Germany is debating primary care – a reform that everyone wants but on which no one can agree

The Compulsory Patient

A draft bill for a mandatory primary care system is due to be presented in late summer. The coalition, health insurance funds and the medical profession are in agreement on the objective, but there is fierce debate over who should oversee the system and how binding it should be. Furthermore, a new evaluation of GP-centred care (HzV) has further fuelled the debate. An attempt to take a comprehensive stock of the situation, balancing reform promises, the shortage of doctors, health insurance fund finances and European models.

>> The German government's coalition agreement sets out a plan intended to fundamentally transform outpatient care in Germany. It involves the introduction of a mandatory primary care system. Whilst politicians, health insurance funds and the medical profession are largely in agreement on the objective of improving patient management, the conflict centres on the concept of mandatory compliance. Without a binding framework, any management structure will fizzle out, as international comparisons and recent evaluations show. A binding framework, however, risks triggering fierce political disputes over the free choice of doctor and the distribution of fees.

So far, the only thing that is binding is the political will. The details are missing, and the timetable is stretched: legislative implementation is on the agenda of the Federal Ministry of Health. Federal Health Minister Nina Warken (CDU) had already launched an expert dialogue on establishing primary care at the end of January and announced a draft bill for the summer. She summarised her reasoning for the urgency succinctly: "We must make the healthcare system more efficient very quickly." However, between this announcement and a functioning system lies a web of interests, definitional issues and figures, which in recent months has sparked a remarkably intense debate ranging from health insurance funds and medical associations to foundations and scientific advisory boards.

What unites them and what divides them

Almost all those involved share the same diagnosis. Navigating the fragmented healthcare landscape today depends all too often on structures that have evolved over time or even on chance; patients complain of difficulties in securing timely outpatient appointments. This is how the Techniker Krankenkasse

(TK) in its position paper from September 2025, and hardly anyone disputes this assessment of the situation. Klaus Reinhardt, President of the German Medical Association, has also summed it up in a simple statement: Germany is the only country in which patients themselves decide where to receive treatment. Given the increasingly complex nature of healthcare systems, people are finding this increasingly overwhelming. "We need stronger coordination," Reinhardt demanded, adding that this must be carefully balanced against the vital principles of free choice of doctor and patient autonomy.

In this balancing act, three basic positions can be distinguished, which differ on one key question: whether a designated doctor coordinates every stage of treatment or whether coordination begins directly when the need arises. The first camp insists that the GP's practice should be the mandatory first point of contact. The second camp considers a focus solely on GPs to be too narrow and calls for direct access to specialists for defined patient groups. The third shifts the focus from the GP's practice to a standardised initial assessment, thereby placing health insurance funds at the centre.

A detailed review of the arguments also reveals the questions that remain unanswered so far:

The concept is most fully developed where work on it has been ongoing for the longest time. The Association of General Practitioners points to general practitioner-centred care (HzV) as an already established primary care system with over ten million participating insured persons. "We already have 17 years of practical experience with GP-centred care (HzV)," says Nicola Buhlinger-Göpfarth, national chair of the Association of General Practitioners. In the HzV system, the GP's practice serves as the central point of access, coordinates the

stages of treatment and collates the findings. However, measured against the total number of people with statutory health insurance, participation remains modest: around twelve per cent of patients are registered. The message from the Association is that there is no need to reinvent the wheel; it simply needs to be scaled up through incentives for health insurance funds and insured persons, an initiative to recruit the next generation of GPs, practical digitalisation and a greater delegation of tasks to practice teams.

The latter is set out in the HÄPPI concept – the 'General Practitioner Primary Care Centre – Interprofessional Patient Care' – which the association has developed in collaboration with the Department of General Practice at Heidelberg University Hospital. A multi-professional working group within the Baden-Württemberg Association of General Practitioners developed the concept over the course of around one and a half years. A six-month feasibility study concluded that it is suitable for widespread implementation. At its heart is an interprofessional team comprising doctors, medical assistants, physician assistants and other healthcare professionals, which – supported by digital solutions and a clear framework for delegation – distributes the tasks in accordance with the law in such a way that the GP practice can fulfil its role as the coordinating primary care provider even as demand rises and doctors' time becomes increasingly scarce.

However, fundamental resistance is emerging at this regulatory interface. Nursing associations are vehemently warning against approaching primary care in a predominantly doctor-centred manner and delegating tasks solely under the right of direction. Against the backdrop of the current debate surrounding the Nursing Reorganisation Act (PNOG), they are pushing for a genuine transfer of medical activities to academically qualified nursing professionals, such as community health nurses, who are to manage care independently.

However, the question of who will be permitted to provide which medical services within the primary care system in future, and how the exceptions to the referral requirement – as broadly outlined by the legislator – will operate in practice, will ultimately be decided elsewhere. It is the responsibility of the Joint Federal Committee (G-BA) to translate these regulatory distinctions into legally binding guidelines for day-to-day healthcare provision.

The tension between politics and evidence

Whether the GP-centred care model actually delivers on its promises has been the subject of a bitter battle over interpretation since the beginning of June 2026. This

was triggered by an evaluation of GP-centred care commissioned by the Techniker Krankenkasse (TK) for its TK-HzV federal contracts, which have been concluded in 13 federal states. The study was led by Prof. Dr Jonas Schreyögg, a health economist at the University of Hamburg, scientific director of the Hamburg Centre for Health Economics and deputy chair of the German Health Council.

