Federal Ministry
of Health

Healthy in Germany

Everything you need to know about the healthcare system in Germany

GUIDE

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Dear Readers,

The German healthcare system delivers high-quality care but is shaped in places by complex structures and a large number of actors. Who is actually in charge of what? You may have already posed this question when considering the structure of the health and long-term care system.

While the strength of our healthcare system might well be rooted in this wide variety of institutions and actors who are committed to helping people, it is still crucial to provide orientation so that people can find their way. This orientation plays an important role in ensuring access to healthcare and its range of services.

Where can I learn more about long-term care insurance? Who can answer my questions about becoming an organ donor? Who or what is the Federal Joint Committee (G-BA)? The questions can be as varied as life itself and the circumstances that prompt people to ask. This guide is intended to help people navigate the German healthcare system. It explains the structure of our healthcare ecosystem, introduces the key actors and explains how they work together. You will also learn where to obtain additional information, how to build on your knowledge and who is available to respond to specific concerns.

This means that you can draw on this guide if you have a specific question on a particular topic and wish to contact the relevant body – or if you are keen to learn more about the healthcare system in general. Insured persons must be well informed in order to maintain a strong healthcare system. With this in mind, I sincerely hope that this guide will prove helpful and beneficial!

Yours,

Prof. Dr. Karl Lauterbach
Federal Minister of Health

Healthy in Germany

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Underlying principles, structure and funding of the healthcare system

A mainstay of political, social and economic life, the German healthcare system delivers services to around 83 million citizens. This part explains the structure of the healthcare system and how it is funded – and who decides on its organisation and financing.

1.1 Underlying principles of the German healthcare system

It is a Herculean task: Around 83 million residents of Germany receive medical care. A comprehensive network has been established for this purpose, which consists of some 1,900 hospitals, approximately 154,000 panel doctors and in the region of 33,700 psychotherapists working in outpatient care. Additionally, there are around 17,500 pharmacies. The costs of this care system are high: the latest statistics released by the Federal Statistical Office (Destasis) indicate that Germany spent just under €500 billion on health in 2022. This is equivalent to more than €1 billion per day. In other words: spending on the healthcare sector accounts for more than one in ten euros of Germany's gross domestic product. But how does the healthcare system work?

A variety of systems are in place around the world, which can more or less be divided into three categories:

- **State healthcare systems** are organised by the state and funded by tax revenue. The United Kingdom and Sweden are examples of this system. These countries pay for all surgeries, treatments and drugs from the national budget. Residents only make co-payments on some treatments. The state also organises the funding of hospitals and health centres in these countries.
- The state plays a subordinate role in **market economy-orientated systems**. Private sector actors organise and control the health sector. Almost all funding comes from the private sector: there are private insurance companies, or residents pay for their medical treatment out of their own pockets. They are responsible for their own living expenses, even during prolonged absence from work due to illness, and do not receive any continued payment of wages. This is the case in the United States, for example.

- **Social insurance systems** are the third category. Social security schemes, so health insurance funds, are largely responsible for funding medical care in these countries. Here, companies and employees both pay into the health insurance funds – as is the case in Germany and elsewhere. Unlike in state-organised healthcare systems, public and private sector providers operate in tandem. The legislator defines the framework within which they organise healthcare – in accordance with what is known as the 'principle of self-administration'.

Germany has a social insurance system to deliver healthcare to its residents. The healthcare sector is largely funded by contributions. The majority of the population is covered by statutory health insurance. It builds on the following basic principles: mandatory insurance *(refer also to Section 1.1.1 on page 18)*, contribution financing *(refer also to Section 1.1.2 on page 18)*, the solidarity principle *(refer also to Section 1.1.3 on page 19)*, the benefits in kind principle *(refer also to Section 1.1.4 on page 20)* and the self-administration principle *(refer also to Section 1.1.5 on page 21)*.

Germany's current healthcare system has grown over time. Nascent forms of solidarity-based health insurance emerged as far back as the Middle Ages. Guilds and some companies organised medical treatments and care on behalf of their members and employees. The various forms of social security that evolved over the centuries were codified during the 19th century. One milestone was the world's first statutory social insurance scheme, which German Chancellor Otto von Bismarck introduced in 1883. It laid the foundation for statutory health insurance in Germany, which provides cover to the majority of residents.

People in Germany have a right to healthcare

The German Basic Law (GG) states:
“Every person shall have the right to life and physical integrity. Freedom of the person shall be inviolable. These rights may be interfered with only pursuant to a law.”
(Article 2 paragraph 2 sentence 1 GG)

Furthermore, the Federal Constitutional Court (BVerfG) has ruled that “Human life represents (...) a supreme value within the constitutional order; it is the vital basis of human dignity and the foundation of all other fundamental rights.” (BVerfGE 39, 1-95, margin note 153)

The fundamental right to life and physical integrity, in conjunction with the principle of a welfare state, means that the **state has a duty** to establish **a sustainable healthcare system**.

The Basic Law does not stipulate precisely what this healthcare system must look like and hence gives the legislator considerable organisational leeway. This is reflected in our healthcare landscape by strong self-administration, statutory and private health insurance and the delivery of comprehensive, nationwide healthcare.

1.1.1 Mandatory insurance cover

Anyone can contract a serious illness at any time over the course of their life. Virtually insurmountable treatment costs that far exceed the person's income and assets may be incurred in no time at all. **But residents must be protected from illness in a modern welfare state.**

Accordingly, everyone residing in Germany is obliged to take out health insurance. **Statutory health insurance** (SHI) is mandatory for everyone, who is not otherwise protected, in case of illness. SHI is primarily intended for employees whose gross annual income is below a certain threshold (€69,300 in 2024). Members of an SHI scheme are automatically covered by social long-term care insurance.

Employees on higher incomes can remain in the statutory health insurance scheme as voluntarily insured members, or opt for **private health insurance** (PHI).

This choice is afforded to some groups of people, even if their income is below the threshold for mandatory statutory health insurance. These include, for example, civil servants and self-employed persons.

1.1.2 Contribution financing

Members finance the health insurance companies – both statutory and private – through **contributions (premiums)**. Their amount is determined by a variety of factors. Premiums for private health insurance, for example, are calculated based on a person's health status, their age of entry and their personal risk of illness. The member and their private health insurance companies agree individually on the services and any co-payments.

By contrast, contributions for SHI depend on the member's income. People who earn more, also pay more. All insured persons still receive the same services. **This reflects the principle of solidarity within SHI** *(refer to Section 1.1.3)*. Unlike PHI, SHI also provides cover to family members without or with only a small income. These persons include, for example, the children and spouses of insured persons. They do not pay contributions themselves. Contributions for persons on unemployment benefits or social assistance are usually paid by the competent social service provider.

Contributions to the statutory health insurance system are currently 14.6 percent. Employees pay half of this contribution – so 7.3 percent of their salary. The employers or pension insurance funds are responsible for the other half. Each health insurance fund also levies a dedicated, supplementary contribution. On average, the statutory supplementary contribution rate is currently 1.7 percent and is also shared.

1.1.3 Solidarity principle

The German healthcare system is financed according to what is known as the 'principle of mutual solidarity'. In other words: all persons with statutory health insurance jointly bear the costs incurred due to the illnesses of individual members. **Each and every person with statutory health insurance has the same right to medical care.** The person's income is irrelevant – and therefore how much they have paid into the health insurance scheme.

Healthy people carry responsibility for the sick, the rich for the poor and single persons for families. Solidarity means that employees continue to receive their wages, even when they are sick. The employer pays the full amount for the first six weeks. Persons with more protracted illnesses receive sick pay from the health insurance fund. At present, it is set at 70 percent of their gross income.

1.1.4 Benefits in kind principle

People with statutory health insurance receive medical treatment without having to make payments in advance. Panel doctors, hospitals and pharmacies bill the health insurance funds directly for the treatments, therapies and drugs. This means that insured persons are entitled to **free treatment** – apart from their individual statutory contributions and co-payments.

1.1.5 Principle of self-administration

The healthcare system is complex. A wide variety of individual interests need to be reconciled at all times: patients, for instance, will always want optimised treatment, while doctors will demand state-of-the-art devices. The health insurance funds, in turn, must ensure that they can pay for all these things with the contributions received from insured persons.

These interests can be reconciled in three different ways: by the state, the market or the involved parties themselves.

Germany has picked the third variant with the principle of self-administration. The state does define a framework for medical care and decides who is responsible for which tasks. It does so by passing laws and directives. However, it is the parties involved in the healthcare system who decide how care should be organised and structured. They define, for example, which medical treatments, surgeries, therapies and drugs are, and are not, financed by the health insurance funds. Representatives of the medical, dental and psychotherapeutic professions, hospitals, health insurance funds and insured persons are jointly in charge of this self-administration within the healthcare system.

Their supreme body is the Federal Joint Committee(G-BA; *refer to Section 2.2.1, from page 42)*. Representatives of patient organisations have the right to submit proposals to and participate in consultations of the G-BA. The G-BA pools all decisions and formulates binding guidelines. They stipulate, for instance, which treatments and new drugs are covered by the health insurance funds.

1.2 Levels within the healthcare system

Everyone should receive prompt medical assistance in the event of illness. A variety of actors are needed to ensure that this happens *(refer to Section 1.2.2 on page 23 and 1.2.3 on page 25)*. They include doctors, therapists, care specialists, hospitals, rehabilitation centres and pharmacies. And the services they provide are not free. The health insurance funds, in turn, are responsible for settling these costs.

All of these things require decisions, regulation and coordination. And the responsibility for these things is divided into **three levels**.

1. Statutory framework: Germany has a federal structure. The federal, state and local authorities jointly define the framework for healthcare by enacting laws and setting guidelines.

2. Self-administration: Institutions and associations decide how healthcare should be organised in practice.

3. Individual actors and their lobby groups: Health insurance funds, hospitals, pharmacies, the medical profession and a wide range of healthcare professionals deliver care to the population. They organise themselves in associations that represent their interests.

1.2.1 Level 1: the legislative framework

The **Federal Ministry of Health** (BMG; *refer also to Section 2.1.1 on page 35)* is mandated with the responsibility for health policies within the Federal Government. It prepares draft legislation, ordinances and administrative regulations and oversees the self-administration organisations at federal level. The Federal Office for Social Security (BAS), in turn, is responsible for supervising the health insurance funds operating nationwide.

A number of authorities and institutions are subordinate to the BMG, which then fulfil tasks in the healthcare system and in healthcare policy: the **Federal Institute for Drugs and Medical Devices** (BfArM; *refer to Section 2.1.2 on page 36)*, the **Paul-Ehrlich-Institut** as Federal Institute for Vaccines and Biomedicals(PEI; *refer to Section 2.1.4 on page 38)*, the **Robert Koch Institute** (RKI; *refer to Section 2.1.5 on page 39)* and the **Federal Centre for Health Education** (BZgA; *refer to Section 2.1.3 on page 37)*. The **Commissioner of the Federal Government for Long-Term Care** *(refer to Section 2.1.8 on page 41)*, the **Commissioner of the Federal Government for Drug and Addiction Policy** *(refer to Section 2.1.6 on page 40)* and the **Commissioner of the Federal Government for Patient Affairs** *(refer to Section 2.1.7 on page 40)* are also assigned to the BMG.

Aside from the German Bundestag and the Federal Government, the **Bundesrat** is the third key player in healthcare policy at federal level. It is the representative body of the federal states: representatives of the individual state governments can express their views on health policy issues in the Bundesrat.

The **federal states** *(refer to Section 2.3.1 on page 46)* have the power to pass laws as well. Administrative authorities in the federal states ensure that federal laws are implemented correctly as well. They also oversee the public health services in the**municipalities** *(refer to Section 2.3.2 on page 47)*.

1.2.2 Level 2: self-administration

The principle of self-administration applies in Germany *(refer also to Section 1.1.5 on page 21)*: The state does create the statutory framework. But the **actors make their own decisions, for instance**on the medical services they provide and which are financed by the health insurance funds – and paid for according to the principle of mutual solidarity *(refer to Section 1.1.3 on page 19)*.

To this end, insured persons, contributors and service providers organise themselves into associations that are responsible for shaping the delivery of medical care to the population.

But how do they decide which treatments and costs are purposeful? The law (Section 12 of the Fifth Book of the German Social Code (SGB V)) stipulates that services must be sufficient, appropriate and economical. In doing so, the actors are guided by the principle of economic efficiency, among other things. This also means that financing is not provided for services that exceed the scope of what is necessary – so insured persons will usually be required to pay for them out of their own pockets.

It is clear from the beginning that many treatments are covered by statutory health insurance: anyone suffering a heart attack will receive immediate treatment from an emergency doctor. These costs are covered by the health insurance fund. Anyone who twists their ankle during exercise will also present their health insurance card to the orthopaedist, receive an x-ray and, if necessary, have their foot bandaged. But there are some borderline cases: what if a patient wants to receive osteopathic treatment instead of physiotherapy following an orthopaedic injury? If they want to take a homeopathic remedy instead of a painkiller? Someone has to decide whether the health insurance fund pays for these services as well.

Social elections

Social elections are held in Germany every six years. Many people are unaware: they can use these elections to have a say in the composition of important decision-making bodies within the system of self-administration, provided they pay contributions into the German social insurance system. For instance, social elections are used to elect representatives who sit on the administrative boards of the health insurance funds on behalf of the insured. The administrative boards decide, in turn, how much money and personnel are allocated to the health insurance funds, which persons manage the funds (executive board) and other things.

This is the purpose of the **Federal Joint Committee** (G-BA; *refer also to Section 2.2.1 from page 42).* The G-BA brings together representatives of health insurance funds, the medical profession, hospitals and patient and disability organisations to jointly discuss whether the health insurance funds should pay for new treatment methods, modern medical technology, new drugs or alternative treatment methods, taking into account the current state of scientific knowledge.

1.2.3 Level 3: individual actors and their lobby groups

The third level is where patients actually receive treatment and care – from doctors,nurses and therapists in hospitals and rehabilitation clinics. They are organised in professional and business associations *(refer to Section 2.3 on page 46)*, which represent the interests of these stakeholders in a wider sense in numerous self-administration bodies and elsewhere. This gives a voice to all those who look after patients on a day-to-day basis.

Examples of these lobby groups include the federal and state chambers of the various medical professions and the Federal Union of German Pharmacists' Associations (ABDA), as well as patient and self-help organisations, professional and lobby groups of the medical profession, associations of the non-physician medical professions, the Association of Private Health Insurers and the associations of pharmaceutical manufacturers.

1.3 Securing health and long-term care

Health insurance in Germany is provided within two different systems: statutory health insurance (SHI) and private health insurance (PHI). With its 95 health insurance funds, the SHI system accounts for the lion's share of insured persons: around 90 percent of the insured population has SHI. People with statutory health insurance can be members of a local, company, professional or substitute health insurance fund. Others are members of an agricultural health insurance fund or the miners' insurance scheme. There are also private health insurance companies.

Health insurance is mandatory in Germany *(refer to Section 1.1.1 on page 18)*. This means that everyone with a permanent residence in Germany must take out health insurance.

The German system of health insurance has a rich tradition. SHI originally dates back to Bismarck's social legislation in the 19th century. Self-administered and funded by contributions, it was initially designed as an insurance scheme exclusively for blue-collar workers. SHI was then expanded to include white-collar workers in 1911.

It is also mandatory to take out **long-term care insurance** in Germany *(refer to Section 1.3.3 from page 30 and 1.3.4 from page 32)*. Its purpose is to ensure that all residents receive good care, even in old age.

All industrial nations have one thing in common: their societies are becoming progressively older. Population development forecasts indicate that the number of older people (aged 67 and over) in Germany is expected to rise to around 20.8 million by 2040, assuming moderate growth. But there is also a flip side to this positive trend towards a longevity society: The statistical probability of requiring long-term care rises considerably from the age of 80.

In other words: the older the population, the larger the number of people who need long-term care. Comprehensive long-term care insurance protects against this risk.

1.3.1 Statutory health insurance (SHI)

Members of an SHI include employees, trainees, pensioners and voluntarily insured persons. The remit of an SHI extends from health promotion and screening to specific medical treatment and rehabilitation. SHI is therefore essential to the German healthcare system.

In addition, members of an SHI must also take out **social long-term care insurance** *(refer to Section 1.3.3 from page 30)*.

The statutory health insurance funds are organised within an umbrella organisation, the National Association of Statutory Health Insurance Funds *(refer to Section 2.2.5 on page 45)*. They enter into contractual relationships with medical associations, hospitals and pharmacies via this organisation or their regional associations and stipulate how much money they pay for individual medical treatments.

The structures of this national association have experienced repeated reforms over the last 25 years. Always with the goal of making the healthcare systems better and more efficient. Among these reforms is the ability of health insurance funds to conclude individual contracts, known as ‘selective contracts’, with doctors, doctors' associations and hospitals. They refer to individual health insurance fund services.

Health insurance funds are also allowed to conclude **rebate agreements** with pharmaceutical manufacturers. In these agreements, companies grant rebates on the pharmaceuticals they produce to individual health insurance funds. In return, health insurance funds provide their insured persons exclusively with pharmacy medications from their contracted suppliers. Here, the legislator is seeking to reduce the SHI expenditure on pharmaceuticals – and therefore the contributions that insured persons and employers are required to pay.

Residents of Germany have been at liberty to choose their statutory health insurance fund since 1996, with just a few exceptions. The SHI functions according to the solidarity principle in this case *(refer to Section 1.1.3 on page 19)*. While contributions are based on the earnings of members, the health services are the same for everyone.

SHI has been financed via the **Gesundheitsfonds or health fund** since 2009. It pools contributions from employers, other social insurance providers, health insurance fund members and a federal subsidy. The resources that the health insurance funds require to fund the services for their members are allocated from the Gesundheitsfonds.

