statistical analysis and that cost estimates are vague or absent. It took Sir William Beveridge and his associates two years to produce their report for Britain and the National Resources Planning Board group three years to complete theirs for the United States. Only a fundamental research approach, calling for first-class staff and ample budget, will provide the data to resolve the differences and answer the questions posed in the three path-finding studies reviewed here. With this job done it should be possible to see clearly for the first time, major alternatives for political decision—and only then will the Canadian parliament be in a position to make sensible decisions on social security.

Medical Reform In Great Britain

By L. E. Bodmer

THE problem of the reorganization of health services on the lines of an up-to-date, comprehensive service for the whole nation has, in recent years, aroused widespread interest in Great Britain. Plans for such a national service have been worked out and proclaimed as their policy by various representative organizations of the medical and dental profession, by political parties, and by other lay groups of citizens or outstanding personalities in different walks of life.

At present there is no unity of health service. Employed persons, under the National Health Insurance Act, receive general practitioner care and medicine, but neither specialist nor hospital treatment. Their dependents are not entitled to medical care, but are frequently voluntarily insured under arrangements made by the medical profession. Persons who are destitute or in need of public assistance obtain general practitioner treatment under the auspices of local authorities who also maintain clinics for venereal diseases, tuberculosis, and certain mental cases.

Hospital services are given, on the one hand, by tax and rate supported hospitals, maintained by local authorities, admitting all patients in their area and charging fees according to ability to pay. So-called voluntary hospitals, on the otherhand—non-profit institutions originally founded for the poor and financed out of subscription—now admit to their general wards' families within certain income limits, but also make provision for middle-class paying patients who cannot afford to go to a private nursing home and pay the full specialist's fee.

Some 10 million persons in the lower income groups are now covered by voluntary hospital insurance schemes with contributions varying from 2d to 3d a week for a family. Both public and voluntary hospitals collaborate in these schemes.

During the war, the government has introduced the emergency Medical Service under which beds in hospitals were first reserved for civilian war casualties and, later, for transferred war workers and numerous other cases. A certain measure of co-ordination of hospital work has been achieved under this scheme which may serve as a basis for future reorganization.

As to general health services, the Minister of Health is the main controlling authority but the Board of Education is responsible for school medical services, the Minister of Labour for industrial hygiene. Moreover, the Ministries of Pensions and of War Transport and the Service Departments, as well as others have their own health and medical

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EDITOR'S NOTE: Miss Bodmer is on the staff of the International Labour Office at Montreal, and the author of the I.L.O. study "Statistical Methods for Measuring Occupational Morbidity and Mortality," Geneva, 1930.

services. The actual administration of general health services, with the exception of industrial hygiene, is entrusted to local authorities of various kinds whose areas are often too small for the purpose.

All plans and suggestions for the future organization of medical care services agree on certain main principles: the service must remove the economic barriers preventing people from taking advantage of available health agencies. The service must, in the first instance, aim at the promotion and maintenance of health; it must be complete, offering all kinds of care including general practitioner, specialist, institutional and auxiliary, and such care must be of the highest quality. The general practitioner must act as "family doctor". The service should be administered within regions sufficiently large for a self-contained service. Co-operation by doctors at health centres and co-ordination of medical care and general health services, such as maternity and infant welfare, health visiting, immunisation, preventive examinations, etc., are deemed desirable.

The proposal for a general health service that attracted the greatest attention, though other plans had preceded it, was the one submitted by Sir William Beveridge in December, 1942.[1] In his famous Report, he claimed that the establishment of comprehensive health and rehabilitation services was one of the indispensable corollaries to his social security income maintenance scheme—("Assumption B").

The British Government, in February, 1943, accepted this proposal in principle and undertook to reorganize existing health services with a view to securing a complete medical care service for the whole community.[2] The Government proceeded to consult representatives of the medical profession and the hospitals, but the profession took exception to some of the Government suggestions, such as the salaried employment of general practitioners by local authorities. The British Medical Association has defined its attitude at a recent meeting, and the Government intends to issue a White Paper on the matter.[3]

The Medical Profession

The most powerful medical organization, the *British Medical Association*, with a membership of nearly 45,000 doctors, has, for many years, been very active in advocating the introduction of a complete general medical service for the nation. Its proposals were first published in 1929 and revised in the light of public reaction and events in 1938.[4] The B.M.A. then suggested an extension of health insurance in two directions: first, by a widening of the scope, to embrace the dependents of persons already insured—(wage-earners and salaried employees earning not more than £240)[5] and persons of like economic status with the present insured persons, and secondly, by an extension of the benefits, to include specialist and hospital care. Hospital and maternity services were to form a separate contributory scheme.

