



Making the care system future-proof

The German care industry caught between rising care requirements and increasing labour shortages

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Summary

By way of the introduction of the new definition of long-term care in 2017, the number of cases has not only risen ad hoc to a higher level, it has been growing at a much faster rate since then. The number of people in need of care has doubled compared to 2016. To date, the increase has been observed in semi-residential care and outpatient care both when practiced by relatives and by professional services. This development has led to dynamic expenditure growth in social nursing care insurance (SNI), which has been exacerbated by additional benefit expansions such as the benefit supplement in accordance with Section 43c SGB XI (German Code of Social Law). By contrast, the ageing of the population, particularly the baby boomer cohorts, will only have a noticeable impact on expenditure in ten to fifteen years' time.

Nevertheless, the demographic trend is already having an impact. This is because the labour supply will shrink in the new legislative period and then well into the 2030s. Labour-intensive sectors are particularly affected by the increasing labour shortages. The care industry - whether private, non-profit or municipal - therefore faces the challenge of guaranteeing the provision of increasing care needs in the future with an increasingly scarce workforce.

A new direction in care policy is needed to ensure that care can be provided in the long term, even under changed conditions. Against this background, current negotiated efforts to extend the pension commitment should be viewed just as critically as the endeavours to extend the obligation to pay contributions.

- Full cost coverage in inpatient care - whether with a limited or no personal contribution - cannot conceal the fact that costs will remain unchanged. The intended financial relief for people receiving full inpatient care would, therefore, lead ad hoc to a higher contribution rate level in the SNI, on which increasing financing requirements will be built in future.
- The system cannot be sustainably financed neither by extending the obligation to pay contributions to previously non-contributory income components nor by including groups of people who were previously not subject to compulsory insurance. Firstly, this would increase the contribution burden and labour costs even if the contribution rate remained stable in the short term. Secondly, even with an extended obligation to contribute, preventing the contribution rate from increasing in the future if funding requirements continue to rise would not be an option. Thirdly, redistributing the financial burden is not a prerequisite for being able to organise care effectively and efficiently under changed conditions.

Instead of looking for new funding sources, potential savings in non-insurance benefits could be mobilised in the short term. More fundamental questions arise in relation to the receipt of care allowance. Cash benefits account for 28 percent of SNI expenditure. Almost two thirds of all people in need of care only receive a nursing allowance, including six out of ten who do not claim support services such as day care or substitute care. To date, neither earmarking funds for care-related expenses nor applying quality standards in the same way as for professional care has been secured. Whether or not the need for care also leads to a need for financial support has yet to be reviewed. These points need to be discussed with an open mind to weigh up the effects of a social policy that is not very effective against the economic effects of increasing contribution burdens.

However, in the long term, even concentrating the performance promise for core nursing services will not suffice to guarantee care amid a shrinking labour supply when demand increases. In the future, the shortage

problem will affect both financing and, increasingly, the labour market. Care requirements and workforce potential will develop differently in different regions. Tailor-made care solutions need to be developed for this.

Nursing staff can be directly relieved by a campaign to reduce bureaucracy. Keeping the triggering regulations to a minimum is taken for granted in that respect. In addition, digitally supported solutions, the use of artificial intelligence (AI) or care robotics can mobilise the potential to reduce the burden on personnel - both in outpatient and inpatient applications. However, lacking innovative ideas is less of a problem than the lacking ability to disseminate them, which is hampered by existing regulations:

- Digitally supported innovations require investment. In view of the complex negotiations on the eligibility of investment costs and care rates, widespread application has reached its initial limits.
- Long amortisation periods can act as a brake on innovation, extending beyond the economic amortisation period. This applies, in particular, to the financing of digital technologies in the care sector because the market is developing very dynamically.
- Investing in digital solutions is aimed at relieving staff of non-care-related activities. However, inflexible handling of rigid guidelines for staff deployment hinders necessary and sensible care innovations. Instead, the assessment instruments need to consider the potential for reducing the workload in care-related activities as well as staffing requirements in IT and organisational development.
- Ultimately, the principle of “Outpatient before inpatient” needs to be critically scrutinised. Scaling potential that facilitates the refinancing of necessary investments is easier to realise in inpatient than in outpatient care.

With an increasingly scarce workforce supply, meeting the growing demand for nursing care in future will only be possible if innovative concepts in nursing care relieve the pressure on staff deployment. The dynamic development of digital support options in the care sector harbours great potential for meeting increasing care requirements as well as regional differences in workforce shortages. Obstacles to the development and application of innovative solutions must be removed to realise this potential. Instead of defining care standards as uniformly as possible and closely monitoring nursing care for compliance with these standards, more freedom of design is needed in nursing care. Pre-determining individual forms of care, on the other hand, unnecessarily limits the options.

Entrepreneurial action is required when implementing innovative solutions. To date, this idea has met with widespread scepticism. However, innovative, regionally customised solutions will only be used if the necessary investments pay off in the long term - irrespective of whether the services are rendered by private, non-profit or municipal providers.

1 Initial situation and political challenges

Amid an increasingly scarce labour supply, the care industry is facing the challenge of guaranteeing comprehensive and needs-based care. At the same time, the SNI has repeatedly run into financial difficulties. The care promise has been continually expanded in the past, most recently with the introduction and increase in service supplements in accordance with Section 43c SGB XI (German Code of Social Law). The funding requirement in the SNI (social nursing care insurance) has increased with each additional benefit commitment. This increases the pressure on political decision-makers to organise sufficient funding for the SNI. However, the possibilities reach their limits when financing is at the centre of the care policy debate:

- Higher contribution rates lead to increasing burdens for employees and their employers. A continued increase in the contribution burden in the statutory social security system will slow down private investment activity in Germany, which has already been weakened, and have a lasting negative impact on the development of disposable income and private consumption. As a result, economic output will permanently fall below the level that can be expected with stable social security contributions (Hüther et al., 2025, 11 ff.). This correlation also needs to be considered with regard to the SNI's promise of benefits, because the majority of expenditure is financed via market income subject to compulsory redistribution.
- Therefore, when reform proposals are discussed with the aim of increasing contribution income while keeping contribution rates constant in the short term (for example by raising the assessment threshold), these approaches cannot hide the fact that the contribution burden is increasing. In the short term, workers with salaries above the previous assessment threshold and their employers would be affected. As a result, labour costs would rise, especially for higher-skilled workers (Beznoska et al., 2024). However, their employment and income opportunities are to be preserved at the location because they are particularly important in overcoming the transformational challenges.
- Similarly, demands intended to secure funding through higher and increasing tax subsidies offer scant prospects of a solution. If such proposals regularly fail due to political prioritisation, this is also due to fiscal restrictions incumbent upon the federal government.

Alternative ways of stabilising the financing of the SNI must be explored if the search for additional funding sources reaches its limits. While it makes sense from an economic perspective to focus on measures that can slow down the development of expenditure, care policy has not yet dared to critically review the SNI performance promise. On the contrary, at present there are calls to extend the pension commitment to include full cost coverage in inpatient care. However, whether with a limited, flat-rate co-payment (as envisaged in the variants of the "Base-peak swap" currently being discussed; Rothgang et al., 2019) or without a co-payment of the care costs, efforts are aimed at relieving the financial burden on people in need of care in full inpatient care. As care costs remain unchanged, all contributors would, however, need to shoulder a higher burden instead. The IGES Institute has calculated an additional contribution rate requirement of 0.4 contribution rate points if the cost of full inpatient care, which is currently borne privately, was to be financed ad hoc at the expense of the SNI (Federal Government, 2024, 118). However, the demographically driven increase in financing requirements expected in the future would then be based on an even higher contribution rate level.

At the same time, the legislator has increasingly tightened requirements in respect of the provision of care services - for example through quotas for the deployment of nursing staff in full inpatient care facilities and through requirements regarding remuneration, which need to be demonstrably fulfilled to bill the SNI for services. In addition to these requirements, the remuneration of carers has risen significantly in recent years

(Rothgang/Müller, 2024, 23 f.). Amid the tension between qualitative and quantitative requirements, rising personnel costs and increasingly scarce financial resources, the care industry faces the challenge of providing economically viable care services of sufficient quality and quantity.

