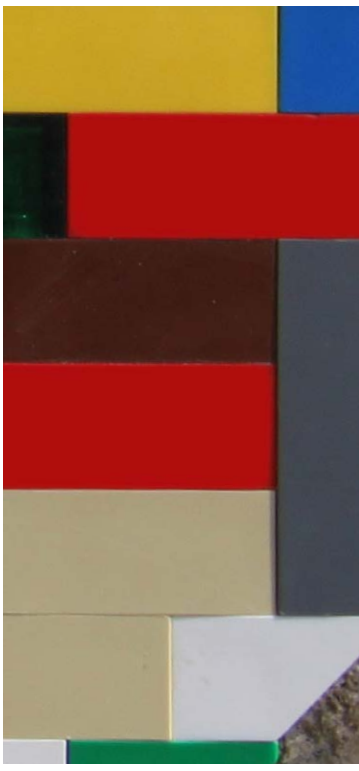
Spitzenverband



Statutory health insurance – Solidarity in action

Annual Report 2018

Imprint

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The National Association of Statutory Health Insurance Funds (GKV-Spitzenverband) is the central association of the health insurance funds at federal level in accordance with section 217a of Book V of the German Social Code (SGB V). It also acts as the national association of the long-term care insurance funds in accordance with section 53 of Book XI of the 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 2018.

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Statutory health insurance – practiced solidarity

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Foreword by the Chairmen of the Administrative Council

Dear Readers,

Just under a year after the Coalition Agreement was signed, a large number of sets of legislative proceedings have already been concluded, and others are still ongoing. Even if the current level of activity of the Federal Ministry of Health may seem remarkable to some, the associated attacks on self-government are not acceptable under any circumstances. The plans would serve to undermine a structural principle of statutory health insurance, and the consequence would be fundamental changes to a healthcare system in which social co-determination and the voice of the contributors would no longer play a significant role. This cannot be regarded as desirable.

The break-up of self-government is being carried out using several laws at once, and at different levels. The planned elimination of social self-government in the Administrative Council of the National Association of Statutory Health Insurance Funds is key. This would exclude the representatives of insured persons and employers, who are elected in social elections, from important decision-making processes aimed at designing high-quality, affordable healthcare and long-term care. This would be a major step backwards in view of our fundamental democratic principles, according to which citizens are directly involved in social decision-making processes. It is to be feared that this change in the decision-making structure of the National Association of Statutory Health Insurance Funds will point the way for statutory healthcare and long-term care insurance as a whole. At the special meeting of the Administrative Council that was held on 24 April 2019, the social partners spoke out vigorously against the planned reorganisation of the Administrative Council in the National Association of Statutory Health Insurance Funds.

The attack continues with the reorganisation of the Medical Service: The planned arrangements provide for its administrative councils to be completely restructured. Administrative council members of a health insurance fund would explicitly no longer be allowed to belong to these bodies. The plans would mean the elimination of social self-government and place a major restriction on the health insurance funds' decision-making powers. In addition to representatives of the health insurance funds, patient organisations as well as representatives of the nursing and medical professions are also to be members of the administrative councils in future. This means that those whose performance is to be reviewed will also be involved in the decision-making process. This possibility of influence being exerted in a manner driven by interests would mean that the Medical Service would no longer be independent.

But the Federal Minister of Health has not stopped there. Further changes are planned in order to introduce specialist supervision of the Federal Joint Committee. The impending abandonment of the basic rules of evidence-based method evaluation prepares the ground for patronage. Encroachments on the financial and personnel autonomy of social self-government have already come into force as a result of narrow legislative stipulations. In addition, the Federal Ministry of Health has granted itself power to take decisions alone with regard to gematik when it comes to the implementation of digitalisation. The attacks on self-government are taking place in such a targeted and regular way that the underlying strategy becomes clear: The Federal Minister of Health is looking to bring about a system change in the healthcare sector.

By fundamentally disavowing the principle of self-government in health insurance, decisions and power are being centralised in the Federal Ministry of Health. This is at the expense of social self-government, and thus of the social partners. It is apparently a matter of getting rid of unpleasant critics in order to be able to consistently enforce policies. This type of policy changes not only the discussion culture in statutory health

insurance and in our society, but it will also not ultimately lead to any improvements in healthcare and long-term care. It has only been about a year since the CDU, CSU and SPD stipulated in their Coalition Agreement that they wanted to strengthen self-government. However, the legislative trend is in the opposite direction, and this is in urgent need of correction.

Yours faithfully,

Uwe Klemens Dr. Volker Hansen

Foreword by the Board

Dear Readers,

After lengthy coalition negotiations, the CDU/CSU agreed with the SPD last year to renew the Grand Coalition. The Coalition Agreement identifies the most important and urgent areas for action in the coming years in healthcare and long-term care. These include boosting geriatric care and nursing care, measures in cross-sectoral care, emergency care, prevention, and digitalisation. In addition, the Coalition Agreement contains a commitment to restoring financing on an equal basis in statutory health insurance.

After a good year of government, it can be said that policy-makers quickly followed up the announcements with action in the shape of large numbers of legislative measures. The burden on the members of statutory health insurance was reduced from 2019 onwards by financing the additional contributions on an equal basis. At the same time, the legislature is obliging the health insurance funds to reduce their reserves. This obligation represents unjustified interference in the financial autonomy of the health insurance funds, and will make it more difficult to keep contribution rates stable in times of economic downturn.

A package of measures was also swiftly adopted in long-term care. The aim is to achieve tangible improvements in the personnel situation in geriatric care and hospital care, as well as to stabilise the financial situation in long-term care. The cross-financing of the urgently-needed additional nursing staff using funds from statutory health insurance, and the proposed system of the flat-rate deduction of contributions from health insurance funds, are questionable. Even more serious is the separating of nursing costs from the diagnosis-related group case flat-rates. The path taken in this way of following the principle of cost coverage for all nursing expenditure in hospitals cannot be financed soundly in the long run. The increase in the contribution rate in long-term care insurance as a result of the desired improvements in benefits does not go far enough in our view.

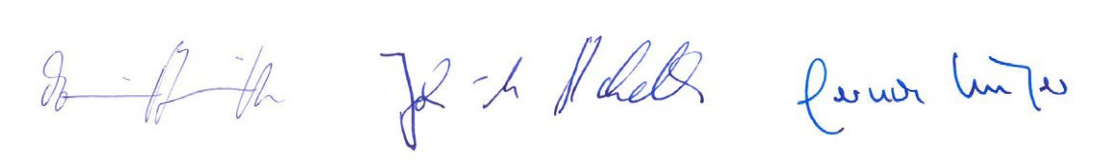
Shifting the costs solely to the community of solidarity may be a politically-convenient solution, but a tax-funded federal subsidy would be more appropriate as compensation for tasks performed by long-term care insurance for society as a whole.

The Appointment Service and Care Act (Terminservice- und Versorgungsgesetz) is intended to speed up and improve the organisation of appointments in out-patient treatment for individuals who have statutory insurance. This is to be welcomed as a matter of principle, as is the intention to support the digitalisation of medical records or prescriptions via legislation. The remuneration regulations associated with the Act however overshoot the mark by far. Simply paying more for services that physicians already have to provide today will not lead to more treatment time for individuals who have statutory health insurance. The further, arbitrarily-distributed increases in physicians' remuneration resulting from the Act will also not significantly reduce long waiting times. Instead, targeted measures are needed, such as the promotion of evening and Saturday consultations, in order to make the range of consultation hours more flexible and more closely geared to patients' needs.

Against the background of this generally expansive spending policy, the National Association of Statutory Health Insurance Funds has repeatedly warned, despite the currently positive economic situation, against frittering money away when times are good, without bringing about adequate structural and quality improvements in terms of care. The National Association of Statutory Health Insurance Funds will continue to be guided in the design of healthcare and long-term care by high-quality care that can also be financed. Only if the financial input is matched by an appropriate healthcare output will the healthcare and long-term care system as a community of solidarity continue to enjoy its high level of acceptance among the population.

With this Annual Report, we would like to give you an overview of how the National Association of Statutory Health Insurance Funds contributes with its manifold design possibilities to a functioning community of solidarity. In view of recent legislation, we would like to make it quite clear at this point that the interests of the community of solidarity are best represented by democratically-legitimised representatives and their active co-determination in the self-government bodies. From our point of view, therefore, the control-orientated tendencies on the part of the State that have been clearly expressed by the Federal Ministry of Health are unacceptable, given that they seek to wilfully damage self-government as the supporting foundation of social insurance, and also to eliminate it from the Administrative Council of the National Association of Statutory Health Insurance Funds.

Yours faithfully,



Dr. Doris Pfeiffer
Chairwoman of the Board

Johann-Magnus v. Stackelberg
Deputy Chairman of the Board

Gernot Kiefer
Member of the Board

Upping the pace in healthcare and long-term care policy

One law follows another in health and long-term care policy. The Act to Relieve the Burden on Insured Persons (Versichertenentlastungsgesetz) and the Act to Promote Nursing Staff (Pflegepersonal-Stärkungsgesetz) were already passed last year, and the Appointment Service and Care Act (Terminservice- und Versorgungsgesetz – TSVG) will reach the home straight of the legislative process at the beginning of 2019 – expanded to include a medical aids reform. And the draft Bill for More Safety in Medicinal Product Supply (Gesetz für mehr Sicherheit in der Arzneimittelversorgung) is already at the acute processing stage.

The announced eHealth Act II (E-Health-Gesetz II) is also eagerly awaited. In addition to the content, the tactical approach of the Federal Government is also exciting: It can be assumed that no all-embracing body of legislation will be introduced, but that the digitalisation of the healthcare system will be promoted in an ongoing iterative process. Initial progress has already been made on electronic medical records. The implementation of the provisions of the Appointment Service and Care Act will provide added value for insured persons and patients. They are to be able to access their data directly via mobile devices and decide autonomously whether and when to pass them on. This legislative step was long overdue.

Patients are to be able to access their data directly via mobile devices and decide completely autonomously whether and when to pass them on.

Further reforms have already been initiated in emergency care, pharmacists' remuneration and psychotherapists' training. The Electronic Medical Products Information Ordinance (Elektronische Arzneimittelinformations-Verordnung), which the National Association of Statutory Health Insurance Funds regards as a thorough success, was launched for the supply of new medicinal products as they are needed. The reform of the risk structure equalisation, eagerly awaited by the member funds, will also already take shape at the beginning of 2019. In addition to these activities, there are a number of important discussion platforms resulting from the coalition agreements from which further decisions of the legislature could emerge. The Federation-Länder working party on cross-sectoral care, the Fees Commission and the Concerted Long-Term Care Campaign are particularly worth mentioning.

Introducing long-term improvements in quality and structure

The legislature can advance its health policy on the basis of comfortable funding from the statutory health insurance community of solidarity. This is attributable to the good economic situation, with a positive development in employment and wages and, in parallel, a rising amount of income subject to contributions. The reserves in the health insurance funds and the Health Fund currently amount to more than 30 billion Euro. What appears very high in absolute figures is quickly placed into perspective with regard to the level of expenditure. The reserves in the health insurance funds only correspond to expenditure for roughly one average month.

In the interest of patients and contributors, the current good financial situation must not tempt us to distribute existing funds arbitrarily. On the contrary, given the demographic challenges and the chances of an economic downturn, long-term quality and structural improvements must now be tackled in order to increase the performance of the healthcare system. The focus must be placed on patient needs in particular, so that improvements are achieved in everyday care. Current statutory activities do not however always serve this purpose, as some only seek short-term public approval. At the same time, the strategy that has been pursued in recent years, namely of distributing financial resources generously, is being continued in order to reduce the high level of conflict on the healthcare policy scene among healthcare providers.

Relieving long-term care insurance in terms of non-insurance tasks

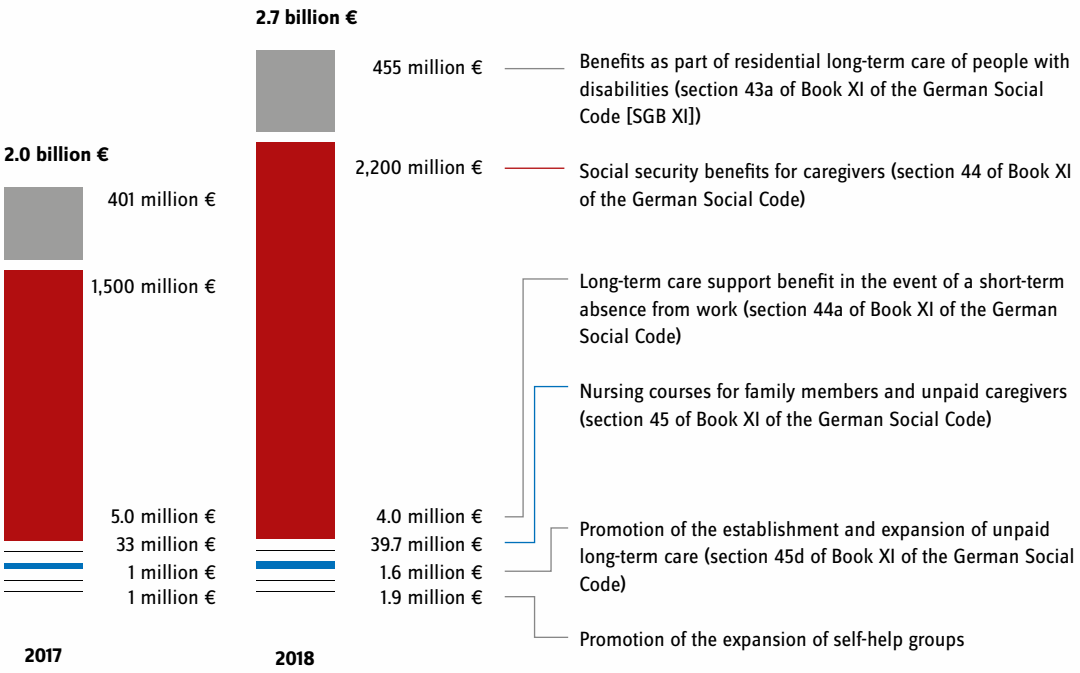
Recent improvements in long-term care insurance benefits, especially in connection with the

introduction of the new definition of need for long-term care, have most recently necessitated a contribution rate increase of 0.5 contribution rate points (CRP). This is likely to be sufficient to fund the increased take-up of long-term care insurance benefits between now and 2022. Increasing the contribution rate should not be seen as the only solution that is able to stabilise long-term care insurance. Long-term care insurance also provides substantial benefits that do not directly serve its original purpose, namely that of protecting insured persons in the event of need for long-term care, but which can be associated with non-insurance tasks. One example is the payment of pension insurance contributions for family caregivers, which serve to provide pension benefits for caregivers. According to a conservative estimate, non-insurance benefits are provided amounting to approximately 2.7 billion Euro per year. This currently corresponds to roughly 0.2 CRP.

Long-term quality and structural improvements must now be tackled in order to increase the performance of the statutory health insurance system.

It remains to be hoped that the reforms still to be discussed and decided on by Parliament will not just be about distributing as much money as possible. Instead, existing instruments and measures must be sharpened, or new ones developed, in order to promote quality, innovation and economic efficiency. Incidentally, this should also be achieved with a set of competitive tools that does not rely in an unbalanced manner on price competition between health insurance funds.

Non-insurance benefits in long-term care insurance – cost development



Source and illustration: National Association of Statutory Health Insurance Funds

Report from the Administrative Council

The third term of office of the Administrative Council started at the beginning of the year under report. In its constituent meeting held in January, the new plenum laid the foundations for the work to be done in the years to come with the election of its chairmen, Dr. Volker Hansen and Uwe Klemens, and the election of the members and chairs of the specialist committees. This was combined with a central decision for the structure of the body in the future: In order to give space to the questions of the digitalisation of the healthcare system also on the level of social self-government, and to introduce targeted impulses for the design from the point of view of patients, insured persons and contributors into the discourse from here, the Administrative Council set up a new specialist committee on "Digitalisation, innovation and benefits for patients". Five specialist committees are thus responsible for the technical preparation of the Administrative Council's deliberations and resolutions. At a workshop, the Administrative Council specified the new committee's areas of responsibility, and agreed on a procedure to be followed in the event of any topical overlaps with the other specialist committees.

The use of digital applications in the healthcare system is intended to improve medical care as a whole, with a special focus on rural areas.

Using the opportunities of digitalisation to improve patient care

When the new Federal Minister of Health Jens Spahn took office, he declared the digitalisation of the healthcare system to be one of his priority concerns. Against this background, a new Directorate-General for "Digitalisation and Innovation" was established at the Federal Ministry of Health. This was reason enough for the Specialist committee on digitalisation, innovation and benefits for patients to invite the head of the Directorate-General, Dr. Gottfried Ludewig, to attend one of the first sessions in order to discuss with him the potential of digitalisation and the need for action from the point of view of self-government. In the context of this lively debate, both sides agreed that the use of digital applications in the healthcare system should improve medical care as a whole. Special attention should be paid to care in rural areas. According to the unanimous assessment, the digitalisation of the healthcare system is a challenge that cannot be mastered within a single legislative period, but which must be implemented gradually over a much longer time.

In an initial content initiative, the Specialist committee on digitalisation, innovation and benefits for patients drew up the declaration entitled "Using the opportunities of digitalisation for better patient care", containing positions on the design of electronic medical records, which was unanimously adopted by the Administrative Council. With this paper, the committee advocates better patient care through digital applications and responsible, secure handling of health data. The Administrative Council reiterated its demand to streamline the decision-making structures of gematik as the operating company for the telematics infrastructure and to extend the responsibility of the statutory health insurance funds, given that they are the sole financiers.

With the position paper entitled "Digital care services in the financing responsibility of statutory health insurance", jointly prepared by the three specialist committees on digitalisation, innovation and benefits for patients, on rehabilitation and long-term care, as well as on contracts and care, the Administrative Council formulates the aspirations of the National Association of Statutory Health Insurance Funds with regard to the digitalisation of medical and long-term care. Digital and telemedical applications that make medical sense and help improve the care of insured persons are to be included in the list of benefits of statutory health insurance. The proviso: The patient-relevant benefit of the innovations must be proven before they are introduced across the board. The paper describes the assessment criteria to be satisfied before digital applications can be introduced into care, and addresses political demands. In accordance with the direct shaping role of the National Association of Statutory Health Insurance

Funds, the positions relate to the area of collective agreements.

Pharmacists' remuneration

In view of the ongoing debate regarding pharmacists' remuneration and the regulation of mail order business, the Administrative Council has taken up a position on this subject at the recommendation of its specialist Committee on contracts and care. It called on policy-makers to further develop the pharmacy market in a sustainable and patient-orientated way so that a secure, prompt and economic supply of medicinal products is guaranteed in the future as well. It was stated in the plenary discussion that the aim could not be to protect historically-evolved structures. Rather, care must be geared to the needs of the patients.

The patient-relevant benefit of digital and telemedical innovations must be proven before they are introduced across the board.

Lower limits for nursing staff

The Administrative Council welcomed the Government's activities to improve the situation in geriatric care and nursing care, and adopted a framework declaration after intensive consultations in the specialist committee on contracts and care. According to the National Association of Statutory Health Insurance Funds, the introduction of lower limits for nursing staff leads to better care for insured persons and ensures greater patient safety. The lower limits for nursing staff must be based on a scientifically-sound personnel assessment instrument that is geared to nursing care needs and the application of which is mandatory. Hospitals should be required as soon as possible to demonstrate compliance with the lower limits for each shift and each ward. At the same time, the Administrative Council stressed that lower limits for nursing staff and additional expenditure on nursing care should not be the only measures undertaken to improve the situation with regard to nursing. It is not enough for the money to reach the long-term care system, but long-term care must also reach the patients.

Misconduct in the healthcare system

The Administrative Council received the Board's report on the work and results of the Anti-Misconduct Office for the Healthcare System for the period 2016/2017. The report is based on the

objective formulated by the legislature, namely that representatives of self-government should be able to form an impression of the actual extent of misconduct in the healthcare system. Following a resolution by the Administrative Council in 2012, comparable key figures are collected from all member funds, in addition to the statutory provisions, and reported to the National Association of Statutory Health Insurance Funds. The key figures are intended to enable differentiated conclusions to be drawn regarding the number of reports and cases, as well as the amount of claims secured according to the respective service areas concerned. As a key finding, the report of the National Association of Statutory Health Insurance Funds includes the aggregated key figures on the all-round view of statutory health insurance. The specialist committee on disease prevention, rehabilitation and long-term care had emphasised the importance of the report in its preparatory consultation: It is highly informative, and creates the necessary transparency. Even though individual facts were already known in the past, there had previously been no overview of concrete quantities and conditions.

Self-government in search of a consensus

The newly-constituted Administrative Council of the National Association of Statutory Health Insurance Funds has provided important impetus with its positions in the first year of the third term of office. Even with changing themes and tonalities of the various players, self-government is maintaining its course and seeing to it that the perspective of patients and contributors is heard by policy-makers. It embodies a middle path in the sense that its players channel the frequently-conflicting interests and – motivated by the will and commitment to compromise – offer solutions which have substantive content. Statutory provisions can be better implemented if they meet with a positive response among those who are affected. Policy-makers should acknowledge these potentials, which are so important for society, and should translate their intention to strengthen self-government, which has been repeatedly expressed in the past, into action.

It is not enough simply for the money to reach the long-term care system, but long-term care must also reach the patients.

Board elections in the National Association of Statutory Health Insurance Funds

Dr. Doris Pfeiffer and Gernot Kiefer confirmed in office for another six years

At its ordinary meeting held in June 2018, the Administrative Council of the National Association of Statutory Health Insurance Funds confirmed Dr. Doris Pfeiffer as Chairman of the Board and Gernot Kiefer as a member of the Board. Both members of the Board were elected for another six years. The new term of office begins on 1 July 2019. Johann-Magnus v. Stackelberg, Deputy Chairman of the Management Board, did not stand for re-election. He will be retiring from office for reasons of age at the end of the current term of office. Dr. Doris Pfeiffer and Gernot Kiefer were re-elected for a third term without opposing votes. The Administrative Council is thus aiming to preserve continuity in the management of the Association, which is highly regarded as a key player in shaping the health and long-term care framework conditions in the political arena, in joint self-government and in the Association's environment in terms of groupings. Re-election also reveals the considerable support enjoyed by the members of the Board among the member funds. At the same time, the Administrative Council would like to acknowledge the close and always trusting cooperation so far between the members of the Board, the Administrative Council and its alternating chairmen, Uwe Klemens and Dr. Volker Hansen. After the re-election, the chairmen of the Administrative Council expressed their gratitude for the work that had been done. They noted with appreciation that they had been able to retain Dr. Doris Pfeiffer and Gernot Kiefer for another term in office, and that they would be able to continue the good cooperation with Johann-Magnus v. Stackelberg for one more year until June 2019, before he takes his well-deserved retirement.

Stefanie Stoff-Ahnis to succeed Johann-Magnus v. Stackelberg on 1 July 2019

The decision on who is to succeed Johann-Magnus v. Stackelberg was taken early on. The Administrative Council of the National Association of Statutory Health Insurance Funds already unanimously elected Stefanie Stoff-Ahnis to the Board of the Association at its meeting on 28 November 2018. She will succeed Johann-Magnus v. Stackelberg as a member of the Board on 1 July 2019. The 42-year-old legal professional Stoff-Ahnis has been working for AOK Nordost since 2006. As a member of the Executive Board there, she is responsible for the Care division. Ms Stoff-Ahnis, who is from Brandenburg, will have responsibility at the National Association of Statutory Health Insurance Funds as a member of the Board for central care areas ranging from out-patient care to hospitals, medicinal products and medical aids, as well as midwife care through to dental and psychotherapeutic care. Stefanie Stoff-Ahnis stated that statutory health insurance is always called upon, together with its partners in joint self-government, to make care future-proof – and to do so in line with people's real needs. She said that she was very much looking forward to playing a decisive role in the further development of the healthcare system. The Chairmen of the Administrative Council congratulated Stefanie Stoff-Ahnis on her election and wished her every success as a future member of the three-member Board, together with Dr. Doris Pfeiffer and Gernot Kiefer.

“As a statutory health insurance system, we are called upon, together with our partners in joint self-government, to make care future-proof – and to do so in line with people’s real needs.”

Stefanie Stoff-Ahnis,
Member of the Board from 1 July 2019 onwards

SOLIDARITY IN STATUTORY HEALTH INSURANCE

means ensuring a good level of

care

Improving the staffing situation in long-term care

In the course of the improvements that have taken place in long-term care insurance services in recent years, the political and media focus has increasingly shifted to the question of how long-term care can be secured both in hospitals and in the residential geriatric care sector, against the background of the increasing number of people in need of long-term care, both now and in the future. The Coalition Agreement contains a large number of measures aimed at improving the situation of nursing staff in hospitals and geriatric care:

- urgent measures to improve staffing levels in geriatric care and in hospitals
- complete refinancing of pay rate increases
- establishing lower limits for staffing for all in-patient departments
- continuation of the Structural Fund for another four years at an annual cost of 1 billion Euro
- better remuneration of nursing staff costs independently of case flat-rates
- initiative entitled "Concerted Long-Term Care Campaign" with the participation of all relevant players in long-term care, with the aim of improving the situation in long-term care

Counteracting the shortage of specialists in nursing care and geriatric care

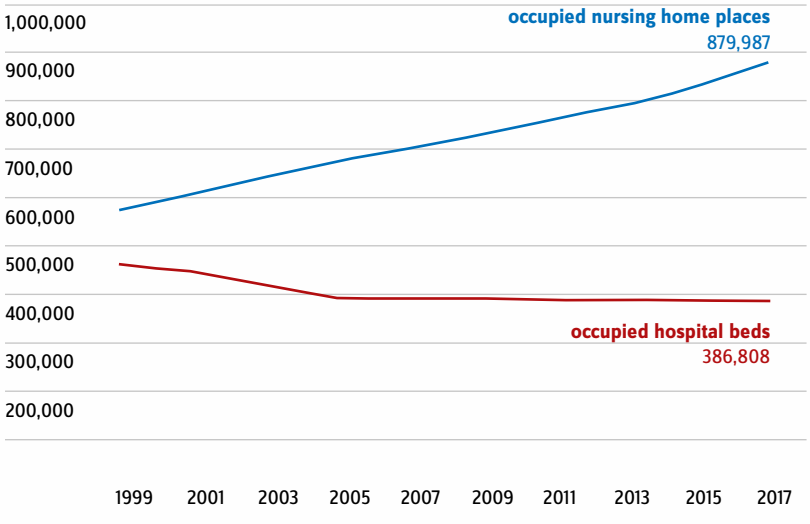
The measures agreed in the Coalition Agreement were particularly taken up in the Act to Promote Nursing Staff (Gesetz zur Stärkung des Pflegepersonals - Pflegepersonal-Stärkungsgesetz - PpSG), and were already passed by Parliament in November 2018. The essential parts of the Act came into force at the beginning of 2019.

The central element is new nursing staff posts in fully-residential long-term care facilities as part of an "urgent action programme". A total of roughly 13,000 additional nursing care posts are to be created here without this entailing a financial burden on the residents of long-term care facilities. The facilities can have additional nursing care posts fully financed through supplementary remuneration on request. Depending on the size of the facility, they are entitled to between one-half and two nursing care posts. The supplementary remuneration is financed as a flat-rate amount from funds from statutory health insurance in the amount of 640 million Euro per year, and by obligatory private long-term care insurance in the amount of 44 million Euro annually, and is made available via the compensation fund of social long-term care insurance. Disbursement to the individual long-term care facility takes place on the 15th of the current month via a long-term care insurance fund.

Depending on the size of the facility, they are entitled to between one-half and two additional nursing care posts.

