Philip Bammert MSc / Dr. oec. publ. Wiebke Schüttig MSc MBR / Saskia Kropp MSc / Dipl.-Betriebsw. (FH) Matthias Brittner / Dr. rer. nat. Roman Gerlach / Prof. Dr. rer. oec. Leonie Sundmacher

Practice networks in Germany: structure, co-operation and priorities

Results of a questionnaire survey

The outpatient sector in Germany is characterised by special features, including organisational separation from the inpatient sector, the free choice of doctor for patients and the lack of standardised communication channels between service providers (1). This makes coordination and continuity of care more difficult, which can ultimately lead to cuts in the quality of care for patients. Examples of negative consequences of uncoordinated care include excessive utilisation of healthcare services, interruptions to treatment pathways or incorrect medication. In particular, multimorbid patients with a high demand for healthcare services are at risk of inappropriate care. There is potential for development with regard to collaborative professional practice in the outpatient sector and care models are needed that improve cooperation and coordination in care.

>> With the second SHI Reorganisation Act in 1997, so-called practice networks were established with the aim of using resources in the healthcare system more efficiently. These offer service providers the opportunity to formally join forces and organise care in regional networks. At the same time, they can act as an interest group. Practice networks can be defined as regional associations of service providers in the medical field that aim to better coordinate the care of a group of jointly treated patients and improve the quality of treatment for them (2). The number of practice networks in Germany is steadily increasing. Since 2012, the legislator has offered practice networks the opportunity to be recognised in accordance with Section 87b (4) SGB V (3), for which they must fulfil certain structural criteria and pursue predefined goals. These objectives relate to patient-centredness, cooperative professional practice, increased efficiency and process optimisation. A distinction is made between three levels of recognition, which are specified in the framework guidelines of the National Association of Statutory Health Insurance Physicians (KBV). Depending on the extent to which the requirements are met, networks receive recognition at basic level, recognition level 1 or recognition level 2. According to the KBV's practice network atlas, there are currently 91 healthcare networks in Germany recognised in accordance with Section 87b (4) SGB V (4). This does not include the many unrecognised networks. There are currently only individual studies that describe the practice network landscape across regions, or those that comprehensively describe the networks in terms of their services.

How can practice networks in Germany be described in terms of their structure, cooperation and focus?
Results of a questionnaire survey

Introduction: Physician networks can be defined as regional collaborations of service providers in the medical field that aim to improve the care of a group of jointly treated patients. The aim of this survey was to obtain and systematically present information on the organization of physician networks, their cooperation and communication as well as established measures to improve the quality of care.

Methods: A questionnaire with the aim of surveying established structural conditions, quality assurance measures and existing means of communication was sent to physician networks in Germany. Furthermore, the acceptance of quality assurance measures, intensity of cooperation in the network as well as success factors and obstacles for success were to be surveyed.

Results: Response was received from a total of 49 physician networks. The design of the networks varied in terms of their structure and their set objectives. In this respect, the number of members is between 10 and 300 and over 20 different focal points were mentioned. Quality assurance measures are widely implemented and communication channels within the networks are also established. For example, 86% of the networks state that there are agreed treatment pathways and 68% state that secure e-mail connections and fax lists are present.

Conclusion: The healthcare landscape of physician networks appears to be highly heterogeneous. In many cases, there are consolidated structures and established quality assurance measures. The networks have clearly formulated aims to improve the quality of care for patients in the future. Further research is needed to map the development of physician networks and evaluate their performance.

Keywords

Physician networks, Quality of Care, Qualitative Research

Methodology

As part of the innovation fund project ATP Arztnetze - division of labour and performance of empirical and organised networks in the outpatient sector in Germany (5), a comprehensive survey of practice networks was conducted.

The aim of the survey was to obtain information on the organisation of practice networks, their cooperation and communication as well as established initiatives to improve the quality of care. To create the questionnaire, the existing evidence on practice networks, the framework guidelines of the National Association of Statutory Health Insurance Physicians (KBV) and the annual care reports of the practice networks in accordance with Section 87b (4) SGB V were analysed at the beginning (3).

