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Economics of Social Secura

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Economics of Social Security

ECONOMICS OF SOCIAL SECURITY

DR. M. M. MEHTA
University of Allahabad

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Dedicated to
Shri Jai Prakash Narayan

&

Acharya Narendra Deva

who have worked ceaselessly and selflessly
for the establishment of New
Economic Order

PREFACE.

The study of Social Security has, in recent years, aroused wide-spread interest among all those who yearn to create a new economic and social order based on the imperishable foundations of peace, justice, security and liberty for all. It is now firmly believed that no enduring and everlasting peace can be established, and no stable economic system can function till millions of people on earth live under conditions of poverty and pestilence, disease and destitution, squalor and idleness. Not until the semi-starved and under-privileged classes in all countries are assured conditions of healthy, progressive and creative life—conditions in which they would be able to develop their individual personality and raise themselves to a position of dignity and self-respect, can there be a real freedom and everlasting joy for the individual. It is futile to dream of a new

and glorious future for mankind till millions of people live under the constant threat of economic and social insecurity, and remain over-ridden with a feeling of futility and frustration, malaise and disgust. The awakening of political and social consciousness, the growth of parliamentary democracy, the spread of education—all have tended to reinforce the determination of the nations, as of individuals, to fight the Five Great Giants of Want, Ignorance, Squalor, Idleness and Disease, and to secure for the people a basis of freer, fuller and richer life. The evolution of the institutions of *social insurance* and *social assistance* on scientific and rational lines now offer prospects of building up a new economic and social order in which 'all men in all lands can live out their lives in freedom from fear and want'.

An attempt has, therefore, been made in this study to analyse and examine the fundamental principles of organization, finance and administration of social security services.

The author discusses how a unified, comprehensive and co-ordinated Plan of Social Security can guarantee to each and every citizen complete security against economic and social risks to which he is perenially exposed. An attempt has also been made to study the Social Insurance Systems of U.S.S.R., Great Britain, U. S. A. , Australia and India. A Chapter has also been devoted to the study of the basic principles of organization, finance and administration of Medical Care Services. The last Chapter surveys the progress that has been made in Medical Care Planning in Great Britain, U. S. A. , Australia and India. A layman may find the subject-matter bit difficult, technical and even un-interesting. The approach and treatment of the subject-matter is, however, descriptive rather than analytical.

The author claims no originality of approach or analysis. Indeed, an expert in Social Security will find in it nothing which

can be characterized as a new and original contribution to the subject, or discovery of some new facts, theories or principles. The book has been primarily written with the object of stimulating the thoughts of the students and of the public in this vital problem and to make them conversant with the basic principles and technique of organizing Social Security measures.

The author owes a deep debt of gratitude to the International Labour Organization over whose publications he has drawn freely in the course of this study. The massive literature published by the I. L. O. and the valuable investigations undertaken by it in the spheres of Social Security and Labour Welfare, undoubtedly, serve as a very valuable groundwork for more intensive study and analysis.

M. M. Mehta.

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CHAPTER I

INTRODUCTION

Genesis of Social Security

The attempt to conceive imaginatively a better ordering of human society than the destructive and cruel chaos, in which mankind has hitherto floundered, is by no means peculiar to our own age. From times immemorial since Plato dreamt of his "Republic"; Aristotle of his "Ideal State"; Thomas Moore of his "Utopia"; Lenin of his classless "Socialist State" and Mahatma Gandhi of his "Ram-Rajya", man has been yearning to create a new economic and social order nearer to his heart's desire. The great hope, that has inspired and stirred his creative vision, is to build a world on a more stable and prosperous foundation—a

world where life would be fuller, richer and freer than it has been hitherto possible. To-day we are all the more convinced that with the help of marvellous technological improvements and scientific inventions, and man's knowledge, ingenuity and skill, it is now within our reach to build an economic and social order in which each individual citizen could be assured conditions of healthy, progressive and creative life. Why should we, then, needlessly allow the unbridled display of evil forces, that account for our social insecurity and economic instability? Why would we, then have the mournful spectacle of watching the existence of appalling poverty amidst plethoric plenty, scarcity amidst gigantic productiveness and superfluity, the terrible suffering and humiliation of mass of mankind in the face of marvellous scientific achievements to human aid? There is little doubt that our society has the potentiality of plenty for all, and it is morally wrong and socially excusable that millions of people should go ill-fed, ill-clothed, ill-housed, and devoid of other

elementary needs of civilised existence. The recurring crises, ever-growing in intensity and amplitude, the persistence of glaring inequalities between "haves" and "have nots" ; the growth of aggressive and rampant nationalism are the other symptoms of a deep-rooted malady, from which our whole body economy is long afflicted. The immense ravages wrought by the recent wars ; their social costs in terms of men and money and the crushing burden of taxation and armaments, have set all the right-thinking men ablaze at the enormous price that humanity has to pay for its incredible folly, neglect and lack of foresight. It is now realised by all that an enduring economic and social order can only be built on the solid and imperishable foundation of justice, peace, security and liberty. Such an economic and social order should eliminate all such causes leading to social insecurity and economic instability viz. poverty, inequality, illiteracy, unemployment, dependence, and squalor. Only in such an

economic order can there be a real freedom and everlasting peace for the individual.

The need for Social Security in India is as great as anywhere else. Ours is potentially the richest country and yet she is the most impoverished of all the civilized nations in the world. The vast masses of our people are groaning under the deadweight of an abject poverty—poverty which saps vitality, joy, charm, beauty and all that is sublime and ecsthetic in human life. The extent of disease and death, starvation and suffering, is almost incredible, and fate of our teeming millions is “born to Endless Night”. Poverty and unemployment have condemned our people to a feeling of futility and frustration, inertia and indifference. To a common man in India, life means nothing but an unremitting toil and struggle for even the barest subsistence of life. Wearied, tired and exhausted the mass of our derelict workers and peasants find themselves encircled in an endless gloom and despair. Our country,

undoubtedly, represents a most heart-rending picture of her pathetic plight-poverty, ignorance, inefficiency, dependance and destitution that has no parallel in any part of the civilized world. No body can deny that of all the causes that account for our political discontentment, social disruption and economic disintegration, poverty and social insecurity are the greatest. They have ravaged and ransacked our villages and towns, battered and blasted our homes and hearths, and pillaged and polluted us morally and culturally. They have created in thousands of sensitive souls a profound sense of disgust, frustration and malaise. If death and disease, ignorance and squalor, starvation and poverty are to be blotted out, the standard of living of our people should be appreciably raised. This undoubtedly is a Herculean task, requiring decades of strenuous and unremitting toil, guided by wise, enlightened and far-sighted leadership. But our task is to proceed, step by step, from precedent to precedent towards the goal of a comprehensive,

unified and integrated Plan of Social Security, designed to cover all the persons and against all possible risks and contingencies. Let us study the fundamental and basic principles in the light of which such a Plan can be evolved, developed and implemented, keeping in mind the special political, economic and social conditions prevailing in the country, and the valuable experiments undertaken in different countries of the world in this direction.

Evolution And Institutional Growth Of Social Security

Social Security is the security that society furnishes through appropriate organizations against certain risks to which its members are perennially exposed. * These risks are essentially unforeseen contingencies and hazards against which the individuals of small means and meagre resources cannot effectively provide. These risks are sickness, maternity,

*. Approaches to Social Security Published by the I. L. O. (Montreal, 1942).

invalidity, accident, unemployment, old age and death. It is of paramount importance and great practical significance to study and examine the different methods, both ancient and modern, by which communities have attempted to alleviate the sufferings caused by the 'Five Great Giants' of Want, Ignorance, Squalor, Idleness and Disease. Such a historical survey will undoubtedly reveal the slow, imperceptible, evolutionary character of social security movement. It can hardly be denied that each of these methods have contributed substantially towards the progress of the social security movement. Moreover a study in the evolution of social security services will furnish some basic principles and postulations for formulation of a comprehensive, unified and integrated plan of Social Security.

"In the life of man" states an I. L. O. Publication "there are two stages of dependency—the childhood and old age and in the intervening years of adult life, there are likely to occur spells during which he

cannot earn his living. Instinct sees directly to the rearing of children but nature's concern for other cases of dependency is less clear and more remote." It is here that the *raison d'être* of social security lies; for where nature cannot function to the good of Man, it is for the social organism to intervene in his interests. It is significant to observe that the family unit of social organization has been the first line of defence against ravages of nature and vicissitudes of fortune. The social canons of all ages and all communities have expressly recognized the reciprocal obligation of parents to support the child in infancy and of the child to support the parents in old age. The institution of family has, therefore, rendered invaluable services in protecting and safeguarding the individuals against unforeseen contingencies. But unfortunately, its capacity to protect the individuals against these risks and hazards is extremely limited. During times of distress and destitution, the individuals are compelled to look to wider circle of acquaintances

and neighbourers for help and assistance. It was indeed in this manner that the system of private charity and voluntary relief grew up. For long, both these institutions catered to the needs of the poor and the hardpressed. In European countries, these institutions had the backing of the churches and priests; in Asiatic countries they received great encouragement and assistance from temples, mosques and shrines. Later on, in European countries, with the substitution of secular for ecclesiastical administration, the institutions of private charity and voluntary relief were replaced by the imposition of Poor Relief, enforced by Law. The passing of the English Poor Relief Act in 1601 marked the beginning of the rational and systematic treatment of the problem of poverty and destitution. A series of Poor Relief Acts were subsequently passed extending the scope of Poor Relief and covering in its orbit a larger working populace. It is, however, a truism that the avowed object of the adoption of poor relief measures was more the maintenance of social peace and

tranquillity than the social welfare or economic salvation of the poor and the depressed.

The development of the institution of private charity and poor relief could not afford adequate protection against all risks and hazards to which the members of the community were perenially exposed. Moreover, the working of these institutions revealed many disquieting features. Private eleemosynary help was always regarded as degrading, vague, insulting and unsure. It was derogatory to one's sense of self-respect and prestige. The conscious object of private charity was more the salvation of the giver than the welfare of the receipient. It is undoubtedly true that the alms and charities received at the hands of philanthropists and the so-called social 'saints' were as condescending as they were humiliating and embarrassing to one's sense of dignity and self-esteem. The institution of Poor Relief, too, manifested similar drawbacks and shortcomings. Only paupers and destitutes were entitled to relief and benefits under the

provisions of various Relief Acts. The "individualistic" philosophy of mediæval ages regarded "pauperism" as a great sin, and the receipt of poor relief under the various Acts deprived the beneficiaries of their voting right. Obviously, such an institution had no respect for human personality, nor it was intended to alleviate the sufferings of the underprivileged persons or equalize the opportunities for self-development and progress. The conscious object of poor relief was undoubtedly the maintenance of political and social tranquillity by appeasing them for fear that they may revolt and drag the privileged aristocracy down into their abyss.

With the awakening of political conscience and growth of democratic institutions, people became increasingly conscious of their rights and privileges. There was a growing realization that the State was the ultimate moral and economic guardian of the community. Its activities for the prevention of exploitation of unorganized labour, stabilization of economic

system and protection of helpless, poor and underprivileged persons were no longer regarded as interferences but as its legitimate functions. It was the primary responsibility of the State to assure to each individual citizen such social services and civilized amenities as were indispensable and integral part of human life and work.

The active participation of the State with the object of mitigating the sufferings of the people resulted in the evolution and development of two important institutions—*Social Assistance* and *Social Insurance*. The institutional growth of these two systems, marked the real beginning of a new and glorious era of social security and economic progress. It is significant to study and examine the contributions that both these institutions have made towards the formulation of a comprehensive, co-ordinated, unified system of Social Security.

Social Assistance : Although the beginnings of social assistance can be traced in the

prevalence of poor relief system, it has, in recent years, undergone a process of rationalisation which has meant specialization of benefits, that can be counted upon and are preventive in intention. The principal forms of social assistance are: non-contributory pensions for (i) Maintenance of Children, (ii) Maintenance of Invalids, (iii) Maintenance of Aged and Disabled, (iv) Maintenance of Mothers and other dependents, (v) Unemployment Assistance, (vi) Rehabilitation of Disabled, and most recent of them all (vii) Rehabilitaion of Refugees.

Social Insurance: The institution of social insurance has made the principal contribution to social security. It originated in Germany in 1881, when the Iron Chancellor of German Empire, Emperor William the First urged upon the Reichstag to adopt compulsory social insurance for industrial workers. The first beginnings were made in the German Legislation of 1883-89. Since then its course and nature have undergone tremendous

transformation and has spread far beyond the continental countries, Great Britain, Canada, North and South America. Thanks to the ceaseless efforts and endeavours of the International Labour Organization, Social Insurance has made surprisingly rapid strides particularly during the last three decades. In 1919 I. L. O. adopted conventions on Maternity Benefits; in 1921, 1925 and 1934 on Workmens' Compensation ; in 1927 and 1936 on Sickness Insurance ; in 1933 and 1934 on Invalidity, Old Age and Survivor's Insurance; and in 1934 on Unemployment Insurance. The war and post-war period has witnessed further far-reaching developments in all spheres of social insurance, and to-day there is hardly any country where some beginnings have not been made in the direction of social insurance.

Social Security : The most remarkable stage in the evolution and institutional growth of Social Security is the integration of the two systems of social assistance and social

insurance—now designed as “Social Security”. The most outstanding feature of the system is the unification of all the social risks, namely invalidity, unemployment, old age and death. These social services are now to be administered under a single directing agency and financed either out of national taxation or by tripartite contribution of workers, employers and the state. The scope is to be gradually expanded so as to cover larger and larger number of persons and against larger and larger number of risks and contingencies. Universality of coverage and efficacy and adequacy of protection are the two important milestones on the road to Social Security.

Meaning of Social Security

Social Security is essentially a term of trans-Atlantic origin. The term was first used when the Government of the United States established, under the Social Security Act of 1935, the Social Security Board to govern and administer the schemes of unemployment,

sickness and old-age insurance. Three years later in 1938, the same term was adopted by New Zealand to describe its comprehensive measure of income security for all citizens. Three years later again, in the Atlantic Charter of 1941, and in various other important pronouncements the Government of the United Nations reiterated their firm determination "to bring about 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". Subsequently in the Beveridge Report on "Social Insurance and Allied Services" submitted to the British Government in 1942, a "Plan of Social Security" was suggested to give British people freedom from want. Finally in the Report on Social Security in Canada prepared by L. C. Marsh and in the Report of the National Resources Board, U. S. A. the term was again used to denote an over-all, integrated Plan of Social Insurance and Assistance to be administered by a central authority.

In the current economic terminology the term Social Security has been defined as "the Security that society furnishes through some appropriate organization, against certain risks to which its members are exposed". These risks are essentially contingencies against which the individuals of small means and meagre resources cannot effectively provide by their own ability or foresight alone or even in private combination with their fellows.* These risks are sickness, maternity, invalidity, old age and death. It is the characteristic of these contingencies that they interrupt their earnings and impair their efficiency.

Social Assistance, Social Insurance and Social Security.

Let us analyse and examine the significant differences between social assistance and social insurance on the one hand and between social assistance, social insurance and social security on the other. A critical examina-

*I. L. O. Approachs to Social Security (Montreal, 1942).

tion of their resemblances and differences will reveal the fundamental characteristic features of these approaches.

Unfortunately there is no generally accepted definition of social assistance, social insurance and social security which can render the task of critical examination less onerous. There is still wide diversity of opinion with regard to the nature, scope and significance of these different approaches. The evolution and institutional growth of these approaches have however tended to delimit their spheres, and now amidst the apparent diversity there is some degree of uniformity in outlook as to the specific category to which each class of social risk belongs.

Social Assistance and Social Insurance : **Resemblances and Differences :**

Social Assistance may be defined as a device to provide benefits for persons of small means granted as of right and in amounts sufficient to meet a minimum standard of need and financed from taxation

or general revenues. Social Insurance on the other hand may be defined as “ a device to provide benefits for persons of small earnings granted as of right in amounts which combine the contributive effort of the insured with subsidies from the employer and the state.” Sir William Beveridge has defined social insurance as “a plan of giving in return for contributions, benefits upto the subsistence level, as of right and without means test, so that individuals may build upon it freely.

A searching analysis of these two definitions will reveal the following common characteristics of these two definitions.

1. Both the schemes viz. Social assistance and Social insurance are intended for persons of small means and meagre resources who cannot effectively provide against risks and contingencies to which they are perennially exposed.

2. Both the schemes grant pensions and benefits according to arithmetical rules, as of right, enforceable by quasi-judicial process.

The fundamental differences between the two approaches are :

(i) Whereas Social assistance represents the unilateral obligation of the community towards those members, who are genuinely in need, Social insurance is based on compulsory mutual aid. The former is an expression of the social responsibility of the state towards its needy, the latter a device to pool the risks and spread their incidence on all the members, so that no one may groan under an excessive burden.

(ii) Whereas Social assistance is financed wholly or in a very large measure, from the general revenues of the state, the Social insurance is mostly financed by a fund created out of the tripartite contributions of the workers, employers and the state. The former is a predominantly governmental affair, the latter a co-operative device to render the existing risks more bearable.

(iii) Whereas Social insurance requires, as a condition precedent for the grant of

benefits, that contributions should have been paid by the prospective beneficiary, Social assistance does not impose any such condition. The former gives benefits in return for contributions, the latter gives gratis.

(iv) Whereas, in Social insurance some proportional relationship is sought to be maintained between risks and premiums, such a question does not arise in case of Social assistance since it is predominantly financed by the state itself.

(v) Whereas Social insurance is generally adopted where the class of workers to be covered is sufficiently well organised, legally regulated, and financially stable and where there exists no apprehension of exaggerated claims or conscious exploitation of common fund, Social assistance on the other hand, is more applicable where the workers to be covered are too poor to contribute, too illiterate to follow the technicalities of insurance and too scattered to be brought under a proper scheme of insurance, and also where

the spheres of service rendered offer little scope for illegitimate claims.

(vi) Social assistance schemes are invariably at the mercy of budget appropriations, and consequently are subject to great irregularities; Social insurance schemes on the other hand are financially more stable and scientific.

(vii) Whereas social assistance requires the fulfilment of certain prescribed conditions before benefits can be granted under such schemes, the social insurance does not require any means test, as a condition precedent to such benefits. They can be claimed as a matter of right and no proof of eligibility is needed.

(viii) Lastly there are also significant differences between social assistance and social insurance relating to the manner or technique of excluding persons with substantial means and resources from the various benefits, and relating to the calculations of pensions and benefits under the respective schemes.

Despite these manifold diversities, both these movements, viz. Social assistance and Social insurance are moving ever closer to one another. If we critically analyse and examine the present day movements, we shall discover an unmistakable tendency that both these movements intersect each other, and merge themselves in a comprehensive, unified plan of social security. The history of social assistance and social insurance between the two Great Wars clearly reveals that "Social assistance is a progression from poor relief in the direction of social insurance, while social insurance is a progression from private insurance in the direction of social assistance."

"The progress of social assistance consists in the improvement of its benefits, in the enlargement of the notion of need, and in dissociation of moral stigma from recourse to its aid. The progress of social insurance consists in extending its protection to an ever larger circle of the population,

in widening the range of risks that it covers, and, as regards the quality and quantity of its benefits, caring more for social adequacy than for actuarial equity." If these movements are correctly diagnosed we shall at once discern an unmistakable tendency for both these systems to come closer to one another, until, as in New Zealand and Denmark, it may become exceedingly difficult to distinguish whether social assistance or social insurance forms the most integral part of the national system of social security.