The National Association of Statutory Health Insurance Funds, in consultation with the federal associations of funding institutions of residential long-term care facilities, determines the details of the application procedure, the verification procedure, and the payment procedure for its members. The Association imposes a levy on the health insurance funds in accordance with the respective insured persons' share of the total number of insured persons of all health insurance funds for the lump-sum payment of supplementary remuneration that is disbursed by the long-

Occupancy figures of nursing homes and hospitals



Source: Federal Statistical Office - Pflegestatistik und Grunddaten der Krankenhäuser
Illustration National Association of Statutory Health Insurance Funds

term care insurance funds. Our Association also determines the details of the levy procedure and the payment to the compensation fund of long-term care insurance. In addition, the Association must report to the Federal Ministry of Health, on an annual basis and for the first time by 31 December 2019, on the number of nursing carers financed by this supplement, on the increase in the number of jobs and on developments in expenditure.

Avoiding misincentives in financing

The National Association of Statutory Health Insurance Funds welcomes the aspirations to improve staffing in fully-residential long-term care facilities. Having said that, the supplementary remuneration model enshrined in the Act to Promote Nursing Staff contradicts the previous system of agreeing and remunerating posts in long-term care facilities. The National Association of Statutory Health Insurance Funds rejects the cross-financing of the additional nursing staff from funds of statutory health insurance and the envisioned system of flat-rate deductions from contributions.

There is a risk that hospitals will be forced to outbid one another for new nursing carers, which in turn will be to the detriment of the lower-paid employees in geriatric care.

The National Association of Statutory Health Insurance Funds has also repeatedly pointed out that the now numerous measures can result in undesirable interactions and misincentives between nursing care and geriatric care, and ultimately render the expensive measures ineffective. This is because the Act will also ensure that additional nursing staff in hospitals are fully refinanced in the future. The National Association of Statutory Health Insurance Funds rejects the path chosen here by policy-makers to return to the principle of cost coverage by separating expenditure caused by care in the hospital sector. This risks hospitals being forced to outbid one another for new nursing carers, which in turn will be to the detriment of the lower-paid employees in geriatric care. In addition, an unlimited funding framework coupled with limited human resources represents a long-term expenditure risk for contributors that should not be underestimated.

Furthermore, with the approaches chosen in the Act to Promote Nursing Staff, the legislature has almost completely ignored the structural component in the debate about staff shortages. The National Association of Statutory Health Insurance Funds is still of the opinion that statutory requirements for hospital structures as they are needed must finally be created so that the urgently-needed nursing staff are not tied up by excess hospital capacity.

Boosting residential geriatric care

The National Association of Statutory Health Insurance Funds has intensively supported the legislative process, and will continue to contribute towards improving the personnel situation in long-term care to the best of its ability. It must be emphasised as a matter of principle in this context that, from the point of view of the National Association of Statutory Health Insurance Funds, the measures should focus more closely on residential geriatric care, since this segment is experiencing a sharp increase in occupancy figures (occupied nursing home places), unlike in the hospital sector. One may also expect in future that for example shorter hospitalisation and a shift to out-patient care will cause occupancy figures in the hospital sector (occupied hospital beds) to remain stable or decline slightly, despite demographic developments.

§§

Further financial incentives for more nursing care in hospitals

The legislature has also established in law further financial incentives to strengthen hospital nursing staff with the Act to Promote Nursing Staff:

- **Additional funding for nursing carers**

Every additional nursing carer hired to work in direct patient care will be fully refinanced from 2019 onwards: initially in 2019 via the expanded nursing care jobs promotion programme, and from 2020 onwards via the new hospital-specific nursing care budgets that are to be introduced, via which hospitals' nursing costs will be financed separately from the diagnosis-related group case flat rates according to the principle of cost coverage.

- **Pay rate refinancing in nursing care**

This arrangement is intended to completely refinance the linear and structural pay rate increases for nursing carers from 2018 onwards, instead of refinancing half of the pay rate increases as is the case at present. Verification arrangements are in place to ensure that the additional funding has been utilised for nursing staff.

- **Training places in long-term care**

From 2019 onwards, trainees in their first year of training in (paediatric) nursing care and nursing care assistance will no longer be credited to full-time employees using the key that is defined by law, and will thus be fully refinanced. In addition, the training allowances for all training occupations stated in the Hospital Financing Act (Krankenhausfinanzierungsgesetz) will be refinanced in future if a training allowance has been agreed. The increase in training budgets resulting from the measures is not subject to an upper limit.

Greater patient safety through lower limits for nursing staff

Hospitals must demonstrate compliance with the lower limits for nursing staff on the basis of monthly average staffing and patient occupancy rates.

There are to be lower limits for nursing staff in German hospitals in the future. The Act Modernising the Epidemiological Monitoring of Transmissible Diseases (Gesetz zur Modernisierung der epidemiologischen Überwachung übertragbarer Krankheiten), which came into force in July 2017, tasked the German Hospital Federation (Deutsche Krankenhausgesellschaft – DKG) and the National Association of Statutory Health Insurance Funds with identifying care-sensitive areas in hospitals and agreeing lower limits for nursing staff for them which are to apply to all hospitals from 1 January 2019 onwards. The provisions on lower limits for nursing staff also included a mandate to agree a verification procedure and remuneration reductions in the event of non-compliance with the limits.

Binding lower limits per shift

Negotiations in 2018 focused on the collection of data on achieved nursing staffing in relation to patient occupancy. These formed the basis for the agreement of binding lower limits for nursing staff. In a discussion brokered by the Federal Ministry of Health, the self-government partners initially agreed on a compromise solution. However, the Board of the German Hospital Federation surprisingly rejected this compromise. The conflict resolution mechanism provided for by law thus took effect, with substituted performance by the Federal Ministry of Health. This came into force on 11 October 2018 in the form of the Lower Limits for Nursing Staff Ordinance (PpUGV). The Ordinance sets binding lower limits for nursing staff for four areas which must be adhered to on a shift-related basis on the wards of the individual areas at each hospital location:

1. intensive medicine
2. geriatrics
3. cardiology
4. traumatology

The self-government partners found a solution in November 2018 for the verification agreement

Statutory tasks and deadlines in section 137i of Book V of the German Social Code

	Task	Deadline	Conflict resolution	Status*
1	Establishing lower limits for nursing staff in care-sensitive areas	30 June 2018	Carried out via substitute performance by the Federal Ministry of Health (Lower Limits for Nursing Staff Ordinance)	✓
2	Agreement on additional costs	–	Arbitration Office on request; Appointment Service and Care Act provides for deletion	–
3	Verification agreement	30 June 2018	Automatic Arbitration Office	✓
4	Sanctions in case of non-compliance	~~30 June 2018~~ 31 January 2019	Automatic Arbitration Office	✓
5	Agreement on the transmission and use of data in accordance with section 21 of the Hospitals Remuneration Act (KHEntgG) as part of the annual update	~~31.07.2018~~ 31 December 2018	Arbitration Office on request	
6	Review and further development of the lower limits for nursing staff in accordance with section 6 of the Lower Limits for Nursing Staff Ordinance	31 August 2019	Automatic Arbitration Office	
7	Agreement on lower limits for nursing staff for neurology and heart surgery	31 August 2019	Automatic Arbitration Office	
8	Annual setting of lower limits for nursing staff in other care-sensitive areas (for the first time for 2021)	31 August (annual)	Automatic Arbitration Office	
9	Scientific evaluation incl. report to Federal Ministry of Health and the Bundestag	31 December 2022	–	

*as per : 31 December 2018
Illustration: National Association of Statutory Health Insurance Funds

during the further negotiation process. In particular, this stipulates that hospitals must demonstrate compliance with the lower limits for nursing staff on the basis of monthly average staffing and patient occupancy rates, and must also report the number of shifts per month in which the lower limits for nursing staff were not complied with.

In accordance with the statutory stipulations, the agreement on sanctions for non-compliance with the lower limits is to be coordinated at federal level by 31 January 2019. Remuneration and case number reductions are intended to prevent it from being worthwhile to undercut the limits or not to provide any personnel information at all. The self-government partners have already been able to reach broad agreement on sanctions. On the other hand, there is disagreement on the design of the rules for reducing the number of cases. Since no agreement has been reached in good time between the self-government partners, the decision is likely to be made by the automatic arbitration procedure provided for by law.

Prioritising patient protection

The National Association of Statutory Health Insurance Funds considers the establishment of lower limits for nursing staff through the Lower Limits for Nursing Staff Ordinance to be an important first step towards ensuring patient protection and care quality in hospitals. This is the first time that binding shift and ward-related minimum requirements have been laid down for nursing staffing.

The Act to Promote Nursing Staff provides for the further development and extension of the lower limits for nursing staff to other care-sensitive areas from 2019 onwards. Patients' differing care requirements are particularly to be taken into account in the future. The National Association of Statutory Health Insurance Funds had always advocated such a risk adjustment during the negotiation process. It will argue in the ongoing negotiation process for an extension of the lower limits for nursing staff to include all in-patient hospital areas in order to avoid staff and patient relocations and early discharges.

Important incentives through nursing staff quotas

In addition to the existing lower limits for nursing staff in individual parts of hospitals, in accordance with the stipulations of the Act to Promote Nursing Staff, the Institute for Hospital Remuneration Systems is to calculate a nursing care quotient for each hospital which represents the ratio of the nursing staff employed to the individual nursing care expenditure of a hospital in order to improve nursing staffing. This quotient provides information on the extent to which the hospital deploys a large or small number of nursing staff for direct patient care. In contrast to the lower limits for nursing staff, the nursing staff quota considers the hospital as a whole. The Federal Ministry of Health issues an ordinance setting a lower limit for the required ratio between nursing staff and care expenditure which still guarantees long-term care that is not hazardous to patients. If the value falls below the specified value, the contracting parties agree at federal level on the amount and details of the sanctions, with effect for the local contracting parties. This measure enhances patient safety on the one hand, and provides an incentive to hospitals to employ more staff on the other. The National Association of Statutory Health Insurance Funds regards the nursing staff quota as an expedient and necessary addition to the existing arrangement on the lower limits applying to nursing staff.

The nursing care quotient represents the ratio of the nursing staff employed to the individual nursing care expenditure of a hospital.

Lower limits for nursing staff in accordance with the Lower Limits for Nursing Staff Ordinance

	Intensive medicine		Geriatrics		Cardiology		Traumatology	
	☀	☾	☀	☾	☀	☾	☀	☾
Max. no. of patients per nursing carer	2.5*	3,5*	10	20	12	24	10	20
Max. share of nursing assistants	8 %	8 %	20 %	40 %	10 %	15 %	10 %	15 %

* These ratios for the care-sensitive area of intensive care medicine apply to 2019 and 2020.
The ratio of 2:1 applies from 1 January 2021 to the day shift and 3:1 to the night shift (section 6 subsection (1) No. 1 of the Lower Limits for Nursing Staff Ordinance)

Illustration: National Association of Statutory Health Insurance Funds

Second report on the nursing care jobs promotion programme presented

A total volume of approx. 157 million Euro has been agreed so far in the first two years of funding, which means that about half of the available funds from statutory health insurance have been utilised.

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

With the Act Strengthening Nursing Staff, the nursing care jobs promotion programme was also adapted and extended to 2019 as a transitional solution until a long-term care budget comes into force. The hospitals' own share and the limitation to an eligible share of the total budget will no longer apply in 2019, so that any additional nursing staff costs will have to be fully financed.

Transparent presentation of take-up and personnel increases

The National Association of Statutory Health Insurance Funds evaluates the take-up of this subsidy annually on the basis of data from the health insurance funds. It submitted the report on implementation in 2016 and 2017 to the Federal Ministry of Health on 30 June 2018. According to the report, a total of 618 hospitals were provided with roughly 97 million Euro in the budget year 2017. A total volume of approx. 157 million Euro has been agreed so far in the first two years of funding, which means that about half of the available funds from statutory health insurance have been utilised. Approximately 2,228 additional nursing care posts were agreed. The first audit certificates from the 2016 annual audits are available for 38 % of the clinics participating in this year's funding, showing an actual increase of around 1,553 full-time positions in the participating hospitals. The proportion of personnel hired from the subsidies cannot be clearly defined due to the partially unspecific nature of the verification. These data are however initially preliminary in nature, as it was not yet known with regard to all eligible hospitals at the time when the report was prepared whether the funding options had been taken up. The updated databases of previous years are always also evaluated in the subsequent reports, so that a reliable assessment of the actual take-up will not be possible until the end of the funding period.

Nursing care jobs promotion programme – agreed funding in the funding years 2016 and 2017

Amount of funding in million Euro

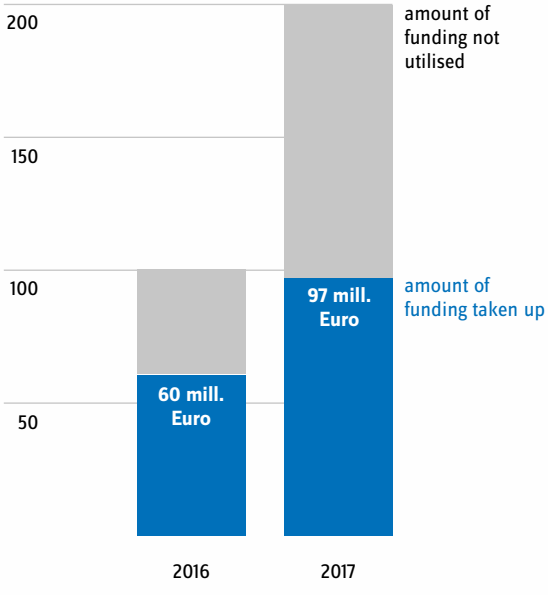


Illustration: National Association of Statutory Health Insurance Funds

Concerted Long-Term Care Campaign launched

One of the major goals of the Federal Government is to make working in long-term care more attractive. More people are to be motivated to take up the nursing profession. The Concerted Long-Term Care Campaign (KAP), which is entrenched in the Coalition Agreement, aims to directly and noticeably improve the everyday working lives and working conditions of professional (nursing) carers, to boost nursing care training, and to identify and implement further comprehensive measures to relieve the burden on nursing carers.

The Federal Ministry of Health – together with the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth and the Federal Ministry of Labour and Social Affairs – launched the Concerted Long-Term Care Campaign with all relevant players in geriatric care, nursing and paediatric nursing care in July 2018, and coordinated the basic structure, the tasks and the composition of the working groups in the umbrella organisation.

Defining and implementing measures together

A total of five topic-specific working groups were set up, all with the active participation of the National Association of Statutory Health Insurance Funds, which also arranges the coordination with the health and long-term care insurance funds. The working groups are to develop concrete measures and recommendations which are to be adopted by the umbrella organisation and presented in the summer of 2019.

The National Association of Statutory Health Insurance Funds actively supports the Concerted Long-Term Care Campaign, and expects a noticeable improvement in the working conditions of professional nursing carers. Neither better payment for nursing carers, nor the recruitment or training of nursing carers abroad, is sufficient by itself to increase the attractiveness of the nursing profession. Rather, it is necessary for all the players involved to make a responsible, reliable and lasting contribution and to play an active part in improving the care situation by implementing the agreements. This includes, for example, that hospitals and long-term care facilities provide more training, that the Länder accordingly ensure sufficient school places, and that they meet their responsibility to assume the investment costs.

The Concerted Long-Term Care Campaign is intended to improve the working conditions of professional nursing carers, boost nursing training and identify and implement further ways of reducing strains.

The working parties of the Concerted Long-Term Care Campaign

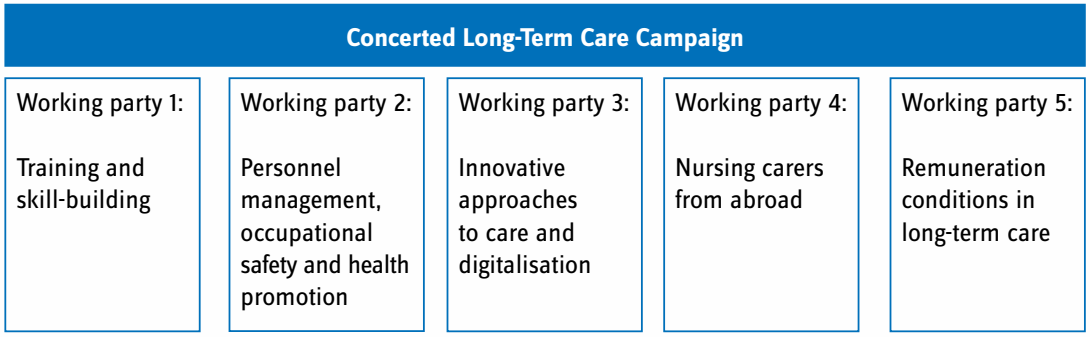


Illustration: National Association of Statutory Health Insurance Funds

SOLIDARITY IN STATUTORY HEALTH INSURANCE

is embarking on

new paths

The Innovation Fund: Focus on tomorrow's care

The Innovation Committee of the Federal Joint Committee has been promoting innovative care models and application-orientated care research since 2016 with an annual funding volume of up to 300 million Euro. In the third year since the Innovation Fund was established, health insurance funds, physicians' associations, university clinics and general hospitals, as well as Universities and research institutes, have again submitted numerous funding applications to the Innovation Committee. As in the previous years, these project proposals were evaluated in accordance with the eligibility criteria published in the respective promotion announcements in order to be able to decide which project proposals are to benefit from funding. The decisions of the Innovation Committee were also influenced by the funding recommendations of the Expert Advisory Council, which contributed its scientific and practical expertise to the assessment process.

Trialling new forms of care

93 individual applicants or application consortia submitted their project proposals in response to the promotion announcement on "New forms of care" published in October 2017 in order to trial care innovations under everyday conditions and to have them evaluated according to scientific standards. The fact that this number is slightly lower than in previous years may be due to the fact that, this year, the Innovation Committee decided not to publish a promotion announcement without any thematic restrictions. Instead, it wanted to accentuate certain aspects of its promotion by selecting specific thematic foci. Amongst other things, the topic area "care models spanning social benefit funding institutions" was put out to tender. The goal is to overcome existing obstacles in the care process arising from the responsibilities of the various branches of social security. Here are two examples:

- An application for funding which tests a structured form of multimodal pain therapy for back pain patients was successful in this field. After a detailed assessment, which also includes psychosocial risk factors, the multimodal therapy begins in a rehabilitation centre. Residential care, financed by statutory health insurance, is to be followed by vocational rehabilitation paid for by the German pension insurance in a seamless procedure and without further examination appointments. The objective is to create short decision-making paths across the boundaries between funding institutions.
- Another example concerns cooperation between facilities of residential geriatric care (Book XI of the German Social Code) and the emergency services financed by statutory health insurance. The project intervention consists of developing and evaluating a cross-sectoral, integrated emergency and availability management system. The aim is to provide nursing carers with a decision-making algorithm in order to be able to do optimum justice to what nursing home residents want to see happen in defined crisis situations.

As a result, a total of 38 projects qualified. They were supported to the tune of 187.7 million Euro. The Innovation Committee therefore did not fully utilise the available funding budget for the first time in 2018. This is due to the fact that the project selection is made strictly according to the eligibility criteria and no compromises are made at the expense of quality.

The topic area "care models spanning social benefit funding institutions" was put out to tender aiming to overcome existing obstacles in the care process.

It is highly gratifying from the point of view of the National Association of Statutory Health Insurance Funds that health insurance funds were again involved in all selected projects as consortium leaders or partners. The care models are based on selective agreements as a rule, so that the respective projects are based on a stable legal construct and the care offers can as a matter of principle be continued even after the subsidy has expired.

Care research

A total of 205 project proposals were submitted in the "care research" funding area. The main topics

of the call for proposals included, for example, the "Usability of learning algorithms", "Care of geriatric patients", "Treatment options in case of resistance" and "Patient safety, quality assurance and promotion". The Innovation Committee selected 55 projects – 53 of them from the topic-specific area – as well as two projects for the further development and evaluation of the Federal Joint Committee's guideline on skin cancer screening. The projects are supported with a total funding volume of 70.0 million Euro.

The Innovation Fund has provided an important impetus for the initiation of innovative care approaches and enhanced the evaluation culture in the German healthcare system.

What will happen with the Innovation Fund?

The Innovation Fund has provided an important impetus for the initiation of innovative care approaches and enhanced the evaluation culture in the German healthcare system. No results are however available for the funded projects at present, so that it was not yet possible to conclusively assess the impact of the Innovation Fund on statutory health insurance care by the end of 2018. The majority of projects in the "New forms of care" funding area will not come to an end until 2020 and 2021, respectively. The governing parties nevertheless agreed in the Coalition Agreement that the Innovation Fund will be continued beyond 2019, with a subsidy budget reduced to 200 million Euro per year.

The path to standard care

In addition to the Grand Coalition's commitment to the future of the Innovation Fund, the Coalition Agreement also aspires to ensure that successful care approaches are rapidly transferred to standard care. The transfer is the central success parameter of the Innovation Fund. From the point of view of the National Association of Statutory Health Insurance Funds, the decision as to whether a new form of care that has been promoted by the Innovation Fund was successful in terms of its objective, and how this innovation is to find

Promoted "New forms of care" in 2018

	No.	Volume
New forms of care by topical areas		
Care models spanning social benefit funding institutions	9	37.5 million €
Care models spanning diseases	1	6.1 million €
Care models for specific diseases/groups of diseases	15	71.1 million €
Care models for vulnerable groups	4	25.2 million €
Care models with comprehensive, measurable responsibility for results and processes	2	7.4 million €
Models for the further development of care structures and processes	7	40.4 million €
Total for 2018	**38**	**187.7 million €**

Source and illustration: National Association of Statutory Health Insurance Funds

its way into (standard) care, should be based exclusively on reliable findings from project implementation. This is possible on the basis of the results and evaluation reports which the project participants or the institutes commissioned with the scientific evaluation must prepare after the end of the project, and which are to be published by the sponsor.

Under no circumstances should the established channels for transferring innovations into standard care be bypassed and the principles and standards of joint self-government undermined. Those institutions that bear responsibility for care quality in statutory health insurance should decide whether and under what conditions a care offer will be continued. The competences and tasks of the Innovation Committee are derived from its function as a funding body. This includes the determination of proper implementation as mandated, as well as the examination and formal acceptance of the evaluation and result reports.

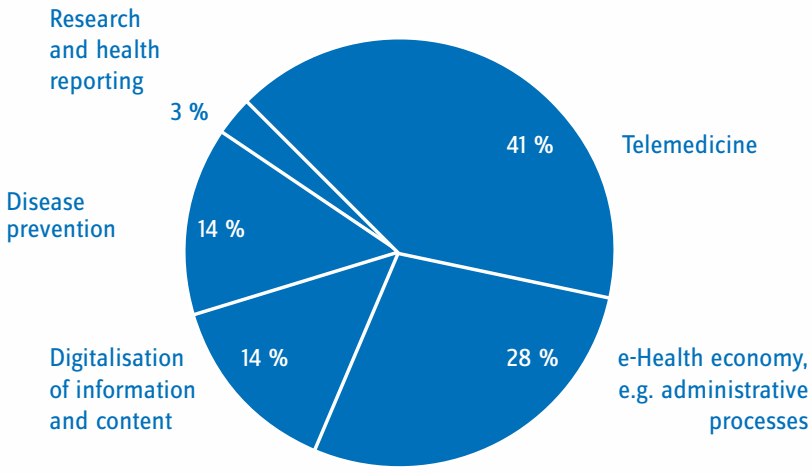
It is possible as a matter of principle to transfer care innovations to statutory health insurance care via collective agreement law, or alternatively within the framework of conditions within selective contracts. In view of the considerable heterogeneity of the care services funded by the Innovation Fund, there can be no across-the-board recommendation to take one or other path. The transition to statutory health insurance care depends on the concrete content or on the complexity of the care innovation. A transfer of positively-evaluated projects via the collective agreement would be best suited to the rules of procedure of the Innovation Committee. The latter define standard care as "care to which all insured persons are entitled, regardless of their health insurance fund membership, their place of residence or their consent to a project or programme". In particular, this would be used to adjust Federal Joint Committee guidelines and fee schedule items in the Standard Schedule of Fees (Einheitlicher Bewertungsmaßstab), or to further develop the Federal Skeleton Agreements.

An alternative to the collective agreement consists of the possibility of embedding a new care approach in selective contract law. The channel via the selective agreement is suitable if the innovation consists of a complex bundle of different interventions that are provided cross-sectorally or spanning social benefit funding institutions, and if there is no tailor-made legal basis for implementation within collective contract law. One of the advantages of selective agreements is that, unlike collective agreements, they can be implemented relatively quickly. After all, many care projects funded by the Innovation Fund are already based on "section 140a contracts", so that in the course of a (spatial) broadening of the model quite simply more contracting partners on the healthcare provider side, or additional health insurance funds, as cost funding institutions would have to be brought in.

Those institutions that bear responsibility for care quality in statutory health insurance should decide whether and under what conditions a care offer will be continued.

E-Health in new forms of care

percentage distribution



Source: Application texts, own evaluation;
Illustration: National Association of Statutory Health Insurance Funds

By contrast, the disadvantages of the selective agreement in accordance with section 140a of Book V of the German Social Code are that "special care" does not reach all individuals who have statutory health insurance, and requires a registration procedure, a time-consuming budget adjustment, and proof of economic viability.

A transfer of positively-evaluated projects via the collective agreement would be best suited to the rules of procedure of the Innovation Committee.

If specific care approaches cannot be implemented within the existing framework of the healthcare system, the legislature handing down the Act or ordinance is called on to do so.

SOLIDARITY IN STATUTORY HEALTH INSURANCE

means lending a

helping hand

Long-term care budget: separating nursing staff costs from the diagnosis-related group system

As per 2020, hospitals' nursing staff costs will be removed from the diagnosis-related group case flat-rates and financed separately via a long-term care budget. In addition to the diagnosis-related group case flat-rates, the new hospital-specific nursing care budget will be financed in future according to the principle of cost coverage. The National Association of Statutory Health Insurance Funds sees the need to make mandatory stipulations for nursing staff appointments. The basis must be formed by a record of the as-is situation that is exact down to individual shifts and wards, and in addition a personnel assessment instrument based on individual nursing care needs, as well as on work and nursing science. The National Association of Statutory Health Insurance Funds considers the return to cost coverage now implemented with the Act to Promote Nursing Staff to be a wrong decision. The reason for the problems that exist in long-term care lies not in the way in which hospitals are financed via diagnosis-related group case flat-rates, but in the misappropriation of long-term care revenues to compensate for the lack of investment financing and the preservation of partly uneconomical structures.

The reason for the problems that exist in long-term care lies in the misappropriation of long-term care revenues to compensate for the lack of investment financing and the preservation of partly uneconomical structures.

The separation of nursing staff costs from diagnosis-related group case flat-rates now planned solves the problem of earmarked financing in long-term care, since the agreement on the nursing staff budgets only finances the cost of nursing posts that are actually documented. The misguided incentives associated with cost coverage are however significant in themselves.

Reorganising the funding of nursing care

The reorganisation of the funding of nursing care requires a large number of adjustments. For example, on the basis of a concept developed by the Institute for the Remuneration System in Hospitals, the contracting parties at federal level have to separate the nursing staff costs for direct patient care on in-patient wards from the remuneration system as per 2020, and develop a new nursing staff cost remuneration system. An unambiguous, nationwide definition of the nursing staff costs to be removed is to be first of all agreed for this by the end of January 2019. At the same time, the codes of procedure must be specified by the end of February 2019 that will no longer be required for the diagnosis-related group system once the long-term care budget has been introduced. The contracting parties at federal level must work out the details of the negotiation of the long-term care budget by July 2019.

The case flat-rates and the additional charges in the diagnosis-related group list are to be reduced by 30 September 2019 by the nursing staff costs that are to be separated. Nursing staff costs are to be reflected in a list of daily valuation ratios by the end of September 2019. This list is to be applied by the contracting parties at local level from 2020 onwards for the payment of the hospital-specific long-term care budget. Finally, the contracting parties at federal level must report to the Federal Ministry of Health on the impact of the introduction of the care budget on the development of nursing staff posts and costs from 2020 to 2024. They must submit an interim report on this matter by August 2021 and a final report by August 2025.

