Implications from Japan-Germany comparisons on social security

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Abstract

Japan followed the German model for its social insurance, but the result is quite different between the two countries in terms of income equality. We did a Japan-Germany macro comparison on social security, and found these features of the Japanese system: the pension system does not prevent the elderly from poverty; usage of medical resources by the elderly, especially at super-old age groups, is intensive; the prevalence rate of the LTC services among the elderly is lower; expenditures on Family and Incapacity-related benefits are low; and correction of inequality through income redistribution is weak. In order to remedy the weaken safety net in Japan, resources should be increased in social security. However, it is not enough to increase social expenditure (public + private) / GDP in order to solve problems existing in the society. Benefits as well as funding structure should be corrected properly.

Key words: income security, health expenditure, social expenditure, social protection, safety net

Introduction

According to the German Institute for Economic Research (DIW), the percentage of people who face poverty while receiving retirement money could increase from 16.8% in 2019 to 21.6% by 2039 in Germany (Schiller, 2019). Individuals at risk of falling into poverty are defined as those receiving less than 60% of the average income, and according to the study, this equated to an income of less than €905 per month. In view of a significant increase in poverty among the elderly in the next 20 years, Germany intends to combat elderly poverty.

The purpose of guaranteed minimum resources in Germany is to enable persons entitled to benefits to live with dignity and to participate in society, namely any person normally residing in Germany and who cannot support themselves by their own means (income and assets), nor by their own efforts (joining the workforce), nor with the help of a third party, is - with a few exceptions - entitled to income support (European Commission). This comes in the form of either basic insurance for jobseekers pursuant to the Second Social Code, or assistance with living costs or benefits of the basic insurance for old age and in case of partial disability according to the Twelfth Social Code (European Commission).

In January 2021, Germany introduced an income-related pension supplement (Grundrente) to those who have made compulsory contributions to the statutory pension insurance for at least 33 years on the basis of relatively low earnings throughout the whole working life (OECD, 2021). In October 2022, 5.3 million people in 2.8 million dependent households in Germany received benefits according to Book II of the German Social Security Code (SGB II): some three-quarters of those eligible for standard benefits were able to work (3.8 million), 1.7 million of whom were unemployed. 1.5 million were persons entitled to benefits who are not currently capable of working; persons entitled to benefits who are not currently capable of working are largely children under 15 years of age (BA, 2022).

After a long debate, the Bundestag and Bundesrat passed the Citizen's Income in November 2022. On 1st January 2023, the Citizen’s Income has replaced Basic Income Support. The Citizen’s Income (Note 1) is to be introduced in two steps (BA, 2022). In the first step, the standard rate will be increased at the beginning of the year and a minimum claims limit will be introduced. In the second step, the key elements surrounding further training

and qualification are set to be introduced mid-year. In addition, beginning in January, families will be receiving increased child benefits (Note 2).

A System of Health Accounts 2011 defines total long-term care expenditure as the sum of long-term care (health) and long-term care (social) (OECD, 2017): LTC (health) includes medical or nursing care (e.g. wound dressing, administering medication, health counselling, palliative care, and medical diagnosis with relation to a LTC condition), and personal care services which provide help with activities of daily living (ADL), such as support with food intake, bathing, washing, dressing, getting out of bed, and managing incontinence; LTC (social) consists of assistance services that enable a person to live independently, relating to help with instrumental activities of daily living (IADL) such as shopping, cooking and performing housework as well as subsidies to residential services in assisted living facilities.

The sustainability of the social security system with the aging of the population is a big concern in many developed countries. Japan and Germany are both suffering with population decline, although the Japanese situation is much more serious compared to Germany. The aim of this paper is to draw some implications from a Japan-Germany comparison on social security.

This paper is structured as follows. The income security of the elderly in Japan and Germany was reviewed in Section 1, using OECD Income Distribution Database. The medical and LTC expenditures in Japan and Germany were compared in Section 2, using OECD Health Statistics and national sources. After briefly reviewed social protection in Japan and Germany in Section 3, we discussed implications from a Japan-Germany comparison on social security in Section 4.

1 Income security of the elderly in Japan and Germany

Elderly people relay on pensions after retirement: public pension and private pension. Public pension is run by the government through a "pay-as-you-go system" in Japan and Germany, but public pension is supplemented by a funded system in Germany. Enrollment in the public pension plan is mandatory for everyone working in both countries. Private pension consists of corporate pension and individual pension. Corporate pension plan is a plan workers can monetarily contribute to via the employer. Individual pension plan is established through insurance organizations and banks, and the government promotes these plans through tax incentives. Despite these pension plans, those who participated in low-earning jobs are at risk of facing poverty after retirement.