Limitations of Social Security

1. The fundamental limitation of Social Security is that it can only be planned as a part of the larger programme which includes measures for promoting employment and maintaining it at a high level, for increasing the national dividend and sharing it more equitably, for improving nutrition and housing, multiplying facilities for medical care, and widening opportunities for general and vocational education. Then alone it

would be possible to finance the social security services, for these measures will not only keep benefit expenditure within bounds, but also tend to reduce it, since improved conditions of life and labour reduce the frequency and severity of social and industrial risks. It is afraid that in the absence of comprehensive social and economic planning, the financial costs of the social security services will be so heavy and onerous that it would be beyond the capacity of the tax payers and the prospective beneficiaries to share the costs. The financial and actuarial success of the social security schemes, depends, to a great extent upon the high level of employment, satisfactory per capita income, ability of the people to meet the financial costs of the social security schemes and lastly upon the provision of adequate medical and housing facilities.

2. It is also maintained by some that the ideal of social security is, to some extent, inconsistent with initiative, enterprise

and personal responsibility. It is an inducement for people "to go on the state." No sooner an individual is assured or guaranteed by the state all the conditions of civilised existence, he loses all initiative, becomes indolent and indifferent to his work. In fact heavy handed largesse at state expense may reduce people to a set of drones, each striving to live at the expense of other." Despite all checks and safeguards, close supervision and strict scrutiny, there will always be loopholes and deliberate malingerings and evasions which will adversely affect the financial and actuarial success of the social security schemes. The success of social security is, therefore, conditioned by the high standard of public morality, realisation by each individual of his responsibilities and obligations towards the community, and rigorous supervision and efficient administration of social security services. People must feel that the social security services are only a co-operative device to pool the social risks, and spread their inci-

dence on the members of the community. "It is not a plan for giving everybody something for nothing but a plan of organized thrift." (Arthur J. Altmeyer, Chairman. U.S. Social Security Board.)

3. The protagonists of industrial interests maintain that the "social security services" impose a heavy burden on the infant industries, and thus retard the rapid industrialization of the nation, firstly by checking flow of capital to industries and secondly by exposing the nations' infant industries to the onslaught of internecine foreign competition. Industries with fresh burdens and enhanced costs (incidental to the compulsory social insurance contributions from the employers) will not be able to compete with foreign goods produced on mass-scale for international markets and subsidized by their respective states. The threat is real and grave to industrially infant countries like India and China, which are still struggling to tap their vast resources

for the rapid industrialization of the country. Excessive burden on the industry and even agriculture will be suicidal to country's interests.

4. Poverty, illiteracy, general ill-health, high mortality, lack of adequate census and lack of competent and experienced personnel to administer and supervise the social security schemes, constitute serious impediments in the way of establishing social security services in the country.

5. Lastly it is contended that the need for social security can be eliminated if we can remove the fundamental causes that account for the prevalence of social insecurity. It is a better course to root out the causes themselves than to find a solution to counteract their effects. Prevention is better than cure. "Our dynamic capitalism must have the shock absorbing cushion of a practical working social security "system. (Eric A. Johnst on in his Social Security and Dynamic Capitalism").

CHAPTER II

SOCIAL INSURANCE

Outline.

- A. Definition of Social Insurance.**
- B. Aims and Functions of Social Insurance.**

- (i) Prevention.
- (ii) Restoration.
- (iii) Compensation.

- C. Scope of Social Insurance.**

- (i) *Range of contingencies covered :*

- (i) Sickness.
- (ii) Maternity.
- (iii) Invalidity.
- (iv) Old age.
- (v) Death of Breadwinner.
- (vi) Unemployment.
- (vii) Emergency Expenses.
- (viii) Employment Injuries.

- (ii) *Range of persons covered :*
 - (i) Employed persons.
 - (ii) Self-employed persons.
- (iii) *Collection of contributions.*
- (iv) *Administration of benefits.*

D. Benefit-rates and Contribution Conditions :

- (i) Benefit-rates, and
- (ii) Contribution conditions.

E. Financing of social Insurance :

- (i) The contributing parties.
- (ii) Distribution of costs.
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- (iv) Financial system :
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- (v) The Reserve fund.

F. Administration :

- (i) Principles of Administration
Unification and Coordination.

- (ii) Machinery of Administration.
- (iii) Character and Composition of Administrative Machinery.

Social Insurance

A. Definition :

Social Insurance may be defined as “a co-operative device for provision of benefits for persons of small earnings granted as of right in amounts which combine the contributive effort of the insured with subsidies from the employer and the state.” Such benefits are designed to prevent or cure disease, to support him when unable to earn and to restore him to gainful activity.

B. Aims and Functions of Social Insurance :

The fundamental objectives of social insurance schemes are :

- (i) To organize the prevention of such contingencies as sickness, invalidity and industrial accidents, the occurrence of which deprives the worker of his earning capacity

and means of subsistence, causes suffering and loss to the worker and his family, and diminishes the productivity of the community ;

(ii) To restore as quickly and fully as possible the working capacity lost or reduced by reason of sickness or accident, and to facilitate the accomplishment of the function of maternity, essential both biologically and socially ; and.

(iii) To supply the means of subsistence necessary in case of cessation or interruption of gainful activity as the result of sickness or accident, temporary or permanent invalidity, unemployment, old age and premature death of the breadwinner.

C. Scope of Social Insurance.

The scope of social insurance comprise :

- (i) Range of Contingencies covered ;
- (ii) Range of Persons covered ;
- (iii) Collection of Contributions, and
- (iv) Administration of benefits.

(i) *Range of contingencies covered :*

The range of contingencies covered by social insurance embraces all contingencies, hazards and associated emergencies in which:-

- (i) an insured person is prevented from earning his living either by inability to work or inability to obtain work ;
- (ii) an insured person dies, leaving a dependent family ; and
- (iii) an insured person has to incur substantial expenses which involve extra-ordinary strain on his limited resources e. g. burial expenses.

These contingencies have been classified under the following categories :

- (i) Sickness ;
- (ii) Maternity ;

- (iii) Invalidity
- (iv) Old Age
- (v) Death of bread winner
- (vi) Unemployment
- (vii) Emergency expenses , and
- (viii) Employment injuries.

(i) Sickness.

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.

It implies, therefore, that sickness benefit can only be granted if the following conditions are fulfilled :

- (i) It must involve total incapacity to work ;
- (ii) The incapacity must be temporary in duration ; and
- (iii) The patient must remain under medical care or supervision.

Usually the prospective beneficiary is not entitled to any compensation unless the sickness lasts a few days at least. The argument in favour of the adoption of such a practice is that it saves considerable inconvenience and administrative expenses by excluding insignificant illnesses, the recurrence of which is a common feature. This will also enable the payment of higher compensation or compensation for a longer duration in cases which involve substantial loss of earnings.

The necessity for abstention should be judged with reference to the nature and character of the work that the insured has to perform.

It is significant to note that sickness terminates with recovery, death or transition to invalidity. It is also considered expedient to limit the duration of benefit, the maximum period should not be more than 26 weeks for a single case, but 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. Persons whose incapacity extends beyond the fixed limit should be deemed to be invalids. The opinion is, however, gaining currency that the rational criterion for determining the transition from sickness to invalidity should be medical and not an arithmetical one.

(ii) 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 payment of maternity benefit is sometimes made conditional on the utilization by the beneficiary of health services provided for her and for her child. The normal duration of maternity leave is usually 12 weeks. This was suggested by child-birth convention of 1919 and ratified by 14 countries.

(iii) **Invalidity**

The contingency for which the invalidity benefit should be paid is inability to engage in any substantially gainful work by reason of a chronic or incurable condition due to disease, injury or other physical or mental disability. Invalidity is associated chiefly with diseases which adversely effect or jeopardize the efficiency of the whole organism.

✓ The essential implications of invalidity are :

- (i) that the prospective beneficiary suffers from a chronic or incurable disease, and
- (ii) He is unable to engage himself in any substantially gainful work.

If however, considering his remaining strength ability and experience, he is fit to adopt himself to other gainful occupations, requiring lesser ability, physical or mental or both, he should accept the change, and supplement his income by benefits under

invalidity schemes. Even beneficirics whose permanent inability to engage regularly in any gainful occupation has been confirmed are allowed to supplement their invalidity benefits by casual earnings of small amounts.

Invalidity benefits are paid from the date when sickness benefit ceases, for the whole duration of invalidity. When however, the beneficiary reaches the age at which old age benefit can be claimed, the latter should be substituted for invalidity benefit.

(iv) Old age

The contingency for which old age benefit is paid is the attainment of a prescribed age. That prescribed age should be one at which persons commonly become incapable of efficient work, the incidence of sickness and invalidity becomes heavy, and unemployment, if occurs, is likely to be permanent. According to the recent legislations of most of the countries like U. S. A., Great Britain, Canada, Australia.

and others, the minimum age at which old age benefit can be claimed is fixed at not more than 65 in the case of men and 60 in the case of women. Persons who have, however, put in a long period of service in arduous or unhealthy occupations, may be entitled to receive benefits at a lower age limit. But provision for earlier retirement should be made under special statutory schemes, and not under general schemes.

Payment of old age benefit should, 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 amounts will, however, not disqualify the prospective beneficiary from receiving the full amount of his old age benefits.

(v) Death of Breadwinner

The contingency for which survivor's benefit is paid is the loss of support suffered

by dependents as the result of the death of their bread-winner.

Survivor's benefit is usually paid to the widow of the insured or to his children, step-children, adopted children or grandchildren subject to their previous registration as dependents.

Widow's benefit should be paid to a widow:—

- (i) Who has in her case a child for whom child's benefit is payable; or
- (ii) Who is an invalid ; or
- (iii) Who has attained the minimum age at which old age benefit may be claimed.

A widow who does not fulfil any one of these conditions is paid widow's benefit only for a limited period, after which if she is capable of being employed in any gainful occupation and secures one, will cease to derive any benefit under the scheme.

Child's benefit is paid for a child who is under the age of 16 or who is under the age of 18 if he is continuing his general or vocational education.

(iv) Unemployment

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

The essential pre-requisites for the grant of unemployment benefits are :

- (i) That the insured is ordinarily employed ;
- (ii) That the insured is capable of regular employment ;
- (iii) That the insured is in search of alternative employment ; and

- (iv) That the insured has lost his earnings due to cessation of employment.

The unemployment benefit usually continues without any limit of time until suitable employment can be offered to the insured. It has been argued that there is no security for the unemployed worker as long as the period of benefit is limited. The unemployed worker who exhausts his unemployment benefit has nothing to fall back upon. It is, therefore, essential that he should be given the benefit until suitable employment can be procured for him. Moreover, the abolition of the time-limit will tighten government's responsibility to pursue a vigorous employment policy and establish a highly organized employment service. It is, however, admitted that in consideration of the abolition of the time limit, the condition that the insured must get employment in his former occupation, should no longer be insisted upon, particularly when

the prospects of getting such a job appear very remote.

It is significant to note that once benefit becomes payable, no fresh waiting period is generally required if unemployment recurs within a few months.

Generally speaking, an employment is deemed suitable provided :

- (i) The insured secures employment in the usual occupation in which he is engaged. Where, however, employment involves a change of occupation, it must be such that can be reasonably offered to the insured person, having regard to his strength, ability, previous experience and any facilities for training available to him ;
- (ii) The employment is such that it would not involve any change of residence. Where, however, employment involves a change

of residence, it must be such that suitable accommodation is available in the new place of residence ; and

- (iii) The employment is such that it will not affect his material well-being and social dignity. Where, however, the conditions are less favourable than the insured person habitually obtains in his usual occupation and district, the employment would be deemed suitable only if the conditions offered conform to the standard generally obtained in the occupation and district in which the employment is offered.

(vii) Emergency Expenses

Emergency expenses include all benefits provided in respect of extraordinary expenses incurred in case of sickness, maternity,

invalidity and death which are likely to strain the budget of the low-paid workers, and which can be conveniently covered by social insurance without any risk or abuse.

Generally speaking the emergency expenses include four different types of contingencies :

- (i) All domestic expenses incurred as a result of the hospitalization of the mother of dependent children. Both the New Zealand Social security Act and the Beveridge Report make provision for compensation during the absence of house wife from home in hospital.
- (ii) All special expenses incurred for the provision of clothing and other equipment on the birth of a child, usually a lump sum is paid to the insured on such occasions.

(iii) A special supplementary benefit to the recipients of invalidity or old age benefit who need constant attendance, and

(iv) A lump sum is paid on the death of an insured person, or of his wife or dependents to meet the burial expenses.

(viii) Employment injuries.

The contingencies for which compensation for an employment injury is paid include all traumatic (causing abnormal condition of the body due to external injuries) injuries or diseases arising out of employment, not brought about deliberately or by the serious negligence or wilful misconduct of the insured.

The contingencies for which compensation is payable can be distinguished as :

- (i) Temporary incapacity
- (ii) Permanent incapacity, and.
- (iii) Death.

(i) Temporary incapacity.

Temporary incapacity compensation is paid under conditions similar to those applicable to the payment of sickness insurance. Some of the countries, however, substitute sickness benefit for temporary incapacity benefit during the first few months. If the temporary incapacity lasts longer than the waiting period, provision is sometimes made to pay compensation from the first day of temporary incapacity.

(ii) Permanent incapacity:

Permanent incapacity compensation is paid in respect of the loss or reduction of earning capacity caused as a result of physical disability due to loss of limbs eyes or legs, or by reason of a chronic condition due to injury or disease. A person who becomes permanently incapacitated is, however expected to resume any alternative employment which keeping in mind his remaining strength, ability, experience and training can

be indicated to him. If no such employment can be offered, the person should receive compensation for total incapacity on a definitive or provisional basis.

In case an alternative employment is offered to him, and the sum which he is able to earn from such employment is significantly less than that which he would probably have earned had he not suffered the injury or disease, he is entitled to receive compensation for partial incapacity proportionate to the difference in earning capacity. Even where no reduction in capacity can be proved due to loss or disfigurement of limbs or other parts of the physique, provision should be made for suitable compensation in every case.

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.

It is very significant to note that the compensation for permanent incapacity, total or partial, is paid from the time when temporary incapacity compensation ceases for the whole duration of permanent incapacity. The rates of benefits, in case of permanent partial incapacity, are usually related to the previous earnings of the insured persons. Where, however, the rates of such benefits are not related to the previous earnings of the insured persons, a maximum may be fixed for the combined rate of compensation and benefit.

(iii) Death or Survivor's Compensation.

Survivor's compensation is paid to the same dependents as could otherwise qualify for survivor's benefits ;

(i) A widow would receive compensation for the whole duration of her widowhood ;

(ii) A child would receive compensation until the age of 18 ;

(iii) Other members of the family of the deceased who were dependent upon him would receive compensation without prejudicing the claims of the widow and children.

(iv) 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 survivor's benefits, whether or not the deceased fulfilled the contribution conditions for such benefit at the time of his death.

In all cases of employment injuries a list of all diseases presumed to be of occupational origin should be prepared and revised from time to time as new revelations are made.

B. Range of Persons 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 emphasized in the Denmark and New Zealand Social security Acts. Only by aiming at universality will it be possible to create a social insurance system under which each individual citizen can achieve 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 is unable to work.

There are, however, certain limitations, hurdles and bottlenecks which stand in the way of achieving universality in the scope of social insurance. They are :

- (i) The difficulty of collecting contributions from persons whose income is below subsistence level,
- (ii) The difficulty of collecting contributions from persons whose income is mainly in kind, such as peasant communities engaged in subsistence farming,

- (iii) The difficulty of collecting contributions from persons who have no employer such as large number of agricultural farmers and tenants, and
- (iv) The difficulty of finding a substitute for the employers' contribution.

Social Insurance, therefore, affords protection, to only those employed and self-employed persons, together with their dependents, in respect of whom it is practicable :

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

All dependent wives who are not employed or self-employed, and dependent children.

who are under the age of 16, or 18, if they are continuing their general and vocational education are also covered in virtue of the insurance of their bread winners.

(i) Employed Persons

Social insurance should protect all employed persons against the whole range of contingencies to which they are exposed, provided :

- (i) the collection of contributions in respect of them can be organized without incurring disproportionate administrative expenditure ; and
- (ii) all necessary arrangements can be made for the administration of benefits.

Persons whose employment is very irregular or likely to be so in its total duration are usually excluded from all benefits to which employed persons are entitled. Similarly, very high-paid workers

are also sometimes excluded from social insurance benefit, but the tendency is now definitely towards including all classes of workers as indicated by the recent legislation in the United States, Brazil and Mexico. Even the Beveridge and Marsh Reports have not contemplated any such exclusion.

Unpaid apprentices are not insured against loss of wages. They are, however, entitled to benefit for employment injuries as from the date at which they would have completed their apprenticeship period.

(ii) Self-employed Persons

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 organized. The Beveridge and Marsh Reports, Wagner-Murray Dingell Bill and the New Zealand, Norway and Finland Social Security Schemes have all recommended the inclusion of self employed persons.

Self-employed persons comprise employers as well as persons working on their own account.

(iii) Collection of Contributions

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 him from their remunerations at the time when it is paid.

It is a fundamental principle of social insurance, and indeed the essential condition of its success, that contributions can only be levied on persons who have a margin of income after subsistence needs have been met.

The main difficulty in the way of collection of contributions arises in the case of self-employed persons. The difficulty is insuperable in case the self-employed persons consist of mass of small shop-keepers and craftsmen spread over a vast area and ~~wh~~

together with peasants and farmers, constitute the bulk of the country's population.

In such cases either the existing system can be utilized for the purpose of collecting contributions from self-employed persons or the services of same intermediaries may be utilized for collection. Indeed, where membership of an occupational association or possession of a licence is compulsory for any class of self-employed persons, the association or the licencing authority may be made responsible for collecting contributions from the persons concerned. Pending the development of such agencies, however, provisions should be made for enabling self-employed persons to contribute voluntarily, either as individuals or as members of association.

It is interesting to note that "National Income-tax" machinery is used in New Zealand and Sweden; "Communal Income-tax machinery" in Norway, and similar suggestions for collection have also been made by U. S. Social Security Board.

(iv) Administrative Benefits

With a view 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 organization of medical and employment services with preventive and medical functions.

C. BENEFIT RATES AND CONTRIBUTION CONDITIONS

1. Benefit Rates

The primary objective of social insurance schemes is to afford to insured persons a sense of economic security. This necessarily implies that the benefits granted under social insurance schemes should be sufficient to support a standard of living not much below their usual standard. They must be adequate to compensate him for the loss of earnings, he has suffered as a result of any of the contingencies against which he is insured.

Whereas it is desirable that the benefit should replace lost earnings upto as high a level as possible, they should not entail such heavy charges on the productive group as may discourage enterprise, reduce employment and check the growth of output. At the same time, the benefit rate should not be so high for any individual as to leave him insufficient incentive to resume work, especially in case of sickness or unemployment. In other words, the benefit rate should not be so high as to render 'sickness' and 'unemployment' more attractive and remunerative than 'physical fitness' and 'employment.' Social insurance benefits should serve as "a net to catch those that fall rather than an 'overly soft' feather bed."

The general principle is that 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, however, relate both contributions and benefits to earnings ; Great Britain being the only exception where contributions to benefits vary, not with earnings, but with sex or age.

(i) Benefit Rates in Different Contingencies

In case of sickness and unemployment, the benefit rate 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 dependents, or 60 per cent if he has a dependent wife or a house-keeper 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. In the case of workers with high earnings, the foregoing proportions of benefits to previous earnings may be reduced.

(ii) In case of maternity, benefits in all cases be sufficient for the full and healthy maintenance of the mother and her child ; it should be not less than 100 percent of the current wage for female unskilled workers or 75 percent of the previous earnings of the beneficiary, which ever is greater, but may be reduced by the amount of any child's allowance payable in respect of the child.

(iii) In case of invalidity and old age benefits should be not less than 30 percent of the current wage commonly recognized for mail un-skilled workers in the district in which the beneficiary resides, if the beneficiary has no dependents, or 45 percent of that wage if he has a dependent wife who would be qualified for widow's benefit or a house-keeper for his children ; for each of not more than two dependent children, an additional 10 per cent of that wage, less the amount of children's allowances for their children, should be payable.

