Appendix 2: Expert interview 1

Which operations do you perform on an outpatient basis (the 5-10 most frequent/important)?

We have different specialties here, neurosurgery, we have eyes, we have ENT, we have orthopaedics, we have gynaecology, we have urology and we have vein surgery. Those are our main specialties. The main procedures are: Disc surgery, spinal stenosis for neurosurgery. Cataract surgery for the eyes. For ENT, adenotomies and nasal operations. For orthopaedics arthroscopies knee and cruciate ligaments and shoulders. For gynaecology keyhole surgery uterus, fallopian tubes, what belongs to it and hysteroscopies. For urology, bladder operations and prostate operations, then vein surgery, it's clear that it's only the veins. That's roughly what our spectrum is about.

What is the approximate ratio of outpatient to inpatient interventions?

At the moment 55% outpatient and 45% inpatient.

What is the development in this area? Which type of surgery is gaining in case numbers?

More outpatient interventions are currently being performed because politicians and health insurers want to avoid inpatient interventions as much as possible. So more is being done on an outpatient basis.

What are the crucial differences between inpatient and outpatient surgery? How do the procedures differ?

Some go home from the recovery room and others go to the ward. There is no difference in the procedures themselves. The difference is simply that inpatient procedures are usually more complex and cannot be done on an outpatient basis. Of course, an intervertebral disc operation is different from a small adenotomy for small children. The size and duration of inpatient procedures is usually longer and more complex, and the procedure is larger. The procedures themselves are the same, some can change in the room, others in the changing room. Some lie in the beds in the recovery room and then go to the ward, others lie on the couches, then change and go home. Otherwise, there is not much difference in the procedure.

A large cost item for inpatient interventions are the ward costs, what percentage of the average ward costs are still incurred for outpatient operations (with pre- and post-operative care or similar) [estimate]?

There is nothing more to do. In principle, the patient goes to the doctor's surgery, let's say the ENT doctor, and then afterwards he goes to the anaesthetist and that is the same for both. Then it comes to the operation, one goes to the ward and the other to the waiting room, then they are picked up, come to the operating theatre, are operated on, then both go to the recovery room and when one goes home, the other goes to the ward and then the ward costs are incurred, the sterilisation costs are also the same. There are no costs that you could somehow push onto the inpatient track.

What cost points arise with outpatient interventions that may not exist with inpatient interventions?

There is always the question of who pays the costs, e.g. for taxi costs. If they are outpatients, then occasionally, if they don't have an escort or something similar, then the health insurance pays for the patient transport. With in-patients who are there for a few days, that is rather rare. Outpatients get a prescription afterwards, so there are no additional costs. Otherwise there is nothing. Outpatient procedures are simply much cheaper and there is nothing that makes them more expensive.

Which operators offer the most operating theatre capacity? (Hospitals, operating centres,...?)

I don't know. It depends on what you mean by outpatient, if I take the dentists, that is also an outpatient unit. Then there are many small surgeons who provide your surgeries, the hospitals could do a lot on an outpatient basis. I can't say any closer than that. Up to now, it was the case that the general practitioners operated much more, now the hospitals are slowly catching up because they have to.

How strong is the competition between these providers? (pricing policy; offers...)/What is the relationship between the providers?

Depending on who you ask, it varies a lot, of course. The competitive situation is already strong, but it varies depending on the city or area. In some cities there is only one surgery centre and in others, for example, there are five or six, including inpatient units, so the competition is much greater. That is totally different. Of course, the pricing policy makes a difference; the hospitals partly subsidise their outpatient surgeries through the inpatient surgeries.

This is an unfair competitive advantage. They can make the rooms available to other surgeons at low prices in the hope that the inpatients will then stay with them and they will make a profit. A purely ambulatory surgery centre cannot do that, because they have to keep their centre alive from the income of the health insurance funds and private patients, and that is almost impossible with the prices. Some have already gone bankrupt because it is hardly possible to finance it from the statutory amount. If you don't have enough private patients, it's over anyway. Then, of course, there are those who go for "dumping prices" in order to contribute at least something to their contribution margin and there is a lot of competition because the surgeons naturally like to go where it is cheapest. In the case of the same services, e.g. purely anaesthesia-operated rooms, the surgeon tends to go where it is cheapest.

What is the average utilisation of the OP capacities without the rentals?/with the rentals?

The occupancy rate is about 75%, although we have fewer external surgeons, so I can't separate that now. It also depends on the time, in summer it's less, in winter it's more, because of course people don't have surgery on holiday.

What are the most important/biggest costs of performing an operation? (What are the costs of the entire operating room provided during an operation?)

We distribute all costs incurred via a cost pool, there are others who cross-subsidise this in a certain way, for example the material costs are borne by the practice, this is not allocated to the OR, or staff are taken from the practice, for example, and thus do not go into the OR cost accounting, these are things that make the whole thing wrong. So it is quite difficult to get realistic costs. In terms of real costs, if I take everything, that would be rent, materials (from clothes, to other materials), the normal incidental rental costs like heating etc. and of course staff costs. It is also important whether the "steri" is outsourced or whether it is an internal one, that makes a difference. As far as rental costs are concerned, it depends on whether the operating theatre is completely rented out, i.e. as a "finished" operating theatre, or whether it is a shell of a building for which you have paid for the furnishings yourself. One has higher investment costs, the other less, which makes the comparison more difficult. For us, the big costs are the rental costs, because we have large areas, and the personnel costs. The electricity costs are also huge.

