Series, Part 3: Paracelsus Kliniken Adorf and Schöneck

When efficiency meets quality

The German hospital landscape is being restructured – and with it, of course, private operators as well. While in many places a new insolvency is reported in the press almost every week and, according to the latest surveys by the German Hospital Institute (DKI) and the German Hospital Federation (DKG), almost 80 percent of hospitals in Germany expect a negative annual result, one private operator in the Saxon Vogtland is taking a somewhat different path. At the two sites in Adorf and Schöneck, Phillip Fröschle, CEO and co-owner of Paracelsus Kliniken Deutschland, implemented a "hybrid model" on October 1, 2025, which strictly separates outpatient and inpatient care and distributes them between two hospitals. It is an attempt not to suffer the logic of the hospital reform – fewer sites, greater concentration of services – but to actively shape it. The third part of the MVF series "Rethinking Care – Germany Restructures" focuses on this model, supplemented by a second, more recent example from Schleswig-Holstein: the cardiology cooperation between Paracelsus Klinik Henstedt-Ulzburg and Segeberger Kliniken, which are also privately owned and the largest private hospital company in Schleswig-Holstein. Both cases raise the same question hanging over the entire industry: can care close to home be maintained even when money becomes scarcer – and if so, on what terms?

>> Anyone wanting to understand the restructuring in the Vogtland must first know the perspective of the person responsible for it. That is Phillip Fröschle, CEO of Paracelsus Kliniken Deutschland and now also a shareholder in the company. Speaking to "Monitor Versorgungsforschung," he assesses the starting point soberly: the financial situation of the health insurance funds is understandably tight.

As a private operator, he says, one by no means rejects the insight that costs must be saved in the overall system, because with public and municipal operators every individual ultimately pays for the deficit through their taxes – a compensation that private hospital groups such as Paracelsus do not receive. However, he does not locate the real cause of the current financial fiasco solely on the expenditure side of the hospitals. Rather, an important factor is that the federal government pays insufficient health insurance contributions for recipients of citizen's income (Bürgergeld). According to an expert report by the National Association of Statutory Health Insurance Funds (GKV-Spitzenverband), in 2022 the contributions paid covered only 39 percent of the actual per capita costs incurred by the health insurance funds – actual consumption is therefore considerably higher than what the federal government spends on it. This, he says, has been causing a structural imbalance in the funds' finances for years. But other causes also play a role.

The conversation between Fröschle and MVF happened to fall on the very day the Bundestag and Bundesrat passed the SHI Stabilization Act (GKV-Stabilisierungsgesetz). His criticism of this reform is directed less at policymakers' understandable desire to save as such, but rather at how it is done. In the SHI Stabilization Act, Fröschle says, he found virtually no passage describing how the health insurance funds themselves should save money – but overwhelmingly only how others must save. At the same time, according to Fröschle, hospitals have hardly any options to counteract: requirements such as the nurse staffing floors remain unchanged, which rules out different staff skill mixes. The result, he says, is almost "pure cost-cutting," in which a very large share of the management options – for private, municipal and church-run hospitals alike – disappears. Adding up the measures, the hospital sector faces a noticeable cut in the mid-single-digit percentage range.

The consequence, he says, will be an even more severe wave of hospital closures, which he does not consider wrong in principle, since in his assessment there are more than enough hospitals in Germany. What is wrong, however, is that the concentration of sites is proceeding "completely unmanaged" as a result of cost-cutting. Who survives is decided not by quality or structure but, as he puts it, by "non-rational factors."

What Fröschle values about the preceding hospital reform is precisely the opposite, because it at least attempts to steer the process.

What is emerging in the Vogtland

Against this backdrop, Paracelsus Kliniken have reorganized their two sites in the Vogtland. According to the company's press release of September last year, the Adorf and Schöneck hospitals have been working closely together since October 1, 2025, as part of a unified care concept, with each site contributing its specific strengths. The aim, it says, is sustainable care close to home as well as a long-term perspective for employees.

Specifically, all inpatient services are being consolidated at the Schöneck site. This includes the departments of general surgery, vascular surgery, internal medicine, orthopedics and trauma surgery (including spine treatment), geriatrics, pain medicine, intensive care and palliative medicine. Orthopedics and geriatrics are being deliberately expanded in Schöneck, so that, according to the operator, a high-performance center for musculoskeletal and geriatric care is being created there. The Adorf site, by contrast,



From left: Phillip Fröschle, CEO, and Timon Gripp, COO. Source: Paracelsus.

will in future focus on outpatient surgery in all surgical specialties as well as the outpatient consultations of the medical care centers (MVZ) – including general surgery, vascular surgery, orthopedics and trauma surgery (including spine treatment), pulmonology and oncology.

