

more effectively organized. No program, whatever its scope, whether public or private, is appropriate or desirable if it does not include financial and other measures to encourage the improvement and, where required, the restructuring of health care, including accessibility, quantity, and quality of health manpower and facilities.

Long-term institutional care

The problem of need among the elderly for long-term institutional care has been examined by the Council from the standpoint of whether it would be desirable to expand Medicare to meet a major part of this need. The Council has concluded that Medicare is not an appropriate mechanism for dealing with the many facets of the larger socio-economic problem of long-term institutional care for the aged. Long-term care encompasses a broad spectrum of institutional services, ranging from intensive medical care rendered by professional and other skilled people at one extreme (a type of care now covered by Medicare for a limited period) to, at the other extreme, essentially residential or personal care services furnished by unskilled people. If coverage of institutional services under Medicare were substantially expanded it would be difficult to draw a reasonable line,

for coverage purposes, within the various gradations of institutional care. Moreover, insurance payment for any institutional care of indefinitely long duration carries with it the danger that aged persons would be encouraged to make excessive use of such care.

The Council believes that attempts to cope with the problem of financing long-term institutional care on a piecemeal basis are bound to be ineffectual. A "Task Force on Medicaid and Related Programs," in its report to the Secretary of Health, Education, and Welfare in June 1970, emphasized this same point when it rejected the idea of dealing with the problem of long-term institutional care through either Medicare or Medicaid and recommended that a major effort be made by the Department to develop a comprehensive policy addressed directly to the need for providing and financing long-term care services (including personal-support services, residential services, and, when needed, medical, dental, and psychiatric services). The Task Force also recommended that the method of financing such care should be developed in relation to the financing of the existing medical care and income-maintenance programs and should take into account the fact that the need for a comprehensive approach to the problem of long-term care is applicable to persons of all ages. The Council concurs with these recommendations of the Task Force and has confined its recommendations under Medicare to a proposal for a modest increase in the number of days available for the same level of care as is now covered.

Social Security Abroad

Health Insurance Legislation in West Germany*

Recent changes in the public health insurance system of the Federal Republic of Germany include measures to broaden membership beyond the 87 percent of the population now enrolled. For the third time in less than 2 years the Government has raised the earnings ceiling in order to make coverage possible for more white-collar workers who had previously been excluded because their earnings exceeded the income maximum. On January 1, 1971, the income ceiling for compulsory coverage under health insurance for white-collar workers was raised from DM 1200 to DM 1425 a month. (On May 1, 1971, one Deutsche Mark equaled 27 U.S. cents.)

As far as coverage is concerned, this change

affects only white-collar workers since all blue-collar workers are already compulsorily covered regardless of income. The same ceiling is used for assessing contribution payments for all health insurance members, however, so the blue-collar worker is also affected by the change since he now has a larger amount of his earnings deducted. The payroll tax rate can vary several percentage points according to the particular sickness insurance society to which the worker belongs. At present it averages about 8.6 percent of earnings below the ceiling. Half of this amount is paid by the employer.

In addition, the new ceiling has been put on a "dynamic" basis by being made subject to automatic adjustment. It is now to be tied to the corresponding ceiling of the old-age and disability pension system at 75 percent of that ceiling. As a result both ceilings will be adjusted automatically each year by a formula that takes into account changes in national wage levels. It is this feature—automatic adjustment—that the Germans have in mind when they refer to a "dynamic pension system." The old-age and disability pension ceiling is like the health insurance ceiling in that it determines the level of benefits

* Prepared by Joseph G. Simanis, International Staff, Office of Research and Statistics.

and amount of earnings subject to payroll tax contributions. It differs, however, in that it does not act as a disqualifying limit for those with earnings exceeding it.

Perhaps as many as 1 in 8 workers have been excluded by the health insurance ceiling, since those white-collar workers whose earnings exceeded it were, with exceptions, generally ineligible for membership in the public system. The most notable exceptions have been those employees who, once having established membership at lower salary levels, were allowed to retain their membership on a voluntary basis.

The new regulations, however, have opened up membership to all white-collar workers—even those who have never before been eligible—if they expressed their desire for membership during the 3-month period ended March 31, 1971. Those currently entering the work force at a salary above the ceiling will have 3 months in which to decide whether or not to join the public system.

