Executive Summary

**Medtech Benefit Assessment Adopted**

The German Parliament adopted the Act to Strengthen Care Provision in the Statutory Health Insurance system. The most important aspect for medtech companies is the planned regulation on benefit assessment procedures for new methods and medical technologies. Compared to the draft, the act provides some improvements: Innovation steps are not intended to be subject to the procedure. Only procedures based on a “new theoretical scientific concept” will be concerned. Furthermore, only “particularly invasive” methods are meant to be included.

**Medtech Benefit Assessment: The Details**

Get an answer to the key questions concerning medtech benefit assessment procedures: Which methods are affected? What is a “new” method? How will the details be determined? What is the role of the G-BA committee? Who will pay for the benefit assessment procedure? Which hospitals are involved?

**The Goals of the New Quality Institute**

“The quality of care for patients will be improved if the quality assurance measures benefit those who care for patients,” said Dr. Christof Veit, general manager of the new IQTIG institute, when speaking at a health policy event hosted by BVMed. Dr. Veit referred to a “paradigm shift and change of culture” through establishing quality as the most important and deciding factor in the healthcare system. Regarding the discussion about pay for performance, he said that the primary motivation for delivering high-quality services could not be replaced by monetary incentives.

**Josef Hecken: Pay for Performance Does Not Work**

In order to implement cross-sectoral quality assurance, we need “reasonable and legally watertight criteria” to gauge the quality of results. “This is one of the major tasks of the new quality institute,” said Josef Hecken, chairman of the Federal Joint Committee, G-BA, at the Bavarian Health Forum in Munich. Nonetheless, the chairman also warned against too much euphoria. There was no system in the world where pay for performance works according to clear-cut quality criteria.

**Treatment Errors: Medical Devices Account for 0.5 Percent**

In 2014, medical devices accounted for only 0.5 percent of confirmed medical treatment errors, the annual statistical data 2014 of the Medical Review Board of the SHI Funds show. In total, 14,663 reported cases were investigated; of 3,796 mistakes found, 18 were caused by medical devices.

**Jens Spahn to Become Secretary of State for Finance**

Healthcare politician Jens Spahn, aged 35, who is the health policy spokesman of the CDU/CSU parliamentary group and a member of the CDU executive committee, will become the new parliamentary state secretary in the Federal Ministry of Finance. He will be succeeded by CDU politician Maria Michalk from Saxony.
1. Issue Monitoring

Medtech Benefit Assessment Adopted

The German Federal Parliament adopted the Act to Strengthen Care Provision in the Statutory Health Insurance system, GKV-VSG, in mid-June 2015. It will come into effect on August 1, introducing numerous new provisions both for the outpatient and for the inpatient sector. For example, patients will be entitled to obtain a second opinion and hospitals will become more involved in the provision of outpatient care if the outpatient sector is unable to arrange appointments with specialists. In addition, a 300-million-euro innovation fund will be introduced to improve cross-sectoral care. The discharge management will also undergo a reform.

Open questions on the medtech benefit assessment procedure

The most important aspect for medtech companies is the planned regulation on benefit assessment procedures for new methods and medical technologies. In this context, the plan of the Institute for Quality and Efficiency in Healthcare, IQWiG, and of the National Association of Statutory Health Insurance Funds, GKV, to involve the Federal Joint Committee, G-BA, in all new device-class Ib and III methods and in the conduct of benefit assessment procedures has failed. Compared to the draft, the act provides the following improvements:

> Innovation steps are not intended to be subject to the procedure. Only procedures based on a “new theoretical scientific concept” will be concerned.
> Only “particularly invasive” methods are intended to be included. This will be further specified in an ordinance.
> To prevent potential delays in the agreement of fees for new methods of diagnosis and treatment, NUB, and due to the planned time limits, it is specified that a remuneration claim by the hospital shall already apply for patients who were hospitalized after the submission of a NUB request.

