Vom Krankenhaus zum kranken Haus? Klinikalltag zwischen ethischem Anspruch und Kostendruck

Öffentliche Tagung des Deutschen Ethikrats

Deutsches Hygiene-Museum, Dresden, 22. Oktober 2014

ETHISCHE AUSWIRKUNGEN EINER ZUNEHMEND ÖKONOMISCHEN AUSRICHTUNG DES KRANKENHAUSES

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Medizin und Ökonomie – wo ist das Problem?

Universität Zürich

- Hohe Lebenserwartung und Lebensqualität
- Hohe Zufriedenheit mit dem Gesundheitssystem
- Universaler Zugang zur Gesundheitsversorgung
- Hohe Kosten

Medizin und Ökonomie – wo ist das Problem?

Universität Zürich

„Qualität hat eben ihren Preis.“ Aber:

? „Value“, „return on investment

? Qualität: Daten, Transparenz

? Nachhaltigkeit

Medizin und Ökonomie – wo ist das Problem?

- Versorgungsziel
- Solidaritätsziel
- ? Kostendämpfungsziel

Einführung DRGs: Vergütung nicht direkt abhängig von tatsächlichem Aufwand bei der Behandlung

→ *„Anreiz für das Spital, die Behandlung im Interesse betriebswirtschaftlicher Effizienz mit möglichst geringem Ressourcenverbrauch durchzuführen“*

Vgl. Indra P: Die Einführungen der SwissDRGs in Schweizer Spitälern und ihre Auswirkungen auf das Schweizer Gesundheitswesen. Schriftenreihe der SGGP, No. 80, 2004.

Medizin und Ökonomie – wo ist das Problem?

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Zürich 20°

Neue Zürcher Zeitu

Mittwoch 8. Oktober 2014 – E-Paper Webpaper

International | Wirtschaft | Finanzen | Schweiz | Zürich | Meinung | Sport | Feuilleton | Wissens

NEWS-TICKER

12:22 **Spitalverband**

Keine blutigen Entlassungen

(sda) Die Einführung von Fallpauschalen zur Finanzierung von Spitalleistungen hat nicht zu blutigen Entlassungen geführt. Dies belegen der Spitalverband H+ und die Verbindung der Schweizer Ärztinnen und Ärzte FMH mit einer Studie. Sie zeigt auf, dass nur leicht mehr Leistungen und Kosten in den ambulanten Bereich verschoben wurden.

Problemfelder im klinischen Alltag

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SAMW Schweizerische Akademie der Medizinischen Wissenschaften

Medizin und Ökonomie – wie weiter?

Positionspapier der Schweizerischen Akademie der Medizinischen Wissenschaften

Problemfelder im klinischen Alltag

1. Qualitätseinbussen durch fehlgeleitete Effizienzsteigerung
2. Interessenkonflikte
3. Aushöhlung des Fürsorgemodells
4. Verlust der intrinsischen Motivation
5. Deprofessionalisierung
6. Verzerrung medizinischer Prioritäten
7. Vertrauensverlust der Patienten

(aus: Positionspapier der SAMW, 2014)

Problemfelder im klinischen Alltag

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Frau B., 72 jährig, wurde nach Sturz notfallmässig an der Hüfte operiert und sollte postoperativ als Prophylaxe von Druckstellen und Pneumonie zwei-, bis dreimal täglich aus dem Bett mobilisiert werden. Weil sie sehr unsicher und schwindelanfällig ist, reicht eine Person für die Mobilisation nicht. Frau B. wird immer weniger mobilisiert und als sie die Pflegende darauf anspricht, sagt diese: «Ich habe jetzt im Moment absolut keine Zeit für Sie. Einfach keine Zeit.» Für sich denkt die Pflegende: «…und da habe ich gedacht: was bist Du für eine Person, dass Du jetzt eine Patientin einfach im Bett liegen lässt. Das ist ethisch einfach nicht vertretbar. Wenn die Frau jetzt eine Lungenentzündung bekommt, weil ich sie hab' liegenlassen… Aber es ist nicht anders gegangen. Da gehe ich so unzufrieden heim und denke, ich bin nie so gewesen. Und ich habe gedacht, ich habe mit Freuden den Beruf vor vielen Jahren gelernt und heute bin ich soweit.…»

