Series, Part 2: The Seelow Health Campus

A laboratory for the future of local healthcare

Ladders stand in the corridors of Seelow Hospital, with cables hanging from the ceiling. Where patients were lying until recently, tradespeople are now at work. The picture painted by Nordkurier journalist Benjamin Lassiwe during his visit in autumn 2025 (1) aptly sums up the situation at the small clinic in the district town of Märkisch-Oderland: this is not a place of winding down, but of transformation. Within four years, the traditional district hospital providing primary care – which once had 90 beds – is to be transformed into a 'health campus' – a place where medical, therapeutic and nursing services come together under one roof and where care is provided according to individual needs. For Brandenburg's Health Minister Britta Müller (2), Seelow is nothing less than a "true flagship project for Brandenburg". For Katja Thielemann, the hospital's managing director, it is one thing above all else: a tenacious attempt to keep healthcare services alive whilst the economic foundations around it are crumbling. However, whether this spirit and this determination – not merely to maintain healthcare provision but to make it fit for the future – will survive the coming months and years will not be decided in Seelow, in eastern Brandenburg, but in Berlin, just some 80 kilometres away.

>> As long as the necessary provision of rural hospitals offering primary care – such as Seelow – is not reliably funded, as long as these mostly smaller hospitals have to cover their deficits out of their own pockets for many months, and as long as they are subjected to regulations that apply to the same extent to hospitals providing the highest level of care, this 'real-world laboratory' for the healthcare of the future will remain a model; one that is working against the framework set primarily by the Social Security Code. The tradespeople in the corridors of Seelow have long since completed the easier part, even though an outpatient surgical centre is still under construction. The far more difficult part – securing the future and, above all, the funding for the healthcare that everyone claims to want to maintain and safeguard – is still in full swing.

The Seelow case provides a textbook example of what is at stake in the biggest restructuring of the German hospital landscape since the introduction of flat-rate payments per case. The Hospital Care Improvement Act (KHVVG) has been in force since December 2024; it is intended to shift healthcare provision from a purely volume-driven approach to a quality-oriented, tiered structure. Among other things, it provides that, in future, around 350 sites – roughly one-fifth of all current hospitals – will operate as cross-sectoral care providers, referred to in reform jargon as 'Level 1i hospitals'. Seelow is a hospital in a rural region that is responsible for ensuring emergency care and, by extension, essential public services. At the same time, it serves as a test case for the question hanging over the entire sector: can local healthcare be maintained in this sparsely populated, expansive region as funds become scarcer and the requirements set by the forthcoming Statutory Health Insurance Stabilisation Act are sure to become even more onerous?

What is taking shape in Seelow

The concept behind the Seelow Health Campus, jointly supported by the partners – 'Innovative Healthcare in Brandenburg' (IGiB) on the one hand and the Brandenburg Ministry of Health (MASGZ) on the other – initially sounds like a downsizing, i.e. a reduction in care provision: The number of inpatient beds is falling from 90 to 45. However, this reduction in beds, driven purely by economic factors, is only one half of the picture; the other is the development of new forms of care, which are not intended to undermine the site's care mandate, but rather to realign it and make it as future-proof as possible.

Specifically, the minimum requirements for a primary care hospital will be maintained – internal medicine, emergency care, and general and trauma surgery. At the same time, the site will increasingly provide outpatient surgical procedures. At the interface between outpatient and inpatient care, a so-called monitoring unit is also being established, where patients can be monitored for up to 24 hours following an outpatient procedure without being formally admitted as inpatients – that grey area where, until now, local healthcare in rural areas has faltered due to formal admission criteria. In addition, a short-stay care ward with up to 18 beds will cater for people who require temporary care. In addition, there are physiotherapy services, a pharmacy, a medical supplies shop, as well as advisory and coordination services. In the long term, telemedicine solutions are also intended to facilitate access to further services, and a continuing professional development network is set to become part of the campus. However, that is still a long way off.

