German Federal Associations of Health Insurance Funds

AOK-Bundesverband, Bonn
(Federal Association of local health insurance funds, Bonn)

Bundesverband der Betriebskrankenkassen, Essen
(Federal Association of company health insurance funds, Essen)

IKK-Bundesverband, Bergisch-Gladbach
(Federal Association of guild health insurance funds, Bergisch-Gladbach)

Bundesknappschaft, Bochum
(Federal Miners‘ Insurance Fund, Bochum)

Bundesverband der landwirtschaftlichen Krankenkassen, Kassel
(Federal Association of agricultural health insurance funds, Kassel)

See-Krankenkasse, Hamburg
(Seamen Health Insurance Fund, Hamburg)

Verband der Angestellten-Krankenkassen e.V., Siegburg
(Association of white-collar substitute health insurance funds, Siegburg)

AEV – Arbeiter-Ersatzkassen-Verband e.V., Siegburg
(Association of blue-collar substitute health insurance funds, Siegburg)

The open method of co-ordination in the field of health care

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German Federal Associations of Health Insurance Funds

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Summary:

The open method of co-ordination is a process by which, at EU level, common objectives/guidelines are established and best practices identified and compared using jointly-agreed indicators. This procedure is already being applied in the areas of employment, social exclusion and pensions. With respect to health care and care for the elderly, a first communication was issued by the European Commission as early as December 2001. Existing experience shows that serious methodological problems exist with regard to the comparability of data and that such problems will persist in the case of health care for some time to come as a result of historical differences inherent in the various systems. In order to preclude erroneous conclusions, policy-related conclusions should, in all seriousness, be drawn only after careful interpretation of the findings with care being taken to bear national peculiarities in mind. Involving the German Federal Associations of Health Insurance Funds in the identification of objectives and development of indicators is absolutely imperative.

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1. Introduction

In the course of various summit meetings, the Heads of State and Government of the Member States of the European Union (EU) developed what is known as the "open method of co-ordination" for the social field. The aim here is not the harmonisation of the different social security systems; in this respect, the EU, explicitly, has no legislative competence (see Article 152 paragraph 5 of the EC Treaty).[1] The objective of this method is rather to continue to improve co-operation between the Member States in the area of social security and to provide them with assistance as they gradually develop their own policies.

The open method of co-ordination is a process by which common objectives/guidelines are established and best practices are identified and compared by means of jointly-agreed indicators. This process is modelled on the European Union's financial and economic policy. In this context, it was employed to lay down the stability and convergence criteria for the introduction of the Euro and to monitor compliance with them.

The open method of co-ordination is an independent political process which complements the Community's legislative process (for example, directives, regulations). Within the Council of Ministers of Employment and Social Affairs, the Member States, supported by the European Commission, lay down Union-wide objectives/guidelines on a voluntary basis. The European Parliament has a right of consultation. The Council establishes quantitative and qualitative indicators (benchmarks) with the aim of identifying and comparing best practices. In addition, a reporting system facilitates the evaluation of progress made by the Member States in achieving the set goals.

The process enables joint objectives to be laid down whilst the path to achieving these objectives remains at the discretion of the Member States. The measures to be taken are decided upon in the context of national action plans and thus remain subject to national responsibility. However, by means of the comparison, the degree to which objectives have been achieved becomes visible and subject to justification. In this way, a common orientation with respect to goals can be arrived at, while at the same time allowing for wide-ranging national autonomy in the implementation of agreed objectives.

The areas of application selected were, in the first instance, employment, followed by pensions and social exclusion. The process has already been implemented, for some time, in the area of employment policy. The first goals and indicators have now also been agreed upon for the areas of pensions and social exclusion. In its conclusions, the European Council held in Lisbon in March 2000, had already stressed that Europe's social security systems were in need of reform so as to put them in a position to continue to provide (medical) benefits of a high quality. In June 2001, the European Council of Gothenburg therefore entrusted the European Commission with a mandate to prepare a report on orientations in the field of health care and care for the elderly for its meeting in Spring 2002. With its communication "The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability" of 5 December 2001, the European Commission submitted the report requested. With it, a first step towards the application of the open method of co-ordination was also taken in respect of the health care system.

[1] Pursuant to Article 152 paragraph 5 of the EC Treaty, the organisation of public health care systems and medical care provision is the exclusive responsibility of the EU Member States.

