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Pay-as-you-go System and Funded System in German Long-Term Care Insurance

– A comparison after more than 25 years

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Summary

In Germany, there has been compulsory Long-Term Care Insurance (LTC) for the whole population since 1995. As in health insurance, there are also two different systems in German LTC insurance. One operates according to the pay-as-you-go system and is offered by public corporations (Statutory LTC insurance ("Soziale Pflegepflichtversicherung" – SPV)), the other operates according to the funded system and is offered by private insurance companies (Private LTC insurance ("Private Pflegepflichtversicherung" – PPV)).

The ranges of benefits of both systems are identical. In addition, further political demands had to be implemented in the design of the PPV. So it was stipulated that there are no premiums for children and that the individual premium for each person may not exceed the maximum contribution to the SPV. This meant that, beyond the usual methods of classic individual insurance, certain cost redistribution elements had to be integrated, yet calculated on an exact actuarial basis.

First, the study shows how the social policy requirements were implemented in the calculation of the PPV and how the pay-as-you-go elements were subsequently reduced.

After that is examined how the two different systems have developed over the past 27 years: How did premiums develop? What influence did the dynamization of insurance benefits have? How did subsequent policy interventions in the scope of insurance benefits affect the development of premiums?

As expected, the development of premiums in the private system is much more stable than in the statutory system, at least with an unchanged range of benefits. The low interest rates of the last decade have had a negative impact on the private system, as has the dynamization of benefits. Overall, however, the premium development in the private system was significantly lower than in the statutory system.

Introduction of compulsory LTC insurance in Germany – initial situation

We know that the demographic changes such as an increasing life expectancy and a simultaneously decreasing rate of birth, which affect a large number of nations, belong to the most important cost drivers in the health sector.

That becomes even more obvious in the long-term care sector. In Germany, compulsory LTC insurance for the entire population has been in place for 28 years, or more precisely since 1995.

The need for LTC insurance has been discussed in Germany since the 1980s. As in all industrialized nations, the number of elderly people in Germany is growing in relation to the rest of the population. In addition, the costs of such care are very high and often exceed the financial means of those affected. Consequently, this burden had to be borne by the general public, or more precisely by the social welfare system financed from taxes. The idea was to find an insurance system that would cover this long-term care, on the one hand to relieve the public purse and on the other hand to spare people the humiliation of having to turn to the social welfare office to check whether they were needy or not, or to make their relatives bear the costs.

Initially, a voluntary model was favored. Both private health insurers and life insurers developed tariffs that provided either daily care allowances depending on the care level or reimbursement

of a certain share of the costs. However, the promise of tax benefits for this form of provision, thus creating an incentive for widespread use, was not fulfilled by the politicians.

The debate then turned to compulsory solutions, including fully funded models on a purely private basis. On the other hand, a way also had to be found to relieve the public purse of the "legacy burden", i. e. those who are already in need of care and those who could soon become so due to their age. At the same time, however, the premium for such insurance had to remain affordable. For this reason, attention gradually focused on a system of social insurance that included the entire population on the basis of cost sharing.

Private health insurance and its actuaries were involved in the debate from beginning to end. Calculations were made for the various models and methods developed to implement them. This was of course especially true for the private long-term care insurance models.

When the political debate began to tend towards general compulsory insurance in the social insurance system, it became the industry's goal to provide LTC insurance through the private health insurance companies for those policyholders with private comprehensive health insurance.

The guiding principle here was: "Care follows health" and meant that LTC insurance should be taken out with the same institution as health insurance. This was to avoid disputes between health and LTC insurance about who should bear the costs of care in the event of a claim.

Parts of the industry were skeptical about whether it could be right to take on the risk of private compulsory long-term care insurance for the entire existing business. The risk lay in particular in the lack of data on the need for long-term care in the population, especially in terms of the new law. The already established voluntary LTC insurance could not provide any data either, since new insured persons were admitted with normal medical risk assessment and thus there were neither older people who were on the verge of needing long-term care nor a significant number of long-term care cases in the portfolio.

After numerous discussions, both the Ministry of Health and the other politicians accepted that such a two-tier system would be appropriate, with the result that the law on compulsory LTC insurance now stipulates that all policyholders with private health insurance must also take out private compulsory LTC insurance.

Thus, LTC insurance in Germany is basically a part of health insurance. Therefore, I will first make some remarks on the system of private health insurance in Germany. Then I will present the social framework conditions for German private compulsory LTC insurance set by the legislator and their effects on the calculation of this insurance.

We then examine how the two different systems have developed over the last 27 years: How have premiums developed? What influence does the dynamization of insurance benefits have? How do subsequent political interventions in the scope of insurance benefits affect the development of premiums?

Framework conditions of the German health insurance system

In Germany, the entire population is covered by health insurance, as there is a general obligation to take out health insurance. There are two different systems of health insurance. One

works on a pay-as-you-go basis and is offered by public corporations (statutory health insurance), the other works on a funded basis and is offered by private insurance companies (private health insurance).

90 % of the population has statutory health insurance, 10 % of the population, especially civil servants, self-employed and high-earning employees, have private health insurance. Civil servants, however, receive a so-called allowance from their employer for health insurance, so that they only have to cover a certain percentage of their health cost risk privately. For the sake of clarity, let me briefly introduce both systems.

In the pay-as-you-go system, premiums are calculated in a way that the amount of premium income within one year exactly covers the amount of payments. That is how social systems work in almost all countries; to be more precise they do not work quite properly.

Contributions to the statutory health insurance are calculated in proportion to the respective gross remuneration for employees (in proportion to the respective gross pension for pensioners), as long as it does not exceed the so-called income threshold; the employer or the pension insurance pays half in each case. The corresponding percentage (contribution rate) and the income threshold are regularly reassessed. Family members of members of the statutory health insurance (especially children) are co-insured free of charge, unless they are members of the statutory health insurance themselves.

There is no capital accumulation for coming years, the solidarity balance is intergenerational. In Germany, we speak of a generational contract: the older generation, which receives many more benefits than it pays in, expects the younger generation to provide these additional benefits.

Due to the dynamic cost development in the health care system, but especially also due to demographic developments, the contribution rate in the German statutory health insurance system has risen from about 10 % of gross income in the last 47 years to about 15.9 % today. Accordingly, the maximum contribution to statutory health insurance today is 770 EUR per month compared to 110 EUR in 1975 (converted from DM to EUR, but without taking into account an adjustment for inflation).

