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SOCIAL LONG-TERM CARE INSURANCE: FOCUSING ON PRIORITIES AND ENSURING INTERGENERATIONAL FAIRNESS IN FUNDING

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KEY MESSAGES

↘ SPV expenditures have risen sharply since the introduction of the Second Long-Term Care Strengthening Act in 2017. The reasons for this are easier access to and the significant expansion of benefits. Demographic ageing will cause long-term care costs to rise further in the future.

↘ The SPV should remain a partial insurance scheme. Restricting access to SPV benefits to a level recommended by experts, along with the abolition of the benefit surcharge and the relief allowance, would significantly curb the rise in expenditure.

↘ In combination with cohort-specific capital funding, such reforms can ensure an appropriate level of benefits with intergenerationally fair financing in the long term.

EXECUTIVE SUMMARY

Social Long-Term Care Insurance (SPV) was introduced in Germany in 1995 as the fifth branch of social insurances to partially cover the financial risk of needing care and to alleviate social hardship resulting from such a need. The need of care predominantly arises in old age and is therefore limited to a few years. Large sections of the population are able to bear the resulting financial burdens themselves, as care is predominantly provided by relatives and many people in need of care can draw on their assets to finance their care.

Expenditures by the SPV have risen significantly in recent years. This is largely attributable to the reforms of the last ten years, in particular the Second Long-Term Care Strengthening Act (PSG II) of 2017. The PSG II has greatly eased access to benefits and expanded the scope of benefits dramatically. The benefit surcharge introduced in 2022 to reduce care-related co-payments in full-time institutional care has further increased expenditures. With demographic ageing, expenditures will continue to rise, whilst revenue grows more slowly. As the SPV is financed via the pay-as-you-go system, ongoing increases in contribution rates will therefore be necessary. By 2040, assuming current legislation remains in place and benefits under the SPV are adjusted in line with wage growth, the GCEE expects the contribution rate to rise from the current average of 3.7 % to 5.2 % of income subject to contributions. This development is problematic for three reasons. Firstly, higher contribution rates lead to greater intergenerational redistribution at the expense of younger generations. Secondly, higher contribution rates place a relatively greater burden on people below the contribution assessment ceiling than on those above it. Thirdly, rising contribution rates can hamper overall economic development.

To address the SPV's structural financing problem, the easier access to SPV benefits introduced in 2017 should be scaled back to a level recommended by experts. In addition, benefits that are not sufficiently targeted, in particular the benefit surcharge for full-time institutional long-term care and the relief allowance across all care grades, should be abolished. Combined with cohort-specific capital funding, these reforms could stabilise an appropriate level of benefits in the long term and ensure a generationally equitable distribution of the financial burdens arising from the need of care.

I. INTRODUCTION

271. The need of care is a fundamental life risk that can entail considerable organisational and financial burdens for those affected and their families. Whilst in the past it was almost exclusively family members who provided care, this is now significantly less common due to falling birth rates, higher labour force participation and a rising number of people living alone. Relatives remain the most important component of care provision today, but their contributions are increasingly being combined with other forms of care. ↘ ITEMS 287 FF. In 1995, Social Long-Term Care Insurance (SPV) was introduced as a separate branch of social insurances. ↘ ITEMS 296 FF. It is intended to distribute part of the financial risk associated with the need of care across the insured community on a solidarity basis. Furthermore, it is intended to ensure that necessary care services are reliably available, that those in need of care can maintain their quality of life and active participation in society, and that the burden on relatives is alleviated.

272. In Germany, around 6.0 million people, or 7.2 % of the population, were officially classified as being in need of care under the statutory definition in 2024. ↘ ITEM 281 In 2016, this figure stood at around 2.9 million people, or 3.6 % of the population. The unexpectedly sharp rise is primarily attributable to the implementation of the Second Long-Term Care Strengthening Act (PSG II), which introduced a new definition of the need of care and a new assessment procedure. ↘ ITEM 304 The risk of being in need of care increases with age and rises sharply, particularly from the age of 75 onwards. **Due to the demographic ageing of society, the number of people in need of care is likely to continue to rise in the future.** ↘ ITEM 286

273. In 2023, around 74 % of those in need of care were looked after at home by relatives (informal care) or by outpatient care services. ↘ ITEMS 287 FF. Around 14 % received institutional care in nursing homes. The remaining 12 % comprised those in need of care with care grade 1.

Informal care is largely provided by people of working age, and predominantly by women. ↘ ITEM 288 The provision of professional care in Germany has been continuously expanded since the introduction of the SPV. ↘ ITEM 291 However, the level of provision varies greatly from region to region. Further expansion is reaching its limits, primarily due to labour shortages. ↘ ITEM 294 Technologies with the potential to boost productivity, such as automation and digitalisation, have so far been used only to a limited extent in the care sector. ↘ ITEM 295

274. The SPV is designed as a partial insurance scheme. This means that **those in need of care must finance part of the care costs from their own income and assets or through private insurance**. ↘ ITEMS 311 FF. These personal contributions have risen in recent years due to substantial wage increases in the care sector, in both home-based and institutional care. ↘ ITEMS 312 FF. A significant proportion of older people have income and assets that can, in principle, be used to finance these care costs. ↘ ITEMS 315 FF. If these funds are insufficient, all those in

need of care are covered by the tax-financed and means-tested 'help with care' on the basis of solidarity. ↘ ITEM 320

275. **A significant proportion of care costs is also borne in the form of informal care provided by relatives and other close associates.** This can place a considerable time burden on carers and, in some cases, lead to long-term disadvantages in terms of employment, income and old-age provision. ↘ ITEMS 321 FF. However, the effects of the informal care sector on the overall economy are comparatively minor. ↘ ITEMS 324 FF.

276. Until 2008, expenditure on the SPV, measured as a share of gross domestic product (GDP), stagnated at a level of around 0.8 %. ↘ ITEMS 304 FF. **With the entry into force of the PSG II in 2017, the rise in expenditure accelerated dramatically.** In 2025, the SPV's expenditures as a proportion of GDP stood at 1.5 %. Key factors here include eased access to benefits, increases in benefits for informal and outpatient care, and the benefit surcharge for full-time institutional care introduced in 2022.

277. **The financial situation of the pay-as-you-go SPV is in deficit despite the gradual increase in the contribution rate in recent years.** ↘ ITEM 307 Without cost-containment measures, further increases in the contribution rate are likely to be necessary in the short term. Simulations by the GCEE show that, under current law and assuming wage-linked indexation of SPV benefits where the benefit level tends to remain constant, the contribution rate is likely to rise from the current average of 3.7 % to 4.7 % in 2030. Thereafter, this increase will continue steadily. For the year 2040, the GCEE anticipates a contribution rate of 5.2 %. In future, the structural financing problem – rising expenditures that revenue cannot keep pace with if contribution rates remain unchanged – will be driven largely by demographic ageing.

278. **The expected trend in contribution rates is problematic in three respects.** Firstly, it places a particular burden on younger generations, thereby exacerbating intergenerational distribution conflicts. Secondly, it places a relatively greater burden on people below the contribution assessment ceiling ↘ GLOSSARY than on those above it. Thirdly, it may impair the overall economy. ↘ ITEMS 113 FF. Further increases in contribution rates should therefore be moderated or avoided.

279. In considering the reform options under discussion, the GCEE focuses on approaches that, from an economic perspective, are suitable for sustainably addressing the structural financing problems of the SPV. The focus is on a reform of the SPV that, under the changed financing conditions, both meets the requirements of intergenerational fairness and ensures care provision in line with needs, whilst strengthening the personal responsibility of those in need of care through co-payments. In doing so, it will be confronted with the conflict of objectives between the scope of benefits, the level of the contribution rate and the level of co-payments. A single measure cannot address all three dimensions simultaneously; a **combination of measures** is **required** for this.

280. The fundamental structure of the SPV as a partial insurance scheme should be retained. To curb the rise in expenditure, access to SPV benefits should initially

be scaled back to the level recommended in 2013 by the Expert Advisory Board on the specific formulation of the new definition of care needs (Expert Advisory Board).↘ ITEMS 339 FF. This would reduce both the number of people classified as being in need of care and their assigned care level.. Benefits that lack precision should no longer be covered by long-term care insurance. These include the benefit surcharge for full-time institutional care ↘ ITEM 349 and the relief allowance ↘ ITEM 342 across all care grades, which together accounted for around 15 % of the SPV's total expenditure in 2025. The introduction of cohort-specific capital funding within the SPV could stabilise the level of benefits and ensure a more equitable distribution of the financial burden across generations.↘ ITEMS 354 FF.

II. CARE NEEDS AND ORGANISATION

1. People in need of care

281. **A person is considered to be in need of care if they require support in everyday life due to limitations** (Mathes et al., 2017). This classification is based on functional impairments and the associated limitations. In Germany, the definition of the need of care in the Social Code Book, ↘ BACKGROUND INFO 14 which is decisive for care provision, is closely aligned with the functional model of care sciences. It also regulates access to long-term care insurance benefits. In the following, the concept of care needs is used in accordance with the understanding of German social law. This concept reflects only those limitations that are identified during an application process.

↘ BACKGROUND INFO 14

Background: Need of care within the meaning of German social law

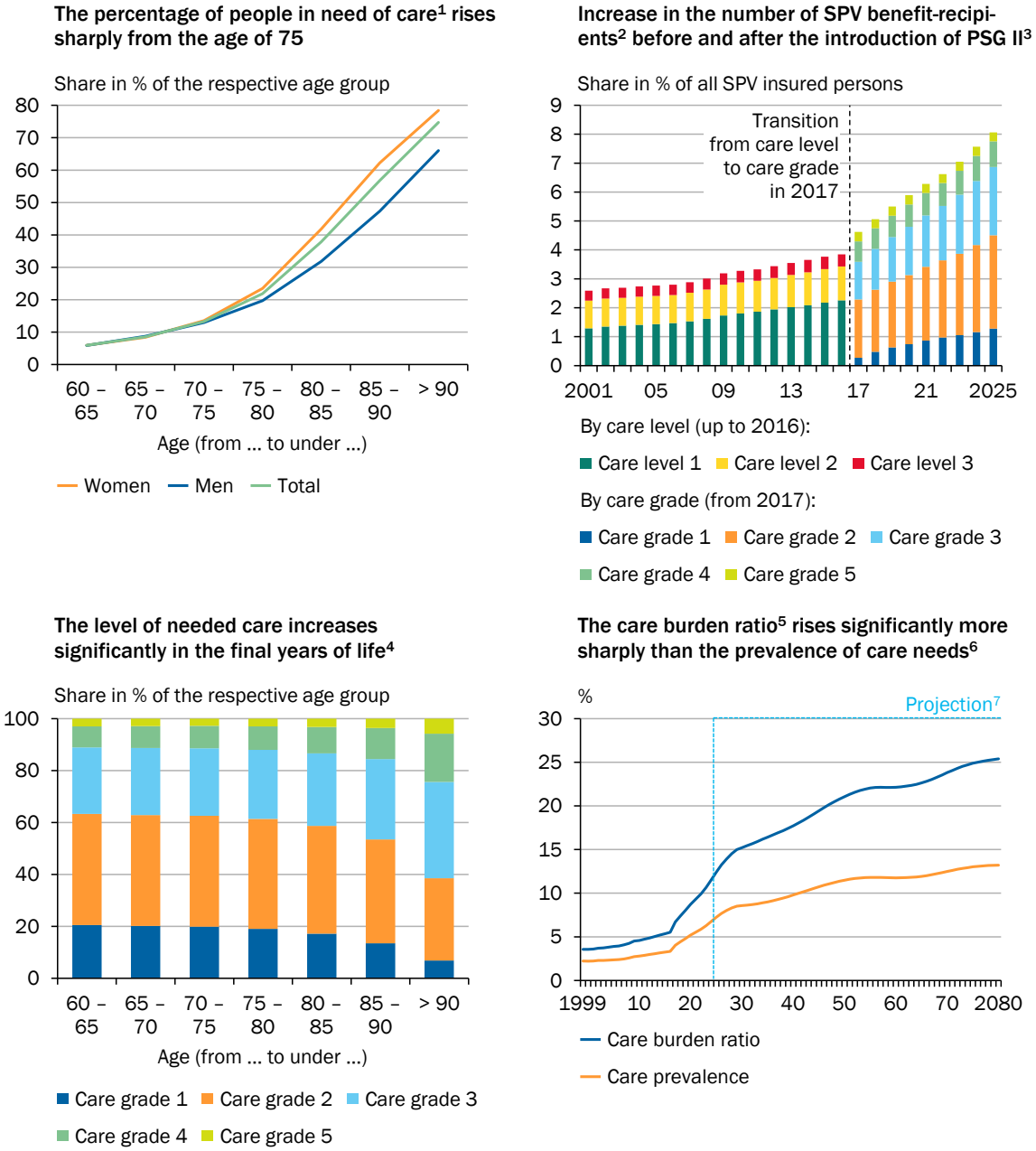
With the introduction of the SPV in 1995, the concept of the need of care was legally regulated (Section 14 SGB XI; Section 15 SGB XI). Until 2016, the need of care was divided into three levels, based on the time required for physical care. To better address the needs of people with cognitive and mental impairments, a new, more comprehensive definition of the need of care was introduced with the Second Long-Term Care Strengthening Act (PSG II) in 2017. The three care levels were replaced by five care grades, the allocation of which is based on the independence of the individuals concerned. A person is considered to be in need of care if, due to physical, cognitive or mental impairments, their independence has been restricted for at least six months and they are therefore dependent on help from others. The need of care is determined as part of an independent assessment carried out by the Medical Service of the Health Insurances. The assessment evaluates impairments in six areas: mobility; cognitive and communicative abilities; health-related behaviours and psychological problems; self-care; coping with and independently managing the demands and stresses associated with illness or treatment; and the organisation of daily life and social contacts. Based on this assessment, the individual is assigned one of the five care grades, which determines the scope of benefits provided by the long-term care insurance scheme.

282. The risk of being in need of care is still 5.9 % between the ages of 60 and 65. However, it rises to 21.9 % between the ages of 75 and 80. ↘ CHART 57 TOP LEFT As people get older, the intensity of care and the associated care costs increase. ↘ CHART 57 BOTTOM LEFT The introduction of the new definition of care needs and a new assessment procedure in 2017 led to a significant increase in the number of people needing care. ↘ BACKGROUND INFO 14 ↘ CHART 57 TOP RIGHT This is attributable, among other things, to behavioural changes within the population, which are reflected in increased uptake of care services as a result of the newly created low-threshold access to care (Federal Government, 2015; Schwinger et al., 2023). ↘ ITEM 304

283. **The risk of being in need of care varies systematically with income and occupation** (Geyer et al., 2021). Men at risk of poverty, i.e. those with an income below 60 % of the median income, need care on average almost six years earlier

↘ CHART57

Trends in the need of care



1 – Calculated as the proportion of social long-term care insurance (SPV) benefit recipients among all SPV insured persons in the respective age group or of the respective gender in 2025. 2 – Calculated as the proportion of SPV benefit recipients among all SPV insured persons in the respective year. 3 – Second Long-Term Care Strengthening Act. 4 – As at 31 December 2025. Care intensity: The extent of the care required for a person in need of care, as reflected in the care grade. 5 – The ratio of SPV benefit recipients to 100 people aged 20 to 64. 6 – The ratio of SPV benefit recipients to the total population. 7 – For the years 2025 to 2030, the most recently observed, non-demographically driven increases in the number of benefit recipients are projected to continue, albeit with a gradual slowdown. Over the longer term, constant age- and gender-specific care prevalence rates are assumed.

Sources: BMG, Federal Statistical Office, SIM.24, own calculations

than men with an income of more than 150 % of the median income. For women, this gap is just under four years. Employees engaged in predominantly physical work need care on average around four years earlier than civil servants.

284. **From a medical perspective, the need of care arises from multiple factors.** In older people, it is frequently attributable to cardiovascular diseases, long-term effects of cancer, physical limitations resulting from chronic illnesses, as well as mental and cognitive impairments (Gerlinger, 2022). Neurodegenerative diseases such as Alzheimer's disease and Parkinson's disease are of particular significance, as they can be associated with progressive cognitive impairments, including dementia, and increasing functional limitations. Social circumstances, mental well-being, subjective health assessment, gender and interactions with medication also influence an individual's risk of being in need of care (Jacobs et al., 2017). For those in need of care who died in 2023, the average duration of care need was 46.8 months (Rothgang and Müller, 2024). This should be distinguished from the duration of care need as of the reference date. This stood at 57.3 months in 2023. Among people receiving full-time institutional care, the length of stay in such a facility on that reference date was 37.8 months.

285. **It is difficult to estimate whether, with rising life expectancy, the prevalence of care needs in the population will increase**, i.e. whether the proportion of people in need of care within the total population will rise. Given a qualitative improvement in morbidity ↘ GLOSSARY, it can be assumed that more people will live into old age with chronic conditions, whilst remaining functionally capable for longer. ↘ ITEM 217 At the same time, it is to be expected that age-related conditions such as cancer, strokes, fractures or dementia, as well as multimorbid health problems, will occur more frequently (Rechel et al., 2013).

286. **Demographic ageing is likely to contribute to a rising number of people in need of care** by the end of the 2070s. This assumes constant age-specific care prevalence rates, i.e. that the proportion of people in need of care in the individual age groups remains unchanged. The baby boomers, born between 1955 and 1969, are expected to have left the labour market almost entirely by 2035. In 2030, the first of the baby boomers, born in 1955, will reach the age of 75, the threshold beyond which the risk of being in need of care increases significantly. ↘ CHART 57 TOP LEFT Furthermore, the age structure of the German population is shifting due to low birth rates and rising life expectancy.

Simulations by the GCEE show that both the long-term care dependency ratio – that is, the proportion of people in need of care within the working-age population – and the prevalence of long-term care in Germany are likely to increase significantly by 2080. ↘ CHART 57 BOTTOM RIGHT A similar trend is evident in a European comparison. For the European Union (EU), the proportion of people aged over 50 needing care is forecast to rise from 11.6 % in 2020 to around 14.1 % in 2070 (Belmonte and Nedee, 2024).

2. Caregivers

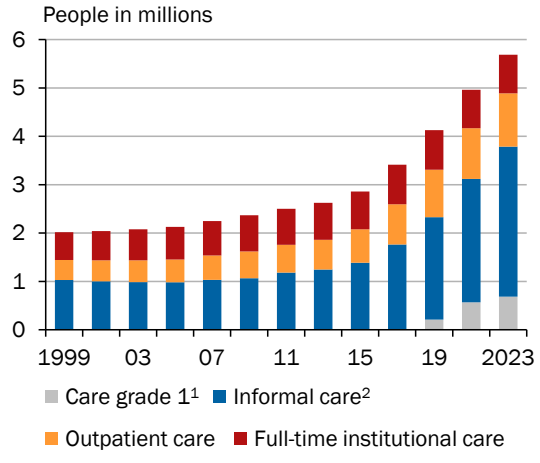
287. Care for those in need of care in Germany is provided by various stakeholders through a multi-provider model. **Informal care** plays a key role in this. ↘ CHART 58 LEFT This refers to non-professional, unpaid care, usually provided by relatives. Informal care is also the most common form of care in other countries. Differences in the proportion of informal care are linked, among other things, to the organisation of the care system, in particular to access to formal services and support for informal carers (Verbakel, 2018; Rocard and Llena-Nozal, 2022; Llena-Nozal et al., 2025). In addition, so-called **live-in care** has become established in recent decades, whereby people, predominantly from abroad, live in the household of the person needing care and, much like family members, provide non-professional care (Fischer and Stempfle, 2024). ↘ BOX 17

These two types of care can be distinguished from formal care, which is provided by professional, trained carers within the framework of **outpatient care services** or **residential care facilities**. Professional care is offered within a wide variety of structures and by different providers. ↘ BOX 18 A distinction is made between private providers, non-profit providers from welfare organisations and churches, and public providers, in particular municipalities and associations of municipalities.

