“An architectural clarification provides clarity, not losses”

In interview: Prof. Dr Udo Janßen, Managing Director of KyberMedis



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The German healthcare system has been suffering for years from a reform crisis for which there seems to be no satisfactory explanation. Prof. Dr. med. Udo Janßen, Managing Director of KyberMedis and former CEO and CFO of several hospitals, as well as a senior partner at KPMG and Deloitte, has published a diagnosis that packs a punch: In his view, the problem lies not in a lack of funds or a lack of will on the part of political actors, but in a fundamental architectural crisis of the system. In an interview with “Monitor Versorgungsforschung”, Janßen explains his model – the welfare state matrix, which is nothing less than a fundamentally new systemic logic for our healthcare system.

>> Professor Janßen, you have published a text on a social media channel putting forward the thesis that the real problem with the German healthcare system is not underfunding, not demographic change, not the shortage of skilled workers – but a flawed system architecture. That sounds like a very bold claim. Why should a design flaw that has existed for decades be considered the root cause, when at the same time hospitals are going bankrupt, there is a shortage of doctors – particularly in rural areas – and care homes cannot find enough nursing staff?

Let me first make an important clarification that is crucial to what follows: the matrix thesis I have put forward does not claim that factors such as underfunding, medical progress, demographic challenges and a shortage of skilled workers are not real problems for the financing of our healthcare system. Undoubtedly, they are – and very real and pressing

ones at that. What I am arguing is something different and far more fundamental: in order to design effective healthcare reforms, structural inconsistencies within the system must first be identified and, ideally, resolved. For it is precisely these inconsistencies that prevent the root causes of the diverse and increasingly apparent problems from being properly addressed.

What is the basis for your diagnosis?

Over the last 20 years, we have pumped countless billions of euros into the system,

initiated more staffing reforms and launched more digitalisation initiatives than ever before – and despite all these well-intentioned reforms, the situation continues to worsen. I contend that the problem lies in the fundamental architecture of the system's logic, within which these reforms are being implemented.

That sounds like a fundamental critique of 30 years of health policy. What evidence is there that the system logic you describe is really the cause, and not merely a perhaps elegant explanation for a far more complex phenomenon?

You are right to demand evidence – and I want to be honest: there is no such evidence in the strict sense, neither for the current system logic nor for the one I am proposing. What we can analyse instead, if we take a more systemic view, is a coherent pattern. The care reform has failed due to the blurring of lines between insurance and welfare. Hospital reform is failing due to the blurring of lines between insurance and public services. And the debate on universal health insurance, which has been ongoing for two decades, is failing due to the blurring of lines between the market and insurance. As long as the dividing linebetween statutory and private health insurance is politically defended, no coherent solution can emerge structurally. In other words: every single reform of the last 30 years has ultimately lost its momentum due to inherent logical inconsistencies.

"The Matrix does not explain that we have problems – it explains why our reforms cannot solve them."

Still: That sounds rather theoretical!

I expressly concede: the welfare state matrix is an analytical diagnostic model – not an empirical causal model that could be verified or falsified through regression analyses. But where the logical separation becomes practically apparent, the effects predicted by the model can be clearly illustrated. So the matrix does not explain that we have problems – it explains why our reforms cannot solve them, however well-intentioned they may be. To put it in an analogy: a team with outstanding individual players but the wrong line-up will struggle against a cleverly assembled team. This is exactly what we are seeing: the parliamentarians at federal level, the civil servants at the Federal Ministry of Health, the experts on the Joint Federal Committee and at the National Association of Statutory Health Insurance Funds are working with great determination – but they are reforming what has been incorrectly pieced together over two or three decades, taking it to a new level, without first addressing the fundamental logical problem.

Let's stick with this observation. Where exactly are logics being mixed up in the German healthcare system? Can you illustrate this with a specific example?

