NATIONAL HEALTH INSURANCE FROM THE WORKERS' STANDPOINT.

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The insured worker is the person most directly concerned in our scheme of Health Insurance. At the age of 16 he is compulsorily brought within its scope, and he continues to be influenced by its provisions until he is 70—altogether for a period of 54 years. In proportion to his means, the demand upon him is a larger contribution than that borne by either of the other partners in the undertaking, and should there be a collapse he will be the chief sufferer.

The main provisions of our Health Insurance system are contained in the National Health Insurance Act, 1911, which is significantly entitled "An Act to provide for insurance against the loss of health and for the prevention and cure of sickness." As the title indicates, the Act was not passed into law merely to enable approved societies to provide "friendly society benefits" for their members. The need for cash benefit payments where the worker is either temporarily or permanently incapacitated for work due to illness was, of course, recognised and provided for, but it did not overshadow the importance which the State attached to the prevention of illness and the cure of disease.

Before proceeding to consider the manner in which the intention of the Act in regard to the prevention and cure of illness has been fulfilled it may be convenient to examine the extent to which the monetary assistance made available by the scheme is availed of. The normal rate of benefit in the case of men is 15s. per week for a period of 26 weeks' illness and 12s. per week in the case of women. After the expiration of 26 weeks of sickness men and women, where incapacity continues beyond that period, are normally entitled to a disablement or invalidity benefit of 7s. 6d. per week. It is estimated that for the year 1927 the cost of sickness and disablement benefit in the Saorstát was in the neighbourhood of £670,000. In addition to this expenditure substantial sums are also distributed under the head of maternity benefit. Twenty-five thousand claims for maternity benefit are paid annually in the Saorstát.

Then there are other benefits which are known as additional benefits, and which are only provided by certain societies, and in any case can be provided by a society only where a surplus has been disclosed on an actuarial valuation of the society's assets. These additional benefits cost in the Saorstát about £50,000 per year. During the sixteen years that the scheme has been in operation the disbursements to insured workers in all Ireland amounts to almost £10,000,000, if we include the direct cash payments, the cost of certification, dental benefit, hospital treatment, grants to nursing institutions, etc.

There is no longer any question as to whether the health insurance scheme is desirable. Public opinion has accepted the scheme as part of our social effort, and those who take an intimate interest in public questions, now relieved from the necessity of rebutting arguments against social insurance, are free to concentrate on methods for its improvement. Before 1912 the trade unions and the friendly societies endeavoured to maintain on a voluntary basis an insurance system for the assistance of workers deprived of their employment through illness, but had the compulsory scheme not been introduced it is doubtful whether they could have carried on. The era of this voluntary effort was passing and young workers were indifferent to its possibilities. The societies were therefore left with older members whose claims were frequent and whose contributions to the common pool were irregular. In any event, under the voluntary system of the trade unions and friendly societies, the large mass of workers most in need of benefit through an insurance system were excluded altogether. While craftsmen and salaried employees could always find voluntary organisations willing to accept them into membership for insurance purposes, the unskilled workers and the low-paid women workers were not sought after and indeed would find it difficult to gain admission to the voluntary funds.

One sometimes hears criticisms of the health insurance scheme because it is alleged to have built up large reserve funds at the expense of the insured workers. This criticism is usually based on a fallacy. In point of fact, the expenditure on cash benefits under the Health Insurance Acts is rapidly increasing. Cash benefits in 1924 cost 20s. per head of the insured population; in 1925 they cost 20s. 8d.; in 1926, 24s.; and it is estimated that in 1927 their cost will be in the neighbourhood of 29s. 9d. per head. As it is difficult to obtain up-to-date figures in a convenient form for all the approved societies, let me illustrate what is happening in regard to benefit expenditure by quoting the figures of the approved society with which I am

most closely connected. The society I refer to must not, however, be taken as typical; its members are in more or less permanent employment and their wages are sufficiently high, speaking generally, to obviate the temptation to draw sickness benefit if they are able to follow their employment. The expenditure of this society in cash benefits during the last six years was as follows:—1922, 12s. 10d. per head of the insured membership; 1923, 15s. 9d. per head; 1924, 14s. 11d. per head; 1925, 17s. 3d. per head; 1926, 21s. 10d. per head; 1927, 23s. 9d. per head. It may, however, be mentioned in passing that as from July, 1926, the rate of benefit was increased by 5s. per week in respect of sickness and 2s. 6d. per week in respect of invalidity, consequent on the report of the actuary on the second valuation of the society. Perhaps it would be convenient if I set out in the form of a cash statement the sources from which the society referred to has derived its income and the manner in which its revenue is disposed of. For that purpose I will take the experience of the year 1924, which is the last date for which authentic figures are available.

