Considerations regarding the introduction of a primary care physician system

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>> What patient would not wish that their treating physicians had more time? This wish is countered by the fact that, compared to other countries, medical care in the statutory health insurance system is characterised by a high number of cases in practices and hospitals. However, medical (and nursing) capacities are more readily available in Germany than in many other OECD countries (OECD, 2025). At the same time, international surveys reveal that, thanks to their currently virtually unregulated access to practices and hospitals, Germans have few medical complaints that go untreated due to high co-payments, long waiting times or long distances (so-called unmet needs) (OECD, 2025).

Against this backdrop, health policy seems to be guided by the obvious assumption that medical advice is sought too frequently, or at least too uncoordinatedly, in the statutory health insurance system. According to the coalition agreement, restricting the free choice of doctor by introducing a mandatory primary care system should ultimately result in faster appointments with specialists for patients who are first treated and referred by their primary care physician than is currently the case.

In fact, around 30% of insured persons currently criticise the waiting times for specialist appointments as too long (Kaiser, 2025). Yet waiting times in Germany are exceptionally short by international standards. According to the latest survey of insured persons conducted by the Central Association of Statutory Health Insurance Funds, 92% of insured persons

are given the opportunity to see a GP within seven days. Waiting times for appointments with specialists can be somewhat longer: 45% of insured persons receive an appointment with a specialist within 7 days, while 31% wait longer than 21 days (Kaiser 2025).

In Norway, which employs 20% more doctors per capita than Germany (Saunes et al., 2024), citizens are entitled to a response from the specialist within 10 days as to whether the referral from their GP will be accepted (HelseNorge, 2023). Waiting times for treatment can then extend to several months, depending on the circumstances and institution. As a result, Norwegians report unmet needs more frequently than Germans, particularly due to waiting lists. In the Netherlands, on the other hand, where a primary care system also exists, unmet needs are similarly low overall as in Germany, but the proportion due to waiting lists is higher and the number of doctor contacts is similarly high (Eurostat, 2025). If the promise in the coalition agreement for faster appointments with specialists is to work, it must be examined how this can be achieved by introducing a referral requirement from a general practitioner.

First, let's look at the volume structure: of the approximately 450 million cases of treatment by contracted doctors with personal doctor-patient contact each year, 168 million are accounted for by GP practices and 282 million by specialist or psychotherapeutic care (Mangiapane et al., 2025).

In the billing data, we find around 100 million specialist cases for which no referral was documented. Only 11 million of these are attributable to patients who did not visit a GP at all this year. For the vast majority (80% of cases), a GP was consulted in the same quarter or in the previous quarter, so that GP management would at least have been possible.

Conclusion: Depending on how the referral requirement necessary for a primary care system is designed, the introduction of a primary care system will lead to approximately 335 to 2,000 additional contacts per GP per year. Not every contact will result in an additional case. Based on an average of 900 cases with an average of two contacts per quarter and GP, an additional workload of 5 to 27% per GP can be expected, depending on the design of the referral requirement.

Based on experience in Germany, what can be expected in terms of the effect of a referral requirement on the number of specialist contacts? There are two key findings in this regard:

- From the evaluation of GP-centred care (HzV), we know that for registered patients, the number of GP contacts has increased by around a quarter and the number of specialist contacts without referral has decreased significantly. Overall, however, specialist contacts in HzV have not declined. Rather, outpatient care has become more intensive overall. (Laux et al., 2023)
- After the abolition of the practice fee at the end of 2012, the total number of specialist contacts in Bavaria remained virtually constant in the following quarters, while the proportion of specialist contacts controlled by referral fell from around 73% to around 27% within 16 quarters. At the same time, the number of GP contacts rose by around 10% (Schneider, 2019).

This suggests that a GP referral requirement alone is unlikely to change much in terms of making room for faster specialist appointments. If

we ask ourselves in which areas specialist care could be reduced without materially restricting care, we arrive at the following hypotheses:

Hypothesis 1

Patients wander around or visit different specialists until they feel they have made the right decision.

Evidence: In the billing data, we see hardly any relevant multiple use of the same specialist . Three or more practices in a single specialty are used by less than 1% of insured persons in almost all specialties. Rather, there appear to be fixed relationships with individual practices of certain specialist disciplines (von Stillfried & Mangiapane, 2026, von Stillfried et. al, 2026).

