Hinrichs, Karl

Working Paper

Social insurances and the culture of solidarity: The moral infrastructure of interpersonal redistributions - with special reference to the German health care system

ZeS-Arbeitspapier, No. 03/1997

Provided in Cooperation with:
University of Bremen, Centre for Social Policy Research (ZeS)

Suggested Citation: Hinrichs, Karl (1997) : Social insurances and the culture of solidarity: The moral infrastructure of interpersonal redistributions - with special reference to the German health care system, ZeS-Arbeitspapier, No. 03/1997, Universität Bremen, Zentrum für Sozialpolitik (ZeS), Bremen

This Version is available at:
https://hdl.handle.net/10419/41547

Karl Hinrichs

Social Insurances and the Culture of Solidarity: The Moral Infrastructure of Interpersonal Re-distributions - with Special Reference to the German Health Care System

ZeS-Arbeitspapier Nr. 3/97

Centre for Social Policy Research
University of Bremen
Parkallee 39
D-28209 Bremen

Revised version of a paper presented at the conference on "Comparative Research on Welfare State Reforms", Research Committee 19: "Poverty, Social Welfare and Social Policy", International Sociological Association, Canberra, 19-23 August 1996. I gratefully acknowledge the valuable comments on an earlier draft by Ulrike Götting, Claus Offe, and Heinz Rothgang.

Abstract

Social insurance schemes have proved to be rather stable welfare state institutions enjoying broad popular support. It is widely assumed that the high degree of legitimacy is due to the insurance analogy because those schemes provide individually equitable returns on prior contribution payments. In this article it is demonstrated that all social insurance schemes contain interpersonal redistributions on a large scale, resulting from uniform contribution rates, provisions geared at social adequacy of benefits, and unequal treatment of different birth cohorts. In Germany, those redistributive elements are most pronounced in the statutory health care scheme. It is argued that the unchallenged functioning of social insurances is dependent on a prevailing culture of solidarity. It denotes an immunity to the temptation of individual utility maximization based upon recognized moral duties which then facilitates ongoing redistributive processes. Results from qualitative interviews with persons insured with the German statutory health care scheme clearly indicate the presence of those solidary virtues. The continued existence of this moral infrastructure appears to be less threatened by progressing individualization. Rather, it might be eroded by current political attempts to shift the balance between solidarity and self-reliance which intensify mistrust in the permanence of comprehensive health care protection.

Contents

1. Introduction

Social insurance schemes are ingenious constructions. In general, this social technology has been quite successful in reducing the distressing consequences of (typical) market risks of wage labor and enjoys broad support among the insured. It could be applied to various social contingencies, and, once introduced, social insurance schemes have proved to be *politically stable* and highly "path dependent" welfare state institutions. Almost nowhere they have been abandoned completely. Rather, political reforms have left their basic principles untouched. And while retaining their institutional structure those schemes have been *flexible* enough as to broaden coverage, to increase initially exiguous benefit levels, and to extend and differentiate entitlement criteria. This paper deals with those basic principles, their contribution to the lasting stability and support of social insurance schemes, and under which conditions these "arks of continuity" could possibly run into jeopardy.

Beside a few other welfare states of continental Europe (Austria, Belgium, France or Italy), Germany can be characterized as *the* "social insurance state" *par excellence*: About 40 percent of the general government's outlays is caused by the various social insurance schemes, and roughly two thirds of total social expenditure (according to national calculations) are made up by these schemes. This amounted to more than one fifth of GNP in 1994 what signifies their substantial impact on the economy.

Very often, the roots and the road taken toward a "social insurance state" are associated with *Bismarck*'s name. However, as an element of the state-building process the *original* "Bismarck approach" was different (cf. Hunkel 1909; Hentschel 1983: 11-29.): Instead of functionally different organizations a unified agency should hand out largely tax-financed benefits to the "soldiers of work". Nevertheless, social insurance legislation in Germany during the 1880s influenced other European countries' social security development albeit the process of "transnational learning" was definitely not a one-to-one adoption of the German model, rather, only certain elements were carried over. And in other countries, after sometimes thorough consideration, the "German" approach was outright rejected due to different cultural and political traditions, socio-economic circumstances and/or administrative capacities, and a completely different design for nationalizing social security was chosen instead (Ritter 1989: 86-101; Henning 1991 - both with further references).

The German and other welfare states of the European continent have been classified as belonging to the "corporatist-conservative" cluster (Esping-Andersen 1990). This label contains the connotation of "backwardness" whereas the "socialdemocratic" welfare states, based on citizenship, being more ambitious for redistribution, and achieving a higher degree of de-commodification,

appear to be the more "modern" variant.[1] In the following I want to show that, although most pure tax-transfer schemes require a higher tolerance for interpersonal redistributions, social insurances, based on contributory financing, are far from being unambitious in this respect: Their aims and effects stretch beyond an undemanding consolidation of unequal market results and preservation of the attained status differences. These redistributive properties are only inadequately grasped by Esping-Andersen's (1990) formally applied concepts of "de-commodification" and "stratification". In his analysis the impact of internal, non-actuarial balancing in *social* insurances is underestimated as are, in consequence, the requirements on part of the contributors to acquiesce in those processes.

My argument is that the broad support for and, hence, the political stability of these welfare state institutions are dependent on and indeed rest upon a *culture of solidarity*. It denotes an immunity to the temptation of individual utility maximization, based upon recognized *moral*, not just effective *legal* (and hence, in essence, contingent) duties. To a large extent, this *moral infrastructure* is the result of formative side-effects on part of the insured due to the lasting existence of those schemes because, like other successful institutions, they perform a "socializing function" in that they generate and cultivate congruent cognitive and moral standards (Offe 1996). The cultural legacy of embodied solidarity norms and their continuous validation are central to the institutional "character" of social insurance schemes. In contrast, all *private* insurances pursuing an actuarially fair treatment of their policy holders can do without a culture of solidarity. Therefore, its prevalence is especially imperative for the legitimacy of a statutory health care insurance, like the German, where substantial non-actuarial redistributions in various dimensions are taking place. The main thesis of this paper is that progressive individualization and emerging mistrust in the continuity of this centerpiece of the German welfare state could possibly lead to a waning of that underpinning of loyalty, and political attempts to reconstruct and partly privatize this scheme would be eased after it has lost its plausibility and attraction.

In the next section (2.) I will outline central principles and characteristics of social insurance schemes, demonstrate their consonance with the functioning of a market economy and the insured persons' expectations regarding reciprocity, and outline the elements of interpersonal redistribution inherent to *social* insurances. In establishing those redistributions the features of private insurance are used as a

1 This largely negative valuation of the social insurance approach is consonant with Titmuss' (1974: 30-1) earlier characterization of the "industrial achievement-performance" model of social policy as a "handmaiden" model because social insurances mainly "insure" for or reproduce (labor) market inequalities (see also Marshall 1992: 102, 121, 141; Heimann 1929/1980: 241-9; for a critique of this perspective see Leisering 1995).

yardstick. It will become clear that it is necessary to differentiate between branches of social insurance or the risks they cover. Thus, the points of reference in the second section are mainly old-age/disability and unemployment insurance schemes. In the third section the focus is narrowed to statutory health care insurance in Germany. It covers a "special" risk, provides foremost benefits in-kind, and is considerably more ambitious with regard to solidary virtues. In the fourth section I will present results from (primarily) qualitative interviews conducted with persons insured with the German statutory health insurances schemes in order to evaluate the prevalence of a "culture of solidarity". Finally, I will point to some developments that could gradually erode this moral infrastructure on which a social insurance state rests.

2. Principles and Characteristics of Social Insurance Schemes

- Demarcations and justifications

Private insurances and social insurance schemes have in *common* that occurrence of a specified risk event causes a flow of *predictable benefits* if the insured person meets certain eligibility criteria - foremost, having paid premia or contributions previously. The benefits are granted without "demonstrated need" (ascertained by a means test) as a *matter of right*, either conditioned by a private insurance contract or, in case of social insurance, due to the legal specification of the "conditions governing eligibility, and the nature and amount of the benefit" (Burns 1949: 31). Thus, private and social insurance benefits are paid to poor and affluent claimants alike.

However, there are two decisive *differences*: First, insurance with a certain scheme or type of social insurance scheme is universally *compulsory* or, at least, mandatory for selected sub-groups of the collectivity (while others are legally excluded or may join voluntarily on special terms). Therefore, the compulsorily insured have no individual discretion to decide on the amount and the terms of the assigned protection: Both, contributions and benefits are politically fixed. Second, in social insurance schemes no individualized, experience-rated risk premium is levied, rather, a *uniform contribution (rate)* unrelated to the risk status is applied for all members of the insured collectivity.[2] Because of this risk pooling without risk classification, contributory social insurance is not merely "insurance" with only *ex post* redistribution occurring or simple intertemporal reshuffling of life-time income.[3]

2 Where experience rating takes place it is limited to contributions solely paid by *employers* on behalf of their workers as is the case with accident insurance in Germany or unemployment insurance in the United States.

3 This and the following paragraph draw on Atkinson 1991 and 1993; Barr

These characteristics of social insurances follow from the rationale why the state, for reasons of efficiency and social justice, intervenes in the protection against certain economic contingencies and sets up those (quasi-)public organizations. Regularly, explanations and justifications of social insurance legislation follow from (private insurance and capital) *market failure* arguments (myopia, adverse selection, protecting the prudent, merit goods, etc.). Furthermore, since the probability of earnings loss due to unemployment cannot be statistically calculated beforehand and is not independent across insured individuals, virtually, no private unemployment insurance could work.[4] And, beside "uninsurable risks", benefits provided by private insurers can hardly be protected against unanticipated inflation or be index-linked to have actual beneficiaries participating in real income growth. This is a most important issue of old-age security (Barr 1993: 195-8 and 216-7; Berthold 1988). Finally, a "monopolistic" and publicly organized and regulated agency needs not to burden their insured with marketing costs and profits. It can, at least in principle, operate at low administrative expenses due to large scale and standardization and is, different from private insurances, not exposed to the threat of economic failure (Beveridge 1942: 277-86; Bismarck, cited in Hunkel 1909: 56-7; Thompson 1994: 8-9). The last aspect is notably important for a retirement program which has to bridge a very long time-span and hence requires durability as well as flexibility (de Swaan 1988: 179-81).[5]

1993 (especially Ch. 4-5 and 7-9); Thompson 1983. Thompson (1994: 4-6) also lists various elements to be included in a definition of "social insurance".

