Spitzenverband

Quality – improving, assuring, publishing

Annual Report 2014

Imprint

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The National Association of Statutory Health Insurance Funds (GKV-Spitzenverband) is the central association of the health insurance funds at federal level in accordance with section 217a of Book V of the German Social Code (SGB V). It also acts as the national association of the long-term care insurance funds in accordance with section 53 of Book XI of the Social Code (SGB XI). The National Association of Statutory Health Insurance Funds is a public-law corporation with self-government. In accordance with section 217b subsection (1) of Book V of the Social Code, an Administrative Council is to be formed as a self-government body which is elected by the Members' Assembly. With this Annual Report, the Administrative Council of the National Association of Statutory Health Insurance Funds is complying with its mandate in accordance with the Statutes to submit to the members, through its Chairperson and in agreement with the alternating Chairperson, an Annual Report regarding the activities of the Association (section 31 subsection (1) No. 9 of the Statutes). The Report covers the business year 2014.

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Introductory Section

The Year's Topics

Foreword by the Chairmen of the Administrative Council

Dear readers,

In 2014, the Grand Coalition focussed intensively on the implementation of the projects on which it had agreed. A central focal point, and one which is welcome from the point of view of the statutory health insurance funds, is the quality of healthcare. From the patients' perspective, the increasingly complex care processes must be accompanied by benefit-orientated service-provision.

A major step towards achieving this goal is constituted by the mandate from the legislature to the self-government bodies to establish a professionally-independent scientific Institute for Quality Assurance and Transparency in the Healthcare System. Rapid progress is being made towards establishing this body. From 2015 onwards, the new Institute will be gradually assuming the tasks which have been assigned to it by law, and will be in full operation in 2016. Also when it comes to additional projects aimed to improve healthcare, the self-government bodies regard it as falling within their responsibility to commit themselves to the rapid implementation of the statutory mandates in a manner that serves everyday needs. The reforms in out-patient and in-patient care, as well as the Prevention Act (Präventionsgesetz), are only a few among the topics where the self-government bodies will demonstrate that they are carrying out their tasks and fulfilling their role in a solution-orientated, responsible manner.

Well-functioning self-government is contingent on unequivocal support from the political arena. The latitude that is available to the self-government bodies must be strengthened and expanded. This is however being repeatedly questioned at the moment: The proposed expansion of the Administrative Council of the Health Insurance Medical Service to include voting representatives of persons in need of long-term care and their family caregivers, as well as of the caring professions, runs counter to the self-government principle. Participation by healthcare providers, in the context of a "Third Bank", who do not have to meet the costs of the decisions that they take blatantly contradicts the concept of self-government, and is rejected by us.

Against this background, we are at best carefully optimistic with regard to the reinforcement of self-government that was announced in the Coalition Agreement. The self-government bodies can do a great deal themselves in order to gain the trust of the population and spark an interest in its work through good consensual solutions. Improvements can however only be achieved if policy-makers unambiguously commit to the self-government principle of statutory health insurance and long-term care insurance. We consider that it is only well-performing self-government that will be able to advance the necessary discussion and implementation of quality improvements at the point of care, even in the face of existing reservations.

When introducing quality standards which are taken for granted today, it was also necessary in the past to repeatedly overcome widespread reservations. On the pages below, the layout of this Annual Report introduces to you some of the pioneers of these advances in quality and their work. We hope you will find it an interesting read.

Yours faithfully,

Christian Zahn Dr. Volker Hansen

Foreword by the Board

Dear Readers,

It was almost without a sound that the legislature dealt with its health and long-term care policy agenda in 2014: The first reforms related to pharmaceutical expenditure, followed by the reorganisation of the funding structures of statutory health insurance (gesetzliche Krankenversicherung, GKV) and the implementation of the first stage of the long-term care reform. The impact has already been tangible for insured persons and patients since the beginning of the year: Persons in need of long-term care and their relatives are benefiting from improved benefits. Competition between the statutory health insurance funds has been placed on a new foundation with additional contribution rates that vary from one insurance fund to another.

It was correct to place a focus on care quality in the Coalition Agreement. The establishment of the Institute for Quality has constituted a major step in order to improve the quality of care, as well as transparency relating to it. We would have liked to see the approaches to institution-related quality assurance also covering the out-patient sector in order not to send out the wrong signal for the discussion on necessary quality improvements and contradict the quality focus of the Coalition Agreement.

The reform agenda for 2015 has proven itself to be no less varied and challenging: The further development of long-term care insurance takes top priority, as does continuing to build up a secure telematics infrastructure, the considerable benefit potential of which must finally be put to use after the massive investment that has been made by the statutory health insurance funds.

Neutral observers no longer seriously question the goal of breaking up the encrusted hospital structures. The key issues for reform that have been drawn up by the Federation-*Länder* working party however fail to meet the expectations of a fundamental reorientation. The quality orientation and the planned reduction of overcapacities in hospital care are the right approaches, but the bil-

lions that this structural reform will cost are being imposed almost exclusively on contributors. At the same time, urgent problems such as the lack of investment funding from the *Länder* remain unresolved.

Reforms that are as comprehensive as they are expensive were already launched at the end of 2014. A major opportunity to effectively counter the misallocation of physicians with the Care Improvement Act (Versorgungsstärkungsgesetz) was missed out on. It is planned to buy up medical practices in oversupplied areas, but this tool is not particularly effective given the large number of exceptions applicable. There are also more shadows than light when it comes to the innovation fund. The positive cross-sectional approach is contrasted by a design which statutory health insurance considers to be mistaken. There is a need here for targeted task attribution and funding mechanisms in order to avoid undesirable regulatory and care policy developments. The planned innovation committee, on which the partners to the collective agreements and representatives of the Ministries of Health as well as of Education and Research are to decide on individual selective contracts of the health insurance funds, contradicts the self-government principle and the competitive orientation of the health insurance funds.

The Prevention Act also fails to go far enough, and will ultimately become a paper tiger if it claims to include society as a whole, but it is ultimately only the statutory health insurance funds that are held to their responsibilities, in both content and financial terms.

On balance, the fear remains that the additional costs caused by the laws will not bring about any tangible improvements in care and that the cost pressure that is created will reduce the competition between the statutory health insurance funds which policy-makers wish to bring about so that this competition will be restricted to the additional contribution pure and simple. In the interest of patients and contributors, the National Association of Statutory Health Insurance Funds will be endeavouring to ensure that sensible structural reforms and quality improvements in healthcare and long-term care go hand-in-hand whilst at the same time the currently still sound financial basis of the statutory health insurance funds is not further undermined.

Yours faithfully,

Dr. Doris Pfeiffer
Chairwoman of the Board

Johann-Magnus v. Stackelberg
Deputy Chairman of the Board

Gernot Kiefer
Member of the Board

Agnodike is considered to have been the first woman doctor in Greek Antiquity. In order to circumvent the bans that applied in Athens, she studied in Alexandria in the 3rd Century BC and practiced in a male disguise. When she was taken to court because of her allegedly suspicious success with female patients, she revealed herself as a woman and was then threatened with the death penalty because women and slaves were not permitted to practice medicine. According to the tradition, she was saved by the intervention of her female patients, some of whom enjoyed high rank, who were successful in their endeavours to have the ban lifted.

The first year of the Grand Coalition – Taking stock of health and long-term care policy

It can be said the Grand Coalition is consistently addressing the key issues of health and long-term care policy negotiated in the Coalition Agreement. Legislative decisions from the previous year, such as the new financial architecture for the health insurance funds and improved benefits for persons in need of long-term care, will already have a tangible impact in 2015. The first legislative proposals of the governing Coalition clearly show that the guidelines formulated in the Coalition Agreement are being followed very closely in terms of their content. Concrete courses of action in health policy are also already on the reform agenda for 2015 in the shape of the draft of a Care Improvement Act, a key issues paper between the Federation and the *Länder* on which a consensus has been reached on structural changes in the hospital landscape, and the renewed attempt to enact a Prevention Act. For long-term care insurance, the second stage of the long-term care reform is already scheduled with the introduction of a new definition of need of long-term care.

Focusing on price competition alone does not go far enough

With the Act concerning the Further Development of Financial Structures and Quality (Finanzstruktur- und Qualitäts-Weiterentwicklungsgesetz), statutory health insurance is returning with regard to several fundamental aspects to the funding system existing prior to the introduction of the health fund. With the change to the income-related additional contribution, this is to be charged from 2015 as a percentage of the member's assessable income. At the start of 2015, the average additional contribution rate charged by the health insurance funds is 0.83 percent (weighted according to the number of members of the health insurance funds). The National Association of Statutory Health Insurance Funds has called on policy-makers not to exclusively focus reforms in statutory health insurance on price competition. There is a need above all of competition instruments aimed at bringing about better care quality and/or greater economic efficiency in healthcare.

An additional financial burden on insured persons

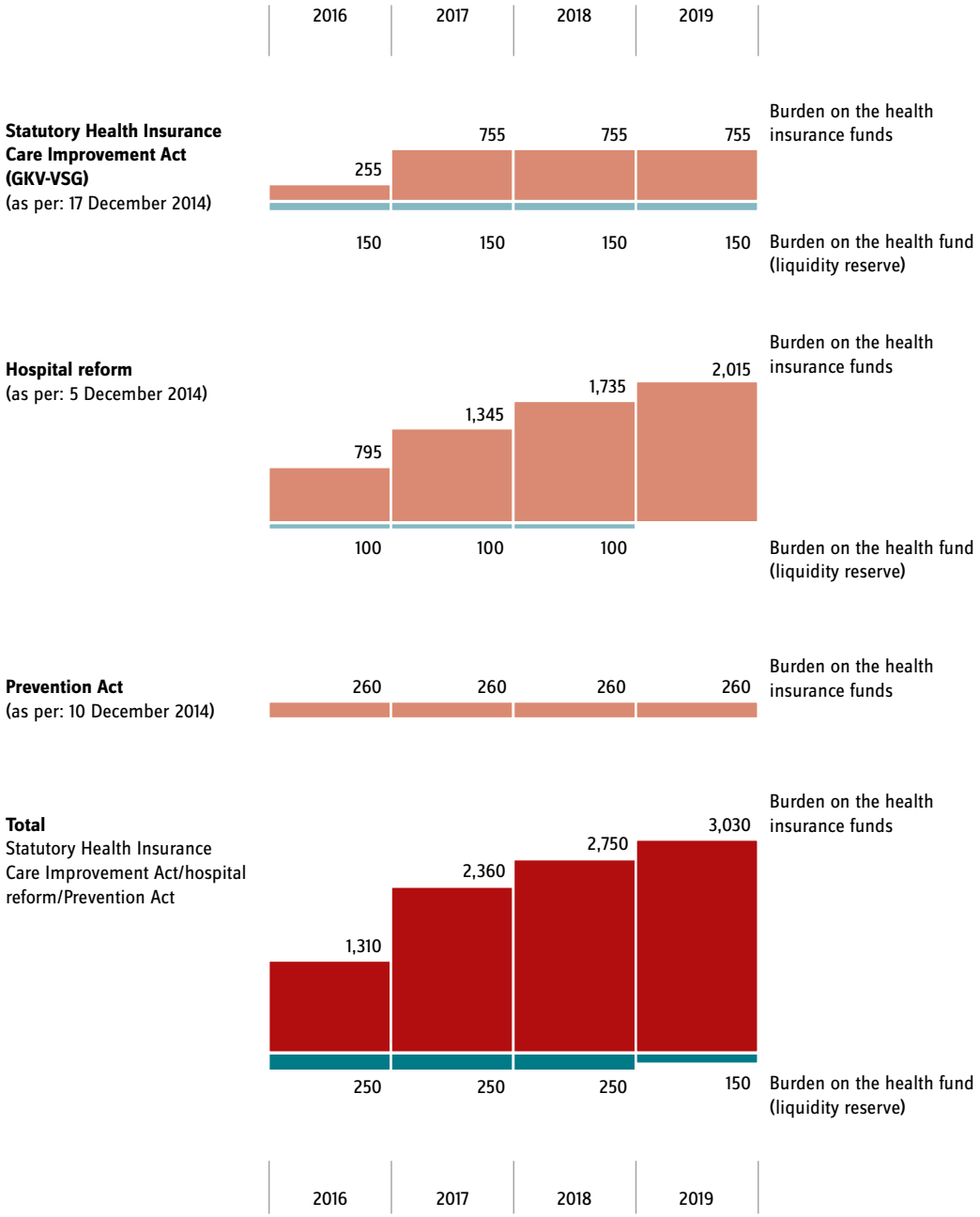
Whilst one may anticipate stable additional contributions for 2015, this is likely to change in the ensuing years: Firstly, the reserves of the health insurance funds and in the health fund will have been partly used up. Secondly, the health insurance funds will be overtaken by the fundamental problem that expenditure rises more quickly than income. Thirdly, the reforms that have been announced such as the Care Improvement Act, the hospital reform and the Prevention Act will lead to additional expenditure of approx. 1.5 billion Euro from 2016 as a result of these laws. This might increase further in the ensuing years, reaching more than 3 billion Euro. The financial strain caused by expenditure dynamics being above revenue trends will have to be met by insured persons via increasing additional contributions while the employer contribution rate remains unchanged.

Missed opportunities in care improvement

How thin is the line between the opportunities and risks of health reforms for statutory health insurance is made clear by the draft of a Care Improvement Act. With this reform, the legislature is pursuing the welcome goal of ensuring a high level of medical care for patients that is in line with their needs, provides universal coverage and is accessible. However, there is still considerable room for improvement here. The plan to buy up medical practices could theoretically do a lot to reduce overcapacities, and hence set the stage for addressing undercapacities elsewhere. This is however ultimately a paper tiger because of the large numbers of exceptions. The path of using an innovation fund to initiate more cross-sectional care projects is right in principle. However, the way it has been done is mistaken: An innovation committee dominated by the partners to the collective agreements and representatives of the Federal Ministries of Health and of Education and Research is to decide in future on concrete selective contractual services which have a direct impact on the finances of the health insurance

Reforms in statutory health insurance should not focus on price competition alone. There is a need for competition instruments aiming to bring about higher care quality and greater economic efficiency.

Fig. 1
Anticipated expenditure impact of new laws; in each case as per the reference year 2015 in millions of Euro



Source: Anticipated expenditure of the National Association of Statutory Health Insurance Funds on the basis of the expenditure estimated by the Federal Government (acc. to draft Bills) and by the Federation-*Länder* working party (key issues of the hospital reform)
Illustration: National Association of Statutory Health Insurance Funds

funds. This composition of the innovation committee runs counter to the self-government principle and the competitive orientation of the health insurance funds.

The starting signal for hospital reform

The governing Coalition has chosen the right focus by announcing a structural hospital reform under the mission statement of "Quality". Statutory health insurance considers there to be a need for a greater quality orientation in in-patient care. It is however equally important for poor quality to have consequences: If a hospital fails to meet the quality requirements, it may not provide and invoice the diagnostic and therapeutic services in question. The key issues for a hospital reform that have been submitted by a Federation-*Länder* working party provide amongst other things for a restructuring fund as has been called for by the National Association of Statutory Health Insurance Funds for quite some time. Given the existing overcapacities, hospitals which are no longer needed to meet the demand must be enabled to leave the market in a socially-acceptable, orderly manner. The proposed fund is the kick-off for this. A reform approach for adequate investment funding by the *Länder* is however nowhere to be seen. By contrast, the key issues do contain a regulation on convergence to balance the base rates in the *Länder* to a uniform corridor at federal level which imposes a one-sided financial burden on the health insurance funds.

The Prevention Act imposes a one-sided financial burden on statutory health insurance funds

Prevention and health promotion have been central tasks of statutory health insurance for years. With the draft of a Prevention Act, from 2015 onwards measures related to the living environment will rightly be placed even more prominently in the public limelight. The goals pursued here by the governing Coalition go far beyond the spectrum of the benefits which the statutory health insurance funds have to fund. They rightly constitute a task for society as a whole in which many players are to be involved. Having said that, the draft Bill that has been submitted does not implement this in financial terms. Once more, it is the statutory health insurance funds which are to pay bills that have been written by others. What is more, the "coercive commissioning" of the Federal Centre for Health Education with the implementation of prevention and health promotion benefits across all types of insurance funds appears to be irrational in terms of regulatory policy. Since this authority knows neither the local need nor the local structures, this is furthermore not expedient. The health insurance funds are therefore deprived of responsibilities, and funding is wasted on unnecessary bureaucracy.

A sound scientific foundation of the new definition of need of long-term care

The governing Coalition and the self-government bodies will face a further major challenge in long-term care policy in 2015, and that is the introduction of the new definition of need of long-term care. In order for long-term care insurance to be accepted, it is important for a definition of need of long-term care, and the allocation of benefits on the basis of the new definition of need of long-term care, not to create fresh injustices. This requires a sufficiently-sound scientific basis. The National Association of Statutory Health Insurance Funds is therefore promoting two projects within the model programme to further develop long-term care insurance in which the necessary knowledge is to be obtained for the quality-assured, responsible introduction of a new definition of need of long-term care.

Statutory health insurance and long-term care insurance are faced with landmark decisions in 2015. The National Association of Statutory Health Insurance Funds will continue to endeavour to ensure that the healthcare of patients, and the care of persons in need of long-term care, are improved and the high level of performance of statutory health insurance and long-term care insurance is lastingly enhanced.

Abu Bakr Muhammad al-Razi, Latinised to Rasis, researched and taught in the 9th Century as a physician and alchemist. He founded paediatrics as a separate discipline and was among the first to carry out research on psychosomatics and infectious diseases. Unlike the philosophical derivation of teachings which was customary at the time, al Razi stressed empiricism, that is the experimental verifiability of hypotheses. Despite the ban on wine which had also been applicable in Persia since Islamification, he developed a procedure to distil pure ethanol, which he successfully introduced to disinfect wounds.

GKV-FQWG* – the health insurance funds in the new price competition

Following on from the comprehensive reforms in the funding of statutory health insurance which took place in 2007 (Act to Improve Competition in Statutory Health Insurance [GKV-Wettbewerbsstärkungsgesetz]) and in 2011 (Statutory Health Insurance Finance Act [GKV-Finanzierungsgesetz]), the topic of financial reform was once more on the agenda of the legislature in the year under report. The CDU/CSU and the SPD continued to battle for voters' favour in the election year 2013 with competing concepts for reform, whilst in 2014 as coalition partners, they rapidly cast their funding compromise into a legislative mould. The legislature aimed to adopt the reform by the summer and to enact it by the beginning of 2015. The draft Bill of an Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance that was issued in February 2014 clearly showed that the Government would orientate itself very closely by the guidelines that had been formulated in the Coalition Agreement in terms of content.

Legislation proceeding at a furious pace

The National Association of Statutory Health Insurance Funds contributed to the overall legislation process with detailed written statements, as well as within the hearings that were held with its experts. However, the parliamentary procedure focussed on other health policy topics. The Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance was also used by the Coalition as a vehicle for many legal amendments in the care sector – in addition to the provisions on the establishment of a professionally-independent scientific Institute in the quality assurance sector that were planned for from the outset. The political and specialist debate on financial reform was particularly focused on the refinement of the morbidity-orientated risk structure equalisation, which is contentious among statutory health insurance funds, as well as on the obligation incumbent on the health insurance funds to notify when charging the additional contribution, which was expanded as the legislative procedure continued. The governing parliamentary groups pushed their compromise through without delay, both in the Committee on Health and in the plenary of the Bundestag. The criticism expressed at the public hearing by the National Association of Statutory Health Insurance Funds with regard to the obligations to notify and publish, which cause considerable administrative effort and are questionable in terms of competition policy, fell on deaf ears. The Bundestag adopted the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance (GKV-Finanzstruktur- und Qualitäts-Weiterentwicklungsgesetz) in June 2014 after a third reading; the Bundesrat accepted the Act in the second round in July 2014. The Act hence largely came into force as planned as per 1 January 2015.

*The Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance

Whilst the equally-funded general contribution rate is set at 14.6 percent, higher expenditure on benefits which are greater than increases in incomes will lead to rising additional contributions for insured persons.

Refining the financial structure

The financial structure was changed as follows with the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance:

- Since January 2015, the additional contribution for each insurance fund has no longer been charged as an amount in Euro regardless of income but as a percentage based on members' assessable income. The abolition of the flat-rate additional contribution results in the elimination of the tax-funded social equalisation, which had only been introduced in 2011, and hence at the same time of the planned relocation of the redistribution of income within statutory health insurance into the tax system.
- The administrative councils of the health insurance funds may decide once more, within the autonomy granted by their statutes, on the amount of the health insurance contribution rate of their health insurance fund. In formal terms, the administrative councils decide on the charging and amount of the new additional contribution rate. Since the general contribution rate for all health insurance funds is uniformly stipulated by law, the total amount of the health insurance contribution is only deter-

mined by the variable additional contribution rate of the health insurance fund.

- The additional contributions of insured persons are once again collected by the collecting agencies together with the other social insurance contributions. Unlike the previous flat-rate additional contribution, which the health insurance funds had to collect directly from each member personally, the new additional contributions of employees and pensioners with compulsory insurance are paid in the wage deduction system via the employer or pension insurance fund.

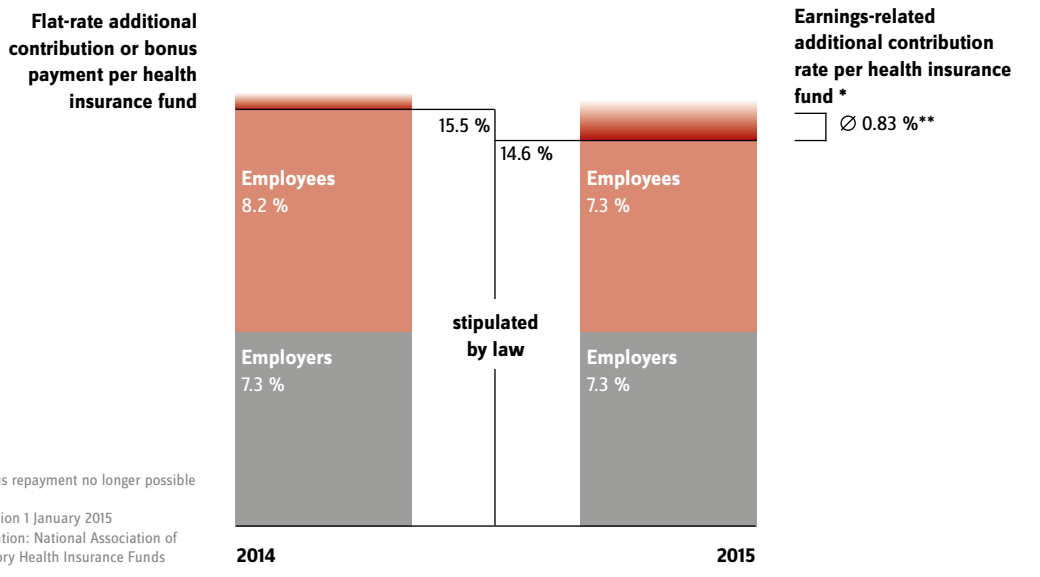
Whilst the equally-funded general contribution rate is set at 14.6 percent, and hence the employer's share at 7.3 percent, a dynamic development of expenditure on benefits above the levels of the income gains of the health fund forecast by the statutory health insurance appraisers will of necessity lead to increasing additional contributions for insured persons.

As the new funding system is launched, some members are benefiting from the reserves that the health insurance funds have established in the past years. Many health insurance funds have been able to undercut the previous uniform level of 15.5 percent through lower additional contribution rates; the anticipated expenditure increases, the vast majority of which are caused by laws, are however likely to lead to higher contributions as early as in 2016. In order to ensure a complete income equalisation, the Act provides a separate equalisation mechanism for the additional contributions that are specific to individual funds. Consequently, the health insurance funds receive from the health fund those sums of money which emerge from the application of their fund-specific additional contribution rate to the average basic wage among statutory health insurance members. The income equalisation thus leads to complete equalisation with regard to the different income structures of the health insurance funds. This ensures that no incentives exist to engage in risk selection by income when it comes to the transition from non-means-tested to earnings-related additional contributions.

Notification obligations incumbent on the health insurance funds

Members' special termination right in the event of

Fig. 2
Earnings-related additional contribution replaces flat rate
Contribution rate in percent



* Bonus repayment no longer possible by law
** version 1 January 2015
Illustration: National Association of Statutory Health Insurance Funds

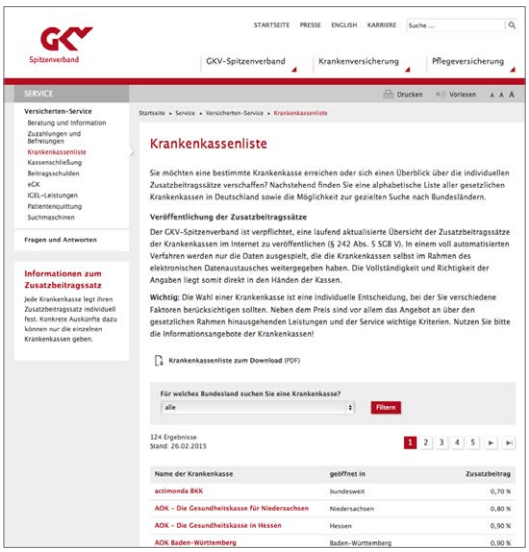
the collection of a first additional contribution or of an increase was not changed by the reform. The termination of membership can still be declared until the end of the month for which the increased additional contribution is charged for the first time. The legislature is also retaining the statutory notification obligation of the health insurance fund vis-à-vis its members. In the case of the first collection or of an increase in the additional contribution rate, the health insurance fund must inform its members of the possibility of special termination. There are no objections to this statutory stipulation. We are however critical about the new two-tier structure of this obligation to notify. In the first phase, all health insurance funds must not only point out the existence of the special termination right, but at the same time must indicate the amount of the average additional contribution rate. According to the reasoning of the Act, this stipulation is intended to ensure that members can form a better picture of the price and service range of the health insurance funds. This aim is however not achieved with the intended regulation because the average additional contribution rate to be stated here is a prospective-arithmetical value calculated by the appraisers, and not the average of the additional contribution rates actually charged by the health insurance funds. The average to be stated hence does not provide a suitable reference value for market transparency.

In the second phase, those health insurance funds which charge an above-average additional contribution rate must additionally notify their members of the possibility to change into a cheaper health insurance fund. In the view of the National Association of Statutory Health Insurance Funds, this tightening up of the obligation to notify contributes towards one-sidedly orientating competition for members between the health insurance funds towards price competition, and hence counters the competition for high-quality care which the legislature itself would like to see. A health insurance fund is not only "cheaper" because its additional contribution rate is lower than the rates of its competitors. Aspects related to performance, service and quality also constitute decisive assessment criteria.

The tightening up of the obligation to notify tends towards one-sidedly orientating competition for members between the health insurance funds to price competition.

Overview of contributions of the National Association of Statutory Health Insurance Funds

Within the obligations to notify that are incumbent on the health insurance funds, the National Association of Statutory Health Insurance Funds must provide a continuously updated overview of the additional contribution rates of the health insurance funds on the Internet. The health insurance funds must notify their members of this overview within their obligations to notify. The National Association of Statutory Health Insurance Funds uses a list of health insurance funds that is posted on its website (www.gkv-zusatzbeitraege.de) in order to publish the overview. The datastock that is kept by the Information Technology Service Point of Statutory Health Insurance (ITSG) was expanded as per 1 January 2015 to include additional contribution rates per fund because of the collecting agencies procedure and of the income equalisation. Recourse to this stock of data enables the National Association of Statutory Health Insurance Funds to update the additional contribution rates of the health insurance funds on the Internet on a daily basis.



www.gkv-zusatzbeitraege.de

The new Quality Institute

With the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance (GKV-FQWG), the legislature has mandated the Federal Joint Committee to establish a professionally-independent scientific Institute for Quality Assurance and Transparency in the Healthcare System (IQTIG). This new Institute is to draw up and implement for the Federal Joint Committee a long-term scientifically and methodically-sound basis for decision-making for quality assurance activities.

Informing patients in a transparent manner

The new Institute is furthermore to improve the transparency of the information on the quality of care. To do so, it is to publish amongst other things comparisons of the quality of service-provision in the individual hospitals so that, prior to selecting a hospital, patients can obtain information on the quality of treatment that they can expect to receive there. Such comparisons would also be expedient and necessary in the sectors of out-patient medical and dental care provided by registered contract doctors. Quality data are collected and analysed here, but so far there has not been any obligation to publish them. This does not facilitate a comparison across the sectors particularly with surgical interventions which are carried out on both an out-patient and an in-patient basis. In order to enable patients to make a real selection, there is also a need to create transparency in the out-patient sector.

In order to give patients a real choice, transparency must also be created in the out-patient sector.

