

„From a primary physicia into a primary care syste

Im Interview: Prof Dr Boris Augurzky, Adjunct Professor at the University of Duisburg-Essen, Managing Director of hcb GmbH and Chairman of the Board of the Rhön Foundation and publisher of the Hospital Rating Report.

'Major reforms that tackle everything at once will be difficult or even impossible to implement because the forces of inertia in the system are simply too great. However, the number of challenges makes them necessary in the meantime.' In an interview with 'Monitor Versorgungsforschung', Prof. Dr Boris Augurzky, adjunct professor at the University of Duisburg-Essen, Managing Director of hcb GmbH, Chairman of the Board of the Rhön Foundation and publisher of the Hospital Rating Report, speaks out in favour of a major healthcare reform. In his opinion, 'the people who are at stake must be cared for primarily according to their individual needs', and not just by doctors: in a primary care system!

>> In 2004, more than 20 years ago, the first 'Hospital Rating Report' co-edited by you appeared with the title 'The hospital, Basel II and the investment backlog'. Recently - as always with your involvement - the Hospital Rating Report 2025 was published with the headline: 'Emerging from the valley of tears'. The title suggests, on the one hand, that a difficult and stressful phase has been overcome and, on the other, that the transition to a better situation is underway, which always requires the will to act: What do you think is the reason for this rather positive mood?

The situation in German hospitals is indeed very critical. We base this statement on 442 annual financial statements for 2023 plus 174 annual financial statements from 2024, which we have already been able to take a look at. The data shows us that the situation is worse than it has ever been since we started collecting the data. This observation gives rise to the title of the current report, 'Emerging from the valley of tears'. In other words: if you are really stuck in a valley, there is only one way up, provided that you manage to really improve the hospital structures - this must of course be added. This will take a while, but it is essential. If this improves operational efficiency, many hospitals will find their way back up again. The hospital reform currently under discussion offers a number of instruments for this. Here I am not only referring to the specifications for the service groups, but also the incentives for structural changes and the transformation of level 1i hospitals .'

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The recently published Hospital Rating Report 2025 coincides almost simultaneously with the publication of the draft bill to amend the Hospital Reform Adjustment Act, or KHAG for short. This will not only reduce the number of service groups as a basis for hospital planning by the federal states, but will also allow the federal states, in consultation with the state associations of health insurance funds and substitute health insurance funds, to assign a service group to a hospital even if the hospital does not fulfil the relevant quality criteria. In future, it should also be possible to allocate a service group to hospital sites that are being completely or partially closed if the allocation is necessary to implement the closure, even if the hospital does not fulfil the quality criteria. Is this delaying the death of hospitals at the expense of quality? How do you assess the softening of the original hospital reform?

Of course, there are certain points in such a complex hospital reform that need to be readjusted and optimised. There is no question about that. The only question is: to what extent is the BMG softening the reform law? The draft bill that recently became available indicates that the BMG wants to open up the possibility for federal states to make completely free exceptions - provided that the health insurance funds agree to this. This is because each federal state is to be able to define for itself when a hospital is required to provide cover and when it is not. As soon as a federal state has determined this for itself, it can - at least according to the current draft bill - make exceptions in principle. This approach should be criticised from a quality assurance perspective. However, it must be recognised that - let's say - 80 percent quality is still better than no quality at all if, as a result of harshly formulated requirements, there is no hospital at all within reach in a region. Because then the result would be zero quality. But the question is: How do we define 'accessibility'? We need a standardised nationwide definition for this as long as the costs of ensuring hospital operations are borne by the federal government. However, if the federal states want to bear the necessary additional costs for generous exceptions, they can of course make as many exceptions as they want.

But that's not what they want. We have seen over the past decades that the federal states have not necessarily done the best job with their respective state hospital plans, because all too often sheer accessibility was far more important than quality.

In densely populated regions, however, accessibility is usually not a problem. But let's take a look at an area like Mecklenburg-Western Pomerania, where in some regions the nearest hospital is perhaps 60 minutes away. Such a hospital cannot simply be abandoned, even if it is no longer economically viable. For such cases, you need the safeguarding exceptions as an emergency anchor. This in turn requires very clear criteria as to which services must be available within how many minutes of travelling time.

However, the guarantee instrument seems to be used all too readily as a kind of panacea because many federal states have simply failed to further develop their hospital structures in a future-proof manner in recent decades.