Based on the literature, the first step was to derive subject areas and consequently the questions. The Medical Research Council (MRC) guidelines on process evaluation were taken into account when creating the questionnaire. The MRC guidelines provide assistance in the process evaluation of complex interventions and are suitable for use in health services research, among other things (6). Figure 1 provides an overview of the topics and subtopics of the questionnaire.

The subject areas of the questionnaire included the established structural conditions, quality assurance measures and existing means of communication in the networks. Furthermore, the acceptance of quality assurance measures, assessments of co-operation in the network as well as success factors and obstacles were to be surveyed.

A list of practice networks to be contacted was made available by the Federal Association of Physician, Practice and Healthcare Networks (ADA). In addition, the AOK Bayern provided a list of all practice networks participating in the QuATRo project. The QuATRo (Quality in Physician Networks - Transparency with Routine Data) project offers participating practice networks the opportunity to evaluate the care provided by the included service providers using various quality indicators and to draw comparisons with other QuATRo practices, QuATRo networks and the national average (7). The questionnaires were sent to the practice networks for the first time in August 2019. For this purpose, at least one representative from each network was contacted by email with the request to complete the questionnaire. The questionnaire was sent to the network representatives in digital form, attached to a cover letter in which the objectives of the project were briefly explained in order to maximise the response rate. Reminders were also sent by email and processing was permitted within several months.

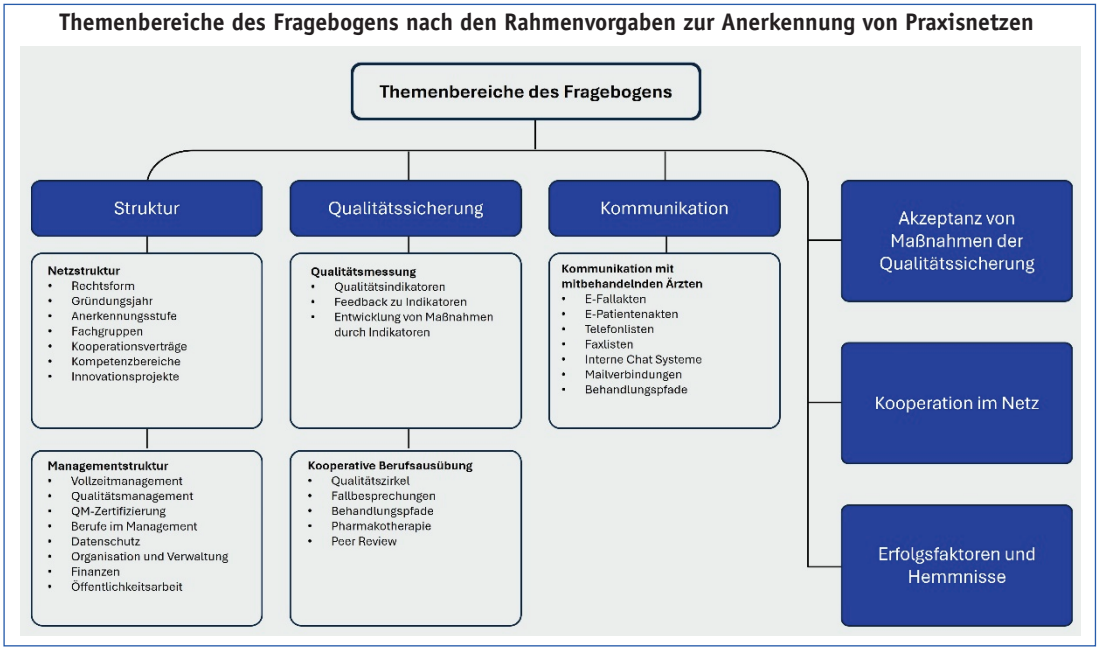


Fig. 1: *The subject areas of the questionnaire were determined on the basis of the framework specifications for the recognition of practice networks in accordance with Section 87b (4) SGB V and the existing literature.*

Results

A total of 49 questionnaires were completed and returned to the research team. The response rate corresponds to 25% of the requested networks, whereby these were the networks registered with the ADA and the QuATRo networks of the AOK Bavaria. The analysis of the questionnaires is presented below. The description of the results is based on the order of the questionnaire.