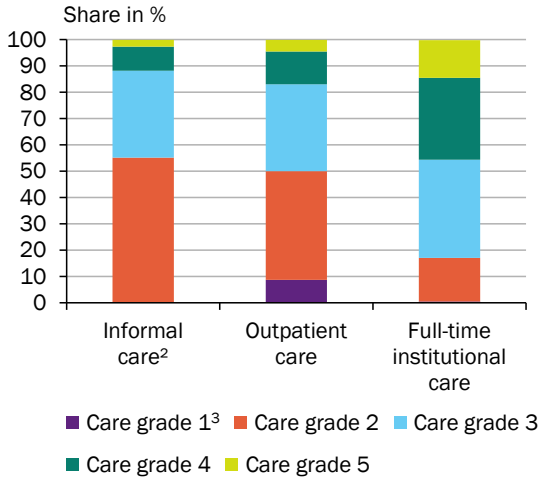
288. **Around 55 % of those in need of care were cared for informally at home by relatives in 2023.** ↘ CHART 58 LEFT According to calculations by the GCEE based on the SOEP, the number of informal carers in Germany stood at

↘ CHART 58
Trends and distribution of care provision

74 % of people in need of care were cared for informally or at home on an outpatient basis in 2023



Around 45 % of people in full-time institutional care had care grade 4 or 5 in 2023



1 – People in need of care receiving semi-institutional care, as well as those receiving benefits exclusively under state law or no benefits at all. 2 – Recipients of care allowance exclusively under Section 37 of SGB XI. 3 – Excluding people in need of care receiving semi-institutional care, as well as those receiving benefits exclusively under state law or no benefits at all.

Sources: Federal Statistical Office, own calculations

around 7 million people in 2023. Of these, around 5.1 million were people of working age between 18 and 66. The age groups approaching retirement, those aged 50 to under 66, form the largest group among informal carers. Women are disproportionately represented in all age groups of carers. In addition to the individual preference for caring for relatives, the extent of informal care is also influenced by the benefit structure of long-term care insurance (Kesternich et al., 2025). In particular, lump-sum cash benefits from the SPV, which can be used flexibly, encourage informal care. ↘ ITEM 299

↘ BOX 17

Focus: Live-in care (24-hour care)

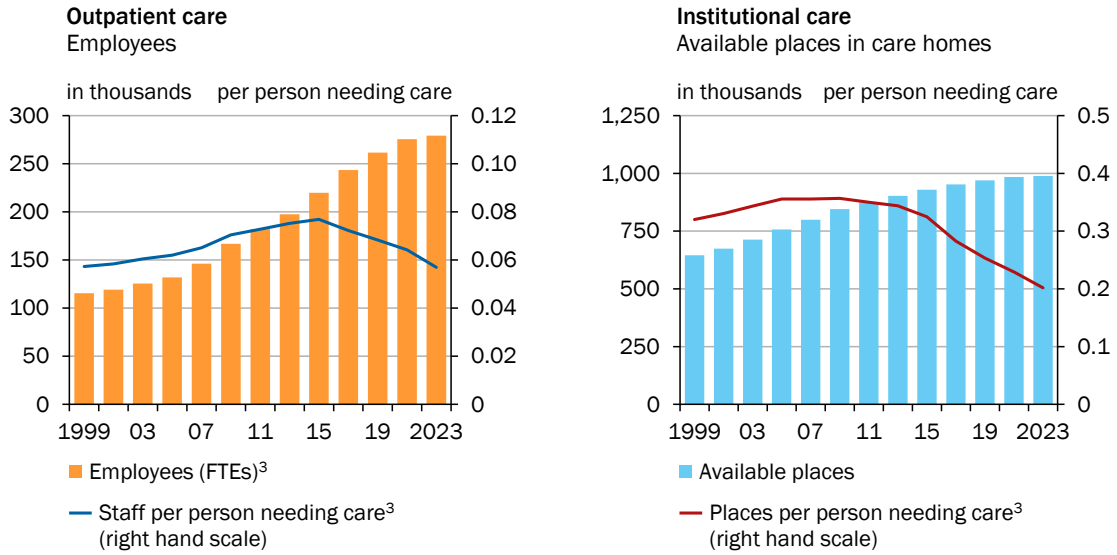
In live-in care, carers live and work in the home of the person needing care, providing assistance with daily living, care services and basic personal care. It is therefore primarily to be regarded as a substitute for care provided by family members, as well as for domestic and care-related support services. In practice, however, it is evident that, particularly in the case of people needing intensive care, more extensive care tasks are often undertaken (Leiber, 2024). In this respect, live-in care can also be understood in part as a substitute for outpatient care services, even if this is only provided for to a limited extent in law. The carers, who are predominantly female, often come from Central and Eastern Europe and are placed in Germany on a temporary basis through agencies (BMG et al., 2024). Studies suggest that live-in care is becoming increasingly important in home care and estimate that between 200,000 and 700,000 people are employed in this sector in Germany each year (Petermann et al., 2020; BMG et al., 2024; Leiber, 2024). The monthly costs for live-in care range between 2,000 and 3,000 euros, depending on the employment model (Büscher et al., 2023).

In practice, there are three working models: the employer model, the agency model and the self-employed model. In the employer model, the person in need of care or someone from their household is the employer of the carer. In the agency model, an agency employs and assigns the carer as an employee or self-employed person to the person in need of care. In the self-employed model, there is no employment relationship and the carer receives a fee. Forms of bogus self-employment and undeclared employment relationships are particularly common in the self-employed and agency models (Habel and Tschenker, 2022; Leiber, 2024). If carers are employed on a dependent basis, the general protective regulations on working hours and rest periods apply (Habel and Tschenker, 2022). Despite the widespread term ‘24-hour care’, the current legal framework, according to the Federal Ministry of Health (BMG et al., 2024), permits a maximum of 12 hours of care per working day, including on-call periods. According to the Federal Labour Court (BAG), the latter must in principle be remunerated at the minimum wage (BAG, 2021). Consequently, the employee model may entail increased costs and bureaucratic burdens for those in need of care (Leiber, 2024).

289. In 2023, around 19 % of people in need of care received professional care at home from outpatient care services. ↘ CHART 58 LEFT The number of outpatient care services has risen by 45.1 % over the last 20 years, and the number of employees in full-time equivalents by 120 % (Federal Statistical Office, 2023). ↘ CHART 59 LEFT **Around 14 % of people in need of care received full-time institutional care in nursing homes in 2023.** This proportion has halved since 1999, although the absolute number of people in need of care receiving full-time institutional care has risen. The declining proportion is linked to the tripling of the number of people receiving informal care and to an increase in the number of people receiving outpatient care. ↘ CHART 58 LEFT This is attributable to the sharp increase

↘ CHART 59

Trends in the provision of outpatient and inpatient care[1]



1 – The underlying statistics are only collected every two years. Values as of December of the respective year. 2 – Employees are reported in full-time equivalents (FTEs). One FTE corresponds to the working hours of a full-time employee. Part-time employees are counted here as 0.5 FTE- Excludes persons in training, retraining or on work placements, as well as volunteers in the Voluntary Social Year or the Federal Voluntary Service. 3 – From 2017 onwards, excluding care grade 1.

Sources: Federal Statistical Office, own calculations

in people in need of care with low care grades since the PSG II reform. ↘ CHART 57 TOP RIGHT Care for those with particularly high care needs is highest in nursing homes, with care grades 4 and 5 accounting for 45 % of all people in full-time institutional care. ↘ CHART 58 RIGHT The number of nursing homes increased by 86 % between 1999 and 2023. The number of places rose by 53 % over the same period, meaning that facilities have become smaller on average. By contrast, the ratio of staff in outpatient care and of nursing home places to the number of people in need of care is falling sharply. ↘ CHART 59

↘ BOX 18

Focus: Alternative care provision models

In the care sector, alternative provision has become established alongside traditional forms of care; some of these are only available locally or have so far only been trialled on a pilot basis and do not make a decisive contribution to increasing the overall scarce care capacity.

These services can be distinguished based on the place of residence of those in need of care and the use of informal and professional care services. In the case of home care for those in need of care, support services can be called upon to provide assistance with everyday tasks, such as housekeeping or organising leisure activities (Rellecke et al., 2018; Nolting and Rellecke, 2020). These support services do not provide nursing care; therefore, support staff do not need to be qualified nurses, but merely require qualified vocational training (GKV-Spitzenverband, 2021). Care services can be funded by those in need of care through the respite allowance or, from care grade 2 onwards, additionally through a portion of the in-kind care benefits.↘ TABLE 13

The neighbourhood care pilot programme is an alternative care concept designed to provide more nursing support within home care (Gesellschaft für Gemeinsinn, 2026). In addition to care provided by outpatient care services, this programme incorporates support from neighbours and family members in the immediate living environment of those in need of care, which is coordinated, supported and further developed by a full-time neighbourhood manager. Formally, this constitutes an outpatient care service that can be funded through the relevant outpatient benefits provided by long-term care insurance. ↘ TABLE 13

For people who live at home but need professional care from time to time, day and night care services are available (BMG, 2026a). Those in need of care are accommodated temporarily in a institutional care facility; this is therefore a semi- institutional form of care. Those in need of care from care grade 2 onwards can finance this care provision through semi-institutional in-kind care benefits, which are granted in addition to the care allowance or in-kind care benefits. ↘ TABLE 13

In addition, there are communal living arrangements that differ in the level of professional support provided. In supported-living groups, several people in need of care live together in a shared flat with both private and communal areas (Stolarz et al., 2006). Care is provided by outpatient nursing and support services, which assist the residential community as required. In contrast, 'stambulanten' care involves accommodation in an institutional facility with professional 24-hour care. The difference from full-time institutional care is that the entire package of services does not have to be utilised; instead, relatives also have the opportunity to take on tasks independently, thereby saving costs. Formally, both forms of accommodation are classified as outpatient care. Accordingly, those in need of care can finance the costs using the outpatient benefits provided by the SPV. In addition, they are entitled to the monthly shared accommodation allowance of 224 euros. In the case of 'stambulanten' care, despite accommodation in an institutional facility, there is no entitlement to the service supplement under Section 43c of SGB XI, which leads to higher personal contributions compared to full-time institutional care (Nolting et al., 2023). ↘ TABLE 13

290. The **supply (and infrastructure)** of care in Germany is determined by free market access for providers. It is subject to only limited state control (Klie et al., 2025). This fundamentally distinguishes the care sector from the healthcare system, in which the capacities of hospitals and outpatient medical practices are regulated by the state to ensure needs-based medical care (Greß and Jesberger, 2023). Responsibility for maintaining an efficient, numerically adequate and cost-effective care provision structure formally lies with the federal states (Section 9 SGB XI). To this end, some federal states provide subsidies towards the **investment costs** of care facilities, which would otherwise have to be borne by those in need of care. The level of investment cost funding varies significantly between the federal states. This was originally intended to be based on the savings made by social welfare agencies through the services provided by the SPV (around 5 to 6 billion euros annually), but in practice, at 1.0 billion euros in 2024, it was significantly lower (GKV-Spitzenverband, 2024; BMG, 2025a). ↘ ITEM 351 The funding can either take the form of individual-based support, such as an income- and asset-dependent care allowance, or, as in the majority of federal states, provide direct support to care facilities as facility-based funding (Ochmann and Braeseke, 2023). In most federal states, funding for investment costs does not follow any systematic regional needs planning (Greß and Jesberger, 2023).

291. **The provision of professional care services varies greatly from region to region.** The ratio of home care workers to people requiring home care fluctuated between districts in 2023 from 0.15 (Donnersberg district) to 0.9 (Heidelberg); that of nursing home places to people in need of institutional care between 0.5 (Straubing-Bogen) and 2.4 (Goslar) (BBSR, 2025). Consequently, regional shortages or overcapacities are evident in some areas. There are also significant regional differences in the availability of specialised services, for example in the care of people with dementia or palliative care (Ditscheid et al., 2023; WIdO, 2025). The necessary data basis is lacking for a more detailed examination of the regional care infrastructure and its utilisation, as well as for an assessment of any regional capacity bottlenecks and their causes. This also complicates needs-based planning. A corresponding data basis is to be established by the end of 2026 (BMG, 2025a).

292. **The quality of care is influenced by the remuneration structure and the funding body of care providers.** For instance, remuneration based on time rather than on service can enable more flexible and needs-based care (Büscher et al., 2007; Miller, 2009). ↘ BOX 19 Studies from the US show that the type of ownership also has a causal influence on the quality of care and the health of those in need of care. Profit-oriented ownership is associated with higher hospitalisation rates than non-profit providers (Grabowski et al., 2013; Bos et al., 2017). Furthermore, nursing homes with private equity investment have higher mortality rates than other private providers (Gupta et al., 2024).

↘ BOX 19

Focus: Organisation of care abroad – The Buurtzorg model

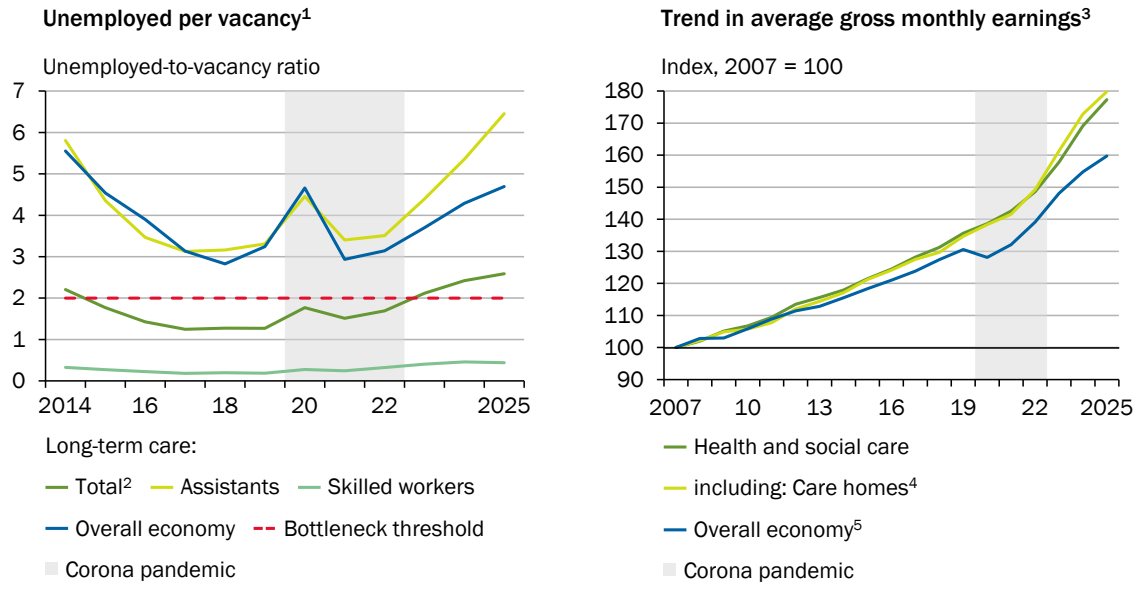
In the Netherlands, the Buurtzorg model ('neighbourhood care') has established itself as an alternative form of community care, characterised by small, self-managed teams (Büscher et al., 2022). The teams work closely with local networks such as relatives or neighbours and are paid on a time-spent basis. This enables a flexible service tailored to the needs of those needing care. To keep costs down, there is no management layer, although a number of experienced carers are available as coaches and a shared IT infrastructure is in place. Evaluations of the Buurtzorg model point to a higher perceived quality of care and increases in satisfaction among carers and those in need of care (Büscher et al., 2022; Hegedüs et al., 2022; Ruotsalainen et al., 2023). Cost reductions, however, have not been conclusively demonstrated. In Germany, the Buurtzorg model has been under trial since 2018, with two teams currently still active. A robust evaluation of this has not yet been carried out (Büscher et al., 2022).

The regulatory framework makes it difficult to establish the model in Germany. For example, although remuneration based on time is in principle possible under the Social Code Book (Section 89(3) SGB XI), general time-based remuneration is not explicitly provided for in every federal state in the federal agreements (BMG, 2024a). It is therefore likely that it is not provided for everywhere as a regular component of the catalogue of services. Furthermore, the level of academic qualification in nursing in Germany is comparatively low. This could make it difficult to find nursing staff who are sufficiently qualified for self-managed work (Büscher et al., 2022).

293. **Prices for outpatient and institutional care services are determined differently.** In outpatient care, care services or their associations negotiate with

↘ CHART 60

Labour market trends in long-term care



1 – As of December of the respective year. A distriction is made between the skill leves of assistants, skilled workers, specialists and experts. Vacancies are jobs reported to the Federal Employment Agency (BA) in accordance with the 2010 Classification of Occupations (KldB 2010). 2 – Specialists and experts account for a minor proportion of the long-term care sector and are not reported separately. 3 – Classification of Economic Activities, 2008 edition (WZ 2008). 4 – Includes care homes, long-term care homes, long-term care institutions for psychosocial care, addiction treatment and similar, and other residential homes (excluding convalescent and holiday homes). 5 – All economic sectors excluding health and social services and excluding agriculture, forestry and fishing. Weighted by the number of employees subject to social contributions.

Sources: BA, Federal Statistical Office, own calculations

care insurance funds and social welfare providers regarding the catalogue of services and its remuneration at the state level. People in need of care receiving outpatient care can choose services from this catalogue depending on their budget.

In institutional care, this choice is not available. The monthly nursing home fee is the same for all residents and covers care-related expenses, the costs of accommodation and meals, investment costs and a contribution towards training costs. These prices are negotiated directly between the nursing homes and the care insurance funds as well as the social welfare agencies.

294. **For years, the care sector has been suffering from severe shortages of skilled workers in certain occupations** (BA, 2025). A comparison of the number of unemployed people with the number of job vacancies reveals significant shortages of qualified care staff, which have only eased slightly since 2014. ↘ CHART 60 LEFT Although the supply of nursing assistants has risen significantly, they are only qualified for 36 % of the vacancies. Wages in the care sector have grown more strongly than in other sectors of the economy, rising by 80 % since 2007 (compared to 60 %). ↘ CHART 60 RIGHT This is attributable to repeated increases in the minimum wage for care workers since its introduction in 2010, as well as to the introduction of the collective agreement requirement in 2022, which obliges care facilities to pay wages at the collective agreement level (BMAS, 2025). This is likely to have had a positive impact on the attractiveness of the profession, as the

number of nursing trainees with newly signed training contracts rose by 4.3 % and 9.3 % in 2023 and 2024 respectively compared with the previous year (Giar and Neumann, 2025). Between 2012 and 2019, however, the annual increase averaged only 3.5 % (BIBB, 2021). 22% of current care workers will leave the labour market by 2033 due to retirement (Klie, 2024). In addition, around three-fifths of employees work part-time (BA, 2025). Employment growth is now driven exclusively by workers from abroad (IAB, 2024).

295. **Automation and digitalisation to optimise processes and reduce the workload of care staff have so far been used only to a limited extent in Germany** (IGES, 2022; Essity, 2025). Social robots are being used in care in various pilot projects (HMD, 2025; vdek, 2025). Connection to the telematics infrastructure (TI) ↘ GLOSSARY is progressing only slowly. The TI enables cross-sector networking within the healthcare system and the exchange of patient-relevant data between service providers and care insurance funds. From 1 December 2026, billing in the care sector will take place exclusively via the TI in a fully electronic format (BMG, 2025b). Although connection has been mandatory since July 2025, by the end of September 2025 only 35 % of care services and 23 % of nursing homes were connected to the TI, with a further 24 % and 21 % respectively in the process of connecting (von Broich-Oppert and Wiesenberg, 2025).

III. COVERAGE OF LONG-TERM CARE COSTS

1. Structure and benefits of long-term care insurance

296. Until 1995, people in need of care and their relatives in Germany had to bear the financial burden of care costs themselves. As parts of the population had made insufficient provision for this eventuality, there was a rise in the uptake of social assistance (Federal Government, 1993). **To close this provision gap and to smooth household consumption over the life cycle**, **compulsory cover against the financial risk of needing care was introduced in 1995**, establishing the fifth branch of the social insurances with the SPV. The compulsory insurance was intended to overcome two incentive problems that could lead to insufficient insurance coverage under a purely voluntary scheme. On the one hand, there is the problem of adverse selection, which, due to information asymmetries between insured persons and insurance companies, can result in individuals with a low probability of being in need of care preferring not to take out insurance (Rothschild and Stiglitz, 1976; Finkelstein and McGarry, 2006). This incomplete risk pooling results in higher premium levels for the remaining contributors. On the other hand, there is the moral hazard problem, whereby people, relying on the state's basic social security, prefer not to take out voluntary insurance.

