OptiMedis study for the Bertelmann Foundation: Analysis of the potential for the use of practice support roles

Can delegation safeguard GP care?

When there is a shortage of GPs, the knee-jerk response is usually: more university places. A new potential analysis by OptiMedis, commissioned by the Bertelsmann Foundation, counters this by arguing that this approach takes far too long. Even with an immediate increase in places, additional medical capacity would not be available for another 12 to 15 years. The current study (1) therefore puts forward a different hypothesis: existing doctors' working hours can be utilised so much more efficiently through a consistent division of labour within the practice team that care can be secured in the short term.

>> The study's findings are clear-cut. Based on two innovative practices with a large caseload, the authors conclude that practice support roles requiring further training and academic qualifications – particularly Physician Assistants (PAs) and non-medical practice assistants (NäPAs) – can, under medical supervision, take on on average around 65 per cent of the workload that GPs would otherwise have to handle themselves. Put another way: a practice can theoretically increase its patient caseload by up to 200 per cent – and this is already possible within the scope of the delegation agreements currently in force.

This comparison is illustrated by two practices that already rely heavily on delegation. The MVZ Birkenallee in Papenburg, Lower Saxony, with four full-time equivalent doctors, treats around 3,200 patients per doctor per quarter – many times the national average of 916. This is made possible by eleven PAs and three NäPAs, who carry out home visits, wound care, technical diagnostics and geriatric assessments, and in some cases even specialist examinations under the telemedical supervision of specialist hospital doctors. The second innovative practice, 'Hausärzte am Spritzenhaus' in Baiersbronn, Baden-Württemberg, combines the delegation of tasks with an unusually high level of digitalisation, including AI-supported documentation and a patient app; there, the patient load stands at 1,817 patients per doctor.

In contrast, there are three municipally run standard medical care centres (MVZs) in rural regions. They operate predominantly on a doctor-centred basis, employ no PAs and only occasionally use nurse practitioners. Their patient profile differs little from that of the innovative practices, with the proportion of patients with chronic conditions standing at around 52 per cent. Nevertheless , it is estimated that only five to ten per cent of services are delegated there – an indication that the differences in care capacity are explained not by the burden of disease, but by the organisation of work.



The study derives a simulation from the 65 per cent figure. This is based on the baseline scenario of the BARMER Institute for Health System Research (bifg), which forecasts an additional requirement of just over 3,200 full-time equivalent GPs by 2030. If the approximately 5,000 currently vacant GP posts are added to this, the result is a target figure of around 8,300 full-time equivalents for what is described as 'successful comprehensive care'. The result: even based on fairly conservative assumptions, the calculated additional requirement can be progressively reduced in the short term and even exceeded by 2030; this would free up the working hours of 8,818 full-time GPs – mathematically enough to enable full coverage nationwide.

A care provision simulator developed by OptiMedis highlights the extent of regional differences. It supplements the previously overly broad GP planning areas with a 100-metre grid based on the Microcensus, which in turn is based on research by the Leibniz Institute for Ecological Spatial Development. This makes it possible to model how additional delegated staff would alter the level of care and the available time for medical consultations in individual sub-regions, and it reveals where additional capacity would be of greatest benefit. Three examples illustrate the principle.

Example: Jüterbog

In the Jüterbog sub-region of Brandenburg, with a population of just over 28,000, the level of care provision stands at 60.4 per cent, supported by 10.6 full-time equivalent GPs and access times ranging from 22 to a maximum of 62 minutes – significantly below the national average of 66 minutes. Under the model allocation of 13.3 delegated staff, the coverage rate rises to 109.6 per cent, whilst travel times increase to between 43 and 93 minutes. By way of comparison: the bifg forecast predicts that Jüterbog will have a coverage rate of just 51.5 per cent by 2040.

The case of Salzwedel

Salzwedel in Saxony-Anhalt presents a similar picture. The current 30.8 full-time equivalent doctors and 34 doctors in 26 practices correspond to an official coverage rate of 77.5 per cent. If 19.8 delegated staff are allocated to the medium-sized practice category, the coverage rate rises to 111.6 per cent. A histogram also illustrates how the population is distributed across the various coverage rates in the scenario and how significantly the baseline situation improves.

Example: Hamburg

The third example shows that this is not just an issue for rural areas: there are also gaps in healthcare provision in city-states. In Hamburg, for example, this affects parts of Neugraben-Fischbek, with a population of just over 27,500 and an average response time of 57 minutes, as well as Finkenwerder and neighbouring areas across the state border in Lower Saxony. Similarly, the Porta Westfalica district in North Rhine-Westphalia, with around 36,500 residents, has a coverage rate of 65.9 per cent and an average response time of 47 minutes. The simulator is explicitly intended as a supplementary decision-making aid; it does not reflect specialisations or actual patient flows, and assumes a linear, homogeneous effect of the delegated staff.

