Spitzenverband

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Annual Report 2015

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Reinhardtstraße 28, D-10117 Berlin

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

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 2015.

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Editors: René Kircher, Florian Lanz, Verena Schröder (image editing),
Elke Sleeboom, Michael Weller (responsible)
Coordination: René Kircher
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Foreword by the Chairmen of the Administrative Council

Ladies and Gentlemen,

Even though we have only just reached the half-way point of the present Parliament, almost all the healthcare and long-term care policy projects of the Grand Coalition have been dealt with. Looking back, a positive assessment can be reached of the emphasis that was placed on the quality of healthcare and long-term care, but the reforms lead to considerable additional expenditure. The legislature has adopted important reforms, some of which are long overdue. These include the initiation of quality-orientated remuneration in in-patient care, and the assessment procedure for the grading of need of long-term care, which has been fundamentally re-orientated.

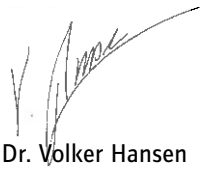
The tangible additional expenditure will lead to a situation in the foreseeable future in which the focus will be placed once more on the affordability of care. Given this fact, steps need to be taken immediately which are long overdue in order to enhance the existing potential for greater efficiency in care. Sectoral thinking continues to be the norm in care, which also in the interest of the patients should be replaced by more cross-sectoral, competitive solutions.
The changes which act to restrict the latitude that is open to the self-government bodies are also coming under criticism. There is a need here to place the central emphasis on the mandatory commissioning of the Federal Centre for Health Education with the implementation of disease prevention and health promotion benefits across different types of insurance fund in living environments, which we consider to be unconstitutional. The commissioning of a supreme federal authority constitutes cross-subsidisation using contributions from the statutory health insurance funds, as well as being in breach of the self-government principle.

There are other critical examples: The legislature has recognised the need to take action with regard to the introduction of the electronic healthcard and the telematics infrastructure, and a large number of newly-planned steps also go in the right direction. Having said that, the planned sanctioning mechanisms are not in line with the causative principle. It particularly affects the wrong party with regard to the National Association of Statutory Health Insurance Funds, which together with its member funds has done its utmost from the very start to advance this major project. Instead, it would be appropriate to create the necessary decision-making structures so that the National Association of Statutory Health Insurance Funds, as the sole funder, is also given adequate decision-making powers within gematik. The contributors have after all invested more than 1 billion Euro so far.

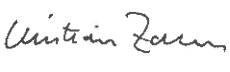
And finally: Even though it is understandable that the decision-making procedures in quality in long-term care need to be fundamentally reformed, the solution that was ultimately opted for is not appropriate. The non-partisan chairperson of the new Quality Committee which is to be established should be appointed by the contracting partners, and not by the Federal Ministry of Health.

All in all, these examples already make it clear that those with political responsibility repeatedly make the work of the self-government bodies more difficult, and hence that they ultimately do not appreciate it. This is not understandable, given that the self-government bodies do a highly-committed, successful job in order to refine healthcare and long-term care in a patient-orientated manner. Not lastly with a view to the coming challenges, it would therefore be important to actually enhance the competences of the self-government bodies. Let us hope that the Coalition will use the second half of the present Parliament in order to do so!

Yours faithfully,



Dr. Volker Hansen



Christian Zahn

Foreword by the Board

Dear Readers,

Were one to compare statutory health insurance and social long-term care insurance with a patient, this patient would have had to undergo no fewer than seven major operations in the past year. It would therefore be right to ask how this patient was getting on. We can sound the all-clear at this juncture: We still have a very high-performance medical and long-term care system, the quality of which stands up to an international comparison. Nonetheless, recent reforms in virtually all care sectors do entail profound changes, given that the legislature started with the goal of modernising the care structures and bringing them closer in line with quality criteria.

Long-overdue reforms have been brought to their conclusion. The re-orientation of long-term care insurance entailed by the introduction of the new definition of need of long-term care, which particularly eliminates discrimination against people with cognitive impairments, should be stressed positively. The Disease Prevention Act (Präventionsgesetz) passed through Parliament on its fourth reading. The strengthening of primary disease prevention and health promotion in living environments is to be welcomed as a matter of principle. The Act has however failed to do justice to the approach of including society as a whole, given that financial burdens are imposed on statutory health insurance alone. There are also highs and lows when it comes to the eHealth Act (E-Health-Gesetz): It is gratifying that policy-makers wish to accelerate the establishment of the telematics infrastructure and the introduction of specific telematic applications by imposing deadlines and sanctions. However, the sanctions must specifically affect those who have caused the problems. As it can already be predicted that industry will be unable to deliver the components within the contractually-agreed deadlines, a sanctioning arrangement which only affects the National Association of Statutory Health Insurance Funds, the National Association of Statutory Health Insurance Physicians and the National

Association of Statutory Health Insurance Dentists is unacceptable.

A great deal of potential was wasted when it came to the restructuring of out-patient and in-patient care. Neither the Care Improvement Act (Versorgungsstärkungsgesetz) nor the Hospital Structure Act (Krankenhausstrukturgesetz) will go far towards significantly reducing excess capacities in the respective sectors. The legislation on hospitals, which was announced as a major structural reform, only offers the chance to initiate quality-orientated remuneration. The unresolved problem of the lack of sufficient investment funding on the part of the Federal Länder, which is now legitimised in de facto terms, weighs heavily. The establishment of the newly-created Hospital Structural Fund, which has now been selected, furthermore leads one to fear that the contributions that were provided by statutory health insurance in order to reduce the capacities and for restructuring will be misappropriated by the Länder as a substitute for investment promotion which has been omitted.

Looking back on the reform year 2015, we are forced to first of all draw the sobering conclusion that, especially when it comes to reorientating the care structures, many measures fail to go beyond good intentions, and that a number of structural problems remain unresolved. The comprehensive changes are capable of helping improve patient care, but it remains questionable as a whole whether these will be tangible.

It is however certain that the additional costs which the reforms cause are costing the contributors dear, and that they will be felt through considerable rises in the additional contributions. The already existing gap in expenditure will continue to widen despite the fact that the revenue situation continues to be good, and it will push the health insurance funds to engage in ever-fiercer price competition. The order of the day needs to be discipline in expenditure when it comes to the reforms which are to be carried out in 2016 in order not to place the financial stability of statutory health insurance at risk. The fact that it is still in good financial shape as a whole should not deceive us about the fact that its reserves are shrinking noticeably. This applies to the health insurance funds themselves, where the reserves available differ greatly in their amount, as well as to the Health Fund, where the reserve was tapped recently in order to fund individual reforms.

As to the future, the National Association of Statutory Health Insurance Funds will also endeavour to ensure that the structural measures, which have now started tentatively, will be consistently continued in the interest of the patients. To this end, it will be actively contributing towards the implementation of the laws and calling for the remaining reforms in the funding and care structures that need to be carried out so that the additional costs also lead to marked improvements in quality and to efficiency gains in care.

Yours faithfully,

Dr. Doris Pfeiffer
Chairwoman of the Board

Johann-Magnus v. Stackelberg
Deputy Chairman of the Board

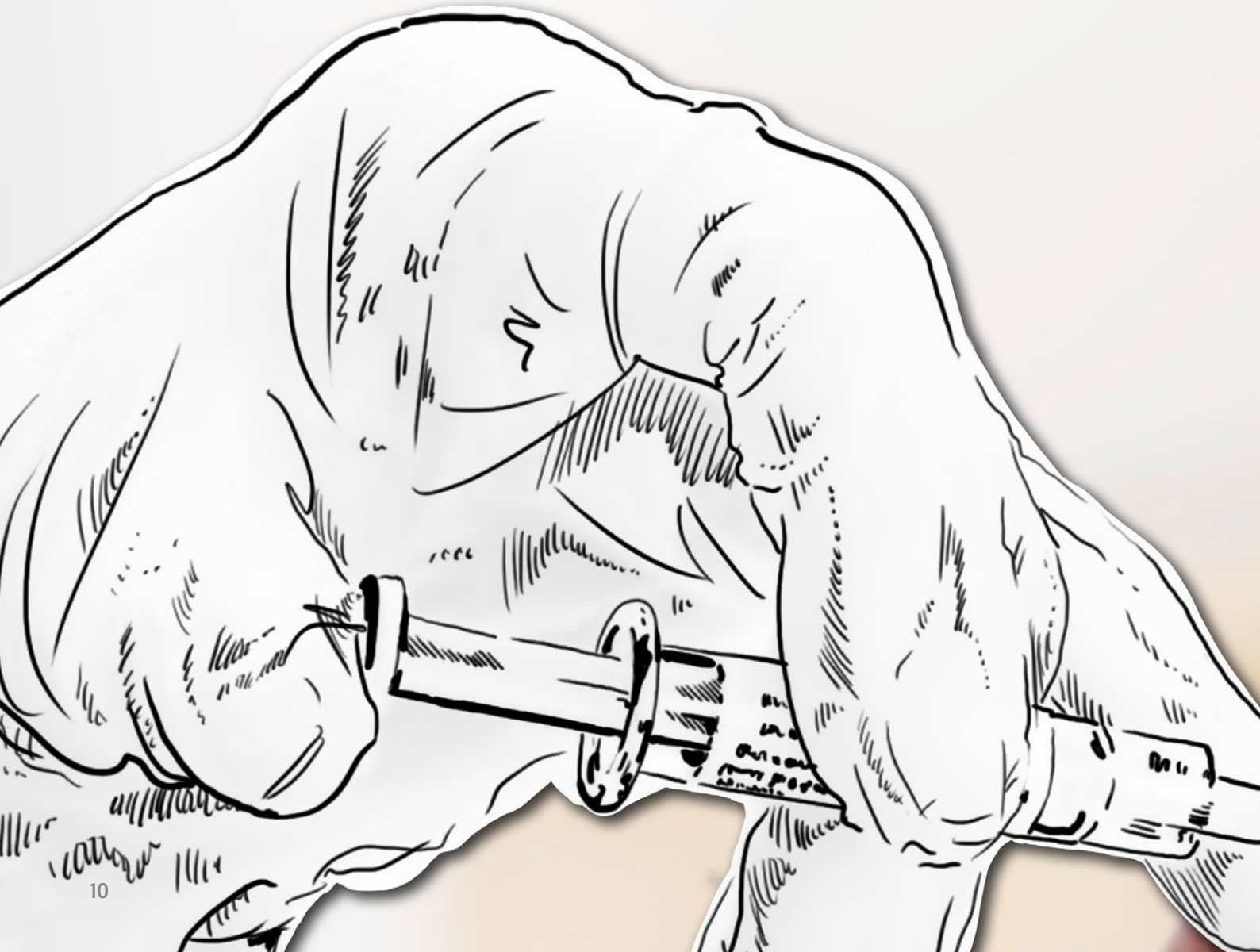
Gernot Kiefer
Member of the Board

Shaping reforms and ensuring sustainable funding

Just after half way through the present Parliament, the Governing Coalition, which is composed of Christian Democrats and Social Democrats, has already worked off a large share of the health policy programme which it entrenched in the Coalition Agreement. Many important activities have been carried out in order to improve care. Particular emphasis needs to be placed on the recognisable focus on quality in healthcare and long-term care. The assessment is less positive, by contrast, when it comes to the financial development of statutory health insurance. The gap between the expenditure of the health insurance funds and the allocations which they receive from the Health Fund is becoming ever wider. This development, which it has been possible to observe for quite some time, is further exacerbated by the reforms that were adopted in 2015. There can certainly be no question of a prudent expenditure policy, as was announced for statutory health insurance in the Coalition Agreement.

The hospital reform:
Record costs without structural changes

Quality is to play a greater role in future, especially in hospital care, and should be introduced into hospital planning as a criterion in perspective terms. When it comes to remuneration, quality



supplements and deductions are to be established for services. The other side of the coin is constituted by the considerable additional financial burdens that are incurred as a result of the hospital reform. The hope that the reform will also trigger urgently-needed structural changes remains vague here at best. The most-favoured-supplier clause, for instance, is not touched upon, which causes approx. 1 billion Euro more to accrue to the hospitals in 2016 alone than they will actually incur in terms of costs. Added to this is the tariff adjustment, the promotion of long-term care posts, etc. All in all, a total of almost 4 billion Euro in additional expenditure can be expected to be incurred in 2016, nearly 1 billion Euro of which will be accounted for by the hospital reform and about 2 billion Euro by the regular annual expenditure increases.

Focus on funding and financeability

The new Disease Prevention Act will also considerably increase the amounts expended by statutory health insurance on disease prevention and health promotion from 2016 onwards. The cross-subsidisation of the Federal Centre for Health Education from contributions made towards health insurance amounting to 31 million Euro per year is a misdevelopment in terms of regulatory policy. The Administrative Council of the National Association of Statutory Health Insurance Funds therefore considers there to be a need to have the lawfulness of this stipulation to pass contributions on to a state authority reviewed by the courts, including by the constitutional courts.

Further major items of additional expenditure are entailed by the Statutory Health Insurance Care Improvement Act (GKV-Versorgungsstärkungsgesetz – GKV-VSG). The Act provides for 1.2 billion Euro for the promotion of new forms of care and for care research up to 2019 with a newly-created Innovation Fund to be established at the Federal Joint Committee. The primary aim here must be to improve cross-sectoral healthcare. By contrast,

there must not be any promotion of products pure and simple to the disadvantage of the contributors. The Hospice and Palliative Care Act (Hospiz- und Palliativgesetz), as well as the eHealth Act, also entail further additional expenditure. This brings the financeability of healthcare back into the limelight of the political debate once more.

Improving on the reforms, accompanying their implementation

Even if virtually all of the Grand Coalition's health-policy agenda has been dealt with, quite a lot remains to be done. One may not expect the legislature to go quiet despite the Bundestag elections, which are due to take place in 2017. The Federal Government will focus on pushing forward the implementation of the reforms. This will also entail necessary refinements of the reforms' content. Moreover, topics which so far have been left out, such as remedies and medical aids, could be taken up. Not lastly, there may be changes in the field of medicinal products. The discussions between the Federal Government and the pharmaceutical industry within the "Pharma Dialogue", for instance on the further development of the Act on the Reform of the Market for Medicinal Products (Gesetz zur Neuordnung des Arzneimittelmarktes – AMNOG), will step up the pressure on the Grand Coalition. However, this Act may by no means be undermined, but the successful principle on which it is based must be refined.

The gap between the expenditure of the health insurance funds and the allocations which they receive from the Health Fund is becoming wider and wider.

Long-term care training: Calling on the Länder to act

More and specific legislative projects are already being worked on. A draft Bill for the Act Reforming the Nursing Professions (Pflegeberufereformgesetz) was submitted at the end of 2015, on which an intensive debate is underway in political circles. Previously separate nursing training courses in geriatric, health and paediatric nursing are to be combined to form uniform training. From the point of view of the National Association of Statutory Health Insurance Funds, the further development of nursing training must consistently take as its orientation the goal of enhancing the existing quality level. Above all here, the long-term care competence spectrum is to be reformed in order to be able to react as flexibly as possible to changing needs for care. It is questionable whether this goal will be achievable with the draft Bill which has been put forward. The Act Reforming the Nursing Professions can hence only be finally assessed once the specific training contents are known. The statutory instrument envisioned for this must therefore be available before the legislative procedure has been completed. Moreover, the funding system provided for in the draft Bill places the funding of social long-term care insurance at considerable risk. The Federal Länder must be challenged within their responsibilities in this regard. The funding of school costs is not a task to be shouldered by the contributors.

Unresolved items from the Coalition Agreement are the Federal Participation Act (Bundesteilhabegesetz) and the Local Act to Strengthen Long-term Care (Kommunales Pflegestärkungsgesetz). The recent legislation on long-term care is to especially strengthen the role of the towns, cities and municipalities in our ageing society and better interlink cooperation between the social insurance institutions. The Federal Participation Act is intended to improve the circumstances encountered by persons with a disability, for instance by providing more counselling and through cooperation with the rehabilitation funders. There is no doubt that these are important reform objectives, but the financial burden may not be shifted any further towards health and long-term care insurance.

The financeability of health and long-term care insurance must be placed more clearly into the limelight of health policy against the background of the reforms that have already been adopted, as well as of the coming legislation. It must always be a matter of bringing high-quality healthcare and long-term care into harmony with affordability for the contributors.

The report from the Administrative Council

The deliberations of the self-government bodies of the National Association of Statutory Health Insurance Funds were characterised by a large number of legislative reform projects in health and long-term care policy in the business year 2015. Since the legislative projects related to almost all fields concerned with health, the self-government bodies were equally called upon in their four specialist committees, and as in previous years proved their skill and ability when it came to exerting an influence at federal level in the interest of the insured persons. The small number of promises in health policy which the Grand Coalition has yet to fulfil include strengthening self-government and reforming the social elections. The self-government bodies of the National Association of Statutory Health Insurance Funds have taken this as an opportunity to examine their existing latitude on the basis of an analysis of the changes in responsibilities of social and joint self-government, and to identify necessary improvements in the political and legal framework (see p. 16).

Within the structure of the bodies and of the advice cascade via the specialist level, that is the specialist committees up to the Administrative Council, the self-government bodies have intensively characterised the positions which have been taken up. The self-government bodies dealt intensively with all relevant health and long-term care policy issues in 2015 at 21 specialist committee sessions, at four Administrative Council sessions and in one workshop. In addition to addressing the Coalition's major reform projects, it also did justice to its responsibility for implementing the many new statutory tasks through organisational decisions within the association.

Reform project: Improving care

In the specialist committees and in the Administrative Council, the self-government bodies principally addressed the partly overdue legal initiatives such as the Disease Prevention Act and the Act to Strengthen Long-term Care for the introduction of a new definition of the need of long-term care. However, considerable scope was also taken up by the Hospital Structure Act and the Act to Improve Hospice and Palliative Care (Gesetz zur Verbesserung der Hospiz und Palliativversorgung). In addition to what it considers to be the positive approaches for improving healthcare and long-term care, the self-government bodies also pointed to the lack of structural changes in hospital reform and to the considerable additional expenditure caused by the reforms that have been adopted. Specific expectations of the political arena were formulated in large numbers of position papers.

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Before a draft Bill for the creation of a new offence of "passive and active corruption in the healthcare system" had even become known, positions and demands for tackling misconduct in the healthcare system were also discussed and made public at the beginning of the year. However, the discussions focussed not only on the reform projects, but also on the refinement of the supply of medical aids, the implementation of the Care Structure Act (Versorgungsstrukturgesetz) and the wording of requirements made of the role that is played by the local authorities in long-term care. With regard to the Federation-Länder working party which was tackling it, central positions of the National Association of Statutory Health Insurance Funds were recorded in a position paper.

The self-government bodies have viewed with concern not only the additional expenditure in statutory health insurance which was forecast because of the legislation that has been adopted, but has also pointed to the rising expenditure on medicinal products. The self-government bodies continue to contribute to the policy debate in order to ensure that high-quality care remains financeable.

The Disease Prevention Act: Shouldering responsibility

Once the Disease Prevention Act had been adopted, the self-government bodies demonstrated

their initiative: As the budget debates progressed, it imposed a budget freeze notice at its December session with regard to the assets that had been earmarked to fund the Federal Centre for Health Education. The Administrative Council justified this decision by referring to what it considers to be the unconstitutional arrangement contained in the Disease Prevention Act which links the commissioning of the Federal Centre for Health Education by the National Association of Statutory Health Insurance Funds with funding for the Federal Centre for Health Education, as a subordinate federal authority, from statutory health insurance contributions. With the budget freeze notice, the Administrative Council has created the possibility to lodge appeals against the anticipated order under supervisory law, and thus to bring about a judicial review of the disputed constitutional issues for the funding of the Federal Centre for Health Education.

The eHealth Card/telematics: Strengthening positions

The introduction of the electronic healthcard (eHealth Card) and of the telematics infrastructure was once more a central topic in the self-government bodies. The Administrative Council sent out an unmistakeable signal as early as the end of 2014 that it no longer intends to accept the further delays, namely by freezing the funds for gematik. The submission of the draft Bill on Secure Digital Communication and Applications in the Healthcare System – eHealth Act (Gesetz für sichere digitale Kommunikation und Anwendungen im Gesundheitswesen – E-Health-Gesetz) was also a reaction on the part of the Federal Ministry of Health to the initiative of the Administrative Council and the demands that it made at its sessions held on 10 December 2014 and 16 January 2015. Although the reform plans as a whole were welcomed, the Administrative Council made it clear most recently at its meeting which was held on 2 December 2015 that it is not justified, given the supply problems in industry, to punish gematik's shareholders by means of sanctioning mechanisms if there are delays or technical problems on the part of the suppliers.

Refugees: Pushing ahead with healthcare

Given the increasing migration by refugees, the self-government bodies of the National Association of Statutory Health Insurance Funds committed themselves early to safeguarding medical care for asylum-seekers, and called on policy-makers to bring about an arrangement for uniform, appropriate care that will apply nationwide. To this end, the self-government bodies consider that the introduction of an electronic healthcard should also be made possible in order to reduce the burden on the local authorities in terms of administrative expenditure.

The Administrative Council took up the topic of medical care for asylum-seekers early, and called on policy-makers to bring about an arrangement for uniform, appropriate care that will apply nationwide.

Enhancing self-government in the healthcare system

The developments and prospects of self-government as a form of control in the healthcare system will be in the focus of the policy debate in the coming Parliament. In light of this, at a workshop held back in 2015, the self-government bodies of the National Association of Statutory Health Insurance Funds addressed in greater detail the existing latitude and the need to make improvements in social and joint self-government. On the basis of the results of the workshop, which are presented below, demands and positions are drawn up in order to improve the latitude that is available to the self-government bodies.

Self-government guarantees a practical orientation

Self-government is a central, high-performance principle of statutory health and long-term care insurance. It is largely typified by the fact that those concerned in the healthcare system shape the provision of care on their own responsibility. Self-government demonstrates its performance on a day-by-day basis by virtue of proper, practical solutions. At the same time, participation by the stakeholders concerned creates greater democratic legitimisation and increases the level of acceptance of the decisions.

The latitude open to the self-government bodies must be strengthened and expanded.

An indispensable prerequisite for well-functioning self-government is strong backing on the part of policy-makers. It is only if the potential of self-government to mould is defined in a relevant, clear fashion that it can react to the coming challenges in a solution-orientated manner. Given the changing sociodemographic framework, the self-government bodies are called upon more than ever. Their margin of appreciation must be strengthened and extended.

A fundamental distinction needs to be made between social and joint self-government as a matter of principle in the discussion on self-government as a form of control in the healthcare system. Social self-government comprises the institutional co-determination of the insured persons, as well as of employers, in the health insurance funds and their associations. Joint self-government describes the interaction between health insurance funds and healthcare providers for lending concrete form to tasks which are laid down by the law. Social and joint self-government follow a common goal: Patient-orientated further development of healthcare and long-term care.

The latitude open to the social self-government bodies

Social self-government helps ensure the shaping of high-quality, economical care. It strives to continually examine the care structures and to launch new forms of care. In doing so, it seeks open, constructive cooperation with the full-time Board.

Actions are led by the commitment to patients and contributors. In order to be able to register care shortages, as well as the problems and interests of the insured persons and patients, and to accommodate them better, self-government is executed in a close orientation towards their living environments.

The legislature has considerably curtailed the latitude open to social self-government in certain fields in recent years. Particular attention needs to be drawn to the encroachment on the decision-making autonomy of the health insurance funds when it comes to selecting the members of their boards owing to the obligation to submit the boards' contracts in advance. This change has ultimately led to a situation in which the self-government bodies are subjected to more exacting state supervision.

It should be acknowledged as a matter of principle that social self-government has taken on additional tasks in the course of the competitive orientation of statutory health insurance. There is however a need to discuss what form of competition is tenable and desirable in statutory health insurance according to the present experience. There is a need for more quality-orientated competition in contracts, the implementation of

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Self-government

which should be centrally formed by social self-government.

Strengthening joint self-government

The Federal Joint Committee (G-BA) is a successful model of joint self-government. It has been shown in practice that the implementation of tasks which are assigned by statute works very well within the reconciliation of interests. The confidence of the political arena in the performance of the Federal Joint Committee is demonstrated by the continuous increase in the number of tasks, especially in the present Parliament. In future too, it must be ensured that the Federal Joint Committee can decide on its own responsibility and carry out its highly-responsible function in the healthcare system.

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The patients' organisations with their right to be consulted in the Federal Joint Committee make a contribution towards completing the perspectives in joint self-government. Given the lack of financial responsibility, no further decision-making rights should be allocated to the patients' organisations. Rather, the tried-and-trusted form of cooperation should be retained.

There is particular criticism of the fact that the direct participation of the executive in the bodies of joint self-government has ultimately been prescribed with regard to a variety of tasks. Additionally, improper changes have been carried out in the structures and in the modus operandi in the past, such as in the appointment of the non-partisan chairperson. This leads to a greater proximity to the State and a restriction in the responsible decision-making ability of joint self-government.

Joint self-government is highly significant when it comes to shaping healthcare and long-term care, not only in the Federal Joint Committee, but also beyond, such as in the framing of the Federal Skeleton Agreements and the remuneration negotiations for registered contract doctors – both at Land and federal level, given the continuously-increasing complexity of both today's and future challenges. Social and joint self-government can only carry out their tasks if they are afforded sufficient latitude.

Understanding disease prevention as a task including society as a whole

The Grand Coalition placed health promotion related to the living environment and primary disease prevention in municipalities, kindergartens, schools and workplaces, as well as in long-term care facilities and recreational facilities, on a new footing by adopting the Act to Strengthen Health Promotion and Disease Prevention – Disease Prevention Act (Gesetz zur Stärkung der Gesundheitsförderung und der Prävention – Präventionsgesetz) in July 2015. Three previous attempts at legislation – in 2005, 2008 and most recently in 2013 – failed due to differences of opinion in the respective coalitions, as well as disagreements between the between Federation and the Länder.

Lack of a responsibility spanning society

The Disease Prevention Act obliges the statutory health insurance funds to provide additional expenditure for preventive and health-promoting benefits. For the first time, the long-term care insurance funds have also received an explicit statutory disease prevention mandate for beneficiaries who live in in-patient facilities. Health insurance fund benefits remain bound by the fields of action and criteria defined in the statutory health insurance guideline on disease prevention. The statutory guideline value for expenditure on disease prevention and health promotion is to be increased from 3.17 Euro in 2015 to 7.30 Euro per insured person in 2016. At least 4.30 Euro of this amount per insured person is to be spent on benefits related to the living environment and on in-company disease prevention and health promotion benefits.

Private health insurers are not legally obliged to provide such benefits. The other social insurance institutions do not incur greater financial burdens as a result of the Disease Prevention Act – statutory accident insurance and pension

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The key elements of the Disease Prevention Act

- National Disease Prevention Conference: established and backed by statutory health, accident, pension and social long-term care insurance (Federal and Land Ministries, central associations of local authorities, the Federal Employment Agency, the social partners, patients and the Federal Association of Disease Prevention and Health Promotion play an advisory role)
- Development of a disease prevention strategy spanning funding institutions
- Increasing the guideline value per insured person for disease prevention and health promotion by statutory health insurance to 7 Euro, of which at least 4 Euro for disease prevention and health promotion benefits that are related to the living environment and operated on an in-company basis
- Disease prevention in in-patient care facilities as a task of social long-term care insurance, funded with 0.30 Euro per insured person
- Mandatory commissioning of the Federal Centre for Health Education for disease prevention tasks of statutory health insurance related to the living environment
- Enhancing the screening tests with children and the preventive check-ups among adults
- Health check-ups: reducing the age thresholds, linking with primary disease prevention
- Medical preventive recommendation: can be issued in the context of health or other examinations
- Bonus programmes of the health insurance funds: mandatory service instead of the previous optional provision
- Care provided by occupational physicians: empowering the health insurance funds to conclude contracts with occupational physicians on the implementation of health check-ups

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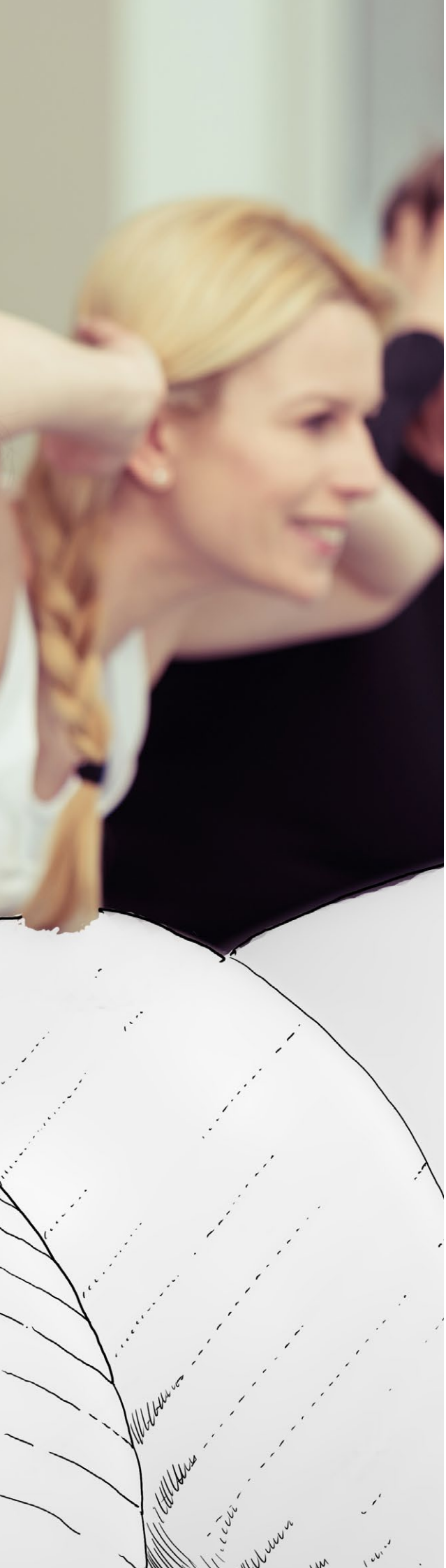
Disease Prevention Act



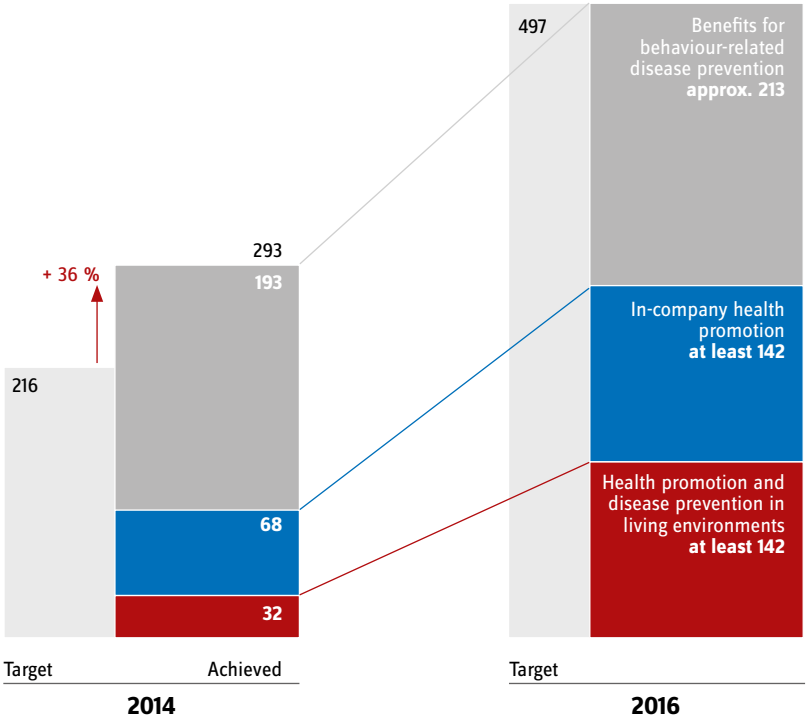
insurance are however involved as relevant partners within the National Disease Prevention Conference. The National Association of Statutory Health Insurance Funds considers the Disease Prevention Act to make a major contribution towards enhancing disease prevention and health promotion in living environments. Having said that, the burden of responsibility is ultimately unilaterally imposed on statutory health insurance and long-term care insurance instead of perceiving funding as a task which includes society as a whole.

