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An international comparison of primary care systems: How do other countries organise their care and what can Germany learn from them?

Summary

The term primary doctor system subsumes various systems in which a designated primary doctor should be consulted before accessing specialist care. The introduction of a binding, nationwide primary doctor system to promote targeted care and fast appointment allocation for Germany was recently agreed as part of the coalition agreement for the 2025-2029 legislative period, although the specific design is still under discussion. In the following, we compare the organisation of primary care systems in nine European countries and in Israel and derive implications for Germany.

Keywords

Primary doctor system, primary care, coordination

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Definition

The term primary physician system subsumes various systems in which a designated primary physician should be consulted before seeking specialist care. The primary doctor assumes a central role in the coordination and management of care and the maintenance of a stable, trusting doctor-patient relationship (Popert et al. 2018; Sachverständigenrat Gesundheit & Pflege 2024). While the specific design variants of different primary doctor systems differ, there are some central components that overlap in almost all of these systems. These are registration with a fixed primary doctor, restrictions on access to specialists and hospitals, and restrictions on the free choice of doctor. Furthermore, in most of the systems analysed, primary care is increasingly provided in interprofessional and interdisciplinary. teams (1= (Orchard et al. 2005; IGES Institute 2020).

In an international comparison, primary doctor systems are the rule rather than the exception. In Europe, for example, such systems are established in Italy, Spain, England, the Netherlands and France, but also in the Nordic countries such as Denmark, Finland and Norway (Or et al. 2023; Keskimäki et al. 2019; Bernal-Delgado et al. 2024; Giulio de Belvis et al. 2022; Anderson et al. 2022; Kroneman et al. 2016; Birk et al. 2024; Saunes et al. 2020). Even beyond the European context, the Israeli healthcare system, for example, utilises elements of a primary care system (Rosen et al. 2015). Germany also introduced a voluntary primary doctor system in 2004 with the Act on the Modernisation of Statutory Health Insurance Funds. In what is known as GP-centred care, patients voluntarily undertake to see a regular GP before using secondary care (Gerlach and Szecsenyi 2011). At around 12% of the population (as of May 2025), the enrolment rate is significantly lower than in Denmark, the Netherlands or Norway, where rates of over 90% are achieved despite formal voluntary enrolment - albeit under different institutional framework conditions and incentive structures (Kroneman et al. 2016; Birk et al. 2024; Saunes et al. 2020; Marchildon et al. 2021; Hausärztinnen- und Hausärzteverband 2025b). The introduction of a mandatory, nationwide primary care system to promote targeted care and rapid appointment allocation for Germany was recently agreed as part of the coalition agreement for the 2025 to 2029 legislative period, although the specific design is still under discussion (Popert et al. 2018; Laux et al. 2015; CDU 2025). In this article, we compare the components of various primary care systems and assess their relevance specifically for the German context

>> Demographic change, increasing numbers of multi-morbid patients, shortages of skilled labour, but also growing demands on medical care pose challenges for healthcare systems and their financing (Sachverständigenrat Gesundheit & Pflege 2024; Glonti et al. 2019). For patients, navigating complex and sometimes fragmented healthcare systems independently is time-consuming and tedious (Griese et al. 2023).

As early as 2008, the World Health Organisation recommended that member states' healthcare systems focus more strongly on primary care in order to meet the challenges of our time in an effective, cost-efficient and patient-centred manner (Robert Bosch Stiftung 2015; van Lerberghe 2008). The overarching goal of primary care systems is therefore to strengthen the coordination, care, documentation and integration function of primary care. Ideally, this can lead to cost savings by avoiding medically unnecessary visits to specialists and duplicate examinations as well as the elimination of interface problems between care levels (2) (Klora et al. 2017).