CASH STATEMENT.

Receipts.	£	s.	d.	*Expenditure.*	£	s.	d.
Members' Contributions	£5,648	6	4	Cash Benefits ...	£4,769	2	4
State Grants ...	1,796	6	3	Non-Cash Benefits ...	595	7	4
Interest on Reserve Values	798	5	5	Sanatorium Benefit...	407	6	3
Interest on Investments	1,933	16	3	Medical Certification	217	13	9
Arrears Grants ...	124	2	0	Administration Costs	1,632	0	0
				Balance	2,679	6	7
	£10,300	16	3		£10,300	16	3

These figures are significant. For the year 1924 this society, and let me again emphasise that it is not a typical society and not more unfavourably situated than any other society, expended on benefits and administration expenses £2,000 more than the total amount contributed for that year by its members and their employers together. Other societies had been expending considerably more resources on a scheme that is even more favourable to the insured members. I should, however, point out that this cash statement as reproduced is not quite detailed, and I have omitted certain entries on both

sides, but their inclusion would not modify the lesson to be drawn from the figures quoted. Another important point: Of the total income of this society 45·2 per cent. arose from sources other than revenue from insurance stamps surrendered by its members. But as the figures relate to the year 1924, when the cash benefits cost the society only 14s. 11d. per head of its membership, the manner indicates but does not disclose the position for 1927, when the expenditure on cash benefits has increased by over sixty per cent.

In Great Britain a similar problem has arisen. Speaking recently at the annual meeting of a British approved society in London its president uttered the following significant warning: "Those most competent to judge affirm that the continued and increasing drain upon approved societies' funds constitutes the gravest crisis since the inception of the scheme. The causes are various, and it would be impossible to stress the relative value of the many facts contributing to the crisis. . . . The position is serious."

But the matter cannot be passed over in that off-hand fashion. It calls for examination and investigation, and if the position is serious in Great Britain it must be much more serious in the Saorstát. In Great Britain 84 per cent. of the population have been brought within the insurance scheme, while in the Saorstát only 32 per cent. are included. All insurance people will agree that the wider the field covered the less serious is the risk involved. Let me illustrate the relative difference in benefit costs between Great Britain and the Saorstát. For the five years to December, 1922, sickness claims actually dealt with represented 72 per cent. of the actuarial expectations; for the same period the percentage in the Saorstát was 108. Illness amongst women both in Great Britain and in this country seems to have far exceeded the actuarial expectations. For the five years to December, 1922, women's claims paid in Great Britain were 101 per cent. of the claims expected, and in the Saorstát they were 193 per cent. It is, however, amongst domestic servants that the highest sickness experience ratio is discovered. For every 100 claims anticipated the actual amount received from domestic servants in Great Britain was 103 and in the Saorstát 225.

The figures which I have quoted point to the necessity, first, for an early examination of the financial structure of the health insurance scheme, and, secondly, to the need of dealing drastically with the causes of disease and ill-health. The financial provisions of the Act were based on the assumption that each employed contributor would on the average surrender 48

stamps in the year and that the sickness ratio would be 29 per cent. lower than our present experience. Over a number of years the contributions have been less frequent than 48 per annum—at the moment they average about 40 in the Saorstát. At one period the frequency fell as low as 36, and in the case of certain societies the average number of stamps surrendered by insured persons was as low as 22. Generally speaking, the frequency of contributions in Great Britain, even during the period of acute depression, was far higher than in this country, and consequently the revenue of the insurance fund per head of the insured population is higher than it is with us. The low average of contributions which we have experienced suggests that either a large percentage of the insured population is not in regular employment or that employers are not paying their contributions with meticulous regularity. Whatever the cause of the low contribution average may be, we must all realise at once what its ultimate effect on the solvency of the insurance fund is likely to be.