(iv) In case of the death of the breadwinner, widow's benefit should not be less

than 30 per cent of the current minimum wage commonly recognized 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 their children, should be payable.

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

(v) In case of employment injuries compensation should not be less than two thirds of the wages lost, or estimated to have been lost, as the result of the injury. Ordinarily 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.

In case of the permanent incapacity and even death, the periodical payments of the worker, should be adjusted currently to significant changes in the wage level in the insured persons' previous occupation.

It is interesting to observe that the recent changes and trends in the benefit provision of social insurance suggest that there is a universal desire to regard social insurance as a means of raising, surely and continuously, the average level of the well being and efficiency of the workers. 'It is weaving more closely the mesh of its protection against lapse into destitution.' Even in cases where the insured persons have failed to contribute due to unavoidable contingency, the insurance rights have been kept intact, and the insured have been given the requisite benefits.

Another interesting feature of the benefit policy is the tendency to attach greater weight to the real need of the beneficiary in determining the rate of benefit and less to juridical

considerations or those of actuarial equity. Indeed it would be more equitable if the needs of the wageless individuals are judged not so much by the rates of their previous earnings as by the number of their dependents. It has been increasingly recognised that the social insurance must concern itself with the family rather than the individual if its resources are to be utilized for maximization of social welfare.

(ii) Contribution conditions

The primary objective of contribution conditions as a pre-requisite for payment of benefits, is to reserve benefits to persons, who have entered insurance with the capacity and the intention to work for their living, and to maintain a reasonable regularity in the payment of contributions. These contribution conditions are designed to prove that the normal status of the claimant is that of the employed and self-employed persons, and that the regular payment of contributions entitles him to derive the full benefit under

the proposed scheme. The failure of his employed to collect the contributions payable in respect of him, will however, not affect his rights to claim the benefits. To sum up : the object of contribution conditions is to test the genuineness of the employed status of the claimant.

Contribution conditions under different contingencies.

To test such genuineness a minimum qualifying period is prescribed, and the beneficiary is entitled to receive compensation only on the completion of this prescribed period. This qualifying period varies according to the nature and character of each contingency. Generally speaking :—

(i) *In case of sickness and unemployment,* the contribution conditions may require that contributions should have been paid in respect of not less than a quarter of a prescribed period, such as two years, completed before the contingency occurs. The practice, how-entitled to beuefit, if the lcss insured against

ever varies from country to country. Some countries impose a longer qualifying period for unemployment than for sickness benefit and such on the whole has been the practice in pre-war legislation. Great Britain has, however, for many years used approximately the same test for both the benefits, namely a period equivalent to 26 weekly contributions in two years. Both the Beveridge Report and the Wagner Murray-Dingell Bill have recommended that the contribution conditions for the both the benefits should be identical, having regard to the practical utility of such simplification. It is also felt that in order to strengthen the feeling of social security, the unemployment benefits should be unlimited in duration, although all existing legislations in almost all the countries have prescribed a limited period for such benefits.

(ii) *In case of maternity benefits, the contribution conditions may require that*

the first contribution should 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 the employed person. The scale of maternity benefits provided for under most of the social insurance schemes is slightly lower than recommended above.

(iii) *In case of basic invalidity, old age and survivor's benefits*, contribution conditions may require that contributions should have been paid in respect of not less than two-fifths of a prescribed period, such as five years, completed before the contingency occurs. It is not unreasonable to impose a longer contribution period as a qualification for old age benefit for such benefits are more likely to attract factitious entries into insurance

than sickness and unemployment benefits, if a substantial qualifying period is not prescribed. On the other hand it is felt that 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. Several countries therefore guarantee a substantial basic benefit after two, three or four years. A contribution condition of only two years is required under the Chilean and Czechoslovak schemes while under the Social Security Act of the United States, Old age and survivor's benefits may be obtained after an even shorter period of insurable employment. In Great Britain, however, the laws require in connection with old age benefits that the first contribution must have been paid at least five years before the benefit is claimed.

The contribution conditions also lay down that 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.

**D. FINANCING OF SOCIAL INSURANCE
AND DISTRIBUTION OF COSTS.**

I. The Contributing Parties.

Generally speaking 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. This tentative division of cost is the result of a broad uniformity of practice adopted in different countries to suit administrative, financial and actuarial convenience. Such a division of cost has been considered not only juridically acceptable and pragmatically sound, but also equitable and just to all the contributing parties. This springs from the

growing conviction that the employers and the State have a duty for the social and economic welfare of the community of its members* and that the workers should gladly contribute to guarantee the security of their future well being.

There are, however, notable exceptions to this general practice. In America, the unemployment schemes are financed by employers only, in Sweden, Norway, and New Zealand, the national invalidity and old age insurance schemes are financed by the insured persons and the state; the Greek pension scheme and Italian unemployment scheme are financed by workers and employers only; in Great Britain, Eire and Norway, sickness insurance receives a substantial grant from the state; in the Soviet Union the cost of temporary incapacity benefits is entirely borne by the undertakings.

THE DISTRIBUTION OF COSTS

The object is to lay down certain objective criteria or guiding principles for fixing

the shares of the contributing parties. Generally speaking, the cost of benefits, including the cost of administration, should be distributed among insured persons, employers and the state in such a way :

- (i) that it may be equitable to insured persons individually,
- (ii) that it may not cause any hardship to insured persons of small means ; and
- (iii) that it may not freeze the incentive and initiative for more production.

THE SHARE OF CONTRIBUTING PARTIES.

As regards the proportion in which several contributing parties should share in the cost of insurance, one broad generalization can be formulated. That where both workers and employers contribute, their shares are equal, whether or not the state contributes as well. There are, however, important exceptions particularly in the most

recent legislations. These exceptions suggest a tendency to increase the employer's share and decrease that of the worker.

(i) Principles governing Worker's Contributions.

Generally speaking, the insured person's contribution should be governed by two important considerations: (i) equity and (ii) avoidance of hardship to the insured. In no case should a compulsory insurance scheme impose on insured persons 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 is also expedient to fix a lower limit for the contributions so that it may, particularly in case of self-employed persons, prevent any malingerings, and at the same time provide a substantial basic component of fixed amount. Secondly, to avoid hardships, the state and employers should subsidize the insurance of low wage-earners.

It would also be equitable if no distinction is made between employed and self-employed persons or between the members of both the sexes in fixing the contributions levied for indentical benefits. In special cases, however, the principle should be that each should share one another's burden.

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 insured person's contribution.

It is important to note that all the above considerations definitely postulate the existence of minimum wage legislation providing adequate wages with a margin of savings. Otherwise only those persons can be expected to contribute who can really afford to make such contributions.

(ii) Principles Governing Employer's Contributions.

The financial participation of employers in any scheme of social insurance is based

on the responsibility of the industry towards its workers. It is held that such scheme of social insurance would lead to improved industrial relations between the workers and employers and result in greater stability of the internal market. Employers will surely find that the productive efficiency has so much increased that the charge of their contributions is amply compensated. Moreover, for industrial accidents and diseases the employer's liability principle has been legally recognized. It is also held that social insurance schemes cannot be financially feasible without employers' contributions.

The principles which should govern employer's contribution are;

(i) Employers should be required to contribute particularly by subsidizing the insurance of low wage-earners, as much as half the total costs of benefit confined to employed persons, excluding compensation for employment injuries.

(ii) 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.

(iii) Considerations should be given to the possibilities of applying some method of merit-rating in the calculation of contributions in respect of compensation for employment injuries.

(iv) Employers are usually given exemption to contribute under schemes of national insurance, which covers not only employed persons but citizenry at large.

It has been suggested that social insurance contributions, specially the contributions for unemployment benefits might be varied from time to time according to the economic barometer, falling when employment is bad and rising when it is good. It is, however, held that the rates of contributions of insured persons and employers should be kept as stable as possible.

(iii) Principles governing State's Contribution.

The state is responsible for the residual cost of social insurance, which is not met by insured persons and employers' contributions. The participation of state in the social insurance schemes is justified by the inadequacy of the financial resources obtained from the joint contributions from the workers and the employers. Moreover, it is the responsibility of the state to promote the economic and social well being of the workers by assisting the financing of their social insurance schemes.

The state subsidy to social insurance may assume either of the two typical forms. It may be granted in aid either of general revenue of the scheme or of certain benefits (or even administrative expenses). As example of the first form may be cited the subsidy equal to half the contributions, in the sickness and pension insurance of Chile, Brazil, Bulgaria and Peru, and in the unemployment schemes

of Great Britain and Poland. The payment of certain benefits directly by state out of state funds is very frequently illustrated in pension schemes when the state undertakes to add a uniform amount to every pension. In Great Britain the state meets the entire deficiency arising in the finances of sickness and pension insurance from the fact that contributions are calculated to cover the risk of persons entering insurance at the age of 16, whereas all persons entering at that, or any later age upto 60, receive the same benefits ; in addition, the state bears the entire cost of pension from 70 onwards. In the Soviet Union the state and local budgets bear the cost of pension for the aged, the totally incapacitated, and survivors.

The State's contribution varies very considerably in the national insurance schemes of different countries, partly to make up for the lower rate of contribution and partly because the universality of scope

and extent of coverage justify a fuller measure of aid from public taxation.

MEASURE OF STATE'S CONTRIBUTION.

The state is responsible for the residual cost of social insurance. Among the elements which may properly be included in the residual cost are :

(a) the contribution of deficit resulting from bringing persons into insurance when they are above the minimum age for entering employment ;

(b) the contingent liability involved in guaranteeing the payment of basic invalidity, old age and survivor's benefit 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.

RELATION OF CONTRIBUTION TO RISK

The principle of equality between the premium and the probable benefit is the essence of insurance, and commercial insurance endeavours as far as is practicable to adjust the premium to the value of the individual risk. Social insurance, because it is insurance, has also to adopt the principle of actuarial equity, but since its purpose is social, it must also have regard to the social adequacy of its benefits and seek to prevent destitution in the largest possible number of cases. Social insurance has, therefore, to strike a workable balance between these two diverse objectives viz. actuarial equity and social adequacy. Such a balance would obviously be arbitrary and tend to shift according to the change in public opinion.

The risk to which an insured is exposed varies with his susceptibility to disease, accident and unemployment. The important indications of the degree of risk are age, sex and occupation, and if the insurance schemes

provide benefits for his dependents, their number, age and sex are also significant. It is interesting to examine how far social insurance take account of these degrees of risk while determining the relation between contributions and benefits.

The principle of grouping of workers by occupation, each occupation covering its own risk is exemplified in all branches of insurance: Special pension schemes for salaried employees, miners, railwaymen, etc., separate social insurance for industry and agriculture, grouping of occupational risk classes within schemes of workmen's compensation as adopted in all countries except Rumania ; temporary incapacity insurance as adopted in Soviet Union and unemployment insurance of South Africa. The trend of the development of social insurance organization is, however, towards the massing of the working population in general, inter-occupational schemes, workmen's compensation alone being left to vary the contribution according to the specific risk of each occupation.

Whether the scheme is general or occupational in its scope, the prevailing rule is that whereas the contribution rate is unaffected by the age, sex or family responsibilities of the worker concerned, these factors do affect the wide range of benefits, to which the claimants are entitled. The manner and degree in which benefits are affected vary from one branch of social insurance to another, and among the several benefits of the same branch.

Social insurance limits its liability by fixing maxima for the rate and duration of benefit, and by reducing its clients to a select group. The selection is affected firstly, by barring from entry into insurance persons whose advanced age marks them as immediate candidates for benefit, and secondly, by obliging insured persons to prove that they possess normal health and employability by completing a qualifying period of insurance before claiming benefit. Within the select group of insured persons entitled to benefit, if the loss insured against

occurs, there remains, however, a wide diversity of risk, as indicated by age, sex and family responsibilities. In contrast to private insurance, compulsory social insurance intentionally allows certain groups to make heavier claims on the benefit fund than others paying the same contributions. For example, elderly individuals and women are a greater charge on sickness insurance while persons having dependents can procure for them the extensive medical benefits, allowances and pensions which social insurance provides for wives and children.

Relation of contributions to wages.

It is interesting to examine the relation of contributions to wages. In the great majority of social insurance schemes, the contributions are proportional, and uniformly so, to wages. The question now to be considered is, whether high and low wage earners obtain proportionate return for the contributions paid on their account.

Generally speaking, in accident, sickness and unemployment insurance, the proportion of the contribution rate to the cash benefit rate is uniform. This proportionality is, however, often modified by provision for minimum rates and dependent's allowances, while, in some recent schemes of unemployment insurance the benefit-rate is graduated so as to favour low-wage earners. In case of accident and sickness insurance, since the contributions also finance medical benefits and administration expenses their impact is identical in content for high and low wage earners.

In case of pension insurance the tendency is to assign greater weight while calculating pension for low wage earners than for highly paid workers. This is specially so in case of Italy and the United States.

It is a truism that the contributions of low-wage earners are, as a rule, insufficient to cover the cost of their benefits. The general

practice is, therefore, to meet the deficit by a transfer from the contributions of high wage-earners, and where such is provided, by the whole or a larger share of the state subsidy. Social insurance laws and explanatory memoranda are reticent concerning the manner in which the contributions paid in respect of an individual are appropriated for the benefit of another whose need is greater. It seems safe to assert, however, that the high wage-earner, in almost every scheme, obtains a full return for his share of the joint contribution. The extent to which the employer's share is used to help the needier beneficiaries, particularly the low wage-earners, depends in part on the extent of state subsidy and on its sufficiency and adequacy.

MERIT-RATING.

One of the primary objectives of social insurance is to abate by all available means, the loss that it has to indemnify. It must

therefore, consider whether the premium-rates can be so manipulated as to afford an incentive for prevention and mitigation of such risks. Such a manipulation of risks has been characterized as 'merit-rating.' Merit-rating can thus be defined as a "device to encourage the reduction and prevention of risk."

It proceeds from the hypothesis that the employer is able, to some extent, to control the frequency and severity of the losses in respect of which social insurance benefits are payable. Consequently it affects undertakings individually, and not groups of similar undertakings. It is interesting to observe that merit-rating is practised extensively in the United States of America.

There is no doubt that merit-rating has encouraged employers to reduce the accident hazards of their undertakings, both by installing better safety devices than the factory legislation requires and by carrying on safety propaganda among their workers.

The system of merit-rating is generally adopted in accident insurance. It accepts the inequalities in risk among industries that result from differences in the processes of production and type of machinery used. The general practice is to fix an average premium for each class of occupation, and variations, up or down, are made in the premiums charged to each undertaking, either according to the number and severity of the accidents that have occurred in it, or according to the nature and character of technical equipment and organization, credit being given, for example, for the installation of safety devices. Merit-rating can be applied only in a limited range of industries and fairly large undertakings.

Merit-rating has two distinct advantages, firstly, it offers financial incentives to the employers for a lower premium, and secondly, it has focussed the attention of the employers to explore the possibilities of preventing accidents. The reduction of accidents also

ensures the uninterrupted working of the productive machinery. Experience, however, shows that only a fraction of accidents are such as can be avoided by preventive measures.

In case of unemployment insurance, merit-rating, or more exactly, 'experience-rating' is found only in the United States. The principle of merit-rating as applied to unemployment insurance is that each undertaking shall bear a large proportion of the cost of benefits paid to its discharged workers. In the United States, the entire premium for unemployment insurance is, therefore, charged to employer, and is varied according to the losses incurred by him in respect of such insurance. It is, however, significant to note that all schemes of compulsory unemployment insurance outside the United States have rejected experience-rating, and have regarded unemployment as a liability to be shared by the industry as a whole and by the State.

Financial Systems of Social Insurance.

The financial system of a social insurance scheme consists of the mechanism whereby an equilibrium is maintained between its resources and its charges. It would always be expedient to balance 'benefit expenditure' by 'contribution income' either over a short period or over a long, even indefinitely long, period. Of course, in long term insurance, the rates of contributions and benefits under a social insurance scheme are established less rigidly than they are under a private insurance. However, in social insurance, as in private insurance, cash must be available to pay benefits as they fall due, and the test of actuarial solvency at any date is the same, namely, the equivalence of the present values of probable revenue and expenditure. But since the correspondence in time between benefits and contributions can never be exact, a social insurance scheme must always provide for a reserve.

The financial systems used in social insurance schemes belong to two principal

types : the Assessment System and the Accumulation System.

The Assessment System. The Assessment System aims at maintaining a current equilibrium between income and outgo by the adjustment of contributions or, occasionally of benefits. The adjustment is affected annually or at longer intervals. A moderate "Contingencies Reserve" is, however, maintained under the Assessment System to meet any unforeseen excesses of benefit liabilities over current payments.

The Accumulation System. The Accumulation System aims at levelling the contribution rates throughout the period. In the earlier stages when the schemes are not fully operative on the benefit side and consequently the outgoings are much less than the inflows into the Fund, surplus is deliberately accumulated into a large "accumulated reserve" in order that the interest earned on it may partly meet, year after year, the future

benefits. The system has therefore been characterized as a "mechanism of methodical savings." In the U. S. A. under the 1935 Social Security Legislation, schemes of social insurance were based on such a prior accumulation of full reserve fund.

The accumulation system is used wherever an insurance scheme provides for benefits the cost which is calculated to increase year by year over a long period, and it is desired to meet the cost by a contribution which remains level throughout the period.

The accumulation system has developed into two separate and distinct forms, namely, *individual accumulation i.e.*, accumulation in respect of an average individual entrant at each particular age, and *collective accumulation* in respect of an average entrant at an average age.

DIFFERENCE BETWEEN THE ASSESSMENT SYSTEM AND THE ACCUMULATION SYSTEM

It is in the size of the reserve and in the part that it plays that the two systems

mainly differ. In the Assessment system the purpose of the reserve is to meet, by a capital payment, any unforeseen and exceptional excess of outgo over income, and the interest which the reserve fund supplies is of quite secondary importance. In the Accumulation system, on the other hand, the function of the reserve is to earn interest, and as it accumulates, to cover an increasing share of the total expenditure, the increase being due, not to chance, but to an expected growth in the rate of benefit or in the number of beneficiaries or to both.

THE FINANCIAL SYSTEM IN PRACTICE

The suitability and appropriateness of any financial system can be judged from numerous considerations, viz. facility in the collection of contributions, nature and character of financial organization and ease of maintaining financial equilibrium, low cost of administrative operations involved in its working and ease of actuarial analysis. Indeed

the whole financial structure of social insurance is never built on one single pattern. It results from a strange mixture of several fortuitous circumstances. But generally speaking some common practices can be easily distinguished. *Sickness insurance* is almost everywhere financed on the assessment system. Only in Great Britain, where health insurance provides incapacity benefits without limit of time, is the accumulation system used. In *unemployment insurance* also the assessment system is used, because its financing is necessarily empirical, as it is difficult to forecast with even moderate precision the movement of expenditure. *Accident insurance* uses a distinctive form of the assessment system. In *Pension insurance* the appropriate financial system may be either that of assessment or that of accumulation, the choice depends on a number of considerations, of which the chief are the probable movement of the pension cost and the scope of the insurance scheme.

The general tendency is, however, that social insurance should as far as it is practicable be financed on a "pay-as-you-go" basis, subsidized, as and when necessary; from other sources.

ADMINISTRATIVE STRUCTURE OF SOCIAL INSURANCE

Evolution of the Administrative Structure

Social Insurance schemes during the initial stages were all administered by small institutions owing their origin to private initiative or to public experimentation on a small scale. The administration of such schemes through numerous and heterogeneous institutions was undoubtedly very costly. A higher ratio of officials was required per thousand insured persons in order to perform a given function, and the work of supervision by higher authorities was more expensive and complicated. Moreover, small institutions, required comparatively large reserves to safeguard their financial integrity.

