VIEWPOINT · ALLERGOCOVER EDITORIAL TEAM

The (very bright) future of private allergology practice

Allergic diseases have been rising since the 1970s — yet specialised supply is not keeping pace. Why allergology is a hidden royal discipline and how AI will shape its future.

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People with allergic diseases in Germany: around 20–22 million (early 2000s) › more than 23 million (2019/2020) › roughly 30 million (2024/2025). Sources: White Paper on Allergy, RKI; absolute totals partly estimates.

It is just after eight on a Tuesday evening. A mother sits with her eight-year-old daughter. For months the child has had a blocked nose at night, sleeps badly, struggles to concentrate. Three doctors have seen her, each with seven minutes, each with a different hunch. Today, for the first time, someone takes their time — asks about the bedroom, the cuddly toy, the holiday, listens, tests. At the end there is no riddle but a diagnosis and a plan. It is a private practice — a picture of what allergology could be.

Today's system can be described in one sentence: a time-intensive, detective discipline is processed within a budgeted seven-minute medicine — so a substantial share of allergy sufferers are misdiagnosed or not diagnosed at all, and have symptoms treated for years instead of the cause.

IN A NUTSHELL

Allergies are among Germany's most common chronic conditions. Around 30.9 % of adults report an allergy within a year (RKI, GEDA 2019/2020); among children around 37 % are sensitised (KiGGS Wave 2). In absolute terms the number affected rose over two decades from 20–22 to roughly 30 million (White Paper on Allergy, RKI). Yet allergology is not a specialty in its own right but an add-on qualification held by around 10,200 physicians. Demand and supply are drifting apart.

Medicine's hidden royal discipline

Allergology is one of medicine's hidden royal disciplines. Hardly any field is so cross-sectional: rhinitis (ENT), asthma (pulmonology), atopic dermatitis (dermatology), food allergy (gastroenterology/paediatrics), anaphylaxis (emergency medicine) — with an immune system at the centre connecting all these organs. Those who master it think in mechanisms, not borders. That makes it demanding and invisible at once: no specialty pillar, no large hospitals bearing its name — and yet it touches almost every second person over a lifetime.

This invisibility has consequences. Allergic symptoms are non-specific — blocked nose, cough, eczema, fatigue — and are treated one by one instead of as a whole. The causal work-up costs time the budget does not allow. So the "chronic cold" is a year-round mite rhinitis, the "nervous stomach" a food allergy, the "exercise asthma" the first step of airway progression — each confusion costs no extra cent but possibly years of the wrong therapy.

