Medical Benefits For Pensioners Under Foreign Social Security Programs

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A NUMBER of countries now furnish protection against the costs of medical care to individuals receiving old-age or retirement benefits or pensions under their social security programs. The usual method is to cover them under the general sickness insurance or other health services programs, along with currently employed workers or other groups.

No attempt is made here to give more than a broad outline of the various kinds of medical benefits and services provided to pensioners in different countries and of the specific methods of providing them. These benefits and arrangements are usually the same as, or fairly similar to, those applicable for insured or eligible persons generally and have been described elsewhere.[1] It may be noted, however, that the benefits provided commonly include general practitioner care and sometimes specialist care, hospitalization, essential medicines, some laboratory services and dental treatment.

There are 56 countries, besides the United States, that may be considered to have some type of statutory old-age benefit or pension system, covering at least important segments of the population. Among these systems are old-age insurance, universal pensions, old-age assistance, and provident fund programs. The precise status of old-age beneficiaries with respect to eligibility for medical benefits differs considerably among these countries, which have therefore been grouped in six classifications. The classifications used do not always lend themselves to exact limits because of the complexity of the provisions concerned; nevertheless they point up certain common patterns.

The six groups represent countries that (1) cover old-age insurance beneficiaries under sickness insurance, without payment of contribution, (2) cover old-age insurance beneficiaries under sickness insurance but require them to contribute, (3) permit old-age pensioners to insure voluntarily under sickness insurance, (4) cover all residents, including pensioners, under a medical care or sickness insurance program, (5) cover pensioners under other arrangements, and (6) either do not cover old-age beneficiaries or pensioners under their sickness insurance program or do not have such a program.

Noncontributory Coverage of Beneficiaries

Twelve countries that maintain both old-age insurance and sickness insurance programs make the old-age insurance beneficiaries, as such, specifically eligible for medical benefits under their sickness insurance programs, without requiring them to pay further contributions after retirement. Of the countries in this group, five—Belgium, France, the Federal Republic of Germany, Greece, and Italy—are in Western Europe and seven—Albania, Czechoslovakia, East Germany, Hungary, Poland, Rumania, and Yugoslavia—are in Eastern Europe.

The medical services available to aged beneficiaries under the sickness insurance programs of these countries are, in general, the same as those provided to currently employed workers. Since the beneficiaries do not have to contribute to sickness insurance after they retire, the medical benefits for which they are eligible as pensioners may be regarded, in one sense, as supplementary benefits to which they become entitled by reason of their coverage or contributions in the past.

The cost of providing medical benefits to aged beneficiaries is, in effect, financed from past and current contributions paid by or on behalf of employed workers.

In Belgium, old-age insurance beneficiaries and their dependents are eligible for medical benefits under sickness insurance. The benefits take the form of cash reimbursement, according to a fixed national scale of fees, of up to 75 percent of expenditures incurred for medical care. Expenditures for medical and dental treatment, surgery, hospitalization, drugs, and laboratory services are included. The unified sickness and invalidity insurance program for wage earners is financed by a 7-percent contribution, divided equally between employee and employer, a regular Government contribution equal to 16 percent of this contribution, and special Government subsidies.

In France old-age insurance beneficiaries, with their dependents, remain covered for medical benefits under sickness insurance after their coverage as active workers ceases. Benefits include general and specialist care, hospitalization, certain medicines, and laboratory services. The benefits are on a cash-reimbursement basis, with the insured person paying the doctor or hospital and then being reimbursed—usually for 80 percent of the cost—according to an approved scale. Both pensions and sickness insurance are financed from a single unified contribution paid by employees (6 percent of earnings) and employers (12½ percent of payroll). The contributions collected are allocated among the various types of benefits and among the regional and primary (district) funds administering the programs, in accordance with rates fixed by ministerial decree.

Beneficiaries of the old-age insurance program and members of their families are automatically insured against sickness in the Federal Republic of Germany through compul-

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[1] See *Social Security Programs Throughout the World, 1958* (Division of Program Research), 1958.

sory membership in one of the sick funds. Benefits include the services of physicians, medicines, and hospitalization. The funds make payments directly to doctors (on a capitation basis), pharmacies, and hospitals for services provided to their members; the patient bears no part of the cost. These expenditures by the sick funds are compensated for, in part, by lump-sum payments made to them by the various pension insurance institutions—the pension-paying authorities—at rates fixed by the Ministry of Labor. The amounts paid by the pension institutions have not been sufficient in recent years to cover all expenditures on behalf of pensioners, with the result that deficits have had to be borne by the sick funds themselves.