This tension will intensify upon the imminent demographic change:

- On the one hand, the first baby boomers will be retiring from the labour market in the coming legislative period. At the same time, these cohorts will no longer be replaced at the same rate due to the persistently low birth rates during the past five decades (Hammermann et al., 2025, 5). This not only threatens to reduce the overall labour supply. It will also increasingly affect the labour-intensive care industry, which is already dealing with shortages of labour and skilled workers in individual local labour markets. Due to the progressive ageing of the population, this trend will continue well into the 2030s (e.g. Commission on a Reliable Intergenerational Contract, 2020, 55). Depending on the federal state, the proportion of employees in the care sector aged 55 and over varies between just under 20 percent (Saxony) and 26.5 percent (Bremen). They will reach the standard retirement age in the next ten years and move into retirement (Isfort, 2024, 106 et seq.). A “tipping point” is likely to be reached in the labour-intensive care sector if replacing at least the same number of staff leaving is not possible.
- Secondly, with the ageing of the baby boomers, the proportion of contributors of retirement age will increase continually from now on. However, pensioners’ contributory income is typically lower than during the working phase (Beznoska et al., 2023, 509; 513). For this reason, too, it is to be feared that the development of contribution income in the pay-as-you-go SNI will continue to fall behind the growth in expenditure because the proportion of members of retirement age increases and the funding pressure in the SNI will continue to rise.
- An updated contribution rate forecast by the IGES Institute on behalf of the DAK-Gesundheit health insurance company shows that the contribution rate to the SNI threatens to rise to more than 5 percent within the next ten years, even if no additional benefit promises are made (Ochmann et al., 2025, 14). However, it is not only the contribution rate to the SNI that will rise sharply by the mid-30s, but also the contributions to health and pension insurance and, therefore, the overall burden of social security contributions due to demographic trends. Overall, the sum of all contribution rates will climb to the 50 percent mark by the mid-2030s or even beyond under less favourable conditions (Ochmann et al., 2025, 21). If the employment and income opportunities of workers subject to social security contributions are impaired to such an extent that the income subject to contributions shrinks overall, the system will enter a negative spiral.

The focus to date of care policy on financing issues does not adequately address these challenges. This is because, in addition to funding, the task of care policy is to create the framework conditions for care service providers in such a way that an appropriate range of services (within the meaning of the legally defined service promises) can be provided. Regardless of whether outpatient or inpatient services are rendered by private, non-profit or public organisations, the companies and facilities in the care sector must be able to successfully operate with the necessary workforce and capital to be invested so that care needs can be met throughout the population. If the care industry is to provide care for an increasing number of people in need of care in the future with an increasingly scarce labour supply, the framework conditions and rules of the game under which facilities and services are forced to operate with increasingly scarce human resources will become more important.

This brief study aims to broaden the care policy discourse, which thus far has been characterised primarily by current care and funding issues, to include the perspective of longer-term challenges. The demographically induced challenges are outlined in brief starting with a categorisation of current performance trends and financing problems. A critical examination of the incentive effects resulting from the current regulations ultimately leads to the question of the rules that are needed to enable players in the care industry to develop solutions for rising care requirements with increasingly scarce personnel resources.

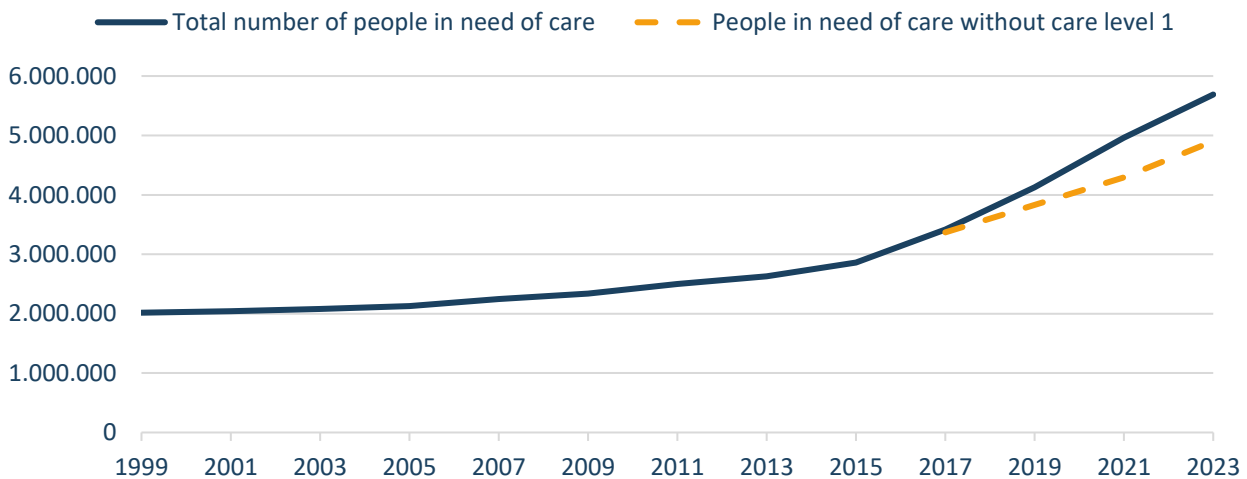
2 Rising case numbers despite still favourable demographics

In view of the renewed funding deficit in the SNI in 2024, Federal Health Minister Karl Lauterbach attempted to explain the sharp rise in the number of nursing cases in May 2024 by referring to demographic trends (Lauterbach, 2024). However, the development of the number of cases since 1999 suggests that the recurring funding problems are largely due to care policy decisions and less a result of the ageing population.

Increase and distribution of care case numbers since 2017

Although the number of people in need of long-term care has been rising continually since 1999, the number of cases increased comparatively moderately between 1999 and 2015 (Figure 2-1). Since the introduction of the new definition of long-term care in 2017, however, growth has been much steeper: within 16 years, the number of people in need of care has risen from just over 2 million in 1999 to 2.86 million in 2015. From 2015 to 2023, i.e. within a period half as long, the number of people in need of care doubled to 5.69 million (German Federal Statistical Office, 2024a).

Figure 2-1: Total number of people in need of care



Source: German Federal Statistical Office, 2024a

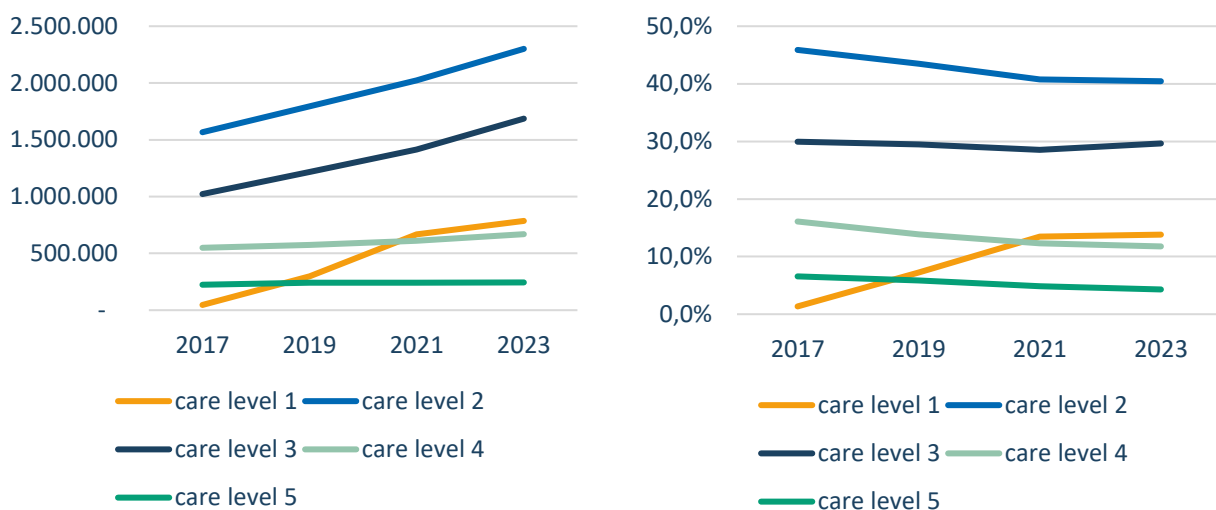
As the baby boomers are still in the working phase and the probability of falling into long-term care is significantly increasing, above all at an advanced age (Matzk et al., 2024, 271), this development can only be attributed to demographic trends to the extent that the number of people of advanced age is increasing as life expectancy rises. However, given the short period since 2017 and the one-off effects of the COVID-19 pandemic, this correlation cannot plausibly explain the developments at the current margin.

