3

STATUTORY HEALTH INSURANCE: CURBING THE RISE IN EXPENDITURE, STABILISING REVENUE

This is a translated version of the original German-language chapter "Gesetzliche Krankenversicherung: Ausgabenanstieg dämpfen, Einnahmen stabilisieren", which is the sole authoritative text. Please cite the original German-language chapter if any reference is made to this text. This translation was generated using AI.

KEY MESSAGES

↘ Despite above-average healthcare expenditure compared to the EU and OECD, Germany achieves only average health outcomes.

↘ On the expenditure side, statutory health insurance (GKV) contribution rates are driven by demographic ageing, unhealthy consumer behaviour and advances in medical technology, whilst the revenue base subject to contributions is growing more slowly.

↘ To curb future increases in GKV contribution rates, reforms aimed at more effective expenditure control in inpatient care and in the pharmaceutical sector are particularly appropriate.

EXECUTIVE SUMMARY

The health insurance system in Germany provides cover in the event of illness. In the statutory health insurance (GKV), which covers around 90 % of the population, this is achieved through solidarity-based financing via a pay-as-you-go system based on the principle of benefits in kind ("Sachleistungsprinzip"). In addition to the GKV, groups of people who are exempt from compulsory insurance have the option of taking out insurance under the funded private health insurance (PKV) scheme, which charges premia based on health status rather than income. Healthcare expenditure as a percentage of gross domestic product in Germany is among the highest in the OECD. At the same time, Germany achieves only average results for key health indicators.

Since 2005, GKV expenditures have risen significantly faster than the income subject to contributions, which forms the contribution base for calculating GKV contributions. As a result, the average contribution rate has risen from 14.2 % in 2005 to 17.5 % in 2026 and is expected to rise further to 19.8 % by 2040. The rise in GKV expenditures can be explained, on the one hand, by general factors that are also at play in other countries. These include demographic ageing, income growth and the prevalence of unhealthy behaviours. Added to this are advances in medical technology, giving rise to new diagnostic and treatment methods that are cost-intensive in both development and application. On the other hand, the rise in GKV expenditures is characterised by system-related cost drivers, which are particularly evident in the hospital sector and medicines.

The rise in healthcare expenditure within the statutory health insurance system can be curbed through improved expenditure control. In the hospital sector, reforms towards greater specialisation, clearly verifiable quality standards and reduced reliance on case numbers for funding offer significant potential for efficiency gains. The underdeveloped state of health prevention in Germany could be strengthened through marketing regulations, binding standards for healthy nutrition in nurseries and schools, and through higher taxes or minimum prices on tobacco, alcohol and foods high in sugar. Higher co-payments by insured persons, on the other hand, are only of limited use, as they may also reduce the uptake of necessary services by insured persons.

Stabilising the GKV primarily requires a cap on expenditure growth. Reforms on the revenue side can contribute to this in a complementary manner. The burden on the GKV caused by non-contributory benefits could be reduced through higher federal subsidies or by limiting such benefits. A reform of the non-contributory co-insurance of spouses, for example, could contribute to this, as it could relieve the burden on the GKV whilst simultaneously strengthening the incentives for secondary earners to work.

I. INTRODUCTION

183. The health insurance system in Germany serves to protect against the financial consequences of illness. It is designed to ensure reliable access to medically necessary care and to protect against financial strain caused by treatment costs. In the statutory health insurance (GKV), which covers around 90 % of the population, funding is provided through income-based contributions under a pay-as-you-go system and benefits are provided on the principle of benefits in kind ("Sachleistungsprinzip"): benefits are independent of the level of contributions and individual health risks, and are accompanied only by minimal co-payments. ↘ ITEMS 189 FF. In addition to the GKV, private supplementary insurance is offered for benefits not covered, or only partially covered, by the GKV, as well as private health insurance (PKV) as an alternative for groups of people not subject to compulsory GKV insurance, such as the self-employed. ↘ ITEMS 203 FF. The PKV charges non-income-based premia based on individual health status and often provides for co-payments. Furthermore, funding is provided through a capital-based scheme. ↘ ITEM 205

184. Both the level and the method of financing healthcare expenditure vary considerably internationally. ↘ ITEMS 210 FF. Conceptually, two basic financing models for healthcare expenditure can be distinguished: on the one hand, financing predominantly from general tax revenue; on the other hand, financing predominantly through earmarked contributions, including income-independent premia, from the insured. ↘ ITEMS 211 FF. Both models have different effects on work incentives and are also associated with different steering and regulatory effects on insured persons and service providers. **The German healthcare system features contribution-based financing with elements of tax-based financing in the GKV, and financing via premia paid by the insured in the PKV.**

At 11.7 % of gross domestic product (GDP), healthcare expenditure in Germany is among the highest in the OECD. ↘ ITEM 210 Despite this above-average expenditure, Germany ranks only around the OECD average for key health indicators, such as life expectancy or subjective health assessment, which suggests low efficiency in healthcare provision. ↘ ITEM 215

185. **Expenditure in the GKV rose by just under 64 % in real terms between 2005 and 2025.** ↘ ITEM 193 Over the same period, the income subject to contributions – which forms the base for calculating GKV contributions – rose by just under 31 % in real terms. To cover expenditures, the average contribution rate for the GKV was therefore increased from 14.2 % to 17.1 % over the same period. ↘ ITEM 195 In 2026, the average contribution rate is expected to rise to 17.5 %. The increases in the GKV contribution rate have thus contributed significantly to the rise in the total social security contribution. ↘ ITEM 106 **Under current legislation, a further increase in the GKV contribution rate to 19.8 % by 2040 is to be expected due to a contribution base that continues to grow only slowly amidst rising expenditures.** This increase raises non-wage labour costs, reduces disposable income and thus private consumption. Furthermore, through behavioural adjustments by households and companies, it affects labour

supply and demand, gross fixed capital formation and the price competitiveness of German exports on the world market. ↘ ITEMS 113 FF.

186. The rise in statutory health insurance expenditures can be explained by various factors. These include, on the one hand, general factors also affecting other countries, such as **demographic ageing**, ↘ ITEM 217 increasing income levels, ↘ ITEM 218 and the prevalence **of unhealthy behaviours**, ↘ ITEM 219 which contribute to the onset and progression of preventable and, at the same time, cost-intensive diseases. Added to this is **medical-technological progress**, ↘ ITEMS 221 F. which gives rise to new, often highly specialised diagnostic and treatment methods that are cost-intensive in both development and application. The significance of these factors varies between countries and can thus explain some of the differences in expenditure trends.

On the other hand, expenditure trends in the GKV are determined by specific **expenditure drivers** resulting from the organisation of the German healthcare system. The largest share of the increase in expenditure since 2004 is attributable to **hospital treatment** ↘ ITEMS 224 FF. and **medicines**. ↘ ITEMS 232 F. The reimbursement system for hospital treatment favours high numbers of inpatient cases and the maintenance of a large number of non-specialist clinics for which there is no corresponding demand. ↘ ITEMS 224 FF. Expenditures on medicines are rising because reimbursement rates for high-cost, patent-protected medicines are not consistently based on additional therapeutic benefit. ↘ ITEM 233

187. **The rise in health expenditure within the GKV could be curbed through improved expenditure control.** Preventive health care in Germany, which is underdeveloped compared to European standards, could be strengthened through marketing regulations, binding standards for healthy eating in nurseries and schools, and higher taxes or minimum prices on tobacco, alcohol and foods high in sugar. Information-based prevention approaches often reach their limits because they are used unequally across social groups and do not adequately address behavioural barriers such as habits, present bias and limited self-control. ↘ ITEMS 239 FF. Price signals through taxes or minimum prices, by contrast, could have a greater steering effect. Higher general cost-sharing by insured persons, however, is only of limited suitability, as it may also reduce the use of necessary services by insured persons. ↘ ITEMS 244 FF. In the hospital sector, reforms towards greater specialisation, clearly verifiable quality standards and reduced dependence of funding on case numbers offer considerable potential for efficiency gains. ↘ ITEMS 250 FF. Finally, the rise in expenditure on medicines could be curbed by consistently aligning the pricing of innovative medicines with their additional therapeutic benefit. ↘ ITEM 256

188. Stabilising the GKV primarily requires limiting the rise in expenditure. **Reforms on the revenue side can contribute to this as a supplement, but cannot replace structural adjustments on the expenditure side.** The burden on the GKV from non-contributory benefits (NBL) could be reduced either by increasing federal subsidies or by reducing these benefits. ↘ ITEM 258 A reform of the non-contributory co-insurance of spouses could also contribute to this, as it would increase the incentives to work for second earners. ↘ ITEM 259 An expansion of the contribution base could strengthen the financing of the statutory health insurance

system, but at the same time trigger a shift towards private health insurance. By raising the income threshold for compulsory insurance under the statutory health insurance scheme or by including civil servants, the financing of the GKV could be strengthened with the help of high-income and, on average, healthier insured persons. ↘ ITEMS 262 F.

II. THE HEALTHCARE SYSTEM IN GERMANY

1. Statutory health insurance

189. The GKV is structured as comprehensive health insurance and covers both compulsorily insured and voluntarily insured persons. ↘ BACKGROUND INFO 9 **Currently, with around 75 million insured persons, just under 90 % of the population is covered by the GKV** (GKV-Spitzenverband, 2026a). Children and non-employed or marginally employed spouses can be covered free of charge under a family insurance policy. In 2023, around 16.8 million people were covered free of charge (Federal Statistical Office, 2025a).

↘ BACKGROUND INFO 9

Background: Compulsory insurance under the GKV and exemption from insurance

Employees are compulsorily insured under the GKV provided their regular annual earnings do not exceed the annual earnings threshold (JAEG, €77,400 in 2026). Apprentices and students are also compulsorily insured as long as they have not yet reached the age of 30. Pensioners are compulsorily insured if they receive a statutory pension and meet the so-called prior insurance period requirement, i.e. they were members of the statutory health insurance scheme for at least 90 % of the second half of their working life. Finally, recipients of social security benefits and certain self-employed persons, such as artists and publicists, are also compulsorily insured.

Employees are exempt from compulsory insurance once their income exceeds the JAEG; the same applies to self-employed individuals who are not subject to compulsory insurance, civil servants, and pensioners who do not meet the criteria for compulsory insurance. Around 23 % of the population is exempt from compulsory insurance (Werbeck et al., 2021), with just over half of these individuals opting for PKV rather than voluntary insurance under the GKV. Even for those exempt from compulsory insurance, there has been an obligation to take out health insurance since 2009. According to data from the Federal Statistical Office, in 2023 around 72,000 people in Germany (less than 0.1 % of the population) were not covered by health insurance or any other entitlement to healthcare (Federal Statistical Office, 2025b).

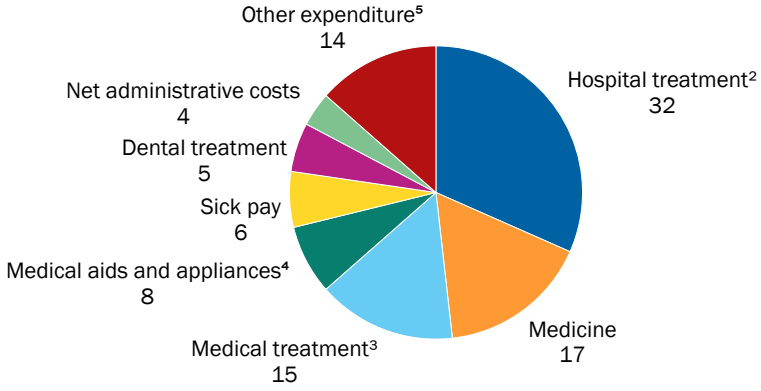
190. The tasks of the statutory health insurance system are carried out by self-governing statutory health insurance funds ("Krankenkassen"). The health insurance funds are public-law bodies and carry out the tasks assigned to them on their own responsibility under the legal supervision of the federal and state governments.

The number of statutory health insurance funds has fallen sharply over time due to increased competition. Whilst there were still 1,147 health insurance funds in 1990, by 2026 there were only 93 (GKV-Spitzenverband, 2026a).

191. **Insured persons under the GKV are entitled to adequate medical treatment** that **meets their medical needs and** is **in line with the generally accepted state of medical science**, subject to the principle of economic efficiency (SGB V). The "Solidaritätsprinzip" and "Sachleistungsprinzip" apply here (GKV-Spitzenverband, 2026b). The **"Solidaritätsprinzip"** ensures that all insured persons receive benefits from the statutory health insurance scheme, regardless of the level of their contributions or their risk of illness. The **"Sachleistungsprinzip"** ensures that benefits are provided without the insured having to make any financial advance payments. The entitlement to benefits for insured persons in the GKV is not regulated in detail by law, but is determined within the framework of self-governance by the Joint Federal Committee (G-BA) (BMG, 2026a). The G-BA consists of representatives of the funding bodies and service providers. It specifies the scope of benefits in binding guidelines and decides on the inclusion of new examination and treatment methods following an assessment of their benefits, medical necessity and cost-effectiveness. The billable medical services and their remuneration are set out in the Uniform Assessment Scale (EBM).

192. Expenditures by the GKV amounted to around €352 billion in 2025. **At 32 %, the largest share of expenditures is accounted for by hospital treatment, followed by medicines (17 %) and medical treatment (15 %).** ↘ CHART 41 A

↘ CHART 41
GKV expenditures by benefit category in 2025[1]
Share of expenditures in %



1 – Preliminary results. 2 – Inpatient care, including all medical and nursing services provided in hospital, including nursing staff costs. 3 – Outpatient services provided by registered doctors, as well as certain cross-sector services in integrated care, university outpatient clinics or treatment by affiliated doctors. 4 – Includes non-medical therapeutic services such as physiotherapy. Medical appliances are physical medical products such as wheelchairs. 5 – Treatment care and home nursing care, travel expenses, early detection measures, rehabilitation and preventive care, vaccinations, pregnancy/maternity and other expenses.

Sources: BMG, own calculations

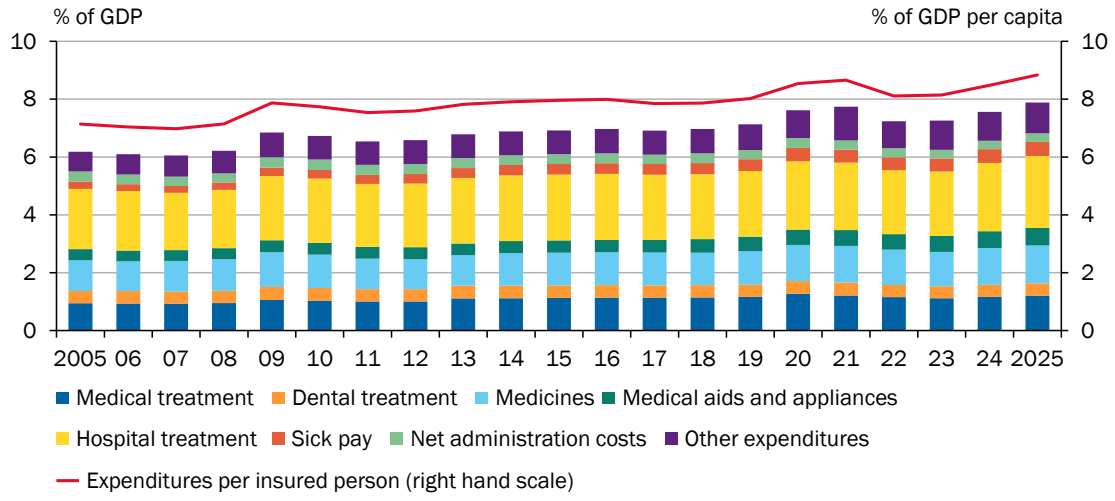
relatively small proportion of expenditures is allocated to preventive and early detection measures. Rehabilitation, preventive care and early detection measures accounted for just under 2.3 % of statutory health insurance expenditures in 2025.

193. **Expenditures by the statutory health insurance system per insured person rose by just under 2.2 % annually (real, adjusted for inflation) between 2005 and 2025**, with the increase in expenditures varying significantly between the individual service areas. ↘ ITEM 223 Measured against GDP per capita, expenditures per insured person have risen from around 7.1 % in 2005 to around 8.8 % in 2025. ↘ CHART 42 This suggests that expenditures per insured person have risen more sharply than economic capacity and are thus tending to contribute to increasing financial pressure on the GKV.

194. The GKV is financed on **a pay-as-you-go basis**, primarily through income-related contributions, which are borne largely on a 50-50 basis by employees and employers, and by pensioners and the statutory pension insurance scheme (GRV), as well as through tax-financed federal subsidies. Since 2009, the GKV's revenue has been managed by the Federal Office for Social Security Funds (BAS) as a special fund known as the 'Health Fund'. The contribution base to the GKV is the annual gross income subject to contributions up to the applicable contribution assessment ceiling (BBG, €69,750 in 2026) or the statutory pension and, where applicable, other retirement income. For those voluntarily insured under the GKV, all types of income up to the BBG are taken into account.

195. **The GKV contribution rate** comprises the general contribution rate and a fund-specific supplementary contribution rate, and is financed equally by employers and insured persons. ↘ BACKGROUND INFO 10 Health insurance funds levy a supplementary contribution to cover their financial requirements beyond the allocations from the Health Fund. Over the past decades, the contribution base – known as 'income subject to contribution' – has grown significantly more slowly than GKV expenditure. Between 2005 and 2025**,** income subject to contribution rose

↘ CHART 42
Trend in GKV expenditures



Sources: BMG, Federal Statistical Office
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by just under 1.3 % annually in real terms, whilst GKV expenditure increased by 2.5 % annually in real terms. Due to this divergence, the **GKV contribution rate** has been **significantly increased in recent decades** and is expected to average 17.5 % in 2026. ↘ CHART 43 The average supplementary contribution rate has risen from 0.9 % in 2015 to 2.9 % in 2026. ↘ CHART 43 The level of supplementary contribution rates varies significantly between health insurance funds and ranges from 2.18 % to 4.39 % for the year 2026.

