jobs upon onset of disability and are likely to give up jobs that require heavy labor. Women go into service occupations.

The family income of the disabled is half that of the general population. Forty percent of the disability units with young children had incomes below the poverty level. But the poorest are the unmarried severely disabled.

Complicating the income problem is the fact that the disabled are less likely than the general population to own health insurance. Yet they need more frequent medical care.

The short-term disabled (those disabled for 4–6 months) and the long-term disabled (disabled 7 months or longer) represent similar populations, with few differences in their characteristics. Race, sex, marital status, and type of impairment did not differ substantially between the two groups. The short-term disabled tended to be younger, however, and more involved with rehabilitation. They also had greater medical costs than the long-term disabled, but this factor was offset by their slightly higher income and greater health insurance. Many received short-term public income maintenance payments from workmen's compensation and similar program sources.

Social Security Abroad

Commission Studies Rising Health Costs in Austria*

Concern over rising health costs in Austria has led to the establishment of a study commission to evaluate the national health insurance system and, in particular, alternative methods of financing. Many other countries are also encountering problems of increasing medical care expenditures. The Austrian experience is selected for summarization because the commission not only thoroughly examined all aspects of the system but it also brought into the discussions representatives from all segments of society.

The commission included representatives of trade unions, chambers of commerce, employers, political parties, provincial and local authorities, the National Government, the professions, farmers, universities, hospitals, and social insurance institutions. Underlying its establishment was the mounting public criticism of various aspects of the national health program. In addition, widely-publicized disputes had occurred between doctors and the social insurance institutions. Critics proposed solutions such as nationalization of hospitals, centralized planning of health care, and a revaluation of the status of private practice.

A World Health Organization team, called in to determine the essential problems of hospital financing, cited four factors that had increased demand for health care: (1) a growing proportion of aged in the population, (2) more frequent hospitalization of persons who formerly received outpatient treatment, (3) a decline in home care, and (4) a longer average stay in hospitals.

The commission favored retaining the national health insurance system as it is—including its benefit structure and method of financing—but found considerable room for expansion and improvement of services. In its final report, it presented a range of limited proposals, such as emphasizing preventive health care in order to reduce hospital utilization, consolidating some of the sickness insurance funds, centralizing administration, Federal-level planning, some drug price control, and greater subsidization by the Government. Limited as these proposals were, they still created sharp divisions of opinion within the commission. The commission felt that any major revision of the system—especially in the area of finances—was the responsibility of political authorities.

THE HEALTH INSURANCE SYSTEM

Austria's health insurance system, which dates back to 1888,[1] covers 92 percent of the population on a statutory basis. The system is composed of

* Prepared by Elizabeth Kreitler Kirkpatrick, International Staff.

[1] The General Workers' Sickness Insurance Act of 1888 covered virtually all workers in trade and industry. Individual health insurance plans had been created even earlier.

four major programs: (1) General Social Insurance (ASVG) which insured 75 percent of all covered persons in 1970; (2) Health Insurance for Public Servants (B-KUVG); (3) Health Insurance for Self-Employed Tradespeople (GSPVG), which is compulsory only for those whose chambers of commerce have voted to participate; and (4) Agricultural Health Insurance (BKVG), the newest (1965). Within these four programs are 40 separate insurance funds for certain occupations and geographic areas. The ASVG, for example, is administered by nine regional insurance institutions (one for each province) as well as by occupational funds.

The following tabulation shows the number of contributors in each of the four programs in 1970. In that year 2.4 million dependents were also covered, but no statistics are available on their affiliation with individual funds. Altogether about 6.8 million persons or 92 percent of the population are now covered for health insurance benefits. The 600,000 persons not covered include small groups of pensioners, certain professionals and self-employed, students, and 370,000 dependents.

Program	Membership	
	Number [1]	Percentage distribution
Total	4,374,949	100
ASVG	3,285,176	75
B-KUVG	425,446	10
GSPVG	317,409	7
BKVG	346,918	8

[1] Includes members of the labor force and retired persons who continue to make contributions in order to maintain eligibility.

Benefits

Sickness insurance, as administered by the insurance funds, pays for services ordinarily provided through doctors and hospitals and for drugs: physician care, hospital care, medicines, maternity care, dental care, appliances, and home nursing. Patients pay 5 shillings per prescription and up to 20 percent of dental care costs. (One U.S. dollar equals 23.14 Austrian schillings, as of March 31, 1972.)

In addition, sickness insurance provides funeral grants and lump-sum maternity grants, as well as cash sickness benefits (sick leave) payable for up to 78 weeks. For the insured, hospital care in public wards is covered without time limit; for dependents there is a 10–20 percent cost-sharing provision. Because present laws require insurance funds to introduce approved additional benefits only as their financial capacity permits, the various funds have different benefits even when contributions are the same.

