Spitzenverband

WE ARE FACING UP TO THE BIG QUESTIONS

Self-government for the future

Annual Report 2017

Imprint

Published by:
GKV-Spitzenverband
Körperschaft des öffentlichen Rechts
Reinhardtstraße 28, D-10117 Berlin

Tel.: 030 206288-0
Fax: 030 206288-88
e-mail: kontakt@gkv-spitzenverband.de
Internet: www.gkv-spitzenverband.de
Twitter: @GKV_SV

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 German 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 2017.

Editorial deadline: 10 April 2018
Editors: René Kircher, Florian Lanz, Verena Schröder (image editing),
Elke Sleeboom, Michael Weller (responsible)
Coordination: René Kircher
Translator: Neil Mussett
Design: BBGK Berliner Botschaft Gesellschaft für Kommunikation mbH
Printed by: Polyprint GmbH, Berlin
Photo credits on page 127

Order number 2018-004

Self-government for the future

Annual Report 2017

Annual Report 2017

Foreword by the Chairmen of the Administrative Council

Dear Readers,

After an extended phase of government-forming, the CDU, the CSU and the SPD have laid in the political course that is to be steered during the new legislative period in the Coalition Agreement entitled "A new start for Europe. A new dynamic for Germany. A new cohesiveness for our country". In the view of the National Association of Statutory Health Insurance Funds, everything now hinges on how the new governing coalition will implement the health and long-term care policy projects in concrete terms.

The existing challenges are known: They range from inflexible sectoral boundaries, through medical care that is frequently uncoordinated as well as alleged innovations the advantage of which does not undergo testing at all stages of their development, to the obvious misallocation of benefits. The necessary structural reforms will have to tackle these issues in the interest of patients and insured persons.

Not only are the challenges known; concrete suggestions for solutions have also already been put forward: The Administrative Council of the National Association of Statutory Health Insurance Funds has drawn up comprehensive positions, such as for the reform of cross-sectoral out-patient care, or for the re-organisation of emergency care under one roof. The implementation of these and other necessary care projects should be tackled as a matter of urgency in the interest of improving quality and ensuring that healthcare can be sustainably funded.

The work done by self-government is indispensable here. The legislature is right to leave the design of healthcare and long-term care, as well as the resolving of issues that are frequently highly specific, to social self-government at the level of the health insurance funds, and to joint self-government, such as in the Federal Joint Committee (G-BA). Balanced decisions are taken here, in each case taking account of the interests of patients, insured persons and contributors, as well as with the involvement of the healthcare providers. The best treatment available is useless if no one can afford it. This sometimes difficult balancing act can only be performed if the different interests are brought into harmony.

The framework for self-government needs to be enhanced in order to enable it to continue to lobby responsibly for care to be provided to insured persons and patients, as well as to persons in need of long-term care, that is orientated towards meeting health and long-term care needs, as well as doing justice to the great expectations arising in the political arena. Political declarations of intent to retain and enhance self-government are not sufficient; they also need to be implemented. A real trend reversal is now needed after the most recent legislative interference, which has done more to weaken self-government than to enhance it.

We are therefore calling on policy-makers and self-government to engage in a more intensive exchange. We should jointly clarify what expectations self-government has of policy-makers, and vice versa. How is the relationship between self-government and supervision to be balanced out? What framework does self-government need in order to shape care in a manner that is orientated towards medical needs? The goal must be to develop shared ideas of cooperation and the future rights to take part in will-formation. Self-government is ready to engage in this dialogue with policy-makers.

Yours faithfully,

Dr. Volker Hansen Uwe Klemens

Foreword by the Board

Dear Readers,

With our Annual Report, we take a look back over the past year. Even though things have settled down when it comes to legislation after the first six months of the year, the reforms continue to have an effect regardless of the legislative periods. One example that is worth mentioning is the hospital reform, the implementation of which by the self-government partners in line with the legislative stipulations will take at least until well into 2018.

If we take a look back somewhat further over the entire four years of government in the last legislative period, we see that the high level of density of legislative activities was unusual in almost all areas of care, even for systems that are as accustomed to reforms as are statutory health and long-term care insurance. The focus of the previous Coalition Agreement on quality and structural reforms was promising. Progress was achieved in some areas, such as the establishment of the Institute for Quality Assurance and Transparency in the Healthcare System. Structural measures that are beneficial to quality were however not effectively addressed in legislative reality. There is still an uncoordinated juxtaposition of specialised doctors working in out-patient care and in hospital out-patient clinics. Emergency medical care remains badly organised from the point of view of patients. What is more, the shortage of investment funding provided by the Länder for the clinics was once again passed on to the contributors by the most recent clinic reform.

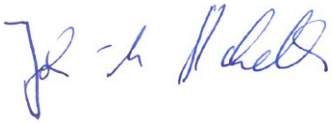
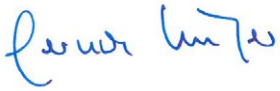
The really rather expensive reforms only rarely lead to tangible improvements for patients in terms of everyday care. The financial input is certainly disproportionate to the health output. It was possible at the beginning of 2017 to effect the transfer to the new definition of need for long-term care in social long-term care insurance with virtually no problems. This introduced improvements in services, in particular for people with dementia. The basic re-orientation was implemented by the Health Insurance Medical Service with considerable success.

Statutory health insurance is currently in good financial health thanks to the persistently flourishing financial situation. The community of insured persons has furthermore reached a new peak in terms of its size due to immigration, and is becoming "younger" and "healthier" for the first time. Policy-makers should not now give in to the temptation to start distributing financial handouts in the new legislative period, but should realise that the stability of statutory health insurance is largely based on the extraordinarily robust economic situation, and that it is by no means written in stone that such a positive development will last forever.

There is an urgent need to make use of the currently good situation of statutory health insurance for structural measures. This entails a requirement to consistently orientate out-patient and in-patient care towards providing patients with high-quality, economical medical care. In order to better interlink the fields of care, there is a need amongst other things for cross-sectoral needs planning. This can be started in the growing border area between out-patient and in-patient care. After the successful conversion to levels of long-term care, the question arises in long-term care even more urgently than ever as to the long-term carers required. Sets of measures should be quickly agreed on, with the involvement of all stakeholders, which improve the framework and working conditions of specialist long-term carers, as well as of family caregivers. There will therefore also be a need here to make the training occupation more attractive.

The Administrative Council of the National Association of Statutory Health Insurance Funds explained in detail, and addressed to policy-makers in its position paper for the new legislative period, how the further development of statutory health insurance and social long-term care insurance can be achieved in the context of the processes of change that are constantly underway in society. The National Association of Statutory Health Insurance Funds will lobby those with political responsibility for good, affordable care to be provided to the more than 70 million individuals who have statutory insurance, and will call for the necessary changes to be made.

Yours faithfully,

Dr. Doris Pfeiffer
Chairwoman of the Board

Johann-Magnus v. Stackelberg
Deputy Chairman of the Board

Gernot Kiefer
Member of the Board

For a modern healthcare system: Enhancing self-government

Social self-government is distinguished by being close to insured persons and patients, and is hence always also a representation of the patients.

Self-government is a central element of the social consensus in Germany. As an underlying principle of the political system, it is entrenched at various levels: at local level, in the professional organisations, in social insurance and in academic circles. Social self-government, with its objectives and tasks, is a modern tool of direct involvement in statutory health and long-term care insurance, by both insured persons and employers, in a system that is based on solidarity, roughly 95 % of which is funded from work earnings and pensions.

Close to insured persons and patients

The actions of social self-government are led by its commitment to the insured persons. It is characterised by its closeness to insured persons and patients. Supply bottlenecks, as well as the problems and interests of insured persons, can thus be registered and taken into account. This enables social self-government to always represent patients too. In doing so, it must take into account the entire breadth of healthcare and long-term care. A major task is to ensure that a balance is struck between care demands on the one hand, and the responsibilities of the representatives of insured persons and employers vis-à-vis the funds, on the other. This is a unique feature. Political discussions about greater patient involvement at self-government level, involving the creation of a new class of officials dealing with patients, bring this balancing of interests into question. This would endanger decisive health and long-term care policy tools, particularly affecting self-government as an economic management principle (economic efficiency). It also remains open whether, given the balancing of interests that would continue to be necessary, different decisions might ultimately be arrived at. Moreover, whilst the representatives of social self-government are democratically legitimated by means of social elections, patients' organisations do not have this kind of legitimation.

Who is self-government in statutory health insurance?

Self-government in statutory health insurance

Social self-government (social partnership)

section 29 subsection (2) of Book IV of the Social Code

- employers' representatives
- insured persons' representatives

Joint self-government

section 91 of Book V of the Social Code, amongst other provisions

- cost funding institutions
- healthcare providers
- highest decision-making body: Federal Joint Committee

Putting an end to state influence

There is a need to put an end to the interference coming from the legislature, which encroaches on the autonomy of self-government with repeated new powers of instruction and supervision. Confusion is also caused by the rising trend from legal supervision towards specialist supervision. This is intended to restrict the activities of the health insurance funds, of the National Association of Statutory Health Insurance Funds, of the Medical Service of the National Association of Statutory Health Insurance Funds (MDS), and also of the Federal Joint Committee (G-BA). Some policy-makers misjudge here the fact that social self-government particularly remains the relevant economic and social steering level in the healthcare system, between the market and the State. It suitably takes account of the particularities of the health market, and lends concrete shape to the principle of the social welfare state in material terms for those who are directly affected, that is insured persons, be they patients or contributors. Legislation that leads to greater interference on the part of the State, or to the commercialisation of health or long-term care, endangers social statutory health and long-term care insurance.

Putting the subsidiarity principle into practice

It is in the application of the regulatory political principle of subsidiarity in designing healthcare and long-term care that lies the strength of the German healthcare system and of statutory long-term care insurance: The legislature focuses on the stipulation of goals and on the creation of the requisite statutory framework in which self-government then acts on its own responsibility. An unambiguous profession of this regulatory policy principle is therefore needed in the new legislative period.

A main task is to guarantee that a balance is struck between care demands and responsible use of funds by the representatives of insured persons and employers.

Joint self-government on the Federal Joint Committee

State legal supervision (Federal Ministry of Health)

▼

Federal Joint Committee

Chair	• **Chairperson** • **2 non-partisan members**
with voting rights	• **5 representatives of statutory health insurance** National Association of Statutory Health Insurance Funds • **5 representatives of the healthcare providers** German Hospital Federation, National Association of Statutory Health Insurance Physicians, National Association of Statutory Health Insurance
entitled to speak and table motions	• **5 patients' representatives**

More options for action and rights to take part in will-formation

Such an acknowledgement is not the whole story, however: The self-government of the health and long-term care insurance funds, as well as of the National Association of Statutory Health Insurance Funds, aspires to optimise care structures, to implement health and long-term care concepts as they are needed, and to quickly provide insured persons with process and product innovations that have been tested as to the benefit which they contribute. There is also a need to make progress in the digitalisation of the healthcare system, as well as of long-term care. Health insurance funds therefore need the necessary scope for more control via competition. The National Association of Statutory Health Insurance Funds needs a framework for negotiation at the level of joint self-government, making quality stipulations binding and setting the stage for more distributive justice and greater economic efficiency. The maxim for the new legislative period must therefore be: A modern, sustainable healthcare system needs more options for health insurance funds, and at the same time more rights to take part in will-formation in social self-government.

A modern, sustainable healthcare system needs more options for health insurance funds, and at the same time more rights to take part in will-formation in social self-government.

The Federal Joint Committee, a model for success

The Federal Joint Committee proves in joint self-government at federal level that the implementation of tasks assigned by law in the balancing of interests works. In times of continuous change, and in light of benefits which are being launched on the healthcare market more and more rapidly, it is proven on a day-by-day basis that it is able to take decisions in a sounder and more patient-orientated manner than could be done by either the legislature or by centralist state medical authorities. The Federal Joint Committee is a model for success. There is potential for improvement in individual areas at most: in strengthening the nomination of the non-partisan representatives by the funding institutions of the Federal Joint Committee on their own responsibility, in refining the communication of the resolutions, and in improving the preparation of the resolutions for patients. At the same time, the independence and legitimation of the patients' representation absolutely must be enhanced and examined for the nomination of the respective representatives. It should be ensured that the Federal Joint Committee will also continue to be able to decide on its own responsibility. This is however at odds with the direct co-determination of the executive in the joint self-government bodies. The tried-and-tested separation of the tasks between self-government and legal supervision must be retained.

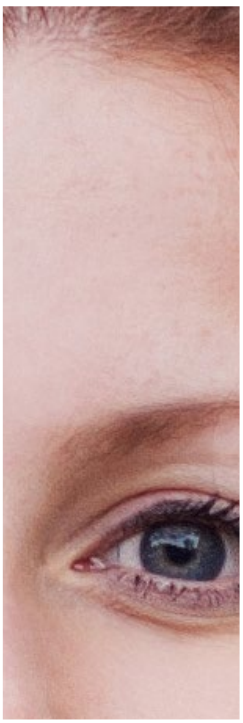
The Health Insurance Medical Service does good, independent work

The Health Insurance Medical Service (MDK), including the Medical Service of the National Association of Statutory Health Insurance Funds (MDS), is the social medical service in statutory health and long-term care insurance. It draws up individual medical reports, as well as fundamental reports in the sense of system support. There have recently been calls in the public debate to re-organise the Health Insurance Medical Service in both staffing and content terms, and to separate it from the health and long-term care insurance funds. The repeatedly alleged dependence on the health insurance funds only exists to the extent, and as is necessary, that the legislature makes express provision for this. The Health Insurance Medical Service is to enable the health insurance funds to make their contribution towards economical funding of proper care for insured persons in line with the medical state-of-the-art in terms of quality where they cannot do so on the basis of their own resources.

The Health Insurance Medical Service enjoys considerable, growing esteem among experts. One example of this is the service done by the Health Insurance Medical Service in the implementation of the long-term care reform. Without the functional, self-governed structures of the Health Insurance Medical Service, the goals of the legislature could not be achieved. The recent survey carried out among insured persons shows that 89 % of insured persons consider the assessors from the Health Insurance Medical Service to be competent, and 92 % find them to be helpful and friendly. Roughly 90 % are satisfied with the assessment. The number of objections is consistently in the single-digit percentage range. The assessors of the Health Insurance Medical Service are independent in terms of their assessment and advice. This independence is guaranteed in Book V of the German Social Code (SGB V). The health and long-term care insurance funds have no influence on the content of the assessments. The highest priority attaches to the expertise and independence of the individual assessments. The assessment itself takes place on the objective basis of the principles of evidence-based medicine in accord with social law. Separating it from the health and long-term care insurance funds in organisational terms, or realigning the Health Insurance Medical Service, is wrong in socio-political and legal systematic terms, and would entail massive risks; the principle of self-government would be undermined even further. In fact, statutory health insurance also continues to need a well-functioning Health Insurance Medical Service.

The health and long-term care insurance funds have no influence on the content of the assessments. The highest priority attaches to the expertise and independence of the individual assessments.

WHO REPRESENTS MY INTERESTS?



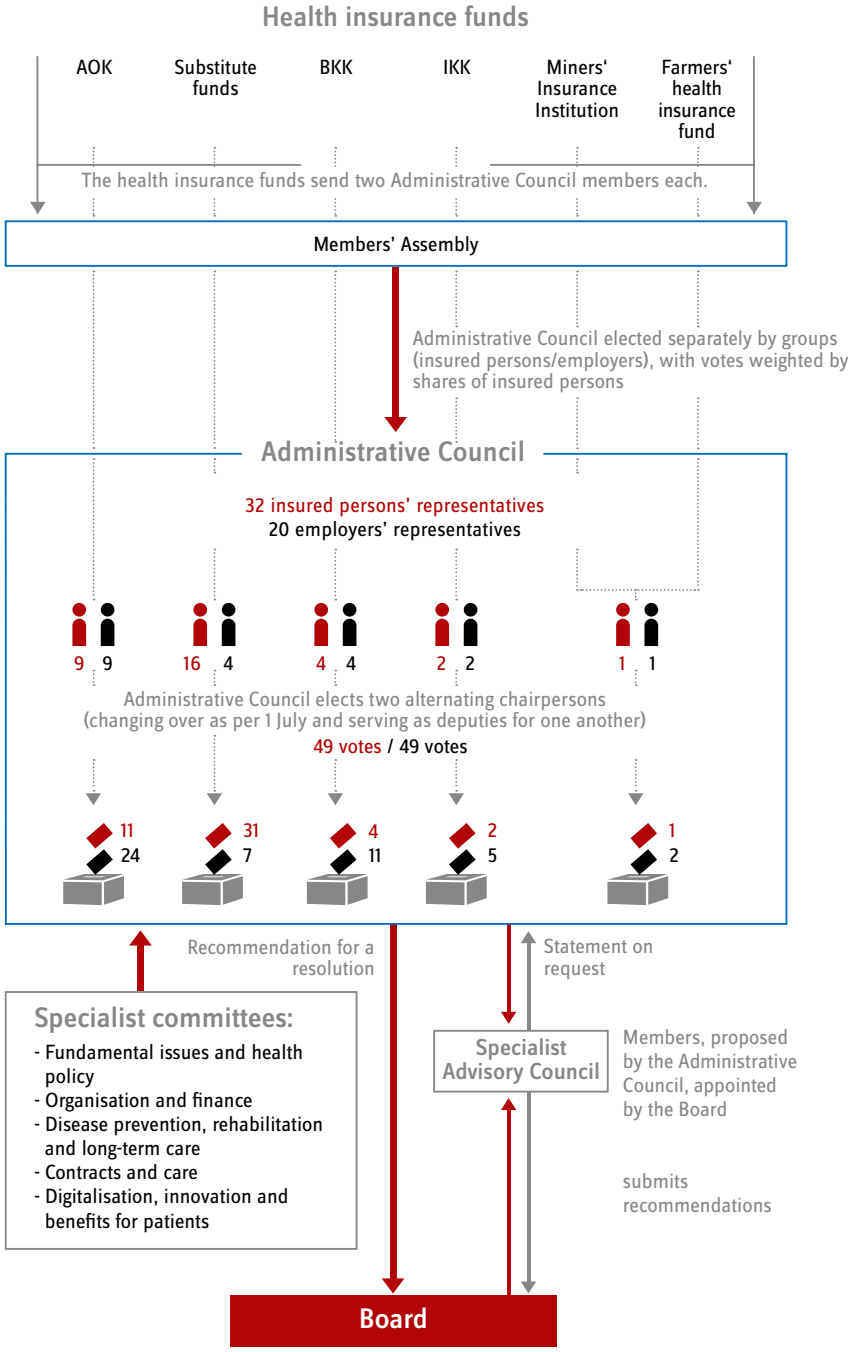
The Members' Assembly elects the Administrative Council of the 3rd period of office (2018-2023)

2017 was the year of the social elections. The members of the self-government bodies were elected for the twelfth time at the funding institutions of statutory health, pension and accident insurance. The newly-constituted administrative councils of the statutory health insurance funds sent their insured persons' and employers' delegates to the Members' Assembly of the National Association of Statutory Health Insurance Funds, which re-elected the Administrative Council of the National Association of Statutory Health Insurance Funds for a period of six years on 13 December 2017. This launched the third period of office of self-government of the National Association of Statutory Health Insurance Funds. Roughly 130 voluntary representatives of more than 70 health insurance funds came together in Berlin. They jointly underlined the pivotal role played by statutory health insurance for high-quality, reliable healthcare in Germany.

Self-government shoulders responsibility

In light of the profound social changes caused by globalisation, migration, as well as demographic and digital transformation, considerable importance attaches to the tried-and-tested statutory health insurance principles of solidarity, benefits in kind and self-government. As the voice of patients, persons in need of long-term care, insured persons and contributors, the National Association of Statutory Health Insurance Funds makes an active contribution to social cohesion. The self-government bodies successfully faced up to this responsibility, as stressed by the Chairwoman of the Members' Assembly, Iris Kloppich (AOK PLUS), in her opening speech, who went on to thank the Administrative Council of the second period of office for its committed work. She was joined in this by the Chairwoman of the Board of the National Association of Statutory Health Insurance Funds, Dr. Doris Pfeiffer. She called on policy-makers to make a clear commitment to social self-government.

The structure of the new Administrative Council



Source and illustration: National Association of Statutory Health Insurance Funds

"The goal was and continues to be to ensure good, affordable care at all times for the more than 70 million citizens who have statutory health insurance."

Dr. Doris Pfeiffer, Chairwoman of the Board

The election of the new Administrative Council

The delegates elected the representative of insured persons Roswitha Weinschenk (AOK PLUS) as the Chairwoman of the Members' Assembly, and the employers' representative Dietrich von Reyher (Bosch BKK) as her deputy. The members of the Administrative Council of the third period of office (2018-2023), including their deputies, were elected in more than twenty regular ballots. The Administrative Council for the second period of office adopted the distribution of seats and votes for the new plenum back in March 2017, in accordance with the Statutes. The Administrative Council will continue to have 52 mandates, as has been the case since 2012. There have however been changes among the types of fund with regard to the number of seats caused by funds merging and by changes in the market shares.

Constituting meeting

The new Administrative Council of the National Association of Statutory Health Insurance Funds started its work with its constituting meeting held in Berlin on 17 January 2018. Dr. Volker Hansen (AOK Nordost) was elected as Chair from among

"One of our key tasks is to maintain the efficiency of the healthcare system, but also to further develop its foundations in a manner that is sustainable and equitable to all generations."

Iris Kloppich, Chairwoman of the Members' Assembly

the employers. He has held the chair since the National Association of Statutory Health Insurance Funds was established. The Administrative Council elected Uwe Klemens (Techniker Krankenkasse) as the alternating Chairman from the group of representatives of insured persons. He replaced Christian Zahn as Chairman of the Administrative Council at the beginning of 2016.

New specialist committee on digitalisation

The new Administrative Council furthermore elected the members and chairpersons of the existing four specialist committees on Fundamental issues and health policy, Organisation and finance, Contracts and care, as well as Disease prevention, rehabilitation and long-term care. Furthermore, a fifth specialist committee on Digitalisation, innovation and benefits for patients was established. The digital transformation has also been underway in the healthcare system for a long time, and is increasingly being incorporated into day-by-day care. Potentials and risks therefore also need to be balanced from the perspective of statutory health insurance and their insured persons and contributors.

Report from the Administrative Council

As an integral element of the democratic structure in Germany, social self-government represents broad swathes of the population with a wide variety of needs in healthcare and long-term care. Given its closeness to patients, insured persons and contributors, its representatives have a specific problem awareness enabling them to formulate authentic, highly-practical solutions which fit the realities of the lives of those concerned. Self-government guarantees an equitable balance of interests, and is therefore very well accepted among those concerned. In a highly-dynamic healthcare system, it is able to bring together traditional values with new developments. This enables it to relieve the burden on policy-makers, and offers it a good, reliable foundation for opinion-forming and legislation.

Self-government guarantees a fair balance of interests, and therefore is very well received among those concerned.

The work of the committees focussed in the first half of the year under report on drawing up and adopting Positions for the 19th legislative period. In order to give the process a direction and depth, the Administrative Council implemented a workshop in March 2017 at which it addressed the questions, prospects and expectations that were relevant in terms of health and long-term care policy in an intensive and differentiated manner, and agreed on the concrete orientation of the positioning. After the details had been fleshed out by its specialist committees, in June 2017 the Administrative Council adopted the position paper of the National Association of Statutory Health Insurance Funds for the 19th legislative period 2017 to 2021. The paper describes the action to be taken in health policy, and at the same time sets the course for the work of the National Association of Statutory Health Insurance Funds in the years to come. It is a committed plea to develop the healthcare system along future-orientated lines and to safeguard its fundability in a sustainable manner. With its position, the Administrative Council takes a stance on the necessary basis for statutory health insurance that is able to perform, the challenges of the future and the design options in the fields of action of statutory health and social long-term care insurance.

In addition to taking up a position on the 19th legislative period in the run-up to the Bundestag elections, the Administrative Council considered that there was a need for legislative action to be taken on further topics in the year under report.

Innovations and patient safety

Statutory health insurance wishes to see to it that all persons with statutory insurance benefit from medical progress in equal measure. Medical innovations are to be available to all insured persons as quickly as possible. This however makes it indispensable for the patient-relevant benefit of the innovations to be proven before they are introduced across the board, given the absolute priority attaching to patient safety. Only then is it also justified for them to be funded by the community of solidarity. Against this background, the Administrative Council already adopted a position paper in December 2010, and explained how non-drug innovations can be introduced into hospital care in a structured, safe manner. The legislature has reacted to this to some degree. It has for instance included a "probationary arrangement for non-drug innovations" in Book V of the Social Code, and created a provision in accordance with which individual high risk-class medical devices are subjected to systematic evaluation and testing by the Federal Joint Committee. This and other statutory amendments contain positive approaches, but are insufficient as a whole, and are not comprehensively effective. The core problem has not been eliminated: Only very few new methods are systematically assessed at an early date. Most are introduced into care without any adequate data basis. They can be offered across the board, above all by hospitals, even if the benefit for, or indeed harm caused to patients is unclear. The stocktake with regard to the existing probationary arrangements is therefore sobering. The Administrative Council hence considered that there was a need for the legislature to take further steps, and has refined its positions from 2010 and adjusted them in line with current circumstances.

Only very few new methods are systematically assessed at an early date. Most are introduced into care without any adequate data basis.

Emergency care

The many health policy debates that have recently been engaged in for emergency care have revealed the considerable pressure for reform that exists in this area. Most parties have recognised that there is a need to take a holistic, cross-sectoral view of emergency care in order to overcome the existing problems. This includes amongst other things the creation of patient-orientated structures. After intensive discussions were held at all advisory levels of the National Association of Statutory Health Insurance Funds,

the Administrative Council adopted a detailed position paper in the year under report containing informed reflection on and proposals for a comprehensive reorganisation of emergency care.

Cross-sectoral care

The further development of cross-sectoral out-patient care must be a central element of future health policy. The existing care structures, institutions as well as planning and billing systems at the sectoral boundaries of out-patient and in-patient care have grown historically. If a care system is to be sustainable, it must focus on the interests of both patients and contributors, and may not get lost in demarcation issues at this crosspoint. Many billions of extra Euros flow into healthcare every year. These contributions must benefit higher-quality, more economic healthcare for patients. A reform of the care structures cannot be realised in one step, but should take place as part of a phased model. As a first stage, the Administrative Council has therefore put forward reform proposals aimed at refining cross-sectoral out-patient care. The core of the proposals is to refine participation by hospital out-patient clinics in out-patient care in the interest of the patients.

Many billions of extra Euros flow into healthcare every year. These contributions must benefit higher-quality, more economic healthcare for patients.

The Federal Centre for Health Education

As provided for in the Disease Prevention Act (Präventionsgesetz), the National Association of Statutory Health Insurance Funds adopted an agreement with the Federal Centre for Health Education in June 2016 relating to support for the health insurance funds in providing health promotion and disease prevention benefits in settings. In cooperation with the associations of the health insurance funds at federal level, a total of nine individual contracts were awarded to the Federal Centre for Health Education. Despite considerable constitutional reservations, the National Association of Statutory Health Insurance Funds met its statutory obligation with regard to funding the Federal Centre for Health Education. A stocktake in the year under report however made it clear that the agreed goals had been fallen short of by a considerable margin. A large share of the money that had been made available was not spent by the Federal Centre for Health Education. Accordingly, it was not possible to spend funds from statutory health insurance amounting to roughly 46 million Euro on health promotion in settings. The Administrative Council has therefore called on the legislature to rescind the obligation incumbent on the National Association of Statutory Health Insurance Funds to commission the Federal Centre for Health Education, and to make the funds from statutory health insurance directly available for the implementation of the Disease Prevention Act. It recommended that the funds be directly spent on enhancing social situation-based health promotion and disease prevention, instead of sitting unused in the bank account of a lower Federal authority.

The autonomy of the self-government bodies

The Act to Enhance Self-Government in Statutory Health Insurance (GKV-Selbstverwaltungsstärkungsgesetz; GKV-VSG) came into force in March 2017. This was preceded by a long legislative procedure which had been flanked by committed, critical debates at all levels. The many submissions and contributions, in particular from the Administrative Council of the National Association of Statutory Health Insurance Funds, ultimately led to the considerable restrictions of the autonomy of the self-government bodies that had initially been planned in the National Association of Statutory Health Insurance Funds and the other self-government organisations at federal level being considerably reduced in the final phase of the legislative procedure. A number of pivotal provisions which had provoked particularly severe criticism were no longer included in the Act. Self-government is nonetheless restricted by new rights of control and instructions given to the supervisory bodies in the Act to Enhance Self-Government in Statutory Health Insurance. The Administrative Council adopted amendments and addenda to the Statutes in the final meeting that was held in the second period of office in November 2017 that were necessitated by the new provisions in accordance with the Act to Enhance Self-Government in Statutory Health Insurance.

The restrictive impact of the Act to Enhance Self-Government in Statutory Health Insurance constitutes a further step towards the State exerting influence on self-government. A restriction of the autonomy of the self-government bodies that took place with the Statutory Health Insurance Care Structure Act (GKV-Versorgungsstrukturgesetz) from 2011 had its greatest effect in joint self-government in 2017: In accordance with the statutory stipulation that was introduced at that time, the Federal Ministry of Health forwards the proposals of the funding organisations for the appointment of the non-partisan chairperson and of the further non-partisan members of the Federal Joint Committee to the Committee on Health of the German Bundestag. The Committee is able to object to the proposal, with a two-thirds majority, after a hearing of the proposed individual has been held in camera. In June, the Bundestag's Committee on Health unanimously rejected the personnel proposal of the National Association of Statutory Health Insurance Funds for the office of the non-partisan member of the Federal Joint Committee. The Administrative Council gave voice to its astonishment in this regard, and considered the vote of the Committee on Health as constituting a drastic encroachment by policy-makers on the actions of self-government. Since the candidate of the medical profession had also been rejected, the two funding organisations each nominated new candidates in a new nomination procedure who were not objected to by the Bundestag's Committee on Health.

A large share of the money that had been made available was not spent by the Federal Centre for Health Education. Accordingly, it was not possible to spend funds from statutory health insurance amounting to roughly 46 million Euro on health promotion in settings.

Self-government will also have to face complex tasks in the new period of office that will need to be carried out in the interest of patients as well as of insured persons. Self-government needs the appropriate competences in order to do so. The Administrative Council is therefore in favour of a constructive dialogue with policy-makers in order to jointly bring about a balanced relationship between framework legislation and will-forming.

Jubilee: It is the birthday of the National Association of Statutory Health Insurance Funds

2017 was a particularly significant year for the National Association of Statutory Health Insurance Funds: The Association celebrated the tenth anniversary of its establishment. Adopted in March 2007 in the Act to Improve Competition in Statutory Health Insurance (GKV-Wettbewerbsstärkungsgesetz), the new Association of all health insurance funds was established within only a few months of that, with effect as per 1 July 2007.