Table 1 compares income security of the elderly aged 65 or over relative to the working age population (18-64) in Japan and Germany. Mean disposable income of the Japanese elderly was 77% of that of the working age population, which is lower than the German counterpart of 84%. Among income sources, earnings are quite important for the Japanese elderly, whereas public pension benefits are commanding for the German elderly. Income inequality is larger among the elderly compared to the working population in Japan, although the situation is quite the opposite in Germany.

There was a program called Basic Income Support (Grundsicherung) in Germany. Beneficiaries to this program must be unable to provide for his or her own subsistence, and have reached the normal retirement age or be assessed with a permanent total loss of earning capacity. This program is means tested, namely the spouse's or

cohabiting partner's income and assets are taken into consideration. Basic Income Support is not provided if a parent or child has an annual income above €100,000. As mentioned above, this program was replaced by the Citizen's Income in 2023.

Table 1 Income security of the elderly in Japan and Germany

		Japan (2018)			Germany (2019)		
		18-64	65+		18-64	65+	
Mean disposable income (1,000Yen, €)	a	3,171	2,431		30,638	25,615	
Proportion to mean disposable income (%)							
Earnings		109.1	42.8		116.1	15.4	
Capital income		3.0	8.2		5.8	11.0	
Income from self-employment		6.1	5.8		12.3	6.4	
Social security benefits		11.0	60.3		11.8	81.8	
Employment-related benefits		0.5	2.5		0.3	5.5	
Taxes & social security contributions		28.7	19.3		36.5	18.1	
Employment-related contributions		0.6	0.2		9.2	1.1	
Gini coefficient		0.324	0.339		0.299	0.270	
Poverty rate (50% of median) %		13.0	20.0		17.5	11.0	
Pension expenditure / GDP (%), 2017	b	Total	Public	Private	Total	Public	Private
		11.9	9.4	2.5	11.0	10.2	0.8
Benefit replacement rate (public+private)		0.5	1	1.5	0.5	1	1.5
according to wage level (%)		43.2	32.4	26.9	46.5	41.5	33.0
Benefit for low income elderly		Public Assistance with means test			Basic Income Support		

a: OECD Income Distribution Database. (accessed in November 2022)
b: OECD Pensions at a Glance 2021.

2 Health expenditure of the elderly in Japan and Germany

2.1 Health expenditure

Based on OECD Health Statistics, Table 2 shows health expenditure, roughly speaking medical expenditure plus LTC expenditure, by function as well as by resources in Japan and Germany.

Table 2 Health Expenditure in Japan and Germany

	Japan (2019)		Germany (2020)	
	100 billion Yen	% of GDP	billion €	% of GDP
Health Expenditure by function				
Total	612.0	11.0	431.8	12.8
Inpatient	167.0	3.0	115.1	3.4
Outpatient	143.8	2.6	90.1	2.7
LTC (Health)	113.0	2.0	84.7	2.5
Medical goods	140.9	2.6	100.2	2.9
Others	47.3	0.8	41.7	1.3
Health Expenditure by resources				
Total	612.0	11.0	431.8	12.8
Transfer from government	253.9	4.5	67.9	2.0
Social insurance contributions	260.0	4.7	270.8	8.0
Compulsort prepayment			28.7	0.9
Voluntary prepayment	13.7	0.2	5.6	0.2
Others	84.4	1.6	58.8	1.7

Source: OECD Health Statistics 2022. (accessed in December 2022)

Germany spends 12.8% of GDP on health compared to 11.0% of GDP in Japan, but its distribution by function is rather similar in both countries. The source of funds, however, is quite different in the two countries with a high share of social insurance contributions in Germany and a high share of government subsidy in Japan.

Using the national sources, medical expenditure was 8.0% of GDP and LTC expenditure was 2.0% of GDP in 2020 in Japan, and health expenditure (including LTC expenditure) in Germany in 2020 was the same as shown in Table 2.

2.2 Age profile of medical expenditure

Universal healthcare coverage through a public health insurance scheme with fee-for-service payment is the basic definition of the Japanese system so far, which has contributed to the equitable distribution of health services and relieved families from unpredictable medical expenditure.