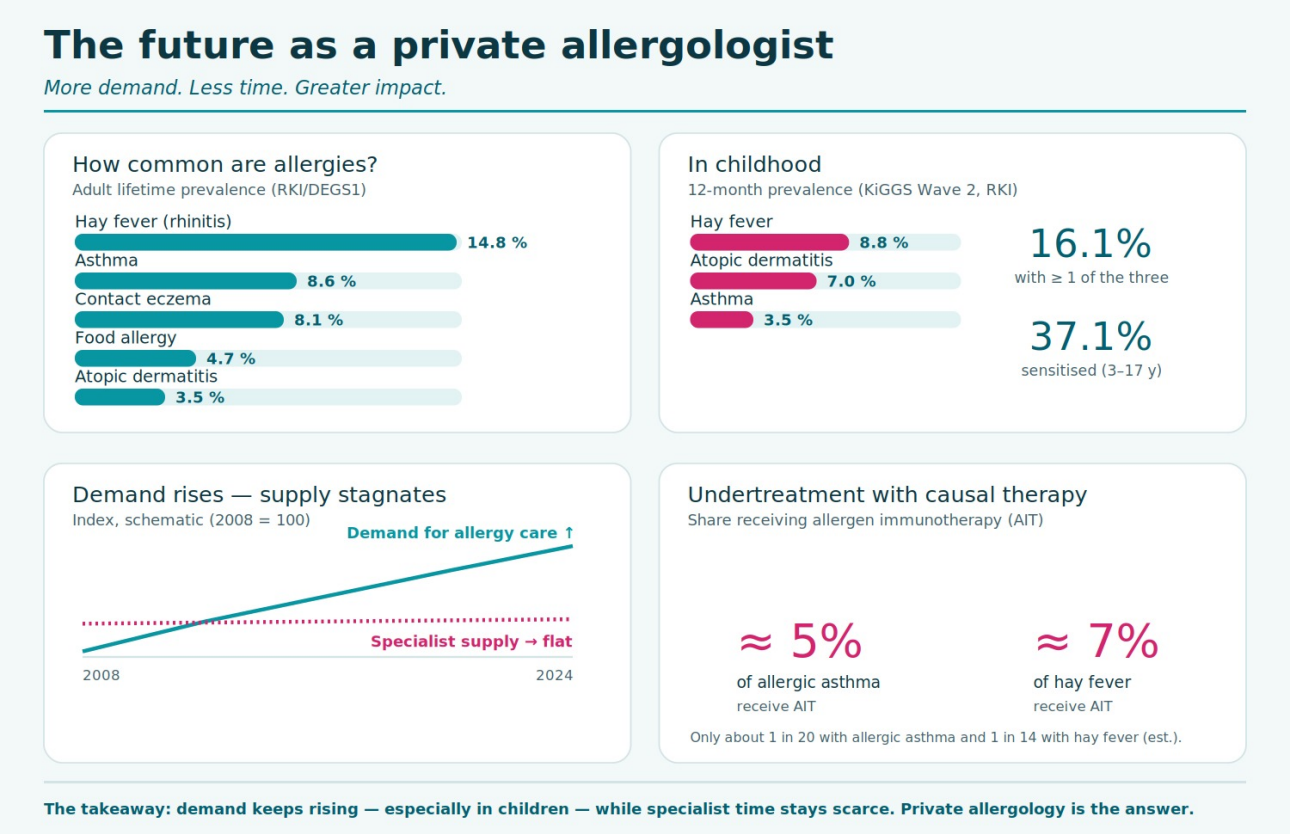
What happens if nothing is done: in roughly one in two patients with untreated mite rhinitis, asthma develops within ten years (National Care Guideline on Asthma 2020). Progression to the lower airways is the rule, not a footnote, when diagnosis is delayed.

Why supply is not keeping pace

The bottleneck is structural. As an add-on qualification, allergology sits on a base discipline. The 2018 reform made it easier to acquire; DGAKI and AeDA openly warn of diluted standards, missing rotation posts and professorships. It is the rare market where demand rises structurally and qualified supply structurally falls.

IN A NUTSHELL — ECONOMICALLY

Statutory insurance reimburses allergology as flat-rate, budget-capped items despite its time demands. Private billing reflects services and time, with no cap. Add bureaucracy, an overdue fee-schedule reform and falling practice-owner numbers — and for many, insurance-independent self-employment becomes a strategic choice.



Overview (Allergocover editorial team). Adult prevalence per RKI/DEGS1, child prevalence per KiGGS Wave 2; the demand-supply index and the AIT shares are illustrative estimates.

In figures: allergies in childhood

How large the allergological task is even among the youngest is shown clearly by the RKI's KiGGS study. In its second wave (2014–2017), the 12-month prevalences were 8.8 % for hay fever (allergic rhinitis), 7.0 % for atopic dermatitis and 3.5 % for asthma. Taken together, more than one child in six (16.1 %) is affected by at least one of these three conditions — over two million children and adolescents in Germany.

More striking still is sensitisation: 37.1 % of 3- to 17-year-olds react in a blood test to a mix of common inhalant allergens. Sensitisation is not yet a disease — but it is a markedly increased risk. House dust mites are among the most frequent triggers: in the KiGGS baseline survey, mite sensitisation was the second most common of all, after grass pollen. And all these figures have been stable for over a decade — at a high level.