Financing

The Austrian health insurance system is financed primarily through employer and employee contributions. Blue-collar workers pay up to 3.65 percent of covered wages; salaried employees pay up to 2.4 percent.[2] Matching contributions are made by the employer. Pensioners pay 1.0–2.5 percent of their pension.

In addition, the Government contributes 50 percent of the cost of cash maternity benefits, pays the sickness insurance premiums of welfare recipients and war survivors, and covers hospital deficits. The pension funds and the accident insurance fund also contribute legislated amounts to the sickness funds.

Expenditures

Austria's health insurance system has been faced with increasing expenditures and inadequate income. The year 1970, for example, showed an unfavorable balance, with total expenditures for all statutory health funds rising by 8.3 percent over those of the preceding year and total income rising by only 6.4 percent. The result was a deficit of 36.7 million schillings. The growth in health care costs is evident from an examination of the data shown in table 1 on ASVG expenditures from 1961 to 1970. The cost of hospital care, pharmaceuticals, and physician services (the three largest components of ASVG's expenditures) increased by 176 percent, 154 percent, and 137 percent, respectively, during this period. Between 1961 and 1969 the average monthly earnings of blue-collar workers in manufacturing did not even double.

[2] The white-collar worker's contribution to the sickness fund is lower than that of the blue-collar worker because the sickness fund pays out less for cash sickness benefits for the former. Employers pay sick leave of 100 percent for up to 12 months to salaried workers.

TABLE 1.—Health expenditures of the ASVG, by type of service, 1961 and 1970

Service	1961		1970		Percentage increase
	Amount (in millions of schillings)	Percentage distribution	Amount (in millions of schillings)	Percentage distribution	
Total	3,546	100	8,047	100	127
Doctors	738	21	1,748	22	137
Hospital care [1]	679	19	1,873	23	176
Pharmaceuticals	548	15	1,389	17	154
Dentists	248	7	486	6	96
Appliances	53	2	116	1	121
Dentures	65	2	137	2	109
Maternity	252	7	615	8	144
Extended and preventive health care	64	2	128	2	100
Death benefits	54	1	145	2	167
Cash sickness benefits [2]	788	22	1,283	16	63
Transportation [3]	57	2	127	2	124

[1] Includes an insignificant number of nursing homes
[2] Sick-leave, family allowances, and daily cash benefits
[3] Payments made to patients whose physical conditions or distance from home to hospital require special transportation
Source Josef Juch, "Entwicklung der Leistungen in der Krankenversicherung nach dem ASVG 1961-1970," in *Soziale Sicherheit*, November 1971, p 366

The insurance carriers have had to allocate a growing proportion of their income to cover the costs of hospital care. The cost of hospital care went up more rapidly than any other major component of health care. Within ASVG it increased 176 percent from 1961 to 1970 (health expenditures in general went up 127 percent). In 1970 total ASVG outlays for hospital care amounted to 23 percent of health expenditures, compared with 19 percent in 1961. The average cost per day of hospitalization has almost tripled since 1961. These increases are attributed in part to the increased use of more expensive equipment, treatments, and drugs, as well as a rise in staff wages. Increased utilization has not been a significant factor in the ASVG: The number of cases of hospitalization per insured person dropped between 1961 and 1967 and has increased only slightly since then.

Expenditures for pharmaceuticals—17 percent of ASVG expenditures in 1970—increased by 154 percent between 1961 and 1970. During the same period, the number of prescriptions increased at approximately the same rate as the number of insured persons. The disproportionate rise in the cost of drugs reflects a variety of developments—improvements in quality, a tendency toward prescribing larger quantities of more expensive drugs, and an increase in the number of pensioners. In 1970, for example, pensioners and their dependents accounted for 43 percent of total expenditures for drugs, although they represented only 30 percent of the membership.

An analysis of total ASVG reimbursements made to physicians shows that cost increases have resulted from a combination of more visits to the doctor and higher physician fees.[8] During the period 1961–67, the number of cases increased by 24 percent and the cost per case almost doubled —going from 54 schillings to 104 schillings. At the same time, the number of persons insured under ASVG increased by only 7.5 percent. The income of doctors is based primarily upon the number of patients treated, so the general practitioner tends to refer all but the simplest cases to specialists. Because of this increased use of higher-paid specialists and the transformation of the general practitioner into a "distribution center," fewer students have sought to prepare for general practice. As a consequence, the total number of general practitioners has been declining and the number of specialists has been increasing. In 1969, there were 34 fewer general practitioners than there were in 1968, but 247 more specialists, as the following figures show.

Physicians	1968	1969
General practitioners	5,451	5,417
Private	4,391	4,370
Public	1,060	1,047
Specialists [1]	4,608	4,855
Private	3,252	3,306
Public	1,356	1,549

[1] Excludes dentists.

