

‚HZV will be at the centre o care in five years‘ time‘

Why does a health care innovation such as GP-centred care (HZV) according to §73b of the German Social Code, Book V, a new world of health care beyond SHI-regulated care, work in Baden-Württemberg of all places? It is not that GP programmes or models do not exist elsewhere in Germany, but firstly not for as long - currently 15 years - and secondly not as consistently and, on top of that, constantly developed. According to Johannes Bauernfeind, Chairman of the Board of AOK Baden- Württemberg, it is important that HZV is not only more economical than so-called standard care, but that more than 90 percent of the voluntarily enrolled patients are ‚very satisfied with this care offer as we have designed it‘.

Interview: Johannes Bauernfeind, Chairman of the Board of AOK Baden-Württemberg.

>> The contract signed by the AOK Baden-Württemberg on 8 May 2008 can be seen as the starting point of the first GP-centred contract and also as a possible blueprint for all HZV contracts. What has become of this competitive departure into a world of selective contracts without the participation of the KV in Baden-Württemberg in 15 years?

One can justifiably speak of a successful model. The contract partners can look back on a very positive development since 8 May 2008. This can be seen, for example, in the steadily growing number of insured persons and doctors enrolled. But the primary goal of the HZV was and is to improve the quality of care for our insured, both on its own and in conjunction with specialist contracts. And the current evaluation results presented in mid-May have proven once again that this has been achieved - chronically ill patients in particular benefit from fewer hospital admissions, shorter waiting times for appointments with GPs and specialists and better coordination of treatment - we will come to the details later. The contractual partners can be proud of the fact that these positive results run like a thread through all evaluations of the past years. We have succeeded in establishing an ‚architecture' that has lasting effects and whose positive effects grow from year to year. The long-term analyses of chronically ill patients and elderly people in need of care show that the quality differences in favour of those insured under HZV have remained stable over the years and in many cases are still improving - the ‚quality gap' is opening in favour of HZV participants. The bottom line is that, within the framework of the partnership entered into, AOK Baden- Württemberg responsibly fulfils its mandate to ensure health care coverage - which, in the case of selective contracts, is transferred to the contracting health insurance fund - in the form of regional and individual solutions.

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In the meantime, there are 8 specialist contracts for 13 specialist groups in Baden-Württemberg, in which about 3,200 doctors and psychotherapists and 835,000 insured persons of the AOK and Bosch BKK participate. Is this an almost nationwide offer or one focused on a few cities and/or metropolitan regions?

From the beginning, we - by this I mean the medical contract partners and the AOK Baden-Württemberg together with the Bosch BKK - had the ambition to establish the offer nationwide. It would also not be in line with our principle if we left out rural and sparsely populated regions in the state. Of course, on the other hand, we must not close our eyes to reality. There are more and more older doctors who are gradually retiring, more and more doctors are working in salaried and part-time positions and, due to demographic change, there are more and more older patients and, as a result, more ‚care cases'. It is becoming increasingly difficult to find the right balance here. However, in order to ensure that the more rural regions in an area like Baden-Württemberg continue to receive good medical care, we are developing the HZV further together with our contractual partners. For example, by further expanding team practices and delegation.

What does this mean in concrete terms?

In addition to GPs, MFAs and VERAHs, other academic non-physician health care professions such as the academic VERAH and physician assistants will be represented in a core team of an HZV practice in the future. From July 2023, the three contractual partners will support the training of physician assistants and the academic VERAH with 300 scholarships of 5,000 euros each. To promote team practices, the allowances for VERAH will also be increased. And a new supplement will be introduced for the employment of academic staff from non-medical professions. Delegation and burden sharing will also play an increasingly important role in specialist practices. Since 2014, the AOK Baden-Württemberg and the Bosch BKK have been promoting the activities of EFA (Entlastungsassistent:in in der Facharztpraxis). In 2022, more than 500 EFAs were already working in the fields of gastroenterology, cardiology, neurology, orthopaedics, rheumatology, pneumology and urology. Similar to a VERAH, the EFA takes on tasks that can be delegated.

With 15 years of selective contracts, the standard care established over many decades before has been changed to some extent. Why not aim for standard care altogether?

The HZV is primarily aimed at people with special care needs, at vulnerable groups, the chronically ill, but also at families with children who need a doctor more often. For them, we have made what we consider to be a better care alternative the rule, so to speak. Insured people who do not need a doctor so often, on the other hand, are in good hands in the collective system.

Will HZV always remain just a ‚better alternative' to KV-based standard care?

