“Out of the innovation dead end and into a transfer space”

In the interview (from left to right): Prof. Dr Martin Dietrich (BMG), Prof. Dr Lutz Hager (BMC), Prof. Dr Wolfgang Hoffmann (DNVF) and Dr Regina Klakow-Franck (impartial member of the G-BA until 2018)









Following the BMC workshop initiated by MSD and entitled "How do we make healthcare innovations successful?", "Monitor Versorgungsforschung" convened a panel of experts to discuss the need for reform of self-governance, new scope for action and the courage required for change, and to draw up a master plan for the German healthcare system. The panellists were (in alphabetical order) Prof. Dr Martin Dietrich, Head of Division 513 at the Federal Ministry of Health (BMG), Prof. Dr Lutz Hager, Chairman of the Board of BMC e. V., Prof. Dr Wolfgang Hoffmann, Chairman of DNVF e. V., and Dr Regina Klakow-Franck, independent healthcare consultant.

The German healthcare system faces a paradoxical situation: whilst we are witnessing a wealth of innovative approaches and research projects, these often run aground in a 'transfer dead end'. The question of systemic blockages is more pressing than ever. Dr Klakow-Franck, as an impartial member, you observed the work of the

Joint Federal Committee (G-BA) for six years. In the BMC workshop entitled "How do we make healthcare innovations successful?" (see page 14 ff.), you spoke of an "organisational defensive stance" on the part of the self-governing body. A provocative question: Is the G-BA, in its current form, the greatest obstacle to modern patient benefit because it prefers to administer rather than shape?

Klakow-Franck: One cannot simply label the G-BA as the "biggest obstacle", if only because there is no serious alternative to joint self-governance. In particular, the division of responsibilities between the legislature and the sub-statutory regulatory body known as the Joint Federal Committee has been very successful over a long period, even by international standards. I do not, therefore, question the principle of self-governance. However, self-governance must keep pace with new challenges. My criticism is that the scope for shaping the continuous further development of healthcare, which does in fact exist, has often been unused or utilised only inadequately. One example is the 2012 Outpatient Specialist Care (ASV) scheme, which was intended to break down sectoral barriers but ultimately ended up as a fragmented set of codes within the EBM without noticeably improving care. The track record of the Innovation Committee's pilot projects is also sobering. The self-governing bodies must engage in self-criticism here: why are we failing to draw lessons from successful projects for standard care?

Professor Dietrich, you are representing the Federal Ministry of Health in this discussion. From this perspective, how do you assess the self-governing bodies' capacity to learn?

Dietrich: I share the view that the self-governing body's capacity to adapt was probably overestimated when the Innovation Fund was introduced, given the particular challenges posed by innovations in healthcare provision. The SGB V offers stakeholders far more opportunities to act innovatively and test new concepts than are currently being utilised. However, we see astructural problem: the pathway leading up to the Innovation Committee's recommendation for transfer is now well established – perhaps even over-administered. After that, however, there is a vacuum. As the G-BA is a body under public law, it needs an explicit mandate to be able to play a proactive role in this area. We are currently examining very closely at the BMG how we can provide clearer guidance to the self-governing bodies. In other words: we must define the transfer task in such a way that the self-governing bodies can actively engage in its implementation. Let us make one thing clear, however: the self-governing bodies are irreplaceable, but we must strengthen the instruments and framework conditions for actively shaping the transfer.

"We are currently examining very closely at the BMG how we can provide clearer guidance to the self-governing bodies."

Prof. Dr Martin Dietrich, BMG

Prof. Hager, as Chairman of the BMC, you view these processes from a systemic perspective. If we also take an outside view of Germany and its approach to innovation in healthcare: why are we falling behind?

