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More management in primary care – ways to improve care processes

For years, international surveys have shown a gradual loss of confidence in the performance of healthcare systems (IPSOS 2024). In Germany, long-term data from private insurers show that the proportion of respondents who are satisfied with the performance of the healthcare system is tending to decline (Continentale Krankenversicherung a. G. 2024). Similar patterns can be found in comparative European studies: the proportion of respondents who complain about long waiting times or perceive the system as "overburdened" has risen significantly (OECD/European Commission 2024); at the same time, the proportion of those who report good access to high-quality care is declining (MLP Finanzberatung SE 2022). This development is taking place in an environment in which the demands on care are increasing due to demographic change and multimorbidity, while the shortage of skilled workers is limiting the available resources. This discrepancy is particularly noticeable where initial and ongoing care takes place – in primary care. This explains why it has slowly been gaining public attention in recent years. This article attempts to convey an idea of the pressing problems facing primary care and to emphasise the need for a pragmatic approach to reform that directly addresses the problems rather than relying on complex structural adjustments to make them disappear.

1. Health policy in Germany

After almost 15 years of public disregard for the topic of "healthcare reform", the topic of "hospital reform" has made its way back into the debate for the first time in the last three years, albeit largely limited to the professional public (Berlin-Brandenburg Academy of Sciences and Humanities (BBAW) 2025). To a much lesser extent, but steadily increasing, the topic of "primary care" has also been discussed publicly for the past five years.

1.1 Current reform debates

It is noteworthy that both reforms are primarily concerned with tackling structural changes rather thanseeking more direct solutions to obvious process oroutcome problems. For example, hospital reform involves assigning hospitals to "care levels" and allowing or denying them the billing of "service groups". The primary care reform involves, among other things, prohibiting patients from consulting specialists directly. In both cases, the idea is that these measures will solve numerous quality and efficiency problems, such as excessive mortality in hospitals and the reduction of duplicate examinations, which lead to additional financial costs.

Summary

Background: In many industrialised countries, public dissatisfaction with the healthcare system is growing. International surveys show increasing criticism of waiting times, perceived overload of the systems and declining perceived quality. At the same time, demographic factors are increasing demands, while human resources are limited. The deficits are particularly evident in primary care, i.e. where patients have their first and most frequent contact with the healthcare system.

Objective: This article develops the concept of more management-oriented primary care. It focuses on the thesis that systematic control of care processes – technically supported by an "ERPartiges" data and process model – can lead to noticeable improvements for patients more quickly than purely structural reforms. The article argues that measurable improvements in the patient experience depend less on the 'right structure' of primary care than on the systematic management of everyday care processes.

Methodology: The article is based on a selective evaluation of current international studies on patient experiences (including OECD PaRIS, Commonwealth Fund, IPSOS Health Service Report) and German studies on health literacy and overprovision. In addition, two real-life care constellations from primary care are reconstructed to illustrate typical weak points.

Results: The analysis reveals a wide range of recurring problems: lack of coordination between practitioners, breaks at sector boundaries, insufficient information, high personal effort on the part of patients, untapped potential for self-management and lack of continuity. These problems can be classified using the internationally established 4C model of primary care (first contact, continuity, comprehensiveness, coordination). A modification of this model is proposed: primary care is understood as a network of several entry points, coordinated via a common data model and standardised process paths. Two case studies (ankle fracture, recurrent loss of consciousness) show how such a model can specifically improve care by avoiding redundancies, reducing "blind spots" and systematically triggering follow-up actions.

Conclusion: Public, technology-related governance (e.g. by an institution such as Gematik) and a competitively organised range of certified technology products are key prerequisites. In addition, incentive systems must be created for service providers and insured persons that reward the use of this process support. In this way, focusing on care processes can take the pressure off the debate about "the right structure for primary care" and at the same time lead to noticeable improvements for patients in the near future.

Keywords

Primary care, care processes, care management, coordination, electronic patient records, healthcare system performance

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1.2 Focus on structure

The structural bias of many reform debates (not only in the health care system, but also in the education system, for example) can be explained as an expression of the German political style of negotiated democracy. In political science discourse, negotiated democracy (following Lehmbruch) described as a type of system in which the majority principle and party competition take a back seat to decision-making through bargaining – especially where the federal constraints of agreement between the Bundestag and Bundesrat shape the political process in the case of laws requiring approval (Mayntz and Streek 2003).