Initiating structural change in residential care

The Hospital Structural Fund was first introduced for the years 2016 to 2018 with the Hospital Structure Act. The National Association of Statutory Health Insurance Funds originally brought the Structural Fund into the political debate in order to support hospital closures and market corrections. The Structural Fund is however used in particular by the Länder to compensate for the steady decline in investment on the part of the Länder. Evaluations of the Structural Fund to date show that only a very small proportion of the funds was used to actually reduce capacity. The Structural Fund can thus be seen as the Federal Länder encroaching on the Health Fund.

Using funds from the Structural Fund in a targeted manner

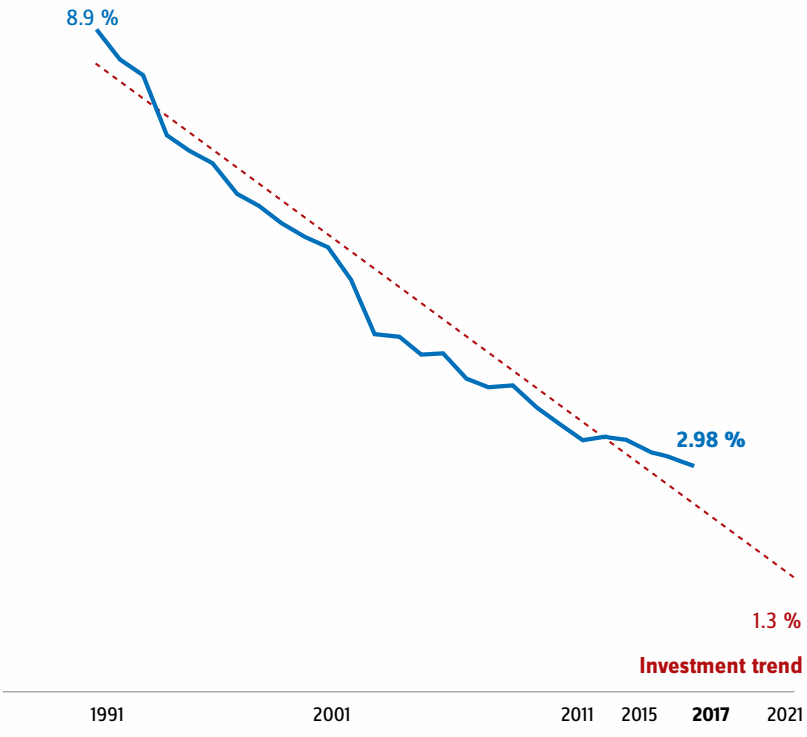
This Fund will now be continued with the Act to Promote Nursing Staff for the next four years with 1 billion Euro per year. As in the past, half of the financing is provided by statutory health insurance, which provides 500 million Euro directly from the liquidity reserve of the Health Fund. Mandatory participation of private health insurance is also not planned in the future. The other half is co-financed by the Länder or the funding institutions. In order to qualify to use the Fund's resources in the coming years, the Länder must continue to provide the same level of investment funding as previously provided in the hospital sector. The possibilities for using the Structural Fund's resources are also enhanced by the Act to Promote Nursing Staff. Amongst other things, digitalisation measures such as the creation of telemedicine network structures and the improvement of information technology security, as well as the creation of additional training capacities, can now also be financed. In addition, 5 % of the financial resources are earmarked for projects spanning several Länder.

The Hospital Structural Fund is an instrument with potential and a sensible approach to achieve the necessary structural change in the in-patient sector. With the expansion of the promotion objectives, the original purpose of the Structural Fund, namely to finance the reduction of overcapacities, is receding further into the background. This threatens an even greater misappropriation of the Structural Fund's resources for general investment measures in hospitals, the financing of which is an original task of the Länder.

The original purpose of the Structural Fund, namely to finance the reduction of overcapacities, is receding further into the background.

Falling investment by the Federal Länder

Ratio of Länder investments to hospitals' total costs



Source: Federal Statistical Office
Illustration: National Association of Statutory Health Insurance Funds

Safeguarding emergency care

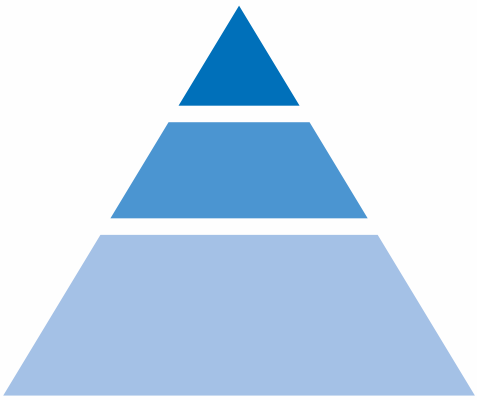
The Federal Joint Committee decided in April 2018 on a three-tiered system of emergency structures in hospitals, comprising basic emergency care, extended emergency care, and comprehensive emergency care. In order to be able to assign hospitals to a level in the future measured by the extent of their provision for emergency care, minimum structural requirements were defined for the following criteria for each emergency level:

- number and type of specialist departments
- the number and qualifications of the specialist staff to be made available
- capacity available for looking after intensive care patients
- medical and technical equipment
- emergency admission structures and processes

On the basis of the level assignment, hospitals can receive supplements for their participation in emergency care that are graduated in terms of their amount. Hospitals that do not meet the minimum structural requirements must accept reductions. The resolution entered into force on 19 May 2018, following its publication in the Federal Gazette. The contracting parties at federal level were obliged to determine the amount and details of supplements and reductions by 30 June 2018, with the assistance of the Institute for the Remuneration System in Hospitals. The agreement on the emergency supplements and reductions is to be reached at local level for the first time for the budget year 2019.

Participation in general emergency care by categories

(n = 1,101; 63 %)



Comprehensive emergency care
97 locations

Extended emergency care
144 locations

Basic emergency care
860 locations

- A total of 1,210 locations satisfy at least the criteria of basic emergency care or of the modules (69 %).
- 538 locations do not satisfy the criteria of basic emergency care or of the modules (31 %).
- The participating locations have handled 95% of emergencies at night and on weekends in the past.

Source and illustration: National Association of Statutory Health Insurance Funds

Targeted payment for participation in emergency care

The arrangement of emergency supplements and reductions that was introduced via the Hospital Structure Act initially provided for a redistribution between hospitals that was neutral in terms of expenditure for statutory health insurance. This was also appropriate in the view of the National Association of Statutory Health Insurance Funds, since the resolution of the Federal Joint Committee does not cause any additional costs for the hospitals as a whole. Rather, it enables a targeted reimbursement of the different levels of existing expenditure through the participation or non-participation of hospitals in emergency care. With the adoption of the Act to Promote Nursing Staff, however, an amendment was adopted which abolishes the lowering or increasing effect of emergency supplements and reductions on base rates in the Länder. If the volume of reductions applying to non-participants in the Land is not sufficient to refinance the supplementary payments made by those providing emergency services, the difference will be compensated for by the health insurance funds in future. According to estimates carried out by the legislature, this will lead to additional expenditure for statutory health insurance in the low three-digit million range from 2019 onwards.

The National Association of Statutory Health Insurance Funds and the German Hospital Federation reached an agreement in December 2018 on the amount of emergency supplements and reductions on the basis of the new legal arrangement. The annual supplement for a hospital location participating in basic emergency care (Category 1) is a flat-rate amount of 153,000 Euro. The flat-rate amount for extended emergency care (Category 2) is 459,000 Euro. A flat-rate amount of 688,500 Euro was set for comprehensive emergency care (Category 3). Arrangements were also made to determine the amount of the supplement for the special emergency care modules, including emergency paediatric services and care of stroke victims. The amount of the supplement in these modules is essentially measured by the ratio of patients in these care units to all fully in-patient cases at the hospital locations. Those locations that do not participate in the graduated emergency care system will have to accept a reduction of 60 Euro per fully in-patient treatment case in future. A total supplement volume of 295 million Euro is to be disbursed nationwide for hospitals' participation in emergency care. This amount is composed of the volume of deductions imposed on non-participants, and the low three-digit million amount to be additionally financed by statutory health insurance.

A total supplement volume of 295 million Euro is to be disbursed nationwide for hospitals' participation in emergency care.

Quality contracts: allotting priority to quality in hospitals

The conclusion of a framework agreement with the German Hospital Federation satisfied the formal prerequisite for quality contracts by health insurance funds and hospitals on the spot.

The legislature placed a strong focus on quality assurance in the in-patient sector in 2015 with the Hospital Structure Act. In addition to strengthening existing instruments, such as minimum quantities, new ones were also created, and these will be successively implemented in the Federal Joint Committee and by the negotiating partners, namely the German Hospital Federation (DKG) and the National Association of Statutory Health Insurance Funds. In addition to the quality contracts, these include for example the quality indicators relevant to planning (first resolution by the Federal Joint Committee in December 2016), as well as the quality-orientated supplements and reductions (in consultation).

Ensuring quality-orientated remuneration

The aim of the quality contracts is to introduce quality-orientated remuneration in four service areas. The order is implemented in two steps. The Federal Joint Committee initially defined four service areas:

- endoprosthetic joint replacement (shoulder, hip, knee)
- prevention of postoperative delirium in the care of elderly patients
- cessation of respirator treatment for patients with prolonged ventilation treatment
- care of people with mental disabilities or severe multiple disabilities in hospital

The Institute for quality assurance and transparency in the healthcare system (IQTIG) has developed a concept for the evaluation of the quality contracts which has since been published on the Federal Joint Committee's website.

The second step was the conclusion of a framework agreement with the German Hospital Federation, which entered into force on schedule in August 2018. This satisfied the formal prerequisite for the initiation and conclusion of quality contracts by health insurance funds and hospitals on the spot. They become effective as soon as the IQTIG has set the stage for the evaluation in procedural terms. This is expected to be the case in July 2019. It has been possible to submit project plans and register concluded contracts with the IQTIG since February 2019.

Creating clear stipulations for special care in centres

Special benefits of centres are benefits which are not provided by all hospitals, and therefore cannot be financed by diagnosis-related group case flat-rates. In particular, these are tasks that involve more than one hospital, such as tumour conferences for patients of other hospitals. Financing via centre supplements was therefore introduced with the implementation of the diagnosis-related group system. The term "centre" has however been used in an inflationary and arbitrary manner by both Länder and hospitals. Bavaria, for example, considered stroke care to be centre-relevant. Baden-Württemberg, on the other hand, focused on geriatrics, and North Rhine-Westphalia on breast cancer centres. The impression was created that every medical facility that considered itself worthwhile referred to itself as a "centre".

The National Association of Statutory Health Insurance Funds and the German Hospital Federation (DKG) were therefore tasked through the Hospital Structure Act with agreeing on the details of the specific tasks to be performed by centres. As it was not possible to reach a negotiated agreement, the centre agreement was fixed in December 2016 by the Federal Arbitration Office, against the votes of the cost funding institutions.

Regulating care in centres clearly and uniformly

The National Association of Statutory Health Insurance Funds believes that the agreement that has been fixed does not create the necessary clarity of norms. The Arbitration Office has left open the question of how centres' "special tasks" can be distinguished from a hospital's standard tasks, and which quality criteria qualify centres to take on special tasks. It was quickly confirmed that the parties differed in how they interpreted the centre agreement. As a result, no centre supplements were paid under the new scheme in 2018. The National Association of Statutory Health Insurance Funds has therefore terminated the contract. Renegotiations with the German Hospital Federation began in November 2017, and failed in July 2018 after a total of five rounds of negotiations.

The National Association of Statutory Health Insurance Funds expressly welcomes the fact that the Federal Joint Committee has been mandated through the Act to Promote Nursing Staff to establish nationwide quality criteria for the centres by the end of 2019.

The National Association of Statutory Health Insurance Funds had already expressed its support for a the uniform national framework established by the Federal Joint Committee for care in centres in its positions for the 19th legislative period. Following the Federal Joint Committee's adoption in the past two years of stipulations on guarantee surcharges and on a tiered system of emergency structures in hospitals – regulations that also affect hospital planning – it is logical that care in centres should also be flanked by nationwide guidelines. The National Association of Statutory Health Insurance Funds therefore expressly welcomes the fact that the Federal Joint Committee has been mandated through the Act to Promote Nursing Staff to establish nationwide quality criteria for the centres by the end of 2019. Starting in 2020, there will then be a nationwide centre concept for the first time which can be implemented in a legally-secure manner at Land and local level.

Hygiene promotion programme: Does more support equal more hygiene?

Approximately 329 million Euro have so far been agreed to recruit hygiene staff, for further and advanced training measures in hygiene, and for external consulting services.

The statutory health insurance funds have been providing additional funds to improve levels of hygiene staff in hospitals via a hygiene promotion programme since 2013. This special subsidy is intended to help hospitals comply promptly with the stipulations of the Infection Protection Act (Infektionsschutzgesetz) relating to the provision of qualified hygiene personnel. This primarily includes the recruitment of new medical and nursing hygiene staff, and supplementing existing staff. Subsidies can however also be obtained for further and advanced training on hygiene topics and external advice from hygiene experts. The Hospital Structure Act extended the promotional period to a maximum of 2023, increased the volume of funding to more than 460 million Euro, and supplemented the funding options to include other professional groups specialising in infectious diseases.

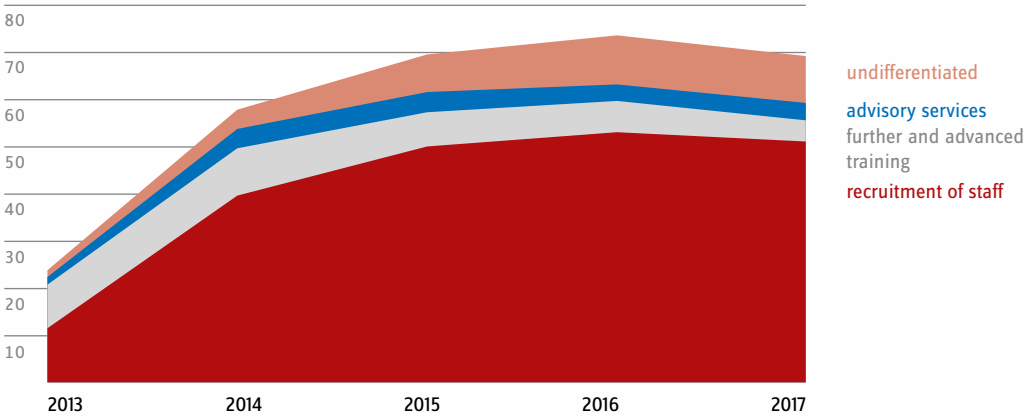
Taking stock

The National Association of Statutory Health Insurance Funds reports annually to the Federal Ministry of Health on the take-up of this subsidy. The fourth report of the National Association of Statutory Health Insurance Funds was submitted to the Federal Ministry of Health in June 2018, and provides an overview of the funding provided so far between 2013 and 2017. According to the report, approximately 329 million Euro have so far been agreed to recruit hygiene staff, for further and advanced training measures in hygiene, and for external consulting services. This means that the funds agreed so far have actually exceeded expectations in terms of take-up in the first funding years. Some of the financial resources were agreed undifferentiatedly, however, and cannot yet be allocated to a specific type of funding. Whether the subsidies are actually used correctly, and for example new posts have been created for hygiene personnel, can only be ascertained retrospectively through the respective annual audit of the clinics. The first confirmations by annual auditors for roughly 42% of the funds agreed between 2013 and 2016 are already available (103 million Euro out of 245 million Euro). Further confirmations will be evaluated in the reports that follow.

It is not yet possible to comprehensively assess on the basis of the current data to what extent effects on the number of hygiene personnel and on the quality of hygiene in hospitals can actually be determined. It remains to be seen what the future effects of the support programme on hygiene quality will be, e.g. in the nationwide evaluations of external in-patient quality assurance for hygiene-related indicators.

Hygiene promotion programme

Promotion from 2013-2017 (as per April 2018)
Amount of promotion in million Euro



Source and illustration: National Association of Statutory Health Insurance Funds


SOLIDARITY IN STATUTORY HEALTH INSURANCE
is shared
strength

Improving access to out-patient medical care

The Appointment Service and Care Act (Terminservice- und Versorgungsgesetz – TSVG) aims to improve access to out-patient medical care for individuals who have statutory insurance. The long waiting times for individuals who have statutory health insurance that exist in some specialist medical areas are unacceptable. The different waiting times of patients who have statutory and private insurance are also to be brought into line.

The legislature is focusing primarily on the further development of the appointment service points and on the expansion of the minimum consultation hours offered. The Act distinguishes between different case constellations: Is the patient new to this surgery? Does the patient visit the surgery on his or her own initiative, or did the appointment come about through the mediation of a general practitioner or an appointment service point? Is there a need for immediate medical care, or does the treatment take place during an open consultation? The following measures are planned:

The legislature is focusing primarily on the further development of the appointment service points and on the expansion of the minimum consultation hours offered.

- promotion of the admission of new patients in doctors' surgeries
- increased consultation hours available for individuals who have statutory insurance
- expanding the range of appointment service points
- accelerating the allocation of specialist appointments in acute cases

A lot of effort for little return

The planned improvements in access to care for individuals who have statutory insurance are basically to be welcomed. However, the National Association of Statutory Health Insurance Funds does not consider the current structure to be effective. Whilst the documentation work to be done by contract doctors and the verification costs incurred by the health insurance funds will increase, it is not to be expected that insured persons will receive noticeably better care. Considerable additional expenditure is demanded of the statutory health insurance funds, although the Act only legally fixes obligations on doctors which already exist, and which doctors should already be performing today.

Depending on the respective case constellation, the Act provides for different forms of financing, all of which are to be remunerated additionally. The admission of new patients, for example, is to be provided with an extra-budgetary supplement of at least 25% on the insured person and basic flat-rate amount. As per the current plan, the treatment of patients who have been referred to a specialist as an urgent case by the appointment service centre or by general practitioners or paediatricians is to be completely extra-budgetary, i.e. covering all benefits. Moreover, only an insufficient one-off adjustment of the morbidity-related total remuneration is planned for this purpose.

A major financial burden on contributors

The National Association of Statutory Health Insurance Funds rejects the remuneration regulations provided for in the Act as inappropriate, as these lead to considerable financial burdens for the contributors. According to estimates by the National Association of Statutory Health Insurance Funds, the arrangements planned for contract doctors alone will result in additional costs of at least 600 million Euro. It should be noted here that this calculation is based on the currently very small number of cases at the appointment service points. A significant increase can be expected to occur in the number of appointments arranged by the appointment service points in future, thus causing a further significant increase in expenditure. In addition, extra-budgetary incentives frequently lead to an increase in benefits that is not medically indicated and the extent of which cannot be accurately predicted.

Orientating the range of consultation hours in line with patient needs

The National Association of Statutory Health Insurance Funds is committed to the targeted financial support of meaningful measures to care for insured persons. Today's consultation services must be geared more closely towards patients' needs. An effective reduction in waiting times could be achieved by making the consultation hours offered more flexible, in particular by promoting evening and Saturday surgery hours, which are scarcely offered at present. This would also effectively reduce medically-unnecessary visits to emergency out-patient departments or standby services provided by contract physicians. In addition, the National Association of Statutory Health Insurance Funds believes that it should be ensured that the 25 consultation hours per week are only available for individuals who have statutory health insurance, and that preferential appointment arrangements with privately insured persons should be regarded as a breach of the obligations of contract doctors.

An effective reduction in waiting times could be achieved by promoting evening and Saturday surgery hours, amongst other things.

The National Association of Statutory Health Insurance Funds considers the proposed measures to be a more targeted way of designing the incentives intended by the legislature. Moreover, the implementation of the proposed measures does not require doctors to provide a relevant amount of additional documentation, nor will the health insurance funds be burdened with additional verification costs.

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Key points of the Appointment Service and Care Act

Promoting the admission of new patients to surgeries

- targeted financial incentives for contract doctors to offer consultation appointments to patients who have not been treated in the same surgery for at least four years

Increasing the number of consultation hours offered for individuals who have statutory insurance

- a minimum of 25 consultation hours per week with contract doctors
- of which at least five hours per week as open consultations with specific groups of specialised doctors without a prior appointment
- financial support for open consultations

Expanding the services offered by the appointment service points

- 24/7 availability on a uniform nationwide telephone number
- expanding the appointment provision activity to almost all groups of specialist doctors
- arranging a treatment appointment within one week if a referral has been issued (with the exception of ophthalmologists and gynaecologists)
- arranging immediate treatment (without a referral) in acute cases on the basis of a standardised initial assessment procedure
- supporting patients in finding a permanent general practitioner or paediatrician
- financial incentives for accepting appointments

Accelerating the allocation of specialist appointments in acute cases

- additional financial support for the arrangement of a specialist appointment by general practitioners or paediatricians
- additional financial support for the acceptance of corresponding appointments in cases of particular medical urgency

New arbitration body weakens contributors' interests

To ensure that insured persons receive care, social law provides in many care areas for the conclusion of contracts between healthcare providers and health insurance funds. If no agreement can be reached, the contracting parties may call on the arbitration offices provided for by law. This tried-and-tested conflict resolution system is modified by the Appointment Service and Care Act (TSVG).

Arbitration office for care by contract doctors and dentists

The Arbitration Office is a proven conflict resolution mechanism in care by contract doctors and dentists that aims to avoid a situation in which there is no contract. The National Association of Statutory Health Insurance Funds welcomes the envisaged revision of the regulations governing the Arbitration Office under the Appointment Service and Care Act, as long as they do not interfere with self-government autonomy. However, the arrangement is rejected by which the non-partisan members of the Arbitration Office are appointed by the supervisory authority if the contracting parties are unable to reach agreement among themselves on the non-partisan members. The proposed exclusive power of the non-partisan parties to decide in the event that decisions are not taken in due time is also viewed critically, as it restricts the rights of the self-government partners.

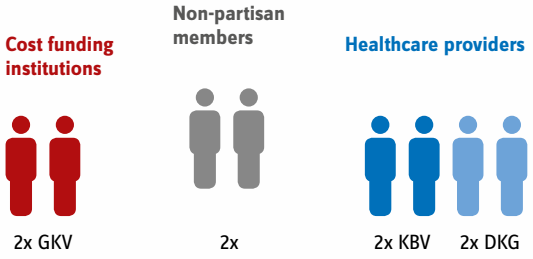
Cross-sectoral arbitration body

The National Association of Statutory Health Insurance Funds fundamentally welcomes the planned establishment of a new cross-sectoral arbitration body. This body is to decide in future in cases of conflict in which health insurance funds' and doctors' representatives as well as the hospital side are involved. This serves to standardise previously area-specific conflict resolution mechanisms. In addition to the aspects already criticised above with regard to the Arbitration Office, the planned regulations on the distribution of votes and on majority relationships must also be rejected: Whereas the Act will grant four votes to the healthcare providers in future (two votes each to the medical profession and the hospitals), the health insurance funds will receive only two votes. Two votes are also allocated to non-partisan members, albeit decisions always require a two-thirds majority (i.e. six out of a total of eight votes). The consequence of this would be that a motion by the health insurance funds could not be granted, even with the votes of all non-partisan members of the arbitration body. In the opinion of the National Association of Statutory Health Insurance Funds, it is appropriate for the body to be made up of equal numbers of representatives of the healthcare providers and of the funding institutions, as is also the arrangement on the Federal Joint Committee. This is the only way of safeguarding the interests of contributors, especially with regard to questions that are relevant to remuneration.

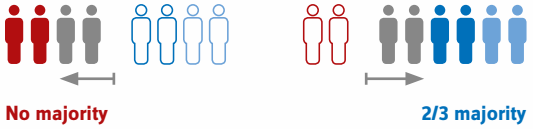
The proposed exclusive power of the non-partisan parties to decide in the event that decisions are not taken in due time restricts the rights of the self-government partners.

The Arbitration Office

Occupation of the cross-sectoral Arbitration Office



Establishing a majority
necessary: 2/3 majority (6 out of 8 votes)



Key:
GKV = statutory health insurance
KBV = National Association of Statutory Health Insurance Physicians
DKG = German Hospital Federation

Illustration: National Association of Statutory Health Insurance Funds

Rapid agreement reached in self-government on doctors' fees for 2019

A 1.58 % increase in the orientation value for 2019 was passed unanimously.

Within the negotiations on the further development of the registered contract doctors' total remuneration for 2019, the National Association of Statutory Health Insurance Physicians (KBV) and the National Association of Statutory Health Insurance Funds agreed in August 2018 on an adjustment of the orientation value for the year 2019 (price component), as well as on the further development of the morbidity-related total remuneration (volume component), with the inclusion of the non-partisan members. Following a complaint raised by the Federal Ministry of Health in December 2018, the assessment committee revised the resolutions on the volume component.

Demands initially widely divergent

The National Association of Statutory Health Insurance Funds had offered a 0.24 % increase in the orientation value for 2019 in this year's negotiations. The increase was intended to offset the moderate cost increases in the doctors' surgeries. The National Association of Statutory Health Insurance Physicians, on the other hand, called for the orientation value to be increased by 4.72 %. It also justified this by pointing to cost developments, but additionally wanted to see the increased doctors' salaries in the hospitals taken into account. In addition, the National Association of Statutory Health Insurance Physicians asserted special circumstances that had allegedly not been included in the procedure for adjusting the orientation value. According to the National Association of Statutory Health Insurance Physicians, these include new provisions on protection from infection and on data protection, as well as existing investment requirements in connection with digitalisation.

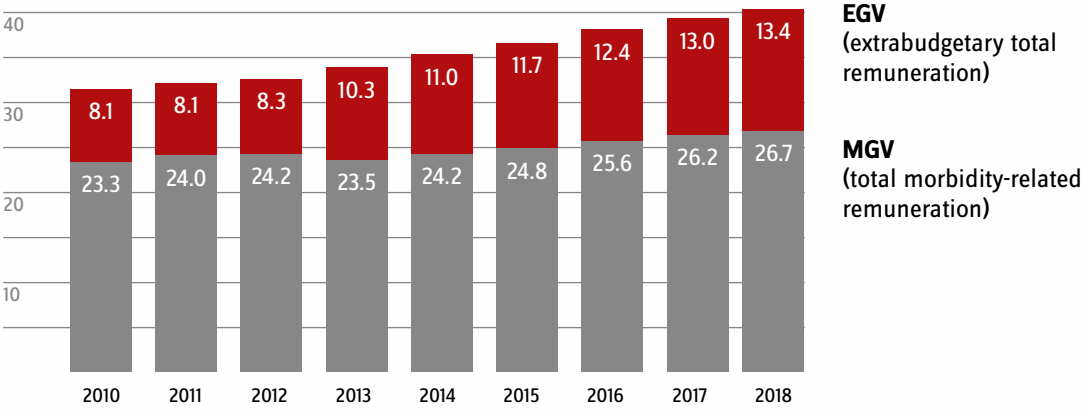
An agreement was reached as early as August, following mediation by the non-partisan chairman of the expanded assessment committee. A 1.58 % increase in the orientation value for 2019 was passed unanimously. The Institute of the assessment committee (InBA) is to first of all carry out corresponding analyses of the special circumstances introduced by the National Association of Statutory Health Insurance Physicians, the results of which are to be submitted to the assessment committee by the end of March 2019.

