BMC Spotlight "Five building blocks for primary care reform"

BMC presents roadmap for primary care

"Uncoordinated interfaces, sector boundaries, duplicate examinations, unnecessary re-appointments, long waiting times and digitalisation that has so far been little used lead to inefficient and uneconomical care. This places a burden on patients, but also on service providers. All areas of care are affected," writes the Federal Association BMC e. V. in its current spotlight entitled "Five building blocks for primary care reform" (1).

>> According to the association, the answer can only lie in improved organisation, coordination and quality of healthcare, supported by modern care and remuneration structures, networked data and interprofessional collaboration. The key to this goal is a strong primary care system, and several neighbouring European countries have already taken this path. Here, the BMC cites the scientific article "Primary care systems in international comparison: How do other countries organise their care and what can Germany learn from them?" by Gina Wittlinger MSc and Prof. Dr oec. Leonie Sundmacher MSc (2), which was recently published in "Monitor Versorgungsforschung".

Like this article, the BMC understands the term "primary care" to mean not only a system of primary doctors, but also "interprofessionally organised healthcare close to home with the aim of providing low-threshold, coordinated and continuous healthcare, in which citizens are directed to the right place in the system based on their needs - be it GP, specialist or non-medical".

Coordinated and interprofessional cooperation between all those involved is the linchpin. The reform should also be centred around structured, recorded reasons for treatment as a starting point and treatment pathways for the coordinated continuation of treatment.

It is also crucial to link this reform with the reorganisation of the hospital landscape and emergency care in a meaningful way: the financial effects of better coordination should have a significant impact there, as already proposed by the German Council of Economic Experts for the Assessment of Developments in Healthcare and Long-Term Care (SVR) in its 2024 report (3). Important steps towards better management have also already been taken with GP-centred care and disease management programmes (DMPs). According to the BMC, these have shown that "coordinated care can improve

care and increase the quality of results". Here, the association cites the 2018 evaluation of GP-centred care (HZV) in Baden-Württemberg, carried out by Goethe University Frankfurt am Main (Department of Medicine, Institute of General Practice), Heidelberg University Hospital (Departments of General Practice and Health Services Research as well as Clinical Pharmacology and Pharmacoepidemiology) and the aQua Institute for Applied Quality Promotion and Research in Healthcare GmbH (4), among others.



The BMC believes that the **first key** to sustainable healthcare is a reform that requires trust among citizens, patients, healthcare professionals and payers: "It needs support and a design that focuses on a few, comprehensible but effective elements rather than an excessive density of rules. The aim is to achieve the highest common denominator in the healthcare system and to trigger positive momentum and further development with practicable proposals. This can only be achieved through dialogue and requires those involved to have the courage to change."

The BMC sees the **second key** to a successful reform in focussing on three overarching goals that need to be translated into measurable indicators. In addition to traditional structural and process indicators, systematically collected patient experiences should also be taken into account:

- Improve access and strengthen coordination
- manage and work effectively
- Improve care and health

According to the BMC, these objectives in turn require five clearly defined, interlocking building blocks, which is referred to as the **third key**. The central

innovations here are **ad 1** an event-related, structured, standardised initial and urgent assessment, which opens up access to the right level of care, **ad 2** expanded coordination and management of care by primary care practices, centres and networks close to the patient's home and **ad 3** a referral and appointment service.

These building blocks would be based on a "telematics infrastructure for primary care", which would require further digitisation of care in particular. Building on this basis, further services could be gradually integrated, as shown in Figure 1:

Furthermore, existing DMPs should be further developed accordingly, as the BMC already outlined in its 2023 position paper "DMP 2.0" (5). Prevention and early detection services, digital health solutions and regionally coordinated interprofessional treatment pathways and collaborations would also be added.



Fig. 1: **Primary care building blocks. Source: BMC spotlight "Five building blocks for primary care reform". Own illustration.**

Citation reference

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However, the broad spectrum of tasks in primary care also makes it necessary to organise care units in such a way that they can optimally cover different needs. Different organisational forms such as primary care practices, centres and networks can be subsumed under the generic term primary care units. These can be organised as larger individual practices, as a cooperative network of several practices or as a health centre, physically on site or

decentralised and digitally networked. There are already numerous examples of new forms, such as group practices, "team practices", MVZs, medical centres or in cooperation with local partners and in practice networks. The trend is towards larger, networked units that integrate digital and on-site services, work interprofessionally and combine various healthcare professions and medical specialisms under one roof.

This could also be developed locally as a decentralised network and in cooperation, taking regional characteristics into account. Regardless of the form, primary care units must fulfil minimum staffing and quality standards and provide medical and nursing expertise.

Other locations and professional groups such as pharmacies, physiotherapists and community health nurses should be included in a continuum of care, as already called for in the BMC impulse paper "Team Health" with its call for "flexibilisation of interprofessional cooperation" (6).

The reform of primary care aims to modernise structures, make use of digitalisation and at the same time noticeably reduce the burden on practices and clinics. This is the **fourth key** for the BMC. In view of demographic change, this must be a central goal for the coming years. This would result in both investment and financing requirements as well as profitability gains, which should be included in a multi-year transformation calculation. It is equally important that incentives and remuneration reflect the reform objectives and are successively weighted more heavily. According to the BMC, the building blocks outlined here make it possible to develop a roadmap in which the individual measures are organised in a sensible chronological order.

For patients, the reform of primary care outlined above all means orientation and reliability. Rare users would be given direct access via the structured initial assessment, chronically ill patients would benefit from continuous support and clear care pathways, and everyone would gain from better accessibility, reliable appointment organisation and transparent documentation, according to the BMC. The BMC: "The reform is working in line with people's expectations; the GP orientation and functioning special forms of care such as GP-centred care are an advantage here. We must not fail to provide the population with comprehensive information about the changes so that the reform is accepted and can realise its intrinsic value."

Finally, a comprehensive digital update is the **fifth key**. To achieve this, the reform of primary care must be combined with the digitalisation boost that people have long been expecting, both in terms of infrastructure and in practices and facilities. Only a reliable and interoperable infrastructure will

make it possible to seamlessly link the new elements, from structured initial assessment and appointment scheduling to cross-sector care. In order for digital solutions to realise their potential, practices need a "digital update". This means modern equipment, user-friendly applications and consistent integration into care processes. <<

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Literature: 1: https://t1p.de/ij4c6 2: https://t1p.de/skyx0 3: https://t1p.de/5iaqt 4: https://t1p.de/yc68t 5: https://t1p.de/rogxj 6: https://t1p.de/m04yq