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German Hospitals in the Covid-19 Crisis – Return to State Control and Regulation

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Resumen

In 2020, there was a massive cut in life worldwide and in Germany. A pandemic caused by a virus called Corona or Covid-19 (presumably) spread from a fish market in Wuhan, China. In the spring, German politicians finally realized that the virus could hit Germany as well as other countries a few weeks and months earlier. The whole country was sealed off. And politics lurched around, unable to cope with the situation in a structured and reliable manner. One bundle of measures chased the next. In the middle: a health system that even before the pandemic had had its own problems coping with larger waves of infections, e.g. the flu wave 2018/2019. This paper deals with the possible chance of a paradigm shift in German health policy due to the pandemic.

In response to the pandemic, several new rules were introduced to try to care for a potentially large number of infected people and track infection pathways. Some of these rules are described here. And it is analyzed whether this pandemic offered health policy in Germany opportunities for change. To this end, reference is made to Peter A. Hall's model and its various stages of change (Hall, 1993). Additionally, the model of path dependencies by Streeck and Thelen (2005) is used to assess the question further.

It begins with a description of the rule changes in German health policy during the pandemic. This is followed by a summary of Hall's theory and a classification of health policies during the pandemic according to this theoretical approach. A similar analysis is proceeded with the different models of change derived from Streeck and Thelen. Finally, it will be examined whether the health policy adjustments opened an opportunity for a paradigm shift and finally a general change in German health policy.

It concludes that despite the crucial role of the pandemic for public life and the health system as such, a change in paradigm does not seem to bear good prospects. It is assessed that this might be due to the multilevel regulation typical for the German health system.

Keywords: hospitals, regulation, state control, covid-19, changes

Expanded abstract

In 2020, there was a massive cut in life worldwide. Germany was no exception. A pandemic caused by a virus called Corona or Covid-19 (presumably) spread from a fish market in Wuhan, China. In spring, German politicians finally realized that the virus could hit Germany as well as it had hit other countries a few weeks and months earlier. The whole country was sealed off in a rush. It seemed like something was pressing the pause button in normal life. And politics

lurched around, unable to cope with the situation in a structured and reliable manner. One bundle of measures chased the next. In the middle: a health system that already had its own problems before the pandemic to cope with larger waves of infections, e.g., the flu wave in 2018/2019. Structural problems, shortage of medical and nursing professionals and financial difficulties had existed before and now became visible as the health system started to prepare for possible huge amounts of ill people. But sometimes exceptional situations lead to exceptional solutions and then to general changes of systems.

In response to the pandemic, several new rules were introduced in Germany to try to care for a potentially large number of infected people and track infection pathways. Some of these rules are described here. A focus is laid on rules that directly affected hospitals. And it is analyzed whether this pandemic offered health policy in Germany opportunities for change. To this end, reference is made to Peter A. Hall's model and its various stages of change (Hall, 1993). This paper deals with the possible chance of a paradigm shift in German health policy. Additionally, the model of path dependencies by Streeck and Thelen (2005) is used to assess the question further.

It begins with a description of the rule changes in German health policy during the pandemic. This is followed by a summary of Hall's theory and a classification of health policies during the pandemic according to this theoretical approach. A similar analysis is proceeded with the different models of change derived from Streeck and Thelen. Finally, it will be examined whether the health policy adjustments opened an opportunity for a paradigm shift and finally a general change in German health policy. It is concluded that a fundamental change cannot be seen so far and a return to state control and regulation is not envisaged.

German Hospitals in the Covid-19 Crisis – Return to State Control and Regulation

1. Introduction and Background

In 2020, there was a massive cut in life worldwide. Germany was no exception. A pandemic caused by a virus called Corona or Covid-19 (presumably) spread from a fish market in Wuhan, China. As the pandemic seems to continue forwards even in spring 2022, there might have been developments during the last two years that needs an examination retrospectively.

In spring, German politicians finally realized that the virus could hit Germany as well as it had hit other countries a few weeks and months earlier. The whole country was sealed off in a rush. It seemed like something was pressing the pause button in normal life. And politics lurched around, unable to cope with the situation in a structured and reliable manner. One bundle of measures chased the next. In the middle: a health system that already had its own problems before the pandemic to cope with larger waves of infections, e.g. the flu wave in 2018/2019. Structural problems, shortage of medical and nursing professionals and financial difficulties had existed before and now became visible as the health system started to prepare for possible huge amounts of ill people.

But sometimes exceptional situations lead to exceptional solutions and then to general changes of systems. Such systematic changes sometime can be seen in advance or at least in the middle of such an exceptional situation. Different research in policies has been attributed to this. This paper tries to take a glance at two types of approaches trying to figure out, whether the pandemic might have induced changes.