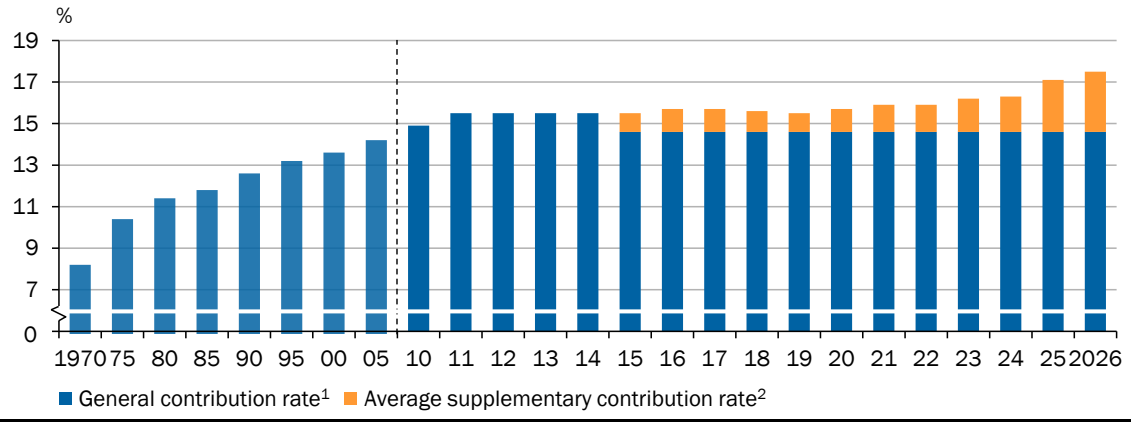
↘ BACKGROUND INFO 10

Financing of special and supplementary contributions

Historically, contributions to the GKV were financed equally by employers and insured persons. This was disrupted in 2005 by the introduction of a so-called special contribution rate of 0.9 percentage points, which was to be borne solely by the insured persons and remained in place until the end of 2014. From 2009 onwards, health insurance funds were able to levy additional monthly supplementary contributions calculated on an absolute basis and thus independent of income, or to grant discounts. The aim was to make differences in the level of health insurance contributions between health insurance funds more transparent, thereby intensifying competition between the individual health insurance funds. Since 2015, both the special contribution rate and the income-independent supplementary contribution have been abolished. Instead, the general contribution rate was reduced from 15.5 % to 14.6 % and the option of a fund-specific, income-dependent supplementary contribution was introduced. Until the end of 2018, this supplementary contribution was borne solely by the insured; since then, however, it has also been shared equally.

↘ CHART 43

Development of the GKV contribution rate



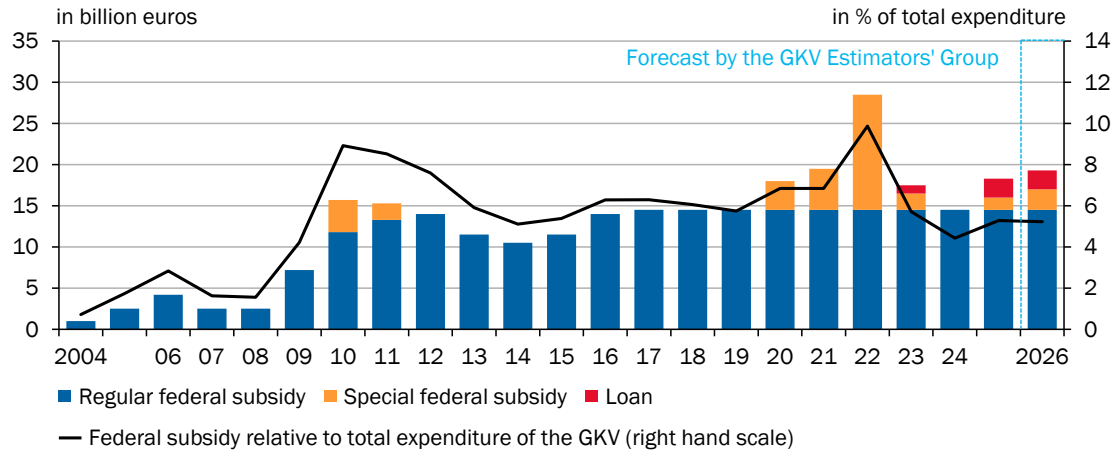
1 – Between 2005 and 2014, including the GKV special contribution of 0.9 %, which was borne solely by the insured. Between 2010 and 2014, excluding income-independent monthly supplementary contributions. 2 – The average supplementary contribution rate is a purely statistical figure and corresponds approximately to the rate that would close any existing funding gap from the GKV's revenue. It does not, therefore, represent the average of all supplementary contributions across individual health insurance funds. Until 2019, the supplementary contribution was borne solely by the insured; from 2019 onwards, it is shared equally between the insured and employers.

Source: Institute for Work, Skills and Training at the University of Duisburg-Essen

196. In addition to income-based contribution revenue, a tax-financed federal subsidy has been in place since 2004, intended to provide flat-rate coverage for so-called **non-contributory benefits** (NBL). In the absence of a legal definition, the actual expenditure on NBL within the statutory health insurance system cannot be precisely determined. According to most estimates, however, it is significantly higher than the federal subsidy provided (BRH, 2021; Albrecht and Ochmann, 2025). ↘ BOX 10 Due to the structural underfunding of these benefits, expenditures are thus shifted from the federal budget to those insured under the GKV. The federal subsidy has been adjusted on several occasions to achieve temporary financial consolidation of the GKV or the federal budget. ↘ CHART 44 Since 2017, the regular federal subsidy has amounted to €14.5 billion. During the COVID-19 pandemic, this subsidy was supplemented by a special federal subsidy and, most recently, topped up by a loan to stabilise the contribution rate. Overall, the federal subsidy's share of total statutory health insurance expenditure has been declining in recent years, with the exception of the COVID-19 pandemic, and is expected to amount to around 5.2 % of total expenditure in 2026.

↘ CHART 44

Trend in the federal subsidy to the GKV



Sources: BAS, BMG, Bundesrechnungshof, GKV Estimators' Group, own calculations

↘ BOX 10

Background: Non-contributory benefits in the GKV

Non-contributory benefits (NBL), also known as non-insurance benefits, are not clearly defined in the GKV. The Federal Ministry of Health (BMG, 2026a) defines them as "medical services that are motivated by family policy or are in the interest of society as a whole". These include, among other things, the non-contributory co-insurance of non-working or marginally employed spouses and children, services relating to pregnancy and maternity, child sickness benefit, and funding for research projects on innovative medical care (BMG, 2026b). Various studies estimate the level of NBL in the GKV at up to €60 billion annually (BRH, 2021; Berndt et al., 2024; Albrecht and Ochmann, 2025).

In most studies, the non-contributory co-insurance of family members is classified as NBL and represents the largest item of expenditure. Expenditures on non-contributory co-insured spouses were estimated at €9.4 billion and €9.7 billion in 2022 and 2023 respectively, and on non-contributory co-insured children at €23.3 billion and €23.6 billion (Berndt et al., 2024; Albrecht and Ochmann, 2025). Older estimates arrive at similar results (Greß and Stegmüller, 2014; GKV-Spitzenverband, 2018). When classifying these expenditures as NBL, it must be borne in mind that children and child-rearing play a constitutive role in the pay-as-you-go system of the statutory health insurance (GKV). Children are future contributors and thus ensure the system's viability. Their non-contributory co-insurance (as well as that of spouses raising children) can therefore also be interpreted as an intrinsic element of the pay-as-you-go system (Albrecht and Ochmann, 2025).

Expenditures by the statutory health insurance scheme on recipients of basic income support are generally also classified as NBL. The difference between the GKV flat-rate contributions paid by the federal government for recipients of basic income support (133 euros per month) and the actual expenditures can be classified as non-contributory. This difference amounted to €5.8 billion in 2022 (or €9.2 billion if expenditures on family-insured dependants are included (Albrecht and Ochmann, 2025)). Alternatively, only the gap between the federal flat-rate payment and the hypothetical GKV contribution resulting from a net income equivalent to the average basic income support benefit can be regarded as not covered by contributions. Albrecht and Ochmann (2025) thus arrive at a hypothetical monthly GKV contribution of around €221, which is significantly higher than the current flat-rate payment of €133. According to this calculation, excluding family members covered under family insurance, the volume of indirect co-financing for recipients of basic income support amounts to 4.2 billion euros per year.

The indirect co-financing of hospital investments through GKV-funded remuneration for hospital services is also frequently classified as NBL. According to the rules of dual financing enshrined in the Hospital Financing Act (KHG), these expenditures should be borne by the federal states. For many years, however, there has been a shortfall between actual requirements and the federal state funding allocated for this purpose. This funding gap is estimated at between €2.5 and €4.5 billion for 2022 and is indirectly covered by the GKV through hospital remuneration (KH-Regierungskommission, 2025).

For the purposes of systematic categorisation, Albrecht and Ochmann (2025) propose a classification according to which benefits are considered not to be covered by contributions if they are not caused by the insured community (personal reference), cannot be attributed to the purpose of the insurance (benefit reference), or have an effect (in part) outside the insured community (scope of effect). On this basis, they estimate that €21.7 billion is 'justifiable' and a further €35.9 billion is 'partially justifiable' as not being covered by contributions. ↘ TABLE 10 Excluding the funding gap in hospital investments, which falls within the remit of the federal states, this would result in a shortfall in the federal subsidy of around €4 to €40 billion.

↘ TABLE 10

Classification of potential non-contributory benefits for the year 2024 according to Albrecht and Ochmann (2025)[1]

	million euros
"Justifiable" non-contributory	
Expenditures for non-contributory co-insurance of spouses (incl. administrative costs)	11,353
Contribution reduction for employable recipients of basic income support[2]	4,200
Indirect co-financing of hospital investments	3,430
Exemption from contributions for parental and maternity benefits	1,000
Contribution reduction for part-time jobs (Midi-Jobs)	808
Miscellaneous[3]	954
Total	21,745
"Partially justifiable" non-contributory	
Expenditure for non-contributory co-insurance of children (incl. administrative costs)	25,125
Benefits for pregnancy and maternity	5,243
Vaccinations	3,224
Contributions not covering costs for recipients of basic income support[4]	1,607
Miscellaneous[5]	704
Total	35,903
"Hardly justifiable" non-contributory	
Hospice and palliative care	1,603
Exemptions for occupational pension scheme benefits	1,200
Telematics infrastructure and data infrastructure	1,011
Prevention of dental disease (individual/group prophylaxis)	681
Structural funds, funding for obstetrics and other	583
Miscellaneous[6]	1,481
Total	6,559

1 – Due to a lack of up-to-date data, some calculations are based on data from 2022 and 2023. 2 – Difference between the contributions paid by the federal government for recipients of basic income support and the contributions that would theoretically be payable on a net income equivalent to the average basic income support. Excludes expenditures for non-contributory co-insurance of spouses and children. 3 – Includes contribution reductions for students with compulsory insurance, primary prevention and workplace health promotion, and proportionate funding for education and training (general practioners, nursing care). 4 – Difference from the actual expenditure for recipients of basic income support, which would arise in addition to the amount classified as "justifiable". Excludes expenditures for non-contributory co-insurance of spouses and children. 5 – Includes child sickness benefit, sickness benefit for preventive and rehabilitation services for parents, and social farm relief and houshold assistance. 6 – Includes services for contraception, proportionate funding for training and further education (general practioners, nursing care), primary prevention (individual approach), innovation funding in the health care sector, and consumer and patient protection.

Source: Albrecht and Ochmann (2025)

197. The statutory health insurance funds receive a uniform basic flat-rate payment from the Health Fund for each insured person, which compensates for differences in the average contributory income of the insured. As part of a **morbidity-oriented risk structure adjustment (Morbi-RSA)**, age-, gender-, risk- and region-adjusted surcharges and rebates are applied to this basic flat-rate payment. The additional contributions specific to each health insurance fund are paid out to the respective health insurance funds. As they are calculated on the basis of the average income of all insured persons, this results in a balancing of the differing

income structures between the health insurance funds. The financial equalisation of the uneven distribution of expenditure risks (morbidity ↘ GLOSSARY) is intended to prevent risk selection of insured persons and create a level playing field for all health insurance funds.

The design of the Morbi-RSA provides only very weak incentives for health insurance funds to promote prevention. Currently, all health insurance funds receive a flat-rate prevention payment from the Morbi-RSA when insured persons make use of preventive services. However, the financial impact of this flat-rate payment is minimal. In 2021, allocations for preventive care accounted for just under 0.1 % of all allocations from the Health Fund and covered 5.2 % of expenditures on preventive care (Drösler et al., 2025).

198. **Opportunities for competition between statutory health insurance funds exist primarily through the supplementary contribution rate**, ↘ ITEM 195 as the catalogue of benefits is largely prescribed by law and the Morbi-RSA financially neutralises differences in the structure of the insured population. ↘ ITEM 197 In an international comparison, insured persons in Germany react more sensitively to price changes than, for example, in the Netherlands (Pendzialek et al., 2016). In particular, between 2009 and 2015, the income-independent supplementary contributions led to an increased rate of switching between health insurance funds (Schmitz and Ziebarth, 2017). Further options for differentiation currently exist through optional tariffs, ↘ ITEM 202 service offerings and selective care contracts. Analyses using the Socio-Economic Panel (SOEP) show that these offerings have little effect on the choice of health insurance fund (Bünnings et al., 2015).

199. **Those insured under the GKV must contribute to the costs** of **certain healthcare services.** This is intended to increase cost awareness when using healthcare services and to promote preventive behaviour (BMG, 2025a), though in practice this is only partially successful. ↘ BOX 11 Furthermore, to a limited extent, additional revenue is generated for the GKV. Cost-sharing aims to address the moral hazard problem inherent in the GKV as a comprehensive insurance scheme: for insured persons, the marginal costs of additional doctor's visits and treatments are low, as the costs are fully covered (Hoh and Honekamp, 2010; Busse et al., 2017). Compared to other countries, the proportion of costs borne privately by insured persons in Germany is low. ↘ CHART 45

↘ BOX 11

Background: Empirical evidence on the impact of co-payments

Empirical studies have shown, both internationally and in Germany, that co-payments have a steering effect on doctor visits, medicines and outpatient care, and reduce the uptake of healthcare services (Kiil and Houlberg, 2014; Fusco et al., 2023). For example, the increase in co-payments for medicines by DM 5 in 1997 led to a 10–15 % decline in the number of doctor's visits (Winkelmann, 2004). In the inpatient sector, however, low co-payments primarily serve a financing function, as utilisation is largely determined by medical decisions or acute emergencies, meaning that co-payments have little steering effect (Kiil and Houlberg, 2014).

The structure and purpose of co-payments are key to their effectiveness as a policy

instrument. International studies estimate the price elasticity of demand to be around –0.2 (Manning et al., 1987; Chandra et al., 2010; Aron-Dine et al., 2013). Insured individuals also react particularly strongly to costs incurred directly at the time the service is provided, and less so to cost-sharing that occurs at a later date (Aron-Dine et al., 2015; Simonsen et al., 2021). For instance, the introduction of a practice fee ("Praxisgebühr") of 10 euros between 2004 and 2012 in Germany did not lead to a reduction in doctor's visits. This is because the fee was charged quarterly rather than per doctor's visit and thus had no steering effect after the first doctor's visit in a quarter (Augurzky et al., 2006; Schreyögg and Grabka, 2010).

Beyond the steering effect, co-payments can be assessed in terms of their impact on short- and long-term health, on healthcare costs, and in terms of their distributional effects. Most empirical studies find no short-term negative effects of higher co-payments on the health of insured individuals (Kiil and Houlberg, 2014; Shigeoka, 2014; Fusco et al., 2023). However, higher cost-sharing can lead to the non-utilisation of medically necessary care, as patients reduce their use of both medically necessary and unnecessary services (Chandra et al., 2010, 2024; Brot-Goldberg et al., 2017). Studies from the US suggest that higher co-payments there cause a shift in treatment from the outpatient to the inpatient sector, but are neutral in terms of absolute healthcare costs (Chandra et al., 2010; Fusco et al., 2023).

Flat-rate co-payments have a regressive effect, as vulnerable individuals such as the chronically ill, the elderly and low-income insured persons are burdened more heavily by out-of-pocket costs. Accordingly, even with low co-payments such as a practice fee of 10 euros, vulnerable groups reduce their demand of services more significantly than other groups (Kiil and Houlberg, 2014; Johansson et al., 2019; Xu and Bittschi, 2022). Consequently, they are also more severely affected by negative impacts on long-term health and mortality (Chandra et al., 2010, 2024).

200. In the GKV, compulsory cost-sharing takes the form of **co-payments**. Insured persons generally pay a co-payment of 10 % for medicines, with a minimum of 5 euros and a maximum of 10 euros, but never more than the actual cost of the medicine in question. For treatments such as physiotherapy, 10 % of the dispensing price plus €10 per prescription is payable, provided the co-payment does not exceed the actual cost. Co-payments for hospital stays, preventive and rehabilitation measures, and nursing care amount to €10 per day for a maximum of 28 days. In 2024, GKV-insured persons paid an average of 66 euros in co-payments, of which 35 euros were for medicines. ↘ CHART 55 APPENDIX The GKV's total revenue from co-payments in 2025 amounted to 5.0 billion euros (BMG, 2026c).

201. Co-payments are only payable by individual insured persons up to the so-called financial burden limit. This amounts to 2 % of annual gross income (less allowances) or 1 % for chronically ill insured persons. The financial burden limit is intended to protect insured persons from excessive financial strain. In 2025, just under 4.3 million insured persons were exempt from co-payments because they had exceeded the financial burden limit of 1 % of their annual gross income, and around 200,000 insured persons because they had exceeded the 2 % limit (BMG, 2026d).

202. In addition to co-payments, the GKV employs other cost-sharing mechanisms (SVR Gesundheit, 2018). Health insurance funds' bonus schemes are designed to encourage insured persons to adopt health-promoting behaviours and take preventive measures. Optional tariffs featuring deductibles, premium refunds or

benefit restrictions are intended, much like co-payments, to limit the uptake of services. Empirical studies for Germany show that such instruments can reduce the use of outpatient services and healthcare costs and promote preventive behaviour (Felder and Werblow, 2008; Thönnes, 2019; Augurzky et al., 2026). At the same time, their voluntary nature encourages selection and deadweight effects. In practice, health insurance funds increasingly use bonus schemes to attract and retain members (German Bundestag, 2021a), and optional plans with reimbursements are scarcely used by the insured. ↘ ITEM 266

2. Private health insurance

203. In addition to the GKV, individuals can take out either supplementary or, under certain conditions, comprehensive private health insurance. In 2023, private health insurance accounted for around 8 % of total health expenditure (Federal Statistical Office, 2026a). Supplementary private health insurance covers services that are not included, or are only partially included, in the GKV benefits catalogue, such as dental prostheses or optional inpatient services. Full private health insurance (PKV), on the other hand, replaces the GKV as the primary insurance. Individuals who are exempt from compulsory GKV insurance may switch to the PKV. ↘ BACKGROUND INFO 9 **In total, almost 9 million people, or around 10 % of the population, have comprehensive private health insurance**, with more than half of these being civil servants and their dependants (PKV-Verband, 2026a). A switch back to the GKV is only possible under strict conditions and is largely ruled out from the age of 55.