The data set is substantial. With over twelve million insured members, the TK is Germany's largest health insurance fund; over one million of these are enrolled in the HzV federal contracts, in which 10,000 doctors are participating. The team analysed more than half a million new enrolments from 2015 to 2022; in the control group, depending on the year, at least eight million observations from standard care were available.

The health insurance fund itself interprets the results as a rebuke of the GP programmes. According to TK, participants were "not better guided through the care system", did not have fewer consultations with specialists or hospital stays, and did not result in lower expenditure. In fact, when applied to the overall population, the analysis paints a sobering picture: the GP programme reduces contacts with GPs only slightly, whilst contacts with specialist doctors are increasing. In the inpatient sector, there is no significant steering effect, and on balance, participation actually leads to increased expenditure across all service areas. The expected mechanism of fewer hospital stays and fewer uncoordinated visits to specialists is not taking effect in this form.

The political interpretation is provided by Thomas Ballast, Deputy Chairman of the TK Executive Board. He deliberately begins by paying tribute to GPs: Germany's approximately 66,000 GPs are a central pillar of healthcare provision, and the TK has been supporting the next generation of GPs for years. After all, with around 1.3 million insured members and some 14,000 participating doctors – representing a good 20 per cent of all GPs – TK is the provider of the largest HzV programme nationwide, which gives it a 'bird's-eye view'.

This is precisely why the findings carry such weight. "GPs provide good care for their patients regardless of whether they are enrolled in a programme or not," says Ballast, putting the downside of the results into perspective. The fact that the HzV programme offers no added value in terms of management comes as no surprise, as the principles of GP practice have long been enshrined in standard care; in his view, this means it is therefore unsuitable as a blueprint for a primary care model.

The health insurance fund is drawing far-reaching conclusions from this. Ballast argues that the status quo results in "expensive duplicate structures in general practice" – a contractual model mandatory for all health insurance funds that offers no real added value alongside the standard care that is already mandatory. A nationwide primary care system with a well-thought-out management framework would render a mandatory HzV programme superfluous; consequently, the obligation to contract must be abolished. The HzV could then be tailored on a voluntary and targeted basis to those who truly benefit from it, such as older, multimorbid patients. At the same time, Ballast criticises the fee allocation system, from which only a few practices have so far benefited from additional HzV fees, whilst the money should benefit the care work of all GPs. He expressly does not view the GP community as the losers of such a reform: "I am convinced that, in a modern primary care system, the majority of care pathways will routinely lead via GPs." Just not to the same extent for every patient group and every treatment issue.

The key lies in mandatory participation

Schreyögg, who is in charge of the study commissioned by the TK, strongly refutes this political oversimplification. The HzV does not fail to steer the system at all, but "only to a limited extent". The reason for this most likely lies not with GPs, but in the design of the model itself. "The real crux of the matter is the structure of the HzV, as it is currently designed," says the economist (see MVF interview on pages 12–17). The crucial lever – binding control – does not lie in the hands of the practices at all, because insured persons are not obliged to follow the prescribed pathway. GPs cannot exercise control if patients are allowed to go directly to a specialist. Unlike in France, where a visit to a specialist without a referral entails a significantly higher patient contribution, or in the Netherlands, where a specialist consultation without a GP referral is practically non-reimbursable, the German HzV lacks any financial incentive. His structural finding – which, by his own admission, can be generalised – is therefore that, without binding requirements, steering remains weak.

The picture painted by the TK-HzV study becomes more nuanced as soon as subpopulations are analysed. In individual sub-groups, a steering effect is certainly evident, particularly among those who adhere to the referral pathway, and more so among older people than younger ones. This is hardly surprising: the average age of the participants is just under 50. "Incidentally, an improvement in care coupled with lower expenditure only becomes clearly evident among the over-80s," says Schreyögg in an interview with the MVF.

The strongest backlash came from the Virchowbund. Its national chairman, Dirk Heinrich, described the study as a "failed contribution to the current debate on a primary care model". Specifically, he criticises the fact that the TK study unfortunately only presents half the truth, because it "distorts the overall message by deliberately ignoring the reality of healthcare provision in Baden-Württemberg". There, he says, GP care is inextricably linked to specialist care. It is only the additional specialist contracts that would make the model viable, as outpatient care is "a joint responsibility of GPs and specialists in equal measure". The association has derived its own concept from this: the 'coordinating doctor' model, in which every patient has a coordinating doctor who refers them to a specialist if necessary. Specialists are also eligible to act as primary doctors in this context, such as gynaecologists for young women who are generally healthy, or ophthalmologists in the case of an isolated condition.

