Redaktion

# "The courage to do things even though they are not yet required by law"

*"NAVIGATION", "ProReVers", "ErwiN" and the hospital in Seelow, which is being converted into a healthcare campus: when you talk to Daniela Teichert, CEO of AOK Nordost, she can think of lots of innovation fund and other funded projects that already show that a different, new type of primary care is possible today. But possible does not automatically mean efficient, because current legislation is only flexible to a limited extent. In general, she feels that politicians and health insurance companies lack "the courage to do things that may not yet be explicitly stated in a law, but are already permitted and therefore possible".*



In interview: Daniela Teichert, CEO of AOK Nordost

**>> Let's imagine the year 2040, when Germany has a nearly perfect healthcare system. What key achievements do you see from the perspective of a health insurance company?**

From the perspective of health insurance companies, things are going exactly as we would like. In 2040 – in less than 15 years – we will finally no longer be at the bottom of the international rankings in terms of the number of doctor-patient contacts and outpatient procedures. These are areas in which we are currently lagging far behind.

**How do you justify this optimism?**

By 2040, we hope to have a healthcare planning system in place that coordinates all levels of healthcare – hospitals, doctors' surgeries, nursing care, therapy facilities and psychosocial counselling centres. However, this system is not based on mere assumptions, but on valid surveys, analyses and all the data already available today, from which concrete needs are derived. This helps us to use human, diagnostic and financial resources

efficiently. Among other things, this creates the basis for easily accessible, specialised and interdisciplinary outpatient primary care. Well-networked, digitally supported structures and a good infrastructure ensure that patients have access to the care they need at all times. We have also ensured that doctor's appointments are handled carefully, although I would prefer to refer to them as practice contacts. This is because a recent Forsa survey conducted by the AOK Federal Association found that patients – our insured members – already want better control over their care.

**This statement is surprising because patients supposedly prefer to be able to choose their own doctor so that they can see a specialist as directly as possible. Your survey now seems to suggest that patients actually want more control and guidance?**

First and foremost, the respondents wanted to be directed to the right level of care at the right time – for example, a specialist's practice, hospital, rehabilitation clinic or therapy facility . This is precisely what many of those affected are not experiencing today because, for example, they have to put up with extremely long waiting times for appointments with specialists.

***"We need guidelines that define structural, personnel and quality requirements in interprofessional teams."***

**What political and structural changes do we need to make so that the scenario you briefly outlined can become a reality in less than 15 years?**

Above all, we need to introduce a cross-sector planning system that includes inpatient, outpatient, nursing and therapeutic care – and ideally social care as well. This requires clear structural features that cannot be constantly changed. It is also imperative that we no longer have to maintain structures that are not evident and, in some cases, no longer necessary. We are already seeing today that, with well-coordinated primary care, many inpatient measures could also be carried out on an outpatient basis with the same quality. What we also need are guidelines that define structural, personnel and quality requirements in interprofessional teams.

**In its 06/25 issue, "Monitor Versorgungsforschung" published an interview with Gesellschaft Gesundheit Österreich GmbH, which introduced a primary care system in Austria exactly ten years ago. In the meantime, over 100 primary care units have been set up throughout our neighbouring country, funded by €100 million from the EU. Brandenburg or Mecklenburg-Western Pomerania could also secure this funding as a model project for Germany.**

There are always solutions; you just have to want them and then have the courage to implement them. We are on board. In our innovation fund project NAVIGATION, for example, patients are already being cared for in a primary care centre by a team of community health nurses, general practitioners, psychologists and social workers. Together, the specialists develop an individually tailored care pathway that also takes social factors into account. The community health nurses are specially trained nursing professionals who are not only part of the interprofessional team in the project, but also have clinical management and central control functions. This distinguishes NAVIGATION from other primary care approaches, where this role is taken on by general practitioners, for example. The

primary care centres we are striving for are not doctor-centred.

