


## ARTICLE

# Strengthening health system governance in Germany: looking back, planning ahead

Tugce Schmitt<sup>1,2\*</sup> , Alexander Haarmann<sup>1</sup> and Mujaheed Shaikh<sup>1</sup>

<sup>1</sup>Hertie School, Berlin, Germany and <sup>2</sup>Department of International Health, Care and Public Health Research Institute – CAPHRI, Faculty of Health, Medicine and Life Sciences, Maastricht University, Maastricht, The Netherlands

\*Corresponding author. Email: [t.schmitt@maastrichtuniversity.nl](mailto:t.schmitt@maastrichtuniversity.nl)

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## Abstract

Health system governance has been receiving increasing attention in health system research since the 1980s. The contemporary challenges that the German health system is faced with are often closely linked to governance issues. Although Germany has the highest health expenditure as a share of Gross Domestic Product (GDP) in the European Union (EU), the spending on healthcare is out of proportion to the health outcomes of the population. The reason for this lies mainly in the complexity of the German health system which is hard to steer due to several administrative levels in the country and numerous policy actors to whom the decision-making power on healthcare provision is delegated. In this paper, we present the results of focus group discussions on governance and build upon the insights gained through the *Neustart* project of the Robert Bosch Foundation. Based on an internationally recognised health governance framework from the World Health Organization (WHO), experts who work in, on or for the German health system addressed health governance challenges. They provided evidence-based recommendations for the new legislative period (2021–2025) on transparency, accountability, participation, integrity and capacity of the German health system.

**Key words:** Evidence-informed policymaking; Germany; Self-governance; Health system transformation; National health governance

## 1. Introduction

Health system governance has been receiving increasing attention in health system research, especially since the advent of New Public Management (NPM) in the 1980s. The World Health Organization (WHO, 2014) describes governance for health as a framework that formulates goals, brings information together, and defines appropriate policy instruments and implementation measures, which in turn ensures transparency, legitimacy and accountability in health systems. Although research on the exact effects of different governance forms on population health may still leave some questions unanswered, there is sufficient evidence that well-planned and well-executed governance can have far-reaching, positive outcomes in health systems (Fryatt *et al.*, 2017; Ruiz-Cantero *et al.*, 2019; Abimbola, 2020). Indeed, governance plays a vital role in the functioning of health systems, such as in the quality of healthcare provision, healthcare funding and training of health professionals (Hurrelmann *et al.*, 2019). Without a governance structure to steer, it would be left to individual policy actors to define the purpose of a health system and specific mechanisms to achieve the objectives of the system.

Typical areas of health governance include health system financing, health service coverage and access to health services (Rothgang *et al.*, 2010). In health governance projects, it should

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be taken into consideration that governance is not an end in itself, but rather a means to reach certain goals. Answers to the questions like which health policies should be developed, what quality levels in healthcare provision would be acceptable, and to what degree health policies should be socially inclusive vary from one jurisdiction to another. For instance, limiting the costs in a health system and increasing efficiency through cost-containment measures are technical goals that focus mainly on the financing part of governance. Alternatively, a reorientation towards quality improvement can serve the goal of greater efficiency (higher quality outcomes for the same use of resources) and ensure at the same time a better health status of the population. Thus, it can be stated that good governance is normative in nature.

To provide guidance in this regard, Kickbusch and Gleicher (2014) describe the main characteristics of smart governance for health as follows:

- The ultimate goal of governance is incorporating the health determinants, health and well-being of populations.
- Governance takes the whole society into account and considers societal changes in health determinants.
- Health is considered across the whole spectrum of public policies through Whole-of-Government (WoG) and Health in All Policies (HiAP) approaches.
- Patients, consumers and citizens are involved in decision-making.
- Common values are formed based on a shared understanding that the health of individuals is influenced and created in everyday life.
- Embedded in an egalitarian framework, transparency as well as effective and efficient use of resources form the basis of the actions above.

The major challenges that the German health system is facing are often closely linked to governance issues. Although Germany has the highest health expenditure as a share of Gross Domestic Product (GDP) in the European Union (EU), the spending on healthcare is out of proportion to the health outcomes of the population (OECD, 2021a). The reason for this lies primarily in the complexity of the German health system which is hard to steer due to several administrative levels in the country and numerous policy actors to whom the decision-making power on healthcare provision is delegated. Vertical separation of powers between the state as a whole and its constituent states as well as the functioning of self-governing bodies, i.e. the interest representation of payers and healthcare providers, shape the fragmented structure of the health system in Germany (OECD, 2019). Generally speaking, inefficiencies resulting from fragmentation can be tackled with a Health Information System (HIS) that provides comprehensive, accurate and timely insights into the health of the population for better policies and research. However, among the Organisation for Economic Co-operation and Development (OECD) countries, Germany is still one of the few that lacks a national health dataset readily available for monitoring and research on its health system (OECD, 2021b), creating a vicious cycle: the absence of such HIS hinders a comprehensive, central oversight of the causal links that could shed light on the unnecessary costs and increase efficiency gains in the health system.

Especially during the Coronavirus disease 2019 (Covid-19) pandemic, it became clear that due importance should be given to the inter-sectoral collaboration, meaningful use of data and better health surveillance in Germany (SVR, 2021). Indeed, even before the pandemic it was obvious that further development efforts would be much needed to overcome the future challenges: digitalisation of administrative processes, increasing urban-rural divide in the country and the demographic trends towards an older population to name a few. For this reason, the *Neustart* project (*Neustart! Reformwerkstatt für unser Gesundheitswesen*), initiated in 2018 by the Robert Bosch Foundation (RBF), developed suggestions for a sustainable health system in Germany, focusing on the population health and citizens' demands. Within the framework of this project, reform proposals were developed together with citizens and experts for a better health system in

Germany in the new legislative period (2021–2025). To this end, a series of focus group discussions were conducted on a variety of topics related to health and wellbeing.