4 Therefore, even public unemployment insurance schemes occupy a special position within the social insurance system: Almost everywhere they are *centralized* schemes in order to balance occupational and regional differences in the national unemployment rate. Furthermore, they are protected from becoming overtaxed due to high and lasting unemployment and large numbers of long-term unemployed: Most schemes in EU countries provide for subsidies out of tax revenues and have a second tier of tax-financed (means-tested) benefits foremost for the long-term unemployed and others who are not or no longer eligible for unemployment insurance benefits (Europäische Kommission 1996: 346-65). In Germany, the unemployment insurance does not belong to the social insurance system in the narrow sense: Those sections of the Basic Law (*Grundgesetz*, sections 74 and 120) referring to "social insurances" separately mention "unemployment insurance" (see also section 4 SGB [*Sozialgesetzbuch*] I and section 1 SGB IV). This borderline position also shows up in the German Employment Promotion Act which lays down that the contributory principle applies both to unemployment benefits and measures of active labor market policies: The "insured" are called "persons liable to contributions" (*beitragspflichtige Personen*), whereas in the laws on the public pension scheme and statutory health insurance the term is "compulsorily insured persons" (*versicherungspflichtige Personen*).

5 Those arguments in favor of state intervention and public organization of social insurance schemes are not undisputed (see e.g. Berthold 1988; World

However, compulsory insurance is required not only to have the potentially imprudent making their contribution but also if the state, for reasons of setting up a *social* insurance, aspires to have low-risk groups contributing to the benefits of high-risk groups.[6] A uniform contribution (rate) results in an *ex ante* redistribution in favor of the risk-prone members when one unit of benefit has the same (average) "price" irrespective of individual risk status and, hence, makes insurance participation affordable for the high-risk individuals (without granting them tax-financed subsidies). This type of interpersonal redistribution (and others as well, see below) can take place only if the low-risk groups are denied the chance to opt out and take out private insurance contracts where mainly *ex post* redistribution occurs.[7]

- *Employment-centeredness*

Regularly, compulsory membership of a social insurance scheme and the payment of contributions to that scheme is dependent on the engagement in certain economic activities - mainly earning an income from *employment*. Although very often self-employed persons are compelled to partake in social insurance schemes, originally, they were introduced to secure (industrial) workers against typical economic contingencies associated with wage labor, and employees still represent the point of reference for the political acknowledgement and institutional transformation of social risks. Those typical contingencies were associated with a "presumptive need" for income replacement and/or in-kind benefits, and the spreading of wage labor under industrial capitalism contributed to the necessary standardization of risk events. Hence, the labor market is not

---

Bank 1994).

6 This is clearly expressed in Beveridge's definition of "social insurance": "The term ... implies both that it is compulsory and that men stand together with their fellows", i.e. that "none should claim to pay less because he is healthier or has more regular employment" (1942: 13; see also Marshall 1975: 55-6).

7 *Ex post* redistribution in private insurances denotes the difference between the premia calculated according statistical probabilities ("experience rating") and the factual occurrence of the insured risk event. It is inherent in any insurance when e.g. in a health care insurance those who fell sick receive benefits while insured who remained healthy do not. *De facto*, most private insurances contain redistribution which stretches beyond pure *ex post* redistribution because assessing every applicant's individual risk and determining the respective premium accordingly is impracticable. Instead, individuals sharing certain risk qualities are combined in risk classes, and it depends on the homogeneity of the members of one and the same risk class to what extent *ex ante* redistribution takes place among them (see e.g. Titmuss 1974: 87-101; Eisen 1980: 539-41).

only regulated by labor laws aiming at the preservation of the marketability of labor power to retain workers' independence from (substitutional or supplementary) public transfers. Complementary to these measures of protecting earnings (capacity), compulsory social insurance schemes confer on the *voluntary labor contract* between private actors a *public status* because the labor contract is the legal foundation for enforced contribution payments to as well as for the subsequent entitlements to benefits from social insurance schemes. Thus, the private labor contract is joined by the state as a "third partner" (see also Marshall 1975: 54-5).

The employment-centeredness of social insurance schemes entails an *enforced solidarity* of the actually employed with those members of the risk collectivity who are permanently or temporarily out of employment. Therefore, solidarity is also *exclusive*: Only those persons who have not always been poor or outside *gainful* employment and have made prior contributions are entitled to benefits from the solidarity funds when they are presumed to be in need.[8] These recipients have passed the "eye of a needle" of covered employment and, thus, had been at pains to provide for themselves and their families.[9] This condition establishes a moral difference between social insurance beneficiaries and the recipients of tax-financed welfare, i.e. it separates the "respectable workers" having property-like claims from the "less eligible" others.

- Employers' interests and the status of the beneficiary

Among other reasons, it is this (exaggerated) distinction why, apart from the petty bourgeoisie in the beginning, employers, by and large, have not opposed attempts to collectivize the typical risks of wage labor (de Swaan 1988:
167-71). If one leaves aside the original "Beveridge approach" of flat-rate contributions for uniform benefits, almost all social insurance schemes providing *cash* benefits are based on *earnings-related contributions*, and benefits are linked to previous (life-time/best years' or last) earnings. Hence, it could be assumed that social insurance schemes would not run

8 On the problem of confining social insurance to persons who are both in *need* of protection against social risks and *able* to provide for those states of need, see Eveline Burns, quoted in Perrin 1984: 410 (n. 68) and Perrin 1984: 402-8.

9 Beside own employment there is only *one* further route to attain access to benefits, namely, receiving "derivative" benefits by virtue of being a *dependent family member* of a formerly or presently insured person (see below). Therefore, social insurance schemes are also "marriage-centered" (Hinrichs 1996; cf. Esping-Andersen 1996).

counter to the industrial work ethic, rather, would promote the "telescopic faculty" (Alfred Marshall) of a not yet "modernized" and "domesticated" working class and the establishment of a deferred gratification pattern.

Over and above this contribution to internalizing workers' willingness to engage in continuous, disciplined and dependent employment as a life-long necessity, the ascertained expectation (*Erwartungssicherheit*) to be protected against the vicissitudes connected with wage labor is undoubtedly conducive to the motivation for industrial work. Insofar, "de-commodification" represents an advantage for employers that has not to be wrested from them against their consent (Lenhardt/Offe 1977).

The fact that in most social insurance schemes the employers participate in the financing of social insurance contributions can be regarded as documenting "responsibility" for their workers' welfare. However, employers' responsibility does not stretch beyond their obligation to pay their mandated share of contributions:[10] Due to their predominantly compensatory objectives social insurance schemes *externalize* social risks, and they *nationalize* solutions for those problems at a calculable and equal (and, in the beginning, low) price for all competing employers.[11] This results in increased productivity. In addition, collectible wage replacement benefits open up the opportunity to get rid of surplus workers and no longer or less productive (disabled/older)

---

10 It is obvious that these liabilities represent *withhold wages* which, together with levied employees' contributions, flow back to the insured in case of risk occurence. And it is no longer contested that employers only *pay* the contributions falling to them. Actually, they *do not bear* these contributions (implying squeezed profits) although the ultimate incidence of this direct tax on employment is hard to ascertain. Generally, it is assumed that there is a variable mixture of shifting them *backward* to wages and *forward* shifting to product prices, depending on which market is "weaker" (Groser 1994). Despite the illusion about "employers' contributions", in the first place, higher contribution rates imply a *mandated increase of total wage costs* determined outside collective bargaining, and employers face the challenge to either have this increment being taken into account during subsequent bargaining rounds or accomplish correspondingly higher product prices at the market. A third alternative to offset the cost increase is to enhance labor-saving rationalization measures. Then it would drop back on labor as well - in a *selective* fashion due to more redundancies.

11 In Germany, it was foremost the fact that employers and employees completely or largely financed the social insurance schemes via contributions which qualified them to participate in decision-making and established the principle of *self-administration* by representatives of employers and employees (tripartism, including state representatives, is only in force at the board of the unemployment insurance system). This feature was not so much an outflow of the corporatist tradition. Today, the scope for autonomous decisions of the self-administrative bodies is rather narrow. They are subordinated to legal interventions (Wertenbruch 1981).

employees without encountering serious social conflicts.[12] An advantage for the economy as a whole is that the nationalization of social security helps to establish a national labor market and, thus, enhances growth-promoting *labor mobility* while not forestalling the strategic development of internal labor markets by additional employer-sponsored programs.

It is contributory financing as such that *permits* social insurance benefits to be higher than the means-tested minimum level, and the earnings-relatedness of contributions *justifies* differential benefit levels to protect accustomed standards of living (if, in principle, the original hierarchy of market wages is considered legitimate). Mandated payments "irrespective of the means of the contributor" (Beveridge 1942: 12) distinguish contributions from (progressive income) taxes. And this *social insensibility* generates "a claim to benefits irrespective of means" (Beveridge 1942: 12, cf. 107-8) because individual gross earnings without any exemptions, (family) allowances or other manipulations to be applied in any income tax system represent the sole basis for the capacity to pay a proportional contribution rate. If the benefits correspond to the principle of *individual equity* they are "earned" at any level and materialize as "deferred wages", immune from political discretion. This conceptualization gives rise to question whether it is actually appropriate to classify social insurance expenditure as "public social spending": Whereas taxes are clearly forced income *reductions*, social insurance contributions can be conceived as mandated income *utilization* which, in functional perspective, are not different from (additional) private provisions against certain risks by intertemporal shifting of life-time income (TEK 1981: 42-4).[13]

But social insurance benefits not only *can* be higher than assistance benefits, they also *have to exceed* them and, furthermore, have to be differentiated according to previous earnings in order not to interfere with the incentive structure of the labor market and established wage inequalities: If workers follow the presumed normalcy of the life-course implying continuous work according to standard conditions under the premise that it maximizes the life-time return then it *has* to pay off (while "cheating" through illicit work does not): "otherwise the insured persons

---

12 Especially during the last decade externalizing strategies of employers to refer substantial parts of the labor force to various pathways to social insurance benefits (foremost early retirement) have resulted in collective moral hazard so that, via an impaired beneficiary/worker ratio, they are now confronted with higher contribution rates (see also Esping-Andersen 1996).