In the MVF interview, Schreyögg rejects the accusation. However, he does so with a justification that elevates the dispute to a far more objective level. Baden-Württemberg was not excluded for scientific or political reasons, but because the contract there is structured differently from the nationwide standard TK federal contracts and thus represents a different approach. To lump both systems together is to compare apples with pears. "This is simply a case of comparing apples with pears," he says. The key difference, however, lies not in the GP contract itself, but in the specialist programme and the resulting closer integration between GP and specialist care. In his view, this could be precisely why the Baden-Württemberg HzV analysis finds a reduction in polypharmacy, whereas his own does not. An editorial by Dr Albrecht Kloepfer of iX-Media points in the same direction, reframing the debate: the real question is not "HzV yes or no", but "under which contractual conditions does a Section 73b model exert a steering effect?".

For Schreyögg, the implication is clear and strikes at the heart of the political reform. The most important insight, he says, is the binding nature of the scheme – already mentioned in the coalition agreement – which significantly increases the likelihood of a steering effect on both the quality of care and cost-effectiveness. "You could also describe this binding nature as the real game-changer," he says. Internationally, the evidence is clear. He knows of no system in the world where patient management is practised but remains voluntary for the insured.

This would entail a compulsory registration requirement – which is already laid down in the Social Code but not currently practised – alongside the option to exempt

certain specialist groups, such as gynaecology, paediatrics or ophthalmology, from the referral requirement. He expressly does not consider the current HzV to be superfluous, but rather "a transitional phenomenon towards a comprehensive primary care system". His proposal is for a binding basic primary care model for all health insurance funds, insured persons and GPs, upon which competitive and selective contracting elements – such as the HzV – could be built without dismantling the established structures. To put it succinctly, the word 'mandatory' is crucial.

Schreyögg, whose study the TK uses as an argument against a GP-centred approach, also views the health insurer's digital initial assessment approach with explicit scepticism. Such triage makes sense, but must not be conceived in isolation from primary care providers, warns Schreyögg, with regard to the issue of fairness: Around 90 per cent of people in Germany use at least one GP or paediatrician's practice; if gynaecologists acting as GPs are included, the figure rises to around 95 per cent. An anonymous system, by contrast, carries the risk of increased utilisation and leaves vulnerable groups in particular by the wayside.

Schreyögg himself sums up the crux of the dispute. His study is not a verdict on the idea of GP-led coordination, but rather a finding regarding the implementation of a contract without binding obligations. This is no attempt at appeasement. It is arguably the most precise statement of the entire debate. It distinguishes between what the political discussion stubbornly conflates: the question of whether GP-led coordination can work. But also the question of whether it can work at all if patients are not obliged to comply with it.

The bottleneck has a name: the GP workforce

This is precisely where the sharpest criticism comes in. For a primary care system heavily tailored to GP and paediatric practices requires robust structures in areas where they are already stretched thin. The proportion of doctors involved in GP care in Germany stands at around 16 per cent, which is relatively low by European standards, as the Association of Alternative Health Insurance Funds notes, citing data from the OECD. Andreas Beivers, Professor of Health Economics at Fresenius University of Applied Sciences and Head of Research Projects at the Rhön Foundation, sums up the dilemma: One of the biggest bottlenecks in the healthcare landscape is GP care; GPs in particular often struggle to find successors, structurally weak rural areas are particularly affected, and even in cities many complain of being overburdened. Therefore, focusing solely on the current state of general practice is not enough.

The figures presented by the Professional Association of Ear, Nose and Throat Specialists (BVHNO) in its position paper illustrate the scale of the problem. In a GP-centred primary care system, GP practices would have to deal with up to 102 million additional treatment cases per year requiring referral to a specialist. These are precisely the patients who, until now, have been seeing a specialist directly. Based on a figure of around 52,000 GPs, this would amount to up to around 2,000 additional consultations. Even today, a GP treats an average of around 3,600 cases a year – roughly 900 per quarter. By way of comparison, an ENT specialist handled around 5,000 cases.

The association warns that creating barriers to access specialist care whilst simultaneously concentrating resources on general practice and paediatrics represents "an unprecedented paradigm shift in the healthcare landscape". The association sees a risk that GP practices could also become a bottleneck when it comes to referring patients.

The current plans are largely fuelled by the debate over waiting times and so-called 'two-tier healthcare', even though waiting times for an appointment with a specialist are short by international standards. According to a 2020 OECD survey, 75 per cent of patients in Germany received an appointment with a specialist within one month. Appointment problems in individual specialist disciplines can therefore be explained primarily by a shortage of doctors in the relevant specialist groups; valid data on specific waiting times is lacking in any case.

Surveys carried out by health insurance funds paint a more detailed picture. For example, a representative Forsa survey commissioned by TK, for which 1,410 people were interviewed nationwide between 25 September and 21 October 2025, found that 31 per cent of respondents had difficulty find a suitable GP practice when they develop new health complaints. Only eight per cent of those with statutory health insurance were able to secure an appointment with a specialist within a few days, 13 per cent within two weeks, and 20 per cent within up to four weeks. Seventy-four per cent were able to secure an appointment with a GP within a few days.

However, this comparison of the surveys masks an important methodological difference between the two data sets. The OECD survey relates to access to a specialist the patient is already familiar with, whilst the Forsa data concerns the search for a new practice when symptoms are unclear. It is understandable that a specialist doctors' association, whose members would be directly affected by referral requirements, should emphasise the first category in particular, but this is not a neutral finding.

