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Lessons from a Comparison of Ambulatory Care in France and Germany

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Germany is the cradle of social health insurance, as the first health insurance scheme was introduced by the German Chancellor Otto von Bismarck at the end of the nineteenth century. While France based its social security system on the German model, the healthcare systems developed differently in the two countries. Healthcare spending in Germany, followed by France, are currently the highest in the world after the United States. However, the compo-sition of these expenditures varies between the two countries. Both in Germany and France, the ambulatory and hospital care sectors are distinctly separate in terms of their organi-sation, funding, and regulation. This analysis, drawn from a broader study that compares healthcare spending in Germany and France, focusses on the organisation of ambulatory care in the two countries. By comparing the principal mechanisms and policies that define and regulate the volumes and prices of ambulatory care, we identify possibilities for im-proving the management of healthcare spending in France.

Germany is the cradle of social health insurance, as the first health insurance scheme was introduced in Germany in 1883 by the German Chancellor Otto von Bismarck. While France based its social security system on the German model, the healthcare systems developed differently in the two countries. The German model is characterised, on the one hand, by the coexistence of public health insurance and substitutive private health insurance, which together provide universal health coverage, and, on the other hand, by decentralised governance of the healthcare system, which gives considerable decision-making power to corporatist bodies: associations of health insurance funds, hospitals, physicians, psychotherapists, and dentists. Healthcare expenditure in Germany (12.7% of the gross domestic product in 2022), followed by France (12.1%), is the highest in the world after the United States.

In Germany, there is a strict a strict separation between the organisation and funding of ambulatory and hospital care, which leads to a fragmentation of the healthcare delivery and problems in terms of efficiency and care quality. The hospital sector is characterised by overcapacity, with a high number of beds, a very high volume of admissions, and long length of stays (Brunn et al., 2022). The hospitals suffer from a lack of attractiveness and there is a shortage of healthcare professionals, which raises problems relating to the quality and security of healthcare. The high rate of avoidable hospitalisations also raises questions about the appropriateness of hospital care, while the low bed occupancy rates raises issues for the financial sustainability of healthcare facilities (Minery and Or, 2024). In this article, we focus on the ambulatory care sector, which has more interesting features for France.

A decentralised and self-governed healthcare system which gives considerable power to healthcare providers in Germany, against a highly centralised healthcare management in France

Germany is a federal State, composed of sixteen federated states (*Länder*) that have legislative authority, except

in areas in which it is exercised exclusively at the federal level. Regarding health, the Federal Ministry of Health (*Bundesministerium für Gesundheit*) is responsible for the management of the healthcare system, but the *Länder* are responsible for the implementation of the federal laws as well as hospital planning and public health services. However, the organisation and funding of healthcare are subject to decisions taken by the actors in the healthcare system: the health insurance funds, hospitals, physicians, psychotherapists, and dentists are represented by associations that sit on the Federal Joint Committee (*Gemeinsamer Bundesausschuss* – G-BA), the supreme decision-making body in German health system.

In France, the governance of the healthcare system is centralised, and mainly shared between the State, the National Health Insurance system (*Assurance Maladie*), and, to a lesser extent, the local authorities (*départements*) for long-term care. The Ministry of Health plays the main role in terms of healthcare policy and is responsible for the preparation and implementation of the government policies regarding the organisation and funding of healthcare as well as public health. The National Health Insurance Fund contributes to the definition of the benefit basket of care, the regulation of prices for procedures, drugs, and devices reimbursed, and the definition of co-payment levels. It also conducts – under the government's control – negotiations with the healthcare professionals' unions to set the fees for self-employed ambulatory care professionals.

Private healthcare insurance: complementary in France, substitutive in Germany

Health insurance is mandatory in the two countries. In France, compulsory health insurance is public and provides a generous basket of care but requires cost-sharing for all types of healthcare, including physician consultations and hospitalisations. Hence, 96% of the population has private complementary health insurance to cover mainly non-reimbursed healthcare costs. In Germany, compulsory health insurance is provided in the framework of a public health insurance plan (*Gesetzliche Krankenversicherung* – GKV) or substitutive private health insurance (*Private Krankenversicherung* – PKV). Persons whose income is higher than a set threshold (66,600 euros gross per year in 2023) or who belong to certain occupational categories (such as self-employed people and civil servants) can choose private health insurance, but without the possibility of switching back to public health insurance. 87% of the population is covered by the public scheme, 11% by private insurance, and the remaining 2% (such as soldiers) by special schemes. There are no user charges under public health insurance for physician consultations (GP or specialist) and hospitalisations (except for the daily set rate of 10 euros, for a maximum of 24 days), but certain hospital services are not covered by the public insurance scheme (such as a private room). The user charges for medications are low: 10% of the sale price per box, with a minimum of 5 euros (unless the price of the medication is lower) and a maximum of 10 euros. The private complementary health insurance play therefore a far less important role in Germany, where, in 2019, a quarter of the population had private health insurance and it represented 1.4% of the healthcare spending, compared to 13.2% in France. Overall, household out-of-pocket spendings are low, in both Germany (12% of the healthcare expenditure in 2021) and France (8.9%).