In recent years, therefore, the leading tendency, in the administration of social insurance, is towards centralization and co-ordination. There is a growing realization that such a centralization and co-ordination will undoubtedly furnish much better opportunities to social insurance to achieve its objective. Both from the standpoint of economy and efficiency, a centrally, coordinated administrative machinery will be much better than the numerous and heterogeneous institutions, each administering a single scheme.

Principles governing the Administration of Social Insurance Schemes.

- (i) The Social Insurance Schemes should be an integral part of the unified, co-ordinated system of social security services.
- (ii) Social Insurance Schemes should be administered under the direction of a central authority. That authority

might be an autonomous statutory body or a government department or agency. In either case it should be associated with the authorities administering social assistance, medical care services and employment services for coordinating matters of common interest, such as the certification of inability to work or to obtain work.

- (iii) The contributors should, through their respective organizations, be represented on the bodies which determine or advise upon administrative policy and propose legislation or frame regulations.
- (iv) 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.

- (v) 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. Even the procedures adopted for claiming benefits should be so simple that the beneficiaries may not feel any hardship or inconvenience.
- (vi) Central and regional advisory councils representing such bodies as trade unions, employers' associations, chambers of commerce, farmer'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.

- (vii) 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, and
- (viii) 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. Such appeals should be referred to special tribunals; which should include judges who are experts in social insurance law, assisted by assessors, representatives of the group to which the claimant belongs, and, where employed persons are concerned, by representatives of employers also.

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 persons. 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:

CHAPTER III

SOCIAL INSURANCE SYSTEM OF U. S. S. R.,

GREAT BRITAIN, U. S. A., AUSTRALIA

AND INDIA.

SOCIAL INSURANCE SYSTEM OF THE U. S. S. R.

Introduction

The beginnings of Social Insurance in Russia can be traced to the year 1912, when compulsory insurance against sickness and employment injury was introduced for the first time. The post-revolutionary scheme dates from 1922, and acquired its present structure and comprehensive scope in the new legislation of 1933, drawn as an integral part and coinciding with the operation of the second five year plan (1933-38). The changes affected in subsequent years are of smaller significance apart from the introduction of family allowances for very large families in 1936 and for families of moderate size in 1944.

CHARACTERISTIC FEATURES OF RUSSIAN SOCIAL INSURANCE SCHEME.

The Russian Social Insurance scheme reveals several interesting and distinctive features in its organization and technique.

Indeed until recently these features were characteristic of the Russian system alone, but now they have been incorporated and adopted in several other national schemes. The most outstanding features are :

- (i) The Soviet scheme provides cash benefits and certain welfare services in kind, but not medical care, which is a free service furnished by the public health authorities. Co-ordination between insurance scheme and medical care service is, however, maintained by local joint committees.
- (ii) The task of organization, administration and supervision of social insurance scheme in Soviet Union is entrusted to the All-Russian Trade Unions of the different industrial branches and to their local organs. Long-term insurance is, however, administered by the Social Welfare Ministries.

- (iii) The financial cost of the insurance scheme is met entirely out of the contribution of each individual establishment. The amount of contribution is proportional to the gross wage bill of each establishment. Payment of contributions is effected, as a rule, by transfer from the bank account of the establishment to the account of the social insurance scheme at the time when the establishment draws cash from its account for the purpose of paying wages. The task of collection of contribution is thereby greatly simplified.
- (iv) The qualifying period for benefit is expressed in terms of duration of employment, and more particularly uninterrupted employment in the same establishment.
- (v) Cases of permanent incapacity are classified in three grades of severity, and a close similarity is maintained

between employment injury benefits and corresponding benefits provided for in case of sickness, or invalidity arising from other causes.

ORGANIZATION OF SOCIAL INSURANCE IN THE U. S. S. R.

Social insurance in the Soviet Union is administered partly by the trade unions and partly by the Social Welfare Ministries. Short-term insurance is administered by trade union organisations, while long-term insurance is administered by the Social Welfare Ministries of the Soviet Republics. For matters of social insurance these Ministries work under the supervision and control of “All-Union Council of Trade Unions”.

The Trade Union organs which participate in the administration of social insurance are :

- (i) Central All-Union Council of Trade Unions ;
- (ii) The Central Trade Union Councils ;

- (iii) Local Social Insurance Councils ;
- (iv) Shop Social Insurance Committees; and
- (v) Social Insurance Delegates.

(i) Central All-Union Council of Trade Unions.—This body has a separate Social Insurance Department, the main functions of which are :

- (a) The organisation and control of activities of all trade union organs entrusted with the administration of social insurance ;
- (b) To control and supervise the activities of Ministries of Social Welfare ;
- (c) The establishment of an over-all social insurance budget ; and
- (d) The drafting of Social Insurance laws.

(ii) Central Trade Union Councils—The central councils of the trade unions of the various industrial branches

propose new legislative measures, collect contributions within their respective industrial branches, and supervise the work of Social Insurance Councils.

(iii) Social Insurance Councils.—The local agencies of the Soviet social insurance organisation are the social insurance councils. They are entrusted with the work of administration and supervision of the social insurance schemes.

(iv) Shop Social Insurance Committees:—In workshops and departments of each establishment, Shop Social Insurance Committees are established which help the social insurance councils in day to day administration.

The Social Welfare Ministries, which administer long-term insurance, have no branches of their own and their functions

are performed by town, city or district councils.

SCOPE OF SOCIAL INSURANCE RANGE OF PERSONS COVERED.

The Social Insurance Scheme of the U. S. S. R. applies compulsorily to all the employed persons. It covers —

- (i) All persons employed in the “socialist sector”. Socialist sector includes State, co-operative and public undertakings, institutions and other establishments.
- (ii) All persons employed in the “private establishments” and on “private farms.”
- (iii) All persons attending training courses, if they worked previously as employed persons.

The following persons are not covered by the State Social Insurance Scheme :

- (i) Collective farmers ;

- (ii) Persons who own farms, and the families of such persons ; and
- (iii) Persons performing occasional works, repairs etc.

These persons are, however, covered by special social insurance schemes administered by special mutual aid funds.

BENEFIT RATES AND CONTRIBUTION CONDITIONS.

Cash benefits are payable under the social insurance scheme in respect of :

- (a) **Short term benefits.**—These benefits comprise temporary incapacity due to employment injury (including occupational disease) or sickness ; maternity leave, sickness of dependants, and quarantine. These benefits are administered by trade unions and their affiliated social insurance organs.
- (b) **Long term benefits.**—These benefits comprise invalidity, whether due to

employment injury (including occupational disease or another causes, old age, death, and family responsibilities. Long term benefits are administered by the Social Welfare Ministries of the Soviet Republics. The trade union, however, administer pensions paid to working invalids.

(c) Other grants.— These include maternity and funeral benefits.

Medical benefits are given to insured persons and their dependants at polyclinics, in hospitals and in other institutions under the administration of the Ministries of Health. Medical aid at home is given by the medical institution which is closest to the worker's place of work.

The rate of benefit is assessed according to the type of work in which the insured person is employed and according to the length of his uninterrupted employment in

the same establishment. In some cases, as in case of old-age pensions or invalidity pensions the insured persons are divided into different categories. In case of maternity, lump sums are granted for infant feeding.

CONTRIBUTION CONDITIONS.

The cost of the scheme is met entirely by contributions from each individual establishment. The amount of contribution paid by each establishment is in proportion to the gross wage bill of each establishment. Payment of contribution is affected by transfer from the bank account of the establishment to the account of the social insurance scheme.

FINANCIAL ADMINISTRATION OF SOCIAL INSURANCE IN THE U. S. S. R.

The social insurance scheme is financed by contributions which cover the cost of all benefits with the exception of medical care, which is administered and financed by Ministry of Health.

In principle, the contributions collected each year for workers in each branch of

industry are to be spent in that year ; any surplus remaining being devoted to social welfare work for the branch concerned.

Contributions are paid in proportion to the amount of Gross Wage Bill. The establishments, belonging to socialist sector, pay their contributions at the time when they draw their cash for paying wages. Private employers pay their contributions at the local branch of the State Bank and employers of domestic workers pay contributions by means of stamps which can be bought at the branches of State Bank or Savings Bank.

The contributions vary considerably from one branch of the industry to another.

SPECIAL SCHEMES OF SOCIAL INSURANCE. IN THE U. S. S. R.

Social Insurance for Collective Farmers

The social insurance of collective farmers is administered by special mutual aid funds which are established at different collective

farms and which operate under the supervision of the Ministry of Social Welfare.

It is interesting to observe that the scheme is financed by contributions in cash and kind (up to 2 per cent. of the annual crops), which is paid by the management of the collective farm to the mutual aid fund concerned.

The establishment of mutual aid fund is voluntary and takes place when the majority of members of a collective farm so decide.

The benefits granted to the members of the mutual aid fund in case of sickness, old age and invalidity are paid partly in cash and partly in kind.

Social Insurance for Artisans and Craftsmen.

The social insurance of artisans and craftsmen is carried out by producers' co-operatives which have their own mutual insurance schemes. The benefits paid by these

co-operatives to their members are almost the same as those paid under the State social insurance scheme.

National Assistance.—Persons who are not covered by the State social insurance scheme or any of the other schemes receive assistance in their old age, and in case of invalidity are placed in homes for invalids. This assistance is furnished by the social assistance authorities at the expense of the Government.

Welfare Projects.—Social insurance funds are also used for welfare projects, such as building and maintenance of rest homes, sanatoria, holiday resorts, parks and institutions for recreation and welfare.

In 1947, an elaborate scheme of “Miner’s Social Insurance” was put into operation.

Conclusion : Thus we see that in U. S. S. R. there exists a comprehensive, and unified scheme in social insurance intended to cover the whole of the population

against almost all the risks, to which mankind is exposed.

Social Insurance System of the United Kingdom.

Introduction—

In June, 1941, Arthur Greenwood, then Minister without Portfolio, announced in the House of Commons the appointment of an Inter-departmental committee to undertake a survey of the national schemes of social insurance and allied services, including workmen's compensation, and to make recommendations. The Committee consisted of its Chairman, Sir William Beveridge and of senior civil servants representing the numerous Government departments which had played some part in the administration of social insurance. In November 1942, William Beveridge presented his "Report on Social Insurance and Allied Services." This was an outline Plan, covering "all citizens without upper income limits, all embracing in scope of persons and needs."

Objectives of the Plan.

(The object of the Beveridge Plan is to bring every man and woman in the country into a comprehensive scheme which would provide them, when unemployed, ill, aged, or widowed, with income at a rate adequate for maintenance and which would provide special grants at the time of marriage, maternity or burial.)

Principles of the Plan.

The Plan embodies six principles : Comprehensiveness, Unification of administrative responsibility, Classification, Adequacy of benefit, Flat rate of contribution and Flat rate of benefit.

The Plan provides for the unification of all existing schemes of social insurance, for the extension of insurance to citizens in general, and for the incorporation of subsidiary social assistance as well, under the control of a single authority, financed by single contribution and granting identical

benefits for loss of income, irrespective of the cause of the loss or interruption of earning. The Plan also retains the principles of tripartite contribution; of contribution and benefits fixed independently of earnings and of administrative decentralisation in regions and localities, in close co-operation with the communities to be served. The flat-rate of benefit is intended to leave a wide scope for supplementary voluntary insurance and savings.

Assumptions of the Plan .

The Beveridge Plan is based on three assumptions :

1. Institution of a scheme of children's allowances ;
2. Establishment of a comprehensive national medical service, and
3. Avoidance of mass unemployment.

Indeed the success of the Plan is conditioned by the institution of a scheme of children's allowances, organization of a National Medical Care Service and avoidance

of mass unemployment, for otherwise the cost of sickness and unemployment benefit may be ruinous.

•Scope of the Plan : Range of persons and risks covered.

Persons covered.—The Beveridge Plan covers the entire population of all ages and all occupations. For administrative purposes the population has been divided into six classes :

- (i) Employees;
- (ii) Self-employed;
- (iii) Housewives;
- (iv) Adults not gainfully occupied;
- (v) Children, and
- (vi) Retired persons (men at 65, women at 60).

Those below working age will be provided for by family allowances ; those of working age by insurance benefits ; and those beyond working age by retirement pensions.

Risks or Contingencies Covered.

The plan covers eight different types of risks or contingencies :

- (i) Unemployment ✓
- (ii) Invalidity
- (iii) Sickness
- (iv) Old Age
- (v) Loss of livelihood
- (vi) Funeral Expenses
- (vii) Children's expenses, and
- (viii) Married women's needs :
 - (a) Marriage expenses
 - (b) Maternity expenses
 - (c) Interruption of husband's earnings
 - (d) Widowhood provision
 - (e) Separation allowances, and
 - (f) Incapacity for household duties.

Needs of each class :

The Plan recognises that each population class has its distinctive group of needs, and provides benefits for them accordingly :

- (i) *Employees* :—For Employees the Plan provides unemployment benefit, invalidity benefit, old age pension, funeral expenses, medical care and workmen's compensation.
- (ii) *Self-Employed* :—For Self employed persons the Plan provides benefits for invalidity, old age, loss of livelihood, funeral expenses and medical care.
- (iii) *Housewives* :—For Housewives, the Plan provides benefits for marriage, maternity, old age, widowhood, invalidity, husband's unemployment, funeral expenses and medical care ;
- (iv) *Others not gainfully occupied* -—Retirement pension, training benefit, funeral grant and medical care.

- (v) *Children* :—Children's allowances, funeral grant and medical care, and
- (vi) *Retired persons* :—Retirement pension, funeral grant and medical care.

BENEFIT RATES AND CONTRIBUTION CONDITIONS.

Benefit rates.

All insurance benefits, provided for under the plan, are cash benefits, except the free training provided as part of training benefit and, where indicated, unemployment and disability benefits.

The cash benefits consist of periodical payments to meet current living expenses and lump sums to meet a single, occasional expenditure.

The rates of the periodical payments are intended to be sufficient for the subsistence of the individual or family concerned.

Duration of periodical payments.

The duration of payments differs considerably in case of different contingencies ;

- (i) *Unemployment* benefit continues as long as the insured person is unemployed and available for work. After a certain period, however, continuance of benefit is subject to the condition of attendance at a work or training centre.
- (ii) *Disability* benefit continues as long as the insured person is incapable of work ; on attainment of the pensionable age, it is replaced by the retirement pension. Where the disability is due to industrial accident, disability benefit is replaced by an industrial pension ;
- (iii) *Training benefit* is provided for persons capable of, and available for, work who are not entitled to unemployment benefit and have to

find a new means of livelihood. It is payable for a maximum of 26 weeks.

(iv) *Retirement pensions* continue until death.

(v) *Maternity benefit* is payable for 13 weeks.

Rates and amounts of insurance payments.

The weekly rate of the periodical payments and the amounts of the lump-sum grants are given in the Plan.

Contribution conditions.

The general rule is that, in order to be entitled to benefits at the full rates for themselves and their dependents, insured persons must have to their credit at least 48 contributions for the previous year.

In case of unemployment or disability benefit, no person can receive benefit until 26 actual contributions have been paid in respect of him, and disability benefit is

only continued after a period of 25 weeks. A person who has less than 48 contributions to his credit has his unemployment and disability benefit reduced either in rate or in duration.

Insurance contributions. A single weekly contribution is payable in respect of all benefits provided under the plan, except the industrial pension and industrial death grant. The industrial pension and industrial death grant are financed by a special levy on risky and hazardous undertakings, proportionate to the degree of the risk they involve and their pay-roll (merit-rating).

For each of the different groups of insured contributors there is distinct contribution rate. The rates are set forth in the Plan, in a separate table.

Exemption from contribution.

The Plan makes provision for exempting from liability to contribute any person (other than an employee) whose income is less

than a prescribed minimum, or who is an inmate of an institution.

National assistance.

Though mainly an insurance scheme, the plan incorporates an assistance scheme, as a minor but integral part. It is the function of assistance to meet, upto a subsistence level, all needs that are not covered by insurance. The grant of assistance is always subject to a needs test and to such conditions as to behaviour as are likely to hasten restoration of earning capacity.

Voluntary insurance. The plan only provides subsistence benefits and leaves sufficient scope for supplementing such benefits by voluntary insurance.

Administration. The Plan provides for the creation of a Ministry of Social Security, which would be solely responsible for the administration of all insurance cash benefits, for assistance, and for the collection of contributions. The Ministry

would also take over the public assistance functions at present performed by local authorities.

The National Health Service, however, would be administered by the Ministry of Health, which would collaborate with the Ministry of Social Security, through a Joint Committee.

The Ministry of Social Security would maintain a network of local offices throughout the country.

Financing of the Beveridge Plan.

The plan provides for the sharing of the cost of insurance benefits among insured persons, the employers and the State.

The State's share shall essentially consist of the deficit in the contributions of persons now of working age who will not have contributed throughout their working life. The entire cost of children's allowances and national assistance is also to be borne by the State.

The Plan also gives the estimates of income and expenditure of the Plan and its complementary schemes of children's allowance and medical care.

Beveridge Report and After :

At the end of September, 1944 the British Government published the two White Papers containing proposals for family allowances, social assistance and national assistance. The Government accepted the main principles and features of the Beveridge Plan. Some changes were however, made in the benefit proposals of the Plan.

Social Security Legislation in Great Britain :-

In order to implement the main proposals of the Beveridge Plan the Government have passed the following Acts relating to family allowances, national insurance national health and national assistance :—

1. Family Allowances Act, 1945.
2. National Insurance Act, 1946.

3. National Insurance (Industrial Injuries) Act, 1946.
4. National Health Service Act, 1946.
5. National Assistance Act, 1948.
6. Children Act, 1948.

(i) Family Allowances Act.

A Bill to provide Family Allowances was presented to the Parliament on the 15th February, 1945 and received Royal Assent on the 15th June, 1945. The primary object of this Act was to provide for the payment by the Minister of National Insurance from the Exchequer of an allowance for each family at the rate of 5s. for each eligible child except the first or only child. This cash benefit is intended for the healthy up-bringing of children.

In case, however, the person is unemployed or sick, the new National Insurance Scheme provides allowances even for the first child. Further assistance is provided

under this scheme by the development of free milk and meals services for the school-going children.

Payment of family allowances began from 6th August, 1946. Allowances are claimed by completing and sending in to the Ministry of National Insurance a special claim form obtainable at any post office. All families living in Great Britain, whatever the nationality of the parents, may qualify for these allowances, but British subjects who were born abroad and aliens are required to satisfy certain residence conditions. The cost of the cash allowances roughly comes to 257 millions a year and that of administration about 22 millions.

(ii) National Insurance Act, 1946.

The National Insurance Bill received Royal assent on 1st August, 1946, and same came into full operation on 5th July, 1948. The Act provides for a unified and comprehensive scheme of National Insurance which will

eventually cover practically everyone in Great Britain.

The Act divides the insured persons into three broad categories.

- (a) Employed persons, *i. e.*, those who work under a contract of service ;
- (b) Self-Employed persons, *i. e.*, those who are gainfully occupied, but not under contract of service ; and
- (c) Non-employed persons, those who are not gainfully occupied.

All these three classes contribute for the following kinds of benefits :

Maternity benefits ;

Widows' benefits ;

Guardian's Allowance (for orphans) ;

Retirement pension ;

Death grant.

In addition employed persons can qualify for sickness and unemployment benefit, and self-employed persons for a sickness benefit. The contribution rates depend on the class into which the insured person falls. Both the employers and the exchequer contribute towards the financing of these schemes. Men aged 65 to 70 and women aged 60 to 65 are required to make contributions only if they are working and have not retired from regular employment. Persons who are unemployed or sick or engaged in full-time education or having an yearly income of less than £104 are also exempt from liability to contribute for the national insurance services.

For the administration of these services a network of regional and local offices have been established throughout the country. These offices work in close co-operation with the employment exchanges. A National Insurance Advisory Committee has also been set up to consider and report on the new regulations proposed or made under the Act.

