The coronavirus pandemic: Challenges for health and long-term care

Annual Report 2020

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The National Association of Statutory Health Insurance Funds (*GKV-Spitzenverband*) is the central association of the health insurance funds at federal level in accordance with section 217a of Book V of the German Social Code (SGB V). It also acts as the national association of 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 2020.

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Foreword by the Chairmen of the Administrative Council

Dear Readers,

The year 2020 was overshadowed by the coronavirus pandemic. This situation posed massive challenges for statutory health insurance and social long-term care insurance. We would like to express our profound gratitude to everyone who is involved in the healthcare system and in long-term care, who have done an extraordinary job in overcoming this crisis. This applies to health professionals in hospitals, medical practices and long-term care facilities, among others, who ensured that patients were cared for, and to the employees in the health insurance funds, who played an important role in informing and supporting the 73 million individuals who have statutory insurance in this exceptional situation.

The pandemic has shown that our healthcare system and long-term care are efficient and robust in many respects: It was therefore possible to adapt structures and capacities flexibly and quickly to meet essential health and care needs. In addition, a large number of practicable rules and ordinances were adopted by the legislature and self-government within a very short period of time. Social and joint self-government have thus taken on core tasks in coping with the pandemic. Last but not least, statutory health insurance and social long-term care insurance made a significant financial contribution towards stabilisation during the pandemic.

Precisely because it is imperative that statutory health insurance and social long-term care insurance provide an anchor of stability in this pandemic, it is vital that the funding base be secured in the long term. Especially some of the more recent reforms follow a different trend, however. The Healthcare and Long-term Care Improvement Act (*Gesundheitsversorgungs- und Pflegeverbesserungsgesetz*) in particular encroaches massively on the financial autonomy of social self-government. The consequence is a one-sided burden on contributors amounting to 11 billion Euro for large numbers of tasks arising from the pandemic that are actually the responsibility of society as a whole. Further expensive reform packages were mainly used to improve remuneration for healthcare providers. The improvements in benefits and quality for insured persons have unfortunately been much smaller, by comparison.

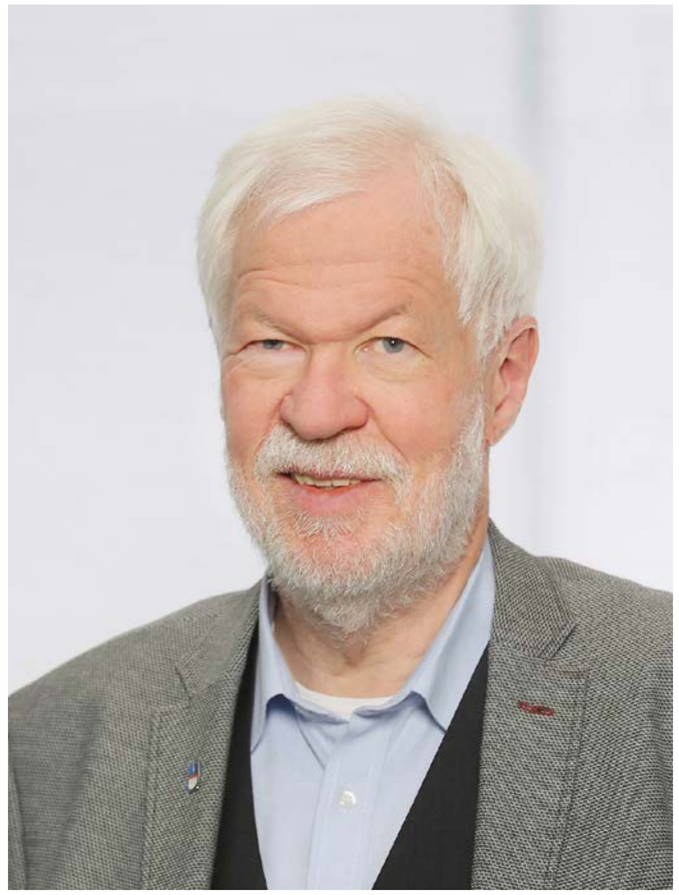
It is essential for this legislation to be reworked in order to prevent a sustained financial and structural weakening of statutory health insurance. Core tasks for securing the funding base will therefore arise after the Bundestag elections at the latest.

One thing is already clear: There must be no additional burdens on contributors, or restrictions on benefits for insured persons. After the elections, we finally need reforms that will improve the quality and in particular the economic efficiency of the care structures, which remain inefficient in many respects.

The Administrative Council has already developed a number of legislative proposals for the respective care sectors during the current legislative period. Social self-government will also continue to propose improvements that benefit insured persons and patients after the upcoming Bundestag elections.

Yours faithfully,

Uwe Klemens   Dr. Volker Hansen



Foreword by the Board

Dear Readers,

No one single event has had such a strong impact on everyday life in all areas of society in recent decades as the coronavirus pandemic. Our health and long-term care systems have very largely passed this stress test amid considerable public scrutiny. As this report makes clear, extensive support, stabilisation and relief measures from policy-makers and self-government bodies have provided the necessary security.

The pandemic will shape the health and long-term care policy debate for the foreseeable future. This is also because existing weaknesses have been clearly revealed under the pandemic's magnifying glass. Despite the highly-frequent previous legislative activity, legislators failed to create care structures orientated more closely towards patients and to quality. The pandemic-related focus on in-patient capacities has shown in an exemplary manner that it is not more of everything that is needed, but enough of the right things. There is a need for hospital structures with centres of excellence and reliable basic care in rural areas in order to resolve the imbalance between too many beds and too few staff in a needs-orientated manner.

The progressive digitalisation of the healthcare system experienced a higher dynamic and, due to the reduction in contacts, a further strengthening of the trend. Statutory health insurance, and with it the health and long-term care funds, have played a significant role in this development with the nationwide launch of electronic medical records and the implementation efforts to introduce digital health applications. Applications in social long-term care insurance are to follow. Experience to date with digital health applications, which are often introduced into care on a trial basis, with unclear benefits for patients and at the same time high prices, however makes it clear that digital progress must be translated even more closely

into concrete improvements in care for insured persons and patients on the basis of a regulatory framework that is orientated towards benefit, quality and economic efficiency.

Structural debates will be just as necessary after the Bundestag elections as are measures to stabilise the financial position of statutory health insurance and social long-term care insurance. Apart from the cost impact of the pandemic, the expensive reforms from the pre-Covid era are exerting significant pressure on the financial situation. The current deficit will be very largely shouldered by the contributors in 2021. Revenues and expenditure must be brought into equilibrium in order to avoid further unilateral burdens. This includes the Federation funding all the actual costs of tasks that are the responsibility of society as a whole, over and above the payments that it has made to date. A permanent, reliable subsidy from the Federation is also indispensable in long-term care, given the short-term efforts that are needed in order to limit the co-payments of persons in need of long-term care, in addition to the objective of compensating for additional costs caused by the pandemic.
Experience with the crisis in particular has made it clear that a positive perspective is necessary: The solidarity-based, self-governed systems of statutory health insurance and social long-term care insurance form a sound foundation for the necessary reform measures in order to ensure high-quality, affordable care in the long term. This includes efficient self-government which needs to be urgently enhanced in terms of what it can do in the face of the further increase in the power that is exercised by the executive.

The National Association of Statutory Health Insurance Funds will continue to contribute to the discussions that need to be engaged in on the further development of medical and long-term care on the basis of the positions adopted by the Administrative Council.

Yours faithfully,

Dr. Doris Pfeiffer
Chairwoman of the Board

Gernot Kiefer
Deputy Chairman of the Board

Stefanie Stoff-Ahnis
Member of the Board

Challenges for statutory health insurance

The large number of laws passed in the current legislative period was further increased in 2020 with the outbreak of the coronavirus pandemic through extensive legislation on civil and infection protection. At the same time, legal ordinances were produced on a quasi-industrial scale based on the existing ministerial empowerments provided. The focus in this context was and still is on ensuring healthcare and long-term care, as well as maintaining the necessary infrastructure. This included revenue guarantees for physicians, dentists, remedy suppliers, premiums for vacant beds in hospitals, financing of intensive care beds, protective equipment, antibody tests (for both symptomatic and asymptomatic individuals), protective masks for groups of vulnerable insured persons, bonuses for long-term care staff, and much more. Altogether, it was possible to ensure a stable care situation with flexible adjustments. The strengths of a self-governed healthcare system were demonstrated, and the system proved its efficiency in the different phases of the pandemic by providing rapid responses and feasible solutions. The experience gained during the coronavirus pandemic must be evaluated in the new legislative period, and the lessons learned must be recorded for the future.

A funding imbalance

The efforts undertaken by the health and long-term care funds to cope with the coronavirus pandemic have however come at a price, and will continue to do so. The pandemic is creating a gap between the funding base and the level of expenditure. It is all the more regrettable that the Healthcare and Long-term Care Improvement Act in the spring of 2021 means that the "Social Guarantee 2021" given by the Federal Government to limit social insurance contributions will entail massive financial burdens for the health insurance funds' contributors. This intervention is socially unbalanced, and also constitutes an encroachment on the financial autonomy of self-government. Two-thirds of the funding shortfall of around 16 billion Euro in 2021 will be covered via contributions. Using the reserves of the health insurance funds for this purpose breaks with a taboo. Whilst insured persons and employers are contributing a total of around 11 billion Euro, the Federation is only making a supplementary contribution of around 5 billion Euro in order to stabilise the additional contribution rates. It should be kept in mind that, quite independently of the pandemic, the cost-intensive reforms of the soon-to-end legislative period have led to considerable additional financial burdens that will however be less beneficial in the long term to insured persons and patients than to healthcare providers, namely in the shape of improvements in remuneration. This means that the financial reserves of statutory health insurance are exhausted. A statutory regulation is needed before the Bundestag elections in order to make up the likely shortfall of 18 billion Euro in 2022, and to stave off increases in additional contributions: A one-off federal subsidy on this scale would enable health insurance funds to plan their budgets reliably.

Two-thirds of the funding shortfall of around 16 billion Euro in 2021 will be covered via contributions.

Lack of important reforms

With or without a pandemic, the discussion on how care structures can be equipped to meet future challenges against the backdrop of the developments in health, medicine and society was only rudimentary in the 19th legislative period. Thus, virtually nothing has been legislated with regard to cross-sector care improvements, and the so urgently-needed reorganisation of emergency care has failed. The pandemic has once again clearly revealed the weaknesses and shortcomings. One particular example of this is the hospital sector. Analyses of the care situation show that care for COVID-19 patients was primarily concentrated in larger hospitals. A confirmation of the existing hospital structures can therefore not be derived from this experience. Since it is not the proximity of hospital locations that is decisive for good treatment outcomes, but rather their equipment, there is a need for a reform that focusses on greater centralisation, specialisation and cooperation. Statutory health insurance and social

long-term care insurance face major challenges due to the financial consequences of the pandemic and the politically-driven expenditure trends. The primary objective must be to ensure a stable financial situation in the new legislative period through the necessary legislative decisions.

Unanswered questions regarding digitalisation

Another central topic in 2020 was the digitalisation of the healthcare system. Two major legislative procedures were completed in 2020 alone, and another one took until the spring of 2021 to complete. It is positive as a matter of principle that this takes the form of an iterative legislative process. This offers opportunities to gather experience, take account of current developments, and nip unsound developments in the bud. Digital solutions in health and long-term care must be integrated with the aim of advancing prevention, diagnostics and therapy, and improving the needs-based distribution of medical and long-term care, if necessary also in order to mitigate existing or impending distribution problems in ensuring that healthcare satisfies demand. These objectives are only partially met by the legislature's current framework stipulations. The cost of digitalising the healthcare system currently rests on the shoulders of the contributors of the statutory health insurance funds. At the same time, the acquisition of 51 % of the shares in gematik by the Federation has deprived social self-government of its scope for action. The new legislative period must finally see an equitable distribution of the cost of digitalisation among all stakeholders in the healthcare system, as well as a regulatory-policy discussion on what role gematik should pursue and what its goal should be.

Digital solutions must be integrated with the aim of advancing prevention, diagnostics and therapy, and improving needs-based distribution.

Report from the Administrative Council

The pandemic scenario, which came to a head at the beginning of 2020, put the healthcare system and long-term care to an enormous test. The health policy agenda for 2020 was put on the back burner, as all forces had to be combined to protect the healthcare system from potentially becoming overloaded. Showing great commitment, the partners of joint self-government succeeded in enacting decisions and agreements within a very short timeframe which stabilised the structures and processes in health and long-term care. The Administrative Council of the National Association of Statutory Health Insurance Funds was actively involved in all the processes through continuous feedback between the voluntary and full-time agents via virtual consultations and written ballots. The first meeting of the Administrative Council in the year under report, which had been planned for March 2020, was cancelled at short notice due to the increasing spread of the coronavirus.

An initial stocktake

As the backbone of the healthcare system, statutory health insurance played a central role both at federal level and in the regions. Its solidarity-based orientation was particularly in evidence, and was facing high demand under the extraordinary conditions. In a first interim stocktake on the coronavirus pandemic, the Administrative Council stated in September that self-governed statutory health and social long-term care insurance had proved to be an anchor of stability for society during the crisis, and had impressively demonstrated their efficiency. The undesirable developments that came to light in the exceptional situation should be analysed, and appropriate readjustments made. At the same time, it should also be evaluated which of the measures that had been taken during the pandemic had proven their worth and were suitable for continuation under normal conditions.

Self-governed statutory health and social long-term care insurance have proven to be an anchor of stability for society during the crisis, and have impressively demonstrated their efficiency.

Prospects and expectations

Beyond the acute need to take action, it was important to keep an eye on the general developments in the healthcare system in the year under report. While the many issues associated with the crisis dominated the agenda, the Administrative Council also consistently focussed its deliberations on the debate around the prospects and expectations regarding a healthcare system designed to meet the challenges of the future, and that system's financial viability. In doing so, it emphasised the fact that the pressure to reform already existing in many areas of health policy has intensified considerably as a result of the coronavirus pandemic. In the interest of the patients, the individuals in need of long-term care as well as the contributors, the legislation urgently needs to provide ground-breaking stimuli and an orientation for the future. According to the unanimous view of the Administrative Council, the first lessons and experiences gained in dealing with the pandemic should be included in the positions taken up by the National Association of Statutory Health Insurance Funds.

Hospitals: forward-looking structures

In its position paper on hospital care, the Administrative Council formulated concrete proposals for the future design of in-patient care and a comprehensive reorganisation of the hospital landscape. It acknowledged in the paper that hospitals had responded quickly to the challenges of the pandemic, and thus prevented the coronavirus from spreading in in-patient facilities. At the same time, the Administrative Council emphasised recent experiences, and thus continued the structural discussion that had taken place before the outbreak of the pandemic: The coronavirus pandemic has also shown that sustainable reforms are indispensable if one wishes to see high-quality, affordable care in the long term. The positions presented include recommendations on care structures with centres of excellence and specialised hospitals which pool the provision of services and ensure greater patient safety, whilst hospitals required to satisfy demand are intended to ensure the provision of care in rural areas.

Reforming long-term care: concrete expectations

Policy-makers are called on to reform the framework for social long-term care insurance so that it can continue to be effective. Providing care for currently more than 4 million people in need of long-term care already poses an enormous challenge to society today. In its position paper on the further development of long-term care insurance, the Administrative Council described the existing need for reform, and outlined possible solutions for sustainable, high-quality, cost-effective long-term care. A key aspect is to make use of the potential offered by digitalisation. In order to improve long-term care, it is above all necessary to place long-term care insurance on a sound, sustainable financial foundation, in addition to ensuring appropriate personnel allocations and making nursing care a more attractive profession. The automatic contribution rate increases being applied at present are not a sustainable solution in the long run, given the foreseeable increase in financial needs. Since the long-term care of the population is a task for society as a whole, the *Länder* and the Federation must be increasingly called upon to take responsibility for financing, along with persons in need of long-term care and the community of solidarity.

Digital health applications: guaranteeing patient protection and economic efficiency

The Administrative Council advocated the introduction and use of digital health applications, and considers that they have the potential to improve care for insured persons in the long term. It however takes a critical view particularly with regard to the shape of assessment criteria and remuneration regulations for which the law provides. As they stand at present, these do not do justice to the principles of patient protection and economic efficiency. A position paper of the Administrative Council on the requirements and criteria of digital health applications points to a need for further development in this care sector, and calls for concrete changes to be made to the law, particularly in terms of governance structure, benefit, quality, patient safety and cost-effectiveness. Scientific evidence of medical benefit for insured persons in accordance with the rules of evidence-based medicine must be a mandatory central requirement for evaluating digital health applications. The use of digital health applications must be sufficient, expedient and economically efficient, and must not overstep the bounds of what is necessary.

Cancer registers: pressing ahead with their establishment

The Administrative Council provoked a resounding response in the year under report with its criticism of the slow development of the clinical cancer registers. The cancer registers are intended to ensure systematic, uniform data collection, and to enhance quality reporting in oncology. In a public statement, the Administrative Council drew attention to the fact that ten out of 18 registers are not expected to meet the funding eligibility criteria, as many as seven years after their development was supported by statutory health insurance. The criteria constitute the statutory prerequisite for the regular funding of the clinical cancer registers by the health insurance funds, which have a considerable interest in continuing this important project in order to improve care for tumour patients. The Administrative Council therefore called on the *Länder* and the registers to fulfil their statutory obligations. A draft Bill on the Consolidation of Cancer Registry Data, which was presented at the end of 2020, now provides for graduated flat-rates of funding to be paid for a transitional period of three years, depending on the degree of fulfilment. This will create incentives to push ahead with the final establishment of the cancer registers.

The automatic contribution rate increases being applied at present in long-term care insurance are not a sustainable solution in the long run given the foreseeable increase in financial needs.

The main burden of compensating for the funding gap in statutory health insurance forecast for 2021 must not fall on insured persons and employers.

The Social Guarantee: preserving financial autonomy

The Administrative Council was discontent with statutory plans to make only 5 billion Euro available from federal funds to compensate for the funding shortfall of 16.6 billion Euro that was forecast for statutory health insurance for 2021. The main burden will fall on insured persons and employers, who will have to shoulder around 11 billion Euro by imposing higher additional contributions and reserves of the individual health insurance funds. The Federal Government had previously promised to stabilise social insurance contributions at a maximum of 40 % by way of the "Social Guarantee 2021", and to cover any additional financial needs from the federal budget. The Chairmen of the Administrative Council criticised the procedure as a massive encroachment on the financial autonomy of self-governed statutory health insurance.

Ensuring capacity to act

In addition to the abovementioned topics, the Administrative Council also adopted a number of decisions resulting from statutory stipulations, and these also safeguard the ability of the National Association of Statutory Health Insurance Funds to act. Amongst other things, this concerned provisions on liability prevention, the revision of the financial aid regulation, or the election and establishment of the new Steering and Coordination Committee.

Establishment of the Steering and Coordination Committee

The National Association of Statutory Health Insurance Funds is the central body representing the interests of all statutory health and long-term care insurance funds. It shapes healthcare and long-term care for the approximately 73 million insured persons. As a corporation under public law, the National Association of Statutory Health Insurance Funds is organised according to the principle of self-government, i.e. representatives of the insured persons and employers make all decisions of fundamental importance in the Administrative Council. In order to carry out its tasks, the National Association of Statutory Health Insurance Funds also needs a close organisational connection to its member funds, as well as institutionalised procedures in order to bundle the positions of all statutory health insurance funds. It therefore needs to also create transparency regarding the contractual and other tasks of the National Association of Statutory Health Insurance Funds, on the one hand, and the operations of the health insurance funds, on the other. This function was previously performed by the Specialist Advisory Council, which was replaced at the beginning of 2020 by the newly-formed Steering and Coordination Committee as a result of the Fair Insurance Fund Competition Act (*Fairer-Kassenwettbewerb-Gesetz*).

Further institutionalisation of coordination structures

Each type of health insurance fund delegates one representative to the Steering and Coordination Committee from among the full-time board members of their health insurance funds. The legislature would like to further institutionalise the coordination structures and the flow of information with the new committee. The statutory plans to change the governance structure of the National Association of Statutory Health Insurance Funds originally went even further: There was a threat of a serious weakening of social self-government. This was successfully

The modus operandi that has been established makes it possible to form opinions quickly, and strengthens the capacity of the National Association of Statutory Health Insurance Funds to act. These new transparent, lean decision-making structures immediately proved their effectiveness during the pandemic.

Fields of activity of the Steering and Coordination Committee*

Statements prior to resolutions of the Administrative Council	Recommendations on care-related issues	Bringing about agreement on care-related decisions of the Board	
Criteria: · "Optional arrangement" or · "Mandatory arrangement" as per Administrative Council's instruction	Criterion: · Important care-related decision of the Board foreseeable, e.g. joint development of strategies and positions for negotiations	Criteria: · Board decision (not related to third-party decisions) · Direct care for insured persons/remuneration for healthcare providers · Binding on funds, insured persons or healthcare providers · Board has discretion (not legally binding)	Non-care-relevant decisions of the Board: "Optional arrangement" on statements
Example: Taking positions on fundamental issues regarding further development of healthcare	Example: Taking positions on fundamental issues regarding further development of healthcare	Example: Board resolution on agreement on the diagnosis-related group case flat-rate system list 2021	

* in accordance with section 217b subsections (5) and (6) of Book V of the Social Code

Illustration: National Association of Statutory Health Insurance Funds

prevented in the legislative process with broad support from the members of the administrative councils of the health insurance funds and from the social partners.

Important changes regarding the composition and competences of the Steering and Coordination Committee to be newly formed at the National Association of Statutory Health Insurance Funds were ultimately achieved before the Act was passed. These ensure that the competences between the full-time and voluntary representative levels are clearly and unambiguously kept apart.

The Administrative Council of the National Association of Statutory Health Insurance Funds elects the members of the Steering and Coordination Committee

All the necessary steps were quickly taken to establish the Steering and Coordination Committee at the National Association of Statutory Health Insurance Funds once the Act had come into force in April 2020. The members of the Committee were elected in the same month by the members of the Administrative Council of the respective type of health insurance fund. The seat of the female board member was left vacant in one type of health insurance fund for the time being. The new Committee was constituted at the beginning of May 2020. The term of office of the members of the Steering and Coordination Committee corresponds to that of the Board. Each Steering and Coordination Committee member has a share of votes which is based on the number of insured persons of the member funds of the respective type of health insurance fund nationwide.

Initial decisions in the course of the constitution process were made on the tasks and modi operandi of the Steering and Coordination Committee. These focussed on the statutory possibilities for the Steering and Coordination Committee to participate in the implementation of care-related decisions of the Board of the National Association of Statutory Health Insurance Funds in procedures that are both legally secure and practicable.

Rules of procedure agreed on

The focus when setting up and implementing this new committee structure was placed on the efficient performance and fulfilment of the tasks of the Steering and Coordination Committee, including making as much use as possible of existing consultation and coordination structures, and preserving the competences of the Board and of the Administrative Council of the National Association of Statutory Health Insurance Funds. The Steering and Coordination Committee adopted its rules of procedure after a phase of intensive exchange with the Board of the National Association of Statutory Health Insurance Funds and the Chairmen of the Administrative Council. The Administrative Council reached an agreement at the beginning of September. At the same time, the members of the Steering and Coordination Committee, the Administrative Council, and the Board of the National Association of Statutory Health Insurance Funds, agreed to regularly review the practicability of the existing processes, and where necessary to optimise and further develop them as part of a learning system. The subsequent election of the deputies simultaneously marked the end of the establishment phase of the Steering and Coordination Committee.

The modus operandi that has been established makes it possible to form opinions quickly. These new transparent, lean decision-making structures immediately proved their effectiveness during the pandemic; the National Association of Statutory Health Insurance Funds was able to take a large number of time-critical decisions with the involvement of the Steering and Coordination Committee.

intubation, noun
(everything is done to prevent it
becoming necessary)

A determined response to the pandemic situation on the part of the self-government bodies

Practical, viable solutions were found quickly in order to stabilise care under pandemic conditions.

Rarely before have health and long-term care been such a focus of public and social debate as they have been since the outbreak of Covid infections. Due to the changed care requirements, existing procedures and things that had previously been taken for granted had to be fundamentally reviewed and re-aligned within a very short space of time. The German Bundestag and the Federal Ministry of Health have adopted healthcare and long-term care policy regulations at short notice, and in several stages, since March 2020 in order to deal with the pandemic and stabilise the healthcare system. For this purpose, the Bundestag has transferred far-reaching decision-making powers to the executive by declaring an epidemic situation of national significance.

Simplified access to digital care services

Both social and joint self-government played a key role, especially in the first wave. Practical, viable solutions were found quickly in order to stabilise care, even under pandemic conditions. For example, self-government quickly and determinedly found arrangements for better, simplified use of digital care channels. Particular use has been made of this in the contract doctor sector, and in the supply of remedies. This has considerably increased the acceptance of greater digitalisation in practical care. It will now be necessary to examine which changes to the legal and qualitative framework conditions are sensible and necessary in order to permanently establish such care services beyond the end of the current pandemic situation.

Financial compensation for healthcare providers

Numerous medical treatments were postponed as a result of the regulations on contact reduction that were imposed in the context of the pandemic, or insured persons themselves decided to forego them. Some care providers suffered considerable losses in revenue through these reductions in treatment. These losses were mitigated with rescue packages, amongst others for long-term care facilities, preventive and rehabilitation facilities, contract doctors and remedy

Health and long-term care laws and ordinances in connection with the coronavirus pandemic (broken down by government department)

	Acts	Ordinances
Federal Ministry of Health	11	68
Federal Ministry of Labour and Social Affairs	2	4
Federal Ministry of Justice and Consumer Protection	1	0
Federal Ministry for Economic Affairs and Energy	1	0
Federal Ministry of Finance	1	0
Total	**16**	**72**

Version: June 2021; Illustration: National Association of Statutory Health Insurance Funds

suppliers. It was also necessary for hospital care to react to the changed funding situation by taking targeted measures. The objective, supported by the National Association of Statutory Health Insurance Funds, was to compensate for revenue shortfalls on a transitional basis, to prevent impending insolvencies, and thus to secure medical and long-term care in the affected areas of care in the long term.

Mitigation for long-term care

The National Association of Statutory Health Insurance Funds has also created a number of relief measures for long-term care insurance. These included temporarily suspending quality audits in long-term care facilities and assessments of quality-assurance indicators in long-term care facilities. Further support targeted the persons in need of long-term care directly: If non-residential long-term care could not be provided by non-residential long-term care services or by a substitute, care was also facilitated by other healthcare providers.

What happens after the crisis?

These highly-practical sub-legislative arrangements within the responsibility of self-government constituted central factors in stabilising the health and long-term care of insured persons. The added value of self-government for society has been demonstrated once again. At the same time, the right conclusions must be drawn from the crisis for the further development of care in order to finally initiate the long-overdue structural reforms. Last but not least, the pandemic has a far-reaching impact on the funding base of statutory health insurance and social long-term care insurance. The urgent task arising here is to ensure that there is a sustainably sound foundation.

The right conclusions must be drawn from the crisis for the further development of care in order to finally initiate the long-overdue structural reforms

hospital bed(s), noun
(expensive to keep available, but
necessary)

Crisis management in the hospital sector

Hospital care has been the focal point of political debate since the beginning of the coronavirus pandemic. There was intensive discussion in 2020 of, in particular, the promotion of additional intensive care beds, as well as of the lump sums introduced in the hospital sector to keep treatment capacities available for COVID 19 cases. A large number of laws and ordinances had to be passed at a high frequency and put into practice by the self-government bodies.

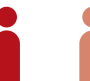
The Expert Advisory Council on Covid

The Federal Ministry of Health set up an Expert Advisory Council in April 2020 with representatives from hospitals, insurance providers and the scientific community in order to review the measures taken for hospitals. On the basis of analyses of the services provided, and of the revenue situation of hospitals in the coronavirus pandemic, the Expert Advisory Council proposed adjustments, e.g. to distinguish between the hospital bed availability lump sums, and the lump sums for personal protective equipment. A final report of the Expert Advisory Council was published in September 2020, as were analyses of the services provided and the revenue situation. The Expert Advisory Council on Covid was reconvened in mid-November 2020 due to the increase in the number of infections observed at that time to discuss the measures that needed to be taken in the hospital sector for the second wave. Since then, the Advisory Council has been consulting on the necessary adjustments to the on-going measures at different intervals.

The following measures formed the focus of Covid crisis management in 2020:

- hospital bed availability lump sums
- lump sum for additional intensive care beds and intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine (DIVI)
- lump sum for protective equipment (50/100 Euro)
- acute in-patient treatment in rehabilitation facilities
- lower-limits for nursing staff
- compensation for COVID-related losses 2020

The Advisory Council on Covid – Composition and tasks



Hospital representatives (3)

Representatives of the statutory (3) and private (1) health insurance funds

Representatives from the scientific community (3)

Tasks and goals

- Reviewing the impact of the coronavirus prevention measures on the economic situation of the hospitals on the basis of transparent procedures, criteria and benchmarks
- Developing necessary measures to contain the coronavirus pandemic and discussing the preconditions and scenarios for the potential to open up social and public life (gradual return to "normality")

Illustration: National Association of Statutory Health Insurance Funds

Hospital bed availability lump sums

In order to keep beds available for COVID-19 patients, the COVID-19 Hospital Relief Act inserted a provision in the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*) at the end of March 2020 which regulated that hospitals were to receive a lump sum retroactively from 16 March 2020 to 30 September 2020 for loss of revenue incurred due to operations being postponed. The hospitals received a standard lump sum of 560 Euro per day for each patient not treated during this period compared to 2019. This payment was pre-financed from the Health Fund's liquidity reserve, and refinanced from federal funds. With the compensation payment agreement, the German Hospital Federation and the National Association of Statutory Health Insurance Funds defined the details for determining, documenting and reporting the entitlement to hospital bed availability lump sums on the part of the hospitals.

The hospitals received a standard lump sum of 560 Euro per day for each patient not treated during this period compared to 2019.

The establishment of a standard daily lump sum of 560 Euro caused considerable friction between

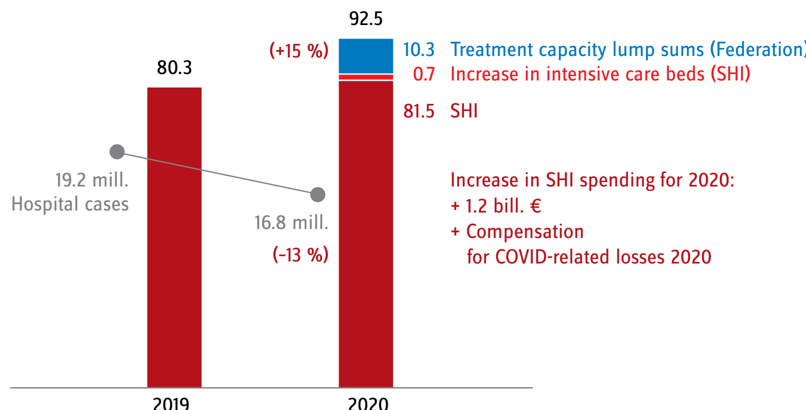
the hospitals due to structural differences and different levels of pandemic impact. The Expert Advisory Council on Covid was able to propose a consensual solution to the Federal Ministry of Health in the context of the review of the effects of the rescue package on hospitals' economic situation in order to take better account of the hospitals' different cost structures. This was implemented from July 2020 onwards with the COVID-19 Compensation Payment Adjustment Ordinance (*COVID-19-Ausgleichzahlungs-Anpassungs-Verordnung*), which provides different bed availability lump sums based on the sector and on the intensity of services provided. There are five per diem lump sums in somatics ranging between 360 and 760 Euro, whilst the lump sum in psychiatry/ psychosomatics is a standard 280 Euro. The need to adapt the compensation payment agreement arising from the Ordinance was implemented by the joint self-government bodies at federal level by adopting a second compensation payment agreement in July 2020.

According to the Federal Office for Social Security, a total of roughly 10.26 billion Euro had been disbursed to hospitals as hospital bed availability lump sums by the end of December 2020.

In response to the ongoing dynamic development of the coronavirus pandemic, the Third Civil Protection Act (*Bevölkerungsschutzgesetz*) enacted new regulations for keeping treatment capacities available with effect from 18 November 2020, and these were later expanded and repeatedly extended by legal ordinances. In contrast to keeping capacities available during the first wave in the spring of 2020, the intention was not to fund vacant beds nationwide, but rather available capacities were to be kept specifically only in those hospitals that are particularly suitable for treating COVID-19 patients due to their equipment and specialisation. The compensation payment agreement concluded in December 2020 by the self-government partners at federal level for hospitals designated by the *Land* regulates the details of this procedure in accordance with the previous compensation payment agreements, and is continuously updated. With the legal ordinance that came into force on 25 December 2020 to adjust the conditions for the eligibility of hospitals, the group of eligible hospitals was expanded, and the period was initially extended until 28 February 2021. Special regulations for the additional designation of hospitals apply in the case of high incidence rates.

According to the Federal Office for Social Security, a total of roughly 10.26 billion Euro was disbursed to hospitals as hospital bed availability lump sums.

Hospital revenues and treatment cases



SHI = statutory health insurance; Hospital revenues in bill. Euro

Sources: Case no. - InEK (Data browser); Revenues: Official statistics KJ1; Federal Office for Social Security; Reports from the *Länder*; Illustration: National Association of Statutory Health Insurance Funds

Lump sum for additional intensive care beds and intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine (DIVI)

When the coronavirus pandemic began to develop at the beginning of 2020, the focus was placed on intensive care capacities in particular. The images from Italy and Spain - countries that suffered particularly badly in the first wave of the pandemic - were crucial in this assessment. According to OECD figures, however, Italy had 8.6 intensive care beds per 100,000 inhabitants, and Spain had 9.7, whereas Germany already had more than three times as many at the beginning of the pandemic, at 33.9.

Regardless of this situation in care, the COVID-19 Hospital Relief Act provided for hospitals to receive a lump-sum bonus of 50,000 Euro for additional intensive care beds to be created by the end of September 2020. The funds necessary for this were withdrawn from the liquidity reserve of the Health Fund. In addition, the DIVI Intensive Care Registry Ordinance made sure that all hospitals only report to the registry on a daily basis those intensive care bed capacities for which sufficient staff are actually provided.

According to the final count as per 8 February 2021, the disbursements for additional intensive care beds amounted to 686.1 million Euro nationwide according to the Federal Office for Social Security. This corresponds to 13,722 additional intensive care beds. The intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine showed a total of 27,612 serviceable intensive care beds on 8 February 2021. The most recent data status from before the pandemic was provided by Destatis in 2019: There were a total of 26,319 intensive care beds at that time. The large discrepancy between the total stock of intensive care beds, plus the newly-funded intensive care beds, and those that are actually serviceable, has still to be satisfactorily clarified. Attempts to explain the discrepancy stem from uncertainties as to the number of intensive care beds at the beginning of 2020, and from the lack of a definition of what an "intensive care bed" is. This might have led to heterogeneous counting methods.

Hospitals report on a daily basis to the intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine with regard to those intensive care bed capacities for which sufficient staff are actually provided.

Lump sum for protective equipment (50/100 Euro)

The COVID-19 Hospital Relief Act introduced a surcharge of 50 Euro per case in order to compensate on a lump-sum basis for price and volume increases for protective equipment as a result of the coronavirus pandemic. This was initially for a limited period up to the end of June 2020. The period of validity of this arrangement was subsequently extended to 30 September 2020. Further provision was made for a surcharge of 100 Euro to be billable per infected patient.

Intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine (DIVI)

Objective and tasks

- Nationwide monitoring of intensive care capacities, identification of potential bottlenecks as a basis for reaction and control
- Mandatory reporting of intensive care capacities by approx. 1,300 hospitals in Germany
- Since April 2020, daily updated recording of available and occupied intensive care treatment capacities and COVID-19 case numbers in ICUs
- Separate recording of serviceable/useable beds based on level of care: intensive care beds without invasive ventilation (ICU low care), intensive care beds with ventilation (ICU high care), with additional extracorporeal membrane oxygenation (ECMO), emergency reserve capacity

Legal basis

- Ordinance on the Maintenance and Safeguarding of Intensive Care Hospital Capacities (*Verordnung zur Aufrechterhaltung und Sicherung intensivmedizinischer Krankenhauskapazitäten - DIVI Intensivregister-Verordnung*), entry into force: 10 April 2020
- First Ordinance Amending the Ordinance on the Maintenance and Safeguarding of Intensive Care Hospital Capacities, entry into force: 3 June 2020

The contracting parties at federal level were tasked via the Hospital Future Act (*Krankenhauszukunftsgesetz - KHZG*) to agree on stipulations for surcharges to finance additional costs, not funded by other means, that hospitals incur in connection with the treatment of COVID-19 patients. This essentially includes the personal protective equipment of the physicians and nursing staff working in the hospital. The period of validity of the surcharge for pandemic-related additional costs to be agreed on this basis was extended until the end of 2021. In order to ensure the seamless transition of financing from October 2020 onwards, the continuation of the surcharges valid until the end of September 2020 was regulated at federal level in a recommendation agreement for the 4th quarter of 2020. An agreement on provisional surcharges for the 1st quarter was initially concluded for 2021.

A lump-sum surcharge of 50 Euro per case was introduced in order to compensate for price and volume increases for protective equipment as a result of the coronavirus pandemic.

Acute in-patient treatment in rehabilitation facilities

As a further measure to relieve the burden on hospitals, the Federal *Länder* were able to designate preventive care and rehabilitation facilities that were to treat patients in acute hospital care on a fully-residential basis. Such an additional path of care was to specifically apply in areas where the available hospital capacities were likely to be insufficient. The legal requirements were created by the COVID-19 Hospital Relief Act. A corresponding agreement on remuneration, and on the details of the billing procedure, was signed by the German Hospital Federation and the National Association of Statutory Health Insurance Funds in due time, in April 2020. The arrangement applied to patients who were admitted up to the end of September 2020. The Third Civil Protection Act put it back in force from 19 November 2020 onwards, and legal ordinances repeatedly extended it subsequent to that. The self-government partners at federal level have again regulated the details of implementation in a Second Rehabilitation/Hospitals Act/COVID-19 agreement (*2. Reha-KHG-COVID-19-Vereinbarung*), and are continuously updating it in line with the legal ordinance.

Greater transparency for better care

- The intensive care register of the German Interdisciplinary Association for Intensive and Emergency Medicine shows that nationwide transparency regarding intensive care capacities can be quickly established and achieved.
- Rapid expansion to all hospital sectors is necessary and feasible, and an up-to-date overview of the services being provided is overdue.
- Transparency is the prerequisite for a needs-based hospital, and leads to better patient care.

Lower-limits for nursing staff

Lower-limits for nursing staff already applied in 2019 to the four care-sensitive areas, i.e. intensive care, geriatrics, cardiology and trauma surgery. In addition, with the entry into force of the Ordinance on Lower Limits for Nursing Staff (*Pflegepersonaluntergrenzen-Verordnung - PpUGV*) of 28 October 2019, nursing staff stipulations were defined for the sectors heart surgery, neurology, neurological early rehabilitation and the neurological stroke unit, which were to be used from 2020 onwards.

It was however virtually impossible to implement the new lower limits, as the coronavirus pandemic prompted the Federal Ministry of Health to “relieve” hospitals of individual regulations, including the Ordinance on Lower Limits for Nursing Staff (PpUGV). The First Ordinance Amending the Ordinance on Lower Limits for Nursing Staff (*Erste Verordnung zur Änderung der Pflegepersonaluntergrenzen-Verordnung*) of 25 March 2020 therefore suspended the PpUGV for the period from 1 March 2020 to 31 December 2020. This meant that hospitals were not required to comply with the defined lower limits for nursing staff during this period, nor were they required to

provide evidence of the extent to which they fell short of the staffing stipulations in the months in question. The PpUGV was partially put back in force, once the first wave of the pandemic had died down, with the Second Ordinance Amending the Ordinance on Lower Limits for Nursing Staff (*Zweite Verordnung zur Änderung der Pflegepersonaluntergrenzen-Verordnung*) coming into force on 16 July 2020. As a result, it became mandatory again for hospitals to comply with the lower limits for nursing staff in intensive care medicine and geriatrics, and to document compliance, as of August 2020.

When the new PpUGV came into force on 9 November 2020, it was regulated that all previous lower limits provided for nursing staff were to be applied again on a mandatory basis. Another four further sectors were added: general surgery, internal medicine, paediatrics and paediatric intensive care. This means that lower limits for nursing staff have applied to a total of twelve areas since February 2021. If hospitals are unable to meet the lower limits for nursing staff requirements due to the pandemic, sanctions are ruled out by the applicable exemptions provided for in the PpUGV and the corresponding agreements reached with the self-government partners.

Compensation for COVID-related losses 2020

The lump sums payable from federal funds to hospitals to keep treatment capacities available expired at the end of September 2020. It was however foreseeable that the case numbers would not go back to the level from before the coronavirus pandemic during 2020. Against this background, the Expert Advisory Council on Covid held intensive discussions on a possible follow-up arrangement for 2020. The Hospital Future Act provided that the German Hospital Federation, the National Association of Statutory Health Insurance Funds, and the Association of Private Health Insurance, were to regulate by the end of December 2020 on details of how pandemic-related declines in revenue for 2020 were to be compensated for. The statutory compensation arrangements largely followed the recommendations of the Expert Advisory Council on Covid. According to these, hospitals are entitled to determine and proportionately compensate for a decline in revenue caused by the coronavirus pandemic in local negotiations with the insurance providers on a hospital-specific basis. The lump sums received from the Federation in 2020 to keep treatment capacities available were also included in the compensation calculations as components of hospitals' revenues. No further revenue compensation is planned for 2020 over and above this compensation for COVID-related losses.

Hospitals are entitled to determine and proportionately compensate for a decline in revenue caused by the coronavirus pandemic on a hospital-specific basis.

The framework for the 2020 compensation for Covid-related losses is set by uniform federal stipulations, criteria and their verification, these having been agreed on by the contracting parties at federal level. These also determined the amount of the uniformly-applicable compensation rate, and thus the proportion of the decline in revenue for which compensation was to be provided. In order to prevent medically-necessary services from being postponed due to financial considerations, the National Association of Statutory Health Insurance Funds considered that an incentive for care should be created when setting the compensation rate. Negotiations began in October 2020, and it was possible to conclude them by the end of 2020.

Financial assistance for medical and dental practices

The Associations of Statutory Health Insurance Physicians can take measures in order to ensure the survival of medical practices, even in the face of pandemic-related declines in the number of cases.

Financial assistance measures were adopted in order to compensate contract doctors' practices for the loss of revenue caused by the pandemic in order to ensure that care could be sustainably provided by contract doctors during the coronavirus pandemic. The COVID-19 Hospital Relief Act, which came into force at the end of March 2020, created the statutory basis for compensation payments to contract doctors' practices. The measures were initially time-limited until 31 December 2020, and are being continued in a modified form in 2021.

Compensation payments for contract doctors' practices

Accordingly, the Associations of Statutory Health Insurance Physicians, in consultation with the *Länder* associations of the health insurance funds and the substitute funds, can take appropriate measures in the regional fee distribution scales for the distribution of morbidity-related total remuneration in order to ensure the survival of medical practices, even in the face of pandemic-related declines in the number of cases.

If the total of fees paid to a contract doctors' practice is nevertheless more than 10 % lower than in the same quarter of the previous year, and if this reduction in remuneration is due to a pandemic-related decline in the number of cases, the Associations of Statutory Health Insurance Physicians may furthermore effect temporary compensation payments to the contract doctors' practices concerned. These compensation payments are limited to benefits outside the morbidity-related total remuneration. The health insurance funds are to reimburse to the Associations of Statutory Health Insurance Physicians the expenditure for 2020 resulting from the compen-

Protective-shield arrangements for contract doctors during the pandemic

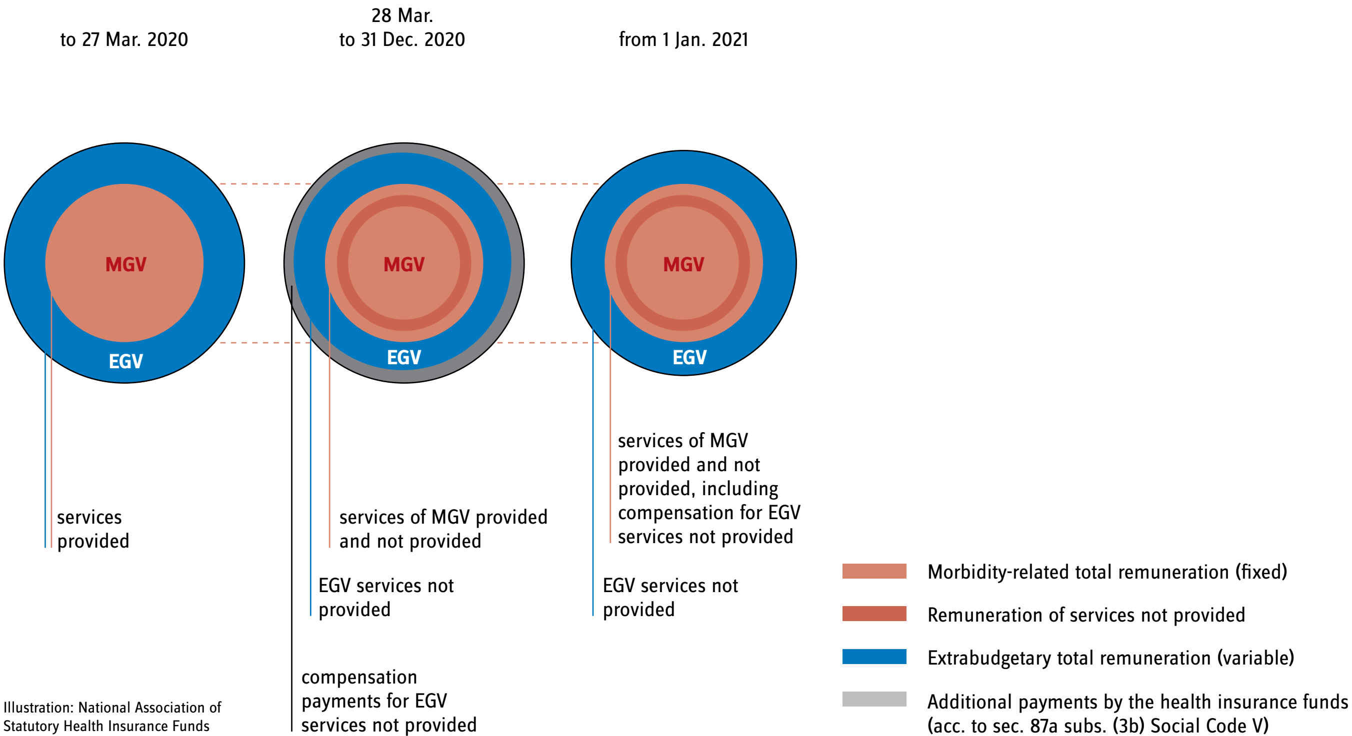


Illustration: National Association of Statutory Health Insurance Funds

sation payments. The health insurance funds thus need to be provided with the data required for reimbursement. The Federal Skeleton Agreement provides that the reimbursement amounts are to be paid by the individual health insurance funds in proportion to the respective number of insured persons. The total amount of the reimbursements due cannot yet be reliably quantified. They have so far amounted to around 210 million Euro for the first nine months of 2020.

The statutory regulations on compensation payments were continued in a modified form in 2021. Declines in turnover for extrabudgetary benefits such as preventive check-ups and out-patient operations are now no longer compensated for by the health insurance funds as was the case in the previous year, but by the Associations of Statutory Health Insurance Physicians, and reserves are also to be drawn on for this purpose.

Advance payments for dental treatment

In the contract dentist sector, the SARS-CoV-2 Care Structures Protection Ordinance (*SARS-CoV-2-Versorgungsstrukturen-Schutzverordnung*) contains provisions to bridge the financial impact of the reduced number of individuals seeking dental treatment as a result of the coronavirus pandemic. According to these regulations, the total remuneration for contract dentist services for 2020 is set as an advance payment at 90 % of the total remuneration paid for 2019. In contrast to the contract doctors' sector, any overpayment that is effected must be refunded to the health insurance funds in full in 2021 and 2022.

At the same time, the Ordinance gave the Associations of Statutory Health Insurance Dentists the opportunity to object to these regulations vis-à-vis the *Länder* associations of the health insurance funds and the substitute funds by June 2020, and to waive the compensation. Nine out of the 17 Associations of Statutory Health Insurance Dentists made use of this option and voted to opt out. An analysis of the services provided by contract dentists for the first half of 2020 has shown that the impact of the coronavirus pandemic on contract dentist care varied from one region to another. The provisions of the SARS-CoV-2 Care Structures Protection Ordinance were transferred to section 85a of Book V of the Social Code (SGB V) by the Healthcare and Long-term Care Improvement Act, and were simultaneously extended by one year.

The total remuneration for contract dentist services for 2020 is set as an advance payment at 90 % of the total remuneration paid for 2019.

Protective equipment for dentists in specialist practices

The National Association of Statutory Health Insurance Dentists and the National Association of Statutory Health Insurance Funds reached an agreement on the provision of protective equipment as early as March 2020. The contracting parties assumed in this process that non-postponable dental treatment for COVID-19 patients, or where an infection was suspected, would predominantly take place in clinics and specialist practices. These specialist practices, as defined by the National Association of Statutory Health Insurance Dentists, are therefore provided with centrally-procured protective equipment. The agreement has been extended several times since then.

Setting the stage for COVID testing

Testing procedures are a key tool for managing pandemic situations and mitigating their consequences. The legislature adjusted its testing strategy several times as the coronavirus pandemic progressed. The goal was to gradually increase testing capacities.

COVID testing in medical treatment settings

The National Association of Statutory Health Insurance Funds, together with the National Association of Statutory Health Insurance Physicians, decided as early as in February 2020 to include a new fee schedule item in the Standard Schedule of Fees (*Einheitlicher Bewertungsmaßstab* - EBM) for the reimbursement of the testing of symptomatic insured persons for the coronavirus. After the fee had been initially set at 59 Euro, it was possible to reduce it to 39.40 Euro in the Extended Evaluation Committee in June 2020. Antigen testing in laboratories was also included in the Standard Schedule of Fees in October 2020, and is remunerated at 10.80 Euro.

Testing of asymptomatic individuals outside of medical treatment settings

In addition to testing patients presenting with symptoms, the Coronavirus Testing Ordinance (*Coronavirus-Testverordnung*) also provides for testing asymptomatic persons such as contact persons, staff working in critical facilities, travellers returning from risk areas or, since October 2020, visitors to long-term care homes.

Expenditure on testing asymptomatic individuals outside of medical treatment settings constitutes a non-insured service which is to be paid for by the Federation.

The costs of these tests are paid from the liquidity reserve of the Health Fund in accordance with the Second Civil Protection Act. The National Association of Statutory Health Insurance Funds has repeatedly pointed out that the costs of testing asymptomatic individuals outside of medical treatment settings, which is a non-insured service, are to be covered by statutory health insurance as a commissioned service only, and that the Federation must ensure that the payments from the liquidity reserve of the Health Fund are settled.

COVID tests in hospitals

The legislature mandated the National Association of Statutory Health Insurance Funds and the German Hospital Federation via the Second Civil Protection Act to agree on a supplementary fee for coronavirus testing in hospital treatment settings. The agreement was to be concluded by 29 May 2020. Since the contracting parties were able to agree on the wording of an agreement within this short period, but not on the amount of the additional fee, the Arbitration Office was automatically consulted. The Office set the following additional fees for PCR tests in 2020:

- 63 Euro per patient if admitted between 14 May 2020 and 15 June 2020
- 52.50 Euro per patient if admitted after 15 June 2020

The reduction results from the decrease in laboratory costs.

In addition, it has been possible since October 2020 to bill antigen tests for direct SARS-CoV-2 pathogen detection via an additional fee. The publication of the Federal Ministry of Health's National Testing Strategy in October 2020 enables both laboratory and point-of-care/PoC antigen tests to be used in hospitals. The amount of the additional fee for the billing of both tests is 19 Euro.

test swab set(s), noun
(quite literally gets up your nose)

Rapid assistance for preventive care and rehabilitation facilities

It was possible for a loss of revenue amounting to 60 % of the average remuneration in in-patient preventive care and rehabilitation facilities to be claimed on a daily basis, with a level reduced to 50 % from 18 November 2020.

The COVID-19 Hospital Relief Act legislated in March 2020 on compensation payments for in-patient preventive care and rehabilitation facilities. Funds from the liquidity reserve of the Health Fund were used by the Federal Office for Social Security to compensate for loss of revenue due to pandemic-related bed availability.

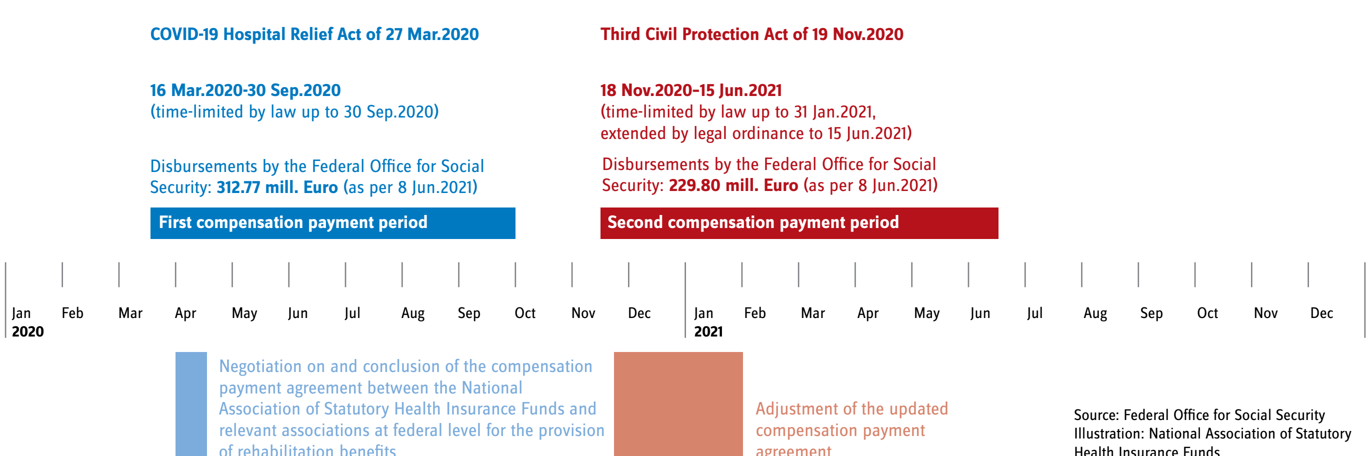
Compensation payment agreement in the field of preventive care and rehabilitation

In order to determine the amount of the compensation payments, the National Association of Statutory Health Insurance Funds had to determine with the associations of healthcare providers how the difference in the number of patients treated per day in 2020, compared to the reference value in 2019, is to be proven, and how the average remuneration rate is determined on this basis. To this end, the compensation payment agreement in the field of preventive care and rehabilitation was concluded in April 2020. With the COVID-19 Care Structures Protection Ordinance (*COVID-19-Versorgungsstrukturen-Schutzverordnung*) of 30 April 2020, additional facilities such as those of the Maternal Convalescence Movement became entitled to compensation payments, so that the compensation payment agreement was already updated as of May 2020.

The compensation payments were initially time-limited to the period from 16 March to 30 September 2020. They made it possible for a loss of revenue amounting to 60 % of the average remuneration in in-patient preventive care and rehabilitation facilities to be claimed on a daily basis. The Third Civil Protection Act reintroduced the compensation claim with effect from 18 November 2020, with a level reduced to 50 % of the average remuneration. The arrangements were extended into June 2021, via legal ordinances. Health insurance funds were designated in 13 Federal *Länder* in order to implement the procedure, whilst *Land* authorities are carrying it out in the other *Länder*. Financial resources totalling 493.8 million Euro had been raised for in-patient preventive care and rehabilitation facilities by April 2021.

The compensation payment agreement, which was implemented quickly and cooperatively, provided the in-patient preventive care and rehabilitation facilities with an important rescue package, especially in the difficult early days of the coronavirus pandemic, and has continued to do so ever since.

Compensation payments for preventive care and rehabilitation facilities in accordance with section 11d of Book V of the Social Code



Source: Federal Office for Social Security
Illustration: National Association of Statutory Health Insurance Funds

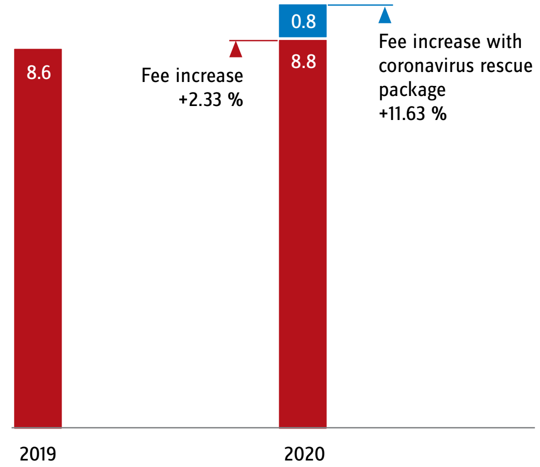
Ensuring the supply of medicinal products and remedies

Pharmacies remained open during the contact restrictions that were in effect in the spring of 2020, and were able to maintain the operations necessary for care. As the economic performance of the pharmacies was largely intact in comparison to other healthcare providers, the statutory measures that were taken were mainly aimed at minimising direct contacts.

The SARS-CoV-2 Supply of Medicinal Products Ordinance (*SARS-CoV-2-Arzneimittelversorgungsverordnung*) created special time-limited regulations for pharmacies and for ensuring the supply of medicinal products. The aim was to reduce the number of contacts, amongst other things by derogating from the usual dispensing rules. In addition, remuneration was introduced for delivery services provided by pharmacies. Statutory health insurance also paid a lump sum of 250 Euro plus VAT per pharmacy for the initial procurement of equipment for this purpose.

The remuneration situation of remedy suppliers

Total remuneration from statutory health insurance funds 2020: 9.6 bill. Euro



Figures in bill. Euro

Sources: Official statistics KV 45, Federal Office for Social Security
Illustration: National Association of Statutory Health Insurance Funds

Access to video consultations regulated

The supply of remedies was affected to different degrees during the contact restrictions that were in place in the spring of 2020. Whilst non-physician medical therapies were prohibited in some Federal *Länder*, and practices there had to close, medically-necessary therapies could still be carried out to a certain extent in other Federal *Länder*, subject to compliance with hygiene measures. In order to maintain care in this extraordinary situation, and to mitigate the economic consequences for the remedy suppliers, the National Association of Statutory Health Insurance Funds, together with the associations of the different types of health insurance funds at federal level, issued recommendations for the remedies sector due to the coronavirus pandemic in March 2020. These recommendations included the possibility of video therapy. The Federal Joint Committee has since then included treatment by video for specific remedies in the special COVID-19 regulations. The prerequisite is that the remedy therapy required in each case cannot take place in direct personal contact due to the current pandemic situation and is suitable from a therapeutic point of view to be provided via video as a telemedical service.

As remedy therapies that were cancelled due to the pandemic could generally not be made up for, and the associated revenue losses could not be compensated for by the healthcare providers themselves, the legislature enacted the COVID-19 Care Structures Protection Ordinance, which provides for a one-off compensation payment amounting to 40 % of the remuneration volume that was billed to the statutory health insurance funds in the fourth quarter of 2019. This does not have to be repaid. Furthermore, a hygiene lump sum of 1.50 Euro per remedy prescription was established in order to compensate for the costs of heightened hygiene measures.

Remedy suppliers received a one-off compensation payment amounting to 40 % of the remuneration volume that was billed to the statutory health insurance funds in the fourth quarter of 2019.

Support for persons in need of long-term care and long-term care facilities

Insured persons in need of long-term care were also able in individual cases to make use of healthcare providers who were not licensed in accordance with Book XI of the Social Code, such as qualified medical long-term care staff, or indeed neighbours.

The legislature has enacted a large number of measures in order to stabilise the long-term care of persons in need of long-term care during the coronavirus pandemic. On the one hand, these provide for services to be taken up more flexibly by persons in need of long-term care, and on the other hand provide financial safeguards for healthcare providers. The performance of quality audits by external auditors in approved long-term care facilities was temporarily suspended in order to protect the particularly vulnerable group of people in need of long-term care, and to relieve the long-term care facilities. Assessments by the Medical Service to determine the need of long-term care could optionally be carried out via telephone interviews. The measures taken from March 2020 onwards were initially time-limited until 30 September 2020, but were extended until 31 December 2020 due to trends in infections.

Core arrangements of the long-term care rescue package to safeguard long-term care in accordance with section 150 subsections (1), (3) and (5) of Book XI of the German Social Code

Compensation for COVID-related extraordinary expenditure and revenue shortfalls for long-term care facilities and support services recognised under *Land* law:

- funding of protective equipment
- funding of additional staff expenditure for long-term non-residential and residential care
- compensation for revenue shortfalls, for instance where it was not possible to admit any persons in need of long-term care in case of quarantine

Support for persons in need of long-term care:

- allowing the use and reimbursement of long-term care services from other healthcare providers or individuals for up to three months in order to prevent care shortages
- making services more flexible by extending the take-up period, and involving other healthcare providers

Increasing flexibility and expanding the use of benefits

The applicable stipulations for the provision of services were made more flexible in order to avoid bottlenecks in long-term care in the domestic sector as a result of the pandemic. Insured persons in need of long-term care were thus also able in individual cases to make use of healthcare providers who were not licensed and accredited in accordance with Book XI of the Social Code (SGB XI), such as qualified medical long-term care staff, or indeed neighbours. At the same time, unclaimed benefits from the previous year were still available beyond June 2020 until the end of the year. The National Association of Statutory Health Insurance Funds had the task of regulating in recommendations the details of the prerequisites, the qualification of the healthcare providers, and the application procedure.

It was equally important for the National Association of Statutory Health Insurance Funds to take into account the special situation on the market for protective equipment. Prices had risen significantly here since the beginning of the coronavirus pandemic. The maximum benefit amount provided by law for long-term care remedies intended for consumption, which also includes protective equipment such as face masks and disposable gloves, was therefore increased from 40 Euro to 60 Euro per month by the COVID-19 Care Structures Protection Ordinance.

Financial security for healthcare providers

Approved long-term care facilities and services recognised under *Land* law to support people in need of long-term care in their daily lives incurred additional costs as a result of the coronavirus pandemic. These were due to higher personnel and material expenditure, e.g. for protective equipment. On the other hand, the facilities had to contend with a considerable reduction in revenue. Some facilities were temporarily closed, and,

all in all, fewer services were taken up in order to minimise the risk of infection. The long-term care rescue package was set up in order to compensate for this additional expenditure and for the revenue shortfalls. The long-term care funds made up for the costs where pandemic-related expenses were not financed by other means. The National Association of Statutory Health Insurance Funds determined the procedure for the practical implementation of the application procedure and the reimbursement of costs. In addition, the costs were reimbursed that were incurred by facility operators and service providers from October 2020 onwards for the procurement of the maximum monthly quantities of rapid antigen tests specified in accordance with the Coronavirus Testing Ordinance for testing employees, persons in need of long-term care, and their visitors. As the infection situation developed, the maximum test quantities were increased since October 2020, and the initial time limit was extended until such time as the epidemic situation of national significance is lifted by the German Bundestag.

Quality audits in long-term care facilities

The annual quality audits were suspended from mid-March to the end of September 2020 in order to protect the residents of long-term care facilities from becoming infected with Covid, and to relieve the burden on the facilities. The Medical Services initially resumed the audit activities in early October 2020 on the basis of extended infection protection measures. However, as the pandemic worsened from mid-October 2020 onwards, the National Association of Statutory Health Insurance Funds and the Medical Service of the National Association of Statutory Health Insurance Funds (MDS) argued in favour of cancelling all direct contact in long-term care facilities that was not absolutely necessary. The quality audits were suspended once again. They are to be continued after the pandemic has subsided, taking into account the special hygienic measures of the auditing institutions.

Assessment of persons in need of long-term care

The assessment of the need of long-term care is carried out as a matter of principle by means of a comprehensive personal assessment in the applicant's home. It was also possible to carry out the assessment without an on-site examination between mid-March 2020 and initially 31 March 2021, subsequently extended to 30 June 2021, if this was absolutely necessary to protect the persons in need of long-term care and the assessors from becoming infected with the coronavirus. Instead of this, it was possible for classifications of need of long-term care to be made during this period exclusively on the basis of available information and via a structured telephone interview. The National Association of Statutory Health Insurance Funds and the MDS jointly developed nationwide uniform standards for this purpose.

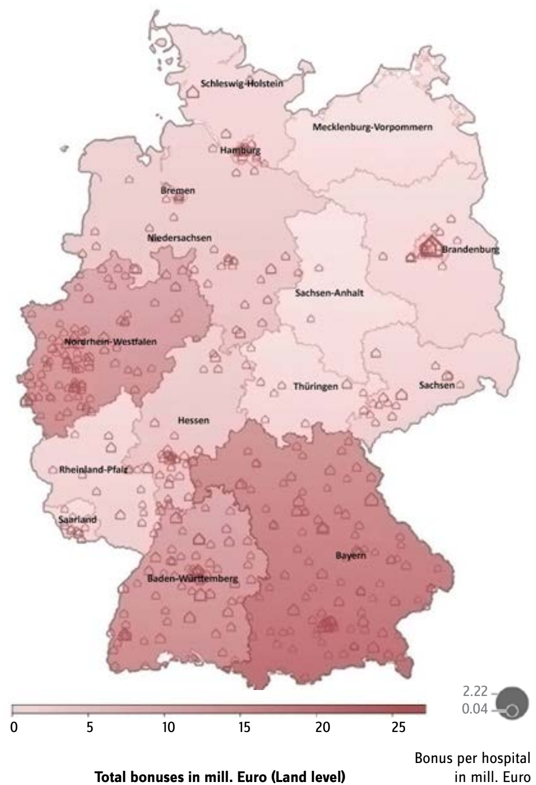
As a result of the pandemic, it was possible for classifications of need of long-term care to be made exclusively on the basis of available information and via a structured telephone interview.

“Corona bonus” for workers in long-term care facilities and hospitals

Employees in long-term care facilities were entitled to a one-off special benefit from their employer which was exempt from tax and social security contributions.

The legislature resolved on “corona bonuses” in order to acknowledge the particular challenges and burdens shouldered by nursing care staff in geriatric care and in hospitals during the coronavirus pandemic. First of all, employees who worked in a geriatric care facility for at least three months between March and October 2020 were entitled to a one-off special benefit from their employer which was exempt from tax and social security contributions. This also included employees working in long-term care facilities as part of temporary employment or under a contract for work or services. The amount of the bonus is determined by statute, depending on the field and scope of the work performed, and is up to 1,000 Euro. The *Länder* can top up the bonus to up to 1,500 Euro. Employers have been given an entitlement vis-à-vis long-term care insurance for the amount to be advanced to them in order to finance these bonuses.

Distribution of special payments in accordance with section 26a of the Hospitals Act in Germany (100 million Euro)



Source and illustration: National Association of Statutory Health Insurance Funds

Disbursement regulated swiftly

The National Association of Statutory Health Insurance Funds quickly regulated the procedure for funding the corona bonuses for long-term care facilities, service providers and long-term care funds. The necessary notification and payment procedure was determined in coordination with the national associations of the operators of long-term residential care facilities and domestic care providers, and with the appropriate associations of other employers. The corresponding specifications and application forms, the lists of the responsible long-term care funds, as well as FAQs, coordinated with the Federal Ministry of Health, were published on the website of the National Association of Statutory Health Insurance Funds. This made it possible for the long-term care funds to make sure that the corona bonuses were disbursed to the applicant employers on the two dates specified by law in July and December 2020.

The expenditure of the long-term care funds for corona bonuses which are paid to employees in non-residential long-term care facilities for services rendered in accordance with Book V of the Social Code was paid proportionately by the statutory health insurance funds in accordance with the statutory stipulation. The National Association of Statutory Health Insurance Funds has levied a charge for this purpose.

Special payments for nursing staff in hospitals in accordance with section 26a of the Hospitals Act (KHG)

After policymakers had raised expectations that not only nursing staff in geriatric care were to receive a bonus, but in fact all care staff, special payments for care staff in hospitals due to special

burdens caused by the coronavirus pandemic were enshrined in law in the shape of the Hospital Future Act. The arrangements for the implementation of the corona bonus contain essential aspects of a joint proposal for a solution made by the National Association of Statutory Health Insurance Funds and the German Hospital Federation which was drawn up on behalf of the Federal Ministry of Health. The self-government partners had agreed in this proposal on a total bonus volume of 100 million Euro.

Distribution mechanism established

The total volume of corona bonuses was distributed among 433 affected hospitals which had treated a significant number of COVID-19 patients in the period from January to May 2020. Hospitals with fewer than 500 beds having treated at least 20 COVID-19 patients, as well as hospitals with 500 beds or more having treated at least 50 patients, are considered as affected within the meaning of the law. The bonus amount received by a hospital was determined by the Institute for the Hospital Remuneration System (InEK), for 50 % on the basis of the existing COVID-19 cases, and for 50 % on the basis of the nursing staff employed. The individual bonus volumes of the hospitals varied between about 44,500 Euro and 2.2 million Euro. The amount of the special payment varied per Federal *Land* in accordance with the variations in the degree to which hospitals were affected by the pandemic in the respective Federal *Länder*

The hospital operator decided on the selection of the recipients, and on the individual amount of the bonus, in consultation with the employee representatives. Care staff in direct patient care on in-patient wards were entitled to receive the bonus. In addition, other employees who were particularly burdened could also be selected to receive a bonus.

The bonus was financed to the tune of 93 million Euro by statutory health insurance from the liquidity reserve of the Health Fund, and an additional 7 million Euro was contributed by private health insurance. The Federal Office for Social Security and the Association of Private Health Insurance paid the amounts to the National Association of Statutory Health Insurance Funds, which forwarded the bonus amounts to the respective hospitals on the basis of the calculations carried out by the InEK. The hospitals then disbursed the bonuses on their own responsibility.

Extended special payment for care staff in hospitals in accordance with section 26d of the Hospitals Act

An extended special payment for nursing staff in hospitals is provided for in section 26 of the Hospitals Act within the framework of the Act on the Continuation of the Arrangements Concerning the Epidemic Situation of National Significance (*Gesetz zur Fortgeltung der die epidemische Lage von nationaler Tragweite betreffenden Regelungen*), for which the Federation is providing 450 million Euro. The period of the entire year 2020 is considered for the distribution of the funds to hospitals affected. The criteria for calculating the bonus amount have been further developed in the statutory provision. The available care staff and the basic care of COVID-19 patients had previously been decisive. Intensive care treatment is now also taken into account in the allocation of funds. The National Association of Statutory Health Insurance Funds will forward the funds from the Federation to the hospitals via the Federal Office for Social Security. Analogous to the special payment in the first wave, the hospital operator decides on the selection of the recipients, and on the respective amount of the payment, in consultation with the employee representatives. The special payment is to be disbursed by the hospitals to the bonus recipients by 30 June 2021.