2. Basic assessment of the process with a view to the health care system

Health care systems in Europe are a product of history and are organised differently from one country to another. They range from government-controlled systems to others which contain competitive management mechanisms. The German system occupies a special position since its self-administration structure has a special role to play at management level. The self-administration partners are either involved in the decision-making process or take decisions themselves. For example, decisions regarding the range of benefits to be financed by the statutory health insurance are taken within the Federal Committee of Doctors and Health Insurance Funds.

However, despite the differences in the way in which the EU's health care systems are organised, the problems and challenges they face are similar. For instance, the demographic challenge posed by an increasingly ageing population, or that of medical and technological progress, have an impact on all of the EU's health care systems. Likewise, in almost all Member States, ways and means of improving efficiency, of effectively utilising limited existing resources, or of managing capacity, are being sought. This is because similar problems are to be observed in the area of health care provision itself, independently of the way in which the individual health care system is organised. The problems encountered can be characterised as follows:

- lack of overall responsibility and clear objectives in the provision of medical care
- dominance of service-provider interests
- insufficient instruments in the hands of the cost-bearing organisations to allow them to control benefits
- the existence of isolated health care sectors owing to the absence of or insufficient dovetailing of the health care sectors
- deficits in the provision of medical care as a result of over-, under- and misallocated provision of benefits.

Moreover, even future challenges, such as the imminent eastward enlargement of the EU, apply in principle to all Member States, even though the degree to which the individual countries are concretely affected - which also depends on their geographic location - will differ. The health divide within the EU is likely to grow as a result of the accession of the Central and Eastern European States.[2]

At present, it is impossible to make inferences regarding the need for further joint development of the health care systems beyond the currently existing possibilities - for example beyond the rules of co-ordination contained in the Regulation on social security (EEC) No. 1408/71 - on the basis of the amount of cross-border consumption of benefits taking place (only 0.24% of total expenditure on health care in the EU in 1993 was accounted for by cross-border take-up of benefits).[3] Nevertheless, similar problems beset all Member States and, in the quest for solutions, it might be worthwhile to take a look across the border.

Against this background, the German Federal Associations of Health Insurance Funds would, in principle, welcome a European comparison (benchmarking) within the framework of the open method of co-ordination since it:

- preserves national autonomy in organisational matters and at the same time,

[2] See also World Health Organization, Regional Committee for Europe: the European Health Report - Summary of the Preliminary Results, EUR/RC51/7, 19 July 2001, pp. 1 et seqq.

[3] DIW: Wirtschaftliche Aspekte der Märkte für Gesundheitsleistungen, Berlin, October 2001, p. 120.

- facilitates a more uniform establishment of objectives among health care systems in Europe,
- leads to enhanced transparency,
- renders the strengths and weaknesses of individual systems more readily visible,
- provides the basis for identifying paths to improvement, and
- makes available suggestions for further development in the form of "best practices".

The German health care system has no reason to fear international comparison. Indeed, it is able to point to considerable strengths. Through the management function exercised by the self-administration, the German health care system offers the possibility of being more attuned to patients' needs, less bureaucratic and more independent from the State. Furthermore, there are no limitations to access and medical benefits are available to all persons covered by the statutory health insurance on the basis of equality and within the framework of a broad catalogue of benefits and services. The efficiency of the German health care system is also evident from the fact that challenges such as German Unification have been met successfully.

The German Federal Associations of Health Insurance Funds must and will actively follow the process of open co-ordination and, as far as possible, be involved in shaping it as well as support the national Government and the responsible ministries concerning its implementation.

3. Experience gained to date with the open method of co-ordination in the areas of employment, social exclusion and pensions

In the areas of employment, social exclusion/poverty and pensions, experience has already been gained with the open method of co-ordination. At the present time the following problems can be identified in the light of this experience:

- *A paucity of democracy*

The objectives pursued by the open method of co-ordination are laid down within the Council of Ministers and are not the outcome of broad national discussions and evaluations in the context of a parliamentary process. To date, no broad-based dialogue, no "concerted" action, no systematic inclusion in the national democratic opinion-forming and decision-making process has been taking place. However, a broad-based opinion-forming process is necessary since health objectives can already be defined differently at national level (for example owing to differences in the incidence and prevalence of disease).