The combination of Social Health Insurance (SHI) and substitutive Private Health Insurance (PHI) is the feature of the German system. SHI covers 88% of the population and finances roughly 58% of the total health expenditure (TFHC, 2019). Employees who earn less than a threshold amount are automatically insured by SHI, and those who earn above this threshold as well as self-employed individuals and civil servants can choose to make use of substitutive PHI or stay under SHI coverage. PHI provides coverage to approximately 10% of the German population, and the remaining 2% are covered under other special schemes (TFHC, 2019). SHI contributions are wage-related and roughly the same across the different sickness funds. The revenue generated through SHI is pooled, and together with tax subsidies from the central health fund are re-allocated to sickness funds based on risk equalization schemes (TFHC, 2019).

Table 3 shows a rough comparison of public medical insurance in Japan and Germany. There is a sharp contrast between the two countries in terms of treatment of the elderly. There is a special program in Japan for those who are 75 years old or over, which reduces patients' cost-sharing considerably. On the other hand, private risk-based health insurance and solidarity-based public insurance co-exist in Germany, although the latter is dominant.

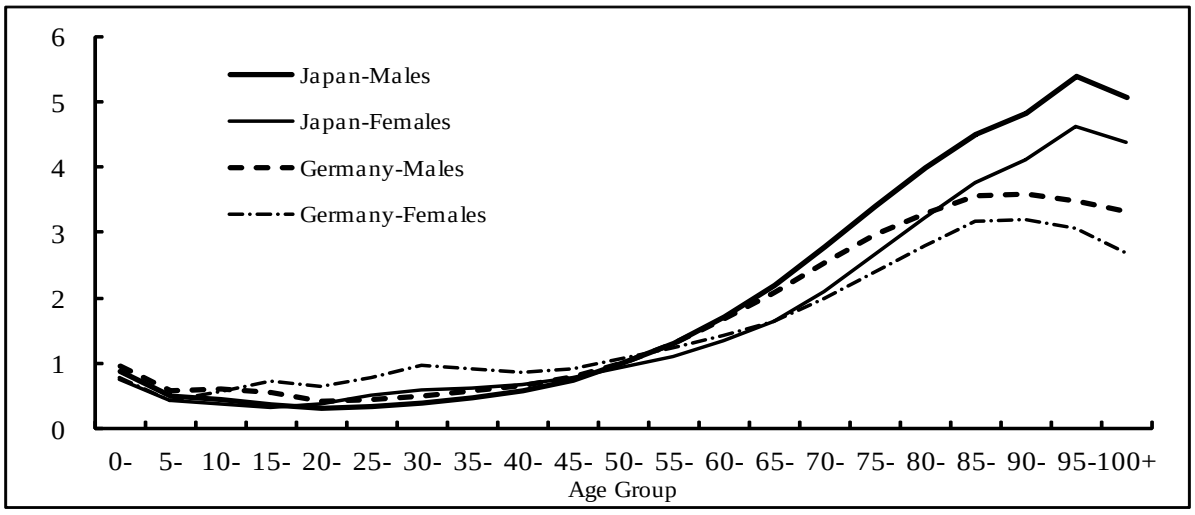
Both inpatient and outpatient services are provided in Japanese hospitals, which causes a severe competition in outpatient services between hospitals and physicians. In order to correct excessive competition and to use healthcare resources effectively, it has been considered that hospitals be classified by function and patient flow streamlined in Japan (Fukawa, 2007). Starting from a clear division between inpatient and outpatient services, more coordination is sought between primary and secondary care in Germany. The Japanese reimbursement system is basically fee-for-service with partial price bundling mainly for chronic diseases of the elderly, and the same nationwide fee schedule is applied to physicians and hospitals (Fukawa, 2007). In Germany, different reimbursement systems are applied to physicians and hospitals. Sickness funds pay for ambulatory (out-patient) care through a global budget that is paid to regional associations of SHI physicians, while individual physicians are paid via fee-for-service within practice-based budgets and unbudgeted for certain services, and inpatient services are reimbursed through diagnosisrelated group (DRG)-based payments (TFHC, 2019).