In connection with health insurance there is another problem which is peculiar to the Saorstát and which upsets the calculations of the British actuary upon which the finances of the insurance fund were based. Between 1911 and 1926 the population of the Saorstát decreased at the rate of 3·7 per thousand of the population. No other country in the world except France is losing its population at the same rate as ours. In the last census interval the population of England and Wales increased at the rate of 4·9 per thousand of the population. It is notorious that the majority of our citizens who emigrate are young and healthy, and inferentially the residue that remains for industrial employment in the country are less healthy, and the proportion of the working class population who may be described as being old is higher than it should normally be. These factors must have a lasting influence on the financial resources of the insurance scheme. It is at least possible that if the system is continued unaltered, both in regard to its financial provisions and its methods of administration, the fund will eventually become insolvent.

When taking stock of our health insurance system, while acknowledging and appreciating the many advantages it has conferred on the work-class population, we should not be unmindful of the fact that as a means of preventing disease and curing sickness it has accomplished very little. After sixteen years of insurance administration we still have in the Saorstát 10,000 people treated annually for tuberculosis. Our deaths from tuberculosis are 1·47 per thousand of the population,

against a rate of 0·96 in England and Wales and 0·99 in Scotland. If we could reduce our death-rate of tubercular people to the level now obtaining in England and Wales we would save 1,500 lives every year. And it is even doubtful whether the official figures published from time to time correctly indicate the ravages of tuberculosis. In the year 1926 there were 10.577 deaths, or 25·3 per cent. of the total which were not certified as to their cause and on which no inquests were held. Knowing as we do the reluctance of people in this country to broadcast the fact that there is consumption in their family, the deduction may be reasonably drawn that a certain proportion of the deaths the cause of which were not certified may be attributed to this dread disease.

Although there is substantial expenditure on maternity benefit little progress has been made in the effort to save child life or to prevent the death of child-bearing women. In 1926 there were 115 deaths of mothers due to septic conditions. For every 100,000 children born in the Saorstát in 1926 538 mothers lost their lives owing to diseases or difficulties associated with pregnancy or childbirth. Out of every 10,000 children born in the County Borough of Dublin in 1926 1,274 died before reaching the age of one year. Perhaps the significance of these figures would be more adequately realised if I set out the infantile mortality experience of the five county boroughs in the Saorstát in juxtaposition with the equivalent figures for the leading county boroughs in Great Britain and Northern Ireland.

INFANTILE DEATH-RATE PER THOUSAND BIRTHS IN—

SAORSTAT.		GREAT BRITAIN AND NORTHERN IRELAND.	
Limerick	146	Derry	118
Kilkenny	128	Belfast	112
Dublin	127	Glasgow	104
Cork	122	Edinburgh	80
Waterford	114	London	64

We have all heard at one time or another of the conditions under which people live in the Poplar Union District of London, but we may not all have realised that the death-rate amongst infants in Dublin is 143 per cent. higher than it is in Poplar. If we could reduce our infantile mortality in Dublin to the level experienced in London we should in 1926 have saved 559 lives of infant children.

There is one other point which I should like to direct attention to when considering this matter. In view of the fact that

so many of our young people emigrate and that naturally such a large proportion of the population must therefore be old, it is remarkable that out of every one hundred persons who died in 1926 70 were between the ages of 15 and 50. In an age when so much is being done in every country in the world to save active lives and to increase industrial efficiency it is an exceedingly regrettable fact that 70 per cent. of the citizens of Saorstát Eireann should die off in the period of life when they are most valuable to the country's economic life.

