REPORT IV(1)

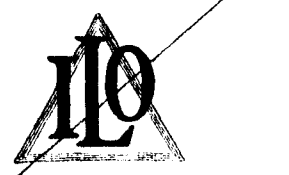
International Labour Conference

TWENTY-SIXTH SESSION

Social Security: Principles, and Problems Arising Out of the War

Part 1: Principles

Fourth Item on the Agenda



MONTREAL
International Labour Office
1944

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PREFACE

The circumstances in which the Governing Body decided to convene the Twenty-sixth Session of the International Labour Conference and the character of the questions placed on its Agenda are unprecedented in the history of the Organisation. The Governing Body considered that the stage had now been reached at which it was imperative that international consideration should be given to the social problems which will arise during the last period of the war and after the close of hostilities, and that it was of the greatest importance that the International Labour Conference should be able to discuss these problems and to take decisions concerning them at the earliest possible moment. It was for this reason that it decided to convene the Conference at the earliest date permissible under the Constitution, namely 20 April 1944, and authorised the Office to submit to the Conference proposals which it might take as the basis of its discussions.

In arriving at these decisions, the Governing Body was of course fully aware that within the time available the usual procedure for the preparation of the Conference could not be followed. This procedure is set forth in paragraphs 5-7 of Article 6 of the Standing Orders of the Conference. These paragraphs are of a special character in so far as they do not regulate the proceedings at the Conference itself but provide for the successive steps to be taken by the Office before the Conference meets. Where a single discussion by the Conference is envisaged, they provide for the circulation to Governments by the Office of a law and practice report and a questionnaire; the preparation of drafts for Conventions or Recommendations by the Office on the basis of the replies of Governments to the questionnaire; and the communication of these reports by the Office to Governments so as to reach them four months before the opening of the Conference.

The principle underlying these provisions was to provide for the communication to Governments of a survey of the law and practice and for the transmission to the Conference of draft proposals based on their replies to a questionnaire before the Conference decided on the adoption of a Convention which, after receiving the approval of the competent authorites, would constitute a binding interna-

tional commitment. Though the principle of such a survey of fact and opinion is desirable whenever possible, it has less practical importance when it is not anticipated that the action of the Conference on a question on its Agenda will take the form of the adoption of a Convention. If the Conference formulates its decision in the form of one or more Recommendations, Members, even if they approve them, are not rigidly bound to apply each and all of their provisions under the system of mutual supervision provided in Article 22 of the Constitution. Moreover, while procedure by means of the adoption of Recommendations leaves this flexibility of application to Members, it also protects the Organisation itself from the danger that in the absence of an adequate survey of practice and opinion Conventions might be adopted on the basis of insufficient information and subsequently fail to secure ratification.

If these points are borne in mind, it will be seen that the departure from the normal procedure which the Governing Body proposes in order to meet the needs of unprecedented circumstances has been carefully designed so as to enable the Conference to exercise its powers in the most effective way possible, while at the same time leaving the Members the necessary latitude in the application of the decisions at which the Conference may arrive.

It is, of course, for the Conference to decide whether it is prepared to follow the suggested procedure. It appears reasonable, however, to assume that the Conference will share the view of the Governing Body that the International Labour Organisation would be failing in its duty if it did not, at the present juncture in the world's affairs, deal by an expedited procedure with the important and urgent questions placed upon its Agenda.

The Office has accordingly prepared the attached Report containing proposals for Recommendations, which the Conference may take as a basis for its discussion, sending them for consideration and report to a Committee of the Conference or dealing with them in plenary sitting as it may desire. In so doing the Conference would recognise that the application of paragraphs 5-7 of Article 6 of its Standing Orders had not been possible in the present abnormal circumstances which clearly were never contemplated when the Standing Orders were adopted.

If more time had been available for preliminary consultation, it might perhaps have been desirable to propose the adoption of Conventions on certain questions at the present Session of the Conference. The subjects dealt with are, however, so broad in scope and developments in regard to them are taking place so rapidly, that it would not seem advisable at this stage for the Conference to adopt Conventions concerning them by an expedited procedure. It may, however, well be desirable that the Conference should at some later date adopt Conventions on some of the questions which are now before it. The knowledge then available concerning the application of any Recommendation which it may adopt on the present occasion will enable it to embody progressively in Conventions those of its provisions in the case of which such action appears appropriate in the light of the experience gained. In order to facilitate such action, if and when desirable, provision has been made in the proposals submitted for reports to be made to the International Labour Office as requested by the Governing Body on the steps taken to give effect to the various Recommendations.

If the Conference approves the suggestions in regard to procedure outlined in the preceding paragraphs, it would be appropriate that it should, when appointing a Committee to consider the present Report, direct the Committee to take the proposals submitted by the Office therein as the basis of its discussion with a view to the adoption by the Conference in the course of the present Session of Recommendations on the question of income security and medical care.

The question of social security principles, and problems arising out of the war, was placed by the Governing Body on the Agenda of the Twenty-sixth Session of the Conference in view of the prominence given to social security as a post-war objective in the Atlantic Charter and by an increasing number of Members individually. The Report on this question, which constitutes the fourth Item on the Agenda, is divided into two parts, of which the first deals with principles and the second with problems arising out of the war.

The present volume is the first part of the Report and consists of two sections, concerning income security and medical care services respectively, followed by proposed Recommendations.

The proposals on income security proceed from the foundation of the series of Conventions and Recommendations adopted by the Conference, especially between 1925 and 1934, on workmen's compensation, sickness insurance, provision for maternity, invalidity, old-age and survivors' insurance, and provision for unemployment. Taking account of the tendency, now manifest in social security planning, to bring together in a single scheme all provisions for assuring maintenance in case of inability to work or to obtain work, and to extend these provisions to all workers, whether employed or self-employed, and whether urban or rural, a comprehensive text has been prepared which embodies the essential principles

already established in international regulations, but amplifies and co-ordinates them.

The proposals on medical care services are of a more original character. The Conventions, and especially the Recommendation, on sickness insurance had, it is true, laid down the principle that medical care should be made available for all employed persons and their families. The Conference, however, had never considered in detail the principles for the organisation of medical care under insurance schemes, while during the war the planning of medical care services on comprehensive lines has been going forward in a number of countries. Thus, so far as the organisation of medical care is concerned, and the standards to be applied in the service, the present proposals had to be based largely on the main trends of opinion as illustrated in the various national plans.

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INTRODUCTION

Income security schemes are intended to afford a secure income in case of inability to work or to obtain work. They are the statutory systems or programmes whereby cash payments are made in these two main classes of contingencies in which a person is deprived of his livelihood. These schemes may have the character either of social insurance or of social assistance: in other words, they may be either contributory or non-contributory from the standpoint of the beneficiary.

During the half century 1880-1930, social insurance was developed as the principal method of affording income security. It took over from poor relief the responsibility for maintaining income, up to a certain level, in a series of well-defined contingencies involving loss of earnings. However, apart from social insurance, and parallel with it in its early development, there grew up a secondary movement to rationalise and improve poor relief for certain categories of needy persons, notably the aged, widowed mothers and the unemployed. These special forms of relief constitute social assistance. Social insurance in its later development has tended to absorb social assistance.[1]

Nevertheless there are important fields in which the absorption of social assistance by social insurance has not been completed: on the contrary there is even a tendency to reverse the process. One of these fields, it may be mentioned in passing, is that of medical care, and the other is that of assistance to mothers and children. In both these fields social assistance loses contact with poor relief and in the second field it becomes an instrument of broad national policy destined to promote healthy childhood and encourage parenthood.

Two countries, New Zealand and Australia, have created or are creating income security schemes which diverge, by their greater

[1] INTERNATIONAL LABOUR OFFICE: *Approaches to Social Security*, Studies and Reports, Series M, No. 18 (Montreal, 1942).

emphasis on social assistance, from the common pattern followed in Europe and in the Americas. In both these countries income security schemes have come into being through the extension of social assistance to ever wider categories of needy persons—to the sick and the unemployed, as well as to the aged, the invalid, widows and children generally. It is true that in New Zealand every resident must contribute 5 per cent. of his income to the cost of the scheme by a special income tax, and that failure to pay the tax may involve loss of cash benefit; but since the cash benefits are, with a single exception, fixed at a subsistence level, and subject to a means test (although a generous one), they have no direct relation to the number or rate of the contributions paid. Consequently the income security scheme of New Zealand forms a class by itself. The income security scheme which Australia is developing is entirely non-contributory and is financed mainly from the general income tax; on the other hand, certain of the benefits, notably children's allowances and maternity benefits, are not subject to a means test.

The social insurance scheme of the U.S.S.R. applies to the entire employed class, but not to the collective farmers, who have their own mutual benefit societies. It contains several features of general interest, such as the active participation of trade unions at all levels of administration and great emphasis on the vocational rehabilitation of the handicapped. Its financial provisions, however, and the fact that the rates of benefits vary with the period of continuous service in a given undertaking are bound up with the special economic structure of the Soviet Union.

The proposed Recommendation on income security relies on social insurance as the principal means of providing cash benefits in case of inability to work or to obtain work. It assigns to social assistance the functions of supplementing social insurance benefits in contingencies of a special or ill-defined character in which such benefits are not provided, and of discharging the eminently national responsibility for creating conditions favourable to the future generation. It is intended to be applicable not only to industrialised communities, but also to agricultural communities if they operate under a money economy. It looks towards the extension, by stages if necessary, of social insurance to the whole working population and its dependants. It envisages a social insurance scheme affording the security of a modest basic income in all contingencies involving inability to work or to obtain work. It does not call for benefits higher than the lowest that peoples trusting in the Atlantic Charter might expect. If it is anchored to the contribution-benefit principle, that is because the view is taken that the economic relation between society and the individual must consist in a fair

reciprocity of rights and obligations, although one that should be tempered by other practical and humane considerations.

The adoption of a contributory basis for the principal form of income security scheme implies no criticism of the value of the non-contributory schemes, such as those of New Zealand and Australia, in which the limitation of a means test may be considered to be compensated for by the advantage of universal coverage and immediate effectiveness. But it is believed that there is only a small minority of countries which would, at this stage at least, be prepared to introduce non-contributory schemes on these lines.

The proposed Recommendation takes as its foundation the series of Conventions and Recommendations on the various branches of social insurance[1], including unemployment insurance[2], which have been adopted by the International Labour Conference, chiefly during the decade 1925-1934. It introduces, however, a number of novel features, drawn partly from legislation enacted since the regulations in question were adopted and partly from bills or reports of national commissions which carry considerable authority and have been widely discussed by the public. In particular, the social security plans of Great Britain[3] and Canada[4] and the Wagner-Murray-Dingell Bill introduced in the United States Congress in June 1943[5], and the proposals of the National Resources Planning Board of the United States[6], have been drawn upon for indications of what experts believe to be both feasible and desirable set-ups for comprehensive income security services.

On the other hand, no account is taken of plans, however great their intrinsic interest, which are sponsored by private persons or groups.[7]

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[1] Cf. *International Labour Code*, pp. 289-370.

[2] *Ibid.*, pp. 25-39.

[3] *Social Insurance and Allied Services*, Report by Sir William BEVERIDGE (London, H.M. Stationery Office, and New York, The Macmillan Company, 1942). Summarised in *International Labour Review*, Vol. XLVII, No. 1, Jan. 1943, pp. 46-57.

[4] *Report on Social Security for Canada, prepared by Dr. L. C. Marsh for the Advisory Committee on Reconstruction* (Ottawa, King's Printer, 1943). Summarised in *International Labour Review*, Vol. XLVII, No. 5, May 1943, pp. 591-612.

[5] 78th Congress, 1st Session: *Congressional Record*, 3 June 1943, pp. 5342-5346. Summarised in *International Labour Review*, Vol. XLVIII, No. 3, Aug. 1943, pp. 247-250.

[6] NATIONAL RESOURCES PLANNING BOARD: *Security, Work and Relief Policies, Report of the Committee on Long-Range Work and Relief Policies to the National Resources Planning Board* (Washington, D.C., 1942); *After the War—Toward Security* (Washington, D.C., Sept. 1942). Summarised in *International Labour Review*, Vol. XLVII, No. 4, Apr. 1943, pp. 450-465.

[7] There is, for example, a proposal which is receiving some attention in Great Britain whereby the whole apparatus of social insurance and social assistance would be superseded by the payment of a subsistence allowance to every man, woman and child in the country. See Lady RHYS WILLIAMS, D.B.E.: *Something to Look Forward To: A Suggestion for a New Social Contract* (London, Macdonald, 1943); A. T. HAYNES, and R. J. KIRTON: *Income Tax in Relation to Social Security*, Paper submitted to the Institute of Actuaries, London, on 14 May 1943; and *Economist* (London), 11 Sept. 1943.

The resulting text is offered as the outline of what appears to be a desirable and practicable income security programme for gainfully occupied persons in the light of present tendencies of legislation and planning.

In order to keep the text as short as possible, a number of details of relatively minor importance which have been mentioned in the Conventions and Recommendations have here been passed over. The whole subject of equality of treatment for national and foreign workers and the maintenance of migrants' pension rights has been left for consideration on another occasion, should revision of the existing permanent provisions on this subject become desirable. Similarly all those provisions of the relevant Conventions and Recommendations which concern medical care have been left to be dealt with in the proposed companion Recommendation on medical care services.

The proposed Recommendation, should it be adopted, could of course not supersede the Social Insurance Conventions or the Unemployment Provision Convention, which retain their legal validity until replaced by other Conventions. But the Recommendation should prepare the way for changes in legislative practice sufficiently wide and uniform to supply the basis for revised Conventions.

SOCIAL INSURANCE

A. Contingencies Covered

Range of Contingencies to Be Covered

The range of contingencies or risks which can and should be covered by social insurance extends to all the principal occasions in which a worker is deprived of the opportunity to earn by physical disability or unemployment, and includes the death of a worker who leaves a dependent family. Such is the thesis of the proposed Recommendation.

These contingencies are everywhere classified under the heads of sickness, maternity, invalidity, old age, death of breadwinner and unemployment. Such is the classification which experience has shown to be expedient in order to adapt benefits to real differences among the needs resulting from the variety of the situations in which a worker and his dependants are deprived of their livelihood. Each of these various situations also has its peculiar implications for the amount of benefit it may be prudent to provide and for the contribution and behaviour conditions to which the grant of benefit should be subject.

All the contingencies just enumerated involve loss of earnings, but there are certain other contingencies which involve substantial expenses beyond the ordinary—expenses which are likely to strain the family budget but which fortunately are susceptible of being covered by social insurance; they include, for example, burial expenses and the cost of domestic help where the wife is incapable of housework.

Sickness, invalidity and the death of the breadwinner if due to an employment injury are, by legislative practice resting on a long tradition, distinguished from the corresponding contingencies due to other causes. They give rise to compensation for loss or reduction of wages at the sole expense of the employer. Workmen's compensation for industrial accidents and occupational diseases, which we here venture to call for short "compensation for employment injuries", is an institution that was invented to supersede court actions invoking the employer's liability at common law for injury

due to his negligence. Compensation, however, should not preclude court action where the injury is due to failure of an employer to comply with some legal regulation for the safety or health of workers, or to any act or omission on his part which is an offence under criminal law.

Sickness

Sickness as viewed by social insurance is characterised by the presumption that it involves total incapacity which is temporary in duration. The patient must abstain from his work while under medical care and, it may be, during convalescence. As a rule he will be able to return to his former job: it is inappropriate therefore to expect him to seek some physically easier job until it is clear he will not be able to resume his previous work.

It is everywhere the rule to pay no benefit unless the sickness lasts a few days at least. This rule is justified by the saving in benefit and administrative expenses which results from the exclusion of insignificant illnesses and which enables a higher benefit or one of longer duration to be paid in cases that involve substantial loss of earnings.

Sickness terminates with recovery, death or transition to invalidity. The majority of laws still set a limit of 26 weeks to the duration of sickness benefit and provide that persons whose incapacity extends beyond that limit shall be deemed, provisionally at least, to be invalids. However, the opinion is gaining currency that the rational criterion for determining the transition from sickness to invalidity should be a medical and not an arithmetic one. No doubt the vast majority of illnesses terminate within 26 weeks. But there are serious illnesses, particularly tuberculosis, which take much longer to cure. Consequently a growing minority of countries no longer tolerate that a person suffering a lengthy illness, but one for which there is a prospect of cure, should in the midst of the treatment be placed on the lower scale of benefit which is provided for invalids, and still less that treatment should be interrupted on the expiry of an arbitrary time limit. Thus it is that Brazil and Czechoslovakia have extended the maximum duration of sickness benefit to 52 weeks, while Chile and Peru do so in selected cases, and this is also the policy recommended in the Marsh Report for Canada; Norway adopts the intermediate figure of 39 weeks, and Poland does so in selected cases. In the U.S.S.R. and New Zealand sickness benefit continues until the patient's condition is found to be chronic. Provided, however, that extension beyond 26 weeks can be granted, that contribution conditions for invalidity

benefit are not too rigorous, and of course that medical care does not cease with sickness benefit, the retention of 26 weeks as the normal maximum duration may be justified.

Maternity

Maternity benefit is an indemnity for the loss of wages incurred by a woman who voluntarily before childbirth and compulsorily thereafter abstains from work in the interest of the health of her child and herself. The Childbirth Convention, 1919, has set the normal duration of maternity leave at 12 weeks. It has been ratified by 14 countries and its revision is not in question. Having regard to the fact that this benefit is as much social as individual in its intent, it is reasonable to make the payment of it conditional not only on abstention from work, but also on the utilisation of health services provided for mothers and infants, and the proposed Recommendation includes a provision to this effect.

Invalidity

Invalidity is an incurable condition which prevents a person from earning his living regularly in any occupation for which he is or can be fitted. It is associated chiefly with diseases which affect the efficiency of the whole organism. It is not the necessary result of loss of sense organs or a limb: in these cases every effort is to be made to restore a measure of earning capacity and to create opportunities for turning it to account for self-support. The proposed Recommendation takes account of the more hopeful and constructive attitudes towards invalidity which now prevail.

Permanently handicapped persons should not be allowed to fall into a gap between invalidity benefit and unemployment benefit: the only physical ground for refusing unemployment benefit to a handicapped person should be that he is physically qualified for invalidity benefit. This appears to be the practice in Great Britain.

Unless a special benefit is instituted for maintaining persons in course of vocational rehabilitation, either invalidity benefit or unemployment benefit should be available for this purpose. All countries—the U.S.S.R. is the sole exception—have refrained from attempting to graduate invalidity. At the same time, following a classic German formula, almost all countries have been ready to regard invalidity as present if the claimant has lost as much as two thirds of his earning capacity. This means that a person will get benefit if he is only fit for odd jobs and not for regular employ-

ment of a normal kind. The assumption is—and it is generally a fair one—that a handicapped person will either obtain employment at a living wage or not obtain it at all.

Old Age

Old age is from the social insurance standpoint a special case of invalidity. It is the age at which unemployment, if it occurs, is likely to be permanent, and invalidity becomes so prevalent that to prove it in individual cases is superfluous. Mingled with this attitude, however, is the humane consideration that aged persons ought to be enabled to rest from their labour after a long productive life.

Hence it is that the concept of a fixed minimum age for the grant of old-age benefit is everywhere adopted. There is but one country—Sweden—that fixes this age as high as 66. The commonest figure for men is 65 and there is an increasing tendency to set the minimum age at 60 for women (*e.g.*, Australia, Belgium, Great Britain, Beveridge Report, Marsh Report, and the Wagner-Murray-Dingell Bill); these are the age limits indicated in the proposed Recommendation. The minimum age for both sexes in France, New Zealand and Peru, however, is only 60: while even lower ages are found in some Latin American countries. In the U.S.S.R. a man may claim old-age benefit at 60, after 25 years of work, and a woman at 55 after 20 years.

There are several miners' insurance schemes which provide for old-age benefit at 55 or 50. Lower age limits for persons who have had long service in arduous or unhealthy occupations are desirable, but it has been considered that provision for earlier retirement for such workers as miners and seamen should be made under special statutory schemes, and not under a general scheme.

Under most general schemes of social insurance a person is not excluded from insurance after reaching the minimum age for claiming old-age benefit, and his benefit increases the longer he contributes. In this way a certain inducement is offered to aged persons to remain at work as long as they can. A few countries, notably Czechoslovakia and the United States, require that, when a person is granted old-age benefit, his subsequent earnings in insurable employment should not exceed a prescribed small amount. A similar condition is proposed in the Wagner-Murray-Dingell Bill and the Beveridge and Marsh Reports. A natural corollary of such a condition is that the benefit, when it is paid, should be sufficient for subsistence, and this reservation appears in the proposed Recommendation.

Death of Breadwinner

The contingency in which benefit is payable in case of death is defined in terms of the kinship and situation of the survivors who have a claim to support. Under all social insurance schemes, the principal beneficiaries are the widow and children.

A number of general schemes grant benefit also to the invalid widower. A few, notably that of the United States, grant benefit to dependent aged parents in the absence of a widow or children, while Brazil and Ecuador grant it also to dependent brothers and sisters in the absence of widow, children or parents. In the U.S.S.R. the range of dependants entitled to benefit is equally extensive. The need to provide benefit for survivors other than the widow and children arises, however, only because the scope of social insurance is still limited to sections of the working population, and it is destined to disappear after a period of transition when this limitation shall have been removed, and other survivors are receiving benefit in virtue of their own insurance. In the proposed Recommendation provision is made for such cases by non-contributory allowances.

Apart from reasonable safeguards against death-bed marriages and the like, a widow is, under European schemes for salaried employees, under the general schemes of Ecuador, Great Britain and Mexico, and the various Brazilian schemes, entitled to benefit unconditionally. Under the majority of general schemes, however, she is only entitled to benefit if she has children in her care, is an invalid or has reached the minimum age for the grant of old-age benefit. Should the widow at the time of her husband's death not find herself in any of these situations, her claim to benefit is suspended until she either becomes an invalid or reaches the minimum age in question. It is here contemplated that, as the Beveridge Report proposes, a benefit should be paid to a childless widow while she is rearranging her life and, in case she is seeking work, during her unemployment. It is expected that she will take up some gainful occupation and, becoming thereby insured, will be able to add to the benefit rights she has inherited from her husband.

In certain countries extra-legal unions are very frequent: so much so that to exclude the unmarried wife from widow's benefit would greatly restrict its utility. The Havana Conference of American Members has insisted on the need for protecting the unmarried wife[1], and the new Mexican Social Insurance Act, for example, provides that an unmarried woman who had been living with an insured man during the five years before his death or by whom he had children, shall receive widow's benefit.

[1] *International Labour Code*, p. 838.

As regards children, the current tendency is certainly towards including, not only stepchildren, but also adopted and legally recognised illegitimate children. These last are admitted to benefit not only by the countries which admit the unmarried wife, but also by others, notably Czechoslovakia, France and Poland.

The age up to which children are deemed to be dependent is tending to rise slowly. Under most general schemes the age is now 16 at least, while under special schemes for salaried employees it is 18 at least. In New Zealand, the United States and the U.S.S.R. it is 16, with extension to 18 in case of continued education, and these are the limits proposed in the Recommendation.

A provision frequently found in social insurance schemes, both general and special, as also in children's allowance schemes, is that the benefit shall continue irrespective of age if the child is an invalid. This provision is not included in the Recommendation because the benefit is not sufficient for the maintenance of an adult and is therefore not a substitute for invalidity benefit. Instead it is proposed that persons already invalid when they would have entered insurance should be entitled to maintenance allowances by way of social assistance.

Unemployment

The provisions defining the contingency in which unemployment benefit should be paid represent a departure from the principles laid down in the Unemployment Provision Convention and Recommendation, 1934, in two respects, namely the duration of benefit and the waiting period.

It is proposed that unemployment benefit should continue without limit of time until suitable employment can be offered. This is the position adopted in the Beveridge Report. There can be no genuine security for the unemployed worker as long as the period of benefit is limited. Unlike the sick worker who, having exhausted his sickness benefit, can still rely on invalidity benefit, the unemployed worker who exhausts his unemployment benefit has nothing to look forward to but assistance of some kind, the grant of which is subject to a means test. The abolition of the time limit pledges the State to pursue a vigorous employment policy and establish a highly organised employment service. In consideration of the abolition of the time limit, it is reasonable that re-employment in one's former occupation should no longer be rigidly insisted upon, when the prospects of such a job appear remote. It must indeed be recognised that the price of unlimited duration of benefit is increased mobility of labour.

It is proposed that once benefit becomes payable, no fresh waiting period should be required if unemployment recurs within a few months. A provision of this kind is often included in unemployment insurance legislation. Thus, for example, in Canada the waiting period is defined as the first nine days of unemployment in any benefit year, and in the United States the Wagner-Murray-Dingell Bill proposes a waiting period of one week in a benefit year.

Emergency Expenses

The Recommendation proposes that benefit should be provided in four contingencies in which insured persons or families must incur substantial expenses likely to strain the budgets of lower-paid workers especially, and which can be conveniently covered by social insurance. These occasions of expenses are associated with sickness, maternity, invalidity and death, respectively.

The first is the inability of a housewife with dependent children to attend to her work while absent from home in hospital. The New Zealand Social Security Act contemplates some provision for this contingency, but the opportunity of implementing it has not yet occurred. The Beveridge Report expressly advocates the provision of domestic help while the wife is in hospital. The provision of benefit or service in kind in this contingency is recommended here as a valuable advantage which can be granted without risk of abuse. The Swedish Population Commission, considering this contingency in connection with maternity, indicated the desirability of providing domestic help during the two weeks before and the two weeks after parturition, whether or not the wife is in hospital.