And the process of demographic change has only just begun; so far it is essentially characterized by rising life expectancy. Scientific studies, for example “Die zukünftige Entwicklung der GKV-Finanzen – Ein Beitrag zur Diskussion um erhöhte Steuerzuschüsse” (“The future development of SHI finances - A contribution to the discussion on increased tax subsidies”), WIP 2021 (Scientific Institute of the PKV (PHI)), claim that in 18 years contribution rates of more than 28 % of gross income are possible or even probable. This will of course dramatically increase the economic pressure on future generations with fewer people per generation.

Private health insurance in Germany works similarly to life insurance. The starting point is the idea of the lifelong equivalence principle. The premiums are calculated in such a way that the expected present value of the premiums – for the entire insurance period – is equal to the expected present value of the benefits. In this way, we take into account the increasing benefit payments in old age in the health sector right from the start.

Consequently, premiums are initially higher than would be necessary to cover current benefits; the remaining part is accumulated in the so-called ageing reserves at interest.

We can see what this means in Figure 1. If a 20-year-old today takes out private health insurance, we use statistical data to calculate how their benefit needs are likely to change over the next years and decades; this is illustrated by the curve.

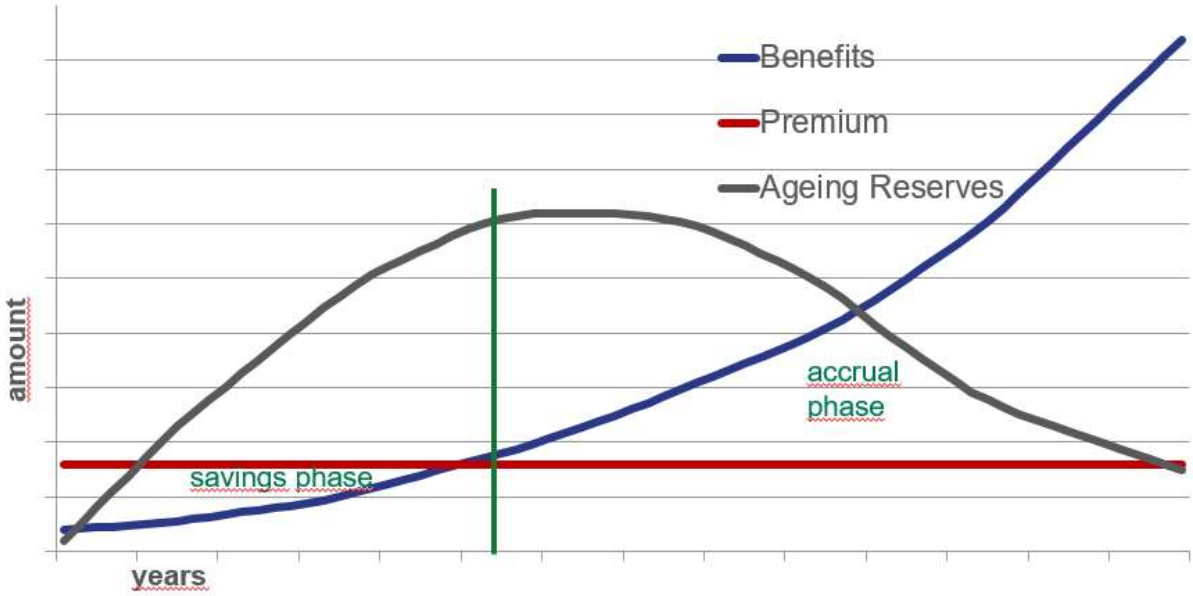

Fig. 1 Simplified Illustration of a funded system

We initially assume that health care costs remain stable and that life expectancy does not change. Under these conditions, an average premium is calculated for the entire contract term, which remains constant throughout the policyholder's life. The difference between the premium and the claimed benefits in the first years is collected in the ageing reserves and later used to cover the then higher benefits, whereby a constant actuarial interest rate is assumed over time.

Thus the system of the German private health insurance is independent of the development of the birth rate and of the general question whether future generations will be financially able to care for previous generations.

Our model is therefore based on the assumption that each generation provides for itself. Additional elements in the calculation take into account the problem that the increase in costs in the health sector usually exceeds the increase in income, as well as the problem of steadily increasing life expectancy.

Private health insurance in Germany is linked to certain social conditions that clearly distinguish this system from private insurance systems in other countries. For example, the contracts are generally life-long, the insurer has no ordinary right of termination; even if the premiums are not paid, the contract may not be terminated, but must be continued in the so-called necessity tariff (a tariff with a reduced range of benefits). Furthermore, deteriorations in the health condition of an insured person after the start of the insurance may not have the effect of increasing premiums; a subsequent increase in risk surcharges is thus excluded. However, I do not want to go into further detail here.

Organization of compulsory LTC insurance in Germany

Let us now turn to compulsory LTC insurance. Like health insurance, LTC insurance in Germany is divided into two branches: On the one hand, there is the statutory or social LTC insurance (SPV), to which 90 % of the population belongs and which, like the statutory health insurance, works on a pay-as-you-go basis. The other is private LTC insurance (PPV), to which 10 % of the population belongs and which basically operates according to the funded system.

In addition to the social framework conditions that already had to be complied with in private health insurance, additional political requirements had to be met when setting up private compulsory LTC insurance. While a person interested in private health insurance usually takes out private health insurance at a young age and then pays lifelong premiums, which depend in particular on the entry age of the policyholder, in private compulsory LTC insurance we had to cover the entire population in one fell swoop, provided they had private health insurance – i. e. also older people and those already in need of long-term care.

The range of benefits of the PPV is identical to that of the SPV; so there is no competition in benefits between the different insurance companies.

It has been stipulated by politics already in 1995 that premiums for men and women have to be equal, that there are no premiums for children and, finally, that the premium for each person must not exceed the maximum contribution to the social compulsory LTC insurance – and this is 3.05 % of income (3.40 % for childless insured persons) up to the so-called contribution assessment ceiling, which is currently 4,837.50 EUR per month.

This means that in addition to the methods of classic individual insurance, which are based on life insurance, certain redistribution elements had to be integrated, but calculated on an exact mathematical basis.

We needed a financial transfer as a consequence of the demand for gender-neutral premiums. Furthermore, we needed an intergenerational transfer from younger to older insured persons, because according to the actuarial calculation, older insured persons who were integrated into the system at the beginning of compulsory LTC insurance would have had to pay higher premiums than the legally prescribed maximum premium.