13 In order to generate broad popular support for the old-age insurance program (OASI) enacted in 1935, U.S. Social Security Administration was eager to promote an ideology and evocative semantic that it was analogous to private insurance (Derthick 1979: 198-205).

get nothing for their contributions" (Beveridge 1942: 141).[14] The perspective to be *deserved* to more than (means-test) minimum benefits and indeed to be granted a higher benefit level subsequently has four effects: (1) It makes wage labor and the endeavor to attain higher earnings more attractive. (2) It adjudges to the recipients of social insurance benefits a non-stigmatizing, reputable status.[15] (3) The appeal of graduated benefits in return for earnings-related contributions renders possible the ready incorporation of the wage-dependent middle classes as the higher contributions they pay to these schemes prove to be beneficial to them as well.[16] (4) This leads, for the sake of legitimacy and broadening the ranks of "defenders", to a "waste" of public transfers: Necessarily, "social insurance states" have a larger welfare expenditure volume than countries which rely on a (lax) targeting approach and tax-financing, like Australia or New Zealand (Castles/Mitchell 1992).

In sum, social insurance schemes, combining legislated obligations and individual responsibility, seem to be *morally undemanding* and should be well protected against popular discontent if the following institutional properties apply (Offe 1990: 180-5): *Earmarked contributions* are paid into separate funds. The contributors are assured that these revenues are spent on *designed purposes* only and shielded from the government's appropriation. They can also be sure that benefits are exclusively *restricted* to persons who have previously demonstrated their willingness and ability to engage in covered employment *and* have not triggered those "event-conditional transfers" due to individual misbehavior. *Compulsory insurance* as well as the *state control and guarantee* of the arrangements strengthen the insured's confidence that their claims to benefits will actually be met at some time or other in the future. And the close tie-up between benefits and workers' earnings records leaves no doubts that these are always *equitable returns*. In Germany, the public pension scheme comes closest to this "ideal" of mandatory (or "heteronomous") self-help because, of all branches of social insurance, it is most "insurance-like".

But contributory social insurances are not private insurance programs

---

14 This has in fact happened in Britain: An ever larger number of previous contributors to National Insurance receives benefits (much) lower than the means-tested assistance level (Alcock 1996).

15 cf. Kohli 1987; Beveridge 1942: 11. For a list of characteristics conducive to low political conflict potential of social security systems, see Øyen 1986.

16 Beveridge's flat-rate logic of treating alike "the poorer man and the richer man" (1942: 108) is less attractive to the middle classes since a uniform cash benefit provides no status maintenance. On the other hand, the "poorer man" paying the same contribution becomes overburdened if the benefits are fixed at a level factually sufficient to meet minimum needs *and* if they are supposed to be exclusively financed out of contribution revenues (which was not Beveridge's intention).

run by the government, rather, do combine the concepts of *commutative* justice and *distributive* justice (Zacher 1987: 592-3). They are a matter of "political risk balancing" (Lauer-Kirschbaum/Rüb 1994: 44) when certain deficient life-situations are considered as socially conditioned and individually non-manageable, are politically acknowledged to be compensated, and, hence, are legally furnished with typified entitlements to benefits in order to stabilize individuals' future and maintain societal integration. Thus, *political* (and not: actuarial) *risk balancing* via social insurance schemes includes deliberate interpersonal redistribution on the revenue (contribution) side as well as on the expenditure (benefit) side. But these institutions which, in the first place, produce solidarity by compulsory membership *cannot provide net benefits for all members at any time*. Thus, because sheer self-interest will not do their long-term feasibility, hence, hinges upon the familiarized recognition of social norms and redistributive principles embedded in the formal (legal) rules of the respective scheme, i.e. a *moral infrastructure* that supplies them with legitimacy.

- *Ex ante redistribution*

Ex ante redistributions emanating from uniform contribution rates (see above) are taking place in both the *horizontal* and *vertical* dimension.[17] Those processes need not to be outright "offensive" if different risk classes according to age (of entry), health status, sex (= different longevity and morbidity), (non-)hazardous working conditions etc. are *not* taken into account, rather, all insured are assumed to bear an *equal* ("average") *risk*. However, disregarding risk differentials of which everyone knows that they are indeed important make up the cognitive element of a moral effort when low-risk individuals who would fare better with no insurance at all or a private insurance based on experience rating are called on to solidarity payments. To put up with this demand without complaining and not trying to individually or collectively escape compulsory insurance becomes questionable if one's *own risk* is assessed to be permanently below average or, what would be a principal-agent problem, *other insured* can be suspected to deliberately induce the risk event that triggers a flow of benefits. The possibilities for "moral hazard" are virtually absent in schemes providing old-age or disability pensions. A birth certificate or unbiased medical expertise clearly substantiate the entitlement (if further provable requirements are fulfilled as well).

But sickness and notably unemployment insurance are different: *Sickness insurance* provides workers with "a modicum of discretionary

17 An example: In a public pension scheme the high risk (*sic*) of women having a greater life expectancy mainly results in horizontal redistribution whereas the lower longevity of the lower social strata entails vertical redistribution.

choice as to whether to work or to pursue alternative activities" (Esping-Andersen 1990: 154). Medical certification, waiting days and other means are thus applied not only to discourage workers from malingering (*"krankfeiern"*) but also to *assure the prudent* that their contributions are properly spent. Whereas the risk to fall ill or to become disabled is universal, the threat of actually becoming unemployed can be (nearly) ruled out by large segments of the work force. It means that, in contrast to a public pension scheme, an *unemployment insurance* is not potentially beneficial for the entire insured population. Moreover and independent of the factual incidence, it is widely assumed that unemployment is often self-inflicted and its duration consciously prolonged due to the access to benefits. Therefore, of all social security programs it is unemployment insurance which (beside social assistance) generally enjoys the lowest popular support (see e.g. Papadakis/Bean 1993: 234-6; Roller 1996). Again, work tests, low replacement ratios (in most countries considerably lower than prevalent in other branches of the social insurance system), and a short duration of benefit eligibility are used to combat moral hazard behavior as well as to remove the misgivings of the regularly employed that funds are spent on people *not* "like us" (Sanders 1988).

- *Interpersonal redistribution for the sake of social adequacy*

Almost all redistributions taking place within social insurance schemes are interpersonal even if merely aims of intertemporal shifting of resources were pursued, e.g. from the young to the old or from the healthy to the sick. But only accidentally do benefits correspond to the principle of *actuarial fairness*: Most social insurance schemes providing *cash* benefits are "defined-benefit plans" where neither varying contribution rates during previous covered employment nor the total amount of prior contributions are taken into account, and, very often, the time when contributions were paid is relevant only as to whether benefit eligibility actually exists. Different from private schemes, the level and stratification of benefits are unrelated to *contributions*. Their payment merely establishes individual entitlements and serves the purpose to balance the scheme's current expenditure on benefits for the risk affected ("unhappy") persons or the preceding generation. Only the underlying (and somehow indexed) *earnings record* matters when (inflation-proofed or otherwise adjusted) benefits are computed. And the standard replacement ratios and respective deviations thereof are *politically* fixed according to sometimes conflicting judgements on appropriateness, proper incentives, financial viability, etc.[18] These distortions of actuarial fairness alone do

18 Regularly, in old-age and disability insurance programs the benefit level is determined by (1) the assessed income, (2) the length of the contribution period, and (3) the accrual factor (OECD 1988: 67-74). In unemployment and sickness

not contradict the conception of *individual equity* if the link between prior earnings and benefit level remains identifiable so that the *image* (and popularity) of a quasi-contractual relationship - "prepaid" benefits on a *quid pro quo* basis - can be sustained.

However, almost all benefit formulas and eligibility rules contain provisions aimed at *social adequacy* of benefits levels. They moderate the principle of individual equity, and by altering the structure of benefit claims the state is relieved from direct redistributive efforts by means of tax revenues. A few examples might suffice to demonstrate the incidence of these *intra*generational redistributions which in Germany are labelled as "sozialer Ausgleich" (*social balancing*): Due to the progressive benefit formula applied in the U.S. public pension scheme a relatively greater percentage of average lifetime earnings is replaced for low-wage workers than for high-wage earners, and noncontributory family supplements result in higher benefit levels for couples (with children) than for singles (in Germany, the replacement rate for the unemployed depends on the presence of children). Likewise, the German public pension scheme contains various provisions which result in horizontal as well as in vertical redistributions (in both directions), e.g. credits for child care and periods spent in formal education or military service, the upgrading of low earnings, or less than actuarially fair benefit deductions in case of early retirement. The same is true for the Swedish superannuation scheme which, among others, has been particularly beneficial for working women so far (Ståhlberg 1990, with further references). Furthermore, almost all old-age insurance programs include survivors' benefits, thus, entailing a different total benefit return from individually equal contributions depending on marital status.[19]

Again, those *distortions* of a strict, although not actuarial connection between contributions and benefits need not to be offensive. Notably horizontal redistributions in favor of families should not give rise to substantial discontent because the situation whether one is positively or negatively affected regularly changes during a "normal" life-course. But vertical redistributions for the sake of socially adequate benefit levels demand forbearance of contributors whose returns (replacement rates) are accordingly lower. Scholars of public finance argue that due to the

---

insurance the length of the contribution period plays no or a less significant role if a minimum period necessary to qualify is accomplished.

19 One could argue that survivors' benefits and contribution-free health benefits for family members (see below) represent an element of an *extended ex ante* redistribution and not of social adequacy. For conceptual reasons I prefer to stick to the distinction: *Ex ante* redistribution refers to the revenue side whereas redistributions aimed at social adequacy relate to the benefit side, and intergenerational redistributions (see below) combine both sides. - For an overview of provisions in social insurance schemes of EU member countries which imply the interpersonal redistributions discussed in this section, see Europäische Kommission 1996.

equivalence principle the resistance against (rising) contributions is significantly lower than against (higher) taxes, and a perceptible weakening of the insurance analogy would endanger this definite advantage of social insurance institutions (Mackscheidt 1985; cf. Beveridge 1942: 11-2 and 119). At the same time, the status of certain recipients of social insurance benefits is injured because they have not "earned" their benefits (completely). Finally, extensive interpersonal redistributions within those schemes imply higher than otherwise necessary contribution rates, possibly resulting in allocative distortions including negative employment effects if employers' non-wage labor costs are increased.