The tasks of the National Disease Prevention Conference

By establishing the National Disease Prevention Conference, the Disease Prevention Act creates a central coordination and decision-making body between the major stakeholders at federal level.

Fig. 1
Expenditure on disease prevention

Figures in million Euro



Source and illustration: National Association of Statutory Health Insurance Funds

Benefits provided on the spot are to be better coordinated between insurers.

This involves the social insurance institutions, including the Federal Employment Agency, the Federation and the Länder, social partners, central associations of local authorities, as well as representatives of the patients and of major specialist organisations. Participation by private health insurance is contingent on benefits for health promotion and disease prevention being provided in line with the minimum per capita expenditure of statutory health insurance. A disease prevention forum consisting of representatives of relevant specialist organisations will be available in future to advise the National Disease Prevention Conference.

The National Disease Prevention Conference was constituted on 26 October 2015. It is tasked with drawing up nationwide framework recommendations for disease prevention and health promotion related to the living environment which are to be adopted for the first time on 19 February 2016. The framework recommendations are orientated towards the stages of life, and hence cover all living environments which may be shaped in such a way that they are beneficial to health. Joint goals and target groups, fields of action, organisations which are to be involved, as well as documentation obligations, are bindingly defined for the first time within this process. Health insurance funds, accident and pension insurance funds, as well as the Federal Länder, must take these into account in framework agreements at Land level. This is to ensure that the benefits are better coordinated between insurers at local level. A disease prevention report, which is to be presented every four years analogously to the disease prevention report of

Fig. 2
National Disease Prevention Conference

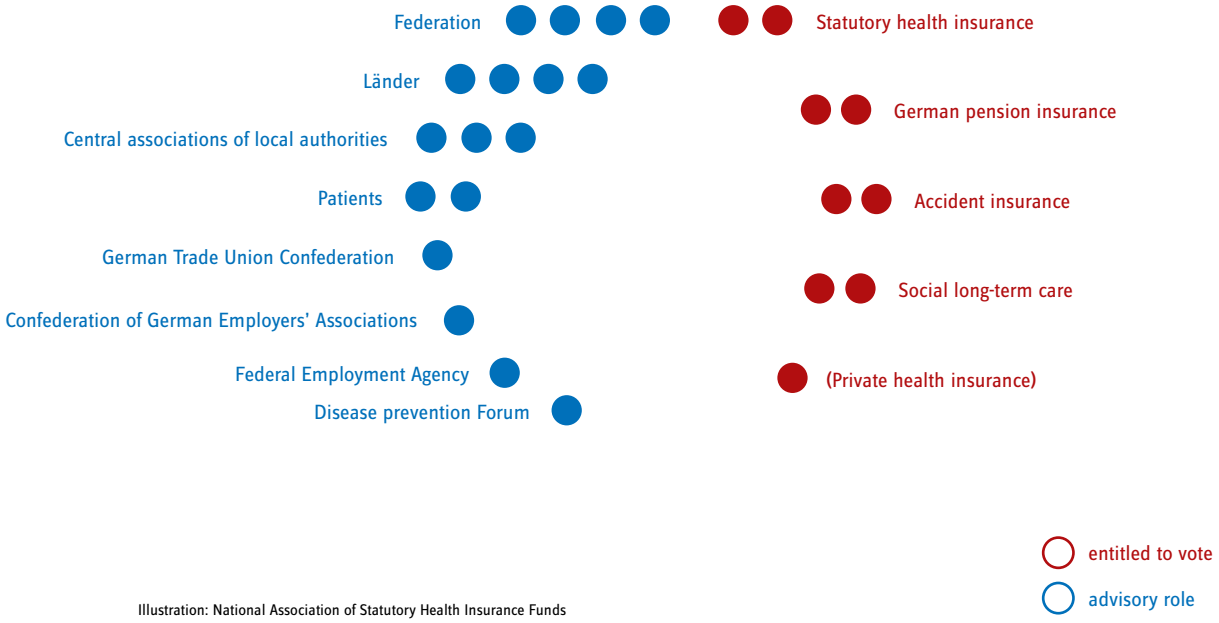


Illustration: National Association of Statutory Health Insurance Funds

statutory health insurance, creates transparency regarding benefits that have been provided and target groups that have been reached.

Strengthening cooperation within statutory health insurance

The Disease Prevention Act furthermore regulates for all living environments that there is to be closer cooperation between the statutory health and long-term care insurance funds. Health insurance funds are obliged to act as follows in in-company health promotion:

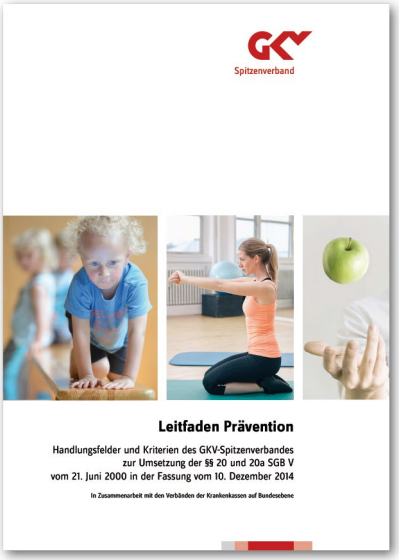
- combine benefits in joint coordination agencies across all types of insurance fund at Land level
- cooperate with regional company organisations
- advise companies with regard to the benefits that are available
- clarify competences for benefit provision in individual cases

The mandatory commissioning of the Federal Centre for Health Education is to be reviewed in court

The Disease Prevention Act obliges the National Association of Statutory Health Insurance Funds to commission the Federal Centre for Health Education – a federal authority within the remit of the Federal Ministry of Health – to provide health promotion and disease prevention measures in living environments with the "development of the nature and quality of health benefits across all types of insurance fund, their implementation and their scientific evaluation". Approx. 31 million Euro per year are to be paid to the Federal Centre for Health Education for this purpose. For comparison: The Centre's budget for 2015 was only 16.3 million Euro. This mandatory commissioning of a federal authority by the health insurance funds, as well as its funding through social insurance contributions, are wrong in terms of regulatory policy and in breach of the self-government principle. The Administrative Council of the National Association of Statutory Health Insurance Funds regards this arrangement as unconstitutional, and hence considers a need to exist to have the lawfulness of passing on contributions to a state authority subject to judicial review.

The mandatory commissioning of a federal authority by the health insurance funds, as well as its funding by social insurance contributions, are in breach of the self-government principle.

It can be concluded that the correct goal of improving disease prevention and health promotion related to the living environment will be difficult to achieve if the financial focus is placed solely on statutory health and long-term care insurance. Rather, all who bear responsibility in society must make their contribution to this joint task, including in financial terms.




#thinking_ahead
Innovation Fund

Promoting cross-sectoral care

In order to promote innovation in care and research into care, the Statutory Health Insurance Care Improvement Act (GKV – VSG) of July 2015 provides for an Innovation Fund with an annual budget of 300 million Euro. From 2016 onwards, it will provide 75 million Euro for research into care and 225 million Euro for new, cross-sectoral care forms. It is to promote projects which

- go beyond the previous standard treatment,
- aim to improve cross-sectoral care,
- have sufficient potential to be permanently included in care ("implementation potential"), and
- can be accompanied and evaluated by research activities.

The funding is provided in equal halves, directly by the statutory health insurance funds and from the liquidity reserve of the Health Fund. In institutional terms, the Innovation Fund has established its own secretariat housed at the Federal Joint Committee. It is to be established for four years (2016-2019). After this, the Federal Ministry of Health is to have the promotion evaluated with regard to its aptitude for refining care. The Innovation Committee, which will have an Expert Advisory Council available, will decide on the promotional projects.

Statutory health insurance perspective strengthened in the Innovation Fund

The National Association of Statutory Health Insurance Funds has already accompanied the legislation process intensively and critically. The Innovation Fund was criticised above all because the Federal Joint Committee is deciding for the first time on specific selective contractual services which have a direct financial impact on the health insurance funds. Moreover, representatives of the Federal Ministries, that is of the executive, are involved in the decision in a joint self-government body. Direct access to the Health Fund by the Federal Insurance Office (Bundesversicherungsamt – BVA), as a subordinate authority of the Federal Ministry of Health, is also incompatible with the system.

The promotion is to be evaluated in 2019 with regard to its aptitude for refining care.

Once the Statutory Health Insurance Care Improvement Act (GKV-Versorgungs¬stärkungsgesetz) had come into force, the focus in the second half of 2015 was placed on the establishment of the Innovation Fund. A temporary internal working structure was established for this at the National Association of Statutory Health Insurance Funds. In order to create the greatest possible transparency on the part of the insurance

Main points of promotion for the Innovation Fund

New forms of care

225 million Euro p.a.;
without thematic restrictions, e.g.:

- care models in structurally-weak or rural areas
- model projects for drug therapy, as well as for the safety of drug therapies
- care models using telemedicine, telematics and eHealth
- care models for specific groups of patients

Care research

75 million Euro p. a.; without thematic restrictions, e.g.:

- further development of quality assurance and patient safety
- improving instruments to measure quality of life
- innovative patient-orientated long-term care concepts
- improving the needs-based justice and economic efficiency of statutory health insurance care
- optimising bureaucratic requirements

funds, and to include the experience of the health insurance funds and of the associations of health insurance fund categories early, at the same time members of the associations of health insurance fund categories and individual funds have met, and will continue to meet, in a regular working party by the name of "Innovation Fund". From the point of view of the funds, it has developed important content-related stages for a Code of Procedure of the Innovation Fund. A total of three sub-working parties were formed, led by different associations of health insurance fund categories, to draw up promotional notifications and project promotion criteria.

This sets the stage for project promotion from the Innovation Fund from the point of view of the funds.

The composition of the Innovation Committee and of the Expert Advisory Council

The Innovation Committee is responsible for granting support. It consists of ten appointed members. The National Association of Statutory Health Insurance Funds seconds its three board members to its three seats. Board members of the associations of health insurance fund categories at federal level were nominated as deputy members who regularly represent the funds.
Furthermore, an Expert Advisory Council was established to contribute scientific expertise to the advisory procedure, as well as expertise related to practical care issues. Amongst other things, it submits recommendations to the Innovation Committee. The ten independent experts were appointed by the Federal Ministry of Health.

Fig. 3
The Innovation Fund: Tendering and assessment

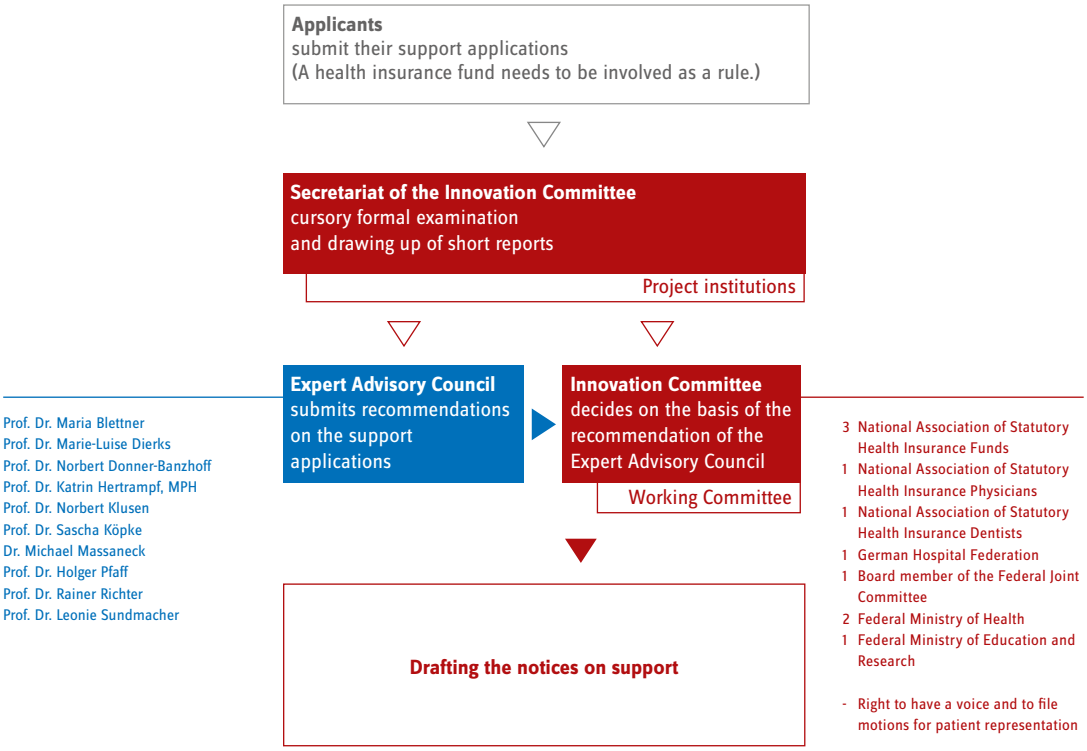


Illustration: National Association of Statutory Health Insurance Funds

Reforming hospital structures

The hospital reform that was outlined in 2013 in the Coalition Agreement reached between the CDU/CSU and the SPD was fleshed out in 2014 in a Federation-Länder working party that was established by the Federal Ministry of Health. In conclusion of the debate that has been going on between the Federation and the Länder since May 2014, the working party adopted a position paper on hospital reform in December 2014, which was transferred in the ensuing months by the Federal Ministry of Health into a draft Bill for the Reform of the Structures of Hospital Care (Hospital Structure Act) (Gesetz zur Reform der Strukturen der Krankenhausversorgung – Krankenhausstrukturgesetz – KHSG). Adopted by the Bundestag at the beginning of November 2015, the principal parts of the Hospital Structure Act have been in force since 1 January 2016.

Statutory health insurance – an important voice in the reform process

The hospital reform was discussed extensively, both at political level in the Federation and in the Länder, as well as in the media. With a campaign and a central demonstration at the Brandenburg Gate in September 2015, the clinics for their part became mobilised against the Hospital Structure Act. The National Association of Statutory Health Insurance Funds accompanied the legislative process with statements, held background talks and organised discussion events. As part of its press work, as well as via clarifications and specialist publications, attention was drawn to the consequences and actual impact of the reform. Moreover, it was possible to put forward the positions of statutory health insurance at the specialist hearing that was held in May 2015 and at the public hearing in the health committee in September 2015. Internal working parties made up of representatives of the funds and health insurance fund categories coordinated the joint action of statutory health insurance, and prepared the negotiations with the German Hospital Federation for the implementation of the Hospital Structure Act.

Improving quality

The topic of quality is one of the most media-effective ones of the hospital reform. Many new regulations were created in Book V of the Social Code for quality assurance in hospitals. The Government is hence consistently implementing the quality orientation contained in the Coalition Agreement. The National Association of Statutory Health Insurance Funds accompanied the policy debate from the outset, and with its position paper entitled "Qualitätsorientierte Versorgungssteuerung und Vergütung" (Quality-orientated healthcare management and remuneration) sent out the unambiguous message that different levels of treatment quality must have consequences.

There is to be quality-orientated remuneration in the Federal Republic for the first time.

Germany is not at the beginning when it comes to quality assurance. The 15-year history of its external quality assurance in hospitals however shows that the quality stipulations frequently have no effect. For instance, benefits are provided and remunerated by the health insurance funds even though the minimum volumes required per hospital are not complied with.

The Federal Joint Committee has been tasked via the Hospital Structure Act to establish what happens if quality stipulations are not adhered to. There will for instance be exclusions from remuneration when it comes to structures which fall short of the minimum requirements. Whether the quality criteria are met will be examined in future by the Health Insurance Medical Service, but this will only take place within stipulations which are to be issued by the Federal Joint Committee.

Considerable disputes are likely to be triggered by the statutory stipulation to pay lower remunerations

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The central topics of the 2015 hospital reform

- improving quality
- refining the structures of in-patient care
- price control and quantitative control

#thinking_ahead

Hospital reform

to clinics offering poorer quality, and ultimately to remove them from the market altogether. There is to be quality-orientated remuneration in the Federal Republic for the first time, a topic which is also not uncontentious among health insurance funds. The important message here is that the health insurance funds do not wish to benefit from poor quality. The funds are however also observing considerable differences in level within the result quality that is tolerable.

Further new topics include creating a closer link between quality and hospital planning in the Länder, or indeed selective quality contracts. Whether the 2015 hospital reform will go down in history as the "quality reform" will largely depend on the degree to which the Federal Joint Committee and the Länder authorities, as well as the hospitals and health insurance funds, manage to consistently implement the Act.

Refining the structures of in-patient care

Whilst the shaping of the hospital landscape previously clearly lay in the field of responsibility of the Länder, a shift is now underway towards the Federal Joint Committee. The Committee receives a large number of additional tasks which also reach far into the planning of in-patient capacities. Amongst other things, for instance, uniform nationwide stipulations are defined in the field of guarantee supplements and emergency care, from which the Länder can however derogate in many ways.

The newly-created Structural Fund can moreover be mentioned as a central measure. Such an idea was already discussed at the end of 2013, but was not included in the Coalition Agreement at that time. The Federation-Länder working party took it up again at the end of 2014. The Structural Fund has now been fleshed out in the Hospital Structure Act and anchored in the law. The National Association of Statutory Health Insurance Funds came out in favour of such a fund in its "14 Positions for 2014".

The Hospital Structure Act is the first Hospitals Act which addresses the problem of overcapacities. Germany has too many beds and too many hospital locations in an international comparison. This is easily shown by a comparison between the Netherlands and North Rhine-Westphalia: With the same surface area and the same number of inhabitants, there are 132 hospitals in the Netherlands, whilst there are 401 in North Rhine-Westphalia.

500 million Euro are to flow in the years to come from the liquidity reserve of the Health Fund into a Structural Fund to finance measures to reduce capacities and facilitate restructuring. Each Federal Land has the opportunity to file corresponding support applications with the Federal Insurance Office, and thus to obtain money from the Structural Fund. The Federal Länder are to also provide co-funding of 500 million Euro. This will enable them to offset the share which they are to pay against a contribution from the funding organisation of the facility which is to be supported. Moreover, private health insurance may voluntarily top up the promotional volume of the Structural Fund, albeit this is not expected to take place.

Fig. 4
Comparison between the hospital density in the Netherlands and in North Rhine-Westphalia

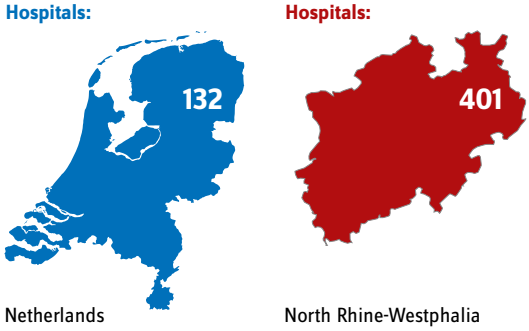
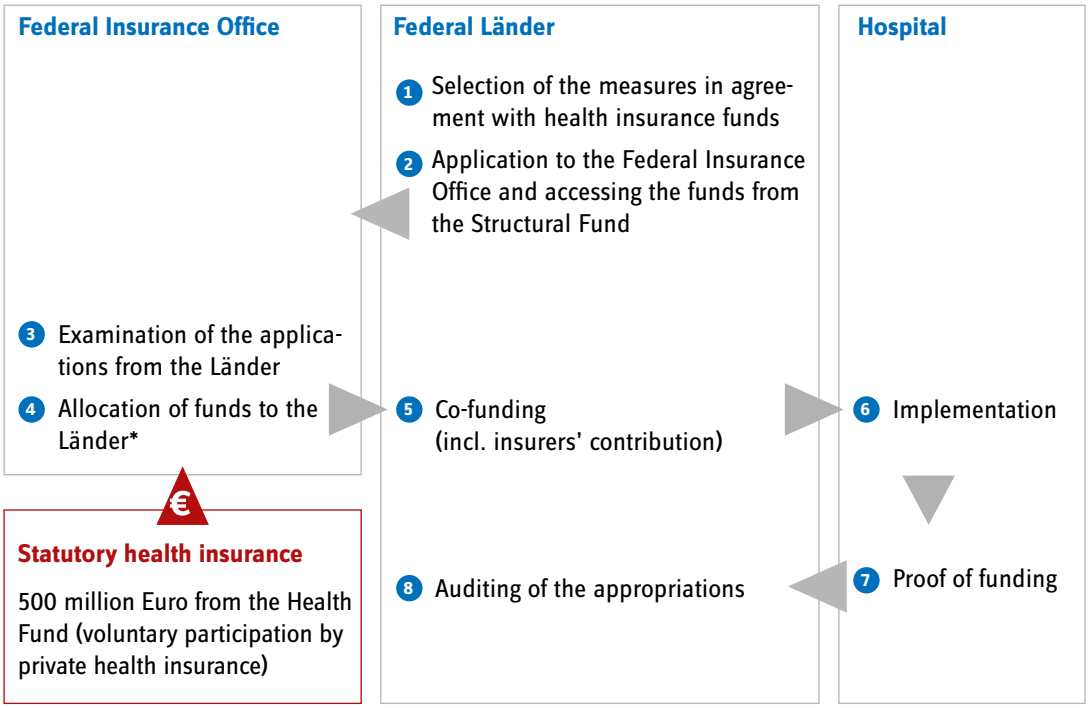


Illustration: National Association of Statutory Health Insurance Funds

Fig. 5
The modus operandi of the Structural Fund



* Ordinance of the Federal Ministry of Health on the Procurement Criteria

Source and illustration: National Association of Statutory Health Insurance Funds

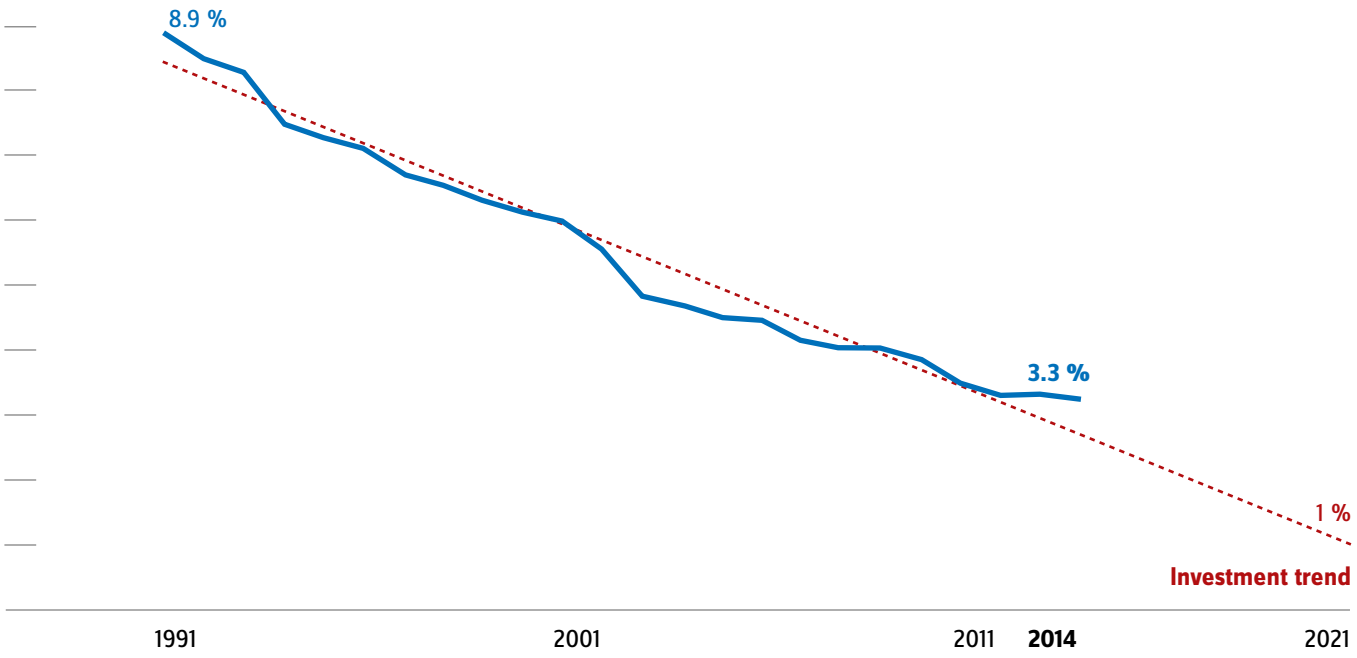
The main flaw in the Hospital Structure Act is the unresolved problems related to the falling investment funding of the Länder.

Back at the end of 2015, the Federal Ministry of Health handed down regulations within a statutory instrument in agreement with the Länder on the allocation criteria for the moneys contained in the Structural Fund. The National Association of Statutory Health Insurance Funds made a statement on this, particularly calling for priority to be given to closures. Focussing on the appropriate use of the funds (hospital closures), knock-on effects were to be ruled out caused by simply changing the name on the door. The Land Ministers of Finance ultimately carried the day in the discussion. From the point of view of statutory health insurance, there is now a risk that the Structural Funds could be misused by the Länder as a substitute for investment promotion which has not been carried out. Despite considerable flaws in the design, it is fundamentally welcome that policy-makers have recognised the need to act with regard to capacity planning and that they wish to advance the coming restructuring process by establishing a Structural Fund.

Price and quantitative control

There are also considerable new developments when it comes to pricing as regards the annual negotiations of the base rates in the Länder. These primarily burden the contributors. For instance, from 2017 onwards, a strong volume development no longer leads to a reduction in the base rates in the Länder. It is only at hospital level that there is a price reduction, where a deduction is made from payments for additional services provided equalling a percentage to account for non-variable costs (Fixkostendegressionsabschlag), which in financial terms does not constitute an equivalent substitute. Additionally, there will be a new convergence phase from 2016 onwards. Increas-

Fig. 6
Falling investment on the part of the Federal Länder
Ratio of investment by the Länder to the overall costs of the hospitals



Source: Federal Statistical Office (total expenditure), Working Group of the Supreme Health Authorities of the Länder (investment costs)
Illustration: National Association of Statutory Health Insurance Funds

ing the lower percentage range threshold will bring the base rates of the Federal Länder closer together. From the point of view of the National Association of Statutory Health Insurance Funds, the adjustments of the percentage range are however unable to resolve the faults in the base rate in the convergence between the Länder. On the contrary: The one-sided burden on the funders is further amplified by the convergence process.

In order to be able to remedy the existing imbalance in pricing, the following measures in particular should be implemented without delay:

- a symmetrical federal base rate corridor
- a federal base rate calculation downstream of the base rate negotiations in the Länder
- the abolition of the most-favoured-supplier clause in the change value

The Hospital Structure Act contains nothing about any of this.

