A long-term view

# Why is there a problem with outpatient care in Germany?

Despite increasing numbers of doctors and doctor density in the outpatient sector, a care problem has developed in Germany in recent years. Obviously, it is becoming increasingly difficult for patients to get an appointment with a specialist or to find a family doctor or paediatrician. On the other hand, doctors are complaining about increasing utilisation, which they can no longer afford. There are many press articles, political and professional policy statements and scientific papers on this subject [1, 2, 3]. Causes cited include: the shortage of GPs, the increasing utilisation of medical services due to demographics, too few medical school places, the work-life balance of the younger generation and others. The healthcare system in general, and outpatient care in particular, is a system with long latencies in relation to the various (professional) policy measures and attempts at control that have taken place in the past. Therefore, the temporal development of various key figures over several decades is presented and analysed here in relation to today's care problems.

>> Using publicly available data, in particular the fee reports of the KBV [4] and the physician statistics of the BÄK [5], the development of outpatient GP and specialist care in recent decades is analysed and presented. For the sake of simplicity, the following refers to the GP (HA) sector and the specialist (FA) sector, although all GPs have also been required to have specialist accreditation since 1996.

In addition to the development of the total number of physicians and the comparison of the number of physicians in the inpatient area with the outpatient area, the development of the number of physicians in the general practitioner area compared with the specialist area since 1980 is a particularly informative parameter. Other important parameters are the development of physician density, the development of the number of cases, especially the number of cases per physician, whereby the analyses are based as far as possible on the number of physicians according to the extent of participation and not the number of physicians according to 'heads'.

These are only listed in the KBV fee reports from 2013 onwards. However, it can be assumed that the difference before then is only marginal. Furthermore, the development of fees is analysed in a comparison of the two areas. The historical (professional) policy decisions and measures that may have had an influence on the development of the number of doctors in the respective area are presented with regard to the development of case numbers in the respective area. Furthermore, the various measures that had and have the aim of strengthening GP care are listed and a possible connection is discussed. In this way, an attempt is made to identify the causes of the current problems in outpatient care.

## Results

The total number of doctors working in outpatient care has increased continuously over the last few decades (Fig. 1). Whereas in 1960 there were 786 inhabitants for every doctor, by 2023 there will only be 197.

From 2010, the number of doctors in the inpatient sector will increase more than in the outpatient sector (Fig. 1). This means that from 2010 onwards, relatively more doctors have remained in the inpatient sector and switched less frequently to the outpatient sector. The proportion of female doctors has increased significantly from around 10 per cent in 1960 to currently over 50 per cent. A dramatic development has taken place in the outpatient sector in recent decades: As Fig. 2 shows, in 1980 the proportion of general practitioners (HÄ) was 65 per cent and the proportion of specialists (FÄ) was 35 per cent. In 2022, the proportion

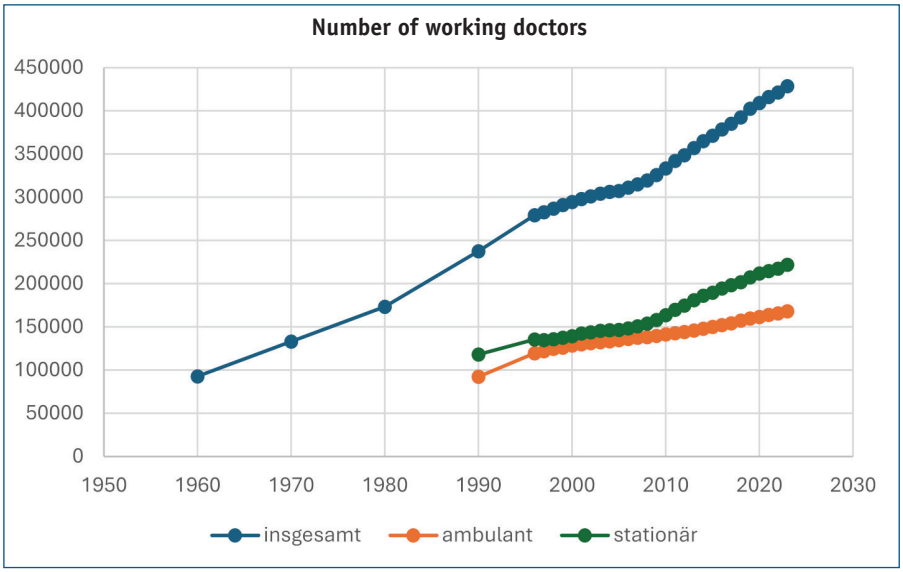



***Fig. 1:*** Number of working doctors in total and by place of work, inpatient or outpatient (Source: own representation).