The course of treatment can also be positively influenced by the strengthened, coordinating role of primary care (Klora et al. 2017). As a rule, referrals to specialists are only issued after an initial diagnostic history has been taken by the primary care provider. In this way, information asymmetries between patients and specialists can be mitigated and specialist capacities can be utilised

1: Interprofessional collaboration in healthcare is defined as a collaboration between a team of healthcare professionals from different disciplines and a patient, in which decisions on health and social issues are made jointly and in a coordinated manner (Orchard et al. 2005; World Health Organization 2010). Interdisciplinarity describes the collaboration between different disciplines within a profession (e.g., the collaboration between physicians from different specialties) (Gurtner and Wettstein 2019).

in line with demand. The latter can enable intensified care for patients with high care needs. In high-performance primary care systems with registration, primary care physicians are automatically notified about the treatment progress of their patients in other care levels (Klora et al. 2017; Bodenheimer et al. 2014; Rotar et al. 2018). This improved communication and documentation can prevent treatment errors, as interactions between medications, for example, can be detected more reliably (Sachverständigenrat Gesundheit & Pflege 2024; Klora et al. 2017). In addition, primary doctor systems with registration can also ensure better enforceability of preventive measures (e.g. breast cancer screenings) and better accessibility in the event of a public health crisis (Sripa et al. 2019; Sachverständigenrat zur Begutachtung 2023). Avoidable hospitalisations, for example as a result of acute exacerbations of chronic diseases, can be reduced through intensified primary medical care and preventive measures (Laux et al. 2015; Garrido et al. 2011).

Comparison of primary care systems in 10 countries

Registration for participation in the primary care system

Registration to participate in the primary care system is either mandatory or voluntary in the countries analysed. If it is voluntary, positive and negative incentive effects are used to incentivise the participating actors to take part in the primary doctor system. In most primary care systems, registration is initiated by the patients and supported by corresponding information services on the Internet. Only in Spain, Finland and Norway is there automatic enrolment with a primary doctor based on place of residence. In Spain and Finland, registration is mandatory. In Norway, there is the option of cancelling registration and leaving the primary care system (Bernal-Delgado et al. 2024; Shahaed et al. 2023). In Italy and England, registration is formally voluntary. However, without registration, access to the services of the state healthcare system is not possible. It is therefore a de facto obligation (Marchildon et al. 2021). Registration is voluntary in the Netherlands, France and Norway. In the Netherlands and France, a lack of registration is associated with higher co-payments or disadvantages when making appointments. In Norway, unregistered citizens must pay for visits to primary care providers in full themselves. In all three countries, over 90% of the population is registered with a primary care doctor (Or et al. 2023; Marchildon et al. 2021; Shahaed et al. 2023). In Denmark, Switzerland and Israel, patients can choose between different tariffs or health insurance companies and a primary doctor is only required for some health insurance companies or tariffs. In Switzerland, in addition to the standard insurance with free choice of doctor, there are also alternative tariffs with a link to a GP and telemedicine tariffs. Only in the tariffs with a general practitioner link does the patient undertake to see a regular general practitioner before consulting a specialist. In telemedicine tariffs, a call centre must first be contacted or a digital initial assessment made before a provider can be consulted. In Switzerland, there are also insurance companies that organise care themselves in so-called health maintenance organisations. In Switzerland, these are usually group practices or networks of doctors operated by the insurers. Premium savings are used to incentivise the choice of one of the alternative insurance models (IGES Institute 2020; Sturny 2020; Pietro et al. 2015). In Israel, too, the four health insurance funds are responsible for both financing and providing care. They own some hospitals, laboratories and pharmacies. They can also employ medical providers directly. Registration with a primary care physician is only required for two of the four health insurance funds. The contributions for the four health insurance funds do not differ (Rosen et al. 2015). In Denmark, a distinction is made between two insurance groups.

In group 1, patients are bound to a primary doctor with whom they must register. In Group 2, patients have direct access to most specialist doctors. However, they have to make higher co-payments for visits to the doctor. The fees are set by the doctors and are only reimbursed up to the fees set for group 1. Assignment to one of the two groups is made automatically at birth based on the parents' group. This is Group 1 in 98% of cases, and it is possible to switch online at any time (Birk et al. 2024; Vrangbæk 2020). An overview of the incentive effects used in the various countries and the estimated registration rates is shown in Table 1

Interprofessional teams at the centre

In most of the countries surveyed, primary care is increasingly being provided by larger, more centralised facilities or by networks of different providers. Here, not only general practitioners but also (depending on regional needs) specialists, nurses, psychologists, physiotherapists, etc. work together in interprofessional teams (IGES Institute 2020). In the following, these are referred to as health centres or practice networks. Many of the centres are operated at a municipal level and the services offered are based on specific regional needs (Schaeffer et al. 2015). The interprofessional team is often accompanied by a broad range of primary care services, which, in addition to the usual diagnostic, curative, preventive, nursing and palliative services, sometimes includes gynaecological or family planning aspects and paediatric activities as well as minor surgical procedures. Minor mental illnesses are treated by primary care physicians or specially trained professionals in almost all countries (Keskimäki et al. 2019; Bernal-Delgado et al. 2024; Anderson et al. 2022; Kroneman et al. 2016; Birk et al. 2024)