The Federation provided 450 million Euro in the second wave.

Corona-App, noun
(attempt to trace human-virus encounters)

A boost for digital care

The coronavirus pandemic has enhanced the importance of digital services in care provided by contract doctors. In order to counteract the spread of the virus by people presenting at medical practices, the National Association of Statutory Health Insurance Funds advocated within the framework of joint self-government easier use of telemedical procedures. The aim was that insured persons should if possible only present at practices in person in cases where it was medically necessary. Against this background, the Federal Joint Committee for instance decided on an exemption for contract doctors to determine incapacity for work by telephone.

Video consultations

Another alternative to personal contact in a medical practice is to consult a doctor by video. Together with the National Association of Statutory Health Insurance Physicians, the National Association of Statutory Health Insurance Funds therefore lifted the applicable limitation regulations for video consultations in April 2020 in order to take account of the special situation brought about by the pandemic. In order to guarantee that medical treatment is provided in person as a matter of principle, these arrangements normally stipulate that physicians and psychotherapists may only provide video consultations to a certain extent.

In addition, the National Association of Statutory Health Insurance Funds has introduced further special regulations due to the coronavirus pandemic. The possibility was for instance created for healthcare providers to be able to bill for certain services even if a patient contact is carried out by (video) telephone. These include trial sessions, psychotherapeutic consultations, measures of a functional development therapy, or therapeutic sessions as part of substitution-supported treatment of opioid addicts.

Prescriptions and referrals

If personal doctor-patient contacts are replaced by (video) telephone contacts, there will be an increasing need for prescriptions and referrals to be delivered by post. The Evaluation Committee therefore recommended that it should be possible for follow-up prescriptions for medicinal products and bandages, certain medical aids, prescriptions for patient transport, and referrals, to be issued without any personal contact and sent to the insured persons by post, if this is medically necessary.

Limitation regulations applicable for video consultations were lifted in order to take account of the special situation brought about by the pandemic.

Midwife care

Digitalisation has also received a boost in midwifery services in the coronavirus pandemic. The National Association of Statutory Health Insurance Funds has concluded a temporary agreement with the midwives' associations that temporarily allows care to be provided by a freelance midwife via video for certain (partial) services. In particular, midwives have been permitted since the end of March 2020 to provide and bill antenatal and postnatal exercise courses, certain types of assistance with pregnancy-related symptoms, and childbed care, via video.

Lessons learned from the pandemic

Central approaches to restructuring hospital care must focus on the existing potential to enhance out-patient treatment, as well as on the insufficient degree of specialisation and concentration of services.

There has been justified hope of the pandemic coming to an end at the latest since the start of vaccinations against the coronavirus immediately before the turn of the year 2020/2021. The dynamics of the infections and the corresponding short-term changes in the demand for care have resulted in unprecedented challenges for the healthcare system and the provision of long-term care. Completely new framework conditions had to be created within a very short period of time in some cases. Under these conditions, the German Bundestag, the Federal Ministry of Health, as well as social and joint self-government, have reacted quickly in creating a large number of practice-orientated special regulations in order to ensure the efficiency of healthcare and long-term care.

Permanent integration of digital services

It is already possible to learn the first lessons from the pandemic. One important realisation is that healthcare providers have fortunately taken advantage of the opportunities for digital healthcare and long-term care. Since the scepticism of the past seems to have been overcome, digitalisation should also become a permanent supplementary component of the usual treatment routines beyond the end of the coronavirus pandemic in order to ensure economic health and long-term care that is orientated towards patient benefit.

Finally getting to grips with restructuring hospital care

Notwithstanding the above, existing shortcomings, especially in healthcare, have also become more apparent during the crisis. In the hospital sector, the pandemic-related focus on intensive care beds must not be allowed to obscure the general capacity surplus, especially in urban areas. Central approaches to restructuring must focus on the existing potential to enhance out-patient treatment, as well as on the insufficient degree of specialisation and concentration of services. The urgent need to catch up in the healthcare system and in long-term care should also be addressed with regard to cross-sectoral care and strengthening the competence of the non-medical health professions. These needs for action are among the important tasks for the next Federal Government. They should be at the top of the health and long-term care policy agenda, especially in view of new challenges such as the foreseeable need for treatment concepts for patients with long-term consequences after a COVID infection.

Strengthening the public health service

In addition, it became painfully clear during the coronavirus pandemic that there is an urgent need for a future concept for the Public Health Service (ÖGD). The developments in the time before the outbreak of the pandemic meant that, on the one hand, the underfunded and understaffed Public Health Service was unable to meet the short-term requirements for action. On the other hand, the previous failures to establish digital reporting channels had a negative impact on response capacity in managing the outbreak and in tracing the chains of infection. It will be crucial in the future for the *Länder* and municipalities to meet their obligations to provide funding and make investments.

Expanding the monitoring of hospital beds

In addition, the existing special arrangements applying in the pandemic situation must be examined. Depending on development going forward, and on the accuracy of the objectives pursued by the existing laws and ordinances, a decision must be made on whether to continue or amend them, or to take them off the statute books. Particularly positive regulations will continue to be justified beyond the pandemic. This certainly includes the intensive care bed register, which for the first time has created a day-by-day overview of the availability of intensive care beds. The establishment of such real-time monitoring should be extended to all hospital care beds.

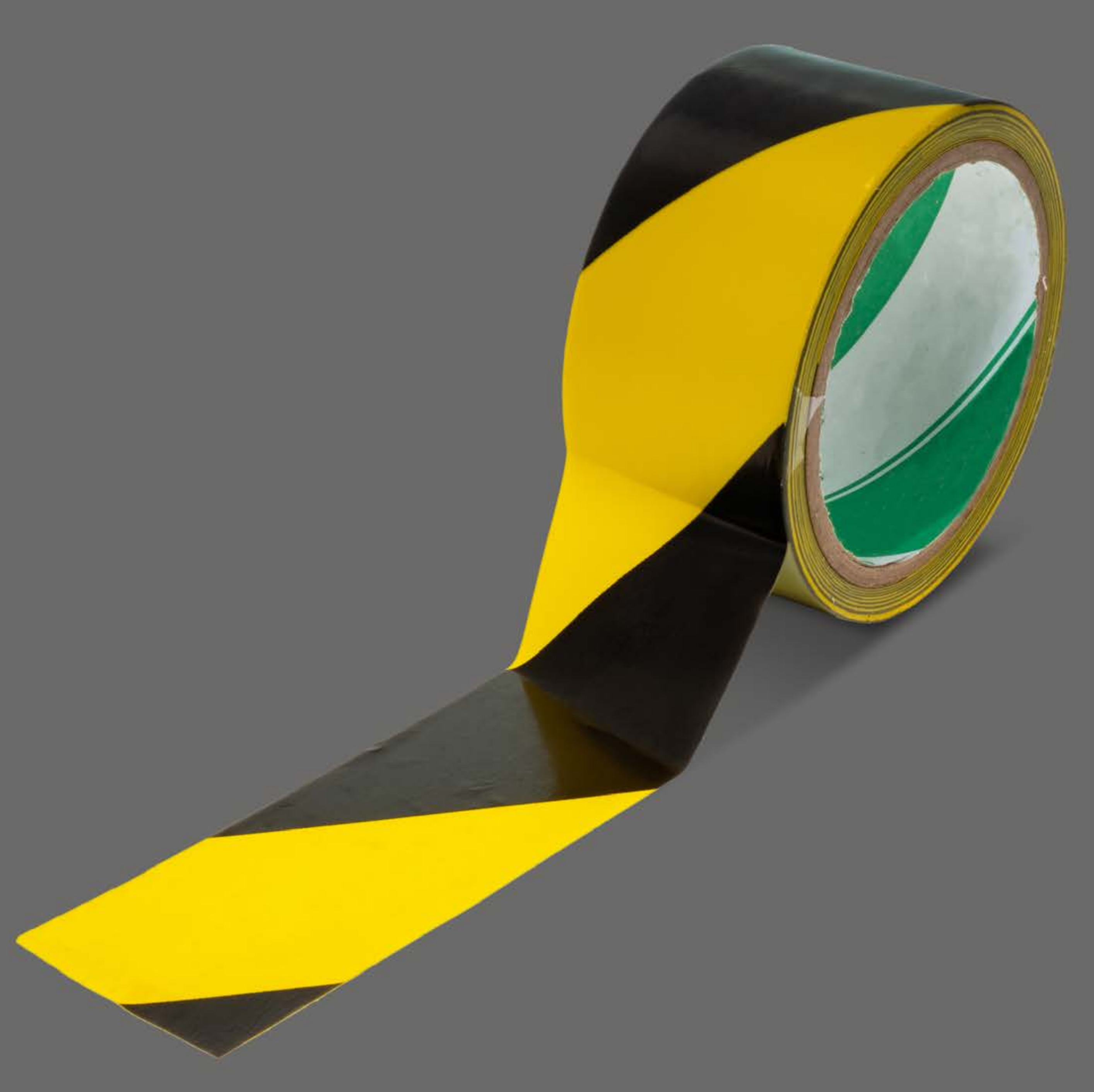
Creating sound funding for health and long-term care insurance

Last but not least, there is an urgent need in the interest of contributors to keep an eye on the financial stability of statutory health insurance and social long-term care insurance. Recent legislation has partially shifted the burden of pandemic-related additional expenditure onto statutory health insurance. True, the Federation has made a major contribution by compensating hospitals for vacant beds during the first wave. That said, tasks within civil protection that are incumbent on society as a whole should be financed entirely from tax revenues. The good overall economic situation before the pandemic was unfortunately not used to set a course to further develop health and long-term care. It was not so much insured persons and patients who benefited from the high-expenditure reforms of the legislative period now coming to an end, but rather the healthcare providers via increased fees.

Further improving healthcare and long-term care

The coronavirus pandemic has been and remains one of the greatest tests of the healthcare system and of long-term care in Germany. The need for optimisation that has become manifest must by all means be taken up by the legislature in the shape of structural reforms. In order to support this process, the National Association of Statutory Health Insurance Funds is developing concrete proposals on how healthcare and long-term care can be permanently improved in the coming legislative period.

The good overall economic situation before the pandemic was unfortunately not used to set a course to further develop health and long-term care.



marking tape, noun
(the best distance by far)

Health apps on prescription leave room for improvement

The Digital Care Act (*Digitale-Versorgung-Gesetz*) introduced the "Health apps on prescription" scheme in 2019, attracting considerable public attention. The National Association of Statutory Health Insurance Funds believes that digital health applications certainly have the potential to improve healthcare. They can help in the detection, monitoring, treatment or alleviation of diseases, and can be used in particular in the context of medical care for chronically-ill people. That having been said, proof of benefit and the economic efficiency requirement must be applied to digital health applications in the same way as to other services in order to protect patients and safeguard the interests of the contributors.

Fast-track procedures violate essential principles

The National Association of Statutory Health Insurance Funds had already voiced justified criticism during the legislative process of the approval and review process for digital health applications carried out by the Federal Institute for Drugs and Medical Devices (BfArM), and of the reimbursement arrangements, and brought about changes. Many problems nevertheless persist. The legislature has provided for a fast-track procedure for the approval and reimbursement of digital health applications which was reasoned by digital health applications' short innovation cycles. Basic principles such as proof of benefit and economic efficiency requirements, which apply to all statutory health insurance services, are however considerably diluted in the process. It is therefore possible for digital health applications to be prescribed, used and reimbursed throughout Germany for up to two years without there being any proven benefit. The provider is free to set prices in the first year. The benefit assessment of digital health applications is not based on a comparison with the previous treatment methods, or with other digital health applications, but only on a comparison with non-use. The National Association of Statutory Health Insurance Funds considers that digital health applications must be just as safe, beneficial and economical as other services. The law must be corrected in order to guarantee that this is the case. The Administrative Council of the National Association of Statutory Health Insurance Funds has issued a position paper calling for specific changes and identifying potential for further improvement.

According to the law as it stands, digital health applications can be prescribed, used and reimbursed throughout Germany for up to two years without there being any proven benefit.

The first approved digital health applications confirm this need for improvement. The price increases, amounting in some cases to 400 to 600 % compared with existing remuneration structures within selective contracts, are an expression of the excessive pricing policy pursued by the providers of digital health applications. What is more, the majority of digital health applications constitute approvals for testing without proven benefit.

Remuneration negotiations with digital health application creators

An important implementation task of the National Association of Statutory Health Insurance Funds has been since the beginning of 2020 to negotiate the framework conditions and criteria for digital health application reimbursement with the providers of such applications. The health insurance funds contributed their expertise from the selective contracts on digital health applications to the negotiations, thus revealing the high-price policy pursued by the creators. The prices that were demanded with a view to the profit expectations, which are totally disproportionate to care otherwise provided under statutory health insurance, in combination with an open statutory framework, partly prevented an agreement being reached. In the interest of the contributors, the National Association of Statutory Health Insurance Funds demanded compliance with the economic efficiency requirement by limiting the free pricing of creators in the first year with maximum amount groups. The newly-established Arbitration Office had to be called in for this purpose.

Agreement on medical services

The price increases, amounting in some cases to 400 to 600 % compared with existing remuneration structures within selective contracts, are an expression of the excessive pricing policy pursued by the creators of digital health applications.

The process for approving digital health applications carried out by the Federal Institute for Drugs and Medical Devices also provides for a definition of contract physicians' services that are necessary and reimbursable in connection with care provided within digital health applications. The National Association of Statutory Health Insurance Funds must agree with the National Association of Statutory Health Insurance Physicians on remuneration arrangements in the Standard Schedule of Fees (in case of the permanent inclusion of digital health applications), or in the Federal Skeleton Agreement for Physicians (in case of digital health applications being included on a trial basis) within three months of the inclusion of a digital health application in the list maintained by the Federal Institute. The National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians have created the contractual basis in the Federal Skeleton Agreement in order to implement the statutory mandate. The aim of the agreement is to create transparency about the separately-billable services without undue delay, in the interest of patients, contract doctors and health insurance funds, and to ensure the fastest possible provision and billing of the medical services in question in accordance with the principle of benefits in kind.

Care process in the context of digital health apps

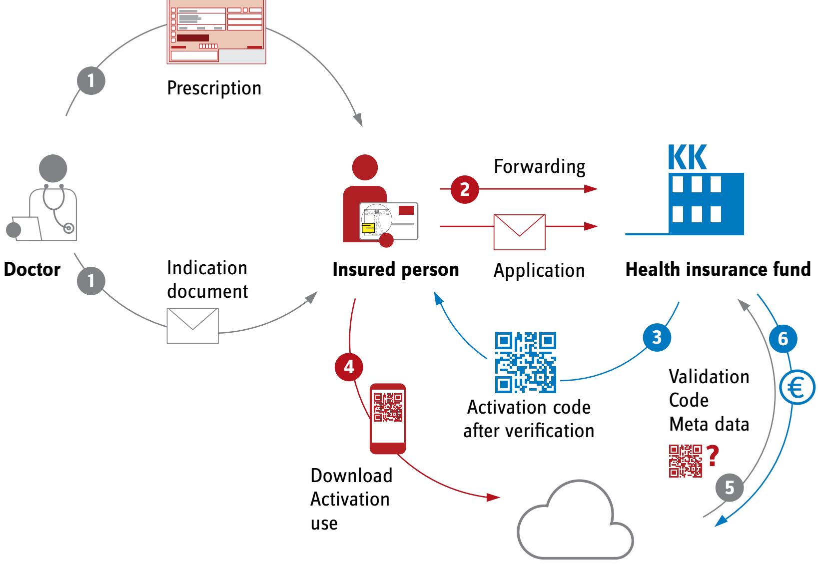


Illustration: National Association of Statutory Health Insurance Funds

Prescription and billing process implemented

The prescription and billing processes also had to be worked out in 2020 for the newly-introduced "Health apps on prescription" service. The National Association of Statutory Health Insurance Funds and the statutory health insurance funds coordinated on this with the digital health application providers. The process provides that insured persons submit their prescription to the health insurance fund, and then receive a code to activate the application. The first two digits identify the health insurance fund. This enables the digital health applications manufacturer to verify the validity of the activation code vis-à-vis the respective health insurance fund, and to transmit the billing data, including the code, to the health insurance fund in electronic form. The billing guideline, which is binding on all parties involved, was developed and published by the National Association of Statutory Health Insurance Funds.

The result is a process for the prescription and billing of digital health applications that is fully digital and designed to meet the needs of insured persons and health insurance funds in compliance with the data protection requirements. Prescriptions will be issued in hard copy on a transitional basis until the e-prescription is available. The National Association of Statutory Health Insurance Funds has adapted the Federal Skeleton Agreement for Physicians accordingly.

The struggle to protect patient data

The Patient Data Protection Act (*Patientendaten-Schutz-Gesetz* - PDSG), which came into force in 2020, marks another stage in the digitalisation legislation for the healthcare system. Three aspects are particularly relevant in the comprehensive package of measures: firstly, the obligation placed on the health insurance funds to offer electronic medical records (ePA), secondly, the secure delivery of electronic health cards (eGK), and thirdly problematic increases in the tasks to be carried out by gematik.

The launch of electronic medical records

Electronic medical records were successfully launched on 1 January 2021, and are now available for use by insured persons. The Appointment Service and Care Act (*Terminservice- und Versorgungsgesetz*) of 2019 already introduced the obligation for the health insurance funds to offer an electronic medical record. Details on the content and use of electronic medical records were regulated by the Patient Data Protection Act.

The preparations in the direct run-up to the introduction of electronic medical records were overshadowed by the criticism expressed by the Federal Commissioner for Data Protection and Freedom of Information (BfDI), Prof. Ulrich Kelber, that parts of the Patient Data Protection Act did not comply with the EU's General Data Protection Regulation. Specifically, he criticised among other things the lack of fine-grained access to the contents of electronic medical records, since a differentiated authorisation procedure is not planned in law until the next expansion stage, starting in 2022. Criticism was not limited to the public domain. When the Patient Data Protection Act came into force, as a means under the law on supervision, the Federal Commissioner sent an official warning to the health insurance funds, which are subject to the data protection supervision of the Federation, to refrain from issuing electronic medical records in their current form.

The statutory health insurance funds were thus placed in a dilemma between the data protection requirements of the Federal Commissioner, on the one hand, and the legal obligations on the other. The National Association of Statutory Health Insurance Funds was however able to reach agreement with the Federal Commissioner with regard to the drafting of the comprehensive information material on electronic medical records which the health insurance funds are to use to inform their insured members prior to issuing electronic medical records. These information materials now point out the weaknesses of electronic medical records in their current form, so that it was possible to resolve the conflict for the time being.

Electronic medical records were successfully launched on 1 January 2021, and are now available for use by insured persons.

Digital progress must go hand in hand with data protection so that a similar scenario is not repeated in the coming expansion stages of electronic medical records. The National Association of Statutory Health Insurance Funds considers it to be the task of policy-makers to bring about the clarity and legal certainty needed here in the run-up to those stages.

Remuneration arrangements regarding electronic medical records

The healthcare providers receive remuneration for entering and maintaining the data in electronic medical records. According to the statutory mandate, a remuneration arrangement must be reached for the regular maintenance and updating of electronic medical records by contract doctors. The Evaluation Committee has included two fee schedule items in the Standard Schedule of Fees with effect from 1 January 2021 for the remuneration of these services. Pharmacies must assist insured persons with the processing of drug-related data in electronic medical records on request after dispensing a medicinal product. The National Association of Statutory Health Insurance Funds and the German Pharmacists' Association have regulated the details of the billing requirements as per 1 January 2021.

In addition to remuneration for regular maintenance and updating of electronic medical records, contract doctors' and contract dentists' practices, as well as hospitals, are to receive a separate remuneration for initially entering the data into the records. The remuneration level for 2021 was set at 10 Euro per electronic medical record in order to promote the use of electronic medical records. In addition, each further data entry will be remunerated. The self-government partners will be able to negotiate the level of remuneration independently from 2022 onwards. The National Association of Statutory Health Insurance Funds, the National Association of Statutory Health Insurance Physicians, the German Hospital Federation, and the National Association of Statutory Health Insurance Dentists, will negotiate the billing requirements and procedures in a four-party agreement.

The legislature has considerably tightened up the requirements for securely issuing the electronic health card and/or the associated PIN/PUK letter.

Secure delivery of electronic health card and PIN

The legislature has also considerably tightened up the requirements for securely issuing the electronic health card and/or the associated PIN/PUK letter as part of the coming introduction of applications such as the e-prescription. The National Association of Statutory Health Insurance Funds has made it clear in this context that it is not practicable to implement the statutory requirements for the extensive obligation placed on insured persons to cooperate when receiving the electronic health card/PIN across the board, and that this would involve an immense financial and organisational effort.

It was possible to clarify here that the issuance of the new electronic health card does not have to take place for all insured persons at the same time, but can follow the regular renewal cycle

Expansion stages of electronic medical records in accordance with the Patient Data Protection Act (PDSG)

	1st implementation step 2021	2nd implementation step 2022	3rd implementation step 2023
Which data may be stored?	· Medical information (diagnoses, findings, therapeutic measures, preventive care examinations) · Emergency data, medication plan, electronic medical report · The insured persons' own health data (e.g. medical diaries)	· Dental bonus booklet, children's examination booklet, maternity passport, vaccination documentation · Electronic prescriptions · Health insurance fund data on the services used	· Nursing care data · Electronic certificate for incapacity for work · Other data made available by healthcare providers for insured persons
Access concept	· Coarse-grained authorisation management: Insured persons can initially grant access to entire areas (e.g. own data, data input by healthcare providers).	· Fine-grained access management: Insured persons can permit healthcare providers to access specific documents and datasets	
Other possible applications	· Insured persons can view logged accesses to the electronic medical records.		· Data donated by insured persons for research purposes · Data provided by insured persons for health insurance fund applications

Illustration: National Association of Statutory Health Insurance Funds

of the insurance card. Furthermore, it is not an absolute must for the PIN to be provided by the end of June 2021, but it can also be sent at the request of the insured person(s) and/or close to the time of the actual use of electronic medical records and the e-prescription. If a PIN has already been delivered insecurely, and third-party access to health data via electronic medical records and e-prescription cannot be ruled out, deactivation can be avoided if insured persons subsequently identify themselves before 1 July 2021. Just like the issuance of the electronic health card, this can be carried out in the offices of the member funds.

Expansion of the tasks to be carried out by gematik

gematik's statutory tasks had previously included the introduction, operation and further development of the telematics infrastructure (TI), the electronic health card and the associated specialist applications. gematik's range of tasks has been expanded in various areas within the framework of the Patient Data Protection Act. gematik will coordinate and monitor the new processes for issuing cards and IDs for electronic identification and authentication in the TI in future. This also concerns the issuance of the electronic health card. In addition to the Federal Office for Social Security, which supervises the federally-incorporated funds, and the supervision by the *Länder*, to which all other health insurance funds are subject, gematik is thus added as a second supervisory body for the statutory health insurance funds, without the demarcation between the supervisory bodies being sufficiently well defined.

The dual role of gematik in the implementation of the e-prescription is also problematic. gematik is responsible at the same time for the development and operation of the e-prescription app, which enables insured persons to digitally access doctors' prescriptions. This means that gematik, on the one hand, draws up the specifications for the app and carries out the corresponding approval procedures and, on the other, creates a product itself according to its own specifications, and is responsible for granting approval here as well. The National Association of Statutory Health Insurance Funds is of the opinion that component developments should be left to the market as a matter of principle, since innovations can only be promoted in the long term through competition.

The dual role of gematik in the implementation of the e-prescription is problematic. gematik is responsible at the same time for the development and operation of the e-prescription app.

The law also provides that gematik can communicate directly with insured persons for the first time and inform them about the TI. This entails it taking over one of the health insurance funds' historic tasks. The National Association of Statutory Health Insurance Funds is resolutely opposed to this.

Reorganising data transparency

The identity of the insured persons is pseudonymised twice in a two-stage procedure in order to ensure comprehensive data protection.

The Digital Care Act (DVG) aims to make health data more usable for research purposes. To this end, the existing data processing centre will be upgraded to a Research Data Centre, and access to data from statutory health insurance will be significantly improved. The amended Data Transparency Ordinance (Datentransparenzverordnung) contains appropriate supplementary details.

National Association of Statutory Health Insurance Funds to become a data collection point

As part of reorganising data transparency, the Federal Institute for Drugs and Medical Devices is to take over the operation of the Research Data Centre. The National Association of Statutory Health Insurance Funds will take on the role of a data collection point, and have the task of collating, verifying and forwarding the data from the statutory health insurance funds to the Federal Institute. The data of privately-insured persons or other groups of individuals are not intended for the procedure. The identity of the insured persons is pseudonymised twice in a two-stage procedure in order to ensure comprehensive data protection. A trust centre at the Robert Koch Institute (RKI) is to take care of this.

In addition to data on insured persons, billing data from out-patient medical care, in-patient care, and the medicinal products sector from the data year 2019 onwards, will be collated in a first stage from the end of 2022. Data from specialised out-patient medical care, out-patient hospital services, as well as billing data from other healthcare providers and from digital health applications, will be added from the data year 2023 onwards. In order to have a meaningful stock of data from the outset, the National Association of Statutory Health Insurance Funds will provide the data of the morbidity-orientated risk structure equalisation from 2016 to 2018 to the Federal Institute for Drugs and Medical Devices as part of a transitional procedure. There, the data will be linked to insured persons with the aid of a cross-period

The data flow in the data transparency procedure

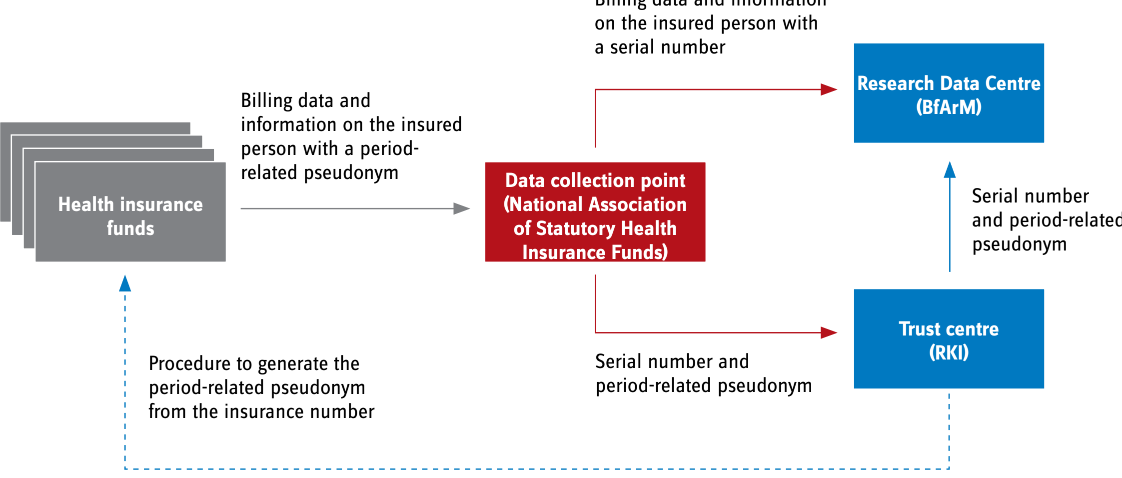


Illustration: National Association of Statutory Health Insurance Funds

pseudonym; this includes the existing data stock at the previous data processing centre, thus making it possible to create time series from 2012 onwards.

The first stage of implementation: the transitional procedure

The National Association of Statutory Health Insurance Funds commenced implementation work immediately after the Digital Care Act came into force. The IT Service Desk of Statutory Health Insurance GmbH (Informationstechnische Servicestelle der Gesetzlichen Krankenversicherung, ITSG GmbH) is also involved here, and will take over certain tasks. A particular challenge is constituted by the volume of data that is to be expected. It is the largest single data stock that has been processed by the National Association of Statutory Health Insurance Funds so far. The first data transfer to the Federal Institute for Drugs and Medical Devices took place within the transitional procedure at the end of 2020. The transmission procedure that is also to be used for regular operations from 2022 onwards was already applied here.

The next step: the technical regulations

The focus in the first half of 2021 will be placed on the development of the technical regulations that are required by law. These will be drawn up for data provision by the health insurance funds and for data transfer to the Federal Institute for Drugs and Medical Devices and to the Robert Koch Institute. The regulations contain stipulations on the delivery procedure, the framework data and the pseudonymisation procedure. In addition, the scale of the necessary verification of the data supplied as required by law is to be agreed with the health insurance funds.

The data providers within the health insurance funds can then begin their preparations for implementation in the second half of the year. While this is happening, the National Association of Statutory Health Insurance Funds and ITSG GmbH are preparing the infrastructure and its applications for the standard procedure. The goal is to start the pilot phase as per the end of the first quarter of 2022.

Data protection takes high priority

The data to be processed provide deep insights into the care provided in Germany. The data protection requirements are correspondingly stringent. The two-stage pseudonymisation of the insurance numbers plays a decisive role. The data on healthcare providers such as medical practices, pharmacies or hospitals are also pseudonymised before they are passed on by the National Association of Statutory Health Insurance Funds. Before data are passed on to the research centres, the Federal Institute for Drugs and Medical Devices must take further measures in order to ensure that they are used in an anonymised manner. Guaranteeing information security also takes high priority.

It is the intention of the legislature for statutory health insurance to bear the costs of the procedure alone.

Funding at the expense of individuals with statutory insurance

It is the intention of the legislature for statutory health insurance to bear the costs of the procedure alone. In addition to the costs for the data collection point in the National Association of Statutory Health Insurance Funds, this also includes the costs of the Research Data Centre and the trust centre. Appropriate administrative and funding agreements will be concluded with the Federal Institute for Drugs and Medical Devices and the Robert Koch Institute.

Progress in the expansion of the telematics infrastructure

The telematics infrastructure (TI) is a secure communication platform for the stakeholders in the healthcare system that are connected to it. It has been gradually built up and further developed since the end of 2017.

The first stage of expansion

Contract doctors', contract dentists' and psychotherapists' practices were connected to the TI in the first stage of expansion by installing the necessary technology such as card readers and connectors. In accordance with the statutory stipulations, statutory health insurance reimburses agreed lump sums for the connection and the technical devices. As a contractual partner, the National Association of Statutory Health Insurance Funds reaches current funding agreements with the respective associations of the healthcare providers. In addition, contracts that have already been concluded must be updated, depending on the stage of expansion.

The first medical applications were successfully tested and rolled out nationwide in 2020.

Other online applications since 2020

Further online applications and groups of healthcare providers are being added as the TI is gradually developed and expanded. The connectors that were enhanced for the "emergency data management", "electronic medication plan" and "communication in medicine (KIM)" applications have been successfully tested in a field trial since the end of the first quarter of 2020. The respective connectors in the practices that had already been connected are being equipped for the new applications by means of a software update, this already applying to approx. 80 % in January 2021.

TI connection of pharmacies and hospitals launched

The connection of pharmacies and hospitals was launched or stepped up, as the case may be, in 2020. Even though it was not possible to fully equip all pharmacies by the deadline of September 2020 set by the law, the process of connecting pharmacies has been underway since the second half of 2020. The situation in the hospital sector is similar.

Developments in the telematics infrastructure

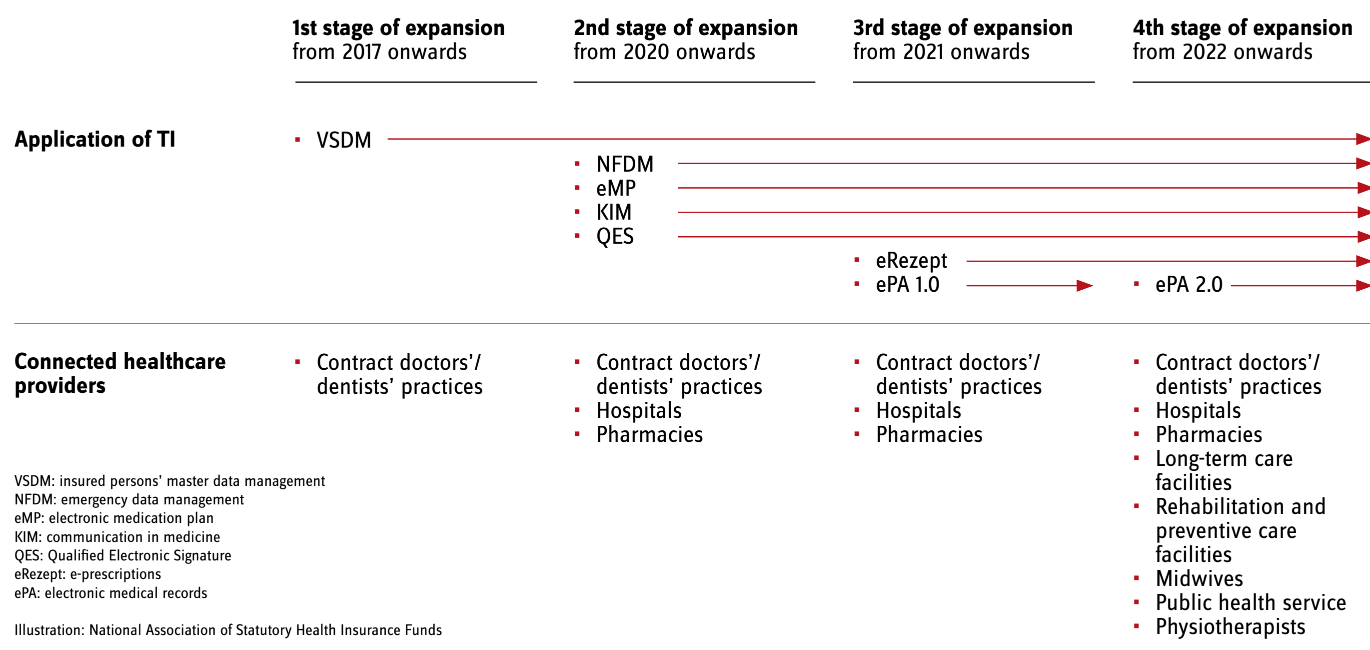


Illustration: National Association of Statutory Health Insurance Funds

According to the legal deadline, hospitals had to connect to the TI by the end of 2020. Sanctions will take effect from 1 January 2022 if the connection has still not been made by the end of 2021.

Connection of further sectors under preparation

The long-term care facilities are to be connected in a subsequent step. The National Association of Statutory Health Insurance Funds has reached a funding agreement with the long-term care associations at national level, and this came into force in the third quarter of 2020. Since there is no joint organisation for billing, unlike in the previously-connected sectors, it was decided during the funding negotiations that billing is to take place via the National Association of Statutory Health Insurance Funds, which is setting up a billing portal specifically for this purpose. As soon as all the necessary technical components for the long-term care sector are available on the market, the facilities will be connected. There is currently still no identification procedure, but this is expected to be available from mid-2021 onwards. Rehabilitation and preventive care facilities, the public health sector, as well as midwives, also need electronic identification in order to connect to the TI, and this is not yet specified and available on the market. The statutory deadline for concluding the funding agreement with the rehabilitation and preventive care facilities and the public health service expired at the beginning of October 2020. The deadline for concluding a funding agreement with the midwives expired at the end of March 2021.