In response to the pandemic, several new rules have been introduced in Germany to try to care for a potentially large number of infected people and track infection pathways. Some of these rules are described here. A focus is laid on rules that directly affected hospitals. And it is analyzed whether this pandemic offered health policy in Germany opportunities for change. This paper deals with the possible chance of a paradigm shift in German health policy. To this end, reference is made to two approaches to analyze policy change.

First, Peter A. Hall's model and its various stages of change are taken (Hall, 1993). Additionally, the model of path dependencies by Streeck and Thelen (2005) is used to assess the question further.

The paper begins with a description of the rule changes in German health policy at the beginning of the pandemic. This is followed by a summary of Hall's theory and a classification of health policies during the pandemic according to this theoretical approach. A similar analysis is proceeded with the different models of processes od change derived from Streeck and Thelen. Finally, it will be examined whether the health policy adjustments opened an opportunity for a paradigm shift and finally a general change in German health policy.

2. New Rules

Starting with the (first) "Law for the Protection of the Population in an Epidemic Situation of National Significance" of 27 March 2020, regulatory measures had already been taken (Deutscher Bundestag, 27.03 2020. p. 587–592). Essential points of the Infection Protection Act were supplemented and tightened. The Infection Protection Act had only recently been amended in February 2020 in connection with measures to improve vaccination control. (ibid. 10.02.2020, p. 148-157). Thus, the Bundestag has now been given the task of determining an "epidemic situation of national significance", so that the executive could call for a series of measures qua empowerment for the period of the epidemic situation. In addition to travel restrictions and lockdown measures, drugs, protective equipment, and disinfectants plus price regulations could now be approved by the Federal Ministry of Health. Regulations or guidelines that were previously privileged to be changed by the health self-administration could now be changed and/or suspended by the Federal Ministry of Health itself by means of a statutory ordinance (ibid. 27.03.2020, p. 587-592.). The “epidemic situation” was only exited in autumn 2021 and replaced by more general measures (Deutscher Bundestag, BGBl I,22.11. 2021). The Federal Ministry of Health, therefore, was given full ordnance for more one and half a year.

In the further course of the crisis, the federal government regulated the central purchase of certain medicines as well as personal protective equipment. An unprecedented process, since in principle each institution had to take care of the procurement of consumables on the market independently. In view of supply bottlenecks and massively rising prices due to the scarcity of goods, the principle of the free-market economy was almost completely abandoned without discussion.

Most of the incipient measures were put into place between March and August 2020 (see Table 1 for an overview).

Table 1. Incipient Legislation in The Context of The COVID-19 Pandemic

March 21st 2020	(1st) Law for the protection of the population in an epidemic situation of national significance
March 21st 2020	Draft of Hospital Relief Act
March 23rd till March 27th 2020	Readings in the Bundestag, Health Committee and Bundesrat
March 27th 2020	Ratification of both Acts
March 20th 2020	Draft of the 2nd law for the protection of the population in an epidemic situation of national significance
May 7th till May 14th 2020	Readings in the Bundestag, the Health Committee and Bundesrat
May 23rd 2020	Ratification
June 4th 2020	Draft of the COVID-19 Compensation Amendment Regulation
June 9th 2020	Ratification
August 6th 2020	Draft of the Hospital Future Act (KHZG) as well as to the Act on the Improvement of Health Care and Care (GPVG)

sources: Deutscher Bundestag 2020, BGBl I, Bundesministerium für Gesundheit 2020-2021, depiction by author

2.1 Hospitals

Assuming that hospitals in particular would bear the brunt of the pandemic-related care of patients, they were to be supported in particular by the "Act to Compensate for COVID-19-Related Financial Burdens on Hospitals and Other Health Facilities" (COVID-19 Hospital Relief Act) (Deutscher Bundestag 27.03.2020, BGBl I, p. 580-586).

The AOK Federal Association – the largest statutory health insurance - together with the German hospital association demanded in advance with jointly agreed cornerstones the renunciation of the flat-rate operating cost financing in hospitals. Instead, the last negotiated budgets should be increased by the change value and a liquidity surcharge. They demanded this on the grounds that this is the only way to ensure liquidity and thus the existence of the institutions during and after the crisis (Tagesspiegel 2020). What is remarkable here is the

solidarity of the otherwise mostly contrary actors of self-administration.[1] But also, the German Interdisciplinary Association for Intensive Care and Emergency Medicine (DIVI) called for a general budget update (Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin, 2020).