Hager: We certainly do not lack cutting-edge medicine or financial resources, but rather the ability to bring about process changes. Internationally, we have long known that care must be cross-sectoral, patient-centred and benefit-oriented. There is no lack of understanding here, but a disconnect in implementation: our many innovation projects are like small cogs trying to move the sluggish main cog of standard care. This simply cannot succeed because they cannot generate sufficient leverage. We must therefore fundamentally realign our innovation system: it is simply not enough to gather individual insights from small pilot projects; we must set the 'big flywheel' in motion. An Innovation System 2.0 must be designed from the outset to further develop healthcare as a whole.

Professor Hoffmann, at the BMC workshop you mentioned that the self-governing structure itself might be the real problem. Why?

Hoffmann: The structure of self-governance dates back to a time when one had to negotiate what was being offered 'too much' or, quite simply, who gets how much of the pie. Today we have too little of everything: skilled workers, resources, money and time. In a system of scarcity management, however, negotiating on the basis of the lowest common denominator no longer works, because none of the banks is prepared, out of self-interest, to forego advantages. Nor can self-governance be the right body for the task of transferring innovations into a system in which everyone has settled in quite comfortably. In other words: if you ask frogs, they will never vote in favour of draining the swamp in the right places. To put it another way: we healthcare researchers do produce valuable evidence with the help of the innovation fund, but we then hand these results over to self-governance for collective dismantling, which almost always ends in non-implementation. This is inefficient and frustrating for everyone involved.

How, then, do we escape the trap of what appears to be 'organised irresponsibility', in which Innovation Fund projects that have been approved receive a recommendation for integration into standard care, yet no one feels responsible for doing so?

Hoffmann: We need to change the structures where innovation meets reality. I advocate a nationwide approach to innovations that have already proven their effectiveness in various settings and regions. We must also think more radically: in the long term, SGB V and SGB XI should be merged to remove the artificial divisions between health and long-term care insurance. Within this new framework, we must set priorities: patient-centred care, sector independence and a 'value-based' approach. 'Business as usual' is no longer an option.

Hager: I fully support that. We need politically defined targets for change. One concrete model would be regional tenders for consortia. We must no longer get bogged down in isolated, small-scale measures. We need regional care plans that, for example, bundle projects on care home provision, pilot schemes or patient empowerment into a single package. These regions would then serve as binding pilot areas for a subsequent nationwide roll-out. So we commit to nationwide adoption right from the start of the regional phase. This gives the change a significant scale and finally sets the flywheel I mentioned in motion.

Dietrich: The direction is right. However, we need to focus on three points: Firstly, the right questions must be asked and the right projects

supported right from the development phase of innovations. So far, projects have often been merely an ‘add-on’, an additional layer on top of existing care. We must also define the concept of improving healthcare provision in operational terms, for example in line with the internationally discussed ‘Quintuple Aim’ approach – that is, better public health, a better patient experience, cost-effectiveness, the working conditions of healthcare professionals, and equity in care. Secondly, we particularly need to strengthen the transfer of successfully tested care concepts, for example by establishing transfer support. Someone must make the decision on what is scaled up – a sort of ‘ownership function’. Thirdly, we must make the system more receptive, for example by enabling provisional reimbursement models and pilot guidelines. This alleviates health insurers’ concerns: if an innovation does not deliver the promised key performance indicators (KPIs) during monitoring at the start of the transfer, there must also be clear criteria for discontinuation. Conversely, if positive project results are evident and robust during the transfer, there must be no more excuses.



Prof. Dr Martin Dietrich ***has been working at the Federal Ministry of Health since 2023, where he heads Division 513, ‘Innovation Funds and Experimental Pilot Projects’. From 2011 to 2016, he was Professor of Business Administration, specialising in healthcare management, at Saarland University, and from 2016 to 2023 he served as Deputy Head and Acting Director of the Federal Centre for Health Education.***

