The Federal Joint Committee

Who we are and
what we do for your health

Gemeinsamer
Bundesausschuss

Foyer of the G-BA office in Berlin.

Inhalt

Good health for everyone

How do we keep German healthcare safe and affordable?

75 million[1] people in Germany are covered by statutory health insurance. By law, they are entitled to healthcare that is adequate, appropriate, and cost-effective. In fact, statutory health insurance (SHI) funds must be used in such a way as to provide real benefits for people who are ill, while also ensuring that health insurance premiums remain affordable for everyone. Given the fast pace of medical advancement – which is also an important economic factor – this is a difficult yet important task. The Federal Joint Committee (G-BA) plays a vital role in fulfilling this task, and legistators have entrusted the G-BA with a number of responsibilities.

The G-BA specifies in detail what adequate, appropriate, and cost-effective healthcare means as defined by German law. In doing this, it determines which benefits persons insured under statutory health insurance are legally entitled to. It also ensures that patients are

[1] Source: National Association of Statutory Health Insurance Funds, March 2025 (74.49 million)

examined and treated according to the state of the art in medical knowledge and expertise. The G-BA bases its decisions on previously conducted scientific assessments.

The G-BA was established on 1 January 2004 through the Statutory Health Insurance Modernisation Act, but its predecessor institutions[2] are much older. It is a body consisting of representatives from those financing healthcare (statutory health insurance funds) and those providing healthcare services (hospitals, licensed doctors, psychotherapists, and dentists). It also includes patient representatives in an advisory capacity.

[2] The predecessors of the G-BA were the former federal committees of physicians, dentists, and statutory health insurance providers, the hospitals committee, and the coordination committee.

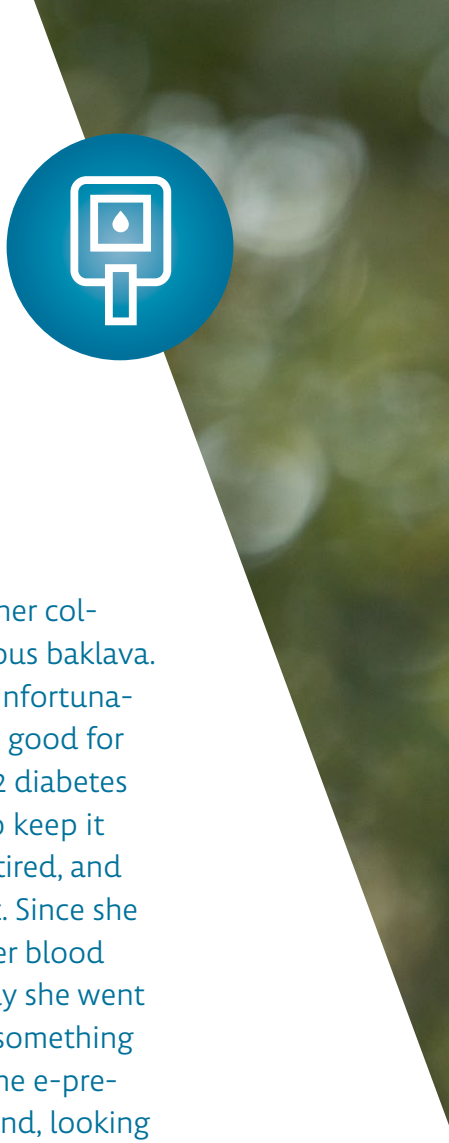
Legislators have empowered the G-BA with a wide range of tasks and responsibilities. The G-BA has the authority to issue directives and guidelines that are binding for healthcare providers, statutory health insurance funds, and patients in Germany. The legal basis for its work is Book V of the German Social Code (SGB V), which defines how the G-BA is composed, how it conducts its work, and what its duties are.

The G-BA makes important decisions on healthcare independently of the powers influencing daily politics. As a self-governing organisation made up of physicians, statutory health insurance funds, and hospitals, it is structured in such a way that it blocks political power moves by individual interest groups during voting, while ensuring that results are reached even when decision-making processes seem to reach an impasse. This is achieved using a system of majority consensus. During the consultation process, it is often possible for opposing interests to reach a consensus, or at least the best possible compromise. In doing so, the G-BA purposefully draws on the expertise of independent scientific institutes and involves them in the development of healthcare solutions.

Examples of the G-BA's work

On the following pages, we provide an insight into the work done by the G-BA. Using examples, we explain some of its decisions and describe the underlying tasks and responsibilities. In order to keep things understandable, we have refrained from presenting all of the G-BA's tasks and responsibilities. A complete overview is provided on our website: ↗ *www.g-ba.de*

The following patient stories are based on real events; however, names have been changed to protect privacy. All portrait pictures are agency photos showing models.



Reference price groups

Lowering the cost of medicines

'No thanks!' says **Fatma Çelik (60)** when her colleague once again offers her some delicious baklava. 'You know I'm not allowed to eat that.' Unfortunately, the pastry from her homeland is not good for her. Fatma has been suffering from type 2 diabetes for around 15 years and has struggled to keep it under control. She often feels weak and tired, and sometimes has a numb feeling in her feet. Since she started taking a new additional tablet, her blood sugar levels have improved. The other day she went back to her doctor for a check-up when something unexpected happened. While finalising the e-prescription, the doctor suddenly stopped and, looking at her screen, said: 'Ms Çelik, I've just noticed that the medication you usually take will now cost you an extra €63.39 at the pharmacy. If you don't want that, I can prescribe something else for you. Wait a moment... this one here has the same active ingredient and the same pack size, and it doesn't cost anything extra.' Fatma nods in approval. But why does she have to take a different medication now?

The G-BA's contribution

The active ingredient sitagliptin in Fatma Çelik's tablet is subject to a fixed reference price. This is an upper price limit for a group of therapeutically equivalent medications. Up to this amount, the health insurance funds will pay for these medicines. Statutory health insurance funds save an average of €3.7 billion[3] per year through fixed reference pricing alone. That is money that can be spent on other necessary treatments. The G-BA has an important responsibility in this regard: it examines which medicinal products can be grouped into reference price groups.

The active ingredient sitagliptin belongs to the DPP-4 inhibitors. The G-BA established a reference price group for these drugs for the first time in 2024. However, the manufacturer of Fatma Çelik's usual medication has not adjusted the price to the fixed reference price. To avoid co-payments, patients can switch to a different medication that is just as suitable for their treatment and is already at or below the fixed reference price.

[3] Source: National Association of Statutory Health Insurance Funds as of 01.07.2025 (annual average for the past 10 years)

Our task:
Determine reference price groups

The G-BA can form reference price groups only if several therapeutically comparable medications have approval to treat the same disease or condition. Within a reference price group, doctors can always choose from a number of different treatment alternatives, which they can prescribe at the expense of the statutory health insurance funds. Around 80%[4] of all prescriptions for pharmaceuticals in Germany are for reference price drugs.

The value of reference prices is regularly revised using market data. The G-BA defines comparative values which are later used to calculate actual reference prices. For example, if the patent on an active ingredient expires, other companies soon begin producing cheaper generics. This results in the value of the reference price group dropping.