The National Association of Statutory Health Insurance Funds celebrated this joyful occasion on 12 December 2017 by holding a jubilee celebration on the eve of the Members' Assembly. Roughly 450 guests from the political arena, the healthcare system and self-government answered the invitation to come to the Maritim Hotel in Berlin. During this celebration, the Chairwoman of the Board Dr. Doris Pfeiffer looked back onto the past decade, and recalled governments, laws and major projects. At the same time, she looked forward to current challenges for statutory health insurance.

The two alternating chairpersons of the Administrative Council, Dr. Volker Hansen and Uwe Klemens, then gave an insight into the work of self-government. In a discussion with Rebecca Lüer, who chaired the evening, Dr. Hansen recalled the not always simple beginnings of the Association, which had started off by being an "unloved child" for the health insurance funds. It was nonetheless possible to refer to the development of the Association in retrospect as a success story. Uwe Klemens agreed with him, and was also in favour of attracting more people to take up voluntary office, saying that they were the "backbone of self-government".

A central element of the celebration was a speech given by the Chairman of the German Ethics Council, Prof. Dr. Peter Dabrock. He addressed the significance of statutory health insurance for social security in Germany. He explored not only the relevance of statutory health insurance for social participation, but also the challenges posed by a digital society.

The celebration was flanked by much-applauded performances by a choir made up of staff from the National Association of Statutory Health Insurance Funds. Eight colleagues serenaded the Association on its birthday, and later gave of their best by singing the "Medicinal Product Song". The staff performance was rounded off with a solo performance of the song entitled "Stroganoff", composed by Friedrich Hollaender. At the same time, the song marked the transition to the social part of the evening, which was used for a lively exchange. To close with, the guests received the jubilee edition of the statutory health insurance magazine "90 percent" – a retrospective of ten lively years of the Association's history, hot off the presses.


2007
2017
erband


2007
2017
Spitzenverband

HOW CAN CARE BECOME BETTER?

A stocktake of the 18th legislative period

Even if health and long-term care policy has always been accustomed to reform, and still is, the large number of laws in the 18th legislative period from 2013 to 2017 was nonetheless unusual. This ultimately reflected the high degree of detail in health and long-term care policy, on which the governing parties had agreed in the Coalition Agreement, and which had now also been implemented almost in full.

The Grand Coalition started the 18th legislative period with the intention of particularly focussing its actions on improving quality in almost all areas of care. Given the large number of statutes that were adopted, policy-makers may not be accused of a lack of will to reform. Having said that, fundamental shortcomings in care and structural problems were only inadequately tackled with the reforms, which were frequently entitled as strengthening or structural statutes. By contrast, a real paradigm shift was brought about in long-term care insurance through the introduction of the new definition of need for long-term care.

Structural problems remain

Little or nothing has changed with regard to the well-known structural problems arising in out-patient and in-patient care, which manifest themselves most clearly in expensive over-capacities that are not required in order to satisfy demand. The statutes that have been launched here have virtually no impact, and also lack cross-sectoral aspects in order to break open and better interlink the encrusted, uncoordinated structures. Above all, the lack of investment funding in hospitals on the part of the Federal Länder was not tackled. This leads to a situation in which contributions continue to be misappropriated to make up for gaps in investment. Other statutes that have been launched in the areas of disease prevention, medicinal products, remedies and medical aids will make care more expensive without contributing to any major improvements in healthcare.

The "Act to Enhance Self-Government" (Selbstverwaltungsstärkungsgesetz) must be regarded as inappropriate and as being contrary to its title. Massive state encroachments were prevented in the legislative procedure at the last minute, but it marks a new high point in the exercise of state influence on the autonomy of the self-government bodies.

It can therefore be stated in an overall view that, given the favourable financial framework in statutory health insurance, there are many places in which the course has not been adequately and consistently set. Against this background, as well as taking into account continuous, highly-dynamic change processes – one need only mention digitalisation, demographic developments, changes at work, the rural exodus or the change in the spectrum of diseases – the Administrative Council of the National Association of Statutory Health Insurance Funds adopted its positions on health and long-term care policy in good time before the start of the new legislative period and introduced them into the political debate.

Fundamental shortcomings in care and structural problems were only inadequately tackled.

Positions for the 19th legislative period

The increasing pace of economic, social, technical and medical change processes poses a great number of challenges for the healthcare system for the years to come. The National Association of Statutory Health Insurance Funds is playing an active role in the necessary further development of the German healthcare system. With the health and long-term care policy positions that have been adopted by the Administrative Council, the National Association of Statutory Health Insurance Funds is pointing to necessary reforms and showing the way towards sustainable, high-quality and economical health and long-term care.

Enabling flexibility whilst safeguarding quality

The current regulatory framework needs to be made more flexible for optimised healthcare in order to intensify the interplay of collective and selective agreements. What is largely lacking for the health insurance funds is sufficient possibilities to be able to offer their insured persons high-quality healthcare services. There is therefore a need for more competitive design freedoms. The consultation rights of the health insurance funds also need to be further enhanced.

The current structures of cross-sectoral cooperation need to be assessed and reformed in the new legislative period, and emergency care needs to be reorientated.

The current structures of cross-sectoral cooperation need to be assessed and reformed in the beginning legislative period, and emergency care needs to be reorientated. There are problems not only between out-patient and in-patient care, but there is also a need for reform within the sectors. Excess capacities and capacity shortfalls in out-patient care exist side by side. The reduction of expensive excess capacities must be continued in order to create better access to registered contract care that is orientated towards needs. Forms of cooperative care such as medical care centres are also to be systematically further strengthened. Where infrastructural conditions are difficult, hospital out-patient clinics should be involved as standard and operate as regional health centres.

There is a need to make a new start in the in-patient sector, in particular when it comes to funding. In order to organise hospital care along high-quality, economical lines, the Länder need to comply with their investment obligation. Pricing should be readjusted in order to limit the years of unjustified increases in the respective base rates in the Länder – over and above the hospitals' actual costs. Staffing allocations need to be defined for quality-critical areas and situations. It needs to be possible to monitor that they are complied with. Minimum amounts must be binding as an important tool of quality assurance.

Seizing the opportunities of digitalisation

New paths need to be opened up in healthcare and long-term care; care processes should be modernised, as well as communication and service improved. The chances offered by digitalisation are to be used for this. Very considerable importance attaches to the introduction of electronic medical records as part of digitalisation. The secure telematics infrastructure needs to be used for this as the central infrastructure, and further expanded. The decision-making structures at gematik need to be streamlined. The design responsibility of the health insurance funds needs to be expanded, as they have responsibility for funding. Quality standards need to be created for digital care services and apps. The medical care situation can be improved in rural or structurally-weak regions by using telemedical applications.

Ensuring sustainable funding and economic efficiency

The good situation on the labour market and stable economic growth are currently ensuring a sound financial basis for statutory health insurance. The phase of financial stability should be used in order to enact sustainable structural reforms in expenditure management that will continue to protect insured persons against additional financial burdens should the economy fall into decline. The contribution from the Federation should also be regularly indexed, and the reserve of the Health Fund should be capped. Financial

overstraining must be ruled out when assessing the contribution for "solo self-employed" persons. Changes in earnings biographies should be taken into account. The shift in the burden from the Federation to the community of solidarity when it comes to contributions for beneficiaries of employment benefit II who have statutory insurance should be ended.

The phase of financial stability should be used in order to enact sustainable structural reforms in expenditure management.

Transparency as to benefit and prices is vital when it comes to the supply of medicinal products for affordable care at a high level of quality. Indications of economic efficiency must already be available when medicinal products are prescribed. The fundamental principle of benefit evaluation followed by negotiations on refund amounts has proven its usefulness. There is a need here for the refund amounts to be retroactive across-the-board from day one in order to avoid fictitious prices. There is no doing without discount contracts between health insurance funds and pharmaceutical companies for the opening up of efficiency reserves. These must be strengthened in the new legislative period.

Positions on the future of social long-term care insurance

A paradigm shift took place in long-term care in 2017, as well as in social long-term care insurance, as a result of the introduction of the new definition of need for long-term care. After long, intensive preparations carried out in academic fields, in the legislature and in self-government, all persons in need of long-term care have now received equal access to the benefits of long-term care insurance since 1 January 2017, regardless of whether they suffer from physical, mental or psychological impairments. This particularly applies to people with cognitive or psychological restrictions such as dementia. The economic framework has also been improved: The amount of the benefits has increased, and eligibility to take up benefits has been made more flexible and improved. Benefits can now be taken up much more individually and in terms of need than was previously the case. The decisive measures for markedly reducing the burden on persons in need of long-term care and their relatives have thus been completed.

There is a need for intelligent solutions enabling family caregivers to reconcile work, family and long-term care better than has been the case in the past.

The National Association of Statutory Health Insurance Funds has actively supported this paradigm shift in its various stages of implementation and reform, and has accompanied it via model projects. Taking a look at the coming long-term care policy, the National Association of Statutory Health Insurance Funds favours monitoring the establishment and impact in the long term and subjecting it to scientific evaluation as to whether the goals of "greater participation" and "fairer distribution of the burdens" are actually being achieved.

Strengthening long-term care staff and family caregivers

From the point of view of the National Association of Statutory Health Insurance Funds, there is also a need to focus more closely on those who provide long-term care. Sufficient, well-qualified staff are vital when it comes to providing good, dignified long-term care. Action therefore needs to be taken to increase the attractiveness of the long-term care professions. Suitable remuneration is a major contribution in this direction. However, family-friendly working conditions and flexible working hours are important here too. Long-term care provided by relatives is also a major resource in this context that requires protection. There is a need for intelligent solutions enabling family caregivers to reconcile work, family and long-term care better than has been the case in the past. The National Association of Statutory Health Insurance Funds considers that the various support opportunities for family caregivers must be combined in a statute in a manner that makes sense and is practicable.

There is no disputing the fact that the number of persons in need of long-term care will continue to rise in future, and with it the challenge arising when it comes to ensuring that long-term care is orientated towards the needs of those concerned. The desire of people in need of long-term care and assistance to continue to live a self-determined life in their familiar settings as long as possible must guide the actions of the common objective of close cooperation between the Länder, local authorities, long-term care insurance funds and long-term care providers. One-sidedly shifting and mixing the responsibility for managing and funding between the players does not lead to the achievement of this goal, and is hence rejected by the National Association of Statutory Health Insurance Funds.

Positions on the reorganisation of the border area between out-patient and in-patient care

The further development of cross-sectoral out-patient care must be a central building block of health policy in the coming legislative period. The existing care structures, institutions as well as planning and billing systems at the sectoral limits of out-patient and in-patient care have developed historically, and leave room for improvement. A sustainable care system must prioritise both the interests of patients as well as those of contributors, and may not become lost in demarcational issues and in institutional questions.

Concrete recommendations for action for reorganisation are shown both in the positions of the National Association of Statutory Health Insurance Funds for the 19th legislative period, and in the position paper entitled "Reform proposals for refining cross-sectoral out-patient care". In content terms, the National Association of Statutory Health Insurance Funds favours in a first step tackling the further development of cross-sectoral out-patient care. The objectives of such a reform are:

- to introduce cross-sectoral needs planning in order to guarantee proper and full access and corresponding capacities,
- to use sector-independent, more case-based lump-sum remuneration structures in order to avoid misincentives in care, and
- to apply seamless quality assurance in order to rule out placing patients at risk.

Clearly regulate the tasks to be performed by hospital out-patient clinics

There has been controversial discussion again and again in this context regarding the role of the hospital out-patient clinics: Depending on how they are viewed, they are either part of the problem or part of the solution. The future role of hospital out-patient clinics must therefore be included in the consideration as part of a reform of cross-sectoral out-patient care. The National Association of Statutory Health Insurance Funds considers that the roughly two-dozen legal provisions in accordance with which out-patient clinics may operate should be strictly re-worded in line with the following three principles:

A sustainable care system must prioritise both the interests of patients as well as those of contributors.

1. If hospital out-patient clinics are empowered to compensate for shortcomings in registered contract care, the regulations on registered contract care, such as those relating to remuneration and quality assurance, are to be applied in full, and supplemented by unambiguous empowerment criteria.
2. If specialised, specific care benefits are provided both by out-patient clinics and by specialised contract doctors, the outlined cross-sectoral management, incl. of joint needs planning, and of a standard remuneration system, is needed.

Between out-patient and in-patient care – The role of the hospital out-patient clinics

Supplementary registered contract care	Equivalent service provision	Highly-specialised out-patient clinic care
Compensating for shortcomings in care	**Avoiding misallocations and excess capacities**	**Creating transparency and defining supply obligations**
· empowerment based on need at all times · remuneration based on Standard Schedule of Fees at all times · clear definition and demarcation of the supply obligations · counted towards needs planning	· cross-sectoral capacity management · time-limited supply obligations · uniform price, quantity and quality assurance system	· simplified documentation, structural requirements and remuneration · strict definition of the supply obligations

3. If highly-specialised out-patient care is provided largely or exclusively by hospital out-patient clinics thanks to quality considerations or because of the need to satisfy specific structural requirements, the list of benefits must at last be clearly defined and made transparent by means of uniform documentation and remuneration standards.

The information from such a first stage of reform must be used exclusively in order to reform specialised care as a whole in the medium term and then to put an end to the duplication of care provision along the sectoral limit existing between out-patient and in-patient care.

13 positions on refining cross-sectoral out-patient care

1. clarify the care function of out-patient clinics
2. empower hospital out-patient clinics as supplementary registered contract care in case of shortcomings in care
3. design cross-sectoral out-patient care as provided by contract doctors as well as hospital out-patient clinics as part of joint self-government
4. plan needs for specialised out-patient benefits on a cross-sectoral basis
5. impose a sunset clause on supply obligations for equivalent benefits of contract doctors as well as hospital out-patient clinics
6. formulate supply obligations in concrete terms
7. provide standard remuneration for specialised out-patient treatment
8. enable fair price and volume developments
9. establish cross-sectoral quality assurance
10. define highly-specialised out-patient clinic care
11. create transparency for the "blackbox" hospital out-patient clinic
12. clearly regulate the use of innovations
13. orientate emergency care towards patients

Positions on the re-structuring of emergency care

There is virtually no health policy topic which is currently being discussed as intensively as emergency care. A reform of emergency care could be found in almost all the party manifestos for the 2017 Bundestag election. The council of experts on the assessment of developments in the healthcare system, as well as the associations of healthcare providers, have also taken up a position on this topic. Building on its Positions for the 19th legislative period, the National Association of Statutory Health Insurance Funds has also drawn up a resolute concept for re-structuring emergency care.

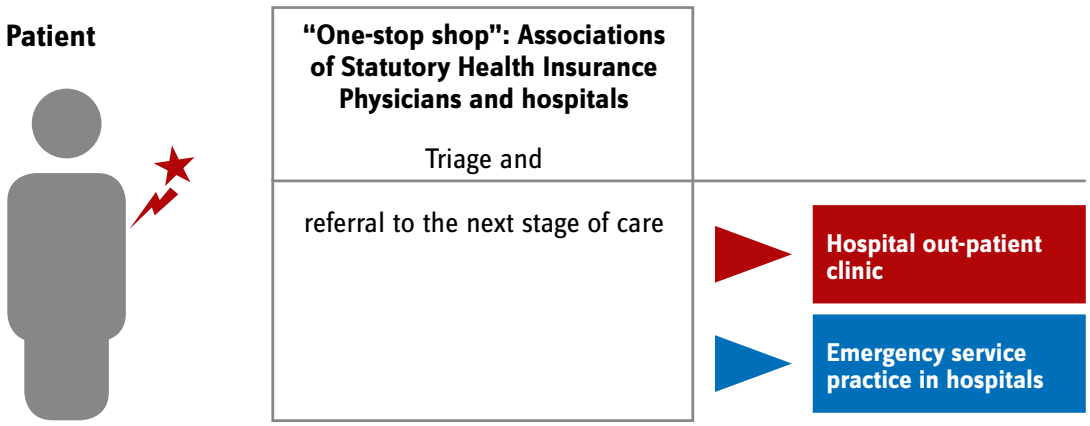
Re-structuring emergency care

Emergency care is characterised by parallel structures in registered contract doctors care and in hospitals. The responsibilities are unclear to patients. Emergency care by registered contract doctors is organised in a fragmentary manner in many instances. All in all, it is not sufficiently concentrated. Since improved coordination is also not sufficient in order to eliminate the existing shortcomings, new patient-orientated structures are needed. Out-patient and in-patient emergency care should be organised centrally "under one roof" where possible. In conjunction with the phased in-patient emergency approach which has already been established in law, this also requires stipulations from the Federal Joint Committee setting out at which hospitals, and in how many hospitals, emergency service practices are to be set up. The service guarantee of the Associations of Statutory Health Insurance Physicians for emergency care is to be lent concrete form and demanded, both for the emergency service practices and for the standby service providing home visits. The management of the patients in emergency service practices of the Associations of Statutory Health Insurance Physicians and hospital out-patient clinics should take place on a one-stop basis (see Figure).

Out-patient and in-patient emergency care should be organised centrally "under one roof" where possible.

The time factor is decisive in many emergencies for the chances of healing and survival. Minimum national standards must be defined and a digital infrastructure created for the emergency services. There is a need to establish integrated control centres made up of emergency control centres and control centres of the emergency services provided by the Associations of Statutory Health Insurance Physicians in order to activate appropriate mobile emergency care. The emergency numbers should all connect to this service.

"One-stop shop" of Associations of Statutory Health Insurance Physicians and hospitals



Source and illustration: National Association of Statutory Health Insurance Funds

Positions on re-structuring emergency care

1. **Orientating emergency care towards patients**
   Emergency out-patient and in-patient structures must be offered centrally "under one roof".
2. **Phased in-patient emergency approach as the basis for reorganisation**
   The phased in-patient emergency approach of the Federal Joint Committee should form the starting point for re-structuring in-patient and out-patient emergency care. The out-patient emergency structures that need to be provided must be defined for each phase of emergency care.
3. **Professionalising and concentrating emergency care**
   The treatment of patients with serious life-threatening diseases should be focussed on a small number of specialised emergency hospitals.
4. **Establishing central accident and emergency units**
   Patients should be looked at in a central contact point by staff who have received interdisciplinary training; they should receive initial medical care there where appropriate and be transferred to the right specialist discipline for further treatment.
5. **Organising Associations of Statutory Health Insurance Physicians-emergency service practices in hospitals**
   The Federal Joint Committee should set out structural stipulations for the establishment of emergency service practices of the Associations of Statutory Health Insurance Physicians in hospitals, in particular in the interest of availability and staffing.
6. **Organising triage and management in care levels**
   Patients must have a central point of call from where they are referred to the suitable care level meeting their needs on the basis of a qualified initial assessment. This initial assessment process should be organised jointly by the Associations of Statutory Health Insurance Physicians and the hospital.
7. **Evaluating the funding of hospital out-patient clinics**
   The Standard Schedule of Fees should create ways to bill for care and monitoring on an hourly basis as part of emergency care in hospital.
8. **Introducing quality standards for the emergency services**
   Transparency of available treatment capacities in hospital must be improved for the emergency services. Furthermore, a guideline should be developed for quality assurance in the emergency services.
9. **Establishing joint control centres**
   Close cooperation is needed between the control centres of the emergency services provided by the Associations of Statutory Health Insurance Physicians and the emergency control centres to better manage the taking up of emergency care. Both emergency numbers should connect to one unit where specially-trained staff decide as to which kind of mobile emergency care is appropriate.
10. **Creating transparency in emergency care and improving quality**
    Improved, standardised documentation creates transparency and forms the basis for quality assurance in emergency care. Emergency cases should be defined, and a national documentation standard should be established for emergency admissions.

Positions on the evaluation of innovations

The legislature has also enacted several statutory amendments in recent years regarding the evaluation of innovations in in-patient and out-patient services against the background of the position taken up by the National Association of Statutory Health Insurance Funds. Nonetheless, only very few new methods continue to be systematically examined at an early stage and are introduced into medical care without a sufficient data basis. The reason submitted for this is that this enables insured persons to gain rapid access to innovations. It is however uncertain for insured persons whether they actually benefit from these alleged innovations. The National Association of Statutory Health Insurance Funds has therefore refined its positions from 2010:

1. Innovative non-drug treatment methods also need to be systematically examined in hospital as to their benefit before being introduced into standard care. The existing provisions are to be refined in a system which ensures early access to innovations under study conditions. This also applies to University out-patient clinics.

2. The legislature has introduced the term "potential to constitute a necessary alternative treatment" for methods the evaluation of which remains unclear. The potential of a method the benefit of which is unclear, or which may do harm, can hence only legitimise its use within studies, but it may not be used in blanket care in the interest of patient safety.

3. The previous regulations on high-risk medical devices cover only a very small number of high-risk innovations. They must be expanded to cover all methods which lead to a change in the course of patients' treatment due to a new mode of action, or to a new type of application.

4. The manufacturers and providers bear the prime responsibility for obtaining the necessary data for the benefit evaluation. The necessary testing studies under the umbrella of the Federal Joint Committee are therefore to be planned by manufacturers or healthcare providers themselves. At the same time as the study concept, they are to submit a binding funding plan for the study overheads and appropriate consent to cost acceptance.

Unlike for providers, it remains uncertain for insured persons whether they actually benefit from innovations.

5. The task of the Federal Joint Committee is to examine these study concepts as to their scientific and methodical suitability.

6. Statutory health insurance undertakes in return to fund an application of the innovations as part of the studies approved by the Federal Joint Committee.

7. The necessary infrastructure for researcher-initiated, and industry-independent clinical studies must be improved and consolidated by means of suitable, tax-funded support.

8. Improvements in the state framework for the implementation of studies and more appropriate activities must be created in tax-funded research promotion.

WHY STATUTORY INSURANCE?

Statutory health insurance is becoming younger

The number of deaths has been higher than the number of births in the Federal Republic of Germany since the beginning of the 1970s. The result of this – if it is not (over)compensated for by a positive migration balance – is a shrinking, ageing population. Since average expenditure on health increases as people age, the question arises as to the influence exerted by demographic factors on current and future developments in the benefit expenditure of statutory health insurance. The increase in benefit expenditure which takes place in arithmetical terms if the expenditure profile of the previous year (amount of expenditure by age and gender) is applied to the structure of insured persons of the following year is referred to as the demography effect. It has been possible to ascertain in the past that the demography effect is less pronounced than is frequently presumed. It was responsible for an average of 18 % of the increase in benefit expenditure per insured person from 2007 to 2010. Additional causes of changes in expenditure include

- general inflation,
- medical-technical progress,
- statutory activities, and
- changes in patient conduct, as well as that of healthcare providers.

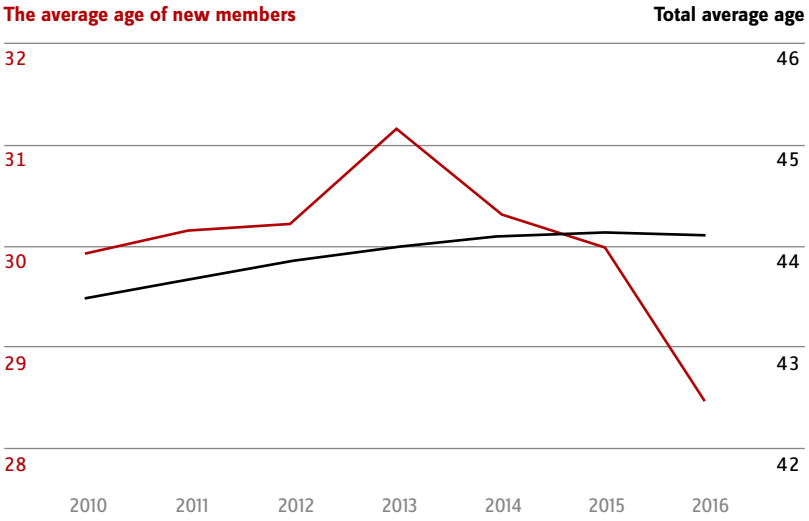
Falling benefit expenditure and rejuvenation of statutory health insurance through migration

With emigrant numbers that have been relatively constant over time, Germany has observed an increasingly growing number of immigrants since the beginning of the decade. The migration balance going into statutory health insurance has outweighed the balance of deaths and births in statutory health insurance since 2012. This has already caused the number of persons with statutory health insurance to increase by 2 million insured person years on an annual average of 2016 as against 2012. The statutory health insurance appraisers are expecting a further increase of 1.8 million insured person years by 2018. The annual increase in the average age of persons with statutory health insurance has fallen markedly since 2013, from its previous regular rate of roughly 0.2 years. The average age of roughly 44 years actually fell slightly for the first time in 2016. This "rejuvenation of statutory health insurance" was caused by new memberships resulting from labour migration from EU States and – particularly since 2015 – through migration by refugees. This caused the average age of new members to fall from 31.2 in 2013 to 28.4 in 2016.

The new intake of statutory health insurance members is not only younger, but these individuals also cause much less benefit expenditure than existing insured persons of the same age.

Analyses using data from the risk structure equalisation show that the new intake of statutory health insurance members is not only younger, but that these individuals also cause much less benefit expenditure than existing insured persons of the same age. The rejuvenation, as well as mixing with healthier insured persons of the same age, lead to benefit expenditure per insured person rising less markedly. The "braking effect" of the respective new members already led to 0.4 percentage points in the year of their joining in 2013, and grew continuously to 0.7 percentage points in 2016. The

The influence of new members on the average age in statutory health insurance



Source and illustration: National Association of Statutory Health Insurance Funds

actual reduction in the burden for expenditure developments per insured person is slightly higher than 1.0 percentage point for 2016 because the new members of the previous year are now making their contribution towards the cost advantage during the entire year. This result corresponds with the marked deceleration in the rate of increase in benefit expenditure per insured person that has taken place in recent years, thus also explaining the current considerable fall in the influence exerted by demographic factors on expenditure developments, which was only just over 7 % for 2016 (or an average of roughly 10 % for the period 2011-2016).

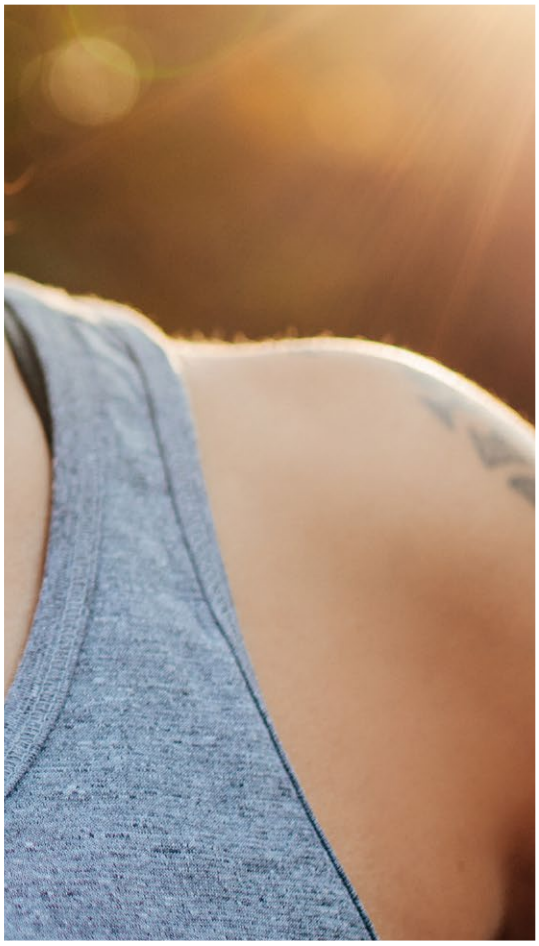
The health insurance funds pay a flat rate to the Associations of Statutory Health Insurance Physicians per insured person, which is calculated as an average per health insurance fund, regardless of the age or benefits taken up by the insured persons.

Provided that new members of recent years largely remain in statutory health insurance, that is they do not return to their home countries or change to private health insurance, the reduction in the demography effect brought about by immigration will have a positive impact beyond the respective year. This applies all the more to funding statutory health insurance if it is also possible to permanently integrate migrants into the labour market beyond marginal employment.

Adjusting the registered contract doctors' remuneration system

The expenditure-limiting effects that have been described will however not be reflected in total registered contract doctors' remuneration unless the remuneration system is adjusted. Approx. 70 % of services in the area of registered contract care are budgeted within total morbidity-related remuneration. The health insurance funds pay a flat rate to the Associations of Statutory Health Insurance Physicians for new insured persons, which is calculated as an average per health insurance fund, regardless of the age or benefits taken up by the insured persons. This is too high for the new insured persons, who are much younger than the average of existing insured persons. The total remunerations in the individual Associations of Statutory Health Insurance Physicians areas are adjusted in line with the changes in morbidity, which can also be negative. These "morbidity rates" are however implemented with a delay of three years at regional level as part of the remuneration agreements between the health insurance funds and the Associations of Statutory Health Insurance Physicians, or may indeed not be implemented, depending on the result of the negotiations.

WHAT WILL CARE LOOK LIKE IN THE FUTURE?



The Innovation Fund 2017: More than 100 funding projects approved

As a cross-sectional task in the healthcare system, digitalisation also plays a predominant role in the Innovation Fund.

The legislature has given joint self-government a tool in the shape of the Innovation Fund to targetedly promote forms of innovative care and application-orientated care research to the tune of up to 300 million Euro per year. The promotional decisions of the Innovation Committee are consistently taken in line with the promotional criteria contained in the calls for tender, and taking account of the recommendations of the Expert Advisory Council that is provided for by law. The volume of applications also remained constantly high in the second year of the Innovation Fund. The Innovation Committee and the Working Committee that reports to it evaluated more than 320 project applications from two waves of promotion in 2017.

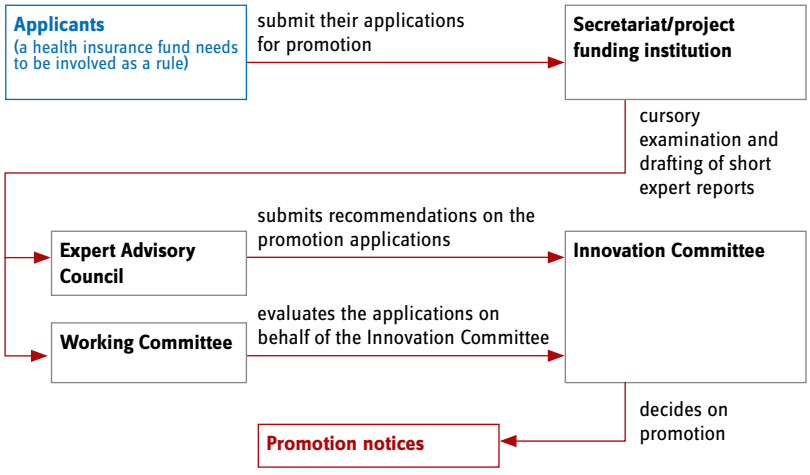
Promotion in the funding area "New forms of care"

There were 52 successful applications in the funding area "New forms of care". These for instance include projects from the topical area of "delegation and substitution". The implementation of these projects will show whether the delegation of medical services, which is already set out in the collective bargaining system but has still not been sufficiently well implemented in standard care, proves its value in care practice. The promoted projects for instance include IT-aided case management for optimising hypertension therapy which the general practitioner delegates to trained specialist medical employees. Delegation projects can however also be found in dentistry. There is for instance promotion for a project in which specialist dentistry employees who have received further training visit persons in need of long-term care in their domestic environments in order to offer them low-threshold preventive dentistry services and to individually train the persons in need of long-term care in oral hygiene, together with their family caregivers.