297. By **designing the system as a pay-as-you-go scheme** with contributions based on income and uniform benefit entitlements, the aim **was to reflect the**

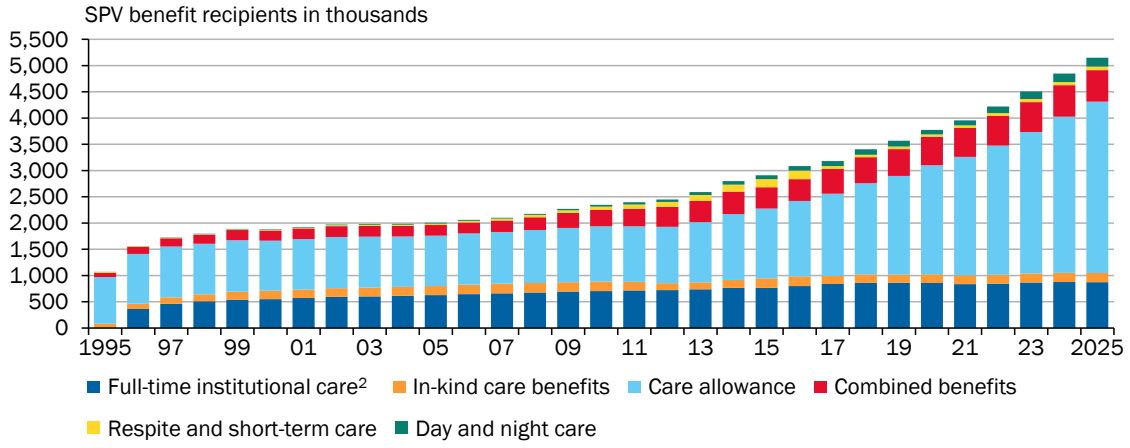
principle that the **need for long-term care** constitutes a **fundamental life risk** that **should be borne**, at least **in part**, **on a solidarity basis**. However, the aim of long-term care insurance was not to fully cover the financial risk of needing long-term care. Rather, the aim was to ensure that the vast majority of those in need of care would no longer be dependent on social assistance (Federal Government, 1993). Long-term care insurance is therefore structured as a partial insurance scheme and is based on the principle of subsidiarity. ↘ GLOSSARY The use of personal funds by those in need of care, as well as support from family members, is therefore a prerequisite. This structure limits typical moral hazard risks associated with comprehensive insurance schemes, which can manifest, for example, in the overuse of benefits. ↘ ITEM 199 Konetzka et al. (2019) show for the US that people in need of care with private long-term care insurance make greater use of outpatient care services in particular than those without.

298. The providers of the SPV are the long-term care insurance funds, which are organisationally situated under the umbrella of the GKV. All those insured under the GKV are also automatically covered by the SPV. ↘ BACKGROUND INFO 9 People who have taken out private health insurance are also obliged to take out private long-term care insurance (PPV). Unlike with health insurance, the scope of benefits for both the SPV and the PPV is prescribed by law and is identical for all insured persons. It is also stipulated by law that the premium for private long-term care insurance must not exceed the maximum contribution to the SPV. This corresponds to the contribution assessment ceiling ↘ GLOSSARY↘ BACKGROUND INFO 8 multiplied by the SPV contribution rate. Actuarially higher premiums for private long-term care insurance are borne by all privately insured persons via a levy.

299. **Long-term care insurance benefits are based on the needs-based principle.** ↘ GLOSSARY They depend on the severity of the care needs and are differentiated according to the type of care. ↘ BACKGROUND INFO 15 ↘ TABLE 13 Long-term care

↘ CHART 61

Trend in the composition of SPV services utilised[1]



1 – Annual averages. Due to introduction of institutional benefits in July 1996, the year 1996 covers only the second half-year. Including double counting due to the simultaneous receipt of multiple benefits. From 2017 onwards, in the outpatient sector excluding care grade 1, as there is no entitlement to the specific types of benefits for this level.
2 – Including full-time institutional care in care homes for people with disabilities.

Source: BMG

insurance follows the principle of 'outpatient care before institutional care'. People in need of care should be cared for in their home environment for as long as possible and only move to an institutional facility in cases where this is no longer possible given their care needs. Long-term care insurance supports this principle financially, for example, by providing care allowances, in-kind care benefits and by covering pension insurance contributions for carers. For institutional care, the legislature had provided for the coverage of care-related costs, but not for the costs of accommodation and meals (Federal Government, 1993). ↘ ITEM 313 In practice, people in need of care in institutional care today also bear parts of the care-related costs, investment costs and costs for the training of care staff.

300. The high proportion of informal and outpatient care is reflected in the uptake of SPV benefits. ↘ CHART 61 **Benefits to support care at home are the most frequently utilised.** These include, for example, the care allowance, a cash benefit that is freely available to those in need of care to ensure the necessary care and support measures. Surveys suggest that in many cases the care allowance is passed on to family carers, but is also used to cover running expenditures or to purchase services not provided for by long-term care insurance, such as domestic help (Klie, 2022; Büscher and Klie, 2024).

301. **The uptake of SPV benefits has risen sharply.** Geyer et al. (2023) show, based on the SOEP, that among people living in private households who state that they are in need of care, the proportion of those receiving SPV benefits rose from just under 73 % in 2012 to around 83 % in 2020. According to the GCEE's own analyses, the proportion for 2023 is around 84 %. In 2001, this figure stood at around 56 %.

↘ BACKGROUND INFO 15

Background: Key benefits of long-term care insurance

Once a person has been assessed as needing care,↘ BACKGROUND INFO 14 they are entitled to long-term care insurance benefits depending on the type of care required. For care at home, there are two key benefits: the care allowance and in-kind care benefits. The person needing care receives a monthly care allowance if the care is predominantly organised privately (e.g. by relatives, friends or volunteers). The money can be used flexibly to facilitate or organise private care. Those in need of care can use the budget for in-kind care benefits for outpatient care services, support or respite care; the care insurance fund then pays the provider directly for the services provided, up to the respective maximum limit. Those who use both can combine the care allowance and in-kind care benefits into a combined benefit. In this case, the care allowance is paid out proportionally to the unused portion of the in-kind care benefits. In addition, there is the respite allowance (up to €131 per month) for support in everyday life, such as care or help with household tasks. In addition, costs for care aids are partially covered (e.g. for consumables or technical aids). Furthermore, measures to improve the home environment (e.g. for the conversion of a bathroom) as well as costs for digital care applications and supplementary support services are financially supported. If the private carer is temporarily unavailable (e.g. due to holiday or illness), the combined annual allowance for respite care (e.g. replacement care at home) and short-term care (e.g. temporary care in a nursing home) applies. As a semi-institutional care option, long-term care insurance provides financial support for day and night care.

However, stagnating availability of short-term care places and the limited availability of night care services effectively restrict the use of this service (Rothgang et al., 2025).

If a person cannot be cared for at home, there are flat-rate monthly benefits for institutional care (nursing home) depending on the care grade. Since 2022, long-term care insurance has also been paying benefit surcharge for full-time institutional care, which increase with the length of stay and reduce the percentage of the care-related expenses that the individual must pay.

↘ TABLE 13

Insured persons' entitlement to benefits from long-term care insurance in 2026[1]

		Care grade				
		1	2	3	4	5
Care allowance[2]	€	0	347	599	800	990
In-kind care benefits[2,3]	€	0	796	1 497	1 859	2 299
Additional services in support living groups	€	224	224	224	224	224
Relief allowance	€	131	131	131	131	131
Total annual amount for respite care and short-term care[3,4]	€	0	3 539	3 539	3 539	3 539
Part-time day and night care[3]	€	0	721	1 357	1 685	2 085
Full-time institutional care[5]	€	131	805	1 319	1 855	2 096
Care aids intended for single use	€	42	42	42	42	42
Technical and other care aids	100 % of costs[6]					
Measures to improve the home environment	€4,180 per measure and per person needing care in the household					
Digital care applications	€	40	40	40	40	40
Additonal support services	€	30	30	30	30	30
Payment of pension insurance contributions for carers	€	0	198.62	316.32	514.94	735.63
Payment of unemployment insurance contributions for carers	€	0	51.42	51.42	51.42	51.42
Health insurance subsidies for carers during a care leave period[7]	€	230.71	230.71	230.71	230.71	230.71
Contributions towards long-term care insurance for carers during a care leave period	€	47.46	47.46	47.46	47.46	47.46
Care support allowance for employees during short-term inability to work	For up to 10 working days per calendar year: 90 % if you have received one-off payments subject to contributions in the last 12 calendar months prior to your leave of absence from work, regardless of the amount; 10 % of the lost net pay					

1 – All amounts are paid out monthly. 2 – The care allowance and in-kind care benefits can also be combined. 3 – Under certain conditions, those in need of care may (additionally) use the relief allowance €131 per month for these benefits. 4 – If respite care is provided by close relatives or members of the household, the annual amount is double the care allowance. Applicable to care expenses for up to eight weeks in a calendar year. 5 – In addition, long-term care insurance grants the following benefit surcharges, graded according to the length of stay: from the first month, 15 % of personal contribution payable towards care-related expenses; after 12 months, 30 %; after 24 months, 50 %; and after 36 months, 75 %. 6 – Under certain conditions, a co-payment of 10 %, up to a maximum of €25 per care aid, is payable. 7 – The calculation is based on the general contribution rate of 14.6 % and the average supplementary contribution rate of 2.9 % in the GKV. For members of the GKV, deviations may arise due to the inclusion of the individual health insurance fund's supplementary contribution rate.

Source: BMG

2. Financial situation of the SPV

302. **The SPV is funded almost exclusively by contributions.** ↘ CHART 62 TOP Since the SPV was introduced, the contribution rate has risen from an initial 1.0 % in 1995 to 3.6 % of contributory income ↘ ITEM 194 in 2026. Childless members pay a surcharge of 0.6 percentage points. From the second to the fifth child, reductions of 0.25 percentage points per child are applied. The contribution rate is levied on contributory income up to the contribution assessment ceiling ↘ GLOSSARY and is shared equally between employers and employees. The long-term care insurance funds collect the contributions and retain as much funding as they need to cover expenditure in the current month. Surplus revenue is transferred to the equalisation fund. ↘ BACKGROUND INFO 16

↘ BACKGROUND INFO 16

Background: Equalisation Fund

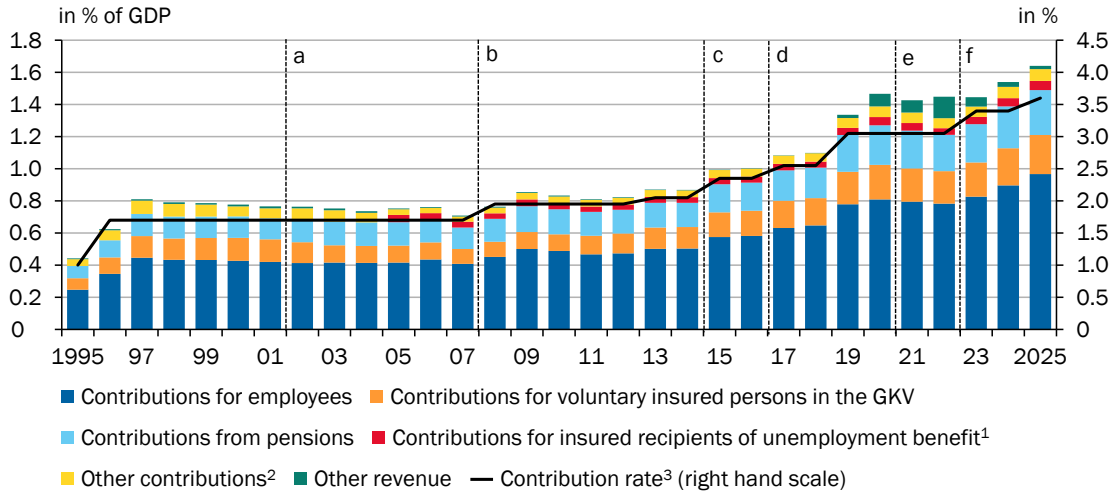
A key control mechanism of the SPV is the Equalisation Fund, which is administered by the Federal Social Security Funds Office (BAS). On the one hand, it serves as a liquidity reserve and, on the other, it provides financial equalisation between the individual long-term care insurance funds to account for their differing risk structures. The expenditure coverage ratio determines how large the reserve to be held in the equalisation fund should be in relation to average monthly expenditure.

303. Since 2020, the SPV has received tax subsidies from the federal government at irregular intervals, ↘ CHART 62 TOP to offset additional expenditure caused by the COVID-19 pandemic. ↘ BOX 20 Unlike in other branches of social insurance, where tax subsidies are paid to cover non-contributory benefits (NBL) on a flat-rate basis, this was not provided for in the SPV for a long time. In 2022, a **flat-rate federal contribution** of €1 billion per year towards the SPV's expenditure was agreed, but this was suspended again from 2024 to 2027 for the purposes of budget consolidation. From 2028 onwards, this federal subsidy is to be paid again.

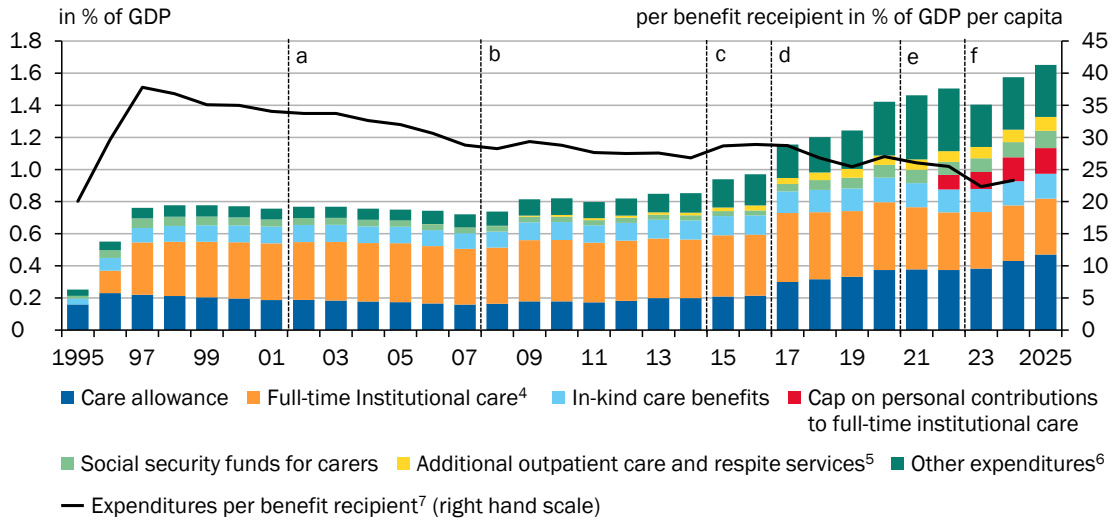
↘ CHART 62

Trend in the SPV's revenue and expenditures

Revenue: Financed almost exclusively through contributions



Expenditures: Expanding access to and entitlement to benefits contributed significantly to the increase



1 – Includes recipients of unemployment benefit (ALG I and ALG II). 2 – Including the differences from total contributions. 3 – As of 1 July of the respective year. Excluding the childless supplement introduced in 2005. 4 – Excluding benefit expenditure for full-time institutional care in care homes for people with disabilities, but including institutional care remuneration supplements and remuneration supplements for additional staff in long-term care institutions. 5 – Includes the respite care allowance introduced in 2017 under the PSG II to support those in need of care. 6 – Including benefit expenditure on respite care, day and night care, short-term care, assistive devices and services to improve the home environment, full-time institutional care in care homes for people with disabilities, care advice, other benefit expenditure, half the costs of the Medical Service, administrative expenditure and contributions to the Care Provision Fund. 7 – Introduction effects are evident in 1995 and 1996. The first stage of the Long-Term Care Insurance Act provided only for the coverage of services in the outpatient sector. On 1 July 1996, a second stage of the Act introduced the coverage of services in the institutional sector as well.

a – Supplementary Long-Term Care Benefits Act (PflEG). b – Long-Term Care Development Act (PfWG) 2008. c – 1st Long-Term Care Strengthening Act (PSG I) 2015. d – 2nd and 3rd Long-Term Care Strengthening Act (PSG II + III) 2017. e – Healthcare Development Act (GVWG) 2021. f – Care Support and Relief Act (PUEG) 2023.

Sources: BMAS, BMG, Federal Statistical Office, own calculations

↘ BOX 20

Focus: Non-contributory benefits (NBL) in the SPV

Like the GKV ↘ BOX 10 and the GRV, the SPV pays not only benefits for members liable for contributions, but also other benefits that can be classified as non-insurance-related benefits. These are benefits that are in the interest of society as a whole and should actually be financed from general Tax revenue. Which benefits of the SPV fall under this category is not clearly defined by law and is a matter of dispute. As with the statutory health insurance (GKV), this could include the non-contributory co-insurance of spouses or partners who are not employed or marginally employed, as well as children.

It is disputed whether wage replacement benefits in the form of care support allowance for carers in the event of short-term incapacity to work (Section 44a SGB XI) or contributions to pension, accident and unemployment insurance for persons who care for relatives on a non-remunerated basis (Section 44 SGB XI; Bundesrat, 2019) should be classified as non-insurance-related benefits. On the one hand, long-term care insurance covers social insurance contributions as part of labour costs when professional carers provide the care services instead. On the other hand, the attractiveness of informal care, which is cheaper than professional care, is enhanced by the social security provided to relatives, which potentially limits the expenditures of the SPV (Greß et al., 2019). Social security funds for carers resulted in expenditures of €4.8 billion in 2025 (BMG, 2026b). The Federal-State Working Group on the 'Future Pact for Care' estimates that a tax subsidy for pension contributions for non-professional carers would immediately reduce the long-term care insurance contribution rate by around 0.3 percentage points (BMG, 2025a).

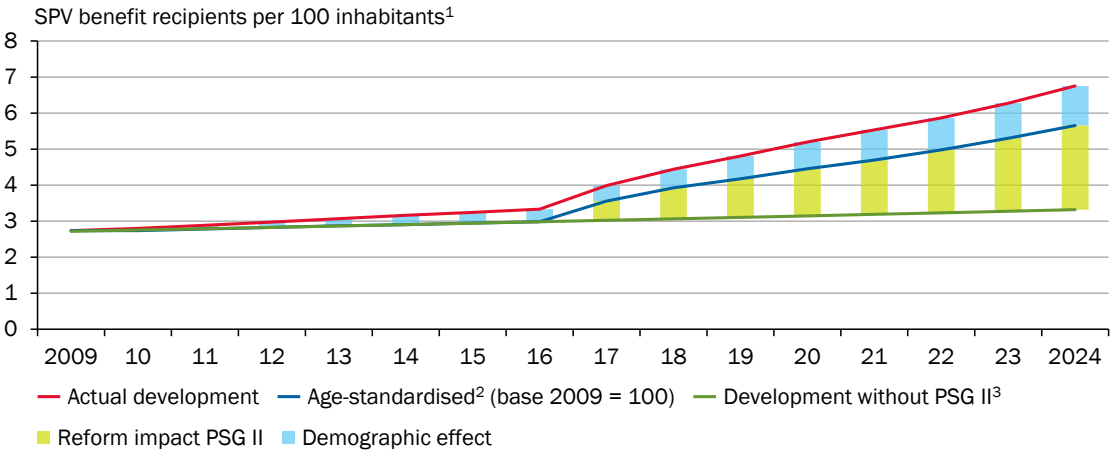
The reimbursement of additional expenses and lost revenue resulting from the COVID-19 pandemic can also be regarded as a one-off NBL payment. As part of the care rescue package, the SPV paid a total of €7.3 billion to care facilities between March 2020 and June 2022. In addition, the care insurance funds covered testing costs amounting to €4.4 billion and the care bonus of around €1.4 billion. This placed a heavy burden on the compensation fund. A legal opinion commissioned by DAK-Gesundheit classifies the financing of these costs from SPV contribution funds as an impermissible misuse of funds (Felix, 2024). Accordingly, a full repayment of these costs from tax revenue is being demanded. To date, the federal government has provided the compensation fund with tax revenue amounting to €5.5 billion to offset these expenditures. After deducting a statutory health insurance (GKV) levy of €1.6 billion to contribute to the SPV's pandemic costs in outpatient and inpatient hospices (Section 150(4) SGB XI), the SPV is left with a shortfall of €6 billion. The Social Association VdK is seeking to bring test cases against the misuse of contribution funds (Frediani, 2026).

304. Until 2008, SPV expenditures remained flat relative to gross domestic product. This was followed by a period of only modest increases due to adjusted services ↘ CHART 64 and demographic trends. ↘ CHART 63 **As a result of the PSG II reform, SPV expenditures have risen sharply since 2017.** A key factor in this is the doubling of the number of people in need of care between 2017 and 2024. This increase was 70 % attributable to the introduction of the new definition of care needs and the new assessment procedure (NBA) as part of the PSG II reform, and far exceeded expectations at the time of the reform's introduction (Federal Government, 2015). ↘ CHART 63 The sharp rise is not solely attributable to the extension of the catalogue of benefits to include people with cognitive and mental impairments. The lowering of the thresholds – both for achieving the new care grades and for calculating the point values within the NBA modules – below the level recommended by the Expert Advisory Board in 2013 has also lowered the barriers

↘ CHART 63

Impact of demographics and PSG II on the development of care prevalence

The rise in care prevalence is only to a small extent attributable to demographic factors



1 – From 2011 onwards: results based on the 2011 census; from 2022 onwards: results based on the 2022 census.
2 – The year 2009 was used as the base year for age standardisation. 3 – The basis is the age-standardised time series, which is extrapolated from 2017 onwards using the linear trend from 2009 to 2016

Sources: BMG, Federal Statistical Office, own calculations

to accessing SPV benefits and facilitated classifications into higher care grades (BMG, 2025c).↘ BACKGROUND INFO 17 The transition of all care recipients from care levels to care grades at the end of 2016 also generally resulted in an improvement in their situation, accompanied by higher entitlements and additional expenditure (BMG, 2013; Rothgang et al., 2019). Around 29 % of the cases transferred in 2017 were still receiving SPV benefits in 2024.