G-BA chairman Hecken sees a need for additional regulations

The new medtech benefit assessment regulation is not met with undivided enthusiasm by the G-BA chairman, Josef Hecken. He criticizes especially that the process must be initiated by the respective hospital intending to use a new medical device. Hecken is concerned that this will lead to a confusing conglomerate of testing procedures. He hopes that the ordinance relating to the new legal framework will ensure a limitation of the number of procedures. “The Joint Federal Committee must not become a bottleneck in the provision of medical devices,” Hecken underlined.

Analysis

The trend remains unchanged: Modern medical technologies must prove their benefits by additional clinical data. However, the details of the new law must yet be specified in the coming months by the Federal Ministry of Health.
Medtech Benefit Assessment: The Details

Which methods are affected?
A benefit assessment procedure will be required for devices in a high risk class and
with a new theoretical-scientific concept. This applies for risk classes IIb and III, if
the device has a particularly invasive character, which means that a benefit
assessment process will not be required for all class IIb devices.

What is a “new” method?
The definition of a new theoretical-scientific concept is based on the definition of
the term provided by the Federal Social Court: According to this definition, a new
method, its mechanism of action or field of application, must differ significantly
from other already established systematic approaches. Accordingly, innovation
steps are not subject to a benefit assessment procedure.

How will the details be determined?
As this is about setting the fundamental direction, the Federal Ministry of Health
will be authorized to specify the details in an ordinance until December 31, 2015,
in consultation with the Federal Ministry of Research. The Federal Joint Committee,
G-BA, will then be bound by these provisions.

What is the role of the G-BA committee?
If the G-BA committee comes to the conclusion that the available information
sufficiently demonstrates the benefit of a method, the service can continue to be
delivered and will be reimbursed by the Statutory Health Insurance, SHI.
The G-BA committee may define additional quality requirements in an ordinance
in accordance with section 137, e.g. a documentation regarding potential side
effects. A positive benefit assessment will have the following effect: If a new
method is not sufficiently reimbursed by the current DRG, hospitals shall be
entitled to request a separate remuneration.

Who will pay for the benefit assessment procedure?
If the G-BA committee comes to the conclusion that a benefit is not sufficiently
demonstrated, but that the method offers the potential to constitute a necessary
treatment alternative, G-BA must reach a decision within six months if a trial in
accordance with section 137 should be conducted. The cost of the evaluation
process shall be borne by the respective medical device manufacturer.
An assessment procedure in accordance with the provisions of section 137e
provides the advantage that the service involving the new medical technology can
also be provided on an outpatient basis.

Which hospitals are involved?
Hospitals providing the service must participate in the trial process. The respective
hospitals will be reimbursed for their service. This may also involve a NUB fee if the
Institute for Hospital Reimbursement, InEK, determines that the case fee is not
cost-covering.
The Goals of the New Quality Institute

“The quality of care for patients will be improved if the quality assurance measures benefit those who care for patients,” said Dr. Christof Veit, general manager of the new Institute for Quality Assurance and Transparency in the Healthcare System, IQTIG, with regard to the institute’s goal, when speaking at a health policy event hosted by BVMed in mid-June in Berlin. The meeting dealt with the quality, transparency and the benefits of medical-technological procedures. At the event, Dr. Veit argued very much with a focus on the patients, as did the health economist Prof. Dr. Axel Muehlbacher: “Quality is the aspect of care that the patient experiences.” With regard to potential dangers and the protection of patients, what matters to Dr. Veit is the “well-founded implementation of thresholds.”

IQTIG institute develops proposals for the G-BA committee

Dr. Veit, who is well known to the medtech industry through his work on the Endoprostheses Register Germany, EPRD, described the tasks of the new quality institute in detail. He referred to a “paradigm shift and change of culture” through establishing quality as the most important and deciding factor in the healthcare system. The IQTIG institute is an independent subsidiary of the Federal Joint Committee, G-BA, and aims to employ 80 members of staff by the end of the year. It will be tasked with developing expert proposals for the decisions made by the G-BA committee on the measurement of quality. “Quality is a legitimate requirement. Quality is what the patients experience when they receive medical care,” said Dr. Veit. The IQTIG methods paper will present the basic values of quality assurance and measurement. According to Dr. Veit the target indicators of quality assurance are feasibility, effectiveness, and justiciability. “We want to serve and be of use to those who provide patient care. Only in this way will we be able to improve the quality of care and also make this quality visible,” Dr. Veit said. As to justiciability, this was a matter of potential dangers and the protection of patients. What was important was “the well-founded implementation of thresholds,” similar to speed limits on roads. The desired quality competition, however, would not be a means of quantity control. “This is wishful thinking,” he said. The definition and measurement of quality would shape the demand for services via the instruments of planning, remuneration, and transparency.