Increase in case numbers almost exclusively in outpatient care

Upon the changeover from three care levels to five care levels, the concept of care was expanded to include dementia. Since 2017, the number of people in need of care with care level 1, in particular, has risen sharply, although the increase has levelled off recently. Their share of all care cases has risen from 1 percent in 2017 to 14 percent (Figure 2-2, left chart). At the same time, the number of care cases with care levels 2 and 3 has risen continually. Despite rising case numbers with care level 3, however, the proportion of all cases has remained almost constant and has even declined in care level 2 (Figure 2-2, right-hand chart). This also applies to the proportion of people in need of care with care degree 4 or 5. Despite a slight increase in the absolute number of cases with care degree 4, the growth is disproportionately low compared to the development of the total number.

Figure 2-2: People in need of care, by care level

People in need of care; proportion of people in percent



Source: German Federal Statistical Office, 2024a

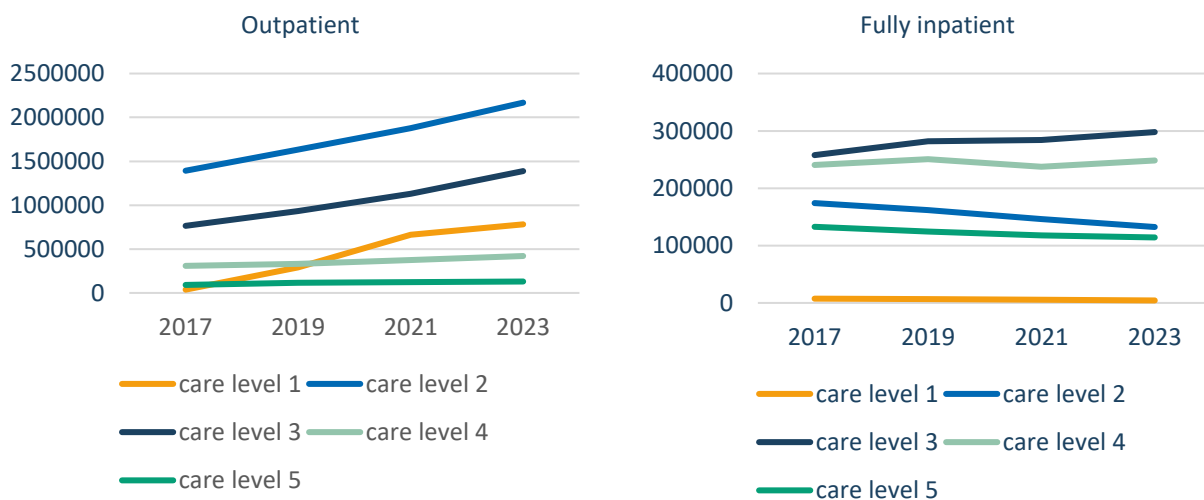
Growth exclusively in outpatient and partial inpatient care

The increase in care cases since 2017 is largely attributable to outpatient forms of care (Figure 2-3, left chart). At just under 4.9 million people, more than five times as many people were cared for in their own homes in 2023 than as inpatients (most recently about 800,000 people) (German Federal Statistical Office, 2024a). While growth in care levels 4 and 5 has been restrained, the number of people with care levels 2 and 3 has risen sharply. The number of cases with care level 1 has risen disproportionately sharply in 2021.

The care statistics also include people who receive day or night care on a semi-stationary basis as outpatient care cases. The statistics on available places in nursing homes explicitly show this subgroup. This shows that the number of cases in semi-residential day and night care has also increased significantly in line with the development of outpatient care cases: by more than 73,400 to more than 177,000 people between 2017 and 2023 (German Federal Statistical Office, 2025). However, this development cannot be solely attributed to the reform of the concept of care. This is because between 2011 and 2017, i.e. during the same period, the number of people in semi-residential care had already risen to about 59,800 (German Federal Statistical Office, 2025).

By contrast, the number of people cared for in fully inpatient care facilities has hardly changed (Figure 2-3, right chart): Compared to 2017, about 20,000 fewer people were recently cared for in inpatient facilities, totalling about 800,000 people. The trend is also influenced by the COVID-19 pandemic, which led to a slight “dip” from 2019 to 2021. A slight further increase has recently been witnessed. Apart from care level 1, people with care level 2 are less frequently cared for in facilities (this also applies to a lesser extent to people with care level 5). By contrast, the number of people in need of care who are cared for in facilities with care level 3 has risen continually, and most recently also those with care level 4.

Figure 2-3: People in need of care in outpatient and inpatient care



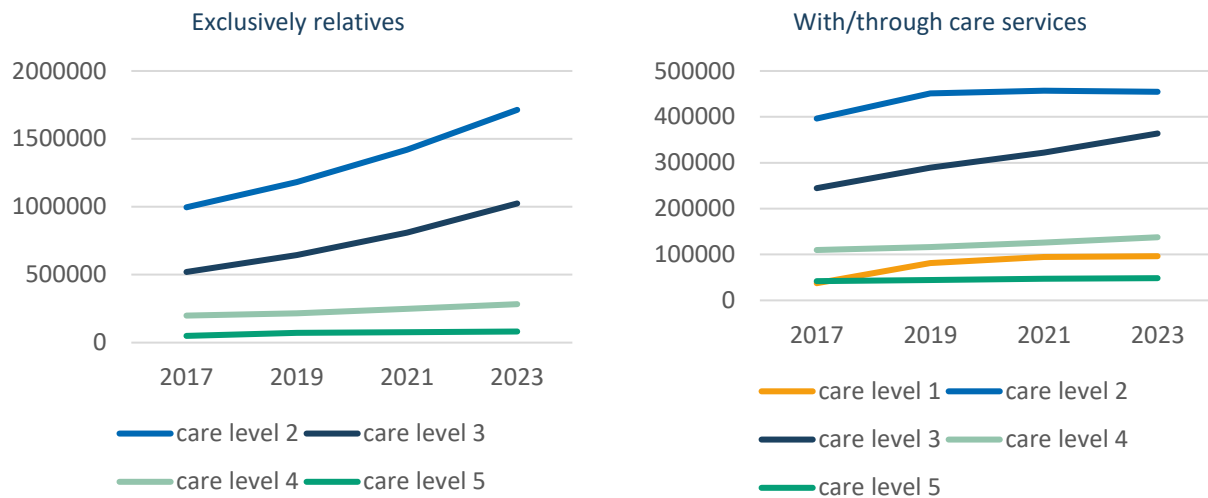
Source: German Federal Statistical Office, 2024a

High proportion of outpatient care for relatives

Rising case numbers in outpatient care are being recorded both for care provided exclusively by relatives and for cases requiring professional care. Care level 1 is not considered for the care of relatives because it does not entitle them to main care benefits (cash benefits and benefits in kind from the nursing care insurance). This is by no means intended to trivialise or ignore the contribution made by family carers. However, this group is not included in the further comments on the development of benefit expenditure (Chapter 3) for methodological reasons.

The increase in care provided by relatives is largely driven by those in need of care with care levels 2 and 3 (Figure 2-4, left-hand chart). In the cases that are cared for with the help of or exclusively by professional care services, the number of people in need of care with care level 3 has risen continually (Figure 2-4, right-hand chart). It is striking that about 100,000 people with care level 1 are cared for with the involvement of outpatient care services, although they (if they are insured via the SNI) cannot claim care allowance or care benefits in kind.

Figure 2-4: Outpatient care by relatives and professional care services



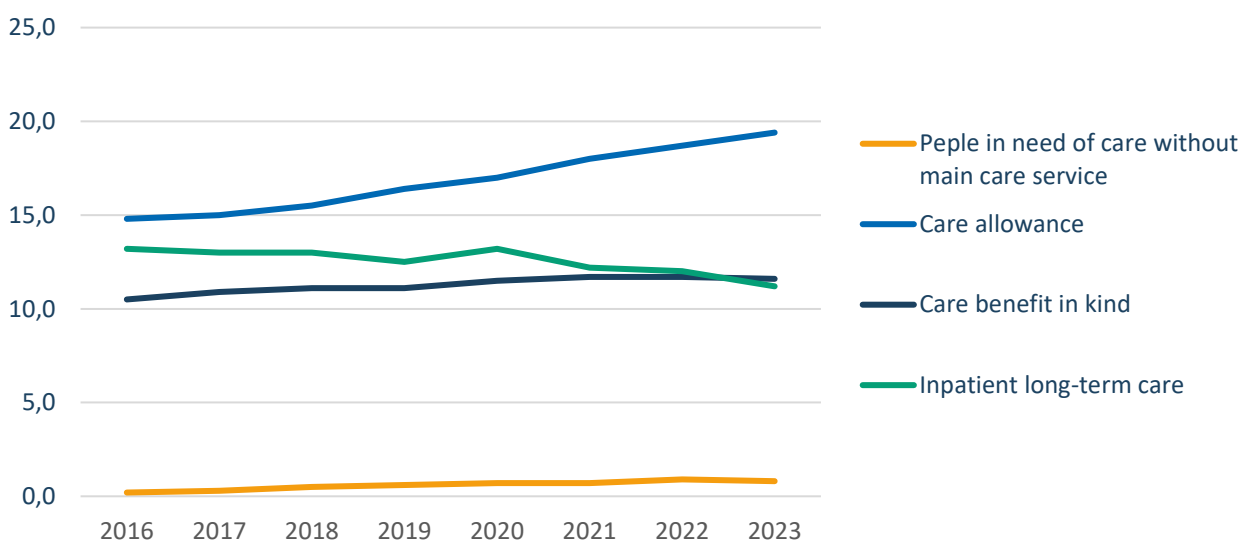
Source: German Federal Statistical Office, 2024a