That is certainly one reason. The other is that there is a lack of realisation on the part of the federal states to make changes to existing structures as long as the health insurance funds and, in some cases, the districts have to shoulder the higher costs. Even more important, however, is the fact that there are different agendas: Politicians are reluctant to deal with anticipated local opposition - for example, if a hospital or just one department is closed - unless they absolutely have to. This can quickly have a negative impact on election results. Municipalities, districts and federal states therefore each have different interests, which also include the issue of hospitals.

It is therefore all the more impressive that the state of North Rhine-Westphalia has already undergone a major planning reform and can already show initial results. The North Rhine-Westphalian hospital plan could have gone even further, but at least a service group system has been introduced for the first time as a basis for planning.

The KHVVG adds further service groups, but this may not necessarily be the decisive factor. The question of how many service groups are right is open to debate. Maybe the ones from NRW are enough, but maybe you need more benefit groups. Like the DRG system, I would see the service group system as a learning system. Other mechanisms are more decisive, such as the requirements for the service groups and the issue of reserve funding, which we will certainly discuss.

Let's do it. Baden-Württemberg, Schleswig-Holstein and Saxony-Anhalt have now brought an action before the Federal Constitutional Court against minimum volumes in premature infant care. But there is much more at stake: the federal states want Karlsruhe to review the constitutionality of the Joint Federal Committee's guidelines. What would happen if minimum volumes were to be abolished as a quality control instrument simply because these federal states felt that their freedom of hospital planning was being restricted?

This plays into the already mentioned issue that the federal states do not want to be ruled over by restricting their planning freedom through quality guidelines - no matter how evident and sensible they may be. When it comes to hospital planning, lege artis the planning sovereignty lies with the federal states. Conversely, however, hospital financing lies with the federal government, which is also where the minimum volume regulation is based. And this is based on analyses that provide evidence-based proof of a connection between the quality of results and the quantity of treatment. It is therefore in the interests of good patient care. However, the minimum quantity must be set somewhere as a cut-off point, below which treatment should neither be provided nor paid for. The definition of such a point is of course subject to a margin of discretion, because the relationship between quantity and quality is constant, i.e. it does not make any sudden leaps at a specific point. It is not the case that quality is poor below 20 cases, for example, and good from 21 onwards. Therefore, such cut-off points are always pragmatic, but based on a statistical correlation between quantity and quality. In my view, this is legitimate. The constitutional court that has now been called upon has a truly difficult task ahead of it: to weigh up the planning sovereignty of the federal states against the quality demands of patients.

There is also a connection between volume and costs.

Yes, which brings us to the minimum reserve figures that the KHVVG stipulates for the service groups. Only through volume scaling can existing structures be well utilised and lead to the establishment of economically viable operations. Economic efficiency is absolutely essential when you consider the ever-increasing SHI contributions.

Let us address this point. Recently, the Federal Audit Office issued a clear warning shot, warning that those with statutory health insurance in Germany are threatened with further increases in additional contributions. If the increase continues at this rate, the contribution rate points will grow year on year, which will cause significant problems for both the economy and private individuals. This shows that even something as solitary as a hospital reform is part of the meta-system of affordability and overburdening of the population and society.

At the end of the day, we must realise that our healthcare system can only take up a certain proportion of our gross domestic product. According to the Federal Statistical Office's forecast, this is currently 12.5 per cent for 2024, and the trend is still rising.

This puts us well ahead of the rest of Europe and even the world.

But the times have changed. Today, we also have to face up to the debate about how much of GDP we want to spend on defence: That is 3.5 per cent, perhaps even 5 per cent temporarily. Germany spends two and a half times as much on health alone compared to defence, around 500 billion per year. On top of this, the GDP shares for pensions and social security are increasing. To make matters worse, gross domestic product has been stagnating for years and has even fallen recently. This presents us with a double problem: if the cake is no longer getting bigger overall, but everyone wants more, ...

... because, for example, in the run-up to the funding negotiations between health insurance funds and GPs, the Virchowbund, the association of doctors in private practice in Germany, is demanding at least 7 per cent more money for outpatient care for patients.

Politicians will then be forced to make cuts elsewhere: in defence, pensions and social services. These are the biggest spending blocks. However, the majority of the electorate will not put up with this because everyone wants to maintain the prosperity they have achieved as best they can. I therefore agree with the Federal Audit Office when it calls for cuts in the system in the form of measures that stabilise the financial situation of the SHI system in the short term and cover all relevant service areas. Incidentally, my colleagues Karagiannidis, Alscher and I have described all of this in the book 'Die Gesundheit der Zukunft' (Editor's note: see page 38 for review). In it, we pointed out very clearly that the social security contribution rate will rise from the current 42 per cent to over 50 per cent by 2035. If this happens, the economy will be stifled even more and the slice of the pie that we can use to finance our healthcare system will automatically become smaller. Mind you, it will get smaller and not bigger, as some people seem to mistakenly believe.