Foundation and Institute for Quality Assurance and Transparency in the Healthcare System

The establishment of the new Institute for Quality required the formation of a private-law foundation which will be the funding institution behind the Institute in future. The resolution on the establishment and statutes of this Foundation was adopted by the Federal Joint Committee on 21 August 2014. The seat of the Foundation, as well as of the Institute, is Berlin. The funding bodies of the Federal Joint Committee (the German Hospital Federation, the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Dentists, as well as the National Association of Statutory Health Insurance Funds) are represented on the Foundation Board. A representative of the Federal Ministry of Health, and the Chairperson of the Federal Joint Committee, are voting members of the Executive Board, as are the funding bodies. The constituting meetings of the Foundation Board and of the Executive Board took place on 9 January 2015. The new Institute will be assuming the tasks provided for by law at first gradually from 2015 onwards, and then completely in 2016.

Fig. 3
The Institute for Quality (IQTIG)

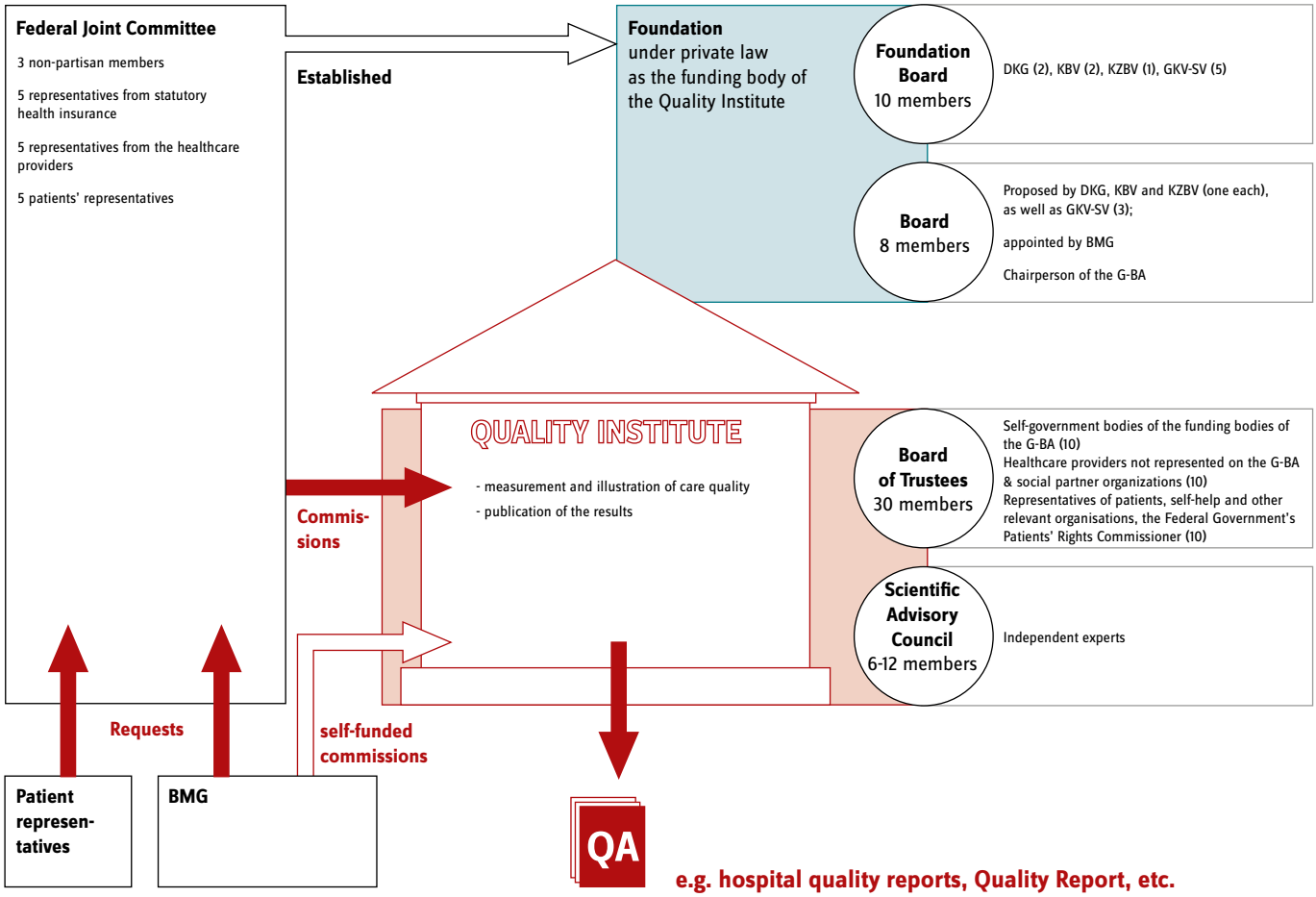


Illustration: National Association of Statutory Health Insurance Funds

Legend to abbreviations:

BMG	Federal Ministry of Health (Bundesministerium für Gesundheit)
DKG	German Hospital Federation (Deutsche Krankenhausgesellschaft)
G-BA	Federal Joint Committee (Gemeinsamer Bundesausschuss)
GKV	Statutory health insurance (Gesetzliche Krankenversicherung)
GKV-SV	National Association of Statutory Health Insurance Funds (GKV-Spitzenverband)
KBV	National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung)
KZBV	National Association of Statutory Health Insurance Dentists (Kassenzahnärztliche Bundesvereinigung)

Avicenna, actually **Abu Ali Ibn Sina**, left his mark on modern medicine and pharmacology with his “Canon”, which was published around 1025. He described the diagnosis and treatment of cancer, infectious diseases and parasites. Avicenna defined binding rules as to how a new drug was to be tested for its effects and side-effects before it may be administered to patients. All in all, he listed 760 medicinal products stating their applications and effects.

The electronic healthcard (eHealth Card) and telematics

The electronic healthcard has been issued by the health insurance funds since October 2011, and is to help improve quality and economic efficiency in the healthcare system in conjunction with the telematics infrastructure. Almost all members of statutory insurance have now been provided with an eHealth Card. In line with the agreement that was reached between the National Association of Statutory Health Insurance Physicians, the National Association of Statutory Health Insurance Dentists and the National Association of Statutory Health Insurance Funds, the health insurance card ceased to be valid as of January 2015. The complete substitution of the health insurance card by the eHealth Cards is a major step towards networking the German healthcare system. The procedure of testing the first online applications has also been pushed forward. The potential of the eHealth Card has so far nonetheless remained largely untapped.

The potential of the eHealth Card currently remains largely untapped.

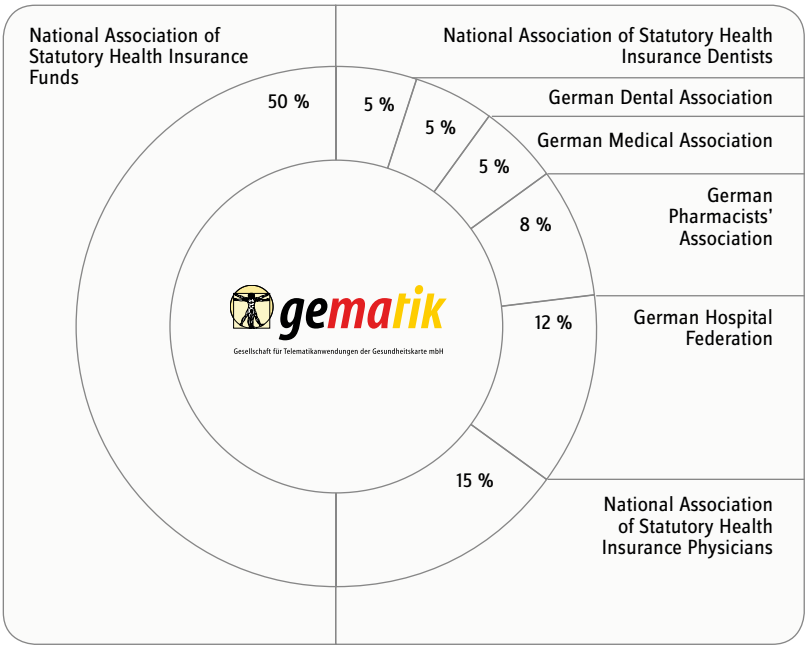
Statements of the Administrative Council of the National Association of Statutory Health Insurance Funds

The Administrative Council took advantage of the visit by the new Minister of Health Gröhe in March 2014 to point out once more that, amongst other things, the organisational structures and majorities within the Gesellschaft für Telematikanwendungen der Gesundheitskarte (gematik) made it much more difficult to reach a consensus and were having an adverse impact on the progress of the project. In a public statement, the Administrative Council called on the legislature to put and end to the contribution-funded standstill and pointed to the considerable costs of more than 800 million Euro which had been incurred so far. The representatives of the insured persons and employers called on the legislature to create a framework in which the advantages of the jointly-developed telematics infrastructure could be put to immediate use. For this, binding deadlines, underpinned by sanctions, were demanded for healthcare providers regarding the obligation to review and update the eHealth Card.

At their December meeting, the representatives of the insured persons and employers however also reached the conclusion for 2014 that all the initiatives, discussions and appeals had not led to a solution. Also against the background of the costs for the establishment of the telematics infrastructure, which had by then increased to approx. 1 billion Euro, the Administrative Council considered that it had no choice but to freeze the funds of approx 57 million Euro for gematik's budget for 2015 since it was no longer willing to take responsibility for contributions being used in this way.

Shortly before a special session of the Administrative Council on the further procedure was held in January 2015, the budget freeze, which attracted considerable media attention, also had an impact in the political arena. With the previously-disclosed draft Bill on Secure Digital Communication and

Fig. 4
The shareholders of Gematik



Voting rights and majorities stipulated in the law apply to the Gesellschaft für Telematik. The share of the vote held by the individual shareholders is in line with their respective share in the company, this being 50 % for the National Association of Statutory Health Insurance Funds. The law requires a majority of 67 % for decisions.

Gematik is 100 % funded by the National Association of Statutory Health Insurance Funds.

Illustration: National Association of Statutory Health Insurance Funds

Fig. 5
Online rollout

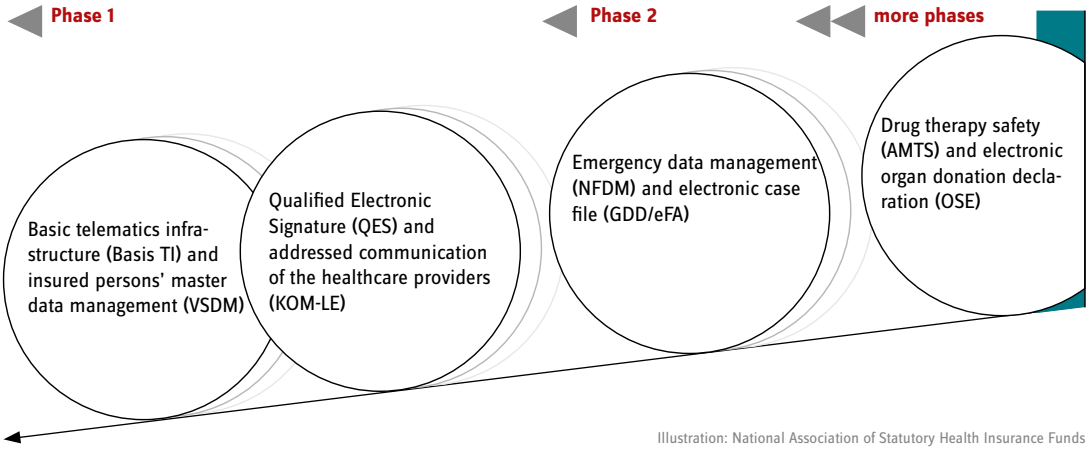


Illustration: National Association of Statutory Health Insurance Funds

Applications in the Healthcare System – eHealth Act (Gesetz für sichere digitale Kommunikation und Anwendungen im Gesundheitswesen – eHealth-Gesetz), the political arena is facing up to the problems exposed by the Administrative Council, and is taking up a number of central demands of the National Association of Statutory Health Insurance Funds in the draft. The budget freeze was thereupon lifted.

The Administrative Council adopted a declaration in which it welcomed the initiative taken by those with political responsibility to at last advance faster as a positive signal, for instance by setting deadlines and sanctioning mechanisms for healthcare providers in establishing the telematics infrastructure and the eHealth Card. The Administrative Council continues to consider that there is considerable need for regulation in the existing networks which compete with the telematics infrastructure, are funded at least indirectly by contributions that are paid by the insured persons and employers, and do not satisfy the same exacting security requirements. Furthermore, the Administrative Council addressed the demand to the legislature to create the necessary decision-making structures within gematik so that the National Association of Statutory Health Insurance Funds, as the sole funder, is also given adequate decision-making powers.

The proposed "telematic bonuses" of 0.55 Euro per medical report and 1 Euro per discharge report are arbitrary and furthermore constitute unjustified cash incentives.

The draft eHealth Bill

The draft Bill takes up many positions of the National Association of Statutory Health Insurance Funds, and is able to advance the major eHealth Card IT project. For instance, the long-called-for sanctioning of healthcare providers who do not use the insured persons' master data management (VSDM) is welcome, as is the clarification that, as soon as it is available, the telematics infrastructure should be the only "data motorway" being used. Also the acceleration by means of setting a specific deadline, such as with VSDM or in emergency data management, is to be assessed positively.

By contrast, the proposed sanctioning mechanism is not acceptable. For instance, if the deadlines provided for in the Act are not adhered to, the budgets of the National Association of Statutory Health Insurance Physicians and of the National Association of Statutory Health Insurance Funds are to be frozen at the level of 2014 minus 1 percent. This leads to the exclusion of some shareholders in gematik or stakeholders from industry. At the same time, this arrangement imposes arbitrary sanctions and would affect the National Association of Statutory Health Insurance Funds even were it to be others who were not cooperating.

The proposed "telematic bonuses" of 0.55 Euro per medical report and 1 Euro per discharge report are arbitrary and furthermore constitute unjustified cash incentives. The proposed arrangement – that the contributors should pay this initial funding, but the National Association of Statutory Health Insurance Funds is only to be informed of the content and technical structure of these projects – is also unacceptable.

The National Association of Statutory Health Insurance Funds will continue to energetically advance the major IT project constituted by the eHealth Card and the telematics infrastructure – and not only because of the statutory obligation, but also based on the conviction that patients and insured persons in Germany can no longer do without a telematics infrastructure.

Trotta von Salerno was one of the first important female European physicians at the beginning of the 12th Century. As with many early female physicians, she concentrated on reproductive medicine. Her book De curis mulierum ("On Treatments for Women") was the standard work of obstetrics at European faculties for four centuries, and amongst other things already shows a profound understanding of birth control based on cycle observation.

The first stage of the long-term care reform

With the First Act to Strengthen Long-term Care and to Amend Further Regulations (First Act to Strengthen Long-term Care [Erstes Pflegestärkungsgesetz – PSG I]), the legislature introduced a refinement of long-term care insurance. Making long-term care benefits more flexible and expanding their scope with a view to the upcoming introduction of the new definition of need of long-term care enhances domestic long-term care and helps to further reduce strains on family caregivers. This meets the demands of the National Association of Statutory Health Insurance Funds.

Improved benefits

The First Act to Strengthen Long-term Care provides for a large number of improved benefits:

- Benefits in day- and night-time care, as well as long-term care benefits in kind and cash, are equal in ranking without being offset against one another.
- Making short-term relief and respite care more flexible improves adequate utilisation of benefits.
- Out-patient benefits for persons with disabilities severely affecting their ability to cope with everyday life (e.g. people with dementia or mental illness) without a care category are being expanded.

This also relates to the accommodation group bonus and start-up funding of out-patient sheltered accommodation groups. The support of out-patient sheltered flat-sharing communities that was introduced with the Act to Reorientate Long-term Care (Pflege-Neuausrichtungs-Gesetz) posed considerable practical problems to the long-term care insurance funds when it came to identifying the benefit requirements. The legislature reacted to this by simplifying the verification of eligibility, particularly by setting the size of the accommodation group and detailing data protection provisions.

Additional relief benefits enable insured persons to pay not only for approved caregiving services, but also for domestic assistance and other services or daytime companions.

New options

By introducing additional relief benefits both for cognitively- and for somatically-impaired persons in need of long-term care, whilst at the same time opening up the additional care benefits for all persons in need of long-term care, a recommendation of the expert advisory council is implemented on the concrete formulation of the new definition of need of long-term care. This enables insured persons to pay not only for approved caregiving services, but also for domestic assistance and other services or daytime companions. A part of the care benefits in kind can be used to claim the additional care and respite benefits. This creates new options to shape long-term care. Approval of these services is given by the *Länder*. The demand made by the National Association of Statutory Health Insurance Funds to ensure uniform quality assurance against this background was incorporated into the Act via corresponding amendments of the draft law. Moreover, care in in-patient facilities is also being further expanded. The dynamic increase of all benefit amounts helps relieve the financial burden on people in need of long-term care. This however does not completely compensate for the failure to adjust long-term care benefits to price developments in the past. There will be an ongoing need to compensate for the decline in value by means of regular, suitable dynamic increases.

Keeping contributions stable in the long term

In order to fund these improved benefits, the contribution rate to long-term care insurance rose by 0.3 contribution rate points to 2.35 percent as per 1 January 2015, and for the childless to 2.6 percent. This leads to additional revenue for long-term care insurance of roughly 3.63 billion Euro in 2015. Of the increase in the contribution rate, 0.1 contribution rate points have been expended to establish a long-term care reserve fund. This fund is to cushion potential contribution increases when the baby boomer generation reaches the age at which they require

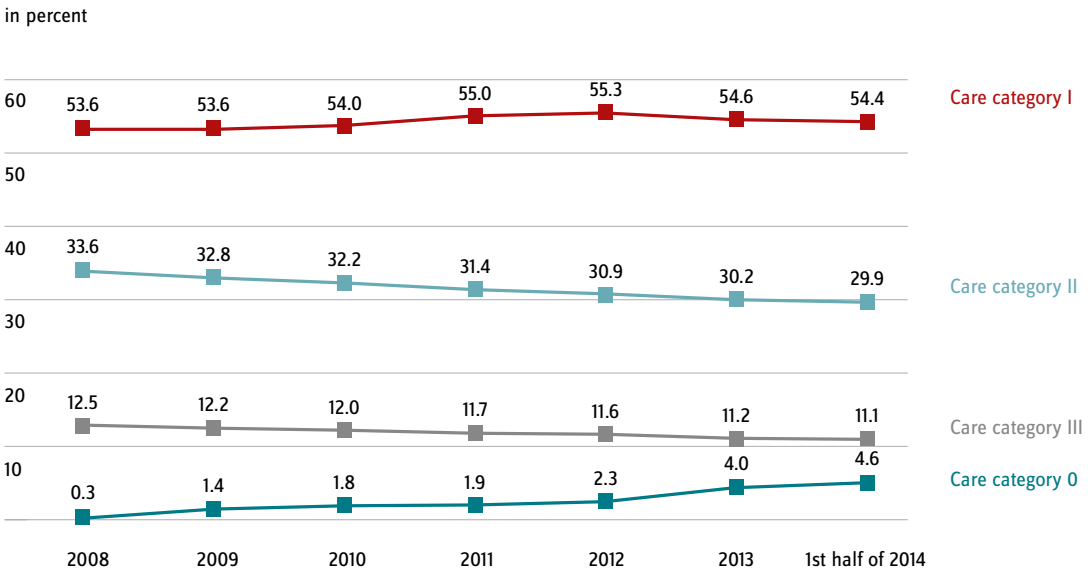
long-term care, that is from 2034 onwards. It is however doubtful whether the desired goal of stabilising the development of the contribution rate in the long term can be achieved with the planned measures alone. This is not the only reason why it must be ensured that the money from the fund is not misused.

Accompanying the implementation of the law

The National Association of Statutory Health Insurance Funds plays a major role in the implementation of the First Act to Strengthen Long-term Care. The National Association of Statutory Health Insurance Funds and the associations of the long-term care insurance funds at federal level described the benefit-law requirements for the new and improved benefits in a "joint circular". The National Association of Statutory Health Insurance Funds furthermore determines the requirements, objectives, duration, content and implementation of the proceedings as well as the promotion of low-threshold respite benefits, together with the Private Long-Term Care Insurance Association. These are implemented through legal ordinances which are enacted in the individual Federal *Länder*. The guidelines on qualification and on the tasks of additional care staff in in-patient facilities need to be adjusted because of the increase in the number of eligible beneficiaries.

In a second phase of the reform, the Federal Government still intends to introduce the new definition of need of long-term care and the new procedure regarding the need of long-term care in this Parliament.

Fig. 6
Developments in the number of beneficiaries in the care categories



Source: Amtliche Statistik PG 2; Illustration: National Association of Statutory Health Insurance Funds

Model projects for testing the new assessment scheme (NBA)

Since April 2014, the National Association of Statutory Health Insurance Funds has been promoting two projects within the model programme for the further development of long-term care insurance in order to obtain the necessary information for the quality-assured, responsible introduction of a new definition of need of long-term care:

1. feasibility study on the introduction of the new assessment scheme (NBA) to determine the need of long-term care in accordance with Book XI of the Social Code (SGB XI),
2. evaluation of the new assessment scheme – recording care expenditure in in-patient facilities.

Proving practicability

The feasibility study follows a recommendation of the advisory council on the concrete formulation of the new definition of need of long-term care. The advisory council proposed to test the new assessment scheme prior to its introduction as to its implementability in assessment practice. The practical handling and the de facto suitability of the new assessment scheme in its current version is to be analysed in the study, as are the comprehensibility and acceptance of the new procedure among insured persons. From the beginning of July to the end of October 2014, the new assessment scheme was applied in assessing adult applicants and children. The sample included more than 2,000 assessments, including 1,720 adults and 300 children. The results of the study will be available in good time for the coming legislative procedures.

Plausibility and transparency of the levels of care to be empirically proven against the background of the care effort.

Calculating the care requirement

The second model project was launched against the background that, in view of the introduction of the new definition of need of long-term care, no empirical data are yet available from which the relative benefit amounts of the new levels of care can be derived. This gap is now to be closed: After an appraisal on the basis of the new assessment scheme and assignment to a level of long-term care in long-term fully-residential care facilities, the care requirement of individual persons is recorded for a week. This is to empirically document the plausibility and transparency of the levels of care against the background of the care requirement. The project furthermore serves as an empirical basis to be able to evaluate the changes achieved after the introduction of the new definition of need of long-term care. It is being implemented with a sample of approx. 1,700 residents in 38 long-term in-patient care facilities in seven Federal *Länder*. The data collection was commenced in July 2014. Here too, the results for the coming legislation will be available in 2015.

Modules of the new assessment scheme (NBA)

The assessments are no longer to focus on restrictions of specific bodily functions, but on impairments of independence or ability in the following areas:

- mobility
- cognitive skills
- behavioural and mental problems
- ability to cater for oneself
- dealing with requirements caused by illness and therapy
- structuring everyday life, as well as social contacts
- activity outside home*
- household management*

*These modules are not included in the arithmetic assessment of the level of care.

Less bureaucracy in long-term care paperwork

Long-term care paperwork forms an important basis to guarantee the quality of long-term care. The paperwork has however become increasingly extensive in recent years – time that was not available to actually provide long-term care. In 2013, the Federal Ministry of Health therefore initiated the project entitled "Practical application of the structural model to increase efficiency in long-term care paperwork in long-term out-patient and in-patient care". The results of the project were presented in April 2014.

The National Association of Statutory Health Insurance Funds has provided intensive assistance to the project and supports the goal of considerably reducing the paperwork in long-term in-patient and out-patient care without making it less informative. Together with the other partners involved in long-term care self-government, which besides the National Association of Statutory Health Insurance Funds consists of the Federal Association of Local Authorities, the Federal Association of Regional Social Assistance Agencies and the associations of the funding bodies of the long-term care facilities at federal level, it was found in July 2014 that the results of the project are compatible with the current legal basis and with the resulting testing requirements of the quality testing guidelines. The blanket introduction of the structural model can hence commence on this basis. The National Association of Statutory Health Insurance Funds will be closely involved in this process.

Refinement of quality testing in long-term in-patient care

External quality testing by the health insurance Medical Services is also to be adjusted to meet the new challenges. External quality tests serve to protect persons in need of long-term care. It is being examined whether the statutory quality requirements are being met and subject to what conditions the results of the quality of long-term care are brought about. Where shortcomings occur with regard to quality, measures to eliminate the shortcomings are imposed on the long-term care facilities by the Land associations of the long-term care insurance funds. At the same time, the test forms the basis for advising the long-term care facilities with the goal of improving quality. What is more, consumer-relevant information is collected which can help persons in need of long-term care and their relatives in selecting a suitable long-term care facility.

The objective is a scientifically-sound, practicable, consumer-friendly system.

In order to be able to continue to carry out these statutory tasks, a new set of testing tools is to be developed at short notice at the same time as developing the result indicators. This is to meet both scientific and methodological quality criteria, as well as systematically linking internal quality management with external quality testing via results indicators. The aim is to implement a scientifically-sound, practicable, consumer-friendly system made up of internal quality management, external quality assurance and quality reporting.

The outlook for long-term out-patient care

The long-term care transparency agreement for the in-patient sector was adjusted in line with the scientific state-of-the-art in 2013. Since June 2014, the National Association of Statutory Health Insurance Funds has been negotiating with the contracting partners on an appropriate adjustment of the long-term care transparency agreement in the out-patient sector. For a reorientation of quality assurance, because of differences in the framework, the path that has been taken in the in-patient sector is not transferable to long-term out-patient care. The out-patient care situation is characterised by a complex structure of formal (long-term care services) and informal players (relatives). The National Association of Statutory Health Insurance Funds advocates a specialist discussion of proposals to refine the quality tests in long-term out-patient care. The development of reorientation concepts must be carried out drawing on scientific expertise.

Expert standards to further develop the quality of long-term care

Expert standards are evidence-based tools to safeguard and refine long-term care quality in

long-term out-patient and in-patient care facilities. In the course of the Act concerning the Further Development of Long-Term Care (Pflege-Weiterentwicklungsgesetz), the legislature has called on the long-term care self-government bodies to ensure the development and updating of scientifically-sound and well-coordinated specialist standards.

The latter had agreed to have a first expert standard developed on the topic of "retention and promotion of mobility". Its development has been tasked to the German Network for Quality Development in Nursing (DNQP), which has had experience with developing and updating expert standards since as long ago as 2000. The expert standard draft, in respect of which an expert consensus has been reached, has been available since mid-2014. It will be implemented on a model basis in line with the agreements within a scientific project from the beginning of 2015 onwards in order to obtain an understanding of the viability and effectiveness of the recommended measures. Once implementation has been completed and resolutions have been passed by the contracting partners, the expert standard will become binding on all approved long-term care facilities and long-term care insurance funds.

Further expert standards on other relevant topics are to follow. The National Association of Statutory Health Insurance Funds would also like to see the specialist updating of existing expert standards of the German Network for Quality Development in Nursing – e.g. on pressure sore prophylaxis, on pain management or on support for continence.

Quality indicators in long-term in-patient care

Against the background of scientific knowledge, an increasing effort is being made in long-term care insurance towards seeking out possibilities as to how the quality of the results – e.g. the degree of independence achieved when it comes to everyday activities or the state of nutrition of the residents – can be taken into consideration more than was previously the case when it comes to measuring and illustrating the quality of long-term care.

On the basis of scientific knowledge in long-term care, the long-term care self-government bodies have agreed on the parameters of an indicator-supported procedure. In a first step, 15 health-related quality indicators are to be tested in long-term in-patient care facilities (e.g. on the consequences of falls and on the incidence of pressure sores) within a model project that is to be put out to tender Europe-wide. Prior to the nationwide roll-out, this is to obtain information on the required conditions in long-term care facilities, as well as on details of the content-related structure of the complex procedure. It is presumed that the project will last for approx. two years. The contracting partners in long-term care will decide on the details of nationwide implementation on the basis of the results of the pilot projects, which will be available in 2017.

Existing and planned expert standards

- pressure sore prophylaxis
- release management
- pain management
- fall prevention
- support for bladder continence
- care of chronic injuries
- nutrition management
- maintenance and promotion of mobility (in the planning stage)

Model project for the continued development of new forms of housing

With the Act to Reorientate Long-term Care, an action plan was adopted for the research-based continued development and promotion of new forms of housing. The goal is to develop, test and evaluate living arrangements for persons in need of long-term care as best practice models. The central criteria for funding and evaluation are user orientation, care quality, economic efficiency, transferability and sustainability.

The multi-tier participation procedure for projects from among practitioners and from Academia was positively received: A total of 232 expressions of interest were submitted. They were evaluated with the involvement of external experts using the quality criteria that apply to the call for tenders; 58 project institutions, including research projects, were requested to make an application. Projects that are already underway which also promise innovative findings are included as evaluation projects without any direct funding. All in all, the applicants represent a wide variety of new accommodation, long-term care and shelter concepts nationwide. The launch has taken place successively from January 2015 onwards. The scientific accompanying research has been implemented since November 2014 through cooperation between Prognos AG and the Kuratorium Deutsche Altershilfe e. V. The results of the overall evaluation will be available at the beginning of 2018.

