Series Part 2: The Holzminden Model

# A blueprint for integrated care

The German hospital landscape is at the epicentre of the most comprehensive structural reform since the introduction of DRGs. The Hospital Care Improvement Act (KHVVG), which has been in force since December 2024, marks a complete paradigm shift: away from a purely volume-driven approach, towards a quality-oriented, tiered care structure. In this strategic redesign, cross-sector care providers (SÜV) – sometimes also referred to as Regional Health Centres (RGZ) or Primary Care Units (PVE), and more technically termed 'Level 1i facilities' in the reform discourse – play a key role. The second part of the new MVF series "Rethinking Care – Germany is Restructuring" (1) focuses on the Holzminden model, which, as one of the very first regional health centres in the country, is far more than just a regional project: anticipating the nationwide hospital reform, it provides the blueprint for the practical implementation of a tiered system based on the division of labour. Furthermore, the federal state of Lower Saxony is playing an absolutely pioneering role in this regard by having already made the necessary legal framework more flexible in its Lower Saxony Hospital Act (NKHG), which makes such hybrid models legally possible in the first place.

>> From a health economics perspective, 'Level 1i' – contrary to how it is portrayed in many discussions and articles – is neither a 'light hospital' nor the embodiment of the demise of local hospitals. Rather, it is the necessary response to the misguided incentives that have been evident for many decades in hospital planning over the past few decades. The current plans of the Federal Ministry of Health (BMG) envisage, among other things, that in future around 350 sites will function as "Level 1i" clinics – more accurately and positively described as cross-sectoral care providers (SÜV). This represents a proportion of around 20% of all current hospital sites in Germany.

However, to grasp the scope of this transformation, one must consider SÜVs within the context of the entire hospital care matrix in Germany: the 350 SÜV sites are contrasted with 419 Level 1n hospitals (primary care), 325 specialist hospitals and a further 136 Level 3 maximum-care providers. As the then Federal Minister of Health, Prof. Dr Karl Lauterbach, emphasised as early as 2023 during the debate on the planned hospital reform (KHVVG) that was beginning at the time, the "establishment of Level 1i hospitals is not an expression of deficit management, but the conditio sine qua non for the success of hospital reform". SÜVs served as a structural safety net for sites that would no longer be economically viable under the conditions of highly specialised medicine or that could not achieve the necessary minimum case numbers for complex service groups.

Or which, as in the case of Holzminden, simply had to file for insolvency. The reasons for the insolvency application filed by the operating body, Agaplesion gAG, on 18 August 2023 for the hospital and the associated medical care centre were a combination of acute insolvency, a

lack of staff for skeleton staff operations and structural problems within the hospital landscape. Following the closure of the hospital at the end of November 2023, the district of Holzminden was at times the first district in Lower Saxony without any inpatient hospital care.

However, with the loss of the central pillar of the regional healthcare infrastructure, the neighbouring Höxter Hospital was also overburdened. Furthermore, the emergency ambulance service was blocked by increased journey times and being tied up in so-called ‘false’ emergencies – patients requiring inpatient monitoring but no acute intervention.

It was therefore high time for the local authority and the state to take action. This was also because an analysis of demographic and healthcare infrastructure data revealed a dramatic escalation that goes beyond the usual extent of rural structural problems:

• **Current situation:** 52,538 people aged over 65 currently live within a 30-minute travel radius of Holzminden.

• **Forecast for 2033 (65+):** An increase to 64,890 people (+23.51%).

• **Critical focus (75+):** The group of people aged over 75, who require particularly intensive care and geriatric support, is set to grow by +26.8%, corresponding to an absolute increase of 7,219 people, making a preventive and geriatrically focused care structure absolutely essential.

• **General practice care:** According to forecasts by the KV North Rhine, the level of care provision in the Northern Planning District is also set to fall to just 50–60% by 2035. A case in point was the impending closure of a practice with three seats and 4,000 patients under its care, with no succession plan in place; however, this was averted following the establishment of the RGZ through its takeover and continuation of the practice.