Another, often overlooked perspective is brought to light by the Bertelsmann study 'Medical Assistants in Outpatient*Care*', which was only published in July 2026. It ties in directly with the medical profession's resource problem, but focuses on the approximately 475,000 medical assistants working in Germany – a figure that exceeds the number of medical staff 'many times*over*' – as the largest and already existing resource in terms of numbers. According to the study's authors, a primary care system can only be sustainable if tasks that do not require medical expertise are systematically distributed amongst the practice team.

At the heart of the argument, therefore, lies a paradigm shift 'from assistance to active participation'. Drawing on the research cited within it, the study demonstrates that GPs today delegate 'significantly more frequently than they did 15 years*ago*' – and increasingly not just routine technical and diagnostic tasks (blood pressure, ECG, wound management), but specifically the functions that constitute a primary care system: structured initial assessment and telephone triage, initial medical history-taking, case management, geriatric assessments, DMP check-ups, care coordination and links to social services. In this way, medical assistants fulfil precisely those interface and coordination roles that are at the heart of the debate surrounding the primary care system.

In its position paper 'Primary Care: Patient-Centred Coordination in Outpatient*Care*', adopted in June 2025, the GKV-Spitzenverband also views the primary care practice as the central point of contact and coordinator of outpatient care. As a rule, they should provide treatment on a case-by-case basis and only guide patients through the different levels of care in a targeted manner where necessary. Through targeted referrals and digital management, specialist resources are to be utilised more efficiently, unnecessary contacts reduced, and needs-based, cost-effective care achieved. Specifically, the paper explicitly stipulates that certain groups of specialists" can no longer be consulted without a referral from primary care practices." Without such a referral, coverage for the specialist service would no longer be possible, as the treatment could no longer be billed through the health insurance scheme. However, the paper points out that this principle already applies today, for example in the case of radiology services, which are also not reimbursed without a referral.

According to this paper, medical oversight is to be retained at its core, but, as

with the Bertelsmann study, it is to be embedded within a multi-professional team. Throughout, the text refers to the "primary care*practice*" as the coordinating unit and to a "primary care*role*" or "primary care coordination". In the view of the Spitzenverband Bund, this is intended to ensure that ultimate responsibility for management, diagnosis and treatment remains with the medical profession. At the same time, this range of tasks is explicitly not to be borne by the doctor alone. The paper calls for" the increased integration of qualified staff from other healthcare professions into care*provision*" and for tasks to be shifted through delegation and, in some cases, even substitution. The care mandate is also to be "interprofessionally*oriented*", and, within the framework of "tiered*patient management*", specialist staff are to be deployed in a more targeted manner to relieve the burden on doctors.

The demographic shadow

The deep, dark shadow of demographics has long loomed over day-to-day policy. In the coming years, the proportion and number of elderly, sick and multimorbid people in the population will rise significantly. This development is cited in almost all policy papers as the actual driving force. In 2024 , the Expert Council for the Assessment of Developments in Healthcare and Long-Term Care stated in its report 'Healthcare Professionals: The Sustainable Use of a Scarce Resource' that, in view of demographic change, an increase in the number of healthcare professionals was not to be expected. Work must therefore be organised more efficiently and intelligently. The then Federal Minister of Health, Prof. Dr Karl Lauterbach (SPD), described the report as very important and set out a political objective: "Good reforms or no reforms".

Since 2016, the Robert Bosch Foundation has been pursuing, through its programme "Patient-Oriented Centres for Primary and Long-Term*Care*" (PORT), the Robert Bosch Foundation has been pursuing an approach that goes beyond the traditional doctor's surgery: multi-professional local health centres that bring together GP care, nursing, prevention and social support, and offer care for all ages. The foundation found models in countries such as Canada, Sweden, Spain and Slovenia. Eleven initiatives are being funded nationwide, including the Gesundheitskollektiv Berlin in Neukölln, a neighbourhood health centre that was awarded the Berlin Health Prize in 2023. At a round-table discussion organised by the Rhön Foundation, the sobering conclusion was reached that, whilst the idea of primary care dates back to the 1970s, it has never really taken hold in Germany. The current preference for focusing on GPs as gatekeepers is seen as more of a systemic adjustment than a genuine break with the doctor-centred approach.

The clearest warnings come from the financial side. A few days after the start of coalition negotiations, a trio of authors presented proposals for structural reforms in book form in March 2025. The central argument of the book *Die Gesundheit der Zukunft* (*The Health of the Future*), written by Prof. Dr Christian Karagiannidis, Prof. Dr Boris Augurzky and Prof. Dr Mark Dominik Alscher from the Bosch Health Campus, is that it is not prices but the high volume of treatments that must be reduced through digitalisation, artificial intelligence, patient management, a shift towards outpatient care and a greater role for nursing staff. Karagiannidis, an intensive care specialist and co-author, warned: "We now have just four years left to bring about a turnaround." By 2030, it will probably be too late, he said, as the problems can no longer be solved with money alone – not even with a special fund.

Three models, one question

Whilst the description of the problem is undisputed, the proposed solutions vary widely. The differences become particularly clear when one looks at the specific systemic flaws they aim to rectify. The first camp sees the problem as a lack of coordination by GPs. The second sees the fault in an overly narrow focus on a single profession. The third sees it in the absence of a standardised initial assessment before a GP practice is involved. The proposed solutions follow these respective diagnoses and highlight the limitations of the concepts.

