Journal of Nursing, Social Studies, Public Health and Rehabilitation 1–2, 2018, pp. 55–66

BREAKING TRADITIONAL BOUNDARIES BETWEEN STATIONARY AND AMBULATORY MEDICAL CARE

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Submitted: 2018-03-18 **Accepted:** 2018-06-18 **Published online:** 2018-06-30

Abstract
In the search for efficiency, new forms of health care have been introduced in the last two decades in Germany. Consecutive governments have set different reform criteria for a successful development of community health centres[1], bordering the ambulatory and stationary systems. Since their efficiency is not well documented, policy makers should be asking: Are community health centres worth further development or is it a redundant regulation driven predominantly by nostalgia? This study combines overall analysis of the reform's outcomes based on political science methods with an examination of public survey results. Findings suggest that all criteria have not been met, and there have been some unexpected results. Different stakeholders benefited from the centres' introduction. However, it also produced an additional administrative burden and uncertainty for stationed practitioners.

Keywords: *ambulatory health care; community health centres; Germany; physicians; health care in GDR*

REVIEW ARTICLE

INTRODUCTION

The dividing line between stationary and ambulatory medical care in Germany is one of the oldest and most impenetrable. Whereas, in East Germany, there used to be a solid tradition of outpatient clinics (*Polikliniken*), the traditional division persisted in the Federal Republic of Germany. For several reasons, and as a result of the Unification Treaty, outpatient clinics were refused as a relic of communism and something barely imaginable for the West German reality. They were not shut down immediately, but were maintained in certain federal states until the mid-1990s.

About ten years later, an initiative of the Cabinet Schröder took place, introducing the Health Care Modernization Act (Gesundheitsmodernisierungsgesetz – GMG). Besides, this brought the possibility to establish community health centres (*Medizinische Versorgungszentrum – MVZ*). The aim was to introduce more competition and freedom of choice. It is sometimes put forward that the main purpose of these reforms was to introduce a competitive environment (Kingreen 2004).

The first phase of the shift towards optional new forms of joint health care between hospitals and practitioners was temporarily boosted by additional money from the public health insurance system. Even after 2008, as the subsidy dissolved, the number of medical care units was rising (Statista 2017). The alternative of MVZ was positively evaluated. On the

[1] The term "community health centre" is mostly used in American literature. However, there are other expressions with the same meaning, such as "medical care centre" used by the WHO.

other hand, it was perceived by many hospitals with mixed feelings.

Especially in new federal countries, medical care units became a phenomenon. The Cabinet Merkel III accepted another strategy to enhance this development. Nevertheless, the solution did not markedly contribute to budget stabilisation, nor to gaining more suitable options for young practitioners in sparsely populated areas of Germany. Besides, the relative gains of doctors employed in these centres might be considered an illustration of establishing exceptional conditions for only a narrow segment, which often causes disparity.

The question examined in this article is: What is the lesson learned from the introduction of medical care units and were they really a shift to a more competitive system?

MATERIALS AND METHODS

This study is not primarily economic, but it must be based on economic premises. Noelle et al. (2005, p. 33) define a health care system as a system with specific features, "yet per se economised", because more than 10 percent of GDP is generated in it and about the same amount is received by this system.

Based on the classification suggested by Nekola and Ochrana (2009, p. 460), this is a study analysing selected elements of a rather complex phenomenon and therefore it is based on participative approaches.

As suggested by Sanderson (2000), there are three levels of dominant preconditions the approach could be based on – epistemological basis, creation and organization of a public policy and conditions impacting the definition of a problem. This study is more or less based upon the third level.

This study also focuses on patients' benefits. The other group of beneficiaries analysed are practitioners; both stationed and employed. A general approach proposed by Bastian et al. (2005) can be described as a scale from "refuse" to "favour", where the tendencies are driven by the factors of "costs" and "benefits". Most strategies are somewhere in between; marked as "arguable". As for the current paper, since the administrative costs of the studied reform are quite high, the benefit gained should at least correspond.