(iii) National Insurance (Industrial Injuries) Act, 1946.

The National Insurance (Industrial Injuries) Act was introduced in the Parliament on 23rd of August, 1945, and received the Royal Assent on 26th July, 1946. The main object of this Act is to make compensation for industrial injuries a part of the country's social services in a scheme based on insurance against risk and not on liability for compensation. Its chief provision are that :

(i) All persons employed in Great Britain under any contract of service or apprenticeship shall be insured without income limit ; and

(ii) Benefits shall be related to the degree of disablement caused by the industrial accident or disease and not to loss of earning power. The degree of disablement is to be assessed by Medical Boards and expressed as a percentage, the maximum being 100 per cent.

The various allowances allowed under this Act are Injury Allowance, Unemployability Allowance, Special Handicap Allowance, Constant Attendance Allowance, Dependent's Allowance, and Widowhood Allowance.

The National Insurance (Industrial Injuries) Act has come into full operation from 5th July, 1948. The cost of the benefits is estimated at £28 1/2 millions with a further £3 1/2 millions for administration. An Industrial Injuries Advisory Committee has also been set up to advise on the new regulations framed or proposed in the present Act.

**(iv) National Health Services Act,
1946.**

The advances made in Britain's public health and medical services during the last three decades culminated in the passing of the National Health Services Act in November, 1946. Although the new service was scheduled to begin on 1st April, 1948, it actually came into force from 5th of July, 1948.

The object of this Act is "to promote the establishment in England and Wales of a comprehensive service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness ; and for that purpose to provide or secure (free of charge except where any provision of the Act expressly provides for the making and recovery of charge) the effective provision of services in accordance with the provisions of the Act. " The object is to be achieved by a number of far-reaching additions and alternations to the existing administrative machinery, preventive and curative services, and financial organization.

Under this new Act, the Minister of Health has assumed direct responsibility for (a) the provision on a national basis of all hospital and of specialist services, (b) the mental health functions from the hands of the Board of Control, (c) the conduct of research work into any matters relating to

the prevention, diagnosis or treatment of illness or mental defect, (d) a Public Health Laboratory Service, and (e) a blood transfusion service. He has also assumed indirect responsibility for the organisation and maintenance of Health Centres, the establishment and maintenance of general medical services and for the management of all other services. The Minister is to be advised by the Central Health Services Council and Standing Advisory Committees, which may be appointed to study various aspects of the service.

The new services are to be financed partly from the Exchequer, partly from local rates, and partly from a proportion of National Insurance contributions. No charge is to be made to the public except for appliances, goods or other articles outside the usual scope of the service.

(For details regarding the nature and character of services rendered under the National Health Services Act, 1948, see Chapter on "Medical Care Services in Great Britain.")

(v) National Assistance Act, 1948

This Act, which received Royal Assent on 13th May, 1948, provides for the supersession of the existing Poor Law, and sets up a National Assistance Board to administer a single comprehensive service replacing outdoor relief, unemployment assistance supplementary pensions, blind domiciliary assistance and tuberculosis treatment allowances.

•The new Act plans to improve provision for the aged by the establishment by welfare authorities of small homes for the accommodation of any old persons unable wholly to look after themselves elsewhere, whatever their means. These small homes would replace the existing institutions for the aged poor which are at present only exceptionally supplemented by small homes. An increasing number of old people's homes or hostels are now being created by voluntary effort. The National Assistance Act also makes provision

for voluntary organisation to act, by arrangement, as agents of the welfare authorities in providing residential accommodation and welfare service of a kind for which the latter have a responsibility. The National Assistance schemes are financed solely by the Exchequer.

(vi) The Children Act, 1948

The Children Act, which received Royal Assent on 30th June, 1948, also formed part of the programme of the social legislation which came into operation when the provisions of the National Assistance Act brought Poor Law to an end on 5th July, 1948. The Act provides that every local authority is to have a children's committee to deal with the care of children removed from their homes by order of the court. The committees are also to deal with child life protection, the registration of 'adoption societies,' and the supervision of children placed by their parents in the care of others. The committees are

also to appoint children's officers to look after the children. Children are to be boarded out, as far as possible, in suitable private homes. The Act will give valuable assistance in the healthy upbringing of destitute children.

With the passing of these Acts Great Britain has been able to establish a comprehensive, nation-wide, unified scheme of social insurance, intended to exterminate the Five Giants of Want, Disease, Ignorance, Squalor and Idleness.

SOCIAL INSURANCE SYSTEM OF U. S. A.

Introduction.—

A bill to amend the Social Security Act of 1935 and to establish a unified national social insurance system was introduced in the United States Senate on 3rd June, 1943 by Senators Wanger and Murray, and was referred to the Committee on Finance. The bill was subsequently to be known as Wanger-Murray-Dingell Bill of 1943. The Bill was strongly endorsed by the American Federation

of Labour and the Congress of Industrial Organisation.

OBJECTIVES, SCOPE AND CHARACTERISTIC

FEATURES OF THE WAGNER-MURRAY-

DINGELL BILL.

The object of the Wagner-Murray-Dingell Bill was to establish a unified national social insurance system, comprehensive in its scope and universal in its coverage. It was to cover the major economic hazards and contingencies of average American families, namely, the cost of medical and hospital care, and loss of income in time of unemployment, temporary sickness, permanent disability and old age. It was to improve the present old-age insurance system, and to extend its scope to persons hitherto excluded, such as farm workers and domestic servants, employees of non-profit institutions, and independent farmers, professional and small businessmen. All these changes were to be effected

under a unified national system of social insurance, with one set of contributions, one set of records and reports, and one set of offices. Moreover, the Bill was to set up an improved, unified system for grants-in-aid to the States for public assistance. It was also to establish a nation-wide system of public employment offices.

Scope of the Bill. The Wagner-Murray-Dingell Bill covered :

(i) Federal Old-Age, Survivors' and permanent Disability Insurance.—

The scope of this branch of the national social insurance was to be extended to include all self-employed persons, agricultural workers and domestic workers. The federal old-age and survivors' insurance was to be amended to include monthly cash benefits where the insured person was permanently disabled before he reached retirement age. The

pensionable age of women was also to be reduced from 65 to 60, and in case of the death of the insured persons, a lump sum was to be granted to his survivors.

- (ii) Federal unemployment insurance, temporary disability and maternity insurance :—**The scope of the federal unemployment insurance was to be extended to all persons in private employment, seamen, agricultural workers and domestic workers. All these persons were also to be insured for temporary disability and maternity benefits in cash. Details were also laid down regarding benefit rates, duration of payment and contribution conditions.

- (iii) Federal medical and hospitalisation insurance :—**The Bill proposed to set up a Federal system of medical and hospitalisation insurance, applying compulsorily to all

persons covered by old-age, survivors', and permanent disability insurance, namely employed and self-employed persons and their dependent wives and children. For non-insured persons, however, benefits were to be provided under contract with public agencies. Insured persons and dependents were to be entitled to general medical, special medical, laboratory and hospitalisation benefits. The duration of benefits was to be unlimited. The technical and professional aspects were to be administered by the U. S. Public Health Service and the financial aspect by Social Security Board.

Financing of Social Insurance in U. S. A.

The Bill proposed to create a Federal Social Insurance Trust Fund, to which were to be transferred the assets of the existing Federal old-age and survivors insurance system. This Trust was to receive all the contributions and pay the sums required for the benefits under the unified national social insurance system. Provision was to be made, in case of employed

persons, for joint contribution of 12 per cent. of wages, to be shared equally by the worker and the employer.

Administration of Social Insurance.

The unified national social insurance system was to be administered by the Social Security Board, with the assistance of a Federal Social Security Advisory Council, composed of men and women representing employers and employed in equal numbers and the public, and charged with the duty of making recommendations on the administration of the system, the adequacy of its benefits and its finance.

Social Assistance : Unified Public Assistance Programme.

The unified public assistance programme was to be designed to replace the separate assistance programmes under the present law for the aged, the blind, and dependent children. Variable Federal grants-in-aid were

to be provided towards the cost incurred by the States for the assistance of all classes of needy persons. The federal grants were to vary from State to State, the proportion being higher as the per capita income of the State was lower.

**After Wagner-Murray-Dingell Bill
(1943-47).**

Most of the recommendations of the Wagner-Murray Dingell Committee were accepted, with necessary amendments, and three important Acts were passed to implement the main proposals of the Wagner-Murray-Dingell Bill :

- (i) *The United States Public Health Service Act, 1944 ;*
 - (ii) *The United States Employment Act, 1946 ; and*
 - (iii) *The United States Social Security Amendment Act, 1946.*
- (i) The United States Public Health Service Act.**—This Act which came

into force in 1944, completely codified and revised the laws upon which the public health service had been operating since 1798. The act was based on the recommendations of the Wagner-Murray Dingell Bill. The details of the act shall be discussed in the Chapter on "Medical Care Services in the United States."

- (ii) The United States Employment Act.**—This act was based on the Full Employment Bill which was presented to the Senate in December, 1944. The principal recommendations of the Bill were accepted and in February, 1946, the U. S. Employment Act, was passed by the Senate declaring a national policy on employment, production and purchasing, so as to prevent mass unemployment and to stabilize economic conditions.

(iii) Social Security Amendment Act, 1946.—Under the U. S. Social Security Amendment Act the scope of survivor's insurance protection has been extended to qualified ex-servicemen for a period of three years after discharge. The scope of unemployment insurance has also been extended to private maritime employment. Another important feature of the Amendment Act is the considerable increase in federal-grants towards the state assistance schemes. The rate of social security taxes payable by employees and employers however remained unaltered. The rates were however scheduled to rise to $2\frac{1}{2}$ per cent. in 1948 and 3 per cent. in 1949.

In May, 1947, the National Health Insurance and Public Health Bill was moved by Senator Murray. The Bill followed closely the principles advocated by President Truman in

his two special messages on health, and laid down conditions for duration of benefit, range of persons covered, participation of doctors, financing and administration of Medical Care Services.

In 1948, two minor amendments of the United States Social Security Act were enacted by the National Congress and passed over the veto of the President, who, however, withheld his approval because of their effects on the coverage of the social security schemes. In addition three laws were adopted amending social insurance legislation for special groups including railway workers, harbour workers and federal civil servants, and providing more liberal federal grants to the States both for public assistance and children's allowances. Although no major legislation was enacted in 1948 to extend the general social security scheme, several committees of Congress continued to study the broadening of the various parts of the scheme and the President made a number of recommendations on the subject.

In December, 1948, the U. S. Advisory Committee on Social Security submitted its final Report on Social Security programmes in the United States. The Report dealt with old-age and survivor's insurance, permanent total disability insurance, public assistance and unemployment insurance.

Administration Bills of 1949.

In February, 1949, Administration Bills were submitted to Congress on National Pension and Sickness Insurance and on National Assistance. These Bills closely followed the recommendations of the U. S. Advisory Committee on Social Security. These bills improved pre-war schemes of pension insurance, old-age, invalidity and sickness insurance. The system covered all employees except railwaymen, and in part all independent workers. In all cases benefits were related to wages and were to be financed by contributions of employers and employees, with

eventual federal subsidy. The assistance scheme was, however, to be financed by federal and state subsidies.

President Truman also approved in October, 1949 the Federal Employees' Compensation Amendment Act which substantially liberalized benefits payable to civilian employees of the Federal Government or their survivors in case of employment injury or death.

Social Security Amendment Act, 1950.

Another important landmark in the evolution of Social Security Services in the United States was the passing of the Social Security Amendment Act of August, 1950, making extensive changes in the scope of social insurance both in regard to the benefit rates and range of contingencies and persons covered.

The most important changes introduced by the Social Security Amendment Act of

1950 relate to the Federal old-age and survivors' insurance, unemployment insurance, public assistance and child welfare.

The Old-Age and Survivors' Insurance has been extended as from 1st January, 1951 so as to cover several classes of employees hitherto excluded as well as non-agricultural self-employed workers. Further two categories of employees are included in addition on a voluntary basis, the employees of non-profit institutions and the employees of State and Local Governments not included under a public retirement system. As a result of these changes about 75 per cent. of the country's gainfully occupied workers would henceforth be covered by the general scheme, and an additional 12 per cent. by other public retirement schemes for railway workers, civil servants etc. The amendments also add several new types of benefits for dependents and survivors of insured persons, and also increase the rates on benefits in respect of existing contingencies. Conditions relat-

ing to qualifying period have also been liberalised.

The new Amendment Act also fixes the rates of contribution for employers and employees. The rates of contribution would henceforth be fixed at $1\frac{1}{2}$ per cent. each for 1950-53, 2 percent. for 1954-59, $2\frac{1}{2}$ per cent. for 1960-64, 3 per cent. for 1965-69, and $3\frac{1}{4}$ per cent. for 1970 and thereafter. Self-employed persons will pay $1\frac{1}{2}$ times the employee rate on their income from self employment. No government contribution is now provided to meet any unforeseen contingency. Aggregate annual outpayments under the new provisions are estimated at about 2,100 million dollars in 1951 and 3,800 million dollars in 1960, as compared with corresponding estimates of 900 and 1,800 million dollars for the scheme before the amendment.

The Social Security Amendment Act of 1950 makes no significant change in the administrative organization of the scheme.

Administration of benefit provision continues to be entrusted in general to the Federal Security Administrator, who is to assign functions relating to social security to the Commissioners for Social Security. The collection of contributions will continue to be a function of the Bureau of Internal Revenue under direction of the Secretary of the Treasury. The amendments provide that the new self-employment contributions will be levied, assessed and collected as a part of the general income tax. The assessment of such contributions would be on an annual basis rather than quarterly basis.

The foregoing survey has clearly revealed that United States have made surprisingly rapid strides towards the goal of social security. Within a period of less than two decades, the United States have evolved a comprehensive, co-ordinated and unified scheme of social insurance designed to cover each citizen against all possible contingencies and hazards—from cradle to the grave.

SOCIAL INSURANCE SYSTEM OF AUSTRALIA.

The Social Insurance System of Australia is governed by the **“Australian Social Services Consolidation Act of 1947.”** The new Act covers :

- (i) Old-Age Pensions ;
- (ii) Invalid Pensions ;
- (iii) Widows' Pensions ;
- (iv) Maternity allowances ;
- (v) Child endowments ;
- (vi) Unemployment benefits ;
- (vii) Sickness benefits ; and
- (viii) Funeral benefits.

The new Act came into force on 1st, July, 1947, and replaced all previous legislations which provided benefits of the same nature under separate enactments ; increased benefit rates and liberalised qualifying conditions. The object of the new Act is to establish a more comprehensive, unified and co-ordinated

system of social insurance, universal in its coverage and adequate in its benefits.

Scope of social insurance. *Range of contingencies and persons covered.* The new Act covers :

- (i) *Old-Age Pensions.*—Old-age Pensions are payable to men who have attained the age of 65, and to women who have attained the age of 60, provided that they reside in Australia, and have been continuously so resident for at least 20 years. The Act stipulates that an Old-age pensioner must be of good character and deserving of a pension.
- (ii) *Invalid Pensions.*—An invalid pension is payable to a person who is permanently blind or permanently incapacitated. He must be continuously residing in Australia for at least five years, before he could be eligible for this benefit.

- (iii) *Widow's Pension.* The term "widow" also includes a dependent female. For the purpose of benefit rates, the Act classifies widows under different categories.
- (iv) *Maternity Allowances.*—The New Act has considerably increased the rate of maternity allowances.
- (v) *Child Endowment.*—A child endowment at the rate of 7s. 6d. is granted to a person having the care of more than one child in respect of those children in excess of one. The endowment must be applied to the maintenance, training and advancement of the child.
- (vi) *Unemployment and Sickness Benefits.*—Unemployment benefits are paid to men between 16 and 65 years of age and women between 16 and 60 years of age who are resident in Australia. A married woman is not qualified

to receive a sickness benefit if it is reasonably possible for her husband to maintain her.

- (vii) *Funeral benefit* amounting to the cost of the funeral or £10 whichever is less, is payable in respect of a deceased.

Financing of Social Insurance in Australia.

All payments of pensions, allowances, endowments and benefits under this Act are made out of the trust account known as the National Welfare Fund, set up under the National Welfare Fund Act of 1943-45. This fund is made up of contributions received under the Social Services Contribution Act of 1945-47. The basic rate of contribution is on a graduate scale and assessed on the basis of taxable income ascertained in accordance with the provisions of the Income Tax Assessment Act.

Administration of Social Insurance in Australia.

The Australian Social Services Consolidation Act is administered by a Director-General of Social Services under the direction of the Minister. The Director-General may be assisted by a Deputy Director-General and Assistant Directors-General. For each State there is a Director of Social Services. The Director-General is empowered to establish Regional offices and appoint registrars of social services for the administration of the Act. The Governor-General is empowered to appoint Special magistrates to settle disputes.

Conclusion.

With the passing of the Australian Social Services Consolidation Act, Australia has now a very comprehensive, co-ordinated and unified scheme of Social Insurance designed to cover all the citizens and against all economic and social hazards, and financed out of National Welfare Fund.

Social Insurance System of India.

Employees State Insurance Act ,1948.

Genesis of the Act.

A Workmen's State Insurance Bill was introduced in the Central Legislative Assembly in November 1946 for provision of compulsory state insurance to all the workers employed in perennial factories against sickness, maternity and employment injury. The Bill was referred to a Select Committee in November, 1947. The Committee submitted its Report to the Dominion Parliament on 11th February, 1948, suggesting many amendments and alterations in the draft Bill. The Committee strongly recommended the extension of the scope of the Bill so as to cover all "employees" instead of only "workmen," and in conformity with such alterations in the scope of the Bill, to rename it as "Employees State Insurance Bill". The Committee also recommended that the administration of the Bill should be entrusted to Employees State Insurance

Corporation instead to Central Board as recommended in the draft Bill. The Central Government should meet two-thirds of the administrative expenses incurred by the Corporation. The Select Committee recommended the raising of the exemption limit from 10 annas to one rupee, and for the extension of medical benefits to all the members of the employee's family. Some alterations have also been suggested in the definition of "sickness" and "factory" and for the inclusion of additional wage-groups in the proposed scheme.

The principal recommendations of the Select Committee have been accepted by the Government and incorporated in the "Employees' State Insurance Bill, which was placed before the Dominion Parliament, in April, 1948 and passed as "Employees State Insurance Act" of 1948.

Scope of Employees State Insurance Act, 1948.—Range of persons and benefits covered.

Persons covered.

The Act applies in the first instance to all personnal factories and covers about 20 lacs of industrial workers. The definition of the word "perennial factory" has been laid down in the Act. We thus see that the Act only applies to workers employed in organized industires, and covers only a fringe of the working population. It is, however, a good beginning towards the road of social security.

Benefits Covered.

The Act provides five types of benefits :

- (i) Sickness benefit ;
- (ii) Maternity benefit ;
- (iii) Disablement benefit :
- (iv) Dependant's benefit, and
- (v) Medical benefit.

(i) Sickness Benefit.

Sickness benefit is payable for not more than 56 days in any continuous period of 365 days at the rate of about half the average

daily wages. The payment of sickness benefit is subject to the condition that the workman is certified as sick and incapable of work by a registered medical practitioner. He should have paid not less than 12 weekly contributions during the period 6 months preceding the claim, before he is entitled to sickness benefits under the scheme. No sickness cash benefit will be paid during an initial waiting period of two days. During treatment as an in-patient in a hospital sickness cash benefit will be reduced by half, but will not be less than a prescribed amount. The sickness cash benefits are payable for all the seven days in a week.

- (ii) **Maternity Benefit.** Maternity benefit is payable at the fixed rate of 12 annas a day for a total period of 12 weeks of which not more than six weeks can be claimed before confinement. The payment of maternity benefit is subject to the condition that the woman worker should have paid not less than

26 weekly contributions during a continuous period of 12 months immediately preceding the week in which she is confined, or in which she gives notice of pregnancy, before she can be eligible to the maternity benefits provided under the scheme. Like sickness benefits, maternity benefits are also payable for seven days in a week.