Die 93-jährige Frau V. S. wurde einem Zentrumsspital zugewiesen wegen Brustschmerzen. Sie bekam eine Koronarografie, welche keine wesentliche Pathologie an den Herzkranzgefässen zeigte, und die Brustschmerzen wurden als «atypisch» beurteilt. Wegen eines AV-Blocks zweiten Grades wurde ein Herzschrittmacher implantiert. Dabei kam es zu Komplikationen, welche eine Eröffnung des Brustraumes erforderte (Thorakotomie). Nur drei Tage nach Entlassung aus der Intensivstation wurde die 93-jährige Frau «wegen Bettenmangels» aus dem Spital nach Hause entlassen. Einige Tage später wurde sie vom Hausarzt einer anderen Klinik wieder zugewiesen wegen Schmerzen im Bereiche der Brustnarbe und völliger Entkräftung.

(aus: Positionspapier der SAMW, 2014)

Problemfelder im klinischen Alltag

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PERSPECTIVE

Money and the Changing Culture of Medicine

Pamela Hartzband, M.D., and Jerome Groopman, M.D.

N Engl J Med 2009; 360:101-103 | January 8, 2009 | DOI: 10.1056/NEJMp0806369

Many physicians are so alienated and angered by the relentless pricing of their day that they wind up having no desire to do more than the minimum required for the financial bottom line.

Problemfelder im klinischen Alltag

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Das „Triple Aim“: **Integration** der drei Parameter Kosten, Qualität, Fairness

Improve patient experience of care

Reducing the per capita cost of health care

Improve health of populations

http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

Zwischenfazit

- Kostenbewusstsein und *good stewardship* für knappe Ressourcen sind moralisch gefordert.
- Doch wenn ökonomische Erwägungen dominieren, können Versorgungsqualität und –gerechtigkeit beeinträchtigt werden *(triple aim* verfehlt).
- Früherkennung möglicher negativer Auswirkungen ist die Voraussetzungen für Korrekturen (“lernende Systeme”).
- Die Wahrnehmung von ÄrztInnen (und Angehörigen anderer Gesundheitsberufe) kann als “sentinel” für Veränderungen dienen.

Assessing the **I**mpact of **D**RGs **o**n Patient **C**are and Professional Practice

Universität Zürich

Overall rationale for the IDoC project (Sinergia grant by Swiss National Science Foundation, 2011-13)

The Swiss health care system introduced in 2012 a new method of reimbursing hospitals for inpatient care, the diagnosis-based model (SwissDRGs).

DRGs intend to set an incentive to operate cost-efficiently. This might lead to compromises in quality and fairness of healthcare delivery, whereas the effects on cost containment are uncertain.

The IDoC project analyses patient care and professional practice before and shortly after the introduction of SwissDRG. It also aims at developing methodological tools for use in monitoring the effects of DRGs on a longer-term basis.

Die IDoC-Studie (SpA)

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1. A quantitative and qualitative analysis of the ethical issues - following the introduction of the DRGs - as perceived by physicians.
2. A qualitative analysis of the legal aspects and the perceptions by experts and hospital managers.
3. A quantitative analysis of the impact of the DRG payment system on the nursing service.
4. An analysis of the impact of the system on treatment of patients with acute myocardial infarction.
5. Development and refinement of indicators measuring the impact on patient safety.

IDoC: Ethical issues and their perception by physician

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Impact of Diagnosis Related Groups (DRGs)
on patient care and professional practice (IDoC)

Subproject A

DRGs and changes in health care: an analysis of the ethical issues and their perception by physicians

Prof. Dr. med. Dr. phil. Nikola Biller-Andorno
Dr. med. Verina Wild
Dr. med. Margrit Fässler
Caroline Clarinval, MPH

Description of study sample

- Random sample of all physicians working with inpatients in Swiss hospitals
- 1048 postal addresses were pulled from the register of the Swiss Medical Association (FMH)
- Exclusions:
  - Invalid addresses (27)
  - psychiatrists and physicians working in outpatient clinics (different reimbursement system), pathologists and physicians working in laboratories (usually not directly involved with patients) (194)
  - affiliated physicians (‘Belegärzte’) (not employed by the hospitals, have specific contracts bearing different potential conflicts of interest than the employed physicians) (9)
- **Response rate:** response rate 47%