Another feature of the new regulations expands the obligation of the employer to pay half his workers' contributions to the health insurance system. Until recently he was required to do so only for those employees who were compulsorily insured. White-collar workers earning above the ceiling benefited from employer contributions toward their health insurance coverage only in those few cases where their employer contributed voluntarily. From now on, the employer will make a payment for all workers no matter how high their earnings are. If they do not join the public system, they can apply the employer's contribution toward their private health insurance premiums. For these high-income, white-collar workers the employer's contribution will equal the maximum he would have had to pay if their earnings were at the ceiling.

EFFECTS ON PRIVATE HEALTH INSURANCE AND SICKNESS INSURANCE SOCIETIES

The Ministry of Labor has estimated that about 40 percent of the newly eligible white-collar workers will opt for public health insurance. In addition, an estimated 25 percent of the white-collar members of private health insurance plans have already taken advantage of the 3-month open season to join the public system. As a result,

the private insurance companies will probably lose about 310,000 members (both workers and dependents), or about 5 percent of their total membership.

West Germany's public health insurance system is administered by over 1,800 sickness insurance societies, not all of which stand to gain equally from the new changes. About 85 percent of eligible white-collar workers have traditionally belonged to the so-called "Substitute Funds" (Ersatzkassen).¹ These white-collar societies have offered more generous benefits because they had higher rates on the higher salaries of their white-collar members. The addition of new members with salaries even greater than the prevailing average should reinforce their relatively favorable financial position.

ECONOMIC IMPLICATIONS

Although the changes in contribution rates in most cases do not represent large sums of money to the individuals concerned, the total funds involved are significant and a large part of the working population is directly affected to some degree. More than 40 percent of the blue-collar work force earns more than the old ceiling of DM 1200. As a result of the raised ceiling they will all pay more for their health insurance coverage. At the same time 58 percent of the white-collar employment is also in this higher income category.

According to one German estimate, the total increased cost of health insurance levies to employers will be about DM 2.96 billion in 1971 and the increase in contributions of blue-collar workers will be DM 359 million. Together these figures represent about 1 percent of total wages and salaries earned by the German work force.

The equivalent of about half this sum will be saved by white-collar workers who on balance will be paying less for sickness insurance. Their

¹The name of these funds has no particular significance today. It arose during the early days of health insurance when white-collar workers were first allowed to join the public system. Under certain circumstances they were allowed to join "substitute" societies in lieu of those that they would logically have had to join if they were grouped together with blue-collar workers according to place of work or residence.

savings in insurance costs will come about in two ways. Those who move into the public system will be benefiting from rates for coverage that are generally lower than the premiums they have been paying for private insurance. Secondly, those who earn above the ceiling will now be receiving supplementary payments toward their coverage from their employers.

Since the health insurance ceiling is also used to determine the taxable base for contributions, the system's finances should improve as a result of the increase and, in fact, are expected to show a surplus of an estimated DM 1.46 billion this year in contrast to the deficits of recent years. This small reserve, however, will provide only a temporary cushion against rapidly rising expenditures. Rising payments are not only due to universal rising hospital and pharmaceutical costs, but also to an increased drain on finances that can be expected from the extended coverage of medical benefits permitted by new regulations. The cost of these additional medical services (mainly physical examinations for children under 4 years, women over 30, and men over 45 years of age) is estimated at DM 200-400 million during the first year.

Family Income Supplement in United Kingdom*

Legislation providing for a new family income supplement, enacted in the United Kingdom in December 1970, is scheduled to become effective in August 1971. The new program is designed to help the families of the country's lowest-paid workers through payment of a weekly cash supplement. The target is a specific segment of the working poor—the group of families with dependent children where the head of the household is working full time but earning minimal wages. By establishing “minimal wages,” the Act in effect approaches the determination of one kind of official poverty level.

The new program will benefit particularly those single persons—divorced, separated, or single women, as well as widowers and other single men—who are bringing up children un-

aided while they work full time since it will help defray the cost of babysitting and related expenses. Widows with dependent children, however, already receive social security benefits so that few of them will qualify for the new family income supplement (FIS).

Payments under the regular children's allowances program are neither means-tested nor work-related but are paid to all residents with more than one child. For the low-income family, the FIS program for all practical purposes is a children's allowances program that for the first time makes benefits available for the first child.

The basic eligible income level under the new FIS is £15¹ a week for a family with one child. Additional income of £2 a week is allowed for each additional child up to a maximum family income of £25 a week. Income for this purpose means the normal gross income of the family (including children's allowances), but it generally excludes earnings of dependent children. When the gross income is short of the prescribed level, the FIS pays half the difference up to a maximum of £3. The level for a three-child family, for example, is £19. If the family is earning £15, then half the difference, or £2, would be paid weekly. Provision is made for changing rates in the future. The usual age limit for children is 16, but it is extended for those in school or vocational training.