Medical Service (MD) and Federal Medical Service (MD Bund)

The MD has the statutory mandate to support the health and long-term care insurance funds in regard to socio-medical and long-term care issues. It operates independently to fulfil this mandate and ensures that all insured persons receive the same adequate care.

MD Bund coordinates the 15 Medical Services in the federal states and their collaboration at national level. It issues guidelines to regulate the work of the Medical Services. This involves, for example, the issue of standardised nationwide criteria for the assessment of medical issues *(refer to Section 2.3.10 on page 57)*.

The standard contribution rate that flows into the Gesundheitsfonds is currently 14.6 percent of gross wages. Health insurance funds are also entitled to levy an individual supplementary contribution.

Risk structure equalisation was introduced to ensure fair competition between the health insurance funds. But what precisely is it equalising? The insured persons and their different life circumstances are not distributed equally across all health insurance funds. This means that the members of some funds may tend to be younger, healthier or earn more, while others might provide insurance to many persons with chronic diseases and families in which not everyone pays contributions. Then there are regional differences. Altogether these factors mean that some funds may have to pay significantly more than others with lower revenue from contributions. Risk structure equalisation cushions the effects of this disparity between the individual funds.

1.3.2 Private health insurance (PHI)

Around 10 percent of German residents have private health insurance. Like with other private sector policies, freedom of contract also applies to private health insurance: Applicants can apply for membership with a private insurance company of their choice.

But the insurer is entitled to deny membership. This may occur if the applicant is suffering from certain pre-existing conditions or is too old. An insurer may potentially impose conditions on the contract, for instance a risk surcharge on the premium, or exclude some services for pre-existing conditions.

Residents with private health insurance are also required to conclude a long-term care policy *(refer to Section 1.3.4 on page 32)*.

Unlike statutory health insurance, the premiums for private health insurance depend on the benefits that an insured person has included in the policy and on the extent of their personal risk of illness. The cost reimbursement principle is another difference: it means that persons with private health insurance initially settle bills from doctors and other service providers themselves. They then submit the bills to their private health insurer who reimburses them for the costs.

Only certain groups are entitled to switch from statutory to private health insurance, for instance the self-employed, civil servants and employees with an income exceeding the mandatory insurance threshold.

1.3.3 Social long-term care insurance

The principle of 'long-term care and health insurance from a single source' applies here as a rule. Everyone with statutory health insurance automatically enters into **social long-term care insurance**. With long-term care insurance, people who require care can decide for themselves how and by whom they receive these services. It is at their discretion to decide whether they receive assistance from professional specialists or whether they would prefer to receive money that they can pass on to family carers as financial compensation, for example. The primary aim is to allow people who require care to retain as much independence as possible in their everyday lives.

However, social long-term insurance is often insufficient to cover all the costs of care. The person in need of long-term care, sometimes direct relatives, or, in cases of financial hardship, the social welfare system, must bear the remaining costs. This is why long-term care insurance is also referred to as a 'partial benefit system'.

Services provided under social long-term care insurance are funded by contributions. The contribution rate is 3.4 percent of the member's income that is subject to health insurance contributions (4 percent for childless members). Contributions are shared in equal parts by the employers and employees*. The Free State of Saxony has a different arrangement, where 2.2 percent is paid by employees and 1.2 percent by employers.

For parents with several children under the age of 25, the share of the contribution paid by the member is reduced by 0.25 contribution rate points from the second to the fifth child up to a maximum reduction of 1.0 contribution rate points.

The issues of when long-term care insurance provides benefits to persons in need of care, and which benefits these are specifically, depends on a variety of factors. Relevant issues include, for example, the length of time a person is likely to need care and the care level they have been assigned. *(refer to Section 3.3 from page 94)* .

* For reasons of improved readability, the female form is not used in some places. The explanations nevertheless apply to all genders.

1.3.4 Private long-term care insurance

Anyone with private health insurance is also required to take out a private policy for long-term care. The benefits are then equivalent to the social long-term care insurance. However, the benefits in kind are replaced by cost reimbursements – like with private health insurance.

In contrast to social long-term care insurance, the amount of the insurance premiums does not depend on the insured person's income or current financial circumstances. It is based instead on the individual insurance risk. This means that the insurer will take a look at the person's age and health status at the start of the policy.

However, private insurance companies are still required to comply with the statutory requirements. For instance, they are not allowed to stagger premiums based on gender, exclude any pre-existing conditions or reject persons who are already in need of care. Children – within certain age limits – are insured free of charge.

Employees who are covered by compulsory long-term care insurance from a private company receive a contribution subsidy from their employer.

Private long-term care insurance companies operate on the basis of the 'projected unit cost method'. This means that at the start of the private long-term care policy, the insured person's premium is higher than the actual risk of becoming in need of care. Insurers are therefore able to put aside money as an 'ageing reserve'.

2

Principal actors: Who is in charge of what?

The healthcare system in Germany builds on a wide network of actors to ensure that everyone receives the healthcare support they need. They are presented in this part.

2.1 The Federal Ministry of Health, its competent agencies and assigned commissioners

The Federal Ministry of Health (BMG) is the highest federal authority responsible for the healthcare system in Germany. Numerous institutions fall within its remit. They take charge of a variety of tasks – also at national level – relating to the health of persons residing in Germany.

2.1.1 Federal Ministry of Health (BMG)

The BMG is responsible for a wide variety of policy areas (*refer also to Section 1.2.1 from page 22*) within the Federal Government. Its work is focused on the drafting of bills and ordinances as well as administrative regulations.

For example, the BMG ensures that statutory health insurance (SHI) and long-term care insurance work well and are fit for purpose. It also strengthens the interests of patients and makes sure that our healthcare system works efficiently and remains financially viable.

Changing remit

The BMG has been the **supreme federal authority** for the healthcare system in Germany since 1961. But its responsibilities and tasks have changed repeatedly over the decades: In 1969, for example, the BMG was merged with today's Federal Ministry for Family Affairs, Senior Citizens, Women and Youth and became independent once again in 1991. The BMG was also responsible for the area of social affairs (and therefore for pension insurance) from 2002 to 2005. Later on, these matters were handed back to the Federal Ministry of Labour and Social Affairs.

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2.1.2 Federal Institute for Drugs and Medical Devices (BfArM)

Scientists from a wide range of disciplines working at the BfArM assess whether drugs are suitable for authorisation. This is because **drugs** can only be authorised in Germany if they are **effective** and **safe**. At the same time, these scientists conduct their own research to increase the safety of drugs and medical devices. By doing so, the BfArM improves patient safety and the public supply of effective drugs.

The BfArM reviews digital applications for the healthcare sector*(DiGA; refer also to Section 3.2.3 from page 78)* to determine whether they are effective, fit for purpose and whether the data is protected and secure. The BfArM has established an index of digital healthcare applications (diga.bfarm.de/de).

The Health Research Data Centre (FDZ Gesundheit; www.forschungsdatenzentrum-gesundheit.de) at the BfArM compiles healthcare data on all people with statutory health insurance in Germany in order to improve healthcare and research in Germany. Among the things that this enables are investigations into whether drugs are effective in everyday care and whether rare side effects exist. It also supports research into novel and effective treatment methods.

Federal Institute for Drugs and Medical Devices (BfArM)
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Email: poststelle@bfarm.de
www.bfarm.de

2.1.3 Federal Centre for Health Education (BZgA), that is, Federal Institute for Prevention and Education in Medicine (BIPAM)

The BZgA provides the general public with information on how to **prevent health risks** and **maintain a healthy lifestyle**. This is intended to help residents monitor and – if necessary – improve their own health status. Topics include blood donation, exercise, nutrition, diabetes mellitus, health in old age, child and adolescent health, organ and tissue donation, sexual health as well as infection protection and control, addiction prevention and resuscitation.

Federal Centre for Health Education (BZgA)
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www.bzga.de

The BIPAM is scheduled to take over the tasks of the BZgA on 1 January 2025. This is predicated on the entry into force of the Act to Strengthen Public Health (legislative process ongoing at the time of going to press). The federal institute will absorb all former employees of the BZgA, as well as some from the RKI.

2.1.4 Paul-Ehrlich-Institut (PEI)

The PEI researches and assesses **biomedical drugs for use on humans and animals.** These include, for instance, drugs that are manufactured with the assistance of bacteria, including certain **vaccinations** or **antibodies**. The PEI also decides on their authorisation. Likewise, these drugs only receive authorisation if they are effective and safe. In addition to approving clinical trials, the PEI also collects and assesses potential side effects.

PEI is home to the Center for PandemicVaccines and Therapeutics (ZEPAI). The centre is tasked with planning and implementing pandemic preparedness and response by means of vaccines and other pharmaceuticals.

The institute also tests drug batches, provides scientific advice and audits pharmaceutical companies, for example.

In order to fulfil this remit, the PEI conducts its own research in the areas of biomedicines and life sciences.

Federal Institute for Vaccines and Biomedicines (Paul-Ehrlich-Institut, PEI)
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2.1.5 Robert Koch Institute (RKI)

The RKI is the central health institution of the Federal Government and performs numerous tasks: As the public health institute for Germany, its remit includes monitoring diseases, infectious diseases in particular. Moreover, it is tasked with identifying and counteracting health hazards and risks at an early stage (prevention). This means that the RKI fulfils a central 'antenna function' akin to an early warning system.

The institute also engages in application-oriented biomedical research. This means that, among other things, the RKI can propose specific measures in the event of an epidemic or pandemic.

After all: **it is the declared objective of the RKI to protect the general public from diseases** and to improve their state of health.

To this end, scientists working at the institute investigate disease and health issues across all levels – from viruses in body cells to obesity in the population. It also collects data on infectious diseases, non-communicable diseases such as diabetes mellitus, cancer and on (new) biological hazards. Scientists draw on this data to develop specific recommendations and concepts for the treatment and prevention of diseases.

The RKI advises the competent federal ministries, the BMG in particular, and contributes to the development of norms and standards. It informs and advises relevant professionals, and increasingly, the general public as well.

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2.1.6 Commissioner of the Federal Government for Drug and Addiction Policy

The **Commissioner of the Federal Government for Drug and Addiction Policy** has a wide and varied remit. They coordinate the addiction and drug policy of the Federal Government and advocate for it in dealings with politicians, the media and the general public. The commissioner speaks with experts and collects their recommendations. They also head the German UN delegation on international drug policy and sit on various European Union committees on behalf of Germany.

The Commissioner of the Federal Government for Drug and Addiction Policy.
Burkhard Blienert
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www.bundesdrogenbeauftragter.de

2.1.7 Commissioner of the Federal Government for Patient Affairs

The **Commissioner of the Federal Government for Patient Affairs** advocates for and strengthens patient rights. They also act in an independent and advisory capacity to represent patient interests in dealings with politicians and the public as well as on committees and at events.

Federal ministries are required to notify the Commissioner about everything concerning the rights and protection of patients – including, for example, when new laws or regulations are to be introduced.

The Commissioner of the Federal Government for Patient Affairs
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Email: patientenrechte@bmg.bund.de
www.patientenbeauftragter.de

2.1.8 Commissioner of the Federal Government for Long-Term Care

The **Commissioner of the Federal Government for Long-Term Care** acts in an independent capacity to represent the interests of persons in need of long-term in dealings with politicians. In doing so, they give people with long-term care needs a voice and strengthen their rights to self- and co-determination. The objective is to shape the care and healthcare system so that it protects and supports those affected.

The federal ministries and authorities must involve the care representative in all legislative, regulatory and other important projects relating to long-term care.

Commissioner of the Federal Government for Long-Term Care
Claudia Moll, Member of the German Bundestag
11055 Berlin
Phone: +49 30 184413420
Email: pflegebevollmaechtigte@bmg.bund.de
www.pflegebevollmaechtigte.de

2.2 Joint Federal Committee and its member organisations

Headquartered in Berlin, the Joint Federal Committee (G-BA) is the most important body within the system of joint self-administration *(refer also Section 1.1.5 on page 21)* in the healthcare sector. The G-BA brings together representatives of health insurance funds, the medical profession, hospitals and patient and disability organisations to jointly discuss whether the health insurance funds should pay for new treatment methods, modern medical technology or novel therapeutic products.

2.2.1 Joint Federal Committee (G-BA)

The G-BA is primarily assigned the legal mandate to adopt the guidelines that are necessary to safeguard medical care. They stipulate, for example, how medical care should be structured and which quality assurance methods must be put in place. What is more, the G-BA decides on which benefits the health insurance funds cover.

The G-BA
receives support in its work from two scientific institutes: The **Institute for Quality and Efficiency in Health Care** *(IQWiG; refer also to Section 2.3.8 on page 55)* is mainly involved in the assessment of the costs and benefits of drugs and treatment methods with statutory health insurance (SHI). The **Institute for Quality Assurance and Transparency in Health Care (IQTIG)** is the central organisation for quality assurance in healthcare as required by law.

The G-BA also evaluates the benefits of drugs containing novel active substances and formulates requirements for structured treatment programmes (disease management programmes, DMPs for short).

The committee is composed of the following members with voting rights: the National Association of Statutory Health Insurance Funds *(refer to Section 2.2.5 on page 45)*, of the National Association of Statutory Health Insurance Physicians (KBV)

and the National Association of Statutory Health Insurance Dentists (KZBV) *(refer to Section 2.2.3 from page 44 and 2.2.4 on page 45)* as well as the German Hospital Federation (DKG).

Representatives of patient and disability organisations have the right to participate in the G-BA committees – so they can contribute their experience, for example on issues such as whether the health insurance funds should cover nutritional advice for patients with diabetes mellitus, which novel treatment methods should be included in care or which dental prostheses the health insurance funds should finance. The representatives are entitled to submit proposals to the G-BA. But they are not entitled to participate in the decision-making process.

Joint Federal Committee (G-BA)
Gutenbergstraße 13
10587 Berlin
Phone: +49 30 2758380
Email: info@g-ba.de
www.g-ba.de

2.2.2 German Hospital Federation (DKG)

Individual hospitals do not advocate for their interests individually in most cases, but through their associations. The hospitals are organised within **state hospital associations** at federal state level. The state associations are, in turn, organised within the **German Hospital Federation (DKG)**. It represents the interests of hospitals in health policy decisions at federal level and is therefore belongs to the system of self-administration within healthcare.

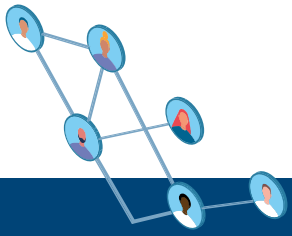
German Hospital Federation (DKG)
Wegelystraße 3
10623 Berlin
Phone: +49 30 398010
Email: dkgmail@dkgev.de
www.dkgev.de

2.2.3 National Association of Statutory Health Insurance Physicians (KBV)

The KBV is the umbrella organisation of the 17 Associations of Statutory Health Insurance Physicians (KVs). Together, these organisations ensure that all people in Germany with statutory health insurance receive (comprehensive and local) outpatient medical care (known as panel doctor care).

At the same time, the KBV represents the interests of outpatient panel doctors and psychotherapists in matters of policy.

National Association of Statutory Health Insurance Physicians (KBV)
Herbert-Lewin-Platz 2
10623 Berlin
Phone: +49 30 40050
Email: info@kbv.de
www.kbv.de



All persons in Germany with statutory health insurance should receive optimal outpatient medical, psychotherapeutic and dental care. The Associations of Statutory Health Insurance Physicians and Dentists (KVs and KZVs) and the respective federal organisation (KBV and KZBV) tare in charge of this area. For example, they negotiate with health insurance funds about which services they are and are not required to cover.

Included in the service guarantee *(refer to Section 2.2.1 on page 42)* is the appropriate and timely delivery of care by SHI-accredited physicians. This stipulates, among other things, that the KVs must operate appointment service centres that must be reachable daily under the standard nationwide phone number **116117** *(for further information refer to Section 4.2.4 from page 118).*

2.2.4 National Association of Statutory Health Insurance Dentists

The KZBV is the umbrella organisation of the 17 Associations of Statutory Health Insurance Dentists (KZVs). Together, these organisations ensure that all people in Germany with statutory health insurance receive (comprehensive and local) outpatient dental care (known as panel dentist care).

At the same time, the KZBV represents the interests of outpatient panel dentists in matters of policy.

National Association of Statutory Health Insurance Dentists (KZBV)
Behrenstraße 42
10117 Berlin
Phone: +49 30 2801790
Email: post@kzbv.de
www.kzbv.de

2.2.5 National Association of Statutory Health Insurance Funds (GKV-SV)

There are many different ways to take out health insurance in Germany. The statutory health insurance *(refer to Section 1.3.1 from page 27)* with its currently 95 funds has the largest number of insured persons. There are also private health insurance funds *(refer to Section 1.3.2 from page 29)*.

The **statutory health insurance funds** and the **long-term care insurance funds** are organised within an association, the National Association of Statutory Health Insurance Funds (GKV-SV). They enter into contractual relationships with medical associations, hospitals and pharmacies via this organisation and their regional associations and stipulate how much money they pay for individual medical treatments.

National Association of Statutory Health Insurance Funds (GKV-SV)
Reinhardtstraße 28
10117 Berlin
Phone: +49 30 2062880
Email: kontakt@gkv-spitzenverband.de
www.gkv-spitzenverband.de

2.3 Other key actors in the healthcare system

The delivery of healthcare to patients builds on an extensive network of various actors. The following section will provide information on the role of the federal states and municipalities as well as many other healthcare providers and lobby groups.