Table 3 Public medical insurance in Japan and Germany

	Japan	Germany
Coverage of population	About 98 %	About 90 %
Choice of insurers	No	Yes since 1996
Risk structure adjustment	(Note 1)	Yes according to age, gender, income, etc.
Benefit	(Note 2)	
Prevention	None	Health screening of cancer and geriatric diseases
Outpatient	70 % of the cost	100 % of the cost with some patient's cost-sharing for pharmaceuticals, etc.
Inpatient	70 % of the cost with additional cost-sharing for meals	100 % of the cost with patient's cost-sharing of €10 per day up to 28 days a year
Others	Benefit for childbirth, injury and sickness allowance	Benefit for childbirth, Kur treatment, transportation, etc.
Upper ceiling of patient's cost-sharing	Per month per household	2 % of a household's annual gross income
Contribution rate (%)	10.0 % for Association-managed HI	14.6 % + additional contribution
Access to hospitals	Free with some limitations	Through family doctor
Expenditure (% of GDP)	8.0 % in 2020	9.7 % in 2020

Note 1: Medical Insurance for the Advanced Elderly can be viewed as a kind of risk structure adjustment through age.
Note 2: Favourable treatment for children and the elderly
Source: IHEP (2021) and European Union (2021) for Germany.

Figure 1 shows per capita medical expenditure by age group and gender in Japan and Germany in 2020, putting males aged 50-54 in each country as 1.0. Per capita medical expenditure is highest for the 85-89 age group for both genders in Germany. However, it is highest for the 95-99 age group for both genders in Japan, which means that the elderly use much more medical services in Japan compared to Germany.



Source: MHLW (2022a) for Japan and Bundesamt fur Sociale Sicherung (2022) for Germany.
Fig. 1 Age and gender profile of medical expenditure in Japan and Germany (Males age group 50-54=1.0): 2020

2.3 Long-term care expenditure

Japan followed the German model in introducing public LTC insurance, but there are many important differences between the two systems:

-The main beneficiaries of the Japanese LTC Insurance are the elderly aged 65 or over (Category 1);

-Persons aged 40 to 64 years old and subscribers of health insurance (Category 2) should pay income-related contributions, but they are entitled to benefits if and only if their care needs are related to cognitive impairments;

-Cash options are not available in the Japanese system;

-Benefits are financed through a combination of contributions from the insured, government subsidies, and user charges in Japan; and

-Regional differences in benefits as well as contribution levels are allowed to leave the management of the system to each municipality's discretion in the Japanese system.

Table 4 shows a rough comparison of public long-term care (LTC) insurance in Japan and Germany. The whole LTC expenditure is related to public LTC insurance in Japan, but German public LTC insurance does not relate to the total LTC expenditure. Service users in Japan must pay 10 to 30 % of expenses depending on their income level, although there is an upper ceiling for this user charge. Premiums for elderly persons (Category 1) vary by income status of the insured and by municipality, and premiums for Category 2 insured persons (age range 40-64) are collected together with medical insurance premiums and pooled at the national level. Expenditures extracting user charges are covered evenly by government subsidies and contributions in Japan.

Table 4 Public LTC Insurance in Japan and Germany

	Japan (since 2000)	Germany (since 1996)
Insurer	Municipality	Pflegekasse
Insured	Category 1: those aged 65 years old or over Category 2: those aged 40-64 who are covered by health insurance	All persons who are covered by health insurance
Contribution (rate)	Category 1: 6,014Yen per person per month (national average) Category 2: 1.64% of annual salary	3.05% of annual salary, additionally 0.35% for those who have no children since 2005
Financial resources	Besides beneficiary's cost-sharing of 10 (20, 30) % of the cost, the rest is covered evenly by public fund and contribution	Contribution: 100%
Beneficiaries	All Category 1 persons plus small portion of Category 2, upon approval of care needs assess.	All persons who have been approved through care needs assessment (insured and their family)
Care needs assessment	Care Approval Board in Municipality	MDK (Medizinische Dienst der Krankenversicherung)
Care management	Introduced since 2000	Introduced since July 2008
Benefits	Domiciliary service, community-based service, and facility service all in the form of benefits- in-kind	Cash benefits or benefits-in-kind or mixture
Expenditure	10.72 trillion Yen in 2020 (2.0% of GDP): 67% for domiciliary services and 33% for facility services	€45.6 billion in 2020 (1.3% of GDP): 64% for domiciliary services and 36% for facility services

Source: IHEP (2021), MHLW (2022).