It is estimated that the new program will benefit more than 160,000 of the lowest-income families (including 54,000 with no father) and more than 500,000 children. About 24,000 families with benefits that are currently “wage-stopped” are also affected. The “wage stop” is the rule that limits benefits for the unemployed worker to the size of his normal wage. Under this limitation, the low-income unemployed in particular have been prevented from receiving the full amount of the benefits to which they would otherwise be entitled. Since the FIS is considered as part of income, the recipient's total income (wages plus new supplement) will be increased. The level for the “wage stop” will also rise, and he may therefore receive higher unemployment and other benefits.

The total cost of the program is expected to reach £8.6 million a year, all financed through

* Prepared by the International Staff, Office of Research and Statistics.

¹ One pound equals \$2.40 in U.S. money.

general revenue. More than half (£4.5 million) of the total will go to families with both parents present and to motherless families; £2.5 million will go to families without fathers. The additional benefits relating to "wage-stopped" cases add another £1 million, and the annual cost of administering the program is estimated at £600,000.

It appears from the current tax structure that the FIS benefits will add little to the taxable income. The tax status of the average recipient family will therefore not be affected.

Explores contemporary theories of economic growth through mathematical models and provides a guide to recent writing on the subject.

DHRYMES, PHOEBUS J. *Econometrics: Statistical Foundations and Applications*. New York: Harper & Row, 1970. 592 pp. \$14.95.

Exposition of techniques used in econometric research.

McKINLEY, CHARLES, and FRASE, ROBERT W. *Launching Social Security: A Capture-and-Record Account, 1935-1937*. Madison: University of Wisconsin Press, 1970. 519 pp. \$12.95.

Deals with both the personalities and problems involved in implementing the Social Security Act.

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Reports on the operation of State-chartered credit unions in 1969. (This is the first report published under the auspices of the National Credit Union Administration; statistics were formerly compiled and published by the predecessor agency, the Bureau of Federal Credit Unions.)

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Anthology of essays dealing with the effect of various interest groups on social policy in contemporary American society which is described as a "service state." Selections concern the "credential society," bureaucracy, education, mass media, housing, and the social-industrial-military complex.

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A longitudinal study of 198 mothers who were part of a 1962 study of 321 women living in New York City who had just had their first baby, were not married to the baby's father, and were not considering adoption.

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Provides complete, single-volume reference for the latest available data on Federal, State, and local revenues, expenditures, and debt, as well as selected economic series.

TAX FOUNDATION, INC. *Federal Trust Funds: Budgetary and Other Implications*. (Research Publication No. 25—New Series.) New York: The Foundation, 1970. 36 pp. \$1.50.

Examines the role of the trust funds in Federal finance: presents major issues that have arisen over their use in relation to expenditure control and the Federal debt.

Recent Publications*

SOCIAL SECURITY ADMINISTRATION

OFFICE OF RESEARCH AND STATISTICS. *The Benefit Structure of Private Health Insurance, 1968*, by Louis S. Reed and Willine Carr. (Research Report No. 32.) Washington: U.S. Govt. Print. Off., 1970. 111 pp. \$1.

OFFICE OF RESEARCH AND STATISTICS. *The Post-Denial Experience of Disability Insurance Applicants, 1957-1962*, by Phoebe H. Goff. (Staff Paper No. 3.) Sept. 1970. 78 pp.

Data from social security records on those individuals whose disability claim was denied in 1957, the first year disability benefits were payable. Examines their experience over the 5-year period through 1962.

SOCIAL AND REHABILITATION SERVICE

ASSISTANCE PAYMENTS ADMINISTRATION. *Characteristics of General Assistance in the United States*. (Public Assistance Report No. 39.) Washington: U.S. Govt. Print. Off., 1970. 122 pp. \$1.25.

Current information on State, State-local, and local programs of general assistance in the United States: supersedes the 1959 publication of the same title and number.

COMMUNITY SERVICES ADMINISTRATION. "A Right to a Decent Home . . .": *Housing Improvement Initiatives for Public Welfare Agencies*. Washington: U.S. Govt. Print. Off., 1970. 40 pp. 30 cents.

Descriptions of innovative programs and suggestions for action, including recommendations from a national study of housing of public assistance recipients.

GENERAL

BURMEISTER, EDWIN, and DOBELL, A. RODNEY. *Mathematical Theories of Economic Growth*. New York: The Macmillan Co., 1970. 444 pp. \$8.95.

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