↘ BACKGROUND INFO 17

Background: Expert advisory board on the specific design of the new definition of care needs

The Expert Advisory Board on the specific formulation of the new definition of care needs was established by the Federal Ministry of Health (BMG) in 2012. Its task was to develop a scientifically sound assessment tool and to prepare for the implementation of a definition of care needs within the Standardised Care Needs Assessment (SPV) that was more strongly oriented towards independence (BMG, 2013). The core of the recommendations was a shift away from a minute-by-minute service logic towards an assessment of independence. Minute-based values were replaced by point-based thresholds between care grades, which were intended to enable a professionally consistent distinction. This allowed for better consideration of cognitive and psychological limitations, as well as aspects of daily life organisation. The approach was generally viewed positively by both future users and the academic community, particularly due to the more nuanced assessment of potential for independence and care needs (GKV-Spitzenverband, 2015). At the same time, implementation issues and conceptual limitations were discussed at an early stage, for example regarding the standardisation of assessments and the limited suitability for staffing calculations (Rothgang et al., 2015; Brühl et al., 2016). In the political implementation process, however, the legislature deviated from the recommendations of the expert advisory board on key points. In particular, the

thresholds for achieving care grades 1 to 3 were lowered, and the thresholds in modules 1 (mobility), 4 (self-care) and 6 (organisation of daily life and social contacts) of the NBA – which convert the scores achieved in the assessment into weighted points in the NBA – were set at lower levels. Furthermore, more comprehensive grandfathering rules ensured that there would be no deterioration in benefits as a result of the system changeover.

305. There are no plans for automatic indexation of SPV benefits. Under the 2008 Care Development Act, the Federal Government was tasked with reviewing benefit amounts for the first time in 2014 and subsequently every three years, and deciding on the need for adjustments. The benchmark for this review is the cumulative inflation rate over the preceding three years, measured against the core inflation rate (Section 30 SGB XI). The increase must not exceed the rise in gross wages over the same period. Over time, the adjustments – also against the backdrop of political objectives to strengthen home care – have been very uneven depending on the care grades. ↘ CHART 64 **In 2017, SPV benefits were sharply increased as part of the PSG II reform**, particularly in the case of care allowances and in-kind care benefits, with adjustments that were significantly higher than price inflation. This may have contributed to the rising uptake of SPV benefits, ↘ ITEM 301 as was the case, for example, with the increase in benefits for additional care options (Section 45b SGB XI) (Rothgang et al., 2010, 2014, 2019). With the entry into force of the Care Support and Relief Act in 2023, the Federal Government's review mandate was removed from the legislation. Instead, the next increase in benefits is set by law to take effect on 1 January 2028 (Section 30 SGB XI).

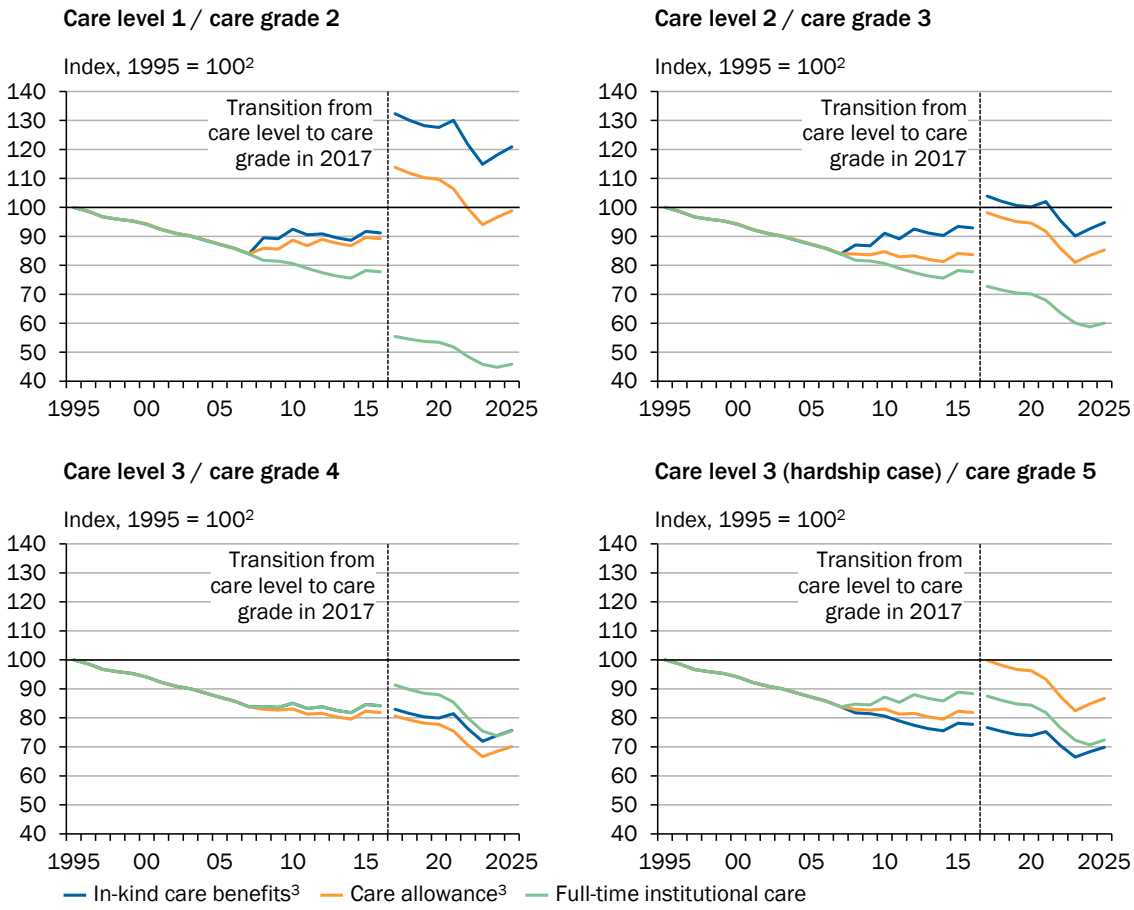
306. In 2022, the introduction of the graduated benefit surcharge on care-related co-payments in full-time institutional care led to a further expansion of benefits. This benefit surcharge increases with the length of stay and is paid out regardless of financial need (Section 43c SGB XI). **The introduction of benefit surcharge in full-time institutional care has contributed to significant additional expenditures by the SPV.** According to the BMG (2024b), the SPV's expenditures on benefit surcharge in the year of introduction amounted to €3.6 billion, ↘ CHART 62 BOTTOM which was 30 % higher than originally forecast (BRH, 2024). Since then, expenditures have risen steadily, reaching €7.1 billion in 2025. According to calculations by the Scientific Institute of Private Health Insurance, they could rise to as much as €13.9 billion per year by 2029 (Bahnsen, 2025).

307. Due to the cost drivers described, **the SPV** is currently running a deficit, despite repeated substantial increases in the contribution rate and a further rise of 0.2 percentage points at the start of 2025 to 3.6 % (or 4.2 % for childless individuals over the age of 23). The liquidity reserves of the long-term care insurance funds have also been largely depleted. ↘ BACKGROUND INFO 16 The Federal Ministry of Health (BMG) anticipates deficits of €0.5 billion and €3.5 billion for the years 2025 and 2026 respectively (BRH, 2025). By 2029, the annual deficit is likely to rise to €12.3 billion without adjustments to the contribution rate.

308. In anticipation of the increasing need of care among the baby boomer generation and the associated financial burdens on the SPV, the **Long-Term Care Provision Fund (PVF)** was established in 2015. Funds amounting to 0.1 percentage

↘ CHART 64

Real development of selected SPV benefits[1]



1 – The transition of people in need of care from care levels to care grades took place at the turn of the year 2016/17, depending on the respective care level and daily living skills. For example, people in need of care with the care level 1 who did not have limited daily living skills were transferred to care grade 2. Those in need of care with limited daily living skills, on the other hand, were transferred from care level 1 to care grade 3. The transition was also subject to the principle that those in need of care should not be placed in a worse financial position (grandfathering clause, §141 SGB XI). The classification shown here attempts to compare care needs that are as similar as possible, but does not necessarily correspond to the transition pathways at the time of the reform. 2 – The index refers to the real maximum benefit entitlement of a person in need of care vis-a-vis the care insurance scheme. Price adjustment was carried out using the consumer price index. 3 – Does not take into account the flat-rate increases applicable between 2012 and 2016 for people with permanently impaired daily functioning (dementia-related functional impairment, intellectual disabilities or mental illness).

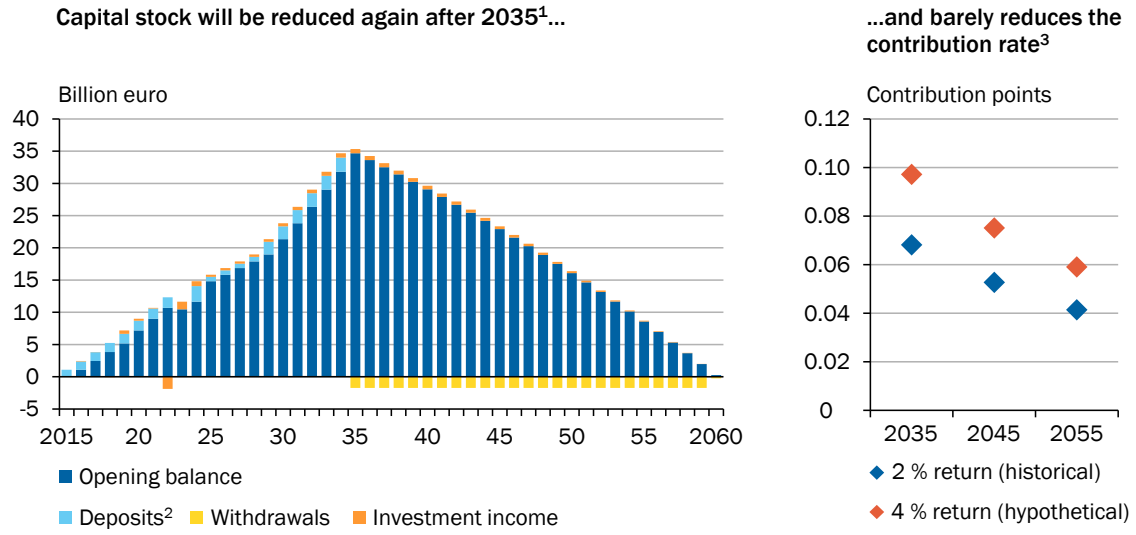
Sources: Deutsche Bundesbank, Federal Office of Administration, Federal Statistical Office, Portal Sozialpolitik, own calculations

points of contribution-based revenue are to be allocated to this fund annually and invested by the Deutsche Bundesbank, with the involvement of an investment committee, until 2034. From 2035 onwards, it is planned to use the accumulated funds gradually to stabilise future contribution rates.

309. **The design of the PVF exhibits several structural weaknesses** (Breyer, 2025). Firstly, the annual contributions are low. Secondly, the withdrawal phase begins at a time when the demographic-driven rise in expenditure is not yet expected to have peaked. This is not expected until around 2050. As a temporary reserve, the fund is therefore only available to a limited extent, particularly during the phase of particularly high demand. Thirdly, the Long-Term Care Provision

↘ CHART 65

Capital development and contribution rate effects of the Long-term care provision fund



1 – Actual performance up to 2025. From 2026 onwards, an annual return of 2% is assumed, which approximates the historical return for the period 2016 to 2024. Negative interest rates and administrative costs may result in negative investment returns. 2 – The contributions for the year 2023 were made in 2024. 3 – The development shown in the left-hand panel is assumed, as well as contribution rate and SPV expenditure trends in line with the simulations in Werding et al. (2026). With a higher return of 4 %, payouts amounting to 6.8 % rather than 5 % of the final assets in 2034 are assumed in order to keep the payout period constant.

Sources: BMG, SIM.24, own calculations

Fund is not sufficiently protected institutionally against short-term political interests. The contributions, which have been repeatedly reduced or suspended in recent years, highlight the limited reliability of the existing framework. For instance, with the entry into force of the Long-Term Care Support and Relief Act in 2023, a contribution of 1.7 billion euros was postponed by one year. To balance the federal budget, the federal subsidy to the SPV for the years 2024 to 2027 has been suspended. This shortfall in funds is offset by a reduction in the SPV's contributions to the provision fund of €1 billion annually. Finally, fourthly, the investment strategy is comparatively conservative, meaning that the returns achieved to date have been low. The annualised nominal return to date is around 2 %. ↘ CHART 65 Given the long time horizon, this level of return is significantly lower than it could be.

310. In its current form, the **positive effects of the PVF** on the financing of the SPV are likely to remain **limited**. Assuming a nominal return of 2 % and annual contributions of 0.1 contribution rate points, ↘ ITEM 308 which, due to the recent reduction or suspension of payments, are not due to resume in full until 2028, this results in a capital stock of around €30 billion by 2035. ↘ CHART 65 LEFT The capital stock will be drawn down again from 2035 onwards and is expected to reduce the contribution rate by less than 0.1 percentage points by 2055 (Scientific Advisory Board to the BMWK, 2022; Federal Government, 2023). ↘ CHART 65 RIGHT Even if a higher nominal return could be achieved in the PVF in future, for example through a less conservative investment strategy, the future relief effect would remain limited. ↘ CHART 65 RIGHT In any case, the scope for this is likely to be limited, as the legal

basis of the PVF stipulates that the portion of the special fund invested in shares or equity funds must be completely phased out over a maximum period of ten years from 2035 onwards (Section 134(2) SGB XI).

IV. PERSONAL CONTRIBUTIONS AND SOCIETAL COSTS OF CARE

1. Financial burden on those in need of care

311. **As a partial insurance scheme, the SPV covers only part of the care costs.** The remainder must be financed by the person in need of care themselves, from their income or assets, or by taking out supplementary private care insurance. Under certain conditions, people in need of care may also be eligible for supplementary general (e.g. housing benefit plus) or care-specific state benefits (e.g. care housing allowance). To a limited extent, relatives may also be called upon to help finance care costs. Those in need of care for whom the aforementioned sources of funding are insufficient to cover care costs are entitled to social assistance ('help with care').

312. **This also applies to home care, where, despite SPV benefits, those in need of care are still required to make co-payments.** In 2019, 38.8 % of benefit recipients reported making private co-payments, rising to 44.7 % in 2023 (Schwinger and Zok, 2024). Among those who made such out-of-pocket payments, the average monthly costs were just under 200 euros in 2019 and 290 euros in 2023. The increase is largely attributable to higher co-payments for outpatient care services. However, these items may underestimate the actual burden, as larger one-off expenses, for example for age-appropriate home modifications, and in particular non-monetary personal contributions, are not recorded. ↘ ITEMS 323 FF. Our own analyses based on the SOEP suggest that around 20 % of people aged 66 and over who are in need of care live in households below the at-risk-of-poverty threshold. For those who do not need care, the figure is 18 %.

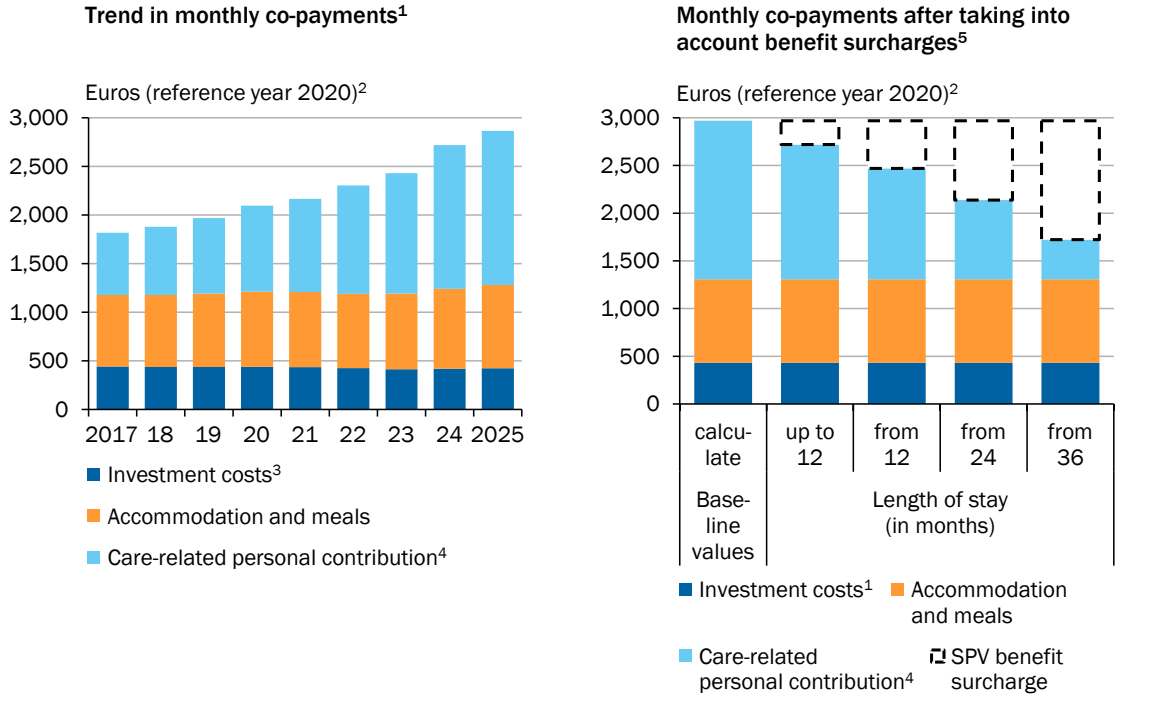
313. **In recent years, co-payments for institutional care have also risen steadily in real terms.** ↘ CHART 66 LEFT These consist of the care-related personal contribution, the costs of accommodation and meals, and the investment costs of the care facilities, which can be apportioned proportionally to those in need of care. A key driver of this increase is the significant rise in wage costs for care staff in recent years (Roth, 2026; vdek, 2026). ↘ ITEM 294

314. The benefit surcharge introduced in 2022 reduces the personal contribution towards care-related expenses in full-time institutional care and increases with the length of stay. ↘ BACKGROUND INFO 15 Its aim was to protect residents of institutional care facilities from financial strain caused by rising personal contributions and, thereby, indirectly to limit the use of 'help with care'. This significantly reduces the care-related personal contribution payable by those in need of care. ↘ CHART 66

RIGHT **The payment of benefit surcharges is made without taking into account the individual income and asset situation** of the person in need of care. In comparable social long-term care insurance systems, such as those in Japan or Korea, however, both an income and an asset test are carried out (Campbell et al., 2009; Karmann and Sugawara, 2021; OECD, 2024).