(iii) Disablement Benefits. Disablement benefits are payable in case of employment injury or incapacity due to scheduled industrial diseases. In general it consists of half pay for the period of disability and certain compensation to relatives in case of death. One important feature of this act is that the responsibility for workmen's compensation has shifted from employers to the Employees' State Insurance Corporation.

(iv) Dependent's benefit.—Dependent's benefits are payable to the survivors or dependents of the insured person who has died as a result of a employment injuries and who is entitled to benefits under the Workmens' Compensation Act. The dependents will receive a weekly pension equaivalent to half the amount of average wæekly wages of the deceased worker.

The disablement and dependent's benefits are payable in lieu of compensation of damages under the Workment's Compensation Act. Periodical payments prescribed under the Employees' State Insurance Act are considered to be a far more suitable method of protection than lump sum payments under the Workmens' Compensation Act, as lump sums are liable to be squandered without regard to future requirements.

(v) Medical Benefits. Closely connecte with sickness benefit is medical benefit which is to be rendered according to

a certain prescribed standard. Medical benefit can be claimed not only during the period for which sickness benefit or maternity benefit may be claimed but during any week for which contributions are payable, and, therefore, starts even before a person becomes entitled to sickness benefit.

Medical benefit will consist of medical care and treatment, with free provision of the necessary drugs etc., and will be available either in the form of visits to the home of the insured persons (if necessary), or by way of out-patient treatment at a hospital or dispensary, or as an in-patient in a recognised hospital. In-patient treatment will only be provided for insured persons who are entitled to sickness cash benefit. Home or out-patient treatment, however, will be provided so long as the worker continues to be insured, and for three months after.

The responsibility for providing medical benefit rests with Provincial Governments and though the scale of medical benefit is left to be decided by Provincial Governments in consultation with the Corporation, it is the intention that the standard of treatment should as far as possible be uniform.

Benefit Rates and Contribution Conditions.

The weekly contributions to be paid by employers and workers have been laid down in the Act. They are as follows :

Group of Workmen	Workers' Employ- Contri- ers' Con- bution tribution		Total
	Rs.	Rs.	Rs.
1. Workmen whose average daily wages are below Re. 1/-		-/7/-	-/7/-
2. Workmen whose average daily wages are Re. 1			

- and above but
below Rs. $1/8$ $-/2/-$ $-/7/-$ $-/9/-$
3. Workmen whose
average daily
wages are Rs. $1/8$
and above but
below Rs. 2 $-/4/-$ $-/8/-$ $-/12/-$
4. Workmen whose
average daily
wages are Rs. 2
and above but
below Rs. 3 $-/6/-$ $-/12/-$ $1/2/-$
5. Workmen whose
average daily
wages are Rs. 3
and above but
below Rs. 4 $-/8/-$ $1/-/-$ $1/8/-$
6. Workmen whose
average daily
wages are Rs. 4
and above but
below Rs. 6 $-/11/-$ $1/6/-$ $2/1/-$

7. Workmen whose average daily wages are Rs. 6 and above but below Rs. 8 -/15/- 1/14/- 2/13/-
8. Workmen whose average daily wages are Rs. 8 and above 1/4/- 2/8/- 3/12/-

The upper income-limit for eligibility to insurance is Rs. 400/- per month. Workers drawing Rs. 400/- or more are not entitled to any benefit under the Act.

It will thus be observed that the contributions are graded in eight different groups according to the average daily wages of the workers concerned. Undoubtedly, this will lead to some practical difficulties in administration. In the United Kingdom the workers' contribution does not vary with earnings and this makes the problem of collection of contributions much easier. In India, however,

the normal wage rates are so low that to fix a single rate of contribution would be impracticable, since workers in the lower wage-groups would be unable to pay a contribution large enough to ensure the financial success and integrity of the insurance fund. The contributions have therefore been weighted in favour of those who can afford to pay a higher contribution-rate.

The principle of varying rates has also been applied to the payment of sickness cash benefit, which will bear a fixed relation to the normal earnings of the insured workers.

Financing of the Employees' State Insurance Scheme.

The scheme will be financed out of contributions from Workers, Employers, Provincial and Central Government and grants donations and gifts from other sources. The total contributions are estimated at Rs. 11 crores, the whole of which would be

spent in meeting the claims of the workers, and in the organization of medical care. Provision has also been made for 'a grant by the Central Government to the Corporation for meeting two-thirds of its administrative expenses. The Central Government has also agreed to grant during the first five years loans to the Corporation to finance the scheme. Provincial Government will not make any cash contribution but will bear the cost of medical care and treatment.

The fundamental principle observed in the financial administration of the Employees' State Insurance Scheme is that all the social insurance funds should be administered by self-governing institutions under the supervision of public authority, and that the insured persons, through elected representatives, should be encouraged to play an important part in the management of the insurance system.

The Employees' State Insurance Act makes provision for the creation of a Central Insu-

rance Fund which shall be held and administered by the Corporation for the purposes of the Act. This provision enables a centralized control as far as administrative, actuarial and statistical aspects are concerned.

Administration of Employees' State Insurance Scheme.

The Scheme will be administered by Employees' State Insurance Corporation, the main functions of which would be to lay down the broad lines of policy, to ensure uniformity in the application of the law and procedure, to prescribe uniform standards for the entire country, and in fact to discharge such measures of supervision, machinery, and direction as may be found necessary in the interests of co-ordination and efficient working of the detailed machinery.

The Employees State Insurance Corporation will work through a Central Board, consisting of representatives of Central and Provincial Governments, Employers, Workers,

Central Legislative Assembly and representatives of the members of medical and allied professions. The Central Board will consist of 31 members. There will be a *Standing Council* of the Central Board which will work like an Executive Council. The Central Government will supervise the appointment of principal officers, auditing and preparation of Budget.

The Corporation will set up a number of Regional Offices which would act as central record offices where contribution records of each insured worker will be maintained along with records of sickness and disease and the benefits paid to each worker. Besides a large number of local offices will be set up which will be concerned with the payment of claims on the basis of authority supplied by the Regional Offices.

The Employees' State Insurance Corporation was inaugurated by His Excellency C. Rajagopalachari on 6th October, 1948. The Act

also proposes to set up a Medical Benefit Council to advise on matters relating to the administration of medical benefits. The first Medical Benefit Council was set up on 29th December, 1948.

Criticism of Employees' State Insurance Act Its Defects and Limitations.

Although the Employees' State Insurance Act is well conceived, and when it is put into operation will mark a great advance in social legislation, it has many defects and limitations. The sponsors of the Act were fully aware and conscious of these defects and limitations, but in the rudimentary stage of India's economic development, it was felt that it would be beyond the financial capacity and means of the Government to embark on a more ambitious scheme, covering a larger section of the populace and against larger number of risks and contingencies to which the workmen were exposed.

The most obvious limitation of the Act is that it caters the needs of a very small proportion of the population. The scheme does not cover all the risks of the employees, nor does it apply to all the workers. The Act is, therefore, very limited in scope, and inadequate in its benefits. It is estimated that the measures adopted will not affect more than 2 per cent. of India's population.

Secondly, although provision has been made to extend the benefit to the families of insured persons, it shall be granted only when "the Provincial Governments and the Corporation are in a position to bear the extra cost involved." In its initial stages the scheme is, therefore, very limited in its application.

Thirdly, the sickness cash benefit is only granted for 8 weeks, and no provision has been made to cover prolonged illnesses.

Fourthly, the range of benefits are very limited in character. There is no provision for convalescent home benefit, dental benefit,

or sanatorium benefit for insured persons who develop tuberculosis. The facilities for indoor-hospital treatment are also very limited and defective. Provincial hospitals are very inadequate to meet the needs of the population, and it is doubtful if the funds available under the scheme would be sufficient to cope with any large scale scheme of hospital building and development. People are suspicious that the whole scheme may not prove a great hoax.

(v) Employees are not well represented on the various bodies. Their representation comes only to about 16 per cent. in the Corporation and the Standing Committee and about 14 per cent in the Medical Benefit Council.

Undoubtedly the Act is very limited in its scope. Indeed the Government itself was faced with a dilemma, whether to embark on an extensive and comprehensive scheme in which the possibilities of failure would be ever present, or whether to embark on a scheme limited in scope and application, but which

would be fairly certain of success, and which would be capable of enlargement both in scope of benefits, and in its coverage as the resources would permit. The Government undoubtedly chose the latter.

Recent Developments (1948-51)

The Employees' State Insurance Act is still in its experimental stage. The object of the 'experimental scheme' is to ascertain the most efficient administrative procedure for collection of contributions and payments of benefits, the most efficient administrative machinery which would secure greatest degree of co-ordination between the medical care and general health services and which would secure effective participation of insured persons and employers in the control of the scheme.

With this end in view, the Government of India have selected the centrally administered areas of Delhi and the City of Kanpur

for effective implementation of two 'pilot schemes'. Pilot surveys were conducted and the scheme was to be put into operation from 1st July 1950, but due to strong and hostile opposition from local industrial interests both on grounds of discrimination and unbearable financial burden, and on grounds of certain administrative difficulties particularly lack of medical facilities, medical personnel, accommodation and equipment, the implementation of the scheme was twice postponed.

The Government has now come to the conclusion that unless the present Act is suitably amended, it would be difficult to implement it under the present circumstances. With this object in view the Government of India drafted the Employees' State Insurance Amendment Bill of 1951, which was placed before the Parliament and approved in its April Session. The most outstanding feature of the above Act is that whereas the collection of contribution would be on an All-India basis even during the experimental stage, the

workers would be entitled to benefit only in areas, where the 'pilot schemes' are to be put into operation. The primary object of this provision is to remove the regional disparities in the incidence of the social security tax so that the industries located in areas, where the "pilot schemes" are put into operation,⁴ may not be inequitably and unjustifiably burdened.

The two "pilot schemes," 'to be launched in Kanpur and Delhi, would, cover all the workers employed in perennial factories. Employers' and employees' contribution would be $1\frac{1}{4}$ per cent, of the total wage-bill. The contribution would be shared equally between the employers and the employees. In areas, where the scheme would not be enforced in the initial stages, the workers would not be entitled to receive any benefit nor have they to pay any contribution. The employers will have to make a uniform contribution of $\frac{3}{4}$ per cent of total wage-bill for the financing of the above Act.

Criticism of the Employees' State Insurance Amendment Act, 1951.

The new provisions of the Employees' State Insurance Amendment Act, have been severely criticized by a section of the industrialists. Some of them have questioned the plausibility of imposing fresh financial burden on the industry at a time when the rising spiral of prices is already hitting hard the poor consumers, while other critics have questioned the justifiability of taxing the industry in areas or regions where the scheme is not going to be tried on an experimental scale, and where neither the industry nor the workers are going to derive any benefit out of fresh financial burden on the industry. Some critics are even doubtful of the success of the two "pilot schemes" to be tried at Kanpur and Delhi, in view of the defective administrative machinery, non-co-operative attitude of the industrialists and the management, deplorable dearth of trained and expe-

rienced medical personnel and technical staff, well versed in the art, and technique of social insurance, and last but not the least, the insurmountable bottlenecks and hurdles in the effective implementation of the scheme.

CHAPTER IV

. SOCIAL ASSISTANCE.

Outline.

1. Definition and Functions of Social Assistance.
2. Forms of Social Assistance :
 - (i) Maintenance of Children ;
 - (ii) Maintenance of Invalids and Aged ;
 - (iii) Mother's Pensions ;
 - (iv) Unemployment Assistance; and
 - (v) Rehabilitation of Disabled.
3. Administration of Social Assistance.

Definition and Functions of Social Assistance

Social Assistance may be defined as a
“device to provide benefits and assistance to

persons of small means, granted as of right, sufficient to meet a minimum standard of need and financed from taxation or general revenues.”

It follows from the above definition that the fundamental characteristic of social assistance is that it takes individual and family need as the basis of all assistance, and always aims at maintaining a minimum standard of civilized existence. Its aim is to guarantee a minimum standard of well-being for all the citizens of the State, and the notion of what constitutes that minimum has ever grown in scope and magnitude.

The desire for social assistance springs from the fact that the society is itself responsible for some of the risks to which an individual is exposed and as such it is the incumbent duty of the society or the State to protect him against such risks and contingencies. To cite an instance, ‘unemployment is a condition created by and inherent in an

economic system based on free enterprise, and as such all unemployed persons have a right to look to the State for protection against hazards and contingencies which result from the imperfections of the economic system. The need for social assistance springs not only from the obligation of the community towards all those of its members who are genuinely in need but also from the deep concern of all states to guarantee a certain modicum of social well-being and economic security to every individual member in the community. It results from the growing realization of social responsibility towards the needy.

Forms of Social Assistance.

It is interesting to observe that until about 1900, almost the only examples of social assistance were to be found in the field of medical care, and especially hospital care. The first decade of the present century, however, witnessed the introduction, as a

humanitarian measure, of non-contributory old-age pensions in several countries. In the post-war period the States began to concern themselves intensively in medical care services and in the thirties of this century, an unprecedented economic depression forced the creation of schemes of unemployment assistance.

In recent years the scope of social assistance has considerably widened in several directions—in the improvement of its benefits, in the enlargement of the notion of need, and in the dissociation of moral stigma from recourse to its aid. All these objectives have been achieved by the creation of specialised schemes or services each catering the needs of a particular category of persons, or specializing in the particular category of risks and contingencies. Specialization is undoubtedly conducive to the attainment of efficiency and economy. It aims at adequacy in quality and quantity of benefits. The scope of social assistance has extended, in recent years, to

cover every variety of basic needs and to include every category of persons who cannot obtain privately such benefits, as it affords. The two remarkable developments in the progress of social assistance are, first, the grant of benefit, in kind or service, as of right, and secondly, the use of discretion in determining the individual's share of benefit. Both these developments aim at giving the individuals complete security against the risks and hazards to which they are exposed.

The principal branches of Social Assistance are :

- (i) Maintenance of Children ;
- (ii) Maintenance of Invalids and Aged;
- (iii) Mother's Pensions ;
- (iv) Unemployment Assistance, and lastly,
- (v) Rehabilitation of the Disabled.

(i) Maintenance of Children.

It need hardly be disputed that the nation's future greatness and well-being greatly depend on the healthy up-bringing of its children. The State should, therefore, actively intervene and co-operate with parents through general measures of assistance designed to secure the well-being of the dependent children.

Such measures of assistance have taken two forms, viz. (i) services in kind and (ii) allowances in cash. The example of first are provision for education, medical care for children, nutritional services including free school meals and child welfare services. The examples of second are children's allowances. While both the forms of assistance are desirable in a co-ordinated, unified scheme of social security, the efficacy and efficiency of each form will depend upon the purpose in view.

Where the object in view is to assist the healthy nurture of children, subsidies should take the form of such advantages as free or very cheap infants' food and school-meals and provision of cheap housing facilities for families with several children.

Where the object in view is to maintain large families, subsidies should take the form of children's allowances.

It has been pointed out that the first measure is more effective than the second for the simple reason that the childrens allowances may be dissipated in meeting the general household expenditure without in any way benefiting the child. It may even stimulate the birth rate in the least responsible sections of the community. While it may not be true of the western countries because of the falling birth-rate, for India this limitation has a vital significance.

The children's allowances are usually payable according to a prescribed scale,

irrespective of the parent's income. It is granted to all children for whom a provision is made through social insurance. It is based on the recognition of the fact that the community as a whole should bear the responsibility for the maintenance of dependent children in so far as parental responsibility for maintaining them cannot be enforced.

Social Assistance for maintenance of children has taken different forms in different countries. In Australia, France and New Zealand childrens' allowances are co-ordinated with social security benefits in case of invalidity, sickness, death, unemployment and compensation for employment injuries. In Denmark and Sweden greater stress has been laid on services in kind, whereas in Great Britain, greater stress has been laid on childrens' allowances, presumably due to falling birth rate. It is only in France that the children's allowances are so high as to be quite adequate for the full maintenance of the children.

**(ii) Maintenance of Invalids, Aged
and Widows.**

All those invalids, aged and widows who are not compulsorily insured and who are not receiving social insurance benefits, and whose incomes do not exceed a prescribed level, should be entitled to special maintenance allowances at prescribed rates. Generally speaking, the following persons are eligible for maintenance allowances under this head :

- (i) all persons belonging to uninsured occupational group ;
- (ii) all persons residing in a region to which social insurance does not apply, and
- (iii) all persons who were invalids at the time of insurance or since childhood.

Maintenance allowances should, so far possible, be quite adequate for full and long-term maintenance. They should vary with the variations in the cost of living, and may

also vary from region to region and as between urban and rural areas, and even between persons of different incomes.

Pensions to invalids and aged may take two forms, non-contributory pensions and contributory pensions. Strictly speaking, only non-contributory schemes should be included under social assistance.

The fundamental character of the non-contributory pension is that it is payable as of right and, in consequence, is granted to persons fulfilling certain statutory conditions. These qualifying conditions can be grouped under three heads : political, moral and economic.

Political conditions require that the claimant must possess the nationality of the country which grants such pensions. The conditions for nationality however varies from country to country. Moral conditions require that the claimant should not only be very needy but should also be dignified and

worthy of such help. He should not have a criminal or disgraceful record. Moral conditions are, however, gradually been relaxed owing to unpracticability in many cases, and in the recent legislations of Canada, South Africa and Great Britain no such conditions have been imposed. The economic conditions impose a 'means test,' viz. that the claimant's income or capital should not exceed a prescribed limit.

Non-contributory old age pensions have been established in New Zealand (1898), Australia (1901-8), France (1905), Great Britain and Ireland (1908), Norway (1923), South Africa (1928) and U. S. A. (1935).

The non-contributory pension schemes of Australia, Canada, Ireland, France, Great Britain, South Africa, the United States are financed solely from taxation levied by local or central Governments. In Australia, Ireland, Great Britain, and South Africa the whole of the cost is borne by the Central Government,

and the general tendency is to increase the share of the central government and to reduce the share of the local governments.

(iii) Mother's Pensions.

The term 'Mother's Pension' has been used in a variety of sense. In the United States it signifies "aid to dependent children", in Canada it signifies "mothers' allowances", in New South Wales, "widow's pension" and in New Zealand the term signifies "widow's and orphan's benefit". Undoubtedly these differences in title have some substantial significance since they specify the category of persons who are entitled to benefits under this head.

Generally speaking "Mothers' Pensions" are awarded with the object of maintaining families of young children which have no fathers to support them. Their underlying object is to enable the mother or foster-mother to care properly for children at home, without having to go out to work.

The schemes of "Mother's Pensions" are in extensive operation in the United States and Canada. They have also been adopted in* New South Wales (1925) and in New Zealand (1911).

The majority of the laws grant the mothers' pension, not only where she is a widow but also where her husband is alive but not supporting his family because of invalidity or because he has deserted his wife.

In case of Mother's Pension also, the claimant must fulfill all the prescribed conditions, moral, economic and political as in case of invalidity and Old Age Pensions.

The pension varies considerably according to the means of the family and the number of dependent children, as also according to the variations in the cost of living. The patterns of administration and financing of Mother's Pension conform generally to those

adopted for non-contributory old-age pensions, and the tendency is to transfer responsibility from local to central Government, since the latter has larger financial resources to make such schemes universal and financially adequate.

(iv) Unemployment Assistance.

The fundamental object of unemployment assistance schemes is to enable the beneficiary to maintain himself and his dependents. To achieve this objective assistance is granted either in kind by provision of relief work or in cash by allowing unemployment assistance allowances. The amount of assistance allowances will however vary according to the size and composition of the family group to be maintained.

