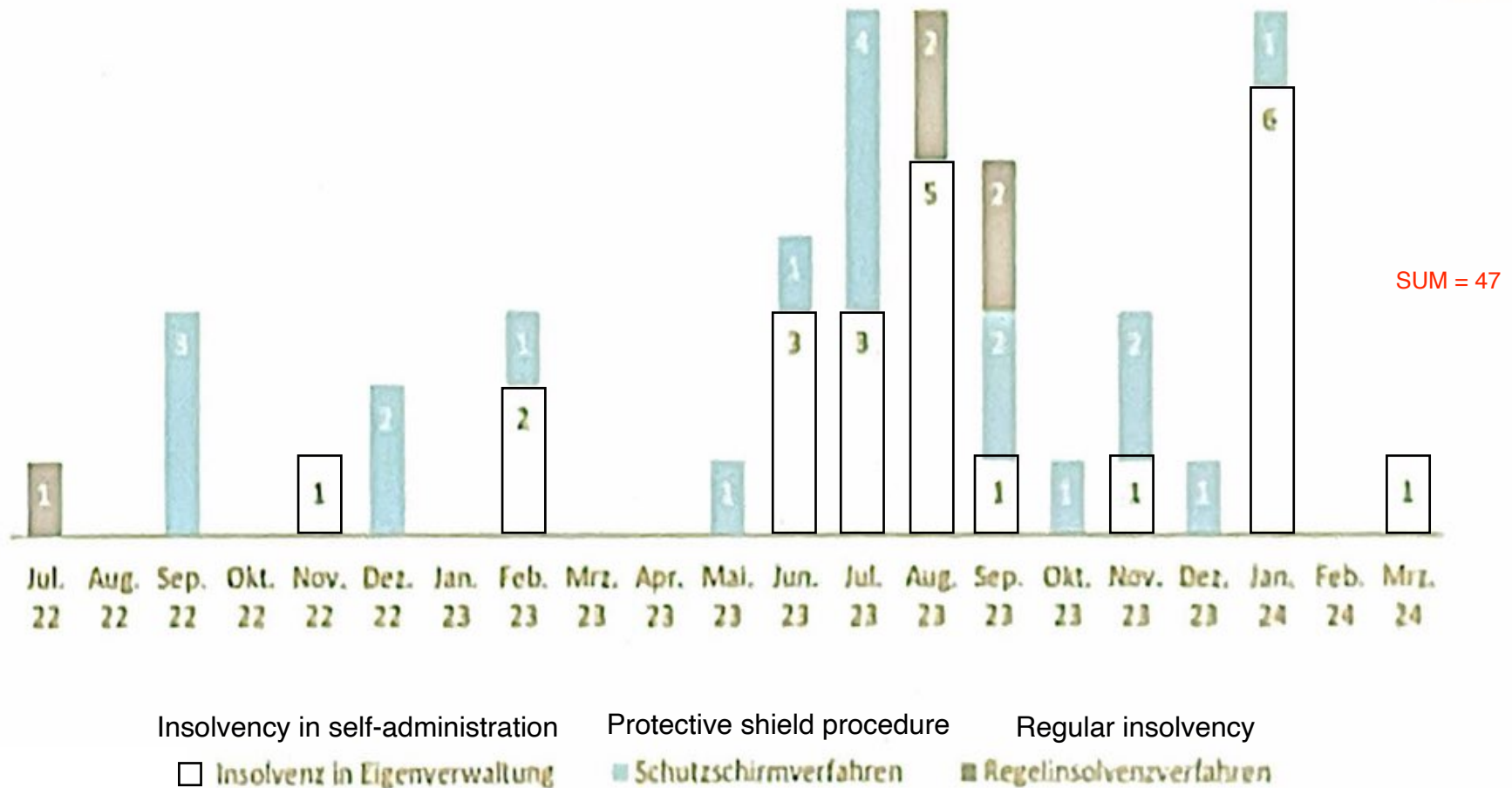
Hospital
Rating Report
2023

(„Krankenhaus
Rating Report“)



Noticeable increase in insolvencies since summer 2023

Number of insolvency proceedings June 2022 to March 2024



Source und Copyright: Krankenhaus Rating Report 2024

- 80% **Negativ** (expectation in 2024 acc. to BW-KG in BW = 85%)
- 7% Positiv
- 13% Unchanged