A moderate change in the morbidity structure

At the same meeting, the expanded assessment committee also unanimously adopted the classifi-

Development in expenditure on contract doctors' remuneration

Figures in billions of Euro



Source Form 3 (uncorrected total remuneration), extrapolation for 2018
Illustration: National Association of Statutory Health Insurance Funds

cation model for calculating the diagnosis-related and demographic rates of change for 2019 (volume component). The resulting recommendations for diagnosis-related and demographic rates of change in the individual districts of Associations of Statutory Health Insurance Physicians were subsequently adopted by the assessment committee in September 2018. The Federal Ministry of Health however objected to these two resolutions in October 2018. The reason given for this was that the task of adequately taking into account purely statistical effects when agreeing on the change in the morbidity structure was incumbent on the regional parties to the overall contract. The assessment committee was not permitted to preempt this when calculating the diagnosis-related rates of change. Both the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds contest this legal opinion, and have therefore brought a joint action against the objection. Since this action has no suspensory effect, the resolutions on the classification model and on the recommendation of the rates of change were revised by the assessment committee in December 2018. This leads to diagnosis-related rates of change amounting to approx. 0.6 % and to demographic rates of change of approx. 0.0 % on a national average.

Contract doctors' remuneration also to increase in 2019

Contract doctors' remuneration is to continue to increase. All in all, the health insurance funds are expected to make available an additional roughly 1.2 billion Euro.

The joint resolutions mean that the fees paid to contract doctors will also rise in 2019. All in all, the health insurance funds are expected to make available an additional roughly 1.2 billion Euro, which corresponds to an increase of 2.6%. At the same time, statutory health insurance members' income subject to contributions will also rise by 2.65 %. This enabled the joint self-government of physicians and health insurance funds to find a viable balance that would not overburden contributors financially. This increase in expenditure does not however take account of any additional fee increases to be agreed between the parties to the overall contract at Land level, expenditure on benefits to be introduced in 2019 under the Standard Schedule of Fees (EBM), as well as expenditure arising from new statutory regulations and the rising number of insured persons.

Increase in doctors' fees in 2019

	Total (million Euro)
Results of the remuneration negotiations at federal level for 2019	
Adjustment in the orientation value	550
Development in morbidity (weighting 50/50) subject to the objection by the Federal Ministry of Health)	80
Additional remuneration due to increases in volume	
Extrabudgetary benefits (extrapolation)	400
Rising number of insured persons (extrapolation)	200
Total	**1,230**

Source: Form 3 (uncorrected total remuneration), extrapolation for 2018
Illustration: National Association of Statutory Health Insurance Funds

New legal framework: uniform Federal Skeleton Agreement for Dentists

The Federal Skeleton Agreement for Contract Dental Care regulates the type and scope of care, and contains provisions on the course of treatment. It also forms the basis for the overall contracts negotiated between the Associations of Statutory Health Insurance Dentists and the health insurance funds at Land level.

A new provision makes Medical Service procedures and contractual expert procedures equivalent with regard to expert opinions.

The uniform Federal Skeleton Agreement for Contract Dental Care came into force in July 2018. The consolidation of the previous Federal Skeleton Agreements for primary and substitute funds is a consequence of the Act to Improve Competition in Statutory Health Insurance, under which the National Association of Statutory Health Insurance Funds assumed the tasks and the continuation of the contractual agreements of the previous national associations of primary and substitute funds.

Agreement reached between the National Association of Statutory Health Insurance Dentists and the National Association of Statutory Health Insurance Funds

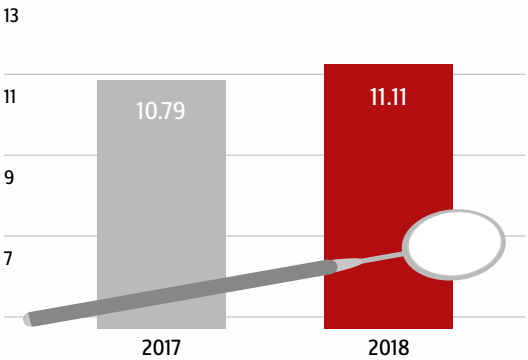
After lengthy negotiations, the National Association of Statutory Health Insurance Dentists and the National Association of Statutory Health Insurance Funds were able to reach agreement on the content of the Federal Skeleton Agreement largely through negotiations. The clarification of the remaining contentious points, such as the inclusion of the Health Insurance Medical Service (MDK) in the assessment of services provided by contract dentists, the implementation of the service guarantee by the Associations of Statutory Health Insurance Dentists, the handling of claims by health insurance funds vis-à-vis an Association of Statutory Health Insurance Dentists, or the employment of dentists in Medical Care Centres, was carried out with the mediation of the Federal Arbitration Office.

The National Association of Statutory Health Insurance Funds considers it to be positive that the new Federal Skeleton Agreement for Contract Dental Care includes a provision making Medical Service procedures and contractual expert procedures equivalent with regard to expert opinions. This point had been disputed between the parties for a long time. With regard to the right of retention of the health insurance funds in the event of an Association of Statutory Health Insurance Dentists failing to comply with its service guarantee for reasons for which it is responsible, the National Association of Statutory Health Insurance Funds was able to obtain similar regulations as in the contract doctors area. Furthermore, the National Association of Statutory Health Insurance Funds has been able to ensure that the number of dentists employed in Medical Care Centres is not unnecessarily restricted.

In addition to the changes in content described above, the National Association of Statutory Health Insurance Funds has also been working to make the structure of the Federal Skeleton Agreement for Contract Dental Care clearer. With topic-related sections and the separate annex section, a comprehensive, transparent set of rules has been created which, when taken together with Book V of the German Social Code, covers the entire spectrum of contractual dental care at federal level.

Expenditure on dental treatment (not including prosthetic treatment)

Figures in billions of Euro



Source official statistics KJ 1, KV 45 1st-4th Quarters (for 2018)
Illustration: National Association of Statutory Health Insurance Funds

Cancer screening further developed on the basis of new data

The Federal Joint Committee passed significant resolutions in 2018 on the further development of existing screening measures for colorectal cancer and cervical cancer. In accordance with the statutory stipulations, these will be offered in future as organised cancer screening programmes. The key points are the regular personal invitations to eligible insured persons and the monitoring of structural, process and result quality.

Colorectal cancer screening for men aged 50+

The invitation procedure for the colorectal cancer screening programme will start in July 2019. The health insurance funds will write to their members when they reach a certain age and provide detailed information about the programme. Men will in future be offered a colonoscopy as a preventive measure at the age of 50 – and not from the age of 55 as has been the case to date – since scientific data show that they already have an increased risk of contracting the disease at the age of 50. Women's risk of developing the disease, on the other hand, only increases from the age of 55, but they can have a stool test carried out from the age of 50. They can also choose between a stool test and a colonoscopy from the age of 55 onwards. The previous stool tests were replaced with immunological stool tests as early as 2017, as these are a more reliable means of detecting colorectal cancer and its precursors.

Cervical cancer screening with combined screening

The National Association of Statutory Health Insurance Funds has been working to ensure that the test for the human papillomavirus (HPV) can also be used as part of screening in the future in the design of the cervical cancer screening programme. As per 1 January 2020, women aged 35 and over will be able to use a combined screening test consisting of a cell smear (Pap smear) and an HPV test. This combined screening is offered every three years. It offers greater certainty for this age group than a Pap smear alone. As before, women aged between 20 and 34 can have their Pap smears taken every year. The invitation procedure for the screening programme will be launched by the health insurance funds in January 2020.

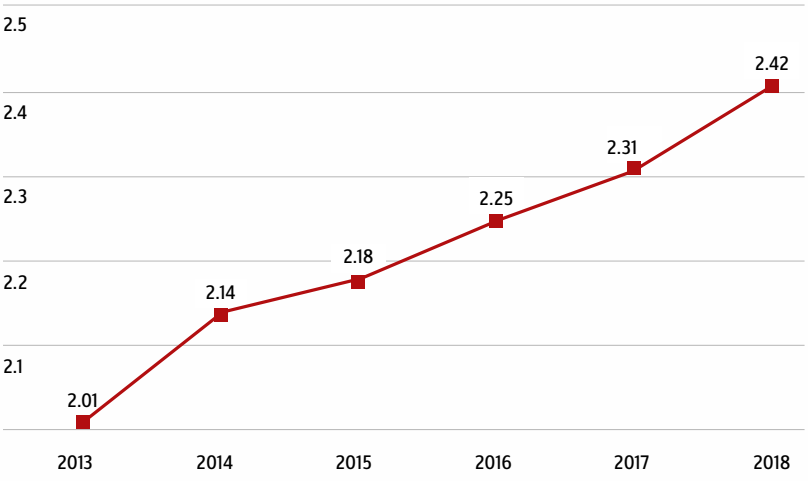
Continuous research support

A restructured data collection will form the basis for the assessment and further development of the two programmes. The data are collected for each insured person and pseudonymised by an independent confidence agency. This enables data from different care areas to be consolidated and evaluated in a longitudinal section. A comparison with cancer registry data is planned in order to evaluate "interval carcinomas", as well as the long-term effects on morbidity and mortality.

Women aged 35 and over will be able to use a combined screening test consisting of a cell smear and an HPV test.

Expenditure of statutory health insurance on all screening measures

Figures in billions of Euro



Source official statistics KJ 1. KV 45 1st-4th Quarters (for 2018)
National Association of Statutory Health Insurance Funds

SOLIDARITY IN STATUTORY HEALTH INSURANCE

means a peaceful

night's sleep

Safeguarding the future of long-term care

The legislature initiated a large number of statutory amendments in long-term care insurance last year. In addition to strengthening the nursing staff, the range of care services on offer will be expanded and the financing of long-term care insurance will be secured by increasing the contribution rate. A large number of the changes came into force as early as 1 January 2019. The remaining changes are expected to take effect during the first half of 2019.

Promoting nursing staff

The Act to Promote Nursing Staff, which came into force on 1 January 2019, is intended to achieve tangible improvements in the everyday lives of nursing carers through better staffing and better working conditions. In addition to the creation of 13,000 nursing staff posts, further measures were adopted to improve the reconciliation of long-term care, family and career, and to facilitate long-term care work through digital applications. The National Association of Statutory Health Insurance Funds has the statutory task of determining the details of the respective application and payment procedures for the measures in guidelines by 31 March 2019.

Advocating better long-term care for society as a whole

The reconciliation of long-term care, family and career is an essential aspect for making the nursing profession more attractive by providing better working conditions. Digital procedures can be used to simplify and accelerate processes, in turn helping to ease the burden on nursing carers. The National Association of Statutory Health Insurance Funds has repeatedly stressed that the funding of family care and digital investment is not a measure directly related to care. They are therefore to be financed primarily from taxation within the framework of investment obligations. If they are financed via long-term care insurance, these costs should be refinanced via a tax-financed federal subsidy.

Placing the finances of long-term care insurance on a secure footing

The definition of need for long-term care introduced on 1 January 2017 has significantly improved the benefits provided by long-term care insurance. More people than originally expected have taken advantage of these improvements in services. The contribution rate to social long-term care insurance was raised by 0.5 percentage points as per 1 January 2019 in order to finance the resulting additional expenditure. This results in a contribution rate of 3.05 %, or 3.3 % for childless persons. The National Association of Statutory Health Insurance Funds considers an increase in the contribution rate of this magnitude to be appropriate. It makes it possible to secure the financing of the additional expenditure resulting from the improvements in long-term care until 2022. It remains to be seen whether the further measures agreed in the Coalition Agreement to improve the wage and working conditions of professional nursing carers and to further ease the burden on family caregivers will be fundable by then. The additional expenditure associated with these measures cannot yet be reliably estimated at present. A Federal subsidy from taxation is required in order to stabilise long-term social care insurance in the long term. In the view of the National Association of Statutory Health Insurance Funds, reflexively increasing the contribution rate does not go far enough, since long-term care insurance is already performing tasks for society as a whole, such as old-age provision for family caregivers.

A Federal subsidy from taxation is required in order to stabilise long-term social care insurance in the long term.

Permanent licensing of caregiving services as healthcare providers

The National Association of Statutory Health Insurance Funds has carried out a pilot project on a statutory basis to test the benefits of home care through out-patient caregiving services. The results have led to plans to permanently introduce caregiving services as licensed healthcare providers in long-term care insurance when the Appoint-

ment Service and Care Act comes into force. The separate licensing of caregiving services is limited to benefits in kind of long-term care support measures, as well as assistance for household management. The provisions for care services apply accordingly to caregiving services unless any deviating regulations have been made.

Caregiving services are to be introduced as licensed healthcare providers in long-term care insurance when the Appointment Service and Care Act comes into force.

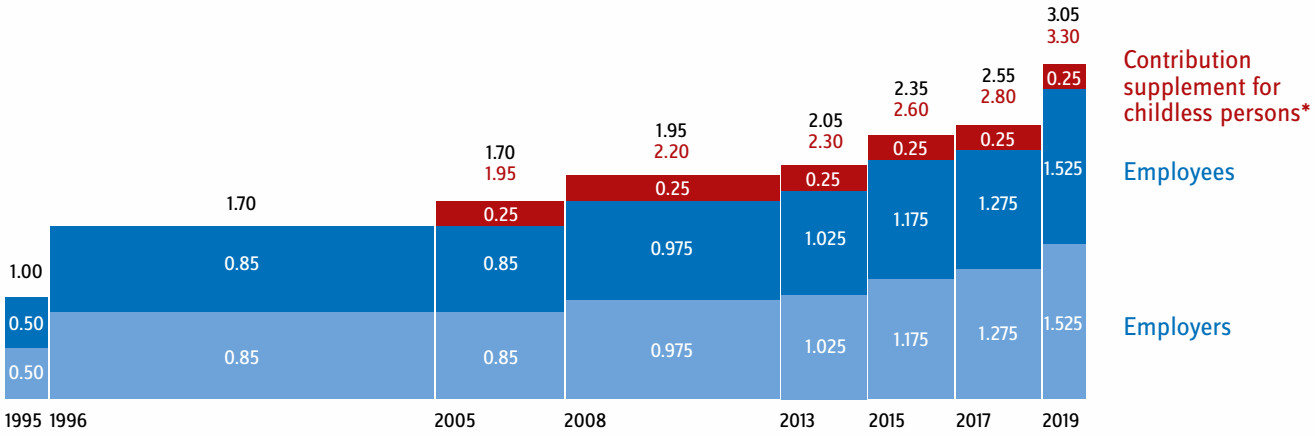
The National Association of Statutory Health Insurance Funds has issued guidelines on the requirements for quality management and quality assurance for out-patient caregiving services in order to ensure the quality of such services. After the guidelines have been approved by the Federal Ministry of Health, the applicable quality control guidelines for out-patient long-term care must be adapted. It is planned to develop quality criteria with the participation of the research community in order to adjust the applicable quality control guidelines in out-patient long-term care.

Using telemedicine procedures

In order to improve the care of people in need of long-term care in nursing homes by contract doctors, binding cooperation agreements are prescribed between long-term care facilities and contract (dental) healthcare providers. New telemedicine procedures such as video-supported consultations or case conferences are to be made possible through cooperation. Video consultations are to be welcomed in connection with providing home visits to people who are in need of long-term care and people with disabilities, as well as care of people in need of long-term care in residential facilities. The National Association of Statutory Health Insurance Funds supports as a matter of principle the inclusion of video consul-

Developments in contribution rates in social long-term care insurance

as a percentage, 1995 to 2019



*contribution supplement for childless persons (section 55 subsection (3) of Book XI of the German Social Code) not incl. employer contribution
Illustration: National Association of Statutory Health Insurance Funds

tations in the lists of benefits of statutory health insurance, as well as the expansion of the areas of application, provided that the aforementioned groups of persons have already been patients.

Video consultations can be used in a medically meaningful way, e.g. instead of a (dental) medical consultation, or advice involving personal contact, or a repeated assessment of a patient's problem which is already known from a personal contact and which can be assessed by means of the supporting visual function via a video contact. The National Association of Statutory Health Insurance Funds is also in favour of holding case conferences via video contact.

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Act to Promote Nursing Staff – Promotion of special measures

Better reconciliation of long-term care, family and work

Long-term care facilities will receive annual funding of 100 million Euro between 2019 and 2024 to support measures aimed at improving the reconciliation of long-term care, family and careers for nursing carers. Individual and community childcare services are eligible, and these are geared to the special working hours of nursing carers (e.g. child day-care centres run by the respective funding agency). A subsidy of up to 50% of the funds expended by the long-term care facility, to a maximum of 7,500 Euro, can be awarded for this purpose.

Simplification of work through digital applications

In order to ease the burden on nursing carers, one-off grants will be provided for long-term care facilities between 2019 and 2021 in order to promote digital applications that serve in particular to make nursing documentation easier, or to contribute to internal quality management. Up to 40 % of the funds spent by the long-term care facility can be subsidised, to a maximum of 12,000 Euro.

Shaping high-quality long-term care training

In future, there will be bodies in the Länder responsible for administering a training fund for long-term care training.

Long-term care training will be placed on a new footing from the training year 2020 onwards. The compromise on the Act on the Nursing Profession (Pflegeberufegesetz) that was reached in a lengthy and controversial legislative procedure forms the framework for the new training. After two years of common basic generalist training, the generalist training can be completed, or specialisation can be sought in nursing or geriatric care. This will open up further career opportunities and options for future nursing carers. Furthermore, tuition fees have been dropped across the board.

The content of the Act was specified in the Training and Examination Ordinance in the spring of 2018, as well as in the Ordinance on Financing. Both ordinances were approved by the Bundesrat in September 2018. The reform that was initiated in November 2015 thus reached its parliamentary conclusion after almost three years.

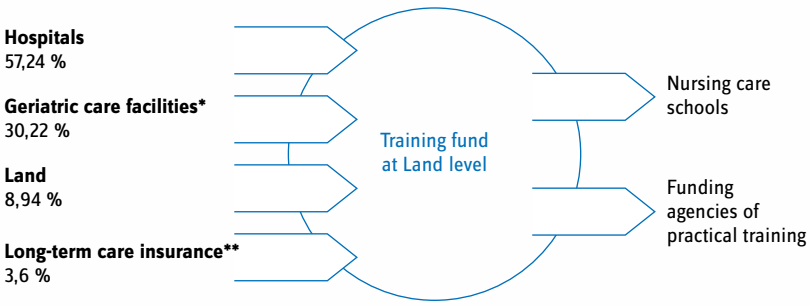
Standardising the regulations for financing training

Based on the previously separate training pathways of the nursing profession, financing is also to be placed on a uniform basis in the Federal Länder in line with the amalgamation of the content of future nursing care training. In future, for example, there will be bodies in the Länder responsible for administering a training fund for long-term care training. The money collected by the funding agencies will be disbursed to the training companies and schools via a levy in order to refinance the training costs.

One critical aspect is that the Ordinance on Financing failed to ensure that a uniform nationwide database, a common calculation basis and a standardised plausibility review were created in connection with the financing. The ordinance thus falls short of the proposals submitted by the National Association of Statutory Health Insurance Funds in November 2017, together with the funding institutions of the long-term care facilities at federal level and with the German Hospital Federation.

The health and long-term care insurance funds expect there to be a boost for long-term care training. At the same time, there is a need for further flanking measures and to embed the new long-term care training in an overall strategy. The Concerted Long-Term Care Campaign announced in the Coalition Agreement can make a major contribution to this and support the Länder in fulfilling their responsibilities, e.g. with regard to assuming the investment costs.

Funding agencies of the new nursing care training



*Refinancing in accordance with the provisions contained in Books XI and V of the German Social Code
**Direct payment
Illustration: National Association of Statutory Health Insurance Funds

Enhancing disease prevention in residential long-term care

The Act to Strengthen Health Promotion and Disease Prevention – Disease Prevention Act (Gesetz zur Stärkung der Gesundheitsförderung und der Prävention – Präventionsgesetz) from 2015 placed the long-term care insurance funds under an obligation to provide disease prevention and health promotion benefits for persons covered by long-term care social insurance in fully- and partly residential long-term care facilities. Long-term care facilities are to be strengthened in their health promotion potential, and long-term care insurance funds are to implement preventive and health-promoting offers together with the residential long-term care facilities. The idea behind this is that people in need of long-term care, despite their physical, cognitive or psychological impairments, have health potential that can be promoted. In the best case, suitable measures can be taken to overcome or reduce the need for long-term care or to prevent further deterioration.

The guidelines of the National Association of Statutory Health Insurance Funds for disease prevention in residential long-term care define the criteria for the benefits of long-term care insurance funds for disease prevention and health promotion in residential long-term care facilities. They support the long-term care insurance funds in developing and implementing disease prevention and health promotion programmes, together with the long-term care facilities. The National Association of Statutory Health Insurance Funds prepared the guidelines in consultation with the associations of long-term care insurance funds at federal level and with the Medical Service of the National Association of Statutory Health Insurance Funds (MDS). The main basis for its preparation was the inclusion of independent expertise as provided for by law. An expert opinion on criteria for disease prevention in the residential setting was awarded for this purpose in 2015. The results were incorporated into the guidelines published in 2016 by the National Association of Statutory Health Insurance Funds.

Development and documentation in research

The guidelines were updated in 2018 on the basis of new scientific findings, in particular on the weight of evidence. In the fields of action "physical activity" and "strengthening cognitive resources", adjustments were also made to the statements on the scope, duration and type of preventive measures on the basis of scientific findings. In addition to the consideration of recent scientific findings, the practical feasibility of the recommendations was also taken into account during further development.

The disease prevention benefits provided in residential long-term care facilities have been systematically documented by the long-term care insurance funds since 2017.

The disease prevention benefits provided in residential long-term care facilities have been systematically documented by the long-term care insurance funds since 2017. The results were published for the first time in 2018 in the disease prevention report of the National Association of Statutory Health Insurance Funds and the MDS, and will also appear in 2019 in the disease prevention report of the National Disease Prevention Conference which spans funding institutions.

Disease prevention goals

Guidelines on disease prevention in residential situations

The uppermost goal of disease prevention in residential long-term care:
to promote the health-beneficial potential of long-term care facilities

Fields of activity:
- **Diet**
- **Physical exercise**
- **Cognitive resources**
- **Psychosocial health**
- **Violence prevention**

Illustration: National Association of Statutory Health Insurance Funds

Better quality information about long-term care facilities

A particular challenge consists of developing quality reporting that is understandable, clear and comparable for persons in need of long-term care and their family members from the different quality information.

The Second Act to Strengthen Long-term Care (Zweites Pflege-Stärkungsgesetz) gave long-term care self-government at federal level the mandate in 2017 to have instruments and procedures for quality control and quality illustration in out-patient and residential long-term care developed as part of the research that was carried out. The project results for the future quality control and quality illustrations in out-patient and residential care have been available since September 2018.

The statutory mandate also provides for piloting the instruments and procedures that have been developed in out-patient care in order to test their practical manageability and application. The results will be available in 2019.

Quality indicators

Quality area 1:
Maintaining and supporting independence
- Maintained mobility*
- Maintained independence when it comes to everyday activities*
- Maintained independence in shaping everyday life and social contacts

Quality area 2:
Protection against damage to health and strain
- Protection against the development of pressure sores*
- Protection against falls with serious consequences*
- Protection against unintentional weight loss*

Quality area 3:
Support for specific needs
- Integration interview after moving into a home
- Use of restraining belts in the case of cognitively-impaired residents
- Application of bedside panels in the case of cognitively-impaired residents
- Topicality of pain assessment

New quality indicators

Long-term care self-government has developed the standards and principles for nursing quality on the basis of the results for residential care. The requirements for an indicator-based procedure were defined for the first time: 15 quality indicators and arrangements for data collection and transmission to a body that evaluates the data. These indicators, which are to be applied by all long-term care facilities from October 2019 onwards, are to be used to assess the quality of the results, e.g. on the issue of maintaining and promoting the mobility of nursing home residents, and to present them in a consumer-friendly manner. The project results also include proposals for future quality control in residential long-term care facilities. The National Association of Statutory Health Insurance Funds, together with the Medical Service of the National Association of Statutory Health Insurance Funds, has drawn up the new quality control guidelines on this basis. The quality control will be carried out on the new basis from November 2019 onwards.

The results from quality control and quality indicators will be supplemented in future by "facility information", e.g. on staffing, and incorporated into the quality illustration. The new quality illustration will replace the previous long-term care grades. A particular challenge consists of developing quality reporting that is understandable, clear and comparable for persons in need of long-term care and their family members from the different quality information, and thus making it possible for everyone to easily recognise good and bad quality. The objective of the National Association of Statutory Health Insurance Funds is to create a reporting system for this that differentiates better than in the past according to the quality of care.

*two risk groups with one key figure each
Illustration: National Association of Statutory Health Insurance Funds

Offering individual long-term care advice

Individual long-term care advice is an important aid for people who are confronted – usually suddenly – with their own need for long-term care. It is intended to record the assistance needs of each individual, and thus clarify which benefits of long-term care insurance are necessary and available to cover these needs. Access to social benefits and assistance should furthermore be facilitated. Family members or other persons are included in the consultation at the request of the person in need of long-term care. The individual needs of the person in need of long-term care are determined and documented as part of the process on the basis of a jointly-developed care plan for the implementation of which the long-term care advisors share responsibility. Networking with other relevant players is also safeguarded in order to make sure that implementation is successful and that the long-term care situation is secured.

The benchmark is self-determination

These and other details will be bindingly regulated in the new long-term care advice guidelines of the National Association of Statutory Health Insurance Funds. These are designed to standardise the quality of advice and improve the overall long-term care advice process. During the preparation of the guidelines and recommendations, self-determination and catering for the individual circumstances of the person in need of long-term care have always been the central element and benchmark of the content of the rules.

The new version of the recommendations on the number, qualification and further training of long-term care advisors appeared at the same time as the guidelines. These recommendations are also addressed to the institutes and schools that offer advanced training for long-term care advisors, and for instance specify how advanced training is to be based on various basic vocational qualifications.

A large number of stakeholders were able to comment on the draft guideline as part of an extensive participation process. These included the Länder, the Federal Association of Regional Social Assistance Agencies, the municipal national associations at federal level, the Federal Association of Independent Welfare Associations and the associations of the funding institutions of the long-term care facilities at federal level, as well as the associations of the nursing professions at federal level, independent experts and the relevant organisations for the representation of the interests and self-help of people in need of long-term care and people with disabilities and their family members. Selected information from the organisations was taken into account in the guidelines. If comments or requests could not be complied with, this was justified in writing and given to the Federal Ministry of Health at the procedural stage of guideline approval. This careful participation ensured that the information from the care practitioners found an appropriate place in the deliberations of a directive to be implemented nationwide.

The long-term care advice guidelines are designed to standardise the quality of advice and improve the overall long-term care advice process.

Paths towards better long-term care and participation

Improving the care of persons in need of long-term care as well as support for and relief of caring family members are central concerns that are dealt with and scientifically evaluated in the various pilot programmes of the Research Unit on Long-Term Care Insurance. The examples below illustrate this.

Intercultural bridge-builders in long-term care (IBIP)

The pilot project, which has been completed, served to test and evaluate the deployment of intercultural bridge-builders in long-term care advice provided by care bases and in the assessment of long-term care. Ten people with different mother tongues (Polish, Russian, Serbo-Croat, Romanian, Turkish and Arabic) worked in the long-term care advice of Berlin care bases, having received six months of skill-building. They were shown to have increased the demand of immigrant people for long-term care advice and improved their access to necessary long-term care services. Their intercultural mediation makes it easier for the Medical Service to assess long-term care for people with a migration background. The Land Berlin took on responsibility for the bridge builders in September 2018, significantly increased their number, and deploys them permanently at the care bases.

The deployment of intercultural bridge-builders made it easier for the Medical Service to assess necessary long-term care for people with a migration background.

Cross-sectoral deployment of care staff at the intersection between hospital and out-patient care (SEBKam)

The current pilot project is testing the deployment of out-patient care staff who are already involved in the domestic care of dementia patients whilst they are being taken care of in hospital. The target group also includes patients in acute hospitals who were first diagnosed with dementia there. The cross-sectoral deployment of the out-patient care staff is intended to increase patient safety and the quality of life of dementia patients during their stay in an acute hospital, and to reduce the risk of complications. The goal is to prevent the move to a residential long-term care facility and to be able to release patients suffering from dementia back into their home environment. The costs are also to be reduced due to shorter stays in hospital and through the avoidance of frequent rehospitalisations, as well as of institutional care. SEBKam received the 2018 Health Networker Award in the Implementation category.