2.3.1 Federal states

The federal states and their administrative authorities are responsible for ensuring implementation of federal laws – and are vested with technical and official supervision of the municipal Public Health Service (ÖGD; *refer to Section 3.1.3 from page 66)*. At the same time, they also have the power to draft and pass their own laws. The federal states also plan and partly finance inpatient care – so clinics and rehabilitation centres.

State health policy

State ministries are generally responsible for health policy in their federal state. The names of these ministries vary, depending on the state in question. Baden-Württemberg, for example, has a Ministry for Social Affairs, Health and Integration, while Saxony has a State Ministry for Social Affairs and Social Cohesion. The state health ministers meet regularly as part of the Conference of State Health Ministers (GMK). Visit www.gmkonline.de for more information.

Responsibility for statutory health insurance rests largely with the Federal Government. Nevertheless, the federal states oversee the regional funds. Chambers for health professions (state chambers of physicians, dentists, pharmacists and psychotherapists) and the associations of statutory health insurance physicians and dentists are supervised by the federal states as well.

The websites of the state ministries provide information about the health situation and structures in their respective states.

Links to the **websites of the state ministries** are found on the website of the Conference of Health Ministers: www.gmkonline.de/Mitglieder-Mitglieder-GMK

2.3.2 Municipalities

At present, 377 public health departments within the municipal public health service provide advice and information on topics such as child and adolescent health, oral and dental health, pregnancy care, mental health, addiction counselling and sexual health. The public health departments have additional responsibility for health protection. This concerns, for example, hygiene and infection prevention and control, including vaccination. They are also responsible for environmental health protection and for outbreak and crisis management.

People mainly look for doctors, physiotherapists and other medical professionals in their own town or city. This means that they seek and receive medical care in their immediate environment. It is this fact that makes municipalities such important political actors, although they are also the smallest: they operate close to the people and are therefore responsible for healthcare delivery where the people live.

Thy provide low-level information on topics such as pregnancy, prevention and /STI treatment (HIV: acronym for 'Human Immunodeficiency Virus'; STI: acronym for 'sexually transmitted infections'so infections that are transmitted through sexual contact), addiction counselling and psychological and psychiatric support. In doing so, they contribute to equal opportunities within the German healthcare sector. The municipal public health departments are also integral to healthcare delivery in Germany. They operate close to where people live. Moreover, the municipalities are often hospital operators as well.

2.3.3 Professional associations

Healthcare professionals come together in professional associations to represent their interests with one voice and communicate their positions to the outside world. There are numerous professional associations in the healthcare sector, including the Federal Association of Pneumologists, Sleep and Respiratory Physicians (BdP) or the Professional Association of Gynaecologists (BVF).

This section presents some of the major professional associations and national organisations, so associations that bring together other organisations:

The **Federal Union of German Associations of Pharmacists (ABDA)** is the umbrella organisation of pharmacists in Germany. It represents the interests of pharmaceutical professions in dealings with politicians and society. Under the umbrella of the ABDA, the chambers of pharmacists in the federal states have joined together in the **Federal Chamber of Pharmacists (BAK)**, while the associations of pharmacists in the federal states are represented by the **German Association of Pharmacists (DAV)**.
www.abda.de

The **German Medical Association (BÄK)** is the umbrella organisation within the system of medical self-administration and represents the professional interests of doctors at policy level in Germany. As a working group of the 17 German **medical associations**, the BÄK is committed to a citizen-centred and responsible health and social policy.
www.bundesaerztekammer.de

The **German Dental Association (BZÄK)** represents the professional interests of dentists in Germany. Its members are the dental associations in the federal states. The BZÄK represents the health and professional interests of dentists at policy level. Its objective is to ensure the delivery of dental health to the

benefit of patients. In doing so, it consistently draws on the latest scientific insights.
www.bzaek.de

The **German Chamber of Psychotherapists (BPtK)** is the working group of all twelve state chambers of psychotherapists. It represents the professional interests of psychological psychotherapists, child and adolescent psychotherapists and future psychotherapists at policy level.
www.bptk.de

The **German Nursing Council (DPR) – Federal Working Group for the Care and Midwifery Sector** is the association of the most important organisations in the German nursing and midwifery sector. It represents the combined interests of professional carers and midwives at federal level.
www.deutscher-pflegerat.de

The **Association of German Social Welfare Organisations (BAGFW)** is the collective voice of the top social welfare organisations in Germany. These are the Arbeiterwohlfahrt, the Deutsche Caritasverband, the Deutsche Rote Kreuz, the Deutsche Paritätische Wohlfahrtsverband, the Diakonische Werk der Evangelischen Kirche in Deutschland and the Zentralwohlfahrtsstelle der Juden in Deutschland. Their common goal is to engage in joint initiatives and socio-political activities to secure and improve social work.
www.bagfw.de

The **Association of German Medical Care Centres – Health Centres – Integrated Care (BMVZ)** is a non-profit organisation whose members consist of medical facilities and interested companies. Its aim is to promote collaboration in the delivery of outpatient healthcare.
www.bmvz.de

The **Association of the Scientific Medical Societies in Germany (AWMF)** represents the interests of scientific medicine, in particular in dealings with state institutions and actors within the system of medical self-administration. The AWMF has coordinated the development of guidelines for diagnostics and therapy by the individual medical associations since 1995. It posts the guidelines on its website, which also provides information for patients in the form of patient guidelines on numerous diseases.
www.awmf.org

2.3.4 Patient organisations

Patients are represented on many committees within the healthcare system. The representatives of patient organisations that take part in the meetings of the G-BA.*(refer to Section 2.2.1 from page 42)* are just one example. Relevant patient organisations include, for instance:

The **German Disability Council (DBR):** The **DBR** actively represents the main associations of chronically ill and disabled persons. The DBR remit includes representing the interests of persons with disabilities and chronic diseases and their relatives across all associations.
www.deutscher-behindertenrat.de

The **German Association of Patient Centres (BAGP):** The **BAGP** is a specialist working group in the area of policy. It sees its role as that of an umbrella organisation for patient centres and patient counsellors. The BAGP was established in order to develop and guarantee common counselling standards, to pool expertise and ensure more effective action at political level.
www.bagp.de

The **Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e. V. (DAG-SH):** The **DAG-SH** supports and promotes self-help groups in Germany. Members include, for example, self-help organisations and employees of self-help contact points, as well as professionals from psychosocial and health professions.
www.dag-shg.de

The **Federation of German Consumer Organisations (vzbv):** The **vzbv** acts as the collective voice of 16 consumer centres and 26 consumer policy associations. For example, it advocates for safe and healthy products and services, appropriate medical care and humane long-term care.
www.vzbv.de

There are also self-help groups that represent the interests of affected persons to the outside world. These include, for example, the Federal Association of Self-Help Groups for Persons with Disabilities, Chronic Diseases and their Relatives (BAG SELBSTHILFE). For more information about self-help groups and organisations, refer to *Section 4.5.8 from page 135*.

Moreover, the **Action Alliance for Patient Safety (APS)** offers a platform for the delivery of safe healthcare in Germany. Representatives from all healthcare professions and institutions, patient organisations and interested parties have come together to establish a joint network. Together they educate the general public and discuss professional issues. Leaflets, information material and checklists are made available to the general public. The alliance also organises activities and campaigns aimed at improving patient safety in Germany and invites patients to become involved. The APS therefore receives support from the BMG.
www.aps-ev.de

2.3.5 Association of Private Health Insurance Companies (PKV-Verband)

The **Association of Private Health Insurance Companies (PKV-Verband)** represents the interests of health and long-term care insurers from the private sector. The association has 42 full members and ten associate members. Companies in the second category only offer supplementary and not comprehensive health insurance.

The health insurance scheme for federal railway employees and its counterpart for Post Office civil servants are affiliated with the PKV-Verband.

Association of Private Health Insurance Companies (PKV-Verband)
Gustav-Heinemann-Ufer 74 c
50968 Cologne
Phone: +49 30 20458966
Email: kontakt@pkv.de
www.pkv.de

2.3.6 Business associations

Pharmaceutical and medical device manufacturers also come together in associations and lobby groups. This section presents a few of them:

Pharma Deutschland , a full-service association of pharmaceutical companies, is the association that has the largest number of members in Germany. It represents the interests of around 400 member companies. Its members include, in addition to pharmaceutical companies, pharmacists, lawyers, publishers, agencies and market and opinion research institutes in the healthcare sector. Pharma Deutschland is a point of contact for politicians, authorities and institutions in the healthcare sector.
www.pharmadeutschland.de

The **Association of Research-Based Pharmaceutical Companies (vfa)** is the organisation representing companies engaged in this field in Germany. This interest group brings together 48 global research-based pharmaceutical companies, along with over a hundred subsidiaries and sister companies.
www.vfa.de

The **Federal Association of the Pharmaceutical Industry (BPI)** advocates for the interests of the pharmaceutical industry in dealings with politicians and the general public. The organisation has around 260 members.
www.bpi.de

Pro Generika is the association of generics and biosimilar companies in Germany. A 'generic' is a drug that contains the identical active substance as a formerly patent-protected preparation and therefore has the same effect. Generics are placed on the market once the patent for the original has expired. Biosimilars are also copycat products, but of drugs manufactured by means of biotechnology. Pro Generika has 17 member companies in Germany.
www.progenerika.de

The **Federal Association of Private Providers of Social Services (bpa)** has more than 13,000 active member organisations and is the largest representative body of private social services providers in Germany. The bpa consists of privately run outpatient and (partial) inpatient care facilities, care for the disabled and child and youth welfare services.
www.bpa.de

The **German Medical Technology Association (BV Med)** represents more than 300 manufacturers, suppliers and distributors in the MedTech sector in dealings with politicians and the general public. Their products include diagnostic or surgical devices, implants, dressings and surgical materials.
www.bvmed.de

The **SPECTARIS industry association** brings together around 130 companies in the medical technology sector in Germany, which is largely shaped by SMEs. The companies primarily develop, produce and market medical technology products in the capital goods sector, medical aids and, increasingly, digital healthcare solutions.
www.spectaris.de

The **German Digital Healthcare Association** acts as the common voice of all e-health providers and promoters in Germany. E-health refers to applications that harness digital information and communication technologies to improve the delivery of treatment and care to patients. The association represents its members to other partners within the health system, politicians and the general public.
www.digitalversorgt.de

2.3.7 National Agency for Digital Medicine (gematik)

As a nationwide competence centre, gematik GmbH is responsible for establishing and operating the telematics infrastructure. The telematics infrastructure connects all actors within the healthcare delivery to ensure secure and fast communication. One of the primary objectives is to enable the delivery of medical information required for the treatment of patients to the right place at the right time. As part of this remit, the digital agency also provides operational support and coordination within the wider framework of implementing the digitalisation strategy for the health- and long-term care sector.

The telematics infrastructure includes digital applications that assist in the communication of medical data, in particular electronic patient files, electronic prescriptions and electronic sick notes *(refer also to Section 3.2.3 from page 78)*.

The Federal Ministry of Health holds a majority share of 51 percent in gematik GmbH. Other shareholders include the following representatives of the service providers: German Medical Association, German Dental Association, National Association of Statutory Health Insurance Physicians and National Association of Statutory Health Insurance Dentists, German Hospital Federation, National Association of Statutory Health Insurance Funds, Association of Private Health Insurers and German Pharmacy Association.

gematik GmbH
Friedrichstraße 136
10117 Berlin
Phone: +49 30 400410
Email: info@gematik.de
www.gematik.de

2.3.8 Institute for Quality and Efficiency in Health Care (IQWiG)

IQWIG examines the benefits and harms of medical interventions for patients as an independent scientific institution. It also provides expert opinions and reports to assist the work of the G-BA *(refer to Section 2.2.1 from page 42)*. The GB-A can then decide to which extent, for example, health insurance funds are required to cover novel drugs or treatment methods.

On the **platform gesundheitsinformation.de**, the IQWiG posts easily understandable health information based on the latest scientific findings. This includes examination and treatments for numerous diseases. The information platform is intended to provide guidance on available healthcare services.

Institute for Quality and Efficiency in Health Care (IQWiG)
Im Mediapark 8
50670 Cologne
Phone: 0221 356850
Email: info@iqwig.de
www.iqwig.de

2.3.9 German Advisory Council on the Assessment of Developments in Healthcare and Long-Term Care (SVR)

The **SVR** is the most prestigious body within the healthcare sector that provides scientific advice to politicians. The council operates independently and consists of seven professors from the fields of medicine, economics and nursing science. In its annual reports, the German Advisory Council analyses various aspects (e.g. digitalisation, skilled workers) concerning trends within health- and long-term care as well as the medical and economic impacts. The objective is to avoid overuse, underuse and misuse and to identify opportunities and ways to continue developing the healthcare system in the interests of patient welfare.

German Advisory Council on the Assessment of Developments in Healthcare and Long-Term Care
Rochusstraße 1
53123 Bonn
Phone: 0228 994414511
Email: svr@bmg.bund.de
www.svr-gesundheit.de

2.3.10 Federal Medical Service (MD Bund)

The **MD Bund** is an expert organisation on aspects of medical and long-term care and represents the interests of its members – the 15 medical services in the federal states – at national level. As an expert organisation in the areas of medicine and long-term care, the MD Bund advises the health and long-term care insurance funds at national level – the National Association of Statutory Health Insurance Funds in particular. It also coordinates the technical work of the Medical Services and introduces guidelines to safeguard assessments and advisory services according to standardised nationwide criteria.
www.md-bund.de

3

Healthcare and long-term care

Patients are entitled to high-quality medical care – including dignified long-term care. This part explains which actors are involved in the delivery of healthcare in Germany.

3.1 Prevention and screening, Public Health Service, quality assurance

However advisable it is to treat illnesses effectively – it is better to prevent them altogether. Prevention, health promotion, screening and a healthy lifestyle can contribute to this aim – and health insurance funds also provide funding.

3.1.1 Disease prevention and health promotion

We all want good health, for ourselves and our nearest and dearest. This is not an area in which we need to remain passive. We can, for example, maintain a healthy diet, exercise and try to maintain a good work-life balance.

Most diseases are not congenital, but emerge over the course of our lives. Given that society is becoming increasingly old, it is essential that we promote health within a mindful framework, avoid risk factors and prevent illness. Only then will we develop as healthy individuals and remain so into old age – with a high quality of life.

Each of us can influence our own health status. For instance, regular physical activity, a balanced diet, regular rest and abstaining from smoking and alcohol all have a positive effect. Widespread diseases in particular, among them type 2 diabetes mellitus *(refer to Section 4.4.7 on page 132)* or cardiovascular diseases (including heart attacks; *refer to Section 4.4.5 on page 130)*, can often be prevented or mitigated in the long term by maintaining a healthy lifestyle. People who regularly engage in positive activities will feel better, both physically and mentally. **Behavioural preventive measures** are therefore relevant for every member of society.

The deliberate adoption of healthy habits, personal monitoring and regular medical screening or early detection check-ups *(refer to Section 3.1.2 from page 64)* help us to strengthen our personal resources, avoid health risks and stress and recognise the first signs of illness at an early stage – even before physical or mental symptoms become noticeable.

Numerous infectious diseases can also be prevented by **vaccinations**. In other cases, vaccination will at least mitigate the risk of becoming seriously ill. Each year, vaccination protects and saves millions of lives. Check with your doctor whether you have already received all vaccinations as recommended by the Standing Committee on Vaccination at the Robert Koch Institute or whetherbooster vaccinations are due. All vaccinations are recorded in your vaccination booklet. For more information on the topic of vaccination, read the BMG **VaccinationGuide**. You can download this document from the BMG website or order a print copy.

Health-promotion measures provided by the health insurance funds are intended to promote self-determined, health-orientated lifestyles among insured persons.

For example, many **health insurance funds** offer their members prevention courses to motivate and empower them to make the most of their ability to adopt healthy lifestyles. In addition, the health insurance funds support the development of health-promoting structures in living environments, for example in day-care centres, schools, clubs, in long-term care and in communities.

We all spend a large part of our lives at work. The working conditions there can impact our personal health in both positive and negative ways. Unfavourable working conditions, for example, can lead to physical complaints, while stress is harmful to mental health.

The healthcare system and other social welfare sectors have adopted the tasks of **prevention and health promotion**. In 2015, the Federal Government passed the Act to Strengthen Health Promotion and Prevention, or **Prevention Act** for short, with the aim of strengthening prevention and health promotion by creating new structures, such as the **National Prevention Conference (NPK),** the **National Prevention Strategy** or the **National Prevention Forum**, and improving cooperation between the various stakeholders. The umbrella organisations of the statutory health, accident, pension and long-term care insurers, the Association of Private Health Insurers and others have come together in the NPK to deliver services that share common goals:

People should develop as health individuals, live and work in a healthy environment and maintain good health into old age.

The health insurance funds, for example, help people in charge of kindergartens, schools, companies and care homes to establish and strengthen structures that contribute to maintaining healthy living and working conditions.

Screening check-ups for children, adolescents and adults are also developed and improved under the Prevention Act. Insured adults are entitled to regular examinations for the early detection of certain cancerous diseases (bowel, skin, breast, cervical and prostate cancer).

Companies can improve their success and competitiveness by keep their employees healthy and motivated. This is why many **companies** promote healthy lifestyles among their staff.

Both approaches – health promotion and preventive measures – help to prevent the emergence of chronic, non-communicable diseases or minimise their progression.

Relevant **contact points and other actors** in the areas of prevention and health promotion are listed in *Section 4.3 from page 118*.

3.1.2 Screening for diseases

The prospects for treating and healing diseases are often better if the conditions are detected at an early stage or as early as possible. This is why the **statutory health insurance funds** *(refer to Section 1.3.1 from page 27)* offer their members early detection check-ups – which are sometimes called screening.

