

New International Standards for Medical Care and Sickness Benefits Under Social Security Programs

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THE FIFTY-THIRD International Labor Conference, which was marked by the celebration of the fiftieth anniversary of the founding of the International Labor Organization (ILO), met in Geneva from June 4 to June 26, 1969. On June 25 the Conference adopted a new international Convention and Recommendation on medical care and sickness benefits. The Convention establishes new advanced standards for these benefits under the social security programs in ILO member countries, and the Recommendation sets new goals for future national action.¹

Under the ILO Constitution, a double discussion procedure provides that proposed instruments are discussed at two successive Conferences before action is taken on them.² In accordance with this procedure, the Social Security Committee of the Fifty-third Conference conducted the second discussion of these instruments (the first discussion took place in 1968 at the Fifty-second Conference). It was intended that these discussions should lead to a revision of two ILO Conventions adopted in 1927—No. 24 Concerning Sickness Insurance (Industry) and No. 25 Concerning Sickness Insurance (Agriculture). The adoption of the new instruments marks the completion of the third stage of a program undertaken by the Conference to revise all social security Conventions containing advanced international standards adopted before World War II.³

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¹ For a discussion of the significance of ILO instruments, see Robert J. Myers and William M. Yoffee, "Social Security Issues: Fiftieth International Labor Conference," *Social Security Bulletin*, November 1966, page 21.

² *Ibid.*, for a more detailed description of the double discussion procedure on Conventions and Recommendations.

³ *Ibid.*, page 22, for a history of ILO instruments on social security. The second stage of the revision program was completed in 1967 with the adoption of Convention No. 128 and Recommendation No. 131 on invalidity, old-age and survivors benefits, and is discussed fully in William M. Yoffee, "New International Instruments on Invalidity, Old-Age, and Survivors Pensions," *Social Security Bulletin*, October 1967. (The first stage—on revision of employment injuries benefit standards—had been completed in 1964.)

This article describes the new advanced international standards and goals, and it offers some insight into how they were formulated. It also compares them with earlier standards and goals for the same two branches of social security and with standards and goals on matters common to other social security branches, including some adopted as part of the revision program.

SOCIAL SECURITY COMMITTEE

The Social Security Committee of the Fifty-third International Labor Conference was generally representative of the Conference as a whole. In its tripartite composition, it included representatives of 60 Governments—about half the total membership of ILO—from all regions of the world, with all shades of opinions on economic and social policy, and at all levels of economic and social development. It also included 25 Employer representatives and 28 Worker representatives.⁴ Weighted voting equalized the voting strength of the Government, Employer, and Worker groups within the Committee.

The Committee accepted as a basis for its discussion the draft instruments prepared by the Social Security Division of the International Labor Office. These drafts were based on conclusions adopted by the Social Security Committee of the Fifty-second Conference concerning the contents of the instruments, as well as on comments made by Member Governments concerning those conclusions.⁵

⁴ The United States was represented on the Committee by the author for the Government; by Lyle Fisher, Vice President, Minnesota Mining and Manufacturing Co., for the Employers; and by Bert Seidman, Director, Department of Social Security, AFL-CIO, for the Workers.

⁵ The report of the Social Security Committee of the Fifty-second Conference and its conclusions, along with preliminary draft instruments, are contained in *Revision of Conventions Nos. 24 and 25 on Sickness Insurance* (Report V (1)), 53d International Labor Conference, Geneva, 1968. The comments of Governments and the revised draft instruments on which the Committee discussions in 1969 were based are contained in Report V (2).

The main problem facing the Social Security Committee at this Conference was the same as at previous Conferences during the program of revision. It was to decide how high the new advanced standards should be above the standards contained in Convention No. 102 concerning Minimum Standards of Social Security, adopted in 1952.⁶ This problem was even more perplexing in 1968 and 1969 than in most previous years because of the number and complexity of the many countervailing factors that had to be taken into account.

On the one hand, the Committee recognized the needs of workers and their dependents for comprehensive medical care and income-loss protection, and the ultimate advantages to the nation that provides them. It also keenly sensed the social and humanitarian considerations that call for encouraging broader coverage and higher benefits through international standards and that argue against limiting medical care or sickness benefit protection to any particular class of workers.

