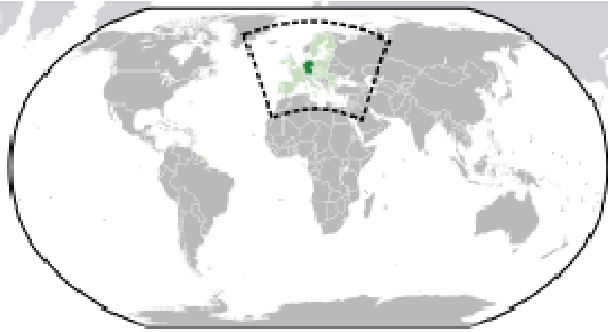


# The new national law in Germany and its implications

IFIC Congress, Venice, October 2011

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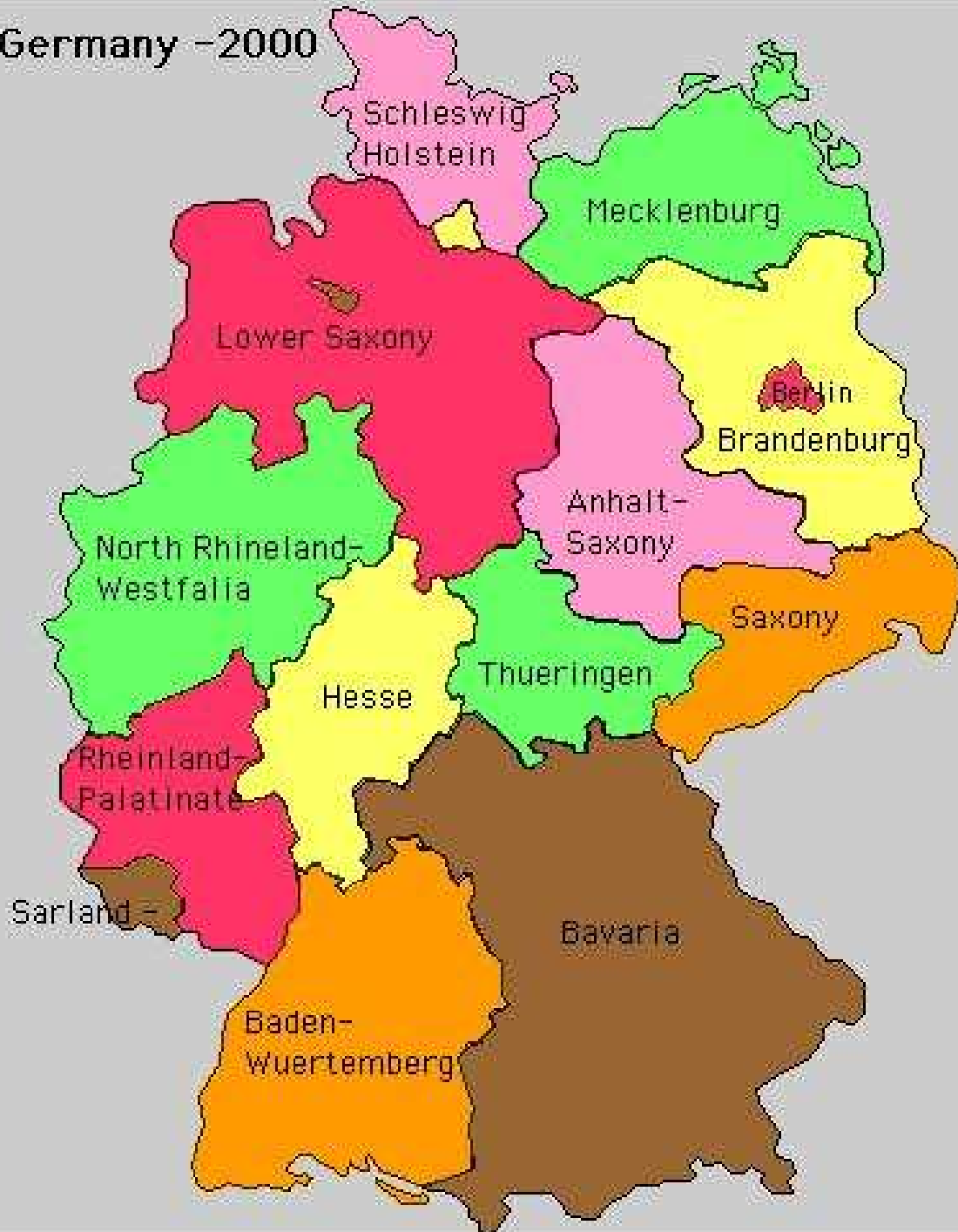


**Germany**

82 mio people.

