

“Design care around the patient – not around structu

In conversation: Prof. Dr. mult. Eckhard Nagel, CEO and Board Member for Patient Care of the Medizinische Universität Lausitz – Carl Thiem (MUL – CT) in Cottbus

The Medizinische Universität Lausitz – Carl Thiem (MUL – CT) in Cottbus is Germany’s youngest university medical school. Since July 2024, a new model of university medicine has been taking shape here. Research, teaching and patient care are not to be conceived for a single site alone, but are to take responsibility for an entire region. In the MVF cover interview, Prof. Dr. mult. Eckhard Nagel, CEO and Board Member for Patient Care of MUL – CT, explains how this model is intended to work and what impetus it could provide for regional care, for the German healthcare system and beyond.

>> Professor Nagel, earlier this year several GP practices in one district of Cottbus closed at the same time. What did that mean in concrete terms for the population's care? And how was your university, founded only in 2024, able to help – possibly differently from a traditional university hospital?

In Cottbus, this doctors' protest triggered an enormous political debate along the lines of: How can this be? Who still guarantees GP appointments? And: will all these people who suddenly have no care turn to the emergency departments?

Many university hospitals would probably have regarded such a situation primarily as a matter for outpatient self-governance. Why did you decide to take action yourselves?

An outpatient care shortfall of this kind must, after all, be resolved primarily by the responsible Association of Statutory Health Insurance Physicians (KV), which is charged with ensuring outpatient care. Here in Cottbus, with the establishment of the Medizinische Universität Lausitz – Carl Thiem, things are a little different. Of course, responsibility for outpatient medicine still lies with the KV Brandenburg – as university medicine, we do not question that at all. Nevertheless, we sat down together in a joint committee and then appeared before the press together with the mayor and the KV, saying: "Okay, we have a GP problem, but we will solve it together." Those are the steps the population can expect from us, from MUL – CT.

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What concrete measures enabled your university to step in at short notice during this acute shortage of doctors?

For example, at "Schwarze Pumpe", a very large industrial site in the Lusatian district of Spree-Neiße, we established a community health nurse – on the one hand as a research project of the model region together with the University of Dresden, but at the same time as a real-world service. This now makes it possible to secure primary care. Before that, there were no longer any GPs in private practice there at all.

That was more than a short-term response to a care bottleneck. What makes your model special compared with established university hospitals?

The basic idea of the new university medicine in Cottbus is precisely not to build yet another large university hospital with the entire range of technological and medical issues concentrated at a single site. Here, local healthcare is given top priority, which is normally possible at a university hospital only in individual cases. Of course, a care mandate is implicit in every university medical center, but it is not even reflected, for example, in the states' hospital plans. Here in Cottbus, by contrast, healthcare is the absolute foundation – not only in relation to the site, but to an entire region: all of Lusatia. This is already reflected in the name under which we operate, chosen by the staff of the former Carl-Thiem-Klinikum: Medizinische Universität Lausitz – Carl Thiem. The name makes clear that we, as the Medizinische Universität Lausitz – which emerged from the former Carl-Thiem-Klinikum Cottbus, incidentally the largest hospital in Brandenburg with 1,200 beds and, with around 4,300 employees, also the largest employer in the city of Cottbus – intend to assume a high degree of regional responsibility. A brief word on the name itself: Carl Thiem, who died in Cottbus in 1917, was a German surgeon and traumatologist regarded as a co-founder of trauma surgery in Germany.

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You say healthcare comes first. What does that mean in concrete terms for your university's professors?

That we are not responsible only for inpatient care. We must – and want to – always consider how we can be available as a cooperation partner to other hospital operators and to the medical profession. Our goal is for our academic standards to be meaningfully applicable at all levels of care. Naturally, this also entails a different obligation with regard to cooperation between outpatient and inpatient service provision. That is not easy at a time when the shift to outpatient care is a top priority and the reduction of inpatient facilities is being discussed. This, too, is something a university hospital does not normally have on its agenda in this way, except perhaps in the debate over how many beds, say, urology should operate with in the future. With us, by contrast, integrated care lies in the basic structure of university medicine – in our DNA, so to speak.