**But what are they?**

We advocate well-coordinated care provided by an interprofessional team. The primary care centre as we envisage it brings together the skills of a wide range of healthcare professions under one roof and goes far beyond the portfolio of a general practitioner. Of course, there will always be general practitioners, and they will always have enough to do.

However, we should define delegable services and tasks that can also be performed independently by specially trained non-medical professionals – for example, community health nurses or well-trained physician assistants, or PAs for short. But this is only economical if a certain number of patient contacts – say, a third – can then be transferred away from the doctor. This will give local doctors the opportunity to focus on cases that require their full attention and time – which will be an important prerequisite, especially in the context of outpatient care and treatment quality. However, with the current guidelines, it will be quite difficult to move away from a doctor-centred approach and towards interprofessional management.

**Why should a doctor or PA work in a primary care centre and not elsewhere?**

Because these new primary care centres are attractive to them. Many healthcare professionals will appreciate it when their skills are challenged, promoted and valued more than before, for example through independent work. But it is also a matter of incorporating this into a concept and environment that patients can get used to and also appreciate. We will succeed in this if patients are given the feeling that "it is not worse treatment just because it is no longer done by a doctor." This must be communicated adequately. And, of course, it must be proven again and again in concrete implementation.

***"I miss the courage in politics to say clearly: 'Our structures must change, and that's a good thing because it will improve care, not make it worse.'"***

**Isn't this also an opportunity to make many professions in the healthcare sector more attractive?**

Absolutely. One major advantage will be that we can once again attract young people to these professions, who may currently be ruling them out because they are not valued as highly as they should be. In places where practices are already working in a similar way, we can see that they have no problems attracting new talent or recruiting staff.

**All of this begs the question: what's the catch?**

From our point of view, the risk is that primary care should not become a new sector in its own right. In our view, a new primary care system must be integrated into cross-sectoral overall planning and arise purely out of necessity. It will thus always be a needs-based alternative, but – and I must emphasise this – a new sector must not be created, because then nothing, absolutely nothing, will change in the other sectors.

**Why?**

Let's take the example of outpatient surgery in hospitals: if clinicsare to perform outpatient surgery with the samesurgeons and in the same setting as before, they simply have a cost problem because they will then do it exactly as they have always done and as they have always been taught to do. However, this will never allow them to achieve the efficiency gains that are entirely possible in purely outpatient facilities, which do not deliver inferior quality. In other words, when a new sector emerges, it may work, but the others will continue to operate as before. How can innovation be introduced into standard care in this way?

**The danger, however, could be that patients perceive primary care as a cost-cutting measure and say, "Now everything will get even worse."**

It is up to us to prevent this by ensuring that quality does not deteriorate, but actually improves. Our innovation fund project "ErwiN – Extended transfer of doctor-relieving activities in doctor networks" shows that patients are satisfied when they receive comprehensive care from a qualified nurse for certain indications – and in consultation with a doctor. Mind you: in their home environment and without having to travel to the nearest town to visit a doctor's surgery.

**How can you tell which patients do not actually need to go to the doctor's surgery?**

Unfortunately, this is not possible under the current system. At the moment, patients have a medical or perhaps also a social care problem that can only be solved by going to a doctor's surgery. This should no longer be the case.

**Where do you see the greatest difficulties in terms of necessary changes: in the lack of political courage to bring about real structural change? Or in the persistence of the actors involved? Or perhaps in the culture of our healthcare system, which has been established for decades?**

Politicians are well aware that structures need to change in order to secure and improve care. Unfortunately, our healthcare system is very sectoral. Hospital reform is currently being implemented, followed by emergency care reform and soon primary care. It makes sense for this to come from a single source and be reflected in joint planning and care processes. And, of course, it takes courage to actually change processes and structures. Instead, important structural innovations are repeatedly thwarted by tendencies to preserve the status quo and particular financial interests. But I also miss the broad support of the medical profession, which says: "We cannot continue like this. We must adapt ourselves and the organisation of our practices, delegate more and substitute." This also applies to the involvement of other players, such as pharmacies and nursing care. So far, I have only very rarely encountered a willingness to redistribute tasks in the region, and then mostly only regionally, namely where the pain points are greatest. Where even the last person has finally understood: we can no longer do this with the existing structures. Yet a willingness to change is necessary everywhere, not only in underserved or rural structures. There are also problems and unmet needs in urban structures.