With the "Draft of a Hospital Relief Act", which the German Federal Government published on 23 March 2020, and which was adopted in the same week by both the Bundestag and the Bundesrat (and immediately came into force), all demands for the suspension of regular hospital financing or a temporary abolition of the flat-rate calculation of the benefit calculation in hospitals were off the table. Now only a lump sum was provided for each unoccupied bed in the hospital. This measure was intended to provide incentives to keep the beds available for potential Covid-19 patients and to compensate for other revenue losses due to the postponement of so-called elective services. The lump sums are pre-financed by the liquidity reserve of the health fund and are to be reimbursed retrospectively by the federal budget. Thus, these are not benefits of the statutory health insurance and thus from health insurance contributions but are financed by tax revenues.

With the vote on the Hospital Relief Act, the Thuringian state government reaffirmed the desire to fully cover the expenses of hospitals in times of pandemic by means of a fixed budget.: „In addition, the liquidity of the hospitals must be secured by allocating a monthly budget that completely covers the actual costs. “, their representative demanded (Bundesrat 27.03.2020, appendix 9)

Nevertheless, the flat-rate (or lump-sum) financing of the vacancy services (in the sense of empty hospital beds) meant a departure from the principle of regulation through market processes and, above all, from the principle that unused fixed costs in hospitals are not financed. The lump sum of 560 euros is de facto the financing of potential services, the scope of which could not be estimated in advance. In addition, there was a clear commitment concerning the additional financing of ventilators and an initially only temporary increase in the value of nursing costs as part of the flat-rate financing logic. With the "Second Act for the Protection of the Population in an Epidemic Situation of National Significance", the original temporary nursing costs value for the budget year 2020 was permanently fixed (Deutscher Bundestag 19.05.2020, p. 1018-1036).

In subsequent measures, a gradation of the flat-rate benefits was made for hospitals with the draft of an “ordinance for amending compensation payments to hospitals due to special burdens caused by the coronavirus SARS-CoV-2” of 4 June 2020 (COVID-19 Compensation Payment Amendment Ordinance) (Bundesministerium für Gesundheit 04.06.2020). The lump sums then ranged in five stages from 360 to 760 euros. The methodology of the assignment of the individual hospitals (and some rehabilitation clinics such as e.g. the Brandenburg Clinic

[1] The first draft bill of the Federal Government initially took up this demand and formulated such a request. But this part of the draft was soon abandoned and cannot be found directly on any official documents anymore.

in Bernau-Waldfrieden) was not (initially) justified in detail, There was only a vague reference to the cost structure and the case mix differences (ibid. p. 1). By limiting the increased lump sum to hospitals that had made at least one notification of intensive care treatment capacities, a distinction is not made per se cost-oriented, since these facilities had also been prepared for the admission of COVID-19 patients (possibly not in intensive care) to be treated and had costs in currently incalculable amounts. Psychiatric day clinics generally received less than half of the normal amount of 190 euros (previously 280 euros), somatic day clinics 280 euros, although day clinics probably do not have "half" of the cost structure of fully inpatient facilities but rather 2/3, since therapeutic services are usually provided in all facilities during the day. The regulation was based on the recommendations of an expert advisory board created especially for the time of the pandemic consisting of hospital managers, scientists, and members of the self-government. The regulation became applicable law on 09.07.2020.

The regulation was widely welcomed and only criticized in places. The German Hospital Association emphasized the need for a further compensatory regulation as well as the compromise-like character of the regulation (Deutsche Krankenhausgesellschaft, 09.07.2020). The Catholic Hospital Association asked for an extension of the measure until at least the end of the year and wished to strengthen child and adolescent psychiatry at the expense of psychosomatics (Katholischer Krankenhausverband, 08.06. 2020).

The Association of Hospital Directors noted that the flat rates for the care of patients in compulsory psychiatric care were insufficient. In addition, they calculated the extent of the cost differences between child and adolescent psychiatry and adult psychiatry, which were not taken into account here, so that the child and adolescent psychiatry was supposedly underfunded by the regulation. (Verband der Krankenhausdirektoren e.V. , 20.06.2020)

Criticism also came from the German Medical Association, especially regarding the short reaction periods. From the point of view of the German Medical Association, hospitals are not yet in a position to assess the financial impact of the pandemic-related adjustments. Provision should be made for an ex-post adjustment of payments (Bundesärztekammer, 08.06.2020).

The GKV-SV waived a regular (official) statement on the ordinance and at the same time implemented it in the "2nd agreement according to § 21 sec. 7 KHG on the procedure of proof of the compensation payments according to § 21 sec. 1 KHG (2nd compensation payment agreement)" together with the DKG (GKV-Spitzenverband,07.08.2020).