Electronic certificate for incapacity for work

According to the legal basis, the electronic certificate for incapacity for work (eAU) is to be transferred from the medical practice to the health insurance fund via TI resources from 1 January 2021 onwards. The National Association of Statutory Health Insurance Funds has agreed with the National Association of Statutory Health Insurance Physicians (KBV) to use the KIM secure transmission procedure for the eAU. This requires both sides, that is medical practices and health insurance funds, to be able to identify themselves electronically. The cryptographic keys and TI certificates which the health insurance funds need for this purpose are being developed on behalf of the National Association of Statutory Health Insurance Funds, and should be available in the third quarter of 2021. In view of the necessary adjustments in the Federal Skeleton Agreement, the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Physicians have agreed that transmission of the eAU is to be mandatory as of 1 October 2021.

Electronic prescriptions

The Patient Data Protection Act is to make the e-prescription a mandatory application for medical practices participating in contract doctors' care provision, and for pharmacies, from 1 January 2022 onwards. The technical infrastructure is to go into operation as early as 1 July 2021, and hence the first e-prescriptions can be issued and billed. The National Association of Statutory Health Insurance Funds agreed by 31 March 2020 with the National Association of Statutory Health Insurance Physicians and the German Pharmacists' Association (DAV) on the amendments to the collective agreements necessary for this. gematik had published the first version of the specifications for the e-prescription by the end of June 2020, and these form the basis for lending more specific shape to the technical arrangements of the healthcare providers. The Patient Data Protection Act and subsequent legislative procedures give rise to an ongoing need to adapt the framework conditions of collective agreements and technical regulations. In particular, the transition period from paper prescriptions to e-prescriptions causes considerable additional work for the complex billing processes with health insurance funds downstream of the pharmacies due to the parallel structures that need to be provided. The National Association of Statutory Health Insurance Funds regularly exchanges information in this regard, especially with the German Pharmacists' Association, in order to set binding targets for as rapid a technical implementation as possible.

It is intended to be possible for the first e-prescriptions to be issued and billed from 1 July 2021 onwards.

The potential of digitalisation for long-term care

Long-term care will also benefit from the possibilities offered by the telematics infrastructure (TI). Digitally exchanging care-relevant data and information between the players involved in medical and long-term care is intended to help organise care processes more efficiently in the future, and to improve the overall quality of care.

A pilot programme for trialling the TI in long-term care

The National Association of Statutory Health Insurance Funds launched a pilot programme in 2020 in order to trial the integration of the long-term care facilities into the TI and the cross-sector exchange of information. The legislature has mandated it to trial various components of the TI, such as secure communication in medicine, by 2024 from the perspective of out-patient and in-patient long-term care, and to review and refine existing standards of digital information exchange for a nationwide roll-out. In addition, other applications are to be developed and trialled that are not yet part of the TI, but which nevertheless hold innovation potential for the organisation of care processes, e.g. for discharge management.

Various components of the TI are to be trialled from the perspective of out-patient and in-patient long-term care, and existing standards of digital information exchange are to be reviewed and refined.

The pilot programme is being monitored and evaluated for research purposes. Particular interest attaches to practical feasibility: How can the new form of cross-sector information exchange be integrated into existing care processes? Can all healthcare providers involved implement it? The impact on workflows and organisational processes in long-term care is furthermore to be investigated.

Selection process for projects and evaluation

The first projects are to kick off at the beginning of 2021. Out-patient and in-patient long-term care facilities that adequately represent the diversity of facilities in terms of their operating entity, size, regional distribution and level of experience in digital communication will be selected to trial the applications that are provided for by law. Concepts for new applications should be characterised by a special level of innovation, a high methodological quality and major improvement potential for cross-sectoral care. Interested long-term care facilities had the opportunity in the autumn of 2020 to apply to take part in the pilot programme in a procedure for expression of interest. The call for applications for the evaluation for research purposes also started in autumn. It is planned for the evaluators to start their work in mid-2021.

homeschooling, noun
(teaches parents to respect what teachers have to put up with every day)

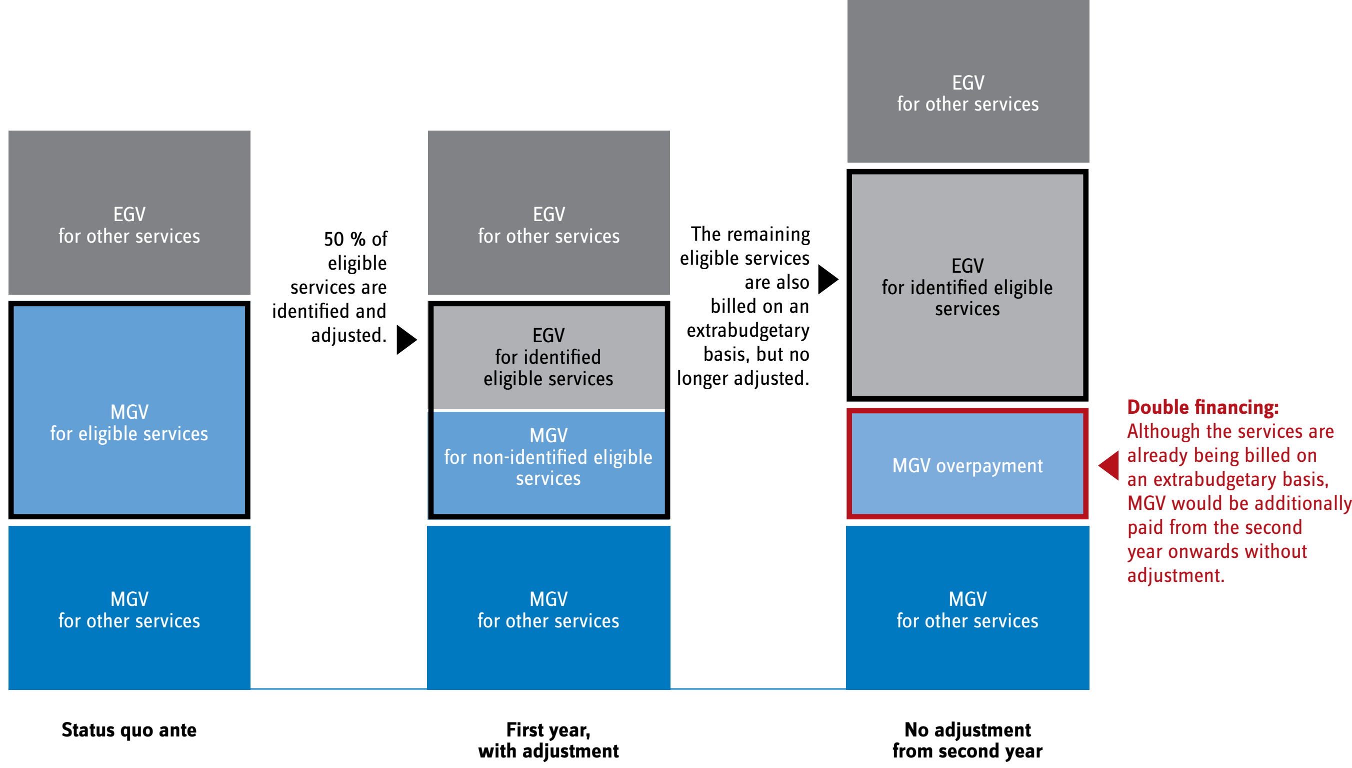
Criticism of financial support for contract doctors' services

This relates to services worth almost 5 billion Euro per year which would have to be remunerated by the health insurance funds in future on an extrabudgetary basis.

The Appointment Service and Care Act, which came into force in May 2019, introduced financial support for contract doctors' services relating to appointment scheduling, open consultations and new patients in order to improve access by individuals who have statutory insurance to out-patient medical care, and to reduce waiting times. This relates to services worth almost 5 billion Euro per year, which in future will be remunerated by the health insurance funds on an extrabudgetary basis and removed from the morbidity-related total remuneration (MGV). More than 80 % of all services that are eligible for funding under the Appointment Service and Care Act are provided to new patients.

The health insurance funds are facing massive financial burdens due to the additional costs that this has triggered, not to mention the special challenges posed by the coronavirus pandemic. Planned additional costs for the health insurance funds will arise from the increase in remuneration for the services funded, from newly-introduced surcharges for appointment scheduling, as well as from future volume increases that exceed developments in morbidity. This adds up to annual additional costs of around 500 million Euro.

Problem of under-adjustment and double financing due to only one year of adjustment (schematic)



MGV = morbidity-related total remuneration
EGV = extrabudgetary benefits

Source and illustration: National Association of Statutory Health Insurance Funds

De facto double financing of services

The adjustment of the total remuneration provided for in the Appointment Service and Care Act, which is limited to the first year, however creates a strong incentive for contract doctors to postpone billing on an extrabudgetary basis for the supported services, or initially to only bill them to a reduced extent. The volume of services provided in the first year is then not representative of the following years, and cannot be used to determine a one-off correction amount. This means that funds remain in the morbidity-related total remuneration after the end of the adjustment year for services that are additionally reimbursed on an extrabudgetary basis, and thus twice. The National Association of Statutory Health Insurance Funds already warned of this in the legislative procedure.

As the billing data available so far show, an extrabudgetary remuneration was actually only claimed for about one in two eligible services. This share was about ten percentage points lower during the coronavirus pandemic than it had been before the pandemic. The massive under-adjustment that this entails, when extrapolated over the entire adjustment year, leads to further unplanned, permanent additional costs in the shape of double financing of over 2 billion Euro per year. This constitutes an additional burden on the budgets of the health insurance funds which are already strained by the pandemic. In addition, it is striking that the share of services identified as Appointment Service and Care Act constellations among all the services in the individual districts of the Associations of Statutory Health Insurance Physicians shows a considerable spread of 0.6 to 9.7 %. This suggests systematic under-identification in some cases, and leads to major divergences in contract doctors' fees in the various regions. All the efforts in recent years to achieve convergence between physicians' remunerations in Germany would be thwarted by this, and individual health insurance funds with corresponding regional focuses would face disproportionate burdens.

The legislature has now acknowledged the under-adjustment problem, and has provided for a corrective procedure to reduce double funding in the future in the draft Bill on Further Development of Healthcare (later then moved to the Veterinary Medicines Act [*Tierarzneimittelgesetz*]). This is a step in the right direction. However, given the structure currently planned, the double financing is only reduced, but is not fully eliminated, given that the adjustment procedure is only to be applied for three out of four quarters. This would continue to lead to improper double remuneration, and to regional divergence in one quarter of each year. Moreover, since the adjustment is furthermore not to begin until the fourth quarter of 2021, there would still be a considerable one-off overpayment in the quarters 4/2020 to 3/2021 until then, likely to amount to more than 2 billion Euro. Finally, it is to be feared that part of the under-adjustment cannot be eliminated, even by a one-off correction, if the pandemic goes on.

The massive under-adjustment, when extrapolated over the entire adjustment year, leads to further unplanned, permanent additional costs in the shape of double financing of over 2 billion Euro per year.

The need for improvements

The National Association of Statutory Health Insurance Funds considers it necessary to start correcting the adjustment in the third quarter of 2021 at the latest in order to avoid this improper additional burden, and to carry it out for at least two years in order to minimise the effects of the ongoing pandemic situation. In addition, the overpayments incurred up to the start of the correction should not be offset against future payments with effect on the basis.

More options in the field of selective contracts

Special care contracts can also be concluded with other service-providers and social benefit funding institutions, or with other providers of services of general interest.

The National Association of Statutory Health Insurance Funds already called in its position paper at the beginning of the 19th legislative period for the regulatory framework to be made more flexible in order to improve healthcare. The health insurance funds need to have greater competitive freedom in order to improve the quality of healthcare. However, the possibilities open to a given health insurance fund to develop healthcare services orientated to the preferences of their insured persons through individual contracts with healthcare providers, and to offer them within a competitive framework, were previously limited, and the interpretation of existing statutory regulations, especially in supervisory practice, has not always been unambiguous. The Healthcare and Long-term Care Improvement Act (GPVG) now brings about important changes in this regard.

The group of contracting partners has been expanded

The Healthcare and Long-term Care Improvement Act implemented a whole range of measures in 2020 to strengthen care within selective contracts. It will now be easier all in all to include different funding agencies and care facilities. The range of special out-patient medical care commissions under selective contracts was previously limited to purely contract doctor healthcare providers or their associations. This is now to change. In future, the legislature will expand the group of possible contracting partners and healthcare providers who are entitled to participate. This means that special care contracts can also be concluded with other service-providers and social benefit funding institutions, or with other providers of services of general interest, e.g. with municipal social and youth welfare facilities. This offers the possibility to also trial care methods that are intended to facilitate the transition between sectors and between different social insurance sectors. The reality of care has shown that care problems frequently occur at the boundaries between different regulatory areas. In this respect, it makes sense to facilitate innovative care concepts even more than was previously the case within selective contracts.

The Act also makes it clear that contracts for special care can be limited to individual regions, and that the group of individuals participating

Expansion of possibilities within the framework of selective contracts in accordance with section 140a of Book V of the Social Code

- expanding the scope of contracting partners, e.g. involvement of other social benefit funding institutions
- promoting special regional care to be implemented independently by providers
- transferring advisory, coordination and management services of healthcare providers and health insurance funds to third parties/contracting partners
- The statutory requirements for selective contracts are deemed to be fulfilled for projects supported by the Innovation Fund.

can therefore be differentiated along regional lines. The contracting partners can also agree that advisory, coordination and management services provided by the healthcare providers, and by the health insurance funds for the care of insured persons within the framework of special care, are provided by the contracting partners or by third parties. These regulations make selective contracting more flexible, and should also lead to clarification in supervisory practice.

Having said that, the amendment provided for in the Act also allows private health and long-term care insurance companies to participate in special forms of care as contracting partners. The National Association of Statutory Health Insurance Funds continues to take the position that it is not appropriate to allow private health insurance companies to accede to innovative care contracts of the statutory health insurance funds. In the existing dual health insurance system, the care innovations that have been developed and financed with the contributions made by contributors in statutory health insurance should in fact exclusively benefit those individuals who have statutory insurance.

Improving access to care innovations

Furthermore, selective contracts were also opened up for care innovations within the framework of the Act: For projects that were financed by the Innovation Fund, it is now possible to continue tried and tested project structures on a voluntary basis within selective contracts. In addition, the continuation of projects that have been financed within selective contracts will in future no longer be hampered by possible differences in supervisory practice. The contracting partners can therefore be confident that it is possible as a matter of principle to continue the contracts as long as they have successfully passed the review by the Innovation Fund. This creates planning security, given that it is made clear that selective contracts are not subject to a reservation of approval in terms of a preventive contract review, but rather to ad hoc supervision with the possibility of intervention in the event of a significant violation of the law. This also includes reviewing the economic efficiency of the selective contracts.

The National Association of Statutory Health Insurance Funds continues to reject private health insurance companies acceding to innovative care contracts of the statutory health insurance funds.

The further development of the Standard Schedule of Fees

An important aspect of the revised version was to clearly promote "consultative medicine" by establishing a more appropriate relationship between the performance evaluations.

The National Association of Statutory Health Insurance Funds, together with the National Association of Statutory Health Insurance Physicians, decided in December 2019 on the new version of the Standard Schedule of Fees in the committee for the evaluation of physicians. The new Standard Schedule of Fees has been in force since 1 April 2020.

Goals of the adjustment

The objectives of the comprehensive adaptation and further development of the Standard Schedule of Fees included taking into account insured persons' real care needs, as well as the current state-of-the-art in science and technology. Another important aspect of the revised version was also to clearly promote the concept of consultative medicine by establishing a more appropriate relationship between the performance evaluations, especially between verbal consultation services and technology-focused services.

A new economic calculation basis

The adjustment of the economic calculation basis for doctors' and psychotherapeutic services formed a significant part of the consultations on the further development of the Standard Schedule of Fees. The calculation system forms the basis for the evaluation of a large proportion of the services covered by the Standard Schedule of Fees. It distinguishes between medical and technical service components, and assigns scores to them. The focus of the consultations was placed on reviewing and adjusting the time units attributed to the services provided by physicians. The current cost structures of the individual groups of physicians were taken into account here. In addition to the adjustments that were made to the calculation basis, numerous structural and content-related changes were also made to the Standard Schedule of Fees. These include extending consultations on Saturdays, new services to promote participation in chlamydia screening, and the inclusion of examinations carried out by means of reflected-light microscopy/dermatoscopy in skin cancer screening.

Goals pursued in refining the Standard Schedule of Fees, and a few focal points

- adaptation of the Standard Schedule of Fees, taking account of the current state-of-the-art of medical science and technology
- promotion of "consultative medicine"
- further development of the economic calculation method

Selection of content and structural changes to the Standard Schedule of Fees as part of the further development of the Schedule:

- extending consultations on Saturdays
- new services to promote participation in chlamydia screening
- inclusion of examinations carried out by means of reflected-light microscopy/dermatoscopy in skin cancer screening
- clarification of the content of birth control services
- restructuring complex reproductive medicine services
- new services and flat-rates for material costs in allergy testing
- removal of services that are no longer or only very rarely performed in out-patient care
- large numbers of editorial changes to fee schedule items in the Standard Schedule of Fees

Fee negotiations for doctors' remuneration

The annual fee negotiations for physicians include adjusting the orientation value (determination of the price component) and the recommendations on the morbidity-related rate of change (determination of the volume component).

Price component increased by 1.25 %

The National Association of Statutory Health Insurance Funds had requested in this year's negotiations in the Evaluation Committee that the orientation value applicable in 2020 be maintained for 2021, against the background of the general cost development, the income development of medical practices, and the anticipated critical financial situation of statutory health insurance in 2021, which is due to the pandemic amongst other things. Referring to the average rate development for physicians providing in-patient care in 2020, the National Association of Statutory Health Insurance Physicians demanded that the orientation value be increased by roughly 3 %.

The Extended Evaluation Committee was appealed to after the contracting partners had been unable to agree on an adjustment of the orientation value. With the votes of the funds, and against the votes of the physicians' representatives, it determined an increase in the orientation value by 1.25 % for 2021. This corresponds to a remuneration increase of approx. 470 million Euro.

Recommendations on the rate of change in the morbidity structure

The Evaluation Committee also made a recommendation on the rates of change in the morbidity structure; the latter take into account the burden of disease of persons with statutory health insurance. It is expected that the nationwide treatment requirement will increase by an average of 0.29 % (approx. 80 million Euro) in 2021 if the diagnosis-related and demographic rates of change are weighted in equal halves.

Fee increases in 2021

Orientation value increased by 1.25 % in 2021 (price component)	approx. 470 mill. Euro
Morbidity-related total remuneration adjusted in 2021 due to changes in morbidity (quantity component)	approx. 80 mill. Euro
Volume development of extrabudgetary benefits (EGV) in 2021 (presumption: 3 %)	approx. 550 mill. Euro
Total increase in 2021	**approx. 1,100 mill. Euro**

Illustration: National Association of Statutory Health Insurance Funds

Fee increases of at least 1 billion Euro in 2021

The income of doctors working as contract doctors will increase noticeably in 2021 due to the resolutions that have been adopted. In addition to the increases in remuneration resulting from the adjustment of the volume and price components, the number of services promoted on an extrabudgetary basis such as preventive check-ups and newly-introduced services will also rise. It can be assumed that this development will furthermore continue next year at a rate of around 3 %, and that this will cause fees to increase by a further 550 million Euro in 2021. Registered doctors will thus receive an additional 1.1 billion Euro in total in 2021 - a year-on-year increase of 2.6 %.

Registered doctors will receive an additional 1.1 billion Euro in total in 2021.

This increase in expenditure does not yet take into account additional costs resulting from the coronavirus pandemic, as well as from the under-adjustment in the implementation of the Appointment Service and Care Act, and further expenditure due to statutory regulations.

sweatpants, noun
(the new casual business wear)

A future programme for hospitals

The investment backlog in the digital infrastructure in German hospitals is undisputed, and considerable benefit can be expected to ensue from digitalisation when it comes to improving care processes and quality. For this reason, a dedicated digital funding programme was passed in October 2020 in the shape of the Hospital Future Act. 3 billion Euro will be made available from the federal budget for this purpose in the shape of a Hospital Future Fund.

Distribution of funds and objects funded

The future programme for hospitals provides for the Federation to contribute funding of 3 billion Euro, and for the promoted projects to be co-funded to the tune of 30 %. This co-funding can be provided by the *Länder* alone, with the financial participation of the hospital operators, or exclusively by the hospital operators. The volume of co-funding over the entire duration of the programme can total up to 1.3 billion Euro.

Irrespective of such promotion, all hospitals are to be motivated to develop their digital infrastructure analogously to the items eligible for promotion defined in the Ordinance. This is to be ensured from 2025 onwards with a deduction arrangement to be agreed between the German Hospital Federation and the National Association of Statutory Health Insurance Funds. According to this arrangement, a deduction of up to 2 % of the invoice amount may apply if a hospital does not provide the corresponding digital services as listed in the Ordinance, and provides documentation of their use.

The focus of the promoted or basic investment measures lies in the areas of patient portals, service documentation as well as IT security and cyber security.

It must be ensured in all IT projects that standards for interoperability are applied, and that measures are taken to guarantee state-of-the-art information security. Where applicable, services and applications of the telematics infrastructure in accordance with Book V of the Social Code are to be used within the framework of the promoted structures as soon as they are available.

Eligible projects in accordance with section 19 subsection (1) of the Hospital Structural Fund Ordinance

Objects of funding

1. Upgrading of the technical equipment (including information technology) of the emergency department of a hospital to the respective state-of-the-art.
2. Patient portals
   - Digital admission management
   - Digital treatment management
   - Digital discharge and transfer management
3. Digital care and treatment documentation
4. Establishment of partially or fully-automated clinical decision support systems
5. Digital medication management
6. Digital service request
7. Service coordination and cloud computing systems
8. Digital care documentation system for bed occupancy to improve cooperation between hospitals and other care facilities
9. Information technology, communication technology and robotics-based equipment, systems or procedures and telemedicine networks
10. IT security
11. Adapting patients' rooms to the special forms of treatment required in the event of an epidemic

Recalculation of nursing staff costs

The extensive removal of nursing staff costs from the lump sums per case was carried out at federal level in 2019. The key agreements on removing nursing staff costs were continued and updated in 2020. This concerned in particular the nursing staff cost delimitation agreement. After nursing staff costs had been removed, the system of "German Diagnosis Related Groups" (G-DRG) is referred to as the aG-DRG system ('a' being the abbreviation of the German word "*ausgegliedert*" = removed).

Nursing care budget negotiations delayed by pandemic

The removal of nursing staff costs at federal level was initially to be implemented as part of the negotiations on the care budgets for the individual hospitals. Since agreement on the hospital and nursing care budgets was delayed across the board in 2020 due to the coronavirus pandemic, almost all hospitals billed the statutorily-fixed provisional per diem in the nursing care sector for a nurse in that year. The legislature increased this price, which was provisionally set for billing, from 146.55 Euro to 185 Euro at the end of March 2020, with effect as per the beginning of April, via the COVID-19 Hospital Relief Act. In addition, it was determined for 2020 that the nursing care revenue generated will remain with the hospital even if the expenditure on nursing staff actually incurred is lower. If the revenue is lower than the actual nursing staff costs, the entire difference must be made up for by the health insurance funds.

The fact that hospitals are reimbursed for all nursing care costs incurred through the nursing care budget in accordance with the principle of full cost coverage creates a strong misincentive.

Nursing care budget negotiations were nevertheless held in a small number of hospitals in the second half of 2020, although they often ended up being the subject of arbitration. The reason for this was the contracting parties' divergent perspectives of the activities comprised in "bedside nursing care", and how these are distinguished from other non-nursing care tasks. Since, in accordance with the principle of full cost coverage, hospitals are reimbursed for all nursing care costs incurred through the nursing care budget, there is a strong misincentive to shift as many activities as possible to the nursing care staff, on the one hand, and to allocate as many staff as possible to the nursing care budgets, on the other.

Avoiding double financing by statutory health insurance funds

The delimitation problem of nursing staff costs was again discussed at federal level at the end of 2020 within the framework of the annual discussion held between the National Association of Statutory Health Insurance Funds and the German Hospital Federation on the further development of the diagnosis-related group case flat-rate system. It became clear that nursing staff costs had risen by roughly 1.6 billion Euro within one calculation year. The adoption of the aG-DRG list (case flat-rates not including nursing care), and of the 2021 nursing care revenue list, was delayed because there was disagreement as to whether, and to what extent, this more than ten percent increase in the nursing care budget had resulted from cost shifts from the aG-DRG, which requires a complementary adjustment of the case flat-rates. Part of this cost increase in the nursing care sector can be explained by developments in collectively-agreed earnings (approx. 430-470 million Euro), the implementation of the nursing care jobs promotion programme (approx. 420 million Euro), and developments in admission wards and out-patient clinics (approx. 100-135 million Euro). It is to be feared, however, that the increase in other costs is partly due to the fact that costs were switched from the aG-DRG budget to the nursing care budget. This would mean that statutory health insurance would double-finance some of the nursing care costs.

Compromise agreed on the delimitation of nursing care budgets

The German Hospital Federation and the National Association of Statutory Health Insurance Funds were able to work out a compromise in early

November 2020 that limits the shifting effects and addresses the fundamental question of the delimitation of the nursing care budget: The aG-DRG system was adjusted by 200 million Euro for 2021. In addition, the compromise provides for the nursing care budget stipulations to be tightened up on the basis of a qualification-related occupational delimitation. The basis for this is formed by the nursing care professions named in the Ordinance on Lower Limits for Nursing Staff.

In addition, the compromise included a joint initiative to adjust, by law, the provisional nursing care payment value to an amount of 163.09 Euro as of January 2021. The legislature took up and implemented this within the Third Civil Protection Act. The compromise that was reached made it possible to unify the aG-DRG list in 2021, and avoid a substituted performance.

Minimum nurse staffing stipulations in hospitals

It is intended to make nursing care needs and the nursing care provided largely derivable from the digital medical records.

Lower limits for nursing staff in care-sensitive areas have been mandatory for hospitals since January 2019. The instrument "lower limits for nursing staff" provides for a specific minimum number of nursing care staff per sector who care for a given number of patients. If fewer nursing staff are deployed on a monthly average than the minimum provided for, the hospital must accept reductions in remuneration or reduce the number of patients in future.

Further development of lower limits for nursing staff for 2021

According to the statutory stipulation, the German Hospital Federation and the National Association of Statutory Health Insurance Funds were to agree in 2020 on how existing lower limits for nursing staff are to be further developed and in which hospital sectors new lower limits for nursing staff are to be introduced. No agreement was however reached for the third year in a row. As a result, the Federal Ministry of Health set lower-limits for nursing staff for 2021 in the eight sectors already defined, and also introduced lower limits in the sectors of general surgery, internal medicine, paediatric intensive care and paediatrics.

Development of a nursing staff assessment tool

The discussion regarding a future-orientated nursing staff assessment tool was continued in 2020, despite the coronavirus pandemic. In the opinion of the National Association of Statutory Health Insurance Funds, a nursing science-based tool should be developed which contributes to the establishment of a uniform terminology of nursing care in Germany by means of standardised, completely digitalised nursing care process documentation. Standardised documentation on nursing care needs (nursing care assessment) and on nursing care services is intended, on the one hand, to enable digitally-derivable nursing staff allocation based on nursing care needs. On the other hand, a digitally-enabled review is required in order to determine whether the nursing care services actually provided in fact meet the needs of the patients. Furthermore, the existing qualification mix of nursing care staff (including nursing staff as well as nursing assistants) must be taken into account when developing the instrument in order to do justice to the actual care and nursing staff situation. It also creates the basis all in all for implementing nursing care in the usual classification systems within the healthcare system.

The German Hospital Federation has proposed as an alternative to refine the 30-year-old nursing staff arrangement for the allocation of nursing staff. This does not however meet today's requirements for needs assessment and patient protection.

Lower limits for nursing staff for 2021 (from 1 February 2021 onwards)

	General and trauma surgery		Geriatrics		Heart surgery		Internal medicine and cardiology		Intensive care medicine and paediatric intensive care medicine *		Neurology		Neurological early rehabilitation		Neurological stroke unit		Paediatrics	
Patients/nurse	10	20	10	20	7	15	10	22	2	3	10	20	5	12	3	5	6	10
Proportion of assistants	10 %	10 %	15 %	20 %	5 %	0 %	10 %	10 %	5 %	5 %	8 %	8 %	10 %	10 %	0 %	0 %	5 %	5 %

* Ratios of "2.5 to 1" apply in the intensive care in the day shift up to 31 January 2021 (proportion of assistants: 8 %) and "3.5 to 1" in the night shift (proportion of assistants: 0 %).
Illustration: National Association of Statutory Health Insurance Funds

Further development of minimum volumes for hospital services

The minimum quantity arrangement is an important tool for quality assurance in hospitals, and is a means of ensuring patient safety. The Federal Joint Committee draws up a list of plannable hospital services for which a correlation between the frequency of these treatments and the quality of care has been established. The Federal Joint Committee defines minimum quantities for these services on the basis of the available scientific knowledge. If hospitals are likely to be unable to achieve a specific minimum volume at their respective locations in the calendar year to come, they are not allowed to offer these services, or are not entitled to remuneration.

Overview of existing minimum quantities (as per March 2021)

Intervention	Minimum quantity
Liver transplantation (incl. partial liver donations by living donors)	20
Kidney transplantation (incl. living donation)	25
Complex operations on the organ system of the oesophagus	26
Complex operations on the organ system of the pancreas	10
Stem cell transplantation	25
Total knee endoprostheses (knee TEP)	50
Care of premature and newborn babies with a birth weight of less than 1,250 grams	25

Source and illustration: National Association of Statutory Health Insurance Funds

The list of plannable services with minimum quantities is continuously reviewed and expanded. The Federal Joint Committee resumed its decision-making process in 2020 in order to determine new minimum volumes and to adjust old ones. The minimum quantity arrangement and the rules of procedure had previously been extensively adapted in accordance with the stipulations from the Hospital Structure Act (*Krankenhausstrukturgesetz*). The National Association of Statutory Health Insurance Funds has advocated for targets and concrete process steps to be defined in order to ensure that a consultation period of two years is no longer exceeded in future.

Decisions and deliberations of the Federal Joint Committee in 2020

An adjustment of the countable interventions in the existing minimum quantity for liver transplants incl. partial liver donations by living donors was decided on in 2020. In addition, the Federal Joint Committee passed resolutions in December 2020 for the adjustment of the existing minimum quantities for the following plannable services:

- kidney transplantation incl. living donation (update of countable procedures while maintaining the minimum volume level)
- complex operations on the oesophagus (increase in the minimum quantity from 10 to 26 per year)
- care of premature babies with a birth weight below 1,250 g (increase in the minimum quantity from 14 to 25 per year)

The following sets of advisory proceedings were also included in 2020:

- adjustment of the existing minimum quantity for complex operations on the pancreas
- introduction of a new minimum quantity for heart transplants
- introduction of a new minimum quantity for catheter-based aortic valve implantation

Resolutions on minimum quantities planned for 2021

The Federal Joint Committee has already determined that new resolutions on minimum quantities for the following interventions requested by the National Association of Statutory Health Insurance Funds should be prepared and adopted for 2021:

- complex interventions on the pancreas
- allogeneic stem cell transplants
- breast cancer operations
- lung cancer operations

The Federal Joint Committee establishes minimum quantities for services for which a correlation has been established between the frequency of these treatments and the quality of care.

In addition, further applications for the introduction of new minimum quantities are being examined and prepared by the National Association of Statutory Health Insurance Funds.

Better working conditions in hospital care

Statutory health insurance has so far provided around 807 million Euro for the creation of nursing staff positions in hospitals in the funding period.

The development of nursing staff positions in hospitals is currently being funded by two statutory health insurance support programmes: the nursing care jobs promotion programme and the programme to promote measures to reconcile long-term care, family and work. The National Association of Statutory Health Insurance Funds is mandated by law to report annually mid-year to the Federal Ministry of Health on implementation.

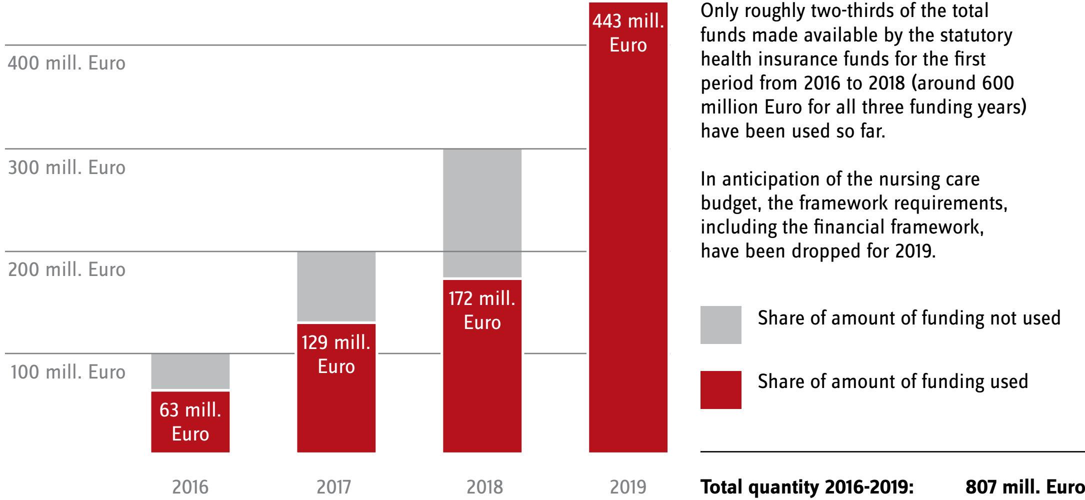
Increasing the level of nursing staff

660 million Euro were available from 2016 to 2018 to enhance direct patient care on in-patient wards due to the nursing care jobs promotion programme. Up to 0.15 % of the hospital budget could be additionally agreed each year for the recruitment of trained nursing staff or to increase the number of existing part-time positions in nursing care. The Act to Promote Nursing Staff extended the funding to 2019, whereby major prerequisites for funding have become redundant.

The National Association of Statutory Health Insurance Funds submitted the fourth report on the utilisation of funds in the funding years 2016 to 2019 to the Federal Ministry of Health at the end of July 2020. This report shows that statutory health insurance has so far provided around 807 million Euro for the creation of nursing staff positions in hospitals. Approximately 700 hospitals benefited from the funding in 2019 alone, and have agreed with the statutory health insurance funds on additional funding amounting to roughly 443 million Euro.

The creation of approximately 7,400 nursing care posts was agreed for all four funding years. It will only be possible to determine the extent to which additional nursing care posts have actually been created as a result of the agreements with a time lag via the audit certificates of the annual audits. At least 2,600 full-time positions have been demonstrably occupied with specialist staff so far. Further audit certificates, especially for 2019, are still pending. All nursing staff costs incurred in the clinics will be refinanced by statutory health insurance via the nursing care budget from 2020 onwards.

Funding agreed in the funding years 2016-2019



Source: Fourth report by the National Association of Statutory Health Insurance Funds on the programme to promote nurse recruitment of 31 July 2020
Illustration: National Association of Statutory Health Insurance Funds

Guaranteeing the reconciliation of long-term care, family and work

A programme to promote measures for reconciling long-term care, family and work in hospitals was established in the shape of the Act to Promote Nursing Staff. Hospitals can receive an additional amount of up to 0.1 % (2019) or 0.12 % (from 2020 onwards) of the hospital budget for additional measures in the period from 2019 to 2024. The overarching goal of the programme is to recruit more qualified nursing care staff and midwives through attractive working conditions.

According to the first report of the National Association of Statutory Health Insurance Funds, approximately 7.8 million Euro were made available by the health insurance funds for 2019 for corresponding measures in 213 hospitals (21 % of the eligible hospitals with a budget agreement). The spectrum of funded measures so far essentially comprises six subject areas (cf. table). The report gives an initial impression of the agreement process in the first year. The start of the funding is considered a success.

