

Response to the Survey

As table II shows, about three-fourths of the persons in the sample returned completed questionnaires by mail. The personal follow-up of 1 out of 2 of those who did not respond or whose questionnaires were undeliverable produced an effective response of 91 percent after allowing

for the weighting of such follow-up cases. Of the 9 percent who did not respond, most (7 percent) represented refusals. The follow-up interviews of persons who returned questionnaires that failed a quality check reduced the number of such inadequately completed questionnaires from 343 to 30.

Notes and Brief Reports

Reports of the 1971 Advisory Council on Social Security*

The Advisory Council on Social Security on March 31, 1971, submitted a comprehensive review of the old-age, survivors, disability, and health insurance program to the Secretary of Health, Education, and Welfare for forwarding to Congress and to the trustees of the social security trust funds. The report made specific recommendations for changes in the cash benefits program and in Medicare.

The Council, the seventh major advisory group to consider social security,¹ was appointed by the Secretary of Health, Education, and Welfare in 1969 in accordance with section 706 of the Social Security Act. The law calls for the appointment of nongovernment advisory councils at specified intervals (every 4 years under present law). The Council is the third to be appointed under this provision of the Act. Its members were:

Arthur S. Flemming, President, Macalester College,
Chairman

Bertha S. Adkins, former Under Secretary of Health,
Education, and Welfare

J. Douglas Brown, Provost and Dean of the Faculty,
Emeritus, Princeton University

Walter J. Burke, Secretary-Treasurer, United Steel-
workers of America

Kermit Gordon, President, The Brookings Institution

Gabriel Hauge, Chairman of the Board, Manufac-
turers Hanover Trust Company

* *Reports of the 1971 Advisory Council on Social Security* (House Document No. 92-80), 1971.

¹ See "Reports of the Advisory Councils," *Social Security Bulletin*, September 1963.

Arthur Larson, Director, Rule of Law Research
Center, Duke University

Bert Seidman, Director, Department of Social Secu-
rity, AFL-CIO

Charles A. Siegfried, Vice-Chairman of the Board
and Chairman of the Executive Committee, Metro-
politan Life Insurance Company

Joseph P. Tonelli, President-Secretary, International
Brotherhood of Pulp, Sulphite and Paper Mill
Workers of the United States and Canada

Robert C. Tyson, Director, and former Chairman of
the Finance Committee, United States Steel
Corporation

Dwight L. Wilbur, M.D., Past President, American
Medical Association

Whitney M. Young, Jr., Executive Director, National
Urban League (deceased March 11, 1971)

The law directs the Council to review the status of the four social security trust funds in relation to the long-term commitments of the social security program, the scope of coverage, and the adequacy of benefits—and all other aspects of the program as well, including its impact on public assistance. In carrying out its review, the Council considered, among other proposals, those that were currently being considered by Congress.

The Council submitted its reports in three parts: The first contains the findings and recommendations on the social security cash benefits program, the second contains findings and recommendations on health insurance for the aged (Medicare), and the third presents recommendations for financing the cash benefits and Medicare programs.

In its main introduction to the report, the Council pointed out that its central task was closely related to other matters of major importance in our society: public concern with the imperfections of present public assistance programs; public concern about our health care system and the need for developing a national

approach to health insurance financing; and the problem of devising a comprehensive approach to the needs of the aged for long-term institutional care. Though the Council did not review these matters in depth or make specific recommendations concerning them, it sought to identify the problem areas and offered judgments and suggestions where it considered them "appropriate and where analysis and discussion led to a consensus." Reprinted below verbatim are the sections of the Introduction dealing with these subjects.

Interrelationship of social security and public assistance

The Council recognizes the widespread agreement that social insurance is preferable to public assistance as a method of income maintenance, and the Council fully concurs in that agreement. The preference for social insurance, though, has led to strong pressures to have it assume an increasingly larger role in income maintenance by providing substantial benefits, regardless of the extent to which the insured worker was covered by the program.

Social insurance cannot and should not be expected to do the whole job of income maintenance. Any program that bases benefit amounts on earnings from work in covered employment and not on the needs of the individual will in some cases require supplementation through public assistance or private means. Responsibility for meeting individual needs in our society continues to remain largely with the individual and with private efforts by him and on his behalf; but to the extent that these efforts and social insurance are inadequate, final responsibility for meeting individual need must rest with public assistance. Assistance is designed to back-stop social insurance programs and private efforts to maintain income when earnings stop. Whenever other measures are insufficient, it is the responsibility of public assistance to assure that people have enough to eat, a place to live, clothes to wear, medical attention, and the other essentials of living.

The Council recognizes that there is a need for a public assistance program which will allow people to receive payments sufficient to meet their needs and to receive such payments with dignity.

The Council believes that the Federal Government's contribution to assistance recipients should be equable throughout the country. Some members believe that to accomplish this objective, public assistance should be a wholly Federal program; others believe that the goal can be accomplished through a Federal-State partnership. All members of the Council agree, however, that the present public assistance programs require a thorough overhaul in order to improve their adequacy, their equity, and their efficiency.

The Council believes that improvements in public assistance programs will reduce pressures to distort the contributory social insurance program. An adequate public assistance program would make it unnecessary for social security to perform functions that are not appropriate to

a wage-related program. A public assistance program which provided adequate payments for people who had worked only sporadically in jobs covered by social security would lessen the need for departing from the principle of earnings-related benefits which underlies the social security program. Social security benefits could then be kept more closely related to a worker's earnings and the length of time he worked under the program, and thus to the social security contributions he had paid, than otherwise could be done.

Development of a national approach to health insurance

The Council is concerned about the wide disparities that exist in the ability of Americans to obtain access to health care of good quality. These variations are not due, however, simply to the inability of people with low income to purchase insurance or pay for care. Americans in many walks of life need the benefits of broader and more orderly provisions for the financing and delivery of personal and family health care.

But more money by itself will not stem the relentless increase in health care costs; indeed, more money alone cannot help but aggravate the existing supply-demand imbalance. Filling the gaps in present health care financing arrangements must be accompanied by plans for improved organization of services as well as better distribution of additional health manpower and facilities. These problems and their potential solutions are complex and interrelated. We have much better models today for dealing with the financing side of the equation than we have experience in resolving problems on the capacity side. Setting the direction and pace that the restructuring of the health care system must take involves judgments on which there should be deliberate effort to preserve and strengthen the many things that are good about health care in America today.

Although the Council did not undertake to develop recommendations in the general area of health insurance as part of its central task, a consensus was reached concerning conclusions and principles which the Council believes should be taken into account during deliberations of the Nation on health policy.

1. We should strive to assure for every individual in our society access to comprehensive health care of good quality.
2. The achievement of this goal calls for a national assumption of responsibility for the resolution of problems that are clearly national in scope. It requires the development of a national approach which takes into account the priorities among needs to be met, and it requires the formulation of plans for financing and administration which recognize that solutions lie beyond the reaches of any single concept or method.
3. Health insurance coverage should be universal in terms of eligibility and comprehensive in scope of benefits. Where gaps in coverage now exist, they should be filled.
4. There is need for improvement in the Nation's health care system. The goal of good health care for everyone at an acceptable level of cost will be reached only if the delivery of health services is

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

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