In this paper, we present the results of focus group discussions with experts on the governance of the German health system and build upon the insights gained through the *Neustart* project. Based on an internationally recognised health governance framework from WHO, experts who work in, on or for the German health system recommended actionable solutions to pressing governance issues. Within the framework of the *Neustart* project, they identified the existing pitfalls in this context and elaborated on the best possible ways to overcome them. In line with the chosen analytical governance framework of WHO, the problems on transparency, accountability, participation, integrity and capacity are addressed and analysed in this paper. Before reporting the outcomes of the focus group discussions in those five thematic areas, the paper provides background information on each of the five dimensions of the WHO framework alongside the relevant literature, drawing on experiences from other European countries. The outcomes of this paper aim to bring evidence-based and actionable policy recommendations for the new legislative period in Germany.

## 2. Methods

We employed a triangulated research approach in this study. In the first step, we searched for a health governance framework on which to base our research. Not long ago, it was ascertained that the sheer volume of literature on health governance had missed the combination of two essential qualifications for researchers: simplicity and practicality. To fill this gap, an internationally recognised health governance framework was developed by Greer *et al.* (2016); the Transparency, Accountability, Participation, Integrity and Capacity (TAPIC) framework of WHO is an analytical tool to measure the quality of health governance within jurisdictions. Essentially, those five aspects build the main components of governance; in health systems, there can be too much, too little or the wrong kind of them (Greer *et al.*, 2016). By classifying the governance domains systematically, providing mechanisms to implement them and giving real-life examples under each domain separately, the TAPIC framework allows health policy researchers to build a pathway to analyse the pitfalls of a health system for improvement. It patterns the main decision-making aspects that in many international studies appeared vital in explaining the ability of health systems to provide accessible, high-quality and sustainable healthcare (Greer *et al.*, 2016).

Our initial literature review and earlier discussions within the *Neustart* project pointed towards the same governance domains as those of the TAPIC framework. For instance, the first one, transparency of the decision-making bodies, had already been discussed at the earlier stages of the *Neustart* project and found to be insufficient in the German health system. Similarly, the lack of patient participation in decision-making was proven to be a politically sensitive issue in Germany (RBF and IKU, 2019). This aspect, too, has extensively been studied by Greer *et al.* (2016) under the participation domain of the TAPIC framework. Similarly, data collection and linkages for HIS in Germany have been found to fall short of modern standards, hindering policymakers to identify problems for improvements, as recently stated in an OECD country comparison report (2021b). This finding points towards the capacity issue; the last domain of the TAPIC framework. Given its high relevance, international recognition and practicability, we chose this analytical framework to guide our research.

In the second step, we reviewed scholarly literature in the German context to gain more detailed insights into the potential improvement areas in the German health system. At the same time, we searched for best practices elsewhere in Europe relevant to each of the five domains of the TAPIC framework to draw lessons for Germany. By paying special attention to context-specific factors and feasibility aspects, we focused on certain governance instruments per governance domain of the framework. For instance, taking the peculiarities of the German health system (decisions on healthcare provision made by self-governance), when searching for best practices in different countries we included those that involve stakeholders with devolved competencies,

**Table 1.** Experts in focus group discussions

No.	Field	Expertise	Focus
8	Academia	Health policy	National
1	Academia	Health policy	International
1	Academia	Communication studies	National
1	Academia	Pharmaceutical policy	National/international
2	Research centre	Health policy	National
3	Foundation	Health policy	National/international
2	International organisation	Health policy	International
1	Organisation (sickness fund)	Health policy	National
1	Organisation (patients)	Health policy	National
1	Organisation (physicians)	Health policy	National
1	Organisation (consumers)	Health policy	National
1	Organisation (quality assurance in healthcare)	Health policy	National
1	Ministry of Health's in-house think tank	Health policy	National
1	District Public Health Authority	Health policy	National
2	Private company	Health management	National
1	Consultancy	Pharmaceutical policy	National

similar to the German context. The outcomes of our literature reviews allowed us to formulate guiding questions that were used in the next step.

As for the third and last step, we conducted focus group discussions with the national and international experts who work in, on or for the German health system between October and December 2020 in five sessions. The experts brought evidence-based and practice-oriented policy suggestions that could be implemented in the new legislative period (2021-2025). Overall, 28 experts from a variety of fields, such as academia, think tanks and district public health authorities, participated in at least one of the five expert discussions that spanned the five domains of the framework (transparency, accountability, participation, integrity and capacity). Detailed information about the participants can be found in [Table 1](#).

### 3. Results

In each of the following five sub-sections, scholarly explanations of the individual domains of the TAPIC framework are provided in the first place, entitled 'Concept'. This is followed by literature reviews conducted in relevance to the German context, entitled 'Context'. Lastly, the results of the focus group discussions with experts on health system governance are presented, entitled 'Expert discussion outcomes'. Originally, each framework domain (transparency, accountability, participation, integrity and capacity) contains a multitude of policy aspects with different implications. Notably, not all of them are of equal relevance to Germany, which is the reason why the experts, and thus this article, focused selectively on the tools and mechanisms of the framework domains. Hence, the best practices provided in this section, recommended by the experts during the focus group discussions, are by no means exhaustive. Rather, these are intended to illustrate examples of some feasible and tailored solutions to the pressing governance challenges that the German health system is facing.

