MSD Symposium at the 2026 Capital City Congress

by: MVF Editor-in-Chief Peter Stegmaier

Strengthening the Transfer of Healthcare Innovations

A large number of healthcare innovations are emerging in Germany – yet their path into standard care remains arduous, protracted and, in most cases, fruitless. It was precisely this tension that the symposium 'Strengthening the Transfer of*Healthcare Innovations*', organised by MSD at the 2026 Capital Congress, sought to address. On the panel, representatives from government ministries, the medical profession, health insurance funds and independent consultancy organisations discussed how proven process innovations can be more reliably integrated into long-term healthcare provision. Four key presentations formed the basis of the discussion – ranging from practical examples in paediatrics and adolescent medicine, through the perspective of the largest statutory health insurance fund, to a transfer model from the Federal Ministry of Health and its prototypical further development. The event was chaired by Michael Weller, a health system expert and former head of department at the Federal Ministry of Health.

>> Weller focused on the key question: "How does one design a transfer framework for integrating successfully tested process innovations into standard care?" He deliberately chose not to limit the scope to the Innovation Fund alone – selective contracts, pilot projects and regional approaches were also included. According to Weller, the aim was to highlight positive examples, identify what had gone well and what had not, adopt a regional perspective, and think ahead in terms of structures, governance, processes and funding."We don't want to complain here, " Weller made clear; the focus should be on what lessons can be learnt for the future.

As part of the shared knowledge base, he outlined the Innovation Fund as an established funding instrument. Since 2016, it has been the central platform for the development of new forms of care (NVF) and care-related research (VSF); there have been 60 calls for proposals and a total of 791 funded projects (254 NVF / 537 VSF), of which 329 are currently being implemented. Funding is provided in particular for projects that improve cross-sector care – a key benchmark for the Innovation Committee – and demonstrate sufficient potential for long-term adoption. Furthermore, all transfer recommendations and reports have been published.

Weller paid particular attention to the financial framework. The total funding volume, valid until 2025, stood at 200 million euros annually. Under the Act on the Extension of Powers and Debureaucratisation in Long-Term Care (BEEP), a one-off reduction to 100 million euros is planned for 2026, to be financed from the Health Fund's liquidity reserve; ongoing projects remain unaffected. The Contribution Rate Stabilisation Act (BStabG) is intended to adjust the funding arrangements: From 2027, the funding would be permanently set at 100 million euros per year; the funds would be channelled directly from the Health Fund to the BAS; the 50 per cent co-funding by health insurance funds would be discontinued; and there would only be a single-stage standard funding procedure lasting up to four years. Weller described the prospect of a return to the €200 million funding level as "highly doubtful".



The speakers, from left: Dr Michael Hubmann, Dr Regina Klakow-Franck, M.A., Michael Weller, Prof. Dr Martin Dietrich and Hans Matz. Photo: Roski.

He described the transfer process as clearly regulated: the Innovation Committee deliberates within three months of receiving the complete project reports and decides whether a recommendation for full or partial transfer can be made, and determines which organisation is responsible. If the G-BA is determined to be responsible, it must adopt regulations for inclusion in the healthcare system within twelve months.

However, the figures painted a sobering picture. Of the 118 'New Forms of Care' projects on which a decision had been made by December 2025, 50 per cent – 59 projects – received no recommendation; the remainder are split equally between 30 projects where the scientific findings were shared and 29 where the projects were under review or in the process of being incorporated into standard care. Weller recalled the original rationale: a successfully evaluated project should not automatically be incorporated into standard care, but should follow the usual route through the committees – he deliberately left open for discussion whether this was the right approach.

Opening address: Dr Michael Hubmann

Dr Michael Hubmann, President of the Professional Association of Paediatricians, opened the proceedings by linking specific examples to a message of reform. The Social Code Book V (SGB V) stipulates that care must be economical, adequate, necessary and appropriate – yet planning

, however, often aims for "the optimal". One lesson he had taken from the pandemic was that success is only possible "together" – a willingness he would like to see restored, particularly in times of increasing financial hardship, in order to make Germany more reform-oriented.

As a first example, Hubmann presented the 'U+E' project, which targets postnatal depression in parents around the time of birth – a condition that can be detected early but is difficult to identify. The advantage of screening lies in the fact that everyone can be reached and the barrier from the practitioner's perspective is removed; the extensive network of paediatric check-ups forms the basis. The project is being implemented digitally: via the professional association's app – which, according to Hubmann, has almost two million children and young people registered – parents automatically receive a questionnaire, the results of which are fed back to the practices; any abnormal findings are reported in a standardised format via KIM. The next step, he said, is to integrate the project into standard care as a selective contract in collaboration with partners.

