

„We have to make the be and quality measurable“

In this interview, Daniela Teichert, CEO of AOK Nordost since January 2020, points out the pain points that are currently weighing on a large pension fund. However, she also proposes solutions that are set out in the AOK community's position paper, but have also been developed by her employees and herself in various pilot projects and based on their daily experience - always with the aim of improving healthcare provision within the framework of legislation. Her core demand: 'Less wrangling over competences between the federal and state governments, and instead more courageous decisions based on healthcare data and actual healthcare needs'.

In an interview: Daniela Teichert, Chairwoman of the Board of AOK Nordost

>> 'At 40.9 per cent, Germany already has one of the highest pension, health, long-term care and unemployment insurance contributions in the world,' writes Handelsblatt (1), quoting economic expert Martin Werding, who warns that the costs could 'derail the still reasonably good development of the labour market'. In addition, the trade associations BDI and BDA (2) stated almost simultaneously in a joint declaration that 'sustainable and expenditure-reducing structural reforms are urgently needed in all branches of social insurance'. This is because the capital buffer of the health fund's liquidity reserve will be exhausted as early as next year. Your health insurance fund will certainly also increase the supplementary contributions, but probably not to double the previous rate, as TK has already done. As chairwoman of one of the largest AOKs in Germany, Mrs Teichert, what can you do to make a leap into a better future by bridging the gap between financial viability, the competitiveness of the German economy and the overburdening of society?

The AOK Association has just published a new position paper on the 2025 federal elections. In it, we have dealt with precisely this topic, analysing the current problems in the healthcare system in detail and proposing constructive solutions. Basically, it can be roughly summarised as: 'More of what helps and less of what harms' - for example, more quality, more efficiency, more accuracy, more justice, more togetherness, more room for manoeuvre. On the other hand, less overuse and misuse, less watering cans, less antagonism, less professional and silo thinking, less centralism. The goal must be an efficient and better-organised healthcare system that citizens can trust again. We need to put the bottom back into the barrel. Expenditure policy must be geared to income and not the other way round. This is the only way we can counteract an unchecked rise in social security contributions.

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Our real problem does not lie in the shortage of financial and human resources, even if this is an undeniable fact. Above all, we have a distribution problem. And this is precisely where our great opportunity lies. Very good results can be achieved with scarce resources if they are used wisely and synergies are created. The position paper provides many examples of this. One of the most important is the quality-oriented modernisation of the hospital landscape in Germany. This is because expenditure on inpatient care continues to account for the lion's share of all SHI expenditure. With the quality-oriented modernisation of the hospital landscape, we will be able to avoid the high follow-up costs that arise from poor care in inadequately qualified hospital departments. And if we strengthen outpatient and medical/nursing care as well as prevention, we can avoid unnecessary hospitalisation from the outset. The paper clearly calls for the establishment of interprofessional and team-based primary care. Funding should be regulated via the extended assessment scale. All measures should then be coordinated via primary care. In this way, we ensure that patients only receive the medical, nursing and therapeutic care that they really need. If necessary, hospitals should be able to be part of this primary care.

'Due to its structure, AOK Nordost has long faced the challenges that many other health insurance funds only now seem to be realising.'

But what can you personally do as Chairwoman of AOK Nordost?

In all official and unofficial talks and appearances, I can always initiate and keep the important discussion about the future of our healthcare system going. I will continue to encourage those involved to take the first important steps towards change themselves and support them with our expertise. I have already done this in the past and I will continue to do so. This interview is a good example of this. In doing so, I am pointing out precisely the pain points and proposed solutions that the AOK community names in its position paper.

These have been known for a long time, or at least should have been.