Furthermore, as a cross-sectional task in the healthcare system, digitalisation also plays a predominant role in the Innovation Fund. A variety of selected projects thus contain care models in which doctors' surgeries, hospitals, pharmacies and other players within the healthcare system are networked with the aid of telemedical applications. The Innovation Committee finds it to be important in this regard that the promoted projects should not create isolated technical applications in addition to gematik's telematics infrastructure which are financed by the Fund. All selected IT projects are hence subjected to the proviso that e-Health solutions must use open interfaces and be interoperable.

The National Association of Statutory Health Insurance Funds considers it to be gratifying that many member funds have proven their innovativeness and also wish to shape the healthcare of their insured persons over and above the collective agreement. It is equally gratifying that joint resources are used within the health insurance funds, and that many applications for promotion have been submitted for new forms of care across different types of insurance fund, and are now being promoted.

The process of evaluating applications



Source and illustration: National Association of Statutory Health Insurance Funds

Promotion in the funding area "care research"

Important foundations are being placed in care research for the further development of care, and new concepts are being developed, implemented as well as evaluated. As was also the case in 2016, new care research projects were submitted and processed in 2017, and the most promising projects were promoted by the Innovation Committee. All in all, there were 54 such projects with a volume of 69.4 million Euro.

Considerable thematic variety was promoted: Exciting research projects were selected, both for special groups of insured persons such as the elderly, migrants and persons in need of long-term care, as well as for specific symptoms such as mental illnesses, cardiovascular diseases or oncological diseases. Important supraordinate topics relate to the examination and management of prescriptions for medicinal products or emergency care, which is analysed and evaluated from three different points of view (in-patient, out-patient and emergency services).

The topic of digitalisation was also taken up: Online tools are for instance evaluated for people with multiple sclerosis, non-metastatic prostate cancer or carriers of the BRCA1/2 mutation, or their development is promoted.

The outlook for 2018

New promotion announcements have already been published for 2018. This includes promoting projects spanning social benefit funding institutions to bridge gaps between out-patient, in-patient or rehabilitative care and for long-term care. Projects spanning funding institutions for instance relate to the interface between statutory health insurance and pensions insurance, or between statutory health insurance and local funding institutions.

The projects which are promoted in care research include several projects which analyse and evaluate emergency care from different points of view.

Projects can be promoted in care research for developing and testing learning algorithms for forecasting the progression of a disease or for generating treatment instructions.

Projects promoted in 2017

	No.	Volume
New forms of care		
Models incorporating the delegation and substitution of services	4	7.7 million €
Establishment and expansion of geriatric care	4	20.5 million €
Improving communication with patients and promoting health skills	9	42.2 million €
Care models for people with disabilities	4	7.1 million €
Call for tenders without thematic restrictions	31	135.3 million €
Care research		
Call for tenders without thematic restrictions	54	69.4 million €
Total 2017	**106**	**282.2million €**

Source and illustration: National Association of Statutory Health Insurance Funds

WHY BECOME AN ORGAN DONOR?

Improvements in in-patient care

The legislature transferred a wide variety of tasks to the self-government partners for 2017 with the Hospital Structure Act (Krankenhausstrukturgesetz – KHSG) from 2016 and the Statutory Health Insurance Care Improvement Act from 2015.

Framework contract on discharge management

The statutory provisions on discharge management have not yet led to a thoroughly reliable organisation of follow-up care after hospital treatment. An arrangement was then created with the Statutory Health Insurance Care Improvement Act in 2015 which explicitly aims to improve discharge management. Discharge management providing support for cross-sectoral care of insured persons remains part of hospital treatment. The entitlement of insured persons vis-à-vis the hospital to discharge management was supplemented to include a right to receive support for discharge management from the health insurance fund. The new provision particularly entails prescribing medicinal products, bandages, remedies and medical aids, domestic nursing care and socio-therapy, as well as determining incapacity for work for a period of up to seven days as part of discharge management. The rules on registered contract care apply to prescriptions in discharge management; the relevant guidelines of the Federal Joint Committee are to be complied with.

The German Hospital Federation, the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds were tasked back in 2015 with arranging the further details in a framework agreement. Despite several months of negotiations, the Expanded Federal Arbitration Office had to act for registered contract care since it was not possible to agree amongst other things on the application of the rules of registered contract care to prescriptions. The framework agreement that was then set out was to come into force as per 1 January 2017, but this did not happen due to a court action filed by the German Hospital Federation. The implementation of the framework agreement was therefore postponed once again. A major point of conflict was the use of a doctor's identification number on prescriptions.

Insured persons' rights vis-à-vis the hospital to discharge management have been supplemented by a right to receive support for discharge management from the health insurance fund.

The stage was set with the Blood and Tissues Act (Blut- und Gewebegesetz) in July 2017 for a new list of hospital doctor's identification numbers, hence facilitating the implementation of the framework agreement from October 2017 onwards. Until the hospital doctor's identification numbers are applied, from 2019 onwards, "provisional doctor's identification numbers" will be used on a transitional basis.

The Centre agreement – court action and termination

The Hospital Structure Act redefined the prerequisites for the funding of centres. The German Hospital Federation and the National Association of Statutory Health Insurance Funds had been called on to agree by 31 March 2016 on details regarding the supplements payable for special tasks to be performed by centres. Centres are to distinguish themselves from the hospitals without a centre function by performing specific tasks, and are to be identified by the Länder. Special tasks may only be services not already paid for by case flat-rates and other charges. The agreement was established in December 2016 by the Federal Arbitration Office, against the votes of statutory and private health insurance. The National Association of Statutory Health Insurance Funds considers that it does not create the necessary clarity of norms. Focussing the centres' tasks in large, suitable hospitals is now to be decided upon by the respective Länder.

The National Association of Statutory Health Insurance Funds has filed an action with Berlin Administrative Court against the finding of the Arbitration Office because the statutory health insurance funds do not consider it to be sufficiently certain that the double financing of services can

The statutory health insurance funds do not consider it to be sufficiently certain that the double financing of services can be ruled out as mandated by the legislature.

be ruled out as mandated by the legislature. Since the action does not have any suspensory effect, the agreement established by the Arbitration Office came into force with effect as per 1 January 2017.

The National Association of Statutory Health Insurance Funds has terminated the contract for the funding of centres, including its Annex, as per the earliest possible date, and has called on the German Hospital Federation to enter into new negotiations. The termination will become effective as per 31 December 2018. The termination of the Annex, which includes the eligible special tasks, already came into effect as per 31 December 2017.

Germany currently has approx. 200 clinics which receive a supplement as a centre. The transitional

Keypoints of the process of discharge management

1. **Assessment:**
   The hospital ascertains the patient's requirements in terms of follow-up care as soon as possible after admission as an in-patient. A differentiated assessment is carried out with patients who have complex care needs.

2. **Drawing up a discharge plan:**
   The discharge plan includes the likely care requirements following on from hospital treatment, and it is adjusted where necessary as the hospital treatment progresses. The establishment/updating of the discharge plan also includes examining the need for benefits that are eligible for prescription or requesting (e.g. short-term nursing care, home help), as well as of incapacity for work continuing immediately after discharge from hospital.

3. **Taking concrete transitional measures:**
   The hospital expeditiously initiates the measures that are necessary on the basis of the care requirements that have been identified and established in the discharge plan and are likely to be needed. To this end, it contacts healthcare providers providing further treatment and possibly care (e.g. general practitioner and specialist physician, rehabilitation facility). The statutory health and long-term care insurance funds are involved when it comes to services that require authorisation or support.

4. **Discharge day:**
   The hospital ensures that patients are seamlessly transferred into follow-up care for the day on which they are discharged. The patient receives a discharge report, but at least a provisional discharge report. It is also mandatory to provide the telephone number of a responsible contact at the clinic for any enquiries that the healthcare provider providing further treatment may have. The patient receives the corresponding prescription(s) and the certificate of incapacity for work, if necessary, on discharge day at the latest.

funding for the existing centres is to expire at the end of 2017. The German Hospital Federation and the National Association of Statutory Health Insurance Funds are now called upon to find successor arrangements by 31 March 2018.

The Health Insurance Medical Service Quality Control Guideline

The entry into force of the Hospital Structure Act as per 1 January 2016 also led to a reorganisation of the statutory stipulations for the implementation of quality controls by the Health Insurance Medical Service in approved hospitals. Accordingly, the Federal Joint Committee has to establish in a guideline the details of assessments carried out by the Health Insurance Medical Service which aim to examine adherence to the quality stipulations of the Federal Joint Committee. The guideline is to establish amongst other things

- which agencies may commission quality controls (for instance health insurance funds),
- what indications can lead to controls (for instance reports by insured persons), and
- what the scope and the procedures of the controls are to look like.

The legislature did not provide for any time stipulation for the design of the guideline.

The National Association of Statutory Health Insurance Funds has lobbied in the Federal Joint Committee for the Health Insurance Medical Service Quality Control Guideline to be elaborated soon and in an expedient manner. Discussions on this have been held with the German Hospital Federation, amongst others, since mid-2016. The latter is not interested in the new possibilities for quality control in hospitals. The negotiations were consequently controversial and time consuming. The National Association of Statutory Health Insurance Funds especially wished to see the procedures for the controls carried out as quickly as possible. Quality controls are triggered in the overwhelming degree by indications which point to shortcomings in quality. It must be possible to investigate indications of this sort immediately in order to protect patients and staff. In the interest of the insured persons, the idea was pursued here to permit as little time as possible to pass between commissioning via the implementation of the controls, through to the drafting of the final report in cases in which there were specific indications of quality shortcomings in hospitals.

It must be possible to investigate indications of quality shortcomings immediately in order to protect patients and staff.

Once the Federal Joint Committee has adopted a resolution, the Health Insurance Medical Service Quality Control Guideline should come into force in the spring of 2018, assuming that it is not objected to by the Federal Ministry of Health. The adoption of this "framework section" will create the legal basis for the tasks of the Health Insurance Medical Service in connection with the arrangements of the Federal Joint Committee. The framework section will not take full effect until arrangements are made in "concretisations", such as verification of compliance with quality stipulations for minimally-invasive heart valve surgery (Guideline on minimally-invasive heart valve surgery). The first concretisations should therefore be made soon, once the objectives of the National Association of Statutory Health Insurance Funds have been established.

Psychiatric treatment equivalent to in-patient treatment facilitated

Psychiatric treatment equivalent to in-patient treatment is hospital treatment provided in the patient's domestic environment by mobile multiprofessional treatment teams led by specialist physicians.

The Act on the Further Development of Care and Remuneration for Psychiatric and Psychosomatic Benefits (PsychVVG) introduced psychiatric treatment equivalent to in-patient treatment as a new hospital service for people with psychological diseases in need of hospital treatment. The self-government partners at federal level set the stage in 2017 for the services to be agreed from January 2018 onwards, as well as stipulating that they were to be provided at the expense of statutory health insurance.

Psychiatric treatment equivalent to in-patient treatment is hospital treatment provided in the patient's domestic environment by mobile multiprofessional treatment teams led by specialist physicians. In content terms, it is to correspond to the contents, flexibility and complexity of fully in-patient treatment. The hospital decides whether the therapeutic goal can be achieved best with patients who require hospital treatment on a fully in-patient basis or as an equivalent to in-patient treatment.

New arrangements for the provision of services

The agreement on framework stipulations, which came into force on 1 August 2017, regulates the following aspects:

1. In order to ensure that the service is provided at a high level of quality, various quality requirements have been established which need to be fulfilled, such as the suitability and consent of the domestic environment.
2. The statutory basis provides that some of the services may be delegated to healthcare providers operating in out-patient psychiatric care or to other hospitals that are entitled to provide the treatment. Overall responsibility always rests with the client hospital.
3. The agreement also regulates provisions for documentation. The medical records must for instance document the need for hospital treatment.

The Operation and Procedure Code (Operationen- und Prozedurenschlüssel) has been adjusted on the basis of the description of performance. The new Codes for psychiatric treatment equivalent to in-patient treatment among adults, as well as with children and juveniles, will include the therapeutic periods to patients separately according to professional groups from 2018 onwards. It was also necessary to include the services in the remuneration schedule, and particularly to lend concrete form to the billing regulations.

It now remains to be seen what significance this new service will take on in care which competes with the other out-patient care services provided by hospitals for people with mental illnesses.

Core elements of psychiatric treatment equivalent to in-patient treatment

- the need for hospital treatment
- suitability of the domestic environment
- consent of the household members
- multiprofessional treatment teams led by specialist physicians
- individual treatment plan
- direct patient contact on a daily basis
- weekly home visits by doctors
- hospital on standby and obliged to admit the patient

Higher quality in nursing care through lower limits for staffing

The Act Modernising the Epidemiological Monitoring of Transmissible Diseases (Gesetz zur Modernisierung der epidemiologischen Überwachung übertragbarer Krankheiten), which came into force in July 2017, also adopted mandatory lower limits for nursing staff in "care-sensitive areas in hospitals". The rapid legislative implementation was triggered by the conclusions drawn by a committee of experts at the Federal Ministry of Health. The committee had been convened in October 2015 in order to draw up proposals as to the portrayal and improvement of the general need for nursing care, of the increased need for nursing care of people suffering from dementia, of persons in need of long-term care, and of patients with disabilities, as well as recommendations for transferring funds from the nursing care jobs promotion programme into standard funding.

The legislature has enacted new regulations, calling on the German Hospital Federation and the National Association of Statutory Health Insurance Funds to reach six agreements within a year, in concurrence with the Association of Private Health Insurance. These start with establishing lower limits for nursing staff, and go on to documentation and remuneration regulations. Furthermore, large numbers of other organisations, such as the German Long-term Care Council, trade unions and employers' associations, as well as patients' representatives and the Association of the Scientific Medical Societies in Germany, are to be involved in the drafting and establishment of lower limits for nursing staff in "care-sensitive areas".

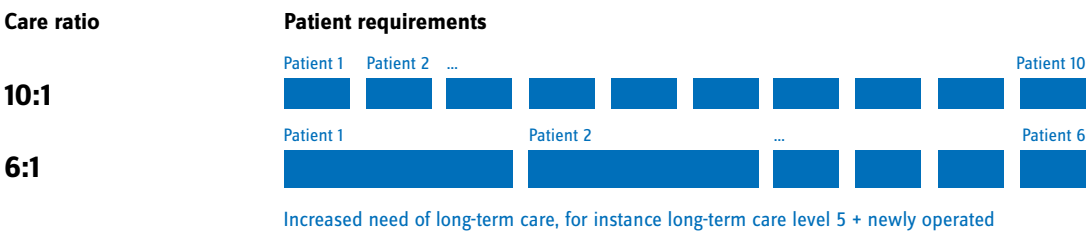
The negotiations focussed in the second half of 2017, firstly, on the identification of care-sensitive areas. Secondly, the self-government partners faced up to the challenge of improving the data available for staffing and developing tools for collecting information on the need for nursing care. The work was founded on a coordinated time and work plan, which was handed to the Federal Ministry of Health in September 2017. The core of the content deliberations was the question of how the patients' nursing care needs could be taken into account in connection with the establishment of lower limits for nursing staff.

The National Association of Statutory Health Insurance Funds favours establishing lower limits for nursing care staffing on the basis of nursing care equivalence in order to ensure nursing care as per requirements.

The nursing care needs have to be recorded and standardised in order to ensure high-quality patient nursing care, as well as the comparability of wards in which individuals receive different treatment or care; i.e. nursing care equivalence must be created. The National Association of Statutory Health Insurance Funds favours establishing lower limits for nursing staff on the basis of nursing care equivalence in order to ensure nursing care as per requirements.

The Act provides that binding lower limits for nursing staff are to be agreed by the summer of 2018, and that they are to take effect from 2019.

Lower limits for nursing care staffing



Patients with different requirements in terms of nursing care must be weighted in the calculation of lower limits. Source and illustration: National Association of Statutory Health Insurance Funds

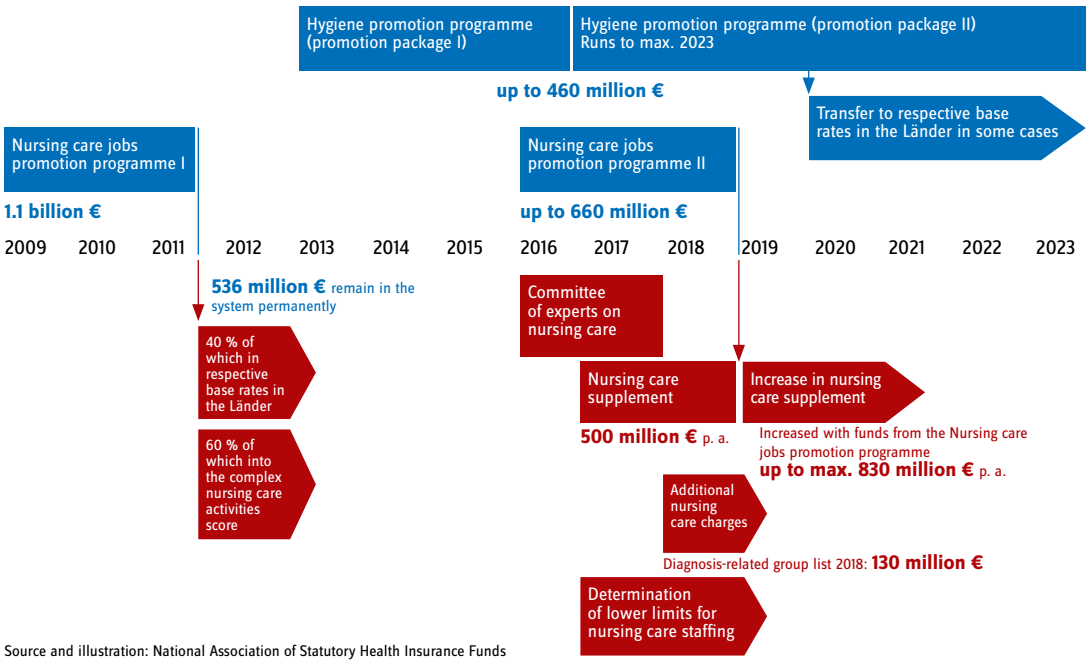
First report on nursing care jobs promotion programme presented

With the Hospital Structure Act, the legislature has established a second nursing care jobs promotion programme with a term of three years (2016-2018). In this period, the statutory health insurance funds will be making available up to 660 million Euro as a top-up to the regular hospital remuneration. Hospitals are to targetedly use these funds in order to increase the number of nursing staff working in direct long-term patient care in in-patient wards, or to top up existing posts. 1,000 hospitals already benefited from the first long-term nursing care jobs promotion programme from 2009 to 2011. A promotional volume of 1.1 billion Euro was spent at that time, enabling 13,600 nursing carers to be recruited.

Hospitals are to targetedly use these funds in order to increase the number of qualified nursing care staff working in direct patient nursing care in in-patient wards, or to top up existing posts.

The National Association of Statutory Health Insurance Funds evaluates the take-up of this promotion every year on the basis of data provided by the health insurance funds. The report on the first year (2016) was submitted to the Federal Ministry of Health in June 2017, according to which approx. 52 million Euro were made available to roughly 600 hospitals in total, thus creating the financial basis for roughly 1,600 new nursing care posts. This constituted an agreement so far for only roughly half of the promotional volume of 110 million Euro for the first year of promotion. These data are initially provisional in nature since it was still unknown when the report was drawn up with regard to roughly one-third of the eligible hospitals whether the promotional options were being used. What is more, the information from the annual audits in the ensuing years needs to be awaited for information on whether these funds were also actually used expediently to establish nursing care staff. The reporting obligation of the National Association of Statutory Health Insurance Funds runs to 2021, so that the updated data stocks of the previous years are always also evaluated in the ensuing reports. It is only once the promotional period has ended that a reliable evaluation of the actual take-up will be possible.

Selected activities for the promotion of nursing care in hospitals



Source and illustration: National Association of Statutory Health Insurance Funds

More money for hygiene

The statutory health insurance funds have made available a hygiene promotion programme since back in 2013 with additional funds for the improvement of hygiene staffing in hospitals. This special support is to help hospitals satisfy the stipulations of the Infection Protection Act (Infektionsschutzgesetz) in terms of the availability of qualified specialist hygiene staff in a timely manner. This primarily includes recruiting new hygiene staff and topping up medical and nursing care hygiene staff. Promotional funding may however also be called up for further and advanced training on hygiene-related topics and external consultancy provided by hygiene experts. The Hospital Structure Act extended the promotional period to 2023 at most, increased the amount of the promotion to up to 460 million Euro, and supplemented the options for promotion to include more professional groups specialising in infectiology.

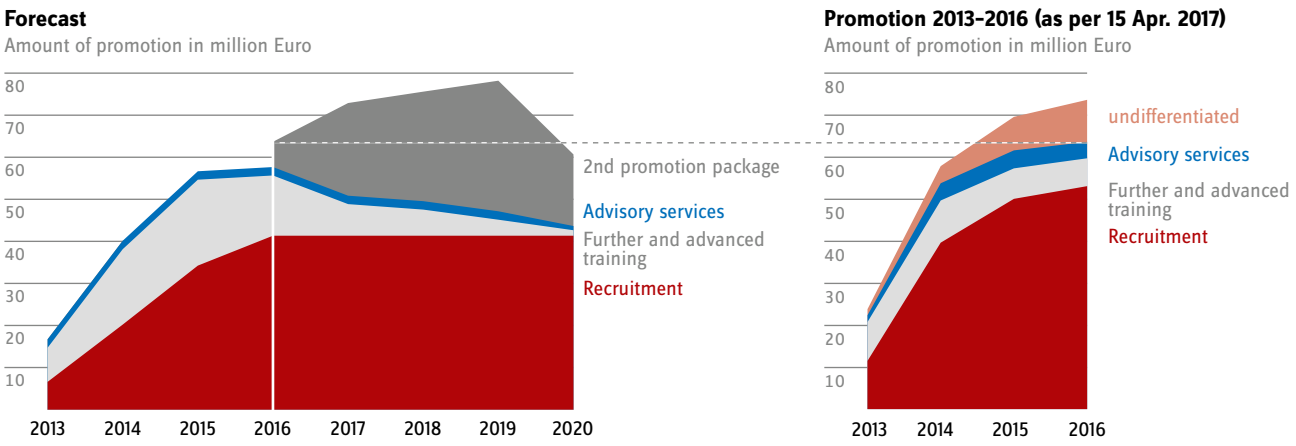
3rd Report of the National Association of Statutory Health Insurance Funds on take-up

The National Association of Statutory Health Insurance Funds submitted the now third report on the take-up of promotion to the Federal Ministry of Health in June 2017. This report documents that roughly 225 million Euro were made available by the health insurance funds for hygiene staff measures in the period from 2013 to 2016. This means that the agreed funding is actually above the expectations for take-up in the first years of promotion (see Figure). Whether the promotional funding actually was properly spent, and for instance new hygiene staff posts created, can only be established after the fact through the respective annual audit of the clinics. First confirmations by annual auditors for roughly 41 % of the funds, and about one-half of the agreed posts in 2013 to 2015, are already available. Further confirmations will be evaluated in the coming reports.

Roughly 225 million Euro were made available by the health insurance funds for hygiene staff measures in the period from 2013 to 2016. This means that the agreed funding is actually above the expectations for take-up.

The data currently available cannot yet be used to comprehensively evaluate the degree to which it has actually been possible to exert an impact on the level of hygiene staff and the quality of hygiene in hospitals. It remains to be seen how possible effects of the promotional programme on the quality of hygiene, for instance in the nationwide evaluations of external in-patient quality assurance on hygiene-related indicators, will be shown in future.

Hygiene promotion programme



A comparison of the projected distribution of funds as the programme progresses (left) with the actual promotion (right) illustrates the brisk take-up of the hygiene promotion programmes by hospitals.

Source and illustration: National Association of Statutory Health Insurance Funds

Improving quality and transparency through the transplantation register

The transplantation centres and the institutions concerned are to obtain additional information to improve their work on the basis of the data.

The establishment of a transplantation register, bringing data on donors and recipients together for the first time, was adopted in 2016 with the Transplantation Register Act (Transplantationsregistergesetz) and entrenched in the Transplantation Act (Transplantationsgesetz – TPG). The "Transplantation Act clients" (the German Medical Association, the German Hospital Federation and the National Association of Statutory Health Insurance Funds) were placed under an obligation to establish the transplantation register. The goals consist of the improvement of the available data for medical transplantation services and research, as well as for refining the quality and safety standards in transplantation medicine and increasing transparency in organ donation and transplantation. These transplantation medical data are to be combined in the transplantation register. The transplantation centres and the institutions concerned are to obtain additional information to improve their work on the basis of these data. Transplantation medical research is also to be facilitated on the basis of national data in an international comparison.

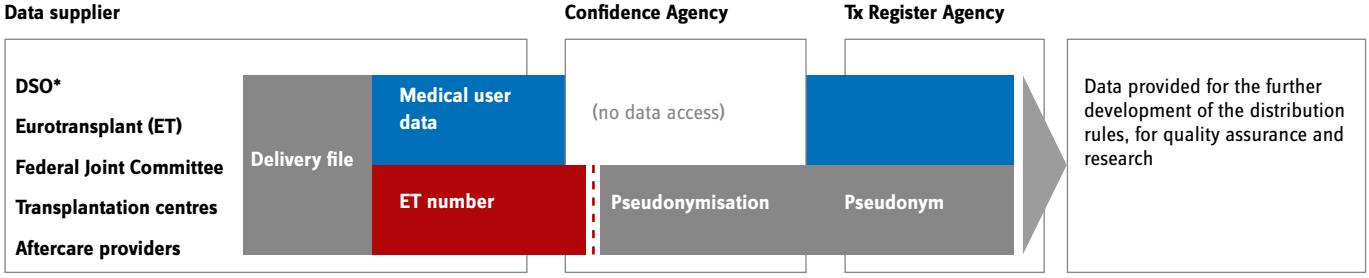
Establishing a Register Agency and a Confidence Agency by 2018

The transplantation register consists of a Register Agency and a Confidence Agency. The Register Agency stores and checks the transplantation medical data, and makes them available to eligible data recipients. Since data may only be processed and stored in the transplantation register in pseudonymised form, the data transmission is organised via a separate Confidence Agency.

Two institutions that are independent from the Transplantation Act contracting authorities are tasked with operating the transplantation Register Agency and the Confidence Agency. The tendering process was launched in June 2017, and ran as per schedule. The contract for the Register Agency and the Confidence Agency was awarded in December 2017.

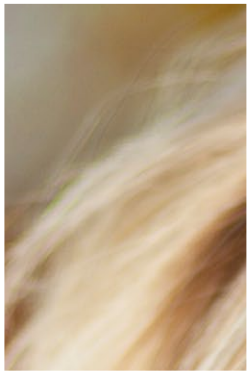
The plan provides for the establishment of the transplantation register to commence in the spring of 2018. The first data are to be delivered to the Register at the beginning of 2019. In a first step, the transplantation medical data from the years 2006 to 2016 are to be combined and made available in anonymised form. Linking donor and recipient data will enable new evaluations to be carried out on scientific questions related to transplantation medicine which were not previously possible. The data from 2017 and 2018 are to follow from mid-2019 onwards.

Transplantation Register



* German Organ Transplantation Foundation

Source and illustration: National Association of Statutory Health Insurance Funds



WHAT TREATMENT IS NECESSARY?

Conflict-ridden negotiations for the further development of registered contract care remuneration in 2018

Holding of the orientation value at the level of 2017 was justified with the fact that surgery costs had risen only slightly, as well as with the marked increase in registered contract care remuneration.

The assessment committee did not reach a unanimous decision in the fee negotiations between the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians for the further development of registered contract care remuneration when it came to the adjustment of the orientation value (price component) and in the delimitation of total morbidity-related remuneration. By contrast, resolutions were adopted in a consensus for the change in the morbidity structure and for transferring medically-prescribed assistance into morbidity-related remuneration.

Involvement of the arbitrators necessary

In addition to a marked increase in the orientation value by 2.43 % as per 1 January 2018 (approx. 840 million Euro), the National Association of Statutory Health Insurance Physicians called for further increases in remuneration as part of the negotiations:

- an increase in morbidity-related remuneration by a total of 500 million Euro for funding the higher evaluations of structural flat rates in the Standard Schedule of Fees (flat-rates for chronic sufferers in domestic care and flat rates for primary care by a specialist physician)
- transferring laboratory services from morbidity-related remuneration to extrabudgetary total remuneration (budgeting no longer applies), which would entail considerable additional expenditure in the medium three-digit million range.

The total volume of claims by the National Association of Statutory Health Insurance Physicians was therefore approx. 1.7 billion Euro. The National Association of Statutory Health Insurance Funds rejected these claims as unfounded, and called by contrast for the orientation value for 2018 to be held at the level of 2017. This was justified with the fact that surgery costs had risen only slightly, as well as with the marked increase in registered contract care remuneration. No agreement was reached between the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds on the basis of these different starting positions. Opting for the adjustment of the orientation value for 2018 was therefore decided on with the votes of the National Association of Statutory Health Insurance Funds and the majority of non-partisan representatives in the expanded assessment committee, against the votes of the National Association of Statutory Health Insurance Physicians.

The determination for the adjustment of the orientation value provides for it to be increased by 1.18 % (approx. 410 million Euro) as per 1 January 2018. No additional increases in remuneration were agreed with this adjustment because of

Results of the remuneration negotiations at federal level for 2018

	Total (million €)
Adjustment in the orientation value	410
Development in morbidity (weighting 50/50)	100
Increase in the amount of extrabudgetary total remuneration (extrapolation)	400
Assistance by non-physician surgery assistants prescribed by a physician	50
Total	**960**

Source: National Association of Statutory Health Insurance Funds

structural measures, as had also been the case in the previous two years.

The demand by the National Association of Statutory Health Insurance Physicians for laboratory services to be decapped did not obtain the necessary majority, and was rejected. The National Association of Statutory Health Insurance Physicians did not submit an application to increase total morbidity-related remuneration by 500 million Euro to the expanded assessment committee.

Agreement on domestic care and on the morbidity structure

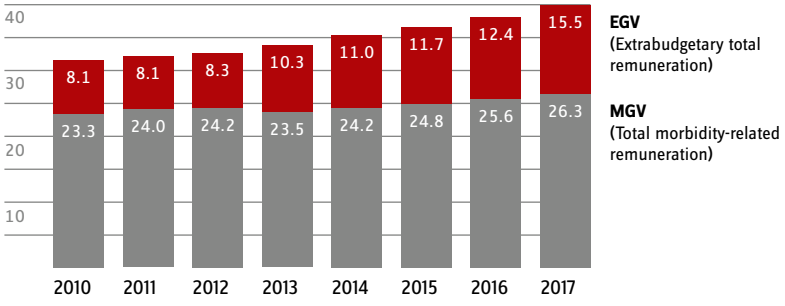
The assessment committee has adopted the transfer of medically-ordered assistance by non-physician surgery assistants in total morbidity-related remuneration, along with an increase in this remuneration range, as per 1 January 2018. Statutory stipulations require the assessment committee to adopt annual recommendations on the demographic and diagnosis-related change rates in the need for morbidity-related treatment. These form the basis for the change in the morbidity structure to be established at Land level by the partners to the overall contract. At an average of 0.67 %, the diagnosis-related change rates were much lower this year than they had been in the previous year, when they were 1.17 %. The downward trend in the previous years' demographic change rates continued at an average of -0.02 % (previous year 0.19 %).