The delegation and substitution of medical services to academically trained nurses, usually at Master's level, hereinafter referred to as Advanced Practice Nurses (APN)3, plays a central role in health centres. In England, Israel, Finland, Norway, Spain and France, APNs can provide a range of medical services largely independently, e.g. prescribing some medications (Brownwood and Lafortune 2024; Lenz 2022). This often works via a model in which doctors make diagnoses and determine the further course of care. In some

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2: This refers to primary care, generally general practitioner care, as well as secondary and tertiary care. Secondary care refers to care provided by practising or inpatient specialists, usually following a referral from primary care. Tertiary care includes highly complex medical services that are provided in large, specialised hospitals. Tertiary services are usually provided after referral by secondary care specialists or transfer from a secondary care hospital (Klauber et al. 2021).

Overview of registration rates and incentive effects in the ten countries										
	ES	FIN	I	GB	DK	CH	IL	NL	N	F
Ablauf der Registrierung										
Automatische Einschreibung	X	X							X[1]	
Patienteninitiiert			X	X	X	X	X	X[2]		X
Geschätzte Registrierungsquote	~100%[3]	~100%	~100%[4]	~100%[5]	~98%	~60%[6]	~60%	~95%	>99%	90-95%
Anreizwirkungen zur Teilnahme am Primärarztsystem										
Registrierung als Voraussetzung für Inanspruchnahme von Primärversorgern[7]	X	X	X	X					X	
Nachteile bei Terminvergabe durch Primärversorger ohne Registrierung								X		X
Überweisung als Voraussetzung für Inanspruchnahme von Spezialist:innen[7]	X	X	X	X			X		X	
Höhere Zuzahlungen bei Spezialistenbesuchen ohne Überweisung					X[8]			X (100%)		X (70% statt 30%)
Anreizwirkungen zum Abschluss von Tarifen mit Hausarztbindung										
Prämienersparnisse						X (bis 20%)				

Tab. 1: Overview of registration rates and incentive effects in the ten countries. Sources: Spain (Bernal-Delgado et al. 2024; Comunidad de madrid 2025), Finland (Shahaed et al. 2023), Italy (Marchildon et al. 2021), England (Marchildon et al. 2021), Denmark (Vrangbæk 2020), Switzerland (Marchildon et al. 2021; Federal Office of Public Health 2024; Presseportal Schweiz - Medienmitteilungen 2018; Schweizer Forum für Integrierte Versorgung 2023), Israel (Waitzberg and Rosen 2020; Medical Systems 2023; Leumit Health Services 2023), the Netherlands (Marchildon et al. 2021; Shahaed et al. 2023; Patiëntenfederatie Nederland 2025), Norway (Saunes et al. 2020; Marchildon et al. 2021; Shahaed et al. 2023; Sperre Saunes 2020), France (Or et al. 2023; (Marchildon et al. 2021). Legend: 1 = Opt-out is possible; 2 = If a patient is unable to find a primary doctor, their health insurance company is responsible for this Marchildon et al. 2021; (Shahaed et al. 2023); 3 = Some groups of civil servants with private insurance are exempt; 4 = There are also a few exceptions here, such as people with difficulties finding a doctor; 5 = Some exceptions are undocumented migrants; 6 = Approx. 60% of the population have an insurance model with family doctor coverage; 7 = Consultation of private medical providers with private cost coverage is usually possible; 8 = Fees are set by the doctors for those insured in group 2 and are only reimbursed up to the fixed rate for group 1 (Birk et al. 2024).

countries, such as England, patients can also visit the APN directly. Patients are then assigned to a module depending on their condition and receive further treatment from the advanced practice nurses. A presentation to the doctor takes place selectively in the further course (Robert Bosch Stiftung 2015). In the other countries, the scope of services provided by advanced practice nurses is more limited and much is only permitted under the supervision of a doctor (Brownwood and Lafortune 2024).

Table 2 shows an overview of the health centres in each country and the medical staff practising there.

