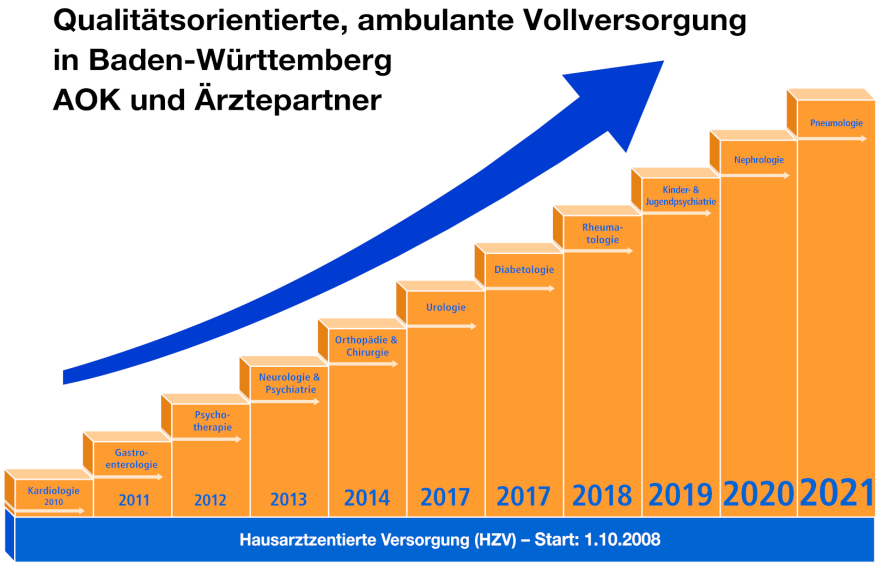
15 years of GP-centred care according to § 73b SGB V in Baden-Württemberg

Szecsenyi: ‚The evidence is on the table'

GP-centred care models, also called GP programmes or models, in which the GP:in acts as the first point of contact for all health issues, are numerous throughout Germany. Mainly AOKs and BKKs, but also Barmer or BIG, for example, offer their insured the opportunity to participate in various, sometimes very different GP programmes - even though overall there are quite few participants compared to the majority of those with regular care who are cared for according to the care contract according to § 75 SGB V (1). The blueprint for GP-centred care (HZV) according to § 73b SGB V (2) is the HZV contract in Baden-Württemberg, for which the contract partners - GP Association Baden-Württemberg, MEDI Baden-Württemberg and the AOK Baden-Württemberg - were able to present scientific evaluation data for the first time over a period of ten years in a direct comparison of HZV and KV care at a press conference in Berlin.



>> A look at the online page of the GP association (3) shows the dimension of what the association calls - quote - ‚the biggest innovation for GPs and their patients in the past decades'. More than 6 million patients have voluntarily participated in this modern form of care. In addition, there are ‚more than 2 million insured persons' who have signed up for so-called ‚add-on GP contracts'. If one considers that currently (as of July 2022) about 74 million of the more than 83 million German citizens are insured in the statutory health insurance (GKV) and therefore have to be cared for accordingly, only 8% have opted for the ‚alternative standard care' and the ‚success story', as the contract partners like to call it. On the GP side, the situation is somewhat different: 16,000 GPs are currently participating in HZV - the competitive departure into a world of selective contracts without the participation of the associations of SHI-accredited physicians - with the Federal Association of SHI-accredited physicians (KBV) registering 55,116 GPs (as of 2020): That is about one third.

One reason for the discrepancy between claim and reality is that in 2004, with the Health Care Modernisation Act (GKV-GMG), a new paragraph on ‚family doctor-centred care' was added to the Social Code Book V, but it merely stated that health insurance funds must offer their insureds special family doctor care (family doctor-centred care). This quasi-obligation is therefore only implemented by some health insurance funds with different contractual partners.In April 2007, the legislatorreacted to the ‚passivity or boycott attitude of very many health insurance funds' inthe Competition Strengthening Act (GKV-WSG) with a new regulation of § 73b, wrote Ulrich Weigeldt, the then Federal Chairman of the German General Practitioners' Association (Deutscher Hausärzteverband e. V.) in 2015 in the journal ‚Gesundheits- und Sozialpolitik' (G&S). In it, all health insurance funds were once again expressly obliged to offer their insured an alternative to the standard care in the KV system, nationwide HZV. However, according to Weigeldt, despite these standardisations, the expected number of HZV contracts did not materialise, because ‚many health insurance funds continued to stay on the sidelines'. The legislator then felt compelled to further clarify the situation by additionally stipulating in § 73b of the Act on the Further Development of the Organisation (GKV-OrgWG), which came into force in January 2009, that ‚the health insurance funds must conclude binding, nationwide HZV contracts with a sufficiently mandated community of GP service providers by 30 June 2009'. In addition, in order to prevent health insurance funds from undermining these requirements again, § 73b was supplemented by the provision that a community of GPs entitled to contract can apply for arbitration if a health insurance fund refuses to negotiate or if no consensual HZV contract can be agreed upon in the negotiations with the health insurance fund.

