in all States, special Federal aid for public assistance should be provided on an objective basis to States with low economic and fiscal capacity. Similarly, Federal and State funds should be apportioned among localities within States in relation to their needs and, where the localities participate in financing, also in relation to their fiscal ability.

The present structure of public aid suffers from two other major weaknesses—lack of Federal participation in general assistance and practical limitations on the use of Federal funds to provide medical care.

General assistance varies far more widely among and within States than the special types of public assistance and is wholly lacking in areas in several States. Needy individuals who are ineligible for the special types of public assistance or for social insurance benefits, or whose assistance or insurance payments fall short of meeting their needs, may receive general assistance in some States and localities but not in others. Federal participation in general assistance would contribute to the development of a flexible and comprehensive program of general assistance, an indispensable element in the social security program.

Federal matching of medical expenses of recipients of the special types of public assistance, under the present provisions of the Social Security Act, may be obtained only if such costs are included in the amount of the assistance payment. Such use of Federal funds in providing medical care is greatly limited by the nature of medical needs—which are usually irregular, unpredictable, and extremely costly—by inadequacy of funds for public assistance and limitations on the amounts of assistance payments, and by observance of the principle of unrestricted money payments. The Social Security Board has recommended that use of Federal funds be authorized to share costs of medical care given to persons on the assistance rolls under agreements between the State assistance agency and hospitals, medical practitioners, and health agencies.

In the future, much of the need now met through public assistance will be obviated by the development of social insurance. At least during the next decade, however, and perhaps for the next generation, public assistance will continue to be a major segment of the social security program in the United States. Just as the first 10 years of public assistance under the Social Security Act have been characterized by dynamic and progressive change, so it may be hoped that in the future legislators and administrators will take the action required to improve and adapt the public assistance programs to meet existing need effectively.

Developments in Other Countries

THE DECADE that has passed since the Social Security Act was adopted in the United States saw a rapid expansion of social security measures throughout the world. When the act was under consideration by Congress in the spring of 1935, Great Britain and almost every country of Europe had one or more social insurance programs providing protection against the risks of old age, death, invalidity, sickness, or—less frequently—unemployment. Outside the European area the most comprehensive nation-wide social insurance system was that established by Chile in 1924, with effective health and invalidity insurance for all manual workers—including agricultural and domestic workers—and retirement funds covering all white-collar groups. Uruguay had extended old-age, invalidity, and survivors' insurance to industry and commerce. Japan had compulsory health insurance for a substantial number of persons employed in large establishments. A number of non-European countries, particularly the British nations, had noncontributory old-age and invalid pensions, while work or relief programs were widely used as emergency measures for the unemployed. In general, however, except in Europe, the need for permanent and broad social insurance programs had not yet been extensively recognized in legislation.

In the 10 years since 1935, important social security laws have been adopted in almost every country in the Western Hemisphere, in New Zealand and Australia, and also in Europe. The most important of these are summarized below.

European Developments

In Europe as in Great Britain the world saw in 1935 the example of well-established social insurance systems emerging successfully from an economic depression whose effects they had helped to mitigate. In spite of war and the threat of war which overshadowed most of the decade, there was some expansion in the years following 1935. Norway introduced national old-age pensions by law of 1936 and adopted a national unemployment insurance act in 1938. The Constitution of the U. S. S. R., adopted in 1936, affirmed the right of the citizen to social security, and Russia has substantially enlarged its social security coverage and expenditure since that time. In July 1944, striking increases were made in Russia's former family allowance law of 1936, and benefits became payable on behalf of the third and succeeding children. Finland enacted legislation in 1937 for compulsory old-age and invalidity insurance to cover all residents of the country. Rumania in 1938 increased social insurance coverage, extended medical benefits, and introduced retirement and survivors' insurance. In Hungary, following legislation of 1938 and 1939, old-age insurance for agricultural workers went into operation in 1940. Changes in the Italian system in 1939 increased contributions and coverage, added survivors' insurance, raised unemployment insurance benefits, and expanded maternity insurance. Spain adopted compulsory health insurance in 1942.