Jüterbog simulation: Level of care before and after the simulation – baseline simulation

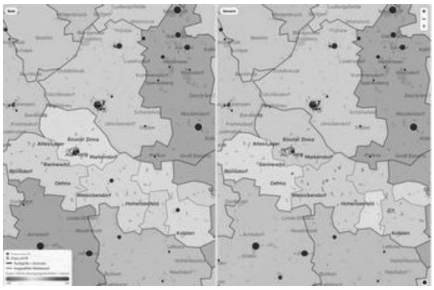


Fig. 1: Example of the simulation in Jüterbog. Source: Presentation by Dr h.c. Helmut Hildebrandt at the BMC web seminar 'How can we safeguard GP care despite a shortage of doctors?' Presentation title: 'Care simulation: Analysis of the potential for utilising practice support roles in general practice / Delegation within the practice team'.

It is noteworthy that this effect persists even under deliberately conservative assumptions. The simulation assumes predominantly part-time work, with only 25 per cent of graduates actually joining GP practices after their training, and with a take-up rate that rises gradually from 15 per cent in 2026 to 70 per cent in 2030. A plausibility analysis also shows that even if doctors were employed exclusively within collaborative structures such as group practices and medical care centres (MVZs), by 2030 only one delegated staff member would need to be employed for every 1.7 full-time equivalent doctors.

The authors openly identify the obstacles: concerns about legal certainty and liability, unresolved issues regarding funding, a lack of knowledge about the training content, and fears of a decline in quality or rejection by patients. However, experience and evidence are already available to address all these issues. A 2018 Cochrane review, for example, suggests that care provided by nursing staff, compared to that provided by doctors, 'probably generates similar or better health outcomes for a broad range of patient conditions'.

The OptiMedis study is explicitly intended as a contribution to the debate. Its vision is an expanded primary care system in which doctors' time remains reserved for core tasks, supervision and team coordination, whilst qualified teams, digital tools and telemedicine handle routine care. The message from Dr Brigitte Mohn, Chair of the Bertelsmann Stiftung, in the study's foreword is clear: There is little cause for concern about a future shortage of doctors if the distribution of tasks in medical practices is modernised – we simply need to take decisive action before the bottlenecks become even more acute. << by: MVF Editor-in-Chief Peter Stegmaier

1: https://t1p.de/2e5af

Citation

Stegmaier, P.: "Can delegation safeguard GP care?", in "Monitor Versorgungsforschung" (04/26), pp. 28–29. https://doi.org/10.24945/MVF.04.26.1866-0533.2844

See your GP first?

>> In the article (1) "See your GP first? How a primary care system affects healthcare provision", published in the "Science Media Center" of SMC Germany gGmbH e.V., Cologne, six experts were asked to assess the evidence available to date for a primary care system and to evaluate it in light of GP capacity.

Prof. Dr Ferdinand Gerlach from the Institute of General Practice at Goethe University Frankfurt emphasises that in 80 to 90 per cent of cases, the focus is on providing primary care that resolves the patient's condition, and that referral to other levels of care is only necessary in 10 to 20 per cent of cases. Germany allows unregulated direct access to all levels of care, which leads to high costs and mediocre outcomes.

The high number of doctor visits is striking. The 9.8 visits per year reported by the OECD represent, according to

Prof. Dr Reinhard Busse of the Technical University of Berlin, only covers billed cases; in reality, the figure is likely to be roughly 20. Misaligned incentives arising from a volume-based, quarterly remuneration system lead to unnecessary repeat appointments.

Prof. Dr Stefanie Joos of Tübingen University Hospital sees the core problem not so much in too many doctor's visits as in a lack of coordination. A good system should not be reduced to access control, but requires a reliable point of contact, multiprofessional teams and a functioning electronic patient record. She considers the simultaneous discussion of sick leave from the first day to be incompatible with the aim of avoiding unnecessary appointments.

Prof. Dr Michel Wensing from Heidelberg University Hospital emphasises that strong primary care improves health and reduces costs.

According to **Prof. Dr Jonas Schreyögg** (University of Hamburg), the key factor is mandatory participation: voluntary, GP-centred care has only a limited steering effect.

Prof. Dr Marco Roos (University of Augsburg) calls, on behalf of DEGAM, for mandatory care pathways and remuneration tailored to needs. The Netherlands, Denmark and other Nordic countries are seen as role models – though none can be copied exactly. <<

1: https://t1p.de/ekei9