The new regulation was explicitly perceived as good by the AOK Federal Association, which feared above all the danger of a withdrawal from healthcare service provision due to the previous uniform lump-sum compensation payment: "The current overpayment sets massive monetary incentives to withdraw from supply and thus harms patients." In their own calculations, the AOKs assumed that the lump-sum 560 euros were set significantly too high and favor certain facilities such as e.g., material-cost-intensive specialist clinics. At the same time, however, the AOK wanted a rapid return to the normal billing logic including the billing controls (AOK-Bundesverband, 09.06.2020).

A first survey by the German Hospital Institute – an admittedly not completely impartial source – showed that in three quarters of the hospitals surveyed, the lump sum was not sufficient to cover the running costs of vacant beds (Blum et al. 2020, p.7). Around 48% of the general hospitals with more than 50 beds were surveyed (ibid., p.6) For the most part, the costs for personal protective equipment were also not covered, as purchase prices for the material had risen sharply (ibid. pp. 8 & 10). Also due to uncompensated revenue losses in other business sectors of the hospitals (cafeteria, parking garages, outpatient areas), they reported a massively worsened financial situation due to the pandemic (ibid. p.16). Depending on the equipment and regional healthcare mandate (e.g., by supplementing the lack of outpatient specialist care), it can be assumed that certain regions and/or hospital operators or specializations will suffer more from the COVID-19 conditions.

With the persistence of the pandemic most of the rules were revoke in autumn 2021, supposedly ending by March 2022 (see 2.3).

2.2 Other Areas

The German healthcare system is divided into strongly differentiated sectors. Besides the inpatient acute care in hospitals, a large sector for outpatient acute care exists. It would be negligent not to mention measures that were taken in this sector during the pandemic.

As politicians expected fewer patients in outpatients practices due to lock-down, some compensatory mechanisms were established. Loss of income in outpatient (statutory health insurance) practices up to 10% was allowed to be compensated by payments from the associations of statutory health insurance physicians outside the morbidity-related total remuneration. Declines in the raw number of cases that threaten the existence of a practice could also be compensated for by additional payments. (Deutscher Bundestag 27.03.2020, p.583). The design of the compensation was left to the contracts between the associations of statutory health insurance physicians and the health insurance companies.

Later, the remuneration of the social pediatric centers (SPCs) and medical treatment centers (MBCs) were adjusted (Deutscher Bundestag 19.05.2020). Both were made against the background that declines in the number of cases were also to be expected in specialized outpatient areas due to the pandemic.

In addition to the regulatory interventions to financially strengthen the service providers, the pandemic showed a lack of equipment in the public health service (ÖGD). For example, infection chains could not be tracked promptly due to a lack of human resources or technical equipment. At times, even the Bundeswehr was used as support in the offices in the course of a so-called administrative assistance. (cf. Schleihermacher 2020; Hennings 2020). The critical shortages in the ÖDG were also recognized by the Federal Government, so that the Second Act for the Protection of the Population in an Epidemic Situation of National Importance provided for a strengthening of the ÖGD. In this law, the deployment of the Bundeswehr for

the tracking of the routes of infection was also formalized (Deutscher Bundestag 19.05.2022). While in previous years many (planned) positions remained unfilled for cost reasons and/or due to a lack of applicants, there are now framework specifications for the scope of positions in the ÖGD depending on the population.

2.4 Continuation After Initial Phase

After an initial phase of rushed decisions, it became clear that the system would not crash immediately but had still to stay prepared. In autumn 2020 some more general reforms were started e.g. the “Future Program Hospitals” (Deutscher Bundestag 28.10.2020).

With the “Future Program” the Federal Government wanted to promote the digitization of the supply landscape. Measures related to the current pandemic were not envisaged, although the federal government presented the law as part of the Covid-19 measures to promote the economy as a whole. For this purpose, a fund analogous to the already existing hospital structural fund was set up, the so-called Hospital Future Fund. In addition to promoting digitization, the draft provided: "the targeted development and strengthening of regional supply structures in order to conceptually coordinate structures both for normal operation and for times of crisis." (Bundesministerium für Gesundheit, 6.8.2020, p. 5) The act did not provide for regulatory interventions in hospital financing – except for a discontinuation of the minimum staff requirements in psychiatric and psychosomatic hospitals. Deviating from previous measures, however, the measures of the fund are financed from tax revenues and not from the resources of the health insurances.

Interestingly, the Federal Government admitted at this point that "The gap created by a lack of investment by the federal countries is closed to a considerable extent by the hospitals' own resources, which also includes cross-financing from operating resources." (ibid., p. 16) At the same time, the government believed that hospitals could finance their part of the cost for the eligible measures from their own resources. This contradiction is often found in hospital financing in Germany. Coupled with a respective federal country that is either unwilling or unable to bear its share of the support measures for financial reasons – as is already the case with hospital structural funds – such a support structure can lead to regional and other disadvantages. Hospitals in regions e.g. with low tax revenues (and correspondingly little money that the state government can provide), cannot fully exploit the funding opportunities. The same applies to hospital revenues which, for a variety of reasons (e.g. low need for care and thus few cases), have no own funds and cannot raise them through loans.