In Greece, old-age insurance beneficiaries and their family members receive free medical care services in clinics and hospitals of the Central Social Insurance Institution or of the special occupational fund with which they were previously affiliated. The services are the same as those available to insured workers covered by sickness insurance and include medical treatment, medicines, and hospitalization. Pensioners do not contribute toward this protection after they retire. The medical-benefit provisions of the sickness insurance program are financed by an employee contribution of 2½ percent and a 5-percent employer contribution.

Old-age insurance beneficiaries in Italy and their dependents are eligible for medical benefits under the sickness insurance program. This is a fairly recent development; the program of pensioners' medical benefits was started in November 1955 under a law of August 4, 1955. Benefits include general and specialist care, medicines, and hospitalization. A decree of December 1956 listed various special diseases of old age that are treated without time limit. The services are usually provided on the basis of direct payments to doctors, pharmacies, and hospitals by the National Sickness Insurance Institute. Pensioners as such do not contribute to the cost of their protection, which is met from current contributions to the pension system itself; a special fund has been established — the equalization fund for pensions and pensioners' sickness benefits. Contributions to the sickness insurance program are now about 7.75 percent of payroll for employers and 3.85 percent of earnings for employees.

In the seven Eastern European countries listed above, pensioners appear to be entitled to medical benefits on the same basis as currently covered workers. Typically, all social security benefits in these countries —whether cash or medical—are financed mainly from a single unified contribution payable by employing enterprises. Thus there is, in effect, a pooling of pension and sickness insurance funds. It may be noted that in Yugoslavia pensioners are entitled to receive prescribed medicines entirely without cost but currently insured workers receive only 30 percent of the cost of such medicines.

Contributory Coverage of Beneficiaries

In a second group of countries, old-age beneficiaries are entitled to medical benefits under the sickness insurance programs but after their retirement are required to pay a special contribution for such protection. There are six countries using this method—Austria, Chile, Luxembourg, Mexico, Panama, and Spain.

In Austria, old-age insurance beneficiaries may be required to pay a contribution of at least 6 schillings a month[2] to the sickness insurance program. In addition, the various pension insurance institutions pay to the sick funds 8.2 percent of the total amounts they pay out in the form of pensions. Pensioners are entitled, in return, to the full range of medical services available under the sickness insurance program, including medical treatment, hospitalization, and medicines. The services are in general provided by doctors under contract with the sick funds and in dispensaries and hospitals belonging to the funds or with which they have a contract. Doctors and hospitals are usually paid directly by the funds.

All pensioners under Chile's social insurance system for wage earners have 5 percent of their pension withheld by law. In return, they are entitled to receive medical care under the National Health Service as long as they continue as pensioners. Care includes both the services of doctors and hospitalization and is furnished directly through dispensaries and hospitals belonging to the health service.

Luxembourg requires recipients of old-age insurance benefits to pay 3.9 percent of their monthly pension to the sickness fund with which they were previously affiliated. They are thereby eligible, on the same basis as the employed members of these funds, for medical benefits, including general and specialist care, hospitalization, and medicines. The cost of their coverage under sickness insurance not met by these contributions is shared by the pension insurance institution that pays their pension and the Government. Surgeons and hospitals are generally paid directly by the funds for services rendered to their members, but for other medical care most funds use a reimbursement system.

Entitlement to medical benefits under Mexico's sickness insurance program was extended to old-age insurance beneficiaries and their families by amendments of December 1956. Pensioners are required to pay 2 percent of their pension for this coverage, which is the same proportion of wages paid by employed workers for sickness insurance. Employers contribute 4 percent of payroll for sickness insurance, and the Government contributes a further 2 percent of taxable earnings. Care is provided mainly in clinics, hospitals, and sanatoriums operated by the Mexican Social Insurance Institute, though some use is made in rural areas of doctors under contract with the Institute.

Persons receiving old-age benefits under the social insurance program of Panama are required to pay 4 percent of their benefit toward the cost of continued coverage under the medical-benefit provisions of the program. In return they are eligible for general medical, dental, and pharmaceutical services in facilities of the Social Insurance Fund and for reimbursement, according to a schedule, for costs of hospitalization and surgery. The general social insurance program, including both pensions and

[2] One schilling equals $0.038.

medical benefits, is financed by an 8-percent contribution shared equally by employers and employees and by a small Government contribution.