Due to the uniform range of benefits and the considerable risk of having to integrate a large number of old and sick people, the calculation was carried out uniformly for all private insurance companies. For this purpose, exact age- and gender-dependent net premiums are first calculated, whereby pure risk premiums are calculated for children and for persons born before 1916, i.e. no ageing provisions have been accumulated for these persons.

As gender-neutral (unisex) premium P_x^u at age x the premium of men with a factor c has been set (since 2015 $c = 1$):

$$P_x^u = \frac{A_x^u}{a_x^u}$$

with

$A_x^u = A_x^m$ (present value of benefits), $a_x^u = \frac{a_x^m}{c}$ (annuity present value)

The next formula deals with the amount of transfer which is necessary to finance this gender-neutral premium:

$$UN = \sum_j P^b(j) - P^u(j)$$

with

$P^b(j)$ individual gender-dependent (bisex) premium for insured person j

$P^u(j)$ individual gender-neutral (unisex) premium for insured person j

In 2021 UN amounts to 282 m EUR, which is about 6.7 % of the total premium income in the PPV.

The next formula shows the transfer amount needed to insure children free of contributions. Benefits must be provided for children as a result of accidents, but also as a result of congenital disabilities in LTC insurance. The transfer volume for the non-contributory co-insurance of children amounts to about 2.3 m EUR per year (0.05 % of the total premium income in the PPV)

$$UK = \sum_j P^b(j)$$

with

$P^b(j)$ individual gender-dependent (bisex) premium for premium-free child j (taking into account reductions in transfer requirements from surplus funds)

The transfer requirement from young to old, i.e., the amount necessary to limit premiums to the maximum contribution of the statutory LTC insurance, adds up to 276 m EUR (6.5 % of the total premium income in the PPV):

$$UG = \sum_j \max\{P^u(j) - (12Hg(j)(1-\sigma) - \Gamma_{pool}); 0\}$$

with

$P^u(j)$ individual gender-neutral (unisex) premium for “normal paying” insured person j

$Hg(j)$ maximum premium for insured person j

σ safety loading

Γ_{pool} maximum unit cost loading accepted by the PPV pool

Development of the transfer volume in the course of time

All in all, due to the basic political conditions the transfer volume in the compulsory LTC insurance (including limitations for couples (UE), the adjustment for Post-Office / Federal Railway clerks (UBP), financial needy (UH), the costs for guaranteed benefits of people needing long term care before 2017 (UL) and for financing structural improvements (US), but also

implying payments included in the premiums of students (BES) and waiting period insurance (BEA)) calculates as

$$U = UN + UK + UG + UE + UBP + UH + UL + US - BES - BEA$$

It amounts to approximately 640 m EUR; this sum corresponds to 15 % of the aggregate premium income of the compulsory LTC insurance. 10 years ago, however, this percentage was even much higher.

The per capita rate of U is shown in the following figure, separated into the two tariff levels PVN, in which salaried employees and self-employed persons are insured, and PVB for civil servants, who, as in health insurance (see above), only have to privately insure a percentage of the care costs - the rest is covered by their respective employer:

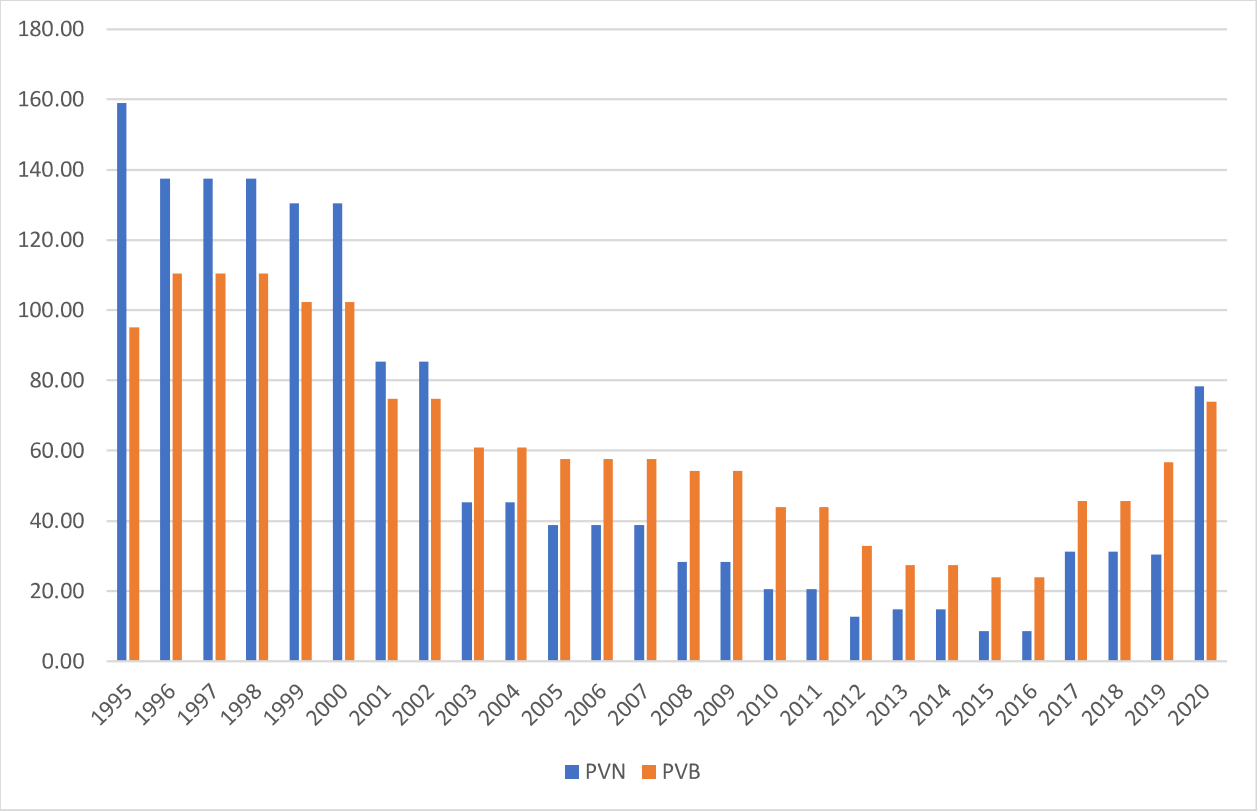

Fig. 2 Cost allocation per capita (U) PPV 1995 - 2020 (source: figures of the Private Health Insurance Association)

As can be seen, the amounts are continuously decreasing until 2015. This is not least due to the use of funds from the reserve for premium refunds over the years. From 2017 onwards, there will be increases again due to new shares in the apportionment (UL, US) and the conversion of care levels into care grades and the associated higher premiums.

