Statements by the MVF Editorial Advisory Board on Prof. Dr. Udo Janßen's welfare state matrix

The diagnosis convinces, the therapy not yet

Prof. Dr. Udo Janßen, Managing Director of KyberMedis GmbH in Berlin and formerly CEO and CFO of the Vienna Hospital Association (Wiener Krankenanstaltenverbund), presented a far-reaching diagnosis in the cover interview of "Monitor Versorgungsforschung" (03/26): the problem of the German healthcare system lies not in a lack of funds, but in a fundamental crisis of architecture. His initial working approach: because the four basic principles – solidarity-based insurance, welfare, public services of general interest and competition – have become mixed over time, all reforms to date have come to nothing. Around two dozen experts from the MVF Editorial Advisory Board have commented on his theory. The result is both remarkably unanimous and remarkably ambivalent: the matrix, which Janßen himself calls a working approach, convinces as a diagnosis, but (as yet) few are convinced by it as a therapy.

>> Janßen's central point is this: "The matrix does not explain that we have problems – it explains why our reforms cannot solve them." He is aware that there is no evidence in the strict sense for his rather provocative working approach, but "neither for today's system logic nor for the one I am proposing". He becomes specific on the citizen's income (Bürgergeld), because on September 11, 2025, the Board of Directors of the National Association of Statutory Health Insurance Funds (GKV-Spitzenverband) had decided to file a lawsuit with the Federal Constitutional Court over systematic underfunding. For Janßen, this is "the most popular example of how attempts are made to transfer a welfare task into an insurance logic". He counters the objection that the reality of care is hybrid with a distinction that is attracting much attention: hybrid services have "not an allocation problem, but an interface problem". Here, he says, his welfare state architecture requires "not one pure logic per service, but one logic per component". Politically, he proposes a "Welfare State Architecture Act", to be completed perhaps within a generation, i.e., in around 30 years.

The diagnosis convinces at its core

The first finding is agreement with the analytical core. Uwe Schwenk, Director of the "Health" program at the Bertelsmann Stiftung, for example, calls Janßen's matrix "very helpful as an analytical tool". Prof. Dr. Stephan Burger, Member of the Board of MedicalContact AG, credits Janßen with the fact that "the debate in healthcare is being brought back to the question of central organizing principles". Dr. Stefan Sauer, Value & Access and Public Affairs Lead DACH at ITF Pharma GmbH, attests to its "remarkable analytical strength". Prof. Dr. Stefan Schröder of APS points to the hospital system, which is expected at once to ensure care close to home, be financed by SHI, hold its own in competition and take on social tasks, whereby conflicts of objectives "inevitably" arise. Dr. Michael Brinkmeier, Member of the Board of the German Stroke Foundation (Stiftung Deutsche Schlaganfall-Hilfe), calls Janßen's matrix "a helpful model". Sarah Schmitter, Director Health Technology Assessment & Outcomes Research at Pfizer, likes the fact "that the model starts with a precise clarification of tasks". Prof. Dr. Axel C. Mühlbacher of Neubrandenburg University of Applied Sciences sees its value in the fact that Janßen "asks a prior question".

It is striking how often similarities appear across the many statements. Sauer, Haustein, Luley, Mühlbacher, Lux, Schwenk and Penske independently mention SHI funding for citizen's income recipients. For Dr. Marco Penske, Head Market Access & Healthcare Affairs at Boehringer Ingelheim, financing from the public budget instead of the SHI budget is "clear in regulatory terms and, seen that way, simple". Dr. Robert Haustein, Head of Value & Reimbursement, Market Access at Abbott, dissects the case: the addressees are persons in need, the legitimation is welfare-state assistance, but the funding comes from contributions, which creates "a shadow budget".