When war came, social insurance was continued but was no longer a primary concern of the European governments. Moreover, many of the social security changes became symptomatic of pathological social conditions. Such were the racial and party provisions in Germany and the German-controlled countries.[1] Germany also set up a "New International Labor Office," which had its own "New International Labor Review."

Social insurance did not disappear among the European belligerents.

[1] See also Erna Magnus, "Social Insurance in Nazi-Controlled Countries," *Political Science Quarterly*, Vol. 7, No. 9 (September 1944), pp. 388–419.

With full employment resulting from war activities, the contributory systems geared to pay rolls had high incomes and most of them increased their benefits to offset higher living costs. In some countries social insurance was a casualty of total war; although it was not eliminated it was distorted to fit the aims of a totalitarian society. Yet, on the whole, social security survived the perversion of totalitarianism better than most social institutions.

The end of active hostilities has seen a number of European countries committed to the development of greatly strengthened social insurance systems. Belgium, by Legislative Orders of December 1944 and later measures, has introduced general compulsory social insurance, with special programs for seamen and miners. The result has been to increase old-age pensions and family allowances, make health insurance compulsory instead of voluntary, provide a single contribution for all benefits, and pay unemployment benefits while planning the establishment of a compulsory unemployment insurance system. In the Netherlands an Unemployment Insurance Fund was established in 1944 to cover persons employed in commerce and industry.

In France a beginning has been made in social insurance reform by Orders of December 1944, which increase employer and worker contributions to offset the deficits of the war years, particularly in old-age insurance. France has also made social insurance applicable to workers who were deported to Germany and to persons who gave up their work to avoid forced labor in Germany or in France.

The Czechoslovakian Government-in-exile has developed detailed plans for consolidating the previously existing separate social insurance systems, with the objective of assuring comprehensive protection for the entire working population.

Norway's Government-in-exile planned in 1944 to raise most social insurance benefit rates, promote wider health insurance coverage, provide for general disability insurance, and make extensive use of the unemployment insurance program to offset the effects of short-term unemployment during the reconstruction period.

In Switzerland, following the 1945 report of a federal commission, action on a nation-wide system of old-age and survivors insurance was expected.

From developments such as the above and from the discussions of European delegates to the International Labor Conference and to the United Nations Conference, it is evident that the people and the governments of Europe intend to reconstitute and expand their social insurance systems.

British Commonwealth

Great Britain.—At the time the United States adopted the Social Security Act, Great Britain was taking measures to improve the condition of the long-term unemployed by linking cash public assistance to unemployment insurance in a systematic national program. The Unemployment Act of 1934 laid the foundation, and in 1935 the newly created Unemployment Assistance Board began its work of checking on individual and family resources and making the grants then considered adequate. The resulting discussion of the needs-test principle and procedures undoubtedly played a large part, if not in the findings of Sir William Beveridge, then in the eager public response to his report on social security.

Great Britain has raised its insurance benefits during the war, but its major recent contributions to social security have been the Beveridge report[2] of December 1942 and the Government's proposals embodying the major features of the program outlined in that report. "The main feature of the Plan for Social Security," Sir William Beveridge wrote, "is a scheme of social insurance against interruption and destruction of earning power—and for special expenditure arising at birth, marriage or death. . . . In combination with national assistance and voluntary insurance as subsidiary methods, the aim of the Plan for Social Security is to make want under any circumstances unnecessary." This aim was to be achieved through a system of flat benefits related to minimum family requirements.

The British Government has undertaken by degrees to write the essential features of this new comprehensive program of social security into the law of the land. The Government program includes acceptance of Beveridge's assumptions that full employment, family allowances, and medical care for all will accompany social insurance. A system of cash family allowances, payable to families regardless of their income, was adopted in June of this year. Full employment has been officially recognized in a governmental statement of policy[3] on which there has as yet been no legislation. A governmental plan for a national health service for all was issued[4] and is now in process of revision and more specific development in consultation with the British Medical Association and other groups.