Check-ups for the early detection of diseases are generally intended for persons who seem healthy and are not experiencing any symptoms. This is because screening is designed to detect a disease or its precursors before they lead to the emergence of symptoms. Pre-stages of bowel or cervical cancer, for example, can develop over many years and initially involve merely harmless tissue changes. Nevertheless: no early detection method is foolproof. This means that there is no screening test in existence that can reliably identify all sick people as sick and all healthy people as healthy.

Persons with statutory health insurance have a right to screening, e.g. for common conditions such as cardiovascular diseases *(refer to 4.4.5 on page 130)* and diabetes mellitus *(refer to Section 4.4.7 on page 132)* as well as for certain forms of cancer *(refer to Section 4.4.3 from page 128)*. Doctors use the check-up for adults to assess the insured person's general health status.

Among the other things they check is whether any health problems or risk factors apply, such as a lack of exercise or obesity. They also review the vaccination status. The cancer screening programme offered by statutory health insurance includes examinations for the early detection of breast, cervical, prostate, bowel and skin cancer.

Pre- and postnatal preventive and early detection check-ups are particularly well known, along with the health check-ups for children and adolescents. Doctors use the early detection check-ups (known in Germany as the U-Untersuchungen) and adolescents (the J-Untersuchung) to review the person's general health status. They check for the presence of certain serious diseases and the extent the child is developing appropriately according to its age. Children can be treated and supported at an early stage if delayed development or risks are identified. At present, children are entitled to ten of these check-ups (U1 to U9, including U7a) from birth to the age of six. Young people have the right to another health check-up (J1) between the ages of 12 and 14.

Do the health insurance funds cover all early detection check-ups?

All screening tests that the G-BA recommends in its guidelines are covered by the statutory health insurance funds and without any co-payment. Some health insurance funds even offer additional check-ups without any co-payment. Simply ask your health insurance fund or learn more in the member magazine or on the website of your health insurer.

3.1.3 Public Health Service (ÖGD)

The ÖGD is an indispensable part of the healthcare system in Germany, in addition to the outpatient and inpatient sectors. While a visit to the doctor or a stay in hospital is intended to ensure the best possible individual care, the ÖGD focuses on the health of the entire population. Overarching tasks include health protection, health promotion, advice and information.

The ÖGD is comprised of institutions within health administration at federal, state and municipal level. At federal level, these include the **Federal Ministry of Health** *(BMG; refer to Section 2.1.1 from page 35)* and its national authorities: the Federal Centre for Health Education *(BZgA; refer to Section 2.1.3 on page 37)*, the Robert Koch-Institute *(RKI; refer to Section 2.1.5 on page 39)* and the Federal Institute for Vaccines and Biomedicines *(Paul-Ehrlich-Institut, PEI, refer to Section 2.1.4 on opage38)*.

Competent bodies at state level *(refer to Section 2.3.1 from page 46)* include the **State Ministries of Health** and **state offices**, so the **State Institutes of Health**, while responsibility at municipal level *(refer to Section 2.3.2 on page 47)* rests with the **public health departments**.

There are currently just under 380 public health departments, which are responsible, among other things, for the following areas of health protection and promotion:

- Infection prevention and control (e.g. reporting, outbreak investigations, contact point management, the imposition of hygiene measures)
- Hygiene (including clean drinking water or hospital hygiene)
- School entry and other screening examinations by the child and adolescent health service
- Vaccination programmes

- Counselling and support services (e.g. on child health, addiction counselling, disability counselling, mental health)
- Counselling, diagnostics and treatment of sexually transmitted diseases such as HIV/AIDS, chlamydia and gonorrhoea
- Assessments
- Health reporting
- Implementation and coordination of projects and campaigns at local level (e.g. school projects, health days)
- Networking (e.g. addiction prevention or mental health networks, health conferences)
- Issues of environmental medicine (e.g. contaminated sites)

In 2020, the Federal Government and states agreed on a Pact for the Public Health Service to learn from the experiences of the COVID-19 pandemic. Its aim is to strengthen and modernise the entire remit of the ÖGD across all administrative levels. The Federal Government will provide €4 billion in funding until 2026 in order to implement the pact.

There are also plans to establish new counselling services for patients in socially disenfranchised regions throughout Germany. Ultimately, this should lead to the opening of around 1,000 '**health kiosks**'. The kiosks will largely be tasked with facilitating access to healthcare delivery for patients with particular support needs. State-certified long-term care professionals will provide low-threshold advice, information about treatments or preventive services and carry out simple routine medical tasks (such as taking blood pressure or changing bandages), among other things.

The contact points are to be organised by the municipalities. The health kiosks will be largely financed by statutory and private health insurers, with contributions from the local authorities.

3.1.4 Quality assurance in health- and long-term care

Persons in need of long-term care have a right to receive it at a high standard. In October 2019, the legislator began the gradual introduction of a new quality system for **inpatient long-term care**. Among the key elements are ten quality indicators that **care homes** have been required to measure every six months since January 2022:

1. maintained mobility
2. maintained independence in everyday activities (e.g. personal hygiene)
3. maintained independence in the organisation of everyday life and social contacts
4. development of pressure sores
5. serious consequences of a falls
6. unintentional weight loss
7. conducting an integration meeting
8. use of straps to restrain residents
9. application of side panels on beds
10. currency of pain assessment

Annual quality audits are also conducted in all care homes to assess compliance with requirements concerning staff and the quality of long-term care. Acting on behalf of the state associations of long-term care funds, the audits are performed by the **Medical Service (MD)** or by **Prüfdienst der privaten Krankenversicherung e. V. (Careproof GmbH)**. Aside from the scheduled audits, additional ones are also permitted on an ad hoc basis

- for example, if there is substantiated evidence of quality defects or other irregularities.
www.medizinischerdienst.de
www.careproof.eu

Patients should also receive high-quality care that builds on the latest scientific findings in **hospitals**, **medical and dental practices**. To ensure that this happens, the legislator has tasked the G-BA *(refer to Section 2.2.1 from 42)* with quality assurance.

Here, the G-BA receives support from the independent **Institute for Quality Assurance and Transparency in Health Care (IQTIG)**. It develops measures to assess and visualise the quality of care in hospitals and medical practices, participates in the assessments and evaluates the findings.
www.iqtig.org

Quality indicators are instruments that are used to measure and evaluate the quality of outcomes in inpatient care. For instance, the 'development of pressure sores' indicator is used to determine how frequently care home residents experience pressure sores.

3.1.5 Patient rights

Patients have numerous rights in matters relating to their health. Associations of statutory health insurance physicians (KVs) are obliged to operate **appointment service centres** (TSS) to ensure that patients do not have to wait too long for an appointment with a specialist, psychotherapist or for other services. These can be reached every day on the nationwide helpline 116117*(for further information, refer to Section 4.2.4 from page 116)*. People may feel uncertain about whether plannable surgeries are absolutely necessary from a medical perspective. In these cases, patients have a right to a **second opinion**, which is paid for by the health insurance funds. This means that they can consult another doctor to obtain their opinion, and the health insurance fund will cover the costs of this second opinion as well. The GB-A decides on the specific interventions for which the patient has a right to a second opinion at the expense

of the health insurance fund *(refer to Section 2.2.1 from page 42)*. Examples include hysterectomies, tonsillectomies, spinal surgery and procedures to insert a pacemaker or defibrillator.

The government has also strengthened the rights of persons withchronic conditions. As part of the Act to Strengthen Statutory Health Insurance (GKV-VSG), the G-BA has been mandated with developing a structured treatment programmes (Disease Management Programmes - DMPs) for additional chronic diseases. Furthermore, insured persons are now entitled to sickness benefit from the day on which they receive a doctor's sick note – and no longer from the following day. This closes a gap in provisions for persons who, on a regular basis, are unable to work for only one day due to the same condition (e.g. due to chemotherapy or a certain form of dialysis).

Patients have a **right of preference and choice** in regard to medical rehabilitation This halves the additional costs incurred by insured persons if they select a rehabilitation centre other than the one allocated by the health insurance fund. The minimum waiting period for repeat rehabilitation of children and adolescents has also been abolished. The necessity of geriatric rehabilitation, which is offered to the elderly in particular, is determined by the attending physician, and the health insurance funds are bound by this determination. For other indications, the health insurance fund is only permitted to deviate from the opinion of the attending physician based on a review by the Medical Service.

3.2 Healthcare delivery – from A for affordable care to Z for zirconia implants

You would be forgiven for believing that it should be quite simple: when people become ill, they go to the doctor. If their condition worsens, they are admitted to hospital. But treatment options have become a little more varied thanks to medical progress. Nowadays, there are people with chronic conditions or care needs who can lead a self-determined life with virtually no impairment.

The German healthcare system is divided into outpatient and inpatient care, as well as long-term outpatient and inpatient care.

Outpatient or inpatient?
Treatments, long-term care or rehabilitation measures and therapies that are provided outside of inpatient institutions such as hospitals are part of outpatient care. Nonetheless, hospitals can also provide outpatient care, for instance in their outpatient treatment centres. Some doctors in private practice or midwives work temporarily in the hospital as attending physicians or attending midwives.

Outpatient medical care
Outpatient means that patients receive treatment from specialists in private practice *(refer to Section 3.2.2 from page 76 to learn more)*.

Outpatient care also refers to surgery for which a patient is not required to remain overnight in a hospital. After undergoing outpatient surgery, patients can return home immediately or a few hours after the intervention.

Inpatient medical care

Patients receive inpatient care in the roughly 1,900 hospitals in Germany. Here, most **hospitals** will treat anyone, irrespective of whether they have statutory or private insurance. To receive treatment, they must only present a referral from a doctor – except, of course, in an emergency, which will be treated by the hospital immediately.

From a single source

There is a growing realisation that patient care requires a team effort *(refer also to Section 3.2.5 from page 85)*. A person with age-related hip pain, for example, will be examined by an orthopaedic outpatient department, may potentially undergo inpatient surgery, then be admitted to a rehabilitation clinic and, after discharge, receive local physiotherapy. This is only one example of many. But it shows nonetheless: medical treatments often exceed the boundaries of a single sector. Persons with chronic conditions in particular benefit from programmes that combine elements of inpatient and outpatient therapies, which are put together to ensure optimised treatment. Novel care models have emerged in recent years for precisely this purpose.

Practical examples:

1 | Certain chronic conditions, including type 1 and 2 diabetes mellitus *(refer to Section 4.4.7 on page 132)*, breast cancer, coronary heart disease, bronchial asthma and chronic obstructive pulmonary disease(COPD) have been dealt with by the health insurance funds according to **structured treatment programmes** . What sets them apart: the entire therapy is coordinated from a single source Persons with chronic diseases can participate voluntarily in these **Disease Management Programmes (DMP)**.

2 | **'Integrated care'** enables doctors and hospitals to prepare joint care strategies – that go beyond the concept of just outpatient and inpatient care. They enter into contractual agreements with the health insurance funds so that they can offer these treatments to their members.

3 | General practitioners play a particular role in guiding their patients in **general practitioner contracts** (GP-centred care). The GPs play a coordinating role in the entire care process. The free choice of doctor – the foundational principle of the German system – is restricted here in that patients are obliged to first see their chosen GP. This means that the entire treatment is coordinated by a trusted person. The health insurance funds conclude these GP contracts on behalf of their members. The aim is to improve the coordination of medical specialists, hospitals and other service providers.

4 | **Outpatient Medical Specialised Care (ASV)**is a treatment programme for patients with rare or serious conditions that exhibit a particular progression (such as tuberculosis, cystic fibrosis or Wilson's disease). Treatment is provided by interdisciplinary teams of doctors from specialist outpatient and inpatient care.

Out- and inpatient rehabilitation facilities

A serious illness, long periods of therapy or surgery will sometimes bring dramatic upheaval to a person's life. Often they will have long-term consequences. A broad spectrum of rehabilitation programmes – both in- and out patient – are available to enable patients to return to everyday life as quickly as possible. Some rehabilitation measures are also provided within a mobile setting, so in the patient's home or an inpatient care facility. Rehabilitation services include physiotherapy, psychological support and assistance with the use of medical aids. Furthermore, the German healthcare system has rehabilitation centres for special indications such as eating disorders or addictions.

But it takes a strong network of additional actors to ensure that people receive good and seamless treatment. They are presented in the following sections.

3.2.1 Pharmacies and pharmaceuticals

Doctors issue prescriptions, which the patient then takes to a **pharmacy**. The health insurance fund pays for most of the costs of a prescribed drug. Persons with statutory health insurance are required to make a **co-payment** amounting to 10 percent of the retail price, which is capped at €10.00 but is at least €5.00. This means that a patient receiving a prescription for a drug that retails at €17.80 euros in the pharmacy would pay the minimum amount of €5.00. By the same principle, their co-pay on a drug costing €70.00 would be 10 percent or €7.00.

Patients can take their prescriptions to any pharmacy. The drugs have the same price in all pharmacies. This is ensured by the Pharmaceutical Price Ordinance. It stipulates a uniform retail price for prescription-only drugs at any pharmacy.

Patients are not required to make any additional payment on several thousand low-cost preparations. Children and adolescents are exempted from co-payments up to the age of 18.

A **cap** has been introduced to ensure that co-payments remain affordable: it is set at two percent of a person's gross income, and one percent in the case of chronic conditions. This calculation includes not only the co-payments for drugs, but also for inpatient treatment, medical products and home nursing care. Patients receive confirmation from the health insurance fund once they have reached the cap. The insured persons are then exempted from all co-payments for the rest of the year.

Drugs

Even if **pharmaceuticals** cost the same in all pharmacies, the price of the same active substance will still fluctuate. Broadly speaking, pharmaceutical companies decide for themselves *(refer to Section 2.3.6 from page 52)* how expensive their products should be. Some pharmaceuticals are patent-protected and are known as originator products. When a new drug is placed on the market, the manufacturer is at liberty to set the price at their own discretion. Pharmaceutical companies and health insurance companies then negotiate the price. The amount also depends on whether the G-BA *(refer to Section 2.2.1 from page 42)* attests the new active substance an additional benefit.

Generics also exist. The term refers to drugs that are developed to replicate original preparations as soon as their patent expires. They contain the same active substance, but are not the original and are therefore often cheaper. Health insurance funds often seek to limit the cost of drugs by stipulating which drugs their members may be prescribed, unless they have been ruled out by the attending physician. So it is not unusual for a pharmacist to suddenly dispense a drug from a different manufacturer than they had done in the years before. But these generics have precisely the same effect. Patients benefit from a lower co-payment.

Pharmaceutical development and authorisation

Drugs undergo clinical trials before they are placed on the market. These are used to ensure the safety and efficacy of drugs. Once the trials are complete, the manufacturer applies to the competent authority for authorisation.

Finished medicinal products may only be sold if they have been authorised. This authorisation is issued at national level by the Federal Institute for Drugs and Medical Devices (BfArM; *refer to Section 2.1.2 from page 36)* and the Federal Institute for Vaccines and Biomedicines (Paul-Ehrlich-Institut, PEI *refer to Section 2.1.4 on page 38)*. The European Medicines Agency (EMA) is responsible for drugs with central authorisation in the EU. Prior to authorisation, the manufacturer must demonstrate that the new active substance is effective and safe.

But new drugs require more than just thorough testing and authorisation. In addition, the G-BA assesses the benefits of a drug compared to other drugs used for the same indication.. This step has been mandatory since 2011 (in accordance with the Pharmaceutical Market Reorganisation Act). The pharmaceutical company and the National Association of Statutory Health Insurance Funds use this assessment as a basis to agree on a price for the new drug.

3.2.2 Medical practices

Outpatient treatment is provided by general practitioners, specialists, dentists, psychotherapists (panel doctors and dentists) in **private practice** and specialists from non-medical healthcare professions such as midwives, physiotherapists, occupational therapists and speech therapists.

Most doctors, dentists and psychotherapists in private practice offer contracted (dental) medical care (health insurance licence). To do so, they have been licensed to provide contracted (dental) medical care; they receive this authorisation by application to the competent licensing committee for dentists and doctors. This gives them membership in an Association of Statutory Health Insurance Physicians (KV) or Association of Statutory

Health Insurance Dentists (KZV) and makes them eligible to treat patients with statutory health insurance and to register their services with the SHI. *(refer to Section 1.3.1 from page 27)*. This license is linked to the location of their practice and therefore to the specific KV or KZV region and its needs-based planning. In addition to doctors in private practice, individual hospital doctors or inpatient facilities with suitable authorisation are authorised to provide outpatient treatment as well. This authorisation is also issued by the competent licensing committee for doctors in all cases.

Free choice of doctor
Most patients will first consult their GP when they feel ill. In principle, however, any person with statutory health insurance is entitled to consult any panel doctor. Free choice of doctor applies. Other doctors may only be consulted in emergencies.

Outside of consultation hours, doctors and dentists in private practice offer dental and medical **emergency services** (on-call services). In many regions, the medical emergency service is no longer provided in the doctor's practice, but on the premises at or in hospitals (known as portal practice). Emergency services may also attend to patients at their homes. Emergency service is reached on the same nationwide number 116117*(refer to Section 4.2.4 from page 116)*.

State Medical Associations and German Medical Association
Panel doctors and doctors working in hospitals, public health departments or other institutions are registered with the state medical associations. As the working group of the 17 German medical associations, the German Medical Association (BÄK) is the central organisation within the system of medical self-administration. It represents the interests of doctors in Germany together with the state medical associations as professional organisations. The same structure is in place for dentists, psychotherapists and pharmacists *(refer also to Section 2.3.3 from page 48)*.

3.2.3 Digitalisation in the healthcare sector

Digitalisation is already integral to everyday life in many areas of society and the economy. It also presents significant opportunities within the healthcare sector: it speeds us communication, makes administration more efficient, renders faxes and paper forms obsolete – and makes patient data available wherever and whenever it is needed.

