# “Regional pragmatism for a future-proof supply”



## In interview: Steffen Bohm, Managing Director of AGENON GmbH and consortium leader of the ProReVers innovation fund project

“Can ProReVers finally overcome the sectoral division in the German healthcare system?” “Monitor Versorgungsforschung” put this question to Steffen Bohm, Managing Director of AGENON GmbH and consortium leader of the ProReVers innovation fund project. In this interesting conversation, he offered a “view from below” on the strategic dilemma facing stakeholders and the necessary levers that policymakers must finally activate if they wish not merely to enable local healthcare provision in some way, but to strengthen it. Above all, this requires structural reform that can finally overcome the “unspeakable sectoral separation”.

**>> Mr Bohm, for over two decades the German Council of Economic Experts and many other experts have been calling for cross-sectoral planning, yet no significant structural changes have taken place. It almost seems like a Sisyphean task: one report follows another, yet the separation between outpatient and inpatient care remains set in stone. Why should your ‘ProReVers’ project, of all things, be more than just another well-intentioned recommendation that disappears into the drawers of bureaucracy?**

Yes, the division is entrenched by federal legislation and subordinate regulations. The project’s remit was not to draft a report for the revision of federal laws and subordinate regulations. It consisted, on the one hand, of developing tools and analytical frameworks that enable a data- and fact-based examination of the local healthcare situation and the existing and future challenges. Secondly, the aim was to develop a proposal on how to

proceed under the given conditions in order to arrive at regionally appropriate healthcare solutions, and furthermore, how to ensure that necessary decisions are actually taken at the supra-regional level. To put it figuratively, we have 'come down' from the ivory tower of theoretical healthcare research into the concrete reality of local healthcare provision. Incidentally, the idea for "ProReVers" arose from the experiences of the preceding Innovation Fund project "Structural Migration in the Templin Mid-Range Area" ( 2017–2020 ) , in which we took a very pragmatic approach to the structural problems of a region – the town of Templin in the Uckermark district. It became abundantly clear here that planning approaches often suffer from the "bird's-eye view" they adopt, because there is a mistaken belief that centralised solutions can be found for all regions equally from a purely scientific, federal and state political perspective. We have therefore completely changed our perspective at "ProReVers": within the project, we have developed a whole toolkit that can be used to systematically record and analyse specific regional conditions.

What are the benefits? A great deal, because from a regional, indeed local, perspective, there is really only one, but very crucial, question: What do the local and regional structures – say, in Prignitz or Ostprignitz-Ruppin – look like today, where are the specific bottlenecks, and how can we use the resources that do exist more intelligently and efficiently?

*"ProReVers is precisely an attempt to achieve the best possible care under the given conditions."*

**The overarching question of your 10-point paper is: "How can healthcare provision be ensured in structurally weak, rural regions despite dwindling resources?" To critics, this sounds suspiciously like 'shortage management'. Is 'ProReVers' intended to teach citizens in rural areas to be content with fewer inpatient facilities, rather than demanding genuine additional funding for the region?**

"Scarcity management" is too negatively connoted a term for my liking and does not do justice to the core of the project or the problem itself. In Germany, we do not primarily have a problem of a lack of funds, but rather a problem of misallocation. We spend enormous sums, but often in the wrong places.

**Even in the rural regions you have studied?**

It may come as a surprise, but our survey of insured people shows, for example, that satisfaction with healthcare provision in the model regions of Prignitz and Ostprignitz-Ruppin is quite high. One of the reasons for this is that people in rural areas clearly have a healthy understanding that they cannot have every specialist or every hospital right on their doorstep. However, they need reliability in their healthcare provision and a sustainable outlook. 'ProReVers' is precisely an attempt to provide the best possible care under the given conditions – after all, staff and financial resources are finite everywhere. If, for example, we recognise that patients are admitted as inpatients because there is no transport available via taxi or ambulance after 4 pm, or because the GP practice cannot provide several hours of monitoring during the staff's normal working hours – for instance, in the case of long-term infusions – then this is not a medical shortfall, but an organisational and management problem. Solving this is not a matter of managing shortages, but rather a question of design at various levels – not

just within healthcare.

**One of the central pillars of the project is a precise understanding of the local healthcare situation. You have developed a comprehensive toolkit for this purpose. If you had to sum it up, what were your key findings from this in-depth analysis of the regions of Brandenburg?**

There are five points in particular that are close to the heart of the entire consortium and also to me as the consortium leader of the Innovation Fund project. Firstly: the demographic challenge is not a theoretical spectre; it is already here and often has massive consequences. For example: in Prignitz, we forecast an old-age ratio of just under 72 per cent by 2030. This means two things: the burden of care is rising significantly, whilst the pool of carers is shrinking. Secondly

: A shortage of GPs is becoming increasingly apparent. Almost one in two doctors in the region is over 60 years old. Thirdly: The theoretical potential for shifting care to outpatient settings is relatively high, at up to 31 per cent of inpatient cases. Fourthly: The biggest hurdles to realising this potential are often not medical but infrastructural in nature – key issues include: more targeted use of outpatient services, including hospital capacity, patient management, transport and aftercare. And fifthly: communication between partners in local public services is often still a major obstacle. If stakeholders do not talk to one another or do not have a shared data foundation, cross-sector solutions cannot emerge.