The data are however not yet final, and may be subject to change, e.g. due to pending budget statements which will be presented in later reports. In addition, it will only be possible to determine the appropriate use of funds in the course of the funding period as more audit certificates of the annual audits are made available. This also applies to data on the increase in the number of jobs in the participating hospitals. The data do not however allow any conclusions to be drawn as to the extent to which the reconciliation measures that are funded lead causally to the recruitment of new nursing staff.

The overarching goal of the programme is to recruit more qualified nursing care staff and midwives through attractive working conditions.

Reconciliation: Type and number of measures according to agreements 2019 (reporting date: 28 April 2020)

Category	Type of measure	Number of hospitals with an agreement on a measure of this type *	Share in percent
1	Counselling services, care quotas and subsidies aimed at relieving the burden of childcare or care for relatives in need of long-term care	117 of which 21 hospitals with more than one item from this sector	55
2	Flexible, reconciliation-orientated working time models	55	26
3	Optimisation of operational processes regarding duty roster management and reconciliation management	19	9
4	Additional company services such as personnel development, bonuses and health promotion	43	20
5	Promoting re-entry after a career break	15	7
6	Undifferentiated agreement	45	21

*Multiple answers possible, total number of participating hospitals: n = 213. 21 hospitals agreed on more than one measure in childcare or long-term care of relatives. A single count was made here.
Source: Report by the National Association of Statutory Health Insurance Funds on promoting suitable measures to improve the reconciliation of long-term care, family and work in the funding year 2019;
Illustration: National Association of Statutory Health Insurance Funds

Promoting hospitals required in order to satisfy demand in rural areas

Hospitals in sparsely-populated areas will receive an annual lump-sum subsidy of between 400,000 and 800,000 Euro in future.

Hospitals that are required in order to satisfy demand in rural areas have received a lump-sum subsidy of 400,000 Euro per hospital since 2020. In order to identify the hospitals that are entitled to receive the supplement, the contracting parties at federal level agree by the end of June of each year on a list of hospitals that meet the criteria set by the Federal Joint Committee. Both primary care hospitals which have specialist departments for internal medicine and for surgery, as well as hospitals that have a specialist obstetrics department, are to be taken into account. The supplement is disbursed even if the hospitals in question do not have a deficit.

The German Hospital Federation and the National Association of Statutory Health Insurance Funds agreed in good time in June 2020 on the list of hospitals required in order to satisfy demand that are entitled to lump-sum funding in the agreement year 2021. A total of 121 hospitals were included in the list.

Hospitals required in order to satisfy demand receiving a supplement in 2021

n=140
Source: agreement in accordance with section 9 subsection (1a) No. 6 of the Hospitals Remuneration Act (KHEntgG),
Illustration: National Association of Statutory Health Insurance Funds

Basic range of service expanded to include paediatrics and adolescent medicine

The Federal Joint Committee expanded the guarantee supplement regulations to include paediatrics and adolescent medicine at the beginning of October 2020. The National Association of Statutory Health Insurance Funds had lobbied for the consultations to be started so that such specialist departments would also be included in the basic range of services to be provided by hospitals in rural regions for local care in future. The Healthcare and Long-term Care Improvement Act (GPVG) mandates the contracting parties at federal level to add hospitals required in order to satisfy demand that have a specialist department for paediatrics and adolescent medicine to the list of such hospitals by 31 December 2020.

The Act furthermore introduces staggered supplement payments. Hospitals in sparsely-populated areas are to accordingly receive an annual lump-sum subsidy of between 400,000 and 800,000 Euro, depending on the number of specialist departments required in order to satisfy demand. The National Association of Statutory Health Insurance Funds had argued for such a change in order to create an incentive to maintain all specialist departments that are required in order to satisfy demand (internal medicine, surgery, obstetrics, paediatrics and adolescent medicine) in rural areas. A total of 140 hospitals required in order to satisfy demand can receive the lump-sum subsidy of 400,000 to 800,000 Euro in 2021, now that the contracting parties at federal level have expanded the list to include paediatrics and adolescent medicine by concluding an agreement to this effect on 18 December 2020. Hospitals required in order to satisfy demand were identified in particular in sparsely-populated regions in the North-East of Germany, on the borders of the country, and on the islands.

Post-pandemic hospital care

The management of the coronavirus pandemic has drawn attention to the provision of hospital care. In addition, the digitalisation of hospitals has come into focus. Both have a decisive influence on the necessary debate about the future design of in-patient care. The hospital landscape needs to be structured on a nationwide basis, and this should be one of the core health policy issues of the upcoming legislative period. The National Association of Statutory Health Insurance Funds has drafted twelve positions on this matter as a constructive contribution, and the Administrative Council adopted these in December 2020.

1. Learning from the coronavirus pandemic
Initial analyses of the care situation show that COVID-19 patient care was initially carried out in an uncoordinated way, and was concentrated in a small number of larger clinics. The historically unique decline in other in-patient case numbers was remarkable. It is not possible to derive arguments speaking in favour of the existing hospital structures from the events.

2. Enhancing the potential of digitalisation
Digitalisation must play an integral role in any comprehensive reform of hospital structures. The expectations and requirements for a digitally-equipped hospital networked with other players must be defined in a graduated chart of objectives in order to achieve the overarching goal of improving care quality and efficiency whilst providing optimal protection for patients and their data.

3. Shaping hospital structures for the future
There is a need to improve quality by concentrating services. Overcapacities lead to unnecessary hospitalisations and to avoidable costs, and they also exacerbate problems due to the limited availability of specialised staff. In addition to the targeted, selective further development of the Structural Fund, there is a need to structure the hospital landscape nationwide with quality-orientated specifications for the respective care mandate.

4. Safeguarding care in rural areas
Structures required in order to satisfy demand must be specifically secured in the reorganisation of hospital care in rural regions. Funding should be provided according to the extent of the capacities required in order to satisfy demand. It must be possible to place hospitals required in order to satisfy demand under an obligation to fulfil their care mandate.

5. Improving the remuneration system
Service-orientated hospital remuneration is correct in principle, but it needs to be improved in several respects: greater consideration of contingency costs, introduction of remuneration components based on care categories, as well as a suitable depiction of nursing care services.

6. Improving the nursing care situation
The course must be set with regard to two important aspects: Unnecessary hospitalisation must be avoided, and unnecessary capacities must be closed so that the nursing staff in hospitals required in order to satisfy demand can remedy the shortfall of specialist staff. The incentives in the remuneration system must be designed in such a way that hospital management has an interest in investing in qualified nursing staff in the long term.

7. Consistently implementing minimum quality assurance requirements
New, methodologically-sophisticated quality assurance concepts offer innovative approaches, but

require a lot of time in order to achieve an impact beyond pilot projects. This makes it important to reinforce and consistently expand previously-established quality assurance instruments:

- definition of minimum quantities and minimum requirements for structures and processes by the Federal Joint Committee
- regular review of and transparency regarding their results.

8. Clearly delimiting expenditure by statutory health insurance

The large number of COVID aid measures has led to significant distortions in responsibilities for funding. These ambiguous competences must be clarified permanently and unambiguously, both for times of crisis and for regular operations. Transparency regarding payments made from both contributions and tax revenues must be established, and fundamentally-undesirable developments with regard to pricing and double financing must be eliminated.

9. Ensuring correct billing

Surcharges for incorrect billing were introduced for the first time in the Medical Service Reform Act (*MDK-Reformgesetz*) in order to reduce incorrect hospital billing. This was an overdue measure, which is not however having any effect due to being suspended during the coronavirus pandemic. Rapid corrections are essential. Statutory health insurance and the Federal Court of Audit have long demanded that there should be consequences for incorrect billing.

10. Tapping into the potential of out-patient services

Making use of the out-patient potential must be one of the central approaches of the next hospital reform. The lack of efforts to enhance out-patient services is revealed by the large number of disputes about the necessity of in-patient treatment in short-stay units. A first important approach is to expand the list of services that can be provided to out-patients. This is currently being initiated.

11. Bringing out-patient psychiatry closer into line with demand

More consistent use must be made of out-patient psychiatric treatment potentials in Germany in order to reduce the misprovision of care in the hospital sector. Continuity of care must be established between in-patient and out-patient care, in addition to the expansion of out-patient psychiatric care structures for those affected and their relatives.

12. Comprehensive reforms in emergency care

Emergency care in Germany is in considerable need of reform. The rescue service needs to become part of the healthcare system and be structured in a uniform manner throughout the country. Deficiencies with regard to digitalisation must be eliminated as a matter of urgency. Only those hospitals that have an emergency service practice operated by an Association of Statutory Health Insurance Physicians and a central contact point to manage patient flows in accordance with the requirements of the Federal Joint Committee should be approved to provide emergency care.

webcam(s), noun
(makes up for a lot, but not for real meetings)

Concerted action on long-term care on the road to success

The National Association of Statutory Health Insurance Funds is working closely with the organisations involved in concerted action on long-term care (KAP) in order to improve the working conditions of employees, strengthen recruitment of junior staff, and relieve relatives providing care with the packages of measures that were agreed on. The measures that were adopted in the concerted action are already having an impact.

Staff management

The project to develop a personnel allocation procedure for long-term care facilities has been successfully completed. This provides a personnel allocation tool that can be used to determine the respective personnel requirements for fully-residential facilities. It is to be developed on a step-by-step basis. The facilities are to be supported in organisational terms by an accompanying evaluation. Researchers see a particular need for the expansion of positions for long-term care assistants. The first step will therefore be to top up the number of nursing assistants by 20,000. A new personnel allocation procedure is then to be anchored in law in 2027.

The first step will be to top up the number of nursing assistants by 20,000.

Long-term care training campaign

The declared goal is to increase the number of vocational training places by 10 % by 2023. The *Länder* are playing a decisive role in order to achieve this goal. Whether it will be possible to provide the requisite number of school and training places for the new generalist training will not become clear until the end of the current training year 2020/2021.

Recruiting long-term care staff from abroad

In addition to creating more vocational training places, recruiting long-term care specialists from abroad is on the political agenda. The focus is particularly on Mexico, Brazil and the Philippines. The pandemic has made recruitment more difficult, but the regulatory requirements have been further simplified and standardised.

Digitalisation and interprofessional cooperation

The National Association of Statutory Health Insurance Funds has launched a pilot programme to integrate long-term care facilities into the telematics infrastructure. The aim is to make communication and work processes more efficient by improving networking between the sectors involved.

Initial proposals for extended care authorisations for long-term care specialists were developed for interprofessional cooperation between physicians and long-term care staff. Focal points are:

- prescribing medical aids
- organising the details of domestic nursing care services
- wound management.

Remuneration conditions

A working group within the concerted action on long-term care assessed remuneration conditions, and spoke out in favour of better pay for long-term care staff and long-term care specialists. Further consultations are being held on this at political level.

Personnel allocation in residential long-term care

After a research project lasting several years carried out by the University of Bremen, commissioned in part by the National Association of Statutory Health Insurance Funds, a draft for a new personnel allocation procedure for residential long-term care has been available since June 2020. The Federal Ministry of Health has developed a "roadmap" within the framework of the concerted action on long-term care, with the participation of the National Association of Statutory Health Insurance Funds and other stakeholders. The roadmap outlines the necessary implementation steps and suggests a timetable for introducing a new procedure.

Steps towards the introduction of a new personnel allocation procedure

The new procedure enables the staffing requirements in fully-residential facilities to be determined on a facility-specific basis. An important factor here is the long-term care levels allocated to the residents. Results from the University of Bremen point primarily to a significant increase in the need for long-term care assistants. According to the results, no comparable personnel allocation procedure is possible for out-patient care. It is considered that further research is needed here.

In a first implementation step, the Healthcare and Long-term Care Improvement Act enables fully-residential long-term care facilities to receive supplementary remuneration for additional nursing care assistants with one or two years of training, depending on the care levels allocated to the residents. Further gradual staffing increases are to be made possible from July 2023 onwards, depending on an accompanying evaluation and on the situation on the labour and vocational training markets. Concepts for qualification-orientated personnel deployment, for personnel and organisational development, as well as for the use of digitalisation and technology, will be developed and tested in a limited number of fully-residential facilities from 2021 onwards as part of a pilot programme of the National Association of Statutory Health Insurance Funds. These facilities will receive staffing based on the new procedure. A revised personnel allocation instrument is to also be available by 2025 as a result of a simultaneous evaluation.

The new procedure enables the staffing requirements in fully-residential facilities to be determined on a facility-specific basis.

Avoiding financial overburdening of persons in need of long-term care; supporting facilities

The introduction of a new personnel allocation procedure must lead to better care in long-term care homes. It is essential that persons in need of long-term care and their relatives are not overburdened in financial terms. The National Association of Statutory Health Insurance Funds considers the procedure envisaged in the roadmap to be comprised of fundamentally suitable steps.

A new mix of qualifications with significantly more assistants will lead to a new distribution of tasks in the medium term. The long-term care facilities must be supported when it comes to reorganising the roles of specialist staff and assistants in the course of organisational and personnel development processes in order to ensure effective, efficient, qualification-orientated staff deployment.

Recent research on long-term care insurance

The Research Unit on Long-Term Care Insurance is dedicated to central, current issues concerning the further development of long-term care insurance, as well as to providing a technically-sound knowledge base for long-term care policy decisions. One important topic in the year under report was pandemic management in long-term care facilities.

Lessons learnt from the coronavirus pandemic

Due to their need for long-term care based on their age and medical history, residents of residential long-term care facilities are at increased risk of contracting severe symptoms from infectious diseases, especially in pandemics. Long-term care homes responded to the threat posed by the virus in the first wave of the pandemic by isolating the people in need of long-term care in order to provide for their protection. This led to a considerable impairment of the persons in need of long-term care when it came to participating in life, and at the same time to a major reduction in the quality of life of persons in need of long-term care being cared for in residential facilities.

The study entitled "Lessons learnt from the coronavirus pandemic for structural developments in the care setting of long-term care homes (COVID Home)", which has been running since July 2020, analyses the impact had by the measures that were taken in long-term care homes. This should allow conclusions to be drawn for necessary measures in the context of infection protection in long-term care homes, including the most comprehensive and complex depiction possible of the crisis situation of very elderly persons in need of long-term care in long-term care homes. The study aims to achieve this by analysing and accessing different data bases and study approaches: In addition to an online survey of long-term care facilities, routine data from health and long-term care funds are being evaluated, and forensic medical findings incorporated. The National Association of Statutory Health Insurance Funds believes that the anticipated results can make a major contribution to preparing long-term care facilities better for similar pandemics in future.

The study is intended to allow conclusions to be drawn for necessary measures in the context of infection protection in long-term care homes.

Minimising emergency admissions

The study entitled "Minimising emergency admissions" is to investigate the extent and necessity of emergency admissions of elderly and very elderly people from residential long-term care facilities. The explorative study is being conducted in cooperation with twelve long-term care facilities in Hamburg. The focus is on the question of the importance attaching to long-term care specialists in the context of emergency admissions, and which options for action within the framework of the existing competences and powers would make it possible to avoid such admissions. The qualification basis that is necessary in order to strengthen the competence and expertise of long-term care specialists is to be worked out on this basis. The results can be used to develop targeted interventions aiming to avoid unnecessary emergency admissions, and thus minimise the number of potentially unnecessary emergency admissions in the medium and long term.

High level of satisfaction with long-term care advice

Individual and continuous advice for persons in need of long-term care is an important prerequisite to ensure good long-term care, and constitutes an original task incumbent on the long-term care funds. Within its statutory mandate, the National Association of Statutory Health Insurance Funds regularly submits an evaluation of long-term care advice and long-term care advice structures. This took place most recently in the summer of 2020. A significant outcome is that only the long-term care funds provide and implement services at nationwide level advice in accordance with section 7a of Book XI of the Social Code which comply with the guidelines for the standardised implementation of long-term care advice.

High quality confirmed

The good practice standards met by the long-term care advice offered by the long-term care funds is evident in many respects:

- Personal advisory sessions are made possible within a few days.
- The vast number of advisory sessions (86.2 %) take place as a visiting service in the individual's own home.
- 90 % of users are satisfied with the advice, its accessibility and effectiveness.
- 95.9 % of the insured persons surveyed who were receiving long-term care benefits rated the long-term care advice of their long-term care fund as independent and neutral.
- Over 90 % of the users interviewed stated that they had always been in contact with the same long-term care advisor, and that they had made concrete arrangements to contact them in future.

The advisory sessions for people in need of long-term care who receive long-term care benefits in accordance with section 37 subsection (3) of Book XI of the Social Code in lieu of benefits in kind also experience a high level of approval:

- 96.1 % state that they were not pressured to make a specific decision.
- Almost 80 % state that they know more about benefit entitlements and services in their region as a result of the advice that they received.

Further developing long-term care advice

The National Association of Statutory Health Insurance Funds considers that there is potential for further development in creating a closer connection between advisory sessions in accordance with section 37 of Book XI of the Social Code and long-term care advice under section 7a of Book XI of the Social Code. In order to guarantee the care of persons in need of long-term care, it is expedient to inform the respective long-term care fund once self-organised care at home is no longer guaranteed. The persons concerned can then be offered long-term care advice in accordance with section 7a of Book XI of the Social Code. The report proposes that a scientific study be carried out in order to identify the situations typically occurring as the need for long-term care develops, and the specific burdens or impairments of persons in need of long-term care that may in each case lead to an increased need for advice.

95.9 % of the insured persons surveyed who were receiving long-term care benefits rated the long-term care advice of their long-term care fund as independent and neutral.

training shoe(s), noun
(enables individuals to exercise and
overcome personal laziness)

The need for reform on the pharmacy market

Making the pharmacy market fit for the future will require new forms of care to be made possible and the existing remuneration system to be designed along performance-related lines. The measures adopted with the Act to Promote Local Pharmacies (*Gesetz zur Stärkung der Vor-Ort-Apotheken*) are however insufficient to ensure patient- and future-orientated care in the long term.

Criticism of the sale of medicinal products by mail order

The new Act was initiated in response to a judgment of the Court of Justice of the European Union (CJEU) from 2016 which considered the granting of bonuses by a Dutch mail-order pharmacy to be lawful. German pharmacies, on the other hand, were still not permitted to deviate from the stipulations of the Medicinal Products Price Ordinance (*Arzneimittelpreisverordnung*). As a consequence, pharmacists demanded a general ban on mail-order sales of prescription medicinal products. The Act to Promote Local Pharmacies now entrenches compliance with the price regulations directly in social law, which is tantamount to a ban on bonuses. Since an official statement by the European Commission on this approach had first to be awaited, the legislative procedure, which had already been launched in 2019, was temporarily placed on hold. A large number of regulations from the original draft bill of 2019 have therefore already been implemented in other laws.

Mail-order pharmacies complement local suppliers

The National Association of Statutory Health Insurance Funds advocates not banning mail-order sales of prescription medicinal products. Mail-order sales of medicinal products enable patients with limited mobility, especially in rural areas, to be supplied with medicinal products more easily. They furthermore help revive the inflexible pharmacy structures, albeit the share of mail-order pharmacies' turnover in pharmacies' total turnover is at a constantly very low level. There will therefore continue to be a need for mail-order pharmacies to complement local pharmacies.

Mail-order sales of medicinal products enable patients with limited mobility to be supplied with medicinal products more easily.

Concerns under European law regarding the Local Pharmacies Promotion Act

The legal arrangement now in force however provides for foreign mail-order pharmacies to also be prevented from giving bonuses by means of a new provision under social law. This means a de facto return to the regulation that the CJEU already considered back in October 2016 to constitute an impermissible encroachment on the free movement of goods. It is doubtful against this background that the de facto return to fixed prices is in conformity with European law. The National Association of Statutory Health Insurance Funds repeatedly pointed out the legal concerns in the legislative procedure, and called

The key points of the Act to Promote Local Pharmacies

- discounts/bonuses from mail-order pharmacies for prescription medicinal products not permissible
- agreement on new pharmacy services reached between the National Association of Statutory Health Insurance Funds and the German Pharmacists' Association
- continuation of the for-a-fee courier service beyond the pandemic situation (2.50 Euro/place of delivery per day)
- automated dispensing machines only within the premises of a pharmacy, no flexible forms of dispensing

for the regulation to be designed in a legally-secure manner.

Creating new forms of care, not new forms of remuneration

The legislature unfortunately missed out on the opportunity to create new needs-based care methods through the Act. Instead, new forms of remuneration were introduced, e.g. for pharmaceutical services or for delivering medicinal products as part of a courier service. The courier service arrangement stems from the statutes and ordinances relating to COVID-19 which were intended to help minimise contacts in the face of the coronavirus pandemic. This emergency measure has now been incorporated into standard care. Courier services were already previously being used extensively as customer retention tools. Instead of introducing a new form of remuneration, it would be more expedient to permit pharmacies to explore more flexible ways of supplying medicinal products. Falling back on digital services would also improve care. Patients' contacts and journeys could be minimised by their enquiring about availability by digital means in advance.

Instead of introducing a new form of remuneration, it would be more expedient to permit pharmacies to explore more flexible ways of supplying medicinal products.

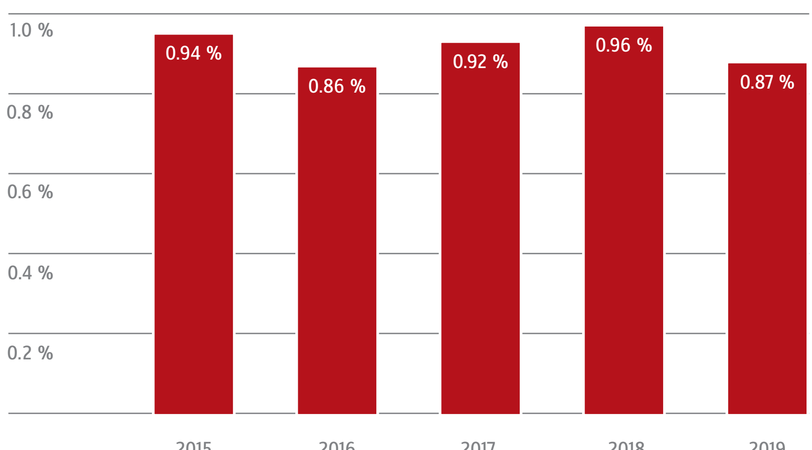
Verifying the added value of additional services

The National Association of Statutory Health Insurance Funds is critical with regard to the introduction of pharmacy services for which additional remuneration is to be paid. Such services should be geared exclusively to the additional needs of insured persons, and should contribute a real added value compared to the current situation. The law as it stands gives rise to a risk of double financing, since existing pharmacy services have already been remunerated via the pharmacy surcharge. It would be more effective to promote additional services within the framework of agreements reached between health insurance funds and pharmacies, and this would make it possible to address specific regional needs, as well as those of specific patient groups.

Conclusion

The National Association of Statutory Health Insurance Funds continues to advocate for a fundamental reform of the care structures and the remuneration system in the pharmacy sector in order to continue to guarantee nationwide supply in the future - both through registered pharmacies and the mail order business, as well as through new providers. In particular, incentives for more in-depth advice, and the development of new, patient-orientated forms of care must be created through greater competition.

Share accounted for by mail order in statutory health insurance expenditure on medicinal products and bandages



Own calculation based on the share of medicinal products and bandages from mail order in the total expenditure on medicinal products and bandages in account group 043. Statutory and contractual discounts as well as lump sums for digitalisation are not included.

Basis: Account group 043 of official statistics KJ1
Illustration: National Association of Statutory Health Insurance Funds

Taking stock of the Act on the Reform of the Market for Medicinal Products in 2020

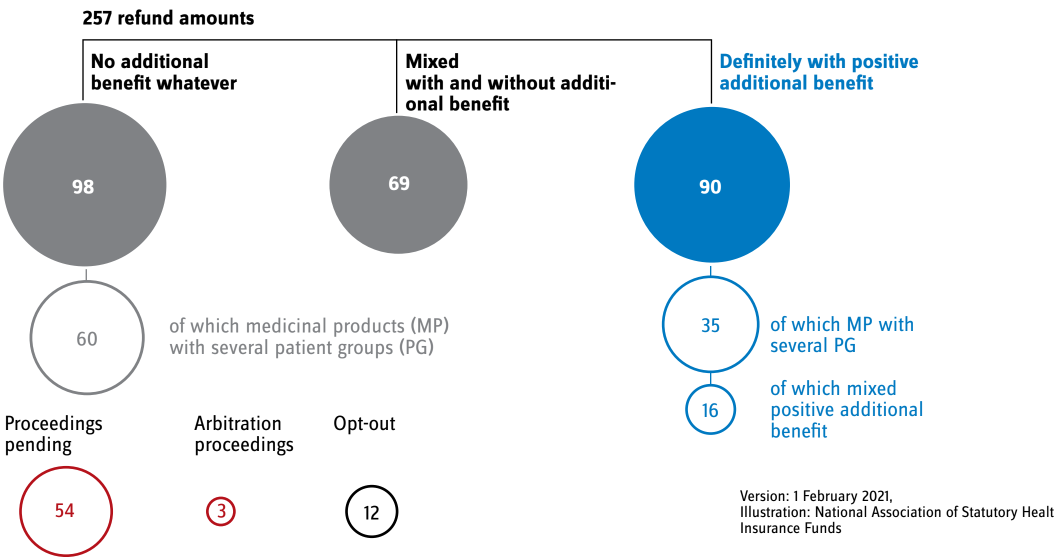
The Federal Joint Committee initiated 688 sets of proceedings for the early benefit evaluation of medicinal products from the new and existing markets between January 2011 and February 2021, and conducted more than 2,045 sets of advisory proceedings. 28 out of 88 sets of exemption proceedings ended with the medicinal product being exempted from the benefit evaluation by the Federal Joint Committee. Refund amounts exist for a total of 257 active ingredients. 227 of these were concluded through agreement being reached between the contracting parties; 30 sets of proceedings were concluded with a ruling handed down by the Arbitration Office.

The lion's share of expenditure in the overall stocktake with regard to the Act on the Reform of the Market for Medicinal Products (*Arzneimittelmarktneuordnungsgesetz* - AMNOG) is accounted for by medicinal products falling under the AMNOG for which the Federal Joint Committee has identified a mixed additional benefit. The second highest level of expenditure is incurred by medicinal products with no added benefit, and orphan drug medicinal products. The smallest share of expenditure is accounted for by medicinal products falling under the AMNOG for which the Federal Joint Committee was actually able to determine an additional benefit with regard to all medical indications.

Five active ingredients have so far been directly attributed to existing fixed-amount groups. Six fixed amounts for active ingredients regulated by a refund amount have now become effective in the period from September 2017 to 1 February 2021. 54 sets of refund amount negotiations, and three sets of arbitration proceedings, are pending as per 1 February 2021. 38 sets of pending refund amount negotiations constitute new negotiations on an active ingredient. These were necessitated by new resolutions of the Federal Joint Committee in conjunction with new areas of application, expiry of a deadline, or the termination of existing refund amount agreements.

A refund amount was agreed for the first time in December 2019 for an active ingredient that had initially been exempted from the benefit evaluation due to low turnover. This active ingredient became subject to the requirement of filing a record as a result of exceeding the minimal level, which is 1 million Euro of turnover within twelve months.

Taking stock of the Act on the Reform of the Market for Medicinal Products



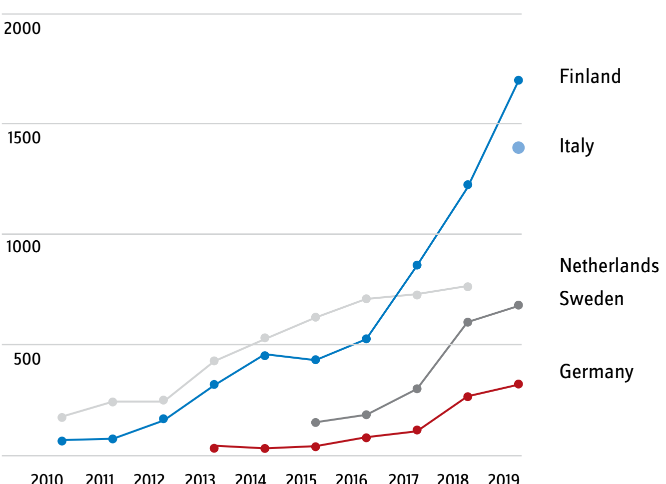
Version: 1 February 2021,
Illustration: National Association of Statutory Health Insurance Funds

Expert opinion on supply shortages of medicinal products

There is no correlation between supply shortages and discount contracts agreed with statutory health insurance funds.

Shortages in the supply of medicinal products have been attracting increasing media attention in recent years. Supply shortages of individual medicinal products are often equated with shortages in the provision of care. Real shortages in the provision of care have a considerable impact on patients. That said, the lack of availability of a medicinal product does not automatically lead to a care shortage. Other medicinal products with the same active ingredient, or medicinal products with comparable active ingredients, are available as alternatives in most cases. Supply bottlenecks are nevertheless unacceptable for patients as well.

Developments in reported supply shortages in Germany and in the countries analysed since 2010



Italy: Data as of 9 January 2020; data not available for 2010-2018. The information relates to 56 % of the total of 2,408 reports, as these also include 1,041 reports classified as "permanently missing".

Source: Gesundheit Österreich Forschungs- und Planungs GmbH und Bundesinstitut für Arzneimittel und Medizinprodukte (2020)
Illustration: National Association of Statutory Health Insurance Funds

The National Association of Statutory Health Insurance Funds commissioned a brief report in order to identify on a scientific basis ways of recognising supply shortages at an early stage and limiting their effects. Gesundheit Österreich GmbH (GÖG) has investigated the availability of a selection of active ingredients in Germany, the Netherlands, Sweden, Finland and Italy.

Supply shortages are not caused by discount contracts

A central finding is that supply shortages are increasing on an international scale, and that they occur independently of the respective national healthcare provision mechanism. There is no correlation between supply shortages and discount contracts agreed with statutory health insurance funds. On the contrary: In the countries covered by the study, supply shortages occurred less frequently for medicinal products subject to discount contracts than for medicinal products without discount contracts.

Transparency and sanctions

The researchers have derived the following recommendations for action to be taken by Germany from the study results:

- binding reporting obligations – subject to sanctions – to a central registry for supply shortages
- more exacting requirements for pharmaceutical companies to comply with supply obligations, as well as sanctioning of violations
- better cooperation between all stakeholders in order to avoid supply shortages
- extensive exchange of information at EU level, e.g. via a European reporting register.

Simplifying access to medicinal products for haemophilia

Manufacturers previously distributed medicinal products used to treat patients with haemophilia (blood clotting disorder) directly to hospitals and medical practices. The Act for More Safety in Medicinal Product Supply (*Gesetz für mehr Sicherheit in der Arzneimittelversorgung* - GSAV) has made these products subject to mandatory dispensing by pharmacies since September 2020. The Act aims to improve patient care, create price transparency, and prevent physicians taking economically-motivated decisions when dispensing medicinal products directly to patients. The National Association of Statutory Health Insurance Funds was tasked with setting manufacturers' dispensing prices for medicinal products for haemophilia that were placed on the market in Germany prior to 2011 on the basis of the prices reported by the pharmaceutical companies and of the refund prices of the health insurance funds.

The price information submitted by the pharmaceutical companies was verified by the National Association of Statutory Health Insurance Funds in a coordinated procedure. The prices were found to be plausible for 31 out of 33 haemophilia medicinal products. It was possible to declare the prices applicable accordingly. The prices for two medicinal products were determined by means of a price-setting procedure on the basis of the health insurance funds' refund prices. The prices provided by the pharmaceutical companies were classified as implausible until the end. The corresponding pricing decisions were served in June 2020. One pharmaceutical company filed a court action against this. An out-of-court settlement was reached with this company.

Price renegotiations successful

The percentage differences between the previously-listed prices and the newly-determined prices range from -6.5 % to -52.5 %, averaging out at -17.5 %. The Act for More Safety in Medicinal Product Supply also granted to the National Association of Statutory Health Insurance Funds a special right of termination for medicinal products for haemophilia placed on the market in Germany after 2011 with an AMNOG refund amount. This means that new refund amounts can be negotiated on the basis of the new prices that were determined first. The special right of termination was used for all medicinal products covered by the Act.

The Act for More Safety in Medicinal Product Supply has made the daily lives of haemophilia patients a little more normal, and less strenuous: They can now simply pick up their medicinal products at their local pharmacy, just like other patients do. Haemophilia patients used to have to travel hundreds of kilometres to pick up their preparations from a centre in other Federal *Länder* in some cases. Emergency services provided by pharmacies near people's homes also relieve the patients concerned in terms of logistics, as well as their families. The guiding principle of physician-assisted self-treatment in haemophilia remains unchanged, and physicians can focus on treatment quality.

The average percentage difference between the previously-listed prices and the newly-determined price is -17.5 %.

Negotiations on the supply of remedies

Contracts at federal level ensure a reliable, high-quality supply of remedies.

The Appointment Service and Care Act tasked the National Association of Statutory Health Insurance Funds with concluding contracts with the relevant national organisations of remedy suppliers at federal level in order to ensure a reliable, high-quality supply of remedies. It was necessary to negotiate the services and prices for each individual remedy for this purpose, and to come to a contractual arrangement. Agreement was further reached on accreditation requirements for healthcare providers, obligations for further training, and information required to be provided on the prescription.

Performance-based and economical

The decisive factor for price setting is the goal of both appropriate and economical supply. Staffing and material costs, as well as the average running costs for the operation of a remedy practice, must be taken into account here.

The contract negotiations were launched in the five remedy sectors in the fourth quarter of 2019. As the contracts are based on the Remedies Guideline (*Heilmittel-Richtlinie*) in many respects, the legislature decided that the contracts should enter into force on the same date as the new version of the Remedies Guideline as per 1 January 2021, and not as per 1 July 2020 as had originally been planned. The National Association of Statutory Health Insurance Funds and the remedy associations negotiated with one another in numerous rounds.

It was possible to conclude the contract at federal level with the professional associations of podiatrists in good time as per 1 January 2021. The contract for voice, speech, language and swallowing therapy was determined by the Arbitration Office on 15 March 2021, and the contract for dietary therapy was determined on 26 March 2021. The procedures of the Arbitration Office for physiotherapy and occupational therapy are ongoing, and are expected to be completed in July 2021.

An overview of the remedies sector

	Physiotherapy	**Occupational therapy**	**Voice, speech, language and swallowing therapy**	**Podiatry**	**Dietary therapy**
Turnover of statutory health insurance, per year	6.23 billion €	1.3 billion €	890 million €	238 million €	approx. 50,000 €
Doctors' prescriptions, per year	33 million	2.7 million	1.7 million	1.8 million	approx. 500
Accredited practices	42,971	10,220	11,674	6,038	approx. 100 active therapists
Accredited professions	· Physiotherapists · Physical therapists · Masseurs and medical pool attendants	· Occupational therapists · Occupational and work therapists	· Speech therapists · Academic language therapists · Breathing, speech and voice instructors	· Podiatrists	· Dieticians · Professionals with a University degree in ecotrophology · Nutritionists
Range of services provided under statutory health insurance	· Physiotherapy · Massages · Manual therapy · Manual lymph drainage · Heat/cold therapy · Electrotherapy · ...	· Motor-functional treatment · Sensorimotor-perceptive treatment · Psychological-functional treatment · Neurocognitive training · ...	· Voice therapy · Language therapy · Speech therapy · Swallowing therapy	· Callus removal · Nail treatment · Complex treatment · (for diabetic foot syndrome and comparable disorders)	· Nutritional-therapeutic counselling · (for rare genetic metabolic diseases and cystic fibrosis)

Source: GKV HIS reports, Bundesbericht HIS 2019, as per04/2019
Illustration: National Association of Statutory Health Insurance Funds

prolonged intermission(s),
noun
(a disturbing silence)

Quality assurance and cost transparency in domestic nursing care services

The verification procedures are intended to ensure that higher remuneration paid by the health insurance funds is also actually used to remunerate the employees.