He went on to express a concern: using the example of the U10, which is soon to be incorporated into standard care as a G-BA contract, he pointed out that the process had taken over ten years. However, a good form of care should not be kept on hold for ten years or provided as an individual health service – "paediatrics and adolescent medicine is not IGeL medicine". This is precisely why selective contracts are needed to make progress without delay.

As a second example, Hubmann cited the REF-HPV vaccination against the human papillomavirus as the first opportunity to actively vaccinate against cancer. The WHO target of a 90 per cent vaccination

rate by 2030 currently stands in contrast to a rate of under 50 per cent in Germany. Digital vaccination reminders via the app alone generated almost 55,000 responses in 2024, and there is potential to bring forward the age at which vaccination takes place; furthermore, boys are now also being vaccinated against HPV. The interplay with health insurance funds' prevention campaigns remains to be seen. In the associated project with consortium partners, the aim is to identify access routes and overcome barriers.

Hubmann linked his examples to a plea for realism. Given that around 90 per cent of vaccinations currently take place within the framework of contracted medical care and that the public health service is tending to be scaled back, low-threshold vaccination provision in GP practices is the realistic approach – and involving pharmacies in this is not a problem.

Hubmann identified the following as key success factors: collaboration with service development teams, the involvement of practitioners right from the application stage, and routines suitable for everyday use. Healthcare research must not be a purely academic subject; there is no longer any time in the healthcare system for a '47th extra project'. Reliable partners and dedicated structures are needed – the professional association has set up a service company (GmbH) for this purpose – as well as the early involvement of health insurance funds. He addressed a request regarding digitalisation to the Federal Ministry of Health (BMG): Instead of planning new initiatives for which there won't even be a beta version by 2026, existing, functioning systems should be integrated. After all, the fundamental task affects everyone: "We must meet more legitimate healthcare needs with fewer people."

Second presentation: Hans Matz

Hans Matz, Head of Brand Contracts and Innovation at TK's head office in Hamburg, provided the perspective of the payers. TK's aim, he said, was to help ensure that innovation remained possible within the statutory system – a matter of both funding and structure, which he illustrated using the example of the Innovation Fund.

Matz warned against underestimating the value that had already been created. Many innovative care solutions had been developed within the framework of the Innovation Fund; what was valuable here were not only the results, but also the project partnerships that had developed and the experience gained. Furthermore, patients had received care – with services they would not have received in standard care. This 'treasure' should not be left to lie dormant, but rather we should examine how individual components could be rolled out regionally or nationwide – something the Innovation Fund has not yet managed to achieve. TK has been involved in almost half of the 'New Forms of Care' projects, as well as in 12 per cent of the healthcare research projects.

Essentially, Matz outlined three requirements. Firstly, there is a need for a recognised, effective transfer model for existing initiatives – preferably from the Innovation Fund, but also from pilot projects that have been tried and tested at regional level. Secondly, an incentive system for funding must be maintained, as the regulatory framework leaves health insurance funds with little scope for independent experimentation. Thirdly – and for him the key point – an alternative funding system is needed: one that focuses less on research and more on the reality of healthcare provision, is 'smartly' designed, geared towards healthcare needs and underpinned by measurable health economic outcomes. Above all, it must be attractive to both patients and healthcare providers – many projects have failed due to insufficient patient participation.

Matz saw the time factor as the greatest lever for change. An innovation fund project takes "10 plus X years"; a project of his own, with an idea from 2017 and an application submitted in 2018, still had no clear prospects by 2026. Bureaucratic red tape ties up too many resources; the funding phase lasts up to four years, whilst the actual period of care often lasts only a maximum of one year, which makes a robust evaluation difficult. The preparation, evaluation and completion phases need to be shortened.

As a solution, Matz outlined a financing model rather than a funding model, one that relies heavily on selective contracts: health insurance funds would be legally required to invest a certain proportion per insured person in innovative care concepts; the submission of applications and the evaluation process would be the responsibility of the funds themselves or of institutions they commission. TK already has such a structured evaluation process in the form of a portal on its website. It is also important to transform the Innovation Fund's data archive into a transparent marketplace, so that service providers can adopt concepts without being asked. At project level, there needs to be a funding outlook extending beyond the project's duration – a business case model planned at an early stage; from TK's perspective, a health economic analysis of effectiveness would suffice.

Third presentation: Prof. Dr Martin Dietrich

Prof. Dr Martin Dietrich from the Federal Ministry of Health provided an overarching, conceptual perspective.