The clearest endorsement

Anne-Kathrin Klemm, Member of the Board of the BKK Dachverband, goes furthest. She first sketches a target vision in which each player finances and does "what it is responsible for – for the most part even by law" and cooperates at the interfaces in such a way "that no disruptions occur". To this end, the state sets goals at federal and state level; shifting responsibilities back and forth is unnecessary, "because the rules are clear and are put into practice". This vision, she says, has been "praised often and for many years", but is not reality. Janßen's finding that exactly the opposite is happening therefore fits: "His matrix structures the issue and makes it transparent." As long as responsibilities are "so blatantly mixed up and irresponsibly shifted", the individual systems can only be "tinkered and fiddled with".

Klemm has three specific demands:

- adequate funding of public services of general interest and welfare, instead of "shifting it onto SHI contribution payers and others",
- limiting the state to the regulatory framework, which joint self-governance fleshes out, and
- an end to ever more detailed requirements in the social codes, whose provisions "increasingly contradict each other and follow no stringent care objective".

She describes the familiar mechanism more sharply than the other statements: less and less money from the state's own budget, "but instead putting more of the contribution payers' money into the repair system" in order to appease in the short term and avoid structural reforms. The fact that the step toward higher funding for citizen's income recipients adopted with the Contribution Rate Stabiliza-

tion Act was originally to be offset by a much larger cut in the federal subsidy shows "how firmly the supposedly bottomless pot of SHI contributions is anchored in political minds as a state treasury to be tapped". Her legitimation argument is a performance argument: although SHI spends EUR 40 million per hour, Germany ranks only mid-table in Europe on outcomes and healthy life years. Her conclusion is the only unreservedly approving one in the group: should the welfare state matrix become "a lived system logic for our healthcare system in a few years, we would already have achieved a great deal".

Where agreement ends

As broad as the recognition of the diagnosis is, the rejection of the claim that a new welfare state matrix can resolve the reform crisis is just as firm. Four patterns of objection emerge.

1 Separation creates new interfaces

Schmitter puts it most sharply: Janßen envisions four clearly separated circles as the target state, "so there would again be interfaces". Her conclusion: the model does not resolve "the central obstacle to reform, the interfaces between responsibilities", but may merely create new ones. Haustein reaches the same conclusion: "The model does not automatically reduce complexity. It shifts complexity from mixed financing to interface management." Sauer warns that more separation might "under certain circumstances even create new coordination costs". And Schwenk asks whether reorganizing the Social Code would not "create many more interfaces".

2 Integration instead of separation

Daniela Teichert, CEO of AOK Nordost, cites statutory accident insurance as a counterexample: there, successful social insurance thrives not on separation, but on "its consistent integration". Sauer therefore reframes the key question: not "How do we separate the logics?", but "Which tasks require separation and which require integration?" He adds a fifth dimension, the "integration logic". Christine Vogler, President of the German Nursing Council (Deutscher Pflegerat), also warns that in chronic diseases, dementia or palliative care, treatment, nursing, prevention and support cannot be neatly separated. Fragmenting them could "create new funding boundaries, contracts and disputes over responsibility".

3 The patient perspective is missing

Sauer sums it up in the formula that patients experience the healthcare system not as insurance, welfare or public services, but as "treatment processes." Brinkmeier contradicts Janßen's claim that the chronically ill are the winners: it is "a long way ... from a financial-economic analysis matrix to an improvement in care that people actually experience". He sees Janßen thinking "still too much in terms of static provider logics", "not in patient-oriented pathway logics". Dr. Katja Gehrke of the Institute for Descriptive Health Data Analysis (DGDA) asks "what specific and improved care effect would follow from the new architecture" and names interfaces, regional gaps in care, staff shortages and overly long patient pathways as the real problems. Vogler calls for a "person-centered care logic". The starting point must not be the responsibility of a payer, but the specific needs of a person, because "for those affected, care must work as if from a single source".

4 Path dependency vs. power interests

Dr. Rolf-Ulrich Schlenker of the Federal Association of the German Rheumatism League (Deutsche Rheuma-Liga) delivers the harshest verdict: the matrix provides "food for thought on regulatory policy, but ultimately no new insight", because the four principles are "long familiar". The approach may be "academically charming", but it "ignores the reality of empty coffers, established structures and the primacy of politics". There will be "no 'pure' regulatory models in the future either, only hybrid solutions". Dr. Anke Schlieker, Project Lead Healthcare at the Association of Private Health Insurers (PKV-Verband), sees the "predetermined breaking point" in the fact that the plea underestimates "the inertia and conflicting interests of the established players" .