What criteria/standards are currently used to calculate the rent for the operating theatre capacities? Which costs are used for this?

We put all the costs that we can record into one pot, then we divide them by the anaesthesia minutes. In the end, we divide the fixed costs that we have defined according to the slots, where everyone contributes their share, and the variable costs are then reallocated to the number of operations. We have to distinguish between whether operations are performed only once in a period and thus cleaning and clothing etc. are only incurred once, or whether operations are performed several times in the same period. We have a common operating theatre and have to bear the costs, so you can't negotiate much, but in the end the rents are as high as the surgeons are willing to pay. You can always assume that if I take in outside tenants, it won't cover costs, it's usually just a contribution margin that I have, but not necessarily cost-covering. That is also a question of how the market presents itself, which is more difficult in big cities than elsewhere. Otherwise I can't tell you much more about it. In our surgery centre, the costs are simply shared and outside tenants who come from outside negotiate. They won't accept anything below a certain price, so I need at least the variable costs and a little bit about the fixed costs.

What are the most common forms of rent? (e.g. rent per OR type; rent per OR minute; rent for fixed time slots...etc.)

They either go by the minute, then there are some where you can rent slots, so either the morning or the afternoon. Then it depends on whether it's the surgeon or the anaesthetist, how it's divided up is totally different. In the hospitals it is sometimes the case that you simply pay a rental price per patient to make the whole thing as simple as possible, some hospitals do it by the hour. These are the most common forms I know.

Why are operating theatre rooms rented out? Apart from the economic aspect, what are the motivations for facilities to rent out operating theatre capacities?

Hospitals naturally want a "win-win situation", if the outpatients are with them and find it good, then they also go there for inpatient treatment or they have a deal with the surgeon, if you can't do it as an outpatient, then you send them to me, i.e. referring patients is an important point and to pick up patients who have to be operated on as inpatients. And otherwise, as I already said, to increase the contribution margin.

What influence does the motivation of renting have on the amount/type of rent?

Hospitals rent cheaply, very cheaply in part to acquire additional patients for themselves, the is the subsidy, from from the stationary sector, which distorts competition.

Which form of rent do you see as the most sensible/practical?

It depends on which system I use, if it's a privately run operating centre, I'm solely responsible as an anaesthetist. It certainly makes sense to rent out time, the best way would be to do it in such a way that if I work five days, then I have ten slots and the best thing is that I have rented out all ten of them and have my fixed costs in there. But that varies from case to case.

What do you see as the most important challenges in the health market at the moment?

The main challenge is to enable competition. There must be a

There must be "equality of arms" between hospitals and outpatient clinics, and prices must not be kept low through cross-subsidisation of inpatient services, but rather more adequate prices must be paid for interventions. These are the most important challenges and this also answers the last question.

What do you see as the most important changes/developments in the outpatient sector at the moment?

There will always be more outpatient care, beds are to be cut. The hospitals are trying to do as much inpatient care as possible. In the end, the free economy and the interests of the state institutions, which want to continue to operate their hospitals, are at odds here.

Appendix 3: Expert interview 2

Which operations do you perform on an outpatient basis (the 5-10 most frequent/important)?

Normal arthroscopy of the knee joint, followed by carpal tunnel syndrome operations, foot operations, then will come proportionately the cruciate ligaments, then shoulder operations, then such trifles as nerve displacement at the elbow joint, hand operations and then the normal minor surgery such as removal of bursa, etc.

What is the approximate ratio of outpatient to inpatient interventions?

I would say 3:1. We ourselves also operate on private patients as inpatients, but we are not included in the bed requirement plan, so we cannot operate on patients covered by the health insurance system; we operate on them in a clinic with which we have contracts for affiliated doctors on a consultative basis. But with a ratio of 3:1, that's about right.

What is the development in this area? Which type of surgery is gaining in case numbers?

The development is disappointing, I have been doing this for 17 years, at that time politicians always said "outpatient before inpatient" because that is cheaper, you may have heard that before, that is always politically advocated, but never implemented in reality. My personal opinion is that there was pressure from the health insurance funds, who know that outpatient care is cheaper, but this means that the beds are empty, and the German Hospital Association and the municipal providers in particular were of course able to put a lot of pressure on the politicians, and if someone sees that the municipal hospital is not doing well, they will make sure that not too much outpatient care is provided. The outpatient sector is not run by municipal hospitals. At the moment, I see more of a development towards the hospitals, i.e. that the hospitals are trying to penetrate more into the outpatient sector, but they are not really succeeding because of the cumbersome structures. The effectiveness in a private institution is much higher, private in the sense of private providers like us. This is a development that is also politically desired in hospitals, but at present the majority of outpatient operations are performed in centres. The outpatient form of surgery will already win, because the influence of the health insurance companies is also great, that they say "this or that operation will no longer be reimbursed as an inpatient. There are catalogues that say what is inpatient and what is outpatient. Which also leads to a lot of irritation when we say

"We don't do that as an inpatient". The insurance companies have a double standard, in our case they simply say "no, we don't do that", but if it's a large maximum-care hospital, they don't look at it that way. The development is moving, albeit very slowly, in the direction that inpatient care is no longer promoted to such an extent. **What are the decisive differences between inpatient and outpatient surgery? How do the procedures differ?**

The operations themselves are no different. Whether I operate on a cruciate ligament as an outpatient or as an inpatient is completely uninteresting at the moment when I stand at the patient's side and cut into the ligament. At the moment when I operate, it doesn't

matter at all. Whether the patient goes home after three hours or stays in the hospital for 2 days.

