Congress

Above all, it must be clear who is in charge

Panel discussions at the 14th MVF Specialist Congress organised by "Monitor Versorgungsforschung"

On the day of the event, the Scharounsaal hall at AOK Nordost was filled with an atmosphere that oscillated between optimism and resigned realism during the 14th MVF Conference of "Monitor Versorgungsforschung", organised in cooperation with the DNVF and supported by MSD as platinum sponsor. Outside, the Berlin winter was dawning, while inside, the future of the German healthcare system was often the subject of heated debate. This was hardly surprising, given that the "Monitor Versorgungsforschung" specialist congress had taken on a huge topic: "Shaping primary care – strategies for a patient-oriented and resilient healthcare system". What began in the lecture sessions (1) as a scientifically evident exchange about care structures developed in the two panel discussions into a fundamental but forward-looking debate about competencies, budgets and the question of who will be "in charge" of the system in the future.

The protagonists on stage roughly represent the fault lines of the current healthcare system: Vera Lux, President of the German Professional Association for Nursing Professions (DBfK), representing increasingly self-confident nursing, Dr Dominik von Stillfried from Zi, representing the guardians of medically dominated standard care, and Michael Zaske, Head of Department 3 at the Brandenburg Ministry of Health, who fought for pragmatic emergency aid across the board. Between the fronts: two Austrians – Dr Maximilian Schwarz and Jan Langner from Gesundheit Österreich GmbH (see MVF 06/25) – who, on behalf of their country, have been successfully building for over ten years what is only now being discussed in Germany: a new, comprehensive primary care system.

The discussion kicked off with a professional group that has long been in the background: nursing. Vera Lux, President of the German Professional Association for Nursing Professions, used the podium to make an impassioned plea in favour of community health nursing (CHN). "We have many young people who are very well trained and ready to start," Lux opened the discussion. Her argument: the shortage of personnel is not the only problem, but rather the legal constraints on the existing potential. As long as the legislature does not create a framework for performance and liability, academically trained nursing staff will remain in a grey area of uncertainty. "But if they have no framework in terms of performance and liability law [...], then there is great uncertainty as to whether or not to go down this path." Lux warned that this uncertainty leads to a waste of resources. Young professionals who would be willing to take on responsibility in primary care are being held back because laws such as the Nursing Competence Act or reforms of the nursing professions (PflBG) are repeatedly postponed or are tied up in other legislative procedures.

A central point of the debate was the clarification of terminology. When asked by the audience whether English terms such as "community health nurse" could not be replaced by "Gemeindeschwester" (community nurse), Lux responded with irritation but determination: "This topic comes up again and again, and I'm tired of hearing it." In a world of "caring communities," she said, the English term is established and expresses a specific academic qualification that goes far beyond the traditional image of a community nurse.

However, even more important to Lux was the distinction from other new job profiles, in particular the "physician assistant" (PA). Here, the DBfK president drew a sharp line: "Let's be honest: we don't think much of it." The introduction of ever new professional groups such as PAs does not make the system more transparent for patients, but rather more complicated and expensive. Instead of creating new auxiliary professions, she advocated "sharpening the profile" of existing nursing professions – from assistant to "advanced practice nurse" (APN). Lux defined the APN as a nursing professional with a master's degree and specialisation in complex clinical fields such as transplant medicine, psychiatry or oncology. She placed the "community health nurse", on the other hand, at the level of "public health": networking, counselling, management and guidance in the home. This, she said, is the key to closing gaps in care without competing directly with highly specialised medicine.

An emotional moment in the discussion arose when the question of the actual workforce came up. Despite 1.7 million nurses in Germany – more than ever before – the system is groaning under the strain. Vera Lux and Dr von Stillfried (Zi) touched on a sore point: the lack of data and the flight to part-time work. "The return on investment is simply not that good," Lux analysed soberly. She referred to data from the Hannover Medical School and the University Hospital of Cologne, which showed that the part-time rate in nursing was around 50 per cent. Surprisingly, it was not primarily older employees or mothers who were reducing their hours. "The older ones usually still worked 90 per cent," said Lux. It was the young graduates who often only wanted to work 50 per cent immediately after completing their training.