Therefore, it has been demanded to completely finance benefits or benefit elements which stretch beyond the principle of individual equity out of the general tax revenue, either within social insurance schemes (via subsidies) or outside as distinct benefits (Mackscheidt 1985; Schmähl 1995) although the concrete definition of those benefits (*versicherungsfremde Leistungen*) has always been disputed (TEK 1981: 246-9). Such a regrouping would not alter the status of certain beneficiaries. However, it would be conducive to the legitimacy of contributory financing, reduce the contribution rates, and to summon all taxpayers could be justified for distributional ends. In Germany, those demands have received much political attention after unification when the volume of benefits "alien" to social *insurances* but not covered by corresponding federal subsidies increased substantially (Hinrichs 1995b: 662-3).

These arguments refer to a tradeoff which has been discussed at length in the United States with regard to the precarious balance of the competing principles of individual equity and social adequacy inherent in Social Security (see e.g. Brown 1977; Meyer/Wolff 1993; Thompson 1983): Giving clear priority to the first principle keeps resistance of both workers and employers against contribution payments low and makes plain the obligation to self-help. But it results in benefit levels not always surpassing poverty thresholds and gives rise to the argument why not mandated *private* insurance instead. Leaning toward social adequacy reduces the frequency of supplementary assistance benefits, but a greater sense of solidarity is asked from other insured at whose expense this redistribution takes place. Moreover, it increases the similarity to a tax/transfer scheme, thus, endangers the property-like claims, destroys the myth of a "fair return", and heightens the political vulnerability to arbitrary interventions.

- *Intergenerational redistributions*

If one leaves aside for a moment the two types of interpersonal

redistributions discussed before, all redistribution occurring would be exclusively intertemporal (or *intra*personal) on condition that a *complete stationary state* for all relevant parameters existed. Among others, this would include a zero-growth economy, constant demographic variables, and "matured" social insurance schemes with fixed beneficiary/worker ratios and no changes of benefit levels. Since their inception, such a situation has never been given for any of these schemes. Therefore, always interpersonal redistributions between insured belonging to different birth cohorts have taken place, i.e. that succeeding cohorts had to pay a different "price" for a same amount of benefits or vice versa. These *intergenerational transfers* are unavoidable in social insurance schemes which operate on a pay-as-you-go basis as more or less all of them do. Only funded schemes which base benefit levels on "defined contributions" can be actuarially fair on intergenerational terms (however, they are never completely immune to demographic shifts).

Social insurance schemes need not to be funded. But they have to attain an *internally balanced budget*, and, therefore, pay-as-you-go financed schemes presuppose structural flexibility on both the revenue and the benefit axis because originally exogenous factors (like demographic variables, employment level, or economic growth) are transformed into *endogenous* elements of their financial viability. The required flexibility to maintain the solvency of the schemes is ensured by the state's continuing power to force citizens into social insurances and to demand contributions from them as well as to change eligibility criteria and benefit levels (Beveridge 1942: 13; Marshall 1975: 56). This entails a variable relationship between contributions and benefits.

Intergenerational redistributions are largely irrelevant in unemployment or sick pay insurance, where positive and negative transfers are confined to the respective generation of employable age. They are, by definition, of substantial concern for old-age pensions and, to a large extent, also for in-kind benefits (health and long-term care) where generations with a different relationship to the labor market are tied together. The metapher of the "generational compact" is a conceptualization of those institutional arrangements that have to overcome the temporal cleavage of contributing to and receiving benefits from them. The term is meant to integrate different generations by appealing to the cohorts of employable age that, if they support the *no longer* economically active generation (and in health care the *not yet* employed generation as well) according to the prevailing levels of protection, their contributions generate claims to benefits met by succeeding generations. Thus, a pay-as-you-go financed public pension scheme implies a revolving build-up and repayment of an implicit debt, and only if the scheme is abandoned completely there will be a "doomsday" generation whose claims remain unfulfilled.

During the phase of non-maturity those old-age insurance programs

had the advantage of immediately "blanketing-in" all elderly people who have not had the opportunity (or obligation) to lengthy prior contribution payments. The accruing "windfalls" for the first generations of beneficiaries helped much to enhance the popularity of social insurances in the United States after 1939 or in Germany after the fundamental pension reform of 1957 while, in addition, improved benefit levels and relaxed eligibility criteria could be enjoyed at a still low burden for the contributing insured (Hinrichs 1993). Dissatisfaction with the privileges for certain generations should have been negligible because, to a large extent, the active contributors were relieved from the obligation to individually support aged parents. However, by approaching maturity the internal rate of return of contributions fell for each succeeding cohort, and due to population aging, implying a deteriorating worker/pensioner ratio, it can be expected to decline further. Numerous calculations have been carried out to demonstrate that cohorts who have recently or not yet entered employable age will even face a *negative* rate of return: The benefits they can expect are not worth the rising contributions they are doomed to pay (for an overview see Leimer 1995). Those calculations, using private protection as a reference point, highlight a weakness of the contributory approach which is commonly assumed to be its particular strength compared to tax-financing: Whereas the various (and partly "invisible") taxes paid are used for the universe of public spending without any specific assignment, the explicit connection of revenues and spending purposes in social insurance schemes (see above) gives cause for an individual evaluation of the contributory burden in view of expected benefits.

Without going into a detailed critique of "money's worth" analyses it seems questionable whether the alternative of private funded provision for old-age (or health and long-term care) would actually be more attractive due to the "fallacy of composition" argument (Barr 1993: 217-35; Wagner 1985: 152-3, 158-9). Nevertheless, those results correct the false image of "earned" benefits because, in fact, contribution payments only qualify to receive them. And they help to reinforce the already widespread *pessimism* among younger workers that contribution rates will go up further whereas the maintenance of present benefit levels (and age of retirement eligibility) appears hardly feasible. From an *individual* perspective, striving for private provision (insurance) appears to be the altogether more advantageous and sustainable alternative which also involves the temptation of not being forced to spend fixed portions of one's earnings in a certain way. Hence, instead of binding together different generations a sense of growing *intergenerational inequities* occurring within certain social insurance schemes can give rise to a perspective of generational cleavages. For the sake of the stability of these schemes (especially younger) workers in covered employment have to swallow a variable and, above all, impaired contribution/benefit ratio (in whatever

variant it materializes) for themselves. It includes to acknowledge that social insurance schemes are not designed to maximize the internal rate of return of one's contributions, rather are adaptable institutions providing calculable as well as dynamic *security* under changing conditions (Wagner 1985: 155, 164). However, to acquire a taste for this perspective presupposes confidence in the political promise of security. And, in view of increased contribution rates, they must not fear that employers' "normal" reaction to higher non-wage labor costs will threaten their job security.

Before entering the questions why, despite their inherent interpersonal redistributions in three dimensions, social insurance schemes have enjoyed a high degree of legitimacy so far and why these schemes might possibly lose their unassailable status I will turn to the German statutory health care insurance where the scope of interpersonal redistributions is even more pronounced than in other social insurance schemes.

3. Health Insurance Is Different and Even More Ambitious

Health insurance is "different" from other social insurance schemes in several respects: First of all, health is consistently considered the most valued "good" and always tops the ranking list of central life-interests (Statistisches Bundesamt 1994: 438-45) because sickness and accidents impair the decisive material basis of the freedom to act which conditions all other individual freedom possible. "Health" is thus *the* most basic need. In contrast, old age is not a misfortune and not bearing comparably dramatic implications for individuals and families: According to an appraisal of the income needed one can individually save for this work-free phase of life one is regularly hoping to enjoy although the "risk" to outlive one's accumulated assets remains. Life insurance contracts or a public old-age insurance can cover this risk. For a large segment of the labor force the occurrence of unemployment is a more unforeseeable event. However, at least according to market liberal wisdom, by lowering one's reservation wage the dependency on substitute resources can be minimized. But it is completely *unforseeable* (and individually almost non-susceptible) *whether* and *when* one has to lay claim to health care benefits. Furthermore, neither the amount of those benefits needed nor whether medical treatment will actually restore one's health is calculable. And whereas a reduction of public pensions or unemployment benefits down to absolute poverty levels would not instantly cause serious consequences, no longer granting medically possible benefits according to need is tantamount to *rationing* and, due to the fatal effects if one possibly cannot afford the full range of medical services, would alarm the currently healthy but virtually eligible persons as well. Therefore, universal and *comprehensive* - i.e. *medically adequate* - health care

coverage is a core element of social protection. Because direct contacts with the health care system are usually more frequent than with other social welfare agencies it can be assumed that individual experiences effectively influence the public's conception of the welfare state and support for it.

Except for Denmark, in all OECD countries social insurance contributions are levied to cover the consequences of poor health. Of course, in typical "social insurance states" the contribution-financed share of expenditure is considerably higher than in those countries with a tax-financed national health system (like the U.K.). Whatever the mix of revenues, two types of benefits are provided: First, *income replacing benefits* are paid to sick employees. Usually, during workers' sickness (and depending on the length of the period) one finds a combination of (reduced) wage continuation payments by the employer, social insurance benefits replacing former wages at a certain percentage, and, sometimes, waiting days where sick employees themselves have to shoulder the income loss. Whereas a less than hundred percent replacement of wages is clearly aimed at lowering the rate of absenteeism, the rationale for employers' wage continuation payments is to prevent an exploitation of insurance funds and to intensify their endeavors for providing sound working conditions. For that part of the cash benefits which is financed out of earnings-related contributions there is no categorical difference to unemployment insurance benefits.

Second, medical services are provided (or their costs are reimbursed) which ease the strain on individual resources due to health-related expenses. Like other benefits in-kind, they are, in effect, *income enlarging* (although, since medical services rarely yield original utility, they rather represent "loss-compensating benefits"). In all developed countries, public health care spending is dominated by medical services. In Germany, due to employers' wage continuation payment usually expiring after six weeks of illness, earnings-related cash benefits of the statutory health insurance system amount to less than eight percent of total expenditure while the costs of medical treatment make up for almost all the rest.

It is not necessary here to describe the structural features and peculiarities of the German statutory health insurance system (*Gesetzliche Krankenversicherung*), which covers about 90 percent of the German population (for details see Hinrichs 1995b: 664-8, with further references). Most relevant is however that all three types of interpersonal redistribution discussed above take place here as well and even on an altogether larger scale.

(1) The renunciation of experience rating implies a considerable volume of *ex ante* vertical and horizontal redistribution, particularly, since individual health risks vary widely. Even "pre-existing conditions" do not imply a rejection of chronically ill persons, the exclusion of benefits for

certain diseases, or a higher than the uniform contribution rate.[20] Furthermore, the scheme is not immune against attempts to alter the individual risk status (malingering, hypochondria and other forms of "over-utilization" resulting from third-party payment).