Measurement and evaluation must benefit patients

Regarding the discussion about quality-oriented remuneration, pay for performance, Dr. Veit said that the primary motivation for delivering high-quality services could not be replaced by monetary incentives. He voiced a skeptical note, saying that “incentives will only have a temporary effect,” and made this appeal: “We must combine quality with learning, for instance by providing feedback to hospital physicians about the development of their patients. After all: ‘No pig has ever grown fat from measuring alone.’ We want to develop useful instruments that will be of use to the medical care institutions. The quality of care for patients will be improved if the quality assurance measures benefit those who care for patients.” To this end, the relevant areas of care will be mapped by the IQTIG institute. According to Dr. Veit, registers will be an important instrument in this respect.
Josef Hecken: Pay for Performance Does Not Work

In order to implement cross-sectoral quality assurance, we need “reasonable and legally watertight criteria” to gauge the quality of results. “This is one of the major tasks of the new quality institute,” said Josef Hecken, chairman of the Federal Joint Committee, G-BA, at the Bavarian Health Forum in Munich. Nonetheless, the chairman also warned against too much euphoria. There was no system in the world where pay for performance works according to clear-cut quality criteria.

Treatment paths become more complex

Cross-sectoral quality assurance was a real challenge, according to Hecken. Treatment paths were becoming ever more complex, as more diseases were treatable and the number of multi-morbid patients was increasing. At the same time, conventional treatment paths were disintegrating.

Example: Hip replacement

The G-BA chairman gave an example to illustrate the situation. Formerly, patients requiring hip replacement were treated by only one hospital. Today everything was much more complex. After seven days in hospital, patients start ambulatory or stationary rehabilitation therapies, with intertwining treatment paths in various settings and by different service providers. In the event of a dislocation of the hip joint, responsibilities were hard to allocate.

Complex treatment paths make the quality of results difficult to gauge.

“We have no media to track patients across sectors with reliable data, to capture treatment paths and finally be able to pinpoint possible weak points when measuring the quality of results,” Hecken described one of the core problems.

Problems with pay for performance

There was also not one single system in the world where “pay for performance” works well on a collective level. But why? “There are no manipulation-safe, risk-adjusted measuring instruments,” according to Hecken. The example from the UK shows: There was an attempt to introduce pay for performance for general practitioners. They were required to make more home visits and shorten their waiting times. As a result, the practitioners’ income increased, while overall patient care did not.

Germany already had an excellent, internationally exemplary quality of care, notwithstanding the Federal Government’s current quality offensive. “The system works,” Hecken stated. “What we need to do now is set the path to be able to adequately react to future challenges.”
2. Documentation:

German G7 Presidency: Health as a Major Focus

Source: German Federal Ministry of Health

The Group of Seven (G7) is made up of seven leading industrialised nations: the USA, Great Britain, France, Italy, Japan, Canada and Germany. In addition, the European Union is represented at all meetings. The Group of 7 (G7) is an informal forum for the heads of state and government. Once a year, they meet for a summit hosted by the country that is holding the presidency to discuss key issues of global politics, exchange their viewpoints and find constructive approaches to resolving problems and implementing them together with other countries. The Presidency of the Group rotates annually among the member countries.

Health is a major focus of Germany’s G7 Presidency. Healthy populations are a strong driver of socio-economic stability and growth. The Federal Chancellor is determined to push for global health to be enhanced.

At the G7 launch event, the Federal Chancellor had assumed the patronage of Gavi, the global vaccine alliance’s, replenishment conference in Berlin on 26/27 January of this year. Under the motto “Reach every child”, Gavi aims to vaccinate 300 million more children in the world’s poorest countries between 2016 and 2020. Thanks to the 7.539 billion dollars pledged on 27 January, this target is within reach and the efforts of recent years can be substantially consolidated and expanded. Germany alone has increased the funding for the 2016-2020 replenishment period to 600 million euros.