The first camp, backed by the Association of General Practitioners, the German Medical Association and the AOK Federal Association, advocates for the GP's practice to be the mandatory first point of contact. The National Association of Statutory Health Insurance Physicians, which is directly affected as a contractual partner of the health insurance funds, has not yet published an independent policy position. Its public reactions to the coalition's plans have been noticeably cautious.

The German Medical Association, however, has presented a policy paper entitled 'Coordination and Guidance in Healthcare', according to which primary care should become the norm. To ensure compliance, patients are to register with a primary care practice for at least twelve months. T

The AOK Federal Association expresses a similar view in its key points paper 'Well looked after from the start'. 'The core element of our concept is primary care practices as an easily accessible and reliable point of contact,' says Carola Reimann, Chair of the Executive Board of the AOK Federal Association. Exceptions to the referral requirement are to apply to paediatric and adolescent medicine practices, gynaecology, patients with chronic conditions and early detection screening. A Forsa survey commissioned by the AOK shows that the majority of the public is in favour of this model: 55 per cent agree with the proposal that appointments with specialists should only be granted following a referral; dentists, gynaecologists and paediatricians are, incidentally, exempt. Furthermore, 79 per cent of those surveyed consider it important to have a designated point of contact to guide them through the system; among people aged 60 and over, this figure rises to 84 per cent.

There is substantial scientific backing for this approach. Indeed, the German Council of Economic Experts had already sought to make GP-coordinated care the standard of care in its report 'Needs-based Management of Healthcare', chaired by Ferdinand Gerlach. "We are convinced that patients need a guide," explained Gerlach – a guide who steers them through the complex system, protects them from excessive or inappropriate medical treatment, and brings all the information together in one place. Patients should be encouraged to participate through incentives such as discounted optional tariffs.

The second camp, centred on the specialist medical associations, rejects a focus solely on GPs and calls for direct access routes for defined patient groups. The Professional Association of German Internists puts it in no uncertain terms: "A blanket focus on GPs falls short in this regard." For defined patient groups, such as those requiring dialysis, people with type 1 diabetes or severe heart failure, the treating specialist should coordinate care directly, albeit in consultation with the GP. This does not weaken primary care provided by GPs, but rather relieves the burden on practices and reflects actual care provision in practice.

Die Positionen der einzelnen Akteure im Überblick			
Institution	**Träger des Systems**	**Verbindlichkeitsmodell**	**vorw. abgelehntes Element**
Hausärzteverband, BÄK, SpiBu, AOK	Hausarztpraxis als Pflicht-Erstanlaufstelle	Einschreibepflicht für 12 Monate	Direktzugang zur Mehrzahl der Fachärzte
Techniker Krankenkasse	standardisierte Ersteinschätzung, digital oder telefonisch	indikationsspezifische Steuerung	fester Primärarzt als allgemeiner Gatekeeper
Virchowbund	Koordinationsarzt, auch als Facharzt möglich	Facharztvertrag als Voraussetzung	reine Hausarztzentrierung
KBV	abwartend	keine Festlegung	Eingriff in den Kollektivvertrag ohne Vergütungsregelung
DEGAM	systemische Primärversorgung über Gatekeeping hinaus	Vergütungsreform als Voraussetzung	isolierte Steuerungsarchitektur ohne EBM-Reform
Patientenbeauftragter, VdK und BAG-Selbsthilfe	koordinierende Erstanlaufstelle	freie Facharztauswahl erhalten	finanzielle Strafmaßnahmen für Nicht-Eingeschriebene
vdek und BKK-Dachverband	skeptisch gegenüber allen Modellen	keine Festlegung	isoliertes Hausarzt- oder App-Modell

Table 1: An overview of the positions of the individual stakeholders. The BMC's position is not shown here. Own illustration.

The German Association of Medical Specialists (Spitzenverband Fachärzte Deutschlands) argues along the same lines, calling for direct access to specialists in defined cases and demanding that specialist services provided on referral be fully exempt from budget constraints, as the need for them has already been demonstrated.

The Professional Association of German Urologists also insists on guaranteed direct access for emergencies, cancer patients and early detection – whilst at the same time leaving no doubt as to its scepticism regarding the political commitment: "In the Ministry's planning, the general practitioner system comes last."

The third camp, centred on TK, is pursuing a fundamentally different approach. The starting point is shifted from the doctor's surgery to a standardised initial assessment. This brings health insurance funds and digitalisation to the fore, following the principle of 'digital before outpatient before inpatient'. Every new course of treatment is to begin with a mandatory, standardised initial assessment, whether online, by telephone via the 116 117 helpline, at the surgery reception or in a new Integrated Care Centre to be established. A central digital appointment platform, linked to the telematics infrastructure and practice management systems, is to allocate appointments according to medical urgency. Above all, however, the TK rejects precisely what the medical associations are prioritising: fixed management models involving a specific doctor who coordinates every stage of treatment across different conditions are "not effective", particularly as GPs are already working to capacity. Instead, TK favours condition-specific management: the primary care doctor should initially be the specialist recommended by the initial assessment.

