

"More opportunities for organising regional healthcare"

Cover interview: Dr Sabine Richard, Managing Director Supply of the AOK Federal Association

"In the long term, we will not be able to record and plan regional needs in parallel on a sectoral basis." "Regional partners on the ground are given too little room for manoeuvre." "We will have to establish completely new forms of work and work processes together." These three quotes from the cover interview with Dr Sabine Richard, Managing Director of Healthcare at the AOK Federal Association, show what is important to her: to influence the ongoing parliamentary process of the Healthcare Reinforcement Act (GSVG) as much as possible in order to "get more opportunities to shape healthcare in the regions, not less."

>> Se>> Dear Dr Richard, please put yourself in the mind of Federal Health Minister Prof. Lauterbach at the beginning of our conversation - even if this may be difficult for you: what do you think could be the "tactical reasons" why the BMG has removed key regionalisation elements from the draft of the Healthcare Reinforcement Act, or GSVG for short?

In view of the difficult coordination situation, which we know from the current coalition and certainly not only with regard to healthcare issues, we can only speculate about the reasons. I find it difficult to recognise a rationale. Particularly in the case of the law in question, it is simply incomprehensible that the name-forming elements of the draft law, which in full is called the "Act to Strengthen Healthcare in the Community", have been dropped. At least for the time being.

What are you hoping for?

We hope that the parliamentary process will at least reintroduce the topics that are essential for improving regional care.

Which "essential" regionalisation elements were exactly removed from the draft of the GSVG and what impact will these deletions have on the future of our healthcare system?

The essential elements that were primarily aimed at the further development of healthcare were the health regions, primary care centres and health kiosks. These topics are already included in the coalition agreement of the current government. The aim should be to get more opportunities to organise healthcare in the regions, not fewer. This is also urgently needed to make our healthcare system fit in view of the changes we are already seeing and which will continue to challenge us.

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The impartial chairman of the G-BA, Prof Josef Hecken, recently pointed out at the Spreestadt Forum of the TU Berlin the dramatic situation that demographics and falling health insurance contributions - triggered by, according to Hecken, "unemployment, the internship generation, the minimum wage or also because Generation Z is working fewer hours and therefore earning less income due to their age" - are causing generation prefers fewer working hours and therefore less income due to their work-life balance" - while at the same time facing increasing financial challenges due to advances in medical technology.

The expected demographic effects have long been known. Now is the time to finally organise the healthcare system more efficiently. We must finally be prepared to work together to find solutions. This is the only way we will be able to cope with change and maintain good, affordable healthcare for the next 20 or 30 years. To achieve this, it is urgently necessary to make outdated care structures more efficient and, above all, to better organise care processes, especially when they are based on a division of labour. This is an important point that has so far been neglected in all reform discussions. In the past, perceived deficits in care were remedied by ever new specialised healthcare services that were placed alongside or in competition with the existing sectoral structures. This ties up a lot of resources and patients find it difficult to navigate through the system without assistance. We want to move away from this.

"Precisely because demand planning is usually carried out primarily at federal level, regional partners are given too little room for manoeuvre on the ground."

Let's go back to the topics of "regionalisation elements" and "regional healthcare". Let's do a fact check: many people would agree with the hypothesis that healthcare is regional and, above all, local. But what evidence is there for this?

The evidence is evident every day. Medical practices and hospitals reach the population with their care structures in a more or less large regional or even just local catchment area, depending on the specialisation. This is in contrast to pharmaceutical manufacturers, for example, who operate worldwide or nationwide. In this respect, the regions differ in their supply density and also in their supply requirements, as the population also differs greatly from region to region in terms of density and socio-demographic composition. This is reflected in very different regional accessibility, journey times and many other indicators. The analyses of routine data that the WIdO regularly carries out show the many regional variations in the provision of care.

It is therefore logical to organise care regionally in order to be able to meet the requirements. In recent years, healthcare policy has too often focussed on standardised nationwide measures. What adjustments need to be made to give regionality more autonomy again?

Precisely because structural requirements and remuneration are usually predominantly set by the federal level, regional partners are given too little room for manoeuvre to act locally. This means, for example, that projects that have been subsidised by the Innovation Fund and have positively tested innovative forms of care almost always function in a narrowly defined laboratory setting, but are unable to develop any connectivity in so-called standard care. The reason for this is often that the standard system in which they have to operate is predominantly nationwide, but not sectoral and regional. As a result, there are far too few new solutions that would be able to sustainably improve care. This is why we, as the AOK, see a considerable need for action, particularly at a local level, because we want to and must be able to react differently to the often very different local and regional challenges.