Your care mandate extends far beyond Cottbus. What role does digitalization play in this?

The rapid development of digitalization was a key factor in the founding of MUL – CT. Back in the 1960s, for example, Hannover Medical School discussed what it takes to deliver highly qualified care – and concluded at the time that all key services had to be brought together at high quality in one place; mind you, at a single large site to which patients from everywhere then have to come in order to receive the best possible care from a single source.

This is how today's 37 university hospitals and 40 medical faculties came into being, which form the backbone of top-level medical care. Is this centralized concept outdated in your view?

It was also the right solution for its time. But digitalization has now reached a stage at which it can complement and to some extent replace such centralized solutions. Communicating over distance has long been possible. Many examination parameters – weight, temperature, heart rate – can be reported online even though the patient

is at home hundreds of kilometers away. In Lusatia, we now want to bring to life the concept of "Hospital at Home", coined back in the 1990s by Dr. Bruce Leff and his team at Johns Hopkins University School of Medicine in Baltimore, by using digitalization to deliver care across an entire region from a lead hospital – which is, of course, needed for this. This fundamentally distinguishes us from other German university hospitals, where, however, the pressure on the care system is not as palpable as it is for us in Lusatia.

"We don't just talk, we act. We recently decided to establish an initial six primary care centers in the region through a structured process."

Describe the care situation in figures: what is the actual state of healthcare in the Lusatia region?

First of all, one has to accept that in a region like Lusatia the population is significantly older than elsewhere. The same applies to practicing colleagues – a problem that will intensify in the coming years. We have one of the most pronounced age trends among physicians in Germany: more than 50 percent of all practicing colleagues are already over 50 today, and a third are even over 60 or 65. That sounds quite normal at first, but becomes worrying when you think 10 or 20 years ahead: it is rather unlikely that all these colleagues will still be working in 2036 or 2046. This has to be set against the time it simply takes for a well-trained physician to be ready to enter patient care.

Lusatia is often described as a model region. Is this primarily a research project or a response to concrete care problems?

The two are not mutually exclusive, and that is exactly the point. I also have roots in basic research – my first scientific studies, for example, concerned xenotransplantation in small-animal experiments. In my later university roles, however, I saw step by step how important and relevant health services research has become when it truly comes to real-world patient care. And we are going one step further and focusing on health systems research. Because the big difference, and the decisive point for me, is that the "laboratory of everyday reality" is at least as important for care as the artificial laboratory. And Lusatia is precisely this laboratory of everyday reality: in the "Modellregion Gesundheit Lausitz" (Lusatia Health Model Region), enshrined in Brandenburg's University Medicine Act, we solve acute care problems and gain scientific insights from them. Not one after the other, but simultaneously.

Many regional networks fail due to a lack of commitment. For this purpose, you founded the "Innovations- und Netzwerkrat" (Innovation and Network Council). Who sits at the table?

The table is square. Seated at it are all the responsible local political leaders of the districts and the mayor of Cottbus – four district administrators and the mayor in total, accompanied by their heads of health departments, among others. We have all the self-governance actors with a corresponding mandate: the Association of Statutory Health Insurance Physicians, the State Hospital Association, the professional representation of nursing, the Medical Association and the payers, which hold two seats. And state politics: in addition to the State Ministry of Science, Research and Culture and the Ministry of Labor, Social Affairs, Health and Social Cohesion, the State Chancellery is also a member.

What concrete tasks does this body take on?

There we discuss everything that is needed in terms of care in our region, for which we jointly bear responsibility. Today and in the future.

Many regional health conferences have had no lasting effect. What makes your Innovation and Network Council different?

We don't just talk, we act. For instance, we recently decided to establish an initial six primary care centers in the region through a structured process.

Who decides in the event of conflict when the interests of municipalities, health insurance funds and healthcare providers diverge?