With this in mind and factoring it into the calculations, it was possible, shortly after the official closure of the clinic, to at least continue the operation of the Medical Care Centre (MVZ) co-run by the hospital, in order to continue to safeguard outpatient care. On the other hand, with the support of the two consultancy firms consus.health (Accenture) and HC&S, a so-called Regional Health Centre (RGZ) was established, which, following a ministerial decision by Lower Saxony’s Health Minister Dr Andreas Philippi (SPD), has been able to offer inpatient care – albeit limited – since May 2025. (2)




**RGZ and MVZ under one roof: together they form the Weser-Med-Zentrum. Copyright: RGZ Holzminden**

The RGZ, which emerged from insolvency, was thus enabled to take a major, if not groundbreaking, step for German healthcare. Although it currently represents 'merely' an integrating bridge between outpatient and inpatient care, it is fully integrated into Lower Saxony's hospital plan. It can thus be understood as a hybrid response to a foreseeable care vacuum, replacing the previous model of strict separation between outpatient GP care and inpatient acute medicine. This is done with the stated aim of being able to meet the care needs of a rapidly ageing society in the future as well – and perhaps even better – because it is adapted to the actual local needs.

This is made possible in Lower Saxony by Section 3(12)(3) of the Lower Saxony Hospital Act (NKHG), which has been under discussion there for several years. Since 1 January 2023 – and thus, fittingly, a few months before the Holzminden hospital went into insolvency – this provision has recognised the concept of the Regional Health Centre (RGZ). Section 3 No. 12 is intended – provided there is 24-hour availability, outpatient specialist care and a nursing unit with beds (also within the meaning of SGB XI) – quite explicitly:

- enable cross-sector, local medical care through interdisciplinary cooperation between various service providers and
- integrate existing service providers into an overall concept geared towards regional needs.

A fresh start without overhead costs It is important to understand that the preceding insolvency was a factor absolutely critical to success, and that the transformation in Holzminden was anything but a voluntary pilot scheme; rather, it was the result of an acute care crisis. This is emphasised by Ingo Goldammer and Tobias Orthmann (formerly a commercial consulting for healthcare professions and involved in developing outpatient care models), who have jointly managed RGZ Holzminden GmbH since its foundation. According to them, a decisive factor in the success of the Holzminden approach was the consistent move away from old structures. Only the principle of a "new organisation free of legacy issues" made it

possible to plan the RGZ from scratch in terms of both business operations and staffing.




A clear advantage: in traditional hospital consultancy, it is well known that the transformation of existing hospitals all too often fails due to legacy issues such as rigid pay structures, pension liabilities and inflexible spatial concepts. However, thanks to the legal re-establishment of the RGZ, every contract – from cleaning to medical technology and IT infrastructure – could be adapted, negotiated and concluded to meet the far lower requirements of a future Level 1i facility. On the one hand, this prevented the overhead costs of the former full-service hospital from being carried over; on the other, it enabled the use of the former hospital's existing infrastructure, with the building passing into municipal ownership.

Furthermore, the close involvement of local politicians and the Holzminden Medical Centre (MVZ) helped build the necessary trust among the local population. Additional synergy effects arose from an interdisciplinary care cluster, as the physical proximity and organisational integration of regional general practitioners, internists, surgeons and radiologists could be utilised further. Another key to operational success was the enhancement of personnel synergies, as specialists from the MVZ can simultaneously provide professional supervision at the RGZ without the need to create duplicate support structures.

**Lower Saxony as a pioneer**

The mere fact that the RGZ Holzminden is designed as a cross-sectoral link, integrating inpatient primary care capacities with a broad outpatient spectrum, and can also operate on the legal basis of the Lower Saxony Hospital Act (NKHG), is a major advantage. What's more, it is one that has so far only existed in this federal state! To date, RGZs are legally possible only in Lower Saxony (first in Ankum, then in Norden, Bad Gandersheim and Holzminden) because they are firmly anchored in the state's hospital plan. All other federal states are, instead, inexplicably waiting for corresponding nationwide regulations.

Although these are laid down in the KHVVG, which has been in force since December 2024, the future daily fees have not yet been determined. This is why the inpatient section of the RGZ Holzminden is currently still financed via diagnosis-related groups (DRGs), as it is formally listed as a hospital in the state-wide bed plan. On the other hand, the MVZ bills for outpatient services via the relevant Association of Statutory Health Insurance Physicians (KV). However, with the planned conversion into a cross-sectoral provider (SÜV/Level 1i), this billing procedure will change, as hospital-specific daily rates will then be introduced. Goldammer and Orthmann: “Exactly how this daily rate will be determined and how high it will be for individual hospitals has not yet been decided. It is up to the self-governing bodies to resolve this as quickly as possible.”