If with the open method of co-ordination, uniform objectives are used as the basis throughout the Union, the upshot will be that an EU standard is defined tacitly and without a broad-based discussion taking place. In this context, it is likely to be ignored that differences exist at national level in the organisation of health protection, which are rooted in the specific societal and health policy context, are decided on at the national policy level, and in the final analysis, also constitute the expression of the different preferences obtaining in the individual Member States with respect to the scope and organisation of their individual health care systems.

- *Danger of over-emphasising fiscal policy aspects*

The impetus and motivation for the introduction of the open method of co-ordination was the implementation and monitoring of the stability criteria for the achievement of the European Economic and Monetary Union. The debate to date shows that financial sustainability is one of the Council's key concerns. It can therefore be assumed that this will also apply in the case of health. Consequently, there is a risk that aspects of health care provision, quality and access will be relegated to second place. The process of open co-ordination in a Europe which explicitly sees itself as a "Citizens' Europe", may not be allowed to restrict itself to establishing objectives and indicators which do not go beyond the (fiscal policy) "metalevel". Indeed, it is precisely the supply side and the evaluation of the effectiveness of various sectoral and cross-sectoral management tools which should be taken into consideration in order to generate findings which can facilitate the provision of higher-quality and more efficient medical care. Limiting the choice of objectives and indicators, for example, to the financial sustainability of health care systems, does not provide an adequate basis for identifying "best practice" for the day-to-day provision of patients' care.

- *Basic methodological problems*

To be able to conduct comparisons on a Community-wide basis, uniform, objectivisable measures and *indicators* are necessary. Experience to date shows that

- the latter either do not exist, or,
- where they do exist, they measure different things often owing to the fact that delimitations/definitions vary from one nation to another,
- although the standardisation of statistics is aspired to, and considerable financial means are expended to this end, the latter will fail to offset the differences inherent in the systems. For instance, British citizens have access to the National Health Service, but the scope of benefits provided by their system is different from that of the statutory health insurance in Germany. If the expenditure of both were to be compared, it would also be necessary to simultaneously take into account the benefits contained in the specific national catalogue of benefits and services.

4. Transfer of existing experience with the the open method of co-ordination to the health care system

Using as a backdrop the experience already gained in other areas of social policy with the open method of co-ordination, as well as the European Commission's Communication on "The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability" of 5 December 2001, various conclusions may be drawn which, from the perspective of the German Federal Associations of Health Insurance Funds, need to be taken into consideration should this method be applied to the health sector in the future. These conclusions refer to two essential elements of the method: the specification of objectives and indicators.

4.1 Possible goals within the health care system

In its Communication "The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability" of 5 December 2001, the European Commission observes that the European Union's health care systems are faced with the challenge of harmonising three goals or target dimensions with one another:

- ensuring general access to medical benefits and services,
- ensuring a high quality of medical care, and
- ensuring the long-term financial sustainability of health care systems.

The German Federal Associations of Health Insurance Funds welcome these goals as a first concrete step towards a Community-wide joint framing of objectives in health care. It is also quite a logical step since the EU's Member States are confronted with the same problems caused, primarily, by demographic change and innovations in medical technology.

Moreover, the core task of every health care system is to maintain and promote the health of its population, as well as to prevent and combat diseases and epidemics. This must also be reflected at the centre of any endeavour to apply the open method of co-ordination in the area of health. In a "Citizens' Europe", this new form of European co-operation must be guided by citizens' needs and expectations. A one-sided focus on the objective of achieving the financial sustainability of health care systems, therefore, does not constitute a sensible approach. What is decisive is invariably the relationship between financial input and health output. This is of significance in as much as, owing to the differing financial capacity of the individual Member States, preferences vary as to the scope and the quality of health care provision. Consequently, the ultimate purpose of a benchmark process cannot be reduced to considering questions of levels (for example, levels of expenditure on benefits) in isolation. Such questions must always be seen in relation to the health outcomes that are produced with the resources expended. However, outcomes can only be determined if the supply side is explicitly taken into consideration.

Against this background, and in broad agreement with the European Commission, the German Federal Associations of Health Insurance Funds consider the following orientations, with regards to objectives, to be appropriate at EU level:

1. Ensuring access for the entire population to health care of an assured quality

The European Union's Charter of Fundamental Rights grants every person the right of access to preventive health care and medical treatment as well as the entitlement to social security benefits in cases of illness and in the event of a need for long-term care. Furthermore, in its Recommendation of 27 July 1992 on the "Convergence of social protection objectives and policies" (Convergence Recommendation) the Council, among other things, declared equal access to health care to be one of the fundamental objectives of social protection systems.