New living arrangements

- community living
- living with service
- living with security of care
- new models in long-term in-patient care
- neighbourhood concepts

Funding and evaluation criteria in the model programme in accordance with section 45f of Book XI of the Social Code

- user orientation
- quality
- economic efficiency
- transferability
- sustainability

Domestic care services of caregiving services

Domestic care was included in Book XI of the Social Code with the Act to Reorientate Long-term Care. Up until the introduction of the new definition of need of long-term care with which the spectrum of benefits will be newly defined, insured persons in all care categories or with disabilities severely affecting their ability to cope with everyday life are entitled to domestic care as a benefit in kind. The new arrangement facilitates the model approval of care services at the same time. While previously only long-term out-patient care services were authorised to do so, caregiving services may now also provide domestic care and housekeeping care, in particular for demented persons in need of long-term care. In model projects, caregiving services may also provide domestic care and housekeeping care, in particular for demented persons in need of long-term care.

The National Association of Statutory Health Insurance Funds has examined all interested caregiving services for compliance with the requirements on the basis of the documents that have been submitted with a view to the professional suitability of the manager, the qualifications of the staff and the quality of the care concept. 122 services were selected nationwide which can now conclude a time-limited care contract with the respectively competent *Land* associations of the long-term care insurance funds. The accompanying scientific research will be investigating the impact of the deployment of these caregiving services on long-term care with regard to quality, economic efficiency, the nature of the services and their acceptance among users. The overall evaluation will be completed in 2017.

In model projects, caregiving services may also provide domestic care and housekeeping care, in particular for demented persons in need of long-term care.

Many know of her as a Catholic mystic and teacher of the Church, but **Hildegard von Bingen**'s scientific significance lies in bringing together folk medicine and Greek-Latin knowledge of diseases and remedies. In her medical works, she particularly stressed the actual availability and affordability of the medicinal plants that she recommended.

Key issues of the hospital reform

The Coalition Agreement of the CDU/CSU and the SPD from 2013 provides for the establishment of a Federation-*Länder* working party to prepare a hospital reform. Managed by the Federal Ministry of Health (BMG), the working party took up this task in May 2014, and in December 2014 submitted a 24-page key issues paper which is to form the basis for the legislative process in 2015. The *Länder* side in the working party was led by the Hamburg Senator Cornelia Prüfer-Storcks (SPD), who also chaired the Conference of Ministers of Health (GMK) in 2014.

The central issues of the total of five meetings of the working party were orientated towards the stipulations contained in the Coalition Agreement: quality, diagnosis-related groups/operating costs, investment costs, as well as the overall funding package. From the point of view of the National Association of Statutory Health Insurance Funds, the key issues, which were adopted in December, contain forward-looking approaches, but the overall result is somewhat unfavourable.

Funding problems persist

The main shortcoming of the key issues, which have been announced as a major reform, strikes one immediately: The proposal does not come close to resolving the problem of falling investment funding from the *Länder*. When the "dual funding" was launched (the *Länder* pay for the investment, and the health insurance funds pay the operating costs), the share of the total hospital costs accruing to the *Länder* remained above 20 percent, whilst today the *Länder* are funding less than 5 percent. As this is far below the hospitals' investment requirements, the diagnosis-related group flat-rate remuneration per case is now being used for investment funding – counter to the statutory requirement. The increasing assumption of the funding burden by the health insurance funds is however by no means compensated for by additional co-determination rights. Hospital planning, which is a matter for the *Länder* alone, leads to excess capacities, particularly in areas with a high population density.

The Federation-*Länder* working party has at least recognised the need to act with regard to capacity planning, and plans to establish a structural fund in order to advance the coming restructuring process. 500 million Euro are to be withdrawn from the liquidity reserve of the health fund as a one-off amount, projects only being eligible for promotion where the *Länder* co-fund the same amount. The National Association of Statutory Health Insurance Funds came out in favour of such a fund in its "14 positions for 2014". Doubts are however justified as to whether the planned volume, which only comes to several one-thousandths of hospital spending, is likely to transform the German hospital landscape in the long term, as it is rife with excess capacities. The conclusion from the point of view of statutory health insurance is therefore: At least it's a beginning.

A structural fund is to be used to reduce excess capacities.

Greater quality orientation

The quality orientation does deserve praise. Similar to the appeal made by the National Association of Statutory Health Insurance Funds in its position paper entitled "Quality-orientated care management and remuneration – positions of the National Association of Statutory Health Insurance Funds", different quality levels should at last lead to consequences. This applies both to the structural quality and to the quality of the results:

- Quality indicators are also to be made useable for hospital planning.
- The binding nature of the quality guidelines of the Federal Joint Committee is to be clarified.
- Stipulation and application of the minimum quantity rules are to become legally secure.
- Quality supplements and deductions are to be introduced for selected benefits.
- "Quality contracts" are to be facilitated for four plannable benefits and benefit fields in order to particularly promote high-quality care.

Fig. 7
Funding table of Federation-*Länder* key issues

	Estimation by the Federation-*Länder* working party		
Measure	Financial impact (in millions of Euro)		
	2016	**2017**	**2018**
Quality supplements and deductions	0	60	60
Service guarantee incentives	0	100	100
Centre supplements	200	200	200
Additional costs of resolutions of the Federal Joint Committee	100	100	100
Land base case value convergence	80	70	60
Volume consideration: from *Land* to hospital level	0	140	280
Long-term nursing care promotion programme	110	220	330
University out-patient clinics	265	265	265
Other hospital out-patient clinics	40	40	40
Structural fund	100	100	100
Total	**895**	**1,295**	**1,535**

If one takes into account the fact that the additional costs caused by the resolutions of the Federal Joint Committee and the costs of the *Land* base case value convergence affect the basis, the costs for 2017 will increase to 1,445 million Euro and those for 2018 to 1,835 million Euro.

Statutory health insurance welcomes this quality orientation, but warns of expecting these declarations of intent to lead to a complete change in care reality.

Further key issues relate to the service guarantee incentives (future definition by the Federal Joint Committee), acute care (differentiation of the advance payment), the better remuneration of centres (facilities which by defined criteria do better than other hospitals as a result of their medical skills and equipment), as well as the introduction of a transplantation register.

Expenditure development tightened up further

The arrangements on volume and price developments are not satisfactory. Taking volume increases into account in pricing at *Land* level is more or less abolished, and the *Land* base case values are only adjusted upwards. The system as it is outlined will only work for a few years without corrective intervention. Even before the specific laws are implemented, it can already be seen today that additional annual costs amounting to much more than 1 billion Euro caused by the reform will further exacerbate the spending development of statutory health insurance and exert an influence on the contribution rate.

Quality-based care management and remuneration

The Federal Government clearly stressed the topic of quality in healthcare in the Coalition Agreement. Quality assurance was already carried out in the past, but "blank spaces" remain. Above all, however, existing quality stipulations are frequently not implemented consistently. The Federal Government therefore intends to enact a law to implement quality-orientated care management and consistently assure quality. The goal is for patients and insured persons to actually benefit from the improvements in healthcare. In a position paper, the Administrative Council of the National Association of Statutory Health Insurance Funds put forward ten demands in September 2014 for the successful implementation of quality-orientated care management and remuneration.

1. Assure quality consistently
Germany has a whole armoury of regulations on structural and procedural quality, but there is a lack of legal certainty and completeness. For instance, the quality assurance procedures in the in-patient sector only cover roughly one-quarter of cases. Shortcomings also exist when it comes to transparency in the out-patient sector. The National Association of Statutory Health Insurance Funds considers that these gaps in the quality of patient care should be closed.

2. Enforce quality as a performance requirement
Minimum requirements as to structural and process quality must be reliably complied with. This has not always been the case so far, in particular in the in-patient sector. It must be arranged beyond any doubt that the benefit requirements in hospitals are regularly checked by an independent agency. If a hospital fails to meet the quality requirements, it may not provide or invoice the diagnostic and therapeutic services in question. The hospital planning may also not invalidate the minimum quality requirements.

3. Structure minimum quantities with legal certainty
Ensuring treatment experience is one of the main tools for quality assurance. Its operationalisation via minimum quantities is widely used in many areas of out-patient care, and also in in-patient care, but implementation in hospitals is extremely dissatisfactory. If the legislature would like to see to it that treatment experience plays a larger role in care, measures would have to be taken in order to simplify the stipulation of minimum volumes in hospitals and to make implementation legally secure.

4. Define staffing requirements
Staffing deployment plays a fundamental role in quality assurance, along with drug testing, technical requirements and procedural stipulations. It is very largely the responsibility of hospital management. There is a need for additional external stipulations on staff deployment, particularly where not meeting targets is quality critical and patient safety is placed at risk. Staffing allocations for entire hospitals do not achieve the objective, however.

5. Refine indicators
Indicators form the indispensable core of all quality assurance. In external in-patient quality assurance, there are already a large number of quality indicators in selected benefit areas. When it comes to refining them, the quality of the result should be positioned more clearly in the limelight. Indicators however still have to be developed in many therapeutic areas for universal, supra-sectoral quality assurance. Routine data should also be used more consistently, including to avoid the documentation effort.

6. Improve transparency

The topicality and transparency of the quality data must be improved in all sectors. In addition to the institutional quality reports for hospitals, there should also be surgery-related quality reports on physicians in their own practice in future. The quality data of both sectors are to be made available to the public by the new Institute for Quality.

7. Involve all forms of contract

So that care quality can be comprehensively evaluated, in future care benefits must be recorded and made transparent, with the same standards being applied in both the collective as well as in selective contracts. This is a task for the new Institute for Quality, which guarantees neutrality in this competitive environment. The compilation and joint assessment of these care data is a necessary guarantor here for well-functioning quality competition.

8. Facilitate quality contracts

One cannot expect consistent, quality-orientated hospital care to arise solely from *Land* planning intervention. Such initiatives would always have been possible, but never took place. Alternatively, a quality-orientated tendering process may be carried out for selected benefits. The path that has now been taken, namely of opening up the in-patient sector for selective forms of contract, must be consistently followed and quality assurance should be carried out collectively for these forms of contract.

9. Launch quality-orientated remuneration now

Good quality must be made worthwhile in future. A requirement for this is remuneration which sets quality incentives. So that high quality becomes the norm, remuneration by quality of results and fulfilment of minimum structural requirements must go hand in hand. There is a need for valid indicators which are resilient to manipulation.

10. Overcome sectoral boundaries

The introduction of suprasectoral quality assurance procedures has not yet been achieved in practice. The legislature must therefore make subsequent adjustments. The new Institute for Quality should refine the sector-specific procedures for quality assurance on a suprasectoral basis: Quality assurance at *Land* level should be transferred to suprasectoral working parties. Individual, sectoral interests of the German Hospital Federation, as well as of the National Association of Statutory Health Insurance Physicians, may not stand in the way of implementation here.

Studies on hospital care

Reports on volume development in the in-patient sector

The award of a joint research project contract on volume development in the in-patient sector by the National Association of Statutory Health Insurance Funds, the German Hospital Federation and the Association of Private Health Insurance was included in the Psychiatry Remuneration Act (Psychiatrie-Entgeltgesetz – 2012). Health economists Prof. Dr. Jonas Schreyögg (University of Hamburg) and Prof. Dr. Reinhard Busse (Technical University of Berlin) analysed changes in the supply of and demand for hospital services in an empirical study. They furthermore worked out proposed solutions in volume development and in quality-orientated remuneration and care management. Their full report appeared on 10 July 2014. It provides a well-founded analysis of the performance and volume development, as well as of the existing influencing factors, for 2007 to 2012.

The volume development and the level of service provision in the hospital sector are very largely not demographically explicable.

The study confirmed the results of the known accompanying research on diagnosis-related groups. The number of cases dealt with on an entirely in-patient basis in German hospitals rose from 17.2 million to 18.6 million (+ 8.4 percent) between 2007 and 2012. In addition to the constant increase in the number of cases, the level of case numbers in an international context is also remarkable: Germany leads the field in the OECD comparison when it comes to absolute case numbers per 100 inhabitants. It was furthermore confirmed that the volume development and the level of service provision in the hospital sector were largely not demographically explicable.

On the supply side, the report underlines the causal link "The price drives the volume". The study stresses that hospitals adjust their case numbers as a response to the changes in the contribution margins, and hence in the price. The report furthermore makes a number of proposals for reforms on which however no joint opinion has been reached by the German Hospital Federation and the statutory health insurance.

Report on hospitals exiting the market

The report entitled "Description and typology of hospitals' exits from the market in Germany from 2003 to 2013" by Dr. Uwe K. Preusker, Dr. Markus Müschenich and Sven Preusker, which had been commissioned by the National Association of Statutory Health Insurance Funds, was published in August 2014. It makes a major contribution towards rendering the discussion on the coming structural reform of the hospital landscape more objective.

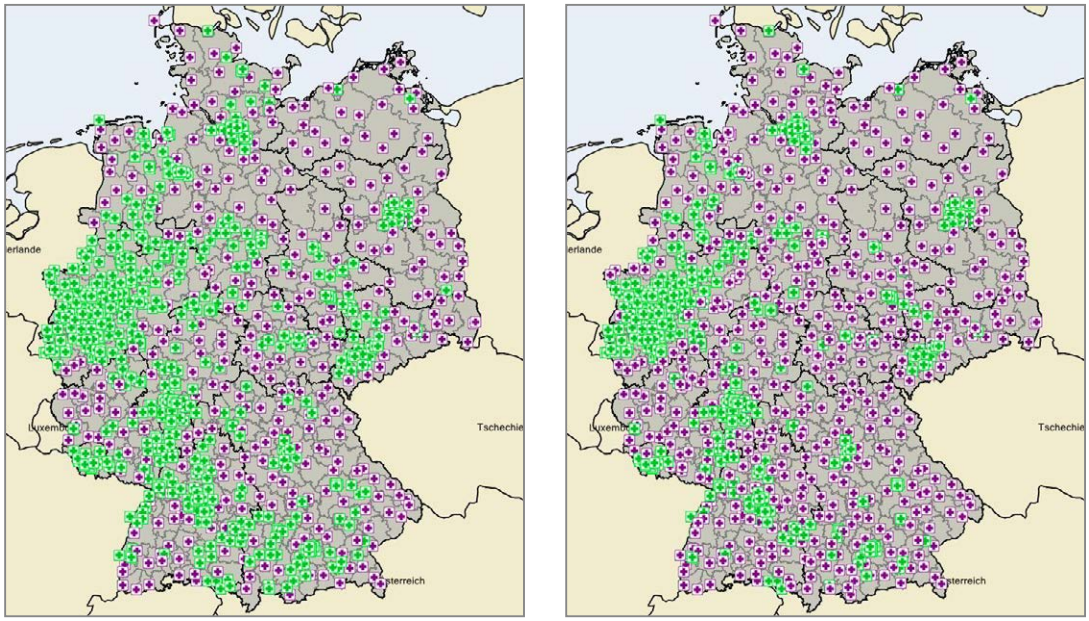
The report concludes that there is no trend towards increased hospital closures. According to Preusker et al., far fewer hospitals left the market than had previously been presumed. For instance, the official hospital statistics of the Federal Statistical Office for the period from 2003 to 2012 record a drop totalling 204, to 2,017 hospitals (as per 31 December 2012). According to the study, however, only 74 of the hospitals that are no longer recorded in the statistics – a good 36 percent – are due to complete market exits. What is more, the major players and factors of market exits and failed market exits were analysed. It was revealed that the decisive players in the closures are the hospitals' funding bodies and the hospital management. The *Land* planning authorities, as well as the cost funders, play a more subordinate role. The high closure costs are a major obstacle to market exits. Against this background, the authors propose to provide more assistance for hospital funding bodies to exit the market.

Hospital care provision simulator

It is obvious that the hospital planning of the *Länder* no longer fulfils its steering function. Excess capacities in the hospital sector are obvious, particularly in areas with a high population density, and there is an urgent need to reduce them. At the same time, it is necessary to continue to guarantee access by insured persons to in-patient care in rural regions. However, the instruments

and studies have been missing to date in order to transparently portray the effects of a market exit as to the availability and provision of capacities. Against this background, the National Association of Statutory Health Insurance Funds commissioned the development of a "Hospital care provision simulator" at the end of 2013. It can be used to estimate the impact of hospitals' exit from the market, or of the closure of individual departments, on regional hospital supply. A prototype was developed over 2014 which is able to simulate the consequences of closures, as well as of minimum volume stipulations (cf. figure). On this basis, the National Association of Statutory Health Insurance Funds can contribute a wealth of knowledge to the regulatory policy discussions on the future design of hospital structures. A refined structure is currently being worked on for use by the health insurance funds, as is a freely-accessible public web variant.

Fig. 8
Hospital simulator



Travelling distance up to 30 km **Travelling distance up to 25 km**

The structural reform in the hospital sector is to be supported by a structural fund providing money for the exit of hospital locations from the market. The implications of a possible market exit are to be taken into account when awarding money from the structural fund. To put it simply: The exit of hospital locations from the market may only be supported with money from the structural fund if the market exit in question does not lead to unacceptable travelling times and distances. Using the simulator, it is possible to calculate down to the level of blocks of houses what travelling times and distances are caused by changes in the hospital structure. The figures show [in green] locations which – each for itself – might leave the market without travelling distances of more than 30 or 25 kilometres, respectively, being caused. This does not mean that all green-marked locations can leave the market without breaching the threshold: Each market exit creates a new situation. Such simulations must therefore be implemented once again recursively after each market exit. This creates transparency regarding hospitals which are needed or which may receive money from a structural fund in order to leave the market.

Source and illustration: National Association of Statutory Health Insurance Funds

Refining the benefit-related remuneration for psychiatry

The remuneration of psychiatric hospitals is to be reorganised in the years to come towards benefit-orientated fees. This is to create greater transparency with regard to the benefits that are provided and to greater fairness between the facilities with regard to remuneration. It has been possible for the new remuneration system of hospitals and health insurance funds to be applied since the beginning of 2013, when the "option phase" began. The first introduction phase is budget-neutral for hospitals. Although the new fees are already used when settling with the individual health insurance funds, it is ensured at the same time that the individual hospitals receive total funds equalling their previous budgets.

Refining the remuneration system

The National Association of Statutory Health Insurance Funds, the private health insurers and the German Hospital Federation agreed in the spring of 2014 on key issues for refining the new flat-rate remuneration system for psychiatric and psychosomatic facilities (PEPP). In September 2014, it was possible for the Institute for the Remuneration System in Hospitals to present the index that had been further developed on this basis. The calculation is based on cost data relating to more than 200,000 treatment cases in 85 facilities. The new list has incorporated major criticisms and taken account of them in the development of the system. What is new is the inclusion of the release day in the calculation and settlement of the fees. The amount of the remuneration for each treatment day of a benefit-related group may vary, depending on the treatment duration. Supplementary per diems were additionally introduced as new remuneration elements to allow for the changing treatment effort in the course of a hospital stay. The German Hospital Federation and the National Association of Statutory Health Insurance Funds were able to agree at the end of October 2014 in negotiations on the PEPP agreement for 2015.

Fig. 9
Introduction phases
according to the old law (Psychiatry Remuneration Act, 2012) and the new law (Act on the Further Development of Financial Structures and Quality in Statutory Health Insurance, 2014)

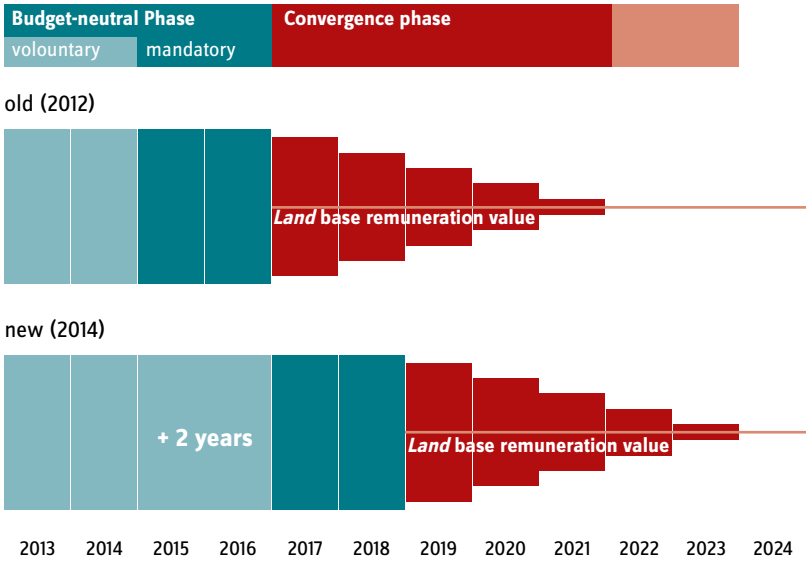


Illustration: National Association of Statutory Health Insurance Funds

The introduction process has hit a rock

Regardless of this further development, the legislature opted to delay the reform by two years as a reaction to the ongoing criticism in June 2014 with the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance: The option phase is being extended by two years. The National Association of Statutory Health Insurance Funds has always been against such a delay as this further extends the already long introduction phase until 2024. A rapid reform process would make sense, away from funding cost-orientated budgets and towards transparent, benefit-orientated remuneration. The most considerable need to act lies at present in increasing transparency with regard to the benefits provided by structuring the classification systems in a manner that is medically more substantive, so that the PEPP system and care quality can be improved. The National Association of Statutory Health Insurance Funds has always been committed to refining the PEPP system and its mandatory application, and has repeatedly warned that delays will impair care quality.

New auditing rules for hospital bills

The billing audits of the statutory health insurance funds in hospitals have been a bone of contention for years. Whilst the audit rate of the Health Insurance Medical Service (MDK) remained virtually constant, the number of invoices which proved to be erroneous has risen constantly.

The dispute on the Health Insurance Medical Service's audits which has been going on for years between the German Hospital Federation and the National Association of Statutory Health Insurance Funds was taken by the legislature in 2013 as a reason to implement new statutory provisions. The self-government partners at federal level were given the following mandate:

- to establish a Federal Mediation Committee to clarify fundamental settlement and coding issues,
- to agree on a procedure for individual audits, and
- to test on a model basis a new audit procedure based on the data in accordance with the Hospital Remuneration Act (Krankenhausentgeltgesetz).

In accordance with the statutory deadline, first of all the establishment of the Federal Mediation Committee was initiated. It was possible to reach agreement via negotiation, so that a conflict resolution mechanism for fundamental invoicing and coding questions was established with effect as per 1 January 2014.

Avoiding disputes on invoicing

The negotiations on the uniform national procedural rules for the audit procedure were not concluded until they reached the Federal Arbitration Board. The National Association of Statutory Health Insurance Funds was able to agree on a preliminary procedure for the future auditing of bills. This firstly enables the hospitals to correct the data, and secondly it affords the opportunity to settle invoice disputes prior to consulting the MDK through optional case dialogues between health insurance funds and hospitals. The implementation of the preliminary procedure requires more communication between health insurance funds and hospitals, but it will help prevent MDK audits and reduce the effort necessary for this on both sides. The German Hospital Federation and the National Association of Statutory Health Insurance Funds are currently working on a computer support system for the newly-implemented process steps.

Invoice disputes which it is not possible to resolve in the preliminary procedure will continue to be audited by the MDK's experts. In this phase, the hospitals only have a one-off opportunity to make corrections. The previous practice of some hospitals to re-code as many times as they wished is hence limited and the quality of invoicing hopefully improved for the future. The agreed audit procedure guarantees that the health insurance fund always remains in charge of the procedure: It may also continue to commission the MDK directly, that is without instigating the preliminary procedure.

Whilst the audit rate of the Health Insurance Medical Service (MDK) remained virtually constant, the number of invoices which proved to be erroneous has risen constantly.

The implementation of out-patient specialist medical care

The new care sector that has been introduced with the Statutory Health Insurance Care Structure Act (GKV-Versorgungsstrukturgesetz) is continuing to take shape. With out-patient specialist medical care, a sector was created in 2012 in which registered doctors and hospitals can perform services for defined areas under the same conditions. The considerable degree of complexity and the considerable need of bureaucracy which this sector necessitates were shown right at the beginning.

The guideline on out-patient specialist medical care was already adopted on the Federal Joint Committee in March 2013. In December 2013, the first disease-specific formalisation was added in the shape of tuberculosis, and this has been in force since April 2014. The formalisation regarding gastrointestinal tumours and tumours of the abdominal cavity has been valid since July 2014. For the first time, the Federal Joint Committee finally established in the formalisations both the staffing and material requirements for the healthcare providers, as well as fee code items for the respective treatment items. In January 2015, it adopted resolutions on gynaecological tumours and on Marfan syndrome. This regulated the second major sector of specialised oncology.

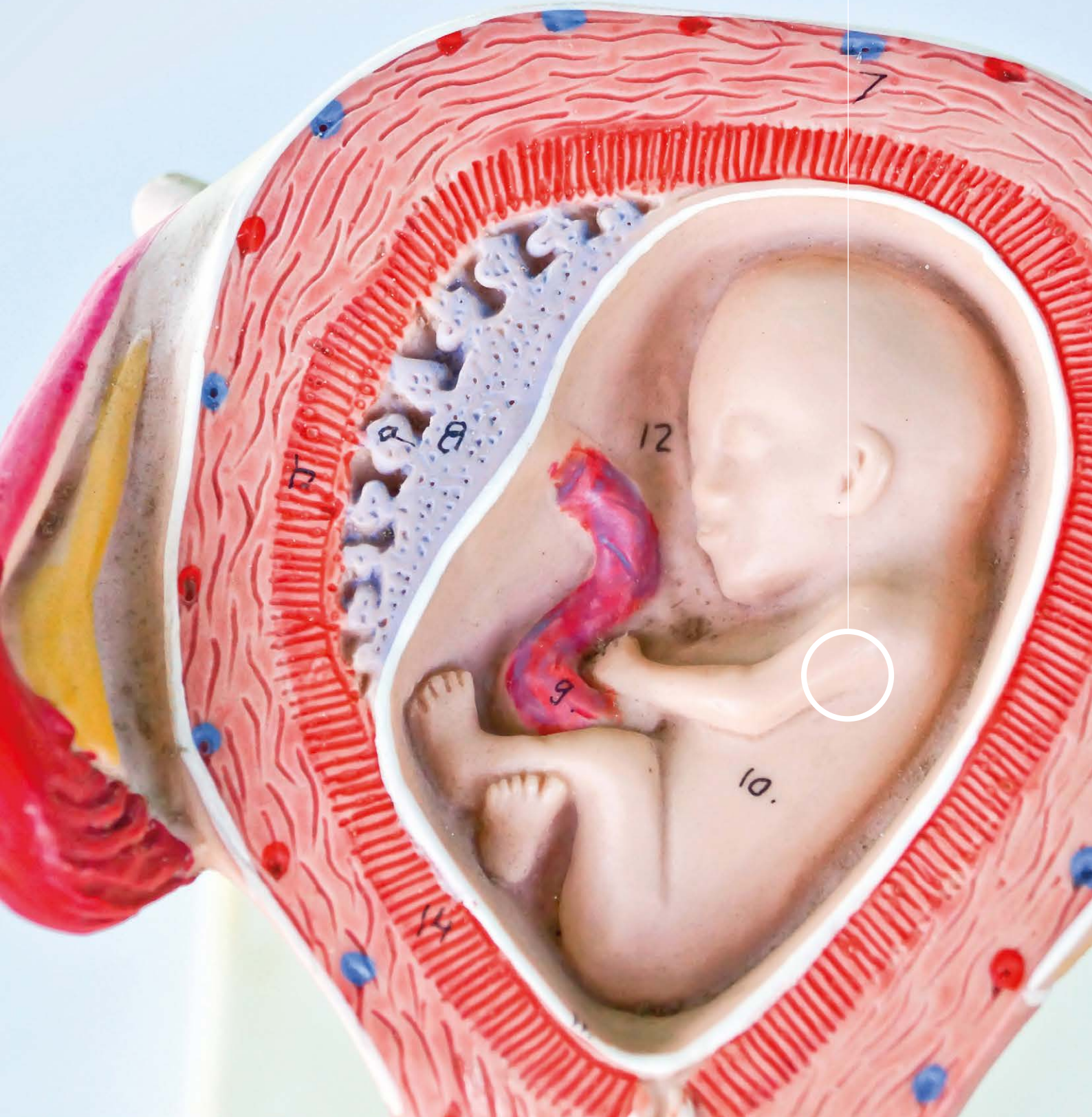
Out-patient specialist medical care service unit established

In tripartite negotiations with the German Hospital Federation and the National Association of Statutory Health Insurance Physicians, the National Association of Statutory Health Insurance Funds in March 2014 concluded an out-patient specialist medical care billing agreement on the form and content of the settlement procedure, as well as the forms. It was also decided in this context that an out-patient specialist medical care service unit would be set up. This unit will be responsible for issuing a unique out-patient specialist medical care team number that is needed for the settlement. The National Association of Statutory Health Insurance Funds has taken on this task in the transitional procedure. In future, the out-patient specialist medical care service is to be made transparent to the insured persons via the Internet.

The supplemented assessment committee, on which the German Hospital Federation, the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds are represented, established in June 2014 how services which are not yet shown in the Standard Schedule of Fees are to be paid for. The long-term aim remains to develop a separate remuneration system for the services in out-patient specialist medical care.

A sector was created in 2012 in the shape of out-patient specialist medical care in which registered contract doctors and hospitals can provide services for defined areas under the same conditions.