Our healthcare and care system is based on four fundamental principles, which can also be described as logics: the principle of solidarity-based insurance, the principle of welfare, the principle of public services, and the principle of competition. These logics, which are actually quite distinct, have become intermingled over time – not deliberately, but because it seemed to the politicians responsible at the time to be the more pragmatic, quicker way to solve an immediate problem. A clear example is health insurance for recipients of the citizen's income. Here, on 11 September 2025, the Board of Directors of the GKV-Spitzenverband decided to bring an action before the Federal Constitutional Court against the Federal Republic of Germany on the grounds of the systematic underfunding of this provision. Rightly so, in my view – for this is the most striking example of how an attempt is being made to transpose a welfare task into an insurance framework. Here, the asymmetry and also the absurdity quickly become visible and tangible: ultimately, the contributors to a mutual insurance association are expected to fund a general welfare principle that was never part of the original insurance logic. This is anything but a sustainable social policy – it is simply fiscal muddling through.

Dissenting view: It has worked for years and decades!

Yes, such an approach works for a while, especially when the statutory health insurance funds are well-funded. But that is no longer the case, which is why premium increases are becoming almost inevitable . Gradually, this creates an imbalance that many citizens increasingly perceive as unfair – and they then make this sentiment clear by how they vote.

You are now proposing a model that clearly separates these four approaches. Please explain first what they are.

The first principle is the classic, contribution-based insurance: benefits are drawn on the basis of the entitlement acquired through contributions – in the event of a claim and without any external burdens.

The second pillar is traditional welfare. It has several historical roots – the municipal poor relief system based on the Elberfeld model since 1853, the Christian charitable tradition and the social democratic labour movement. All three have this in common: welfare is value-based, it concerns us all and must therefore be financed entirely through taxation. This means: it must be accounted for in the federal or state budget, decided upon by parliament – and must not, as is the case today, disappear into a sort of shadow budget.

The third principle is territorially managed public services. We need comprehensive provision through local authorities, which must then also bear responsibility. Hospital planning, for example, is a classic task of public services. At present, however, I see many politicians pushing this issue far away from themselves and saying: 'That is not my responsibility.' That is a misguided approach.

The fourth principle is the market and competition, which are intended to deliver tailor-made services for specific needs. This requires clear

interfaces. I could well imagine a private health insurance provider defining its interface in such a way that there is a basic insurance package for everyone covered by statutory health insurance – alongside voluntary supplementary insurance policies provided via the free market.



That sounds impressively simple on paper. Yet the reality of healthcare provision is highly hybrid. Take acute psychiatric care or obstetrics: such services have simultaneously the character of insurance, social care and public services. How can they be clearly assigned to a single logic?

In my view, hybrid services do not have a classification problem, but an interface problem. The architecture I propose does not require a single logic per service, but a logic per component. Take acute psychiatric care: at its core, there are three clearly distinguishable components. The first is the acute medical treatment itself – a classic, collectively contribution-based insurance benefit. The second is the regional provision function of an appropriately equipped clinic within a specific geographical area – a classic, collectively tax-funded public service at state level. The third component is social-psychiatric aftercare, including supplementary low-threshold support – a classic welfare issue, individually tax-funded and provided through local authorities.

And what about obstetrics?

It works in exactly the same way. The birth itself is a purely medical insurance benefit. The obstetric provision structure within the geographical area is part of public services. The family midwife and, where necessary, psychosocial support are, in turn, welfare services. As you can see: even hybrid services can be clearly presented and made visible within a logic that initially appears complicated. However, there is more to it than that: a clear clarification of the system architecture helps the relevant authorities to find sustainable solutions – and then to take responsibility for them.

Your proposal jumps around quite a bit between different books of the Social Code. Isn’t that an objection to the model?

On the contrary: it is a further finding. If a model has to jump across several Social Security Code books, it simply means that these books have long since defied their own logic. The structure of the Social Security Code was established as far back as 1972, more than 50 years ago. In the many decades since then, we have forgotten how to classify things correctly.

Professor Janßen, you are the managing director of a consultancy firm and a university professor. You first published your model on a social media channel, not in a specialist journal. What prompted you to choose this unusual route?