Moreover, it facilitates the process of analysing medical data and enables its transmission in a structured form. This makes it easier to identify diseases and many other things. What's more, it opens the door to tailored therapies and presents fresh opportunities for healing. Patients use mobile applications that improve their independence and self-determination.

Digital technologies can therefore assist the healthcare system in meeting the challenges faced by almost all counterparts across the western world: treating increasing numbers of older patients and those with chronic conditions, despite a shortage of specialists, as well as paying for expensive medical innovations or continuing to deliver good medical care in structurally weak, rural areas.

Applications that are powered by artificial intelligence (AI) are particularly suitable to help practitioners make diagnoses more accurately and quickly, prepare tailored therapies and optimise processes so that doctors and other healthcare professionals, care staff especially, have more time to attend to patients.

These, and other aspects, are included in the Digitalisation Strategy for the Health- and Long-term Care Sectors that was published in March 2023 and that has been progressively put into practice since then.

The **National Agency for Digital Medicine (gematik)** supports the Federal Government in the implementation of this strategy *(refer to Section 2.3.7 from page 54)*. It is responsible for what is known as the telematics infrastructure. This includes, for example, digital applications that assist in the communication of medical data, in particular electronic patient files, electronic prescriptions and electronic sick notes.

Electronic patient file (ePF)
All persons with statutory health insurance have been entitled to receive an electronic patient file (ePA) from their health insurance fund since 1 January 2021. These files contain medical findings and information from previous examinations and treatments across all facilities.

In particular, the Act to Accelerate the Digitalisation of the Healthcare System (Digital Act) stipulates that the electronic patient file (ePA) should be switched to an opt-out application. Starting January 2025, the ePA will be made available for all persons with statutory health insurance ('ePA for everyone'), unless they object. Private health insurance companies are also planning to offer their members an ePA that adheres to the same principles. Access will be made available on smartphones by means of digital identities.

But it will be entirely at the discretion of insured persons to decide whether and to what extent they use the ePA. For instance, they can decide which information is placed in – or erased from – the file and which treatment provider should have access to their data. Insured persons can access their ePA on their smartphones or tablets.

Treatment can only improve if doctors and other service providers have more detailed access to their patients' medical history. The ePA is also intended to facilitate the process of sharing health data. It connects insured persons with doctors, pharmacies and hospitals. The ePA will digitalise and simplify many workflows that have been based, until now, on paper records.

Insured persons also have access to a single repository with individual findings from various doctors and other relevant documents. This makes the whole treatment process easier to understand and can, for example, prevent patients from experiencing the stress of duplicate examinations.

Electronic prescription (e-prescription)
The e-prescription replaced its pink hardcopy counterpart on 1 January 2024. Now, persons on statutory health insurance can only obtain prescription-only drugs with an e-prescription and can present this to the pharmacy – both brick-and-mortar and online – using their electronic health card (eHC) in gematik's e-prescription app or by printing it out on paper. This transition makes the process more convenient for patients and reduces the number of visits to a medical practice.

Digitalisation of hospitals
The Future of Hospitals Act (KHZG) came into force on 29 October 2020. It aims to make hospitals faster and to modernise and digitalise their processes, among other things. The Federal Government has allocated €3 billion for this purpose. The federal states and hospital operators are adding another €1.3 billion. The money will be channelled into the proprietary Future of Hospitals Fund (KHZF), from which hospital operators, for example, can withdraw funds – after applying for support.

Digital healthcare applications (DiGA)
Insured persons have been entitled to reimbursable DiGA since 2020. These 'apps on prescription' can be prescribed by doctors and psychotherapists in a similar way to drugs. But manufacturers must are still initially required to demonstrate to the BfArM *(refer to Section 2.1.2 from page 36)* that their DiGA have positive impacts in regard to healthcare delivery. This means that patients feel better after treatment than before. The DiGA must also meet certain security, quality and data privacy requirements, among other things.

Approved DiGA are listed in the DiGA index by the BfArM. At present, the index contains apps and web applications that persons with migraines, tinnitus, obesity, depression and other conditions can use.

The content and features of the DiGA vary. Some detect or monitor symptoms that necessitate a check-up. Others can improve the ability of users to take charge of their own health and motivate them to improve their own lifestyles. Most DiGA provide direct support in the treatment of diseases or ease their symptoms.

German Electronic Reporting and Information System for Infection Protection (DEMIS)

DEMIS has enabled electronic reporting of infectious diseases since June 2020. This is intended to ease the strain on laboratories and public health departments. In addition, all actors receive the complete data that is relevant for infection prevention and control faster than before. They can then initiate prompt infection prevention and control measures to stop a further spread. Notifiable infectious diseases include, for example, measles, whooping cough and COVID-19.

Notifying bodies, such as laboratories, send the information to DEMIS. The software used already contains the data in an electronic form. Alternatively, the notification can be sent via the DEMIS notification platform. DEMIS automatically determines which public health department is authorised to receive the reports and sends them to the responsible public health department in an encrypted form.

3.2.4 Occupational therapy, speech therapy and physiotherapy

Comprehensive therapeutic assistance is often required to cure, alleviate or prevent illnesses and complaints. The specific therapies are determined by the attending physician. Other partners within the healthcare system provide the necessary therapeutic support. Drugs *(refer to Section 3.2.1 from page 74)* such as painkillers play a vital role in this process. But other **therapeutic products** such as physiotherapy, speech therapy or occupational therapy are an integral part of modern medical treatment.

Persons with statutory health insurance are entitled to **therapeutic products** that are medically necessary. Only doctors are authorised to prescribe these treatments, although panel psychotherapists are also permitted to prescribe occupational therapy. However, this only applies if the therapeutic product helps to heal or alleviate an illness. Patients may also be entitled if, for example, the treatment prevents a person from becoming dependent on long-term care or if it promotes the healthy development of a child.

Health insurance funds cover the costs when therapeutic products are prescribed by a doctor. Insured persons pay a share of the costs – the co-payment. Insured adults make a co-payment of 10 percent on the cost of these therapeutic products. Added to this is €10.00 per prescription, although this may cover several treatments.

The therapeutic products that doctors may prescribe and that the health insurance funds are required to cover are set out in the **Therapeutic Products Directive** or the Therapeutic Products Directive for Dentists as issued by the G-BA. The Catalogue of Therapeutic Products is a key part of the Directives on Therapeutic Products. It describes which therapeutic products, and in what quantities, are medically appropriate and adhere to the principle of efficient care for particular indications. The Catalogue of Therapeutic Products stipulates the maximum quantity per prescription, broken down for each illness. The treatment can continue if this is not sufficient. But doing so requires a fresh prescription from the doctor.

However, there are some illnesses that will, as a rule, require therapeutic treatments lasting several months. In these cases, the attending physician can prescribe the therapeutic product for twelve weeks, provided that doing so is medically necessary. The patient must return to the doctor for a check-up and a repeat prescription for therapeutic products after twelve weeks at the latest. This is referred to as a ‘particular care requirement’.

Therapeutic products

Physiotherapy, voice, speech, language and swallowing therapy, occupational therapy or nutritional therapy – all of these treatments are categorised as therapeutic products.

- **Physiotherapy** includes active and passive exercises and physicaltherapies such as massages, neuromuscular and heat therapy. The aim is to administer physical stimuli such as pressure, heat or cold to alleviate discomfort and to improve mobility, muscle strength and coordination.
- **Occupational therapy** is intended to help people with physical impairments to increase their independence in life management. This is why it frequently involves everyday activities such as getting dressed, eating or writing. Occupational therapists use various exercises for this purpose. Among the aspects they train are fine motor skills, balance, concentration, coordination, strength and stamina.
- **Speech therapy:** Voice, speech, language and swallowing therapy is used to treat speech, language, voice and swallowing disorders. These therapies are provided by speech therapists, among others. Treatment is provided, for example, to children with speech development or pronunciation problems, people who stammer or those who need to regain the power of speech.

3.2.5 Integrated care and medical centres

The purpose of integrated care is to dovetail various sectors within the healthcare system – in other words, so to encourage cooperation between outpatient and inpatient care, rehabilitation and many other service providers. **General practitioners**, **specialists**, **hospitals**, **preventative care and rehabilitation clinics,** as well as **members of other healthcare professions,** work together within the framework of integrated care – from the start of treatment and using a shared dataset. This procedure designs treatments in which each specialist discipline is ideally integrated for the benefit of the patient.

The **health insurance funds** take charge of various tasks within integrated care: they coordinate and organise the treatment and streamline quality assurance. To do so, they have established cross-sectoral and interdisciplinary, connected structures.

Health insurance funds must offer their policyholders separate elective optional tariffs to participate in an integrated form of care. In some cases they also offer a bonus. The long-term care insurance funds **are also involved in integrated care in order to improve healthcare delivery to** elderly and frail patients. These funds can also enter into or join suitable contracts for integrated care.

Medical centres (MVZ) are independent service providers in which several doctors offering **outpatient** care work together within a single facility. This promotes patient-centred care from a single source, as MVZs often employ specialists from a wide range of disciplines and, in some cases, members of other medical professions.

Unlike other collaborative forms of professional practice, MVZs are characterised by organisational separation of ownership structures from the medical treatment itself. Among others, MVZ can be established by panel doctors, hospitals, certain non-profit organisations and municipalities. They maintain

their own administrative structures that keep the centres running smoothly. Nevertheless, MVZ always have a medical director who is not bound to outside instructions in medical matters. The medical director works at the MVZ.

3.2.6 Hospitals

Hospitals frequently provide **inpatient** care. This means that people remain at the hospital for several days to receive treatment, an examination or surgery. Partial inpatient (without overnight stay) or outpatient treatments are possible as well.

Partial or full inpatient treatment in a hospital do not become necessary until the general practitioner or specialist in private practice has exhausted all options to cure or alleviate an illness. This may be the case if major surgical intervention becomes necessary or for a treatment that requires particular technical devices.

In addition, the hospitals are, of course, available for **emergencies** if immediate treatment is medically necessary and outpatient treatment from a doctor in private practice is not possible.

Patients are entitled to choose a hospital. The **SHI** cover the costs, provided the care facility is **licensed** for patients with statutory health insurance. Persons with statutory health insurance are only required to make a co-payment on accommodation and catering during inpatient treatment. The amount of this co-payment is set out in a hospital contract that is concluded between the patient and the hospital prior to treatment. Most hospitals will treat anyone, irrespective of whether they have statutory or private insurance. They are only required to present a referral from a doctor.

The **federal states** are required to ensure that an adequate number of hospitals and hospital beds are available to deliver medical treatment to the population. To do so, they prepare hospital plans and decide on the licensing of hospitals.

Additional information on the topic of hospitals is available in the **Hospital Guide** published by the BMG, which you can download from the BMG website or have sent to you. The guide provides an introduction to the hospital landscape in Germany and contains detailed information on the important procedures and services before, during and after hospital treatment.

Many hospitals have patient advocates as independent contact points for your concerns and wishes, as well as for suggestions and criticism. In this role, they act as mediators between patients, relatives and hospital staff.

Licensed hospitals

There are various ways for hospitals to obtain authorisation to treat persons with statutory health insurance.

- Hospitals under the official hospital plan: The hospital is listed in the state hospital plan and is eligible for state subsidies.
- The hospital has concluded a care contract with the statutory health insurance funds or private health insurance companies.
- The hospital is recognised as a university hospital in accordance with federal state regulations.

Private sector, non-profit and public sector hospital ownership is possible.

3.2.7 Psychotherapy

Psychotherapy describes the use of psychotherapeutic methods to provide targeted treatment of mental illnesses or physical illnesses with a psychological component. Psychotherapy is a collaborative procedure intended to steer patients' thoughts, experiences, feelings and behaviour in a healthier direction.

In principle, psychotherapy will never exclude a diagnosis from the outset. Psychotherapy can help to alleviate symptoms, exert a positive influence on the course of the illness, strengthen coping mechanisms, improve social adjustment or facilitate understanding of the illness.

Common mental illnesses in Germany include anxiety disorders, depression, addictions, personality disorders, psycho-organic disorders and psychoses. Psychotherapy can help to deal with illnesses that, from a professional perspective, can experience a positive and lasting change by means of therapy. A specialist, such as a general practitioner, may recommend psychotherapy.

Indeed, psychotherapy may be the only treatment method, depending on the clinical picture. However, it might also take place in addition to, or as an alternative to, medication and other treatments. Psychotherapies can be administered in an **outpatient, partial inpatient** or **inpatient** (within a facility) setting.

Persons with statutory health insurance do not incur any costs for recognised psychotherapy procedures, provided that the psychological and medical psychotherapists administering the treatment hold a suitable health insurance licence. Persons with private insurance must clarify with their provider which costs are covered. The costs of stationary psychotherapy are covered, irrespective of the type of health insurance.

Psychotherapy methods that are scientifically recognised and covered by statutory health insurance include:

- (cognitive) behavioural therapy
- psychotherapy based on depth psychology
- (psycho)analytic psychotherapy (psychoanalysis)
- systemic psychotherapy

Client-centred conversational psychotherapy is also scientifically recognised. But this form of therapy is not covered by SHI.

A **psychotherapeutic consultation** offers low-threshold access to outpatient psychotherapy. It is used as an opportunity for therapists to recognise at an early stage whether a mental illness is present and which professional assistance is necessary. Other elements of the consultation include: counselling, information, clarification of individual treatment needs, initial diagnosis, corresponding treatment recommendation and – if necessary – a brief psychotherapeutic intervention. The patient must meet face-to-face with the therapist in psychotherapeutic consultations.

3.2.8 Emergency services

Emergency services bring together people and facilities that provide assistance in medical emergencies. Emergency services are reachable 24/7. Emergencies are classed as life-threatening injuries, poisoning or acute illnesses, such as strokes and heart attacks.

The federal states are responsible for organising and providing emergency services. The federal states, districts and municipalities provide their residents with the necessary infrastructure. In most cases, they will contract aid organisations such as the German Red Cross (DRK), the Johanniter-Unfallhilfe (JUH), the Malteser Hilfsdienst (MHD), the Arbeiter-Samariter-Bund (ASB) and the Deutsche Lebens-Rettungs-Gesellschaft (DLRG) with these services or establish their own municipal companies or professional fire brigades with performance.

Aside from emergency doctors, members of other healthcare professions also work in emergency services. These are largely emergency paramedics.

An emergency paramedic responsible for medical matters is usually deployed in each ambulance. In Germany, there is a type of paramedic known as a 'Notfallsanitäter' who have three years of training and are therefore authorised to perform many medical procedures under their own responsibility. This includes the administration of certain medicines. In cases of life-threatening emergencies requiring complex procedures, an emergency doctor is notified as well. They have completed additional medical training to ensure that they are qualified for emergencies. These include, for example, administering anaesthesia, keeping the airways free and surgical interventions that become necessary at the scene of an emergency if the injuries are severe enough. Telemedical services can also be provided in the event that the paramedic requires consultation from an emergency doctor. In these cases, the paramedic can transmit findings, readings and images to the connected doctor.

Treatment, and transport to the hospital, incur a charge and are usually covered by health insurance.

The emergency services coordination centre is reachable 24/7 without an area code via landline, mobile phone or emergency call pillars. Calls are free.

Important emergency numbers and contact options include:

- Emergency call: 112
- Emergency medical service: 116117
- NORA emergency call app (the official emergency call app of the federal states is available for free from the app stores)

Anyone experiencing mental health problems and crises can contact social-psychiatric services. Information on these regional counselling services is available, for example, from the city and local administrations. There are also various other specialised crisis hotlines and contact options:

- Telephone counselling 116 123
- Email and chat counselling: online.telefonseelsorge.de
- Nummer gegen Kummer: 116 111 (psychological help for children and young people)
- KrisenKompass (app; accessible on the website of the telephone counselling service: www.telefonseelsorge.de/krisenkompass)

3.2.9 Dental care

Dentistry deals with injuries and diseases of the teeth, gums and jaw area. Common problems and diseases include tooth decay, misaligned teeth and inflammation of the gums. Many diseases of the teeth and gums can be minimised or prevented by regular prophylaxis (prevention).

Dentists carry out dental treatments that are intended to cure or, through early detection, prevent dental, oral and maxillofacial diseases. This involves the removal of hard dental plaque ('tartar removal'), the performance of root canal treatments and fillings and the treatment of diseases affecting the oral mucosa.

Like with medical treatments: the **statutory health insurance funds** cover the costs when an insured person receives services from a dentist who is authorised to provide panel dental care. Dental services are generally exempted from co-payment. There are exceptions for services that exceed the scope of panel dental care, but which the insured person elects to receive. The 'additional cost regulation' applies in these cases, for example in the case of inlays or alternative fillings.

Statutory health insurance funds pay a fixed allowance towards medically necessary **dental prosthetics**. Its specific amount depends on the dental findings and the necessary care. Insured persons must themselves cover the costs that exceed this fixed allowance. They also pay for additional aesthetic or cosmetic services.

The health insurance fund provides an additional bonus if patients attend an annual **check-up**. It provide a higher subsidy on prosthetics. In these cases, insured persons must keep a bonus booklet documenting the regular and preventive check-ups.

3.3 Long-term care

The purpose of good long-term care is to help people to lead their most independent and self-determined lives and to preserve their dignity, despite the impairments. Mandatory insurance for long-term care risk for everyone with statutory and private insurance was introduced in Germany on 1 January 1995 in order to provide persons in need of care, and their relatives, with the best possible support.

