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No clear architecture without a clear goal

>> I agree with Mr. Janßen that statutory health insurance (SHI) mixes elements of different design principles as set out in the four-field matrix.

1 However, I do not share the view that this mixing of principles is the cause of the reform problems. Rather, it can be shown that different design principles were already mixed when SHI was founded more than 140 years ago – precisely because adhering to clear design principles of the insurance principle led to problems that could not be solved within that logic and whose consequences were politically unacceptable. Over the decades, the mixing of different design principles increased whenever seemingly insoluble problems or contradictions arose in the status quo.

2 The benefits-in-kind principle, for example, changed in meaning because it was no longer the individual community of insured persons that decided on the benefits catalog; instead, benefits were gradually standardized across all SHI members. With a strict occupational structuring of fund membership, contributions based on income could also be compatible with the insurance principle. Today they clearly and intentionally belong to the solidarity principle and thus to public services of general interest. Their meaning changed gradually and lastingly with the expansion of the insured population, the creation of health insurance for pensioners, and the introduction of compulsory insurance and the Health Fund. The current deficit – which has arisen to a large extent because the Finance Minister does not consider himself able to cover the cost of medical care for recipients of basic income support from the federal budget – shows the forces at work here: because the political framework has changed massively, the basic consensus reached with the GKV-WSG some 20 years ago – that social security financed through payroll costs needs a rising state subsidy in an aging society to keep the burden on labor costs low – is being ruthlessly abandoned.

3 At the same time, this look at the historical development also shows that the disentangling of design principles proposed by Mr. Janßen is likely to remain little more than an intellectually stimulating exercise: helpful for understanding the different elements of the system, but largely irrelevant to legislative practice. There will be no redesign of the welfare state on the drawing board; all health systems evolve continuously from the status quo, and their specific characteristics can therefore only be understood historically and against the background of each country's prevailing economic conditions.

4 I would agree with Mr. Janßen that his allocation matrix could help in a discussion about how to curb the federal legislator's tendency toward ever more detailed regulation and how to reorganize responsibilities so that competencies are defined without predetermining the results of those competencies. Anyone who follows the development of the SGB V will note that it has roughly doubled in size over the past 15 years. Laws such as the GeDIG accelerate this trend further. Large parts of the latter cannot be clearly assigned to any of the four fields. An allocation matrix intended to focus responsibility would therefore have to refer instead to the responsibility of specific institutions for processes.

5 In any case, the performance of our health system is likely to improve less through questions of architecture than through clearly defined goals. Here I would agree with Mr. Janßen's diagnosis regarding the debate on a primary care physician system. We will achieve neither architectural nor procedural clarity in the system if the goal is not clearly defined. Why a primary care physician system should be introduced in Germany remains rather unclear to date. The coalition agreement states that the goal is to shorten waiting times for specialist treatment. But is a primary care physician system the right instrument for this at all? So far, there is no empirical evidence for it. Perhaps there are other reasons for introducing it?

6 There are. And there are as many different ones as there are interest groups in the health system. Each interest group associates the term with a different kind of system. To make this possible, people now prefer to speak of a primary care system. Each interest group contributes a few goals in order to have some say in the future. Architectural clarity is therefore always the first casualty of our parliamentary processes. That is why the health system – not only in Germany but in all industrialized countries – is permanently under reconstruction. There is no magic solution anywhere. This is where I differ from Prof. Janßen, because in every generational project, perspectives and allocations change, as we can see in retrospect. <<

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