increased so that half the men in the Boston study who were employed earned more than $1,150. In 1948–49 the median earnings of the employed male old-age insurance beneficiaries in the Philadelphia-Baltimore study were $1,574.

Potential Employability

Only a small proportion of old people leave the labor market for good unless they have to do so. The psychological factor of hating to be put on the shelf by poor health or the loss of a job makes many elderly workers resentful of enforced retirement. The principal reason they want to continue working, however, is that without earnings they do not have resources enough to live at the level to which they are accustomed, or even to meet the cost of their basic needs. Of the old-age insurance beneficiaries studied between 1941 and 1949, those whose retirement incomes[4] were lowest as a rule went back to work much more frequently than beneficiaries whose retirement incomes were more nearly adequate.

Roughly 60 to 90 percent of the able-bodied beneficiaries had some employment during a 12-month period within 1 to 3 years after their entitlement, the proportion depending almost entirely on the state of the labor market. Except in the most favorable employment period, a majority of those who said they were able to work and did not have jobs would gladly have accepted employment had it been offered to them. Even a few of the men who said they were not able to work were nevertheless employed after their entitlement because they needed their earnings.

The facts presented indicate that at least a fifth of the men who become entitled to insurance benefits in any year might remain at work in their regular jobs if their employers were willing to keep them or might take comparable jobs with other employers if their regular jobs were terminated. Another fifth might be able to take jobs requiring shorter hours or less physical effort or in other ways making less demand on the workers.

Part-time jobs might solve the employment problem of many old people; they could work a few hours a day or a few days a week and would be glad to do so. Work for some might have to be adapted to their handicaps—poor eyesight, a bad heart, inability to stand for long hours. Wartime employment of old people demonstrated that all that many of them need is a chance to show what they are able to do.

[4] Money income from 12 months' old-age insurance benefits, retirement pay from a former employer, veterans' and union pensions, and annuities; money income from trust funds and estates, public and private insurance, and assets; and the imputed income from an owned home.

Notes and Brief Reports

Benefits and Contributions Under National Compulsory Health Insurance Programs

Health insurance is the oldest form of social insurance. After long experience with voluntary programs, the central European countries pioneered with broad compulsory coverage, beginning with the German law of 1883, which was followed by legislation in Austria (1888) and in Hungary (1891). England adopted compulsory health insurance in 1911. In 1924, Chile adopted the first national compulsory insurance law in the Western Hemisphere. In the Orient, the Japanese national health insurance law of 1922 became operative in 1926–27.

Today, 37 countries have in operation either national compulsory contributory health insurance programs or programs having many of the same basic characteristics—either because they evolved out of such insurance systems or were developed as variants of them. A number of countries provide medical services to all or to substantial groups in the population through public programs supported from general revenues and usually employing the physicians on a salary basis. Such public medical service programs are not included in this summary. In many cases, traditional criteria for the identification of an insurance system are difficult to apply, and some programs that are on the borderline between national health insurance and national public medical service have been included. Most of the older health insurance systems included both medical benefits and cash benefits in partial replacement of wage loss. All the countries shown here that provide medical benefits through what can be regarded as a public medical service also have contributory cash sickness benefit programs. Insurance systems not national in scope are excluded.

The accompanying chart summarizes the general scope of the medical and cash benefits provided, the coverage of the systems, and a few aspects of their financing. Further details on the programs for each country will be found in a comprehensive report published by the Social Security Administration last year.[1] The chart is based primarily on data from that report, brought up to date where changes have occurred. Only programs known to be in operation are included in this summary.

Several other countries have adopted laws under which compulsory systems will be established. In 1951, health insurance is scheduled to go into effect in parts of India and in Turkey. Guatemala, Haiti, and El Salvador have enacted laws that may be implemented in the near future. The effective date of the Swedish compulsory health insurance law of

[1] Carl H. Farman and Veronica Marren Hale, *Social Security Legislation Throughout the World,* Division of Research and Statistics (Office of Commissioner), Bureau Report No. 16.

1947 has been indefinitely postponed.