On social insurance itself, the Government plan calls for somewhat lower contributions and benefits than those proposed by Beveridge, but the benefits nevertheless are substantial and for aged persons would take effect sooner than the Beveridge report contemplated.[5] Although the general social insurance plan has not as yet been put into a bill, a Ministry of National Insurance has been set up, and the Government's bill for insurance against industrial injuries was introduced in June.

Australia.—In Australia, with its federal system of government, the States have had authority over unemployment benefits, miners' pensions, health services, workmen's compensation, and child welfare services. In 1935, in addition to emergency unemployment measures, there were three Commonwealth programs—noncontributory old-age pensions, invalid pensions, and maternity allowances—all dating back to 1908–12. Recent legislation and plans for the postwar period call for more adequate social security on a national basis, either by direct programs or (as in the health plan) through Commonwealth grants to States. The insurance principle appeared in the comprehensive National Health and Pensions Insurance

[2] See "Social Security for Great Britain—A Review of the Beveridge Report," *Social Security Bulletin*, Vol. 6, No. 1 (January 1943), pp. 3–30.

[3] "The British White Paper on Employment Policy," *Social Security Bulletin*, Vol. 7, No. 9 (September 1944), pp. 20–22.

[4] "A National Health Service: The British White Paper," *Social Security Bulletin*, Vol. 7, No. 3 (March 1944), pp. 12–18; also August 1944, pp. 11–15.

[5] "A Social Security Plan for Great Britain: The Government's White Paper," *Social Security Bulletin*, Vol. 7, No. 11 (November 1944), pp. 27–35.

Act of 1938, but this program was not brought into operation. Instead, planning in recent years has concentrated on social security benefits financed by general taxation and restricted generally—though not in case of family allowances and maternity benefits—to persons of limited means.

The child endowment program of 1941 now pays 7s. 6d. (about $1.25) weekly for each child except the first. It is financed mainly by a tax on employers of 2.5 percent of pay rolls which exceed £20 weekly. The income-tax exemption for children after the first has been revoked.

A National Welfare Fund was established in 1943, to receive £30 million annually from individual income-tax revenue or one-fourth of the total revenue from individual income taxes, whichever is less. First charged with the cost of maternity benefits, for which there is no means test, and the funeral costs of old-age and invalid pensioners, the Fund, it is planned, will after the war finance cash benefits for unemployment and sickness, as well as a national health and drug service and the costs of a system of public employment offices. Legislation on unemployment and cash sickness benefits to be paid from the Welfare Fund to persons of limited means was adopted in April 1944. The date for commencing the programs—originally left open—was subsequently set for July 1, 1945. The first step in the national health service was enactment of the Pharmaceutical Benefits Act of 1944, to take effect when proclaimed. Medicines and drugs will be provided to all residents of the Commonwealth, the pharmacists to be compensated by the Government from the National Welfare Fund.

Canada.—Canada also has had to adapt its social insurance programs to a federal system of government. Its first attempt at unemployment insurance, the Employment and Social Insurance Act of 1935, foundered on the rock of unconstitutionality, in the form of decisions by the Canadian Supreme Court and the Privy Council of Great Britain. Upon the request of Canada's Senate and House of Commons, unanimously supported by the Provinces, the British Parliament then amended the British North America Act in 1940, to give the Dominion Government exclusive jurisdiction over unemployment insurance. The Canadian Parliament adopted unemployment insurance in the same year. By an executive agreement of 1942 between the Canadian and United States Governments, State unemployment compensation agencies and the Canadian insurance institution act as agents for each other in the payment of unemployment benefits to workers having rights under the Canadian or the United States insurance system but residing in the other country. As a result of abnormal wartime employment, actual amounts paid under these arrangements have as yet been very small.

To date, the unemployment insurance system is the only national social insurance program in Canada. The Dominion-Provincial noncontributory old-age pension systems, which are supported mainly by Federal grants and provide pensions to persons aged 70 or over, after investigation of income, were liberalized in 1943 and 1944.