Choice of primary doctor

In Spain, Finland and Norway, citizens are initially automatically assigned to a primary doctor or health centre based on their place of residence. They then have the right to change this (Bernal-Delgado et al. 2024; Shahaed et al. 2023; Comunidad de Madrid 2025). In the other systems analysed, there is usually freedom of choice. In Italy and Denmark, this freedom of choice is slightly restricted to the municipality in which one lives or to a radius of 15 km. Depending on the insurance model chosen, in Switzerland, the Netherlands and Israel it is only possible to see doctors contracted through one's own insurance without higher co-payments (Or et al. 2023; Giulio de Belvis et al. 2022; Birk et al. 2024; Rosen et al. 2015; Shahaed et al. 2023; Pietro et al. 2015; Tikkanen et al. 2020). In England, it is possible to change primary care providers, but they have the right to refuse registration if you do not live in their catchment area.

Initial assessment mechanisms in primary care

Another central task of primary care as the first point of contact for patients is initial counselling and assessment as well as the determination and coordination of subsequent treatment steps (World Health Organization). In England, Finland and Switzerland, structured initial assessment tools are used for this purpose. Patients can answer a series of questions about their symptoms online or over the phone, accompanied by healthcare professionals (usually a carer). The tool provides an assessment of urgency and then either forwards them to an appointment centre, they receive a call back from the healthcare professional or advice on self-care. In an emergency, help is provided immediately (DigiFinland; The Wellbeing Services County of Ostrobothnia; Liu et al. 2023; National Health Service 2022; NHS England 2023a).

In Finland and England, the use of these tools is voluntary (NHS England 2022). In Switzerland, there are insurance tariffs in which the use of an initial assessment tool is a necessary first step before a healthcare provider can be consulted (KPT: Die Krankenkasse mit dem Plus 2025; Helsana).

3: The International Council of Nurses, ICN, defines APNs as generalist or specialist nurses who, through further academic education (at least at Master's level), have comprehensive specialist knowledge, complex decision-making skills and clinical competences for advanced nursing practice. The two most frequently named roles in the field of advanced practice nursing are the clinical nurse specialist (CNS) and the nurse practitioner (NP) (Brownwood and Lafortune 2024).

Overview of health centres and the medical staff working there								
	ES	FIN	I	GB	IL	NL	N	F
Lokale Bezeichnung Gesundheitszentren (Übersetzung aus Landessprache)	**Primärversor-gungs-zentren / Gesund-heitszentren**	**Kommunale Gesund-heitszentren**	**Häuser der Gesundheit, Häuser der Gemein-schaft**	**Netzwerke der Primär-versorgung[10]**	**Primärver-sorgungs-kliniken**	**Gesund-heitszentren**	**Bezirksge-sundheits-zentren**	**Zentren für interpro-fessionelle Gesund-heitsversor-gung**
Personal in den interprofessionellen Teams (kann regional variieren)								
General Practitioner[11]	X	X	X	X	X	X	X	X
Fachärzt:innen für Geriatrie		X						
Ernährungsberater:innen								X
Kinderärzt:innen	X		X					X
Pflegefachkräfte[12]	X	X	X	X	X	X	X	X
Pharmazeut:innen				X				
Physiotherapeut:innen	X	X		X			X	X
Podolog:innen								X
Psycholog:innen	X	X		X		X		X
Sozialarbeiter:innen	X			X				
Zahnärzt:innen	X	X						
Weitere Fachärzt:innen[13]	X	X	X		X	X	X	

Tab. 2: Overview of health centres and the medical staff working there (9). Sources: Spain (Bernal-Delgado et al. 2024), Finland (Deutsches Ärzteblatt 2024; Schmitt-Sausen 2010), Italy (Brownwood and Lafortune 2024), England (Anderson et al. 2022; NHS England 2025; McDermott et al. 2022 May), Israel (Waitzberg and Rosen 2020), Netherlands (Tikkanen et al. 2020), Norway (Sperre Saunes 2020; Ministry of Health and Care Services 2024), France (Or et al. 2023). Legend: 9 = In Spain and Finland, primary care is provided almost exclusively via health centres. In the remaining countries, these are a complementary service to the GP (group) practice; 10 = Mainly general practitioners who work together in networks; 11 = Usually general practitioners or internists (referred to as GPs in German); 12 = Mostly trained to Master's level (also referred to as Advanced Practice Nurse); 13 = Selected according to regional need.