Our aim is not to let conflicts escalate in the first place. That is why all relevant actors sit at the table together from the outset. Of course there are differing interests. But we have agreed to put the care perspective first. So far, we have succeeded in making decisions by consensus. I consider that a key success factor of our approach. Should there ever be no consensus, we must continue the discussion process. Classic majority logic is not our priority.

How will you know whether the council is working successfully?

We did not wait for an amendment to the Social Code, because none is actually needed for this. We took a different route: we established agreement among all the actors represented on the Innovation and Network Council and simply decided jointly to establish these centers. Through this instrument of joint action, we are now implementing a corresponding structure. As a result, the classic rivalry between different stakeholders, which often leads to paralysis in our processes, does not even arise. AOK Nordost subsequently described us publicly as a "community of confidence." I believe that is what we truly want to be and can be.

The term "community of confidence" sounds very harmonious. Were there also reservations or mistrust among regional actors during the set-up phase?

There certainly was skepticism. I have been supporting the process for the state government since 2022. A year and a half ago, I still saw noticeable skepticism among other actors. The basic idea was: well, all very nice, but in the end the university hospital, with the financial means at its disposal, will grab everything for itself. The second point was: now there is an initiative with money from the Structural Strengthening Fund, but what do we get out of it? Or even worse: will they now use their many billions of euros to buy up all the hospitals?

The special funds from the Structural Strengthening Fund are earmarked. How do you communicate this separation to local actors?

We do have to explain it again and again: the money from the Structural Strengthening Fund is intended exclusively for developing

the university. Everything else, by contrast, we have to solve independently from within the care system. That is a task in itself. What is important, however, is that over the past few years we have been able to develop a culture of togetherness that now serves as an important basis of trust in our daily work. We already managed to adopt rules of procedure in the first two meetings. Anyone who considers how difficult it usually is to adopt rules of procedure among the many self-governance institutions in newly created structures – where every last detail is debated in case a wording might give one stakeholder an advantage or disadvantage – knows what that means: we are pulling together, and all in the same direction.

One of the decisive levers for primary care centers is that multiprofessional teams quickly reach the limits of delegation and substitution, for which SGB V still imposes restrictions. Are you using the scope offered by state law to show that it is feasible in practice?

In our University Medicine Act – alongside the structural elements – we have enshrined the two research priorities "health systems research" and "digitalization of healthcare" as essential aspects of our mandate. Partly to ensure that these priorities do not fall by the wayside in the future. A third point, which is important for the question you just asked: we have also enshrined in it that our university is dedicated to interprofessionalism. Even in training, we will teach different professional groups together – in the best sense of delegation and substitution of medical services, but above all with the goal of defined systemic and systematic collaboration among the professions. Of course, this is not something we can implement overnight. All professional groups must move toward one another here.

That is a promising but long-term approach until the first graduates work in standard care. But how will you solve the most pressing problem in the short term: standard financing of multiprofessional teams beyond the special structural-change funding?

Within the joint framework of the Innovation and Network Council, we will define very carefully what this means in billing terms and how responsibility is organized under the Social Code. We have a clear mandate to appropriately take into account different professional groups according to their skills in the planned primary care centers – and this must also be adequately financed. I am a realist here and would say: this will certainly lead to one or two debates beyond our region as well.

Does that mean existing professional and sectoral boundaries will have to be redrawn in the future?

We are completely open. We want to design care around the patient and not around the structures to which we adapt patient care.

There is a precedent for this: since 2023, Lower Saxony has had regional care centers enshrined in state law. Does the Holzminden model serve as a blueprint for Cottbus?

These are forerunners that can serve as a reference – for developing a framework under Brandenburg law. But mind you: everything we establish in the Innovation and Network Council will be scientifically evaluated according to jointly predefined criteria.

Which concrete parameters and endpoints will you use to evaluate whether these new care structures are successful?

We look at several dimensions. First of all, these include classic care parameters such as accessibility, waiting times, utilization and avoidable hospital stays. But we are equally interested in patient-related endpoints, such as quality of life, health literacy and whether we can reduce health inequalities. In addition, we will examine how people subjectively experience care and whether new forms of care actually lead to better cross-sectoral collaboration.