The second contingency is the necessity of incurring a variety of special expenses for the provision of clothing and other equipment on the birth of a child. A small grant for this purpose is provided for in several countries, notably in Sweden and the U.S.S.R.

The third contingency is one which is as rare as it is deserving of consideration: the need of the helpless invalid for constant attendance. Czechoslovakia, Poland and the U.S.S.R. are among the countries which grant an increase of as much as 50 per cent. in the invalidity benefit in cases where the invalid needs constant attendance.

The last contingency is perhaps the most important: the need for a benefit to cover the cost of a simple funeral whether for the insured person or for his wife or child. Benefit for the funeral of the insured person is an almost universal feature of social insurance. Funeral benefit on the death of a dependent wife or child is much less frequent, but it is found in Czechoslovakia, Norway, the U.S.S.R.

and some other countries, and is proposed in both the Beveridge and the Marsh Reports.

It may be noticed that no provision is made for meeting the expenses of travel and removal for an unemployed person who is offered employment in a district not accessible from his place of residence. Such provision, it seems, should be of a flexible character and might preferably take the form of a benefit rendered in kind by the employment service. Similarly, it is presumed that necessary artificial limbs and surgical appliances will be supplied and repaired by the medical care service.

Employment Injuries

Whether special legislation for securing compensation to workers injured by accidents in connection with their employment would have developed once a complete social insurance scheme had been instituted covering sickness, invalidity and death, irrespective of their cause, is a question which may be discussed, but which is now of little practical significance. For there is no country in the world which possesses social insurance and does not accord separate and more favourable treatment to the victims of employment injuries.

One may believe, indeed, that public opinion would not indefinitely have been content that workers in such a dangerous employment as mining should be deprived of benefit because of some failure to comply with contribution conditions; and would not, especially in our day, have failed to appreciate that the worker injured in a hazardous industry is worthy of compensation just as a disabled soldier. As for the doctrine of assumption of risk by the worker, it must remain untenable from the social standpoint until the opportunity of deliberate choice of occupation, as between safe and dangerous ones, becomes much more effective than it is now and, for that reason, the wage level in hazardous industries could fairly be said to take account of the greater risk of injury. Only when these conditions are satisfied would it be plausible to hold that all accidents, however caused, should attract the same benefits because the need has no relation to the cause.

Apart from the considerations of justice, there is the practical argument, which will be referred to later, that, by the device of merit rating, compensation can be used as a lever for promoting industrial safety. Furthermore, by loading the price of products which endanger life and limb with their full compensation costs, their use is discouraged and the search for substitutes is encouraged, although in the short run too heavy a load on such products, if

indispensable to industry, might have undesirable repercussions on employment and the national economy generally.

The principle of occupational risk as the basis of compensation for employment injuries appears firmly established—as much in the U.S.S.R. as in any other country. The employer is responsible for paying compensation at prescribed rates in case of accidental injury, whether ascribable to the employer's negligence or the worker's, or involving the fault of no one in particular. In many countries it has long been applied, as consistency requires, not only to employments involving an obvious hazard, but to all others also, and the tendency to recognise the right to compensation as an incident of the contract of service or apprenticehip continues.

The principle does not prevent a close co-ordination of workmen's compensation provisions with social insurance against sickness, invalidity and death of non-occupational origin. It does demand, however, that there should be no contribution conditions to be complied with by the worker in order to be entitled to compensation. Thus sickness, invalidity and survivors' benefits might, if their level were high enough, be granted as compensation.

In reality, however, legislative practice has set higher levels for workmen's compensation than for other social insurance benefits, with the exception that in some countries sickness benefit and temporary incapacity benefit are the same. Indeed, compensation implies more exact correspondence between indemnity and loss in the individual case than need be observed for other benefits, since both the contingencies in which the latter are payable and their rates are settled, not so much by any juridical principle, as by what the contributing parties consider is socially the most advantageous way of distributing the available financial resources.

Under the pressure of the principle of occupational risk, occupational diseases become compensable on the same footing as traumatic injuries, and the range of diseases recognised as occupational is constantly extended. The Havana Conference of American Members voted that compensation should be provided for all occupational diseases. Hitherto many countries have provided compensation only for certain enumerated diseases, and the Workmen's Compensation (Occupational Diseases) Convention, 1934, which contains such a list, requires compensation to be paid only if the person contracting a disease enumerated was employed in one of the occupations placed opposite it in the list. This is a simple and positive arrangement, but since the list can never be complete, and is always behind the times, a movement has developed, in the United States especially, to grant compensation in any case where the claimant can prove that he contracted the disease as the result

of his employment. Such a provision in conjunction with a list of the generally recognised diseases would afford sufficiently complete protection. The combination of both provisions is found notably in Brazil and the States of New York and Ohio.

The contingencies in which compensation is payable may be distinguished as temporary incapacity, permanent incapacity and death, which, as we have already indicated, correspond approximately to sickness, invalidity and death from non-occupational causes.

Temporary incapacity in modern legislation lasts as long as the healing period and differs therefore from sickness benefit which, as we have seen, is limited commonly to 26, 39 or 52 weeks. A minor difference found in several countries is that the waiting period of a few days, which is almost universal, is waived retrospectively if the incapacity lasts for say a month; such a provision is recommended in the Beveridge Report both for temporary incapacity compensation and for sickness benefit—also unemployment benefit, for that matter.

The present Recommendation contemplates that the sickness benefit might be substituted for compensation during temporary incapacity of limited duration. This means of simplifying administration has been adopted in a number of European countries, and is proposed in the Beveridge Report.

The differences between permanent incapacity and invalidity are deeper. Here a distinction between an indemnity for loss and social benefit to meet a serious need is sharply evident. The theory usually followed is that compensation should be paid for every permanent injury, however small, which reduces earning capacity (*e.g.*, in Belgium, France and Great Britain). Nevertheless, in a number of countries no compensation is payable for permanent incapacity of less than 5, 10 or 15 per cent. (*e.g.*, in the Netherlands, Sweden and the U.S.S.R.).

Strict adherence to the rule that compensation is only due if a reduction of earning capacity ensues would exclude any payment for certain types of mutilation or disfigurement which destroy a person's physical integrity without affecting his ability to work or even to obtain it. Compensation for facial disfigurement is the object of an express legal provision in a number of countries. In the State laws of the United States and in those of the Canadian Provinces, examples are to be found of provisions granting compensation for disfigurement, or any substantial physical impairment, whether it affects earning capacity or not. If earning capacity is not affected, the amount of the compensation must necessarily be arbitrary or discretionary and subject to a prescribed maximum limit.

As a rule it should not be possible to draw more than one type of benefit for inability to work or to obtain work simultaneously under a general scheme of social insurance, but an exception appears to be necessary for the case of the worker who suffers permanent partial incapacity as the result of an employment injury. Since both compensation and most of the social insurance benefits are proportional to wages, the partially incapacitated worker will earn lower wages and consequently the benefits he will receive in case of sickness, unemployment, etc., will be correspondingly low and should therefore be drawn in their entirety in conjunction with permanent incapacity compensation.

A final problem, which has, it seems, received very little attention but which is important, is that of the provision to be made for the survivors of a permanently incapacitated person who dies otherwise than as the result of his injury. In less serious cases he will have resumed a gainful occupation and thereby acquired an insurance status which will qualify his survivors for minimum benefits at least. But in some cases, such as those in which two thirds or more of earning capacity are lost, he may never be able to resume employment or otherwise re-enter the scope of social insurance. For these cases it is recommended that the minimum survivors' benefits should be paid, whether or not the deceased fulfilled the contribution conditions prescribed for such benefits.

B. Persons Covered

Range of Persons to be Covered

Universality of scope is of the essence of the modern conception of social insurance as illustrated in the Beveridge and Marsh Reports and the Wagner-Murray-Dingell Bill, and as practised in Denmark and New Zealand. Only by aiming at universality will it be possible to create a social insurance system under which the citizen as worker achieves the status of effective partnership in society by contributing his quota to its resources and receiving in return from the State the opportunity to work and maintenance when he cannot work.

Hitherto the great majority of social insurance schemes have been limited to employed persons: they are therefore class measures, not national measures. There are two important practical reasons for this limitation. The first is the difficulty of collecting contributions from persons who have no employer, and the second is to find a substitute for the employers' contribution. A further relevant consideration is that sickness and unemployment benefits—not to

mention compensation for employment injuries—have been designed in order to cover the needs of employed persons only, and the technique of affording similar protection to other gainfully occupied groups remains to be developed. The first two difficulties are real but not insuperable. For the third, only partial solutions can be offered.

The vast majority of the population are comprised in four groups:

employed persons;
self-employed persons;
dependent wives and children;
persons unable to work or to obtain work.

The first three groups are susceptible of being protected by social insurance. Existing members of the fourth group can only be cared for by social assistance allowances, but future members should increasingly consist of recipients of social insurance benefits as the scope of insurance is extended.

Social insurance cannot be applied to groups whose income is mainly in kind, such as peasant communities engaged in subsistence farming. Such groups, it is true, possess a primitive form of income security, especially where family and communal feeling remains unimpaired. It would be a mistake, however, to regard this as a situation to be tolerated, more particularly in countries suffering from rural over-population. The fact remains, nevertheless, that social insurance cannot be introduced in such communities until other general measures have been taken to raise agriculture to the level where it is directed mainly to a market and the peasants receive a substantial part of their income in cash.

In so far as agriculture is carried on by share farmers or tenant farmers, and in so far as there exists a class of agricultural workers who are mainly dependent on wages, the basic condition for the introduction of social insurance is already fulfilled, since the share farmer has an associate who stands in the same relation to him as an employer, the tenant farmer has, by definition, a certain cash income, and the agricultural worker has his employer.

There remain persons of working age who are capable of work but, because they have private means or are supported by relatives, are not gainfully occupied. Some of these may be engaged in unpaid social service: they have a claim to enjoy the privileges of social insurance. Members of religious orders may properly be excluded from any social insurance system, since their livelihood is fully assured. But the State has no obligation to assist in economic misfortune persons who have not made, when they could, a fair contribution to the national economy. The alternatives are either

to exclude such persons from the scope of social insurance, or require them to take up some form of work. As the British Prime Minister, Mr. Churchill, has indicated: "Unemployables, rich or poor, will have to be toned up".

It is clear that social insurance can only approach universality in countries which are sufficiently organised economically and administratively, and can only penetrate the rural population in proportion to the extension of cash incomes.

Collection of Contributions

The position taken in the Recommendation is that social insurance implies a contribution from the insured person, except for the purpose of compensation for employment injuries. Contributions can only be levied on persons who have a margin of income after subsistence needs have been met. The device, proposed in connection with contributions for medical care services in Canada, Great Britain and the United States, of charging a public assistance authority with the contributions for the indigent, does not appear appropriate to social insurance for income security. The amount of the contribution to be levied on persons with low incomes is another question. It need only be suggested here that the amount should be sufficient for the contribution to serve as an effective symbol of participation in social insurance.

If contributions are to be collected, as they must, without disproportionate cost or irritation, either existing taxation systems must be utilised or the central insurance authority must enlist the service of intermediaries who are in contact with the group to which the contributor belongs.

For employed persons, the intermediary is the employer. In the earliest social insurance schemes it was only the larger or urban employer and his employees who were reached, whereas now in a dozen countries at least it is the employer in industry, commerce and agriculture, irrespective of the size of his undertaking, and even the employer of a domestic servant.

As soon as the insurance organisation is good enough to permit of the effective inclusion of domestic servants, it is surely good enough also to permit of the inclusion of the householder himself, besides all larger employers. In this connection it is interesting to note that in Brazil and Uruguay the employers of insured persons have been the first group of self-employed persons to be brought within the scope of social insurance; they pay their contributions along with those of their employees.

The main difficulty in the way of insuring the self-employed

arises in connection with the mass of small shopkeepers and craftsmen who, together with peasants and farmers, bulk largely in the population of all countries, but especially those in which industrialisation is only beginning. Many countries, however, have some form of direct taxation which reaches most householders, and the tax machinery can be used to collect the insurance contribution not only from taxpayers, but also from persons who have been formally exempted from taxation, while nevertheless able to pay a minimum contribution. National income-tax machinery is used in New Zealand and Sweden, and communal income-tax machinery in Norway. In Czechoslovakia a Bill which was under consideration before the war would have extended invalidity, old-age and survivors' insurance to all self-employed persons who were liable to income tax or land tax. A similar method is contemplated by the Chairman of the United States Social Security Board in order to collect contributions from the self-employed who would be insured under the Wagner-Murray-Dingell Bill: the contributions would be collected together with income tax[1], or, since a self-employed person is in some cases an employer, together with the contributions of his employees.

In order to be allowed to exercise certain occupations, a licence is often necessary and the issue of the licence may be made conditional on proof of payment of social insurance contributions. Brazil and Peru, for example, use this device in the case of taxi drivers.

Where tax machinery is insufficiently developed or not wide enough in its range, recourse may be had to co-operative societies or guilds, especially if membership in these is compulsory. These are the intermediaries used in Bulgaria, for example, while in Mexico the Social Insurance Act contemplates bringing the members of peasant communities into its scope through their organisations.

Administration of Benefits

The Recommendation recognises that, in order to cover effectively the various contingencies, social insurance must be able to count upon the help of other extensive public services, such as medical care and employment services.

In this connection it is worth recalling the means by which Peru has introduced compulsory sickness insurance. During an initial period the State and the employers, but not the workers, paid contributions which were used to build and equip area by area the hospitals and dispensaries that would be necessary in order to

[1] A. J. ALTMEYER: *Old-Age and Survivors Insurance for Small Businessmen* (Social Security Bulletin, Oct. 1943).

afford a satisfactory medical service. Only when these establishments were complete were the workers called upon to contribute, and they responded all the more easily because they could see the new buildings ready for their use.

Employed Persons

The Recommendation proposes that social insurance should be applied to all employed persons, and should, in their case, cover the entire range of contingencies which involve inability to work or to obtain work.

Of the various allowable exceptions enumerated in the Social Insurance Conventions, the only one which it seems indispensable to mention is that of persons who do not ordinarily earn their living in employment and only engage therein occasionally, so that they are unlikely to qualify for such benefits as may be confined to employed persons. If their principal occupation is self-employment, the persons so excepted should be insured in that capacity.

It is not proposed that higher-paid workers might be excluded from insurance, because to do so would not be consonant with the classless character with which it is desired to endow social insurance for the future, and because, with the fluctuation of earnings, workers would pass in and out of insurance. It is true that, in the majority of existing schemes, higher-paid employees are still excluded, or else are insured under a special scheme for salaried employees. But in the United States, Brazil and Mexico, for example, whose legislations are of recent date, this limitation does not exist, and it is not contemplated in the Beveridge or Marsh Reports.

Unpaid apprentices cannot be insured against loss of wages. An exception to this rule, however, is justly made where the apprentice is disabled by an employment injury and remains so beyond the date when he would probably have completed his apprenticeship. Following the practice of the majority of countries, it is recommended that in such cases compensation should become payable from the abovementioned date at a rate based on the wages of a skilled worker.

No lower or upper age limits are indicated in the Recommendation. The lower limit may be set in each country by the minimum legal age for entry into employment, but it is recommended that children's benefits should be payable until 16 at least. An upper limit is undesirable and most laws do not prescribe one, though persons in receipt of invalidity or old-age benefit are naturally excluded from sickness and unemployment benefits. No doubt, sickness and unemployment benefits may become very costly in respect

of aged persons, but physical old age and old age as measured by the calendar do not always correspond. Where they do correspond, the aged person is an invalid and as such not qualified for either of these benefits. Where they do not, it is unreasonable to exclude the individual in question from insurance if the policy is to encourage old people to work as long as they are able and willing to work, meanwhile deferring their claim to old-age benefit and incidentally qualifying for a higher rate of benefit or even completing the qualifying contribution condition for this benefit. It is noteworthy that neither the Wagner-Murray-Dingell Bill nor the Beveridge Report provide for upper age limits.

Self-Employed Persons

The inclusion of self-employed persons within the scope of invalidity, old-age and survivors' insurance is not a novel proposal. It was already a feature of the relevant Recommendation of 1933. Ten years ago the self-employed, like all other citizens, were compulsorily insured in Denmark and Sweden. Since then, New Zealand, Norway, Finland and Bulgaria have brought this group into insurance either as citizens or, in Bulgaria, as peasants or craftsmen. But inclusion of the self-employed is insisted upon now in the Beveridge and Marsh Reports and is provided for in the Wagner-Murray-Dingell Bill. A recent article by the Chairman of the Social Security Board of the United States has argued strongly for the inclusion of small-business men within the scope of social insurance.

The self-employed comprise employers as well as persons working on their own account. Negatively this class might be defined as workers whose temporary inability to work or to earn a living cannot be verified by the simple objective criteria that can be applied to employed persons: inability to journey to a workplace and perform one's work under ordinary conditions, and inability to find a regular job. From this negative standpoint, members of the employer's family who live in his house (and especially if this is their workplace) may be treated on the same footing as self-employed persons, since collusion between employer and his employed relative at the expense of the benefit fund is all too easy and probable where sickness and unemployment benefits are concerned.

Exemption will have to be granted to any self-employed person whose earnings leave no margin for a minimum contribution. Such persons, as is pointed out in the Marsh Report, are in need of help from the employment service or any special service that

may be developed for helping farmers, fishermen, craftsmen, etc., to improve their efficiency and earning capacity.

The Recommendation does not attempt to provide for persons who are not ordinarily engaged in a gainful occupation, either because they have independent incomes or are supported by relatives though not employed by them; it does not purport to secure unearned incomes. It does, however, propose, following the practice of most countries, that persons who have completed a minimum period of insurance, for example, the contribution period prescribed as a qualification for invalidity and survivors' benefits, should be allowed to continue their insurance on a voluntary basis.

It is true that the exclusion of persons who are not gainfully occupied makes a gap in the universality of the scope of insurance. But under an insurance scheme as such there will always be individuals who have not complied with the qualifying conditions for benefits or who need some supplementary assistance. Moreover, nowhere except in New Zealand do we find that the self-employed are eligible for unemployment benefit. If it is necessary to maintain social assistance in order to fill the gaps which cannot be closed by social insurance, it is questionable whether there is sufficient justification for distorting and complicating a social insurance scheme by bringing into it persons who do not depend for their living on their work.

Invalidity, old age and death are not the only contingencies against which it is practicable to insure self-employed persons. Thus it should be feasible in case of sickness to pay a cash benefit during hospitalisation and, as the Beveridge Report proposes, in cases where a serious illness has lasted for, say, thirteen weeks. Finally, the indemnities suggested in case of extraordinary expenses in connection with sickness, maternity, invalidity and death may very well be granted to the self-employed in the same way as to the employed.

C. Benefit Rates and Contribution Conditions

Benefit Rates

In order to attain its purpose, social insurance must afford to insured persons a sense of economic security, and that implies a benefit level which will suffice to support a standard of living not much below their usual standard. But social insurance, subsidised as it is by tax payers and consumers generally, should not aim at maintaining the standards of living of persons whose earnings have left them an ample margin for private thrift.

There must indeed be a point—though it may be hard to deter-

mine—where the cost of the unproductive to the productive would be so heavy as to discourage enterprise, reduce employment and check the growth of output. Before that point is reached, however, we may expect social insurance charges to yield increasing returns in the heightened physical and moral well-being that the fact and sense of security and justice can procure. Benefit funds must be expended to the best social advantage; benefits must be not only fair to the individual contributor, but also socially adequate. They must therefore be adjusted as far as may be to the size of the family, though without children's allowances this adjustment is limited in its range to the consideration of a few children only.

The benefit level must perforce not be so high for any individual as to leave him insufficient incentive to resume work, especially in case of sickness or unemployment. It follows that the benefits of low income earners may be below the minimum of subsistence. Social insurance by itself may mitigate, but cannot cure, the evil of low wages. It has to take earnings as it finds them, with or without children's allowances, and to provide the highest benefit it safely can for the low-income earner, and the most moderate benefit it fairly can for the high-income earner. The improvement of the earning capacity of the lowest ranks of earners is a task that calls for the combined efforts of all branches of social and economic policy, and not merely of social insurance. For this reason no absolute minimum benefit rates are indicated in the Recommendation.

If benefits are to maintain a standard of living not far below that which the beneficiary had when at work, they must be commensurate with his previous earnings. The term "commensurate" is intended to convey the ideas of sufficiency and proportionality without, however, implying a uniform proportion of benefit to earnings for all ranks throughout the income scale.

The great majority of social insurance schemes relate both contributions and benefits to earnings, and Great Britain is an important exception in that it fixes both elements at rates which vary, not with earnings, but with sex or age. Benefits which are fixed without regard to earnings, however, can be rendered comparable with those which are commensurate with earnings if the former are, indirectly at least, linked with the earnings of unskilled wage earners, as they appear to be, for example, under the British scheme of unemployment insurance.

The Recommendation indicates the minimum levels of benefits only, and does so in terms of the previous earnings of the insured person or the current earnings of unskilled workers. The cost of living in health and decency is doubtless a proper standard to which

regard should be had in fixing minimum wages, but not for fixing social insurance benefits, which, as already stated, must be adapted to wages as they are. It is assumed, even so, that the wages even of unskilled workers are sufficient for the support of a family consisting of the parents and one or two children.

Women's wages, however, are generally less than men's—often considerably so, as in Australia, for example, where the minimum wage for women is 54 per cent. of that fixed for men. Accordingly a proportion of his wage which might be considered sufficient for the support of a man, would, if applied to a woman's wage, be insufficient for her support. Here again, however, the remedy does not lie with social insurance, but in the adoption of the principle of equal pay for equal work.

The minimum rate of sickness and unemployment benefits is related to the rate at which the insured person was being remunerated just before he ceased work. The commonest rates of sickness benefit are 50 per cent. and 66⅔ per cent. of the basic wage, the benefit being invariable with respect to family responsibilities or sex. In unemployment insurance schemes, however, which, being mostly of later origin, are more definitely keyed to the note of social adequacy, we often find a substantial difference between rates of benefit for persons with and without dependants, respectively. The Canadian Act of 1940, for example, provides a benefit which is greater by one sixth for persons with dependants, and varies from about 60 per cent. to about 40 per cent. of the basic wage from the lowest to the highest wage earners, respectively. The Polish Act provides a benefit ranging from 30 per cent. to 50 per cent. of the wage according to the number of dependants. The Norwegian Act provides a maximum benefit equal to about one third of the average industrial worker's wage and adds a small flat benefit for each dependant. In Great Britain, in 1938, unemployment benefit for men was about 25 per cent. of the average wage of male industrial workers, and for women about 50 per cent. of that of female industrial workers; it was supplemented by about 13 per cent. of the male wage for an adult dependant and by about 3 per cent. of the same for each dependent child. The Beveridge Report provides for subsistence benefits in case of disability (temporary or permanent) and unemployment which are the same for both sexes and would represent nearly 30 per cent. of the average male wage, as increased according to the rise in the cost of living since 1938, and about 60 per cent. of the average female wage, as similarly increased; the addition to the benefit for an adult dependant would increase the main benefit by about 18 per cent. of the male wage; and the proposed average children's allowance would be about

9 per cent. of the male wage for each child. The Wagner-Murray-Dingell Bill proposes a sickness and unemployment benefit varying from 50 per cent. to 30 per cent. of the basic wage for the lowest to the highest wage earners, respectively. This main benefit would be increased by half for each dependant, but not so that the total benefit would exceed 80 per cent. of the basic wage or about 54 per cent. of the highest wage taken into account for insurance, whichever is the less.

The minimum rates of sickness and unemployment benefits proposed in the Recommendation could be regarded as a compromise between those of the Beveridge Report and those of the Wagner-Murray-Dingell Bill, but they are also believed to be in harmony with the trend followed by short-term benefit rates during the period immediately before World War II.

Maternity benefit is the same as sickness benefit under the laws of almost all countries, and likewise under the Wagner-Murray-Dingell Bill. On the other hand there are a very few countries, Poland among them, which grant a maternity benefit somewhat higher than the sickness benefit, and the Beveridge Report provides for a maternity benefit which exceeds sickness benefit by 50 per cent. The Childbirth Convention, 1919, prescribes a benefit "sufficient for the full and healthy maintenance" of mother and child. The Havana Conference of American Members adopted a Resolution in which this expression is interpreted as meaning a benefit "at least equivalent to her full regular wage". The proposed Recommendation regards maternity benefit as an indemnity for wages lost during the periods of voluntary and compulsory abstention from work, namely, the six weeks before and the six weeks after childbirth, respectively, which were prescribed by the Conference of 1919. Following the Convention, the benefit is here recommended for employed women only. The grant of a maternity benefit to self-employed women and dependent wives whose abstention from work cannot be verified, might very likely be justifiable from the standpoint of general population policy, but in that case its cost should presumably be borne by the taxpayer: such is the policy in Australia, where a subsistence allowance is paid to every mother for four weeks before and four weeks after childbirth, whether she abstains from work or not. The Beveridge Report would grant a maternity benefit both to employed and to self-employed women on an insurance basis, subject to their abstention from work.

The possible rates of benefit that might be recommended lie between 50 per cent. and 100 per cent. of the wages. The lower limit corresponds to the practice of the majority of countries, and

the higher to the Havana Resolution. As a compromise, a benefit of 75 per cent. of wages is suggested. In support of this figure it could be argued that during the period of compulsory abstention from work, full wages ought to be paid, whereas during the period of optional abstention from work, 50 per cent. of wages might suffice, so that on the average the rate might properly be fixed at 75 per cent. over the two periods together. At the same time it seems necessary to provide, on the one hand, that the benefit should in no case be less than 100 per cent. of the current wage for female unskilled workers and, on the other hand, that any child's allowance may be deducted from the benefit as so calculated.