Overall evaluation:
A hospital reform, but not a major one

The National Association of Statutory Health Insurance Funds considers that the Hospital Structure Act contains promising approaches, especially when it comes to quality measures. The overall result is however rather critical. The main shortcoming here relates to the unresolved problems concerning the drop in the investment funding that is forthcoming from the Länder. What is more, the expenditure burden of statutory health insurance must be referred to. The additional expenditure brought about by the law might already increase to a total of 6 billion Euro between 2016 and 2018. The additional financial burden caused by this Act hence exerts an influence on the contribution rate.

Better coordination of geriatric care

Geriatric care in private practice is unanimously regarded as unsatisfactory. The legislature therefore introduced a careful opening of the hospitals for out-patient geriatric treatment with the Psychiatry Remuneration Act (Psych-Entgeltgesetz) from 2012. The law provides that specialist geriatric hospitals and geriatric sections in general hospitals can be empowered to provide structured, coordinated out-patient geriatric care for insured persons. The National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians detailed the following points in this regard in an agreement at federal level that was reached with the German Hospital Federation:

Specialist geriatric hospitals and geriatric sections in general hospitals are empowered to provide structured, coordinated out-patient geriatric care for insured persons.

- the content and scope of structured, coordinated geriatric care
- the group of patients to be cared for
- requirements as regards service-provision and quality assurance
- requirements for referrals

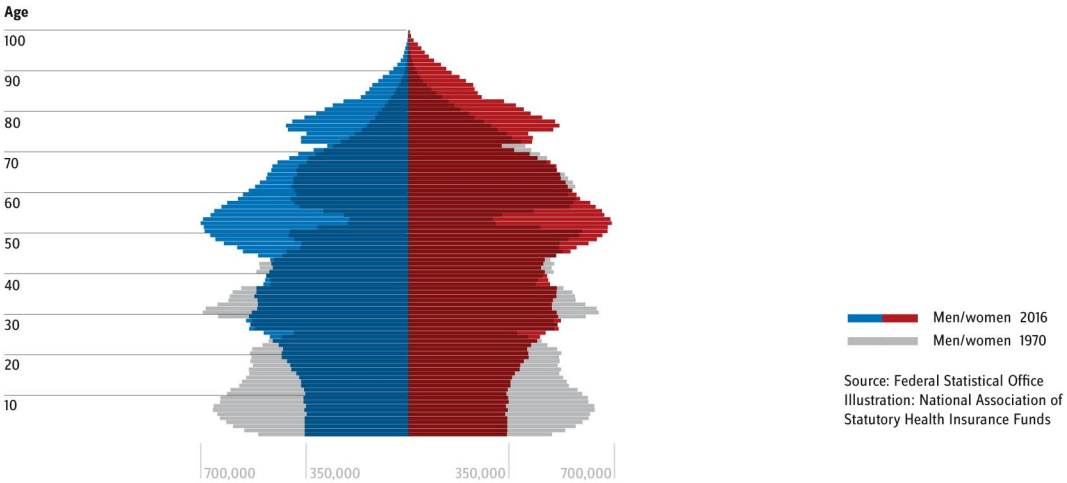
Major requirements enforced

On this basis, tripartite negotiations have been carried out since 2013 in order to conclude a first agreement on Geriatric Out-Patient Clinics (Geriatrische Institutsambulanzen – GIA). Given that it was not possible to reach a consensus on all the items contained in the Agreement, it was ultimately necessary for the Federal Arbitration Office to decide. Major positions of the National Association of Statutory Health Insurance Funds were taken into account in the negotiations and in the determination of the Agreement on Geriatric Out-Patient Clinics in July 2015:

- close interlinking of the treatment of out-patient geriatric patients by general practitioners in private practice and in Clinics
- clear-cut requirements as to qualifications and conditions for empowerment
- focussing the scope of treatment on the planning of specialist geriatric diagnostics and treatment
- first use of the lifelong doctor's identification number in out-patient clinics.

The Agreement on Geriatric Out-Patient Clinics came into force as per 1 October 2015. The National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians need to create a remuneration arrangement in the Standard Schedule of Fees (Einheitlicher Bewertungsmaßstab – EBM) in the assessment committee by 31 March 2016.

Fig. 7
Age pyramid 1970 vs. 2016



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

Accountability in quality assurance

A major concern of the National Association of Statutory Health Insurance Funds within the hospital structural reform is to make quality assurance activities more accountable. This applies not only to the new tools which the Federal Joint Committee needs to establish in the years to come, but also to existing procedures such as hospitals' quality reports. These transparently describe the facilities' range of medical and long-term care as well as technical services, and the quality results established within external quality assurance at hospital and location level, hence constituting a major element of external quality assurance. Patients and their referring physicians can use online portals of the health insurance funds to access the data in a structured form and take an informed decision regarding the place in which planned treatment is to take place.

A greater degree of liability

The introduction of a phased sanctioning arrangement in 2013 defined for the first time consequences for hospitals which have not yet delivered their quality report, or not in full. This has launched a procedure which has developed over a period of ten years: Deadlines and contents became binding in a completely new way; the question as to the hospital under an obligation to report and its location became an essential issue.

The first phase of the sanctioning arrangement was to be implemented in 2015: the drafting and publication of a list of hospitals which had not complied with their obligation to report for 2013. This however was at risk of failure because of the lack of a legal definition of the term "location" – the precondition for a list that would be binding nationwide.

No list of hospital locations

At the initiative of the National Association of Statutory Health Insurance Funds, a two-phase procedure was established in the Federal Joint Committee in order to compile a list of locations and thus ascertain which locations have not submitted quality reports.

The respective decision on an obligation to report is based on hospital planning in the Länder and on assessment notices. This was followed by a dialogue with those hospitals which had not adequately complied with their obligation to report. From the point of view of the National Association of Statutory Health Insurance Funds, this is a worthwhile effort in order to achieve the following goals:

- reaching the full number of reports for providing information to insured persons, patients and referring physicians
- legal security for hospitals and their locations with regard to their future obligation to report

This procedure does not resolve the underlying problem, however. There is still a need to bindingly define the term "location", as well as to clearly label the place of performance. This is not only a prerequisite for attributing result data for structure and quality assurance within the Federal Joint Committee's quality assurance procedure, but it is also decisive for topics such as the reachability, assurance and use of the funds available within the Structural Fund which are established in the Hospital Structure Act.

The hospitals' quality report constitutes a major element of external quality assurance.

Advancing need-based healthcare

It remains questionable whether the additional expenditure which will be caused by the Statutory Health Insurance Care Improvement Act in the years to come will be compensated for by a corresponding benefit for the insured persons.

The Statutory Health Insurance Care Improvement Act came into force in July 2015, and was one of 2015's central legislative projects in health policy. Moreover, a large number of individual provisions were implemented through this Act which had been agreed on in the consensus process in the coalition negotiations.

The Statutory Health Insurance Care Improvement Act is to ensure a high level of medical care for patients that is in line with their needs, provides nationwide coverage and can be accessed easily. This is also in line with the demands that statutory health insurance has been making for years. It is particularly welcome that the legislature has lent concrete form to the service guarantee of the Associations of Statutory Health Insurance Physicians. The obligation to set up appointment service points makes it clear that the guarantee also extends to making specialist care available quickly. When it comes to the appointment of replacements in medical surgeries in oversupplied regions, the Association of Statutory Health Insurance Physicians "is to" buy up the medical surgery (no longer an option). This is presumably an indication to the Associations of Statutory Health Insurance Physicians to make better use of the available tools for the management of care. Having said that, the provision was watered down in response to pressure from the medical profession shortly before the conclusion of the parliamentary procedure: The optional arrangement with a level of care of 110 % has been initially retained. The mandatory arrangement which was provided for in the original draft Bill from this level of care was increased to a threshold of 140 %.

No unambiguous connection with care recognisable

The National Association of Statutory Health Insurance Funds considers some of the provisions not to have been worded consistently enough. For instance, the arrangement whereby medical surgeries are to be mandatorily bought up is likely to remain a paper tiger because of the many exceptions and of the prerequisite of a majority of votes in the Registration Committee, on which there is equal representation. The law on registration is hence virtually unchanged, and the possibilities available to manage healthcare remain limited. Added to this is exaggerated expectations as to the possibilities to manage in terms of needs planning. Ever more detailed, smaller-scale planning cannot create greater needs-based justice – in fact quite the contrary, the risk of unintended effects, such as exacerbating distribution problems, is increased. It is in fact more likely that a registration could be facilitated in previously oversupplied planning districts if areas were to be revealed there which provide a poorer level of care.

A structured care concept is missing with regard to other provisions. For instance, hospitals are to be opened up more for out-patient care. However, the problems which currently exist at the contact points have not been resolved. There is still no uniform regulatory framework, so that this field constitutes largely uncontrolled "add-on care" with various overlaps. Merely distinguishing between cases of out-patient specialist care in accordance with section 116b of Book V of the Social Code and cases in University out-patient clinics in accordance with the new section 117 of Book V of the Social Code appears to be virtually impossible in practice. This means that the phenomenon of the dual provision of services by specialist physicians is not reduced, but in fact expanded.

A concrete connection with care is also lacking from the arrangement for convergence in physicians' remuneration. The intention to increase the below-average total remuneration in individual Länder to an average national mean disregards the fact that existing differences in remuneration are the result of considerable regional structural divergences. The latter cannot be eliminated by increasing total remuneration. The Statutory Health Insurance Care Improvement Act hence causes up to 500 million Euro in additional expenditure per year in terms of increased remuneration for physicians without this being accompanied by an improvement in healthcare for insured persons.


#thinking_ahead
Statutory Health Insurance Care Improvement Act

Contradictory signals for the future of the health system

There are contradictory signals for determining the future of the health system. On the one hand, self-government is weakened and the State given greater opportunities for encroachment, whilst on the other hand the tasks of the self-government bodies are expanded, and "falls from grace" under regulatory policy cannot be overlooked. Particular significance in this context attaches to the expansion of the responsibilities of the Federal Joint Committee. Through the Innovation Committee, the Federal Joint Committee acts for the first time as a decision-maker regarding specific selective contractual services which have a direct financial impact on the health insurance funds. What is more, representatives of government are directly involved in the decision-making process for the first time.

It remains questionable in the final analysis whether the additional expenditure which is to be caused by the Statutory Health Insurance Care Improvement Act in the coming years will be compensated for by a corresponding benefit for insured persons. We are also awaiting an answer to the question of how the contact area between out-patient and in-patient care can be refined and the problems at the sectoral limits resolved. It will also be shown how well the self-government bodies will manage to design future care structures in the collective agreement, and what impetus is created from competitive approaches.

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The core concerns of the Statutory Health Insurance Care Improvement Act

- rapid adjustment of the Standard Schedule of Fees for medical services if the Federal Joint Committee has recognised new services
- arrangement on convergence to reduce ill-founded disadvantages in total remuneration (but no reduction in ill-founded advantages in the amount of the regional remuneration)
- inclusion of University out-patient clinics in out-patient care (with serious and complex diseases)
- establishment of medical care centres: the possibility to involve local authorities in co-founding and funding, medical care centres consisting of members of the same group of physicians permitted as an option
- change to the arrangements for the appointment of replacements in medical surgeries, verification of care-policy necessity by Registration Committees
- increasing the posts for further training for general practitioners that are to be promoted from 5,000 to 7,500, a further 1,000 posts for specialist physicians providing universal service
- mandatory establishment of appointment service points by Associations of Statutory Health Insurance Physicians, arranging specialist physician appointments within four weeks
- revision of the Psychotherapy Guideline: expansion of benefits, including establishing a general consultation
- refining the needs planning by the Federal Joint Committee: revising the size of the planning areas
- empowering treatment centres for adults with a mental disability or with serious multiple disabilities
- entitlement to a second-opinion procedure with certain procedures (elective operations)
- establishment of an Innovation Fund
- benefit evaluation of high-risk medical devices
- health and long-term care insurance funds foregoing claims vis-à-vis self-employed mid-wives

Re-thinking physicians' remuneration arrangements

The negotiations at federal level for registered contract doctors' remuneration for 2016 between the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Funds were completed with the decision reached in the expanded assessment committee to increase the orientation value by 1.6 % as per 1 January 2016. This result falls far short of what was demanded by the National Association of Statutory Health Insurance Physicians, and hence constitutes a justifiable compromise. Moreover, the assessment committee has submitted recommendations on the diagnosis-related and demographic change rates of the morbidity-related demand for treatment. These form the basis on which it is decided at Land level what the annual change in the morbidity structures is. Whilst the demographic change rates now only average approx. 0.2 %, unstable, inexplicable results were observed in recent years involving considerable fluctuations of up to two percentage points in the diagnosis-related change rates. Against this background, the morbidity-related change in the demand for out-patient treatment should only be measured by reliable, non-influenceable demographic factors. It is possible to do without the legally-stipulated inclusion of a morbidity measurement that is based on self-documented diagnoses made by physicians. The National Association of Statutory Health Insurance Funds was furthermore able to avert in the assessment committee the removal of further benefits from the budgeted total remuneration that had been asked for by the National Association of Statutory Health Insurance Physicians, and the additional expenditure which that would have entailed.

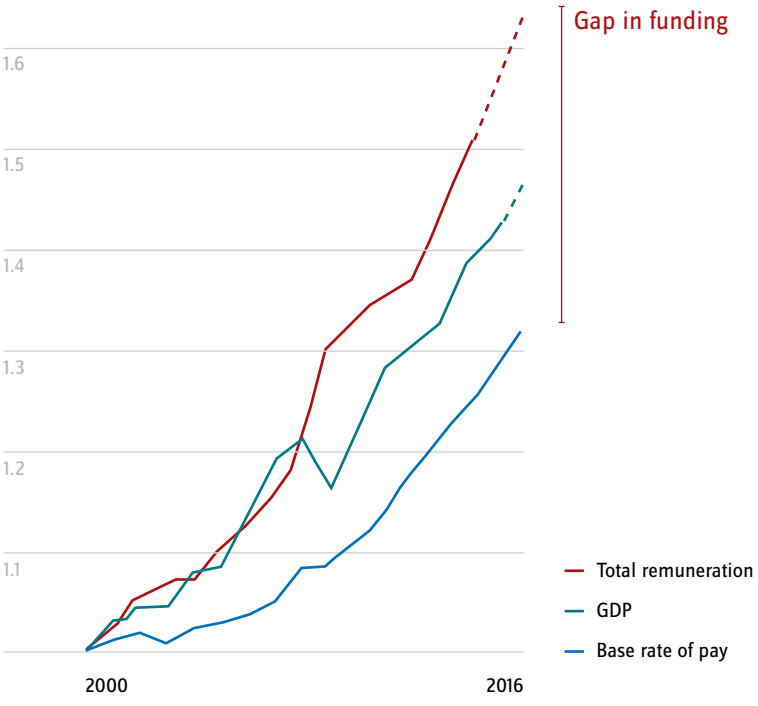
Changes in the remuneration system needed

The round of negotiations on fees at federal level for 2016, including the anticipated increase in volume and the additional expenditure for the adjustment of the psychotherapeutic remuneration, will lead to an increase of about 1.35 billion Euro, or 3.8 %, in the health insurance funds' expenditure on medical services. Added to this is the additional expenditure caused by the implementation of coming legislative projects, as well as as a result of the negotiations at Land level on the overall contract. The dynamics in expenditure on physicians' remuneration which have been observed since 2013, which are actually ahead of the extremely healthy development in the basic wage, lead all in all to a widening gap in funding which runs to billions. Against this background, there is a need to make fundamental changes in the statutory remuneration arrangements. Expenditure-driving arrangements which have no significance in terms of care policy should be abolished, and the physicians' remuneration system should be simplified.

The dynamics in expenditure on physicians' remuneration which have been observed since 2013 lead all in all to a widening gap in funding which runs to billions.

Fig. 8
Comparison of developments in the total remuneration of registered contract doctors, of gross domestic product (not adjusted for price) and of the statutory health insurance base rate of pay

Figures 2000 = index 1.0 (indexing); incl. selective contract income; estimate of total remuneration in 2015 and 2016



Source and illustration: National Association of Statutory Health Insurance Funds

Continuing to suitably remunerate psychotherapy

The evaluations of psychotherapeutic benefits are to be established in line with the statutory stipulations in such a way that a suitable remuneration per unit of time is guaranteed. The expanded assessment committee decided in December 2013 to review the payment of psychotherapeutic benefits. The analyses and calculations needed for this review were carried out by the institute of the assessment committee.

After several months of intensive consultations between the funds and the National Association of Statutory Health Insurance Physicians, the expanded assessment committee unanimously resolved in September 2015 to increase the evaluations of the benefits that are subject to application and approval by 2.7 %, and this retroactively to 1 January 2012. Moreover, all medical and psychological psychotherapists receive a structural supplement linked to the remuneration of an hour of therapy if their workload – related to the individual scope of activity according to the registration or approval notice – was higher than 50 % in the respective quarter. The additional expenditure resulting from this resolution of the expanded assessment committee is approx. 80 million Euro per year. This corresponds to a 5.5 % increase in remuneration for psychotherapeutic benefits which are subject to application and approval. A subsequent remuneration claim for psychotherapists only exists if they have filed an objection against their fee notice and the impugned fee notices have not yet become final.

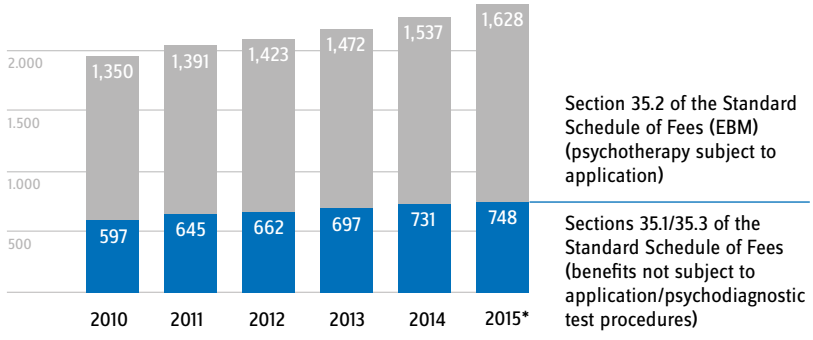
Psychotherapeutic benefits that are subject to application and approval formed a component of the morbidity-related total remuneration in 2012. This leads to an obligation incumbent on the Associations of Statutory Health Insurance Physicians to pay the subsequent remunerations from 2012 resulting from this resolution. Benefits subject to application and approval were transferred from morbidity-related total remuneration as per 1 January 2013 into extrabudgetary remuneration, so that this may lead to an obligation for the health insurance funds to assume the subsequent remuneration for 2013 to 2015.

Reduction in the burden of the health insurance funds and suitable remuneration

The National Association of Statutory Health Insurance Funds was able to see to it in the negotiations that the financial burdens for the health insurance funds resulting from this resolution have been permanently reduced: The morbidity-related total remuneration was reduced affecting the basis in order to compensate for the higher evaluations which are to be financed outside the budget from 2016 onwards. There will moreover be a further reduction in the morbidity-related total remuneration in the period from 2016 to 2018. This additional reduction in burdens serves to compensate for the additional expenditure likely to be incurred by the health insurance funds for 2013 to 2015 in the shape of subsequent remuneration.

The psychotherapeutic remuneration has been increased several times in the past six years. The current resolution of the expanded assessment committee ensures that the evaluations of the psychotherapeutic benefits are suitable, considering the statutory stipulations and the case-law of the Federal Social Court. The ongoing criticism of psychotherapists as to the amount of the remuneration is hence not appropriate.

Fig. 9
Development in expenditure on psychotherapy
without subsequent remuneration; figures in million Euro



*Extrapolation on the basis of the 1st half of 2015
Source and illustration: National Association of Statutory Health Insurance Funds

Ensuring quality in home births

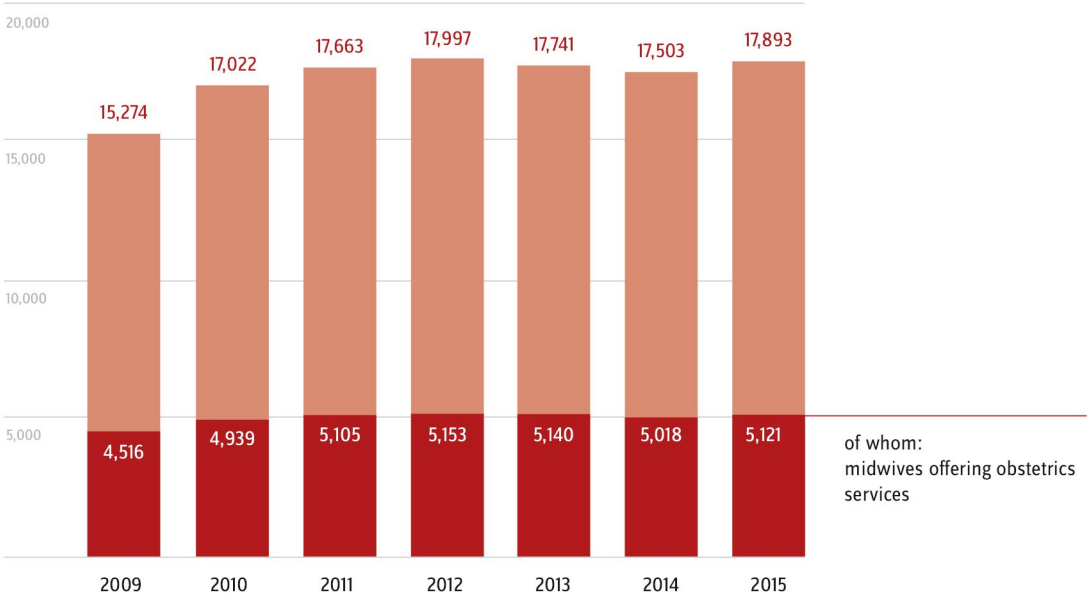
The legislature has created a large number of new provisions in recent years in order to improve the care provided by midwives. It obliged the contracting partners at federal level – the midwives' associations and the National Association of Statutory Health Insurance Funds – to agree by the end of 2014 amongst other things on specific minimum requirements as to the quality of midwifery. This included a five-percent increase in all remuneration items. In addition, the contracting partners were called on to agree contractual regulations for the disbursement of a "guarantee supplement" for midwives working in obstetrics by the summer of 2015. This is to compensate for the high annual cost of professional liability insurance in obstetrics – more than Euro 6,200 for the vast majority of midwives since 1 July 2015. The National Association of Statutory Health Insurance Funds called on the arbitration tribunal in June 2015 because it was not possible to reach an agreement on either point with the midwives' associations.

Exclusion criteria for home births decided on

The contracting partners had previously managed to agree on almost all quality assurance-related measures for the structure, process and result quality which the law requires. The midwives' associations were however unwilling to agree to the exclusion criteria for home births which the funds considered to be indispensable, similar to those which have been applicable to births in birth centres since 2008. The arbitration tribunal then decided in September 2015 to approximate this quality measure for all non-clinical births, so that the five-percent increase in remuneration applies from this time onwards. Only if the calculated due date was exceeded were the applicable exclusion criteria slightly derogated from in the birth centres.

The regulations mean greater safety for expectant mothers who opt for a home birth. Binding quality criteria apply for the first time to home births too.

Fig. 10
No. of self-employed midwives



Source: List of contracting midwives, version, as per October of each year
Illustration: National Association of Statutory Health Insurance Funds

The regulations mean greater safety for expectant mothers who opt for a home birth. Binding quality criteria apply for the first time to home births too. These serve to protect mother and child. An absolute exclusion criterion is for instance blood group incompatibility. If relative exclusion criteria apply, such as coagulation disorders, an additional medical examination is necessary in order to be able to carry out the birth at home.

It has been possible since 1 July 2015 for each midwife working in obstetrics to apply twice per year to have her actual liability insurance costs disbursed.

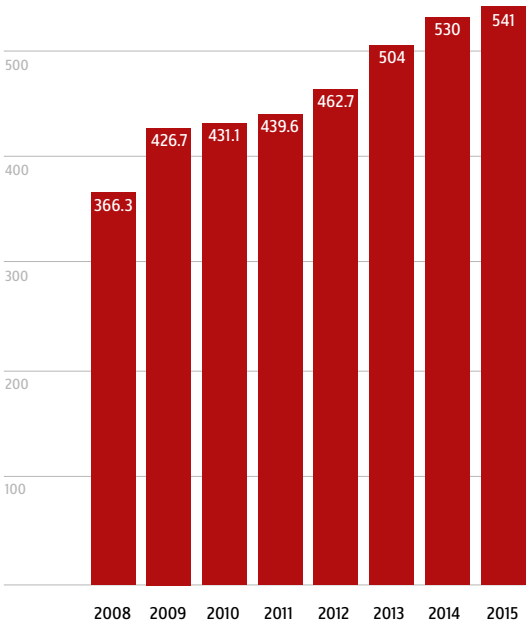
Fair compensation for liability for all midwives

In September 2015, the arbitration tribunal defined both the arrangements and the calculation formula for the guarantee supplement for cost increases in the professional liability insurance of midwives working in obstetrics. This makes obsolete the excess payments which were previously granted via flat-rate liability supplements to the items of the obstetrics fee. This arrangement constituted an advantage to midwives who were able to supervise large amounts of births. It has now been possible since 1 July 2015 for each midwife working in obstetrics to apply twice per year to the National Association of Statutory Health Insurance Funds to have her actual liability insurance costs disbursed. This is contingent on her having provided at least one obstetric service per quarter, or four per insurance year, and on liability costs being documented. The liability costs that are to be compensated for are however still to be reduced by certain cost components (including a share for private liability insurance policies).

Further new developments in the law and outlook

The July 2015 Disease Prevention Act increased insured persons' entitlement to childbed care from eight to up to twelve weeks after birth. The legislature is thus pursuing the goal of making the uptake of this benefit more flexible in terms of time for insured persons. The total number of possible care services in childbed care that have been contractually agreed between the contracting partners remains unchanged in other respects.

Fig. 11
Expenditure on midwifery services
in million Euro



Source: Official statistics KJ1; 2015: KV45 Q1-Q4
Illustration: National Association of Statutory Health Insurance Funds

Expanding out-patient specialist care

A new care sector was created with the out-patient specialist care that was introduced in 2012 within the Statutory Health Insurance Care Structure Act (GKV-VStG). Since then, it has been possible in this sector for both registered contract specialist physicians and hospitals to provide services for defined diseases under conditions that were as similar as possible.

The negotiations in the Federal Joint Committee and in the expanded assessment committee for the design of the new sector are extremely complex, particularly given that the first reform has already taken place in the shape of the Statutory Health Insurance Care Improvement Act. The restriction of the disease spectrum for oncological and rheumatological diseases has been relaxed. Instead of "severe progression", it now says "special progression". This new definition of the access criteria will enable more patients to receive out-patient specialist care in future.

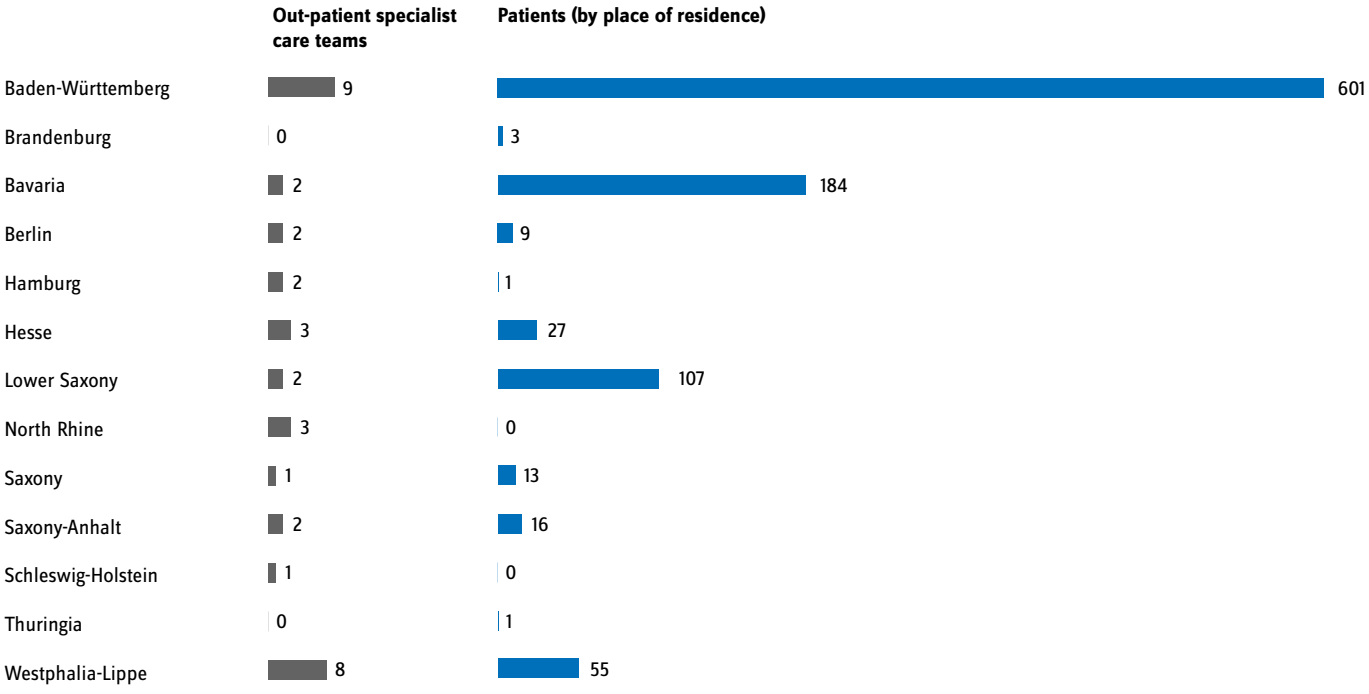
Out-patient specialist care services expanded

In December 2015, the Federal Joint Committee adopted a number of changes on the basis of the changes to the law. The Framework Guideline on Out-patient Specialist Care, as well as the disease-specific formalisation regarding gastrointestinal tumours and tumours of the abdominal cavity and on Marfan syndrome, were revised. An amending resolution for the formalisation of tuberculosis has been largely prepared. The formalisation for pulmonary hypertension was adopted for the first time. This now enables patients in five therapeutic areas to receive out-patient specialist care.