Under such conditions, reform elements that can be packaged as legally unambiguous, distribution-relevant packages become politically "manageable": division of competences, planning responsibilities, financing logic, minimum and reserve requirements, catalogues or new institutions. Process reforms (such as new coordination routines, cross-sector treatment pathways, digital workflows), on the other hand, are more difficult to negotiate and guarantee because they interfere heavily with professional practice, are context-dependent and require ongoing monitoring and adjustment.

Scharpf describes the extent to which institutional logic dominates in such constellations using the example of federalism reform: The central negotiations did not focus primarily on substantive problem analysis and solution-seeking, but rather on the self-interests of the veto players and criteria of legal consistency and constitutional systematics – a pattern that favours structural debates over procedural control (Scharpf ca. 2010).

In the healthcare sector, this tendency is reinforced by the particular constellation of arenas and actors: Bandelow describes German healthcare policy as a network of interlinked arenas that is negotiated on a consensus-oriented basis and in which both competing party blocs and numerous interest groups have opportunities to block new solutions. In such a setting, political influence typically focuses on structural parameters (rules, responsibilities, institutional architecture), while the concrete design of processes often shifts to downstream levels of implementation (Bandelow 2003).

In addition, the argument that reforms must prevent "two-tier healthcare" is a central category of legitimation and veto. This narrative of fairness acts as a hard guardrail: reforms must be justified as "equally applicable to all" – which again pushes the political process towards universal, rule- and structure-based solutions. This is exemplified in the debate on access to appointments: the Scientific Services of the German Bundestag summarise that the perception of preferential appointment allocation for privately insured persons is "widespread" and has been triggering calls for legal adjustments for years; at the same time, this suspicion is reinforced by reports of online portals offering prompt appointments to those with statutory insurance who pay themselves.

The TSVG is described as a structural policy response (including minimum consultation hours, open consultation hours, appointment service centres, remuneration incentives). Overall, the two-tier argument thus stabilises the tendency towards structural policy: structure is the politically more defensible way to promise equality – even if inequalities in everyday life often arise from processes, incentives and local implementation

(Scientific Services of the German Bundestag 2026).

1.3 Rethinking

Reforms in the German healthcare system are tough and lengthy (Blümel et al. 2020). One need only think of the more than 20-year history of the introduction of electronic patient records. In addition, we have often seen in this country that a "big hit" such as "integrated care" has fizzled out in terms of its impact. However, the current disappointment with the performance of statutory health insurance should not be subject to a long-standing reform debate until the ideal primary care system is in place one day. The function of the healthcare system in Germany for the legitimacy of the state, the economy and society is too important for that (Häussler 2025).

Against this backdrop, a reform model is outlined here that addresses much more directly the problems that users of the healthcare system find dysfunctional, obstructive and, in some cases, even dangerous.

2. What it's all about: improving care processes

2.1 Two case studies 2.1.1 Ankle fracture: management of a "simple" case

The first case study describes an elderly patient who is discharged from hospital after undergoing surgery for an ankle fracture. In the real care process, the general practitioner receives a preliminary doctor's letter; radiology images and findings arrive late; a planned orthopaedic appointment has to be repeated due to a lack of findings; the organisation of physiotherapy is left to the relatives.

In the ideal scenario of management-oriented primary care, the primary care provider receives a structured data set with diagnosis, therapy and follow-up recommendations upon discharge. On this basis, binding pathways are defined: radiology in week X, orthopaedic check-up afterwards, scheduling of physiotherapy and fall prevention. Radiology reports are automatically imported into the ePA or primary care file. Before the orthopaedic appointment, the system checks whether the findings are available and, if necessary, initiates queries or appointment rescheduling. In addition, non-medical professionals in the network maintain contact with the patient by telephone or through home visits. This scenario illustrates how numerous break points can occur even with "standardised" problems and how systematic process management avoids duplicate examinations, unnecessary travel and frustration.