Generally speaking, the unemployment schemes have taken two forms. Some consist wholly or mainly in the provision of relief

work and others in the payment of allowances. Some are only of temporary duration to tide over a crisis, others are of a permanent character, generally an integral part of a comprehensive, co-ordinated scheme of social security or national reconstruction. It is a characteristic feature of all unemployment schemes that they are administered separately from poor relief. As such, benefits under social assistance can be claimed as a matter of right. They are neither discretionary nor derogatory to one's self respect and dignity.

The unemployment schemes of different countries vary considerably in the nature and extent of benefits. In the United States the relief for the unemployed is provided mainly in the form of employment at normal wages on public works. In Canada and Sweden also assistance is provided mainly in the form of relief work, with cash assistance as a subsidiary alternative. While in Great Britain, France, Switzerland, Belgium and

Ireland assistance is normally given in cash under conditions similar to those required for unemployment insurance.

All schemes of unemployment assistance require that the claimant should be necessitous, capable of work, registered at an employment office and willing to accept employment defined as suitable. The interpretation of the term "necessitous" and "suitable" is, however, left to the discretion of the administrative machinery.

The duration of assistance allowance is unlimited in Great Britain, Ireland, and Sweden and limited in France and Switzerland.

The financial and administrative structure of unemployment assistance schemes is wholly centralized in Great Britain and Ireland and the entire cost of the scheme is met from national taxation. In Belgium, France and Switzerland, on the other hand, the central government grants subsidies to local or volun-

tary unemployment assistance funds. The amount and qualifying conditions for such benefits are, however, prescribed by the central government.

(v) Rehabilitation of Disabled.

Social Assistance for the rehabilitation of Disabled includes all measures taken by the Government, Central or Local, for the education, training or sheltered employment of physically defective children and adults without means, especially the blind, the deaf and the seriously crippled. Most of the schemes consist in the provision of facilities for vocational training, utilization of the potential productive capacity of the disabled by provision of suitable work, and provision of financial and medical assistance to the disabled and crippled.

In the United States, the Federal Government provides subsidies to the State Governments to set up schemes of vocational

rehabilitation. The Social Security Act of 1935 increased the federal subsidies. The subsidies are granted as of right to any person who suffers from permanent physical disablement, is of employable age and is susceptible of being fitted for normal, full time employment. In the Soviet Union the local authorities provide facilities for re-training in special workshops or in ordinary technical schools, and allowances are granted for their maintenance and that of their families. In Great Britain, schemes have been introduced for the training and placement of the disabled, and creation of fully equipped fracture and orthopaedic departments in hospitals for provision of artificial limbs. Training is given in a wide variety of occupations suitable to disabled persons, and allowances are paid during the training period. In Germany, since 1920, it has been compulsory for employers to engage a certain number of disabled persons in their undertakings, such number to vary according to the nature and character of the industry.

The recent legislations of most of the countries reveal increasing concern of the State towards economic and social well-being of the disabled people.

Administrative Structure of Social Assistance.

The recent social assistance legislations of different countries suggest an unmistakable tendency for centralization of the administrative machinery. This tendency, which is the characteristic feature of many other sectors of economic and social life, can be ascribed to the fact that the central authority has better resources and is in a better position to make the social assistance schemes universal in scope and adequate in benefits than the local authorities. Both, the convenience of administration and uniformity of operation have accelerated the tendency towards centralization.

The degree in which the administration of the various branches of social assistance

can be centralized, however, depends on three main considerations :—

- (i) the simplicity and relative permanance of the need of social assistance ;
- (ii) the nature, character and magnitude of the need ; and
- (iii) the desirability and need of introducing uniform standards.

In general it may be said that the greater the degree of centralization the more the assistance in question acquires the character of a right, just because a national scheme implies uniformity in operation and rate of benefit.

CHAPTER V

MEDICAL CARE SERVICES.

NEED FOR ORGANIZED MEDICAL CARE.

Preservation and Maintenance of national health have now become important functions of a modern State. The future happiness, progress and prosperity of the nation much depend upon the physical well-being of its citizens. It is undoubtedly true that ill-health and disease are responsible for the enormous loss of nation's productive capacity. Healthy and physically-fit citizens are the nation's most precious treasure for it is they who are responsible for nation's survival and economic, social and cultural advancement. For an individual health is a pre-requisite for resourceful, progressive and creative life.

The need for collectively organized and financed services for the preservation and maintenance of nation's health has, therefore, been increasingly recognized in recent years.

It is of fundamental importance that such medical care services should be accessible to every member of the community. For achieving this objective such services should be organized collectively and financed either on the basis of social insurance or out of general or specified taxation.

It is the essence of medical care services that they should be both curative and preventive in character, and must be integrated or co-ordinated with other measures aiming at the protection and improvement of health. Inded the co-ordination of medical care with general health services is an essential condition for the success of a nation-wide and comprehensive medical care service. The unity of all health services should be clearly borne in mind while framing principles that

should govern the organization of medical care services.

Nature and Form of Medical Care Service.

Definition of Medical Care Service:—

Generally speaking, the term “service” denotes the organized provision of care or other co-operative and protective measures provided by public institutions as distinguished from their provision by non-governmental agencies through private arrangements. Medical Care Services, therefore, refer to provision of medical facilities by medical institutions, organized collectively with the object of :

- (i) restoring the individual's health, preventing the further development of disease and alleviating suffering, when it is afflicted by ill-health (curative care) ; and
- (ii) Protecting and improving his health when it is threatened (preventive care).

Medical Care Service, therefore, includes both curative and preventive measures, for restoration and improvement of health.

Evolution of Medical Care Services .— Provision for organized medical care has in the past been made chiefly by social insurance as a branch of income security or by social assistance and poor relief through maintenance of hospitals and relief institutions. In recent years, the scope of medical care services has considerably widened. The essential unity of all health problems has been recognized and emphasis is now been laid on the co-ordination and integration of medical care service with all other measures aiming at the protection and improvement of health. The modern concept of medical care, therefore, transcends both the concept of sickness insurance and that of social assistance by provision of medical relief and other benefits essential for the maintenance and preservation, of good health to all the strata of the popula-

tion without subjecting them to a 'means test.'

Essential Features of Medical Care Service.

The essential characteristics of medical care service are :

- (i) It should provide to each and every individual citizen all facilities for medical care by members of the medical and allied professions.
- (ii) Such medical facilities should include both curative and preventive measures. Curative measures are those that help in the restoration of the individual's health, while preventive measures are those that protect, improve and safeguard the individual's health whenever it is threatened.
- (iii) It is essential that the nature and character of such medical care

service should be clearly defined by law or regulations. The ultimate aim should, however, be comprehensive care and unlimited availability of such care.

- (iv) Such medical care service should be organized, financed and administered by responsible authorities or bodies. Such services can be arranged by contracting with members of the medical or allied professions and by provisions of hospitals and other institutional services.
- (v) The cost of such services should be borne collectively by all members of the community. Each member should be required to make a periodical contribution into the Medical Care Fund of an amount depending on his ability to pay.

Forms of Medical Care Service.

Such Medical Care Services can be organised in two different ways :

- (i) **Public Medical Care Service**, and
- (ii) **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.

Public Medical Care Service.—The essentials of Public Medical Care Service are :

- (i) Every member of the community is entitled to all care provided by the service without any qualifying conditions as to payment of contributions or taxes and without means test, and
- (ii) Such a medical care service is financed either by a tax specifically imposed for this purpose, as in New Zealand, or out of general taxation or funds as in U. S. S. R. In U. S. S. R. all the health services are financed by the State.

The advantages of Public Medical Care Service are :

- (i) No test or enquiries are needed before a person can obtain benefits. This undoubtedly remove all obstacles which might prevent him from getting immediate medical help and advice.
- (ii) Administration, too, is concerned exclusively with the beneficiary's health and not with administrative formalities.
- (iii) The financing of public service can be entirely divorced from the administration of care, thus ensuring greater efficiency.

Both owing to simplicity of administration and universality of coverage without any means test, most of the recent plans propose to organize medical care in the form of public service. This form has been recommended

in the Social Security Schemes of Australia, U. S. A. and South Africa.

Social Insurance Medical Care Service

The essentials of social insurance medical care service are :

- (i) Every insured person, including a dependent wife or husband and a dependent child, are entitled to all care provided by the service ;
- (ii) Care for other persons if they are unable to obtain it at their own expense should be provided by way of social assistance ; and
- (iii) Such 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 for those unable to pay for it.

This method of organizing medical care service has been criticized on the ground that it is undesirable to have two categories of beneficiaries, those who have a right to care as insured persons and those whose needs are met by social assistance. The qualifying conditions and the means test, in case of social assistance, will undoubtedly involve much delay and hardships and burden the medical care authorities with great administrative formalities.

Persons Covered.

Complete Coverage. There is a unanimity of opinion that medical care should be available to every member of the community, irrespective of his economic status. Opinions only differ as to which sections of the community should have free access to a medical care service and which should pay for it. It has been increasingly recognized that the community should assume responsibility at least for those of its members who are patently unable to pay for medical care,

the indigents and the destitutes. The need in such cases is greater because insufficient food, inadequate housing conditions and absence of other necessities of life are among the main causes of ill-health.

Should there be an income limit ?

Some favour the exclusion of the well-to-do classes from the scope of a national medical care service, firstly on the ground that they are in a position to meet their own expenses and secondly, on the ground that the medical profession would also retain the advantage of attending privately to those able to pay higher fees than could be granted under the service.

Those who are opposed to the fixation of income limit argue that such an imposition will entail great financial and other controls and administrative formalities which, under a nationwide service, are hardly worth the trouble. Moreover, this well-to-do income group will be contributing substantially to the financing of a national service.

The inclusion of the whole population without income limit has, therefore, been recommended by the majority of the experts, organisations and commissions who have worked out plans for the future of medical care service. Sir William Beveridge in this "Plan of Social Security", the Joint Parliamentary Committee on Social Security in Australia, the Dominion Government's Plan for health insurance—all favour a nationwide medical care service. The Wagner-Murray-Dingell Bill of 1943 also recommended medical and hospital care both for employed and self-employed persons, without income limit.

Should Private Practice Continue Under a National Medical Care Service ?

There is considerable apprehension that the co-existence of private and public practice might result in two different standards of medical care, a higher private standard and lower public one. Experience, however,

shows that the misapprehension is not altogether without foundation. The insufficiency of the remuneration received by doctors under a public medical care service is responsible for this state of affairs. If, therefore, private practice is to continue side by side with national public practice, adequate remuneration for the medical and allied professions engaged in public practice would be an indispensable condition for safeguarding the quality of the care given.

The Mechanism of Coverage.

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.

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.

As the public medical care service covers the whole population, no special mechanism of coverage is required. Every person is entitled to medical care without any qualifying conditions, such as payment of taxes or compliance with means test. All beneficiaries whether rich or poor will have an equal right to the care provided.

Coverage through a Social Insurance Medical Care Service.

Under Social Insurance Medical Care Service, every insured person has a right to medical care. All adults whose income exceeds the subsistence level are required to pay insurance contributions. For members

whose income does not exceed the subsistence level, the public authority should pay the insurance contribution. This payment would automatically entitle the dependent wife or husband to the same care as in case of the insured persons. No additional contribution is to be made in case of dependent wife or husband and children under the age of 16 years or more if they are continuing their general or vocational education.

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

A Medical Care Service should provide full range of medical care, both preventive and curative, to all the members of the community at any time. A medical Care Service should be rationally organized with a view to securing the utmost efficiency of the service without waste of resources and should be integrated or co-ordinated with general health services so as to make these readily available to the beneficiaries. For achieving maximum

economy and efficiency, such services must work in close contact with other health agencies.

Constant Availability of Complete Care.

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.

It is essential that medical care should be available at any time and without time limit, when and as long as they are needed.

The care afforded should comprise both general-practitioner and specialist out and in patient care, including 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, sanatoria.

or other medical institutions with the requisite dental, pharmaceutical and surgical supplies. .

The beneficiary should be able to obtain care at any centre or office, wherever he happens to be when the need arises irrespective of his membership in any particular insurance institution provided he fulfils other requisite qualifications.

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, to ensure co-ordination and uniform standards.

Where Medical Care Services are administered by different types of insurance institutions, care should be taken for adequate co-ordination and unification of such services by contracts of mutual agreement.

Rational Organization of Medical Care Services.

Greatest possible care should be readily available through an organization which would be most economical in working and conducive to maximum of efficiency and utility. Such an organization should pool all the available resources of knowledge, staff and equipment of all participating members of the medical and allied profession and agencies. The whole-hearted 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 general and specialized services should be distributed over the whole area according to the needs of the beneficiaries.

Complete diagnostic and treatment facilities including laboratory and X-ray services and all specialist advice and care should be

readily available to the general practitioner. Specialists should have at their disposal complete and up-to-date technical equipment for all branches of specialist treatment and all necessary hospital and research facilities and auxiliary services.

For achieving this object 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, should be encouraged.

Where the medical care service covers the majority of the population, health centres should be organized, equipped and operated by the central administering authority all over the country. Such health centres should provide full range of curative and preventive care.

Where the medical care service does not cover the majority of the population and the existing hospitals and other medical facilities

are inadequate, the insurance institutions should jointly establish a system of health centres which affords all care. If this is uneconomical, they should make adequate arrangements for general and specialized care of the beneficiaries.

Collaboration with General Health Service.

The beneficiaries of medical care service should have access to all general health services. The object of general health services is to promote and protect the beneficiary's health. They include maternal and infant health services, industrial hygiene services, nutrition services, health, education and like measures.

The general health services should be properly co-ordinated with medical care services. They should either be integrated in one single health service or where this is impracticable, adequate arrangements should

be made for their co-ordination and central control.

Quality of service

The medical care service should aim at providing the highest possible standard of care. Due regard should be paid to doctor-patient relationship and professional and personal responsibility of the Doctor. The interests of both should be safeguarded.

Choice of doctor and continuity of care.—
The beneficiary should have a right to select, from among the general practitioners, available within a reasonable distance, his family doctor and family dentist, who would attend to him in a permanent capacity. The beneficiary has, however, a right subsequently to change his family doctor.

Residential care and care given by specialists and members of allied professions, such as nurses, midwives, etc. should be available on the recommendation and through the agency of the beneficiary's family doctor.

Status and Remuneration of members of medical and allied professions.

The remuneration and the working conditions of the doctors and members of allied professions, should be such as to relieve them of financial anxiety and enable them to participate whole-heartedly in their profession. 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 etc. Where, however, they are engaged in private practice, and undertake only part-time work for a medical care service, it may be appropriate to pay them a fixed basic amount per year.

Working conditions for members of the medical and allied profession participating in the service should be uniform, throughout the country and agreed on with the representative bodies of the profession. Pro-

vision should also be made for the submission of complaints by the beneficiaries, and disciplinary measures in case of default or negligence.

Standard of Professional skill and knowledge.

The highest possible standard of skill and knowledge should be achieved and maintained for the profession participating in the national medical care service. Such a standard can be maintained by prescribing high standard of education, training and licensing and by giving to the participating members medicines, equipment and research facilities. All new entrants should be required to work as assistants under the supervision and direction of more experienced practitioners. A minimum period to work as hospital assistant should be prescribed for every new entrant. Adequate facilities for teaching and research should be made available at the hospitals administered by or working with the medical care service.

Financing of Medical Care Service.

Financing of Medical Care service can be studied under two heads :

1. Financing of Public Medical Care Service, and
2. Financing of Social Insurance Service.

Financing of Public Medical Care Service

The cost of financing the public medical care service should be distributed among the members of the community in proportion to their ability to pay. Each member of the community should contribute either as part of general income tax or as a special tax, imposed with the object of financing such services as in case of New Zealand. It is of fundamental importance that the cost of service should be distributed as equitably as possible, according to income and ability to pay.

The individual's contribution will, therefore, include two elements :—

(i) Payment for the care he is entitled to, and

(ii) share in the cost of care provided to those unable to pay for it—the poor and the destitutes.

Choice Between General Tax or Special Tax.

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

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.

As general health services are, in most of the 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 method of financing public medical care services.

Where, however, a special tax is imposed for financing public medical care service, following points would be clearly borne in mind :

- (i) The special tax should be paid into a separate fund especially created for this object ;
- (ii) The special tax should be progressively graded ;
- (iii) It should yield an income sufficient to finance the medical care service ; and
- (iv) Persons whose income does not exceed the subsistence level should not be required to pay the special tax.

The special tax may appropriately be collected by the national income tax authorities as in case of New Zealand, or where there is no national income tax, the task of such collection should be entrusted to authorities responsible for collecting local taxes.

Financing of Social Insurance Service.

The maximum contribution that a beneficiary is required to pay 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. The total cost also includes the cost of care given to the dependent wives or husbands of insured persons, and children who do not pay contributions. The insured persons' contribution should be related to his income and should be such that can be borne without hardship. Persons whose income does not exceed the subsistence level should be exempted from

paying insurance contribution. The cost in respect of them should be borne by the public authority, if they are unemployed or by their employers, if they are employed. The collection of contribution in respect of employed persons may appropriately be made by their employers, and in case of self-employed persons, by national or local authority.

Administration of Medical Care Service.

There is a unanimity of opinion that 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 through the help and agency of local bodies or regional authorities. The necessity of unified central supervision and of regionalisation of all health services have been emphasised in almost all the plans prepared for the reorgani-

zation and establishment of a comprehensive national medical care service.

It has also been emphasised that both beneficiaries and the medical and allied professions giving care under the service should participate in the administration. Indeed unification of all health services and democratic control are indispensable ingredients of an efficient national care service.

Form of administrative machinery.—Opinions, however, differ as to the form of administration most desirable and appropriate for a national medical care service. Some favour the establishment of a “Corporate Body ” created by statute or charter for the administration of a national service. Others are in favour of central administration by a government department or agency. Those who oppose governmental control argue that such control will inevitably be tainted by political influence which might cripple initia-

give and interfere with professional discretion. Moreover, there is a risk of bureaucracy and predominance of the layman over the technician. A "Corporate Body" on the other hand will have greater freedom from parliamentary control over its day to day functions. Those who favour administration by a government department or agency argue that the democratic principle demands direct and constant responsibility to the legislature or government. The existing health departments have already accumulated vast experience and knowledge and there is no reason to doubt that they will be less efficient in administration than the specially constituted "Corporate Body."

Local administration.—Local administration of medical care and general health services should be unified or co-ordinated with areas specially constituted for the purpose of administration.

Medical care service in the areas should be administered by or with the advice of

bodies representative of the beneficiaries and representatives of medical and allied professions, so as to safeguard the interests of beneficiaries and the professions, and to ensure the technical efficiency of the services and the professional independence of the participating doctors.

Proper arrangements should be made for the administration of health units and for the complaints from beneficiaries in case of negligence and inefficiency of the members of the medical profession.

CHAPTER VI
MEDICAL CARE PLANNING IN
GREAT BRITAIN, U. S. A.,
AUSTRALIA AND
INDIA.

MEDICAL CARE PLANNING IN GREAT BRITAIN

Introduction.

Medical care Services in Great Britain are governed and regulated by the National Health Service Act of 1946. Although the new services were scheduled to begin from 1st April, 1948, some unavoidable circumstances and long preliminaries postponed the establishment of such services till July, 1948. It is a very bold, imaginative and comprehensive piece of legislation ever attempted in Great Britain. Coming as it is after the National Insurance Act and the National Insurance (Industrial Injuries) Act of 1946, it is a definite step forward towards the establishment of a comprehensive, co-ordinated and unified system of social security services in Great Britain.

Scope of the new Act :

The new Act is very comprehensive in scope and universal in its coverage. It is

“designed to secure improvement in the physical and mental health of the people, and the prevention, diagnosis and treatment of illness”. It, therefore, provides both preventive and curative care. The services are accessible to every citizen of Great Britain without any limitations based on financial means, age, sex, employment or vocation, area of residence or insurance qualifications. It is interesting to note that no waiting period or qualifying conditions have been prescribed in the Act. The provision of medical care service is free and no fees or charges are made except for loss or renewal of appliances caused through one's own negligence. No one is, however, prevented from obtaining medical care privately should he so desires.