Invalidity and death are contingencies whose incidence becomes heavier with advancing age, while old age itself is but invalidity as presumed to set in at a fixed age; invalidity benefit must, on practical grounds, be designed to coincide with old-age benefit, when that fixed age is reached. All three benefits are costly, and, in order to moderate their apparent cost, the power of compound interest as applied to accumulated contributions has generally been invoked. Of the three benefits, it is old-age benefit which has seemed to be the most important, and the method adopted for constituting this benefit has been applied also to the others. Old-age benefit has been thought of as the reward for a lifetime of work and its rate has accordingly been made to vary with the length of the contribution period. The fact that every contribution paid will increase the benefit when the time comes to claim it preserves the interest of the individual in the regularity of his contributions. Accordingly invalidity, old-age and survivors' benefits in most countries vary with the number and rate of the contributions paid by the insured person. But invalidity and death also occur to the young, and therefore sufficient benefits must be provided after even a few years of contribution. Hence it is that most laws construct invalidity and survivors' benefits, and for that matter old-age benefit also, in two parts, the first being a uniform basic benefit which may be granted to all who have completed the qualifying period of contribution, and the second a supplement varying with the amount of the contributions paid. These two components illustrate the principles of insurance and saving, respectively.

Under the older laws the basic benefit may be so small as to be insufficient for subsistence, with the result that only those who have contributed for many years obtain a tolerable total benefit. This means that there is a long transitional period during which benefits will remain inadequate; moreover, at no time will the contingencies of invalidity and death occurring to persons under, say, forty years of age, be properly covered. Under the later schemes a trend

can be observed for increasing the basic benefit. France, for example, provides an invalidity benefit of 30 per cent. of previous earnings after two years of insurance; Brazil (industrial workers) one of 30 per cent. after three years; Peru one of 40 per cent. after four years; and Mexico one of 20 per cent. for the same period of insurance. The Wagner-Murray-Dingell Bill, using the method prescribed in the Social Security Act of the United States, provides an invalidity benefit of about 40 per cent. of previous earnings for the lowest wage earners, and about 30 per cent. thereof for the highest wage earners after 18 months of insurance. Under all these newer schemes, the basic benefit, though itself substantial, is supplemented by increments depending on the number and amount of the contributions paid.

In the Beveridge and Marsh Reports we find invalidity and survivors' benefits which are acquired after a short qualifying period and do not vary with wages or the length of the contribution period. These benefits consist therefore entirely of an insurance element to the exclusion of any savings element. The old-age benefits under these British and Canadian plans are of a similar character, except that, if they are claimed after the minimum retiring age, they are supplemented in proportion to the period for which the claim is deferred. The great advantage of benefits so designed is that a few years after the introduction of insurance all persons reaching old age may obtain a subsistence benefit.

Under most existing laws, invalidity and old-age benefits comprise no supplement for dependants. Among the minority which do provide for the dependants of beneficiaries are Czechoslovakia and Poland, where 10 per cent. of the benefit is added for each child. In Great Britain, under the existing law, the old-age pension is doubled if the insured person has a wife who has reached the age of 60; the Beveridge Report recommends that the ultimate rate of old-age benefit should be the same as disability and unemployment benefit, and that children's allowances should be paid in conjunction with it. According to the Wagner-Murray-Dingell Bill, old-age benefit is increased by one half if the insured person has an uninsured wife who has reached the age of 60, or has the care of dependent children, and by the same amount in respect of one or more dependent children. The same provisions are found in the Wagner-Murray-Dingell Bill under which they apply also in connection with invalidity benefit.

Children's allowances may be combined with any periodical insurance benefit. At first the allowances were paid only to wage earners and only while they were at work, but they are gradually being extended to the self-employed, to the sick and the unemployed, and then to invalids and widows. This development has been most marked in France where children's allowances are provided for the self-employed, and are paid as additions to sickness, maternity, invalidity and unemployment benefit, while widows—there being no widow's pension in the social insurance scheme—receive both children's allowances and the special allowance which is granted to all families in which there is only one earner. Belgium, Portugal and Spain also grant children's allowances as an addition to compensation, and certain other benefits. In Australia, children's allowances are paid in respect of the second and subsequent child in every family without exception, but they are paid also for the first child of an invalid or widow. In New Zealand provision is made for the dependent children of persons receiving any form of periodical benefit by a special children's allowance, which is 40 per cent. higher than the allowance paid to a parent who is not in receipt of benefit.

The invalidity and old-age benefits proposed in the present Recommendation consist of a basic benefit acquired on the completion of the qualifying period of contribution and an increment proportional to the amount of the contributions paid.

The minimum rate proposed for the basic benefit is related to the minimum wage for unskilled workers. It is intended that the basic benefit should be kept in harmony with changes in the level of the minimum wage, so that beneficiaries may share the current fortunes of the working population. That some means of keeping long-term benefits adjusted, even if indirectly, to changes in the cost of living is necessary is proved by the spectacle which we have witnessed in many countries of the constant procession of amendments to increase benefits, which are lagging far behind prices.

The secular upward trend of prices and wages has not been sufficiently recognised in social insurance, perhaps because of the reluctance to include an unknown element in the financial estimates. However, once the number of recipients of long-term benefits has reached stability (apart from the growth resulting from the aging of the population) the adjustment in the basic benefit rate—related, as it is here proposed, to current wages of unskilled workers—can be taken care of currently, by the rise in the earnings on which contributions are calculated. Even so, it might be hazardous to adopt such a sliding scale without a State guarantee of the solvency of the insurance scheme. Among insurance schemes of the type contemplated in the proposed Recommendation, there is none which provides for a basic benefit varying with the current wage level, although a Bill which includes such a provision is under consideration in the Chilean Congress. It should be mentioned,

however, that in Australia and Denmark the subsistence payments which are granted in case of invalidity and old age are kept in permanent adjustment to changes in the cost of living.

The basic benefit provided for in the present Recommendation is intended to take the place of a subsistence benefit, in contrast to the increments, which take account at once of the contribution period and the rate of the contributions paid. The basic benefit differs from sickness and unemployment benefits in that it is invariable with respect to previous earnings and on a lower level. That long-term benefits should be on a lower level than short-term benefits accords with the practice of the great majority of countries, which presumes that a person who has given up gainful activity may be expected to adapt himself permanently to a lower standard of living.

The figure of 30 per cent. of the male unskilled worker's wage for a beneficiary without dependants is somewhat less than that provided for in several laws, but the figure of 45 per cent. for the beneficiary with a dependent wife is, on the contrary, somewhat higher, and so also is the children's supplement at the rate of 10 per cent. for each of the first two dependent children. The relations among these figures are identical with, or very close to, those which are used in the Social Security Acts of New Zealand and the United States, and to those suggested in the Beveridge and Marsh Reports, both of which documents offer analyses of family budgets in support of their proposals.

It will be noted that the basic benefit is to be related to the male wage, irrespective of the sex of the insured worker. The assumption is that the needs of an invalid or aged man and woman are practically the same, and therefore, if the female wage is substantially less than the male, 30 per cent. of the former would be inadequate. That the supplement for a child who has lost both parents should be double that payable for a child whose mother is alive, is a provision found in many laws; the higher supplement serves to assist the foster-parent who takes care of the child.

The wife's supplement, which it is proposed should be added to the invalidity or old-age benefit, would be subject to restrictive conditions such as have not been suggested for the wife's supplement attached to sickness and unemployment benefits. The former indeed would only be granted in respect of a wife who, supposing her husband were dead, would be entitled to widow's benefit by reason of her having the care of children, of being an invalid, or of having attained the minimum age at which old-age benefit may be claimed.

The widow's benefit which we recommend would be the same as

the benefit for an invalid woman entitled to benefit in virtue of her own contributions, but with the difference that provision is made for the support of a third child. This difference is based on the considerations that in the case of a widow with dependent children, there would be no point in leaving a margin between benefit and earnings as an incentive to take up work, and that children's allowances are in most countries—France is a striking exception—well below the amount required for full support.

The scale of compensation for employment injuries which is indicated in the present Recommendation is based on that laid down in the Workmen's Compensation (Minimum Scale) Recommendation, 1925. The proposed Recommendation, however, requires that long-term compensation should be adjusted currently to changes in the wages of the class of workers to which the insured person belonged. A provision to this effect is incorporated in a 1943 amendment to the British Workmen's Compensation Act.

Contribution Conditions

The purpose of the contribution conditions outlined in the present Recommendation is to reserve benefits for persons who have entered insurance with the capacity and the intention to work for their living, and to secure a reasonable regularity in the payment of contributions. As long as the scope of insurance is not practically identical with that of the population of working age; as long as entry into insurance remains to some extent optional for the individual; and as long as he has some opportunity to elude the obligation to contribute: so long will contribution conditions be necessary. Those proposed in the present Recommendation are, it is believed, no more than the minimum which is expedient for this purpose.

The same conditions are proposed with respect both to sickness and to unemployment benefits. In either case it is a question of testing the genuineness of the employed status of the claimant. Admittedly the will to work is harder to test than capacity for work, and a longer qualifying period might therefore be imposed for unemployment than for sickness benefit, and such on the whole has been the practice in pre-war legislation. Nevertheless, Great Britain has for many years used approximately the same test for both benefits, while the Beveridge Report and the Wagner-Murray-Dingell Bill would make the contribution conditions identical, having regard to the practical utility of simplification. The conditions here proposed—equivalent to 26 weekly contributions in two years—are more stringent than those laid down in the sickness insurance legislation of most countries; in this connection, however,

it should be remembered that we are concerned in the proposed Recommendation with cash benefits only, and not with medical care. As regards unemployment benefit, the proposed conditions are easier than those imposed in most countries, but they are about the same as those adopted in Canada, Great Britain and South Africa.

It is true that, according to the present Recommendation, unemployment benefit is to be unlimited in duration, whereas the contribution conditions in all existing legislation are devised in view of a benefit for a limited period. Meanwhile, however, great advances and extensions have been made in the efficiency and scope of the employment services, and it is upon these advances that the great gain to social security, which the unlimited duration of unemployment benefit would signify, is predicated. It is perhaps worth pointing out that, while the duration of any spell of unemployment may be unlimited, the very absence of limitation means that the right to draw benefit for a subsequent spell of unemployment—or sickness—is jeopardised: it is still to the insured person's interest to resume work as early as he can.

The scale of the maternity benefit recommended is higher than that provided for under most social insurance schemes. It is proper therefore that the right to this benefit should be subject to the completion of a substantial qualifying period, which may even extend to the entire duration of pregnancy. Nevertheless, since abstention from work is compulsory during the period following confinement, it seems that title to benefit for this period should arise in any case in which it can be shown that the claimant's normal status is that of an employed person.

The basic long-term benefits—for invalidity, old age and death—are even more likely to attract factitious entries into insurance than sickness and unemployment benefits, if a substantial qualifying period is not opposed to such designs. Yet the qualifying period must be relatively short if the contingencies of invalidity and death are to be covered. It is not unreasonable to impose a longer contribution period as a qualification for old-age benefit. Nevertheless, with the extension of compulsory insurance to the self-employed, the area from which factitious entries might arise is greatly reduced. Long transitional periods resulting from long qualifying periods for old-age benefits are not conducive to a sense of security or even of social justice among the population at large. We have already indicated that several countries guarantee a substantial basic benefit after two, three and four years of insurance. A contribution condition of two years of insurance only is, however, all that is demanded under the Chilean, Czechoslovak and British laws for all long-term benefits, and for invalidity benefit in France; under

the Social Security Act of the United States, old-age and survivors' benefits may be obtained after an even shorter period of insurable employment. At the same time we find several laws, including that of Great Britain, which require, in connection with old-age benefit, that the first contribution must have been paid at least five years before the benefit is claimed.

The present Recommendation proposes, on the basis of existing practice and new tendencies, that the contribution conditions for invalidity, old-age and survivors' benefits may require that contributions should have been paid for at least two fifths of a prescribed period, such as five years, completed before the claim, subject to the possibility of the added condition of a total of five years of insurance for the purpose of old-age benefit. It is proposed, moreover, that the claimant should have the option of invoking an alternative condition in case he should not satisfy the principal one. The alternative condition is related to the whole duration of the insurance of the claimant, and may enable him to compensate for any recent irregularity of contribution or contributions by the consistency with which he has fulfilled his contribution obligations during his insurance career as a whole. Such an alternative condition is found in a number of laws. As here formulated, it may require that contribution periods should account for as much as three quarters of the time which has elapsed since entry into insurance, and which may well be subject to a minimum, such as ten years.

D. Distribution of Cost

In social insurance schemes for employed persons the cost of invalidity, old-age and survivors' benefits and unemployment benefit is usually shared among insured persons, employers and the State, and that of sickness and maternity benefits between insured persons and employers, while the cost of compensation for employment injuries is borne solely by the employers, except in so far as sickness benefit may be paid during a short initial period of incapacity.

Under the national invalidity and old-age insurance scheme of Sweden and the New Zealand scheme, both of which cover the citizenry at large, the cost is shared between the insured person and the State (including local governments), but the employer continues to be liable for compensation for employment injuries.

The proposed Recommendation contains a series of guiding principles for financing the various types of benefits provided for under the unified social insurance scheme which it contemplates. These principles concern only the sources from which the benefit

fund is to be supplied. They do not deal, except by implication, with the distribution of the cost over periods of time; and not at all with the investment of insurance monies.

As regards the insured person's contribution, the principles recommended look to the considerations of equity and the avoidance of hardship. It may be agreed that in no case should a compulsory insurance scheme impose on insured persons, as such, a contribution higher than the average premium which could have financed their benefits if they had been brought under the scheme at the minimum age for entry. It seems proper to set a lower limit also to the contribution, if any of the benefits contain, as do the long-term benefits here proposed, a substantial basic component of fixed amount. In such circumstances a merely token contribution would appear inconsistent with the idea of insurance and, especially where self-employed persons are concerned, might give rise to abuse. Accordingly provision is made in the Recommendation for enabling a minimum absolute amount of the contribution to be specified with respect to the abovementioned benefits particularly. No precise rule is suggested for the degressive reduction of the contribution rate on behalf of low-wage earners. It is merely recommended that, in order to avoid hardship, employers and the State should subsidise the insurance of this group. No mention is made of the possibility that men and women might contribute different proportions of their earnings. The view taken here is that the sexes should share one another's burdens: women would draw in some cases a somewhat higher proportion of their earnings in benefit than men and claim old-age benefit at an earlier age, but they should help to pay benefits for wives and widows; the heavier sickness experience of women might be set off against their often lighter unemployment experience; and both sexes should contribute to the cost of maternity benefit.

It would seem equitable that no distinction should be made between employed and self-employed persons in fixing the contribution levied for identical benefits. An exception might, however, be made from this rule where a minimum absolute rate of contribution is in question. Every person who is regularly employed, however small his wages, may be assumed to be engaged in substantial gainful activity and should, on that account, be entitled to protection against invalidity, old age and death; he should not therefore be excluded on the ground that his contribution is insignificant in amount.

It has been the employers' contribution that in most countries has made social insurance financially feasible, and while arguments may be adduced against it, as well as for it, so convenient a source

of revenue is not likely to be abandoned easily by governments. The employer's contribution is traditionally equal to the insured person's, except that he is often required to pay the entire contribution on behalf of persons with very low wages or wages in kind only. There are, too, a few schemes under which the ratio of the employer's share of the joint contribution to the insured person's varies inversely with the wage, although on the whole employers may contribute as much as insured persons; the present Recommendation contemplates favourably such a possibility.

A reservation is made in the Recommendation with respect to the employer's contribution to benefits (such as invalidity, old-age and survivors' benefits) which are not confined to employed persons, but for which the self-employed persons also are insured. The Invalidity, Old-age and Survivors' Insurance Convention, 1933, allowed employers exemption from contributing under schemes of national insurance which are not restricted in scope to employed persons. It is now proposed that, if the employer is required to contribute under such a scheme, careful consideration should be given to the possible harmful effects on employment, in the short run at least, of a heavy contribution from the employer.

In the long run, when the beneficent effects, hard to measure but very real, of income security have had time to show themselves on morale and health, in improved industrial relations and in greater stability of the internal market, employers will surely find that productive efficiency has so increased that the charge of their contributions is amply compensated. It is, then, to employers as a group, the trustees of the productive system, rather than as individual owners or shareholders of particular undertakings, that social insurance is likely to bring advantage.

Employers normally bear the cost of compensation for employment injuries, and this rule is maintained in the proposed Recommendation. Apart from any juridical ground, there is a practical justification for placing this liability on the employer. For this is the one branch of social insurance in which the application of merit-rating has been proved to possess a certain utility. In certain countries, such as the United States and Switzerland, the variation of premiums according to the accident experience of the employer or the safety of his installations is said to afford a substantial incentive to employers to develop procedures for the prevention of accidents and diseases arising out of employment, although the saving in the premium is only a minor element in the total saving resulting to the employer from the prevention of accidents. It is true that zeal to prevent accidents may cause unemployment among handicapped persons, but it should be possible to overcome this

incidental disadvantage by a better organisation of placement for the handicapped.[1]

The suggestion has been mooted that social insurance contributions, especially the contribution for unemployment benefit, might be varied from time to time according to the economic barometer, falling when employment is bad and rising when it is good. The contrary position is taken in the present Recommendation. Employers in any case must be allowed to base their programmes as far as possible on fixed costs. That purchasing power should be liberated in bad times and withdrawn in good times is doubtless sound doctrine, but taxation, especially widely extended income taxes, would seem to be a more appropriate instrument for regularising the economy. It is not inconsistent with this view, however, to suggest, as is done in the present Recommendation, that contributions, especially those for invalidity, old-age and survivors' benefits, might begin at a low rate and gradually be raised to the permanent rate necessary according to the actuarial estimates for solvency. This consideration naturally does not apply under conditions such as those prevailing in wartime when there is abundant purchasing power which may advantageously be withdrawn from circulation for release in benefits when needed.

The State is responsible for the residual cost of social insurance, which is not met by insured persons and employers' contributions. It has to divide with the employer whatever share of the cost cannot equitably or without hardship be imposed on the insured person; the proportion in which that division is made may well differ according to the fiscal capacity of the State. There are some elements of the cost, however, which appear to be peculiarly the responsibility of the State. They include the deficit of contributions of persons brought into insurance late in life, the contingent liability involved in guaranteeing basic long-term benefits, adequate maternity benefit, and, in times of heavy unemployment, unemployment benefit, and subsidies to the insurance of persons of small means. Apart from these charges the State has of course the considerable burden of social assistance, children's allowances and health services, all of which are essential features of a social security system.

E. Administration

The social insurance scheme contemplated in the present Recommendation for the provision of cash benefits would be administered by a central social insurance authority. That authority might be

[1] Cf., in the Report on the third Item on the Agenda, paragraph 44 (3) of the Recommendation.

an autonomous statutory body or a government department or agency. In either case it should be associated in a joint body with the authorities administering social assistance, medical care services and employment services for the purpose of regulating questions of common interest.

The proposed social insurance scheme would operate uniformly throughout the territory within its competence, so that the rates of benefits and contributions would be paid uniformly or according to uniform principles. Since, however, the Recommendation proposes only minimum rates of benefit, considerable scope is left for private insurance and for the operation of special insurance schemes providing supplementary benefits for miners, seamen, public officials or the staffs of individual undertakings and for the activity of mutual benefit societies. No category of workers should be excepted from the general scheme, so that, irrespective of changes in his occupation and level of earnings, a person would remain insured under that scheme throughout his working life.

It will be in the field of supplementary insurance that local and occupational autonomy and spontaneity will find its chief expression. Nevertheless the general scheme must be constantly subject to the criticism, though not to the interference, of statutory commissions on which the various groups of contributors would be represented. Such commissions might be set up in conjunction with both the central administration and with its local branches. They would maintain a contact between the administration and the public, voicing complaints and making suggestions for improvements. They might select the assessors who, it is proposed, should participate in the settlement of disputes between insured persons and the administrative authority. It might well be that the same commissions should exercise similar functions in connection with medical care and employment services also.

In connection with the administration of compensation for employment injuries it seems fair and expedient that employers as such should be closely associated through their representatives in all that pertains to the fixing of risk classes and premium rates and to any safety policies that may be developed under the general scheme.

Besides the economy of the elimination of duplicate staffs and the justice of the elimination of anomalous inequalities of treatment, and of gaps and overlapping in the network of protection, the unification of social insurance can yield the advantage of a set of regulations simple enough to be understood by the insured person. At present in certain countries it is impossible for an insured person to understand the rights that the law allows him without studying hundreds of pages of regulations.

SOCIAL ASSISTANCE

A. Maintenance of Children

A nation's future depends on its children, and investment in the improvement of the quality of the next generation and in the preservation or increase of its numbers may well be more important for its economic, as well as its cultural advance, than investment in physical capital. National concern for children seems to have been felt more acutely in Europe than in other continents, and has led to the introduction, through social insurance, of medical care for the children of wage earners in a dozen countries and of children's allowances in nearly as many. School meals and maternity and child welfare services, on the other hand, are to be found more or less extensively developed in many countries both in Europe and elsewhere.

Of the various fields in which social provision may be made for children, two are excluded from the purview of the proposed Recommendation: education, because it is referred to in the Recommendation on Item III on the Agenda, and medical care, because it is dealt with in the companion Recommendation to the present one. Here we mention only nutritional and housing services for children and children's allowances, as additional means of assuring the healthy nurture of children and reducing the economic handicaps of parenthood.

While it will be generally acknowledged that both services in kind and allowances in cash are desirable features of comprehensive population policy, there is a division of opinion as to the comparative efficacy of these two methods of subsidising the family, and therefore as to which is to be preferred when financial limitations forbid the provision of both.

Subsidies in kind towards the cost of rearing children are advocated by those who are primarily interested in improving the quality of children. Such services as free food for infants and schoolchildren and subsidised rents for large families are destined to assure healthy nurture. They are considered more effective than cash allowances for this purpose, since the latter tend only too easily to be lost in household expenditure as a whole. It is even

argued that a cash allowance, just because it can be misused, is likely to stimulate the birth rate in the least responsible section of the community. Considerations such as these appear to have influenced the Population Commissions of Denmark and Sweden decisively against children's allowances.

Governments, however, may be properly apprehensive of the results of a falling birth rate and may try to check or reverse this movement without being suspected of aggressive intentions towards their neighbours. Such governments have introduced children's allowances without excluding the simultaneous development of subsidies in kind of varying extent and value. In Europe these allowances are, in the main, reserved for wage earners' children, and are financed by employers alone or by employers and the State. In Australia, New Zealand and Brazil, on the other hand, they are financed wholly from taxation, since it has been recognised that children's allowances are necessary for the welfare of society as a whole, that they may depress wages if their cost is charged to employers, that they should not be confined to wage-earning families but extended to all families, and that they should be payable whether the parent is in work or out of work. In France, where children's allowances began as an employers' responsibility, we have witnessed in 1939 the assumption by the State of the major part of the charge. The position taken in the present Recommendation is that children's allowances, if established, should be the exclusive responsibility of the State.

In no country, except perhaps France in 1939, could children's allowances be considered adequate for full support, and it is probable that there are few countries where public opinion at this time would approve of allowances on so high a level as that standard would require. All that can be expected is that the allowances should represent a substantial contribution towards the cost of rearing a child.

As we have mentioned already, in Australia, France and New Zealand children's allowances are co-ordinated with social security benefits in case of invalidity, sickness, death, unemployment and compensation for employment injuries. If, as in Australia, the allowance for the parent at work is paid for the second and following children only, then when he is out of work it is paid for the first child also. Children's allowances are, as the Beveridge Report has demonstrated for Great Britain at least, indispensable if social insurance benefits are to secure at least a subsistence minimum for low-wage earners with several children without removing the necessary margin between income when at work and income when out of work.

In the present Recommendation we have proposed two children as the maximum number for whom maintenance can be specifically provided as part of social insurance benefits, and have assumed that countries which wish to assure maintenance for larger families will do so by means of children's allowances.

B. Maintenance of Invalids and Aged

Among adult claimants of assistance special consideration should be shown to invalids and aged persons who have never had the opportunity of working in an insurable occupation, either because they were invalids in childhood, or because they were already invalids or aged when social insurance was applied to the area or the occupational group to which they or, in the case of widows, their husbands had belonged.

Provision was made by the Invalidity and Old-age Insurance Conventions, 1933, for the granting of non-contributory allowances as of right to needy invalids and aged persons. It is proposed that maintenance allowances on the lines there laid down should be granted during the period which will elapse before social insurance reaches all gainfully occupied persons and thereafter as a permanent measure to persons who are invalids at the age when they would normally have entered insurance.

Non-contributory widows' allowances according to the principles laid down in the Survivors' Insurance Conventions, 1933, should be provided for needy widows who have children in their care. The children's supplement attached to the widow's allowance should be sufficient for their full support.

C. General Assistance

It follows from the very nature of social insurance, which is founded on the principle that benefit is provided "on condition", as the Beveridge Report puts it, "of service and contribution", that there will always be individuals who fail to comply with the contribution conditions; and from the necessary limitation in the range of contingencies of loss of earnings which it is practicable to cover by social insurance, that cases of want will occur for which no benefit is provided; while the benefits of social insurance, being fixed in advance according to probable average need, will be insufficient to meet needs in some individual cases. Income security schemes based on the ascertained need of the claimant, that is to say social assistance, are therefore permanently required in order to supplement the protection—far reaching though it be—which a national social insurance scheme can afford. Both the Beveridge

and the Marsh Reports, and likewise the Wagner-Murray-Dingell Bill, include proposals for supplementary social assistance of an inclusive character.