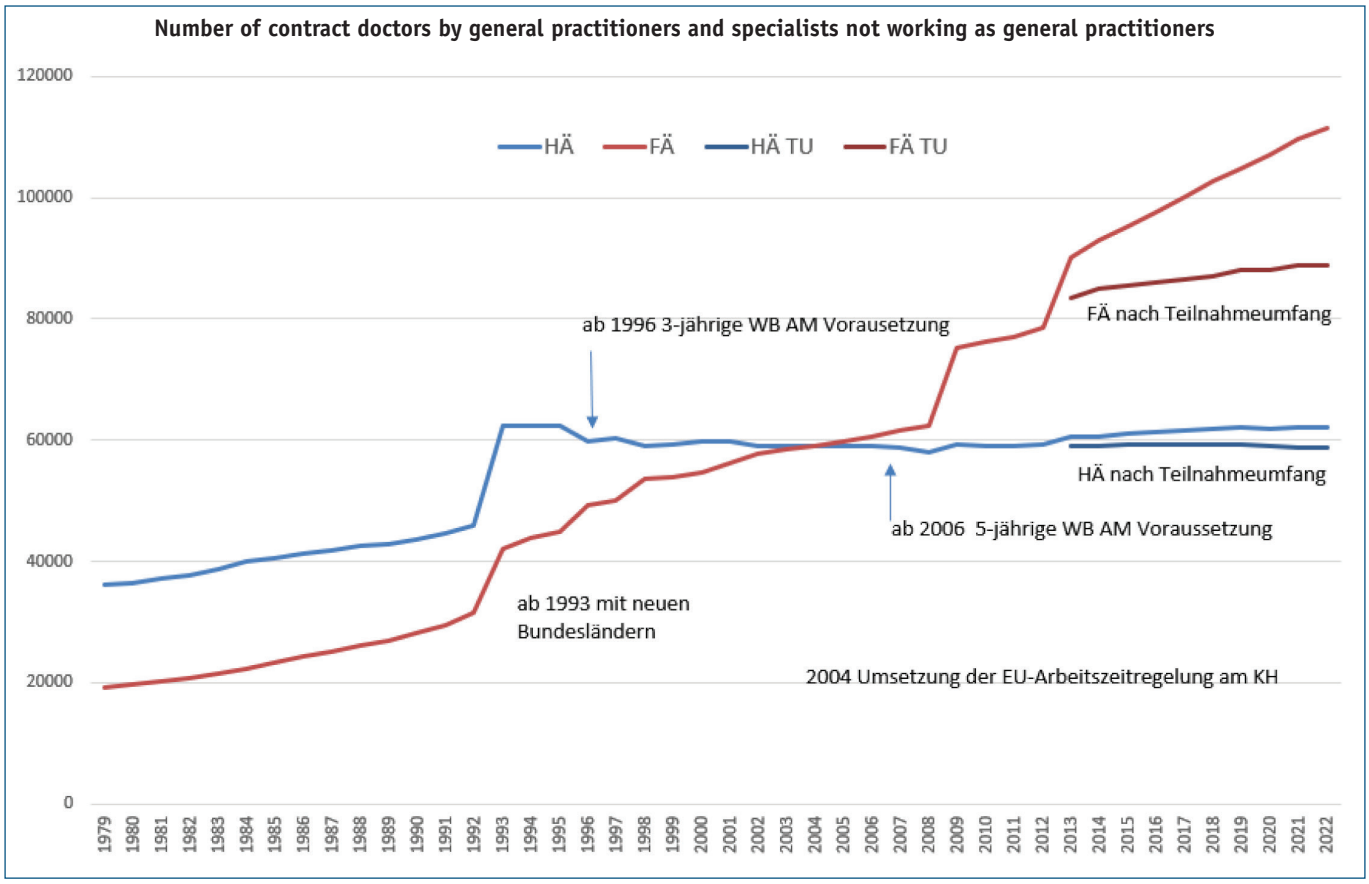



***Fig. 2:*** Number of contract doctors by general practitioners and specialists not working as general practitioners. (Source: own illustration).