Receiving care allowance extends the phase of life in care

From a time-related perspective, the growth in the number of cases can be explained inter alia by a longer period of benefit receipt. This is because if a constant number of care cases follow with unchanged care prevalence rates and cohorts with the same number of people, but the people in older cohorts who require care remain in receipt of benefits for longer, this leads to an overall increase in the number of care cases. In fact, the phase of life with a need for long-term care has developed differently depending on the type of care (Rothgang/Müller, 2024, 137) (Figure 2-5).

Figure 2-5: Length of stay in care level 1 to 5

In months



Development of the length of stay based on data of persons insured under BARMER nursing care insurance.

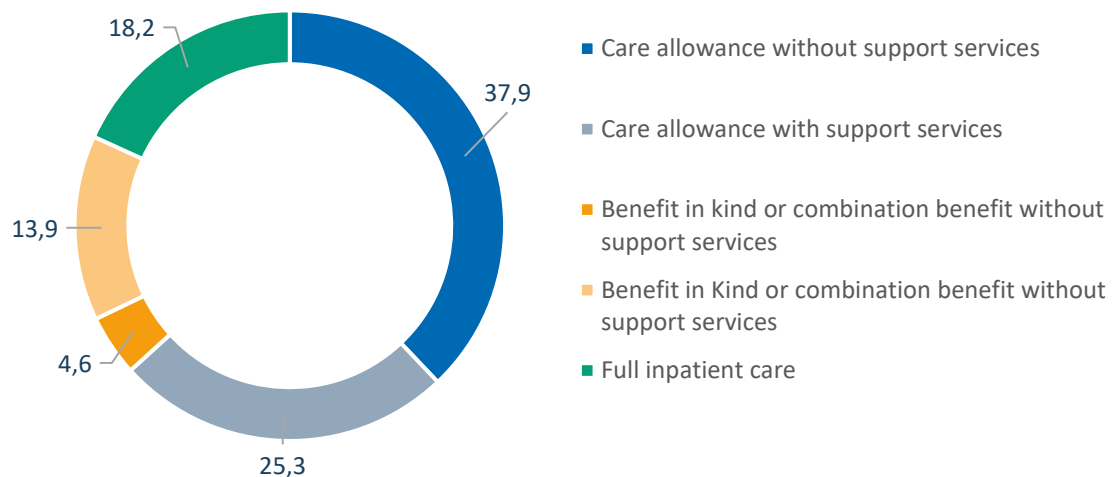
Source: Rothgang/Müller, 224, 138

- Apart from a slight increase in 2020, the length of stay in long-term inpatient care among those with statutory health insurance has fallen since 2016. Starting from a little over 13.2 months, the average length of time that those in need of care lived in fully inpatient care was 11.2 months in 2023.
- There is an opposing trend in the receipt of care services, i.e. outpatient care provided by professional services: while the average length of stay in 2016 was still 10.5 months, it had risen to 11.2 months by 2023.
- Without wishing to over-interpret these findings, the opposing trend can also be categorised in the context of the politically intended priority of “outpatient over inpatient.” This may also be supported by the fact that the duration of receipt of care allowance has risen continually - from 14.8 months in 2016 to 19.4 months in 2023.

Despite the low level, the increase in the length of stay in care level 1 is also striking (Figure 2-5). If this group of people is excluded, almost two thirds (63.2 percent) of those in need of care who claim a main care benefit (care allowance, care benefit in kind or full inpatient care) receive the care allowance. In this group, about 6 out of 10 people do not make use of support services such as respite or day care (Matzk et al., 2024, 278). In 2022, 18.5 percent of people in need of long-term care receiving main benefits received outpatient care from or with the involvement of professional services, with a further 18.2 percent receiving fully inpatient care (Figure 2-6).

Figure 2-6: People in need of care by benefit receipt

2022, in percent



Without care level 1 or facilities for the disabled; support services: for example, respite care or day care.

Source: Matzk et al., 2024, 278

An initial categorisation

Since 2017, the number of cases in care levels 2 and 3 as well as outpatient care provided by relatives and with the help of professional services has developed much more dynamically than in the past. By contrast, the trend in fully inpatient care is unremarkable. In view of the inclusion of dementia-related illnesses and their typically progressive progression, it makes sense to interpret the increasing number of people in need of care primarily in conjunction with the expansion of the concept of care. The steady extension of the life

phase with care needs is driven by two developments: on the one hand, by a growing number of people with care level 1 (albeit with a comparatively short length of stay) and, on the other, by a steadily increasing duration of receipt of care allowance.

There are mainly epidemiological reasons for the developments in outpatient care, particularly for people with care levels 2 and 3. Since the changeover to five care levels, care needs due to dementia have been systematically considered, i.e. even if dementia patients are not dependent on professional support, for example in respect of personal hygiene.

In addition, supply- and demand-induced reasons can be cited to explain the rising number of care cases, for example due to better availability and a higher level of awareness of the services on offer. Obtaining care level 1 may also be perceived as a precursor to being able to obtain a higher grade more easily and quickly when the need for care increases. This may also have led to a change in social norms, which has led to a destigmatisation of care needs. Last but not least, socio-economic factors may play a role, as with increasing life expectancy, the probability of living as a single person in old age and, therefore, being dependent on professional care services to a greater extent than couple households, has risen.

On the other hand, this trend cannot be explained by the ageing population. The number of very old people is increasing as life expectancy continues to rise. However, over the short period from 2017 to 2023 and due to the special effects resulting from the COVID-19 pandemic, this has not changed to an extent that can plausibly explain the current trend in case numbers. By contrast, the ageing of the baby boomer cohorts is not contributing to the current trend. The baby boomer generation is in the last phase of working life, in which the probability of needing long-term care is comparatively low (Matzk et al., 2024, 271). They will only gradually reach the age groups with a significantly higher risk of long-term care in ten to fifteen years' time.

3 Care policy drives expenditure development

While the previous findings related to the population as a whole, the following section focuses on the financial impact of rising case numbers on SNI. Looking at the development of nominal expenditure since 2000 (Figure 3-1, left chart), a slight increase in growth in 2008 to 2010 and in 2015 is initially noticeable. However, the introduction of the new definition of long-term care from 2017 will create a gap. Starting from the higher level, expenditure growth then accelerated significantly. In 2023, the trend slows down because the allocation to the long-term care provision fund was set to zero in that year.

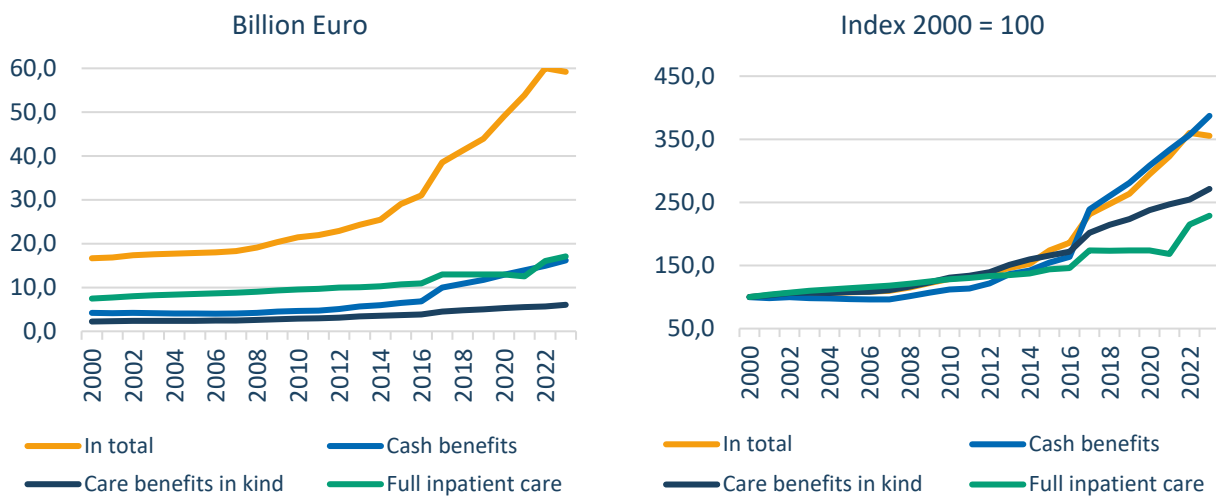
Looking at the three expenditure categories with the highest shares of total SNI expenditure, a connection with care policy decisions is obvious:

- Benefit expenditure for full inpatient care recently accounted for 30 percent of the total expenditure of the SNI. The first jump in 2017 occurred at the same time as the switch to five care lines. A second jump occurs in 2022 (Figure 3-1, right chart). It emerges in conjunction with the introduction of service supplements in accordance with Section 43c SGB XI. Since then, the SPV has financed an increasing percentage of the care costs depending on the duration of the case. Expenditure on full inpatient care has continued to rise after 2022, and the benefit supplements were increased again in 2024.