Meantime, a number of studies of social services have been made at the National and Provincial levels by public bodies and private investigators. A comprehensive social security plan, the Marsh report, was presented to Parliament in 1943 but was not acted upon. In 1943–44 the Joint Parliamentary Committee on Social Security reviewed the work of the Advisory Committee on Health Insurance, which had been set up in 1942. Plans for a Dominion-Provincial system of medical care have been formulated, but legislative action was postponed until after the recent general election.

The recommendations of the Marsh report for family allowances were broadly followed in the Canadian Child Allowance Act of 1944, effective July 1, 1945. One of the most generous family allowance systems in the world, this program pays from $5 to $8 monthly, according to age, to the parents or guardians of all Canadian children, from the first to the fourth. The amounts are reduced somewhat for the fifth and additional children. It is estimated that approximately 1.3 million families will receive allowances at a total cost of about $250 million annually.

New Zealand.—A high degree of income security for the entire population of New Zealand has been achieved through the Social Security Act of 1938, which welded a number of older scattered programs into a unified whole. The New Zealand social security system represents a considerable departure from the pattern followed or proposed elsewhere, particularly with respect to cash benefits. The medical care benefits of the program—including relatively complete medical, hospital, and laboratory services—are available to the entire population. The cash benefits are paid upon the occurrence of specified risks—old age, invalidity, widowhood or orphanhood, sickness, and unemployment—to individuals whose income is less than a specified amount. To assure the broadest possible protection, emergency benefits are paid in case of hardship to any person not qualifying for other cash payments. The program thus has features that resemble both social insurance and public assistance. While there is a means test of sorts, it is really an income test; an essential part of the program is a fairly generous exemption of independent income in the computation of the benefit, the exemption varying in amount from about one-third to well over the full value of the benefit. Thus the noncontributory old-age pension, or "age benefit," payable at age 60, is £1 12s. 6d. per week (about $5.25 at current exchange rates), and outside income up to £1 weekly is permitted, without any reduction in the benefit; above this exempt amount the benefit is reduced by the amount of any additional income. A superannuation benefit, payable at age 65 without any inquiry as to the recipient's income, is also available, but current payments are small and are scheduled to increase very gradually until they are the same size as the old-age benefit; eventually these superannuation benefits will replace the old-age benefit for all persons at or after age 65.

The social security benefits in New Zealand are financed primarily from income taxes, including 5 percent on wages and salaries, and 5 percent on net company income and net individual income other than wages. In addition, everyone over 16 pays a social security registration fee. A Government contribution from general revenues, which up to the present has amounted to about one-fourth of total disbursements, supplies the re-

mainder of the income for the social security system.

South Africa.—The Union of South Africa adopted an Unemployment Benefit Act in 1937 which has been put into effect in five industries in limited areas, mainly in the Transvaal, where owners and trade-unions have requested or consented to its introduction. Employer-worker committees administer collections and benefits; supervisory and appeals authority rests in the Department of Labour. Workers, employers, and the Government contribute.

Social security planning from 1941 to 1944 led to broad recommendations for cash benefits and medical care. In 1944 the Parliamentary Select Committee on Social Security urged prompt enactment of a social security program providing for higher old-age pensions; invalidity pensions; unemployment benefits; and certain types of aid to dependent children, to be payable to widows and those in similar circumstances and also for children in families receiving old-age, unemployment, and other benefits. Previously recommended schemes of family allowances, cash sickness benefits, and maternity allowances would be deferred, but native Africans not eligible for other benefits would receive small old-age, invalidity, and leper grants. The program would be financed from general revenue, by social security taxes on wages and income, and by the collection of fixed annual sums from certain groups which include agricultural and domestic workers.

The medical service plan was developed in part by the Medical Association of South Africa (1943) and in part by the Government's Commission on National Health Services (1944).[6] The program would be governmentally administered on a regional basis and financed through a special health tax levied on all income groups and supplemented by general revenue. It would establish a national health service providing medical, hospital, and preventive care for all and operating through some 400 health centers staffed by salaried personnel.