Coverage.—Of the 37 systems, seven explicitly or in effect cover all or nearly all persons in the country. Twenty of the other 30 systems cover practically all persons working for an employer, including agricultural workers and in most cases domestic servants. The remaining 10 cover mainly workers in commerce and industry. Public employees may fall within the scope of the general system, but in some countries there are separate programs for this special group, and in some they are not insured.

A few countries having national laws but limited industrialization are bringing their programs into effect in their more industrialized sections first.

Scope of benefits provided.—Medical benefits include general medical services in all countries listed except Australia and Ireland. All the countries except Australia provide specialist services, although New Zealand until April 1950 made no higher payments for specialist care. The scope of specialist services varies, depending in large measure on medical practices and the development of medical science in the country. The nature and quality of the other types of medical insurance benefits also vary from country to country, of course, as does the character of medical services available outside the insurance system. Prescribed medicines are covered almost without exception, though in some cases the beneficiary pays a substantial part of the cost or a nominal fee. Some dental services are usually included. Hospitalization is covered by all programs summarized here, but availability of hospital beds is often a limiting factor. Where existing facilities have proved inadequate to meet the effective demand, health insurance has in many cases made possible the construction, staffing, and maintenance of new or enlarged facilities, with resulting provision of more services and their improvement.

Cash benefits are usually only partial replacement of wages lost because of incapacity—rarely less than half or more than three-quarters of the wage or salary on which contributions are assessed. In most of the Communist countries these benefits vary with the length of employment in the same establishment—presumably to discourage labor turn-over. Benefits are increased in Czechoslovakia, France, and Mexico after a specified duration of incapacity, presumably on the ground that the insured person's need is greater after a long period of incapacity for work; benefits are reduced in Chile, Colombia, Ecuador, and Portugal after a certain time, presumably to encourage the earliest possible return to work. In Czechoslovakia and Greece, benefits are a higher percentage of the poor man's wage than of the better-paid worker's wage or salary. In most of the countries the period necessary to qualify for cash benefits is the same as that needed for medical benefits. In nine of the countries, however, it is longer; in one case (Ireland, where there is a 3-year qualifying period for medical benefits) the qualifying period for cash benefits is shorter.

Medical benefits for dependents.—Medical benefits for the dependents of the insured worker have been included by a growing number of countries, and today 29 of the 37 systems make little or no distinction between the medical care provided the insured worker and that provided to his family. Three other countries that exclude dependents from most of these benefits assure maternity care to the worker's wife and have pediatric care for infants. Five do not cover dependents, but in at least two of these cases voluntary insurance is available for family members through the program.

Distribution of costs.—Systems that have been providing benefits for some length of time are commonly found to have a contribution rate of 6 or 7 percent of covered earnings (for cash and medical benefits together). The chart shows these rates for 22 countries. Of the 15 for which the rate as a percent of covered earnings is not available, five countries (British and Scandinavian) have flat-rate contributions (a definite amount specified by law or in the rules of the sickness insurance societies) and most of the others have unified social insurance programs for which information on the share allotted to compulsory health insurance is not available.

The growth of the unified social insurance contribution system makes valid generalization concerning the distribution of the health insurance program costs difficult. For most countries the distribution of costs as shown in the chart is that specified in the law. For Denmark, Ireland, and Norway the distribution shown is based on actual revenue allocations in a recent fiscal year. For a number of countries in which the cost distribution is not fixed but varies from year to year, the basis of financing and the source of revenues in a recent year are summarized in the explanation of chart entries. In Great Britain and possibly in the Soviet Union and Rumania, the Government provides over half the cost of cash and medical benefits from general revenues. The employer is a principal contributor in half the programs; in more than a third of the countries he contributes either the full cost (6 countries) or more than half the cost (8 countries), and he contributes 50 percent in seven other programs. The insured person contributes in 28 of the 37 programs, meeting more than half the cost in five programs (in 1949), just half (with the employer contributing the other half) in four more, and smaller proportions in the others.

Administration.—In many cases, compulsory health insurance is administered by health insurance societies (often termed "sickness funds"), which may be agencies serving a given area, factory, industry, or trade union. Where such a pattern exists, Government supervision is the rule, but the societies have considerable "autonomy." In a number of countries, a Government department administers the benefits directly; in a small but growing number of cases the medical care benefits are administered by the Ministry of Health and not by the agencies administering cash benefits. The pattern usual in Latin America and also found in some other countries is the autonomous social insurance institution, a public corporation operating under national law and general governmental supervision, authorized to make its own administrative rules, contract for services, and handle its own funds subject to the provisions of the legislation.