315. **A significant proportion of the older population has assets that can be used to finance care costs.** According to calculations by the GCEE based on the SOEP, around 27 % of people aged 66 and over have real net assets of more than €100,000 shortly before becoming in need of care. ↘ CHART 67 LEFT Net assets also include the individual's share of property assets. Around 60 % of people have real net assets of more than €10,000. An analysis by Pimpertz and Stockhausen (2024) based on the SOEP examines the financing potential of private households

↘ CHART 66
Personal contributions to institutional care



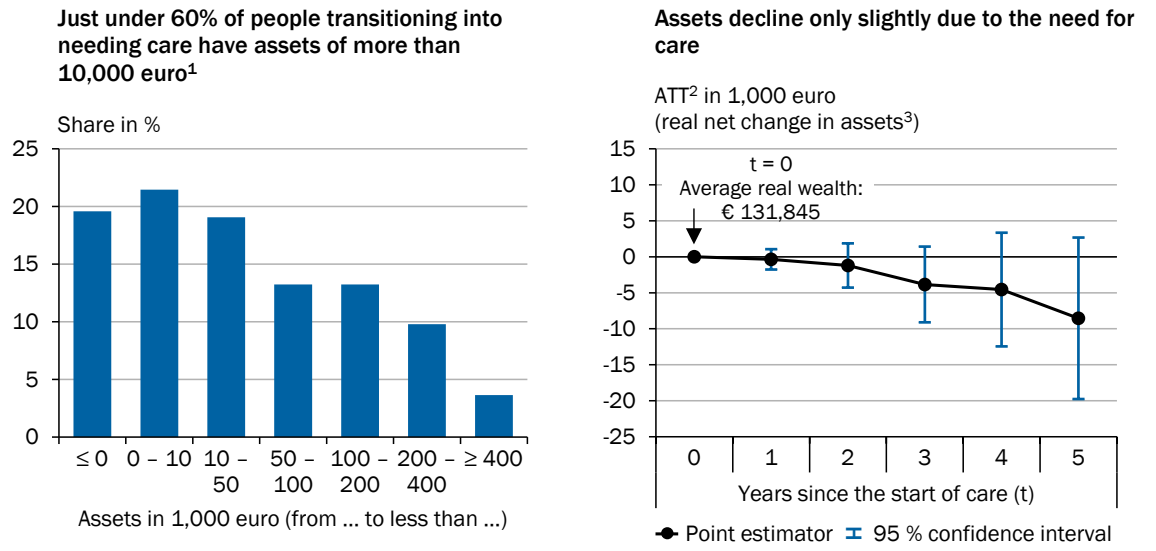
1 – Excludes benefit surcharges graded according to length of residence (§ 43c SGB XI). The reference date is 31 December of the respective year or, for Saxony-Anhalt, 21 October 2025. 2 – Price-adjusted with the consumer price index (base year 2020). 3 – Investment costs comprise the care facility operator's costs for construction work (new builds, conversions and refurbishments), for technical assets and for depreciation of the building. These costs may be apportioned to the residents. 4 – The care-related personal contribution applies to all residents of a care facility, but varies between facilities. It reduces through a subsidy from the long-term care insurance funds that depends on the length of stay, which is only taken into account in the chart on the right. The care-related personal contribution includes training levels. 5 – The reference date is 1 January 2026. Since 1 January 2022, a cap has been in place on the personal contribution towards care-related expenses through benefit surcharges under § 43c of SGB XI. The benefit surcharges were increased as of 1 January 2024. Since then, those in need of care who have lived in a full-time institutional care for up to one year have received a surcharge from the long-term care insurance fund amounting to 15 % of their co-payment for care-related expenses. Those in need of care who have lived there for between one and two years receive 30 %, those who have lived there for between two and three years receive 50 % and all those who have been living in a care facility for more than three years are reimbursed 75 % of their co-payment by the long-term care insurance fund.

Sources: Federal Statistical Office, own caculations, vdek, WIdO, own calculations

in the case of full-time institutional care, including the benefit surcharge and taking into account an exempt asset of €10,000 per household member. The costs of institutional care amount to just under €30,000 in the first year and just under €120,000 over a five-year period. According to the findings, around 55 % of pensioner households in Germany can cover the costs of full-time institutional care for one person for a period of up to five years from their income and assets, provided that the owner-occupied property is included in the exempt assets. If it is not included in the exempt assets, around 72 % would be able to do so.

316. **People in need of care have lower assets compared to the rest of the population**, whereas their income situation hardly differs. For people aged 60 and over, the average net assets of those in need of care in 2017 were around €60,000 lower and the median assets €51,000 lower than for the rest of the population (Geyer et al., 2023). This difference can likely be explained in part by the use of assets to finance care-related expenditures. An analysis by the GCEE based on the SOEP examines the development of assets among people who become in need of care, compared to those who do not become in need of care during the same period. ↘ CHART 67 RIGHT The individuals in the initial sample have an average net worth of 131,845 euros. The individuals are on average 73 years old, with women and men represented in almost equal numbers. In the first five years after

↘ CHART 67
Financial situation of people in need of care



1 – Includes individuals who do not require care at t = 0 but do require care at t = 1. The figure shows their wealth distribution at t = 0. 2 – Average treatment effect on the treated; Average annual effect of the need for care on the change in real net wealth for individuals who require care from t = 1 onwards. At time t = 0, none of the individuals under consideration require care. From t = 1 onwards, those requiring care are compared with statistically comparable individuals who do not require care. Comparability is established by forming a statistically comparable control group based on socio-economic characteristics at t = 0, including the baseline value of real net wealth in 2021 prices. The analysis uses the methodology of Schmitz and Westphal (2017) based on the SOEP (v40.1). The estimate covers the years 2002 to 2017 and individuals aged over 65. 3 – Compared to t = 0. Net wealth comprises owner-occupied residential property, other real estate assets, financial assets, private insurance companies and building society savings contracts, as well as business and tangible assets, less liabilities.

Sources: Schmitz and Westphal (2017), SOEP v40.1, own calculations

becoming in need of care, those affected deplete their assets on average only to a limited extent, namely by around 8,500 euros or 6.5 % of their assets prior to needing care. ↘ CHART 67 RIGHT The comparatively low depletion of assets suggests that the lower assets of those in need of care may also be attributable to less favourable socio-economic starting conditions, which influence both the risk of needing care and the accumulation of assets over the course of a lifetime. ↘ ITEM 283

317. **Private supplementary** care insurance can be used to cover financial risks not covered by the SPV. Policyholders can choose between three options: Under daily care allowance insurance, fixed, freely disposable payments are made in the event of a need of care. Under long-term care cost insurance, care-related costs are reimbursed upon presentation of proof. Under long-term care annuity insurance, lifelong annuity payments are made in the event of a need of care.

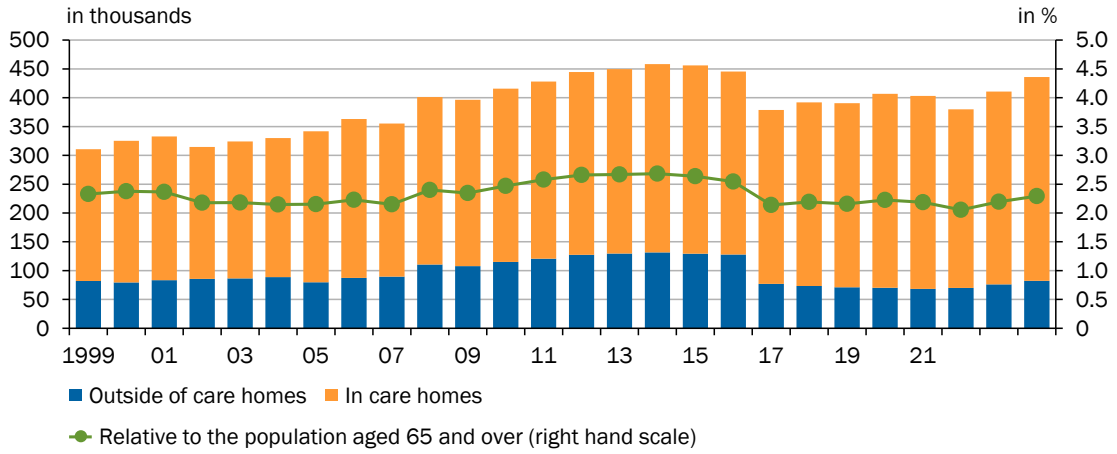
318. In 2024, around 3.2 million people in Germany had private **supplementary long-term care insurance** (GDV, 2025). Overall, uptake is heavily concentrated among households with above-average income and assets (Haun, 2025). The number of supplementary long-term care insurance policies taken out has roughly doubled since 2010. A large proportion, around 94 %, was accounted for by daily long-term care insurance in 2024. To ensure that people who, due to their age or pre-existing conditions, can only take out very expensive policies or none at all can also obtain cover, there are state-subsidised long-term care insurance tariffs, also known as 'Pflege-Bahr' (BMG, 2026c). Here, the state supports private long-term care provision with an allowance of 60 euros per year, and the policy can be taken out without a medical examination.

319. Those in need of care can, provided they meet the requirements, also claim 'housing benefit plus' to help cover general housing costs. In the case of institutional care, some federal states also offer 'care housing allowance' to cover investment costs. ↘ ITEM 290 If income, assets and these benefits are insufficient, or if there is no entitlement to them, **social assistance** is provided in the form of **'help with care**'. In 2024, a total of just under 436,000 people in Germany received "help with care". ↘ CHART 68 Following the introduction of benefit surcharge in 2022 for full-time institutional care, there was a slight reduction in the number of recipients. Between 2022 and 2024, the number of recipients rose by 14.7 %. However, the proportion of recipients of 'help with care' within the population aged 65 and over has remained stable since 1999. This suggests that the risk of needing social assistance due to a need of care in old age has not fundamentally changed in the long term. The vast majority (81 %) of recipients received 'help with care' in a nursing home. In 2023, the 'help with care' rate in facilities – measured as the proportion of recipients of 'help with care' among all those in need of care receiving full or part-time institutional care – stood at 34.3 %.

320. **Access to 'help with care' is means-tested.** Those in need of care must, in principle, use their entire current income. As regards assets, a personal allowance of 10,000 euros has applied to single persons since 2023; any assets exceeding this amount must be used. Own-occupied residential property is generally retained as long as a spouse or registered partner lives there. Since 2020, a high

↘ CHART 68

Recipients of "help with care" from 1999 to 2024



1 – the data covers all Länder except Bremen for the period 2005 to 2007. Under-reporting is evident for 2007: in North Rhine-Westphalia approximately 14,500 cases of "help with care" are missing, and in Saarland, approximately 700 cases of integration assistance outside institutions are missing. The data for 2017 and 2018 exclude recipients of "help with care" under chapter 7 of SGB XII who have not been assigned a care grade. Bremen additionally includes persons under § 264 section 2 SGB V.

Sources: BMG, Federal Statistical Office, own calculations

exemption limit has applied to children with a maintenance obligation: they are only required to contribute if their gross annual income exceeds 100,000 euros. Only the income of the child liable for maintenance is relevant here; the spouse is not directly liable for maintenance towards the parents-in-law. This means that, in the case of married couples, the child's income is only taken into account if the child liable for maintenance exceeds the income threshold themselves. Even then, the law stipulates that an assessment of income circumstances is only permissible if there are concrete indications of a correspondingly high income (Section 94(1a) SGB XII). Without such indications, it is generally assumed that the conditions for taking the child's income into account are not met. Against this background, the inclusion of relatives' income is, in practice, severely restricted.

2. Impact of informal care

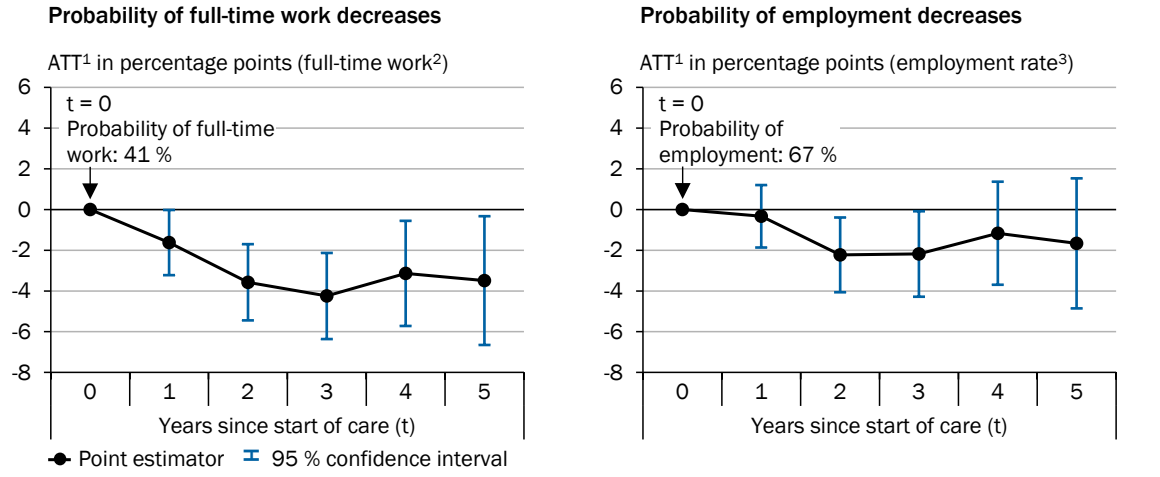
321. **Informal care involves a significant time commitment, which can affect the carer's employment, working hours and long-term career progression.** Analyses by the GCEE based on the SOEP for the year 2023 show that informal carers of working age (25 to 64) spend an average of 2.6 hours per day on care during the week. For informal carers aged 65 and over, the daily care time is higher at 3.7 hours.

322. An analysis by the GCEE based on the SOEP, which follows the methodology of Schmitz and Westphal (2017), shows that for people aged 25 to 64, taking on informal care has lasting effects on full-time employment and employment. ↘ CHART 69 Three years after starting care work, the probability of being in full-time employment or in employment at all is 4.2 and 2.2 percentage points lower, respectively, than before taking on care work. **Informal care is thus not only associated with short-term adjustments to labour supply, but** also **reduces lifetime earnings on average and, consequently, the old-age provision of carers.** At the same time, social costs arise due to lower tax payments, lower social security contributions and higher expenditures on social benefits (Geyer et al., 2017).

323. The empirical literature reaches similar conclusions. Schmitz and Westphal (2017) show that for women aged 25 to 64, the probability of full-time employment falls by up to 5 percentage points after taking on informal care. Korfhage and Fischer-Weckemann (2024) estimate a 2.6 % decline in hours worked for women aged 55 to 67 as a result of informal care. Ehrlich et al. (2019) also show that for women aged 25 to 59, there is no increased likelihood of extending working hours or returning to the labour market after ceasing caregiving activities.

324. **The loss of earned income, lower human capital accumulation and the increased depreciation of human capital during the care period shift care-related risks in part from those in need of care to their relatives.** Financial compensation for this is at the discretion of those in need of care. They

↘ CHART 69
Informal care and labour supply



1 – Average treatment effect on the treated; average annual effect of informal care on the respective target variable for individuals who begin providing care from t = 1. At time t = 0, none of the individuals under consideration are providing care. From t = 1 onwards, informal carers are compared with statistically comparable non-carers. Comparability is ensured by establishing a statistically comparable control group based on socio-economic characteristics at t = 0, including the baseline value of the respective target variable. The analysis uses the methodology of Schmitz and Westphal (2017) based on the SOEP (v40.1). The estimation covers the years 2015 to 2023 and individuals aged 25 to 64. 2 – Indicator variable with a value of 1 for full-time employment. The probability of working full-time falls by around 4.2 percentage points three years after the start of caregiving. 3 – Indicator variable with a value of 1 for employment. The probability of being in employment falls by around 2.2 percentage points three years after the start of caregiving.

Sources: Schmitz and Westphal (2017), SOEP v40.1, own calculations

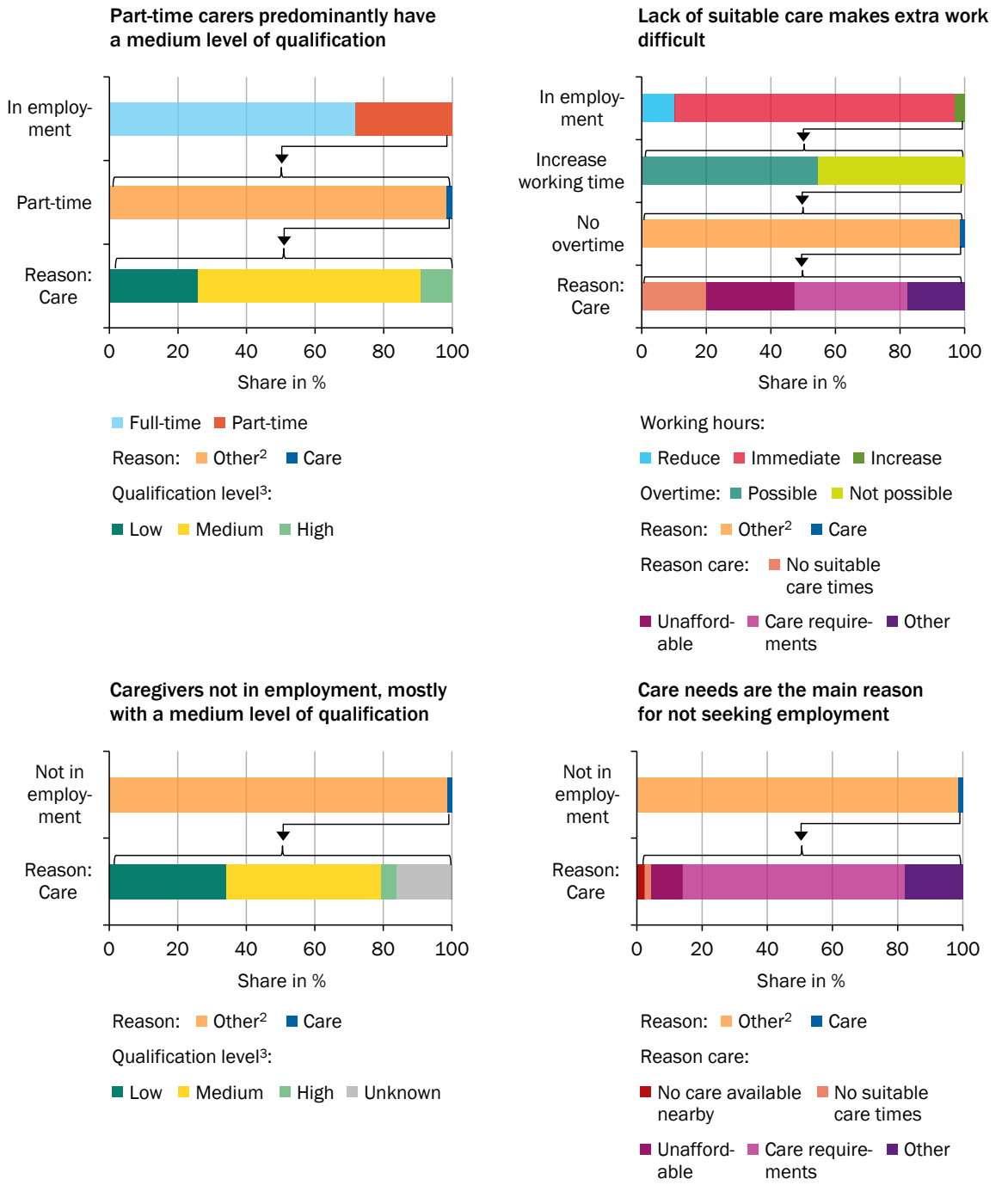
can, for instance, pass on the care allowance to the supporting relatives. Caregivers also receive pension insurance contributions for the periods of care provided. ↘ TABLE 13 Informal care therefore means that a significant proportion of care costs is borne by private households through their own contributions. Against this background, the question arises as to whether care-related part-time work or non-employment is more a reflection of individual preferences or rather a consequence of economic or social conditions. In the literature, the focus is primarily on the opportunity costs for carers and care allowances as key determinants of care decisions (Barczyk and Kredler, 2018; Mommaerts, 2025). Barczyk et al. (2025) demonstrate, based on European data, that the care preferences of those in need of care and their relatives also play an important role.

325. **Only among a small proportion of 25- to 64-year-olds, care responsibilities are the reason for part-time work or economic inactivity.** According to the 2023 microcensus, caregiving is a reason for part-time employment for 0.5 % of the labour force and a reason for economic inactivity for 1.3 % of the economically inactive population aged 25 to 64 surveyed. ↘ CHART 70 TOP LEFT AND BOTTOM LEFT Compared to the labour force, childcare is a reason for part-time employment for 7.5 % of the labour force and a reason for inactivity for 11 % of the inactive population. In total, care-related part-time work and economic inactivity affect around 300,000 people, the majority of whom have a medium level of qualification. Furthermore, it appears that only 0.02 % of the labour force who would like to increase their working hours are prevented from doing so for care-related reasons. ↘ CHART 70 TOP RIGHT For this group, the lack of suitable care provision is the main determining factor. Among those not in employment, however, the desire to provide care themselves is more frequently a factor. ↘ CHART 70 BOTTOM RIGHT

326. Overall, the results based on the 2023 microcensus suggest that the direct **labour market effects** resulting from informal care are comparatively small when viewed in the overall context. Around 7,350 people reduce their working hours under a care leave scheme in accordance with the Care Leave Act or the Family Care Leave Act. The resulting difference between the hours normally worked and those actually worked corresponds to just under 0.01 % of the total working hours of the labour force aged 25 to 64, or around 3,200 full-time equivalents based on a 40-hour working week. For those working part-time due to care responsibilities, the comparison between desired and normally worked hours results in an additional loss of 0.002 % of the total working hours, or around 750 full-time equivalents. Added to this are just under 30,000 economically inactive people who would generally like to work but are currently unable to do so due to care responsibilities. Assuming an average weekly working time of 35.44 hours for the employed population under consideration, this corresponds to a loss of 0.08 % of the total labour volume, or around 26,300 full-time equivalents. In total, the care-related loss thus amounts to just under 0.09 % of the labour force, or around 30,250 full-time equivalents.

