management, notably as regards the maintenance of fertility in the grey-bush soils of the prairies.[1]

During the war with favourable weather conditions agricultural production was increased by more than 40 per cent above pre-war, with about 25 per cent less male workers on the farms, with no increase in cultivated acreage, with little new farm machinery and farm building construction, and with an actual shortage of certain other farm supplies. This is an indication of what increased production is possible on the present occupied farms if the financial returns to producers are sufficiently attractive.

No human heart can be happy without assurance of freedom from want and hunger. To have peace the nations of the world must have the same assurance. Science which has made such phenomenal progress during the past century and which has developed instruments that can cause the instantaneous destruction of thousands of human beings must be directed towards the construction of a world from which want and hunger have been forever removed. It is imperative that the governments and the people of all nations recognize, as do the scientists of the world, that better human relationships, mutual trust and understanding between nations must be established or else our civilization is in imminent danger of destruction. Canadians as individuals, and Canada as a nation, can make an important contribution to the realization of that kind of a better world which the United Nations are trying to build.

1. From "Future of Canadian Agriculture," by E.S. Archibald in the *Agricultural Institute Review*, Vol. 1, No. 5, May, 1946.

Voluntary Health Insurance—It's Growth and Coverage

By MARGARET C. KLEM

WHEN the Honorable Brooke Claxton, K.C., Minister of National Health and Welfare, stated last fall that this is the most exciting and challenging time in medical history, and that all forces of government—federal, provincial and municipal—must join with the voluntary agencies to bring the power of the nation into the attack on disease and poverty,[1] he voiced the opinion of a large percentage of the citizens of Canada and the United States. Both countries have taken many important steps to increase their health activities during the past few years, but the necessity for the further extension of medical care and facilities through well-planned, coordinated effort is self-evident.

One of the subjects uppermost in the minds of all who are interested in accomplishing this extension, by means of effective cooperation and the proper allocation of responsibility, is the principle of prepaid medical care. By this time there has been more or less general acceptance of the fact that insurance can be used to advantage for distributing the costs of medical care and, therefore, as a means for increasing medical services. But the type of insurance to be used is a different matter. On this point, probably more than on any other concerning national health, legislators, members of the medical professions, and citizens in general are divided in their opinion. Many believe that health

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1. Claxton, Brooke, K.C., "Mapping Our New Frntiers of Health," *Canadian Journal of Public Health*, Vol. 36, No. 12 (December, 1945), pp. 455-464.

insurance in order to be effective muts be federally administered, some feel that it is a State or Provincial responsibility, and others believe that neither a national nor a local program is desirable and that voluntary plans similar to those now in operation can be used successfully.

Discussion of the merits of these various systems of health insurance has led to much interest in voluntary programs and many questions have been asked regarding the type of plans now in operation.

The Growth of Voluntary Health Insurance

The citizens of the United States and Canada are insurance-minded, but it was not until the early and mid-thirties that they showed much interest in prepaid medical care. Prior to that time, employees in some industries, particularly those in hazardous occupations such as lumbering and railroading, were eligible for medical care for non-industrial as well as industrial illnesses; in comparison with non-covered employees, however, their number was exceedingly small. A few private group clinics had been established by physicians who had grouped together to provide medical services on a prepayment basis; and an unknown but small percentage of the population were receiving benefits through fraternal or consumer-sponsored organizations. Accident and health policies were available through commercial insurance companies on an individual policy basis only and at a premium rate so high that they could be purchased only by those in the middle and higher income groups.

In 1929, an experiment in prepaid hospitalization among a group of school teachers at Baylor, Texas, was to become the precurser of the present Blue Cross program. The idea won public favor immediately, and membership by 1938 had reached one million. During the thirties, commercial insurance companies gave impetus to the increasing interest in health insurance by offering group accident and health policies to industrial groups. It was during the thirties, also, that the United States Government recognized the value of prepayment medical care and made use of this method by assisting farmers who were clients of the Resettlement Administration (now the Farm Security Administration) to organize prepayment groups. The United States Department of Agriculture is now sponsoring three types of medical care programs; the Farm Security program, an experimental program among self-supporting farm families in selected counties in four states, and a program for seasonal farm workers connected with the War Food Administration. During the present decade the medical societies have become much interested in voluntary health programs and have sponsored a number of plans, many of which cover an entire State or Province.