The whole burden of the transfer is borne by those policyholders whose premiums are below the maximum premium.

Next you can see the formula for the monthly gross premiums, and this is the first time that company-specific data are included, to be precise a company-specific cost loading.

$$b^u(j) = \frac{P^u(j) + U}{12 \cdot (1 - \sigma)} + \frac{\Gamma}{12 \cdot (1 - \sigma)}$$

This calculation model ensures that the sum of all contributions of the insured community of private LTC insurance is sufficient to cover the benefits. Due to the different insured structures of the individual companies, this is by no means guaranteed for every company. For example, insurance companies with a comparatively old insured structure can suffer considerable losses. Therefore, two transfer procedures have been developed that affect all insurance companies in the long-term care sector and are carried out separately for PVN and PVB: The so-called D1 transfer and the D3 transfer.

The D1-transfer makes allowance for the different age- and gender structures of the individual portfolios of policyholders. Having a look at the formula you can see that here the aggregate actually raised annual net premiums are compared to the actuarially required annual net premiums for the respective portfolio of policyholders (the sums are to be understood as sums over all respectively insured months):

$$D^1_{VU} = \sum_j \left(\frac{P^u(j) + U - P^b(j)}{12 \cdot (1 - \sigma)} \right) + \sum_{j'} \left(Hg(j') - \frac{P^b(j') + \Gamma_{Pool}}{12 \cdot (1 - \sigma)} \right)$$

with

$P^u(j)$	individual gender-neutral (unisex) premium for each uncapped insured person j
$P^b(j)$	individual gender-dependend (bisex) premium for each uncapped insured person j
$P^b(j')$	individual gender-dependend (bisex) premium for each capped insured person j'
$Hg(j')$	maximum premium for insured capped person j'
σ	safety loading
Γ_{pool}	maximum unit cost loading accepted by the PPV pool

The premium-income of traditional companies with a comparatively high proportion of older policyholders, whose premiums are limited by the stipulated maximum premium, systematically fall below the actuarially required income. These deficits are balanced proportionately by those companies which have positive D1-values.

But also, notwithstanding the limitation of the maximum premium, losses may already come into being due to the risk structure of the portfolio of policyholders of a single company, which may diverge from the average portfolio and for which the respective company is not responsible. In

this case the so-called D3-transfer applies: The actual benefit payments $D_{VU}^{3,Lstg}$ are compared to the actuarially considered benefits $D_{VU}^{3,Kx}$:

$$D_{VU}^{3,Kx} = \sum_j K(j)$$

$$D_{VU}^{3,Lstg} = 2 \cdot b_{VU}^{capped,n} + S_{VU}$$

with

$K(j)$	actuarial claims amount per risk (depending on age and gender) as assessed for insured Person j
S_{VU}	actual benefit payments for company VU
$b_{VU}^{capped,n}$	total (capped) monthly premiums for newly insured persons in company VU (to take account of acquisition costs)

From the sums over $D_{VU}^{3,Kx}$ and $D_{VU}^{3,Lstg}$, a compensation ratio over all insurance companies is determined

$$aq^{Schaden} = \frac{\sum_{VU} D_{VU}^{3,Lstg}}{\sum_{VU} D_{VU}^{3,Kx}}$$

If the compensation ratio is less than or equal to one, the calculation for this fiscal year was sufficient. If it is greater than one, the calculation was not sufficient overall. Equalization takes place in both cases.

The equalization value is now determined for each company:

$$A_{VU}^{D3} = aq^{Schaden} \cdot D_{VU}^{3,Kx} - D_{VU}^{3,Lstg}$$

The compensation of losses leads to the following cash flows:

Companies with $A_{VU}^{D3} < 0$ receive $-A_{VU}^{D3}$,

Companies with $A_{VU}^{D3} > 0$ pay A_{VU}^{D3}.

Comparison of the development of SPV and PPV since their introduction

After 27 years it is interesting to see how the two different systems – 74 million insureds within the statutory compulsory LTC system vs. 9 million policyholders in the private compulsory LTC insurance – have developed.

Now let me make a few remarks about the PPV. Due to the fact that there are two main groups in the private health insurance, civil servants on the one hand and self-employed and high-earning employees on the other hand, the PPV is divided into two groups: Civil servants in tariff PVB and the other two in tariff PVN. This division into two tariffs is due to the fact that in

Germany the state contributes a fixed percentage to the medical costs of civil servants. The PVB tariff only reimburses the part of the costs that is not covered by the state and is therefore correspondingly cheaper.

Another difference in the contribution structure between the PPV and the SPV is that in the SPV, due to a ruling of the Federal Constitutional Court in 2005, a supplement for childless insured persons was introduced (0.25 contribution rate points), which does not exist in the PPV.