Access to medical specialists and hospitals

In almost all countries, a referral from the primary doctor is required for access to most specialists and hospitals (except for emergencies). Without a referral, specialists generally do not make appointments or are not reimbursed (Keskimäki et al. 2019; Bernal-Delgado et al. 2024; Giulio de Belvis et al. 2022; Anderson et al. 2022; Waitzberg and Rosen 2020; Sperre Saunes 2020; Tikkanen et al. 2020; NHS England 2023b). Selected specialisations can often be visited without a referral (see Table 3 for an overview). Exceptions to this are Switzerland, Denmark and France. In Switzerland, access to specialists and hospitals is generally free, unless you have opted for one of the alternative insurance models (Pietro et al. 2015). In Denmark, specialists are only accessible to insured persons in Group 1 with a primary doctor link with a referral (with a few exceptions, see Table 3). Insured persons in group 2 have free access to almost all specialisations. They pay a higher co- payment for this. In Denmark, a referral is always required for access to hospitals (except in emergencies) (Vrangbæk 2020). In France, referrals for specialist or elective hospitalisation are voluntary. Without a referral, only 30% (instead of 70% otherwise) of the costs of the visit are reimbursed (Or et al. 2023)

Choice of specialist and hospital

The freedom of choice of specialists and hospitals is only slightly restricted in most primary care systems. As the majority of specialists in Spain, Italy, Israel, Finland, England, Denmark and the Netherlands are employees of clinics and other larger facilities, freedom of choice is usually limited to these facilities (IGES Institute 2020; Keskimäki et al. 2019; Bernal-Delgado et al. 2024; Giulio de Belvis et al. 2022; Anderson et al. 2022). In England, it has been possible to choose providers from a list of qualified providers since 2012 (NHS Confederation 2011). In Switzerland, the Netherlands and Israel, freedom of choice is also restricted by the health insurance funds, depending on the chosen tariff. The health insurance funds generally conclude selective contracts with various providers or organise care themselves in Health Maintenance Organisations (HMOs).

The people insured with them can then generally only go to these organisations or have to make higher co-payments if they use a non-contracted provider (IGES Institute 2020; Rosen et al. 2015; Government of the Netherlands 2025). In the remaining countries, patients' freedom of choice is not restricted by law or by health insurance companies (Or et al. 2023; Birk et al. 2024; Saunes et al. 2020). Obtaining a second opinion is generally possible in most systems (Or et al. 2023; Keskimäki et al. 2019; Giulio de Belvis et al. 2022; Kroneman et al. 2016; Saunes et al. 2020; Helsana; Ministry of Health Israel 2024). In Spain, there are regional differences and in Denmark the right to a second opinion is limited to seriously ill patients (Bernal- Delgado et al. 2024; Birk et al. 2024)

Further treatment and information exchange

After hospitalisation and treatment by specialists, the primary doctor is usually responsible for further treatment and coordinati-

Overview of primary care physicians with a coordination and management function and other specialist groups that can be consulted without a referral (14).								
	I	GB[15]	DK[16]	CH	IL	NL	N	F
Primärärzte mit Koordinations- und Steuerungsfunktion								
General Practitioner[17]	X	X	X	X	X	X	X	X
Kinderärzt:innen	X			X	X			X
Alle Fachärzt:innen								X[18]
Medizinisches Personal, das ebenfalls ohne Überweisung aufgesucht werden kann[19]								
Augenärzt:innen	Überweisung immer erforderlich		X	Kann sich je nach Krankenkasse unterscheiden (Helveticare 2023)	X[20]		Überweisung immer erforderlich	X
Chiropraktiker:innen		X	X					
Dermatolog:innen					X[20]			
Gynäkolog:innen					X			X
Hals-Nasen-Ohren-Ärzt:innen			X		X[20]			
Hebammen		X				X		
Hörakustiker:innen		X						
Internist:innen					X			
Kinderärzt:innen					X			
Neurolog:innen								X
Orthopäd:innen					X[20]			
Physiotherapeut:innen		X				X		
Podolog:innen		X						
Psychiater:innen								X
Zahnärzt:innen		X	X			X		X