Ongoing expenditure increases in registered contract care remuneration

The resolutions that were passed in 2018 for registered contract care remuneration mean that expenditure for the statutory health insurance funds is likely to increase by approx. 960 million Euro, or 2.5 %, in comparison to expenditure in 2017. The adjustment of the orientation value accounts for approx. 410 million Euro, the change in the morbidity structure for approx. 100 million Euro, the forecast volume increase in extrabudgetary services for approx. 400 million Euro, and the increase in total morbidity-related remuneration caused by the assistance provided by non-physician surgery assistants but prescribed by a physician for approx. 50 million Euro. Furthermore, statutory stipulations that still need to be implemented as a result of the remuneration negotiations at Land level, as well as in 2018, such as emergency data management, permit one to presume that there will be further not inconsiderable increases in expenditure. As a result of this, the trend of developments in expenditure in the area of registered contract care is set to continue in 2018. It is not possible at present to say with any certainty whether the change rate in income subject to contributions, estimated at 2.97 % for 2018, will be exceeded, taking account of the anticipated increases in remuneration.

The diagnosis-related change rates were much lower than they had been in the previous year. The downward trend in the previous years' demographic change rates continued.

Developments in expenditure in registered contract care remuneration



Source: Form 3 (uncorrected total remuneration), extrapolation for 2017,
Illustration: National Association of Statutory Health Insurance Funds

Better supply of midwifery services

The outcome means that expectant mothers will receive more individual, comprehensive care in clinics from self-employed midwives in future.

After the negotiations with the midwives' associations had broken down, the National Association of Statutory Health Insurance Funds called on the Arbitration Office in February 2017, and in particular requested an improvement in care quality in clinical natal care. The Arbitration Office agreed in September 2017 to a joint request for arbitration from the Federation of Freelance Midwives in Germany and the National Association of Statutory Health Insurance Funds. This had been preceded by tough negotiations from the summer of 2016 onwards regarding the structural changes proposed by the National Association of Statutory Health Insurance Funds and the demands for a more than 300 % increase in remuneration on the part of the German Midwives' Association (DHV); the Federation of Freelance Midwives in Germany (BfHD), by contrast, had asked for an increase of 20 %.

Central points and results of the agreement:

- The fees for all services were increased by 17 % retroactively from 15 July 2017, and apply until 1 July 2020.
- Clinical natal care provided by self-employed attending midwives is to be designed from 1 January 2018 onwards in such a way that each attending midwife does not take care of more than two pregnant women at once as a rule. At the same time, this involves further financial improvements for these midwifery services.
- Further new services have been added, such as a third consultation during pregnancy.
- Together with the re-structuring measures for more personal care in clinical midwifery, the new services lead to further increases in expenditure amounting to up to 5 %.

The outcome means that expectant mothers will receive more individual, comprehensive care in clinics from self-employed midwives in future. This guarantees high-quality care in the long term in the interest of protecting both mother and child.

Disbursement of the guarantee supplement

The National Association of Statutory Health Insurance Funds has paid since 1 July 2015 compensation for the cost of professional liability insurance to those midwives active in providing midwifery services who supervised a minimum number of births. Certain shares, for instance for those with private insurance and self-paying patients, are removed from the calculation of the proof of liability insurance costs that are submitted. The midwives receive their compensation payments within a few weeks via the procedure for the disbursement of expense compensation of the professional liability insurance of midwives providing midwifery services.

The group liability insurance policy taken out by the German Midwives' Association for its midwives increased on both 1 July 2016 to 6,843 Euro with cover of 6 million Euro and as per 1 July 2017 to 7,639 Euro with cover of 7.5 million Euro. These increases were taken into account by the guarantee supplement procedure in favour of the applying midwives. This however leads at the same time to corresponding additional expenditure for the health insurance funds, and hence ultimately for contributors. A total of more than 17 million Euro have been disbursed for this since 1 July 2015 (as per January 2018).

Auditing quality and invoices in out-patient long-term care

The Third Act to Strengthen Long-term Care (Pflege¬stärkungs¬gesetz – PSG III) set the stage for further development in the auditing of quality and invoices by the Health Insurance Medical Service, in particular in relation to domestic nursing care services. Auditing of quality and invoices on domestic nursing care services was previously only possible with those long-term care services which had a contract in accordance with Book XI of the Social Code (SGB XI) and provided long-term care benefits in kind in accordance with Book XI of the Social Code. The Third Act to Strengthen Long-term Care also closed this gap in auditing on the basis of information collected from cases of invoice fraud. The Land associations of the health insurance funds must therefore commission the Health Insurance Medical Service with regular auditing of quality and invoices in all long-term care services which only provide domestic nursing care services at the expense of the health insurance funds. Moreover, the health insurance funds and their Land associations may also request appropriate audits on an ad hoc basis. This right to audit is not restricted to long-term care services which only provide domestic nursing care services.

The National Association of Statutory Health Insurance Funds has regulated on the details in the Domestic Nursing Care Quality Audit Guideline, in particular reasons for auditing, contents and implementation of the examinations, the involvement of the health insurance funds as well as the coordination of these audits with those in accordance with Book XI of the Social Code. A priority is formed here by specific auditing parameters for "intensive long-term care". Auditing of quality and invoices is to focus on medical long-term care treatment services prescribed by a physician for which detailed audit criteria are stipulated in the Annexes to the Guideline.

Coordinated audits of health and long-term care insurance

The statutory amendments made by the Third Act to Strengthen Long-term Care were also implemented in the Quality Audit Guidelines for out-patient and in-patient long-term care. This ensures that both the audits in accordance with Book V and Book XI of the Social Code take place on the basis of standard audit regulations for overlapping auditing areas, and that standard procedures also apply with regard to the organisation and implementation of the audits. The Domestic Nursing Care Quality Audit Guideline and the amendments in the Quality Audit Guidelines in accordance with Book XI of the Social Code came into force on 1 January 2018.

Auditing of quality and invoices is to focus on medical long-term care treatment services prescribed by a physician for which detailed audit criteria are stipulated in the Annexes to the Guideline.

Developments in expenditure on long-term care treatment services and domestic nursing care

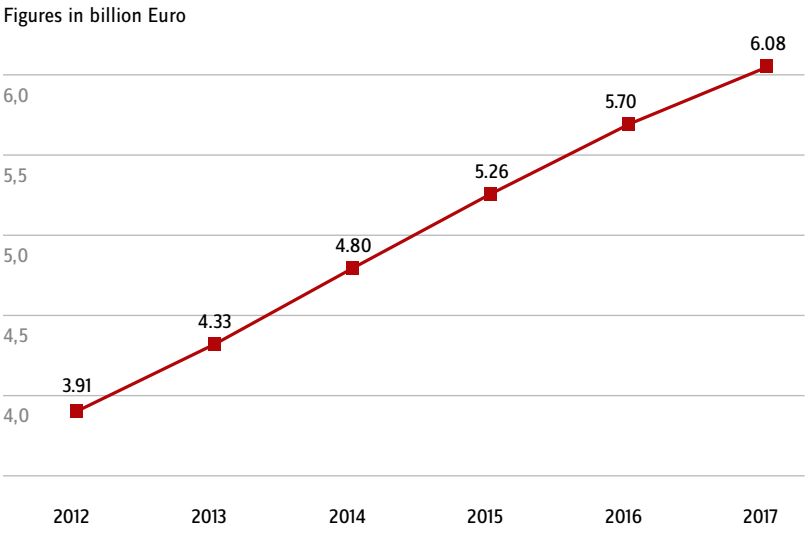


Illustration: National Association of Statutory Health Insurance Funds; Source: official statistics KJ 1, value of 2017, KV 45

HOW CAN I PARTICIPATE

Better participation through supply of medical aids

The Remedies and Medical Aids Supply Act (HHVG) is intended to refine the previous quality tools in medical aids, to enhance patients' rights as well as the principle of benefits in kind, and to design the supply of medical aids in a sustainable manner in financial terms. The major provisions came into force in April 2017. The National Association of Statutory Health Insurance Funds contributed to the discussion and to the parliamentary procedure at an early stage by submitting concrete proposals for the improvement of care. Most of these were taken up in the Act.

Updating the list of medical aids

As a core statutory task, the National Association of Statutory Health Insurance Funds must examine the list of medical aids as to its topicality by the end of 2018 and systematically update it where necessary. In this context, the medical-technical requirements of all product groups of the list of medical aids are to be adjusted in line with the medical and technical state-of-the-art and with requirements defined for the first time as to the care processes.

Independently of the provisions contained in the Remedies and Medical Aids Supply Act, the National Association of Statutory Health Insurance Funds had already started revising the list of medical aids, and has so far drawn up the product groups incontinence products, insoles, radiation therapy equipment, nursing care articles, medical aids for the blind, measuring devices for physical states and bodily functions, hearing aids, artificial eyes, bathing aids, toilet aids and certain nursing aids to facilitate long-term care, and have drawn up the product group hair replacement. The product requirements were increased in all areas, and new types of product were included in the list of medical aids. For instance, devices for Continuous Interstitial Glucose Monitoring with real time measuring devices (rtCGM) for therapy management in patients with insulin-dependent diabetes mellitus have now been included in the list of medical aids. Comprehensive advisory and other services are described in the product group of hearing aids, which also includes comparative customisation using several hearing aids so that care is achieved which is suited to each individual. Special requirements were also placed on the material used in sanitary products as to their disinfectability.

The focus of the further updates, which are currently under preparation, will continue to be placed on ensuring that the insured persons continue to have access to quality-assured, modern medical aids.

Code of Procedure for updating the list of medical aids

So that the updates can be carried out in a legally-structured context that is easy to understand for all concerned, the National Association of Statutory Health Insurance Funds has defined the procedures and steps for refining the system and the quality requirements of the list of medical aids and the framework for hearings and rights to submit statements in a Code of Procedure. This also regulates details on the procedure for obtaining information from the Federal Joint Committee where the use of a product can be an indispensable component in a new examination or treatment method. In order to ensure that the list of medical aids remains informative, and to safeguard a high standard of care, the Code of Procedure also stipulates deadlines and measures so that the list is able to show the current market developments, medical knowledge and quality requirements as soon as possible. This is to enable insured persons who rely on being supplied with medical aids to benefit from medical and technical progress. Transparency is created for manufacturers who register their products for inclusion in the list of medical aids, independently of individual cases, as to the power to make applications, the form of the applications, deadlines in the administrative procedure, the nature of the proof to be provided, rights to make statements before a notice is issued by the National Association of Statutory Health Insurance

Insured persons who rely on being supplied with medical aids are to be enabled to benefit from medical and technical progress.

Funds, as well as possibilities to file an objection. The Code of Procedure needs to be authorised by the Federal Ministry of Health.

Framework recommendations to safeguard quality in the supply of medical aids

The health insurance funds were placed under an obligation when the Remedies and Medical Aids Supply Act came into force to monitor healthcare providers' observance of statutory and contractual obligations by carrying out tests in case of abnormality as well as on a random basis. The National Association of Statutory Health Insurance Funds drew up framework recommendations in good time on the basis of statutory stipulations, which in particular contain abstract regulations concerning the scope of the random samples to be taken, on possible further monitoring tools (e.g. data evaluations, comparison of billing documents, evaluation of complaints filed by insured persons, test purchases, surveys among insured persons or evaluation by the Medical Service), as well as criteria for the implementation of tests in case of abnormality.

Increasing remuneration for remedy services is also to benefit employed therapists.

Expansion of the right to be provided with visual aids

A further major new provision contained in the Remedies and Medical Aids Supply Act is the expansion of the right to be provided with spectacle lenses in certain cases. So that this expansion in services benefits insured persons as soon as possible, the National Association of Statutory Health Insurance Funds has launched and guided the corresponding adjustment of the Federal Joint Committee's Guideline on Medical Aids. Furthermore, it has published recommendations for the approval of visual aids for the health insurance funds on the basis of the new entitlements.
The Remedies and Medical Aids Supply Act also created arrangements for remedies intended to lead to an improvement in care, but which will definitely have an expenditure-driving effect.

Blank prescription model project (section 64d of Book V of the Social Code)

In order to enhance the therapeutic responsibility of remedy suppliers, the Land associations of the health insurance funds and the Substitute Funds are to trial with the relevant remedy suppliers' associations, jointly and uniformly, model projects for testing what is referred to as "blank prescriptions". Remedy suppliers themselves can determine the selection and duration of the therapy, as well as the frequency of the treatment units, on the basis of a diagnosis and indication made by a physician. The model agreements are also to take account of the qualification requirements linked with greater responsibility, as well as of the impact on the volume development. The duration of model projects is to be limited to three years as a rule, and they are to be evaluated on a scientific basis.

Remedy remuneration and transparency stipulations

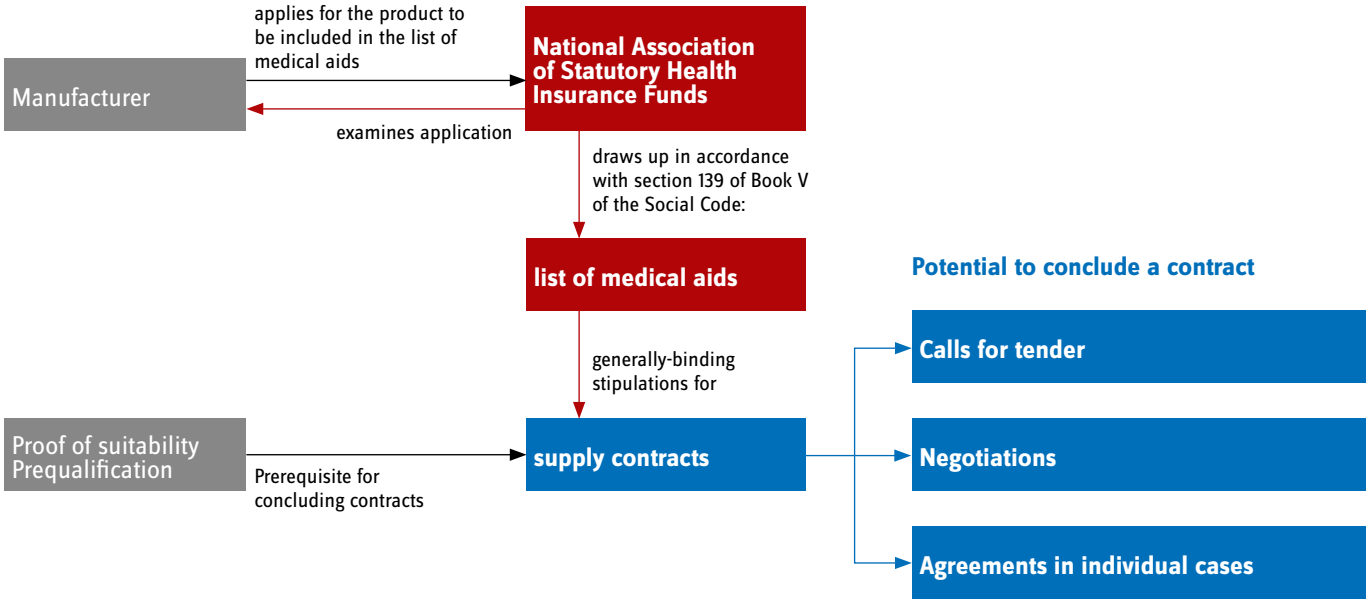
The principle of stable contributions was withdrawn for the remedy remuneration for 2017 to 2019. The time-limited suspension of the base rate of pay as the ceiling for remuneration negotiations is to enable the contracting partners in the area of remedies to be more flexible when agreeing on the prices of remedies. In order to ensure that increasing remuneration for remedy services also benefits employed therapists, the legislature has instructed the parties to the framework recommendations to agree transparency stipulations for the remuneration negotiations in order to prove the salaries that were actually paid to the salaried employees. The National Association of Statutory Health Insurance Funds has approached the parties to the framework recommendations among the service-providers and put forward proposals. The talks on this are ongoing.

Further training

The further training that has been agreed for the special activities of physiotherapy between the health insurance funds and remedy associations (on "certificate items" such as manual therapy, e.g. equipment-aided physiotherapy) has been expanded to include a statutory regulatory mandate in the framework recommendations. The National Association of Statutory Health Insurance Funds and the relevant professional associations of physiotherapists are to regulate necessary activities for further training which are then fleshed out in content terms by the partners among the funds and service-providers, and then flanked with supplementary contracts via a central examination and listing of further training facilities as well as specialist instructors. The National Association of Statutory Health Insurance Funds has submitted key points for further training arrangements in the ongoing negotiations on physiotherapeutic framework recommendations, and will be continuing the negotiations on this basis.

The previous requirements as regards quality in the medical aid area are being further developed by updating the list of medical aids as well as the framework recommendations.

The path of a medical aid onto the list of medical aids of the National Association of Statutory Health Insurance Funds



Source and illustration: National Association of Statutory Health Insurance Funds

HOW DO I STAY HEALTHY?

Enhancing setting-related health promotion

A central concern addressed by the Disease Prevention Act, which came into force in 2015, is to expand disease prevention and health promotion in settings – in particular in municipalities, kindergartens, schools, long-term care facilities and companies – in a targeted and quality-assured manner. At the same time, the supra-disease prevention commitment of the social insurance funding institutions is to be enhanced.

The figures contained in the Statutory Health Insurance Disease Prevention Report 2017 prove that the health insurance funds are complying with their statutory obligation, and that they are continually expanding their disease prevention activities. Cooperation spanning funding institutions is also being actively implemented: Back in 2016, the National Association of Statutory Health Insurance Funds adopted federal framework recommendations together with statutory accident insurance and pension insurance as part of the National Disease Prevention Conference, and thus defined the content orientation of a joint national disease prevention strategy. On this basis, framework agreements were signed for local disease prevention work by mid-2017 in 15 Federal Länder. The Land framework agreement in Berlin is expected to be adopted in the first Quarter of 2018.

Further development of the national framework recommendations

The National Disease Prevention Conference decided in February 2017 to update the national framework recommendations for the first time with the following priorities:

- further design of cooperation between social insurance funding institutions
- coordination of the objectives related to workplaces with those of the Joint German Occupational Safety Strategy
- development of priorities for disease prevention related to settings, as well as health, safety and participation promotion

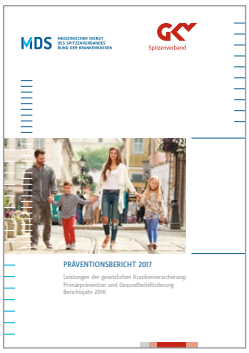
Knowledge from the Land framework agreements and the results of the disease prevention forum are to be taken into account.

The disease prevention forum has been implemented on an annual basis since 2016 by the Federal Association of Disease Prevention and Health Promotion (BVPG) on behalf of the National Disease Prevention Conference funding institutions. More than 200 experts attended in 2017 once more, this time in order to discuss the guiding question of: "How can local disease prevention and health promotion be enhanced?". Local health officials, as well as the national independent welfare associations and all the health (promotion) associations at Land level, were also invited to discuss this key topic.

The Federal Centre for Health Education was able to carry out the concrete project work for the support of the health insurance funds in the implementation of health promotion related to settings to a highly-limited degree only.

Disease prevention report spanning funding institutions in preparation

For the first time, the National Disease Prevention Conference has to draw up a disease prevention report spanning funding institutions by July 2019, in which it is to draw initial conclusions for the implementation of the national disease prevention strategy. A draft plan for the report was resolved on in 2017, and a detailed plan is to be submitted by the beginning of 2018. The National Disease Prevention Conference funding institutions are being supported by the Berlin IGES Institut in the development and implementation of the detailed plan. The process also involves the advisory National Disease Prevention Conference members – the Federation, the Länder, central associations at local level, the Federal Employment Agency, the social partners, patients' representatives and the Federal Association of Disease Prevention and Health Promotion as the representative of the disease prevention forum –, the Robert Koch Institute, an advisory scientific council and the Association of Private Health Insurance, which has been involved in the National Disease Prevention Conference with voting rights since February 2017.



Commissioning of the Federal Centre for Health Education in implementation

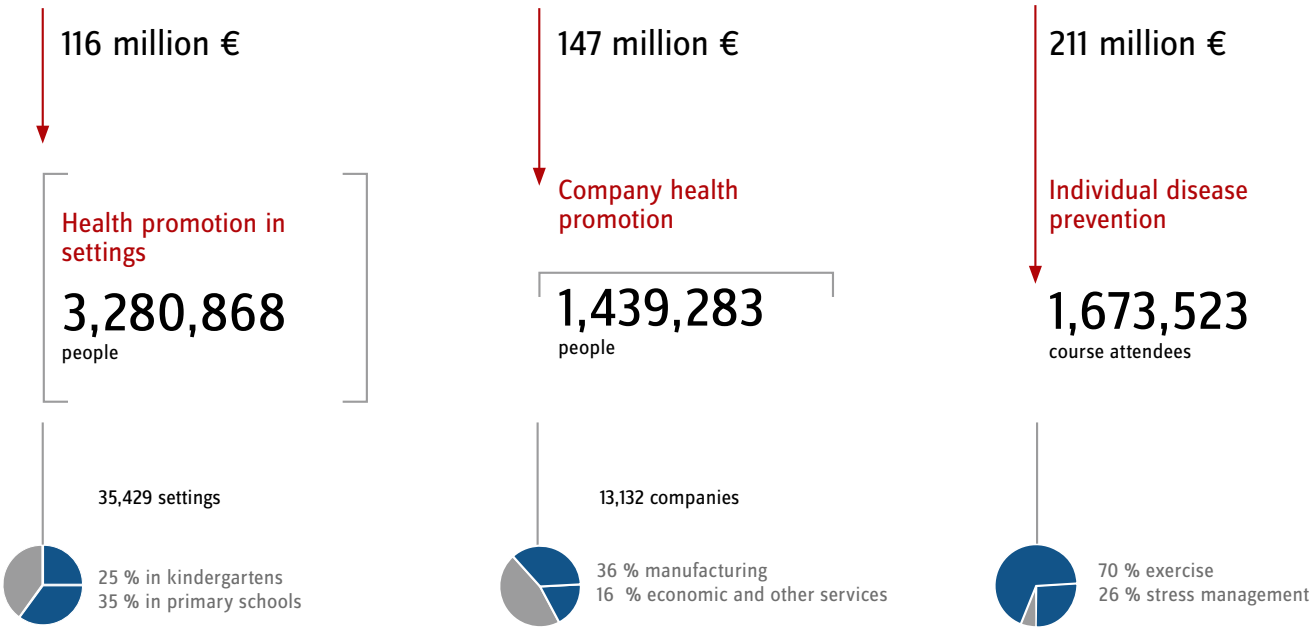
As provided by the law, the National Association of Statutory Health Insurance Funds has commissioned the Federal Centre for Health Education with supporting the health insurance funds in the expansion of health promotion related to settings. Amongst other things, the commission encompasses:

- support in establishing the structure and networking processes,
- developing and trialling health-promoting concepts, in particular for target groups with social and health-related disadvantages, and
- measures for quality assurance and scientific evaluation.

The commissioning has strengthened the coordination units on equality of healthcare opportunities, which support the health insurance funds in the implementation of the Land framework agreements, and activities for the health-promoting support of unemployed people were expanded. Two multipliers' conferences were also held for local addiction prevention. All the activities within the commissioning of the Federal Centre for Health Education are operated under the name "Statutory Health Insurance Alliance for Health".

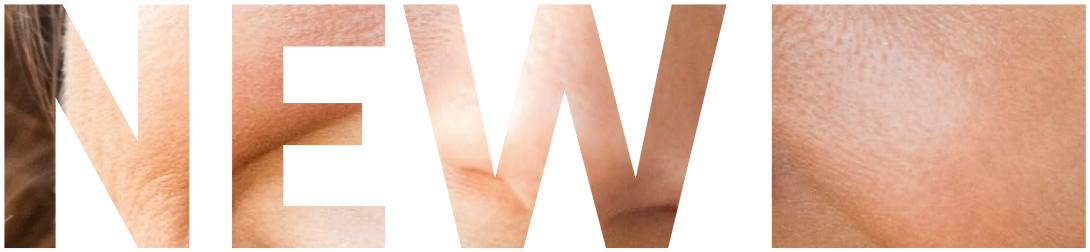
The Federal Centre for Health Education was however able to carry out the concrete project work for the support of the health insurance funds in the implementation of health promotion related to settings to a highly-limited degree only. Fewer than 10 million Euro out of the total of approx, 63 million Euro made available by statutory health insurance in 2017 were actually spent.

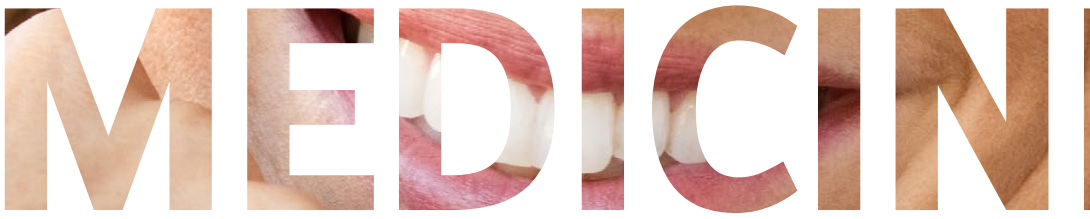
Key figures on disease prevention



Source: Disease Prevention Report 2017

HOW GOOD ARE NEW MEDICINES REALLY?





Information system for doctors on medicinal products

A major novelty in the Statutory Health Insurance Medicinal Product Supply Improvement Act (AMVSG) is the envisaged transfer of the results of the benefit evaluation of medicinal product to doctors' software. With the statutory foundations for the further development of the practice management systems, an information system for doctors is to provide information on the results of the early benefit evaluation in future. For instance, all relevant information on potential therapies is to be displayed quickly in order to facilitate informed decision-making for each individual patient when writing prescriptions. The successful integration of the information system for doctors into the practice management systems requires a close, constructive interplay between a variety of stakeholders in self-government.

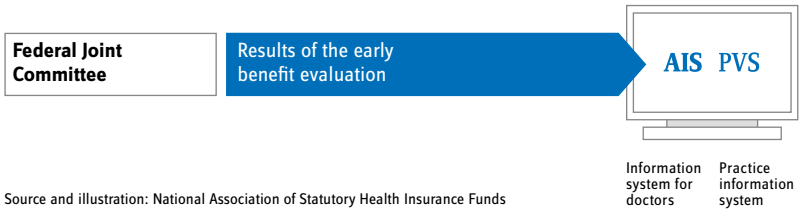
The information system for doctors is to quickly display all relevant information on potential medicinal product therapies in order to facilitate informed decision-making for each individual patient when writing prescriptions.

The National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians negotiated on requirements as to the certification of the practice management systems used by contract doctors. The latter are recorded in the schedule of requirements for prescription software/medicinal product databases. Agreement was reached in August 2017 as to the further procedure in the displaying of the results of the early benefit evaluation in the practice management systems. A major precondition for the implementation of the information system for doctors is to update the practice management systems. As a transitional measure, the medicinal product information is to be updated on a monthly basis with effect from April 2018 onwards, instead of quarterly as was previously the case. The information on medicinal products must be updated on a 14-day basis in 2020 at the latest.

The Federal Joint Committee is now obliged to establish a high-performance, practicable database with the contents of its Guideline on Medicinal Products, in particular with the results of the early benefit evaluation. The linking between these items of information, starting with the sub-indications, will form a new information base for doctors' therapy decisions in future.

The portrayal of the information from this database in the practice management systems will then be negotiated between the contracting partners of the schedule of requirements. The interplay of information for the therapeutic quality of the active ingredient, as well as nationwide, regional and fund-specific contracts and current price information on the respective medicinal products in the practice management systems, will make it much easier in future for doctors to opt for a therapy, taking possible economic efficiency aspects into account.

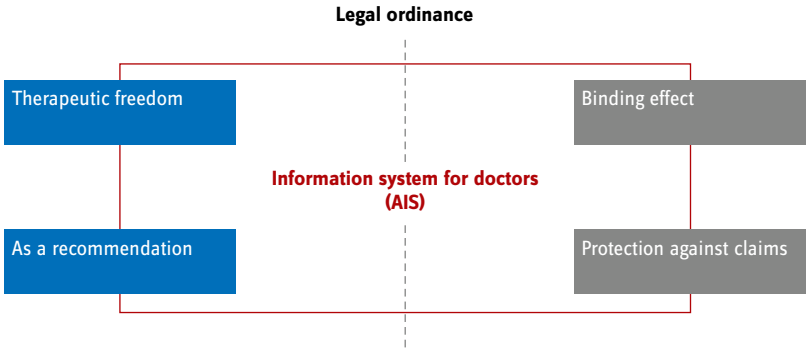
Information system for doctors



Source and illustration: National Association of Statutory Health Insurance Funds

Legal ordinance on the information system for doctors

Conflict between responsibility for economic efficiency and therapeutic freedom



Source and illustration: National Association of Statutory Health Insurance Funds

New regulations in the supply of medicinal products

The Statutory Health Insurance Medicinal Product Supply Improvement Act came into force in May 2017. The new provisions focussed on adjustments to the Act on the Reform of the Market for Medicinal Products (AMNOG) process in the areas benefit evaluation and refund amount negotiations. Moreover, the Statutory Health Insurance Medicinal Product Supply Improvement Act brought about amendments in the supply of cytostatics and pharmacists' remuneration in the prescription segment. The continuation of the price moratorium by the above Act is also a major building block in safeguarding the financial stability of statutory health insurance.

Price ceilings for medicinal products watered down

As part of the refund amount negotiations, a price ceiling was applied to medicinal products without additional benefit amounting to the cost of the expedient comparison therapy. This stipulation, compliance with which was previously mandatory, has been replaced by an optional provision: It is permissible to exceed this limit in justified individual cases. The National Association of Statutory Health Insurance Funds considers that this amendment runs counter to the aim of the Act on the Reform of the Market for Medicinal Products, namely to ensure the appropriate additional benefit-orientated pricing of patent-protected medicinal products. It is not understandable why an unproven additional benefit is to justify additional expenditure on the part of the community of insured persons.

It is not understandable why an unproven additional benefit is to justify additional expenditure on the part of the community of insured persons.

The legislature also wishes this watering down of what used to be a fixed refund amount limit to apply to medicinal products that had been negotiated before the Statutory Health Insurance Medicinal Product Supply Improvement Act came into force. A time-limited special right of termination has been introduced for refund amounts for this purpose, the claiming of which was contingent on two prerequisites:

1. It should be a medicinal product for which the Federal Joint Committee was not able to recognise a proven additional benefit in any application area.
2. It was necessary for there to be a refund amount that had already been negotiated or set by the Arbitration Office on the medicinal product.