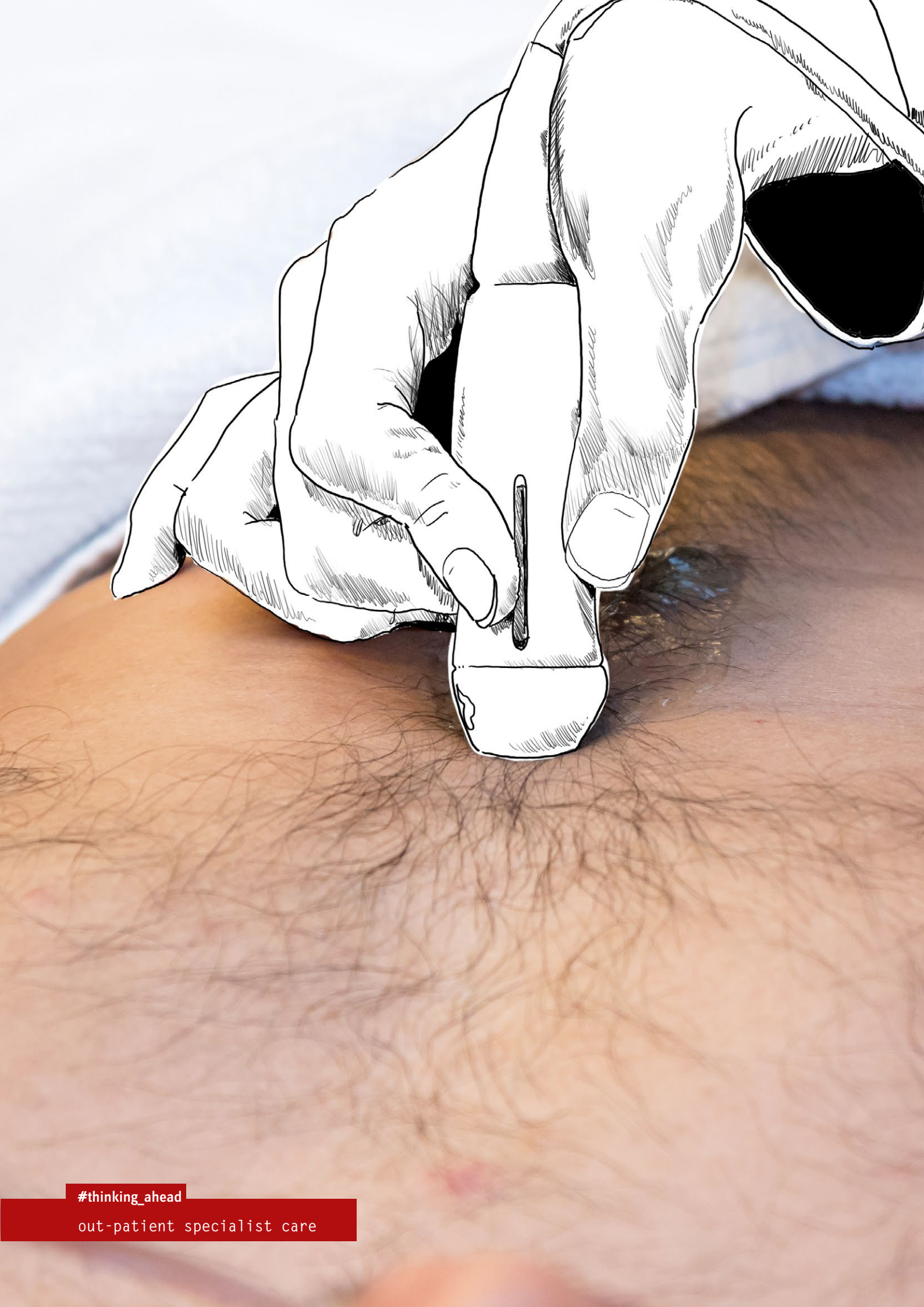
The new definition of the access criteria for out-patient specialist care enables more patients to participate in future.

The Federal Joint Committee was also obliged by the reform Bill to evaluate the resolutions which it had adopted within out-patient specialist care at

Fig. 12
Correction of out-patient specialist care



as per: December 2015
Illustration: National Association of Statutory Health Insurance Funds



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out-patient specialist care

the latest two years after the respective indication-specific annex came into force as to quality, uptake and economic efficiency. The Federal Joint Committee has to inform the Federal Ministry of Health of the results.

Correction of the total remuneration of registered contract doctors

The legislature has provided that the morbidity-related total remuneration payable with discharging effect by the health insurance funds to the Associations of Statutory Health Insurance Physicians for the care of insured persons should be adjusted to accommodate the benefits which form part of out-patient specialist care. The structure of the stipulations for implementation by the regional partners to the overall contract was transferred to the physicians' assessment committee. It has been established for all parties involved in implementation what tasks are to be carried out by whom and by when: The assessment committee defines a flat-rate correction amount per out-patient specialist care patient, for each out-patient specialist care indication according to appropriate calculations made by its institute. The regional partners to the overall contract within the district of an Association of Statutory Health Insurance Physicians establish the specific correction amount by multiplying this value by the number of out-patient specialist care patients. The main methodical work is hence to be carried out at federal level, thus minimising the effort for implementation at regional level.

Stipulation of flat-rate correction amounts

In order to ascertain a flat-rate correction amount, it is verified which benefits that are taken up from registered contract doctors by insured persons could also have been cared for with the appropriate indication within out-patient specialist care. The assessment committee carries out deductions here for benefits which continue to be provided by registered contract doctors for out-patient specialist care patients because of multiple morbidity or of multiple uptake. The flat-rate correction amounts are established by the assessment committee, once per district of the Association of Statutory Health Insurance Physicians and indication, and are only indexed by the partners to the overall contract. This was completed subsequent to intensive deliberations on methodical calculation details, and has been carried out so far for the indications tuberculosis, gastrointestinal tumours and Marfan syndrome.

Because of the restriction of out-patient specialist care to severe progressions being rescinded by the Statutory Health Insurance Care Improvement Act with oncological and rheumatological diseases, the assessment committee once examines the flat-rates that have been decided for the indication of gastrointestinal tumours for their need of correction. Over and above this, a data-based examination of the supra-indicational correction stipulations from 2016 was agreed. From the point of view of the National Association of Statutory Health Insurance Funds, the benefit volumes that are invoiced in out-patient specialist care and the correction amounts should also be comparatively examined here.

The assessment committee sets for each out-patient specialist care indication a flat-rate correction amount per out-patient patient in specialist care.

Ascertaining the number of out-patient specialist care patients

The number of out-patient specialist care patients is transmitted on a quarterly basis by the health insurance funds to the Associations of Statutory Health Insurance Physicians. It is permanently reduced by the number of patients who are already being treated in the hospital on an out-patient basis under the old law and receiving highly-specialised services, in order not to subsequently correct the historic volume of patients of this care sector. Moreover, a limitation to the number of patients being treated by registered contract doctors in the respective quarter of the previous year with a corresponding indication is carried out, leaving the volume risk with the health insurance funds.

The actual correction is carried out, starting after the first calculation of corresponding out-patient

specialist care services for a period of currently three years, and is to be permanently frozen at the correction level reached at that time, affecting the basis. So far, the correction was included in the first Association of Statutory Health Insurance Physicians districts for the indications tuberculosis and gastrointestinal tumours with the second and third quarters of 2015.

The National Association of Statutory Health Insurance Funds considers that the benefit volumes invoiced in out-patient specialist care and the correction amounts should be examined and compared with one another.

Development in care reality and outlook

32 teams of doctors were providing out-patient specialist care at the end of 2015 all over Germany exclusively carrying out treatment of gastrointestinal tumours, tumours of the abdominal cavity and tuberculosis. A relevant cause of the rather hesitant development of the new form of care is that many hospitals, as potential healthcare providers of out-patient specialist care, continue to take part in care in accordance with the old version of section 116b (out-patient treatment in hospital).

The protection of vested rights for hospitals which may already provide highly-specialised out-patient services under the old law has been extended from two years to three by the Statutory Health Insurance Care Improvement Act. This is likely to once more clearly increase the number of out-patient specialist care patients from the third year to the fourth. The National Association of Statutory Health Insurance Funds considers that the correction period must hence be extended to at least four years.

Refining the principle of the Act on the Reform of the Market for Medicinal Products

The Act on the Reform of the Market for Medicinal Products has become established as an instrument that is successful so far. In the long term, it can guarantee patient benefit-orientated care quality and a suitable price level. Not lastly, the constantly-increasing number of refund amounts that have been agreed so far, as well as the high agreement rate, show that the procedure works and is accepted. The Federal Joint Committee initiated 208 sets of proceedings between 1 January 2011 and 31 December 2015 for the early benefit evaluation of medicinal products from the new and established markets, and carried out more than 538 sets of advisory proceedings.

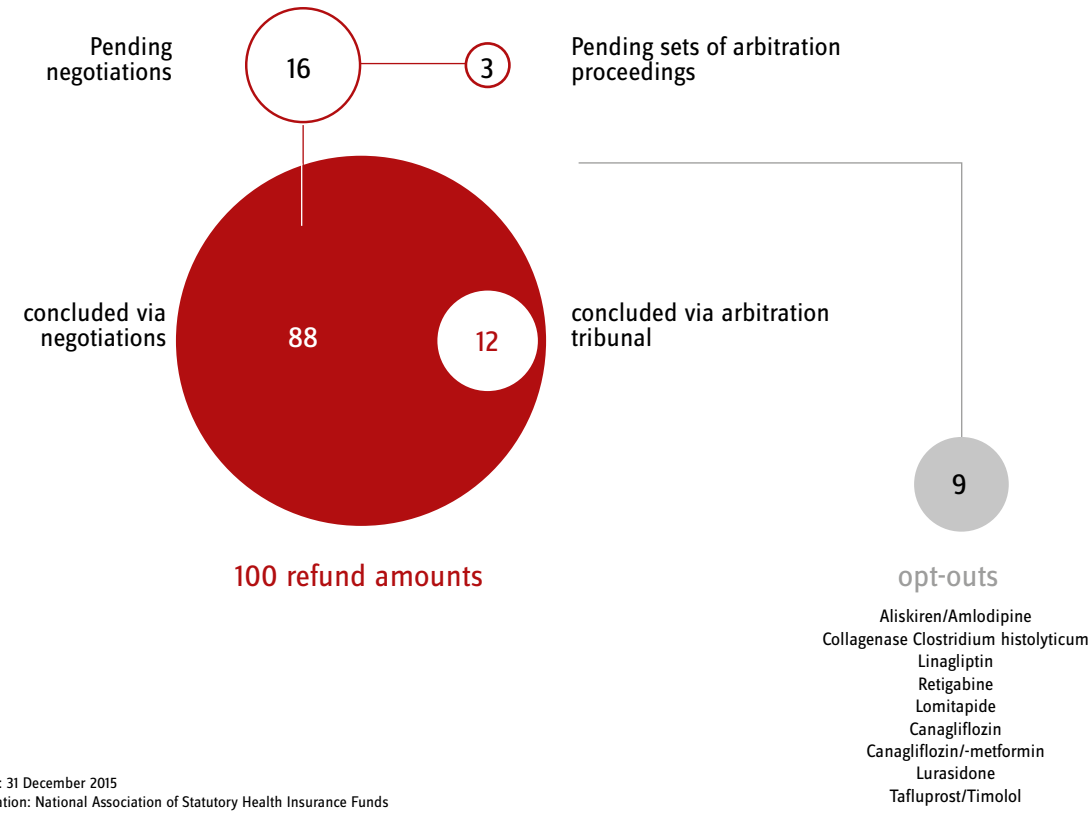
The entry into force of the 14th Act Amending Book V of the Social Code made it possible to involve health insurance funds in the negotiations on refund amounts. Each health insurance fund which has opted to participate has been actively included in the negotiations since January 2015. 28 health insurance funds have stated their fundamental desire to take part in the first phase of participation.

Long-term financial viability

The National Association of Statutory Health Insurance Funds considers it to be necessary for reasons of financial stability and quality to consistently refine the principle of the Act on the Reform of the Market for Medicinal Products as to the procedures for the benefit evaluation, as well as the negotiations for the refund amounts.

The in some cases completely excessive prices for medicinal products in the first year after being

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



as per: 31 December 2015
Illustration: National Association of Statutory Health Insurance Funds

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placed onto the market make it clear that it is necessary to apply the refund amount retroactively to the first date on which a product was placed onto the market. This is how unsuitable prices which are charged by individual enterprises within the one-year period without price fixing can be effectively prevented. Financial stability and the protection of contributors against further increases in burdens furthermore require the regulatory instruments constituted by the manufacturer's discount and the price moratorium to be maintained. Both instruments make a major contribution towards ensuring the long-term financial viability of a high-quality supply of medicinal products in the face of increasing expenditure on medicinal products.

The financial stability and the protection of contributors against a further increasing burden require the regulatory instruments manufacturer's discount and price moratorium to be maintained.

Patient benefit as the standard

The National Association of Statutory Health Insurance Funds is still of the view that, from the patient perspective, a benefit evaluation of established market medicinal products is needed, followed by negotiations on refund amounts. Moreover, the patient-relevant benefit resulting from the care must be portrayed even more effectively than was previously the case: Refund eligibility must be adjusted in line with the results of the benefit evaluation. This means that the refund by the health insurance funds, as everywhere in Europe, is focussed on certain intrinsic sub-indications. Higher costs which do not entail increased benefit can thus be avoided and the care quality enhanced. The state of knowledge of new medicinal products which has been reached in real patient care, as well as in other research-based studies, must also be portrayed as standard in a benefit evaluation. Particularly against the background of reduced documentation requirements for registration, patients with rare diseases still need to be able to rely on good treatment. The high quality and safety of their drug therapies must be guaranteed. The worrying conclusion reached in the benefit evaluations which have been carried out to date for orphan drugs is however that, at the time of the early benefit evaluation, a very weak data situation can be found to exist with regard to benefits and risks. In the view of the National Association of Statutory Health Insurance Funds, the irrefutable additional benefit fiction even with contrary indications is not an adequate means for ensuring care quality with orphan drugs: An extensive evaluation also of orphan drugs is necessary for the benefit of the patients.

Patients with rare diseases must also be able to rely on good treatment.

Positioning in the pharmaceuticals dialogue

The pharmaceuticals dialogue with the medicinal product manufacturers in Germany for which the Federal Government provided in the Coalition Agreement commenced on 15 September 2014. Following the meetings which took place in January, June and October 2015, the dialogue is to be concluded in the spring of 2016. The goal of the interdepartmental dialogue within the remit of the Federal Ministry of Health, as well as of the Federal Ministry of Education and Research and of the Federal Ministry for Economic Affairs and Energy, is to strengthen Germany as a pharmaceuticals location in the areas of research, development and production. Thus, a universal, high-quality, safe supply of medicinal products is to continue to be guaranteed in Germany. Representatives of the Federal Government, from Academia, industry, trade unions and associations, as well as from the remit of the participating Ministries, are taking part in the pharmaceuticals dialogue. The second meeting took place on 3 June 2015, and was specifically devoted to the topic of regulating the medicinal products market. The National Association of Statutory Health Insurance Funds was also invited to attend. It presented the success story of the Act on the Reform of the Market for Medicinal Products, and called for it to be developed further.

Comparing the supply of medicinal products in Europe

The study entitled "Arzneimittelversorgung in der GKV und 15 anderen europäischen Gesundheitssystemen" (Supply of medicinal products in statutory health insurance and 15 other European health systems) by Prof. Dr. Reinhard Busse, Dimitra Panteli and Cornelia Henschke, which had been commissioned by the National Association of Statutory Health Insurance Funds, was published in June 2015. The study examines which mechanisms and regulatory activities characterised the supply of medicinal products in the countries which were studied. The study makes a major contribution towards facilitating an objective discussion of the supply of medicinal products in German statutory health insurance in comparison with other European countries.

The study shows that the co-payments made by patients in statutory health insurance are at a low level in a European comparison.

A major realisation ensuing from the analysis is that patients in Germany have both the fastest and the most extensive access to medicinal products. This is related amongst other things to the fact that, in the statutory health insurance system, refund eligibility exists for virtually all new medicinal products which are placed on the market and for all registered indications. Germany is quite distinct from other European countries in this regard. What is more, other countries generally restrict the use of new medicinal products to those application fields where a particularly intrinsic value exists for the patients. The authors of the study further established that the co-payments made by patients in statutory health insurance are at a low level in a European comparison.

Fig. 14
European study on medicinal products
Countries studied

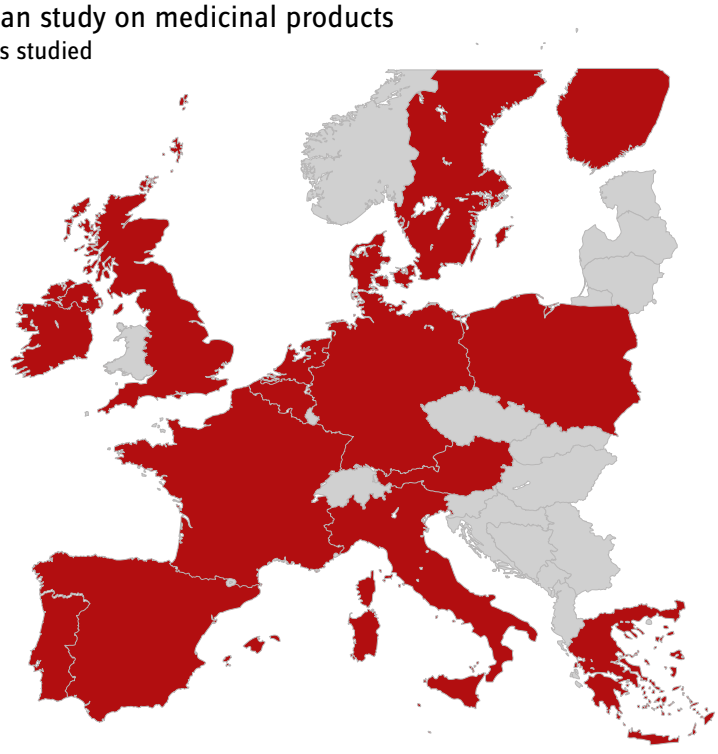


Illustration: National Association of Statutory Health Insurance Funds

Medicine prices in a European comparison

Because the prices of medicinal products still remain above average, and due to the high level of sales of new preparations, most of which are sold at a high price point, the level of expenditure in Germany continues to be much higher than the European average. In order to also anchor the much discussed "value for money" principle in Germany, the study presents a model of differentiating refund eligibility in order to facilitate more targeted benefit management with regard to new medicinal products.

The authors go on to state that the fundamental precondition is already met today for such a change as a result of the benefit evaluation which is carried out at the level of sub-groups. The Federal Joint Committee's resolution on benefit presents the additional benefit ensuing from a medicinal product, stratified by various groups of indications. This can also serve as a foundation for a benefit-orientated refund as it is called for by the National Association of Statutory Health Insurance Funds. The principle of the uniform refund amount is to be upheld here. Such an approach ensures that the supply of medicinal products within statutory health insurance remains at a high level of quality. At the same time, a more targeted management of benefits makes care more economical. This is said to enhance the fundamental principle of the Act on the Reform of the Market for Medicinal Products, namely to identify real innovations and to reward them with an additional benefit-based price.

For a clearer regulation of the economic efficiency of the supply of medicinal products

The Statutory Health Insurance Care Improvement Act established two new negotiation mandates for the National Association of Statutory Health Insurance Funds and the associations of the healthcare providers in medicinal products. These relate to the Framework Agreement on the Supply of Medicinal Products, which has been concluded between the National Association of Statutory Health Insurance Funds and the German Pharmacists' Association (DAV), as well as the framework stipulations for the performance audit of physicians' services agreed on between the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians.

Framework Agreement for the Supply of Medicinal Products and Billing

The debate regarding the non-payment of incorrect prescriptions, so that the bill is reduced to zero, brought the topic of prescription bill auditing to the attention of a broader media audience in the autumn of 2011. Policy-makers thereupon called on the National Association of Statutory Health Insurance Funds and the German Pharmacists' Association to reach an amicable solution regarding prescription bill auditing activities in the Framework Agreement. The negotiations which were commenced in May 2012 did not lead to the desired result, however.

Within the Statutory Health Insurance Care Improvement Act, the legislature has now mandated the contracting partners to regulate "in what cases of a complaint regarding billing by the health insurance funds, especially with regard to formal errors, prescription bill auditing is completely or partly foregone". Both the current case-law and aspects of the safety of drug therapies should be taken into

Fig. 15
Performance audit of medically-prescribed benefits in accordance with section 106b of Book V of the Social Code

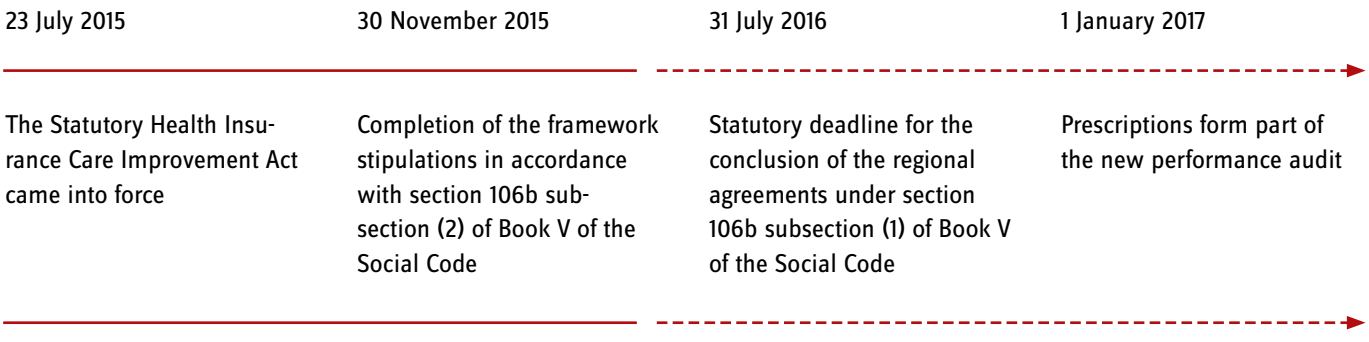


Illustration: National Association of Statutory Health Insurance Funds

Policy-makers called on the National Association of Statutory Health Insurance Funds and the German Pharmacists' Association to reach an amicable solution on prescription bill auditing activities in the Framework Agreement.

account here. The stipulations contained in the Framework Agreement are furthermore to avoid misincentives, and should not permit disproportionate administrative effort to arise for the health insurance funds. Since the contracting partners were unable to agree on an arrangement by the beginning of 2016, it is now up to the arbitration tribunal to carry out the corresponding adjustments to the Framework Agreement.

Uniform rules for the performance audit

The performance audit of prescriptions for medicinal products and remedies was previously conclusively regulated in the law in section 106 of Book V of the Social Code. In the past, any audits of the economic efficiency of prescriptions for medicinal products and remedies has generally had to be carried out by auditing guideline sizes. The Coalition partners agreed in their December 2013 Coalition Agreement to transfer the stipulations for the implementation of performance audits, which previously had been regulated uniformly nationwide, in their previous form into regional agreements from 2017 onwards. With the statutory reform in accordance with the Statutory Health Insurance Care Improvement Act, the regional contracting partners will be free in future when it comes to selecting the type of audit. The performance audit is combined in a newly-created section 106b for all prescribed services. To this end, according to the reasoning of the Act, as well as prescribing medicinal products and remedies, especially also medical rehabilitation benefits, prescriptions of medical aids, patient transport, as well as hospital treatment or treatment in disease prevention or rehabilitation facilities, domestic nursing care and socio-therapy should belong here.

Inadequate conditions imposed by the legislature for the content of the framework stipulations made it more difficult for the contracting partners to agree on the detailed content of the Agreement.

Framework stipulations need to be agreed at federal level between the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians in order to define uniform rules on the range which these audits are to encompass. The National Association of Statutory Health Insurance Funds already pointed out in its statements on the Statutory Health Insurance Care Improvement Act that the legislature's specifications for the content of the framework stipulations had been inadequate. This made it difficult for the contracting partners to reach an agreement on the details of the text of the contract since there was a diverging understanding at federal level as to the subject-matter of the regulation.

Subsequent to intensive negotiations, the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians finally agreed on 30 November 2015 on uniform framework stipulations in accordance with section 106b subsection (2) of Book V of the Social Code on the basis of the draft of the National Association of Statutory Health Insurance Funds. The framework stipulations, which came into force on 1 December 2015, consist of a General Part which applies to all prescribed benefits. The details of the performance audit of prescribed medicinal products, prescribed remedies and benefits going over and above medicinal products and remedies prescribed by physicians, are regulated in three supplementary Annexes.

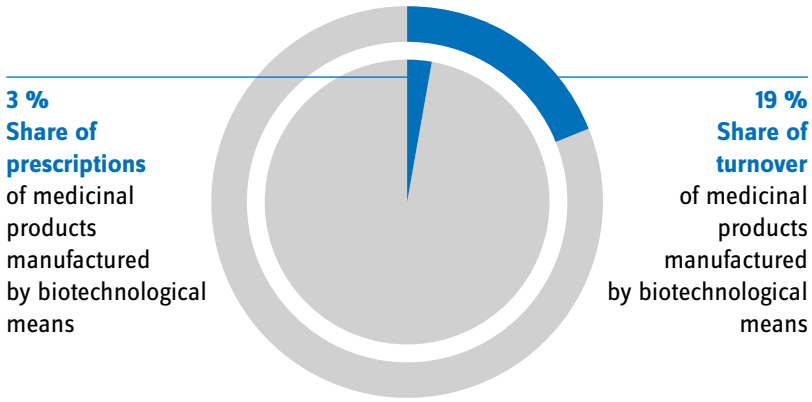
Increasing the market share of biosimilars

The market for medicinal products in Germany is characterised by a large share of generic medicinal products in comparison with other European countries. This avoids uneconomically high expenditure on medicinal products which are no longer patented. The spread of generic preparations results primarily from the existence of a large market share of chemically-synthesised generics.

Generic preparations have so far only played a subordinate role in the segment of biological medicinal products, especially also those manufactured by biotechnological means. Generic biological medicinal products only differ from their reference preparations by virtue of the production process. If the quality, biological activity, safety and effectiveness are the same, they are referred to as biosimilars.

Biological medicinal products are among the medicinal products with the highest turnover that are prescribed at the expense of statutory health insurance. This high expenditure arises less through large volumes, but rather can be particularly traced back to the high price level of these medicinal products. Medicinal products manufactured by biotechnological means accounted for almost 19 % of the total turnover of finished medicinal products in statutory health insurance in 2014, accounting for a turnover of 6.4 billion Euro, whilst their share of prescriptions was only 2.5 %. A large share of these medicinal products is currently still patent protected.

Fig. 16
The economic significance of medicinal products manufactured by biotechnological means



Source: 2015 Arzneiverordnungsreport (report on prescriptions of medicinal products)
Illustration: National Association of Statutory Health Insurance Funds

A low level of competition

The production processes of biological medicinal products are more complex than those of chemically-synthesised medicinal products. The information to be provided for a referential application for the registration of a biosimilar is more extensive than for the registration of a chemically-synthesised generic product. Amongst other things, preclinical and clinical data are required. Because of this, no biological medicinal products are expected to enter the market any time soon. The intensity of competition on the market for medicinal products manufactured by biotechnological means is tending to fall. These estimates are confirmed by the experience to date with the reaction of the market to biosimilars. There is no marked competition between the pharmaceutical companies with regard to the first biosimilars registered in Europe. Unlike with chemically-synthesised active agents, where large numbers of generic products are available for an active agent as a rule, only a small number of biosimilars are being sold at present for biological medicinal products. The market share of biosimilars is smaller than that of most generic medicinal products, as is the price differential between the original preparation and the biosimilar. Since very high-turnover biological medicinal products will also become

Biological medicinal products are among the highest-turnover medicinal products which are prescribed at the expense of statutory health insurance.

The market share of biosimilars is smaller than that of most generic medicinal products, as is the price differential between the original preparation and the biosimilar.

patent free in the years to come, there is a need to create incentives to further develop this segment of the market.

Targetedly creating incentives

The National Association of Statutory Health Insurance Funds has identified several major approaches for such framework conditions:

- The previously unsatisfactory competition in the market segment should be increased by creating incentives for biosimilar suppliers to make them available at lower prices.
- At the same time, incentives should be created for physicians to preferentially prescribe in the segment of biological medicinal products those equally effective, safe medicinal products which are economical.
- A further obstacle on the market is the lack of a possibility for pharmacists to substitute these medicinal products. It can however be anticipated in the medium term that sufficient scientific data will also be available for biosimilars on the safety of such substitutions. It would then have to be possible to use these data in order to expand the obligation to substitute.

The National Association of Statutory Health Insurance Funds will be preparing these areas of activity in a target group-orientated manner, and will draw up specific policy positions.