***“If we want outpatient rather than inpatient care, we must also create the conditions for it: reliable transport routes, case management and alternative care options.”***

Let’s stick with the topic of ‘shifting to outpatient care’. Your analyses show a theoretical potential of over 30 per cent, yet as soon as you ask medical professionals, this potential shrinks dramatically. Isn’t ‘social circumstances’ often used as an excuse here to safeguard inpatient privileges?

I wouldn’t make such a sweeping assumption. The information we’ve compiled for selected case groups has helped to make this discussion very concrete. A doctor must ask themselves, for example: what happens to my acutely ill patient if they live alone and have no one at home to look after them, or what should I do if I need various test results promptly so that I can make the right treatment decision? From the doctor’s perspective, the hospital is often the only safe option.

What is the proposed solution?

We are dealing here with a ‘system of communicating vessels’ or interdependencies between different sectors of public services: If we want outpatient rather than inpatient care, we must also create the conditions for it: reliable transport routes, case management, alternative care options – for example, for low-threshold monitoring and transitional care for acute patients – targeted outpatient use of hospital resources, improved coordination and, of course, telemedicine, which, however, often requires the further expansion of the 5G network. Without such structural and technical support, any rate of transition to outpatient care, however high, remains a pipe dream.

This is where game theory comes into play, a topic Professor Riedel addressed at the ‘ProReVers’ symposium hosted by your consortium partner, AOK Nordost (see MVF 01/26). He describes the situation between health insurance funds, associations of statutory health insurance physicians (KVs) and hospitals as a ‘game’ in which defensive blocking is more rational than cooperation. How does “ProReVers” intend to resolve or even overcome this dilemma, which is so deeply rooted in human nature?

Professor Riedel has hit the nail on the head: agreement on regulations to overcome sectoral boundaries cannot succeed if the stakeholders are not prepared to cooperate. However, as soon as cooperative behaviour carries the risk of achieving a worse outcome for one’s own clientele than if one did not cooperate, defensive behaviour is the rational strategy. If all stakeholders – or, as in our case, even just a single one – behave rationally in this sense, either no solutions will emerge, or only those that change the status quo very little. From the perspective of regional planning, we therefore propose modifying the ‘rules of the game’ in several respects: a key instrument is the ‘Regional Planning Conference’, or RPK for short. To this end, all stakeholders important for public services in the region are brought together to develop suitable solutions for the region based on a uniform data set – the “Regional Dossier”. However – and this is a crucial point: for further implementation, a transmission mechanism must be clearly defined that includes the state level. At this level, there must be a ‘point of contact’ for the RPK’s proposals. It is from this point that the necessary subsequent steps must be initiated. We propose a “state committee of healthcare stakeholders” for this purpose. This could, for example, be a committee under Section 90a of the Social Code Book V (SGB V). It is important that this committee also agrees on general design guidelines for regional care, or AGRs for short. These AGRs would need to be binding on subsequent decisions, so that sound regional proposals do not fail due to the veto of individuals.

That sounds like even more committees and even more complexity. Professor Riedel suggested instead radically awarding care contracts to consortia in order to rationally enforce cooperation. Why is this competitive approach not more clearly reflected in your recommendations? Are you afraid of self-governance?

No, it is based on the substance of the matter. Professor Riedel’s proposal to organise care tasks as procurement projects with shared budgets is theoretically sound and would resolve many deadlocks. But particularly with regard to rural regions, one must acknowledge the realities or, as the saying goes, keep things in perspective. On the one hand, competitive approaches reach their limits here, simply because there is no alternative to the available provision that can be achieved at a reasonable cost. On the other hand, care pathways within these structures, which have evolved over the years, cannot be arbitrarily dismantled and, for example, split up according to health insurance fund affiliation. In healthcare practice, this quickly reaches organisational limits, finds little acceptance among healthcare providers, incurs additional costs and therefore yields no economic benefit either. Another reality that must be acknowledged is of a more fundamental nature: our system of self-governance has evolved historically and the separation of sectors has taken deep root. Consistently

enshrining region-based, cross-sectoral planning in law would, amongst other things, affect the allocation of responsibilities set out in the Basic Law, the Hospital Financing Act and SGB V. Radical upheavals of this kind are currently hardly feasible in Germany. We have therefore focused in 'ProReVers' on finding viable solutions within the existing framework as far as possible.

Michael Zaske from the Brandenburg Ministry of Health is calling for "regional opening clauses". If the money cannot follow the service, "ProReVers" remains a "toothless tiger", doesn't it?