The historical objection

Dr. Dominik von Stillfried, CEO of the Zi, reverses Janßen's causality. He agrees that SHI mixes elements of different design principles, but does not share the view that this is the cause of the reform problems. Mixing already took place when SHI was founded more than 140 years ago, "because it was precisely adherence to clear design principles of the insurance principle that led to problems that could not be solved within this logic and whose consequences were politically unacceptable". Today, income-related contributions are "clearly and intentionally attributable to the solidarity principle and thus to public services of general interest". His verdict on the proposed disentanglement is sober: it is likely to remain "little more than an intellectually stimulating exercise", "but largely irrelevant to legislative practice". There will be no redesign of the welfare state on the drawing board; health systems emerge "continuously from the status quo".

Dr. Christopher Hermann, healthcare consultant and CEO of AOK Baden-Württemberg from 2011 to 2019, takes a fundamental approach. He calls Janßen's intervention "overdue and commendable", but then takes it apart. Even the premise that the four principles only became mixed over time hardly "stands up to closer scrutiny": welfare dates back far into the pre-industrial era, social insurance is a product of industrialization, and tax revenues flowed into pension insurance from the very beginning.

Hermann also reproaches Janßen for not escaping such mixing himself: benefits under the provision principle, such as child benefit, education grants and compensation payments, he "wrongly also assigns to the welfare principle", although they are not subject to a means test. And in the case of the citizen's income, it is by no means clear under constitutional law what counts as non-insurance benefits. In its ruling on the risk structure equalization scheme (RSA), the Federal Constitutional Court made clear that bearing the consequences of social equalization does not constitute a non-insurance benefit. Hermann's final question: even if the architecture were clarified, why should that solve the problems of an aging society, the shortage of skilled workers and the financing of medical progress?

Several commentators share this point. Schlenker cites unlimited funding needs, unambiguous demographics and ever more expensive medical progress. Teichert notes that a clearer financing logic could facilitate reforms, "but is no substitute for answers to the actual problems of care". Gehrke asks whether a shift into the tax system is a solution at all, given the budget situation. After all: "The scarcity of resources does not disappear; it is merely distributed differently."

A second strand of criticism concerns the

internal consistency of the fields. For Dr. Martin Danner, Federal Managing Director of BAG SELBSTHILFE, the "market" logic actually belongs "on a different level": the market is not an end in itself, "competition is a steering instrument". He also criticizes that the market logic was "not worked through" for psychiatry and obstetrics. Vogler adds that insurance and welfare are principles of financing and entitlement, public services of general interest a state guarantee responsibility, and the market a coordination mechanism – dimensions that cannot always be clearly separated. Schlieker directly contradicts this classification: "Contrary to what Janßen suggests, however, PHI does not belong to the 'market' system but, like SHI, to the 'insurance' *system*".

The blind spot of nursing

Vogler raises a criticism found in no other statement: "In my view, the biggest blind spot is the role of professional nursing." Although the interview states that physicians and nurses could benefit from clearer responsibilities, it remains open which decision-making rights, competencies and billing options nursing should receive. A new financing architecture does "not automatically change the existing distribution of power among the professions". Her key sentence: "Clarifying the architecture without clarifying competencies and power remains incomplete."

Vogler also finds it problematic that nursing, midwife-led or social-psychiatric services are classified as welfare: the term could give the impression of charitable aid, whereas professional nursing is "independent, knowledge-based healthcare and at the same time an indispensable part of public services of general interest". According to Vogler, Janßen's obstetrics example – birth as an insurance benefit, the family midwife as welfare – reproduces "a medicine-centered hierarchy". Further gaps: staffing levels, unpaid care work performed predominantly by women, the risk of "care by postal code" and the fact that tax-funded services are "subject to annual budget decisions". She also directly contradicts Janßen's core promise: she considers the claim that there would be no losers "unrealistic". An architecture reform is "not neutral, but always also a reform of power and distribution".