Antimicrobial resistance is ballooning worldwide, threatening to wipe out or at least eat away at the major successes achieved in the fight against infectious diseases. Multidrug-resistant pathogens do not stop at borders, they are a problem that concerns the whole world. This is why Germany will be campaigning for our G7 partner countries to step up their commitment to fighting antimicrobial resistance.

The Federal Government is leveraging the G7 Presidency to learn, together with its partner countries, important lessons from the Ebola crisis. The international community wants to ensure a swifter response to similar global crises.

GAVI, the Global Alliance for Vaccination and Immunisation

Speaking at the conference of the global vaccine alliance – Gavi – in Berlin, Federal Minister of Health Hermann Groehe highlighted the worldwide importance of immunisations as a shield of protection from life-threatening infections. Federal Minister of Health Hermann Groehe: “Immunisations offer effective protection from potentially fatal infectious diseases. We will be using the Gavi replenishment conference to ensure that 300 million more children will get life-saving immunisations by 2020.”
Since the Gavi vaccine alliance was founded, it has been providing vaccines for 500 million children in developing countries. Fresh funding to the tune of US$ 7.5 bn shall help to ensure that another 300m children can be vaccinated by 2020. In his address, Minister Groehe also appealed to the German citizens to have their vaccination status checked and catch up on any missed immunisations.

Antimicrobial resistance

Antibiotics play an essential role in human medicine and animal husbandry. Globally, antibiotics consumption rates in human medicine alone rose by 36% between 2000 and 2010. Antibiotic resistance is becoming more and more prevalent worldwide. To an ever greater extent, therefore, doctors have to resort to reserve antibiotics for effective treatment. Many diseases, especially those that affect mainly children, such as malaria, pneumonia and diarrhoea, are no longer amenable to treatment with the conventional antibiotics. For more information on antimicrobial resistance, go to "Krankenhausinfektionen" (German) or WHO’s factsheet.

The Davos World Economic Forum has identified antimicrobial resistance as a global risk that no country or organisation can eliminate on its own. The European Centre for Disease Control (ECDC) assumes that, every year, antibiotic resistance will cause 25,000 deaths across the EU and approx. 1.500m euros worth of economic damage due to added health costs and loss of productivity. According to the U.S. Centers for Disease Control and Prevention (CDC), resistant pathogens will cause an added 8m hospital days in the U.S. alone.

In 2014, WHO had submitted a global report on global surveillance of antimicrobial resistance. The figures illustrate that resistance rates have dramatically increased throughout the world.

In 2015, WHO had submitted also a report on worldwide country situation of antimicrobial resistance. The report provides an analysis, by region and globally, of the initiatives under way to address antimicrobial resistance and identifies areas in which more work is needed.

Moreover, it stressed that new substantial classes of antibiotics have not been developed in recent years. As a consequence, WHO had prepared a draft global action plan on antimicrobial resistance for submission to the World Health Assembly (WHA) in January 2015. If it is adopted by the World Health Assembly in May 2015 as planned, it could form the basis of further activities on antibiotic resistance within the G7 context.

Germany’s Antimicrobial Resistance Strategy (Deutsche Antibiotika-Resistenzstrategie – DART) is already pursuing a cross-sectoral approach to fighting antimicrobial resistance. Its priorities match those of the Global Action Plan.
Lessons learned from the Ebola crisis – Six point plan

The Federal Government has drafted a six-point plan in an effort to improve international health crisis response efforts. These key points include the setting up of a detachment of doctors and medical workers that can be flexibly deployed. The Federal Chancellor has unveiled the initiative at the Gavi Pledging Conference.

At its special session on Ebola on 25 January, the WHO Executive Board adopted a relevant resolution that had been sponsored by 63 countries. It reaffirms that the primary aim must be to swiftly end the Ebola epidemic in West Africa and strengthens WHO’s leadership role in the global health architecture on emergencies with public health consequences. Moreover, major steps were taken to allow WHO to fulfil its mandate even better and more efficiently. Specifically, this involves structural changes in the following areas: human resources, global health workforce, availability of financial resources and research and development of new medicines. In addition, the Resolution has ushered in an evaluation process that is expected to bring an interim result in time for the World Health Assembly in May 2015.

