Transfer barriers in innovation fund projects

Impact of the Innovation Fund – Part 3 of the series: Transfer barriers

Since 2016, the Innovation Fund has provided the German healthcare system with a tool that enables the systematic advancement of the development and scientific evaluation of new forms of care. The first two parts of the series on the Innovation Fund in Monitor Versorgungsforschung demonstrated that the fund is effective: successful projects reach healthcare practice – often via intermediate steps, regional solutions or selective contractual arrangements. It became clear that innovation in healthcare is not an automatic process, but a path to be shaped, ranging from the initial idea through evaluation to implementation – and which explicitly also includes the de-implementation of ineffective or uneconomical forms of care.

From this process-oriented perspective, the question of barriers to transfer takes centre stage (1). This is because positive evaluation results and a transfer recommendation from the Innovation Committee are necessary but not sufficient conditions for the sustainable integration of a positively evaluated new form of care into standard care. The DNVF's 2025 survey of completed Innovation Fund projects, as well as the analysis by Lindemann et al. on responses to transfer recommendations, show that the transition into healthcare practice is associated with structural, procedural and institutional hurdles. Low response rates from relevant stakeholders, unclear responsibilities, divergent interests and the absence of binding procedures for the transfer of innovative care models illustrate that, to date, the transfer has not taken place within clearly defined structures or according to established processes. [2]

Steffen Bohm (AGENON – Gesellschaft für Forschung und Entwicklung im Gesundheitswesen mbH)

"Challenges in transferring projects from the New Forms of Care (NVF) sector into statutory health insurance (GKV) provision and possible solutions"



According to the Innovation Committee's report, 254 projects in the New Forms of Care (NVF) sector had received funding as of January 2026. By the end of December 2025 , decisions had been made on 118 projects , whilst for 29, a recommendation was issued to examine the possibility of transferring them into standard care or utilising the findings. As there are no special regulations for Innovation Fund projects, the transfer takes place in accordance with the relevant regulations governing standard care. A transfer can be considered complete once remuneration for the services covered by the project has been realised as a service under statutory health insurance. Depending on the specific services involved in each case, the pathways and stages that must be completed prior to reimbursement vary. Depending on the complexity of the project approach, it may also be the case that different pathways, each with different stages, must be followed for services based on the same approach. Stages may include necessary adjustments to the guidelines of the Joint Federal Committee of Doctors and Health Insurance Funds (G-BA) (e.g. for early detection, for disease management programmes, for outpatient palliative care, for outpatient specialist medical care).

Further stages involve adjustments to the service definitions and/or the valuations of individual items in the relevant fee schedules (Uniform Valuation Scale for Medical Services, DRG catalogue), and, where necessary, the creation of separate billing items. In all cases, consultations must be initiated with the relevant committees or contractual partners; consultation and decision-making documents must be drafted and decisions reached. The principle of consensus applies here, meaning that the conclusion of a transfer process with integration into standard care is successful only if agreement can be reached at every stage among all parties legally responsible. Reaching agreements is no easy feat, as differences in interests exist not only between service providers and health insurance funds, but also because the interests of health insurance funds competing with one another are by no means homogeneous.

A look at the multifaceted landscape of funded projects also shows that components of funded projects are in various cases services that fall within the scope of what are known as ‘optional services’ provided by health insurance funds. Examples of this include information and self-learning programmes that health insurance funds can offer as part of their statutory mandate. The complexity of transfer processes described above explains why implementation takes a long time or can ultimately fail even when the Innovation Committee has given a positive vote. A remedy could be found, for example, by devising ways to make implementation decisions more binding for those responsible for implementation and by linking implementation to deadlines, compliance with which is monitored.

Necessary prescriptive guidelines are, by their very nature, unpopular. On the other hand, current practice will have to be changed if it is a policy objective that successful healthcare approaches actually find their way into statutory health insurance provision with as little delay as possible.