The point is, however, that we as AOK Nordost have long been facing the challenges that many other health insurance funds only now seem to be realising. We were therefore quick to consider how we could best meet these challenges. One thing was clear: we can't do it alone. It quickly became clear that it was not a matter of tweaking a few screws or carrying out minor cosmetic repairs. What we need are real structural reforms. And such an endeavour requires allies. That's why the term 'alliance of the willing' was coined years ago. Together with our partners in the North East region, we have initiated and implemented many important projects. One of the most important was certainly the innovation fund project 'Structural Migration in the Templin Central Area', or StimMT for short. The centrepiece of StimMT was the conversion of a rural hospital into an outpatient-inpatient centre. So while others were still talking about 'more outpatientisation', we did it. And we realised that this could be a good way to solve many problems in rural care.

But then the project ended and with it came disillusionment.

That's how it is. The political framework conditions in Germany have so far not allowed such innovative and good projects to be easily transferred to standard care. Not even if the Federal Joint Committee makes a clear recommendation in favour. However, we have not allowed ourselves to be discouraged by this and, together with the AOK community, have developed ten proposals on how, through greater regionalisation and the introduction of a new legal basis, such important projects can not only be launched more quickly in future, but can also be easily implemented in standard care once they have been successfully completed.

And as in the microcosm, so in the macrocosm. With our regional

projects, we show on a small scale how things can work on a large scale. We gather the necessary experience, recognise the hurdles and find ways around them. And then we share this experience so that other regions can benefit from it. After all, the challenges are essentially the same everywhere. Only the regional or local circumstances differ. That's why it's so important that supply planning can be organised in a regional and decentralised way. Incidentally, this is also an important demand in the position paper.

Where do you see the particular challenges for healthcare provision in north-east Germany?

First of all, the north-east faces the same challenges as Germany as a whole. Like all other health insurance funds and regions, we are suffering from the misguided financial policies of recent years. The reserves of the statutory health insurance scheme (SHI) were deliberately melted down by law and insured persons' money was repeatedly misappropriated for numerous political projects and non-insurance benefits. Added to this is the unfavourable development of expenditure compared to income. All of this has now given the SHI system a dangerous slippery slope. The demographic trend - the population is shrinking, while at the same time people are getting older and there is an increase in chronic illnesses - poses a major challenge, particularly in rural regions. Combined with the growing shortage of skilled labour, this does not make things any easier. In this context, I usually talk about the challenge of managing the triple shortage.

What does that mean specifically for your fund?

As a large provider fund with a high proportion of so-called vulnerable policyholders - those in need of care and the socially disadvantaged - we also have the problem of the unfair distribution of policyholder contributions from the large SHI funding pot. Several scientific reports have confirmed that there is an urgent need to reform the financial equalisation between the health insurance funds: the so-called manipulation brake should be abolished and there should no longer be any incentives for risk selection. People in need of long-term care and other vulnerable groups are at a disadvantage in the current morbidity-oriented risk structure equalisation system. This leads to funding gaps for health insurance funds with a high proportion of people in need of long-term care and socially disadvantaged people, while funds with many young and healthy policyholders benefit. This unequal distribution jeopardises the fairness of care and undermines the solidarity principle of statutory health insurance. In order to ensure equal health opportunities, we must adjust the Morbi-RSA on an insurance-related basis and ensure a fair distribution of funds. In future, those in need of long-term care and other vulnerable insured persons should be given greater consideration in the RSA so that the financial resources go where they are most urgently needed for care. In this way, we will prevent risk selection and ensure fair financing in the healthcare system.

'The challenge is managing the triple shortage.'

What additional problems are there in the north-eastern part of Germany?

We are indeed facing additional challenges that affect the north-east in particular. For example, a nationwide analysis shows that the statutory health insurance funds in Brandenburg and Mecklenburg-Western Pomerania spend more on average than they take in for each insured person. And this cannot be explained solely by the structure of the insured, i.e. age, gender and illnesses. In some regions, for example, patients are too often treated unnecessarily in a clinic. On the other hand, numerous clinics are currently experiencing financial difficulties. In the north-east, we have the highest proportion of hospitals to which health insurance companies have to pay a so-called guarantee surcharge, namely a third of all hospitals in Germany.

So the hospital reform was passed by the Bundestag just before Christmas?