The returned questionnaires came from 12 of the 17 KV regions. The majority were from Westphalia-Lippe (n = 17), followed by Bavaria (n = 11) and Schleswig-Holstein (n = 5). The majority of the networks (n = 23) included between 50 and 100 members at the time of the survey, 15 networks even included more than 100 service providers. Most of the networks had a highly diversified composition of specialist groups. 48 of the 49 networks consisted of 3 or more different specialist groups and 41 of the 49 networks even consisted of 10 or more specialist groups. Figure 2 provides information on how many networks included the respective specialist groups.

Just under half of the networks (n = 24) stated that they had voting members from other sectors, such as hospitals or care facilities. Furthermore, at the time of the survey, 11 of the networks were not recognised by the KBV in accordance with Section 87b (4) SGB V, 24 networks had basic level recognition, 14 had level 1 recognition and none had level 2 recognition. However, several stated that recognition at the next higher level was being planned.

Figure 3 provides an overview of the indications and patient groups on which the networks focussed. The most common topics were diabetes (n = 25), heart failure (n = 19) and geriatric care (n = 17).

Most networks were organised as a registered association (e. V.) (26 of 45 networks), followed by the legal forms of corporation and partnership.

With regard to the structure of the networks, a comprehensive picture emerged: the number of employees in management was quantified, which was one person in around 45% of the networks, between two and five employees in 45% of the networks and more than five employees in around 10% of the networks. In 64% of the networks, there were employees with commercial training in management. 56% of the networks stated that they had health economists in management, 36% doctors and 25% medical assistants. Only 20% of the networks were QM-certified, but the majority had concluded cooperation agreements with health insurance companies through selective contracts. 45% of the networks stated a co-operation according to § 140 SGB V special care and 27% according to § 73a SGB V. Not a single network concluded a contract in accordance with Section 63 SGB V Modellvorhaben. The majority of networks (63%) had a contractual regulation for the collection of quality indicators. 39% of the networks use the QuATRo system (7) and 27% the BrAVo system (8).

Other indicator systems used were AdaM (9), RESIST (10) and

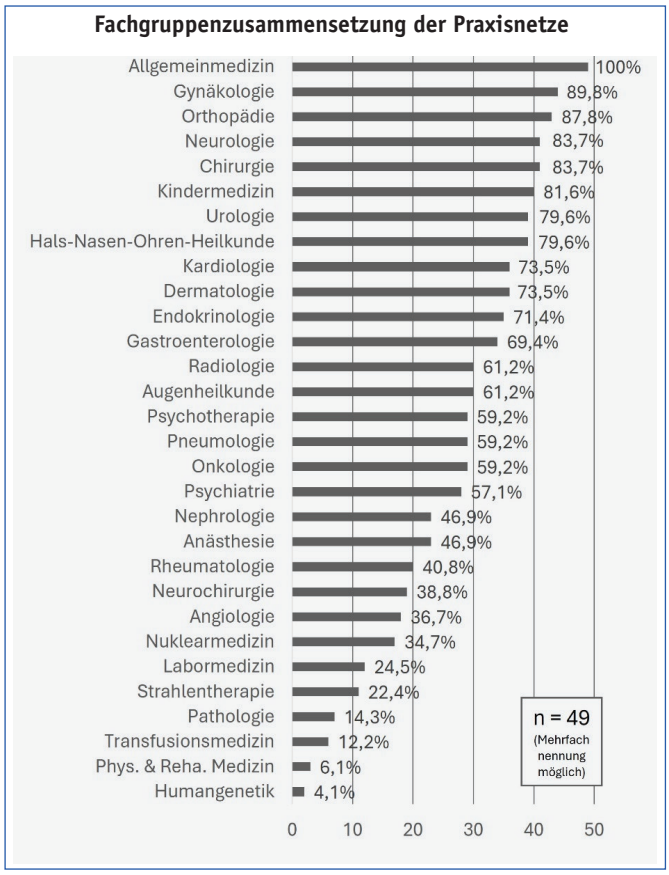


Fig. 2: *The graph shows the percentage of practice networks in which a doctor was represented as a member in the respective specialist group. A total of 49 practice networks responded and multiple answers were possible.*