204. In 2024, 43 % of those insured under the GKV had at least one **supplementary private health insurance policy** (PKV-Verband, 2026a). With 20.2 million policyholders, supplementary dental insurance is the most common form of private supplementary insurance to statutory health insurance cover, followed by policies for outpatient services (9.3 million policyholders) and optional hospital services (6.9 million policyholders). Some of the services covered by supplementary insurance primarily relate to comfort (e.g. single rooms) and are not necessarily linked to better health outcomes.

205. Whilst the GKV is predominantly pay-as-you-go, **PKV is based on the funded system** ↘ GLOSSARY, with an arrangement that is virtually unique internationally. In addition to covering current medical costs, contributions to PKV serve to build up individual ageing reserves, which smooth out premia over the course of a lifetime and limit premium increases in old age. The capital-market-based assets of these reserves make the financing of PKV largely independent of expected demographic trends, in contrast to the statutory health insurance. Their volume amounted to around €355 billion in 2025 (PKV-Verband, 2026b). Due to the limited transferability of ageing provisions, switching between private health insurance providers is virtually impossible. Furthermore, PKV does not offer free co-insurance for family members, meaning that a separate premium is payable for each insured person. For civil servants, the employer covers part of the healthcare costs as part of the tax-financed **allowance** (“Beihilfe“).

206. The restriction of access to certain groups exempt from compulsory insurance, the risk-based premium structure of PKV, and the option of voluntary GKV membership imply **systematic risk selection**. Access to comprehensive PKV is only available to persons of a certain employment status or income ↘ BACKGROUND INFO 9 and is subject to a medical assessment. Premia are calculated on a risk-based basis and depend in particular on the age at entry, the state of health at entry, and the chosen tariff, but not on current income. This contrasts with the GKV, which pools risks collectively and provides for explicit income and risk equalisation. The premium structure in the PKV achieves actuarial equivalence; risk-sharing based on solidarity only takes place in relation to deteriorations in health following admission to the insurance scheme.

People with PKV are older, more often male, better educated and have a significantly higher disposable income than those with statutory health insurance. ↘ TABLE 12 APPENDIX Furthermore, they have better health, as measured by subjective health and the prevalence of chronic conditions. Despite being in better health, they visit doctors' surgeries with the same frequency as those insured under the statutory health insurance scheme, but spend less time in hospital. Their better state of health is also linked to a more preventive lifestyle, such as lower tobacco consumption.

207. The PKV allows for extensive **customisation of cover** through the choice of plan, deductibles, and supplementary and optional benefits, thereby enabling greater adaptation to individual preferences and willingness to pay. The scope of benefits under the PKV is, depending on the chosen plan, either more extensive or more limited than under the GKV. For example, sick pay is not included in the PKV and can only be covered by private supplementary insurance. In outpatient care, privately insured individuals benefit from faster access to new and innovative treatment methods than those insured under statutory health insurance (Walendzik et al., 2021); in the inpatient sector, entitlement to benefits is equivalent. Whether the PKV achieves better health outcomes for its policyholders is empirically disputed (Hullegie and Klein, 2010; Stauder and Kossow, 2017; Dauth, 2021).

208. On the supply side, statutory and private health insurance differ in their remuneration mechanisms. Treatments provided by general practitioners are remunerated under the PKV according to the German Scale of Medical Fees (GOÄ) and under statutory health insurance according to the EBM, which entails different fee levels and **treatment incentives**. Thus, for the same service, doctors receive on average up to more than twice the fee for privately insured patients than for those with statutory health insurance (Walendzik et al., 2008). The reform of the GOÄ announced for 2026 could further exacerbate these remuneration differences (Reinhardt, 2025). Private billing accounts for a disproportionately high share of medical practices' revenue – 28 % – relative to the number of privately insured patients (Federal Statistical Office, 2025c). However, there is no empirical evidence to suggest that differences in remuneration lead to over-treatment of privately insured patients.

Differences in remuneration and quarterly volume limits within the EBM mean that privately insured patients are given priority when it comes to booking appointments and, as a result, have **waiting times** that are half as long as those of patients with statutory health insurance (Schmitz, 2013; Werbeck et al., 2021). International studies show that longer waiting times have little effect on recovery from minor illnesses (Lewis et al., 2018), but can increase mortality where they delay treatment for more serious conditions (Han et al., 2021; Arabadzhyan et al., 2025; Costantini, 2025). In the field of mental health in particular, longer outpatient waiting times can increase sickness-related absenteeism and thus the immediate costs of the overall economy related to illness, whilst reducing long-term labour force participation (Godøy et al., 2024; Prudon, 2025). In inpatient care, the uniform, flat-rate per-case remuneration system does not create any separate incentives for treatment.

209. The PKV fulfils both a supplementary and a substitute function within the German health insurance system. As a substitute for the GKV, it enables certain population groups to switch systems entirely. Due to positive selection into private health insurance, insurance companies under the statutory scheme are more expensive than they would be if there were full pooling of the risks and incomes of all insured persons (Ochmann et al., 2020). However, the PKV can generate positive externalities for those insured under the GKV if, through the demand for additional services and higher outpatient remuneration, it promotes gross fixed capital formation in the area of medical infrastructure and quality of care, which also improves care for those insured under the statutory scheme. Furthermore, the earlier reimbursement of new treatment methods in the PKV compared to the GKV could encourage medical innovation or the dissemination of new procedures. However, there is no empirical evidence regarding the significance of these mechanisms. Through its ageing provisions, however, the PKV contributes substantially to the pre-financing of future healthcare expenditure, which is likely to rise significantly in the coming years and decades as a result of demographic ageing.
↘ ITEM 235

3. The German healthcare system in an international comparison

210. Among OECD countries, the US has the most cost-intensive healthcare system, with healthcare expenditure amounting to 16.7 % of GDP. ↘ CHART 45 **In a European comparison,** however, **healthcare expenditure in Germany is the highest,** at 11.7 % of GDP in 2023 (OECD and European Observatory, 2025). In Germany, just under 79 % of this expenditure is financed by compulsory health insurance schemes and just under 8 % by government programmes such as subsidies and investments in hospital infrastructure. The remaining healthcare expenditures are covered by voluntary private supplementary insurance (3 %) and out-of-pocket payments (11 %). An international comparison reveals significant differences in the financing structure, particularly in the balance between tax-financed systems and contribution-funded compulsory insurance schemes. These differences have implications for work incentives, distributional effects, and

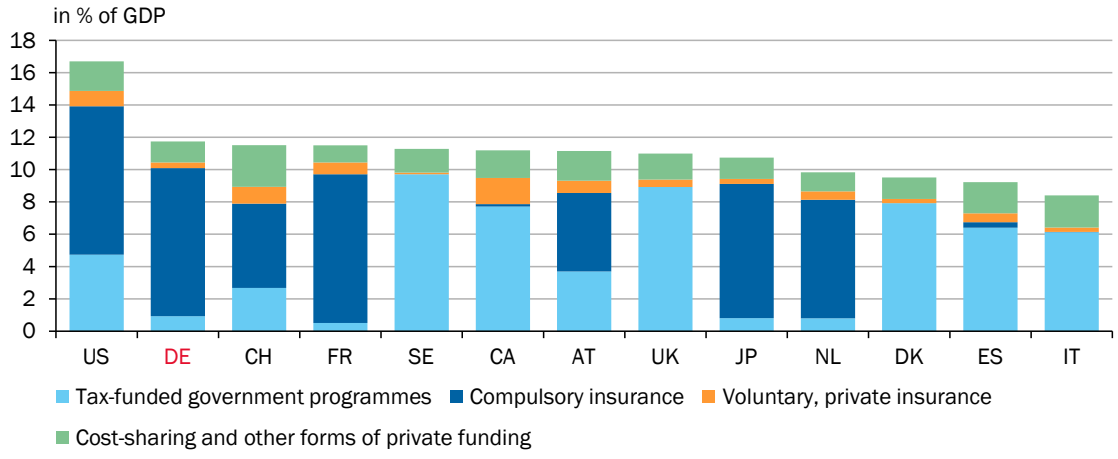
expenditure dynamics. These differences in the financing structure of healthcare systems are shaped by historical and institutional path dependencies.

211. The differences in **funding structures** can be traced conceptually to **two fundamentally different models**: in an extreme scenario, healthcare expenditure could be funded either entirely according to the **principle of solidarity** through general tax revenue, or entirely according to the **insurance principle** through premia paid by insured persons that are independent of income. **Internationally**, **mixed systems predominate**, with some countries (e.g. the UK and Italy) relying more heavily on tax-financed systems, whilst others (e.g. Switzerland) rely more heavily on contribution- or premium-based systems. ↘ CHART 45 In Germany, the earmarked contributions paid by employees and employers are the most important source of revenue for the GKV. ↘ ITEM 194 These contributions are income-dependent and, due to the associated redistribution mechanisms, are similar in nature to taxes. ↘ ITEMS 125 AND 127 In addition, there are tax-financed subsidies for the GKV. ↘ ITEM 196 Alongside the GKV, the PKV is a system based on income-independent, risk-oriented premia. ↘ ITEM 203 **The German healthcare system is thus predominantly financed according to the principle of solidarity, but also features elements of insurance-based financing**.

212. In **tax-financed systems**, the costs of the healthcare system are covered by general tax revenue. The distributional effects therefore depend on the tax structure. A higher funding requirement for the healthcare system is not immediately reflected in separately reported costs for the insured. In premium- or contribution-based systems, this link is more direct, because the costs of healthcare are covered separately and are thus immediately visible to the insured. In a tax-financed system, access to healthcare services is, in principle, independent of income and is therefore also guaranteed for low-income households. Overall, such a system provides for a balance both in terms of individual health risk and economic capacity.

↘ CHART 45

International comparison[1] of health care financing in 2023



1 – US-USA, DE-Germany, CH-Switzerland, FR-France, SE-Sweden, CA-Canada, AT-Austria, UK-United Kingdom, JP-Japan, NL-Netherlands, DK-Denmark, ES-Spain, IT-Italy. 2 – For Germany, this includes among other things, government subsidies to the GKV. 3 – For Germany, this includes contributions to the GKV and the PKV.

Source: OECD

However, by integrating healthcare expenditure into the general government budget, the scope and development of services may depend on the respective budgetary situation, which can lead to expansions or restrictions in the range of services. Empirically, this is evident, for example, in the UK, where healthcare services are increasingly being rationed through waiting lists, leading to long waiting times and an erosion of the actual scope of services (Darzi, 2024).

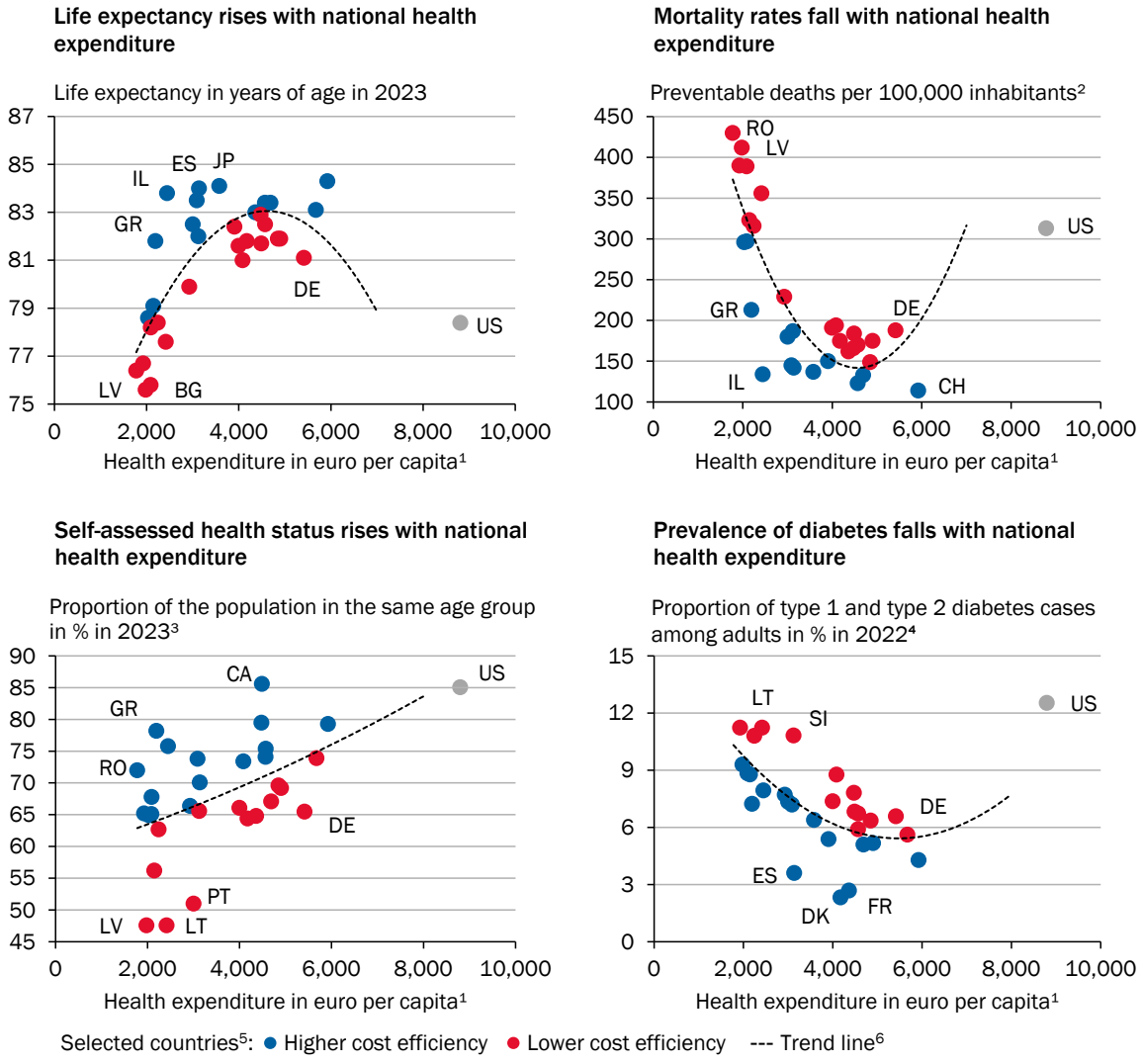
213. In Switzerland and the Netherlands, a large proportion of healthcare expenditure is financed through **premia that are** largely **independent of income** (De Pietro et al., 2015; Kroneman et al., 2025). In these countries, the level of the premium is, in principle, independent of income and the individual health status of the insured, and varies primarily according to the insurance providers' plan structures. This results in social equalisation with regard to individual health risk, but not with regard to economic capacity. To limit regressive distributional effects, however, systems with income-independent premia are in practice combined with a (tax-financed) social equalisation scheme.

214. **In addition to financing, the healthcare systems of different countries also differ in terms of their performance.** The high per capita expenditures in Germany, compared to other countries, are not automatically an indicator of a correspondingly high volume of services, but may also reflect high prices or high profit margins within the healthcare system. Thus, higher healthcare expenditure can result, even with the same level of utilisation, from rising prices and fees or from widening mark-ups in the healthcare sector, for example due to the market power of individual providers, staff, and capacity shortages, or a remuneration structure that does not necessarily link higher prices to a proportional increase in services (OECD, 2025; Zeeb et al., 2025).

215. Germany's high healthcare expenditure can be assessed in terms of the efficiency of care delivery, i.e. the relationship between the use of resources and the health benefits for patients. An international comparison of healthcare systems is methodologically challenging, as healthcare systems differ not only in terms of their financing but also across a wide range of other dimensions (Cylus et al., 2016). Nevertheless, despite having one of the highest levels of expenditure in the OECD, Germany ranks below comparable countries with lower healthcare expenditure on key health indicators. ↘ CHART 46 Per capita health expenditure in Germany is significantly higher than the OECD average (OECD, 2025), whilst Germany achieves only average results on indicators such as life expectancy, preventable deaths, self-assessed health and diabetes prevalence, despite the high level of funding. This pattern is evident in both recent and older data, suggesting **that the high level of resource allocation in this country is not being translated into correspondingly better health outcomes, and that efficiency deficits therefore exist**. Dlouhý and Havlík (2024) arrive at a similar conclusion, classifying the German healthcare system as inefficient in an international comparison based on a multivariate input-output model. Similarly, Varabyova and Müller (2016) demonstrate in a meta-analysis of existing studies that Germany exhibits low efficiency across various model specifications when compared to other OECD countries. Blümel et al. (2020) cite, among other things, the marked separation of outpatient and inpatient care, the high density of hospitals, and tendencies towards overprovision in the inpatient sector as structural causes.

↘ CHART 46

Indicators of the cost efficiency of the healthcare system



1 – Purchasing power parity figures for 2023. 2 – Data for 2023: Latvia, Lithuania, Luxembourg, the Netherlands, Austria, Sweden, Switzerland, Slovakia, Slovenia, Spain, the Czech Republic, Hungary; data for 2022: Bulgaria, Denmark, Estonia, Finland, France, Greece, Ireland, Iceland, Israel, Italy, Canada, Poland, Portugal, Romania, USA; data for 2019: Belgium, Germany, Japan, Croatia, United Kingdom. No figures available for Norway. 3 – No data available for Iceland and Japan. 4 – Age-standardised figures based on the WHO standard population. No figures available for Bulgaria, Croatia and Romania. 5 – AT-Austria, BE-Belgium, BG-Bulgaria, CA-Canada, CH-Switzerland, CZ-Czechia, DE-Germany, DK-Denmark, EE-Estonia, ES-Spain, FI-Finland, FR-France, GR-Greece, HR-Croatia, HU-Hungary, IE-Ireland, IL-Israel, IS-Iceland, IT-Italy, JP-Japan, LT-Lithuania, LU-Luxembourg, LV-Latvia, NL-Netherlands, NO-Norway, PL-Poland, PT-Portugal, RO-Romania, SE-Sweden, SI-Slovenia, SK-Slovakia, UK-United Kingdom, US-USA. 6 – Trend line excluding the US in each case.

Sources: OECD, WHO, own calculations

III. HEALTH EXPENDITURE IN GERMANY AND ITS DRIVERS

216. Expenditures by the GKV have grown significantly faster than their revenue in recent years. ↘ ITEM 195 General factors, which also affect other countries, are considered to be drivers of this development on the one hand. These include demographic ageing, ↘ ITEM 217 income growth ↘ ITEM 218 and the prevalence of unhealthy lifestyles, ↘ ITEM 219 which favour the onset and progression of preventable and, at the same time, cost-intensive diseases. Added to this is medical-technological progress, ↘ ITEMS 221 F. which gives rise to new, often highly specialised diagnostic and treatment methods that are cost-intensive in both their development and application. On the other hand, the trend in GKV expenditure is determined by specific expenditure drivers resulting from the organisation of the German healthcare system. ↘ ITEM 223 Due to their high share of total expenditure, the largest part of the increase in expenditure is attributable to the areas of hospital treatment ↘ ITEMS 224 FF. and medicines. ↘ ITEMS 232 F.