The hospital reform was a very important step towards tackling the challenges described above. However, it now depends on how the federal states deal with the hospital reform, as this will be fundamental to the future of medical care. Unlike in the past, every exception approved by Brandenburg and Mecklenburg-Western Pomerania, for example, will be at the expense of hospitals that fulfil the quality criteria of the service groups with great effort.

'Enable more regionality with a coalition of the willing,' you demanded in the cover interview with 'Monitor Versorgungsforschung' at the end of 2023 (3). Now you could add: 'And finally dare to deliver more quality'. The question: From the perspective of AOK Nordost, how do we achieve more quality instead of constant savings and, above all, a more efficient and economical use of resources, including their fair distribution?

Expenditure trends over the last ten years clearly show that there have been no constant savings. And yet we know exactly where we can start in order to finally achieve more quality and, above all, an efficient and economical use of increasingly scarce resources. And at the same time to achieve a fair distribution. We need many more opportunities at regional level to plan and manage care precisely from the outset, taking into account the available resources and clearly defined quality standards set by the joint self-administration. Quality care means nothing other than that the available resources are utilised in such a way that they bring the greatest possible benefit to patients. At the moment, the exact opposite is the case. The costs are exploding, but low-threshold access and care are perceived to be getting worse for many people. For me, however, this also means that we have to make the benefits - and the quality - measurable. The AOK community has been setting a good example here for a long time. We use so-called routine data in both outpatient and inpatient care to measure quality.

And, of course, a very central point is that the available financial resources are channelled to where they are actually needed and where they will have the greatest possible benefit. So it's actually quite sim-

ple: by modernising the hospital landscape with a focus on quality, improving emergency management, driving forward interprofessional outpatient care and strengthening prevention and early detection, for example through digital care solutions, unnecessary hospital stays, expensive treatments and follow-up costs can be avoided. The financial resources freed up can then be used sensibly elsewhere.

And speaking of financial reserves ... ...

... it is imperative that these can be utilised more efficiently by using the insured persons' money: The instruments of price competition need to be strengthened again - particularly with regard to the pricing of patent-protected medicines - and a benefit assessment of digital health applications analogous to the benefit assessment for medical methods, remedies or aids. And if money becomes tighter, we as health insurers will of course demand greater opportunities for billing and performance audits. However, I would also like to make it clear that, in view of our own capacities, we would prefer to use these for other (more meaningful) tasks for our policyholders.

How can you as a health insurer utilise your limited capacities sensibly and efficiently?

More push into digital support services - and, thinking ahead, artificial intelligence - which are used sensibly and in compliance with data protection regulations to streamline processes, reduce bureaucracy and avoid inefficiencies.

Let's take a positive look into the near future. The AOK Nordost is finally being given the legal freedom to further develop and restructure the healthcare landscape in the three federal states in which it is represented in a sustainable and resilient manner: How can the AOK Nordost quickly realise the efficiency reserves lying dormant in the system in order to end the above-mentioned three-way split between financial viability, competitiveness of the German economy and overburdening society? There are many approaches: Patient-centricity and results orientation, outpatient care and decentralisation and, above all, regionalisation and truly integrated care without sector boundaries!

Ambitious goals are needed, especially at the beginning of the year: If we as AOK Nordost had the legal freedom to organise care, then we would do this together with the other partners in social self-administration and the service providers. You have basically already answered the question of how. The approaches you mentioned - patient-centricity and outcome orientation, outpatient care and decentralisation, regionalisation and integrated care without sector boundaries - are all points that I have repeatedly mentioned as possible solutions to the problems, particularly in rural care. The AOK Nordost sees these as pioneering steps on the way to an efficient, quality-orientated healthcare system and to care that is precisely tailored to people's needs. This means regional care close to home, without sector boundaries, which is embedded in an overarching, state-wide care plan. In this way, economically and infrastructurally weak municipalities and regions can also be supplied in the sense of equal living conditions.