Coverage

Voluntary health insurance now in operation has been developed by the agencies described above and may be classified as either commercial or non-profit. Non-profit plans have achieved such importance in the United States during the last ten years that many States have recognized them as charitable and benevolent institutions and have granted them the special privileges accorded such organizations.

During the past ten years, particularly during the war years, commercial group insurance has grown rapidly, and many industries now cover their employees under group contracts. At the end of 1944 there were 18,000 commercial group hospital and 17,600 surgical benefit contracts in force in the United States and Canada.[2] About 8 million persons were eligible for hospital indemnity, approximately 6 million of whom were also eligible for surgical indemnity, through these contracts.

By far the largest number of persons enrolled in non-profit plans are those who are members of Blue Cross. On July 1, 1946, over 23 million people in

2. Brower, F. Beatrice. *Company Group Insuranec Plans*, National Industrial Conference Board (Studies in Personnel Policy No. 70), N.Y.C., p. 4, 1945.

the United States and Canada were eligible for hospitalization through these plans. Eighty-seven plans were in operation, 81 in the United States, five in Canada, and one in Puerto Rico.[3]

The number of persons enrolled in non-profit plans providing medical or medical and hospital benefits is considerably smaller than the Blue Cross enrollment. About 6 million persons are eligible for some degree of medical services through plans now in operation in the United States.

Benefits Provided

Voluntary health insurance provides two types of benefits—cash and service. Cash reimbursement in the event of illness is provided by commercial insurance companies. Until recently, reimbursement for medical expenses under commercial group contracts was restricted principally to payments toward hospital and surgical bills. Some policies now include provision for reimbursement for certain physicians' services for other than surgical illness. The person who is hospitalized receives a cash reimbursement, usually $4.00 or $5.00 a day for room and board, and an additional allowance toward incidental hospital expenses. The maximum period covered is usually thirty-one days for any one illness. Payment for surgical services is on the basis of a fee schedule; the maximum amount which is paid in most instances is $150 for any one operation.

With the exception of commercial insurance, almost all health insurance plans provide service benefits. The outstanding exceptions are the few medical society plans which are organized on a cash indemnity basis, or which provide a combination of cash and service benefits. Persons enrolled in plans providing service benefits are guaranteed that in the event of illness they are entitled to receive a specified amount of medical or hospital care or both.

Voluntary plans of all types limit the benefits they provide. All plans exclude care for certain conditions, such as tuberculosis and mental diseases after diagnosis; most of them will not provide care for conditions that existed prior to enrollment such as chronic diseases, or for maternity cases during the first ten months of membership. Some limit the total dollar value of the services that will be provided for any case or during a yearly period and many will not treat a case for more than one year. Many plans which give care to the dependents of the insured limit the services still further or provide care only on a reduced-fee basis, usually at 50 per cent of the current charges in the locality.

Prepayment Plans Reviewed

In the early part of 1945 a study was made of more than 200 prepayment medical care plans covering over 5 million people in the United States and Canada.[4] These plans all gave service benefits but differed greatly in the type and volume of services provided. In the following table they have been grouped according to sponsorship and both the total number of persons eligible for care and the per cent eligible for specified services are indicated. In addition to the physicians' and hospital services shown in the table, a few of the plans provided fairly comprehensive and others only limited dental care; about one-fifth of the members in plans in operation in the United States were entitled to receive either special duty or visiting nurse service or both. A number of the plans included laboratory services and X-rays among their benefits and a few even provided drugs and medicines.