1. General drivers of healthcare expenditure

217. As a result of demographic change, the German population will age significantly in the coming decades. ↘ ITEM 92 **The future demand for healthcare services is determined less by the age reached by the population and more by whether the additional years of life are spent in health or illness**, and to what extent the relatively expensive treatment phase is concentrated near the end of life (Manton, 1982; Fries, 2002; Breyer et al., 2015; Nowossadeck et al., 2024). The empirical literature identifies several coexisting effects in this regard. On the one hand, there is a compression of morbidity. This involves a decrease in the proportion of years of life with significant limitations, as illnesses onset later. On the other hand, morbidity expands as the number of years of life with diagnoses increases. These are often chronic diagnoses with minor impairment. For Germany, Sperlich et al. (2022) use health insurance data to illustrate that in older age groups there tends to be a compression of severe illnesses (e.g. heart attack or stroke), whilst younger and middle-aged age groups experience an expansion of chronic conditions such as diabetes or obesity. Overall, this suggests an improvement in the quality of morbidity: more people are living longer with chronic conditions, but are less restricted by them, for example in terms of their ability to work.

218. **In addition to demographics, other structural trends are driving up health expenditure.** Firstly, as incomes rise, demand for health services increases at a disproportionately higher rate, meaning that the share of expenditure on health grows even if the health system remains unchanged. ↘ ITEM 98 Secondly, 'Baumol's cost disease' comes into play. In the case of labour-intensive healthcare services that are difficult to automate, wages rise in line with productivity in the overall economy, whilst sectoral productivity increases only slowly. This leads to

an increase in relative prices and the share of expenditure even without a rise in volume. ↘ ITEM 99

219. **Health-damaging behaviours**, such as alcohol and tobacco consumption, lack of exercise and an unbalanced diet, **can exacerbate the rise in healthcare expenditure** because they contribute to the onset and progression of preventable and, at the same time, cost-intensive diseases (Murray et al., 2020). These include, in particular, diabetes, cardiovascular diseases, and various types of cancer. Especially when such diseases occur early in life, this results in higher and more prolonged use of healthcare services. Current trends suggest that the resulting pressure on expenditure in Germany is increasing rather than easing in several areas. For instance, harmful alcohol consumption has risen again since 2020 (Federal Government's Drug and Addiction Commissioner , 2026), the previously declining trend in tobacco consumption has levelled off (Starker et al., 2025), and the proportion of the population affected by obesity has risen from 12.2 % to 19.7 % since 2003 (Starker et al., 2025).

Unhealthy lifestyles in Germany generate external effects in the form of high healthcare costs for the solidarity-based community of contributors. The incidence of obesity is rising, and according to estimates, the annual costs of obesity amount to up to €113 billion, including direct healthcare costs of €28 billion (Effertz et al., 2016; Leopoldina, 2026). For tobacco, the costs of the overall economy are estimated at around €97.2 billion per year (Effertz, 2020), of which about one-third is accounted for by direct healthcare expenditure. For hazardous alcohol consumption, the harmful health consequences of which are particularly severe among young people, the economic costs in Germany are estimated at between €39 billion and €57 billion per year, depending on the definition used, including direct healthcare costs of €8 billion (Effertz et al., 2017; Effertz, 2020), with the lower pension benefits resulting from shorter life expectancy already factored in.

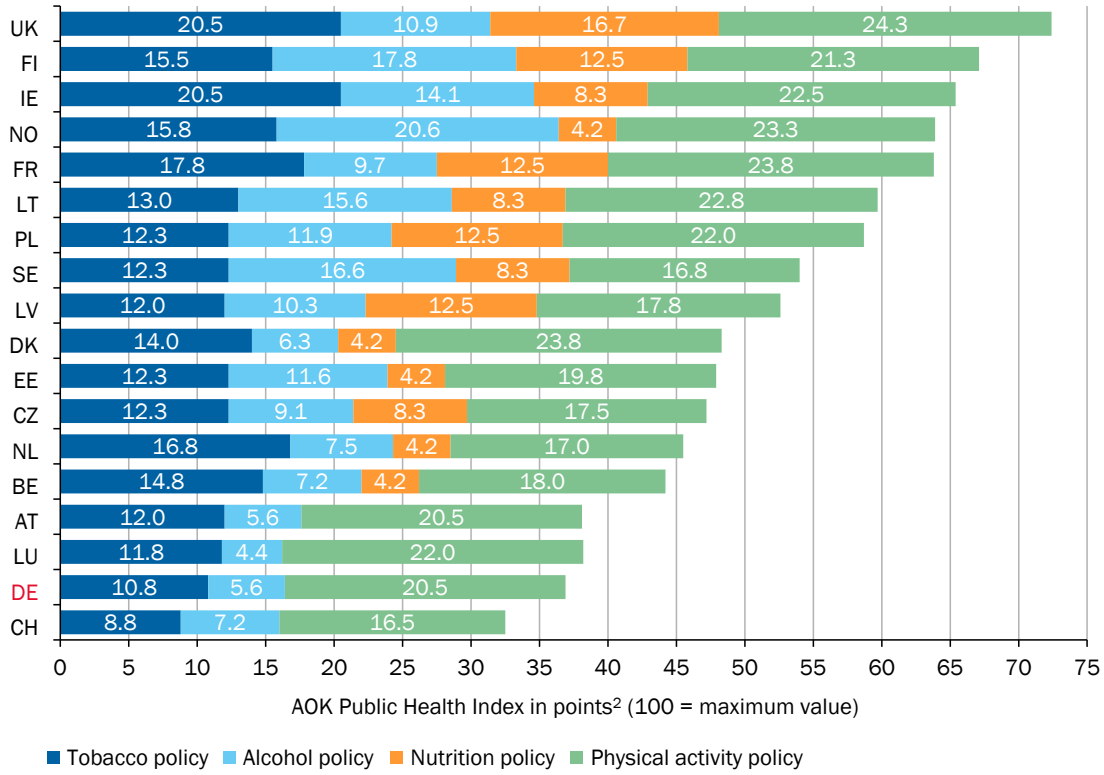
220. **The AOK Public Health Index indicates that, in a European comparison, Germany has significant ground to make up in the prevention of harmful behaviours.** ↘ CHART 47 The index measures the degree to which scientifically recommended prevention measures are implemented in 18 European countries (AOK, 2025). Prevention encompasses not only information and education but also the availability and marketing of products (environmental prevention) as well as price signals (behavioural prevention). Germany lags behind in international comparisons, particularly with regard to environmental prevention measures. These include advertising bans and marketing regulations (Donaldson et al., 2025; Saad et al., 2025), such as those concerning advertising of foods high in sugar and fat aimed at children (von Philipsborn et al., 2022; Boyland et al., 2025). Furthermore, there are comparatively few restrictions in Germany on the temporal and spatial availability of alcohol and tobacco, which could measurably reduce harmful consumption and, consequently, its negative externalities (Sherk et al., 2018).

Germany performs particularly poorly in international comparisons when it comes to preventive measures in the field of nutrition. ↘ CHART 47 Key preventive tools are non-binding. Although the Nutri-Score provides a scientifically sound nutritional labelling system (BMLEH, 2026a), its use remains voluntary. However, purely informational initiatives are only of limited effectiveness (Jepson et al., 2010). They rely on children actively perceiving and understanding health-related content and translating it into behavioural changes in their daily lives. According to empirical evaluations, measures are particularly effective that either alter the food environment itself, such as binding quality standards (von Philipsborn et al., 2022; Hundeshagen et al., 2024), or support this translation process through practical nutrition education (Charlton et al., 2021; van der Horst et al., 2024; Vaughan et al., 2024). However, the quality standards for catering in nurseries and schools developed by the German Nutrition Society (DGE, 2023) are not binding nationwide. Furthermore, no levy on foods high in sugar and fat has yet been implemented.

221. **Medical-technological progress (MTF) enables new diagnostic and treatment methods**, which are often cost-intensive to develop and apply.

↘ CHART 47

Prevention policy in international comparison[1]



1 – UK-United Kingdom, FI-Finland, IE-Ireland, NO-Norway, FR-France, LT-Lithuania, PL-Poland, SE-Sweden, LV-Latvia, DK-Denmark, EE-Estonia, CZ-Czechia, NL-Netherlands, BE-Belgium, LU-Luxembourg, AT-Austria, DE-Germany, CH-Switzerland.
2 – The results from the four areas of action – tobacco, alcohol, diet and physical activity – are each weighted equally in the overall assessment. The maximum possible 100 points in the overarching AOK Public Health Index are derived from the four assessed areas of action, each contributing 25 %. Minor discrepancies in the scores achieved may arise due to rounding.

Source: AOK and German Cancer Research Center

Furthermore, innovations expand the range of treatable diseases, leading to an overall increase in the use of healthcare services (German Bundestag, 2015). MTF can also result in health conditions that were not previously recognised as diseases being diagnosed and/or treated. Finally, life-prolonging MTF can lead to higher healthcare expenditure because additional costs for illness and care are incurred during the remaining lifetime of the treated individuals. In the field of digitalisation, MTF can contribute to cost containment, for example by reducing documentation times and achieving efficiency gains through the further development of IT infrastructure. ↘ ITEMS 267 FF.

222. In principle, the MTF can have a cost-reducing effect on healthcare expenditure through process or product innovations (Breyer, 2015). Cost increases are to be expected primarily in the case of product innovations that do not provide cost-saving substitutes but instead increase treatment intensity, case numbers and quality standards, whilst economies of scale fail to materialise and the marginal utility of additional applications declines. The impact of the MTF on healthcare expenditure is also determined by the rules governing the reimbursement of innovations, for example through inclusion in the EBM, and the conditions under which they are reimbursed. ↘ BOX 14 **Empirical findings suggest that the MTF tends to lead to cost increases** (Blanco-Moreno et al., 2013; Breyer, 2015; Cinaroglu and Baser, 2018; Mason et al.). An analysis of expenditure in the GKV by the GCEE estimates the average contribution of the MTF to expenditure growth between 1998 and 2022 at around 30 %. This corresponds to an increase in expenditure of 0.9 % per year. ↘ BOX 12

↘ BOX 12

SVR analysis: Drivers of GKV expenditures

Demographic change, alongside other demand-side factors, is cited as a key driver of expenditure growth in the healthcare sector. ↘ ITEMS 217 F. Taken together, however, these factors can only partially explain the most recent observed increase (Chandra and Skinner, 2012; Pretnar and Feldman, 2026). Empirical analyses of expenditure trends highlight the cost-increasing effect of the MTF and estimate its contribution to the rise in expenditure at 25 to 50 % (Marino and Lorenzoni, 2019). For Germany, Willemé and Dumont (2016) estimated a contribution of 40 % to the rise in total health expenditure between 1981 and 2012, corresponding to an annual expenditure growth of around 1.6 %. Analyses based on GKV expenditures between 1970 and 2009 estimate the MTF-induced increase at 0.8 to 2.3 % per year (Breyer and Ulrich, 2000; Breyer et al., 2015).

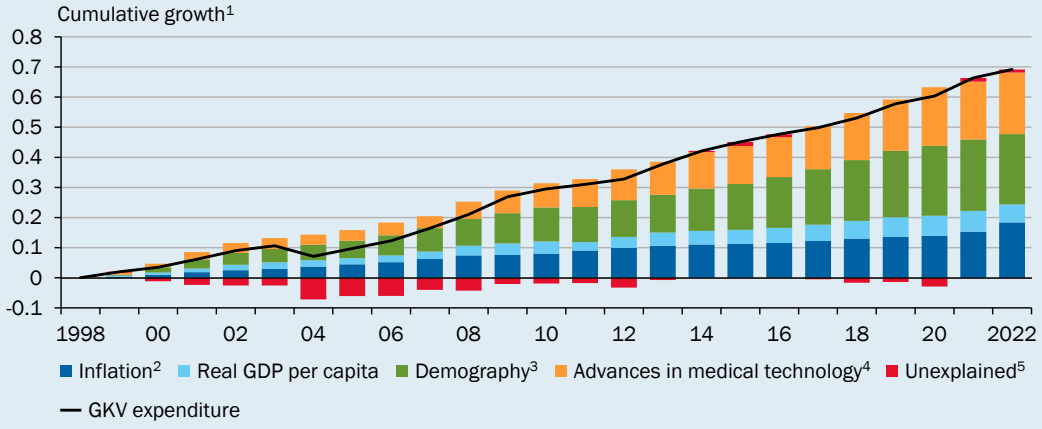
The GCEE follows the empirical approach of these studies and decomposes historical expenditure growth for the years 1998 to 2022 using panel data from the BAS. In doing so, the following regression equation is estimated:

$$\Delta \log LA_{it} = \alpha \, \Delta \log X_{it} + \omega \, \Delta \log GDP_{t-2} + \delta_t + \epsilon_{it}$$

LA_{it} are per capita benefit expenditure in year t for age group i. X_{it} are control variables whose correlation with output growth in benefit expenditure is measured by the estimators α (and ω). The MTF is measured here using the proxy variables research and development (R&D) and productivity in the healthcare sector. Further control variables include inflation, the growth rate of real per capita GDP, and demographics (changes in the proportion of people aged 65 to 79 and those over 80, as well as changes in life expectancy). Due to descriptive evidence of a

delayed response of healthcare expenditure to changes in gross domestic product, a time lag of 2 years is introduced (OECD, 2025). The use of age-group-specific life expectancies in X_{it} takes into account particularly high medical costs in the final years of life (Zweifel et al., 1999; Breyer and Lorenz, 2021). All variables were transformed into growth rates and cumulated for graphical representation. Annual dummies δ_t in the years t = 1998, 2004, 2020 and 2021 control for special effects of reforms and the COVID-19 pandemic.

↘ CHART 48
Drivers of growth in GKV expenditure



1 – Empirical decomposition of benefit expenditure excluding sick pay in the GKV into economic, demographic and technical drivers based on a panel regression of growth rates. 2 – Consumer price index. 3 – Share of older people in the population and life expectancy. 4 – R&D and productivity in the health sector. 5 – Model residuals and variables for reforms and the Corona pandemic.

Sources: BAS, Eurostat, Federal Statistical Office, own calculations

The decomposition suggests that expenditure growth in the GKV system depends on several factors. Around 34 % of the estimated output growth is attributable to demographic factors. ↘ CHART 48 This corresponds to an average contribution to growth of 1 percentage point per year. A further 30 % results from the positive correlation with the MTF, whose average contribution stands at around 0.9 percentage points per year. This contribution is in line with the average of previous estimates (Marino and Lorenzoni, 2019). It is striking that the contribution of demographics is growing relatively steadily, whilst the contribution of the MTF has shown stronger momentum in recent years. This is particularly relevant from an economic policy perspective, as the MTF is not a purely exogenous factor, but its impact on expenditure is also determined by the regulatory framework and incentive structures.

The remaining third of the increase is attributable to general price rises and the rise in real GDP per capita. In addition, health policy reforms and exceptional events such as the COVID-19 pandemic have an independent influence on expenditure trends. In particular, the 2004 reform has had a cost-reducing effect, whilst the COVID-19 pandemic has accelerated expenditure growth from 2021 onwards.

2. Specific drivers of expenditure in the GKV

223. The rise in GKV expenditures ↘ ITEM 193 varies significantly across the individual service areas. ↘ CHART 49 TOP The highest growth rates are recorded for expenditures on inpatient care and home nursing care. By contrast, real expenditures on dental treatment and the administrative costs of health insurance funds have barely

risen. However, high growth rates in individual service areas do not necessarily correspond to a correspondingly high contribution to the rise **in total expenditure**. Rather, the decisive factor is the weight of the respective service areas in the total expenditure volume. ↘ CHART 49 BOTTOM **Due to their high share of total expenditure, the largest part of the increase is attributable to hospital treatment and medicines.** In addition, expenditure on medical treatment and sick pay also contributed significantly to the increase. ↘ BACKGROUND INFO 11 By contrast, the high growth rates in treatment care have so far had only a limited impact on total expenditures due to the low baseline level.

↘ BACKGROUND INFO 11

Background: Development of expenditures on sick pay

Real expenditure per insured person on sick pay rose by an average of 4.3 % annually between 2005 and 2025 ↘ CHART 49 TOP and currently accounts for around 6.1 % of total GKV expenditures. ↘ CHART 41 The rise in these expenditure figures is closely linked to trends in sick leave. Since 2008, sick leave has risen significantly, with the average number of sick days per insured person increasing from 8.6 to 14.8 days in 2024 (Federal Statistical Office, 2026b). However, sick leave only affects the GKV if it is driven by longer periods of illness, as continued pay is provided by the employer for the first six weeks of incapacity for work.