Nature and Provision of Medical Care :

The Medical Care Services in Great Britain have taken three forms :

- (i) Hospital and Specialist Service.

- (ii) General Practitioner Service, and
- (iii) Local Authority Health Service.

(i) *Hospital and Specialist Service* :—

The hospital and Specialist Service includes hospital accomodation, medical, nursing and other services and specialist care whether at a hospital, a health centre or if necessary at patient's home. The Service covers accommodation in general and special hospitals, maternity homes, tuberculosis sanatoria, mental hospitals and units for infections and chronic diseases. No charge is made for such services except for supply of very costly appliances.

- (ii) *General Practitioner Services* :—Such services include care by qualified doctors, dentists, and pharmacists, outside the hospitals but under the area or local authorities. All medical practioners are entitled to

join the new service within the area where they are practicing provided they fulfil the requisite qualifications. They can practice either at the health centres maintained by the local health authorities or at and from their own surgeries. Every person is entitled to choose his own family doctor and family dentist subject only to the doctor's consent. No doctor can, however, accept more than a prescribed maximum number of patients. Every person in the area is also entitled to sight-testing and the supply of spectacles free of charge. Charges may, however, be made for optical appliances of a more expensive type than is normally supplied, or for repairs and replacements due to negligence.

The status, remuneration and terms of service of the members of the medical and allied profession are laid down in the Act.

(iii) *Local Authority Health Service.*—

The local authorities maintain health centres and provide certain specified forms of medical care and general health care, such as care for expectant and nursing mothers and for young children, complete midwifery care, nursing services vaccination against small-pox and ambulance services, in case of need.

**Financing of Medical Care in
Great Britain.**

The medical care service in Great Britain is financed from (i) General Revenue, (ii) Local Revenue, and (iii) a contribution from the National Insurance Fund.

The full cost of Hospital and Specialist Service and other central services, of the general practitioner, dental and pharmaceutical services and of central administration, and one half of the cost of local health authority services are borne out of the

General Revenues, and contribution from National Insurance Fund.

Local health authorities pay one half of the cost of their health services, the balance being paid by the Exchequer out of general revenues and contribution from National Insurance Fund.

The total annual expenditure of the Exchequer and the local authorities is estimated at £152 million per year for the provision of these services.

ORGANIZATION AND ADMINISTRATION OF MEDICAL CARE SERVICE IN GREAT BRITAIN.

The Minister of Health is responsible for organising and promoting the establishment of the medical care services in Great Britain. He is guided, on all expert aspects of the service by the Central Health Council composed of people, expert in different fields of the service.

Hospital and Specialist Services are organised on regional basis, and although the Minister, assumes direct responsibility for these services, the task of actual administration is entrusted to regional or local bodies more particularly Regional Hospital Boards. The Regional Hospital Board appoints hospital management committees for each hospital or groups of hospitals.

Care by general practitioners and dentists is administered by Executive Councils composed of representatives of local authorities and Ministry of Health and medical and profession practitioners. The Councils make arrangements for providing adequate care for all persons in their respective areas.

The administration of health centres and of a variety of medical and general health care services is entrusted to Local Authorities, generally the County and County Borough Councils.

Administrative decentralization and integration and co-ordination are the outstanding

characteristics of medical care services in Great Britain.

**MEDICAL CARE PLANNING IN
THE UNITED STATES.**

(1935-51)

The recent developments in the Medical Care Services in the United States can be studied under the following three heads :—

- (i) Pre-War Development (1935-39)
- (ii) War-time Development (1939-45),
and
- (iii) Post-war Development (1945-51).

Pre-war Developments. (1935-39)

The Social Security Act of 1935, which sponsored the United States Social Security programme, contained no provisions regarding medical care or sickness insurance. An Inter-departmental Committee was, however, appointed in 1937 to study the problem of

national health insurance. The proposals of the Committee were discussed at a National Health Conference in July 1938, and in 1939 Senator Wagner moved in the Senate a National Health Bill for the establishment of a comprehensive Medical Care Service. No final action was however taken on the Report, but the Social Security Amendment act of 1939 did increase the annual grants for public health work and for maternal and child welfare.

War-time Developments (1939-45)

In 1943 Senators Wagner and Murray and the Representative Dingell introduced a measure calling for a comprehensive and unified national social insurance programme. The Bill proposed the setting up of a Federal system of medical and hospitalisation insurance, applying compulsorily to all persons covered by old age, survivors and permanent disability insurance.

Under this Federal system of medical and hospitalization insurance the insured per-

sons were to be entitled to general medical, special medical, laboratory and hospitalization benefits, and the supply of surgical appliances and eye-glasses. The duration of medical benefit was to be unlimited and that of hospitalisation benefit limited to 30 days in a period of 12 months.

Each insured person was entitled to choose his own doctor from among all physicians who had voluntarily agreed to participate in the insurance system, and the doctor had similar right of choice. Provisions were made in the Bill for assuring highest quality of medical care. The technical and professional aspects of this service were to be administered by the Surgeon-General of the United States Public Health Service and the financial aspects by the Social Security Board.

This Bill was referred to the Finance Committee but no action was taken, except the passing of the United States Public Health Services Act, in 1944. A substantially similar Bill for a unified social insurance system

was reintroduced in May, 1945 by Wagnor and Murray. This Bill was also referred to the two Tax Committees, which took no action on its health sections throughout 1945 and 1946.

Post-war Developments. 1946-51

On May, 20, 1947, the National Health Insurance and Public Health Bill was introduced by Senator Murray for himself and five other Democratic Senators and by Representative Dingell. This Bill was based on the principles advocated by President Truman in his two special messages on health.

CHARACTERISTIC FEATURES OF NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH BILL, 1947.

The most important features of this Bill are :—

- (i) The range of services covered would include general medical services, including prevent and diagnostic care

and medical examination, specialist services, general dental services, hospitalization care and other auxiliary and laboratory services.

- (ii) The range of persons covered would include nearly all employed workers, self-employed persons and beneficiaries under Federal old-age and survivor's insurance together with their dependents. Needy persons could be eligible through payment of premiums on their behalf by State and local agencies.
- (iii) The administration of the scheme would be in the hands of "National Health Insurance Board" which would promulgate regulations, review State plans, allot funds to the States and perform related functions.
- (iv) The Bill also proposes Federal grants to States for an expanded programme

of public health services and the full amount to meet recurring expenditure.

Apart from the National Health Insurance and Public Health Bill of 1947, many other Bills have been moved in the Senate proposing a series of health measures. In February, 1947 Senator Taft moved a National Health Bill for establishment of an independent National Health Agency. A new Maternal and Child Health Bill was moved by Senator Pepper in July 1947. The Federal Government, however, abstained from taking any legislative action. Only two important Acts received the approval of the President, the National Mental Health Act providing the establishment of a National Institute of Mental Health and the Hospital Survey and Construction Act which authorised grants to States for a five-year programme of hospital and health-centre construction.

Ten-Year Health Programme in the United States.

In September 1948, a ten-year programme for raising the national level of health was prepared at the request of the President by the Federal Security Administrator. The programme proposed is based, in part, upon the deliberations and conclusions reached at the National Health Assembly in May, 1948. The primary object of this programme is to increase the supply of medical manpower until there is enough medical personnel to satisfy the health and medical needs of all the people. This is to be accomplished by expansion of medical colleges, training hospitals and institutions of medical research.

Conclusion :—Thus we see that the ultimate object of medical care planning in U. S. A. is that every individual without regard to his economic status shall be assured full access to adequate medical services for the prevention of illness, the care and relief

of sickness, and the promotion of a high level of physical and mental health.

Medical Care Planning in Australia.

Introduction.

Medical Care Services in Australia are governed and administered by the Australian National Health Services Act of 1948. This Act received the Royal Assent on 21st Dec., 1948, and gave wide powers to the Commonwealth for the establishment and administration of national health services, accessible to all classes of people.

This Act proposes the establishment of a scheme of medical benefits under which the Commonwealth will pay a determined proportion of the prescribed fees for professional services from medical practitioners. The Governments' proposals are to pay 50 per cent of the fees charged by the doctor, and to pay this amount on behalf of the patient directly to the doctor, in accordance with a prescribed schedule of fees chargeable by

doctors who participate in the scheme. Gradually this scheme is to be expanded to include various classes of specialists.

Financing of Medical Care Planning in Australia.

All current expenditure under the Australian National Services Act. of 1948 would be paid from the National Welfare Fund, but capital expenditure would be paid out of monies provided by Parliament. It is expected that with the full participation of doctors in the medical benefit schemes, the cost would be about £6 million a year, while the dental services when fully developed would cost about £4 million a year.

Administration of Medical Care Services in Australia.

The general administration of the Act will be the responsibility of the Director-General of Health, who will be subject to any directions of the Minister. The Director-General of Health is to provide

or arrange for general-medical and special-medical care services. In order to make provision for these services, he would, on behalf of the Commonwealth, establish, maintain and manage hospitals, laboratories, health centres and clinics and medical institutions for education and training of doctors, and dissemination of medical information to the general public relating to health and prevention of disease. For provision of dental services the Government proposes to establish a Directorate of Dentistry which would diffuse public education in the principles of dental hygiene and also provide the services of the dentists.

Indeed the Australian National Health Services Act of 1948 gives only the broad outline of the proposed National Health Services, the details and administration of which are left to progressive development by regulations.

It is, however, hoped that in course of time Australia would be able to develop

highly efficient, co-ordinated and organized Medical Care Services accessible to every section of the community without any distinction of class, creed or sex.

MEDICAL CARE PLANNING IN INDIA.

Bhore Committee Report and after.

Introduction.

The Health Survey and Development Committee was appointed by the Government of India in October, 1943 under the Chairmanship of Sir Joseph Bhore to make a broad survey of the present position in regard to health conditions and health organization in British India, and to make recommendations for the post-war planning of medical care services in India. The Report of the Committee was published on 4th March, 1946, and consisted of two main parts, the first dealt with a comprehensive study and examination of the pitiable health conditions obtaining in the country, and the lack of adequate facilities for organization of

medical care ; the second dealt with the recommendations for future development and organization of public health services in India. •

The Committee drew attention of the Government to the pitiable health conditions prevailing in the country. The factual information which the Committee gave in its Report shows the extent of poverty and pestilence, disease and death, squalor and destitution so widely prevalent in the country. The Committee estimated that in 1944, the general death rate per 1,000 of the population was 24.1 in India, as against 9.9 in New Zealand, 10.6 in the U. S. A. and 11.9 in England and Wales. In the same year, India's infantile death rate per 1,000 live-births was 169, as against 30 in New Zealand, 40 in the U. S. A. and 46 in England and Wales. It is more disheartening to note that nearly half the total deaths in India are among children under 10 years of age and, of the mortality in this age-group, one half takes

place within the first year of life. The Committee further estimated that at least 100 million individuals or one in four of the people suffer from malaria every year. The number of tuberculosis patients is about 2.5 millions and about half a million persons die from this disease every year. About a million persons suffer from leprosy and more than 37 out of every 1,000 persons have venereal diseases. This is indeed a very pathetic tale of our swarming multitudes. The enormous loss caused through the low vitality and ill-health of the people is almost inestimable. Disease and destitution, squalor and ill-health tend to deprive an individual of joy, happiness, charm, beauty, and all that is sublime and precious in human life.

In putting forward its recommendations, the Committee kept in view certain objectives. They are :

- (i) The health schemes when fully developed should provide each and

every individual irrespective of caste, creed or sex, all adequate care, both curative and preventive, irrespective of his ability to pay for such services ;

- (ii) The rural population must have access to the same amount of care, both preventive and curative, as is available to the urban population. In this connection the Committee observed : “The debt which India owes to the tiller of the soil is immense and although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attendance he receives is of the most meagre description. The time has come to redress the neglect which has hitherto been the lot of the rural areas” ; and
- (iii) No scheme of Medical Care Planning in India could be successful

without the active co-operation of the people with the health authorities, and without infusing in the minds of the people a spirit to lead a healthy and hygienic life.

The Committee has outlined a forty-year programme for the establishment of a complete health service for the entire population, with special attention to the needs of rural districts, and a ten-year programme on similar lines but limited in scope by the financial resources and trained personnel at present available.

LONG-TERM PROGRAMME.

Organization of Long-term Plan :

The Committee recommended that health services be organized both at the Central and Provincial level with a Central Statutory Board of Health consisting of the representatives of the Central and Provincial Governments to promote mutual consultations and to secure co-ordination in formulating a

unified health policy and carrying it out. Co-ordination of medical care with general health services is to be the essence of long-term planning.

According to the proposed plan, there should be a Ministry of Health both at the Centre and in the Provinces. The Ministry should be responsible for organization of health services within its jurisdiction. A Council of experts, including representatives of the medical and allied professions, should be attached to each Ministry for providing technical guidance. In case of Central Government the Director-General of Health Services, and in case of Provincial Governments the Director of Health Services should be responsible for the organization of all curative and preventive departments of health, administration of medical care, public health, professional education and research, public health engineering and town and village planning. Health services should also be organized at the local level on the basis

of the administrative district under an officer responsible for curative and preventive care in that area. Health authorities in the District should be represented on a District Health Board which should be aided by a District Health Council of experts.

The outstanding characteristic feature of the long-term plan is the provision of health services at primary, secondary and district headquarter units. A primary unit, serving about 20,000 persons, will have 75-bed hospital, as well as dispensaries, and will be staffed by six medical officers, hospital and public health nurses, midwives, sanitary inspectors and health assistants. Hospital and Dispensaries would provide medical care; four public health nurses would carry on preventive work in the homes of the people and two public health nurses and two medical officers would be available to give domiciliary curative care. A secondary unit would include 30 primary units and would have a 650-bed hospital and medical staff of 140

doctors. The heads of the various hospital departments would guide and inspect the work of the primary units within the secondary unit. *

The district headquarters organization would be responsible for the health of some 3,000,000 persons in five secondary units. It would be staffed by 267 medical officers and would have a 2,500 bed-hospital to which complicated cases from smaller hospitals would be removed. The Officer-in-charge of the District Health Services and his deputies would be responsible for medical care, public health, environmental hygiene, maternity and child welfare work.

The Committee emphasised that preventive and curative health work should be dovetailed into each other to produce the maximum results and the employment of social workers for educating the public opinion in the technique of preventive measures.

Short-Time Programme.

The Ten-Year Plan recommended by the Health Survey and Development Committee covers two stages of five years each. It was of the opinion that although health services should be established on as wide a territorial basis as possible, and cover the largest number of people, in the initial stages, however, the progress would be marred by two limitations, the lack of trained personnel and inadequacy of financial resources. Bearing in mind these two limitations the Committee drafted the ten year programme. The District Health centres would not be set up during this period, but district health organization would supplement the existing health facilities by preventive and curative care provided through primary and secondary units, and special agencies and services dealing with malaria, tuberculosis, venereal diseases, leprosy, mental diseases, maternity and child welfare, school health, dental services and nutrition should be developed. Field training

centres for teaching institutions should be set up and special arrangements should be made for training medical and social workers. Curative and preventive care should be provided on a co-ordinated basis, but special emphasis should be placed on the latter since in view of the limited staff and funds available, it would yield the more lasting health results.

Five primary and one secondary unit, less fully staffed and equipped than the units of the long-term scheme, should be established simultaneously in each district. During the first ten years a primary unit should provide preventive and curative care to some 40,000 persons. A secondary unit should at first supervise five primary units. According to the Plan, at the end of ten years, there will be 25 primary units and two secondary units in each district with 13 "thirty-bed hospitals, one 200 bed-hospital and one 500 bed-hospital.

Financing of the Plan :

The Committee was of the opinion that medical services should be free to all and that the scheme should be financed by general and local taxation. It was of the opinion that the Central Government with its larger resources should give financial assistance to the provincial health schemes and suggested that the Central Statutory Board of Health should make recommendations to the Central Government as to the distribution of grants-in-aids for this purpose.

Recent Developments (1947-51)

The inauguration of the All-India Medical Institute Committee at Delhi in February, 1947 was the first step taken by the Government to implement one of the recommendations contained in the Bhore Committee Report. The Committee is to advise the Central Government on the practical measures to be taken to establish an All-India Medical Institute for the training of medical personnel and for research.

As a result of the recommendations of the Health Survey and Development Committee, the Medical and Public Health Departments were amalgamated on the 15th August, 1947 and consequently the post of the Public Health Commissioner with the Government of India merged with that of the Director-General of Health Services.

The two most important landmarks in the development of Medical Care Services during the post-Independence period are, however, the passing of the Indian Factories Act of 1948 and the Employees' State Insurance Act of 1948. The Indian Factories Act of 1948 now makes it obligatory for every factory employing more than 1,000 workers, to provide for first aid boxes easily accessible to all the workers and the maintenance of an ambulance room or a dispensary for medical treatment of workers. The nature and character of Medical Care Services accessible to the workers under the Employees'

State Insurance Act, have already been discussed in one of the previous Chapters. Here it may only be re-stated that the medical benefit under the Employees' State Insurance Act would be given in the form of out-patient treatment and attendance in a hospital or a dispensary, clinic or other institutions or by visits to the home of the insured person or treatment as an in-patient in a hospital or other institution. The responsibility of providing medical treatment has, however, been placed on the State Governments who are expected to provide reasonable medical, surgical and obsteric treatment.' The standards, i.e. the nature and scale of medical benefit, are to be laid down by an agreement between the Corporation and the State Governments. Such an agreement will also fix the proportion of cost of medical benefits between the Corporation and the State Governments concerned.

The various State Governments have also prepared "five-year" medical and public

health development schemes. These schemes are being examined by the Employees' State Insurance Corporation and the Ministry of Health of the Central Government in the light of the recommendations of the Bhore Committee and approved for the grant of the Central Government's contribution in respect of the approved schemes. The State Governments have to submit periodical reports to the Government of India regarding the progress made in the execution of various schemes. The Government of India has, however, decided that in view of heavy financial commitments it would not be possible for the Central Government to give financial assistance to the various State Governments during the year 1950-51 for the development of health services.

The Government of India have adopted various other measures to implement some of the recommendations of the Bhore Committee. A Medical Scholarship Scheme was instituted in 1945. Under this scheme a number of

medical and dental graduates were selected for post-graduate training abroad at Government expense in medical and allied subjects, dentistry and nutrition. The scheme was further revised in 1948 and a number of travel fellowships of shorter durations were granted to selected officials, holding responsible posts in Medical Colleges, Hospitals, Teaching and Research Institutions. On the recommendation of the All-India Medical Institute Advisory Committee, the Government set up in May, 1948 an "Up-grading Committee" to suggest the list of various medical institutions, where research and training facilities could be developed in specialized fields. A Committee on Indigenous system of Medicine was also appointed under the Chairmanship of Sir R. N. Chopra in January, 1947 to enquire and report on the ways to improve the facilities for research and training on indigenous system of medicine.

The Government of India have taken a series of measures for health and welfare of

coal miners and tea plantation workers. A number of regional hospitals and maternity and child welfare centres have been constructed and are now being equipped. Anti-malaria operations are being continued and the incidence of this disease in the coal fields has been considerably reduced. The construction during 1948-49 of three clinics, at places to be selected by the Coal Mines Labour Welfare Fund Advisory Committee is under consideration in connection with the campaign against tuberculosis. Finally, a grant of Rs. 25,000 has been made from the Coal Mines Welfare Fund for an X-ray unit for the benefit of colliery workers in the C. P. and a further grant of Rs. 14,000 has been made to the Bengal Coal Fields Subcommittee of the Coal Mines Labour Welfare Advisory Committee for the organisation and conduct of a second refresher's training course for colliery medical officers. The Government is formulating an elaborate scheme for providing adequate health services to the tea plantation workers.

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