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We have now reached the absolute meta-level: no hospital reform, however good and stringent, will suffice here. Instead, we need structural reforms that are as bold as they are holistic, for example a primary care system that includes all areas - from inpatient to outpatient, from emergency to rehab and from prevention, care to social services. The coalition agreement only mentions a primary care system, although no-one knows where the doctors needed for this will come from.

However, major reforms that tackle everything at once will be difficult or even impossible to implement because the forces of in-

ertia in the system are simply too great. However, the sheer number of challenges now make them necessary. Instead, the persistent forces are banging their heads against the wall for as long as they can, perhaps hoping that they can somehow get round the wall in time.

Okay, one by one: what do you think of the primary care system mentioned in the current coalition agreement?

It's right that we are looking into it. But we need to think about the primary doctor system further and - as you rightly say - develop a primary care system in this country. We need to provide the people we are concerned with with primary care according to their individual needs, and not just in a purely medical sense. GPs are too valuable and too limited a resource for this.

The Central Institute for Statutory Health Insurance Physician Care, or Zi for short, expects an additional 200 to 2,000 contacts per year for GP practices as a result of a new primary doctor system. That would be around two more contacts per day per GP practice. That seems feasible.

In regions where there are still enough family doctors, this will certainly be the case. Unfortunately, however, there are many regions, especially in rural areas, where no successors can be found for family doctors who are retiring and therefore want to sell their practices. In these cases, the additional workload generated by a primary care system cannot be managed on its own. The only solution is to redistribute tasks by changing the way services are provided, which has traditionally been focused on doctors. It is wrong to focus solely on medical resources in this area. We must learn to think more in terms of teams. By this I also mean independent nursing professionals such as community health nurses who look after a community or district. Where necessary and appropriate, they consult with a doctor—via telemedicine, of course. Firstly, this will mean that healthcare can be provided even when a doctor is not available on site, and secondly, it will reduce the demand for medical services.

For all of this, however, it is essential that we finally get to grips with digitalisation.

Above all, it is crucial that all players in the healthcare system are integrated into the electronic patient record system, or ePA for short. Everyone - patients and service providers alike - must be able to access the data relevant to them. This is where the third point comes into play: Of course, in addition to human intelligence, we will also need to use artificial intelligence in the future to analyse data intelligently, make diagnoses and recommend therapies. All of this could already be done today with the resources available and is also being done in some cases in other countries. Digitalisation is the great ray of hope for increasing the efficiency of healthcare and avoiding rationing.



Prof. Dr. Boris Augurzky

handed over the management of the 'Health' competence area to the next generation in October and is now still available to RWI as health policy spokesperson, having been head of the competence area from August 2003 to September 2024. He is an adjunct professor at the University of Duisburg-Essen, Managing Director of hcb GmbH and Chairman of the Board of the Rhön Foundation.

His work focuses on the inpatient healthcare sector, issues relating to the reform of the healthcare system and the evaluation of policy measures. Among other things, he is the author of the Hospital Rating Report.

He was part of the 'Government Commission for Modern and Needs-based Hospital Care' of the Federal Ministry of Health.

Then, in the area of healthcare, it is primarily about a mandatory, nationwide primary doctor system that is no longer voluntary, such as the HzV system that has been successfully trialled in Baden-Württemberg for years.

Patients in Germany are used to choosing the service providers they believe will provide them with the right treatment. They are happy to go to a doctor two or three times in parallel until they think they have found the right one.

Even if it is only that the doctor pulls out the prescription pad and prescribes the desired medication.

This mismatch only occurs because our healthcare system is largely free of charge for the individual and we lack transparency due to the lack of an ePA. The absolutely necessary and sensible matching of demand with the right supply is the task of a primary care model.

Who outside of politics could think about such a primary care model and, above all, drive it forward?

We feel somewhat abandoned because politicians seem to be so silent on the subject of healthcare. We can only hope that federal politics will once again take on the important task of organising the health sector.

Let's hope for an eventful and insightful autumn.

Let's hope so. The aim of this legislative period will be to establish a coordinating primary care system in combination with the ePA.

Let's not kid ourselves: In the end, the

decisive factor will be how demand can be reduced without people suffering and still receiving adequate care. And that the efficiency of service providers is finally increased.