### 3.1 Transparency

#### 3.1.1 Concept

Greer *et al.* (2016) argue that if the governance problem is, among other things, about opacity, poor communication or distrust in decision-makers, then it is an issue of transparency. Transparency is achieved when the public is informed about policy decisions as well as the processes by which the decisions were made. Data and policy decisions should be available to the experts who can challenge the decision-making processes, their outcomes and grounds for the public. When devolving functions to local governments or delegating power to external organisations, transparency can suffer. In that case, it is up to the government to take measures to ensure transparency in vulnerable areas.

#### 3.1.2 Context

Based on a federal government with decentralisation to 16 federal states (*Länder*), the German health system reflects the fragmented and, in some respects, complex governance structure of the country. Whilst the *Länder* are mainly responsible for hospital planning and the supervision of public health authorities in districts, at the federal level, decisions on health service provision are taken by the self-governing bodies of the Federal Joint Committee (FJC). The role of the Federal Ministry of Health in this structure is only supervisory; it is not directly involved in the decisions of self-governance (Busse *et al.*, 2017). It has the right, however, to object to the decisions of the FJC within two months of their submission to the FJC. Moreover, the government shapes the framework conditions of the functioning of self-governing bodies and can thereby set rules for better transparency. The reliance on self-governance is continuously at the centre of political discussion, and the government has started to assume a more direct regulative role in health policies (Blümel *et al.*, 2020).

When talking about transparency, decisions taken by the self-governing bodies gain much attention. Discussions about the structural deficits and the legitimacy of self-governance are far from new and have been addressed for almost 50 years (Muhr, 1974; Bogs, 1977; von Ferber, 1977; Nowak and Schaper, 1981; Grosshaus and Herber, 1985; Braun and Klenk, 2006; Braun *et al.*, 2008). When looking at some other European countries, such as Belgium or France, increasing centralisation of power and state influence on self-governance can be seen as a way to tackle the transparency issue. While an assessment of the implications of such power concentration at a higher level depends on individual framework agreements and specific goals to be achieved in the system, more state influence is usually associated with less competency of self-governing actors (Matthes, 2012; Weyrauch, 2012a, 2012b). Austria and the Netherlands, both coming historically closest to the traditional German self-governance structure, applied different approaches to exercise state authority. While the first one has centralised, merged and professionalised the various branches of social insurance at the federal level (Haarmann, 2012a; Bachner *et al.*, 2018; Österreichische Sozialversicherung, 2018), the latter diminished the role of corporatism in social insurance and relied primarily on managed competition (Haarmann, 2012b; Kroneman *et al.*, 2016).

At the FJC, the self-governing bodies of payers and providers make decisions about healthcare provision in Germany. Registered patient organisation groups are allowed to participate in the decision-making process, albeit without voting rights. While the plenary sessions of the FJC can be followed via live-stream on the FJC website, documents of the preparatory work done in the working groups and sub-committees are not open to the public (G-BA, 2021a, 2021b, 2021c). Despite the past endeavours to improve the transparency of policy decisions of the FJC, current debates indicate a lack thereof (RBF, 2021). Neither citizens nor external professional bodies can receive detailed information on the policy discourse and agenda-setting processes at the FJC.

Another deficiency from the citizens' perspective in this context might be the technical jargon to communicate the FJC decisions. Clear and useful public information is, however, one of the

common transparency mechanisms (Greer *et al.*, 2016). Besides higher health literacy levels of the population, a simplified language of policy documents would help the public and media to comprehend the policy content and challenge them where necessary, contributing to greater transparency in the health system. This point is also in line with the demands of the citizens involved in the latest citizen dialogue of the *Neustart* project (RBF and IKU 2021).

### 3.1.3 Expert discussion outcomes

The experts discussed both the advantages and disadvantages of having self-governance in Germany, which can be summarised as follows: self-governance means autonomy of certain professional groups and, as such, finding compromises and balancing conflicting interests between those groups. This bottom-up approach provides a constructive basis for effective negotiations between Statutory Health Insurances (SHIs) and healthcare provider organisations, creating a favourable ground for the acceptance of adopted measures among frontline healthcare workers. Despite their principally clashing interests in terms of budget allocation, the representative organisations of payers and providers of the FJC often act in harmony and enjoy a high level of autonomy from the state. In turn, this resilient system of self-governance offers technical expertise in policymaking, detached from party politics and political interference.

Despite these advantages, the pitfalls of relying on a decision-making system that is mostly steered by self-governance cannot be overlooked. As per law, self-governing bodies should be oriented towards the common good. However, they tend to advocate for their own interests in a silo mentality, creating a robust defence mechanism to preserve the *status quo* at all costs, although the *status quo* is unsustainable. Their change-resistant and self-centred *modus operandi* create a vicious cycle in the fragmentation issue of the health system, as they focus on the distinction of their tasks and responsibilities instead of the overall coordination of health services. However, to overcome the future challenges in financing and modernising healthcare, an interconnected, patient-oriented and agile self-governance is more than needed. To date, major reforms resulting in substantial changes in the SHI system have mainly been initiated from outside, namely by the federal government. For this reason, the experts argued that it would take massive political pressure to bring more transparency to self-governance and their decisions.