Tab. 3: Overview of primary care physicians with a coordination and management function and other specialist groups that can be consulted without a referral (14). Sources: Italy (Giulio de Belvis et al. 2022), England (Anderson et al. 2022; NHS England 2024; Jefferies 2024), Denmark (Birk et al. 2024), Switzerland (KPT - Die Krankenkasse mit dem Plus 2024), Israel (Waitzberg and Rosen 2020), Netherlands (Kroneman et al. 2024), Norway (Sperre Saunes 2020), France (L'assurance maladie 2025). Legend: 14 = In Spain and Finland, primary care is provided almost exclusively in health centres; see Table 2; 15 = Since 2024, local services have been able to extend the option of self-referral to other services - based on the needs of the population; 16 = Refers only to insured persons in Group 1. Insured persons in group 2 have free access to all specialisations except physiotherapy, psychology and podiatry; 17 = Usually general practitioners or internists (referred to as GPs in German); 18 = In France, registration is possible for all specialisations. In practice, the majority of the population is registered with a general practitioner (Durand-Zaleski 2020); 19 = Listed specialities are partly counted as primary care providers (dentists, paediatricians, internists, midwives, chiropractors) and partly as secondary care providers (ophthalmologists, dermatologists, ENTs, psychiatrists), who can be consulted without a referral. Gynaecologists are only counted as primary care providers in Israel; 20 = A referral to these providers is required for those insured with the Clalit health insurance fund.

on of the next steps (e.g. physiotherapy) (Keskimäki et al. 2019; Bernal- Delgado et al. 2024; Kroneman et al. 2016; Birk et al. 2024; Saunes et al. 2020). In Denmark, for the first 96 hours after discharge, the hospital is obliged to support the primary physician and municipal healthcare staff in providing further treatment (Region Syddanmark 2025). In France, it is often still up to the patient to coordinate the further course of treatment. An important prerequisite for good cooperation between primary care, specialists and hospitals is information continuity, i.e. the precise exchange of information between different care providers (Saultz 2003).

In most of the systems analysed, information on the course of treatment is shared automatically and digitally and consolidated in an electronic patient file (SBK 2024; Fascicolo Sanitario Elettronico 2025; Healthcare Denmark; Sturm et al. 2025; eHealth Suisse: Competence and Coordination Centre of the Confederation and Cantons 2025; Thiel et al. 2018; Hägglund et al. 2024). In some countries, the level of utilisation of electronic patient records is still too low or there are different systems that are not yet fully integrated (Or et al. 2023; Mon espace santé: Un service de l'assurance maladie ministère de la santé et de l'accès aux soins, santé famille retraite service 2025). Figure 1 provides an overview of the central elements of the patient pathways in the primary care systems analysed - from registration with a primary care physician to access to and selection of specialists and hospitals.

Implications for the implementation of a primary doctor system in Germany

First step towards a primary doctor system: GP-centred care

In Germany, no primary doctor system has yet been implemented in standard care (Popert et al. 2018; Laux et al. 2015; CDU 2025). HZV currently exists as an optional tariff, which the health insurance funds are obliged to offer in accordance with Section 73b (1) SGB V. It is implemented via selective contracts; almost exclusively between health insurance funds and the regional GP and general practitioner associations. Participation has so far been voluntary for patients and doctors (Sachverständigenrat Gesund-

heit & Pflege 2024; AOK Baden-Württemberg; Bundesamt für Justiz; Hausärztinnen- und Hausärzteverband 2025a).Pflege 2024; AOK Baden-Württemberg; Bundesamt für Justiz; Hausärztinnen- und Hausärzteverband 2025a).

If patients opt for HZV, they are required to register with a participating primary care doctor. With a few exceptions, a referral from the primary doctor is required for access to specialists and hospitals. The HZV thus already contains some of the central components of a primary doctor system (Federal Office of Justice). However, a key difference to the countries analysed lies in the degree of incentivisation. While the HZV is based on smaller bonuses and additional benefits such as exemption from co-payments for medicines and health check-ups, the majority of the primary doctor systems analysed use co-payments of up to 100% of the costs for visits to the doctor or significant premium savings (Techniker Krankenkasse 2025). In Switzerland, insured persons can reduce their premiums by up to 20% if they opt for one of the alternative insurance models (Federal Office of Public Health 2024).