Table 5 compares resources of LTC expenditure in Japan and Germany. Total LTC expenditure was 2.0% of GDP in 2020, most of which was covered by the public LTC insurance in Japan. The share of contributions

among total revenue was 45%, and public funding covers 53% of it. There exist beneficiaries cost-sharing in Japan, but its share among total revenue is negligible.

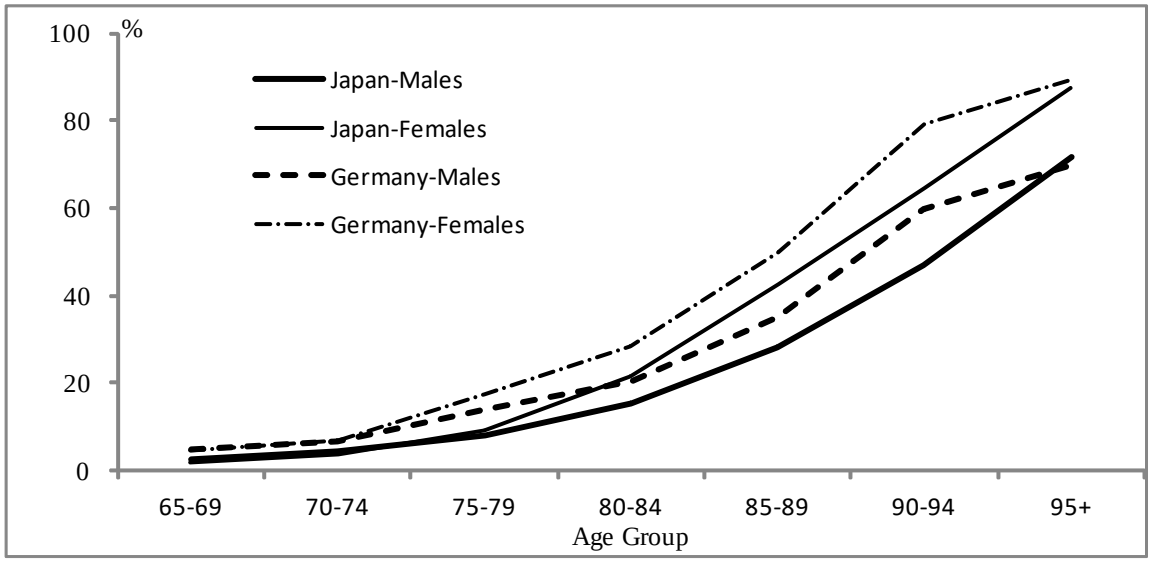
Total LTC expenditure was 1.8% of GDP in 2019 (Note 3), and the public LTC insurance covers two thirds of it in Germany. German public LTC insurance is basically financed by the contributions. About one fourth of the total LTC expenditure was covered by outside public schemes in Germany.

Table 5 Resources of LTC Expenditure in Japan and Germany

Japan (2020): Public LTC Insurance				Germany (2019)			
	100 billion Yen	% of GDP	Prop. (%)		billion €	% of GDP	Prop. (%)
LTC Expenditure	107.78	2.01		Total	61.00	1.76	100.0
Revenue total	115.58	2.15	100.0	Public scheme	46.92	1.35	76.9
Contributions by 65+	23.56	0.44	20.4	Public LTC Insurance	40.69	1.17	66.7
Contributions by 40-64	28.73	0.53	24.9	Private LTC Insurance	1.57	0.05	2.6
Beneficiarie's cost-sharing	0.05	0.00	0.0	Public assistance	4.57	0.13	7.5
Transfer from national govern.	26.50	0.49	22.9	Kriegsopferfursorge	0.09	0.00	0.1
Transfer from regional govern.	15.91	0.30	13.8	Private arrangement	14.08	0.41	23.1
Transfer from city government	18.34	0.34	15.9	Institutional care	5.04	0.15	8.3
Others	2.49	0.05	2.2	Home care	9.03	0.26	14.8

Source: MHLW (2022b) for Japan and BARMER (2021) for Germany.