Nonetheless, the experts agreed that the self-governance structure does not need to be abolished to achieve transparency. From the government's perspective, specific technical qualifications of the self-governing bodies would be difficult and costly to gain from outside of this framework when making policies. Moreover, by delegating responsibility to self-governance, the government prevents possible conflicts between the payer and provider organisations, securing the continuity of one of the most important public services: the provision of healthcare. Hence, despite the aforementioned weaknesses, it would be neither desirable nor feasible to establish a functional equivalent to the FJC from scratch.

For these reasons, the experts suggested that the strategies for more transparency could be developed in two ways. At the local level, it is worth considering increasing the proximity of decision-making processes of self-governance to citizens and ensuring closer cooperation between public health authorities and healthcare providers. At the federal level, transparency can be achieved through regular, comprehensive, timely and user-friendly information from the FJC to the citizens. Such communication can be published, for instance, in an online platform where bilateral information exchange between citizens and the FJC is ensured. Self-governing bodies of the FJC should be more inclusive, taking the patients' and citizens' opinions into account when making policies. In this context, strengthening the health literacy of citizens can support better-informed perspectives in decision-making processes. Thus, transparency can be increased through a timely disclosure of policy discussions in the FJC in simple language on the one hand and a higher health literacy level of the population on the other (see also Section 3.3. below).



### 3.2 Accountability

#### 3.2.1 Concept

Accountability is a relationship between an actor and a forum (such as an agency and a legislature) in which the actor must inform their decisions, explain them and thus can be mandated and sanctioned. Hence, accountability is concerned with explaining actions as well as the answerability and responsibility of those actions and the underlying decisions: its main goal can be, among others, to ensure patient safety (Greer *et al.*, 2016). This particular aspect of accountability has garnered much attention in Germany for the last two decades. In response to growing dissatisfaction among providers with cost-containment measures and recognition of quality problems in health services, efficiency and quality of services have become the core values from 2000 onwards (Busse *et al.*, 2017).

Accountability can be improved through different policy instruments, depending on the stakeholders in focus; the most crucial point in this context is to define ‘accountability to whom?’ (Greer *et al.*, 2016). Considering the course of the major health policy discussions in Germany, the answer to this question can be given as ‘to patients’, essentially because they are the ones who fund the SHI system. With this in mind, the following paragraphs elaborate on the quality standards of health services, the policy instruments for assuring quality and the implementation of appropriate measures in the German health system.

#### 3.2.2 Context

The literature suggests that a number of policy instruments can be considered for quality improvement efforts; managed competition, bundled payments and disease management programmes (DMPs) to name a few (Eurohealth, 2013). With regards to managed competition, van Ginneken *et al.* (2011) and Siciliani *et al.* (2017) report the potential for quality improvement, stating, however, that this might affect the relationship between healthcare providers, patients and health insurers. They highlight that the balance from established governance structures is usually so delicate that any change in this equilibrium should be managed in a well-regulated framework. According to van Ineveld *et al.* (2018), the specialisation, cooperation and networking of service providers can complement managed competition arrangements to ease such transformation. Bundled payments, as one of the most discussed forms of quality-based remuneration, can also be a promising approach for cost containment, cooperation and integration of health services (Struijs and Baan, 2011; Llano, 2013). Moreover, Schneider *et al.* (2016) show that integrated care, even in its imperfect form of DMPs, results in overall better health outcomes by enhancing the quality of healthcare provision. Although selective contracting of health services for integrated care through DMPs requires some financial resources at the beginning, the burden can be compensated by higher quality services in the long run (Kifmann, 2017). Even though studies demonstrate the potential of integrated care in terms of quality of care, improved health outcomes and higher patient satisfaction, evidence on the economic impacts of integrated care approaches remains thin (Müller *et al.*, 2015). In the evaluation of complex care programmes with high contextual influence, there is a need for better knowledge about what works for whom, under which circumstances and with what forms of collaboration. To reach this goal, it is advisable to use pluralistic quasi-experimental methods in evaluation studies with the right set of indicators (Nolte and Pitchforth, 2014).

Accountability *vis-à-vis* patients (thus, indirectly, payers) can be increased through a more patient-oriented health system. In this context, Traxler (2019) reports positive effects on patients’ quality of life when their preferences and lifestyles are taken into account during their treatments. Even small changes in their medical care and organisational adjustments in the doctor’s office to better suit patients’ daily routines can make a difference in health outcomes. As for the individual forms of participation at the clinical level, there is a growing understanding of the importance of well-implemented shared decision-making arrangements, especially when cooperating with

general practitioners (Joosten *et al.*, 2008). While Patient-Reported Experiences (PREs) and Patient-Reported Outcomes (PROs) have mainly been used in the context of managing specific diseases thus far, their integration into standard care can contribute to improving the quality of services in general practice (Eichhorn *et al.*, 2015). Extending the application of PREs/PROs, mostly collected through questionnaires, can be a good starting point for a better patient-centredness and higher accountability *vis-à-vis* patients (Desomer *et al.*, 2018).

### 3.2.3 Expert discussion outcomes

The experts stated that important stakeholders for healthcare provision, among others self-governing bodies, must be involved in policy discussions on quality assurance and quality standards. This is seen to be the only way to ensure that the quality assessments based on quality indicators are accepted, adopted and applied by frontline healthcare workers. Although the self-governing bodies of the FJC have developed a number of quality indicators, the accountability aspect in quality assessments is still missing, and subpar healthcare provisions may remain unrecognised. Ideally, a quality assurance mechanism should be in place to detect when provided services do not meet quality criteria in a systematic way over a considerable period of time.