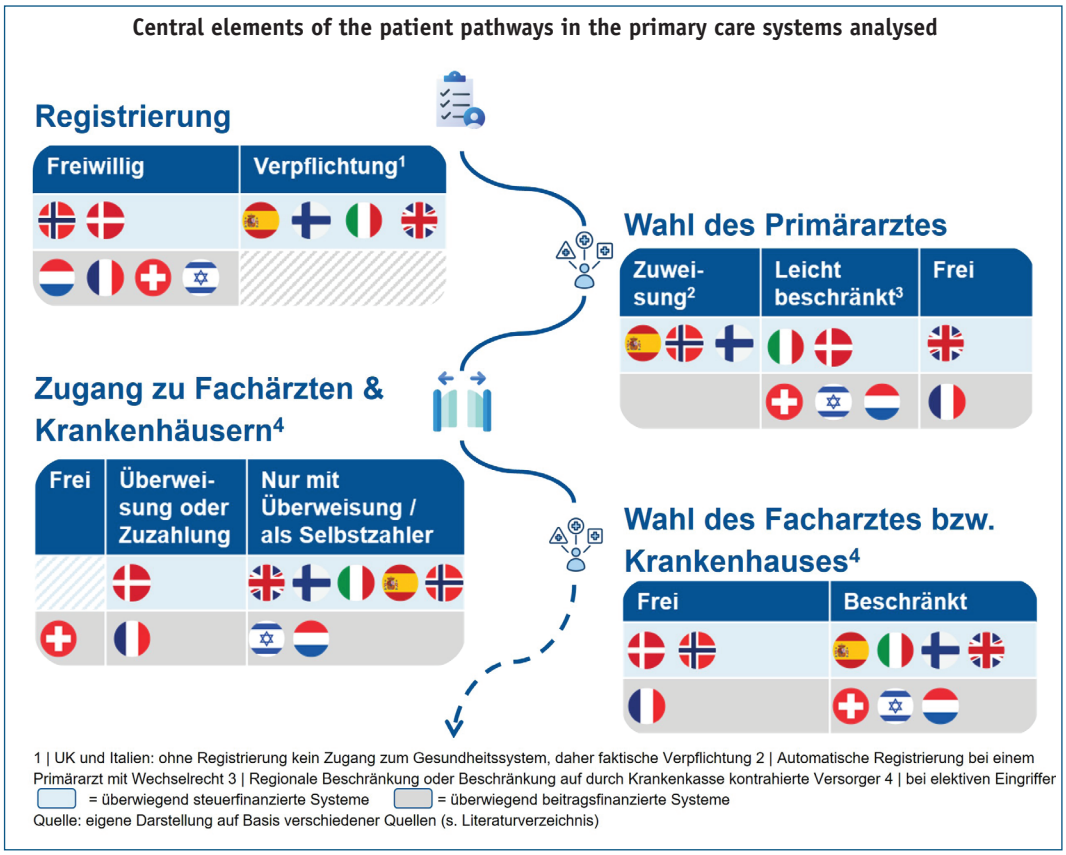


Fig. 1: Central elements of the patient pathways in the primary care systems analysed. Source: Own illustration.

Primary care needs to be strengthened

In Germany, general practitioners fulfil essential tasks of primary medical care. Since the 2000s, however, there has been a shortage of young GPs and regional bottlenecks are jeopardising the provision of GP care, particularly in rural regions (Sachverständigenrat Gesundheit & Pflege 2024; Laux et al. 2015; Robert Bosch Stiftung 2015). In most countries, a primary doctor system is associated with greater utilisation and expanded provision of outpatient primary care services (Laux et al. 2015; Sripa et al. 2019; Shahaed et al. 2023). Strengthening primary care and structural reforms are therefore necessary to enable a nationwide primary care system in Germany. In Germany, for example, academically qualified nurses who relieve doctors do not yet play a decisive role in primary care compared to the countries analysed. Outpatient primary medical care in Germany is still Germany is still very much based on the model of the individual GP practice. In contrast, the primary care systems analysed are usually centred around interprofessional teams that plan, coordinate and provide care for a specific region in line with demand (Robert Bosch Stiftung 2015). In its report for the German federal government on the skilled labour situation in the healthcare sector, the German Advisory Council on Health and Care recommends the establishment of interprofessional teams and the formation of healthcare centres depending on local needs and conditions. The Council is in favour of expansion of the delegation of original medical tasks to specially qualified nursing staff within existing GP practices or practice networks in order to counteract the shortage of skilled labour (Expert Council on Health & Care 2024). A well digitally supported initial assessment, as used in England, Finland and Switzerland, for example, could - if well embedded - provide additional relief and strengthen primary care in Germany. <<

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