However, since the 2009 amendment to § 73b did not explicitly specify the form of contract in which an HZV is to be agreed, according to Weigeldt, who was dubbed the ‚pioneer of HZV' when he left office as Federal Chairman of the German GP Association in 2022, this vagueness in the form of contract to be agreed has led to disputes between individual health insurance funds and individual GP associations. Therefore, a joint press release of the contract trio states that the collective contract is still too convenient for many health insurance funds.According to the experience of the contract partners, the statutory HZV health insurance fund obligation, whichprescribes offering HZV, is not sufficient. In order for significantly more patients nationwide to be able to benefit from the proven advantages, they therefore demand that in future full care contracts be explicitly promoted by federal policy through start-up financing and bonuses.

Baumgärtner: ‚The coordination of utilisation works'.

You need to know all this to be able to assess what a big step the contract partners took almost exactly 15 years ago - on 8 May 2008 - when they signed the first nationwide HZV, initially designed for a period of five years. And before that, 50% of the GPs working in Baden-Württemberg had to mandate that such a contract could be concluded at all, as Dr. Werner Baumgärtner, Chairman of MEDI Baden-Württemberg since 2003 and driver and co-initiator of the HZV idea from the beginning, stated at the press conference. ‚We started as a five-year contract, now it's 15,' Baumgärtner was pleased to say and added: ‚The contract has now been working for 15 years, we are very proud of that'. If that were not the case, the contract would have been renegotiated or terminated if necessary. But, Baumgärtner said, ‚The control and coordination of the utilisation in the contracts works.' According to him, this is ‚certainly also the biggest difference to standard care' and with guarantee for ‚better care, especially for the chronically ill'. This statement hides a hint as to why only a part of the patients are registered by the general practitioners.

Gerlach: ‚The quality gap between HZV and standard care is widening from year to year'.

‚People with chronic diseases in particular benefit from HZV,' said Prof. Dr. Ferdinand M. Gerlach, Director of the Institute of General Medicine at Goethe University in Frankfurt/Main, commenting on the evaluation results currently presented: ‚For example, we see significantly fewer serious complications and even longer life expectancy among diabetics. This is most likely due in part to the 20 percent higher participation in disease management programmes (DMPs), which are specifically encouraged in the HZV. This makes care more structured and continuous, which is particularly important for chronic diseases. In addition, there are mutually reinforcing control measures, such as the quality circles established in HZV for guideline-based pharmacotherapy or the strengthened role of GPs in HZV as pilots through the health care landscape.

It is also remarkable that the quality gap between HZV and standard care (RV) is widening from year to year in favour of HZV. ‚And this also applies under the more difficult conditions of the pandemic', Gerlach added.



v. l.: Dr. Jörg Schweigard, AOK Baden-Württemberg; Prof. Dr. Joachim Szecsenyi, University of Heidelberg; Prof. Dr. Ferdinand Gerlach, University of Frankfurt/Main; Johannes Bauernfeind, AOK Baden-Württemberg; Prof. Nicola Buhlinger-Göpfarth, GP Association Baden-Württemberg; Dr. Werner Baumgärtner, MEDI Baden-Württemberg and MEDI GENO Germany (Source: AOK BW, Photo: Jens Schicke).