2.1.2 Recurrent loss of consciousness: avoiding the "blind spot"

In the second example, a patient over 80 years of age is cared for by her family doctor over many years as part of regular home visits. After recurring episodes of loss of consciousness, she is admitted to hospital for investigation with a suspected diagnosis of "syncope" – without result. It is only when an external colleague happens to make a precise diagnosis of the course of the episodes that the suspicion of age-related epilepsy is

raised, which is confirmed by a neurologist.

The long-standing personal continuity didnot prevent a "blind spot" in this case. In a data-based primary care system, recurring, unexplained crisis events would be marked as a "red flag" in the file. The ERP system could trigger an in-depth structured medical history, a specialist neurological second opinion or specific diagnostic pathways according to defined rules. The GP remains the central point of contact, but receives additional algorithmic support to recognise patterns that are easily overlooked in the pressure of everyday life.

2.2 Typical problem areas

International and national studies (e.g. Gunja et al. 2025; Valderas et al. 2025; Hurrelmann et al. 2020) paint a consistent picture of recurring problem areas in primary care processes:

1. Lack of coordination between practitioners

Findings are transmitted late or not at all, leading to duplicate examinations. Patients have to recount their medical history each time they make a new contact. Information flows often depend on the initiative of individual practices or on patients and relatives.

2. Unclear or missing information and communication

Diagnoses and therapies are not explained in an understandable way, and risks and alternatives remain vague. Written or digital materials that could be read at home at leisure are rare.

3. Breaks at sector boundaries, especially after hospital stays

After discharge, there is often uncertainty about who is responsible for further care. GPs, specialists and hospitals do not coordinate sufficiently; medication plans are contradictory or out of date.

4. High administrative burden on patients

Appointments must be coordinated independently, findings requested by telephone, and forms organised. In effect, patients or relatives take over the management of care.

5. Insufficient support for self-management of chronic diseases

Structured training courses and programmes are patchy, and help with managing multiple medications, symptoms and everyday adjustments remains the exception.

6. Lack of continuity and familiarity

Frequent changes in contact persons prevent anyone from having an overview of a patient's overall situation and recognising long-term patterns.

7. Dwindling access

Especially in rural areas or socially disadvantaged urban areas, timely access to personal medical advice is deteriorating.

These problems primarily affect the quality of processes – i.e. the way in which care is organised, managed and experienced on a day-to-day basis – rather than the question of which institution is formally responsible for primary care.

3. Enabling process management now

Internationally, primary care is often described according to Barbara Starfield (Starfield 1994) using the four "Cs":

1. **First contact** – the first point of contact for new health problems
2. **Continuity** – continuity of care in terms of time and personnel
3. **Comprehensiveness** – comprehensive care that takes physical, psychological and social aspects into account
4. **Coordination** – coordination of treatment processes and cooperation between different service providers.

This model has proven itself as an analytical framework, but in many national debates it remains limited to an institutional perspective. This implicitly assumes that a single point of entry can cover all four Cs equally.

Here, however, a modified interpretation of the 4Cs is proposed, which understands primary care as a network-like function based on a common data and process model.

3.1 First point of contact

Against the backdrop of growing complexity, this narrow approach no longer seems appropriate. Patients actually use a variety of access points: general practitioners, specialist practices, emergency rooms, telemedicine services or digital health applications. The challenge is therefore not so much to define a "single correct" point of entry, but rather to intelligently consolidate and control the resulting care processes.

Instead of relying on a single entry point, several possible first points of contact are assumed here. It is crucial that all contacts – regardless of whether they take place in a GP's practice, in a hospital, in radiology or in telemedicine services – are mapped in a common data model. This avoids bottlenecks without losing track of usage and risks.

3.2 Continuity

Continuity is traditionally understood as a long-term relationship between doctor and patient. This personal dimension remains important, but it is not enough. Data-based continuity is also necessary: all relevant information should be available in a structured form in a primary care file or electronic patient record (ePA) so that everyone involved – within defined access rights – can recognise patterns over time.

3.3 Comprehensiveness

Comprehensiveness means that psychological and social aspects are taken into account in addition to physical aspects. This can only be achieved to a limited extent by a single practice and must be ensured by a network of partners – such as nursing, social counselling, psychotherapy, rehabilitation and digital services. The primary care function consists of making controlled use of this network.