Mid-wife **Louise Bourgeois Boursier** helped deliver more than 2,000 children, including Louis XIII and Elisabeth of Spain. The documentation which she wrote in 1609, entitled "Diverse Observations on Sterility (...), Diseases of Women and of Newborn Infants" became a standard reference at medical schools.



Further developments in out-patient care

In order to ensure need-based, high-quality out-patient care, the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians also successfully negotiated in 2014 on the inclusion of new benefits in the Standard Schedule of Fees (Einheitlicher Bewertungsmaßstab – EBM). Furthermore, binding quality stipulations were agreed on.

Re-structuring the Standard Schedule of Fees

In order to improve care by general practitioners, the assessment committee adopted the reform of the general practitioner care sector in the Standard Schedule of Fees. The National Association of Statutory Health Insurance Funds submitted a plan for this which envisions ensuring a broad spectrum of services to be provided by general practitioners for insured persons, as well as the refinement of the Standard Schedule of Fees calculation system. The measures that are called for aim to bring about high-quality as well as both need-based and cost-efficient care.

Promoting a broad spectrum of GP services

There are certain basic GP services in the field of general practitioner care which are presently not provided universally. The National Association of Statutory Health Insurance Funds is therefore striving to ensure in the negotiations with the National Association of Statutory Health Insurance Physicians that these services must be mandatorily provided by GPs in future. By promoting this care sector, the National Association of Statutory Health Insurance Funds is helping to ensure universal care provision by GPs.

Particularly surgeries are to be promoted here which cost-effectively offer a broad range of services for insured persons based on the recognised state of the art in medical research and technology.

Refining the Standard Schedule of Fees calculation system

The current Standard Schedule of Fees calculation system is prone to creating economic disincentives for care. Currently, both variable costs (service-related costs such as costs for materials) and fixed costs (non-service-related costs such as rent for surgery premises) of the medical surgeries are paid for on a pro rata basis with every Standard Schedule of Fees service that is invoiced. Surgeries which provide a large volume of services thus have their actual fixed costs overcompensated. This creates an economic incentive to expand in particular highly technology-intensive services, even if they are not medically necessary. For this reason, the National Association of Statutory Health Insurance Funds calls for a restructuring of the Standard Schedule of Fees calculation system. In future, the fixed costs of a medical surgery are only to be paid for up to a maximum value enabling registered contract doctors to cover these costs.

The following additional services have been available to insured persons since 2014 within healthcare provided by registered contract doctors:

- **Osteodensitometry**
  An expansion of the possible indications for the implementation of osteodensitometry (bone density testing) was agreed as per 1 January 2014. By introducing a corresponding new service, it will be possible in future to also perform a bone density test in patients where a specific medication is to be initiated in order to treat osteoporosis.

- **Intravitreal injection treatment**
  In order to treat various indications such as age-related wet macular degeneration, patients have received intravitreal injection treatment since 1 October 2014 as a service provided by contract doctors. What is more, stipulations on quality assurance have been agreed and a new service for the care, follow-up and aftercare of a patient after the performance of intravitreal injection treatment has been introduced.

- **Prenatal care**
  When it comes to prenatal care, sonography with systematic examination of the foetus has been included in the Standard Schedule of Fees as per 1 January 2014. This ultrasound examination may only be carried out by specially-qualified physicians who have proven their qualification. What is more, pregnant women are entitled to a special information consultation with a physician prior to the implementation of the examination.

- **Capsule endoscopy**
  It has been possible since 1 October 2014 to have an examination carried out using capsule endoscopy in patients with a diseased small intestine given specific indications. This is an imaging method which transmits images to an external evaluation device for diagnostic purposes. The National Association of Statutory Health Insurance Funds has agreed on special quality stipulations with the National Association of Statutory Health Insurance Physicians for this service too.

Negotiations on the remuneration of registered contract doctors in 2015

This year's negotiations at federal level on the remuneration of registered contract doctors in 2015 were carried out rapidly, and were completed on 27 August 2014, without arbitration proceedings, between the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds. Consequently, the orientation value is to be increased by 1.4 percent in 2015 and the flat-rate basic remuneration for specialist care set higher. What is more, separate funding of house visit services by qualified non-physician surgery assistants is being introduced in GP care. With additional expenditure of around 132 Euro million in each case, it was therefore possible to achieve a moderate result – also against the background of the billions demanded by the National Association of Statutory Health Insurance Physicians.

The need for treatment to be determined should be orientated in line with demographic developments in future.

Additional burdens with negligible improvements

Whilst the annual increase rates of physicians' remuneration remained below 2 percent in the years before the Act to Improve Competition in Statutory Health Insurance and the Statutory Health Insurance Care Structure Act, increase rates of 3 percent and more have now become the norm. This is caused by the large numbers of demands which physicians can make at federal and *Land* level. The draft Statutory Health Insurance Care Improvement Act also does nothing to help matters here. In fact, contributors are burdened to the tune of up to 500 million Euro per year in the form of additional expenditure caused by alleged "ill-founded differences" between the regional remunerations from 2017 onwards, without this appreciably benefiting patient care. This is particularly not a matter of compensating for potential distortions between the remunerations of the Associations of Statutory Health Insurance Physicians, but of a one-sided increase pure and simple. Back in 2012, the convergence of the remunerations carried out at that time (Statutory Health Insurance Finance Act) caused additional burdens of 500 million Euro affecting the basis.

Longer list of "wants" despite high surgery surpluses

It cannot be anticipated that the Associations of Statutory Health Insurance Physicians will forego further demands for a renewed adjustment. On the contrary, there is fear that new "wants" of those Associations of Statutory Health Insurance Physicians will arise which do not benefit from this arrangement and which are then at the bottom of the remuneration ranking. Policy-makers are subjecting themselves to ever-increasing pressure to act through their repeated financial "acts of charity". This is despite the fact that the surgery surpluses of physicians nationwide have already reached a very high level.

Renewing the physicians' remuneration system

In order to reverse the unfavourable trend towards upward-spiralling expenditure, there is a need to renew the physicians' remuneration system. The goal must be to remove regulations which push up expenditure but have no significance in terms of care policy, and to reduce the remuneration system to a small number of well-founded regulations. This concerns the forward projection of the need for treatment that is to be remunerated, as well as the procedure to adjust the price (value for orientation). In particular, the need for treatment that is to be calculated should be solely orientated towards the demographic change rate in future, and no longer towards the diagnosis-related change rate which has methodological weaknesses that result from physicians' coding conduct. Unjustified additional expenditure, such as through existing double financing, must be avoided. This is the only way that the stability of statutory health insurance that is funded on the basis of solidarity and universal care provided by registered contract doctors can also be guaranteed in the future.

Report on the convergence of remuneration

In the spring of 2014, the National Association of Statutory Health Insurance Funds commissioned the Institute for Health and Social Research to draw up a report. This was to explore the question of whether the base adjustment of total regional remuneration is appropriate to adjust for regional divergences in remuneration. The report's authors consider the existing remuneration system as a matter of principle to be only orientated towards remunerating benefits which are "medically necessary and which are/can be provided by the regional out-patient care system". An approach based on convergence, which intends to orientate regional remuneration towards average nationwide values, by contrast, would take into account neither the actual regional take-up nor different supply structures. It could therefore "also not be anticipated that an adjustment of remuneration without attaching priority to the creation of the suitable structures could bring about an improvement in care". The Federal Social Court has now also concurred with this argument.

Fig. 10
Comparison of developments in the total remuneration of registered contract doctors, of GDP (not adjusted for price) and of the statutory health insurance base rate of pay

Figures 2000 = Index 100; incl. selective contract income; estimate of total remuneration 2014; Destatis and autumn 2014 report of the economic research institutes; geometric mean in % (2000-2007 and 2008-2014)

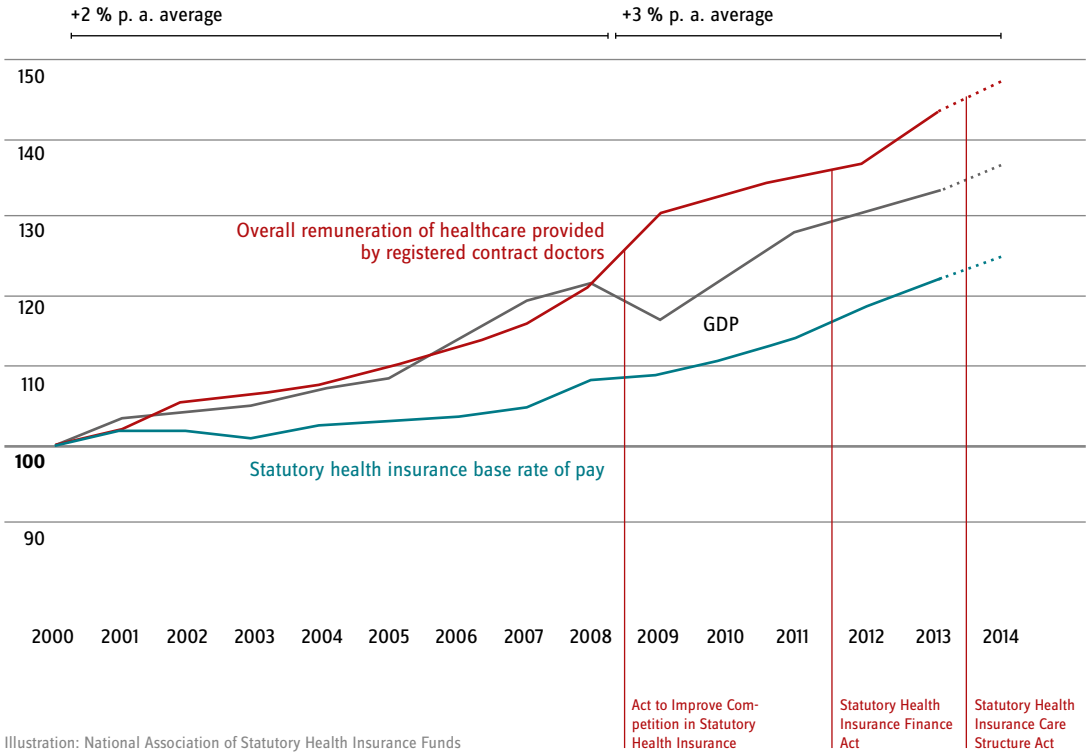


Illustration: National Association of Statutory Health Insurance Funds

Obstetric care: Safe midwifery

The National Association of Statutory Health Insurance Funds has been negotiating with the midwives' associations since 2009 on the content of the contract on provision of midwifery care. It has not yet been possible here to agree on specific service descriptions, quality requirements and their documentation. Given this fact, the National Association of Statutory Health Insurance Funds has repeatedly called on the legislature to prescribe this by law. In the summer of 2014, the legislature obliged the contracting partners to reach an agreement on specific minimum quality requirements with the Act to Reorientate Long-term Care and the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance.

The need for a minimum quantity arrangement

In order to ensure quality assurance in obstetrics, the National Association of Statutory Health Insurance Funds is calling for a determination of how many births midwives working on a self-employed basis are to oversee per year as a minimum. This is the only way to guarantee that self-employed midwives are aware of the spectrum of obstetric care and possible complications during birth and are able to take the right decisions at the right time. It should be avoided that more and more midwives carry out fewer and fewer births because this poses a threat to the quality of care. The introduction of service guarantee incentives for midwives' liability cost increases with only a small number of births per year and the waiver of recourse which the legislature is considering promote this unfortunate situation: It will become worthwhile for more and more midwives to oversee a smaller number of births (one or two per year) in future.

A midwife working on a self-employed basis must oversee a minimum number of births per year in order to assure quality in obstetrics.

Exclusion criteria for home births indispensable

In accordance with the Midwives Act (Hebammengesetz), midwives may oversee "normal" births at insured persons' homes alone. However, there is no definition of this according to evidence-based criteria. This means that the midwife decides prior to the birth whether the woman is "healthy enough" for a home birth. This works differently in midwife-led delivery rooms. Exclusion criteria also apply in birth centres: In this case, the contracting partners have already defined unambiguous stipulations in the contract as to when a birth can be overseen in the birth centre and when births overseen by midwives are precluded there.

The need for standard nationwide further training

Land-specific rules have applied to self-employed midwives for decades via the professional regulations of the respective Federal *Länder*. The National Association of Statutory Health Insurance Funds considers there to be an urgent need to require midwives all over Germany in particular to take the same number of hours of further training on emergency and risk management during the birth (e.g. further training on infant reanimation). The health and safety of newborns and mothers in emergency cases must be safeguarded wherever the delivery takes place.

Fig. 11
Important facts on midwife care and obstetrics 2014

		Tendency in the past 5 years
No. of self-employed midwives	17,869	▲
No. of birth centres	133	►
No. of births*	682,069	▼
Cost of out-patient births in clinics in Euro	from 920	►
Cost of home births in Euro	from 1,188	▲
Cost of births in birth centres in Euro	from 1,670	▲

*No. from 2013; more recent figures were not yet available at the time of going to press.
Source: Official statistics, National Association of Statutory Health Insurance Funds;
Illustration: National Association of Statutory Health Insurance Funds

The prodigious Jesuit scholar **Athanasius Kircher** used the latest available technology and a presumably incorrectly-interpreted observation to make a pioneering breakthrough: He used a microscope as early as 1646 to analyse the blood of plague victims, observing "little worms", and was the first to conclude that the Black Death was caused by microorganisms. This conclusion was correct, as was his hygiene advice, although he was presumably only able to observe blood cells, and not the actual Yersinia pestis bacterium.

New statutory strategic direction for the medicinal products market

It was agreed in the Federal Government's Coalition Agreement for the 18th Parliament to end the evaluation of medicinal products already on the market for medicinal products that have already been introduced but have not yet undergone a benefit evaluation. The originally-anticipated savings volume is to be achieved by continuing the price moratorium and increasing the manufacturer's discount.

With the Thirteenth Act Amending Book Five of the Social Code (13. SGB V-Änderungsgesetz), the legislature first of all ensured that the price moratorium will be continued without interruption for the period from 1 January to 31 March 2014. In the Fourteenth Act Amending Book Five of the Social Code (14. SGB V-Änderungsgesetz), the extension of the price moratorium was then regulated for medicinal products up to 31 December 2017. At the same time, as per 1 April 2014 the manufacturer's discount for finished prescription medicinal products dispensed at the expense of the health insurance funds (with the exception of medicinal products with the same active agent not covered by a patent) was increased from 6 to 7 percent. Increasing the manufacturer's discount by one percentage point reduces the burden on statutory health insurance by much more than 100 Euro million. The savings however do not reach the potential of the benefit evaluation on the established market, which is to be compensated for by increasing the manufacturer's discount.

If one takes as a basis the manufacturer's discount of 16 percent applicable until 31 December 2013, the fact of the manufacturer's discount being nine percentage points lower means for 2014 an additional financial burden on contributors of up to 1 billion Euro.

Elimination of the benefit evaluation on the established market

The Fourteenth Act Amending Book Five of the Social Code did away with the possibility to also carry out a benefit evaluation for medicinal products already on the market, retroactively to 1 January 2014. Considering this cut-off date, it was hence only possible to subject the active agents and combinations thereof from the group of gliptins to a benefit evaluation.

In the view of the National Association of Statutory Health Insurance Funds, this is a setback for patients and contributors. The established market is highly significant in economic and supply terms. It also provides multiplier effects in the AMNOG procedure itself. Within the early benefit evaluation, medicinal products already on the market as a rule constitute the expedient comparative therapy. They are hence vital to the evaluation of any additional benefit, and therefore ultimately also for the calculation of the refund amounts for new medicinal products. What is more, they can also satisfy the criterion of comparable medicinal products within the refund amount negotiations, and hence exert unjustified upward price pressure.

It should hence be at least ensured that the approval of a new therapeutic indication of these medicinal products becomes a criterion for a benefit evaluation in future. On the other hand, for patented medicinal products on the established market for which there is no longer any possibility of a benefit evaluation and of refund amount negotiations being carried out, an increase in the manufacturer's discount, as well as the continuation of the price moratorium for established market medicinal products, which is to expire at the end of 2017, is to be provided.

Participation by the health insurance funds in the refund amount negotiations

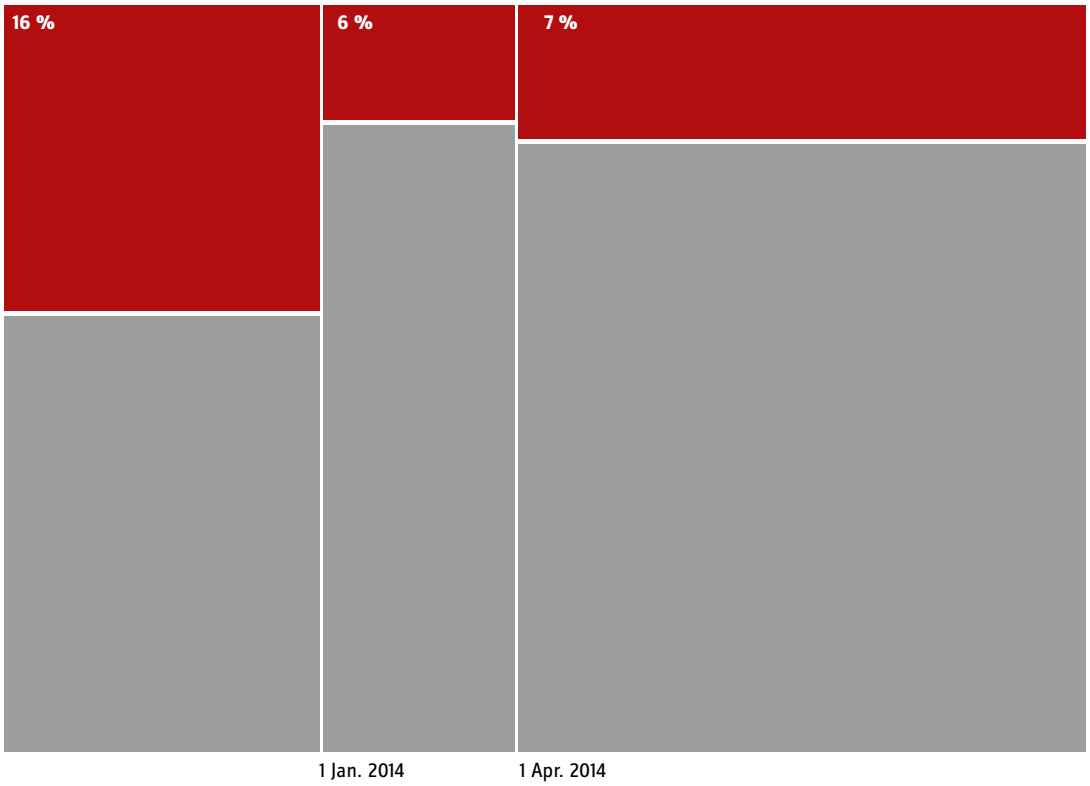
With the implementation of the Fourteenth Act Amending Book Five of the Social Code as per 1 April 2014, the legislature provides that one representative of each health insurance fund is now to take part in the negotiations on the refund amounts. During the second quarter of 2014, the National Association of Statutory Health Insurance Funds developed a concept as to how the health insurance funds are to participate in the negotiations, and drew up the provisions in the Statutes

needed for this. The necessary changes which were pointed to by the legal supervision as to the detailed contents of the Statutes were carried out promptly by the National Association of Statutory Health Insurance Funds. The amendment to the Statutes was passed at the Administrative Council's meeting in September 2014, and was approved by the Federal Ministry of Health in the same month.

When the amendment to the Statutes came into force in October 2014, the National Association of Statutory Health Insurance Funds enquired among its members as to whether they were willing to take part in the negotiations on refund amounts. In line with the Statutes, the outcome of the responses on this query forms the basis for the attribution of the negotiation procedures. The negotiations on refund amounts have been taking place since the beginning of 2015, with the participation of representatives of the health insurance funds.

The possibility to also carry out a benefit evaluation for patented medicinal products of the established market has been done away with. This is a step backwards for patients and contributors.

Fig. 12
Manufacturers' discounts in accordance with section 130a subsections (1) and (1a) of Book V of the Social Code for medicinal products for which no fixed amount has been set*



*In derogation, a manufacturer's discount in accordance with section 130a subsection (1) of Book V of the Social Code of 6 % in place of 7 % has applied since 1 April 2014 to medicinal products not covered by a patent containing the same active agents.

Illustration: National Association of Statutory Health Insurance Funds

Summary assessment of the implementation of the AMNOG

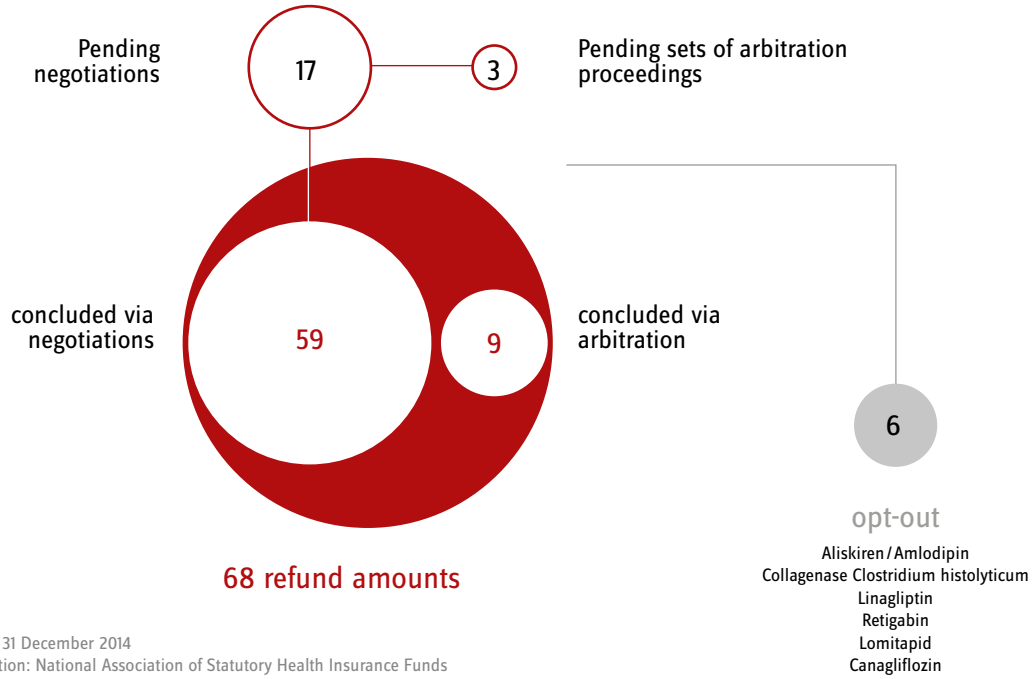
The refund amount is now the reference value for calculating the market supplements, and replaces the former list price of the pharmaceutical company.

The Federal Joint Committee has initiated 148 sets of proceedings on medicinal products from the new and established markets for an early benefit evaluation since the beginning of 2011, and has implemented roughly 350 sets of discussion proceedings. Ten medicinal products were exempted from the benefit evaluation by the Federal Joint Committee. Refund amounts were agreed upon for a total of 68 active agents. 59 of these were concluded by agreement between the contracting parties, and nine sets of proceedings ended with a ruling from the arbitration body. Five medicinal products have so far been directly allocated to existing fixed-amount groups. 17 sets of refund amount negotiations were pending at the end of 2014, as well as three sets of arbitration proceedings. Eight of the pending refund amount negotiations are renegotiations, that is negotiations necessitated for instance because of new resolutions of the Federal Joint Committee in conjunction with new therapeutic indications or the termination of existing refund amount agreements.

Technical implementation and settlement of the refund amount

With the implementation of the Fourteenth Act Amending Book Five of the Social Code as per 1 April 2014, it was made clear that the refund amount is now the reference amount for calculating the market supplements, and hence replaces the former list price of the pharmaceutical company. It was hence possible to largely resolve the different legal views on the refund amount and the considerable distortions in their practical implementation within the concrete settlement. The clarification has led to the refund amounts being largely reported to the Information Office for Proprietary Medicinal Products in accordance with the rules, and has simplified the settlement process. What was also made clear with the Act was that the refund amount applies to all medicinal products with the same active agent, including imported medicinal products. The implementation of this new regulation by importers is being checked on a continual basis.

Fig. 13
No. of finished medicinal products with currently-valid refund amounts and pending procedures



as per: 31 December 2014
Illustration: National Association of Statutory Health Insurance Funds

Positions of the National Association of Statutory Health Insurance Funds on medicinal products

The German healthcare system assures a supply of medicinal products to patients at a high level of quality, and guarantees that new medicinal products are available immediately after having been placed on the market. There is nonetheless an ongoing need to increase the quality of the medicinal products supplied. In December 2014, the Administrative Council of the National Association of Statutory Health Insurance Funds therefore adopted a position paper identifying ten areas of action for the quality and financial viability of the supply of medicinal products.

1. Advance patient-orientated medicinal product policy

In the view of the National Association of Statutory Health Insurance Funds, medicinal product innovations which have a proven added benefit for the affected patients must continue to be available as quickly as possible in the future. The low level of co-payments towards pharmaceutical expenditure by insured persons is excellent in an international comparison. Suitable, affordable co-payments on the part of patients must remain the goal of supplying medicinal products in a manner that both does justice to patients and is economically viable.

2. Improve the quality of medicinal product supply

Given the growing challenges posed by multimorbidity and polymedication, the National Association of Statutory Health Insurance Funds considers a need for action to exist when it comes to the exchange of data between healthcare providers with the help of the electronic healthcard (eHealth Card). This will help avoid intolerances caused by interactions or misadministration. Given this real benefit for patients, the introduction of the eHealth Card and of the telematics infrastructure must be systematically pushed forward.

3. Ensure that independent information is available on medicinal products

Extensive, independent information on medicinal products, as well as on the topicality of this information, is important in order to take the right treatment decisions and increase patients' compliance. From the patients' point of view, there is furthermore also room for improvement when it comes to providing information on diagnoses and therapies for diseases.

4. Early benefit evaluation and refund amounts – Continue the success

The introduction of the early benefit evaluation and the negotiation of refund amounts for new patented medicinal products are regarded as constituting major progress towards improving quality and economic efficiency in the supply of medicinal products. Real innovations can now be distinguished from spurious ones. The twelve-month period of grace from price fixing for new medicinal products however causes a misincentive to increase profits regardless of the additional benefit to patients. Given this fact, it is necessary to make the negotiated refund amount retroactive from the first day on which the product is placed onto the market. What is more, it continues to be in the interest of patients and contributors to also examine the benefit of medicinal products of the established market, and hence to comprehensively ensure high-quality medicinal product supply.

5. Fixed amounts – A guarantor of economically-viable medicinal product supply

The tried-and-tested fixed amounts for medicinal products remain indispensable in order to open up efficiency reserves. They make a major contribution towards ensuring that the supply of high-quality medicinal products remains financeable in the long run. The National Association of Statutory Health Insurance Funds is hence firmly in favour of maintaining the established fixed amounts for medicinal products. Fixed amounts and refund amounts complement one another here in the sense that they help nurture a supply system which is both economically viable and quality orientated.

6. Promote contractual competition in the supply of medicinal products

Discount contracts concluded between health insurance funds and pharmaceutical companies are a tried-and-tested steering instrument to exploit efficiency reserves. They help achieve an economically-viable supply of medicinal products in the long term. Selective contract agreements should be supported which facilitate improvements in the quality, price and volume of the supply of medicinal products.

7. Keep the supply of medicinal products affordable

A major contribution towards keeping the supply of medicinal products affordable for insured persons and patients is made by the manufacturer's discount in conjunction with the price moratorium. It has not yet been possible to achieve the financial relief in the sector of new patented medicinal products that was hoped for by the legislature. The National Association of Statutory Health Insurance Funds continues to hold the view that, from the point of view of the patients, a benefit evaluation of medicinal products on the established market followed by refund amount negotiations is needed. Alternatively, for patented medicinal products on the established market for which there is no longer any possibility to evaluate the benefit and carry out refund amount negotiations, one should increase the manufacturers' discount, as well as retaining the price moratorium for medicinal products on the established market, which is to expire at the end of 2017.

8. Create transparency regarding medicinal product prices

Transparency regarding medicinal product prices is important for the work of the health insurance funds. There is a particular need to make improvements here when it comes to the refund amounts. The introduction of an EU-wide reporting system is needed here in order to make reference prices available for inspection. Such a reporting system would place the refund amount negotiations on a broader information basis.

9. Equip the pharmacy market to face the future

The German pharmacy landscape continues to be largely spared competition for providing good healthcare for patients. An urgent need remains to abolish the ban on third-party and multiple ownership. The sales structure for medicinal products should be refined such that a suitable supply of pharmaceuticals for patients is also ensured in regions with a lower population density. What is more, the remuneration system must be refined both consistently and on the basis of representative data. From the patients' perspective, the right incentives also need to be provided with regard to the quality-orientated allocation of medicinal products.