Family members of dementia sufferers in exchange: a supra-regional exchange platform to activate untapped care potential (AniTa)

The ongoing pilot project is testing the use of an online platform for long-distance caregiving in the Hamburg and Munich regions. In view of increasing mobility, more and more children who live far away cannot assist their parents when they need help. The network of far-flung family members that is offered is designed to enable the participants to look after an elderly person in the place where they live, while someone else offers support for their own parents who live far away. This is not about long-term care or household management, but visits, activities and lending a helping hand in everyday life. The aim of networking is to ensure a certain degree of participation for the aging parents (at home or in a residential long-term care facility), and to counteract the threat of isolation. The family members who live far away benefit by having a local contact person who is confronted with a similar situation.

Successful completion of the pilot programme for the further development of new forms of accommodation

The pilot programme for the further development of new forms of accommodation for people in need of long-term care in accordance with section 45f of Book XI of the German Social Code ran out at the end of 2018. The 53 projects included here were examined in their diversity according to the evaluation criteria user orientation, quality of care, economic efficiency, sustainability and transferability. New forms of accommodation meet the needs of their users in terms of care

security, self-determination and social integration, according to the conclusion reached by Prognos AG and the Kuratorium Deutsche Altershilfe, who accompanied the pilot programme in academic terms. The successful balancing and implementation of these needs was presented at the closing event of the pilot programme in September 2018.

Overall, the results indicate a high level of user satisfaction with the forms of accommodation investigated. This can be seen for example in quality of living and security of care. The opportunity to shape one's life according to one's own needs and habits, even whilst needing assistance and nursing care, is highly appreciated. The assumption of responsibility associated with the desired self-determination can however prove to be a challenge. There is still room for improvement when it comes to social inclusion and opportunities for participation.

The evaluation recommends that new forms of accommodation be expanded because they do justice to the diversity of individual needs and to the desire for self-determination of people in need of long-term care. The statutory and contractual frameworks and responsibilities, as well as the effects of new care concepts on employees in nursing care and support, are cited as unresolved issues.

New forms of accommodation meet the needs of their users in terms of care security, self-determination and social integration.

The report of the overall scientific evaluation will be published in early 2019. The anthology published by the National Association of Statutory Health Insurance Funds already provides an insight into the results of the individual projects from the pilot programme, in which all project sponsors present their concepts and offers and report on their experiences in implementation.

Together for people with dementia

The National Association of Statutory Health Insurance Funds has been actively supporting the Alliance for People with Dementia since September 2014 as part of the Federal Government's strategy on demography. The final report entitled "Together for People with Dementia" was published in September 2018, and a review was drawn up of the work carried out by the Alliance.

The Alliance for People with Dementia is an initiative of the Federal Government. The Federation, the Länder and municipal central associations, as well as more than 20 associations and institutions from long-term care and healthcare, academia and civil society, have joined forces to ensure a sustainable improvement in the quality of life of people with dementia and their family members.

Pilot projects to improve care for dementia sufferers

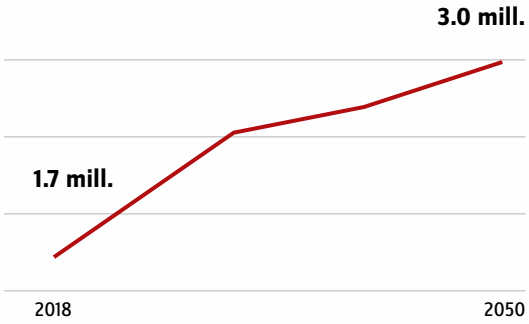
The report provides information on the measures taken over the past four years by the alliance partners to improve and expand assistance and support for those affected. A total of 450 different projects have been implemented. With its Research Unit on Long-Term Care Insurance, the National Association of Statutory Health Insurance Funds promotes the care of people suffering from dementia in pilot projects, including the projects "Technology for better quality of life despite need for long-term care in case of dementia", "Time to talk - telephone support groups for family members of people with dementia", "Pflege@Quartier" and "Cross-sectoral deployment of care staff at the crossroads between hospital and out-patient care". In addition, amongst other things there are also pilot projects at Land level, the implementation of the laws promoting nursing care, and the directive for long-term care advice.

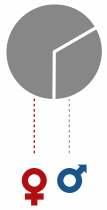
A total of 450 different projects have been implemented to improve and expand assistance and support for those affected.

The Alliance will be further developed with the "National Dementia Strategy" and launched in early 2019. The National Association of Statutory Health Insurance Funds will continue to play an active role.

Key figures on dementia

Persons suffering from dementia aged over 65 years in Germany (estimate)





300,000
new cases p.a.

Potential risk factors

- advanced age
- lack of exercise
- hypertension
- depression
- diabetes
- obesity
- low level of education
- smoking
- hearing impairment
- social isolation

Source: Short report by the Alliance for People with Dementia, 2018
Illustration: National Association of Statutory Health Insurance Funds

SOLIDARITY IN STATUTORY HEALTH INSURANCE

means contributing ideas on

dementia

High-quality supply of medical aids

Service requirements were defined for the first time which are to be addressed to the healthcare providers, and on which the contracts are to be based.

In accordance with its statutory tasks, the National Association of Statutory Health Insurance Funds draws up and regularly updates a systematically-structured list of medical aids. The Remedies and Medical Aids Supply Act (Heil- und Hilfsmittelversorgungsgesetz – HHVG), which came into force in April 2017, provides amongst other things that the National Association of Statutory Health Insurance Funds is to subject all product groups on the list of medical aids that have not been fundamentally updated since 30 May 2015 to a systematic review, which is to be carried out by 31 December 2018, and to update them to the required extent. This is to enable the level of supply of medical aids currently available to be comprehensively illustrated and the requirements of all product groups to be adapted in line with the recognised medical and technical state-of-the-art.

Cross-product group requirements for high-quality supply of medical aids

In the course of the revision of the list of medical aids, service requirements will also be defined for the first time which are to be addressed to the healthcare providers, and on which the contracts are to be based. These include requirements for advising insured persons, including care options where there are no additional costs, requirements for selecting the appropriate medical aid for the individual case, for instructing insured persons in the use of medical aids, and for the delivery and dispensation of the respective product.

The product and service quality requirements formulated as part of the update create a systematic, uniform basis for corresponding contracts of the health insurance funds. This sets the stage for supplying insured persons with high-quality medical aids in line with the current medical and technological state-of-the-art.

The National Association of Statutory Health Insurance Funds fundamentally revised and updated all of the 41 product groups included in the list of medical aids within the statutory deadline.

Updating the list of medical aids

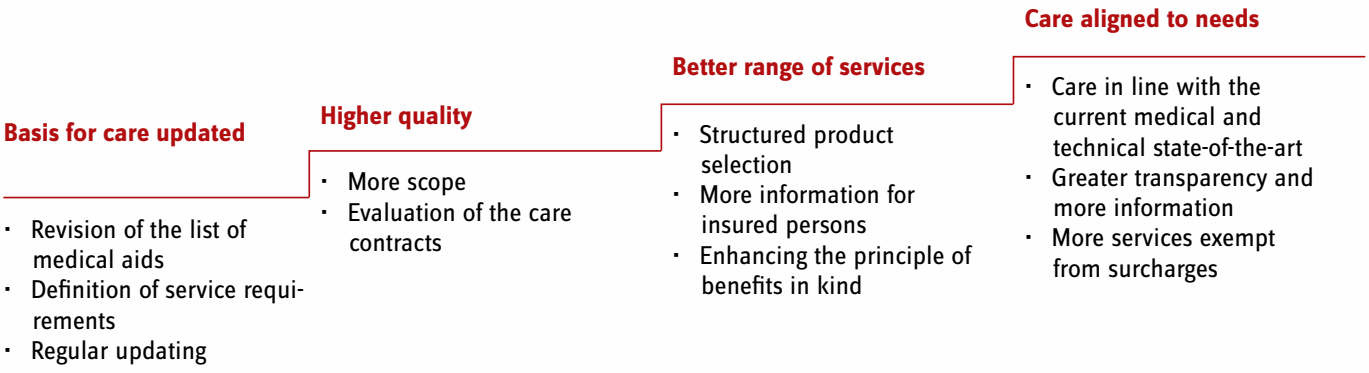


Illustration: National Association of Statutory Health Insurance Funds


SOLIDARITY IN STATUTORY HEALTH INSURANCE
provides
shelter

Using the opportunities of digitalisation to improve patient care

The Administrative Council of the National Association of Statutory Health Insurance Funds adopted the position paper entitled "Using the opportunities of digitalisation to improve patient care" at its meeting held in August. The Administrative Council calls in its declaration for the digitalisation of the healthcare system to be placed at the service of better care for patients, whilst ensuring that health data are handled responsibly and securely. Patients alone must have unrestricted data ownership and be able to decide on access rights. The legislature must provide the necessary framework. The first steps towards simplifying consent options for the use of medical applications have been taken under the Appointment Service and Care Act, and are welcomed by the National Association of Statutory Health Insurance Funds.

In order to harness the potential of digital applications in the healthcare system for all insured persons, all applications must be based on a powerful, secure TI.

Expanding powerful, safe TI

In order to harness the potential of digital applications in the healthcare system for all insured persons, all applications must be based on a powerful, secure telematics infrastructure (TI). The Gesellschaft für Telematikanwendungen der Gesundheitskarte (gematik) is responsible for creating the necessary preconditions for its establishment. The other core tasks of gematik are licensing, operational responsibility and establishing the necessary technical standards. The binding standards that must be taken into account by all participants should be orientated towards established international stipulations so that cross-border applications in care can be made possible at a later date. In addition, gematik must define criteria for all medical applications that enable the complete data and authorisations for insured persons to be migrated seamlessly in the event of a change of provider.

That said, gematik is not responsible for defining technical-medical content and designing applications. Whilst gematik establishes data protection and technical stipulations in security and interoperability, the health insurance funds and their associations are to be responsible for the specifications of the application. In addition, technical innovations, such as new authentication procedures for access to the TI or the switch from hardware to software connectors, must be made usable by the TI at short notice. This enables insured persons to use mobile devices, and provides healthcare providers with more flexible, cost-effective solutions, e.g. in long-term care.

Implementing electronic medical records

The National Association of Statutory Health Insurance Funds regards electronic medical records as a central element in achieving improved care. In addition to a structured data pool, interfaces must be used to create facilities for the consumer-friendly provision and storage of insured persons' individual health data. Beyond these basic requirements, the funds must be given the opportunity to offer and take responsibility for fund-specific functionalities. Whilst fully preserving insured persons' data ownership, these design options provide the funds with the necessary competitive scope of action for innovative digital applications.

Furthermore, the National Association of Statutory Health Insurance Funds believes that electronic medical records must be designed as the central application and storage platform for insured persons and their health data, into which further (specialist) applications can be integrated through appropriate technical prerequisites. The statutory obligation incumbent on the health insurance funds to make an electronic medical record available to all insured persons by 2021 at the latest is therefore to be expressly welcomed. In addition, it should be made clear that the electronic medical record is offered exclusively through health insurance funds. As a storage platform, the data should be stored online within the electronic medical record, with the exception of emergency data.

Digitalisation as a responsibility for society as a whole

The digital transformation affects all of society. That is why statutory health insurance cannot be expected to shoulder the entire financial obligation that it involves. All players participating in the TI (surgeries, hospitals, pharmacies, etc.) must in fact assume their own investment responsibilities in full. At the same time, however, the design flaw within gematik, in which statutory health insurance bears 100 percent of the responsibility for financing, but where the shared decision-making responsibility leads to time-consuming, costly delays, should be corrected. gematik's decision-making structures should be streamlined in such a way that the responsibility of the health insurance funds is extended to match their financing responsibility.

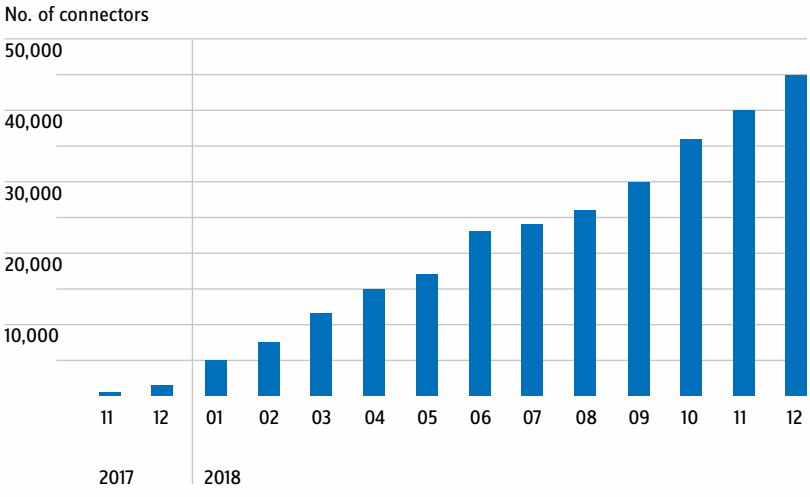
The design flaw within gematik, in which statutory health insurance bears 100 percent of the responsibility for financing, should be corrected.

Telematics infrastructure delivered by self-government

To connect a doctor's or dentist's surgery to the telematics infrastructure (TI), various components, including a connector – a kind of secure router – must be installed in the surgery. TI's nationwide rollout with insured persons' master data management (VSDM) as the first online application started at the end of 2017 with the approval of the first complete product chain of the manufacturer CGM. The aim is to equip more than 170,000 doctors' and dentists' surgeries across Germany with the necessary components, and to connect them to the TI. The players involved had assumed at the end of 2017 that up to three additional manufacturers would receive approval for their connectors during the first half of 2018 and take part in the rollout. At that time, the legislature had already extended the statutory deadline for sanctions to 31 December 2018 as the necessary components were unavailable in 2017.

The aim is to equip more than 170,000 doctors' and dentists' surgeries across Germany with the necessary components, and to connect them to the telematics infrastructure.

Equipping healthcare providers with connectors over time



Source: gematik; Illustration: National Association of Statutory Health Insurance Funds

In accordance with the statutory stipulations to complete the online rollout by the end of 2018, the National Association of Statutory Health Insurance Funds concluded agreements with the contracting parties, namely the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Dentists, to finance the initial equipment and operating costs. Quarterly instalment payments were therefore made on the basis of the anticipated installation rates.

Delays in market launch

Contrary to the original expectations, the market launch of further connectors was delayed until December 2018. As is usual for quality assurance reasons, the manufacturers concerned initially rolled out only a small number of connectors as part of "field tests". It is estimated that a total of around 45,000 connectors had been installed by December 2018. According to gematik, however, the electronic health card had already been inserted approximately 105 million times between the start of the live online operation of the TI from the end of 2017 to the end of September 2018.

Due to the considerable delays in the approval of the connectors, the number of installations did rise steadily, but the rollout proceeded more slowly than had been anticipated. As it had become increasingly predictable that the surgeries could not be equipped by the end of 2018 due to the lack of availability of the products, the legislature reacted and decided within the framework of the Act to Promote Nursing Staff to once again extend the deadline for the obligation to examine the insured persons' master data, subject to sanctions. Accordingly, healthcare providers participating in contract doctor care must have ordered the components for connection to the TI by the end of March 2019, and the surgeries must be connected to the TI by the end of June 2019.

In line with developments in the actual pace of equipment provision, the contracting parties had agreed in financing negotiations in mid-2018 to

adjust the instalments. Accordingly, the instalment rate for the fourth quarter of 2018, as stipulated in advance in the financing agreements, was suspended. The financing of the initial equipment for the basic rollout will not be completed until the end of the second quarter of 2019 in accordance with the law.

Online rollout Category 2.1

The online applications emergency data management and electronic medication plan – as the first stage of a medicinal product therapy safety test –, as well as the secure communication between healthcare providers, will be introduced with TI expansion category 2.1. Industry will need to further develop the components for this purpose. It is becoming apparent that industry will not be able to provide the first e-health connector required for these applications until the third quarter of 2019 at the earliest. The National Association of Statutory Health Insurance Funds has concluded the necessary financing agreements, which provide for additional regulations for the introduction of medical applications, with all relevant organisations (National Association of Statutory Health Insurance Physicians, National Association of Statutory Health Insurance Dentists, German Hospital Federation and German Pharmacists' Association).

Letter of intent on electronic medical records

At the suggestion of Federal Minister of Health Jens Spahn, gematik, the National Association of Statutory Health Insurance Physicians, representatives of the health insurance funds or their IT service-providers and the National Association of Statutory Health Insurance Funds discussed and further coordinated the current activities on electronic health records (eGA), as well as the specification work on the electronic medical record. The similarities and differences between the approaches were worked out in the course of several meetings. In a joint letter of intent on electronic medical records, the National Association of Statutory Health Insurance Funds, the National Association of Statutory Health Insurance Dentists and the National Association of Statutory Health Insurance Physicians confirmed to the Federal Ministry of Health and to policy-makers that they had agreed on the gematik model as a common perspective of the electronic medical records architecture. The previous files of the funds are to be migrated into this solution. The concept of authorisation provides for insured persons to have full data ownership, and aims at central data storage in the electronic medical record of the respective insured person. In addition, transition and migration regulations are to be developed for the current file solutions. The minimum scope of the electronic medical record as per the starting date of 1 January 2021 is also to be defined in this context. To this end, a working group was set up between gematik and the health insurance funds to be nominated by the National Association of Statutory Health Insurance Funds in accordance with the special shareholders' meeting of gematik held on 15 November 2018, with current file solutions.

The electronic health card had already been inserted approximately 105 million times between the start of the live online operation of the TI from the end of 2017 to the end of September 2018.

Difference between the current record models and common consensus for the "219a record"

Consensus: The gematik model as a common perspective of the electronic medical records architecture (especially in the authorisation concept). Data will be transferred to the insured person's central electronic medical records environment, after he or she has given consent, from the primary system of the healthcare provider (HP). The electronic medical records provider is responsible for the underlying decentralised data storage concepts.

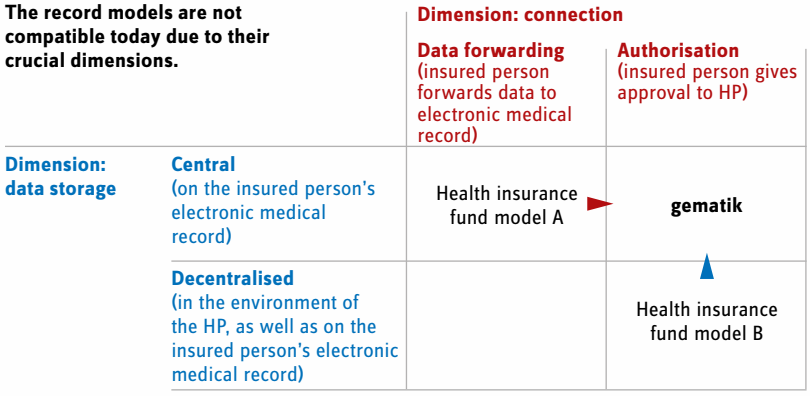


Illustration: National Association of Statutory Health Insurance Funds

Benefit orientation also with digital care services

Digital care services offer considerable potential for improving care and mobilising the potential for efficiency in the healthcare system. In this context, fundamental quality and economic efficiency requirements must also be placed on digital care services. The Administrative Council of the National Association of Statutory Health Insurance Funds described criteria in a position paper issued in November 2018 against which digital care offers are to be evaluated.

Proof of medical benefit remains an important prerequisite

Digital care services are described which are covered by the previously valid evaluation criteria. A restriction is made to those areas in which the National Association of Statutory Health Insurance Funds is directly involved in shaping the conditions for inclusion in the list of benefits: primary prevention, medical aids, new examination and treatment methods, as well as innovative care and communication channels in out-patient care such as video consultations. The evaluation instances and criteria that apply to these types of benefit are transferable to digital care services. This applies in particular to proof of medical benefit, since from the perspective of statutory health insurance the central question is always: Does a care service lead to a quantifiable improvement for patients?

The central question is: Does a care service lead to a quantifiable improvement for patients?

Framework conditions for beneficial, secure application

Further steps must be taken in order for digital care products to find more beneficial application within the scope of statutory health insurance:

- implement a relaxation of the ban on exclusively remote treatment
- integrate digital services into the existing system in order to avoid interface problems
- expand the broadband network as an infrastructural prerequisite for teleconsultations
- abolish separate consent on the part of insured persons for secure provision of telemedical services
- secure cooperation between devices of insured persons and telematics infrastructure
- maintain data protection standards: no unauthorised third-party access to medical patient data
- binding criteria to make consent documents comprehensible

Digital: a new channel for certificates for incapacity for work

Approx. 77 million certificates for incapacity for work are issued each year and submitted to 109 health insurance funds and approx. 3.47 million employers. That makes more than 300 million forms every year, including their carbon copies. Insured persons, health insurance funds and employers incur multiple, extensive and avoidable administrative burdens as a result of the current paper-based procedure. According to current practice, insured persons are responsible for submitting the certificates for incapacity for work to their health insurance fund and employer in good time. The health insurance funds scan these certificates, but in some cases do not have complete data on the periods of incapacity for work, or do not have them in good time, and this can lead to a large number of queries to employers and contract doctors on the part of the health insurance funds.

A joint approach to electronic certificates for incapacity for work

Against this background, statutory health insurance aims to digitalise the certificates for incapacity for work. For some time now, various health insurance funds have been testing the implementation of an electronic certificate for incapacity for work (eAU) – i.e. the electronic transmission of incapacity for work data by contract doctors to the health insurance funds – in a wide variety of projects, some of which involve the Associations of Statutory Health Insurance Physicians. In this context, the National Association of Statutory Health Insurance Funds, in consultation with the associations of health insurance funds at federal level, has drawn up a concept for the implementation of an eAU, and has deliberated in its committees in order to establish a uniform framework and avoid isolated solutions.

Contract doctors are to transmit the complete incapacity for work data to the health insurance funds electronically in future using the telematics infrastructure.

The concept provides for contract doctors to transmit the complete incapacity for work data to the health insurance funds electronically using the telematics infrastructure. The health insurance fund would also provide the employer with the data intended for it electronically on request. Employees would however still be obliged to report their incapacity for work to their employer. To implement the concept, the National Association of Statutory Health Insurance Funds has made concrete proposals in the legislative procedure for the Appointment Service and Care Act (TSVG).

Certificates for incapacity for work

300 million analogue forms p. a. (corresponding to 1,500 t – or 62 HGV trailers)

Illustration: National Association of Statutory Health Insurance Funds

SOLIDARITY IN STATUTORY HEALTH INSURANCE

means responsible use of

medicinal products

Ensuring a good, economical supply of medicinal products

The opportunities offered by innovative and more flexible approaches to the supply of medicinal products by pharmacies have gone untapped so far. In times of increasing digitalisation, new paths must be opened up in pharmaceutical care. Against the background of the ongoing discussion on the sustainable orientation of the supply of medicinal products by pharmacies, the Administrative Council of the National Association of Statutory Health Insurance Funds has developed concrete positions on the reorganisation of pharmacy structures and remuneration.

Making care structures more flexible

The pharmacy market in Germany is characterised by stringent regulation, which primarily follows the guiding principle of preserving existing privileges and structures that have evolved over time. The focus is not on patients, but rather on the remuneration of pharmacists. The central guiding idea of the supply of medicinal products by pharmacies should however be patient orientation. Structural changes on the pharmacy market must be realigned accordingly, whilst the current structures must be put to the test both in economic terms and with regard to patient care.

In order to make further improvements possible, much more flexible structures are needed that are geared to the needs of patients and also take economic circumstances into account. For example, rigid stipulations for opening hours in sparsely-populated regions with few customers over a given period of time do not seem appropriate. Instead it would make sense to make it possible to increase mobile care. Digitalisation opens up further opportunities for improving care, especially in rural regions. A possible approach could be pharmaceutical consultations by telephone, in analogy to telemedicine. Cooperation between main and branch pharmacies, supported by tele-assistance, would also be conceivable in order to create synergy effects.

Reorganising pharmacists' remuneration

The focus of recent years' political debate has been especially on pharmacists' fee demands, rather than on improving patient care. The fee structure of the future will have to be much more transparent than before. The remuneration must be cost-covering and performance-orientated, and must provide incentives to focus more closely on pharmacists' core activities once again. The priority must be to advise patients, particularly when it comes to dispensing medicinal products.

The central guiding idea of the supply of medicinal products by pharmacies should be patient orientation.

Figures on pharmacists' remuneration are now available for the first time on the basis of a report published by the Federal Ministry for Economic Affairs and Energy. This transparency, which has been needed for a long time, reveals the existing shortcomings of the remuneration system: Pharmacists' fees are distributed unevenly, there are considerable economic efficiency reserves, and there are uneconomical excess supply capacities in many regions.

The framework must therefore be further developed in such a way against this background that innovative care solutions can be approved and performance-related remuneration ensured. Particular attention should be paid to areas in which above-average savings could be achieved. This applies in particular to the significantly overfunded remuneration of individually-manufactured parenteral preparations. Further additional expenditure on the supply of medicinal products by pharmacies can no longer be justified on account of the economic efficiency reserves discovered.

Maintain mail order business and introduce maximum prices

It has been apparent for over a decade that the mail order business also guarantees security of supply. It can help avoid longer journeys, particularly in regions with a low population density. This is especially relevant for patients with limited mobility. The mail order business offers considerable advantages in these cases, thus making a major complementary contribution to the nationwide supply of medicinal products. It absolutely must be maintained. It should also not be overlooked that competition from the mail order business provides incentives for more intensive advice, and that patients benefit from this.

The mail order business makes a major complementary contribution to the nationwide supply of medicinal products, especially for patients with limited mobility.

In order to ensure an appropriate competitive framework between the mail order business and registered pharmacies after the 2016 judgment of the European Court of Justice, the Medicinal Products Price Ordinance (Arzneimittelpreisverordnung) for medicinal products by mail order must be converted to a maximum price model. Remuneration for mail-order medicinal products that deviates from the maximum price can be contractually agreed between the mail-order pharmacy and the health insurance fund. This would ensure that the required price competition is implemented in line with European law, and would prevent potential misincentives in patient supply.

Benefit evaluation and refund amounts for medicinal products

The Federal Joint Committee initiated 426 sets of proceedings for the early benefit evaluation of medicinal products from the new and existing markets from January 2011 to November 2018, and conducted more than 1,366 sets of advisory proceedings. 27 out of 70 sets of exemption proceedings ended with the medicinal product being exempted from the benefit evaluation by the Federal Joint Committee.

32 refund amount negotiations and one set of arbitration proceedings are currently pending as per 15 January 2019. 13 of the pending sets of refund amount negotiations are renegotiations that had become necessary due to new resolutions by the Federal Joint Committee in connection with new areas of application, expiration of deadlines or termination of existing agreements on refund amounts.