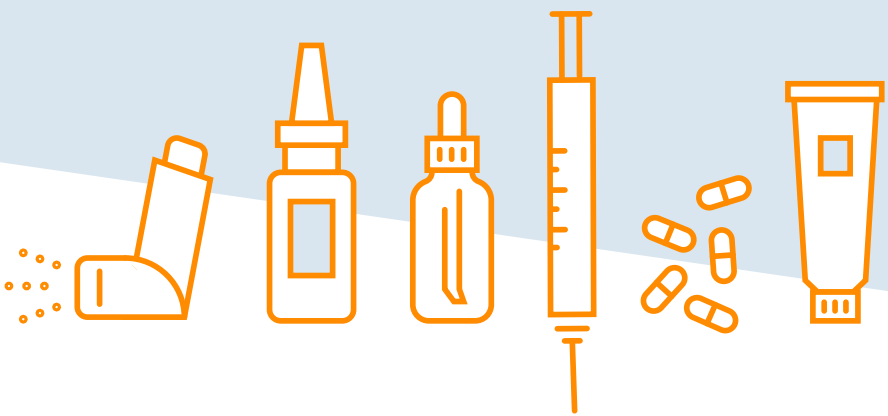
Reference prices are calculated by the National Association of Health Insurance Funds (GKV-Spitzenverband). It sets a reference price for each group the G-BA forms in accordance with legal criteria, and forwards that information to the Federal Institute for Drugs and Medical Devices (↗ *www.bfarm.de*) for online publication. Both steps – forming a group and setting a reference price – result in the cheapest medicines in the reference price group creating downward price pressure. Pharmaceutical manufacturers often align themselves with the reference price but do not have to lower their prices. If they maintain a higher price, patients can only avoid co-payments by switching to an equivalent product that is fully reimbursable. If doctors want to prescribe a medicine that is more expensive than the reference price, they are required to give this information to their patients and discuss alternatives with them.

[4] Source: National Association of Health Insurance Funds

FYI:
Medicinal products

For persons covered by statutory health insurance in Germany, prescription medications are available as SHI benefits immediately upon market authorisation. However, because insurance premiums should be spent on medications that are most beneficial for patients – at a fair price – legislators have given the G-BA the mandate to act as a regulatory body in the pharmaceuticals market.

In addition to the reference price grouping mentioned above, the G-BA has other means to ensure that healthcare is safe and affordable. For example, it can limit prescription of drugs that are ineffective or uneconomical. It can also issue therapy guidelines that doctors should follow. It can also assess whether drugs can be prescribed outside their authorised indications in exceptional cases ('off-label use'). It also puts newly authorised active pharmaceutical ingredients through an early benefit assessment (see the following example).



Additional benefit assessment

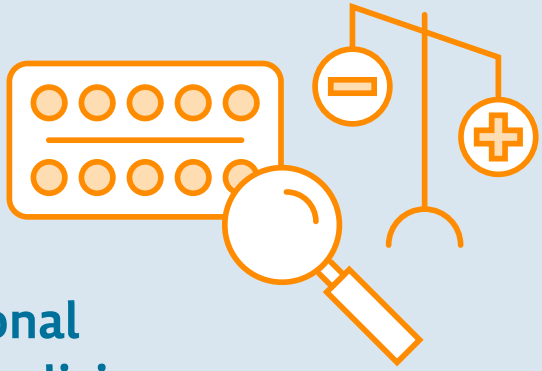
Real progress or pseudo-innovation?

With one hand, **Leo Ammann (14)** holds his inhaler, with the other he scrolls through his school's list of cancelled lessons on his smartphone. He's in luck, first double lesson cancelled! Leo takes a few deep breaths to move the mucus that is constantly forming in his lungs towards his mouth and then coughs it up. He manages to do it quickly today. Since he started taking his new medication, there's hardly any more mucus. The inhaler, the respiratory therapy exercises to clear his lungs, and more than 10 medications are all part of his everyday life. Leo has cystic fibrosis – a congenital gene mutation causes his body's secretions to be sticky and thick. The mucus interferes with his breathing, causes inflammation, and strains his internal organs. Since he started taking the new medication, he is doing better. Leo has gained weight, he has more energy and is more resilient. Unfortunately, he now gets headaches more often, but that doesn't really matter. In the kitchen, he grabs his medicine box and washes down the orange tablet with a glass of milk. More time for breakfast – he can use that.

The G-BA's contribution

Leo Ammann's new drug is a fixed combination of three active ingredients: ivacaftor, tezacaftor, and elexacaftor. Two of them, ivacaftor and tezacaftor, have been around for a while, also in combination with other active ingredients. The compound that Leo takes came onto the German market in June 2021. It's used to treat cystic fibrosis patients aged 12 and older who have certain mutations on the gene that causes the disease. This results in defects in building blocks (chloride channels) of mucus-forming glands. The drug can compensate for some of these defects. Mucus and digestive juices become thinner as a result.

In November 2021, following an elaborate assessment procedure, the G-BA found indications that the new drug combination has a significant additional benefit over comparative therapies for patients over 12 years of age with certain gene alterations. For these patients, the benefits clearly outweigh the side effects associated with the therapy. In the meantime, the G-BA has assessed the fixed combination of three active ingredients ivacaftor, tezacaftor and elexacaftor for many other patient groups. Not all groups benefit to the same extent.



Our task:
Assess the additional benefits of new medicines

In Germany, newly authorised active pharmaceutical ingredients can be prescribed immediately upon market launch, and are thus available to patients right away. Such newly developed active ingredients under patent are usually very expensive. Until 2010, pharmaceutical companies were allowed to charge any price they wanted for such drugs and the statutory health insurance system, or so to speak, the people who pay insurance premiums paid. Since the beginning of 2011, a testing procedure is initiated as soon as a drug is approved for the market to find out if it is better than others that are already available. This makes it possible to distinguish real innovations from pseudo-innovations.

The G-BA plays an important role in this. It must put every new active pharmaceutical ingredient through an early benefit assessment within six months of its launch on the German market. During this assessment, the G-BA evaluates the extent of the benefit for the patient groups covered by the approval compared to previously available therapies. An example of an additional benefit can also be if the drug has fewer side effects.

The G-BA's assessment is the basis for the reimbursement amount that the statutory health insurance funds negotiate with the manufacturer – the amount they end up paying. If the G-BA establishes that the medicinal product does not offer patients any additional benefit, it can assign the drug to a reference price group. However, if the new medication is a genuine improvement with demonstrable added benefit, the manufacturer negotiates the future reimbursable amount with the National Association of Health Insurance Funds based on the G-BA's benefit assessment.