I believe that HZV does not have to hide behind standard care in any way. On the contrary. We are the drivers and always bring innovations into the care system. I believe that in five years, HZV will be at the centre of care. We will have proportionally fewer GPs and less doctor time. That is why we urgently need better patient management. HZV will be a model for the health care landscape, as it has been for the past 15 years.

The question of all questions: Why does HZV work inBaden-Württemberg, but - with a few exceptions - not in Saarland, Saxony or elsewhere in Germany? Conversely, could HZV work everywhere if one wanted it to?

You would have to ask this question of the institutions involved in the aforementioned states. I can only speak for the AOK Baden-Württemberg and why it works here. Our GP contract is based on a certain mechanism that the contract partners negotiated together. For example, the contract contains a comprehensible remuneration structure and simple billing without excessive bureaucracy. A ‚simple'

transfer of HZV to standard care will not work. GP and specialist contracts are about structural issues - you can't just implement GP and specialist contracts in passing and certainly not impose them from above through politics. You need partners in the regions who want to shape care with the same understanding and the health insurance funds have to make an advance financial contribution, the whole thing has to be refinanced. The AOK Baden-Württemberg contract has been so successful because the contract partners have pulled together and have taken the regional organisation of health care into their own hands instead of imposing central requirements. Many health insurance funds recognise the advantages, but issues such as streamlining, administration of the contracts, the associated expenditure in personnel and also material costs, e.g. for IT solutions, may also deter them.

At a recent press conference in Berlin, you were able to present the current evaluation data on 15 years of the GP contract of the AOK Baden-Württemberg and - we will come to this in detail later - a success story, especially for the chronically ill, who receive better and more economical care with the help of their HZV and specialist contracts and, on top of that, live longer. If the evaluation results are correct, which we can assume, after all, Prof. Gerlach and Prof. Szecsenyi, among others, vouch for this with their good names: Why hasn't there been a legal right to better care for a long time?

The legal right to GP-centred care - and it has been scientifically proven many times over to provide better quality care - has existed for a long time. More important is the concrete implementation. Better care can only be achieved if care is changed. This can only be done with contracts that cover and structure services and their remuneration in their entirety. Enrolment fees alone have no effect.

Let's go into the detailed results. In the implementation of interventions, it often happens that health care innovations show positive effects quite quickly, but these are often not sustainable. What do your long-term analyses look like?

That is what is absolutely gratifying: The ten-year data that have now been presented show that the ‚quality gap' continues to widen even after this long period of time in favour of those insured with HZV. If we look at the so-called basic indicators over ten years, we see significant and relevant quality differences in favour of SHI participants. Prof. Szecsenyi used five projections for the year 2020 as examples to demonstrate this. The number of GP contacts was two million higher, at the same time there were 1.9 million fewer uncoordinated specialist contacts without referral, the hospitalisation rate shows 27,000 fewer hospital admissions. As a result, there were 125,000 fewer hospital days and, last but not least, there were about 5,500 fewer readmissions. But that is not all. The Frankfurt team around Prof. Gerlach also presented impressive figures. The results show that for approximately 119,000 diabetics enrolled in HZV, a total of more than 11,000 serious complications were avoided within ten years - between 2011 and 2020 - and that ‚HZV diabetics' had a longer life expectancy compared to standard care. In figures, this means that about 350 cases of new blindness and about 2,250 strokes were avoided.



Johannes Bauernfeind

has been chairman of the board of AOK-Baden-Württemberg since January 2020.

Before his appointment to the board, the graduate economist held various management positions at AOK Baden-Württemberg, first as head of the hospital department and head of the staff unit ‚Care Controlling and Analytics', which he set up at the Stuttgart head office, then as managing director of the Neckar-Fils district office in Esslingen from 2014 to the end of 2019.

His predecessor in office as Chairman of the Board of AOK-Baden-Württemberg was Dr Christopher Hermann, who - like Bauernfeind - is a member of the editorial advisory board of ‚Monitor Versorgungsforschung'.

What are the most important parameters of the evaluation for you?

For me, one of the most pleasing results is that we reach exactly the target group that needs better and more comprehensive care - namely multimorbid and chronically ill people suffering from diabetes, coronary heart disease, heart failure or asthma. The results explained in the question before confirm this.

For those affected, the occurrence of avoidable complications often means severe restrictions in quality of life and a shortening of life span, while for the health care system it often means high follow-up costs. What does the health economic evaluation look like?