As an interested observer of the long-standing reform efforts, I have always found it a pity that – at least in my view – too few voices from academia and theory are heard in the debates. In Germany, good policy has always been achieved when those in power have listened to the scientific community and involved advisors in their decisions. I have increasingly missed this in recent decades. As I have been working in the health and social care sector for over 25 years, this topic has clearly struck a chord with me – precisely because so many reforms are pending. And I said to myself: someone who isn't entrenched in the system must raise the voice of economics and pragmatism – and do so quickly, and therefore on a social media channel, precisely because so many reforms are currently pending. For whenever knowledge wanes, belief takes hold. At present, however, we have no great need for belief – but for knowledge.

Critics might suspect that your model signals a dismantling of the welfare state – or classify it as ultra-conservative. How do you respond to that?

I disagree with both. At its core, the Four-Logic Matrix is a return to financial and economic clarity – to a perspective that served as a guiding principle in the early decades of our republic and has increasingly been lost over the last three decades. This perspective can be applied to any economic task: What is the task? If I carry it out in one way or another, what expenditure will result? Only then: where does the revenue come from? Not the other way round, following the motto: how much revenue do I have, and which task fits that. This is explicitly not meant nostalgically, but analytically. What may be pleasing to some critics is that I come neither from the milieu of the 'New Social Market Economy' nor from a similar school of thought that posits that everything must be scaled back. To begin with, I will simply say, freely adapted from Georg Christoph Lichtenberg: "Things must change if they are to improve." I do not intend to dismantle the welfare state. Such a dismantling mayoccur, but it need not – that would ultimately be the result of a social negotiation process, but certainly not my starting point.



Prof. Dr. med. Udo Janßen *is a university professor and managing director of Kyber-Medis GmbH in Berlin. A doctor, business economist and commercial lawyer, he has been active in the health and social services sector for over 25 years. He was CEO and CFO of the Vienna Hospital Association and a senior partner at KPMG and Deloitte in the Health Care and Public Sector division. His academic research focuses on the economic and regulatory architecture of healthcare systems. With the Welfare State Matrix, he has presented an analytical framework that interprets the reform crisis in the German healthcare system as a consequence of mixed system logics. The accompanying article has been published in the KyberMedis series "Beiträge zur Versorgungs- und Sozialstaatsarchitektur". ORCID: 0009-0002-6579-9645*

You are, of course, aware that your model is politically inconvenient. Which specific actors would gain structurally from your separation of logics – and which would lose so much that their resistance could block implementation?

Let me break this down in terms of winners and losers, even if the picture remains rather rough at this stage. The main winners are the chronically ill, because interface losses are significantly reduced, and patients requiring hybrid care, because responsibilities are clarified. Perhaps most importantly: the majority of statutory health insurance contributors are winners, because the insurance framework is noticeably streamlined and defined more clearly in terms of competence and responsibility. The patient and citizen currently has no discernible voice in the concert of self-governance. But: their voice will – and this must be clear to us all – become very significant on the days of the upcoming state elections; all the more so if, out of frustration, the famous cross is ticked where it might not have been ticked had there been no negative experiences with the health and social care system.

And what can the organised stakeholders, the members of the G-BA, expect?

Local hospital authorities, for example, will clearly be in a better position than before, because urgently needed provision structures will finally be adequately funded and recognised. The medical profession and nursing staff will also be winners, because their structure and their respective responsibilities can be defined more clearly.

What – there are no losers?

I am deliberately not describing it as a loss: there will be structural reductions in influence. Primarily on the part of the Ministry of Finance, because welfare costs will suddenly become visible. But also on the part of private health insurance, because the scope for interaction at the interfaces will have to be defined more precisely. And on the part of the health insurance associations, because they mayhave less involvement in the administration of the welfare state, but in returnface greater pressure to reform theactual insurance logic – meaning they must take sole responsibility for structure and outcomes. But to be clear: ultimately, the stakeholders are not losing substantial tasks, but rather tasks that were previously incorrectly allocated within the system. This is not a loss of power or budget, but a clarification of responsibilities that is critical to success. In other words: all tasks still need to be carried out. They are simply being allocated more clearly, assigned responsibility for, and, above all, logically justified.