On the other hand, the Committee recognized that many nations have neither adequate financial resources nor sufficient trained manpower to provide comprehensive protection for their entire working population and that some nations can barely provide adequate protection for a small segment of the working population despite their wish to do more. The main issue then was whether the new standards should reflect an advanced social philosophy, with the prospect of relatively limited practical applicability in most countries—at least for the time being—or whether they should aim at greater practical applicability in a large number of countries.

SCOPE OF THE INSTRUMENTS

In Convention No. 102, the entire field of social security is divided into nine branches. Each branch is related to a specific contingency for which social protection in the form of benefits is to be provided. For purposes of ratification of that Convention by a Member of ILO, however, the branches are divided into two groups.

⁶ Robert J. Myers, "Minimum Standards of Social Security: New International Convention," *Social Security Bulletin*, October 1952.

Ratification requires compliance with the standards for only three of the nine branches, but at least one of the three must include unemployment, old-age, employment injury, invalidity, or survivors benefits. The other two may include any of these or medical care, sickness, maternity, or family benefits.

The new instruments continue to treat medical care and cash sickness benefits as two branches of social security, but a significant advance over the earlier minimum standards is the fact that in order to ratify the new Convention, an ILO member must undertake to meet the new advanced standards for both branches. This requirement may be considered offset, but only slightly, by the Committee's rejection of the formal requirement contained in Convention No. 102 that a member must satisfy itself, before ratification, that it has attained the required level of coverage.

Conventions No. 24 and 25 dealt separately, for purposes of ratification, with benefits for industrial workers and agricultural workers, as did a number of other social security Conventions adopted before World War II. The new Convention continues the practice in postwar social security Conventions of avoiding a distinction between these two sectors of employment for ratification purposes.

Like Convention No. 128, however, the new Convention makes possible, for those countries whose legislation covers employees only, some delay in meeting the new standards for some agricultural workers. Under Convention No. 128, those agricultural workers who are not protected at all under legislation establishing invalidity, old-age, or survivor benefit schemes may, at the time of ratification, be temporarily excluded from that Convention's application. Those agricultural workers who are protected must be given the same standard of protection that is required for other workers.

Recognizing the inherent unfairness of this formula, which gives better treatment for purposes of ratification to Members that have no coverage for agricultural workers than to those that have below-standard coverage, the Committee adopted a slightly modified formula for the new Convention. This new formula permits a Member, for purposes of ratification, to exclude temporarily from the Convention's application any agricultural workers not yet protected under

legislation for medical care or sickness benefits that is in conformity with the new Convention's standards at the time of ratification. Those agricultural workers who are without any protection or with below standard protection need not be considered in determining the Member's compliance with the new Convention, if the Member's legislation is designed to apply only to employees.

As in Convention No. 128, reports must be made regularly to the ILO on the plans and progress being made to bring protection of agricultural workers up to the Convention's standards and the Member, by ratifying with this exception, is committed to progress as rapidly as circumstances permit. Both Conventions permit this temporary exception in recognition of the fact that even in some countries with advanced social security systems for industrial workers, practical problems still prevent the extension of comparable protection to the agricultural sector.

As in all the postwar social security Conventions, and in some of those before World War II, a number of special exceptions to the standards in the new Convention are made and designed for developing countries, in accordance with the ILO constitution. In this Convention the exceptions are available to countries declaring at the time of ratification that their economies and their medical facilities are insufficiently developed. Until they are in a position to renounce their right to the exception, such countries must indicate in their reports to the ILO on the application of the Convention that the reason for the exception continues to exist. Furthermore, they must undertake, as circumstances permit, to increase the number of persons protected under both medical care and sickness benefit programs and to extend both the range of medical benefits and the duration of sickness benefits. Specific exceptions that are available to developing countries are noted here in the discussion of the standards to which they relate.

As for all previous postwar social security instruments, Members need not apply these new advanced standards to seafarers or sea fishermen or to public servants where they are protected by comparable special schemes.

The new Convention permits Members to take into account protection through noncompulsory insurance—voluntary private insurance meeting certain criteria, for example—in determining

their compliance with its standards. Similar provisions were included in Conventions No. 102 and No. 128 but with one major difference.