TK Chairman Jens Baas draws the most direct conclusion from this: "Primary care should not rest exclusively with the GP practice." Consequently, TK argues that, with a primary care approach in standard care, there is no longer any need for a parallel management system in the form of the HzV – the obligation to contract must be abolished. This represents the sharpest possible rejection of the GP model. The Association of General Practitioners reacted promptly, describing the TK's proposal as "absurd and out of touch with healthcare provision".

However, there are other sceptical voices as well. For instance, the Association of Alternative Health Insurance Funds is fundamentally sceptical of GP and primary care models. "The GP models frequently discussed in public do not offer a convincing solution to this," it states, referring to its own analyses, according to which neither the number of visits to specialists nor the number of hospital stays has decreased among participating insured persons.

DEGAM Vice-President Prof. Marco Roos, for his part, warns against the opposite approach: managing patient flows solely via an initial assessment app is a dead end. What is needed, he says, is a comprehensive strategy that links digital initial assessment with care pathways and a reform of the remuneration system. As the scientific professional association for general practice, DEGAM also takes the view that primary care structurally encompasses more than mere gatekeeping. Without a fundamental overhaul of the remuneration system – one that rewards ongoing doctor-patient relationships rather than individual services – any management framework will remain incomplete.

The BKK umbrella organisation, on the other hand, maintains that neither designating primary care doctors as gatekeepers in a 30:70 GP-to-specialist ratio nor the completion of a brief questionnaire alone will lead to any noticeable easing of the pressure.

Institutionalised patient representative bodies play a central role in the question of acceptance; in the debate between health insurance funds and the medical profession, they often appear merely as the recipients of the reform. The Federal Government's Patient Ombudsman, as well as social welfare organisations such as the VdK and BAG-Selbsthilfe, are in principle in favour of a coordinating first-point-of-contact to provide guidance within an increasingly complex system. However, they reject a strict 'gatekeeper' approach. The freedom to choose a specialist must be preserved. Above all, however, these stakeholders draw a red line when it comes to potential sanctions. Financial penalties for insured persons who do not register with a primary care system or who seek direct access to a specialist are categorically rejected. This stance highlights the political dilemma of the reform. Effective manage-

ment requires compliance, yet tangible sanctions are virtually unenforceable.

In October 2025, the Federal Association for Managed Care (BMC) presented a compromise designed to reconcile the different approaches, entitled 'Five Building Blocks for Primary Care*Reform*' (MVF 05/25). It redefines the terminology: Primary care is defined as"not merely a system of general*practitioners*", but rather an interprofessional, community-based system of care in which people are directed to the appropriate service – whether a GP, a specialist or a non-medical provider – based on their needs. In doing so, the association adopts the triage logic of the third camp, but does not carry out the initial assessment itself; instead, it makes the local 'primary care*practice*' – operating as part of an interprofessional team – the anchor. The BMC deliberately remains noncommittal on the key issue of binding commitments: affiliation with the primary care practice should 'always be*voluntary*' and be achieved through incentives rather than sanctions.

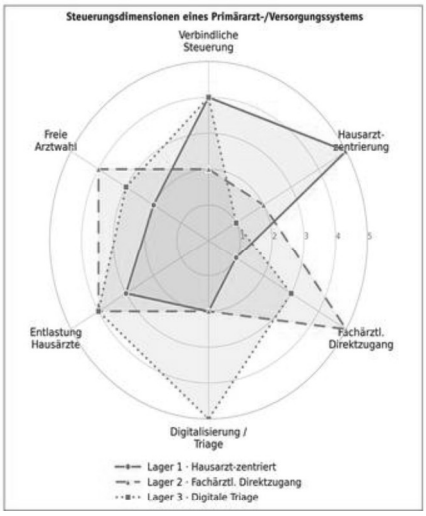


Fig. 1: Control dimensions of a primary care/ healthcare system. Scale of 0–5 (interpretation by Stegmaier/Roski). The BMC's position cannot be pinpointed here. Own illustration.

Gaps in the data

The provisions of the coalition agreement are not empirically substantiated. The gaps can be clearly delineated. Firstly, there is a lack of data on steering effects at different levels of binding commitment. It is as yet unknown which enrolment rate produces which

steering effect. In addition, there is a lack of longitudinal analyses – broken down by income group and healthcare region – for the years following the introduction of gatekeeping, as exists in France and the Netherlands. Finally, there is a lack of reliable German figures on inappropriate direct access: of the approximately 102 million treatment cases that could potentially be redirected, how many are actually misdirected contacts, and how many are appropriate direct referrals?

Particularly contentious is the fact that, whilst some of this data does exist, it is scarcely drawn upon in the political debate. Without it, any proposal for a patient-management framework remains a well-founded hypothesis, but by no means an evidence-based one. The German debate on patient management therefore continues to take place in a context largely devoid of empirical evidence. This inevitably raises the question: have the authors of the coalition agreement perhaps fallen for a buzzword?