Furthermore, pioneering projects such as Holzminden are operating in a transitional economic environment. Although the hospital reform promises advance funding, models such as Holzminden must fight for their economic viability through radical cost efficiency in their operations. For Holzminden, however, the delay is not critical to success, precisely because part of the revenue can be settled via flat-rate payments per case.

The situation is different for countless other locations across Germany. These have complained of a resulting lack of planning certainty, which is why locations there are “on tenterhooks” and desperately awaiting the KHVVG.

However, there is also a degree of uncertainty for Holzminden in the future: “As soon as it is clear how the hospital-specific daily fees are calculated, we will have to analyse whether our approach will still be economically viable. We do not yet know the details, but we assume it will be,” Goldammer and Orthmann explain to “Monitor Versorgungsforschung”. In their view, the self-governing parties should also take this opportunity to consider the remuneration structure for the outpatient RGZ component, which can be regarded as a classic primary care unit (PCU). In the context of the introduction of future primary care centres, the two Holzminden-based managing directors note that consideration must be given to a remuneration structure for GPs adapted to the new care structure, as the current system, with its tightly scheduled consultation hours, for example, makes it economically difficult to operate an open emergency service or a contact point for long-term nursing care.

Based on the MVF discussion with Goldammer and Orthmann, the operational experiences, structural obstacles and strategic recommendations can be summarised as follows:

**1. Practical experience: “Think outpatient, act inpatient”**

A key lesson is that a Regional Health Centre (RHC) can only be successful if it is consistently “designed with outpatient care in mind”. Their advantage: both are familiar with both the outpatient and inpatient worlds and were able to set up the project in Holzminden with a lean cost structure that differs significantly from traditional hospitals.

**2. High patient satisfaction**

Another finding after a year of RGZ operation is the high level of patient satisfaction, which, according to their reports, is perceived (as no surveys or evaluations were conducted) to be almost 100%. They report that patients

even appreciate the added value compared to larger hospitals:

distances are short, processes are faster and care is more personalised thanks to the close integration with nursing. Furthermore, a specialist at the RGZ can often be with the patient within ten minutes, whereas in a crowded A&E department at a higher-level or even a maximum-care hospital, the patient would often have to wait for hours.

**3. Viability of the concept**

Financially, their experience shows that both units – the outpatient medical centre and the inpatient section of the RGZ – can be viable on their own in the long term. Whilst the previous medical centre had been running at a loss for a long time, a turnaround has already been achieved in Holzminden. However, the inpatient sector has not yet reached break-even. This is achieved with an occupancy rate of around 10 to 12 beds out of the 20 available (18 for internal medicine, 2 for surgery – tailored to a patient population with straightforward internal medicine and surgical diagnoses, as well as older, multimorbid patients).

**Obstacles and legal hurdles**

Despite their already evident success story, Goldammer and Orthmann identify barriers to the implementation of their transfer model. Above all, they lament a “lack of acceptance” and “resistance to change”. For instance, there is a tendency among some GPs and the ambulance service to stick to old referral pathways. According to them, one of the most significant problems is the safety-first mindset of referring practitioners (A&E doctors, emergency services, GPs). Out of concern about subsequent transfers, patients are sometimes directed straight to Level 2 or 3 hospitals, even when treatment at the RGZ would be medically more appropriate.

This type of “defensive medicine” leads to unnecessary transfers and an overload of the maximum-care hospitals. In other words: new care services require a “communication ramp-up period”. According to Goldammer and Orthmann, constant personal communication and “knocking on doors” are necessary to gradually build trust in a new model. However, the two RGZ heads are confident in this regard: following the strenuous set-up phase of the last year and a half, they now have a little more time for these important communication tasks and will make use of it. Their experience also shows, however, that the model’s gradually growing acceptance is driven primarily by its live operation and, above all, by the quality of the care provided here. On the other hand, restrictions on admission times have a direct impact on referral flows and require precise management of occupancy capacities.