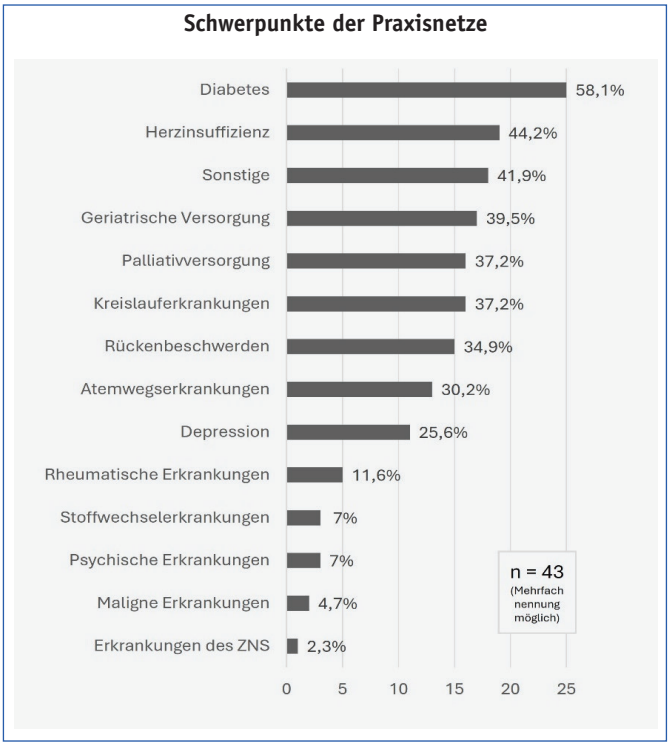


Fig. 3: *The chart shows which indications and patient groups the practice networks have defined as the focus of their work. A total of 43 practice networks responded to the question and multiple answers were possible.*

the KVWL practice network review (11). The extent to which the participating network physicians received feedback on the indicators and whether measures for work in the network were derived from this varied greatly. The majority of networks (36%) stated that the values of the indicators had remained unchanged in recent years, whereas only 11% of networks stated that the indicator values had improved. Areas in which improvements were achieved were in particular vaccination rates, participation rates in disease management programmes, reduction of waiting times and medicines management. The evaluation of the questionnaires showed that other quality assurance measures were established in addition to the collection of quality indicators. For example, 86% of the networks stated that agreed treatment pathways had been established for one or more indications. In all networks that answered the question, quality circles are held regularly and in 11% of the networks, peer review procedures are part of the co-operation.

Table 1 shows the network representatives' assessment of the acceptance of various measures among the network physicians. Here, quality circles and treatment pathways in particular were widely accepted, whereas acceptance of quality indicators and peer review procedures was relatively low.

With regard to communication in the network, a wide range of means of communication were mentioned. The most frequently established means are telephone lists (86%), followed by fax lists (68%) and secure e-mail connections (68%). In contrast, electronic patient files (37%), in-network chat systems (33%) and electronic case files (22%) were mentioned less frequently as means of communication. The survey also asked about the networks' agreed priorities. The most frequently cited priorities were the expansion of cross-sector co-operation (79%), the implementation of further quality assurance measures (63%) and progress in the field of telemedicine (44%).

Table 2 shows the network representatives' assessments of co-operation within the network. The clear division of tasks with regard to tasks, competences and responsibilities of the network management was rated particularly positively. Furthermore, the cooperation between network management and network physicians was rated as very good.