About one-half of the plans studied were established in connection with industry. Of the total membership in all plans, almost one-third of those eligible for care through plans in the United States and more than one-half of those in Canada were members of these indus-

3. Rorem, C. Rufus, Director. *Blue Cross Enrollment—2nd Quarter, 1946* (Special Study No. 81) (July 25, 1946), 00 pp.

4. Klem, Margaret C. *Prepayment Medical Care Organizations.* Ed. 3. Washington, D. C., U. S.

TABLE 1.—Number of persons eligible for care and per cent eligible for specified services under prepayment medical care organizations. Data furnished by 245 organizations in Canada and the United States

Type of Organizations	Number of Organizations	Number of Persons Eligible for Care	Per Cent Eligible for Physicians' Services						Per Cent Eligible for Hospitalization
			Total	At Home and Office; and in Hospital for—		At Home and Office Only	In Hospital Only		
				Medical and Surgical Cases	Medical Cases Only		Medical and Surgical Cases	Surgical Cases Only	
CANADA[1]									
Total	16	187,435	100	96.4	...	....	....	3.6	76.1
Industrial	7	97,212	100	100	...	....	....	....	98.6
Medical society	7	86,123	100	92	...	....	....	8	54.3
Government	1	1,600	100	100	...	....	....	....	.....
Red Cross	1	2,500	100	100	...	....	....	....	.....
UNITED STATES									
Total	229	4,975,850[2]	100[2]	60.0	0.8	4.1	10.7	22.9	66.3
Industrial	115	1,512,148	100	86.8	0.3	3.9	0.5	3.8	93.9
Medical society:									
Washington and Oregon	22	954,100	100	100.0	...	....	....	....	100.0
Other States	31	1,640,256	100	6.2	0.8	....	26.7	66.3	13.3
Private group clinic	21	406,330	100	76.1	4.6	....	19.3	....	92.3
Consumer sponsored	32	350,114	100	55.3	0.3	41.1	3.0	.3	62.2
Governmental	8	112,902	100	100.0	...	....	....	....	100.0

1. Canadian coverage is incomplete as no attempt was made to contact all voluntary Canadian plans.
2. Includes some dependents eligible only for hospitalization.

trial plans. The majority could receive the services of a physician in office, home, and hospital for medical and surgical illness as well as hospitalization. The amount of services provided varied considerably among the plans.

In Canada about 46 per cent, and in the United States about 52 per cent of the persons eligible for care were associated with medical society plans.[5] Members of these plans were in most cases eligible for surgical and obstetrical care and, in some instances hospitalization. Many members of these plans receive hospitalization through Blue Cross contracts. In the above table, medical society plans in Washington and Oregon have been distinguished from those in other sections of the United States, since they are so dissimilar. These plans, as well as the medical society plans in Canada, provide a more comprehensive type of care than medical society plans more recently established in the United States.

Membership in consumer-sponsored and governmental plans, as well as those sponsored by private group clinics, is much smaller than in the industrial and medical society plans. Services provided to members of governmental plans are relatively more comprehensive and include limited hospitalization.

5. Membership in medical society plans in the United States had increased to approximately 3 million by May 1, 1946.

About three-fourths of the members of private group and more than one-half of those in consumer-sponsored plans also receive relatively complete care, that is, medical and surgical care at home, office, and hospital in addition to hospitalization.

Although they were active at that time, the plans established by clients of the Farm Security Administration were not included in the 1945 study because reports describing these plans were otherwise available.[6] At the beginning of 1945, these plans were in operation in 37 States. Clients and their families enrolled in these plans were eligible for a considerable volume of medical, hospital, and in many instances, dental care.

Eligibility Requirements

Voluntary health insurance plans are by their very nature limited as to the number of people they can serve. Unless the group which is insured contains a sufficient number of healthy people to make the cost of illness per person reasonably low, the plan either cannot remain solvent or must charge a very high premium. It has been necessary, therefore, to set up certain eligibility requirements regarding membership. These requirements vary not only with the type of plan but among individual plans of the same type. Some plans limit enrollment to groups of workers employed by certain establishments, or to groups not formed primarily for the purpose of obtaining medical care, and they will accept the group only if a substantial proportion enroll. Others enroll both groups and individuals, usually giving the groups the benefit of a smaller premium. Many plans have age restrictions. Some plans require physical examinations; others do not. Some industrial plans require a certain period of employment before enrollment is permitted, and others limit the services provided until after the employee has been with the company for a certain period of time. Groups enrolled in commercial insurance plans must meet certain requirements as to the number and percentage of employees participating. Some insurance companies require a minimum of 25 persons but more frequently the number is 50. In most plans as much as 75 per cent of the group must participate, or, if the group is small, the percentage may be even larger.