In parallel with the expansion of outpatient services, specialist services are being relocated: the cardiac catheterisation laboratory previously operated in Seelow and the cardiology services are moving to Strausberg, some 40 kilometres away. This is fully in line with an economic principle from the hospital reform, which Katja Thielemann repeatedly emphasises: Not every site needs to provide everything if the region as a whole is to be well served. That is why, within the district's healthcare network, each of the three local hospitals plays its own role: Seelow, as the smallest hospital, provides rural primary and emergency care, including an outpatient centre; Wriezen, as the second-largest, also provides primary care, supplemented by a joint replacement centre and a spinal centre; and finally, Strausberg provides specialist medical care ranging from gynaecology and obstetrics through vascular and oncological surgery to cardiology. "We can provide everything that can be treated on an outpatient basis here, with high quality, excellent facilities and qualified staff," says hospital director Thielemann, describing Seelow's new remit.



Katja Thielemann is managing director of Krankenhaus Märkisch-Oderland GmbH, the organisation responsible for three local authority hospitals: Seelow (see picture), Wriezen and Strausberg. Image: Krankenhaus Märkisch-Oderland GmbH.



This is the only way to close a gap in healthcare provision that a single hospital could never have filled on its own: For example, a private gynaecological practice in Seelow would never have been viable on its own, but as part of the network – with a well-trained senior consultant from Strausberg and the interdisciplinary use of rooms at the already established Medical Care Centre in Seelow – the service could be established. However, Thielemann says this is by no means a sure-fire success; recruiting staff remains a challenge. She describes her location as having awoken from a "Sleeping Beauty slumber"; she calls the reorganisation a "revitalisation programme" for the benefit of healthcare provision in the region, though it comes at a price: a constant juggling act to somehow keep the whole structure running.

The dilemma of maintaining services

To understand why a hospital that is genuinely needed for primary care nevertheless finds itself in financial distress, one must understand the logic of rural healthcare provision. Katja Thielemann explains it with the patience of a woman who has been working in the hospital sector since 1992 and, since 2021, has been responsible for all three hospitals in Seelow, Wriezen and Strausberg by the municipal healthcare network Krankenhaus Märkisch-Oderland GmbH, has been responsible for all three sites. Brandenburg, she says, has the highest density in Germany of so-called 'essential care hospitals' – hospitals whose closure would leave a 'gap in healthcare provision' on the map. In the Märkisch-Oderland district, this status even applies to two out of three hospitals. Put simply: if two of the three hospitals were taken out of the equation, there would be a genuine shortage of healthcare provision in the region.



The problem lies in the structure of hospital funding. The federal states provide investment funding – for buildings, medical technology and maintenance – whilst the health insurance funds cover day-to-day operations using the revenue generated. Wherever it is located, every hospital must maintain the defined infrastructure round the clock, regardless of whether a patient turns up or not: 24/7 emergency care, doctors on site and on call, and an A&E department in operation. The gap between the costs of maintaining these services and actual usage almost inevitably leads to deficits: services are maintained, but the lack of usage means a constant shortfall in revenue. It's a very simple equation.

On the other hand, hospitals with a statutory obligation to provide care are legally entitled to have their annual deficit covered. However, this compensation is paid out late – the subsidy can only be applied for in August of the following year at the earliest, once the annual accounts have been finalised and audited. Until then, the sponsoring body must advance the funds to cover the deficits and finance its fixed costs itself. Seelow Municipal Hospital currently receives no subsidies from its sponsoring body, but operates using liquidity loans and balances the costs within the network until the deficit funding takes effect. Even this does not cover the costs in full: the guarantee subsidies only partially offset the shortfall. Without this guarantee, Thielemann makes clear, the hospital would stand no chance under insolvency law – there is no going concern assumption, as there is never any prospect of breaking even.