Treatment methods

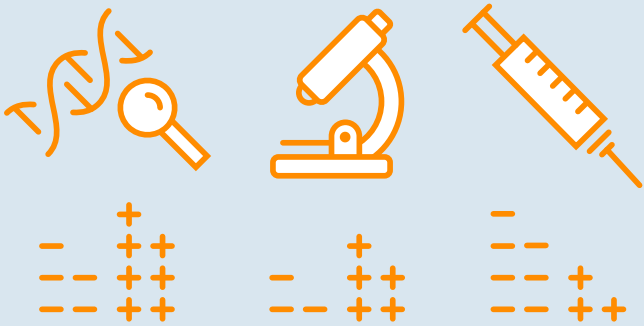
Telecare for heart failure

Climbing stairs is the hardest part. Panting heavily, **Lina Spallek (69)** puts down her shopping bags. Everything goes black. Her granddaughter is almost at the top but then comes back down. 'Grandma, give me the keys and I'll open the door'. Lina Spallek is breathing heavily and has to sit down on the stairs. 'Just a moment … I'll be … right there!' she gasps. Lina Spallek suffers from heart failure (cardiac insufficiency). Her heart doesn't work evenly and its pumping capacity is weak. As a result, she can hardly take any strain. Her legs are swollen, she often has water in her lungs, and every little effort pushes her to her limits. But recently she has started to feel more confident and secure because she now uses digital telecare. Her vital signs are closely monitored, and her doctor can intervene early on if her condition worsens. In the evening, she shows her granddaughter how it all works on her tablet. Together they put on Lina's blood pressure cuff and enter the reading. Then they go to the electronic scales and her tablet asks if there were any irregularities or problems. Yes, there were – the stairs!

The G-BA's contribution

The fact that people with a heart condition such as Lina Spallek have a better chance of survival thanks to additional digital monitoring is due to a decision made by the G-BA. In December 2020, the G-BA made telemedical care for patients with advanced heart failure an outpatient health insurance benefit. Important metrics, such as blood pressure, heart rate, and weight, are measured and recorded daily by the patients themselves. They take part in a training course to learn how to use the measuring and input devices provided by their health insurance fund.

The data entered is transmitted to a telemedical centre where it is evaluated. Data from pacemakers that are already implanted can even be read directly by appropriate devices. In the event of any irregularities, the centre immediately informs the attending physician. This allows the therapy to be adjusted immediately. After examining current studies, the G-BA found that there are significantly fewer deaths among those affected by heart failure who also participate in telemonitoring.

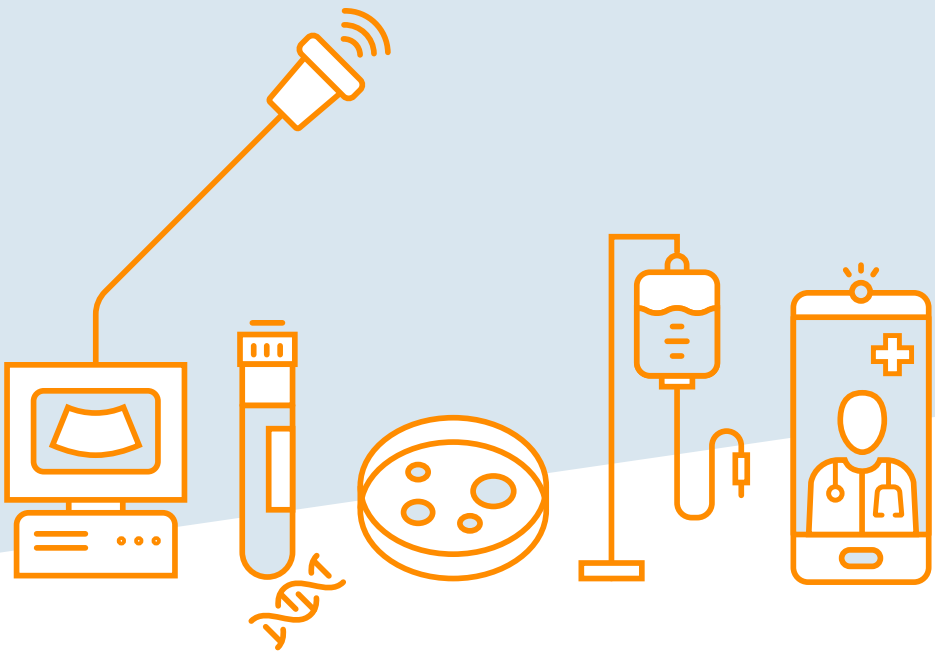


Our task:
Review new treatment methods

The G-BA assesses new examination and treatment methods to determine whether they benefit patients and if they are necessary and cost-effective. The G-BA looks closely at the current standard of medical research and takes into consideration every relevant study of the method in question.

For example, it also examines whether the examination or treatment method can cure patients, what side effects or complications it might cause, and what impact it has on quality of life. The G-BA must always identify the patient groups for whom the method is particularly effective, and under which circumstances.

FYI:
Examinations and treatments



Hospitals and doctors' practices are subject to different regulations regarding examination and treatment methods under statutory health insurance. Doctors in private practice can only offer new methods as SHI benefits after the G-BA has assessed those methods for outpatient care and concluded that they are beneficial, necessary, and cost-effective for patients (right of authorisation).

But by law, hospitals can offer new examinations and treatments without this preliminary assessment. However, upon request[5], the G-BA does examine whether the method is adequate, appropriate, and cost-effective in an inpatient setting. If it becomes apparent that a method used in hospitals cannot be proved beneficial and does not show potential as a necessary treatment alternative (e.g. because it is ineffective or even harmful), the G-BA can remove it from the list of benefits financed by SHI funds (right to prohibit).

[5] Requests for assessments of outpatient examination and treatment methods can be submitted by the impartial members of the G-BA, the National Associations of Statutory Health Insurance Physicians and Dentists, the National Association of Health Insurance Funds, and the patient representatives. Requests for assessments of inpatient examination and treatment methods can be submitted by the German Hospital Federation, the federal associations of hospital funding providers, the National Association of Statutory Health Insurance Funds, and the patient representatives.

Early detection methods

Bowel cancer screening programme

First you have to manage to drink two to three litres of liquid in two hours. **Klaus Ellert (50)** has a colonoscopy tomorrow, his first. It won't be fun. But Klaus Ellert's grandfather died of bowel cancer in the 70s. Reason enough for him to go in for a closer look. When he recently received an invitation from his health insurance fund for colon cancer screening, he immediately made an appointment with a gastroenterologist. If he finds anything, it will most likely be in the early stages. And a lot of it can probably be removed right away during the examination – throughout which he will thankfully be asleep. Klaus Ellert has just started drinking a special laxative solution with a thick straw, always alternating with water. To distract himself, he keeps going back and forth to his laptop and checks out family-friendly hotels for the next summer holiday. Tomorrow morning, he has to repeat the whole thing again; his appointment is at 1.00 pm.

The G-BA's contribution

The colonoscopy that Klaus Ellert will undergo tomorrow is part of a bowel cancer screening programme. The G-BA made nationwide screening a health insurance benefit in 2018. All persons with statutory health insurance between the ages of 50 and 65 are now invited to participate every five years by their health insurance fund. They can choose between a faecal occult blood test once in two years and two colonoscopies – one ten years after the other.