Latin America

The countries of Latin America have probably enacted more new social security legislation since 1935 than any other comparable group of nations. In large part, the Latin-American nations have had to gear their progress to the economic realities of modest national income by selecting as a starting point certain types of programs, groups of workers, and geographic zones where social security should first be applied. But the goal of comprehensive protection has been widely recognized in governmental planning and is generally written into the laws themselves.

Argentina has had retirement programs for special occupational groups—public employees, railway workers, bank employees, journalists, and seamen—for a number of years. Since 1943, when a Ministry of Labor and Social Insurance was created, it has moved rapidly toward expansion and unification of the social insurances. In 1944 the administration of all the social insurance Funds was centralized in a new body, the National Social Insurance Institute, with a view to the eventual coordination of the benefit and contribution provisions. That year also saw enactment of old-age, invalidity, and survivors' insurance for commercial employees, effective January 1, 1945. Another law of 1944 adds preventive and curative medical care for workers insured under the retirement systems. Physical examinations and preventive rest, with continuation of salary in case of certain diseases, such as tuberculosis, cardiovascular diseases, and rheumatism, are contemplated. The budget for the new program, which is administered by the National Social Insurance Institute, is to be prepared within 2 years from adoption of the law.

Bolivia set up a Workers' Insurance and Savings Fund in 1935 to administer the systems of compulsory savings and workmen's compensation then operating in the mining industry. The savings are repaid as lump sums in the case of death, old age, invalidity, or prolonged unemployment. In addition to the enactment in 1938 of retirement systems for railway and streetcar workers and for journalists, Bolivia now has under consideration a general social insurance law.

In Brazil, by 1935, "Institutes of Retirement and Survivors' Pensions" had been formed by public law to cover, on a national basis, occupational groups such as seamen (1933), commercial employees (1934), transport and cargo workers (1934), bank workers (1934), and stevedores (1934). An institute for persons employed in industry was set up in 1936. Between the half-dozen Institutes and some 32 Funds for various groups of public utility employees, Brazil has achieved a substantial coverage among nonagricultural workers. Old-age, invalidity, and survivors' insurance is the usual pattern, but industrial workers are protected by cash sickness, invalidity, and survivors' benefits without having old-age insurance. A nutrition service providing low-cost prepared meals and food supplies for insured persons was created in 1940, and a technical commission was formed in 1944 to manage social insurance reserves.

A far-reaching reorientation and expansion of social security in Brazil was set in motion by a decree-law of May 1945 entitled the Organic Law of Social Services of Brazil. This law extends compulsory insurance to the whole employed or income-receiving population over 14 years of age, the system to be guaranteed and administered by the National Government through a new agency, the Institute of Social Services of Brazil. The only groups exempted from the unified program are public employees and military personnel, who will retain their existing systems. Contributions for employed persons will be shared equally by employers, workers, and the State. The new law defines benefits broadly, to include insurance payments and assistance services. Among the benefits to be provided are old-age, invalidity, and survivors' insurance, cash sickness benefit, workmen's compensation, medical and hospital care, and family and child aid in the forms of marriage, prenatal, and infant assistance. Better nutrition, clothing, and housing are also among the forms of social assistance listed. Total benefits (including services and goods) will be related to contributions paid, varying with the size of the family but never amounting to less than 70 percent of the minimum regional wage.

Pending formation of the Institute, an Organizing Commission—which was appointed by the President on May 13—is authorized to supervise the

[6] See "A Health Service Plan for South Africa," *Social Security Bulletin*, Vol. 7, No. 5 (May 1944), pp. 18–21; see also the May 1945 issue, p. 22.

existing Institutes and Funds, draw up in detail the benefit and contribution schedules for the new program, and prepare a plan for investing social insurance reserves. It will also draft a bill for the statutes of the new Institute. The Commission must report on its work in 180 days. Meantime, the Department of Social Security of the National Labor Council is directed to prepare a general balance and inventory of all the properties of the existing Institutes and Funds, as of December 31, 1944, and to bring their accounts up to date.

