pended for blind recipients, and that for aid to dependent children and for general assistance was somewhat less.

Tenth Anniversary

The tenth anniversary of the signing of the Social Security Act received widespread attention throughout the country and was officially recognized by the Governors of a number of States. Several cited the progress made in their States in caring for the needy aged and blind and dependent children, the bulwark provided by the unemployment reserve funds against the risks of unemployment, and the protection afforded the State's insured workers and their survivors under old-age and survivors insurance. At the same time they called attention to the number of workers without protection under the insurance programs.

Governor Davis of Louisiana proclaimed August 12–19 as "Louisiana Social Security Week," declaring that "social security has become an effective force in the prevention and relief of misfortunes that come when earnings are cut off by unemployment, old age, blindness or death, and when children are deprived of care or support." He urged all citizens of the State "to acquaint themselves with the social security programs by attending local meetings on this subject during 'Social Security Week'."

In New Mexico, Governor Dempsey also called for special observance of the tenth anniversary and proclaimed the week of August 12 as "Social Security Week." He compared social security's "quiet but consistent battle against old age, ill health and unemployment" with the battle our soldiers were then waging "on world battle fronts for the American way of life," declaring that "In both these battles, victory is in sight."

Governor Williams of South Carolina commended the "achievements" of the social security program in South Carolina and said that it was his "hope and belief" that the future accomplishments would be even greater. Both Governor Williams and Governor Arnall of Georgia advocated allocation of Federal funds to the States for public assistance on the basis of the State's financial ability.

The New Zealand Social Security Program

By Jacob Fisher*

NEW ZEALAND'S social security program embodies the far-reaching objectives of universal protection against the hazard of income loss and the provision of medical care as a community service comparable to public education in availability and financing. Its achievements and shortcomings both hold many lessons for other countries.

The New Zealand Social Security Act became law in 1938. The cash benefits provided were for the most part already in existence, however, and the health benefits represented an extension of the principle of governmental responsibility for the citizen's health expressed in the public hospital system and in Dominion-aided maternal and child health services, which have undoubtedly contributed to giving New Zealand one of the best health records in the world.

Old-age pensions date from 1898, widows' pensions from 1911, Maori War pensions from 1912, and miners' pensions from 1915. Blind pensions have been paid since 1924, children's allowances since 1926. A program of unemployment relief was enacted in 1930 and one of invalidity pensions (absorbing the blind pension program) in 1936. In the variety of risks covered, the scale of benefits, income-exemption features, and underlying philosophy, the cash benefits established by the 1938 act derive largely from this long history of governmental effort in the field of family security.

The health benefits departed more radically from existing practice, but many of the elements were not entirely unfamiliar. Before 1938 most New Zealanders went to private practitioners for medical care, but about one-fifth of the population was enrolled in friendly societies providing such care on a prepaid basis. Four out of five hospital beds were in public hospitals, under local management and supported largely out of local levies and Government subsidy, and out-patient departments functioned on a far larger scale than we have known in this country. Nine out of ten babies were born in hospitals. State aid provided half the income of the Plunket Society, active since 1907 in the field of infant and maternal health. Free health services in the school system were well developed by 1938; a health examination program had been instituted in 1912, dental treatment for school children in 1919, and a school milk program in 1937.

These precedents made the new program easier of adoption; they in no wise diminish the historic importance of the 1938 act, which reorganized the basis of social security financing, brought together in one comprehensive system the separate cash benefit programs, covered additional risks, liberalized benefit amounts and qualifying conditions for benefit, and established a health benefits program under which hospital and home medical care were to be made available to all persons irrespective of income.

Cash Benefits

The cash benefits part of the New Zealand program is best understood as an effort to put a floor under family income. This objective explains the universality of its coverage of risks and of population, use of an income test in determining eligibility, and relationship between the benefit scale and the level of the minimum wage.

Except for a vestigial program under local authorities, there is no public assistance program in the American or British sense of that term. The cash benefits system displays some characteristics usually associated with public assistance, other aspects, with social insurance. On the occurrence of specified risks, the system pays benefits at specified rates varied by risk, by number of dependents, and to some extent by the beneficiary's age and physical condition. With some exceptions, however, eligibility does not require evidence of attachment to the labor force. Benefit amounts are not related to previous earnings and are reduced or denied altogether to persons whose income from other sources exceeds the in-

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come-maintenance minimum. Benefits are adjusted to income, fixed amounts of income are exempted in the calculation of the benefit, and the poor-law concept of relatives' responsibility is completely absent.

The Social Security Act accounts for all but a small section of the Dominion's social insurance cash benefits. Work-connected injuries (except for permanent disabilities acquired by miners) are covered by the workmen's compensation program, administered by the courts. The Secretary for War Pensions has charge of benefits to veterans, members of the merchant marine, and their dependents and survivors. Programs for the retirement of aged or permanently disabled government workers and for benefits to their survivors are under the auspices of Dominion and local governments.

Eligibility Conditions

Occurrence of the risk, income, and property ownership are the principal conditions governing eligibility for benefit. The name of the benefit suggests the character of the risk which qualifies a person for the particular benefit.

Superannuation benefit.—Attainment of age 65.

Age benefit.—Attainment of age 60.

Invalids' benefit.—Attainment of age 16, not qualified for an age benefit, totally blind, or permanently incapacitated for work as the result of an accident (not covered by workmen's compensation), illness, or a congenital defect.

Widows' benefit.—Widowed with one or more children under age 16 (or under 18 if at school); or has had children and had been married at least 15 years at the time of husband's death; or was at least 50 years old at husband's death and had been married 5 years; other specified combinations of age and number of years married. For benefit purposes, deserted wives and wives of men in mental institutions are considered widows if they have one or more children under 16 in their care.

Orphans' benefit.—Full orphan, under age 16 (or under 18 if at school).