Competition between the health insurance funds in Germany compared with a single-payer system in France

In France, affiliation to a health insurance fund is automatic and there is no competition between the various schemes. The Health Insurance Funds operate as a single payer. The health insurance in Germany is a multi-payer system, with 96 public health insurance funds and 46 private funds in 2023. Unlike France, people can freely select their health insurance fund based on the available information on the cost and quality of the insurance. Health insurance funds can compete on price to attract new affiliates: they can offer price options which allow to benefit from additional services or reduce their contributions. However, the basket of care covered by the public health insurance system is defined at the federal level by the Federal Joint Committee (G-BA), which lists the services that should be covered by any health insurance provider. It covers a broad range of services and the insurance providers only marginally complement them with additional services. Furthermore, the insurers are contractually obliged to accept all applicants, no matter what their risk profile is (health status).

Similar densities of ambulatory physicians, but more general practitioners in France compared with more specialists in Germany

Relative to the number of inhabitants, the number of physicians in the ambulatory sector is similar in France and Germany (190 physicians per 100,000 inhabitants at the beginning of 2022 compared with 183 in Germany at the end of 2021). However, the number of general practitioners (GPs) per inhabitant is far higher in France than in Germany (107 compared with 66 per 100,000 inhabitants), while the number of specialists per inhabitant is higher in Germany (83 compared with 117 per 100,000 inhabitants in Germany). Hence, GPs represent 56% of the ambulatory physicians in

Context

This study was conducted as part of a collaboration between the Institute for Research and Information in Health Economics (IRDES), the High Council for the Funding of Social Protection (*Haut Conseil du financement de la protection sociale* – HCFIPS), the Ministry of Health's Directorate for Research, Studies, Assessment and Statistics (*Direction de la recherche, des études, de l'évaluation et des statistiques* – DREES), the National Health Insurance Fund (*Caisse nationale de l'Assurance maladie* - CNAM), the High Council for the Future of Healthcare Insurance (*Haut Conseil pour l'avenir de l'Assurance maladie* – HCAAM), and the Organisation For Economic Co-Operation And Development (OECD). The study led to the publication of an IRDES report (Minery and Or, 2024). The authors would like to thank Dominique Libault (HCFIPS) for initiating and supporting this project, as well as all the members of the project steering committee and the German experts called upon.

B1

Psychotherapists are recognised as healthcare professionals in Germany

In France, psychotherapy has been a recognised profession since 2012, but psychotherapists are not considered as healthcare professionals and the cost of ambulatory psychotherapy is not reimbursed. Since 2022, in the framework of the "*Mon Soutien Psy*" scheme, the health insurance fund reimburses the cost of up to eight therapy sessions per year with a registered psychologist. Nevertheless, there is no common and approved training requirements to practise psychotherapy in private practice, nor to be reimbursed by the National Health Insurance. In Germany, more than 31,000 "non-medical" psychotherapists are recognised as healthcare professionals and reimbursed by the public health insurance funds, in addition to 6,200 medical psychotherapists. Following a five-year university training in psychotherapy, the students take a State exam that authorises them to practise as psychotherapists. They then undergo a five-year specialised training in hospital or ambulatory care facilities, which is an essential requirement to be listed on the registry of physicians and psychotherapists and to get reimbursed by the public health insurance. The physicians (most of whom are psychiatrists and also other specialists who have undergone additional training) who work as psychotherapists cannot, however, prescribe medication. The therapy sessions are remunerated according to their duration: for example, a 25-minute session costs around 55 euros, and a 50-minute session around 110 euros.

France, compared with 36% of physicians (excluding non-medical psychotherapists) in Germany. This difference can be explained by the larger number of ambulatory surgeons in Germany (twice as many, with 18.6 surgeons per 100,000 inhabitants, compared with 8.8 in France) and gynaecologists (almost three times as many, with 15.4 gynaecologists per 100,000 inhabitants, compared with 5.3 in France). Furthermore, Germany has 38 psychotherapist-psychologists per 100,000 inhabitants, who are recognised as healthcare professionals and are reimbursed by the health insurance, in contrast with France (see Box 1).