**The RGZ team (left) and the two RGZ managing directors on the right: Ingo Goldammer and Tobias Orthmann. Copyright: RGZ Holzminden**

## Strategic recommendations from the RGZ managing directors

Goldammer and Orthmann offer clear recommendations for their own future and for the transition of Level 1i hospitals in other regions:

### 1. Use of the Transformation Fund:

As the conversion costs (redundancy plans, contract terminations) cannot be financed from the running revenue of the 20-bed ward, state start-up funding is absolutely essential to ensure the new facilities do not go bankrupt immediately after opening.

### 2. Consistent division of labour:

Care must be organised according to the 'lowest level first' principle. The RGZ should act as an 'overflow' for simple cases, in order to keep the maximum-care providers (especially Level 3) free for highly complex treatments.

### 3. Networking and coordination:

An RGZ can only function in close collaboration with local government, referring doctors and neighbouring acute hospitals

. The ideal solution is to establish a care region in which patients are directed in a targeted manner.

### 4. Integration of innovative roles:

In the long term, they recommend the use of "flying nurses" or community health nurses to provide patients with telemedical support in their home environment. This would further relieve the burden on the outpatient sector, but requires new, previously non-existent billing channels within the standard healthcare system.

In summary, both emphasise quite explicitly that an RGZ model is not a sign of scarcity, but rather an "independent, high-quality care model that bridges the gap between GPs and large hospitals". The RGZ also sees itself as the nucleus of a "health campus". Beyond the core elements, further services have been and are being integrated:

### 1. Outpatient Surgical Centre:

Enables surgical procedures without an overnight stay, but uses the RGZ's infrastructure as a back-up.

**2. Medical Care Centre:**

Close cooperation with the MVZ Holzminden ensures access to radiological and endoscopic diagnostics as well as a wide range of specialist services (cardiology, neurology, surgery, etc.).

**3. Further potential services:**

Plans include the integration of day care places and an inpatient care facility. Complementary service providers such as opticians, pharmacies and social psychiatric services are also planned as satellite services to establish the site as a holistic hub.

**The RGZ model as a blueprint for integrated care**

The Holzminden Regional Health Centre has already passed the practical test. Despite the massive challenges posed by a hospital closure and the considerable need for explanation within the system, it is clear that the quality of care and patient satisfaction are surprisingly high. Furthermore, the cost structure is already better than originally calculated in the start-up phase – the revenue structure largely corresponds to the plans. In summary , it can be stated that the RGZ Holzminden can indeed be seen as a blueprint for integrated care centres of the future, because it breaks the dogma of sectoral separation through a lived and agile practice of cooperation and integration. Moreover, it optimises maintenance costs without any loss of quality and offers an economically sustainable response to ever-increasing demographic pressure. For German hospital reform, however, this also means that success will not be determined in the major cities, but rather by the ability to roll out models such as Holzminden across the board. The RGZ is not a 'second-class hospital', but rather the necessary evolutionary step towards a new – and above all intelligent, division-of-labour-based and patient-centred – healthcare system. The transformation of 20% of hospital sites to Level 1i is therefore not a threat, but must be seen as an opportunity to permanently secure local primary healthcare across the country. In particular, this will relieve Level 2 and 3 hospitals of cases that do not require highly specialised infrastructure. Without this relief, the A&E departments of maximum-care hospitals face the risk of systemic collapse due to "overcapacity utilisation for low-threshold diagnoses".

| Erfolgskritische Faktoren versus operative Umsetzung | |
|---|---|
| **Erfolgskritischer Faktor** | **Strategische Umsetzung (Modell Holzminden)** |
| Maximale Kosteneffizienz | Nutzung gemeinsamer Infrastruktur (MVZ/RGZ), radikaler Verzicht auf redundante Verwaltung. |
| Konsequente Arbeitsteilung | RGZ für Basis/Geriatrie, Level 3 für Akutintervention; klare Definition von Ausschlusskriterien |
| Einbindung der Verteiler | Aktive Einbindung von Pflegediensten und Heimen als Hauptzuweiser für das RGZ-Klientel |
| Innovation in der Pflege | Einsatz von „Flying Nurses“ und sektorenübergreifenden Pflegepools zur Abdeckung von Lastspitzen |
| Digital-First-Ansatz | Telemedizinische Anbindung an Spezialist:innen zur Kompensation der geringeren ärztlichen Präsenzzeit |
| Marketing & Akzeptanz | Offensive Kommunikation des RGZ als moderne, spezialisierte Einrichtung für die Generation 75+ |