Klakow-Franck: Self-governance will not be able to achieve the necessary structural change on its own. At the decision-making level, the theory of action that is espoused and the theory that actually guides action are drifting further and further apart – our healthcare system is a long way from being a learning organisation, and the development gap compared to other modern healthcare systems is widening. All too often, protracted negotiations result in the lowest common denominator. This is simply too slow and insufficient for today’s challenges. Legislators are increasingly intervening in what are essentially self-governing tasks through substitute measures and detailed legislation, yet the resulting patchwork of regulations is no solution either. Prof. Hager and I therefore propose, on behalf of the BMC, a completely new approach: a genuine, dedicated innovation space within SGB V in the sense of greater scope for action, with new, sector-independent guidelines for patient-centred and cost-effective care. This

includes systematic innovation management with a structured transition of successfully tested process innovations into standard care. Currently, the Innovation Committee at the G-BA issues a recommendation, and then a huge vacuum ensues. Nobody feels responsible.

Prof. Hoffmann, you have often referred to this as an 'experimental space'. Isn't that just another piece of the puzzle?

Hoffmann: I don't really care about the term; it must be a space in which stakeholders and those willing to shape the future can act free from conventional obstructionist strategies. This is about a genuine breakthrough. In this space, one must be able to act free from conventional constraints. We can already see today that investors are buying up hospitals and medical practices torun cross-sector careon a for-profit basis – often without any evidence-based scrutiny. That cannot be our goal. Instead, we need a legal framework for professionals who structure patient pathways with the common good in mind and incorporate prevention. And we must factor in the risk of failure. I propose a rescue fund. Stakeholders who embark on such innovative experiments must not be allowed to go bankrupt if a project fails to deliver the desired results. Such a fund would provide the necessary security to take truly bold steps.

Hager: I would prefer to speak of a "transformation engine". We are no longer at the experimental stage – we often already have the evidence, not only from the innovation fund, but also internationally and from other projects. The focus now and in the future is on developing the solidarity-based healthcare system for the future. Innovation must not be a 'side issue' here, but must be linked to the central challenges of health policy. It is a core task of health policy; and by that I mean innovation that reaches the grassroots. Our healthcare system is like Gulliver, bound by a thousand tiny regulatory threads. Instead of trying to reweave each thread individually, we must cut some threads to create a new framework for dynamism.

Klakow-Franck: Exactly. In doing so, we should not make the mistake of viewing the new sector-independent care sector as an 'add-on' sector with new interface problems. I foresee three levels of care in the future: firstly, a profoundly reformed, multi-professional primary care system. Secondly, integrated, more complex care, provided on a sector-independent basis through flexible cooperation between service providers. And thirdly, traditional inpatient care, which in future will, however, be defined by whether patients have a need for overnight care and treatment that cannot be provided on an outpatient basis. In this respect, the proposal for a new sector-independent care sector should not be seen as yet another patch at the outpatient-inpatient interface, but as a conceptual component of the cross-sectoral structural change that is required.

A key, and also sensitive, point would be an obligation to provide better care. If something is demonstrably better, why is it not made mandatory – and why is the old system not abolished?

Hoffmann: This point is absolutely crucial. We need not only a commitment to implementation, but also to de-implementation. If an innovation is demonstrably better, the old, inferior method must be compulsorily excluded from reimbursement. This would also relieve the burden on health insurance funds, which currently often rightly fear that innovations merely incur additional costs. Of course, there will be an outcry

within the system from those who have settled into the old routine. But this noise must be endured politically. Quality must prevail.



Prof. Dr Lutz Hager *has been Chairman of the Board of the Federal Association of Managed Care (BMC) e. V. since 2022 and is a Professor of Healthcare Management at SRH Fernhochschule. There, he heads the Executive MBA programme for doctors; previously, he served as Managing Director at IKK Südwest and worked for McKinsey & Co., and is a recognised expert in healthcare research and health policy.*

Klakow-Franck: Yes, we must also adapt the principle of economic efficiency under SGB V to the 21st century. However, when it comes to individual examination and treatment methods, demonstrating a better cost-benefit ratio will rarely be successful. But if an innovative care offering along a patient-centred treatment pathway demonstrates greater patient benefit than existing care, and also a better or at least non-inferior cost-benefit ratio, then standard care should be changed and not continue as before – that would be a consistent implementation of value-based care. This is the only way to make progress financially viable whilst simultaneously improving quality.