As a rule, social long-term care insurance is financed in equal shares by employers and employees. However, social long-term insurance does not cover all the costs of care. All costs for care and support services that exceed the prescribed benefits are borne by the people in need of care or their relatives – or by social welfare if necessary. This does not apply to full inpatient long-term care. In this case, additional payments are made in accordance with Section 43c of the Eleventh Book of the German Social Code (SGB XI) in order to cap co-payments incurred due to long-term care.

The need for long-term care has been redefined as an important step in the evolution of long-term care insurance. It enables the allocation of persons in need of care to five care levels that determine their eligibility for benefits.

The care levels are:

1. minor impairment of independence or abilities
2. significant impairment of independence or abilities
3. severe impairment of independence or abilities
4. most severe impairment of independence or abilities
5. most severe impairment of independence or abilities with particular requirements for long-term care

This allocation is particularly important for people who are largely physically fit but still need a considerable support to cope with everyday life – for example, persons suffering from dementia *(refer to Section 4.4.1 on page 126)*. Since 2017, mental and psychological impairments of a person's independence, such as those associated with Alzheimer's and dementia in its various forms, have been taken into account in addition to physical limitations.

Additional information on the topic of long-term care is available in the **Hospital Guide** published by the BMG, which you can download from the BMG website or have sent to you.

3.3.1 In need of long-term care – what now?

Broadly speaking, a person may become in need of long-term care in any phase of life. Persons who are not (or no longer) able to lead independent lives are considered in need of long-term care. This may be due to physical, cognitive or mental impairments or health-related stress. Affected persons are then entitled to benefits from social long-term care insurance *(refer to Section 1.3.3 from page 30)* and can apply for assistance.

When is a person eligible for benefits?
In order to be eligible for long-term care benefits, the insured person must have paid into the long-term care insurance fund as a member for two years during the ten years prior to submitting the application or have been covered by a family policy.

Nobody will find it easy to submit this kind of application. But the purpose of good long-term care can and should be to help people to lead their most independent and self-determined lives and to preserve their dignity, despite the impairments.

To receive long-term care insurance benefits, a person must submit an application to the long-term care insurance fund – also by telephone. The long-term care insurance fund is part of the health insurance fund. Family members, neighbours or close acquaintances can submit the application, provided they have the necessary authorisation. As soon as the application has been submitted to the long-term care insurance fund, it commissions the Medical Service or other independent experts to determine whether the insured person is actually in need of care.

Persons with private health insurance submit the application to their insurance provider. Assessment is then performed by experts from the Medicproof, the medical service of the private long-term health insurance providers.

The expert assesses six areas of life in order to determine the level of a person's independence or need for long-term care.

1. Mobility; for example: Is the person able to stand up and walk from the bed to the bathroom without assistance? Is the person able to move independently through their home? Can they climb stairs?
2. Mental and communication skills; for example: Does the person exhibit temporal and spatial awareness? Do they understand facts, recognise risks, and are they able to hold conversations with other people?
3. Behavioural and psychological problems; for example: Restlessness at night or anxiety and aggression, which are stressful for the person in need of care, but also for their relatives.
4. Self-sufficiency; for example: Is the applicant able to wash and dress themselves, use the toilet, eat and drink independently?
5. Independence and stress relating to the management of the demands of illness or treatment; for example: Is the person concerned able to take their own medication, measure their blood sugar independently, use aids such as prostheses or a walking frame and see a doctor?
6. Management of everyday life and social contacts; for example: Can the person concerned manage their daily routines independently? Are they able to establish direct contact with other persons – without assistance?

For each criterion, the assessors determine the degree of independence of the person in need of long-term care. This usually involves a score of between 0 (person can perform the activity without an assistant, with aids if necessary) and 3 (person cannot perform the activity, not even partially). At the end, the points are added together with different weightings to give an overall score that is equivalent to one of the five care levels.

The state associations of long-term care insurance funds publish comparative lists online of the services and prices of licensed long-term care facilities and of support services in everyday life that are recognised under state law. Those affected can also order the list from the long-term care insurance fund.

By law, the processing period for applications attesting a need for long-term care is 25 working days. Shorter assessment periods apply, for example, if persons in need of care are receiving treatment in a hospital or in an inpatient rehabilitation facility and if the shorter assessment period is necessary to ensure uninterrupted care.

3.3.2 Prevention and rehabilitation in long-term care

Demographic change is also evident in Germany: the share of older and very old people in the population is rising steadily. With this in mind, it is becoming increasingly important to strengthen health promotion and **prevention** later on in life. The underlying idea is that persons should become healthier going forward, and not just older.

A healthy lifestyle can help to prevent or delay many diseases that are common among older people. These include, for example, diseases of the cardiovascular system, the locomotor system and metabolism, as well as dementia. Physical exercise, a balanced diet, mental activity and social contact in particular contribute to healthy ageing, maintaining independence and avoiding the need for long-term care. The Federal Centre for Health Education (BZgA; *refer to Section 2.1.3 on page 37)* has compiled relevant information on the website www.gesund-aktiv-aelter-werden.de.

In addition, people can improve the status of many diseases by taking part in **rehabilitation** measures. These help to restore capabilities and to prevent or delay the worsening of symptoms or impairments. The principle of 'rehab before care' aims to enable people in need of care to lead largely self-determined lives for as long as possible, strengthen their self-esteem, improve their quality of life and increase their ability to participate in everyday life.

Before experts acting on behalf of the long-term care insurance organisation attest that patients are in need of care, they assess the life circumstances and lifestyle of the predominantly older persons. The aim is to avoid or delay the need for long-term care. Another purpose is to maintain the person's independence for as long as possible, even if they are already in need of long-term care.

Where appropriate, the experts recommend preventative and rehabilitation measures. All of this focuses on the specific circumstances of the person in need of long-term care. How do they cope with everyday life? Are there aids available that would make life easier? Are there ways to improve the person's living situation? These points are also included in the long-term care assessment and – if necessary and assuming the insured person has given their consent – trigger an application for medically necessary rehabilitation measures from the competent rehabilitation provider.

From 2016, the **Prevention Act** introduced a requirement that long-term care insurance funds must provide specific preventative services in **partial and full inpatient long-term care facility** settings. These include nutrition, physical activity, strengthening cognitive resources, psychosocial health and the prevention of violence.

3.3.3 Home care

In Germany, over three quarters of persons in need of long-term care are treated **at home**. Long-term care insurance covers (some of the) assistance and aids to support people in need of long-term care. A wide range of support services are available to enable people to remain at home for a long time – including outpatient services from nursing and care services, the long-term care allowance and the relief allowance.

Persons in need of care should be able to decide for themselves where and how they receive the necessary care. This is why the long-term care insurance also provides support if people opt to be cared for by relatives, friends or other volunteers instead of by an outpatient care service. For this purpose, the **long-term care insurance** provides the so-called **care allowance**.

To be eligible for the care allowance, measures must be in place to ensure home care, for example by relatives or other voluntary carers. The person must also have been allocated to **at least care level 2**. The care allowance is transferred by the long-term care

insurance fund to the person in need of long-term care. They can use the care allowance at their own discretion, but usually pass it on to their carer as a form of recognition. This can also be combined with outpatient care services.

The monthly care allowance differs according to the level of care needs:

- Care level 2: €332
- Care level 3: €573
- Care level 4: €765
- Care level 5: €947

The **outpatient care or support service** helps persons in need of care and their relatives to organise care in a home setting. It provides families with support and assistance in everyday life so that family carers can improve the organisation of their work and care, among other things. The service also takes over when there are no family members available to provide care. At the same time, long-term outpatient care helps the person to remain in their familiar setting for as long as possible.

Essentially, carers take charge of almost all tasks relating to physical, mental and psychological health and enable people to maintain the greatest degree of independence. Examples include:

- body-related care measures, such as assistance with eating and drinking, personal hygiene, dressing and undressing
- accompanying measures, for example everyday support, cooking together, walks and support with hobbies and social contacts
- Housekeeping assistance: laundry, changing bed linen or cleaning the home

- where necessary, home treatments such as wound care or the administration of medicines
- advice on care-related issues, such as how to maintain and promote mobility and prevent falls, how to avoid bed sores, how to manage pain or wounds, how to use aids or digital care applications (DiPA) and tips on eating and drinking
- advice on organisational issues, such as on where to buy aids or how to organise trips to hospital and hospital stays, how to place applications for a higher care level or for other benefits from the long-term care insurance funds

Care services must be overseen by state-certified **care professionals**. In addition to care professionals, housekeeping assistants or care assistants can also work in an outpatient care service.

Persons in need of long-term care can also commission **support services** instead of a care service. But they exclusively offer support and assistance in the household. A support service may be sensible for people with dementia or mental impairments, for example, who are still largely physically fit. Support services must also be overseen by a trained professional and employ qualified staff, preferably from the health, care and social sectors.

Individual carers are persons with a care qualification who are now self employed. They fulfil the same role as care services.

Long-term care insurance covers home care benefits in kind for persons in need of care who have been allocated to at least **care level 2**.

The statutory maximum amount depends on the care level.

The monthly amounts rise with the care level:

- Care level 2: €761
- Care level 3: €1,432
- Care level 4: €1,778
- Care level 5: €2,200

Persons with care level 1 receive neither care benefits in kind nor care allowance, although they are entitled to commission care or support services. They can use the monthly **relief allowance** of €125 to cover the costs.

Long-term care benefits in kind only include services, which are billed according to the principle of non-cash benefits: Insured persons receive professional support in care and support, without having to settle the costs in advance. The provider of care or support services settles their bills directly with the long-term care insurance fund.

Long-term care benefits in kind can only be provided by outpatient long-term care services, support services or individual carers that have entered into a care contract with the statutory long-term care insurance funds. This is also known as licensing. Licensing from the long-term care insurance fund is intended for quality assurance purposes and facilitates the process of billing for services provided to persons in need of care.

Relief allowance
Persons in need of care who are looked after at home are entitled to a monthly relief allowance of up to €125 (so up to €1,500 per year in total). The allowance is also provided to those in care level 1. The amount must be ringfenced for quality-assured services intended to ease the burden on carers and relatives and to promote the independence and self-determination of persons in need of care, which helps them to organise their everyday lives. This includes, for example, certain programmes for support in everyday life, as well as day, night or short-term care services.

Persons with private insurance are subject to the same requirements and have the same eligibilities as in statutory long-term care insurance. However, they do receive an invoice that they must first settle and then submit to their insurance company. The insurance company reimburses the costs up to the maximum amount, depending on the person's care level.

Long-term care benefits in kind do not usually cover all the basic care needs that arise in everyday life. The insured person is required to pay for costs that are not covered. Insured persons may be eligible, under certain circumstances, to apply for care assistance if their own income and assets are not sufficient.

Subject to application, the long-term care insurance fund can pay **a subsidy of up to €4,000** for home improvement measures for persons in need of care in levels 1 to 5. The insurance funds pay this kind of subsidy if, on a case-by-case basis, the measures

will enable or significantly facilitate home care or would restore the greatest possible degree of independence to the person in need of care. These measures include, for example, stair lifts, ramps or bathroom conversion to accommodate the care needs.

It is also possible to combine the care allowance with outpatient long-term care services in what is known as a combination service that ensures optimised care that is tailored to individual needs. Care allowance is then reduced on a prorated basis.

In the event that a private carer is temporarily unable to work, long-term care insurance will cover the proven costs of necessary substitute care – known as respite care – for persons in need of care in levels 2 to 5. This applies up to a maximum of six weeks per calendar year. **Respite care** can be provided by an outpatient care service, respite carers, volunteer carers or by family members.

It is also possible to claim **short-term care** if a person in need of long-term care is dependent on full inpatient care for a limited period.

Benefits for respite care and short-term care will be combined into a **joint annual amount** for respite and short-term care on 1 July 2025. This means that from 1 July 2025, a total annual benefit will be available to cover respite care and short-term care, which beneficiaries will be able to use flexibly and at their own discretion to cover both forms of care.

3.3.4 Partial and full inpatient care

Most persons in need of care prefer to receive services in their own home. Occasionally, though, care in a home setting will no longer be adequate. Those affected are then able to claim partial or full inpatient care.

Partial inpatient care means that patients are attended to for some of the time in a care facility, either for certain periods of the day or **at night**. For example **day care** may become necessary if relatives who otherwise look after for the person work during the day. The persons in need of care are then picked up in the morning and brought back home in the afternoon.

Full inpatient care is an option if persons in need of care can no longer be looked after at home. They receive round the clock support in **care facilities**.

Trained **carers and support staff** help the persons in need of care in all areas of their lives in which they rely on assistance. This involves more than just care and support, medical treatments, catering and accommodation. The aim is also to attend to their social needs, for instance by encouraging gatherings, social settings and communal activities. Residents also receive assistance in structuring their everyday lives. After all, full inpatient care is intended to provide a new focal point in the person's quality of life and good housing, and not just cover the most essential areas of a person's existence.

When dealing with older people and those in need of care, it is particularly important that they undergo regular medical examinations. Treating illnesses and health problems at an early stage can prevent complications. Care facilities are therefore obliged to conclude cooperation agreements with **GPs, medical specialists and dentists** and for the supply of **medicines**.

Moreover, residents have a right to consult a doctor of their choice. As usual, the costs are settled using the electronic health insurance card and covered by the **statutory health insurance funds**.

The **long-term care insurance** subsidises the costs of care and support for persons of need of care in at least level 2. All other costs must be covered by the person themselves. Long-term care insurance only pays a subsidy if there is an agreement between the facility and the insurance company, so if it has licensed the care home.

3.3.5 Care for the seriously ill and dying

Care for the dying is explicitly included in the **social long-term care insurance** mandate. People who are close to death need certainty that they will not spend the last phase of their lives alone, and that they will be well cared for and accompanied in every way. Included in this is the right to **palliative care**. The purpose of palliative medicine is to alleviate the consequences of an illness (palliation) when there are no longer any prospects of healing.

The delivery of palliative care can take place wherever people spend the final phase in their lives – at home, in inpatient care facilities, in hospitals or in inpatient hospices. Palliative care includes medical, nursing, psychological and counselling support. People from different professions work together as a team to attend to the needs of the patients.

Many seriously ill people express the wish to spend their last days at home, in their familiar surroundings. To make this possible, outpatient care services, general practitioners and specialised interdisciplinary teams assist with care during the final phase of life.

Depending on their state of health, patients with statutory health insurance are entitled to:

- basic palliative care and counselling
- 'general outpatient palliative care' (GOPC)
- 'specialised outpatient palliative care' (SOPC)

SHI patients are also eligible for **outpatient hospice services**. These are largely provided by volunteers. They regularly visit the patients in their homes, talk with them and advise family members. Their task is to help seriously ill and dying people, and their relatives, to cope with the situation. But outpatient hospice services do not provide any medical, nursing or palliative care.

The statutory health insurance funds provide subsidies for outpatient hospice services as well as for partial inpatient and inpatient hospices.

When outpatient care is no longer possible in the insured person's home or with family, patients can receive care in **inpatient palliative wards**. Care in **inpatient hospices** is possible as well.

Palliative support of residents belong to the remit of **care homes**. The homes are therefore obliged to cooperate with outpatient hospice services, and they must enter into cooperation agreements with general practitioners and specialists. Where necessary, care home residents can also opt for 'specialised outpatient palliative care' (SOPC).

Where appropriate outpatient palliative care is not possible, patients may be looked after in a **hospital**. This may occur in the event of severe symptoms that cannot be treated at home. Some hospitals have established specialised palliative care wards for this purpose. Specialists on these wards look after the patients to alleviate both physical complaints and the emotional stress as much as they can. Relatives also receive support here.

What do GOPC and SOPC mean?

'General outpatient palliative care' (GOPC) describes a particularly qualified and coordinated form of outpatient palliative care. It is suitable for persons whose lives are nearing their end due to an advanced illness. Doctors with a special qualification in palliative medicine usually take charge of this treatment. Their first step is to determine the person's palliative care needs and then to prepare a (pain) therapy and emergency plan. They also coordinate other aspects of palliative and long-term care with therapists, care services or hospices.

'Specialist outpatient palliative care' (SOPC) can be initiated if the patient's state of health continues to deteriorate, necessitating particularly complex care from specialists. In this case, the patient receives care from a specialist team comprising of various professions: qualified palliative care staff and medical specialists take charge of the pain therapy and treatment. Teams also cooperate on a case-by-case basis with specialists from the fields of psychology, physiotherapy and social work.

The aim is to alleviate the symptoms to such an extent that patients are able to return home, be admitted to a care facility or be discharged into a hospice. Patients receive palliative care in a suitable specialist unit if the hospital does not have a palliative care ward. Some hospitals have a palliative service specifically for this purpose. It provides support in palliative care to the team on the ward.

Hospices are inpatient facilities in which the most seriously ill persons with a limited life expectancy receive integrated care until they pass away. They are intended for patients who require specialised support, but not intense medical care. Hospices employ full-time staff and trained volunteers, who work hand in hand. Medical support is usually provided by general practitioners.

The main focus is on care and psychosocial support for the seriously ill patients and their relatives. This means that hospice counsellors help people to process their feelings and fears, as well as to deal with practical matters. They also support the relatives and temporarily take charge of care for the dying on the relatives' behalf.

4

Points of contact: Who is there to help you?

You will probably have many questions if you become ill: What does my diagnosis actually mean? Whom can I contact to ensure that I receive good treatment? And: where can I find trustworthy information? The following part lists the most suitable points of contact.

4.1 Federal Ministry of Health services

Information provided by the Federal Government and its organisations and authorities is regarded as credible. It is put together by specialists and is evidence-based.

4.1.1 Website of the Federal Ministry of Health (BMG)

You will find the latest information from the BMG on: www.bundesgesundheitsministerium.de

4.1.2 National Health Portal

The National Health Portal gesund.bund.de provides residents of Germany with evidence-based, neutral and easily understandable information relating to questions of health and the healthcare sector. This helps them to make informed decisions together with their doctors.