Daniela Teichert

has been working for the Allgemeine Ortskrankenkasse (AOK) for more than 35 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 early on, at the age of 22. After studying health and social economics at the Berlin Academy of 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 Market and Insurance Services. Daniela Teichert has been CEO of AOK Nordost since January 2020. In addition to her full-time work for AOK Nordost, she also volunteers for school projects and youth sports. Daniela Teichert is married and has two children.

Which brings us back to the StimMT innovation fund project.

Genuinely integrated care without sector boundaries also requires sector-independent financing. As part of the project, we were able to utilise the available funding flexibly. After the end of the project, we endeavoured to maintain the innovative and well-functioning structures that had been established via selective contracts. Unfortunately, we were not completely successful. But we are continuing to work intensively on this. We are not alone in facing this problem, which affects most innovation fund projects. That's why we currently have a patchwork of hundreds of individual selective contracts and mosaic-like solutions.

In our position paper, we therefore reiterate our call for an independent legal basis for regional contracts. This should enable local partners to organise healthcare provision with real freedom, without coming up against the limits of the German Social Code. This would also include, for example, that the financing of medical and nursing services could be provided from a single pot and no longer differentiate between outpatient and inpatient care. This would also allow specialised staff to be deployed across the board, which is not possible under the existing regulations. The professional competences are basically the same - regardless of whether

the carer works in home care, in hospital or in inpatient care facilities, for example. And there are no longer any good arguments for defending these outdated structures and funding logics, especially in a European comparison.

'With a view to patient-centred care with the overarching goal of achieving the greatest possible benefit for patients, remuneration in the healthcare sector should move away from its current focus on volumes and incentives.'

Is the StimMT innovation fund project an isolated case?

No, we have many good projects already underway or still in the pipeline that are just waiting for us to finally be given the legal freedom to implement them. The next challenge would then be to reconcile the interests of all those involved and find good compromises that are more than just the lowest common denominator. Then we can also realise the dormant efficiency reserves in the system.

In your keynote speech at the 13th MVF Congress 'With PROM and PREM to Patient Centered Care', which thankfully took place again in December on the premises of AOK Nordost, you asked the participants present whether they all had the same idea of what patient-centred care means, whether a common approach was really being pursued or whether the ideas of the various stakeholders were so different 'that in the end little or no patient-centred care remains'. Such a statement from a high-ranking health insurance manager is sobering. What is your definition of patient-centred care?

For me, patient-centred care means putting patients, with their needs, requirements and values, at the centre and thinking about and managing healthcare on an individual basis. You could also put it like this: Healthcare is adapted to the patient and not the other way round. The top priority is to treat people who need medical care with dignity and respect, to involve them in all decisions about their health and treatment and to keep them well informed. At the patient's request, family members can be involved in this process. Patients receive relevant information promptly and quickly and their decisions are accepted and respected. The highest priority is always the physical and psychological well-being of the patient. This type of care is also referred to as 'person-centred care', an approach that is closely linked to patients' rights.

Patient-centred care should be a basic attitude of all professions in the healthcare system and should be practised. Consistent patient-centred care leads to an increase in health literacy and an improvement in patient safety. And I am convinced that this is also in the interests of most healthcare professionals working with patients. This should be the common focus of all transformation initiatives.

This leads to the question of whether, in view of differing ideas and in the course of what appears to be an ever-intensifying battle for as large a share of the budget as possible, a systemic change is not necessary: away from competition and payment for individual services towards truly patient-centred healthcare with a consistent pay-for-result approach.

Absolutely right and also groundbreaking. With a view to patient-centred care with the overarching goal of achieving the greatest possible benefit for patients, remuneration in the healthcare sector should move away from its current focus on volumes and incentives and reward elements that are more dependent on results and quality. The financing logic should provide incentives for more patient-orientation in care and for cooperation between healthcare stakeholders. In principle, remuneration should apply to all healthcare stakeholders across all sectors and be based on the healthcare needs of the population in a healthcare region to be defined. Other aspects, such as the care structures, the specific clinical pictures and specific patient groups, for example geriatric and multimorbid patients, must also be taken into account.