Clinic remains. For both procedures, the patient has to be seen by the anaesthetist as an outpatient beforehand, and there is also no longer this "admission one day beforehand"; patients come in the morning even for inpatient procedures. The only difference is in the follow-up treatment.

A large cost item for inpatient interventions are the ward costs, what percentage of the average ward costs are still incurred for outpatient operations (with pre and post care or similar) [estimate]?

Ward costs are, in the sense of hotel services, which of course do not apply. The DRG is much higher than the outpatient remuneration because the DRG includes the entire infrastructure of a hospital. It is difficult to say because it depends on what exactly is being operated on. In the case of medium-sized orthopaedic operations, foot, shoulder, cruciate ligament, the pure operation costs are only a quarter as high, the whole rest goes on the DRG. In the case of pre- and post-operative care, it also depends on what is done. For example, changing a bandage is not a significant cost factor and is covered by the outpatient remuneration anyway.

What cost points arise with outpatient interventions that may not exist with inpatient interventions?

Implants are always such a story when you do a cruciate ligament that you have implants for a few hundred euros, which we also get reimbursed for, depending on the federal state. If you do it as an inpatient, the implants are covered by the DRG. In the outpatient sector, I can bill the implants separately and get paid for them. In the inpatient sector, I can save on the implants, the DRG remains the same, in the outpatient sector I can basically install whatever I want, because I get paid for it separately.

Which operators offer the most operating theatre capacity? (Hospitals, operating centres,...?)

These are still operating centres, because there are hospitals that have also started this, have an outpatient operating theatre that is not profitable, they cannot get these operations into the black. They are subject to such high quality controls and such a cumbersome system that they can't manage it sensibly, which is why some have already closed their outpatient operating theatres again, and for others not much is happening. So currently most outpatient operating theatre capacities are at operating centres and most are run by anaesthetists or larger centres.

How strong is the competition between these providers? (pricing policy; offers...)/What is the relationship between the providers?

There is already a competitive situation between hospitals and private practices or freelancers. Some of them are also limited companies, the operating centres. People are already taking people away from each other. The hospitals are constantly working with "dumping prices", because of course they cross-subsidise. They just want to have the people, but even more is the issue of MVZs and buying seats, that's a very hot story. I can only say it from here, basically we don't have a bad relationship, we are a healthy competition, elsewhere there is war, I know that too. It varies greatly from region to region and always depends on how the stationary provider is represented on the market. If it's a municipal provider, if it's a private clinic, it varies greatly.

What is the average utilisation of the OP capacities without the rentals?/with the rentals?

We have about 40% occupancy without rentals and with rentals I would say about 80-90%.

What are the most important/biggest costs of performing an operation? (What are the costs of the entire operating room provided during an operation?)

Of course, this is also difficult because the operations are so different. There are operations with very expensive anchor systems, for example, or with the cruciate ligament the implant costs are significantly higher than the fee for the operation. With such operations, this is the biggest factor, with others it makes almost no difference at all. If you take the implant costs out of it, then for us it is a large proportion of rent and energy costs and depreciation. We have high investment costs for such an operating centre and there are, for example, air-conditioning systems that have to run day and night so that they don't get germs, and you wouldn't believe how much energy costs are involved if the capacity utilisation is low in the summer. Staff is actually not such a big item, especially we rent out the OP without staff, they just come and use the premises. Depreciation, energy, rent, I think those are the biggest items. **What criteria/standards are currently used to calculate the rent for the operating theatre capacity? What costs are used for this?**

Compared to the normal economy, where business economists look exactly to the cent what costs them what, it has been a problem in medicine for years that it is often not possible for us to penetrate what the operating theatre time costs us. That is, one takes a very rough estimate,

What have we invested, what will it cost over 10 years, what are the ancillary costs, that is what is taken into account. Then you determine the amount of rent. Staff is only added if they need it, they usually come and have their entire staff with them. Instruments are also something like that, if someone needs our instruments, we also have to make a surcharge. But there is no business calculation for that. It's a lot of gut feeling and "by the thumb", because we are simply doctors and not business economists.

What are the most common forms of rent? (e.g. rent per OR type; rent per OR minute; rent for fixed time slots...etc.)

There are basically two, depending on whether one works in EBM or whether it is a purely private service, such as plastic surgeons. The problem is, of course, that with EBM the revenues often fluctuate. If you now make a fixed price for a surgeon who largely does SHI patients, then the risk of this fluctuation is with the surgeon and if he has a fixed contract, it can really cost him something. That's why we are moving towards this, because there is a certain constancy, and for most of them we make a share of the fee. For those who only do private things or only have special contracts, e.g. ophthalmologists, we simply take an hourly rate. "You occupy the operating theatre from then until then and it costs you X amount". We have actually abandoned these "cut-suture times" because then we cannot say how long they will occupy the operating theatre. But there is the big time expenditure of the change, i.e. the patient has to wake up again, is taken out, the anaesthetist has to say goodbye, the next patient is taken in, etc., which would all be unpaid time, although we rent out the operating theatre. That's why we said it doesn't matter what they do in that time. That is the safest calculation for us. With these

The risk on our side would be too high for "cut-suture times". We take about 10-20% of the GOÄ for private patients.

Why are operating theatre rooms rented out? Apart from the economic aspect, what are the motivations for facilities to rent out operating theatre capacities?