### How can we break out of this exhausting cycle, which is almost inevitably leading to increasingly poor results?

We need the courage to do things even though they may not yet be explicitly stated in a law, but are already permitted and therefore possible. Incidentally, this is also the case with our health insurance funds: we want to do something, but because the legal basis is lacking, nothing is done at first, or at least not what is actually already possible. I admire the courage of some players in the healthcare sector who simply tackle projects such as converting a hospital into an outpatient-inpatient centre and say, "We'll find a solution somehow." We need to talk much more about such positive examples and approaches, because they encourage us and may go some way towards counteracting the paralysis and despondency currently evident in politics.

### Apart from courage and the will to shape the future, what else is needed?

Regular exchange between all relevant stakeholders is extremely important. The state of Brandenburg, for example, has analysed the structures in five healthcare regions as part of the "Brandenburg Healthcare Needs Analysis" project and initiated initial discussions with local stakeholders via regional forums and project groups. This is the only way we will make progress. We need to give local stakeholders an idea of how they can change processes in practices or institutions across the board and adapt them to real needs.

### And how do you intend to identify these real needs?

To this end, we havelaunched the ProReVers innovation fund project– Prospective Regional Cross-Sector Care Planning. It addresses the central question: How can healthcare be stabilised – especially in a predominantly rural region – in the face of increasingly scarce resources? This question can only be answered in a well-founded manner if the current problem situation is thoroughly analysed and described. ProReVers shows that surveying local healthcare providers and the population about their experiences with healthcare provides important additional insights. Based on this analysis of the regional problem situation, local stakeholders met in regional planning conferences and jointly developed concrete recommendations for structural adjustments to healthcare provision from a cross-sectoral perspective. The focus was particularly on the opportunities and regional challenges for the outpatientisation of services. But it is not only the exchange of ideas that is very important.

**Daniela Teichert**



*has been working for the Allgemeine Ortskrankenkasse (AOK) health insurance fund for more than 35 years. She began her career in 1990 with an apprenticeship as a social insurance clerk in Cottbus, subsequently taking on her first management responsibilities at the early age of 22. After studying health and social economics at the Academy of Administration and Economics in Berlin, she held various other management positions and worked on various projects. From April 2016, she was a member of the management board and responsible for the market and insurance services department. Daniela Teichert has been Chair of the Board of AOK Nordost since January 2020. In addition to her full-time job at AOK Nordost, she volunteers for school projects and youth sports. Daniela Teichert is married and has two children.*

**What else?**

In rural areas of Brandenburg and Mecklenburg-Western Pomerania – but also in other federal states – there are, for example, hospitals that are on the verge of insolvency or whose shareholders want to close them down entirely or individual departments for economic reasons or due to requirements arising from hospital reform. This usually triggers an immediate knee-jerk reaction from politicians and local authorities: "That's out of the question; we have to maintain the existing structures." Regardless of whether this makes sense or not. The reaction is also understandable. People are afraid that, in case of doubt, their medical care will no longer be guaranteed or that they will have to travel very long distances for it in the future. Doctors and other healthcare professionals may fear negative effects on their own work. State and local politicians want to fulfil their public service obligations and not alienate voters. That is why, in such change processes, it is important to involve all local stakeholders from the outset andpresent a good alternative. So that they know that it is not just a case of closing something down, but that something better will emerge.