Transparently presenting prescription content

The statutory health insurance rapid medicinal product information system (GAmSi) has been reporting for more than ten years on current developments in pharmaceutical expenditure in statutory health insurance. Each month, more than 100,000 individual reports are produced for the registered contract doctors in order to provide them with topical, detailed information about their prescriptions of medicinal products. In parallel, reports are provided for the Associations of Statutory Health Insurance Physicians and the federal level on the GAmSi website, and are available there to the interested public. This makes GAmSi an important tool for analysing and managing the supply of medicinal products in the regions. The reports need to constantly do justice to the requirements of a changing medicinal product market, and have appeared in a new design since the year under report 2015.

An orientation towards high-quality, economical care

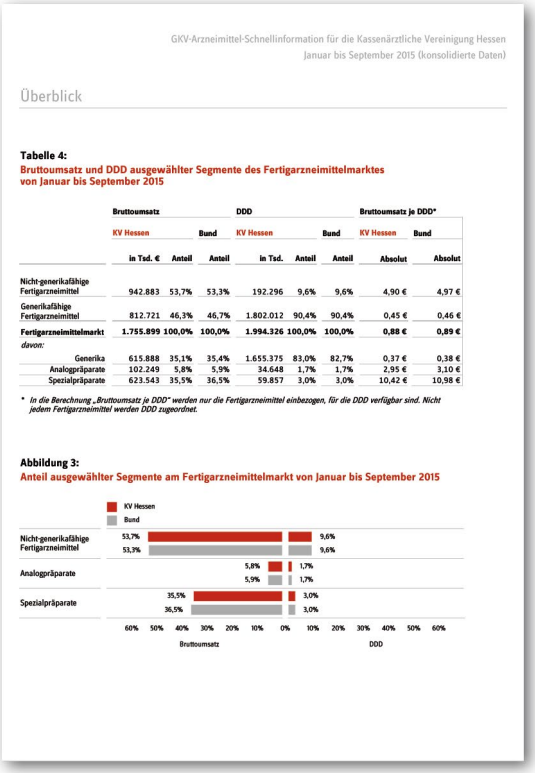
The most noticeable change vis-à-vis the previous version lies in the scope of the new reports: The monthly reports have become more compact, whilst the consolidated quarterly reports have become more detailed. This new structure makes sense because the natural information and billing cycle for services provided by registered contract doctors covers a quarter in each instance. Additionally, a further report format has been published for the federal level since 2015, so that one report offers evaluations at federal level, whilst the other provides regional comparisons. This means that new, cross-sectoral information services provided by GAmSi are available here.

In content terms, the reports have been reformed on the basis of stable benchmarks. The most important reforms are as follows:

- The Anatomical Therapeutic Chemical Classification (ATC) replaces the classification according to the Red List in the indication-related hitlists of the highest-turnover finished medicinal products. Thanks to its hierarchic structure, the ATC classification offers better, more flexible comparisons for active agents and groups of active agents vis-à-vis the Red List.
- Formulations as are used for instance in cancer therapy or with skin diseases are no longer described in aggregated form only, but their active agents are also listed.
- A differentiated description of the vaccines that have been prescribed was included in the reports in order, for instance, to support the implementation of regional inoculation strategies.
- The evaluations at expert group and patient level have been expanded to include important aspects where the GAmSi data enable this.

The GAmSi reports therefore continue to provide a reliable, topical orientation for a high-value and at the same time economical supply of medicinal products in Germany.

Additionally, a further report format for the federal level has been published since 2015.



GKV-Arzneimittel-Schnellinformation für die Kassenärztliche Vereinigung Hessen
Januar bis September 2015 (konsolidierte Daten)

Überblick

Tabelle 4:
Bruttoumsatz und DDD ausgewählter Segmente des Fertigarzneimittelmarktes von Januar bis September 2015

	Bruttoumsatz			DDD			Bruttoumsatz je DDD*	
	KV Hessen		Bund	KV Hessen		Bund	KV Hessen	Bund
	in Tsd. €	Anteil	Anteil	in Tsd.	Anteil	Anteil	Absolut	Absolut
Nicht-generikafähige Fertigarzneimittel	942.883	53,7%	53,3%	192.296	9,6%	9,6%	4,90 €	4,97 €
Generikafähige Fertigarzneimittel	812.721	46,3%	46,7%	1.802.012	90,4%	90,4%	0,45 €	0,46 €
Fertigarzneimittelmarkt	**1.755.899**	**100,0%**	**100,0%**	**1.994.326**	**100,0%**	**100,0%**	**0,88 €**	**0,89 €**
davon:								
Generika	615.888	35,1%	35,4%	1.655.375	83,0%	82,7%	0,37 €	0,38 €
Analogpräparate	102.249	5,8%	5,9%	34.648	1,7%	1,7%	2,95 €	3,10 €
Spezialpräparate	623.543	35,5%	36,5%	59.857	3,0%	3,0%	10,42 €	10,98 €

* *In die Berechnung „Bruttoumsatz je DDD" werden nur die Fertigarzneimittel einbezogen, für die DDD verfügbar sind. Nicht jedem Fertigarzneimittel werden DDD zugeordnet.*

Abbildung 3:
Anteil ausgewählter Segmente am Fertigarzneimittelmarkt von Januar bis September 2015

Improving the quality of long-term care

After the benefits provided by long-term care insurance had been expanded and improved in a first phase as per 1 January 2015 with a view to the coming introduction of the new definition of need of long-term care, the legislature is introducing the new definition of need of long-term care, and the new procedure for the assessment of need of long-term care that is needed for this, as per 1 January 2017 with the Second Act to Strengthen Long-term Care and to Amend Further Regulations (Second Act to Strengthen Long-term Care – PSG II). The Federal Government is thus implementing the re-orientation of long-term care insurance which it had announced, and which the National Association of Statutory Health Insurance Funds had been requesting for quite some time.

The new definition of need of long-term care takes a look at the scale of the remaining independence of each person in need of long-term care and the resulting dependence on personal assistance.

Introduction of the new definition of need of long-term care

Unlike previously, the understanding of need of long-term care is no longer characterised by a point of view that is orientated towards the limitations of the person in need of long-term care. Rather, the new definition takes a look at the extent of the remaining independence of each person in need of long-term and the resulting dependence on personal assistance. Taking the extent of independence into account in the assessment means that physically-, cognitively- and mentally-impaired people receive equal treatment when being assigned within the five levels of long-term care that will be applied in future.

Comprehensive protection of vested rights

Persons in need of long-term care who are drawing benefits at the time of the conversion will be transferred into the new system without a re-assessment. Persons in need of long-term care who only have physical restrictions hence receive the next-higher level of long-term care, whilst persons in need of long-term care with mental restrictions receive the level of long-term care after next. With the transition, the drawing of benefits will improve for the majority of beneficiaries. The protection of legitimate interests ensures that no one needs to expect additional burdens after the transition. The funding of the protection of vested rights is ensured by the reserves of long-term care insurance, which were 6.65 billion Euro at the end of 2014.

Improvements in benefits

The introduction of the new definition of need of long-term care entails further changes. Bodily long-term care, long-term care support measures and assistance for household management will have equal standing in future, so that insured persons can assemble benefits themselves. This enables people with somatic, cognitive and mental impairments to gain individual access to the benefits provided by long-term care insurance. What is more, the Second Act to Strengthen Long-term Care provides amongst other things for an improvement in advice for persons in need of long-term care and their family members, a simplification of benefit applications and the enhancement of the principle of "rehabilitation before long-term care". In order to fund the introduction of the new definition of need of long-term care, the contribution rate for long-term care insurance will be increased by 0.2 contribution rate points, reaching 2.55 % as per 1 January 2017, and 2.8 % for the childless.

Drawing up the assessment guidelines early

In order to ensure that the new assessment procedure is introduced by 1 January 2017, the National Association of Statutory Health Insurance Funds was already legally tasked in July 2015 with adjusting the guidelines for the assessment of need of long-term care to the new definition of need of long-term care. The National Association of Statutory Health Insurance Funds has drawn up the assessment guidelines jointly with the Medical Service of the National Association of Statutory Health Insurance Funds, and with the participation of the long-term care insurance funds, of the Health Insurance Medical Service (MDK), of the expert report service of private health insurance, as well as of representatives of the persons in

#thinking_ahead

Long-term care

need of long-term care. As well as the report for adults, the special needs of children will be taken into account in future via a separate report. The assessment guidelines are to be submitted to the Federal Ministry of Health in April 2016, after the participation of the healthcare providers' associations, of the social assistance institutions and of the central associations of local authorities.

In order to ensure a problem-free transition, the new definition of need of long-term care, the assessment procedure including the evaluation system, as well as the transition arrangements, must be communicated to insured persons, care facilities, senior citizens' lobbies/self-help groups and information centres. The National Association of Statutory Health Insurance Funds is in favour of providing transparent, comprehensible information to insured persons.

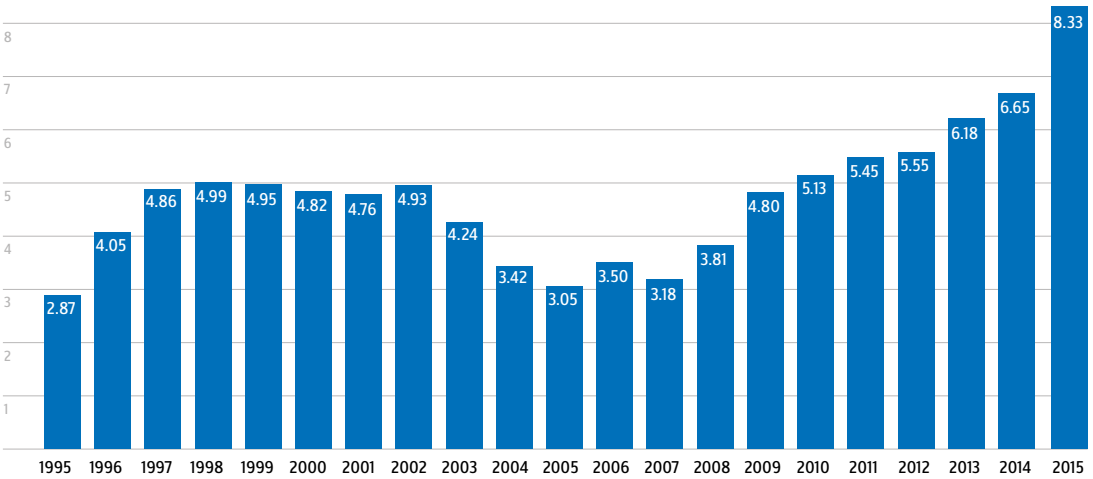
Bodily long-term care, long-term care support measures and assistance for household management will have equal standing in future.

Reshaping quality reporting

Since 2009, information on the quality of outpatient long-term care services and in-patient care facilities has been provided to persons in need of long-term care and their relatives in the shape of care ratings. These are based on criteria which are collected in annual quality audits by the Health Insurance Medical Service and by the audit service of the Private Long-Term Care Insurance Association, on behalf of the long-term care insurance funds.

Quality indicators are increasingly being introduced at international level in order to provide information to consumers regarding the quality of long-term care and health facilities. Selected health-related indicators are to supplement reporting on the quality of long-term care for long-term care facilities from 2018 onwards. This provides an opportunity to accommodate questions of process quality more than was previously the case, as well as the quality of the results of long-term care, such as the incidence of pressure sores or the state of nutrition of the person in need of long-term care. Against the background of the criticism, which has been repeatedly levelled by the National Association of Statutory Health Insurance Funds in particular, as to the authoritativeness of the care ratings, the addition to the information for consumers for the quality of long-term care to include authoritative, scientifically-tested quality indicators is highly welcome.

Fig. 17
Development of the reserve in social long-term care insurance
Figures in billions of Euro



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

Fig. 18
The timeline of the long-term care reform

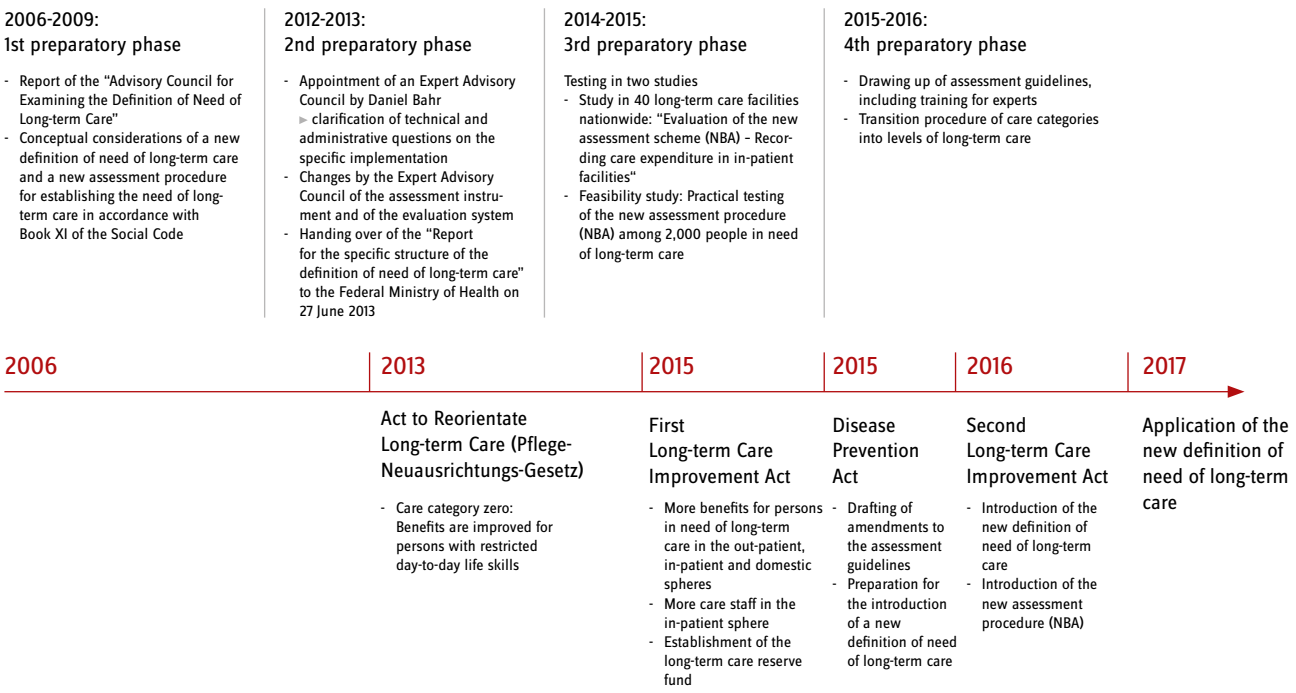


Illustration: National Association of Statutory Health Insurance Funds

The introduction of quality indicators leads to new challenges for testing facilities and care facilities when it comes to securing and refining the quality of long-term care. The National Association of Statutory Health Insurance Funds is keen to establish a practicable, interlinked system of in-house quality management and external quality testing. These form the basis for the future consumer-friendly quality presentation of the approx. 13,000 in-patient long-term care facilities in Germany.

Reforming self-government in long-term care

From 2016 onwards, the parties to the agreement in long-term care will decide how to further develop and secure the quality of long-term care in the newly-established Quality Committee, which is supported by an also scientifically-qualified secretariat. The Quality Committee consists of the representatives of the National Association of Statutory Health Insurance Funds, as well as of the associations of the funders of the care facilities at federal level. A maximum of ten members may be appointed in each case, including one person each authorised to represent the institutions of social assistance, the central associations of local authorities, and the associations of the nursing professions and those of private health insurance. The organisations defending the interests of self-help for persons with a disability and in need of long-term care play an advisory role. If no amicable agreement is reached, the Committee will be expanded to include a non-partisan member as its chairperson and two further non-partisan members with voting rights. The new conflict-resolution mechanism accelerates decision-making in long-term care. Having said that, the appointment of a non-partisan member by the Federal Ministry of Health constitutes an unusual encroachment on the self-government principle. This should be left to the parties to the agreement in long-term care.

Research into the long-term care reform

There has been a consensus for quite some time in policy and specialist terms that there is a need for a fundamental reform of the definition of need of long-term care and of the assessment procedure. The Expert Advisory Council for the specific structure of the new definition of need of long-term care submitted a number of proposals in 2013, but in doing so did not conclusively answer major questions for implementation. The National Association of Statutory Health Insurance Funds has thus been working hard since the summer of 2013 to draw up the information that is still missing in two model projects and to implement the evaluation of the revised assessment instrument which was considered to be necessary. It was possible to submit the corresponding final reports in the spring of 2015. This set the stage for the rapid, responsible introduction of the new definition of need of long-term care.

Examination of the new assessment procedure (NBA)

The "Feasibility study on the introduction of the new assessment scheme (NBA) to determine the need of long-term care in accordance with Book XI of the Social Code (SGB XI)" examined both the practical handling of the new assessment procedure (NBA) and its de facto suitability. All changes which have taken place since the Report of the Advisory Council for Examining the Definition of Need of Long-term Care were taken into account here. These particularly related to the categorisation of children in need of long-term care and of persons in extreme need of long-term care in the highest, fifth level of long-term care, as well as to the recommendations for rehabilitation. Its testing led to differentiated evaluations of the changes: For instance, the special needs constellation of the inability to use arms and legs was confirmed, but not that of "pronounced behavioural disorders relating to motor skills entailing an endangerment to self and others". The latter are said as a rule not to be permanent impairments, but were shown as an acute state, in particular with regard to dementia. The manageability of the new assessment procedure (NBA) in its everyday application by the experts, as well as the comprehensibility and acceptance of the new procedure among insured persons, were also studied and confirmed on a model basis. The project was carried out by the Medical Service of the National Association of Statutory Health Insurance Funds with the participation of the University of Applied Sciences for Health in Bochum: Almost 1,700 assessments were carried out, both in accordance with the old and with the new procedure.

The manageability of the new assessment procedure (NBA) in its everyday application by the experts, as well as the comprehensibility and acceptance of the new procedure among insured persons, were studied and confirmed on a model basis.

Recording the concrete care expenditure

The second model project related to the concrete care expenditure on and benefits for people in need of long-term care. The goal was to facilitate an assessment of what long-term care and support benefits different people in need of long-term care actually need, against the background of their current care category and with regard to their future level of long-term care. The following questions were investigated on the basis of empirical data:

- What is the structure of the benefit expenditure in the individual levels of long-term care?
- Can homogeneity be observed in benefit expenditure in the individual levels of long-term care?
- Are the gaps between the benefit expenditure of the individual levels of long-term care plausible?

All in all, the care expenditure amount corresponds to the levels of long-term care: As the level of long-term care rises, the care expenditure also increases. This notwithstanding, the care expenditure varies within the individual levels of long-term care – as it does today within the individual care categories –, given that the causes of need of long-term care can be different, and the benefits that are needed therefore also diverge.

With regard to recording expenditure on care, the basis for the future structure under the law on benefits of the five levels of long-term care and the relative amounts of the benefits was established, the concrete establishment of which was to be decided at political level. Moreover, the model project constituted the empirical foundation for being able to measure and evaluate the changes in care after the introduction of the new definition of need of long-term care. Roughly 1,600 persons in need of long-term care in seven Federal Länder were involved in the study for whom the level of long-term care and the benefit expenditure to which they were entitled were recorded.

The two studies of the National Association of Statutory Health Insurance Funds, which were published in the summer of 2015, contained the information and knowledge needed to form a topical empirical basis for the further political decision-making process and the preparation for the Second Act to Strengthen Long-term Care. They hence made a very important contribution towards the new definition of need of long-term care being introduced in a way that is technically reliable, involves minimal friction and is responsible.

The model project for recording the actual care expenditure constituted the empirical foundation for being able to measure and evaluate the changes in care after the introduction of the new definition of need of long-term care.

Enhancing cooperation between long-term care insurance funds and local authorities

The Federal Government intends to enhance the role of the local authorities in long-term care in the present Parliament. On the basis of the Coalition Agreement, and led by the Federal Ministry of Health, a Federation-Länder working party was established. It drew up proposals in the year under report 2015 as to how the various local geriatric care services and long-term care insurance can be more closely interlinked and the planning and management skills of the local authorities enhanced.

The working party furthermore developed recommendations on the group of topics of safeguarding care, low-threshold services, consultation and dwellings adapted to the needs of the elderly. For instance, in order to safeguard care, it was proposed to improve institutionalised cooperation between bodies at Land level. This entails obliging the long-term care insurance funds to remedy the quantitative shortcomings in care discovered by the Länder within the services for which they are registered. Further proposals relate to optimising dataflows or testing new consultation structures by a total of 60 model local authorities. On the basis of the recommendations, the local authorities are to be allotted a key role when it comes to making the everyday lives of persons in need of long-term care and their relatives simpler. The statutory changes are to come into force at the beginning of 2017 at the latest.

The local authorities are to be allotted a key role when it comes to making the everyday lives of persons in need of long-term care and their relatives simpler.

Joint activity

The Administrative Council of the National Association of Statutory Health Insurance Funds took up a position in June 2015 with regard to the role played by local authorities in long-term care: In order to sensibly enhance their role, the expertise of the health and long-term care insurance funds may not be simply transferred to the local authorities. Rather, joint activity needs to be carried out within the respective competences. The available structures are to be used for this, and added to wherever necessary. The establishment of dual structures is not an alternative.

§§

Key positions of the National Association of Statutory Health Insurance Funds for the guidance of the legislative procedure

- The provision of long-term care is a task for society as a whole.
- Local geriatric assistance and the regional interlinking of care services are tasks for the local authorities.
- Low-threshold services are to be targetedly established and expanded.
- Long-term care counselling and individual case management are tasks for the long-term care insurance funds.
- Cooperation is to be enhanced between the local authorities and the long-term care insurance funds.

Creating a secure telematics infrastructure

As part of its efforts aimed at improving the economic efficiency, quality and transparency of the German healthcare system, the National Association of Statutory Health Insurance Funds is playing an active role in the establishment of the telematics infrastructure, and explicitly favours the use of the electronic healthcard (eHealth Card) within this highly-secure network. In order to implement the project successfully, it is however indispensable for the first online applications to be introduced rapidly, given that the considerable funds that have been invested in the project to date can only be justified by creating benefits for insured persons as soon as possible. Last year, the National Association of Statutory Health Insurance Funds thus once more vigorously called for visible progress to be made in the project.

The eHealth Act

The Administrative Council of the National Association of Statutory Health Insurance Funds took action in December of last year because of the lack of progress in the project. It imposed a budget freeze on the allocations to the Gesellschaft für Telematikanwendungen der Gesundheitskarte (gematik), and called for relevant decision-making powers for the National Association of Statutory Health Insurance Funds as the sole funder within gematik. This directed the attention of the public and policy-makers alike to the problems. The Federal Ministry of Health submitted a draft Bill in January on Secure Digital Communication and Applications in the Healthcare System (Gesetz für sichere digitale Kommunikation und Anwendungen im Gesundheitswesen), known as the "eHealth Act" (E-Health-Gesetz). This included some of the central demands put forward by the National Association of Statutory Health Insurance Funds:

- binding deadlines, which amongst other things are to achieve an acceleration of the development of insured persons' master data management (VSDM) and emergency data management (NFDM)
- sanctions for healthcare providers who do not examine the eHealth Card as to whether it is up to date

For the applications of the eHealth Card, the Act provides that gematik must have complied with the necessary measures for the implementation of insured persons' master data management by 30 June 2016 and of emergency data management by 31 December 2017. The envisioned sanctions for this are however undifferentiated in terms of their structure, and are not in line with the causative principle. Three of gematik's shareholders (National Association of Statutory Health Insurance Funds, National Association of Statutory Health Insurance Physicians and National Association of Statutory Health Insurance Dentists) are hence to be punished for the failings or technical problems of others, and particularly of industry in this case. The National Association of Statutory Health Insurance Funds strongly criticised this in its statements and at hearings which were held at the Federal Ministry of Health and in the German Bundestag. It furthermore pointed to the potential for extortion which this created in industry.

The supreme priority for the statutory health insurance funds is that the secure telematics infrastructure is to be permissible in future as the only network for the transmission of medical data. The corresponding clarifications in the Act are hence welcome. The creation of financial incentives in the shape of telematic bonuses for applications such as the electronic medical report or the discharge report before a telematics infrastructure is available is however rejected. This above all promotes expensive parallel structures, which moreover have not been tested by the Federal Office for Information Security (BSI).

The envisioned sanctions for this are undifferentiated in their structure, and are not in line with the causative principle. Three of gematik's shareholders are also to be punished for the failings or technical problems of others, and particularly of industry in this case.

The state of the project with regard to the online rollout

- The health insurance funds are on time when it comes to providing the services for insured persons' master data management, and will be ready to test them by the prescribed deadline.
- The arvato Systems company that is responsible for setting up and operating the central

#thinking_ahead

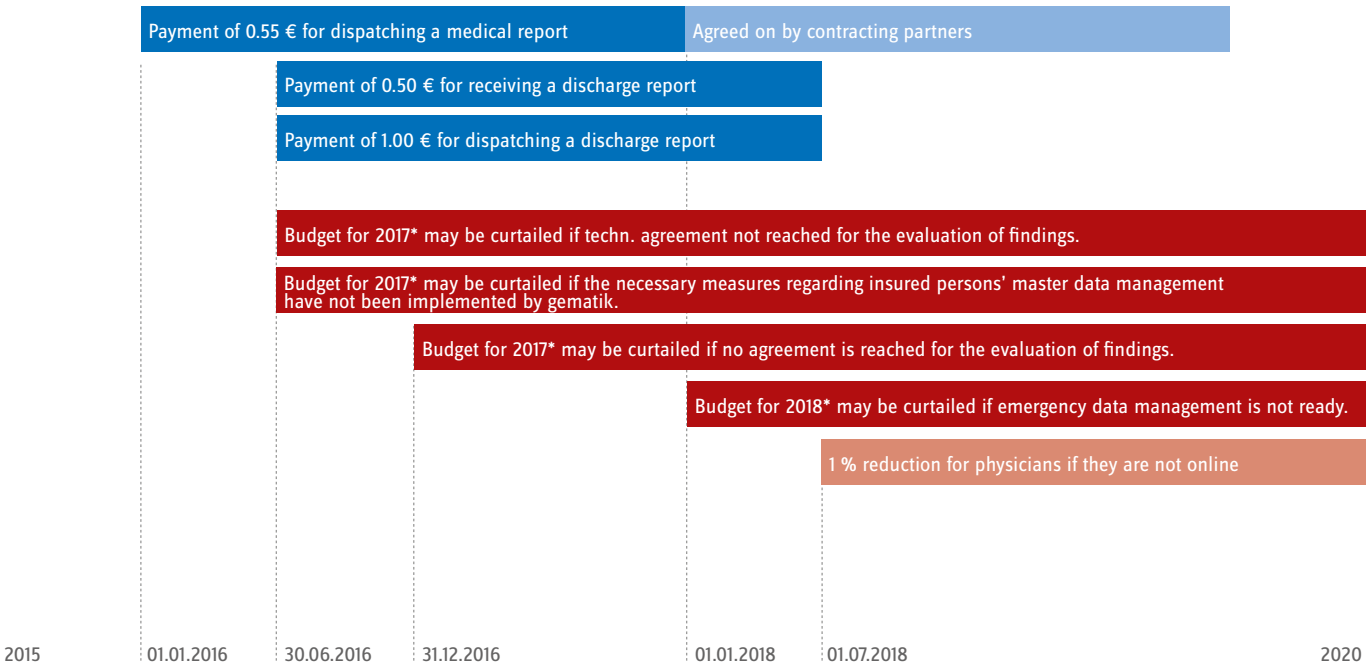
eHealth Act

telematics infrastructure announced last year that both the central network and the necessary services were ready for operation.

- The T-Systems company, which is responsible for setting up the test regions and developing and providing the local components of the telematics infrastructure, and the Strategy& industrial consortium, however also repeatedly pushed back the delivery dates in 2015. The companies continue to have massive problems particularly with regard to the development and hence the delivery of the connector which is to facilitate the secure connection between the medical surgeries and hospitals and the telematics infrastructure.
- According to the current project planning, the result of these problems is that neither of the two consortia can make it possible to complete the testing by the end of the second half of the year.
- The deadline of 30 June 2016 set in the eHealth Act can therefore not be met. Given the fact that the envisioned sanctioning does not impact the budget of the National Association of Statutory Health Insurance Funds until 2017, it is being examined at present to what degree significant testing results can nonetheless be achieved in 2016.

Given the project's very slow progress, the Federal Minister of Health also felt obliged to act, and entered into a dialogue with the relevant stakeholders. Three meetings were already held on the state of the project at the highest level in the second half of 2015 between the Federal Ministry of Health, the Federal Office for Information Security, industry, gematik and its shareholders.

Fig. 19
Timetable of the eHealth Act – payments and sanctions



* related to the core budget reduced to the level of 2014 minus 1 %
Illustration: National Association of Statutory Health Insurance Funds

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Hospice and palliative care

Providing hospice and palliative care nationwide

Statutory health insurance and social long-term care insurance (SPV) consider their fundamental tasks to consist in providing to their insured persons the necessary medical and long-term care benefits, within the statutory provisions, at all ages and in all circumstances, as well as supplying any accompanying support and consultation. The suitable further development of hospice and palliative care is therefore a major concern for statutory health insurance and social long-term care insurance. In line with this principle, the Administrative Council of the National Association of Statutory Health Insurance Funds adopted a position paper in June 2015 in which central points are put forward for refining hospice and palliative care.