Remuneration of preparations made from substances in accordance with section 5 subsection (3) of the Medicinal Products Price Ordinance

Purchasing	Fixed supplement of 90 % on top of the purchase price
Manufacture	Formulation supplements 3.50 € to 8 € (section 5 subsection (3) of the Medicinal Products Price Ordinance) and 51 € to 90 € for parenteral preparations (section 5 subsection (6) of the Medicinal Products Price Ordinance)
Sale	The Statutory Health Insurance Medicinal Product Supply Improvement Act led to the introduction of a fixed supplement of 8.35 € plus VAT (not for parenteral preparations)

Analogously to finished medicinal products, the discount is 1.77 € (including VAT) for non-parenteral preparations. In other cases it is 5 % of the pharmacists' sales price.

The National Association of Statutory Health Insurance Funds and the German Pharmacists› Association may agree on alternative amounts of remuneration in the ancillary charge.

Source and illustration: National Association of Statutory Health Insurance Funds

This special right of termination was explicitly also applicable to medicinal products which were no longer on sale in Germany. The special right of termination was only taken up three times up to the expiry of the statutory deadline as per 13 August 2017.

Pharmacists' remuneration needs a valid databasis

The Statutory Health Insurance Medicinal Product Supply Improvement Act caused pharmacists' remuneration to increase considerably for the area of prescriptions and the dispensing of medicinal products that are classified as narcotics. It must be anticipated that statutory health insurance will incur additional expenditure of 115 million Euro per year. The National Association of Statutory Health Insurance Funds considers that fee adjustments should only be carried out on the basis of valid, representative data concerning the current remuneration situation. These are not available. It would hence have been desirable to wait with fee adjustments until the results of the research project of the Federal Ministry for Economic Affairs and Energy for pharmacists' remuneration are available. Strict remuneration decisions can only be taken on such a basis.

The health insurance funds were denied the opportunity in the supply of cytostatics to ensure both quality criteria and supply structures via contracts, and in doing so to establish substantial economic efficiency reserves.

The expert report that has now been published analyses amongst other things the extant care situation, the expenses incurred when dispensing medicinal products, as well as potential reforms. The analysis concludes that the expenditure of the cost funding institutions (statutory health insurance, private health insurance as well as self-paying patients) could be reduced by a total of 1.24 billion Euro for prescription-only medicinal products, were performance-related, cost-covering remuneration to be introduced. No danger to the blanket supply of prescription-only medicinal products can be ascertained, by contrast. Mail order also does not entail any disadvantageous effects.

Making medicinal product prices transparent and economical

The health insurance funds were denied the opportunity in the oncology segment to ensure that insured persons were supplied with cytostatics via calls for tender with pharmacies. As this is a relatively intransparent field, the contracts offered the health insurance funds the opportunity to ensure both quality criteria and supply structures via contracts, and in doing so to establish substantial economic efficiency reserves at the same time. In order to compensate for the additional expenditure that could be anticipated, the legislature commissioned the National Association of Statutory Health Insurance Funds and the German Pharmacists' Association with reaching a fresh agreement on the billing agreement for those parenteral preparations that were not regulated in the Medicinal Products Price Ordinance (Arzneimittelpreisverordnung) in the oncology segment. A clarification of the rights of the National Association of Statutory Health Insurance Funds to receive price information vis-à-vis pharmaceutical companies and pharmacies as well as production companies is to ensure that prices that are close to the needs of the market can be agreed between the contracting parties. A corresponding contract text will be established by the Arbitration Office for the supply of medicinal products. As a second measure for the reduction of the additional expenditure, the possibility was created to conclude discount contracts at regional level for finished medicinal products which are processed in these preparations.

It cannot be currently anticipated that these new measures will substantially compensate for the increase in costs caused by the law.

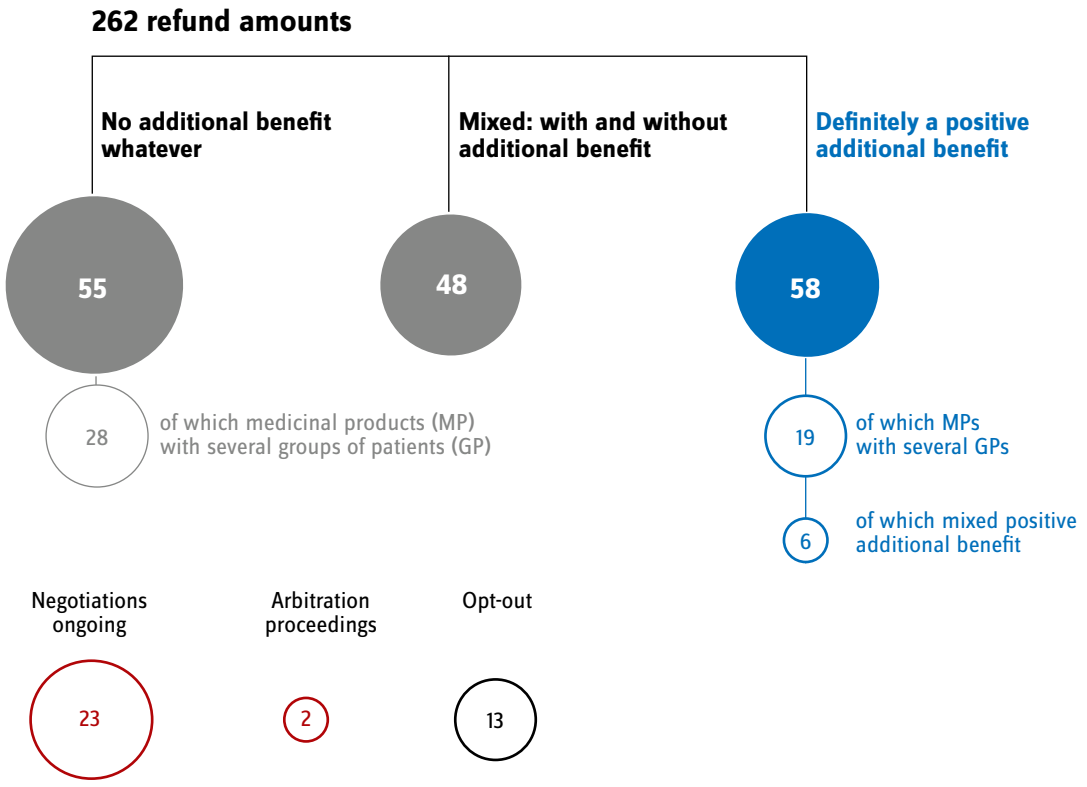
Orientating the refund amount towards the additional benefit

The Federal Joint Committee initiated 337 sets of proceedings on the early benefit evaluation of medicinal products from the new and established markets, and implemented more than 1,067 sets of advisory proceedings from January 2011 to January 2018. Out of 68 sets of exemption proceedings, the Federal Joint Committee exempted the medicinal product from the benefit evaluation in 27 cases. Refund amounts exist for a total of 161 active ingredients. 135 of these sets of proceedings were concluded through an agreement that was reached between the contracting parties, and 26 with a ruling handed down by the Arbitration Office. Four active ingredients have so far been directly attributed to existing fixed-amount groups. A fixed amount for an active ingredient regulated by a refund amount became effective for the first time as per 1 September 2017.
23 sets of refund amount negotiations and two sets of arbitration proceedings were pending as per 1 January 2018. 13 sets of pending refund amount negotiations constitute new negotiations that were necessitated by new resolutions of the Federal Joint Committee in conjunction with new areas of application, because of the expiry of a deadline or of the termination of existing refund amount agreements.

National Association of Statutory Health Insurance Funds' successful court action against arbitration rulings

The Arbitration Office has set a refund amount in several sets of arbitration proceedings which the National Association of Statutory Health Insurance

Stocktake of the Act on the Reform of the Market for Medicinal Products (AMNOG)



Version: 31 January 2018, Illustration: National Association of Statutory Health Insurance Funds

Funds considered to be disproportionate to the additional benefit set by the Federal Joint Committee. It was also not possible to ascertain from the reasoning of the arbitration rulings how the refund amount was formed in relation to the expedient comparison therapy and the additional benefit. The National Association of Statutory Health Insurance Funds was also unable to concur with the view of the Arbitration Office that the resolution handed down by the Federal Joint Committee on the benefit evaluation was not to be binding on the Arbitration Office. The National Association of Statutory Health Insurance Funds therefore filed suit against several arbitration rulings of the AMNOG Arbitration Office.

It was not possible to ascertain from the reasoning of the arbitration rulings how the refund amount was formed in relation to the expedient comparison therapy and the additional benefit.

Berlin-Brandenburg Regional Social Court, which has jurisdiction for the court actions, has now concurred with the view of the National Association of Statutory Health Insurance Funds in the first two sets of main action proceedings. It ruled that the arbitration rulings are already unlawful in formal terms, particularly because they are not sufficiently well reasoned. The Court has therefore rescinded the arbitration rulings. In doing so, it has allowed the motions of the National Association of Statutory Health Insurance Funds in full. The respondent Arbitration Office has submitted an appeal on points of law only (Revision) to the Federal Social Court against the judgment of the Regional Social Court in the case of "Albiglutid". One may therefore anticipate a supreme court ruling to be handed down soon on these questions, which are important for statutory health insurance.

The National Association of Statutory Health Insurance Funds had additionally requested injunctory legal protection proceedings with regard to the "Albiglutid" arbitration ruling. Berlin-Brandenburg Regional Social Court had ruled in these injunctory proceedings that the arbitration ruling was also unlawful because the Arbitration Office had set a "mixed price" without being authorised to do so. The mixed price came about by virtue of the medicinal product having an additional benefit for one group of patients only. The Federal Joint Committee had been unable to ascertain any additional benefit for any other groups of patients. The Arbitration Office had therefore first of all calculated a price for the group of patients with an additional benefit – where this could be ascertained – and a price for the group of patients without any additional benefit. Since however only a uniform sales price can apply for the medicinal product within today's legal framework, the Arbitration Office had linked these prices to form a uniform (mixed) price. The Court ultimately no longer based its ruling in the main proceedings on the prohibition of mixed prices, but only criticised it in its legal statement on the adjudication, on which the judgment is however not based.

Nutrition therapy as a new remedy area

The Federal Joint Committee resolved in March 2017 to expand the supply of remedies (physiotherapy, ergotherapy, voice, speech and language therapy as well as podology) to include the remedy area of nutrition therapy. The new benefit may be prescribed from 1 January 2018 onwards, but is restricted to two indications in the area of rare diseases:

1. In the first therapeutic area "cystic fibrosis"/CF, nutrition therapy is a main pillar of treatment without which damage to health and reduced life expectancy would be the result. Nutrition therapy aims above all here to avoid malnutrition or undernutrition.
2. The second therapeutic area is rare genetic metabolic diseases, where a diet is indispensable, otherwise there is a risk of death or serious disability. Nutrition therapy aims here to circumvent the metabolism disorder by means of dietary measures, and hence contribute towards physical and mental development in line with the patient's age.

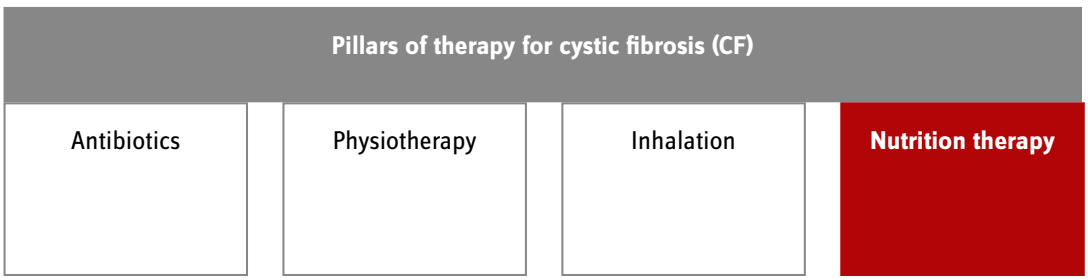
It is estimated that approx. 23,000 people live in Germany today who are generally supplied with nutrition therapy in specialised centres (e.g. University out-patient clinics). In order to broaden the care that is available, the Federal Joint Committee has established nutrition therapy as a remedy that is eligible for prescription. It is largely prescribed by the physician in attendance, who specialises in the respective disease. In exceptional cases, however, it may also be issued by general practitioners or other doctors specialising in a different field.

Successful launch of care

The National Association of Statutory Health Insurance Funds engaged in successful talks on framework recommendations, as well as on the content of the licensing conditions, in the year under report 2017, together with the professional associations of nutrition therapy. The "framework recommendations" describe both the conditions for the provision of the services, as well as the content of the individual nutrition therapy activities. On this basis, the health insurance funds are negotiating with the professional associations of nutrition therapy on the details of care, in particular remuneration for services. The licensing recommendations defined the requirements to be met by a nutrition therapy remedies practice, both in terms of space and materials, as well as the necessary specialist qualification of the new remedy suppliers. Billing arrangements were also adjusted. This largely set the stage to launch the new remedy area on time as per 1 January 2018.

In order to broaden the care that is available, the Federal Joint Committee has established nutrition therapy as a remedy that is eligible for prescription.

Pillars of therapy for cystic fibrosis (CF)



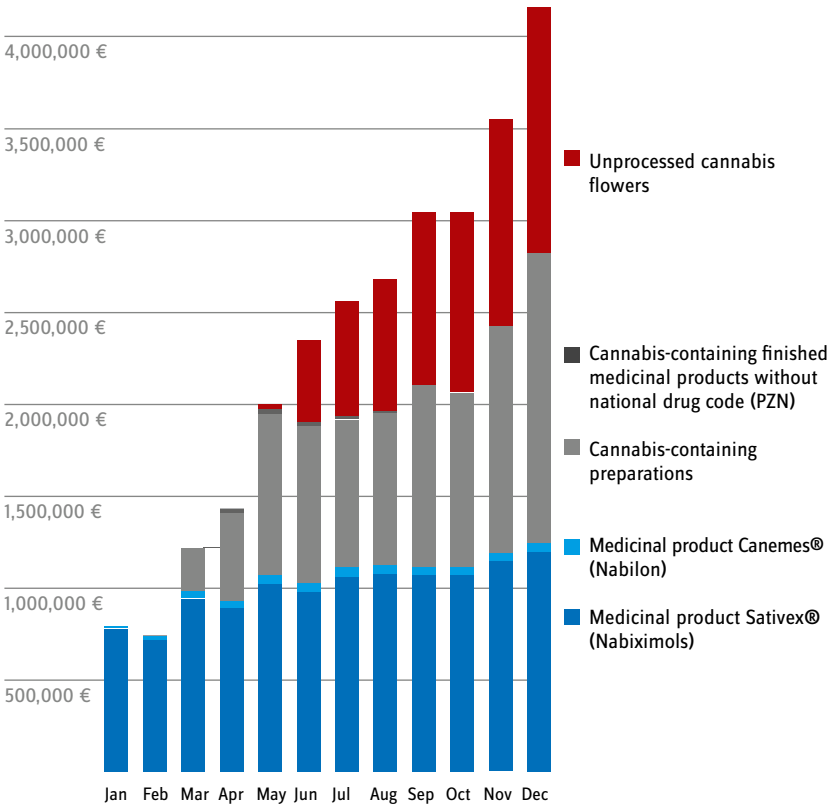
Source and illustration: National Association of Statutory Health Insurance Funds

Evidence unsatisfactory with regard to cannabis

The evidence runs counter to the hopes that had arisen among patients with regard to the widespread supply of cannabis.

In March 2017, the Act Amending Narcotics Regulations and other Provisions (Gesetz zur Änderung betäubungsmittelrechtlicher und anderer Vorschriften) established the marketability and eligibility for prescription of medicinal products made of cannabis. Insured persons with a serious disease are entitled to be supplied with cannabis if there is no service available according to the generally-recognised state of medicine, or none can be applied, and there are non-distant prospects for a successful therapy.

Gross expenditure of statutory health insurance on the supply of cannabis 2017



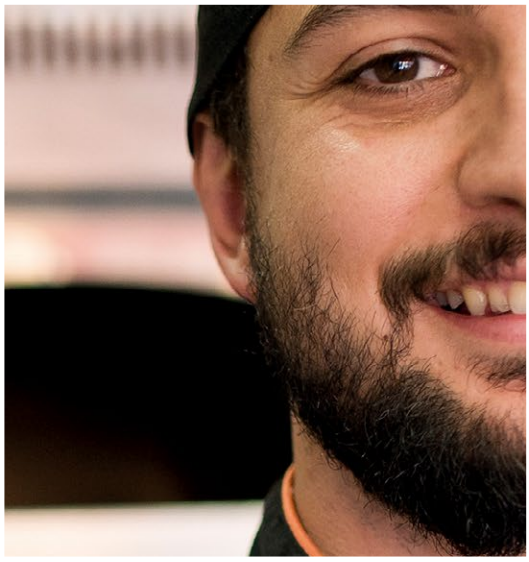
Source and illustration: National Association of Statutory Health Insurance Funds

The first time an insured person is supplied via this service must be authorised by the health insurance fund. Authorisation may only be refused in well-founded exceptional cases. The prerequisites are established as a rule by means of an expert report from the Health Insurance Medical Service, based on information from the patient and the physician in attendance.

Benefits and risks inadequately researched

The National Association of Statutory Health Insurance Funds considers this new provision to be a break with the system: Cannabis as a medicinal product has yet to undergo any test of the benefit and risks by a licensing authority. Supplying patients with cannabis flowers at the expense of the statutory health insurance therefore fails to do justice to the fundamental stipulations which must be satisfied in order for statutory health insurance to be obliged to pay for it. The evidence underlying attempted therapy with cannabis is also unsatisfactory in most areas of application, both with regard to the effectiveness and the side-effects. This runs counter to the hopes that had arisen with regard to the widespread supply of cannabis.

Prescribing cannabis flowers as a formulation is also of financial consequence for statutory health insurance. Pharmacies bill an additional fixed supplement of 90 % on top of the price of the substance – which is already much higher than other formulations – in accordance with the Medicinal Products Price Ordinance. Added to this is a commodity price dependent on the quantity and form sold as set out in the Ordinance, a fixed supplement of 8.35 Euro, minus the pharmacy discount of 1.77 Euro, as well as the narcotics fee of 2.91 Euro. The German Pharmacists' Association and the National Association of Statutory Health Insurance Funds have been engaged in negotiations since April 2017 in search of an agreement for the billing of cannabis formulations at reasonable prices.



WHO WILL TAKE CARE OF ME?

Trouble-free further development of long-term care insurance

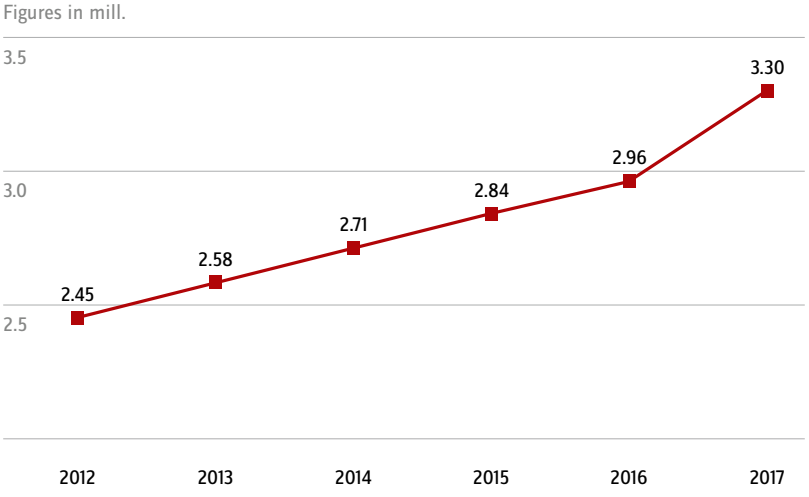
The aim is to formulate stipulations for uniform standards and principles, in particular for the procedure and the main contents of long-term care advice.

The new definition of need for long-term care was implemented seamlessly as per 1 January 2017 on the basis of the comprehensive preparations carried out by all concerned; roughly three million persons in need of long-term care were transferred to the new system. As expected, the positive echo among the public has led to a considerable increase in the number of applications for long-term care benefits, and hence the number of the assessment requests to establish a need for long-term care, since the end of 2016. Roughly 2.2 million applications for long-term care were filed in 2017. This is a year-on-year increase of 12.9 %. The number of new beneficiaries has also considerably increased as a consequence. An increase by roughly 300,000 individuals receiving long-term care benefits for the first time was recorded in the long-term care reform year 2017, in comparison to 2016.

Long-term care advice

The Second Act to Strengthen Long-term Care (PSG II) transferred authority to the National Association of Statutory Health Insurance Funds to issue guidelines for the uniform implementation of long-term care advice (Long-term Care Advice Guidelines), with the involvement of the Medical Service of the National Association of Statutory Health Insurance Funds by 31 July 2018. Together with representatives of the long-term care insurance funds and their associations at federal level, as well as with the Medical Service of the National Association of Statutory Health Insurance Funds, the National Association of Statutory Health Insurance Funds has drawn up a draft of the Long-term Care Advice Guidelines. The National Association of Statutory Health Insurance Funds aims to formulate stipulations for uniform standards and principles, in particular for the procedure and the main contents of long-term care advice, as well as for the quality-assured implementation of long-term care advice. The

Total no. of beneficiaries in social long-term care insurance*



* incl. care category 0
Illustration: National Association of Statutory Health Insurance Funds; Source: official statistics PG 2

Long-term Care Advice Guidelines are intended to improve access to social insurance benefits, enhance the rights to self-determination of persons in need of long-term care, as well as guaranteeing the expedience and economic efficiency of the implementation of the advisory activities through a coordinated procedure and organisation. The law provides for broad participation by the expert groups, which the National Association of Statutory Health Insurance Funds has consulted on this matter.

The National Association of Statutory Health Insurance Funds has also to review its recommendations for the number and qualification of long-term care advisors by 31 July 2018. A novelty is that the recommendations are also submitted for the further training of long-term care advisors. The parties that are to be involved were consulted on the draft of the revised recommendations.

Adapting the Quality Audit Guidelines

The Guidelines of the National Association of Statutory Health Insurance Funds on the Auditing of the Services Provided in Long-term Care Facilities and their Quality (Quality Audit Guidelines) form the basis for audits to be carried out by the Health Insurance Medical Service and the auditing service of the Private Health Insurance Association. These Guidelines needed to be adjusted in line with the provisions contained in the Third Act to Strengthen Long-term Care (PSG III). The major amendments related, firstly, to the expansion of the sample of individuals in the out-patient area. Secondly, the auditing criteria for intensive long-term care as part of domestic nursing care services were included which were developed in connection with the newly-introduced Domestic Nursing Care Quality Audit Guideline of the National Association of Statutory Health Insurance Funds. The National Association of Statutory Health Insurance

Local agencies are to be enabled to combine advisory tasks of the long-term care insurance funds with their own advisory tasks, and to provide them jointly on their own responsibility.

Total expenditure on social long-term care insurance benefits

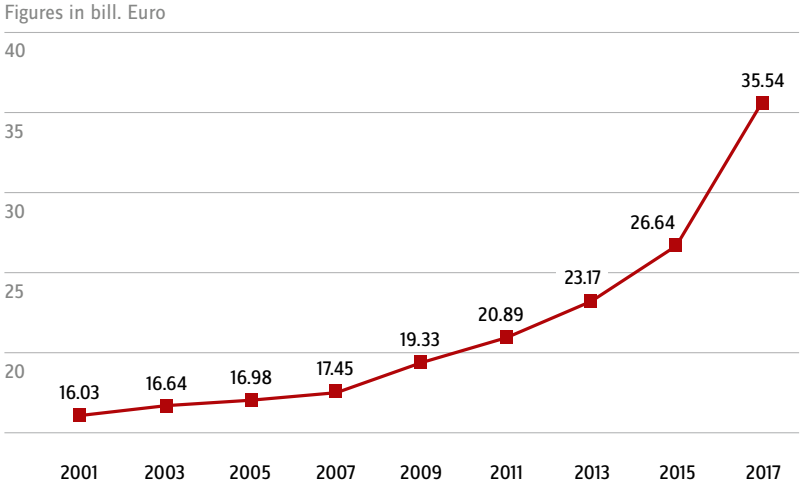


Illustration: National Association of Statutory Health Insurance Funds; Source: official statistics PV 45, taking account of the compensation fund

Funds is therefore pursuing the goal of creating uniform foundations for auditing domestic nursing care services, regardless of whether a long-term care service is subject to a standard audit in accordance with Book XI or Book V of the Social Code. The adjusted quality audit Guidelines came into force on 1 January 2018, after being approved by the Federal Ministry of Health.

Pilot local authorities

The legislature made arrangements as part of the Third Act to Strengthen Long-term Care envisaging up to 60 pilot projects nationwide to provide advice at local level for persons in need of long-term care and their relatives. The pilot projects are to trial a holistic and socio-spatial advisory approach. In particular, local agencies are to be enabled to combine advisory tasks of the long-term care insurance funds with their own advisory tasks, and to provide them jointly on their own responsibility. The National Association of Statutory Health Insurance Funds has adopted recommendations on the concrete prerequisites, goals, contents and implementation of the pilot projects for local advice of persons in need of assistance and long-term care and their relatives. The recommendations are to be used as the basis for both the provisions of Land law for the approval of pilot projects, and for the cooperation agreements to be concluded between the funding institution of the pilot project and the Land associations of the long-term care insurance funds. It is now up to the Länder to regulate the details, in particular on the requirements to be made of the advice centres, through provisions of Land law that are to be enacted by 31 December 2018.

The long-term care insurance funds make available approx. 21 million Euro per year for disease prevention services in in-patient long-term care.

Disease prevention in in-patient long-term care

The Disease Prevention Act, which came into force in 2015, imposed an obligation on the long-term care insurance funds to provide disease prevention services in long-term care homes and in day long-term care facilities. The long-term care insurance funds make available approx. 21 million Euro per year for disease prevention services in in-patient long-term care. The National Association of Statutory Health Insurance Funds published a guideline in August 2016 establishing the requirements made of disease prevention services. Areas for action include healthy eating, as well as encouraging physical exercise and cognitive resources. The guideline is currently being updated on the basis of a scientific expert report.

When long-term care insurance benefits and integration assistance come together

Where long-term care insurance and integration assistance benefits coincide, the competent long-term care insurance fund and the competent integration assistance funding institution are to conclude an agreement, with the consent of the beneficiary. By means of these agreements, the concept of providing services on a one-stop basis should be taken care of, whilst at the same time conflicts of responsibility between the funding institutions should be avoided. The integration assistance funding institution thus funds the long-term care insurance services vis-à-vis the person in need of long-term care, and the costs of the services for which it is to pay are refunded to it by the long-term care insurance fund. In order to encourage the national legal application of the agreements, the National Association of Statutory Health Insurance Funds has been tasked with developing the details in recommendations on the conditions for takeover and implementation of the services, as well as the cost refund, together with the Federal Association of Regional Social Assistance Agencies.

Nursing training with a future

The Act Reforming the Nursing Professions (Pflegeberufereformgesetz) was published in the Federal Law Gazette (Bundesgesetzblatt) in July 2017, after more than a year of parliamentary procedure. After many health and long-term care reforms had been completed relatively quickly in this legislative period, this building block of the long-term care reform actually looked at times like it might fail.

Particular controversy attached to the unification, planned in the original draft of the Act, of the previously separate training schemes for geriatric, health and paediatric nursing to become a uniform (generalist) nursing training scheme. Opponents of the reform, by contrast, were in favour of developing on the previous training paths in an integrative approach, but continuing to lead to separate qualifications.

After the public hearing that was held in May 2016, and the previous criticism that was forthcoming from a large number of associations, organisations and facilities, the parliamentary procedure came to a halt. In light of the need for legislative action, the National Association of Statutory Health Insurance Funds had repeatedly pointed out that, besides all the political difficulties, it was necessary to keep an eye on the goal of ensuring that high-quality nursing care was provided with sufficient specialist staff. In order to bring the political debate forward, the National Association of Statutory Health Insurance Funds suggested at an early date to implement the training models being debated on a provisional basis in parallel.

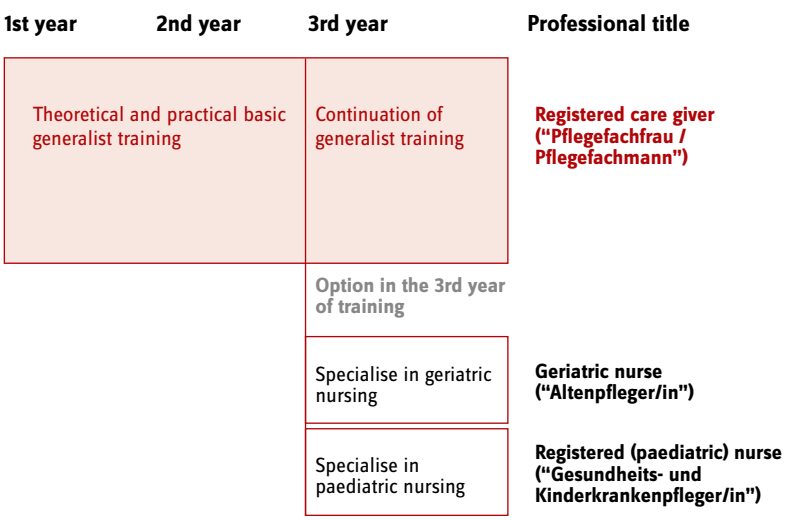
Option model in nursing training

The compromise that was then anchored in the Act links to an option model that is now envisaged, due in large part to the proposal of the National Association of Statutory Health Insurance Funds. The training initially begins for everyone with two years of nursing training. Trainees then decide whether they would like to continue it as generalist training, or whether they wish to spend the third year of training in paediatric nursing or geriatric care, culminating in the previous qualification. There will not be a separate nursing care qualification in future. The new provisions are to apply for the first time to the training years from 2020 onwards.

The re-orientation of nursing training has however not yet come to a conclusion with the publication of the Act Reforming the Nursing Professions. The Act as it was passed is only the shell which must be filled with the concrete training curricula by legal ordinances. The National Association of Statutory Health Insurance Funds has drawn up proposals for the legal ordinance regarding the question of funding nursing training in line with the statutory mandate, in coordination with the German Hospital Federation, the Association of Private Health Insurance and the organisations of the long-term care associations at federal level.

It is necessary to keep an eye on the goal of ensuring that high-quality nursing care is provided with sufficient specialist staff.

Nursing training from 2020



Source and illustration: National Association of Statutory Health Insurance Funds

Pilot projects for better long-term care

Long-term care insurance has proven its value as an important pillar of social insurance in providing security against the risk of needing long-term care. Because even tried-and-tested schemes can always be refined, and indeed should be, research, pilot testing and evaluation form the specialist and technical foundation for innovations and long-term care policy decisions. The Research Unit on Long-Term Care Insurance of the National Association of Statutory Health Insurance Funds guides the various pilot programmes for the further development of long-term care insurance, which are always concerned to improve the situation of those in need of long-term care through the projects and studies that it promotes.