2. Ensuring high-quality, demand-oriented, cost-effective health care

In its Convergence Recommendation of 27 July 1992, the Council observed that one of the objectives should be to maintain and further develop a high-quality health care system, "which is geared to the evolving needs of the population and especially those arising from the dependence of the elderly, to the development of pathologies and therapies and the need to step up prevention."

3. *Ensuring the long-term financial viability of health care systems geared towards social equity (while upholding solidarity between generations, between singles and families and between people with different levels of income)*

In its Conclusions of 17 December 1999, the Council[4] declared the provision of health care, which meets high standards of quality and is financially viable in the long-term, to be one of the main objectives of European co-operation in the field of social protection. Guaranteeing long-term financial viability must go hand in hand with upholding the principle of solidarity on which - despite manifest differences - all EU health systems rest.

4. *Preserving and improving the health status of the population*

Both health and insurance against the risk of illness constitute factors of productivity and are thus essential prerequisites for economic development. However, the health status of the inhabitants of most of the Central and Eastern European candidate countries is currently poorer than that of EU citizens and is deteriorating steadily (life expectancy, infant mortality, communicable diseases).[5] In the light of this clear health divide, the task of improving health and combating communicable diseases is destined to gain considerable significance in view of the eastward enlargement of the EU.

4.2 Requirements for the setting of indicators for health care systems

The overriding aim of the open method of co-ordination is to utilise increased voluntary co-operation in order to learn from each country's national experience and best practice. In order to do this, the EU health systems must be adequately depicted in their totality. A distorted picture of the individual health care systems must be avoided as this will nullify the meaningfulness of measures and indicators.

Although it is true that the data situation, in terms of what is required for a comparison of health care systems, has improved with respect to scope, depth and quality - with all European countries, in the meantime, operating a system of health reporting – the experience gained thus far, both in the framework of international comparisons of health care systems (WHO, OECD) and in the context of the open method of co-ordination in the area of social exclusion/poverty, indicates nevertheless that the current levels of data are insufficient to mount a comparison of health care systems throughout the EU:

- *The data required to develop indicators are either non-existent or exist in varying degrees of quality*

  There are still, for example, considerable gaps in data and deficits in the quality of the collected data. This applies especially to data on inputs, structures and processes, as well as to the results of the health care systems. Moreover, data are lacking, in particular, which would enable a comparison of the treatment of individual diseases and the structure and distribution of improvements in health outcomes.

[4] As proposed by the European Commission in its Communication of 14 July 1999 on "A concerted strategy for modernising social protection".

[5] See also World Health Organization, Regional Committee for Europe: The European Health Report - Summary of the Preliminary Results EUR/RC51/7, 19 July 2001, pp. 1 et seqq.

In measuring the health status of a population, for instance, the so-called "DALE" indicator (Disability-adjusted life expectancy) - developed by WHO - is frequently used. The REVES Group[6] has shown that this concept poses methodological problems for the EU (for example with regard to statistics on invalidity). As a result, the DALE concept can only be implemented by a few EU Member States.[7]

- *Even when data exist, they are not comparable with one another (differing delimitation criteria)*

  In international comparisons (such as those conducted by the OECD) the "share of gross national product spent on health care" is often used as a measure. This measure places a country's expenditure on health in relation to its gross national product or gross domestic product. The problem with this approach is that no standard international definition of "health expenditure" exists. Moreover, since the delimitation of health expenditure is not the same in every country, one is faced with a situation where, for example, there are deviations from one country to another when health system related outlays are paid by different ministries (such as the health and social affairs ministries) or different sectors.