Several aspects were mentioned in free text fields which, from the respondents' point of view, could represent success factors and obstacles to successful networking. Firstly, regular contact and informal dialogue between the service providers involved was mentioned. This should aim to create a favourable working environment. By getting to know each other at an early stage, networking can develop and the joy of working together can grow. This also promotes successful communication and the easier elimination of misunderstandings. According to the network representatives, it is also important to reduce competitive thinking among the participants and enable collegial cooperation. The creation of framework conditions for such successful communication should ideally also involve non-medical practice staff and, if necessary, include stakeholders from other sectors. According to the interviewees, an appropriately organised network office is also required for a cooperative network structure. This includes a clear distribution of tasks and transparent action, which is reflected, among other things, in an open dialogue about the advantages and disadvantages of

Akzeptanz verschiedener Maßnahmen der Qualitätssicherung					
Aussage	Stimme voll zu	Stimme eher zu	Teils/teils	Stimme eher nicht zu	Stimme nicht zu
Qualitätsindikatoren werden von den Netzärzten voll und ganz akzeptiert. (n=37)	5	12	18	-	2
Qualitätszirkel werden von den Netzärzten voll und ganz akzeptiert. (n=40)	29	7	2	2	-
Behandlungspfade werden von den Netzärzten voll und ganz akzeptiert. (n=37)	8	18	9	1	1
Maßnahmen zur Pharmakotherapie werden von den Netzärzten voll und ganz akzeptiert. (n=35)	3	22	8	1	1
Peer-Review wird von den Netzärzten voll und ganz akzeptiert. (n=13)	-	1	7	3	2

Table 1: The table shows how accepted the network representatives consider various quality assurance measures in the practice networks to be. This includes quality indicators, quality circles, treatment pathways, pharmacotherapy measures and peer review.

Einschätzung der Kooperation					
Aussage	Stimme voll zu	Stimme eher zu	Teils/teils	Stimme eher nicht zu	Stimme nicht zu
Aufgaben, Kompetenzen und Verantwortlichkeiten des Netzmanagements sind klar definiert. (n=41)	29	10	1	1	0
Bei wichtigen Themen einer guten Patientenversorgung gelingt es den Netzmitgliedern, Entscheidungen zu treffen, die im Anschluss von allen Netzmitgliedern getragen werden. (n=41)	7	18	13	2	1
Konsentierte bzw. getroffene Entscheidungen werden zeitnah umgesetzt. (n=41)	8	19	13	1	0
Die Zusammenarbeit zwischen Netzmanagement und Netzärzten verläuft sehr gut. (n=41)	19	18	3	1	0
Mitbehandelnde Ärzte im Arztnetz werden zeitnah über relevante medizinische Befunde der von ihnen versorgten Patienten informiert. (n=38)	12	22	4	0	0
Insgesamt funktioniert die Koordination der Patientenversorgung im Arztnetz sehr gut. (n=40)	16	20	3	1	0

Table 2: The table shows how the network representatives assess certain aspects of cooperation in the practice networks.

participating in practice networks.

The further development of digital communication options and technical infrastructure is also cited as a success factor. Standardised solutions for a reliable and comprehensive flow of information between network members could facilitate collaboration and contribute to an intensification of cooperative professional practice. A Germany-wide or at least regional implementation of the electronicpatient file was mentioned by the interviewees in this context.

According to the interviewees, the biggest obstacle to successful participation in the practice network is the heavy time burden on practitioners in their day-to-day work, which makes it difficult to become involved in the network beyond this. Free time would have to be invested in consultation hours and bureaucratic work. This challenge is further exacerbated by the general shortage of doctors. This results in a lack of willingness to devote time to work in the practice network, which is described as relatively time-consuming in terms of administration and documentation requirements.

Finally, a lack of motivation and scepticism towards the network work of individual participants were cited as obstacles. Cooperation could be hindered in the practices by emotional reservations, fear of being controlled by others and concerns about losing patients. Interprofessional cooperation would continue to be restricted by the ingrained habits of some service providers. In this regard, it was stated that a generational change in the medical profession could represent an opportunity for the development of cooperative forms of care. Young doctors in particular could benefit from a coordinated exchange and fill the existing structures with life.