Family benefit.—Available to all families with one or more children under age 16 (under 18 if at school) and with a weekly income of not more than 105s. (110s. since October 1, 1944).[1]

Sickness benefit.—Over age 16, temporarily incapacitated for work through sickness or accident (not covered by workmen's compensation), and suffering loss of earnings.

Unemployment benefit.—Over age 16, unemployed, available for work.

Miners' benefit.—Permanently and seriously incapacitated for work by pneumoconiosis contracted while employed as a miner, or permanently and totally incapacitated for work because of other diseases associated with the occupation; employment as a miner in New Zealand for 2½ years.

Maori War benefit.—Active service in any of the Maori wars.

Emergency benefit.—According to circumstances.

Some of these benefit types need explanation. The superannuation benefit is intended to absorb by 1970 most of the beneficiaries of the age benefit. It differs from the latter in disregarding other income, in the qualifying age, and in the benefit rate. The benefit was set at £10 a year in 1940, with provision for an annual increase of £2 10s. until the maximum of £84 10s. is reached in 1970, when both superannuation and age benefits are to be equal in amount. Miners' benefits and Maori War benefits differ from the others in requiring prior attachment to a particular industry or type of military service and in the lack of income qualifications. Their inclusion in the 1938 act is largely for historic reasons. The emergency benefit program is in a sense New Zealand's residual program, comparable to the general assistance program in this country. It accounts, however, for a far smaller proportion of social security expenditures, which may be taken as a commentary on the differences between the two countries in the scope of protection afforded by their respective systems.

There are no income qualifications for superannuation, miners', and Maori War benefits. In the other eight programs, nonbenefit income is taken into account in determining eligibility and establishing the benefit amount. A person who qualifies for benefit on the basis of the occurrence of a particular risk receives the full benefit if his income is below a specified amount, which we would term exempt income.

Exempt income in the age, widows', and invalids' benefits ranges from 30 to more than 100 percent of the benefit. The amount is discretionary in the sickness and unemployment program (table 1). When income exceeds the standard, the benefit is reduced by the amount of the excess; when income from other sources equals the sum of the benefit amount and exempt income, the applicant becomes ineligible.

For eligibility and benefit computation, the income must be currently available, not anticipated or imputed. The income of persons in the immediate family group—wife, husband, dependent children—is taken into account, but there is no assumption that other relatives should contribute. An applicant living with relatives who supply room or board or both will enter this fact on his application form, and the Social Security Department will credit him with the money value of the contribution (usually put at a low figure); but if the applicant states that the relatives are not providing room or board, or have been but cannot continue to do so, no inquiry is ordinarily made. Similarly, money contributions from relatives are credited as income received, but only if such contributions are actually made.

Property qualifications for benefit follow the income-requirement pattern in disregarding the value of property below a specified amount and in reducing the benefit, on the basis of a fixed scale, for property owned in excess of this amount, ineligibility being established when the value of the property reduces the benefit to zero.

Benefits to the aged, to widows at age 60 with no dependent children, and to invalids are reduced £1 a year for each £10 of property owned in excess of £500, exclusive of the value of home and furniture, interest on land or mortgages on land, or interest in any annuity or unmatured life insurance policy. The value of the accumulated property of a married applicant is the equivalent of half the combined properties of husband and wife. Discretionary reductions for property ownership may be made in the sickness, unemployment, orphans', and emergency benefit programs.

[1] The exchange rate for the New Zealand £ was $3.06 in 1940 and has been fixed at $3.24 since 1943. There are 20 shillings in the £ and 12 pence in the shilling. All monetary references in the article are to New Zealand currency, since the amounts of cash benefits and of exempt income are appropriately related to New Zealand wage levels and living costs rather than to American dollars.

In the treatment of both property and income the New Zealand program implies an intent to conserve the beneficiary's equity in resources needed for current living or for which some future use may reasonably be anticipated.

Income Levels Under the Program

The statutory rates of benefit and of exempt income are given in table 1. The benefit and exempt-income scales guarantee, in effect, a minimum income (the benefit rate) to all beneficiary groups, varied primarily by size and to some extent by risk (benefit amounts tend to fall into two broad groups—long-term benefits and short-term benefits), but the scales allow the total income of beneficiary groups to rise from about one-third to more than twice the benefit amount.

Since the principal purpose of New Zealand cash benefits is to sustain at least a minimum family income, it may be of some interest to indicate briefly the relation between the income level of beneficiaries and that of wage earners' families.

In March 1943, age, widows', and invalids' benefits averaged about one-fourth the average earnings of male production employees in manufacturing, and about three-eighths the minimum wage for male adult workers, fixed by the Arbitration Court "at a rate which will in the opinion of the court be sufficient to maintain a man, wife, and three children in a fair and reasonable standard of comfort."

This comparison does not, however, take into account the possession of nonbenefit income. Examination of the benefit and exempt-income scales suggests that, for families with four and five beneficiaries and with no other income, the benefit scale permits a standard of living from two-thirds to three-fourths of that purchasable by the minimum wage for adult males but about half that available to the families of men with average factory earnings. When other income is available, the scales of exempt income permit a total family income equal to the minimum wage for male adult workers and from two-thirds to three-fourths of the average wage in manufacturing.

During the war, the benefit and exempt-income rates were increased several times to compensate for the rise in living costs and to further the long-range objective of liberalizing the social security program.

Relation of Beneficiaries to Population at Risk

With broad risk and population coverage and relatively liberal income qualifications, New Zealand may be expected to show a rather high proportion of beneficiaries among persons experiencing a given risk.