***Table 1:*** **Critical success factors versus operational implementation. Own illustration.**

## Strategic recommendations and systemic significance

The ‘lessons learnt’ from Holzminden can be directly applied to other structurally weak regions facing the challenge of a vast, sparsely populated area with a risk of under-provision and an ageing population. For such regions – of which there are more than is commonly expected (4) – this means that local authorities and the state must not wait until the last hospital is insolvent. The planning of care logistics and the establishment of Level 1i hospitals must be proactive, with the digital component acting as the ‘glue’ between the sites. A factor that has often been underestimated to date, but which must play a central role in future development, is digital connectivity. The ‘lowest level first’ principle can only work if patient data (electronic records, telemedicine) flows seamlessly between regional healthcare centres,

GPs and tertiary care providers. The pilot project in Holzminden provides empirical evidence for the practical feasibility of these previously purely theoretical concepts.

## Regional Healthcare Centres in five federal states

The establishment of Regional Health Centres has developed in Germany since 2023 as a potential response to hospital closures and to ensure healthcare provision in rural areas. As of May 2026, there are – as far as can be ascertained online – six RGZ or RGZ-like sites nationwide, spread across five federal states. The distribution shows that the roll-out is primarily taking place in large, sparsely populated federal states where the distances to the nearest inpatient maximum care facilities are particularly long and/or at risk.

For instance, the Association of Supplementary Health Insurance Funds (vdek) is promoting the RGZ concept under the term “Regional Health Partners” in North Rhine-Westphalia and Brandenburg. At the Gronau-Epe site (NRW), which opened in June 2024, the focus is on the delegation of medical tasks. Physician Assistants (PAs) assist in the treatment of chronically ill patients, whilst non-medical practice assistants are equipped with special telemedicine backpacks for home visits. This

enables medical data to be transmitted in real time to the practice, where a doctor can be connected via telemedicine if necessary.

The federal state of Lower Saxony plays an absolutely pioneering role thanks to its progressive hospital law: it is home to around half of all current RGZ sites – almost all of which are 'genuine' RGZs, i.e. those with inpatient facilities.

Some of the established RGZs stem from the STATAMED project, which received €11 million in funding from the Innovation Fund (5). The target group consists primarily of older patients with acute infections or chronic conditions who require round-the-clock medical and nursing care for a few days without having to be admitted to a traditional hospital. The concept also includes patient navigators and 'flying nurses' who are tasked with continuing to care for patients at home following discharge.

At the Bad Gandersheim and Norden (as well as Sulingen) sites, short-stay

general medical care. The RGZ BürgerGesundheitsPark Bad Gandersheim has a unique feature, as inpatient services had to be discontinued on 31 March 2026 for financial reasons and the service is to be converted to short-term care.

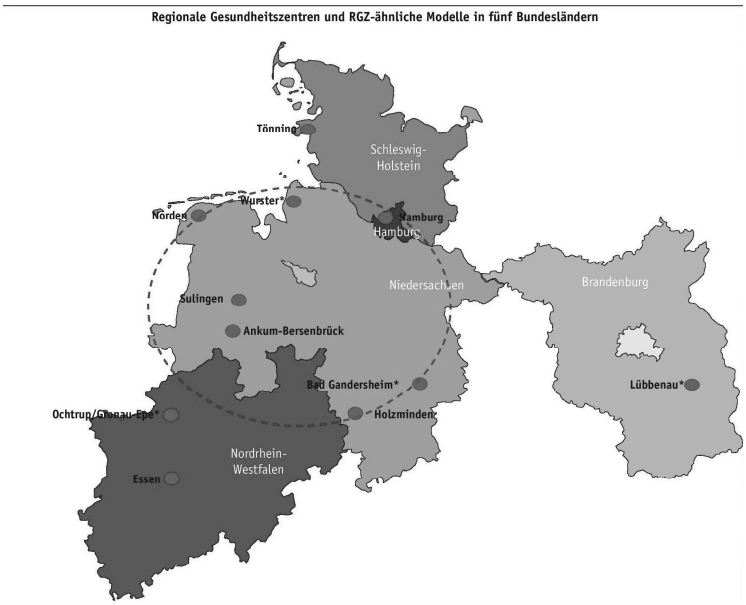
Despite these innovative approaches, the financial situation of many RGZs remains strained. One example is Anevita, the operating body for the Aurich-Emden-Norden clinics, which is also responsible for the RGZ in Norden (also a STATAMED partner). It has recorded a consolidated annual loss running into millions. However, the hospitals under the operating company's management are showing positive development in many key areas. Both the consolidated annual result for 2024 and the results, performance figures and staff development for 2025 demonstrate a clear upward trend (6). Incidentally, the RGZ in Norden is also the only site to maintain a limited emergency care unit, which, however, is only to be retained subject to continued funding, even until the move to the Zentralklinik Ostfriesische Meere.