The AOK Federal Association has now presented a position paper entitled "Health regions: Shaping sector-independent care",

which the entire AOK community, including self-administration, has agreed on. How difficult was it to reach a common position? The paper is not a first, as we have already presented joint positions on many other areas of care. Helping to shape regional healthcare provision together with local stakeholders is an important concern for all AOKs. Locally, the AOKs are confronted with the whole range of regional care situations, and many AOKs are particularly concerned with the question of whether good access to care services can be maintained across the board in the long term. It is often apparent that nationwide management instruments are no longer sufficient. Regional solutions with regional partners are required.

Some of these "joint" players have just published a press release entitled "East German medical profession united against the AOK's quest for supremacy". It states that the recently presented position paper by the "history-forgetting AOK strategists" of the AOK federal association - which probably also means you - would jeopardise the contractual partnership between the associations of statutory health insurance physicians in eastern Germany and their regional AOKs.

There will always be players with a different point of view, and we can live with that. Nevertheless, we stand by the statements in our position paper. It is surprising, however, when we are accused of striving for supremacy. We are certainly not, because we can only help shape healthcare together with the local players. Furthermore, the AOK does not want to and cannot develop its own healthcare provision, and that is not the subject of this position paper. On the contrary: it is explicitly in favour of strengthening regional cooperation together with the various local service partners. Naturally also together with associations of statutory health insurance physicians. Incidentally, we have already realised many projects with many KVs, which is why this statement surprises us.

Perhaps it is just the unusually open and harsh tone that bothers us. What you write here is certainly true. Perhaps it is just formulated a little too harshly, but on the other hand, the time is certainly ripe for a clear edge.

Criticising the problem of sector boundaries is certainly nothing new. It has been around for decades and has been expressed in many thousands of pages of expert reports. We are still in a position to set the right course in order to bring together the existing capacities and resources available locally to provide good, future-proof care. We have discussed the "how" and "why" very intensively with all AOKs, which have gained a lot of experience with individual regional and local projects - we have utilised this knowledge and brought it together in a position paper.

In your paper, for example, you have reformulated Section 123 of the German Social Code, Book V (SGB V) and addressed, among other things, the authorisation of contract doctors. This may have been the pain point for the KVs in eastern Germany. What do you mean? Maybe. But it is obvious that we also need more flexibility here. We have also looked closely at the reasons why innovative projects have failed, been made more difficult or delayed. In particular, medical authorisation has come to the fore.

Let's go back to your position paper. It includes a description of the situation, a solution concept, examples of adaptation and even proposals for legal regulations. What do you consider to be the key tipping points in the description of the situation that must lead to the regionalisation components, which were probably removed from the draft bill for purely political reasons, being reinstated? The hospital structure reform, which the federal and state governments are currently working on extensively, will also have an impact on outpatient care, as further outpatientisation is an important goal. In addition, we must take into account the preferences of younger doctors: in favour of more salaried work, more teamwork and increasingly interprofessional work. We need new prescriptions. The waiting times for appointments as perceived by patients are another issue, as is the overloading of emergency departments - often with a patient clientele that basically belongs in outpatient care and not in the emergency department of a hospital. Access and accessibility are a key issue, particularly in outpatient care: primary care centres and health kiosks would make an important contribution here. We will therefore have no choice but to utilise our human resources more efficiently and, for example, discuss how we can better involve other healthcare professions.

The question will be: How many different service partners will take on which part of patient care in the future?

Most certainly. We will have to try out completely new forms of work and work processes and establish them together. It is therefore all the more important to provide a new basis for such initiatives, for example by proposing in our paper to consistently focus on local contractual regulations and to create legally regulated freedom for this. In all of this, however, the following applies: because regional conditions are extremely different, the solutions must also be different.

This brings us to the solutions proposed by the AOK community. Could you name the most important ones that you consider to be effective in making our healthcare system more future-proof and resilient?

Firstly, we must manage to better utilise the inpatient resources that are currently still available for outpatient care concepts, beyond sectoral thinking. Secondly, we need to clarify what happens to patients after they have been hospitalised. Cross-sector care providers can be a link here, especially for geriatric hospital patients or those with chronic concomitant illnesses, e.g. units with monitoring beds with nursing care and on-call doctors. We must be allowed to talk about authorisations that allow doctors working in hospitals to work on an outpatient basis. There are already examples of this, such as paediatric care in Templin in Brandenburg. We must be able to organise such steps more easily in future. However, this has absolutely nothing to do with the AOK wanting to dictate anything here, no: we want to try to formulate possible solutions and then define them together with our service partners on site.

You are talking about a regionalised outpatient-inpatient care strategy, including the same kind of demand planning, which does not yet exist.

That is correct. In the long term, we will not be able to record and plan regional demand on a sectoral basis in parallel. We need cross-sectoral demand planning, a project that is already included in

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the coalition agreement. Continuing to plan with doctor's practices and bed numbers instead of real needs, care mandates or tasks is simply no longer in keeping with the times.