Neglected Tropical Diseases

WHO’s definition of neglected tropical diseases (NTDs) in the narrower sense comprises 17 diseases that are endemic in tropical regions and that are, for the most part, completely unknown here. They include, for instance, human African trypanosomiasis (sleeping sickness), leishmaniasis and dengue fever. They affect more than 1.4 billion people worldwide, killing many millions of them each year.

As a result, neglected tropical diseases are highly relevant for global health. Their rate and spread cannot be fully explained by climatic conditions alone, though. Other major reasons for the high disease burden due to NTDs are, first and foremost, lack of access to medicines or vaccines that can be effectively used in resource-poor settings. There are next to no financial incentives to develop such medicines or vaccines, since the affected countries tend to have weak economies. Also, a lack of, or insufficient access to, health services adds to the poor health care delivery. In many cases, moreover, these diseases are caused by poor hygiene and lack of access to clean water. Improvements are possible if the various factors at play are properly addressed.

Since 2011, the Federal Ministry for Education and Research has been continuously expanding the funding provided within its research funding concept for neglected and poverty-related diseases and has meanwhile become the biggest German sponsor in this field.
3. In Brief

**Treatment Errors: Medical Devices Account for 0.5 Percent**
In 2014, medical devices accounted for only 0.5 percent of confirmed medical treatment errors, the annual statistical data 2014 show. They are based on the assessment of treatment errors by the Medical Review Board of the Statutory Health Insurance Funds (Medizinischer Dienst der Krankenkassen, MDK). In total, MDK investigated 14,663 reported cases. Around a quarter of the expert opinions found treatment errors. Of 3,796 mistakes found, 18 were caused by medical devices. Almost two thirds of the accusations made with regard to treatment errors concerned treatments in hospitals. One third concerned accusations made against a practice-based physician. The majority of accusations regarding treatment errors concerned surgical procedures. 7,845 cases are directly connected with surgical procedures. “As far as our experience goes, this is due to the fact that in cases of post-operative courses of treatment that do not meet the patient's expectations, a treatment error is suspected. Errors made in connection with medication, on the other hand, are often not noticed by the patient,” said Prof. Dr. Astrid Zobel, head physician of MDK Bavaria. In around 24 percent of cases, the expert opinions found a treatment error during operations.

**Government Passes Hospital Reform Law**
The government passed the draft of the Hospital Structural Reform Law, Krankenhausstrukturgesetz (KHSG), on June 10, 2015. The law is to come into effect on January 1, 2016. The main points of the law are: Quality will be introduced as a criterion of hospital planning. In order to improve actual nursing care for patients (patient in bed), a nursing care support program will be established. With a view to the further development of hospital financing, the framework for the application of the so-called safeguarding bonuses will be refined. The restructuring of quantity controls will be carried out in two steps. In order to improve the care structures, a structural fund will be established. What remains unchanged is that the federal states will continue to plan the number of hospitals as part of their public services while providing the investment funds for their hospitals to the extent required. The German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG) is not at all satisfied with the draft law and intends to take a proactive stance with a nationwide campaign.

**Hospitals: Trend Reversal in Volume Growth**
With regard to the growth of the service quantity in hospitals, there are signs of a trend reversal. The number of hospital cases only grew by 0.9 percent in 2013 while the total volume of services (case mix volume) remained nearly unchanged, as stated in the current Hospital Rating Report published by the economic research institute RWI. According to the report, the risk of insolvency among German hospitals increased slightly in 2013 when compared to the previous year. 16 percent of hospitals were in the “red area” of increased insolvency risk. At the same time, the earnings position was slightly improved and the average return on sales increased from 0.7 to 1.4 percent.
Government Passed eHealth Law
In order to advance the digitization of the healthcare system, the federal government passed the draft Law on Safe Digital Communication and Applications in the Healthcare System, eHealth Law, in June 2015. The draft law will now be brought to parliament for voting. It contains specific deadlines for the further expansion of networks as well as for electronic applications and provides for incentives as well as penalties if time schedules are not kept.