In March 1944, three out of every four persons in New Zealand aged 60 or over were receiving either age or superannuation benefit. Probably more than half the widows under 60 were on the widows' benefit rolls. Data on the number of child survivor beneficiaries are lacking but, if it can be assumed that there was an average of one child beneficiary for every two widows receiving benefits, the proportion of children receiving benefits

Table 1.—*Cash benefit rates, income limitations, average benefit, and number of beneficiaries, as of March 31, 1944*

Benefit	Weekly rate	Exempt income	Maximum income permitted beneficiary	Average weekly benefit	Number of beneficiaries
	s. d.	s. d.	s. d.	s. d.	
Superannuation	[1] 6 9	[2]	[2]	6 9	49,289
Age				31 10	102,530
Nonmarried	32 6	20 0	52 6		
Married persons, both eligible	65 0	20 0	85 0		
Married persons, spouse ineligible	[3] 43 0	42 0	85 0		
Each child under 16	[4] 10 6				
Family group maximum	100 0	52 6	152 6		
Invalids' [5]				34 2	12,126
Male, with dependents	32 6	30 0	62 6		
Wife	10 6				
Each child	10 6				
Married woman	32 6	40 0	72 6		
Under 21, unmarried	22 6	20 0	42 6		
21 or over, no dependents	32 6	20 0	52 6		
Family group maximum	100 0	30 0	130 6		
Widows'				34 10	10,836
With children under 16	30 0	30 0	60 0		
Each child	10 6				
Without children	25 0	20 0	45 0		
Family group maximum	100 0	30 0	130 0		
Orphans'	[6] 15 9	0	15 9	20 6	412
Family				25 5	15,950
Each child under 16	7 6				
Family group maximum	[7]	105 0	[2]		
Miners'				36 3	795
Miner	32 6	[2]	[2]		
Wife	10 6				
Each child under 16	10 6				
Widow [8]	20 0	[2]	[2]		
Family group maximum	100 0	[9] 40 0	[9] 140 0		
Sickness				[10]	4,446
Age 16–20, no dependents	10 6	[4]	[4]		
Others	20 0	[4]	[4]		
Wife	15 0				
Each child	10 6				
Family group maximum	[11] 80 0	[4]	[12] 80 0		
Unemployment				[10]	292
Age 16–20, no dependents	10 6	[4]	[4]		
Others	20 0	[4]	[4]		
Wife	15 0				
Each child	10 6				
Family group maximum	80 0	[4]	80 0		
Maori War	32 6	[2]	[2]	32 6	1
Emergency	[13]	[4]	[4]	[10]	1,915

[1] Annual rate in effect Mar. 31, 1944, was £17 10s. This rate is increased annually by £2 10s.

[2] No income qualification for benefit or fixed limit on total income.

[3] Allowance of 10s. 6d. for ineligible spouse is discretionary. If allowance is not paid, allowable income may rise to 52s. 6d. Note that the maximum permissible income is the same as when spouse is eligible.

[4] Discretionary with Department.

[5] Totally blind beneficiaries may earn up to 60s. with no reduction in benefit. In addition the benefit will be subsidized to the extent of 25 percent of earnings, provided that total income does not exceed 92s. 6d., exclusive of benefit payable on behalf of wife or children. If beneficiary is a married woman and nursing or housekeeping service is necessary, allowable income may rise to 70s. at discretion of the Department.

[6] Maximum, actual rate fixed by Department in relation to other income.

[7] No maximum on number of children for whom benefit may be granted.

[8] If miner died while in receipt of benefit.

[9] No limitation on either exempt or total income so far as benefit of miner, wife, or widow is concerned; if income (other than benefit) exceeds £2 a week, however, amount of benefit payable for children is reducible by £1 for each £1 of excess.

[10] Not available.

[11] May not exceed actual loss of earnings.

[12] May rise to 100s. if applicant is a member of a friendly society or like society.

[13] Discretionary with Department, but is usually as nearly as possible equal that payable for the type of benefit for which the applicant most nearly qualifies.

Sources: Annual report of the Social Security Department, 1943–44; statutes and regulations as amended.

as survivors may be estimated at a minimum of four in ten. At least one-third of all full orphans in New Zealand were in receipt of orphans' benefit. About 12 percent of all children under the age of 16 were being aided by the family benefit program.

Administration

The Social Security Department is the operating agency for all 11 cash benefits. The Department's chief local officer is the registrar, under whom are district agents located in the smaller towns. In 1943 there were 19 registrars in as many major cities, and 29 district agents.

Application for benefit is made on a designated form, which may be sworn to before the registrar or the district agent or other authorized officer of the Department, or, in more sparsely populated areas, before a justice of the peace, notary public, member of the legislature, solicitor, clergyman, clerk of court, postmaster, or constable. If submission in person at the local office is not convenient, the application may be mailed to the district office.

The local officer verifies by interview and correspondence the information contained in the application. If there is a reference to wage or salary income, he sends the employer an inquiry form requesting a statement of earnings. Ownership of real property is checked with the district office of the Land and Deeds Department.

When the required information is at hand, he forwards the application and the forms and other materials bearing on eligibility to the chief officer in Wellington together with his recommendation.

Discrepancies observed in Wellington in the application are referred to the local officer for explanation. The incidence of such cases is said to be small and willful misrepresentation negligible. There is a severe penalty for false statements, but of even greater importance are the wide knowledge local officers are supposed to have of the circumstances of beneficiaries, the cooperation inspired by the relatively generous provisions for income exemption, and the liberal spirit in which the program is construed by the Department.

Qualifying conditions relating to age, marital status, number of children, loss of earnings, income, property, and residence are established largely on the basis of the application statement and inquiries made by local officers. Other conditions of eligibility involve other procedures. An application for sickness benefit must be supported by a certificate from a registered medical practitioner chosen by the applicant. If there is any doubt as to incapacity, the Department may request another physician to review the certification. Medical certification for invalids' or miners' benefit is made by a physician designated by the Department. An unemployment beneficiary must register with the National Service Department (before the war, with the State Placement Service of the Labor Department) and maintain eligibility by renewing his registration periodically. Supervision of the latter requirement is facilitated by the fact that in some of the smaller towns the Social Security Department represents the National Service Department; in other places the two Departments work in close cooperation. No benefit is paid until the placement officer has certified that the beneficiary has renewed his registration.