10. Reduce over-regulation

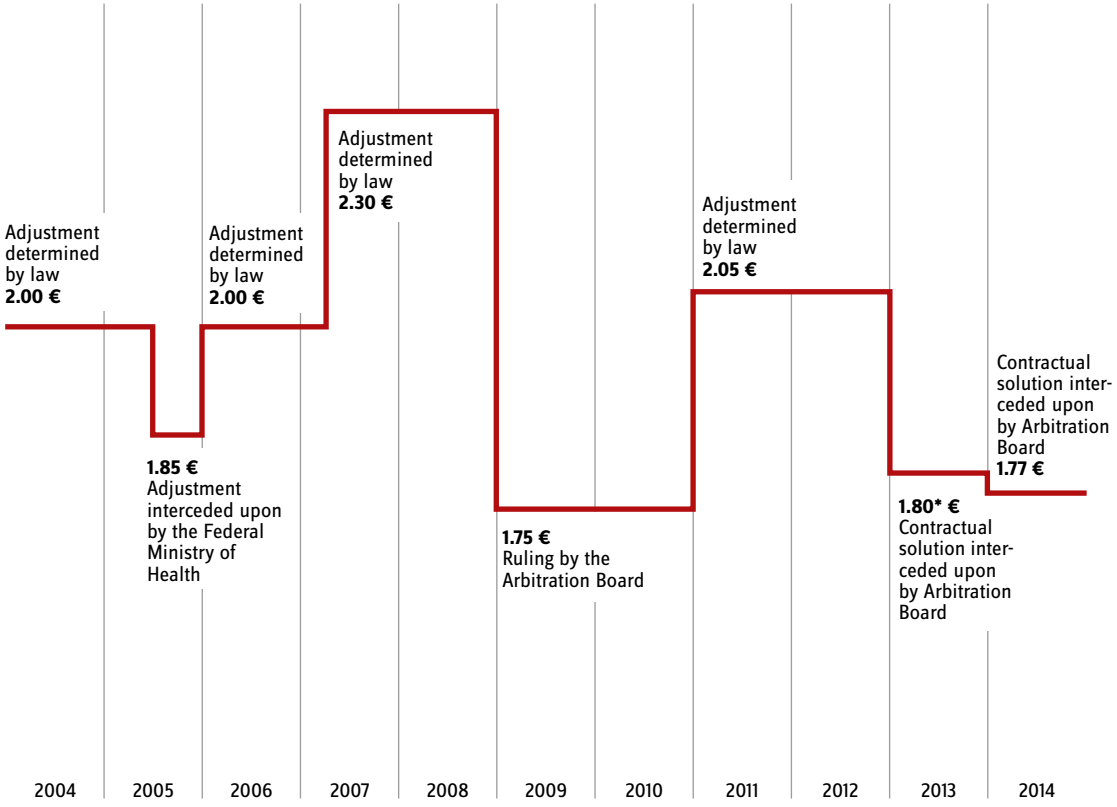
A number of regulatory tools exist on the German medicinal product market at various levels of control. What is needed here is to disentangle the statutory regulations and replace them with non-contradictory, comprehensible rules.

Agreement on the pharmacy discount

The main element of pharmacists' remuneration in Germany is the fixed supplement for the sale of finished prescription medicinal products. This fixed supplement is an unchanging amount in Euro per medicinal product package, the amount of which is regulated in the Medicinal Products Price Ordinance (AMPreisV). This form of remuneration is adjusted by the Federal Ministry for Economic Affairs and Energy in agreement with the Federal Ministry of Health. In accordance with the Act on Medicinal Products (Arzneimittelgesetz), "the legitimate interests of medicinal product consumers, veterinarians, pharmacists and wholesalers shall be taken into account" when setting it.

The Fifth Book of the Social Code contains a further, parallel adjustment mechanism for pharmacists' remuneration. The health insurance funds receive a discount per package from pharmacists for finished prescription medicinal products. This pharmacy discount must be adjusted annually in line with economic developments in the pharmacies since 2013. The adjustment is negotiated by the National Association of Statutory Health Insurance Funds and the German Pharmacists' Association (DAV) as the contracting partners at federal level. In the negotiations that were held for 2013, the contracting partners at federal level were initially unable to agree on an amount for the

Fig. 14
A timeline of the pharmacy discount



*1.75 € was discounted in the first half of the year and 1.85 € in the second half of the year.
Illustration: National Association of Statutory Health Insurance Funds

discount. In addition to disagreement regarding the starting point and the underlying information to be used to calculate the adjustment needed, the parallel nature of the two instruments for adjusting the remuneration made it more difficult to reach an agreement.

Joint initiative with the German Pharmacists' Association

Mediation by the Arbitration Board ultimately led to an agreement. In addition to determining the pharmacy discount for 2013 to 2015, the contracting partners also agreed to approach the legislature with a joint initiative to set the pharmacy discount. The discount is to be set at the amount of 1.77 Euro (value of 2015) from 2016 onwards. Adjustments to pharmacists' remuneration based on changes to pharmacy services and costs are then to be taken into account in future via the Medicinal Products Price Ordinance.

In the spring of 2014, a vote was taken on the joint proposals for legislation, as well as on the reasoning for the Act. The Statutory Health Insurance Care Improvement Act was to take account of this with a corresponding revision of section 130 of Book V of the Social Code.

The German Pharmacists' Association and the National Association of Statutory Health Insurance Funds agreed to approach the legislature with a joint initiative to set the pharmacy discount.

25 years of medicinal product fixed amounts: The model for success marches on

The fixed amounts, which were introduced in 1989, go a long way towards helping ensure that the high-quality supply of medicinal products remains fundable in the long term. The savings for the health insurance funds brought about by this instrument now amount to 7.1 billion Euro per year. The gloomy picture of the future painted by the pharmaceutical industry at that time regarding the supply of medicinal products in Germany and medical progress have however not come to pass.

Adjustments of fixed amounts ensure high-quality care

The National Association of Statutory Health Insurance Funds adjusted the fixed amounts for a total of 59 groups in 2014 because of changes on the market, and furthermore set fixed amounts for eleven groups for the first time. The fixed amounts are set by law. Accordingly, at least 20 percent of prescriptions and 20 percent of the medicinal product packages of a fixed amount group must be available to insured persons without any co-payment.

If pharmaceutical companies do not orientate their prices to the fixed amount, other medicinal products with identical active agents, pharmacologically- and therapeutically-comparable active agents or a therapeutically-comparable effect within the respective fixed-amount group are available to insured persons without any additional payment. Otherwise, additional payments are to be made by insured persons amounting to the difference between the sales price at the pharmacy and the fixed amount.

As an addition to the fixed-amount arrangement, the National Association of Statutory Health Insurance Funds is able to exempt particularly low-priced medicinal products from the statutory co-payment. The statutory co-payment is 10 percent of the sales price of a medicinal product, but at least 5 Euro and at most 10 Euro. In order to also be able to ensure an adequate supply of non-co-payment medicinal products where changes occur in fixed amounts, the fixed amounts were not reduced quite as considerably in this year's adjustments for a total of ten groups.

New guideline "Fixed-amount medicinal products"

According to recent social court case-law, insured persons are entitled in particular, highly-limited exceptional constellations to have the co-payment for fixed-amount medicinal products met by their health insurance fund. This relates to medicinal products for which the pharmaceutical companies demand higher prices than the respective fixed amount. The National Association of Statutory Health Insurance Funds adopted a guideline entitled "Fixed-amount medicinal products" for the first time in 2014 regulating cooperation on this matter between the health insurance funds and their Medical Services.

The savings for health insurance funds through fixed amounts are 7.1 billion Euro per year.

Fig. 15
The fixed-amount arrangement as per 1 January 2015

Total no. of fixed-amount medicinal products	33,623
No. of medicinal products exempt from co-payments	3,664
Total no. of fixed-amount groups	433
No. of fixed-amount groups with medicinal products exempt from co-payments	144
Share of prescriptions of fixed-amount medicinal products on the overall statutory health insurance market	79.6 %
Share of turnover for fixed-amount medicinal products on the overall statutory health insurance market	40.5 %
Annual savings volume	7.1 billion €

Source and illustration: National Association of Statutory Health Insurance Funds

Transparency in the supply of medicinal products: The statutory health insurance rapid medicinal product information system

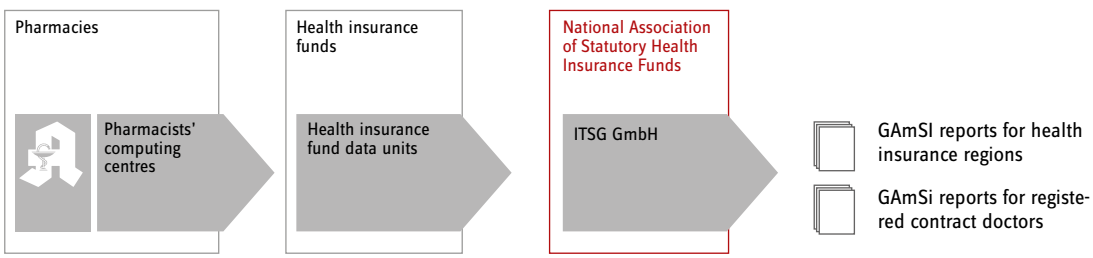
The statutory health insurance rapid medicinal product information system (GAmSi) is a procedure with which the prescription structures in the Associations of Statutory Health Insurance Physicians are to be made transparent, trend information on pharmaceutical expenditure imparted and data made available facilitating a regional comparison. For more than ten years now, a monthly report has been drawn up on the current development in prescriptions of medicinal products, both at the level of individual physicians and at the level of the Associations of Statutory Health Insurance Physicians. The project is based on data from prescription invoicing which is locally generated on a monthly basis by the pharmacists' computing centres, processed in a further step within the funds' systems and compiled by the Information Technology Service Point of Statutory Health Insurance.

Modernising the GAmSi reports

The focus of the information that is customised for various target-groups lies on the quality and economic efficiency of the supply of medicinal products. Potential undesirable developments can be recognised early at regional level, and remedial action can be taken. Given the changing prescription landscape and the changes in the demands made on the specialist information of GAmSi which this involves, in 2013 the National Association of Statutory Health Insurance Funds together with the health insurance funds and their associations commenced a project to modernise the GAmSi procedure.

As well as adjusting the data logistical standards, and the content of the reports and presentation formats, a further measure consists of the establishment of a new segment of reporting which in future is to provide information in the participating Associations of Statutory Health Insurance Physicians on regionally-agreed goals for medicinal products. For instance, the GAmSi reporting will continue to make a major contribution towards increasing the transparency of the supply of medicinal products within statutory health insurance.

Fig. 16
GAmSi dataflow



Delivery of the medicinal product prescription data in accordance with section 300 of Book V of the Social Code

Reporting in accordance with section 84 subsection (5) of Book V of the Social Code

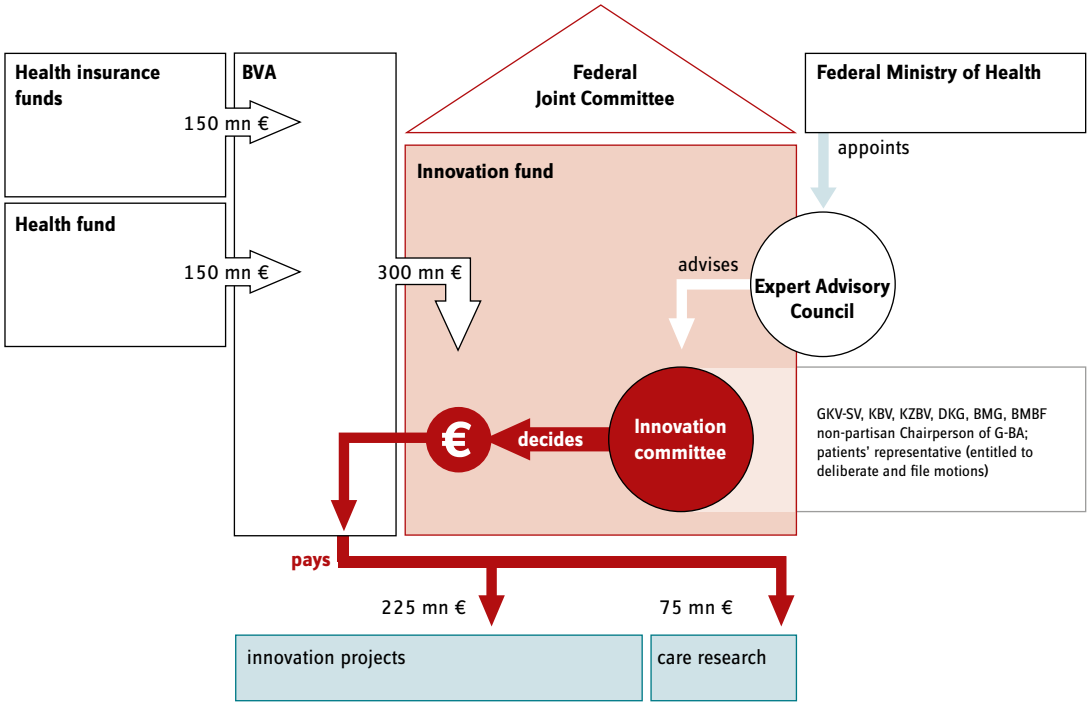
Source and illustration: National Association of Statutory Health Insurance Funds

At the end of the 18th Century, psychological disturbances were still regarded as a mental impairment. Those affected were locked up in internment institutions like criminals. **Phillipe Pinel**, who was head of two such institutions from 1792 onwards, was the first to draft precise clinical descriptions of various psychological diseases, thus making it possible to integrate psychiatry into medicine and to treat sufferers as patients.

The innovation fund for suprasectoral care

The Coalition Agreement reached between the CDU/CSU and the SPD provides for an innovation fund to promote suprasectoral forms of care and care research to the tune of 300 million Euro. 150 million Euro are to be contributed by the health insurance funds, whilst the remaining 150 million Euro are to be provided from the liquidity reserve of the health fund. In order to be able to make a constructive contribution towards the coming legislative process at an early date, the National Association of Statutory Health Insurance Funds worked out a concept of its own for an innovation fund. The model that was established constituted an early specialist scheme with proposals for implementation to the legislature.

Fig. 17
Planned innovation fund acc. to the draft Care Improvement Act (version 17 December 2014)



Legend to abbreviations:

BMG	Federal Ministry of Health (Bundesministerium für Gesundheit)
BVA	Federal Insurance Office (Bundesversicherungsamt)
BMBF	Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung)
DKG	German Hospital Federation (Deutsche Krankenhausgesellschaft)
G-BA	Federal Joint Committee (Gemeinsamer Bundesausschuss)
GKV-SV	National Association of Statutory Health Insurance Funds (GKV-Spitzenverband)
KBV	National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung)
KZBV	National Association of Statutory Health Insurance Dentists (Kassenzahnärztliche Bundesvereinigung)

Illustration: National Association of Statutory Health Insurance Funds

Low-bureaucracy design process with maximum involvement on the part of the health insurance funds

The National Association of Statutory Health Insurance Funds has drawn up a coherent plan which is acceptable for the statutory health insurance funds. The guidelines for the content here were made up of two stipulations:

- Project promotion is to be accompanied in both approval and implementation by selective contracts that are very closely coordinated with health insurance funds. The health insurance funds have a high degree of experience when it comes to the design of care contracts. What is more, it is their contributors who are financing the innovation fund.
- The creation of any additional bureaucracy should be avoided as far as possible.

Casting a critical eye on legislation

The Cabinet draft of the Statutory Health Insurance Care Improvement Act, which was adopted in December 2014, incorporated many aspects of the proposals made by the National Association of Statutory Health Insurance Funds for an innovation fund. However, both the structural layout of the innovation fund provided in the draft, as well as the plan for financing the care projects, are incompatible with the system, and constitute a paradigm shift. This is made particularly clear by the staffing of the planned innovation committee which is to be hosted by the Federal Joint Committee, which is to decide on how to allocate the promotional funding. Its members are to include in future both representatives of the statutory health insurance, the neutral chairperson of the Federal Joint Committee, and hospital and physician representatives, who are to have a vote, as well as representatives of the Ministries of Health and of Research. These will not only outvote statutory health insurance, but involving Ministry representatives also constitutes a massive encroachment on the self-government principle. Moreover, the establishment and administration of the fund's finances as a special fund at the Federal Insurance Office creates a dangerous precedent where third parties are given direct, legally-legitimated access to contributions made to statutory health insurance and intervene in the competition between the health insurance funds.

The structure of the innovation fund and the concept for funding it are incompatible with the system, and constitute a paradigm shift.

Within the further legislative procedure, it is the task of the National Association of Statutory Health Insurance Funds to rigorously point to this blatant imbalance, which has far-reaching consequences for the underlying system and for the expedient segregation of tasks in the German healthcare system.

Florence Nightingale is known as the self-denying nurse from the Crimean War. In fact, she was first and foremost a pioneer of nursing sciences who (with a sound mathematical training) drew up and evaluated detailed statistics on nursing situations, put together international best practice on prevention, long-term care and rehabilitation and finally, from 1860 onwards, founded the first scientifically-orientated schools for professional nursing staff.

Prevention legislation launched

Prevention and health promotion as a task for society as a whole are elementary contributions to effectively maintain and improve the health, well-being and quality of life of all citizens. The legislature set the stage for a Prevention Act early in this Parliament, aiming to strengthen prevention and health promotion and to give it a sustainable orientation.

The National Association of Statutory Health Insurance Funds welcomes the fundamental goals of the legislative project, particularly the intended expansion of prevention and health promotion in the living environment and enhancing cooperation between the various responsible parties and decision-makers. The envisioned organisation of a prevention conference and strategy, bringing together social insurance institutions with regional authorities and social partners, has the potential to considerably increase the goal orientation, cooperation, quality, transparency and broad impact of prevention in Germany. The implementation of the agreements in the *Länder* which have been coordinated at the conference, taking regional needs into account, is also certainly positive.

Despite the essentially cohesive fundamental orientation of the draft, it contains a number of unfavourable provisions which for instance unnecessarily restrict the self-government responsibilities of statutory health insurance or create a misalignment in the allocation of financial burdens. In particular, the need for a pan-societal approach is not adequately reflected in the provisions on financing. The National Association of Statutory Health Insurance Funds will therefore lobby to ensure that the necessary amendments are made in the parliamentary procedure in order to place the re-orientation of prevention on a broad basis that is as stable as possible.

Statutory health insurance the most important player in prevention for years

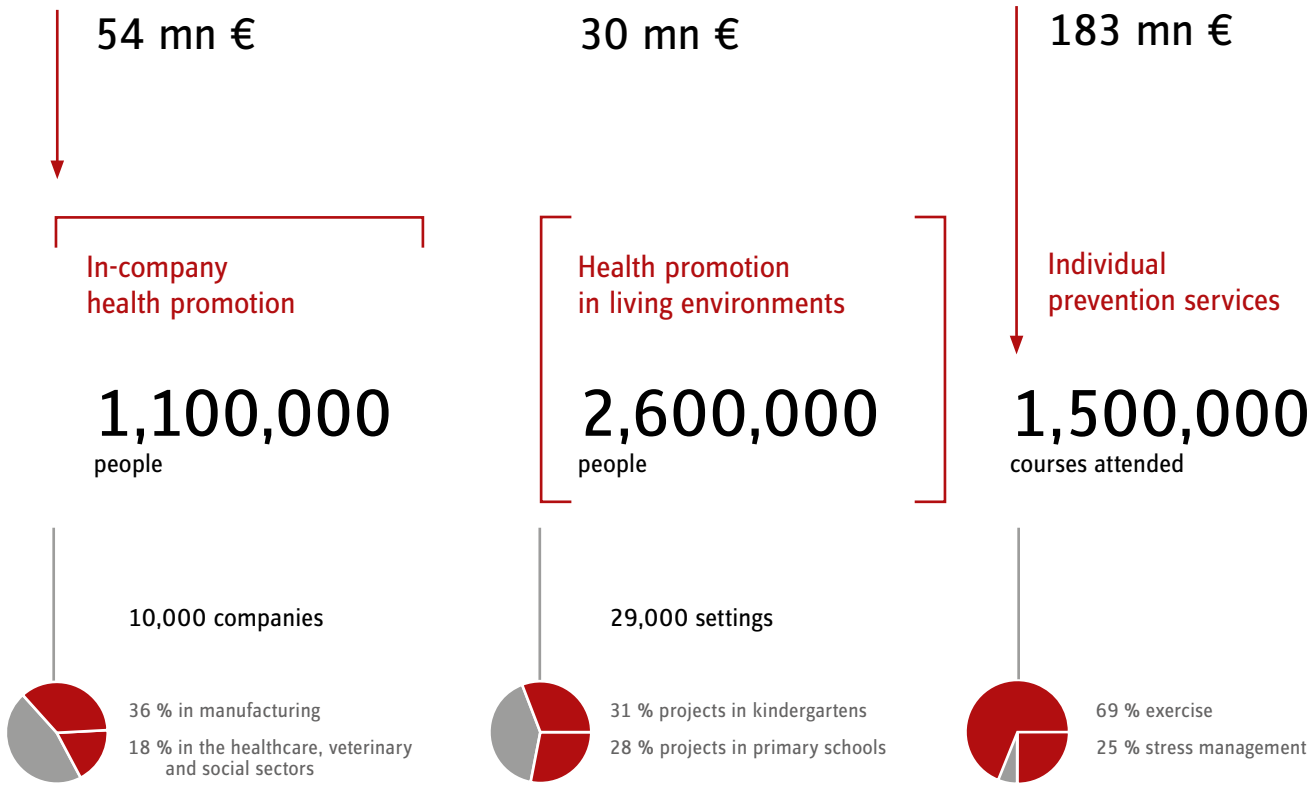
Instead of waiting for a Prevention Act, the health insurance funds have been active themselves for years. They offer their members high-quality prevention activities, and cooperate with important partners:

- In-company health promotion: social insurance institutions, in particular statutory accident insurance
- Living environment-related health promotion: funding bodies of schools and kindergartens, charity associations, local authorities and the like
- Prevention based on individual activities: sports clubs, freelance and commercial providers

Unfavourable provisions in the new Prevention Act

- The lack of mandatory involvement of private health insurance in the funding of prevention threatens to lead to continued financial misalignment as a result of which persons with statutory insurance and their employers contribute towards the prevention services for privately-insured persons in living environments.
- No new bureaucratic structures such as the planned coordination agencies in the *Länder* are needed in in-company health promotion. The health insurance funds can provide the framework themselves so that, in particular, more SMEs and their employees reap the benefits of in-company health promotion.
- It is not acceptable in terms of regulatory policy to fund the Federal Centre for Health Education as the supreme federal authority through contributions from insured persons and employers.

Fig. 18
Expenditure by statutory health insurance on prevention



Source: Prevention Report 2014, Illustration: National Association of Statutory Health Insurance Funds

Whilst the expenditure share of the public sector in the funding of prevention has fallen considerably in the past 20 years, it has stridden ahead in statutory health insurance. The annual Prevention Report makes the services provided by statutory health insurance in this sector transparent, and presents in each case a major topic from prevention and health promotion – currently the topic of cooperation between the health insurance funds and their associations with other partners, as well as inter se.

Success factors for prevention and health promotion

With its prevention guidelines, the National Association of Statutory Health Insurance Funds defines binding quality requirements for measures of prevention and health promotion. The new guidelines both illustrate the current state-of-the-art and contribute practical experience towards achieving further improvements within new statutory frameworks. The prevention and health promotion goals of statutory health insurance that were developed on an epidemiological-health science basis help to ensure that the benefits are focussed on sectors with particularly high priority. The framework agreement with the German Statutory Accident Insurance, which has been in force since 1997, as well as the more recent cooperation recommendations with the Federal Employment Agency and with the central associations of local authorities, can be used as a model for the more intensive cooperation spanning funding institutions that the Prevention Act is intended to bring about.

In 1872, **Linda Richards** was part of the first graduation year of professionally-trained nurses in the USA. One year later, she already headed the night watch in the Bellevue Hospital Center in New York, where she introduced the first concept of the organised administration and storage of patients' files. In 1885, she established the first nursing care training courses in Japan.

Federal Participation Act under preparation

The Federal Government intends to reform integration assistance for persons with a disability during this Parliament. According to the Coalition Agreement, a Federal Participation Act (Bundesteilhabegesetz) is to be drawn up to include the financial relations between the Federation and the *Länder*, and it is to be examined whether a Federal Participation Act is to be introduced.

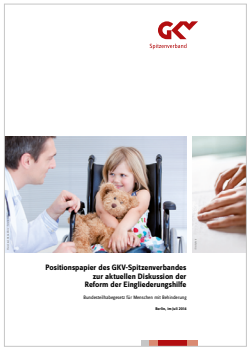
The goal is to remove people with major disabilities from the "welfare system", to improve their lives and to refine integration assistance to become a modern participation right orientated towards the stipulations of the UN Disability Rights Convention. The services provided are to be orientated towards personal needs, and it should be possible to identify them in a standardised national procedure per person. At the same time, the Federal Participation Act is to relieve local authorities of a burden of 5 billion Euro when it comes to integration assistance.

Several security systems are relevant to people with disabilities in many cases, including health and long-term care insurance. The National Association of Statutory Health Insurance Funds has therefore taken up a position on the reform of integration assistance, which it contributed to the political debate in July 2014.

Participation in drawing up the Federal Participation Act

To prepare the Federal Participation Act, which is to be adopted in 2016, an extensive participation procedure was initiated in July 2014 under the leadership of the Federal Ministry of Labour and Social Affairs. A working party is to identify reform topics and goals by the beginning of 2015, clarify potential compromises and carry out a binding assessment of individual reform items. With the participation of representatives from various groups within society, of the Federation, of the *Länder* and of the local authorities, as well as of the social insurance institutions and social partners, the reform is to be implemented in as broad a societal consensus as possible.

The ongoing consultation procedures, as well as the coming legislation procedure, will be used by the National Association of Statutory Health Insurance Funds to achieve the requirements in which to improve the circumstances of the people concerned. It will be necessary to avoid building shunting yards that are paid for by the contributors of the health insurance funds.



Core positions of the National Association of Statutory Health Insurance Funds on the reform of integration assistance

- The reform must focus on people and not on the financial interests of the *Länder*.
- Specialist integration assistance services must be uniformly defined.
- There must be no new isolated solutions with new structures, but existing cooperative structures must be used and expanded.
- Person-centring should create more options – it must not lead to the demolition of established service structures.
- Interactions with other social services must be taken into account without imposing a burden on other social service providers.

Ignaz Semmelweiß discovered in 1848 that when clinic staff simply wash their hands, this protects against the spread of child bed fever, which is frequently fatal. Because many doctors refused to consider themselves as potential carriers of disease, even these minimum hygiene standards did not become the norm in hospitals until after 1867, two years after his death.

High-risk-class medical devices in hospital care

Innovative medical technology is important for medical progress. However, authoritative study results must be available before high-risk medical devices are used universally in care. It is only then that patient safety is not placed at risk and doctors and patients can reliably assess the benefit of the products.

Clinical studies for high-risk medical devices

The National Association of Statutory Health Insurance Funds has been demanding for years that early studies should be carried out for high-risk medical devices which have a novel mechanism of action. Reality however frequently tells a different story: Many of these products are insufficiently studied before they are placed on the market. They are then used on a large scale without enough being known about their long-term effect or potential to do harm. It frequently only emerges in retrospect which patients benefit from the treatment – and which would be better off not having been treated with the allegedly beneficial innovation because of the risks involved.

New high-risk-class innovative medical devices that are introduced into care are to be identified at an early date and rapidly and systematically evaluated by the Federal Joint Committee.