Added to this is a structural absurdity which the forthcoming reform of the Statutory Health Insurance Stabilisation Act is likely to exacerbate rather than resolve. The shift towards outpatient care – which makes perfect sense from both a medical and economic perspective – is displacing the need for inpatient treatment. Particularly in rural areas, with a clientele that is often very elderly, there are many cases which – according to Thielemann – would be 'quite appropriate' for a hospital bed for 24 or 48 hours, simply so that someone can keep an eye on the patient. However, where care must be provided on an outpatient basis and inpatient admission is permitted only under strict criteria, there are hardly any inpatient cases left across the board. The small hospital then finds itself – to put it bluntly – with more doctors than patients, trapped by staffing, structural and qualification requirements designed for a maximum-care hospital but which, as Thielemann points out, cannot be applied one-to-one to a rural hospital providing primary care.

This is precisely where the Seelow model applies its pragmatic approach. Instead of having nursing staff, who are available for several wards, working with too few patients, short-term care is integrated into the hospital. However, this is not spun off as a separate limited company, but operates as a ward under the hospital's umbrella, billed through long-term care insurance rather than via hospital fees. The service has been running since January; of the 18 places, an average of ten to twelve are occupied – almost two-thirds. However, managing capacity remains difficult because very elderly people in need of care repeatedly end up requiring hospital treatment or – as naturally happens – pass away. At its core, however, something remarkable is being achieved: existing care staff are generating revenue and, above all, meeting a need that has long existed in the district but could not previously be met.

"We are in free fall"

However much optimism the campus concept exudes – the managing director's confidence comes to an abrupt halt the moment federal policy comes into play. On 29 April 2026, the federal government passed its draft bill on the stabilisation of statutory health insurance contribution rates. According to calculations by the German Hospital Association (DKG), the law will mean immediate revenue cuts for hospitals of 4.6 billion euros in 2027, rising to 10.5 billion euros by 2030; totalling around 30 billion euros over the years 2027 to 2030. It is this austerity programme that Thielemann associates with the Federal Minister for Health – whose name she repeatedly mentions in conversation – and against whose serious consequences she warns.

The situation across the country is already precarious even before these cuts. According to DKG figures, around 75 per cent of hospitals were already in the red by 2025. Local authorities have to allocate around five billion euros annually from their budgets to cover the deficits of their hospitals. Nevertheless, between 2023 and 2025, 90 hospitals – affecting around 39,000 staff – had to undergo insolvency

proceedings. An analysis published at the end of April 2026 by the authors of the independent 'Hospital Rating Report' paints a bleak picture of the consequences the planned cuts would have: By 2030, only 19 per cent of hospitals would be in the black; the sector would find itself in an unprecedented crisis, with an average decline of six per cent; and 49 per cent of sites would be at high risk of insolvency.

For a hospital like Seelow, the mechanics of the system are particularly tricky. Thielemann regards the reserve funding mechanism laid down in the KHVVG as a 'sham': It is linked to inpatient cases – but if everything is shifted to outpatient care, the question arises as to which cases the reserve flat-rate is actually supposed to be refinanced from. Her fundamental criticism: the reform calls for a shift to outpatient care, yet continues to finance the reserve through inpatient volumes. Anyone who goes along with both, says Thielemann, is sawing off the branch they're sitting on. "We're in free fall," she says. There was no impact assessment carried out beforehand; nobody analysed what the outcome of the transformation currently taking place would be. The uncertainty is actually increasing: she simply cannot say what the forthcoming cost-cutting legislation will bring over the next five years – only that it will probably mean "even more money being taken out of our budgets".

It is worth noting that this criticism does not stem from a refusal to cooperate. Thielemann emphasises that most hospitals agree that healthcare reform is necessary. The criticism is not directed at the restructuring itself, but at the way it is being carried out: against the pace, the hectic rush ("driven on and on"), against the imposition of detailed directives from above, against excessive bureaucracy and against the lack of transitional funding to ensure the financial survival of essential hospitals until the new plans take effect.

What reforms the hospital sector is calling for

On this issue, Thielemann explicitly refers to a paper by the German Hospital Association (3). This comprises a comprehensive catalogue of measures that could reduce costs in the short term. This refers to the list of demands entitled 'Deregulation and cost-cutting now!', presented on 8 May 2026, in which the DKG sets out 25 measures that can be implemented immediately.