All sources used for the purpose of this paper can be divided into three categories. First, there are various comments in favour of introducing MVZs, usually representing authors with a rather socialistic point of view. They are both texts describing the positive effects pro futuro, as well as their following evaluation. It is typical that they usually concern only a limited number of indicators. More complex approaches are very rare. Typically, they describe the initial situation. Second, there are critical texts and statements defending liberal positions. However, even the socialistic approaches usually highlight the argument of more competition and freedom of choice. Materials issued by Bundesverband MVZ e.V. (BMVZ)[2] offered solid comparable data. Some other data have been collected by a systematic analysis of the last ten volumes of Deutsches Ärzteblatt, Ärztezeitung and Gesundheits- und Sozialpolitik[3]. For the overview of different attitudes towards MVZs coalition agreements, press releases of the Federal Ministry of Health (BMU) regarding MVZs and newspaper articles reflecting some of them were analysed.

The third type of sources comprises statistics, usually produced by the Federal Statistical Office (*Destatis*), the Federal Joint Committee (*Gemeinsamer Bundesausschuss – G-BA*), or insurance companies or unions. A problem may occur when analysing various sources dealing with East Germany and the Bundesrepublik in the times of unification, because of different methods.

Regarding the historical background, the articles mentioned by Wasem (1997) were further analysed. The deciding factor for their acceptance was firstly the country of origin (East or West Germany) and its relation with stakeholders.

For an appropriate analysis of the intentions it is necessary to define a liberal framework preferring innovative alternatives to the existing unified system. Socialists (SPD) par-

2 The website www.bmvz.de includes an archive section.

3 Altogether 45 articles were analysed.

ticipated in three out of four Governments during the observed period. Except for Cabinet Merkel II (2009–2013), freedom of choice was not the highest priority. However, the demand on positive, innovative approaches was still quite high. As usual, an innovative system is never budget neutral. A good way to assess the reasonability of MVZs is to analyse the attitude of Cabinet Merkel II towards them. Toleration or even a plea for MVZs would be a persuasive argument for their economic and social reasonability.

Specifics and evaluation of GDR stationary health care

It should be pointed out that *Poliklinik* was hardly an invention of GDR. The first *Poliklinik* was established already in 1809 in Berlin – Charité. It was connected with Christoph Wilhelm Hufeland. It is interesting to note that during the Weimar Republic, several *Polikliniken* became the inspiration for a group of Russian doctors who implemented this pattern in the USSR. Thus, the development of a dense net of *Polikliniken* was not a part of an unknown element (Kreibich 2009).

However, the Golden Age of *Polikliniken* started after World War II. There were 184 *Polikliniken* in East Germany in 1950, going up to 622 in 1989. Only some of them, usually one in a district, offered a full service that covered a wide range of blocks provided by 50 practitioners on average (Knieps and Reiners 2015, p. 93). A big advantage of this system was connected with postgraduate training. It was much easier for general practitioners to get a 5-year education degree (postgraduate certification) once they were employed in a *Poliklinik*. In 1988, half of all practitioners were specialists in general medicine. From today's point of view it is an incomparable level (Kreibich 2009). The shortage of general practitioners seems to be a constant problem.

Furthermore, the system brought another unusual type of health care – *Dispensaires*. Typically, chronically ill patients were treated there. *Dispensaires* represented a combination of prevention, diagnostics, therapy and rehabilitation. Therefore, this approach is often considered a good way to connect medicine, prevention and patient motivation. In the mid-80s, a model of Managed Care was introduced in the USA and it soon became a matter of discussion in West Germany. Ray Elling, President of the Research Committee on Sociology of Health RC15 of ISA, stated that in the sphere of connection between work and health protection and prevention measures, East Germany ranges – despite many problematic points – among the best of the examined countries (Elling 1986). The findings of his analysis of six countries (West Germany, East Germany, Finland, UK, USA and Sweden) have been repeatedly cited as an example of the appreciation of East Germany´s system.