Solution proposed by the National Association of Statutory Health Insurance Funds

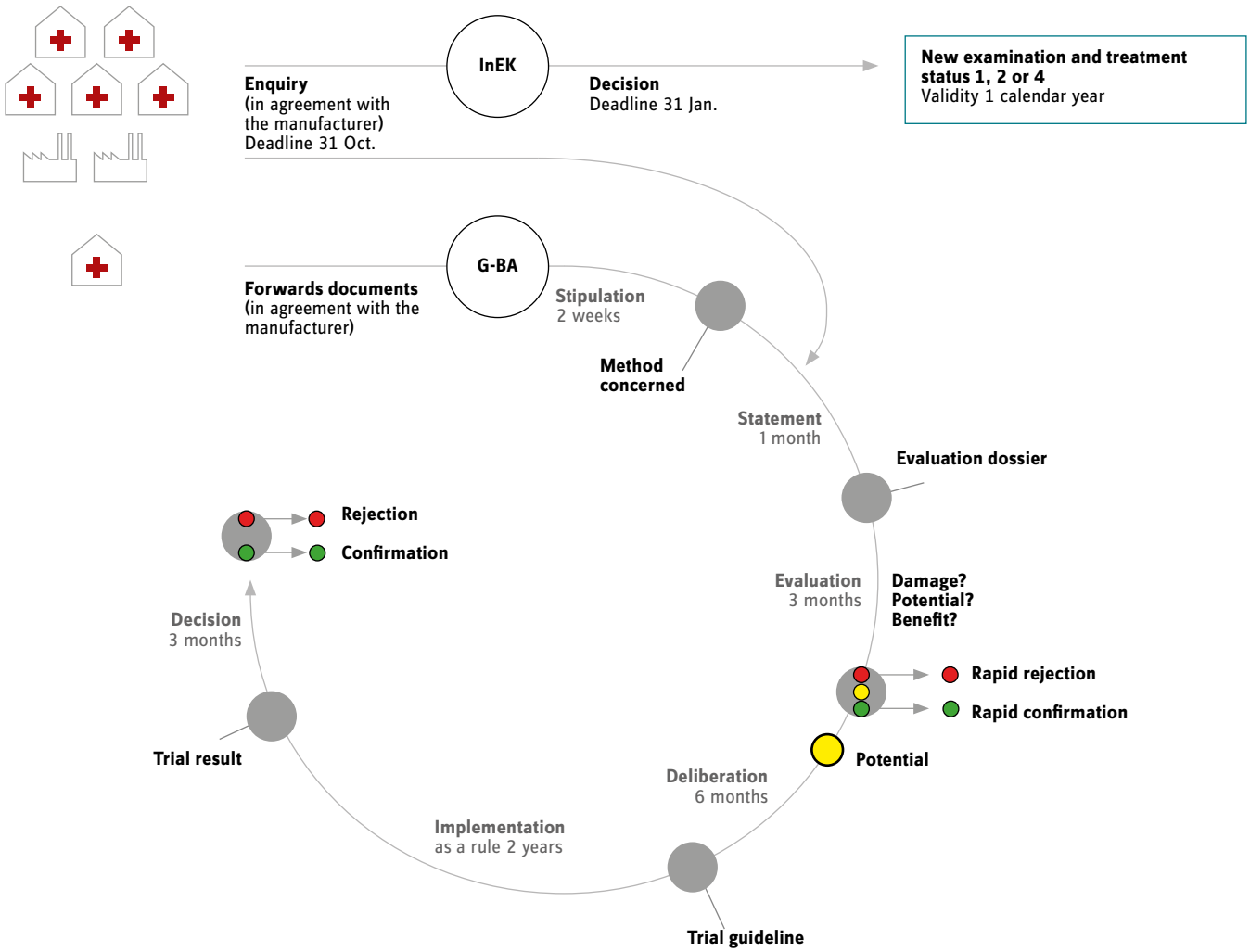
In the Coalition Agreement, the governing parties agreed to always legally stipulate clinical studies for high-risk medical devices and to oblige hospitals to take part if the Federal Joint Committee has so resolved. The National Association of Statutory Health Insurance Funds went on to draw up a plan with which the project can be legally implemented. This was adopted in September 2014 by the Administrative Council of the National Association of Statutory Health Insurance Funds and introduced into the public debate. The main core points are as follows:

- New high-risk-class innovative medical devices that are introduced into care should be identified at an early date and rapidly and systematically evaluated by the Federal Joint Committee.
- If the benefit of these products is not yet proven, but they nonetheless constitute a potential alternative treatment, hospitals and manufacturers are required to develop study plans and put them forward for approval.
- The insurance funds undertake to pay for the medical service provided within the studies approved by the Federal Joint Committee.
- Members of statutory health insurance therefore obtain rapid, safe access to the innovative method – first in the protected context of a clinical study, and then in the knowledge that there are reliable data regarding the actual benefit of the innovation.

Planned provisions in the Care Improvement Act

In October 2014, the Federal Government presented a draft Care Improvement Act with which the systematic evaluation of high-risk medical devices is to be entrenched in law. The National Association of Statutory Health Insurance Funds welcomes this long-overdue step and continues to constructively support the legislative procedure in the interests of the members of statutory health insurance on the basis of its implementation approach.

Fig. 19
Systematic evaluation of high-risk medical devices as provided in the draft Care Improvement Act (version: 17 December 2014)



Legend to abbreviations:
G-BA Federal Joint Committee (Gemeinsamer Bundesausschuss)
InEK Institute for the Remuneration System in Hospitals (Institut für das Entgeltsystem im Krankenhaus)

Illustration: National Association of Statutory Health Insurance Funds

The principle of immunisation through a survived infection was already known at the beginning of the 18th Century, and was already being used against fatal smallpox, which was very common at that time – the intentional infection of healthy people in the hope of a mild infection (variolation). English country doctor **Edward Jenner** discovered that milkmaids (cows were almost always infected with cowpox) did not fall victim to smallpox. He carried out his first (successful) vaccination with cowpox in 1896 on an eleven-year-old boy. The WHO registered smallpox as an eradicated disease in 1979.

Initial trial guidelines launched

Research efforts are inadequate in many cases to evaluate the benefit ensuing from a new examination or treatment method by the Federal Joint Committee. Since the Statutory Health Insurance Care Structure Act came into force, the Federal Joint Committee has been able to initiate clinical studies itself through guidelines and to contribute to them financially. This is contingent on the respective method revealing the potential of a necessary alternative treatment.

Manufacturers of medical devices or other providers of non-drug examination and treatment methods have been able since 2013 to apply for a trial guideline from the Federal Joint Committee. The Federal Joint Committee issues a notice on the applications that have been lodged within three months, on the basis of an evaluation of the potential for trial by the Institute for quality and economic efficiency in the healthcare system (IQWiG).

Guideline for four new examination and treatment methods

In April 2014, the Federal Joint Committee decided on the deliberation of trial guidelines on the basis of the notices that had been handed down. These are

- the non-invasive molecular genetic prenatal test to determine the risk of foetal trisomy 21 among pregnant women whose unborn child has a heightened risk for this (Pränatest®),
- therapy with hyperbaric oxygen in case of sudden acute hearing loss,
- the measurement of nitrogen monoxide in exhaled air to determine a specific form of inflammation of the respiratory tracts (such as bronchial asthma),
- the measurement of nitrogen monoxide in the exhaled air of pregnant women with asthma to manage the asthma treatment.

The key points for a study will be set out in the trial guidelines which are to facilitate an evaluation of the benefits of the method at a sufficiently safe level of information. A professionally-independent scientific institution will be commissioned in each case to draw up the study protocol, as well as to provide academic guidance and to evaluate the trial study.

The public debate on the announced trial of the "Pränatest®"

There has been public criticism of the announcement of the trial of the maternal blood test for the presence of a trisomy 21 (Down's syndrome) in the unborn child. In contradistinction to the fears that have been voiced, the current trials are by no means to be expanded. In fact, it is to be ascertained whether the current practice of an amniocentesis can be replaced by a non-invasive examination which is gentler on mother and child. The question to be explored in the trial exclusively relates to an indication which currently gives rise to an amniocentesis as a service to be provided by statutory health insurance. The question of the degree to which a less invasive method promotes willingness to be tested, and hence may also lead to an abortion, requires a broader debate within society than can be carried out on the Federal Joint Committee.

Even if it remains unresolved whether relevant progress for care is achieved via the trial guidelines, it is revealed that the implementation of the legislation by the Federal Joint Committee has opened up a path which is workable as a matter of principle.

The trial guidelines define the key points for a study which is to facilitate an evaluation of the benefit of the method at a sufficiently secure level of information.

In 1924, **Willem Einthoven** was awarded the Nobel Prize for Medicine for an invention which he had already made 23 years before, and which was to take another 25 years to become the norm on a broad basis – the ECG. Einthoven not only developed the recording device, but already described the changes in the curve that would be caused by the most common heart conditions.

Combating misconduct in the healthcare system

A report is to be drawn up at intervals of two years on the work and the results achieved by the Anti-Misconduct Office for the Healthcare System. In 2014, the now third report was submitted to the Administrative Council of the National Association of Statutory Health Insurance Funds for the period under report 2012 to 2013, and was then forwarded to the Federal Ministry of Health as the competent legal supervisory authority.

The report, which is not public, documents not only the many activities of the Office within the National Association of Statutory Health Insurance Funds. On a voluntary basis, it once more compiles comparable benchmarks of the reports of the units that have been established at all statutory health insurance and long-term care insurance funds and turns to the legislature with positions and demands.

In order to further strengthen the fight against misconduct in the healthcare system, there are plans for the Administrative Council to adopt for the first time in 2015 a position paper of the National Association of Statutory Health Insurance Funds which is also to appear as a separate publication.

For a criminal offence of passive and active corruption in the healthcare system

The Federal Court of Justice called on the legislature back in 2012 to "effectively counter irregularities" that are caused by corruption in the healthcare system and "which – by all appearances – cause major financial burdens on the healthcare system with the means available to criminal law". The National Association of Statutory Health Insurance Funds therefore explicitly welcomes the announcement of the governing Coalition to create a new criminal offence of passive and active corruption in the healthcare system within the German Criminal Code (Strafgesetzbuch) in the 18th Parliament.

At a specialist forum organised by the Federal Ministry of Justice and Consumer Protection, the National Association of Statutory Health Insurance Funds made it clear that the agencies to combat misconduct in the healthcare system currently did not have sufficient investigating powers of their own. They were therefore not able to effectively prosecute corruptive activities in the healthcare system that are banned under social law. In practice, the health and long-term care insurance funds initially depend on the results of investigations by the public prosecution offices in order to be able subsequently to enforce refund claims and contractual measures under social law.

So that the fight against corruption in the healthcare system can be successful in future, it is however not sufficient to simply create a new criminal offence in the Criminal Code. There is furthermore also an absolute need for the legal protection of whistle-blowers, as well as to set up (specialist) public prosecution offices for property crimes and corruption in the healthcare system in all the Federal *Länder*.

Fig. 20
Combating property crimes and corruption in the healthcare system
(Specialist) public prosecution offices

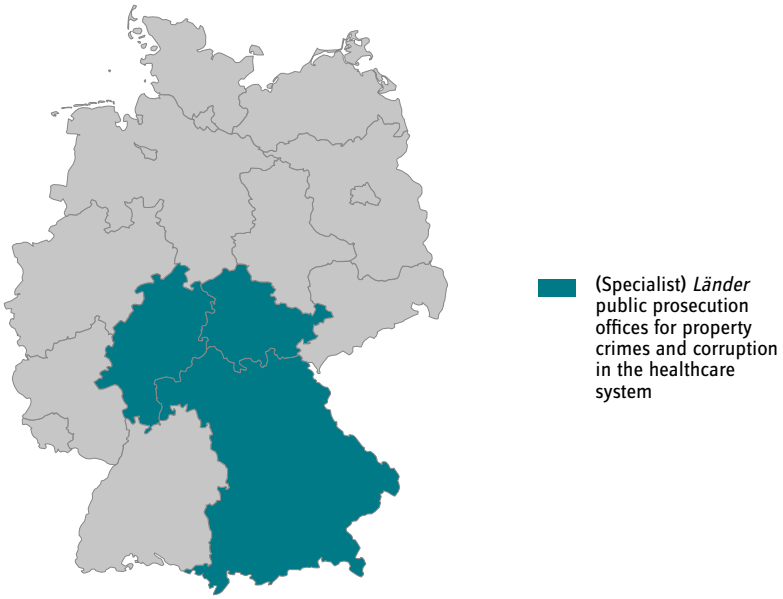
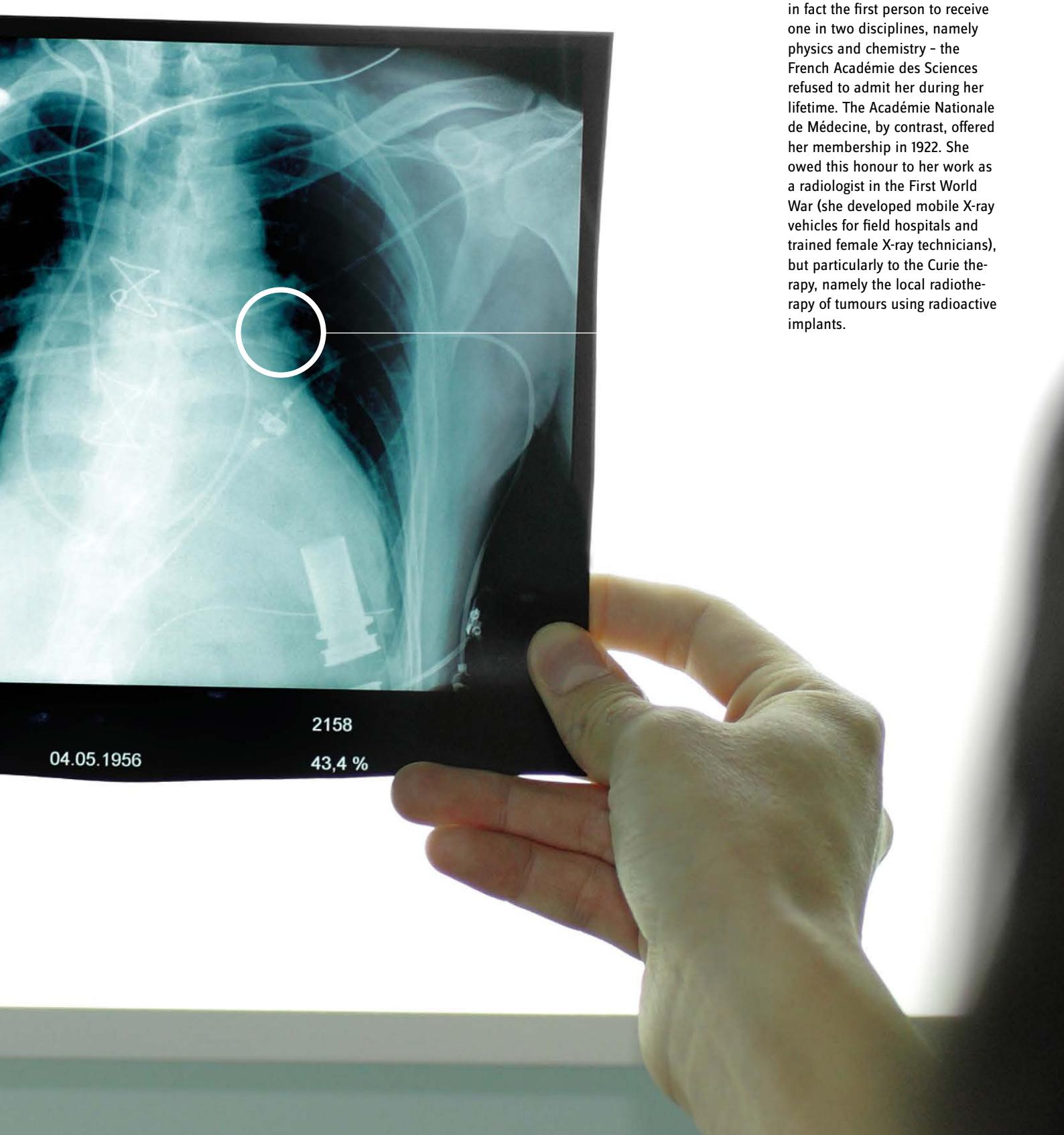


Illustration: National Association of Statutory Health Insurance Funds, version 31 December 2014

Even though **Marie Curie** was awarded a Nobel Prize – and was in fact the first person to receive one in two disciplines, namely physics and chemistry – the French Académie des Sciences refused to admit her during her lifetime. The Académie Nationale de Médecine, by contrast, offered her membership in 1922. She owed this honour to her work as a radiologist in the First World War (she developed mobile X-ray vehicles for field hospitals and trained female X-ray technicians), but particularly to the Curie therapy, namely the local radiotherapy of tumours using radioactive implants.



The financial situation in statutory health insurance: Disproportionate growth in expenditure

As had been anticipated, after three consecutive years of revenue surpluses – the health fund in fact after four "good" years –, statutory health insurance was no longer able to achieve a positive financial result in the year under report. Both the health fund and the health insurance funds closed 2014 with an overall revenue deficit. Because of the new funding system with a reduced contribution rate level, in October 2014 the statutory health insurance appraisers forecast an expenditure shortfall in the health insurance funds for 2015 amounting to 11.2 billion Euro. The health insurance funds will partly compensate for the forecast shortfall by reducing existing reserves. Statutory health insurance has hence been drawing since 2014 on the economic substance which it had built up in the previous years.

Financial development in 2014

Assessable income increased by 3.9 percent in 2014 (2013: + 3.4 percent), this constituting another marked increase. The contribution revenue which thus rose to 188.2 billion Euro – with an unchanged contribution rate of 15.5 percent – was however unable to completely compensate for the improper reduction of the Federation's contribution by 3.5 billion Euro. Thus, the health fund's revenue of 198.6 billion Euro in 2014 compared to allocations to the health insurance funds of 199.6 billion Euro. The resulting deficit in the fund amounting to 1 billion Euro had to be financed from the Fund's liquidity reserve, which hence remained at a level of 12.6 billion Euro at the end of the year under report.

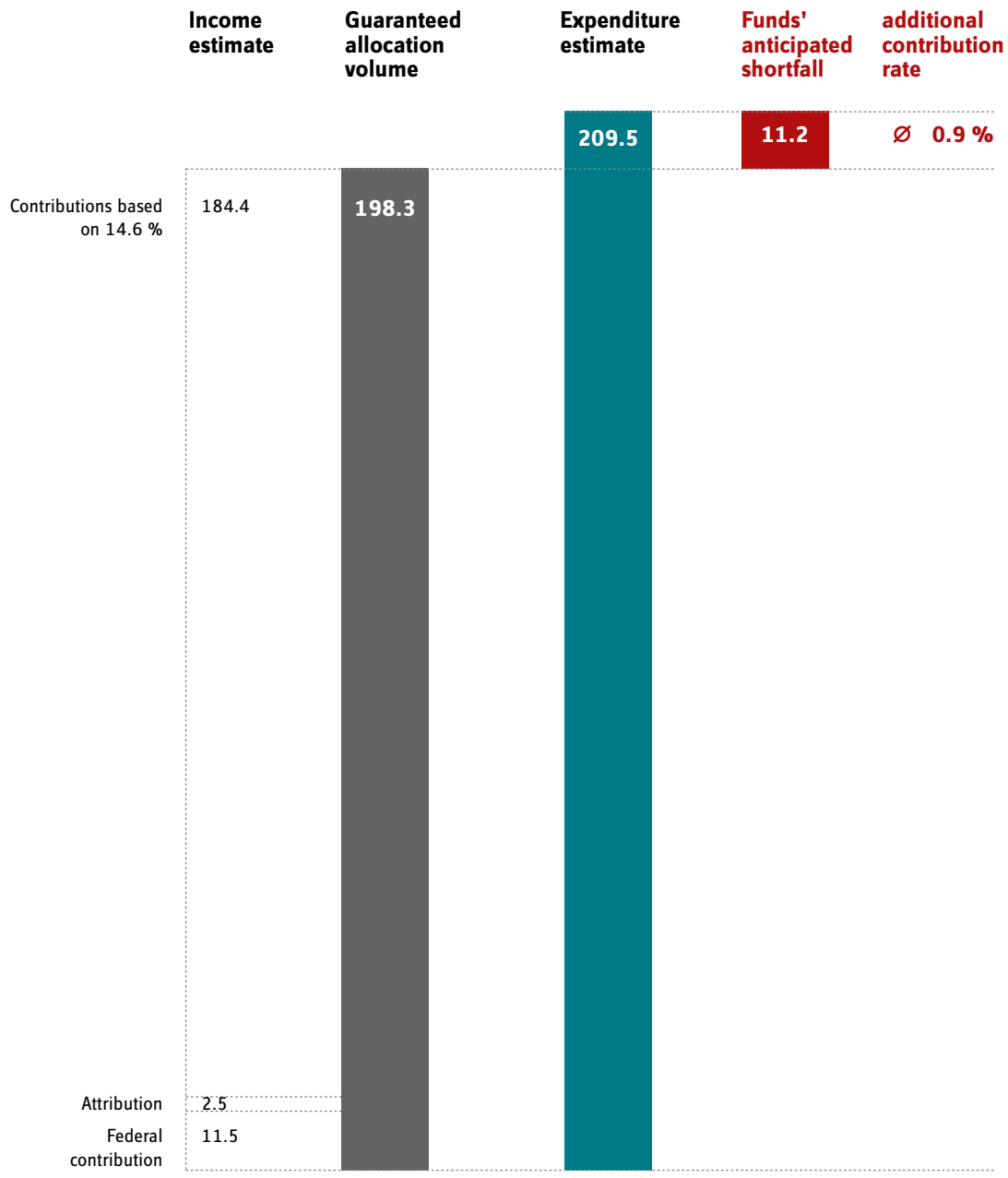
When it came to the health insurance funds, income from allocations of 199.6 billion Euro compared with estimated fund-relevant expenditure of 200.4 billion Euro. The expenditure of the health insurance funds thus rose by 10.9 billion Euro year-on-year. This corresponds to expenditure growth of 5 percent per insured person. As a consequence, the health insurance funds ran up a deficit of 0.8 billion Euro in 2014, which was financed from reserves. Happily, it was not necessary for any health insurance fund to levy flat-rate additional contributions under the old law in the year under report. On the contrary: The better off health insurance funds were able to pay bonuses from their reserves to their members amounting to roughly 0.7 billion Euro.

The financial forecast for 2015

Contribution income for 2015, including contributions from marginal employment, was estimated by the statutory health insurance appraisers to be 184.4 billion Euro. In spite of an anticipated increase by 3.8 percent in assessable income, the year-on-year income loss of 3.8 billion Euro results from the general contribution rate having been reduced by 0.9 contribution rate points to 14.6 percent, by the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance (GKV-FQWG). In addition to income from contributions, the Fund is able to count on a contribution from the Federation of 11.4 billion Euro, as well as a statutory attribution from the liquidity reserve coming to 2.5 billion Euro, so that the estimated revenue totals 198.3 billion Euro. This anticipated total income is guaranteed for the health insurance funds as allocation volume for 2015, so that arithmetically the Fund will reach a financial result of zero. This balance is however only possible because of the attribution from the liquidity reserve, which will hence be reduced by 2.5 billion Euro as per the end of 2015, reaching an anticipated 10.1 billion Euro.

The anticipated fund-relevant expenditure of the health insurance funds in 2015 was estimated at 209.5 billion Euro (+ 4.1 percent per insured person). This consequently leads to an arithmetical shortfall of 11.2 billion Euro on the part of the health insurance funds, which – where the health insurance funds are unable to fall back on reserves – is to be raised through additional contributions by the insured persons. The deficit, related to the estimated base rate of pay for 2015, corresponds to an arithmetic additional contribution rate of 0.9 percent. Accordingly, the Federal Ministry of Health also set the average additional

Fig. 21
Revenue-expenditure forecast
(in billion Euro)



Source: Forecast by statutory health insurance appraisers, Illustration: National Association of Statutory Health Insurance Funds

contribution rate for 2015 at 0.9 percent. This average additional contribution rate is relevant for the additional contributions of beneficiaries of unemployment benefit II (Arbeitslosengeld II), as well as for other groups of members of the health insurance funds. All other members pay their additional contributions in each case on the basis of the fund-specific additional contribution rate of the health insurance fund which they have selected.

Health insurance funds launch new price competition

The funding system that was reformed as per 1 January 2015 creates new price competition among the health insurance funds by producing a general shortfall among the health insurance funds and introducing fund-specific additional contribution rates. The administrative councils of the health insurance funds decided on the additional contribution rates in their Statutes in the final weeks of the year under report. The additional contribution rates to be announced by the National Association of Statutory Health Insurance Funds according to the statutory requirement ranged from 0.3 to 1.3 percent as per the cut-off date of 1 January 2015; only two smaller regional health insurance funds were not charging an additional contribution at this time.

The National Association of Statutory Health Insurance Funds was obliged by the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance to publish a currently updated overview of the additional contribution rates on the Internet. For the selection of a health insurance fund – in addition to the additional contribution rate that is charged –, however, further factors should be considered, in particular the fund-specific Statute benefits, special care programmes and services. A one-sided focus on the price component ultimately also runs counter to the desired performance and quality competition in health insurance.

With a view to the future funding of statutory health insurance, in particular it deserves continued criticism that the legislature, with the Annex to the 2014 Budget Act (Haushaltsbegleitgesetz), once more lays claim to large parts of the liquidity reserve of the health fund in order to consolidate the Federal budget. All in all, the Federation is depriving statutory health insurance of 8.5 billion Euro by cutting the Federal contribution for 2013, 2014 and 2015. These considerable financial reserves, which were contributed solely by insured persons and their employers, are hence misappropriated for general state tasks, and are no longer available for the future funding of the healthcare of persons with statutory insurance. This shift of funding loads contradicts the goal of spreading burdens equitably, as well as the objective of the sustainable, sound funding of social insurance.

Only six percent of patients survived a brain operation under general anaesthetic at the end of the 19th Century. While he was still studying medicine, **Harvey Williams Cushing** developed an anaesthetic protocol in 1885 incorporating the permanent monitoring of the vital signs respiration, pulse rate and temperature, which he subsequently expanded to include a continuously-measuring blood pressure monitor that he himself developed. This caused the survival rate to increase to 90 percent. Derived from his vital sign protocol, he designed and founded the first intensive care ward, which he headed from 1923.

Shaping health together in Europe

The citizens of Europe were called upon in May 2014 to elect a new European Parliament. In the following months, the new European Commission was selected. This gave the European Union (EU), which also plays a growing role in health and long-term care policy, a new political orientation. In order to be able to incorporate the interests of patients and contributors in the Brussels debate as early as possible, the National Association of Statutory Health Insurance Funds has dealt intensively with questions relating to the structure of health policy in Europe. The Administrative Council of the National Association of Statutory Health Insurance Funds has adopted a position paper entitled "Shaping health together in Europe".

The National Association of Statutory Health Insurance Funds is concentrating on the important structural principles of statutory health insurance and long-term care insurance, such as the benefit-in-kind and solidarity principles, funding via contributions, as well as management via self-government. These principles are the bedrock on which one of the best-performing health and long-term care systems in Europe is built, and may not be placed in question by EU policy-makers.

Maintaining the health systems in good shape

In line with the principle of subsidiarity, a sensible division of tasks between the EU and its Member States means taking up challenges in a self-determined, responsible manner wherever they arise. Also in a Europe which is growing ever closer together, all Member States must remain able to ensure the functioning of their healthcare systems as well as efficient health and long-term care. The EU level is only asked to act when joint action becomes necessary.

Different forms of cooperation make sense on the medicinal product and medical device market, in combating widespread diseases or in ensuring health insurance for increasingly mobile European citizens. The European Health Insurance Card (EHIC) must be refined together and its acceptance strengthened in order to guarantee unbureaucratic care of insured persons when they travel to another EU country. The EU takes particular responsibility for the quality and safety of medical devices. It must place the focus on patient safety in the ongoing negotiations on a new Regulation on medical devices in order to restore lost trust in this sector after several scandals.

Joining forces

Cooperation enables the healthcare systems of the EU to meet challenges together, learn from one another and unite their forces where it makes sense. For instance, prevention and health promotion are also a central topic in all of Europe's ageing societies. Major widespread diseases such as cancer or dementia affect people in all EU Member States.

Current EU topics

Regulation for medical devices and in vitro diagnostic (IVD) medical devices

- Scandals concerning "metal-on-metal endoprostheses" and breast implants have recently made it clear that there is a need to modernise the law on medical devices in the long term.
- In the interest of patient safety, high-risk medical devices need approval by a central facility at European level which is independent of economic interests; sound clinical trials and reliable market monitoring studies and tools. Despite two years of negotiations, the EU Member States have also not yet been able to agree on a common position to present to both the European Parliament and the Commission.
- The National Association of Statutory Health Insurance Funds considers the draft originally submitted by the European Commission not to go far enough.

General Data Protection Regulation

- The goal is to modernise and standardise European data protection law, which dates back to 1995.
- In Germany, the provisions on social data protection and special provisions for the healthcare system already constitute coordinated regulations the coherence of which must not be endangered by European stipulations. In the final analysis, social and health data constitute highly-sensitive personal information worth protecting.

The EU's value-added tax reform

- The European Commission is considering the imposition of obligatory value-added tax on public services and services of general interest, including health and long-term care insurance benefits.
- Statutory health insurance and German social insurance as a whole consider these plans to be completely unacceptable.
- Imposing value-added tax would have led to additional social insurance costs of around 34 billion Euro for 2014 alone. This corresponds to an increase in contribution rates of more than three percentage points without any improvements in services.

Consultation on mobile health services

- The European Commission has held a consultation process on mobile health applications as they are used for instance on mobile phones. The aim is to explore opportunities and requirements for better regulations.
- The National Association of Statutory Health Insurance Funds – together with German social insurance and via the European Social Insurance Platform (ESIP) – is in favour of greater data security, as well as improving the reliability and quality of such applications.
- Applications which for instance support medicinal product therapies or screening and prevention measures must be treated like medical devices.

International free trade agreements

The EU is negotiating on a number of free trade agreements. The most prominent among them is the Transatlantic Trade and Investment Partnership (TTIP) with the USA. The National Association of Statutory Health Insurance Funds welcomes as a matter of principle the concern of the EU to reduce red tape through such an agreement and to promote economic growth. At the same time, it has intensively studied the potential impact on health insurance and the healthcare system, and has drawn up positions on this, including together with other European social insurance organisations, within the European Social Insurance Platform.

The Administrative Council stated the following in its key points on a European policy:

- International agreements should not restrict the competence of the Member States to shape their own healthcare systems.
- The structural principles of statutory health insurance based on solidarity may not be placed in question.
- Social services, healthcare and health insurance services are not merchandise.
- They must be unambiguously excluded from the scope of trade agreements, permanently and with legal certainty, and it must be conclusively determined to which fields free trade agreements are to apply.