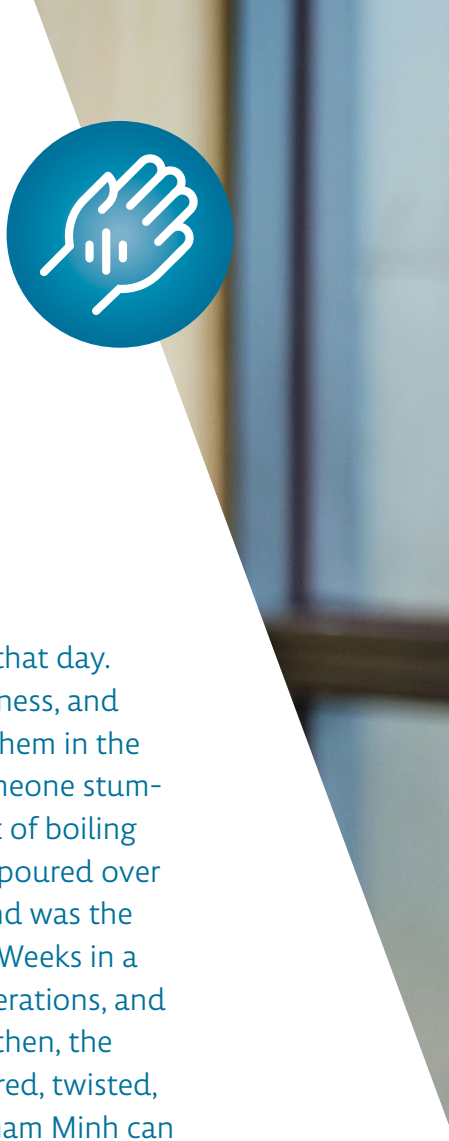
Both examination methods increase the survival chances of insured persons because they find tumours well before the onset of symptoms. Out of 100 tumours, a stool test detects about 70 and a colonoscopy about 95. In addition, precancerous lesions can be found and immediately removed and examined. The G-BA has developed a brochure that explains all this in detail to insured persons. It is enclosed with the invitations to the screening and can also be accessed online in easy-to-understand language.

Our task:
Develop early detection methods

The G-BA also assesses early detection methods (screenings) for their benefit, necessity, and cost-effectiveness. In terms of this, there is more to consider than just assessing the examination methods described earlier. That's because screening is a medical examination for children, adolescents, and adults who show no symptoms of a disease. The costs and effort must be reasonable compared to the patient benefit if a disease is detected and treated early on.

The G-BA is responsible for determining whether a specific disease can be detected accurately through screening. It must also know whether good treatment methods are available. If these exist, the G-BA then investigates whether the success of the treatment really depends on how early the disease is discovered. If this does play a role, the G-BA then examines screening methods in depth. Good screening methods must detect diseases reliably without triggering false alarms, because this creates stress in people who are actually healthy. They must never be dangerous or harmful to those being screened.

Many screenings have successfully met the evaluation criteria set by the G-BA. Examples of screenings available today include skin cancer, hepatitis B and C, chlamydia, and gestational diabetes. Organised screening programmes offered nationwide include the early detection of colorectal cancer, breast cancer, and cervical cancer. In addition, the G-BA ensures that hearing disorders, heart defects, cystic fibrosis, or spinal muscular atrophy can be detected in newborns and treated early.



Prescribed services

Long-term care for burn injuries

Huyen Pham Minh (32) will never forget that day. All it took was a tiny moment of carelessness, and everything changed. There were four of them in the kitchen preparing food for Têt[6]. Then someone stumbled next to her and knocked a huge pot of boiling fat off the cooker. Five litres of frying oil poured over her wrist, her trousers, her shoes. Her hand was the worst affected, with third-degree burns. Weeks in a special ward for burn injuries, several operations, and rehabilitation are now behind her. Since then, the wounds have healed, but the skin is scarred, twisted, and has a tendency to tighten. Huyen Pham Minh can hardly feel anything in her fingers and still cannot grip properly with her injured hand. She now attends occupational therapy and physiotherapy several times a week. The aim is to regain mobility in her hand again through specific gripping and everyday exercises. There are also massages to prevent scarring, as well as lymph drainage and manual therapy.

[6] Vietnamese New Year

The G-BA's contribution

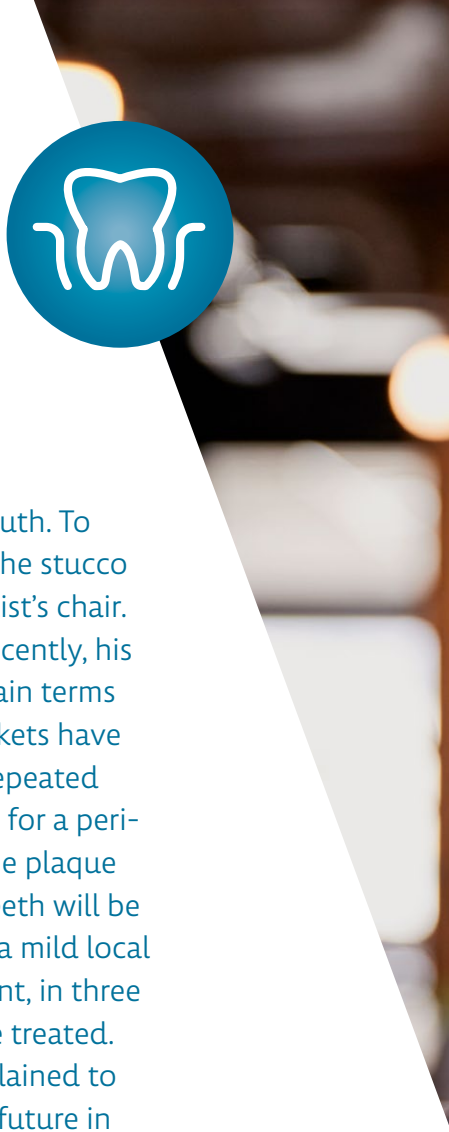
Huyen will need occupational therapy and physiotherapy for a long time to regain mobility in her hand. The G-BA has made it possible for this to be straightforward. Since March 2021, third-degree burns and chemical burns have been recognised as requiring long-term treatment. Thus, patients such as Huyen are entitled to ongoing treatment without pre-examinations. Her attending doctor can authorise the necessary remedial treatment for 12 weeks at a time.

Remedial treatments includes medical services such as physio-therapy, swallowing therapy, or occupational therapy which are provided by trained therapists. They are only covered by health insurance if they are prescribed. Generally speaking, remedial therapy is required for weeks or months, but sometimes for much longer. This can require long-term remedial therapeutic services. In 2016, the G-BA defined a list of diagnoses to which this applies because they are associated with severe injuries. Since then, the G-BA has expanded this list of diagnoses several times.

Our task:
Update the schedule of benefits

The G-BA determines which therapies can be prescribed as health insurance benefits and what has to be taken into account. In its guidelines, it determines the conditions under which doctors, dentists, and psychotherapists can prescribe therapies. The guidelines also specify which therapies can be prescribed for which diseases and in what quantity and frequency. Combinations of different therapies are also possible. In the case of severe burn injuries, for example, a special combination of occupational therapy, physiotherapy, voice therapy, speech therapy, and swallowing therapy are possible.