What political leverage do you hope these scientific evaluations will provide for nationwide standard care?

With these evaluations, we will then approach not only the state legislature but also the federal legislature. During the development of our University Medicine Act, we already had close contacts with the BMG, which supported the project favorably and will certainly continue to do so.

How far has the development of the university progressed, particularly in health services research?

We have the opportunity to fill a total of ten research profile professorships in health services research, plus a scientific advisory



Prof. Dr. mult. Eckhard Nagel

has been CEO of the Medizinische Universität Lausitz – Carl Thiem (MUL – CT) since July 2024. Previously, he worked for nearly a decade at the University of Bayreuth, including as Executive Director of the Institute of Healthcare Management and Health Sciences and as Head of the Medizincampus Oberfranken project office. There he played a key role in establishing university-based human medicine in Upper Franconia.

From 2010 to 2015, he was Medical Director and CEO of University Hospital Essen. Before that, he headed the Transplantation Center and the Surgical Center at Klinikum Augsburg.

Prof. Nagel combines many years of experience in university medicine, health sciences and hospital management.

board. The second level is the foundation for health services research: we cooperate closely with the RKI and with other institutions that conduct population-based studies. Implementing the so-called Lausitz Panel will provide a basis for conducting long-term health services research with the people of Lusatia – and thus for studying a specific rural cohort.

Which thematic priorities do you focus on within health services research?

I am particularly interested in structural change. The term implies that there was something that previously defined the reality of the region. We want to investigate – also in exchange with the Ruhr area – what specific health risks those who used to work in mining face. This is a special mission for our health services research that simply cannot be pursued in other regions.

You anchor your concept in a salutogenic model. How does this translate methodologically into measurable health services research endpoints, or does it remain mere rhetoric?

Well, you look for a specific context. For example, we selected sports clubs where we offer services at heart health events – where people can volunteer and, for instance, receive feedback on possible risks via a 24-hour ECG. That is initially a technological entry point, which is evolving toward our plan to develop a health app for Lusatia. Such an app makes it easy for everyone to share their data, but is also meant, very practically, to motivate them to use it actively. Then digitalization helps us very concretely to bring together identification and health behavior with meaningful data collection for health services research. Added to this is the German Science and Humanities Council's paper on prevention, which aims to get "from research to action" – a good basis for also considering prevention in academic medicine.

When it comes to health data, you are competing with the large, globally operating IT corporations. Where do you see your comparative advantage in Lusatia over these global players?

There is growing reluctance – not only, but also in our region – to hand over one's own data to large international IT companies. With health data this is particularly sensitive, even emotional: if I am personally affected, I might do it, otherwise not. Data quality also plays a major role. The big players rely on large numbers and, in a sense, define data quality away mathematically. What we want to achieve is particularly scientifically valid: trust-based health reporting that contributes to data quality. We can define the framework conditions much better than if you do it on a global scale. And with regard to medical care, we can do many things better than the big players – because we genuinely cover all areas of care. The large providers struggle here because they have no direct access to care – and certainly none that is consistent across all elements of care.

On October 11, Cottbus will hold its first matriculation ceremony – and the next day, 36 students will begin their medical studies with you. How is health systems research anchored in the curriculum, and to what extent does it shape the profile of the program?

In terms of content, teaching will be a classic model degree program, with patient-related topics from the outset. What plays a major role for us: we are seeking training capacity in the outpatient sector; that means practices participate in teaching. And we are in talks with the public health service and the Medical Service Berlin-Brandenburg about how their perspectives, such as social medicine, can also be taught in the program.

How do you plan to retain graduates in the region in the long term?

We do not require any commitment from our students that those who study with us must ultimately stay in Brandenburg. MUL's task is to create a kind of positive sticky effect. That means our students should be so satisfied with what we offer them that they come to feel: I never want to leave. That sounds a bit romantic at first. But from my experience in Bayreuth I can say: of our first cohort of graduates, two thirds stayed in Bayreuth and the surrounding area.

