Social Security Abroad

Private Health Insurance in West Germany and Great Britain*

In recent months there has been growing discussion in the United States on the introduction of some form of national health insurance under government sponsorship. Some of the proposals provide for the continued existence of private health insurance and even for considerable expansion within the context of a government-operated scheme.

It is interesting to note in this connection that in both the Federal Republic of Germany and Great Britain, which have long had comprehensive public medical care systems, private health insurance continues to play a role. Private health insurance is somewhat more important in Germany where, according to the latest figures, more than one-tenth of the population, mainly in the higher income groups, is still largely ineligible for public health insurance and depends on private carriers for basic coverage. In that country there is also a rapidly growing system of private health insurance that supplies supplemental medical services to those who seek coverage for services in addition to the basic items paid for by the public scheme. About one-sixth of the population now contracts for such coverage. In Great Britain, a much smaller proportion of the population carries private insurance.

FEDERAL REPUBLIC OF GERMANY

The government-sponsored health insurance system covers about 87 percent of the population. The most important single category among those not covered is composed of salaried employees earning above a stipulated ceiling who are not eligible for coverage under the statutory scheme. Periodically this ceiling is raised, but those who wish have the option of retaining private health insurance if it provides certain minimum risk coverage and if they make their preference known within a specified time. All who earn less than the ceiling, however, are required to carry some sort of health insurance, either public or private.

For a number of years, despite several changes in the ceiling, the relative number covered by private insurance instead of the public scheme has remained stable at 11 percent of the total population. This is partly because many of the newly eligible persons chose to continue their private coverage rather than join the public system. Furthermore, although the ceiling has risen slightly more rapidly than wages, it has not significantly outpaced them in the long run; as a result the number of eligible persons did not grow appreciably. Developments in the past few months represent something of a departure from this pattern, since two relatively big ceiling increases have taken place, greatly enlarging the number of workers entitled to public insurance.[1] It is thus possible that a larger percentage of workers are currently enrolled than has been customary in recent years.

In addition to basic coverage, private health insurance companies in Germany also extend a considerable amount of supplemental health insurance to individuals who want to increase their coverage beyond that provided under the public scheme.[2] The number of individuals who have private supplemental insurance has been rising in recent years. In 1967 it rose by about one-tenth from the preceding year to 10 million or about 16 percent of the total population, up from 7 million or 12 percent in 1963.

There are a number of reasons why a German citizen would consider such supplemental insur-

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[1] The ceiling was raised to DM 11,880 per year in July 1969 and to DM 14,400 in January 1970. The last previous change took place in 1965 when the ceiling was raised from DM 7,920 to DM 10,800. (One U.S. dollar equals 3.62 deutsche marks.)

[2] Wide variation exists even in the benefits offered by different plans under the public insurance scheme. The *Ersatzkasse*, originally started as associations for white-collar workers, usually provide the most generous benefits and in some cases even include private accommodations in hospitals. Contribution rates for the *Ersatzkasse* are also usually higher than those established by other sickness insurance societies affiliated with the public system.

ance desirable. First of all, with the proper coverage a "private" patient is entitled to a private room (for a higher fee, of course), the cost of which is met by his private insurance. There is also a traditional aura of prestige attached to being a private patient and a belief that such patients get more attention from the hospital's consulting physicians than others. Furthermore, though anyone covered by the public health insurance scheme is entitled to free choice among the contract physicians, most popular doctors have long waiting lists that can be circumvented by private clientele.

The private patient, in addition, has access to university professors and other highly qualified specialists who are not under contract to the public insurance system. Finally, there is a widespread belief that a private patient receives more individual attention from the general practitioner. In the past many doctors have even had special waiting rooms for private patients.

From the viewpoint of the doctor, estimates are that typical practitioners derive between one-third and one-fourth of their total income from such private patients since their fees are set at a level several times higher than the amount charged publicly insured patients.

In 1968 the average worker would have paid 40 DM per month (about $10) for his public insurance coverage and his employer would have paid an equal amount. The contribution not only covered insurance for medical care but also entitled the worker to cash benefits in case of sickness. Private insurance fees vary widely, depending upon coverage.

GREAT BRITAIN

Before the inception of the National Health Service (NHS) in 1948 there were two types of hospital insurance societies in Great Britian: the contributory societies and the provident societies. The latter, oriented from the outset toward the middle and upper classes, continued to provide coverage for private medical and hospital treatment after the introduction of NHS. The contributory societies, however, found that their subscribers, generally from lower income groups, were well satisfied with the free medical care now offered by the NHS and had little interest in insurance coverage entitling them to private medical care. Nonetheless, a large number of these societies managed to survive by offering a much more circumscribed package of supplemental benefits for an extremely low premium. Even after losing a substantial proportion of their membership, they still have about 4 million members, and the total number covered is about 11 million, with dependents counted in.