I said we are not business economists, but we also want to earn money. Besides that, of course, we want to establish a foothold on the market, which means that when completely different specialities come to us, they all walk through our practice. They get to know us, especially the ophthalmologists make a very high frequency. I think we have already gained a lot of patients because of this, where relatives, for example, also walk through our practice. In addition, the doctors also tell each other that they can have an operation with us.

What influence does the motivation of the tenant have on the amount/type of rent?

Of course, if we get a "big player" who brings a lot of patients, then we would be a bit more accommodating in the rent.

Which form of rental do you see as the most sensible/practical?

The most reasonable is the OP time when the OP is used.

***What do you see as the most important challenges in the health care market at the moment? An** important challenge or danger is the slow erosion of the principle of benefits in kind, that the SHI pays everyone the same. The SHI funds throw money into a black hole, into the SHI fund, and the SHI fund distributes it over everyone and the SHI funds basically don't know what comes out of it and what the quality is like. I think one challenge is "pay-for-performance", that in the future people will really look at who does what and how well. It will perhaps increase that health insurance companies will make individual contracts with certain specialists and send more patients directly to certain doctors. I think the organisational aspects will be so great that individual practices will have no chance of survival. I see this as a new challenge, that there will also be new remuneration systems.*

What do you see as the most important changes/developments in the outpatient sector at the moment?

I think I answered the last two questions in one. Well, and the challenge is, of course, that when we have new legal quality requirements, that never flows into the fee. If there are new requirements, the hospitals can solve that more easily through local politics, we only have our fees with which we have to solve new investments. One problem, also for young doctors, is that hospitals buy doctors' practices to strengthen their market position. This cross-subsidisation from the outpatient sector to the inpatient sector is an insane problem.

Appendix 4: Expert interview 3

Which operations do you perform on an outpatient basis (the 5-10 most frequent/important)?

We make hernias, metal removal, hand surgery, knee arthroscopy, so a rather broad spectrum without vascular surgery and no proctology. In the meantime, more or less everything that can be done is done on an outpatient basis.

The criteria for outpatient operations are not the operations, but the patient. I could tell you the most frequent ones in the field of surgery; I have current statistics from the KBV. The most common are dermatosurgery, followed by varicose vein surgery, then various forms of arthroscopy. Then there are various smaller procedures on the musculoskeletal system, such as metal removal and removal of tumours, hand surgery, tendon sheath procedures, so the spectrum is relatively wide. The statistics are relatively difficult to evaluate because different groups are evaluated according to different fee schedules, according to EBM and OPS.

What is the approximate ratio of outpatient to inpatient interventions?

We do not perform any inpatient procedures, so it is 100% outpatient. If you now draw the question in general, in Germany, then it is difficult to answer because there is no reliable data on inpatient interventions. But there are general statistics worldwide, according to which in the Federal Republic of Germany 30-40% of outpatient procedures are actually performed on an outpatient basis and 60% are still performed on an inpatient basis, which puts us in the lower midfield. In other countries, the situation is much different, with much more outpatient surgery. That always has something to do with the prevailing social insurance systems.

What is the development in this area? Which type of surgery is gaining in case numbers?

Stagnating in the outpatient panel doctor sector. The numbers have been stable for about ten years and practically do not change. This has something to do with the financing in this area.

What are the crucial differences between inpatient and outpatient surgery? How do the procedures differ?

The actual surgical procedure, i.e. the intervention itself, is identical. That would be fatal, because then we would produce differences in quality. The difference between outpatient and inpatient surgery is the patient selection. The patient must fulfil certain criteria according to which he can only be operated on as an outpatient; if he does not fulfil these criteria, then he must go as an inpatient. These are essentially concomitant diseases, but they are also social factors, for example, if he has no home care, then he can be as healthy as he wants, then he will not be operated on as an outpatient. That is the difference, the procedure itself is individually a matter for the departments themselves, it is not really different from inpatient. Preliminary examinations are necessary, an indication is required, an order management is necessary, when

the patient comes, is required, he is prepared in the same way as for inpatient surgery, he just goes home afterwards.

A large cost item for inpatient interventions are the ward costs, what percentage of the average ward costs are still incurred for outpatient operations (with pre- and post-operative care or similar) [estimate]?

You can simply calculate, you have the calculation according to InEK, if you take this calculation approach, then the surgical intervention as such is to be taken over 1:1. The ward costs in brackets are a patient stay of between two and four hours in our outpatient centre. In our case, the patient is then also treated as an inpatient, i.e. he ends up in a bed in some wake-up unit, receives nursing care and has four hours instead of four days. Otherwise the InEK calculation is a bit fuzzy, of course we have all the overhead costs just like in the hospital, that means we have all the pre- and post-operative care, the instrument preparation, it is not quite clear in the InEK calculation whether that is included in the surgical procedure. In addition, and this is no different in hospitals, we have the imputed changing times, on the one hand we have the criterion of the "incision-suture time", which is shorter for us than in hospitals, but we also have the criterion of the "suture-incision time", i.e. the changing times. They vary depending on the organisation, but you also have to calculate them, because the outpatient surgeries usually only have one operating theatre and you can only start the next one when the first one is finished. We can't start in parallel, so our "suture-cut times" are longer.

What cost points arise with outpatient interventions that may not exist with inpatient interventions?

For us, it's organisational costs, we have to make quite a lot of phone calls and do good management so that it works out in terms of timing. Otherwise, there are no extra costs that would not be the same for inpatient procedures.