The selective contracts of the AOK are not only better in terms of quality of care, but also more economical than standard care. All evaluations have shown that the average annual costs of care for an HZV-insured person are lower than for comparable insured persons in a collective contract; most recently, before the pandemic - i.e. in 2019 - they were around 40 euros lower per year. However, successful health care structures such as HZV can only be designed if the efficiency advantages through selective contracts remain where they are achieved. It is not expedient if regions such as Baden-Württemberg with high quality and efficiency in health care are penalised financially for this.

What would have to be done on the part of policy-makers to enforce a right of all insured

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persons to HZV?

In principle, full-coverage contracts should be explicitly promoted by federal policy through start-up financing and bonuses. If you look at the past, 15 years ago we were much freer in the design of care, we could try something out. Today, we have to directly prove the economic efficiency of a new offer. Another expectation would therefore be more freedom for the contractual partners in the design of care. And we would have to think further about GP-specialist contracts in the direction of neighbouring sectors, i.e. hospitals. The AOK Baden-Württemberg therefore also relies heavily on selective contracts with selected hospitals in order to increase the quality of interventions there. It is important that patients are also well cared for before and after the operation - preferably in the well-developed GP and specialist programme. In the past two years, we have concluded the first quality contracts in the areas of hip and knee endoprosthetics. The response of the clinics is basically positive. In order to dovetail the quality contracts with outpatient care, the ‚osteoarthritis' care pathway was anchored in the specialist contract together with the orthopaedic surgeons, which includes needs-based counselling and care from the initial diagnosis to the potentially necessary joint implantation to rehabilitation and aftercare. This takes into account the scientific finding that in hospitals with a high number of cases, complications and follow-up interventions are less frequent in such operations. However, the elaborate documentation for the evaluation of these quality contracts by the Institute for Quality Assurance and Transparency in Health Care - IQTIG for short - still poses a major challenge. Therefore, in order to facilitate the practical implementation of such quality contracts, especially with regard to the evaluation effort, there is a need for fewer regulations and, here too, more regional design freedom. <<

Mr. Bauernfeind, thank you for the interview.

The interview was conducted by MVF editor-in-chief Peter Stegmaier.

For non-discriminatory data access

>> ‚We are looking for more supporters who want to actively shape the EHDS in Germany,' explains Prof. Dr. med. Dr. iur. Christian Dierks, lawyer and managing partner of the consultancy Dierks+Company, which he and his wife Juliana founded in Berlin in 2018, on his homepage (1). Dierks, who wants to combine legal advice with strategic thinking and political communication with his company, has launched the EHDS Coalition, which currently has ten supporters, both ideally and financially - these are, in addition to some pharmaceutical companies, the Action Alliance for Patient Safety and Vision Zero, as well as the health data service provider Flatiron Health and the IT company DMI.

The idea of the EHDS coalition is to influence the current EU legislative process (2) and the national implementation based on it in order to achieve the most non-discriminatory access possible for private and public research projects to the European Health Data Space (EHDS). According to Dierks and his supporters, who are all in favour of making better use of the potential of health data, there is a threat of restrictions in the current EU legislative process and in national implementation that would jeopardise the goals set.

Under the leadership of Dierks+Company, the EHDS coalition has not only developed a position paper (3) in a first phase, but also a communication strategy based on it, with which primarily the target group of politics is to be addressed. Among other things, it states that the draft EHDS regulation is causing uncertainty among many stakeholders and is fuelling the desire for more clarity and legal certainty. In addition, there are various risks that, for example

- public research projects could be prioritised to the detriment of private research ,
- the data access point could be insufficiently staffed, financed and technically equipped ,
- Germany does not participate fully in the EHDS due to its restrictive data protection regulations - and Germany continues to lose importance from a research perspective .

The general demand of the paper: ‚The acceptance of the use of health data requires a paradigm and attitude change in the population - towards a more public welfare-oriented availability and usability of health data. Only in this way can a valuable, sustainable contribution to the common good be created in the sense of a community of solidarity.'

According to the position paper, seven points are particularly important for the design of the EHDS in Germany:

1. a broad qualified data basis
2. establishment of a functional, trustworthy data access in Germany
3. integration of companies in the health care industry as valuable data owners
4. equal participation of the companies as data users
5. creation of a fair fee schedule
6. integration of small medical practices as voluntary data holders
7. use of data for educational purposeske <<

Links:
1: https://www.dierks.company/initiatives/ehds-coalition/
2: https://bit.ly/3IsRINa
3: https://bit.ly/42XMH7t