Under the new Convention only noncompulsory insurance in existence at the time of the Member's ratification may be taken into account but not that coming into existence thereafter. Thus, if a Member ratifies the Convention before it fully meets the coverage standards, it commits itself in effect to further coverage by means of compulsory insurance. The United States Government took strong exception to this provision and reserved its position, primarily because the restriction might tend to retard the growth of private voluntary medical care insurance where it could be effective. In addition, the United States believes that it is not appropriate for international social security standards to determine the means by which Member States should implement them.

CONTINGENCIES COVERED

Under the new Convention the contingencies for which protection should be granted are defined with respect to medical care as the need for medical care of a curative nature and, under prescribed conditions, the need for medical care of a preventive nature. For sickness benefits the contingency is defined as incapacity for work resulting from sickness and involving suspension of earnings, as defined by national legislation.

Considerable discussion took place in the Committee, particularly in 1968, on whether the new instruments should be limited to contingencies of a nonoccupational origin. Arguments were advanced that Convention No. 121 already provides for both medical care and cash benefits in the case of occupation-related illness or injury. The Committee accepted instead the argument that a number of worthy cases might fall through the net of social protection if the new Convention were specifically limited to nonoccupational illnesses. The Committee's report, however, included a statement that, in accepting this argument, it did not intend to prejudice the protection of occupationally caused illnesses under programs of employment injury benefits

Some opposition also arose, especially in 1968, to including provisions for preventive care, on

the grounds that they might be more appropriate for public health programs than for social security and because neither the concept nor the requirements are further defined in either instrument. The Committee rejected both arguments, and the Convention leaves it up to national legislation to determine by what agency and to what degree preventive care should be provided.

The new definition of the curative and preventive medical care contingencies represent a significant advance over earlier definitions. The earlier definitions required the clear presence of an illness or condition necessitating curative or preventive care, but the new one does not. The new definition speaks in terms of the need for care. Early drafts would have required the presence of a "morbid condition" for curative care, but this reference was deleted by the Committee. What remains can only be interpreted to mean that, as a practical matter, when an individual appears to need medical attention, international standards require that he be given access to it, even if it later turns out that he did not need it.

No reference is made in the new Convention to medical care in the case of pregnancy and confinement and their consequences, although the question was raised in 1968. Such references were made in the medical care part of Convention No. 102 and again in Convention No. 103 concerning Maternity Protection, which was adopted the same year—1952. This omission is based on the theory that conditions relating to pregnancy should not ordinarily be considered as illnesses.

STANDARDS FOR MEDICAL CARE PROGRAMS

The new international standards require that curative or preventive medical care be provided when needed and under prescribed conditions "with a view to maintaining, restoring or improving the health of the person protected and his ability to work and to attend to his personal needs." Statements of purpose of social security medical care have appeared previously in Recommendations adopted by the ILO, but this is the first statement of this type in an Article of a Convention. The statement is especially significant because it encompasses every possible purpose of medical care and relates them in an

integrated fashion to the overall aim of social security.

The medical care offered by developed countries, in order to meet the standards of the new Convention, must include general practitioner care (including domiciliary visits), as well as specialist care at hospitals for both inpatients and outpatients. Specialist care outside the hospital, as available, must also be provided. In addition, the care offered must also include pharmaceutical supplies necessary for the patient, both in and out of the hospital, upon prescription by a physician or other qualified practitioner, and hospitalization when the patient's condition demands it. The standards also require the provision of dental care and medical rehabilitation, but the degree to which they are provided is left to the discretion of the Member's national legislation. The new Recommendation calls for the addition of medical aids, such as eyeglasses, as well as services for convalescents.

For developing countries, a number of exceptions are made in the requirements with respect to provision of medical care. Domiciliary visits by general practitioners and specialist care outside the hospital are not required, except where it is possible to provide them. There are no requirements for providing dental care or medical rehabilitation.

In the new Convention, dental care and medical rehabilitation appear as requirements for the first time, though only in a limited form. In the past they have only appeared in Recommendations. The exceptional requirements for developing countries too may be regarded as an advance, in one sense, since they take more realistic account of the potential of most developing countries than did previous Conventions.

