

‚Enabling more regionality a coalition of the willing‘

In the cover interview with ‚Monitor Versorgungsforschung‘, Daniela Teichert, CEO of AOK Nordost, not only dispels narratives such as the shortage of doctors and the death of hospitals. She also uses many examples to show what a large, responsible health insurance company can achieve in the interests and for the benefit of its policyholders in its respective region if it wants to. Her petition: ‚The DNA for more regionality should also be characterised by a focus on real care problems, on people, on patients at the centre of improvement efforts and on results orientation. If you focus primarily on costs, you will reduce quality - if you focus on quality, you will reduce costs.‘

In the cover interview: Daniela Teichert, CEO of AOK Nordost.

>> Ms Teichert, the number of clinics and their accessibility, especially in rural areas, has been the subject of criticism, and not just since the debate about minimum volumes for the special care of extremely premature babies. Last year, when the WiZen study on the effectiveness of care in oncology centres was published, it was said that such results would give extreme parties even more support. The background to this is that the results of this project, which was funded by the Innovation Fund and received a positive decision, almost inevitably suggest that cancer patients should be directed to specialised centres. Patients would have massive survival advantages there, but this would mean that hospitals with an inadequate outcome would have to close. As the head of the largest health insurance fund in the north-east of Germany, what do you think about this?

Even now, the distances are rather long in large states such as Brandenburg or Mecklenburg-Western Pomerania. As a result, the new regulations on minimum volumes will hardly change anything for many patients. Anyone suffering from cancer in rural regions, for example, who cannot be treated on an outpatient basis will have to accept a longer journey to a specialist treatment centre. But it's worth it: in return, these patients are less likely to suffer complications from their treatment. And the likelihood of dying from the disease is also reduced. For example, according to a large-scale study, breast cancer patients are twelve percent more likely to survive if they are treated in a certified breast cancer centre. And this is certainly more important for most of the patients concerned than receiving less high-quality treatment close to home.

There is also another aspect: the discussions about distances and journeys are mainly held by residents who do not need to seek such treatment at the moment. If they are then affected by such illnesses at some point, their view on the question of distance may also change. I do think that these patients will accept a slightly longer journey in search of the best treatment. This ‚voting with one's feet' is already evident from the available data.

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This shows the tension between providing care as close to home as possible on the one hand, but at the highest possible level of quality on the other. This is an aspiration that is particularly high in Germany.

In order to achieve meaningful changes here, an exchange with other stakeholders in the healthcare system on specific local care issues is a key prerequisite. A good example of this are the contracts with a good dozen networks of doctors, which can also be expanded into co-operations with other regional providers of care services. In addition, we have successfully concluded special contracts and innovation fund projects with hospitals and doctors in private practice and have also involved care facilities. For example, we are also involved in a joint venture with KV Brandenburg for innovative healthcare in the state of Brandenburg, for which we founded IGiB GbR. One successful result of this collaboration to date is the IGiB-StimMT model in Templin, which is a pioneering model for outpatient and inpatient care.

Briefly on the Templin flagship project of structural migration: How can things continue after the withdrawal of KV Brandenburg?

If you look at the factual content, the KV Brandenburg is apparently not concerned with an exit, but rather with a changeover. This is because there are opportunities to answer the questions raised within the given framework of the consortium - the Sana Hospital Templin, the KV Brandenburg, the ‚Healthy in Templin' network of doctors and the mayor of the town of Templin - for the Central Templin health region. We see a good opportunity for the members of the consortium to discuss and implement possible solutions in the short term.

What are the lessons learnt from this type of cooperation?

The improved exchange through such cooperation makes us smarter as AOK Nordost. If, for example, doctors say in a confidential discussion that healthy diabetics are more welcome in the DMP or that they have to devote their time to healthy patients in an inappropriate way for business reasons and cite business reasons for this, then this does raise questions. However, these have little or nothing to do with a general ‚de-economisation' of the healthcare system. Rather, these questions relate to whether there is something wrong with the structures, processes, cooperation and - above all - incentives in our healthcare system.