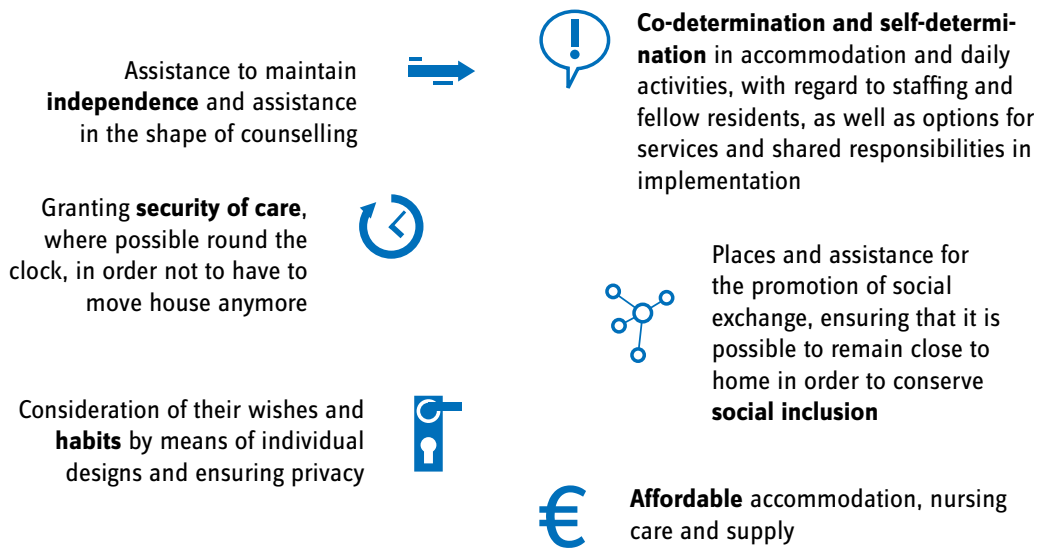
How and under what conditions the quality of life of persons in need of long-term care and caring relatives can be further improved in future are central questions that are addressed in the various pilot projects.

How and under what conditions the quality of life of persons in need of long-term care and caring relatives can be further improved in future are central questions that are addressed in the various pilot projects of the Research Unit on Long-Term Care Insurance. New research methods and results from two pilot projects which were completed in 2017 make this clear. Both projects scientifically evaluated the respective intervention and assessed them on an empirical basis.

The PLiP pilot project

The pilot project "Problem solving in long-term care advice (PLiP)" has trained long-term care advisers from three long-term care insurance funds in the application of the problem-solving method, which was then applied in advisory practice. The method enables family caregivers providing long-term care to recognise problems and resources, and to develop solutions, using a set of cards.

Expectations of users of new forms of accommodation



Source: Prognos AG/KDA 2017; Illustration: National Association of Statutory Health Insurance Funds

Effectiveness was measured at the level of the participating long-term care advisers and at the level of the family caregivers receiving advice. As a result, the problem-solving method is positively evaluated by the long-term care advisers; it shows a significant enhancement of their advisory competence and a reduction of their workload. The method also shows marked successes among the target group of family caregivers when it comes to reducing stress. The long-term care insurance funds participating in the project appreciate the problem-solving method, and will continue to work with it.

The DeTaMAKS pilot project

The pilot project entitled "Non-drug activation scheme for people with dementia in day long-term care with brief telephone intervention with relatives for enhancing the reconciliation of long-term care and work (DeTaMAKS)" has tried and evaluated the activation programme in 34 day long-term care facilities with more than 450 test persons. It was originally developed, trialled and evaluated for the in-patient care of persons in need of long-term care. MAKS is made up of four modules for motor, practical everyday, cognitive activation and social acclimatisation. The MAKS programme was refined for specific target groups for use among dementia sufferers in day long-term care. It has proven to be effective among day long-term care visitors as well as their family caregivers. In comparison to the control group, the practical everyday skills the of day long-term care visitors of dementia sufferers were stabilised, and skills were retained.

Pilot programme on new forms of accommodation

How new forms of accommodation can be refined for persons in need of long-term care is another important question addressed by the Research Unit on Long-Term Care Insurance. At present, we do not yet know enough about the living, long-term care and care quality of new forms of accommodation and about whether they also meet users' expectations. It is therefore consistent for their perspective to be in the focus of the accompanying research. The 53 projects included in the pilot programme are being analysed in their diversity, in line with the following evaluation criteria that have been established:

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

The initial results of the pilot programme were presented to the National Association of Statutory Health Insurance Funds as part of a public stocktake in September 2017. The focus here was on the interim results of the user surveys. These anticipate amongst other things that assistance in the accommodations supports their independence. Furthermore, more than 90 % of the respondents so far no longer wish to move house should their state of health worsen.

Guaranteeing self-determination and security of care are therefore requirements of the new forms of accommodation which are to be evaluated at project level as the pilot programme progresses. Initial project experience has been reported from the model projects, and methods for reaching solutions have been discussed which can help strike out on new paths, for instance as part of further development of in-patient care. A practical project should be particularly emphasised at this juncture which received the 2017 Telematics Award at the Berlin IFA. In cooperation between a housing association, a long-term care insurance fund and other partners, it was possible to individually equip 30 existing flats occupied by very old tenants who are in need of long-term care with assistance systems adapted to the needs of the elderly.

Guaranteeing self-determination and security of care are important requirements of the new forms of accommodation.

New quality tools in long-term care

As the body tasked with negotiations and decisions in long-term care self-government at federal level, the Quality Committee on Long-Term Care, on which the National Association of Statutory Health Insurance Funds is also represented, is amongst other things to scientifically refine the procedures and tools of quality assurance in long-term care. Contracts have been awarded to scientific institutions for this purpose.

Quality audits and indicators

The connection desired by the legislature for the in-patient area of external quality audits with quality indicators constitutes a particular challenge. The quality indicators are to be collected in future by all long-term care facilities, as well as evaluated at nationwide level. The results of quality audits and quality indicators are to form the basis for the information of the insured persons regarding the quality of the long-term care facilities, and are to replace the previous long-term care grades.

The quality indicators are to be collected in future by all long-term care facilities, as well as evaluated at nationwide level.

Long-term care activities, including non-clinic intensive long-term care, as well as care of persons in need of long-term care, will be focussed on in the out-patient area. For the first time, a concept will also be developed for quality assurance for the setting "new forms of accommodation", taking account of the quality requirements of the different types of new form of accommodation.

Quality assurance of advisory visits

Beneficiaries of the long-term care allowance must prove that they have received mandatory advice in their domestic setting in order to safeguard the quality of domestic long-term care and regular assistance and practical long-term care specialist support for domestic long-term carers. The recommendations, which are to be resolved on by the Quality Committee on Long-Term Care, set out the requirements as to the quality-assured implementation of these advisory visits. The recommendations are to be used to implement standard nationwide quality-assured advice.

Reductions in long-term care remuneration

The Quality Committee on Long-Term Care adopted a procedure on 22 December 2017 for reducing the long-term care remuneration of long-term care facilities in the event that long-term care facilities have acted in violation of their statutory or contractual obligations. A legal amendment, which is welcomed by the National Association of Statutory Health Insurance Funds, means that the procedure is not only applied when quality shortcomings have been ascertained, but also if a long-term care facility deliberately fails to provide the agreed level of staffing over a prolonged period of time.

The tasks of the Quality Committee on Long-Term Care

- award of contracts for the development of tools and procedures for quality audits and presentation for out-patient and in-patient long-term care
- development and trialling of a concept for quality assurance in new forms of accommodation
- development of supplementary tools for calculating and evaluating quality of life
- commissioning of an independent institution for the data of the indicator-supported procedure (section 113 subsection (1b) of Book XI of the Social Code)
- agreement on the standards and principles for safeguarding and refining the quality of out-patient and in-patient long-term care (section 113 of Book XI of the Social Code)
- agreement for the quality portrayal of out-patient and in-patient care (section 115 subsection (1a) of Book XI of the Social Code)
- development and updating of expert standards
- agreement on a procedure for reducing long-term care remuneration
- recommendation for advisory visits

WHAT IS QUALITY OF LIFE AT THE END OF LIFE?

Hospice framework agreements re-orientated

The Act to Improve Hospice and Palliative Care in Germany (Gesetz zur Verbesserung der Hospiz- und Palliativversorgung in Deutschland) from 2015 expanded the entitlements of those who have statutory health insurance to include a supplement that is to be paid towards in-patient care in hospices. The following statutory provisions were adopted:

- The National Association of Statutory Health Insurance Funds and the central organisations that are relevant to defending the interests of in-patient hospices are to adopt an independent framework agreement at federal level for care in children's hospices.
- A standard framework agreement is to govern hospice services for adults and children in Germany.
- Nationally-applicable standards with regard to the scope and quality of the services that are to be eligible for the supplement in in-patient hospices and children's hospices are to be established in future by the partners to the framework agreements.

The new framework agreements came into force in May 2017, and very largely do justice to the statutory mandate of setting standards in that arrangements were made for the necessary staffing and for needs in terms of space. The National Association of Statutory Health Insurance Funds considered it to be particularly important for the necessary flexibility of the regional contracting partners not to be lost, despite standardisation. The stipulations hence provide, firstly, the necessary uniform nationwide orientation, whilst at the same time enabling the scope needed to take account of the conceptual and regional particularities of the respective hospice.

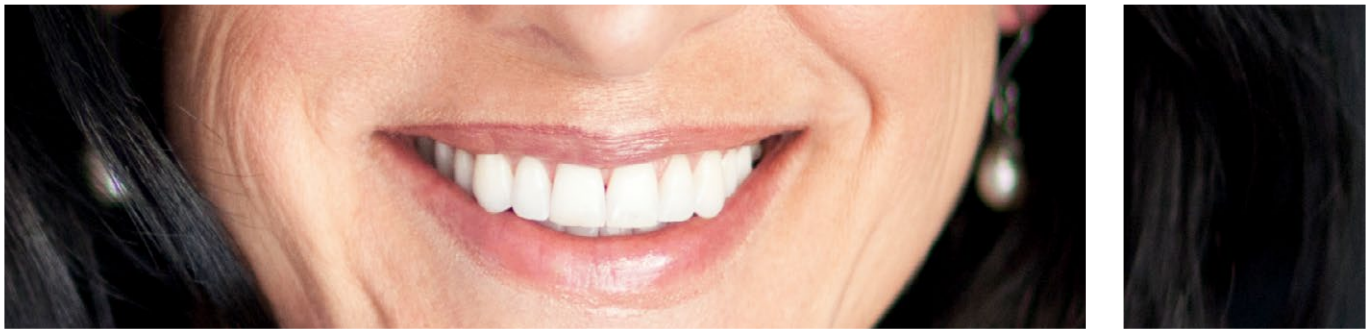
The conceptual and regional particularities of the respective hospice continue to be taken into account regardless of the uniform nationwide orientation.

Healthcare planning for the last stage of life

The Act to Improve Hospice and Palliative Care in Germany of 1 December 2015 enabled the approved in-patient long-term care facilities and the facilities providing integration assistance for people with disabilities to offer advice to their residents and to the people with disabilities being cared for and supplied regarding healthcare planning for the last stage of life in order to develop their own ideas as to the care that they would like to receive on this basis and to express any decisions as part of living wills. The services are funded by the health insurance funds for persons who have statutory health insurance.

The National Association of Statutory Health Insurance Funds has a statutory mandate for the implementation of this new service entitlement to agree with the associations of the funding institutions of the in-patient long-term care facilities, as well as with the facilities of integration assistance at federal level, on the details regarding the content and requirements of healthcare planning. A consensus was reached regarding this agreement at the end of 2017, after all the institutions and organisations that were to be involved had been included in a very comprehensive statement procedure. The agreement came into force as per 1 January 2018, so that the services can be built up in 2018.

WHAT DO WE GET OUT OF THE DIGITAL TRANSFORMATION?



The telematics infrastructure about to be launched

The National Association of Statutory Health Insurance Funds also closely accompanied the establishment of a telematics infrastructure by gematik in 2017. The first step in this complex, major IT project provides for the trialling and introduction of the online insured persons' master data management (VSDM) application. The content of the application is the examination of the topicality of the insured persons' data in real time (online) and their automatic updating where necessary, as well as examining whether a valid insurance relationship exists. The application is mandatory for all doctors, dentists as well as facilities taking part in registered contract care.

Trialling and error correction

Trialling already started at the end of 2016, and ended in July 2017. 1,169,744 online trials were carried out over the entire active probationary period. These tests were accompanied by continuous, comprehensive analyses and evaluations. With regard to significant trialling results, particular attention also attached to the performance of the online application during periods when it came under strain. This strain comes about particularly after a new quarter, since electronic health cards are scanned more frequently at the beginning of the quarter.

1,169,744 online trials were carried out over the entire active probationary period.

It emerged in the evaluation that the stipulations for the processing times of the online trials are largely adhered to. In particular the specialist services of the health insurance funds ran stably in the trial period. gematik initiated activities in order to counter those errors which did occur, so that the error rate was falling. In addition to the technical analyses, trialling was also scientifically evaluated as to acceptance and practicality among users. Parallel to the trialling activities in the test regions, the National Association of Statutory Health Insurance Funds reached the necessary funding agreements with the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Dentists for the necessary initial equipment and running costs for the roll-out phase.

Launching live online operation

On the basis of the extensive trial results, the management of gematik decided on time in the middle of 2017 to launch live online operation, and therefore averted the sanctions that were threatened in the eHealth Act (E-Health-Gesetz). The originally-planned second series of trials in the South-Eastern test region was however not held because the contractor was unable to provide the necessary components in good time.

Industry was now called on with the shareholders' resolution to partially develop new components on the basis of the knowledge gained from the trials. These had to be subsequently certified by the Federal Office for Information Security, approved by gematik and then produced in sufficient quantities. The certifications and licences for the first products were available in November, so that the actual nationwide roll-out was able to commence in 2017.

The introduction of further applications accelerated

Once VSDM had been introduced, the next step is to introduce emergency data management (NFDM) and the electronic medication plan (eMP). Sanctions are also threatened here if the deadlines specified in the eHealth Act are not met. The shareholders of gematik adopted a different procedure for trialling at the beginning of September in order to accelerate the introduction of these two gematik applications. Whilst VSDM was tested in the contract award model, these two applications are to be trialled as part of a market model. The contract award model still involved the complete development and trialling being put out to tender and funded by gematik. The specifications and licensing conditions for NFDM and eMP were published at the end of 2017 in good time for the deadline that was stipulated in the eHealth Act and underpinned by sanctions. Industry must now independently develop the applications on this basis as an investment for funding in live operation. One condition for licensing in this context is a field test that has to

be carried out on an initiative basis prior to the blanket roll-out. The necessary addenda to the funding agreements with the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Dentists have already been signed. The funding agreements with the German Pharmacists' Association and the German Hospital Federation for refinancing the equipment costs are presently under negotiation.

gematik also agreed on behalf of its shareholders with the enterprises that had been commissioned to provide the service to forego the separate development of the Qualified Electronic Signature (QES) and its trialling. It can be anticipated here that the parallel development of QES and medical applications now planned can take place more quickly.

One condition for licensing is a field-test that has to be carried out on an initiative basis prior to the blanket roll-out.

New telemedical services: teleconsult and video consultations

As a result of the statutory mandates from the Act on Secure Digital Communication and Applications in the Healthcare System (eHealth Act), the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians introduced additional telemedical services for contract doctors in the Standard Schedule of Fees on time for 1 April 2017:

- teleconsultancy-based evaluation of findings of X-rays and CT scans (teleconsult)
- implementation of video consultations

A technical agreement was initially concluded between the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians for each of these two telemedical applications in a two-tier procedure, initially as an Annex to the Federal Skeleton Agreement for Physicians. This includes amongst other things provisions on data protection and for information safety. In a second step, remuneration arrangements were created in the Standard Schedule of Fees.

A teleconsult can be obtained if questions have come up that are complex and relate to a different discipline.

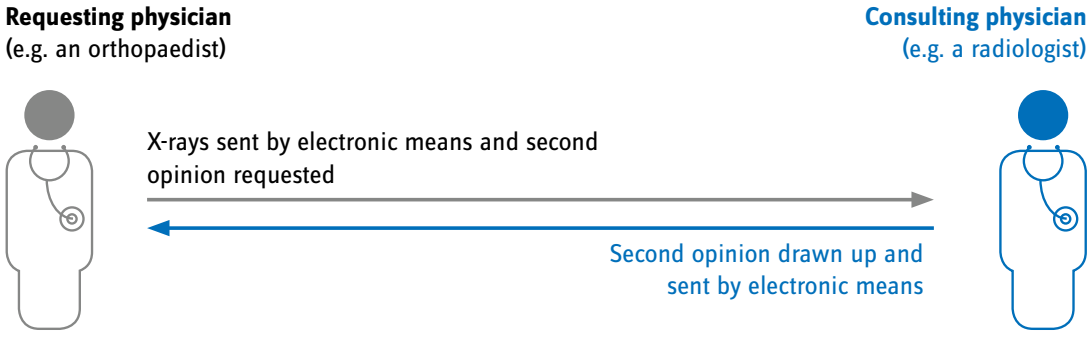
Teleconsult

New services have been included in the Standard Schedule of Fees to obtain a teleconsultancy-based evaluation of findings as well as teleconsultancy-based assessment of X-rays and CT scans by the physician. These also provide for the costs to be paid that arise from the electronic sending of the images.

This facilitates a rapid exchange between doctors in case of specific medical facts. A teleconsult can only be obtained if questions have come up that are complex and relate to a different discipline. The exchange can take place either between specialist physicians in the same group of specialist physicians, or with specialist physicians for radiology.

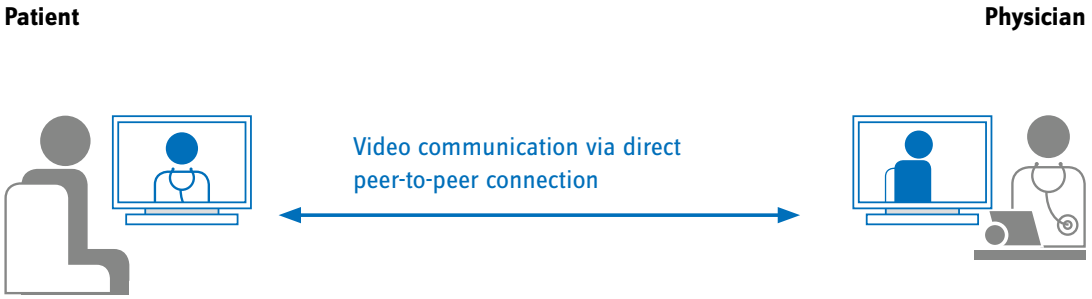
The funding for the new services within teleconsult is provided during an introductory period of two years, first of all outside the total morbidity-related remuneration (MGV), before it can be transferred to morbidity-related remuneration.

Teleconsult



Source and illustration: National Association of Statutory Health Insurance Funds

Video consultations



Source and illustration: National Association of Statutory Health Insurance Funds

Video consultations

Video consultations are to facilitate telemedically-supported care for known established patients in order to replace repeat attendance at the doctor's surgery. Patients are left with the unrestricted option as to whether the consultation is to take place at the doctor's surgery or via video consultation.

The National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians have defined suitable, useful pathologies and areas of indications for the implementation of video consultations. The medical services for the implementation of video consultations in the Standard Schedule of Fees were structured via existing services under the Standard Schedule of Fees. Furthermore, a technology supplement has been included in the Standard Schedule of Fees for the remuneration of costs incurred through the use of a certified video service-provider.

Since the medical service replaces the advice and follow-up examinations in personal contact between doctors and patients as part of a video consultation, the funding is provided as part of morbidity-related remuneration. By contrast, the technology supplement is initially funded outside morbidity-related remuneration.

Patients are left with the unrestricted option as to whether the consultation is to take place at the doctor's surgery or via video consultation.

HOW MUCH SOLIDARITY DOES HEALTH NEED?

Financial development remains sound

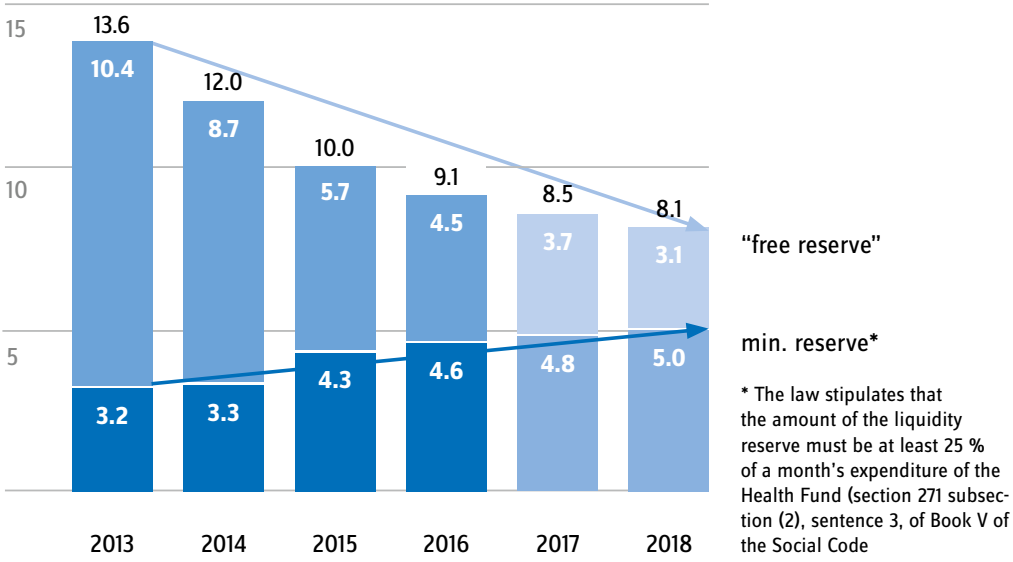
Financial development in statutory health insurance has continued along sound lines in the year under report 2017.** True, the Health Fund suffered a shortfall of approx. 0.7 billion Euro, but this shortfall was much smaller than had originally been planned in comparison to the one-off withdrawal of 1.5 billion Euro from the liquidity reserve required by law. There were no problems when it came to funding the shortfall from the liquidity reserve without falling back on the minimum statutory reserve. For their part, the health insurance funds can anticipate the outstanding accounting results for the whole of 2017 to lead to a positive result on a scale far in excess of 2 billion Euro. The vast majority of health insurance funds have thus been able to keep the respective additional contribution rate stable as per the year-end; 17 health insurance funds were able to reduce their rates, whilst eight funds had to increase their additional contribution rate.

Financial development in 2017

At 4.4 %, the income subject to contributions of the statutory health insurance members increased much more pronouncedly in the year under report, in comparison to the previous year, than had been anticipated by the appraisers in the autumn of 2016 (forecast for 2016: 3.9 %). It reached a volume of 1,350 billion Euro, and led to the Health Fund having an unchanged general contribution rate of 14.6 % with income from contributions of approx. 197.1 billion Euro. Factoring in contributions from marginal employment (approx. 3.1 billion Euro) and the contribution from the Federation (approx. 14.4 billion Euro), reduced by the share accounted for by farmers' health insurance, the total income of the Health Fund was about 214.5 billion Euro. This income was added to in line with the statutory stipulation on a one-off basis for the calendar

The health insurance funds can anticipate the outstanding accounting results for the whole of 2017 to lead to a positive result.

Development in the Health Fund's liquidity reserve 2013–2018



* The law stipulates that the amount of the liquidity reserve must be at least 25 % of a month's expenditure of the Health Fund (section 271 subsection (2), sentence 3, of Book V of the Social Code

Source: Federal Ministry of Health, official statistics KJ 1 (2013-2016); Forecast by statutory health insurance appraisers (2017 and 2018)
Illustration: National Association of Statutory Health Insurance Funds

year 2017 by an additional 1.5 billion Euro from the liquidity reserve. The total income of the Health Fund was hence approx. 216.0 billion Euro. This income enabled the Health Fund to finance the allocations of 214.7 billion Euro which had been assured to the health insurance funds in full. The excess funds of 1.3 billion Euro had to be credited back to the liquidity reserve. As a result, this led to an annual shortfall of the Health Fund of approx. 0.7 billion Euro, taking account of the other financial obligations of the Health Fund for the Innovation and Structural Funds, as well as of the balance from the income equalisation of the additional contributions. The liquidity reserve therefore fell to approx. 8.5 billion Euro up to the end of the year under report.

The appraisers were unable to agree on a unanimous forecast for the expenditure side.

The liquidity reserve fell to approx. 8.5 billion Euro in the year under report.

According to the evaluation of the National Association of Statutory Health Insurance Funds, the income of the health insurance funds from allocations of 214.7 billion Euro contrasts with Fund-relevant expenditure of 227.2 billion Euro. The shortfall in fund-relevant expenditure is therefore approx. 12.5 billion Euro for 2017. The Federal Ministry of Health and the Federal Insurance Office, by contrast, reached an arithmetic shortfall of approx. 11.6 billion Euro, with an expenditure forecast of 226.4 billion Euro. The additional contribution rates actually charged for funding the shortfall in the Fund in 2017 varied between 0.3 % and 1.8 %. None of the health insurance funds was able to avoid charging an additional contribution in the year under report.

The financial forecast for 2018

The statutory health insurance appraisers anticipate a further marked increase in income subject to contributions, by 3.9 %, to 1,400 billion Euro for 2018. They estimate that income from contributions, incl. contributions from marginal employment, will be approx. 207.9 billion Euro in 2017. Together with the contribution of the Federation amounting to approx. 14.4 billion Euro, an allocation volume totalling approx. 222.2 billion Euro emerges which is to be assigned as income to the health insurance funds for 2018. Because of the financial share that the Health Fund must provide for the Innovation Fund (149 million Euro) and for the Structural Fund (188 million Euro), the liquidity reserve will be reduced from approx. 8.5 billion Euro to approx. 8.1 billion Euro at the end of 2018 according to the forecast. Having peaked at approx. 13.6 billion Euro in 2013, the Health Fund would therefore have withdrawn 5.5 billion Euro from the liquidity reserve within five years.

In line with the results of the estimate for the base year 2017, the appraisers were also unable to agree on a unanimous expenditure forecast for 2018. The National Association of Statutory Health Insurance Funds estimated the likely fund-relevant expenditure of the health insurance funds in 2018 to be 237.3 billion Euro (+3.4 % per insured person), whilst the Federal Ministry of Health and the Federal Insurance Office estimated it as 236.2 billion Euro (+3.3 % per insured person). The health insurance funds are hence expecting a shortfall of 15.1 billion Euro for 2018, whilst the Federal Ministry of Health and the Federal Insurance Office anticipate the figure to be 14.0 billion Euro. Whilst the shortfall of 15.1 billion Euro leads to an arithmetical additional contribution rate of 1.1 %, an arithmetical additional contribution rate of 1.0 % is sufficient to fund 14.0 billion Euro. As could be expected, the Federal Ministry of Health, which is responsible for determining the average additional contribution rate, has concurred with the appraisal of its own financial experts in the statutory health insurance appraisers, and in October 2017 announced this rate for 2018 as 1.0 %. The average additional contribution rate is used partly as a relevant additional contribution rate for calculating the contribution among specific groups of members whose contributions are paid for by third parties, for instance for employment benefit II beneficiaries. It is also used as a benchmark for competition in contribution rates between the health insurance funds.

The National Association of Statutory Health Insurance Funds was critical of the determination made by the Federal Ministry of Health. With a view to the expenditure expectation of the health insurance funds and the need for long-term stability, it had requested to leave the average additional contribution rate at a constant 1.1 %. True, health insurance is said to be in good overall financial shape, but the reserves of the health insurance funds as a whole were lower than the level of a month's expenditure of statutory health insurance. The reserves are also said to be unevenly spread over the health insurance funds. The National Association of Statutory Health Insurance Funds considers that it would therefore have been correct to continue the stabilisation process enacted in recent years and to leave the additional contribution rate unchanged.

** Because of the early publication of the Annual Report, the illustration of the financial situation of statutory health insurance in the year under report was carried out largely on the basis of the results of the appraisers' autumn prognosis (appraisal table of 13 October 2017). The illustration does therefore not include the additional financial data arising at the level of the funds and in the official statistics at later dates, especially the Other income and expenditure of the health insurance funds.

The health insurance funds are expecting a shortfall of 15.1 billion Euro for 2018, whilst the Federal Ministry of Health and the Federal Insurance Office anticipate the figure to be 14.0 billion Euro.

Agreement reached on remuneration of contribution collection costs

Agreement reached after many years of struggling: A new agreement was concluded six-and-a-half years after the termination of the agreement for the remuneration the collection costs for contributions.

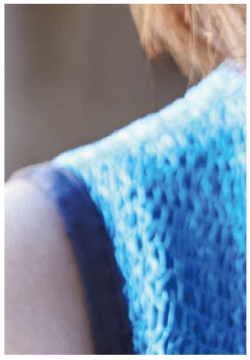
In the German social security system, the health insurance funds are tasked by the law with collecting the total social insurance contribution from employers. As "collecting agencies", they accept the contribution statements regarding the contributions that are payable for health, long-term care, pensions and unemployment insurance, decide on issues of mandatory insurance and contribution amounts in the various branches of social insurance, and monitor payment receipts. They forward the contributions that they receive on every working day to the respective recipients – the Health Fund, long-term care insurance fund, the German pension insurance and the Federal Employment Agency.

Pension and unemployment insurance, as well as the Artists' Social Welfare Fund, also take on joint tasks for safeguarding the income of social insurance. For instance, pension insurance is tasked with auditing employers. Contributions for health and pension insurance for persons in marginal employment are collected by the mini-job centre. The law stipulates that those concerned receive a flat-rate remuneration for performing their respective tasks reciprocally, the amount and distribution of which they must regulate in a joint agreement. The health insurance funds, which bear the main burden of the contribution procedure, hence rightly also receive the highest net remuneration. The National Association of Statutory Health Insurance Funds is a party to the agreement for the health insurance funds.

The Federal Employment Agency terminated the agreement for remuneration of the collection costs back in May 2011. Termination was followed by controversial and laborious negotiations. A clause ensuring continued application ensured that this did not lead to a state in which there was no contract, but the agreement that had been terminated continued to be effective whilst suspended. It was not until May 2015 that an interim agreement was concluded between the parties to the agreement which regulated the amount of remuneration of the collection costs for 2014 to 2016, and which defined the process steps for concluding a new agreement. As a first step, in the autumn of 2015, data regarding the costs of the processes to be remunerated were collected from 21 volunteer health insurance funds from all fund types, as well as from the Federal Employment Agency and the German Federal Pension Insurance. On this basis, in the second step, a joint issue group was to draw up a new remuneration agreement by mid-2016 and announce a recommendation as to the amount of the remuneration of the collection costs from 2017 onwards.

The results of the deliberations of the joint issue group were threatening to go to arbitration proceedings. The Federal Employment Agency submitted a new proposal for a negotiated solution in August 2017. The partners to the agreement finally reached an agreement on this basis. The Federal Employment Agency, the German Federal Pension Insurance, the Artists' Social Welfare Fund and the National Association of Statutory Health Insurance Funds were able to conclude the new agreement in November 2017. This successfully proved the ability of self-governed social insurance to reach an agreement on this difficult set of topics that is ridden with conflicting interests.