Principles for the policy debate

The National Association of Statutory Health Insurance Funds considers a need to exist for high-quality, guideline-based palliative medical and long-term care, as well as hospice and palliative culture, to concentrate more intensively on non-specialised care services. Safeguarding and where appropriate refining the medical long-term care structures, as well as the consultation and support services, must be suited to the needs of people who are dying and their relatives. Care that is as universal as possible needs to be achieved here within networked, coordinated services.

Given the highly-differentiated services, the transparency of structures and care needs to be increased. This is important both from the perspective of the people concerned, who rely on such services, and from that of the contracting partners, who need sound information in order to structure the services for the quality of the care and for the needs situation. Professional palliative care, as well as sound hospice support services provided on a voluntary basis, should be included in an overall structure with regional consultation and support services which do justice to the challenges of an ageing society, also over and above medical long-term care.

On the basis of these principles, the National Association of Statutory Health Insurance Funds contributed to the policy debate on an Act to Improve Hospice and Palliative Care, as well as to the consultations which have already been underway since 2013 for the development of the Charter for Care of Severely-Ill and Terminally-Ill People (Charta zur Betreuung schwerstkranker und sterbender Menschen) to become a national strategy.

Professional palliative care, as well as hospice support services provided on a voluntary basis, should be included in an overall structure with regional consultation and support services.

Core positions of the National Association of Statutory Health Insurance Funds on the legislative procedure

- increase the transparency of existing hospice and palliative care services and expand interlinked consultation of insured persons regarding the services offered
- entrench palliative medical and palliative long-term carer skills and hospice accommodation in "standard treatment"
- expand cooperation and networking between healthcare providers
- improve the quality of the out-patient care provided by physicians and promote networking
- expand general palliative care provided in hospitals
- improve care in in-patient care facilities
- improve care in in-patient hospices and the care provided by out-patient hospice services
- expand specialised out-patient palliative care as needed and improve the database

The Hospice and Palliative Care Act

The German Bundestag adopted the Hospice and Palliative Care Act (HPG) in November 2015. The Act basically aims to enhance hospice and palliative care, and thereby establish a universal service all over Germany. This is to ensure that insured persons are well cared for and accompanied, even when they are dying, in the place where they spend the last phase of their lives. This concern is shared unrestrictedly by the health and long-term care insurance funds. The Act takes up major aspects of the position paper of the National Association of Statutory Health Insurance Funds, such as the expansion of consultation and networking. The impulses have also been incorporated into the Act that were called for by the National Association of Statutory Health Insurance Funds aimed at bringing about a firmer anchoring of palliative medical and long-term carer skills, as well as hospice accommodation in "standard treatment".

It is to be ensured that insured persons are well cared for and accompanied, even when they are dying, in the place where they spend the last phase of their lives.

The Hospice and Palliative Care Act has given the National Association of Statutory Health Insurance Funds modified and in some cases also new creative tasks. These include:

- further formalisation of more recent agreements for in-patient hospice care, as well as for the promotion of out-patient hospice services
- content conceptualisation and agreement on a new service for healthcare planning in the last phase of life in in-patient care facilities
- obligations to report and evaluate

The appropriate consultation with the partners among the healthcare providers was taken up in order to achieve the necessary improvements in the interest of those concerned.

Scientifically proving the quality of medical services

Cardiac catheters: the first cross-sectoral QA procedure

The Federal Joint Committee adopted the first Guideline for a Cross-Sectoral QA Procedure in February 2015. The QA procedure entitled "Peripheral Component Interconnect (PCI) and Coronary Angiography" will go into standard operation as per 1 January 2016. For the first time, it covers the quality of cardiac catheter operations performed by registered contract doctors in the same way as in hospitals. The National Association of Statutory Health Insurance Funds considers this to constitute a major success in patient care. There was previously no comparable documentation of the quality of service provision by registered contract doctors.

The National Association of Statutory Health Insurance Funds considers a need for change to remain when it comes to the publication of the quality results. According to the current legislation, only the hospitals' quality reports are accessible to patients, physicians and health insurance funds. The same should also apply to the quality results of registered contract doctors.

The Guideline also entails new tasks for the health insurance funds: They must provide social data for use in quality assurance and transmit them to the Quality Institute of the Federal Joint Committee. This enables serious complications or the death of patients to also be recorded once the treatment has been concluded in the clinic or in the practice. The technical stipulations needed for this were drawn up by the National Association of Statutory Health Insurance Funds, together with the health insurance funds, and included in the Guideline.

For the first time, the quality of cardiac catheter operations performed by registered contract doctors is recorded in the same way as in hospitals.

Arthroscopy with arthrosis of the knee joint: No lasting benefit

The National Association of Statutory Health Insurance Funds is endeavouring in the Federal Joint Committee to see to it that effective, safe treatment methods are available to patients in the list of services provided by statutory health insurance. In order to sensibly structure the list of services, there is also a need to exclude ineffective or even damaging procedures.

Chronic degeneration of the knee joint (gonarthrosis) is one of the most frequent health problems encountered at advanced ages today. The reduction in quality of life which this entails, caused by pain and reduced mobility, can be considerable. The customary treatment methods include various types of pain therapy, physiotherapy or, if other procedures fail, the implantation of a knee joint endoprosthesis. Arthroscopy of the knee, a keyhole operation which is by no means without its risks, is frequently also applied. Several high-quality studies have however shown in recent years that an arthroscopy has no lasting benefit for patients suffering from arthrosis of the knee.

More than 100,000 such arthroscopies are carried out on patients suffering from degeneration of the knee joint in Germany every year, both as out-patients and in hospitals. Given the negative results of the studies and the widespread use of the operation, the National Association of Statutory Health Insurance Funds applied to the Federal Joint Committee to have the benefit ensuing from and the necessity of the method examined. A report by the Institute for Quality and Economic Efficiency in the Healthcare System confirmed that arthroscopy is not expedient in the case of arthrosis of the knee joint. The Federal Joint Committee thereupon decided to comply with the request of the National Association of Statutory Health Insurance Funds and, in agreement with the other insurers and with the patients' lobby, decided that arthroscopy may no longer be carried out on gonarthrosis in hospital and by registered contract doctors at the expense

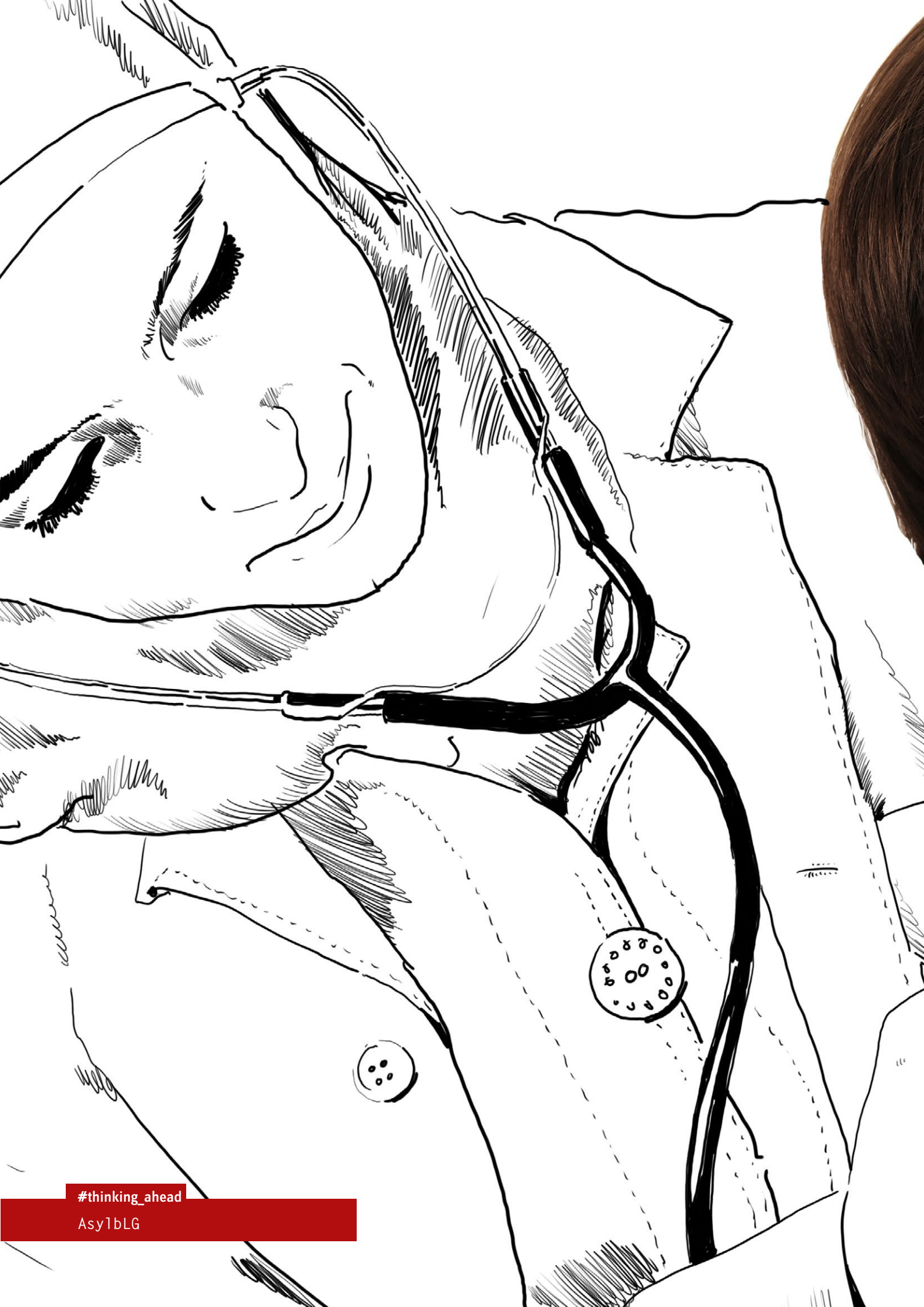
#thinking_ahead

QA procedure

of statutory health insurance. Special cases were accommodated via differentiated exceptions.

The National Association of Statutory Health Insurance Funds expects that far fewer knee arthroscopies will be carried out on insured persons suffering from degeneration of the knee joint, and no unnecessary ones at all, once the resolution of the Federal Joint Committee has come into effect, as is planned for 2016. Arthroscopy with other indications, such as meniscus injuries, will remain on the list of services.

Several high-quality studies have shown in recent years that arthroscopy has no lasting benefit for patients suffering from arthrosis of the knee.



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Supporting local authorities

A central social policy topic of 2015, namely the organisational, social and financial challenges caused by the considerable increase in the number of refugees, has also been keeping statutory health insurance busy. In line with the statutory mandate, the health insurance funds take over the organisation of healthcare for asylum-seekers once a waiting period has expired which is provided for in the Asylum-Seekers' Benefits Act (Asylbewerberleistungsgesetz – AsylbLG). From that time on, these people also receive an electronic healthcard (eHealth Card), and can therefore largely claim the same benefits as persons with statutory insurance. The Act Amending the Asylum-Seekers' Benefits Act and the Social Court Act (Gesetz zur Änderung des AsylbLG und des Sozialgerichtsgesetzes), which came into force as per March 2015, reduced this waiting period from 48 to 15 months.

The question of the future structure of healthcare for asylum-seekers during the waiting period – that is in the first 15 months of their stay in Germany – is becoming increasingly significant. The National Association of Statutory Health Insurance Funds made it clear to the policy-makers at an early date that statutory health insurance supports the development of an effective solution which involves as little administration as possible in order to ensure the provision of healthcare to asylum-seekers and to make sure that it is available to the state institutions as a service-provider with the existing infrastructure, if this does not entail any additional financial burdens for the community of solidarity. In view of the changes to the law which are being intensively discussed between the Federation and the Länder for the healthcare of asylum-seekers, the Administrative Council of the National Association of the Statutory Health Insurance Funds appealed to the legislature to create an arrangement which would apply nationwide enabling asylum-seekers to receive uniform, appropriate healthcare. The legislature however failed to comply with this request coming from statutory health insurance.

Statutory health insurance is available to the state institutions as a service-provider to ensure the healthcare of asylum-seekers.

Framework recommendations for the Länder and local authorities

In fact, as part of the Asylum Procedure Acceleration Act (Asylverfahrensbeschleunigungsgesetz), which was adopted in an emergency procedure in October 2015, an expanded statutory basis was created for the involvement of statutory health insurance. Accordingly, the health insurance funds can also be obliged to assume the healthcare of asylum-seekers during the waiting period if the respective Federal Land so requires and agreements are reached at least at the level of the rural districts or non-district towns. This means that the question of the structure of medical care during the waiting period continues to be decided upon in the Länder and the local authorities. In order nonetheless to achieve as equal a structure in the regional agreements as possible, there is provision for the National Association of Statutory Health Insurance Funds to agree on framework recommendations with the central organisations of local authorities which exist at federal level, and for these to be incorporated into the agreements at Land and local level. The framework recommendations are to particularly contain provisions on the scope of the benefits in accordance with the Asylum-Seekers' Benefits Act, on the billing and the auditing of invoices, as well as on refunding the expenditure and the administrative costs. The National Association of Statutory Health Insurance Funds took up the consultations with the central associations of local authorities on 5 November 2015. The consultations are expected to be concluded in the spring of 2016.

The fight against corruption in the healthcare system

The Federal Court of Justice called on the legislature back in 2012 to "effectively counter with the means available to criminal law the irregularities" that are caused by corruption in the healthcare system and "which – to all appearances – cause major financial burdens on the healthcare system". The Governing Coalition thereupon announced that a new criminal offence of passive and active corruption in the healthcare system would be created in the Criminal Code (Strafgesetzbuch) in the 18th Parliament. The lead Federal Ministry of Justice and Consumer Protection ultimately submitted a corresponding departmental draft Bill in February 2015.

Within the National Association of Statutory Health Insurance Funds' event series entitled "Statutory health insurance live – Dialogue with policy-makers", the Parliamentary State Secretary at the Federal Ministry of Justice and Consumer Protection, Christian Lange (MdB), presented the draft Bill to a specialist public for the first time in February 2015. The State Secretary stressed once more that corruption in the healthcare system impaired competition, made medical services more expensive and undermined patients' confidence in the integrity of physicians' decisions. The new criminal offence is furthermore to protect the financial interests of statutory health insurance, and hence the community of solidarity of the insured persons.

The new criminal offence is to protect the financial interests of statutory health insurance, and hence of the community of solidarity of the insured persons.

Fig. 20
Establishment of (specialist) public prosecution offices to combat financial crime and corruption in the healthcare system

Illustration: National Association of Statutory Health Insurance Funds

#thinking_ahead

Anti-Corruption Act

Consistently preventing misconduct in the healthcare system

The National Association of Statutory Health Insurance Funds strongly supports the draft Bill. Under the law as it stands, the statutory health insurance funds lack sufficient powers to investigate and verify. Corrupt practices in the healthcare system certainly cannot be countered with the necessary effectiveness under the existing prohibition regulations of social law alone.

The creation of new criminal offences of passive and active corruption in the healthcare system is however not sufficient by itself. There is in fact a need to make further changes to the law. The main demands were adopted by the Administrative Council on 25 March 2015 in the position paper entitled "Consistently preventing misconduct in the healthcare system".

The National Association of Statutory Health Insurance Funds is strident in its calls amongst other things for a statutory provision protecting informants with regard to in-company breaches of duty against disproportionate disciplinary actions on the part of their superiors. Many cases of misconduct in the healthcare system can only be detected with the aid of such informers. In accordance with the statutory provision, "any person" should be able to approach anti-misconduct units in the healthcare system which have been set up in all the health insurance funds. However, there is no legally-anchored protection for such individuals as yet. Many of them therefore remain anonymous for fear of losing their jobs, and are no longer available as witnesses.

Establishing (specialist) public prosecution offices

In its statement on the governmental draft Bill to Combat Corruption in the Healthcare System (Gesetz zur Bekämpfung von Korruption im Gesundheitswesen), given at the public hearing before the Committee on Legal Affairs and Consumer Protection, the National Association of Statutory Health Insurance Funds called on the parliamentary groups represented in the German Bundestag to endeavour to ensure that the Länder set up particularly qualified (specialist) public prosecution offices. At present, the statutory health insurance funds are to inform the public prosecution office without delay if the review reveals that an initial suspicion of punishable acts could exist which was more than only slightly significant for statutory health insurance. Since investigation proceedings in the healthcare system constitute specialist material within criminal commercial law, and the legal and contractual framework is altered frequently, (specialist) public prosecution offices could work more effectively. At the same time, such a concentration of material powers would relieve the judiciary of a burden on its resources.

The National Association of Statutory Health Insurance Funds is strident in its calls for a statutory provision protecting informants of in-company breaches of duty against disproportionate disciplinary action.

Reducing barriers, guaranteeing participation

The new Act is to become a key element in a broad-based overall process intended to enhance the participation and self-determination of persons with disabilities.

Integration assistance is to be developed to become a modern participation right. The Federal Government intends to adopt a Federal Participation Act in this regard in this Parliament. The new Act is to become a key element in a broad-based overall process intended to enhance the participation and self-determination of persons with disabilities. This process is to reduce the burden on the local authorities by 5 billion Euro. The central topics are:

- enhancing personal responsibility
- formalising service-provision
- making changes to the allowance of income and property
- independent advice
- skill-building offensive for staff

Representatives of all the relevant organisations prepared for this within a participation procedure by forming a working party which determined what the reform topics would be and evaluated their content. The National Association of Statutory Health Insurance Funds was involved in the structured dialogue as the representative of statutory health and long-term care insurance. The working party's final report was published by the Federal Ministry of Labour and Social Affairs in July 2015. It also reflects the positions of the National Association of Statutory Health Insurance Funds.

Positions of the National Association of Statutory Health Insurance Funds on the participation procedure

- The reform must focus on persons with a disability and their specific needs. The goal is to actually guarantee to such people full participation in society and self-determination, as determined by the UN Convention on the Rights of Persons with Disabilities, which calls for equal rights and opportunities for persons with disabilities. This permits one to establish a focus on the individual, which must relate to aspects of an individualised assessment of needs and affordability. This principle does not mean however that the structures of in-patient services are dissolved so that complex services are consequently dissected into small individual benefits with different competences and new interfaces. Persons with disabilities are to continue to be able to make varying demands on their living environment, depending on their individual life plans.
- Local authorities need more latitude in integration assistance and a greater margin of financial appreciation when performing their tasks. It must be ensured here that the deburdening effect is actually felt at local level, given the different structures in integration assistance at Land level. What is more, this must not impose greater burdens on the social insurance institutions.
- The planned reform of integration assistance has a direct impact on benefit entitlements vis-à-vis other social insurance institutions, especially in long-term care, participation and medical care. There is therefore a need to take interactions into account. Imposing additional burdens on other social insurance institutions should also be avoided.
- Constellations of needs spanning more than one insurer in turn require consultation, planning and coordination spanning more than one insurer, so that persons with disabilities receive customised benefits from a broad spectrum of services. Improvements can be achieved if the benefit entitlements are better coordinated and made transparent within the existing structures, and hence within the respective insurers' competence. This also applies to consultation that is tailored to such individuals.

The statutory health and long-term care insurance funds will continue to campaign for the principle of an inclusive society within the meaning of the Convention on the Rights of Persons with Disabilities. They also consider themselves to have an unrestricted responsibility to consistently pursue their goals in terms of participation. The health and long-term care insurance funds make a major contribution towards this by funding high-quality medical and long-term care benefits with which restrictions caused by disabilities can be alleviated or even overcome.

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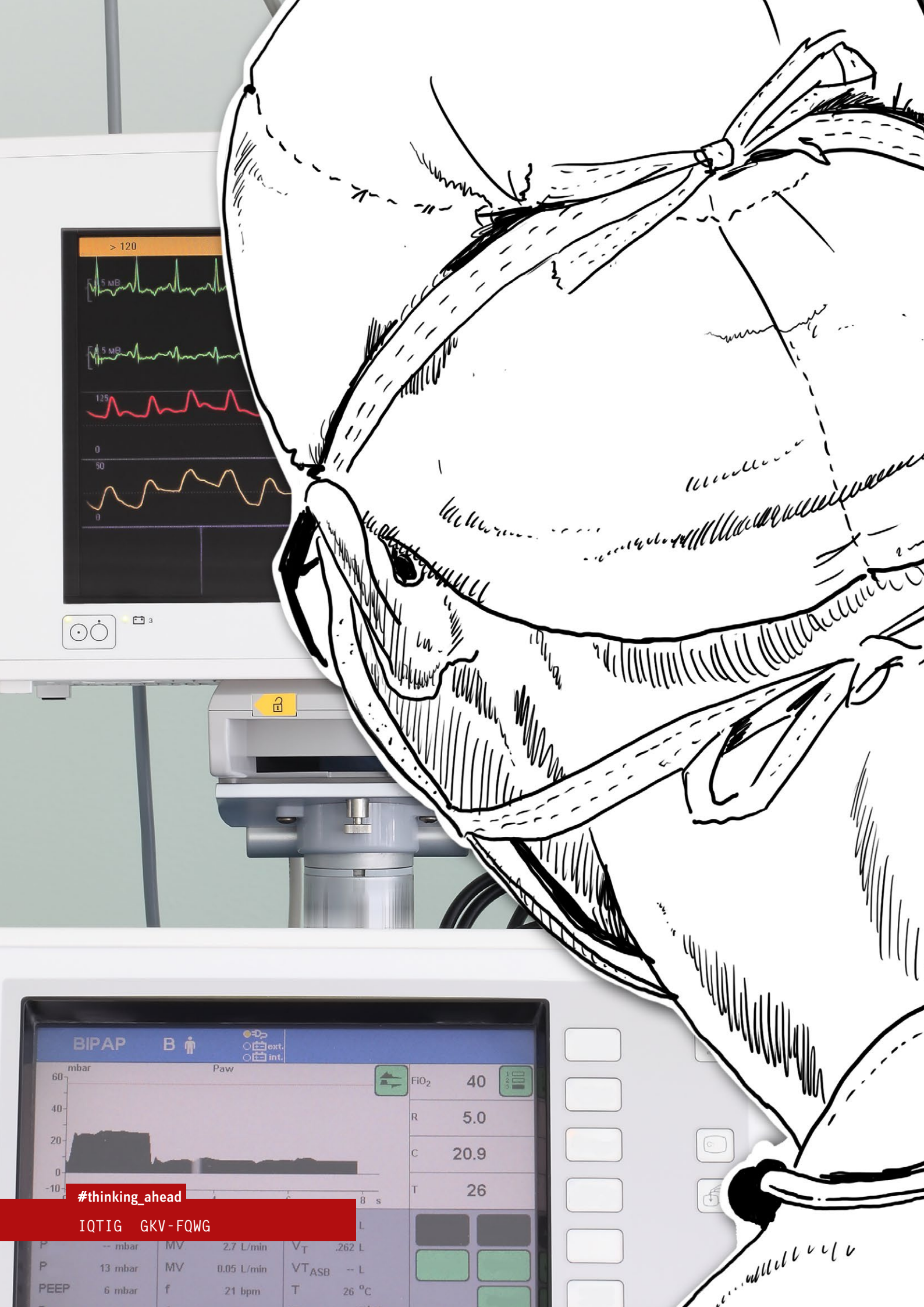
Participation



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IQTIG GKV-FQWG

Safeguarding transparency and quality

With the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance (Gesetz zur Weiterentwicklung der Finanzstruktur und der Qualität in der gesetzlichen Krankenversicherung – GKV-FQWG), the legislature has mandated the Federal Joint Committee with establishing a professionally-independent scientific Institute for Quality Assurance and Transparency in the Healthcare System (IQTIG). This new Institute is to draw up and implement for the Federal Joint Committee a long-term, scientifically- and methodically-sound basis for decision-making in quality assurance activities, and to improve the transparency of information on the quality of care. Amongst other things, the IQTIG is to publish comparisons of the quality of service-provision in the individual hospitals. This will make it easier for patients to obtain information prior to selecting a hospital on the quality of treatment that they can expect to receive there.

The Federal Joint Committee set the stage for the establishment of the new Quality Institute back in August 2014. At that time, it established the Foundation for Quality Assurance and Transparency in the Healthcare System as the Institute's funder, and adopted Statutes. The supervisory agency competent for foundations recognised the Foundation as having legal capacity soon after this. The constituting meetings of the Foundation's Council and Board were held in Berlin on 9 January 2015. The Institute was formally established at that meeting, and Dr. med. Christof Veit appointed as its director. On the Foundation's Council, two individuals each represent the German Hospital Federation and the National Association of Statutory Health Insurance Physicians; one person represents the National Association of Statutory Health Insurance Dentists, and five more represent the National Association of Statutory Health Insurance Funds. The Board is composed of eight members with voting rights, including one member each proposed by the German Hospital Federation, the National Association of Statutory Health Insurance Physicians and the National Association of Statutory Health Insurance Dentists, and three proposed by the National Association of Statutory Health Insurance Funds. They are appointed by the Foundation's Council. There is also a Board member seconded by the Federal Ministry of Health, and the Chairman of the Federal Joint Committee is also on the Board.

Amongst other things, the IQTIG is to publish comparisons for the quality of service-provision in the individual hospitals.

Funding and structure

In the same way as the Federal Joint Committee and the Institute for Quality and Economic Efficiency in the Healthcare System, the IQTIG is funded by system supplements. These are composed of a supplement for each billable hospitalisation, as well as by the additional increase in the remuneration for out-patient registered contract doctors and for out-patient registered contract dentist care.

After the IQTIG had been formally established on 9 January 2015 and its website www.iqtig.org launched, the development of the Institute was pushed forward. From January 2016 onwards, the IQTIG has taken on the tasks which were previously carried out by the AQUA Institute. A support contract was concluded with the AQUA Institute to ensure that the implementation of comparative quality assurance, which is outsourced by the Federal Joint Committee, is also continuously guaranteed during the transitional phase to the IQTIG in 2016.

Advising patients independently

Those in search of advice have been able since the beginning of 2016 to obtain information more simply on issues related to health and the law on health from Independent Patient Advice for Germany (UPD). The new provider, UPD Patientenberatung Deutschland gGmbH, primarily focuses on user-orientated telephone consultations and innovative access to consultation in order to reach insured persons and patients better. The change of provider took place on the basis of a Europe-wide call for tender that was carried out by the National Association of Statutory Health Insurance Funds, in which the concept of the new provider was clearly convincing.

The promotional amount was considerably increased from 2016, to 9 million Euro per year. This is to particularly improve the reachability of the UPD by telephone, as well as in person.

The National Association of Statutory Health Insurance Funds initiated the outsourcing of support early in October 2014 in order to seamlessly maintain the UPD's consultation service after the first standard promotion phase had ended on 31 December 2015. The call for tender was needed because, by introducing the UPD as a standard service in Book V of the Social Code, in 2011 the legislature had also imposed a sunset clause on the "outsourcing" of the support and limited the first standard promotion phase to a period of five years.

Quality competition on the concept and the strategy

When the outsourcing was launched, in agreement with the Federal Government's Patients' Rights Commissioner, the National Association of Statutory Health Insurance Funds opted to implement a negotiation process with competitive bidding. This engenders a maximum of transparency, and ensures that all involved enjoy the same opportunities. The quality competition was to encourage bidders to work out clear strategic and conceptual considerations. The most important requirements, especially with regard to the neutrality and independence which needed to be guaranteed, were defined in a performance specification by the National Association of Statutory Health Insurance Funds, the Patients' Rights Commissioner and the accompanying advisory council.

With the Act concerning the Further Development of Financial Structures and Quality in Statutory Health Insurance, the legislature has set the stage once more for the structuring of promotion. In place of a five-year promotion phase, seven years are now provided for. What is more, the promotional amount has been considerably increased from 2016 onwards, namely from 5.2 million Euro to 9 million Euro per year.

The new UPD at a glance

- The telephone consultation is provided via the familiar nationwide hotline: 0800 0117722, and is free of charge for those seeking advice, even from mobile networks.
- A personal consultation takes place where needed twice per week on barrier-free premises (e.g. in citizens' offices) at 30 locations (previously 21) once an appointment has been agreed in advance. The previous locations are also taken into account here.
- The deployment of three mobile consultation units enables consultations to be offered more flexibly in future, including to advice-seekers who do not live close to a location.
- The UPD will also visit and advise advice-seekers at home in exceptional cases.
- Advice-seekers can also seek advice online conveniently, and if necessary anonymously.

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UPD

According to the reasoning for the Act, this is intended amongst other things to expand the staffing resources and the number of information centres in order to particularly improve the reachability of the UPD on the telephone, as well as in person. The legislature thus reacted to the results of the accompanying scientific research, according to which the reachability of the UPD had successively deteriorated during the promotional phase.

Neutral, independent consultation

Neutrality and independence are indispensable requirements as to the quality of the UPD.

The tendering process was completed on 18 September 2015 when the contract was awarded to the bid submitted by Sanvartis GmbH, after the Federation's public procurement tribunal had confirmed the decision of the National Association of Statutory Health Insurance Funds in full. The new bidder particularly also satisfied "the preconditions with regard to the neutrality and independence prescribed in accordance with section 65b of Book V of the Social Code".

The National Association of Statutory Health Insurance Funds considers that its procurement decision, which was taken in agreement with the Patients' Rights Commissioner, has been confirmed by the resolution of the procurement tribunal. The new provider ensures by means of a large number of legal, organisational and institutional measures that the advice given to consumers and patients is provided with no conflicts of interest. Amongst other things, all the advisors are permanent employees of a specially-established not-for-profit organisation.