(2) The scope of interpersonal redistribution is increased because *family members* (children and spouses) who have no earnings or are only marginally employed are insured at no extra cost. They are covered under the scheme of the principal insured who contributes to the sickness fund.[21] From a cross-sectional perspective, this redistribution mainly occurs on the horizontal level. Longitudinally, to a large extent, this arrangement amounts to an intertemporal, life-cycle redistribution.

The most important deviation from the principle of individual equity, however, stems from the fact that funds are allocated and benefits in-kind are distributed according to a prevailing *dualism of principles*: The *ability to pay* determines the revenue side when earnings between a lower threshold and a maximum ceiling make up the sole base of calculating the amount of individual contributions.[22] In contrast, all insured are

---

20 Whereas in the other social insurance schemes the contribution rates are fixed at a uniform level, in health insurance, actually, the rates vary across the sickness funds due to the different risk structures of their respective membership and their members' average level of earnings although all provide an approximately equal package of benefits. Cross-subsidies between sickness funds in place since 1994 and aimed at to balance risk differentials and revenue structures have narrowed the range of contribution rates (Hinrichs 1995b: 666, 672). It implies that members of sickness funds which end up with a negative balance of those cross-subsidies have a larger proportion of their consequently increased contribution rate used for solidarity purposes than before.

21 Therefore, more housewives taking up covered employment and a declining birth rate reduce the volume of this type of interpersonal redistribution. But in German statutory health insurance former housewives do not gain additional benefits when they enter employment. In this respect the effects are much the same as with U.S. Social Security providing spouse benefits: Many employed women pay contributions which do not materialize in higher public pensions.

22 Insofar, the vertical redistribution aimed at "social balancing" has a cut-off point when earnings exceeding that ceiling are excluded from participating in this process. Furthermore, employees with earnings above the contribution assessment ceiling (1996: DM 6,000 per month in West Germany) are not compulsorily insured. They can become (remain) voluntary members or opt out in favor of private health care coverage (if they become/remain voluntary members of the statutory health insurance they pay the maximum amount as a lump-sum contribution based on the prevailing assessment ceiling). The problem with this provision has always been that these groups can either opt for the pure self-help principle (i.e. going private) or the solidarity principle (voluntary members) whatever appears to be more beneficial for them, e.g. in view of their family size or "pre-existing conditions".

equally entitled to medical service benefits, which are in no way related to the length or amount of previous contributions. Utilization exclusively depends on medical need and is, in principle, unlimited.[23] This dualism of differentiated contributions and *always* medically adequate benefits (or: complete dissociation between the amount paid and consumed) makes this scheme morally more demanding than the other branches of social insurance due to the *vertical* interpersonal redistributions it entails.[24]

It also gave rise to the question whether the term "insurance" is really appropriate and contributions to the German statutory health insurance actually represent a proportional earmarked tax (on certain kinds of income) with an upper cap. A weak and not fully convincing argument in favor of a conceptualization as a social *insurance* scheme is that for high-wage employees the medical services received are of greater worth to them because they help to restore or maintain a higher earnings capacity (Schmähl 1985).

(3) Intergenerational redistribution occurs between employed and retired persons: In principle, pensioners remain members of the same sickness fund they belonged to before retirement and they continue to pay contributions. These are calculated on the basis of their (normally) lower public retirement benefits. One-half of the contribution is deducted from the pension benefit, and the other half, the "employer's share", is transferred by the public pension agency. Because the elderly are disproportionate "consumers" of health care benefits, the retirees' share of total expenditure of the statutory sickness funds is decreasingly covered by their contributions (at present, less than 40 percent[25]), but, effectively, these contributions are as well predominantly borne by the economically

---

23 When "need" comes into play in health care it is clearly "demonstrated need". But it has to be distinguished between the proof of a lack of *means* and the medically determined need of *treatment*. While the gate-keeping function of the medical profession remains unaffected, the costs of medical treatment as such are covered as a matter of right and no means-test applies. However, the statutory scheme in Germany contains an interesting "means-test": Copayments are subject to ceilings on their total amount per year (depending on income level - *Überforderungsklausel*) and to exemptions (mainly for children and persons below a certain income threshold - *Sozialklausel*). In effect, these "stop-loss" provisions imply higher benefits for the poorer part of the sick covered by contributions of the collectivity of insured. At the same time, the more
well-off patients are demanded to bear the full amount of these out-of-pocket payments.

24 This redistributional effect at the cost of high-wage earners (if one disregards individual earnings mobility over the life-course) is moderated by the well known fact, that the middle classes consume a disproportionate share of social benefits in kind (TEK 1981: 62-79; Goodin/LeGrand 1987: esp. Ch. 10). The "beneficial involvement" of the non-poor can be assumed to make them interested in maintaining or improving the quality of services or level of benefits.

active who pay into the public pension funds and not by the pensioners themselves.

This type of redistribution which, viewed from a cohort perspective, is *not* merely intertemporal is continuously on the increase: In 1970 the average contribution rate stood at 8.2 percent (and the assessment ceiling was DM 1,200 per month, which is one fifth of today's level). Of course, a substantial part of the risen contribution rate (at present 13.5 percent) and of the statutory scheme's outlays has to be attributed to "cost disease" factors of the labor-intensive medical sector as well as to strategies of health care providers and increased aspirations of the insured propelling demand for and costs of health care services. But a non-negligible part is due to advances in medical technology. These innovations were mainly to the benefit of elderly patients. Hence, the present elderly have contributed to the health insurance scheme at much lower rates and comparatively small total contribution amounts (but nothing more was expected from them during their working lives) while enjoying an improved level of medical services during their retirement, implying considerable positive life-time transfers.[26] Since the share of retired persons is continuously on the rise as well as is life expectancy of the elderly (i.e. a prolonged retirement phase) further increases of the contribution rate are inevitable. Having in mind the reservations against "money worth" analyses, it has been shown that all cohorts born after 1960/1970 will make payments to the statutory health insurance *larger* than the present value of their life-time benefits (Schulenburg 1989; Behrens 1991). The degree of intergenerational inequity would come out to be even higher if future advances in medical technology and an inflation rate of health care benefits constanly exceeding the development of gross wages were taken into account.[27]

---

25 It means that about one third of the contribution rate of the economically active insured is used to subsidize the retirees' health care consumption.

26 Insofar, the recently introduced *long-term care insurance*, meant to complete the social insurance system, is very similar: It involves new types of benefits and a changed mode of financing, and will nearly treble the previous volume of public (hitherto: largely means-tested) expenditure on long-term care after complete implementation. This institutional innovation contains re-distributional provisions analogous to those occurring in health care insurance, namely, (1) a legally fixed *uniform* contribution rate of 1.7 percent levied up to the same earnings ceiling, (2) *no extra contribution* for non-employed family members, graduated benefits for domiciliary and nursing home care solely according to the need of the frail person (although the benefits are not completely needs-oriented: due to an upper limit on each of the three grades they do not in any case cover the full costs of professional care). (3) Persons already in need of long-term care are *immediately eligible* for full benefits from this unfunded scheme which amounts to considerable "windfalls" for the elderly generation of today (for more details, see Hinrichs 1995a).

27 However, if the more recent birth cohorts were equally allowed to take

4. Health Care Insurance - the Attitudes of the Insured

The patterns of "social balancing" and *ex ante* as well as intergenerational redistribution reflect the *logic of solidarity* in German statutory health insurance, and the emanating interpersonal redistributions far beyond a pure insurance model are politically intendend or, in case of unequal treatment of different birth cohorts, are considered unavoidable. But young, male, healthy, single, and high-wage earners have to acknowledge that these redistributive mechanisms operate at *their* disadvantage.

Proposals aimed at a reduction of the redistribute effects have been brought forward by actors adhering to a market liberal doctrine. They play a more or less prominent role in the ongoing reform debate (Hinrichs 1995b: 674-9): (1) Introducing or increasing copayments and deductibles are advocated as means to fight "over-utilization" (moral hazard behavior) and to reduce the volume of collectively financed health care. At the same time, these changes would partly reindividualize the financial consequences of health risks and hence curtail the effectiveness of the components of solidary redistribution. Excluding benefits for diseases which are contingent upon individual behavior or levying surcharges for risky (mis-)behavior ("malus model") would also help to approximate contributions and individual risk status which are diverging due to the uniform contribution rate. An equivalent strategy, also bearing a regressive impact, would be to refund a certain percentage of contributions if no benefits had been claimed over a defined period of time ("bonus model"). (2) The abolition of free insurance for non-employed (adult) family members or a lowered ceiling of earnings liable to contributions would reduce the statutory health insurance's internal volume of "social balancing". (3) Finally, a partial funding of the public scheme's future outlays, to remove a wide range of services from the catalogue of covered benefits or not to include new, costly medical therapies are proposed in order to curtail intergenerational redistribution. And extending the contributory base of pensioners to all income sources would immediately make the elderly pay a greater share of their health care consumption.

It can be assumed that those insured who are aware of their high-risk status (e.g. the chronically ill) or due to their constant low earnings can expect to be "net beneficiaries" will readily *accept* this scheme and do not want to see it changed in the direction of more "insurance". But for what reasons should the other insured without such self-interested motives

---

advantage of medical progress like their predecessors their life-time contributions would not necessarily surmount the value of benefits received. Then the accumulative process would shift the increased intergenerational burden to the succeeding birth cohorts.

stand loyal to the present arrangement? A number of plausible arguments can be brought forward which are conducive to broad popular support. I want to list them first before I will present conceivable reasons why acquiescence and support might become endangered. Then these arguments are evaluated in view of empirical results gained from quantitative and qualitative interviews.