HOW GOOD IS EUROPE FOR MY HEALTH?



Dealing sensitively with health data

When dealing with social data, which also include health data, the health and long-term care insurance funds attach considerable importance to data protection when performing their tasks.

The EU's General Data Protection Regulation (GDPR) will be coming into direct effect in all its Member States in May 2018. The legislature took this fact into account in 2017, and took the first legislative steps towards transposition with the Data Protection Alignment and Implementing Act (Datenschutz-Anpassungs- und -Umsetzungsgesetz) and the amendments that were made in Books I and X of the Social Code. The other area-specific adjustments also have to be carried out in the other Books of the Social Code by the above cut-off date. With regard to the need to make specific amendments in the Books of the Social Code that are relevant to the statutory health and long-term care insurance funds, the National Association of Statutory Health Insurance Funds drew up positions at an early date and notified them to policy-makers.

The health and long-term care insurance funds also collect and process a number of social data as part of their statutory tasks which include health data. These are also data over and above purely and simply invoicing services, establishing mandatory insurance, as well as taking up and funding services. The legislature also obliges the health and long-term care insurance funds to ensure high-quality, economical care, and in doing so assigns to them an advisory, steering and navigational function. When dealing with social data, which also include health data, the health and long-term care insurance funds attach considerable importance to data protection when performing their tasks, as well as to the need for transparency, so that insured persons are able to properly exercise their rights to data protection.

Facilitating care management and research

The National Association of Statutory Health Insurance Funds has repeatedly made it clear in its positioning that the performance of the tasks of the health insurance funds may not be placed at a disadvantage by the application of the GDPR. Moreover, the National Association of Statutory Health Insurance Funds considers that there is further need to adjust the contents. Regulations on data protection for the statutory health and long-term care insurance funds must be suitably adjusted in the context of the multifarious task attributions provided for by law, in particular with regard to digitalisation and new care services for insured persons.

The possibilities for care research using pseudonymised and anonymised data must also remain in place in future when the GDPR applies. The data that have been obtained here provide important epidemiological and disease-related indications. They may inform about the interaction between different symptoms and their risk factors, as well as being relevant to the structure of care services. The established use of pseudonymised and anonymised data guarantees a high degree of data protection for insured persons.

Care management belongs among the tasks of the health insurance funds. Health insurance funds can support insured persons with care management programmes, model projects, disease management programmes, case management as well as in the field of "special care" (integrated care, special out-patient care provided by physicians) if the necessary knowledge is available regarding the individual case and care constellation. The applicable provisions on data protection are currently making this task difficult. The National Association of Statutory Health Insurance Funds is therefore calling for stipulations to be created under data protection law to strengthen care management as a core skill of the health insurance funds and anchoring this role of the health insurance funds set out in the law to the benefit of insured persons.

Coordinating social security on a Europe-wide basis

The European Commission intends to make the existing provisions relating to the coordination of the social security systems in Europe fairer and more user-friendly. The Coordination Regulations are to ensure that EU citizens are always covered by a social security system, even if they for instance travel to another country as tourists, to study or to work or live there, and that they should have the same rights there as locals. The Coordination Regulations are to be easier to implement in order to avoid errors or even fraud.

The European Commission presented a proposal for the overhaul of the Coordination Regulations in December 2016. The focus was on coordinating long-term care benefits. Following the case-law of the European Court of Justice, long-term care benefits in European coordination are already dealt with as healthcare benefits today. The European Commission is now providing to create a separate chapter for long-term care benefits and a joint definition of these benefits. It also intends to list all long-term care benefits in the Member States. This is to do better justice to the specific nature of long-term care. At the same time, the rules are also to follow the principles of coordinating sickness benefits in future.

Regulating benefits jointly

The National Association of Statutory Health Insurance Funds considers that a joint definition and listing of long-term care benefits helps to create greater transparency and a better application of the law on coordination. Creating a separate chapter for long-term care would however make life more difficult for EU citizens, or might even lead to a loss of entitlements since many Member States do not have their own long-term care insurance systems.

The Coordination Regulations are to ensure that EU citizens are always covered by a social security system if they travel to another country or live there, and that they have the same rights there as locals.

The National Association of Statutory Health Insurance Funds has called on the Federal Government, the European Commission and the European Parliament to regulate sickness benefits and long-term care benefits jointly. Appropriately adjusting the existing provisions can enable long-term care to be coded more transparently without there being undesirable deviations from the previous coordination and disadvantages for insured persons.

The negotiations on the proposed regulation will be continued in 2018.

Consultations on health policy topics at EU level

Access to social protection

The European pillar of social rights calls for an improvement in access to social security for the self-employed and those in atypical employment. The European Commission intends to submit an initiative in 2018. The Commission considers there to be gaps in security in some countries with regard to health and long-term care. The digital transformation at work might further exacerbate these problems.

Positions of the National Association of Statutory Health Insurance Funds

- The principle of "insurance protection for all" has been largely realised in Germany.
- A high level of social protection in all EU Member States forms the basis for long-term economic and political cohesion in the EU.
- An exchange of best practices at European level can help the Member States to implement the goal of providing suitable social protection.

Change in health and long-term care in the digital Single Market

The European Commission intended to ascertain how digital innovations can improve both people's health and the healthcare systems. The focus was placed on cross-border access to personal health data, their use for research purposes and the changing role of insured persons.

Positions of the National Association of Statutory Health Insurance Funds

- It may make sense to exchange treatment data and information on the prescription of medicinal products over borders in case of treatment abroad. The "eHealth Digital Service Infrastructure" is currently being built up for this.
- Individual insured persons may make their personal health data available for the health research on request. Any further exchange of health data between the healthcare systems is regarded critically.
- Digitalisation can enhance the role of patients. Systematic improvement and examination of care is however vital to its quality.

Maintaining high evaluation standards for medicines

The European Commission has initiated a consultation procedure to enhance EU-wide cooperation in Health Technology Assessment (HTA). The spectrum of the considerations here ranges from long-term voluntary cooperation in this area, through to the joint drawing up of complete benefit evaluations for medicinal products and medical devices at EU level and making the use of these assessments binding in the Member States. The European Commission presented a proposal for a regulation on this in January 2018.

In its contribution to the consultations, the National Association of Statutory Health Insurance Funds welcomes the discussion on enhancing EU-wide HTA cooperation, in particular on medicinal products and medical devices. It however does not consider differences in the evaluation procedures of the Member States and their results to cause problems. These reflect diverging preferences, social frameworks and particularities in the healthcare systems. There are no negative effects on innovation or commercial planning certainty.

Voluntary cooperation makes sense

Benefit evaluation, resolutions on additional benefits, and pricing, are kept separate in the German healthcare system. New medicinal products, medical procedures and medical devices are made available for the treatment of patients quickly, and are assessed rapidly. The evaluation procedures and decisions are published, and are therefore transparent.

An exchange of opinions and a discussion of methodical questions in the EU can also provide important motivations for national procedures.

According to the view of the National Association of Statutory Health Insurance Funds, European cooperation to date in the evaluation of health technology is useful as a matter of principle since an exchange of opinions and a discussion of methodical questions in the EU can also provide important motivations for national procedures. The results of the cooperation at EU level have however been published too late so far to be included in the assessment procedures in Germany.

The National Association of Statutory Health Insurance Funds and the European Social Insurance Platform are in favour of continuing the cooperation in the evaluation of health technology at European level beyond 2020. Cooperation and the inclusion of new concepts in individual Member States must however remain voluntary.

The National Association of Statutory Health Insurance Funds is of the view that the national assessment organisations are to play the central role when it comes to the management and organisation of future cooperation. The European Medicines Agency, by contrast, is not suited to manage or organise future European cooperation in HTA.

WHO WILL LOOK AFTER ME ABROAD?

Coordination of the social security systems

If a person who has insurance with a foreign health insurance institution receives treatment in Germany, the German health insurance fund that is chosen has a major interest in the costs that it advances for this being refunded to it as quickly as possible. According to the regulations currently in force, these costs are to be settled within 18 months. This period, which appears long, however results from the fact that the communication is still largely carried out in paper form. Claims and obligations of the German statutory health insurance funds are roughly balanced out, albeit there are major differences between the individual funds.

Accelerating cross-border cost settlement

All cross-border communication is to be take place in electronic form in the EU from July 2019 onwards. The new working process aims to considerably accelerate the examination and clarification of open claims. It can be anticipated that this will take sustainable effect at the end of 2020 because one may still expect significant volumes of paper files until that time.

The National Association of Statutory Health Insurance Funds has already introduced into the discussions a shortening of the currently valid payment deadlines. This necessitates amending the relevant provisions at European level. Since these are adjusted much more rarely than national provisions, the National Association of Statutory Health Insurance Funds approached the German Federal Government, the European Commission and the European Parliament at an early date suggesting to shorten the deadlines applicable in cost settlement when the time comes. This would be a way to reduce the liquidity problems that currently occur as a result of long payment periods.

The European Commission in particular is to set the stage in 2018 for a shortening of the payment deadlines. This is needed in order to be able to subsequently achieve the desired amendment of the statutory provisions at European level.

Applicable social insurance law

The European Commission has also proposed amendments with regard to the provisions regulating in which State a person is covered by social insurance if they work on a cross-border basis. These are to ensure above all that social insurance contributions are actually paid for an individual who works on a cross-border basis in the State that is responsible for this. The following was proposed in particular:

The stage is to be set in 2018 for a shortening of the payment deadlines.

- A more concrete procedure to clarify individual cases in which the institutions of the respective States take different views as to the State in which a person is to be insured.
- Enhancing the principle that social insurance contributions are always to be paid in the State in which the employment is actually carried out.

The National Association of Statutory Health Insurance Funds supports most of the amendments that have been proposed in the context of the applicable law. Given the high level of worker mobility within the EU, it considers that there is a need to define joint standards and consistently enforce them.

WHAT CONTRIBUTION DOES STATUTORY HEALTH INSURANCE MAKE?

Focus of communication in 2017

2017 was characterised for the National Association of Statutory Health Insurance Funds in terms of external communication by joint projects with the departing Federal Government. Right at the beginning of the year, the National Association of Statutory Health Insurance Funds together with the Federal Ministry of Social Affairs presented the new "Employers' social insurance portal". Small and medium-sized enterprises in particular can now find assistance on complex questions related to the law on reporting and contributions in social insurance at www.informationsportal.de. Only a few months later, this was followed by the National Association of Statutory Health Insurance Funds being invited by the Federal Minister of Health Hermann Gröhe, and forming the "Alliance for Excellence in Health", together with other institutions. The National Regulatory Control Council, jointly with the self-government of the healthcare system funding institutions and the Federal Ministry of Health, presented a stocktake of the debureaucratisation project in October entitled "More time for treatment" on the premises of the National Association of Statutory Health Insurance Funds. The Association has been able to ensure that the positions of the National Association of Statutory Health Insurance Funds for the coming legislative period have been placed well in the media, along with priorities from the areas of medicinal products, finance, out-patient care and hospital and long-term care.

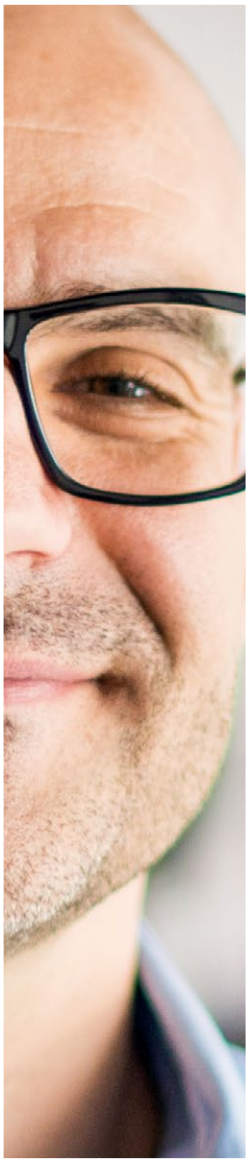
Relaunching the intranet

The intranet of the National Association of Statutory Health Insurance Funds was given a new lick of paint in 2017. There is now for the first time a joint platform for staff – regardless of whether they work in Bonn or Berlin. The relaunch entailed the implementation of several social media elements; the optical interface was changed and user friendliness was improved. The re-orientation of the intranet was simultaneously aimed at functional points: All relevant documents and information are now bundled in one place; internal information channels have been shortened, staff can access contents more quickly, and they can now engage in direct exchanges with one another. This is intended to make workflows more transparent and understandable, and ideally shorter too.

Staff were involved in the development process. This led to a considerable degree of acceptance from the outset, as well as to major interest. The new intranet is to be systematically refined in the months to come, and in future will be expanded to become the central internal communication medium of the National Association of Statutory Health Insurance Funds.

There is now for the first time a joint platform for staff – regardless of whether they work in Bonn or Berlin.

WHAT HAPPENS TO MY CONTRIBUTIONS?



The budget and personnel work of the National Association of Statutory Health Insurance Funds

The annual financial statement for 2016

The annual financial statement of the National Association of Statutory Health Insurance Funds for 2016 was drawn up in March 2017. The audit, including the departmental budget of the German Liaison Agency Health Insurance – International (DVKA), was carried out by the BDO firm of auditors. "Processing and disbursal of the guarantee supplement for midwives in accordance with section 134a subsection (1b) of Book V of the Social Code", as well as "Reserves of the National Association of Statutory Health Insurance Funds" were also audited. The firm of auditors issued an unqualified audit report. At its session that was held on 28 June 2017, the Administrative Council thereupon approved the activities of the Board and approved the 2016 annual financial statement.

The Association's budget for 2017

The 2017 budget plan of the National Association of Statutory Health Insurance Funds shows an overall budget of 194.9 million Euro. This includes the contribution towards the core budget of the National Association of Statutory Health Insurance Funds, as well as the following pay-as-you-go financing arrangements:

- German Liaison Agency Health Insurance – International (DVKA departmental budget)
- Medical Service of the National Association of Statutory Health Insurance Funds (MDS)
- Federal Centre for Health Education (BZgA) in accordance with section 20a of Book V of the Social Code
- The guarantee supplement for midwives in accordance with section 134a subsection (1b) of Book V of the Social Code
- The promotion of special therapy facilities in accordance with section 65d of Book V of the Social Code
- Gesellschaft für Telematikanwendungen der Gesundheitskarte mbH (gematik)
- Promotion of facilities for consumer and patient advice (UPD) in accordance with section 65b of Book V of the Social Code
- Data transparency in accordance with sections 303a to 303f of Book V of the Social Code

The budget for 2018

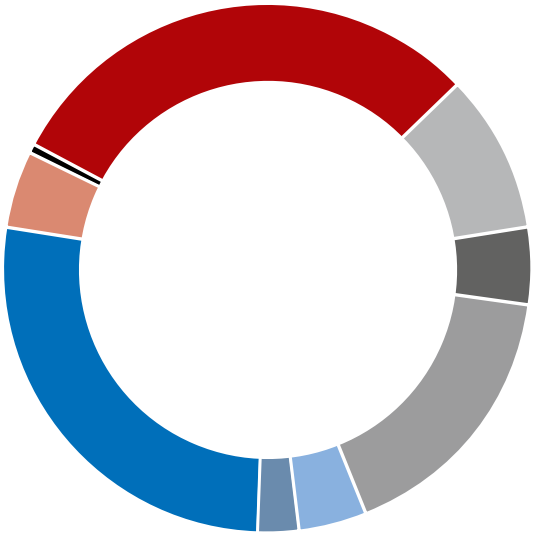
The budget plan for 2018 that was drawn up by the Board on 13 November 2017 was unanimously adopted by the Administrative Council of the National Association of Statutory Health Insurance Funds in November 2017. The Association's overall budget was set at 168.6 million Euro. It hence fell by 26.3 million Euro year-on-year. This is especially a result of the smaller pay-as-you-go arrangement to fund the Gesellschaft für Telematikanwendungen der Gesundheitskarte mbH (gematik).

The personnel work of the National Association of Statutory Health Insurance Funds

The staff budget for 2017 totalled 470.72 established posts. 353.86 target posts were accounted for by the Berlin location, and 116.86 target posts by the DVKA, albeit 14.36 target posts were subject to a freeze notice. The occupation of initially five of the frozen posts at short notice was decided on at the session of the Administrative Council that was held on 22 March 2017. The freeze notice for the remaining 9.36 posts was rescinded at the session of the Administrative Council that was held on 15 November 2017.

455.65 posts were occupied on 1 December 2017, 353.15 of which at the Berlin location and 102.5 at the DVKA. The occupancy rate is 96.8 % for the Association as a whole. The occupancy rate at the Berlin location is 99.8 %, and 87.7 % at the DVKA.

Elements of the overall budget 2017



Core budget sum	**58,788,000 €**	
DVKA	18,685,000 €	
MDS	9,538,000 €	
Federal Centre for Health Education	32,600,000 €	
Guarantee supplement midwives	7,744,000 €	
Special therapy facilities	5,000,000 €	
Contribution of the National Association of Statutory Health Insurance Funds	**132,355,000 €**	Cost per insured person: 1.85 €
gematik	52,558,000 €	
UPD	9,217,000 €	
Data transparency	794,000 €	
Allocation of further budget elements	**62,569,000 €**	Cost per member: 1.13 €
Overall budget	**194,924,000 €**	

Illustration: National Association of Statutory Health Insurance Funds

Staff development in 2017 (not including the DVKA department)

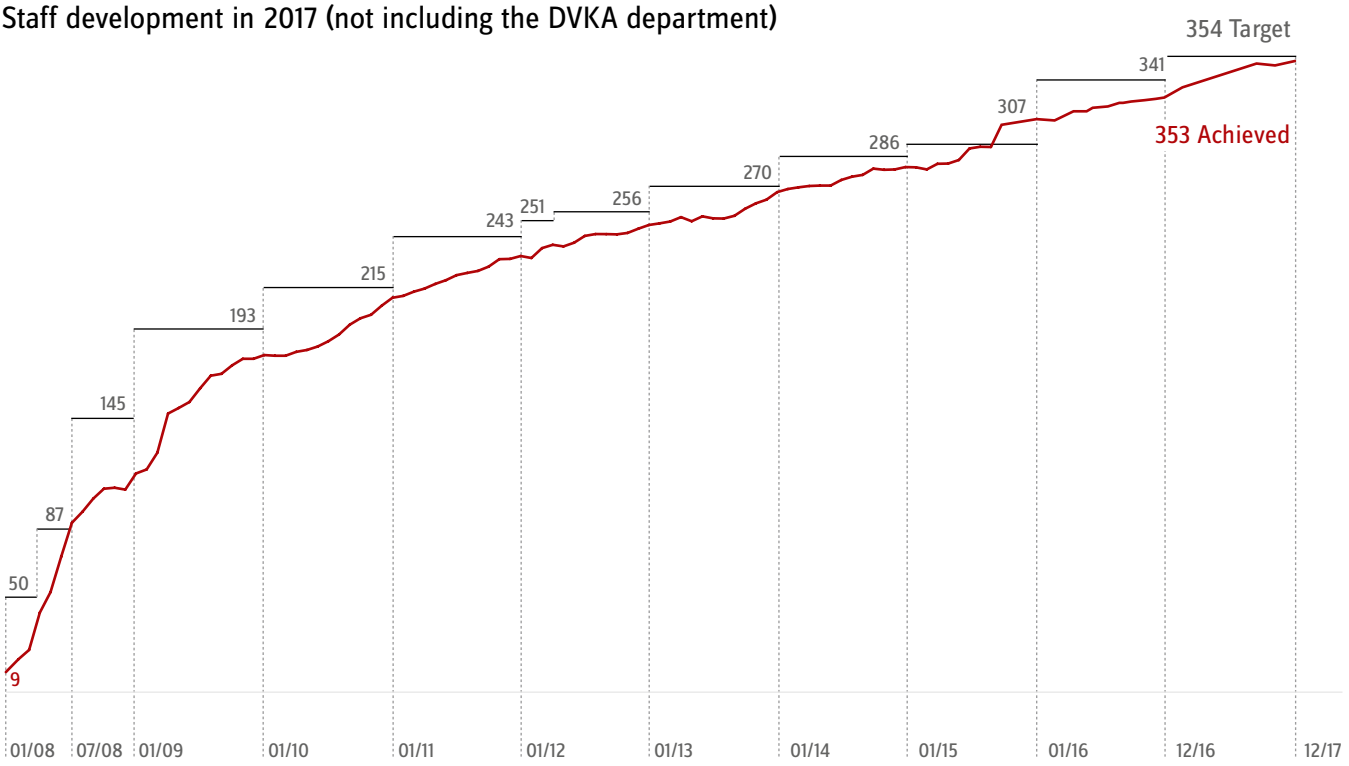


Illustration: National Association of Statutory Health Insurance Funds

The members of the National Association of Statutory Health Insurance Funds 2017

1. actimonda BKK
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
17. Bertelsmann BKK
18. Betriebskrankenkasse Mobil Oil
19. Betriebskrankenkasse PricewaterhouseCoopers
20. BIG direkt gesund
21. BKK Achenbach Buschhütten
22. BKK Aesculap
23. BKK Akzo Nobel Bayern
24. BKK B. Braun Melsungen AG
25. BKK BPW Bergische Achsen KG
26. BKK Deutsche Bank AG
27. BKK Diakonie
28. BKK EUREGIO
29. BKK EVM
30. BKK EWE
31. BKK exklusiv
32. BKK Faber-Castell & Partner
33. BKK firmus
34. BKK Freudenberg
35. BKK Gildemeister Seidensticker
36. BKK GRILLO-WERKE AG
37. BKK Groz-Beckert
38. BKK HENSCHEL Plus
39. BKK Herford Minden Ravensberg
40. BKK Herkules
41. BKK KARL MAYER
42. BKK KBA
43. BKK Linde
44. BKK MAHLE
45. BKK Melitta Plus
46. BKK Miele
47. BKK MTU
48. BKK PFAFF
49. BKK Pfalz
50. BKK ProVita
51. BKK Public
52. BKK Rieker.RICOSTA.Weisser
53. BKK RWE
54. BKK Salzgitter
55. BKK Scheufelen
56. BKK Schwarzwald-Baar-Heuberg
57. BKK STADT AUGSBURG
58. BKK Technoform
59. BKK Textilgruppe Hof
60. BKK VDN
61. BKK VerbundPlus
62. BKK Verkehrsbau Union (BKK VBU)
63. BKK Voralb HELLER*INDEX*LEUZE
64. BKK Werra-Meissner
65. BKK Wirtschaft & Finanzen
66. BKK Würth
67. BKK ZF & Partner
68. BKK_DürkoppAdler
69. BKK24
70. BMW BKK
71. Bosch BKK
72. Brandenburgische BKK
73. Continentale Betriebskrankenkasse
74. Daimler Betriebskrankenkasse
75. DAK-Gesundheit
76. Debeka BKK
77. DIE BERGISCHE KRANKENKASSE
78. Die Schwenninger Betriebskrankenkasse
79. energie-Betriebskrankenkasse
80. Ernst & Young BKK
81. HEK-Hanseatische Krankenkasse
82. Heimat Krankenkasse
83. Handelskrankenkasse (hkk)
84. IKK Brandenburg und Berlin
85. IKK classic
86. IKK gesund plus
87. IKK Nord

88. IKK Südwest
89. Kaufmännische Krankenkasse – KKH
90. Knappschaft
91. Krones BKK
92. Merck BKK
93. Metzinger BKK
94. mhplus Betriebskrankenkasse
95. Novitas BKK
96. pronova BKK
97. R+V Betriebskrankenkasse
98. Salus BKK
99. SECURVITA BKK
100. SIEMAG BKK
101. Siemens-Betriebskrankenkasse (SBK)
102. SKD BKK
103. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
104. Südzucker BKK
105. Techniker Krankenkasse
106. Thüringer Betriebskrankenkasse
107. TUI BKK
108. VIACTIV Krankenkasse
109. Wieland BKK
110. WMF Betriebskrankenkasse

cut-off date: 1 January 2018

Mergers in 2017

Merged funds	**Merger partners**
BKK24	BKK24 BKK advita
BKK Pfalz	BKK Pfalz BKK Vital
Metzinger Betriebskrankenkasse	BKK MEM Metzinger Betriebskrankenkasse
BARMER	BARMER GEK Deutsche BKK

cut-off date: 1 January 2018

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
Aschenbeck, Rolf-Dieter	DAK-Gesundheit
Balser, Erich	Kaufmännische Krankenkasse – KKH
Berking, Jochen	BARMER
Beier, Angelika	AOK Hessen
Bilz, Rosemie	Techniker Krankenkasse
Brendel, Roland	BKK Pfalz
Ermler, Christian	BARMER
Hamers, Ludger	VIACTIV Krankenkasse
Hoof, Walter	DAK-Gesundheit
Katzer, Dietmar	BARMER
Keppeler, Georg	AOK NORDWEST
Kirch, Ralf	BKK Werra-Meissner
Klemens, Uwe	Techniker Krankenkasse
Lersmacher, Monika	AOK Baden-Württemberg
Linnemann, Eckehard	Knappschaft
Märtens, Dieter F.	Techniker Krankenkasse
Metschurat, Wolfgang	AOK Nordost
Moldenhauer, Klaus	BARMER
Müller, Hans-Jürgen	IKK gesund plus
Reuber, Karl	AOK Rheinland/Hamburg
Roer, Albert	BARMER
Römer, Bert	IKK classic
Schoch, Manfred	BMW BKK
Schösser, Fritz	AOK Bayern
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

Representatives of the employers

Name	Health insurance fund
Avenarius, Friedrich	AOK Hessen
Blum, Leo	SVLFG
Chudek, Nikolaus	IKK Brandenburg und Berlin
Hansen, Dr. Volker	AOK Nordost
Hornung, Ernst	Novitas BKK
Jehring, Stephan	AOK PLUS
Kuhn, Willi	AOK Rheinland-Pfalz/Saarland
Landrock, Dieter Jürgen	AOK Baden-Württemberg
Münzer, Dr. Christian	AOK Niedersachsen
Parvanov, Ivor	AOK Bayern
Reyher, Dietrich von	Bosch BKK
Ropertz, Wolfgang	AOK Rheinland/Hamburg
Schnurr, Hansjürgen	Kaufmännische Krankenkasse – KKH
Schrörs, Dr. Wolfgang	Handelskrankenkasse (hkk)
Schweinitz, Detlef E. von	Siemens-Betriebskrankenkasse (SBK)
Stehr, Axel	AOK NORDWEST
Unzeitig, Roland	Techniker Krankenkasse
Wegner, Bernd	Techniker Krankenkasse
Wollseifer, Hans Peter	IKK classic

cut-off date: 13 December 2017

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
Baer, Detlef	IKK Brandenburg und Berlin
Baki, Brigitte	AOK Hessen
Becker-Müller, Christa	DAK-Gesundheit
Berger, Silvia	IKK Südwest
Bink, Klaus-Dieter	AOK NORDWEST
Böse, Annemarie	DAK-Gesundheit
Bumb, Hans-Werner	DAK-Gesundheit
Christen, Anja	BKK Verkehrsbau Union (BKK VBU)
Coors, Jürgen	Daimler BKK
Date, Achmed	BARMER
Decho, Detlef	Techniker Krankenkasse
Dollmann, Klaus	BARMER
Dorneau, Hans-Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Feichtner, Richard	AOK Rheinland-Pfalz/Saarland
Fenske, Dieter	DAK-Gesundheit
Gabler, Heinz-Joachim	Kaufmännische Krankenkasse – KKH
Goldmann, Bernd	BARMER
Gosewinkel, Friedrich	Techniker Krankenkasse
Gransee, Ulrich	AOK Niedersachsen
Hauffe, Ulrike	BARMER
Heinemann, Bernd	BARMER
Hippel, Gerhard	DAK-Gesundheit
Hoppe, Klaus	Siemens-Betriebskrankenkasse (SBK)
Höhmann, Ralf	BARMER
Hüfner, Gert	Knappschaft
Jena, Matthias	AOK Bayern
Kaczmarek, Irina	IKK classic
Karp, Jens	IKK Nord
Kloppich, Iris	AOK PLUS
Knerler, Rainer	AOK Nordost
Knöpfle, Manfred	BKK Stadt Augsburg
Korschinsky, Ralph	BARMER
Krause, Helmut	BIG direkt gesund
Lambertin, Knut	AOK Nordost
Leitloff, Rainer	DAK-Gesundheit
Lubitz, Bernhard	HEK–Hanseatische Krankenkasse
Muscheid, Dietmar	AOK Rheinland-Pfalz/Saarland
Salzmann, Rainer	BKK B. Braun Melsungen AG
Schmidt, Günther	BARMER
Schneider, Norbert	Techniker Krankenkasse

Name	Health insurance fund
Scholz, Jendrik	IKK classic
Schorsch-Brandt, Dagmar	AOK Baden-Württemberg
Schröder, Dieter	DAK-Gesundheit
Schuder, Jürgen	HEK-Hanseatische Krankenkasse
Schulte, Harald	Techniker Krankenkasse
Schultze, Roland	Handelskrankenkasse (hkk)
Sonntag, Dr. Ute	BARMER
Staudt, Alfred	AOK Rheinland-Pfalz/Saarland
Stensitzky, Annette	Techniker Krankenkasse
Vater, Birgit	BARMER
Vieweg, Johanna	Techniker Krankenkasse

Representatives of the employers

Name	Health insurance fund
Beetz, Jürgen	Die Schwenninger Betriebskrankenkasse
Bruns, Rainer	Techniker Krankenkasse
Dick, Peer Michael	AOK Baden-Württemberg
Diehl, Mario	Kaufmännische Krankenkasse – KKH
Empl, Martin	SVLFG
Fitzke, Helmut	Techniker Krankenkasse
Gantz-Rathmann, Birgit	BAHN-BKK
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
Kreßel, Prof. Dr. Eckhard	Daimler Betriebskrankenkasse
Kruchen, Dominik	Techniker Krankenkasse
Lang, Dr. Klaus	pronova BKK
Lübbe, Günther	Handelskrankenkasse (hkk)
Lunk, Rainer	IKK Südwest
Malter, Joachim	AOK Rheinland-Pfalz/Saarland
Nicolay, Udo	Techniker Krankenkasse
Nobereit, Sven	AOK PLUS
Reinisch, Dr. Mark	BKK VerbundPlus
Selke, Prof. Dr. Manfred	AOK Rheinland/Hamburg
Scheer, René	BIG direkt gesund
Schirp, Alexander	AOK Nordost
Söller, Wolfgang	AOK Bremen/Bremerhaven
Steigerwald, Claus	BKK Faber-Castell & Partner
Wadenbach, Peter	IKK gesund plus
Wilkening, Bernd	AOK Niedersachsen
Witt, Axel	Kaufmännische Krankenkasse – KKH

cut-off date: 13 December 2017

Ordinary members of the Administrative Council of the National Association of Statutory Health Insurance Funds in the 3rd period of office (2018-2023)