Discussion

The aim of this questionnaire survey was to map the organisation, structures and conditions of cooperation in practice networks in Germany. The results relate to 49 practice networks from different regions.

The analysis shows how heterogeneously the practice networks are organised. This applies to the number of participants, which ranged from 10 to 300, the composition of the specialist groups and the existence of cross-sector collaborations. There were also differences in terms of the legal form of the network, the year of foundation and the level of recognition at the time of the survey. Some of the networks surveyed were still in the start-up phase, while others had already been established for many years. The size and structure of the respective management organisations also differed greatly. The number of employees ranged from 1 to 14, and there were also differences in the training of network employees, which was more economically orientated in some networks and more medically orientated in others.

A diverse picture emerged not only in terms of structural aspects, but also in terms of content and objectives. Although there were focus topics that were frequently mentioned, such as diabetes and heart failure, the 49 networks surveyed named more than 20 different areas in which they specialised.

Further implications emerge from the survey with regard to the use of quality indicator systems. The analysis showed that a wide variety of systems are used, some of which have been contractually agreed with the health insurance funds. A standardised set of quality indicators that is suitable for use in practice networks is desirable in order to enable a comparison between the networks and at the same time take their special features into account. The possibilities for using evaluations of the quality indicators should also be researched here, as there is also potential for optimisation in some networks. Many quality assurance measures appear to have already been implemented. Even if most of them meet with a high level of acceptance, there appears to be a need for clarification, particularly with regard to the quality indicators, in order to increase their acceptance.

In the following, a link will be established between the present analysis and the quantitative evaluation of the performance of practice networks in the ATP project (12). Using quasi-experimental methods, a comparison was made between various practice networks in the regions of Bavaria, Brandenburg and Westphalia-Lippe and standard care. The practice networks scored positively for several indicators relating to preventive services, including vaccination rates against influenza and pneumococci. This is consistent

with the information provided in this survey on the areas in which improvements have been made. The evaluation also showed that practice networks performed better than standard care in some indicators that approximated the adherence of care to guidelines. In this survey, many networks stated that they focussed on specific indications or disease groups. The positive results of the quantitative evaluation could therefore be explained by the fact that treatment pathways or other measures to ensure coordinated care are implemented in practice networks for these focus indications. In the quantitative analysis, it was also noticeable that medications from the PRISCUS list (13) were prescribed more frequently in practice networks and that polymedication was present in a larger proportion of the patients treated. At first glance, this result seems surprising, as the majority of networks implement pharmacotherapy measures in the questionnaires and these are largely accepted by the network physicians. However, it should be noted that a large number of medications could be appropriate, especially for multimorbid patients, after an assessment has been carried out by the treating healthcare providers and undesirable interactions have been ruled out.

To our knowledge, this is the first Germany-wide questionnaire survey on the characteristics of practice networks. The survey contained both descriptive information on the formal structure of the networks and questions on the specific organisation of cooperation in the provision of care. A large number of recognised and non-recognised networks were contacted via the project partners, and a high response rate of 49 was achieved. Nevertheless, this study only represents a portion of the networks in Germany and there may be a selection bias, which means that well-structured networks in particular may have responded. Further distortions could also have occurred in questions in which the network representatives answered on behalf of the participating doctors and, for example, assessed their acceptance of quality assurance measures. Last but not least, the time period of the survey, 2019, must be taken into account. Since then, there may have been changes in the structure of the networks surveyed and in the networks as a whole. For example, according to the KBV practice network monitor, there were already 5 networks with recognition level 2 in 2022 (14).