In the administration of social assistance it is recommended that the well established policy of differentiating claimants according to the main cause of their being in want should be continued. It is obvious, for example, that a farmer or a shopkeeper who is forced out of business by circumstances beyond his control has a claim on public charity very different from that of a person who is unemployable by reason of intemperance or chronic misconduct; for the former group the Beveridge Report even proposes a special insurance benefit consisting of maintenance while in training for another occupation. For the latter group on the other hand, some process of control and re-education is necessary. All assistance allowances to needy persons capable of work, or who may be rendered capable, may naturally be granted on condition of compliance with instructions given with a view to remedying their situation.

PROPOSED RECOMMENDATION CONCERNING INCOME SECURITY

The General Conference of the International Labour Organisation,

Having been convened at by the Governing Body of the International Labour Office, and having met in its Twenty-sixth Session on 20 April 1944, and

Having decided upon the adoption of certain proposals with regard to income security, which is included in the fourth Item on the Agenda of the Session, and

Having determined that these proposals shall take the form of a Recommendation,

adopts, this day of May of the year one thousand nine hundred and forty-four, the following Recommendation which may be cited as the Income Security Recommendation, 1944:

Whereas the Atlantic Charter contemplates "the fullest collaboration between all nations in the economic field with the object of securing for all improved labour standards, *economic* advancement and social security"; and

Whereas the Conference of the International Labour Organisation, by a resolution adopted on 5 November 1941, endorsed this principle of the Atlantic Charter and pledged the full co-operation of the International Labour Organisation in its implementation; and

Whereas income security is an essential element in social security; and

Whereas the International Labour Organisation has promoted the development of income security—

by the adoption by the International Labour Conference of Conventions and Recommendations relating to workmen's compensation for accidents and occupational diseases, sickness insurance, provision for maternity, old-age, invalidity, and widows' and orphans' pensions, and provision for unemployment,

by the adoption by the First and Second Labour Conferences of American States of the resolutions constituting the Inter-American Social Insurance Code, the participation of a delegation of the Governing Body in the First Inter-American Conference on Social Security which adopted the Declaration of Santiago de Chile, and the approval of the Governing Body of the Statute of the Inter-American Conference on Social Security established as a permanent agency of co-operation between social security administrations and

institutions acting in concert with the International Labour Office, and by the participation of the International Labour Office in an advisory capacity in the framing of income security schemes in a number of countries and by other measures; and

Whereas it is now desirable to take further steps towards the attainment of income security by the unification of social insurance schemes, the extension of such schemes to all workers and their families, including rural populations and the self-employed, and the elimination of inequitable anomalies; and

Whereas the formulation of certain general principles which should be followed by Members of the Organisation in developing their income security schemes along these lines on the foundation of the existing Conventions and Recommendations, pending the unification and amplification of the provisions of the said Conventions and Recommendations, will contribute to this end:

The Conference recommends the Members of the Organisation to apply the following principles, as rapidly as national conditions allow, in developing their income security schemes with a view to the implementation of the fifth principle of the Atlantic Charter, and to report to the International Labour Office from time to time, as requested by the Governing Body, concerning the measures taken to give effect to these principles:

GENERAL

1. Income security schemes should relieve want and prevent destitution by restoring, up to a certain level, income which is lost by reason of inability to work or to obtain work or by reason of the death of a breadwinner.

2. Income security should be organised as far as possible on the basis of social insurance, whereby insured persons fulfilling prescribed qualifying conditions are entitled, in consideration of the contributions they have paid into a benefit fund, to benefits payable at rates and in contingencies defined by law.

3. Provision for needs not covered by social insurance should be met by social assistance, and certain categories, particularly dependent children and needy invalids, aged persons and widows, should be entitled to allowances at rates fixed according to a prescribed scale.

4. Social assistance appropriate to the needs of the case should be provided for other persons in want.

I. SOCIAL INSURANCE

A. Contingencies Covered

Range of Contingencies to be Covered

5. (1) The range of contingencies covered by social insurance should embrace all contingencies in which an insured person is prevented from earning his living, whether by inability to work or

inability to obtain work, or in which he dies leaving a dependent family, and should include certain associated emergencies, generally experienced, which involve extraordinary strain on limited incomes.

(2) Compensation should be provided in cases of incapacity for work and of death arising out of employment.

(3) In order that the benefits provided by social insurance may be closely adapted to the variety of needs, the contingencies covered should be classified as follows:

(*a*) sickness;
(*b*) maternity;
(*c*) invalidity;
(*d*) old age;
(*e*) death of breadwinner;
(*f*) unemployment;
(*g*) emergency expenses; and
(*h*) employment injuries.

Sickness

6. The contingency for which sickness benefit should be paid is loss of earnings due to abstention from work necessitated on medical grounds by an acute condition, due to disease or injury, requiring medical treatment or supervision.

7. The necessity for abstention from work should be judged, as a rule, with reference to the previous occupation of the insured person, which he may be expected to resume.

8. Benefit need not be paid for the first few days of a period of sickness, but if sickness recurs within a few months, a fresh waiting period should not be imposed.

9. Benefit should preferably be continued until the beneficiary is fit to return to work, dies or becomes an invalid. If, however, it is considered necessary to limit the duration of benefit, the maximum period should not be less than 26 weeks for a single case, and provision should be made for extending the duration of benefit in the case of specified diseases, such as tuberculosis, which often involve lengthy, though curable, sickness.

Maternity

10. The contingency for which maternity benefit should be paid is loss of earnings due to abstention from work during prescribed periods before and after childbirth.

11. (1) A woman should have the right to leave her work if she produces a medical certificate stating that her confinement will probably take place within six weeks, and no woman should be permitted to work during the six weeks following her confinement.

(2) During these periods maternity benefit should be payable.

12. Absence from work for longer periods or on other occasions may be desirable on medical grounds, having regard to the physical condition of the beneficiary and the exigencies of her work; during any such periods sickness benefit should be payable.

13. The payment of maternity benefit may be made conditional on the utilisation by the beneficiary of health services provided for her and her child.

Invalidity

14. The contingency for which invalidity benefit should be paid is inability to engage in any substantially gainful work by reason of a chronic condition, due to disease or injury, or by reason of the loss of a member or function.

15. (1) A handicapped person should be expected to engage in any occupation which may reasonably be indicated for him, having regard to his remaining strength and ability, his previous experience, and any facilities for training available to him.

(2) A person for whom such an occupation can be indicated but is not yet available, and a person following a training course, should receive provisional invalidity benefit, or unemployment benefit, if he is otherwise qualified for it.

(3) A person for whom no such occupation can be indicated should receive invalidity benefit.

16. Beneficiaries whose permanent inability to engage regularly in any gainful occupation has been confirmed should be allowed to supplement their invalidity benefit by casual earnings of small amount.

17. Where the rate of invalidity benefit is related to the rate of the previous earnings of the insured person, the right to benefit should be admitted if the handicapped person is not able to earn by ordinary effort as much as one third of the normal earnings in his previous occupation of able-bodied persons having the same training.

18. Invalidity benefit should be paid, from the date when sickness benefit ceases, for the whole duration of invalidity: Provided that when the beneficiary reaches the age at which old-age benefit may be claimed the latter may be substituted for invalidity benefit.

Old Age

19. The contingency for which old-age benefit should be paid is the attainment of a prescribed age, which should be that at which persons commonly become incapable of efficient work, the incidence of sickness and invalidity becomes heavy, and unemployment, if present, is likely to be permanent.

20. The minimum age at which old-age benefit may be claimed should be fixed at not more than 65 in the case of men and 60 in the case of women.

21. Payment of old-age benefit may, if the basic benefit is sufficient for subsistence, be made conditional on retirement from

regular work in any gainful occupation; where such retirement is required, the receipt of casual earnings of small amount should not disqualify for old-age benefit.

Death of Breadwinner

22. The contingency for which survivors' benefits should be paid is the loss of support suffered by the dependants as the result of the death of their breadwinner.

23. Survivors' benefits should be paid to the widow (or, subject to her previous registration as a dependant, to an unmarried woman with whom the deceased, himself unmarried, cohabited as man and wife) and for the children, stepchildren, adopted children and, subject to their previous registration as dependants, illegitimate children of an insured man or of an insured woman who supported the children.

24. Widow's benefit should be paid to a widow who has in her care a child for whom child's benefit is payable or who, at her husband's death or later, is an invalid or has attained the minimum age at which old-age benefit may be claimed; a widow who does not fulfil one of these conditions should be paid widow's benefit for a minimum period of several months, and thereafter if she is unemployed until suitable employment can be offered to her, after training if necessary.

25. Child's benefit should be paid for a child who is under the age of 16, or who is under the age of 18 and is continuing his general or vocational education.

Unemployment

26. The contingency for which unemployment benefit should be paid is loss of earnings due to the unemployment of an insured person who is ordinarily employed, capable of regular employment in some occupation, and seeking suitable employment, or due to part-time unemployment.

27. Benefit need not be paid for the first few days of a period of unemployment reckoned from the date on which the claim is registered, but if unemployment recurs within a few months, a fresh waiting period should not be imposed.

28. Benefit should continue to be paid until suitable employment is offered to the insured person.

29. During an initial period reasonable in the circumstances of the case, only the following should be deemed to be suitable employment:

(*a*) employment in the usual occupation of the insured person in a place not involving a change of residence and at the current rate of wages; or

(*b*) another employment acceptable to the insured person.

30. After the expiration of the initial period:

(*a*) employment involving a change of occupation may be deemed to be suitable if the employment offered is one which may reasonably be offered to the insured person, having regard to his strength, ability, previous experience and any facilities for training available to him;

(*b*) employment involving a change of residence may be deemed to be suitable if suitable accommodation is available in the new place of residence;

(*c*) employment under conditions less favourable than the insured person habitually obtained in his usual occupation and district may be deemed to be suitable if the conditions offered conform to the standard generally observed in the occupation and district in which the employment is offered.

Emergency Expenses

31. Benefits should be provided in respect of extraordinary expenses incurred in cases of sickness, maternity, invalidity and death.

32. Necessary domestic help should be provided, or benefit paid for hiring it, during the hospitalisation of the mother of dependent children, if she is an insured woman or the wife of an insured man and is not receiving any benefit in lieu of earnings.

33. A lump sum should be paid at childbirth to insured women and the wives of insured men towards the cost of a layette and similar expenses.

34. A special supplement should be paid to recipients of invalidity or old-age benefit who need constant attendance.

35. A lump sum should be paid on the death of an insured person, or of the wife, husband or dependent child of an insured person, towards the cost of burial.

Employment Injuries

36. (1) The contingency for which compensation for an employment injury should be paid is traumatic injury or disease arising out of employment, not brought about deliberately or by the serious and wilful misconduct of the victim, and resulting in temporary or permanent incapacity or death.

(2) Where compensation for an employment injury is payable, the foregoing provisions should be subject to appropriate modifications as indicated in the following paragraphs.

37. (1) Any disease which occurs frequently only to persons employed in certain occupations or is a poisoning caused by a substance used in certain occupations, should, if the person suffering from such a disease was engaged in such an occupation, be presumed to be of occupational origin and give rise to compensation.

(2) A list of diseases presumed to be of occupational origin should be established and should be revised from time to time by a simple procedure.

(3) In fixing any minimum period of employment in the occupation required to establish the presumption of occupational origin and any maximum period during which the presumption of occupational origin will remain valid after leaving the employment, regard should be had to the length of time required for the contraction and manifestation of the disease.

38. (1) Temporary incapacity compensation should be payable under conditions similar to those applicable to the payment of sickness benefit.

(2) Sickness benefit may be substituted for compensation during the first few months at most of temporary incapacity.

(3) Consideration should be given to the possibility of paying compensation from the first day of temporary incapacity if the incapacity lasts longer than the waiting period.

39. (1) Permanent incapacity compensation should be payable in respect of the loss or reduction of earning capacity by reason of the loss of a member or function or by reason of a chronic condition due to injury or disease.

(2) A person who becomes permanently incapacitated should be expected to resume employment in any occupation which may reasonably be indicated for him, having regard to his remaining strength and ability, his previous experience, and any facilities for training available to him.

(3) If no such employment can be offered, the person should receive compensation for total incapacity on a definitive or provisional basis.

(4) If such employment can be offered, but the sum which the person is able to earn by ordinary effort in the employment is significantly less than that which he would probably have earned had he not suffered the injury or disease, he should receive compensation for partial incapacity proportionate to the difference in earning capacity.

(5) Consideration should be given to the possibility of paying suitable compensation in every case of loss of a member or function or disfigurement, even where no reduction of capacity can be proved.

40. Persons exposed to the risk of an occupational disease of gradual development should be examined periodically, and those for whom a change of occupation is indicated, should be eligible for compensation.

41. Compensation for permanent incapacity, total or partial, should be paid from the time when temporary incapacity compensation ceases for the whole duration of permanent incapacity.

42. (1) Persons receiving compensation for permanent partial incapacity should be able to qualify for other benefits under the same conditions as able-bodied persons, where the rates of such benefits are related to the previous earnings of the insured person.

(2) Where the rates of such benefits are not related to the previous earnings of the insured person, a maximum may be fixed for the combined rate of compensation and benefit.

43. (1) Survivors' compensation should, subject to the provisions of the following sub-paragraphs, be paid to the same dependants as could otherwise qualify for survivors' benefits.

(2) A widow should receive compensation for the whole duration of her widowhood.

(3) A child should receive compensation until the age of 18.

(4) Provision should be made for compensating other members of the family of the deceased who were dependent upon him, without prejudice to the claims of the widow and children.

(5) The survivors of a person permanently incapacitated in the degree of two thirds or more who dies otherwise than from the effects of an employment injury should be entitled to basic survivors' benefits, whether or not the deceased fulfilled the contribution conditions for such benefit at the time of his death.

B. Persons Covered

Range of Persons to Be Covered

44. Social insurance should afford protection, in the contingencies to which they are exposed, to all employed and self-employed persons, together with their dependants, in respect of whom it is practicable:

(*a*) to collect contributions without incurring disproportionate administrative expenditure; and
(*b*) to pay benefits with the necessary co-operation of medical and employment services and with due precautions against abuse.

45. Dependent wives (that is to say, wives who are not employed or self-employed) and dependent children (that is to say, persons who are under the age of 16, or who are under the age of 18 and are continuing their general or vocational education) should be protected in virtue of the insurance of their breadwinners.

Collection of Contributions

46. The employer should be made responsible for collecting contributions in respect of all persons employed by him, and should be entitled to deduct the sums due by them from their remuneration at the time when it is paid.

47. Where membership of an occupational association or the possession of a licence is compulsory for any class of self-employed persons, the association or the licensing authority may be made responsible for collecting contributions from the persons concerned.

48. The national or local authority may be made responsible for collecting contributions from self-employed persons registered for the purpose of taxation.

49. Pending the development of agencies to enforce payment of contributions, provision should be made for enabling self-employed persons to contribute voluntarily, either as individuals or as members of associations.

Administration of Benefits

50. In order to facilitate the efficient administration of benefits, arrangements should be made for the keeping of records of contributions, for ready means of verifying the presence of the contingencies which give rise to benefits, and for a parallel organisation of medical and employment services with preventive and remedial functions.

Employed Persons

51. Persons employed for remuneration should be insured against the whole range of contingencies covered by social insurance as soon as the collection of contributions in respect of them can be organised and the necessary arrangements can be made for the administration of benefit.

52. Persons whose employment is so irregular, or likely to be so short in its total duration, that they are unlikely to qualify for benefits confined to employed persons, may be excluded from insurance for such benefits.

53. Apprentices who receive no remuneration should be insured against employment injuries, and, as from the date at which they would have completed their apprenticeship for their trade, compensation based on the wages current for workers in that trade should become payable.

Self-Employed Persons

54. Self-employed persons should be insured against the contingencies of invalidity, old age and death under the same conditions as employed persons as soon as the collection of their contributions can be organised.

55. Members of the employer's family living in his house, other than his dependent wife or dependent children, should be insured against the said contingencies on the basis of either their actual wages or, if these cannot be ascertained, the market value of their services; the employer should be responsible for the payment of contributions in respect of such persons.

56. Self-employed persons whose earnings are ordinarily so low that they can be presumed to be a merely subsidiary or casual source of income, or that payment of the minimum contribution would be a hardship for them, should be excluded provisionally from insurance and referred for counsel to the employment service

or to any special service that may exist for promoting the welfare of the occupational group to which they may belong.

57. Persons who, after completing the contribution period prescribed as a qualification for invalidity and survivors' benefits, cease to be compulsorily insured, either as employed or as self-employed persons, should be given the option, to be exercised within a limited period, of continuing their insurance under the same conditions as self-employed persons, subject to such modifications as may be prescribed.

58. Consideration should be given to the possibility of insuring self-employed persons against sickness and maternity necessitating hospitalisation, sickness which has lasted for several months, and extraordinary expenses incurred in case of sickness, maternity, invalidity or death.

C. Benefit Rates and Contribution Conditions

Benefit Rates

59. Benefits should replace lost earnings, with due regard to family responsibilities, up to as high a level as is practicable without impairing the will to resume work where resumption is a possibility, and without levying charges on the productive groups so heavy that output and employment are checked.

60. Benefits should be related to the previous earnings of the insured person on the basis of which he has contributed: Provided that earnings higher than those prevalent among skilled workers may be ignored for the purpose of determining the rate of benefits, or portions thereof, financed from sources other than the contributions of the insured person.

61. Benefits intended to cover the cost of maintenance only may be appropriate for countries where adequate and economical facilities exist for the population to procure additional protection by voluntary insurance. Such benefits should be commensurate with the earnings of unskilled workers.

62. (1) Sickness and unemployment benefits should, in the case of unskilled workers, be not less than 40 per cent. of the previous earnings of the insured person if he has no dependants, or 60 per cent. if he has a dependent wife or a housekeeper for his children; for each of not more than two dependent children, an additional 10 per cent. thereof, less the amount of any children's allowances for these children, should be payable.

(2) In the case of workers with high earnings, the foregoing proportions of benefit to previous earnings may be reduced.

63. Maternity benefit should in all cases be sufficient for the full and healthy maintenance of the mother and her child; it should be not less than 100 per cent. of the current wage for female unskilled workers or 75 per cent. of the previous earnings of the beneficiary, whichever is the greater, but may be reduced by the amount of any child's allowance payable in respect of the child.

64. Basic invalidity and old-age benefits should be not less than 30 per cent. of the current wage commonly recognised for male unskilled workers in the district in which the beneficiary resides, if the beneficiary has no dependants, or 45 per cent. of that wage if he has a dependent wife who would be qualified for widow's benefit or a housekeeper for his children; for each of not more than two dependent children, an additional 10 per cent. of that wage, less the amount of any children's allowances for these children, should be payable.

65. Basic widow's benefit should be not less than 30 per cent. of the current minimum wage commonly recognised for male unskilled workers in the district in which the beneficiary resides; for each of not more than three dependent children, child's benefit at the rate of 10 per cent. of the wage, less the amount of any children's allowances for these children, should be payable.

66. In the case of an orphan, basic child's benefit should be not less than 20 per cent. of the current minimum wage commonly recognised for male unskilled workers, less the amount of any child's allowance payable in respect of the orphan.

67. (1) A portion of every contribution additional to those paid as a qualification for basic invalidity, old-age and survivors' benefits may be credited to the insured person for the purpose of increasing the benefits provided for in paragraphs 64, 65 and 66.

(2) In every case in which retirement is deferred beyond the minimum age at which old-age benefit could have been claimed, basic old-age benefit should be equitably increased.

68. (1) Compensation for employment injuries should not be less than two thirds of the wages lost, or estimated to have been lost, as the result of the injury.

(2) Such compensation should take the form of periodical payments, except in cases in which the competent authority is satisfied that the payment of a lump sum will be more advantageous to the beneficiary.

(3) Periodical payments in respect of permanent incapacity and death should be adjusted currently to significant changes in the wage level in the insured person's previous occupation.

Contribution Conditions

69. The right to benefits other than compensation for employment injuries should be subject to contribution conditions designed to prove that the normal status of the claimant is that of an employed or self-employed person and to maintain reasonable regularity in the payment of contributions: Provided that a person shall not be disqualified for benefits by reason of the failure of his employer duly to collect the contributions payable in respect of him.

70. (1) The contribution conditions for sickness, maternity and unemployment benefits may require that contributions shall have been paid in respect of not less than a quarter of a prescribed period, such as two years, completed before the contingency occurs.

(2) The contribution conditions for maternity benefit may require that the first contribution shall have been paid not less than ten months before the expected date of confinement, but even though the contribution conditions are not fulfilled, maternity benefit at the minimum rate should be paid during the period of compulsory abstention from work after confinement, if the claimant's normal status appears, after consideration of the case, to be that of an employed person.

71. (1) The contribution conditions for basic invalidity, old-age and survivors' benefits may require that contributions shall have been paid in respect of not less than two fifths of a prescribed period, such as five years, completed before the contingency occurs; payment of contributions in respect of not less than three quarters of a prescribed period, such as ten years, or of any longer period which has elapsed since entry into insurance, should be recognised as an alternative qualification for benefit.

(2) The contribution conditions for old-age benefit may provide that the first contribution shall have been paid not less than five years before the claim for benefit is made.

(3) The right to benefit may be suspended where an insured person wilfully fails to pay any contribution due by him in respect of any period of self-employment or to pay any penalty imposed for late payment of contributions.

72. The insurance status of an insured person at the date when he becomes entitled to invalidity or old-age benefit should be maintained during the currency of such benefit for the purposes of ensuring him, in the event of recovery from invalidity, as full protection under the scheme as he was entitled to on the occurrence of the invalidity, and of entitling his survivors to survivors' benefits.

D. Distribution of Cost

73. The cost of benefits, including the cost of administration, should be distributed among insured persons, employers and taxpayers in such a way as to be equitable to insured persons individually, to avoid hardship to insured persons of small means, and to cause the least disturbance to production.

74. (1) The contribution of an insured person should not exceed such proportion of his current earnings taken into account for reckoning benefits as, applied to the estimated average earnings of all persons insured against the same contingencies, would, assuming such persons to contribute while earning from the minimum age for entering employment onwards, yield a contribution income the probable present value of which would equal the probable present value of the benefits to which they may become entitled (excluding compensation for employment injuries).

(2) In accordance with this principle the contributions of employed persons and self-employed persons for the same benefits may, as a rule, represent the same proportion of their respective earnings.

75. A minimum absolute rate, based on the minimum rate of earnings which may be deemed to be indicative of substantial gainful work, may be prescribed for the insured person's contribution with respect to benefits the whole or part of which does not vary with the rate of previous earnings.

76. (1) Employers may be required to contribute, particularly by subsidising the insurance of low-wage earners, as much as half the total cost of benefits confined to employed persons, excluding compensation for employment injuries.

(2) If employers are required to contribute with respect to benefits not confined to employed persons, regard should be had to the possible effect of employers' contributions on the volume of employment.

77. (1) The entire cost of compensation for employment injuries, except in so far as sickness benefit may be substituted for compensation in case of temporary incapacity, should be contributed by employers.

(2) Consideration should be given to the possibility of applying some method of merit rating in the calculation of contributions in respect of compensation for employment injuries.

78. The rates of contribution of insured persons and employers should be kept as stable as possible: Provided that the initial rate of contributions for invalidity, old-age and survivors' benefits may, in order to avoid disturbance to the national economy and having regard to an expected increase in national productivity, be fixed substantially below the permanent rate, to be attained gradually in a limited period or as soon as favourable economic conditions are present.

79. (1) The residual cost of benefits should be met from taxation.

(2) Among the elements which may properly be included in the residual cost are:

(*a*) the contribution deficit resulting from bringing persons into insurance when above the minimum age for entering employment;
(*b*) the contingent liability involved in guaranteeing the payment of basic invalidity, old-age and survivors' benefits and the payment of adequate maternity benefit;
(*c*) the liability resulting from the continued payment of unemployment benefit when unemployment persists at an excessive level; and
(*d*) subsidies to the insurance of persons of small means.

E. Administration

80. The administration of social insurance should be unified within a co-ordinated system of social security services, and contributors should, through their organisations, be represented on the bodies which determine or advise upon administrative policy and propose legislation or frame regulations.

81. Social insurance should be administered under the direction of a single authority; this authority should be associated with the authorities administering social assistance, medical care services and employment services in a co-ordinating body for matters of common interest, such as the certification of inability to work or to obtain work.

82. The unified administration of social insurance should be compatible with the operation of separate insurance schemes, compulsory or voluntary in character, providing supplementary, but not alternative, benefits for certain occupational groups, such as miners and seamen, public officials, the staffs of individual undertakings and members of mutual benefit societies.

83. (1) The law and regulations relating to social insurance should be drafted in such a way that beneficiaries and contributors can easily understand their rights and duties.

(2) In devising procedures to be followed by beneficiaries and contributors, simplicity should be a primary consideration.

84. Central and regional advisory councils, representing such bodies as trade unions, employers' associations, chambers of commerce, farmers' associations, women's associations and child protection societies, should be established for the purpose of making recommendations for the amendment of the law and administrative methods, and generally of maintaining contact between the administration of social insurance and groups of contributors and beneficiaries.

85. Employers should be closely associated with the administration of compensation for employment injuries, particularly in connection with the prevention of accidents and occupational diseases and with merit rating.

86. (1) Claimants should have a right of appeal in case of dispute with the administrative authority concerning such questions as the right to benefit and the rate thereof.

(2) Appeals should preferably be referred to special tribunals, which should include judges who are experts in social insurance law, assisted by assessors, representative of the group to which the claimant belongs, and, where employed persons are concerned, by representatives of employers also.