Description of study sample (2)

Table 1: Demographic data		
Age	mean ± SD	37.5 ± 8.8 years
Years of clinical activity as a physician	mean ± SD	10.0 ± 7.7 years
Years worked in hospitals in which services were (at least in part) billed according to DRGs	mean ± SD	4.1 ± 3.8 years
Gender		
Male		55%
Female		45%
Most prevalent specialties		
Internal medicine specialties		30%
Surgical specialties		23%
Anaesthesiology		12%

Description of study sample (2)

Table 1: Demographic data (continuation)	
Position	
Assistant physician / resident	46%
Senior physician / fellow	33%
Chief physician or head of department	20%
Other	1%
Hospital	
Public	85%
Privately owned	11%
Unknown	4%

Questionnaire

- 16 simple or multi-unit questions
- German and French version
- 5 parts:

(A) personal data
(B) working environment and future perspectives
(C) economic pressures in everyday clinical work
(D) increased focus on efficiency
(E) physicians' moral standards

B. Working environment and future perspectives

Quality of patient care in their department

- 32% very good
- 60% good
- 6% poor
- 2% very poor
- 1% did not know

B. Working environment and future perspectives

Job satisfaction in the last six months

- 24% very satisfied
- 59% satisfied
- 15% dissatisfied
- 2% very dissatisfied

82% of those who were dissatisfied or very dissatisfied with their present working conditions were currently considering changing their job or reducing their hours at the hospital because of their dissatisfaction, 12% were not, and 6% did not know.

B. Working environment and future perspectives

Improvement of job satisfaction since January 2012 because of the DRG-based hospital financing

- 0% improved
- 56% unchanged
- 29% a decrease
- 15% did not feel qualified to make a statement

B. Working environment and future perspectives

Table 2: Changes in time allocation for certain activities since the introduction of SwissDRG in 2012

	Significantly less	Less	Equal	More	Significantly more	Don't know	P value*
Time for administrative tasks	1%	2%	36%	32%	20%	9%	p<0.0001
Time for communication within the care team	2%	15%	67%	5%	1%	9%	p<0.0001
Time for communication with patients and relatives	4%	21%	64%	2%	0%	9%	p<0.0001
Time for own training / education	5%	22%	63%	1%	1%	9%	p<0.0001
Time for training of young colleagues	5%	23%	60%	0%	1%	11%	p<0.0001
Overtime	1%	1%	53%	28%	8%	10%	p<0.0001

* Binomial test of the overall direction of changes in time allocation

C. Economic pressures in everyday clinical work

Table 3: Economic pressure in everyday clinical work

		How often have you experienced this situation in the last 6 months in your hospital?					
Situations in everyday clinical work	**Currently I sense pressure in this respect**	At least once a day	At least once a week	At least once a month	Less than once a month	Never	Question does not apply to me
(1) A **measure useful to the patient** was **not executed because of cost-related reasons**, or substituted by a less expensive and also less effective medical procedure.	**18%**	3%	17%	17%	27%	36%	-
(2) For a patient with various diagnostic and therapeutic options**, a riskier option was chosen** for cost reasons.	**5%**	1%	4%	5%	14%	65%	11%
(3) A **medical procedure** was applied for economic reasons **although it was not medically necessary.**	**8%**	5%	10%	15%	19%	52%	-

C. Economic pressures in everyday clinical work

Table 3: Economic pressure in everyday clinical work (continuation)

		How often have you experienced this situation in the last 6 months in your hospital?					
Situations in everyday clinical work	**Currently I sense pressure in this respect**	At least once a day	At least once a week	At least once a month	Less than once a month	Never	Question does not apply to me
(4) I decide for or against a medical intervention because **management urged me to for economic reasons**. If I could have decided in the interest of the patient, I would have chosen a different medical procedure.	**14%**	3%	11%	17%	18%	44%	7%
(5) **I attend to more patients** than I am able to with due care .	**14%**	11%	19%	18%	19%	34%	-
(6) **Certain patients are not admitted to the hospital because** they represent a **financial risk** (e.g. multimorbid patients; patients with a less lucrative DRG).	**7%**	1%	3%	4%	12%	65%	13%
(7) **Patients are discharged too early** due to DRG-limited length of stay.	**12%**	4%	13%	14%	19%	36%	13%