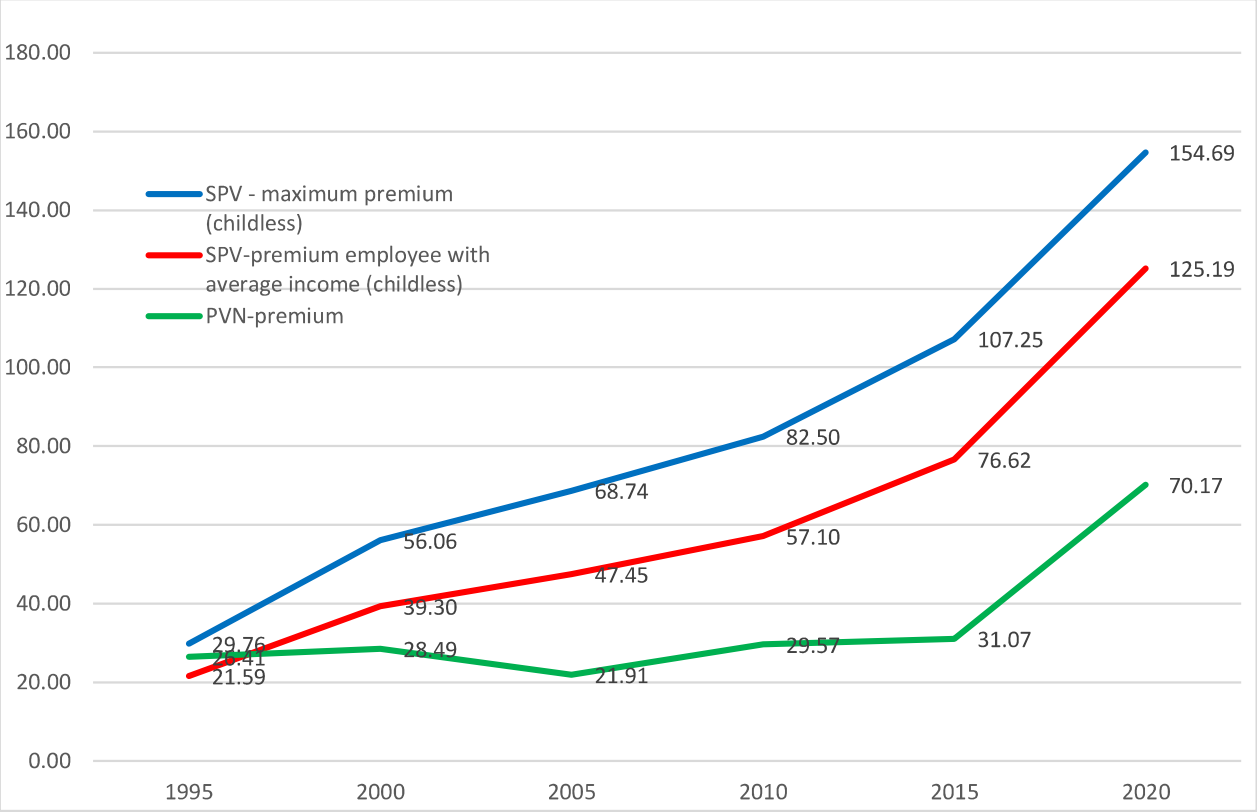

Fig. 3 SPV: Demographic development with more and more people in need of care causes premium increase (source: figures of the Private Health Insurance Association)

We see that 25 years ago the contribution of the private policyholder was about the same as that of a statutory LTC insured person. Today, on the other hand, it is only half as high. This circumstance is due to the fact that the younger generation had to take over a significantly higher transfer volume at the beginning of the private compulsory LTC insurance than is necessary today. Between 2000 and 2015 we have been able to reduce premiums for the private LTC insurance several times, although the latest mortality tables have always been integrated into the calculation to anticipate the increasing life expectancy. As we can see, both SPV and PPV premiums have increased significantly over the last 5 years due to higher benefit expenses.

The change of the age structure in both systems

The more favorable development of contributions in the PPV quickly gave rise to envious voices calling for a merger of the SPV and PPV or for risk equalization between the systems. This was justified by the older structure of the insureds and thus the higher proportion of nursing cases in the SPV.

In contrast, in 2007 the economists at German Federal Bank (Deutsche Bundesbank) pointed out the fundamental differences between the two systems: „Whereas for the pay-as-you-go system the distribution of risk among the insured at a given point in time is relevant (cross-sectional view), for systems with ageing reserves it is the development of the care risk over time that matters (longitudinal view). For example, in pay-as-you-go social insurance schemes, a disproportionately high share of older insured persons triggers a compensation claim. In funded insurance, on the other hand, different age structures are irrelevant. A below-average frequency of care, which is due to a relatively favorable age composition of the insured population, therefore does not justify a compensation obligation."

A comparison of the age distribution of the SPV and the PPV shows that the age cohorts from the age of 75 are more strongly represented in the SPV than in the PPV. Two decades ago, however, the differences were even more serious: at that time, even those aged 60 and older were more strongly represented in the SPV than in the PPV.