National programs for compulsory health insurance: Coverage, benefit, and financing provisions, 37 countries, 1950

Country	Year of first law	Coverage				Benefits							Financing			
			Wage and salary workers			Medical					Cash			Percent of cost paid by—		
		All or nearly all persons	All (including agriculture)	Mainly commerce and industry	Dependents also entitled	General practitioner services	Specialist services	Prescribed medicines	Hospital care	Qualifying period for medical benefit	Benefit as percent of wage	Qualifying period	Contribution as percent of covered earnings	Insured	Employer	Government
Albania	1947		x		x	x	x	x	x	1 month	50–100	1 month	4	0	100	0
Australia	1944	x			x			x	x	None	(1)	None	(2)	(2)	(2)	(2)
Austria	1888		x		x	x	x	x	x	None	50–70	None	7	50	50	0
Belgium	1944		x			x	x	x	x	3 months	60	3 months	(2)	(2)	(2)	(2)
Brazil	1935			x	x	x	x		x	1 year	66	1 year	(3)	33⅓	33⅓	33⅓
Bulgaria	1918	x			x	x	x	x	x	None	65–100	None	3.5	0	100	0
Chile	1924		x			x	x	x	x	7 months	50–12½	7 months	(3)	0	75	25
Colombia	1946			x		x	x	x	x	5 weeks	67–50	5 weeks	8	25	50	25
Costa Rica	1941			x	x	x	x	x	x	4 weeks	50	4 weeks	7	43	43	14
Czechoslovakia	1888		x		x	x	x	x	x	None	75–25	None	6.8	(2)	(2)	(2)
Denmark	1892	x			x	x	x	x	x	6 weeks	(1)	6 weeks	(1)	74	0	26
Dominican Republic	1947		x			x	x	x	x	1 week	50	6 weeks	(3)	28	55	17
Ecuador	1935			x		x	x	x	x	26 weeks	50–40	26 weeks	(3)	36	50	14
France	1928		x		x	x	x	x	x	60 hours	50–67	60 hours	6	50	50	0
Germany	1883		x		x	x	x	x	x	None	50	None	6	50	50	0
Great Britain	1911	x			x	x	x	x	x	None	(1)	26 weeks	(3)	(2)	(2)	(2)
Greece	1934			x	x	x	x	x	x	6 months	60–35	6 months	9	17	83	0
Hungary	1891		x		x	x	x	x	x	None	55	None	8	0	100	0
Iceland	1936	x			x	x	x	x	x	None	(1)	None	(1 3)	(2)	(2)	(2)
Ireland	1911		x				x	x	x	3 years	(1)	26 weeks	(1)	27	29	44
Italy	1943		x		x	x	x	x	x	None	50	None	5	0	100	0
Japan	1922		x		x	x	x	x	x	None	60	None	5.5	50	50	(2)
Luxembourg	1901		x		x	x	x	x	x	None	50	None	6	67	33	(2)
Mexico	1942			x	x	x	x	x	x	None	50–58	6 weeks	8	25	50	25
Netherlands	1929		x		x	x	x	x	x	None	80	None	6.6	42	58	0
New Zealand	1938	x			x	x	x	x	x	None	(1)	None	(2)	(2)	(2)	(2)
Norway	1909		x		x	x	x	x	x	None	(1)	14 days	(1)	55	18	27
Panama	1941			x		x	x	x	x	30 weeks	(4)		1.1	45	45	10
Paraguay	1943			x	x	x	x	x	x	None	(4)		(3)	25	60	15
Peru	1936		x			x	x	x	x	4 weeks	70	4 weeks	6.3	27	55	18
Poland	1920		x		x	x	x	x	x	None	70	4 weeks	5	0	100	0
Portugal	1935			x	x	x	x	x	x	None	67–50	1 year	4	25	75	0
Rumania	1912		x		x	x	x	x	x	None	50–100	3 months	(2)	0	(2)	(2)
Spain	1942		x		x	x	x	x	x	None	50	6 months	9	33	67	0
Union of Soviet Socialist Republics.	1912	x			x	x	x	x	x	None	60–80	None	(2)	0	(2)	(2)
Venezuela	1940			x	x	x	x	x	x	None	67	None	10	30	30	40
Yugoslavia	1922		x		x	x	x	x	x	None	75–100	3 months	6	0	100	0