**Do you have an example of how this can work well?**

The hospital in Seelow is a good example of how this can work. We spoke to all the stakeholders there and worked out a solution together. A healthcare campus is now being built at this location. It will no longer be just an inpatient facility, but will have a much broader focus, be multi-professional and include short-term care, a pharmacy and a medical supply store. This will create a new, sustainable structure that will enable needs-based healthcare.

**Could this be a model for all regions in Germany?**

Certainly. The idea of converting hospitals to meet demand can actually be implemented anywhere, if there is a real will to do so. This would also make hospital reform more effective than if the focus is always on closing locations or departments. Above all, it is important to convey the positive message of change in line with demand.

**In addition to Seelow, you mentioned the innovation fund project "ErwiN" as an example of such a needs-based change. Can you say a little more about that?**

Exactly, as I said, ErwiN stands for the extended transfer of tasks that relieve doctors in medical networks. During the project period, a state-recognised additional training programme for specialised nursing professionals, or SPFP for short, is to be developed and implemented. We are receiving feedback from patients that they feel very well cared for in the project because they no longer necessarily have to visit the doctor's office but, after consultation with their treating physician, are cared for by specially trained nursing staff in their home environment. But the project has also shown us limitations that should not really exist.

**What are these?**

The participating patients are often elderly people, many of whom live in rural areas with poor infrastructure. It helps them enormously not to have to constantly worry about how to get to the nearest doctor. But these people then sometimes ask the perfectly understandable question: "Can't you vaccinate me at the same time?" However, well-trained nursing staff currently have to refuse this, as vaccinations are only permitted in a doctor's surgery, even though the doctor is not always personally present there either.

**Shouldn't we be focusing more on state rather than federal policy here, or is it always a question of SGB V?**

The example mentioned explicitly concerns a necessary amendment to the relevant paragraph. This is precisely why we are campaigning in several areas for an amendment to SGB V, not only with regard to the vaccination situation, but especially with regard to cross-sector care planning. However, this requires political will. Only then can we move away from the many pilot projects that are well-intentioned but always come up against the harsh reality of legal norms. As long as politicians do not explicitly stipulate that positively evaluated results must be incorporated into standard care, little or nothing will happen.

**You will soon have the first results of the "ProRe-Vers – Prospective Regional Cross-Sector Care Planning" project on the table. What are your hopes for this?**

We hope that the instruments and procedures developed in the ProReVers research project will also be applied in other regions. The prerequisite is that there are people in a region who are willing to break new ground. And, of course, the framework conditions must be such that different or new care approaches can be agreed and implemented in the regions. A large number of solutions would already be legally possible, but are not currently being implemented due to the rigidity of the systems. The project also formulates proposals for this. Thanks to ProReVers, we can work with local care providers to develop concrete ideas on how the often quite different municipal and local needs can be met in the future. However, in future we should no longer focus solely on doctors' surgeries, care centres and hospitals, but must also consider and involve other care structures. This requires a legal opening up of delegation and substitution. However, this must not be a case of coexistence, but must always be a case of cooperation. It must also be absolutely clear who does what and who is responsible. All this can only work if the system is based on a relationship of trust.

**And what about incentives?**

Of course. We need those too. But they already exist. For example, we have the removal of budgetary constraints in general practice. This means that a registered doctor could treat many more patients than before. But then they realise that they cannot manage this alone. So, for example, a physician assistant is hired. However, this also means that delegation or substitution must be organised, otherwise the whole thing is not worthwhile. This means that the doctor will delegate certain services out of purely financial self-interest, if he or she is allowed to do so.

**This system can already work today.**

With the removal of budgets, there should be no problem for GP-centred care. For specialists, it is a question of distribution. That is why I say: there must be no separate sector. The money is only there once. As long as this is done on the basis of data and real needs, however, the distribution mechanism can be organised differently. But that also means that certain vested interests will be called into question.