All decisions on the granting of benefit are made in Wellington, although in the more urgent situations, principally unemployment and sickness, the local officer can authorize a grant in advance of review by the central office.

When application for a grant is approved, the beneficiary receives a benefit certificate, which sets forth the particulars of the benefit, including name, amount, period of validity, and office at which benefits will be paid. Recertification is made annually for long-term benefits, more frequently for short-term benefits.

On the due date the beneficiary presents his certificate at the local social security office or, in small towns or villages, at the nearest post office and, on satisfying the officer of his identity, receives the benefit in cash. The date of the payment is entered on the certificate, which is then returned. A beneficiary who cannot call in person for his benefit may ask that an agent be appointed to receive payment on his behalf.

If there is any change in status affecting the benefit amount, the benefit certificate must be forwarded to the Department, where it is amended or canceled as circumstances dictate; if not canceled, it is returned to the beneficiary. When the last installment covered by the period of validity is paid, the paying officer retains the certificate, and a new certificate is issued by the local registrar if eligibility status has not changed.

Benefit is discontinued when nonbenefit income exceeds the sum of the benefit rate plus exempt income, when the value of the property owned exceeds specified limits, or when any of the qualifying conditions related to the risk (unemployment, disability, widowhood, and so on) disappear.

Health Benefits

The major aim of the health benefits, in the words of the Director-General of Health, "is in effect to ensure that in the treatment of the sick the economic circumstances of the individual patient will cease to be a consideration either from the viewpoint of patients or of those actually rendering the services."[2] Individuals are free to continue making their own arrangements, but it was expected that the great majority, as in the field of education, would use the tax-supported public service. All residents of New Zealand are entitled to the health benefits, and eligibility is not conditional, as in most of the cash benefits, on an income test.

It should be made clear at the outset that, with some exceptions, the health benefits are not health services rendered directly by the Department of Health, the administrative agency. They represent, rather, provision for payment for specified services offered by medical practitioners (including nurses, radiologists, and masseurs), pharmacists, and hospitals under arrangements set forth in law and regulation.

To date, eight classes of benefit have been made available: medical (treatment by a general practitioner), hospital in-patient, hospital out-patient, maternity, pharmaceutical, X-ray, massage (physical therapy), and district nursing.

Medical Benefits

Medical benefits generally include all proper and necessary services of general practitioners except those provided under other benefits (e. g., maternity benefits), services in workmen's compensation cases, treatment of venereal disease in a communicable form, extraction of teeth, administra-

[2] Report of the Director-General of Health, New Zealand, for the year ended 31st March, 1939, p. 11.

tion of an anesthetic to patients of another doctor, and medical examination to obtain a medical certificate. The services of a specialist were originally wholly excluded from benefit; under a 1942 amendment such services were made reimbursable but at the same rate as the general medical benefit under the fee-for-service plan, described below.

Medical benefits are provided under alternative methods of payment—capitation and fee-for-service. A few persons in sparsely settled areas receive the services of a salaried physician under a third arrangement; 16 doctors were providing such general practitioner service at the end of 1943.

Under the capitation method, a person seeking medical service fills out an application form obtainable at any district health office or post office and takes or sends it to the doctor he chooses. If the doctor accepts the patient, he signs the form and mails it to the district medical officer, who issues a medical benefits card to the patient as evidence of his right to treatment and records the patient's name on the doctor's patient list. Monthly the physician receives a statement of additions to and separations from his list. Payment is made monthly at the annual rate of 15s. per patient, plus certain mileage fees.

The doctor is obligated to provide suitable office and waiting-room accommodations, maintain regular office hours, visit patients unable to come to the office, write prescriptions, issue medical certificates for social security purposes, and answer all reasonable inquiries from the medical officer concerning treatment. Both patient and doctor may terminate an agreement by formal notice under procedures established for that purpose.

Most general practitioner services, however, are provided under the fee-for-service plan. This arrangement does not involve any contract with the Health Department, and payment may be made in one of three ways. The physician may bill the Health Department monthly for payment at the Government-established rate per unit of service (uniform for all types of service), submitting forms signed by the patient certifying to the service given; he accepts the Government rate in full payment of the services rendered. The second method differs from the first in that the doctor charges the patient a fee over and above the standard fee payable by the Government, i. e., the Government rate is not accepted in full payment. No doctor has to accept the official fee in full satisfaction of his charge, but, except in special circumstances, he cannot recover by legal process any charge in excess. Under the third method, the doctor bills the patient monthly, as in private practice, charging either the Government rate or a larger fee. In either case, the patient pays the doctor directly and sends the receipt to the post office for a refund at the Government rate. Direct claims on the Social Security Fund by doctors, with or without an additional charge to the patient, are becoming increasingly common because of the simplicity of collection.

The Government rate is 7s. 6d. per visit, whether office or home; it is raised to 12s. 6d. for Sunday or night visits. Though the 7s. 6d. fee is smaller than the 10s. 6d. which the New Zealand Branch of the British Medical Association claims is the customary fee for general practitioner service, the Government regards it as adequate remuneration when bad debts under the old arrangement, and the variety of attendances for which fees are payable, are considered. The doctors' average income has increased substantially under the medical benefit system.