Nevertheless, the author himself admits that his analysis is a preliminary one (Elling 1986, p. 477). His book was not accepted unanimously. As some critics say, the author "tends to generalize single observations or cite them as general regularities" (Wanek and Elling 1989, p. 421).

There has been a constant discussion between opponents and defenders of the former GDR health care system. The current mainstream thesis says that the structure of health care in East Germany was modern, sufficient and providing some extra features in comparison with the western system. Its only disadvantage was the general lack of money. The underfunded system was not able to provide comparable standards to the West. Personnel is sometimes considered even more competent than in West Germany; the most visible problem was the old and insufficient technical equipment. Buildings were extremely damaged as well. According to the documents issued by *Sachverständigenrat – Gesundheit* (SVR-G) in 1991, more than 20 percent of hospital buildings required profound reconstruction (Sachverständigenrat zur Begutachtung… 1991, p. 125).

However, the same document states "The deficiencies and problems in the former GDR originated in the socialist system, which represented a planned economy. The crisis is not a result of the deficient personal engagement, but of the fact that it was incorrectly constituted and oriented" (ibid). The planning process distracted individuals from the focus on efficiency. On the other hand, SVR-G recommended to the politicians to be inspired by some aspects of the eastern model. The state-managed system of *Polikliniken* was admired for its ability to distribute health care regularly, which helped to minimize the differences among regions (Harych 1990, p. 101). It is also important to mention that an oversupply of

ambulatory health care emerged as a serious problem in the mid-80s at the latest (Herder-Dorneich and Wasem, 1986). In addition, the density of physicians was uneven in different regions of BRD.

What was the official strategy of the GDR in planning ambulatory health care? The practice was driven by (1) socialization, (2) democratization, (3) overcoming the contradictory nature of health care – doctors in tension between profit and ethics, (4) a combination of both prevention and therapy, (5) cost effectiveness – in comparison with detached practitioners (Winter 1948). As will be shown later, the fourth and the fifth argument prevail even nowadays. Besides, company outpatient clinics began to be established very soon. The GDR regime considered the system designed by its own rules as successful until 1961, when hundreds of physicians fled to the BRD. Physicians were forced to join *Polikliniken*, yet the methods were strictly indirect. There was no single act or regulation coercing them to do so. However, the conditions were successively changed in favour of collective facilities. The process can be compared to the collectivization of agriculture at the same time.

Decision making process in 1990

It is obvious that in 1990 there was a strong interest to detach as many physicians as possible in the long run. But on the other hand, there were many important participants with a different opinion. Table 1 describes the relevant players in the system in 1990.

Table 1 – System of Health Care in Germany before the Unification and its stakeholders (Wassem 1997)

		West Germany	East Germany
Macro-level	State	Upper House Lower House Government	Parliament Government
	Parastatal bodies	Federal Association of SHI Physicians (KBV) Central Federal Association of Health Insurance Funds (*GKV-Spitzenverband*)	
	Associations	German Federations of Medical Practitioners National Association of Employers Trade Unions	"Free" Federations of Medical Practitioners Eastern subdivisions of German Federations of Medical Practitioners
Micro-level			Polikliniken – Establisher – Physicians – Other personnel Patients

There was a specific situation among participants at the state level. Whereas the CDU-led coalition advanced a shift to market-oriented health care, the opposition (consisting of SPD and the Greens) was much more reluctant to alter the East German system in this way. Their chances to influence the decision-making process were limited though. The only chance to reverse the coalition's decisions was via the Upper House, where forming a majority was conceivable. However, in the legislation in the field of health care, the Upper House seldom plays a role, apart from in a very few exceptions (Wasem 1997, p. 105). SPD utilized these rare occasions in different fields. It can be concluded that neither SPD nor The Greens considered enriching the western model with some "eastern" features as a key priority. The situation after the Unification and after the parliamentary vote in December 1990 is another story.