However, self-governance could also include stakeholders who shut down at the very idea of a separation of logic.

One must see clearly: the agendas of all stakeholders are firmly rooted in their own interests – some would say: set in stone. With such a proposal, one is, in a sense, driving a spear into a rapidly turning wheel – in terms of content, but above all in terms of political interests. An example from the recent reform debate: when the separation of maintenance costs was discussed, this was attractive to some health insurance funds and a problem for others – simply because the burden of contribution rates would have shifted between the different types of fund. That is the reality. That is precisely why I assume that my approach will not be well received at federal level – simply because the shunting yards will become transparent and, in political-economic terms, potential for power will be curtailed.

So where will your model actually be discussed – and where will opposition arise simply because agendas are being called into question?

You can almost pick and choose who you want to name: the Federal Ministry of Health, the Bundestag, the G-BA or even the GKV-Spitzenverband. This level is very much geared towards continuing the existing game. And there will always be individual service providers who do not want to present the tasks for which they are responsible in a transparent manner in their performance.

In a federal system like Germany's, the introduction of a new approach would require a far-reaching policy decision by the federal government. Who should tackle this?

The whole thing is indeed a far-reaching regulatory self-commitment. But we have already solved such tasks in Germany – think of the Stability and Growth Act of 1967 or, more recently, the debt brake. And we have

seen similar negotiations in the Federalism Commissions of 2003 and 2007. What I propose – and I certainly see my set of theses as a working basis, not as a finished concept – is a kind of 'Welfare State Architecture Act' that regulates four things at federal level. Firstly: the definitional separation of the four logics. Secondly: the allocation of funding per logic. Thirdly: the allocation of responsibilities – the federal government for the regulatory framework, the Länder for public services, the local authorities for welfare provision in defined areas. And fourthly: a conflict resolution mechanism that applies particularly to hybrid services and interfaces. I know that this is constitutionally challenging – but it is possible if there is a will to do so.

Grandfathering rights, existing contracts, well-establishedcoalitions of interests – these make any system overhaul a protracted process. What transition path do you realistically envisage for the millions of existing care contracts, statutory health insurance benefits and state regulations?

There will certainly be no 'Big Bang' that shatters everything and reorganises it from scratch. Such a restructuring can only take place gradually. I would take a very pragmatic approach and start with the most costly inconsistencies – accompanied by extensive grandfathering provisions for existing contracts and structures. New regulations are introduced for new cases, whilst existing care contracts are allowed to continue for the time being; they are not reallocated. This is significantly simpler from both an administrative and political perspective.

Over what timeframe?

Once a political consensus has been reached, one can begin to structure the financial redistribution over a transitional period of five or ten years, so that neither the statutory health insurance system nor the federal budget is subjected to a sudden shock. The issue of state-provided public services will also need to be addressed through a federal-state pact – not by shifting existing funds, but through dedicated funding for this pillar of the system.

Your model presupposes a coherent, comprehensive implementation. What happens in a typical political scenario, which, as experience shows, usually means only partial implementation? Won't things then get worse rather than better?

Implementation will always be phased – but always accompanied by sequential clarifications of the architecture, so that individual logical inconsistencies are gradually resolved. And every resolution improves the status quo, even if other inconsistencies remain.

Let us illustrate this with an example.

Take the basic income we mentioned earlier. If we separate the welfare function from the statutory health insurance (GKV) contribution pot and transfer it to municipal or federal budget-based funding, clarity emerges: the GKV could then actually conduct its contribution discussions on the basis of uniform insurance benefits – no longer distorted by non-insurance-related tasks. That would be a first step towards reform, without simultaneously resolving the issues of hospital reform and the interfaces with private health insurance. This is what I call 'architectural islands': every clarification creates an island to which others can be linked – and with every island, the

continent grows. Initially, one can imagine the four logics as four overlapping circles, which are gradually controlled and separated until, in the end, four clearly distinct circles remain. It won't work any other way – for example, as a single grand sweep – anyway.