Moreover, the experts mentioned that the existing quality indicators are mainly based on the interests of individual stakeholders that predominantly have a cost-benefit analysis in mind. Policy discussions on health in Germany are very much medicalised and lack crucial elements that can foster evidence-informed decision-making for preventing ill health. Thus, the political agenda has a bias towards curing diseases rather than keeping citizens healthy. Even the indicators on healthcare services fail to reflect the reality of care pathways that patients experience throughout their life. Although the directives of the FJC on quality management and quality assurance include relevant clauses for patient safety, they are formulated in vague terms, hampering the traceability of quality problems in the chain of health services provided by different healthcare organisations.

When discussing quality, the experts also highlighted that the inner motivation of frontline healthcare workers should be of utmost importance. Quality assurance instruments should be put in place to support a development process in healthcare organisations and create a learning environment, meaning, any victim-blaming and scapegoating should be avoided. This is especially important when the health services result in low-quality outcomes mainly due to structural weaknesses of the system or in healthcare settings on which the providers have little influence. Indeed, one of the greatest challenges when defining policy instruments and technical components of a quality assurance system is to find the right balance between sustaining the inner motivation of frontline workers and detecting at the same time opportunistic behaviours that lead to subpar clinical outcomes.

For this reason, the experts advised using aggregated data on health outcomes at a higher level than in clinical settings and warned against singling out healthcare providers individually. At the local level, they recommended collecting and sharing information about good practices and quality improvement measures, such as quality circles among health care providers. Making good practices publicly available can contribute to reflecting on some structural or process-related weaknesses and bring promising insights for the development of quality indicators. Moreover, they suggested that quality assessment and governance models should go beyond the existing silos and examine the entire treatment chains, foregrounding the importance of integrated care and data sharing between sectors (see also Section 3.5. below). In this context, the experts envisaged integrated care as the new standard of regular care, which should go well beyond DMPs by achieving the coordination of all health services across several sectors (see also RBF, 2021b).

In the context of integrated care, it was also stated that sickness funds, as advocates of patients, should be given more leeway in their contractual arrangements with individual providers, which in turn could improve their accountability to patients. Bundled payments and selective contracting, alongside sharing and using data across sectors, can be suggested as ways to improve the



existing system that is primarily based on collective contracts. Based on a joint agreement between the payers and providers on what health outcomes could be feasible to achieve, incentives should be offered for meeting or excelling the quality targets (pay-for-performance). Similarly, sanctions should be put in place if healthcare organisations fail to achieve the targets repeatedly over a certain time period (non-pay-for-non-performance).

### 3.3 Participation

#### 3.3.1 Concept

According to Greer *et al.* (2016), participation becomes an issue when there is a lack of legitimacy in the decisions taken on the populations affected by them. Participation enables those affected by policies to gain insights into the decision-making process and empowers them to make their voice heard. At the minimum, it should be ensured by law that the people who are affected by the decisions taken for them can express their views on those very decisions.

#### 3.3.2 Context

To draw lessons on the participation domain of the TAPIC framework, some examples of collective citizen and patient participation initiatives from other European countries can be provided. For instance, in the Netherlands, the participation of insured people is enabled through patient representation in health insurance funds as well as institutionalised patient councils in hospitals and care homes (van de Bovenkamp *et al.*, 2008). Dutch patient umbrella organisations, such as the *Patiëntenfederatie Nederland* and *Landelijk steunpunt (mede)zeggenschap*, serve as advocates of patients. In that function, they are regularly involved in legislative processes and major organisational changes, supporting their members through training, concepts and information (van de Bovenkamp *et al.*, 2008). Furthermore, in Italy the grassroots movement *Cittadinanzattivi* has been a successful collaboration of numerous civic and patient organisations. Today, about 500 local centres across the country help to resolve patients' complaints about their treatment experience in hospitals and other healthcare settings, engaging in dialogues with healthcare providers to suggest improvements at the local level (Markenstein, 2000; Ferré *et al.*, 2014). Lastly, Portugal involves a wide range of stakeholders in its national health council, including patient representatives, similar to the FJC in Germany. Stakeholders serve as advisory bodies, discuss emerging issues with each other and take joint decisions whenever possible (Dalton *et al.*, 2016; de Almeida Simões *et al.*, 2017).

In Germany, organisations that represent the interests of patients and self-help groups of chronically ill and disabled people have the right to participate in policy discussions and submit proposals at the FJC. Currently, four patient and self-help organisations are entitled to nominate patient representatives for participation in the FJC discussions, however, without voting rights. This raises the question of whether patients, or in general terms insured people as beneficiaries of SHI services, are accurately represented in health policymaking. On the one hand, it should be acknowledged that insured people (and employers) are represented via trade unions and employer associations, among others, in the governing board of the umbrella organisation of the sickness funds (GKV-Spitzenverband, n.d.). Hence, although indirectly involved through this umbrella organisation, it can be stated that the insured (sickness fund beneficiaries) are represented at the FJC. In practice, however, doubts have been raised as to what extent accurate and representative participation is ensured, given the decline in trade union membership, the professionalisation of governing bodies and the concentration of decision-making power at the federal level (Braun *et al.*, 2008, 2009).

Nonetheless, initiatives such as municipal health conferences in Germany show how citizens and patient representatives can successfully be involved at the local level in Germany. Indeed, the conferences taking place in North-Rhine Westphalia (LZG NRW, 2018) and in Baden-Wuerttemberg (Baden-Württemberg, 2021) are some of the most suitable platforms to bring sports associations,

educational institutions and self-aid organisations together for holistic decision-making processes on health and wellbeing (RBF and Hertie School, 2021a, 2021b). It is against this background that the political and financial reinforcement of municipal health conferences is deemed desirable for a more inter-sectoral and wellbeing-oriented approach in health policies in Germany (Hollederer, 2014). However, the conferences have little political influence with hardly any law-making competence since the necessary funding for their projects is constantly lacking.