In 1940, under the influence of war-time experience, the matter was again taken up by the Medical Planning Commission, a body appointed by the B.M.A. in co-operation with the Royal Colleges and Corporations and the Society of Medical Officers of Health, altogether 11 appointing bodies. The Commission studied "war-time developments and their effects on the country's medical services both present and future". Its "Draft Interim Report,"[6] submitted in June, 1942, contained suggestions to be submitted to the profession as a whole for discussion.

The tentative plan outlined in the Report goes beyond the mere extension

1. *Social Insurance and Allied Services*, Report by Sir William Beveridge, Cmd. 6404 (London, 1942). See also *International Labour Review*, Vol. XLVII, No. 1, Jan., 1943, p. 48.
2. *Parliamentary Debates, House of Commons*, 16 Feb., 1943, columns 1654 *et seq.* (Vol. 386, No. 30).
3. *Supplement to the British Medical Journal* of 10 July and 7 Aug., 1943.
4. British Medical Association: *A General Medical Service for the Nation* (London), Nov., 1938).
5. The present limit is 20 a year.
6. British Medical Association, Medical Planning Commission: *Draft Interim Report* (London, 1942). See also *British Medical Journal*, 20 June, 1942, and *International Labour Review*, Vol. XLVII, No. 1, Jan., 1943, p. 57.

of national health insurance, though pronouncing against a whole-time salaried Government medical service. All persons earning £420 or less a year and their dependants are included under the scheme. Practitioners are appointed to a national service under the control of a central authority which may be either a Government department or a corporate body predominantly medical in composition. Now local authorities, covering wider areas than the larger existing authorities, or regional health councils repre-administer all civilian medical services within regions large enough to justify self-contained services, both comprehensive and well-balanced. General practitioners, under the plan, practice at health centres built and equipped by the regional authority, but administered by the doctors working at the centre. Each citizen covered by the service can choose his centre within a reasonable distance of his home and select his general practitioner from among those working at the centre. The doctor attends his own patients, both public and private, at the centre, which is also the headquarters for nurses and midwives and such general health services as can be undertaken by the doctors and the auxiliary staff of the centre. The plan suggests remuneration by a basic salary, with additions for special qualifications and length of service, plus a capitation fee for each person or family on the doctor's list—an ingenious combination of the security and the reward system. Invalidity, old-age and survivors' pensions are provided. The sale of practice by practitioners within the service ceases, compensation being paid for loss of capital to practitioners entering the service. Assistants at the centre receive fixed salaries. Hospital services are regionalised, and specialist treatment for beneficiaries of the scheme, both in- and out-patient, is based on hospitals. Specialists receive whole-time or part-time salaries for all care given under the scheme.

The Representative Body of the B.M.A. and the other constituent bodies of the Medical Planning Commission, approved in broad outline the plan suggested by the Commission which was asked to continue its work and elaborate its proposals.[7] The Government's decision to introduce comprehensive medical care services for the whole community, and the ensuing discussion, however, convinced the B.M.A. of the necessity of defining without delay the main principles which in its view should govern any future health services. These principles, adopted at the Annual Representative Meeting in September, 1943, reiterate the need for a complete medical care service, removing economic barriers to medical care, but emphasize the dependence of health on environmental and social conditions. The B.M.A. is anxious to limit the functions of the State in such service and to prevent it from interfering with the doctor-patient relationship. Free choice of doctor and patient is proclaimed as one of the basic principles, and every citizen according to the Association should have a right to consult a doctor privately. Moreover, those able to provide for themselves, should not be included under the scheme.

Whole-time salaried employment by the central or local Government is emphatically repudiated. The Association favours central administration by a corporate body rather than a Government department which would be submitted in its day to day work to Parliamentary criticism, and depend on changes in Government. Locally, new administrative bodies, as suggested by the Medical Planning Commission, should be responsible for the service. Both central and local bodies should be advised by medical committees.

Pending the completion of such administrative changes, considered as fundamental, the extension of health insurance, as originally proposed in 1938 is recommended as a first step towards the fulfilment of "Assumption B" of the Beveridge Report. Group practice and

7. It was greatly stressed by the B.M.A. that the Draft Interim Report did not contain definite proposals but only suggestions for discussion.

health centres should first be tried out by experiment before being chosen as the basis of a future medical service.[8]

While this is the official attitude of the most powerful medical association, other medical groups have advanced more radical plans.

The *Socialist Medical Association*[9] opposes maintenance of any private practice which would mean two different standards of care. Its national health service is controlled by a government department—the Ministry of Health—and administered by new Area Councils, through their health departments. Health centres provide both general practitioner care and all ancillary services, consultant services run by specialists from the hospital unit and certain general health services. Larger health centres are closely attached to hospitals which, in turn, are developed into specialist centres. All health workers are employed as whole-time officers of the Area Council. A national income maintenance scheme, providing allowances during sickness or incapacity from injury, disability pensions and accident compensation for every worker and his dependents, is deemed indispensable; without it "the benefit derived from the destruction of economic barriers in health services would be nullified by fear of financial loss."