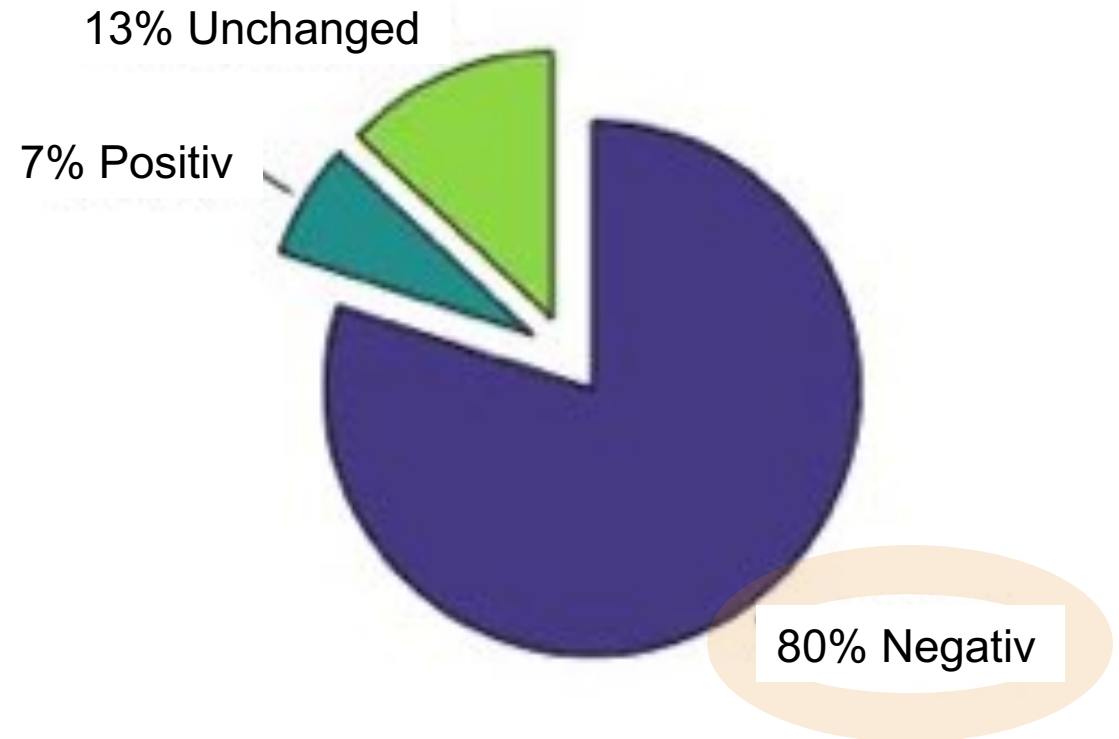
EBIT

Results / surpluses

“Ergebnisse / Überschüsse“

Hospital- barometer 2023

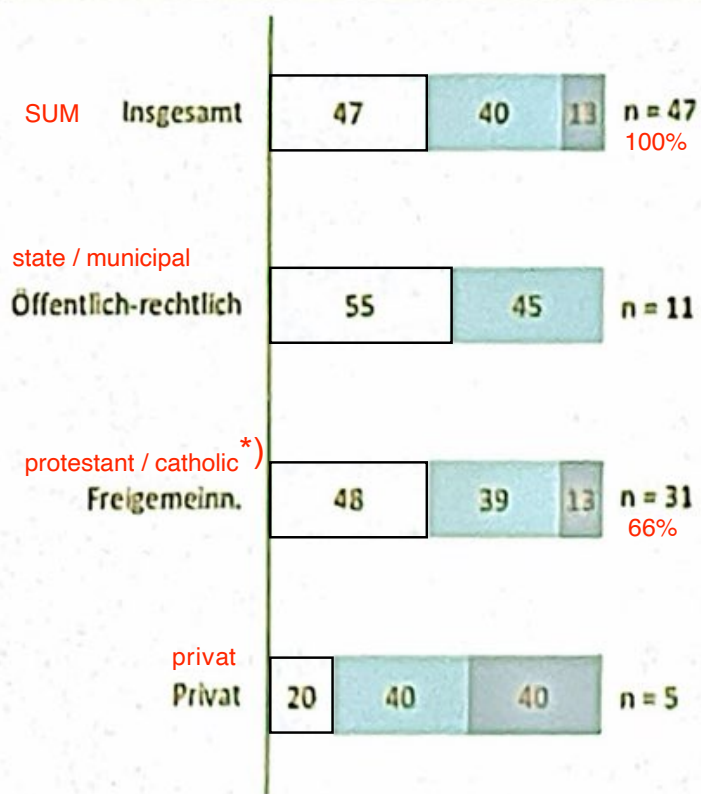
(„Krankenhaus Barometer“)