Exception: General practitioner care. Here, the proportion of multiple visits is 2.3%, even after excluding emergencies and substitute cases.

Conclusion: Registration with a GP practice could free up the additional workload caused by the primary care system in GP practices.

Hypothesis 2

Duplicate examinations lead to a high and avoidable number of visits to specialists.

Evidence: This hypothesis was already refuted in 2008 by a report commissioned by the German Association of Medical Specialists and prepared by IGES (Albrecht et al., 2008). The report concludes that the potential savings from avoiding multiple examinations are probably greatly overestimated, as they account for only 0.1% to 0.2% of total SHI expenditure.

Hypothesis 3

A significant number of patients visit several practices of the same speciality (doctor hopping) because they are dissatisfied with the medical response to a health complaint.

Evidence: Analyses by the Central Institute for Statutory Health Insurance Medical Care (Zi) show that the proportion of patients who visit three or more practices per year in the same speciality in specialist medical care is significantly below 1%, with the exception of gynaecology, radiology, nephrology, haematological oncology and rheumatology, is significantly below 1% (von Stillfried & Mangiapane, 2026).

Hypothesis 4

Specialists re-order patients. This results in a high number of avoidable visits to specialists.

Evidence Previously unpublished analyses by the Zi have shown that the proportion of patients who returned to a specialist practice within four quarters is well below 40%, with the exception of nephrology, haematology-oncology and rheumatology; based on an observation period of eight quarters, this proportion increases to roughly half of all patients. Whether and to what extent these repeat visits can be reduced by a primary care system has not been investigated using German data.

Hypothesis 5

There is a large amount of inappropriate care that can be reduced by a primary care system.

Evidence: This area is the most difficult to quantify. There is certainly room for manoeuvre in assessing the necessity of one or the other specialist treatment, including that initiated by a general practitioner, as well as the urgency of such treatment. This is likely to be difficult or impossible to assess from billing data. It is generally assumed that there is considerable room for manoeuvre in this regard. However, international evidence, e.g. from Canada, shows that strategies to bind patients more closely to primary care through rules and financial incentives are ultimately of limited success (Lavergne et al., 2018, Institute of Health Economics Alberta Canada, 2025, Jiang, 2025, Dangerfield, 2024). According to recent studies, the scope that could be opened up, for example, by reducing services in the area of so-called low-value care is also much smaller in Germany than is often assumed by proponents of the "misallocation hypothesis" (Hildebrand et al, 2025).

Conclusion

Against this background, is it to be expected that a primary care system – as announced in the coalition agreement – will lead to faster appointments in specialist practices? Studies that have examined the current reality of healthcare provision often conclude that more rather than less specialist co-treatment is necessary. The task of healthcare research is therefore to further examine the assumptions about the causes of the shortage of specialist appointments. It is likely that specialist capacity could be freed up primarily through greater content-based control in the sense of shifting a certain proportion of care to primary care practices. However, this would require an expansion of the preliminary diagnostic and treatment options available in primary care practices.

In addition, practices would have to be transformed into team practices and more services delegated to qualified non-medical practice staff in order to free up GP capacity. It is crucial that no new parallel structures are created in connection with the delegation, but that the delegation takes place within the framework of the practice structures. In order to avoid placing an excessive burden on general practitioners' practices through the introduction of a primary care system, it is also relevant how the future referral reservation is designed.

If, in future, every referral has to be issued by GPs (star model), this would lead to a significantly greater additional burden than in a chain model, in which referrals between specialists are still possible. In addition, the approach of digital control by means of initial assessment should also be expanded to include the allocation of specialist appointments. If, in addition, the regulations on sick leave were changed to allow up to three days of sick leave without a doctor's note, this could also relieve the burden on GP practices.

All of this requires a longer-term process, with a focus on changes in primary care practices. These practices must be able to invest and make arrangements to expand team structures and digital communication with their patients, for example, in order to avoid unnecessary visits to the practice (Grosse & Jäger 2024). In addition, remuneration structures must be adjusted if primary care practicesare to devote more time to registered patients andprovide more intensivetreatment. It is essential to avoid coordination chaos due to parallel services and duplicate structures, as is

threatened, for example, by the planned regulation of the emergency reform on the 24/7 on-call service to be provided by the associations of statutory health insurance physicians (Zi, 2025) or by the regulation of the Act on the Extension of Powers and Debureaucratisation in Nursing Care (BEEP). <<

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