In the press release, the management of Paracelsus Kliniken Adorf/Schöneck explicitly placed the approach in the context of the reform: the aim is to use the opportunities offered by the current health reform to make care in the Vogtland future-proof. And Dr. Martin Ebert, chief physician and medical director of both hospitals, emphasized the close integration of processes from first contact through diagnostics to aftercare, as well as the link to office-based colleagues. "We are not just helping to shape these changes, but actively shaping them in the interest of the local people and with a clear long-term perspective for the site. The new model secures the continuous development of our hospital structures and ensures that medical care in the Vogtland is guaranteed in the future," Fröschle stated in the press release (1).

The logic of the split

According to Fröschle, the reorganization is based on a combination of quality and efficiency dictated by the hospital reform itself: fewer hospitals on the one hand, specialization and concentration of services on the other. The idea behind it: "If I do something more often, I do it at a higher quality." But it becomes not only better but also cheaper – the general surgery operating suite, for example, is then only needed at one site instead of two, and the same largely applies to staff.

For Fröschle, the decisive factor in whether such a split benefits or harms patients is emergency care. The most important yardstick in his view: how many minutes does it take a patient to reach an emergency department? Here, nothing has effectively changed in Adorf. Hospital emergency care was already moved to Schöneck five to six years ago; since then, there has been no hospital emergency department in Adorf, only inpatient care for elective joint replacement and geriatrics. Even geriatric emergencies were usually taken to Schöneck, treated there and then transported to Adorf for inpatient care – a procedure that costs money, is medically problematic and also ties up the ambulance.

For elective procedures – such as a planned knee or hip replacement – it makes no difference whether patients drive, so to speak, "left or right." Ultimately, it does not matter to planned patients whether they drive 20 or 22 minutes to surgery – irrelevant to the quality of elective care and only relevant in emergency medicine.

A second consideration concerns the separation of outpatient and inpatient procedures. If an outpatient procedure – Fröschle cites hernias as the classic example – is performed in a central operating suite that also handles emergencies, a smooth workflow can hardly be guaranteed: when an emergency arrives, it naturally takes priority. It therefore makes sense to separate outpatient and inpatient procedures. In Adorf, where the facilities are available, not only almost all SHI practice licenses (KV-Sitze) but also outpatient surgery are therefore being located. Higher-risk patients are operated on in Schöneck as planned and, if medically necessary, subsequently admitted as inpatients. According to Fröschle, the decision rests solely with the physicians. The model apparently works: since the changeover, Fröschle says, not a single patient operated on as an outpatient in Adorf has had to be transferred to Schöneck afterwards.

Why a "hybrid model"?

The name under which the model operates stems from a formal peculiarity. Both sites continue to belong to a joint hospital network and are also still listed in the state's hospital plan. According to Fröschle, the term "hybrid model" was chosen because one site is run purely as an outpatient facility and the other purely as an inpatient one. When he spoke with the authority around two years ago, the new designations – such as "Level 1i" – did not yet exist. The aim at the time was therefore to describe the status of the two hospitals more accurately.

According to Fröschle, the reorganization was preceded by a needs analysis from two perspectives. On the one hand, the catchment areas were examined: how many people live where and what medical needs can be derived from this. On the other hand, the hospitals' own occupancy was evaluated. Since hospital planning is the responsibility of the authority, the planned change was coordinated very intensively with it. The authority received Fröschle's proposals very positively and fully supported them.

The process is not yet complete. As of July 2026, the authority has not yet given final feedback on which hospital will receive which service groups. However, the structural audit at the site has been carried out and looks "good so far," and one or two minor issues

were resolved afterwards. Whether exactly the same range of services will be permitted in the end remains to be seen. Fröschle is optimistic: Paracelsus orthopedics is, after all, the largest in the region, and he considers basic and standard care with internal medicine, geriatrics and general surgery, as well as an emergency department covering these areas, to be a given.

Good medicine – good results

Asked what "well positioned" means for a private operator, Fröschle initially argues in economic terms. For 2025, a positive result was achieved in the income statement – despite a negative result in the previous year. The result was thus improved against the industry trend. However, nothing is distributed: every euro of profit flows back into the company to finance investments. The fact that private operators have to bear a considerable part of their investments themselves underlines the situation – while nationally investment is funded roughly half from public subsidies and half from own funds, the ratio for private operators is more like 70 to 30.

Especially with a private operator, Fröschle concedes, the question of profit quickly arises. The fact that all profits are reinvested, however, makes this point easier to explain. There is no "huge financial backup" – the result has to be right in the end. For him, quality and efficiency only work together: "We can only practice good medicine if we generate good results." On the other hand: "We can only generate good results if we practice good medicine." If one of the two levers is pushed too far, the balance fails – investments such as a new operating suite or new X-ray equipment can only be financed if results remain, and staff and patients alike only come if the medical outcomes are very good.