The National Association of Statutory Health Insurance Funds and the national organisations responsible for representing the interests of long-term care services have agreed on further arrangements in the Federal Framework Recommendations on domestic nursing care services. This firstly concerned the provision of psychiatric domestic nursing care services, and secondly related to principles of remuneration as well as to stipulations on cost transparency for remuneration negotiations. A central subject of regulation here is proof of the collectively-agreed wages and salaries actually paid. In addition, principles were agreed on the remuneration of longer journey times.

Requirements placed on psychiatric domestic nursing care services

In the consultations on supplementing the Framework Recommendations to include requirements for psychiatric domestic nursing care services, the National Association of Statutory Health Insurance Funds placed the focus on guaranteeing high-quality care. Uniform requirements now apply nationwide, particularly with regard to the qualifications of the care specialists employed in psychiatric domestic nursing care services, but also with regard to the design of the care. The amended Framework Recommendations came into force at the beginning of October 2020. The provisions are to be implemented in the care contracts concluded between health insurance funds and care service providers.

Arbitration award on the remuneration principles of domestic nursing care services

The expectations of the negotiating partners in the negotiations on the principles of remuneration and remuneration structures, including transparency stipulations, were far apart. A central concern of statutory health insurance was to create a uniform foundation on which to carry out remuneration negotiations on the basis of the greatest possible cost transparency, so that health insurance funds and long-term care services can agree on performance-related remuneration, whilst taking account of the appropriate remuneration of care staff at the collective wage level. The Arbitration Office reached a decision in October 2020, given that the negotiating parties were unable to reach a consensus.

The arrangements established by the Arbitration Office basically follow an approach orientated towards actual costs. These costs are to be comprehensibly presented and verified by the nursing care service providers. The verification procedures are intended to ensure that higher remuneration granted by the health insurance funds for domestic nursing care services which is justified by increased personnel costs is also actually used to remunerate the employees. The Framework Recommendations expanded in this respect came into force at the beginning of 2021.

Better care for persons in need of intensive long-term care

Discussions have been ongoing for many years about improving the quality of intensive long-term care in non-hospital settings. The focus is particularly on insured persons requiring ventilation and those with a tracheostomy tube (external access to the windpipe). The National Association of Statutory Health Insurance Funds has called repeatedly in the past for the law to be amended, for example because the potential to wean patients off ventilation in out-patient long-term care is not being fully exploited. The legislature removed non-hospital intensive long-term care from the provisions on domestic nursing care services via the Intensive Long-Term Care and Rehabilitation Strengthening Act (*Intensivpflege- und Rehabilitationsstärkungsgesetz* - IPReG) of October 2020, and transferred it to a separate legal provision. The Federal Joint Committee now has one year in which to adopt its own guideline on non-hospital intensive long-term care, containing amongst other things specific regulations on respiratory care.

Early examination of the potential to wean patients off ventilation

The Intensive Long-Term Care and Rehabilitation Strengthening Act, with its comprehensive, cross-sectoral approach, is expressly supported by the National Association of Statutory Health Insurance Funds. It provides a major motivation to provide high-quality care, especially for insured persons who are being ventilated or who have undergone tracheotomy, and removes existing misincentives. The Act contains the following provisions for this group of patients:

- obligation for the hospital to assess the potential to wean patients off ventilation and for tube removal before transfer from the hospital to a non-hospital care setting
- obligation to document the identified potential to wean patients off ventilation and for tube removal, and the measures to be taken each time non-hospital intensive long-term care is prescribed

The improvements in care also increase the degree of self-determination of the insured persons concerned.

Reducing the financial burden on intensive long-term care patients

A crucial advantage for insured persons who receive intensive long-term care in residential long-term care facilities is that insured persons no longer have to make high financial co-payments now that the Act has been amended. This has removed a previous incentive to opt for out-patient care, which is often less expensive, thus helping to increase freedom to choose between the individual care settings.

Insured persons who receive intensive long-term care in residential long-term care facilities no longer have to make high financial co-payments.

The National Association of Statutory Health Insurance Funds will work in the context of the implementation of the complex provisions contained in the Intensive Long-Term Care and Rehabilitation Strengthening Act to be carried out in 2021 and 2022 to ensure that the full improvement potential for insured persons is indeed tapped in the deliberations of the Federal Joint Committee and in the negotiations with the healthcare providers' organisations.

Implementation steps for non-hospital intensive long-term care

up to 31 Oct. 2021	up to 31 Oct. 2022	up to 31 Oct. 2023
Federal Joint Committee: Elaboration of a guideline on non-hospital intensive long-term care	**National Association of Statutory Health Insurance Funds and contracting partners:** Elaboration of framework recommendations	**Health insurance funds' associations and health-care providers at Land level:** Concluding care contracts
Establishing the procedure for the prescription, content and scope of non-hospital intensive long-term care, including agreeing on requirements for the qualification of physicians to prescribe non-hospital intensive long-term care, and for identifying weaning and tube removal potentials	Reaching an agreement between the National Association of Statutory Health Insurance Funds and the national associations of healthcare providers on the basis of the Federal Joint Committee's guideline on the essential content and structural stipulations of future care contracts, including on staffing requirements for care, determination of personnel requirements, quality assurance measures, and principles regarding remuneration	Concluding contracts at *Land* level between healthcare providers and the health insurance funds' associations on the basis of the Framework Recommendation; transfer to the new service contracts within one year

Illustration: National Association of Statutory Health Insurance Funds

Changes in access to rehabilitation

Rehabilitation services in statutory health insurance serve to enable people who are chronically ill, people with a disability, or people at risk of disability, to continue to live as independently as possible. The measures are intended to help prevent the permanent manifestation of a disability or need of long-term care, or to help individuals cope better with the consequences of an illness.

Health insurance funds prohibited from verifying claims

The Intensive Long-Term Care and Rehabilitation Strengthening Act (IPReG) modified access to geriatric rehabilitation services, amongst other things. According to this Act, the health insurance funds may no longer separately verify the medical necessity of these services once they have been prescribed by a contract doctor, after suitable assessment tools have been applied in the form of medical assessments. The National Association of Statutory Health Insurance Funds raised this issue in the legislative procedure for the Intensive Long-Term Care and Rehabilitation Strengthening Act. It is a first for a social benefit funding institution to be prohibited from verifying eligibility for benefits.

It is a first for a social benefit funding institution to be prohibited from verifying eligibility for benefits.

Before the regulations can be implemented, the Federal Joint Committee must first regulate the details of the selection, use and proof of application of suitable assessment tools in the rehabilitation guideline by 31 December 2021. The National Association of Statutory Health Insurance Funds expects these regulations to ensure that the selection of assessment tools is based on professionally sound decisions, and that a high level of transparency in the application of the tools and a high prescription quality are ensured so that insured persons can be provided with rehabilitation services tailored to their individual needs.

Uniform framework recommendations for preventive care and rehabilitation

Furthermore, the Intensive Long-Term Care and Rehabilitation Strengthening Act mandated the National Association of Statutory Health Insurance Funds and the associations representing the providers of medical rehabilitation services to reach an agreement at federal level on Framework Recommendations concerning the content, scope and quality of rehabilitation services, as well as the principles of performance-based remuneration. If the Framework Recommendations are not established in whole or in part, the partners to the Framework Recommendations can appeal to the Federal Arbitration Office, which is to be newly established. The Framework Recommendations create a uniform basis for the conclusion of care and remuneration contracts of the *Land* associations of the health insurance funds and of the substitute funds.

Core provisions contained in the Intensive Long-Term Care and Rehabilitation Strengthening Act regarding rehabilitation

- facilitating access to rehabilitation from the contract-doctor or hospital care sector
- principles for care and remuneration contracts standardised by Federal Framework Recommendations
- amendments to remuneration contracts: payment of salaries and wages up to the collectively-agreed wage level not considered uneconomical

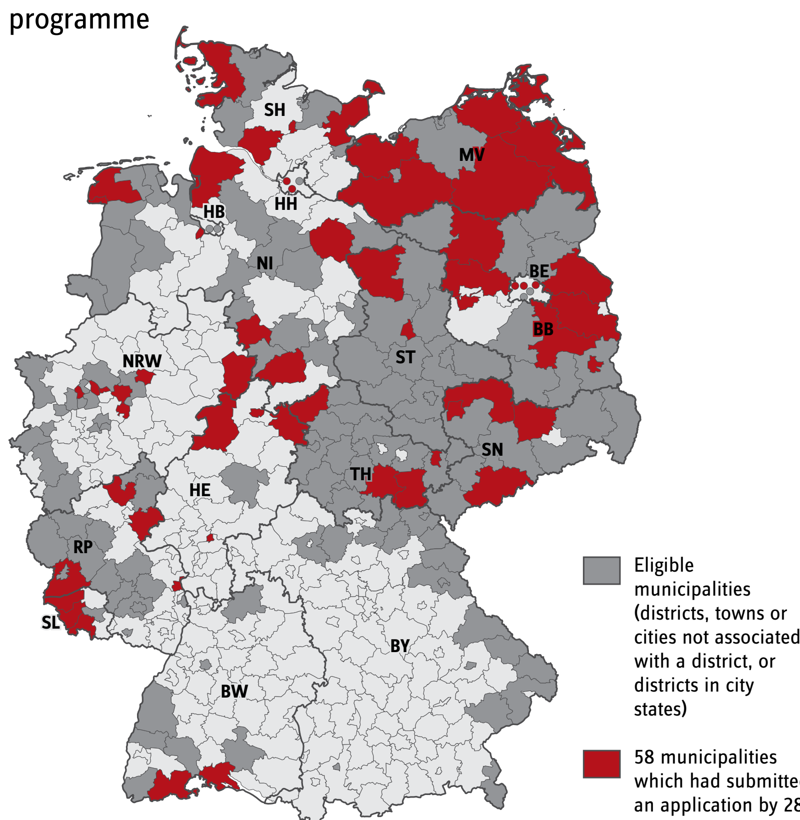
set of scales, noun
(measures duration of lockdown
in kilos)

Programme for municipal health structure development launched

30 to 40 % of all eligible municipalities will receive funding from the Statutory Health Insurance Alliance for Health in the coming years in order to build up and network municipal structures for health.

Particular importance attaches to the municipal management of health promotion and prevention where it is the objective to create tailor-made and as-needed prevention and health promotion services for citizens. Against this background, the Statutory Health Insurance Alliance for Health launched a support programme for municipalities in 2019. The portfolio of the Statutory Health Insurance Alliance for Health complements the diverse health promotion activities of the health insurance funds in the Federal *Länder*.

Municipal funding programme:
Applications in the "Municipal Structural Development" funding programme



Source and illustration: National Association of Statutory Health Insurance Funds

Funding offer meets with good response from municipalities

58 out of the total of 195 eligible municipalities had applied for funding by the end of February 2021, and had already successively begun implementation since the end of 2019. In addition, a further 21 municipalities that had availed themselves of the simplified application procedure that was provided due to the coronavirus pandemic in order to meet the deadline by 30 June 2020 have submitted expressions of interest in applying. This means that 30 to 40 % of all eligible municipalities will receive funding from the Statutory Health Insurance Alliance for Health in the coming years in order to build up and network municipal structures for health. The financial support is supplemented by advisory and qualification services.

Central contact points in the Federal *Länder*

The programme offices of the Statutory Health Insurance Alliance for Health act as central contact points in the Federal *Länder* for interested stakeholders in the municipalities. They provide advice and information on further promotion and support offers of the Statutory Health Insurance Alliance for Health. The offer of health promotion for vulnerable target groups, which also focuses amongst other things on the health of children and young people from families with addiction problems, is particularly worth mentioning here.

Evaluation improves scientific foundations

The funding programme is intended to help initiate and support a nationwide development process in municipal health promotion. A major element that contributes to this is improving the scientific basis. PROGNOS AG was tasked with the accompanying evaluation of the funding programme. The evaluation also records the different starting and framework conditions of the municipalities in order to be able to assess changes more accurately. Areas of interest in the research also include factors that inhibit or promote the achievement of the funding objectives as well as the benefits and effects of the implemented measures.

Digital applications in disease prevention

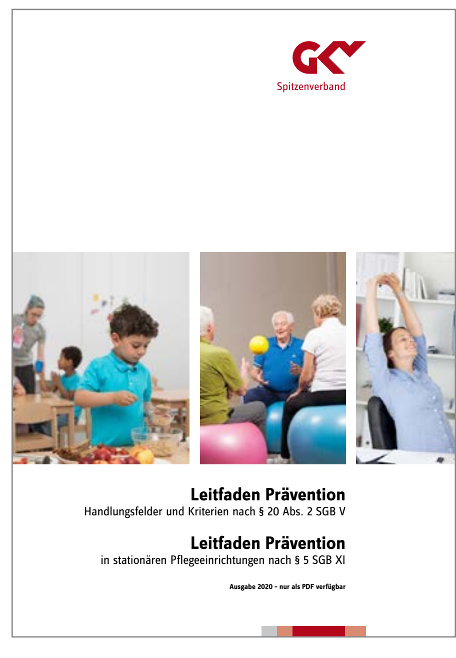
Digitalisation has also long since found its way into disease prevention. Whether it is choosing healthy food and preparing it, trying to give up smoking or to exercise every day - the market now offers a multitude of digital helpers to achieve these good intentions. Digitalisation legislation has so far focussed on implementing digital applications for the detection, monitoring, treatment or alleviation of diseases, but not on their prevention. Digital applications that have been approved by the Federal Institute for Drugs and Medical Devices for a given disease can only be prescribed to insured persons who have the respective disease and require treatment.

More individual and flexible

The National Association of Statutory Health Insurance Funds considers digital disease prevention applications to be a valuable addition to the existing range of services. Such apps have the potential to meet the individual needs of insured persons, and thus to reach more people all in all. Insured persons should be able to use these preventive potentials with support from the health insurance funds. The National Association of Statutory Health Insurance Funds therefore defines extended quality criteria for digital applications as primary prevention services in its guidelines on disease prevention, which go beyond the e-courses that are already being funded. Breaking away from health course designs with exercise units that are weekly in most cases enables offers such as learning a relaxation method to be individualised and integrated more flexibly into everyday life.

Digital services have the potential to meet the individual needs of insured persons, and thus to reach more people all in all.

The revised version of the guidelines defines, among other things, the evidence to be provided that digital applications have a health benefit, the requirements for data protection and data security, and the availability of personal support. The provider must prove the health benefit of the application through at least one prospective observational study with three measurement times.



A digital transformation in self-help

Self-help groups, self-help organisations and self-help contact points have been using digital applications for many years, and to an increasing extent. In order to do so, they receive funding from statutory health insurance for self-help. They offer their members helpful information on their websites, use tools to coordinate appointments, or enable a digital exchange of information, e.g. in chat groups or online forums. The objective of promoting the digital transformation in self-help is more topical than ever against the backdrop of the coronavirus pandemic.

The Digital Care Act, which came into force at the beginning of 2020, will further advance digitalisation in self-help. Funding from statutory health insurance for self-help supports the use of analogue and digital services in equal measure. That said, only those digital applications are considered which meet the most stringent data protection requirements and guarantee state-of-the-art data security.

Adapting the principles of funding for self-help

Despite difficult conditions due to the coronavirus pandemic, the National Association of Statutory Health Insurance Funds and the associations of health insurance funds at federal level have been able to expeditiously integrate the legal amendment into the principles applied to the promotion of self-help. Representatives of self-help organisations were consulted on this in an advisory capacity. The new regulations have been in force since 1 January 2021, a date which took into account the necessary lead times for adapting application forms and procedures.

Digital applications must meet the most stringent data protection requirements and guarantee state-of-the-art data security.

What is known as "level-based funding" is ultimately to be retained. This means that self-help groups, self-help organisations or self-help contact points can continue to submit their applications at the respective funding levels (Federation, *Land* and local level), regardless of the type of exchange practised (analogue and/or digital). In addition, further adjustments were made to the Guideline on Self-Help Funding (*Leitfaden zur Selbsthilfeförderung*) in order to ensure that funding practices are as uniform as possible.

Feedback inter alia from self-help groups on addiction, and from self-help groups on mental illnesses, however shows that digital encounters can often only partially or temporarily replace face-to-face encounters between people.

The Guideline on Self-Help Funding in the version of 27 August 2020 has been published at www.gkv-spitzenverband.de/selbsthilfe.

GKV Spitzenverband

Leitfaden zur Selbsthilfeförderung

Grundsätze des GKV-Spitzenverbandes
zur Förderung der Selbsthilfe gemäß § 20h SGB V
vom 10. März 2000 in der Fassung vom vom 27. August 2020

In Zusammenarbeit mit den Verbänden der Krankenkassen auf Bundesebene sowie unter beratender Beteiligung der Vertretungen der für die Wahrnehmung der Interessen der Selbsthilfe maßgeblichen Spitzenorganisationen

the no-go bistro,
(take-away just isn‘t the same)

A stronger role for the EU in medical devices law

Regardless of the level of regulation, top priority must be given to protecting insured persons and patients when it comes to the approval of medical devices.

Medical devices law is undergoing a fundamental transition. The new EU regulations on medical devices and in vitro diagnostic medical devices will mean that the medical devices law that was previously valid at European and national level will cease to apply in 2021. Unlike before, these EU regulations will come into force directly in all Member States. Only certain parts of them still need to be transposed into national law. Regardless of the level of regulation, top priority must be given to protecting insured persons and patients when it comes to the approval of medical devices. The National Association of Statutory Health Insurance Funds is committed to ensuring that medical care is only provided with safe, high-quality medical devices.

The Medical Devices EU Adaptation Act (*Medizinprodukte-EU-Anpassungsgesetz* - MPEUAnpG), and thus amongst others the Medical Devices Law Implementation Act (*Medizinprodukterecht-Durchführungsgesetz* - MPDG), were passed in the spring of 2020 in order to align national laws with the new European framework conditions. Many of the provisions that were adopted lend concrete shape to the areas that are to be regulated by national law, e.g. market surveillance or the implementation of "other clinical trials".

Adaptation of German law

Germany's medical devices law will be completely restructured when the Medical Devices Law Implementation Act comes into force. The Act on Medical Devices (*Medizinproduktegesetz*) will no longer be in force, and will only apply to medical devices that were placed on the market or put into service under the old law during a transitional phase. Three provisions of the amendment legislation are worth highlighting from the perspective of the National Association of Statutory Health Insurance Funds:

1. The competences of the authorities responsible for market surveillance have been reassigned. It is highly welcome that several competences have been consolidated at national level under the auspices of the Federal Institute for Drugs and Medical Devices. This should improve patient safety, and fulfils a long-standing demand of the National Association of Statutory Health Insurance Funds.
2. Very far-reaching legal provisions have been introduced for special approvals of medical devices at national level. The National Association of Statutory Health Insurance Funds believes that the question remains open as to whether they are compatible with the new EU law that has come into force. After all, national approval of entire product groups is thus possible, in contrast to what is envisaged by the EU Regulation.
3. Whereas the new EU Regulations provide for very extensive access to information on medical devices placed on the market, and their clinical trials, this idea of transparency is not sufficiently reflected in some of the national provisions contained in the Medical Devices Law Implementation Act. The National Association of Statutory Health Insurance Funds considers that it would have been necessary in the interest of patient autonomy to provide access to information on special national approvals that have been granted, and on the outcome of "other clinical trials".

The start of application of the EU Medical Devices Regulation was postponed from 2020 to 26 May 2021 due to the coronavirus pandemic. This means that the entry into force of the Medical Devices Law Implementation Act, as well as of other provisions of the Medical Devices EU Adaptation Act related to medical devices law, had to be postponed.

vaccination, noun
(a game changer with teething problems)

Reorganisation of the method evaluation

The reorganisation of the evaluation of non-medical innovations by the Federal Joint Committee was completed with the Ordinance on the Procedural Principles for the Evaluation of Examination and Treatment Methods (*Verordnung über die Verfahrensgrundsätze der Bewertung von Untersuchungs- und Behandlungsmethoden*), which was presented in June 2020.

The statutory basis for the reorganisation of the method evaluation was created with the Act Establishing an Implant Register (*Implantateregister-Errichtungsgesetz*). This included the authorisation for the Ministry of Health to reorganise the principles of the method evaluation in the Federal Joint Committee in a legal ordinance by 30 June 2020. It was possible to prevent in the legislative procedure further-reaching forms of state intervention, which would not only have served, as intended, to accelerate the procedure, but would have allowed even greater scope for political influence to be exerted on evidence-based method evaluation.

It was possible to prevent further-reaching forms of state intervention, which would have allowed even greater scope for political influence to be exerted on evidence-based method evaluation.

Scientifically-sound advisory procedure made more difficult

The aim of the ordinance that was submitted is to ensure the rapid application and remuneration of innovations. However, it also calls into question essential methodological and scientific foundations of the Federal Joint Committee and of the Institute for Quality Assurance and Transparency in the Healthcare System. The new arrangement jeopardises the methodologically-sound weighting and evaluation of the evidence with regard to its reliability and quality, and makes the formal procedure more complicated. At the same time, the deadlines for scientific processing and consultation are further curtailed. This makes it considerably more difficult for the Federal Joint Committee to conduct a consultation process that is appropriate in terms of content.

Subsequent to distinct criticism of the first draft of the Ordinance, it was possible to achieve amendments on certain points. The arrangement that had originally been planned, namely that all documents and evidence must be included in the determination of the state-of-the-art of medical knowledge without exception, was toned down. The Ordinance now provides that the search is to be carried out under consideration of the principles of evidence-based medicine, and thus that it is not required for documents from all evidence levels to be included in their entirety in every case. The methodology of evidence-based medicine requires that, depending on the research question, it be determined before the search is carried out which types of study are suitable as a matter of principle for demonstrating the benefit of an innovation. This is because it is de facto impossible in evaluation practice to comprehensively research and document all case reports and individual opinions, and to include them in the evaluation. This ensures that the research work is both reliable and feasible.

The Federal Joint Committee has now integrated the Ordinance into its Rules of Procedure. It remains to be seen how this will be implemented in the practical work of the Federal Joint Committee.

The National Association of Statutory Health Insurance Funds will continue to ensure in the Federal Joint Committee that questions of patient benefit, and the scientific data needed for this, play a central role in Committee's decisions.

hand sanitiser, noun
(made daily alcohol use socially acceptable)

Continuation of the Innovation Fund

The Digital Care Act (DVG) extended the Innovation Fund until the end of 2024, and made revisions to the funding procedure.

The Innovation Committee that is part of the Federal Joint Committee has been promoting innovative care models and application-orientated care research since 2016. An annual funding volume of 300 million Euro was available from 2016 to 2019. The Digital Care Act (DVG) extended the Innovation Fund until the end of 2024, and made some revisions to the funding procedure. The annual funding volume has been reduced to 200 million Euro from 2020 onwards.

Innovation Committee implements new regulations

The Innovation Committee has successfully recruited the pool of experts introduced with the Digital Care Act. These experts are to co-assess the funding applications with broad-based expertise. In addition, a public consultation process was carried out for the first time to include topics also proposed by stakeholders in the healthcare system from outside the Innovation Committee. The Innovation Committee published the first funding announcement for the new funding category "(Further) Development of Medical Guidelines" in October 2020. At least 5 million Euro from the funding volume for "Care research" are to be earmarked annually for guideline projects.

The two-stage application procedure provided for by the Digital Care Act in the funding category "New forms of care" was also launched in 2020. Applicants here must first submit a brief outline of their ideas. If the Innovation Committee evaluates this positively, it grants the applicants six months and up to 75,000 Euro in funding with which to prepare a full proposal. As a rule, the Innovation Committee can ultimately fund 20 projects out of the full proposals submitted.

It remains to be seen whether all the new developments can achieve the improvements in the funding process envisaged by the legislature.

Funding decisions in 2020

The Innovation Committee once more received numerous funding applications from health insurance funds, physicians' associations, hospitals, Universities and research institutes in 2020. 33 research projects were selected for funding in the funding category "Care research", out of 186 applications submitted. This means that the funding

Submitted and funded proposals

Funding category	Proposals/ outline of ideas submitted	Funding volume of proposals/outlines of ideas submitted	Promoted projects/ outlines of ideas	Funding volume of promoted projects/ outlines of ideas
Care research	186	247.6 million €	33	37.3 million €
Full proposals for New forms of care (one-stage procedure)	73	421.8 million €	28	146.9 million €
Outlines of ideas for New forms of care (two-stage procedure, stage 1)	136	9.4 million €	33	2.4 million €

Source and illustration: National Association of Statutory Health Insurance Funds

volume was exhausted. The Innovation Committee approved 28 projects out of 73 proposals in the last single-stage application procedure to take place in the funding category "New forms of care".

The quota arrangement for non-topic-specific and topic-specific funding was also applied for the first time in 2020. In accordance with this stipulation from the Digital Care Act, a maximum of 20 % of the funding volume in the respective funding category may be used for proposals submitted for all fields. This is intended to achieve greater control over the content of the projects. The two-stage application procedure for "New forms of care" was launched in parallel to the final single-stage application procedure. The Innovation Committee selected 33 of the 136 outlines of ideas received at the turn of the year 2020/2021 for the preparation of full proposals in 2021.

The health insurance funds contributed 42 % to the research projects funded from 2020, and 93 % to the single-stage-funded "New forms of care".

First project results and recommendations

The Innovation Committee published the reports of 14 completed care research projects in 2020. It also made recommendations on how to put the findings to use. Among other things, a consultation process was initiated to review the Federal Joint Committee's guideline on specialised out-patient palliative care. The first two recommendations on completed "New forms of care" were also published at the end of 2020. In one of the recommendations, the Innovation Committee asked the Ministries of Health of the *Länder* to examine whether a tele-emergency physician system can be implemented as a supplementary rescue system for their respective Federal *Land*.

New laws

The Care Improvement Act (*Versorgungsverbesserungsgesetz*), which was passed in December 2020 and came into force as per January 2021, establishes regulatory relief for the continuation of contracts in accordance with section 140a of Book V of the Social Code from the Innovation Fund after the end of funding. The requirements for the existence of integrated or special care, as well as improvement of care, are considered to be fulfilled once the Innovation Committee has made its funding decision.

DEPARTURES

TIME	DESTINATION	FLIGHT	GATE	REMARKS
12:39	BERLIN	BA 903	31	CANCELLED
12:57	SYDNEY	QF5723	27	CANCELLED
13:08	TORONTO	AC5984	22	CANCELLED
13:21	TOKYO	JL 608	41	CANCELLED
13:37	HONG KONG	CX5471	29	CANCELLED
13:48	MADRID	IB3941	30	CANCELLED
14:19	LONDON	LH5021	28	CANCELLED
14:35	NEW YORK	AA 997	11	CANCELLED
14:54	PARIS	AF5870	23	CANCELLED
15:10	ROME	AZ5324	43	CANCELLED

refund, noun
(rule-of-thumb: takes four times as long
as the journey you hoped to take)

Establishment of the clinical cancer registers

Clinical cancer registers are an important tool for improving and securing high-quality oncological care. With the entry into force of the Early Cancer Detection and Register Act (*Krebsfrüherkennungs- und -registergesetz*) in 2013, all Federal *Länder* were given the task of setting up *Land*-wide clinical cancer registers. The cancer registers must fulfil certain requirements so that they can receive funding from the statutory health insurance funds. These 43 funding criteria relate to structures, processes and results of the registry activities, and are intended to ensure that the clinical cancer registers and their data satisfy a minimum level of quality. The funding was provided independently of meeting the funding criteria during the establishment and refinement phase. This phase ended on 31 December 2020, so that the cancer registers have to fulfil all the funding criteria from 2021 onwards.

The *Land* associations of the health insurance funds and of the substitute funds are responsible for auditing the compliance status of the funding criteria for the 18 clinical cancer registers. They did so for the fourth time as per the end of 2020.

The clinical cancer registers are now fully operational

The current audit as of 31 December 2020 shows that all 18 clinical cancer registers now meet the 43 funding criteria. This means that the establishment phase is considered as being complete and the cancer registers are fully operational. The requirements in terms of process and outcome quality nevertheless still need to be audited on a yearly basis and documented using the respectively current

The cancer registers must fulfil certain requirements so that they can receive funding from the statutory health insurance funds.

Degree of satisfaction of the funding criteria in the 18 clinical cancer registers in 2019 and 2020

43 funding criteria to be met

	2019		2020	
Baden-Württemberg	**43**	✓	**43**	✓
Bavaria	41		**43**	✓
Brandenburg/Berlin	36		**43**	✓
Bremen	**43**	✓	**43**	✓
Hamburg	42		**43**	✓
Hesse	41		**43**	✓
Mecklenburg-Western Pomerania	29		**43**	✓
Lower Saxony	31		**43**	✓
North Rhine-Westphalia	39		**43**	✓
Rhineland-Palatinate	**43**	✓	**43**	✓
Saarland	**43**	✓	**43**	✓
Chemnitz	40		**43**	✓
Dresden	39		**43**	✓
Leipzig	40		**43**	✓
Zwickau	40		**43**	✓
Saxony-Anhalt	35		**43**	✓
Schleswig-Holstein	42		**43**	✓
Thuringia	34		**43**	✓

Source and illustration: National Association of Statutory Health Insurance Funds

data. The National Association of Statutory Health Insurance Funds considers this result to be very positive because the health insurance funds assumed in their forecast based on the situation of the cancer registers in 2019 that several cancer registers would not meet the funding requirements in 2020. Methodological changes on the part of the cancer registers in determining the epidemiological data required for the audit are likely to have played a significant role.

If the health insurance funds cease to provide funding, the *Länder* will have to step in as things stand at present.

Outlook

As the cancer registers were still falling far short of the requirements at the end of 2019, the National Association of Statutory Health Insurance Funds appealed to the *Länder* and to the registers most recently in August 2020 to immediately fulfil their statutory obligations in order to satisfy the funding criteria by the end of 2020. Only then can the statutory health insurance funds continue to support the registers. If the health insurance funds cease to provide funding, the *Länder* will have to step in as things stand at present. The legislature reacted to this, and included in its draft Bill on the Merging of Cancer Register Data a three-year transitional arrangement with graduated case lump-sum payments, inter alia for cancer registers which do not yet fulfil all funding criteria at the beginning of 2021.

All cancer registers will now meet the funding criteria in 2021. The situation was reassessed by the National Association of Statutory Health Insurance Funds in the still pending legislative process. The three-year transitional period for cancer registers which do not satisfy the funding criteria after 2020 is therefore no longer necessary.

hiking, noun
(unexpected discovery of the delights
of the nearby countryside)

Combating misconduct in the healthcare system

Statutory health insurance and social long-term care insurance incurred damage of more than 186 million Euro due to misconduct in the healthcare system.

The agencies responsible for combating misconduct in the healthcare system that have been established at all statutory health and long-term care funds and at the National Association of Statutory Health Insurance Funds investigate reports of "irregularities" or of the "unlawful use of funds" in connection with the tasks of statutory health insurance and social long-term care insurance, in particular billing fraud and corruption. In accordance with its duty to report, the Board of the National Association of Statutory Health Insurance Funds informed the Administrative Council on 2 December 2020 about the work and results of its agency responsible for combating misconduct in the healthcare system in the completed reporting period 2018/2019. The report, which is also published on the Internet, furthermore compiles the findings of its members' activity reports into an overall statutory health insurance overview, and derives current positions and demands.

Significant increase in the number of reports received and damage caused

The number of reports received from external parties by the agencies responsible for combating misconduct increased by 38 % in comparison to the previous reporting period. More than 80 % of all reports are submitted by external whistleblowers. The total amount of secured claims increased by 26 % in comparison to the previous reporting period. The total of secured claims amounted to more than 62 million Euro. This is the highest value since reporting began. The actual damage incurred was also quantified for the first time: Statutory health insurance and social long-term care insurance incurred damage of more than 186 million Euro due to misconduct in the healthcare system.

A detailed analysis of the overall statutory health insurance overview shows that the largest claims were secured in domestic nursing care services. By far the greatest damage, on the other hand, occurred in medicinal products and medical dressings.

These and other findings in the report prove that misconduct in the healthcare system can be successfully combated - and the trend is still rising. The systematic work of the agencies responsible for combating misconduct is carried out in the interest of the community of insured persons.

Key figures of statutory health insurance – a complete overview

Description of contents	2016/2017	2018/2019	+/-	%	Tendency
1. Number of **reports received**	33,041	42,350	+ 9,309	+ 28.17	▲
1.1 Number of external reports	25,039	34,542	+ 9,503	+ 37.95	▲
1.2 Number of internal reports	8,002	7,808	- 194	- 2.42	▼
2. Number of **cases pursued**	40,090	43,644	+ 3,554	+ 8.87	▲
2.1 Number of existing cases pursued	14,853	15,447	+ 594	+ 4.00	▲
2.2 Number of new cases pursued	25,237	28,197	+ 2,960	+ 11.73	▲
3. Number of **completed cases**	24,172	26,236	+ 2,064	+ 8.54	▲
4. Amount of **secured receivables** in Euro	49,081,369	62,012,385	+ 12,931,016	+ 26.35	▲
5. Number of **cases reported to the public prosecution office**	3,371	2,952	- 419	- 12.43	▼

Source: Report by the Board to the Administrative Council- "Arbeit und Ergebnisse der Stelle zur Bekämpfung von Fehlverhalten im Gesundheitswesen", version 2 December 2020;
Illustration: National Association of Statutory Health Insurance Funds

Administrative Council calls for a Whistleblower Protection Act (*Hinweisgeberschutzgesetz*)

In order to make the fight against misconduct in the healthcare system even more efficient in future, the Administrative Council of the National Association of Statutory Health Insurance Funds has identified a need for further action in a declaration, and has proposed concrete measures. The Administrative Council is in favour of transposing the EU's "Whistleblowers Directive" into German law by means of a separate "Whistleblower Protection Act" aimed at regulating the protection of external whistleblowers in a uniform manner. The external agencies responsible for combating misconduct of statutory health insurance and social long-term care insurance already receive the largest number of reports in Germany today by far. The Administrative Council therefore calls on the Federal Government to extend statutory whistleblower protection in future to cover the reporting of indications of misconduct in the healthcare system. In order to protect the identity of whistleblowers more effectively, the agencies responsible for combating misconduct in the healthcare system should also be granted the right to refuse to testify.

The Administrative Council also calls for the concretisation of the provisions under social law regarding the billing process for the provision of care. According to the statutory regulations currently in force, when billing for out-patient care services, the services provided must be described in terms of their type, quantity and price. In addition, the date and the duration of the provision of services must be indicated, but not the specific period of time. This is not sufficient to enable a plausibility check of the billed services. It is highly relevant to indicate the start and end times in real time for the respective care assignment in order to avoid and detect accounting and benefit fraud.

Establishing specialised law enforcement agencies in all Federal *Länder*

Finally, the Administrative Council appeals to the *Länder* to consistently pursue the course that has already been set in some cases, and to discuss it in the bodies at cross-*Länder* level. The Conference of Ministers of Justice should for instance also take up the issue of making the prosecution of billing fraud and corruption in the healthcare system more effective. Investigation proceedings in the healthcare system are a specialist field in their own right. Effective prosecution of property crimes and corruption in the healthcare system can only succeed where not only judges but also public prosecutors can engage in this specialist field on a long-term, consistent basis and build up corresponding expertise. (Specialised) public prosecution offices or central offices for combating fraud and corruption in the healthcare system should therefore be established in all Federal *Länder*.