Agile project management/Scrum

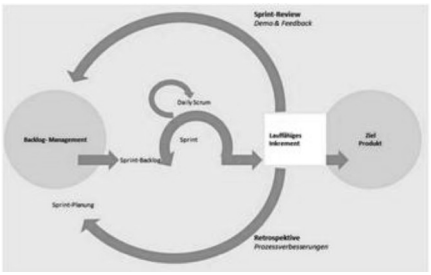


Fig. 1: Agile project management/Scrum. From: Presentation by Dr Regina Klakow-Franck, M.A. Source: Federal Office of Administration Organisational Handbook; https://t1p.de/w4gfhl, accessed on 14 June 2026.

A colleague had written that Germany had "no innovation problem", but rather "a scaling problem". Dietrich responded with "agreeing disagreement": whilst expenditure on research and development was disproportionately high and there were many patent applications, Germany's performance in commercialisation was below average; given the figure of almost two billion euros spent over ten years, it is not sufficiently clear what actually reaches patients. The real problem, he argued, is that innovation is viewed too narrowly – solely as project or research funding.

Dietrich countered this with a three-phase model (see MVF 02/26): development, transfer and adaptation. The development phase is scientifically driven, because – unlike with an iPhone app – it concerns health and life; funds raised on the basis of solidarity should not be spent without a demonstrable impact on healthcare provision. Successfully tested innovation fund projects are therefore "extraordinary achievements by extraordinary people in extraordinary situations". It is precisely this stability, however, that comes to an end with the transfer phase, which operates 'in a world with which scientists are unfamiliar' and without stable outcomes. What constitutes the efficacy hypothesis during the development phase must become the transfer hypothesis during the transfer phase – the question of whether an effective model is also transferable; this has so far been "somewhat underdeveloped". The subsequent adaptation requires suitable contractual forms such as selective contracts, which, however, by their very nature can only be supplementary contracts and merely a step towards the goal, not the goal itself.

Dietrich summarised the key message by drawing a distinction: innovation successes should not be confused with project successes. For some stakeholders, simply securing a project is regarded as a success, regardless of the impact on care; the actual innovation success, however, lies "much, much further down the line". Transfer and adaptation account for "more than half of innovation success"; project successes are merely the necessary pre-

requisite. For this reason, the Federal Ministry of Health (BMG) is working on a technical concept for transfer architecture and healthcare innovation; a technical dialogue on this subject had recently been successfully concluded.

Dietrich then outlined the key points of a transfer framework. Firstly, there is a need for agreed criteria for improving healthcare provision; he cited the "Quintuple Aim" as a guide: better health outcomes, a better patient experience, greater cost-effectiveness, improved clinician well-being, and greater equity in care – criteria which have not yet been officially agreed upon. Secondly, it is not projects but care models that should be made permanent; the aim cannot be simply to secure jobs. Thirdly, a flexible framework is needed for different care models, which is why there cannot be a single standardised pathway for their implementation. Fourthly, provisional regulation and reimbursement with an expiry date are required: if defined key performance indicators are not met, a model must be able to be scaled back. Transfer monitoring is therefore needed instead of a new inclusion evaluation, as well as support for the transfer process from the relevant stakeholders – this cannot be achieved without health insurance funds.

Further points concerned the focus on benefits. Ultimately, it is the service providers who would have to work with the models; there is a risk of a 'not invented here' problem here if models developed elsewhere were to be introduced into a field of work that is already under maximum strain. Concepts must be 'ready for adoption' in such a way that they can be implemented immediately. Dietrich did not view 'agile' as a buzzword in the context of transfer, but rather in the sense of rapid, validated learning. The net bureaucratic impact need not be zero, but no new authorities or protracted decision-making processes should be created that impose more of a burden than they relieve. Ultimately, a knowledge-generating transfer is required: experience gained during the transfer must be channelled back, in a structured manner, into the development of new ideas.

To illustrate his point, Dietrich drew on an analogy from space travel: a great deal of energy is invested in developing high-performance 'propulsion systems', but these are then simply placed 'in front of the hangar' without building the launch pad from which they are to be launched. It is precisely this launch pad that transfer represents. Putting as much passion into transfer as into demonstrating effectiveness – that is the motivation that would link a development and transfer model; this link does not yet exist.

Fourth presentation: Dr Regina Klakow-Franck

The fourth presentation was given by Dr Regina Klakow-Franck, an independent expert and consultant, and an impartial member of the Joint Federal Committee from 2012 to 2018. She saw her contribution as supporting the transfer model proposed by Prof. Dietrich

, the development of which she has been following for some time.