Conclusion

The organisation of practice networks varies greatly in Germany. Both the structural organisation and the defined objectives and intensity of cooperation are highly heterogeneous. Quality assurance measures are widely implemented, and ways of effective communication within the networks have also been agreed. Some of the established measures are already having an effect with regard to the individually set goals, which could be quantitatively proven. The networks have named a range of goals for their own further development, which must be pursued in order to optimise the quality of care. <<

Literature

1. Blümel, M. / Spranger, A. / Achstetter, K. / Maresse, A. / Busse, R. (2020): Germany: Health System Review. Kopenhagen: European Observatory on Health Systems and Policies
2. Bundesverband der Arzt-, Praxis- und Gesundheitsnetze (2024): Was sind Praxisnetzwerke. https://www.arztnetze.info/praxisnetzwerke/was-sind-arztnetze (abgerufen am 29.08.2024)
3. Kassenärztliche Bundesvereinigung (2022): Rahmenvorgabe für die Anerkennung von Praxisnetzen nach § 87b Abs. 4 SGB V. https://www.kbv.de/media/sp/Rahmenvorgabe_Anerkennung_Praxisnetze_Ausfertigung.pdf (abgerufen am 29.08.2024)
4. Kassenärztliche Bundesvereinigung (2024): Praxisnetzatlas. https://www.kbv.de/html/praxisnetzatlas.php (abgerufen am 29.08.2024)
5. Bammert, P. / Flemming, R. / Franke, S. / Iashchenko, I. / Kropp, S. / Sundmacher L. (2023): Ergebnisbericht: ATP - Arbeitsteilung und Performance empirischer und organisierter Netzwerke im ambulanten Sektor in Deutschland. https://innovationsfonds.g-ba.de/downloads/beschluss-dokumente/443/2023-09-20_ATP-Arztnetze_Ergebnisbericht.pdf (abgerufen am 29.08.2024)
6. Moore, G. / Audrey, S. / Barker, M./ et al. (2021): Process evaluation of complex interventions: a summary of Medical Research Council guidance. https://www.ukri.org/wp-content/uploads/2021/11/MRC-291121-PHSRN-ProcessEvaluationSummaryGuidance.pdf (abgerufen am 29.08.2024)
7. Milde, S. / Arnold, M. (2014): Qualitätsvergleich für Arztnetze. https://www.aok.de/gp/fileadmin/user_upload/Arzt_Praxis/QuATRo/QuATRo_Veroeffentlichungen/G_G_3_2014.pdf (abgerufen am 29.08.2024)
8. Repschläger, U. / Schulte, C. / Osterkamp, N. (2013): Gesundheitswesen aktuell 2013. Köln: BARMER
9. Brünn, R. / Lemke, D. / van den Akker, M. (2021): Ergebnisbericht: AdAM - Anwendung digital-gestütztes Arzneimitteltherapie- und Versorgungs-Management. https://innovationsfonds.g-ba.de/downloads/beschluss-dokumente/369/2023-02-23_AdAM_Evaluationsbericht.pdf (abgerufen am 29.08.2024)
10. Iwen, J. /Liebrenz, C. (2020): Ergebnisbericht: RESIST - RESISTenzvermeidung durch adäquaten Antibiotikaeinsatz bei akuten Atemwegsinfektionen. https://www.vdek.com/content/dam/vdeksite/vdek/themen_vertragspartner/innovationsfonds/2021-04-16_RESIST_Ergebnisbericht.pdf (abgerufen am 29.08.2024)
11. KV Innovations Scout (2018): Praxisnetz Spiegel. https://kv-innovationsscout.de/projekt/praxisnetzspiegel (abgerufen am 29.08.2024)
12. Bammert, P. / Franke, S. / Flemming, R. / et al. (2024): Comparing the quality of care in physician networks to usual care for elderly patients in three German regions: a quasi-experimental cohort study. In: Public Health Jul:232:161-169
13. Mann, N. / Mathes, T. / Sönnichsen, A. / et al. (2023): Potentially inadequate medications in the elderly: PRISCUS 2.0—first update of the PRISCUS list. In: Dtsch Arztebl Int 2023; 120: 3–10
14. Kassenärztliche Bundesvereinigung (2022): Praxisnetzmonitor 2022.https://www.kbv.de/media/sp/Praxisnetzmonitor_Strukturdaten_2022.pdf (abgerufen am 29.08.2024)

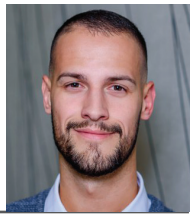
Author's abstract

Philip Bammert, Wiebke Schüttig, Saskia Kropp and Leonie Sundmacher work at the Chair of Health Economics at the Technical University of Munich. The analysis was carried out as part of the ATP physician networks project (01VSF17030) funded by the Innovation Fund. Roman Gerlach from the Association of Statutory Health Insurance Physicians in Bavaria and Matthias Brittner from the Association of Statutory Health Insurance Physicians in Westphalia-Lippe contributed free of charge to the interpretation of the results.