Which operators offer the most operating theatre capacity? (Hospitals, operating centres,...?)

As before, most of the work is done in panel doctors' practices. I don't want to make a distinction here between surgery centres and individual practices, because it is difficult to separate them by definition. Hospitals have caught up, but they are still nowhere near the same level as the panel doctors' practices in the outpatient sector.

How strong is the competition between these providers? (pricing policy; offers...)/What is the relationship between the providers?

It's like the competition between doctors' practices, they live from their standing in the population, you have that or you don't have that, that's what it's based on. It's not like we're fishing away the interventions, the patients come or they don't come. There is no brutal competition, it is a normal competitive situation. **What is the average utilisation of the operating theatre capacities without the rentals/with the rentals?**

That is difficult and very different. There are surgery centres that run the whole week and there are individual practices that have one morning, which is nonsense from an economic point of view. Full capacity utilisation is not always a given in surgery centres, but it is more likely than in individual practices. Generally speaking, an outpatient facility can never be as busy as an inpatient unit, also from a costing point of view, because in our case the patients have to go home, which means we cannot start after 3 pm or after 4 pm. The patients then have to stay sober for endless hours and wait another two to three hours before they go home. That is very risky because the patients are not there beforehand. This means that due to patient management, outpatient surgery has to be limited to 3 p.m. at the latest, which alone does not give them 100% capacity utilisation. In the hospital, they could operate 24 hours a day if they wanted to, which is not patient-friendly, but medically justifiable. The poor workloads are mostly in individual operations, and then it is a question of whether I should take in an outside surgeon who would disrupt my practice. These are individual factors that decide whether renting out capacity makes sense; in principle, renting out unused capacity is of course always a sensible consideration. But you also have to consider what exactly he rents, e.g. does he rent staff that I need myself or does he bring his staff with him. What about the unrest that is brought into the regular practice by the operations, by accompanying persons and the need to look after foreign patients? So it depends very much on the individual constellations whether I should rent out the surgery.

What are the most important/biggest costs of performing an operation? (What are the costs of the entire operating room provided during an operation?)

These are always the personnel costs. The personnel costs are basically 50% of the costs in the private practice, you can guess that, all the surveys we do come to that. In surgery we have a cost rate of 68-70% of the turnover and half of that, i.e. 35% of the turnover, is personnel costs.

Turnover, personnel costs. In the outpatient area, these are fully reflected because it is a matter of presence, which means that the entire staff, including the surgeon, is tied up for the entire time of the operation. So personnel is the biggest item. This is followed by investments and the associated capital commitment costs. The third block is rent. Rent is about 25% of the costs, because in the meantime the investment costs are very low, as less and less is invested in medical practices. There is a substantial investment backlog. That is why the costs are very distorted at the moment.

What criteria/standards are currently used to calculate the rent for the operating theatre capacities? Which costs are used for this?

It is precisely these types of costs described that are now used to determine the amount of rent. For the surgeon himself, his liability premium, which he has to pay for operating on an outpatient basis, should not be completely disregarded. But that doesn't matter when it comes to renting, because I'm not renting that out. The costs for staff, rent and equipment remain, and the rent also depends on what the surgeon brings with him, for example, if he brings the staff with him, then they have to calculate the rent differently, or if he brings his instruments with him, they have to calculate that differently too. There is a lot of talk about energy consumption, but that is relatively harmless. With the room costs, of course, one would not take the gross costs but the net costs including heating, electricity, etc.. We had once calculated and that hasn't changed much, an operating hour costs about 300€ if they use all cost types, that's what an operating hour costs in the calculation. Variables that have to be taken into account are, of course, location-dependent rents or also imputed costs such as investments. These €300 are approximate and also calculated at a high level, so they may be lower in real terms. If you come as a tenant and bring your own staff, then of course you have to reduce these 300€ by this amount. That goes down pretty quickly and becomes little. We demand from our people, and that is always the point of contention, that they should agree on a market price, supply and demand, but if no agreement is reached, they should orient themselves on data that can actually be proven. The landlord should be in a position to calculate his rent with ancillary costs per square metre, and that can be calculated. The same applies to the staff, there are so and so many staff, that costs one staff hour and thus these costs arise. If you want, you can calculate an exactly verifiable price for the concrete unit. But usually no one wants to do that, which is why there are these

"Bartering" and that's where the occasional argument comes in.

What are the most common forms of rent? (e.g. rent per OR type; rent per OR minute; rent for fixed time slots...etc.)

There are three different types. There is the rent per operation in the form of a payment of a "bounty premium" per patient operated on and per operation had. These are paid differently, so there are percentage deductions that the landlord collects. The second variant is that there is a price per actually used operation time or frequency or whatever. And, what we propose is to bypass fuzziness that comes with percentage markdowns, which are also not pertinent, and transfer the risk of actual use to the tenant by giving fixed time slots. This model, which we recommend, is rather less lived in practice. The most common model is actually that the anaesthetist as provider A and the surgeon as provider B are usually the two parties involved, very rarely there is a provider C who only provides the operating theatre and both have to come there. Then it is the case that with split billing, the anaesthetist bills his part and the surgeon his part. In addition, there are certain surcharges, e.g. for post-operative care, where we say that the fee is incurred where the patient is lying, because that could be billed by both the anaesthetist and the surgeon, but only by one at a time. This is the simplest of all things, has nothing to do with business administration, but a lot to do with collegial cooperation. The reason why we rarely use the time slots we recommend is that it is labour-intensive, i.e. I force them to calculate what their actual operating theatre costs are, most of them don't even know that. They can't do cost unit accounting because they can't delineate the cost centres properly. So the most common form of rent is that everyone collects their own fees and the joint share is paid where it actually accrues. However, there are also a lot of "rip-off models", where one demands additional capitation fees from the other, e.g. shares of the other's fee positions. The problems that arise in this context are problems with the anti-corruption law and the most economical processing of the costs actually incurred.