All this sounds very systemic. What, in concrete terms, will change for the chronically ill pensioner who is shunted back and forth between their GP, a care home and social services?

Today, a person in need of care experiences the system as fragmented – because we mix the fundamental logics together and, in the end, no one is clearly responsible. It is precisely this mixed logic that is the reason why patients experience gaps in care.

Clarifying the architecture, on the other hand, is inextricably linked to guaranteed continuity of care. But that also means: we must allow the existing care system to continue running, build new structures in parallel, and only switch over once the new architecture is stable. The greatest risk, however, is doing nothing. Then our care structure will continue to erode – and in the end, no one will be responsible, because everyone in their own niche has done only exactly what the law required of them for that one niche.

Keyword: pilot schemes and integrated care: that is precisely what the contracts under Section 140a of the Social Security Code (SGB V) were supposed to resolve. Why has that not worked sufficiently?

Integrated care was an attempt at a service underpinned by the idea of single-source funding. People joined forces, pooled funds and used them to purchase services – but without first clarifying the necessary architecture. This clarification does not in itself create integration, but it does provide clarity on who is in charge and who is responsible. And that alone is a major gain. The idea of integrated care remains a good one. It's just that we currently have such a fragmented system – one that is irresponsible in terms of outcomes – that hardly anyone knows who is supposed to integrate with whom, when, and how. My proposal is therefore this: let us first establish clarity in the basic structures. Once that is in place, the next step must be to introduce clearer accountability for outcomes – fiscally, budgetarily and organisationally.

How long would such a transformation process realistically take?

It is likely to be a generational project – but please, one that starts without delay. For it is the only realistic path, which, incidentally, some of our neighbouring countries have long since embarked upon. What we cannot afford under any circumstances is to wait another ten years before we begin to clarify the necessary architecture. We can already feel it today: hospital reform isn't working, the GKV Stabilisation Act is faltering, and the care crisis is worsening. These are all symptoms – and symptoms usually get worse, not better, if you don't treat the cause.

Which neighbouring countries do you have in mind?

Let's take the Netherlands first. Between 2006 and 2015, our immediate neighbour introduced strictly separate social security systems in phases. Firstly, there is the Zorgverzekeringswet, which provides compulsory basic insurance for all residents; secondly, the Wet langdurige zorg, which regulates long-term care as a compulsory solidarity-based

insurance scheme; and thirdly, the Wet maatschappelijke ondersteuning, or Wmo for short, which organises local authority responsibility for home support, social participation and social support. Three laws, three clearly distinct logics – that is precisely what we lack in Germany. Incidentally, Sweden established a similar system five decades ago, around the

the time when the SGB books were being written here. With these timelines in mind, I would suggest three horizons: one parliamentary term – that is, four years – for the first serious structural steps and the resolution of two to four of the most significant logical inconsistencies. Then it will certainly take a whole decade for the essential transition to the new system architecture. Perhaps the project will then be completed in a generation – in around 30 years – once all legacy assets have been transferred and the new structures are fully operational.

"Criticism will come; we'll just have to put up with it. But it will be on a manageable scale – if only because the architectural logic does not, in fact, ensure that any stakeholder stands to lose anything."

The primary care model currently under discussion , which was actually intended to be a primary care model, would surely be a concrete testing ground for your separation of logic.

Absolutely right. Primary care, as it is currently being discussed among experts, could be a prime example of how clarifying the architecture can ensure that a new form of care is set up correctly from the outset – from medical healthcare through to provision and welfare issues, right up to the social level.

Is there an EU country that has already set up primary care in this way?