Another good practice from Germany in the participation domain is the citizen dialogues that were organised within the framework of the *Neustart* project. After a representative selection of participants, almost 700 citizens discussed the future of the German health system in the course of the project. Offering a platform for citizens' voice, in the two rounds of citizen dialogues, a number of citizens' demands pointed towards the governance aspects of the German health system (RBF and IKU, 2019, 2021), greater authority and involvement of patients and citizens on policy discussions being a few of them.

The literature shows that establishing a participative decision-making process entails substantial challenges. The most obvious and probably the most difficult challenge in this context is ensuring a representative participation that at the same time is not prone to exploitation by companies whose main business is to make profit (Bogs, 1977; Braun *et al.*, 2008, 2017; Gerlinger *et al.*, 2016). When increasing participation, elected officials struggle with the best ways to balance citizens' voice against the influence of other actors than those regarded as legitimate decision-makers by ordinary citizens (Papadopoulos, 2007). Moreover, in participative models, it cannot be ruled out that individuals with more time and motivation, such as retired people, are overrepresented, and thus not all voices are equally heard (de Savornin Lohman, 2000; van de Bovenkamp, 2010). Hence, one of the greatest challenges of establishing a framework for the democratic participation of citizens is ensuring the representativeness of the whole population, which could reflect their needs and concerns.

### 3.3.3 Expert discussion outcomes

The experts recommended introducing new forms of participation at two different levels: in clinical settings (through treatment decisions) and at the population level (through self-governance, citizen committees and juries, and patient advisory boards). As for the feasible approaches for participation at the individual level, the experts suggested implementing a shared decision-making framework for healthcare provision and evaluating health outcomes through regular PREs/PROs. For enhancing participation at the population level, investing in citizens' assemblies and health conferences at the district or *Länder* level was found to be favourable. An unbalanced representation of citizens in such fora should be avoided by ensuring regular participation from patient and consumer representatives. However, the aim should not be to maximise their participation at all costs, but to complement and improve the existing opportunities in a meaningful way. It can be assumed that the success of participation will be higher if individuals are involved at the earlier stages of the decision-making process. The question of whether they should have voting rights on policy decisions or not remained controversial among the discussants. Regardless of this question, an informational notice about their rights and responsibilities before establishing such a set-up was deemed essential to avoid any misunderstandings. It must be made clear in advance what can be achieved with their participation and what happens after policy consultations.

In this context, the experts touched on the communication of health-related content through mass media. A large part of the technical information on health is conveyed to citizens via media channels, including social media. Given that health-related topics are usually complex, it is not surprising that their quality and comprehensiveness in media vary heavily from one outlet to another, resulting often in mis- and disinformation. Improved health literacy of (specialist) journalists can make an important contribution to improving the health literacy of the population.

Enhanced health literacy with a thorough understanding of health-related issues should be considered a prerequisite for citizen participation, as also discussed earlier in [Section 3.1](#).

### 3.4 Integrity

#### 3.4.1 Concept

According to Greer *et al.* (2016), integrity means that reasonable expectations about the roles and responsibilities of the governing organisations are met. Integrity measures work at the organisational level, focusing on rules about the use of resources that preserve the integrity of organisations. These measures aim at, among others, increasing the sense of mission and coherence of each organisation in a system. In essence, integrity can simply be interpreted as bureaucracy. It necessitates that the process of representation, decision-making and enforcement is in place within organisations. This can be enhanced by strengthening financial, personnel and administrative management.

#### 3.4.2 Context

One of the key features of the German health system is a collaborative form of making decisions on healthcare provision in various committees, associations and umbrella organisations of the self-governing actors (Busse *et al.*, 2017). As discussed earlier, whereas the decisions on healthcare provision are taken at the federal level, hospital planning is carried out at the *Länder* level. Moreover, most of the *Länder* transferred their authority in public health services to the local authorities. Complications resulting from shared competencies at different levels and among various stakeholders lead to a lack of coordination between providers, patients and citizens (Busse and Blümel, 2014). Whereas the health system in Germany is considered to work well, the spending on healthcare provision is disproportionate to the health outcomes of the population, mainly due to the fragmented nature of the health governance (OECD, 2019). One solution to this unbalanced cost-benefit issue might be empowering the public health authorities as the institutions responsible for holistic health promotion activities at the local level by improving their integrity.

In practice, empowering and restructuring public health authorities necessitate shedding light on the weak points of federalism in health policymaking. Person-centred care in Germany implies first and foremost making a clear definition and differentiation of tasks, functions and responsibilities of the federal, state and local-level authorities (RBF, 2021). In particular, communication, coordination and cooperation at the local level should be strengthened by giving more authority to the municipalities and their decision-making capacity on health services. In essence, regional and local authorities that are able to assess the health needs of their communities should also be entrusted with the responsibility of taking necessary decisions on health policies without high bureaucratic hurdles.

Collaboration between key stakeholders relevant to health is important for higher efficiency, better health outcomes and increased patient satisfaction (Hildebrandt *et al.*, 2015; Schubert *et al.*, 2016; Schmid *et al.*, 2020). Especially in sparsely populated regions, various local approaches exist to safeguard primary care. In most cases, these initiatives are based on close cooperation between districts, cities, health insurance funds, associations of physicians and, if applicable, local hospitals (KV Hessen, 2019; Hildebrandt *et al.*, 2020). Arguably, the collaboration and, where possible, the delegation of tasks to other complementary professional groups are even more essential at the local level as in this way the provision of services can be enabled even in underserved areas.