The association estimates that the potential cost savings from these measures could amount to as much as 15 billion euros annually – without, as the DKG emphasises, any negative consequences for the quality of care. In doing so, it rejects the argument put forward by representatives of the coalition parties against any proposal for cost relief, on the grounds that they do not wish to "compromise on quality". Thielemann also addresses precisely this point: Quality is often held up as a banner, but as an argument it is frequently an empty shell. Their hospital does not provide poor-quality care – and, according to their logic, if they can prove this, one must also concede that they should be allowed to organise care in the best possible way according to their own professional judgement.

The thrust of the DKG's proposals is deregulation. Even its position paper for the 21st legislative period of the Bundestag – a ten-point catalogue – called for "consistent deregulation, a shift towards incentive schemes and a comprehensive reduction in bureaucracy". Specifically, the hospital association is calling for detailed staffing requirements to be replaced by a 'whole-hospital approach' and for nationwide planning requirements to be aligned with the more flexible 'NRW model'. Above all, however, the DKG insists on "genuine structural cost funding" that provides "adequate funding, regardless of patient numbers", even for small sites providing local primary care – precisely the problem Seelow is grappling with.

The DKG devotes its fifth point to the "hospital as a health campus" – the very concept under which Seelow is being transformed. The argument put forward is that, given the growing difficulties faced by the associations of panel doctors in ensuring comprehensive outpatient care across the board, hospitals are the central point of contact for patients and must be consistently opened up to provide clinical outpatient care. Where GPs can no longer guarantee specialist care, the federal states should be able to assign outpatient tasks to hospitals on a permanent basis – bypassing the Association of Statutory Health Insurance Physicians' accreditation committees.

Here, the association's position coincides almost word for word with Thielemann's own wish. Essentially, she says, much would already be gained if the sectoral boundaries were removed and the hospital were allowed to 'simply provide care', without needing a separate authorisation for every service and without encroaching on other budgets. "I don't care who walks through the door and needs medical care," she says, articulating the philosophy of care that underpins the idea of the health campus. Today, however, the hospital is only permitted to bill for a patient requiring outpatient treatment – for example, following a fall or in the case of unexplained abdominal pain – as a single, low-reimbursement flat rate, whilst the same service in the private practice sector is paid for individually and is therefore eligible for reimbursement.

If the hospital were allowed to provide basic outpatient care, other healthcare costs could be avoided whilst at the same time cross-subsidising the provision of care – which, according to Thielemann, is currently not cross-subsidised. She is therefore calling for greater creative and financial leeway for local stakeholders in such transformation projects. It is also a call for trust rather than regulation – a theme that runs like a common thread through many statements on such cases, from the DKG through the health insurance funds to the managing director in Seelow.

Consensus as a recipe for success – and its limits

What sets Seelow apart from other sites of structural change is not so much the medical objective as the manner of its implementation. As the*Nordkurier* article* noted, the restructuring has so far proceeded "completely quietly" – a beacon, as Müller put it during her visit, without a foghorn. District Administrator Gernot Schmidt (SPD) attributes this to the consistent involvement of all stakeholders: "We have always discussed everything together in the committees," he says; there has never been a destructive debate over the location of the district's three municipal hospitals. Instead, the district relied on supporting measures such as the remunicipalisation of the ambulance service to secure the Seelow emergency doctor base in the long term, and on the medical care centre (MVZ) system to bring specialist consultations to the area.

The contrast with other regions is deliberate. In the Elbe-Elster district, for example, the dispute over hospital locations became synonymous with public controversy and location debates. In Wittstock, Brandenburg, the closure of a private hospital caught the local authority completely unprepared. Minister Müller uses both these negative examples to illustrate her key point: "No one can manage it alone any more" – healthcare provision only succeeds if the stakeholders talk to one another at an early stage and draw up plans together. In Lusatia, with the economically hard-hit hospitals in Guben and Forst, the same principle demonstrates its viability: moving away from competition for the same services towards a structured division of labour based on the principle that not every location needs to offer everything, but every region must be well provided for.