Hospital Benefits

Hospital in-patient.—Hospital benefits are not specifically defined in the act or regulations, and the benefit does not confer any rights to receive hospital treatment. It provides, in effect, that a patient may not be charged for treatment in a public hospital and that payments by the Social Security Fund on behalf of patients in duly licensed private hospitals shall be accepted in partial satisfaction of the expenses for treatment. Treatment includes active medical and surgical services, isolation or physical restraint under medical supervision, and medical observation or examination, including laboratory and X-ray examinations for patients in public hospitals. There is no restriction on the type of hospital used. The benefit applies to treatment in general hospitals, tuberculosis hospitals or sanitariums, hospitals for infectious diseases, mental hospitals, and approved hospital wards in homes for the aged. There is no limitation on the period of hospital stay subject to benefit.

Payment is made directly to the hospital at the rate of 9s. a day (6s. before April 1943). For treatment in State mental hospitals, payment is made annually in a lump sum related to the amounts collected from or on behalf of patients under arrangements in effect before the inauguration of benefits.

Hospital out-patient.—This benefit ensures free care to out-patients of public hospitals for all medical, surgical, or other services except dental treatment, laboratory services for bacteriological or pathological purposes, and services subject to other benefits. Payment, which must be accepted in full satisfaction of charges, is on a lump-sum per annum basis equivalent to 60 percent of the hospital's expenditures for salaries and materials on behalf of out-patients.

Maternity Benefits

Maternity benefits cover care in maternity hospitals under public or private auspices, the services at home of an obstetrical nurse, and physician's services. The maternity benefit is payable for the day or days of labor and for 14 days after the birth of the child. For hospital treatment received before or following that period, hospital benefits may be payable. The patient has free choice of type of service desired, and completion of the service is designated by her signature on the claim for payment submitted to the Health Department by the medical practitioner or hospital. The standard rate of payment to a hospital is £2 5s. for the day or days of labor and 12s. 6d. a day for the following fortnight. If confinement is in a public hospital, an additional fee of £2 is allowed for medical attendance. The physician attending a woman in a private hospital or at her home receives £6 6s. for his service, somewhat less if fewer than five antenatal attendances are rendered, £4 4s. if no antenatal attendance is given. For specified special services he may charge the patient an additional fee. An obstetrical nurse who delivers a woman in her own home receives £2, plus 13s. for each day in which she lives at the patient's home during the succeeding 14 days. Payments must be accepted in full satisfaction of all services, although a private hospital may impose an additional charge on the patient according to a schedule negotiated

with the Department of Health, and an officially recognized obstetrical specialist may charge a reasonable fee in addition to those payable from the Fund.

Other Benefits

Pharmaceutical.—Popularly known as "free medicine," this benefit provides patients with such medicines, drugs, appliances, or materials as are prescribed by a medical practitioner or the out-patient department of a hospital and are included in the Drug Tariff issued by the Department of Health. Prescriptions may be filled by any pharmacist under contract with the Health Department. The patient's signature on the back of the prescription blank constitutes a receipt for the items prescribed. Payment is based on a schedule of prices and rules issued by the Pharmacy Plan Industrial Committee, an official body which controlled prescription prices even before 1939. Bills are submitted semimonthly to the Department by the pharmacist, with the prescriptions that have been filled.

X-ray.—Payment for X-ray diagnostic services by recognized radiologists or by public hospitals is made in accordance with a schedule set up by regulation. Claims are made directly to the Department of Health on a form signed by the patient and certified to by the practitioner recommending the service. If private radiologists charge the patient fees above the standard rate, the fees must be within limits set by the Department and must be posted in the practitioner's office.

Massage.—Massage treatment, which corresponds in general to what we call "physiotherapy," is subject to benefit only if recommended by a medical practitioner. The Social Security Fund will not pay for more than 4 weeks' treatment on a single recommendation. Payment is based on individual contract with the Department of Health, at the rate of 3s. 6d. for each treatment. Any additional fee charged the patient by the masseur cannot be more than 3s. 6d. for each treatment at his office or 7s. elsewhere.

District nursing.—Visiting nurse service, the latest health benefit to be introduced, is still in the course of development. Under the regulations the Social Security Fund reimburses the Health Department, public hospitals, and recognized voluntary associations for salary and other direct costs of nursing service provided by them to patients in their own homes. Conditions of employment and areas of work of district nurses must be approved by the Health Department to make the operating agency eligible for reimbursement. There are approximately 200 visiting nurses in New Zealand, all of whom are expected to be brought within the district nursing program soon.

Relationships With the Medical Profession

It is clear that the health benefit program involves fundamental changes in the distribution of medical care. This factor and the necessity to negotiate arrangements with the suppliers of the services, as well as opposition by the principal physicians' organization to some phases of the program, help explain the piecemeal introduction of the benefits and their incomplete character today, 7 years after the passage of the original act.

The benefits requiring the fewest changes in current practice were the first to be inaugurated: care in mental hospitals (April 1, 1939), the loss in patient fees being covered completely by lump-sum subsidy from the Social Security Fund; maternity benefits (May 15, 1939), providing payment for a well-defined service eminently suited for remuneration on a fee-for-service basis and presenting few administrative problems; hospital in-patient benefits (July 1, 1939), a benefit which met with general approval from public hospitals because it substituted a 6s. per diem payment for each occupied bed for an average per diem income from patient fees of 2s. 8d., amounting to an estimated initial saving of £200,000 per annum to local authorities.

The remaining benefits did not come into effect until 1941, 1942, and 1944, largely because of the refusal of organized physicians to accept the Government's proposals for a general practitioner service, on which some of the supplementary benefits depended. The capitation method of payment for general practitioner service was inaugurated March 1, 1941, but was accepted by only a small group of doctors; hospital benefits for out-patients, on the same day; pharmaceutical benefits, May 5, 1941; X-ray diagnostic services, August 11, 1941; a fee-for-service method of payment for general practitioner service, alternative to the capitation method, November 1, 1941; massage benefits, September 1, 1942; and district nursing, July 1944.