In November 2020, the number of Covid-19 cases rose again. As already often suspected, a second wave of infection began. The federal and state governments responded with a so-called lockdown light. Public events, restaurant visits and the like were prohibited. Schools, day-care centers, and shops remained open. Test strategies were adapted. The tracking of infection chains was hardly possible anymore. Some hospitals reached their capacity limits, especially in intensive care. In response to the once again difficult situation in the health sector,

some measures from the first wave were taken up again. A telephone sick leave for respiratory infections was made possible again. The payment periods for hospital bills were reduced again to 5 days. Exams of minimum structural characteristics, etc. suspended. The nursing costs value temporarily increased. Once again, the Federal Ministry of Health was given the opportunity to react to the infection situation by means of a legal ordinance. Hospitals received allowances (compensation payments) until the end of January 2021, depending on the infection (incidence) in the district and the care of Covid-19 patients. The amount of the compensation payments was reduced by about 10%. In this wave, however, the allowances were not distributed to all hospitals, but were subject to new requirements. On the one hand, they were based on the free and reported intensive care capacities as well as the 7-day incidence of Covid-19 cases. On the other hand, only hospitals that offer so-called "extended emergency care" in accordance with the emergency level remuneration agreement or a corresponding designation in the hospital plan are favored (cf. Deutscher Bundestag 18.11.2020). This also eliminated compensation payments for clinics that provide special services, e.g. orthopedic clinics and psychiatric clinics without somatic emergency care as well as hospitals that only provide basic emergencies.

The usefulness and appropriateness of this new regulation were clearly criticized. Above all, the problem of missing patient flows due to people's fears of visiting hospitals and quarantine cases in the workforce were not taken into account in this measure. Of particular interest in this context is the protocol declaration of the eastern German states and Bremen, which believed that they will be disadvantaged by the measure: "However, the regulation now adopted by the German Bundestag can rather lead to false incentives in the admission of patients and to further centralization at the expense of the care of the area. There is a risk that primary and regular care providers as well as specialist clinics will be in distress." Other state governments also put concerns about the regulation on record (Bundesrat, 18.11.2020, p. 467).

In the course and aftermath of the pandemic, there were further demands for possible developments of the German health care system. At the end of November 2020, one of the large health insurance companies, the BARMER published a "Directional Paper on Medium and Long-Term Teachings" with the help of the Bertelsmann Foundation and well-known authors from the field of health economics (Augurzsky et al., 2020). In this paper states that the German health system had coped well with the pandemic. It also makes some propositions about what should be reformed in the aftermath of the pandemic. Beside systematic changes in regulative areas like health care planning, it proposes changes in financing. It also declares that digitalization would be the key (ibid.).

Comentado [IK1]: Hier weiter

In the spring of 2021, a third wave developed despite renewed lockdowns since December 2020. Many health policy measures have been extended. Further processes were initiated to cushion the loads in the hospitals. On 15 March 2021, there was a draft bill of the BMG on the "Ordinance on the Regulation of Further Measures for the Economic Security of Hospitals".

This provided for another round of lump-sum transfers for empty bed and other measure already used during the first wave.

Around the same time, motions were submitted by the then opposition factions Bündnis 90/ Die Grünen (Deutscher Bundestag 19/27830), the DIE LINKE (Deutscher Bundestag 19/26168) and the FDP (Deutscher Bundestag 19/26191), some of which provided for massive changes to the logic of hospital financing. None of these initiatives were adopted as summer and with it fever Covid-19-cases came. In addition to the ebbing away of the pandemic the election campaigns started and thereby stopped serious governmental activities.

Until then there has not been a clear sign of general changes in financing methods for hospitals. But the new government that was installed in December 2021 has agreed upon some reforms envisaged to be started during their mandate.

According to the coalition agreement the new government plans amongst others (Bundesregierung 2021, p. 84-88):

- to promote methods of financing along the treatment cycle (Hybrid-DRG)
- specific financing of healthcare in close range of residence
- to ease options for more flexible and customized contracts between insurance companies and regional healthcare facilities
- to extent community nursing and case management
- to advance an integrated planning of ambulatory and hospital healthcare provision
- to develop a revenue independent financing of structures in hospital care

These measures could possibly proof to implement major changes in health care financing and paradigms in hospitals. The actors of the hospital sector have also opened more debates of the further future of the hospital financing system (cf. Gesundheitswirtschaftskongress 2021, DRG-Forum 2022[2]). But with yet another wave (or waves) of infections in the winter of 2022 and the war in Ukraine since February 24th 2022 there seem to more pestering problems ahead.