3.4 Coordination

Coordination is becoming the central management function of primary care. It includes standardised care plans, systematic enforcement monitoring (Have the findings arrived? Was the appointment kept?) and active follow-up actions. Due to the complexity – even with few participants, numerous dependencies arise – technical support via an ERP-type system is required to map tasks, deadlines and feedback.

An ERP is a central business software that bundles and controls all important processes in a common system. Today, an ERP is indispensable for most companies because it forms the central data and process basis for almost all core processes. A frequently used ERP is, for example, the software from SAP.

The thesis here is that, analogous to a corporate ERP, ERPs can be used in everyday healthcare to integrate all relevant participants in a defined healthcare network. Participation in such a network could be based on the acceptance of basic rules of cooperation, process management and transparency, and the active use of the software.

4. Technical and governance requirements

In order to ensure a high-quality user experience and continuous innovation, a market for efficient "healthcare ERPs" should be allowed to develop. Monopoly-like structures should be expressly discouraged. However, central requirements for corresponding technology products would have to be bindingly defined:

- Transparent coding and open interfaces (APIs) to ensure interoperability and auditability.
- Unconditional data portability to enable switching providers without loss of information and to avoid lock-in effects.
- Certification by an independent body that checks security, quality and interoperability requirements.
- Clear distribution of roles: Practice management systems have often evolved over time; their participation in the new infrastructure requires special control. Health insurance companies should not simultaneously act as providers of the central technology in order to avoid conflicts of interest.

For Germany, an institution such as Gematik is well suited to defining the framework conditions for such products. What is needed is a public definition of minimum requirements, reference models and certification processes, combined with a maximum degree of independence.

5. Incentive structures and implementation

Technology alone is not enough. Its use must be clearly incentivised for service providers and insured persons.

For service providers, selective contracts or special remuneration components that reward participation in structured care processes could be considered . For insured persons, bonuses or optional contracts could provide incentives to participate in structured primary care. This also strengthens personal responsibility, for example through active participation in digitally supported aftercare plans.

At the same time, a market for professional services should be created that supports coordination tasks in particular. Hybrid providers that combine telemedical consultation with case management can be part of this ecosystem within the framework of clear governance, as models from Switzerland show. Against this backdrop, the debate about the "true" structure of primary care can be defused: whether the coordinating function is primarily anchored in individual GP practices, primary care centres or regional networks becomes less decisive when binding process standards, data models and incentive systems are in place.

6. Discussion

The proposed focus on processes rather than structures is not a substitute for necessary structural reforms, but rather a complement to them. More management in primary care does not necessarily mean more bureaucracy, but rather a shift in coordination work away from patients and informal engagement towards professionally supported, digitally mapped processes. At the same time, the concept raises questions:

- **Professional autonomy:** How can we ensure that algorithmically defined pathways support medical decisions without replacing them?
- **Data protection and acceptance:** Patients must consent to the intensive use of their data; trust in security and purpose limitation is a prerequisite.
- **Investment requirements:** Setting up such an infrastructure requires considerable investment in technology, training and change management, which is difficult to mobilise given the current financial situation of healthcare systems.
- **Inequalities:** There is a risk that regions with already good healthcare provision will benefit from new technologies more quickly than underserved areas. These challenges are real, but they do not justify abandoning efforts to improve healthcare processes. Rather, they should be addressed in a step-by-step implementation plan that combines pilot projects, evaluation and scalable roll-out strategies.

7. Conclusions

Analysis of the current situation and the case studies presented suggests that the biggest problems in primary care lie less in the formal structure than in everyday care processes. Patients experience uncoordinated procedures, information gaps and a significant shift of management tasks to themselves and their relatives.

A primarily process-oriented approach with the following core elements therefore seems appropriate:

1. Modified 4C definition that understands primary care as a network-like, data-based function.

2. Introduction of an ERP-like process and data model that enables coordination, enforcement control and red flag mechanisms.

3. Public governance of technology products with clear specifications for interoperability, portability and certification.

4. A competitively organised market for technology and service providers that promotes innovation and is also embedded in regulations.

5. Incentive systems for service providers and insured persons that make the use of structured primary care processes attractive.

Under these conditions, "more management" in primary care can help to halt the decline in satisfaction, reduce experiences of overload and achieve noticeable improvements, especially for chronically ill and elderly patients – long before major structural reforms take effect.

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Keywords

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