Note

This report is based on the verbatim transcripts of the two panel discussions at the 14th MVF Specialist Congress. Quotes have been slightly edited for clarity without changing their meaning. All presentation content from the morning and afternoon sessions can be viewed or downloaded in PDF form and as audio recordings on the MVF portal: **https://t1p.de/caxch**



Fig. 1: **Morning panel discussion (from left): Cordula Hoffmanns (Robert Bosch Centre for Innovation in Healthcare), Dr David Wachabauer (GÖG), Dr h. c. Helmut Hildebrandt (CEO of OptiMedis), Dr Sabine Richard (Managing Director of Healthcare at the AOK Federal Association) and Prof. Dr Bertram Häussler (Chairman of the Management Board of the IGES Institute).**



Fig. 2: **Afternoon panel discussion (from left): Prof. Dr. Volker Amelung (Hannover Medical School / Managing Director of the Institute for Applied Health Care Research GmbH - inav), Steffen Bohm (Managing Director of Agenon), Vera Lux (President of the German Professional Association for Nursing Professions (DBfK) Federal Association), Michael Zaske (Head of Department 3 MGS Brandenburg, currently Interim Minister of Health of Brandenburg), Dr Dominik von Stillfried, Chairman of the Central Institute for Statutory Health Insurance Medical Care (Zi). Moderator: Prof. Dr Wolfgang Hoffmann (DNVF).**

She attributed the reasons for this not to salary, but to working conditions and a lack of autonomy. "We always have to ask, we have to run after the doctors – whether it's for a prescription or a care level assessment," said Lux, describing the frustrating everyday life of her profession. Young people no longer accept these hierarchies and are

seeking their own path – often away from full-time work or out of the profession altogether.

There was agreement on the podium about the statistical failure of the German healthcare system. "We have no statistical data that differentiates between how many one-year trainees, how many nursing assistants or how many academics we have," criticised Lux. Without this data, targeted personnel planning is impossible.

Dr Dominik von Stillfried, CEO of the Central Institute for Statutory Health Insurance Medical Care (Zi), confirmed this "blind flight" also applies to the medical sector when it comes to healthcare management. He compared the billing data of the associations of statutory health insurance physicians (KV) to a "dinosaur skeleton". Although therough structure can be seen, the bones (i.e. data points) have to be painstakingly pieced together to understand how the healthcare system works.

While the nursing side pushed for more responsibility, von Stillfried also urged caution. However, his argument was not based on professional pride, but on concerns about the efficiency and coordination of care. Von Stillfried's main criticism of the federal government's current reform efforts was fragmentation. He outlined a scenario in which patients are surrounded by countless actors without it being clear who is pulling the strings. "We have a home visit service from the KV that is active 24/7, we have a parallel telemedicine service, and we are introducing the telemedicine emergency doctor and the community emergency paramedic. That's four new entities addressing the same clientele," he calculated.

If the "community health nurse" is now added as a fifth entity, the idea of focusing on "one" responsible party will suffer greatly. For von Stillfried, however, this is precisely the goal of a primary care system: to bundle responsibilities, not to distribute them. He warned that "Grandma Krause" would end up not knowing who was responsible for her and whether the measures taken by the physiotherapist or nurse would also have to be corrected by the doctor.

To illustrate the scale of the problem, von Stillfried presented some impressive figures that should ground any discussion of reform: 600 million outpatient treatments per year, 220 million of which are in general practitioners' surgeries. He dismissed as illusory the idea that this burden could simply be redistributed to newly established "Level 1i hospitals" or primary care centres. "Even if we convert a large number of hospitals into Level 1i locations, we might end up with 500. These locations will not be able to cope with the primary care system," explained von Stillfried.

A murmur went through the hall when Dr von Stillfried pointed out the 133 different practice management systems (PMS) in Germany. This fragmentation of the software landscape is one of the biggest obstacles to innovation. The Zi is the first institute to provide transparency about the quality of these systems. The damning verdict: "This is one of the main reasons why we can do relatively little with AI at present: we do not have a uniform data basis."

However, the main problem, the Zi board member went on to explain, is not that patients are not seeing doctors at all – only about 11 million cases concern patients who have not yet been to their GP. The problem is

managing the huge volume of real-life contacts. Von Stillfried therefore advocated strengthening the existing structures (50,000 GPs, 35,000 practices) and connecting them digitally, rather than building parallel worlds.

And above all, to manage them better, added Prof. Dr. Bertram Häussler from the IGES Institute. He called for a paradigm shift in the approach. Instead of getting lost in endless debates about structure, the focus must be on managing care processes. According to Häussler, patient dissatisfaction stems primarily from a lack of coordination and the feeling that the system is "overloaded".