of GPs is 40 per cent and the proportion of specialists is 60 per cent. Until 1993, the increase in GPs and specialists was fairly parallel. After a brief plateau phase, however, there was a reduction in the number of GPs in 1996, which continued in the following years. A slight increase can only be observed from 2012 onwards, but only in terms of the number of 'heads'. If we look at the extent of participation in care, the numbers of GPs continue to fall, while they continue to rise for specialists. Since 1996, therefore, more and more doctors who go into the outpatient sector have decided in favour of working as a specialist rather than as a GP. This is also reflected in the proportion of general practitioner specialisations as a percentage of all specialist specialisations (Fig. 3).

This development was already described in the 2014 SVR report [6], without any sustainable measures being taken. An important parameter in relation to care is the number of treatment cases. This has risen continuously, with a dip during the coronavirus pandemic, by 7.2 per cent in the last ten years. This increase is significantly higher than the 4.3 per cent increase in the population over the same period.

If we differentiate between GPs and specialists, Figure 4 shows that despite stagnating numbers of doctors, the number of treatment cases per doctor (based on the number of attendances) is on an upward trend among GPs, while the number of treatment cases among specialists (excluding the treatment cases of laboratory doctors and radiologists) is tending to decline. Looking at the development of fees, it can be seen that specialist fees have risen somewhat more strongly in the last ten years than in the GP sector. However, it was not possible to take into account the increase in fees within the framework of GP-centred care (HZV), as there is no publicly available data on this. It is

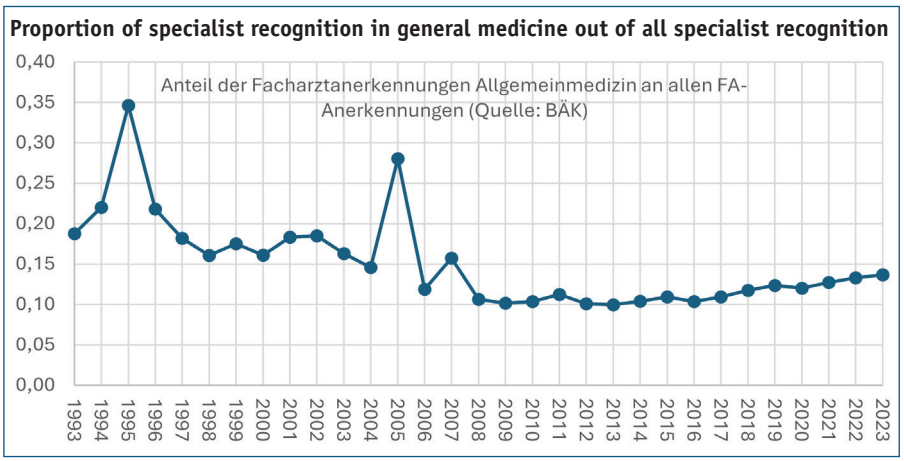



***Abb. 3:*** Proportion of specialist recognition in general medicine out of all specialist recognition (source: own illustration).

estimated that the additional remuneration within the framework of HZV is currently still less than 4 per cent of the KV fee on average nationwide. It should be borne in mind that practice costs vary greatly, particularly among general practitioners. Income outside the KV sector also varies greatly; across all speciality groups, KV fees account for approx. 72% of practice income, while this proportion is approx. 90% for GP practices [7].

Relevant professional policy decisions have been included in Fig. 2:
- 1992 'Lahnstein' Health Structure Act: introduction of authorisation restrictions, age limit for panel doctors (68 years, later abolished), specialist doctor requirement for authorisation as panel doctor [8].
- From 1993 3-year training period for general practitioners.
- From 2004 Implementation of the new EU working time regulations at hospitals.
- From 2006, 5-year training period for general practitioners.