When a scientist says ‚probably'

In his keynote speech, Prof. Dr. Ferdinand M. Gerlach stated that HZV is the ‚longest evaluated and also most deeply evaluated health care innovation' in Germany. Nevertheless, in his statement that 11,000 serious complications could be avoided and a longer life expectancy for diabetics could be extrapolated in comparison to standard care, he used the qualification that ‚very probably' the 20% higher participation in disease management programmes (DMP), which is specifically encouraged in HZV, is partly responsible for this. Care is thus becoming more structured and continuous, which, with mutually reinforcing control measures as well as established quality circles for guideline-based therapy and the strengthened role of GPs as pilots through the care landscape, together with a particularly well-structured cooperation between GPs and specialists, results in comprehensive, quality-oriented care control. All these measures taken together would result in fewer complications and a longer life for diabetics - even under the difficult conditions during the pandemic.

At the press conference in Berlin, ‚Monitor Versorgungsforschung' asked the two health care researchers present when sufficient evaluation had actually been carried out to justify a political decision or when the introduction of HZV was left to the individual taste of each health insurance fund boss; and also why the statement was only ‚probable'.

‚The evidence is on the table,' Prof. Dr. med. Joachim Szecsenyi answered the first part of the question. For 15 years, he said, analyses have been presented in regular waves, always pointing in the same direction: that HZV in interaction with the specialist contracts is superior to the completely uncontrolled use of standard care. Szecsenyi: ‚It is more of a political question what one makes of it.' The positive results also of the current evaluation should be ‚a call to the politicians' to go a step further, just as the contract partners would regularly do when they decided to introduce further care innovations on a scientific basis.

Gerlach answered the second part of the question about the statement ‚probably' with a short excursion into the methodology underlying the evaluation. In the meantime, several thousand pages of evaluation reports have been submitted and more than 30 publications have appeared, also in international journals; in addition, the methodology of the HZV evaluation has been discussed at methodological congresses. In order to be able to compare HZV and standard care, classic survival time models are calculated, according to Gerlach. These are adjusted for several factors such as age structure, gender distribution, comorbidity and disease burden, but also nursing home and care level status as well as nationality up to the size of the practice providing care, in order to exclude the possibility of ‚comparing apples with oranges'. Likewise, only those patients would be taken into account who would actually have a GP - on the one hand in HZV, on the other hand in standard care. Gerlach: ‚We adjust for these relevant factors in order to form two groups that are really comparable. The evidence that can be generated in this way, says Gerlach, ‚is overwhelming'. But with the restriction that this methodology is not a prospective, randomised study or a double-blind trial that can generate the highest level of evidence. However, an RCT cannot be implemented in the reality of health care, if only because insured persons who would like to be cared for in HZV cannot be put into standard care for study reasons, where they have to be cared for until a political decision is made that enables HZV for all. That is why the chosen methodology allows for the highest degree of reliability of the statement, whose plausibility is extremely high, that HZV represents the better structured and, on top of that, more cost-effective care, whose customer must spread so that there are political consequences. Gerlach: ‚We have repeatedly had critics consciously analyse the methodology we use and have thought about how we can make it even better.' But under the given circumstances it is ‚the optimum in methodological validity and reliability that can be achieved'.

Citation

Stegmaier, P.: ‚Szecsenyi: The evidence is on the table, in „Monitor Versorgungsforschung" (03/23), PP. 18–20. http://doi.org/10.24945/MVF.03.23.1866-0533.2506

For example, in the current evaluation of 422,000 older insured persons (65 years and older), impressive results were achieved in the HZV group compared to the RV: The projections for the first pandemic year 2020 showed more than 35,000 more influenza vaccinations, about 6,500 fewer prescriptions for potentially inadequate medicines and about 195 fewer hospital stays due to hip fractures. In addition, fewer potentially avoidable hospital stays were observed in patients over 65 years of age due to the close care provided by general practitioners for so-called outpatient sensitive diseases. Likewise, in patients with coronary heart disease, more and more statin prescriptions and fewer hospital stays were detectable over ten years. Gerlach considered all this to be a ‚strong indication' of the improved quality of HZV.

These positive statements on clinical endpoints achievable via HZV were confirmed by Prof. Dr. med. Joachim Szecsenyi, Senior Professor and previously Medical Director of the Department of General Medicine and Health Services Research at the University Hospital Heidelberg as well as Managing Director of the aQua Institute Göttingen, together with Prof. Dr. Gunter Laux and his team responsible for the evaluation on the GP side.

Szecsenyi: ‚Advantages for HZV-insured patients in many basic indicators'.