The German welfare state presents itself to the public as an extraordinary complex, diversified and unintelligible institutional arrangement. Such a perception has been confirmed by an officially appointed commission which was not able to ascertain conclusive results on the overall distributional effects of the multitude of positive and negative transfers (TEK 1981). Zacher (1987: 594-5) turns this complexity into a positive argument when he speaks of the "blessing of intransparency" that discourages a rational calculation of one's own position in the distributional game and an evaluation of whether proclaimed aims of social justice are actually achieved. Thus, a complex structure also of financing permits a higher level of resources to be extracted from individual incomes. The "ignorant support" might be reinforced by the *useful illusion* of the employers' share to the social insurance schemes which does not appear on the pay cheque. It hides the true costs of social security (TEK 1981: 244).[28]

Furthermore, the long standing existence of social insurance schemes produces formative effects, i.e. *experiences* and *expectations* of continuity which largely exclude positive answers to questions like "how could it be different?" or "what would be the alternative?". Thus, insofar as these institutions are deeply entrenched and commonly perceived as an unchallenged "matter of course" in social life, social insurance schemes and health care insurance in particular deliver what the "product" of *any* insurance is, namely, to provide *information on the security of future life situations* (or normal conditions) and not just to compensate for actually suffered losses (Kaufmann 1973: 254, 300-4, 314). If social security for oneself and others is taken for granted the need to bother about details is reduced. It also means to refrain from actively gathering complete information on the working of social insurance schemes. Rudimentary knowledge promotes notions of self-help, reciprocal relationships, redistribution over the life cycle etc. and thus consolidates the myth of an "insurance" analogy.

Whereas the above arguments refer to a *habitual* or passive pattern of

---

28 The German statutory sickness funds use a "contract model" in which services rendered to patients are supplied in kind. It enhances the "hiding effect" because the insured have no exact information on the money value of the benefits received and, hence, cannot calculate whether it matches the amount of contributions paid and, thus, private insurance is possibly more advantageous. Furthermore, it removes the incentive to retreat to "over-utilization" if unavoidable contributions exceed the amount of hitherto received benefits.

support or (cognitive) indifference, the *legitimacy* of interpersonal redistributions according to the types ascertained in the two previous sections is dependent on a *conscious acknowledgement* of social norms and moral intuitions which have led to the incorporation of the respective provisions. Without corresponding moral dispositions these redistributions become a potential source of conflict and compulsory social insurance as such precarious. The necessary "culture of solidarity" was build up and became entrenched in the course of welfare state development and *stabilized* its institutions. However, the behavioral orientation to comply with norms of social justice and ethical standards and, hence, setting aside narrow self-interests cannot be enforced. It rather has to be confirmed and revived by *discoursive justification* of principles embedded in programs and their respective provisions and by reccurent appeals to moral intuitions and obligations which, when adhered to, would contribute to social integration. The post-war compromise on the concept of "social market economy" was the ideological (and largely consented) platform for political parties (at least, the two large *Volksparteien*) and other collective actors to promote the culture of solidarity in a *Sozialstaat* (which is the German version of a constitutionally vested welfare state).[29]

Since health (care) is "special" (see above) one can presume that the culture of solidarity is most effective (and resistant to erosion) in this branch of the social insurance system. If the involved redistributive provisions lose their plausibility the support for other schemes should be eroded even further. One can distinguish two complementary strands of arguments why the tolerance for interpersonal redistributions and the support for statutory health care insurance is diminishing.

(a) It can hardly be ascertained whether the adherence to principles of solidarity was stronger or more common in the past. However, the ongoing processes of *individualization* have reduced the biographical relevance of traditional social institutions, dissolved social milieus, and lead to a greater heterogeneity of life situations. Welfare state activities (notably education) have contributed to this process. Hence, an unconditional commitment to norms of solidarity and other inculcated duties can no longer be expected while the definition and formation of common interests are harder to overcome. Having more options *and* being pressed to deliberately decide on one's biography does not spare welfare state institutions from being approached strategically in view of individual utility, especially since they no longer (if ever) convey a sense of community (*Gemeinschaft*) emanating from occupational, class or local affiliation when they nowadays cover almost the whole population and are

29 The juridification (*Verrechtlichung*) of claims of the insured emanating from section 20 of the German Basic Law (*sozialer Bundesstaat*) and related decisions of the Constitutional Court have to be regarded as an effective barrier against political interventions. It guarantees a *comparatively* greater stability of social protection than in a number of other European countries.

perceived as large, anonymous, bureaucratic entities. It is possible that the subjective appraisal of "costs" and "benefits" leads to misinterpretations of one's own location (this would be the "*evil* of intransparency"). If it turns out unfavorable - not the least, because the value of the promise of "security" is generally underestimated as against the perception of negative transfers - the legitimacy of embedded principles could be questioned and support withdrawn.

(b) Since the guarantee of "security" is the central product of social insurance schemes it is important that on part of the insured stable expectations on the continuity of this promise and the future "price" one has to pay for it exist. *Confidence* in the stability of these institutional arrangements could be shaken by simple common sense considerations: Foremost due to high unemployment contribution rates have been increased several times while the level of benefits and access to them were curtailed. The possibilities of further increases in order to cope with the aging process, advances in medical technology etc. appear limited especially since, in view of economic globalization, the need to reconstruct and streamline the system of social security is emphasized time and again in the public discourse. And the consequences of frozen contribution rates on the benefit quality are easy to recognize by everyone.[30] Under these circumstances, reforms which are proclaimed to "stabilize" the respective schemes might be suspected to infringe on expectations of "security": Social risks which were believed to be firmly redressed at high levels re-emerge as uncertainties due to "rule instability" which is one aspect of what Lindbeck (1994) calls "policy-induced risks".[31] If instrumental concerns are no longer displaced by "a healthy dose of ritualism and conservatism" (Offe 1996: 200) fading confidence in the guarantee of "security" is likely to prompt reflections on the distributional principles of social insurance schemes and, in anticipation of further deteriorations, on alternative modes of protection, hence, leading to diminishing loyalty. This situation corresponds to the prerequisites for continuing an *assurance game*: It works as long as the expectation prevails that the future will be like the past; otherwise an accelerating

30 The recently implemented long-term care insurance in Germany is designed to operate on a fixed contribution rate. In view of rising numbers of beneficiaries (due to population aging) and foreseeable price increases of professional care a restricted budget implies a declining real value of benefits so that the needs of frail people will be met to an ever lower degree (Hinrichs 1995a).

31 This relates to Scitovsky's (1976) distinction between (*dis-*)*comfort* and *pleasure*: The introduction of a social benefit (like health care) should have generated *pleasure* because a discomforting life-situation was changed for the better. When its existence is simply "taken for granted" this experience is superseded by *comfort*. Attention is renewed when (potential) beneficiaries become aware that cuts or other deteriorations are at stake which arouse fears of an imminent state of *discomfort*.

breakdown of the game is initiated. Therefore, effectively upholding the public's belief in the reliability of the promise of "security" springs up as an additional challenge of the welfare state (defenders).

One significant finding from our *interviews* with *employed* members of the statutory sickness funds is that almost all respondents emphasized the importance of being amply protected against the vicissitudes and contingencies related to their health.[32] Mandatory insurance is welcomed for *autopaternalistic* reasons, and there are only very few objections to earnings-related financing of needs-based benefits. The answers of the insured confirm that the present public arrangement can still maintain the secure expectation of having equal access to competent and adequate medical treatment at any time and *even* in the long run.[33]

Most of the insured interviewed were generally content with the range of benefits, the level of contributions and the system as a whole.[34] They want comprehensive, high quality benefits and are willing to pay for them. Despite the fact that the health care system is a central feature in nearly every person's everyday life, exact knowledge of the "price" (the rate or the amount of monthly contributions) and details of entitlement are not widespread. Very often, members' information is vague or even incorrect (see also Alber/Ryll 1990; Kaufmann 1973: 284-5), however, in most cases it is absolutely sufficient in view of decisions they can or have to make. Insofar, the insured persons show a rational behavior in acquiring information.

Although it can hardly be factually true most persons *believe* they are "*net contributors*" to the system (due to their earnings level, their good health in past and present, or not having a large family insured free of charge) and generally accept this subjectively assumed imbalance of benefits and contributions. Extreme *risk aversion* is at the bottom of one cluster of answers: Here the constant threat to fall ill precludes any

---

32 The report of the study "Gesetzliche Krankenversicherung und sozialpolitische Kultur" (financed by grants from the *Deutsche Forschungsgemeinschaft*) which is based on seventy-four qualitative interviews will be published in 1997 (co-authors: Karl Hinrichs, Claus Offe, and Carsten G. Ullrich). Lack of space prevents me from quoting interview passages which would provide an enriched picture of the (non-)compliance of the insured with the scheme's principles and characteristics.

33 This optimistic assessment we found in 1993 when the interviews where carried out should no longer be accurate. Annually conducted surveys applying identical questions clearly demonstrate a quite dramatic decline of positive expectations of one's well-being as well as of the satisfaction with the political system after 1993. Perceptions of future insecurity and mistrust in the robustness of the social security system and the political manageability of problems have grown in 1994 and again in 1995 (Forschungsschwerpunkt Sozialer Wandel 1996).

34 This result has been repeatedly confirmed by representative quantitative surveys (Rinne/Wagner 1995; MAGS 1995: 64-72).

calculation of one's distributional position and attempts to alter it. Simply *being* comprehensively insured stands above any other consideration.[35] Another cluster of reasons refers to the desirability of benefits: Classifying oneself as a "net contributor" within the statutory scheme does not imply that other members take advantage of a service one would prefer to obtain as well. On the contrary, one is not concerned with striking a more balanced account (in contrast to one's contributions to the public pension scheme). The benefits of the health care system are necessarily associated with a negative - being sick and suffering from this condition. Besides being glad *not* to be a "net beneficiary" now but, realizing future selves, possibly later in life, approval of the system's mode of financing and the occurring redistributions rests on the normatively based and *explicitly* mentioned acknowledgement of the prevailing principle of solidarity: All through it is considered legitimate that insured with low earnings (and/or family members without income) are *not* denied full medical coverage because they are *unable* to pay higher contributions.

Most persons interviewed reject the idea of surcharges for persons who expose themselves to increased "everyday risks" (like smoking or malnutrition) as either not justified or suitable (to change individual behavior) and support the status quo: Oneself *and* everyone else should have unrestricted access to a comprehensive set of health care services when it is needed. Although the primacy of distributing benefits according to medical need is almost never put into question, nearly all respondents are aware of the fact that "over-utilization" takes place in different variants and they regret it. Very often, this goes along with demands for political interventions to obviate this behavior and restore "solidary discipline". Likewise, those who have left the statutory health insurance in order to save contributions should not be given the opportunity to slip back under the "roof" of solidarity.