In Spain, old-age pensioners and their dependents are covered for medical care under the sickness insurance program. They are required to pay 2 percent of their pension for this coverage, which is the same percentage of wages payable by currently employed workers. Employers also contribute at the rate of 5 percent of payroll to the sickness insurance program. Benefits include the services of general practitioners and specialists (who are paid directly by the National Welfare Institute on a capitation basis), medicines, and hospitalization in facilities owned by the Institute or with which it has contracts.

Voluntary Coverage

In a few countries old-age pensioners are permitted to insure themselves voluntarily under the public sickness insurance program. They are required, in all cases, to pay a contribution if they wish to avail themselves of this privilege. The countries in which this situation exists include Denmark, the Netherlands, Peru, and Switzerland.

Like other residents with low or moderate incomes in Denmark, recipients of national old-age pensions may decide for themselves whether or not to be active members of one of the numerous sick clubs. Those who elect active membership receive, through the clubs, free medical care, hospitalization, 75 percent of the cost of essential medicines, and a small daily cash benefit of 1 crown[3] a day while ill. Some clubs also provide specialist and dental care or other services. Doctors are paid by the clubs directly, usually according to the capitation method. The contributions payable by pensioners who are active members vary somewhat among the clubs but average about 4 crowns a month. In addition to membership fees, the sick clubs receive substantial financial aid from the Government, including a subsidy of 25 percent of the cost of medical care furnished, a 50-percent reduction in hospital charges in public hospitals, and 75 percent of the cost of extra care for chronic disability.

A somewhat similar plan is found in the Netherlands, where recipients of the quasi-universal old-age pensions may join one of the approved sickness funds voluntarily, if their income does not exceed 3,530 guilders[4] a year. The contribution payable by the pensioner is 0.67 guilders a week if his annual income is less than 2,520 guilders; otherwise, it is 1.34 guilders. These contributions meet one-fourth and one-half the cost, respectively. Half the remaining cost is covered by a Government subsidy, and the other half is met from a general equalization fund set up under the sickness insurance program. Benefits provided by the sickness funds include medical treatment, medicines, and hospitalization. The funds make direct payments to doctors (usually on a capitation basis) and hospitals.

In Peru, pensioners under the wage earners' social insurance system are permitted to choose, when retiring from employment, whether to continue to be covered for medical benefits under the sickness insurance provisions. If they elect continued coverage, they are required to pay a regular contribution equal to 4 percent of their pension. Medical services are provided through clinics and hospitals operated by the National Social Insurance Fund. Other revenues of the social insurance program, for both pension and sickness insurance, include a 3-percent employee contribution, a 6-percent employer contribution, and a 2-percent Government contribution.

Sickness insurance in Switzerland is mainly voluntary; it is compulsory in only a few Cantons. About three-fourths of the population, however, now belong to one of the more than 1,000 public and private sickness funds. An old-age insurance beneficiary may become a member of any one of these funds, just as any other resident, unless a fund imposes an age limit, which it is permitted to do under the Federal law. About five-sixths of the revenues of the sickness funds, on the average, come from members' contributions and the remainder from Government subsidies. Benefits are required by Federal law to cover at least 75 percent of the cost of medical treatment and of specified medicines. Many funds pay up to 90 percent of the cost of medical treatment, however, as well as a part of hospital costs and the costs of additional medicines. The funds generally pay doctors directly for their services, on a fee-for-service basis.

Coverage of All Residents

In a fourth group of countries are those maintaining comprehensive programs of medical benefits, which by law apply in general to all residents. Old-age pensioners are covered under all these programs, but their coverage is based essentially on residence rather than stemming from any special status as a pensioner. The countries that may be regarded as falling within this classification, although their programs differ considerably in some respects, include Australia, Bulgaria, Iceland, New Zealand, Norway, Sweden, the Union of Soviet Socialist Republics, and the United Kingdom.

In three of these countries—the United Kingdom, the Soviet Union, and Bulgaria—old-age benefits are provided on an insurance basis, but medical care services are, in principle, provided free to all residents regardless of their insurance or beneficiary status. These services, including doctors' services, hospitalization, and drugs, are provided directly to the population, within the limits of available facilities, through a national health service or public health system, rather than on a reimbursement basis. They are financed in large measure from general revenues, except for limited cost-sharing by patients for some medicines or other items and, in the United Kingdom, a small social insurance contribution.

The same broad coverage of all residents, including the aged recipients of universal superannuation benefits and of age benefits based on a means test, is found in the health benefits program of New Zealand. In that country, however, general practitioners' fees are reimbursed on a fee-for-service basis, with patients

[3] One crown equals $0.145.

[4] One guilder equals $0.263.

usually bearing part of the cost, and payment for private hospital care is reimbursed at a fixed daily rate. Health benefits and social security cash benefits are financed mainly through special earmarked income taxes on individuals and corporations, with only the deficit being met from general revenue.