[1] Not available as a percent of wages or covered earnings but only as a flat amount given in the law (Australia, Great Britain, Iceland, Ireland, New Zealand) or in regulations of health insurance fund (Denmark, Norway).
[2] See appropriate item in explanations of chart entries.
[3] Not available because health insurance contribution cannot be separated from unified contribution; distribution of cost shown for combined programs, except for Chile.
[4] No cash benefit in Panama; none in Paraguay in 1949.

Explanation of Chart Entries

Australia: Australian medical benefits include a comprehensive tuberculosis program as well as public-ward hospital care and certain prescribed medicines. The National Health Service Act (No. 81 of 1948, December 21) provides a basis for partial payment of doctors' fees from Commonwealth funds; it had not been put into effect by November 1950. All social security benefits are paid from the National Welfare Fund, which consists of the receipts from an earmarked income tax and a payroll tax of 2.5 percent. The Government is responsible for meeting any deficit. In 1948–49 the earmarked tax produced 82 percent and the payroll tax 18 percent of current receipts (other than interest). (Statistical data from Proceedings of Parliament on 1948–49 Budget, quoted in reports of U. S. Department of State, 1949.)

Austria: The Government pays the contributions of unemployed workers. The rate shown is that for the Vienna Territorial Sick Fund; slight variations exist among the health insurance societies.

Belgium: Wage earners and salaried employees have different cash benefit (and contribution) rates; the wage earners' system is shown. Most provisions are the same for both groups. In financing, the Government contributions have actually been higher than the legally specified amount of 16 percent of the combined employer and employee payments. In 1949 the Government allocation was fixed in the budget at 31 percent of total health insurance expenditures. It consisted of—in addition to 605 million francs for the regular share—700 million francs to make up a deficit from earlier years, 390 million francs for payment of contributions of unemployed workers, and 16.5 million francs to reduce the price of sanatorium and other institutional treatment. (M. W. Leen, "Le Statut Financier de La Sécurité Sociale en Belgique," *Public Finance*, Amsterdam, No. 3, 1950, pp. 457–496.)

Brazil: Commercial, public utility, bank, transport, and maritime workers receive medical benefits under the social insurance programs. Workers in industry currently receive only cash benefits under social insurance; but in urban areas they receive medi-

cal and other benefits through special employer contributions under employer-managed social services. Maternity care and medicines are not generally available through either program. The date shown for Brazil's first law is that for commercial workers. The industrial system was enacted a year later, but some of the smaller programs began earlier.

Bulgaria: The cash benefit shown, as well as the duration of medical care, varies according to the insured person's continuous service in the same establishment.

Chile: The wage earners' system is shown; provisions for salaried employees are much more limited. In the wage earners' system, maternity care for the wife of the insured worker and pediatric services for infants and children under age 3 are provided as benefits; otherwise an additional voluntary contribution is required to cover dependents. The cash benefit for a worker with dependents is 100 percent of earnings the first week, 50 percent the second, and 25 percent thereafter. The rate shown is for persons without dependents. The distribution of costs shown in the chart is for health insurance and the Preventive Medicine Act combined.

Colombia: The program is not now operating in all parts of the country. The cash benefit is 67 percent of wages for the first 120 days and 50 percent of wages thereafter.

Costa Rica: The program is not now operating in all parts of the country.

Czechoslovakia: The total Government contribution for all social insurance programs is approximately 10 percent of the total contributions (or about 2 percent of earnings). Information on the proportion allotted for health insurance is not available. The Government meets the cost of hospital care. Cash benefit varies inversely with the income of the insured worker.