Group practices are increasingly popular in both countries …

In France and Germany, ambulatory physicians can practise alone in an individual office, in collaboration with other physicians, or in multidisciplinary health centres. In both countries, ambulatory physicians have traditionally worked on an individual basis. In France, collaboration between GPs and other healthcare professionals has been encouraged over the last two decades through financial incentives in the framework of primary care facilities: health centres (primary care professionals paid by salary), mono-disciplinary group practices (self-employed GPs), and multidisciplinary group practices (self-employed primary care professionals, including GPs, nurses, and physiotherapists). Hence, the number of GPs working in a group practice has been increasing in France: 69% of the GPs were in a group practice in 2022 (compared with 54% in 2010). In Germany, there are similar structures for group practice. Several physicians can get together to work in a group practice (*Berufsausübungsgemeinschaft*) and create a single economic and organisational entity. The multidisciplinary ambulatory healthcare centres (*Medizinisches Versorgungszentrum* – MVZ) are run by self-employed physicians and employ other specialist physicians, as well as medical assistants, nurses, and medical secretaries. Despite the increase in group practice in Germany, 54% of the GPs continue to work in an individual private practice (*Einzelpraxis*) in 2021.

… but a greater variety of healthcare professionals, in particular medical assistants, are employed in individual practices in Germany

Although individual practice remains the most common form of medical practice in Germany, physicians do not work there alone. They are generally assisted by medical assistants or nurses. In 2019, the average number of medical assistants and nurses employed was 3.4 persons in individual private practices and 8.1 in group practices with a single medical specialty. In multidisciplinary centres (MVZ) and group practices with several specialties, their number was estimated to be around 19 and 12 persons respectively. In total, 341,000 medical assistants worked in ambulatory practices in 2021. These medical assistants (*Medizinische Fachangestellte*) undergo a three-year post-secondary education training course. In addition to various administrative tasks (booking appointments, documentation, invoicing, etc.), they assist physicians by performing various medical tasks (they apply dressings, prepare syringes, measure blood pressure, take blood samples, etc.). They can carry out protocolised care with the physician, notably for chronic wounds (this care is reserved for nurses in France). Medical assistants and nurses who have more than three years of professional experience in ambulatory care can undergo continuous vocational training which enables them to carry out home visits and visits in nursing homes on behalf of physicians. Unlike Germany, the profession of medical assistant remains underdeveloped in France: at the beginning of 2022, only 5% of the GPs had a medical assistant and 5% had no medical assistant but worked with a healthcare professional (salaried nurse) who assisted them. Since the creation of medical assistant posts in 2019, only 6,000 contracts have been signed. In addition to the fact that there are fewer medical assistants than in Germany, the medical assistants in France undergo shorter training. They perform mainly administrative tasks, help the physician during consultations, and organise the coordination with other healthcare professionals, but they cannot work autonomously.

Physician consultations are more often but shorter in Germany

The fact that German physicians employ many healthcare professionals, even in individual practices, seems to contribute to ensuring a high volume of activity: in 2019, the average number of con-

tacts with a physician per inhabitant was 9.8 in Germany, compared with 5.9 in France. This reduces the medical time per patient by 50% compared with France (8 minutes in Germany, compared with 16 to 18 minutes in France) [Irving, 2017; DREES, 2019]. Furthermore, German family physicians report shorter working hours than the GPs in France: 52.4 hours in 2018 according to the National Association of Public Health Insurance Physicians (KBV) and 49.3 hours in 2019 according to the data from the Central Research Institute of Ambulatory Health Care (ZI) in Germany, compared with 54 hours in 2019 in France (DREES, 2019).

Ambulatory care budgets allocated according to predefined costs and volumes of care to remunerate German physicians

In Germany as in France, self-employed ambulatory physicians are primarily paid on a fee-for-service basis, but with notable differences. In France, ambulatory physicians' remuneration is directly dependent on the number of consultations and procedures they perform. Around 15% of physicians' remuneration come from flat-rate payments, in particular the Performance Based Payment (P4P) scheme (*Rémunération sur Objectifs de Santé Publique* - ROSP). In Germany, the payment mechanism for ambulatory physicians is quite complex. The physicians are primarily reimbursed based on a combination of fee-for-service payments and capitation (quarterly payments per patient). There is no fixed price for a consultation, physicians are remunerated according to services provided which are defined by the "EBM" classification system (*Einheitlicher Bewertungsmaßstab*). The rationale behind this classification system is similar to that of the Diagnostic Related Groups (DRGs) used in hospitals. The grouping of medical services take into account the patients' profiles (such as a diabetes follow-up consultation with an elderly person) rather than only individual procedures as the case in France. The EBM contains almost 1,500 medical groups (against 13,000 procedures in France). Each medical service is given a reference price in euros and a number of points, which reflect the intensity of the medical service, by the evaluation committee (*Bewertungsausschuss* – BA), based on an evaluation of the real costs of the services. Indeed, the monitoring of the cost of ambulatory healthcare is impressive in Germany, and data regarding the cost of private practices, which are regularly updated, are open to general public. In France, the Common Classification of Medical Procedures (*Classification Commune des Actes Médicaux* - CCAM) contains more than 13,000 procedures and the last global update of the costs dates from 2005. This means that technical progress is not sufficiently taken into account in the prices, which can generate unjustified income and contribute to the development of private equity funds' market for certain profitable activities and underfunding of others.