"*Medical Planning Research*",[10] a body of 400 doctors of not more than 21 years standing, many of them serving in the forces, plans an even more ambitious scheme dealing with all aspects of social security and the standard of living. The scheme proposed covers all persons in receipt of income and their dependants. In return for a progressively graded single social security contribution of 8%-10% of the income on an average—the income earner is entitled to all benefits in cash and kind, without means test. Persons who so desire can contract out of the medical care service, and resort to private practice their contribution being reduced in this case. The plan also favours a corporate body, the "National Health Corporation" as central authority, comprising lay and medical members in equal numbers. Such a choice would not only guarantee greater freedom from political control, but permit of the division of authority among persons of equal rank and avoid predominance of the layman over the technician. Local administration is entrusted to the regional organization of the National Health Corporation—a form of administration fundamentally different from that proposed in the other national plans. A network of local health centres for general practice is established around local hospitals which are developed into medical centres for institutional and for specialist out-patient treatment. These local hospital-centres are in turn attached to the large "key" hospital-centres. "Medical Planning Research" also claims the right of the patient to select his general practitioner as family docter, and proposes remuneration on the lines suggested by the Medical Planning Commission.

Political Parties

Plans advanced by lay bodies are inspired by much the same principles. Only a few can be mentioned here.

The *Labour Party*[11] desires a planned medical service open to all, irrespective of social position, without lower or upper income limit. In agreement with the Socialist Medical Association, it prefers a government department as central authority to a corporate body as the more democratic form of control. Regional administration by new democratically elected authorities, and organization of the medical profession as a national full-time salaried pensionable service is suggested. The family doctor system and health centres associated with hospitals also find favour with the Labour Party. The scheme, including general health

8. *Supplement to the British Medical Journal* of 2 Jan. and 2, 9, 16 and 20 Oct., 1943.

9. "The Socialist Programme for Health" in *Medicine To-day and Tomorrow*, Vol. 3, No. 7, Sept. Quarter 1942, p. 3 *et seq.*

10. *The Lancet*, 21 Nov., 1942. See also *Supplement to the British Medical Journal* of 6 March, 1943.

11. The Labour Party: *National Service for Health: The Labour Party's Post-war Policy*, publ. Transport House, Smith Square, London, S.W.1.

services is financed out of national taxation and rates.

The *Liberal Party's*[12] sub-committee on health services is equally opposed to a mere extension of health insurance. Its plan is much on the same lines as the tentative proposals of the Medical Planning Commission. Although no income limit is provided, patients are free to obtain care privately, but not at the health centres: private patients, in the opinion of the Liberal Party's sub-committee, should be kept entirely distinct from patients obtaining free care at the centres. The service, should be financed out of public funds voted by Parliament, and not by insurance contributions, the cost is estimated at £66 million. It may be mentioned that the complete social security service proposed by "Medical Planning Research" would cost £1,000 million, of which 30% would be raised in the form of insurance contributions, the rest being paid out of public funds.

It will be seen that modern plans for medical care services in Great Britain are far ahead of the old principles of "health insurance." The unification of all health services under one administration is preferred to a combination of cash benefits and medical care as obtaining under the continental European sickness schemes. Not only employed persons, but all those unable to afford proper medical care at their own expense, are to be provided for by the service. As to the financing of the complete health service, the idea of a tax-supported scheme available to all without either contribution conditions or means test is gaining ground, not only in Great Britain, but also in other parts of the British Commonwealth such as Australia and South Africa. The New Zealand medical care service is already financed by a special tax and open to all residents without qualifying conditions.

12. Liberal Publication Department: *Health for the People*, 1942.

Social Security in New Zealand

By Walter Nash

THE provision of security against misfortune and deprivation in old-age has a long history in New Zealand. The first legislation on the subject was in November 1898 when an Old Age Pensions Act authorised the payment of a small pension for aged persons, the first such statutory provision of any British country. This pension was improved from time to time and was followed in 1912 by a pension for widows authorised by an Act of the previous year. Military pensions were also provided in the same year for veterans of the Maori War and the Boer War, and from 1915 onwards for veterans of World War I. In 1915 coal and gold miners suffering from miners' phthisis were provided for by special pension. In 1927 family allowances were provided for parents of large families.

The Labour Government which took office at the end of 1935 adopted as one of its first statutory measures a comprehensive act increasing the amounts of all pensions then in force and instituting for the first time pensions for invalids permanently and totally disabled.

The unemployment problem became a matter of national importance during the 1929-35 depression and legislation passed in 1930 for the first time authorised the payment of relief to unemployed persons,

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