Plans also vary with regard to the eligibility requirements for dependents. Some industrial plans exclude them entirely. Other plans accept them on a reduced-fee basis, and the dependent pays for services at a rate which is usually about one-half that charged by physicians in the community. Plans which accept dependents on a prepayment basis often provide the same services as to subscribers; in other instances dependents' services are more limited. Recently among both commercial and non-profit plans, there has been a tendency to liberalize provisions for dependents to approximate those for subscribers. Membership in plans studied in 1945 was about equally divided between subscribers and dependents.

Voluntary Plans and a National Program

Despite the fact that interest in the principle of voluntary health insurance has increased tremendously during the past few years, enrollment in these plans is still small when compared with the total civilian population. Blue Cross plans, after more than 10 years of operation, at present cover only about 17 per cent of the civilian population in the United States and about 12 per cent of the population in Canada.[7] The percentage covered by other non-profit plans and by commercial insurance is much smaller.

The small percentage covered does not indicate a lack of interest in health

6. Goldmann, Franz, M.D. "Medical Care for Farmers," *Medical Care*, Vol. 3, No. 1 (February 1943), pp. 19-35.

7. Op. cit., Rorem, p. 4.

insurance. There is definite proof of the fact that people are well aware of the value of prepayment medical care and are not only willing but anxious to protect themselves through prepayment medical care programs. The reason for the small coverage, therefore, must be found elsewhere.

The growth of voluntary insurance is blocked by many barriers. Its development is often impeded by such controversy that the potential subscriber is often incorrectly or indifferently informed as to the real value of the plan. The eligibility requirements which plans must keep in force in order to protect themselves financially exclude many who would be glad of an opportunity to participate. The plans are too costly for the type and amount of services provided, charges are prohibitive for low-income families, and in many instances persons with incomes over a specified amount are accepted as members only on the condition that physicians providing services to them may make additional charges. Also plans now in operation are unequally distributed and there are still large areas where prepayment plans are not in operation, or, if they are, where eligibility is limited to some particular industry or group. Finally voluntary plans are limited in growth by the very fact that they are voluntary. Many families among the moderate and high-income groups will not participate on a voluntary basis; and the low income groups, those most in need of care, because of the pressure of high living costs prefer to "take a chance" in the hope that they will escape expensive illness.

Consideration of these difficulties has led many persons to doubt seriously that voluntary plans can ever reach the public in such a manner as to achieve national coverage or anything approaching it. In their opinion voluntary plans are valuable not only for the services they are rendering at present but as an experiment which can point the way to a broader program. They believe that in the future the experience of these plans in business and medical administration, and in the provision of services, can be of definite assistance in developing a national health program, but that voluntary insurance can never be considered as a substitute for compulsory health insurance.

Britain's New Health Service

By Norman Wilson

THE first provision of medical care at the public expense was that made by Justices of the Peace for the sick destitute, long before the Poor Law Commissioners in 1837 authorized their successors, the Boards of Guardians, to give medical relief and to appoint medical officers for the purpose. It was not until thirty years later that an institutional service especially for the sick poor was inaugurated, treatment being provided in infirmaries maintained separately from workhouses or in sick wards in or attached to workhouses. The definition of destitution was gradually broadened; and during this century it has generally been accepted that although a person may be able to secure out of his own resources food, clothing and shelter he may be destitute in the sense that he cannot secure necessary medical care. As a consequence accommodation became more and more readily available in Poor Law general hospitals which steadily expanded in number and size. When the Boards of Guardians were abolished by the Local Government Act, 1929, hospitals containing 130,000 beds were transferred to the county and county borough coun-

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