Just how far such a proactive approach can take us is demonstrated by Holzminden in Lower Saxony, which is cited in the MVF specialist series as a 'blueprint' (4) for integrated care. After the operating company Agaplesion filed for insolvency in August 2023 and the hospital closed at the end of November 2023, the district was, for

a time, the first in Lower Saxony without any inpatient hospital care. A Regional Health Centre was subsequently built on a 'greenfield site', combining 24-hour accessibility with an inpatient care unit. Holzminden thus demonstrates that such centres can work and that patient satisfaction is high. But it also shows that such concepts require a considerable amount of explanation to all those involved.

It is this need for explanation that Thielemann is also working on. In Seelow, the concept was prepared over several years in confidential discussions before it was presented to the public last summer – a 'Plan B', as one expert describes it: a voluntary commitment by the hospital, closely coordinated with the ministry, because the legal framework is often too rigid and nationwide reforms often come too late for financially strained hospitals. It is precisely this approach – not waiting for 'instructions from Berlin', but acting regionally and in a tailored manner – that the trade press describes as the model now being followed by more regions than is generally realised.

The outstanding bill

Nevertheless, Seelow remains a model on probation. When asked where the hospital stands in its transformation plan, Thielemann replies with an almost triumphant "80 out of 100": essentially, all that remains is the structural conversion into an outpatient surgical centre; the rest has already been implemented. Her vision for the coming years is sober and clear: if they manage to carry on as before and make the most of the current funding opportunities, the hospital could maintain care across the spectrum from general to specialist medicine – "and just about make ends meet financially". But what will happen when the forthcoming Contribution Rate Stabilisation Act comes into force? "I simply don't know."

This is where the local becomes political once again. Thielemann warns that should renewed pressure to make savings overwhelm the hospitals, the sites would face new and very real threats to their very existence. And with them comes the question of who can plug the resulting funding gaps so that care can be maintained at all. For one thing is certain: the Seelow hospital cannot simply be closed down. As long as the criteria for ensuring healthcare provision – catchment areas, population figures – remain unchanged, the site is essential for healthcare provision. This means that someone must ensure emergency care is provided. If the hospital no longer does so, someone else must. From this, Thielemann derives a simple rule of responsibility: "If you say A, you must also say B." Anyone who wants to ensure healthcare provision must, ultimately, also ensure that someone is able to provide it.

One such entity is, for example, a thoroughly modern and well-equipped healthcare centre such as Seelow. What she's calling for is not special treatment, but flexibility – the scope to adapt "without it coming back to bite you" – and a little more courage to take unorthodox approaches where healthcare needs it. She would like politicians to take a closer look at individual locations and what they actually need, rather than casting "a blanket over everything". High quality standards and minimum staffing levels are certainly rightly set for maximum-care providers – but what is not practically necessary and cannot be achieved cannot be imposed either.

In this respect, Seelow is a prime example of the crucible the German healthcare system is facing. The hospital is doing what the reform aims to achieve on a larger scale – it is integrating outpatient and inpatient care, reducing excess capacity and developing new services, and thinking in terms of regional strategies rather than individual institutions. What's more, it is doing so sooner, more quietly and more cooperatively than elsewhere, supported by the solidarity between the state, the district, the health insurance funds and the Association of Statutory Health Insurance Physicians – a development that Katja Thielemann regards as an "important and positive signal to the local population". Her sober assessment is that keeping the hospital open "will safeguard healthcare provision in the region" – shaped, as she puts it, "with heart, commitment and foresight". << by: MVF Editor-in-Chief Peter Stegmaier