One crucial question, however, is whether the contributions paid for collective health care are considered too high. Survey research shows that about one-third of the population thinks that health insurance contributions are too high (Dehlinger/Brennecke 1992: 239-41; Rinne/Wagner 1995: 17-9). Findings from our own empirical research do not

35 Only few insured who had the opportunity to choose from sickness funds with different contribution rates had actually changed to a "cheaper" fund in order to reduce their (avoidable) share of "solidarity payments". Inertia, custom, and the (*unjustified*) fear to possibly experience less generous treatment when giving up long-standing membership were the most frequent arguments for not taking options or not even comparing contribution rates. Since 1996 all (potential) members of the statutory health insurance are allowed to choose from nearly all sickness funds. Despite extensive reports in all mass media and concrete advice given how to individually save up to one thousand Deutschmark per year by simply moving to another sickness fund, so far, only a very small percentage of members of sickness funds asking an above-average contribution rate has chosen a "cheaper" one.

confirm this, however. Past increases in the contribution rate have been tolerated as largely justified, and even further increases would not be met with much resistance as long as the health care system is considered efficacious and efficient. However, many interviewees mention concrete possibilities to save on expenditure, chiefly those which would affect providers' behavior and income. But in any case, higher contributions are more readily accepted than the prospect of curtailed benefits. This is hardly surprising because removing a benefit is felt as a greater loss than never having been entitled to it in the first place. Furthermore, it would imply a reduced potential return for already made contributions. But most important should be that contributions and benefits are of differential significance for the respective group of payers and recipients: For the contributors the monthly payment represents a small part of their income whereas the benefit constitutes a major share of the recipients' resources or, in case of health care, is of really vital importance. Therefore, it is the level of benefits that matters most for factual and potential recipients alike and not so much the contribution rate. Although a few persons interviewed supported the idea of copayments for certain benefits as a proper means to contain costs, their extension is generally regarded as a curtailment of benefits and is widely criticized.[36] As out-of-pocket costs, copayments are perceived as more troublesome than the automatic deduction of (increased) contributions from income one never had at one's disposal. Given the generally low level of correct information held by the sickness funds' members (which must not be equated with a lack of interest in the statutory scheme's development), those quasi-curtailments are sure to heighten mistrust in the statutory scheme to deliver all medically necessary benefits.

5. Conclusion

Do the empirical results presented in the previous section imply that there is no reason to worry about institutional destabilization? First of all, they show a limited explanatory power of "rational actor" models. Certain political cultures, institutional settings as well as continuous discoursive confirmation of ideas, values and traditions incorporated in redistributive institutions are suitable for promoting reflexions on the consequences of pursuing "interests" in view of certain "norms". At the same time, this

36 The level of copayments and other forms of cost-sharing by patients is still comparatively low in Germany (OECD 1995: 16-7). Nevertheless, results from a recent representative survey show that no more than 6 percent of the adult population in West Germany favors a further extension of copayments further, whereas 41 percent consider the existing provisions as already too excessive. Similarly, 80 percent oppose the idea of decreasing the contribution rate in response to intensified copayments (Jung 1995: 17-8; for comparable results see MAGS 1995: 124-42).

would explain different "levels" of the culture of solidarity or prevailing visions of distributive justice among countries.

In Germany, and here related to the very "special" but nevertheless "ambitious" statutory health insurance, that moral infrastructure has been *preserved* despite advanced processes of individualization. The widespread acceptance of the present health care system *partly* stems from "institutional fatalism" in which, over time, the basic (formal) rules and their redistributive implications developed a hegemonic, almost natural normative status and thus assure habitual loyalties and uncontested support. In this case, the culture of solidarity is less visible but not absent, and the legitimacy of welfare state institutions and their redistributive impact still depends on a continued reproduction of these (latent) cultural norms.

Most persons are willing to accept the normative obligation to practise solidarity and support the present arrangement and its financial consequences. They reject proposals aimed at to restrict the magnitude of interpersonal redistribution within the health insurance system (see beginning of section 4.; cf. MAGS 1995: 100-23 and 135-42). And, related to the German social security system as a whole, a fundamental restructuring of the system that places a higher priority on individual responsibility would not be in accord with the preferences of most of the population (Dehlinger/Brennecke 1992; Roller 1996). Although no mandate exists for certain political elites to pursue a far-reaching reorganization, substantial changes to this central element of the German welfare state are already enacted or presently dealt with in the legislative process. The direction is quite obvious: restriction of covered benefits, less uniform and universal access to medical care, social rationing, and partial assimilation of the statutory scheme to principles employed in private sickness insurance. Since corresponding proposals cannot be implemented at once, these issues will remain on the agenda, at least as long as the protagonists of "lean welfare" dominate public discourse and strategically disseminate a bleak interpretation of the future of social policy if there would not be a decisive departure from the "vested rights" attitude. But independent of the success of the "more self-reliance" ideology, it is indeed questionable to stick to the employment-centeredness of social security in a post-full employment economy and in an aging society after central normalcy assumptions (on life courses and family patterns) have become obsolete.

These developments already give rise to concerns about institutional destabilization which are intensified by the fact, repeatedly demonstrated for U.S. Social Security, that support and confidence are at odds (Friedland 1994). Our interview results and those from survey research clearly show that the large majority of the insured (the population) prefers comprehensive coverage of medical benefits (MAGS 1995: 130-3; FORSA 1996). But, at the same time, about two thirds of the respondents in a

recent representative survey fear that very soon the statutory sickness funds cannot provide comprehensive coverage for all insured because it becomes "too expensive" (FORSA 1996), indicating an awareness of imminent deteriorations.

The reduced commitment of certain collective actors, notably the employers' association, to statutory health insurance and its principles in combination with constantly emphasizing the need for fundamental reform and frequent policy changes could enhance the public's *perception* of a "crisis" in the welfare state's protection against health risks and, hence, further *destabilize expectations* about the continuance and proper performance of the health care scheme. On the one hand, it would improve the prospects of the protagonists of extended market mechanisms that large parts of the insured fatalistically put up with a gradual reindividualization of health risks. On the other hand, another part would perceive that opting for private insurance is more advantageous or additional private coverage appears to become necessary.[37] This is exactly the group of insured who can afford protection outside the statutory scheme and on whose unquestioned normative recognition of the ongoing interpersonal redistributions *and* solidary contributions the statutory health insurance is crucially dependent. If they are no longer politically encouraged to adhere to norms of solidarity a morally ambitious social institution such as statutory health insurance makes less and less "sense" to them and once curbed "opportunistic" modes of behavior gain the upper hand. Then the remaining majority should have more reasons to be anxious about the unconditional promise to deliver benefits based solely on medical need.

37 Some lessons can be drawn from the German public pension system: The structural reform of 1992 will hold the contribution rate in check without affecting present and future pensioners excessively. But it obviously has not reversed the decline of confidence in the stability of the system and the future adequacy of pension benefits. Younger persons, clearly afraid of massive future deteriorations (Jung 1995: 20), have responded to the perceived insecurity and have enhanced their private savings efforts to provide for old age (Hinrichs 1993).

References

Alber, Jens; Ryll, Andreas, 1990: "Die Krankenversicherung im Bewußtsein der Bevölkerung. Die Welt hinter den Bergen oder Objekt rationalen Kalküls?", *Sozialer Fortschritt* 39: 165-172.

Alcock, Pete, 1996: "The Advantages and Disadvantages of the Contribution Base in Targeting Benefits: A Social Analysis of the Insurance Scheme in the United Kingdom", *International Social Security Review* 49, No. 1: 31-49.

Atkinson, Anthony B., 1991: "Social Insurance", *The Geneva Papers on Risk and Insurance* 16: 113-131.

Atkinson, Anthony B., 1993: "Private and Social Insurance, and the Contributory Principle", in: Nicholas Barr; David Whynes (eds.), *Current Issues in the Economics of Welfare*. Houndmills, Basingstoke/London: Macmillan, 20-44.

Barr, Nicholas, 1993: *The Economics of the Welfare State*. 2nd ed., Oxford: Oxford University Press.

Behrens, Cornelia S., 1991: *Intertemporale Verteilungswirkungen in der gesetzlichen Krankenversicherung der Bundesrepublik Deutschland*. Frankfurt a.M.: Peter Lang.

Berthold, Norbert, 1988: "Marktversagen, staatliche Intervention und Organisationsformen Sozialer Sicherung", in: Gabriele Rolf et al. (eds.), *Sozialvertrag und Sicherung*. Frankfurt/New York: Campus, 339-369.

Beveridge, William H., 1942: *Social Insurance and Allied Services*. Cmd. 6404, London: HMSO.

Brown, J. Douglas, 1977: *Essays on Social Security*. Princeton, NJ: Industrial Relations Section, Princeton University.

Burns, Eveline M., 1949: *The American Social Security System*. Boston: Houghton Mifflin.

Castles, Francis G.; Mitchell, Deborah, 1992: "Identifying Welfare State Regimes: The Links Between Politics, Instruments and Outcomes", *Governance* 5, No. 1: 1-26.

Dehlinger, E.; Brennecke, R., 1992: "Die Akzeptanz der sozialen Sicherung in der Bevölkerung der Bundesrepublik Deutschland", *Zeitschrift für Gesundheitswesen* 54: 229-243.

Derthick, Martha, 1979: *Policymaking for Social Security*. Washington, D.C.: The Brookings Institution.

Eisen, Roland, 1980: "Das Äquivalenzprinzip in der Versicherung. Unterschiedliche Folgerungen aus verschiedenen Interpretationen", *Zeitschrift für die gesamte Versicherungswissenschaft* 69: 529-556.

Esping-Andersen, Gösta, 1990: *The Three Worlds of Welfare Capitalism*. Princeton, NJ: Princeton University Press.

Esping-Andersen, Gösta, 1996: "Welfare States Without Work: The Impasse of Labor Shedding and Familialism in Continental European Social Policy", in: Gösta Esping-Andersen (ed.), *Welfare States in Transition*. London: Sage, 66-87.

Europäische Kommission, 1996: *Soziale Sicherheit in den Mitgliedsstaaten der Union. Stand am 1. Juli 1995 und Entwicklung*. Luxemburg: Amt für amtliche Veröffentlichungen der Europäischen Gemeinschaften.

FORSA, 1996: Einstellungen zum deutschen Krankenversicherungssystem. DAK-Gesundheitsbarometer, o.O. (mimeo.).