For developed countries, the prescribed duration of medical care under the new standards is the same as that required by the minimum standards in Convention No. 102. In principal, care must be provided throughout the contingency. It may, however, be limited to 26 weeks after a protected individual is no longer in the category of protected persons, but it may not cease while he continues to receive a cash sickness benefit. Even where the 26-week limit might apply, special provision must be made for extending care for prescribed diseases recognized as entailing prolonged care. It reflects perhaps an apprecia-

tion of practical limitations on most national programs that the basic principle of providing care throughout the contingency, without exception, has not yet been accepted. One advance in this direction, made by the Committee, was to put developed and developing countries under the same obligation by failing to adopt an exceptional provision for the developing countries, like that included in Convention No. 102. The new Recommendation calls for providing care throughout the contingency for any one who belonged to the category of protected persons when his illness began.

Two issues that aroused considerable disagreement among the members of the Social Security Committee, both in 1968 and in 1969, were the appropriateness of international standards that continue to endorse qualifying periods for medical care protection and cost sharing by the beneficiary. Indeed, proponents of both measures disagreed considerably as to what purposes they served. In the end it was agreed that both measures should be permitted since they are widely employed in national practice. They were not endorsed, however, and their use is made subject to social limitations. Where the Member's legislation makes medical care conditional on the fulfillment of a qualifying period, the condition may not deprive anyone of his benefit rights who normally belongs to the categories of persons protected. Where the Member's legislation requires cost sharing, it must be designed to avoid hardship for the beneficiary and not to prejudice the effectiveness of medical and social protection. The new Recommendation calls for the elimination of qualifying periods for medical care protection and eliminating cost sharing for persons of limited means and for diseases that require prolonged care.

STANDARDS FOR SICKNESS BENEFIT PROGRAMS

To comply with the new international standards, a member must provide a cash benefit to a protected person whose incapacity for work results from sickness and involves suspension of earnings. The standard benefit for a family of four—a worker, his wife, and two children—must be at least 60 percent of the combined wages and family allowances paid to a typical worker in

the country (determined by a formula first introduced in Convention No. 102 and repeated in Convention No. 121 on employment injury benefits and Convention No. 128 on invalidity, old-age, and survivors benefits). This proportion represents a considerable increase over the 45 percent required by Convention No. 102, and the Recommendation calls for a still further increase to 66⅔ percent.

There was some disagreement in the Committee on whether the standard sickness benefit should be patterned after the standard employment injury benefits in Convention No. 121 for both temporary incapacity and total loss of earning capacity (60 percent of combined wages and family allowance) or after the standard invalidity benefit in Convention No. 128 (50 percent). The Committee chose the former, on the grounds that the sickness and employment injury benefits should be parallel. The arguments favoring the latter proportion were that sickness and invalidity are a continuum and that differences in the size of the two benefits tend to shift the burden from the more liberal program to the other program. In addition, if the invalidity benefit is smaller, hardship to the beneficiary might result when his entitlement is shifted. The arguments on both sides are based on matters of principle, but as a practical matter the choice of a 60-percent standard may well result in action by some members who do not already provide invalidity benefits as high as their sickness benefits to bring the two benefits into line at the higher level.

In principle, the Convention requires that a cash sickness benefit be paid throughout the contingency. In practice, however, it permits developed countries to limit benefits to 52 weeks—a significant advance over previous standards that required no more than 26 weeks benefits in any case. The 26-week limitation remains in effect as an exception for developing countries.

Both the qualifying period for cash benefits and the initial period of suspension of earnings—the waiting period for cash benefits to begin—aroused some controversy within the Committee. The question of the qualifying period was disposed of in the Convention in the same manner as for medical care, but the Recommendation does not call for its elimination. Several unsuccessful attempts were made to make the waiting-period requirement more flexible than the unqualified

3-day maximum carried over from Convention Nos. 24, 25, and 102 and to tie its length to the potential length of the benefits. These attempts were based on the belief of some governments that more attention should be given to medium- and long-term illnesses than to short-term ones.