A specific therapy goal can usually be achieved with the amount of treatment specified in the remedial therapy guidelines. Further therapy can be prescribed if there is appropriate medical justification.



Dental treatment

Periodontal therapy

Markus Roth (42) patiently opens his mouth. To distract himself, he is carefully studying the stucco ornaments on the ceiling above the dentist's chair. He's glad that it's finally getting done. Recently, his dentist made it clear to him in no uncertain terms that he needed to take action. Deep pockets have formed in his teeth, and lately he's had repeated infections as a result. So, it was high time for a periodontal treatment. Over two sessions, the plaque on Markus's teeth and the necks of his teeth will be thoroughly removed. This is done under a mild local anaesthetic. Today is the first appointment, in three weeks the other side of his mouth will be treated. Prior to the appointment, his dentist explained to him in detail what he needs to do in the future in terms of oral care. It's important that he uses an interdental brush to get into the small spaces between his teeth, something he hasn't done at all in the past. The dentist has promised him that it will be worth the effort. If he does a good job, he'll keep his teeth for a long time.

The G-BA's contribution

Periodontitis is an inflammation of the gums caused by bacteria. Without treatment, it spreads over time, causing damage to teeth, roots, and jaw bones, and can eventually lead to tooth loss. The G-BA made it possible for Markus to avoid this and for gingivitis to now be treated from its onset. In December 2020, it added systematic periodontitis therapy as a new health insurance benefit.

Periodontitis therapy combines diagnostics, education, and comprehensive care instructions with anti-infective therapy. This involves removing plaque from the tooth surfaces above and below the gum line. In severe cases, surgery or antibiotics may also be used. To ensure the success of the treatment, regular follow-up appointments take place over a period of two years. These consist of a check-up, teeth cleaning, and further care instructions.

Our task:
Define dental services

Keeping your own teeth for as long as possible is the most important goal of dental care for SHI-insured persons. The range of services provided by statutory health insurance includes regular early detection examinations and a lot of educational work. Treating dental diseases is also part of this, always with the aim of 'saving' a person's own teeth. The G-BA determines when and to what extent the health insurance funds pay for dental fillings, pain therapy, orthodontic treatment, or root canal treatment. In doing so, it focuses on ensuring that dental care is adequate, appropriate, and cost-effective. As such, the G-BA specifies the standards that dentists must observe when carrying out these treatments.

Tooth replacements, such as crowns, bridges, dentures, or implants, usually have to be paid for by the patients themselves. The health insurance funds only cover a portion of the costs, which is known as the fixed allowance. The amount of the fixed allowance is determined annually[7] and published by the G-BA. The G-BA specifies what is considered as standard care for the various diagnoses. Patients must then pay the difference between the dental practice's schedule of fees and the fixed allowance paid by the health insurance fund (or take out additional insurance). The G-BA regularly adapts the description of standard care to reflect medical advancements.

[7] Negotiations on the amount of the fixed allowance are conducted between the National Association of Statutory Health Insurance Funds and the National Association of Statutory Health Insurance Dentists (KZBV) (for dental services) or the National Association of Statutory Health Insurance Funds and the Association of German Dental Technicians' Guilds (VDZI) (for dental technician services).

Developing quality standards

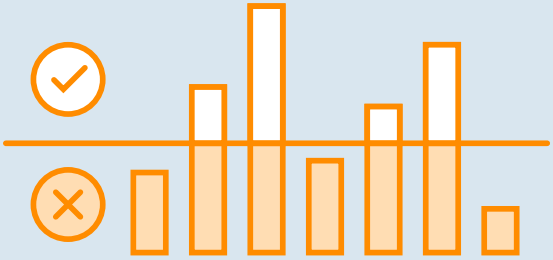
Paediatric cardiac surgery

Paul (8) is the youngest child in the Krüger family and seems perfectly healthy. But unfortunately, he's not. Paul has a congenital heart defect. His illness has completely changed the way his family lives, because Paul doesn't have much physical stamina; he is often tired and doesn't eat very well. He is on regular medication and often has to see a paediatric cardiologist or spend time in hospital. But all that might change in four days, when Paul undergoes surgery. His mother, Laura, is packing suitcases for her and her husband. She's also giving her sister instructions, because she will be looking after their other children for the next two weeks. The hospital where the operation will take place is 200 kilometres away and has large departments for cardiac surgery and paediatric cardiology. The Krügers will accompany their son and be with him as much as possible. Laura Krüger is trying not to show how worried she is.

The G-BA's contribution

Paul's parents can rest assured that the hospital where their son will have his surgery meets strict quality standards and has the appropriate equipment it needs to perform this operation. In February 2010, the G-BA passed guidelines on paediatric cardiac surgery. They set the standards clinics must meet if they want to perform such highly delicate heart operations on children. The guidelines have been updated several times since then, most recently in January 2023.

Following the introduction of the guidelines, only those hospitals or heart centres which have the necessary equipment are allowed to perform certain procedures on children and adolescents with heart problems. In addition, doctors and nursing staff in these facilities must meet strict standards for training and experience. These criteria greatly influence the success of the surgery and treatment, and thus the quality of life for children who receive it. Each year, these clinics must prove to the statutory health insurance funds that they meet the defined quality criteria.



Our task:
Set quality standards

One of the G-BA's responsibilities is to set quality standards for certain medical interventions, for example, for exceptionally difficult procedures. To do so, it first investigates which criteria influence quality, using study results already available and by requesting expert opinions. The G-BA specifies how many doctors and nursing staff with the necessary additional qualifications and training are required. It takes into account the qualifications of the staff in the relevant intensive care units. Continuing with our example of paediatric heart surgery, more than half of all operations for congenital heart defects are performed on infants under the age of one. Therefore, in paediatric cardiac intensive care units, a certain proportion of the intensive care nurses on each shift must have further training specifically in paediatric intensive care or be able to demonstrate appropriate professional experience.

However, it is not only structures, but also the hospital's processes, facilities, and technical equipment which can have an impact on the success of operations and treatment. One example of this is good discharge management. For example, since 2019, hospitals must prepare further paediatric cardiological treatment after a patient is discharged following paediatric heart surgery. This includes establishing contact with a specialised practice, helping parents to get an appointment for their child there quickly, and providing a discharge letter with specific recommendations for further treatment.

Set minimum quantities

Safety for newborns

993 grams – she is light like a feather. **Darja Langhof (26)** is lying on the bed in the neonatal intensive care unit with her 3-week-old daughter Sofia on her stomach. Time blurs, it is warm. Her husband **Tom (29)** will relieve her shortly. Darja Langhof looks at her daughter with a pocket mirror. Sofia looks like she's from another world: the baby's cap is far too big and the little fists barely bigger than those of a doll. A tiny tube feeds oxygen into her lungs through her nose. Darja Langhof feels her daughter's short, rapid breaths and tries not to pay attention to them. Hoses and monitors everywhere, whirring and beeping softly. With cervical insufficiency, an early shortening and opening of the cervix, she came to this perinatal centre in the 22nd week of pregnancy on the advice of her gynaecologist. Here, they were able to delay the birth for another week. Valuable time for her daughter's organs to mature even further.