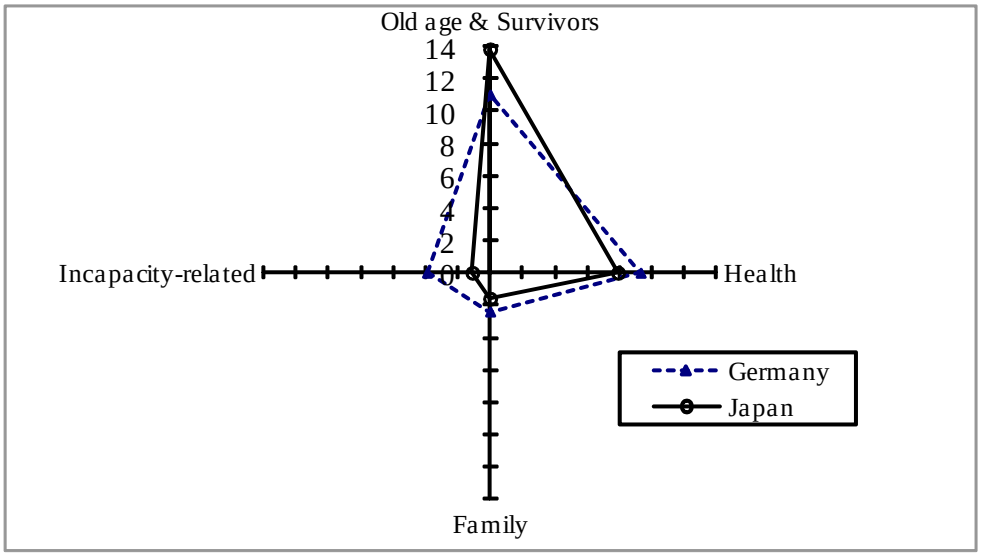
Figure 2 compares the prevalence rates of LTC services among the elderly by age group and gender in Japan and Germany. The prevalence rate increases with age, and females are higher than males for most age groups in both countries. It is clearly shown in this figure that the prevalence rate in Germany is higher than that in Japan.



Source: MHLW (2022) for Japan, and Statistisches Bundesamt (2022) for Germany.
Figure 2 Prevalence rate of LTC services among the elderly by age group and gender in Japan (2021) and Germany (2019)

3 Social protection in Japan and Germany

According to the OECD Social Expenditure Database, Japanese social expenditure (Public + Private) was 25.2% of GDP in 2017, which was lower than that of the 29.0% in Germany. Fig. 3 shows some components of the social expenditure in Japan and Germany: Old age and Survivors (including pension and LTC), Health (not including LTC in this case), Family, and Incapacity-related. Compared to Germany, Japanese social expenditure (Public + Private) is higher in Old age and Survivors due to the advanced aging of the population, but lower in Health, Family, and Incapacity-related. Japan has been suffered low fertility rates for many years, but actual expenditure on families is still quite low from an international standard.



Source : OECD Social Expenditure Database. (accessed in December 2022)
Fig.3 Social expenditure (Public + Private) as percent of GDP: 2017

Figure 4 plots social expenditure (Public + Private) as percentages of GDP on the X-axis and Gini coefficient of equivalized disposable income of the total population on the Y-axis for Japan and Germany from 1985 to 2017 (5-year interval, except 2017). Social expenditure / GDP has increased rapidly during the period in Japan. Although Gini coefficient has gradually increased in both countries, income distribution in the two countries seems quite different. Figure 4 implies that Japan was a country of unequal distribution since the mid-1980s, and there still exists a huge difference in terms of income distribution between the two countries.