This is less a matter of shortcomings in individual projects than a structural problem: the regulatory framework provides defined and detailed approval pathways for medicines and medical devices. However, there is a lack of similarly structured procedures for complex healthcare innovations. In a system of joint self-governance, in which various stakeholder groups operate with their own responsibilities and interests, the implementation of new forms of care is inevitably linked to intensive coordination and negotiation processes. These processes require time, transparency and suitable facilitation and management tools.

The transfer process must therefore be further developed in such a way that self-governance bodies drive forward the implementation of successful Innovation Fund projects with a proven impact on the quality, safety and efficiency of healthcare in their own interest. At the same time, numerous examples demonstrate that transfer can succeed despite existing hurdles – factors that facilitate this include, for instance, early political involvement, active regional networks and selective contractual solutions with one or more health insurance funds as an intermediate step. Barriers should therefore not be understood merely as the counterpart to success factors, but represent a distinct level of analysis that provides insight into where the innovation process should be further developed institutionally. [3]



Short interview with Prof. Dr Timm Laslo (Head of the in-house emergency medical service in the district of Vorpommern-Greifswald and of the 'LandRettung' project)

"The biggest sticking point is funding after the project ends"

Your project was successfully evaluated and has demonstrated clear benefits. Why is the transition to standard care nevertheless so difficult, and at which specific point in the system did you encounter the greatest resistance?



Laslo: Essentially, it boils down to this: if you want to implement innovations and make the transition to standard care, you have to adapt the regulations. There is often no legal basis. You might be working within the framework of one of the experimental clauses, but ultimately the legal foundations must be established. We are a district – depending on which levers need to be pulled, things become more complex as the state or federal government are involved. You have to weigh things up: do I have the time to endure the uncertainty until the end of the project? The evaluation results often only come in six to nine months later – and then a political process begins to amend the legal regulations. The biggest sticking point is funding after the project ends. The G-BA reviews the project, but it takes months before a decision is made. During this time, we have to maintain staff and infrastructure – which is often very challenging. We are a local authority with limited budgetary resources. Without a legal basis, we cannot continue to provide voluntary services. In the case of emergency medical care, regarding the establishment of the tele-emergency doctor service, a legal framework was already in place, so the transition went smoothly. However, this framework is still lacking today for the first-aider app. The health insurance funds have signalled interest, but without a legal basis for further funding, we cannot sustain the services we have developed.

Projects often fail due to a lack of political will or sectoral boundaries. How did you manage to engage local stakeholders or decision-makers in such a way that your model remains viable beyond the funding phase?

Laslo: There are various success factors – I would also call them political-strategic factors – that simply have to be in place. First of all, I need a legal framework within which I can situate my project. This means: there must be the right funding programme for the project, with the appropriate guidelines, enabling the whole thing to be implemented in such a way that it can achieve its full effectiveness. Another important point is to get all stakeholders on board. In our case – we work in the field of rescue services and emergency care – these included, for example, our supervisory authority, namely the Ministry of Social Affairs of Mecklenburg-Western Pomerania, the health insurance funds, the Association of Statutory Health Insurance Physicians and, of course, the state government, which also supported the project. It was important that everyone was involved and felt they were part of the process. That is crucial: recognising the interests of all those involved and aligning them as effectively as possible. We even received letters of interest from the organisations. This naturally lends a high degree of legitimacy to the project one wishes to implement. Another key aspect was that we deliberately did not want to create an isolated solution. Instead, our aim was to develop a blueprint that could be replicated. This also made the project interesting for others, as they could adopt it accordingly. Replicability was therefore a central objective.

Is it the case that obstacles or factors leading to failure are often the negative counterparts of the factors for success? Would the absence of the stakeholders and success factors you mentioned, for example, have posed a risk to your project?

Laslo: Yes, exactly. Ultimately, it is those who have to live with the consequences, because what we implement has an impact on others. That is why I want to be at the table and be allowed to contribute my perspective. And that is exactly what we did: we took the different viewpoints into account. In my opinion, there is no single truth – there is my subjective perspective and that of the other party. It is important to take these seriously and, where possible, to incorporate them. We have tried to implement this within the legal framework under which we organise the emergency services and set up the project.