The G-BA's contribution

Although Darja and Tom Langhof had to drive further to reach the maternity hospital, it was worth it. Darja and her little daughter now benefit from a wealth of experience in caring for premature babies with a birth weight of less than 1,250 grams. This safety for the newborns is also based on the work of the G-BA. It has set a so-called minimum quantity for the care of severely underweight premature babies. Only hospitals that deliver and care at least 25 of these particularly immature babies per year are allowed to continue doing so.

The G-BA introduced this minimum quantity of treatments per year for the first time in 2010. In 2020, it was gradually increased from 14 to 25. Scientific studies have shown that the experience of the entire team leads to significantly better results and more premature babies survive.

Sometimes the journey to a hospital with a level 1 perinatal centre that meets the minimum quantity takes longer. However, the chance that the child will survive and, thanks to the team's extensive experience, get through the critical first few weeks without permanent damage outweighs this inconvenience.

Our task:
Establishing reasonable minimum quantities

The aim behind the legislative idea of minimum quantities of treatments per year is to ensure that particularly difficult treatments are only carried out by hospitals with sufficient experience for quality reasons. This ensures a high treatment standard: more patients survive, and complications and follow-up procedures are reduced.

The G-BA proceeds in several stages: it specifically looks for highly complex, plannable services that are rare and therefore require special expertise. Emergency operations are therefore excluded from the outset. In the next step, the G-BA examines whether there is a scientifically proven correlation between the frequency of performance and the quality of the of the planned treatments it has identified. For these services, the G-BA sets a well-defined minimum quantity of treatments per year per doctor and/or hospital location. It also considers whether the travel times to the facility are still reasonable.

The G-BA also regularly checks whether its minimum quantities are still scientifically up-to-date. Developments in the hospital landscape also play a role here. If the distances become too great (they should not exceed around 25 minutes extra), the G-BA will adjust the minimum quantities slightly downwards – as far as quality allows. This allows more hospitals to offer the service and the distances for patients become shorter. The G-BA has now defined a minimum quantity for 13 services, for stem cell transplants, heart or liver transplants, and oesophageal surgery.

Quality measurement

Early sepsis detection

Although **Michael Holst (53)** has fought his way back, nothing is the same as before. Four of his fingers had to be partially amputated, he can no longer concentrate for long periods, and he has had to give up his previous job. These are the consequences of surviving sepsis and four weeks in an induced coma. And this happened to him, who was always so resilient. His old life ended a year and a half ago. After a persistent feverish infection, Michael Holst never fully recovered. 'Come on, don't be pathetic,' he said to himself and forced himself back to the office as soon as his sick leave ended. However, the severe fatigue weighed him down, and the fever returned. At night, he felt sicker than ever before. On his way to the bathroom, he collapsed. He later learned that he had suffered septic shock and multiple organ failure. He was immediately admitted to the intensive care unit and placed in an artificial coma. For more than four weeks, he was treated with high doses of antibiotics. Unfortunately, due to reduced blood circulation, four of his fingertips could not be saved. Since waking up, he has been a different person. And yet, medically speaking, he was still lucky to have survived.

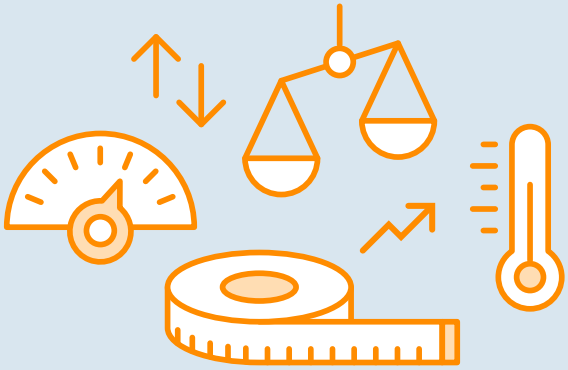
The G-BA's contribution

What happened to Michael Holst happens to around 500,000[8] people in Germany every year: they developed sepsis (blood poisoning). This dysregulated immune response can lead to severe tissue damage. Triggers can be bacteria as well as fungi or viruses. Many cases of sepsis are hardly detectable because the initial symptoms, such as severe fatigue and fever, are often so nonspecific that sepsis is not immediately suspected. This has fatal consequences: up to 200,000[9] people die from it every year. The earlier sepsis is detected, the greater the chances of survival.

To ensure that sepsis is detected even more quickly in hospitals in the future, the G-BA has developed a new quality assurance procedure. It will be applied in all German hospitals starting in 2026. It helps to design processes in such a way that, in the event of non-specific symptoms, the correct diagnosis is made immediately, and treatment is provided quickly. 14 indicators show hospitals how they are performing each year.

[8] Source: Sepsis Foundation, as of 8/2025

[9] Source: Institute for Health Metrics and Evaluation (IHME), www.healthdata.org, values from 2021

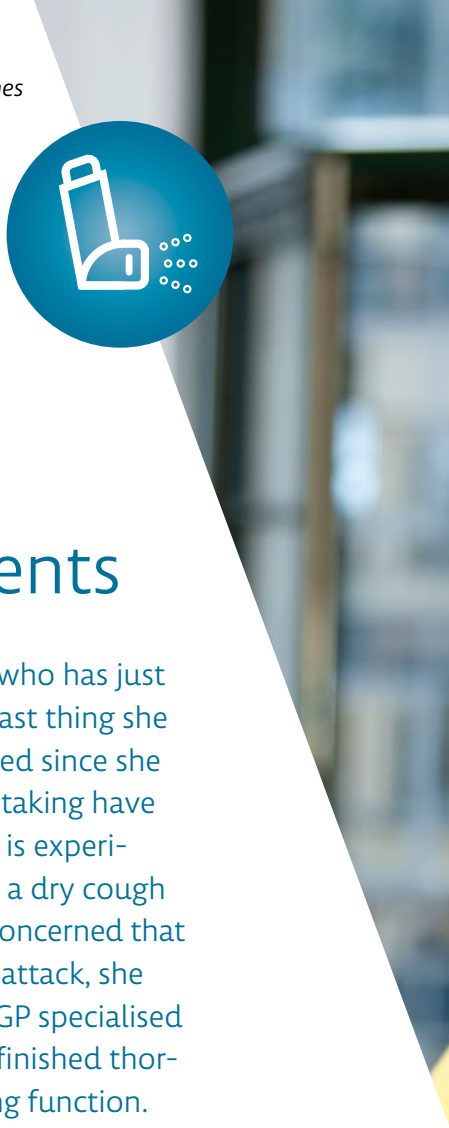


Our task:
Measure quality

The responsibilities of the G-BA in the area of quality assurance are extensive. Among other things, it ensures that hospitals can measure the effectiveness of certain treatments using key performance indicators and evaluate the results.

The G-BA develops measurement procedures that allow comparisons between treatment quality to be made. Hospitals in Germany are legally required to record the quality of their treatments and results, and to provide that information for nationwide comparison. If any peculiarities become apparent, a specially appointed panel of experts investigates whether they are merely statistical outliers or if there are actual quality problems. If the latter, professional consultations are scheduled to look into causes and possible solutions.