(3) In any dispute concerning liability to insurance or the rate of contribution, for an employed or self-employed person, and where an employer's contribution is in question, an employer should have a right of appeal.

(4) Provision for uniformity of interpretation should be assured by a superior appeal tribunal.

II. SOCIAL ASSISTANCE

A. Maintenance of Children

87. Society should normally co-operate with parents through general measures of assistance designed to secure the well-being of dependent children.

88. Public subsidies in kind or in cash or in both should be established in order to assure the healthy nurture of children, help to maintain large families, and complete the provision made for children through social insurance.

89. Where the purpose in view is to assure the healthy nurture of children, subsidies should take the form of such advantages as free or below-cost infants' food and school meals and below-cost dwellings for families with several children.

90. (1) Where the purpose in view is to help to maintain large families or to complete the provision made for children by subsidies in kind and through social insurance, subsidies should take the form of children's allowances.

(2) Such allowances should be payable, irrespective of the parents' income, according to a prescribed scale, which should represent a substantial contribution to the cost of maintaining a child, should allow for the higher cost of maintaining older children, and should, as a minimum, be granted to all children for whom no provision is made through social insurance.

91. Society as a whole should accept responsibility for the maintenance of dependent children in so far as parental responsibility for maintaining them cannot be enforced.

B. Maintenance of Needy Invalids, Aged Persons and Widows

92. Invalids, aged persons and widows who are not receiving social insurance benefits because they or their husbands, as the case may be, were not compulsorily insured, and whose incomes do not exceed a prescribed level, should be entitled to special maintenance allowances at prescribed rates.

93. The persons who should be entitled to maintenance allowances should include:

(*a*) persons belonging to occupational groups, or residing in districts, to which social insurance does not yet apply, or has not yet applied for as long as the qualifying period for basic invalidity, old-age or survivors' benefits, as the case may be, and the widows and dependent children of such persons; and

(*b*) persons who are already invalids at the time when they would normally enter insurance.

94. Maintenance allowances should be sufficient for full, long-term maintenance; they should vary with the current cost of living, and may vary as between urban and rural areas.

95. Maintenance allowances should be paid at the full rate to persons whose other income does not exceed a prescribed level and at reduced rates in other cases.

96. The provisions of the present Recommendation defining the contingencies in which invalidity, old-age and survivors' benefits should be paid should be applied, in so far as they are relevant, to maintenance allowances.

C. General Assistance

97. (1) Appropriate allowances in cash or partly in cash and partly in kind should be provided for all persons who are in want and do not require internment for corrective care.

(2) The range of cases in which the amount of the allowance is entirely discretionary should be gradually narrowed as the result of the improved classification of cases of want, and the establishment of budgets corresponding to the cost of maintenance in short-term and long-term indigency.

(3) The grant of allowances may be subject to compliance by the recipient with directions given by the authorities administering medical or employment services in order that the assistance may yield its greatest constructive effect.

SECTION II

MEDICAL CARE SERVICES

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MEDICAL CARE SERVICES

INTRODUCTION

Health is the most precious asset both of the individual and of the nation. No amount of wealth can compensate for its loss, and ill-health is frequently at the very root of poverty. Though the importance of health for the well-being of a country had been realised centuries ago by the more farsighted among its citizens, the recognition of this fact has but recently found such universal and emphatic expression that the need for collectively organised and financed health services is conceded by the majority of those responsible for the conduct of public affairs, and by a large section of the medical profession.

The war has greatly contributed to the conviction that health is an indispensable condition for a nation's survival. Schemes and plans for organised health services have followed each other in rapid succession during the last two years. Parliamentary commissions, government institutions, the medical profession, political parties and other groups of professional and lay men have advanced proposals for comprehensive health services. All these proposals purport to make such care available to every human being by entrusting to the community the task of organising the provision of medical care for its members and assuming collectively the cost of illness and the care of health.

The care of the people's health has two aspects which in the past have been dealt with by different agencies, a development that has tended to obscure the essential unity of all health problems.

Medical care, on the one hand, is given by members of the medical and allied professions to the individual patient with a view to restoring his health, preventing the further development of disease and alleviating his suffering when he is afflicted by ill-health. The efficient doctor, inspired by modern concepts of preventive medicine, moreover extends his care and advice to the client[1] who consults

[1] The term "client" is used in this context as denoting a person for whose health a family doctor is responsible; he becomes a "patient" when he actually receives the doctor's care.

him in good time, with a view to protecting and improving his health when it is threatened. In the first case, his care is curative; in the second, it is preventive. In both cases, it is afforded to a person whose health is threatened by illness or impending illness.

Organised collective provision for curative medical care has in the past been made chiefly by social insurance as a branch of income security schemes, or by private or public charity, mainly in connection with hospitals or poor relief institutions. Recognition of the essential unity of all health problems, however, gradually widened the concept of organised medical care beyond that underlying these insurance or assistance schemes. Illness must not only be cured—it should be prevented. Health must not only be protected—it should be improved. Care of the sick, therefore, cannot be divorced from care of the healthy. Curative, preventive and health-promoting care are but different facets of the same problem. To be altogether effective, medical care must be both curative and preventive, and must be integrated or co-ordinated with other measures aiming at the protection and improvement of health.

By these other measures, the whole community or groups of individuals are provided with means for promoting and protecting their health before it is threatened, or known to be threatened. Catering, as they do, for groups of persons exposed to special health risks before these risks materialise, measures of this kind are by their very nature amenable only to collective provision in the form of services and have, in fact, for many decades been organised and financed collectively, first by charitable and religious institutions, later by public authorities. They include immunisation and quarantine, maternity and child welfare, factory hygiene, health visiting or social work, preventive periodical examinations, physical fitness campaigns and health education, nutrition, and the like. As a rule, these services are now provided by the public authorities of both central and local governments, out of tax funds. Whether for this reason or because they deal with community health problems, they have been designated as "public health services".

This denomination, however, is liable to misinterpretation. On the one hand, medical care, as above defined, is no less a concern of the community than "public" health services, and the people's health is as much affected by the availability and quality of the one as of the other.

Public authorities, on the other hand, in addition to organising "public" health services, also provide medical care for the destitute and sometimes for those whose illness obviously endangers the health of the community, such as persons suffering from tuberculosis, venereal disease, or other infectious disease. In New Zealand and the U.S.S.R. they provide medical care for the whole population, out of funds raised by special taxation in the former, and out of general public moneys in the latter country. The qualification "public" for health services other than medical care is therefore just as misleading if purporting to refer to the agency responsible for organising such services, as it is erroneous if meant to single out their special significance for the community. It is accordingly proposed to designate health services other than medical care as "general (rather than public) health services" (defined in paragraph 43).

To sum up, the term "health services", as used in the proposed Recommendation, comprises both medical care and general health services, the connotation "service" referring to the organised provision of the care or other protective measures as distinguished from its provision by non-governmental agencies through private arrangements.

Measures of environmental hygiene, such as sanitation and health standards for housing or other premises, are not in this context included under "health services", because they do not deal with the physical and mental condition of human beings, but with the creation of a healthy environment, tasks for sanitary engineering and town planning authorities rather than for health and insurance authorities.

The proposed Recommendation deals chiefly with the principles that should guide the collective organisation of medical care. The unity of all health problems, however, must be considered as one of the principal issues in arriving at a modern health policy. The co-ordination of medical care with general health services is accordingly treated as an essential prerequisite to the success of a nation-wide and comprehensive medical care service. But the Recommendation does not deal with the organisation of general health services as such—a domain at present hardly within the scope of social security.

NATURE AND FORM OF MEDICAL CARE SERVICE

Concept of Service

The modern concept of a medical care service transcends both the concept of sickness insurance and that of social assistance.

The older sickness insurance schemes, on the one hand, lacked qualities essential for meeting the requirements of an effective medical care service: they fell short of universality in scope, did not provide unlimited care of every description, available at any time, nor ensure a rational organisation of such care and its effective co-ordination with general health services. Most often, employed persons within prescribed income limits only were insured; benefits were often limited to six months or one year and linked with cash benefits, or restricted to certain kinds of care; the service was based chiefly on individual practice, and its administration was divorced from that of general health services.

The social assistance medical care services of public authorities, on the other hand, largely based on hospitals and dispensaries, were often more rationally organised than social insurance services. Their benefits, however, were granted to indigents only, subject to a means test.

Excluded from both forms of organised care were not only the upper classes, but also the middle classes with incomes above the insurance limit.

An income security service is intended to bridge the period when the beneficiary's normal income ceases; it supplements the normal income system. A medical care service, on the contrary, is intended to meet in its entirety one of the most essential needs of mankind, the need for the protection of health when illness occurs or threatens.

The institution of such a service, if it is to be effective, cannot be left to the initiative of individuals. Voluntary insurance or pre-payment plans do not reach those strata of the population most in need of organised care, nor, as a rule, those best able to contribute to a collective scheme. A complete up-to-date medical care service is too expensive to be financed by a relatively small group of individuals.

Equally insufficient and unsatisfactory are systems which merely

grant financial assistance to the beneficiary towards the fees paid by him to the doctor consulted—as does the French system. The financial barrier preventing the person of small or moderate means from obtaining full care in good time is not entirely removed, and a truly rational organisation of the care is excluded under this "refund" system.

In the first section of the proposed Recommendation the essential criteria of a compulsory medical care service are set out.

Such a service should meet the need of the individual member of the community for care by members of the medical and allied professions, and for such other facilities as are provided at medical institutions, with a view to restoring the individual's health, preventing the further development of disease and alleviating suffering, when he is afflicted by ill health (curative care), and with a view to protecting and improving his health when it is threatened (preventive care).

It is essential that the care provided by the service be defined by law or regulations, both as to the kinds of care available and as to its extent—with comprehensive care and unlimited availability as the ultimate aims.

No less essential is the condition that care be organised and not merely financed by the responsible authorities or bodies. Arrangements must be made with members of the medical and allied professions for securing their participation in the service. Contracts to this effect between the administrative bodies and the doctors, dentists, nurses and other health workers on the basis of national agreements with their organisations, are deemed the most suitable means of securing such participation. Similar arrangements should be made with public, non-profit or approved private hospitals if the service does not itself own and maintain such institutions.

Finally, the cost of the service must, by definition, be borne collectively by all members of the community: instead of paying as and when care is received, each member of the community able to do so pays a periodical contribution into the medical care fund of an amount depending on his ability to pay.

A medical care service, thus defined, can be organised in different ways. Two main schools of thought have in recent years evolved, both purporting to make adequate care available to all members of the community.

A Public Service

One school may be said to develop the principle of social assistance, according to which care is granted out of public funds raised by taxation, without the establishment of any relation between

obligation for payment of such taxes and the right to care given under the service. The means test has, however, been abolished under the plans of this school, and care is made available to all members of the community who need it, irrespective of their economic status.

A service thus conceived may be financed by a tax specifically imposed for the purpose, or out of general income tax. Whether the one or the other method is chosen does not affect the basic principles, namely, that care is provided without any qualifying conditions as to payment of contributions or taxes and without means test, making the service a public one as are general health services and education in more advanced countries.

Two countries possess a public medical care service organised on these lines: the U.S.S.R. has a complete health service financed by the State and available free to all its people; New Zealand provides a wide range of care for all its residents by means of a special tax, collected with general income tax, though non-residential treatment given outside hospitals is only paid for, but not yet organised, collectively.

Among the many plans advanced, a considerable number propose to organise medical care in the form of a public service. This form is sponsored by the Joint Parliamentary Committee on Social Security of Australia[1] and the National Health and Medical Research Council of that country[2]; the South African Medical Association[3]; the British Labour Party, the British Liberal Party's Subcommittee on Health Services, and, as an alternative to insurance, by the Socialist Medical Association of Great Britain, and others.

The advantages of a public medical care service for the whole population are manifold. In the first instance, no test or enquiries are needed before a person can obtain benefits, and every obstacle is removed which might prevent an ailing person from resorting to medical advice before the illness has developed. Administration is thereby greatly simplified: the doctor is concerned exclusively

[1] The Parliament of the Commonwealth of Australia: *Sixth Interim Report from the Joint Committee on Social Security, dated 1 July 1943, brought up and ordered to be printed 1 July 1943.* Cf. INTER-AMERICAN COMMITTEE ON SOCIAL SECURITY: *Provisional Bulletin*, No. 4, pp. 15-25; also *International Labour Review*, Vol. XLIX, No. 1, Jan. 1944, pp. 107-110.

[2] Commonwealth of Australia: *Report of the National Health and Medical Research Council, Twelfth Session, held at Canberra, A.C.T., 26th and 27th November 1941* (Canberra, Commonwealth Government Printer, 1941). Cf. *International Labour Review*, Vol. XLVII, No. 6, June 1943, "The Planning of Medical Services in Australia", pp. 731-745.

[3] "The Future of Medicine", by the Planning Committee, in *South African Medical Journal*, Vol. XVII, No. 13, 10 July 1943, pp. 199-206; also Vol. XVII, No. 22, 27 Nov. 1943, p. 350 (voting on draft plan). Cf. *International Labour Review*, Vol. XLIX, No. 3, Mar. 1944, "A Health Service Plan for South Africa"; also INTER-AMERICAN COMMITTEE ON SOCIAL SECURITY: *Provisional Bulletin*, No. 4, pp. 25-29.

with the beneficiary's health and records, and not with administrative formalities. The hospital, too, has to deal only with the doctor and the patient.

The financing of a public service, furthermore, is entirely divorced from the administration of care, and the collection of the taxes can be placed in the hands of the Treasury if desired, while the funds set aside for the service are controlled by the authority in charge of the service. Though no relation is established between payment of the tax and the right to care, every member of the community can and should be obliged to contribute towards the cost according to his ability.

SOCIAL INSURANCE AND ASSISTANCE

Another school of thought favours social insurance as the vehicle for making medical care available to the whole or a large majority of the population, because it retains the dependence of the right to benefit on the beneficiary's or his breadwinner's insurance status, or, in other words, because it maintains the relation between contribution and benefit. This, in turn, implies that the contribution bears some rational relation to the cost of care. Such cost, under a medical care service, can be measured by comparing the total probable cost of the service to the total income of all beneficiaries of the service. The ratio of this total cost to the total income of those covered represents the relative average cost of the service. If every insured income earner would pay a corresponding proportion of his income, the whole cost of the service would be covered. The insurance contribution should therefore not exceed this relative average cost. Such cost has been estimated at 3 to 5 per cent. of the income, but under a universal scheme giving complete care, it may well be higher.

If this relative average cost is the maximum contribution that can be demanded of an insured person, however, the amount actually paid by the individual must be adapted to the contributor's ability to pay, as for many—probably the majority—of the beneficiaries the relative average cost of the service would be too heavy a burden. Consequently, part of the cost will have to be borne by the employer or the taxpayer as such, in addition to the contribution he may be paying as an insured person.

One of the main difficulties encountered in any attempt to institute a universal service by means of social insurance is that of providing for those not able to pay an insurance contribution and not dependent on an insured breadwinner. At present, these strata of the population are cared for by public assistance. Their title to care thus depends on a means test, while it is the very purpose of

social insurance to do away with this remnant of poor relief or charity. It is undesirable, under a scheme of general scope, to have two categories of beneficiaries—those who have a right to care as insured persons or dependants of insured persons, and those whose needs are met by social assistance in case of indigency. The ultimate aim, if social insurance is to be adopted as a vehicle for organised medical care, must be the insurance of the whole population, the public authority, instead of granting assistance, paying the contribution on behalf of those unable to pay. Should the income of persons insured in this way at any time rise above the subsistence level, they would become liable to pay such part of the insurance contribution as corresponded to their income category. This would not entail any change in the ultimate incidence of the cost; the community, in the person of the taxpayer, in any event bears such part of the cost as is not met by contributions actually paid by the insured persons and their employers.

Employers evidently derive benefit from the improvement of their employees' health, and it is for this reason, as well as on grounds of social solidarity, that they have been asked, and should be asked, to contribute to the insurance of their workers under schemes intended wholly or mainly for employed persons.

A medical service embracing the whole or the great majority of the population also benefits the employer, but not so much in his capacity of a producer as in his capacity of a member of the community. An improvement in the health of the community will result in a higher standard of production and of living for all its members. Though it may for reasons of expediency and policy be deemed desirable for employers to pay part of the insurance contribution on behalf of their employees, the employer's share in the cost of the service as a taxpayer should, if such cost is equitably distributed, be the greater the larger the number of his employees and the higher his profits. These yardsticks, namely, number of workers and profits, will probably measure his financial ability more correctly than the payroll of his employees. Moreover, his share as a taxpayer goes to pay for the care not only of his workers, but of all his less fortunate fellow citizens. The residual cost of a medical care service of universal scope—*i.e.*, that part which is not met by contributions of insured persons themselves—can be more fairly distributed if each member of the community, whether employer or not, pays according to his ability, as taxpayer, than by imposing on employers a share depending on their workers' wages on the one hand, and on them and all other taxpayers a share of the residual cost according to ability.

PERSONS COVERED

The Need for Organised Medical Care

There is general agreement among those planning the future of health services that medical care should be available to every member of the community, irrespective of his economic status. But opinions differ as to which sections of the community should have free access to a medical care service collectively organised.

The necessity of providing for those members who are themselves patently unable to pay for medical care, the indigent and the very poor, is generally conceded. These strata of the population are not even in a position to contribute by way of insurance contributions or taxes to the financing of the care afforded them. They have in the past been cared for, if at all, by public assistance or private charity. In many countries, doctors have given care free of charge to the poor, but it has rightly been pointed out both by the medical profession and by lay men that the community should assume responsibility for these its least fortunate members. They should receive such care as of right and not as a charity, and should have the same class of service as the remainder of the population.

In the case of the indigent or unemployed, the need for collectively organised medical care is evident. Between the destitute and the other member of the community with low or moderate income, however, there is but a difference of degree: while the former is unable himself to obtain any care at his own expense, the latter's ability to obtain care depends on, and is proportionate to, his income. Yet the need for medical care has been shown by numerous investigations[1] to be the greater the lower the income. The state of health of the citizen is largely dependent on his economic status. Insufficient or unsuitable food, inadequate housing conditions and the absence of other necessities of life are among the main causes of ill health. But inability to afford adequate care adds to the effect of these conditions by aggravating and perpetuating ill health.

A high proportion of the population in most countries comes

[1] Cf. for instance, Social Security Board, Bureau of Research and Statistics: *Medical Care and Costs in Relation to Family Income.* A Statistical Source Book. Bureau Memorandum No. 51 (Washington, D.C., Mar. 1943).

within the lowest income groups of these investigations, namely, $1,000, without being indigent or permanently indigent. It is thus obviously not sufficient to make provision for the free treatment of persons on relief or too poor otherwise to obtain any care. The lower middle classes are not in a position to meet the cost of serious illness out of their own income, and those with moderate incomes cannot meet such cost without serious hardship. A major illness may ruin the family. The striking development of medical science, with its specialisation involving complex and costly services and apparatus, has greatly raised the cost of comprehensive medical care and placed it increasingly outside the reach of families of moderate means. As a result, the majority of the people cannot or do not have recourse to medical care at a stage when prevention of serious illness or aggravation would still be possible.

A collectively organised medical care service of wider scope is therefore an urgent necessity. Such a service should not be limited to any particular section of the community, such as employed persons. The large majority of those working on their own account, the self-employed, whether engaged in farming, handicraft or business, and whether or not they employ others, enjoy but moderate incomes liable to fluctuate with changes in economic conditions. They are in no better position to obtain regular and adequate care for themselves and their families than those in employment. Moreover, a self-employed person may at any time change over to work under a contract of employment. Other sections of the community with bare subsistence incomes, such as pensioners, evidently cannot be excluded.

Provision for the families of all these income receivers must of course be the foremost concern of the community, as the health of mothers and children is the very foundation of national prosperity.

There is practical unanimity among those planning for the future that all classes and sections of the population should come within the scope of a medical care service, employed, self-employed, housewives, children, retired, unemployable and indigents, as well as their families, as rapidly as may be practicable.

Should There Be an Income Limit?

Limitation of the scope of a medical care service to certain sections of the population has thus, in theory at least, been ruled out. Such is not, however, the case as regards limitation to certain income categories. The very fact that health is largely influenced by economic status would appear to justify the exclusion of the well-to-do classes from the scope of a national medical care service.

In this event the medical profession would retain the advantage of attending privately to those able to pay higher fees than could be granted under the service.

The British Medical Association, for instance, proposes to maintain the income limit obtaining under the National Health Insurance Act, but to include dependants of insured persons and others of an economic status similar to that of the present beneficiaries of health insurance.[1] Persons with higher incomes could be permitted to join the service voluntarily.

Against the exclusion of persons whose income exceeds the prescribed, but necessarily arbitrary, limit, it can be argued that income may fluctuate for the majority of the population. Those who are today in a position to pay for adequate care may find themselves in need of organised aid at some future time, especially in old age. The Danish health insurance scheme provides for this case by requiring persons whose income exceeds the insurance limit to become passive members: they pay a low premium and receive no benefits, but become active members if and when their income falls below the prescribed level.

Further, none but the rich can without serious hardship meet unaided the cost of a major and prolonged illness.

From the administrative point of view, the imposition of an income limit entails financial and other controls and formalities which, under a nation-wide service, are hardly worth the trouble. In Great Britain, for instance, not more than 10 per cent. of the population would be outside the scheme if the income level were fixed at £420. This residual population, moreover, will in any case be contributing substantially to the financing of a national service as taxpayers, whatever the scope.

The inclusion of the whole population without income limit is recommended by the majority of the experts, organisations, and commissions who have worked out plans for the future of medical care services: Sir William Beveridge[2]; the Subcommittee on Health Services of the British Liberal Party; the Labour Party of Great Britain; the Socialist Medical Association, and a group of young doctors "Medical Planning Research"—both in Great Britain; the Planning Committee of the South African Medical Association; and the Joint Parliamentary Committee on Social Security in Australia. The Canadian Dominion Government's plan for health insurance also favours a nation-wide medical care service, although

[1] *British Medical Journal, Supplement*, 30 Oct. 1943, p. 75. Cf. *International Labour Review*, Vol. XLIX, No. 2, Feb. 1944, pp. 250-255.

[2] *Social Insurance and Allied Services*, Report by Sir William Beveridge (Cmd. 6404, London, Nov. 1942). Cf. *International Labour Review*, Vol. XLVII, No. 1, Jan. 1943: "Social Security Plans in Great Britain", pp. 46-57.

Provinces would be allowed to prescribe income limits.[1] The Wagner-Murray-Dingell Bill of 1943[2], now before the United States Congress, provides medical and hospital care both for employed and self-employed persons without income limit, or some 80-90 per cent. of the population. The British Government has undertaken to make all manner of medical care available to every man, woman and child who wants it.[3]

Many of these plans, however, propose to retain private practice for persons who would prefer not to avail themselves of the facilities offered by the medical care service.

Should Private Practice Continue under a National Medical Care Service?

Fear has been expressed that the coexistence of private and public practice[4] might conceivably result in two different standards of medical care, a higher private standard and a lower public one. It is frequently alleged, in fact, that insurance practice has not in the past been of the same standard as private practice. If this be true, it might be ascribed to the insufficiency of the remuneration received by doctors for the care of insured persons, a fact largely due to the restriction of services to persons within low income limits. Adequate payment for medical and other professional care rendered under an insurance or public medical care service, and provision for economic security in the event of sickness, old age and death, would probably go a long way towards improving the standard of medical care under such service.

If private practice were to continue side by side with national public practice, adequate terms for the medical and allied professions engaged in public practice would be an indispensable condition for safeguarding the quality of the care given. The doctors so engaged could also attend private patients at the health centres and hospitals maintained by the service. Adequate financing,

[1] Draft of "An Act respecting Health Insurance, Public Health, the Conservation of Health, the Prevention of Disease, and Other Matters Related Thereto", in *Health Insurance, Report of the Advisory Committee on Health Insurance appointed by Order-in-Council P.C. 836 dated Feb. 5, 1942* (Ottawa, King's Printer, 1943). Cf. *International Labour Review*, Vol. XLVIII, No. 4, Oct. 1943: "Canada's Health Programme", pp. 466-478.

[2] 78th Congress, 1st Session: *Wagner-Murray-Dingell Bill*, S. 1161. Cf. *International Labour Review*, Vol. XLVIII, No. 2, Aug. 1943, pp. 247-250.

[3] *Parliamentary Debates, House of Commons*, 16 Feb. 1943, cols. 1660-61. As this Report goes to press, the publication of a White Paper on Health Services by the British Government is announced. It is proposed to introduce a nation-wide service based on free choice of family doctor and health centres for general practice, with free hospital and specialist care.

[4] By "public practice" is meant the provision of medical care under a collectively organised medical care service, whether this takes the form of a public service or social insurance.

however, is incompatible with a low income limit for insurance coverage, unless a large subsidy is provided from general taxation.

The Mechanism of Coverage

Under a public medical care service which, by definition, covers the whole population, no special mechanism of coverage is required. Every member of the community, that is to say, every person living in the country, is entitled to care. It is not advisable to make this right dependent on length of residence, citizenship or other qualifying conditions. As regards transients, their exclusion may involve considerable administrative complications. These might be obviated by collecting the special tax for the medical care service from hotel proprietors for their guests, or, if the service is financed out of general income tax receipts, by imposing a special tax on hotels, proportionate to the average number of guests.