↘ CHART 70

Care-related part-time work and non-employment[1]



1 – In 2023 and people aged 25 to 64. 2 – Illness or incapacity for work, education or training, notice periods in current job, childcare, other family reasons, other personal reasons, other main reason. 3 – The skill level is based on the current occupation for those in employment and on the most recent occupation for those not in employment. Three skill levels are distinguished based on the 12 occupational categories of the Blossfeld classification. The low qualification level comprises agricultural occupations, unskilled manual occupations, unskilled service occupations, and unskilled commercial and administrative occupations. The medium qualification level comprises skilled manual occupations, technicians, skilled service occupations, semi-skilled occupations, and skilled commercial and administrative occupations. The high qualification level comprises engineers, professionals and managers.

Sources: RDC of the Federal Statistical Office and Statistical Offices of the Federal States of Germany, DOI: 10.21242/12211.2023.00.00.3.1.0, own calculations

V. FUTURE FINANCING OF CARE EXPENDITURE IN THE DEMOGRAPHIC CHANGE

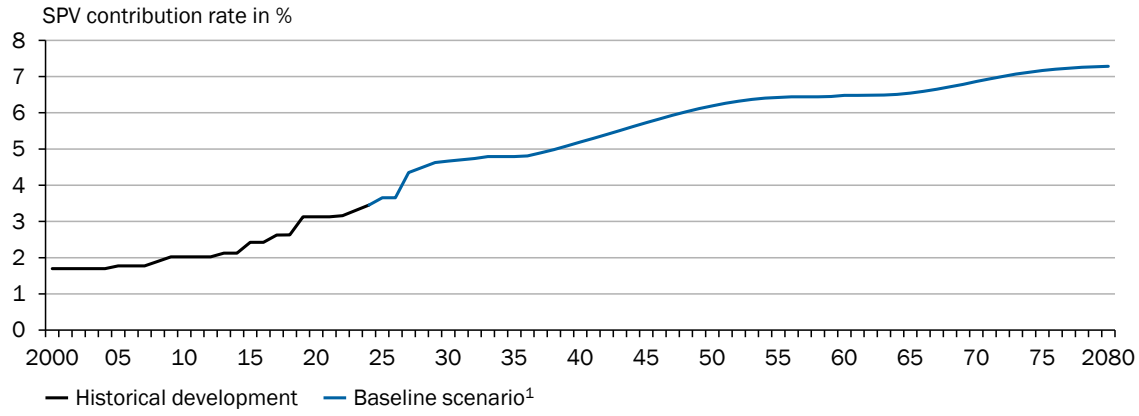
327. The recent sharp increases in SPV expenditures have been driven primarily by eased access to benefits and the increase in SPV benefits under the PSG II in 2017. Due to the SPV's pay-as-you-go financing, this has led to rising contribution rates. **Demographic ageing has so far had little impact on SPV expenditures. In future, however, it will be the key driver.** This results in a structural financing problem for the SPV. Due to the ageing population and the growing proportion of older people at increased risk of needing care, expenditures are rising even if benefit levels remain unchanged. However, contribution-based revenue cannot keep pace with this: the proportion of people of working age is falling, whilst the proportion of retired people is rising. As a result, contribution-based revenue is declining in relative terms and the SPV's revenue is growing more slowly than expenditures.

328. The GCEE projects the future development of the SPV's revenue and expenditures based on the long-term simulations by Werding et al. (2026). This involves estimating how the contribution rate under the existing SPV system will develop up to 2080 under current legislation. This is calculated as an average contribution rate and also includes the surcharges and rebates for insured persons with and without children.

In **the baseline scenario, all SPV benefits** are **indexed to gross wage growth,** and rising funding requirements are offset by higher contribution rates. Although current legislation does not provide for indexation beyond 2028, the baseline scenario thus **assumes a constant level of SPV benefits**. This is because if benefits are adjusted in line with gross wage growth, the co-payments of those in need of care also rise by the same proportion. The burden of co-payments thus remains constant relative to gross wages. In the baseline scenario, the GCEE therefore assumes a scenario favourable to those in need of care. This corresponds to a proposal discussed by the Federal-State Working Group on the 'Future Pact for Care'. ↘ BOX 21 APPENDIX

329. Furthermore, the long-term simulations are based on a couple of **assumptions** regarding the future development of the population and overall economic potential output. ↘ BACKGROUND INFO 5 In the context of the SPV, the gender- and age-specific prevalence of care needs from 2024 is kept constant. Due to rising life expectancy, the duration of care dependency is thus extended. The pattern of uptake of individual SPV benefits is kept constant at the 2024 level throughout the simulation period; due to an assumed rise in female labour force participation, there is merely a slight shift towards institutional care. Sensitivity analyses, for example regarding the significance of increasing take-up of care benefits in kind or alternative assumptions regarding labour market developments, can be found in the working paper by Werding et al. (2026).

↘ CHART 71
Simulation of the SPV contribution rate under the status quo



1 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth.

Sources: BMG, SIM.24
© Sachverständigenrat | 26-065-01

330. **The simulations carried out by the GCEE show that, assuming benefit levels remain constant, demographic ageing will lead to a steady rise in expenditures and contribution rates within the SPV.** ↘ CHART 71 In the baseline scenario, the average contribution rate is expected to rise from the current 3.7 % to 4.7 % by 2030. Thereafter, it will rise continuously until 2040 to a level of 5.2 % and reach 7.3 % in 2080. Such a development is problematic for three reasons. Rising contribution rates lead to greater intergenerational redistribution at the expense of younger generations. If the contribution assessment ceiling ↘ GLOSSARY and the tax base remain unchanged, individuals with incomes below the contribution assessment ceiling ↘ GLOSSARY will be relatively more heavily burdened than those above the ceiling. In addition, the overall economy could be adversely affected.

331. **Expansions of benefits and the potentially associated increases in contribution rates lead, in a pay-as-you-go system, to greater intergenerational redistribution at the expense of younger generations** (Bahnsen et al., 2020). Provided that all insured persons are immediately entitled to the expanded benefits, persons entitled to benefits or those who are already on the verge of becoming eligible for benefits will benefit from initial gains. Although younger insured persons will receive the same entitlement to benefits in the event of needing care, they are likely to pay the higher contributions over a longer period and thus contribute disproportionately more to the financing of these benefits.

332. Due to the interaction of the contribution assessment ceiling, the absence of tax-free allowances and the predominant inclusion of earned income, the **burden of the contribution rates** is **not uniform**: up to the contribution assessment ceiling ↘ GLOSSARY, contributions are proportional to income. Above the contribution assessment ceiling, however, a regressive effect sets in, as additional income is no longer used to finance the scheme and the average burden decreases as income rises.

333. **Rising contribution rates can hamper macroeconomic development.** ↘ ITEMS 113 FF. If they are not fully passed on, they dampen the growth in private households' disposable income whilst simultaneously increasing companies' labour costs. This curbs both the labour supply and private household consumption, as well as companies' demand for labour, thereby weakening overall economic output growth. In sectors with international exposure, price competitiveness also deteriorates, which can have a negative impact on gross fixed capital formation and Location decisions. At the same time, lower tax bases reduce revenue from income-related taxes, leading to fiscal losses. Furthermore, there could be a shift in behaviour among those voluntarily insured under the statutory health insurance (GKV) scheme – and thus also under the supplementary pension insurance (SPV) scheme – as they are more likely to opt for risk-based private health and long-term care insurance, thereby withdrawing from the solidarity-based system.

VI. REFORM OPTIONS FOR SUSTAINABLE FINANCING OF LONG-TERM CARE

334. Previous reforms in the care sector have focused primarily on improving care provision. The associated additional expenditure was financed via the pay-as-you-go system through increases in contribution rates, and thus primarily by younger generations. However, expenditure trends were regularly underestimated, necessitating further adjustments to the contribution rate.↘ ITEM 304 Most recently, the financing problem was postponed into the future by drawing down the reserves of the long-term care insurance funds**. Structural reforms to ensure the sustainable financing of the SPV have so far failed to materialise.** ↘ BACKGROUND INFO 4 An exception to this is the Long-Term Care Provision Fund (PVF), introduced in 2015, the design of which, however, has significant weaknesses. ↘ An exception to this is the Long-Term Care Provision Fund (PVF), introduced in 2015, the design of which, however, has significant weaknesses. ↘ ITEM 309 The federal-state working group "Zukunftspakt Pflege" presented initial proposals for reforms to the provision and financing of long-term care insurance in December 2025.↘ BOX 21 APPENDIX

335. **In this section, the GCEE focuses on reform options which, under the changed financing conditions**, both better meet the requirements of intergenerational equity and ensure needs-based care, whilst strengthening the personal responsibility of those in need of care through co-payments. However, there is a conflict of objectives between the scope of SPV benefits, the level of the contribution rate and the level of co-payments by those in need of care. A single measure cannot resolve this conflict of objectives; rather, a combination of measures is necessary. The fundamental structure of the SPV as a partial insurance scheme should be retained.

336. To limit the growth in expenditure, access to SPV benefits should first be realigned more closely with the level recommended by the Expert Advisory Board in 2013.

↘ ITEMS 339 FF. This would reduce both the number of eligible recipients and the average care needs classification. Furthermore, benefits with low targeting accuracy should no longer be covered by the SPV. These include, in particular, the benefit surcharge for full-time institutional care ↘ ITEM 349 and the respite care allowance ↘ ITEM 342 across all care grades. In addition, the introduction of cohort-specific capital funding within the SPV could secure the current level of benefits and ensure that the distribution of the financial burden is more equitable across generations. ↘ ITEMS 354 FF.

337. A favourable **trend** in SPV expenditure should also be achieved by systematically integrating **preventive measures** into care provision. These measures should aim to reduce the risk of people needing care, delay the onset of the need of care, and limit progression to higher levels of care. The voluntary regular screening examinations proposed by the Federal-State Working Group on the 'Future Pact for Care' – in the sense of a health check-up – could identify health risks at an early stage and enable preventive measures to be initiated (BMG, 2025d). Internationally, comparable monitoring tools (e.g. preventive home visits) have been shown to have beneficial effects on the onset of the need of care and on cost-effectiveness (Liimatta et al., 2019; Bannenberg et al., 2021; OECD, 2025). Furthermore, measures to promote physical and cognitive activity, social participation and a healthy diet are considered particularly effective in preventing the need for long-term care (Kuhlmey and Budnick, 2024).

338. To strengthen the revenue side of the SPV, reforms that encourage an increase in the volume of work are the primary option. ↘ ITEM 159 For further measures, similar considerations to those in the GKV must be taken into account. Additional revenue could be generated through a contribution obligation for spouses without young children who were previously insured without paying contributions. ↘ ITEM 260 The currently discussed increase in the contribution assessment ceiling ↘ GLOSSARY for long-term care insurance could also boost revenue, but would be accompanied by increased incentives to avoid contributions among higher earners, constitutional issues, and a further shift towards a tax-like structure for financing. ↘ ITEM 262 Including all new civil servants could also increase revenue and thus gradually reduce the SPV contribution rate over time. ↘ CHART 77 APPENDIX However, this would entail a significant additional fiscal burden on the general government during a long transitional phase. ↘ ITEM 263

As with the other branches of social insurance, the SPV's tasks relating to society as a whole should be clearly defined and tax-financed. ↘ ITEM 154 In the view of the GCEE, this includes the non-contributory co-insurance of spouses during the first years of child-rearing. ↘ ITEM 154 Furthermore, the one-off reimbursement of additional expenditure arising from the coronavirus pandemic appears appropriate. ↘ ITEM 303

1. Access to benefits and the scope of benefits provided by the SPV

339. The PSG II reform has both eased access to SPV benefits and expanded the scope of benefits. This has led to a significant increase in expenditure. A first step towards curbing the growth in SPV expenditure should therefore be a critical review of this catalogue of benefits.

340. For instance, the PSG-II reform has made access to long-term care insurance benefits and the attainment of higher care grades easier than would be justifiable on the basis of care science. ↘ ITEM 304 A key contribution to curbing the growth in SPV expenditure should therefore be to adjust the **thresholds** for all future initial applications and upgrades to the values recommended by the Expert Advisory Board in 2013, ↘ BACKGROUND INFO 17 thereby raising them, as also proposed by the Federal-State Working Group on the 'Future Pact for Care'. ↘ BOX 21 APPENDIX This would limit access to SPV benefits and thus curb the annual output growth in the number of people needing care. At the same time, this would make it more difficult to move to higher care grades with correspondingly higher benefit entitlements, thereby having a dampening effect on SPV expenditures.

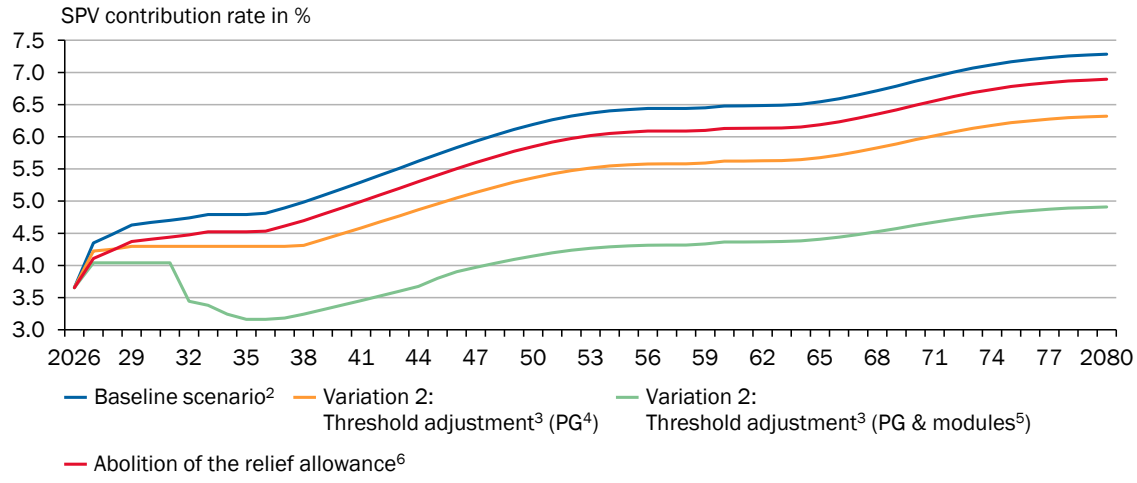
341. The GCEE has simulated **the effects of such a reform** on the contribution rate based on two variants. ↘ CHART 72 In the first variant, only the threshold value relevant for reaching care grades 1 to 3 is raised. In the second variant, the threshold values within the NBA modules are also raised. Both adjustments affect both whether a care grade is attained and the severity of the care needs as assessed. In both variants, there are sustained dampening effects on the contribution rate. In the first variant, this stands at 4.5 % in 2040, around 0.7 percentage points below the baseline scenario. Even more favourable effects are evident in the second variant. Under this variant, the contribution rate in 2040 would be 3.4 %, which is even below the current level of 3.7 % and around 1.8 percentage points below the baseline scenario.

342. The **relief allowance** for home care (Section 45b SGB XI), which was introduced across all care grades as part of the PSG II reform in 2017, should be abolished. Arguments in favour of this include, in particular, overlaps with care benefits in kind in care grades 2 to 5 (Section 45a(4) SGB XI) and the administrative costs associated with recognition as a care service and the cost reimbursement principle (Helms and Röder, 2024; Arentz and Wasem, 2026).

In care grade 1, given the only minor impairments, it is questionable whether the relief allowance is absolutely necessary to maintain independence. A survey of assessors from the medical service of private health insurances suggests that the main motive for a care application by people with minor limitations is to obtain cash benefits (Medicproof, 2024). Measures that could have a positive influence on the development of care needs (e.g. rehabilitation or therapeutic interventions), however, do not appear to be of interest to applicants. It is therefore questionable whether the benefits of care grade 1 actually achieve the intended goal of early support and the effective use of preventive measures (Wasem et al., 2025). Around 36 % of assessors state that people with care grade 1 do not need long-

↘ CHART 72

Contribution rate development with adjustment of entry[1] and benefits of the SPV



1 – The estimation of the effects is based on a special analysis provided to the GCEE by the Medical Service covering all initial assessments of applicants aged 18 and over in 2024. 2 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth. 3 – In the model, contribution rate reductions are only implemented once the SPV's reserves have been replenished. Consequently, the reduction in the contribution rate does not take effect immediately, but with a time lag. 4 – The thresholds for care grade (PG) determine the point value at which those in need of care are assigned to the respective care grade. In the scenario, the thresholds for care grades 1 to 3 are raised to the level recommended by the Expert Advisory Board in 2013. 5 – The thresholds within the individual modules of the NBA determine how the points actually achieved in the assessment are converted into weighted NBA points, thereby influencing the total score in the respective module. In this scenario, these thresholds are raised to the level recommended by the Expert Advisory Board in 2013 for modules 1, 4 and 6, in addition to the (PG) scenario. 6 – The expenditure volume of the relief allowance is not reported separately in the BMG financial statistics. The category "additional outpatient care and respite services" serves as an approximation. The calculated uptake of these services in 2023 was around 40 % of those in need of care receiving outpatient care and is assumed to remain constant over the simulation period.

Sources: BMG, Federal Medical Service, SIM.24, own calculations

term care insurance benefits (Medicproof, 2024). According to calculations by the GCEE, a complete abolition of the relief allowance could reduce the contribution rate by up to 0.3 percentage points in 2040 compared with the baseline scenario. ↘ CHART 72

2. Retain the partial insurance scheme

343. **The SPV is designed as a partial insurance scheme and, as such, provides for a co-payment by those in need of care.** This systemic decision takes account of the fact that the need of care, whilst representing a high life risk, is generally of a limited duration, the costs of which can be borne by large sections of the population themselves and covered by their own provision. It is therefore not necessary to collectivise it entirely. In the past, SPV benefits were expanded irregularly and, most recently, saw a sharp increase following the PSG II reform, particularly in home care. ↘ ITEM 305 In particular, benefits for institutional care have not kept pace with cost developments. This has led to a continuous rise in co-payments for institutional care. ↘ ITEM 313 Co-payments in home care have also risen recently, but remain at a comparatively low level. ↘ ITEM 312 This is largely

due to the high proportion and expansion of informal care, the costs of which are not quantified in monetary terms. ↘ ITEMS 321 FF.

344. In order to reduce the rising co-payments in institutional care or to limit their further increase, welfare organisations propose expanding the SPV into **comprehensive insurance** (Paritätischer Gesamtverband, 2026; VdK, 2026). On behalf of these associations, Rothgang and Domhoff (2025) simulate such a reform, assuming full coverage of care-related costs in institutional care and the provision of additional per capita benefits in home care amounting to 230 or 360 euros per month to cover the co-payments incurred there. ↘ ITEM 312 According to these simulations, the contribution rate for such comprehensive cover would have to rise by 1 to 1.3 percentage points, depending on the level of per capita benefits in home care. Instead of increasing contribution rates for SPV policyholders, it is proposed to extend the scope of cover to the entire resident population (citizens' insurance) and to all types of income, as well as to raise the contribution assessment ceiling ↘ GLOSSARY to the level of the GRV.

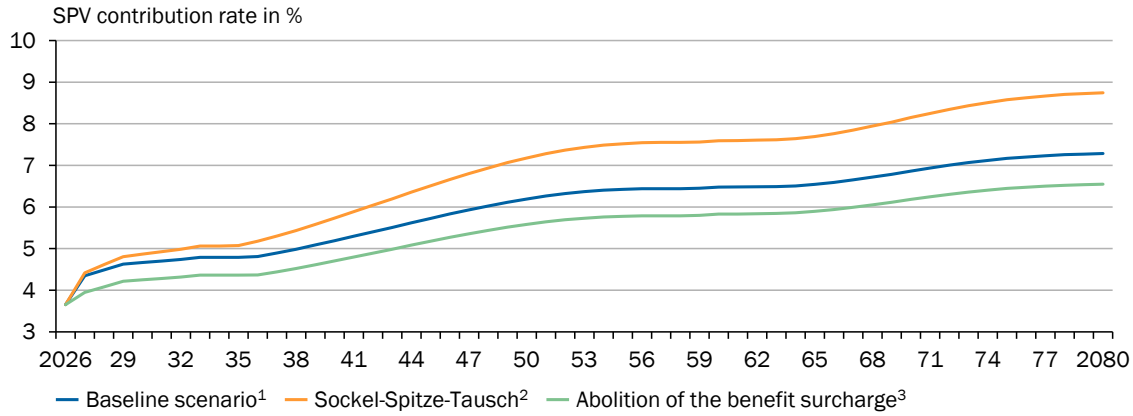
345. The Federal-State Working Group on the "Future Pact for Care" ↘ BOX 21 APPENDIX discusses two options for limiting co-payments: the introduction of a 'Sockel-Spitze-Tausch' (a fixed co-payment model) or the introduction of a rule-based indexation of benefits (BMG, 2025a). The GCEE has already assumed in its baseline scenario that benefits would be indexed to gross wage growth, thereby maintaining a constant level of benefits under the SPV. ↘ ITEM 329 The following therefore examines how, by contrast, a 'Sockel-Spitze-Tausch' would affect the development of contribution rates.