The G-BA defines what details hospitals are required to document and how the data are to be processed, compared, evaluated, and published nationwide. For some years now, follow-up treatments in the same or other facilities have also been documented. Treatment effects or problems that only occur after a certain amount of time are thus also taken into account. This detailed procedure helps hospitals provide the best possible care for their patients and to continually improve. To achieve the same goal, the G-BA also sets quality standards for contracted medical and dental practice.



Disease management programmes

Help for asthma patients

Tina Glaumann is a 23-year-old student who has just moved to a new city. Getting ill was the last thing she needed. But her grass allergy has worsened since she moved. The antihistamines she has been taking have suddenly stopped working, and now she is experiencing a strange shortness of breath and a dry cough during some of her allergy attacks. She's concerned that it might be asthma. Last week, during an attack, she felt like she was almost suffocating. The GP specialised in allergies she consulted today has just finished thoroughly examining her and testing her lung function. After a look through the results, she undergoes a multi-phase allergy test. Then comes the diagnosis – bronchial asthma. Her doctor advises Tina to take part in a structured treatment programme. She will then receive systematic care, if needed, in cooperation with other specialists.

The G-BA's contribution

Patients with certain chronic diseases can sign up for structured treatment programmes with their SHI fund. These programmes mean that treatment is coordinated across various facilities and ensure that it is based on scientifically proven findings. The aim is to prevent complications, subsequent harm, and hospital stays. These structured treatment programmes, also called disease management programmes (DMPs), are developed by the G-BA.

The DMP for asthma was introduced in 2005. It specifies which steps doctors must take for a diagnosis and which results actually confirm the presence of the condition. Patients receive training on how to manage the disease. The DMP also prescribes which substance groups are to be used for pharmaceutical treatment as part of a customised step-by-step approach. In addition, the DMP defines the qualifications doctors and therapists involved in the treatment are required to have.

Our task:
Develop DMPs

Legislators have mandated the G-BA to identify diseases suited to DMPs and to define the requirements for structured treatment processes. In developing DMPs, the G-BA looks into all evidence-based guidelines available for that particular disease and then evaluates their recommendations according to previously defined categories. It must carefully compare the scientific sources these treatment guidelines are based on, which are often quite numerous. The recommendations the G-BA then filters from the existing guidelines must be built on the most robust scientific foundation possible and have the widest possible support of the scientific community.

So far, the G-BA has developed DMPs for twelve chronic conditions: asthma and chronic obstructive pulmonary diseases (COPD); diabetes mellitus types 1 and 2; coronary heart diseases and chronic heart failure; breast cancer; depression; chronic back pain; obesity; osteoporosis; and rheumatoid arthritis. They are updated regularly to reflect the latest scientific research.

The Innovation Fund

Ideas for better healthcare

The German healthcare system is considered one of the best in the world. However, there are still some deficits in the German system. These can be caused by long travelling distances, ambiguous structures, inappropriate incentives, or expert knowledge that is not immediately available. In order to identify such issues and find suitable solutions, legislators launched the Innovation Fund in 2016. It promotes new forms of healthcare and research projects that help to make the healthcare system better.

The Innovation Committee, which is part of the G-BA, is responsible for allocating monies from this fund. The Innovation Committee uses calls for proposals (funding announcements) to decide which topics and projects will be funded for a certain period of time. On conclusion, it reviews the results on the basis of scientific evaluations: Do the results of the projects bring measurable improvements for patients? Can they be applied well on a broad scale? If the answers are yes, the Innovation Committee recommends them to be used in standard healthcare. By December 2024, the Innovation Committee had supported 252 projects on new forms of healthcare and 475 on healthcare research. It has already recommended numerous results be transferred to standard healthcare or for other use.

Here are two examples:

Paediatric practices and early intervention services

The P.A.T.H. intervention system helps families with young children in psychosocially stressful situations receive help more quickly: Paediatricians are trained to reliably recognise warning signs and to network with child welfare services. At the core of P.A.T.H. is a medical training course on how to talk to parents. The results show, among other things, that the intervention improves the families' awareness of early intervention services, and that distressed families are identified more frequently by healthcare practitioners. The Innovation Committee funded the accompanying research on the effectiveness of P.A.T.H. and recommended the results to German medical associations.

Dialysis training therapy

Around 80,000 people in Germany require regular blood purification (haemodialysis) due to chronic kidney failure. The DiaTT project tested sports therapy during dialysis: patients trained their endurance and strength under supervision while sitting or lying down. The results show that mobility and quality of life improve significantly, and the number of hospital admissions decreases. The Innovation Committee funded the project. It recommended that the associations of the German statutory health and long-term care insurance funds examine whether DiaTT approaches could be included in their contracts.

↗ innovationsfonds.g-ba.de

All results of the projects and the decisions of the Innovation Committee are published on this site.

The G-BA – Procedures and structure

The Federal Joint Committee (G-BA) is the highest decision-making body in the German healthcare system. It consists of representatives from healthcare service providers and the statutory health insurance funds working together. Its core decision-making body is the ↗ ***plenum***, which has 13 voting members.

Procedures

The G-BA bases all of its decisions on the generally recognised state of medical knowledge. In doing so, it is committed to the standards of evidence-based medicine (EBM). All available studies worldwide on a specific issue are systematically researched, weighted according to their significance, and analysed.

The key assessment criterion for the G-BA is always the benefit to the patient. This means results such as healing/recovery, relief from pain and other complaints, improvements in quality of life, the prevention of death, or the reduction of side effects. The G-BA compares the results with those of existing alternative therapies. To determine the current state of research, the G-BA is supported by two independent scientific institutions: the Institute for Quality and Efficiency in Health Care (IQWiG) in Cologne (↗ *www.iqwig.de/en/*) and, in matters of quality assurance, the Institute for Quality Assurance and Transparency in Health Care (IQTIG) in Berlin (↗ *www.iqtig.org*). Both institutes are supported by independent foundations established by the G-BA according to requirements stipulated by legislators.[10]

Prior to making a decision, the G-BA conducts extensive public consultation procedures which ensure that external expertise is involved from a variety of sources. In its consideration and decision-making process, the G-BA also takes into account the entire healthcare situation, for example, the severity of the disease and available therapy alternatives. All the steps taken by the G-BA to reach its decisions are detailed in its Rules of Procedure.

The German Federal Ministry of Health is responsible for the legal supervision of the G-BA. It examines whether G-BA resolutions meet legal requirements and if the Rules of Procedure have been followed. Many G-BA resolutions must be reviewed by the Federal Ministry of Health and published in the Federal Gazette before they take effect.

[10] The legal foundation for the establishment, responsibilities, and workflows of the IQWiG is Section 139a–c of Book V of the German Social Code, and Section 137a for the IQTIG.

A total of ten subcommittees are responsible for preparing all decisions taken in the plenum. Like the plenum, they too are made up of SHI representatives, service providers, and patient representatives in the same ratio. The subcommittees are chaired by one of the impartial members. To address specific issues, the subcommittees appoint working groups with additional experts.