Denmark: Active membership in health insurance societies, with entitlement for benefits, is not required by law, but approximately 85 percent of the population is insured against sickness. Inactive membership, with nominal charges, is required by law and is a prerequisite for old-age pensions. The distribution of cost is shown for 1947–48 (*Socialt Tidsskrift,* Copenhagen, Nov.–Dec. 1949, pp. 337–376).

Dominican Republic: Maternity care for the wife of the insured worker and pediatric services for infants up to 8 months of age are the only services provided to dependents.

Ecuador: The cash benefit is reduced after 4 weeks to 40 percent of earnings.

France: The cash benefit is increased to two-thirds of earnings after the thirty-first day. In cases of extended illness of a curable nature, the full cost of medical care is reimbursed, as compared with 80 percent reimbursement for short-term illness; the qualifying period for extended illness benefit is somewhat longer than that shown on the chart for short-term illness.

Germany: The provisions for Western Germany are shown; they are substantially the same in Eastern Germany.

Great Britain: The British National Health Service (service benefits only) is financed on an annual appropriation basis. Revenues in the fiscal year 1949–50, exclusive of service charges, recoveries, superannuation contributions, and certain miscellaneous income, were derived from the following sources: Government contribution out of general revenues, 90 percent; contribution from the National Insurance Fund, 10 percent. Cash sickness benefits in Great Britain are paid from the National Insurance Fund, which is also responsible for unemployment, maternity, retirement, and survivor benefits. The Fund is built up in the main from contributions by insured persons, employers, and the Government. The contribution rates are flat weekly amounts, established by statute, and vary with the worker's sex, age and employment status. Of the contributions paid on behalf of an employed male adult, the employee pays 44 percent; the employer, 36 percent; and the Government, 20 percent. (For health service costs, see the *Social Security Bulletin,* June 1950, pp. 14–15.)

Greece: The program is not now operating in all parts of the country. Cash benefit is adjusted inversely with the income of the insured worker.

Iceland: The law of 1946 provides for a complete health service by the Social Security Institution. This has not as yet been achieved, and the national and municipal governments still support hospital and other costs. In 1948 the combined expenditures of the Social Security Institution, health insurance societies, and the national and municipal treasuries for all public medical services provided under the 1946 law were distributed as follows: insured, 35 percent; employers, 15 percent; government, 50 percent (U. S. Department of State report).

Ireland: Optical, medical, and surgical appliances are provided. The distribution of costs is shown for the calendar year 1948. (Department of Social Welfare, *White Paper Containing Government Proposals for Social Security,* Dublin, Oct. 1949, appendix C, table I.)

Italy: The system for workers in industry is shown (workers in commerce and certain other groups have similar but not identical programs). Italy also has a tuberculosis insurance system with broad coverage providing cash and medical benefits, including hospital and convalescent care. The contribution for tuberculosis insurance (paid by the employer) is 2.5 percent of wages and salaries paid, plus small flat-rate amounts specified in earlier legislation.

Japan: The Government contribution toward administration, 1949–50, was about 1 percent of expected employer-employee contributions. In addition to the program shown, which is compulsory only for persons in firms with five or more employees, Japan has a widespread system of health insurance societies in which membership may be made compulsory at the option of the local community. This program provides medical benefits only, either directly or through partial reimbursement of fees paid.

Luxembourg: The wage earners' system is shown. There is a small Government contribution toward the costs of administration.

Mexico: The program is not now operating in all parts of the country.

The Netherlands: Cash and medical benefits are separately administered. The former program was established in 1929; the latter in 1941. The date shown is that of the amending and promulgating of a 1913 law that had not previously been made operative.

New Zealand: The regular payment of 7s. 6d. for a visit to a general practitioner was available (with no additional payment) for specialist services until April 1950, when specialist services were provided. Health benefits and cash sickness benefits are paid out of the general Social Security Fund. The Fund's principal revenue sources are a tax of 7½ percent on the gross income of individuals and on the net income of business firms and a contribution from the Government to keep the Fund in balance. In 1948–49 these sources contributed the following shares to the Fund's income: tax on individual income, 56 percent; tax

on business firm income, 10 percent; Government contribution, 34 percent. (Social Security Department, *The Growth and Development of Social Security in New Zealand*, Wellington, 1950, pp. 161–162.)