Why are operating theatre rooms rented out? Apart from the economic aspect, what are the motivations for facilities to rent out operating theatre capacities?

Well, that's clear, apart from the economic aspect there is none. At some point it will be the case that the operating rooms in the individual practices can no longer be maintained because the hygiene guidelines are becoming more and more stringent and we will no longer be able to reinvest.

or whether one goes to centres. In principle, the formation of centres will continue. It is clear that hospitals speculate that external surgeons will also acquire inpatient cases, but whether I really refer inpatient cases there when I perform outpatient surgery in a hospital is obvious, but not self-evident. Nevertheless, hospitals have to think about how much they invest in advertising measures and then they would have to generate that. If they rent out their units well below operating costs, then you have to consider under which item I book these losses, which can then only be booked as advertising costs, not from a tax point of view, but from a business management point of view.

What influence does the motivation of the tenant have on the amount/type of rent?

We live in a free market economy, if my rooms are empty, I'm happy if I get anything at all and then I will put my business calculation at the back of my mind. Conversely, if I'm a singular provider, I can say I'm well occupied, I don't need it at all, I'll pull up the prices. And if you have a secondary motivation, like the hospital, then it is an entrepreneurial risk whether this calculation will work out. But you also have to be careful, we are under heavy scrutiny in the medical sector as far as corrupt behaviour is concerned, and if these are "moon prices", then that's one thing.

Which form of rent do you see as the most sensible/practical?

I already told you that. The least favourable is actually the percentage discount on something, that always leads to disputes. The most sensible thing is the slots, although when determining the rent, you have to look at exactly what is actually being supplied, space, staff, investment costs, you have to look at these three blocks in isolation, because they are brought in differently or not. And the other thing is that you say that there are different fee schedules, one for the anaesthetist, one for the surgeon and one for both and that for both falls where it is done.

What do you see as the most important challenges in the health care market at the moment? *The most important point is to make this market generation-proof and to adapt it to the requirements of the changing social security system. Due to the cost explosions, not only in the health care system but also in the pension system, due to the changing demographics and the ever decreasing number of people paying into the system while at the same time the number of people withdrawing from the funds is increasing, we have to think about a very fundamental concept of how the steering conditions can be changed.*

be changed. Nowhere in the world is the catalogue of benefits as extensive as in Germany, so I think - and this is my personal opinion - that we need a system equipped in some way with deductibles in order to reduce the use of health services. It is a central challenge to deal with the fact that the population is shrinking at the expense of those who pay full contributions and that this shift is massively to the detriment of the social security funds.

What do you see as the most important changes/developments in the outpatient sector at the moment?

More and more care is being shifted to the outpatient sector, i.e. more and more inpatient care is being shifted to the outpatient sector, which has serious consequences for us in terms of further specialist training. They no longer see certain clinical pictures in the hospital, because they no longer arrive there. So we are thinking about further training networks, so that colleagues in the outpatient practice, regardless of the speciality, complete a certain compulsory further training so that they know the clinical pictures they need. The second point is that when services are shifted to the outpatient sector, there is no shift in the amount of money involved. The money does not come along with the service. Another point is that we will have a recognisable shortage of doctors in the outpatient sector in the next few years, because the average age of a doctor in private practice has now risen by four years in the last ten years. In other words, there are no new ones coming into the system. The average age of doctors in private practice is now 55/56. With the work intensification and the earning opportunities, it is unattractive to go into private practice. Apart from that, there are no longer enough junior staff in the hospitals. The only way to counteract this is to make the medical profession attractive again. The problem in the private practice sector is that, compared to the inpatient sector, there are fewer opportunities to earn money and the workload is much higher.

Appendix 5: Expert interview 4

Which operations do you perform on an outpatient basis (the 5-10 most frequent/important)?

We mainly perform orthopaedic procedures, i.e. arthroscopies, foot surgery, hallux valgus or other corresponding procedures such as meniscus dissection or diagnostic orthoscopic surgery.

What is the approximate ratio of outpatient to inpatient interventions?

We perform about 600 outpatient operations a year and another 2300 inpatient operations.

What is the development in this area? Which type of surgery is gaining in case numbers?

The development in the outpatient sector is increasing, but both sectors have increased in recent years. However, certain things are being shifted to the outpatient sector.

A large cost item for inpatient interventions are the ward costs, what percentage of the average ward costs are still incurred for outpatient operations (with pre- and post-operative care or similar) [estimate]?

Realistically, most hospitals do not calculate the costs. There is the InEK calculation for the inpatient area and there are certainly hospitals that can also calculate the case costs in the outpatient area as a by-product, but these are very few. It has to be said that because of the remuneration in the outpatient sector, outpatient surgery never covers its costs; in principle, it is always a subsidy business. That is the reason why the hospital always asks itself how it can be done economically, for example by outsourcing the outpatient area and letting a doctor in private practice carry out the outpatient operations, which are then billed via the doctor's KV authorisation and thus offer better billing possibilities than as an institutional service in the hospital itself. If they can cover the costs of the procedures in the hospital, i.e. +/- 0, then that's okay; as a hospital, that is already a service. The problem is that when a hospital doctor does it, he cannot change his mind, because I have an infrastructure in the inpatient area that is financed and I do not have this in the outpatient area. That means you have to look at how many people are at the table for an operation. As a rule, we always have two people at the table, plus a float. If I don't get this structure changed, an outpatient operation doesn't cover its costs.