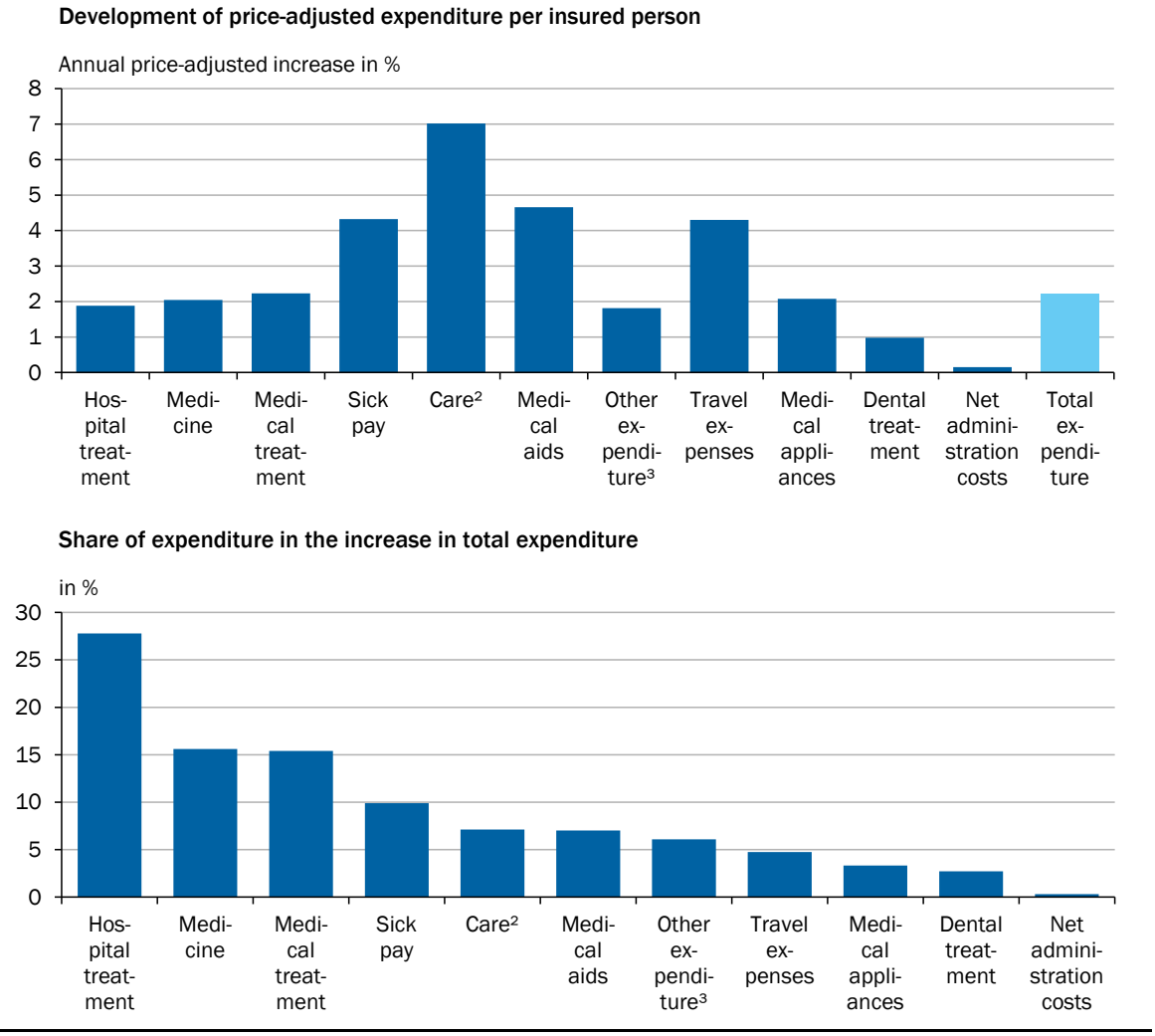
Hospital treatment

224. At €111.4 billion in 2025 and accounting for just under 32 %, hospital treatment represents the largest expenditure category for the GKV. Expenditure per insured person rose by 1.9 % per year in real terms between 2005 and 2025. ↘ CHART 49 TOP **Key factors driving this rise in expenditure include, in particular, incentive-driven increases in volume, structural overcapacity and the design of hospital funding.**

225. Hospital costs are primarily billed to the GKV via a **diagnosis-related group** (DRG) **system**. ↘ BACKGROUND INFO 12 The DRG system creates economic incentives to increase the number of cases, as additional treatments generate additional revenue. Against the backdrop of pronounced information asymmetries between doctor and patient, this creates scope for supply-induced demand (McGuire, 2000; Schneider, 2002). Empirical studies show that whilst the introduction of flat-rate payments per case tends to reduce costs per stay (Böcking et al., 2005), it has simultaneously led to a systematic increase in the number of inpatient treatments (Quentin et al., 2010; Messerle and Schreyögg, 2024). A reform that aligns funding more closely with available capacity than with the number of cases treated was initiated by the 'traffic light' coalition government of the 20th legislative period and is the subject of legislative proposals by the current Federal Government. ↘ BOX 13

↘ CHART 49

Development of GKV expenditure between 2005 and 2025[1]



1 – Data for 2025 based on preliminary accounting results. 2 – Medical care and home nursing. 3 – Rehabilitation and preventive care, early detection measures, pregnancy/maternity and other expenses.

Sources: BMG, Federal Statistical Office, own calculations

↘ BACKGROUND INFO 12

Background: Diagnosis-Related Group (DRG) system

The amount of the DRG flat-rate payments is determined primarily by the type of illness (diagnosis), the severity of the condition and the treatment method. The flat-rate payment covers a defined condition and its treatment within a specific range for the length of the hospital stay. Within this range, the same flat rate — calculated for an average length of stay — is paid regardless of the patient's actual length of stay. For patients with a significantly longer or shorter length of stay, surcharges or discounts are generally applied to the flat-rate payments. From year to year, the flat rates are increased by a statutory adjustment rate (state base case value, Section 10 of the Hospital Remuneration Act). This rises in line with the cost index for hospital costs (reference value); however, in accordance with a most-favoured-rate clause, it rises by at least the rate of growth in GKV revenue (basic wage rate).

↘ BOX 13

Background: Hospital reform in Germany

The Hospital Care Improvement Act (KHVVG), passed in 2024, is intended to address structural disincentives and efficiency problems in the previous, case-volume-oriented hospital financing system. The aim of the reform is to reduce incentives for volume expansion and to bundle services without jeopardising comprehensive basic care. At the same time, the aim is to improve economic sustainability and promote greater specialisation among hospitals (BMG, 2024).

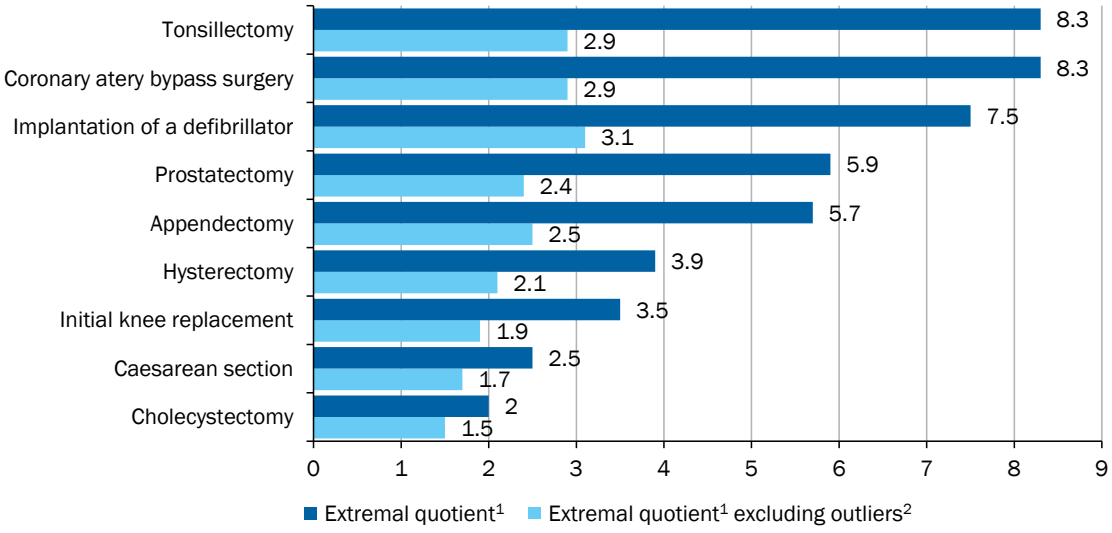
At the heart of the reform is the shift from almost entirely case-based remuneration to a reduced DRG component and combined funding with case-independent standby flat rates. These compensate hospitals for maintaining capacity (beds, staff, technology), regardless of the actual number of patients, and are intended to cover around 60 % of operating costs (BMG, 2024). Uniform service groups for hospitals across Germany at quality-based care levels are intended to enable a concentration of complex services and greater specialisation. To support these structural adjustments, a Hospital Transformation Fund with a volume of up to €50 billion has been established for the years 2026 to 2035 (BMG, 2025b). Among other things, this is intended to finance the restructuring of sites and the creation of telemedicine network structures. Under the Hospital Reform Adjustment Act (KHAG), the Federal Government plans to shift part of the fund's financing from the GKV health fund to the Special Fund for Infrastructure and Climate Neutrality in order to alleviate short-term pressure on GKV contributions (Federal Government, 2025). In the short to medium term, higher expenditures are to be expected due to transformation and adaptation costs as well as parallel structures during the transition phase (BMG, 2024). In the long term, however, a reduction in beds and hospital sites is likely to curb the rise in expenditures (Augurzky and Karagiannidis, 2026).

226. **By international standards, Germany has a high density of hospitals, with many small sites and a low level of specialisation.** Empirical efficiency analyses of German acute care hospitals show that larger hospitals and specialised service profiles are systematically associated with higher technical efficiency, whilst small hospitals with a broad range of services tend to provide their healthcare services less efficiently (Lindlbauer and Schreyögg, 2014; Varabyova et al., 2017).

227. The significant regional differences in inpatient utilisation cannot be explained by differences in need and point to supply-induced demand and structural inefficiencies. Analyses based on the SOEP document that, even after controlling for morbidity and socio-economic factors, systematic regional differences in utilisation, measured by the extremal quotient, ↘ GLOSSARY persist. This disparity points to differences in supply and practice styles as a source of potential inefficiencies (Eibich and Ziebarth, 2014). On the one hand, varying levels of economic pressure across regions may prompt hospitals to increase the utilisation of existing capacity (Reifferscheid et al., 2015). On the other hand, there are considerable differences in the prevalence of outpatient surgery (Messerle et al., 2024; Tillmanns and Jäckel, 2024). Overall, these differences are more pronounced in inpatient care than in outpatient care (Chuard and Hochuli, 2026). Nolting et al. (2011) show that, for example, the relative frequency of tonsillectomies in children varies by a factor of more than 8 between districts in Germany. ↘ CHART 50 Compared to this, regional differences in outpatient care appear to be much more strongly explained by patient-side demand. For instance, Salm and Wübker (2020) demonstrate, based on

↘ CHART 50

Regional differences in the frequency of surgical procedures



1 – Ratio of the surgery index between the district with the highest and that with the lowest surgery frequency. 2 – Ratio of the surgery index at the 95th and 5th percentiles of surgery frequency.

Source: Nolting et al. (2011)

routine GKV data, that in outpatient medical care, over 90 % of regional variation is explained by patient-side demand factors.

228. **The dual hospital financing system** under the Hospital Financing Act (KHG, with operating costs covered by GKV flat-rate payments and investment costs by the federal states) **leads to a persistent investment deficit**, as investments by the federal states in hospital infrastructure has fallen by around 40 % in real terms since 1991 (DKG, 2025). Augurzky et al. (2024) show that currently only about half of the annual investment requirement of around €6.8 billion is covered by public funds. The Hospital Future Fund, financed by the federal government, the federal states and hospital operators with a funding volume of €4.3 billion, was established in 2020 to support the necessary modernisation (BAS, 2026a). However, it cannot cover the financial requirements in the long term. **Hospitals are therefore increasingly financing necessary gross fixed capital formation from surpluses in service fees**, ↘ BOX 10 **which reinforces the incentives to increase volume** (DKI and BDO, 2015). Particularly at many small and, in some cases, under-utilised sites, this increases the pressure to boost case numbers and encourages avoidable inpatient treatments.

229. The DRG payment system for inpatient hospital services is the most important source of revenue for acute care hospitals. The **removal of nursing staff costs from the DRG system** in 2020 has partially weakened the flat-rate nature of hospital remuneration. An increasing proportion of inpatient staffing costs – currently 25 % of GKV expenditures on hospitals – is financed via a **nursing budget** to be agreed on an individual hospital basis, which is earmarked specifically for the financing of nursing staff costs (BMG, 2026d; Hentschker et al., 2026b). As a result, cost increases in nursing care (e.g. due to staff expansion or wage developments) can have a more direct impact on GKV expenditures, even if case numbers

and flat-rate payments remain unchanged (Hentschker et al., 2023). **Parallel funding via DRGs and the nursing care budget thus weakens the cost-curbing effect of the flat-rate system whilst simultaneously increasing the complexity of the reimbursement structure.**

230. The hospital reform aims to reduce existing misleading incentives, in particular by decoupling funding more effectively from patient numbers and by promoting specialisation. ↘ BOX 13 At its core is the introduction of flat-rate maintenance fees independent of patient numbers, as well as standardised service groups across the country. Simulation models show that, in the long term, a significant reduction in the number of hospitals (from around 1,400 to fewer than 600 sites), coupled with greater specialisation, could improve the quality of care and unlock efficiency gains (Böcken, 2019). In the short term, however, expenditures are expected to rise due to transformation costs and parallel structures. These will be covered between 2026 and 2035 by a transformation fund totalling €50 billion, financed equally by the federal and state governments (BMG, 2024). **Long-term efficiency gains require that capacities are actually reduced and services are concentrated more effectively.**

231. In Germany, hospital care is characterised by both comparatively frequent hospital admissions and long lengths of stay (OECD and European Observatory, 2025; GCEE Annual Report 2018 items 802 ff.). This points to misleading incentives in the sectoral remuneration structure, which favour inpatient treatment over outpatient services. As part of the hospital reform, a cross-sector remuneration system ('Hybrid-DRG') was therefore introduced for selected procedures from 2024 onwards. A uniform flat-rate payment thus applies to these services, regardless of whether treatment is provided on an outpatient or (short-term) inpatient basis. Accordingly, the flat-rate fees for hospitals are decreasing, whilst outpatient treatment is remunerated at a higher rate compared to billing under the EBM or GOÄ. **This shifts the relative remuneration incentives in favour of outpatient treatments, so that services which can be provided on an outpatient basis with comparable quality are to be increasingly shifted away from the inpatient sector.** In the long term, this is intended to reduce both the number of inpatient cases and the demand for inpatient capacity. Initial analyses point to a higher proportion of outpatient treatments and falling overall costs despite rising case numbers (Hentschker et al., 2026a). However, there is a risk that an increase in the total number of treatments may partially offset potential cost savings.

Expenditure on medicines

232. In 2025, €58.5 billion was spent on medicines in the GKV, accounting for just under 17 % of total expenditure.↘ ITEM 192 **The rise in expenditure on medicines is largely driven by the use of increasingly high-priced, patent-protected medicines.** In an international comparison, Germany exhibits both high consumption and high price levels for medicines (SVR Gesundheit & Pflege, 2025). Between 2005 and 2025, real expenditure on medicines per insured person rose by just under 2.1 % per year.↘ CHART 49 TOP The net costs for medicines are calculated as the sum of expenditures by the GKV and co-payments by insured

persons, minus manufacturer and pharmacy discounts (Schröder et al., 2025). Between 2015 and 2024, the net costs per prescribed daily dose rose by around 106 % for **patented medicines** and by just under 39 % for non-patented medicines. At the same time, the share of prescriptions for patented medicines fell from 10 % to 7 %, whilst their share of total expenditure rose from 53 % to 54 %. Patented medicines thus account for a disproportionately high share of total expenditure despite a declining share of prescriptions. A key factor in this development is the trend towards high-cost, personalised therapies triggered by the MTF (SVR Gesundheit & Pflege, 2025).

233. Expenditure on medicines under the GKV is largely determined by the frequency of prescriptions and the **reimbursement amount** for the medicines. Insured persons under the GKV have the majority of their prescription medicines reimbursed by their respective health insurance fund, whilst the costs of non-prescription medicines are usually not reimbursed. In its latest report, the SVR Gesundheit & Pflege pointed out that the current pricing of medicines in the statutory health insurance system is contributing to the rise in expenditure on medicines (SVR Gesundheit & Pflege, 2025).↘ BOX 14

In particular, there is criticism that the pricing of innovative medicines is not consistently enough aligned with **the additional therapeutic benefit**, measured against an appropriate comparative therapy, and that the MTF therefore has a significant cost-increasing effect in this area. In particular, so-called orphan drugs for rare diseases benefit from comprehensive special regulations, yet often have no demonstrable additional benefit. ↘ BOX 14 They account for less than 0.1 % of prescribed daily doses, yet are responsible for 14 % of expenditures in the GKV's pharmaceutical market (Schröder et al., 2025). This illustrates the high concentration of expenditures on a small number of very expensive medicines.

↘ BOX 14

Background: Pricing of prescription medicines in the GKV

The pricing of prescription medicines in the GKV operates under a two-tier system. In the new market for patent-protected medicines without a suitable fixed-amount group, reimbursement amounts are negotiated between the GKV-Spitzenverband and the companies in the so-called AMNOG procedure. The price is intended to reflect the additional therapeutic benefit. Under this procedure, medicines are immediately eligible for reimbursement following approval, with pharmaceutical companies being free to set the price for the first six months. In parallel, the added benefit is assessed, on the basis of which a reimbursement amount is subsequently negotiated that applies retroactively (Schröder et al., 2025). A proven added benefit justifies a surcharge on the costs of the comparative therapy. If this is lacking, the price is usually capped at the level of the most cost-effective standard therapy. This interplay of early market access and subsequent price negotiation means that innovative medicines initially enter the market at high prices, but are quickly available by international standards (SVR Gesundheit & Pflege, 2025).

In the existing market, which consists predominantly of generics and off-patent active substances, pharmaceutical companies are generally free to set their own prices. However, the price level is limited by fixed amounts for therapeutically comparable groups of medicines. For each of these fixed-amount groups, the GKV-Spitzenverband sets a maximum limit for reimbursement by the GKV (BfArM, 2026).

A special provision applies to orphan drugs, i.e. medicines for the treatment of rare diseases. For these medicines, the added benefit is deemed to be established upon authorisation and up to an annual turnover limit, without the need for empirical proof of benefit ('fictitious added benefit'). Subsequent regular benefit assessments show that no added benefit can be demonstrated for a significant proportion of orphan drugs (SVR Gesundheit & Pflege, 2025). Furthermore, their reimbursement price is closer to the original market entry price than for other medicines and is therefore generally inflated.

IV. CONTRIBUTION RATE TRENDS IN THE STATUS QUO

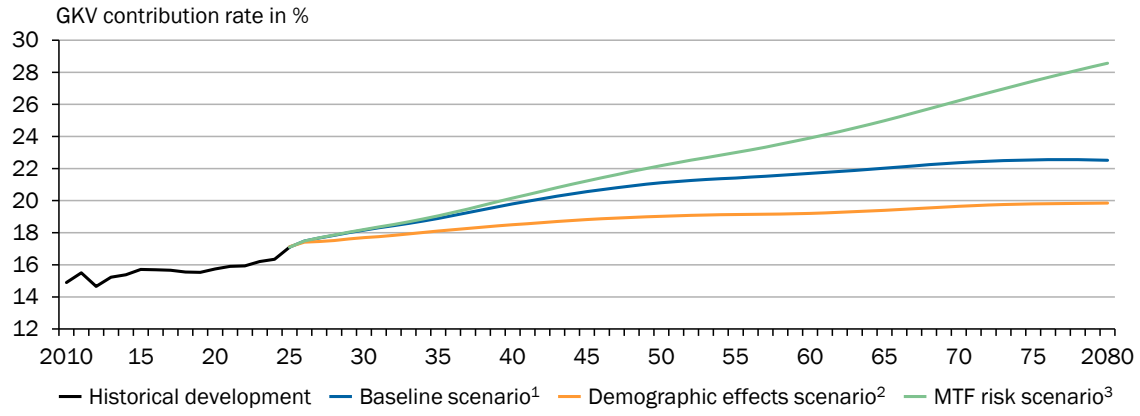
234. The GCEE projects the future development of GKV revenue and expenditures based on the long-term simulations by Werding et al. (2026). This involves estimating how the average contribution rate under the existing GKV system will evolve up to 2080, assuming the current legal framework remains in place. In the baseline scenario, rising funding requirements are offset by higher contribution rates, whilst federal funding is projected on a rule-based basis. ↘ ITEM 108 In addition, further scenarios are considered, including those with different assumptions regarding future population trends. ↘ BACKGROUND INFO 5 In the GKV, alongside demographic effects, MTF is a key cost driver, although there is fundamental uncertainty regarding its future development. The baseline scenario therefore assumes that MTF currently contributes 0.9 percentage points per year to the rise in benefit expenditure and will subsequently weaken continuously until the end of the projection period. ↘ ITEM 222

235. The simulations by the GCEE show that there is likely to be a long-term increase in expenditures and contribution rates in the GKV. ↘ CHART 51 The contribution rate is expected to rise to an average of 17.7 % in 2027 and to 18.2 % by 2030. Thereafter, it will continue to rise steadily to a level of 19.8 % in 2040 and reach 22.5 % in 2080.