- In the case of long-term care benefits in kind (excluding day or respite care), which accounted for 11 percent of total SNI expenditure in 2023, the same jump was witnessed in 2017 followed by continual, accelerated growth compared to previous years.
- Cash benefits (care allowance) recently accounted for 28 percent of total expenditure. Here, too, the leap that occurred in 2017 with the redefinition of the concept of care stands out. Among the three largest categories of expenditure, cash benefits have increased continually and with the highest growth rate since then.

Figure 3-1: Social long-term care insurance benefit expenditure

Overall and in the three largest expenditure categories



Full inpatient care: excluding facilities for the disabled, substitute or short-term care.

Source: BMG, 2024

Extending the obligation to pay contributions does not provide a sustainable solution

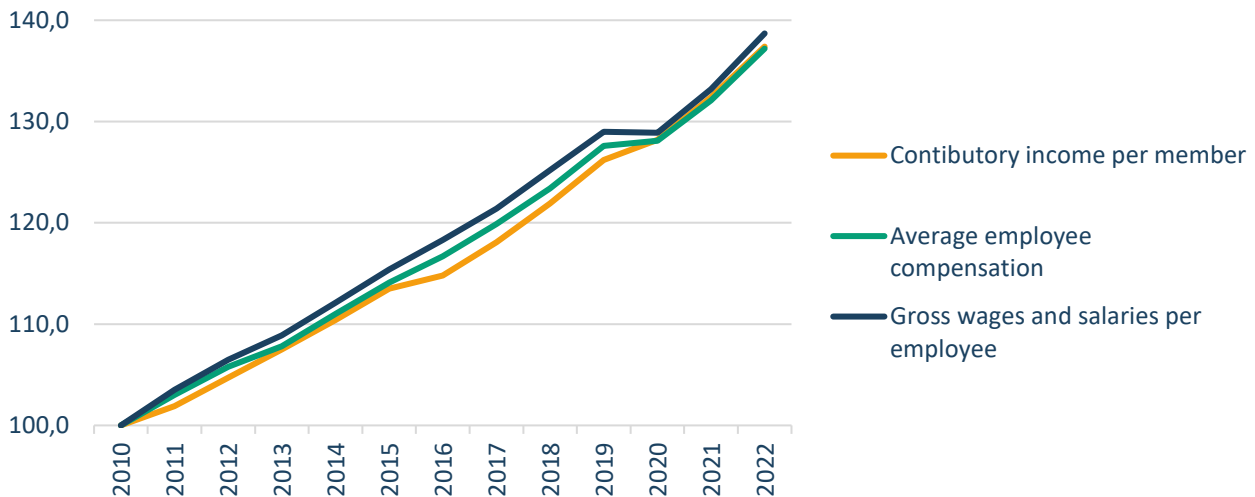
Despite this conspicuous development in SNI expenditure, the care policy debate has so far focussed primarily on potential improvements on the benefits side. This in turn means that supposed solutions are primarily sought on the revenue side of the SNI. In light of this, the question is whether the reform models currently under discussion (on the one hand, an expansion of the group of persons subject to compulsory insurance and, on the other, an expansion of the contribution assessment base) would be able to secure long-term care financing in the long term. According to the ideas of the protagonists, this should ideally facilitate the additional generation of revenue with a stable contribution rate. However, without discussing the advantages and disadvantages of different models, it is not clear why an extension of the insurance and contribution obligation should make a sustainable contribution to financing rising care requirements at permanently constant contribution rates.

If we compare the development of contributory income per SNI member with the development of average gross wages and salaries or average employee compensation, we can initially see that all three variables have grown at approximately the same rate during the past decade (Pimpertz, 2023, 70; Figure 3-2). According to the system of national accounts, average salaries include both the salaries of civil servants and remuneration

components above the assessment threshold. The average employee compensation also includes the employer's share of the social security contribution.

Figure 3-2: Contributory income in the light of the national accounts

Index 2010 = 100



National accounts: National accounts of the German Federal Statistical Office; gross wages and salaries: including civil servants' salaries and remuneration components above the assessment threshold; compensation of employees: gross wages and salaries plus employers' social security contributions.

Source: Pimpertz, 2023, 70

This finding has far-reaching implications:

- If an expansion of the group of compulsorily insured persons and/or the contribution assessment is linked to the hope of being able to generate additional income at a constant contribution rate, then this may succeed on a one-off basis. Even then, however, the contribution burden will increase for members and their employers for whom remuneration components are not yet subject to compulsory contributions (Beznoska et al., 2024). However, rising contribution burdens are slowing economic development regardless of the distribution of the burden (Hüther et al., 2025).
- If the three variables continue to develop at an almost identical rate, the extension of the contribution obligation will not result in a contribution that can finance rising expenditure at constant contribution rates in the future. The measures are also not a prerequisite for slowing down the development of expenditure in nursing care. On the contrary, the hope of generating additional revenue in the short term threatens to postpone measures that are necessary to slow down the growth in expenditure and secure the labour supply in the care sector.

Interim conclusion

Rising case numbers are driving the development of expenditure in SNI. With the introduction of the new definition of long-term care in 2017, expenditure has not only risen to a higher level on a one-off basis, it has been growing at a much faster rate since then. Other care policy decisions in favour of a more generous service promise are reflected above all in the development of expenditure for full inpatient care. There will be a further jump in 2022, which can be explained by the introduction of benefit supplements to the own contributions to full inpatient care costs.

Other measures have contributed to the general increase in expenditure, such as the introduction of “Tariff loyalty,” according to which, since September 2022, care services may only be invoiced to the SNI on the condition that the remuneration of care staff is based on a collective agreement or the usual regional wage level (Rothgang/Müller, 2024, 8). Overall, geriatric care is characterised by above-average wage growth - nominal wages in geriatric care have risen around twice as much as in the rest of the economy since 2015. The wage level of skilled workers in geriatric care is now higher than that of all skilled workers (Rothgang/Müller, 2024, 23 f.; German Federal Statistical Office, 2024b).

In view of the challenges posed by the ageing of the baby boomers in the near future, the expansion of benefits in the past is proving to be a burden. This is because constantly rising case numbers have accelerated the growth in expenditure and led to ever greater funding requirements. This has not only increased the contribution rate to date, but the future increase in financing requirements will also saddle the system with a higher contribution rate level. To limit the associated negative economic effects, care policy needs to take a closer look at the future prospects instead of striving for further short-term expansions of the care promise.

4 Demographic challenges for the care sector

The development in expenditure induced by care policy in recent years has increased the political pressure to adequately subsidise the care promises once they have been made. However, efforts to stabilise the contribution rate in the short term via the revenue side will not be able to solve the fundamental problems. This is because the pay-as-you-go SNI, as in the case of the provision of nursing care, is facing demographic challenges that call into question the ability to fulfil the previous benefit promises in the medium to long term.