As is so often the case, money is the "elephant in the room" when it comes to shifting care to the outpatient sector. If the aim is to provide more outpatient and less inpatient care, the financial resources must be able to follow suit; otherwise, it won't work. For services falling under sector-specific budgeting – MGV services here and services under practice-specific budgets there – this is anything but a trivial undertaking. Regional rather than sectoral budgets would be one approach. However, the legal scope for this would first have to be created. And for more far-reaching changes to the status quo, a regional budget would not only have to be cross-sectoral; it would also have to be supported by all stakeholders – including the health insurance funds competing with one another. This brings us back to the strategic dilemma already mentioned. A distinction must be made for services not covered by budget allocations. As for hybrid DRGs, I am – to put it mildly – more than sceptical as to whether the chosen path will ultimately lead to the desired economic and redistributive effects. To return to the 'toothless tiger': The example of paediatric care in Templin shows that solutions are, in principle, possible within the existing system even without regional budgets. However, the example also shows that, under the given conditions, many favourable factors must come together. Mr Zaske is therefore right: regional opening clauses would make many things easier. A set of rules through which strategic behaviour can be balanced would also be helpful.

In the RPK, you also call for the inclusion of public transport and



digital infrastructure. Do health planners not run the risk here of morphing into transport planners and ultimately having to foot part of the bill for the structural failure of rural public services out of the already severely strained healthcare budget?

We are not morphing, but we do recognise the interdependencies. Healthcare does not take place in a vacuum. Here is another very pragmatic and real-life example: if a 70-year-old patient can no longer visit a specialist because the regular bus also doubles as a school bus, then that is a very real care bottleneck. Healthcare planning and public services must be linked within the regional planning process. That is part of our proposal.

**Who is responsible?**

The local authority must take on a leading role here. But the state is also called upon to act, among other things, as the coordinating body for the collection, processing and provision of data and facts. Overall, we need a 'Pact for Public Services' that goes beyond the traditional SGB V stakeholders. Only by successfully bringing together transport, digital infrastructure and social security can we ensure that care provision in rural areas is made future-proof in the long run. Ideally, this should be fact-based.

**A practical problem with your RPKs seems to be the moderation. You yourself have over 30 years' experience. Who is to chair such highly complex conferences if no expert like yourself is available? Is the approach even scalable?**

That is indeed a critical point and certainly a limiting factor at present. This moderation role is often greatly underestimated. You need someone who can not only facilitate, but also understands the intricacies of the statutory health insurance system and anticipates the interests of the stakeholders. Qualified intermediaries are required. The project has highlighted a gap here. One solution could be appropriate training or qualification of specialists at state and district level.

**Let us return to one of the initial questions: the citizens**

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**often call for more specialist doctors and shorter travel distances in the surveys conducted during the project, whilst the project tends to focus on centralisation and the shift to outpatient care. Are you not selling citizens a "better" healthcare system here that, in reality, feels like "less" to them?**

The project anticipates the centralisation of complex inpatient services through hospital reform and the shift towards outpatient care as a fundamental healthcare policy direction. Unfortunately, one is not immune to alarmist propaganda. However, there are also examples showing that fears can be addressed and protests prevented through forward-looking public relations and communication. Templin, with its largely uncontroversial closure of inpatient paediatrics, is one such example. It is advisable to have alternative options ready from the outset that can be presented with a clear

conscience as being of equal value. It is essential to be able to convey to people in a credible manner that change does not necessarily mean a deterioration.

**Funding for the Innovation Fund project ended in January 2026. What happens now? Will we end up with just another nice final report for the G-BA, or is there a binding commitment to fund the RPKs across the board?**

The state of Brandenburg has already signalled that it takes the results very seriously. In the coalition agreement, the SPD and CDU explicitly advocate the establishment of regional health conferences in the districts and independent cities. Our toolkit is ready and can be used anywhere in Germany. Sustainability now depends on the will of the stakeholders.

Finally, because Christmas is sure to come round again at some point: if you had one wish to make to the Federal Minister of Health, what would it be?

That a structural reform be set in motion to overcome the unspeakable sectoral separation through planning, licensing practices and remuneration that are functionally aligned with regional needs. I would like to see ALL existing responsibilities and powers put to the test and, where necessary, consistently readjusted. By that measure, however, the current hospital reform would be a mere token reform. Realistically, such a major overhaul cannot be expected. The forces of inertia inherent in the system are too great. But perhaps many small steps will eventually lead to the goal. ProReVers may be one of them. That would already be something.

**Mr Bohm, thank you very much for this interesting conversation and the insights into your work. << The interview was conducted by MVF Editor-in-Chief Peter Stegmaier.**

**Further reading** Innovation Fund project site: https://t1p.de/in1ei MVF 01/26 article on ProReVers: https://t1p.de/a17a1 10-point paper: https://t1p.de/xyjr8 Instrument for outpatient needs planning (MGS): https://t1p.de/7zsem

Steffen Bohm has been a partner and managing director of AGENON Gesellschaft für Forschung und Entwicklung im Gesundheitswesen mbH, based in Berlin, since the end of 2011. His work focuses on the design and management of projects for the cross-sectoral adaptation of regional care structures, as well as on conducting preparatory data and feasibility analyses. In addition to the ProReVers project, recent examples include the StimMT innovation fund project – structural migration in the Templin mid-range region – and the healthcare needs analyses for the health regions in the state of Brandenburg, carried out in collaboration with the IGES Institute on behalf of the Brandenburg Economic Development Agency.