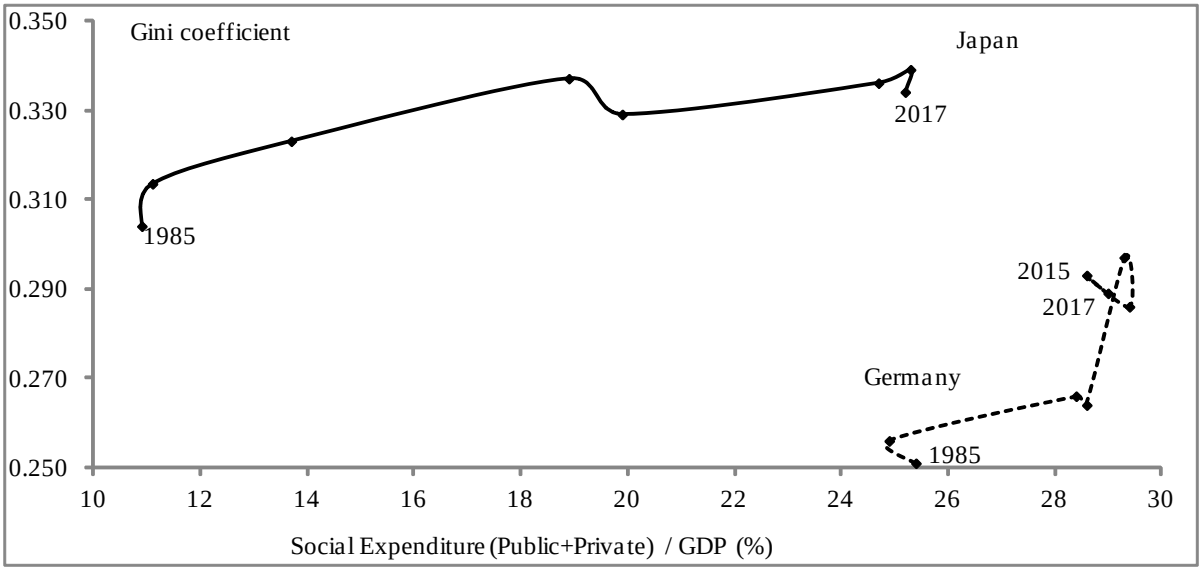
4 Discussions

The followings are some features of the Japanese system obtained from a Japan-Germany macro comparison on social security:

-The pension system does not prevent the elderly from poverty;

-Usage of medical resources by the elderly, especially for super-old age groups, is intensive;

-The prevalence rate of the LTC services among the elderly is lower;



Source: OECD Social Expenditure Database and Income Distribution Database. (access on 18 Nov. 2022)
Fig. 4 Social expenditure/GDP (X axis) and Gini coefficient (Y axis) in Japan and Germany: 1985-2017

-Expenditures on Family and Incapacity-related benefits are low; and

-Correction of inequality through income redistribution is weak.

The public pension provides the pensioner with much higher levels of benefits in Germany compared to that in Japan, but it is not enough for citizens who spent their lives working in low-paying positions in Germany. Therefore, Germany has initiated a path towards combating elderly poverty. The debate on reforming the German means-tested Basic Income Support (Hartz IV) resembles the discussions in other European countries such as Finland, the Netherlands and the United Kingdom, but the reform debate in Germany focusses strongly on aspects of social justice (Bruckmeier and Konle-Seidl, 2019). Although the introduction of a system of means-tested and flat-rate unemployment benefits (Hartz IV) for the majority of the unemployed interfered with the widely accepted principles of social justice embodied in an insurance-based system with earnings-related benefits, a complete abandonment of existing forms of social security would be associated with high fiscal costs and raise new distributional issues (Bruckmeier and Konle-Seidl, 2019).

A universal basic income (UBI) is a fixed payment, paid equally by the government to every citizen of a country, regardless of their financial situation. People in favor of a universal basic income argue that all citizens deserve a decent standard of living and propose that a UBI could radically reduce poverty. Great Britain, Germany, Spain and Italy are all more in favor of a basic income than against it, with Sweden split, and France and Denmark more opposed (Kirk, 2022). For those who support the introduction of a UBI, the question then becomes what level the payment should be set at. Finland's universal basic income experiment, conducted in 2017-18, set the level at €560 a month, but the main debate centers on whether a person should be able to survive wholly on a universal basic income, or whether it should be supplemented by other forms of income (Kirk, 2022; Note 4). A major argument against the introduction of a universal basic income is the cost of the scheme. Despite high levels of support for the policy itself in some of the countries, all nations polled (except Germany) felt that their governments could not afford to give citizens a basic income (Kirk, 2022).

Despite various experiments to simplify basic income systems, a paradigm shift towards unconditional basic income is observable nowhere. As a result, European welfare states have so far focused on reforms within existing

benefit systems and have tried to develop them further in order to address existing weaknesses (Bruckmeier and Konle-Seidl, 2019). Developing regional and time-limited experiments might be a way of testing alternative activation approaches as well in Germany.