Examples of benefits now offered are such items as care at convalescent homes operated by the societies, small cash benefits during hospitalization, assistance toward meeting the cost of home help, and contributions toward the expense of eye glasses. In 1964 the average cash value of the benefits dispensed by the largest of these societies was the equivalent of about $6. Contribution rates have been correspondingly low—less than the equivalent of 25 cents a month per member in 1964.

Before the NHS was established the contributory societies were considerably more important than the provident societies. The situation is now reversed. Because of the extremely limited scope of the contributory societies, it is usually the provident societies to which reference is made whenever private health insurance in Great Britain is currently discussed. The provident societies have been growing rapidly in the past few years and have doubled their membership since 1960. With family members counted, total coverage has perhaps reached 2 million or roughly 4 percent of the overall population of England and Wales.

Private coverage for a family of three, depending on the benefits offered by the particular plan, runs from a minimum of a little over $1 per week to slightly over $3 per week.[3] In recent years a growing number of policies have been issued in conjunction with group insurance plans for which the firm contributes part of the premium as a fringe benefit to its employees.

The reasons why private insurance holds an attraction for some of the British are similar to those that motivate the Germans. The National

[3] For the British worker, the weekly NHS contribution is the equivalent of 46 cents (38 cents paid by the employee and 8 cents by the employer); in general, it also covers the worker's spouse and children. These contributions traditionally have met only about 15 percent of the cost of the NHS, which in essence is financed from general revenue.

Health Service allows for free choice of doctor when a general practitioner is needed, but surgeons are usually assigned by the hospital upon admission. Private schemes, however, allow their members to choose their own specialist with a guarantee that he himself will tend to the needs of the patient. Visitor regulations are also more lenient for the private paying patients.

Waiting time to enter a hospital is also a consideration. In a genuine emergency there is no waiting period under NHS, but waiting periods of up to 1 year are not uncommon for certain types of elective surgery. A private patient can more readily gain admission to the hospital, where he has access to one of the 4,400 private beds that NHS sets aside for those who are willing to pay for all their hospital and medical services. Alternatively, the privately insured patient may also use one of the 14 nursing homes (private hospitals affiliated with private insurance organizations) that provide 464 beds to paying patients.

Two types of private accommodations for which a fee is charged are provided in NHS hospitals. First, there are the so-called "pay beds" set aside for private patients. Any patient choosing such an arrangement must pay for all medical expenses connected with his illness (including physicians' fees and laboratory tests), in addition to the cost of the hospital room. A schedule of fees to be charged by the hospitals is kept by the Secretary of State for Health and Welfare. Recently, after a review of the national need for private beds, their number was reduced from 5,764 to about 4,400 to bring them into line with what was judged to be a supply-demand ratio comparable to that prevailing for hospital beds in general.

In addition, a varying number of private beds are set aside for those patients who need privacy on medical grounds. If such beds are temporarily not needed for medical cases they are made available as "amenity" beds to patients willing to pay a small fee for privacy. Patients who choose to pay for this second type of "pay bed" continue to receive other medical services free of charge through NHS.

It is difficult to determine how much of the typical British doctor's income is derived from private practice. Indications are that most general practitioners do not have private patients partly because they find it unprofitable to engage in the extra bookkeeping involved. Some doctors, however, have a large number of private patients, and the fees received from private patients probably far exceed in the aggregate the amount suggested by the small numbers involved: 4 percent of the population covered by private insurance plus the small number who carry no insurance but have sufficient means to pay for private medical care from their own financial resources. Fees charged private patients tend to be higher, and utilization of medical facilities seems to be considerably greater among this group than for the population as a whole.

Many public officials and private citizens share the views of Richard Crossman, former Secretary of State for Social Services, who has expressed concern that the growth of private health insurance schemes may not only open the way to undesirable practices such as "queue jumping" but also may instigate the development of two categories of health service, a privately financed system of high quality and a publicly financed program of inferior services. The Political and Economics Planning Institute, which has been designated by Crossman to conduct a study of the private health insurance system, has yet to submit its report.

THE ROLE OF SUPPLEMENTAL INSURANCE

A two-tiered medical system has in fact existed in the past in Germany—a public system for the masses and a prestigious, private scheme for the more affluent. It is widely believed, however, that, for a number of reasons—the most important of which is the increase in premiums necessary to meet the rapidly rising cost of medical care—the private health insurance system of basic coverage will decline just as the separate waiting rooms have virtually disappeared in the doctors' offices.

In the meantime, supplemental insurance coverage will continue to grow in order to pay for items not met by the public scheme. In the Federal Republic of Germany the idea has long been advocated that public insurance should be limited to meeting minimum needs and that the increasing demand for additional services, fed by rising standards of living, should be met through private

financing. Unfortunately, it is difficult to reach a consensus on what is or is not necessary in medicine and what minimum services should be provided by the public system.