And what does the other side of the coin look like?

Of course, there are also hurdles and resistance to these cooperative approaches. However, these are often not due to the people we are talking to about solutions, nor are they due to the different interests that we harmonise with our partners in the contract business. Rather, difficulties often arise due to the existing regulations. This is why we need to dare to be even more regional in Germany, we need to facilitate coalitions of the willing, set up free trade zones in SGB V and ensure greater utilisation of local expertise.

What does that mean in concrete terms?

For the positioning of health insurance funds in the healthcare market, this means that they must move closer to the actual healthcare situation in the regions. To do this, the health insurance funds need to sharpen their planning accordingly and organise concrete solutions with their partners in the region. One example of this is the Cardiolotsen project that we have developed together with Vivantes. The cardio pilots contact patients in hospital immediately after a heart operation and provide them with support and advice for a year after discharge, so that they need to return to hospital less often.

Of course, there are still centralised regulations. It is unlikely that anyone would suddenly want to regulate the authorisation and prices of medicines and other products individually at regional level. But it should be permissible to ask whether all care structures and processes need to be regulated down to the last detail at centralised level. We can see that this is precisely where criticism is often levelled, which often leads to clear dissatisfaction. On the other hand, health is still a local commodity despite increasingly hybridised care. This applies both in the fight against illness and with regard to the resources that can be used to maintain health.

Deficits are repeatedly criticised in healthcare provision. What are they? And is there an urban-rural difference here between so-called rural areas and structurally weak regions on the one hand and medium-sized centres and metropolises and conurbations on the other?

Almost all of us are familiar with this: first you wait a long time for an appointment with a specialist and when it finally takes place, you usually don't get there on time, but sit in the waiting room for hours. I can well understand that patients still see potential in the coordination between general practitioners and specialists, but also between community-based doctors, hospitals and care providers. I don't even want to talk about double or triple anamnesis processes and diagnoses here. And these reports reach us not only from so-called rural areas or structurally weak regions, but also from cities and urban centres. This is why, with our ‚Healthcare 2030' programme, we are committed to providing regional, holistic and patient-oriented care. AOK Nordost is strongly committed to this and is campaigning for all those involved to finally take the plunge and organise healthcare in a much more networked, interdisciplinary and therefore efficient way, close to where people live.

Is one possible solution for healthcare in rural areas a stronger focus on the outpatient sector?

In addition to exchanging information with our partners, we are trying to improve our knowledge of healthcare provision and expand our expertise in a variety of ways. For example, when analysing treatments in hospitals, we look at the question of whether the patients treated there could also have been treated on an outpatient basis. There are various ways of analysing this question, one of which is the so-called Outpatient Sensitive Hospital Cases (ASC) approach, which was developed by Professor Sundmacher and others. Here it becomes clear that very often the proportion of hospital cases that could in principle have been treated on an outpatient basis is over 20 per cent and can be as high as 60 per cent. And even if we change our perspective and look at the hospital cases from the perspective of the AOK-insured population in the centre areas, it becomes clear that often more than one in five hospital cases could also have been treated on an outpatient basis. Despite all possible criticism of such approximate indicators: There are considerable opportunities and potential here!

Does a health insurance fund have to be regionally based in order to provide the best regional care? What are the requirements?

If you are asking about the prerequisites - on the health insurance side, they are not so bad because some health insurance funds still have ‚regional references' in their DNA from their history: operational focal points, regional trade-related focal points or even references to municipalities and districts. But that is not enough. More building blocks need to be added. Let me answer this with a small advertising block for AOK Nordost. Last month, this year's MSD Healthcare Awards for outstanding changes in the German healthcare system were presented in Munich. According to the jury, their award is based on three points in particular: award-winning solutions must address real deficits in healthcare, they must put the patient at the centre and they must have proven their results in an independent evaluation. Since 2014, six AOK Nordost projects have been included in the competition, six times they have been shortlisted among the final ten projects, four times they have been awarded one of the top three prizes, twice of which were first prize. So the DNA for more regionality should also be characterised by a focus on real care problems, on people, on patients at the centre of improvement efforts and on results orientation. And perhaps something else that we have learnt from competent doctors: If you focus primarily on costs, you will reduce quality - if you focus on quality, you will reduce costs.