Behind the numbers lies a pattern, the atopic march: it often begins in infancy with atopic dermatitis and early food allergy, shifts during kindergarten and school years to indoor and pollen allergens, and not rarely progresses from the nose to the lungs — many children with hay fever go on to develop asthma. Intervening early, carefully and with time can change the course. That is precisely allergological work — and precisely what the budgeted statutory system has no room for.

Sources: RKI, KiGGS Wave 2 — "Allergic diseases in children and adolescents", Journal of Health Monitoring 3/2018, DOI 10.17886/RKI-GBE-2018-075 · KiGGS baseline survey (sensitisation patterns) · German Society for Paediatric Allergology (GPA).

Allergology is a frontrunner for artificial intelligence

Allergology is, like hardly any discipline, made for AI: data- and pattern-rich — sensitisation profiles, molecular component diagnostics, cross-reactions, years-long immunotherapy courses. A well-trained AI cross-reads component profiles, recognises cross-reactivities, suggests guideline-based steps and relieves documentation.

This is shown by AllergoGPT — this hub's allergology-trained assistant. In a young practice it pre-structures the history before the appointment, explains diagnoses in over twenty languages, supports the interpretation of molecular findings, accompanies the often three-year immunotherapy and drafts reports. The division of roles is decisive: the AI prepares and unburdens — the diagnosis and therapy are decided by the physician. No report leaves the practice without medical sign-off; responsibility under medical-device and data-protection law stays with the human.

For a young practice this is a double lever: depth of care and availability with a small team — and a position where medicine is heading.

Idea becomes practice: AllergoGPT launches in the fourth quarter of 2026 — and is available first to all private practices. This is a deliberate choice. The knowledge core starts where time and depth make the difference anyway: in private allergology. Those who position themselves now will, from day one, work with a tool that accelerates the field instead of chasing it.

Where the opportunities concretely lie

For ENT — and partly paediatrics — a separate private allergology practice is especially plausible: clinical proximity, high counselling demand, marketable self-pay logic. Concretely: molecular diagnostics as a self-pay service; unhurried immunotherapy follow-up; a dedicated paediatric allergology clinic; private and self-paying patients who reward a thorough work-up; a digital companion service. As a dedicated practice — or, lower-risk, as a second pillar.

In detail this becomes a viable service profile. Molecular component diagnostics separates genuine sensitisation from cross-reaction and makes the immunotherapy indication robust — a service that private billing rewards with time and care instead of capping it. Allergen immunotherapy binds patients over years and is disease-modifying: it can prevent new sensitisations and progression to asthma. Non-pharmacological allergen avoidance — from counselling to the medical encasing as a self-pay building block — rounds out the concept. And a dedicated paediatric allergology clinic intervenes early, where the atopic march is decided.

What is special: these services demand exactly what the statutory system does not reward — time, depth and continuity. In a private practice they turn from a bottleneck into an offering.

And the risks?

The real risk is entrepreneurial — and it deserves an honest word. A statutory-insurance physician essentially has a secured income: with a care mandate, an assigned flow of patients and the safety of contract-based reimbursement, he or she is almost an entrepreneurial civil servant. A private practice has no such net. It must prove itself on the health market — through performance, reputation and an offering that convinces people and that they are willing to pay for themselves. Whoever founds privately trades security for freedom and carries the market risk personally.

Yet this is exactly where allergological demand acts as a shock absorber. Where demand grows structurally and qualified supply shrinks, the market risk is unusually low: the patients are there, in rising numbers, seeking precisely the time and depth that statutory care offers ever less. That makes allergology one of the few fields where entrepreneurial freedom meets a robust, growing market. What remains are manageable duties: a location with enough self-payers, a clean presentation within medicines-advertising law, and an AI kept under medical supervision.

FOR EARLY-CAREER PHYSICIANS

For younger colleagues the entry is attractive: since 2018 the qualification can be acquired alongside clinical work, demand grows over decades, an AI-supported way of working makes small teams strong — and a clearly defined, unhurried field offers autonomy and predictability.