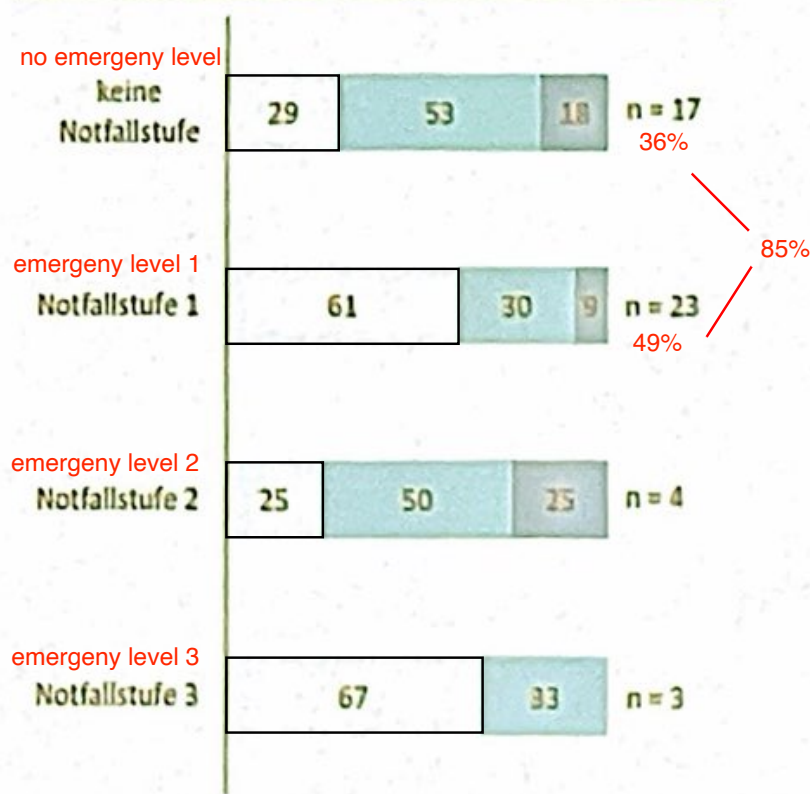
Two thirds of all 47 insolvent clinics are non-profit under church administration / ownership^{*)} and 85% have emergency level 0 or 1



acc. to administration / ownership
and type of insolvency procedure



acc. to emergency level
and type of insolvency procedure



Insolvency in self-administration Protective shield procedure Regular insolvency
 □ Insolvenz in Eigenverwaltung ■ Schutzschirmverfahren ■ Regelinsolvenzverfahren

Source und Copyright: Krankenhaus Rating Report 2024

IV. Where is the journey going?

Is this the way?

Denmark

2007



today



"All that glitters is not gold" - Proverb

"Es ist nicht alles Gold was glänzt" - Sprichwort

OLD vs. NEW: Easier and better financing?

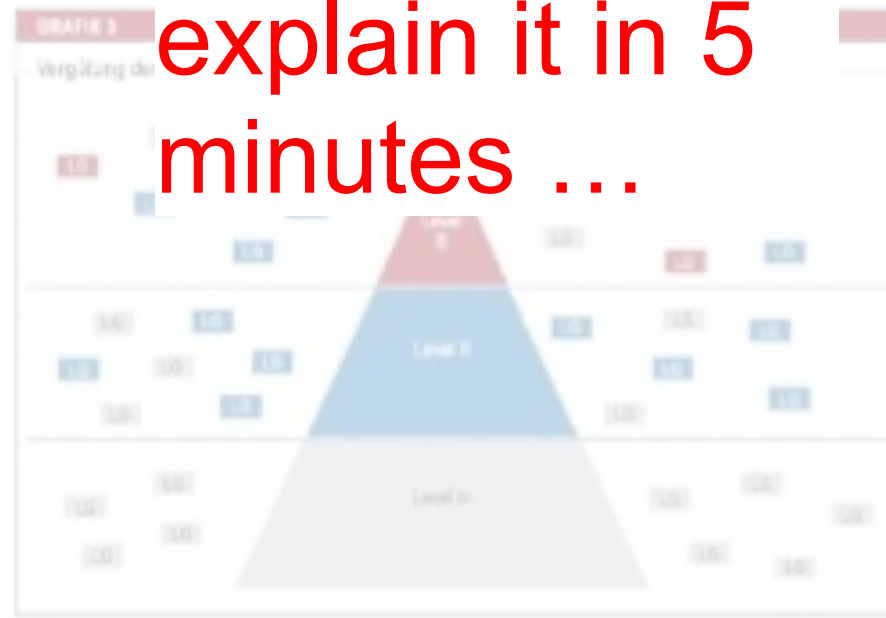
Vorschlag für eine grundlegende Vergütungsreform

Wie der Versorgungsprozess zu verbessern und die Qualität der Versorgung zu verbessern. Wichtige Bausteine sind die Einführung einer bedarfsgerechten Finanzierung und die Sicherung der Versorgung durch eine bedarfsgerechte Struktur der Krankenhausleistungen.