Asked about his own quality, Fröschle remains deliberately pragmatic. He speaks of "good" medicine, not cutting-edge medicine – the latter, for him, is the domain of university hospitals. But in joint replacement, basic and standard care and cardiology, Paracelsus is good, he says. The same applies to the two specialist hospitals for Parkinson's disease and urology. The group participates in IQM (Initiative Qualitätsmedizin) and is slightly above average there.

The local response

Fröschle describes the feedback on the changeover as consistently positive, especially from employees. Of course, some staff had to move from Adorf to Schöneck – and vice versa, for example to the MVZ. Such changes always cause a certain amount of unrest among the workforce; overall, however, this remained minor and almost no staff were lost. What matters, he says, is that emergency care – for him the crux of the matter – has not changed: anyone who previously went to the emergency department in Schöneck still goes there. Outpatient care in and around Adorf has improved significantly thanks to the pooled SHI practice licenses. Among other things, a pulmonologist has been added.

Communication with the municipality, the district administrator and the Association of Statutory Health Insurance Physicians (KV) was also conducted openly. Fröschle presented the model personally at a committee meeting. With the backing of the planning authority, the process went relatively smoothly. That some patients now have to travel a little further to their doctor and others less far is acceptable, he says, and balances out within the region.

In conversation, CEO Fröschle somewhat qualifies the "nationwide pioneering role" claimed in the press release. This wording, he says, is partly due to marketing; the actual trigger was the discussion with the authority. He understood its feedback – not quotable, but in essence – as recognition of a "bold but constructive" proposal.

Second example: cardiology in Schleswig-Holstein

A second, more recent example shows that the logic of the split is not limited to the Vogtland. As the Hamburger Abendblatt reported on July 2, 2026, Paracelsus Klinik Henstedt-Ulzburg and Segeberger Kliniken (2) will cooperate in cardiology in the future. As part of the reorganization of the hospital plan for Schleswig-Holstein, a joint concept for cardiology care in the south-west region was developed (3).

According to this, inpatient interventional cardiology is to be consolidated in Henstedt-Ulzburg, supplemented by outpatient and possibly day-clinic services in Norderstedt. According to the report, the Paracelsus hospital has a cardiac catheterization laboratory that is operational around the clock, opened in 2024, and already treats emergency cardiac patients from Norderstedt and the southern district of Segeberg. Patients requiring further specialized care – for example for complex cardiac arrhythmias, heart valve disease or cardiac surgery – are to receive further treatment at the heart center of Segeberger Kliniken. The aim of the cooperation is a seamless chain of care within Schleswig-Holstein.

Timon Gripp, hospital Managing Director of Paracelsus in Henstedt-Ulzburg and COO, is quoted as saying that the responsible Ministry of Justice and Health expressly welcomes the cooperation plans. And for patients, the concept means that emergency cardiology care remains secured close to home while access to highly specialized cardiology in Bad Segeberg is guaranteed.

The hospital reform, he says, is being shaped constructively and through dialogue in Schleswig-Holstein. The fact that genuine collaboration across operators has emerged from the planning process shows that reform and good care need not be a contradiction.

Fröschle puts this second example into context in the MVF interview. It follows the same basic pattern – the integration of outpatient and inpatient care and the division of tasks between two hospitals. The difference, however, is that in Schöneck both hospitals belong to the same owner, whereas in Schleswig-Holstein a competitor is involved. The Vogtland was therefore not the blueprint for it. His openness about how it came about is remarkable: here, too, the pressure came via the authority, which had asked "how things would continue there." Without this pressure, the conversation with the competitor would not have taken place in this way – in the end, it led to a good solution for all parties.

The limits of the model

Within the current seven Paracelsus hospitals, Fröschle classifies the Vogtland arrangement as a special case: it is somewhat isolated because there the group really has two complete sites of its own. The other hospitals are mostly standalone facilities. As specialist providers, he names the neurology and Parkinson's hospital in Kassel and the urology hospital in Düsseldorf. In Bremen there are several MVZs and SHI practice licenses, but only one hospital site. A comparable

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split between two sites as in the Vogtland is not possible elsewhere for geographical reasons alone. In principle, however, the group is open to contributing constructively to the hospital reform – even if everything one loses "hurts in the first instance." Sometimes, he concludes positively, external pressure produces creative solutions.

Whether the model in the Vogtland will hold up in the long term therefore does not depend on the site itself – similar to the cases previously described in this series. Fröschle himself does not expect the reform to survive as it currently stands on paper: in its implementation, he predicts, things will get "ugly in the industry." For Paracelsus Kliniken, he nevertheless draws a confident conclusion: the group is among the well-positioned operators, is monitoring developments closely and is trying to shape the whole process constructively. <<

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