Forschungsschwerpunkt Sozialer Wandel, 1996: "Stabilisierung und Ängste. Wohlfahrtsentwicklung im vereinten Deutschland", *WZB-Mitteilungen* Nr. 73 (September 1996): 5-9.

Friedland, Robert B., 1994: *When Support and Confidence Are at Odds: The Public's Understanding of the Social Security Program*. Washington, D.C.: National Academy of Social Insurance.

Goodin, Robert E.; Le Grand, Julian, 1987: *Not Only the Poor: The Middle Classes and the Welfare State*. London: Allen & Unwin.

Groser, Manfred, 1994: "Der Arbeitgeberbeitrag - eine sozialpolitische Illusion?", in: Barbara Riedmüller; Thomas Olk (eds.), *Grenzen des Sozialversicherungsstaates*. Leviathan-Sonderheft 14/1994. Opladen: Westdeutscher Verlag, 205-216.

Heimann, Eduard, 1980: *Soziale Theorie des Kapitalismus. Theorie der Sozialpolitik*. Frankfurt a.M.: Suhrkamp (first: 1929).

Henning, Hansjoachim, 1991: "Bismarcks Sozialpolitik im internationalen Vergleich", in: Hans Pohl (ed.), *Staatliche, städtische, betriebliche und kirchliche Sozialpolitik vom Mittelalter bis zur Gegenwart*. Stuttgart: Franz Steiner, 195-223.

Hentschel, Volker, 1983: *Geschichte der deutschen Sozialpolitik (1880-1980)*. Frankfurt a.M.: Suhrkamp.

Hinrichs, Karl, 1993: Public Pensions and Demographic Change: Generational Equity in the United States and Germany, Universität Bremen, Zentrum für Sozialpolitik, ZeS-Arbeitspapier Nr. 16/93, Bremen.

Hinrichs, Karl, 1995a: "Die Soziale Pflegeversicherung - eine institutionelle Innovation in der deutschen Sozialpolitik", *Staatswissenschaften und Staatspraxis* 6: 227-259.

Hinrichs, Karl, 1995b: "The Impact of German Health Insurance Reforms on Redistribution and the Culture of Solidarity", *Journal of Health Politics, Policy and Law* 20: 653-687.

Hinrichs, Karl, 1996: "Das Normalarbeitsverhältnis und der männliche Familienernährer als Leitbilder der Sozialpolitik. Sicherungsprobleme im sozialen Wandel", *Sozialer Fortschritt* 45: 102-107.

Hunkel, Ernst, 1909: *Fürst Bismarck und die Arbeiterversicherung*. Erlangen: K. B. Hof- und Universitätsdruckerei von Junge & Sohn.

Jung, Matthias, 1995: *Bürger und Staat. Ergebnisse repräsentativer Bevölkerungsumfragen, im Auftrag des Bundesverbandes deutscher Banken e.V.*. Mannheim: IPOS-Institut für praxisorientierte Sozialforschung.

Kaufmann, Franz-Xaver, 1973: *Sicherheit als soziologisches und sozialpolitisches Problem*. Stuttgart: Ferdinand Enke.

Kohli, Martin, 1987: "Retirement and the Moral Economy: An Historical

Interpretation of the German Case", *Journal of Aging Studies* 1: 125-144.

Lauer-Kirschbaum, Thomas; Rüb, Friedbert W., 1994: "Politik mit dem Risiko: Der politische Risikoausgleich bei Krankheit", in: Bernhard Blanke (ed.), *Krankheit und Gemeinwohl*. Opladen: Leske + Budrich, 37-73.

Leimer, Dean R., 1995: "A Guide to Social Security Money's Worth Issues", *Social Security Bulletin* 48, No. 2: 3-20.

Leisering, Lutz, 1995: "Grenzen des Sozialversicherungsstaats? Sozialer Wandel als Herausforderung staatlicher Einkommenssicherung", *Zeitschrift für Sozialreform* 41: 860-880.

Lenhardt, Gero; Offe, Claus, 1977: "Staatstheorie und Sozialpolitik. Politisch-soziologische Erklärungsansätze für Funktionen und Innovationsprozesse der Sozialpolitik", in: Christian von Ferber; Franz-Xaver Kaufmann (eds.), *Soziologie und Sozialpolitik*. Opladen: Westdeutscher Verlag, 98-127.

Lindbeck, Assar, 1994: "Uncertainty under the Welfare State - Policy-induced Risk -", *The Geneva Papers on Risk and Insurance* 19: 379-393.

Mackscheidt, Klaus, 1985: "Über die Belastbarkeit mit Sozialversicherungsbeiträgen aus der Sicht der Steuerwiderstandsforschung", in: *Schmähl (ed.)*, 27-54.

MAGS 1995 = Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen (ed.): *GKV 2000. Einstellungen zu Reformplänen der gesetzlichen Krankenversicherung. Eine Repräsentativbefragung der Bevölkerung Nordrhein-Westfalens*. Düsseldorf.

Marshall, Thomas H., 1975: *Social Policy in the Twentieth Century*. 4th ed., London: Hutchinson (first: 1965).

Marshall, Thomas H., 1992: *Bürgerrechte und soziale Klassen. Zur Soziologie des Wohlfahrtsstaates*. Frankfurt/New York: Campus.

Meyer, Charles W.; Wolff, Nancy, 1993: *Social Security and Individual Equity: Evolving Standards of Equity and Adequacy*. Westport, CT/London: Greenwood Press.

OECD, 1988: *Reforming Public Pensions*. Paris: OECD.

OECD, 1995: *New Directions in Health Care Policy*. OECD Health Policy Studies, No. 7. Paris: OECD.

Offe, Claus, 1990: "Akzeptanz und Legitimität strategischer Optionen in der Sozialpolitik", in: Christoph Sachße; H. Tristram Engelhardt (eds.), *Sicherheit und Freiheit*. Frankfurt a.M.: Suhrkamp, 179-202.

Offe, Claus, 1996: "Designing Institutions in East European Transitions", in: Robert E. Goodin (ed.), *The Theory of Institutional Design*. Cambridge: Cambridge University Press, 199-226.

Oyen, Else, 1986: "The Muffling Effect of Social Policy: A Comparison of Social Security Systems and Their Conflict Potential in Australia, the United States and Norway", *International Sociology* 1: 271-281.

Papadakis, Elim; Bean, Clive, 1993: "Popular Support for the Welfare State: A Comparison Between Institutional Regimes", *Journal of Public Policy* 13: 227-254.

Perrin, Guy, 1984: "A Hundred Years of Social Insurance", *Labour & Society* 9: 179-191, 297-308 and 399-410.

Rinne, Karin; Wagner, Gert, 1995: Zufriedenheit mit dem sozialen Sicherungssystem und seiner Finanzierung in Westdeutschland, Ruhr-Universität Bochum, Fakultät für Sozialwissenschaft, Diskussionspapier 95 - 20, Bochum.

Ritter, Gerhard A., 1989: *Der Sozialstaat. Entstehung und Entwicklung im internationalen Vergleich*. München: R. Oldenbourg.

Roller, Edeltraut, 1996: Abbau des Sozialstaats. Einstellungen der Bundesbürger zu Kürzungen von Sozialleistungen in den neunziger Jahren, Wissenschaftszentrum Berlin für Sozialforschung, Diskussionspapier FS III 96-205, Berlin.

Sanders, Arthur, 1988: "Rationality, Self-Interest, and Public Spending Attitudes", *Social Science Quarterly* 69: 311-324.

Schmähl, Winfried (ed.), 1985: *Versicherungsprinzip und soziale Sicherung*. Tübingen: J.C.B. Mohr.

Schmähl, Winfried, 1985: "Gesetzliche Krankenversicherung: Sachleistungen, Art der Einkommensumverteilung und Wahl der Finanzierungsart", in: *Schmähl (ed.)*, 89-97.

Schmähl, Winfried, 1995: "Funktionsgerechte Finanzierung der Sozialversicherung", *Deutsche Rentenversicherung* Nr. 10-11: 601-618.

Schulenburg, J.-Matthias Graf von der, 1989: "Verteilungswirkungen demographischer Verschiebungen", in: Christian von Ferber et al. (eds.), *Die demographische Herausforderung. Das Gesundheitssystem angesichts einer veränderten Bevölkerungsstruktur*. Gerlingen: Bleicher, 341-369.

Scitovsky, Tibor, 1976: *The Joyless Economy*. New York: Oxford University Press.

Ståhlberg, Ann-Charlotte, 1990: "Lifecycle Income Redistribution of the Public Sector: Inter- and Intragenerational Effects", in: Inga Persson (ed.), *Generating Equality in the Welfare State*. Oslo: Norwegian University Press, 97-121.

Statistisches Bundesamt (ed.), 1994: *Datenreport 1994. Zahlen und Fakten über die Bundesrepublik Deutschland*. Bundeszentrale für politische Bildung, Schriftenreihe Bd. 325. Bonn.

Swaan, Abram de, 1988: *In Care of the State: Health Care, Education and Welfare in Europe and the USA in the Modern Era*. New York: Oxford University Press.

TEK 1981 = Transfer-Enquête-Kommission: *Das Transfersystem in der Bundesrepublik Deutschland*. Stuttgart: W. Kohlhammer.

Thompson, Lawrence H., 1983: "The Social Security Reform Debate", *Journal of Economic Literature* 21: 1425-1467.

Thompson, Lawrence H., 1994: "The Advantages and Disadvantages of Different Social Welfare Strategies", *Social Security Bulletin* 57, No. 3: 3-11.

Titmuss, Richard M., 1974: *Social Policy: An Introduction*. London: Allen & Unwin.

Wagner, Gert, 1985: "Zur Meßbarkeit eines versicherungsgemäßen Risikoausgleichs und der Umverteilung in der gesetzlichen Rentenversicherung", in: *Schmähl (ed.)*, 141-203.

Wertenbruch, Wilhelm, 1981: "Sozialversicherung?", in: Wolfgang Gitter et al. (eds.), *Im Dienst des Sozialrechts. Festschrift für Georg Wannagat zum 65. Geburtstag am 26. Juni 1981*. Köln: Carl Heymanns, 687-713.

World Bank, 1994: *Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth*. New York: Oxford University Press.

Zacher, Hans F., 1987: "Grundtypen des Sozialrechts", in: Walter Fürst et al. (eds.), *Festschrift für Wolfgang Zeidler*. Bd. 1, Berlin: Walter de Gruyter, 571-595.