In Germany, the notion of extra billing does not exist. However, a physician's remuneration differs according to whether he/she provides medical care to a patient covered by public health insurance (GKV) or private health insurance (PKV). In the case of private insurance, the Price List for Privately Delivered Medical Services defines the basic and maximum fees that physicians can charge, but the phsyicians have some room for manoeuvre to set their fees. In the case of public insurance, the physicians are not paid directly by the health insurance funds: they pay an annual prospective budget to each regional association of public health insurance physicians (*Kassenärztliche Vereinigungen* – KV)[1], which then distributes the budget between the public health insurance physicians in its "region" on a quarterly basis (quarterly capitation). This global budget which is adjusted by the morbidity or patient profile in each *Land*, sets the maximum limit of ambulatory care expenditure (a fixed budget). The amount of the budget is negotiated between the associations of physicians and the public health insurance funds, by taking into account the prices and volumes of the medical services provided in the preceding year in the region. The sum can be adjusted to take into account the number and changes in the age structure and health status of the insured population in the *Land*. Furthermore, the price of the EBM point is adjusted each year to reflect the changes in investment and operating costs in the *Land*. This procedure primarily aims to maintain the expenditure within reasonable limits, while promoting a high volume of healthcare. The physicians are only partly reimbursed beyond a certain volume of activity per quarter to adhere to the allocated budget. Certain medical services, such as preventive acts, ambulatory surgical procedures, and psychotherapy, are not subject to budgetary constraints and are therefore reimbursed on a fixed price basis to encourage physicians to perform them. While, initially, only a few medical services were remunerated outside the budget, the extrabudgetary remuneration now represents almost 40% of the total remuneration of the public health insurance physicians.

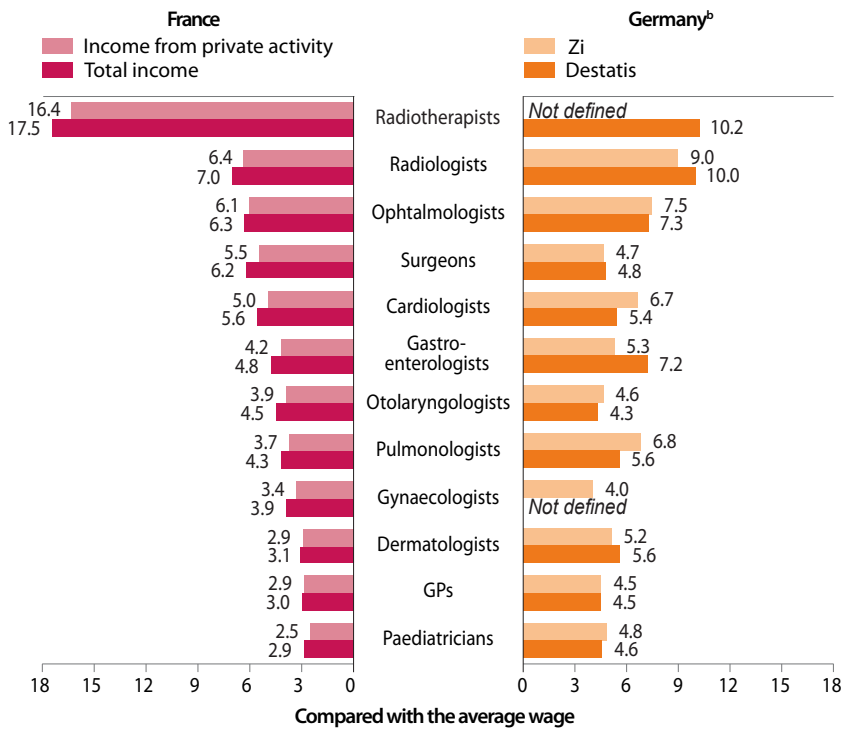
Ambulatory physicians have a higher income in Germany and the income disparities between medical specialties are less pronounced than in France