Chile, a hemisphere pioneer by reason of its 1924 comprehensive Compulsory Social Insurance Act, has planned to use its social insurance funds to raise the general standard of living through programs such as milk pasteurization and low-cost housing, clothing, and food. It has also emphasized the preventive medical functions of social insurance. The Compulsory Insurance Fund, which covers all manual workers and is much the largest social insurance organization in Chile, created its Mother and Child Section in 1936 and extended from 8 months to 2 years the period during which medical care services are available for children of insured workers. More than one-fourth of all Chilean infants are cared for under this program. The Preventive Medicine Law of 1938 provided that all insured workers—manual or white-collar—should have health examinations and that for certain serious causes of disability—tuberculosis, syphilis, and heart disease—the resources of social insurance should be directed to diagnosis, medical attention including rest, and payment of full wages during this rest.

The retirement system for private salaried employees in Chile was strengthened in 1937 by the addition of unemployment insurance and family allowances. Merchant seamen came under the protection of a special insurance fund, created in 1937, to provide health, old-age, invalidity, and survivors' insurance, unemployment benefits, and family allowances; the cash benefits payable from this fund were increased in 1944. A bill drafted in 1941 but not yet acted upon would substantially increase all cash benefits, extend medical care to the family of the insured workers, add unemployment insurance, and in general provide much broader protection for all manual workers.

In Costa Rica the social insurance program, broad in scope under the original act of 1941, now provides health and maternity benefits in the six leading cities. Plans are under consideration for introducing the system of old-age, invalidity, and survivors' insurance contemplated in the law.

The Cuban program of maternity insurance, established by legislation of 1934, is now operating under the law of December 15, 1937, as amended. It makes medical care and cash benefits available to women workers except those in agriculture. Cuban systems of old-age, invalidity, and survivors' insurance for persons in private occupations have been extended to journalists (1935), bank employees (1938), employees throughout the sugar industry (1941), and physicians (1943). A comprehensive plan for social security was issued by the Ministry of Labor in 1944.

Ecuador established a National Insurance Institute in 1935 to supervise the already existing old-age, invalidity, and survivors' insurance system for public employees and bank employees. At the same time it added a new program of sickness, maternity, old-age, invalidity, and survivors' insurance for persons employed in industry and commerce. The Ecuadorean law was revised in 1942 to provide better financing, extend health insurance to public and bank employees, and improve benefits generally.

Mexico promulgated a comprehensive social insurance law in 1943, the program to be put into effect gradually. Operations under the law began in 1944 in the Federal District, where cash and medical benefits are now provided for sickness, maternity, and occupational injuries. The dependents of persons covered by health and maternity insurance receive medical care.

Panama in 1941 adopted old-age, invalidity, health, and maternity insurance for industrial and commercial workers in the cities of Panama and Colón and for Government employees throughout the country. The law was amended to provide more adequate financing in 1943.

Paraguay enacted a social insurance law in 1943 which, as first applied in 1944, provides workers in commerce and industry with medical care for general illness and maternity, in addition to cash payments and medical attention for occupational injuries. Old-age, invalidity, and survivors' insurance are to be introduced later, and eventually coverage will be extended to agricultural and domestic employment and self-employment.

Peru adopted social insurance legislation providing health benefits for manual workers, including agricultural labor, in 1936. This law has resulted in the completion of many hospitals and polyclinics, which under the Peruvian system are regularly developed in new areas in advance of the introduction of the insurance program to these zones.

Uruguay, which had begun in 1919 to establish old-age, invalidity, and survivors' insurance, with dismissal allowances, for persons in private employment, has attained practically complete coverage under its contributory systems. Laws to cover employers, domestic servants, and agricultural workers were enacted in 1941, 1942, and 1943, respectively.

Venezuela adopted in 1940 a program of health and maternity insurance, combined with protection for occupational accidents and diseases, and put the system into operation in the Federal District in 1944. Expansion to four additional provinces has already been advocated by the Central Insurance Institute.