As I have already indicated, it is as much the functions of health insurance properly understood to prevent premature death and by curing disease and illness to increase the nation's wealth as it is to provide cash payments for those deprived of their earning capacity. In fact, every social service should first of all aim at eliminating the wastage arising from sickness, disease, unemployment, accidents and the like and the disbursement of benefit to the victims of these social uncertainties should be regulated to a secondary place. There is a growing need for proper clinical and institutional treatment, especially for incipient cases of tuberculosis and mental and nervous diseases especially amongst the insured population. The sufferers from these diseases are becoming more numerous and the death-rate is increasing. If we are to achieve industrial efficiency more and more care must be bestowed on the health of the people, and the insurance scheme, to which the workers themselves contribute vast sums, affords an excellent opportunity of grappling with the problem. The close association of the workers themselves with the scheme in its administrative machinery is one of its most valuable features. It tends to make better citizens and it gives the people a direct appreciation of its possibilities and of its responsibilities.

In my opinion the outstanding defect in the health insurance scheme as administered in this country is the approved society system. In their efforts to popularise the Act of 1911 the British Government consented to the approval of every type of society willing to administer its benefits. The result has been chaotic. There are in the Saorstát eighty approved societies, some of them with substantial membership spread all over the country and others merely small local societies with less than 100 members, and these sometimes spread over large areas. Each society has its own committee of management and administers the insurance scheme in whatever manner it thinks best without any regard to the policy or methods of any other society. Out of this chaos has arisen waste, inequality and inefficiency.

To turn first of all to the question of inequality. The standard benefit in the case of men is 15s. per week, and normally the insured workers, no matter to what society they belong, are entitled to receive this rate during periods of sickness. But an approved society with a disposable surplus at the end of a valuation period is authorised to provide additional benefits for its members. A society when providing additional benefits is authorised to increase the cash payments or to provide benefit in kind or it may do both.

The members of society "A" may therefore because their society has no disposable surplus, receive only the standard rate of benefit, *i.e.*, 15s. a week for 26 weeks of sickness, but the members of society " B," because their society has a surplus, may receive 20s. a week during a period of 26 weeks' illness. And in addition to the increased cash benefit the members of society "B" may, and in fact do, receive free hospital treatment, including the cost of travelling from their home to the hospital, free dental treatment, free optical treatment, medical and surgical appliances, etc. But both sets of members pay exactly the same rate of contribution, and their employers in both cases pay the same rate. The inequality in the benefit rate may not, and as a rule does not, arise from bad management or mismanagement on the part of a particular society, but arises most frequently from the fact that society "B" has a selected membership, such, for instance, as bank employees, post office employees, railway employees or such like, while society "A" has to recruit its membership amongst the industrial classes where conditions of employment are most unhealthy, where there is considerable unemployment, and where the sickness ratio is heaviest. A society composed wholly or mainly of domestic servants, foundry workers, casual dock labourers, and employees in unhealthy occupations will not in existing circumstances have a surplus in its reserve funds to justify increasing the benefit expenditure; while a society composed of selected workers in healthy and in constant employment must almost inevitably have a surplus. The scheme, however, that permits inequality of this kind cannot seriously be termed a national system of insurance.

Now as to the wastefulness of the approved society system. Eighteen or twenty countries have already inaugurated systems of sickness insurance, but of that number Great Britain was the only country that thought of organising its compulsorily insured workers in voluntary societies administered on a competitive basis. In his evidence before the Royal Commission on Health Insurance in Great Britain, Sir Walter Kinnear, the

Controller of National Insurance in England, admitted that "from the point of view of prevention of sickness, it is difficult to defend a position whereby a man who transfers (from one society to another) has to wait five years in order to get treatment benefit"; but as "there is of course pretty keen competition between the various approved societies," it was the only means that could be devised to prevent a rush of dissatisfied members from a society that was paying only the standard benefit to a society that was providing additional benefits. This is surely chaos. Workers who desire to qualify for hospital treatment, dental treatment or some other treatment benefit, that is, for a benefit that may prevent sickness, are penalised for five years if they transfer to a new society. But this serious step is taken by the State to neutralise one of the effects of competition between approved societies.