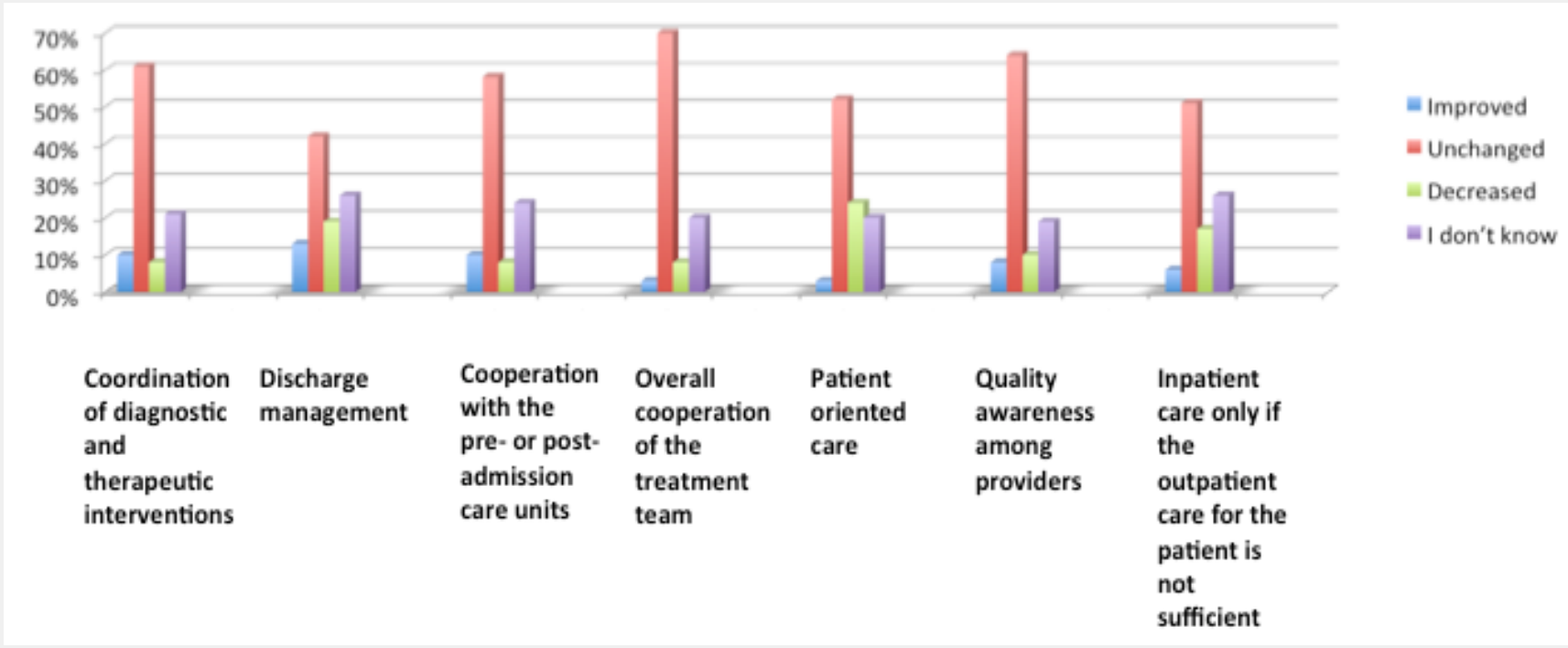
C. Economic pressures in everyday clinical work

Universität Zürich

Table 3: Economic pressure in everyday clinical work (continuation)

		How often have you experienced this situation in the last 6 months in your hospital?					
Situations in everyday clinical work	**Currently I sense pressure in this respect**	At least once a day	At least once a week	At least once a month	Less than once a month	Never	Question does not apply to me
(8) **Patients are not discharged** although it would be medically justifiable, as the minimum length of stay has not yet been reached.	**11%**	6%	15%	13%	16%	35%	15%
(9) To increase reimbursement, patients are **admitted to hospital although** a **treatment as outpatients** would be **appropriate**.	**12%**	4%	14%	14%	16%	36%	14%
(10) For economic reasons, patients are **admitted more than once**, for a treatment that could have been completed in the first stay.	**8%**	2%	7%	15%	17%	40%	17%