Structural deficits threaten the long-term operation of many centres, even if, for example, the Norden site is secured for 2026 for the time being. At the Ankum-Bersenbrück site, Lower Saxony's first RGZ, the future of the former Marienhospital also remains uncertain, as the exact implications of the reform on the funding and status of such facilities have not yet been conclusively clarified. However, the participants in the STATAMED project will also face considerable financial and regulatory challenges after the project ends in March 2027, should no hospital-specific daily fees have been negotiated or individual successor solutions agreed by then. <<

by: MVF Editor-in-Chief Peter Stegmaier

**References:** 1: Series part 1 in MVF 02/26: https://t1p.de/530fn 2: https://t1p.de/vhm1z 3: https://t1p.de/vx94l 4: https://t1p.de/7uvpt 5: https://t1p.de/iwmmt 6: https://t1p.de/rz29h

# Citation note




**Regionale Gesundheitszentren (RGZ) und RGZ-ähnliche Modelle in fünf Bundesländern**

| Stadt | Land | Start | Name/Trägerschaft | Link |
|---|---|---|---|---|
| Ankum-Bersenbrück | NS | April 2023 | Niels-Stensen-Kliniken Marienhospital Ankum-Bersenbrück: erstes RGZ in Niedersachsen | https://t1p.de/vgxnf |
| Essen | NRW | Juli 2023 | Teilnehmende des Innovationsfondsprojekts STATAMED: drei Klinikstandorte in der Region der AOK Rheinland/Hamburg sowie drei Klinikstandorte in der Region der AOK Niedersachsen | https://t1p.de/ppsrn |
| Hamburg | HH | | | |
| Norden | NS | | | |
| Sulingen | NS | | | |
| Bad Gandersheim* | NS | | Der BürgerGesundheitsPark Bad Gandersheim hat den stationären Betrieb zum 31. März 2026 eingestellt. Stattdessen ist geplant, das Angebot auf Kurzzeitpflege umzustellen | https://t1p.de/kcfup |
| Tönning | SH | Juni 2016 / 2024 | Klinikum Nordfriesland mit drei Akutkliniken in Husum, Niebüll und Föhr-Amrum plus Integration von MVZ-Facharztpraxen im RGZ Tönning | https://www.klinikum-nf.de |
| Ochtrup/Gronau-Epe* | NRW | Mai 2024 | Gemeinschaftspraxis Gesenhues & Partner; Pilotprojekt der „Regionalen Gesundheitszentren" (RGZ) des Verbands der Ersatzkassen e. V. (vdek) | https://t1p.de/o35kr |
| Wurster* | NS | Mai 2024 | Regionales Versorgungszentrum Wurster Nordseeküste, vdek-Pilotprojekt | |
| Lübbenau* | BB | Oktober 2024 | Pilotprojekt der „Regionalen Gesundheitszentren" (RGZ) des Verbands der Ersatzkassen e. V. (vdek) | https://www.mzl-gmbh.de |
| Holzminden | NS | Mai 2025 | Umwandlung in RGZ nach Klinikschließung | https://rgz-holzminden.de |

***Table 2:* 'Regional Health Centres (RGZ) and RGZ-like models in five federal states' provides an overview of active RGZs and comparable pilot projects in Germany. * RGZ-like models – often medical care centres (MVZ) – mostly without an inpatient component. Key: BB = Brandenburg, HH = Hamburg, NRW = North Rhine-Westphalia, NS = Lower Saxony, SH = Schleswig-Holstein. Table: own representation; as at 12 May 2026. Graphic: Sonja Hamann. Copyright: MVF.**

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