Entwicklungsprozess: Netzwerk-Kommunikation, Arbeitskreis, Tom Bachor



To complex to explain it in 5 minutes ...



Regierungskommission
für eine moderne und bedarfsgerechte
Krankenhausversorgung

Abschrift für die Verfasser:

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Prof. Dr. jur. Laura Munkler
Prof. Dr. med. Jochen Schmitt
Prof. Dr. med. Rajan Suresh
Prof. Dr. med. Leonie Sundmacher

Die gesamte Dokumentation im Internet:
<http://rosabi.de/FWS3>

Deutsches Ärzteblatt | Jg. 119 | Heft 51-52 | 27. Dezember 2022

OLD vs. NEW: Easier and better financing ?

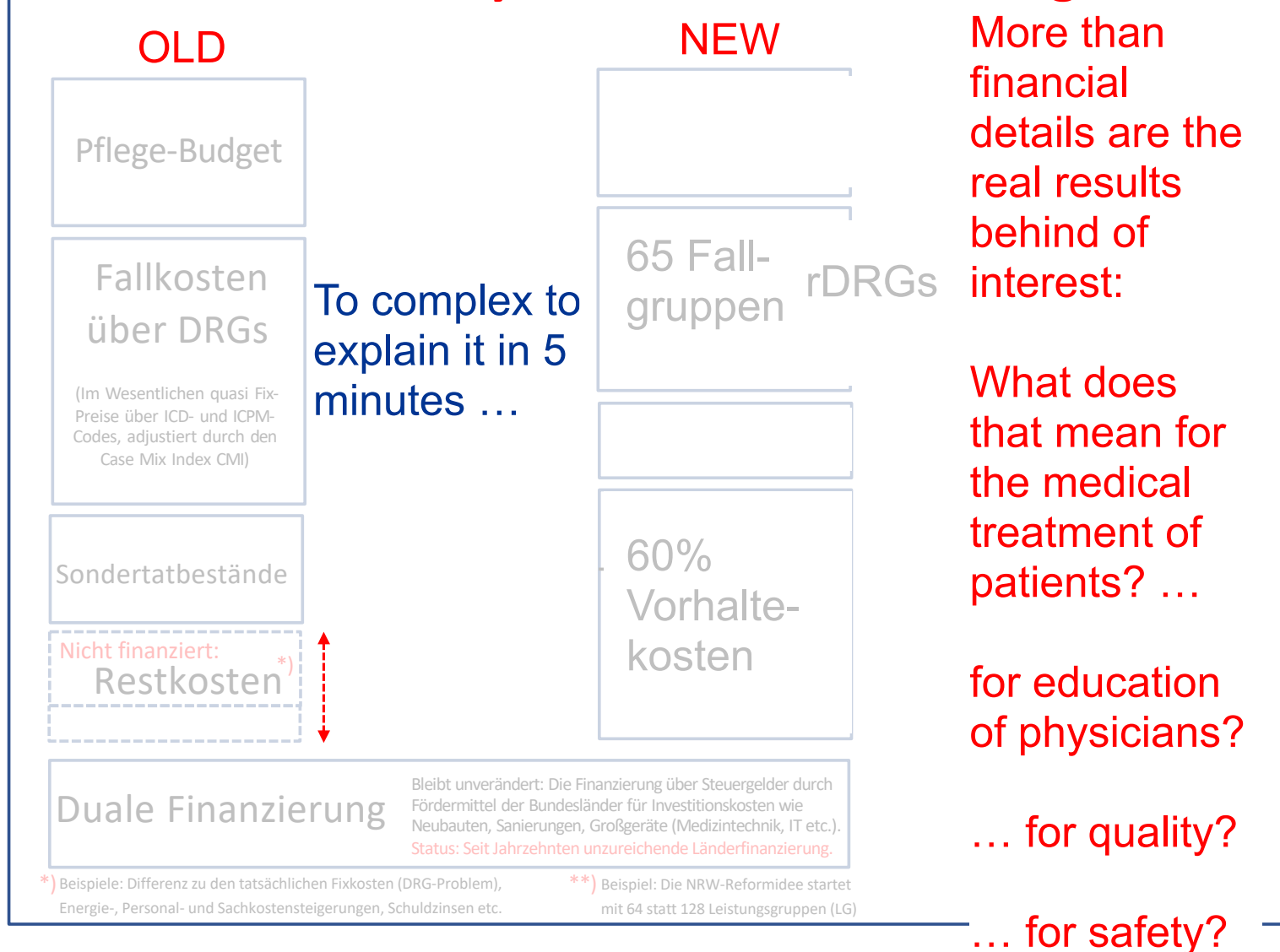


Abb. 1: Eigene Darstellung der künftigen KrankenhausFINANZIERUNG in Anlehnung an: Karagiannidis C, Busse R, Augurzky B, Schmitt J, Bschor T: Vorschlag für eine grundlegende Vergütungsreform. Deutsches Ärzteblatt 119 (51–52) 27. Dez. 2022: A2290A2292 - <Goldschmidt AJW Dez. 2022>



Herbert Spencer (UK, 1864)
picture: Wikipedia

emergency level

-> „Survival of the Fittest“ hospitals

(„Überleben der Passendsten“)



Gestuftes System von Notfallstrukturen

Anforderungen (ohne Module)

Notfallstufe
emergency level

	1	2	3
Vorgabe	Basissnotfallversorgung	Erweiterte Notfallversorgung	Umfassende Notfallversorgung
Art und Anzahl Fachabteilungen	Jeweils ein Facharzt/eine Fachärztin im Bereich Innere Medizin, Chirurgie und Anästhesie innerhalb von maximal 30 Minuten am Patienten verfügbar	zusätzlich 4 Fachabteilungen der Kategorien A und B*; mindestens 2 davon aus Kategorie A	zusätzlich 7 Fachabteilungen der Kategorien A und B*; mindestens 5 davon aus Kategorie A