The **National Health Portal** strengthens patients in their self-determination. Available in five languages, the portal provides detailed information on health topics, as well as practical search services, for example on ICD codes (International Classification of Diseases) and medical practices.

4.1.3 Federal Hospital Atlas

The **Federal Hospital Atlas** guides residents of Germany through the potentially confusing hospital landscape. By accessing the database, they can obtain quick and clear information on the services offered at the various hospitals, their quality standards and staffing. This enables simple comparisons of the various hospitals and allows visitors to make informed decisions about which hospital is best suited to specific cases – even without prior knowledge of the healthcare sector.
www.bundes-klinik-atlas.de

4.1.4 Migration and Health Portal

The multilingual web portal at www.migration-gesundheit.bund.de provides numerous brochures and information materials on the key topics of Healthcare, Health & Prevention, Care and Addiction & Drugs in over 40 languages. The portal is designed to help people find their way in the healthcare system in Germany. Constantly updated to include additional topics in the area of health, the website is available in German, English, Turkish, Arabic and Russian.
www.migration-gesundheit.bund.de

4.2 Central points of contact and patient rights

4.2.1 Commissioners and representatives of the Federal Government at the Federal Ministry of Health

The Federal Government appoints three commissioners or authorised representatives to advocate for the interests and concerns of citizens at federal level. They are: the **Commissioner of the Federal Government for Drug and Addiction Policy** *(refer to Section 2.1.6 on page 40)*, the **Commissioner of the Federal Government for Patient Affairs** *(refer to Section 2.1.7 on page 40)* and the **Commissioner of the Federal Government for Long-Term Care** *(refer to Section 2.1.8 on page 41)*.

4.2.2 Independent Patient Advice Service for Germany (UPD)

The law amending the Fifth Book of the German Social Code – Foundation for Independent Patient Advice for Germany – and amending other laws of 11 May 2023 restructured the **Independent Patient Advice Service (UPD)** and created a permanent foundation under civil law. The foundation is currently being established and is intended to deliver independent, quality-assured and free information and advice to patients on matters of health and health law. Its aim is to strengthen the ability of patients to navigate the healthcare system and to identify potential problems in the healthcare system. The UPD Foundation's information and counselling services are currently being established. Patients can contact the UPD Foundation (freephone 0800 011 77 22) with their questions on Monday, Tuesday and Thursday from 9:30 AM to 12:00 PM and from 3:00 to 5:00 PM, as well as on Wednesday and Friday from 9:30 AM to 2:00 PM.

www.patientenberatung.de

Email: info@patientenberatung.de

4.2.3 Assured health information

You will also find generally understandable information about diseases, examination and treatment methods on the website **gesundheitsinformation.de** by the Institute for Quality and Efficiency in Health Care *(refer to Section 2.3.8 on page 55).*
www.gesundheitsinformation.de

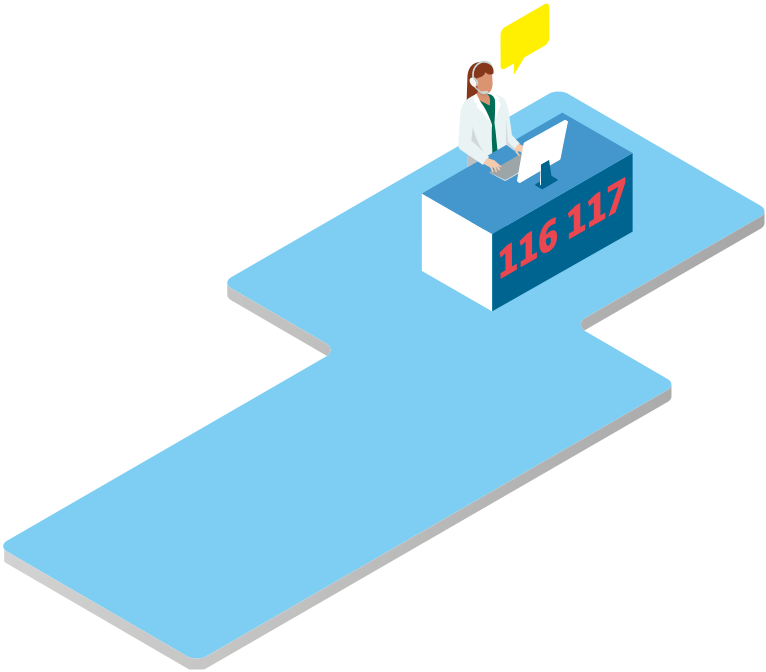
4.2.4 Nationwide out-of-hours helpline for non-emergency medical assistance 116117

Patients can call the **helpline on 116117** to receive out-of-hours medical assistance (on-call service), as well as to arrange appointments with the appointment service points (TSS). The helpline must be reachable 24/7. A nationwide, standardised initial triage procedure is applied to arrange the appropriate level of necessary medical care, which may include, for example, details of an open doctor's practice, an on-call practice, the emergency outpatient department of a hospital or, in suitable cases, medical consultation by telephone.

In principle, you can also contact this service to arrange specialist appointments, but will be required to present a relevant referral with a referral code. GPs, paediatricians, ophthalmologists, gynaecologists and psychotherapists do not require a referral.

The TSS is tasked with arranging an appointment at a reasonable distance within one week. Waiting times must not exceed four weeks. An appointment for outpatient treatment in a licensed hospital must be arranged if it is not possible to provide a suitable slot within this period. This regulation does not apply to routine or screening examinations that can be postponed, unless they are scheduled health check-ups for children.

The service can also be accessed at www.116117.de or via the 116117.app.



4.3 Health promotion and disease prevention

There are numerous points of contact that help people to prevent diseases and improve their state of health.

The **Federal Association for Prevention and Health Promotion (BVPG)** is a non-profit association, currently with 132 member organisations, that is not affiliated with any political party or denomination. It advocates for maintaining and improving the disease prevention and health promotion structures in Germany. Among other things, the BVPG website provides information on the topics of Healthy Living and Chronic Diseases.
bvpraevention.de

4.3.1 Exercise, nutrition and relaxation

People can improve their health status by maintaining a balanced diet, exercising regularly, sleeping well and managing stress in a purposeful way. The Federal Centre for Health Education (BZgA; *refer to Section 2.1.3 on page 37)* has launched programmes that are intended to promote suitable lifestyles among children and adolescents – in the interests of positive physical and mental development. At the same time, a healthy lifestyle prevents disease later on in life.

Widespread **obesity** – also among young people – is among the most serious health issues in Germany. Obesity is compounded by inadequate exercise, stress and a lack of sleep. The BZgA provides evidence-based information and everyday tips on the topics of exercise, nutrition, relaxation, sleep and media use on its **Übergewicht vorbeugen (Preventing obesity)** internet portal. It is intended to help the parents of primary school children to encourage healthy lifestyles in their youngsters. The portal is also aimed at multipliers. Paediatricians' practices, clinics, counselling centres and day-care centres can use the materials, while educators will also find teaching materials for primary and secondary schools.
www.uebergewicht-vorbeugen.de

In addition, the BZgA provides quality-assured information on the topic of **eating disorders**. Eating disorders are serious illnesses that require treatment, and can affect children and adolescents as well as adults, girls, women, boys and men.

The aim of the BZgA is to ensure that people with an eating disorder seek professional help at the earliest opportunity. To do so, it is necessary to raise public awareness for the issue and to provide information to those affected and their relatives.
www.bzga-essstoerungen.de

4.3.2 Sexual health, sex education and family planning

Liebesleben.de provides sometimes serious, sometimes playful and always very frank information on all topics relating to sexual health. With more than 300 pages, it covers every issue from using condoms and symptoms of sexually transmitted infections (STI) to online dating and sexual rights, coming out and protection against conversion therapy.

The online portal mainly addresses the concerns of adolescents and young adults. Aside from a range of content, visitors will also find various tools such as an online version of the condometer size guide or the personalised safer sex check.
www.liebesleben.de

Sexuality and STI are closely related. This fact prompted **Liebesleben.de** to develop the social media format entitled **Die Infektastischen STI (The Infectastic STI)**: Trippo gonorrhoea, Feig genital warts, Chlam chlamydia, Hepp hepatitis and Philis syphilis explain in an age-appropriate manner what the names of these conditions mean, how people can become infected and the best ways to protect against STI. All the clips and the most important background information are posted on the website.
www.die-infektastischen-sti.de

Anyone with questions or concerns on matters relating to sexual health, sexual and gender diversity of HIV and other STI will also find answers and suitable content on **Liebesleben.de**. Visitors to the website will also be able to access the BZgA **telephone and online counselling service**. They can also use the navigation feature to find counselling centres nearby:
www.liebesleben.de/fuer-alle/lass-dich-beraten

Assured information and advice on protecting against conversion therapy is found here:
www.liebesleben.de/fuer-alle/konversionsbehandlung

Available in 13 languages, the **Zanzu.de** web portal contains simple explanations on topics such as the human body, pregnancy and childbirth, contraception, HIV and other STI.
www.zanzu.de

Trau-dich.de provides information for children aged 8 to 12 to protect them from sexual abuse. It uses simple language to explain to young people what sexual violence against children is and that every child has the right to say NO.
www.trau-dich.de

The **Jung und schwanger (Young and pregnant)** website is an information service for young women who are, or suspect they might be, pregnant and are looking for assistance.
www.jung-und-schwanger.de

The **Sexuality Education, Contraception and Family Planning**portal provides a variety of target audiences information about these subject areas. This includes, for example, materials for medical practices and the latest research findings.
www.sexualaufklaerung.de

4.3.3 Vaccinations and personal infection prevention and control

Vaccinations prevent infectious diseases or reduce their severity. They are therefore among the most effective and cost-efficient medical prevention measures. With this in mind, it is important to raise popular awareness for the benefits of vaccinations and increase immunisation readiness. The BZgA online presence contributes to this objective:
www.bzga.de/programme-und-aktivitaeten/schutzimpfungen-und-persoenlicher-infektionsschutz

The introduction of **antibiotics** is among the most important examples of medical progress in the 20th century. But their improper use can contribute to bacterial pathogens developing resistance to antibiotics and no longer responding to treatment. It is therefore essential to ensure proper use of these drugs. The BZgA online presence raises awareness for this topic:
www.infektionsschutz.de/infektionskrankheiten/behandlungsmoeglichkeiten/antibiotika

In force since March 2020, the Measles Protection Act is intended to protect people in nurseries and schools, as well as in other community facilities and medical centres. The website provides information about the legislation, measles itself and its vaccination. Interested people will also find information to download.
www.masernschutz.de

The **Standing Committee on Vaccination (STIKO)** is part of the Robert Koch Institute (RKI; *refer to Section 2.1.5 on page 39).* It develops vaccination recommendations for Germany with due consideration of their benefits for each vaccinated person and for the population as a whole.
www.rki.de/stiko

4.3.4 Addiction prevention

Alcohol
Alkoholfrei Sport genießen (Enjoying sport without alcohol) aims to raise awareness for responsible alcohol consumption among adult members of sports clubs.
www.alkoholfrei-sport-geniessen.de

The two online presences **Alkohol? Kenn dein Limit (Alcohol? Know your limit)** educates adults and teenagers about the consequences of excessive alcohol consumption for the human body and raises awareness for responsible drinking habits.
www.kenn-dein-limit.de (adults)
www.kenn-dein-limit.info (young people)

The prevention programme **Null Alkohol – Voll Power (Zero Alcohol - Full Power)** is aimed primarily at school students and young people aged 12 to 16, and seeks to educate teenagers and young adults about the risks of alcohol consumption and to achieve sustainable awareness for the dangers of alcohol abuse.
www.null-alkohol-voll-power.de

Cannabis
Information about cannabis and the Cannabis Act (CanG) is available for various audiences on www.infos-cannabis.de. Young people, parents and multipliers can visit www.cannabis-praevention.de to learn more about the effects and health risks of cannabis. Its aim is to promote a critical attitude towards consumption and to encourage young people to remain abstinent for as long as possible. The preventative measures by BZgA place a particular focus on vulnerable target groups, such as children and adolescents, young adults, pregnant women and children from families with addiction problems.

Controlled substances
The **Addiction and Drug Hotline** is a joint service run by the drug hotlines in Berlin, Frankfurt am Main and Munich under the patronage of the Commissioner of the Federal Government for Drug and Addiction Policy.
www.sucht-und-drogen-hotline.de

Gambling
The **Check dein Spiel (Check your game)** website provides information on **gambling** and **gambling addiction** to persons struggling with the issue, their relatives and interested persons. Use the self-test to assess whether your gambling habits are (still) within reasonable limits, or visit the online counselling programme if you are looking for help.
www.check-dein-spiel.de

Media
Ins Netz gehen (Caught in the net) provides information about **media use** and literacy. The website is mainly designed for young people aged 12 to 18.
www.ins-netz-gehen.de

The **multiplier portal** aims to dismantle common tropes, stereotypes and prejudices and to address the joint challenge of supporting children and young people to move away from excessive media use.
www.ins-netz-gehen.info

Smoking
The two **Rauchfrei (Smoke-free)** online presences inform adults and young people about the effects, risks and health consequences of smoking.
www.rauch-frei.info (young people)
www.rauchfrei-info.de (adults)

4.4 Diseases

The following sections contain information on selected diseases. You can also obtain information about additional diseases on the following pages: www.gesund.bund.de of the BMG and www.gesundheitsinformation.de of the IQWiG *(refer to Section 4.1.1 on page 113)*.

4.4.1 Dementia

Persons suffering from **dementia** experience a deterioration in their memory, concentration and learning abilities. This is caused by changes in the brain. **Alzheimer's disease** is the most common form of dementia. People with dementia find it increasingly difficult to cope with their everyday lives.

In Germany, around two thirds of people with dementia are cared for at home by relatives. But this is often associated with significant challenges for the caregivers. These include communication difficulties, behavioural changes, nocturnal restlessness and other 'atypical' changes.

The **German Alzheimer's Society** is a federal association of more than 130 Alzheimer's associations and is committed to improving quality of life for those dealing with dementia. It supports and advises people with dementia and their families.
www.deutsche-alzheimer.de

Anyone who decides to care for a relative suffering from dementia will face a major challenge. The **Dementia Guide** from the Federal Ministry of Health starts with a brief introduction to the clinical picture of dementia, and then explains how the laws to strengthen long-term care can help you to care for your relative affected by dementia, which benefits you can claim and how you can source caregiving assistance.
www.bundesgesundheitsministerium.de/service/publikationen/details/ratgeber-demenz

4.4.2 Rare diseases

Diseases are classed as rare in the European Union if they affect no more than 5 in 10,000 people. But given that more than 6,000 different rare diseases exist, the total number of persons affected is high despite their individual rarity. Estimates suggest that around four million people live with a rare disease in Germany, and that there around 30 million people affected in the EU as a whole.

Rare diseases represent a group of highly heterogeneous and usually complex clinical pictures. Over 70 percent are entirely or partly congenital and are rarely curable. They are mostly chronic, lead to health restrictions and/or reduced life expectancy and often cause symptoms even in childhood. One challenge involves the relative scarcity of experts, which means that different medical specialities need to work together to produce diagnoses and treatment strategies, and that little research has been conducted into the individual conditions.

In response, the **National Action League for People with Rare Diseases (NAMSE)** was established in 2010 with the aim of improving the health status of people with rare diseases in Germany. In addition to the Federal Ministry of Health, the Federal Ministry of Education and Research and ACHSE – Rare Diseases Germany, the league brings together another 26 members – largely umbrella organisations of the main players in the German healthcare sector.
www.namse.de

ACHSE, a network of self-help organisations, offers counselling services in addition to information about rare diseases. It also advocates for the interests of people with rare diseases in dealings with politicians, health insurance companies and other funding organisations.
www.achse-online.de

An online knowledge platform, the **Orphanet** database provides detailed information about rare diseases, care options and directories. Orphanet Germany is a permanent establishment within the Federal Institute for Drugs and Medical Devices (BfArM; *refer to Section 2.1.2 from page 36).*
www.orpha.net/de

The **se-atlas – Mapping of Health Care Providers for People with Rare Diseases**is a web-based information platform and provides an overview of care providers for people with rare diseases in Germany.
www.se-atlas.de

4.4.3 Cancer

Cancer refers to diseases in which the body's own cells become 'malignant'. In other words: the cells grow and divide in an uncontrolled manner, invading and destroying healthy tissue. Once there, they often produce a tumour. Spread to other regions of the body is called metastases.

The **Cancer Information Service** of the German Cancer Research Center is an important point of contact in Germany for all people with questions about cancer. It uses understandable language to provide evidence-based information on the entire spectrum of ontology. A free service accessible by telephone, email and on the internet, it is aimed at anyone who has questions about cancer: patients, their families and friends as well as people who want to learn more about prevention and screening for cancer. The Cancer Information Service also provides independent facts for professionals who care for cancer patients that builds on unbiased research.
www.krebsinformationsdienst.de

With the slogan "Help. Research. Inform.", **German Cancer Aid** provides a wealth of information materials and leaflets – including the Blue Guide – for those suffering from cancer and interested persons. INFONETZ KREBS also draws on the latest medical and scientific findings to offer free telephone or email counselling for all phases of cancer.
www.krebshilfe.de

4.4.4 AIDS

AIDS stands for 'Acquired Immune Deficiency Syndrome'. The syndrome can develop after infection with **HIV**, the 'Human Immunodeficiency Virus'. The virus infects cells that are responsible for the body's defence against pathogens. In doing so, the virus weakens the immune system and is therefore referred to as an immunodeficiency virus. A weaker immune system makes people more susceptible to, and eliminates their protection against, diseases that would otherwise be harmless. Doctors speak of AIDS when this condition has been reached. People will often contract pneumonia or develop tumours. Other diseases may occur as well. There are now drugs that can treat AIDS, although it is still incurable.