In this connection, the Swedish delegation at the World Medical Assembly meeting in Paris in June 1969 proposed that national medical associations take responsibility for determining what minimum requirements for medical care should be considered to be a citizen's right under public medical schemes. The delegation further proposed that any extra services should be extended at additional cost to the recipient. More recently in Great Britain, the British Medical Association proposed that the Health Service be revised so that basic medical services would be provided through public, compulsory insurance and that unspecified "higher benefits" be available under a voluntary insurance arrangement.

RECENT PUBLICATIONS

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OKUN, ARTHUR M., and PERRY, GEORGE L., eds. *Brookings Papers on Economic Activity: I.* Washington, D.C.: The Brookings Institution, 1970. 162 pp. $2.50.

First of a series of papers from conferences of the Brookings Panel on Economic Activity.

ORAM, C. A. *Social Policy and Administration in New Zealand.* Wellington, New Zealand: Price, Milburn, for New Zealand University Press, 1969. 268 pp. $5NZ.

REUSS, HENRY S. *Revenue-sharing: Crutch or Catalyst for State and Local Governments?* New York: Praeger Publishers, 1970. 170 pp. $6.50.

Examines myths and realities of local government and its Federal and State relationships; suggests ways of meeting financial and organizational emergencies and of making federalism work.

RETIREMENT AND OLD AGE

DAVIS, HARRY E., and STRASSER, ARNOLD. "Private Pension Plans, 1960 to 1969—An Overview." *Monthly Labor Review*, vol. 93, July 1970, pp. 45–56. 75 cents.

Describes coverage of private pension plans at the end of 1969 and their provisions on plan participation, normal retirement, early retirement, and vesting.

HARPER, JOHN H., compiler. *State and Local Pension Funds, 1970.* Washington, D.C.: Investment Bankers Association of America, 1970. 93 pp. $7.50.

"Digest of authorized investments and actual investments."

JEFFERS, FRANCES C., ed. *Proceedings of Seminars, 1965–69, Duke University Council on Aging and Human Development.* Durham, N.C.: Center for the Study of Aging and Human Development, Duke University Medical Center, 1969. 330 pp. $7.50.

Papers relate to methodology of geriatric research, psycho-physical aspects of aging, health care, ecology, retirement, mortality, and longevity.

ROSENBERG, GEORGE S. *The Worker Grows Old.* San Francisco: Jossey-Bass, Inc., 1970. 206 pp. $8.50.

Reports a study of social isolation of low-income, white, working-class men and women in Philadelphia.

SHEPPARD, HAROLD L., ed. *Towards an Industrial Gerontology.* Cambridge, Mass.: Schenkman Publishing Co., 1970. 165 pp. $7.95.

Papers on the problems of employment faced by the aging, from the proceedings of a 1968 Seminar sponsored by the National Council on Aging and the W. E. Upjohn Institute for Employment Research.

SUMNER, GRETA, and SMITH, RANDALL. *Planning Local Authority Services for the Elderly.* London: George Allen and Unwin, 1969. 406 pp. 80s.

English study discusses estimation of needs and resources, project evaluation, and consideration of future policy.

PUBLIC WELFARE

GREENFIELD, MARGARET. *Medi-Cal—The California Medicaid Program (Title XIX), 1966–1967.* Berkeley: University of California, Institute of Governmental Studies, 1970. 71 pp. $2.

HAMILTON, GLEN, and WHARF, BRIAN. "Registration for Social Workers—Yes or No?" *Canadian Welfare*, vol. 46, May–June 1970, pp. 14–16. 75 cents.

Gives two views of the Registered Social Workers Act passed by the British Columbia legislature in 1968; describes its background, provisions, and early experience.

HANSEN, NILES M. *Rural Poverty and the Urban Crisis: A Strategy for Regional Development.* Bloomington: Indiana University Press, 1970. 352 pp. $12.50.

Presents a policy for dealing with the problems of Appalachia, the South, Indians, and Mexican-Americans.

KONOPKA, GISELA. *Group Work in the Institution, a Modern Challenge.* rev. ed. New York: Association Press, 1970. 304 pp. $7.95.

For professional and lay persons doing institutional work with children, unmarried mothers, handicapped, delinquents, the elderly, and prisoners.

HEALTH AND MEDICAL CARE

ALTMAN, ISODORE, and others. *Methodology in Evaluating the Quality of Medical Care: An Annotated Selected Bibliography, 1955–1968.* Pittsburgh: University of Pittsburgh Press, 1969. 214 pp. $3.95.

Material organized under these headings: Standards and Recommendations, Elements of Performance, Effects of Care, and General Approaches.

FOX, JOHN P., and others. *Epidemiology: Man and Disease.* New York: The Macmillan Co., 1970. 339 pp. $12.95.

Treats epidemiology as the fundamental science of preventive medicine; considers vital statistics, occurrence

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