Prof. Dietrich, how realistic is such a 'transfer space' – let's not call it a transfer engine – with mandatory coordination from the Ministry's perspective?

Dietrich: We cannot establish new structures or authorities for this in the current situation. However, we can create a flexible commissioning solution in which a single body assumes responsibility for the transfer and binds the stakeholders together in a binding manner. That would be a pragmatic and appropriate way to utilise the technical expertise of the self-governing bodies, whilst also putting it into practice without prescribing every single detail. I am convinced that there are now enough proactive stakeholders within local government who support such a collaborative approach. However, an authority must then be found or created that is both able and willing to take on and implement this task. So yes: local government could be mandated to orchestrate the transition through specialised consortia.

Where could we start immediately?

Hoffmann: In regions where the needis alreadygreatest. Take Mecklenburg-Western Pomerania or the Lusatia region in Brandenburg. We have already developed a concept for Lusatia in which – as we propose – provisions of the Social Code Book V (SGB V) can be temporarily suspended to allow for whatever makes sense in terms of care provision. If we demonstrate there that it works, everyone will ultimately approve. We don't need years of new studies; we must act now. We have the professionals, we have the evidence – we just need the political courage for the exemptions. But we cannot wait until the next legislative term to do this. We can and must start setting an example right now, using the resources available in regions where the need is greatest. To do this, we need a list of the necessary exemptions to finally allow stakeholders to do everything that – where it is evident – actually makes sense. The current SGB V provides for various exemptions, which are unfortunately all too often undermined by the self-governing bodies, and in some cases also by the Ministry. The aim must always be to improve the quality and security of care, not merely to cling to old privileges.

Hager: Regionality is key in two respects: it provides the concrete framework for innovation in healthcare. After all, this is always part of a broader context. Furthermore, regions differ in terms of their demographics, healthcare infrastructure and needs. Sustainable solutions will therefore vary; 'one size fits all' is not the right approach.

The final word goes to the vision: we need a system that learns, takes responsibility and truly puts patients at the centre. Thank you very much for your in-depth insights and your time.

The interview was conducted by MVF Editor-in-Chief Peter Stegmaier.

"We need a legal framework for professionals who structure patient pathways and incorporate prevention. And we must factor in the risk of failure."

Prof. Dr Wolfgang Hoffmann, DNVF



Prof. Dr. med. Wolfgang Hoffmann MPH *has been Managing Director of the Institute for Community Medicine since 2007 and has held the W3 Chair in Population-Based Health Services Epidemiology and Community Health at the University Medical Centre Greifswald since December 2011. Since December 2012, he has been spokesperson for the Rostock/Greifswald Partner Centre of the German Centre for Neurodegenerative Diseases (DZNE). In May 2018, Hoffmann became Deputy Chair, and in October 2022 Chair of the DNVF.*



Dr Regina Klakow-Franck *is an expert in quality assurance in the German healthcare system. As a specialist in gynaecology, she served, among other roles, as Deputy Chief Executive of the German Medical Association (2005 to 2012), an impartial member of the Federal Joint Committee (G-BA, 2012 to 2018) and subsequently as Deputy Director of the IQTIG (2019 to 2023). Her professional focus lies on cross-sector quality assurance, patient safety and the further development of the medical fee schedule.*

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Conference

Ways out of the innovation transfer impasse

BMC Congress: MSD workshop entitled “Necessity is the mother of invention?!”

At the 2026 BMC Congress held at the Langenbeck-Virchow-Haus in Berlin, a workshop initiated by the pharmaceutical company MSD and entitled “Necessity is the mother of invention?! How do we make healthcare innovations successful?” addressed a critical problem in the German healthcare landscape: the failure of successful innovation projects at the threshold of standard care. Moderated by Prof. Dr Lutz Hager, Chairman of the BMC Board, representatives from politics, academia, health insurance funds and clinical practice discussed how isolated project successes can be transformed into sustainable systemic changes.