Neutrality and independence are indispensable requirements. This will also be scientifically evaluated in the coming promotion phase, and is evaluated by the accompanying advisory council, headed by the Federal Government's Patients' Rights Commissioner. The new provider has granted comprehensive rights to the accompanying advisory council to give instructions and to monitor in order to ensure independence – this too is a novelty in the history of the UPD.

Fig. 21
User survey: No. of call attempts

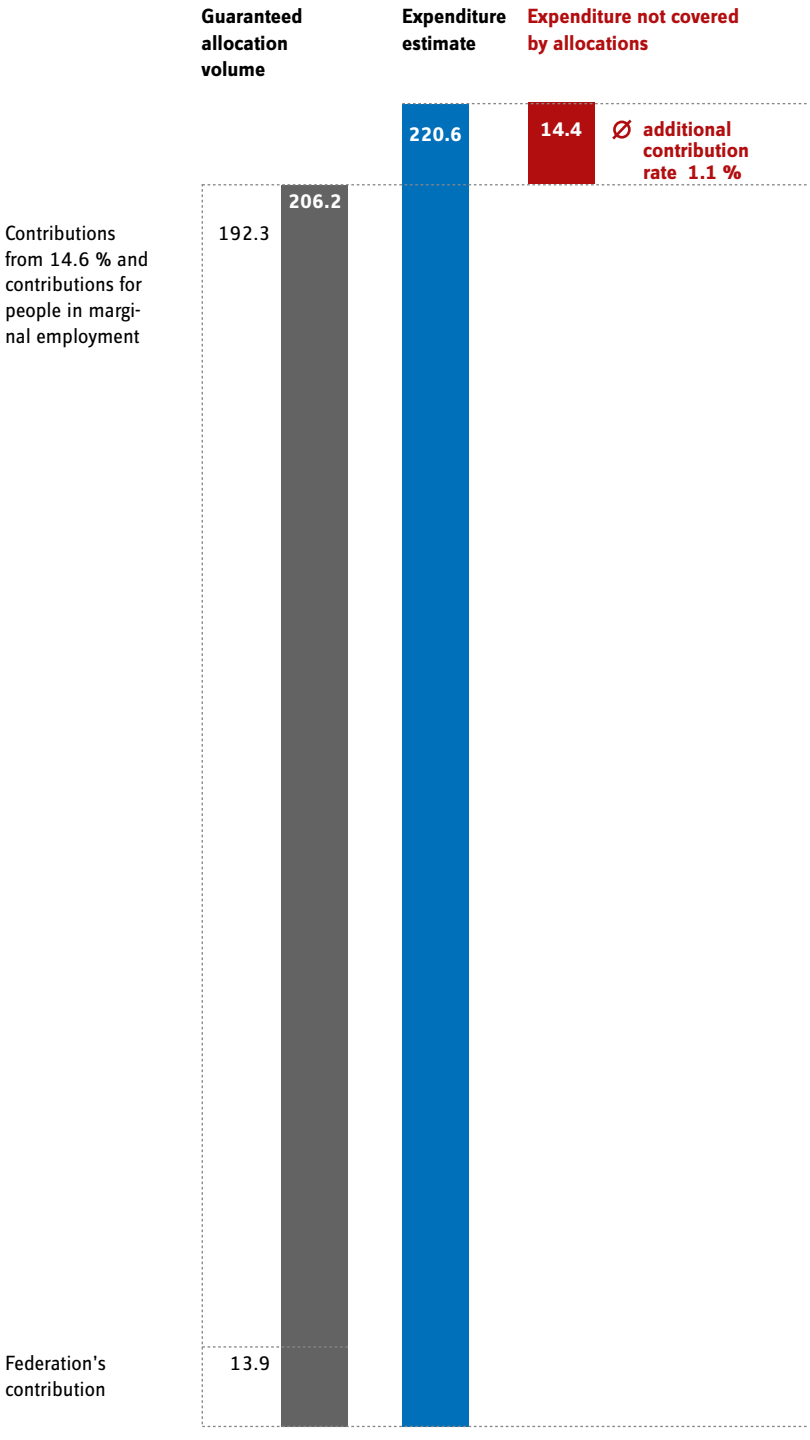
	2012		2013		2014	
No. of call attempts	No.	valid percent	No.	valid percent	No.	valid percent
1 call attempt	292	70 %	494	50 %	506	53 %
2-3 call attempts	109	26 %	297	30 %	315	33 %
4-5 call attempts	10	2 %	94	9 %	63	6 %
>5 call attempts	7	2 %	104	11 %	74	8 %
no comment	12	-	46	-	53	-
Total*	430	-	1,035	-	1,011	-

*Number only takes account of individuals who state that they received their consultation by telephone.
Source: IGES Institute

Making statutory health insurance funding sustainable

After four years of financial consolidation, 2014 was followed by a second year in which there was a negative financial result. The Health Fund closed in 2015 with a deficit of 2.3 billion Euro. The health insurance funds also anticipate a negative financial result. Statutory health insurance therefore had to tap its reserves once more – the Health Fund accessing the liquidity reserve and the health insurance funds their operating funds and reserves. The particularly worrying aspect of this development is that it was necessary to call on the reserves despite a considerable increase in revenues. This development will continue in 2016: Despite an anticipated 5.2 % increase in the revenue of the Health Fund, the allocations to the health insurance funds, amounting to 206.2 billion Euro, are unlikely to be sufficient to finance the growing expenditure at the previous level of additional contribution rates. The Federal Ministry of Health has accordingly set the theoretical average additional contribution rate of the health insurance funds at 1.1 %, up from 0.9 %. This trend was also followed by the actual additional contribution rates of the health insurance funds. In view of the prognoses, the administrative councils of the majority of health insurance funds saw themselves forced to increase their additional contribution rates as per 1 January 2016; the new additional contribution rates range from 0.3 % to 1.7 %. There is now only one health insurance fund, operating regionally, which still does not charge an additional contribution rate, whilst 26 health insurance funds charge the forecast average rate of 1.1 %. It is the legislature which is very largely responsible for the increase in expenditure causing this development: The laws that were adopted in 2014 and 2015 by themselves – and the Hospital Structure Act and the Statutory Health Insurance Care Improvement Act in particular – add an estimated increased additional burden of 1.4 billion Euro to the health insurance funds in 2016.

Fig. 22
Revenue-expenditure forecast
in billions of Euro



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

Financial development in 2015

The assessable income of statutory health insurance members increased by 4.2 % in the year under report to 1.244 trillion Euro (2014: +3.9 %). Given the general contribution rate, which was re-

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statutory health insurance funding

duced to 14.6 % as per 1 January 2015, contribution income was 181.6 billion Euro. The total income of the Health Fund was hence 196 billion Euro when added to by the contributions from marginal employment (3 billion Euro) and the Federation's contribution (11.4 billion Euro). An additional attribution of 2.5 billion Euro was available from the liquidity reserve for funding allocations. With this total income of 198.5 billion Euro, the Health Fund was able to adequately finance the allocations that were assured to the health insurance funds amounting to 198.3 billion Euro. As a result, only the attribution from the liquidity reserve to the allocation volume led to a deficit in the Health Fund of 2.3 billion Euro. The liquidity reserve accordingly fell from 12.5 billion Euro to 10.2 billion Euro in the year under report.

Revenue from allocations in the health insurance funds of about 198.3 billion Euro compared to fund-relevant expenditure of roughly 209.3 billion Euro. The expenditure of the health insurance funds hence increased by 8.9 billion Euro in comparison to the previous year. This corresponds to expenditure growth of 3.7 % per insured person. The shortfall of the health insurance funds was 11.1 billion Euro in the year under report, which mostly needed to be made up by charging the new fund-specific additional contributions. The additional contribution rates that were charged in 2015 varied between 0.3 % and 1.3 %. Some of the health insurance funds drew on existing reserves in order to avoid higher contribution rates. The amount of the revenue from additional contributions – and hence the financial performance of the health insurance funds for 2015 – will not be available until after the provisional accounting results have been published in March 2016. However, a further deficit is anticipated to occur here too for 2015, given the considerable increase in expenditure on benefits and the targeted reduction in reserves.

The financial forecast for 2016

The contribution income for 2016, including contributions from marginal employment, was estimated by the statutory health insurance appraisers to be 192.3 billion Euro. In addition to income from contributions, the Fund is able to count on a 13.9 billion Euro contribution from the Federation, so that the estimated revenue totals 206.2 billion Euro. This anticipated total income is guaranteed for the health insurance funds as allocation volume for 2016, so that the Fund will reach a financial result of zero in arithmetic terms. Having said that, the Health Fund will be additionally burdened by the funding for the Innovation Fund, as well as for the Structural Fund which has been established for in-patient care. The liquidity reserve will hence be reduced by almost 250 million Euro by the end of 2016, reaching an anticipated 9.9 billion Euro.

The anticipated fund-relevant expenditure of the health insurance funds in 2015 was estimated at 220.6 billion Euro (+4.6 % per insured person). This consequently leads to a shortfall of 14.4 billion Euro on the part of the health insurance funds. Where the health insurance funds are unable to fall back on reserves, this amount is to be raised through additional contributions made by the insured persons. The shortfall, related to the estimated base rate of pay for 2016, corresponds to a theoretical average additional contribution rate of 1.1 %. This is relevant for the additional contributions of beneficiaries of unemployment benefit II (Arbeitslosengeld II), as well as for some other groups of members of the health insurance funds. All other members pay their respective additional contributions on the basis of the fund-specific additional contribution rate of their particular health insurance fund.

One year of fund-specific additional contribution rates

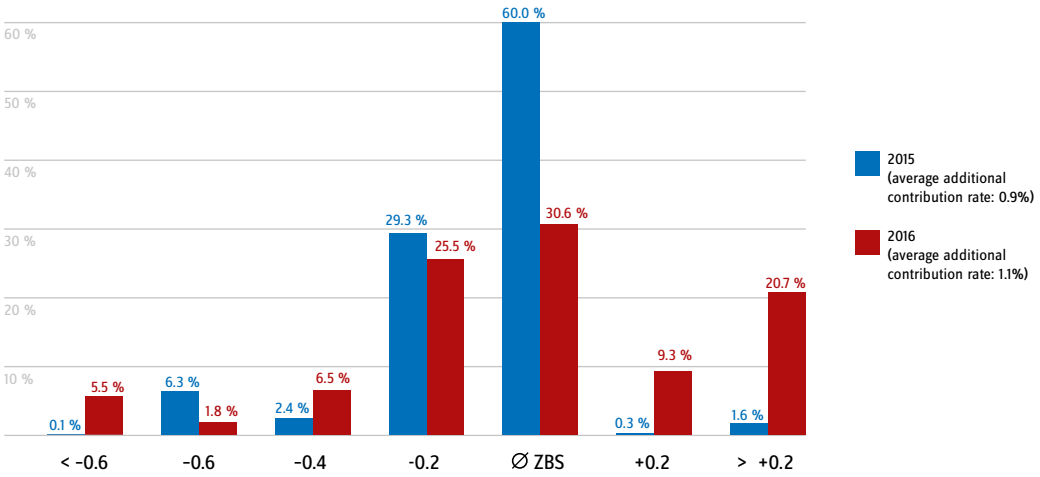
Statutory health insurance was able to implement the launch of the new funding system with fund-specific additional contribution rates and a new mechanism to compensate for the different basic wages of the members (the "income equalisation") on time and smoothly. Thanks to reserves that have been created, the health insurance funds were able on average to remain slightly below the

forecast additional contribution rate level of 0.9 % which had been set. The average additional contribution rate actually charged, which was weighted according to members, was 0.83 %. Spread over the year, this reduced the burden on statutory health insurance members by about 870 million Euro. The health insurance funds charged additional contribution rates of between 0.3 % and 1.3 % in the year under report. Only two health insurance funds were able to do without charging it altogether.

The new fund-specific contribution rates also led to turnover within the membership. Health insurance funds with below-average additional contribution rates recorded tangible membership gains. All in all, however, the migratory movements were much less pronounced than in the previous funding system with income-independent flat-rates. This is evidently largely the result of income-related additional contributions in the system, which are charged in the withholding tax procedure. A considerable financial destabilisation of health insurance funds with above-average additional contribution rates was certainly not observed in the year under report.

In line with its statutory mandate, the National Association of Statutory Health Insurance Funds has been publishing an overview of the current additional contribution rates of the health insurance funds on the Internet since 1 January 2015 at www.gkv-zusatzbeiträge.de. By providing fully-automated daily access to the datastocks of the Information Technology Service Point of Statutory Health Insurance, which are managed by the health insurance funds, the National Association of Statutory Health Insurance Funds ensures that the daily-updated additional contribution rates of the health insurance funds are published on a daily basis. This meant that all new additional contribution rates of the health insurance funds were online on 1 January 2016. 77 of the 118 member funds of the National Association of Statutory Health Insurance Funds saw themselves forced to adjust their additional contribution rates at the end of 2015/beginning of 2016 because of the continuing expenditure dynamics.

Fig. 23
Membership shares in statutory health insurance by additional contributions 2015 and 2016



Example: The additional contribution rate for 60 % of statutory health insurance members in 2015 was 0.9 %.
The additional contribution rate was up to 0.2 percentage points higher (0.9 < additional contribution rate <= 1.1) for only 0.3 % of statutory health insurance members in 2015 (average additional contribution rate: 0.9 %)

Source and Illustration: National Association of Statutory Health Insurance Funds

Defending interests at international level

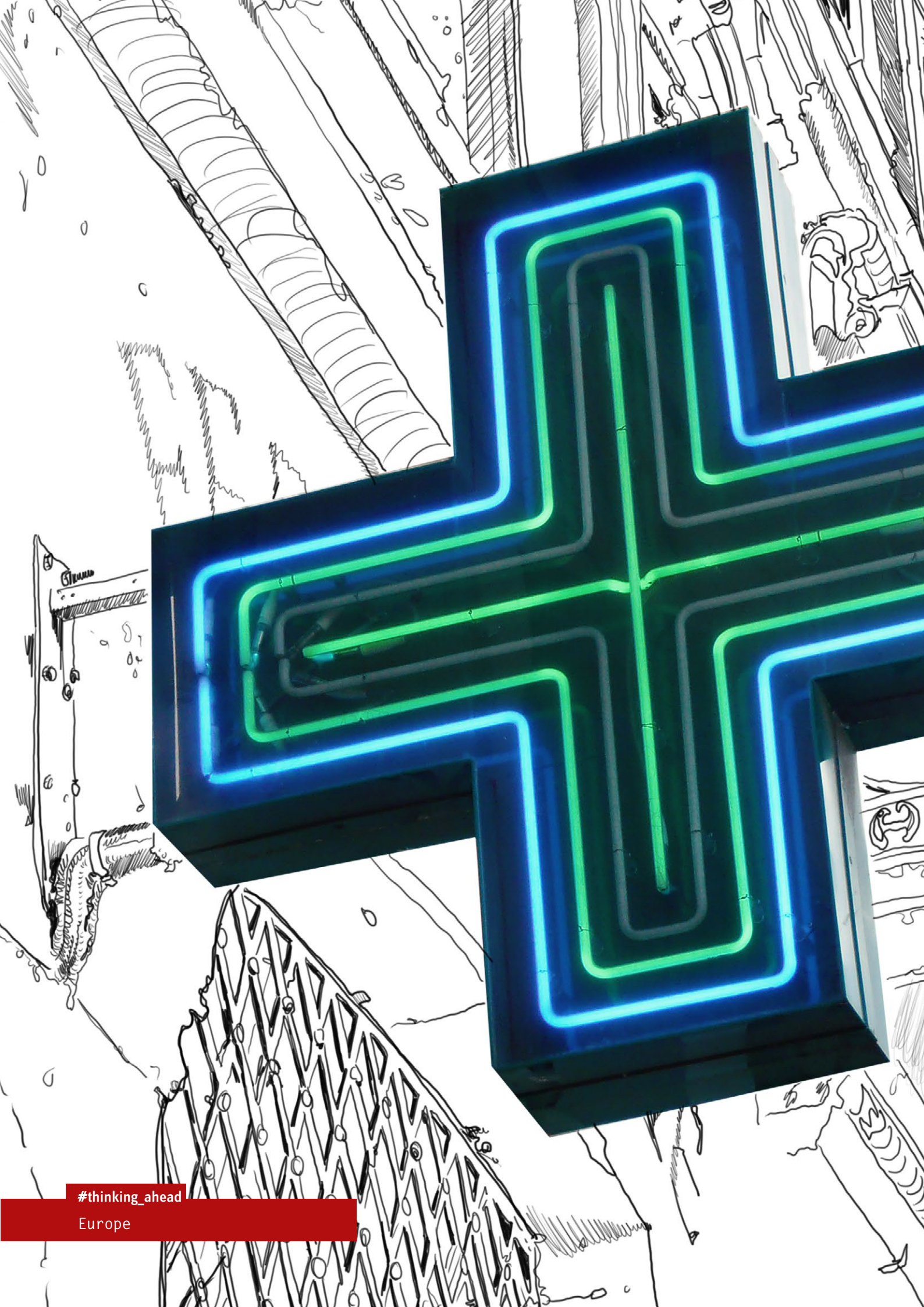
The National Association of Statutory Health Insurance Funds stepped up its activities in the international arena once more in 2015. Given the growing influence which the European Union has on national actions, defending the interests of German statutory health insurance at European level is at the centre of its activities. Jointly with statutory accident and pension insurance, as well as with the associations of health and long-term care insurance funds at federal level, the National Association of Statutory Health Insurance Funds, as the lead voter for statutory health insurance, is among the institutions which are members of the German Social Insurance Working Party on Europe. In order to achieve effective networking, the National Association of Statutory Health Insurance Funds also contributes to the European Social Insurance Platform, which combines the interests of approx. 40 statutory social insurance organisations from all over Europe. The National Association of Statutory Health Insurance Funds is also a member of the International Social Security Association (ISSA).

The International Social Security Association

The ISSA looks back on a long tradition: It was established in 1927 under the umbrella of the International Labour Organization, and today has more than 330 member institutions in over 160 countries. It is regarded as the leading organisation in cooperation between social security institutions at international level. The goal of the ISSA is to establish and expand the social security systems worldwide and to offer to its members specific knowledge, expert advice and information platforms in this area.

The National Association of Statutory Health Insurance Funds has been a member of the ISSA since 2013 – as have pension, accident and social insurance for agriculture, forestry and horticulture. Manfred Schoch, who is a member of the Administrative Council of the National Association of Statutory Health Insurance Funds, has been a member of the ISSA's Board since the halfway point of the triennium 2014 to 2016. With him, the Association has nominated a representative of statutory health insurance who can offer experience on the international stage to the work of the ISSA.

The goal of the ISSA is to establish and expand the social security systems worldwide and to offer to its members specific knowledge, expert advice and information platforms in this area.



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Europe

Thinking health at European level

The market for medical devices is developing apace. Innovations in medical technology which make possible previously-unknown medical treatment methods are increasingly penetrating the care sector. The European law on medical devices, which sets the rules for access to markets and market monitoring, has however not been able to keep pace with this development. Scandals concerning "metal-on-metal endoprostheses", stents and breast implants have made it clear that there is an urgent need to modernise the law on medical devices.

The institutions are taking up their positions

The European Commission put forward a proposal for a regulation on medical devices back in September 2012. The European Parliament also took up its position in April 2014. The European Council agreed in June 2015 on the contents of a negotiating position. The central official registration of high-risk medical devices, for which the National Association of Statutory Health Insurance Funds and the European Social Insurance Platform had repeatedly called, is not being called for by any of the European institutions.

There is however a recognisable effort to create greater clarity and accountability in some areas, for instance with regard to the earmarking of high-risk medical devices, the rules for clinical evaluations or the formalisation of publicly-available information. In a new control procedure, known as the scrutiny procedure, an independent group of experts is for instance to be established to evaluate conformity assessment procedures for risk class III implants. Their vote is to be counted towards the decision of the notified body which examines the conformity assessment of a medical device; reasons are to be given for deviations. Since the Council's proposal however is still unsatisfactory in some regards, the National Association of Statutory Health Insurance Funds and the ESIP submitted fresh improvement suggestions.

The central official registration of high-risk medical devices is not being called for by any of the European institutions.

Starting negotiations

The long-awaited trilogue negotiations between the European Commission, Parliament and the Council started in October 2015. It will be decided here whether market access for medical devices will be sustainably regulated in future. This includes guaranteeing care with adequately-researched high-risk medical devices in Europe the effectiveness and application risks of which are already known.

Fig. 24
EU medical devices

Draft regulation (September 2012)

1st reading, Parliament's key points October 2013

"Partial general approach" of the European Council, June 2015

Trilogue negotiations Start October 2015

Illustration: National Association of Statutory Health Insurance Funds

The regulatory proposals which have been put forward by the negotiating parties contain a variety of measures the implementation of which is to contribute towards improving patient safety in the supply of medical devices. The National Association of Statutory Health Insurance Funds underlined the positive provisions contained in the available drafts in a position paper on the trilogue negotiations. An appeal was made to those concerned to establish clear rules by implementing these proposals, in order thus to improve patient safety.

There is a need to make data available on the safety, effectiveness and performance of high-risk medical devices.

Enhancing patient safety

From the point of view of the National Association of Statutory Health Insurance Funds, there is a need for a robust, reliable market access system which does justice to the technical challenges, whilst at the same time guaranteeing transparent registration and market monitoring of high-risk-class medical devices. A major demand of the National Association of Statutory Health Insurance Funds aims to improve the competence and independence of the notified bodies and to raise it to a level that is comparable all over Europe.

There is also a need to increase the quality of the clinical evaluation of medical devices. Especially high-risk medical devices therefore need to be examined in clinical studies for their effectiveness with regard to end points which are relevant to patients. Only on this data basis can both physicians and patients reach sufficiently informed decisions on the application of these products. There is therefore a need to make the data concerning the safety, effectiveness and performance of high-risk medical devices publicly available and to ensure that they are always up-to-date. Manufacturers are furthermore to be obliged to conclude product liability insurance so that patients are able to enforce their well-founded claims to compensation or damages for pain and suffering, for instance also vis-à-vis a manufacturer who is insolvent.

Acting quickly

The National Association of Statutory Health Insurance Funds is pushing for the negotiations to be concluded quickly. Further delays to this important reform project will only come at the expense of patient safety. It is all the more regrettable that the European Commission has not listed the negotiations on the law on medical devices as a priority project in its Work Programme for 2016.

Acting together

The statutory health insurance organisations in Europe are faced with a number of common challenges. Making medical devices safer and guaranteeing a good supply of medicinal products are goals of the statutory health insurance funds in Germany and of their cooperation partners in other European countries alike. The National Association of Statutory Health Insurance Funds invited decision-makers from health insurance organisations from Austria, Belgium, Croatia, France, Luxembourg and the Netherlands to come to Berlin in June 2015 to discuss joint strategies.

Focussing on medicinal products and medical devices

The consultations focussed on the European policy on medicinal products and on the impact on patient care of high-priced medicinal products. The high prices charged for new medicinal products had led to some health systems questioning the benefit evaluation and financial viability. This also sparked discussions at European level.

The planned new arrangement for medical devices is one of the most important EU reform processes for health insurers. Scandals regarding prostheses and breast implants have attracted attention all over Europe and underlined the need for new regulations. The National Association of Statutory Health Insurance Funds and the European health insurers have repeatedly defended patient safety interests in this process, particularly calling for a strict, independent registration procedure for high-risk medical devices.

Different systems, similar reforms

The challenges and also the reform efforts are similar not only at European level, but also in the different health systems. Questions relating to restructuring in the hospital sector arise today in Croatia, just as they do in Germany. When it comes to the topic of the regional spread and specialisation of physicians, informative parallels can be drawn between Germany and France. The national reform agendas therefore have varied, and in some cases similarly-orientated, topics at the ready for the further exchange between the health insurers.

The planned reform for medical devices is one of the most important EU reform processes for health insurers.

Fig. 25
Regulatory provisions for medicinal products and medical devices in a comparison

	Medicinal products	Medical devices
Official registration procedure	Yes	No
Authoritative clinical studies available	Yes	No
Transparency and provision of information	Yes	No
Defined areas of application	Yes	No
Price refund also depending on additional benefit	Yes	No

Illustration: National Association of Statutory Health Insurance Funds

Regulating cross-border healthcare

The German Liaison Agency Health Insurance – International (DVKA), department of the National Association of Statutory Health Insurance Funds, is an international partner of cross-border healthcare, including in the EU, in the European Economic Area and in Switzerland. It helps ensure that insured persons can exercise their rights in the European region when it comes to healthcare.

The European Coordination Regulations regulate amongst other things the cross-border take-up of healthcare services by insured persons within these states. The coordination is intended to facilitate mutual coordination and interlocking between the individual healthcare systems. Entitled individuals staying in another state may receive the same medical care as insured persons there, in accordance with the principle of mutual benefits assistance. The costs incurred are refunded to the healthcare provider by an insurer in the treatment state. In Germany, these are the health insurance funds, which then in turn request a refund of the costs from the insurer with whom the individual in question is insured. The cost refund principle of the Coordination Regulations is based on the idea of creating a balanced distribution of burdens among the Member States. Specifically in the field of illness, this procedure is to do justice to the interests both of those Member States which make their health systems available, and to those whose insurers meet the costs of the benefits in kind.

It is the Member States which shoulder responsibility for the funding and organisation of the healthcare systems and for medical care. This leads to differing health system structures within the EU, where standards may vary.

It is the Member States which shoulder responsibility for the funding and organisation of the healthcare systems and for medical care. This leads to differing health system structures in the EU, and standards may vary. Since the provisions contained in the regulations provide for the systems to be coordinated, and not to be harmonised, differences in benefits between the individual states are accepted as a matter of principle.

Medical treatment in another EU country

The Coordination Regulations enable insured persons to also undergo medical treatment in another Member State. If the treatment is planned, the individual in question must as a matter of principle obtain the prior consent of the competent insurer. If a planned benefit cannot be carried out in the home state, or not in time, the insurer must give their insured person advance approval.

The framework conditions for the affordability of the national health systems are not fixed. This means that health systems within the EU can for instance temporarily be in a difficult financial situation. The health insurance funds in these states are then frequently faced with the question of whether they must approve planned treatment in the other state because the benefit cannot be provided in the home state in good time due to temporary problems with care. The health insurance fund in the treatment country initially advances these costs.

The impact of financial compensation mechanisms

These and other reasons can lead to asymmetries in the mutual claims between two Member States, and in the case of Germany have already led to imbalances in the compensation of claims with other Member States. Different price levels in service-provision can exacerbate the situation further. This circumstance makes it more difficult amongst other things to establish and rebuild own care structures in the health sector. It is the insured persons who suffer, especially if they are less mobile for reasons of age or because of language barriers.

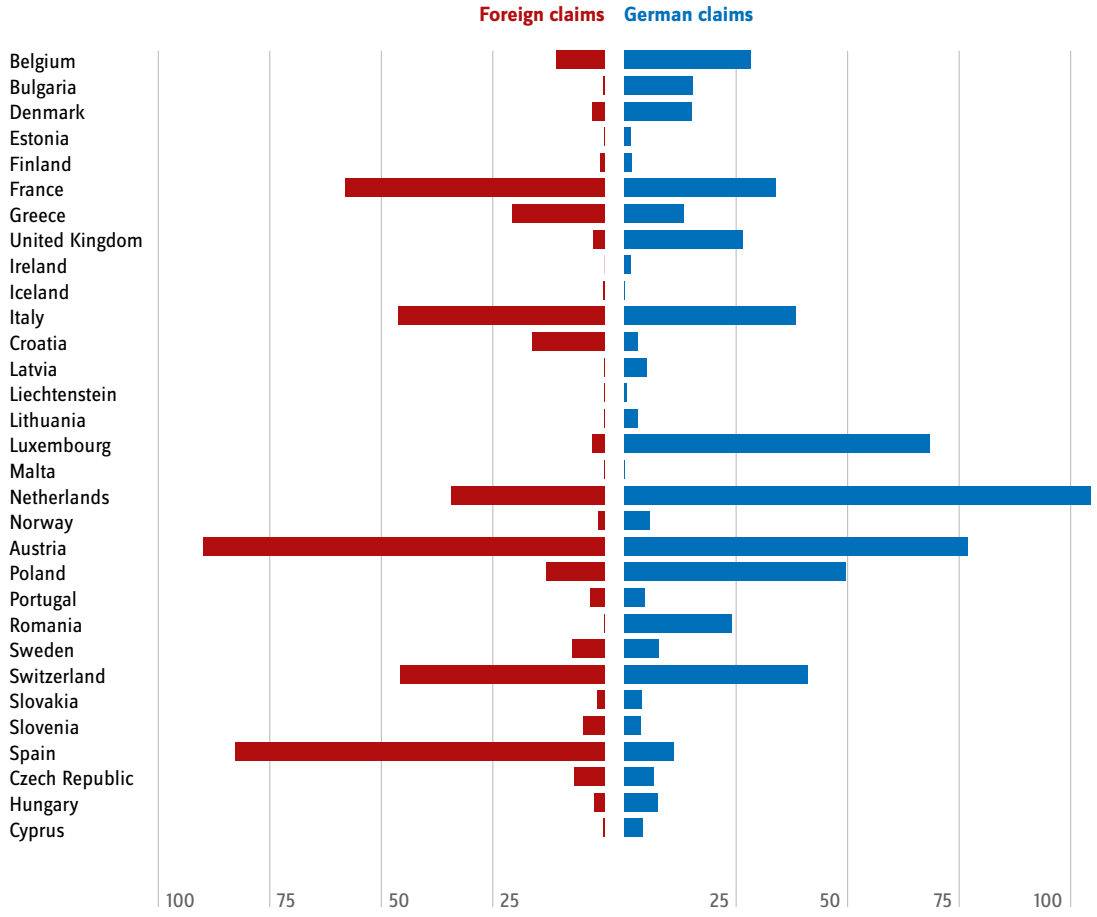
The regulations provide for deadlines for the payment of the claims which most states in fact meet. States which are in financial trouble do not always meet their payment obligations in

time. In order to defend the financial interests of the German health insurance funds, the DVKA has already used control tools in the past such as negotiating offsetting agreements and payment plans with individual states.