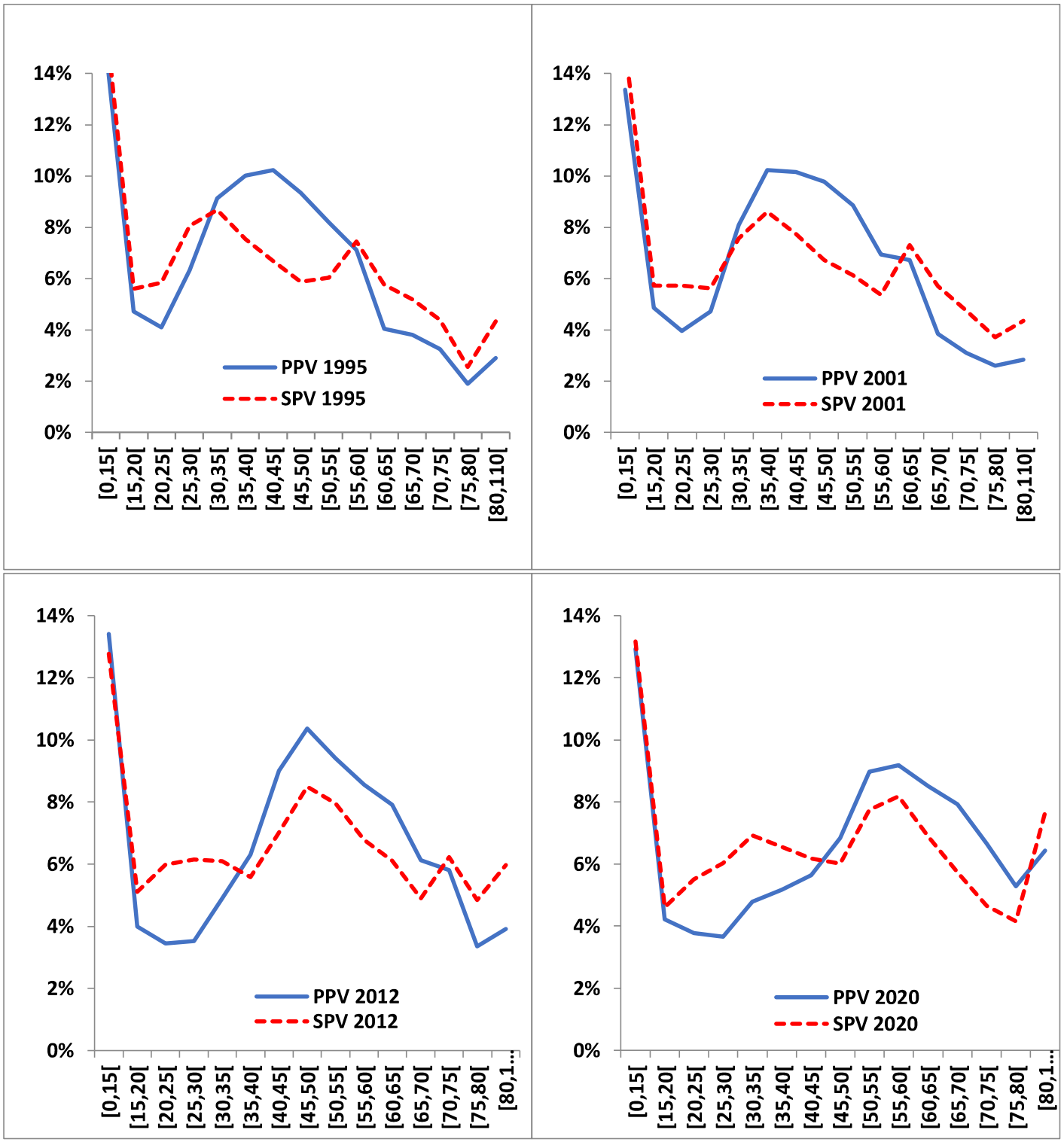

Fig. 4 Distribution of insureds 1995 – 2020 (source: figures of the Private Health Insurance Association)

The age development of the entire private LTC insurance portfolio, which is still to come in the next few years, has already occurred in the civil servant tariff PVB, as figures 5 show.

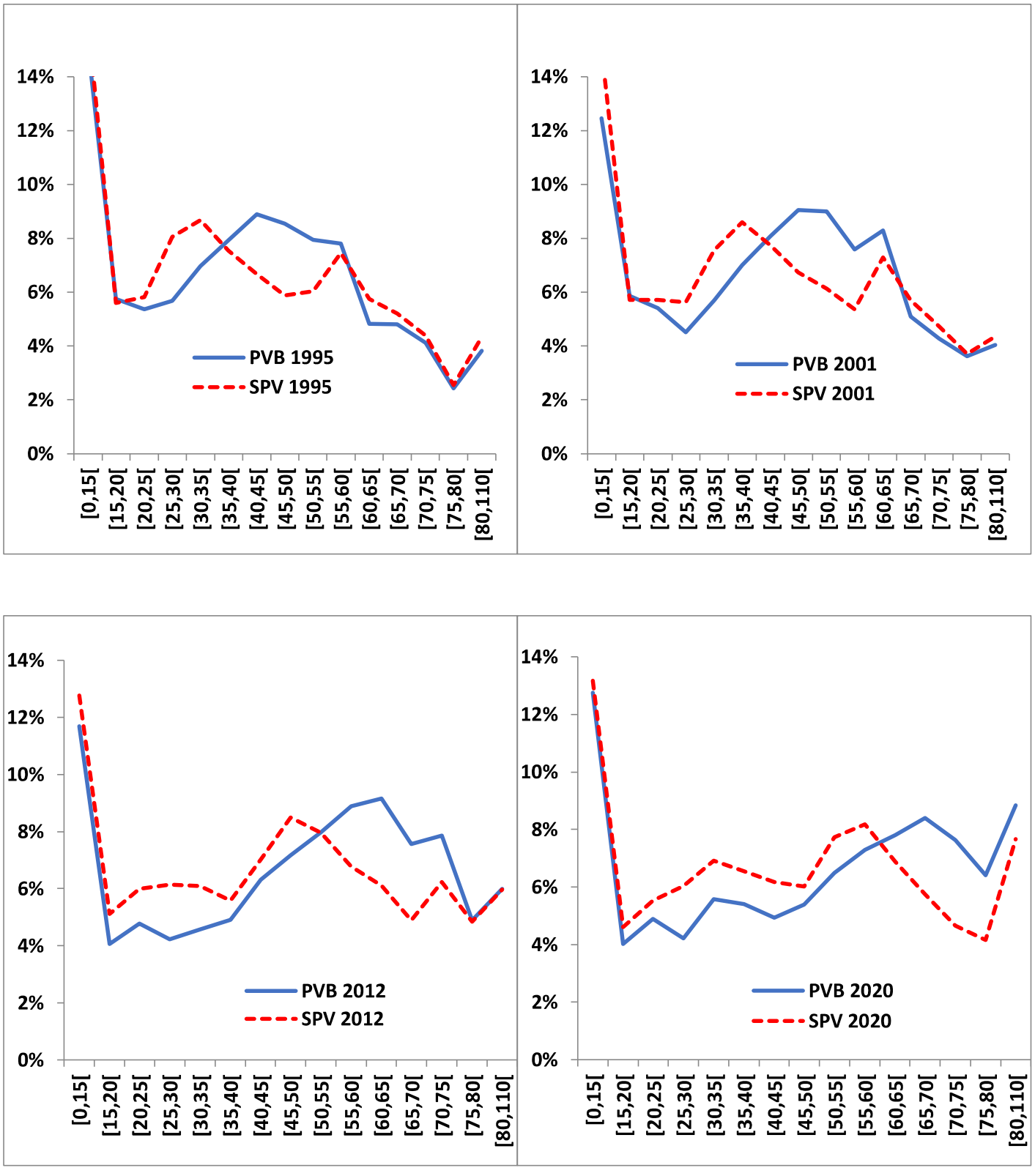

Fig. 5 Distribution of insureds 1995 – 2020 (source: figures of the Private Health Insurance Association)

However, this ageing of the PPV portfolio and its convergence with the age structure of the population as a whole is factored into the premiums from the outset by the funded system – as is the demographic development of private LTC insurance to be expected in the future.

The main reason for the (partly) different development of premiums in SPV and PPV is the divergence between the revenue and expenditure development of the SPV due to the ageing of the population despite almost full employment and economic growth.