Notaufnahme	Zentrale Notaufnahme (ZNA) unter anderem mit Einschätzung der Behandlungspriorität spätestens 10 Minuten nach Eintreffen (3 Jahre Übergangszeit)	zusätzlich Beobachtungsstation für Kurzlieger (maximal 24 Stunden) mit mindestens 6 Betten	
Intensivkapazität	Intensivstation mit mindestens 6 Intensivbetten, davon mindestens 3 mit Beatmungsmöglichkeit	Intensivstation mit mindestens 10 Intensivbetten mit Beatmungsmöglichkeit	Intensivstation mit mindestens 20 Intensivbetten mit Beatmungsmöglichkeit

Notfallstufe
emergency level

	1	2	3
Vorgabe	Basissnotfallversorgung	Erweiterte Notfallversorgung	Umfassende Notfallversorgung
Medizintechnische Ausstattung	• Schockraum • 24-stündige Verfügbarkeit von Computertomographie (auch in Kooperation)	<i>wie Basisstufe plus grundsätzlich zu jeder Zeit (24 Stunden an 7 Tagen pro Woche) Verfügbarkeit von:</i> • notfallendoskopischer Intervention oberer Gastrointestinaltrakt • perkutaner koronarer Intervention • Magnetresonanztomographie • Primärdiagnostik Schlaganfall und Initialtherapie	
Transport bzw. Verlegung	Möglichkeit der Weiterverlegung auch auf dem Luftweg	Hubschrauberlandeplatz	
Ambulant	Soll-Vorgabe: Kooperation gemäß § 75 Abs. 1b Satz 2 SGB V mit Kassenärztlicher Vereinigung		