In every little town and village in the country there are five, ten or perhaps twenty approved societies operating amongst 300 or 400 insured workers. All of these societies may have not more than three or four members in the town and they may not have another member within a radius of twenty miles of that town. What service beyond the mere payment of benefit can such a society provide for a membership isolated in this way? They render no service in fact of any value so far as the health of the nation is concerned that could not be equally well provided by a tontine society. It is even probable that the old tontine societies with their medical benefits did more useful work from a national health point of view at least amongst the section of the population covered by their activities than is now done by most of the approved societies. One can understand the point of view of those that believe that competition between shopkeepers and manufacturers is a public advantage because it is alleged to keep prices down, but it is extremely difficult to discover any wisdom in a system that encourages eighty organisations in a small area like the Saorstát to compete for the administration of a State Insurance Service. The approved societies are part of the national service, and the money they waste in their competitive enterprises is public money committed to their care for public purposes, and its misuse is a matter of national concern.

Lastly, the society system is inefficient. When we consider that there are eighty approved societies with their eighty staffs and eighty management committees and that they employ hundreds of agents, and that at the offices of the Insurance Commissioners there is again another very large staff, it can hardly be urged that the results expressed in terms of efficiency are

quite satisfactory. There is practically no effort made to stamp out disease, there is no research work, and there is no attempt to educate public opinion in matters of public health. As it is impossible to co-ordinate the work of eighty rival organisations, the service for which 450,000 insured workers are contributing and for which their employers contribute and which is aided by State funds, is haphazard and unrelated. So long as this system continues there cannot be an attack made on the causes of disease and very little can be done to cure illness. The societies must therefore continue to expend their funds on the payment of benefit to relieve the insured people who have already fallen victims to disease. That surely is a memorial of inefficiency.

It has been urged of course that the approved society system is democratic. Anybody who knows even remotely the manner in which the larger approved societies are administered will not be surprised to hear that these big societies have degenerated into sheer bureaucracy. In a statement of evidence before the Royal Commission Sir Walter Kinnear admitted that " in the light of experience we are of opinion that as regards certain large societies the rules do not provide for an adequate degree of control by the members."

In my opinion the health insurance scheme may be made an effective instrument in the work for which it was originally designed on condition that, in the first place, its purpose includes the provision of medical benefits, and, in the second place, that its administration is placed in the hands of a society organised on a territorial basis.

The existing system of medical certification is defective, wasteful and unsatisfactory to everybody. The extension of medical benefit would eliminate medical certification as we understand it, and it would at the same time enable the State to trace health history and grapple with disease, particularly industrial diseases, in a manner hitherto unattempted. The Committee of Enquiry into Health Insurance and Medical Services in the Saorstát have in fact already recommended the extension of medical benefit, and rather suggest they favour a State Medical Service covering the whole population if the necessary financial backing is forthcoming. When the public realise what is at stake there is no doubt the necessary money will be forthcoming for a service with such important implications for the nation and its citizens. In this connection I should like to quote one sentence from a minority report presented by Dr. Rowlette, a member of the Committee of Enquiry. He says: " The demand for an efficient health service stands on

higher grounds than can be expressed in pounds, shillings and pence. If the health of a man is his most important possession so the health of a nation is its most important asset, and the care of that health is one of the first duties of a Government."

The formation of territorial societies would be a further valuable asset in this campaign for a healthy race. It would, apart from the more effective administration of the existing Health Insurance Act, permit the amalgamation of other social services that are closely bound up with health insurance. For instance, it would enable the State to take over the administration of accident insurance and to couple with both the administration of the Unemployment Insurance Acts. It might be even possible to link up old age pensions with these other services and to introduce new ameliorative measures such, for instance, as widows' and orphans' pensions, death benefit and the like. All these benefits can be administered much more cheaply by a State service than they are now administered by private enterprise. A British Government Committee of Enquiry stated that burial insurance is administered by private companies at a cost of 40 per cent. of the premium income and workmen's compensation at a cost of 50 per cent. It was at the same time calculated that under a State scheme the administration of burial insurance would not cost more than 3 per cent. and workmen's compensation 5 per cent. of the premium income.

In the territorial society the element of democratic control could and should be preserved not only in theory but in practice. Its functions naturally would be more comprehensible than those of the approved societies, and there seems no valid reason for withholding from it the functions now exercised by the insurance committees which cost considerable sums of money and render very little value in return. The matter is, however, one for study and discussion, and as the issue at stake has considerable interest for workers, for employers, and for the State no time should be lost in getting to close quarters with it.