Improving the data basis for mixed price calculation

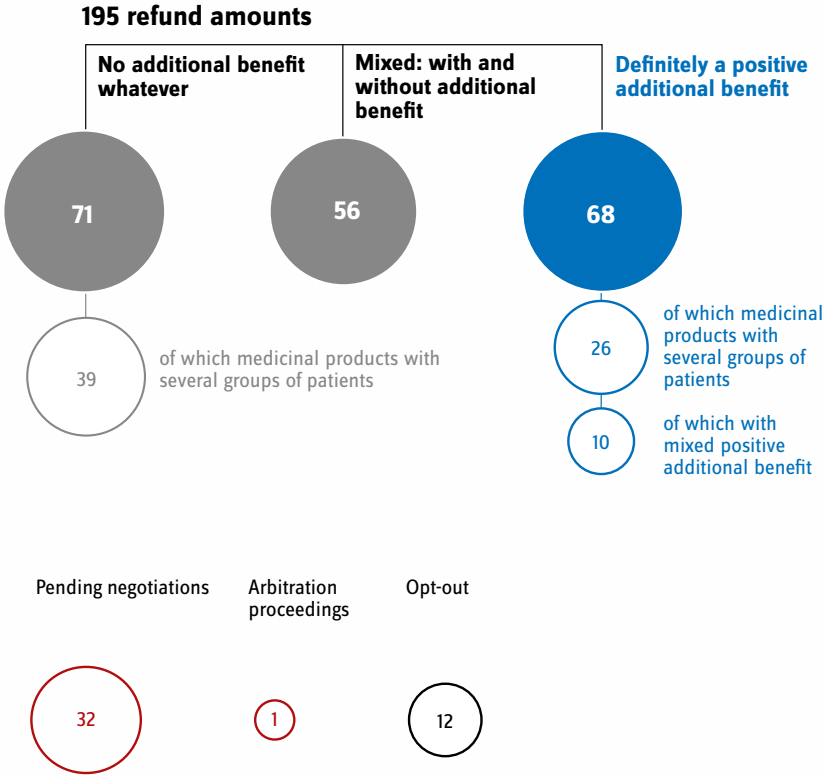
The negotiated refund amount for new medicinal products is based on a mixed price calculation. The Federal Joint Committee's assessment of the additional benefit differentiated by sub-indications is not reflected in the refund amount. The Federal Social Court (Bundessozialgericht – BSG) confirmed the method of mixed pricing for medicinal products which had been practised for a period of years as lawful in July 2018, contrary to doubts voiced in the lower courts.

Having said that, the negotiating partners and the Arbitration Office currently only have data at their disposal on the actual patient distribution among the sub-indications in exceptional cases. The initial refund amount is therefore often based on market expectations. A comparison between the presumed and actual prescription quantities in everyday clinical practice would have to be carried out at specific intervals in order to come closer to the economic efficiency of mixed prices. An unexpected market development should be reflected in the mixed refund amount. The legislature must set the stage here for a prompt, precise data basis founded on data from statutory health insurance accounting.

The Federal Social Court also confirmed by judgment of July 2018 that doctors must always decide on a case-by-case basis whether a prescription is economically expedient. In order to be able to take an economical decision in individual cases, contract doctors should be informed in the surgery management software of the respective prices in the sub-indications in the case of a mixed price.

The legislature must set the stage for a prompt, precise data basis founded on data from statutory health insurance accounting.

Stocktake of the Act on the Reform of the Market for Medicinal Products (AMNOG) – Number of valid refund amounts and pending sets of proceedings



Version: 15 January 2019, Illustration: National Association of Statutory Health Insurance Funds

Fair prices through medicinal product fixed amounts

The Federal Social Court once more confirmed the approach taken by the National Association of Statutory Health Insurance Funds with regard to the adjustment of fixed amounts.

Fixed amounts make a significant contribution to a supply of medicinal products that can be financed in the long term. When determining the fixed amounts, the National Association of Statutory Health Insurance Funds makes sure that a number of medicinal products for which insured persons do not have to make any additional payments is available for the necessary medical care. The Federal Social Court once more emphasised the importance of fixed amounts for an economical supply of medicinal products in a total of three judgments in May 2018. At the same time, the Court confirmed the approach taken by the National Association of Statutory Health Insurance Funds with regard to the adjustment of fixed amounts and the inclusion of medicinal products exempted from co-payments when determining the fixed amount.

Changes in fixed amounts in 2018

The National Association of Statutory Health Insurance Funds examines the medicinal product market on a regular basis and adjusts the fixed amounts as required to any changes in the market situation. It changed the fixed amounts for a total of 58 fixed-amount groups in 2018:

- reductions in 23 groups
- increases in 12 groups
- repeals in 11 groups
- established for the first time in 12 groups

In addition, the National Association of Statutory Health Insurance Funds is able to exempt particularly reasonably-priced medicinal products from the statutory co-payment of at least Euro 5 and at most Euro 10 if this is expected to result in greater savings for the community of solidarity. This too is intended to promote price competition on the fixed amount market. The situation with regard to medicinal products which are exempted from co-payments is to be taken into account when adjusting fixed amounts. In 2018, therefore, the fixed amounts were only moderately reduced for two groups with medicinal products which are exempted from co-payments in order wherever possible to continue to guarantee the adequate supply of medicinal products without any co-payments after the adjustment has been carried out. Overall, the fixed amounts established in 2018 lead to additional savings of around 360 million Euro per year.

Figures and data

Fixed amounts promote competition in the interest of fair medicinal product prices. All in all, the arrangement encompasses roughly 35,000 finished medicinal products as per 1 January 2019. Fixed-amount medicinal products account for a share of 81 % of prescriptions and a turnover share of 37 % of the total statutory health insurance medicinal products market.

The fixed amounts market as per 1 January 2019

	Level 1	Level 2	Level 3	Total
Grouping in accordance with section 35 of Book V of the Social Code	**Identical active ingredients**	**Active ingredients comparable in terms of pharmacological treatment**	**Comparable effect in terms of treatment**	
Fixed-amount groups	319	65	63	447
with	212 active ingredients	172 active ingredients	173 active ingredients.	
Turnover (€)	6.5 bill.	5.0 bill.	2.4 bill.	13.9 bill.
Prescriptions	237.9 mill.	227.9 mill.	70.8 mill.	536.6 mill.
Packages	18,264	10,267	6,063	34,594

Source and illustration: National Association of Statutory Health Insurance Funds

SOLIDARITY IN STATUTORY HEALTH INSURANCE

means a commitment to disease

prevention

Making healthcare opportunities more equal

The newly-formulated disease prevention and health promotion goals aim in particular to support health-promoting structures and equality of healthcare opportunities.

The National Association of Statutory Health Insurance Funds defines binding quality requirements for disease prevention and health promotion measures in its guidelines on disease prevention. The guidelines for the health insurance funds provide a binding framework for disease prevention within which the local funds can decide for themselves which concrete offers they make.

The new version, which was published in 2018, was developed with the involvement of independent scientific expertise, and contains the disease prevention and health promotion goals of the health insurance funds for the years 2019 to 2024:

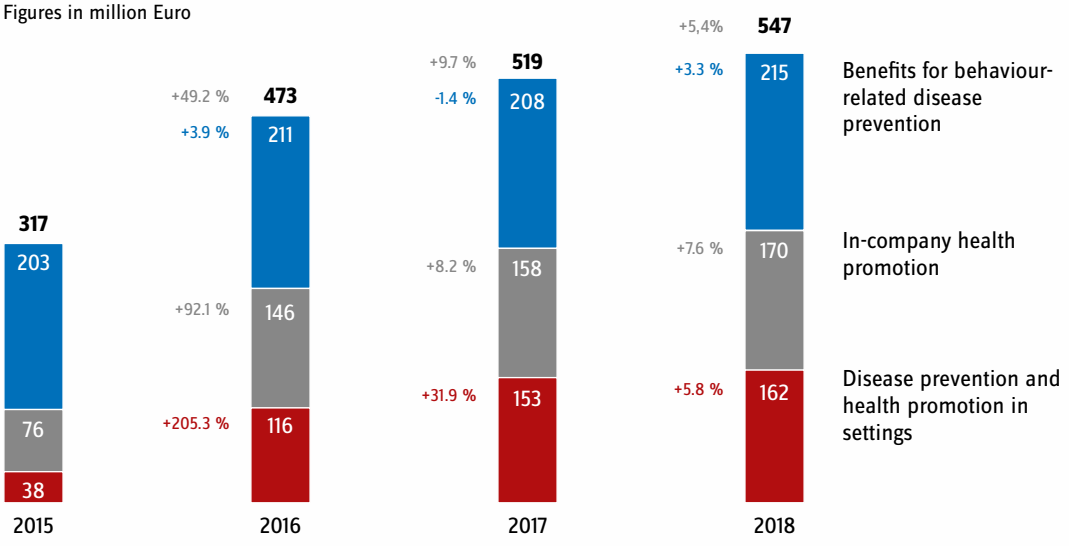
- strengthening health-promoting structures and a systematic approach
- promoting equality of healthcare opportunities
- participation and empowerment
- cooperation and networking with other partners
- focusing on diseases and risks that are particularly important from an epidemiological point of view

Disease prevention commitment at all levels

The newly-formulated disease prevention and health promotion goals aim in particular to support health-promoting structures and participation by the target groups, equality of healthcare opportunities, as well as cooperation and networking with other partners in settings and companies. By focusing on efforts to prevent musculoskeletal disorders, as well as against mental and behavioural disorders, statutory health insurance is facing up to current epidemiological challenges. The statutory health insurance objectives are synergistically related to the objectives of the National Disease Prevention Conference spanning funding institutions, and thus also serve to strengthen a society-wide approach in this important, promising field of health policy.

Expenditure by statutory health insurance on primary prevention and health promotion 2015 to 2017

Figures in million Euro



Source: official statistics KJ 1, KV 45 (for 2018); Illustration: National Association of Statutory Health Insurance Funds

Enhancing health promotion and disease prevention in settings

2018 was the third year in which the provisions of the Disease Prevention Act were in force. The health insurance funds have further stepped up their commitment to health promotion and disease prevention in settings and companies.

The National Association of Statutory Health Insurance Funds commissioned the Federal Centre for Health Education in 2016 to support the statutory health insurance funds in performing their tasks in health promotion and disease prevention in settings. One focus of the resulting statutory health insurance Alliance for Health is the enhancement of municipal health promotion. In addition, vulnerable target groups in particular, including unemployed people and people with disabilities, are to benefit from health-promoting measures to a greater extent than was previously the case.

Numerous activities have already been initiated as part of the statutory health insurance Alliance for Health. For example, the equality of healthcare opportunities coordination centres in all Federal Länder were increased to an average of two full-time posts. The health promotion of unemployed people will also be improved at 129 locations nationwide through interlinked offers of work and health promotion at municipal level. A number of literature and database searches on good practice models have been commissioned in order to strengthen the empirical basis for setting-related health promotion and disease prevention. The evaluation reports and practical aids for players and experts are publicly available on the web at www.gkv-buendnis.de.

Support programme for municipalities launched

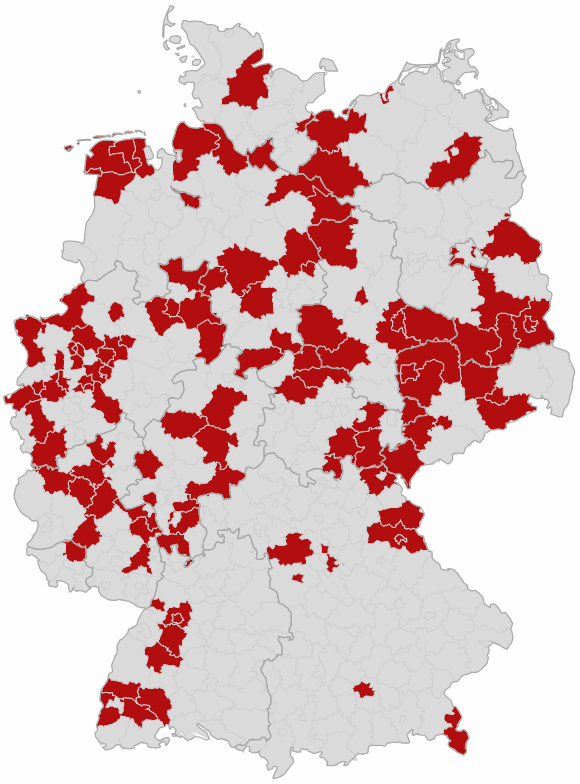
The National Association of Statutory Health Insurance Funds launched a statutory health insurance "Alliance for Health" funding programme in 2018 to strengthen municipal health promotion nationwide and initiate a quality development process. Selected municipalities have been able to apply since the start of 2019 for three to five years of financial support totalling 210,000 to 250,000 Euro for the establishment of municipal structures for control and cooperation in health promotion. The statutory health insurance Alliance for Health has thus set the stage for improving the planning, implementation and sustainable establishment of health-promoting services in municipalities.

The health promotion of unemployed people will also be improved at 129 locations nationwide through interlinked offers of work and health promotion at municipal level.

Municipalities are to be boosted in their responsibility for health promotion and disease pre-

Locations at which the project for work and health promotion is being implemented

2018



Source: www.gkv-buendnis.de
Illustration: National Association of Statutory Health Insurance Funds

vention. Support is to be given to municipalities that have a population which is considered to be socially disadvantaged ("deprived") in terms of the indicators education, employment and income. The programme will be expanded from mid-2019 to include the promotion of target group-specific health promotion measures for vulnerable target groups. The funding programme, which will initially run for five years, will be supported with research in order to generate insights into the effectiveness of municipal coordination processes.

In terms of content, the focus in the world of work was placed on the goals of "protecting and strengthening the musculoskeletal system" and "protecting and strengthening mental health".

Federal framework recommendations refined for the first time

The National Disease Prevention Conference published a revised version of its Federal Framework Recommendations (BRE) for the first time in 2018. The recommendations form the basis for the agreements that have now been concluded between the social insurance funding institutions and the Land in all Federal Länder in order to regulate disease prevention work on the ground.

Particular emphasis is placed in the new Federal Framework Recommendations on the objective of "living and working healthily", and thus on workplace-related disease prevention, health, safety and participation promotion, as both health and pension as well as accident insurance institutions have a support mandate in this area. Amongst other things, the possible contributions of the social insurance funding institutions to in-company health promotion, company integration management and company risk assessment tasks are explained and compared. The access channels for companies are also described in detail, e.g. via the newly-created regional coordination offices of statutory health insurance, the company service of the German Federal Pension Insurance, or the regional disease prevention services of the accident insurance institutions. In terms of content, the focus in the world of work was placed on the goals of "protecting and strengthening the musculoskeletal system" and "protecting and strengthening mental health" – and thus on the same topics that the National Occupational Safety Conference will also focus on in the current and coming target period.

All in all, the new Federal Framework Recommendations place even greater emphasis on the fact that setting- and world-of-work-related disease prevention, health, safety and participation promotion can only be successful if those responsible locally, and also the target groups addressed, assume ownership of them and an approach is adopted that encompasses society as a whole. To illustrate the responsibility of society as a whole and the responsible interaction between the various players, two examples of application are described in the Federal Framework Recommendations: one for quality-assured promotion of physical activity, and one for quality-assured community catering in settings.

SOLIDARITY IN STATUTORY HEALTH INSURANCE

helps people to

help themselves

Promoting self-help

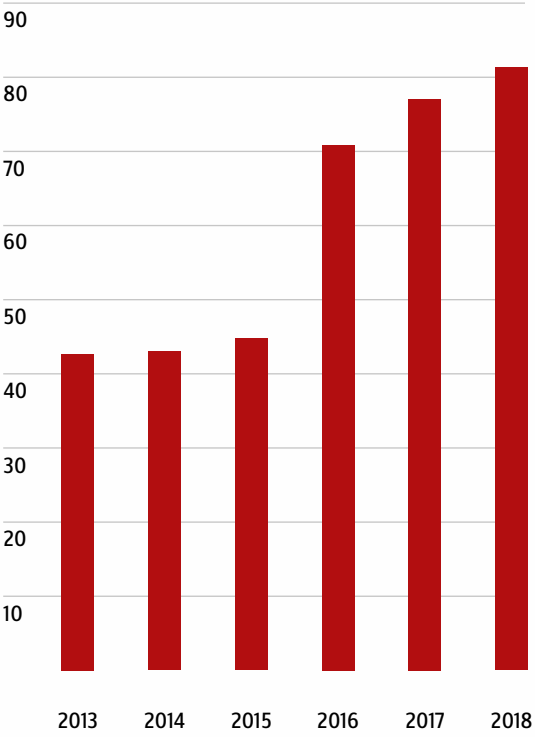
The funds are to be used in such a way that they effectively strengthen the resources of those affected and their family members.

The health insurance funds and their associations have been promoting self-help in Germany for 25 years now, and are its most reliable partner, whilst the public sector is increasingly withdrawing from promoting self-help. Approximately 82 million Euro (1.13 Euro per insured person) in funding will be made available in 2019 as lump-sum and project funding. The eligibility requirements are set out in the National Association of Statutory Health Insurance Funds' "Guide to Self-Help Promotion".

The Guide was revised in 2018 in collaboration with the associations of the health insurance funds at federal level, and in consultation with the leading self-help organisations at national level. Among the reasons for the revision were the doubling of statutory health insurance self-help subsidies provided for in the Disease Prevention Act 2016, as well as improved access to Internet-based self-help services and their increasing uptake. The central concern of statutory health insurance is to use the funds in such a way that they effectively strengthen the resources of those affected and their family members.

Statutory health insurance expenditure on self-help

absolute figures, in million Euro



Source: official statistics KJ 1, KV 45 (for 2018); Illustration: National Association of Statutory Health Insurance Funds

Enabling the further development of self-help

An overview of several important new regulations contained in the Guide to Self-Help Promotion:

- Self-help organisations which enable their members to exchange information, including for instance via the Internet, are eligible provided that it is ensured that a face-to-face meeting takes place once per year. This arrangement takes account of the fact that self-help is also becoming increasingly digitalised and is meeting or exchanging information on the Internet.
- Projects of self-help organisations' umbrella organisations can also receive subsidies from the community support provided by statutory health insurance. According to the previous guidelines, support was provided exclusively within the framework of individual support for health insurance funds.
- In addition to local self-help contact points, one Land-wide self-help contact point can be subsidised per Federal Land. This provides a secure legal basis for the promotion of such structures that already exists in some Federal Länder.

The new version of the Guide to Self-Help Promotion was completed and published in the summer of 2018, so that it was available to the health insurance funds and their associations, as well as to self-help, in good time for the preparation of the promotion procedure for 2019. It entered into force on 1 January 2019, and was published at: www.gkv-spitzenverband.de/selbsthilfe.

also calls for

personal responsibility

Combating misconduct in the healthcare system and in long-term care

In order to prevent misconduct in the healthcare system, it is necessary to set up a "fraud prevention database in statutory health insurance".

The anti-misconduct offices for the healthcare system that have been established at all statutory health and long-term care insurance funds, and at the National Association of Statutory Health Insurance Funds, investigate reports which point to "irregularities" or to the "illegal use of funds" in connection with the tasks of statutory health and long-term care insurance – especially when it comes to accounting fraud and corruption. In accordance with its reporting obligation, the Board of the National Association of Statutory Health Insurance Funds informed the Administrative Council on 28 November 2018 of the work and results of its Anti-Misconduct Office for the Healthcare System. The report, which has also been published on the Internet, describes the focal points in the completed period under report 2016/2017, combines the results of its members' activity reports into an all-round view of statutory health insurance, and identifies current positions and demands.

Main focus of the work in the period under report 2016/2017

The Act to Combat Corruption in the Healthcare System (Gesetz zur Bekämpfung von Korruption im Gesundheitswesen), as well as the Second and Third Acts to Strengthen Long-term Care (Pflegestärkungsgesetz), assigned new statutory tasks to the National Association of Statutory Health Insurance Funds. The National Association of Statutory Health Insurance Funds issued binding "Detailed provisions on the organisation, work and results of the anti-misconduct offices for the healthcare system". The legislature is pursuing this path in order to take even greater account of the considerable importance attaching to combating misconduct in the healthcare system and to ensuring that the agencies that are responsible for this are working according to comparable standards. The provisions entered into force as per 1 January 2018.

Statutory health insurance key figures on misconduct in the healthcare system

Description of content	2014/2015	2016/2017	Development	Trend
1. Total number of **reports received**	**25,168**	**33,041**	**+7,873**	▲
1.1 Number of external reports	16,764	25,039	+8,275	▲
1.2 Number of internal reports	8,404	8,002	-402	▼
2. Number of **cases prosecuted**	**37,014**	**40,090**	**+3,076**	▲
2.1 Number of existing cases prosecuted	15,968	14,853	-1,115	▼
2.2 Number of new cases prosecuted	21,046	25,237	+4,191	▲
3. Number of **completed cases**	**23,654**	**24,172**	**+518**	▲
4. Number of **cases in which the public prosecution office was informed**	**3,029**	**3,371**	**+342**	▲
5. Amount of **secured claims in Euro**	**41,838,146**	**49,081,369**	**+7,243,223**	▲

Source and illustration: National Association of Statutory Health Insurance Funds

Audits of the invoices for long-term care services provided are to be obligatory in future as part of the regular quality control carried out on non-residential long-term care services. The National Association of Statutory Health Insurance Funds has taken this measure in order to adjust its Quality Control Guidelines (Qualitätsprüfungs-Richtlinien – QPR). Accounting audits are now an integral part of the quality control, and are carried out throughout Germany by the Health Insurance Medical Services (MDK). In the event of any discrepancies being found to exist between the services invoiced and those provided, the long-term care insurance funds or their associations in the Länder are to consult the anti-misconduct offices in order to take account of the need for protection of the insured persons' community of solidarity. The successful implementation of the Second Act to Strengthen Long-term Care is also reflected in the consolidated results of the "All-round view of statutory health insurance".

A marked increase in the number of reports, cases and secured claims

The number of external reports received by the anti-misconduct offices increased by approx. 49 % (8,275 reports) compared to the previous period under report. As a result of the newly-introduced accounting audits, the Medical Services alone submitted approximately 5,700 audit reports containing anomalies to the long-term care insurance funds in 2017. This corresponds to a significant increase by approx. 20 % (4,191 cases) in the number of such new cases that were pursued. As a result, the amount of secured claims also increased significantly, namely by approx. 17 % (7,243,223 Euro). At over 49 million Euro, the secured claims have reached their highest value since reporting began. Further analysis of the figures shows that misconduct in long-term care, i.e. taking into account benefits in accordance with Books V and XI of the German Social Code, has now moved to the top of the list in terms of both the number of cases completed, and of the amount of claims secured.

Positions and demands of the National Association of Statutory Health Insurance Funds

Information from the Federal Criminal Police Office on the nationwide organised accounting fraud committed in non-residential long-term care stresses the need to consistently refine the existing statutory framework. In order to prevent misconduct in the healthcare system, it is necessary to set up a "fraud prevention database in statutory health insurance" with which statutory health and long-term care insurance funds, together with the Medical Service, health authorities and professional chambers, as well as the funding institutions of social assistance appointed in accordance with Land law, may transmit and process personal data. There is therefore also a need to regulate by law in the course of the announced clarification of the powers to transmit data in terms of data protection that the exchange of personal data across types of organisations using databases is permitted, regardless of whether the data that are transmitted in doing so may also be made available using databases, and irrespective of whether the databases are operated by the aforementioned facilities themselves or by third parties.

The statutory health and long-term care insurance funds are to inform the public prosecution office without delay if there is initial suspicion of property crimes or of corruption in the healthcare system. But only Hesse, Thuringia, Bavaria and Schleswig-Holstein currently have specialised public prosecution offices with competence throughout their respective Länder. Investigation proceedings concerning the healthcare system are an absolutely specialist matter. It will be particularly possible to prosecute property crimes and corruption in the healthcare system in a truly effective manner where public prosecutors can also deal with this special subject on a longer-term, continuous basis and build up an appropriate expertise base by pooling their specialist knowledge. The National Association of Statutory Health Insurance Funds is therefore calling for the establishment of specialised criminal prosecution authorities in all the Federal Länder.

The National Association of Statutory Health Insurance Funds is calling for the establishment of specialised criminal prosecution authorities in all the Federal Länder.

SOLIDARITY IN STATUTORY HEALTH INSURANCE

maintains the

balance

The finances of statutory health insurance – a good financial position permits reductions in contributions

The financial development of statutory health insurance remains positive

Developments in the financial situation in statutory health insurance continued along positive lines in the year under report 2018.* Despite the additional, temporary payment obligations vis-à-vis the Innovation Fund and the Structural Fund, the Health Fund realised a revenue surplus of approximately 260 million Euro. The liquidity reserve thus rose to roughly 8.9 billion Euro. Once the still awaited accounting results for the full year 2018 have bee received, the health insurance funds can expect an overall positive result in the order of around 2.5 billion Euro. The vast majority of health insurance funds have thus been able to reduce their additional contribution rates as per the year-end, or at least keep them stable. The average additional contribution rate for 2019 was reduced from 1.0 % to 0.9 %.

Financial development in 2018

The total income subject to contributions of the statutory health insurance members (basic wage and pension total) increased in the year under report year-on-year by 4.1 % to reach Euro 1,405.8 billion. An unchanged general contribution rate of 14.6 % resulted in income from contributions of approx. 205.2 billion Euro. Factoring in contributions from marginal employment (approx. 3.2 billion Euro) and the contribution from the Federation (approx. 14.4 billion Euro), the total income of the Health Fund was about 222.8 billion Euro. This income enabled the Health Fund to fully finance the allocations of 222.2 billion Euro which had been assured to the health insurance funds. The excess funds had to be credited back to the liquidity reserve. This increase in income was reduced to around 260 million Euro, once other statutory financial obligations of the Health Fund vis-à-vis the Innovation Fund and the Structural Fund, as well as the balance from the income equalisation of the additional contributions, had been taken into account. The liquidity reserve therefore rose to approx. 8.9 billion Euro as per the end of the year under report (as per: 15 January 2019).

The appraisers forecast an increase of 8.6 billion Euro, or 3.8 %, to approximately 234.2 billion Euro, for the expenditure side of the health insurance funds. Given allocations of roughly 222.2 billion Euro from the Health Fund to the health insurance funds, the shortfall in fund-relevant expenditure was therefore approx. 12.0 billion Euro in 2018. The additional contribution rates actually charged in 2018 in order to finance this shortfall varied between 0.3% and 1.8%, with the additional contribution rate averaging out at the rate of 1.0% set by the Federal Ministry of Health in the autumn of 2017. One smaller regional health insurance fund was able to avoid charging an additional contribution in the year under report.

The shortfall in fund-relevant expenditure was approx. 12.0 billion Euro in 2018.

The financial forecast for 2019

The statutory health insurance appraisers anticipate a further 4.0 % increase in income subject to contributions, which is thus set to reach 1,462.4 billion Euro in 2019. They estimate that income from contributions, incl. contributions from marginal employment, for 2019 will be approx. 216.7 billion Euro. This forecast already takes into account the fact that health insurance can expect lower income due to a reduction in the minimum assessment basis (as per 1 January 2019) as a result of the Act to Reduce the Burden on Individuals who have Statutory Health Insurance (GKV-Versichertenentlastungsgesetz – GKV-VEG).

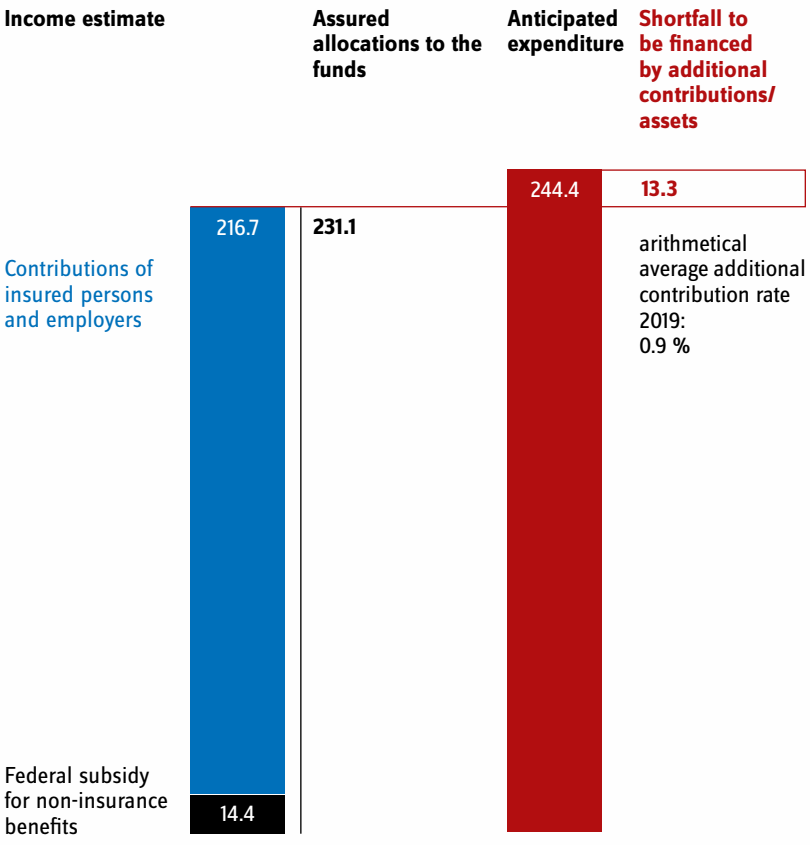
Together with the contribution of the Federation amounting to approx. 14.4 billion Euro, an allocation volume totalling approx. 231.1 billion Euro emerges. This amount is to be assigned as income to the health insurance funds for 2019. Because of the financial share that the Health Fund must also provide for the Innovation Fund and for the Structural Fund in 2019, the liquidity reserve will be reduced to approx. 8.4 billion Euro at the end of 2019 (as per: 15 January 2020).