236. Compared to the baseline scenario, a scenario based purely on demographic dynamics – which disregards cost-increasing innovations of the MTF – shows a significantly lower increase in expenditure in the GKV. In this case, the contribution rate rises to 18.5 % by 2040 and to 19.8 % by 2080. In a risk scenario, by contrast, a stronger impact of the MTF is assumed, with its historical dynamics projected to continue unchecked. ↘ BOX 12 This leads to a considerably sharper rise in expenditure and thus to a significantly higher contribution rate of 20.2 % in 2040 and 28.6 % in 2080.

↘ CHART 51

Simulation of the GKV contribution rate under the status quo



1 – Development under current legislation, assuming a rule-based roll-over of federal funding, expected demographic trends and a moderate roll-over of the MTF. 2 – Development under current legislation, with rule-based updating of federal funding and expected demographic trends. 3 – Development under current legislation, with rule-based updating of federal funding, expected demographic trends and continuation of the MTF with unchecked growth.

Sources: BMG, SIM.24

V. REFORM OPTIONS FOR SUSTAINABLE FINANCING OF HEALTH INSURANCE

237. In this section, the GCEE discusses reform options on both the expenditure and revenue sides that have the potential to secure the sustainable financing of the GKV whilst ensuring an appropriate level of benefits. ↘ BACKGROUND INFO 4 A number of further reform options were recently presented by the Health Finance Commission ("Finanzkommission Gesundheit", FKG). ↘ BACKGROUND INFO 13 On this basis, the Federal Government adopted a draft of the planned Statutory Health Insurance Contribution Rate Stabilisation Act in the Federal Cabinet on 29 April 2026 (Federal Government, 2026).

↘ BACKGROUND INFO 13

Background: Reform proposals from the Health Finance Commission (FKG)

On behalf of the Federal Ministry of Health (BMG), the FKG is developing reform proposals to stabilise the contribution rate in the GKV whilst ensuring a high standard of quality and service provision (FKG, 2026). The first report presented proposals for measures intended to take effect from 2027 onwards, thereby delivering results in the short term. A second report containing further medium- and long-term structural reforms has been announced for the end of 2026. The Commission identifies rising prices and remuneration in the healthcare sector, which have become increasingly decoupled from revenue trends, as the key cause of the dynamic expenditure growth. Against this backdrop, it presented a package of 66 reform recommendations with a potential savings of €42.3 billion in 2027, rising to €63.9 billion by 2030.

The reform proposals on the expenditure side aim to limit the rise in spending. Measures are proposed to improve efficiency, reduce over-provision and under-provision, and to focus more strongly on evidence-based medicine. In addition, adjustments to the cost-sharing arrangements for insured persons are proposed. The central guiding principle is a return to a revenue-oriented spending policy, under which increases in expenditure are to be more strictly capped in future. On the revenue side, the Commission recommends a moderate expansion of the funding base. This includes the abolition of non-contributory co-insurance, greater tax funding of non-insurance benefits, and preventive measures such as increasing excise duties on products harmful to health (e.g. tobacco, alcohol and sugary drinks).

1. Managing healthcare costs more effectively

238. The financial strain on the GKV is primarily due to a sharp rise in expenditure, which is largely driven by non-demographic factors. ↘ ITEMS 216 FF. Expenditure-side reform options are therefore discussed first and foremost here. In particular, hospital funding should be made less dependent on case numbers, and remuneration should be aligned more closely with actual cost increases by suspending the most-favoured-rate clause. Additionally, adjustments to the nursing budget should prevent nursing staff from being deployed for other tasks. Furthermore, prices for new medicines should be consistently aligned with their additional

therapeutic benefit. This should slow the rise in the two key drivers of statutory health insurance expenditures. ↘ ITEM 223 Furthermore, cost-sharing measures should be applied in a more targeted manner, and the prevention of harmful consumption behaviour should be strengthened through marketing regulations, binding standards for healthy nutrition in nurseries and schools, and price signals.

Curbing expenditures in the long term through stronger prevention

239. **Information and education initiatives are an important component of prevention, but are often insufficient to bring about a lasting reduction in unhealthy behaviours** (Jepson et al., 2010). They rely on individuals actively engaging with health-related information, understanding it, and translating it into behavioural changes in their daily lives. However, health literacy is distributed unequally across society (Nickel and von dem Knesebeck, 2020; Karran et al., 2023). Consequently, information-based prevention strategies often have less impact on disadvantaged groups (the prevention paradox; Rose, 2001; Wissenschaftsrat, 2026) and may in some cases even exacerbate existing differences in health behaviour (Kaba-Schönstein and Kilian, 2023), for example when municipalities with socio-economically disadvantaged populations are less likely to participate in health promotion programmes (Herbert-Maul et al., 2023). Furthermore, harmful consumption is often characterised by habits, present-bias and weak self-control, which can only be addressed to a limited extent through the mere transfer of knowledge (Matjasko et al., 2016). This suggests that information and education initiatives should be supplemented by measures such as **advertising bans and marketing regulations**, **as well as binding standards for health-promoting nutrition in nurseries and schools**.

240. **In behavioural prevention**, **the state can make targeted use of the steering effect of price signals** by raising consumer prices through excise duties or minimum prices. Empirical evidence shows that rising prices for harmful products such as tobacco, alcohol or foods high in sugar lead to a decline in consumption and thus, in the medium to long term, to a lower disease burden. For alcohol, empirical studies consistently show negative price elasticities of demand, meaning that price increases are accompanied by noticeable declines in consumption (Wagenaar et al., 2009; Fogarty, 2010; Neufeld et al., 2022). According to estimates, a significant increase in excise duties could prevent a substantial proportion of alcohol-related illnesses and deaths (Kilian et al., 2022). The price elasticity of demand for tobacco products is also high, with the response being particularly pronounced among households with low socio-economic status (Hanewinkel and Isensee, 2003; Chaloupka et al., 2011).

241. **Germany performs particularly poorly in a European comparison when it comes to preventive nutrition policy.** ↘ CHART 47 For instance, no tax on foods high in sugar and fat has yet been implemented in Germany. Previous prevention measures, such as the National Reduction and Innovation Strategy (BMLEH, 2026b), which expired in 2025, relied on voluntary reduction targets set by the food industry. Interim reports show progress in individual product

groups, but emphasise the continuing need for action (Gréa et al., 2025). **Against this backdrop, a broad-based levy based on the respective ingredient content can serve as a structural prevention tool** (Fischbacher et al., 2025). Unlike a value-based tax, such an approach not only provides an incentive for consumers but also encourages producers to reduce their use of the taxed ingredients (Bandy et al., 2020; Dickson et al., 2025).

242. In the short term, excise duties on tobacco, alcohol or foods high in sugar tend to have a regressive effect, because households in the lower income bracket spend, on average, a larger proportion of their income on the consumption of these products (Klosterhalfen and Kotz, 2025; Staudigel et al., 2025). Compared to European standards, socio-economic inequalities in the incidence of these risk factors are significant in Germany (OECD and European Observatory, 2025). In the long term, price responses in these groups are often more pronounced, meaning that price increases have a disproportionately strong health-related steering effect there (Allcott et al., 2019) and can reduce existing inequalities in the burden of disease (Rogers et al., 2023; Cobiac et al., 2024). Over the course of a lifetime, the net incidence of such taxes is likely to be progressive when long-term health gains and the associated higher lifetime earnings are taken into account (Nomaguchi et al., 2017; Fuchs et al., 2018).

243. For tax increases to effectively steer behavior, potential substitution effects must be taken into account. On the one hand, significant price differentials can lead to cross-border shifts in demand. Whilst the price of tobacco in Germany has already risen significantly compared to neighbouring countries due to a series of tax increases in the past, the price of alcohol remains at a comparatively low level (Eurostat, 2025). In this respect, substitution effects are likely to be less pronounced there. Secondly, the steering effect is likely to be particularly high if tax increases affect broad product groups equally, thereby avoiding substitution effects towards alternative products such as sweeteners, which are themselves potentially harmful to health (BfR, 2023) in the case of an excise duty on sugar (Plamper et al., 2006; Müller et al., 2010; García-Chávez et al., 2025).

Targeted use of cost-sharing

244. Cost-sharing by insured persons aimed at reducing demand for services of limited medical benefit often fails to achieve its intended effect, as it also reduces the uptake of medically necessary services. ↘ BOX 11 The medical necessity of services can generally be better assessed by healthcare professionals than by insured persons. **Measures to reduce medically unnecessary services should therefore primarily target service providers.** Insured persons, on the other hand, can influence the healthcare costs they incur primarily through their state of health. To improve this, the regulatory framework for health-promoting behaviour should be strengthened ↘ ITEM 239 and the use of preventive services encouraged. ↘ ITEM 248

245. Co-payments in the outpatient sector are particularly appropriate where, whilst maintaining the same level of effectiveness, they provide incentives to **choose a more cost-effective healthcare service** over a higher-priced alternative. This

is currently the case in the area of medicines and with cost-sharing for dental prostheses. ↘ ITEMS 199 F. A blanket extension of cost-sharing, for example through the reintroduction of the practice fee, should, however, be viewed critically, as it may also reduce necessary visits to the doctor. Instead, **measures to reduce the costs of individual doctor's visits** should be strengthened, for example through the use of telemedicine or improved patient management. ↘ ITEM 254 Co-payments for inpatient services, on the other hand, exhibit low demand elasticity and therefore primarily serve a **financing function**.

246. The flat-rate co-payments for GKV services have not been increased since 2004. The FKG estimates the potential additional revenue from **an inflation adjustment of the flat-rate co-payments** at €1.9 billion (FKG, 2026). However, the co-payment caps significantly dampen the additional revenue. ↘ ITEM 201 In simulations by the GCEE, the additional revenue falls to as low as €1.1 billion when the co-payment caps are taken into account. This corresponds to an increase in the statutory health insurance scheme's revenue from co-payments of around 22 % and would enable an immediate reduction in contribution rates of 0.1 percentage points. The actual additional revenue is likely to be even lower if insured persons adjust their behaviour or if more insured persons reach the financial burden limit. Furthermore, higher co-payments may increase the expenditures of individual health insurance funds, as they bear the costs when the financial burden limits are exceeded and these are not offset via the Morbi-RSA (FKG, 2026).

247. An isolated increase in patient contributions would also have distributional implications. Although the current cost-sharing limits of 2 % of gross income (or 1 % for the chronically ill) cap the total annual burden, one-off, flat-rate co-payments incurred before these thresholds are reached place a particular strain on low-income households facing liquidity constraints. Empirical evidence shows that cost-sharing can lead to health-damaging behavioural changes, particularly among vulnerable groups. ↘ BOX 11 To mitigate these distributional effects, it would be sensible to introduce an **exemption from co-payments for low-income insured persons** at the start of the year, in addition to the existing cost caps (WHO, 2025). Health insurance funds could implement this upon application by the insured. A similar exemption scheme already exists under the fixed subsidy system for dental prostheses. ↘ ITEM 265

248. Cost-sharing schemes in the form of bonus programmes designed to promote preventive behaviour have only a limited effect in their current form (German Bundestag, 2021a). From the insured persons' perspective, they often reward not only behavioural changes but also existing behaviour, leading to selection and deadweight effects. To encourage effective behavioural changes, bonus schemes should only promote services that have a scientifically proven additional benefit for health (BVA, 2018). Broader cost-sharing measures such as deductibles have neither a targeted nor a positive effect on prevention efforts (Brot-Goldberg et al., 2017). On the part of health insurance funds, further development of the Morbi-RSA could create incentives to invest in effective preventive services and incentives. ↘ ITEM 197 Reform proposals include, in particular, an increase in the financial volume (Drösler et al., 2025), an extension to further preventive measures

(Berndt et al., 2025) and adjustments to the disease weighting in the Morbi-RSA (Häckl et al., 2016).

249. In addition to cost-sharing, the digitalisation of the healthcare system also has the potential to influence the behaviour of insured persons and thereby reduce healthcare costs. In this context, the electronic patient record (ePA), introduced in 2025, could be used for digital nudging by providing insured individuals with personalised digital reminders regarding preventive check-ups, booster vaccinations or medication intake (Strandbygaard et al., 2010; Milkman et al., 2021; GKV-Spitzenverband, 2026c). Furthermore, the ability to view billing data in the ePA could, in principle, encourage greater engagement with one's own healthcare costs and thus lead to more cost-conscious use of services. Billing fraud could also be more easily detected by insured individuals in this way (Deutsches Ärzteblatt, 2023; GKV-Spitzenverband, 2025). As the user-friendliness and actual usage of the ePA can still be significantly improved, this potential remains largely untapped at present (von Kalckreuth et al., 2025; BMG, 2026e). ↘ ITEMS 267 FF.

Hospital funding and service provision structured to meet needs

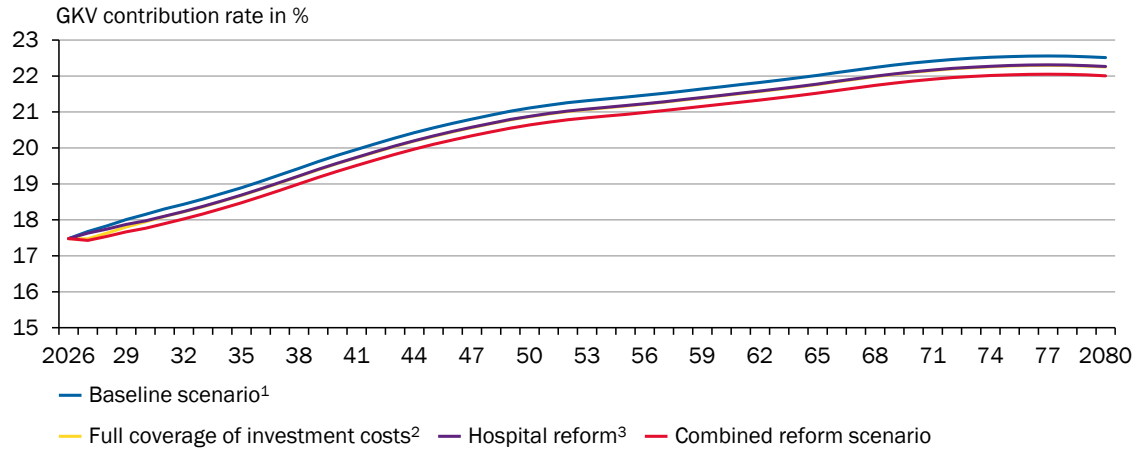
250. **A sustainable cap on rising expenditure in the hospital sector requires a combination of structural reforms, adjusted remuneration mechanisms and clearer financial accountability.** The hospital reform initiated by the previous government in the 20th legislative period opens up the possibility of unlocking efficiency gains and strengthening the quality of care through greater specialisation, better quality assurance and a further decoupling of hospital funding from the number of patients treated (BMG, 2024). In doing so, it addresses key structural causes of rising expenditure in the hospital sector.

Consistent implementation of the reform could permanently reduce the average contribution rate by up to 0.4 percentage points. However, following the current amendments under the Hospital Reform Adjustment Act (KHAG), only about half of this potential for cost relief is likely to be realised (Augurzky and Karagiannidis, 2026). Nationally defined service groups for hospitals with clearly verifiable quality criteria can make a significant contribution to achieving these goals. ↘ BOX 13 However, as the reform is being revised, it is becoming apparent that quality standards are being relaxed and implementation deadlines and exemptions extended. ↘ ITEM 230 Transitional and exemption provisions should therefore be strictly limited to cases where they are demonstrably necessary to prevent gaps in care. Based on the simulations by the GCEE, **implementing the scaled-back reform** from 2026 onwards is likely **to reduce** the **contribution rate** in 2030 **by up to 0.2 percentage points to 18.0 %** compared with the baseline scenario. ↘ CHART 52 Judging by expenditures on inpatient care and the presumed extent of inefficiencies in the German healthcare system, these effects appear to be rather small.

251. In addition to structural reforms, adjustments to reimbursement mechanisms can also help to limit the rise in expenditure. To limit the rise in expenditure on inpatient care in the short term, the **most-favoured-rate clause** could be suspended for the next few years. ↘ BACKGROUND INFO 12 During this period, it could be

↘ CHART 52

Effects of hospital financing reforms on the insurance GKV contribution rate



1 – Development under current law with rule-based roll-over of federal funds, expected demographic trends and roll-over of the MTF with moderate growth. 2 – Effects of the federal states fully covering hospitals' investment costs. 3 – Effects of the hospital reform if all measures planned by the previous government in the 20th legislative period are implemented.

Sources: BMG, SIM.24

replaced by a mechanism that limits remuneration to the actual cost trend (reference value). The scale of the effects of the one-off suspension of the clause in 2026 is illustrated by the following figures: this will prevent increases in GKV expenditure of up to €1.8 billion in 2026 (German Bundestag, 2025a). This also has a base effect in subsequent years, as future increases will start from a correspondingly lower baseline.

To curb the rise in expenditure more effectively, the current approach of basing expenditure on average cost trends could be replaced by a benchmark that takes the quality of care into account and promotes the efficient delivery of services. However, overly strict indexation could lead to gaps in care in the long term, particularly if hospital costs rise more sharply than expected due to advances in medical technology or exceptional cost shocks faced by hospitals. ↘ ITEMS 221 F. To avoid systemic underfunding, a reform of the most-favoured-rate clause could be supplemented by a **temporary exemption**, for example in the event of pandemics. Its activation could be linked to formal determinations, such as the declaration of an epidemic situation of national significance (Section 5 IfSG). In crisis years, a temporary surcharge would then be possible.