Which operators offer the most operating theatre capacity? (Hospitals, operating centres,...?)

I don't know the capacities of the other hospitals, so it's difficult to judge, but I assume that all hospitals with their outpatient capacities account for the larger share. But it is always a question of the structure in which I provide the services; we have built two operating theatres here in the hospital and created the structure accordingly. Of course, I can also perform outpatient operations in the central operating theatre, but the structure there is completely different. From the point of view of the cost structure, the question is whether I, as a hospital, have created separate structures for outpatient operations. In the central operating theatre they never get the mental leap, the outpatient patient is always treated in the same way as the inpatient patient, which just can't work.

What is the average utilisation of the OP capacities without the rentals?/with the rentals?

There is no difference whether I rent them out or not. What I hear is that it is generally difficult to utilise the operating theatre capacities; I know doctors who wanted to set up or have set up a centre and hardly get the capacities utilised. For us it doesn't matter, for us it's a necessary extra income to retain doctors in private practice and to acquire inpatients. For me

e.g. an arthroscopic service a future knee endoprosthesis.

What are the most important/biggest costs of performing an operation? (What are the costs of the entire operating room provided during an operation?)

The personnel costs in the end. That also depends on the surgery. In the outpatient setting, it's definitely the staff. There are also expensive implants, but it is usually the operating theatre staff.

What criteria/standards are currently used to calculate the rent for the operating theatre capacities? Which costs are used for this?

We have proceeded in such a way that we have tried to calculate them as far as possible. There are different options, depending on what he uses, he has to pay accordingly. That means we measure the use of staff, from the cleaning lady to the float, anaesthesia is usually not possible if it is an external service, because he then bills himself and we as a hospital cannot bill the anaesthesia service separately. As a rule, we also try to outsource the material costs in the form that he obtains and invoices them separately, because he can also invoice the KV better than we can as a hospital.

What are the most common forms of rent? (e.g. rent per OR type; rent per OR minute; rent for fixed time slots...etc.)

There is a charge rate per hour, which depends on the extent of the infrastructure used, i.e. only the room or if I provide staff, it can of course go higher, he can also have the things sterilised with us, then it also goes higher again. That is added to it, these are individual building blocks that we then also map. There was also a contract where we had a share in his revenues, but usually it is an hourly rate.

Why are operating theatre rooms rented out? Apart from the economic aspect, what are the motivations for facilities to rent out operating theatre capacities?

Outpatient surgery is a necessary evil for a hospital. Purely from the revenue/expenditure point of view. On the other hand, every patient I contact or who passes through my clinic, I have patient loyalty or at least the initial contact. Most of the time, these are also cases that will lead to more extensive care later on. Another aspect is, of course, that you bind referrers to the hospital; I personally believe that 80-90% of patients follow the referrer's recommendation when it comes to choosing a hospital. **Which rental form do you consider the most sensible/practical?**

I would take the charging per hour as the most practicable, insofar as it makes little effort, since it is so for us that it is a necessary evil. The billing should therefore be as little effort as possible.

Appendix 6: Expert interview 5

Which operations do you perform on an outpatient basis (the 5-10 most frequent/important)?

The focus is on arthroscopies, knee arthroscopies and shoulder arthroscopies are the most common in the orthopaedic field, inguinal hernia operations. In ENT, ear operations are very frequent in terms of numbers. Abdominal endoscopies are also a relatively frequent part. Neurosurgery is also an area that we have added, but these are not outpatient procedures, they require supervision.

What is the approximate ratio of outpatient to inpatient interventions?

A good 1:10, i.e. about 8-10%, are performed as inpatient procedures and the rest as outpatient procedures.

What is the development in this area? Which type of surgery is gaining in case numbers?

It is quite clear that in the future, more and more operations will be performed on an outpatient basis in Germany. There will be a clear trend towards outpatient surgery. The form of short inpatient procedures will also develop, we are talking about when the length of stay is a maximum of three days. This is also an area that will increase.

What are the crucial differences between inpatient and outpatient surgery? How do the procedures differ?

We have pretty much harmonised the procedures of our operations. This means that the patients come immediately before the operation, regardless of whether they are outpatients or inpatients, and are informed in a preliminary discussion. The difference is really only organisational, in that we have agreed on either IV contracts or cost coverage for patients with health insurance. The difference is really only administrative. In the case of outpatient operations, one of the relatives must be available for 24 hours afterwards, while the other simply goes to the ward.

A large cost item for inpatient interventions are the ward costs, what percentage of the average ward costs are still incurred for outpatient operations (with pre and post care or similar) [estimate]?

That is a difficult question and you always have to look at what you want, we have care and supply costs as ward costs and possibly building costs, etc. But they amount to an amount that is not as high as in the hospital sector. But these amount to a sum that is not as insanely high as in the hospital sector. The nursing costs are there in any case, even with an outpatient operation there has to be follow-up care, dressings have to be changed and so on. We have calculated that the hotel services, including staff, are about 200 € per day and per patient and that is about cost-covering for accommodation, rent, staff costs and so on.

What cost points arise with outpatient interventions that may not exist with inpatient interventions?