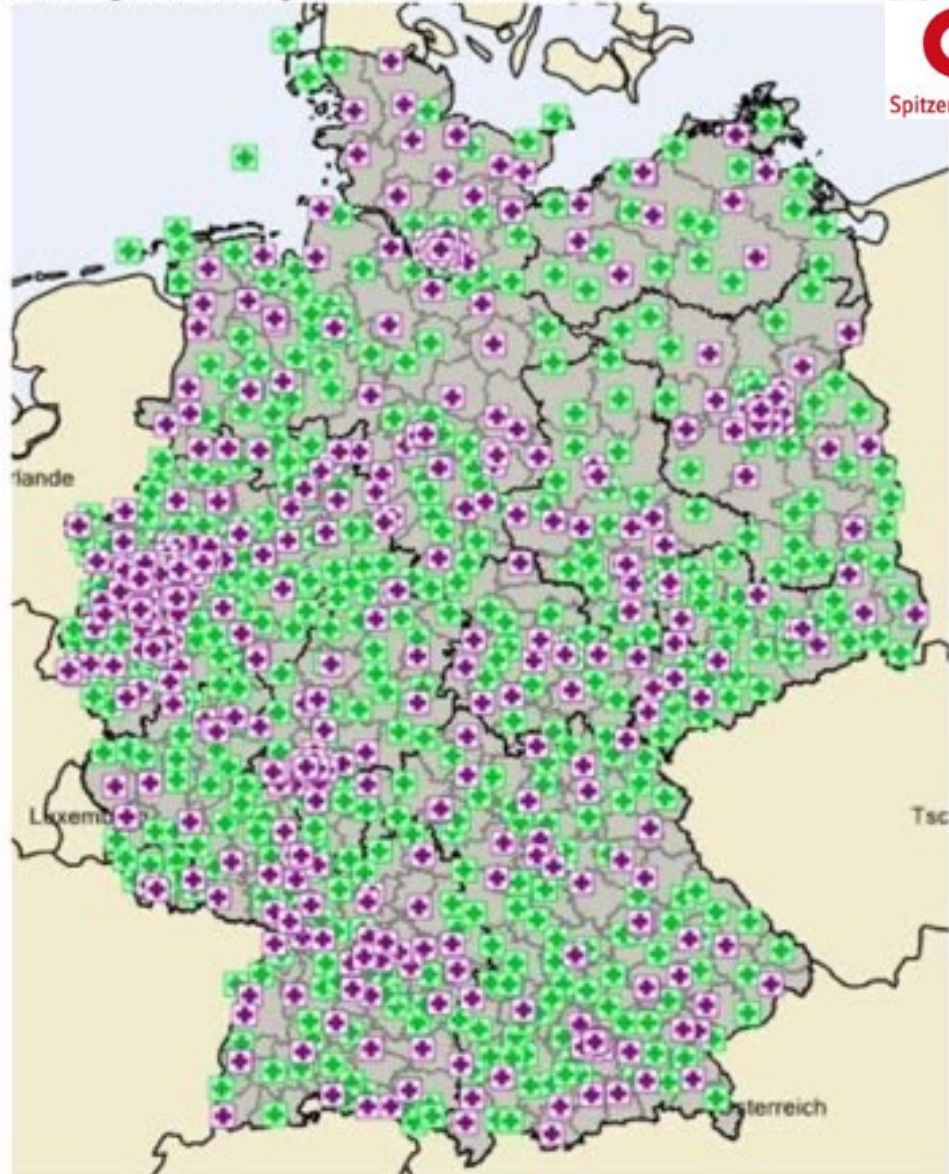
* Kategorie A: Neurochirurgie, Orthopädie und Unfallchirurgie, Neurologie, Innere Medizin und Kardiologie, Innere Medizin und Gastroenterologie, Frauenheilkunde und Geburtshilfe
Kategorie B: Innere Medizin und Pneumologie, Kinder- und Jugendmedizin, Kinderkardiologie, Neonatologie, Kinderchirurgie, Gefäßchirurgie, Thoraxchirurgie, Urologie, HNO-Heil- und Hals-Nasen-Ohrenheilkunde, Augenheilkunde, Mund-, Kiefer-, Gesichtschirurgie, Innere Medizin und Hämatologie und Onkologie

Stand: 2018

Source: <https://www.g-ba.de/themen/bedarfsplanung/notfallstrukturen-krankenhaeuser/> - Retrieval of the website Okt 7, 2024 05:34 CET

green = emergency level 1 (primarily in rural regions)

Abb. 1 Regionale Verteilung der Notfallkrankenhäuser



Die Abbildung zeigt alle Krankenhausstandorte, die voraussichtlich eine Basisnotfallstufe (grüne Kreuze, n=632), eine erweiterte oder umfassende Notfallstufe (violette Kreuze, n=432) gemäß G-BA Notfallstufen-Regelungen nach § 136c Absatz 4 SGB V erfüllen (gesamt: n=1.064).

Abb. 2 Regionale Verteilung der Notfallkrankenhäuser der erweiterten und umfassenden Stufe



Die Abbildung zeigt alle Krankenhausstandorte, die voraussichtlich eine erweiterte oder umfassende Notfallstufe gemäß G-BA Notfallstufen-Regelungen nach § 136c Absatz 4 SGB V erfüllen (n=432).