The **German AIDS Service Organizations (DAH)** is the umbrella organisation of around 115 organisations and institutions in Germany. It represents the interests of people with HIV/AIDS in dealings with the public and politicians, as well as with the scientific and medical research communities.
www.aidshilfe.de/deutsche-aidshilfe

The **German Association of Outpatient Physicians for Infectious Diseases and HIV Medicine (dagnä)** is the central representative body for practising HIV specialists and infectiologists working in outpatient settings. Its work centres on the prevention, diagnosis and treatment of HIV and other infectious diseases.
www.dagnae.de

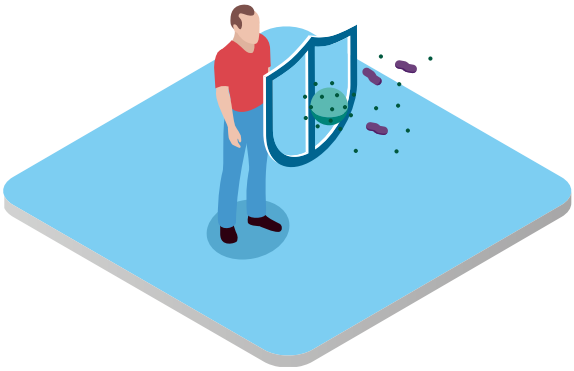
HIV is a virus that can be transmitted during sexual intercourse. The virus therefore belongs to the **sexually transmitted infections (STI)**. For more information on this topic, especially on prevention, refer to *Section 4.3.2 from page 119*.

The BZgA also runs a **telephone counselling service on HIV and other sexually transmitted diseases**. You can reach the information line on **0221 892031** from Monday to Thursday between 10:00 AM and 10:00 PM and on Friday to Sunday from 10:00 AM to 6:00 PM.

4.4.5 Cardiovascular diseases

Diseases of the cardiovascular system – especially acute events such as heart attacks and strokes - are the most common causes of death in Germany. Other cardiovascular diseases, such as chronic coronary heart disease, can severely impair a person's capabilities and reduce their quality of life. Aside from hereditary predispositions, an unhealthy lifestyle is viewed as a risk factor in the emergence of cardiovascular disease. These include smoking, insufficient exercise, obesity and an unbalanced, unhealthy diet.

You can learn what you can do to benefit your cardiovascular system on the information portal **gesundheitsinformation.de** run by the Institute for Quality and Efficiency in Health Care (IQWiG; *refer to Section 2.3.8 on page 55).*
www.gesundheitsinformation.de/was-kann-ich-selbst-fuer-herz-und-gefaesse-tun



4.4.6 Long COVID

Although COVID-19 is now a less relevant factor in the everyday lives of most people, the effects of the coronavirus pandemic are still noticeable. Numerous people affected by long COVID still struggle with the after-effects of an infection with the coronavirus SARS-CoV-2. Many of them have become less physically resilient – and some are now unable to work. Therefore, the BMG and the entire Federal Government are driving research into long COVID and myalgic encephalomyelitis/chronic fatigue syndrome **(ME/CFS)** as one of the most severe forms of long COVID.

The website of the **BMG initiative Long COVID** provides affected persons and their families with up-to-date and evidence-based information that has been prepared specifically for employees, employers and others.
www.bmg-longcovid.de

4.4.7 Diabetes mellitus

Diabetes mellitus is one of the most common non-communicable diseases. An elevated blood sugar level is not the only symptom of this metabolic disorder. This can be caused by a deficiency of the hormone insulin, impaired insulin action or a combination of both. Around nine out of ten people with diabetes mellitus have type 2 diabetes mellitus, which usually emerges as people grow older. People with type 1diabetes tend to develop the disease during childhood and adolescence.

The leading diabetes research centres in Germany have joined forces to create the **Diabetes Information Portal**: Helmholtz Munich, the German Diabetes Center in Düsseldorf and the German Center for Diabetes Research in Munich. Their online portal provides quality-assured and easily understandable information about prevention and living with diabetes mellitus – including background articles, as well as explanatory films and podcasts. In addition, people with diabetes mellitus, relatives and interested parties can ask personal questions in the online forum, which are each answered by experts.
www.diabinfo.de

The BZgA has established the **Diabetes Network Germany** to connect the key actors in the area of diabetes mellitus and diabetes prevention in Germany. Its aim is to pool expertise, gradually implement and continue the development of the National Education and Communication Strategy on Diabetes mellitus within a collaborative framework.
www.diabetesnetz.info

4.5 Other topics

4.5.1 Organ, tissue, blood and plasma donation

The BZgA website provides detailed and open-ended information on the subject of **organ and tissue donation** to encourage more people to consider the issue and reach a personal decision.
www.organspende-info.de

Visitors to **blutspenden.de** will find information about the topic of **blood and plasma donations:** from the requirements and procedure to the use of their donation.
www.blutspenden.de

4.5.2 Gender-specific health

The BZgA women's health portal provides quality-assured information and practical tips on all aspects relating to the health of women. Regular information on related topics is published in the BZgA newsletter.
www.frauengesundheitsportal.de

The BZgA men's health portal provides quality-assured information and practical tips on all aspects relating to the health of men. Regular information on related topics is published in the BZgA newsletter.
www.maennergesundheitsportal.de

4.5.3 Health in old age

The **Gesund und aktiv älter werden (Healthy and active ageing)** website provides data and evidence-based, unbiased health information on the topic of healthy ageing.
www.gesund-aktiv-aelter-werden.de

In addition, the BZgA offers materials on the topic of ageing that is available to download or order.

4.5.4 Child and adolescent health

Children need attentive and competent support in their family and living environments in order to develop and flourish. This online programme by the BZgA supports parents in ensuring the healthy development of their children.
www.kindergesundheit-info.de

The **National Centre on Early Prevention (NZFH)** aims to provide children with better and earlier protection from danger. The centre combines healthcare and child and youth welfare services to achieve this objective. Its focus is on families living in highly stressful circumstances and whose children are younger than approximately three years old.
www.fruehehilfen.de

4.5.5 Climate and health

Climate change is affecting human health in many different ways. Extreme weather and environmental changes, such as heatwaves, can exacerbate existing problems, or even cause new ones. The BZgA information portal provides content on the impacts of climate change on human health and recommends courses of action to protect against climate-related health risks.
www.klima-mensch-gesundheit.de

4.5.6 Long-term care

The **Care Network Germany** encourages dialogue within the profession of long-term care and brings together local and national actors.
www.pflegenetzwerk-deutschland.de

The **Centre for Quality in Care (ZQP)** has conducted Germany-wide research to locate non-commercial counselling services for persons in need of assistance and long-term care, and their relatives, and has also created a database.
www.zqp.de

Numerous insurance companies provide information about all aspects relating to long-term care. This refers, for example, to long-term care facilities and the quality of care services as well as to long-term care counselling centres in Germany.
www.pflege-navigator.de (AOK)
pflegefinder.bkk-dachverband.de (BKK)
www.pflegelotse.de (vdek)

4.5.7 Resuscitation

Coordinated by the BZgA, the **National Action Alliance for Resuscitation (NAWIB)** advocates for increasing knowledge about non-professional resuscitation in Germany. Its purpose is to show: resuscitation is very simple and that anyone can save lives.
www.wiederbelebung.de

What matters most is to take action in the first place. After all, immediate assistance is paramount in the event of a cardiac arrest. And only a few steps are necessary if an emergency happens: check – call – compress! The 'You can save lives' cheque card, the stand-up set and the 'How does resuscitation work?' leaflet are available to order free of charge at
www.shop.bzga.de/catalogsearch/result/?q=wiederbelebung

4.5.8 Self-help groups and organisations

The **National Contact and Information Centre for the Encouragement and Support of Self-Help Groups (NAKOS)** provides information about the available self-help options and brings together interested parties, affected persons and relatives. It maintains extensive address databases for nationwide self-help organisations and local self-help contact points and the services they provide.
www.nakos.de

The **German Association of Self-Help Groups (DAG-SH)** supports and promotes self-help groups in Germany. Members include, for example, self-help organisations and employees of self-help contact points, as well as professionals from psychosocial and health professions.
www.dag-shg.de

The **Federal Association of Self-Help Groups for Persons with Disabilities, Chronic Diseases and their Relatives** (BAG SELBSTHILFE) is the association of these groups in Germany. It represents the political and social interests of chronically ill and disabled persons and their relatives.
www.bag-selbsthilfe.de

4.5.9 Assistance abroad

The website of the **German Liaison Centre for Health Insurance – Abroad (DVKA)** provides insured persons with up-to-date information to ensure that they maintain health insurance cover when travelling abroad.
www.dvka.de

The website of the **National Contact Point for Cross-border Healthcare** offers information to patients and healthcare providers relating to all matters of cross-border healthcare between Germany and other EU countries.
www.eu-patienten.de

Among other things, the **Deutsche im Ausland (Germans Abroad, DIA)** website provides information on social insurance outside of Germany, including health and long-term care insurance.
www.deutsche-im-ausland.org/absicherung-und-finanzen/sozialversicherung-im-ausland

The **European Union** pages contain general information about healthcare services in the EU.
www.europa.eu/youreurope/citizens/health/index_de.htm

4.5.10 Other information services and points of contact

The **Allergy Information Service** by Helmholtz Munich provides up to date, evidence-based information about allergy research and allergology in an easily understandable form.
www.allergieinformationsdienst.de

The **Medical Service** website provides information about all areas of the Medical Services' work, including long-term care assessments, rehabilitation or aids.
www.medizinischerdienst.de/versicherte

There are medical services that patients have to pay for themselves at the doctor's practice. These include, for example, certain preventative care measures or check-ups for sports or international travel. These services are known as **'individual health services', IGeL for short**. The **IGeL Monitor** evaluates this range of services. An interdisciplinary team from the area of evidence-based medicine and public relations departments of the Federal Medical Service receives support from external scientists.
www.igel-monitor.de

The **German Ethics Council** evaluates scientific, medical and legal issues from an ethical perspective. It focuses primarily on potential ramifications for individuals and society. Relevant topics include genetic diagnostics, organ donation and germline interventions in humans, as well as patient welfare in hospitals and big data in the healthcare sector.

As a forum for dialogue and advisory body, the remit of the German Ethics Council includes informing the public and encouraging societal dialogue. It also drafts opinions and recommendations for the Federal Government and the German Bundestag.
www.ethikrat.org

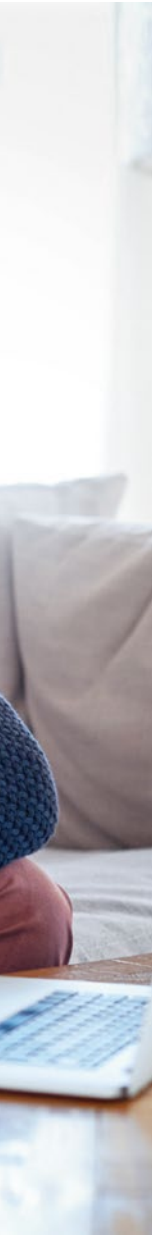
The **Ombudsman for Private Health- and Long-Term Care Insurance** is recognised by the Federal Ministry of Justice as an arbitration body and mediates in disputes between private health and long-term care insurance policyholders and private health and long-term care insurance companies. Its aim is to achieve out-of-court settlements. The ombudsman operates independently and at no cost to those involved.
www.pkv-ombudsmann.de

The BMG has funded the **genomDE** project to establish a nationwide platform for medical genome sequencing in healthcare and research since 1 October 2021. Its initial focus is on rare diseases *(refer to Section 4.4.2 on page 127)* and hereditary and non-hereditary cancer diseases *(refer to Section 4.4.3 on page 128)*.
www.genom.de

The **Federal Environment Agency (UBA)** is tasked with keeping the scientific basis and standards for safe drinking water up to date at all times. It evaluates health risks that may occur during the extraction and treatment of drinking water. Another of the tasks is to mitigate these risks as much as possible. You will find information about drinking water on the website.
www.umweltbundesamt.de/themen/wasser/trinkwasser

Stiftung Gesundheit is a non-profit foundation under civil law. Since 1996, it has been campaigning for greater transparency in the healthcare sector and helping consumers to navigate this frequently confusing area. To do so, Stiftung Gesundheit offers a free doctor search tool atwww.arzt-auskunft.de.
www.stiftung-gesundheit.de

Keyword index



Information services

Im Dialog magazine
Im Dialog is the magazine of the Federal Ministry of Health. It contains information on all important topics and events relating to health and long-term care. Readers will find helpful services, as well as information on our events and descriptions of current campaigns. Issues contain editorial articles and charts to provide clear explanations of even complex technical topics.

If you would like to order an issue or subscribe to the digital and/or print version of the magazine, please send an email to: ImDialog@bmg.bund.de

Internet presences
You will find the latest information from the Federal Ministry of Health on:
www.bundesgesundheitsministerium.de

The National Health Portal gesund.bund.de provides evidence-based, neutral and easily understandable information relating to questions of health and the healthcare sector. You will find the internet presence at:
www.gesund.bund.de

Multilingual information materials on various health topics is available at:
www.migration-gesundheit.bund.de

Other publications

Publications are available to order free of charge from:

Email:	publikationen@bundesregierung.de
Phone:	+49 30 182722721
Video relay service:	gebaerdentelefon@sip.bundesregierung.de
Fax:	+49 30 18102722721
Postal address:	Publikationsversand der Bundesregierung Postfach 48 10 09, 18132 Rostock
Website:	www.bundesgesundheitsministerium.de/publikationen

Ratgeber Impfen – Alles, was Sie zum Thema Impfen wissen sollten

Vaccinations against infectious diseases are among the most successful measures in he history of medicine. This brochure provides information on the benefits and risks of vaccinations and is intended to help people make the right vaccination decision.
Order number: BMG-G-11183

Ratgeber Krankenversicherung – Alles, was Sie zum Thema Krankenversicherung wissen sollten

This guide helps you to navigate our healthcare system. From the choice of health insurance fund
to tips for about visiting a pharmacy – this brochure explains the most important regulations at a glance.
Order number: BMG-G-07031

Ratgeber Krankenhaus – Alles, was Sie zum Thema Krankenhaus wissen sollten

This guide provides an introduction to the hospital landscape in Germany and contains detailed information on the important procedures and services before, during and after hospital treatment.
Order number: BMG-G-11074

Ratgeber Pflege – Alles, was Sie zum Thema Pflege wissen sollten

The guide provides an overview of the long-term care system and answers the most frequently asked questions regarding long-term care insurance and other services to support people in need of long-term care and caregivers.
Order number: BMG-P-07055

Ratgeber Demenz – Informationen für die häusliche Pflege von Menschen mit Demenz

This guide provides information on caring for people with dementia, answers frequently asked questions and presents the services provided by long-term care insurance.
Order number: BMG-P-11021

Citizens' helpline

Operated on behalf of the Federal Ministry of Health, the citizens' helpline is reachable from Monday to Wednesday from 8:00 AM to 4:00 PM, on Thursday from 8:00 AM to 6:00 PM and on Friday from 8:00 AM to 12:00 PM on the following numbers:

Citizens' helpline for health insurance
+49 30 3406066-01

Citizens' helpline for long-term care insurance
+49 30 3406066-02

Citizens' helpline for preventative healthcare
+49 30 3406066-03

Counselling service for the deaf and persons with impaired hearing

Video relay service:
www.gebaerdentelefon.de/bmg

Email:
info.gehoerlos@bmg.bund.de

Your questions will be answered by the staff of the citizens' hotline, which is operated by Telemark Rostock Kommunikations- und Marketinggesellschaft mbH on behalf of the Federal Ministry of Health. Personal data is only collected, processed and used in compliance with the General Data Protection Regulation (GDPR) and the Federal Data Protection Act (BDSG).

Visit the following website for further information:
www.bundesgesundheitsministerium.de/buergertelefon

Information helplines of the Federal Centre for Health Education (BZgA)

BZgA information helpline for addiction prevention[1]
+49 221 892031

Addiction & drugs hotline[2]
+49 1806 313031

BZgA telephone counselling to stop smoking[3]
+49 800 8313131

BZgA telephone counselling on gender and sexual diversity and protection against conversion therapies[4]
+49 221 8992876

BZgA information helpline for questions about organ donation[5]
+49 800 9040400

BZgA telephone counselling on HIV and other sexually transmitted infections[6]
+49 221 892031

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[1] Monday to Thursday from 10:00 AM to 10:00 PM, Friday to Sunday from 10:00 AM to 6:00 PM.

[2] Monday to Sunday from 8:00 AM to midnight; subject to a charge (€0.20 per call from the German landline and the mobile networks)

[3] Monday to Thursday from 10:00 AM to 10:00 PM, Friday to Sunday from 10:00 AM to 6:00 PM; calls are free

[4] Monday to Thursday from 12:00 to 4:00 PM

[5] Monday to Friday from 9:00 AM to 6:00 PM; calls are free

[6] Monday to Thursday from 10:00 AM to 10:00 PM, Friday to Sunday from 10:00 AM to 6:00 PM

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Service hotline: +49 30 182722721
Service fax: +49 30 18102722721
Email: publikationen@bundesregierung.de
Orders via the video relay service:
gebaerdentelefon@sip.bundesregierung.de
Online orders: www.bundesregierung.de/publikationen

Order number: **BMG-G-11088e**

You will find additional publications by the Federal Government to download and order at:
www.bundesregierung.de/publikationen

For further information about the German healthcare system, visit:

AR1

www.blauer-engel.de/uz195

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