Combating property crime and corruption in the healthcare system

(Specialised) public prosecution offices and specialist commissariats of the criminal police

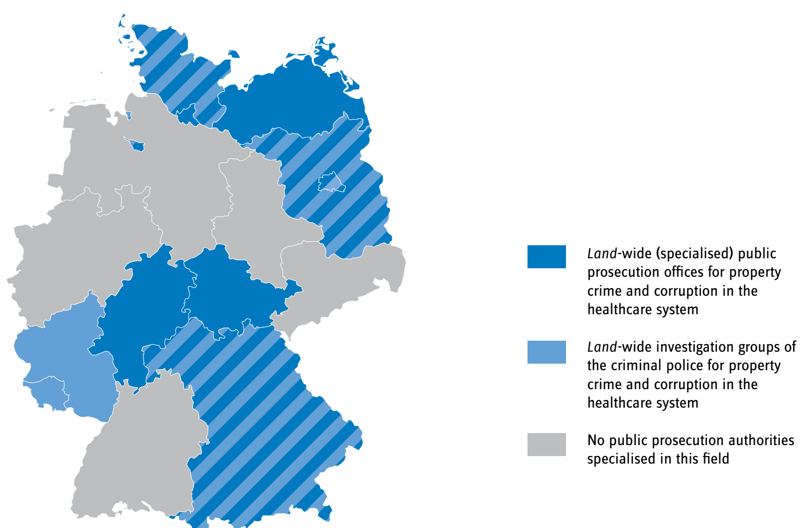


Illustration: National Association of Statutory Health Insurance Funds, as per 1 June 2021

TV news special(s),
(ratings on the up-and-up)

Continued negative trend in statutory health insurance financing in the first year of the pandemic

After the financial status of the statutory health insurance funds had already stood at a deficit of around 1.7 billion Euro at the closure of 2019, the deficit in the first year of the coronavirus pandemic amounted to around 2.7 billion Euro according to the preliminary financial results[1]. In parallel to this, the Health Fund closed the year under report 2020 with a deficit of around 3.6 billion Euro. The financial result of statutory health insurance thus added up to a deficit of roughly 6.2 billion Euro.

Negative financial results are also expected for 2021 - both for the health insurance funds and for the Health Fund itself. The health insurance funds will have to bear an additional expenditure burden of roughly 8 billion Euro in 2021 due to the statutory stipulations to reduce reserves alone. The legislature stipulated in the Healthcare and Long-term Care Improvement Act at the end of 2020 that the wealthier health insurance funds must transfer significant portions of their reserves in order to reduce the pandemic-induced shortfall in funding that is expected for 2021. What is more, the Fund will also have to spend roughly 1 billion Euro more than its revenue, if the revenue estimate is accurate, especially due to its obligation to partially compensate for the shortfall in revenue resulting from the introduction of the allowance on company pensions. This outlook on financial developments is worrying insofar as it does not yet take into account any pandemic-related burdens. This is because their extent cannot yet be calculated at the beginning of 2021.

Against the backdrop of the deficit in the health insurance funds' budgets of at least approximately 20 billion Euro that was determined by the statutory health insurance appraisers for 2021, and of the statutory obligation to drastically reduce assets, large numbers of health insurance funds had to increase their contribution rates as per the turn of the year. 40 out of the 103 health insurance funds raised their additional contribution rates, and only two were able to lower them. The average additional contribution rate charged went up from 1.0 % in December 2020 to 1.28 % in January 2021. This means that the actual average is currently equivalent to the average additional contribution rate for 2021 of 1.3 % published by the Federal Ministry of Health.

Against the backdrop of an estimated deficit in their budgets of at least approximately 20 billion Euro, large numbers of health insurance funds had to increase their contribution rates as per the turn of the year.

Financial development in 2020

According to the preliminary accounting results, the income of the statutory health insurance members used as the basis for the assessment of contributions (basic wage and pension total) only increased in the year under report by 1.9 %, to 1,496.8 billion Euro, as a result of the pandemic. A general contribution rate of 14.6 % hence resulted in income from contributions amounting to approx. 218.6 billion Euro. Factoring in contributions from marginal employment (approx. 2.9 billion Euro), a separate appropriation from the liquidity reserve of 225 million Euro, and the contribution from the Federation increased by 3.5 billion Euro to improve the financial standing of the Health Fund in the pandemic (roughly 17.9 billion Euro), the total income of the Health Fund was about 239.4 billion Euro. This income did not enable the Health Fund to fully finance the allocations of 240.2 billion Euro which had been assured to the health insurance funds for 2020. The missing funds amounting to 0.6 billion Euro therefore had to be taken from the liquidity reserve of the Health Fund. Other statutory financial obligations, including vis-à-vis the Innovation Fund and the Structural Fund, but in particular as a result of the disbursal of financial assistance to providers in the healthcare system which were not fully refunded by the Federation, caused the Fund to generate a deficit of around 3.6 billion Euro as per 31 December 2020. The fund reserve thus still amounted to around 6.2 billion Euro as per the end of the year.

According to the preliminary financial results, the fund-relevant expenditure of the health insurance funds increased by 4.0 % to 257.3 billion Euro, and - due to the pandemic-related reduction in service provision - thus remained slightly lower

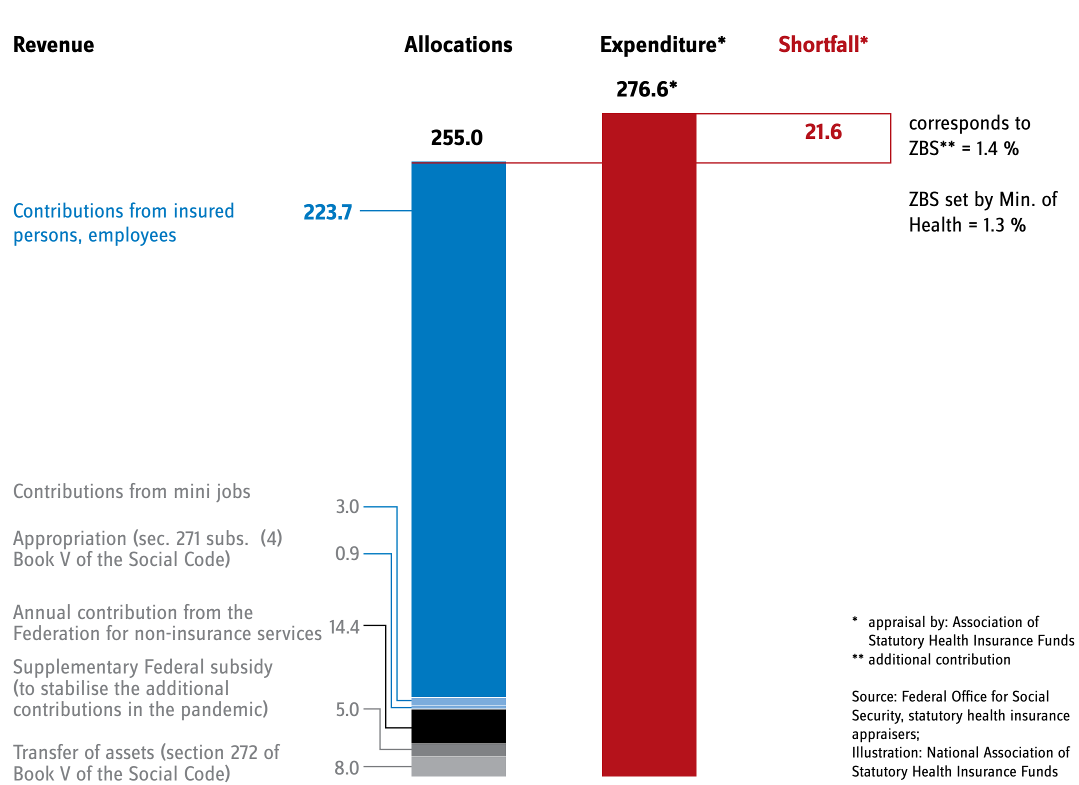
The Health Fund generated a deficit of around 3.6 billion Euro as per 31 December 2020.

than the expenditure forecast by the Federal Ministry of Health and the Federal Office for Social Security from the autumn of 2019. The financial experts of statutory health insurance had expected expenditure to rise by 4.6 %, to 258.6 billion Euro. With allocations from the Health Fund to the health insurance funds amounting to around 240.2 billion Euro, the shortfall in the coverage of fund-relevant expenditure in 2020 was therefore around 17.1 billion Euro. The additional contribution rates actually levied to fund this shortfall in 2020 varied between 0.2 % and 2.7 %, bearing in mind the average additional contribution rate of 1.1 % set ex ante by the Federal Ministry of Health. One health insurance fund was able to forego levying an additional contribution in 2020.

The financial forecast for 2021

The appraisers unanimously anticipated in the autumn of 2020 a further 2.4 % increase in income subject to contributions, to reach 1,523.2 billion Euro for 2021. They estimate that income from contributions will be approx. 223.7 billion Euro on this basis, plus contributions from marginal employment amounting to approx. 3.0 billion Euro. Furthermore, the health insurance funds will receive 900 million Euro from the reserve of the Fund for the calendar year 2021 to partially compensate for the shortfall in revenue as a result of the allowance on company pensions introduced on 1 January 2020. In addition to the contribution from the Federation for the non-insurance expenditure of the statutory health insurance funds (14.5 billion Euro), the Federation will pay a supplementary federal subsidy of 5 billion Euro in 2021 in order to stabilise the

Revenue and expenditure forecast for 2021
in billion Euro (figures rounded)



* appraisal by: Association of Statutory Health Insurance Funds
** additional contribution

Source: Federal Office for Social Security, statutory health insurance appraisers;
Illustration: National Association of Statutory Health Insurance Funds

additional contribution rate level, and at the same time to secure the Social Guarantee pledged by the Federal Government for the year 2021[2]. Furthermore, the mandatory transfer payments of around 8 billion Euro payable by the wealthier health insurance funds accrue to the revenue of the Health Fund. This results in a total allocation volume of approximately 255 billion Euro. This record amount, which includes one-off transfers from the federal budget and from the assets of the health insurance funds amounting to 13 billion Euro, is pledged to the health insurance funds as the allocation sum for 2021.

Based on the expenditure estimate for 2020, the statutory health insurance appraisers were also unable to provide a unanimous expenditure forecast for 2021. The Federal Ministry of Health and the Federal Office for Social Security estimated the anticipated Fund-relevant expenditure of the health insurance funds for 2021 at 274.9 billion Euro, and the National Association of Statutory Health Insurance Funds at 276.6 billion Euro. This corresponds to an increase of 6.6 % (Federal Ministry of Health/Federal Office for Social Security) vs. 6.9 % (National Association of Statutory Health Insurance Funds) compared to the previous year. The estimate includes the anticipated financial impact of the COVID-19 legislation, and of other laws that were passed. No reduction in service provision as a result of further waves of infections was however expected.

This resulted in a projected shortfall in expenditure coverage of roughly 19.9 billion Euro (Federal Ministry of Health/Federal Office for Social Security), vs. roughly 21.6 billion Euro (National Association of Statutory Health Insurance Funds), respectively, for the health insurance funds in 2021. On the basis of the estimates of the Federal Ministry of Health/Federal Office for Social Security, the Federal Ministry of Health raised the average calculated additional contribution rate from 1.1 % to 1.3 % in October 2020.

Outlook for 2022

The question of how to finance statutory health insurance in 2022 must be right at the top of the agenda. The additional contribution rate to health insurance can only be maintained at 1.3 % in 2021 with the assistance of additional federal funding and the drastic, one-off withdrawal from the reserves of the health insurance funds. Although the revenue base will rise again due to the foreseeable economic recovery, it will certainly not make up for the negative basis-related effect caused in 2020 and 2021. It is obvious that the additional contribution rate will rise dramatically next year if there is no assurance of supplementary federal funding for 2022. The Administrative Council of the National Association of Statutory Health Insurance Funds was astonished and very concerned to note at its meeting in March that the Federal Government had not included any additional budgetary funds in its key figures for the 2022 federal budget in order to stabilise the additional contribution rate. This however simply ignores the fact that statutory health insurance alone is expected to require additional funding of 18 billion Euro in the coming year. In order to avert the risk of a doubling of additional contributions, it is however crucial for additional funds to be guaranteed by law when the appraisers make their forecast in October 2021. This is the only way that the appraisers can take such funds into account, and the health insurance funds can calculate correspondingly lower contribution rates.

The additional contribution rate will rise dramatically next year if health insurance does not receive any supplementary federal funding for 2022.

1 The presentation of the financial situation of statutory health insurance in 2020 is based on the preliminary financial results of 9 March 2021 (Federal Ministry of Health, KV45, total year 2020), and on the results of the autumn forecast of the statutory health insurance appraisers of 13 October 2020 with regard to the forecast for 2021.

2 According to the Federal Government's "Social Guarantee 2021", the contribution rates to social insurance financed on a parity basis are not to rise above 40 % in total. The contribution rates for pension, unemployment, health and long-term care insurance added up to 39.95 % as per 1 January 2021, taking into account the average additional contribution rate of the health insurance funds of 1.3 %.

Financial assistance provided by statutory health insurance to healthcare providers

The legislature has been able to rely on well-functioning statutory health insurance in the coronavirus pandemic. It set up rescue packages in 2020 for specific healthcare providers who suffered severe financial burdens as a result of the loss of revenue caused by the extensive contact restrictions. These were intended to help maintain established care structures for patients in the long term. A large part of this financial assistance was made available through statutory health insurance's Health Fund that is maintained by the Federal Office for Social Security and financed from the liquidity reserve.

Funds disbursed by the Federal Office for Social Security for 2020 related to the pandemic

Purpose/recipients of the disbursement	**Amount in million Euro**
Compensation payments for hospitals in accordance with section 21 subsection (4) of the Hospitals Act (loss of revenue)	9,410
Compensation payments for hospitals in accordance with section 21 subsection (5) of the Hospitals Act (ensuring availability of additional intensive care beds)	701
Compensation payments for preventive care and rehabilitation facilities in accordance with section 111d of Book V of the Social Code (loss of revenue)	335
Compensation payments for remedy suppliers in accordance with section 2 of the COVID-19 Care Structures Protection Ordinance (COVID-19 VSt-SchutzV)	814
Subsidy amounts for social service providers in accordance with section 9 of the Social Services Provider Deployment Act (SodEG) (interdisciplinary early intervention centres, social paediatric centres)	7
Expenditure for testing for coronavirus SARS-CoV-2 in accordance with section 20i subsection (3), second sentence, of Book V of the Social Code/Testing Ordinance (TestV) (asymptomatic tests)	286
Compensation payments for preventive care and rehabilitation facilities in accordance with section 111d of Book V of the Social Code – compensation period from 18 November 2020 onwards	38
Expenditure on protective masks in accordance with section 20i subsection (3), second sentence, No. 1 (c) of Book V of the Social Code/Protective Masks Ordinance (SchutzmV)	491
Other expenditure related to the coronavirus pandemic (Covid bonuses in accordance with section 26a of the Hospitals Act)	93
Total	**12,175**
Of which reimbursed by the Federation (marked in blue)	9,940
Burden on the Health Fund	**2,235**

Source: Federal Office for Social Security, figures rounded
Illustration: National Association of Statutory Health Insurance Funds

Federation reimburses most of the payments, statutory health insurance continues to shoulder burdens

According to the preliminary financial results of the statutory health insurance funds, a total of approximately 12.2 billion Euro was disbursed from the liquidity reserve of the Health Fund for financial assistance provided in the context of the pandemic in 2020. The financial assistance was channelled to hospitals, preventive care and rehabilitation facilities, remedy suppliers and social service providers. Payments from the Health Fund were also made for Covid testing, vaccinations, protective masks and Covid bonuses for care staff. The Federation reimbursed approximately 10 billion Euro of this amount to the Health Fund, including in particular the compensatory payments made to hospitals in the amount of 9.4 billion Euro. The remaining burden on the Health Fund thus amounted to approximately 2.2 billion Euro.

Referring to the additional pandemic-related expenses to be covered by the Health Fund, the Federation provided a supplementary federal subsidy in the amount of 3.5 billion Euro in July 2020. This lump sum was intended at the same time to compensate for the reduction in contributions resulting from the pandemic. The National Association of Statutory Health Insurance Funds estimates these at roughly 3 billion Euro. Together with the additional expenditure, the total pandemic-related burden on the Health Fund amounts to approximately 5.2 billion Euro. This resulted in the Health Fund being burdened with approximately 1.7 billion Euro in 2020, once the supplementary federal funds had been deducted.

New arrangements for competition between the health insurance funds

A central provision of competition law was introduced in Book V of the Social Code in accordance with the Act for Fair Competition in Statutory Health Insurance (*Gesetz für einen fairen Kassenwettbewerb in der gesetzlichen Krankenversicherung* - GKV-FKG). One aim of the new provision is to create greater legal certainty for the health insurance funds and their supervisory authorities in competition.

The new provisions not only define the requirements for the advertising in which a health insurance fund is permitted to engage, but also regulate the entire competitive behaviour. The health insurance funds can use this as a basis to demand from one another to cease and refrain from all non-permissible measures that impair their interests in competition. This has considerably expanded the health insurance funds' scope for action.

The Act empowers the Federal Ministry of Health to regulate details regarding the permissibility of advertising measures by way of a legal ordinance. The Ministry may delegate this power to the Federal Office for Social Security.

The first step towards separate provisions of competition law in Book V of the Social Code

Competition between health insurance funds was previously regulated primarily by case-law and by the practice of the supervisory authorities. The case-law of the social courts developed the behavioural measures for competition from the requirement of cooperation, as well as from the duties incumbent on the health insurance funds to inform and advise. The supervisory authorities had also issued general, uniform competition principles. In addition to the lack of direct legally-binding force of these competition principles, the enforcement and the punishment of (avoidable) anti-competitive practices were not always uniform in the practice of the supervisory authorities. This enabled potential distortions of competition.

The National Association of Statutory Health Insurance Funds has been calling for quite some time for separate provisions of competition law for the health insurance funds. The indiscriminate adoption of civil competition law does not do justice to the health insurance funds' care mandate. For this reason, the National Association of Statutory Health Insurance Funds welcomes the fact that the competition framework for health insurance funds is regulated in Book V of the Social Code. Competition between health insurance funds, which is expressly intended by the legislature, will thus be placed on a uniform legal foundation. The Federal Ministry of Health intends to make use of its power to issue a legal ordinance. A draft ordinance has been prepared. The ministerial procedure has however not yet been completed.

The new provisions regulate the entire competitive behaviour of the health insurance funds.

border(s), noun
(connecting line between countries,
suddenly becoming a wall)

Arguments in favour of a common EU Health Data Space

One of the priorities for the German EU Presidency was to tap the potential of digitalisation in the health sector across Europe. Data protection-compliant access to and exchange of health data within the European Union (EU) should be improved. A future common Health Data Space can create new opportunities for research, diagnosis and therapy.

Exploring potentials

The National Association of Statutory Health Insurance Funds contributed to the associated programme of the German EU Council Presidency with an online conference entitled "Big data, big deeds? Towards data-driven European healthcare systems", held on 28 September 2020. The potential for cooperation in Europe in terms of cross-border use of data to optimise healthcare and healthcare systems was explored, together with representatives of the World Health Organization, the European Commission, the Federal Ministry of Health and the Standing Committee of European Doctors. The National Association of Statutory Health Insurance Funds paid particular attention to the role of the EU and to the potential contribution of health insurance systems in Europe.

Advancing research

The National Association of Statutory Health Insurance Funds supports the EU's goal of jointly tackling Europe-wide challenges through research on healthcare systems and care, and of pooling efforts at European level. New opportunities for cooperation are arising, particularly in the context of digitalisation in the healthcare system. According to the assessment of the National Association of Statutory Health Insurance Funds, there is considerable potential for European cooperation in the generation, use and evaluation of data on rare diseases, but also on widespread diseases such as cancer and dementia, and on infectious diseases.

In particular, the data transmitted to the German Research Data Centre could also be made available across borders. The necessary legal

and technical foundations should be provided to enable the cross-border exchange or sharing of treatment data, billing data and other stocks of data generated in the healthcare systems through research data infrastructures.

Creating a European Health Data Space

The National Association of Statutory Health Insurance Funds welcomes the European Commission's plans to create a framework for a European Health Data Space. This Data Space is intended to improve the accessibility, usability and interoperability of data, whilst at the same time reducing the costs of data transactions. The National Association of Statutory Health Insurance Funds advocates for the creation of a uniform legal framework that provides for publicly-available data to be exchanged between Member States. The careful handling of sensitive data, as well as the transparency and traceability of its use, should be clearly regulated, as was the case with regard to the uniform application of the General Data Protection Regulation.

There is considerable potential for European cooperation in the generation, use and evaluation of data on rare diseases, but also on cancer and dementia, and on infectious diseases.

The National Association of Statutory Health Insurance Funds considers that European structures for data sharing should be established. The competent authorities in the Member States and the social security institutions should be fully involved in the exchange of best practices, in setting standards, as well as in drawing up priorities and conditions as to how data are used. Statutory health insurance should not only be seen as a data provider, but rather as a key stakeholder in a European Health Data Space. It must be able to draw amongst other things on data analyses in order to fulfil its key task, i.e. designing care

in such a way that it satisfies demand, is benefit orientated, meets high quality standards, and is sustainably financeable.

Joining forces in the fight against fraud and corruption

In view of increasing cross-border connections in health and long-term care, it is necessary to develop a common European definition of cross-border misconduct in the healthcare system. Using and analysing data across Europe can help detect and prevent misconduct in the future, and fill the currently still large knowledge gap as to the actual number of cases of cross-border fraud in the healthcare system.

Statutory health insurance should not only be seen as a data provider, but rather as a key stakeholder in a European Health Data Space.

Social security after Brexit

The United Kingdom left the European Union (EU) with effect from 31 January 2020. The withdrawal agreement concluded between the two partners contains the terms of the separation, regulations for a transition period, as well as for the protection of the status quo and of legitimate expectations.

The Regulations on the coordination of the social security systems continued to apply without restrictions to cases relating to the United Kingdom until the transition period ran out on 31 December 2020. The Withdrawal Agreement provides from 2021 onwards for special protection for individuals who already had a cross-border connection with the United Kingdom and the EU Member States beforehand. The previous provisions will continue to apply in full to these persons for all branches of social insurance.

Future relationship

The Trade and Cooperation Agreement negotiated between Brussels and London will apply to new cases from 2021 onwards where there is no prior cross-border connection. The negotiations on this lasted until shortly before the end of the year. The Agreement was initially applied on a provisional basis until it was finally ratified at the end of April 2021. It contains provisions for the coordination of the social security systems which are largely identical to the previous ones. For example, people insured in Germany can continue to receive treatment in the United Kingdom via the European Health Insurance Card (EHIC). UK citizens who are covered by the National Health Service can also continue to receive healthcare services in the EU via the EHIC. That said, unemployment, family and long-term care benefits are not within the scope of the agreement. Long-term care allowance for persons insured in Germany can therefore only be claimed in the United Kingdom for a maximum of six weeks.

The National Association of Statutory Health Insurance Funds, German Liaison Agency Health Insurance - International (DVKA), has created and continuously updates an online guideline to make it easier for health insurance funds to assess cases of this type. Relevant information for insured persons, employers and healthcare providers is also available on the DVKA's website.

People insured in Germany can continue to receive treatment in the United Kingdom via the European Health Insurance Card.

Contractual relations with the United Kingdom

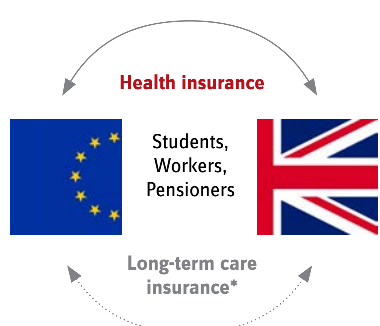
Withdrawal as per 31 January 2020

1 February 2020
Withdrawal agreement

The European social protection rules continue to apply in full during a transitional period until 31 December 2020 under the withdrawal agreement concluded between the EU and the United Kingdom.

1 January 2021
Trade and Cooperation Agreement*

The Cooperation Agreement regulates the coordination of social security systems on a permanent basis. Insured persons can continue to be treated in the United Kingdom in the event of illness. The agreement does not make any provisions for the coordination of services provided to persons in need of long-term care. Long-term care benefits can however be transferred to the United Kingdom for up to six weeks under German law.



* Long-term care benefits not covered by the Agreement: Long-term care benefits can be drawn in the UK for a maximum of 6 weeks

Illustration: National Association of Statutory Health Insurance Funds

Challenges for health policy in Europe

The National Association of Statutory Health Insurance Funds engages in and helps to shape important processes at EU level with statements and consultation contributions. As a leading insurance institution of the German Social Insurance European Representation and of the European Social Insurance Platform (ESIP), it contributes the positions of statutory health and long-term care insurance, and provides important stimuli for shaping European health policy.

The future of the supply of medicinal products

The coronavirus pandemic has highlighted a number of areas where action is needed in the EU, such as:

- preventing supply shortages of medicinal products
- securing supply chains
- avoiding dependence on third parties in the production of active ingredients

Structural problems on the global medicinal products market must be resolved in order to ensure supply security for patients in Europe.

The German Social Insurance European Representation posed the following question at the event that it organised within the framework of the German EU Council Presidency: "Medicinal products for future generations - more supply security through strategic independence". With the participation of the National Association of Statutory Health Insurance Funds, representatives of the European Parliament and the European Commission discussed the priorities in dealing with the pandemic and the role of the EU in the supply of medicinal products. The National Association of Statutory Health Insurance Funds considers the most urgent common challenges to be posed by the distribution of vaccines, medicinal products and protective equipment. The EU must help improve supply security in medicinal products. This can be achieved through better coordination and greater transparency, for example with regard to production problems and backup capacities.

The EU shares responsibility for ensuring an affordable supply of medicinal products at a high quality level for patients.

Pharmaceutical Strategy for Europe

The European Commission presented a Pharmaceutical Strategy at the end of 2020 which is intended to ensure that there is a sufficient supply of safe and affordable medicinal products in Europe to meet demand. The focus is on strategic independence from other regions of the world, and on -economically- and ecologically- - sustainable production conditions. The European Commission also focuses on the financial stability of the healthcare systems. Parts of the strategy include the revision of the legislation on medicinal products for rare diseases and paediatric medicinal products, as well as the further development of the European Medicines Agency (EMA). An action plan on supply shortages, as well as initiatives

The social insurers' platform: Working together to achieve more for insured persons

- ESIP is the voice of the social insurance bodies in Europe. It represents roughly 50 organisations from 18 EU States and Switzerland. Ilka Wölfle has headed the Platform as its President since 2019. The National Association of Statutory Health Insurance Funds has headed the Health Committee for more than six years.
- The ESIP is committed to ensuring that medicinal products remain affordable. In addition to evaluating health technologies, last year's focus was on securing the supply of medicinal products. Against the background of the coronavirus pandemic, ESIP's members also exchanged views on how to tackle the challenges in the Member States.

within the framework of fund programmes, are to complement the reforms.

German Social Insurance and the ESIP had already contributed their own positions to the debate on the new Pharmaceutical Strategy in the preliminary stages, and discussed them with the EU Commissioner for Health, Stella Kyriakides, and others. The National Association of Statutory Health Insurance Funds attaches importance not only to securing the supply of medicinal products through diversified production and supply chains, but also to greater transparency. Mandatory Europe-wide reporting of supply shortages and their causes would make it possible to compensate for bottlenecks in the short term and to take targeted measures in the longer term. The EU shares responsibility for ensuring an affordable supply of medicinal products at a high quality level for patients. This is a challenge facing all of Europe in view of high medicinal product prices.

The potential offered by Artificial Intelligence

The European Commission published a White Paper on Artificial Intelligence (AI) in February 2020, in which it presented its proposals for the safe and responsible use of AI, putting them up for discussion. In its statement, German Social Insurance emphasised the major potential for improving healthcare and health systems that lies in using AI, and in particular in cooperation within Europe.

AI applications must not lead to new forms of discrimination.

AI entails not only opportunities, but also risks. AI applications must work transparently, and responsibility for decisions, for instance with regard to social insurance benefits, must continue to rest with the decision-makers. Moreover, they must not lead to new forms of discrimination.

mask(s), noun
(filtered air doesn‘t clear the air for
everyone)

Electronic exchange of data in European social insurance

The Electronic Exchange of Social Security Information (EESSI) is intended to improve, speed up and simplify the international electronic exchange of social security data in Europe. The EU Member States have created corresponding infrastructures, and have largely put business processes into operation since 2019. The National Association of Statutory Health Insurance Funds, German Liaison Agency Health Insurance – International (DVKA) has set up the national access point for statutory health insurance in Germany, and operates it. Even though not all Member States are using the electronic procedures yet, the volume of messages transmitted has increased significantly.

Expanding the A1 electronic application procedure

If companies in Germany deploy employees in other European countries and the German legislation is to continue to be applied, this must be proven with an "A1 certificate". More than 90 % of A1 certificates are issued by the health insurance funds or by the National Association of Statutory Health Insurance Funds, DVKA. Health insurance funds have been sending A1 certificates for posted workers to the applicants exclusively in electronic form since 2019. This simplifies processes for all parties involved, and shortens response times.

The National Association of Statutory Health Insurance Funds, DVKA, initiated further digitalisation measures in 2020. Employers who habitually employ persons who reside in Germany in several Member States will also be able to apply for the A1 certificate electronically in future. This was already previously the case when applying for exemption agreements. Applications will be made and the A1 certificate will be transmitted electronically in both cases from the beginning of 2021 onwards.

Impact of the coronavirus pandemic

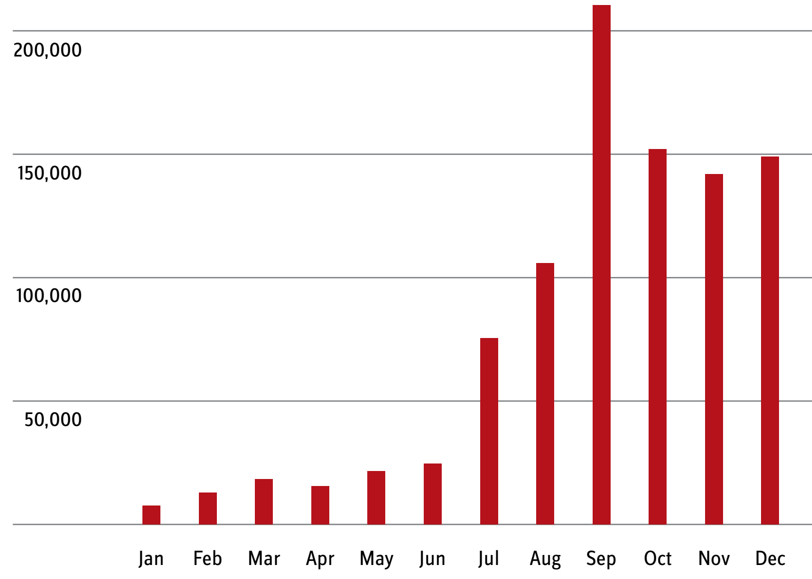
The coronavirus pandemic posed new challenges for social insurance with regard to the regulation of cross-border employment and medical care in other EU States. The National Association of Statutory Health Insurance Funds, DVKA, brought about or was involved in various special and basic agreements at EU and bilateral level for employers, workers, insured persons, statutory health and long-term care funds, and healthcare providers:

a) Cross-border employment

Remote working has taken on huge significance in the coronavirus pandemic, and helps counteract the spread of COVID-19. In order to reduce potential obstacles, the Member States have agreed on general principles for the legal framework for social insurance. There are no changes with regard to the applicable social insurance law for persons who temporarily work from home, either all the time or partly, for up to 24 months within the Member States. The National Association of Statutory Health Insurance Funds, DVKA, has published a corresponding recom-

Employers who habitually employ persons who reside in Germany in several Member States will also be able to apply for the A1 certificate electronically in future.

Number of EESSI messages relating to statutory health insurance exchanged with other EU Member States in 2020



Version: 31 December 2020
Source and illustration: National Association of Statutory Health Insurance Funds

mendation to the member funds, and this is also available on its homepage.

b) Receiving benefits in other EU States

The Member States have made arrangements to ensure that insured persons can continue to receive treatment in other EU States, e.g. via their European Health Insurance Cards, despite the coronavirus pandemic. The National Association of Statutory Health Insurance Funds has been involved here on a topic-specific basis. Member States in which treatment capacities were or are exhausted due to the coronavirus pandemic have concluded agreements with the Federation or with the Länder on medical care for their patients in Germany. According to a provision that was introduced for this special situation, the Federation meets the costs of the corresponding treatments for a fixed period of time. The costs are settled via the National Association of Statutory Health Insurance Funds, DVKA.

The Member States have made arrangements to ensure that insured persons can continue to receive treatment in other EU States, despite the coronavirus pandemic.

c) Settlement of claims

The coronavirus pandemic has adversely affected health insurance providers and liaison bodies in some EU Member States when it comes to settling claims. This has led to a risk of it being impossible to meet applicable deadlines, especially for the settlement or contestation of claims. The National Association of Statutory Health Insurance Funds, DVKA, has successfully lobbied at EU level for a uniform extension of the deadlines for a limited period of time. This will enable the institutions involved to submit cases on time.

Aha! moment, noun
(the point in time when the penny drops for everyone)

Communication during the coronavirus pandemic

Around the turn of the year 2019/2020, the Association was still taking up positions via interviews that were held with all three Board members on the major health and long-term care policy topics to be anticipated for 2020. The communication year continued as normal, with a joint press conference being held with the Medical Service at the end of February on the new personnel allocation instrument in long-term care, despite the fact that infections had already reached German and European shores. But then, only one day later on 26 February 2020, the Federal Ministry of Health made the first mention of a beginning pandemic. This caused the press office of the National Association of Statutory Health Insurance Funds to evolve from being a health policy all-rounder for the more health-policy-orientated media, to a general information point on COVID for journalists who had had no previous dealings with the healthcare system up to that point in time. This triggered a huge need for information, as the entire media community had to start reporting on COVID more or less overnight.

Our most important message from day one of the pandemic onwards was that statutory health and social long-term care insurance would finance everything that is necessary in medical terms and in terms of care, and that it would keep the supply structures stable.

A particular challenge here was to repeatedly explain and point out which measures and activities in the fight against the pandemic belong to the State's tasks in order to protect the population, and which belong to the tasks of statutory health insurance. The question was often raised as to which services were to be financed by the Federation, and which out of the funds input by contributors. The most important message of the National Association of Statutory Health Insurance Funds from day one onwards was that statutory health and social long-term care insurance would finance everything that is necessary in medical terms and in terms of care, and that it would keep the supply structures stable.

Expanding the members' portal ("GKV-Dialog")

Despite the huge demand for information among the public, it has been possible to further develop the internal communication tool. "GKV-Dialog" (statutory health insurance dialogue), the members' portal of the National Association of Statutory Health Insurance Funds, which has been in operation for ten years, underwent its second relaunch after the first one in 2015. The circulars as the central information medium of the Association for its members, and approx. 80 group rooms - the centrepiece of GKV-Dialog - were brought more consistently into focus, and the group rooms were equipped with additional new functions and made more intuitive still. The overhauled members' portal went live in December.