Though the Recommendation does not call for the elimination of the waiting period, it does propose payment of a cash benefit in four cases where the waiting period might prevent it: When a person is absent from work and loses earnings (1) because he is required to undergo curative or preventive care, (2) because he is isolated for purposes of quarantine, (3) because he is under medical supervision for purposes of rehabilitation, or (4) because he is on convalescent leave.

In two other instances, the Recommendation calls for action that would avoid the need for cash benefits because of lost earnings by aiming at keeping the protected person at work. In one case, the Recommendation calls on employers to give a worker not too ill to work a reasonable opportunity to obtain necessary medical treatment during normal working hours. In the other, the Recommendation calls for appropriate provision that would enable an economically active protected person to care for a sick dependent.

Despite considerable disagreement over whether it is germane to sickness benefits, the Committee approved the insertion of a requirement that a funeral benefit must be paid to the survivors of a person who was in receipt of or qualified for a sickness benefit or to other persons who were his dependents, or to the person who has borne the funeral expenses. Voluntary insurance against the cost of funeral expenses, supervised by public authorities, would be an acceptable substitute in very limited circumstances.

EXTENT OF PROGRAM COVERAGE

As in previous postwar social security Conventions, provision is made for the three major approaches to coverage in common use: protection of employees only, protection of the economically active population, which includes both employees and the self-employed, and protection based on residence.

If a Member's legislation protects employees, then it must in principle cover all employees

(including apprentices) for cash benefits; for medical care, it must also cover their wives and children. Under Convention No. 102 only 50 percent of all employees (and their wives and children for medical care) had to be covered for either benefit. The new Convention, for practical administrative reasons, permits the exclusion of casual workers, the employer's family members living in his house with respect to any work for him, and other categories of employees not exceeding 10 percent of all employees other than the two categories named. If the Member follows this approach, the Convention also permits the temporary exclusion of certain agricultural workers, as previously explained.

If the Member's legislation is designed to protect the economically active population, then for medical care it must cover at least 75 percent of all economically active persons, their wives, and their children. For sickness benefits the requirement is coverage of 75 percent of all economically active persons. In Convention No. 102 the requirement for both benefits was coverage of economically active persons equal to 20 percent of all residents and, for medical care, coverage of their wives and children.

If the Member's legislation is designed to cover residents, then it must cover 75 percent of all residents for medical care. For sickness benefits, the requirement is coverage of all residents whose means do not exceed prescribed limits. These limits should be set in order that the total benefits paid would be 30 percent higher than if 75 percent of the economically active population were covered. In Convention No. 102 the requirement for medical care was 50 percent of all residents and, for sickness benefits, all residents below a specified level of means, with the total benefits paid 30 percent higher than if 20 percent of the economically active population were covered.

There is, of course, no obstacle to following one of the three approaches for medical care and another for cash benefits. Developing countries under exceptional provisions may ratify if, for medical care or sickness benefits or both, they cover at least 25 percent of all employees or 50 percent of all industrial employees, including, for medical care, their wives and children.

One additional coverage requirement for medical care is that old-age, invalidity, survivor, and unemployment beneficiaries and their wives and

children, where appropriate, must continue to be protected, under conditions prescribed by national legislation, if they were protected before becoming beneficiaries.

The Recommendation calls for virtually universal protection under medical care and cash sickness benefit programs, by stages if necessary and under appropriate conditions.

STANDARDS COMMON TO BOTH BRANCHES

In its common provisions, the Convention makes the suspension of either medical care or sickness benefits permissible in a limited number of cases, as do previous Conventions: (1) If the beneficiary is abroad; (2) if he is being indemnified by a third party for the same contingency; (3) if there is a fraudulent claim; (4) if the contingency has been caused by the beneficiary's criminal act or his serious willful misconduct; (5) if he neglects without good cause to use the care or services put at his disposal or to certify his continuing eligibility; and (6) if he is either already being maintained at public or at social security expense or, with respect to the cash sickness benefit, if he is receiving another social security cash benefit (other than family allowances). Even in these cases, at least part of his dependent's benefits must be continued.

The Convention requires that nonnationals who normally reside or work within the territory of the Member be treated equally with nationals with respect to the rights to medical care or sickness benefits.