The inclusion under social insurance of the whole population, a considerable section of which, under existing insurance schemes, depends on social assistance, presents greater problems. Various methods are recommended in paragraphs 12-19, the combined effect of which would be to confer ultimately upon all members of the community the status of insured person. For members whose income does not exceed the subsistence level, the public authority would pay the insurance contribution. This payment would automatically entitle the dependent wife or husband to the same care. It is proposed that, once the service covers the whole population, all children should be entitled to care in virtue of the contributions paid by or on behalf of adult insured persons in general, and not in virtue of their parents' or guardian's insurance. This principle is recommended in the health insurance plan of the Canadian Government. Provision is thus made for children without regard to their family status. Under insurance schemes of limited scope, children must of course be included in virtue of their parents' insurance.

Social assistance is accordingly considered only as a transitional expedient to provide care for people without a disposable margin in their income, until they have been included under social insurance. It is recommended to replace the usual *ad hoc* means test now obtaining under social assistance by a periodical test ascertaining that the applicant's income has no disposable margin for payment of an insurance contribution.

THE PROVISION OF CARE AND ITS CO-ORDINATION WITH GENERAL HEALTH SERVICES

The Interdependence of Health Services

A health policy presupposes that the full range of medical care services is available to the members of the community at any time. Provision must be made for the care of the mother during pregnancy and at confinement. The child needs, not only medical treatment in the event of illness, but also the constant advice of a family doctor as well as dental supervision. Throughout life, medical advice and attendance, both general, specialist and dental, and nursing and other auxiliary services, hospital and similar institutional facilities, medical rehabilitation services, pharmaceutical, dental and other medical and surgical supplies should be within reach of the citizen if his health is to be maintained and strengthened.

The health approach to medical care makes it imperative that special attention be paid to early diagnosis and other preventive measures. If illness ensues, treatment should be available as long as it is needed or useful, or until the patient is completely rehabilitated for work and for normal life.

It is not, however, sufficient to ensure that medical care is constantly available to each member of the community. Other health agencies must work in close contact with the medical care service. For example, the mother needs advice as to her diet during pregnancy, and as to the proper feeding of the infant. The child must be kept under regular medical inspection at the welfare centre or nursery and at school and the family doctor should be informed of any deficiencies thus discovered. School dental services must be co-ordinated with the dental treatment provided under the medical care service so as to ensure regular dental examination and care of all children. Physical exercise organised by schools is indispensable to the healthy development of the child, and proper nutrition should be secured by school meals and provision of milk. The adolescent's fitness for the work he intends to engage in should be established by pre-employment examination. The physician entrusted with this task should work in close collaboration with the family doctor, who should be able to give him valuable information on the youth's physical and mental disposition and abilities.

Constant supervision of health conditions at the place of work is required, and periodical examinations of workers could do much to prevent occupational disease and secure timely treatment. Retraining of a disabled worker following medical rehabilitation should be based on his own doctor's findings. Generally, preventive examinations[1], including mass x-ray photography, and financial assistance to persons suffering from tuberculosis, are prominent features of most modern plans for the organisation of medical care. A scheme of this kind has been in operation for some time in Chile and is being put into force in Great Britain.[2]

Finally the public should be made health conscious by education and instruction, and by the organisation of a "physical fitness campaign", as recently inaugurated in Great Britain and in Canada. By the aid of research and statistical records of health conditions, the success and the needs of the medical care service can be gauged and future measures planned.

The interdependence of all health care thus calls for a medical care service offering complete curative and preventive care which is constantly available to all who need it, organised with a view to securing the utmost efficiency of the service without waste of resources, and integrated or co-ordinated with general health services, so as to make these readily available to the beneficiaries of the medical care service.[3]

Constant Availability of Complete Care

To make the complete range of care constantly and generally available to any beneficiary[4] of the service, there should be no barriers of any kind to delay or hinder recourse to the service. Neither political nor racial distinctions, nor conditions as to moral conduct or good citizenship, nor arrears in contributions under a social insurance scheme, should prevent the beneficiary from obtaining all care he needs immediately and as long as he needs it. This does not mean that the beneficiary should have direct access to all departments: as a matter of fact, as will be shown in paragraphs 48-56, he should consult the general practitioner he has chosen as his family doctor before obtaining any other kind of care, with the

[1] Cf. *International Labour Review*, Vol. XLVI, No. 2, Aug. 1942: "The Aims and Achievements of the Chilean Preventive Medicine Act", by Dr. Manuel de Viado, pp. 123-135.

[2] Cf. *idem*, Vol. XLVIII, No. 5, Nov. 1943, pp. 666-668.

[3] Cf. *idem*, Vol. XLVI, No. 6, Dec. 1942: " 'A New Structure of Social Security': The Work of the Inter-American Conference on Social Security at Santiago de Chile", pp. 677-681; also Vol. XLV, No. 1, Jan. 1942: "Social Medicine in Chile", by Dr. Salvador Allende G., pp. 25-43.

[4] "Beneficiary", as used in this context, denotes any person entitled to the care provided by the service.

exception of first aid and dental treatment. Such other care, however, should commonly be available through the general practitioner without delay or formality. No enumeration of the services required can be exhaustive, and the final arbiter for deciding as to whether or not a new profession claiming to be indispensable to a complete care service should be recognised as an "allied" profession must be the legislature.

The requirement that care must be available at any time will necessarily be subject to certain restrictions due to the technical organisation of the service. Patients at a busy health centre will have to await their turn; the general practitioner will refer the patient to a specialist as soon as this can be arranged; in outlying districts, transport facilities must be made available to convey him to the next specialist centre, or the specialist to the patient. Such technical restrictions must, however, be reduced to a minimum, an aim that may be furthered by a system of appointments, as proposed in paragraph 56.

A limitation by law of the period during which treatment is granted, as formerly obtaining under most European health insurance schemes, is incompatible with one of the main objects of a medical care service, the restoration of health. None of the more recent plans contemplates a limitation of the period during which out-patient care is granted, though limitation of hospital care is still retained in some. The patient's doctor is the only judge of the length of time for which medical care is needed.

Care must be readily available wherever the person needing it may be at the time when the need becomes apparent to him. It is, therefore, not advisable to limit the services of any town, village or other area, to the people ordinarily resident in that town, village or area. Nor should the members of an insurance institution, such as an occupational or works fund or a local institution, be obliged to obtain care from doctors or members of allied professions working for that particular fund (except, of course, where this is the only fund with a medical care service). Care should, as a rule, be available at or near the beneficiary's residence, and first aid at any place he may be in, until his own doctor can again take charge of him. Residential care must be made available on the same conditions as out-patient care.

It is essential, if care is to be readily available at any time and place, that the service be unified within areas sufficiently large to permit of the establishment of a complete service, including all branches of care. Areas with a population of 500,000 have been suggested by the Planning Commissions of the British Medical Association and the South African Medical Association, as this

number would be sufficient to justify self-contained services which are both comprehensive and well-balanced[1] and for keeping a general hospital occupied[2]; smaller areas have been suggested by others. In practice, the size will depend on local conditions, such as climate, rate of morbidity, distribution of population, transport facilities, etc.

The work of all area services must be supervised by a central authority—whether State or Federal—to ensure co-ordination and uniform standards (see under paragraphs 91-111). Where the service is not yet universal or is still administered by insurance institutions of various types, such as local, occupational or works funds, collaboration between the institutions concerned, and between them and the responsible public authorities, should be temporarily substituted for unified area administration.

The Rational Organisation of Care

The Dispersal of Resources

Health insurance was originally grafted on private practice, as a rule without any serious attempt at a rational organisation of the medical care given to its beneficiaries. The provision of medical benefit was regarded as a subsidiary function of sickness benefit insurance, required mainly for the certification of incapacity and as a means of restoring the patient's working capacity.

Recourse was had to the services of private practitioners working from their own offices. Though doctors worked at hospitals more or less in co-operation, either as medical officers employed by the hospital, or as members of the visiting staff, beneficiaries of insurance medical care services were left to obtain out-patient treatment from doctors practising individually. The insurance institution either refunded part of the fees paid by the beneficiary himself to the doctor (refund system), or approached doctors directly and secured their services by contract, the institution paying the doctor's fees (contract system). None of these systems, the one obtaining in France, the other in Great Britain, Czechoslovakia and other European countries, precluded doctors from working in groups at offices rented and managed in common, and reaping themselves the advantages from the economy of group practice in this form. In fact, however, there was no sufficient incentive from within the profession for doctors, on their own initiative, to undertake such a

[1] Medical Planning Commission: *Draft Interim Report* (British Medical Association House, London, 1942), p. 22. Cf. *International Labour Review*, Vol. XLVII, No. 1, Jan. 1943: "Social Security Plans in Great Britain", pp. 57-61.

[2] "The Future of Medicine", in *South African Medical Journal*, 10 July 1943, p. 202.

venture. Competition for clients divided their interests, and individualistic tradition often determined their outlook. The incentive came either from without, from the administrators of insurance, or from the medical profession as an organised body, and other interested groups.

On the European continent, sickness insurance led to an increase in the volume of medical care demanded by, and given to, insured persons and their families, as it largely removed the economic barriers which kept these sections of the population from making use of existing facilities.[1]

It also brought sickness experience within the purview of public interest. A few days of illness, the doctor's fee, the disruption of a family's life, might seem insignificant for the community as a whole in each individual case. Added up for millions of workers and their families, and expressed in terms of working days lost, cash benefits paid and expenditure on medical care by sickness funds, the loss amounted to impressive figures. At the same time, medical science and practice developed by leaps and bounds, the scope of proper medical care widening accordingly and involving ever greater cost.

The need for a more rational use of resources thus became apparent. Experiments with health centres—mainly for specialist care—were made in some European countries, not without encountering opposition on the part of the medical profession. In certain Latin American countries, such as Brazil, Chile, Peru and Costa Rica, where insurance was introduced more recently, medical care has from the outset been organised in the form of group practice at health centres.[2] In Russia, the medical care service is based on such centres.[3] China is establishing rural centres.

In the British Commonwealth, the initiative in proposing group practice has recently been taken by the organised medical profes-

[1] It has been adduced as an argument against health insurance that morbidity in countries possessing such insurance has increased since medical care services were introduced. This rests on a confusion between the actual total amount of sickness and the amount which is recognised and attended. In fact, health insurance would have defeated its very purpose if recorded morbidity had not increased at the outset: it makes care available to those who could not otherwise afford it. Cf. *International Labour Review*, Vol. XLIII, No. 5, May 1941, "Morbidity Trends and Trade Cycles", by Laura E. BODMER, pp. 514-541.

[2] Cf. INTER-AMERICAN COMMITTEE ON SOCIAL SECURITY: *Provisional Bulletin*, No. 1, "Panorama of Social Insurance in the Americas" (International Labour Office, Feb. 1943); also, INTER-AMERICAN COMMITTEE TO PROMOTE SOCIAL SECURITY, Report I, 4: *Protection of the People's Health Through Social Insurance* (Montreal, 1942).

[3] *Constitution (Fundamental Law) of the Union of Soviet Socialist Republics adopted at the Extraordinary Eighth Congress of Soviets of the U.S.S.R., Moscow 1937* (Co-operative Publishing Society of Foreign Workers in the U.S.S.R.), Arts. 79-87 and Art. 120. Cf. THE AMERICAN RUSSIAN INSTITUTE: *The Soviet Union Today*, an Outline Study (New York, 1943); Rose MAURER: *Soviet Health Care in Peace and War* (New York, 1943); also H. E. SIGERIST: *Socialised Medicine in the Soviet Union* (New York, 1937).

sion of Great Britain and South Africa. In New Zealand, the Government plans to organise health centres, and in Australia, the Joint Parliamentary Committee favours this form of organisation. The Canadian draft Bill permits of arrangements with clinics. Practically all other plans for nation-wide medical care services at present under discussion recommend fully developed group practice at health centres.

In the United States, experiments in group practice have been attracting wide attention for more than a generation, and some have been developed under voluntary insurance schemes. The Wagner-Murray-Dingell Bill of 1943 proclaims as a guiding principle "co-ordination among the services furnished by general practitioners, specialists, laboratory and other auxiliary services. . . ." The highest type of group practice has been achieved in the large hospitals, especially in the teaching hospitals of the university medical schools.

Group Practice at Health Centres

The draft schemes and plans under discussion thus, almost unanimously, advocate and encourage some form of group practice, or provision of care by doctors and members of allied professions co-operatively at centres where staff, premises and equipment are placed at the participants' disposal.

The sponsors of these plans point out that under a system of individual practice, every practitioner needs separate premises, equipment and staff. Frequently, he cannot afford the most modern and perfected apparatus, nor the most highly qualified assistance. This is particularly true for specialists, who need more costly and complex equipment than the general practitioner.

Medical resources, under the system of individual practice, are not generally distributed according to needs. Doctors settle where private practice appears most profitable, preferably in the more well-to-do residential districts and in the larger cities, while poorer districts and the country often go short of doctors. Certain corrective measures have been taken by sickness funds to secure a more adequate distribution, such as the limitation of the number of doctors admitted to insurance practice and of the proportion of specialists admitted in a given area, and financial aid to doctors in sparsely settled districts. These measures, however, could not be more than palliatives.

The doctor practising individually, moreover, does not enjoy the moral and professional advantages of collaboration: exchange of knowledge and experience, stimulus of team work, and friendly

competition. He also lacks the material advantages of collaboration which permits of regular hours, night rest and holidays made possible by a rota system.

The general principles underlying most of the plans for comprehensive medical care services may be summed up as follows:

To the beneficiary, all services should be ultimately available at or through a centre where at least first aid and advice from the general practitioner and dental care should be immediately available.

To the general practitioner acting as family doctor, the centre should offer all diagnostic facilities and the assistance of office staff, nurses, midwives and other auxiliary professions, and such facilities as the services of a pharmacy, a laboratory, x-ray apparatus, a small operating theatre, etc. He must be able to obtain for his patients specialist advice and treatment and residential care as necessary, either at his centre or at a reasonably accessible larger centre, which may be a hospital. The dentists need similar aid, corresponding to their particular duties. The specialist requires, in the first instance, complete up-to-date technical equipment, judicious reference of patients by the general practitioner, hospital work and research facilities.

The family doctor should also collaborate with the general health services. The location at the centre of such services as those of ante- and post-natal maternal and infant welfare, immunisation, health visiting and school medical treatment is recommended notably by the Medical Planning Commission of the British medical profession. These services, as far as medical care goes, could be entrusted to the medical staff of the centre, while in other respects they would be the responsibility of health medical officers, health visitors and social workers. The present artificial distinction between medical care given privately or under health insurance on the one hand, and other health protection given under the auspices of public authorities on the other, could thus be discarded.

Area Organisation of Health Centres

Whether group practice will yield optimum efficiency and economy of service must depend largely on the degree of organisation.

The advantages of group practice at health centres can be fully reaped only where area authorities administer the medical care services, and possibly also general health services, and organise the provision of care for the whole or the majority of the population within the area. Practically all plans at present under discussion envisage such area organisation of group practice, which would

evidently need to take both advantage and account of existing health facilities. Different types of area organisation have accordingly been proposed by those planning the future of medical services.

One viewpoint, represented by the Australian National Health and Medical Research Council, the South African Medical Association, and the group of British doctors known as "Medical Planning Research", bases the entire health centre system on hospitals. The modern hospital is equipped for all kinds of special and general treatment given, not only to in-patients, but also to a steadily growing number of out-patients.[1] The need for a readjustment of the work of hospitals and that of individually practising general practitioners and specialists calls for a rational organisation of which the hospital is the natural central unit.

The "area" health service would be grouped around one or more large general hospitals developed into health centres. These hospital centres would, in addition to treatment for in-patients, provide all out-patient specialist treatment for the whole area or the part of the area served by the hospital, and general-practitioner treatment for beneficiaries living or staying in the hospital's immediate vicinity. The central hospital would receive cases needing residential and specialist treatment from smaller health centres established throughout the area according to density and needs of population. The larger of these centres, forming a ring around the central hospital, would be attached to the smaller hospitals in the area and would relieve the central hospital of minor cases requiring residential care, dental cases or those needing certain special services. They would be visited by specialists from the central hospital, or specialists employed by the area authority to serve several smaller hospitals. The local hospital centre would also provide general practitioner's services for the beneficiaries residing or staying within its orbit. In places without hospitals, health centres would be staffed by general practitioners or possibly one general practitioner only, aided by some nursing and other auxiliary staff.

Another body of opinion, represented by the British Medical Planning Commission, favours the concentration of general practice and auxiliary services at centres provided by the area authority. The British Government also appears to envisage such health centres. Specialists under the plan of the Medical Commission would give both in- and out-patient advice and treatment, including domiciliary visiting, at or from hospitals. The plan takes account of the fact that under the conditions at present obtaining in Great

[1] The term "out-patient" denotes any patient who is not confined to a hospital or other medical institution, whether such patient is receiving care at his home, at a health centre, at the doctor's office or at a hospital out-patient department.

Britain, general practice is strongly developed outside the hospital system. Specialists practise mainly as consultants to whom patients are referred by the general practitioner, and in addition, work for the hospitals, as a rule in an honorary capacity. Voluntary hospitals, in particular, have developed large out-patient departments chiefly for specialist treatment.[1]

A third type of area health organisation would be the out-patient centre for all non-residential care. This form may be appropriate where both general and specialist practice are strongly developed outside hospitals, as in central Europe and the U.S.A., while public hospitals deal mainly with residential cases treated by their own medical staff or specialists attending their own patients. The centre would provide general and specialist care and all auxiliary out-patient services. Specialists could, as under group practice schemes in the U.S.A., work also at the hospitals to which their patients are sent.

Group Practice for Limited Services

Knowledge and resources can be pooled to some extent, and their distribution be adapted to the number and needs of members, at health centres maintained by insurance institutions with limited range—limited to a section of the population in a local fund, or to the members of a works, or to those of an occupational group, for instance. Such centres, however, will be profitable only where the number of beneficiaries at any one place is sufficient to occupy one or several general practitioners and auxiliary staff. If this is not the case, it might nevertheless prove desirable for the institution or institutions to establish specialist clinics where its members could consult, on the recommendation of their general practitioner, specialists in all the main branches of medicine, more particularly if such facilities would not otherwise be available, as such a centre need not be in proximity of the beneficiaries' residence. Specialists engaged in private practice, both within the institution's area and in outlying districts, could be engaged by contract to attend at the clinics during agreed hours. Experiments on these lines were made in Czechoslovakia, Hungary and Poland.

[1] Under the tentative plan of the British Medical Planning Commission, consultant specialist service for persons within the medical care scheme would be based on the hospitals. These would have to provide a non-hospital as well as a hospital service of specialists. Consultations would be given at the hospital, in the patient's home or at health centres, as required. Specialists would be employed either whole time on the staff of a particular hospital or as consultants for a group of smaller hospitals, or part time. In the latter case, the specialists would devote part of their time to the medical care service and part to private practice. Specialists would receive inclusive salaries for all work done under the service, whether in- or out-patient work.

Where the number of beneficiaries is substantial, health centres giving more comprehensive service, including both general-practitioner and specialist treatment, and hospitalisation at the larger centres, should be set up by insurance institutions if existing facilities are inadequate. This will be the case, more particularly, where the insured population is dispersed over a sparsely settled area. Under these circumstances, however, an extension of the service to the whole population would be eminently desirable.

Travelling clinics providing first aid, some general treatment and possibly dental care, or at least dental examination, will be needed in thinly populated regions, under any kind of organisation. Transport and ambulance services will have to bring patients to centres and hospitals. A flying doctor's service, as introduced in some parts of Australia, could bring the physician to the patient where large distances have to be traversed.

If it is not profitable for an institution or institutions with limited scope to maintain their own health centres, and existing facilities are adequate, voluntary co-operation between members of the health professions participating in the medical care service at centres owned and run by these members for both insurance and private practice, would achieve some economy through the pooling of resources and division of labour, and permit of a certain measure of co-operation.

The Federal Council of the British Medical Association in Australia, at its meeting in March 1943, adopted a motion in favour of co-operative group practice at centres where each doctor would see his own patients.

Where beneficiaries of a service are few and dispersed over a populated area, the institution would have to rely on existing facilities, while for few beneficiaries in a sparsely settled area inadequately supplied with doctors, no service could be instituted.

The introduction of a medical care service should not, however, be delayed because health centres cannot immediately be organised. While centres are being built and equipped, or experimented with, the service can have recourse to established practitioners, working from their own offices.

Collaboration with General Health Services

Though the introduction of a medical care service may not go hand in hand with that of general health services, as defined in paragraph 43, because the latter are already organised and financed collectively, the two sets of health measures cannot reasonably be separated. Their integration in one single health service is the

ideal solution. Where this is impracticable, co-ordination and central control of all health services are indispensable. Such co-ordination has been organised with success in Chile and, more recently, in Costa Rica.[1] Locally and technically, continuity of all care can and should be assured by establishing common headquarters and entrusting certain general health services to the medical and auxiliary staff giving the medical care. Suggestions on these lines have already been mentioned earlier in this Report.

[1] Cf. *International Labour Review*, Vol. XLVIII, No. 4, Oct. 1943, p. 534.

QUALITY OF SERVICE

It is an axiom that a medical care service should be of the highest possible standard. Yet, fear has been expressed—not entirely without foundation—that in actual application a medical care service may tend to be of a relatively low standard, owing to the limitation of funds. The first and foremost condition for a service of high standard is the provision of adequate financial means. But such means must be used in a manner ensuring that the best service is given by those participating, and that certain conditions essential to the creation of a fruitful doctor-patient relationship are fulfilled.

Among these conditions are the patient's right to choose his family doctor, continuity of treatment, adequate conditions of service and protection of the doctor's professional independence and discretion, as well as the furtherance and maintenance of professional skill.

Choice of Doctor and Continuity of Care

Much has been said and written in defence of the patient's right to choose his doctor. The arguments are well known. They may perhaps be summed up in the statement that mutual confidence and personal contact between doctor and patient are greatly enhanced, if not altogether guaranteed, where this right of selection is conferred both on the patient and on the doctor.

There can be no doubt that this argument is intrinsically sound. In reality, however, there is no such thing as complete freedom of choice, and the claim must accordingly be qualified in various respects. Even under private practice, only the rich man can freely choose his doctor, and his choice will normally be restricted to the doctors in his district, and limited by his knowledge of the capacity and qualifications of all doctors within his reach.[1]

The less wealthy citizens cannot, as a rule, afford to select their doctor among any considerable number. Even with a partial refund of the fees, the patient may not be able either to travel to consult

[1] Cf. also "Sistemas de Admissão dos Médicos nas Instituições de Previdência Social", by Helvecio Xavier Lopes, in *Revista do Trabalho*, Rio de Janeiro, Dec. 1942, pp. 3-8.

the best qualified specialist to treat him, or to pay the additional fees charged by the betterknown doctors.

Under a medical care service which relieves the individual of any direct financial liability, his choice of doctors must, at best, be limited by considerations of distance and of organisation: He cannot, for financial reasons, be permitted to select the doctor whose office is at a great distance from his home unless he undertakes to pay the additional travelling expenses, both for himself in case of a call at the office and for the doctor in case of a home visit.[1] In reality then, his choice is limited to doctors who practise in the neighbourhood. Under a medical care service utilising individual practice, the beneficiary living in a working-class district would, as a rule, have to consult a practitioner who has to serve a large number of private clients to make a living out of his practice, and who cannot therefore afford to devote much of his time and energy to any one patient. Moreover, where the service is financed by a sickness fund of restricted scope, only a limited number of doctors can be placed at the member's disposal. As to the choice among the available doctors practising near his home, the beneficiary would rarely be in a position to appraise the qualities and capacity of a doctor before having been treated by him for some time; it is all the more necessary, therefore, to allow him to change his doctor if he is not satisfied with his first choice.

This brings us to the second and most important aspect of the doctor-patient relationship, the continuity or discontinuity of treatment. Both in North America and on the European continent, the rapid development of special branches of medicine has resulted in a growing proportion of doctors practising as specialists, and a tendency on the part of the public to consult specialists directly. With the evolution of medical thought and public opinion towards a preventive and constructive concept of medical care, however, a movement has originated in favour of a return to the general practitioner as a physician, health adviser, and co-ordinator of health services.

The case for the general practitioner as a family doctor has been convincingly stated by the subcommittee of the Federal Council of the British Medical Association of Australia in its report on a general medical service[2]:

> . . . it is of primary importance that the organisation of the health service of the nation should be based upon the family as the normal unit, and on the family doctor as the normal medical attendant and guardian. It is not for disease or diseases in the abstract that provision has to be made, but for persons liable to or suffering from disease. The first essential for the proper and efficient treatment of individual persons is, therefore, not institutional but personal service, such as can be rendered in the homes of the people only by a family doctor who has the continuous care of their health, to whom they will naturally turn for advice and help in all matters pertaining thereto, who will afford them such professional services as he can render personally, and who will make it his duty to see that they obtain full advantage of all the further auxiliary services that may be otherwise provided.

[1] In exceptional cases, additional travelling expenses may be justified by the special medical need of the patient.

[2] *Medical Journal of Australia*, 1 Nov. 1941, p. 517.

In fact, without a thorough knowledge of his patient's past records and physical and mental disposition, his economic condition and environment, a doctor will never be able to give the full measure of his capacity, help and advice.

The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem. It is all the more dangerous to leave the beneficiary to make his own choice in each case if specialist treatment is available, as he cannot be expected to know what kind of special treatment his condition requires.

But free choice of doctor may be deemed all the more essential under a system that entrusts the health of the beneficiary almost exclusively to one doctor. As pointed out by the Federal Council of the British Medical Association of Australia, few illnesses are without an underlying psychological factor, and lack of confidence greatly impairs the value of a family doctor to his patient.