Vera Lux, President of the German Nurses Association (DBfK), shares the diagnosis: attempts have been made to tackle problems "with more and more resources", and the system has become "ever more complex and expensive, but not more effective and efficient". At the same time, she marks the limit: medical progress and an aging society are causing costs to explode. The welfare state matrix cannot solve this problem either; it merely makes the system's breaks visible. Her conclusion: "To avoid rationing in the future, we have to think about prioritization today." For her, a streamlined system logic would be the starting point for structural reforms – combined with a redistribution of tasks among the health professions: not delegation, but substitution.

Proposals for expansion

It is remarkable how many commentators do not want to discard the model, which Janßen himself describes as a working hypothesis, but to expand it. Christian Luley, Director Payer & Healthcare Services at Insight Health, links subsidiarity with the economics of externalities: "A decision on resource allocation can only be made efficiently where benefits and funding decisions coincide." Using a maximum-care hospital as an example, he demonstrates a "double breach of subsidiarity": the district benefits from jobs and value creation, while the costs fall on SHI and the state. His conclusion: combine functional and level-based order.

Mühlbacher starts at a second level: alongside the architecture question of who is responsible, he poses the decision question of how decisions are made and on what evidence. Systems get out of hand not only because logics are mixed, but also "because decisions within the respective logics are made without robust evidence on benefits, risks, costs and preferences". He proposes supplementing the four-logic matrix with a decision and evidence matrix that defines separate evidence standards for each logic. In the market, weighing costs, benefits and risks often fails due to information asymmetries and supplier-induced demand. In insurance, the clinical evidence on which the G-BA, for example, relies is not sufficient on its own, as it does not reflect how those affected weigh benefits, risks, access and waiting times. In welfare, decisions remain vulnerable to political distortions from electoral cycles and media pressure. In public services of general interest, the systematic inclusion of citizens' preferences is often lacking. His conclusion: a preference-based decision and evidence architecture that systematically captures the preferences of patients, insured persons, citizens, taxpayers, healthcare providers and vulnerable groups, and defines efficiency not only fiscally but also in terms of acceptance. Decisions that are not accepted, Mühlbacher argues, lead to evasive behavior, resistance and additional spending. His conclusion: "Clarifying the architecture is necessary, but not sufficient."

Haustein wants to add a fifth cross-cutting logic: public health. In addition, the matrix should be combined with patient journeys. He also identifies a political risk: if welfare costs moved into the federal budget, there would be more transparency, "but also more pressure to cut". Schwenk calls for adding the service side: incentives "that reward volume instead of value and lead to overuse" are hardly addressed. A Welfare State Architecture Act would therefore help "only to a limited extent". Burger considers the architecture check in the regulatory impact assessment the "pragmatic proposal", but disputes Janßen's references: the Stability and Growth Act and the debt brake are "unfortunately poorly chosen, because self-commitment does not work".

Industry voices express pragmatic reservations. Dr. Jan Daniels-Trautner, Roche Pharma AG, leaves open whether a reorganization on the drawing board would save the system, and warns against forgetting the economy as the engine of the welfare state. A perfectly structured system without economic strength ends in "administered stagnation". Dr. Marco Pensky, Boehringer Ingelheim, also criticizes the lack of concrete detail. The model is plausible in systems-theory terms, but apart from the clear funding of the citizen's income remains "unfortunately rather vague" with regard to care and financing. In practice, one cannot afford the composure of a generational project.