The power of the GDR political representation during the negotiation process was affected by several factors, such as lack of experience of the relatively young Hans Modrow's Government, and almost no experien-

ce with political competition (Wasem 1997, p. 108). After the election in December 1990, the leading coalition gained a majority in the New Federal States. It was no surprise that not even hypothetic support for a restrained and cautious reform succeeded.

There is no serious evidence about the intentions of the Federal Association of SHI Physicians and the Central Federal Association of Health Insurance Funds. However, there was a tendency to preserve the status quo, at least by the former (Wasem 1997, p. 111). Thinking about the high professionalism and expertise on the side of SHI Physicians, their attitude has to be taken seriously. If there were a strong interest to refresh the system and introduce *Polikliniken* in the manner of the GDR, it would be expressed clearly by the Central Federal Association of Health Insurance Funds. There are some interesting findings presented by Jürgen Wasem, which show that most doctors supporting the preservation did so only on a few conditions. A significant reduction of the number of *Polikliniken* was one of them.

It is important to mention the opinion of the greatest associations of German doctors. Although the official position of the *Virchow-Bund* was to "preserve *Polikliniken*, yet as complex health centres", there was another request expressed. The doctors should freely choose which form suits them (Rudolf-Virchow-Bund 1990, p. 19). In contrast, the *Hartmannbund* strongly opposed the eventual preservation of *Polikliniken*. Moreover, aided by a rapid establishment of its branches in the GDR it managed to influence practitioners in the former GDR. The only compromise the *Hartmannbund* was willing to abide by was a postponed termination. It is clear the *Hartmannbund* supported the privatization of doctors. Compared to other key associations, such as *Marburger Bund, Hartmannbund* consisted mostly of resident doctors. The nature of its organisation influences the position of *Marburger Bund* in the long term (Bandelow 1998, p. 80). The course of *Marburger Bund* was so obvious that *Verband der niedergelassenen Ärzte (NAV)* did not even try to establish its own branches in the new federal states and merged with the *Hartmannbund* instead (Wasem 1997, p. 169).

Regarding associations, there was a different situation. Generally speaking, it has always been much easier to formulate strong opinions on various topics for the associations. Unlike parastatal bodies they do not represent both a state institution and an interest group at the same time. Thus, it is much more helpful to concentrate on their opinion regarding the question to what extent the GDR-system should be taken into account. According to Wasem (1997), KBV-members were familiar with the fact that if they preserved the GDR-system characterised by *Polikliniken*, it would affect the efficiency of the whole system, not only in GDR, but – in the long term – the Bundesrepublik as well.

Extinct species – *Polikliniken* in the 1990s

In the end, there was the Unification Treaty of August 1990, which stated that the regular form of ambulatory health care would be based on private practitioners, with an option for Federal States to extend the transitional period. The only Federal State that applied the exception was Brandenburg during the socialist administration. It is obvious that if any single period could be used for a comparison of both systems existing at the same time, it would be this one. Many authors deny the link between the extraordinary financial benefits that *Polikliniken* provided from the state budget for *Polikliniken*. According to these authors, it was no benefit at all, since the interest rates and grace periods were equal to the special contributions from the Federal budget for the freshly established practitioners (Knieps and Reiners 2015, p. 257). Moreover, it was labelled as "from an extinct species to an alternative" in Ärzteblatt ten years later (Richter 2001).

One has to ask why no comprehensive comparison has been issued yet. The biggest problem is the relatively small extent of residual *Polikliniken*. In 1995, they represented less than 2% of practitioners (BMVZ 2017). One of the very few contemporary evaluations was the report of *Bundesverband der Gesundheitszentren und Praxisnetze e.V.*, written by Rainer Janiche. The study defended associative structures with typical arguments, such as economies of scale, sharing and pooling, etc. Neither this study nor the others backed up the opinion with numbers.