How can the right of every citizen to free choice of doctors be safeguarded under an all-inclusive system providing not only curative general treatment, but also specialist, dental, preventive care and other health services? Can it be reconciled with the claim for an effective centralisation of all these services in health centres?

The problem has been considerably simplified on the part of the sponsors of health service plans by the elimination or restriction of free choice in the consultation of specialists. The U.S.A. Wagner-Murray-Dingell Bill prescribes that "the services of specialists shall ordinarily be available only upon the advice of the general practitioner" (p. 45). The Canadian health insurance plan, in the model Provincial draft Bill, confers on the insured person the right to benefit by the services of specialists and consultants, ordinarily after consultation with and on recommendation of the family doctor selected by the beneficiary, and the right to select this specialist or consultant "subject to any regulations made in that behalf". Other plans provide that, in principle, the general practitioner attending the beneficiary shall refer him to one of the specialists available under the service if specialist treatment is needed.

Free choice is thus limited to the general practitioner who has to

assure the continuity of treatment and care and who is the link between the patient and all other medical care and general health services.

Provision must, of course, be made for cases in which the general practitioner does not advise specialist treatment but the patient claims that he needs it—possibly by consultation of another doctor.

The problem is further simplified in sparsely settled districts: whether the one doctor available in such a district receives beneficiaries at his own office or at a health centre is irrelevant in this respect. It is, however, of great importance that, at a health centre equipped and provided by the authorities administering the service, all other care should be at the doctor's disposal, permanently or through travelling services.

How the right to free choice can be reconciled to the need for continuity of care under the particular circumstances of each case is shown in paragraphs 48-56 of the proposed Recommendation.

Status and Remuneration of Members of Medical and Allied Professions

Doctors cannot be expected to give the full measure of their ability, knowledge and skill if they are not relieved from financial anxiety. Their remuneration under a medical care service must be sufficient for maintaining the standard of living which the great responsibility and the great exigencies of the vocation demand. The doctor should not have to worry about sickness and old age or the fate of his family in the event of his death. He must be enabled to recuperate by being assured of adequate night rest and holidays. His remuneration should be related to the amount and the quality of his work, so as to allow him to devote ample time to each patient, but it should not rob him of the incentive to maintain and improve his clients' health. He should not be cramped in the exercise of discretion by red tape and lay interference, but the quality of his work and the integrity of his professional conduct must be watched over by his own colleagues in the profession.

The Status of the Doctor

Doctors, very rightly, are greatly concerned about their professional independence and discretion under a medical care service. Unfortunately, in the discussion of this matter, considerable confusion has been created by the somewhat indiscriminate use of such terms as "State medical service", "salaried medical service", "State salaried medical services" or "socialised medicine".

The two issues involved in determining the doctor's condition of service should be clearly distinguished, namely: (1) the status of the doctor participating in the medical care service; and (2) the method by which he is paid for such participation.

If salary is taken to mean a fixed periodical payment made to a person doing other than manual or mechanical work, it will immediately be apparent that payment for service by salary is in no way identical with whole-time employment in the service of the central or local government, as a public servant, or in the service of an insurance institution as an officer of such institution.

Most of the objections raised by the medical profession against "salaried State service" are directed against the civil service, or officer, status of a doctor employed by a political body or a non-medical institution, as is very aptly pointed out by the South African Planning Committee in one of its interim reports:

> Against such a system there is a definite body of feeling in the profession:
>
> (*a*) that the intimate relationship between doctor and patient puts medical work on a somewhat different plane from other professions, unsuited to control on civil service lines as ordinarily understood;
>
> (*b*) that the practice of medicine is a technical matter and should be as far as possible in the hands of the profession itself. One medical man at its head responsible for all the various workings to the Minister is not enough;
>
> (*c*) there is a great fear that a service run as a pure civil service department would tend to become very bureaucratic...; also that there would be grave risk of the service being captured by party political machines, and nothing worse could be imagined for the health of the country than that medical appointments and promotions should be made on political grounds instead of on those of professional ability.[1]

These objections, in the opinion of the Committee, could be overcome, or at any rate minimised, by introducing between the Minister and the medical head of the Health Department responsible for the National Health Service and the profession carrying out the health work, a body partly or mainly composed of elected representatives of the professions and having not merely advisory but also certain executive powers.

The Planning Committee of the Australian National Health and Medical Research Council, on the other hand, suggests that its medical salaried service should be a departmental one under the Public Service Act, and that doctors should have the right of collective approach to an impartial tribunal in respect of questions of salary, while any individual doctor should be able to appeal against the promotion of any other doctor.

[1] *South African Medical Journal*, Vol. XVI, No. 24, 26 Dec. 1942, p. 427.

In either case, whether the doctor is employed as a civil servant or by a self-governing or predominantly professional body, permanent and whole-time employment implies the payment of a salary, and the questions that remain to be settled are the scale of such salary and the indirect forms of remuneration, such as superannuation, holidays, sick leave, etc. (see below p. 88).

If, however, the status of the doctor as a more or less independent registered practitioner doing also private practice is retained, as under the plan suggested by the British Medical Planning Commission and the Canadian draft Bill, there are several methods of payment that can be applied separately, or in combination, namely: (1) fees for every individual service rendered, or for every case treated; (2) payment on a per capita basis; (3) a salary, that is, a fixed periodical payment covering all or the greater part of the services rendered during the period under review.

The merits and defects of each of these methods as judged in the light of the requirements outlined above, are briefly characterised below.

Payment for Services Rendered

This method of payment takes at least partial account of the work actually done by the doctor under the service, but provides no safeguard against excessive treatment by the less scrupulous members of the profession, however small their number may be. Nor does it offer an incentive, in the form of material advantages, to maintain or improve the patient's health.

From the administrative point of view, the method would involve a most elaborate system of book and record keeping and of controls against professional abuses, both for the administration of the service and for the doctor. A complicated nomenclature would be required if account were to be taken of the nature of each individual service, more particularly in the case of specialists. If the system is simplified by adopting as the unit of service the visit or consultation, as, for example, in New Zealand, or the cases treated during a given period, as in some parts of Czechoslovakia, the sole advantage of the method—reward for work done—is largely lost, while its defects are enhanced. Experience in Germany has shown up all the drawbacks of the system. Elaborate precautions were deemed necessary to prevent excessive treatment. The sickness funds' liabilities were finally limited to a global sum proportionate to their membership, such sum being eventually distributed among insurance practitioners roughly in proportion to the number of cases treated, but with a degressive scale, the unit of payment diminishing with an increase in the number of cases treated. The whole system was discarded on the outbreak of war and exchanged for a guarantee of incomes "frozen" at pre-war level.

Payment for services rendered is recommended only where other methods cannot advantageously be applied, mainly for the remuneration of specialists under a service of very limited scope.

The "Capitation Fee"

The "family doctor" system has led to the adoption, under the British Health Insurance scheme, of a method of payment which limits the liabilities of the medical care service and undertakes, by severing the relation between the number and amount of services rendered and the amount of the remuneration, to pay the doctor for preserving the beneficiary's health. The doctor receives a flat-rate payment for every beneficiary who has chosen him and who is included in his list, irrespective of the care his client actually requires and receives. He is thus, in theory, interested in maintaining his client's health and treating him with a view to prevention, and not tempted to furnish excessive service. The better the patient's health, the greater the doctor's remuneration per service rendered. The combination of a capitation fee and free choice of doctor and patient is said to preserve a salutary element of competition among doctors.

Where this form of payment is not combined with free choice, as in Hungary and Yugoslavia and in parts of Czechoslovakia[1] before the war, it amounts for all practical purposes to payment of a part-time salary and will be discussed below.

The most serious of the objections raised against it may be summarised in the words of the National Health and Medical Research Council of Australia that "the more time the doctor devotes to his panel patients, the smaller his income". He is tempted to increase his income by adding to the number of his clients at the expense of professional efficiency.[2]

The capitation fee system suffers from the fundamental defect that doctors receive an income inversely proportionate to the amount of work involved or given, and is not, therefore, recommended as a method of remuneration in the proposed Recommendation. It encourages the few less conscientious doctors to give summary care, and penalises the majority for being conscientious.

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[1] Cf. INTERNATIONAL LABOUR OFFICE, Studies and Reports, Series M (Social Insurance) No. 15: *Economical Administration of Health Insurance Benefits* (Geneva, 1938).

[2] *Medical Journal of Australia*, 16 Aug. 1941, p. 183.

Part-Time Salary

Many members of the medical profession contend that, without the stimulus of competition, there might not be a sufficient incentive for the doctor to do his best.

To this the partisans of a salaried service reply that competition for profit or position is not the only or the best form of competition for a profession. "Competition against the elements or against a common enemy (including disease), and friendly rivalry in connection with a common task, have all proved equally effective."[1] Professional jealousy engendered by commercial competition is not conducive to efficient collaboration. Relieved of financial worries and of the necessity of competing for patients, the doctor could devote his whole energy to the preventive care of his patients, and collaborate with his colleagues in giving the best services, securing the best health standards and advancing medicine in his municipality or region.

These aims, however, can be achieved on condition only that the salary paid the doctor or dentist is adequate, that the doctor or dentist is freed from all anxiety for his own and his family's well-being by provision for sickness, old age and death, that regular annual leave and relief from, or compensation for, night duty contribute to the maintenance of his health, and that study leave permits him to keep abreast of developments in medical science and practice. The possibility of promotion to a higher and more interesting post would act as a further incentive to efficient work.

It may be doubted whether these requirements can be met where the doctor works part time only for the medical care service for a part-time salary and undertakes practice outside the medical care service to supplement his income.

The salary can in this case be fixed either in proportion to the number of beneficiaries in the doctor's charge, if the doctor is a general practitioner or dentist, or in proportion to the hours of work at the doctor's office or at the health centre.

A part-time salary has, for the general practitioner or dentist, all the disadvantages of the capitation fee, plus that of precluding free choice, if the salary is related to the number of clients in the doctor's or dentist's charge, which accordingly has to be fixed by assigning to the doctor the beneficiaries for whom he is to be responsible.

Where the general practitioner or dentist is paid on the basis of the hours during which he attends to beneficiaries of the service

[1] *British Medical Journal, Supplement*, 21 Feb. 1942: "A Whole-Time State Medical Service", by John A. RYLE, Regius Professor of Physic in the University of Cambridge, p. 35.

at the health centre or at his office or at their home, these hours would have to be fixed according to the number of beneficiaries who have chosen to be the doctor's clients if the right of free choice was to be safeguarded.

In this case, the time the doctor or dentist could devote to each patient would be the shorter the greater the frequency and volume of illness among his clients—certainly a most undesirable result. In practice, part-time salaries have not, to our knowledge, been combined with free choice.

The case is different for specialists doing both private and public practice who are mainly consultants under the medical care service and working at hospitals. The hours of attendance at his office or at the centre, devoted to the beneficiaries of the service, and the time he spends at the service's hospitals, if any, may be deemed a fair measure of the work furnished by the specialist. There must, of course, be a sufficient number of beneficiaries to occupy the specialist's time.

A Combined Salary and Capitation Fee System

The system of remuneration by a basic salary supplemented by a capitation fee, as proposed by the British Medical Planning Commission and the British Liberal Party's Subcommittee on Health Services, meets the objections to the employment of doctors as civil servants or officers of a non-medical institution, safeguards the doctors' and the patients' right to free choice, and preserves some measure of competition for profit, while securing to the doctors at least certain of the economic advantages of the salary system. It is accordingly recommended as the method of payment for the services of general practitioners devoting the greater part of their time to a medical care service with extensive though not universal scope, but also doing some private practice.

Full-Time Employment

Doctors working exclusively for a medical care service could be paid either for services rendered, or by a capitation fee, or by salary. The reasons militating against the first two alternatives and the economic and social advantages of a salary system have already been discussed. In the event of full-time employment for a salary, the doctors' professional independence must, however, be safeguarded by placing them under an authority largely consisting of representatives of the medical profession, and not under the direction of laymen or purely political bodies.

A salary system is actually in force in Chile, Peru, Costa Rica,

and Russia, and its introduction is proposed in the plans of the South African Medical Association, the Parliamentary Committee on Social Security and the National Health and Medical Research Council of Australia, and the Labour Party and the Socialist Medical Association of Great Britain.

Working Conditions for Allied Professions

Nurses, midwives, laboratory workers and other members of allied professions work under the direction of doctors. In their case, full-time employment by the service would seem most appropriate, guaranteeing them adequate conditions and security in case of illness and old age, and for their survivors in case of death.

Salaries of these auxiliary workers, and especially of nurses, should be more adequate than at present and in proportion to the exigencies of the profession. The unsatisfactory conditions now obtaining for nurses in many countries have repeatedly been pointed out.

Where medical supplies, such as medicines, appliances, artificial limbs, spectacles, etc., are supplied to the service by qualified persons, tariffs both for the supplies and for the services rendered—such as dispensing, making of casts, repairs, etc.—should be fixed by the central authority administering the service in agreement with the representative organisations of the suppliers.

Professional Supervision

It is desirable that the professional supervision of the medical care service be entrusted to bodies predominantly composed of representatives of the professions concerned, created for this purpose, and responsible to the public authority.[1]

Uniform Working Conditions

If care of equal quality is to be available, working conditions for doctors, dentists, nurses and other health workers must also be equally fair to all of these participants. Salaries and other terms should depend on qualifications, and the only variations that may be justified within the same grades are privileges to compensate the doctor or other professional worker for special hardships or difficulties, such as service in a remote district calling for travelling and for night visits; severe climate or rough country, etc. Differences in the cost of living may, of course, be taken into account.

[1] Cf. INTER-AMERICAN COMMITTEE TO PROMOTE SOCIAL SECURITY: *Efficacy and Economy of Medical and Pharmaceutical Benefits in Health Insurance Plans*, Report I, 2 (Montreal, 1942).

Working conditions must be agreed on with the representatives of the profession. If the profession in question is not organised or if its organisations are not representative, it might be advisable to make provision for its representation by statute.

Professional Standards

The medical profession, very rightly, attaches the greatest importance to the maintenance and furtherance of professional standards under a medical care service. This aim can be achieved by prescribing the qualifications required for doctors and other members of the medical and allied professions desiring to participate in the service, by organising post-graduate study for the participants, and, generally, by organising, promoting and supporting education and research.

FINANCING OF MEDICAL CARE SERVICE

Distribution of Cost

Under any medical care service of wide scope, whether it takes the form of a public service or social insurance, a substantial proportion of the cost will be borne by taxpayers. As already stated, the insurance contribution under a social insurance service should not exceed the relative cost of care which is represented by the proportion of the individual's income corresponding to the proportion of the total income of insured persons required to cover the full cost of the medical care services. The total cost includes that of care given to the dependent wives or husbands of insured persons, and to children, who do not pay contributions. Moreover, the insured person's actual payment must be related to his income. The residual cost, not covered by revenue from insured persons' contributions, will consequently be considerable. It is recommended, in view of the considerations set out in the first chapter, that funds raised by general taxation be used not only for providing care to contributors and their dependants by supplementing income from their contributions, but also to pay insurance contributions for persons who would not otherwise be insurable. These persons are those whose income does not exceed the subsistence level and who have thus no disposable margin for a contribution. By payment of contributions on their behalf out of public funds, they acquire insurance status, and their wives or husbands become insured persons, all receiving care under the service as of right, instead of being left to the ministrations of social assistance and use of the means test for medical service. Children, it is proposed, should be insured in virtue of all adults' contributions.

Under a public medical care service, as defined in paragraph 6, no such problems arise. Every member of the community pays one contribution, either as part of general income tax, or as a special tax, and adapted to his ability to pay. Though this contribution contains the same two elements—payment for the care he is entitled to, and share in the cost of care for the less wealthy—no such division need be made in practice. The total cost of the service has only to be distributed as equitably as possible, according to income and ability to pay.

Special Tax or General Tax

A special tax, it is contended, would make beneficiaries feel that they are paying for the care they receive under the service, and are not receiving it "free" from the State. This argument, however, loses much of its weight where the service is comprehensive and universal and where direct taxation is equally general. Every person paying general income tax would be a beneficiary and probably very much aware of the fact that he was paying for the care received, as the tax would evidently be increased by an amount equivalent to any special tax meeting the cost of a medical care service, unless funds could be diverted from other, less productive, fields of public expenditure.

A special tax would still have the advantage of facilitating the establishment of a special medical care fund, the resources of which would be both secured and limited by the receipts from the tax, and a reduction in morbidity would be translated either in a reduced tax or an improved service. These advantages, however, will accrue only on condition that the tax be progressively graded in such a way as to yield returns which are sufficient for meeting the whole cost of the service, as otherwise it will need to be supplemented out of receipts from general taxation, and the distribution of the cost will be veiled.

However, the unification of all health services, both medical care and general, is widely deemed one of the most desirable developments in the health field. As general health services are, in most countries, already financed out of general taxation funds, their integration with a medical care service would call for a common method of finance. General income tax would, here, appear the most appropriate and refined instrument.

It is highly undesirable to finance a service out of miscellaneous public funds derived from such sources as rates, duties, etc., as the final incidence of such taxes cannot be ascertained and no assurance is given that the cost will be shared according to ability.

THE ADMINISTRATION OF MEDICAL CARE SERVICES

Unity of Health Services

The divorce of sickness insurance from general health services and social assistance administered by public authorities has in many countries resulted in a patchwork that is the very negation of a system guaranteeing continuity of care. In the almost unanimous opinion of those concerned in the future of health services, a central authority, whether State or Federal, should formulate a health policy for the whole country and control, supervise or co-ordinate the administration of medical care and general health services by the local bodies.[1] The country should be divided into appropriate health units, or areas, as discussed on p. 71.

There is no division of opinion, among sponsors of plans for a reorganisation of health services, as to the necessity of unified central supervision and of regionalisation of all health services, with the reservation that the Canadian draft Bill, though providing for common health regions, envisages separate administrations of health insurance and of general health services. The Advisory Committee on Health Insurance was in favour of unified administration but gave way to the wishes of the medical profession and other lay and professional groups. In countries like the U.S.A., where general health activities are primarily functions of the States and local governments, a national medical care service would need to be co-ordinated with the general health activities at all levels of government.

Government, Self-Government or Expert Body

It is also generally accepted that both beneficiaries and the medical and allied professions giving care under the service should participate in its administration.

The form and degree of this participation must evidently depend on the choice of the administrative body.

No preference is expressed in the proposed Recommendation for any particular form of administration, as long as the principles of

[1] The term "body" is used to designate an aggregate of persons, whether a public authority, a corporation or any other such aggregate.

democratic control are observed, with the exception of one case: an insurance medical care service of limited scope, though it must be under the general supervision of a central authority, should be administered by a body largely representative of the beneficiaries and the participating doctors and other professions. The employers may request representation if the service covers employees only.

Central Administration

The form of administration most desirable for a national service is being widely discussed at present. The organised medical profession in Great Britain and South Africa has recently shown a marked preference for a "corporate body", created by statute or charter, rather than a Government department. Opposition to departmental control is based on the fear of overbearing political influence which might cripple initiative and interfere with professional discretion. Hierarchical organisation would, it is argued, further enhance the risk of bureaucracy and predominance of the layman over the technician, especially if the central authority employed the health workers. A corporate body, it is alleged, would have "greater freedom from parliamentary control over its day-to-day functions".[1]

In favour of central administration by a government department or agency, it is argued by others that the democratic principle demands direct and constant responsibility to the legislature or government. Existing health departments, moreover, have "accumulated knowledge of national health conditions"[2], and already administer general health services.

Whether the members of a "corporate body" will in practice show more initiative than the head and high officials of a government department, and respond less to the undue pressure of political influence and public opinion, will depend mainly on the personality of the responsible administrators.

Complete independence from public opinion would certainly not appear to be a desirable aim in a democratically organised world.

A "corporate body" as distinct from a government department or agency, however, is a somewhat vague notion as regards its constitution and attributes under a medical care service. As a matter of fact, the corporations proposed by the various planning committees represent the whole gamut, from purely expert bodies,

[1] "Corporation or Department", editorial in *British Medical Journal*, 2 Oct. 1943, p. 425.

[2] *National Service for Health. The Labour Party's Post-War Policy* (London, Apr. 1943), p. 15.

lay and professional, or predominantly professional in composition, to bodies fully representative of all interested parties, appointed or elected, with various combinations of these types in between.

The two main types of corporate bodies proposed by various planners are thus the representative body and the expert body. The former includes representatives of the health professions, of the government, and, if the service is not of universal scope, of the beneficiaries of the medical care service. The plan of the Canadian Dominion Government, for instance, proposes administration of health insurance through a corporate body appointed by the Provincial Government and representing the organised health professions, Provincial health authorities, insured persons and a variety of other interests such as labour, industry, farming, etc.

An expert body administering a medical care service would, according to various plans, consist of members of the health professions only, or of professionals and laymen qualified for the office, the members being elected or appointed by the Government, as the case may be. The "corporation" is responsible to Parliament through the Government for its general policy. The possibility of division of authority among persons of equal rank, as opposed to hierarchical organisation, is considered by its sponsors as the outstanding advantage of such a "corporation".

Local Administration

The area administration of medical care services involves problems of a more technical nature than central administration. According to modern concepts, powers may either be vested in area authorities constituted on the same lines as the central authority—government, representative body or expert body—or derived from the central authority who appoints area officers or establishes branches.

Generally, where local autonomy both of political authorities and of medical associations is extensively developed, administration by area authorities will be preferred. Two alternative methods have been suggested: under some plans, existing local governments are entrusted with the administration of health services, either in their present form or newly constituted for all purposes of local administration, and assisted by technical advisory bodies. Under others, special area health authorities are formed. The second alternative permits of a direct representation on the executive body itself both of beneficiaries and of the professions. A special health authority would not be preoccupied by other, political and cultural, tasks and would be less directly affected by local election issues. The choice is considered as of particular importance where salaried employment of doctors and other health personnel by the area authority is planned.

Administration through offices or branches of the central health authority is the solution proposed under plans endowing the central authority with extensive functions, such as the schemes of the South African Medical Association and "Medical Planning Research". The Canadian Dominion Government's plan also provides for regional offices of the Provincial Health Insurance Commission, and not for representative bodies. Fear has been expressed that administration from the centre may not be as democratic as administration by area authorities and might not make sufficient allowance for local needs, customs and convictions.

Democratic Control

A central government department or agency in charge of a medical care service of universal scope in a democratic country represents the whole community and, therefore, all beneficiaries of the service. Nevertheless, it may be desired to establish a more direct contact with beneficiaries than that secured by elections which do not always take place at regular and short intervals. Advisory bodies representing beneficiaries should be consulted by the Minister or officer in charge on all essential matters affecting the health services. All important groups of the population should have representatives on such bodies: labour in industry, agriculture and seafaring, industrialists, farmers, merchants, housewives, the liberal professions, civil servants, etc.

The beneficiaries of a medical care service of limited scope should be consulted by the central government department or agency supervising health services on all matters affecting the medical care service. Advisory bodies can be elected by the members of the insurance institutions administering the service, either by ballot or through their general meetings.

The medical and allied professions should be similarly consulted through advisory bodies to the department or agency. Even under a service of limited scope, the profession as a body should be consulted by the government rather than insurance doctors only, though these must be assured of adequate representation on the advisory bodies.

When a representative body or a body of experts is put in charge of central supervision of all health services, rather than a government department or agency, such body should be composed of representatives of beneficiaries and the professions or of professional

members and lay men, respectively. Any such body, whether representative or expert, must be responsible to the government, and, in countries where the government is parliamentary, to the legislature.

It is the considered opinion of those competent in the matter that "regionalisation" of local administration is essential to the success of a medical care service. Regionalisation, as already stated, means the formation of areas sufficiently large and otherwise suitable both for the administration of the medical care service and of general health services. If the former is of general scope, administration of medical care and general health services by one and the same area authority is proposed in many plans. The health area may, according to density of population and other factors, be the whole State or a group of States in a Federation, a county or a group of counties, a large city or part of a city, etc.

In the health area, a medical care service of universal scope should be administered by the beneficiaries and the professions jointly. Should area governments be the administrative authorities, as representing all members of the community and, accordingly, all beneficiaries, then the professions should participate through committees, not only in an advisory capacity, but in the technical execution of the tasks. The supervision of the professional and technical aspects of health centres and hospitals and that of the professional work of doctors and other staff, responsibility for the maintenance of the prescribed standards of medical care and hospitals, etc., are duties that can best be discharged by expert committees of the medical and allied professions. If a representative executive body is chosen as area authority, beneficiaries, through their area government, and the professions, through their area organisations, should be represented, preferably in equal numbers.

Finally, if the area administration is merely a function of the central authority, as in Chile and Peru, and as proposed in the Canadian draft Bill and by the South African Medical Association and "Medical Planning Research", who both entrust central administration to corporate bodies of experts, the professions should participate in the technical work in the same way as under area government administration.

Administration of Health Units

The day-to-day administration of health units owned and administered by the service is, without doubt, predominantly the concern of medical men, who alone are competent to vouchsafe that proper ministration of care which administration should here imply.

Health centres for out-patient care should, in the opinion of the organised medical profession and others concerned, be administered by the doctors working at the centres. Other members of the staff should take part in the election of the doctors entrusted with the supervision.

Hospitals, or hospital centres, are composite units involving a considerable variety of managerial duties. A superintendent will be required who should be agreeable to the members of the professions working at the hospital and appointed on the recommendation of the medical staff of the hospital, or of the organised professions if the service is of universal scope. He should co-operate with the doctors working at the hospital. The general control of health units and their policy will, of course, be exercised by the authority administering the service, as above stated.