The modRNA sequence of BioNTech/Pfizer's vaccine is 4,284 nucleotides long

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research, noun
(the response to the virus on a single page)

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

The annual financial statement for 2019

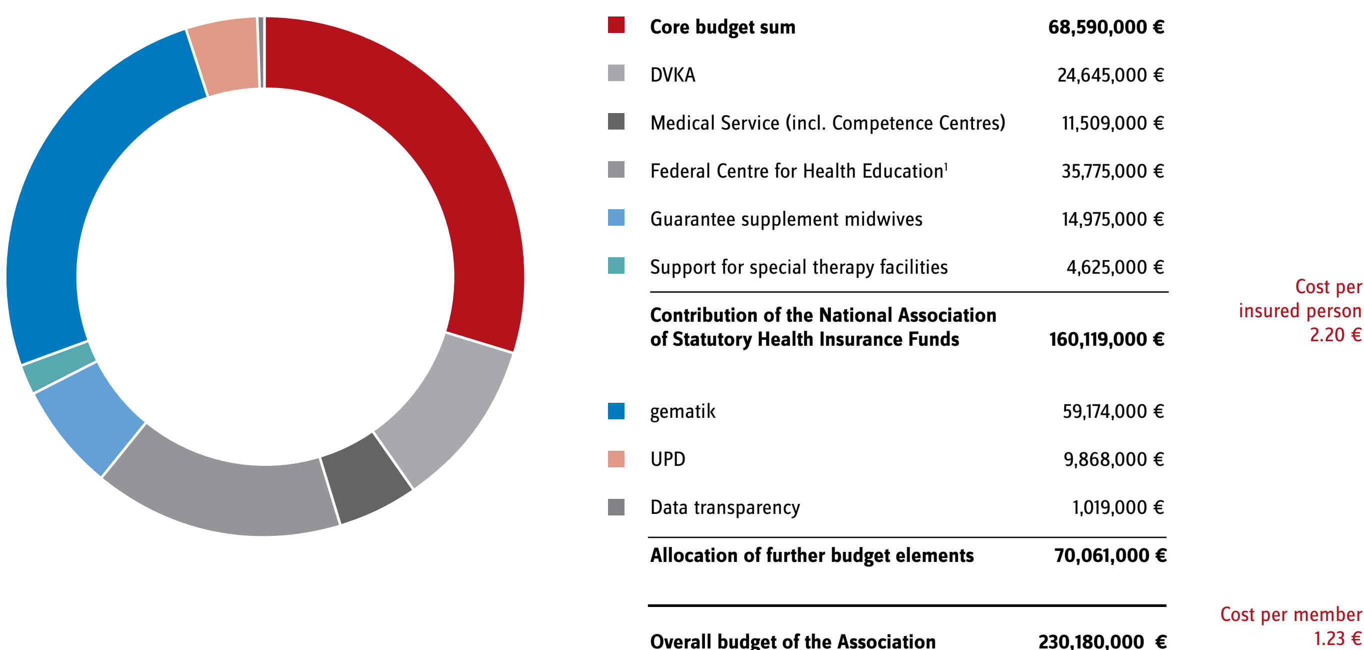
The annual financial statement of the National Association of Statutory Health Insurance Funds for 2019 was drawn up in April 2020. The audit, including the departmental budget of the German Liaison Agency Health Insurance – International (DVKA), was carried out by the KPMG AG firm of auditors. The "transposition of the General Data Protection Regulation" was also audited. KPMG issued an unqualified audit report. At its session that was held on 17 June 2020, the Administrative Council thereupon approved the activities of the Board, and approved the 2019 annual financial statement.

The Association's budget for 2020

The 2020 budget plan of the National Association of Statutory Health Insurance Funds shows an overall budget of 230.1 million Euro. This includes the contribution towards the core budget of the National Association of Statutory Health Insurance Funds, as well as the following pay-as-you-go financing arrangements:

- DVKA departmental budget
- the Medical Service of the National Association of Statutory Health Insurance Funds (MDS)
- the Federal Centre for Health Education (BZgA) in accordance with section 20a of Book V of the Social Code
- the guarantee supplement for midwives in accordance with section 134a subsection (1b) of Book V of the Social Code
- the promotion of special therapy facilities in accordance with section 65d of Book V of the Social Code
- gematik GmbH
- the promotion of facilities for consumer and patient advice (UPD) in accordance with section 65b of Book V of the Social Code
- data transparency in accordance with sections 303a to 303f of Book V of the Social Code.

Components of the Association's total budget for 2020



Core budget sum	**68,590,000 €**	
DVKA	24,645,000 €	
Medical Service (incl. Competence Centres)	11,509,000 €	
Federal Centre for Health Education[1]	35,775,000 €	
Guarantee supplement midwives	14,975,000 €	
Support for special therapy facilities	4,625,000 €	
Contribution of the National Association of Statutory Health Insurance Funds	**160,119,000 €**	Cost per insured person 2.20 €
gematik	59,174,000 €	
UPD	9,868,000 €	
Data transparency	1,019,000 €	
Allocation of further budget elements	**70,061,000 €**	
Overall budget of the Association	**230,180,000 €**	Cost per member 1.23 €

1 The Act on the Protection of the Population in the Event of an Epidemic Situation of National Significance (*Gesetz zum Schutz der Bevölkerung bei einer epidemischen Lage von nationaler Tragweite*) of 19 May 2020 provides for the suspension of the application of the statutory orientation and minimum expenditure values for disease prevention and health promotion services provided by the statutory health and long-term care funds in 2020. This also includes the suspension of the lump-sum remuneration for the services provided by the Federal Centre for Health Education (BZgA) in accordance with section 20a subsection (3) of Book V of the Social Code for 2020 (cf. Art. 4 No. 2 of the abovementioned Act) in the total amount of 35,775,000.00 Euro. In this context, the pay-as-you-go contributions for the Federal Centre for Health Education already paid by the member funds in 2020 were repaid on 22 June 2020.

Illustration: National Association of Statutory Health Insurance Funds

The budget for 2021

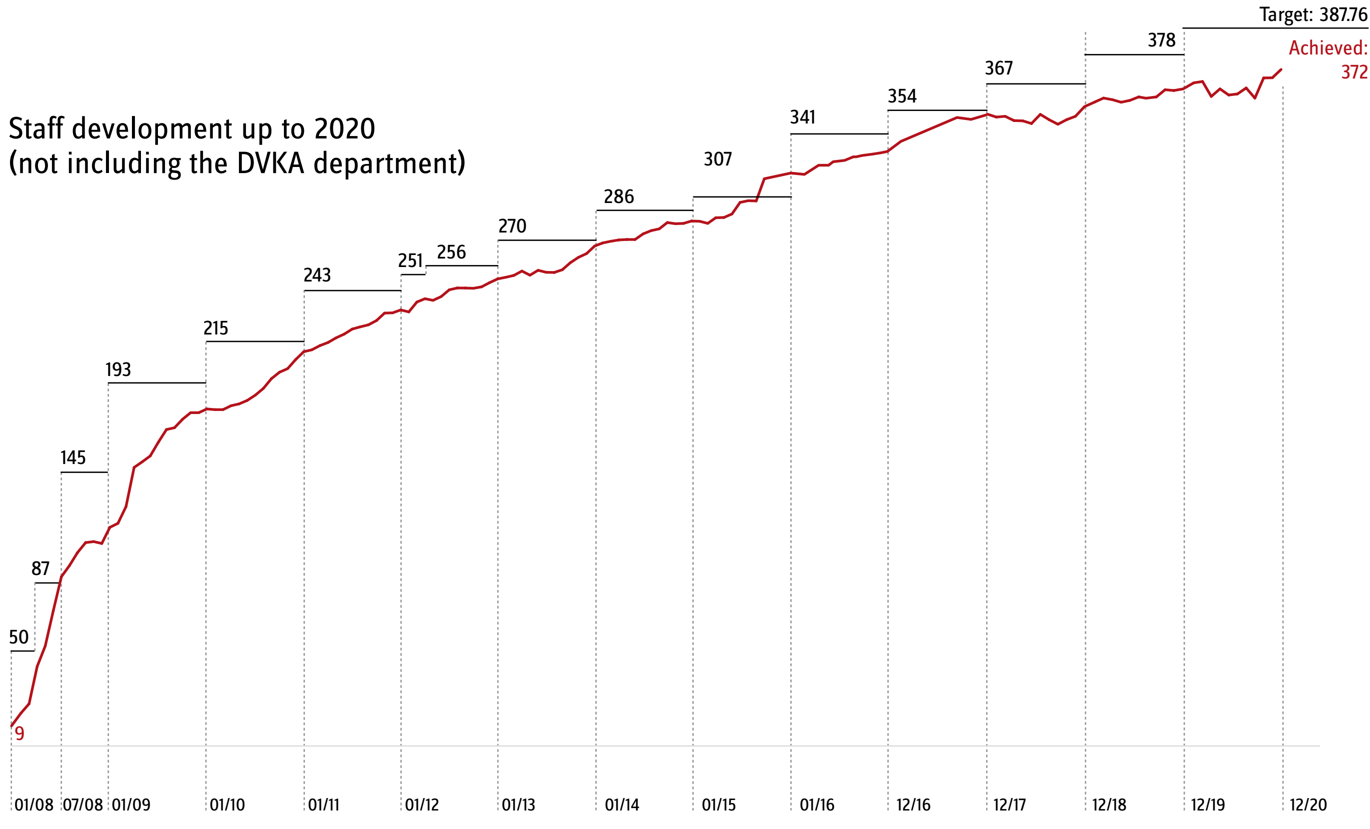
The budget plan for 2021 that was drawn up by the Board on 13 November 2020 was unanimously adopted by the Administrative Council on 8 January 2021 in a written resolution procedure, and approved by the Federal Ministry of Health, as the supervisory authority of the National Association of Statutory Health Insurance Funds, on 15 January 2021. The Association's overall budget was set at 282.4 million Euro. It hence rose by 52.3 million Euro year-on-year. This is partly a result of the higher pay-as-you-go arrangement to fund gematik, the MDS, the guarantee supplement for midwives, data transparency and the lump-sum payment for services provided by the Federal Centre for Health Education (BZgA), as well as of the higher contributions towards the core budget of the National Association of Statutory Health Insurance Funds (especially due to new or changed statutory tasks).

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

The staff budget for 2020 totalled 510.62 established posts. 387.76 target posts were accounted for by the Berlin location, and 122.86 target posts by the DVKA.

488.52 posts were occupied on 1 December 2020, 371.92 of which at the Berlin location and 116.61 at the DVKA. The occupancy rate was 95.7 % for the Association as a whole. The occupancy rate at the Berlin location is 95.9 %, and 95.0 % at the DVKA.

Staff development up to 2020
(not including the DVKA department)



Source and illustration: National Association of Statutory Health Insurance Funds

The members of the National Association of Statutory Health Insurance Funds in 2020

1. AOK – Die Gesundheitskasse für Niedersachsen
2. AOK – Die Gesundheitskasse in Hessen
3. AOK Baden-Württemberg
4. AOK Bayern – Die Gesundheitskasse
5. AOK Bremen/Bremerhaven
6. AOK Nordost – Die Gesundheitskasse
7. AOK NORDWEST – Die Gesundheitskasse
8. AOK PLUS – Die Gesundheitskasse für Sachsen und Thüringen
9. AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
10. AOK Rheinland/Hamburg – Die Gesundheitskasse
11. AOK Sachsen-Anhalt – Die Gesundheitskasse
12. Audi BKK
13. BAHN-BKK
14. BARMER
15. Bertelsmann BKK
16. Betriebskrankenkasse Mobil Oil
17. Betriebskrankenkasse PricewaterhouseCoopers
18. BIG direkt gesund
19. BKK Achenbach Buschhütten
20. BKK Akzo Nobel Bayern
21. BKK B. Braun Aesculap
22. BKK BPW Bergische Achsen KG
23. BKK Deutsche Bank AG
24. BKK Diakonie
25. BKK EUREGIO
26. BKK EVM
27. BKK EWE
28. BKK exklusiv
29. BKK Faber-Castell & Partner
30. BKK firmus
31. BKK Freudenberg
32. BKK GILDEMEISTER SEIDENSTICKER
33. BKK GRILLO-WERKE AG
34. BKK Groz-Beckert
35. BKK Herford Minden Ravensberg
36. BKK Herkules
37. BKK KARL MAYER
38. BKK Linde
39. BKK MAHLE
40. BKK Melitta Plus
41. BKK Miele
42. BKK MTU
43. BKK PFAFF
44. BKK Pfalz
45. BKK ProVita
46. BKK Public
47. BKK Rieker.RICOSTA.Weisser
48. BKK RWE
49. BKK Salzgitter
50. BKK Scheufelen
51. BKK Schwarzwald-Baar-Heuberg
52. BKK STADT AUGSBURG
53. BKK Technoform
54. BKK Textilgruppe Hof
55. BKK VDN
56. BKK VerbundPlus
57. BKK Verkehrsbau Union (BKK VBU)
58. BKK Voralb HELLER*INDEX*LEUZE
59. BKK Werra-Meissner
60. BKK Wirtschaft & Finanzen
61. BKK Würth
62. BKK ZF & Partner
63. BKK_DürkoppAdler
64. BKK24
65. BMW BKK
66. Bosch BKK
67. Continentale Betriebskrankenkasse
68. Daimler Betriebskrankenkasse
69. DAK-Gesundheit
70. Debeka BKK
71. DIE BERGISCHE KRANKENKASSE
72. energie-Betriebskrankenkasse
73. Ernst & Young BKK
74. HEK – Hanseatische Krankenkasse
75. Heimat Krankenkasse
76. Handelskrankenkasse (hkk)
77. IKK Brandenburg und Berlin
78. IKK classic
79. IKK gesund plus
80. IKK Nord
81. IKK Südwest
82. Kaufmännische Krankenkasse – KKH
83. KNAPPSCHAFT
84. Koenig & Bauer BKK
85. Krones BKK
86. Merck BKK
87. mhplus Betriebskrankenkasse

88. Novitas BKK
89. pronova BKK
90. R+V Betriebskrankenkasse
91. Salus BKK
92. SECURVITA BKK
93. SIEMAG BKK
94. Siemens-Betriebskrankenkasse (SBK)
95. SKD BKK
96. Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
97. Südzucker BKK
98. Techniker Krankenkasse
99. TUI BKK
100. VIACTIV Krankenkasse
101. vivida bkk
102. Wieland BKK
103. WMF Betriebskrankenkasse

cut-off date: 1 January 2021

Mergers

Merged fund	Merger partners
vivida bkk (renaming of Schwenninger BKK)	Schwenninger BKK atlas BKK ahlmann
BIG direkt gesund	BIG direkt gesund actimonda BKK

cut-off date: 1 January 2021

Ordinary members of the Administrative Council in the 3rd period of office (2018–2023)

Representatives of insured persons

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

Representatives of the employers

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

cut-off date: 2 December 2020

Deputy members of the Administrative Council in the 3rd period of office (2018–2023)

Representatives of insured persons

Name	Health insurance fund
Adrian, Quentin Carl	Techniker Krankenkasse
Aichberger, Helmut	DAK-Gesundheit
Baer, Detlef	IKK Brandenburg und Berlin
Balzer-Wehr, Dr. Alexandra	Kaufmännische Krankenkasse – KKH
Berger, Silvia	IKK Südwest
Böntgen, Rolf-Dieter	DIE BERGISCHE KRANKENKASSE
Böse, Annemarie	DAK-Gesundheit
Brück, Peter	Kaufmännische Krankenkasse – KKH
Coors, Jürgen	Daimler Betriebskrankenkasse
de Win, Thomas	pronova BKK
Dehde, Klaus-Peter	BARMER
Dorneau, Hans Jürgen	BAHN-BKK
Düring, Annette	AOK Bremen/Bremerhaven
Frackmann, Udo	Techniker Krankenkasse
Fritz, Anke	Kaufmännische Krankenkasse – KKH
Fritsch, Herbert	BARMER
Funke, Wolfgang	BARMER
Gosewinkel, Friedrich	Techniker Krankenkasse
Grellmann, Norbert	IKK classic
Hauffe, Ulrike	BARMER
Hindersmann, Nils	KNAPPSCHAFT
Hippel, Gerhard	DAK-Gesundheit
Huppertz, Claudia	BAHN-BKK
Johannides, Meinhard	DAK-Gesundheit
Karp, Jens	IKK Nord
Klemens, Luise	DAK-Gesundheit
Korschinsky, Ralf	BARMER
Krause, Helmut	BIG direkt gesund
Kuklenski, Mirko	AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
Lohre, Karl Werner	BARMER
Löwenstein, Katrin von	BARMER
Mohr, Hans-Dieter	AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
Nimz, Torsten	Handelskrankenkasse (hkk)
Plaumann, Karl-Heinz	BARMER
Roloff, Sebastian	DAK-Gesundheit
Schmidt, Günther	BARMER
Schönewolf, André	AOK – Die Gesundheitskasse in Hessen
Scholz, Jendrik	IKK classic
Schorsch-Brandt, Dagmar	AOK Baden-Württemberg
Schümann, Heinrich Joachim	HEK – Hanseatische Krankenkasse
Staudt, Alfred	AOK Rheinland-Pfalz/Saarland – Die Gesundheitskasse
Treuter, Uta	BARMER

Name	Health insurance fund
Vieweger, Birgitt	BARMER
Wagner, Dieter	AOK Bayern – Die Gesundheitskasse
Wagner, Christine	mhplus Betriebskrankenkasse
Weilbier, Thomas	AOK Rheinland/Hamburg – Die Gesundheitskasse
Weinschenk, Roswitha	AOK PLUS – Die Gesundheitskasse für Sachsen und Thüringen
Wiedemann, Andrea	BARMER
Witte, Michael	Kaufmännische Krankenkasse – KKH
Wonneberger, Klaus	HEK – Hanseatische Krankenkasse
Zierock, Carola	AOK Nordost – Die Gesundheitskasse

cut-off date: 2 December 2020

Representatives of the employers

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

cut-off date: 2 December 2020

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

Specialist committee on fundamental issues and health policy

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

Ordinary members

Representatives of the employers

1. Jehring, Stephan (AOK)
2. Stehr, Axel (AOK)
3. Nicolay, Udo (EK)
4. Empl, Martin (SVLFG)
5. Dohm, Rolf (BKK)
6. Kastner, Helmut (IKK)

Representatives of insured persons

1. Märtens, Dieter F. (EK)
2. Balser, Erich (EK)
3. Auerbach, Thomas (EK)
4. Schultze, Roland (EK)
5. Lersmacher, Monika (AOK)
6. Lambertin, Knut (AOK)
7. Müller, Hans-Jürgen (IKK)
8. Hamers, Ludger (BKK)

Deputy members

Representatives of the employers

Söller, Wolfgang (AOK)

Meinecke, Christoph (AOK)

Breitenbach, Thomas (EK)

Heins, Rudolf (SVLFG)

Ries, Manfred (BKK)

Leitl, Robert (IKK)

Wollseifer, Hans Peter (IKK)

Representatives of insured persons

Hippel, Gerhard (EK)
1st deputy on the list for insured persons 1-4
Breher, Wilhelm (EK)
2nd deputy on the list for insured persons 1-4
Korschinsky, Ralph (EK)
3rd deputy on the list for insured persons 1-4
Schümann, Heinrich J. (EK)
4th deputy on the list for insured persons 1-4
Kolsch, Dieter (AOK)
1st deputy on the list for insured persons 5-6
Weinschenk, Roswitha (AOK)
2nd deputy on the list for insured persons 5-6
Linnemann, Eckehard (Kn)
1st deputy on the list for insured persons 7-8
Strobel, Andreas (BKK)
2nd deputy on the list for insured persons 7-8
Scholz, Jendrik (IKK)
3rd deputy on the list for insured persons 7-8

Specialist committee on organisation and finance

Chaired by: Bernd Wegner/Andreas Strobel (alternating)

Ordinary members

Representatives of the employers

1. Wegner, Bernd (EK)
2. Landrock, Dieter Jürgen (AOK)
3. Ropertz, Wolfgang (AOK)
4. Reyher, Dietrich von (BKK)
5. Ries, Manfred (BKK)
6. Lunk, Rainer (IKK)

Representatives of insured persons

1. Roer, Albert (EK)
2. Fritz, Anke (EK)
3. Stensitzky, Annette (EK)
4. Keppeler, Georg (AOK)
5. Kloppich, Iris (AOK)
6. Tölle, Hartmut (AOK)
7. Baer, Detlef (IKK)
8. Strobel, Andreas (BKK)

Deputy members

Representatives of the employers

Lübbe, Günther (EK)

Nobereit, Sven (AOK)

Meinecke, Christoph (AOK)

Bley, Alexander (BKK)

Chudek, Nikolaus (IKK)

Wollseifer, Hans Peter (IKK)

Representatives of insured persons

Schröder, Dieter (EK)
1st deputy on the list for insured persons 1-3
Balzer-Wehr, Dr. Alexandra (EK)
2nd deputy on the list for insured persons 1-3
Wiedemann, Andrea (EK)
3rd deputy on the list for insured persons 1-3
Firsching, Frank (AOK)
1st deputy on the list for insured persons 4-6
Lersmacher, Monika (AOK)
2nd deputy on the list for insured persons 4-6
N. N. (AOK)
3rd deputy on the list for insured persons 4-6
Brendel, Roland (BKK)
1st deputy on the list for insured persons 7-8
Berger, Silvia (IKK)
2nd deputy on the list for insured persons 7-8
N. N. (BKK)
3rd deputy on the list for insured persons 7-8

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

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

Ordinary members

Representatives of insured persons

1. Parvanov, Ivor (AOK)
2. Ropertz, Wolfgang (AOK)
3. Söller, Wolfgang (AOK)
4. Thomas, Dr. Anne (EK)
5. Reyher, Dietrich von (BKK)
6. Kastner, Helmut (IKK)

Representatives of insured persons

1. Date, Achmed (EK)
2. Holz, Elke (EK)
3. Gosewinkel, Friedrich (EK)
4. Düring, Annette (AOK)
5. Kolsch, Dieter (AOK)
6. Firsching, Frank (AOK)
7. Linnemann, Eckehard (Kn)
8. Schoch, Manfred (BKK)

Deputy members

Representatives of insured persons

Nobereit, Sven (AOK)

Heß, Johannes (AOK)

Schomburg, Uwe (AOK)

Fitzke, Helmut (EK)

Franke, Dr. Ralf (BKK)

N. N. (BKK)

Wadenbach, Peter (IKK)

Wollseifer, Hans Peter (IKK)

Representatives of insured persons

Aichberger, Helmut (EK)
1st deputy on the list for insured persons 1-3
Hauffe, Ulrike (EK)
2nd deputy on the list for insured persons 1-3
Brück, Peter (EK)
3rd deputy on the list for insured persons 1-3
Lambertin, Knut (AOK)
1st deputy on the list for insured persons 4-6
Firsching, Frank (AOK)
2nd deputy on the list for insured persons 4-6
Wiedemeyer, Susanne (AOK)
3rd deputy on the list for insured persons 4-6
Brendel, Roland (BKK)
1st deputy on the list for insured persons 7-8
Römer, Bert (IKK)
2nd deputy on the list for insured persons 7-8
Scholz, Jendrik (IKK)
3rd deputy on the list for insured persons 7-8

Specialist committee on contracts and care

Chaired by: Martin Empl/Knut Lambertin (alternating)

Ordinary members

Representatives of the employers

1. Avenarius, Friedrich (AOK)
2. Söller, Wolfgang (AOK)
3. Japing, Kim Nikolaj (EK)
4. Bley, Alexander (BKK)
5. Leitl, Robert (IKK)
6. Empl, Martin (SVLFG)

Representatives of insured persons

1. Ermler, Christian (EK)
2. Katzer, Dietmar (EK)
3. Johannides, Meinhard (EK)
4. Schröder, Dieter (EK)
5. Lambertin, Knut (AOK)
6. Wiedemeyer, Susanne (AOK)
7. Brendel, Roland (BKK)
8. Römer, Bert (IKK)

Deputy members

Representatives of the employers

Schomburg, Uwe (AOK)

Schirp, Alexander (AOK)

Parvanov, Ivor (AOK)

Wegner, Bernd (EK)

Reyher, Dietrich von (BKK)

Wadenbach, Peter (IKK)

Lunk, Rainer (IKK)

Heins, Rudolf (SVLFG)

Representatives of insured persons

Breher, Wilhelm (EK)
1st deputy on the list for insured persons 1-4
Plaumann, Karl-Heinz (EK)
2nd deputy on the list for insured persons 1-4
Aichberger, Helmut (EK)
3rd deputy on the list for insured persons 1-4
Nimz, Torsten (EK)
4th deputy on the list for insured persons 1-4
Lersmacher, Monika (AOK)
1st deputy on the list for insured persons 5-6
Tölle, Hartmut (AOK)
2nd deputy on the list for insured persons 5-6
Hindersmann, Nils (Kn)
1st deputy on the list for insured persons 7-8
Karp, Jens (IKK)
2nd deputy on the list for insured persons 7-8
Schoch, Manfred (BKK)
3rd deputy on the list for insured persons 7-8

Specialist committee on digitalisation, innovation and the benefit for patients

Chaired by: Nikolaus Chudek/Jochen Berking (alternating)

Ordinary members

Representatives of the employers

1. Wegner, Bernd (EK)
2. Meinecke, Christoph (AOK)
3. Söller, Wolfgang (AOK)
4. Dohm, Rolf (BKK)
5. Chudek, Nikolaus (IKK)
6. Heins, Rudolf (SVLFG)

Representatives of insured persons

1. Berking, Jochen (EK)
2. Hoof, Walter (EK)
3. Vieweger, Birgitt (EK)
4. Kloppich, Iris (AOK)
5. Lambertin, Knut (AOK)
6. Hamers, Ludger (BKK)
7. Krause, Helmut (IKK)
8. Hindersmann, Nils (Kn)

Deputy members

Representatives of the employers

Japing, Kim Nikolaj (EK)

Landrock, Dieter Jürgen (AOK)

Selke, Prof. Dr. Manfred (AOK)

Ries, Manfred (BKK)

Leitl, Robert (IKK)

Empl, Martin (SVLFG)

Representatives of insured persons

Klemens, Luise (EK)
1st deputy on the list for insured persons 1-3
Gosewinkel, Friedrich (EK)
2nd deputy on the list for insured persons 1-3
Brück, Peter (EK)
3rd deputy on the list for insured persons 1-3
Löwenstein, Katrin von (EK)
4th deputy on the list for insured persons 1-3
Roloff, Sebastian (EK)
5th deputy on the list for insured persons 1-3
Keppeler, Georg (AOK)
1st deputy on the list for insured persons 4-5
Wiedemeyer, Susanne (AOK)
2nd deputy on the list for insured persons 4-5
Strobel, Andreas (BKK)
1st deputy on the list for insured persons 6-8
Grellmann, Norbert (IKK)
2nd deputy on the list for insured persons 6-8
Linnemann, Eckehard (Kn)
3rd deputy on the list for insured persons 6-8

cut-off date: 2 December 2020

Ordinary members and deputy members of the Steering and Coordination Committee

	Ordinary members	Deputy members
AOK	Stippler, Dr. Irmgard (AOK Bayern)	Teichert, Daniela (AOK Nordost)
	Ackermann, Tom (AOK NORDWEST)	Striebel, Rainer (AOK PLUS)
BKK	Galle, Andrea (BKK VBU)	1st deputy Demmler, Dr. Gertrud (SBK) 2nd deputy Stamm, Sabine (DIE BERGISCHE KRANKENKASSE)
	Fuchs, Gerhard (Audi BKK)	1st deputy Kaiser, Lutz (pronova BKK) 2nd deputy Gerhardt, Jens (BMW BKK)
EK	Walkenhorst, Karen (TK)	no deputy
	Rafii, Dr. Mani (BARMER)	Kafka, Torsten (HEK)
IKK	Hippler, Frank (IKK classic)	1st deputy Kaetsch, Peter (BIG direkt gesund) 2nd deputy Loth, Prof. Dr. Jörg (IKK Südwest)
KNAPPSCHAFT	am Orde, Bettina	Held, Heinz-Günter
SVLFG	Sehnert, Gerhard	Lex, Claudia

cut-off date: 1 January 2021

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

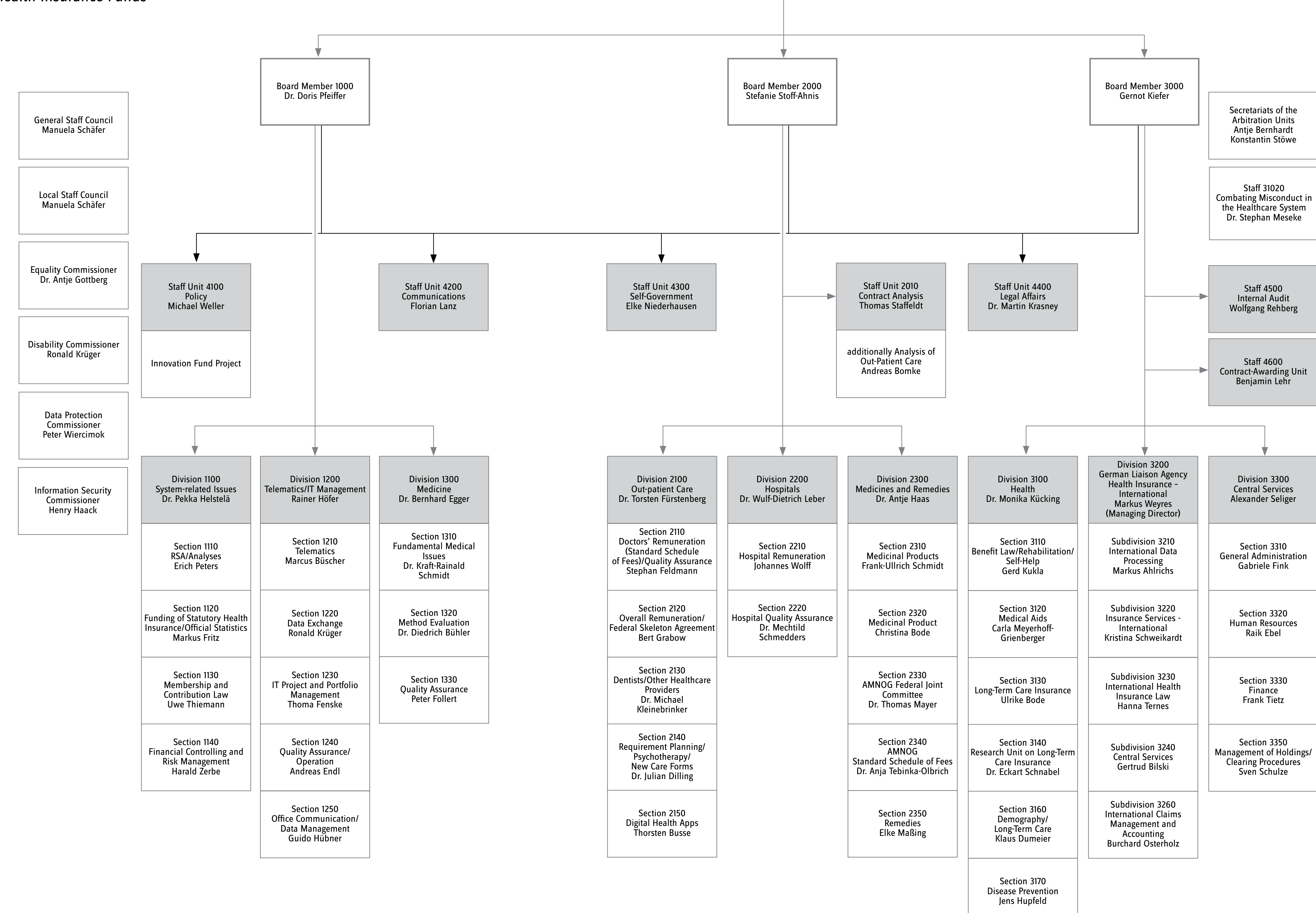
N.B.: The Specialist Advisory Council was replaced by the Steering and Coordination Committee to be formed at the National Association of Statutory Health Insurance Funds on entry into force of the Fair Insurance Fund Competition Act (GKV-FKG).

	Ordinary members	**Deputy members**
AOK	Litsch, Martin	Hoyer, Jens Martin
	Stippler, Dr. Irmgard	Peter, Dr. Jürgen
BKK	Knieps, Franz	Heinz, Verena
	Galle, Andrea	Kaiser, Lutz
EK	Elsner, Ulrike	von Maydell, Boris
	Meyers-Middendorf, Dr. Jörg	Blatt, Oliver
IKK	Hohnl, Jürgen	Hippler, Frank
	Schröder, Uwe	Kreutz, Enrico
KNAPPSCHAFT	am Orde, Bettina	Castrup, Dieter
	Jockenhöfer, Gerd	Neumann, Jörg
SVLFG	Lex, Claudia	Ender, Dirk
	Sehnert, Gerhard	Helfenritter, Jürgen

cut-off date: 1 January 2020

Organisational chart

National Association of Statutory Health Insurance Funds



Version: 1 January 2021

Publications

Position papers

Author(s)	Title	Publication date
GKV-Spitzenverband	Qualitativ hochwertige Medizinprodukte: Versorgungssicherheit in Europa auch unter Corona gewährleisten.	March 2020
GKV-Spitzenverband	Positionspapier zur Sicherung der finanziellen Stabilität der gesetzlichen Krankenversicherung in der COVID-19-Pandemie	May 2020
GKV-Spitzenverband	GKV-Positionen zur Krankenhausversorgung aus den Erfahrungen der Corona-Pandemie 2020	December 2020
GKV-Spitzenverband	Anforderungen und Kriterien an Digitale Gesundheitsanwendungen	December 2020

Series of publications on long-term care

Author(s)	Title	Publication date
GKV-Spitzenverband	Schriftenreihe Pflege, Band 16: Prävention in der ambulanten Pflege – Bestandsaufnahme von zielgruppenspezifischen präventiven und gesundheitsförderlichen Bedarfen, Potenzialen und Interventionsmaßnahmen	May 2020
GKV-Spitzenverband	Schriftenreihe Pflege, Band 17: Schmerzmanagement bei älteren Pflegebedürftigen in der häuslichen Versorgung	October 2020
GKV-Spitzenverband	Schriftenreihe Pflege, Band 18: Weiterentwickung der Pflegeberatung – Evaluation der Pflegeberatung und Pflegeberatungsstrukturen gemäß § 7a Abs. 9 SGB XI	December 2020

Other publications

Author(s)	Title	Publication date
GKV-Spitzenverband	Lieferengpässe bei Arzneimitteln: Internationale Evidenz und Empfehlungen für Deutschland – Gutachten im Auftrag des GKV-Spitzenverbandes	February 2020
GKV-Spitzenverband	Leitfaden zur Selbsthilfeförderung: Grundsätze des GKV-Spitzenverbandes zur Förderung der Selbsthilfe gemäß § 20h SGB V vom 10. März in der Fassung vom 27. August 2020	August 2020
GKV-Spitzenverband	Gutachten Stand der klinischen Krebsregistrierung zum 31.12.2019. Ergebnisse der Überprüfung der Förderkriterien	August 2020
GKV-Spitzenverband, MDS	Präventionsbericht 2020, Berichtsjahr 2019	November 2020
GKV-Spitzenverband	Leitfaden Prävention. Handlungsfelder und Kriterien nach § 20 Abs. 2 SGB V	December 2020
GKV-Spitzenverband	Leitfaden Prävention in stationären Pflegeeinrichtungen nach § 5 SGB XI	December 2020
GKV-Spitzenverband	Arbeit und Ergebnisse der Stelle zur Bekämpfung von Fehlverhalten im Gesundheitswesen, 1. Januar 2018 bis 31. Dezember 2019	December 2020

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