The anticipated Fund-relevant expenditure of the health insurance funds for 2019 was estimated

by the statutory health insurance appraisers at 244.4 billion Euro. This corresponds to a year-on-year increase of 4.3 %. Amongst other things, the already foreseeable financial effects of the draft Act to Promote Nursing Staff and the draft Appointment Service and Care Act were taken into account here. This results in an estimated shortfall in expenditure of around 13.3 billion Euro for the health insurance funds in 2019. Based on anticipated income subject to contributions in 2019, this results in arithmetical terms in an additional contribution rate requirement of 0.91%. As expected, the Federal Ministry of Health, which is responsible for the determination, therefore reduced the average additional contribution rate from 1.0 % to 0.9 % in October 2018. The average additional contribution rate serves on the one hand as the additional contribution rate relevant to the calculation of contributions for specific groups of members, e.g. for beneficiaries of Unemployment Benefit II, and on the other hand as a benchmark for the price competition between the health insurance funds that is intended by the law.

The positive financial development enabled 36 health insurance funds to reduce their additional contribution rate as per 1 January 2019. This benefited a total of 24.2 million individuals who have statutory health insurance.

Revenue-expenditure forecast 2019
in billions of Euro



Calculation and illustration: National Association of Statutory Health Insurance Funds

Reduced contributions at the turn of the year

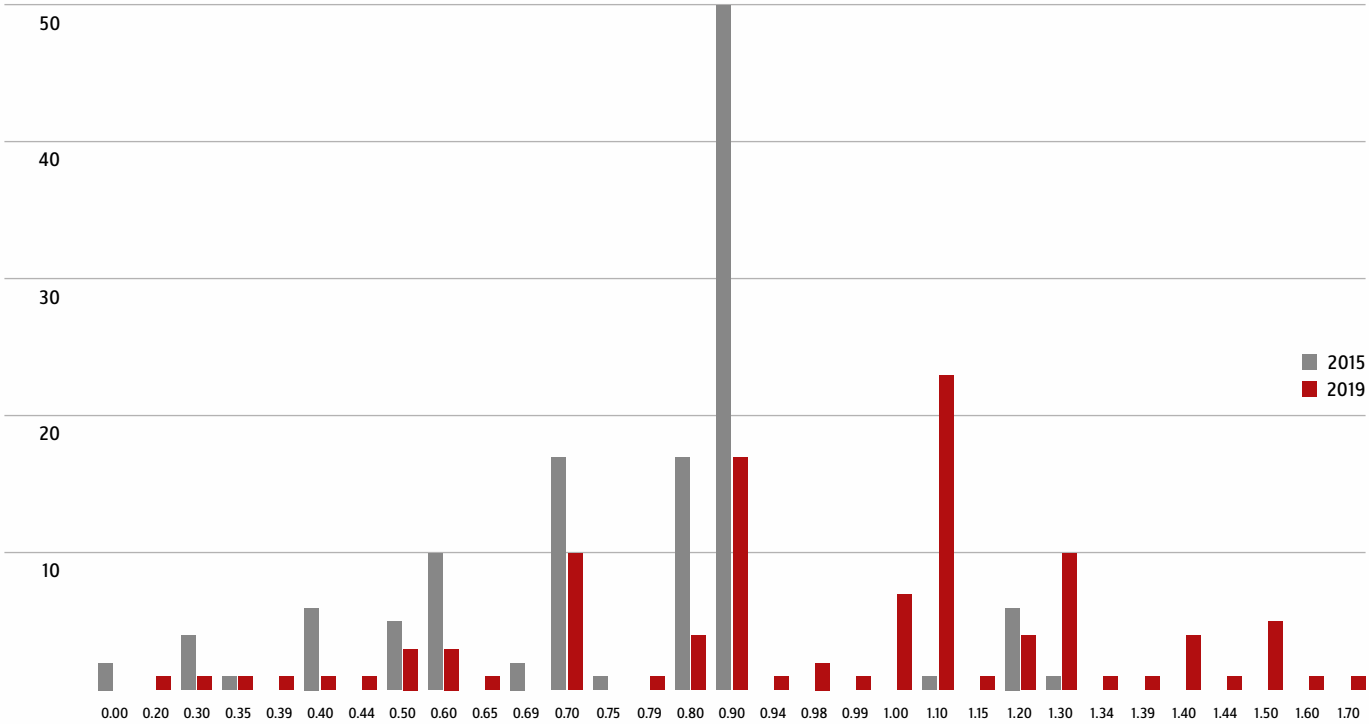
The positive financial development enabled 36 health insurance funds with a total of 24.2 million insured persons to reduce their additional contribution rate as per 1 January 2019. Three other health insurance funds with a total of 4 million insured persons have also decided to reduce their contribution rate at a later date in the 1st half of 2019. By contrast, six smaller health insurance funds with a total of around 120,000 insured persons had to increase their additional contribution rate as per the turn of the year, whilst the other health insurance funds kept their additional contribution rate constant. The contribution rates vary between 0.2 % and 1.7 % as per the beginning of 2019. No health insurance fund is currently able to dispense with levying an additional contribution.

In addition, all employed members of statutory health insurance, all pensioners with statutory insurance, as well as the majority of self-employed persons with statutory insurance who are on a low work income, benefit from lower health insurance contributions. This is because the Act to Reduce the Burden on Individuals who have Statutory Health Insurance, which came into force on 1 January 2019, reintroduced equal contributions, so that from 2019 onwards employers and pension insurance funds will have to pay half of the general contribution, and half of the additional contribution that previously had to be paid by

insured persons alone. This measure alone will relieve statutory health insurance members of a burden of roughly 6.9 billion Euro in 2019 according to estimates carried out by the legislature, whilst employers and pension insurance funds will be burdened accordingly. Self-employed persons with statutory insurance who are on a low work income benefit from the abolition of the previous minimum assessment basis for full-time self-employed persons. Whilst the minimum assessment basis for full-time self-employed persons was 2,283.75 Euro in 2018, a uniform minimum assessment basis of 1,038.33 Euro has been in force for all voluntarily insured persons since 1 January 2019. The group of self-employed members of statutory health insurance will thus be relieved of a burden of an estimated 700 to 800 million Euro.

*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 15 October 2018).

Distribution of the health insurance funds by additional contribution rates



In each case as per 1 January. Whilst 41 % of health insurance funds continued to levy the average additional contribution rate of 0.9 % in the introductory year of the earnings-related additional contribution rates, at the beginning of 2019 only 16 % of the health insurance funds had levied the average additional contribution rate, which was also 0.9 %.

Illustration: National Association of Statutory Health Insurance Funds

Reduced contributions for individuals who have statutory health insurance

The new Federal Government tackled the Grand Coalition's plans to reform statutory health insurance funding in April 2018 as its first health policy measure. In their Coalition Agreement, the CDU/CSU and SPD had agreed on four core provisions for the further development of the law on contributions and of the financial structures of statutory health insurance:

1. restoration of the equal financing of contributions to statutory health insurance, which the legislature had repealed with effect from 1 July 2005 by adopting the Statutory Health Insurance Modernisation Act (GKV-Modernisierungsgesetz)
2. gradual introduction of cost-covering health insurance contributions for beneficiaries of unemployment benefit II from taxation
3. reduction of the burden on self-employed persons with statutory insurance by halving the specific minimum assessment basis for full-time self-employed persons
4. further development of the morbidity-orientated risk structure equalisation, taking account of the expert opinions of the Scientific Advisory Board of the Federal Insurance Office in the interest of fair competition

With its draft Bill to Reduce the Burden on Individuals who have Statutory Health Insurance, which was passed by the Federal Cabinet in June 2018, the Federal Ministry of Health, under the leadership of Federal Minister Spahn (CDU), presented legislative proposals for the implementation of two of these four financial policy decisions of the Coalition. Both measures were subsequently adopted by the Federal legislature, and entered into force as per 1 January 2019.

From 2019 onwards, there will only be a minimum assessment threshold equal to one 90th of the monthly social insurance reference value (2019: 1,038.33 Euro per month).

Returning to financing on an equal basis

Starting in 2019, contributions to health insurance will again be paid equally by employees and their employers, or by pensioners and statutory pension insurance. Since the beginning of 2019, half of the fund-specific additional contributions which members of statutory health insurance previously had to pay by themselves have therefore been paid by employers and pension insurance funds.

Relieving the burden on the self-employed

The burden on full-time self-employed members of statutory health insurance with a low work income has been reduced. The Federal Government's draft Bill provided that the specific minimum assessment basis for self-employed persons should be reduced from the previous level of one 40th of the monthly social insurance reference amount (2018: 2,283.75 Euro per month) to one 80th of the reference amount (2018: 1,141.88 Euro) by 1 January 2019. Depending on the level of their work income, this would already reduce the contribution burdens of "small self-employed persons" by up to 50%. In the course of the further deliberations, however, the legislature then decided to completely unify the minimum assessment basis for voluntary members. From 2019 onwards, there will therefore only be a minimum assessment threshold equal to one 90th of the monthly reference value (2019: 1,038.33 Euro per month). All persons with voluntary insurance who can prove that they have a lower monthly income must pay at least contributions based on this minimum income threshold.

In view of the fundamental differences in income determination between self-employed and other voluntary members, the National Association of Statutory Health Insurance Funds would have preferred a wider gap between the minimum assessment bases for the full-time self-employed (one 60th of the monthly reference amount) and other voluntary members (one 90th of the monthly reference amount). However, this reform option, which was well justified on the statutory health insurance side, was not received by policy-makers in view of the clear definition in the Coalition Agreement ("halving"). With a view to the simplification of procedures intended by the law, the National Association of Statutory Health Insurance Funds supported the legislative

proposal in the further procedure. This is because the new arrangement that was adopted entails a significant reduction in administrative effort, and was therefore to be regarded as constituting progress compared with the original legislative proposal.

Complete implementation of the plans set out in the Coalition Agreement

The two remaining financial policy provisions in the Coalition Agreement have however not yet been taken up. This applies, firstly, to the announced gradual introduction of cost-covering health insurance contributions for beneficiaries of unemployment benefit II from tax revenues. In this regard, statutory health insurance is still waiting for a statutory initiative which will raise the contribution assessment for unemployment benefit II recipients to an appropriate level. The Administrative Council of the National Association of Statutory Health Insurance Funds has repeatedly pointed out that the monthly flat-rate amounts currently paid by the Federation do not come close to covering expenditure, and that contributors are therefore called on to shoulder considerable unjustified financial burdens. Secondly, the planned further development of the morbidity-orientated risk structure equalisation, for which the opinions of the Scientific Advisory Board have been available since November 2017 and July 2018 respectively, is still pending. This reform is due to be launched in the spring of 2019.

The monthly flat-rate amounts currently paid by the Federation for beneficiaries of unemployment benefit II do not come close to covering expenditure.

§§

The Act to Reduce the Burden on Individuals who have Statutory Health Insurance – further legal amendments

- new arrangement on operating resources and reserve requirements for health insurance funds: The permissible upper limit for operating resources and reserves is now only 1.0 times one average month's expenditure.
- regulations for the reduction of existing financial reserves which exceed the new upper limit for permissible operating resources and reserves
- prohibition of increases in the additional contribution rate if resources and reserves exceed this upper limit
- regulations on the adjustment of the verification and clarification of memberships and on the reduction of contribution debts in the case of unresolved voluntary memberships
- increase in the permissible proportion of shareholdings from 10 % to 20 % in the formation of the actuarial reserve for the old-age provisions of the health insurance funds
- new right to join statutory health insurance for soldiers leaving the service after having served a fixed term

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Improved data protection

The EU's General Data Protection Regulation (GDPR) has been in effect in all its Member States since May 2018. Previous national data protection provisions and the relevant Books V, IX and XI of the Social Code have therefore had to be aligned with European law, and further amendments still need to be made.

The legislature presented a comprehensive Act in June 2018 adapting numerous special legal provisions: A comprehensive 153-Article draft Bill was published under the auspices of the Federal Ministry of the Interior, Building and Community (BMI). This also includes the adjustments for statutory health and long-term care insurance. The Act largely provides for conceptual adaptations to the GDPR, as well as deletions from national laws as a result of the prohibition of the repetition of the directly-applicable contents of the Regulation.

Patients' data ownership will be preserved

Two provisions that had been criticised by the health and long-term care insurance funds, and which the National Association of Statutory Health Insurance Funds had requested to be removed in its statement on the first draft, were no longer included in the draft that was submitted in September. It was originally envisaged that health insurance funds could only process health data with the consent of insured persons if Book V of the German Social Code explicitly provided for consent. This could potentially have led to a restriction of the performance of the tasks of health and long-term care insurance funds stipulated by law, and also have called into question the data ownership of patients and insured persons.

The abolition of this provision is welcomed, as is the deletion of the specific provision on fines for Books V and XI of the German Social Code. Although Book X contains an exception rule according to which fines are not imposed on authorities and other public bodies, this was to be made possible for organisations and institutions in accordance with Books V and XI of the German Social Code. The GDPR provides for fines of up to 20 million Euro. In addition, the offences eligible for fines are regulated more comprehensively there than was the case in the past, and the legal concepts are far more vague. This regulation would result in considerable legal uncertainty in the area of application of statutory health and long-term care insurance, and would have an incalculable financial impact on health and long-term care insurance funds.

Patients' or insured persons' data ownership must be preserved despite the adaptation.

The National Association of Statutory Health Insurance Funds accompanied the practical implementation of the GDPR with several circulars which were drawn up together with the associations of the types of health insurance funds on background issues. In particular, a model contract for sub-contracted data processing was published. A working aid for the implementation of the stipulations on "joint responsibility" was agreed by the end of 2018.

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Health and social policy in the European Union

In 2018, the European Commission continued its project to further develop the provisions on the coordination of social security systems in Europe. After the Commission, the Council and Parliament have each taken up their positions, the trilogue negotiations will begin in January 2019. The National Association of Statutory Health Insurance Funds has introduced the positions of statutory health insurance here, as well as in the following initiatives, at European level.

European Labour Authority

The European Commission would like to create a European Labour Authority in order to ensure that EU rules on labour mobility are enforced in a simpler, more effective way. Some tasks relating to the coordination of social security systems are to be transferred from the Member States to the planned authority. This includes the tasks of the Audit Committee, the Conciliation Committee and the specialist Committee for Data Processing. The National Association of Statutory Health Insurance Funds is calling here for the expertise of the social insurance funding institutions to be preserved, and for the responsibilities of the Member States not to be transferred to the EU level.

European Social Security Number

The European Commission is planning a European Social Security Number (ESSN) to complement the reform of the regulations on the coordination of social security systems and the introduction of a system for the electronic exchange of social security data. The aim is to identify insured persons quickly and accurately across borders and to verify their insurance coverage status. The ESSN can reduce the administrative burden at the social insurance funding institutions and contribute advantages in electronic data exchange. It should be issued nationwide in Germany, together with the electronic health card.

Unified digital access path

The social insurance institutions and other authorities of the EU Member States are to be obliged in future to provide information on specific administrative procedures online and in several languages, and to link it to a central European platform. This includes the rights and obligations of insured persons and employers in social security, information on medical treatment, access to health insurance and disease prevention, as well as purchases of medicinal products. Insured persons are to be able to apply for and obtain a European health insurance card or an A1 certificate for business trips or secondments abroad online in future. The information services will be created by the end of 2020. The online administrative procedures are to be available from the end of 2023 onwards. The National Association of Statutory Health Insurance Funds believes that the planned online application channels are appropriate. In view of the plethora of benefits in kind and cash benefits with very different application or approval procedures, it is not appropriate to apply this to all benefits.

The ESSN can reduce the administrative burden at the social insurance funding institutions and contribute advantages in electronic data exchange.

Evaluating health technology across Europe

The European Commission would like to centralise Health Technology Assessment (HTA) in Europe. It has presented a proposal for a regulation to this end. In its statement, the National Association of Statutory Health Insurance Funds advocates the consolidation and gradual expansion of the existing cooperation between the national assessment organisations.

Health Technology Assessment has established itself internationally as an important pillar for high-quality healthcare. The National Association of Statutory Health Insurance Funds considers that all patients in the European Union should benefit from scientifically-sound, independent information on the benefits of medicinal products and medical devices and be able to rely on a secure, economical supply of these products.

All patients in the European Union are to benefit from scientifically-sound, independent information on the benefits of medicinal products and medical devices.

Cooperation, not centralisation

The guiding principle of European cooperation on HTA is cooperation between national evaluation organisations. This principle, in which Member States' HTA organisations play the leading role, should be maintained. Cooperation between the evaluation organisations must be independent of influence and transparent in order to strengthen confidence in the joint evaluation processes and their outcomes. The role of the European Commission should be limited to providing purely administrative support to HTA organisations.

Developing common methods, enabling own evaluations

A major step towards stepping up cooperation within the EU is to reach a consensus on the procedural design of the Health Technology Assessment and the methodology underlying it. This is the only way to ensure that the evaluation results can be used by the national HTA organisations in a meaningful way. The statutory health insurance funds believe that a future EU regulation must refer to the scientific criteria of evidence-based medicine. Developing cooperation within the EU in a gradual and straightforward manner also means that the national HTA organisations can decide for themselves whether and to what extent they accept the assessment results from the European level, and which of their own assessments or additional information they require.

Including medical devices

The National Association of Statutory Health Insurance Funds considers it important not to exclude medical devices from the joint benefit assessment. This does not do justice to these products and their importance for care. Patients would benefit from better information about the advantages ensuing from medical devices. The original plans of the rapporteur in the European Parliament, namely to extend the criteria for the selection of medical devices for assessment, pointed in the right direction in the view of the National Association of Statutory Health Insurance Funds.

The National Association of Statutory Health Insurance Funds takes a critical view of the proposal to further restrict the number of medical devices that are eligible for a Health Technology Assessment. The National Association of Statutory Health Insurance Funds rejects the Federal Government's position that medical devices should be removed from the regulation altogether.

The National Association of Statutory Health Insurance Funds provides stimulus

The National Association of Statutory Health Insurance Funds formulated its requirements for the joint European benefit assessment in a comprehensive statement, and discussed these directly with the European Commissioner for Health, Vytenis Adriukaitis, at a meeting in Berlin.

The National Association of Statutory Health Insurance Funds welcomes MEPs' proposals to give HTA organisations greater flexibility in adopting assessment reports. The organisations should also be allowed to carry out additional assessments where this is necessary in the national context.

The European Parliament reached a broad consensus on the content as early as October 2018, and it would be possible to use this as a basis for negotiations with the Council and the European Commission. The Austrian Council Presidency presented its own compromise proposal for major parts of the proposal for a regulation in the second half of 2018, and ultimately submitted a progress report. Some contentious issues, such as the binding nature of the joint assessments, processes and assessment methods, have not yet been agreed on, so that negotiations in the Council Working Group will continue in 2019.

The National Association of Statutory Health Insurance Funds rejects the Federal Government's position that medical devices should be removed from the regulation altogether.

German social insurance celebrates 25 years of its European Representation

What is the European Commission planning on medicinal products? What stipulations on the digitalisation of insured persons' communication come from the EU? What does the European pillar of social rights mean for health and long-term care insurance funds? The list of tasks is long, and the topics are wide-ranging: They extend from cross-border healthcare through the European Social Security Number, to insolvency law. The European Representation of the National German Social Insurance Associations (DSV) addresses these questions and topics. It informs the German social insurance institutions on current developments at EU level. This includes legislative proposals and consultations, as well as long-term policy strategies. But it is crucial to bring the interests and positions of health and long-term care insurance funds to Brussels and to convince the European Commission and the European Parliament of the positions of the statutory health and long-term care insurance funds.

It is crucial to bring the interests and positions of health and long-term care insurance funds to Brussels.

On the occasion of the 25th anniversary of the European Representation, the DSV organised a conference in Brussels entitled "Bismarck meets Bytes: Digital Change and Social Security". International guests and representatives of the DSV discussed the effects of digitalisation in the world of work and in the healthcare system with the Bavarian Ministers of Social Affairs and of Health, as well as with high-ranking representatives of the European Commission. In addition to effective disease prevention work and adequate social protection for as many employees as possible, the conference also focused on digitalisation processes in the healthcare system. The focus was on the opportunities and European added-value of digitalisation in disease prevention and care.

Praise for the DSV's European Representation

European Commissioner Günther Oettinger paid tribute to the work of the European Representation of the DSV at a festive evening reception with Members of the European Parliament, representatives of the European Commission, self-government and the associations. He referred to the changes that globalisation, automation and digitalisation have brought and that need to be shaped. Dr. Peter Rösgen, Germany's Deputy Permanent Representative to the EU, stressed the role of the European Representation as a link between social security in Germany and European politics. He described it as far-sighted to have recognised the relevance of European politics to social security and taken the decision to establish the European Representation 25 years ago.

The structure of the European Representation of the German Social Insurance

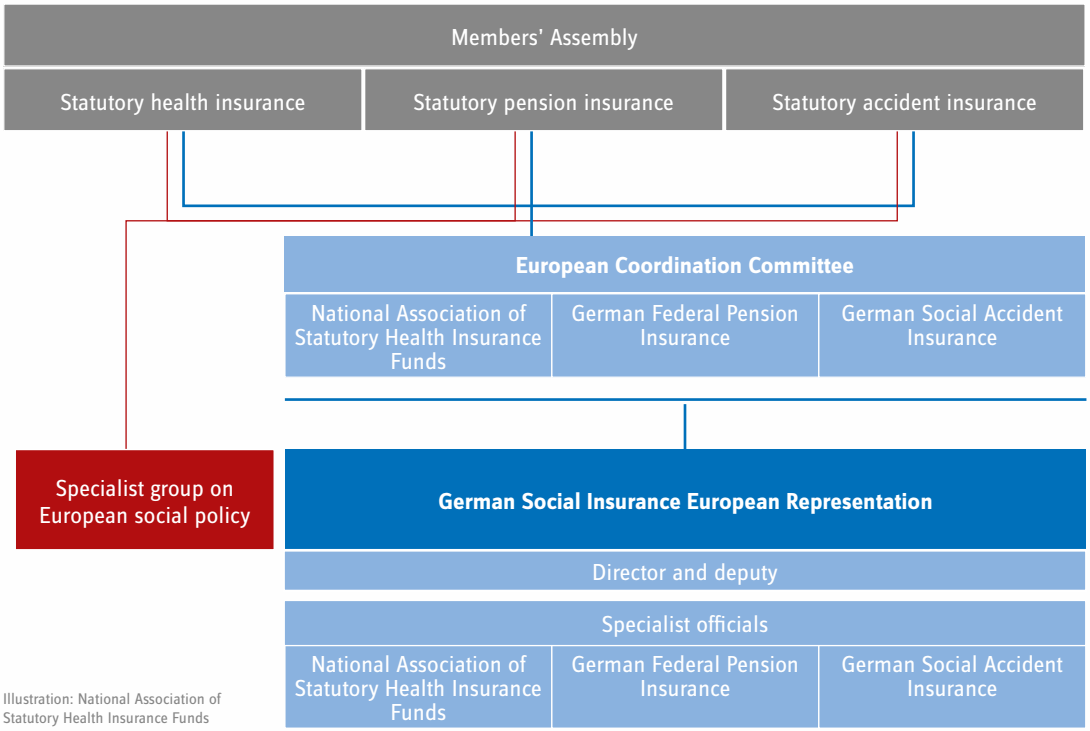

Illustration: National Association of Statutory Health Insurance Funds

Political tasks

- Representing the interests of the German social security system vis-à-vis the institutions of the European Union and other European institutions
- Advising the European bodies and institutions on questions relating to German social security and German social law
- Monitoring and analysing the development of European health and social policy, European economic and competition law, international trade law and the rulings of the European Court of Justice
- Providing early information to members on European legislative projects and action programmes relating to social security, including proceedings pending before the European Court of Justice
- Promoting cooperation with the lobbies of other Member States of the European Union, with German institutions in Brussels, and with institutions of the European Union
- Drafting and preparing joint statements and position papers, as well as disseminating them in a targeted fashion at EU level
- Brokering discussions between representatives of the German social insurance system and the European institutions
- Lectures on topics relevant to social security at EU level

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Secure digital exchange between EU social security systems

The EESSI system (Electronic Exchange of Social Security Information – EESSI) links the institutions of social security in the EU Member States across the EU's internal borders, and facilitates the electronic exchange of information. The system was developed for the Member States by the European Commission. It can however also be used by non-EU countries such as Iceland, Liechtenstein, Norway and Switzerland.

Paper-based procedures to be replaced by 1 July 2019

The exchange of messages and data takes place between the competent social security institutions of the participating countries. The existing paper-based procedures will be completely replaced by standardised and structured messages by 1 July 2019. As of this date, for example, some 200 paper forms will no longer be required for migrant workers. Messages and data will be exchanged between countries at a higher quality level and without any media discontinuities. Speeding up and simplifying procedures will enhance the rights of citizens in the EU.

The European Commission implemented the necessary IT infrastructure and the EESSI system from 2014 to mid-2017, and made them available to the Member States for the first time in July 2017 to connect their national structures and specialist application systems. The Member States must integrate the Commission's components into their IT environments within a period of two years and take into account the uniformly-specified cross-border business processes in the existing specialist national applications. New data interfaces must be operated, database structures adapted, and user interfaces of specialist applications revised, so that the health insurance funds and the other social security institutions can exchange messages and data with the partner institutions in other EU countries. Enquiries about entitlement documents, cost reimbursement applications and claims for financial equalisation are transmitted electronically and checked for formal correctness en route.

Speeding up and simplifying procedures will enhance the rights of citizens in the EU.

High standards of data protection and IT security

The data are exchanged between the access points which are operated under national responsibility, in encrypted and digitally-signed form. All electronic communication takes place via a secure public administration network in Europe in order to meet the stringent requirements in terms of IT security and data protection. All participating organisations are entered in a central register after careful examination. This is a prerequisite for participation in the cross-border exchange of messages and data. The correct implementation of the Commission's business and technical stipulations is also verified in advance. These components may only be used once the conformity of the national data exchange procedures and specialist applications to be connected has been confirmed. Extensive, complex test procedures of the participating countries guarantee the secure operation of all IT components involved in the computing centres and IT networks.

Extensive, elaborate IT security and data protection measures are being implemented in the interest of the data subjects.

Comprehensive training measures on the new business processes and new procedures for exchanging messages and data ensure that users receive the necessary support, especially in the initial phase of this new era of cross-border cooperation. The uniform interfaces and supranational standards of information exchange in Europe constitute major building blocks of the European Commission's digitalisation strategy, and provide the Member States with a sound basis for optimising their own social security organisations.

The National Association of Statutory Health Insurance Funds, German Liaison Agency Health Insurance – International (DVKA), is involved in developments at central level, and is using the introduction of the EESSI system to comprehensively digitalise and automate operational processes, primarily in international cost accounting and insurance services.