For most of the specialties, the income relative to the average wage is higher in Germany than in France, with several noteworthy exceptions (see Figure 1): surgeons, cardiologists and otolaryngologists earn between 6.2 and 4.5 times more than the average wage in France, compared to between 5.4 and 4.3 times in Germany. In France, paediatricians, GPs, and dermatologists are the specialities that earn the least, with around three times the average wage, while the other specialities earn between four and seven times the average wage, with the exception of radiotherapists. Certain specialties systematically earn more, whether in France or Germany, in particular radiotherapy, radiology, nuclear medicine, ophthalmology, cardiology, and gastro-enterology. In France, radiotherapists are exceptionally well paid in this selection of specialties compared with the average wage (17.5 times the

[1] The associations of Public Health Insurance physicians (KV) are public sector entities under the control of the ministry of health or social affairs in each *Land*. At federal level they form the National Association of Public Health Insurance Physicians (*Kassenärztliche Bundesvereinigung* – KBV). The KV and the KBV are responsible for organising the ambulatory medical and psychotherapeutic care for the beneficiaries of public health insurance throughout the country. At the federal level, the KBV makes agreements with the National Association of Public Health Insurance Funds (GKV-*Spitzenverband*) concerning the organisation of healthcare. Every doctor and psychotherapist who is authorised to treat patients with public health insurance is automatically a member of the KV in his/her *Land*.

F1

Income of self-employed physicians compared to the average wage[a] in France and Germany, 2019



[a] Before deduction of social charges. Includes revenues from both public and private patients. Average annual gross wage in 2019: 39,152 euros in France and 42,376 euros in Germany (OECD statistics).

[b] For Germany, representative samples of 64,754 medical practices for the Federal Statistical Office (Destatis) and 4,020 practices for the Central Research Institute in of Ambulatory care (Zi) for 2019. Financial data reported matched with the tax data. The category 'radiotherapists' also includes nuclear medicine specialists and radiologists.

Sources: DREES, 2022; ZI, 2020; Destatis, 2020. Calculations: IRDES (Minery and Or, 2024, p. 34).

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average wage), followed by radiologists (7.0 times the average wage), which may be the result of the priority given to cancer, but may also be a manifestation of a failure to update fees: the gap between prices and costs generates undue profit (Cour des Comptes, 2022).

Overall, the disparities in income between different specialties are less pronounced in Germany than in France. For example, ophthalmologists earn on average 80% more than the GPs in Germany compared with more than two times (110%) in France. In France, the average income of radiotherapists corresponds to almost six times the average income of GPs (5.8 times), compared with 2.3 times in Germany. However, the income of hospital physicians seem to be similar in France and Germany, and globally lower in the two countries when compared with the income of ambulatory physicians (see Box 2).

The fees for medical services in Germany are updated regularly considering the changes in real costs

The income differences amongst the specialties, in both Germany and France, may arise from differences in fees (public versus private in Germany and sector 1 versus sector 2 in France), as well as profit margins for different procedures that vary according to the speciality. Technical and novel procedures are often more profitable and some technical specialties may increase their volumes more easily than others (more medical). In France, the income may be higher, in the specialties for which the share of physicians in sector 2 (can set higher prices) is larger, as it is the case for the physicians who have more patients with private insurance in Germany. However, a large proportion of the income disparities between ambulatory specialists in France is the direct result of the failure to update fees on the basis of costs. For example, more than 80% of radiotherapists practise in sector 1 (with regulated public prices).

The setting up of medical practices in the ambulatory sector: freedom of choice in France, regulated in Germany

In France, at the end of their studies, physicians are free to choose where to practise their medical activity on the national territory. In Germany, physicians and psychotherapists must register in a State (*Land*) and have a licence to practice which is regulated within a planning framework (*Bedarfsplannung*). This instrument provides the reference for the number of physicians required in an area to ensure equal access to healthcare. It is based on a target ratio of physicians per inhabitant, which depends on the density and structure of the population's morbidity, age, and gender. The geographic perimeter of a planning area varies from one speciality to another: the more the medical care is specialised, the larger the planning area. The planning framework is defined on the federal level by the Federal Joint Committee (G-BA), but the associations of physicians (KV) set their own rules, by agreement with the health insurance funds, by taking into account regional and local context of healthcare.

A tool that allows regulating supply in high-density areas in Germany, but does not remedy all the problems of inequality in healthcare access

In Germany, requirement of licence is a restrictive tool: in areas where the density of physicians is high, it is impossible for new physicians to set up a practice. However, it does not suffice alone to combat the lack of attractiveness in under-dense areas. The initial aim of the planning, which has existed since 1993, was not to combat the lack of physicians in certain regions, but to prevent that too many physicians practise in the same area, in order to guarantee the economic interest of the physicians who already had set up a practice.