2,000 hospitals.

## Germany - 2000



## Germany

16 federal states.

States have many duties in healthcare, e.g. legislation.



## Existing national law until 2011

Federal Plague Law since 50ies.

→ Infection Protection Act since 2001.

Robert Koch Institute (RKI):

- Make recommendations in hospital hygiene

  - Commission for Hospital Hygiene and Infection Prevention (KRINKO) since 1976, evidence based since around 10 years

  - Implementation not mandatory – e.g. MRSA isolation.

  - Also recommendations about staff in hospital hygiene – new in 2009.

- Define how nosocomial infections have to be counted and documented.

- Also bacteria with special resistance and multi-resistance.

Obligation to report certain diseases (n=15) to local state health department (→ RKI).

Also report outbreaks.

Regulations how to manage certain diseases by state health departments (isolation, quarantine, ...)

Regulations about school, water, kitchen hygiene.

Hygiene plan (written standards) in hospitals, rehabilitation, ambulant surgery, dialysis, delivery clinics.

Inspections by state health departments in these institutions.



## Additional regulations

### **Medical devices law** (Medizinproduktegesetz, MPG):

High standards for reprocessing of medical devices:  
Validation of washing desinfectors and autoclavs,  
Training for staff.

### **Social Code Book V** (SGB V):

Quality management in all hospitals.

### **Hospital laws** on state level, e.g. North Rhine Westfalia:

Each hospital needs an infection control (hygiene) commission,  
also fulltime infection control nurses

### Technical standards:

Reprocessing of medical devices (DIN EN).  
Water supply (DVGW, Federal Environment Agency).  
Air supply (DIN, VDI)



## Reality

**Infection control nurses** are working in nearly all hospitals:

Infection control nurse/bed ratio only in 4 states –

e.g. North Rhine Westfalia 1/400 beds.

2 years training.

Tendency to buy the knowledge from external services (better knowledge and more experience – less time available).

**Infection control doctors** only fulltime in university clinics.

All other hospitals only link doctors (5 day course).

**Infection control commission** in all hospitals.

Activity and quality of work varying very much.

Written infection control **standards (hygiene plan)** in all hospitals.

Quality varying.