Breaking the Taboo of Incontinence Care
At least 5 million people in Germany are living with incontinence. "However, the condition is still considered a taboo subject. We must create awareness among decision-makers in politics, health insurance funds, and care institutions for the problems of incontinence care and encourage the patients concerned to exchange views and information about incontinence," declared BVMed CEO Joachim M. Schmitt on occasion of the World Continence Week, which was held from June 22 to 28, 2015. Incontinence is a disease recognized by the WHO and occurs as a consequence of different underlying conditions. Incontinence care is therefore part of the performance obligation of the Statutory Health Insurance funds. The latter are obliged to fund adequate medically necessary care with incontinence helps and medical-technological treatment methods for their insured members.
4. People

**Jens Spahn to Become Secretary of State for Finance**
Healthcare politician Jens Spahn, aged 35, who is the health policy spokesman of the CDU/CSU parliamentary group and a member of the CDU executive committee, will become the new parliamentary state secretary in the Federal Ministry of Finance. He succeeds Steffen Kampeter, who will become director general of the Confederation of German Employers’ Associations, BDA. CDU politician Maria Michalk from Saxony, presently a committee member of the working group on healthcare of the CDU/CSU parliamentary group, is to succeed Jens Spahn as the health policy spokeswoman of the group.

**Coalition Wants to Secure Hecken’s G-BA Position**
Josef Hecken is to remain head of the Federal Joint Committee, G-BA, after 2018 as well. This was agreed by the CDU/CSU and SPD governmental parties in a proposed amendment of the Act to Strengthen Care Provision in the Statutory Health Insurance system, GKV-VSG. So far, the office terms of impartial members are limited to six years without the possibility of re-election. However, the coalition will abolish the re-election ban, justifying this with “the large number of present and new tasks” of the G-BA committee. The limit on the term of office, which had originally been envisaged, conflicted with the goal of G-BA’s effective and continuous fulfillment of its tasks. The amendment would “create the opportunity to assure continuity in terms of staffing.”

**IGW Heads Re-elected**
Prof. Heinz Lohmann has been re-elected as chairman of the healthcare economy association Initiative Gesundheitswirtschaft, IGW, at the organization’s annual meeting. Prof. Dr. Norbert Klusen was also re-elected as its deputy chairman. The other deputy chairmen elected were the chairman of the P.E.G. purchase cooperative, Anton J. Schmidt, and the board member for care and patient management of the University Medical Center Hamburg-Eppendorf, Joachim Proess. They will represent the IGW initiative during the next three years. The other members of the newly elected board are: Dr. Christoph Straub, chairman of Barmer GEK, Juergen Biberstein, director market access at Pfizer Germany, Dr. Meinrad Lugan, chairman of B. Braun Melsungen, Dr. Jens Baas, chairman of Techniker Krankenkasse, Prof. Dr. Joerg F. Debatin, vice president and chief technology officer of GE Healthcare.

**New Head of German Diabetes Association**
Prof. Dr. Baptist Gallwitz is the new president of the German Diabetes Association, DDG. He is the deputy director of the Medical Clinic IV of the Tübingen University Hospital and succeeds associate professor Dr. Eberhard Siegel. Prof. Gallwitz will be in office until 2017.
5. Events

17 September 2015  
**German Medtech Sales Conference, Duesseldorf**  
First sales conference for the medtech industry by MedInform  
[www.bvmed.de/vertriebskonferenz](http://www.bvmed.de/vertriebskonferenz)

6 - 8 October 2015  
**Biotechnica, Hanover**  
Exhibition and conference for biotechnology and life sciences  
[www.biotechnica.de](http://www.biotechnica.de)

14 - 17 October 2015  
**Rehacare International, Duesseldorf**  
Trade show and congress on rehabilitation and care  
[www.biotechnica.de](http://www.biotechnica.de)