At the ‚halfway point' of the current government term, what do you specifically expect from healthcare policy and, in particular, from Federal Health Minister Karl Lauterbach?

My wish in this regard is not only directed at the Federal Minister of Health, but above all at the legislator, the Bundestag. My wish, based on the experience of the past three or four years, is not to regulate everything in the area of healthcare centrally and in detail, but to increase the scope for decentralised solutions and to create clear responsibilities for the results.

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An equally frequently cited narrative is the ageing of doctors in private practice, from which a shortage of doctors is often inferred. Is this really the case? Do we really have too few doctors in the three federal states of your health insurance fund, Berlin, Brandenburg and Mecklenburg-Western Pomerania?

Of course, the boomer generation also exists in the medical profession. And it cannot be denied that the focus of doctors on a so-called ‚work-life balance' has certain effects. But we should also take note of the facts here. For example, in 1990 there were 238,000 working doctors in Germany, twenty years later in 2010 there were 340,000 and in 2022 there were even 421,000 doctors. Between 2012 and 2021, around 10,000 women and men graduated from medical school each year. In the same period, the number of outpatient doctors rose from 144,000 to almost 164,000.

If we take a complementary look at the hospital landscape ...

... then a similar sham battle can be observed in the debate about hospital care. The impression is being created that a reduction in hospital capacity in Germany is massively jeopardising healthcare provision. We urgently need changes here too - not only to maintain and stabilise care, but above all to improve patient

care. Compared to the Netherlands, Germany has more than twice as many hospital beds and almost three times as many cases that are discharged from hospital. Is it really that dangerous to live in Germany? I think not. And: in other European countries, patients are quite prepared to accept longer journey times to the nearest hospital - if they receive better quality care there. So we shouldn't just look at the ageing of the medical profession and derive worrying narratives from it, but ask ourselves whether the real challenge isn't outdated structures, excessive regulations, unused digitalisation potential and, above all, misguided incentives.

We are living in a time of double demographics. It is not only those treating and caring for patients who are getting older, but also those insured, with more and more patients suffering from multiple illnesses. How is a health insurer like AOK Nordost preparing for foreseeable problem areas and the associated challenges?

In my opinion, the guard rails for the development of our healthcare have been known for a long time and have been named many times since the turn of the millennium, and not only by the AOK. However, the challenge that more and more people are getting older and older only now seems to have reached the wider public consciousness. This developing imbalance between the increasing demand and the limited supply of healthcare services cannot be solved by a single health insurance fund. It needs to be considered at all levels of society. Of course, we should hope for the positive effects of digitalisation. And of course, targeted immigration can also provide a solution here. But perhaps we also need to clarify how many tax officials we as a society want to deploy for the production of justice and how many people should be involved in maintaining health.

If it weren't for the excessive bureaucracy.

Everyone involved in illness and health experiences this aspect on an almost daily basis: there are problems in many areas of the healthcare system. Bureaucratic regulations, inconsistent processes, organisational deficiencies, incorrectly set incentives for the provision of services - a closer look often reveals that we could save on the deployment of some staff without any loss of quality and that significantly better quality of care could be achieved with the existing staff. In order to make progress here, the question of how care can be improved and avoidable use of resources can actually be avoided should be a central component of the various current legal reform efforts in healthcare. Perhaps the new regulations can be tested for their contribution to ‚demographic resilience'. Simple and digitalisablelaws are needed hereto reduce the burden of too many, too complicated regulations described by the Federal Chancellor.



Daniela Teichert

has been working for the Allgemeine Or tskrankenkasse (AOK) for more than 25 years. She began her career in 1990 with her training as a social insurance clerk in Cottbus; she then took on her first management tasks at the early age of 22. After studying health and social economics at the Berlin Academy of Public Administration and Economics, she worked in various other management positions and projects. From April 2016, she was a member of the Executive Board and responsible for the Market and Insurance Services department. Daniela Teicher t has been Chairwoman of the Executive Board of AOK Nordost since January 2020. In addition to her full-time work for AOK Nordost, she is also involved in school projects and youth sports on a voluntary basis. Daniela Teicher t is married and has two children.