Behind this assumption lies a serious problem. The term 'primary care system' does not yet exist as a defined concept within the German healthcare system. Similarly, there is no clear distinction between general practitioners and primary care practitioners. Since the coalition's plans were made public, however, the German Medical Association, the National Association of Statutory Health Insurance Physicians and the professional associations have been working separately to draw up their own definitions in line with their respective interests. Prof. Dr Andreas Beivers, Professor of Economics and Health Economics at Freseinus University of Applied Sciences, sums up the mood in a statement that expresses both approval and reservation: "Good idea, but now let's get to work on developing successful concepts!"

A comparison of management models across the EU

There is ample international evidence that primary care systems work. It is precisely this finding that all sides claim as their own. In an international comparison, they are in fact the rule rather than the exception, as seen in Italy, Spain, England, the Netherlands and France, as well as in the Scandinavian countries of Denmark, Finland and Norway (see MVF article on p. 54 ff).

According to an analysis by the *Zeitschrift für*Allgemeinmedizin* (Journal of General Practice)*, a structured primary care system is established in 15 out of 28 European countries, such as Bulgaria, Croatia, Estonia, Finland, Hungary, Ireland, Italy, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Spain, Sweden and the United Kingdom. In a further seven countries, referral by a GP is encouraged by the avoidance of co-payments. A comparison of 18 industrialised countries showed that mortality rates are lower the more a country is oriented towards primary care – particularly in the case of chronic conditions.

The models differ primarily in the degree to which registration is compulsory. In Italy and England, registration is formally voluntary but effectively compulsory, as without it there is no access to the state healthcare system. In the Netherlands, France and Norway, registration is voluntary but has significant consequences: in the Netherlands and France, a lack of registration results in higher co-payments or disadvantages when booking appointments; in Norway, unregistered citizens must pay for their visits to a primary care provider in full themselves.

The Dutch model, in which the GP acts as a gatekeeper, with a maximum of around 1,500 patients registered per GP and approximately 70 per cent of income covered by per-capita flat-rate payments, has long been regarded as the benchmark. The Dutch professional association was awarded the Carl Bertelsmann Prize for this as early as 2000.

It is important to note that this model is under considerable pressure. Dutch GPs are among the most overburdened in Europe. Many practices are closing their patient registers, and waiting times for an initial GP appointment have increased in recent years. This does not fundamentally diminish the model's value as a benchmark, but it does rule out its suitability as an uncritical model to emulate. Anyone recommending the Dutch model must also explain what distinguishes Germany from the problems that the model itself has created.

Denmark, on the other hand, allows its insured people to choose annually between a GP model with a gatekeeper and a variant without such a system.

As is so often the case, the overarching evidence comes from the OECD. In its first report, 'Realising the Potential of Primary Health Care', published in 2020, it describes primary care as the first point of contact which, when organised in a comprehensive, continuous and coordinated manner, can improve the efficiency of the system and health outcomes across all social strata. At the same time, it highlights untapped potential: avoidable hospital admissions still accounted for six per cent of bed-days across 30 OECD countries. Estimates of inappropriate antibiotic prescriptions in primary care ranged from 45 to 90 per cent. A quarter of people with chronic conditions in EU countries had not received a single preventive screening test in the past twelve months. Between 29 and 51 per cent of respondents in eleven OECD countries reported experiencing coordination problems between primary and specialist care.

Another, very recent OECD Working Paper No. 196, 'Incentivising patient pathways in outpatient*care*', funded by the ZI, goes one step further. Published as recently as the end of May this year, the paper maps the two management tools– *'gatekeeping'* and*'co-payments'* – across all 38 member countries. The findings fit almost seamlessly into the debate on mandatory gate-

keeping outlined above: More than three-quarters of OECD countries (31 out of 38) use gatekeeping; in 24 of these, it is even compulsory – and in almost all compulsory systems (21 out of 24), registration with a GP practice is mandatory or effectively universal. Only seven countries, including France and Switzerland, rely solely on financial incentives. Voluntary registration without consequences, as characterised by the German HzV, is the exception rather than the rule in the international context – precisely the point on which Schreyögg focuses his critique of the reform.

At the same time, the new OECD study dampens expectations regarding the HzV mechanism itself. According to the findings of the OECD study, whilst gatekeeping does shift care from specialist to GP level across countries – thereby reducing contacts with hospitals and A&E departments – overall expenditure hardly decreases. The OECD's findings are also sobering with regard to the main driver of the German reform – waiting times: countries with mandatory gatekeeping tend to have longer waiting times for specialist appointments than those with direct access. This may indicate that the gatekeeping function reacts to scarcity rather than resolving it. The OECD authors emphasise in their report that it is not gatekeeping alone that explains the good outcomes of strong primary care systems, but above all continuity and coordination. The paper offers a particular insight for Germany: voluntary registered practice (HzV) has little impact at population level, which aligns the OECD's view with the TK evaluation. However, as with Schreyögg's TK study, this applies with certain caveats. For those actually enrolled, the literature cited in the OECD paper does indeed document effects: higher vaccination and preventive care rates, fewer avoidable hospital admissions, but – unlike in Schreyögg's study – even a reduction in total expenditure.

Learning from other systems?

However much evidence there may be, the German debate is almost obsessively permeated by warnings against copying foreign models. For example, internists warn that primary care systems only work if they are suited to a country's structures and are not created as replicas of the systems that other European countries introduced a decade and a half ago. At the Rhön Roundtable, one expert highlighted a further hurdle that carries particular weight in Germany: experience in other countries shows that "more than 90 per cent of insured people are needed for such a system to work". Either participation must be made compulsory – which is hard to imagine after decades of free choice of doctor – or the threshold must be reached through significant financial incentives.