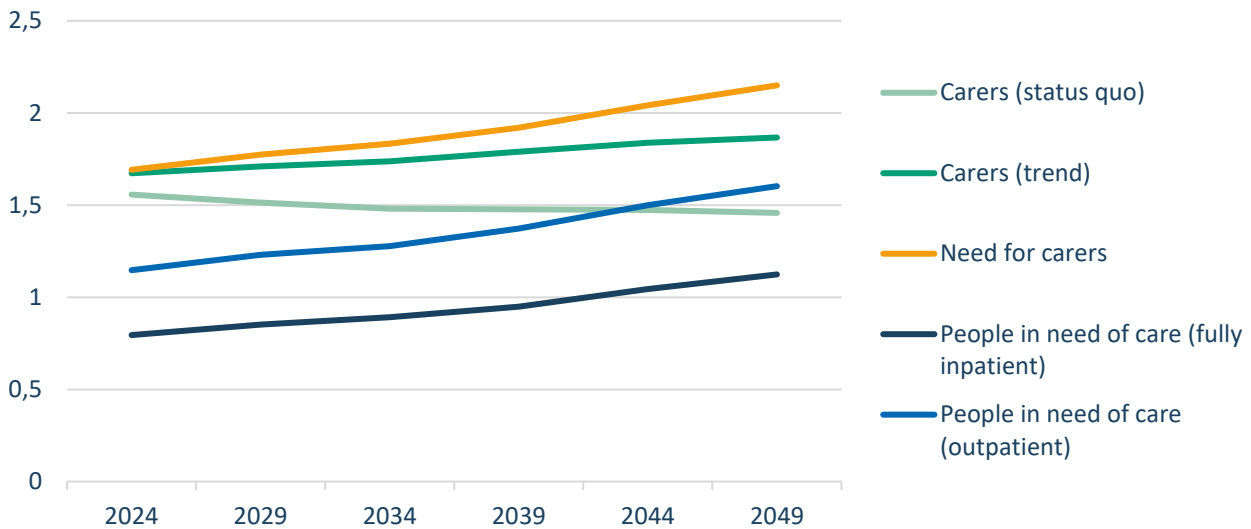
Long-term increase requirements with shrinking labour force potential

In its nursing staff forecast, the German Federal Statistical Office simulated the development of care requirements and the supply of nursing staff based on variant 2 of the 15th coordinated population forecast (German Federal Statistical Office, 2024c). If we extrapolate the probabilities of long-term care cases observed in the cross-section of the population with the future composition of the age cohorts, we will see an accelerated increase in the number of cases from the mid-2030s onwards, particularly for people in need of outpatient care. In the case of people requiring full inpatient care (excluding hospital cases), growth is accelerating with a delay of around five years (Figure 4-1).

Based on the 2019 micro census, the development of the need for nursing staff can be projected into the future in a mirror image. The currently observable, mathematical per capita ratio of care workers to people in need of care is updated with the changes resulting from the population projection for the number of care cases. The projection implicitly assumes that the staffing ratio will not change over time. The micro census data includes staff outside of facilities for the elderly and disabled and, therefore, overestimates the figures from the healthcare personnel accounts by just under 290,000 people (information on methodology, German Federal Statistical Office, 2024c; own calculations).

Figure 4-1: Rising care requirements, shrinking labour supply

Persons in million



People in need of care: excluding hospital cases; basis: variant 2 of the 15th coordinated population projection; carers (status quo): demographically induced development with constant, age-dependent employment rates; carers (Trend): extrapolation considering cohort-specific employment behaviour.

Source: German Federal Statistical Office, 2024c

Ultimately, the German Federal Statistical Office calculates the development of the supply of nursing staff in two scenarios: in the status quo variant, it is assumed that the labour force participation in nursing remains unchanged in the various age groups. The overall shrinking labour supply in the economy will result in a corresponding decline in the supply of nursing staff, so that by 2049 there will be a gap between the calculated labour demand and supply of a good 690,000 people.

In an optimistic scenario (trend variant), on the other hand, the labour force participation of younger cohorts is extrapolated. The trend variant, therefore, explicitly considers the higher proportion of male carers, for whom it is assumed that they do not reduce their working hours to the same extent as female carers when starting a family. The scenario also considers the increase in the standard retirement age in statutory pension insurance and, therefore, assumes a longer working phase in the care profession. Based on these assumptions, the German Federal Statistical Office calculates a slight increase in the supply of nursing staff by a good 190,000 people by 2049, but even then, there will still be a gap of over 280,000 people compared to the calculated need for nursing staff.

Even if the methodology of the German Federal Statistical Office's simulations is debatable, the trend statement can hardly be refuted. As a result, the scarcity problem no longer extends solely to the question of how sufficient funding can be ensured for the benefits promised. Instead, care policy is focussing on the question of how personnel-intensive care can succeed in the future with increasing staff shortages but rising care requirements.

Derivation: rethinking care policy under changing scarcities

In the future, demographic trends will lead both to rising case numbers in the care sector and to a shortage of labour in the care sector. All efforts to ensure stable financing of the existing structures are not only coming up against economic limits. Similarly, they are unable to provide any answers as to how increasing care requirements can be met in the future with a shrinking labour supply. Developing economically viable solutions for this requires rethinking the care policy. It is important to further develop framework conditions that enable new concepts of care under changed conditions. However, the development and application of innovative solutions require room for manoeuvre and time, which must be used now before the need for care increases significantly in ten to fifteen years' time.

5 Limits to staff expansion in nursing care

The introduction of the SNI on 1 January 1995 has led to a professionalisation of the care sector. This unlocked a new area of employment in a phase characterised by high unemployment. This applies particularly to women who took significantly longer breaks from work at this time due to child-raising periods than has been the case since the introduction of the Parental Allowance and Parental Leave Act in 2007. Overall, women had significantly lower employment rates than today. Care for the elderly enabled women to (re-)enter the labour market at a low threshold. The care sector as a field of employment, therefore, contributed significantly to the growth in employment subject to social insurance contributions. Employment subject to social insurance contributions in Germany increased by 6.9 million people between 2001 and 2023 (German Federal Statistical Office, 2024d). Nine percent of this growth can be explained by the increase in employment in the care sector and first and foremost by the increase in employment in the outpatient sector. The number of nursing staff in care homes rose by 72 percent between 2001 and 2023 (from 475,400 to 817,700 people; German Federal Statistical Office, 2023b), while the outpatient sector recorded an increase of 135 percent. The number of employees there rose from 189,600 to 446,400. This employment potential, which was primarily activated among women, will not be realised to the same extent in the care sector. It is, therefore, questionable to what extent it will be possible to secure and expand employment in the care sector in other ways.

Employment structure in geriatric care

Employees in geriatric care are characterised by an above-average proportion of part-time employees. The part-time rate in 2021 was 68 percent; across all sectors of the economy, the part-time rate is around 30 percent (German Federal Statistical Office, 2024a). It is noticeable that a particularly large number of people work in geriatric care without any specific vocational training. In both outpatient and inpatient care, the proportion of people with "other professional qualifications" is a good quarter. This means that the proportion of this employment group is higher than the proportion of state-recognised geriatric nurses.

At just over 22 percent of employees, this figure was just below this. Since 2017, the proportion of workers without professional qualifications has also increased in both inpatient and outpatient care. In outpatient care, there was an increase from 7 percent in 2017 to 13 percent in 2023. In inpatient care, the increase from 11 to 15 percent was somewhat flatter, but at a higher level.

Carstensen et al. (2024b) were able to show that employment growth in the care sector since 2022 has been exclusively attributable to foreign employees. In the care professions for the elderly, the proportion of foreign employees has risen from 7 to 19 percent in the last decade. Employees with German citizenship are comparatively often close to retirement. Therefore, two developments characterise the current skilled labour situation in geriatric nursing: on the one hand, the proportion of unskilled employees is increasing, and on the other hand, the proportion of foreign employees is rising.

These two developments may be related if foreign vocational qualifications are not recognised and the increase in employees without vocational qualifications is due to people without recognised vocational training. This could be the case on the one hand for EU foreigners who enjoy freedom of movement, and on the other for people who have not immigrated to Germany via the skilled labour migration route.

Potentials and limits of employment policy

Immigration of labour holds potential in the care sector but also has its limits. On the one hand, Germany is in competition with other companies that recruit skilled labour from abroad. On the other hand, the societies from which the skilled workers come are also ageing. Carers are increasingly needed in the countries of origin. This can also be observed in the shifts between the regions of origin from which foreign nursing staff have been recruited to date. While Poland and other Eastern European countries were the main countries of origin for a long time, immigration is now increasingly coming from third countries such as Turkey, Serbia and Bosnia-Herzegovina, as well as the Philippines, India, Tunisia and Vietnam. The shifts also result from the fact that nursing staff may not be recruited from countries that themselves have shortages in the nursing sector (Flake et al., 2018, 36).