Japan's healthcare delivery system raised many questions during the COVID-19 pandemic. Although Japanese universality concerning healthcare delivery and pricing of the services provided may have some significant effects in terms of preventing the occurrence of moral hazard on both service provider sides and service user sides, mal-coordination among hospitals and between administration and service provider sides caused many unnecessary sacrifices to COVID-19 patients. As implied from Fig.1, it is safe to say that there is some room to reduce medical expenditure for the Japanese elderly. German medical expenditure is higher than that of Japan due to higher physician density and higher pharmaceuticals. Both countries are seeking the right incentive structure for all parties concerned because this is crucial for the sustainable development of healthcare systems (Fukawa, 2007). Prevention and the empowerment of patients are gaining importance in Japan as key factors to advance higher quality and greater efficiency in healthcare systems (Fukawa, 2009). Oldest old patients receive less costly treatment for the same illness than younger patients, suggesting that health care is informally rationed according to the age of the patient, and the age related rationing may be more pronounced in Germany than in the United States (Brockmann, 2000). As medical resources are limited, age profile of medical expenditure suggests that there exist a severe question about equitable distribution of medical resources among age groups even if there is reason to believe that lives at advanced ages could be saved if maximum medical treatment applied to everybody irrespective of age.

The Netherlands and Scandinavian countries (Denmark, Norway and Sweden) are by far the highest spenders on LTC, with around 3.5% of GDP or more dedicated to caring for people with LTC needs, and a second group of high-income countries, including Switzerland, France, Belgium, Finland, the United Kingdom, Germany and Japan, allocate between 2-2.5% of their national wealth to LTC (OECD, 2017). Public support for institutional care usually completely reduces poverty risks associated with needing LTC, while in more than 20 countries, regions and municipalities, public support for home care for moderate and severe needs does not bring relative income poverty levels back to pre-LTC levels, suggesting more could be done to align public support with ageing-in-place policies (Hashiguchi and Llena-Nozal, 2020). Public support should be targeted at those groups of older people that are most likely to be at risk of poverty from developing LTC needs, and the level of protection should be proportional to that risk (Hashiguchi and Llena-Nozal, 2020). It is not feasible to shift the costs of care to individuals and their relatives as well as to other programs that provide income and housing assistance to the needy elderly in order to increase the sustainability of the LTC Insurance. By investing in prevention and in community resources, Japan is creating supportive communities that seek to maintain wellness and reduce social isolation in order to prevent or delay the need for state-funded services (Curry et al., 2018).

The Japanese Government has been trying to change the social security system to be sensitive to the needs of people of all generations. So far, the Japanese system seems to be working by increasing insurance premiums and user co-payments. However, the Japanese safety net is already quite weak and more fundamental reforms are necessary under significant pressure as a result of its ageing population and shrinking workforce. In view of the severe population decline, it is an urgent agenda to increase support for child bearing & rearing in Japan. However,

the room to do so is limited because Japan is suffering a huge financial debt and there is another area to strengthen urgently, national defense.

Japan followed the German model in terms of pension insurance, health insurance, and LTC insurance, but Fig. 4 suggests that Japan is a quite different country from Germany. In order to remedy the weaken safety net in Japan, resources should be increased in social security. However, it is not enough to increase social expenditure (public + private) / GDP in order to solve problems existing in the society. Benefits as well as funding structure should be corrected properly. One example of this is what national subsidy should be. Solidarity contribution (namely national subsidy) is required to finance solidarity benefits in social security, and the prerequisite for this is that the social security system is consistent and fair, and the purpose of the system is supported by the general public (Fukawa, 2009).

Japan followed the German model for its social insurance, but the result is quite different between the two countries in terms of income equality. In view of a significant increase in poverty among the elderly in the next 20 years, Germany intends to combat elderly poverty. Japan is still quite inactive in reforming its social security, although the Japanese safety net is already quite weak and the pressure of its ageing and shrinking population is quite obvious.

(Note 1) The Citizen's Income replaces the previous Basic Income Support for job-seekers and the elderly in January 2023. In Germany, the system was known as Hartz IV. In addition to increased payments of more than €50 per month, the main focus is on placement in permanent work instead of simple temporary jobs. At the heart of the Citizen's Income Act is providing people with better opportunities for support and qualification-based training (BA, 2022). Basic Income Support and/or the Citizen's Income from 2023, is paid out by the job centers. The job centers also provide support in the search for jobs and apprenticeships, and help people to enter and re-enter employment with new qualifications and further training (BA, 2022).
(Note 2) Child benefits, which have been staggered up to now, will rise to a uniform €250 per month and child as of 1 January. This means €31 more per month for the first and second child up to the age of 18 and €25 more for the third child. Families with three children will thus receive almost €90 more per month.
(Note 3) The scope of LTC expenditure in Germany shown in Table 3 seems smaller than that shown in Table 2.
(Note 4) Six in 10 Germans who support a basic income say a UBI should be set at a level that is at least enough to pay for a person's basic living costs (62%).

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