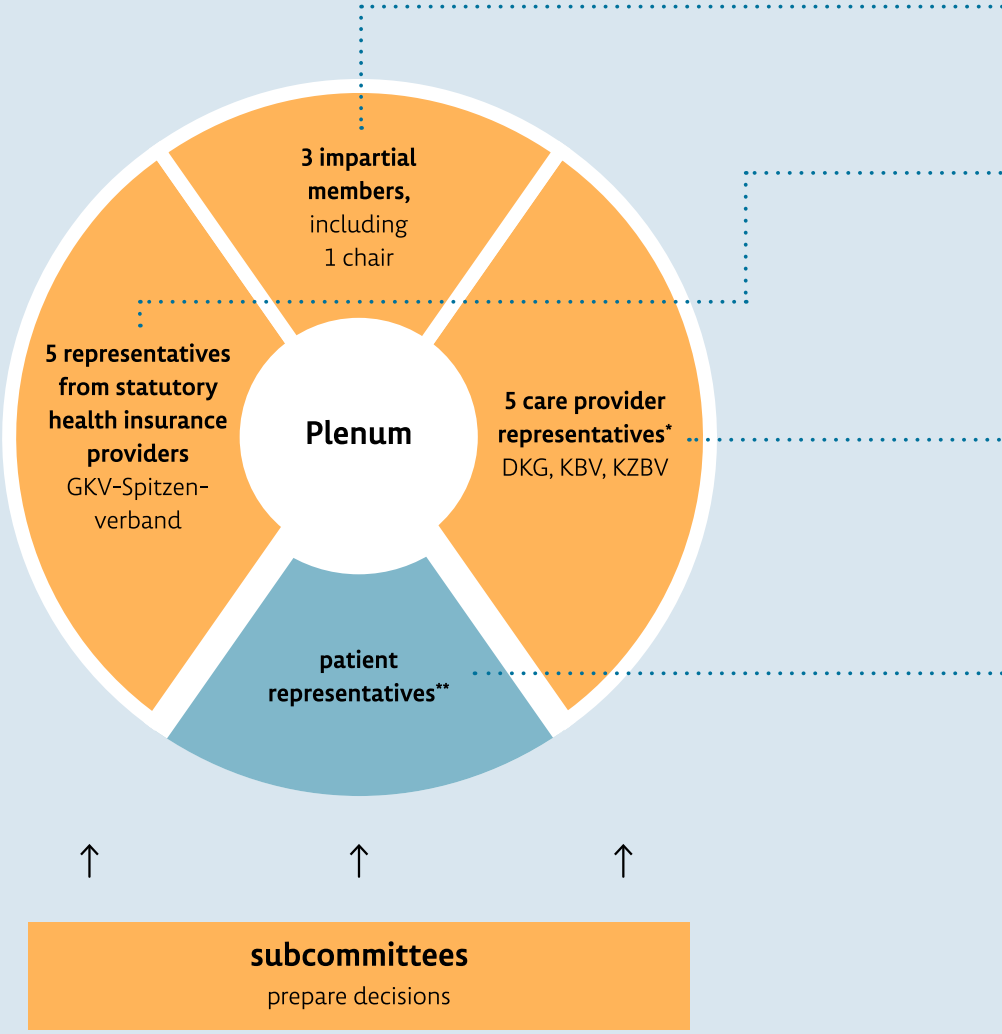
Representatives of the following organisations may take part in the plenum and subcommittees in an advisory capacity if this is provided for by law: the German Medical Association, the Federation of Private Health Insurance Providers, the German Nursing Council, the German Psychotherapy Association, the German Dental Association, and the Conference of Health Ministers of the German Federal States.

Financing

The G-BA is financed by a ↗ ***system surcharge***, which is revised annually. It is a fixed sum that is invoiced for each eligible inpatient or outpatient treatment case. Its legal basis is specified in Book V of the German Social Code, Section 91, Paragraph 3 in combination with Section 139c.

In 2025, the system surcharge amounted to €3.17 per inpatient case and 8.1654101 cents per case in a contracted medical or dental practice. This system surcharge finances the budgets of the G-BA, the IQWiG, and the IQTIG. The G-BA budget also includes costs for commissioning scientific institutes.

The plenum



* Care providers are entitled to vote only on issues affecting their area of expertise. Otherwise these votes are allocated proportionally in accordance with the bylaws, section 14a, paragraph 3.

** Entitled to take part in discussions and submit petitions, but not to vote

Abbreviations: GKV-Spitzenverband = National Association of Statutory Health Insurance Funds; DKG = German Hospital Federation; KBV = National Association of Statutory Health Insurance Physicians; KZBV = National Association of Statutory Health Insurance Dentists

Structure of the plenum

Impartial members
One of the impartial members is appointed chair of the G-BA. He or she conducts the plenary sessions and works with the other two impartial members to prepare the meetings.

National Association of Health Insurance Funds (GKV)
represents all statutory health insurance funds

German Hospital Federation (DKG)
the interest group representing hospitals

National Association of Statutory Health Insurance Physicians (KBV)
represents all licensed physicians and psychotherapists who invoice SHI funds

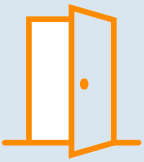
National Association of Statutory Health Insurance Dentists (KZBV)
represents all licensed dentists who invoice SHI funds

Patient representatives
Patient representatives take part in all plenary sessions, subcommittee meetings, and working group meetings. They have the right to take part in discussions and file motions, but not to vote.

Appointment of members

All plenary members – except for the three impartial members – serve in the G-BA on an unpaid basis. They are appointed by their respective organisations. The positions of the impartial members are filled by mutual agreement between the member organisations of the G-BA (GKV-Spitzenverband, KBV, DKG, KZBV) and with the approval of the Health Committee of the German Bundestag. The three impartial members hold full-time office for six years and are salaried.

The plenary sessions are open to the public



The plenum usually meets on the first and third Thursday of every month at the G-BA staff office in Berlin. The sessions have been available as a livestream since 2020. The video recordings can also be viewed later in the media library. Interested persons can also register for the meetings as guests. More information on the public sessions can be found on the G-BA ↗ ***website*** (www.g-ba.de).

You can find the decisions online

Resolutions passed by the plenum are published on the G-BA ↗ ***website*** regularly. This extensive database is updated daily. A free ↗ ***e-mail information service*** provides all decisions that have come into force and other information from the G-BA, updated daily.

The G-BA in four minutes

You can find a short ↗ ***explanatory video*** about the G-BA in German and ↗ ***English*** on the G-BA website. It provides an initial overview of the G-BA. The video illustrates the G-BA's tasks and working methods using three examples from the areas of medicinal products, medical examination methods, and quality standards in hospitals.

The G-BA on social media

Follow us on social media.

The staff office in Berlin

The G-BA staff office in Berlin supports the G-BA committees in their work. The team in Berlin prepares these meetings, ensures that meetings run smoothly and according to the rules, and makes sure the wording of resolutions is legally sound. They provide legal and methodological advice to the committees, maintain a specialised library, organise events, and provide information to the general public. A dedicated staff unit assists the patient representatives with exercising their participation rights.

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