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Focus of communication in 2018

Eight legislative initiatives as well as numerous ordinances are the result of the work of Federal Minister of Health Jens Spahn, who did not take office until March 2017. A number of opportunities presented themselves in this context for the communication of the National Association of Statutory Health Insurance Funds to draw attention to the positions of statutory health insurance for improved care of insured persons. The Association took up its position in the discussions regarding emergency care and the sometimes long waiting times for appointments with registered doctors and psychotherapists. The problem of the shortage of nursing carers in clinics and retirement homes, but also the financial situation of statutory health and social long-term care insurance, were further central topics of communication. In the discussion on the future quality system in residential long-term care, the National Association of Statutory Health Insurance Funds was concerned not only with pointing out the shortcomings in the proposals made by the researchers, but also with emphasising its own concern for greater transparency. In addition, the National Association of Statutory Health Insurance Funds increasingly used social media channels in 2018 in support of traditional media work.

The National Association of Statutory Health Insurance Funds took up a position on the sometimes long waiting times for appointments with registered doctors and psychotherapists.

From emergency admission to the finances of the funds – "GKV Live" 2018

In its political event series entitled "GKV Live" ("Statutory health insurance live"), the National Association of Statutory Health Insurance Funds addressed both emergency care and the Act to Reduce the Burden on Individuals who have Statutory Health Insurance. The National Association of Statutory Health Insurance Funds discussed in January with representatives of the Government and the medical profession how the necessary reform of emergency care can be achieved. The finances and the financing of statutory health insurance were the main issues in October. The Board of the National Association of Statutory Health Insurance Funds engaged in a discussion with the health policy spokespersons of several parliamentary groups in the Bundestag.

Further development of the intranet

This year, the Association's intranet, which was launched in 2017, specifically addressed the development and implementation of accessibility. The Ordinance on Barrier-Free Information Technology (Barrierefreie Informationstechnik-Verordnung – BITV) applies to all the websites of the National Association of Statutory Health Insurance Funds, as well as to all publicly-accessible intranet offerings of authorities of the Federal administration. A so-called BITV test is carried out to verify the goal and quality of accessibility. The National Association of Statutory Health Insurance Funds' intranet scored 90.75 out of 100 points attainable, meaning that it was assessed as "easily accessible". In addition to the quality assurance of accessibility, a large number of new functions went online in the second half of the year.

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overview

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

The annual financial statement for 2017

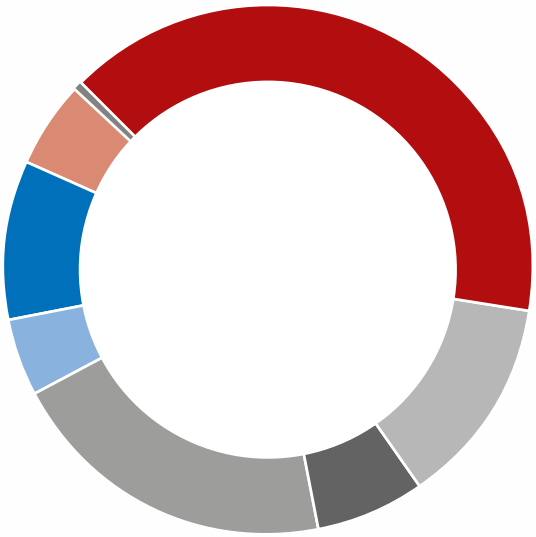
The annual financial statement of the National Association of Statutory Health Insurance Funds for 2017 was drawn up in April 2018. The audit, including the departmental budget of the German Liaison Agency Health Insurance – International (DVKA), was carried out by the BDO firm of auditors. "Promotion of advanced training in out-patient general medicine in accordance with section 75a Book V of the German Social Code", as well as "Interfaces to other organisations as a control component: the example of gematik" were also audited. The firm of auditors issued an unqualified audit report. At its session that was held on 6 June 2018, the Administrative Council thereupon approved the activities of the Board and approved the 2017 annual financial statement.

The Association's budget for 2018

The 2018 budget plan of the National Association of Statutory Health Insurance Funds shows an overall budget of 168.6 million Euro. This includes the contribution towards the budget of the National Association of Statutory Health Insurance Funds and of the German Liaison Agency Health Insurance – International (DVKA), as well as the following pay-as-you-go financing arrangements:

- the Medical Service of the National Association of Statutory Health Insurance Funds (MDS)
- the 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

Elements of the overall budget 2018



Core budget sum	**67,624,000 €**	
DVKA	21,771,000 €	
Medical Service (incl. Competence Centres)	10,986,000 €	
Federal Centre for Health Education	34,229,000 €	
Guarantee supplement midwives	7,831,000 €	
Support for special therapy facilities*	0 €	
Contribution of the National Association of Statutory Health Insurance Funds	**142,441,000 €**	Cost per insured person 1.97 €
gematik	16,784,000 €	
UPD	8,764,000 €	
Data transparency	622,000 €	
Allocation of further budget elements	**26,170,000 €**	Cost per member 0.47 €
Overall budget	**168,611,000 €**	

*The planned expenditure of 5 million Euro for the 2018 budget was fully financed by the levy that was charged in 2017 (5 million Euro), as the originally-planned funds were not called up in 2017.
Illustration: National Association of Statutory Health Insurance Funds

- the promotion of special therapy facilities in accordance with section 65d of Book V of the Social Code*
- the Gesellschaft für Telematikanwendungen der Gesundheitskarte mbH (gematik)
- the 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

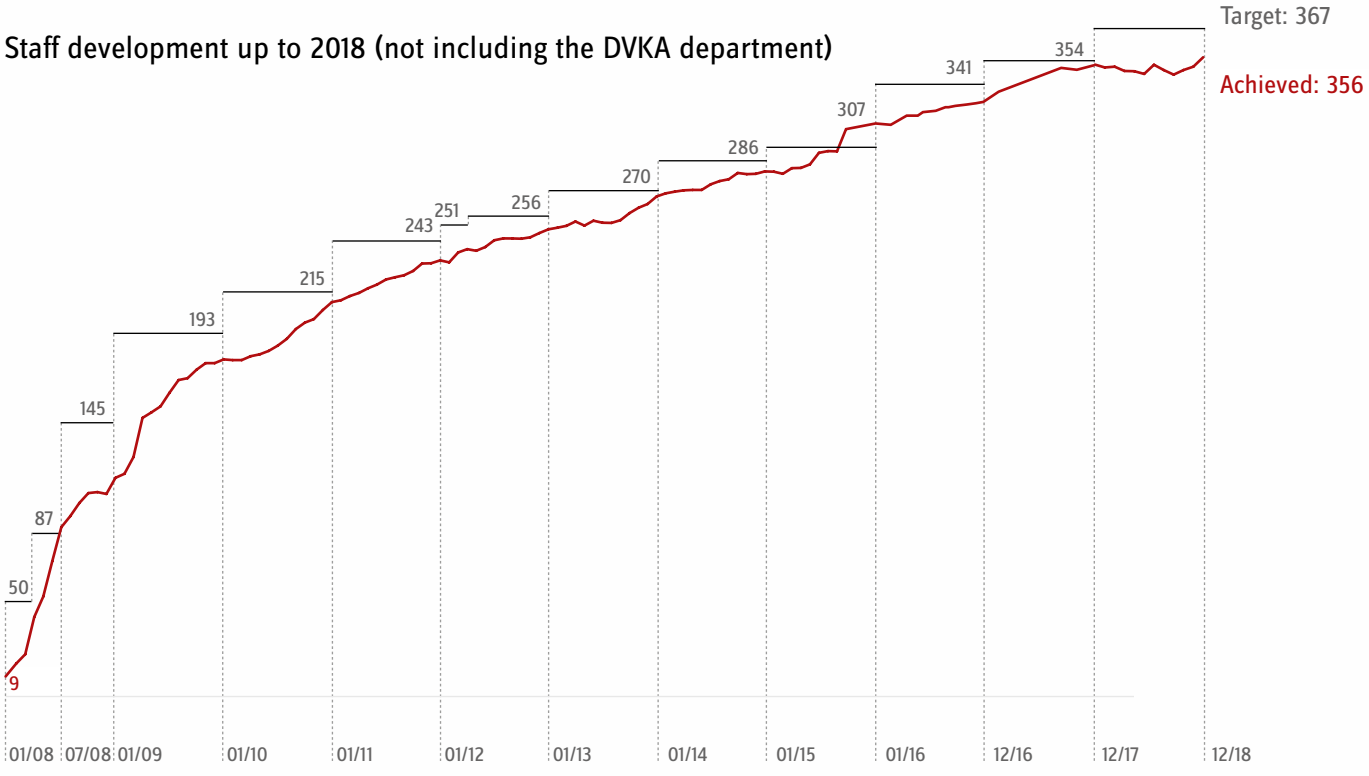
The budget for 2019

The budget plan for 2019 that was drawn up by the Board on 1 October 2018 was unanimously adopted by the Administrative Council of the National Association of Statutory Health Insurance Funds in November 2018. The Association's overall budget was set at 192.2 million Euro. It hence rose by 26.3 million Euro year-on-year. This is especially a result of the higher 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 2018 totalled 484.72 established posts. 366.86 target posts were accounted for by the Berlin location, and 117.86 target posts by the DVKA, 470.38 posts were occupied on 1 December 2018, 355.52 of which at the Berlin location and 114.86 at the DVKA. The occupancy rate is 97.0 % for the Association as a whole. The occupancy rate at the Berlin location is 96.9 %, and 97.5 % at the DVKA.

Staff development up to 2018 (not including the DVKA department)



Source and illustration: National Association of Statutory Health Insurance Funds

The members of the National Association of Statutory Health Insurance Funds 2018

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. Koenig & Bauer BKK (name changed as per 1 July 2018; formerly 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 (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. mhplus Betriebskrankenkasse
94. Novitas BKK
95. pronova BKK
96. R+V Betriebskrankenkasse
97. Salus BKK
98. SECURVITA BKK
99. SIEMAG BKK
100. Siemens-Betriebskrankenkasse (SBK)
101. SKD BKK
102. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
103. Südzucker BKK
104. Techniker Krankenkasse
105. Thüringer Betriebskrankenkasse
106. TUI BKK
107. VIACTIV Krankenkasse
108. Wieland BKK
109. WMF Betriebskrankenkasse

cut-off date: 1 January 2019

Mergers in 2018

Merged funds	Merger partners
mhplus Betriebskrankenkasse	mhplus Betriebskrankenkasse Metzinger Betriebskrankenkasse

cut-off date: 1 January 2019

Ordinary members of the Administrative Council 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 – Die Gesundheitskasse in Hessen
Berking, Jochen	BARMER
Breher, Wilhelm	DAK-Gesundheit
Brendel, Roland	BKK Pfalz
Date, Achmed	BARMER
Firsching, Frank	AOK Bayern – Die Gesundheitskasse
Hamers, Ludger	VIACTIV Krankenkasse
Holz, Elke	DAK-Gesundheit
Hoof, Walter	DAK-Gesundheit
Katzer, Dietmar	BARMER
Keppeler, Georg	AOK NORDWEST – Die Gesundheitskasse
Klemens, Uwe	Techniker Krankenkasse
Kloppich, Iris	AOK PLUS – Die Gesundheitskasse für Sachsen und Thüringen
Kolsch, Dieter	AOK Rheinland/Hamburg – Die Gesundheitskasse
Lambertin, Knut	AOK Nordost – Die Gesundheitskasse
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)
Stensitzky, Annette	Techniker Krankenkasse
Strobel, Andreas	Siemens-Betriebskrankenkasse (SBK)
Tölle, Hartmut	AOK – Die Gesundheitskasse für Niedersachsen
Wiedemeyer, Susanne	AOK Sachsen-Anhalt – Die Gesundheitskasse

Representatives of the employers

Name	Health insurance fund
Avenarius, Friedrich	AOK – Die Gesundheitskasse in Hessen
Bley, Alexander	SIEMAG BKK
Chudek, Nikolaus	IKK Brandenburg und Berlin
Dohm, Rolf	pronova BKK
Dombrowsky, Dr. Alexander	AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
Empl, Martin	SVLFG
Hansen, Dr. Volker	AOK Nordost – Die Gesundheitskasse
Heß, Johannes	AOK NORDWEST – Die Gesundheitskasse
Jehring, Stephan	AOK PLUS – Die Gesundheitskasse für Sachsen und Thüringen
Landrock, Dieter Jürgen	AOK Baden-Württemberg
Meinecke, Christoph	AOK – Die Gesundheitskasse für Niedersachsen
Nicolay, Udo	Techniker Krankenkasse
Parvanov, Ivor	AOK Bayern – Die Gesundheitskasse
Ries, Manfred	BKK ProVita
Ropertz, Wolfgang	AOK Rheinland/Hamburg – Die Gesundheitskasse
Schrörs, Dr. Wolfgang	Handelskrankenkasse (hkk)
Thomas, Dr. Anne	Techniker Krankenkasse
Reyher, Dietrich von	Bosch BKK
Wegner, Bernd	Techniker Krankenkasse
Wollseifer, Hans Peter	IKK classic

cut-off date: 31 December 2018

Deputy members of the Administrative Council 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 – Die Gesundheitskasse in Hessen
Balzer-Wehr, Dr. Alexandra	Kaufmännische Krankenkasse – KKH
Berger, Silvia	IKK Südwest
Böntgen, Rolf-Dieter	DIE BERGISCHE KRANKENKASSE
Böse, Annemarie	DAK-Gesundheit
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 – Die Gesundheitskasse
Lohre, Karl Werner	BARMER
Löwenstein, Katrin von	BARMER
Metschurat, Wolfgang	AOK Nordost – Die Gesundheitskasse
Mirbach, Helmut	DAK-Gesundheit
Mohr, Hans-Dieter	AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
Nimz, Torsten	Handelskrankenkasse (hkk)
Plaumann, Karl-Heinz	BARMER
Rahmann, Petra	Techniker Krankenkasse
Reimer, Jürgen	AOK NORDWEST – Die Gesundheitskasse
Roloff, Sebastian	DAK-Gesundheit
Schmidt, Günther	BARMER
Schöb, Katrin	Techniker Krankenkasse
Scholz, Jendrik	IKK classic
Schorsch-Brandt, Dagmar	AOK Baden-Württemberg

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

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 – Die Gesundheitskasse
Gural, Wolfgang	AOK Bayern – Die Gesundheitskasse
Heins, Rudolf	SVLFG
Heymer, Dr. Gunnar	BKK BPW Bergische Achsen KG
Hoffmann, Dr. Wolfgang	BKK Verkehrsbau Union (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 – Die Gesundheitskasse
Nobereit, Sven	AOK PLUS – Die Gesundheitskasse für Sachsen und Thüringen
Reinisch, Dr. Mark	BKK VerbundPlus
Schirp, Alexander	AOK Nordost – Die Gesundheitskasse
Selke, Prof. Dr. Manfred	AOK Rheinland/Hamburg – Die Gesundheitskasse
Söller, Wolfgang	AOK – Bremen/Bremerhaven
Stehr, Axel	AOK NORDWEST – Die Gesundheitskasse
Vahle, Torben	Techniker Krankenkasse
Wadenbach, Peter	IKK gesund plus
Wilkening, Bernd	AOK – Die Gesundheitskasse für Niedersachsen
Winkler, Walter	Techniker Krankenkasse

cut-off date: 31 December 2018

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

Specialist committee on fundamental issues and health policy

Chaired by: Stephan Jehring/Hans-Jürgen Müller (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: Dr. Wolfgang Schrörs/Andreas Strobel (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. Annette Stensitzky (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: Dietrich von Reyher/Eckehard Linnemann (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: Martin Empl/Angelika Beier (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: Nikolaus Chudek/Jochen Berking (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
Robert Leitl (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
	Norbert Grellmann (IKK)
	2nd deputy on the list for insured persons 6-8
	Eckehard Linnemann (Kn)
	3rd deputy on the list for insured persons 6-8

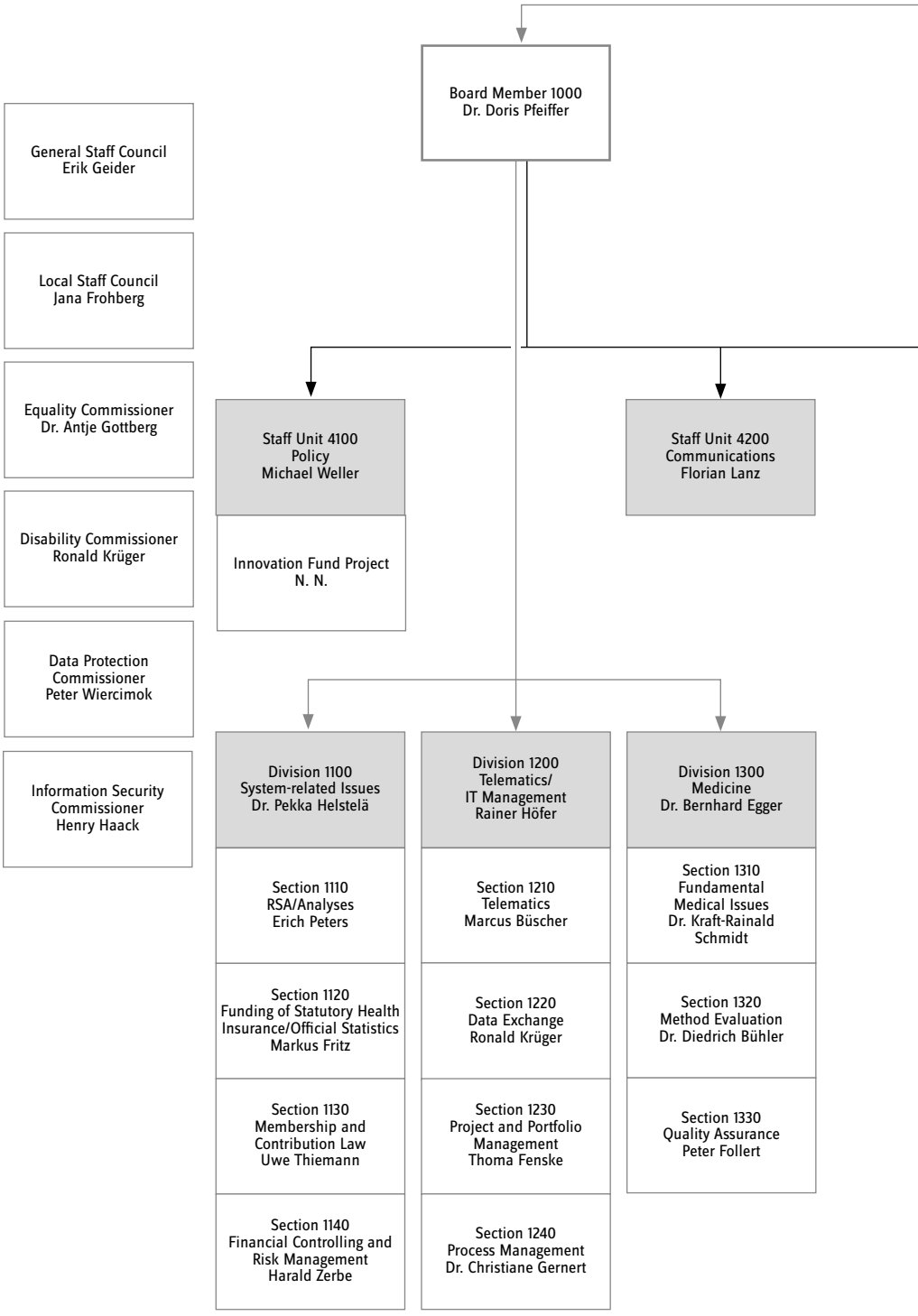
cut-off date: 31 December 2018

Ordinary members and personal deputies of the Specialist Advisory Council

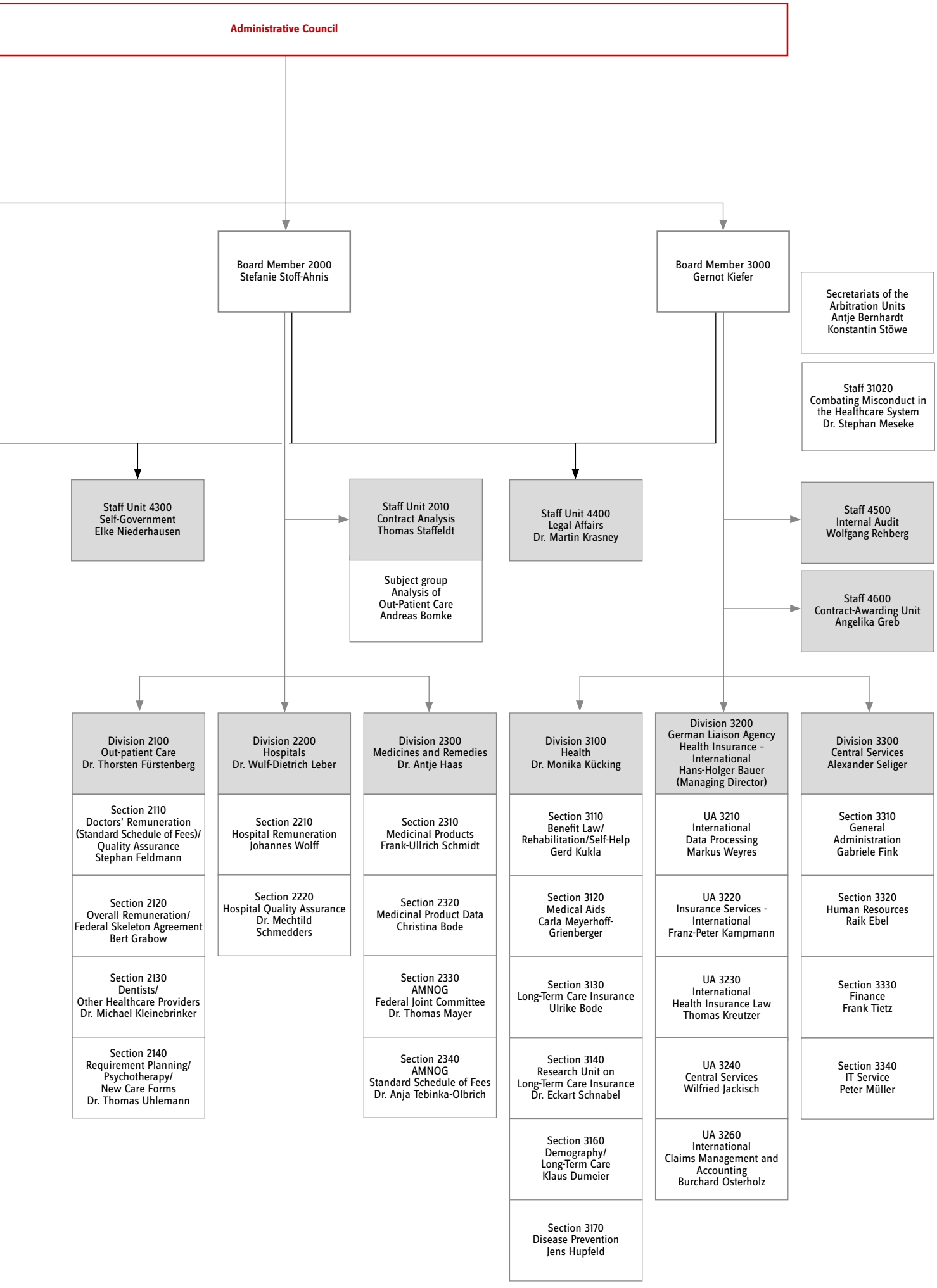
	Members	**Deputies**
AOK	1. Martin Litsch 2. Dr. Christopher Hermann (since 9 April for Dr. Helmut Platzer)	Jens Martin Hoyer Dr. Jürgen Peter
BKK	1. Franz Knieps 2. Andrea Galle	Verena Heinz Lutz Kaiser (since 9 April for Winfried Baumgärtner)
Ersatzkassen	1. Ulrike Elsner 2. Dr. Jörg Meyers-Middendorf	Boris von Maydell Oliver Blatt
IKK	1. Jürgen Hohnl 2. Uwe Schröder	Frank Hippler Enrico Kreutz
KNAPPSCHAFT	1. Bettina am Orde 2. Gerd Jockenhöfer	Dieter Castrup Jörg Neumann
Landwirtschaftliche Sozialversicherung	1. Claudia Lex 2. Gerhard Sehnert	Dirk Ender Jürgen Helfenritter

cut-off date: 31 December 2018

Organisational chart



Cut-off date: July 2019


Administrative Council
Board Member 2000
Stefanie Stoff-Ahnis
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. Thorsten Fürstenberg
Section 2110
Doctors' Remuneration (Standard Schedule of Fees)/ Quality Assurance
Stephan Feldmann
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. Mechtild 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)
UA 3210
International Data Processing
Markus Weyres
UA 3220
Insurance Services - International
Franz-Peter Kampmann
UA 3230
International Health Insurance Law
Thomas Kreutzer
UA 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
GKV-Spitzenverband	Neuordnung der Apotheken-strukturen und -vergütung	June 2018
GKV-Spitzenverband	Chancen der Digitalisierung für eine bessere Patientenversorgung nutzen	August 2018
GKV-Spitzenverband	Digitale Versorgungsangebote in der Finanzverantwortung der gesetzlichen Krankenversicherung	November 2018

Further publications

Author(s)	Title	Publication
GKV-Spitzenverband, DKG	Pflegepersonaluntergrenzen in Krankenhäusern nach § 137i SGB V. Zwischenbericht des GKV-Spitzenverbandes und der Deutschen Krankenhausgesellschaft an das Bundesministerium für Gesundheit	January 2018
GKV-Spitzenverband	1. Bericht des GKV-Spitzenverbandes gemäß § 139 Abs. 9 Satz 3 SGB V zur Fortschreibung des Hilfsmittelverzeichnisses	February 2018
Klaus Pfeiffer, Martin Hautzinger u. a.	Problemlösen in der Pflegeberatung. Schriftenreihe Modellprogramm zur Weiterentwicklung der Pflegeversicherung, Band 14, herausgegeben vom GKV-Spitzenverband	February 2018
GKV-Spitzenverband	Forschungsstelle Pflegeversicherung. Bericht 2016–2017	May 2018
Ursula Kremer-Preiß, Tobias Hackmann	Modellprogramm zur Weiterentwicklung neuer Wohnformen für pflegebedürftige Menschen. Konzeptionelle Grundlagen und methodische Vorgehensweise der wissenschaftlichen Begleitung, in Auftrag gegeben vom GKV-Spitzenverband	May 2018

Author(s)	Title	Publication
GKV-Spitzenverband	Bericht des GKV-Spitzenverbandes zum Pflegestellen-Förderprogramm in den Förderjahren 2016 und 2017 an das Bundesministerium für Gesundheit	June 2018
GKV-Spitzenverband	Bericht des GKV-Spitzenverbandes zum Hygienesonderprogramm in den Förderjahren 2013 bis 2017 an das Bundesministerium für Gesundheit	June 2018
Die Nationale Präventionskonferenz (GKV-Spitzenverband, DGUV, SVLFG, DRV Bund, PKV-Verband)	Bundesrahmenempfehlungen nach § 20d Abs. 3 SGB V	September 2018
GKV-Spitzenverband	Weiterentwicklung neuer Wohnformen für pflegebedürftige Menschen. Das Modellprogramm nach § 45f SGB XI. Die Projekte	October 2018
GKV-Spitzenverband	Leitfaden Prävention – Handlungsfelder und Kriterien nach § 20 Abs. 2 SGB V Leitfaden Prävention in stationären Pflegeeinrichtungen nach § 5 SGB XI	October 2018
GKV-Spitzenverband	Arbeit und Ergebnisse der Stelle zur Bekämpfung von Fehlverhalten im Gesundheitswesen 1. Januar 2016 bis 31. Dezember 2017	November 2018
Prognos AG	Gutachten: Stand der klinischen Krebsregistrierung. Ergebnisse der Überprüfung der Förderkriterien zum 31.12.2017	November 2018
GKV-Spitzenverband, MDS	Präventionsbericht 2018 Berichtsjahr 2017	December 2018

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