I don't think there really is such a thing. It is no secret that outpatient surgeries are cheaper than inpatient procedures, whereby not only the ward costs play a role, but also other things. The only thing that would be conceivable is that travel costs might be incurred if the patients have complaints and have to go to the surgery, for example, i.e. taxi costs. But that is a rarity.

Which operators offer the most operating theatre capacity? (Hospitals, operating centres,...?)

I don't have a figure for that, I would think that hospitals theoretically have the most capacity but don't use it, but it will already be the case that hospitals have more capacity than surgery centres because of the number of hospitals. I believe that hospitals are not yet in a position to offer outpatient surgery on a cost-covering basis and will therefore join forces with surgery centres, set up medical care centres or withdraw from the sector altogether. Another aspect is the surgeries in individual practices, where the problem will arise in the long run that the surgeons will have to fulfil very high quality requirements and this can almost only be implemented in larger associations. There is a trend towards this, and many practices are not in a position to meet the quality requirements. So far, however, I would say that most outpatient operations are still performed in the practices.

How strong is the competition between these providers? (pricing policy; offers...)/What is the relationship between the providers?

As I said, hospitals cannot currently offer outpatient surgery on a cost-covering basis, which means that hospitals are losing outpatient surgeries to surgical centres, which is a major source of competition. You can definitely see a tough competitive situation. There are too many inpatient beds and these are also being made redundant by facilities such as surgery centres. There is serious competition above all with the small hospitals; the maximum care hospitals, for example, are less affected by this.

What is the average utilisation of the OP capacities without the rentals?/with the rentals?

We only offer the complete package (surgeon comes alone and we provide all the premises, staff and instruments), you can also call that renting, we rather call it service. We operate about ten to twelve hours a day in an operating theatre, that would be 100%. In a normal hospital that would be far more than 100%, they actually only calculate six hours of operating time and the rest is preparation time.

What are the most important/biggest costs of performing an operation? (What are the costs of the entire operating room provided during an operation?)

The question is, what do you take in? The surgeon is paid, the nurses we need are paid, the steri is paid, the anaesthesia is paid. We have a scheme in which the distribution between the surgeon, the anaesthetist and the posts of the whole is regulated, approximately one third each, whereby the anaesthetist has somewhat less, i.e. 35/35/30. The cost blocks are such that 70% of the total costs are loosely in the personnel area. The material costs are a big factor in individual, specific operations, but not really so in the broad mass. With the InEK calculation it is so that these are difficult to understand in some areas, but basically there is the block of inpatient further care, which looks somewhat different with us, but basically the InEK calculation is something that is very similar with us. We also use the DRGs for our cost accounting in cost absorption contracts with health insurance funds. In contrast to the InEK calculation, our personnel costs are lower because we have faster operations and therefore less personnel is tied up.

What criteria/standards are currently used to calculate the rent for the operating theatre capacities? Which costs are used for this?

I've already said that a little bit. The costs have also arisen from the experience of other operating centres and then it is the case that we do not make individual charges, but carry out a distribution. There is a general distribution between the surgeon, the institution and the anaesthetist. In the case of private patients, the surgeon can make additional payments. There is no concrete cost accounting, it is a mixed calculation and we do it according to distribution. There are various things that play into this. There are, for example, operating centres that charge according to time, but there is always the problem of who is to pay for what.

"It is the surgeon who takes longer, or the anaesthesia that is more difficult to induce. In the end, there is a constant hick-hack about who is to blame. It is an insane amount of work to allocate every single cost centre and it doesn't pay off in the end, so we do it by distributing it among the surgeon, facility and anaesthesia.

What are the most common forms of rent? (e.g. rent per OR type; rent per OR minute; rent for fixed time slots...etc.)

There are all these forms, but with us, as already said, it works differently then. **Why are operating rooms rented out? Apart from the economic aspect, what is the motivation for facilities to rent out operating theatre capacities?**

The alternative for an anaesthetist working in private practice would be to travel around. The conditions at the surgeons' are not optimal and we can offer more optimal procedures at the OP centre. That is a big advantage and the reason why we offer operating rooms at all. Of course, there is also the economic aspect.

What influence does the motivation of the rental have on the amount/type of rent?

We have fixed amounts and a motivation, e.g. a particularly important surgeon, plays a rather subordinate role for us. In hospitals, of course, the unused operating theatre capacities are the most expensive, which is why they often offer operating theatre capacities at "dumping prices", but with a view to the fact that patients are then assigned. It may well be the case in other facilities that the rent also depends on how important the surgeon is, but that is not the case here.

Which form of rent do you see as the most sensible/practical?

Basically, you can do everything. You can assign fixed times, but we are often annoyed when operators do not use their capacities and cancel, which is above all a handicap because we provide the staff. That's bad for us economically. Nevertheless, from our point of view, it is important for the atmosphere of cooperation that we have done it this way, but of course it is a very unusual way. The most common and widespread way is to actually give time slots. Our system, the way we do it works, that's how we started, it gets some disputes out of the way and you couldn't agree on anything else with the operators who have been cooperating here for 15/16 years. There would be a huge outcry if we were to say we sell you the time, regardless of whether you use it or not. But you can't say that in a generally valid way.

What are the most important challenges in the health care market for you at the moment? What are the most important changes/developments in the outpatient sector for you at the moment?

The development that significantly more outpatient operations are being performed creates a lot of time and can actually reduce costs in the health care system. Making this clear is an important aspect for us.