Both options are politically sensitive: the former because it involves coercion, the latter because it costs money. Opinions in the group were correspondingly divided on a possible penalty scheme for insured people who do not follow the prescribed procedures – similar to the practice fee levied until 2012.

Andreas Storm's sense of urgency

Few express the urgency of introducing a primary care system as bluntly as Andreas Storm, the CEO of DAK-Gesundheit. For him, such a system is not just one reform amongst many, but part of what he calls 'a fundamental overhaul of the healthcare system'. He paints a stark picture of the current situation: the financial position of statutory health insurance and social care insurance is worse than ever. And despite the highest rise in contribution rates in the history of the Federal Republic at the turn of the year, reserves have fallen well below the legally prescribed level, with some health insurance funds already in debt. Before the coalition negotiations were concluded, Storm called for a comprehensive financial review – a thorough stock-take. Later, he warned against a 'yo-yo effect' involving further sharp rises in contributions and called for a stability pact featuring permanently higher federal subsidies and a revenue-based spending policy. One position of particular importance to him is that, for years, the federal government has provided insufficient funding for the healthcare of basic income recipients, resulting in an annual deficit of around ten billion euros.

His stance on outpatient care fits into this picture. This, in particular, needs to be regulated differently, says Storm, citing as an example the introduction of a primary care system, as planned by the federal government – which is important for getting the sometimes dramatic situation regarding appointment allocation under control. Under Storm's proposal, patients would always initially consult only one designated doctor, who would arrange further steps if necessary. Anyone wishing to retain the freedom to choose their own doctor could do so by taking out supplementary cover. He sums up the benefits succinctly: "A primary care system ensures that patients receive faster and more holistic care." At the same time, he tempers expectations regarding the pace of implementation: such a system cannot be introduced in six months; a clear timeline is needed. This call for a rigorous timetable runs through Storm's public appearances – coupled with the warning that, without decisive reform during this parliamentary term, Germany risks falling behind in international comparisons.

Storm's voice carries weight. However, he naturally also has his own vested interests: as CEO of a major health insurance fund, he is directly affected by the issue of the obligation to contract. Which reform benefits which health insurance fund is not a neutral question. This must be taken into account.

A reform in search of a direction

What the current debate on health policy obscures is more sober than its sheer scale might suggest. All three camps are sidestepping the same fundamental design flaw: a system that must cover more than 90 per cent of the insured population in order to achieve genuine regulatory effects requires a level of compulsory participation that voluntary enrolment models are structurally incapable of achieving. This is not an opinion, but a finding from healthcare research, evident both from the Schreyögg study on the TK evaluation and from evidence from comparable European countries. In none of the systems that demonstrably manage patient flows efficiently does participation remain voluntary.

This gives rise to a systemic risk that has so far been largely ignored at a political level. A reform that claims to be mandatory but fails to consistently deliver on this in practice will reproduce the very conditions under which GP-centred care (HzV) previously failed to achieve its intended steering effect across the board. A de facto voluntary system that operates solely on the basis of weak financial incentives will result in pseudo-compliance. The fear is that, ten years after its introduction, an evaluation will yield the same findings as Schreyögg's report does today – findings which all stakeholder groups will then once again claim for their own sectoral interests.

In a paper published in early 2026, the Friedrich Ebert Foundation has advocated an alternative to this 'either/or' approach, setting out 70 recommendations for action. A phased introduction, beginning in well-served regions or designated pilot regions, rather than launching nationwide. This reduces the risk of a nationwide failure, but raises the follow-up question of whether a regionally limited system can ever achieve the necessary enrolment rate of over 90 per cent.

Whether the draft bill recognises this pitfall will be evident from a single critical point in the system: the consequences for insured persons who do not enrol. The seriousness of the reform is evident in one very specific area: only if the consequences for uninsured people are tangible will the system change be more than just a political announcement.

The core structural problem of resource allocation remains unaffected by this:

a primary care system that does not simultaneously relieve the burden on general

practitioners through consistent delegation and interprofessional teamwork will narrow the bottleneck rather than widen it.

With the primary care system, the Federal Government has undertaken one of the few genuine structural reforms in the healthcare sector. However, whether it manages to move from the conceptual stage to the implementation stage will not be decided by the formulation of new care models in expert discussions. The litmus test of the reform lies in the consistency of its regulatory approach. A primary care system that aims to achieve genuine patient management must address the question of what structural or financial consequences it will have for those who evade this management. If the legislation remains vague on the meaning of the term 'binding', the reform risks being reduced to yet another voluntary supplementary service which does not resolve the shortage of resources within the system, but merely continues to manage it.

<< by: MVF Editor-in-Chief Peter Stegmaier and MVF Publisher Prof. Dr Reinhold Roski

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Artificial intelligence was used to support the literature review and the structuring of the lines of argumentation during the working process. The results were reviewed by the authors; responsibility for the text remains with the authors.

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Table 1: Status of research: 22 July 2026. Own illustration.