However, as far as I am aware, there is no current and validated model with regional budgets.

Not yet! In my view, an important point in such a model - which I would very much like to work on - would be performance-related remuneration components: In order to achieve a pay-for-result, Patient Reported Outcome Measures and Patient Reported Experience Measures could be used as success criteria on the one hand, and quantitatively measurable targets on the other.

At the opening of the congress, you also said that you and your colleagues 'see healthcare research as an important lever' for improving the quality and efficiency of our healthcare system. According to Archimedes (4), where do you think health services research should apply the most leverage?

AOK Nordost is focussing on testing regional care networks. The Innovation Fund offers us the necessary - also financial - room for manoeuvre to overcome sectoralisation and address regional healthcare needs and structures. AOK Nordost is currently involved in innovation fund projects in particular, which aim to utilise medical and nursing resources in such a way that as many patients as possible continue to receive the best possible care - despite a shortage of specialists and despite demographic and financial challenges.

For example, in the current research project 'ProReVers - Prospective regional cross-sectoral care planning', we are developing practical instruments and procedures for the systematic creation and implementation of small-scale cross-sectoral care planning. These instruments are initially being developed in relation to the project regions, the districts of Prignitz and Ostprignitz-Ruppin, but should be applicable to other regions in the future. In the innovation fund project 'ErwiN - Extended transfer of activities that relieve physicians in physician networks', we are trialling the 'substitution' of medical services by other professions, in particular by nursing staff.

We are also supporting the Medical University of Lausitz Carl Thiem in its prospective research programme.

The course has been set for the hospital structural reform and the emergency reform, but there are still delays in the emergency reform. What do you expect - as things stand today - for 2025 and the following years?

The development of both reforms once again underlines the im-

portance of our demand: in the coming legislative period, there must be less wrangling over competences between the federal and state governments. Instead, sustainable structural change requires more courageous decisions based on care data and actual care needs.

To implement the hospital reform, there will be three legal ordinances that require the approval of the Bundesrat, i.e. the federal states: on the organisation of service groups, on the regulation of minimum reserve figures and on the transformation fund. We expect all parties involved to take the necessary steps quickly and courageously to push ahead with this important structural reform.

The hospital reform is an essential, expenditure-reducing structural reform within the SHI system that we urgently need in order to reduce the overall expenditure burden in the long term. This is the only way to ultimately reduce the financial burden for each and every insured person and their employer.

With regard to a reform of the ambulance service and emergency care, we expect the next federal government to tackle the issue right at the beginning of the legislative period. The most important point here is well-coordinated cooperation between outpatient and inpatient facilities and the rescue service.

Your conclusion?

The current structures are inefficient and false incentives cost the insured billions. The problem is well known and there are also proposals for solutions and key point papers - both from the time of the coalition with the traffic light coalition and from the previous government under Health Minister Jens Spahn. So we can and should get started right away.

Ms Teichert, thank you for the interview. <<

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

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Literature/Links:

1: https://www.handelsblatt.com/politik/deutschland/gesundheit-krankenkassen-erwarten-2025-bisher-hoechsten-anstieg-der-zusatzbeitraege/100031951.html
2: https://arbeitgeber.de/muenchner-spitzengespraech-zehn-punkte-um-vertrauen-zurueckzugewinnen-und-den-standort-deutschland-zu-staerken/
3: https://www.monitor-versorgungsforschung.de/wp-content/uploads/2023/11/MOVS-0623_Teichert.pdf
4: „Gebt mir einen Hebel, der lang genug, und einen Angelpunkt, der stark genug ist, dann kann ich die Welt mit einer Hand bewegen.“ Archimedes

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Teichert, D., Stegmaier, P.:'We must make the benefits and quality measurable', in „Monitor Versorgungsforschung“ (01/25), S. 6–11. http://doi.org/10.24945/MVF.01.25.1866-0533.2683