  The cash benefits provided by the German statutory health insurance for example (in particular sickpay) are not taken into account in the OECD's calculations. The computed share of gross national product spent on health care is therefore lower than the result that would be elicited using the German delimitation of health expenditure. In addition, when using the share of gross national product spent on health care as a measure, it is generally assumed that the numerator (health expenditure) refers to the total population. This is, however, often not the case (for example, in Germany only some 90% of the population are covered by the statutory health insurance). Since the denominator is not accordingly adjusted to reflect reality, the outcome is a systematic underestimation, for example, of the statutory health insurance's health quota.[8]

- *Data only permit meaningful statements if they are interpreted against the background of the specific health policy context*

  There are cases, for example, where the structural characteristics of a system (such as centralisation/decentralisation, focus on prevention or cure) are often left out - partly because they cannot be adequately quantified in input-output analyses - or added afterwards for the purpose of comparison as "independent" factors. By contrast, measurable structural factors such as the number and distribution of doctors, hospital beds and high-cost, sophisticated medical equipment are employed much more frequently. Most often,

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[6] REVES is the abbreviation for: "Réseau d'Espérance de Vie en Santé" (The International Life Expectancy Network / Internationales Lebenserwartungsnetzwerk).

[7] Schneider, Markus: Lecture "Internationale Gesundheitssystemvergleichsforschung und Gesundheitsstatistik - Vergleichbarkeit und Eignung international vorliegender Daten", Workshop of the Federal Associations of Health Insurance Funds, Erkner, 8- 9 October 2001.

[8] See Schwartz, F.W./Busse, R.: Denken in Zusammenhängen: Gesundheitssystemforschung, p. 406, 395f. in: (ed.) Schwartz, F.W./Badura, et al.: Das Public Health Buch: Gesundheit und Gesundheitswesen, Munich: Urban and Schwarzenberg, 1998.

however, they can only be properly interpreted if the system's structural characteristics are known and included in the analysis.[9]

A similar example is the - by international standards - high level of expenditure on medicines in France. In order to evaluate this finding it would be necessary to assess the data in the specific health policy context and verify, for example, whether this has led to less hospital admissions.

In the light of this less than optimum data situation prevailing throughout Europe, cross-national comparisons of health care systems are lacking in meaningfulness and reliability to a greater or lesser extent.[10] Consequently, it is wise to exercise great caution in utilising and interpreting these data, which have not been collected in a standardised manner, to avoid serious misinterpretations and, as a result, counterproductive recommendations for action.

Against this background, the German Federal Associations of Health Insurance Funds see it as imperative that the development of indicators in health care meet the following requirements, at the very least:

1. <u>Data quality: high demands must be placed on the quality of data</u>

   To be able to make meaningful statements one must have access to meaningful data. Accordingly, high demands have to be placed on the quality of data. Data must, for example, be *objective* (in other words independent of the person collecting them), *reliable* (formally able to capture a specific attribute with precision) and *valid* (in other words, really measuring what is meant to be measured). Moreover, the data must be *available*, virtually in real time.

   In international comparative studies, special attention must be given to the transnational *comparability* of data. This is particularly important in the area of health, since different sets of benefits and national delimitations - in some cases highly detailed – do exist. Accordingly, there is a great danger that differing delimitations will be pooled in an undifferentiated manner.

2. <u>Dynamic approach: process-oriented data analysis</u>

   The data may not simply depict specific variables at a fixed point in time (static approach). As a rule, it is more meaningful to have the *development of the individual variable depicted over time* (dynamic approach/longitudinal approach). Moreover, in addition to the rate of change, the *different distributions* as well as the *different baseline positions* (absolute values) need to be taken into account. This is the only way to adequately depict processes of change and thus measure the efficiency and sustainability of a specific political measure.

[9] See Schwartz, F.W./Busse, R.: Denken in Zusammenhängen: Gesundheitssystemforschung, p. 398, in: (ed.) Schwartz, F.W./Badura, et al.: Das Public Health Buch: Gesundheit und Gesundheitswesen, Munich: Urban and Schwarzenberg, 1998.

[10] According to Schwartz and Busse, strictly speaking, attempts at international comparisons of health care systems are at the present state of knowledge premature, owing to the high degree of incongruency in delimitation criteria, quality of data and problems of transcultural comparability. From: Schwartz, F.W./Busse, R.: Denken in Zusammenhängen: Gesundheitssystemforschung, p. 405, in: (ed.) Schwartz, F.W./Badura, et al.: Das Public Health Buch: Gesundheit und Gesundheitswesen, Munich: Urban and Schwarzenberg, 1998.