Several times in the recent past legislative action has been required to raise additional funds to cover deficits in the health insurance system. Beginning January 1, 1971, new sources of income for the program had to be found. Remedial measures included raising the contribution base, increasing the prescription charge paid by the patient, and raising the size of subsidies to the health insurance funds by the pension funds. In addition, the workmen's compensation fund was required to transfer an increased amount to the health insurance funds for the treatment of work-related accidents.

[8] Physician care is a benefit "in kind" and its cost is assumed by the sickness funds who pay the physicians directly. The sickness funds and the various medical professional groups negotiate to determine the scale of reimbursement.

FINDINGS

The commission sought to determine longer-range solutions to the financial problems of the sickness funds. New methods of financing have to be developed to meet the anticipated increasing costs of providing medical care to the Austrian people. The commission foresaw that a system of periodic health check-ups for the entire population (possibly financed through a tax on tobacco and alcoholic drinks as in Germany and Switzerland) could, by early detection of certain diseases, serve to reduce hospital utilization and costs. Individual members of the commission favored Provincial or even Federal management of hospitals to promote efficiency. Many hospitals are now owned by towns and districts that are having difficulty in sustaining the deficit operation.

In addition, the commission recommended establishing a contractual arrangement between drug producers and the social insurance institutions to govern the price of drugs. A further source of revenue was seen in greater Government subsidization.

Recent Publications*

HEALTH AND MEDICAL CARE

PACHI, MARGITH. *The Use of Hospitals by Blue Cross Members in 1970.* (Blue Cross Reports, Research Series 8.) Chicago: Blue Cross Association, 1971. 11 pp.

A longitudinal study based on a national sample of Blue Cross membership: also includes utilization data for Federal employees and their dependents enrolled in the Government-Wide Service Benefit plan.

"The Nation's Health: Some Issues." *Annals of the American Academy of Political and Social Science*, vol. 399, Jan. 1972, entire issue. $3.

Contributions by various authors organized under the headings: "Medicine: The Poor, The Sick, The Student," "Hospital and Physician Costs and Charges," "The Experience with Medical Provision and Insurance Programs in the United States," and "Problems of Health in the United States in Perspective."

PUBLIC WELFARE

BERNSTEIN, BLANCHE. *Welfare and Income in New York City.* New York: Center for New York City Affairs, The New School for Social Research, 1971. 34 pp $1.50.

Analyzes income and welfare data from 1969 to examine claims concerning the number of persons eligible for assistance.

CATALYST. *Part-time Social Workers in Public Welfare.* New York: Catalyst, 1971. 56 pp. PODELL, LAWRENCE. *Evaluation Research Report on the Catalyst Demonstration Project. . . .* New York: Catalyst, 1970. 55 pp.

A report and an evaluation of that report on a demonstration project in Boston in which mature women college graduates were employed half-time by the Massachusetts Department of Public Welfare

COMMUNITY COUNCIL OF GREATER NEW YORK. BUDGET STANDARD SERVICE. *Annual Price Survey: Family Budget Costs, October 1971.* New York: The Council, 1972 80 pp. $3

Data on the impact of rising prices on family living costs in New York City.

ESTERLY, STANLEY, and ESTERLY, GLENN. *Freedom from Dependence: Welfare Reform as a Solution to Poverty.* Washington: Public Affairs Press, 1971. 178 pp. $6.

Focuses on the idea of income maintenance and discusses the Family Assistance Plan.

HANDLER, JOEL F. *Reforming the Poor: Welfare Policy, Federalism, and Morality.* New York: Basic Books, 1972. 168 pp. $5 95.

Discusses major forces that have shaped welfare policy, describes legal and administrative issues, considers reformation by "deterrence" and "rehabilitation," and includes a section on the Family Assistance Plan.

MORRILL, RICHARD L, and WOHLENBERG, ERNEST H. *The Geography of Poverty in the United States.* New York: McGraw-Hill, 1971. 148 pp. $4 95.

Considers salient social, political, and economic factors; describes the geographical distribution of poverty, explaining different levels and types of poverty in different areas; and evaluates current and suggested anti-poverty measures.

New Strategies for Social Development: Role of Social Welfare. (Proceedings of the XV International Conference on Social Welfare, 1970) New York: Columbia University Press for the International Council on Social Welfare, 1971. 356 pp. $10

Discussions include consideration of human resources and national development in developing countries, innovative changes, and United Nations programs for social development.

Public Welfare, vol. 29, Fall 1971, entire issue. $2.

A series of articles on the theme "To Be Old and Poor Is To Spend Time Waiting"

Public Welfare, vol. 30, Winter 1972, entire issue. $2.

A report on the National Round Table Conference of December 1971; contributors include Elliot L. Richardson, Robert M. Ball, and Wilbur J. Cohen.

REIN, MILDRED, and WISHNOV, BARBARA. "Patterns of Work and Welfare in AFDC." *Welfare in Review*, vol. 9, Nov.–Dec. 1971, pp. 7–12. 35 cents.

RESCHER, NICHOLAS. *Welfare: The Social Issues in*

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