The New Zealand Branch of the British Medical Association particularly disaproved of the "contract basis of service" used in providing general practitioner and maternity benefits. Few doctors responded to the formal offer of contract for maternity benefit made April 1939 by advertisement and circular, although the great majority of private hospitals and obstetrical nurses did. After further negotiations with the BMA, the act was amended in September 1939 to eliminate the individual contract provision as it applied to the services of a general practitioner in maternity cases, and in October a new arrangement came into effect providing for payment to the doctor at a standard rate on certification that service was rendered. Few general practitioners have refused to come in under the new procedure, and the Department of Health publishes their names for the information of the general public.

Controversy also marked the Government's effort to introduce a general practitioner service on a capitation basis. Fewer than 50 of the approximately 800 general practitioners in the Dominion signed up in response to the offer of contract made early in 1941, to be effective March 1. Their reluctance has been attributed partly to objections based on the experience of Great Britain, whose capitation fee was considered insufficient by New Zealand standards. Fear was expressed that the Government's method would lead to excessively large panels, skimping on medical attendance, abuse—that is, excessive demand for service—by the patient, 24-hour a day 7-day a week duty by the doctors, and deterioration of the quality of service because a uniform capitation fee provides no direct financial reward for skill and experience.

Faced with this unyielding attitude, the Government put through an amendment in October 1941 establishing a fee-for-service procedure effective November 1. The BMA instructed its members to charge their regular fee, leaving to patients the responsibility of obtaining by refund the Government-fixed fee; in other words, to ignore as far as possible the health benefit program. (They cannot

shut it out altogether, of course, since the doctor who charges the patient the full fee is legally obliged to give his patient a receipt enabling the latter to collect the statutory refund.) The large majority of New Zealand physicians in subsequent months undertook to provide service on a fee-for-service basis, but the particular method of charging proposed by the BMA has not proved popular. Patients resent being billed when the Government is supposed to pay all doctor charges, and they object to being required to make application for refunds. According to recent reports, more and more doctors are obtaining their payments directly from the Fund.

There is some evidence that physicians are increasingly dissatisfied with the negative position of the BMA. Experience in operation of the plan, the intense interest displayed in all English-speaking countries in the Beveridge report, the acceptance by the British Government in its White Paper of the principle of a universal "free" medical service, and the willingness of the BMA in Great Britain to discuss the details of such a service with the Government have all contributed to the growth of opinion favoring cooperation with the New Zealand Government in its health program objectives.

Few difficulties, on the other hand, were experienced in developing contractual relationships with other groups furnishing medical services. Local hospital boards welcomed the hospital benefit for the financial security it provided. Private hospitals, with very few exceptions, are maternity hospitals; by the end of the first year of the program all but 3 of the 189 private maternity hospitals in the Dominion had contracts with the Department of Health to supply maternity benefits. Of the 201 under contract on March 31, 1943, 31 accepted the social security fee in full payment of the service rendered, 139 were permitted to make an additional charge to the patient, and 31 had the right to charge the patient for accommodations not covered under the contract. Almost every obstetrical nurse and registered masseur is under contract to provide maternity and massage benefits, and by March 1943 all but 5 of the 558 retail pharmacists in the Dominion were participating. All visiting nurses, as noted, are expected to participate in the district nursing plan at an early date.

Relative Success in Attaining Goals

To what extent has the health program achieved its objective—elimination of ability to pay as a factor in the distribution of medical care?

A completely satisfactory answer is not possible because information is lacking on the total volume of medical care in New Zealand and its relative distribution among the several income classes. For some fields of service it is possible to strike a balance, because the relevant data are at hand. Inspection of recent annual figures on births and on the number of maternity benefits paid suggests that very few babies are born outside the maternity benefit program. All patients in public hospitals and all patients in private hospitals other than purely convalescent homes receive the hospital benefit. Since March 1941, all treatment in out-patient departments of public hospitals has been without direct charge.

The extent to which the general practitioner, pharmaceutical, X-ray, massage, and district nursing benefits cover total expenditures for these services is more difficult to judge. At the end of March 1943 only 5 percent of the population was under the capitation system for general practitioner service. The fee-for-service system accounted for 82 percent of expenditures for general practitioner benefits in 1942–43. If the BMA is correct in its claim that 10s. 6d. is the usual fee for a general practitioner service, then the cost to the Social Security Fund, which averaged 7s. 7d. per service in that year, meant that the Fund covered about 70 percent of the cost of general practitioner services rendered under the health benefit program. This proportion may be an understatement, since all doctors do not charge the patient an extra fee.

There are no published clues to the relative place of the other benefits in total expenditures for the specified service. As mentioned, however, the suppliers of pharmaceutical and massage benefits represent all but a negligible proportion of the pharmacists and masseurs in the country.

For the year ending March 31, 1944, per capita expenditures for all health benefits were £2 18s. 1d., distributed among the several benefits as follows: hospital (including out-patient), £1 6s. 6d.; general practitioner, 14s. 4d.; pharmaceutical, 9s. 4d.; maternity, 6s. 3d.; X-ray, 1s. 4d.; massage, 4d.

Financing the Social Security Program

Source of Funds

Expenditures are financed on a pay-as-you-go basis from a 5-percent income tax on individuals and business firms and a universal social security registration fee, supplemented by a deficiency grant from the general funds of the Dominion Government. The Land and Income Tax Department collects the income tax and registration fee.

Social security charge.—The 5-percent income tax, known as the social security charge, is deducted at the source in the case of wages or salary and is payable quarterly for other income. The income taxed is gross income, with no exemptions or deductions for dependents. For self-employed persons and companies, however, the taxable income is net income; the law and regulations permit deduction of necessary business expenditures, depreciation, and business losses. Not liable for the charge are cash benefits under the social security program, war-service pensions, workmen's compensation, pay received by members of the armed forces, and payments from other specified sources.