20 - 23 October 2015  
**German Orthopedic Convention 2015, Berlin**  
Organizer: Joint annual Convention of the German Society for Accident Surgery, the German Society for Orthopedics and Orthopedic Surgery and the Professional Association of Orthopedic Specialists  
[www.dkou.de](http://www.dkou.de)

16 - 19 November 2015  
**MEDICA 2015 & Compamed, Duesseldorf**  
The biggest medical trade show in the world  
[www.medica.de](http://www.medica.de)  
High-tech solutions for medical technology  
[www.compamed.de](http://www.compamed.de)

8 - 10 March 2016  
**Altenpflege 2016, Hanover**  
Leading exhibition for the care sector  
[www.altenpflege-messe.de](http://www.altenpflege-messe.de)

8 - 10 June 2016  
**Capital Congress “Medicine & Health”, Berlin City Cube**  
Biggest German healthcare congress for decision makers (8,000 participants)  
[www.hauptstadtkongress.de](http://www.hauptstadtkongress.de)

8 - 10 November 2016  
**VISION, Stuttgart**  
World trade fair for vision technology  
[www.messe-stuttgart.de/vision/](http://www.messe-stuttgart.de/vision/)

16 - 18 March 2017  
**Therapy Leipzig**  
Trade fair and congress for therapy, medical rehabilitation and prevention  
[www.therapie-leipzig.de](http://www.therapie-leipzig.de)
6. Abbreviations

AOK  Allgemeine Ortskrankenkasse(n) (Local Health Care Fund(s))
AWMF  Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften (Association of the Scientific Medical Societies)
BKK  Betriebskrankenkasse(n) (Company Health Insurance Fund(s))
BMG  Bundesministerium für Gesundheit (Federal Ministry of Health)
BPfLV  Bundespflegesatzverordnung (National Ordinance on Hospital Rates)
BQS  Bundesgeschäftsstelle Qualitätssicherung gGmbH (German National Institute for Quality Measurement in Health Care)
BR  Base Rate (average case value)
BVMed  Bundesverband Medizintechnologie e. V. (German Medical Technology Association)
DIMDI  Deutsches Institut für Medizinische Dokumentation und Information (German Institute of Medical Documentation and Information)
DKG  Deutsche Krankenhausgesellschaft e. V. (German Hospital Federation)
DRG  Diagnosis Related Groups
FPV  Fallpauschalenvereinbarung (Diagnosis Related Groups Agreement)
G-BA  Gemeinsamer Bundesausschuss (Joint Federal Committee)
G-DRG  German-DRG
GKV  Gesetzliche Krankenversicherung (Statutory Health Insurance)
GMG  Gesundheitssystemmodernisierungsgesetz (Health Care System Modernization Law)
HTA  Health Technology Assessment
ICD  International Statistical Classification of Diseases and Related Health Problems
IKK  Innungskrankenkasse(n) (Craft Guild Health Insurance Fund(s))
InEK  Institut für das Entgeltsystem im Krankenhaus gGmbH (Institute for Hospital Reimbursement)
IQWiG  Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (Institute for Quality and Efficiency in Health Care)
JFC  Joint Federal Committee (Gemeinsamer Bundesausschuss)
KHEntgG  Krankenhausentgeltgesetz (German Hospital Remuneration Law)
KHG  Krankenhausfinanzierungsgegesetz (Hospital Financing Act)
LKK  Landwirtschaftliche Krankenkasse(n) (Agricultural Sickness Fund(s))
MDS  Medizinischer Dienst der Spitzenverbände der Krankenkassen e. V. (Medical Review Board of the Statutory Health Insurance Funds)
MPG  Medizinproduktgesetz (Medical Devices Act)
NUB  new examination and treatment method (Neue Untersuchungs- und Behandlungsmethode)
OPS  operations and procedures code (Operationen- und Prozeduren schlüssel)
RW  relative weight
SGB V  Social Security Code Book V (Sozialgesetzbuch Fünftes Buch)
SHI  Statutory Health Insurance (Gesetzliche Krankenversicherung – GKV)
VÄndG  Vertragsarztrechtsänderungsgesetz (SHI-physician amendment law)
vdek  Verband der Ersatzkassen e. V. (Association of Employees’ Health Insurances)