Here you are also implicitly addressing the issue of bureaucracy, which plays a major role because a lot of scarce resources are tied up here. But existing structures also need to be scrutinised and the cost-benefit ratio of services made more transparent. Here too, a functioning ePA will be a game changer: For example, it would finally make it clear which treatment pathways bring which benefits and also which costs are incurred.

„Which hospital do we define as necessary at the moment?"

Let's briefly return to the valley of tears you described. Professor Busse from the TU Berlin often explains that 400 hospitals could actually provide sufficient care. The only question will be, are they the right ones that are dying if the figures are as bleak as you analysed in the Hospital Rating Report with the figures for 2024?

Let's start with the thesis that 400 hospitals are actually enough to ensure adequate care. This statement is basically correct if you follow a greenfield approach. We also did this once and plotted on a map of Germany where the best locations should be placed in terms of accessibility and availability. The result is actually around 400 houses, perhaps even a few fewer, depending on how strictly you define the accessibility measures: The difference between 30 or 40 minutes accessibility makes a big difference here. But that is not the decisive factor. The important thing is that this greenfield approach is impractical as long as we are not willing to rebuild the entire hospital landscape. Of course, in individual cases, hospitals may be located exactly where they would be in a greenfield approach. But that will be pure coincidence, most of them would have to be rebuilt. That costs an enormous amount of money and even more time, which we no longer have.

So we will end up with 800 or 1,000 sites after all.

Which would also be a big step and affordable with the help of the 50 billion euro transformation fund. With the help of the transformation fund, the current number of around 1,700 sites could be reduced to around 1,200 by relocating and building new centralised clinics, plus around 350 level 1i clinics.

The question remains: In the event of bankruptcy, will exactly those remain that we need to provide care?

That cannot be guaranteed. We would first have to define what 'right' means. Does 'right' only mean the maximum care providers? There are also medium-sized hospitals or specialised clinics that deliver good quality. However, if you analyse the economic situation of the hospitals, you can see in our rating that the smaller basic care providers are more likely to be affected by a possible bankruptcy. However, maximum care providers are also at risk. Generally speaking, hospitals in the middle range - between 500 and 900 beds - can operate reasonably well economically. However, there are always exceptions to the average.

What would be a survival strategy?

For example, if you have two or three primary care providers in a district, you should merge them into one larger unit if accessibility allows. This is not only good for profitability, but also for the quality of care, because there has to be a certain minimum size for both. And if a new, larger central hospital is built in the centre of the region, it may even be possible to achieve a higher emergency level, which will benefit the population. Whatever happens: Politicians and hospital operators will have to take active steps. It won't help us to let everything continue as before. Otherwise we will never have a sustainable target structure.

This brings us almost automatically to the subject of reserve funding. There is a quote from Dr Reimann from the AOK-Bundesverband, according to which this is a technical distribution instrument with no recognisable added value. She is therefore in favour of demand-oriented reserve financing.

This criticises the fact that the reserve budgets are calibrated by the respective previous year's case numbers of a hospital. Basically, this means that a hospital enters the world of reserve funding with its previous case volume. One can regret this and call for independent, demand-orientated reserve financing. But which hospital do we currently define as need-based? We also need a smooth transition from the old to the new system. This means that when reserve funding is introduced, it must be based on a hospital's previous case numbers. If this is not done, shockwaves will run through the system because many hospitals will quickly reach the point where they can no longer pay their staff due to excessive revenue fluctuations during the introduction. For example, some hospitals would suddenly have 25% less revenue if the reserve funding was suddenly calculated on a population basis. This is only possible in the target scenario, which must then be approached in a longer convergence phase.

You could also consider a primary care system based on the regional budget.

That's right. In the meantime, especially in rural areas, neither inpatient nor outpatient care is working well or is even future-proof. There, more and more hospital operators are being pressurised to provide outpatient care because the population is understandably exerting corresponding political pressure due to the gradual disappearance of outpatient care structures. So let's take a regional hospital reserve budget of - let's say - 60 million euros and add the corresponding outpatient budget to it. Now we need someone to take responsibility for the budget and care. A large hospital is naturally better placed to do this than many small medical practices, of which there are fewer and fewer anyway.

So we need a kind of system-preserving transition.

Yes, in the target scenario, a population-based budget for care in a region would actually make sense. This would mean that the existing services in a region would not be paid for what they currently provide, but for what is required to provide care to the local population. In the Government Commission, we considered models for this type of population-oriented approach and argued in favour

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of introducing them in the long term, at least in regions with clearly defined catchment areas. However, supra-regional specialist clinics and maximum care providers must be considered separately.