3. Weighting and indexing: limited meaningfulness as a result of value judgements

   If many different data are aggregated, it means that weighting must perforce be carried out. This could produce a distorted picture since *weighting makes value judgements necessary and carries the danger that it is never value-neutral* and is driven by interests of some type. Consequently, aggregation or weighting and indexing of data should, in principle, be avoided.

4. Input-outcome measurement: no structural preference of input indicators

   The health care system is a complex entity which can basically be broken down into a large number of individual data, whereby quantitative indicators are more easily available. As a rule, these are more likely to measure input, for example, the financial resources invested in health care. Alongside these is a set of significant *qualitative indicators* which tend more to measure outcomes, for example: health status, the quality of care or the level of satisfaction with health care provision. A health care system cannot be analysed in any serious manner without reference to the health of the population and its demand for health care.[11]

5. Causality: identifying cause and effect relationships between measured results and measures/derived national action plans

   The health status of an entire population or that of a single individual depends not only on general access to high-quality health care, but is decisively determined by a number of *factors which lie outside of the health care system*, such as: social status, general circumstances, working, transport and living conditions, nutrition and health-related behaviour.

   In order to conduct a comparative assessment of the progress made by Member States in the attainment of agreed objectives, and in so doing identify alternative possibilities for action on the part of policy-makers, it is imperative that the *compared parameters be* really *attributable to the measures actually implemented in the health care system*.

In the view of the German Federal Associations of Health Insurance Funds the requirements described above constitute *minimum requirements* which must be fulfilled in the process of establishing common and uniform indicators, to enable the comparison of best practices and innovative measures and approaches. However, it should be borne in mind that, given the considerable differences which exist among the various EU health care systems, the concomitant fundamental methodological problems will persist in the long term. As a result, cross-border comparisons will always be flawed in terms of meaningfulness and reliability. Consequently, there is a real danger that false policy conclusions might be drawn from the comparisons and the resulting rankings and so lead to counter-productive recommendations for action. The findings gleaned in the application of the open method of co-ordination are therefore to be analysed closely, without ever losing sight of the specific national peculiarities, before policy-related conclusions are drawn at national level.

5. Conclusions

[11] See Schwartz, F.W./Busse, R.: Denken in Zusammenhängen: Gesundheitssystemforschung, p. 393, in: (ed.) Schwartz, F.W./Badura, et al.: Das Public Health Buch: Gesundheit und Gesundheitswesen, Munich: Urban and Schwarzenberg, 1998.

Against the backdrop of shared present-day problems and future challenges for the health care system in the Member States, a glance across the border can be helpful to pick up some tips for making improvements based on strengths and weaknesses observed. A health policy by the Member States based on best practice could contribute in this way to a closer co-ordination of health policy in the medium term. The German Federal Associations of Health Insurance Funds agree with the European Commission that the goals of universal access, high quality and long-term financial sustainability of medical services need to be reconciled.

The process of open co-ordination in a Europe which explicitly sees itself as the “Citizens' Europe” cannot be restricted to establishing objectives and indicators which are decided on the (fiscal policy) “metalevel”. Rather, the supply side should be taken into consideration to gain insight into better quality, more efficient medical care. Limiting the choice of objectives and indicators, for example, to the financial sustainability of health care systems, does not provide an adequate basis for identifying “best practice” for the day-to-day provision of patients' care.

The application of the open co-ordination method in other socio-political fields has already made the basic methodological problems visible. These will become even more serious in the health care field due to the multidimensional aspects of health and the frequently-encountered limited comparability of health systems. Unrestricted comparability cannot be created in the short term, partly due to systems that have grown differently for historic reasons.

To this extent, in the view of the German Federal Associations of Health Insurance Funds, it should be borne in mind that rankings can exacerbate the methodological problems due to the necessary, but value-laden and not unbiased weightings used to aggregate the data. Contrary to popular opinion, this makes the required interpretation of the results more difficult and can lead to incorrect policy-related conclusions. All participants need to be clear about the fact that following the process of the open co-ordination method, policy-related conclusions can, in all seriousness, only be drawn after careful interpretation of the findings with care being taken to bear national peculiarities in mind.

The process of open co-ordination requires a broad-based national and European debate about the objectives and guidelines in health care and care for the elderly as well as extreme caution in the formation of indicators and the interpretation of the results. The German Federal Associations of Health Insurance Funds, which play a substantial role in the implementation of objectives and guidelines at national level, must therefore take part in the entire process of open co-ordination.