252. **To reduce misleading incentives arising from separate care funding and simultaneously ensure that care staff are deployed in line with needs, a legally and operationally clear definition of eligible care services** ('bedside care') **is crucial**. This limits the risk of care staff being deployed for non-care-related tasks and the associated costs being charged to the care budget. A reform of the care budget should aim to ensure that cost increases are passed on less directly to the insured, but that service providers bear greater responsibility for efficient staffing and budget management. ↘ ITEM 229 Furthermore, improvements in nursing staffing levels in the hospital sector should be considered across sectors, as increasing staffing in the inpatient sector during nursing

staff shortages can lead to displacement effects and thus potential care deficits in other areas, such as elderly care.

253. The declining investment grants from the federal states increase the incentive for hospitals to finance necessary modernisation through additional treatment revenues. ↘ ITEM 228 The investment deficit thus not only acts as a financing problem but simultaneously reinforces the incentives to expand the volume of care. Greater acceptance by the federal states of their responsibility for hospital investments could reduce these incentives. **A full assumption of investment costs by the federal states would relieve the GKV of up to €4.5 billion annually.** ↘ BOX 10 This would ease the burden on contributors, but at the same time increase the pressure for consolidation in state budgets and thus potentially the burden on taxpayers.

The extent of the funding shortfall in the long term also depends on the consistent implementation of the hospital reform: if the number of hospital sites falls, maintenance and repair requirements may also decrease in the long term. The medium-term transition costs are to be cushioned by the Transformation Fund. This fund is limited in time until 2035 and is financed half from the liquidity reserve of the Health Fund – i.e. from GKV funds – (BAS, 2026b). It can thus support the transition, but does not permanently replace investments by the federal states. This requires an increase in state funding on the scale of the remaining investment needs following the completion of the reform. Based on the simulations by the GCEE, a full assumption of the investment costs from 2026 onwards is likely to permanently reduce the contribution rate by up to 0.2 percentage points compared with the baseline scenario. ↘ CHART 52

254. Another key lever for curbing expenditure lies in reducing avoidable inpatient treatments. Compared to other countries, Germany has a very high proportion of such avoidable inpatient treatments (OECD and European Observatory, 2025). ↘ ITEM 231 Some of these cases can be avoided by **expanding outpatient care** and **improving patient management** along the care pathway, without compromising the quality of care. On the one hand, the **AOP catalogue** can be further developed so that suitable procedures are routinely performed on an outpatient basis. This requires clear quality and aftercare requirements to prevent gaps in care. Secondly, an expansion of sector-neutral remuneration schemes, such as hybrid DRGs, could alter the incentives for service providers in such a way that the choice between outpatient and (short-term) inpatient treatment is determined more by medical considerations than by economic ones (Hengel et al., 2026). Furthermore, expanding patient management in primary care can help to reduce avoidable inpatient treatments (Sripa et al., 2019; Marchildon et al., 2021). For instance, GP-centred models can consolidate care more effectively, reduce unnecessary referrals to specialists and duplicate examinations, and reliably organise outpatient follow-up care (Hofmann and Mühlenweg, 2017; Gerlach and Szecsenyi, 2020).

Aligning drug prices more closely with therapeutic benefit added

255. The rise in GKV expenditure on medicines in recent years has been driven primarily by new, patent-protected medicines. ↘ ITEMS 232 F. Given the increasing number of new, individualised treatment methods resulting from medical-technological progress, the **design of drug pricing** plays a central role in determining future expenditure growth for the GKV.

However, there is a conflict of objectives here. Stricter, value-based pricing rules may help to limit GKV expenditures and increase incentives for manufacturers to generate robust evidence and demonstrate additional therapeutic benefit. At the same time, however, there is a risk that lower expected revenues will lead to a delayed market launch of new medicines and reduce manufacturers' innovation activity, particularly in the case of incremental innovations. Empirical studies show that stricter price regulation can lead to a delayed market launch of new medicines (Kamphuis et al., 2021; Büssgen and Stargardt, 2023). However, there is no clear empirical evidence on the extent to which price regulation influences the innovation and location decisions of pharmaceutical companies (SVR Gesundheit & Pflege, 2025). Furthermore, the promotion and funding of private-sector research and development activities is not part of the statutory remit of the GKV (SVR Gesundheit & Pflege, 2025). Support for Germany as a pharmaceutical hub should therefore not be provided through price mechanisms, but through appropriate funding measures, for example those financed from tax revenue.

256. The SVR Gesundheit & Pflege has recently put forward comprehensive reform proposals under which the pricing of innovative medicines could be aligned more closely with their additional therapeutic benefit (SVR Gesundheit & Pflege, 2025). Among other things, this could involve abolishing the current privilege enjoyed by orphan drugs, which allows them to be granted a notional additional benefit without undergoing a standard assessment. The draft of the Statutory Health Insurance Contribution Rate Stabilisation Act, on the other hand, provides for a certain relaxation of the current price regulation. In future, medicines with low or non-quantifiable added benefit would again be able to claim a higher price than the comparative therapy in order to reward the associated innovation. Only for medicines with no added benefit or with an unproven added benefit will strict price limits continue to apply. These measures are accompanied by a dynamic manufacturer discount, which links the rise in expenditure on patent-protected medicines with a negotiated reimbursement amount more closely to the development of revenue subject to contributions. At the same time, the draft bill provides for the possibility of an exemption from this dynamic manufacturer discount for medicines containing new active substances, provided that clinical trials have been conducted to a relevant extent in Germany and the production of the active substance in Germany is expected to make a relevant contribution to meeting supply needs (Federal Government, 2026). Such location-based policy exceptions at the expense of the GKV must be rejected for the reasons already mentioned above.
↘ ITEM 255

2. Recalibrating financing

257. The financing of the GKV can be stabilised primarily through reforms on the expenditure side. ↘ ITEM 238 Nevertheless, reform proposals for the GKV often focus on the revenue side. While such proposals would often limit the foreseeable rise in GKV contribution rates, they would not reduce the burdens associated with financing healthcare costs, but merely shift them. This would simultaneously reduce the pressure to overcome existing inefficiencies in the healthcare system. Furthermore, some proposals are not compatible with the existing, historically developed dual health insurance system comprising statutory and private health insurance. Significant improvements could only be achieved through very fundamental reforms, which, however, would also entail potential drawbacks. ↘ BOX 15 Against this background, the following section examines revenue-side reform options that appear feasible within the existing statutory health insurance contribution system. It considers the effects of increasing the federal subsidy to cover non-covered benefits (NBL), ↘ ITEM 258 as well as restricting the non-contributory co-insurance of spouses. ↘ ITEMS 259 F. In addition, the effects of a greater increase in the federal contribution ceiling than that associated with general wage growth, an extension of the contribution base to include further types of income, and an increase in the annual income threshold or the inclusion of further groups of people, such as civil servants, in the statutory health insurance scheme are discussed. ↘ ITEMS 262 FF.

↘ BOX 15

Background: Alternative financing options for the GKV through taxes vs. premia

Discussions on fundamental reforms of the revenue side of the GKV can be narrowed down to two basic alternatives, which can also be observed to some extent in an international comparison: full tax financing of healthcare expenditure or financing via income-independent premia. ↘ ITEMS 211 FF. It is questionable to what extent such reforms could be implemented in the historically evolved German healthcare system. Nevertheless, it is interesting to examine the foreseeable institutional and economic consequences of each option in greater detail, as both sides have their advantages and disadvantages.

A transition to full tax funding of the healthcare system would see the current contributions to the GKV abolished and replaced by correspondingly higher taxes. Based on current contribution revenue, this would result in an additional tax revenue requirement of around €350 billion. The distributional effects of such a system change would depend largely on the specific design of the alternative funding mechanism. Funding via personal income tax would tend to have a progressive effect, whereas greater reliance on indirect taxes, such as VAT, would tend to have a regressive effect. Whilst the distributional effects could be shaped during the transition, they would become significantly less transparent in the further course of budgetary developments than under the existing contribution-based system. Furthermore, on the one hand, the fundamental cap on the budget for state healthcare services resulting from contribution-based financing would be removed. On the other hand, in the long term, these funds would be included in the competition for general budgetary resources without any special prioritisation. The effects on labour supply incentives would also depend significantly on the extent to which the required tax revenue were generated through taxes on earned income. However, the burden on labour is likely to be lower than under the status quo, provided that funding is at least partially sourced from other tax revenues. A key advantage would be that tax-based funding would incorporate

those previously covered by private insurance into the redistribution process, which currently takes place only within the group of GKV policyholders. At the same time, the business model of PKV would be fundamentally called into question. Private health insurers would only be able to offer supplementary insurance for services not included in the GKV benefits catalogue. A complete abolition of PKV, however, would face legal hurdles. ↘ ITEM 264 Finally, with full tax funding, the scope for influencing insured persons would also change. Whilst varying supplementary contributions and optional tariffs currently provide at least some incentives for cost-consciousness or the choice of more cost-effective forms of care, such control over services would be largely eliminated in a tax-financed system. In the case of full tax funding, steering effects vis-à-vis service providers could no longer be achieved through competition and the contractual arrangements of health insurance funds, but would have to be pursued solely through regulatory instruments, remuneration structures and budgeting.

A shift towards a system of non-means-tested premia in the statutory health insurance scheme would separate the insurance function of health insurance from its redistributive function. Such a separation may make economic sense, as insurance and redistribution objectives can be pursued more efficiently and transparently through different instruments. To avoid regressive distributional effects, the redistribution previously carried out within the GKV would have to be shifted to the general tax and transfer system, so that those previously privately insured would also contribute to it in this case. Premium financing would have to be firmly linked to a reliable and, as far as possible, low-bureaucracy social equalisation scheme, which is likely to prove difficult. According to calculations by the GCEE, a cost-covering premium in 2025 would amount to around 390 euros (or 480 euros if children continue to be co-insured free of charge) and would place an excessive financial burden on low-income households. Social compensation would need to be permanently linked to the development of premia and designed to be as automated as possible in order to avoid cases of non-take-up. One advantage of such a system would be that the financing of healthcare expenditure would no longer be directly linked to labour. Income-based contributions currently increase the marginal tax burden on earned income; flat-rate premia would remove this burden. At the same time, tax-financed social compensation would draw on other types of income alongside earned income, similar to full tax funding. However, this would still result in marginal tax burdens on earned income. Furthermore, social equalisation would also come into conflict with general budgetary constraints, which could undermine the reliability of its funding. Flat-rate premia expand the scope for managing insured persons, as they allow for more differentiated plans with deductibles, premium refunds or supplementary insurance. This could strengthen competition between health insurance funds. These control options could be further expanded if premia were no longer financed equally by employers and employees, but instead the employer's share were transferred into higher gross wages and the premia were borne solely by the insured. In this case, future premium increases would have to be borne entirely by the insured, but they would be more aware of differences in premia. In addition, premia could be defined and levied for individuals who are currently co-insured without paying contributions, such as non-employed spouses without care responsibilities. ↘ ITEM 260 The scope for influencing service providers would remain in principle and could be intensified through stronger care management by the health insurance funds. Finally, a system with income-independent premia could continue to exist in parallel with private health insurance.

Such a model was briefly trialled in Germany in the past in the form of flat-rate supplementary contributions, which were intended to influence insured persons' marginal decisions regarding their insurance cover without bringing about an abrupt change to the system. However, it was abolished again before reliable findings on the effects on competition and insured persons' behaviour could be obtained. ↘ BACKGROUND INFO 10

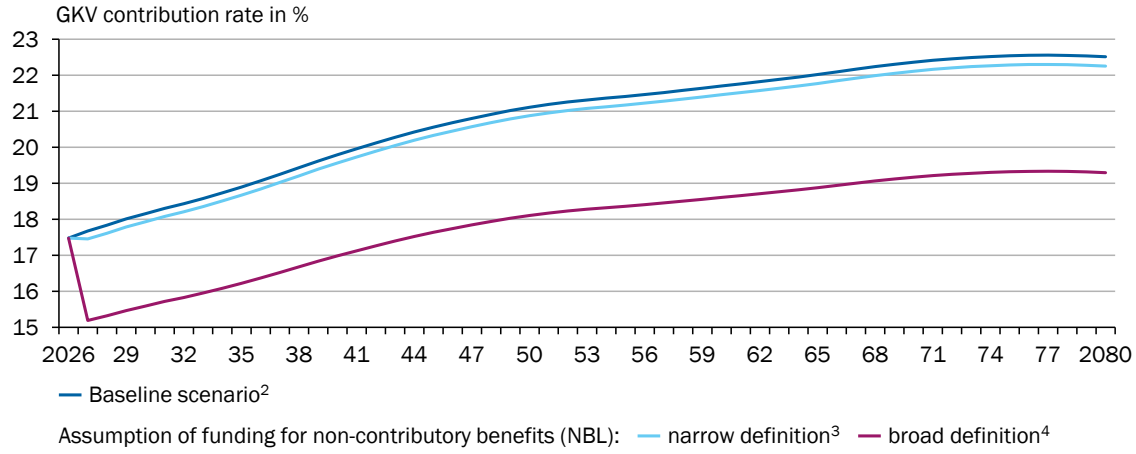
Adjustments to NBL and non-contributory co-insurance

258. Through the federal subsidy, the federal government contributes to the costs of services provided by the GKV in the interests of society as a whole. ↘ ITEM 196 The federal subsidy is intended to cover these so-called NBL on a flat-rate basis. However, in the absence of a legal definition, it is not possible to determine exactly to what extent the subsidy covers such services. If the NBL is narrowly defined, the current regular federal subsidy of €14.5 billion falls short by around €4 billion of the actual NBL costs incurred and attributable to the federal government. ↘ BOX 10 If a broader definition is applied, which in particular classifies the non-contributory co-insurance of children as not covered by contributions, the shortfall amounts to up to €40 billion. **An increase in the federal subsidy on this scale would permanently reduce the contribution rate by 0.2 to 2.5 percentage points**, ↘ CHART 53 but would only marginally dampen the long-term rise in the contribution rate overall. At the same time, a higher federal subsidy would not be financially viable without corresponding adjustments to the federal budget, which could be substantial depending on the extent of the NBL.

In any case, the federal subsidy should be indexed to ensure that its share of total revenue does not fall. ↘ CHART 44 In particular, the federal subsidy should not be reduced for the sake of consolidating the federal budget. In addition, the federal government should promptly increase at least the flat-rate payment for basic income support recipients from the current €133 to €221, in line with the contribution for an employment income with a net income equal to the average basic income support payment. This would lead to **additional revenue for the GKV of** at least **€4.2 billion** and reduce the contribution rate by just under 0.2 percentage points. ↘ BOX 10

↘ CHART 53

Effects of NBL[1] funding on the GKV contribution rate



1 – Effects of financing non-contributory benefits (NBL) through the federal budget. 2 – Development under current law with rule-based roll-over of federal funds, expected demographic trends and under a moderate roll-over of the MTF with moderate growth. 3 – The narrow definition covers 'justifiable' NBLs (see Table 10), excluding the funding gap for hospital investments. 4 – The broad definition covers 'justifiable' and 'partially justifiable' NBLs (see Table 10), excluding the funding gap for hospital investments.

Sources: BMG, SIM.24

259. One of the largest benefits classified as not covered by contributions is the **non-contributory co-insurance of spouses** who are not in employment themselves or are only marginally employed. According to estimates by Albrecht and Ochmann (2025), benefit expenditure for non-contributory co-insured spouses amounted to around €11.4 billion for the year 2023. Compared to the non-contributory co-insurance of children, this cannot always be justified by the expectation of future contributions to the pay-as-you-go financing of the GKV. An exception could be the non-contributory co-insurance of spouses who are raising children. Calculations based on the SOEP show that only one third of married couples with a spouse covered under non-contributory co-insurance have a child under the age of 18. **Consequently, spouses who are not involved in child education benefit to a significant extent from non-contributory co-insurance.** It favours single-earner households and reduces incentives to work. ↘ BOX 16

↘ BOX 16

Background: Potential incentives to work resulting from the abolition of non-contributory co-insurance in the GKV

The provision of free co-insurance for spouses leads to a sharp rise in the effective marginal tax burden for second earners, as even a slight exceedance of the income threshold triggers the loss of free co-insurance and thus the obligation to pay their own GKV contributions. ↘ ITEM 116

↘ TABLE 11

Change in the labour participation rate of mothers and household income in the scenario[1]: "Loss of non-contributory co-insurance in the GKV

	Change in the labour participation rate of mothers	Change in the average working hours of mothers	Change in disposable net household income[2]
	Percentage points	absolute (%)	Euros/month in prices of 2025[3]
Total	1.1	1.4 hours (3.9 %)	23.5
Family with 1 child[4]	0.9	0.4 hours (3.3 %)	30.4
Family with 2 children[4]	1.3	0.5 hours (4.4 %)	16.6
Family with 3 children[4]	1.4	0.5 hours (6.5 %)	– 4.2
Youngest child < 1 year	0.4	0.2 hours (7.2 %)	– 29.1
Youngest child >= 1 year and < 2 years	1.6	1.2 hours (5.7 %)	9.7
Youngest child >= 2 and < 3 years	1.3	1.4 hours (3.8 %)	20.8
Single parent	0.2	0.3 hours (0.8 %)	15.2
Income: 1st quartile	0.1	0.3 hours (0.7 %)	6.9
Income: 2nd quartile	1.2	1.4 hours (4.7 %)	8.3
Income: 3rd quartile	1.7	2.3 hours (6.5 %)	24.9
Income: 4th quartile	1.4	1.4 hours (3.8 %)	15.2

1 – All spouses previously covered free of charge must pay a monthly contribution to the GKV of €132.15 in 2010 (€182.85 in 2025 prices). Based on the DIW's STMS tax-transfers model, using data from SOEP 2010 and FiD 2010. 2 – Expected value of changes in income following adjustments for employment and care arrangements. 3 – Adjusted for inflation using the consumer price index, based on calculations by the GCEE. 4 – Children under the age of twelve, there may be older children living in the household.

Sources: Federal Statistical Office, Müller et al. (2013), own calculations

Several empirical studies for the US show that non-contributory health insurance for married women has negative effects on their labour force participation. The studies are based predominantly on a comparison of women whose husbands have employer-sponsored health insurance and those without such access. This identification strategy assumes that the husband's health insurance coverage is exogenous. However, this assumption is problematic when households make a joint labour supply decision (Gruber and Madrian, 2002). The estimated effects on women's labour force participation range from around 2.6 % to 12 % (Olson, 1998; Buchmueller and Valletta, 1999; Cebi and Wang, 2013).

A simulation study using SOEP data from 2010 by Müller et al. (2013) examines a hypothetical scenario of a revenue-neutral reform for Germany. They estimate that the employment rate of mothers would increase by 1.1 percentage points if all spouses currently covered without paying contributions were required to pay a monthly contribution of €132.15 (€182.85 in 2025 prices). However, couples with many and younger children in particular would face income

losses, as single-earner couples are more common among these families, where the second earner has limited scope to expand their labour supply. ↘ TABLE 11 It would therefore make sense to retain non-contributory co-insurance for spouses raising children.

