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Original article

Introduction of the German case tariff fee system and its effects on patient satisfaction in inpatient naturopathy

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Abstract

Introduction: For certain indications, methods of classical naturopathy are now being used in German hospitals originally dedicated to the treatment of acute conditions using orthodox medicine. Because the hospital sector currently represents the focal point of German healthcare, both professionally and economically, the introduction of the German Diagnosis-Related Groups (G-DRG) acts as an important stimulus to the process of applying business management principles to the country's health service. Against this background, the present study examines effects on patient satisfaction as a quality indicator of medical and nursing care in the setting of providing inpatient complementary medical treatment.
Methods: Between 2004 and 2008, randomised, blinded interviews were performed of 4598 hospitalised patients receiving treatment in an acute clinic for internal medicine focusing on naturopathy. The aim of this survey was to analyse the satisfaction with the provision of inpatient naturopathic treatment in the context of the prevailing system of hospital financing.
Results: Neither for the professions providing medical services, nor for those providing nursing services, were any significant differences detected in patient satisfaction between the two groups of patients ($p > 0.05$).
Conclusion: Negative effects of a case tariff fee remuneration system on the doctor–nurse–patient relationship – which have been discussed and expected by some – could not be confirmed. The results of the survey allow the conclusion that the holistic care of patients can generate a considerable increase in patient satisfaction in the provision of inpatient services, even under the conditions of the DRG system.

Keywords: DRG; Holistic care; Patient satisfaction; Quality of care; Naturopathy

Introduction

The demand for naturopathic methods for treating disease has increased globally [1–5]. The areas of use and the efficacy of naturopathy in different diseases, and the demand for naturopathic treatment by the population in different countries, have been addressed by numerous studies [6–10].

The methods of complementary and alternative medicine (CAM) differ from the methods of classical naturopathy as practised in Western Europe. These differences are frequently related to the nature of the health system and continuing medical education [11].

Classical naturopathy encompasses dietetic treatment, hydrotherapy, phytotherapy, lifestyle regulative therapy and exercise therapy. These five pillars of the treatment process were developed by pastor Sebastian Kneipp towards the end of the 19th century. The Kneipp therapy (in contrast to many other alternative forms of therapy) does not claim to oppose orthodox medicine, but is intended to complement it. The extended scope of naturopathy includes detoxification methods and neural therapy.

The methods of CAM are frequently used in addition to conventional, orthodox medicine [12]. In Germany, classical naturopathy is also used in hospitals as a complement to orthodox medicine.

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Hospitals which integrate classical naturopathy into their orthodox medical treatment concept are rare in Germany.

Background

The case tariff fee system in Germany

The introduction of a performance oriented tariff fee price system on the basis of diagnosis related groups was implemented in Germany on 01.03.2003. The legal framework for this was laid down in the newly introduced §17b of the *Krankenhausfinanzierungsgesetzes* (*KHG*) (Hospital Remuneration Act). This obligated the self-governing bodies, the German Hospitals Association (*DKG*), the central associations of the statutory health insurance funds (*GKV*) and the association of private health insurance funds (*PKV*) to develop a standardised remuneration system for inpatient hospital services, that should be oriented on an internationally proven remuneration system on the basis of DRGs. Agreement was reached on the adoption of the Australian system, the "Australian Refined Diagnosis Related Groups (AR-DRG)". DRGs originated in the USA. In 1967, Robert Barclay Fetter and John Devereaux Thompson at Yale University started to develop a patient classification system [13]. Diagnosis related case groups (DRGs) are defined as "a patient classification system that in a clinically relevant and understandable way correlates the type and number of hospital cases treated with the hospital's use of resources" [14].

As a result of the changeover from the costs reimbursement principle to prospective, case oriented remuneration, the hospitals in Germany were encouraged to provide their services in a more business-like way with the objective of generating increasing rationalisation effects at a national level.

The intended outcome is a continual increase in the quality of the service provided, with simultaneous reduction in costs.

Diagnosis related groups designate an economic-medical classification system, with the benefits to patients on the basis of primary and secondary diagnoses for each treatment case. Each new recording of a patient in hospital, rehabilitation and care each defined a new case. The hospital expects the DRG from the health insurance company.

The key criteria for the assignment of the case to a diagnosis-related group are:

The main diagnosis (the main responsible for the hospitalization, often the underlying disease), procedures (surgery, intensive investigations), comorbidities and complications that significantly influence the course of treatment, ventilation time and patient-related factors such as age, sex of the patient or the birth or admission weight in premature infants, and length of stay and recording (Fig. 1).

Developments deriving from introduction of the DRG system

The introduction of a case tariff fee remuneration system for the inpatient sector in Germany is intended to achieve an improvement in quality and a more economical provision of care in every individual hospital as a response to the setting of competitive incentives. To that extent, the introduction of the G-DRG remuneration system is a means of achieving statutory targets, but without transferring an area previously regulated by the state into competition oriented market control.

The introduction of the DRG has brought changes in the working conditions of all those involved in the central process of providing services. Patients' hospitalisation times are shortened as a result of a case tariff fee system [15]. It is argued by some that the patients' shorter hospitalisation times and the growing number of patients must lead to an intensification of the workload. Results from studies of hospital nurses show an increase in assisting in medical activities and a decrease in direct involvement with the patient [16]. The increased demand for documentation of the services provided would also amplify this effect considerably. Less individual patient-oriented care could be the result. A further suspected effect of the G-DRG system is the temptation to ration services, since a fixed fee is paid for the service provided, independently of the use of individual resources. Shorter hospitalisation times can result in the patient being readmitted to hospital more often [17].

With regard to holistic treatment of elderly, especially multimorbid patients, criticism has been expressed at an inadequate reflection of these patients in the DRG system [18].

Many actors in the German health care system discuss other disadvantages of the introduction of DRGs:

They watched the problem of "upcoding" by unfair finished coding of secondary diagnoses to increase revenue. The goal of combating the rise in health care costs was not achieved with the introduction of the DRG.

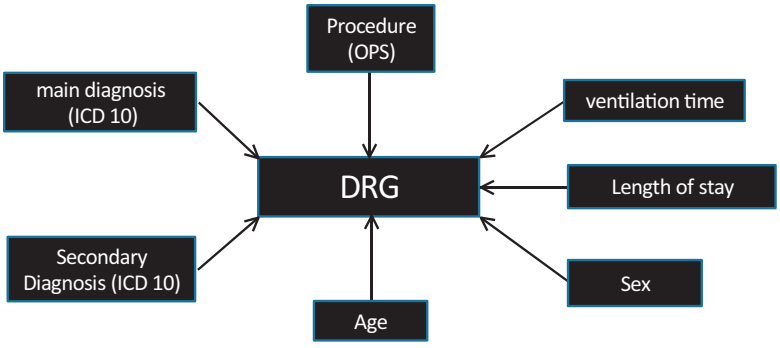

Fig. 1. G-DRG systematic.