The burden of the deduction from wages or salary, maintenance of records, and payment is on the employer. Neither the Social Security Department nor the Land and Income Tax Department keeps records of taxes paid on the earnings of particular individuals; benefit eligibility is not conditioned on the payment of the tax. Employers' records are subject to inspection, however, and the Social Security Department may, at its discretion, refuse to make a grant or allow a reduced amount if default is made in payment.

For income other than wages or salary, all persons except totally disabled 1914–18 war pensioners, and all firms, must make an annual declaration in May for the year ended the preceding March.

Registration fee.—The registration fee is a head tax for which all persons 16 years and over, with some exceptions, are liable. The fee is 5s. a year for women and for men aged 16 to 20, and 5s. per quarter for all men over age 20. On reaching age 16, all persons must register, usually at the local post office, and obtain a registration fee coupon book. The fee may be

Table 2.—*Receipts of the New Zealand Social Security Fund, by source, fiscal years 1939–40 through 1943–44* [1]

Source	1939–40	1940–41	1941–42	1942–43	1943–44
	Amount				
Total	£11,367,117	£13,967,823	£14,687,682	£16,013,640	£17,492,084
Social security charge	8,860,920	10,109,577	10,432,314	11,624,046	12,796,108
Wages and salaries	5,540,643	6,174,092	6,488,691	7,548,391	8,561,578
Company income	658,373	1,107,338	1,282,500	1,403,475	[2]
Other	2,661,904	2,828,147	2,661,123	2,672,180	[2]
Registration fee	635,440	604,179	605,222	540,921	551,064
Transfers from Consolidated (general) Fund	1,809,367	3,200,000	3,600,000	3,800,000	4,100,000
Penalties and miscellaneous	61,390	54,067	50,146	48,673	44,912
	Percentage distribution				
Total	100.0	100.0	100.0	100.0	100.0
Social security charge	78.0	72.4	71.1	72.6	73.2
Wages and salaries	48.7	44.2	44.2	47.1	48.9
Company income	5.8	7.9	8.7	8.8	[2]
Other	23.4	20.2	18.1	16.7	[2]
Registration fee	5.6	4.3	4.1	3.4	3.2
Transfers from Consolidated (general) Fund	15.9	22.9	24.5	23.7	23.4
Penalties and miscellaneous	.5	.4	.3	.3	.3

[1] For fiscal years ended Mar. 31. Excludes balance carried over from previous year.
[2] Not available separately.

Source: Annual reports of the Social Security Department.

paid at the post office, and the receipted stub of the coupon constitutes proof of payment. Coupon books are in general renewable every 5 years.

Income of the Social Security Fund

In 1938 the Government estimated that the cost of the program would be divided more or less equally between general revenues and the receipts of the two earmarked taxes. A contribution of as much as 50 percent from general revenues has not been necessary, however, because the yield of the income tax exceeded the Government's expectations. About £7 out of every £10 of Fund revenue in the fiscal years 1940–41 to 1943–44 came from income tax, a little more than £2 from general revenues, and the balance from the registration fee and miscellaneous sources (table 2).

Fund receipts increased approximately 54 percent between 1939–40 and 1943–44. Since the contribution from general revenues is in the nature of a deficiency appropriation, this rise reflects in part a growth in expenditures. The income-tax yield rose 44 percent, roughly corresponding to the rise in aggregate private income under the impact of the war. The Government contribution more than doubled.

Social security taxes play a relatively large role in the Dominion's total tax program. In 1939–40, receipts from the 5-percent income charge and the registration fee accounted for 18 percent of tax collections of both the National Government and local authorities. This ratio declined to 12 percent in 1943–44 because of the more pronounced growth in other tax revenues during the war.

Expenditures of the Social Security Fund

Expenditures under the social security program increased 63 percent between 1939–40 and 1943–44 (table 3). Some of the increase was due to the introduction of superannuation benefits in 1940, extension of the family benefit program to the second child in a family in 1940 and to the first child in 1941, and several increases since 1939 in the scale of most cash benefits. The most important single factor, however, has been the health benefit program, outlays for which quadrupled between 1939–40 and 1943–44.

In 1943–44, cash benefits took 70 percent of all expenditures, health benefits 27 percent, and administration 3 percent. Almost three-fourths of all cash benefit expenditures went to the aged (table 4). Among the health benefits, expenditures for hospital benefits bulked largest and were almost twice the total spent for general practitioner services (table 5).

Social security expenditures accounted for 15 percent of all Dominion Government outlays in 1939–40 but declined to 8 percent in 1942–43 because of heavy spending for war. The proportion which cash benefits represented of aggregate private income remained relatively stable, however. In the first 4 years of the program, cash benefits constituted between 4 and 5 percent of all private income received in the Dominion.

The Significance of the New Zealand Program

Many countries have ventured as far as New Zealand in the quest for social security; very few have produced results quite so challenging. In rejecting as unnecessary and inequitable the division of the population into classes—one to be aided by social insurance and one by public assistance—it avoided at the outset many troublesome questions raised by the differences in treatment inherent in such a division. It has demonstrated that universality of risk and of population coverage is administratively feasible; its experience thus far indicates that the cost need not be an excessive burden on the national economy. This universality has been achieved by going

Table 3.—*Expenditures of the Social Security Fund, fiscal years 1939–40 through 1943–44*

Year ended March 31	Total	Cash benefits	Health service benefits	Administration
	Amount			
1939–40	£10,843,217	£9,337,243	£1,056,699	£449,275
1940–41	12,624,284	10,405,460	1,776,685	442,139
1941–42	13,531,289	10,703,239	2,435,588	392,462
1942–43	15,950,674	11,711,465	3,721,179	518,030
1943–44	17,633,746	12,397,773	4,726,680	509,293
	Percentage distribution			
1939–40	100.0	86.1	9.7	4.1
1940–41	100.0	82.4	14.1	3.5
1941–42	100.0	79.1	18.0	2.9
1942–43	100.0	73.4	23.3	3.2
1943–44	100.0	70.3	26.8	2.9

Source: Annual reports of the Social Security Department.

beyond the employment relationship as a basis for both contributions and benefits. The citizen's income is the measure for his contribution; his requirements are the measure for his benefit.