The geriatric care sector has long been faced with the challenge of having to recruit staff from abroad because the domestic labour supply does not meet the demand in the care sector. The fact that this can only be achieved with increasing effort is demonstrated, for example, by the above-average vacancy periods in geriatric nursing, i.e. the time between a position being advertised and filled. While the average vacancy period for geriatric nursing specialists was 125 days in 2013, the filling time has doubled to 250 days in the last 10 years (Carstensen et al., 2024b). It is true that the time span has increased at a similar rate for all skilled workers during the last 10 years. However, at 170 days in 2023, it is significantly below the level in geriatric care. Increasingly greater efforts will be required to ensure that urgently needed nursing staff can continue to be recruited abroad in the future in the face of rising nursing requirements and a shrinking domestic labour supply – whether and with what success, however, remains uncertain.

Even the above-average wage increases in geriatric care were unable to stop or reverse the trend towards ever longer vacancy periods. Between 2012 and 2023, wages for skilled workers in the care for elderly increased by 64 percent (Carstensen et al., 2024a, 3). Across all skilled occupations, the increase over the same period was 32 percent. The significantly more dynamic pay development in geriatric care is also due to the Care Wage Improvement Act, which has been in force since 2019, as well as the collective bargaining obligation in long-term care, which has been in force since 2022. However, higher wages cannot overcome the developments described above - an exhausted labour supply, especially for women, and the limits of labour migration into the care sector. Higher wages in the labour-intensive care sector have, however, resulted in an increase in costs and prices for care services. This can be seen, among other things, in the development of the standardised facility co-payments in the inpatient care sector.

In addition, about 38 percent of employees in geriatric care were aged 50 and over in 2023 (German Federal Statistical Office, 2024a). They will reach the statutory retirement age by 2040 at the latest and retire. However, the pressure to act will not only arise in the distant future. About a quarter of all employees in the care sector are already in the last decade of their working lives (Isfort, 2024, 108). In geriatric care, this increases the challenges of recruiting staff and retaining them in the long term in the face of a dwindling labour supply. It will only be possible to judge in the coming years whether the introduction of generalist training in nursing in 2020 will have a positive impact on the skilled labour situation in geriatric nursing. However, demographic trends will also increase the need for treatment in medical care. We should, therefore, caution against overly optimistic expectations. Even if the overall number of trainees increases, nursing staff will still be able to choose a career in geriatric care or medical care.

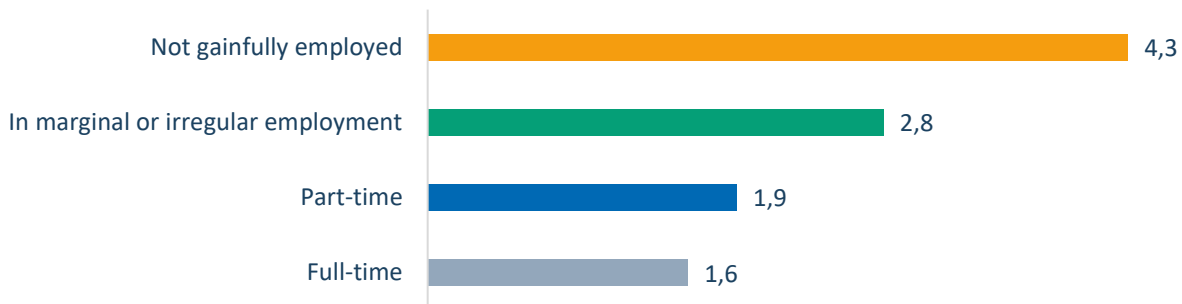
Caring for relatives – limited potential for subsidiary responsibility

Improved reconciliation of care and work is thought to offer further potential for ensuring care provision on a subsidiary basis and indirectly relieving the burden on professional care services in outpatient care. This is supported not least by the sharp rise in the number of people in need of care who have been cared for solely by relatives since the introduction of the new concept of care. The introduction of a leave of absence entitlement with continued remuneration for working family carers *inter alia* is being discussed in order to strengthen this pillar of care provision. However, the potential of caring for relatives is reaching its limits.

- A right to time off and continued payment of remuneration for family carers in gainful employment immediately raises the question of how to finance the associated costs. Financing via tax revenue would place a burden on the federal budget and provoke conflicts with budgetary prioritisation, because the treasury is also economically limited in its ability to generate revenue. Alternative financing at the expense of employers would increase the cost of continued remuneration by an estimated 77 billion euros (Pimpertz, 2024). With gross wage levels remaining high, there is a threat of rising labour and unit labour costs, which will put additional pressure on economic development prospects. Finally, a statutory obligation to take time off with entitlement to continued remuneration could, therefore, become an obstacle to employment for people of advanced working age who are more likely to be carers in their parents' generation.
- For working relatives in particular, the question arises as to the opportunity costs arising from the trade-off between splitting working hours and caring hours. An analysis of household data from 2017 shows that an average of 2.9 hours of care per day per week were provided by persons over the age of 70. In the 30 to 59 age group, on the other hand, the daily time allotment for caring for relatives is only 1.8 hours, while in the 60 to 69 age group it is barely more at 2 hours (Kochskämper et al., 2020, 77 f.). Under the assumption that caring for relatives is predominantly carried out by the working generation of children between the ages of 30 and 59, the working day (Monday to Friday) differs according to the extent of employment (Figure 5-1). Full-time employees stated that they spent an average of 1.6 hours per day on care, while the figure for part-time employees was slightly higher at 1.9 hours. The quota is significantly higher for marginally or irregularly employed persons (2.8 hours) and persons not in gainful employment (4.3 hours).

Figure 5-1: Care hours of those in employment

Average hours of care per working day (Monday to Friday) for carers aged 30 to 59, 2017



Source date: German Socio-economic Panel v35.

Source: Kochskämper/Neumeister/Stockhausen, 2020, 78

In the descriptive analysis, it remains unclear whether people who were already in marginal employment before their relative became dependent on care were more involved in caring for relatives, or whether employment that originally went beyond marginal employment was reduced. Irrespective of the unexplained causalities, the findings suggest that the willingness to care for relatives (by the children's generation or spouses and partners) is limited, among other things, by the fact that caring periods are in competition with periods of employment and the income that can be earned. This is supported by the fact that across all age groups, the daily time spent on care decreases with increasing net income - albeit within a narrow corridor from 2.8 hours in the lower quartile of the net income distribution to 1.8 hours in the third quartile and 1.3 hours in the last quarter of the distribution with the highest net income values (Kochskämper et al., 2020, 79).

- The potential of caring for relatives is also limited by demographic developments. While the proportion of childless women aged 45 and 49 rose continually over three decades to 20 percent by 2010, the childless rate has remained at a high level since then (German Federal Statistical Office, 2023a). This means that one fifth of the predominantly baby-boomer cohorts will not be able to fall back on family networks to provide care on a subsidiary basis in old age. Instead, they are dependent on professional care and compete with the other members of their cohort for care from increasingly scarce nursing staff.

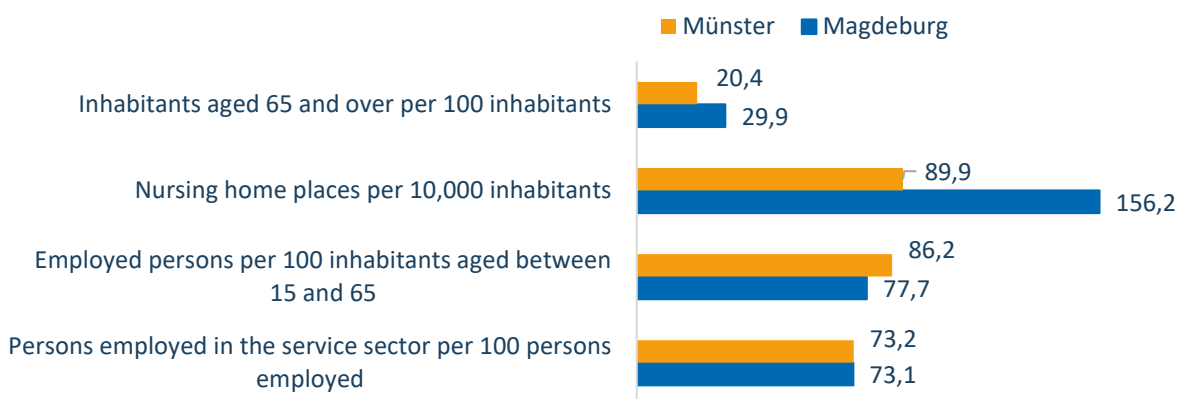
In any case, the support provided by family carers reaches its limits as soon as the need for care reaches a level that requires professional support. In light of this, proposals aimed at improving the compatibility of care and work must be relativised.