To begin with, she showed a slide from the Innovation Committee – one that is rarely seen – concerning the recipients of the transfer recommendations. Across a total of 187 recommended projects – far more than the 29 pilot projects under the 'New Forms of Care' initiative – the recommendations were distributed amongst numerous recipients: around 14 per cent were addressed to the G-BA, the majority went to the scientific professional associations, many also to the contracting partners at state level (9 per cent) and just under 10 per cent to state planning authorities and ministries. Her conclusion: There are other recipients besides the G-BA – a narrow focus on the G-BA as*the 'bottleneck'* falls short.

She then highlighted individual key points that had not yet been sufficiently understood, even by a highly qualified specialist audience. The first three Quintuple Aims – Better Health Outcomes, Lower Costs, Improved Patient Experience – correspond exactly to the aspects of value-based care as implemented, for example, by Kaiser Permanente. She attributed a pithy summary to the Dutch Minister of Health, who had literally summarised the improvement in care as: "No longer paying for low-value care." This "brilliant one-sentence summary" as a coherent vision was missing from the German debate.

The core of her presentation centred on applying Agile and Scrum principles to the transfer process. Its fundamental principle is the continuous improvement cycle of 'Plan, Do, Check, Act' in small, incremental steps – with a Product Owner, a Scrum Master overseeing the process, and a team that brings the product to maturity in recurring sprint cycles. She applied this model to her own prototype for a future transfer model.

In this prototype, the Product Owner could be the G-BA – but could equally be a planning authority from the federal states or the contracting parties at state level; it was explicitly stated that this should no longer be the 'old-school' Innovation Committee, which largely overlaps with the G-BA's sponsoring bodies. The Product Owner would commission a Scrum Master – a new*'Transfer Council'* – to put out a call for tenders for transfer management system that would not conduct a new pilot study, but would work towards integration into standard care in continuous cycles, for example via new EBM fee codes or flat-rate payments per case. In the event of negative monitoring results, her model deliberately provided for an exit option. Active cooperation and relationship management are crucial to ensure that projects neither peter out nor get bogged down in the transitional solution of a selective contract.

Klakow-Franck emphatically endorsed Dietrich's position: no perpetuation of projects and no repeat piloting during the transfer phase. In her view, the "absolute worst" would be a new pilot scheme guideline modelled on Section 137e of the German Social Code, Book V (SGB V) – following ten years of pilot projects, a further ten years of piloting. That would be "the death of any innovation transfer". Her aim is a paradigm shift: from proving effectiveness through a study to transfer in the sense of an agile development cycle.

Discussion: From successful care provision to the role of self-governance

In the ensuing discussion, the participants explored key themes in greater depth. When asked how the transition to standard care could be achieved, Hubmann referred to child health check-ups, where selective contracts had been in place for over 15 years since 2011 before the basis for standard care was established; he cited the "U10 neu" and the increase in the HPV vaccination rate as key objectives. Fundamentally, he argued for greater "system-wide honesty" and the "omnibus principle": if something new is added and no new funds are available, something else must be cut – otherwise, one would lose either the patients or the healthcare providers.

Matz outlined the obstacles beyond the time factor: his approach aimed at simpler models that would better facilitate the substitution of services, as no additional funding was available. The transfer of individual models – previously based on selective contracts – would be more successful if viable ideas were discussed with health insurance funds at an early stage.

Dietrich used the example of the NPPV Innovation Fund project – designed to treat complex mental health conditions – to illustrate what could constitute a success in healthcare provision. Even before the project was completed, it had been stipulated by law that the G-BA was to issue a corresponding guideline; this was adopted in 2021, the EBM codes were established in October 2022, and a provider is now driving implementation forward through a campaign-style approach. For him, the number of patients treated ac-

cording to this approach would be the hallmark of a successful healthcare outcome – and an example of simple monitoring. When asked about 'quality over*quantity*', he replied with a 'definite yes and no': in the field of healthcare research, he tends to acknowledge the argument; out of over 30 funded pilot projects, not a single one had truly succeeded according to rigorous evidence criteria. The solution could be to examine similar projects for common effective components and use these to formulate a healthcare concept that is commissioned for a fixed term and either continued or discontinued based on KPIs.

Klakow-Franck explored the relationship between her model and self-governance, noting that the latter is not the only stakeholder; hardly any healthcare system has so many actors with such diverse responsibilities, and it is precisely this extreme sectoral division and fragmentation that have contributed to the problem. If the aim is to improve cross-sectoral care – which she sees as the key to success – it must be made possible for other parties to commission services as well: in the case of the emergency response chain, for example, the local authority, in conjunction with the state authority, and ultimately the self-governing partners, including the state associations or a health insurance fund. The State Committee at state level is not a suitable platform for this. She therefore advocated a neutral model in which different stakeholders could commission services professionally, followed by professional transfer management. <<

Citation

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