260. **By levying contributions from spouses who were previously co-insured free of charge, the GKV could be relieved and incentives for second earners to work could be increased.** To avoid placing a burden on couples who can hardly expand their labour supply due to child-rearing, ↘ BOX 16 it seems sensible to continue the contribution-free co-insurance during the first years of child-rearing. For spouses currently covered free of charge who are not raising children, an appropriate contribution would need to be defined. For instance, similar to voluntary insurance under the GKV, a minimum contribution could be set. For those voluntarily insured under the GKV, this would amount to an average of €222.80 in 2026, the contribution that would apply to a notional monthly income of €1,318.33 (BMG, 2026f). The FKG estimates the potential additional revenue from levying a minimum contribution on married couples without children under the age of six – excluding spouses over the standard retirement age – at up to €4.4 billion (FKG, 2026). However, it must be borne in mind that the actual additional revenue for the GKV will change if the collection of contributions produces the desired positive incentives to work. If previously contribution-exempt spouses take up employment, the minimum contribution would no longer apply; at the same time, however, additional contribution and tax revenue would be generated. The positive effect could be limited by the fact that simply taking up a 'midi-job' just above the 'mini-job' threshold would be sufficient to trigger the waiver of the minimum contribution (Breyer, 2025).

261. The draft GKV Contribution Rate Stabilisation Act proposes limiting contribution-free co-insurance to spouses with children up to the age of 7, with children with disabilities, with dependants requiring care, and after reaching the standard retirement age (Federal Government, 2026). In other cases, members with spouses currently covered free of charge are to pay a contribution surcharge amounting to 2.5 % of their contributory income. The amount payable is therefore always significantly lower than the minimum contribution for voluntarily insured persons under the GKV and results in lower revenue than estimated by the FKG. Furthermore, given the low contributions, it is questionable whether the collection of contributions will significantly increase the incentives for second earners to work.

Expansion of the contribution base or the insured group of insured persons

262. GKV revenue could also be increased by expanding the contribution base, either by raising the BBG or by including further types of income. **Raising the BBG to the level of the JAEG** (from €69,750 to €77,400 per year) would involve insured persons not exempt from insurance with incomes above the current BBG more heavily in the financing of the GKV. At the same time, incentives for insured persons exempt from insurance and with incomes above the current BBG to

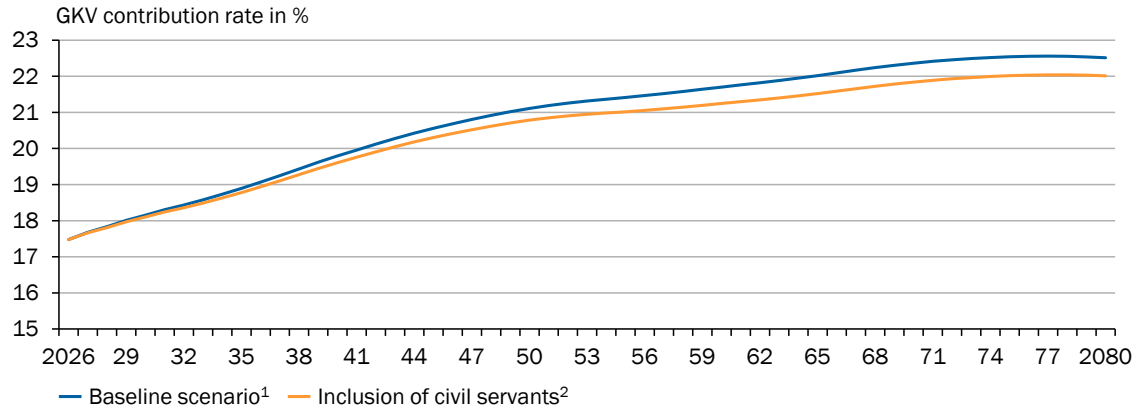
switch to the PKV would increase. This could dampen the GKV's additional revenue. The draft GKV Contribution Rate Stabilisation Act proposes a one-off, extraordinary increase in the BBG of €3,600. At the same time, the JAEG is to be raised by €3,600 to limit switches to the PKV. A more significant increase or complete abolition of the BBG could raise constitutional issues (German Bundestag, 2021b). Unlike the GRV, the principle of equivalence does not apply in the GKV. An increase in the individual contribution is therefore not matched by higher benefits, meaning that the tax-like nature of GKV financing would be further reinforced. ↘ ITEM 211 To prevent people switching to PKV, the JAEG would also need to be adjusted both in the event of an increase in the BBG and the inclusion of further types of income (German Bundestag, 2010). For the reasons stated, this is logically consistent with the system, but it also raises constitutional questions. ↘ ITEM 264

An expansion of the contribution base in the GKV to include **further income components** such as interest, dividends or rental income would formally broaden the funding base. However, it would only affect those with compulsory insurance, as all types of income up to the BBG are currently already included for voluntarily insured persons. According to calculations by Steuernagel and Thum (2023) based on 2019 figures, income subject to contributions would rise by a maximum of 2.5 %, which would have increased the GKV's revenue by €4.2 billion. Due to administrative costs and avoidance behaviour, particularly switching to PKV upon exceeding the JAEG, the net effect is likely to be even smaller. Extending the scheme to include investment income would also reduce the incentives to generate such income. Including further types of income therefore does not appear to be advisable.

263. The inclusion of (some) privately insured individuals in the statutory health insurance scheme, for example by raising the JAEG or by transferring civil servants to the GKV, would also have positive effects on revenue. Due to the income- and risk-based selection into PKV, the significantly higher contributory income of privately insured individuals would be offset by their slightly higher benefit expenditure, resulting from the less favourable age structure. ↘ TABLE 12 APPENDIX **According** to estimates by Ochmann et al. (2020), a positive net financial surplus of up to €10.6 billion per year for the reference year 2016, which at the time would have corresponded to a reduction in the cost-covering contribution rate of a maximum of 0.7 percentage points. However, if the volume of payments for outpatient care had been adjusted at the same time so that the previous expenditures of the PKV were additionally covered by the GKV, the net financial surplus would have amounted to a maximum of €4.3 billion per year and would have allowed for a reduction in the cost-covering contribution rate of no more than 0.3 percentage points (Ochmann et al., 2020).

Including civil servants in the GKV appears to be a possible reform scenario. Simulations by the GCEE show that including all new civil servants could gradually reduce the contribution rate over time. ↘ CHART 54 In 2030, this would reduce the contribution rate by 0.05 percentage points, and by 0.19 percentage points in 2040. As a simulation of the effects of including civil servants in the GKV and supplementary health insurance (SPV) schemes on their finances and on state subsidy expenditure shows, this would place an additional burden on the general

↘ CHART 54
Effects of including civil servants on the GKV contribution rate



1 – Development under current law based on a rule-based roll-over of federal funds, expected demographic trends and a roll-over of the MTF with moderate growth. 2 – Inclusion of new civil servants from 2027 onwards in the GKV.

Sources: BMG, SIM.24

government during a long transitional phase shaped by the age structure of civil servants in the various systems. ↘ CHART 56 APPENDIX Ochmann et al. (2017) simulate the financial effects of a different reform, in which, with immediate effect, all civil servants would be subject to the same compulsory insurance under the GKV until reaching the age of 65 as employees. In this reform scenario, 88 % of civil servants would be insured under the GKV. This would also generate additional revenue for the GKV whilst simultaneously providing net relief for the general government and civil servants. Another reform proposal under discussion is the introduction of a flat-rate allowance modelled on schemes in some federal states, whereby the employer would provide a subsidy equivalent to the employer's share of the statutory health insurance contribution (German Bundestag, 2025b). This would enable civil servants to take out GKV without suffering any financial disadvantage compared to private health insurance policies.

264. **Reforms that would lead to the complete abolition of the PKV would face significant legal hurdles**, particularly regarding the use of accumulated capital reserves (German Bundestag, 2010). A uniform compulsory insurance scheme effective from a specific date, modelled on the Netherlands, which unified its dual health insurance system in 2006, therefore does not appear feasible (Greß and Lüngen, 2017). Instead, various transitional solutions are proposed involving a general compulsory insurance scheme within the GKV, with grandfathering provisions for existing private health insurance contracts and the option to switch to the GKV (Rothgang and Götze, 2013; Greß and Lüngen, 2017). As a result, the premia for existing PKV members would age significantly without new entrants. However, problems regularly arise regarding the role that the accumulated ageing provisions might play in this context and whether the GKV fund should be granted access to them. In any case, this would resolve the current issue of partial capital coverage for future healthcare costs. Instead of compulsory insurance under the GKV, there are other options for strengthening the rights to choose and switch between statutory and private health insurance (Kingreen, 2025).

APPENDIX

1. Cost sharing

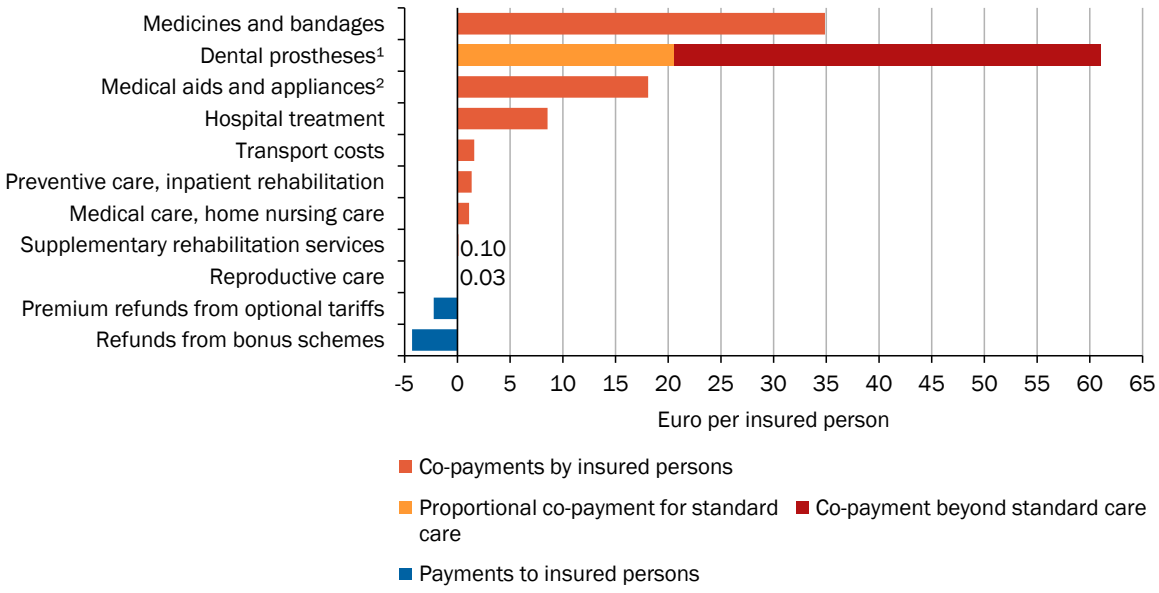
265. In the GKV, cost sharing is mainly levied in the form of co-payments. ↘ ITEM 200 An exception is the fixed subsidy system for dental prostheses. For dental prostheses, the GKV grants diagnosis-based fixed subsidies amounting to 60 to 75 % of the average costs of standard care, depending on the insured person's preventive care behaviour. The remaining share of these costs, as well as additional costs incurred when opting for higher-quality services, are borne by the insured and averaged 61 euros per insured person in 2024. ↘ CHART 55 Overall, two-thirds of the costs for dental prostheses are thus borne privately. Cost sharing for standard care is not subject to the maximum contribution limit; only for insured persons below defined income thresholds (€1,582 gross income for single persons in 2026) are the costs of standard care covered in full upon application.

266. Optional plans with deductibles, premium refunds or benefit restrictions are a further instrument of cost-sharing in the GKV. Despite reimbursement options of up to €600 per year, in 2024 only 1 % of GKV policyholders opted for plans with deductibles or premium refunds (BMG, 2026g), resulting in only minor payments from health insurance funds to policyholders. ↘ CHART 55 In PKV, cost-sharing through such instruments is significantly higher. Deductibles can be chosen as a

↘ CHART 55

Cost-sharing in GKV by service area in 2024

Average amount per insured person



1 – For dental prostheses, the percentage cost-sharing for standard care corresponds to the difference between the GKV's fixed subsidy for standard care and the cost of the service. The fixed subsidy system for dental prostheses acts as a form of partial insurance; consequently, co-payments for standard care are not formally recorded as co-payments.
2 – Medical aids are non-medical therapeutic services such as physiotherapy. Medical appliances are physical medical products such as wheelchairs.

Sources: BMG, KZBV, own calculations

fixed amount or as a percentage when taking out a policy and are capped at 9,000 euros per year. In 2026, they averaged 575 euros (PKV-Verband, 2026c). In 2023, PKV paid out premium refunds amounting to 3.1 % of revenue to policyholders (PKV-Verband, 2025).

2. Electronic patient records – potential and obstacles

267. A key component of digitalisation in the healthcare sector is the standardised electronic patient record (ePA), which has been mandatory for healthcare providers since 2025. By avoiding duplicate examinations and enabling more efficient cross-sector communication between healthcare providers, the ePA offers significant potential for cost savings (Haas, 2017). International studies on the introduction of an ePA show that it can increase productivity in the healthcare sector, reduce the average costs of hospitals by up to 12 % and significantly reduce documentation times in the long term (Campanella et al., 2016; Highfill, 2020).

268. The savings realised depend largely on the widespread use of the ePA. To encourage this, the ePA was introduced with an opt-out scheme, whereby those insured under GKV are automatically included and must actively opt out. No such scheme currently exists for privately insured individuals (SVR Gesundheit & Pflege, 2024). However, the number of users actively using the ePA stood at just 4 million (4.8 %) insured persons in February 2026 (BMG, 2026e). This is due to barriers to digital use for insured persons as well as a slow uptake by doctors' practices (vzbv, 2026).

269. These implementation difficulties point to deeper-rooted problems with digitalisation in the German healthcare system. The lack of user-friendliness in digital services provided by public authorities is a fundamental problem in Germany (Initiative D21 and TUM, 2024). Similarly, the multitude of stakeholders involved, as well as the absence of an overarching coordinating body and measurable targets, have so far delayed the digitalisation of the healthcare system (Caumanns, 2019; Bratan et al., 2022; BRH, 2025). As long as these shortcomings persist, the potential savings offered by the ePA are likely to remain largely untapped (SVR Gesundheit & Pflege, 2025).

The use of ePA data for research purposes has also fallen short of its potential so far due to legal and technical hurdles (SVR Gesundheit & Pflege, 2025). Yet population-wide health data could enable significant progress, for example in the early detection of diseases or in healthcare research (SVR Gesundheit , 2021).

270. International experience shows which measures enable the successful use of the ePA. Denmark combines financial incentives for doctors with the automatic integration of the ePA into GP practice systems, standardised registration via a national portal and transparent data access for patients, thereby achieving full adoption by doctors (Commonwealth Fund, 2010; Jensen and Thorseng, 2017; Dewing et al., 2018). In Estonia, the ePA is part of a mandatory electronic information

system that includes additional functions such as e-prescriptions and e-billing and is used by almost all doctors (Metsallik et al., 2019).

3. Additional tables and charts

↘ TABLE 12

Socio-economic characteristics by type of health insurance

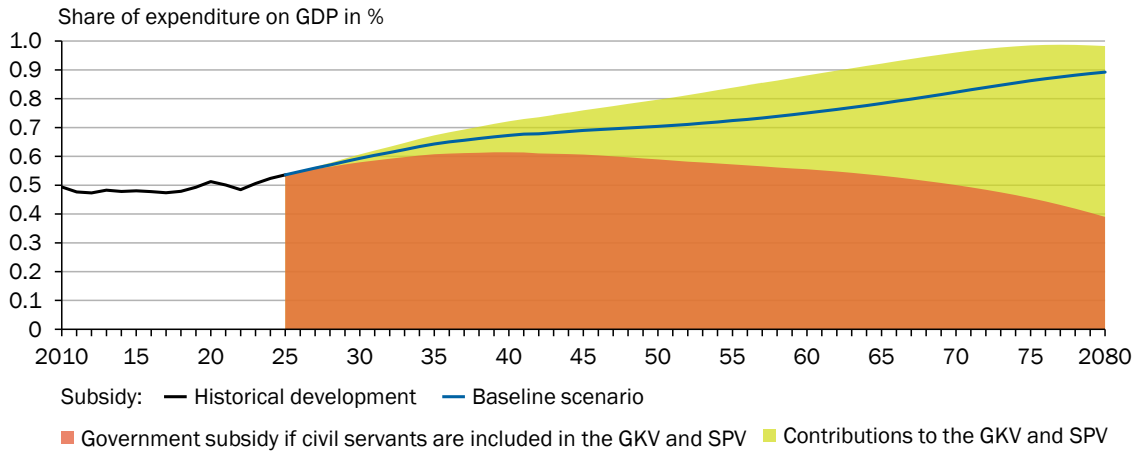
	Unit	GKV	PKV	Difference
		%		percentage points
Demographic composition				
Age	years	51.1	55.5	4.3
Women	%	53.0	39.4	–13.6
Children under 14 in the household	%	17.8	19.0	1.2
High level education[1]	%	29.3	62.2	32.9
Employment structure				
Employed[2]	%	64.6	62.2	– 2.5
Civil servants[2]	%	0.7	44.4	43.7
Self-employed persons[2]	%	6.4	26.5	20.1
Employees[2]	%	73.4	25.8	–47.6
Workers[2,3]	%	19.5	3.3	–16.2
Unemployed	%	3.8	0.4	– 3.5
Pensioners	%	21.4	28.6	7.2
Not in employment	%	8.2	6.1	– 2.2
Net household income per capita[4]	euros	27,501	45,162	17,661
Health status				
Good health[5]	%	45.0	54.4	9.4
Chronically ill	%	46.9	42.4	– 4.4
Doctor's visit in the last 3 months	number	2.5	2.5	– 0.0
Nights spend at hospital in the previous year	number	1.2	0.8	– 0.3
Body Mass Index[6]		26.7	25.6	– 1.0
Smokers	%	23.8	14.7	– 9.1

1 – Tertiary education according to ISCED-2011. 2 – Civil servants, self-employed persons, employees and workers, employees as a share of the employed population. 3 – Including apprentices and trainees. 4 – Equivalence-weighted according to the modified OECD scale. 5 – Self-reported "very good" or "good" health status. 6 – Body weight (kg) / height squared (m^2); measure for classifying overweight (≥ 25).

Sources: SOEP v40.1, own calculations

↘ CHART 56

Effect of including civil servants[1] in the GKV and social long-term insurance (SPV) on general government expenditures



1 – Inclusion of new civil servants appointed from 2027 onwards in the GKV and SPV.

Sources: BMG, SIM.24

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