D. Increased focus on efficiency



E. Physicians' moral standards

Table 5: Moral principles for physicians – relevance and realisability [percentages]

Principals	Relevance				Feasibility			
	Very impor-tant	Impor-tant	Less impor-tant	Unim-portant	Easily realis-able	Reali-sable with limita-tions	Difficult to realise	Com-pletely unrea-lisable
A) The health status of the patient is top priority for a physician's action.	**87%**	12%	1%	0%	**38%**	56%	5%	2%
B) As a physician I treat my patients according to the highest current medical standards.	**82%**	16%	2%	0%	**41%**	53%	5%	1%
C) As a physician I take sufficient time to build a good relationship with my patients and take their psychosocial condition into account.	64%	31%	4%	1%	14%	51%	31%	4%
D) As a physician I am able to make independent decisions regarding the type and extent of services I offer to the patient based on medical criteria.	51%	45%	5%	0%	23%	61%	14%	3%

E. Physicians' moral standards

Table 5: Moral principles for physicians – relevance and realisability (continuation) [percentages]

Principals	Relevance				Feasibility			
	Very impor-tant	Impor-tant	Less impor-tant	Unim-portant	Easily realis-able	Reali-sable with limita-tions	Difficult to realise	Com-pletely unrea-lisable
E) As a physician I strive for cost-effective treatment so that everyone can receive medical care.	33%	53%	14%	0%	15%	65%	18%	2%
F) As a physician I inquire about and respect the will of the patients.	**85%**	14%	1%	0%	**51%**	44%	5%	1%
G) As a physician I treat all my patients with equal diligence.	81%	17%	2%	0%	44%	47%	7%	2%
H) As a physician I am committed to good cooperation between all medical professions in patient care.	58%	37%	5%	0%	20%	64%	15%	2%

The total percentage may not equal 100 due to rounding.

E. Physicians' moral standards

Patient interest vs. economic considerations

Question: Various considerations play a role in the decisions you make during your everyday clinical work. On one hand you strive to achieve the best possible medical outcome for your patients and, on the other, you try to consider the economic interests of your department.
Please estimate the relative weight of your considerations.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Consider the economic interests of the hospital

Consider the patient's interests and well-being

In my current job: Mean value 5,5 (SD 2,4)

In my ideal situation: Mean value 7,7 (SD 1,8)

Conclusions of study

- General quality of patient care is perceived to be good or rather good and despite financial pressure, work satisfaction is (still) high
- A significant number of physicians have experienced situations in the recent past that indicate important impairments to quality and equity of patient care for cost-reasons.
- Physicians put more weight on economic considerations (vs. wellbeing of their patient) than they would like.
- Findings challenge the declared goals of SwissDRG to discourage unnecessary care and to promote an overall increase in efficiency of health care services

Mögliche Ansatzpunkte für die Integration medizinischer und ökonomischer Ziele

Universität Zürich

Rahmenbedingungen für „ethical incentives“

- an institution whose tradition, culture, and **mission** health care professionals can identify with;
- a climate of respectful social interactions that allows physicians to **uphold their professional standards and their sense of moral responsibility**;
- transparency about institutional aims and the way they are promoted;
- a **proactive attitude toward monitoring effects of incentives on the quality and fairness of patient care and incentive-related conflicts of interests perceived by physicians**; and
- processes that encourage physicians and other stakeholders to **engage in the development of a shared purpose** and the continuous evaluation and revision of incentive schemes.

PERSPECTIVE

ETHICAL PHYSICIAN INCENTIVES

Ethical Physician Incentives — From Carrots and Sticks to Shared Purpose

Nikola Biller-Andorno, M.D., Ph.D., and Thomas H. Lee, M.D.

Mögliche Ansatzpunkte für die Integration medizinischer und ökonomischer Ziele

Universität Zürich

Empfehlungen

1. Aktiver Einbezug der Patienten
2. Schaffung einer Kultur, die Offenheit und kritische Reflexion fördert
3. Verbesserung der Vergütungs- und Anreizstrukturen
4. Verbesserung der bestehenden Zertifizierungsprozesse
5. Gezieltes Auswerten und Erheben von Daten

(aus: Positionspapier Medizin der SAMW, 2014)

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Vielen Dank für Ihre Aufmerksamkeit

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