Citation

Bammert et al.: 'Practice networks in Germany: structure, cooperation and focal points? Results of a questionnaire survey', in: „Monitor Versorgungsforschung" (MVF 06/24), S. 53–59. http://doi.org/10.24945/MVF.06.24.1866-0533.2669

Philip Bammert MSc ORCID: 0000-0003-0239-6320
ist wissenschaftlicher Mitarbeiter am Fachgebiet für Gesundheitsökonomie der Technischen Universität München von Frau Prof. Sundmacher. Er studierte sowohl im Bachelor als auch im Master an der Technischen Universität München im Fach Gesundheitswissenschaften. Kontakt: Philip.Bammert@tum.de



Dr. oec. publ. Wiebke Schüttig MSc MBR ORCID: 0000-0003-2669-2933
ist stellvertretende Leiterin und wissenschaftliche Mitarbeiterin des Fachgebiets für Gesundheitsökonomie der Technischen Universität München. Zuvor arbeitete sie als wissenschaftliche Mitarbeiterin am Fachbereich Health Services Management an der LMU München. Sie studierte im Bachelor Economics und im Master Industrial and Network Economics an der Technischen Universität Berlin.
Kontakt: Wiebke.Schuettig@tum.de



Saskia Kropp MSc ORCID: 0009-0003-0922-7797
ist wissenschaftliche Mitarbeiterin am Fachgebiet für Gesundheitsökonomie der Technischen Universität München. Zuvor studierte sie Betriebswirtschaftslehre an der Ludwig-Maximilians-Universität München sowie Gesundheitsökonomie an der Universität Bayreuth. Kontakt: Saskia.Kropp@tum.de



Dipl.-Betriebsw. (FH) Matthias Brittner ORCID: 0009-0005-7829-6387
ist seit 7 Jahren als stellv. Geschäftsbereichsleiter Innovative Versorgungsformen und Praxisnetze bei der KVWL. Zuvor arbeitete er in vergleichbaren Positionen bei der Kassenärztlichen Vereinigung Hessen. Er studierte wirtschaftliches Gesundheitswesen an der FH Gießen.
Kontakt: Matthias.Brittner@kvwl.de



Dr. rer. nat. Roman Gerlach
ist seit 2004 in verschiedenen Funktionen bei der Kassenärztlichen Vereinigung Bayerns tätig. Aktuell ist er als Referent der Geschäftsführung für die Koordination von Versorgungsforschungsprojekten mit KVB-Beteiligung zuständig und wirkt an strategischen Analysen sowie der konzeptionellen Weiterentwicklung von strategischen Informationssystemen mit. Er studierte Physik an der TU München und promovierte an der LMU über Tumortherapie mit Schwerionen. Kontakt: Roman.Gerlach@kvb.de



Prof. Dr. rer. oec. Leonie Sundmacher ORCID: 0000-0001-6057-8363
leitet das Fachgebiet für Gesundheitsökonomie an der Fakultät für Sport- und Gesundheitswissenschaften an der Technischen Universität München. Sie studierte Volkswirtschaftslehre, Gesundheitsökonomie und Politikwissenschaft an der University of York und an der Freien Universität Berlin. Leonie Sundmacher ist seit 2023 Mitglied des Sachverständigenrats für Gesundheit & Pflege sowie Mitglied der Regierungskommission für eine moderne und bedarfsgerechte Krankenhausversorgung beim Bundesministerium für Gesundheit.
Kontakt: Leonie.Sundmacher@tum.de