[2] The Health Economy Congress (Gesundswirtschaftskongress) as well as the DRG-Forum are some of the most import gatherings in the German health sector each year. Usually, some trends and prospects for the health system are anticipated there. See also: https://gesundheitswirtschaftskongress.de/17-gesundheitswirtschaftskongress; https://drg-forum.de/programm/03200-finanzierung-reformbaustelle-fallpauschalen/

3 Perspectives and change

The current situation can be analyzed, among other things, using methods of policy research. A pandemic can be seen as the kind of shock that might lead to fundamental policy changes. But it need not be. Political theorists have looked at changes in policies and found an array of possible developments that could imply different kinds of changes. The following section will look at two theories and will try to analyze how the pandemic and the reaction of Germany health policy could fit into these theories.

3.1 Theories of Change

Against the background that change is hoped for and feared in the political space (see motions of the then opposition in spring 2021) and extraordinary events tend to bring about change, it seems useful to consider two widely used theories that deal with political change. One of them is by Robert Hall (1993) and looks at the paradigm shift in British politics and its theoretical causes. Hall's approach is based on the theoretical approaches of "social learning". In doing so, he assumes a mixture of policy legacies, key agents, and the political framework conditions ("capacities of states to act autonomously from social pressures") that enable learning processes. Hall underpins these elements. And divides policymaking into three sub-variables: the overarching objective, the policy technology (i.e. the instruments) and their exact usage. Taking these variables into account, he distinguishes three different types of change: first order change in policy, second order change in policy and third order change in policy. The differences are represented in table 2. Basically, in higher orders of change more of the sub-variables are altered (leading to more fundamental changes).

table 2. Hall`s order of changes

	1st order change	**2nd order change**	**3r order change**
overarching objective	remain constant	remain constant	are altered
policy technique	are altered	are altered	are altered
exact usage (instruments)	remain constant	are altered	are altered

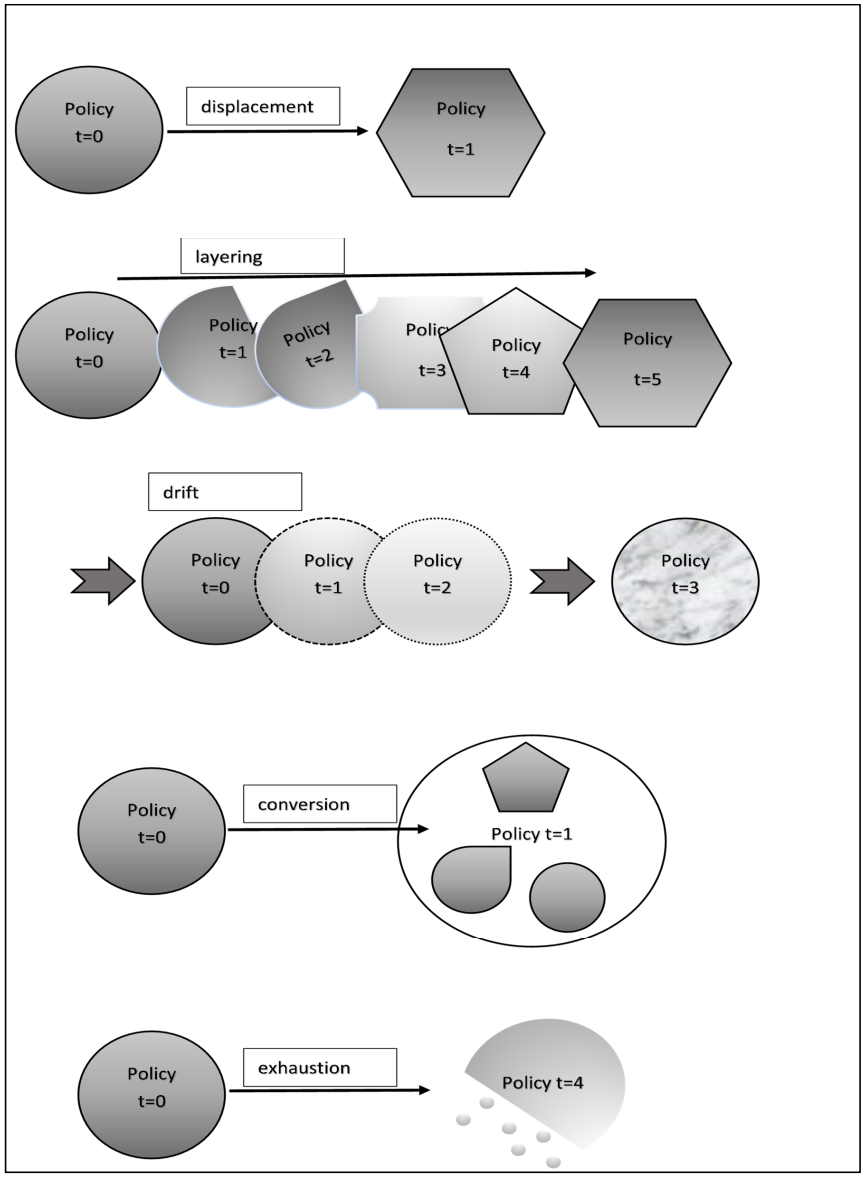
source: with reference to Hall 1993, depiction by author