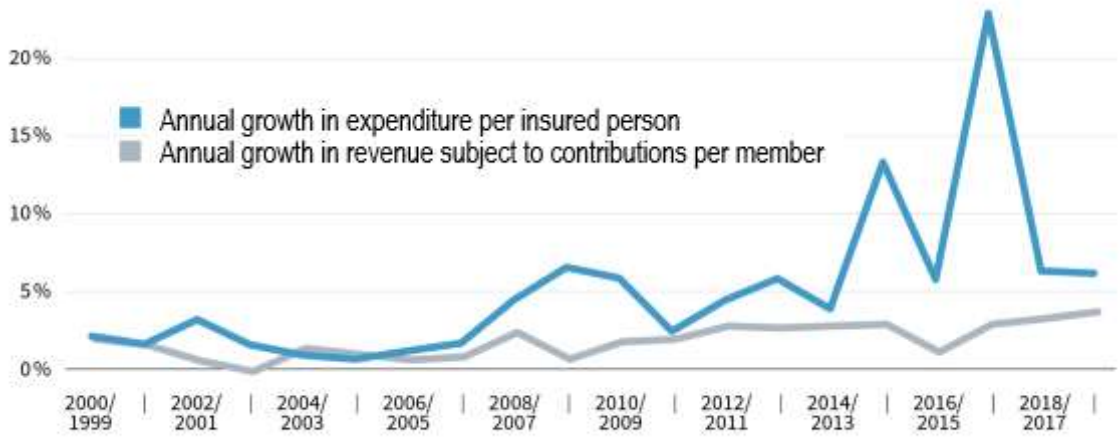

Fig. 6 Revenue vs expenditure development of SPV (source: Scientific Institute of the Private Health Insurance Association)

Introduction of a provision fund in the SPV

An attempt to stabilize the SPV was made with the establishment of the long-term care provision fund in 2015.

It was established by law that 0.1 % of SPV contribution income is collected in a fund. This fund is to be filled until 2035 in order to cushion increases in the SPV contribution rate. At the end of 2021, there was around 12 billion EUR in the fund.

However, this law has two weaknesses:

The accumulated amount will not be sufficient to prevent sharp increases in SPV contributions.

The law does provide for the following (§131 - 139 SGB XI):

„As of 2035, the special fund can be used to ensure contribution rate stability of the SPV if a contribution rate increase would be necessary without an allocation of resources to the equalization fund […].”

Nevertheless, the accumulated funds are highly vulnerable to misuse, as the following statements by politicians show:

Annalena Baerbock (then chancellor candidate of BÜNDNIS 90/DIE GRÜNEN):
“We wanted to dissolve the long-term care reserve fund so that we could use the money immediately.”

Maria Klein-Schmeink (MdB BÜNDNIS 90/DIE GRÜNEN in a conversation 08/30/2021):
“Die GRÜNEN were already against the long-term care reserve fund when it was introduced. They are therefore not doing much to retain it.”

The dangers to which such a fund is exposed can also be well seen in the federal government's draft Hospital Care Relief Act. Since the financial situation of the SPV in 2023 is going to be poor, that year's addition to this fund is not to take place until December 2023. The law does not specify how this allocation is to be financed. It remains to be feared that it will be financed by tax revenues.

In recent years, care benefits have been considerably expanded within the framework of the "Care Strengthening Acts" (“Pflegestärkungsgesetze”):
01.01.2015 First Care Strengthening Act:

- Expand care services, make benefits more dynamic and flexible
- Introduction of a care provision fund (0.1 contribution points in fund)
- Increase of the contribution rate in the SPV from 2.05 % to 2.35 %.

01.01.2016 Second Care Strengthening Act (implementation in two stages)

01.01.2016:

- Improvement in care advice
- Improvement in care aids
- More flexible combination options for home care

01.01.2017:

- Changeover from care levels to care grades (one of the main goals of the changeover is to put people with "limited everyday competence" on an equal footing with physically impaired people)
- Safeguarding of vested rights and transition rules for those already in need of care
- Dynamization of benefits brought forward by one year
- Introduction of uniform care-related co-payments in nursing homes
- Increase in the contribution rate in the SPV from 2.35 % to 2.55 %.

01.01.2019 Nursing Staff Strengthening Act

- Provision of funds to create new nursing positions, costs to be covered proportionately by SPV and PPV
- Better support for nursing staff to reconcile work, care and family life
- Promotion of digitization in nursing care
- Increase in the contribution rate in the SPV from 2.55 % to 3.05 %.

As a reminder, let’s take a look at the picture with the development of contributions from above to illustrate the effects of the changes in the law:

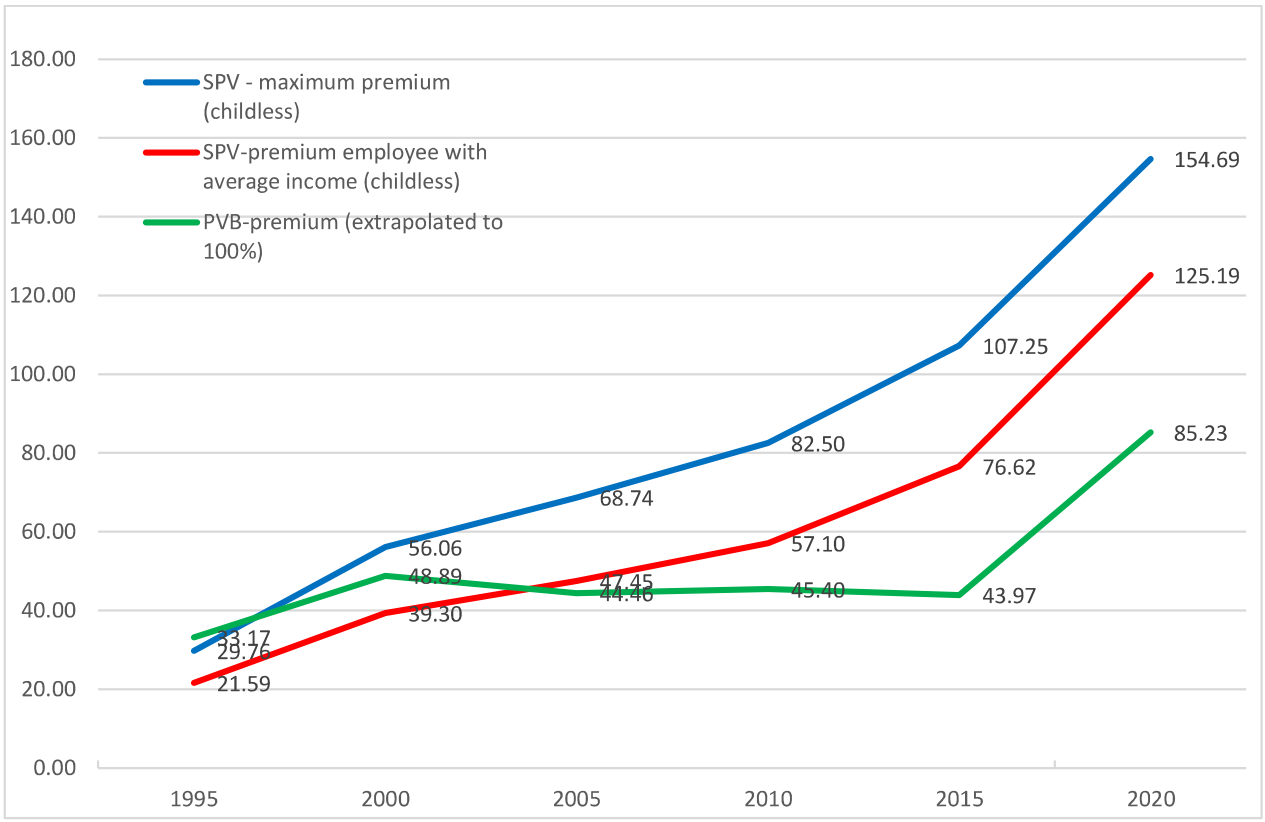

Fig. 7 SPV: Demographic development with more and more people in need of care causes premium increase (source: figures of the Private Health Insurance Association)

It can be seen that premiums have started to rise faster since 2015.