It is becoming increasingly clear that the compensation mechanisms in place today are not effective given the financial fluctuations. The application of the cost refund regulations in the cross-over between patient mobility and the burden of cost distribution must therefore be structured more effectively. In order to also be able to guarantee the principle of mutual benefits in the future, further steering tools will need to be developed soon for the formalisation of the cost refund arrangements, both at national and at European level.

Different price levels in service provision make it more difficult amongst other things to maintain or rebuild own care structures in the health sector.

Fig. 26
Claims by EU country
in million Euro



as per: claims submitted in 2014
Illustration: National Association of Statutory Health Insurance Funds

#thinking_ahead

@gkv_sv

Making health policy understandable

The communicative year 2015 was typified by large numbers of legislative projects. A focus was consequently placed in the press work of the National Association of Statutory Health Insurance Funds on responding to the rapid succession of legislative initiatives of the Federal Ministry of Health. The National Association of Statutory Health Insurance Funds issued public statements in the interest of statutory health and long-term care insurance on large numbers of topics, thus clearly stating its position. This was no simple task given the considerable topical variety – ranging from long-term care and disease prevention through digital communication in the healthcare system, as well as hospice and palliative care, to hospital reform and the fight against corruption.

The re-tendering of Independent Patient Advice dominated the media in the summer. During the several months during which the procurement procedure lasted, the topic was discussed controversially and highly-emotionally by third parties. It was therefore important for the National Association of Statutory Health Insurance Funds to be able to counter presumptions that consultation would be restricted in the future by putting forward good arguments at a press conference.

The debate on finances and on the issue of the additional contributions that vary from one insurance fund to another lasted throughout the year. Once again, care-related issues regarding midwifery services, new medicinal products and medical care were popular topics in the press. It was possible here for the National Association of Statutory Health Insurance Funds to successfully make it clear to the public that the health policy legislation of the Grand Coalition causes massive financial burdens.

Once again, care-related issues regarding midwifery services, new medicinal products and medical care were popular topics in the press.

The relaunch of the DVKA's website

The DVKA department has also been presenting itself in the new online design of the National Association of Statutory Health Insurance Funds since the end of 2015. The website is used largely by the health insurance funds themselves, but also by insured persons and employers. A large number of forms and background information are available, especially for the funds. User-friendly filtering and search functions help users to locate the contents they would like to find.

A major item of the Association's online strategy was implemented with the relaunch: All the websites now have a uniform presentation – in both optical terms and in terms of the applications.

"GKV live" becomes more established

After a successful start of the new "GKV live" ("Statutory health insurance live") event format in 2014, the National Association of Statutory Health Insurance Funds also issued an invitation once more to attend three topical evenings in 2015. In this framework, the Board of the National Association of Statutory Health Insurance Funds discussed with representatives from the political arena the topics of misconduct in the healthcare system, the eHealth Act and hospital reform. The growing public interest in the events confirms that the Association does well to continue "Statutory health insurance live" as a regular series in the future.

The budget of the National Association of Statutory Health Insurance Funds

The annual financial statement for 2014

The financial statement of the National Association of Statutory Health Insurance Funds for 2014 was drawn up in April 2015. The audit of the annual financial statement, including the departmental budget of the German Liaison Agency Health Insurance – International (DVKA), was carried out by the BDO firm of auditors. The migration of the SAP system of the National Association of Statutory Health Insurance Funds to a new computer centre was also audited. The firm of auditors issued an unqualified audit report. At its session that was held in June 2015, the Administrative Council thereupon approved the activities of the Board and approved the 2014 annual financial statement.

The Association's budget for 2015

The 2015 budget plan of the National Association of Statutory Health Insurance Funds shows an overall budget of 137.1 million Euro. This includes the contribution towards the core budget of the National Association of Statutory Health Insurance Funds, minus the refunds from the refinancing of the start-up funding for the statutory health insurance communication server. The following pay-as-you-go financing arrangements are also included:

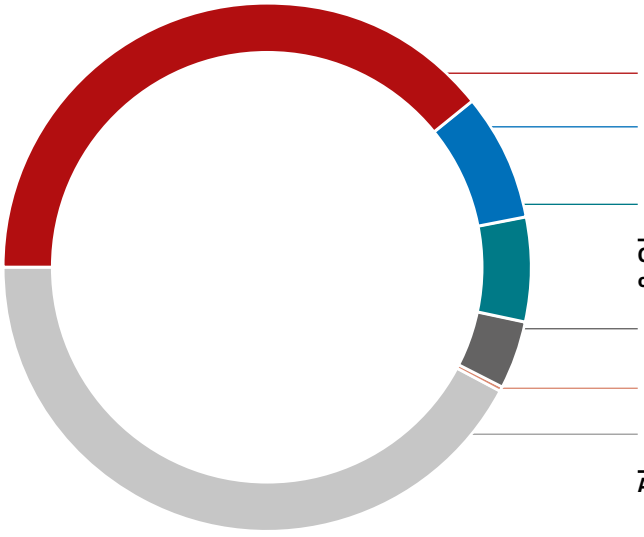
- German Liaison Agency Health Insurance – International (DVKA departmental budget)
- The Medical Service of the central association of the health insurance funds at federal level (MDS e. V.)
- Gesellschaft für Telematikanwendungen der Gesundheitskarte mbH (gematik)
- Data transparency in accordance with sections 303a to 303f of Book V of the Social Code
- Promotion of facilities for consumer and patient advice (UPD).

The expenditure on data transparency amounting to 640,000 Euro planned for the 2015 budget is funded to the amount of 306,000 Euro from the allocation collected in 2013 since not all of the funds that had originally been planned in 2013 were drawn on by the German Institute of Medical Documentation and Information.

The budget for 2016

The budget plan for 2016 that was drawn up by the Board on 28 October 2015 was adopted by a majority of the Administrative Council of the National Association of Statutory Health Insurance Funds on 2 December 2015; there was one abstention. The Association's overall budget was set at 184.4 million Euro. It hence increased by 47.3 million Euro year-on-year. This is especially a result of the allocations to the Federal Centre for Health Education in accordance with section 20a of Book V of the Social Code, amounting to 31.8 million Euro, which was incorporated into the overall budget of the National Association of Statutory Health Insurance Funds for the first time in the budget year 2016, and to the service guarantee incentive for midwives amounting to 14.8 million Euro in accordance with section 134a subsection (1b) of Book V of the Social Code.

Fig. 27
Elements of the overall budget



Core budget	56,541,000 €	
Communication server	-2,675,000 €	
Core budget sum	53,866,000 €	
DVKA*	10,712,000 €	
MDS**	8,785,000 €	
Contribution of the National Association of Statutory Health Insurance Funds	**73,363,000 €**	Cost per insured person 1.04 €
UPD	5,722,000 €	
Data transparency	334,000 €	
gematik	57,671,000 €	
Allocation of further budget elements	**63,777,000 €**	Cost per member 1.21 €
Overall budget for 2015	**137,140,000 €**	

* DVKA: German Liaison Agency Health Insurance – International
** MDS: The Medical Service of the central association of the health insurance funds at federal level
Illustration: National Association of Statutory Health Insurance Funds

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

The staff employment plan provided for a total of 389.86 established posts for 2015. 97 of these were accounted for by the German Liaison Agency Health Insurance – International (DVKA) in Bonn. At its second meeting held on 2 September 2015, the Administrative Council decided to form 33 posts on an intra-year basis. In this regard, it complied with the implementation recommendations of the organisational study for the optimisation of the organisational structure and process organisation and of the staffing situation, as well as with the recommendations made in this regard by the specialist committee on Organisation and Finance and by the specialist committee on Basic and Health policy. The staff employment plan therefore provides for 422.86 established posts from 1 October 2015 onwards. The number of established posts of the DVKA in Bonn remained unchanged. The rate of occupied posts was 94.53 % at the end of the year.

Fig. 28
Staff development (not including the DVKA department)

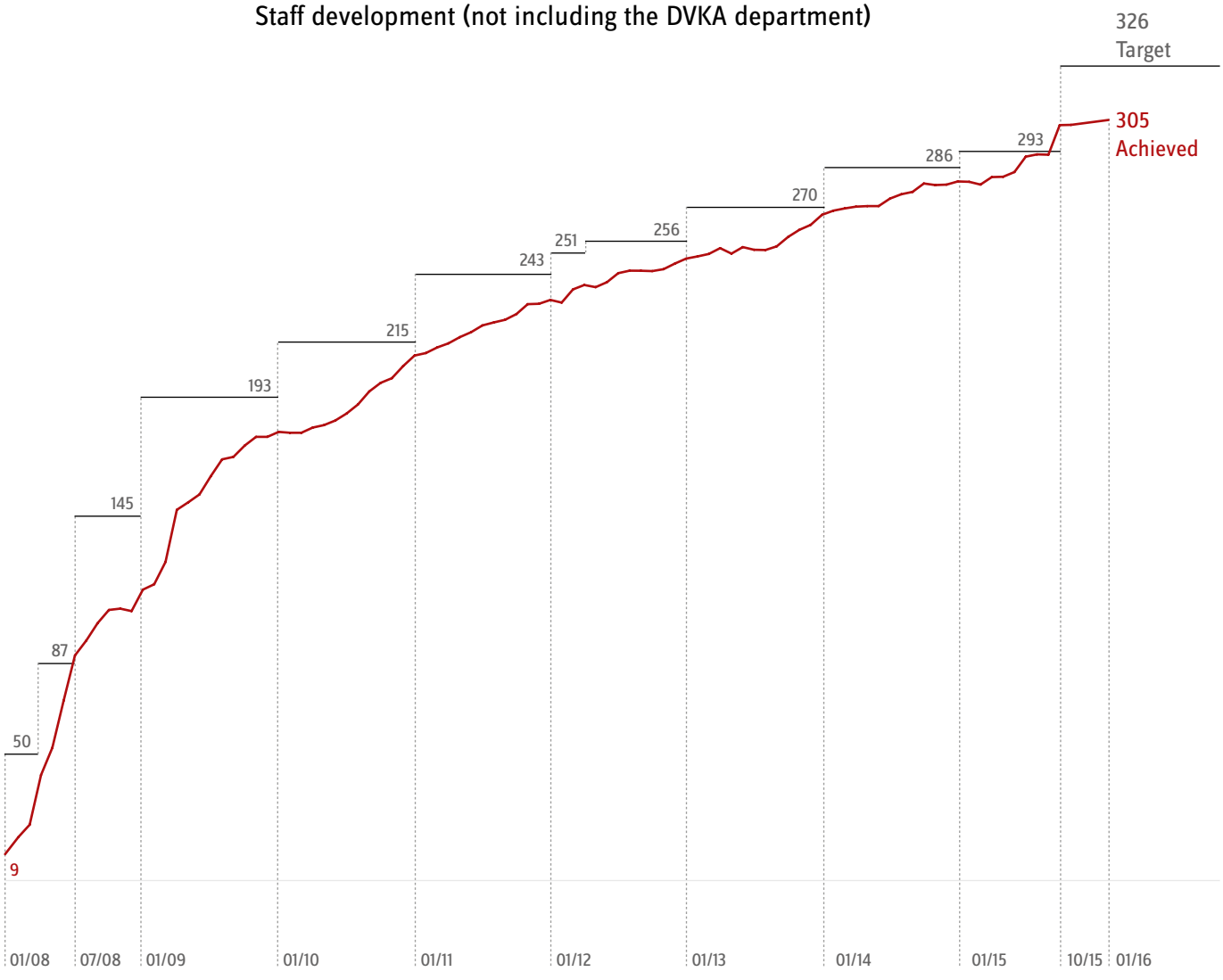


Illustration: National Association of Statutory Health Insurance Funds

The members of the National Association of Statutory Health Insurance Funds in 2015 (cut-off date: 1 January 2016)

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

88. Hanseatische Krankenkasse
89. Heimat Krankenkasse
90. hkk
91. IKK Brandenburg und Berlin
92. IKK classic
93. IKK gesund plus
94. IKK Nord
95. IKK Südwest
96. Kaufmännische Krankenkasse – KKH
97. Knappschaft
98. Krones BKK
99. Merck BKK
100. Metzinger BKK
101. mhplus Betriebskrankenkasse
102. Novitas BKK
103. pronova BKK
104. R+V Betriebskrankenkasse
105. Salus BKK
106. SECURVITA BKK
107. SIEMAG BKK
108. Siemens-Betriebskrankenkasse (SBK)
109. SKD BKK
110. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
111. Südzucker BKK
112. Techniker Krankenkasse
113. Thüringer Betriebskrankenkasse
114. TUI BKK
115. Vereinigte BKK
116. VIACTIV Krankenkasse
117. Wieland BKK
118. WMF Betriebskrankenkasse

Mergers in 2015 (cut-off date: 1 January 2016)

Merged funds	Merger partners
pronova BKK	Vaillant BKK pronova BKK
BKK Linde	BKK Linde HEAG BKK
BKK ProVita	BKK family BKK ProVita
BKK Verkehrsbau Union (BKK VBU)	BKK Verkehrsbau Union (BKK VBU) BKK Schleswig-Holstein BKK Basell BKK DEMAG KRAUSS-MAFFEI

Ordinary members of the Administrative Council in the 2nd period of office (2012-2017)

Representatives of insured persons

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

Employers' representatives

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

Deputy members of the Administrative Council in the 2nd period of office (2012-2017)

Representatives of insured persons

Name	Health insurance fund
Aichberger, Helmut	DAK-Gesundheit
Baer, Detlef	IKK Brandenburg und Berlin
Baki, Brigitte	AOK Hessen
Becker-Müller, Christa	DAK-Gesundheit
Berger, Silvia	IKK Südwest
Berking, Jochen	Deutsche BKK
Bink, Klaus-Dieter	AOK NORDWEST
Bumb, Hans-Werner	DAK-Gesundheit
Christen, Anja	BKK Verkehrsbau Union (VBU)
Coors, Jürgen	Daimler BKK
Date, Achmed	BARMER GEK
Decho, Detlef	Techniker Krankenkasse
Dollmann, Klaus	BARMER GEK
Dorneau, Hans-Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Feichtner, Richard	AOK Rheinland-Pfalz/Saarland
Fenske, Dieter	DAK-Gesundheit
Gabler, Heinz-Joachim	Kaufmännische Krankenkasse – KKH
Goldmann, Bernd	BARMER GEK
Gosewinkel, Friedrich	Techniker Krankenkasse
Gransee, Ulrich	AOK Niedersachsen
Hauffe, Ulrike	BARMER GEK
Heinemann, Bernd	BARMER GEK
Hippel, Gerhard	DAK-Gesundheit
Hoppe, Klaus	Siemens-Betriebskrankenkasse (SBK)
Hüfner, Gert	Knappschaft
Jena, Matthias	AOK Bayern
Karp, Jens	IKK Nord
Kemper, Norbert	AOK Rheinland/Hamburg
Kindler, Dieter	IKK classic
Kloppich, Iris	AOK PLUS
Knerler, Rainer	AOK Nordost
Knöpfle, Manfred	BKK STADT AUGSBURG
Korschinsky, Ralph	BARMER GEK
Krause, Helmut	BIG direkt gesund
Lambertin, Knut	AOK Nordost
Leitloff, Rainer	DAK-Gesundheit
Lubitz, Bernhard	HEK–Hanseatische Krankenkasse
Matthesius, Dr. Rolf-Gerd	BARMER GEK
Muscheid, Dietmar	AOK Rheinland-Pfalz/Saarland
Salzmann, Rainer	BKK B. Braun Melsungen AG
Schiwnak, Bianca	Techniker Krankenkasse

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

Employers' representatives

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

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

Specialist committee on fundamental issues and health policy

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

Ordinary members

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

Deputy members

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

Specialist committee on organisation and finance

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

Ordinary members

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

Deputy members

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

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

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

Ordinary members

Employers' representatives	Representatives of insured persons
1. Ivor Parvanov (AOK)	1. Harald Schulte (EK)
2. Wolfgang Ropertz (AOK)	2. Christian Ermler (EK)
3. Hans-Jürgen Schnurr (EK)	3. Rolf-Dieter Aschenbeck (EK)
4. Dietrich von Reyher (BKK)	4. Wolfgang Metschurat (AOK)
5. Dr. Andreas Tautz (BKK)	5. Roswitha Weinschenk (AOK)
6. Nikolaus Chudek (IKK)	6. Knut Lambertin (AOK)
	7. Eckehard Linnemann (Knappschaft)
	8. Manfred Schoch (BKK)

Deputy members

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

Specialist committee on contracts and care

Chaired by: Angelika Beier/Ernst Hornung
(alternating; Dietrich von Reyher acting as deputy for E. Hornung)

Ordinary members

Employers' representatives	Representatives of insured persons
1. Dr. Volker Hansen (AOK)	1. Albert Roer (EK)
2. Friedrich Avenarius (AOK)	2. Dietmar Katzer (EK)
3. Wolfgang Söller (AOK)	3. Hans-Peter Stute (EK)
4. Bernd Wegner (EK)	4. Helmut Aichberger (EK)
5. Ernst Hornung (BKK)	5. Angelika Beier (AOK)
6. Rainer Lunk (IKK)	6. Susanne Wiedemeyer (AOK)
	7. Roland Brendel (BKK)
	8. Bert Römer (IKK)

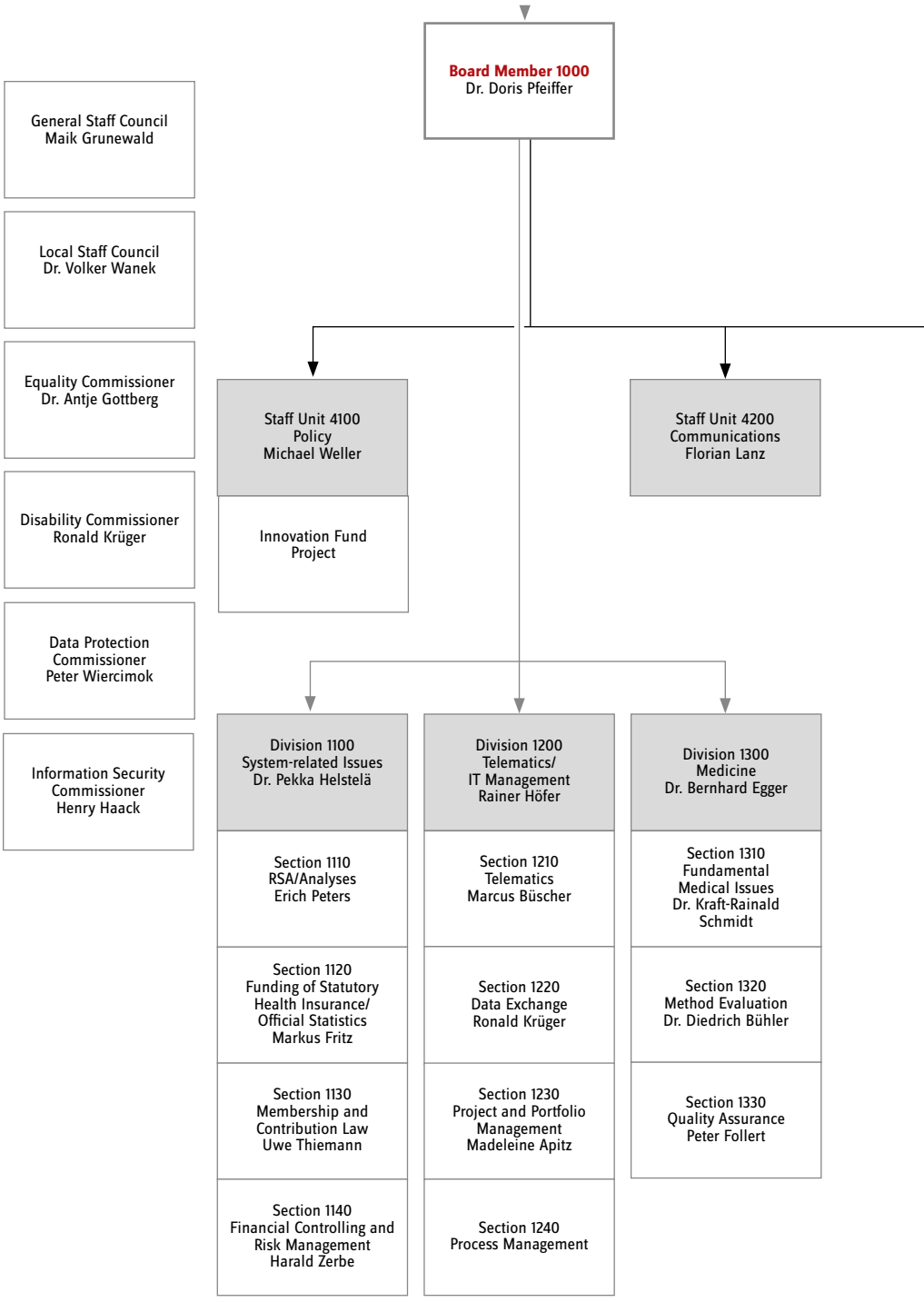
Deputy members

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

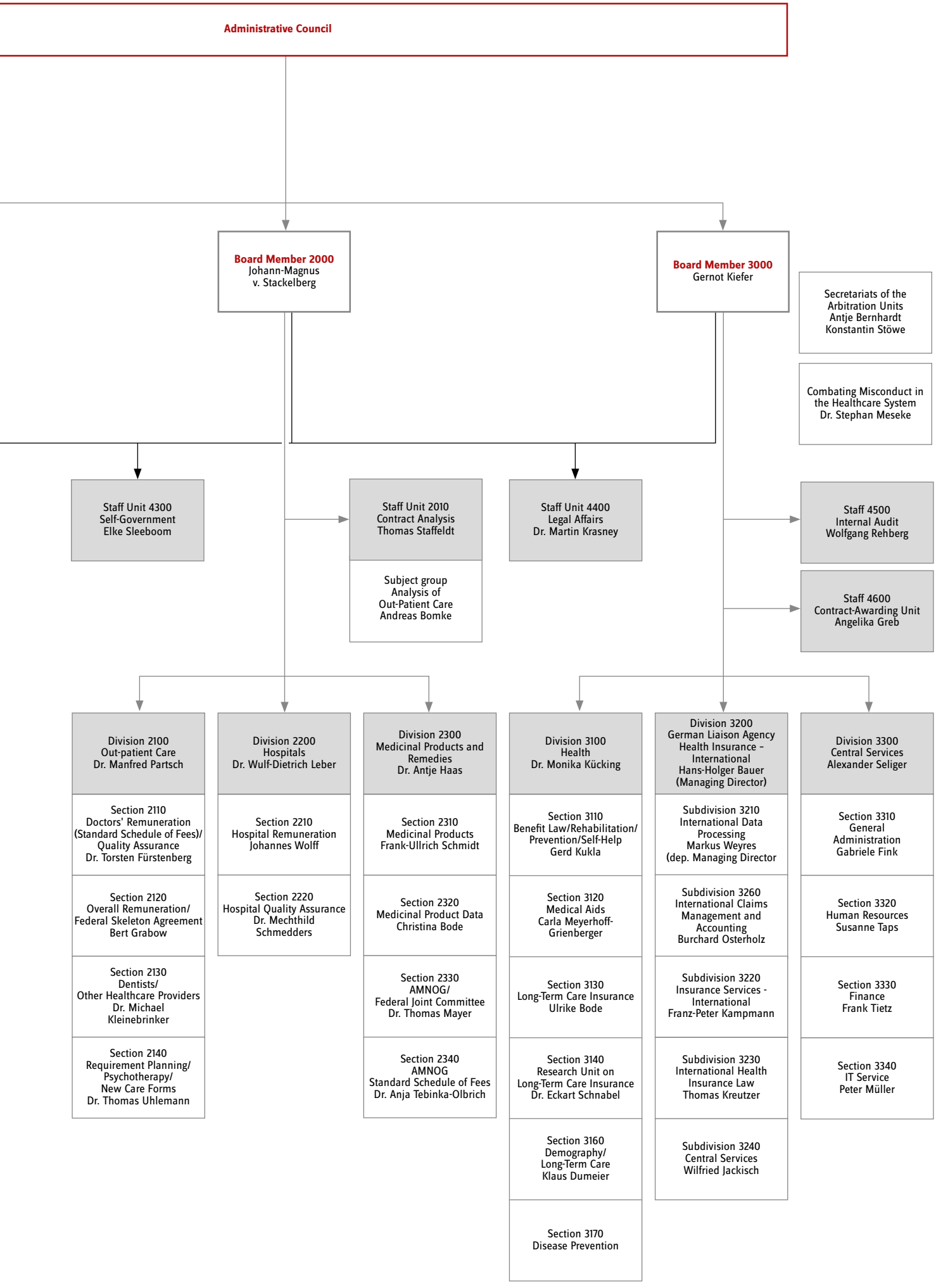
Ordinary members and personal deputies of the Specialist Advisory Council

	Members	**Deputies**
AOK	Jürgen Graalmann (until 9 July 2015) Dr. Helmut Platzer	Uwe Deh (until 9 July 2015) Dr. Jürgen Peter
BKK	1. Franz Knieps 2. Achim Kolanoski (until 31 December 2015)	Andrea Galle Winfried Baumgärtner
Ersatzkassen	1. Ulrike Elsner 2. Dr. Jörg Meyers-Middendorf	Boris von Maydell (since 18 December 2015 for Manfred Baumann) Oliver Blatt
IKK	1. Jürgen Hohnl 2. Uwe Schröder	Frank Hippler Enrico Kreutz
Knappschaft	1. Bettina am Orde 2. Gerd Jockenhöfer	Dieter Castrup Jörg Neumann
Landwirtschaftliche Sozialversicherung	1. Claudia Lex 2. Gerhard Sehnert	Reinhold Knittel Dr. Erich Koch

Organisational chart National Association of Statutory Health Insurance Funds



As per March 2016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Board Member 3000
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Arbitration Units
Antje Bernhardt
Konstantin Stöwe
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Thomas Staffeldt
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Wolfgang Rehberg
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Division 2100
Out-patient Care
Dr. Manfred Partsch
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Doctors' Remuneration
(Standard Schedule of Fees)/
Quality Assurance
Dr. Torsten Fürstenberg
Section 2120
Overall Remuneration/
Federal Skeleton Agreement
Bert Grabow
Section 2130
Dentists/
Other Healthcare Providers
Dr. Michael
Kleinebrinker
Section 2140
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Dr. Thomas Uhlemann
Division 2200
Hospitals
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Hospital Remuneration
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Medicinal Products and
Remedies
Dr. Antje Haas
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Standard Schedule of Fees
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Klaus Dumeier
Section 3170
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(Managing Director)
Subdivision 3210
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Insurance Law
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Susanne Taps
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Finance
Frank Tietz
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Peter Müller

Publications of the National Association of Statutory Health Insurance Funds

Position papers

Title	Publication/ adoption date
Für eine konsequente Bekämpfung von Fehlverhalten im Gesundheitswesen	March 2015
Anforderungen an die Rolle der Kommunen in der Pflege – Positionen des GKV-Spitzenverbandes anlässlich der Verhandlungen zwischen Bund und Ländern	June 2015
Positionen des GKV-Spitzenverbandes zur Weiterentwicklung der Hospiz- und Palliativversorgung	June 2015
Position der gesetzlichen Krankenversicherung zum Trilog Medizinprodukteverordnung	November 2015

Further publications

Author(s)	Title	Publication/ adoption date
GKV-Spitzenverband	Argumentationspapier des GKV-Spitzenverbandes zur Arzneimittelpolitik	April 2015
GKV-Spitzenverband	Vorschlag für eine Verordnung über Medizinprodukte Aktuelle Verhandlungen im Rat der Europäischen Union Positionierung der gesetzlichen Kranken- und Pflegeversicherung	April 2015
Reinhard Busse, Dimitra Panteli, Cornelia Henschke	Arzneimittelversorgung in der GKV und 15 anderen europäischen Gesundheitssystemen. Ein systematischer Vergleich	June 2015
GKV-Spitzenverband	Bericht des GKV-Spitzenverbandes zum Hygienesonderprogramm in den Jahren 2013/2014	June 2015
Andrea Kimmel u. a.	Praktikabilitätsstudie zur Einführung des NBA in der Pflegeversicherung. Schriftenreihe Modellprogramm zur Weiterentwicklung der Pflegeversicherung, Band 12	July 2015
Heinz Rothgang u. a.	Versorgungsaufwände in stationären Pflegeeinrichtungen. Schriftenreihe Modellprogramm zur Weiterentwicklung der Pflegeversicherung, Band 13	July 2015
GKV-Spitzenverband und MDS	Präventionsbericht 2015 Leistungen der gesetzlichen Krankenversicherung: Primärprävention und betriebliche Gesundheitsförderung, Berichtsjahr 2014	November 2015

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GKV-Spitzenverband
Reinhardtstraße 28
10117 Berlin
Tel.: 030 206288-0
Fax: 030 206288-88
www.gkv-spitzenverband.de