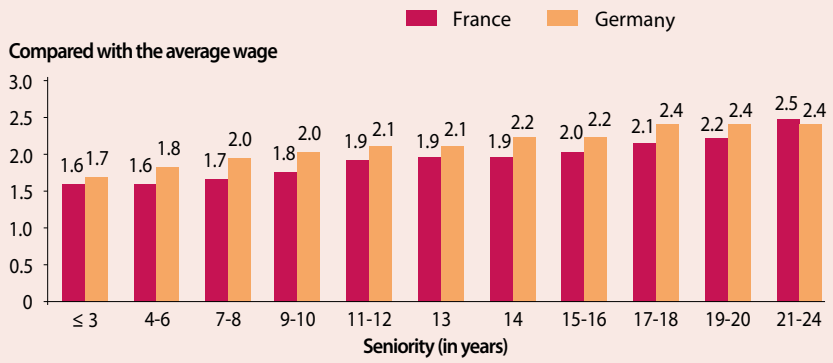
B2

The basic pay of hospital doctors and interns in France and Germany

In France, the wages of medical staff in public hospitals is set by decree and varies according to their status and seniority. In Germany, the basic pay of hospital doctors is set by collective agreements, which differ according to the type of healthcare facility (university hospital, general facility, or private clinic). It varies according to the status of the doctor and his/her seniority.

The difference in basic pay of hospital doctors in France and Germany is relatively small, but the remuneration is generally higher in Germany until twenty years of seniority. However, this comparison does not include the chief doctors (*Chefärzte*) in Germany, whose remuneration is fixed through wage negotiations and may be particularly advantageous.

Basic pay of a hospital doctor*, who becomes department head after ten years of seniority, compared to the average wage in France and Germany



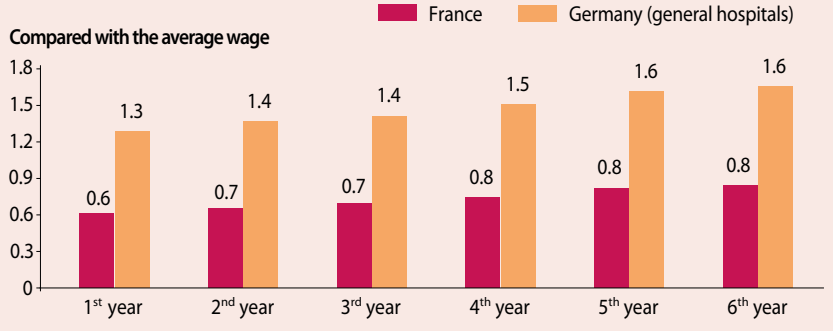
* Corresponds to "*praticien hospitalier*" in France and "*Facharzt*" in Germany.

Scope: In France, basic pay of a hospital doctor, complemented by the exclusive public service commitment allowance (1,010 euros gross/month) and department head allowance (200 euros gross/month) after ten years of seniority; in Germany, basic pay of a *Facharzt* (specialist doctor), an *Oberarzt* (department head) after ten years of seniority in a general hospital. Wages as on 1 July 2022. Allowances and bonus payments, particularly for out-of-hour medical services, are not included in both countries. Average monthly gross wage of 3,475 euros in France and 3,788 euros in Germany in 2022.

Sources: Légifrance; Marburger Bund; öffentlicherdienst.info. OECD statistics. IRDES Calculations.

Nevertheless, the basic gross income of an intern, after six years of medical studies in both countries, is much higher in Germany. It is about 1,617 euros in the first year and 2,374 euros for a "junior doctor" at the end of their internship (sixth year) in France against 5,085 euros and 6,536 euros gross per month for an in intern in a general hospital in Germany. In the second year, the interns earn approximately 60% of the average national wage in France, while they earn 35% more than the average wage in Germany. In the fifth year, in France, they still earn almost 20% below the average wage, compared with 60% more in Germany.

Basic pay for medical interns in France and Germany compared with the average wage



Scope: Wages on 1 July 2022. In both countries, out-of-hour medical service allowances complements the interns' basic pay.

Sources: Légifrance; Marburger Bund; öffentlicherdienst.info.

To remedy the lack of physicians in certain areas, various incentives, including financial ones, such as the guarantee of resources or subsidies to cover the initial investment costs when physicians takeover a medical practice in these areas, have been implemented. However, in both Germany and France, these types of financial incentives have been mostly ineffective in attracting new physicians to these areas mainly rural and under populated. Today, young physicians in both countries appear to be more interested in having a salaried activity than an independent practice to have a better work/life balance. Teamwork that enables the delegation of administrative and organisational tasks, a part-time activity, and regular working hours are also increasingly sought after.