346. Under a **'Sockel-Spitze-Tausch'**, those in need of care would pay only a base amount, whilst the long-term care insurance scheme would cover any care-related costs exceeding this. Compared to the status quo, this would reverse the financial burden between those in need of care on the one hand, and the long-term care insurance scheme and contributors on the other. The impact of this model on the SPV's expenditures and contribution rate depends largely on two factors: the level of the flat-rate amount and the extent to which the flat-rate amount is adjusted in accordance with set rules (e.g. based on price or wage trends). The Federal-State Working Group on the 'Future Pact for Care' proposes a flat-rate amount of 1,200 euros. This would place the base amount considerably below the care-related co-payments currently required in institutional care facilities (BMG, 2025a). ↘ ITEM 313 The base amount is also to be adjusted in line with annual pension adjustments.

347. In its **simulations**, the GCEE has calculated how a **shift** from **a flat-rate** to a **sliding-scale system** would affect the contribution rate. The basis is a base rate of €1,762, corresponding to the care-related co-payments applicable in 2024 for institutional care and thus higher than the base rate of €1,200 proposed by the Federal-State Working Group. ↘ ITEM 313 The base amount remains fixed in nominal terms for the entire simulation period. This leads to a complete shift of future cost increases to the SPV and significantly increases the contribution rate compared with the baseline scenario, which includes indexation of benefits based on gross wage growth. ↘ CHART 73 Under such a reform, the contribution rate in 2040

↘ CHART 73

Contribution rate development following a reform of co-payment



1 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth. 2 – Assuming a nominal freeze on the personal contributions of those in need of care (Sockel) at the 2024 level. 3 – Cap on the personal contribution to care-related expenses according to § 43c SGB XI.

Sources: BMG, SIM.24

would be 5.7 %, around 0.5 percentage points higher than in the baseline scenario. A further reduction in co-payments via a correspondingly lower base would increase contribution rates even more sharply.

348. The call for a **reduction in co-payments** is justified on the grounds of protecting those in need of care from financial hardship. However, there is insufficient empirical evidence to show that co-payments in long-term care lead to financial strain for large sections of those in need of care. In fact, in 2023 only around 17 % of those in need of care were receiving care in institutional facilities and were therefore affected by the co-payments for institutional care. Of these, around 34 % received 'help with care'. ↘ ITEMS 289 AND 319 Furthermore, the vast majority of people over the age of 65 have significant assets shortly before becoming in need of care, which can be used to finance care costs. ↘ ITEM 315 A reduction in co-payments would protect these assets at the expense of contributors and to the benefit of potential heirs. Furthermore, the financial risk can be covered by taking out private care insurance. Finally, assistance in cases of financial hardship is guaranteed by the state through 'help with care', which is granted on a means-tested basis. ↘ ITEM 320

349. The **benefit surcharge** introduced in 2022 to cap the personal contribution for full-time institutional care (Section 43c SGB XI) **should therefore be abolished**. This does not specifically address financial hardship because no means test is carried out. Furthermore, the benefit surcharge systematically hinders the implementation of innovative care models, such as 'stambulante' care, as those in need of care are not eligible for this hybrid form of accommodation and must therefore pay higher personal contributions than in full-time institutional care. ↘ BOX 18 Abolishing the benefit surcharge would strengthen the SPV's principle of subsidiarity through higher personal contributions. ↘ ITEM 297 At the same time, incentives for early transfer of assets could increase, in order to be deemed in need in the event of needing care. Currently, gifts made more than 10 years ago are

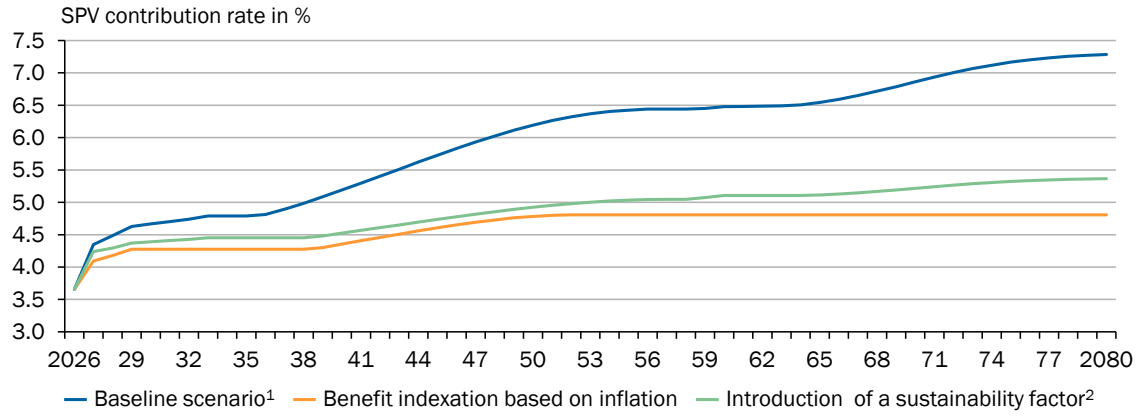
protected from recovery claims by social welfare authorities (Section 528 BGB). To counteract this, this time limit could be extended.

350. **Financial hardship due to the need of care is already specifically addressed today through a strict means test for 'help with care'.** ↘ ITEM 320 Internationally, too, financial assistance in the context of nursing homes is usually linked to an income test and, in some cases, also to an asset test (OECD, 2024). The abolition of the benefit surcharge would lead to a shift in costs and burdens onto the local authorities responsible for 'help with care'. In the year the benefit surcharge was introduced, expenditure on 'help with care' fell by €1.2 billion. As the number of cases rises, the administrative workload for social welfare authorities would also increase. The processing time for applications for 'help with care' varies significantly between social welfare offices (Landtag BW, 2025; Schober, 2025). Staff shortages, missing supporting documents and analogue processes significantly delay processing (Kloss, 2025). Against this backdrop, the question arises as to suitable alternative funding and the administrative handling of the higher caseload.

351. **To ease the financial burden on local authorities**, **a means-tested care housing allowance could be introduced at the state level**, as already exists in some states. This would relieve people in need of care in nursing homes, either fully or partially, of the need to bear the investment cost share themselves. In doing so, it addresses, alongside the housing allowance plus – which targets the burden of accommodation and meal costs – ↘ ITEM 319 a further cost factor in institutional care, thereby precisely reducing the use of 'help with care'. This would take account of the fact that the federal states have so far fulfilled their obligation to promote the care provision structure in an inadequate, inconsistent and poorly targeted manner. ↘ ITEM 290 The bureaucratic burden should be limited through the implementation of the 'once-only' principle and consistent digitalisation (GCEE Spring Report 2025 item 228).

352. Future increases in personal contributions should be limited and made predictable through a **rule-based indexation of SPV benefits**. At present, the law provides only for an adjustment to benefits in 2028, which is to be based on price trends. ↘ ITEM 305 Furthermore, this adjustment does not take place automatically. Due to the high proportion of wages in the cost structure, care costs tend to follow wage trends rather than price trends. As wages generally rise faster than prices, current legislation inevitably leads to a devaluation of long-term care insurance benefits and thus to rising co-payments over time. Simulations by the GCEE show that, compared to the baseline scenario with wage indexation, pure inflation indexation has a favourable effect on the rise in contribution rates due to the falling benefit level and rising co-payments. ↘ CHART 74 In 2040, the contribution rate is expected to be 4.4 %, around 0.8 percentage points below the baseline scenario. At the same time, the level of benefits will decrease by around 30 % compared to the baseline scenario by 2060.

↘ CHART 74
Contribution rate trends under various benefit adjustment scenarios



1 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth. 2 – The sustainability factor is calculated from the annual change in the long-term care dependency ratio multiplied by a beta factor of 0.5. The care dependency ratio is defined as the ratio of those in need of care to contributors.

Sources: BMG, SIM.24

353. The distribution of the financial burden of demographic ageing between those in need of care and contributors could instead be managed through the **introduction of a sustainability factor**. Similar to the GRV, this factor could, in the context of rule-based indexation of benefits, dampen adjustments depending on the insured population structure (changes in the ratio of those in need of care to contributors) and thus achieve intergenerational burden-sharing. In the GCEE's simulations based on this, it is assumed that changes in the insured population structure are borne half by contributors (via rising contribution rates) and half by those in need of care (via a smaller increase in benefits). ↘ CHART 74 This scenario would also significantly curb future contribution rate trends through a roughly 20 % decline in benefit levels by 2060 and rising co-payments. In 2040, the contribution rate is expected to be 4.5 %, around 0.7 percentage points below the baseline scenario.

3. Strengthening the SPV's capital funding

354. The introduction of the SPV in 1995 led to considerable initial gains for older age groups, particularly those who were already in need of care at the time. They had not paid any contributions during their working lives up to that point, but were able to benefit directly from the SPV's benefits. The expansion of benefits in the SPV, in particular the PSG II, has increasingly involved subsequent generations in the financing through steadily rising contribution rates. ↘ CHART 35 Demographic ageing will lead to a further rise in the contribution rate in the future. Even a combination of cost-containment measures cannot change this in the long term. ↘ CHART 75 In the short term, there would indeed be a significant reduction in the contribution rate and a degree of stabilisation until 2040. After that, however, the trend continues in a similar manner to the baseline scenario. Due to the long-term

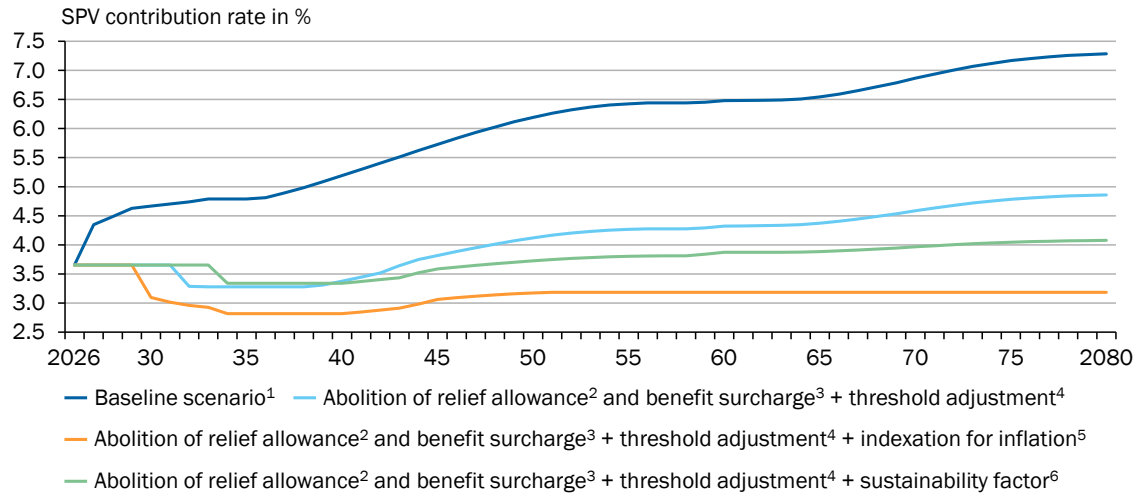
rise in contribution rates, the burden on younger generations continues to increase and the intergenerational distribution of the burden becomes more acute.

A combination of expenditure-curbing measures with an indexation of SPV benefits that diverges from wage growth could stabilise the contribution rate almost entirely in the long term. ↘ CHART 75 However, this would be accompanied by a falling benefit level and rising personal contributions. **To stabilise** the **level of SPV benefits** following expenditure-curbing reforms **and to ensure intergenerationally fair financing, it is appropriate to strengthen funded elements within the SPV**, with contributions structured on a cohort-specific basis.

355. Unlike in other branches of social insurance, the SPV already has an institutional starting point for such a funded system in the form of the Long-Term Care Provision Fund (PVF). ↘ ITEM 309 However, in its current form, the PVF exhibits fundamental conceptual and institutional weaknesses (Breyer and Janeba, 2025). ↘ ITEM 309 The fund is designed as a temporary demographic reserve and is intended to be gradually wound up, a process set to begin as early as the mid-2030s. ↘ ITEM 309 Against this backdrop, the existing fund does not provide a suitable starting point

↘ CHART 75

Contribution rate development under a combination of expenditure-restraining reforms



1 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth. 2 – The expenditure volume of the relief allowance is not reported separately in the BMG financial statistics. The category "additional outpatient care and respite services" serves as an approximation. The calculated uptake of these services in 2023 was around 40 % of those in need of care receiving outpatient care and is assumed to remain constant over the simulation period. 3 – Cap on the personal contribution to care-related expenses according to § 43c SGB XI. 4 – The thresholds within the individual modules of the NBA determine how the points actually achieved in the assessment are converted into weighted NBA points, thereby influencing the total score in the respective module. In this scenario, these thresholds are raised to the level recommended by the Expert Advisory Board in 2013 for modules 1, 4 and 6, in addition to the (PG) scenario. 5 – Benefit indexation based on price trends. 6 – The sustainability factor is calculated from the annual change in the long-term care dependency ratio multiplied by a beta factor of 0.5. The care dependency ratio is defined as the ratio of those in need of care to contributors.

Sources: BMG, SIM.24

for reform. Instead, funded provision in long-term care should be further developed by building up a new, structurally different capital stock, and a **PVF II** should be established for this purpose (Pimpertz, 2020; Breyer, 2025).

356. The required size of the capital stock is determined by the funding gap that would arise if the contribution rate were to be capped. This capping of the contribution rate in the pay-as-you-go system can be achieved by fixing the contribution rate, which leads to a sharp decline in benefit levels. It can also be achieved through a rule-based adjustment of the benefit level, for example by linking it to price trends or introducing a sustainability factor. ↘ ITEMS 352 F. **The resulting gap in the benefit level can then be closed by funded elements**, whereby the accumulated funds and returns from the capital stock are used to supplement pay-as-you-go financing. Funding would thus enable the benefit level to be stabilised at a given contribution rate.

357. The PVF II should be organised on the basis of **cohort-specific capital funding** in order to counteract the unequal burden on generations resulting from initial gains and future demographic ageing. ↘ ITEM 354 Under this system, additional contributions would be set aside on a generation-specific basis and later used to finance the long-term care expenditure of that particular cohort (Breyer, 2025). This allows for a stronger focus on the principle of intergenerational justice. The link between contributions and subsequent benefits is clearer, so that financial burdens are distributed more in line with individual contributions. This ensures that the baby boomer generation also continues to contribute to financing the financial burdens they have caused.

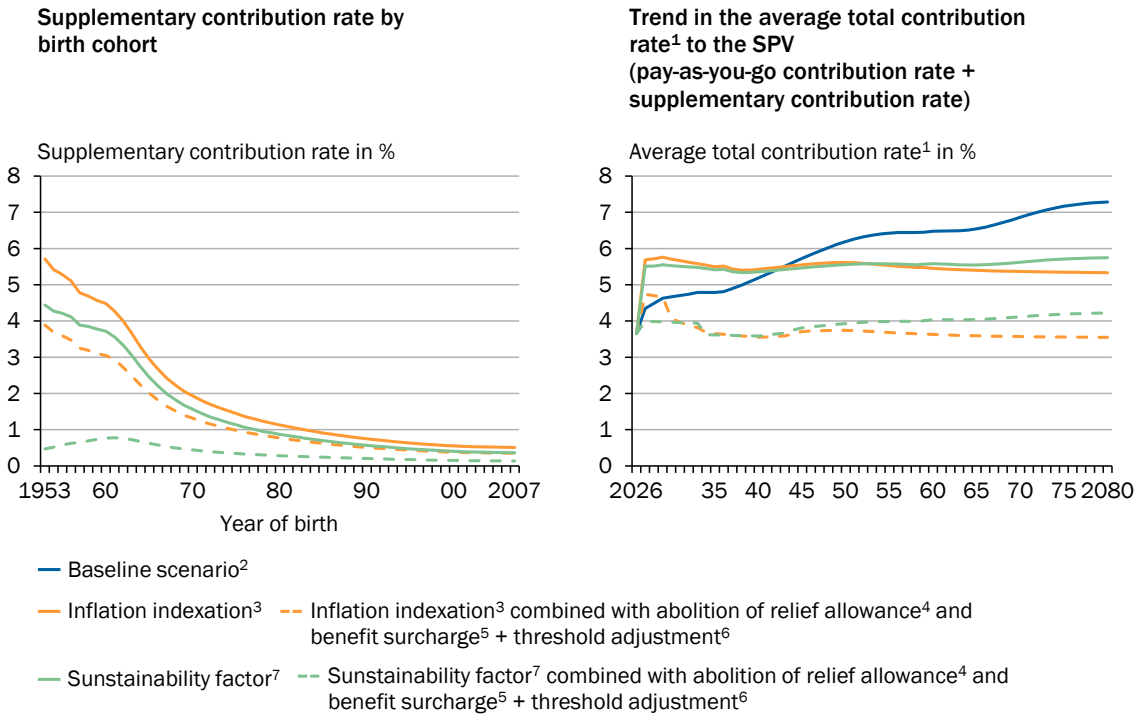
358. Cohort-specific capital funding offsets the intergenerational disadvantage that arises in a purely pay-as-you-go system due to the fact that part of the intergenerational contract (education of children who will later finance the pay-as-you-go system) is only inadequately fulfilled. In cohort-specific capitalfunding, **income-related redistribution** takes place primarily within the respective cohorts (**intragenerationally**). Furthermore, cohort-specific capital funding can reduce the **risk** of funds **not being earmarked for** their **intended purpose**, as a clear allocation of funds to specific beneficiary groups is likely to limit political access to them more effectively than was the case under the previous PVF (Breyer, 2024).

359. For the cohort-specific PVF II, a **more long-term investment strategy with broad international diversification and a higher proportion of equities** should be adopted. This could significantly increase long-term returns without jeopardising the long-term stability of the funding. Thanks to its long investment horizon, the funded system in long-term care has a high risk-bearing capacity. A predominantly conservative investment policy does not make sufficient use of this structural advantage. The PVF's current investment strategy provides for only a small proportion of equities and thus forgoes potential returns from the funded system. ↘ ITEM 309

360. The simulations by the GCEE show that the **cohort-specific additional contributions** required to stabilise the benefit level of the SPV **in PVF II depend heavily on the year of birth**. ↘ CHART 76 LEFT For those born from 1953 to the

↘ CHART 76

Contribution rate development upon the introduction of cohort-specific capital funded provision to compensate for a declining benefit level of the SPV



1 – Weighted average of the age-specific total contribution rates, weighted by cohort size (number of insured persons per age group). 2 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth. 3 – Cohort-specific capital funded provision with inflation indexation. 4 – The expenditure volume of the relief allowance is not reported separately in the BMG financial statistics. The category "additional outpatient care and respite services" serves as an approximation. The calculated uptake of these services in 2023 was around 40 % of those in need of care receiving outpatient care and is assumed to remain constant over the simulation period. 5 – Cap on the personal contribution to care-related expenses according to § 43c SGB XI. 6 – The thresholds within the individual modules of the NBA determine how the points actually achieved in the assessment are converted into weighted NBA points, thereby influencing the total score in the respective module. In this scenario, these thresholds are raised to the level recommended by the Expert Advisory Board in 2013 for modules 1, 4 and 6, in addition to the (PG) scenario. 7 – Cohort-specific capital funding with wage indexation and a sustainability factor. The sustainability factor is calculated from the annual change in the long-term care dependency ratio multiplied by a beta factor of 0.5. The care dependency ratio is defined as the ratio of those in need of care to contributors.

Sources: BMG, SIM.24

mid-1960s, these contributions amount to approximately 3 % to 6 % of contributory income, depending on the structure of the benefit adjustment. For subsequent generations, the additional contribution is significantly reduced and stands at less than 1 % for those born from 1980 onwards. Due to the comparatively high additional contributions from the baby boom cohorts, the average total contribution rate to the SPV (contribution rate for the pay-as-you-go scheme + cohort-weighted supplementary contribution rate for capital funding) would initially be above the baseline scenario. ↘ CHART 76 RIGHT From the early 2040s, this trend reverses, and the average total burden develops comparatively favourably.