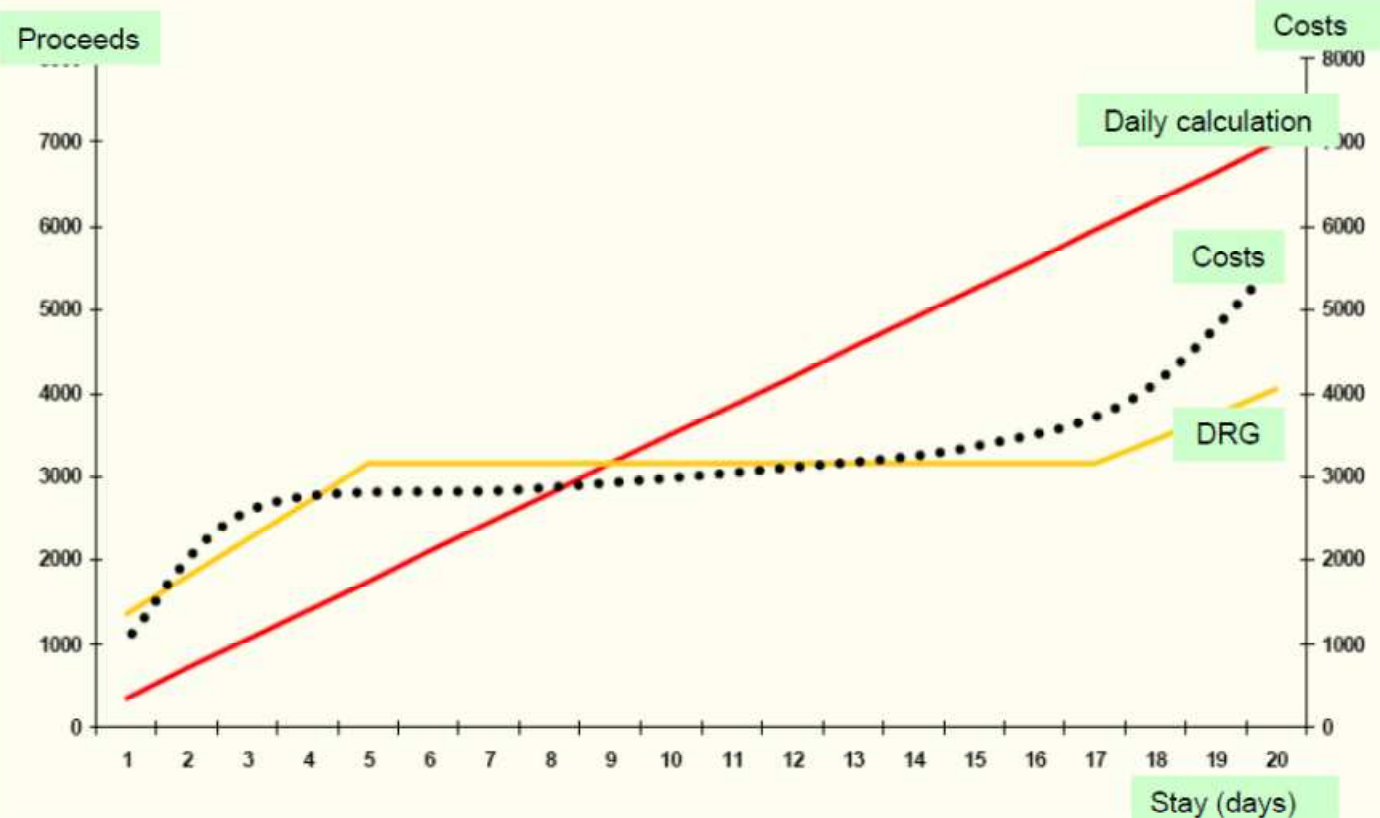


In 2000, financing of hospitals was completely changed to **DRGs (diagnoses related groups)**.

Hospitals must finance themselves.

Example: money for MRSA case 0 to 1,600 €

### Hospital proceeds: Daily calculation and DRG case rates



## **Federal Joint Committee (G-BA)**

Established in 2004.

Main decision making body in German health care.

Issues legally binding directives.

Represents organisations of physicians, hospitals, sickness funds and patients.

Evidence-based coverage decisions regarding innovations for outpatient and hospital care (which therapy, drugs... sickness funds have to pay for)

### **Quality directives according to Federal Joint Committee (G-BA)**

Quality reports of all hospitals every 2 years (mainly structure, most important DRGs).

External quality report every year, e.g. structure data, some mortality and infection data on federal mean level.

Minimum rates for treatment, e.g.

Liver transplantation: 20

Bone marrow transplantation: 25

Neonatology regulations.



## **2011: Infection Protection Act changed - a**

Additionally to the Hospital Hygiene Commission (KRINKO) at the Robert Koch Institute (RKI), another RKI commission on Anti-infectives, Resistance and Therapy (ART) will be established to create general principles for diagnosis and antimicrobial therapy.

Hospitals are forced to work according to the recommendations of both commissions.

The recommendations of both committees must be constantly updated according to the scientific findings.

Hospitals and facilities for outpatient surgery have to document the consumption of antibiotics.

Practicing physicians will get money for screening and decontamination of patients with MRSA.



## **2011: Infection Protection Act changed - b**

The federal states have to make their own legislation based on the new hygiene regulations by the end of March 2012.

Hospitals have to employ a fulltime hygiene doctor if they have more than 400 beds.

Hospitals have to employ a fulltime hospital hygiene nurse for every 150-200 beds (very complicated way to determine, depending on risks for patients).

This means a doubling of the currently employed hygiene professionals.

The quality of reports of hospitals now have to be provided annually.

The Federal Joint Committee (G-BA) is to define indicators for measuring the hygienic quality, which serve as benchmark for hospitals and should be included in the quality reports.



## Hygiene staff

Hygiene doctor (specialisation) fulltime over 400 beds.  
5 years training.

Perhaps some reduced specialisation or transitional solution.

Hygiene nurse per 150-200 beds.  
2 years training.

Link doctor per department.  
40 hours training.

Link nurse per ward and functional area.  
40 hours training.



## Conclusions

Big step for hospital hygiene.

Will lead to a massive upgrading of hygiene.

Effect of the Commission ART remains to be seen.

KRINKO recommendations have to be implemented.

Management is responsible.

Increased responsibilities for documentation, evaluation and implementation (eg infection rates, antibiotic use).

More hygiene staff.

Assessment of external staff unclear.

Adaption of federal states' regulations.

More patients will go to court.

Quality parameters of G-BA remain to be seen.

Effect of the MRSA billing remains to be seen.