Some lessons can be drawn from the experiences of other European countries in the context of regionalisation of healthcare. Best practices from Italy and Spain highlight the importance of setting quality criteria at the federal level to avoid different levels of spending and quality standards across the country (Ferré *et al.*, 2014; Bernal-Delgado *et al.*, 2018). In essence, the literature shows that governments strive to find a balance between giving regions and municipalities sufficient leeway to meet the local needs for health, while at the same time trying to ensure similar quality standards to prevent

inequalities (Fredriksson and Winblad, 2008; Fredriksson, 2012; Bernal-Delgado *et al.*, 2018; Terlizzi, 2019).

### 3.4.3 Expert discussion outcomes

The central point of the discussion on integrity was to ascertain which governance issue should be decided at what decision-making level (local authorities, *Länder*, federal government) and to define the responsibilities of main actors at those levels. The essential element to building a person-centred health system is to ensure an inclusive approach that can bring different stakeholders and professions together for decision-making. In this context, the experts found the financial and organisational support of the government for strengthening the local public health authorities laudable. According to the government's plans, it is expected that local public health authorities will receive four billion euros over the coming years for more personnel and better (digital) infrastructure. In this way, public health authorities can gain more competencies with a better sense of mission, pointing towards better integrity. As discussed earlier in this study, concepts such as HiAP, One Health and Doughnut Cities can guide to shape their vision. Apart from providing the local authorities with the necessary means for collecting timely epidemiological data and hiring qualified staff (see also Section 3.5. below), their decision-making power should be strengthened to implement a cross-sectoral approach in health promotion, medical care, long-term care and rehabilitation services.

The experts acknowledged that the transformation of health systems towards regionalisation has its limits, especially for the tasks that are too costly for smaller units to handle alone or require cross-sectoral and inter-regional cooperation due to the complexity of health issues. Thus, the experts concluded that before a structural reorganisation of local authorities, a comprehensive, well-functioning and country-wide HIS should be established. Good communication and coordination across local authorities and *Länder* are essential to reduce health inequalities in Germany. Hence, although the regionalisation of healthcare is praiseworthy, certain decisions should still be taken at the federal level, such as setting quality measures for healthcare provision. Medical guidelines, quality standards and remuneration frameworks should be organised centrally to avoid disparities between the regions (see also Section 3.2. above).

## 3.5 Capacity

### 3.5.1 Concept

Capacity is the ability to understand the system and how to change it, whether in terms of budgeting, legislating, managing or developing policy (Greer *et al.*, 2016). Among others, one of the mechanisms to improve capacity is passing sufficient information about the performance of the health system to policymakers to identify problems. Strategies for enhanced capacity can be used for forecasting, gathering intelligence on processes and for better research and analysis to this end.

### 3.5.2 Context

In Germany, the perceived risk of misuse of health-relevant data by public authorities is of high concern compared with other European countries; cultural reasons and historical circumstances shaped the strong sense of individual self-determination in data privacy matters today. However, taking the increasing proportion of the population affected by chronic diseases, rising healthcare costs and much-needed shift in the health system towards better prevention and healthy lifestyles into account, the reward of using health data more meaningfully (e.g. for integrated care and better surveillance) seems to outweigh the perceived risks.

According to the country-specific recommendations of the European Commission to Germany within the framework of the 2020 European Semester, the coordination between the providers in primary and hospital care could be improved and supported by digital tools

(European Commission, 2020). Lost medical information due to lacking use of the inter-sectoral Electronic Health Record (EHR) system is found to be a major contributor to the highly fragmented and uncoordinated care in Germany (OECD, 2019). Data silos in healthcare organisations and self-governing bodies hinder the meaningful use of health data for a more patient-oriented care. Currently, apart from regular comprehensive surveillance reports of the Robert Koch Institute (RKI), self-governing bodies offer some advantages to the health system with their own technical reports and research capacities (Tennstedt, 1977; Hendler, 1984; Reutter and Rütters, 2001), which however fail to provide relevant data in a timely manner.

### 3.5.3 Expert discussion outcomes

To draw on the experiences of other European countries, discussions on the capacity domain of the TAPIC framework took place with experts from the health division of an international organisation. According to the experts, the German health and social system is characterised by lacking data linkages between the sectors mainly because key organisations keep their data in individual silos. Even between ministries, crucial information gaps exist, reflecting a lack of clarity about data ownership in terms of what can be accessed by whom in the government. Moreover, information on the health status of citizens does not reflect the complete picture; health information is usually not timely and scattered in different silos, making it difficult to capture the actual health needs of the population. However, decisions on how to govern a health system require a sound and comprehensive evidence basis. Ideally, researchers, including those in the public sector, should have low threshold access to use the secondary data in the SHI, which is currently not possible in Germany.

Compared with other European countries, data security issues seem to be an overly emphasised concern in Germany. However, data sharing and data privacy are two sides of the same coin, requiring coherent and complementary policies. According to the experts, experience from other countries shows that when patients are given the opportunity, they seem to be confident to share their data with healthcare providers. For example, Finland's patient portal has been developed into one of the most visited websites after its inauguration. To gain citizens' trust in government, policies for use of data and data privacy should go hand in hand. In Germany, decisions for health data infrastructure and data security take place among separate stakeholders, jeopardising a holistic national policy to this end. The national legal basis concerning health data protection is vague and prone to individual interpretations, creating different starting points for policies developed in different organisations according to their own interests (see also OECD, 2021b). Paradoxically, although data security is one of the most articulated concerns, it is not part of any (continuous) education in the public administration system.