Right of Complaint and Appeal

No organisation, however perfect, can prevent occasional negligence or abuse on the part of health workers participating in the service, nor errors of judgment on the part of the supervisory bodies. Provision is therefore made under existing schemes, and should be made under any scheme, for the submission of complaints by beneficiaries concerning the care received, preferably to joint bodies, from whose decision appeal should lie to independent tribunals.

Equally, professional workers participating in the service should be able to appeal from the decisions of supervisory bodies entitled to take disciplinary measures.

Conclusion

It will be seen from the foregoing that, while it is widely recognised that the provision of medical care services is a necessary element in any comprehensive system of social security, there is as yet no general consensus of opinion on the form in which they should be organised. Different forms of organisation may in fact be considered suitable in different countries in view of the existence or otherwise of insurance machinery, of the variations in the organisation of medical institutions and of differences in other conditions. There are, however, a number of general principles which should be applied whatever the system preferred if the objective aimed at is to be adequately achieved. The attached draft Recommendation may seem at first sight unduly long and detailed, but it would be of little practical use to state only these general principles without showing how they should be applied under one or other system.

The Office has therefore thought it desirable, in the light of such experience as is available, of such documentation as it has been able to collect, and of such consultation of experts as it has been able to undertake, to provide guidance for Governments in whatever organisation of medical care services they may contemplate or decide to institute. The text therefore provides for the possibility of various solutions. A series of separate texts, each dealing with one or other of the main variants which require consideration, might have been prepared, but the method adopted of a single text has the advantage of keeping the main principles steadily in view as their application to one or other system is successively dealt with. If this is borne in mind and if it is remembered that only a selection of the provisions can apply in any given case, it will be evident that the text has been made as brief as is consistent with practical utility.

PROPOSED RECOMMENDATION CONCERNING MEDICAL CARE

The General Conference of the International Labour Organisation,

Having been convened at by the Governing Body of the International Labour Office, and having met in its Twenty-sixth Session on 20 April 1944, and

Having decided upon the adoption of certain proposals with regard to the question of medical care services which is included in the fourth Item on the Agenda of the Session, and

Having determined that these proposals shall take the form of a Recommendation,

adopts, this day of May of the year one thousand nine hundred and forty-four, the following Recommendation which may be cited as the Medical Care Recommendation, 1944:

Whereas the Atlantic Charter contemplates "the fullest collaboration between all nations in the economic field with the object of securing for all improved labour standards, economic advancement and social security"; and

Whereas the Conference of the International Labour Organisation, by a resolution adopted on 5 November 1941, endorsed this principle of the Atlantic Charter and pledged the full co-operation of the International Labour Organisation in its implementation; and

Whereas the availability of adequate medical care is an essential element in social security; and

Whereas the International Labour Organisation has promoted the development of medical care services—

by the inclusion of requirements relating to medical care in the Workmen's Compensation (Accidents) Convention, 1925, the Sickness Insurance (Industry, etc.) and (Agriculture) Conventions, 1927,

by the communication to the Members of the Organisation by the Governing Body of the conclusions of meetings of experts relating to public health and health insurance in periods of economic depression, the economical administration of medical and pharmaceutical benefits under sickness insurance schemes, and guiding principles for curative and preventive action by invalidity, old-age and widows' and orphans' insurance,

by the adoption by the First and Second Labour Conferences of American States of the resolutions constituting the Inter-American Social Insurance Code, the participation of a delegation of the Governing Body in the First Inter-American Conference on Social Security which adopted the Declaration of Santiago de Chile, and the approval by the Governing Body of the Statute of the Inter-American Conference on Social Security, established as a permanent agency of co-operation between social security administrations and institutions acting in concert with the International Labour Office, and

by the participation of the International Labour Office in an advisory capacity in the framing of social insurance schemes in a number of countries and by other measures; and

Whereas it is now desirable to take further steps for the improvement and unification of medical care services, the extension of such services to all workers and their families, including rural populations and the self-employed, and the elimination of inequitable anomalies; and

Whereas the formulation of certain general principles which should be followed by Members of the Organisation in developing their medical care services along these lines will contribute to this end:

The Conference recommends the Members of the Organisation to apply the following principles, as rapidly as national conditions allow, in developing their medical care services with a view to the implementation of the fifth principle of the Atlantic Charter, and to report to the International Labour Organisation from time to time as requested by the Governing Body, concerning the measures taken to give effect to these principles.

I. General

Essential Features of Medical Care Services

1. A medical care service should meet the need of the individual for care by members of the medical and allied professions and for such other facilities as are provided at medical institutions—

(*a*) with a view to restoring the individual's health, preventing the further development of disease and alleviating suffering, when he is afflicted by ill health (curative care); and

(*b*) with a view to protecting and improving his health when it is threatened (preventive care).

2. The nature and extent of the care provided by the service should be defined by law.

3. The authorities or bodies responsible for the administration of the service should secure medical care for its beneficiaries, preferably by contracting with members of the medical or allied professions and by arranging for hospital and other institutional services.

4. The cost of the service should be met from funds raised in the form of regular levies on the income of members of the community able to pay.

5. Medical care should be provided either through a public medical care service, or through a social insurance medical care service with supplementary provision by way of social assistance to meet the requirements of needy persons not covered by social insurance.

6. Where medical care is provided through a public medical care service—

(*a*) every member of the community should be entitled to all care provided by the service;

(*b*) the service should be financed out of funds raised by a progressive tax specifically imposed for the purpose of financing the medical care service or all health services, or by general income tax.

7. Where medical care is provided through a social insurance medical care service—

(*a*) every insured person, including a dependent wife or husband and a dependent child, should be entitled to all care provided by the service;

(*b*) care for other persons if they are unable to obtain it at their own expense should be provided by way of social assistance;

(*c*) the service should be financed by contributions from insured persons and possibly from their employers, and by subsidies from public funds to meet the cost of care not covered by such contributions.

II. Persons Covered

Complete Coverage

8. The medical care service should aim at covering all members of the community, whether or not they are gainfully occupied.

9. Where the whole of the population is to be covered by the service and it is desired to integrate medical care with general health services, a public service may be appropriate.

10. Where the service is limited to a section of the population or to a specified area, or where the contributory mechanism already exists for other branches of social insurance and it is possible ultimately to bring under the insurance scheme the whole or the majority of the population, social insurance may be appropriate.

Coverage through a Public Medical Care Service

11. Where medical care is provided through a public medical care service, the provision of care should not depend on any qualify-

ing conditions, such as payment of taxes or compliance with a means test, and all beneficiaries should have an equal right to the care provided.

Coverage through a Social Insurance Medical Care Service

12. Where medical care is provided through a social insurance medical care service, all members of the community should have the right to care as insured persons or, pending their inclusion in the scope of insurance, should have the right to receive care at the expense of the public authority when unable to provide it for themselves.

13. All adults whose income exceeds the subsistence level should be required to pay insurance contributions.

14. The dependent wife or husband of an adult contributor should be insured in virtue of the contribution of her or his breadwinner, without any addition on that account.

15. Other adults who prove that their income does not exceed the subsistence level should preferably be entitled to care as insured persons, the contribution being paid on their behalf by the public authority.

16. If and so long as adults unable to pay the contribution are not insured as provided in paragraph 15, they should receive care at the expense of the public authority.

17. All children under the age of 16 years or who are dependent on others for regular support while continuing their general or vocational education, should be insured in virtue of the contributions paid by or on behalf of adult insured persons in general, and no additional contribution should be payable on their behalf by their parents or guardians.

18. If and so long as children are not insured as provided in paragraph 17, because the service does not extend to the whole population, they should be insured in virtue of the contribution paid by or on behalf of their father or mother without any addition on that account, or where they are orphans or abandoned or otherwise in need of care should receive care at the expense of the public authority.

19. Where any person is insured under a scheme of social insurance for cash benefits or is receiving benefit under such a scheme, he and his dependent wife and dependent children should also be insured under the medical care service.

III. The Provision of Medical Care and its Co-ordination with General Health Services

Range of Service

20. Complete preventive and curative care should be constantly available, rationally organised and co-ordinated with general health services.

Constant Availability of Complete Care

21. Complete preventive and curative care should be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an administrative, financial or political nature, or otherwise unrelated to health matters.

22. The care afforded should comprise both general-practitioner and specialist out- and in-patient care, including domiciliary visiting; dental care; nursing care at home or in hospital or other medical institutions; the care given by qualified midwives and other maternity services at home or in hospital; maintenance in hospitals, convalescent homes, sanatoria or other medical institutions; together with the requisite dental, pharmaceutical and other medical or surgical supplies, including artificial limbs, and the care furnished by such other professions as may at any time be legally recognised as belonging to the allied professions.

23. All care and supplies should be available at any time and without time limit, when and as long as they are needed, subject only to the doctor's judgment and to such reasonable limitations as may be imposed by the technical organisation of the service.

24. Beneficiaries should be able to obtain care at the centres or offices provided, wherever they happen to be when the need arises, whether at their place of residence or elsewhere within the total area in which the service is available, irrespective of their membership in any particular insurance institution, arrears in contributions or of other non-health factors.

25. The administration of the medical care service should be unified for appropriate health areas sufficiently large for a self-contained and well balanced service, and should be centrally supervised.

26. Where the medical care service covers only a section of the population or is at present administered by different types of insurance institutions and authorities, care should be secured collectively by the institutions and authorities concerned through joint contracts with, or employment of members of the medical and allied professions, and by the joint establishment or maintenance of health centres and other medical institutions, pending the regional and national unification of the services.

27. Arrangements should be made by the administration of the services for securing adequate hospital and other residential accommodation and care, either by contracts with existing public and approved private institutions, or by the establishment and maintenance of appropriate institutions.

Rational Organisation of Medical Care Service

28. The optimum of medical care should be made readily available through an organisation that ensures the greatest possible economy and efficiency by the pooling of knowledge, staff, equip-

ment and other resources, and by close contact and collaboration among all participating members of the medical and allied professions and agencies.

29. The wholehearted participation of the greatest possible number of members of the medical and allied professions is essential for the success of any national medical care service. The number and proportion of general practitioners, specialists, dentists, nurses and other professions within the service should be adapted to the distribution and the needs of the beneficiaries.

30. Complete diagnostic and treatment facilities, including laboratory and x-ray services, should be available to the general practitioner, and all specialist advice and care, as well as nursing, maternity, pharmaceutical and other auxiliary services, and residential accommodation, should be at the disposal of the general practitioner for the use of his patients.

31. Complete and up-to-date technical equipment for all branches of specialist treatment, including dental care, should be available, and specialists should have at their disposal all necessary hospital and research facilities, and auxiliary out-patient services such as nursing, through the agency of the general practitioner.

32. To achieve these aims, care should preferably be furnished co-operatively at centres of various kinds working in effective relation with hospitals (group practice at health centres).

33. Pending the establishment of, and experiments with, group practice at health centres, it would be appropriate to obtain care for beneficiaries from members of the medical and allied professions practising at their own offices.

34. Where the medical care service covers the majority of the population, health centres may appropriately be built, equipped and operated by the authority administering the service in the health area, in one of the forms indicated in paragraphs 35, 36 and 37.

35. Where no adequate facilities exist or where a system of hospitals with out-patient departments for general-practitioner and specialist treatment already obtains in the health area at the time when the medical care service is introduced, hospitals may appropriately be established as, or developed into, health centres providing all kinds of in- and out-patient care and complemented by local outposts for general-practitioner care and for auxiliary services.

36. Where general practice is well developed outside the hospital system while specialists are mainly consultants and working at hospitals, it may be appropriate to establish health centres for non-residential general-practitioner care and auxiliary services, and to centralise specialist in-patient and out-patient care at hospitals.

37. Where general and specialist practice are well developed outside the hospital system, it may be appropriate to establish health centres for all non-residential treatment, general-practitioner and specialist, and all auxiliary services, while cases needing residential care are directed from the centres to the hospitals.

38. Where the medical care service does not cover the majority of the population but has a substantial number of beneficiaries, and existing hospital and other medical facilities are inadequate, the insurance institution, or insurance institutions jointly, should establish a system of health centres which affords all care, including hospital accommodation at the main centres, and transport arrangements; such centres may be required more particularly in sparsely settled areas with a scattered insured population.

39. Where the medical care service covers too small a section for complete health centres to be an economical means of serving its beneficiaries, and existing facilities for specialist treatment in the area are inadequate, it may be appropriate for the insurance institution, or the institutions jointly, to maintain posts at which specialists attend beneficiaries as required.

40. Where the medical care service covers a relatively small section of the population concentrated in an area with extensive private practice, it may be appropriate for the members of the medical and allied professions participating in the service to co-operate at centres rented, equipped and administered by the members, at which both beneficiaries of the service and private patients receive care.

41. Where the medical care service covers only a small number of beneficiaries who are scattered over a populated area with adequate existing facilities, and co-operative group practice is not feasible, beneficiaries may appropriately receive care from members of the medical and allied professions practising at their own offices, and at public and approved private hospitals and other medical institutions.

42. Travelling clinics in motor vans or aircraft, equipped for first aid, dental treatment, general examination and possibly other health services such as maternal and infant health services, should be provided for serving areas with a scattered population and remote from towns or cities, and completed by transport arrangements for conveying patients to centres and hospitals.

Collaboration with General Health Services

43. There should be available to the beneficiaries of the medical care service all general health services, being services providing means for the whole community and/or groups of individuals to promote and protect their health while it is not yet threatened or known to be threatened, whether such services be given by members of the medical and allied professions or otherwise; general health services include maternal and infant health services, health visiting, immunisation, industrial hygiene services, preventive examinations, health education, nutrition services, and like measures.

44. The medical care service should be provided in close co-ordination with general health services, by combining medical care

and general health services in one public service, or by means of joint bodies of the social insurance institutions providing medical care and the authorities administering the general health services.

45. Local co-ordination of medical care and general health services should be aimed at either by establishing medical care centres in proximity to the headquarters for general health services, or by establishing common centres as headquarters for all or most health services.

46. The members of the medical and allied professions participating in the medical care service and working at health centres may appropriately undertake such general health care as can with advantage be given by the same staff, including immunisation, examination of schoolchildren and other groups, advice to expectant mothers and mothers with infants, and other care of a like nature.

IV. The Quality of Service

Optimum Standard

47. The medical care service should aim at providing the highest possible standard of care, due regard being paid to the importance of the doctor-patient relationship and the professional and personal responsibility of the doctor, while safeguarding both the interests of the beneficiaries and those of the professions participating.

Choice of Doctor and Continuity of Care

48. The beneficiary should have the right to make an initial choice, among the general practitioners available within a reasonable distance from his home, of the doctor by whom he wishes to be attended in a permanent capacity (family doctor); he should have the same right of choice for his children. These principles should also apply to the choice of a dentist as family dentist.

49. Where care is provided at or from health centres, the beneficiary should have the right to choose his centre within a reasonable distance from his home and to select for himself or his children a doctor and a dentist among the general practitioners and dentists working at this centre.

50. Where there is no centre, the beneficiary should have the right to select his family doctor and dentist among the participating general practitioners and dentists whose office is within a reasonable distance from his home.

51. The beneficiary should have the right subsequently to change his family doctor or dentist, subject to giving notice within a prescribed time, for good reasons, such as lack of personal contact and confidence.

52. The general practitioner or the dentist participating in the service should have the right to accept or refuse a client, but may not accept a number in excess of a prescribed maximum nor refuse such clients as have not made their own choice and are assigned to him by the service through impartial methods.

53. The care given by specialists and members of allied professions, such as nurses, midwives, masseurs and others, should be available on the recommendation, and through the agency, of the beneficiary's family doctor, who should take reasonable account of the patient's wishes if several members of the specialty or other profession are available at the centre or within a reasonable distance of the patient's home. Special provision should be made for the availability of the specialist when requested by the patient though not recommended by the family doctor.

54. Residential care should be made available on the recommendation of the beneficiary's family doctor, or on the advice of the specialist, if any, who has been consulted.

55. If residential care is provided at the centre to which the family doctor or specialist is attached, the patient should preferably be attended in the hospital by his own family doctor or the specialist to whom he was referred.

56. Arrangements for the general practitioners or dentists at a centre to be consulted by appointment should be made whenever practicable.

Working Conditions and Status of Doctors and Members of Allied Professions

57. The working conditions of doctors and members of allied professions participating in the service should be designed to relieve the doctor or member from financial anxiety by providing adequate income during work, leave and illness and in retirement, and pensions to his survivors, without restricting his professional discretion otherwise than by professional supervision, and should not be such as to distract his attention from the maintenance and improvement of the health of the beneficiaries.

58. General practitioners, specialists and dentists, working for a medical care service covering the whole or a large majority of the population, may appropriately be employed whole time for a salary, with adequate provision for leave, sickness, old age and death, if the medical profession is adequately represented on the body employing them.

59. Where general practitioners or dentists, engaged in private practice, undertake part-time work for a medical care service with a sufficient number of beneficiaries, it may be appropriate to pay them a fixed basic amount per year, including provision for leave, sickness, old age and death, and increased if desired by a capitation fee for each person or family in the doctor's or dentist's charge.

60. Specialists engaged in private practice who work part time for a medical care service with a considerable number of beneficiaries may appropriately be paid an amount proportionate to the time devoted to such service (part-time salary).

61. Doctors and dentists engaged in private practice who work part time for a medical care service with few beneficiaries only may appropriately be paid fees for services rendered.

62. Among the members of allied professions participating in the service, those rendering personal care may appropriately be employed whole time for salary, with adequate provision for leave, sickness, old age and death, while members furnishing supplies should be paid in accordance with adequate tariffs.

63. Working conditions for members of the medical and allied professions participating in the service should be uniform throughout the country or for all sections covered by the service, and agreed on with the representative bodies of the profession, subject only to such variations as may be necessitated by differences in the exigencies of the service.

64. Provision should be made for the submission of complaints by the beneficiaries concerning the extent of the care received or the manner in which it was given, preferably to joint bodies representing beneficiaries and the medical and allied professions participating in the service, and subject to appeal to independent tribunals.

65. The professional supervision of the medical care service should be entrusted to bodies predominantly composed of representatives of the professions participating in the service, with adequate provision for disciplinary measures, and subject to appeal to independent tribunals.

Standard of Professional Skill and Knowledge

66. The highest possible standard of skill and knowledge should be achieved and maintained for the professions participating both by requiring high standards of education, training and licensing and by keeping up to date and developing the skill and knowledge of those engaged in the service.

67. Students of the medical and dental professions should, before being admitted as fully qualified doctors or dentists to the service, be required to work as assistants at health centres or offices, especially in rural areas, under the supervision and direction of more experienced practitioners.

68. A minimum period as hospital assistant should be prescribed among the qualifications for every doctor entering the service.

69. Professional certification of doctors qualified to furnish special services should be required.

70. Doctors and dentists participating should be required periodically to attend post-graduate courses organised or approved for this purpose by the representative bodies of their professions.

71. Adequate periods of apprenticeship at hospitals or health centres should be prescribed for members of allied professions, and post-graduate courses should be organised and attendance periodically required for those participating in the service.

72. Adequate facilities for teaching and research should be made available at the hospitals administered by or working with the medical care service.

73. Professional education and research should be promoted with the financial and legal support of the State.

V. Financing of Medical Care Service

Raising of Funds under Public Medical Care Service

74. The cost of the medical care service should be distributed among the members of the community in proportion to their ability to pay.

75. Where the whole population is covered by the medical care service and all health services are under a unified central and area administration, the medical care service may appropriately be financed out of receipts from general income tax.

76. Where the administration of the medical care service is separate from that of general health services, it may be appropriate to finance the medical care service by a special tax.

77. The special tax should be paid into a separate fund reserved for the purpose of financing the medical care service.

78. The special tax should be progressively graded and should be designed to yield a return sufficient for financing the medical care service.

79. Persons whose income does not exceed the subsistence level should not be required to pay the special tax.

80. The special tax may appropriately be collected by the national income tax authorities or, where there is no national income tax, by authorities responsible for collecting local taxes.

Raising of Funds under Social Insurance Service

81. The maximum contribution that may be charged to an insured person should not exceed such proportion of his income as, applied to the income of all insured persons, would yield an income equal to the probable total cost of the medical care service, including the cost of care given to dependent wives or husbands and dependent children.

82. The contribution paid by an insured person should be such part of the maximum contribution as can be borne without hardship.

83. Persons whose income does not exceed the subsistence level should not be required to pay an insurance contribution.

84. It may be appropriate to require employers to pay part of the maximum contribution on behalf of persons employed by them.

85. Equitable contributions should be paid by the public authority in respect of persons whose income does not exceed the subsistence level: Provided that in the case of employed persons, such contributions may be paid wholly or partly by their employers.

86. The cost of the medical care service not covered by contributions should be borne by taxpayers, preferably in proportion to their ability to pay.

87. Contributions in respect of employed persons may appropriately be collected by their employers.

88. Where membership of an occupational association or the possession of a licence is compulsory for any class of self-employed persons, the association or the licensing authority may be made responsible for collecting contributions from the persons concerned.

89. The national or local authority may be made responsible for collecting contributions from self-employed persons registered for the purpose of taxation.

90. Where a scheme of social insurance for cash benefits is in operation, contributions both under such scheme and under the medical care service may appropriately be collected together.

VI. Supervision and Administration of Medical Care Service

Unity of Health Services and Democratic Control

91. All medical care and general health services should be centrally supervised and should be administered by health areas as defined in paragraph 25, and the beneficiaries of the medical care service, as well as the medical and allied professions concerned, should have a voice in the administration of the service.

Unification of Central Administration

92. A central authority, whether State or Federal, representative of the community, should be responsible for formulating the health policy or policies and for supervising all medical care and general health services, subject to consultation of, and collaboration with, the medical and allied professions on all professional matters, and to consultation of the beneficiaries on matters of policy and administration affecting the medical care service.

93. Where the medical care service covers the whole or the majority of the population and a central government agency supervises or administers all medical care and general health services, beneficiaries may appropriately be deemed to be represented by the head of the agency.

94. The central government agency should keep in touch with the beneficiaries through advisory bodies comprising representatives of organisations of the different sections of the population, such as trade unions, employers' associations, chambers of commerce, farmers' associations, women's associations and child protection societies.

95. Where the medical care service covers only a section of the population, and a central government agency supervises or administers all medical care and general health services, representatives

of the insured persons should participate in the supervision, preferably through advisory committees, on all matters of policy affecting the medical care service.

96. The central government agency should consult the representatives of the medical and allied professions, preferably through advisory committees, on all questions relating to the working conditions of the members of the professions participating, and on all other matters primarily of a professional nature, more particularly on the preparation of laws and regulations concerning the nature, extent and provision of the care furnished under the service.

97. Where the medical care service covers the whole or the majority of the population and a representative body supervises or administers all medical care and general health services, beneficiaries should be represented on such body either directly, through elected members, or indirectly, through members appointed by the central government.

98. In this event, the medical and allied professions should be represented on the representative body, preferably in numbers equal to those of the beneficiaries or the government as the case may be; the professional members should be elected by the profession concerned, or nominated by their representatives and appointed by the central government.

99. Where the medical care service covers the whole or the majority of the population and a corporate body of experts established by legislation or by charter supervises or administers all medical care and general health services, such body may appropriately consist of an equal number of members of the medical and allied professions and of qualified laymen.

100. The professional members of the expert body should be appointed by the central government from among candidates nominated by the representatives of the medical and allied professions.

101. The representative executive body or the expert body supervising or administering health services should be responsible to the government for its general policy.

Local Administration

102. Local administration of medical care and general health services should be unified or co-ordinated within areas formed for the purpose as provided for in paragraph 25, and the medical care service in the area should be administered by or with the advice of bodies representative of the beneficiaries and partly composed of, or assisted by, representatives of the medical and allied professions, so as to safeguard the interests of the beneficiaries and the professions, and secure the technical efficiency of the service and the professional independence of the participating doctors.

103. Where the medical care service covers the whole or the majority of the population in the health area, all medical care and general health services may appropriately be administered by one area authority.

104. Where, in this event, the area government administers the health services on behalf of the beneficiaries, the medical and allied professions should participate in the administration of the medical care service, preferably through technical committees elected by the professions or appointed by the area or central government from among nominees of the professions concerned.

105. Where a medical care service covering the whole or the majority of the population in the health area is administered by a representative body, the area government, on behalf of the beneficiaries, and the medical and allied professions in the area, should be represented on such body, preferably in equal numbers.

106. Where the medical care service is administered by area offices or officers of the central authority, the medical and allied professions in the area should participate in the administration, preferably through executive technical committees, elected or nominated in the manner provided for in paragraph 104.

107. Whatever the form of the area administration, the authority administering the medical care service should keep in constant touch with the beneficiaries in the area through advisory bodies, elected by representative organisations of the different sections of the population, in the manner provided for in paragraph 94.

108. Where the social insurance medical care service covers only a section of the population, administration of that service may appropriately be entrusted to a representative executive body responsible to the government, and comprising representatives of the beneficiaries and of the medical and allied professions participating in the service; if the service is confined to employed persons whose employers share in the cost of the service, representation of the employers may be appropriate.

Administration of Health Units

109. Health units owned and operated by the medical care service should be administered wholly or predominantly by doctors elected by, or appointed after consultation of, the members of the medical and allied professions participating in the medical care service, in co-operation with all the doctors working at the unit.

Right of Appeal

110. Beneficiaries who have submitted complaints to the joint bodies referred to in paragraph 64, concerning the extent of the care received or the manner in which it was given, should have a right of appeal from the decision of a joint body to a tribunal consisting of independent persons appointed by the central government.

111. Members of the medical and allied professions against whom disciplinary measures have been taken by the bodies referred to in paragraph 65 should have a right of appeal from the decision of such body to a tribunal consisting of independent persons appointed by the central government.