Furthermore, the National Association of Statutory Health Insurance Funds took up a position at an early date on the negotiations in the sector of medical devices and medicinal products.

Adhering to high safety standards

It is in the interest of patients and contributors for a good framework to be put in place for innovation and quality, for a secure supply of medical devices and medicinal products, as well as for their sustainable funding by the healthcare systems in the EU. When considering a further approximation of the approval procedures for medicinal products, high standards must be adhered to in order to guarantee patient safety. Cooperation with the USA in the medical devices sector offers a number of possibilities to enhance patient safety in the long term. In the view of the National Association of Statutory Health Insurance Funds, in particular market access and monitoring are regulated better and more transparently in the USA than in Europe. Patients would benefit from the European safety and performance requirements being adjusted in line with the US system.

Transparent negotiations, impact assessment

The National Association of Statutory Health Insurance Funds considers that the negotiations on free trade agreements should be more transparent as a whole, and interest groups should be suitably involved, such as via public consultations with a sound data basis. In order to create clarity regarding the health-policy impact of the international agreements, the European Commission must present a comprehensive social and health policy impact assessment in good time.

Transatlantic Trade and Investment Partnership

The EU and the USA decided in February 2013 to take up negotiations on a Transatlantic Trade and Investment Partnership (TTIP). According to the European Commission, the planned agreement would be the largest trade agreement ever negotiated in economic terms. It is to increase the economic output of the EU by 0.5 percent in ten years. The Agreement relates to reducing customs tariffs, opening up markets for investment, services and public procurement. The TTIP is intended to remove further non-tariff trade barriers, such as in the areas of consumer, environmental and health protection, insurance and financial products, as well as data and patent protection.

The DVKA – The point of call for international corporations

Enterprises that are domiciled in Germany have a particular international orientation. The export of goods and services accounts for a major share of global trade. Germany's intensive global economic links are reflected in the high import rates, as well as in the increase in cross-border direct investment.

German enterprises, be they groups of companies or SMEs, form part of this global economic order in which an international division of tasks and international companies are a matter of course. This process is accompanied and facilitated by thousands of persons working in other countries who, in addition to the economic transfer, guarantee economic success through their expert knowledge. What however does this mean for the employees who are deployed all over the world, and for German social insurance?

The uninterrupted coverage of employees by the German social system is a major element of international staff deployment, and hence of companies' success.

Continued coverage by German social insurance with the aid of the DVKA

The German Liaison Agency Health Insurance – International (DVKA) is a major player in answering this important question. It concludes "exemption agreements" to provide social insurance to persons who are temporarily working abroad. The effect of these is that, even while working abroad, contributions for a person are only made to the German social system and entitlements are only acquired there. A continuous insurance career is in the employees' interest. Companies which temporarily deploy workers abroad also benefit from exemption agreements. Uninterrupted, relatively unbureaucratic insurance of their employees in the German social system is a major element of the international staff deployment, and hence of companies' success.

Binding regulations on the social insurance law that is applicable exclusively – beyond European Community law – can only be brought about by concluding bilateral social security agreements. Germany has hence been endeavouring for a long time to conclude social insurance agreements with economically-relevant partner states.

Fig. 22
No. of states with which Germany is linked by social insurance agreements and/or EU coordination law

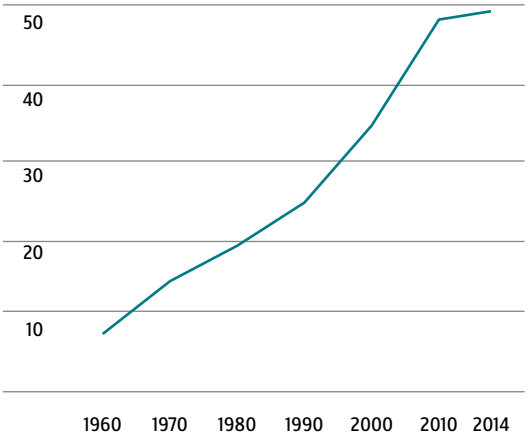


Illustration: National Association of Statutory Health Insurance Funds

Foreign trade links and exemption agreements

The number of exemption agreements with other states correlates with the main partners of German foreign trade. These include in particular the People's Republic of China and the USA. It is hence no coincidence that the DVKA reaches the largest number of exemption agreements with these two countries.

A relatively small number of exemption agreements are needed within the EU since European Community law provides special arrangements for persons who habitually work in several states. The trend towards internationalisation is currently continuing unabated. Social insurance agreements are therefore in preparation amongst others with Algeria and the Philippines, or they have already been signed. What is more, the agreement with Uruguay will be coming into force in 2015.

Fig. 23
Foreign trade turnover and exemption agreements

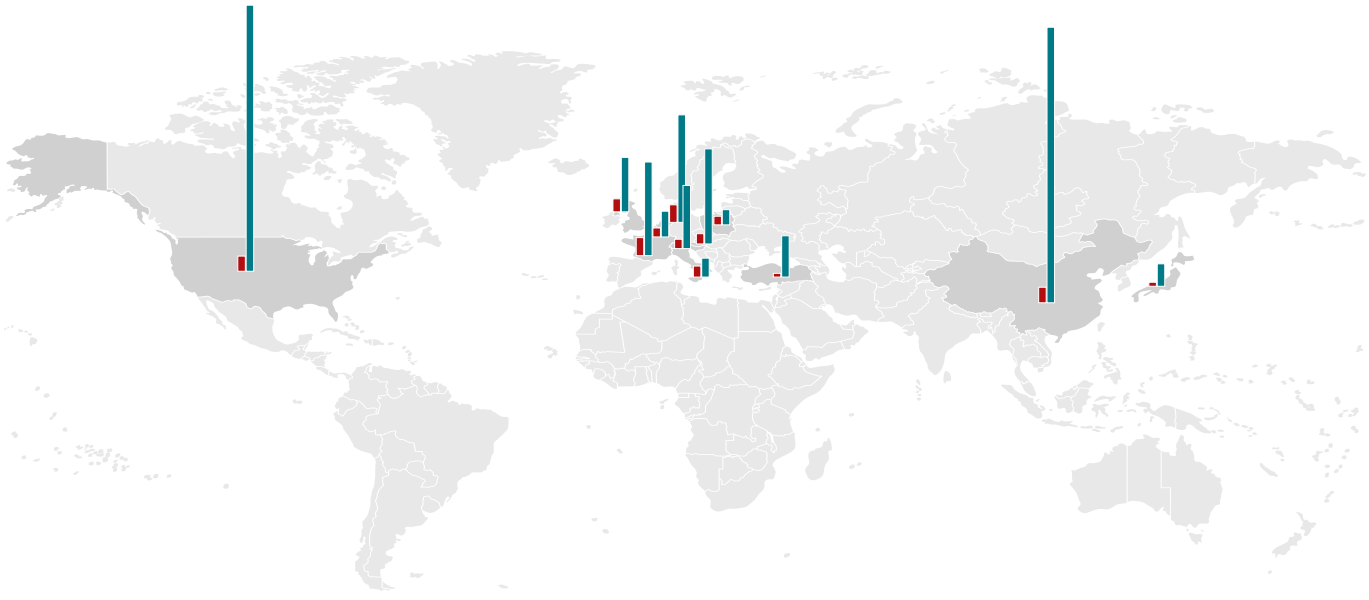


Illustration: National Association of Statutory Health Insurance Funds

Charles Drew was the first African American to obtain a doctorate in medicine, in 1940, with his research work on the drying and long-term storage of blood plasma. He was then immediately commissioned with organising the collection of US blood plasma to support the United Kingdom. Blood plasma can be transfused from any donor to any recipient regardless of the respective blood group – theoretically: The military guidelines applicable at that time prohibited blood transfusions between Whites and Coloreds. Drew resigned from the project as a result of the dispute on this racist policy and started to establish the Red Cross' civilian blood bank. The US Navy named a ship after him in 2010 in belated recognition.

Key topics of communication of the National Association of Statutory Health Insurance Funds

2014 was marked by the new Government coming into power. The communication of the National Association of Statutory Health Insurance Funds hence also concentrated on the many new legislative projects and reforms. The Association communicated its own view points and demands at press conferences, as well as in interviews and background discussions, including on the topics of out-patient and in-patient care, and on the topic of quality orientation in patient care.

New series of events entitled "Statutory health insurance live" ("GKV live")

The National Association of Statutory Health Insurance Funds very recently also started communicating and discussing its goals and positions within discussion events entitled "Statutory health insurance live – Dialogue with policy-makers". Since mid-2014, the Association has been organising irregular events on topical issues in the Association's new building in Reinhardtstraße. The first events in the series addressed the Act concerning the Further Development of Financial Structures and Quality, as well as the topics of long-term care reform and hospital care. Here, the Association's Board discussed with representatives from the political arena. The public also had the opportunity to take part in the discussion. The major interest in "Statutory health insurance live – Dialogue with policy-makers" shows that the National Association has set off in a new direction with the new event format. The series of events will be continued in 2015.

Statutory health insurance dialogue ("GKV-Dialog") with a new design

A further focus of the past communication year was on the online sector: GKV-Dialog, the members' portal of the National Association of Statutory Health Insurance Funds, has been presented in a new design since the end of November 2014. A completely revised information architecture, a modern design and new functions improve the portal in terms of its appearance and content. After more than one year of planning and development, it was possible for the GKV-Dialog portal to go online successfully at the end of November 2014. The project focussed on refining the entire portal, focussing on circular letters and meeting places. The new information architecture now consistently brings these areas into focus. New functions make it easier to find relevant information, and enhance user friendliness. With its modern design, GKV-Dialog has also been aligned with the series of online portals of the National Association of Statutory Health Insurance Funds in terms of its visual appearance. Hence all of the Association's major online projects are presented in a modernised, uniform appearance. A further focus of the project was the complete system conversion to modern software components. The conversion has provided a sound technical basis for the years to come.

Communication of the additional contribution rates

The topic of additional contributions became a focus of the Association's communications as per the end of 2014: As determined in the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance, the National Association of Statutory Health Insurance Funds has posted on its website since 1 January 2015 a daily-updated overview of all the health insurance funds' additional contribution rates. Furthermore, a Call Center was available to cope with increased numbers of insured persons' enquiries on the topic of the additional contribution. Active public relations rounds off the communication activities.

The APGAR score was developed and introduced in 1952 by **Virginia Apgar** as the first standardised test for newborns. Apgar, who was actually a surgeon, was unable to find employment in her field, and finally became specialised in the new field of anaesthesiology. She recognised when assisting in deliveries that the lives of many newborns could be saved if prenatal or birth damage could be discovered quickly and reanimation initiated immediately. Used as an aide-mémoire today, the APGAR test is a back-ronym for the five parameters that are examined (Appearance, Pulse, Grimace, Activity, Respiration).

The budget of the National Association of Statutory Health Insurance Funds

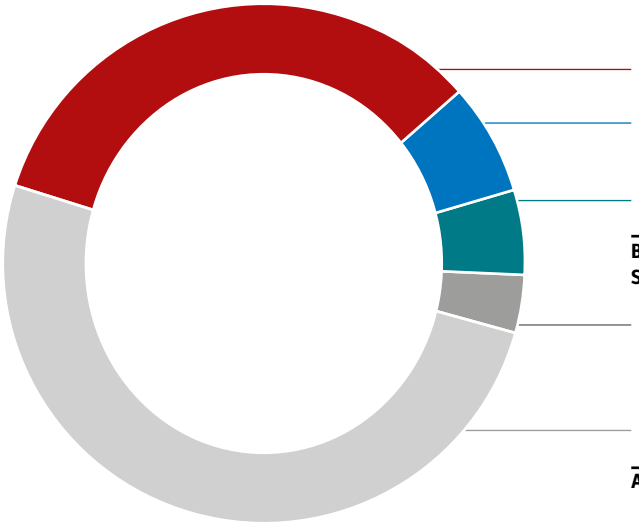
The annual financial statement for 2013
The financial statement of the National Association of Statutory Health Insurance Funds for 2013 was drawn up in April 2014. The audit of the annual financial statement, including the departmental budget of the German Liaison Agency Health Insurance – International (DVKA), was carried out by the BDO firm of auditors. The financial assets of the National Association of Statutory Health Insurance Funds were also audited in terms of their security and compliance with the standards. The firm of auditors issued an unqualified audit report. At its session that was held on 4 June 2014, the Administrative Council thereupon approved the activities of the Board and approved the 2013 annual financial statement.

The Association's budget for 2014
The 2014 budget plan of the National Association of Statutory Health Insurance Funds shows an overall budget of 156 million Euro. This includes the contribution towards the core budget of the National Association of Statutory Health Insurance Funds, minus the refunds from the refinancing of the start-up financing for the statutory health insurance communication server.
The following pay-as-you-go financing arrangements are also included:

- The DVKA departmental budget
- The Medical Service of the central association of the health insurance funds at federal level (MDS)
- Gesellschaft für Telematikanwendungen der Gesundheitskarte mbH (gematik)
- Tasks within data transparency that is prescribed by law
- Promotion of facilities for consumer and patient advice (UPD)

The expenditure planned for the 2014 budget for tasks within the data transparency that is prescribed by law amounting to 494,000 Euro is entirely funded from the allocation collected in 2013, since not all of the funds that had originally been planned in 2013 were drawn on by the German Institute of Medical Documentation and Information – DIMDI.

Fig. 24
Components of the Association's overall budget



Core budget	55,390,000 €	
Communication server	-2,675,000 €	
Core budget sum	52,715,000 €	
DVKA	10,689,000 €	
MDS	8,522,000 €	
Budget National Association of Statutory Health Insurance Funds	**71,926,000 €**	Cost per insured person 1.03 €
UPD	5,629,000 €	
Data transparency	0 €	
gematik	78,456,000 €	
Allocation – Further budget components	**84,085,000 €**	Cost per member 1.61 €
Association's overall budget for 2014	**156,011,000 €**	

Illustration: National Association of Statutory Health Insurance Funds

The budget for 2015

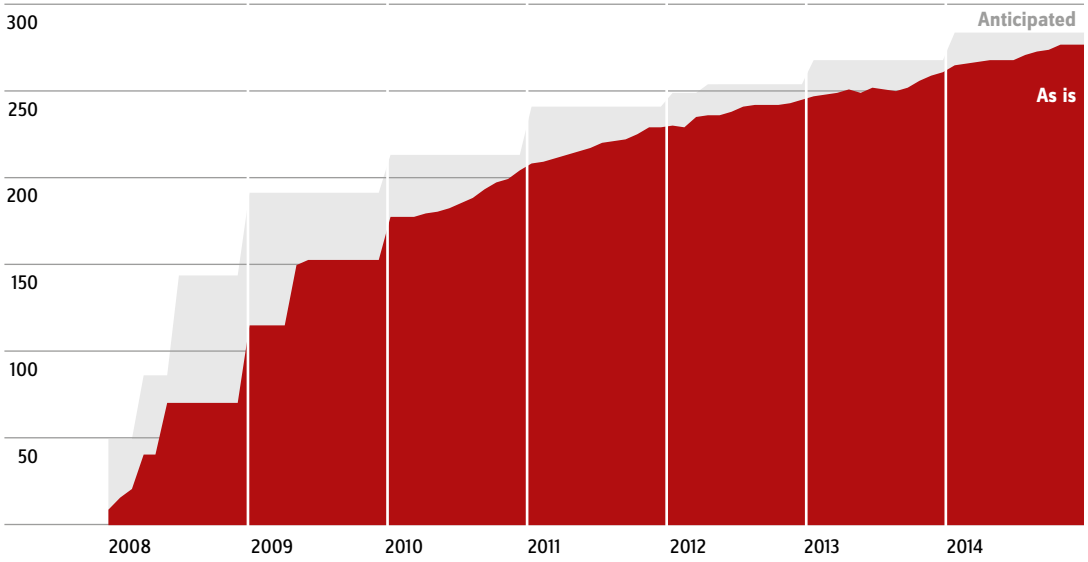
The budget plan for 2015 that was drawn up by the Board on 5 November 2014 was adopted unanimously by the Administrative Council of the National Association of Statutory Health Insurance Funds on 10 December 2014. The Association's overall budget was set at 137.1 million Euro. It hence fell by 18.9 million Euro vis-à-vis 2014. This is especially a result of the smaller allocation to gematik. The Administrative Council had furthermore decided that the payment of the gematik allocation requires its approval (budget freeze notice in accordance with section 10 subsection (2) sentence 1 of the Ordinance on Budget Management in Social Insurance (Verordnung über das Haushaltswesen in der Sozialversicherung). This budget freeze notice was rescinded at its special session held on 16 January 2015.

The administrative building of the National Association of Statutory Health Insurance Funds

After the National Association of Statutory Health Insurance Funds had relocated in 2013 to the administrative building in Reinhardtstraße 28 in Berlin-Mitte, which was initially rented, the building was purchased as per 1 June 2014 with the approval of the supervisory authority. Prior to the purchase, the purchase price was calculated by an independent expert in an assessment of current market value at that time.

Human resources activities of the National Association of Statutory Health Insurance Funds

Fig. 25
Staff development January 2008 to December 2014*



* without DVKA Division

Illustration: National Association of Statutory Health Insurance Funds

The staff employment plan was for a total of 383 established posts for 2014. 97 of these were accounted for by the German Liaison Agency Health Insurance – International (DVKA) in Bonn. The rate of occupied posts was 97.53 percent at the end of the year.

Report from the Administrative Council

The main topics of the deliberations of the Administrative Council and of its four specialist committees in 2014 included the reform plans, as well as the course set by the health and long-term care policy of the new Federal Government. The self-government bodies of the National Association of Statutory Health Insurance Funds once more made major contributions to the discussions on the refinement of the healthcare system, and lobbied with expertise and commitment for the interests of insured persons and contributors.

The plenary met in four quarterly sessions in the year under report. The coordination and content processing of the broad spectrum of topics, which encompasses both health and long-term care policy issues and focus areas within the Association, was carried out by the specialist committees in 16 routine and seven extraordinary sessions. This procedure, which concluded with a recommendation to the Administrative Council for a resolution, has proven its value, and has now become indispensable given the large number of topics to be covered. Furthermore, two workshops were held in the year under report.

Dialogue with the new Federal Minister of Health

In March 2014, roughly 100 days after taking office, the new Federal Minister of Health, Hermann Gröhe, attended the session of the Administrative Council and used this for an intensive exchange with members of the body. The Minister explained to the plenary the health policy goals of the Coalition Agreement, namely to create a framework for a consistent quality orientation in the out-patient and in-patient sectors and to secure the strengths of the system for the future. It was said that new

emphases were also to be expected for long-term care insurance, and that the necessary steps to introduce the new definition of need of long-term care should be implemented soon. The Minister outlined measures planned to implement the projects and discussed with the Administrative Council various aspects from the perspective of statutory health insurance and long-term care insurance. On the basis of the agreement reached in the Coalition Agreement, namely to strengthen self-government and to modernise the social elections, the Minister reported that steps were currently being considered to make clear the advantages and opportunities of direct involvement in the system of self-government. This was intended to position the value of participation more strongly in the awareness of the public. The Minister announced that he intended to pursue a dialogue on this matter with all parties concerned.

Shaping health together in Europe

The Administrative Council broke new ground with the positions on European health policy after the legislature had tasked the National Association of Statutory Health Insurance Funds in the previous year with defending the interests of the health insurance funds vis-à-vis supra- and international organisations and facilities. The coordination of the social security systems is a good example of sensible European cooperation in the interest of patients and contributors. The Administrative Council stressed that the structural principles of statutory health insurance – namely care orientated towards medical needs, as well as benefits in kind, solidarity and self-government – are decisive as guidelines for a patient-orientated healthcare system. On this basis, the National Association of Statutory Health Insurance Funds also defends the interests of insured persons and contributors in

the European context. It is also necessary to bear in mind here that the principles that are important for German statutory health insurance must not be torpedoed by decisions taken by the European Union.

Quality-orientated care management and remuneration

With its position paper entitled "Quality-orientated care management and remuneration", the Administrative Council, in analogy to the Coalition Agreement, focussed on the further development of in-patient quality assurance. It addressed specific claims to the legislature and to the Federal Joint Committee so that the quality of care will really improve. Furthermore, the Administrative Council favoured overcoming the sectoral limits in the interest of a transparent portrayal of quality in the in-patient and out-patient sectors. The National Association of Statutory Health Insurance Funds considers this to be implementable with the involvement of the newly-founded Institute for Quality.

Medical technology innovations in hospitals

The self-government bodies have once more addressed the ongoing need for regulation in dealing with medical technology innovations. In recent years, the Administrative Council already formulated proposals in order to sustainably increase safety in patient care in hospitals. The statutory provisions which have now been introduced are however insufficient to prevent new methods being applied in hospital care without prior investigation. In order to be able to counter this at short notice, in their position paper entitled "Medical technology innovations in hospitals", the self-government bodies have proposed to implement major improvements for patient safety in medical devices in social law. The proposals were sparked by the regulation announced in the Federal Government's Coalition Agreement, according to which hospitals are to be obliged to participate in studies with new high-risk-class medical devices. Beyond the recommendations that it has put forward, the Administrative Council however also considers a need to exist to make far-reaching legal changes at European level and to fundamentally reform the remuneration of medical services in Germany in order to make the way in which medical technology innovations are applied fit for the future, in the interest of patient safety.

Positions on the supply of medicinal products

Increasing demands from the pharmaceutical industry for changes to the control tools in the medicinal product sphere in its favour have caused the Administrative Council to take up a comprehensive position in this field. It has proposed a bundle of coordinated measures to assist further increases in the quality and economic efficiency of the supply of medicinal products. The ten fields of action that have been formulated are presented in detail on pages 51 et seqq.

Refining integration assistance

With a view to the Federal Benefits Act for People with Disabilities announced by the Government, which is expected to be adopted by 2016 at the latest, the Administrative Council addressed the topic of integration assistance. After detailed deliberations, it adopted a "Position paper on refining integration assistance – Federal Benefits Act". It was stressed as one of the core positions that the envisioned reform should focus on people with disabilities, and not on the financial interests of the *Länder*.

Position determination on the eHealth Card and on the telematics infrastructure

The introduction of the electronic healthcard (eHealth Card) and of the telematics infrastructure, as well as the problems which this entailed, were once more among the dominant topics on the agenda of the self-government bodies in the year under report. A workshop that was held in January 2014 concentrated on the still unsatisfactory overall development, as well as on possible ways of accelerating the implementation of the project and limiting the costs.

The visit by the new Minister of Health, Hermann Gröhe, at its March session was used by the Administrative Council to point out the problems. It stressed here its demand to the political arena to redefine the organisational and statutory framework for the project. Healthcare providers should be obliged to play a constructive, goal-orientated role in the processes. A public declaration based on these demands was also launched by the Administrative Council. At its session held in December, the representatives of the insured persons and employers however also had to sum up for 2014 that all the initiatives, discussions and appeals had not led to a solution. Whilst the development costs for the project have reached almost 1 billion Euro from contributions, it is still not possible to anticipate any added value ensuing from the card for insured persons. The Administrative Council furthermore strongly criticised the multiple burden on contributors caused by the establishment of high-cost parallel networks. When approving the budget for 2015, it refused to continue to take responsibility for the use of contributions which it considered not to be justifiable. The Administrative Council consequently froze the funds provided for the budget of gematik, amounting to roughly 57 million Euro. In addition to a broad media echo, this measure sparked the long-awaited political momentum: Directly prior to the special meeting of the Administrative Council in mid-January 2015, which took place in order to deliberate on the further procedure, the draft of an Act for Safe Digital Communication and Applications in the Healthcare System was announced.

The draft Bill contains unambiguous stipulations and sanctions for all the parties involved, and on a first reading appears to be suited, with the planned new regulations, to now stringently promote the establishment of a uniform telematics infrastructure. The Administrative Council considered this initiative to constitute a signal that the legislature had obviously taken criticism and demands from the self-government bodies seriously, and released the funding that had been frozen in December 2014. It confirmed in this context its conviction that the introduction of the eHealth Card and the telematics infrastructure was indispensable, and pointed out that in the further legislative procedure amongst other things a readjustment of the decision-making structures in gematik would have to be carried out in order to achieve this goal. The Administrative Council furthermore considered that there was considerable need to regulate the existing networks as competition for the telematics infrastructure, which are at least indirectly funded by contributions from insured persons and employers. This was said to no longer be acceptable in the interest of putting funds to economical use. The members of the Administrative Council finally agreed to discuss the new statutory provisions in detail in the coming committee sessions and to take up positions in order to help ensure that patients and contributors are able to fully benefit from the potential and resources of the telematics infrastructure, particularly when it comes to quality and economic efficiency.

Decision structures need to be created within gematik so that the National Association of Statutory Health Insurance Funds, as the sole provider of funds, is equipped with sufficient decision-making powers.