Random or planned events are the source of learning processes that influence policymaking and bring about changes in different "orders". This can change political paradigms, which Hall defines as an interpretative framework of politics in the sense of the ideas and standards of the work of political actors. At this point, he refers to the similarity with Thomas Kuhn's definition of scientific paradigms. A paradigm shift takes place with the change of the 3rd order. Decisive elements that bring about this change, however, are less scientific than sociological in nature

and can be found in the keyword's institutional framework, auxiliary resources, exogenous factors and, in particular, questions of authority. Above all, the role of political experiments and policy failures in the occurrence of anomalies that can only call into question the foundations of politics or make them appear (more) uncertain must be considered. According to Hall's investigations, decisive for the occurrence or possibility of a change in the 3rd order is the occurrence of such anomalies with which the current paradigms cannot keep up, whereby the current positioning of authorities in the sense of reference order to them is questioned.

Streeck and Thelen propose an enhanced approach (2005). They distinguish institutional changes based on the nature of the process of (institutional) change (incremental, abrupt) and the consistency of the results (gradual transformation, collapse or replacement) (Streeck/ Thelen, 2005, p. 9). The focus of this consideration is on gradual transformations in incremental processes (ibid. p. 18). Various types of change are differentiated: displacement, stratification, drift, transformation, exhaustion (ibid. p.31). Graphically, these can be displayed and summarized as in Figure 1. Accordingly, change from one point in time to another can create a completely different policy (replacement/displacement), by sequencing overlapping policies a change can happen (layering), quasi "pushing" a policy over similar policies to a new policy ("drift"). Conversion is done by converting a policy into various related policies from the original policy. In the case of change through exhaustion, the change happens when the original policy dissolves or survives and exists only proportionately. Many of these changes can also be observed in elements of health policy over the years. For example, the introduction of the nursing value budget may seem to be a symptom of the exhaustion of the rigid policy of lump sums per treatment in German hospital financing. Hacker has identified a "drift" in US health policy (Hecker, 2005, p. 40 ff.).

Figure 1: Change processes in politics, own depiction based on Streeck/ Thelen 2004



Taking these theoretical foundations, first it will be examined below whether there has been a paradigm shift in German health policy in the course of the "event" Covid-19 pandemic or whether there is a possibility that this paradigm shift will still take place. To this end, the first step must be to clarify which paradigm can currently be found in German health policy. In addition, the individual variables in health policy must be clarified: overarching objective, policy technique and instrument. These variables and how they deal with them during the crisis should show whether and which change is recognizable in the sense of the policy explained above. Second, the actual policy measures will be classified according to the processes of change.

3.2 Paradigms And Orders of Change

The basic paradigm of German health policy is a strong belief in market forces. This is reflected in the constant use of the word 'competition' in every policy measure. The level of competition seems to be high when you look at the health insurance system with its more than 100 statutory health insurance companies and around 12% of private health insurance companies. It is also often mentioned when discussing possible changes in the number of hospitals and in the way doctors' offices should operate.

Even the basis for hospital financing – the DRG – is founded on the regulatory model of markets – the so-called yardstick competition, in which the lowest costs are the benchmark for all in financing patterns. The understaffing and underfunding of the public health system also shows that there is a strong belief in the "market" as a solution to health problems. Regulation is usually outsourced to self-administration, and the Federal Ministry of Health only provides legal supervision. The overarching goal of German health policy is nonetheless to maintain an appropriate state of health in the population.

Beside a tendency to focus on markets and competition the political reality still is based on regulation established by a myriad of red tape. This bureaucracy composes two of the three mentioned individual variables of German health policy.

The political techniques are actions, decrees and rules with legal bases that are implemented by the self-administration. The instruments used are a mixture of financial incentives, centralized but mostly weak standards and framework agreements.