Measures to strengthen general practice:
- Development and expansion of the subject of general practice at medical faculties, establishment of chairs.
- Changes to the licensing regulations: since 2004, 2-week compulsory block internship in general medicine, clinical traineeship in general medicine, elective subject in general medicine, PJ tertial in AM.
- Financial support for further training in general practice since 2010, total funding to date approx. 2.1 billion euros (up to and including 2022)

## Discussion and conclusions

Until 1992, the development of the number of GPs and specialists was roughly parallel, with the proportion of GPs remaining constant at around 65 per cent and the proportion of specialists at 35 per cent (Fig. 2). From 1993 onwards, a drastic change in the development of the number of GPs can be observed. After a brief plateau phase, there was a slight decline, which has continued with minor fluctuations until today. In contrast, the number of medical practitioners continues to rise steadily. Has general practitioner medicine become less attractive or has the work of a specialist become more attractive? What factors could have determined this development [9, 10, 11]?

Despite the diverse, numerous and cost-intensive measures (see above), it has not been possible to significantly increase the number of GPs since 1993. The extent to which these measures have prevented a further decline must remain speculative. The introduction of the regulation in the GSG 1992 that you can only practise as a specialist doctor and the subsequent decisions of the medical associations that the training period in general practice should be three years from 1996 and five years from 2006 could be a major reason why many doctors have decided and still decide against training as a general practitioner.

This is also supported by the development of specialist approvals (Fig. 3), which show a peak in the year before the introduction of the 3-year or 5-year further training as a prerequisite for authorisation as a panel doctor and then continue to decline in the following years until 2013. After that, the numbers slowly rise again, but without this being reflected in an increase in the number of GP contract doctors. These general practitioners either remain at the clinics, where there are an increasing number of posts for general practitioners, or they work part-time in the outpatient sector (or sometimes not at all).