You are also discussing a "regional bonus" for admission. Is that even legally tenable?

We are discussing whether there are legal options for granting a regional bonus. This is currently under review. Anyone who deals with constitutional law knows that this is a highly complicated matter. But here, too, we are not letting up. We want young people from the region to have the opportunity to actually obtain a place to study with us in open competition with others – in the conviction that it is easier to win people for the region who come from the region. Perhaps in Germany as a whole we struggle somewhat too much with the aspect of equal access when, in the end, we keep asking: where else do we need to establish a medical faculty so that enough people stay in the region? The US and other countries show us, however, that regional care can be covered much more effectively with students from the region than we have done so far in Germany.

Lusatia depends on international skilled workers and students. At the same time, migration-critical parties achieve high election results in parts of the region. What impact does this have?

I don't want to play down the problem. Support for political views that undermine openness to the world exists here in Brandenburg, as it unfortunately does in too many places in Germany, and worldwide we are seeing it even more strongly. I find that threatening. And it also hurts me personally, because I belong to the postwar generation that grew up hoping that we would never have to discuss this issue in Germany again. But that does not change the fact that we must reach out to people who think this way and make the advantages of an open society comprehensible to them. Look at the reality: among the roughly 4,500 employees currently at our hospital, people from over 60 nations work together, and we also have strong partnerships with Brazil, Morocco and Vietnam.

Many models only work as long as special funding is available. What results would have to be achieved for individual approaches to last without this funding?

The funds are needed above all for the basic build-up, because no corresponding structure existed before. These funds are also necessary for creating positions that have long been established at existing university hospitals.

How is permanent operation to be financed without special funds,

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and what prerequisites would other regions have to meet in order to adopt this model?

What I consider transferable, and what does not cost additional millions or billions, is the setting of priorities: the clear recognition that, for all the necessity of high-tech and basic natural science research, health services research is a field in which medical successes can be achieved – in the sense of care improved by data. Together with digitalization, health systems research is an important answer to many of today's care problems, such as the boundaries between outpatient and inpatient care. Bringing these issues to a solution locally, via regional solutions, all the way up to the federal legislature – that is something I can recommend to others. The more of us who go in this direction, the sooner we will succeed in sensibly tackling the reform backlog in healthcare.

If we were to have this conversation again in ten years, what would you need to have demonstrated by then for MUL – CT to be considered a model for Germany?

If we are successful, we will have created and established in Lusatia over the years a range of medical, nursing and therapeutic care that provides regionally all well-studied services of proven medical success. That means: a differentiation between maximum-care medicine delivered in the region and centers focused on specific advanced developments. In Cottbus, however, we will not offer pediatric heart surgery, for example, or bring liver transplantation here – these are areas that must remain in specialized centers. Knowing full well that everything in high-performance medicine that can be offered to the population in the region does not require 200 or 300 kilometers of travel, but can be offered here.

Many maximum-care hospitals are convinced that they can only be a full-fledged site with a complete range of services.

The calculation of maximizing revenue may often play a role here as well. For us, by contrast, the top priority is our university medicine's responsibility for ensuring care across the region.

And how will a future political decision-maker one day recognize that the model has become a new standard?

By our demonstrating that the social divide is narrowing. We are learning precisely from health services research that, despite all medical progress and all excellent services, the social divide in life expectancy and chronic diseases is steadily increasing rather than decreasing. We want to stand up against this with our project as well. My real goal goes further, however: I hope that, through structural change with the Medizinische Universität Lausitz, people in the region will gain a new or transformed sense of community. That means health is not a thorn in the side – that is, the fear of becoming ill – but that people, having developed competence themselves, can pay attention to their own health and influence it positively. If that succeeds, it is successful structural change – and truly a reconciliation that I could not have imagined before.

Thank you for the interview. <<

Interview by MVF Publisher Prof. Dr. Reinhold Roski and MVF Editor-in-Chief Peter Stegmaier.