Yet in 1998, three important factors met at the same time. Firstly, the liberal-conservative

Government was substituted by a socialists--green one. Green Minister Andrea Fischer was seeking alternatives to the current system. The support of resident doctors at the expense of doctors in *Polikliniken* and the ban on extension of *Polikliniken* were revoked in 1999. Secondly, the socialist experts supported the introduction of the American model of Disease Management Programs (DMP).[4] "Medicine Centers could be born contract partners to health insurance funds during the introduction of DMPs", stated Ulla Schmidt, Federal Minister of Health Care in 2001–2009 (Ärztezeitung 2002). A mild GDP growth after 2000 can be considered as the third factor. The anticipation of markets, together with an improved tax revenue, which grew gradually between 2004 and 2009, influenced the general conditions of health care. Many experts involved, even those who supported the reform steps, expressed their doubts. Hans-Joachim von Essen, director of the biggest existing Medical Center in Potsdam, and his colleague Elimar Brandt, conceded that the development would not be incident-free (Ärztezeitung 2002).

Resurrection – MVZs in the recent years

MVZs were introduced as a result of GMG, which entered into force in 2003. Section 95 (1a) of the Sozialgesetzbuch V (SGB V) states that both a natural and a legal person can establish a MVZ. There are various forms of ownership allowed, including joint-stock companies. However, partnership prevails as the most common form. Mixed forms of ownership have been permitted since 2006. A MVZ can be established by a group of natural persons, usually physicians, and great investors, such as municipalities or insurance funds. The experience of other countries shows that this kind of alliance is predisposed to corrupt behaviour. Since many practitioners are members of the City Council, the risk has to be taken into account.

What was the economic motive to introduce this integrated form of health care? According to the expert opinion in 2003, integrated forms of health care in other countries, mainly in the United States, had brought more positive results in prevention, but in other aspects it had not contributed very much. According to many researchers (Miller and Luft 1997 or Steiner-Robinson 1998), the availability was not higher and the patients' satisfaction was even worse. These results were published in the official recommendation of *Sachverständigenrat Gesundheit (SVR-G)* for 2003 (Sachverständigenrat 2003, pp. 148–149). Moreover, the document mentions a clash of interests between owners (operators) and other practitioners.

Another conflict appears in the framework of the German Federations of Medical Practitioners, where the fragile balance between resident and employed practitioners might be disrupted (Sachverständigenrat für konzentrierte Aktion… 2003, p. 143). The resistance of stationed practitioners might have been fuelled by the recommendation to replace some doctors with physician assistants. The aim of this proposal was to relieve senior consultants of routine work (Sachverständigenrat 2012, pp. 86–87). On the other hand, the same brochure says that some failures could be caused by other differences between systems (e.g. availability of benefits) (Sachverständigenrat für konzentrierte Aktion… 2003, p. 149).

MVZs were never considered an ideal tool for improvement, but rather the only possibility left. Acute challenges to the system were (according to SVR-G recommendations) an aging population, the expected lack of physicians after 2020, a need for the elimination of duplicities and obsolete hospital beds (Sachverständigenrat 2012, p. 80). From this point of view, a return to a more collective system of ambulatory care seems logical.

A closer look at the areal distribution of MVZs in Germany shows their enormous

[4] There are several reasons why DMP failed to be introduced on a massive scale. Karl Lauterbach, social-democratic health care expert, sees the underdevelopment of general practitioner contracts (Hausarztvetrag) as one of them. As a result of two legislation acts – Gesundheitsmodernisierungsgesetz (GMG) (2004) and GKV-Organisationsstruktur-Weiterentwicklungsgesetz (GKV-orgWG) (2008), there were expectations that this scheme would be broadly used in the future. Only some 3.7 million insured persons are inscribed into this scheme nowadays (Lauterbach et al. 2010).

density in heavily populated regions – North Rhine-Westphalia, Bavaria and Berlin. Only 42% of them are situated in the countryside (Knieps and Amelung 2010, p. 17). It is quite likely that MVZs failed to contribute to reducing differences between regions, which was one of their original aims. Lauterbach et al. (2010, p. 159) concede that "despite the early presumptions that MVZs would be established in the countryside, in order to mitigate the risk of undersupply in the regions (...), the geographic distribution shows more activity in conurbations...". The alleviation of regional discrepancies was one of the recommended goals (Sachverständigenrat 2012, p. 88).