And the organised medical profession would be upside down.

Not in certain regions. Comprehensive primary care models with regional budgets can be an opportunity in difficult, already underserved regions. There are some of these in the new federal states, but also some in the old federal states.

Do such models already exist?

The healthy Kinzigtal or one of its offshoots or even Templin could be the nucleus of such a model. However, hospitals plus prevention and rehabilitation would always be needed to form a real regional budget for outpatient and inpatient care - ideally including care for the elderly. If it only included outpatient care, the leverage of a budget model would simply not be large enough. <<

Professor Augurzky, thank you for talking to us.

The interview was conducted by MVF Editor-in-Chief Peter Stegmaier

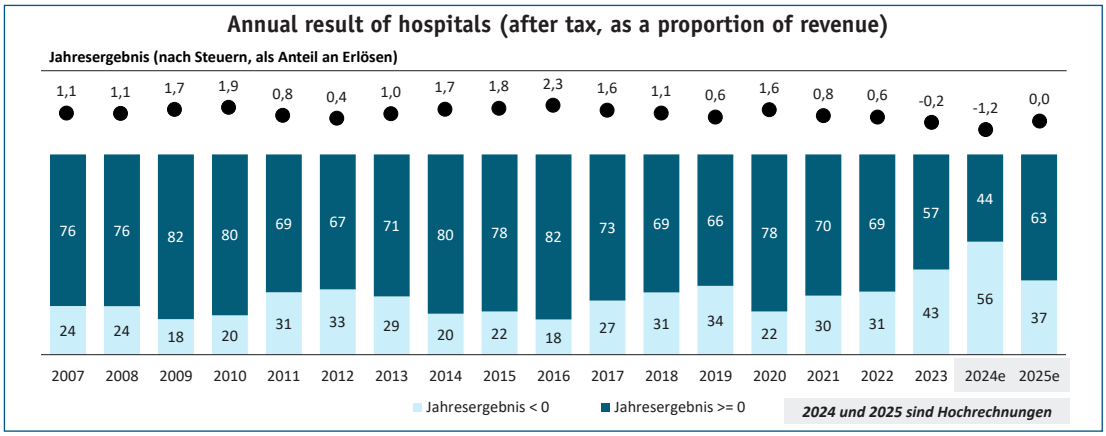


Fig. 1: Annual result of hospitals (after tax, as a proportion of revenue). Source: Hospital Rating Report 2025

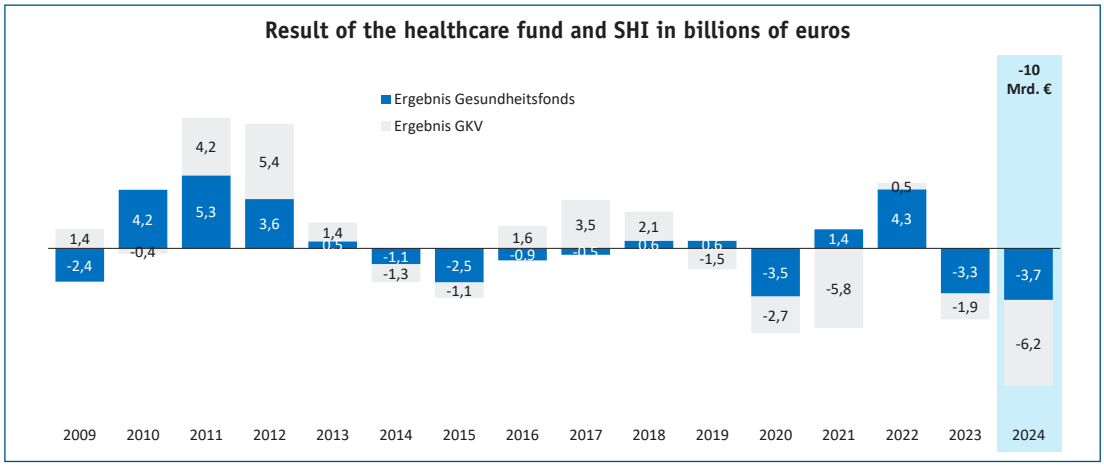


Fig. 2: Result of the healthcare fund and SHI in billions of euros.
Source: Krankenhaus Rating Report 2025, beide Abbildungen wurden freundlicherweise von Prof. Augurzky für MVF zur Verfügung gestellt.