Representatives of insured persons

Name	Health insurance fund
Auerbach,Thomas	BARMER
Balser, Erich	Kaufmännische Krankenkasse - KKH
Beier, Angelika	AOK Hessen
Berking, Jochen	BARMER
Bilz, Rosemie	Techniker Krankenkasse
Breher, Wilhelm	DAK-Gesundheit
Brendel, Roland	BKK Pfalz
Date, Achmed	BARMER
Firsching, Frank	AOK Bayern
Hamers, Ludger	VIACTIV Krankenkasse
Holz, Elke	DAK-Gesundheit
Hoof, Walter	DAK-Gesundheit
Katzer, Dietmar	BARMER
Keppeler, Georg	AOK NORDWEST
Klemens, Uwe	Techniker Krankenkasse
Kloppich, Iris	AOK PLUS
Kolsch, Dieter	AOK Rheinland/Hamburg
Lambertin, Knut	AOK Nordost
Lersmacher, Monika	AOK Baden-Württemberg
Linnemann, Eckehard	Knappschaft
Lohre, Dr. Barbara	BARMER
Märtens, Dieter F.	Techniker Krankenkasse
Müller, Hans-Jürgen	IKK gesund plus
Roer, Albert	BARMER
Römer, Bert	IKK classic
Schoch, Manfred	BMW BKK
Schröder, Dieter	DAK-Gesundheit
Schuder, Jürgen	HEK - Hanseatische Krankenkasse
Schultze, Roland	Handelskrankenkasse (hkk)
Strobel, Andreas	Siemens-Betriebskrankenkasse (SBK)
Tölle, Hartmut	AOK Niedersachsen
Wiedemeyer, Susanne	AOK Sachsen-Anhalt

Representatives of the employers

Name	Health insurance fund
Avenarius, Friedrich	AOK Hessen
Bley, Alexander	SIEMAG BKK
Chudek, Nikolaus	IKK Brandenburg und Berlin
Dohm, Rolf	pronova BKK
Dombrowsky, Dr. Alexander	AOK Rheinland-Pfalz/Saarland
Empl, Martin	SVLFG
Hansen, Dr. Volker	AOK Nordost
Heß, Johannes	AOK NORDWEST
Jehring, Stephan	AOK PLUS
Landrock, Dieter Jürgen	AOK Baden-Württemberg
Meinecke, Christoph	AOK Niedersachsen
Nicolay, Udo	Techniker Krankenkasse
Parvanov, Ivor	AOK Bayern
Reyher, Dietrich von	Bosch BKK
Ries, Manfred	BKK ProVita
Ropertz, Wolfgang	AOK Rheinland/Hamburg
Schrörs, Dr. Wolfgang	Handelskrankenkasse (hkk)
Thomas, Dr. Anne	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 3rd period of office (2018–2023)

Representatives of insured persons

Name	Health insurance fund
Aichberger, Helmut	DAK-Gesundheit
Baer, Detlef	IKK Brandenburg und Berlin
Baki, Brigitte	AOK Hessen
Balzer-Wehr, Dr. Alexandra	Kaufmännische Krankenkasse – KKH
Berger, Silvia	IKK Südwest
Böntgen, Rolf-Dieter	DIE BERGISCHE KRANKENKASSE
Böse, Annemarie	DAK-Gesundheit
Böttcher, Mario	BARMER
Brück, Peter	Kaufmännische Krankenkasse – KKH
Büricke, Andrea	Kaufmännische Krankenkasse – KKH
Coors, Jürgen	Daimler Betriebskrankenkasse
Decho, Detlef	Techniker Krankenkasse
Dorneau, Hans Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Ermler Christian	BARMER
Frackmann, Udo	Techniker Krankenkasse
Fritz, Anke	Kaufmännische Krankenkasse – KKH
Funke, Wolfgang	BARMER
Gosewinkel, Friedrich	Techniker Krankenkasse
Grellmann, Norbert	IKK classic
Hauffe, Ulrike	BARMER
Hindersmann, Nils	Knappschaft
Hippel, Gerhard	DAK-Gesundheit
Huppertz, Claudia	BAHN-BKK
Karp, Jens	IKK Nord
Kautzmann, Beate	BARMER
Korschinsky, Ralph	BARMER
Krause, Helmut	BIG direkt gesund
Kuklenski, Mirko	AOK Rheinland-Pfalz/Saarland
Lohre, Karl Werner	BARMER
Löwenstein, Katrin von	BARMER
Metschurat, Wolfgang	AOK Nordost
Mirbach, Helmut	DAK-Gesundheit
Mohr, Hans-Dieter	AOK Rheinland-Pfalz/Saarland
Nimz, Torsten	Handelskrankenkasse (hkk)
Plaumann, Karl-Heinz	BARMER
Rahmann, Petra	Techniker Krankenkasse
Reimer, Jürgen	AOK NORDWEST
Roloff, Sebastian	DAK-Gesundheit
Schmidt, Günther	BARMER
Schöb, Katrin	Techniker Krankenkasse
Scholz, Jendrick	IKK classic
Schorsch-Brandt, Dagmar	AOK Baden-Württemberg

Representatives of insured persons (continued)

Name	Health insurance fund
Schümann, Heinrich-Joachim	HEK-Hanseatische Krankenkasse
Staudt, Alfred	AOK Rheinland-Pfalz/Saarland
Terzieva, Neli	Techniker Krankenkasse
Treuter, Uta	BARMER
Vieweger, Birgitt	BARMER
Wagner, Dieter	AOK Bayern
Wagner, Christine	mhplus Betriebskrankenkasse
Weber, Roman Gregor	DAK-Gesundheit
Weilbier, Thomas	AOK Rheinland/Hamburg
Weinschenk, Roswitha	AOK PLUS
Win, Thomas de	pronova BKK
Wonneberger, Klaus	HEK-Hanseatische Krankenkasse
Zierock, Carola	AOK Nordost

Representatives of the employers

Name	Health insurance fund
Breitenbach, Thomas	Techniker Krankenkasse
Dick, Peer Michael	AOK Baden-Württemberg
Fitzke, Helmut	Techniker Krankenkasse
Franke, Dr. Ralf	Siemens-Betriebskrankenkasse (SBK)
Gemmer, Traudel	AOK Sachsen-Anhalt
Gural, Wolfgang	AOK Bayern
Heins, Rudolf	SVLFG
Heymer, Dr. Gunnar	BKK BPW Bergische Achsen KG
Hoffmann, Dr. Wolfgang	BKK Verkehrsbau Union (BKK VBU)
Kastner, Helmut	IKK Nord
Kittner, Susanne	BAHN-BKK
Knappe, Mirko	Techniker Krankenkasse
Kruchen, Dominik	Techniker Krankenkasse
Leitl, Robert	BIG direkt gesund
Lübbe, Günther	Handelskrankenkasse (hkk)
Lunk, Rainer	IKK Südwest
Malter, Joachim	AOK Rheinland-Pfalz/Saarland
Nobereit, Sven	AOK PLUS
Reinisch, Dr. Mark	BKK VerbundPlus
Schirp, Alexander	AOK Nordost
Selke, Prof. Dr. Manfred	AOK Rheinland/Hamburg
Söller, Wolfgang	AOK Bremen/Bremerhaven
Stehr, Axel	AOK NORDWEST
Vahle, Torben	Techniker Krankenkasse
Wadenbach, Peter	IKK gesund plus
Wilkening, Bernd	AOK Niedersachsen
Winkler, Walter	Techniker Krankenkasse

Ordinary and deputy members of the specialist committees of the Administrative Council 2017

Specialist committee on fundamental issues and health policy

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

Ordinary members

Representatives of the employers	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. N. N. (BKK)	5. Monika Lersmacher (AOK)
6. Hans Peter Wollseifer (IKK)	6. Fritz Schösser (AOK)
	7. Hans-Jürgen Müller (IKK)
	8. Andreas Strobel (BKK)

Deputy members

Representatives of the employers	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)	Susanne Wiedemeyer (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
	Irina Kaczmarek (IKK)
	3rd deputy on the list for insured persons 7-8

Specialist committee on organisation and finance

Chaired by: Walter Hoof/Dieter Landrock (alternating)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Dieter Jürgen Landrock (AOK)	1. Jochen Berking (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

Representatives of the employers	Representatives of insured persons
Sven Nobereit (AOK)	Klaus Moldenhauer (EK)
	1st deputy on the list for insured persons 1-3
Wolfgang Ropertz (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
N. N. (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 disease prevention, rehabilitation and long-term care

Chaired by: Eckehard Linnemann/Nikolaus Chudek*, Dietrich von Reyher (alternating)*

* Changing half-way through their period of office

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Ivor Parvanov (AOK)	1. Harald Schulte (EK)
2. Wolfgang Ropertz (AOK)	2. Christian Ermler (EK)
3. Hansjürgen Schnurr (EK)	3. Rolf-Dieter Aschenbeck (EK)
4. Dietrich von Reyher (BKK)	4. Wolfgang Metschurat (AOK)
5. Claus Steigerwald (BKK)	5. Roswitha Weinschenk (AOK)
6. Nikolaus Chudek (IKK)	6. Knut Lambertin (AOK)
	7. Eckehard Linnemann (Knappschaft)
	8. Manfred Schoch (BKK)

Deputy members

Representatives of the employers	Representatives of insured persons
Sven Nobereit (AOK)	Achmed Date (EK)
	1st deputy on the list for insured persons 1-3
Johannes Heß (AOK)	Klaus Dollmann (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
N. N. (BKK)	Angelika Beier (AOK)
	2nd deputy on the list for insured persons 4-6
Peter Wadenbach (IKK)	Fritz Schösser (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: Angelika Beier/Ernst Hornung (alternating) – Dietrich von Reyher (acting)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Dr. Volker Hansen (AOK)	1. Albert Roer (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. Angelika Beier (AOK)
6. Rainer Lunk (IKK)	6. Susanne Wiedemeyer (AOK)
	7. Roland Brendel (BKK)
	8. Bert Römer (IKK)

Deputy members

Representatives of the employers	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 and deputy members of the specialist committees of the Administrative Council 2018

Specialist committee on fundamental issues and health policy

Chaired by: Hans-Jürgen Müller/Stephan Jehring (alternating)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Stephan Jehring (AOK)	1. Dieter F. Märtens (EK)
2. Axel Stehr (AOK)	2. Erich Balser (EK)
3. Udo Nicolay (EK)	3. Thomas Auerbach (EK)
4. Martin Empl (SVLFG)	4. Roland Schultze (EK)
5. Rolf Dohm (BKK)	5. Monika Lersmacher (AOK)
6. Helmut Kastner (IKK)	6. Knut Lambertin (AOK)
	7. Hans-Jürgen Müller (IKK)
	8. Ludger Hamers (BKK)

Deputy members

Representatives of the employers	Representatives of insured persons
Wolfgang Söller (AOK)	Gerhard Hippel (EK)
	1st deputy on the list for insured persons 1-4
Christoph Meinecke (AOK)	Wilhelm Breher (EK)
	2nd deputy on the list for insured persons 1-4
Thomas Breitenbach (EK)	Ralph Korschinsky (EK)
	3rd deputy on the list for insured persons 1-4
Rudolf Heins (SVLFG)	Heinrich J. Schümann (EK)
	4th deputy on the list for insured persons 1-4
Manfred Ries (BKK)	Dieter Kolsch (AOK)
	1st deputy on the list for insured persons 5-6
Robert Leitl (IKK)	Roswitha Weinschenk (AOK)
	2nd deputy on the list for insured persons 5-6
Hans Peter Wollseifer (IKK)	Eckehard Linnemann (Kn)
	1st deputy on the list for insured persons 7-8
	Andreas Strobel (BKK)
	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 organisation and finance

Chaired by: Andreas Strobel/Dr. Wolfgang Schrörs (alternating)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Dr. Wolfgang Schrörs (EK)	1. Albert Roer (EK)
2. Dieter Jürgen Landrock (AOK)	2. Anke Fritz (EK)
3. Wolfgang Ropertz (AOK)	3. Rosemie Bilz (EK)
4. Dietrich von Reyher (BKK)	4. Georg Keppeler (AOK)
5. Manfred Ries (BKK)	5. Frank Firsching (AOK)
6. Rainer Lunk (IKK)	6. Hartmut Tölle (AOK)
	7. Detlef Baer (IKK)
	8. Andreas Strobel (BKK)

Deputy members

Representatives of the employers	Representatives of insured persons
Günther Lübbe (EK)	Dieter Schröder (EK)
	1st deputy on the list for insured persons 1-3
Sven Nobereit (AOK)	Dr. Alexandra Balzer-Wehr (EK)
	2nd deputy on the list for insured persons 1-3
Christoph Meinecke (AOK)	Beate Kautzmann (EK)
	3rd deputy on the list for insured persons 1-3
Alexander Bley (BKK)	Iris Kloppich (AOK)
	1st deputy on the list for insured persons 4-6
Nikolaus Chudek (IKK)	Monika Lersmacher (AOK)
	2nd deputy on the list for insured persons 4-6
Hans Peter Wollseifer (IKK)	Angelika Beier (AOK)
	3rd deputy on the list for insured persons 4-6
	Roland Brendel (BKK)
	1st deputy on the list for insured persons 7-8
	Silvia Berger (IKK)
	2nd deputy on the list for insured persons 7-8
	N. N. (BKK)
	3rd deputy on the list for insured persons 7-8

Specialist committee on disease prevention, rehabilitation and long-term care

Chaired by: Eckehard Linnemann/Dietrich von Reyher (alternating)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Ivor Parvanov (AOK)	1. Achmed Date (EK)
2. Wolfgang Ropertz (AOK)	2. Elke Holz (EK)
3. Wolfgang Söller (AOK)	3. Friedrich Gosewinkel (EK)
4. Dr. Anne Thomas (EK)	4. Annette Düring (AOK)
5. Dietrich von Reyher (BKK)	5. Dieter Kolsch (AOK)
6. Helmut Kastner (IKK)	6. Iris Kloppich (AOK)
	7. Eckehard Linnemann (Kn)
	8. Manfred Schoch (BKK)

Deputy members

Representatives of the employers	Representatives of insured persons
Sven Nobereit (AOK)	Helmut Aichberger (EK)
	1st deputy on the list for insured persons 1-3
Johannes Heß (AOK)	Ulrike Hauffe (EK)
	2nd deputy on the list for insured persons 1-3
Traudel Gemmer (AOK)	Peter Brück (EK)
	3rd deputy on the list for insured persons 1-3
Helmut Fitzke (EK)	Knut Lambertin (AOK)
	1st deputy on the list for insured persons 4-6
Dr. Ralf Franke (BKK)	Frank Firsching (AOK)
	2nd deputy on the list for insured persons 4-6
N. N. (BKK)	Susanne Wiedemeyer (AOK)
	3rd deputy on the list for insured persons 4-6
Peter Wadenbach (IKK)	Roland Brendel (BKK)
	1st deputy on the list for insured persons 7-8
Hans Peter Wollseifer (IKK)	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: Angelika Beier/Martin Empl (alternating)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Friedrich Avenarius (AOK)	1. Dr. Barbara Lohre (EK)
2. Wolfgang Söller (AOK)	2. Dietmar Katzer (EK)
3. Torben Vahle (EK)	3. Roman G. Weber (EK)
4. Alexander Bley (BKK)	4. Dieter Schröder (EK)
5. Robert Leitl (IKK)	5. Angelika Beier (AOK)
6. Martin Empl (SVLFG)	6. Susanne Wiedemeyer (AOK)
	7. Roland Brendel (BKK)
	8. Bert Römer (IKK)

Deputy members

Representatives of the employers	Representatives of insured persons
Traudel Gemmer (AOK)	Wilhelm Breher (EK)
	1st deputy on the list for insured persons 1-4
Alexander Schirp (AOK)	Karl-Heinz Plaumann (EK)
	2nd deputy on the list for insured persons 1-4
Ivor Parvanov (AOK)	Helmut Aichberger (EK)
	3rd deputy on the list for insured persons 1-4
Bernd Wegner (EK)	Torsten Nimz (EK)
	4th deputy on the list for insured persons 1-4
Dietrich von Reyher (BKK)	Monika Lersmacher (AOK)
	1st deputy on the list for insured persons 5-6
Peter Wadenbach (IKK)	Hartmut Tölle (AOK)
	2nd deputy on the list for insured persons 5-6
Rainer Lunk (IKK)	Nils Hindersmann (Kn)
	1st deputy on the list for insured persons 7-8
Rudolf Heins (SVLFG)	Jens Karp (IKK)
	2nd deputy on the list for insured persons 7-8
	Manfred Schoch (BKK)
	3rd deputy on the list for insured persons 7-8

Specialist committee on digitalisation, innovation and benefits for patients

Chaired by: Jochen Berking/Nikolaus Chudek (alternating)

Ordinary members

Representatives of the employers	Representatives of insured persons
1. Bernd Wegner (EK)	1. Jochen Berking (EK)
2. Christoph Meinecke (AOK)	2. Walter Hoof (EK)
3. Wolfgang Söller (AOK)	3. Birgitt Vieweger (EK)
4. Rolf Dohm (BKK)	4. Iris Kloppich (AOK)
5. Nikolaus Chudek (IKK)	5. Knut Lambertin (AOK)
6. Rudolf Heins (SVLFG)	6. Ludger Hamers (BKK)
	7. Helmut Krause (IKK)
	8. Nils Hindersmann (Kn)

Deputy members

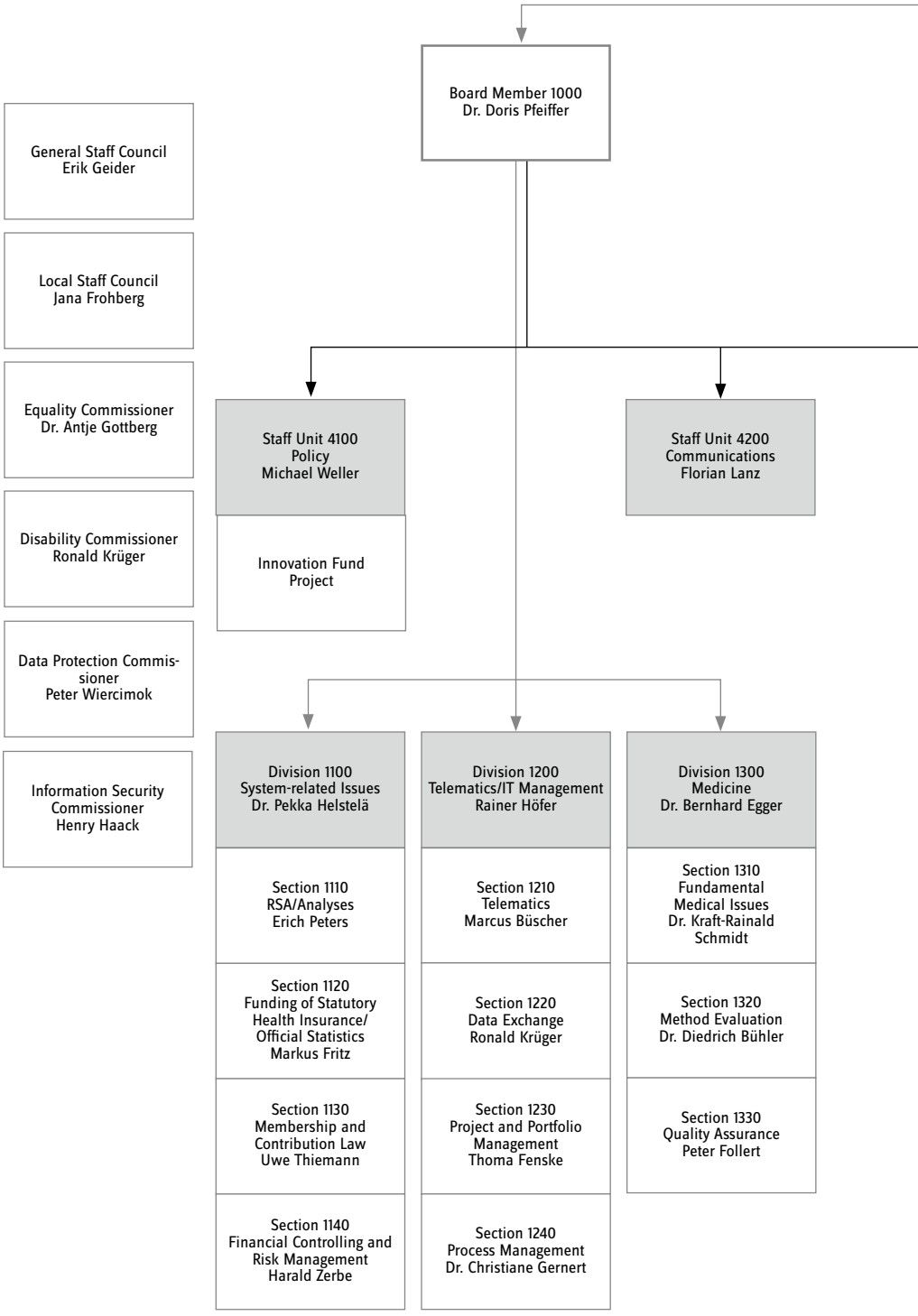
Representatives of the employers	Representatives of insured persons
Torben Vahle (EK)	Helmut Mirbach (EK) 1st deputy on the list for insured persons 1-3
Dieter Jürgen Landrock (AOK)	Detlef Decho (EK) 2nd deputy on the list for insured persons 1-3
Prof. Dr. Manfred Selke (AOK)	Peter Brück (EK) 3rd deputy on the list for insured persons 1-3
Manfred Ries (BKK)	Katrin von Löwenstein (EK) 4th deputy on the list for insured persons 1-3
N. N. (IKK)	Sebastian Roloff (EK) 5th deputy on the list for insured persons 1-3
Martin Empl (SVLFG)	Georg Keppeler (AOK) 1st deputy on the list for insured persons 4-5
	Susanne Wiedemeyer (AOK) 2nd deputy on the list for insured persons 4-5
	Andreas Strobel (BKK) 1st deputy on the list for insured persons 6-8
	N. N. (IKK) 2nd deputy on the list for insured persons 6-8
	Eckehard Linnemann (Kn) 3rd deputy on the list for insured persons 6-8

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

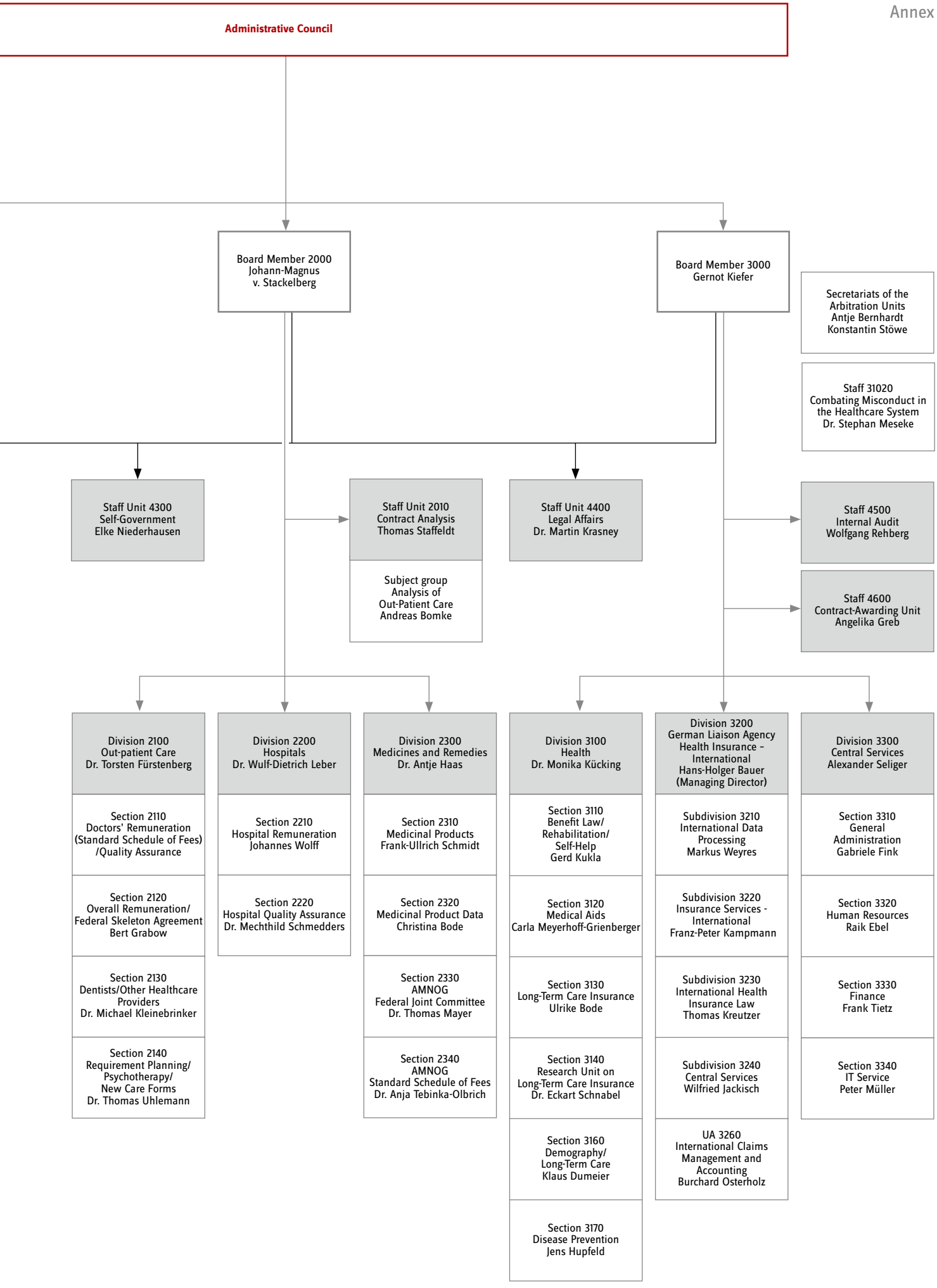
	Members	**Deputies**
AOK	1. Martin Litsch 2. Dr. Helmut Platzer	Jens Martin Hoyer Dr. Jürgen Peter
BKK	1. Franz Knieps 2. Andrea Galle	Verena Heinz Winfried Baumgärtner
Substitute Funds	1. Ulrike Elsner 2. Dr. Jörg Meyers-Middendorf	Boris von Maydell Oliver Blatt
IKK	1. Jürgen Hohnl 2. Uwe Schröder	Frank Hippler Enrico Kreutz
Miners' Insurance Institution	1. Bettina am Orde 2. Gerd Jockenhöfer	Dieter Castrup Jörg Neumann
Farmers' Social Insurance	1. Claudia Lex 2. Gerhard Sehnert	Dirk Ender Jürgen Helfenritter

cut-off date: 31 December 2017

Organisational chart National Association of Statutory Health Insurance Funds



cut-off date: August 2018


Administrative Council
Board Member 2000
Johann-Magnus
v. Stackelberg
Board Member 3000
Gernot Kiefer
Secretariats of the
Arbitration Units
Antje Bernhardt
Konstantin Stöwe
Staff 31020
Combating Misconduct in
the Healthcare System
Dr. Stephan Meseke
Staff Unit 4300
Self-Government
Elke Niederhausen
Staff Unit 2010
Contract Analysis
Thomas Staffeldt
Subject group
Analysis of
Out-Patient Care
Andreas Bomke
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. Torsten Fürstenberg
Section 2110
Doctors' Remuneration
(Standard Schedule of Fees)
/Quality Assurance
Section 2120
Overall Remuneration/
Federal Skeleton Agreement
Bert Grabow
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
Federal Joint Committee
Dr. Thomas Mayer
Section 2340
AMNOG
Standard Schedule of Fees
Dr. Anja Tebinka-Olbrich
Division 3100
Health
Dr. Monika Kücking
Section 3110
Benefit Law/
Rehabilitation/
Self-Help
Gerd Kukla
Section 3120
Medical Aids
Carla Meyerhoff-Grienberger
Section 3130
Long-Term Care Insurance
Ulrike Bode
Section 3140
Research Unit on
Long-Term Care Insurance
Dr. Eckart Schnabel
Section 3160
Demography/
Long-Term Care
Klaus Dumeier
Section 3170
Disease Prevention
Jens Hupfeld
Division 3200
German Liaison Agency
Health Insurance -
International
Hans-Holger Bauer
(Managing Director)
Subdivision 3210
International Data
Processing
Markus Weyres
Subdivision 3220
Insurance Services -
International
Franz-Peter Kampmann
Subdivision 3230
International Health
Insurance Law
Thomas Kreutzer
Subdivision 3240
Central Services
Wilfried Jackisch
UA 3260
International Claims
Management and
Accounting
Burchard Osterholz
Division 3300
Central Services
Alexander Seliger
Section 3310
General
Administration
Gabriele Fink
Section 3320
Human Resources
Raik Ebel
Section 3330
Finance
Frank Tietz
Section 3340
IT Service
Peter Müller

Publications

Position papers

Author(s)	Title	Publication date
GKV-Spitzenverband (National Association of Statutory Health Insurance Funds)	Positionspapier des GKV-Spitzenverbandes für eine am Nutzen für die Versicherten orientierte Einführung von Innovationen in die medizinische Versorgung	June 2017
GKV-Spitzenverband	Positionspapier des GKV-Spitzenverbandes für die 19. Legislaturperiode 2017–2021	June 2017
GKV-Spitzenverband	Reformvorschläge zur Weiterentwicklung der sektorenübergreifenden ambulanten Versorgung	August 2017
GKV-Spitzenverband	Neustrukturierung der Notfallversorgung	August 2017

Further publications

Author(s)	Title	Publication date
GKV-Spitzenverband	Bericht des GKV-Spitzenverbandes zum Pflegestellen-Förderprogramm im Förderjahr 2016 an das Bundesministerium für Gesundheit	June 2017
GKV-Spitzenverband	Bericht des GKV-Spitzenverbandes zum Hygienesonderprogramm in den Förderjahren 2013 bis 2016 an das Bundesministerium für Gesundheit	June 2017
GKV-Spitzenverband and MDS (Medical Service of the National Association of Statutory Health Insurance Funds)	Präventionsbericht 2017 Berichtsjahr 2016	November 2017
GKV-Spitzenverband	GKV 90 Prozent Jubiläumsausgabe: 10 Jahre GKV-Spitzenverband	December 2017

Photo credits

Title: vicu9/fotolia.de
p. 7: Tom Maelsa/tommaelsa.com
p. 9: Tom Maelsa/tommaelsa.com
pp. 16/17: Tom Maelsa/tommaelsa.com
pp. 22/23: Tom Maelsa/tommaelsa.com
p. 14: Poike
p. 24: Ridofranz
p. 34: Ridofranz
p. 37: Jacob Ammentorp Lund
p. 40: Amazigmikea
p. 49: Nadofotos
p. 54: Lenanet
p. 58: Emely
p. 61: Ridofranz
p. 69: Max Riesgo
p. 77: Katarzyna Bialasiewicz
p. 79: Nadofotos
p. 84: Nadofotos
p. 89: monkeybusinessimages
p. 94: Poike
p. 96: Shironosov
p. 97: GKV-Spitzenverband
p. 98: Theverest

GKV-Spitzenverband
Reinhardtstraße 28
10117 Berlin
Germany
Tel.: +49 30 206288-0
Fax: +49 30 206288-88
www.gkv-spitzenverband.de