The members of the National Association of Statutory Health Insurance Funds 2014 (cut-off date: 1 January 2015)

1. actimonda krankenkasse
2. AOK – Die Gesundheitskasse für Niedersachsen
3. AOK – Die Gesundheitskasse in Hessen
4. AOK Baden-Württemberg
5. AOK Bayern – Die Gesundheitskasse
6. AOK Bremen/Bremerhaven
7. AOK Nordost – Die Gesundheitskasse
8. AOK NORDWEST – Die Gesundheitskasse
9. AOK PLUS – Die Gesundheitskasse für Sachsen und Thüringen
10. AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
11. AOK Rheinland/Hamburg – Die Gesundheitskasse
12. AOK Sachsen-Anhalt – Die Gesundheitskasse
13. atlas BKK ahlmann
14. Audi BKK
15. BAHN-BKK
16. BARMER GEK
17. Bertelsmann BKK
18. Betriebskrankenkasse der G. M. PFAFF AG
19. Betriebskrankenkasse PricewaterhouseCoopers
20. BIG direkt gesund
21. BKK 24
22. BKK Achenbach Buschhütten
23. BKK advita
24. BKK Aesculap
25. BKK Akzo Nobel Bayern
26. BKK B. Braun Melsungen AG
27. BKK Basell
28. BKK Beiersdorf AG
29. BKK BPW Bergische Achsen KG
30. BKK Braun-Gillette
31. BKK DEMAG KRAUSS-MAFFEI
32. BKK der MTU Friedrichshafen GmbH
33. BKK Deutsche Bank AG
34. BKK Diakonie
35. BKK EUREGIO
36. BKK EVM
37. BKK EWE
38. BKK exklusiv
39. BKK Faber-Castell & Partner
40. BKK family
41. BKK firmus
42. BKK Freudenberg
43. BKK Gildemeister Seidensticker
44. BKK GRILLO-WERKE AG
45. BKK Groz-Beckert
46. BKK HENSCHEL Plus
47. BKK Herford Minden Ravensberg
48. BKK Herkules
49. BKK KARL MAYER
50. BKK KBA
51. BKK Krones
52. BKK Linde
53. BKK MAHLE
54. BKK Melitta Plus
55. BKK MEM
56. BKK Miele
57. BKK Mobil Oil
58. BKK Pfalz
59. BKK ProVita
60. BKK Public
61. BKK Rieker.Ricosta.Weisser
62. BKK RWE
63. BKK Salzgitter
64. BKK Scheufelen
65. BKK Schleswig-Holstein
66. BKK Schwarzwald-Baar-Heuberg
67. BKK Stadt Augsburg
68. BKK Technoform
69. BKK Textilgruppe Hof
70. BKK VDN
71. BKK VerbundPlus
72. BKK Verkehrsbau Union (BKK VBU)
73. BKK VITAL
74. BKK vor Ort
75. BKK Voralb HELLER*LEUZE*TRAUB
76. BKK Werra-Meissner
77. BKK Wirtschaft & Finanzen
78. BKK Würth
79. BKK ZF & Partner
80. BKK_DürkoppAdler
81. BMW BKK
82. Bosch BKK
83. Brandenburgische BKK
84. Continentale Betriebskrankenkasse
85. Daimler Betriebskrankenkasse
86. DAK-Gesundheit
87. Debeka BKK

88. Deutsche BKK
89. DIE BERGISCHE KRANKENKASSE
90. Die Schwenninger Betriebskrankenkasse
91. E.ON Betriebskrankenkasse
92. energie-BKK
93. Ernst & Young BKK
94. HEK – Hanseatische Krankenkasse
95. HEAG BKK
96. Heimat Krankenkasse
97. hkk
98. IKK Brandenburg und Berlin
99. IKK classic
100. IKK gesund plus
101. IKK Nord
102. IKK Südwest
103. Kaufmännische Krankenkasse – KKH
104. Knappschaft
105. Merck BKK
106. Metzinger BKK
107. mhplus Betriebskrankenkasse
108. Novitas BKK
109. pronova BKK
110. R+V BKK
111. Salus BKK
112. SECURVITA BKK
113. SIEMAG BKK
114. Siemens-Betriebskrankenkasse (SBK)
115. SKD BKK
116. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
117. Südzucker-BKK
118. Techniker Krankenkasse
119. TBK
120. TUI BKK
121. Vaillant BKK
122. Vereinigte BKK
123. Wieland BKK
124. WMF Betriebskrankenkasse

Mergers in 2014 (cut-off date: 1 January 2015)

Merged funds	Merger partners
Novitas BKK	Novitas BKK, BKK PHOENIX
Deutsche BKK	Deutsche BKK, BKK ESSANELLE
Novitas BKK	ESSO BKK, Novitas BKK
DAK-Gesundheit	DAK-Gesundheit, Shell BKK/LIFE
BKK Verkehrsbau Union (BKK VBU)	BKK Verkehrsbau Union (BKK VBU), BKK MEDICUS
BIG direkt gesund	BKK Victoria-D.A.S., BIG direkt gesund
BKK Gildemeister Seidensticker	BKK BJB, BKK Gildemeister Seidensticker
BKK VerbundPlus	BKK Kassana, BKK VerbundPlus

Ordinary members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 2nd period of office (2012-2017)

Representatives of insured persons

Name	Health insurance fund
Balser, Erich	Kaufmännische Krankenkassen – KKH
Beier, Angelika	AOK Hessen
Bilz, Rosemie	Techniker Krankenkasse
Brendel, Roland	BKK Pfalz
Ermler, Christian	BARMER GEK
Güner, Günter	AOK Baden-Württemberg
Hamers, Ludger	BKK vor Ort
Hoof, Walter	DAK-Gesundheit
Katzer, Dietmar	BARMER GEK
Keppeler, Georg	AOK NORDWEST
Kirch, Ralf	BKK Werra-Meissner
Langkutsch, Holger	BARMER GEK
Linnemann, Eckehard	Knappschaft
Märtens, Dieter F.	Techniker Krankenkasse
Metschurat, Wolfgang	AOK Nordost
Moldenhauer, Klaus	BARMER GEK
Müller, Hans-Jürgen	IKK gesund plus
Reuber, Karl	AOK Rheinland/Hamburg
Römer, Bert	IKK classic
Schäfer, Günter (†)	DAK-Gesundheit
Schoch, Manfred	BMW BKK
Schösser, Fritz	AOK Bayern
Schulte, Harald	Techniker Krankenkasse
Strobel, Andreas	Siemens-Betriebskrankenkasse (SBK)
Stute, Hans-Peter	DAK-Gesundheit
Tölle, Hartmut	AOK Niedersachsen
Weinschenk, Roswitha	AOK PLUS
Wiedemeyer, Susanne	AOK Sachsen-Anhalt
Wittrin, Horst	HEK – Hanseatische Krankenkasse
Zahn, Christian	DAK-Gesundheit

Employer representatives

Name	Health insurance fund
Aust, Michael	Bertelsmann BKK
Avenarius, Friedrich	AOK Hessen
Blum, Leo	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
Chudek, Nikolaus	IKK Brandenburg und Berlin
Hansen, Dr. Volker	AOK Nordost
Hornung, Ernst	ESSO BKK
Jehring, Stephan	AOK PLUS
Kuhn, Willi	AOK Rheinland-Pfalz/Saarland
Landrock, Dieter	AOK Baden-Württemberg
Münzer, Dr. Christian	AOK Niedersachsen
Parvanov, Ivor	AOK Bayern
Reyher, Dietrich von	Bosch BKK
Schnurr, Hans-Jürgen	Kaufmännische Krankenkasse - KKH
Schrörs, Dr. Wolfgang	hkk
Schweinitz, Detlef E. von	Siemens-Betriebskrankenkasse (SBK)
Selke, Prof. Dr. Manfred	AOK Rheinland/Hamburg
Stehr, Axel	AOK NORDWEST
Tautz, Dr. Andreas	Deutsche BKK
Unzeitig, Roland	Techniker Krankenkasse
Wegner, Bernd	Techniker Krankenkasse
Wollseifer, Hans Peter	IKK classic

Deputy members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 2nd period of office (2012-2017)

Representatives of insured persons

Name	Health insurance fund
Aichberger, Helmut	DAK-Gesundheit
Aschenbeck, Rolf-Dieter	DAK-Gesundheit
Baer, Detlef	IKK Brandenburg und Berlin
Baki, Brigitte	AOK Hessen
Becker-Müller, Christa	DAK-Gesundheit
Berger, Silvia	IKK Südwest
Berking, Jochen	Deutsche BKK
Bink, Klaus-Dieter	AOK NORDWEST
Bumb, Hans-Werner	DAK-Gesundheit
Christen, Anja	BKK Verkehrsbau Union (BKK VBU)
Coors, Jürgen	Daimler Betriebskrankenkasse
Date, Achmed	BARMER GEK
Decho, Detlef	Techniker Krankenkasse
Dorneau, Hans-Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Feichtner, Richard	AOK Rheinland-Pfalz/Saarland
Fenske, Dieter	DAK-Gesundheit
Franielczyk, Peter	BARMER GEK
Friederichs, Günter	Shell BKK/LIFE
Gabler, Heinz-Joachim	Kaufmännische Krankenkasse – KKH
Goldmann, Bernd	BARMER GEK
Gosewinkel, Friedrich	Techniker Krankenkasse
Gransee, Ulrich	AOK Niedersachsen
Hachtmann, Götz-Wilhelm	SECURVITA BKK
Hauffe, Ulrike	BARMER GEK
Heinemann, Bernd	BARMER GEK
Hippel, Gerhard	DAK-Gesundheit
Hoppe, Klaus	Siemens-Betriebskrankenkasse (SBK)
Hüfner, Gert	Knappschaft
Hupfauer, Georg	BARMER GEK
Jena, Matthias	AOK Bayern
Karp, Jens	IKK Nord
Kemper, Norbert	AOK Rheinland/Hamburg

Name	Health insurance fund
Kindler, Dieter	IKK classic
Kloppich, Iris	AOK PLUS
Knerler, Rainer	AOK Nordost
Knöpfle, Manfred	BKK Stadt Augsburg
Korschinsky, Ralph	BARMER GEK
Krause, Helmut	BIG direkt gesund
Lambertin Knut	AOK Nordost
Leitloff, Rainer	DAK-Gesundheit
Lersmacher, Monika	AOK Baden-Württemberg
Lubitz, Bernhard	HEK – Hanseatische Krankenkasse
Matthesius, Dr. Rolf-Gerd	BARMER GEK
Muscheid, Dietmar	AOK Rheinland-Pfalz/Saarland
Salzmann, Rainer	BKK B. Braun Melsungen AG
Schiwnak, Bianca	Techniker Krankenkasse
Schmidt, Günther	BARMER GEK
Schneider, Norbert	Techniker Krankenkasse
Scholz, Jendrik	IKK classic
Schröder, Dieter	DAK-Gesundheit
Schuder, Jürgen	HEK – Hanseatische Krankenkasse
Schultze, Roland	hkk
Slovinec, Gertrude	Techniker Krankenkasse
Sonntag, Dr. Ute	BARMER GEK
Staudt, Alfred	AOK Rheinland-Pfalz/Saarland
Vater, Birgit	BARMER GEK
Vieweg, Johanna	Techniker Krankenkasse

Employer representatives

Name	Health insurance fund
Bauer, Egon	Kaufmännische Krankenkasse – KKH
Beetz, Jürgen	Die Schwenninger Betriebskrankenkasse
Bruns, Rainer	Techniker Krankenkasse
Dick, Peer-Michael	AOK Baden-Württemberg
Diehl, Mario	Kaufmännische Krankenkasse – KKH
Empl, Martin	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
Fitzke, Helmut	Techniker Krankenkasse
Gantz-Rathmann, Birgit	BAHN-BKK
Geers, Dr. Volker J.	BIG direkt gesund
Gemmer, Traudel	AOK Sachsen-Anhalt
Gural, Wolfgang	AOK Bayern
Henschen, Jörg	Techniker Krankenkasse
Heß, Johannes	AOK NORDWEST
Heymer, Dr. Gunnar	BKK BPW Bergische Achsen KG
Kastner, Helmut	IKK Nord
Köster, Hans-Wilhelm	AOK Rheinland/Hamburg
Kreßel, Prof. Dr. Eckhard	Daimler Betriebskrankenkasse
Kruchen, Dominik	Techniker Krankenkasse
Lang, Dr. Klaus	pronova BKK
Lübbe, Günther	hkk
Lunk, Rainer	IKK Südwest
Malter, Joachim	AOK Rheinland-Pfalz/Saarland
Nicolay, Udo	Techniker Krankenkasse
Nobereit, Sven	AOK PLUS
Reinisch, Dr. Mark	BKK Kassana
Schirp, Alexander	AOK Nordost
Söller, Wolfgang	AOK Bremen/Bremerhaven
Steigerwald, Claus	BKK Faber-Castell & Partner
Wadenbach, Peter	IKK gesund plus
Wilkening, Bernd	AOK Niedersachsen

Ordinary and deputy members of the specialist committees of the Administrative Council

Specialist committee on fundamental issues and health policy

Chaired by: Andreas Strobel*, Hans-Jürgen Müller*/Stephan Jehring (alternating)
* changing half-way through their period of office

Ordinary members

Employer representatives	Representatives of insured persons
1. Stephan Jehring (AOK)	1. Dieter F. Märtens (EK)
2. Axel Stehr (AOK)	2. Erich Balser (EK)
3. Roland Unzeitig (EK)	3. Klaus Moldenhauer (EK)
4. Leo Blum (SVLFG)	4. Horst Wittrin (EK)
5. Michael Aust (BKK)	5. Angelika Beier (AOK)
6. Hans Peter Wollseifer (IKK)	6. Fritz Schösser (AOK)
	7. Hans-Jürgen Müller (IKK)
	8. Andreas Strobel (BKK)

Deputy members

Employer representatives	Representatives of insured persons
Dr. Christian Münzer (AOK)	Roland Schultze (EK)
	1st deputy on the list for insured persons 1-4
Wolfgang Söller (AOK)	Gerhard Hippel (EK)
	2nd deputy on the list for insured persons 1-4
Udo Nicolay (EK)	Ralph Korschinsky (EK)
	3rd deputy on the list for insured persons 1-4
Martin Empl (SVLFG)	Hans-Peter Stute (EK)
	4th deputy on the list for insured persons 1-4
Detlef E. von Schweinitz (BKK)	Günter Güner (AOK)
	1st deputy on the list for insured persons 5-6
Rainer Lunk (IKK)	Georg Keppeler (AOK)
	2nd deputy on the list for insured persons 5-6
Helmut Kastner (IKK)	Knut Lambertin (AOK)
	3rd deputy on the list for insured persons 5-6
	Eckehard Linnemann (Knappschaft)
	1st deputy on the list for insured persons 7-8
	Roland Brendel (BKK)
	2nd deputy on the list for insured persons 7-8
	Dieter Kindler (IKK); bis 20.03.2013
	3rd deputy on the list for insured persons 7-8

Specialist committee on organisation and finance

Chaired by: Holger Langkutsch/Dieter Jürgen Landrock (alternating)

Ordinary members

Employer representatives	Representatives of insured persons
1. Dieter Jürgen Landrock (AOK)	1. Holger Langkutsch (EK)
2. Dr. Christian Münzer (AOK)	2. Walter Hoof (EK)
3. Dr. Wolfgang Schrörs (EK)	3. Rosemie Bilz (EK)
4. Leo Blum (SVLFG)	4. Georg Keppeler (AOK)
5. Detlef E. von Schweinitz (BKK)	5. Karl Reuber (AOK)
6. Peter Wadenbach (IKK)	6. Hartmut Tölle (AOK)
	7. Detlef Baer (IKK)
	8. Ralf Kirch (BKK)

Deputy members

Employer representatives	Representatives of insured persons
Sven Nobereit (AOK)	Klaus Moldenhauer (EK) 1st deputy on the list for insured persons 1-3
Prof. Dr. Manfred Selke (AOK)	Erich Balser (EK) 2nd deputy on the list for insured persons 1-3
Günther Lübbe (EK)	Dieter Schröder (EK) 3rd deputy on the list for insured persons 1-3
Martin Empl (SVLFG)	Richard Feichtner (AOK) 1st deputy on the list for insured persons 4-6
Dr. Andreas Tautz (BKK)	Annette Düring (AOK) 2nd deputy on the list for insured persons 4-6
Helmut Kastner (IKK)	Wolfgang Metschurat (AOK) 3rd deputy on the list for insured persons 4-6
Nikolaus Chudek (IKK)	Angelika Beier (AOK) 4th deputy on the list for insured persons 4-6
	Ludger Hamers (BKK) 1st deputy on the list for insured persons 7-8
	Silvia Berger (IKK) 2nd deputy on the list for insured persons 7-8
	Hans-Jürgen Dorneau (BKK) 3rd deputy on the list for insured persons 7-8

Specialist committee on prevention, rehabilitation and long-term care

Chaired by: Eckehard Linnemann/Nikolaus Chudek*, Dietrich of Reyher* (alternating)
* changing half-way through their period of office

Ordinary members

Employer representatives	Representatives of insured persons
1. Ivor Parvanov (AOK)	1. Harald Schulte (EK)
2. Prof. Dr. Manfred Selke (AOK)	2. Christian Ermler (EK)
3. Hans-Jürgen Schnurr (EK)	3. Günter Schäfer (EK)
4. Dietrich von Reyher (BKK)	4. Wolfgang Metschurat (AOK)
5. Dr. Andreas Tautz (BKK)	5. Roswitha Weinschenk (AOK)
6. Nikolaus Chudek (IKK)	6. Fritz Schösser (AOK)
	7. Eckehard Linnemann (Knappschaft)
	8. Manfred Schoch (BKK)

Deputy members

Employer representatives	Representatives of insured persons
Sven Nobereit (AOK)	Achmed Date (EK) 1st deputy on the list for insured persons 1-3
Johannes Heß (AOK)	Peter Franielczyk (EK); 2nd deputy on the list for insured persons 1-3
Helmut Fitzke (EK)	Christa Becker-Müller (EK) 3rd deputy on the list for insured persons 1-3
Ernst Hornung (BKK)	Susanne Wiedemeyer (AOK) 1st deputy on the list for insured persons 4-6
Michael Aust (BKK)	Angelika Beier (AOK) 2nd deputy on the list for insured persons 4-6
Peter Wadenbach (IKK)	Knut Lambertin (AOK) 3rd deputy on the list for insured persons 4-6
Helmut Kastner (IKK)	Karl Reuber (AOK) 4th deputy on the list for insured persons 4-6
	Roland Brendel (BKK) 1st deputy on the list for insured persons 7-8
	Bert Römer (IKK) 2nd deputy on the list for insured persons 7-8
	Jendrik Scholz (IKK) 3rd deputy on the list for insured persons 7-8

Specialist committee on contracts and care

Chaired by: Günter Güner/Ernst Hornung (alternating)

Ordinary members

Employer representatives	Representatives of insured persons
1. Dr. Volker Hansen (AOK)	1. Klemens, Uwe (EK)
2. Friedrich Avenarius (AOK)	2. Dietmar Katzer (EK)
3. Wolfgang Söller (AOK)	3. Hans-Peter Stute (EK)
4. Bernd Wegner (EK)	4. Helmut Aichberger (EK)
5. Ernst Hornung (BKK)	5. Günter Güner (AOK)
6. Rainer Lunk (IKK)	6. Susanne Wiedemeyer (AOK)
	7. Roland Brendel (BKK)
	8. Bert Römer (IKK)

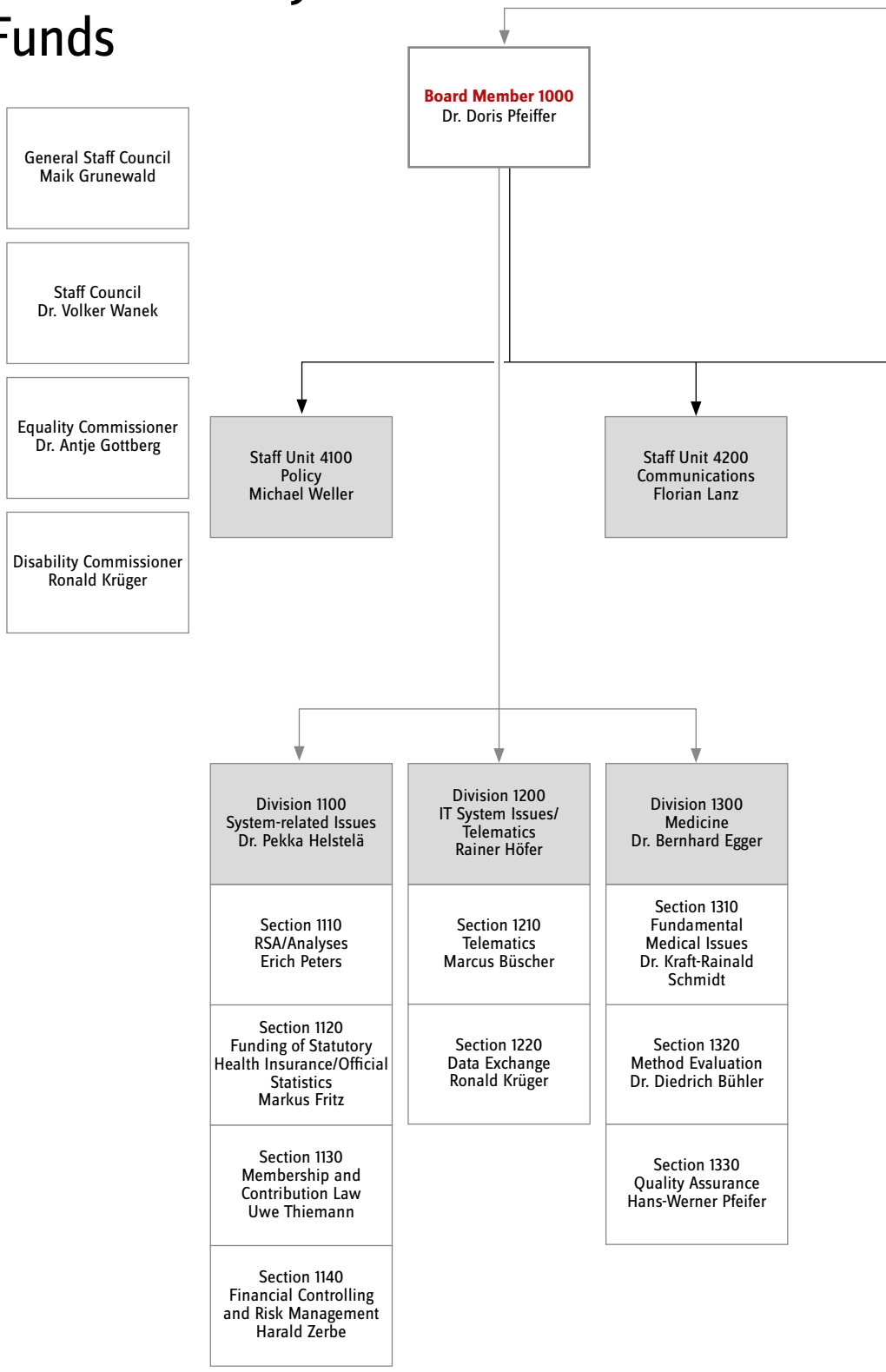
Deputy members

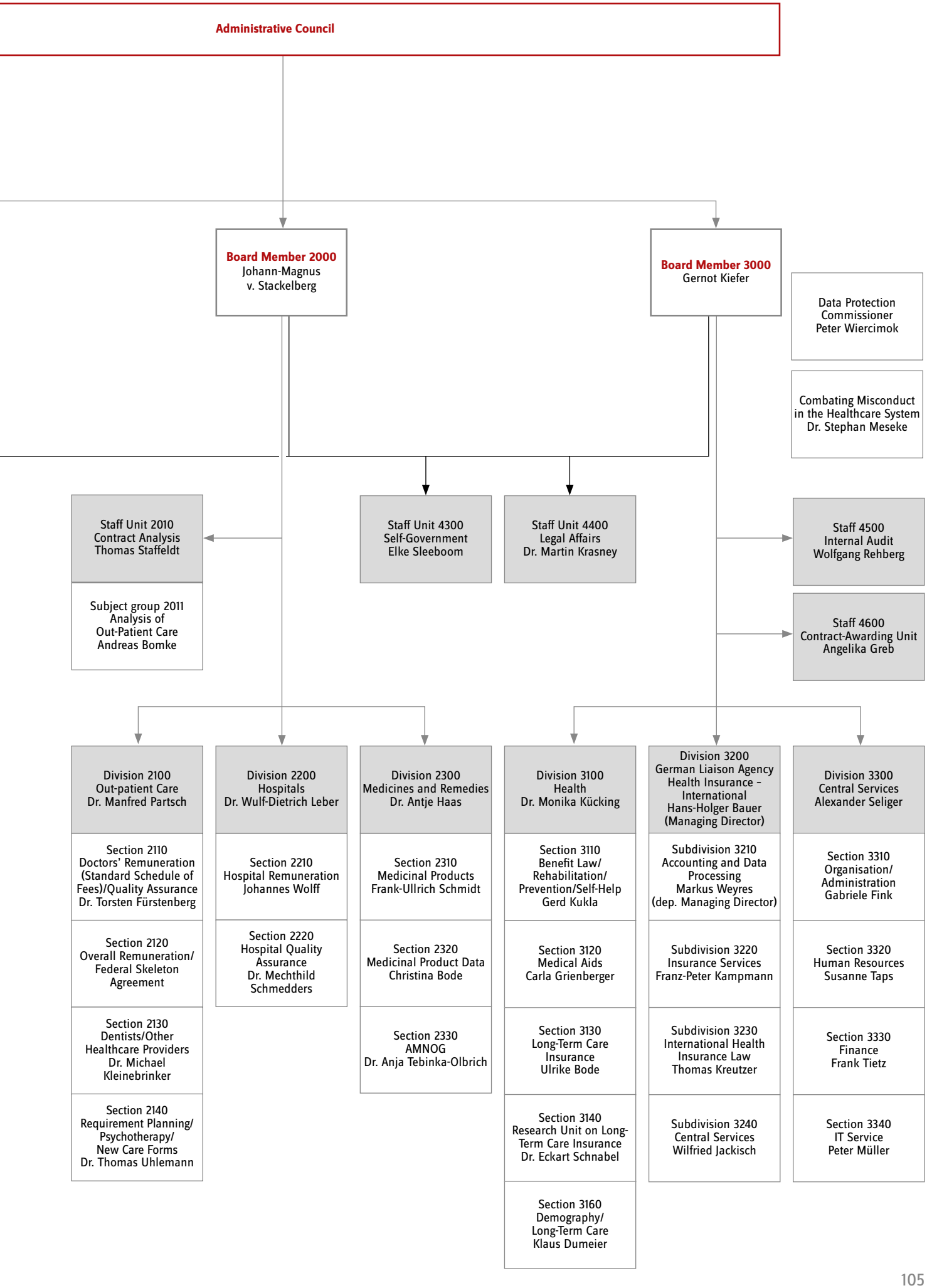
Employer representatives	Representatives of insured persons
Traudel Gemmer (AOK)	Roland Schultze (EK)
	1st deputy on the list for insured persons 1-4
Alexander Schirp (AOK)	Harald Schulte (EK)
	2nd deputy on the list for insured persons 1-4
Ivor Parvanov (AOK)	Ulrike Hauffe (EK)
	3rd deputy on the list for insured persons 1-4
Jörg Henschen (EK)	Dieter Fenske (EK)
	4th deputy on the list for insured persons 1-4
Dietrich von Reyher (BKK)	Wolfgang Metschurat (AOK)
	1st deputy on the list for insured persons 5-6
Nikolaus Chudek (IKK)	Fritz Schösser (AOK)
	2nd deputy on the list for insured persons 5-6
Peter Wadenbach (IKK)	Georg Keppeler (AOK)
	3rd deputy on the list for insured persons 5-6
	Roswitha Weinschenk (AOK)
	4th deputy on the list for insured persons 5-6
	Ludger Hamers (BKK)
	1st deputy on the list for insured persons 7-8
	Jens Karp (IKK)
	2nd deputy on the list for insured persons 7-8
	Gert Hüfner (Knappschaft)
	3rd deputy on the list for insured persons 7-8

Ordinary members and personal deputies of the Specialist Advisory Council of the National Association of Statutory Health Insurance Funds

	Members	**Deputies**
AOK	1. Jürgen Graalmann 2. Dr. Helmut Platzer	Uwe Deh Dr. Jürgen Peter
BKK	1. Franz Knieps 2. Achim Kolanoski	Andrea Galle Winfried Baumgärtner
Ersatzkassen	1. Ulrike Elsner 2. Dr. Jörg Meyers-Middendorf	Manfred Baumann Oliver Blatt
IKK	1. Jürgen Hohnl 2. Uwe Schröder	Frank Hippler Enrico Kreutz
Knappschaft	1. Bettina am Orde 2. Gerd Jockenhöfer	Dieter Castrup Jörg Neumann
Sozialversicherung für Landwirtschaft, Forsten und Gartenbau	1. Claudia Lex 2. Gerhard Sehnert	Reinhold Knittel Dr. Erich Koch

Organisational chart of the National Association of Statutory Health Insurance Funds




Administrative Council
Board Member 2000
Johann-Magnus
v. Stackelberg
Board Member 3000
Gernot Kiefer
Data Protection
Commissioner
Peter Wiercimok
Combating Misconduct
in the Healthcare System
Dr. Stephan Meseke
Staff Unit 2010
Contract Analysis
Thomas Staffeldt
Subject group 2011
Analysis of
Out-Patient Care
Andreas Bomke
Staff Unit 4300
Self-Government
Elke Sleeboom
Staff Unit 4400
Legal Affairs
Dr. Martin Krasney
Staff 4500
Internal Audit
Wolfgang Rehberg
Staff 4600
Contract-Awarding Unit
Angelika Greb
Division 2100
Out-patient Care
Dr. Manfred Partsch
Section 2110
Doctors' Remuneration
(Standard Schedule of
Fees)/Quality Assurance
Dr. Torsten Fürstenberg
Section 2120
Overall Remuneration/
Federal Skeleton
Agreement
Section 2130
Dentists/Other
Healthcare Providers
Dr. Michael
Kleinebrinker
Section 2140
Requirement Planning/
Psychotherapy/
New Care Forms
Dr. Thomas Uhlemann
Division 2200
Hospitals
Dr. Wulf-Dietrich Leber
Section 2210
Hospital Remuneration
Johannes Wolff
Section 2220
Hospital Quality
Assurance
Dr. Mechthild
Schmedders
Division 2300
Medicines and Remedies
Dr. Antje Haas
Section 2310
Medicinal Products
Frank-Ullrich Schmidt
Section 2320
Medicinal Product Data
Christina Bode
Section 2330
AMNOG
Dr. Anja Tebinka-Olbrich
Division 3100
Health
Dr. Monika Kücking
Section 3110
Benefit Law/
Rehabilitation/
Prevention/Self-Help
Gerd Kukla
Section 3120
Medical Aids
Carla Grienberger
Section 3130
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List of publications

Position papers of the National Association of Statutory Health Insurance Funds

Title	Publication date
Positionspapier des GKV-Spitzenverbandes zur aktuellen Diskussion der Reform der Eingliederungshilfe	July 2014
Gesundheit gemeinsam gestalten in Europa/Shaping health together in Europe	September 2014
Medizintechnische Innovationen im Krankenhaus: Nutzen- und Sicherheitsstudien	September 2014
Qualitätsorientierte Versorgungssteuerung und Vergütung	September 2014
10 Handlungsfelder für Qualität und Finanzierbarkeit der Arzneimittelversorgung	December 2014

Further publications by the National Association of Statutory Health Insurance Funds

Authors	Title	Publication date
Dr. Doris Pfeiffer, Johann Magnus v. Stackelberg, Gernot Kiefer (eds.)	**GKV-Lesezeichen 2014**	March 2014
Prof. Dr. Jonas Schreyögg et al.	**Forschungsauftrag zur Mengenentwicklung nach § 17b Abs. 9 KHG – Endbericht**	July 2014
Dr. Karsten Neumann, Patrick Gierling, Jean Dietzel/IGES Institut	**Gute Praxis in der ambulanten Versorgung. Anregungen für Deutschland auf Basis internationaler Beispiele**	July 2014
Dr. Uwe K. Preusker, Dr. Markus Müschenich, Sven Preusker	**Darstellung und Typologie der Marktaustritte von Krankenhäusern – Deutschland 2003–2013**	August 2014
PROGNOS	**Wirtschaftlichkeitsreserven im Rahmen der Bestimmung des Orientierungswertes nach § 87 Abs. 2g Nr. 2 SGB V**	August 2014
GKV-Spitzenverband und Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e. V. (eds.)	**Präventionsbericht 2014 Leistungen der gesetzlichen Krankenversicherung: Primärprävention und betriebliche Gesundheitsförderung Berichtsjahr 2013**	November 2014
GKV-Spitzenverband in Zusammenarbeit mit den Verbänden der Krankenkassen auf Bundesebene	**Leitfaden Prävention. Handlungsfelder und Kriterien des GKV-Spitzenverbandes zur Umsetzung der §§ 20 und 20a SGB V vom 21. Juni 2000 in der Fassung vom 10. Dezember 2014**	December 2014

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