Easier access to primary care in Germany

While there are still differences in the distribution of physicians across different regions in Germany, the problems of access to care seems to be less pronounced than in France. The geographical differences in GP densities are less marked in Germany than in France[2]. According to the G-BA, in 2018, almost all of the German population had access to a GP in less than a ten-minute drive (99.8%) and most of the specialists in less than 30 minutes (99%). Most of the persons questioned also declared that they were able to arrange a consultation within a few days.

Drug prescriptions in Germany are closely monitored…

In Germany, the physicians are free to prescribe any medicine as soon as it is authorised for sale. However, they are expected to respect the principle of economic efficiency (*Wirtschaftlichkeitsgebot*): the services must be appropriate and economical with regard to treatment needs and must not go beyond the strictly necessary. The respect of this principle is monitored. Thus, physicians must be particularly

[2] In terms of regional and departmental distribution in France compared respectively with the distribution between the *Länder* and spatial planning regions (*Raumordnungsregionen*) in Germany.

prudent, especially when it comes to prescribing new medicines that may be more expensive than the equivalent therapeutic alternatives.

Since 2017, the associations of public health insurance physicians (KV) and public health insurance funds have been monitoring economic efficiency on the State level. In several *Länder*, the monitoring is based on reference budgets: each physician is allocated an average budget per patient and per quarter for drug prescriptions, bandages, and therapeutic products. This budget varies from one speciality to another. If a physician exceeds the global budget for the patient list, a verification is initiated in the form of a personal consultation during which the physician is asked for explanations and given advice. If budget overrun occurs again (more than 25% of the budget), a reimbursement procedure may be undertaken by the association of physicians. Certain associations compare the average costs of a physician's prescriptions with those in the same speciality at the end of each year. If there is an overrun (of more than 50% in North Rhine-Westphalia and Lower Saxony, 45% in Hesse, and 40% in Berlin), the physician is evaluated, unless he/she can justify the additional expenses by the particularities of the practice. Furthermore, all physician associations set target quotas (minimum or maximum) for the prescriptions of certain groups of medication or active substances, such as generic or biosimilar drugs. The physicians who respect them may also be exempt from inspections.

… which helps to reduce prescription costs

The existence of these controls and the associated risk of reimbursement are constraints for physicians, because the evaluations take time and necessarily generate paperwork. All the same, the number of financial penalties after controls seems to be low. According to a study conducted in 2018 on the impact of pharmaceutical budgets on the physician behaviour (Fischer et al., 2018), the budgets, calculated rather generously, have primarily helped to reduce the cost of prescriptions, especially by increasing the proportion of generic drugs, but have not really reduced inappropriate prescriptions for older persons. It appears that the budgets do not affect the global volume of physicians' prescriptions but encourage them to prescribe more generic medicine to reduce costs. Even if this system of monitoring prescriptions is considered as too restrictive by German physicians, prescriptions in Germany seem to be more in line with clinical recommendations compared with France.

High prescription volumes in France that raise questions about their appropriateness

A comparison of the number of defined daily doses (DDD) prescribed per 1,000 inhabitants for certain groups of medicines in 2021 shows a far greater consumption in France of anxiolytic drugs (almost 15 times more than in Germany), hypnotic and sedative drugs (12 times more), and sex hormones (2.4 times more). Also, the consumption of antibiotics per 1,000 inhabitants is 2.5 times higher in France. However, for certain medicines recommended for the treatment of chronic diseases, the number of prescriptions is higher in Germany, but differences with France are less significant: antihypertensive drugs (1.6 times more than in France), betablockers (1.5 times more) and, to a lesser degree, the medications used to treat diabetes (1.1 time more). Some of these differences may be linked to epidemiological factors (differences in populations in terms of age and morbidity) and the limitations of data comparability. Nevertheless, these numbers raise questions about the quality of prescriptions in France (Minery and Or, 2024 for more details).

More advanced quality monitoring of ambulatory care in Germany

In contrast with France, where little data is available about the quality of care in the ambulatory sector, the monitoring of the quality of ambulatory care in Germany is relatively rigorous and mainly undertaken by the physician associations (KV). Physicians must provide proof to their association of continuous effective training that maintains