The Austrian model is instructive. The first primary care unit was established in Vienna in 2015, but the real impetus for its establishment only came when Austria mobilised around 100 million euros for primary care from the EU Recovery and Resilience Plan in 2022. In July 2025, the hundredth primary care unit was opened, including thirteen units specifically focused on paediatrics and adolescent medicine. What Austria got right here is the architectural separation of spheres of responsibility: medical services are provided as insurance benefits through the Austrian Health Insurance Fund, the establishment of infrastructure is funded by EU and federal funds, and regional integration is managed by the state and social insurance providers. Translated into my matrix, this means: insurance covers outpatient treatment, public services provide the local infrastructure, and social care provides social support – for example, through social prescribing, which is already established in some units. Market elements – the free choice of unit by the insured – are specifically permitted where competition promotes quality. It is precisely this architectural clarity that is lacking in the German primary care debate. We are currently discussing the general practitioner system as a matter of healthcare policy governance – without having clarified which component belongs to which logic. This is why this reform, too, could fail at the same point as many before it: due to the unresolved blurring of logics at the institutional level.

The tactical advantage would also lie in the fact that the debate on primary care is currently at the heart of a legislative initiative.

This is precisely why primary care presents a genuine opportunity to treat the four-logic approach not merely as an abstract architectural theory – Janßen, U., Stegmaier, P.: “An architectural clarification creates clarity, not losses”, in “Monitor Versorgungsforschung” (03/26), pp. 6–12. http://doi.org/10.24945/MVF.03.26.1866-0533.2839

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One final question, and perhaps the most difficult: the German healthcare system has seen many clever reform proposals – and yet little has changed. What makes you certain that your model will not suffer the same fate: first ridiculed, then opposed, and finally ignored?

This pattern occurs everywhere and always when it comes to new or even just different ideas. After all, the idea is not new at all – it is being put into practice in the Netherlands, and with success. First, ideas are ridiculed, then taken more seriously, but pigeonholed by deliberately exaggerating points of criticism. Yet eventually, good ideas prevail. We can only hope that by then it will not be too late. A viable approach would be to skip the initial phases, which merely consume time and energy, and move straight into a goal-oriented and forward-looking discussion. What makes me optimistic about this is that a logical separation leads to visibility right from the first step – and that is perhaps the most important step forward in reform. What currently has a destabilising effect when concealed suddenly becomes visible and thus politically negotiable. There is a world of difference between the Federal Minister of Finance having to explain why welfare costs several billion euros, and that same sum remaining hidden within the statutory health insurance funds’ contribution pools.

To put it more soberly: friction generates heat – and heat sets reactions in motion.

That is how it is. Importantly, clarifying the architecture does not initially shift any costs – as one might assume. However, it does reveal what is currently having a destabilising effect behind the scenes. For that reason alone, this step – also in anticipation of the forthcoming landmark decision resulting from the GKV-Spitzenverband’s appeal to the Federal Constitutional Court – can no longer be stopped; this new reality demands clarity. Criticism will come; we must endure it. Yet it will be of a manageable scale – not least because the architectural logic does not ensure that any stakeholder stands to lose anything. That is the crucial difference from other reform proposals. We therefore need the courage of the current generation to address this architectural question clearly and openly. Only in this way can we emerge from the reform crisis of the last 20 or 30 years: less chaos through greater architectural clarity. That sounds simple – but it is the correct diagnosis and perhaps even our only option.

Professor Janßen, thank you for this interesting conversation. <<

The interview was conducted by MVF Editor-in-Chief Peter Stegmaier.

References: Social media post: https://t1p.de/74sa2 Further reading: The detailed rationale for the four logics, the empirical evidence and the four case studies can be found in the publication “The Welfare State Matrix. An Architectural Diagnosis of the German Welfare State” (Kyber-Medis

Working Papers / Contributions to the Architecture of the Welfare State No. 01), DOI: 10.5281/zenodo.20318090 or on MVF: https://t1p.de/64mk9

Comments?

The 4-logic matrix proposed by Prof. Janßen needs to be discussed. Please email your reasoned response to this proposal. MVF will publish a summary of the comments received in MVF 04/26. Email: stegmaier@m-vf.de