6 A future-proof care system needs innovation-friendly framework conditions

Demographic change will have a regionally differentiated impact on the development of care requirements and care options (see Figure 6-1 for the Magdeburg and Münster regions as examples). This is a direct result of the age structure, inpatient care capacities and labour force participation in the regions (BBSR, 2025): In 2022, the proportion of residents aged 65 and over in the eastern German federal states was significantly higher than in the rest of Germany. Conversely, the proportion of people in employment in the 15 to 65 age group was significantly lower in 2021. The proportion of the labour force working in the service sector (tertiary sector), on the other hand, varies greatly depending on the spatial planning region. Inpatient care capacities are distributed differently again: The number of nursing home places per 10,000 inhabitants is significantly higher in the neighbouring regions of Lower Saxony and Saxony-Anhalt, as well as in the border regions of Saxony and northern Bavaria with the Czech Republic, than in the Rhine-Main region or the Rhineland, for example.

Figure 6-1: Comparison of selected indicators

Using the example of the Münster and Magdeburg spatial planning regions



Population: Date for 2022; all other indicators: Data for 2021.

Source: BBSR, 2025

Even this simple inventory suggests that not only will the need for care develop differently in the various regions, but also the requirements and possibilities for providing this care. Care policy is, therefore, required to create framework conditions that enable local players to develop regionally differentiated solutions for care. Overcoming these challenges will not be possible by focussing on financing issues. Similarly, achieving uniform standards of care will not be possible, especially not with rigid guidelines for staff deployment.

Short-term savings potentials – review the receipt of care allowance with an open mind

Instead of looking for additional sources of income to close short-term deficits, it is important to realise relief on the expenditure side that does not jeopardise the provision of core care services. Even if so-called “Non-insurance-related” benefits can only be determined on a normative basis, benefit promises that are obviously

not care-related should be avoided. These include, for example, pension insurance contributions for family carers.

The requirements for receiving care allowance can also be fundamentally scrutinised:

- Up to now, the care allowance has been disbursed after a degree of care entitlement has been determined, without ensuring that the funds are earmarked for care-related expenses.
- Even if funds are earmarked for a specific purpose, it is not yet guaranteed that the targeted nursing care will be provided in accordance with the quality standards applied to professional nursing care.
- It is still unclear whether households receiving care allowance could finance the necessary expenses for care from their own resources.

There is direct potential for savings in the SNI if a distinction is made between benefits for those in need of long-term care and the material support needs of households with members in need of long-term care. This is suggested by a finding that was made in the context of the affordability of personal contributions to full inpatient care costs: according to this, seven out of ten pensioner households in 2023 would have been able to cover their own share of inpatient care costs for one person for up to five years from current retirement income and previously accumulated pension assets (Pimpertz/Stockhausen, 2024). Applied to the receipt of care allowance, it can be assumed that comparable financing potential would arise if the care allowance were to be paid out for a specific purpose and depending on material support needs.

“Outpatient before inpatient” – (not) a forward-looking strategy

In view of the regional differences in the development of care requirements and the labour supply, the politically intended priority of outpatient care over inpatient care must be critically questioned. The wide regional variation in the supply of fully inpatient care facilities alone suggests that a one-sided prioritisation of outpatient care cannot be the superior alternative in every region. On the one hand, staff assessment instruments are already leading to a situation where existing capacities can only be utilised with great effort at local locations with a shortage of nursing staff. This can, in particular, hinder a demand-orientated expansion of capacities in inpatient care. On the other hand, outpatient care is of great importance in regions where there are not yet a sufficient number of inpatient care places.

Reducing bureaucracy via deregulation

The strict separation between outpatient, day-care and inpatient forms of care, each with different regulations, personnel policy requirements and billing options, provokes bureaucratic administrative burdens and false incentives. After all, providers of outpatient and inpatient care services increasingly need to devote human resources to the complex administration and billing of the services rendered, instead of focussing staff deployment on nursing care. The widespread demand for a reduction in bureaucracy in care has its origins not only in the handling of documentation obligations, but rather in the complexity of the regulations that trigger it. Therefore, the first step must entail enabling the rendering of services across sector boundaries (i.e. outpatient, partial and full inpatient care) by considerably simplifying the implementation of comprehensive care contracts without additional staffing requirements.

The rules and processes need to be drastically simplified for care to succeed even under changed conditions. The fact that bureaucracy and administration are becoming increasingly important in the care sector is shown by the increase in the SNI's administrative expenditure alone. In 2023, they accounted for 1.7 percent of SNI expenditure, compared to 0.8 percent ten years earlier (BMG 2024). However, this does not include the mirror-image expenses incurred by the care services and facilities. However, it can be assumed that this development has occurred to at least the same extent among care service providers and that scarce personnel resources are therefore increasingly being channelled into non-care-related activities. To end this misallocation, all bureaucracy-inducing regulations must be critically scrutinised and, in case of doubt, reduced to a minimum - starting with the requirements for nursing care and the associated documentation obligations, through the avoidance of (double) audits, to requirements for staff deployment. Last but not least, the regulations result in increasing complexity in contract law and in the procedures for determining remuneration, which ties up additional resources (see also ASMK, 2024). The need for leaner processes and simplified rules also arises from the fact that the needs and requirements for care will develop differently in the individual regions. To develop customised care concepts, we need diversity rather than uniformity. The statutory provisions must fulfil this requirement.

Future-proof care requires innovation-friendly framework conditions

In the future, it will be increasingly important to utilise the potential of personnel policy to reduce the workload to ensure nursing care with an increasingly scarce workforce. In addition to the urgently needed deregulation and de-bureaucratisation, digitally supported concepts, the use of AI and care robotics, promise potential solutions - both in outpatient and inpatient applications. However, there seems to be less of a lack of innovative ideas than a lack of disseminating such ideas. But then it cannot be the task of care policy to identify individual technical solutions to enshrine their financing in law. Rather, it is important to identify which regulations have so far hindered their application and use.

Legal provisions and ordinances have a particularly inhibiting effect on innovation when specific requirements that are well-founded from a nursing science perspective come into conflict with economic realities. This conflict can be vividly described using the example of the framework conditions in full inpatient care:

- Digitally supported innovations require investment. In view of the complex negotiations on billable investment costs in full inpatient care, widespread use is reaching its first limits.
- Long amortisation periods can act as a brake on innovation, extending beyond the economic amortisation period. This applies to the financing of digital applications in the care sector, because the technology and therefore the market are developing very dynamically.
- Investing in digital applications aims to relieve staff of non-care-related activities. From a business perspective, such investments are viable if they can overcome staff shortages and reduce operating costs while maintaining the same quality of care. What appears to make sense in view of changing labour market conditions can, however, be hampered by the fact that neither the potential for reducing the workload in the application of personnel assessment instruments nor other equally necessary qualifications are considered. It is, therefore, necessary to consider both the potential reductions in care-related staffing ratios and the personnel requirements in IT and organisational development.
- After all, the principle of "Outpatient before inpatient" contradicts fundamental principles of economic efficiency. This is because scaling potential, which makes it easier to refinance necessary investments, is

easier to realise in fully inpatient care than in outpatient care. After all, the more frequently a resource-saving technology can be used, the more likely it is that investments will pay off economically. However, this will not be possible in the same way everywhere because the need for nursing care and the supply of nursing staff will develop differently from region to region and, at the same time, the regions have different capacities in full inpatient care. The development of care and economically viable solutions therefore requires flexibility and room for manoeuvre instead of standardised specifications. Prioritising one form of care in terms of care policy does not meet these requirements.

Conclusion

With an increasingly scarce labour supply, it will only be possible to meet the growing demand for nursing care in the future if innovative concepts in nursing care relieve the pressure on staff deployment. The dynamic development of digital support options in the care sector harbours great potential for meeting both increasing care requirements and regional differences in labour shortages.

To realise this potential, obstacles to the development and application of innovative solutions must be removed. Instead of defining care standards as uniformly as possible and closely monitoring nursing care for compliance with these standards, more freedom of design is needed in nursing care. A bureaucracy reduction campaign is urgently needed and requires, as a first step, that the regulations that trigger it are critically scrutinised and kept to a minimum. Pre-determined care policies for individual forms of care further restrict the room for manoeuvre. Instead, the next step is to make the rules innovation-friendly, also with a view to business requirements.

If entrepreneurial action is required instead of administration to make care possible under changed conditions, then this idea has so far been met with widespread scepticism. However, innovative, regionally customised solutions will only be used if the necessary investments pay off in the long term. This applies to all providers, regardless of whether the services are provided by private, non-profit or municipal organisations.

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