361. **From the age of 75** (born in 1952), the risk of being in need of care rises sharply. For these individuals, there is no longer sufficient time to build up a significant capital stock to fully finance the gap in benefit levels. The additional contribution

rates required for this would be very high due to the short savings period and the low return potential. Instead, an additional contribution at the rate applicable to 74-year-olds could also be levied on those over 74. The remaining benefit gap could be covered by the accumulated funds of the existing PVF. ↘ ITEMS 309 F. No further funds should then be allocated to it upon the introduction of PVF II.

362. **The necessary cohort-specific additional contributions can be significantly reduced if funded provision is combined with the other policy options discussed in this chapter**. Funded provision compensates for the gap in benefit levels arising from the introduction of inflation indexation or a sustainability factor. If, in addition, the abolition of the relief allowance ↘ ITEM 342 and the benefit surcharge ↘ ITEM 349, as well as the increase in the thresholds to the values technically recommended by the Expert Advisory Board in 2013 ↘ BACKGROUND INFO 17 and ↘ ITEMS 304 FF. the gap in benefit levels to be closed is reduced, and with it the required level of capital cover. ↘ CHART 75 This is particularly evident in older cohorts. The additional contributions are significantly lower in the combined reform than in the isolated variant of cohort-specific capital funding. ↘ CHART 76 LEFT

Under inflation indexation, the additional contributions required for the baby boom cohorts of the late 1950s and early 1960s fall to around 3 % of income subject to contributions. When the sustainability factor is applied, the additional contributions are even lower, falling to below 1 % for older cohorts. Compared to the baseline scenario, the adjustment of the thresholds leads to a more favourable trend in the ratio of those in need of care to contributors. As a result, the growth in benefits is dampened less sharply than in the baseline scenario, and the funding gap is smaller. The significantly lower supplementary contributions for older cohorts in the combined scenario also have a correspondingly favourable effect on the development of the average total contribution rate to the SPV (contribution rate for the pay-as-you-go scheme + cohort-weighted supplementary contribution rate for capital funding). ↘ CHART 76 RIGHT This remains well below the contribution rate level in the baseline scenario for almost the entire simulation period.

A differing opinion

363. One member of the Council, Achim Truger, cannot agree with the majority position of the GCEE in the chapter 'Social long-term care insurance: focusing on priorities and ensuring intergenerational fairness in funding' on a number of points. **Firstly, this dissenting opinion** concerns the Council majority's **reweighting of the objectives of long-term care insurance** towards greater subsidiarity and personal responsibility, undertaken on the grounds of the primacy of contribution rate moderation. In doing so, the original objective of the SPV – to ensure that the vast majority of those in need of care do not have to rely on social assistance – is pushed into the background. **Secondly**, it concerns the **neglect of** potentially **serious distributional side-effects** and **social hardship** arising from the proposed policy options. **Thirdly**, therefore, the proposed policy options of **abolishing the benefit surcharge**, **inflation adjustment or the sustainability factor,** as well as the introduction of a cohort-specific **Long-Term Care Provision Fund (PVF) II**, are specifically **rejected**. **Fourthly**, preference is given to a **reform strategy focused** on the original objective of long-term care insurance, which relies not only on expenditure-side measures but also on **strengthening the revenue side**.

Shift in focus neither necessary nor convincingly justified

364. The majority of the Council considers it necessary to curb or entirely avoid further increases in contribution rates within the SPV. To this end, it intends to strengthen the personal responsibility of those in need of care through higher co-payments. It is prepared to accept a significant increase in the number and proportion of nursing home residents who are dependent on 'help with care'. In doing so, the **Council majority** is making a **significant shift in objectives** away from the original aims of the SPV.

As Rothgang (2026) emphasises, the original **main justification** for **the SPV** was **to prevent** the **dependency on care-related social assistance** that would otherwise threaten those in institutional care. To this end, long-term care insurance was intended to ensure a basic level of care that would normally be sufficient to cover care-related expenses, which was initially achieved. In the meantime, however, co-payments for institutional care have risen so sharply that, according to estimates by Rothgang et al. (2026), 37.1 % of nursing home residents are dependent on 'help with care'. Against this backdrop, policymakers have sought and continue to seek ways to limit co-payments. The **council majority** clearly distances itself from this and **is steering in the opposite direction**.

365. The **council majority** justifies the **significant shift in focus** it advocates – towards greater personal responsibility and higher co-payments – with the need to curb the rise in contribution rates. This, in turn, is necessary, firstly, to defuse intergenerational distribution conflicts; secondly, to prevent insured persons be-

low the contribution assessment ceiling from being relatively more heavily burdened by increases in contribution rates than those above it; and thirdly, to avoid undermining the overall economy.

366. From an overall economic perspective, however, it **does not** appear **necessary to place** a **very high priority** on the objective of **limiting contribution rate increases**, as the macroeconomic negative effects of such increases are only moderate. ↘ ITEMS 140 FF. Furthermore, depending on how it is combined with other reform options, the PVF II proposed by the Council majority could well lead to a significant rise in the total long-term care insurance contribution rate (contribution rate for the pay-as-you-go scheme + cohort-weighted additional supplementary contribution rate for capital funding) over a transitional period of more than 15 years. Assuming lower returns from the funded reserve than the real 5 % assumed by the Council majority, the level of supplementary contributions would rise and the duration of the transitional period with higher total contribution rates would be extended. A similar potential contradiction between the Council majority's targets and the advocated PVF II would arise in this case, due to the contribution rate increases, regarding the criticised relatively greater additional burden on insured persons below the contribution assessment ceiling compared to those above the ceiling. However, an increase in the contribution assessment ceiling, which would be suitable for alleviating the problem, is being discussed by the Council majority in the context of the SPV.

Drastic rise in the help with care rate expected

367. According to calculations by Rothgang et al. (2026), the help with care rate (HzP rate) for nursing home residents stood at 36.8 % in 2025. An increase to 37.1 % is expected for 2026. **The proposals put forward by the council majority would, on the whole, lead to a drastic rise in the HzP rate.** Two factors are primarily responsible for this: first and foremost, the proposed abolition of the benefit surcharge, which significantly limits personal contributions on a sliding scale based on the length of stay in a nursing home. Secondly, even the gross wage-related adjustment of long-term care insurance benefits – which the Council majority considers favourable for insured persons – is unlikely to prevent a further rise in the long-term care insurance contribution rate. Added to this are considerable risks arising from PVF II and the capping of pension adjustments advocated by the Council majority in the 2023 budget.

368. The Council majority proposes the abolition of the benefit surcharge. According to calculations by Rothgang et al. (2026), however, **failing to introduce the benefit surcharge** in 2022 would have led to HzP ratio of 43.9 % last year – over 7 percentage points **higher** – and, under the assumptions made, the difference could rise to over 10 percentage points by 2035, with the HzP ratio reaching 52.7 %.

369. The gross wage-related adjustment of long-term care insurance benefits assumed by the Council majority in the baseline scenario could, in principle, be suitable for stabilising the HzP ratio at roughly the current level. This could be the case in particular if gross wages in the care sector develop in line with gross wages in the

overall economy. In that case, care-related co-payments would also rise at this rate. However, if pensioners' incomes also grow in line with gross wages, they would be able to finance the increase in co-payments, and the HzP ratio would remain constant. However, as Rothgang (2026) and Rothgang et al. (2026) argue, due to the strong labour demand for care workers, both above-average wage growth and an additional increase in the workforce are to be expected for care-related institutional care costs, meaning that the **HzP ratio** is likely to continue rising **even with a gross wage-related adjustment of benefits**. Under the assumptions made by Rothgang et al. (2026) based on the medium scenario of the WIdO (2026) regarding care-related co-payments, the HzP ratio would rise by 5 percentage points to 42.1 % by 2035 compared to current levels.

Added to this are risks arising from the PVF II: should the actual return fall short of the high return of 5 % per annum (in real terms) assumed therein, long-term care insurance benefits would be lower than anticipated and the co-payments to be made by nursing home residents would rise further accordingly. Finally, if the reform proposals put forward by the council majority regarding changes to pension adjustments were implemented (GCEE Annual Report 2023 items 420 ff.), pension benefits would also rise significantly more slowly than gross wages, meaning that some pensioners would no longer be able to afford the rising co-payments on their own.

Increasing financial and administrative burden on municipalities

370. **The drastic increase in help with care rates** and the number of recipients of 'help with care' expected if the Council majority's proposals were implemented would **present municipalities with massive financial problems**. According to Rothgang et al. (2026), the abolition of benefit surcharge alone would, in the long term, lead to a doubling of real help with care expenditures. If, for illustrative purposes, we disregard the grandfathering provisions for nursing home residents currently receiving benefit surcharges, municipalities' long-term care expenditures would double in the current year from €4.5 billion to €9 billion if the benefit surcharges were abolished. In the long term, expenditure increases of €10 billion or more could become necessary. It is clear that, given their extremely strained financial situation – with a budget deficit of €31.9 billion last year – municipalities are not in a position to shoulder such additional burdens.

The council majority does note that its proposal is likely to "lead to a shift in costs and burdens onto the local authorities responsible for help with care" and that the question of suitable counter-financing arises. ↘ ITEMS 349 F. However, it merely proposes the introduction of a means-tested care housing allowance at state level to relieve those in need of care of the investment cost share. However, given the relatively small proportion of investment costs in the total personal contributions of nursing home residents, this measure is unlikely to come anywhere near offsetting the additional burden on municipalities. Furthermore, such a measure would not alleviate the burden on municipalities at all in federal states where a care housing allowance already exists, such as in North Rhine-Westphalia.

371. Given the rising number of recipients of help with care (HzP) and the nationwide introduction of the care housing allowance, municipalities would also face a significant administrative burden. The council majority also notes that the question of how to manage this administratively arises. In addition, following the housing benefit reform (housing benefit plus) in 2023, access to a further means-tested transfer has already been significantly expanded, which nursing home residents can also use. This means that there are now three means-tested benefits available that would have to be administered by municipalities: help with care, the care housing allowance (to be used as a priority for investment costs) and housing benefit plus for accommodation and meals. This undoubtedly represents an **increase in bureaucracy** for municipalities and the nursing home residents concerned. As the council majority rightly notes, the impact of this could, in the long term, be limited by the implementation of the 'once-only' principle and consistent digitalisation. However, it is difficult to predict whether and when this will succeed.

The structure of PVF II is problematic and risky

372. The council majority proposes a **cohort-specific PVF II**, in which the individual cohorts of insured persons save additional contributions, which are to be invested primarily on the international capital markets with the highest possible returns. In the payout phase, the accumulated funds are then to be used to raise long-term care insurance benefits – which have been reduced by the sustainability factor or inflation adjustment – to the level that would result from a gross wage-based adjustment.

The cohort-specific additional contribution rates, which increase with age, could be **legally problematic**. For instance, Breyer (2025) points out, in relation to his cohort-specific model with uniform additional contribution rates, that it must be clarified whether it is legally permissible to grade long-term care insurance benefits according to year of birth. In the Council majority's model, the question of whether it is possible to grade contribution rates according to year of birth would therefore need to be clarified. A potential problem here is that the additional contribution rates rise sharply up to the 1953 birth cohort, only to remain constant after this – ultimately **arbitrarily set – age**. At the same time, only those born before 1 January 1953 would benefit from the PVF I payments, which are intended to close the care gap caused by reductions.

373. If there is to be no systemic break in the SPV, whereby the burden of the supplementary contributions would be borne unilaterally by employees alone, the supplementary contributions for employees would have to continue to be levied equally by employees and employers, as is the case in the SPV and under the current PVF I. In this case, employers would then have to pay different contribution rates depending on the age of their employees, with significantly higher contributions required for older employees than for younger ones. This raises the question of potential incentive effects regarding the attractiveness of employing older workers and the promotion of early retirement.

374. The proposed funded scheme under PVF II entails considerable risks. Unlike in the existing PVF I, the Council majority wishes to invest the funds on the international capital markets with a view to higher returns. In doing so, it assumes a real return of 5 % per annum. This is, in principle, already optimistic. Furthermore, with shorter investment horizons, which apply to older cohorts, the risk of significantly lower returns or even capital losses increases. **In the Council majority's model, the capital market-related risk would be borne entirely by the insured, who would then be burdened by higher personal contributions.** This risk applies in principle to all investment horizons and cohorts. Experience with price trends from past decades cannot simply be extrapolated.

For this reason, a more cautious approach with a lower assumed rate of return would have been appropriate. Although Breyer (2025) points to the possibility of real returns of 4 or 5 % for internationally diversified investments, his calculations are based on a real return of 3 %. With such a **lower return**, however, the additional **cohort-specific contribution rates required** to close the care funding gap advocated by the council majority would be considerably higher. If they are calculated on the basis of higher returns, the difference falls entirely on the shoulders of those insured with SPV.

Serious distributional side-effects and social hardship

375. The implementation of **the Council majority's proposals** would be accompanied by significant distributional side effects and social hardship. Firstly, this concerns the drastically increasing need to claim means-tested social benefits such as care housing allowance and, above all, help with care. This would **further undermine** the **original aim of long-term care insurance**, and the humiliating trip to the social security office for many people in need of care is likely to become increasingly common.

376. Secondly, it concerns the **transitional**, **substantial increase in contribution rates** under PVF II, which for many insured persons below the contribution assessment ceiling would entail a relative additional burden compared to those above the ceiling and to privately insured individuals. Thirdly, pensioners affected by the additional contributions under PVF II would, depending on the reform option, face **additional contribution rates of up to 5.4** %. This would likely result in a further noticeable **rise in the poverty risk rate for pensioners,** as well as **a further increase in the rate of older people receiving basic income support**. Assuming a lower return on PVF II, the additional contribution rates would have to be set at a significantly higher level.

SPV's focus on the expenditure side and strengthening the revenue side as an alternative

377. Instead of allowing the co-payments borne by nursing home residents – and thus the HzP rate – to rise ever further, a **reform of long-term care insurance** should **return to its original objective and effectively prevent any further increase in the HzP rate**. To this end, a variant of **the 'Sockel-Spitze-Tausch'** rejected by the council majority – i.e. **capping co-payments** – could

serve as a solution. As simulated, this would in itself significantly increase long-term care insurance expenditures and thus the contribution rate. If, contrary to the assumptions in the simulations, the cap on co-payments were indexed to the inflation rate or wage growth, the increase would be somewhat mitigated over time (Rothgang et al., 2026). The same applies if, in return, the benefit surcharge were largely abolished without grandfathering provisions, i.e. for new care cases. However, as the cap on co-payments would have to be set significantly below the current level of co-payments in order to effectively prevent a further rise in the HzP ratio – for example, at €1,200 – a considerable increase in the contribution rate would still be expected (Rothgang, 2026). This can, however, be mitigated if the expenditure side of the SPV is refocused in line with its original function and, at the same time, the revenue side of the SPV is strengthened.

378. The Council's simulations show that **refocusing the expenditure side** alone would open up **considerable scope for financing**. For instance, abolishing the relief allowance and raising the thresholds for care grades would together enable a reduction in the contribution rate of around one percentage point in the medium term. However, it could also be used to cap co-payments. If the thresholds were also adjusted within the modules – which would, however, represent a very far-reaching restriction – this would even result in a total expenditure-side margin of two contribution points.

379. **On the revenue side**, the SPV should – as also proposed by the majority of the Council – initially be **strengthened** by the federal government **taking** over **non-insurance benefits**. At the very least, the federal government should finally transfer to the SPV the €6 billion in **additional expenditure** arising from the **coronavirus pandemic** that has not yet been reimbursed. If this amount were used to replenish the SPV's reserves, the sharp rise in the contribution rate due in 2027 could be significantly mitigated. If, going beyond the position of the council majority, the costs of old-age provision for carers were additionally **financed** through a **tax-financed** federal subsidy, this would immediately relieve the SPV of a further 0.3 contribution points. Furthermore, the **federal states** should be **more effectively obliged to cover higher investment costs**. If they were to provide grants equivalent to the social assistance saved – as originally envisaged when long-term care insurance was introduced – this would require up to an additional €5 billion. These funds would directly reduce the personal contributions of nursing home residents. They could be financed, for example, through a **reform of inheritance tax**.

The SPV should also be strengthened on the revenue side through a significant increase in the annual income threshold and the contribution assessment ceiling. In the medium term, the inclusion of civil servants, for example, could lead to a further reduction in contribution rates.

APPENDIX

↘ BOX 21

Results of the Federal-State Working Group "Future Pact for Care"

The "Future Pact for Care" is a working group comprising the federal government, the Länder and local authority umbrella organisations. Its aim is, on the one hand, to place the SPV on a stable financial footing and, on the other, to ensure adequate care provision. The working group's proposals were published on 11 December 2025. They can be divided into the areas of care provision and financing (BMG, 2025a).

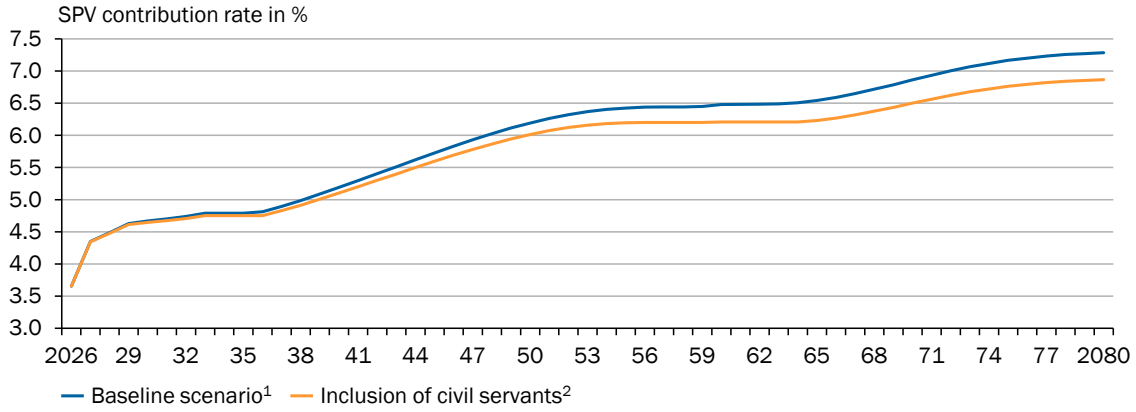
To prevent or delay the need of care, prevention measures are to be strengthened. The proposed voluntary "U 60+" screening programme and the expansion of preventive home visits could contribute to this, for example. For home care, the range of "professional guidance and support" services is to be reorganised and supplemented by an emergency budget for crisis situations. To guarantee comprehensive care provision, care insurance funds and municipalities should in future be able to act more easily as providers of care facilities themselves. If those affected cannot find a suitable service, the insurance funds should be obliged to provide referral or case management. The Federal Ministry of Health (BMG) should also examine closer cooperation between insurance funds and federal states to strengthen local infrastructure. Furthermore, improved staff planning by municipalities is to be facilitated through increased data exchange and systematic monitoring of care staff. In institutional care nursing homes, providers are to be given greater autonomy in staff deployment, whilst the federal states examine targeted investment support for digital efficiency improvements. In addition, innovations in the field of digitalisation and AI are to be specifically promoted through the creation of dedicated innovation hubs.

Sustainable financing is to be achieved through measures on both the expenditure and revenue sides. The partial insurance scheme for long-term care insurance is to be retained. At the same time, co-payments are to remain limited. To curb the rise in expenditure, the thresholds for care grades 1 to 3 are to be adjusted and more intensive support and advice introduced at the start of care provision. The relief allowance for care grade 1 is to be abolished in order to finance the new specialist support and stabilise expenditure trends. To limit co-payments, two models are being offered as options: a 'Sockel-Spitze-Tausch' with a fixed co-payment of €1,200 per month, or regular indexation of benefits in line with inflation or wage growth. In addition, the Long-Term Care Provision Fund is to be further developed to generate higher returns and invested for the long term.

Revenue for long-term care insurance is to be boosted through a higher contribution assessment ceiling, financial equalisation with private long-term care insurance, and the inclusion of further types of income. In addition, flat-rate contributions for those in marginal employment and a graduated supplementary contribution of 0.1 contribution rate points for baby-boom cohorts are under discussion. Pension contributions for carers are to be financed entirely from tax revenue, the federal subsidy is to be permanently increased by €1 billion annually, and the SPV's pandemic costs are to be reimbursed from tax revenue. In addition, compulsory or voluntary supplementary insurance schemes are proposed.

↘ CHART 77

Contribution rate development when civil servants are included



1 – Continuation of current legislation, based on expected demographic trends and assuming that benefits are indexed to gross wage growth. 2 – Inclusion of new civil servants appointed from 2027 onwards in the SPV.

Sources: BMG, SIM.24

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