In Norway and Sweden, which pay universal old-age pensions, and in Iceland, which provides pensions on an income-test basis, all residents or family heads, including pensioners, must belong to a sickness fund or club furnishing medical and cash benefits. These funds derive part of their revenue from members' contributions, but pensioners are exempt from payment of contribution. Employer contributions are also collected in Norway and Sweden, and in all three countries the funds receive substantial Government subsidies. The medical benefits include general and special medical care, hospitalization, and various medicines. In Iceland the sick clubs contract with doctors for provision of services to their members. In Norway the funds pay doctors directly, according to a fee schedule; the balance is paid by the patients. The Swedish funds reimburse 75 percent of doctors' fees incurred by members, according to an approved schedule. They also reimburse for fees incurred for ward treatment in public hospitals; pensioners may receive reimbursement for only 6 months of hospital care, however, compared with 2 years for other members.

In Australia, where old-age pensions are on a means-test basis, all residents, including pensioners, receive free from the Government a hospital-maintenance benefit of 8 shillings[5] a day and also pharmaceutical benefits covering the full cost of "life-saving" medicines. These benefits are paid directly by the Department of Health to the hospital or pharmacy. Moreover, all old-age pensioners receive free general practitioner care, an additional hospital-maintenance benefit of 4 shillings a day, and the full cost of any prescribed medicines. These benefits are financed entirely from general revenues. The Government also pays subsidies to approved voluntary benefit organizations that provide medical and additional hospital benefits to members.

[5] One shilling equals $0.112.

Other Types of Coverage for Pensioners

The three countries discussed below have programs under which old-age pensioners receive medical benefits under certain circumstances. The programs are of such a nature, however, that they do not fit readily into any of the groups described above.

Ireland provides only old-age assistance to aged persons, although it has a contributory system of disability and survivor insurance. It also furnishes free general medical services, hospital and specialist services, and necessary medicines to all persons, including pensioners, in the "lower income group." This group is defined, in general, as consisting of persons unable to procure these services from their own resources. The services are usually furnished through clinics, dispensaries, and hospitals belonging to local health authorities. Hospital and specialist services only are also provided to all currently insured workers and to other persons in the "middle income group." The entire cost of these health services is shared equally by national and local governments.

Canada, which pays a universal old-age pension, adopted a system of hospitalization insurance in 1957 under which the Provinces establish their own programs and receive in turn a national subsidy covering about half the cost.[6] All the Provinces but Quebec are participating in the system, and their programs cover all residents, including old-age pensioners. The benefits include, in general, standard ward hospital care, inpatient drugs, diagnostic and laboratory services, operating-room facilities, and limited outpatient benefits; there is some variation among the Provinces, however, in the range of services. The Provincial share of the cost is met in Manitoba, Ontario, and Prince Edward Island through premium payments by the insured; in Alberta, British Columbia, and Newfoundland, out of general revenue; in New Brunswick and Saskatchewan, through a combination of premiums and general revenues; and in Nova Scotia, through a sales tax.

[6] See Agnes W. Brewster, "Canada's Federal-Provincial Program of Hospitalization Insurance," *Social Security Bulletin*, July 1959.

Japan has an old-age insurance system and also two separate systems of health insurance. The compulsory health insurance system applies to currently employed workers of firms of a specified size in industry and commerce; it does not cover old-age beneficiaries. The national health insurance system, which is somewhat larger, applies compulsorily to all householders not otherwise covered, including pensioners, in communities where the municipality is the insurance carrier. A large number of clinics and hospitals are operated by the latter system for direct provision of care to its members, but in some areas medical benefits are furnished on a reimbursement basis. Financing is through members' contributions and Government subsidies.

Coverage Not Available for Pensioners

Twelve countries maintain both old-age insurance and sickness insurance programs but do not cover old-age beneficiaries for medical benefits. These countries are Bolivia, Brazil, Communist China, Costa Rica, the Dominican Republic, Ecuador, Iran, Nationalist China, Nicaragua, Paraguay, Portugal, and Turkey.

Another group of countries maintain some kind of benefit or pension program for aged persons but do not have in operation any general statutory program providing medical benefits in the event of sickness, either for pensioners or others. In this group are Argentina, Ceylon, Cuba, Finland, Iraq, Israel, Malaya, the Philippines, the Union of South Africa, the United Arab Republic, and Uruguay. In Israel and Cuba, however, fairly extensive voluntary sickness insurance programs are in operation.