International Developments

More than ever before, the international aspect of social security has come to the front in recent years. The importance of economic and social security to the future peace and welfare of the peoples of the world has been recognized in the Atlantic Charter, in the resolutions of the Pan American Conferences at Lima (1938) and Mexico City (1945), in the recommendations adopted by the Philadelphia Conference of the International Labor Organization (1944), and in the creation by the United Nations Conference at San Francisco of an Economic and Social Council.

In the field of social security proper, the International Labor Organization,

whose original roots were in the European soil where social insurance first germinated, took special notice of the Western World by convening in 1936, at Santiago, Chile, the First Labor Conference of American States which are members of the Organization. This was followed by a second conference at Havana, Cuba, in 1939. Both sessions gave special attention to social insurance as "the most effective means of affording to the workers the security to which they are entitled" (Santiago), and recommended, for each type of insurance, guiding principles developed out of the common experience of the various countries and the pool of knowledge in the hands of the ILO itself. The meetings were important mediums, too, for recording the history of the American nations in their efforts to attain social justice.

In 1940, at the dedication of the workers' hospital at Lima, Peru, representatives of 10 nations and of the ILO and the Pan American Sanitary Bureau formed the Provisional Inter-American Committee on Social Security. Its purpose of promoting the creation of a permanent Inter-American Committee on Social Security was realized at Santiago, Chile, in September 1942. Here the First Inter-American Conference on Social Security set up the statutes of a permanent hemispheric body—the Inter-American Committee on Social Security—and brought about exchange of information resulting in new recommendations on social security. The second meeting of this Committee has just been held in Mexico City, in July 1945.

Meantime, the ILO became a war refugee, with its working center in Montreal instead of Geneva. As a result of this transfer, ILO experts were able during the war to give special aid to the Western Nations and were in an advantageous position to study, interpret, and promote the new social security ideas coming to the front in Latin America, the British Commonwealth, and the United States.

As the war effort of the United Nations gave signs of proceeding to a successful conclusion, the Twenty-Sixth Session of the International Labor Conference was convened and met at Philadelphia from April 20 to May 12, 1944. The two main resolutions on social security adopted at Philadelphia affirm that all persons should be guaranteed—through social insurance and public assistance—income sufficient to free them from want and destitution, and secondly that all should have adequate medical care. A set of guiding principles by which the nations may progressively reach these goals was included in the recommendations adopted by the Conference.

The Philadelphia Conference also unanimously approved certain social objectives—jobs and income security among them—for inclusion in the peace agreements of the United Nations. And in the "Philadelphia Charter" it set forth the social security principles that should govern the ILO and its member nations. Affirming that "poverty anywhere constitutes a danger to prosperity everywhere," the declaration proclaimed that the war against want must be "carried on with unrelenting vigor within each nation and by continuous and concerted international effort."

Summary

The past decade has seen significant and far-reaching changes in the concepts of social security and in public attitudes toward social security. The early pattern of development was generally that of separate social insurance systems established to deal with particular forms of insecurity for selected groups of workers. This pattern persists, in greater or lesser measure, in the social security organizations throughout the world. But in many countries, especially those with a long history of social security operations, steps have already been taken, or plans developed, to consolidate and bring together separate systems and to expand both the risks and the population covered.

It was perhaps natural and inevitable that attention should center first on the separate aspects or types of insecurity which come with industrialization and the growing importance of a money economy. As more and more people came to depend upon wages and earnings from employment, more attention was given to continuity of income during periods when earnings were interrupted or cut off—as by sickness, invalidity, old age, or lack of a suitable job. It has become increasingly evident, however, that what is most important is not just old-age benefits or sickness benefits or unemployment benefits, but security for all workers and all families against income loss due to any of the major economic risks to which they are exposed. Increasingly, in the legislation and the legislative planning of the past 10 years, social security measures have been accepted as one of the major devices for assuring a satisfactory national minimum level of living. As expressed in the Atlantic Charter, in resolutions of the International Labor Conference, and in the world charter of the United Nations, social security has become one of the positive goals of national and international policy.