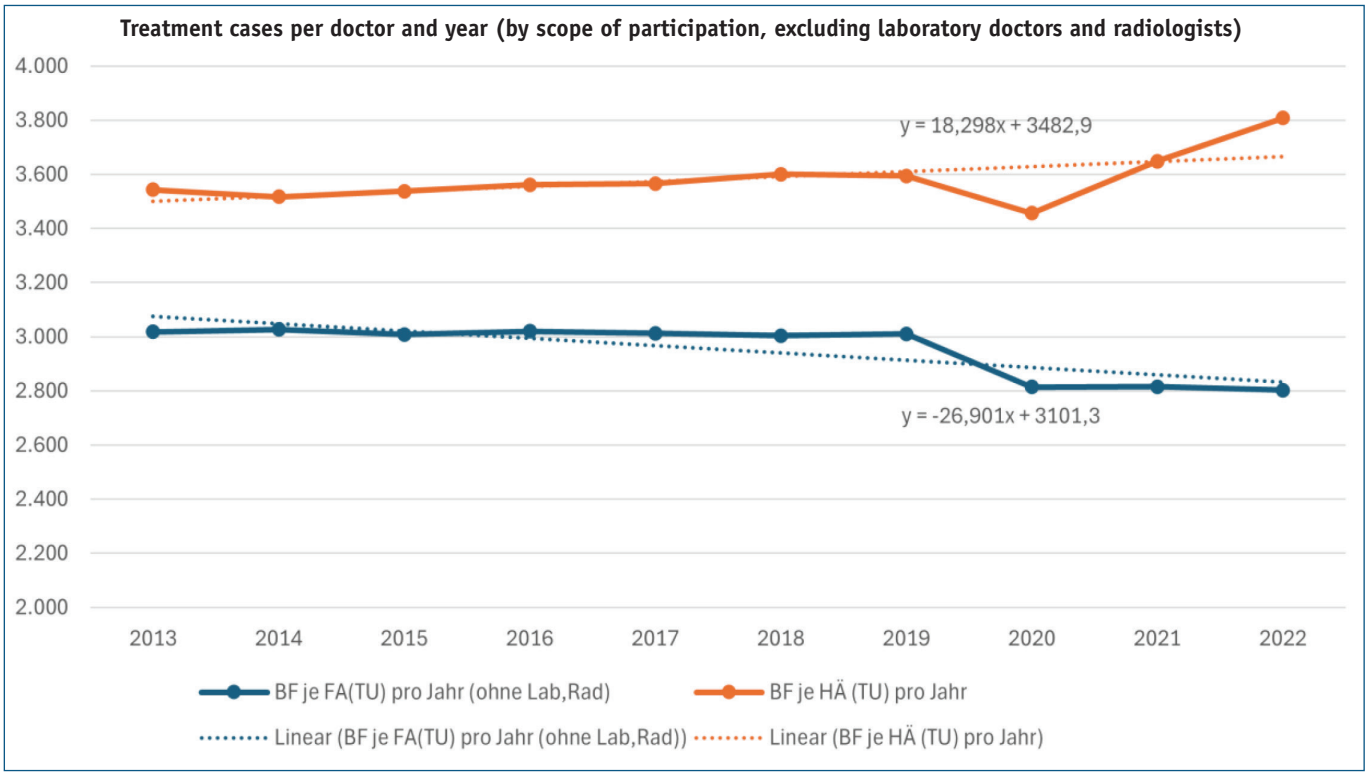



***Abb. 4:*** Treatment cases per doctor and year (by scope of participation, excluding laboratory doctors and radiologists). (Source: own illustration).

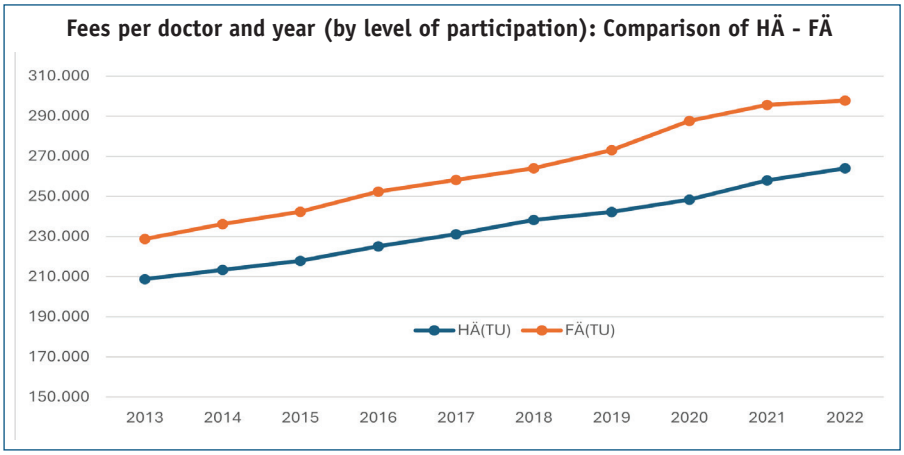



***Abb. 5:*** Fees per doctor and year (by level of participation): Comparison of HÄ - FÄ. Source: own illustration).

It should be noted that these measures were also associated with positive effects: The reputation of the speciality of general practice and the quality of GP work have certainly increased.

The different development in remuneration (Fig. 5) is also likely to influence the decision in favour of specialist training and against setting up as a GP if the training period is the same. The fact that the number of GPs has stagnated over the last 20 years is certainly a major reason for the current supply problems, as a large proportion of acute outpatient care, but also the continuous long-term treatment of chronically ill patients, takes place in the GP sector and the demand for outpatient care services has increased for various reasons.

This demand obviously cannot be compensated for by the significant increase in the number of doctors in the FA sector. Another aspect is the question of the extent to which the increase in regular programmes such as health check-ups, other prevention programmes, DMPs, paediatric check-ups, etc. is 'clogging up' appointments for acute patients. These programmes should be subjected to a critical evaluation if they have not already been done. The reappointment practices in some FA areas should also be scrutinised with regard to their appropriateness and, as far as possible, evaluated using data from the KBV and health insurance funds.

As the various measures to strengthen GP care have not yet had the desired effect, new concepts should be considered as to how the decision in favour of general practice and working as a GP can be made more attractive. One approach could be to change the requirements for authorisation as a contract doctor in such a way that authorisation would be possible after just three years of further training, possibly with a 'specialist in family medicine'. This would be unproblematic under European law, as in some European countries the training period is only three years. After working for a further two years in a GP practice under supervision, a 'Specialist in General Practice' could then be obtained.

Another approach would be to introduce a compulsory 'GP year' for all specialities, i.e. one year of compulsory further training in a GP practice, similar to a 'rural doctor year', as was the case many decades ago. However, this raises the question of funding. Alternatively or in addition, the billing rules should be amended to make acute care in the GP sector more attractive. In any case, new ideas are needed, as previous approaches have obviously not brought any improvement in care and approaches such as the 'rural doctor quota' will only have an impact on care after 12 or 15 years at the earliest. <<

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