The IGES director redefined the classic "4 Cs" of primary care (first contact, continuity, comprehensiveness, coordination). Today, continuity no longer has to be ensured by one person (the family doctor who has known the family for decades), but by an intelligent data model that makes the patient's history available.

While discussions and debates about legislation are taking place in Berlin (at the MVF Congress), Brandenburg has long been taking action. Michael Zaske, head of department at the Brandenburg Ministry of Health, contributed the perspective of a large state that simply does not have the time for theoretical discussions of principle. "It is not our job to always look to politics and ask: Has someone forgotten something?" Zaske called out to the hall. His message: The laws already offer scope for action; we just have to use it.

Brandenburg is relying heavily on delegation models. Zaske reported that the famous "Sister Agnes" (a modern version of the community nurse) provides a significant part of the care in areas where there is a shortage of doctors. "Where one in three doctors stops working, Sister Agnes can partially compensate for this," explained Zaske. To this end, the state also trains "community health nurses" or comparable personnel and places them in nursing services, paying them according to pay grade E12, even if E13 is not (yet) possible.

Zaske's approach is characterised by entrepreneurial thinking: if a system is inefficient, it must be restructured. "An entrepreneur would not make the mistake of having five or six people working in parallel," he agreed with the criticism of fragmentation, but concluded that integrated models must be built locally.

When asked how Austria succeeded in enshrining primary care in law (Primary Care Act), Dr David Wachabauer from Gesundheit Österreich GmbH outlined the process: 1. Target setting (2013): Agreement between the federal government, the provinces and social security on the goal of strengthening primary care.

2. Concept phase: In order to get the medical profession on board, the concept was initially called "The team around the family doctor". 3. Legislation (2017): Creation of legal certainty and definition of care mandates. An important aspect here was protection against purely capital-driven investors (restriction to non-profit organisations or doctors).

4. Financing: Provision of 100 million euros (including EU funds) as start-up financing to minimise risk for founders.

Wachabauer emphasised that the massive resistance from the medical profession could only be overcome through a consistent political stance

over many years.

Towards the end of the discussion, the debate took a philosophical turn. One participant reported on the World Expo in Osaka, where a "senior washing machine" was presented – a fully automated personal care facility. While Vera Lux called for "fears to be put aside" and technology to be seen as an opportunity to address staff shortages, there were also sceptical voices.

Vera Lux herself warned against losing human contact. "I'm also a little afraid of what would happen if everyone really just ended up in the washing machine," she admitted. Especially when it comes to issues such as violence against women (187,000 cases last year) or child neglect, nothing can replace the physical, human gaze – not even the best telemedicine. "Not everything can be done digitally."

A common thread that ran through the entire afternoon was criticism of the rigid separation of sectors in the German healthcare system (outpatient vs. inpatient). Many pinned their hopes on the new "regional sector-independent care" (RegioSV). But disillusionment quickly followed: "What is that?" asked one participant polemically, criticising that although a nice headline had been created, no one knew how the new facilities were to be financed or what they were legally allowed to do. "No one who has their wits about them will set up something like that," was the harsh verdict on the current legal uncertainty.

Vera Lux also expressed scepticism about the implementation of outpatient care in accordance with Section 115f of the German Social Code, Book V (SGB V) (sector-specific remuneration). She described the current design as a "monstrosity" because it still relies too heavily on inpatient logic. Her alternative proposal: health centres that can operate flexibly – for example, in the premises of closed hospitals – where nurses, doctors and therapists work under one roof without every move being blocked by sector boundaries.

When MVF editor and congress president Prof. Dr. Reinhold Roski ended the discussion, one central question remained: Who will lead the change? The discussion made one thing very clear: the players are no longer willing to wait for the "big move" from Berlin; they want to act. NOW. And quickly, because:

- Nursing is demanding its place and creating facts with models such as CHN, even if liability law is lagging behind.
- The medical profession (represented by the Zi) is defending its coordinating role, but must admit that without digital support and relief from other professions, it will collapse under the burden of 600 million cases.
- Regions (such as Brandenburg) are stretching federal guidelines in cases of doubt to prevent the collapse of care.

The 14th MVF specialist congress ended with the realisation that "Agenda 2030" will not be decided on the drawing board in Berlin, but in local negotiation processes. Or as Michael Zaske, currently Brandenburg's interim health minister, put it: "We must move forward. [...] Even if the framework conditions are not yet as we would like them to be."

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