If funding for the Innovation Fund were to be permanently cut – as feared in the health policy debate – could practical initiatives like yours even get off the ground? Or would the risk be too high for the organisations without this start-up funding?

Laslo: Without the Innovation Fund, it would be very difficult. As a district, we cannot shoulder such sums on our own. The budgetary situation is tight, and voluntary services are barely affordable. The Innovation Fund provides the necessary start-up funding and reduces the risk. Without this support, such projects would be virtually impossible to realise.

Against this backdrop, the third part of the series focuses on the potential barriers to the transfer of Innovation Fund projects – particularly from a practical perspective. The aim is to examine structural, procedural and project-specific obstacles in a nuanced manner, to place them within the context of existing findings, and to identify strategies for overcoming them. After all, the long-term effectiveness of the Innovation Fund is ultimately measured by the extent to which it succeeds not only in successfully testing evidence-based healthcare innovations, but also in transferring them responsibly, regionally and ideally nationwide into standard care with the support of the self-governing bodies.

Conclusion

The Innovation Fund has established itself as a key instrument for promoting and testing new forms of care within the German healthcare system. However, a closer look at the transfer processes reveals that the transition of successful projects into standard care is associated with structural, procedural and institutional barriers, some of which are considerable. Despite positive evaluation results and transfer recommendations from the Innovation Committee, sustainable implementation often fails due to unclear responsibilities, divergent interests and a lack of binding procedures. Particularly problematic is the lack of institutional continuity following the end of the funding phase: without bridging finance or binding deadlines for implementation, innovative approaches risk being lost in a ‘transfer vacuum’.

The practical examples cited here – such as the ‘LandRettung’ project or INVEST Billstedt/Horn – illustrate that the success of transfer depends largely on the early involvement of all relevant stakeholders, the creation of a clear legal framework and the development of transferable solutions. Political and strategic factors, such as involving stakeholders as early as possible and establishing legitimacy through broad support, are crucial. At the same time, it is clear thatfunding after the project ends remains the greatest challenge: without secured refinancing or a legal basis, successful models cannot be sustained.

Alexander Fischer (GfBH Gemeinsam Gesund gUG)

“Transfer barriers from a practical analytical perspective – the example of INVEST Billstedt/Horn”



The INVEST Billstedt/Horn project was funded by the Innovation Fund, received a positive evaluation and was recommended for integration into standard care. Nevertheless, sustainable continuation has so far only been achieved to a limited extent. This discrepancy points less to shortcomings in the intervention than to structural transfer barriers.

Lack of institutional follow-up

Innovation Fund funding is project-based and ends upon completion of the funding phase. A period of several years regularly elapses between the end of the project, the technical evaluation and political decision-making. No regular bridging funding exists for this phase. Follow-up funding was therefore initially provided via selective contracts. However, this instrument is geared towards insured-person-based refinancing in the context of competition between health insurance funds – not towards the continuation of evidence-based care models whilst decision-making processes are ongoing. Population-oriented models such as INVEST, which primarily address vulnerable, socially disadvantaged or multimorbid groups of insured persons, are only of limited appeal under competitive conditions: These groups of insured persons already incur high costs, are unlikely to switch providers and generate little potential for short-term savings for individual health insurance funds. Preventive and coordinating interventions have a cross-sectoral and long-term impact on population health and the quality of care; however, their effects cannot be attributed to competition in the short term.

Fragmented responsibilities

Population-oriented care models operate at the interface of several social security codes – in particular between medical care (SGB V), nursing care (SGB XI) and rehabilitation and participation (SGB IX) –

and simultaneously within the context of local health promotion and socio-spatial public services.

This fragmentation leads to coordination challenges, gaps in funding and fragmented structures of responsibility without a clear governing body. Key services such as case and care management are functionally necessary, but can only be implemented to a limited extent and sustainably funded within the existing legal framework. Services that are systemically necessary thus come up against sectoral budgetary logic.