The calculation is simple and forward-looking: growing demand, scarce supply, a model that gives care room, and a technology that accelerates the field. This is no niche — it is one of the most future-proof decisions a physician can make today.

Outlook: the decade of allergology

The lines all point one way. Prevalence keeps rising, diagnostics grow more molecular and precise, immunotherapy more effective and more broadly indicated — and AI shifts the limit of what a small team can do. Whoever builds a private allergology practice today is not building for the moment but for a decade in which precisely this competence will be scarce and sought after. The next generation of patients will not have fewer allergies, but more — and they will look for physicians who take their time and find the cause.

AllergoGPT belongs in this picture. With its launch in the fourth quarter of 2026 — first for all private practices — the allergology knowledge core turns from a promise into a working tool. It is the moment when preparation pays off.

Considerations for the present

It is often said that the best moment for a decision already lies in the past. In allergology it is different. Thanks to modern, allergology-trained AI such as AllergoGPT, the best moment is followed by a better one — and that is now: what once required a large team and a great deal of time becomes possible today with a small structure, high availability and clinical depth. Whoever begins today does not begin too late, but at the best moment so far.

From this, a few considerations for the present follow. The first concerns your own position — whether a dedicated private practice or a focused second pillar suits your situation better, depending on discipline, location and risk appetite. The second concerns the service profile — molecular diagnostics, immunotherapy follow-up, a paediatric allergology clinic and a clean presentation within medicines-advertising law. The third concerns the way of working — to work AI-supported from the outset, so that the availability and depth which define the field can emerge.

At the end of these considerations stands a concrete option: the allergological private practice — or, lower-risk, the allergological branch as a second pillar of an existing practice. Either finds a growing market, a grateful patient base and a field that finally receives the time it deserves. It is not a decision that must be forced — but one that can be made today with good reason.

Frequently asked questions

Is allergology economically future-proof?

Yes. Around 30.9 % of adults report an allergy within a year (RKI), and the absolute number affected rose over two decades from about 20–22 to roughly 30 million (White Paper on Allergy). The bottleneck is not the patients but qualified time — and that can be delivered privately. Because demand grows structurally while qualified supply shrinks, the economic risk is lower than in almost any other form of private practice.

Why is allergology a cross-sectional discipline?

Because it spans organs: rhinitis (ENT), asthma (pulmonology), atopic dermatitis (dermatology), food allergy (gastroenterology/paediatrics) and anaphylaxis (emergency medicine) are connected through the immune system. Allergological thinking links fields that otherwise work separately and recognises connections lost within a single specialty.

What role does artificial intelligence play?

Allergology is data- and pattern-rich and therefore predestined for AI support. Tools such as AllergoGPT pre-structure the history, explain findings multilingually and relieve documentation. AllergoGPT launches in the fourth quarter of 2026, first for all private practices. Diagnosis and therapy remain the physician’s; no report leaves the practice without sign-off.

For which disciplines is the step especially worthwhile?

Above all for ENT and partly paediatrics: both are base disciplines of the add-on qualification, so clinical proximity is already there. High counselling demand and a clear self-pay logic add to this. Internists, dermatologists and general practitioners with an allergology focus also find a viable market.

Own private practice or second pillar?

Both are viable. Lower-risk is building it as a focused second pillar alongside an existing practice, because baseline utilisation is secured; a pure private practice offers more freedom and higher earning potential. What matters is that the model does justice to time-intensive diagnostics and years-long immunotherapy follow-up.

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SOURCES: RKI (GEDA 2019/2020-EHIS · DEGS1) · KiGGS Wave 2: allergic diseases, JoHM 3/2018, DOI 10.17886/RKI-GBE-2018-075 · White Paper on Allergy in Germany/RKI · German Medical Association (physician statistics) · DGAKI & AeDA, Allergo Journal (2018 reform) · National Care Guideline on Asthma (2020). The index, waiting times and reimbursement comparison in the infographic are estimates; official nationwide figures do not exist.