The administrative standards required by the Convention are similar to those in previous instruments. The right of appeal with respect to refusal of benefits or to their quantity or quality must be guaranteed. The Member is required to accept responsibility for due provision of benefits and proper administration. In addition, worker participation in the management of quasi-public or private social security institutions is required, as are employer and public authority participation where they are deemed appropriate.

RATIFICATION ON HIGHER OVERALL PROTECTION

The new Convention follows the precedent established by Convention No. 128, which permits

ratification by a Member whose system may be considered to provide a higher overall level of protection than that required by the Convention, even if the Member's system does not meet all of its detailed requirements. This route is open to a Member that has not made use of the exceptions for developing countries and whose total relevant expenditure on medical care and sickness benefits amounts to at least 4 percent of its national income.

The Member's system must also satisfy two of the three other criteria. One of the three criteria is that at least 85 percent of the economically active population is protected for both contingencies or at least 85 percent of all residents is protected for medical care. Another is that curative and preventive medical care are provided at an appreciably higher standard than that prescribed for developed countries. A third criterion is that the standard sickness benefit is at least 70 percent of the combined wages and family allowances paid to a typical worker. Temporary derogations then may be made to any of the standards set for either of the separate branches but only after consultation with representative national employer and worker organizations.

CONCLUSIONS

The standards for medical care and cash sickness benefits contained in the new Convention represent a significant advance over previously adopted minimum and advanced standards. The Recommendation also represents a meaningful program for future development of international standards as well as of national programs. Both instruments should rank high in importance among other significant instruments on social security and social policy.

Some governments, however, at both the 1968 and 1969 Conferences, as well as in written comments, have raised some searching questions about both instruments and about the Convention in particular. One important question is whether or not the instruments are ahead of their time and hence not practically applicable to existing national circumstances. A related question is whether there is any relevance at all in either instrument for most developing countries.

On the first question, many Committee members expressed doubt that any ILO Member could ratify the Convention without resort to the provision for ratification on the basis of higher overall level of protection. Oddly enough, considerable criticism of this provision came from many highly developed countries with advanced social security systems, some of whom favor this type of provision in principle. They believe the provision is not what it appears to be but rather is so indefinite in its standards as to nullify the progress made in the rest of the Convention and to open ratification to almost any developed country. Eight governments including the United States, which favored the principle, specifically noted their reservations about this provision in the Committee's report.

On the second question, a number of governments of developing countries expressed the feeling that neither instrument was relevant to the problems of such countries that stem from their lack of resources and manpower to establish meaningfully effective medical care and cash sickness benefit programs. Some of these governments actively sought to introduce still lower standards for developing countries—by way of special exceptions—than had already been accepted for the new Convention and for some previous ones.

It was and apparently remains the view of some developed countries that what is most needed for the developing countries is not lower standards but rather a set of guidelines for the gradual establishment and extension of programs in both branches. Such guidelines, possibly in the form of a separate Recommendation, would presumably call upon the experience of countries

that have already overcome similar problems to some degree. Yet, it was felt, the guidelines should grow out of initiatives by the developing countries themselves. Unfortunately, the pressure of the Committee's work at the Conference in this 50th anniversary year was too great to have been conducive to such initiatives. The hope was expressed, however, that they might be forthcoming sometime in the near future.

A number of Committee members, both formally and informally, have characterized the instruments as highly advanced and progressive from the point of view of social policy but of limited immediate practical use from the viewpoint of government action in most countries.

Though the new Convention is largely unsuitable for ratification by countries like the United States with Federal systems and despite serious reservations on several specific points, the United States Government supported its adoption and that of the Recommendation. The United States Worker Delegate also voted for both instruments, and the United States Employer Delegate voted against the adoption of both.

Only one government voted against the Convention. Twenty governments, only one of them that of an industrially advanced country, abstained. The Convention was adopted by the Conference by a vote of 261 in favor, 5 against, with 67 absentions.

No governments voted against the Recommendation, 24 governments abstained—three of them from industrially advanced countries. The Recommendation was adopted by the Conference by a vote of 231 in favor, 47 against, and 48 abstaining.