Another point that has an impact on the level of premiums in the PPV is the reduction in the actuarial interest rate due to the low interest on investments in recent years. The following figure shows the change in the actuarial interest rate:

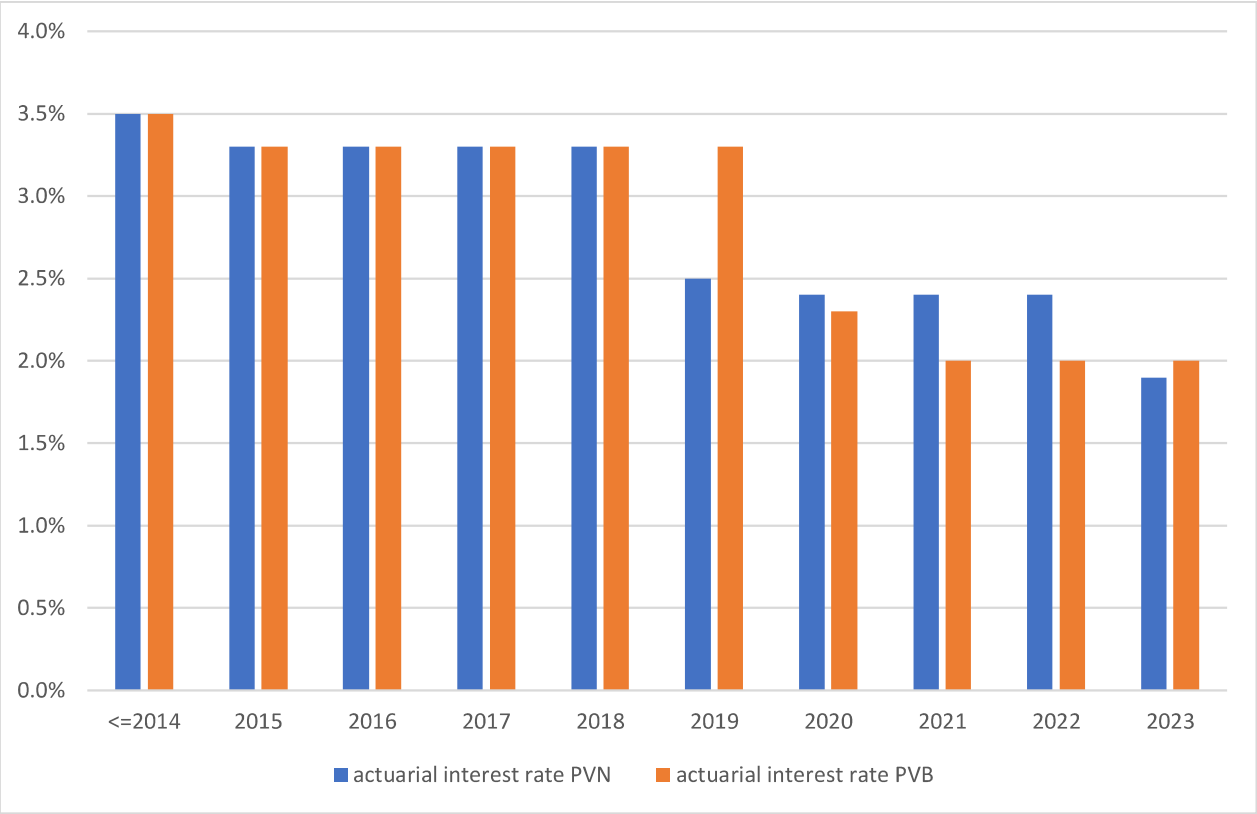

Fig 8 Actuarial interest rates in the PPV 1995 – 2023 (source: figures of the Private Health Insurance Association)

However, further significant reductions in the actuarial interest rate should no longer be expected, as the interest rate environment set by the European Central Bank is already returning to normal. The expected increases in the actuarial interest rate will lead to corresponding premium reductions. In general, it can be assumed that such interest rate fluctuations will even out over the very long contract terms in private compulsory LTC insurance.

Conclusion

As we have seen, the funded system is better equipped to deal with the problems of the future, especially the demographic problem. Since each cohort takes care of itself, the ageing of population, in contrast to the pay-as-you-go SPV, is no reason to raise contributions. However, the PPV system is somewhat more susceptible to benefit expansions, since higher benefits also lead to higher actuarial reserves, which must be refinanced accordingly.

This is also confirmed by the report "Sustainable Financing of Care Services" of the Scientific Advisory Board of the Federal Ministry of Economics and Climate Protection, which comes to similar conclusions in 2022.

The decline in interest rates is largely priced in with the premium adjustment as of January 1, 2023; at the same time, we can see an initial, slight recovery in interest rates, which additionally reduces the pressure to further lower the actuarial interest rates.

The pay-as-you-go system of the SPV, on the other hand, is demographically uncertain – fewer contributors in active working life and more insured persons moving into the age range close to nursing care (in particular the baby boomer cohorts). Economic crises accompanied by job losses and thus declining contribution revenues also put pressure on the revenue side of the SPV.

In any case, ever-increasing federal subsidies have nothing to do with sustainability. This is because they would ultimately be financed by new debts, which we would bequeath to younger generations and thus massively restrict their opportunities: the payment of benefits promised today would be postponed to future generations. Moreover, the increasing dependence of the SPV system on federal subsidies would mean that health care (including long term care) would be provided on a cash basis in the long term. This is because it would then be in direct competition with other acute political goals in the federal budget, such as education, climate protection, digitization, or defense.