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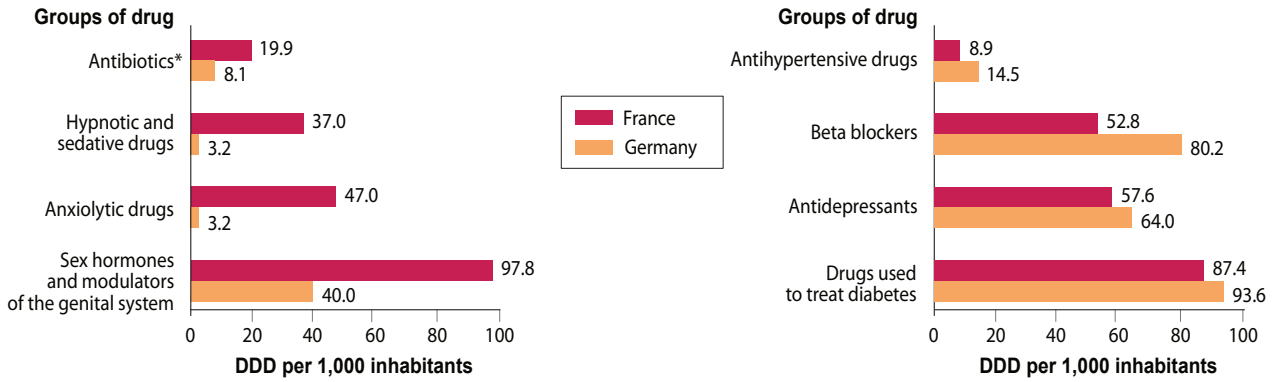
Defined daily doses (DDD) per 1,000 inhabitants per day for a selected groups of medicines in France and in Germany (2021)



* Antibacterial agents for systemic use in the ambulatory care sector (ATC J01 group) [European Centre for Disease Prevention and Control].
Scope: In France, DDD per 1,000 inhabitants; in Germany, DDD per 1,000 insured persons with public health insurance.
Source: OECD Health Statistics.

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their competencies (points accumulated over five years through their participation in congresses or seminars, the publication of articles, etc.). If this obligation is not respected physicians may get penalties ranging from a pay reduction to the withdrawal of the authorisation to practise medicine within the public health insurance system. In France, it existed until now no comparable mandatory mechanism to re-assesses the skills of ambulatory physicians. Since January 2023, physicians, as well as dentists, pharmacists, midwives, nurses, physiotherapists, and chiropodists are required to undergo periodic certification every six years. This new certification process aims to guarantee the maintenance of professional skills, the quality of professional practices, and continuous updating of knowledge and skills, and will be based on a list of criteria established at the national level (including mandatory continuous training determined by the professional associations).

In Germany, certain services can only be provided and invoiced if authorised by the associations of the public health insurance physicians (KV). Around fifty types of service are concerned, such as coloscopy, hearing aids, and outpatient surgery. To obtain an authorisation, the physician must prove that he/she has the necessary qualification and sufficient numbers of patients, that the equipment and premises of the surgery are suitable, and that the medical and non-medical collaborators also have the necessary qualifications. In 2021, almost 95,000 patient files were examined as part of more than 10,000 inspections conducted amongst the physicians. The KVs conduct many inspections, especially of equipment, hygiene, continuous training, and the frequency with which certain services are provided. In the event of serious shortcomings regarding quality, the most significant penalty may be the withdrawal of the authorisation (317 cases in 2021).

Since 2004, all public health insurance physicians have a legal obligation to develop a quality management process in their practices, to guarantee and constantly improve the quality of care. Physician associations verify that this obligation is respected by carrying out random checks of at least 2.5% of the public health insurance physicians. Once a year, the National Association of Public Health Insurance Physicians (KBV) publishes the results of these inspections in a report.

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The German healthcare system is distinguished from the French system through its greater regulation of ambulatory care: the freedom of practice of ambulatory physicians on the national territory is regulated by planning; the associations of public health insurance physicians monitor the quality of outpatient care and the costs of the medical prescriptions, and the remuneration of the ambulatory physicians is distributed by the physician associations via ambulatory care budgets that are predefined on the State level. This strict regulation is largely accepted by the actors of the healthcare system as it is a form of self-regulation, in which the associations of healthcare professionals play an essential role. Overall, this mechanism helps to ensure income levels that are slightly higher than in France for most of the physicians, with wage differences that are less pronounced between the specialties. It also helps to ensure that patients have greater access to ambulatory care with a high level of consultation. The organisation of ambulatory practices, where many medical assistants are employed to help physicians, may be a source of inspiration for France in terms of task shifting. However, it is important to note that this model involves higher healthcare spending than in France. Ambulatory budgets, while allow maintaining productivity, is a conservative system that does not encourage allocative efficiency, as the budgets reflect the healthcare costs and volumes from one year to the next. In fact, the Federal Ministry of Health is planning to reform ambulatory budgets for GPs with the objective of increasing financial incentives to expand their patient base and provide new services, while limiting unnecessary consultations at the physicians' practice. ♦

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