Methodological framework

Short project durations and high recruitment pressure influence the intervention logic. The quantitative focus on case numbers can dilute the intended target group focus and thus potentially also influence the measured effects. At the same time, integrated care approaches often only take effect in the medium to long term. The temporal logic of funding periods, recruitment and evaluation therefore does not always align with the logic of complex care outcomes.

At the same time, the Innovation Fund has fulfilled a key function: it enables new care models to be developed under real-world conditions and tested on an evidence-based basis. Projects such as INVEST would scarcely have been feasible without this seed funding. The Innovation Fund opens up important spaces for innovation. The central challenge, however, lies in reliably transitioning successful models from project status into permanent care structures.

The fragmentation of responsibilities across different social security codes and the competition-oriented focus of health insurance funds particularly hinder population-based approaches that aim for long-term and cross-sectoral effects. There is an urgent need here for a reform of the transfer architecture that provides for binding decision-making processes, clear responsibilities and a long-term funding perspective. There is also a need for new approaches to ensure that population-based strategies can be implemented across sectors. Furthermore, self-governance must be further developed so that the self-interests of the stakeholders involved do not hinder evidence-based initiatives for change.

It can therefore be concluded that the Innovation Fund opens up important avenues for innovation. It can realise its full potential if structural and procedural barriers to transfer are overcome. Then, evidence-based care innovations can be embedded across the board and sustainably within standard care – for the benefit of patients and for greater cost-efficiency in the healthcare system!

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References

[1] Interview with Hecken, J., Hoffmann, W. in: Monitor Versorgungsforschung 05/25 pp. 6–12: https://www.moni-tor-versorgungsforschung.de/abstract/konzept-systematischer-transfer/ (accessed on: 17/12/2025)

[2] Lindemann C., et al. Does the Innovation Fund improve healthcare provision? A critical analysis. Gesundheitswesen. 2024; 86: 451–462. doi:10.1055/a-2270-3537.

[3] Hoffmann, W. et al. (2025) The Innovation Fund works! Health Services Research Monitor 06/25 pp. 30–34) Available at: https://www.monitor-versorgungsforschung.de/abstract/der-innovationsfonds-wirkt/ (Accessed on: 17 December 2025)

Saxony also moving towards outpatient care

"Today, the Saxon Cabinet adopted the principles of hospital planning, thereby securing the framework for medical care in urban and rural areas. A significant milestone for the new Hospital Plan 2026 has thus been passed," according to Zielbildpartner*. "It is important to us to ensure the long-term

quality of care for the population and to develop regionally appropriate structures that can cope with the upcoming changes in demographic trends. We agree that we must take an integrated approach to outpatient and inpatient care and find a common path to implementation. We assume that the Free State of Saxony will support us in this endeavour. Adequate funding is essential for this," the statement continues.

This paves the way for better coordination of hospital care provision across the Free State in future. In line with the hospital reform, various specialist service areas are to be established at the hospitals, which will also have the required specialist staff. Maintaining comprehensive emergency care is also an important objective of the hospital plan. The first structural changes are set to come into force on 1 January 2027.

There are many reasons why adjustments are needed in the hospital landscape. Since the last major hospital reform in the early 1990s, the population of the Free State has fallen by around 500,000, compounded by a significant decline in birth rates over recent years. Thanks to less invasive treatment methods, patients often spend only a few days in hospital. These developments are leading to low hospital occupancy rates, whilst the number of outpatient treatments in clinics is rising steadily. It is also emphasised that further legislative adjustments are required. These include regulations to improve cooperation between hospitals and medical practices, as well as a reliable framework for the planned flat-rate maintenance fees. <<

* The partners in this initiative are the Saxony Hospital Association, the associations of statutory health insurance funds and the Association of Supplementary Health Insurance Funds in Saxony, the Saxony Association of Statutory Health Insurance Physicians, the Saxony State Medical Association, the Saxony County Council and the Saxony Association of Towns and Municipalities.