The overarching goal of health policy remained the same during the pandemic. The overarching goal of Covid-19 measures continued to be to maintain general and specific health care in the event of high numbers of infections. The goal of maintaining a decent general state of health in the population was slightly limited and the hospitals were only instructed to cancel so-called elective treatments, namely treatments that could possibly be postponed.

By allowing the executive – in particular the Federal Ministry of Health – to act on its own, policy techniques were massively changed temporarily (with a fixed terminal date). Nevertheless, it remained the case that some measures were still responsible for and

implemented by the self-administration, e.g. the compensatory financing in the outpatient sector.

First and foremost, the policy instruments themselves have been changed. Lump-sum, non-performance-related payments to ensure the liquidity of hospitals are completely new in German healthcare. Until now, the principle of "money follows performance"[3] applied. Since the lump sums were graded in the further course of the pandemic and ultimately expired completely at the end of September, this change was quite temporary and by no means permanent in nature. The proposal to completely abandon the previous budget standards was rejected very quickly at the beginning of the pandemic.

Therefore, this crisis does not seem to show any sign to provoke a change of any order so far, since none of the three sub-variables of the Halls theory changes permanently (cf. table 3).

table 3 Hall`s order of changes and the German Policy measures

	German Health Policy 2020-2021
overarching objective	remained constant
policy technique	were slightly and temporarily altered
instruments	were altered, but temporarily

source: with reference to Hall 1993, depiction by author

3.3 The Processes of Change

Looking at the process of changes takes a quite different angle of view. Rather than seeing the results or performance of a political action it sees the pathways of it.

From the perspective of theories of path dependencies, the development of potential change in regulation cannot be seen to have taken the form of replacement nor conversion. The core measures and new regulations were temporary, and the old policy is at least envisaged to return as soon as the pandemic is over. Looking backwards and including changes that started before the pandemic such as the nursing value and other minor changing in the system of hospital financing maybe a layering is occurring. To evaluate that a deeper look at the final outcome (t=5) might be necessary in retrospect a few years after the pandemic. Drift could be laying ahead, especially when seeing that the adaptions are mostly minor in nature. Here also, a retrospective comparison might be in order. Exhaustion could have started years before the pandemic when the lump-sum funding of supply of health care in hospitals started to erode, e.g. by manually changing lump-sums for certain procedures like spinal surgeries. In this case,

[3] Performance is used in the sense of health care treatment.

it might not have been the pandemic that is inducing a gradual change of the policy. Especially, since the measure during the pandemic were rapid and rather adapted to concrete situations of the pandemic, and these do not look like they would be what Streeck and Thelen called “exhaustive changes”. As it is the nature of pathways an analysis of policies that are within the process of change a more detailed analysis is hardly valid when there are – up to now - only two years and additionally a still ongoing crisis. This should nonetheless be scheduled for further examination in the future to come.

4 Conclusion

As can be seen from this analysis, a paradigm shift in the sense of the Halls theory does not seem to be underway – just close to a change in the 1. Order. There might be a further drift or layering within the process of change where the pandemic is just one element within it. A fundamental change cannot be seen so far and a return to state control and regulation is not envisaged.

But why is it, that a change is hardly possible in the German health care system? Several explanations are possible. For one: this system has its inbuilt stability due to the multilayered authority mechanism in the German federal and self-administrative system. “To many cooks spoil the broth.”, as the proverb says. This fits with Hall`s notion of “capacities of states to act autonomously”. In the multilayered system autonomous handling of changes simply does not exist. Furthermore, this analysis cannot be in-depth as the pandemic is not over yet. It can just be an initial glance at the policy. Above all, the methods above are just two of large amounts of other possible ways to analyze policy changes. Additionally, it only sheds light on a small part of German health care policy. There is still the outpatient sector, the nursing sector, rehabilitation, pharmacies etc. But analyzing these goes beyond the scope of this paper.

The Covid-19 pandemic is not over yet. The numbers are rising again, and restrictions and policy measures are suspended.

This paper sheds light on some of the most important measures of German politics. Many of them have not been fully implemented. The full consequences for the health system as such are currently not foreseeable. But a look at the measures taken so far shows the despondency of German health policy - a characteristic that has been true for decades. It's not surprising that even an anomaly like this pandemic doesn't lead to a paradigm shift. However, what is evident, for example, in the initial reactions to the financing measure is a great deal of uncertainty within the self-administration. This could potentially lead to a new orientation in understanding how the health system should be financed and staffed, e.g., by financing a certain level of equipment that is only used in times of crisis but must be permanently available.

As the pandemic continues to have an impact on society, its economy, and people, it is still unclear what the response will be. 2020-2022 will be quite interesting years to look at from the future.

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