There are undeniable advantages of MVZs mentioned by the practitioners involved, such as a better work-life balance for the doctors, or pooling and sharing. Being backed up by large hospitals, some further ambulatory procedures are conceivable (Knieps and Amelung 2010, p. 20). It is necessary to note that none of these aspects were mentioned before implementation. Some experts say that there are some synergic effects among various fields of medicine leading to major savings. Yet, at the same time, the article gives the example of *Elbland Polikliniken GmbH*, where 10% of the total revenue goes to the administration (Rieser 2014, pp. 994–995).

One of the reasons mentioned in the GMG explanatory report is a better implementation of Integrated Care (Orlowski 2004, pp. 202–203). One and a half decades after the implementation of Integrated Care in Germany, it seems that this concept may not succeed after all. According to the latest research of IGES--Institute (one of the most renowned research institutes in the field of Health Care), the most serious problem threatening further development of Integrated Care is too strong and mostly confusing regulation. This document also predicts that MVZs could help women to benefit from part-time jobs.

Positive opinions are based on intended further reform steps that are necessary for a successful implementation. E.g. progress in regional distribution and the reduction of local differences could be achieved only if further administrative barriers were eliminated. Bernd Köppel (The Greens) complains about "persisting small administrative hurdles", which do not allow the potential of MVZs to be properly realized (Rieser 2014, p. 995). Köppel suggests introducing further legislation to regulate allowance procedures in order to support disadvantaged employed practitioners. Yet, this is exactly a pattern that has been used by a group of politicians since the 90s. Since that time, the regulations increased manifold. The effort to level employed and self-employed (stationed) practitioners resembles a vicious circle.

Bernd Köppel also mentions that "employed practitioners are normal, they will not be humiliated, they are not considered bad doctors anymore." Having a closer look at the history of practitioners, it is not with certainty that his wish will come true in the near future. Stationed practitioners have always considered themselves as the only ones able to provide ambulatory health care. Self-management as a sign of democratic society became a necessary condition for practitioners after WWII in Germany. The position is strongly connected with a middle-class feeling (Vogt 1998, p. 44).

Karl Lauterbach, a social-democratic health care expert, summarizes the advantages of MVZs especially in connection with DMP. As mentioned previously, this argument can barely be valid, since DMP is no longer considered a success. His second argument is based on the variety of health care providers: The more forms and alternatives, the bigger competition. Yet after four years of development in the field of MVZs, he admitted "the number of new MVZs did not meet the expectations" (Lauterbach et al. 2009, p. 155).

If we look at the initial stages, there were some pros and cons regarding the competitiveness and MVZs examined. SVRG's support of MVZ's was based on the experience of the health care system in the United States. There were studies in the supporting of "a new type of health care on the intersection". Some of them considered such a new order as more competitive (Ciliberto and Dranove 2006). However, many studies have pointed out that a further concentration of physicians can lead to severe cartel effects and, on the contrary, limit competition (Cuellar and Gertler 2006). There are other studies proving that both effects are always present, and which one prevails depends on many conditions (Rundall et al. 2004).

The Federal Union of MVZs (BMVZ) examined the state of play five years after GMG

entered into force. This study can barely be accused of favouring traditional forms of health care. It does not show satisfying results though. Firstly, it was not proved that part-time jobs for female doctors are more accessible. In contrary to the GMG explanatory report, the survey shows that in an average MVZ, 5.8 practitioners work in 4.4 commitments (Köppel and Müller 2008, p. 2500). Secondly, the chance to employ additional labour exclusively for administrative work is used only by 44% of MVZs. In the category of small MVZs (up to 4 practitioners) it is only 14%. One of the biggest advantages mentioned by Knieps and Amelung (2010), the co-operation with other specialised doctors, does not seem to be utilised either. According to the research, less than 10% of patients receive further treatment within the same clinic (Köppel and Müller 2008).