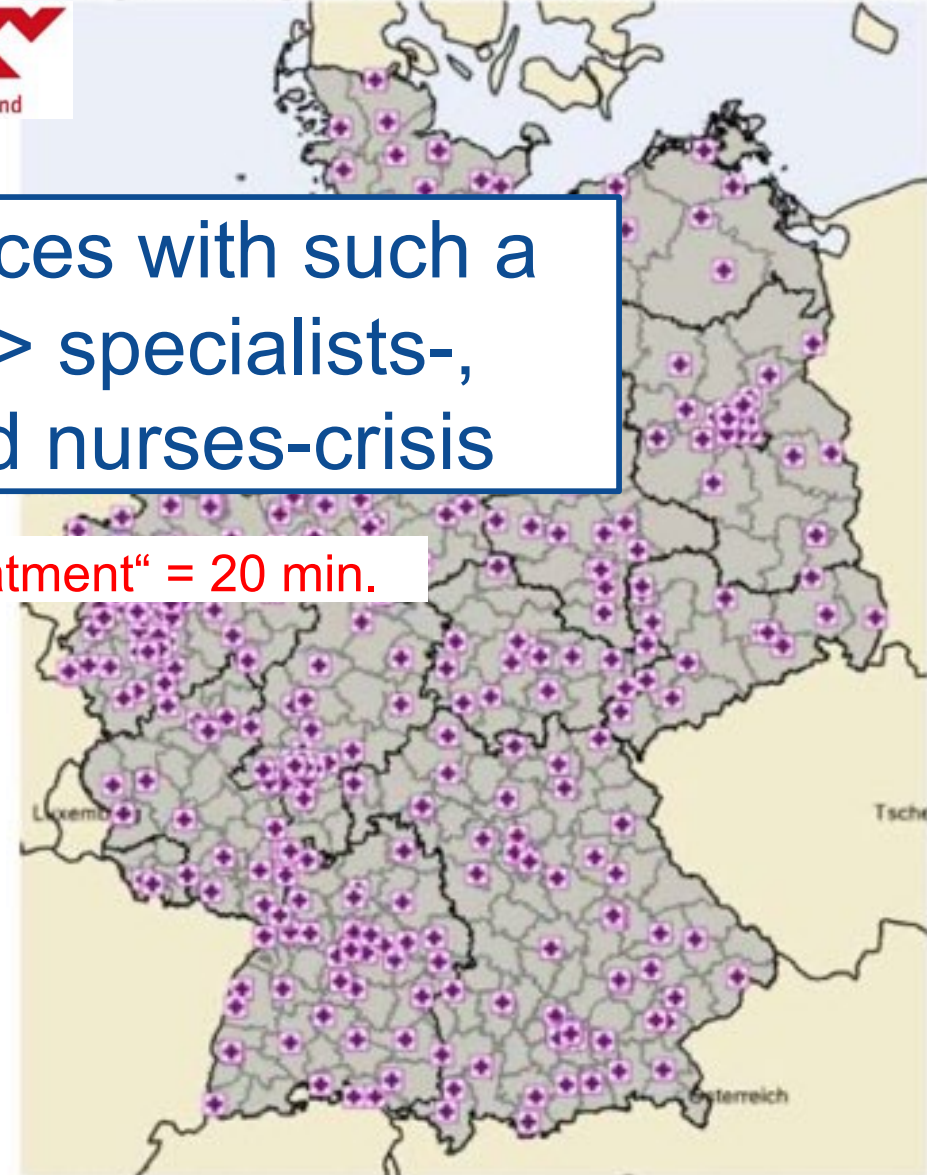
Source: https://www.gkv-spitzenverband.de/media/dokumente/krankenversicherung_1/krankenhaeuser/Begleitinformationen_Prognose_der_Notfallstufen_Stand_16-03-2021.pdf - Retrieval of the website Okt 7, 2024 05:34 CET

green = emergency level 1 (primarily in rural regions)

Abb. 1 Regionale Verteilung der Notfallkrankenhäuser



Abb. 2 Regionale Verteilung der Notfallkrankenhäuser der erweiterten und umfassenden Stufe



NL has experiences with such a new situation -> specialists-, „midwives“-, and nurses-crisis

arrival „time to treatment“ = 20 min.

Die Abbildung zeigt alle Krankenhausstandorte, die voraussichtlich eine Basisnotfallstufe (grüne Kreuze, n=632), eine erweiterte oder umfassende Notfallstufe (violette Kreuze, n=432) gemäß G-BA Notfallstufen-Regelungen nach § 136c Absatz 4 SGB V erfüllen (gesamt: n=1.064).

Die Abbildung zeigt alle Krankenhausstandorte, die voraussichtlich eine erweiterte oder umfassende Notfallstufe gemäß G-BA Notfallstufen-Regelungen nach § 136c Absatz 4 SGB V erfüllen (n=432).