What does this mean in concrete terms for a health insurance company like AOK Nordost?

Such a development would also enable the health insurance funds, as representatives of the interests of the insured and patients, to get involved more easily and better. After AOK Nordost has long been committed to determining the future demands on healthcare, AGENON and IGES have been conducting a needs assessment in the regions of Brandenburg on behalf of the state of Brandenburg since 1 October this year. We associate this with the expectation that the actual needs today and, taking into account demographic developments, for example in five and ten years' time, will be mapped and that the services will then be geared towards this from the perspective of the insured persons and their living environments, i.e. in their region. Technically speaking, the central areas should be the basis and the principle of service planning should be from the perspective of the insured: as much outpatient care as possible, as much inpatient care as necessary.

Furthermore, there must simply be more opportunities to test improvements that are geared towards the early detection of illnesses and more prevention. One example of this is the ‚HerzCheck' innovation fund project. The German Heart Centre Berlin is investigating whether heart failure can be detected earlier by using MRIs that can be transported on trucks and bring the latest technology to rural regions. The hope is that early detection will not only reduce individual suffering, but also the resources required to combat the disease. Given the right opportunities, health insurance companies can be a driver of significant change and thus support the adaptation to demographic change in the regions.

Let's look to the future, perhaps also in the context of your ‚Health 2030' programme: The morbidity orientation of risk structure equalisation has long since led to a shift in

competition between health insurance funds from the insurance market to the care market. How must a large health insurance fund like AOK Nordost position itself for the future?

We are firmly convinced that the answer lies in holistic healthcare that integrates its services much better and always puts people at the centre - from health promotion to all aspects of acute care and palliative care. In my view, it should not matter to a health insurance fund in future whether someone lives in the city or in the country, and health insurance funds must be able to cater in particular for regions where there are more indications than elsewhere. In our view, the integration of services should take place via the structures, the indications and the target groups. In the area of structures, we are working on outpatientisation on the basis of our ‚Health 2030' programme in accordance with the aforementioned principle of ‚as much outpatient as possible, as much inpatient as necessary'. This also requires changes to hospital structures. In terms of indications, we are focussing on ‚cardiac issues', with early detection of heart failure and better care for those affected taking centre stage. Special target groups are children and people in inpatient care. However, this also includes our contract to improve the care of multimorbid patients, with which we are endeavouring to support the corresponding DEGAM recommendation. Here, too, we're exchanging information with the professional association, not least with regard to the quality assurance of these approaches.

One last question on a topic that is rarely discussed in Germany: Pay for Result. Wouldn't it finally be time to bring about a social consensus or at least discuss the fact that patients and doctors are jointly responsible for the success of an intervention of any kind?

You are addressing an issue that is very important to me. We should pay more attention to what is achieved in the chain of diagnosis, therapy and care, for example, and what can realistically be achieved. This should become a basic approach in all our design considerations. And we should also compare the results actually achieved much more frequently with those that should actually be achieved and draw concrete conclusions from this as quickly as possible. It could really make sense to link at least part of the remuneration in the healthcare sector to the result and to reward the result-orientation of healthcare providers with this ‚pay for result'. Regional free trade zones could be helpful for this approach. It is possible to act more freely there because it is possible to deviate from SGB V regulations, which still cement old structures too much, with the agreement of those involved locally. This requires regional associations of local service providers and a regional agreement with statutory health insurance funds. We can already use routine data to measure the quality of care in order to recognise improved efficiency. In order to include the patient perspective, these could theoretically be expanded to include Patient-Reported Experience Measures, or PREMS for short. Theoretically, but unfortunately not yet practically, because PREMS are not collected across the board. This could pave the way away from purely sectoral funding towards better integrated and more patient-centred remuneration. <<

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Ms Teichert, thank you for the interview. <<

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