Moreover, the experts mentioned that the legal framework in countries may seem to be the main barrier to data sharing at first sight; this is, however, only the tip of the iceberg. Rather, the institutions that bring different datasets together and their responsible management, data access security, communication of data with the end-users (citizens) and public trust in government are the most crucial factors. Thus, the EU General Data Protection Regulation (GDPR) should not be used as an excuse for not taking political action. Indeed, GDPR allows European countries to create their own datasets and use outcomes for policy decisions while guaranteeing the protection of health data at the same time. Countries that were lagging in creating a HIS already before the adoption of GDPR have currently an even wider gap as their 'historical heritage'.

The experts, moreover, highlighted that health-relevant data can be used in a number of ways in health systems; not only to cure illnesses but also to promote the health status of citizens. Indeed, a system cannot be improved without measuring it. To make better policies for health promotion, data should be a public good. Data collection, access and control should be centrally authorised, using pseudonymisation or anonymisation techniques that are compliant with data protection laws. Experience from other countries suggests that for better data collection, access

and control, opt-out implementation models are better suited than opt-in, especially in EHRs. The fact that opt-in adoption (as in France) results in a much fewer number of EHR users than opt-out models (as in Austria) has also been stated in a comprehensive report on Germany's digital health policies (see SVR, 2021: 85–100). Arguably, data sharing is a framing issue: when communicated in a different way, the acceptance and willingness of the public to share their data will also be higher.

The European Health Union and the European Health Data Space initiatives are bold steps towards a stronger integration of European health systems, according to the experts. To make them a reality, both the technical and governance challenges in health information systems should be overcome. On the technical side, data terminology should be standardised across European countries. Only after solving this issue can interoperability and scalability would be possible. On the data governance side, a flexible framework which could be applicable to all European countries is strongly needed.

#### 4. Discussion and conclusion

The TAPIC framework has proven to be helpful in the analysis of health system governance in Germany by identifying the weaknesses to address during the new legislative period. As the framework provided conceptual guidance, our literature review and expert group discussions indicated a strong interconnection of the five dimensions with each other. An issue identified in one dimension (e.g. transparency) can hint at some other problems in a different dimension (e.g. participation), suggesting a more structural, comprehensive change in the health system, as also pointed out by Greer *et al.* (2016). As such, the main findings of this paper regarding the transparency, accountability, participation, integrity and capacity aspects of the German health system summarised below should not be interpreted as separate but interwoven recommendations:

- **Transparency:** Transparency is a prerequisite for the active participation of citizens in the decision-making and involvement in health governance. It creates mutual trust between policy stakeholders and citizens. As a starting point in Germany, more transparency (and consequently inclusiveness) should be ensured in the policy decisions of the FJC. This recommendation is also relevant to the participation aspect below.
- **Accountability:** In health policies, more emphasis should be given to the quality assessment of healthcare services to increase the accountability of the SHI system to patients. Introducing new remuneration models can be an appropriate approach to achieving this goal. In the new legislative period, the competencies of sickness funds for selective contracting with individual providers should be strengthened, allowing them to take a greater role in safeguarding the quality of healthcare. In the long run, integrated care should replace the (outdated) sectoral healthcare provision in standard care.
- **Participation:** To increase participation, two levels of intervention are feasible; in healthcare organisations and policy decisions. Public involvement in health policies should be supported; however, for that, a higher level of health literacy in the population and fair and just participation of all citizens would be necessary. Political endeavours to improve the health literacy of the population should be further developed and strengthened.
- **Integrity:** A better understanding of local needs, especially in rural areas, should guide future actions in health policies. To achieve this goal, a higher level of decision-making responsibility should be given to local public health authorities. In line with the findings on the participation domain above, greater involvement of citizens in decision-making should be ensured at the local level. Tasks, functions and responsibilities on different administrative levels in the country should be clearly defined; regulatory contradictions between those levels should be solved.



- **Capacity:** Despite the abundance of health-relevant data in Germany, timely and comprehensive insights for research and policy are lacking. Ideally, data for research and evidence-informed policies should be readily available in the health system or can be collected with as little effort as possible. As a first step, the newly introduced EHR system should follow an opt-out implementation model for a higher number of users. With better data flow between the sectors, patients should be guided through the entire healthcare process (primary use of health data). Moreover, data infrastructure in local public health authorities should be improved to the extent that they can provide timely guidance for policy decisions (secondary use of health data). This finding is relevant also to the integrity domain above.

The findings of this study have to be seen in light of some limitations. First of all, we would like to highlight that it was beyond the scope of this article to conduct a systematic review of the health system governance in Germany and Europe. Considering the wealth of different approaches to tackling governance challenges in European countries, the provided best practices remain inevitably illustrative in nature. Moreover, despite our endeavours to incorporate as many different perspectives as possible in our expert discussions, this approach had its limits both in terms of the capacity of focus groups and the availability of experts that were willing to attend the focus group discussions. Even though several different professions and organisations were represented, it cannot be ruled out that certain aspects and views might have not been included. Nevertheless, the interdisciplinary composition of the expert groups and the years of experience of those experts in the German health care system are the main strengths of this paper. They have provided evidence-based and action-oriented suggestions that are, thanks to their comprehensive policy expertise, highly relevant to the German health system.

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