

Germany - country profile

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Overview of the health workforce planning process (series of actions taken)

In Germany, the healthcare system is characterized by self-governance of corporatist actors. Instead of one central, federal planning model, a variety of regulation mechanisms for different professions apply differently to hospital and to outpatient care in the states (*Länder*). Planning processes in Germany apply to distribution of seats for physicians practicing under statutory health insurance, medical school admission at universities (under control of the ministries for education, not the ministries of health), and specialist training.

88% of the German population is insured under statutory health insurance (*Gesetzliche Krankenversicherung*, GKV), making the sickness funds of the GKV the largest corporatist actors in medical self-governance (Rothgang et al. 2010). These sickness funds are public bodies, as are the national and regional associations of statutory health insurance physicians; whereas the Federal Association of Hospitals is a private association. All of these actors negotiate outpatient planning mechanisms for physicians and psychotherapists as part of the Federal Joint Committee (*Gemeinsamer Bundesausschuss*, GBA), where the German states are also represented. The planning guideline for these two health professions is called *Bedarfsplanungsrichtlinie* (literally: demand planning guideline), and has been revised in 2012/2013. The process of planning under this guideline is discussed in detail under planning model. It is important to note that the *Bedarfsrichtlinie* aims at distributing physicians in the country and ensuring sufficient access to outpatient care rather than guaranteeing a particular number of physicians.

Hospital capacity planning is organized and controlled by the individual states (*Länder*). The states create hospital plans, defining the number of hospitals and number of beds by specialties (Rothgang et al. 2010). Sickness funds are included in the hospital planning process but play a lesser role than in the outpatient care planning. Access to medical schools is regulated by one agency jointly set up by all states. The foundation for the allocation of study places (*Die Stiftung für Hochschulzulassung*, *hochschulstart.de*) controls the number of medical students (future physicians, dentists, psychologists) and pharmacy students, not, however, access to nursing education.

Overview of the health workforce planning model

Owing to medical self-governance and decentralized nature of the German healthcare system, there is not just one workforce planning model. As described above, outpatient and hospital care are planned by different corporatist and/or state actors in a self-regulatory system.

Under statutory health insurance, the *Bedarfsplanungsrichtlinie*, (demand planning guideline) determines a method to regulate access for physicians and psychotherapists to outpatient care. Please note that the following refers only to outpatient care delivered by statutory health care physicians.

The guideline clusters all the different specializations into 23 physician groups (e.g. GP, paediatricians, radiologists etc).

The 23 physician groups are divided into four categories for planning purposes:

- General physicians
- General specialist care (for example, ophthalmologists, pediatricians, OB/GYN, general surgeons, psychiatrists) (the psychotherapists, even though they are not physicians are included in the same planning category).
- Highly specialized specialist care (anesthesiologists, specialized internists, radiologists, child psychiatrists)
- Separate specialist care (for example, human geneticists, neurosurgeons, pathologists, nuclear medicine specialists, transfusion medicine specialists)

Each category is related to a specific type of planning region. Size and definition of planning region varies across the four different categories and are specified in the guidelines. Generally higher specialisations are associated with larger planning regions.

Ratio numbers are specified in the planning guideline for each group of physician, ranging from 1 GP per 1671 inhabitants to 1 transfusion medicine specialist per 1.322.452 inhabitants. These ratio numbers were originally derived normatively from the status quo of supply in 1990 and updated infrequently (see also ratio number modifications).

Based on these ratio numbers, regional over- and undersupply can be determined.

Determination of oversupply

If within a planning region the ratio of physician per inhabitants exceeds the target ratio number by 10 percent, oversupply is assumed. This leads to an immediate stop of any further admissions for physicians.

Determination of undersupply

If within a planning region the ratio of general physicians per inhabitants falls 25 percent below the target ratio, or the ratio of specialists per inhabitants falls 50 percent below the target ratio, undersupply is likely. In those cases several instruments are used to incentivize physicians to start practicing in those regions.

Altogether most regions and most physician groups oversupplied and the instruments of undersupply are only used in rural areas mostly for the group of GPs.

Ratio number modifications by demography are possible except for the groups of pediatricians and child psychiatrists. The demography factor is based on an age and a service use factor. To modify the ratio number, the number is multiplied by the demography factor. Generally speaking the demography factors ensures that regions with more old inhabitants have more doctors to serve the needs of the population.

In limited, special cases, regional exceptions to the targets specified in the guidelines are possible through the *Sonderbedarfsregelung* (extra needs regulation).

Regarding hospital planning; only hospitals included in a hospital plan at state level are able to

get reimbursed for services under statutory health insurance. Hospital plans incorporate data on population, average stay at a hospital, frequency of inpatient care use and degree of use of hospital beds (Greib & Stegmüller 2011). Calculations of the Hill-Burton formula give information on demand of hospital beds by specialty and location. Thus, hospital planning in Germany can be characterized as capacity planning.

The Hill-Burton formula is derived as follows:

Need for beds = no. of inhabitants x frequency of hospital care use x duration of stay x 100 / 1000 x degree of use of beds x 365 days

Where frequency of hospital care use is, for one region, percentage of patients in hospital care per entire population of that region in one year, and degree of use of beds is, for one region, number of days of nursing services provided in relation to number of existing beds.

Qualitative data collection

As stated above, in the self-regulatory system in Germany, planning mechanisms vary between outpatient and hospital care, involving different actors. Thus, no central efforts to collect qualitative data exist.

During the yearly calculations to check for over- or undersupply in outpatient care provided by statutory health insurance physicians, a demography factor based on population age, sex and outpatient services use is applied. Thus, recent population aging is taken into account.

Research institutes and corporatist actors frequently use scenarios to project future supply and demand of health workforce (see for example Rothgang et al. 2012, Afentakis & Maier 2010, both for nursing professions). These project-based projections may be used for planning purposes, but are not a regulated part of planning mechanisms in neither outpatient nor hospital-based care.

Analysis of qualitative information

- How is qualitative information processed
- Stages which use expert groups

Information on population age, sex and use of services is used yearly to potentially adjust physician per population ratio numbers in outpatient care under statutory health insurance. Demographic variables such as age and service use (derived from services financing data) are also used to adjust the number of needed beds in hospital plans.

Healthcare “expert groups” are responsible for planning so are always included in the (self-governed) planning process. There is no formalized staged of external expert elicitation.

References

Afentakis, A., & Maier, T. (2010). Projektionen des Personalbedarfs und -angebots in Pflegeberufen bis 2025. *Statistisches Bundesamt (Hg.): Wirtschaft und Statistik, 11*, 990-1002.

Bedarfsplanungsrichtlinien (planning guidelines)

- Physicians and psychiatrists: <http://www.g-ba.de/informationen/richtlinien/4/> (accessed

8 Oct. 2013)

- Dentists: <http://www.g-ba.de/informationen/richtlinien/30/> (accessed 8 Oct. 2013)

Greß, S., & Stegmüller, K. (2011). *Gesundheitliche Versorgung in Stadt und Land - Ein Zukunftskonzept*. Wiesbaden: Friedrich-Ebert-Stiftung.

Rothgang, H., Cacace, M., Frisina, L., Grimmeisen, S., Schmid, A., & Wendt, C. (2010). *The State and Healthcare: Comparing OECD Countries*. London: Palgrave Macmillan.

Rothgang, H., Müller, R., Unger, R., Klie, T., Göhner, A., & Schumacher, B. (2012). *Themenreport, Pflege 2030*. Gütersloh: Bertelsmann Stiftung.