The German healthcare system is considered rich in innovative approaches, yet their widespread implementation remains a cause for concern. Whilst clearly defined access routes exist for medicines and medical devices, there is no structured pathway into the statutory health insurance (GKV) system for process and care innovations.

The starting point: a system in an innovation bottleneck

Prof. Hager pointed out that, in terms of healthcare development, Germany lags behind other countries – such as the Netherlands – by as much as 15 to 20 years. Although the Innovation Fund was an attempt to address this, simply funding research does not in itself generate widespread improvement. The central question of the masterclass was therefore: How do we shape the ‘second half of the journey’ so that innovations actually reach patients?

Paradigm shift: project success is not innovation success

Prof. Dr Martin Dietrich, Head of Division 513 at the Federal Ministry of Health (BMG), opened the debate with a clarifying reference to the scientific understanding of innovation processes. He emphasised that an innovation necessarily consists of two phases: development and transfer. The development phase focuses on evidence-based proof of efficacy under controlled conditions (internal validity), whilst the transfer phase must focus on feasibility under dynamic environmental conditions (external validity). Dietrich made it clear: “Project success does not equate to innovation success”. Only when an innovation penetrates the reality of healthcare provision and establishes a new routine can we speak of a successful transformation. He identified transfer as the current main bottleneck, as the recommendations of the Innovation Committee to the Joint Federal Committee (G-BA) often come to nothing if they are merely forwarded to stakeholders for a ‘review of responsibility’.

To overcome this bottleneck, Dietrich proposed a blueprint for a transfer model based on eleven principles. These include, amongst others:

• Agreed criteria for improvements in care (patient benefit, efficiency, but also the experience of healthcare professionals).

• The consolidation of care concepts, not project structures.

• Interim regulations and remuneration to enable promising approaches to get off the ground, similar to the French model.

• Agility as a principle: the transfer must be able to respond to changing conditions, which requires a move away from rigid, research-oriented settings.

• Net bureaucracy effect ≤ zero: Dietrich rejected the creation of new authorities or institutes as 'transfer bodies' so as not to place a further burden on the system.

The practice of transfer: the "human factor" and the management gap

René Engelmann from IVP-Networks provided an insight into the operational reality using the example of the NPPV (Neuropsychiatric and Psychotherapeutic Care) project. The project was successful because it built on previously evaluated approaches to integrated care and consistently rolled these out across the board. Engelmann emphasised that innovations consist of "10 per cent technology, 20 per cent processes and 70 per cent people".



Prof. Dr Martin Dietrich, BMG,

The success in the North Rhine-Westphalia region, with over 1,000 service providers and 14,000 patients, was largely due to the deployment of network managers. These coordinated collaboration between specialists and psychotherapists, organised group services and overcame local resistance. The key insight: complex forms of care require a permanent management and IT structure. In the case of NPPV, this led to the establishment of the KSVPsych guideline by the G-BA, with the management costs now being funded via specific codes in the EBM (approx. 24 euros per case per quarter). Nevertheless, start-up funding for new networks remains an unresolved challenge.

Systemic barriers from the perspective of the payers

Patricia Ex from the BKK umbrella organisation added the health insurance funds' perspective to the discussion. She acknowledged that the initial euphoria surrounding the innovation fund had given way to a certain disillusionment, as the translation into standard care often stalled. One

“elephant in the room” is the fact that services once established within the system can hardly be removed, which fuels a “fear of a permanent financial burden” among payers.