RESULTS AND DISCUSSION

As mentioned at the beginning of this article, there is no complex and persuasive evaluation of the efficiency of MVZs available. Only indirect mentions and hints can be found. Table 2 shows specific targets set by the supporters of both *Polikliniken* and MVZs in relation to the level of their fulfilment.

Table 2 – Review of the success of different measures regarding MVZs – own compilation

	Intended goals	Unintended results	Level of fulfilment
1.	Alleviate the differences between cities and countryside		Very low (the opposite in some regions)
2.	Liberate employed doctors from the stigma of "second class" doctors		Not proved
3.	Increase cost-effectiveness		Not proved / Low
4.	Reinforce Disease Management Programme		Low (DMP considered unsuccessful)
5.	Strengthen Prevention		Medium
6.		Work-Life Balance	Medium
7.		Some operations available being backed up by large hospitals	Medium
8.		Keeping balance in German Federations of Medical Practitioners	Very low
9.		Necessity to pass further legislation	Medium/High

As can be seen, there are 5 main goals identified among various statements of all supporters of MVZ, two positive trends, which are partially followed, and two other results. The last four fields represent unintended goals. The level of fulfilment of each field represents the author's personal evaluation based on the above-mentioned outputs of the analysis. Apart from Strengthen Prevention (5), all intended tasks can be rated with lower grades. Sometimes they are not easy to evaluate. The second aim (2) can only be evaluated in the long term.

In fact, there are doubts about cost-effectiveness. On the one hand, there are significant economies of scale. On the other hand, case studies, e.g. *Elbland Polikliniken*, are showing the current high ratio of administration costs, which is not negligible (Blöß and Rabatta 2003, p. 2195). Moreover, new forms of inequalities have been found – the financial situation of some MVZs is so poor that a

specific form of compensation was measured. Hospitals (financed mostly by federal countries) have to render 5% of their revenue for individual beds to MVZs in the same region.[5]

Nonetheless, there was a kind of reflection issued by SVR-G in 2012. The repeated motive of this recommendation is: If there is any effectivity gap, it is situated on the intersection of the stationary and ambulatory sector (Sachverständigenrat 2012, p. 45, 87, 242). It is interesting that the documents say nothing about the further development of the successful system of practitioner nets (*Ärztenetze*). A further development of this type of (mostly regional) cooperation might be a solution for at least some of the issues.

Concerning efficiency, these documents distinguish several types – financial efficiency, physical efficiency, use efficiency and cost--value efficiency. The logic of reform processes has to lead from the first one to the last one, so financial efficiency is the one to begin with (Sachverständigenrat 2012, p. 41). It recommends an aiming at different efficiencies in particular fields. An efficient approach to pharmaceuticals should have been improved by Arzneimittelmarkt-Neuordnungsgesetz AMNOG (2010) at the same time.

The same recommendation brochure admits that the introduction and further development of MVZs demands additional legislation. Not only do the activities of MVZs need to be regulated as every new system does, but the aforementioned cartel conditions need to be eliminated. Yet prior to 2004, it was clear that the field of health care insurance is not considered competitive, as CJEU stated (CJEU 2004). Therefore, competition law is hardly applicable (Sachverständigenrat 2012, p. 49).

From the very beginning, there was a strong demand for the improvement of the release management of patients (*Entlassungsmanagement*). Sachverständigenrat (2012, p. 137–140) suggested new ways of release, which could be easily connected with MVZs. Nonetheless, there has been no convincing evidence about its cost-effectiveness yet.