Source: https://www.gkv-spitzenverband.de/media/dokumente/krankenversicherung_1/krankenhaeuser/Begleitinformationen_Prognose_der_Notfallstufen_Stand_16-03-2021.pdf - Retrieval of the website Okt 7, 2024 05:34 CET

Overcrowding in Emergency Department



Picture/Copyright: [Dtsch Arztebl 2018; 115\(6\): A-228 / B-200 / C-200](#)

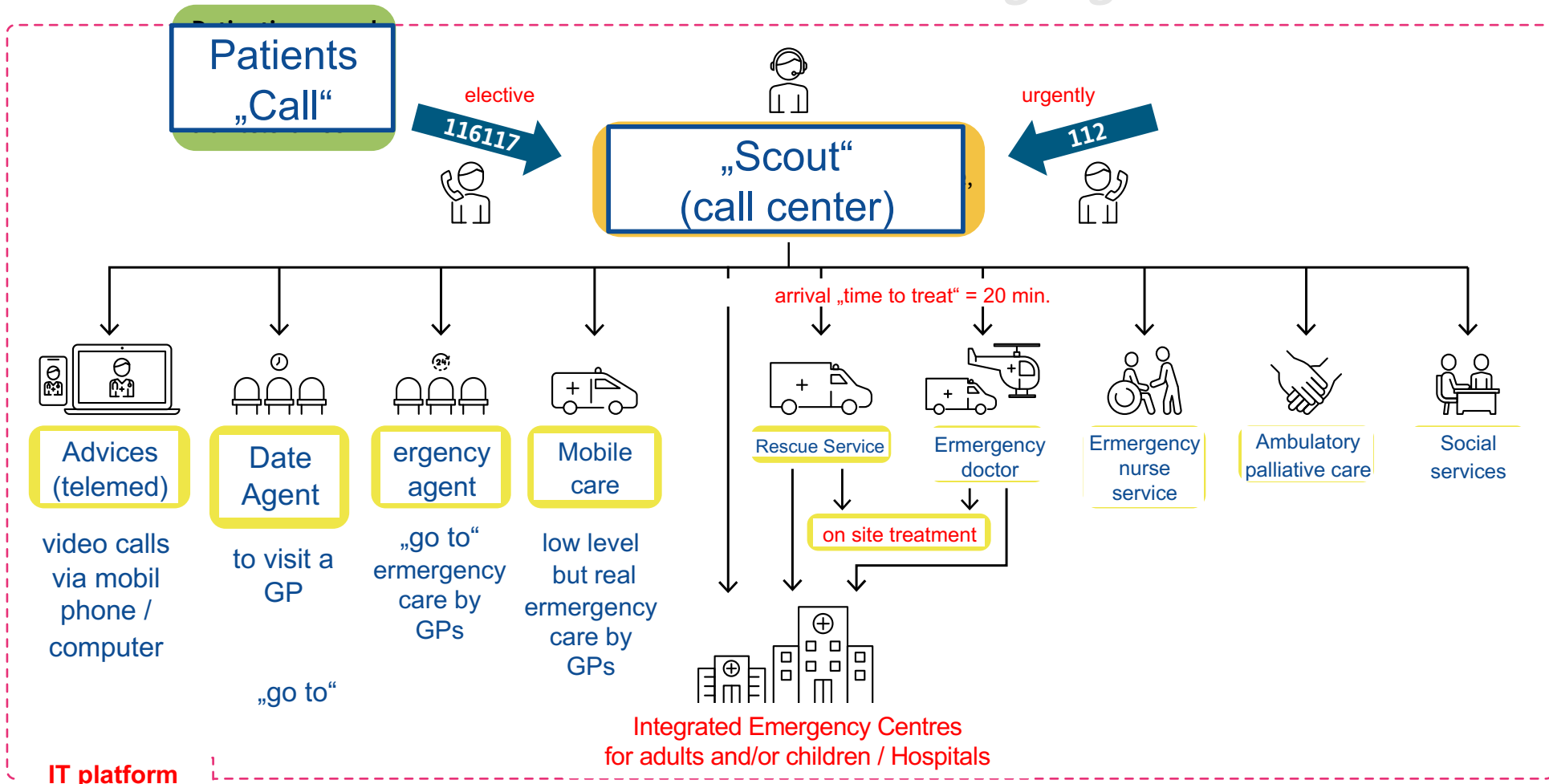
Many people bypass their family doctor and specialists and go straight to hospital because they can receive comprehensive medical treatment there quickly



Picture/Copyright: Nord24, 23. November 2015
<https://www.nord24.de/blaulicht/Staus-in-der-Notaufnahme-2864.html>

Reform of emergency care

Reform der Notfallversorgung



IT platform

AI anytime?

Source/URL: https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/K/Krankenhausreform/Vierte_Stellungnahme_Regierungskommission_Notfall_ILS_und_INZ.pdf - Recall 19. Nov. 2024 4:51 p.m.

And a lot more ...

Thank you!