Norway: Special provisions are included for tuberculosis, cancer, and polyarthritis—2 years' hospitalization and cash benefit, as against a maximum of 1 year in each instance for other sickness.

Panama: The program is not now operating in all parts of the country. There is no cash benefit except for maternity. The contribution rate shown is that indicated for health, maternity, and funeral benefits; cost of administration is not included.

Paraguay: The program is not now operating in all parts of the country. Only dependents in low-income families (earning not more than a specified sum) are entitled to medical benefits.

Peru: The program is not now operating in all parts of the country.

Poland: The contribution provisions of the wage-earners' system are shown; other provisions apply equally to salaried employees. Administrative changes were enacted in July 1950: a single Social Insurance Institute, under the Minister of Labor and Social Insurance, and a single Workers' Medical Assistance Office, under the Minister of Health, were created. Cash benefits will be under the former, and medical benefits under the latter.

Portugal: Under Portuguese law, collective contracts usually determine social security provisions. A typical case is shown.

Rumania: Medical benefits are provided as a public service by the Ministry of Health; they are not part of the social insurance system. Contributions are not described in detail in the law of December 31, 1948, and no later information is available. The unified contribution rate (cash benefits only, for pensions, health, and work accidents) was to be 10 percent of earnings.

Spain: A Government contribution is paid for both cash and medical benefits in maternity cases, but not for sickness.

Union of Soviet Socialist Republics: A public medical service exists for all persons. A fee is charged for medicines. Cash benefits vary according to the insured's continuous employment record and other factors. The medical benefits are financed from the Ministry of Health budget; cash benefits are financed from a unified social insurance contribution paid entirely by the employing enterprise and varying with the industry.

Venezuela: The program is not now operating in all parts of the country.

Public Assistance Terms

Public assistance programs, financed from Federal, State, and, in some instances, local funds, provide aid to families or persons on the basis of need and usually also of other eligibility conditions. The programs furnish assistance primarily to families or individuals in their homes, although they may also assist recipients living in boarding or nursing homes or in some types of public or private institutions. The assistance may be in the form of money (cash or check) or vendor payments for goods or services, including payments for medical care. The cost of remedial care may be included in vendor payments for medical care. Public programs providing allowances or benefits to persons on a basis other than need are not considered public assistance. There are four special types of assistance—the State-Federal programs—and the State-local programs of general assistance.

Special Types of Public Assistance

Old-age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled are designated as special types of public assistance because they aid special groups of needy persons. These categories of persons are broadly defined by the assistance titles of the Social Security Act and are specifically defined for each State by State law and administrative regulation.

The data presented in the monthly series are for programs administered under plans approved by the Social Security Administration for Federal financial participation and for similar programs in States in which the only public program for a particular category is administered without Federal funds. The data exclude a few small programs, similar in type, that are financed from State or local funds only but administered concurrently with State-Federal programs.

General Assistance

General assistance is administered and financed by State and/or local governments and is designed to aid individuals and families when their needs are not otherwise met. General assistance is variously called general relief, home relief, direct relief, indigent aid, and so on. The term excludes programs that are limited to special groups, such as statutory veterans' relief or foster-family care for children, but it may include programs limiting eligibility on the basis of employability. Since the unifying influence of Federal participation is lacking in general assistance, variations in State and local practices affect the comparability of such data even more than they affect data for the special types of assistance.

Recipients

Data on recipients of old-age assistance, aid to the blind, and aid to the permanently and totally disabled represent the number of persons to whom or on whose behalf payments are made for a specified month. Data on recipients of aid to dependent children are shown in terms of (a) the number of children on whose behalf payments of this type of aid are made, (b) the number of families in which these children are living, and (c) the number of recipients, which includes the children and one parent or other adult relative in families in which the requirements of at least one such adult are considered in determining the amount of assistance. In some cases the needs of more than one parent may be included in the budget for families receiving aid to dependent children, but not more than one adult is counted as a recipient in each family.

Under general assistance, recipients represent the number of cases receiving assistance. The unit of count follows the administrative practice of the agency. Thus two families in a single household may be regarded as a single case by one agency and as two cases by another agency. The number of general assistance cases is increased in some States by the practice of supplementing payments of the

(*Continued on page 29*)