There is an interesting innovation fund project called "ProReVers" that aims to research exactly what you are calling for: Based on a patient survey, local needs are to be determined and a set of methods developed for a new regional care structure. The upcoming hospital reform will at least open a window for a cross-sectoral approach. To do this, we need to take a completely different view of regional and local needs.

What chance do you think you have of being able to influence the parliamentary process? We assume that these gaps will be filled again in the parliamentary process so that a law to strengthen municipal healthcare provision will ultimately contain more provisions to strengthen healthcare provision.

Thank you very much for the interview. <<

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



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is head of the healthcare management unit at the AOK-Bundesverband. She studied economics in Göttingen. After completing her doctorate, she worked for the Federal Association of Company Health Insurance Funds before moving to AOK Berlin in 2001, later AOK Nordost, and then to the AOK Bundesverband in 2013.

Auszug aus Vorschlag zum Gesetzestext: „Regionale sektorenunabhängige Versorgung“*

1. Die regionale sektorenunabhängige Versorgung umfasst regionale, verschiedene Leistungsbereiche, übergreifende oder interdisziplinär fachübergreifende Versorgungsangebote sowie besondere Versorgungsaufträge. 2Sie ist insbesondere auf die regionale Sicherstellung einer wirtschaftlichen und qualitätsorientierten medizinischen und pflegerischen Versorgung ausgerichtet und kann besondere präventive und koordinative Angebote beinhalten.
2. Die Krankenkassen, Pflegekassen oder ihre Landesverbände können Verträge über die regionale sektorenunabhängige Versorgung mit Leistungserbringenden oder Gemeinschaften von Leistungserbringenden nach diesem Kapitel sowie nach §§ 71f. Elftes Buch und Kommunen abschließen. Die Verträge können auch Regelungen enthalten, die die regionale sektorenunabhängige Versorgung auf bestimmte Regionen beschränken. 3Krankenkassen, Pflegekassen oder ihre Landesverbände können mit Zustimmung der beteiligten Vertragspartner auf Leistungserbringendenseite einem Vertrag auch nachträglich beitreten. Sofern sie mindestens 70 vom Hundert der gesetzlich Versicherten eines KV-Bezirks vertreten, können die Vertragspartner auf Kassenseite mit Zustimmung der beteiligten Leistungserbringenden einen Beschluss herbeiführen, der die Geltung des Vertrages für alle gesetzlich Versicherten in dem KV-Bezirk herstellt; § 211a Satz 2 gilt entsprechend. Es besteht kein Anspruch der Leistungserbringenden auf Vertragsabschluss.
3. In den Verträgen nach Absatz 2 sind das Nähere über den Inhalt und die Durchführung der Versorgung sowie die Vergütung zu regeln. 2Die Verträge können auch Leistungen nach dem vierten Kapitel Elftes Buch umfassen. Die Verträge können auch Abweichendes von den Vorschriften dieses Kapitels, des Krankenhausfinanzierungsgesetzes, des Krankenhausentgeltgesetzes, des siebten Kapitels und der §§ 84-90 Elftes Buch sowie den nach diesen Vorschriften getroffenen Regelungen und von den im Dritten Kapitel Fünftes Buch und Vierten Kapitel Elftes Buch benannten Leistungen beinhalten sowie ärztliche Leistungen einschließlich neuer Untersuchungs- und Behandlungsmethoden betreffen. Satz 3 gilt insoweit, als über die Eignung der Vertragsinhalte als Leistung der gesetzlichen Krankenversicherung der Gemeinsame Bundesausschuss nach § 91 im Rahmen der Beschlüsse nach § 92 Absatz 1 Satz 2 Nummer 5 oder im Rahmen der Beschlüsse nach § 137c Absatz 1 keine ablehnende Entscheidung getroffen hat In den Verträgen sind Wirtschaftlichkeitskriterien und Maßnahmen bei Nichteinhaltung der vereinbarten Wirtschaftlichkeitskriterien sowie Regelungen zur Qualitätssicherung zu vereinbaren.
4. Die Partner eines Vertrages nach Absatz 2 können sich auf der Grundlage ihres jeweiligen Zulassungsstatus für die Durchführung der regionalen sektorenunabhängigen Versorgung im Rahmen der berufsrechtlichen Grenzen darauf verständigen, dass Leistungen auch dann erbracht werden können, wenn die Erbringung dieser Leistungen vom Zulassungs-, Ermächtigungs- oder Berechtigungsstatus der bzw. des jeweiligen Leistungserbringenden nicht gedeckt ist. ...

* Quelle: Seite 10-12, Positionspapier 2024 des AOK-BV: „Gesundheitsregionen: Sektorenunabhängige Versorgung gestalten”

(Anm: Das 32-seitige Positionspapier liegt dieser MVF-Ausgabe bei)