The scale for cash benefits is built around essential needs and guarantees a minimum income to families with interrupted earnings. The absence of any effort to impute income where none exists and the exemption of significant amounts of income serve to remove the income test from many unpleasant associations which the means test carries in public assistance. Benefits are fixed by statute on the reasonable assumption that the normal requirements of families at the minimum level are sufficiently known to permit standardized money payments to meet them, an approach facilitated by the availability of health benefits. The income-exemption feature encourages beneficiary families to raise their standard of living beyond that set by the benefit rate alone. Since both benefit rates and income exemptions are standardized, the administration of the program is simple and public understanding and cooperation are facilitated.

The health benefits assure the availability of diagnostic and treatment services (within the limits fixed by their implementation to date) to persons in need of medical care. The benefits are sufficient to meet the ordinary run of medical hazards in everyday life; persons are free to purchase additional services if they wish. The program has been criticized for limiting its objective to the more effective distribution of existing facilities and services, leaving untouched the problems of the quantity and quality of medical care rendered, the coordination of hospital facilities, the integration of practitioner and hospital services, and the state of medical education and research. There is general agreement, however, that measurable progress has been made in solving the problem of the distribution of medical care despite the disagreements between the Government and the Medical Association and the special problems arising from inauguration of these benefits during the war.

The smallness of the country, the relative homogeneity of its population, the absence of regional variations in living standards, and the lack of large differences in the distribution of wealth account no doubt for some of the simplicity and directness of the New Zealand social security program. No little credit is due its people, however, for their boldness in attacking systematically and imaginatively the social and economic problems common to all industrial nations.

Table 4.—*Expenditures for cash benefits, by type of benefit, fiscal years 1939–40 through 1943–44*

Benefit	1939–40	1940–41	1941–42	1942–43	1943–44
	Amount				
Total	£9,337,243	£10,405,460	£10,703,239	£11,711,465	£12,397,773
Superannuation		240,336	445,686	603,124	778,758
Age	6,517,899	7,101,346	7,190,694	7,783,084	8,101,668
Widows'	785,952	836,368	844,928	866,597	949,099
Orphans'	14,880	17,713	18,275	20,628	22,442
Family	252,562	411,811	539,183	790,719	876,858
Invalids'	942,196	999,648	1,011,375	1,036,373	1,067,409
Miners'	92,653	88,656	83,258	80,100	76,652
Maori War	1,103	744	440	190	119
Unemployment	434,497	299,161	138,528	49,639	32,316
Sickness	208,790	279,581	304,154	362,088	376,878
Emergency	86,711	130,096	126,718	118,923	115,574
	Percentage distribution				
Total	100.0	100.0	100.0	100.0	100.0
Superannuation		2.3	4.2	5.1	6.3
Age	69.8	68.2	67.2	66.5	65.3
Widows'	8.4	8.0	7.9	7.4	7.7
Orphans'	.2	.2	.2	.2	.2
Family	2.7	4.0	5.0	6.8	7.1
Invalids'	10.1	9.6	9.4	8.8	8.6
Miners'	1.0	.9	.8	.7	.6
Maori War	(1)	(1)	(1)	(1)	(1)
Unemployment	4.7	2.9	1.3	.4	.3
Sickness	2.2	2.7	2.8	3.1	3.0
Emergency	.9	1.3	1.2	1.0	.9

[1] Less than 0.05 percent. Source: Annual reports of the Social Security Department.

Table 5.—*Expenditures for health service benefits, by type of benefit, fiscal years 1939–40 through 1943–44*

Year	Total	Hospital	Medical	Maternity	Pharmaceutical	Supplementary
	Amount					
1939–40	£1,056,699	£772,886	(1)	£283,813	(1)	(1)
1940–41	1,776,685	1,257,688	(1)	518,997	(1)	(1)
1941–42	2,435,588	1,372,405	£205,673	549,850	£279,698	£27,962
1942–43	3,721,179	1,539,282	1,016,032	505,219	563,247	97,399
1943–44	4,726,680	2,133,389	1,179,331	513,939	762,198	137,823
	Percentage distribution					
1939–40	100.0	73.1	(1)	26.9	(1)	(1)
1940–41	100.0	70.8	(1)	29.2	(1)	(1)
1941–42	100.0	56.3	8.4	22.6	11.5	1.1
1942–43	100.0	41.4	27.3	13.6	15.1	2.6
1943–44	100.0	45.1	25.0	10.9	16.1	2.9

[1] Not in effect. Source: Annual reports of the Social Security Department.

Table 6.—*Expenditures for health service benefits, by type of service, fiscal year 1943–44*

Service	Amount
Total	£4,726,680
Maternity benefits	513,938
Hospitals	334,639
Medical practitioners	167,272
Obstetrical nurses	12,027
General practitioner services	1,179,331
Capitation method	55,610
Fee-for-service method	1,026,073
Special arrangements	37,256
Mileage	60,392
Hospital benefits	2,133,389
Public hospitals	1,536,558
Private hospitals	238,772
Mental hospitals and other State hospitals	238,014
Other institutions	43,908
Out-patient benefits	73,137
Other	3,000
Pharmaceutical benefits	762,198
Chemists and medical practitioners	722,172
Institutions	40,026
Supplementary benefits	137,823
X-ray diagnostic service	109,426
Massage	27,331
Other	1,066

Source: Parliamentary Paper B-7 (Pt. I), Estimates of Expenditure, pp. 151, 152.