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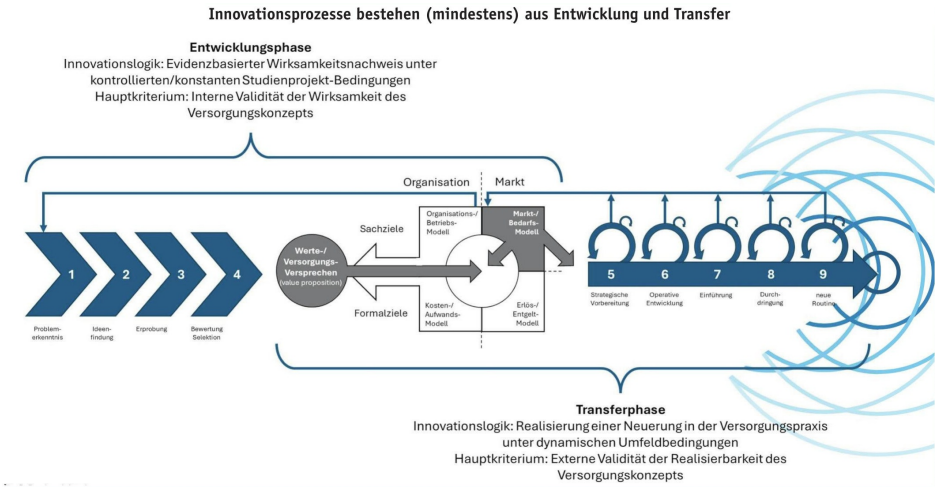


Fig. 1: **Innovation processes consist (at least) of development and transfer. From: Lecture “Healthcare Innovations – Development, Transfer and Adaptation” by Prof. Dr Martin Dietrich, BMG, Team 513 | Innovation Fund, Future Region Digital Health, 27 January 2026. Source: c. Dietrich (2025).**

Ex also notes that a mere billing code does not guarantee a genuine improvement in care. She called for interoperability and translation to be mandatorily assessed as early as the project application stage. Projects must clarify from the outset whether they fit within existing legal frameworks or require new ones. Another obstacle is the rigid sectoral boundaries: many innovations operate in the ‘grey area’ between outpatient and inpatient care, for which there is no uniform regulatory framework, but merely a ‘patchwork’ of special provisions (Section 115 SGB V et seq.). According to Ex, successful transfer requires not only organisational and financial conditions but, above all, the acceptance of those involved. Therefore, all stakeholders who may later be involved in a transfer should be engaged at the project level. Furthermore, projects must provide answers and generate added value, particularly in view of limited human resources.

“Standard care” as an unclear destination

The concluding reflection by Dr Regina Klakow-Franck (former independent member of the G-BA) touched on a sore point in the systemic architecture. She pointed out that there is no legal definition for the term “standard care”. This allows stakeholders within the self-governing bodies to exploit room for interpretation to slow down reforms.

Klakow-Franck noted a defensive organisational mindset within the system that prevents genuine learning. Whilst medical research (and development) is often excellent, there is a lack of a body that sees itself as an active innovation manager. The G-BA tends to administer rather than shape. Furthermore, data from the Innovation Committee (as of December

2025) showed that, of 118 projects involving new forms of care, 50% did not receive a recommendation for implementation, and the G-BA saw itself as the intended recipient for only 14% of the recommended projects.

Solution: sector-neutral design and value-based care

As a way out of this impasse, Klakow-Franck presented the BMC's proposal to introduce a new regulatory framework within SGB V. Instead of further fragmenting the system through ever-new selective contracts or minor provisions, a sector-neutral scope for design must be created. This scope should: 1. Define uniform rules for patient benefit, quality and cost-effectiveness.

2. Establish a sector-neutral remuneration system.

3. Offer flexible opportunities for cooperation regarding regional or morbidity-related care provision.

The aim of this approach is value-based care that optimises the ratio of patient benefit to costs in order to ensure the long-term affordability and quality of the system.

Conclusion and outlook: "Think Big"

At the end of the masterclass, Hager called for the courage to scale up. Successful projects should not remain mere "occupational therapy" for healthcare research, but must be rolled out on a scale that transforms the entire system. The slogan "Think Big" marked the closing remarks: only if transfer is conceived not as an optional add-on but as an integral part of every innovation can the crisis in the system be overcome through genuine inventiveness.

by: MVF Editor-in-Chief Peter Stegmaier