A methodological reservation runs through almost all the texts – based on Janßen's admission that his model is "an analytical diagnostic model" and not an empirical causal model. Sauer derives the central limitation from this: the matrix can explain why conflicts arise, "but it cannot prove that mixed logics are the cause of the reform problems". Teichert calls the admission "scientifically ho-

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nest". Mühlbacher calls the matrix "plausible (but not proven)". Vogler considers it "a good heuristic, but not yet a sufficient theory". Skills shortages, lack of investment, inadequate staffing levels and sectoral power structures are "not merely symptoms of a flawed architecture, but causes in their own right". Roland Nagel of Gesundheitsforen Leipzig says that a critical assessment can be carried out "very well" with it. Its result fits the picture: the model is "so far only partially operationalized and empirically testable", hence "not a proven explanatory model, but a scientific working hypothesis". Gehrke calls for showing, using specific cases, what actually improves for patients, practices, nursing, hospitals and payers – but please "combined with a corresponding measurement instrument".

What follows for policy

Taken together, the statements yield a catalog of tasks that neither adopts nor rejects Janßen's model. The architecture matrix check in the regulatory impact assessment meets with approval across camps. Vogler expands it into a "care architecture check", which should also clarify which profession bears professional decision-making responsibility and which quality targets apply. On the funding of citizen's income recipients, the diagnosis is almost undisputed: Klemm points to the company health insurance funds' 2024 campaign "Was fehlt, zahlst du!" ("You pay for what's missing!"), which culminates in the funds' lawsuit. And Schwenk points out that what is being demanded is not the clarification of the logics, but "their actual implementation". Sauer's formula: assign funding clearly, make responsibilities transparent and integrate care across sectors.

That leaves Hermann's still open question: does a clarified architecture really solve the cardinal problems? Janßen's answer aims at visibility rather than savings: it makes "a difference whether the Federal Minister of Finance has to explain why welfare costs several billion euros, or whether this amount remains hidden in SHI contribution pots". Many commentators do not share Janßen's promise that the architecture logic ensures "precisely that no stakeholder loses anything". According to Schlenker, "ultimately it will simply come down to which of the four organizing principles gains more dominance in democratic discourse". This requires fundamentally political decisions "which the architecture model can support intellectually". On the one hand, that is much less than Janßen claims for his model. On the other: it is far more than health policy currently musters in terms of regulatory self-understanding. <<

1: https://t1p.de/iv5gi

The welfare state matrix: overview of arguments

PRO cluster: Good analysis	**Architecture cluster:** Mixed logics	**CONTRA cluster:** Criticism of implementation	**Expansion cluster:** Proposals & consequences
Helpful analytical tool Analytical strength in clarifying tasks and creating transparency in the system **Return to regulatory policy** The debate is steered away from individual issues toward the central principles of regulatory policy. **Exposing breaks in logic (citizen's income)** Funding welfare tasks through insurance contributions is exposed as a "shadow budget" that runs counter to the system. **Strongest endorsement (Klemm)** Sees the matrix, as a lived system logic, as improving care and derives three demands: adequate funding of public services and welfare, limiting the state to the regulatory framework, an end to ever more detailed requirements.	**Reform gridlock from mixed logics** The problem is the unclear mixing of solidarity-based insurance, welfare, public services and competition, not a lack of money.	**Separating logics creates new interfaces** Separating the logics solves no problems, but shifts complexity and potentially creates high coordination costs. **Lack of patient orientation** Static provider logics vs. treatment processes ("patient journeys") **Integration vs. clean separation** The key question is not how to separate the logics, but which tasks require separation and which integration (integration logic). **Blind spot: nursing** Professional nursing is absent from the matrix. The existing distribution of power among the professions remains unchanged. **Power & path dependency** The matrix ignores historically evolved power structures, demographics and skills shortages. The four principles were already mixed when SHI was founded more than 140 years ago. **Methodological reservation** The matrix is a plausible thought model (heuristic), not a scientific causal model.	**Consequences for policy** Broad support for an architecture matrix check in the regulatory impact assessment and for the demand to assign responsibilities for funding and care across sectors
Open final question (Hermann): Does a clarified architecture solve the cardinal problem of how to cope with an aging society, skills shortages and the financing of medical progress?			

Table 1: The welfare state matrix: overview of arguments based on the article "Die Diagnose überzeugt, noch nicht die Therapie" by Stegmaier & Roski.