‚HZV patients receive more coordinated care in the long term'. This is one of the important interim results that Szecsenyi presented. The scientist reads this, among other things, from the evaluation result, according to which HZV patients with fewer uncoordinatedbut more coordinated specialist contacts - with a referral obtained in advance in each case - would increase significantly and thus receive more coordinated care in the long term. Likewise, this gap is widening over the years - and, according to Szecsenyi, ‚fortunately in a positive direction'. The hospitalisation rates of those participating in HZV have also gone down over the years compared to those receiving standard care. As an example, Szecsenyi cited the year 2020, in which 27,000 fewer hospital admissions and thus 124,731 fewer hospital days were observed than should have been expected. In addition, further advantages for SHI insurants could be observed in many basic indicators (see Tab. 1).

Vorteile für HZV-Versicherte bei Basisindikatoren

	HZV* Ø ± Standardabw. Interventionsgruppe n=1.227.245	**Nicht-HZV*** Ø ± Standardabw. Kontrollgruppe n=709.402	**Hochrechnung** HZV vs. Nicht-HZV auf Basis des Regressionsmodells
Hausarztkontakte	12,85 ± 11,27	8,37 ± 10,84	+ 2.056.313 K
FA-Kontakte: koordiniert	3,96 ± 7,89	2,42 ± 5,20	+ 1.726.195 K
FA-Kontakte: unkoordiniert	1,94 ± 7,54	3,24 ± 9,80	-1.885.298 K
Hospitalisierungsrate	0,232 ± 0,692	0,229 ± 0,691	-27.269 KHA
Krankenhaustage (KH)	11,97 ±16,50	11,97 ±16,50	-124.731 T
KH-Wiederaufnahmen	0,211 ± 0,660	0,220 ± 0,675	-5.489 KHA
Vermeidbare KH-Aufnahmen	14,87 ± 32,94	14,48 ± 32,61	-1.673 KHA
Stationäre Kosten	8.102,50 ± 12.666,49	8.196,53 ± 13.437,30	-
Amb. Medikamentenkosten	1.439,17 ± 81.166,52	1.534,34 ± 133.729,44	-
Polymedikation	5,07 ± 4,92	4,57 ± 4,66	-95.954 W
Rot hinterlegte Präparate	2,28 ± 8,47	2,93 ± 10,46	-1.222.989 V

Tab. 1: Advantages for SHI insurants for all basic indicators. From: Evaluation of GP-centred care according to §73b SGB V in Baden-Württemberg: Prof. Dr. Gunter Laux, Prof. Dr. med. Joachim Szecsenyi (Department of General Medicine and Health Services Research, University Hospital Heidelberg). Legend: K = contacts, KHA = hospital admissions, T = days, W = active substances, V = prescriptions. Note: table shortened by ‚adjusted difference' and ‚difference in % significance'.

Buhlinger-Göpfarth: for satisfied patients and enthusiastic doctors

For the contract partners, these results are of great importance, as they underpin central strategic development strands, as Prof. Dr. Nicola Buhlinger-Göpfarth, Chairwoman of the GP Association of Baden- Württemberg, emphasised: ‚The GP practice must remain the central place of care. With the HZV innovation engine, we are focusing intensively on the expansion of delegation and the development towards GP practice-centred care.' In addition to GPs, MFAs and VERAHs , the core team of a team practice should also include other academic, non-physician health care professionals. These include, above all, the academic VERAH and physician assistants. From July onwards, the contractual partners will support their training with 300 scholarships of 5,000 euros each and, after graduation, also the payment of these specialists. A contemporary step towards HZV should also take place through registration in practices instead of with individual doctors. ‚Such expanded HZV practices are more efficient, more flexible and more attractive for employees. And they can care for significantly more patients. This is an eminently important contribution to being able to offer high-quality primary care nationwide in the future,' said Buhlinger-Göpfarth, who was convinced: ‚HZV stands for satisfied patients and for enthusiastic doctors in modern practices. However, the potential is far from exhausted, and for this to happen, health insurance funds must use the opportunities of GP-centred care instead of calling it into question. For this reason, it is important that the right of the insured to GP-centred care remains secured in the future through an obligation on the part of the health insurance funds to offer contracts, ideally through full-service contracts specifically promoted by the government. <<

by: MVF editor-in-chiefPeter Stegmaier

Literature

1) https://www.gesetze-im-internet.de/sgb_5/__75.html
2) https://www.gesetze-im-internet.de/sgb_5/__73b.html
3) https://www.hausaerzteverband.de/themen/hausarztvertraege