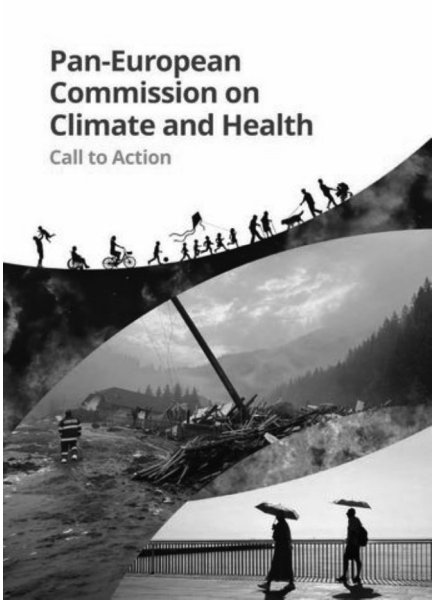
References:

1: https://t1p.de/ffcht
2: https://t1p.de/qnbx9
3: https://t1p.de/6cslr
4: https://t1p.de/myb4g

Citation

Stegmaier, P.: 'A future-oriented laboratory for local healthcare provision', 'Monitor Versorgungsforschung' (04/26), pp. 32–36. http://doi.org/10.24945/MVF.04.26.1866-0533.2845

>> Bxnken. << WHO call to action sets out concrete paths for transformation



>> Europe's healthcare systems face a double dilemma. They are expected to become more resilient to the growing impacts of climate change whilst simultaneously reducing their own environmental footprint – all against a backdrop of rising patient numbers, staff shortages and increasingly tight budgets. In its 'Pan-European Commission on Climate and Health: Call to Action' (1), the Pan-European Commission on Climate and Health has set out concrete ways in which this transformation can be achieved.

A key obstacle lies in training: currently, only around one in five European countries with available data includes climate-related content or planetary health issues in its accreditation standards for medical and nursing professions. This is alarming. After all, those working in the healthcare sector make decisions every day that have a direct impact on emissions and resilience. The members of the Commission – including Prof. Dr Karl Lauterbach – are therefore calling for climate literacy to be made a mandatory part of the educational standards for all healthcare professions – not as a peripheral topic, but as an integral part of an interdisciplinary, systems-oriented approach.

The Commission sees procurement as an equally significant lever for change. An estimated 70 to 80 per cent of the healthcare sector's emissions arise along supply chains – from medical devices and building energy to logistics. As long as each country applies its own procurement criteria, the pressure on manufacturers remains low. Harmonising sustainable procurement standards across the entire pan-European region, on the other hand, would send a clear signal to industry: lower emissions, fewer single-use products and resilient supply chains must become fundamental requirements in future.

At the same time, the Commission is calling for a reorientation of care pathways. Europe's healthcare systems need a more proactive approach that reduces unnecessary treatments, strengthens prevention and systematically integrates climate-related risks into clinical guidelines. In future, treatment recommendations should therefore also prioritise non-pharmacological alternatives where medically justifiable, and focus on diagnostic methods that consume fewer resources. In addition, heat alerts and similar climate-related events should be incorporated directly into care protocols to ensure patient safety even under extreme weather conditions.

The Commission places particular emphasis on one often underestimated aspect: mental health. Climate change is not only a physical threat – it is also a creeping mental health crisis. Grief and trauma following floods or wildfires, fear of an uncertain future – particularly among children and young people – all leave their mark, yet these factors have so far been largely overlooked in climate-related health planning. The Commission calls for psychosocial support not to be treated as a secondary issue, but to be enshrined as a core element of national adaptation strategies. In the Commission's view, community-based services, immediate psychological support following extreme events and a strengthened civil society are not luxury measures, but the cornerstones of genuine resilience.

Finally, there is a lack of transparency and accountability in many places. More than three-quarters of the countries in the region have no clear strategies for measuring their progress towards climate-resilient health systems. The Commission advocates the development of publicly accessible performance dashboards that regularly report on key indicators of sustainability and climate resilience. Only what is measured can be improved. Health systems can no longer pretend that climate change is an external variable. They are part of the problem – and can be part of the solution. <<

1: https://t1p.de/banvn