From the point of view of various stakeholders, the MVZs brought both benefits and negative effects. Regarding physicians, the acceptation was ambiguous. The improvement of work-life balance should have led to e.g. a higher share of women in MVZs. However, the share rose from 36.5% in 2004 to 41.7% in 2013 only (Köppl 2015, p. 4). According to the same survey, 47% of respondents characterised MVZs as a negative phenomenon. However, the acceptation was not as negative as it used to be at the beginning. (Köppl 2015, p. 6).

The conservative-liberal Government did not follow the tendency of further development of MVZs. In accordance with the coalition agreement, the conditions for the establishment of MVZs were restricted (CDU 2009, p. 88).

Many surveys suggesting general satisfaction with MVZs tend to ignore the different initial state. In a survey led by *Deutsches Ärzteblatt* in 2008, patients were asked about their relationship towards physicians. There was a significant gap between the new and the old federal states. Whereas, in the old countries more than 50% considered their relationship to be conflict-free, in the former GDR it was only 36%. However, the old federal states experienced a much higher increase of MVZs (Köppl and Müller 2008, p. 47).

According to the recent research in the field of strategic management, this form of cooperation brings a brand-new type of connection between stakeholders. Renger (2016) defines at least three dimensions. This could have some positive effects, but the development of such measures could be quite demanding at the same time.

CONCLUSION

To sum up, the introduction of MVZs was a logical step towards a more efficient system of health care. Although there were other possibilities discussed, the political willingness to try something new prevailed. From the very beginning, it was mentioned by both politicians and experts that the success would be limited and that it demands further development. It was also clear that the early stage could cause some problems. After a decade

[5] See § 116b Sozialgesetzbuch V.

of eliminating all symbols of the communist health care systems, some features experienced a resurrection. This study suggests some points in which the resurrection was driven by a partially false understanding of the success of *Polikliniken* in GDR. On the other hand, it admits that the decisions from 1990 were agreed thanks to a specific (and not always clear) political situation.

However, there were up to five important goals set in 2004 and repeated regularly. After 12 years of implementation, measured by the level of their fulfilment, the results are not very convincing. There are some unexpected positive effects, though. A chance for some ambulant operations to be backed up by facilities of a hospital seems to provide some benefits. New forms of release of patients from hospitals were suggested, yet without any persuasive results so far.

The whole system of MVZs is usually (in some stakeholder groups unanimously) seen as a great reform success. This study partly disputes this statement, at least from some points of view, not primarily from the Government's perspective.

Regarding the intensity of support of MVZs, there was a significant decline after 2009, implying the willingness of the Cabinet Merkel II not to continue in this support, at least temporarily. The peak of new MVZs established in Germany was reached in 2006, followed by stagnation between 2006 and 2009. After 2009, a slight slowdown is evident. Certainly (and it can be applied for other results) it does not prove the economic unreasonability, but together with other factors it does not convince of efficiency.

The main beneficiaries are political parties (SPD primarily) that seemed to be performing well at the time of the financial crisis. It has to be stressed that the demand for cost-saving approaches has been extremely high in the last two decades and was preferred by both SVRKAiG and advisors to the Government. In both cases, the logical link between the need of savings and the intersection between ambulatory and stationary care was underpinned.

On the other hand, the system was heavily criticised by all bodies protecting the interest of stationed practitioners. Between 2009 and 2013, the development was hampered by FDP's Ministers Rösler and Bahr. Without any doubt, there were some winners among employed practitioners in some regions. The awaited benefits for some groups of practitioners occurred at a smaller scale.

Nowadays, the whole system of MVZs tends to be described as "developing" or "promising" on some conditions. It will demand further steps towards a complex system with no clear boundaries between the two subsystems. New forms of managements or new ways of thinking about management should be developed as well.

A complex, indisputable study on the real benefits of introducing MVZs is needed. Otherwise, huge amounts of money could be spent in a way that does not bring additional effectiveness and makes the whole system even more incomprehensible.

CONFLICT OF INTERESTS

The author has no conflict of interests to disclose.

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