**Can you already see this willingness?**

We still have a long way to go. But at least in Brandenburg, we have already taken far more than the famous first, most difficult step. Through the regional conferences initiated as part of "ProReVers", we have been able to bring all stakeholders for a care region together around one table for the first time ever. Previously, there were separate planning structures for inpatient and outpatient care, but there was no coordination between them. Now, however, we are in a position to take a cross-sectoral view and deploy the human resources available in the region accordingly – in line with needs and efficiently.

**Isn't the only thing missing now a concept for how best to structure the many primary care centres that are needed in order to inspire prospective doctors and nurses?**

That would, of course, be the icing on the cake. We are already happy when we talk to each other, analyse the data together, reach a consensus and then plan for the future together.

**How would you measure success once these primary care centres have been introduced?**

One indicator would be fewer doctor-patient contacts with at least the same – if not better – quality of care, with prompt appointments and high patient satisfaction. Ongoing surveys of patients and service providers must show us that managed care works better. If that is not the case, then we would have to make adjustments.

**It's a shame: we invest so much money in healthcare, but we measure the results so little.**

This is done in every other industry: those who invest want to see what the return on investment is. In the healthcare system, on the other hand, more and more money is being poured into the same structures without asking why. That is why I would like to see us move away from the current scattergun approach to budgeting and instead invest only in needs-based structures that really change standard care. These should not be cost-cutting measures, but explicitly quality-improving measures. We must credibly convey that efficiency in care is also process optimisation.

**Ms Teichert, thank you for talking to us.**

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

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**Telemedicine: opportunities and obstacles**

>> Paediatric care is facing a digital revolution. While telemedicine experienced a massive boost during the Covid-19 pandemic out of necessity, experts are now investigating how virtual visits (VVs) can be permanently and effectively integrated into everyday clinical practice. A recent Spanish study (1) by a research team led by Isabel Castro Garrido from the Department of Paediatrics at the Hospital Universitario de Navarra in Pamplona paints a clear picture: the willingness of the more than 300 professionals surveyed is high, but the technical infrastructure and digital competence are still lagging behind in many places.

Acceptance among paediatricians and nursing staff is impressive: almost 90% of those surveyed are in favour of their workplace offering virtual visits. The technology is primarily seen as a supplement to personal care and not as a replacement. According to the respondents, VVs are considered particularly useful for discussing test results (81.6%), follow-up appointments (74.5%) and monitoring chronic conditions. The perceived benefits vary greatly with the age of the patient: while virtual visits are considered very suitable for adolescents (86.5%), healthcare professionals see much more limited applications for infants (39.7%) due to the need for physical examinations.

Despite the positive overall mood, the study identifies significant obstacles. First and foremost are technical problems such as unstable internet connections (52.6%) and concerns about data security (37.4%). However, a much deeper problem is the human element: around a quarter

of professionals stated that they lack confidence in using digital tools.

To ensure the success of the digital transformation, the authors of the study published in the open access medium "Children" call for targeted measures: after all, over 72% of professionals signal interest in specific training programmes. <<

**Link:** 1: https://doi.org/10.3390/children13010031

**What will happen when ChatGPT Health arrives?**

>> "Structural change with ChatGPT Health – a starting signal for substitution and a leap in productivity?" is the title of a new LinkedIn post by Prof. Dr. Axel Mühlbacher, Professor of Health Economics and Health Care Management at the Neubrandenburg University of Applied Sciences. In his article, he discusses the announcement by the US company OpenAI to establish a separate health section in ChatGPT with "ChatGPT Health" (initially without the EEA/Switzerland/UK), where users can ask health questions and (depending on the region) link documents and data from apps.

"ChatGPT Health" is to be created as a separate section within ChatGPT, separate from normal chats, with increased data protection measures. Users will be able to use it to better understand lab results, prepare for doctor's appointments or identify patterns over time, for example. Mühlbacher: "Disruption does not mean 'AI replacing doctors or human know-how'. Disruption means a new player taking over large parts of the preparatory and ancillary work involved in healthcare – and shifting power, processes, roles and value creation." <<